Understanding Service Delivery to New and Expectant Fathers by Health and Welfare Professionals

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Certificate of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the dissertation. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this dissertation be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services or nominee, for the care, loan and reproduction of theses.
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Ethics approval

Ethics Approval Number: 2012/047

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Abstract

This dissertation aims to discover the kind of services health and welfare professionals deliver to new and expectant fathers; why new and expectant fathers receive minimum services or are excluded from some services; and to suggest strategies to improve service delivery to them. A grounded theory approach was used to conduct and analyse 35 interviews with new and expectant fathers, their partners, health and welfare professionals and managers in the Richmond-Tweed area of northern NSW, Australia. The analysis suggests that current research and practice is dominated by medical and feminist ontology, both of which exclude fathers from service and engaging in pregnancy, birth and early parenting experiences. Further, it identifies several barriers emanating from cultural constructs and perceptions, work and family contexts, relationships and transitions, both in accessing fathers and in providing support to them. It argues that the best way for health and welfare professionals to improve service delivery to new and expectant fathers is to focus on the whole new and expectant family and accordingly, it suggests some possible strategies. The study has implications for both policy and practice to improve services to new and expectant families.
## Glossary

### Coding and thematic analysis
See (p64) for a detailed explanation of coding and thematic analysis, including open, axial and selective coding as elements of grounded theory.

### Fatherhood
Fatherhood refers to the state of being a father, and of having the qualities or spirit associated with a father. Importantly for this research the ‘journey to fatherhood’ may begin long before children arrive and end long after, if it could be said to end at all. It is perhaps better defined as the ‘journey of fatherhood’ and for this reason, as with any shifting and multifarious form, defies definition.

### Father
The word father in is used in this context as any person who identifies as a father, and is not limited to biological, traditional or any other role. Instead it is applied to any person who acknowledges parental type responsibility for a child.

### Grounded theory
Grounded theory is a systematic qualitative methodology which aims to create theory from the data, rather than testing a theory using data. Data is coded into similar concepts and categories which are used to form a theory. It was developed in the 1960’s by sociologists Barney Glaser and Anselm Strauss (1967) (see p56).

### Health and welfare professional
A health and welfare professional is any person providing a service to a father or their family in a professional role which is intended to aid or support their health or welfare. For the purposes of this study it includes, but is not limited to, nurses, medical doctors, social workers, midwives, case
managers, support workers, advocates, speech therapists, naturopaths, paramedics, educators and service coordinators and managers of health and welfare services.

Metathemes

Metathemes are themes that are consistent throughout the text are referred to here as metathemes, as distinct from the concept of axial themes in grounded theory. They are used to highlight ideas that resisted classification into axial themes as they were present at all levels of coding and in all other themes. They are discussed in Chapter 8.

New and expectant fathers

New and expectant fathers refers to fathers who are experiencing the arrival of any child – be it their first, subsequent, adopted or a result of a blended family – and who identify as new or expectant.

Program

A program is a discrete form in which services are delivered. This may take the form of a series of antenatal class, a self-help group or anger management group. There are usually time limited.

Service Barrier

Service barriers as defined for this research are elements which limit or obstruct fathers accessing or receiving service. They may be located at direct service, management, policy levels of service delivery. See (p138) for examples.

Service delivery

Service delivery is the process by which health and welfare support is provided by health and welfare professionals, usually funded by the state, to fathers and their families. This may take the form of direct
education, medical support, advocacy, welfare payments or any other method of influencing the health and welfare of a father or their family.

**Service Support**

Service supports as defined for this research are elements which enable or sustain fathers accessing or receiving service. They may be located at direct service, management, policy levels of service delivery. See (p163) for examples.

**Services**

Services that may be provided to these fathers are diverse and include, but are not limited to, child protection, income support, counselling, homelessness, social work, midwifery, medical services, parenting education, disability support, housing support and legal support.

**Whole of family approach**

The resultant grounded theory that emerged from the data in this research is referred to as a whole of family approach. This borrows from a number of other existing theories explored in Chapter 2 and from the emergent data. It is explored in Chapter 8.
‘In the absence of professional guidance or research-based information on effective service approaches to fathers, participants appear to rely on their own experiences, biases, and professional concerns in thinking about what constitutes appropriate services for fathers.’

(O'Donnell, et al. 2005)

‘…couples are prone to “figuring it out on the run”, and …they often lack awareness of options and frequently operate from assumptions about men’s and women’s roles and duties.’

(Fletcher 2009)
Chapter 1. Introduction

New fatherhood is a period of personal crisis, which for most men will be the most significant identity change in their adult lives. This period, from conception, to birth and early parenting, is not only of importance for the father, but for his child, family and community. Fathers who complete this transition successfully are able to adapt to their new identity, contribute to their families and communities, providing support for subsequent generations to contribute themselves. Men who are unable to transition may find the widening gap between themselves and their families too difficult to bear, or they may bear this gap with resentment and anger. Either way, the children of these men grow up without the best possible father.

New motherhood is if anything a period of greater crisis and transition, however a period in which more support is available to them than any time in a health adult’s working life. There are entire hospitals, and wings in hospitals all over the country, dedicated to supporting new and expectant mothers. New and expectant mothers are screened for physical and medical health, offered services including maternity services, antenatal and postnatal services, case management, parenting skills and socialisation. These services are necessary for mothers, suggesting that some of them may be necessary for fathers as well.

This research demonstrates that fathers are capable of passing through the new and expectant period without ever coming into contact with a health or welfare professional. No statistics exist on how often this occurs, reflecting the lack of statistics and basic research on how fathers interact with the service system. The primary researcher, as a new and expectant father, and health and welfare professional, experienced the service system in such a way that suggests there is a significant amount of work to do before fathers will receive adequate support from health and welfare professionals, and began this research to address this issue.

The problem

With personal experiences of receiving and providing service, but little literature available and little public debate, the initial research question formed was: ‘How can health and welfare workers improve the service they deliver to new and expectant fathers?’ As demonstrated in the following chapter, there are number of competing
discourses which either attempt to answer or ignore this question. Rather than support one or more of these discourses initially, working from a social work perspective, an emancipatory approach was chosen to guide the initial formulation as described by Alston & Bowles (2003, 12-4). This recognises that research is traditionally a tool of enforcing power, of studying service users rather than practitioners. From this perspective, this research needed to give voice to the fathers in question, something few other studies have done. More than this, emancipatory research aims not only to study the status quo, but to actively change it.

Significance

As will be indicated in the next chapter, the significance of providing or not providing support to fathers may be long lasting and considerable. Most importantly, fathers have the same right to service as any other member of society. Skene (1998, 132) claims that ‘government policy, employment conditions, child-care provisions and the conservative attitudes of professionals, employers and sections of the community’ have prevented fathers from engaging with services. While men in general usually occupy privileged positions, new and expectant fathers are often neglected and excluded from service. This alone is, and should be justification enough for increased attention to this issue. Beyond this, engaged fathers provide support to their partners, children, and other family members and to service providers themselves. New and expectant fathers may be an untapped resource, but more than that they may be people in crisis, who are entitled to support.

Political stance

It should be noted that this is not an attack of the kind described by Flood (2007) or Wilson (2005) on the importance of supporting women’s rights. Pease (2000, 62) has warned that the ‘campaign to identify and treat forms of male victimisation, should not shift attention away from women’s victimisation.’ This paper instead aims to support the rights of men as new and expectant fathers without attempting to impinge on the rights of women.

Aims and objectives

The primary aim of this research is to understand and make recommendations to improve the service provided to new and expectant fathers by health and welfare
professionals. This will attempt to discover the kind of services health and welfare professionals deliver to new and expectant fathers; why new and expectant fathers receive minimum services or are excluded from some services; and to suggest strategies improve service delivery to them. This will be done by generating a grounded theory which will provide a detailed approach for health and welfare workers to apply to their own practice. It will provide a voice for new and expectant fathers, their partners and workers that provide them service. Allowing the participants to direct the flow of the research allows their priorities to dominate, and allows for the feedback loop of grounded theory coding and recoding to operate unheeded.

**Research questions**

In order to initiate the research in a meaningful way, five research questions have been conceptualised to guide the initial interviews. Beyond that point, the emergent themes will dictate later interview questions. The research questions that will guide this research are:

1. How do fathers feel about the service delivery they have received, or are receiving?
2. What service delivery do health and welfare workers feel fathers should receive?
3. What do new and expectant fathers want from service providers?
4. What do health and welfare workers think fathers are being provided with?
5. Do the answers to the above questions fit into the paradigms explored in the literature review, or is an overhaul of the conceptualisation of service delivery to new and expectant fathers required?

These questions form the initial guide for the researcher conducting this study.

**The researcher and the research**

This research is as much about me and my journey as it is about the participants who took part. Much as Ronai (1998) struggled as both a subject of the research and the researcher, this research maps my journey as first a service deliverer, then an expectant father, then a new father, and now a mix of all three.
This underpins the initial motivation for conducting this research. As a service provider, I could see that the service that I was being provided as a father was lacking. It didn’t seem to me that there was any undercurrent of prejudice – quite the opposite - as many workers struggled to better engage fathers. It was only through the lens of both roles that I could see the gaps – fathers I spoke with informally identified the same issues; missing links with other fathers, lacking positive role models, geographical dislocation, an lack of connection with their baby being memorable examples, however they could not see that a service response could potentially address them. My own experience of services providing support where communities failed to do so suggested that services should be doing so in this case – but were not.

What seemed to be lacking was a way to actually do this – a set of rules, a theory to guide workers on how best to go about it. The medical and feminist models were unconcerned with the plight of fathers, and while not always actively excluding them, ultimately ignored them to the point of exclusion. I decided to combine my roles, father, social worker, husband and researcher, to try and find some voices to help me define that theory. Ronai, who was an erotic dancer who researched with other erotic dancers, communicated her struggle with defining multiple identities:

“The meaning of being a researcher or a dancer is not inherently present in itself. These identities exist in the traces of the past and in the context of the unfolding situation as it dissolves into the future. The final meaning of what it means to be a dancer or a researcher is always deferred because there is no absolute starting point from which to triangulate these identities.” (Ronai 1998)

This postmodern stance has guided my interaction with research participants. Looking through my interview transcripts, I often see myself saying, ‘as a father myself, I see this in this way...’ or ‘as a social worker, I don’t see how that...’ I’m defining, and refining my practice, my research, and my parenting as I explore the interactions between systems and people. I’m asking different questions, exploring different lines of thought based on my interpretation of the context.

As with any identity, fatherhood is both common and unique. The ‘absolute starting point from which to triangulate’ the identity, could be traced to the birth of my child, conception, the first ultrasound, or to some indefinite point in my own experience...
of childhood. What makes a father, a worker, or a researcher is as indistinct, common and unique as the individual. As Ronai goes on to say:

Derrida's (1982) non-concept of différance alludes to the idea that meaning exists in reference to other meanings. When pursuing the meaning of a concept, it is understood relative to other meanings, which, in turn, also exist in relation to still more meanings, and so forth into infinity. There is no firm reference point that cannot be deconstructed as existing in relation to something else. (Ronai 1998)

As I struggled to define myself in my roles, as they changed and shifted beneath me, I was pushed and pulled by larger forces; the ethics committee stipulated required changes to my research, funding was cut to my family mental health case management program, my wife backed further away from my dream of being a stay at home dad, replacing it with her own dream of being a stay at home mum (at which she excels). All my set in stone identities became fluid, reformed and deconstructed. I became a perfect postmodernist being; indefinable, released from identity. This, I feel, allowed me to challenge the ‘truth’ about fatherhood and father-inclusive practice.

This multifarious identity has also prevented me from seeing the whole truth, or any of the truths clearly. The spark that began this research came from mediocre service received as a new and expectant father, not from mediocre practice as a social worker. This meant that I identified with the father-inclusive movement, with fathers crying, ‘what about me?’ This approach, born of the masculinist movement, demanded equal rights for fathers. The fathers of grounded theory had foreseen this tendency:

Potential theoretical sensitivity is lost when the sociologist commits himself exclusively to the one specific preconceived theory... He becomes insensitive, or even defensive, towards the kinds of questions that cast doubt on his theory... (Glaser and Strauss 1967, 46)

What was needed was an inclusive approach, a lesson I learned from participants far wiser than me. What I originally saw as internalised discrimination by fathers who had a mother focus, was actually fathers sharing their genuine love for their families. What they taught me, and what father-inclusive advocates need to learn, is that supporting fathers isn’t about supporting fathers at all, but about supporting families.

I could have manipulated the data to justify my original pro-father position, but grounded theory forced me to let the participants speak, and they were clear, that families, not fathers, are who we need to be listening to.
To highlight this personal link I have used photos of my own journey in the research to remind the reader of the influence of my experience on the work. Filmmaker Federico Fellini (1965) claimed that ‘All art is autobiographical; the pearl is the oyster’s autobiography’ and that ‘Even if I set out to make a film about a fillet of sole, it would be about me.’ This is a cyclical influence, as my work crosses over into my parenting, and back again.

The real grounding of this research in a grounded theory sense is in my own experience of service delivery and my own desire to be serviced as part of a family, to be empowered by my service providers and to be valued as a father. This should not deduct from the outcomes or recommendations of the research - this involvement is an understanding and appreciation of the finest elements of the topic and is participant led research at its best – backed by years of academic rigour and a comprehensive understanding of both the literature and the realities of practice.

Dissertation précis

The following chapter, a review of the literature, examines the nature of fatherhood, then addresses the perceived supports and barriers to fathers presented in the literature. The themes of medical and feminist models and their conflict are examined, with an appreciation for the solutions present in practice and those proposed by the literature. While grounded theory would usually require a literature review to be completed after or in parallel with data collection, this can be said to have occurred as the researcher received ‘grounding’ in the field both as a new and expectant father and as a health and welfare professional for some years prior to the beginning of the research.

Grounded theory principles are covered in the third chapter under Methodology, particularly the considerations of abduction, theoretical sampling and reaching saturation point, and the processes used to interact with these elements. A main limitation for this research is the implications on the restrictions placed by the ethics approval process on the natural processes of grounded theory.

The results are divided into four chapters, beginning with the issues associated with accessing fathers. The experience of the research process is used to provide insight
into some of the challenges faced in accessing fathers for service, with experiences of fathers and workers used to provide insight into addressing this challenge.

Chapter 5 examines the underlying perceptions and cultural constructs that inform services delivery – from both fathers’ and workers’ perspectives. This also includes an examination of cultural change over time, with an understanding that changes to service delivery require changes to culture.

The following chapter examines the barriers and supports to providing a service to fathers, considering aspects of services, cultural issues, and a number of other elements. This chapter highlights the major barriers in place, but also that there are supports that can be used to overcome them.

Chapter 7, the final results chapter, looks at gender roles, relationships and transitions for new and expectant fathers and their families. This chapter examines themes usually not considered by health and welfare professionals when providing service, and gives an insight into the personal sphere of the interview participants. At this point, the shift away from father-inclusive practice toward whole of family practice can be seen, as fathers in particular reject a notion of father focus on the grounds that the whole family is having a baby, not just one member.

The penultimate chapter, the discussion, identifies the metathemes present in the results, mapping the emergence of the grounded theory, then examining that approach in practice. A model derived in conjunction with participants of providing service to fathers is presented both as a workable model and as a model of process for engaging participants in the planning of their own services.

The final chapter, the conclusion, summarises the research, presents implications for policy and practice and highlights areas for further research.

Conclusion

This introduction has mapped out this dissertation, justifying and explaining the research topic. Research aims and objectives, and questions have been detailed, with context provided by the researcher regarding the research journey. It has been shown that this research is grounded in personal experience with a good comprehension of inherent bias. The following chapter reviews relevant literature.
Understanding Service Delivery to New and Expectant Fathers by Chris Maylea

Introduction
Chapter 2. Literature review

This review outlines the current environment in providing service to new and expectant fathers, both in Australia and overseas. Beginning with a genealogy of fatherhood and an analysis of the current practice, we will examine the conceptualisation of fathers in the literature, then look at barriers and supports to father engagement. This is followed by an exploration of current initiatives and solutions to build on the work done by others in this field, and finally by a contention that critical social work, and critical social workers, have a significant contribution to make.

Literature in this area is fraught with bias, as McAllister, et al (2012, 63) point out that despite a lack of empirical data collected from and about fathers, ‘is a consensus - and much descriptive evidence - that involving fathers in their children’s lives is a good thing.’ Writers such as Bonson (2004), Coleman and Garfield (2004), Cowan et al. (2009), Featherstone (2003), Flemming (2007, 2004), Fletcher (2009, 2011), Geiger (1996), Lamb (2007, 2010), King (2011, 2005) and Mattock (2012) all assume or argue that fathers are beneficial for their children. This is unsurprising, when considering that the literature that is available is aimed at promoting and justifying father-inclusive practice. There are few, if any, rigorous studies conducted with the aim of justifying the exclusion of fathers. However even when accounting for this pro-father-inclusive practice standpoint, the research is overwhelmingly in favour of the benefits of supporting fathers.

Review parameters

This review includes sources from a range of domestic and international English language authors, most from Western countries, but does not seek to exclude non-Western cultures or considerations of fatherhood. This approach has been taken to include the broadest range of sources from a research area that is still immature in its development, and lacks a broad body of knowledge.

This literature review is aimed at analysing a variety of practice approaches and disciplines in the service they provide to new and expectant fathers. These include social work, medicine, nursing, midwifery and welfare. While the review will be undertaken from a social work perspective, this approach allows research from other disciplines to be incorporated.
Genealogy of fatherhood

Two main themes emerge from a review of the literature – the conflict between the medical and the feminist views of ownership of birth and the resultant infant, and the exclusion of men from this conflict. Medical writers tend to focus on the body as a machine, operating distinctly to the mind, a modernist approach critiqued by Illich and Foucault. Feminists see this approach as taking ownership away from women, identifying it with patriarchal dominance and ultimately with men (van Krieken, et al. 2000, 143-146).

It is suggested in this literature review that fathers are men, and therefore are excluded by the feminist critique, and are largely uneducated in the ways of birth and infant healthcare, and are therefore excluded by the medical establishment. Despite this, both sides agree on the importance of fathers, while simultaneously excluding them. This genealogy explores this dichotomy.

Medical and feminist models

The conflict between the medical and feminist models of health and welfare is not limited to the sphere of the new and expectant family, extending to all aspects of control over a women’s body, from menopause to anorexia and to rape (Murtagh and Hepworth 2003, Birke 1999). Birke (1999, 7) describes how the ‘heart, for example, may be ‘just a pump’ to the transplant surgeon, but has a history of being a repository of emotion in Western culture’. Pease and Camilleri (2001, 1-2) detail the exclusion of men from feminist and social work literature, arguing that this ‘limits the potential for challenging gender injustice.’

The medical model, also known as biomedicine, holds science and the scientific method as the main approach to understanding and curing illness, upholding the Cartesian dualism of the separation of mind and body, resulting in a machinelike paradigm of the body (van Krieken, et al. 2000, 142). Medical practitioners and other medical model workers hold a privileged place in society, defining the legitimacy of health problems and interventions and enjoying legal government recognition to maintain their monopoly (Bessant and Watts 2007, 399). The medical model’s reliance on positivist ontologies renders the feminist, post-positivist ontologies largely void due to lack of positivist evidence.
Feminism is both an intellectual tradition and a social movement, forcing men to accept that women and women’s experiences have been excluded from society (Bessant and Watts 2007, 78). While it is conventional to accept that there are number of different feminist approaches, including liberal, Marxist, radical and post-modernist, this research regards the feminist model of childbirth as being generally informed by a number of different feminisms and does not seek to either challenge or reinforce any particular understanding of this process. It is assumed that a feminist model struggles against patriarchy, gender inequity and inequality, sex-role discrimination or coercive socialisation and identifies the medical model as being a key player in the patriarchal oppression of women and their experiences.

Directly relating to childbirth, Malacrida and Boulton (2012, 749) suggest that women have birth options from the medical to the feminist, from ‘medicalized birth (including planned, non–medically mandated C-sections) to natural birth (optimally conceived of as midwife attended, drug- and intervention-free vaginal delivery at home)’. Miller and Shriver (2012) argue that in the West the medicalisation of pregnancy has disempowered women. This is countered by articles which point to the dramatic drop in maternal and infant mortality rates, linking these drops to ‘performance of health systems, reflecting access to and quality of prenatal and obstetric care...’ (Donati, Senatore and Ronconi 2011). Women who refused obstetric care were found in one study to have ‘a perinatal mortality rate three times higher and a maternal mortality rate about 100 times higher than the statewide rates’ (Kaunitz, et al. 1984).

Other analyses of the approaches to childbirth and rearing include technocratic, humanistic and holistic paradigms (Davis-Floyd 2001). The technocratic paradigm views the body as a machine, loosely corresponding to a medical model, while the humanist views it as an organism, loosely corresponding to the feminist model. The holistic paradigm ‘insists on the oneness of body, mind, and spirit and defines the body as an energy field in constant interaction with other energy fields’ (Davis-Floyd 2001, 5). Virtually all these approaches have a common theme – the exclusion through indifference of the father.
'Father - father [OE] Father is the English representative of a general Indo-European family of words for ‘male parent’. Its ancestor is Indo-European pater, which probably originated (like the words for ‘mother’, and indeed like English daddy and papa and Welsh tad ‘father’) in prearticulate syllables interpreted by proud parents as words. Its multifarious descendants include Greek patēr, Latin pater (whence French père, Italian and Spanish padre – borrowed into English in the 16th century – and English pater, paternal, patriarch, patrician, patriot, and patron), Irish athair, Armenian hayr, German vater, Dutch vader, Swedish and Danish fader, and English father. A less obvious relation is perpetrate [16]; this comes ultimately from Latin perpetrāre, a derivative of the verb patrāre, which originally meant literally ‘perform or accomplish in the capacity of a father’.’ (Ayto 2005, 212)

Figure 1 plots the prevalence of the words ‘father’ and ‘mother’ in English texts between 1800 and 2008. While the word father had higher prevalence up until 1920, the two words maintain a similar level from then on. This reflects the dominance of the father figure, not just in the home but in literature, up until the 1960’s, when it is surpassed by the use of the word mother.

Moving away from the descriptive noun to the verbal noun, the terms ‘motherhood’ and ‘fatherhood’ saw almost no usage in English literature until 1880. The term fatherhood has remained fairly static since then, while motherhood experienced major spikes in use during both world wars, and a resurgence since the 1960’s.

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1 Image courtesy of Google Books Ngram Viewer http://books.google.com/ngrams/info
2 The higher prevalence of the word ‘father’ is not impacted by the clerical use of the word ‘Father’ as search terms are case sensitive.
Figure 2 - Use of the words “fatherhood” and “motherhood” in English 1880-2008

Figure 3 illustrates the potential connection between the feminist movement and the ascent of motherhood.

Figure 3 - Use of the words “feminist” and “motherhood” in English 1960-2008

Fathers and fatherhood have had no such ascendancy or associated emancipatory movement, however they have experienced significant changes over time in attitude if not in prevalence. Closer inspection of the literature over time confirms this – from Emily Clark’s 1817 Tales at the Fire Side:

“I was engaged in writing a letter my mother and sisters working at a little round table and my father reclined in an arm chair before the fire to rest himself after the fatigue of shooting” (Clark 1817)

This fragment portrays the contemporaneous view of the father in the home, as a figure at the head of the household with little interaction with the children. Even as
early as 1866 fathers were portrayed as having an active role in the direct care of babies, as in *Father and Daughter* produced by the Society for Promoting Christian Knowledge:

‘The first word she said was “Dada;” and in all her baby ailments and fretfulness, none could soothe so well as her father. There never was a man who bore so well with loss of rest at such times, or who felt so little the worry of a crying child; and he would walk up and down his bedroom for hours together, on winter nights, clad in painfully light attire; but with his darling warmly cuddled up in her mother’s woollen shawl, and closely pressed to his broad breast, while the little head was snugged down on his shoulder…’ (Society for Promoting Christian Knowledge 1866)

This excerpt shows an evolution in thinking – the father is no longer a remote figure, but critical to the parenting process. Compare it with this quotation, over 50 years later, from Mary Rieder Boardman’s article in *The Rotarian*, November 1920:

“Mother-love has, and always will, play a leading part in family life. A man, as a husband, loves his wife and as a father, his daughter; but it is not the same as the love of a mother. Mother love is true love of service without reward; no sacrifice is too great; it is pleasure for a mother to serve the child she loves... Tho it is the duty of every man to provide for his own, the man who is regarded by his daughter as only the financial asset of the family, is a failure... The average daughter, rightly raised, looks to her father as a model of all men.” (Boardman 1920)

This concept of the distinction between mothering, fathering and parenting persists today – and is clearly articulated in Brenda Geiger’s 1996 *Fathers as Primary Caregivers*:

“Over the past twenty-five years, fathers’ involvement in parenthood has increased... Fathers have been found able to assume caregiving duties with competence and sensitivity to their newborn’s needs... They were as competent as mothers in holding, feeding, cuddling, and talking motherese to their infants... However, fathers’ accessibility to their infants remained limited during the first year of life.” (Geiger 1996)

Note the use of the phrase ‘motherese’ – it can only be concluded that the phrase ‘fatherese’ was considered too outlandish. Figure 4 highlights use of “fatherese” and “motherese”, demonstrating the relative acceptance of these terms.
These passages briefly chart the evolution of fatherhood in English literature over time, combining Ngram data with citations illustrating the changing nature of fatherhood.

Gender roles over time

Morman and Floyd (2006) and Daniel and Taylor (2001, 43) argue that fathers’ roles change significantly over time and place. Mahalik and Morrison (2006, 62) suggest that in cultures that primarily farmed for sustenance, fathers had a very close relationship with their children due to the close relationship between farm work and family life. The Industrial Revolution took fathers out of the home to work, making the breadwinner role distinct from the role of care giver. In colonial America, the father was seen as the primary moral leader, while in eighteenth and nineteenth century Europe, children were seen as the property of their fathers (Morman and Floyd 2006). The middle part of the twentieth century saw the father as breadwinner role gain precedence, as distinct from the dominance of the early twentieth century ‘sex-role father’ alluded to by Boardman (1920) in the above text. In the UK, during the 1980’s and 90’s, the government policy focused on forcing fathers to parent, tying them to their families (T. Miller 2010). In the West in the 1970’s, a new role emerged, one of nurturing and caring. None of these roles achieved supreme dominance and all are still present today, informing current fathering concepts (Mahalik and Morrison 2006, 62). The most poignant implication for this shift in fathers’ roles is that it is socially constructed, and can be socially reconstructed partly with the assistance of health and welfare workers.
Gender roles today

Scholars are intensely interested in separating men from women, and the role of the mother from the role of the father (Stolz, et al. 2010). Furman (2010, 74) suggests that the conceptualisation of men and women as different species, from different planets, although exaggerated, is useful for understanding their cultural differences. He suggests that the traditional view of men is that they are inclined towards externalisation and independence, with women inclined towards internalisation and interdependence.

Contemporary views of men as new and expectant fathers largely recognise that while men have historically occupied a privileged place in society, they have been restricted to a narrow range of family roles, and excluded from others (Goldenberg and Goldenberg 2008, 62). This view has been established as a reaction to feminist critiques of that challenged sexist attitudes which were harmful towards women, adapting these approaches to better challenge sexist attitudes that may be harmful towards men.

Much of what happens in the home between mothers and fathers is informed by social and community expectations. Burgess and Ruxton (in Daniel & Taylor, 2001) suggest three stages of contemporary community expectations of father involvement;

Stage 1. Mothers are seen as necessary to child rearing – fathers only necessary as providers and disciplinarians.

Stage 2. Fathers are seen as valuable supports to mothers, but mothers are infinitely superior, and could do without fathers if necessary.

Stage 3. Fathers are seen as valuable, necessary and well supported to become equal, or equitable, parents. (Daniel and Taylor 2001, 43)

This Stage 3 involvement does nothing to detract from the contribution of the mother – it is a whole of family level of interaction. Many fathers aspire to Stage 3 involvement - 86% of European men and 96% of Australian men think that fathers should be closely involved in child rearing (Fletcher 2009, Burgess and Beardshaw 2005, 51-3). Skene (1998, 129) argued in 1998 that the current norm within families was for an equalisation of gender roles. This suggests that fathers are becoming more interested in engaging with their children, although while attitudes are shifting, practical fathering
may not be – in 2006 residential Australian fathers with children under 15 spent an average of only 8 hours a week with their children – roughly half of what mothers spend (Australian Bureau of Statistics 2008, Fletcher 2009).

![Bar chart showing time per day spent by parents caring for their children](image)

Figure 5 – Time per day spent by parents caring for their children

As Figure 6 demonstrates, fathers of younger children spend more time with their children – on average 34 hours per week, but still less than half as much as mothers. In addition to this, fathers in 2006 spent less time with their children than they did in 1997. In 2006 Australians watched 179 minutes, nearly 3 hours of television a day (Australian Bureau of Statistics 2011a). During the same period, Australian fathers with their youngest child between 6 and 14 spent 2 ½ hours parenting.

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3 (ABS 2013)
Figure 6 - Time per day spent by parents caring for children by age of youngest child

Figure 7 shows the national average of hours spent in unpaid work by people who care for their own children. This shows that women are still undertaking the majority of unpaid work in Australia.

Figure 7 - Child care gender comparison

Perhaps surprisingly, in Figure 8 it is shown that women are more likely to feel that their work and family responsibilities are in balance, but not significantly.

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(Australian Bureau of Statistics 2012c)

(Australian Bureau of Statistics 2012c)
This suggests that most men feel that their work and family responsibilities are in balance, and certainly not many more men than women. This may be due to social norms dictating to men their place in the family, or it may be that most fathers are content with the level of involvement they have. It is not evident that they feel restricted in their roles, something assumed by many father focused advocates.

Mahalik & Morrison (2006) outline a number of masculine schemas which they claim restrict men’s fathering roles. These are; Emotional Control, Primacy of Work, Pursuit of Status, Self-Reliance, Power Over Women, Be a Winner, Dominance and Homophobia. These schemas form part of a cognitive therapy approach to enhancing father involvement, suggesting that the blockers for increased father involvement are located within fathers, rather than in society. They do recognise these schemas as culturally constructed, but see that the challenges faced by fathers can be addressed at a micro level, although acknowledging that engaging men can be a difficult task for workers.

These limited roles for fathers can have a polarising effect – Strega et al. (2008, 707) state that, ‘when not threatening or abusive (and sometimes when they are) men

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6 (Australian Bureau of Statistics 2012b)
are generally constructed as irrelevant or rendered invisible, while men who take even the slightest responsibility for parenting are frequently regarded as heroic figures.’

Hearn (2002, 245) argues that ‘debates about fathers and fatherhood need to be more explicitly gendered and more explicitly about power.’ He sees fatherhood as an historical institution, rather than a biological state. Hewlett (1987, 296) alternatively remarks that father-child bonding is so consistent that it may have some biological origin, although, curiously, perhaps only existing in American males.

Whatever the cause, Slade et al. (2009, p. 28) articulate a strong theme across fatherhood literature, which is that ‘men feel excluded from a central role in the parenting process… as if pregnancy is an exclusive club to which only women can belong.’ Until recently, the roles men have been able to play have been limited to breadwinner, disciplinarian and, in some cases, reprobate (Fleming 2007, 13-4). Furthermore, Burgess and Beardshaw (2005, 54) articulate the view that successful fatherhood is viewed as learned or taught, whereas successful motherhood is seen as innate.

Fletcher (2011, 168-75) attributes this view of women as nurturers and men as providers to an evolutionary construct of men as hunters. He debunks this by pointing out that while early human males may have hunted, the closely knit family groups in which they existed relied on cooperation and engagement. Huber (2007, 20) further critiques this by arguing that the man as prehistoric hunter paradigm was generated by male dominated anthropology in the 1960’s and 70’s. Any claim that biology predisposes men to an inability to parent has yet to be substantially supported – in fact clinical studies have shown that up until 7-9 months, babies do not demonstrate a consistent preference for either caregiver (Zeanah and Smyke 2009, Geiger 1996). Despite this, child rearing, especially for newborns, retains a ‘women’s business’ mantle.

This relates to an important theme, that what women do when they mother is the same thing as parenting. This concept is rooted in the view that parenting is women’s business and not the domain of the father at all. In reality, mothers and fathers both parent, either together or separately. Strega et at. (2008, 713) found in their study that ‘the dominant discourse that mothers are primarily responsible for the safety, wellbeing
and care of children is routinely enacted in child welfare even when fathers are present and involved.’

In clinical academia this theme of focusing on the mother persists, with Favez et al. (2009, 469) noting that the traditional emphasis has been on maternal-child relationships, with studies focusing on paternal factors only appearing more recently. This is also reflected in the view of Post-Natal Depression as exclusively female, despite its common occurrence with new fathers (E. Lee 2009, 161).

Much of the impact that fathers are judged to be able to have is in a supporting role - Burgess and Ruxton’s stage two. Burgess and Beardshaw (2005, p. 56) suggest that fathers should be ‘doing the housework’. While in some circumstances this support role is clearly relevant, such as during the actual birth, or in the later stages of pregnancy, this ‘support’ role could be seen to pigeonhole fathers in the same way that traditional ‘breadwinner’ roles did in the past. In addition, Ramsay (1998, 147) argues that this is counterproductive as it disempowers the woman – the implied suggestion is that the new mother is incapable of looking after herself.

Many women may resist changes to pre-established gender roles due to internalised sexism, because they believe that they will do a better job of parenting or because of the increased power being the primary caregiver affords them (Coleman and Garfield 2004, Slade, et al. 2009, 28). Hand (2006) found that many mothers perpetuated these beliefs because they assumed that fathers lacked the necessary patience for caring for small children.

Fletcher (2011, 69) suggests that the different parenting styles that men and women demonstrate can be seen as complementary, not as competitive. This approach rejects the exclusivity of the support and breadwinner roles, and honours father’s parenting as an equal contribution to child rearing. This is supported by Lamb (2010, 11), who argues that the modern, involved, version of fathering is increasingly similar to mothering. Lamb also cites studies which indicate that the qualities of the father have less impact than the quality of the relationship between the father and child – this also applies to the amount of time a father spends with his child – quality is more important than quantity.
Health and welfare workers

In Vernon (2011) new fathers recount their impressions of birth being informed by movies, birthing literature, mates at the pub, watching videos of actual births, and a dozen other influences. When these men do mention health workers, they either praise the somehow magical ability of the midwife, or criticise the overly clinical approach of the obstetrician.

One new father in Vernon (2011), Michael, describes the impression he developed that the obstetrician did not believe that women were capable of giving birth, warning his partner that a vaginal birth would be fatal. He asks, ‘Was it arrogance or was it fear of nature that drove him to this attitude?’ Another man recounts how his wife refused to abort their baby despite ongoing cancer treatment. Both babies were eventually born naturally, despite the obstetricians’ assertion that to continue unassisted would be fatal. These case examples show that even in a situation where a professional holds the ultimate threat over a family, they can be unswayed by their advice. How then, can health and welfare professionals expect to positively influence something as subtle as gender roles?

Another man, David, recounts how he found a birthing class particularly helpful, completely changing his perception of childbirth from one of fear, to a joyous activity in which he could participate. This is an example of how much of an impact workers can have on the experience of new and expectant fathers. This relates clearly to the imperative workers have to include fathers – if they can be enacting positive change then they should be.

Burgess and Beardshaw (2005, 65) suggest that workers need to assist mothers to assist fathers – the internalisation of gender roles by women is one of the major contributors to father disengagement. Ultimately it is not the responsibility of workers to dictate gender roles to mothers or fathers, but to assist the family with skills to determine gender roles for themselves. Michael’s case demonstrates a worker working contrary to the views and ideals of the family and failing to have an impact; David’s case shows how workers can successfully provide education to enable families to make their own decisions.
As Pease and Camilleri (2001, 47) advise, while men may present as if they are in control or only requiring practical support, workers need to ‘assume that men do experience a range of emotions.’ While this may seem elementary, the fact that Pease and Camilleri feel the need to state such a basic concept gives insight into the way fathers are viewed by health and welfare workers.

As Fletcher (2009, 2) points out, mothers and fathers determine gender roles as their families change, and can experience disappointment and grief when they are not able to act in the roles they set for themselves. By providing fathers, and families, the ability to determine their own course, and by reflecting on their own practice, workers can assist in the formation of healthy, happy families, which show the kinds of positive outcomes associated with high levels of father involvement.

**Alternative paradigm fatherhood**

If the field of research concerning fathers in the West is slowly developing, research concerning non-Anglo or non-heterosexual Australian fathers is even less developed. Some anecdotal insight is available, such as Bonson’s (2004, 3-4) recollection that for her father, an Aboriginal Health Worker, that ‘the most important things in his life are for his children to learn about our ways of culture and never forget where they’re from and who they are.’ This role of cultural guide contrasts with the nurturing or breadwinner roles that Anglo fathers may be expected to take. Bonson also describes her father’s response to his own father’s death; ‘Dad was devastated, he stopped eating and also stopped going to work too.’ Bonson’s father took a year off, and recovered after spending time in his homeland with his family. While this anecdote cannot paint a complete picture of Aboriginal fatherhood, it shows an image deeply rooted in culture, land and family, and quite distinct from mainstream fatherhood.

In other countries, fatherhood takes on still more meanings. In recent decades there have been distinct shifts in family values and constructions across OECD countries, attributed to higher educational attainment and labour market participation leading to autonomy and financial independence among women (D’Addio and d’Ercol 2005). These include the age of birth of the first child increasing for men and women, income gender wage gaps decreasing and hours of work gender differentials decreasing, although
women are still poorer, less educated, have less leisure time, and work longer than men (Organisation for Economic Co-operation and Development 2010).

From an international cross-cultural perspective, fathering becomes more variable. Ostner (2002, 150) discusses the link between the Führer as father figure in Nazi and contemporary Germany, while Hewlett (1987, 295) contrasts, with cheerful racism, the holding and play styles of fathers of the Aka tribe, of Central Africa with that of American fathers. Ho (1987, 228) claims that in traditional Chinese culture, ‘filial piety was the guiding principle in the traditional pattern of socialization.’ Ho also describes the increasing strictness of gender role differentiation in higher social status families – the higher the social status, the wider the gap between the sexes.

From a power perspective, sexism and racism are not gender or culture normative – Arshad (1996, 147) quotes the Combahee River Collective “we struggle together with black men against racism, whilst we also struggle with black men about sexism.” Arshad points out that for many women, racism and sexism are intertwined, which holds meaning for non-Anglo fathers in Australia – they may be experiencing not only the conflict of their family and cultural roles, but of adapting these roles to mainstream society and to the expectations of their peers.

Gay fathers also face a whole raft of challenges not always experienced by hetero fathers – surrogacy, legal issues, adoption constraints and general prejudice to name a few (Tuazon-McCheyne 2010). This area is even more neglected than mainstream fatherhood research, and requires more attention in further research.

These examples demonstrate the variable elements of cross cultural fathering which can all be seen in contemporary Australian society and around the world. This area requires more in depth investigation – while there is minimal research on fathers, there is even less on different types of fathers, or even recognition of their existence (Featherstone, Fraser, et al. 2010, 25).

**Fathers are useful**

Academics and practitioners alike agree on the importance of engaging fathers, both from a harm prevention perspective and due to the positive aspects of involved fathering (Fletcher 2011, 77-111, McAllister, et al. 2012). Burgess and Beardshaw (2005, p. 55) point to the risk of babies being shaken by overwhelmed fathers, Favez et al.
(2009, 469) cite studies showing the impact of fathers on infant development and mental health. Useful in this context is from a health and welfare worker’s perspective – assisting the health and welfare of the family, particularly the mother and child.

Cowan et al. (2009, 664) identifies two ways fathers are viewed – either from a deficit model, designed to address the moral or social problem of ‘fatherlessness’ resultant of a decline in ‘family values,’ or an ecological model which assumes there are systemic factors preventing fathers from engaging with their children. They go on to outline five key ways in which fathers have either a positive or negative impact on the family:

(a) Individual family members’ mental health and psychological distress
(b) The patterns of both couple and parent-child relationships transmitted across the generations from grandparents to parents to children;
(c) The quality of the relationship between the parents, including communication styles, conflict resolution, problem-solving styles, and emotion regulation;
(d) The quality of the mother-child and father-child relationships; and
(e) The balance between life stressors and social supports outside the immediate family.

(Cowan, et al. 2009, 664)

Supportive fathers reduce the incidence of Post-Natal Depression in their partners and increase positive development and the IQ of their children (McAllister, et al. 2012). Their children are also less likely to possess a criminal record by the time they are 21 (Burgess and Beardshaw 2005, 59). Fathers who play roughly (although not too roughly) with their children improve their children’s aerobic and muscle development, problem solving skills, social skills and emotional development. These fathers also teach their children how not to play, how to sense boundaries and what is safe, both for themselves and for others. While the authors do not suggest that mothers cannot partake in this kind of play, they claim fathers are much more likely to relate to their children in this way (Fletcher 2011, 82-93). Simply having fathers spending time with children can be beneficial to their general health and development (Coleman and Garfield 2004).
Fathers can be vital in improving health and welfare outcomes for the mother, in reducing the incidence of post-natal depression, supporting breastfeeding and improving communication (Coleman and Garfield 2004).

Fletcher (2009, 3) relates a relevant study which strongly reinforced the importance of positive interaction by parents. The results of this longitudinal study showed that children with one supportive parent and one unsupportive parent performed better over time than children with two unsupportive parents and not as well as children with two supportive parents. What the study also showed was that it didn’t matter which parent was supportive – the improvement was visible if the father or the mother was supportive. This reinforces a main theme in the literature – fathers are important, but this suggestion in no way detracts from the importance of mothers. None of the literature explicitly suggests that women or men are better parents, although implied bias may. What it does suggest is that fathers and mothers are different, and that they are both important – that parenting is best done collaboratively, not competitively, and by families, not individuals.

Lamb (2010, 9) relates that ‘children with highly involved fathers were characterized by increased cognitive competence, increased empathy, fewer sex-stereotyped beliefs, and a more internal locus of control.’ He theorises that it may not simply be the presence of a father, but that the presence of a father in a child’s life also signifies the presence of a supportive partner in the mother’s life, which in turn leads to higher levels of wellbeing in the mother, which further contributes to the wellbeing of the child and the father. In short, fathers form a key component of a virtuous circle in which the whole family is better able to support itself. This theory is upheld by Lamb’s recount of studies which demonstrated fathers who were forced to be more present, such as those unable to obtain work, had detrimental impacts on their children.

Sieber (2008, 334) points out that the space left empty by absent or disengaged fathers is not just left empty by fathers - grandparents, godparents, aunts, uncles, cousins, family friends, or other parenting figures will also have impacts. The usefulness of fathers does not detract from the usefulness of other figures in a child’s life. Sieber also uses Greenspan (1982) to explain why fathers may have such a significant impact; ‘During the “dyadic phallic” phase of development the presence of a “second other” (namely the father) is important in helping the child stabilize basic ego functions such as
reality testing, impulse regulation, mood stabilization, delineation of self from others, and focused concentration.’

Burgess and Beardshaw (2005, 51-3) argue that a father may be underutilised as a resource, not necessarily due to unwillingness, but due to ‘institutional practices that do not help him develop sufficient skills and self-confidence.’ The literature indicates that fathers can be very useful, particularly in relation to supporting their partners and children.

**Fathers need support**

Across the health and welfare fields there is an understanding that new and expectant fathers face challenges, and that they need to be better supported during this time. Giallo (2012, 1912-3), et al. found that ten per cent of fathers experience psychological distress during the postnatal period. Slade et al. (2009, 28) outline a number of variables that can impact on these challenges, such as life experience and relationship strength. Compounding the issue is that when services are developed based on research of what fathers want or need, fathers are not always interested in participating (Burgess & Beardshaw, 2005, p. 54). This highlights a potential problem with the way these programs are developed or implemented. Cowan et al. (2009, 664) argue that ‘fathers are more likely to be engaged in a positive way with their young children when they have few symptoms of poor mental health, are securely attached to their own parents, communicate effectively with the child’s mother, are under less external life stress, and have more social support.’ They also indicate that when fathers struggle in these areas, the risk of abuse and neglect increase. Fathers can be a force for good, although without support, can inflict significant harm.

Hagell & Dent (1999, 168-9) relate to the importance of fathers as capable of harm, both from commission, such as physical violence, and omission, such as neglect. They remind us that most harm comes to children from people they know, and much harm comes to children from their fathers. From this perspective it is even more critical to recognise the importance of positively engaging new and expectant fathers in the lives of their children. Matthey, et al. (2009, 30) argue that fathers have previously unforeseen impact on their children, pointing to studies that indicate that depression in
fathers in their child’s first months is predictive of emotional and behavioural problems for that child in later childhood.

Many men, envisaging a relationship with their child based on sporting activities, active play and discussion, are unable to relate to a newborn baby with limited capability for interaction (Burgess and Beardshaw 2005, 63). Both parents may find they are challenged by memories and misgivings from their own childhood (Ramsay 1998, 147). Men and women’s gender roles, which may have been negotiated in less stressful times, need to be readjusted as new requirements and constraints emerge (Ramsay 1998, 150). Giallo, et al. (2012, 1913) state that ‘the postnatal period may be a time of increased risk for mental health difficulties in men... the birth of a baby can result in profound changes to lifestyle and recreation, sleep patterns, couple relationships and identity...’

Another area that can be challenging for new fathers is that of sex and sexuality. In one sense the sexuality of new and expectant fathers is covered extensively in the literature, both in parenting books such as What to Expect When You’re Expecting (Murkoff and Mazel 2009) or Cheers to Childbirth (Perry 2010). These sources tend towards the hetero-normative, and advise new parents on safe perinatal and postpartum intercourse. They do not cover same sex couples, or challenges new fathers face with the sexuality of their children. They also view fathers as limited to providing support, rather than as a part of a parenting or pregnancy team.

Fletcher (2009, 2) makes one of the most poignant comments about the challenges new fathers face, suggesting that couples define their gender roles based on assumptions and preconceptions, and are then surprised and disappointed by their actual parenting experience. Workers are suitably placed to provide new and expectant families with the skills to make these decisions based on the kind of family they want to be.

What is clear is that fathers say they want to be involved, and that workers say they want father to be involved, and that the benefits to involvement are clear. Why, then in 2006, did Australian father spend an average of only 8 hours a week with their children? (Australian Bureau of Statistics 2008) More importantly, what can service providers do about it?
Barriers and supports to father engagement

Barriers

Cowan et al. (2009, 677) have demonstrated using randomized clinical trials that providing support to fathers leads to the kind of outcomes discussed above, in Fathers are useful. Furthermore, academics such as Fletcher (2009) and King (2004, 2005) have provided tools for workers to use to provide this support. This section explores the literature on the barriers to providing support to new and expectant fathers.

There are a number of barriers to providing support to new and expectant fathers identified in the literature, mainly; service, biophysical, internalised and cultural, which will be discussed in this section. Thematically these fit either into a medical model, where fathers and mothers are excluded, or a feminist model, where fathers and medical professionals are excluded.

Despite the fact that health and welfare workers almost universally acknowledge the importance of fathers, men often report being ignored or dismissed by those same workers (Daniel & Taylor, 2001, pp. 140-2). This is not limited to fathers – men in general can be difficult to engage due to a number of issues, including institutional disillusionment, the ‘feminisation’ of waiting rooms and inflexible health provision outside of working hours (Malcher 2009, 94). Fathers are so excluded in some services, particularly in basic elements such as in child protection investigations and case planning, that they have been described as ‘irrelevant’, ‘invisible’, ‘ghosts’, or an ‘afterthought’ (Lee, Bellamy and Guterman 2009, 229). Strega et al. (2008, 713) found that in their study ‘fathers whose children are involved with child welfare continue to be seen through a lens of absence, dangerousness and marginality.’

One of the most telling examples of how workers regard fathers is the language used to describe fathers. Etymologically, the words father and perpetrate have the same etymological root (Ayto 2005, 212). As Christie (2001, 25) and Featherstone (2003, 250) point out, fathers in welfare are usually described as good or bad, as present or absent. Christie compares this discourse to the views of mothers, and especially single mothers, as ‘fit’ or ‘unfit’ which dominated debate earlier in the last century. This view neglects the potential for a father to be non-residential, and be a committed father, or to be living with his children and be abusive or neglectful. Christie suggests that this has led...
to a no-win situation for fathers in welfare, who are either condemned for their absences, or distrusted based on their presence. Studies have shown that while workers recognised that fathers were excluded, they did not necessarily see this as a problem (Lee, Bellamy and Guterman 2009).

This theme persists throughout the literature, especially social work literature, assisted by a view amongst some feminist social workers that ‘real’ feminist health and welfare workers don’t work with men (Cavanagh and Cree 1996). Sieber (2008, 333) points out that ‘social work literature offers praise for resilient single mothers who are able to provide adequate emotional sustenance for their children in the absence of a father,’ and that given single mothers’ demonstrated capacity, working with fathers is an unnecessary, and sometimes risky, chore.

Health and welfare workers may have good reason to mistrust fathers, as the embodiment of patriarchy and as potential perpetrators of violence. Seiber (2008, 335) suggest that therapists will most often work solely with the mother in post-divorce therapeutic sessions because they believe fathers are disengaged by choice, or are not as developmentally influential as the child’s mother. Cavanagh and Lewis (1996, 87) discuss how after interviewing 122 men accused of violence against a female partner, their way of viewing men was altered – ‘We spent over 300 hours listening to men excuse, deny, minimise and blame. Some have cried, some have raged, some have laughed, some have flirted, some have challenged. Some have sought to humour us, to enlist our sympathy, to control us, to outsmart us, to convince us.’ Having been exposed to this, over an extended period, it is no surprise that when confronted with other men they see similar evidence. Having their trust and professionalism abused by violent and abusive men, health and welfare workers may see men in general in a different light.

Statistically, Australian men are twice as likely to experience violence, and only slightly less than one half as likely to experience sexual assault as Australian women (Australian Bureau of Statistics 2005). While men are far more likely to commit violent acts, health and welfare workers should not exclude all men on this basis – this is exactly the kind of base prejudice health and welfare workers should fight against. As Fleming (2007, 15) points out, despite the indication that fathers are becoming more engaged in family life, they are still regarded as problematic. Cavanagh and Cree (1996, 6) argue that this has left a gap in feminist social work that has not been explored. One study
found that fathers were often viewed as posing a risk to their children, even when it was they who had initially alerted the authorities to the child welfare concerns (Featherstone, Fraser, et al. 2010).

As Flood (2002, 1) explains as ‘men are the problem, they are also part of the solution.’ Burgess and Beardshaw (2005, 65) suggest that an element of the ‘deficit perspective’ that workers have of fathers is that ‘fathers are much more likely to harm children than women.’ Some workers may fail to take this concept to its logical conclusion, that fathers are much more likely to harm children than women if they are not properly skilled and supported. How is it, then, that the workers who are tasked with properly skilling and supporting men are excluding them because they are violent or abusive?

In addition to this, a range of obstacles have been put forward against working with violent men, other than their inherent duplicity. Wilson (1996, 31) outlines some of these arguments; that men who are ‘cured’ of violence will simply revert to ‘terrorist tactics’ of non-physical violence, that workers who validate men’s attempts to change will lend credibility to their lies that ‘they did not mean it,’ and ‘it won’t happen again,’ and that women whose partner’s show signs of improvement may miss their opportunity for escape.

These perspectives are reflected in the Fitting Fathers into Families report, which found that over half of the female staff and one-third of male staff interviewed thought that 24% of fathers physically abuse their children (Russell, et al. 1999). Paradoxically, Furman (2010, 79) relates a study which found that men, on becoming fathers and gaining family responsibility, significantly increased their pro-social behaviour.

These viewpoints, born of hard line feminist practice, make working with men difficult, ignoring the argument put forward by Wilson (1996, 32) that ‘We need to challenge violent men, and traditional social and institutional tolerance of their violence.’

Cavanagh and Cree (1996, 4) discuss how the dominant discourse concerning men may have been further altered by having the men’s movement shift from a staunch pro-feminist ally into a combatant and a perceived perpetrator of patriarchal dominance. This conceptualisation depicts men as either pro- or anti- feminist and
revolves around contentious issues such as parental custody and child support, the use of pornography and men’s violence. This has led to an environment where social work, dominated by feminist and anti-oppressive approaches, has been unable to address men who may be non-violent, as the lines of battle have been drawn along gender differences. Sieber (2008, 336) supports this concept with his argument that the prevalence of women in the caring professions leads to ‘sisterly transference in danger of being formed on an anti-male basis.’ 81% of workers in the community services sector in 2009 were women (Australian Bureau of Statistics 2009).

Even critical thinkers such as Pease (2003), in his contribution to Critical Social Work, seems to consider men only as objects requiring change. He also argues in the pro- or anti-feminist sphere, suggesting that pro-feminism should be the basis for working with men. From this position, men are considered to be requiring change, which can be enacted by pro-feminist reflection. While there is no doubt that Pease makes a strong case, well grounded in theory and practice, it may lead readers to imagine that this is the only way that health and welfare professionals can view men, and therefore fathers.

Furman (2010, 277) suggests that social workers, despite tending to view people in terms of strengths, can often pathologise and focus on men’s problems. Furman himself, despite claiming to take a strengths-based perspective in his book, Social Work with Men at Risk, is inevitably drawn towards changing violent, abusive, or disadvantaged men, again ignoring men’s actual strengths, those that don’t require changing. These might include their commitment to their children, their determination to provide the best for their families, or their abilities to share and communicate with their partners.

Hearn (2002) sees fatherhood as an historical institution, rather than a biological state. This approach allows workers to discriminate between fathers who need to be ‘fixed’ or changed, and those who have strengths that can be utilised to support their children. King (2005, 34) suggests out that in the family arena, outside of the public sphere, men tend to have very ‘quiet’ voices. He is not referring to the manipulative men that Cavanagh and Lewis (1996, 87) interviewed in their study, but to fathers that feel disempowered. This reminds us of Slade et al.’s (2009, 28) comment that ‘men feel
excluded from a central role in the parenting process... as if pregnancy is an exclusive club to which only women can belong.’

Workers can assist their clients by better understanding where fathers are abusive, violent, absent or dismissive in terms of power, and can better support their clients by addressing these imbalances. Historically, it may be that workers have attempted to correct these power imbalances simply by excluding or ignoring the father.

Cavanagh and Cree (1996, 6) argue that social workers have been able to ignore men due to the influence of feminism on the social work agenda. Authors such as Flood (2007) have detailed the harm that anti-feminist men’s movements have done. As Cavanagh and Cree (1996, 7) wrote over 15 years ago, ‘The question is no longer ‘do we work with men?’ but ‘how do we work with men?”

Fletcher (2009, 6) points to a study that found that counsellors and family workers were more likely to blame fathers for relationship conflict and exclude them from conflict resolution if they held stereotypical negative beliefs about men. Burgess and Beardshaw (2005, 51-3) suggest that fathers are underutilised as a resource, not necessarily due to unwillingness, but due to ‘institutional practices that do not help him develop sufficient skills and self-confidence.’ They point to a study in Bristol, UK where in 50% of cases health workers did not know the name of the fathers in their programs. Furthermore, there seems to be no good reason for fathers to be excluded, other than institutional and worker bias. In their study O’Donnell et al. (2005) found that there was no professional guidance or research based information available to the participating child welfare workers, and that they had to ‘rely on their own experiences, biases, and professional concerns in thinking about what constitutes appropriate services for fathers.’ The workers in this study viewed parenting classes as gender neutral, and saw no need to assist fathers with employment or vocational services, despite an identified need to do so. Instead, they focused on mothers as the primary caregivers, and when they did provide a service to fathers, they attempted to provide the same service to both, so as not to appear biased. This ignores many of the differences that have been identified between mothers and fathers – a service designed and tailored to suit the needs of mothers cannot be fairly applied to fathers.
A key theme which arises is that of the obvious biophysical differences between men and women. The concept that there are differences is generally accepted, although how these differences translate to parenting is not. For example Slade et al. (2009, pp. 28-9) outline couvade, the manifestation of pregnancy like symptoms in expectant fathers, also known as ‘sympathy symptoms’ and Fletcher (2011, pp. 63-4) describes how men and women’s brain functioning reacts differently to unknown babies crying. Fletcher comments on the inability to determine what part genetics or social conditioning plays in regards to these biophysical differences, which in turn makes research into this area conflicting and difficult to draw inference from.

Ramsay (1998, 145) relates his study which found that men found women increasingly introspective during pregnancy, and that the men did not feel their relationship with the baby was ‘real’. This perception may also extend to the (mostly female) workers who are supporting new and expectant families. The physical connection between a mother and her child is clear and obvious, the connection between a father and his child is not – Ramsay (1998, 150) cites studies that indicate the manifestation of pregnancy symptoms in expectant fathers is based on a kind of jealousy aimed at bridging this connection.

Ultimately new and expectant mothers have a more obvious physical connection than fathers, via the umbilical cord or the breast. This in itself does not seem a well thought out reason to exclude fathers, but it does make it possible to do so – a baby may survive without a father, but may not without a mother.

Burgess and Beardshaw (2005, 62-3) and Furman (2010, 77) point out that fathers may ‘choose’ to disengage for a number of reasons, such as personal motivation, social supports, institutional barriers, inexperience with young children or perceived gender roles. Burgess and Beardshaw consider the argument that men may lack the skills to address these issues, suggesting that most new fathers are disappointed at the time restrictions their breadwinner role places on them.

Fletcher (2009, 4) points out that simply ‘the belief that fathers should be involved in services for families has not resulted in the successful recruitment of fathers.’ This may be relevant to the concept of choice: while workers assume that because they want to include fathers, this should be enough to get fathers on board.
Supports

Culturally, contemporary men and families are looking to engage more with their children, and are more aware of the benefits of doing so (T. Miller 2010, 376, Fletcher 2009, Burgess and Beardshaw 2005, 51-3). Despite centuries of confining gender roles restricting the ability of men to father, social and systemic changes are currently creating a space where men can define their own parenting approaches. Despite the dominance of men in general society, they do not feel comfortable vocalising in the area of new and expectant babies – often only stepping forward when it is too late, as they reflect on wasted lives at work or after family separation (King 2005, 34). Fathers are keen to be involved even when they are excluded - one study found that while participating services invited fathers to core assessments less than 50% of the time, when fathers were invited, they attended more than 75% of the time (Featherstone, Fraser, et al. 2010, 16).

Positive aspects in the service delivery for new and expectant fathers in the health and welfare field are easy to find – individual programs are appearing, men and families are shifting their attitudes, workers are keen to improve their service and the system itself is showing signs of change.

This is an area that has seen much development in recent years, with programs such as parenting classes and playgroups aimed at fathers (Burgess and Beardshaw 2005, 53). Many academics and practitioners are already working towards an inclusive practice model for men; King, Sweeney and Fletcher (2004) have developed a checklist for organisations to self-assess and improve their service delivery for men, while Fleming (2004, 33) has developed rules as ideas for engagement of men in child protection. In 2009 FaHCSIA released a Father-inclusive Practice guide for workers (Department of Families, Housing, Community Services and Indigenous Affairs 2009). A Father-inclusive Practice Forum facilitated by the University of Newcastle in 2005, has produced a set of principles for father-inclusive practice and a list of competencies for engaging with fathers (Australian Fatherhood Research Network 2011). There are also mailing lists, websites and professional groups such as King’s (2011) Working with men and generative practice learning group or his Working with men newsletter. These tend to focus on fathers as a whole, or problem fathers, rather than new or expectant fathers.

Other studies have shown that workers are not only able to improve their service delivery for new and expectant fathers, but that they want to (O’Donnell, et al. 2005).
Taylor and White (2009, 3-5) describe the impetus in the health and welfare system towards improving practice. This can also be seen in the Federal Government sponsored review of Australian fatherhood research in 2005, and the resultant conference (Fletcher 2009). For those workers and agencies that do want to improve service delivery for new and expectant fathers, organisations such as the University of Newcastle’s Family Action Centre have a range of materials available, including the Bringing Fathers In Handbook and 113 Ways to Be Involved As a Father poster (Australian Fatherhood Research Network 2011).

The lack of academic consideration for fathers who are neither abusive nor separated from their children is also being addressed. Government funded clearinghouses such as the Australian Family Relationships Clearinghouse, journals such as The Journal of Men’s Studies and Fathering and books such as The Dad Factor and Men at Birth are contributing to this (T. Miller 2010, Fletcher 2011, Vernon 2011, Fletcher 2009). More specific supports such as My Journey to Her World : How I Coped with My Wife’s Depression are available to assist fathers through sharing other men’s experiences (Lurie 2007). Educational institutions such as the University of Newcastle are facilitating conferences and establishing research networks, and others are including subjects such as “Work with men”, “Engage fathers into family based programs” and “Working with separated fathers” in health and welfare programs (Australian Fatherhood Research Network 2011, Fletcher 2009).

Building on the supports already present and addressing barriers identified above, the next section examines potential solutions to the issues raised so far in this literature review.

Solutions

By having a comprehension of not only the research gaps and potential challenges, but also the previously identified potential solutions, this research is grounded in existing theory as well as in the data. The first half of this section examines how the role of professionals has changed, fathers in policy and how professionals work in order to understand how these elements might be changed in the future. The second half looks at critical social work, reflective practice, family-centred care and the future
of providing service to new and expectant fathers, with a view to incorporating useful elements of these into a grounded theory.

Changing role of professionals

The medicalisation of childbirth and pregnancy has been widely opposed from a feminist standpoint as it is viewed as a form of patriarchal dominance, and a way of controlling women’s bodies (Henley-Einion 2009, 173, van Krieken, et al. 2000, 145). Feminist writers such as Henley-Einion (2009, 174) argue that before the rise of positivism, birthing was women’s work, and was seen as a natural, normal part of life. Lay midwives, or doulas, would attend births and external intervention was not required. These writers often omit statistics such as those that show that women were 40 to 50 times less likely to die from childbirth in 1999 than in 1939, mainly due to positivist medical expertise (Loudon 2000, 2418). The resurgence of the midwife led, rather than obstetrician led approach to birth combines the person focused approach with the medical, maintaining a low maternal and infant mortality rate while allowing women to reclaim some ownership of childbirth.

This may be an excellent thing for mothers, but neither proponents of the natural, joyous birth or of medical approaches, consider the role of men other than as supports. It appears that in fighting so fiercely against the patriarchal dominance of modern medicine, advocates of mothers’ rights have rejected any reduced role for the patriarchs, and that in their drive for increased knowledge and reduced risk, medical experts have excluded the inexpert fathers. While men in general may dominate the power structures of society, there are few men as powerless or inexpert as the new or expectant father.

Pemberton and Locke (1971, 96), over 40 years ago, stated that ‘The 'client in trouble', however, often has little choice but to invest his interests and loyalty in the professional who mediates and dispenses access to 'reality' in a powerful context.’ This critique of social work practice could still be seen today. Workers dispense the reality of a mother focused service, and father have little choice but to adhere to this.

Fathers in health and welfare policy

Health and welfare policy concerning fathers mainly relates to fathers either as perpetrators of abuse, or as non-residents seeking custody. Public debate in these areas
is vicious, brutal and unforgiving, with participants and commentators alike resorting to drastic tactics (T. Wilson 2005, Price 1998). Wilson (2005, 30) claims that ‘woman-bashing and feminist-bashing are common occurrences on fathers’ rights message boards and email lists.’ Kidnapping, stalking, picketing of ex-partner’s houses and harassment are not unheard of, and this emotionally and politically charged arena is difficult to navigate for both sides. Wilson (2005, 31) claims ‘that fathers’ rights groups are harmful to children, women, and men,’ portraying them as paramilitary terrorist-like organisations. Combatants in this arena may do well to refer to Fletcher’s (2009, 3) suggestion that children thrive most with both parents amicably involved.

Stepping away from this highly charged arena, very little public policy applies to fathers who are not abusive or living away from their children. Even less commentary focuses on this arena. The Australian 13 week Paid Parental Leave Scheme, introduced January 2011, sidesteps the issue almost entirely, referring only to parents, and not to mothers or fathers (Family Assistance Office 2011). Almost entirely, as the Federal Government deferred until 2013 a complementary scheme specifically for fathers, which provides two weeks of paid paternity leave, referred to as Dad and Partner Pay (Department of Education, Employment and Workplace Relations 2009, Department of Human Services 2012). The easy insinuation to draw from this is that the parental leave is for mothers, as the Dad and Partner Pay is for fathers. While this complementary scheme was deferred for budgetary reasons, it demonstrates the perception of mothers as parents, with fathers presumably still at work, as breadwinners. Ultimately, the Federal Government neatly avoided any outcry by making the final scheme available to whoever is the primary carer. While it may be easy to be cynical about this positioning by the Federal Government, it in fact allows families to make their own decisions about who the primary carer is, and who receives the paid parental leave.

In 2005 review of Australian fatherhood research was sponsored by the (then) Commonwealth Department of Family and Community Services, the Child Support Agency and the Bernard van Leer Foundation (Fletcher 2009, 6). This led to a forum on father-inclusive practice, which showcased successful initiatives aimed at engaging fathers. These forums are significant indicators that change is imminent, however little evaluation has been conducted, and the majority of these programs are aimed at fathers who are abusive or not living with their children.
As Cowan et al. (2009, 677) point out, it is not whether father-inclusive practice works, or what its benefits are, but whether ‘this type of intervention could feasibly brought to scale in a climate of decreasing government resources or whether the intensity and staffing levels could be reduced to make it less costly without sacrificing its effectiveness.’ Ultimately, while early intervention strategies such as engaging fathers may have significant long term benefits, the money to implement programs needs to come from somewhere initially, and in the current climate, fathers are an unlikely target group for large injections of funding.

How workers work / how practitioners practice

Schön (1991, 22-3) articulates the difference between a profession and an avocation; a profession being based on an underlying theory, and an avocation being based on intuition and experience. He puts forward the view that professions such as social work are unable to develop a single, systematic underlying theory because they operate in an ambiguous practice environment – compared to the legal profession, which exists in a relatively stable statutory environment. While the Technical Rationality that subsequently places the legal above the social in the professional hierarchy may be problematic, Schön’s point is important when considering the nature of service delivered to new and expectant fathers. This service necessarily takes place in a literally and figuratively messy environment – that of the delivery room, or in a homeless shelter. Men are re-examining their roles, their relationships with their partners and their relationship with themselves during this period; even when there is a theory that may be relevant, such as feminism, it does not claim to be coherent or all encompassing. For every theory, there is a counter theory, often with little in the way of empirical evidence in support. Without this strong theoretical base, service delivery in this area moves decidedly towards the avocation sphere. Murdach (2010) discusses how social workers have to evaluate their practice using both hard (scientific) and soft (unscientific) evidence. One of the ways social work attempts to manage this dichotomy is from a critical social work perspective.

Critical social work

Critical social work is a collection of practice theories committed to social as well as individual transformation. Etymologically stemming from the Ancient Greek prefix *krei*, meaning to sieve, discriminate or distinguish, a critical approach as applied to
practice focuses on discriminating and distinguishing between competing theoretical perspectives and practice approaches (Harper 2010). It essentially holds that users of social work services should be empowered by addressing oppression and inequality through and empowerment framework (Mendes 2009). The power of critical social work is its ability to critique not only mainstream ontologies such as positivistic rationalism, but also progressive ontologies, such as Marxism, feminism and postmodernism. By scrutinising concepts and constructs, health and welfare workers can ensure that theory and practice are based on strong foundations.

Critical social work has been described technically as belonging to the Frankfurt school of Western Marxism, which incorporates subjectivity into Marxist approaches (Allan, Pease and Briskman 2003, 2). This belies the fact that critical social work is more accurately a mixed group of theories united under a single banner. This makes definition difficult, as critical social work may be described as focusing on dislodging oppression in constructs as well as institutions, although this applies to the branch of critical theory known as anti-oppressive practice, as well as ‘non-critical’ theories such as feminist and radical approaches. Healy (2005, 173) distinguishes between modern and postmodern critical social work, incorporating feminist approaches in the former. What this highlights is the socially constructed nature of critical social work – while some struggle to define it, others, such as Allan, Pease, and Briskman (2003, 1), debate whether it needs to be articulated at all, as it so clearly represents the nature of social work itself. Still other academics such as Pozzuto (2000) view the approach both as social work that is critical, and as work that is both critical and social.

Consistently critical social work is viewed as having evolved from and with radical social work, which focused on social change, highlighting social workers’ role in maintaining the status quo (Payne 2005, 229). As articulated by Pemberton and Locke (1971, 101) ‘the social worker is a double-agent; while claiming to be working on behalf of the client, he is really an agent of socio-political control, bolstering the existing social order by reinforcing and interpreting moral, social and political rules.’ Fook (2002, 4), however, suggests that social work has maintained some level of critical tradition since its beginning, with Healy (2005, 175) citing Jane Addams as a ‘first wave’ critical social worker in the 1890’s. Fook goes on to outline five major elements of the critical approach. Critical social work:
Views oppression as personal as well as structural

Has an understanding that social structures are constructed

Critiques positivism

Works for progress

Challenges the preference for expert over local knowledge.

(Fook 2002, 17)

These elements incorporate themes from postmodernism, radicalism and structuralism. Importantly, unlike these antecedents, critical social work does not exclude positivist approaches, but critiques them. Following this concept through, it could be said that critical social work critiques everything, not just positivism, although this concept has been passed over by the majority of critical theorists.

A critical social work perspective is exceptionally useful for viewing service delivery for new and expectant fathers, as it can simultaneously recognise the need for empowering women, for timely and adequate medical intervention and the need to include men as fathers. It can critique the excesses of both feminist approaches and of medical positivism. This prevents an analysis of this kind subsiding into the brutish and violent combat described by Wilson (2005).

The postmodern aspect of critical social work requires that workers ‘reject the notion that there is one desirable path for any individual or collective to follow and, instead, invite us to recognize and celebrate different paths and possibilities’ (Healy, 2005, p. 212). In this context, it allows a perspective on service delivery to new and expectant fathers which does not dictate to fathers, but provides them with both the awareness of the gender roles and other social constraints that determine fatherhood, and the tools to redefine fatherhood as they see fit. This liberates health and welfare workers from the need to support or suggest particular approaches to fathering – instead assisting fathers to determine their own approaches.

Yet Healy (2005, p. 213) goes on to appreciate the sense of loss social workers feel when deprived of a ‘moral and political framework for action.’ Critical social work doesn’t prescribe direction for the tools that it provides.
And these tools are many – Butcher (2007, 34) tells us that ‘critical theory is both descriptive and emancipatory’ – it can critique the gender roles and gender bias that impact on fatherhood, and provide methods of adjustment. Fook (2002) outlines contextual conceptualisation, advocacy, education, casework, narrative strategies and empowerment approaches to name a few. These are tools that all critical social workers use on a daily basis, however the descriptive side of critical social work doesn’t lead directly into the emancipatory – this requires a third, and most vital aspect. Reflective practice is the first principle in critical social work practice, and provides a link between description and emancipation (Healy 2005, 183).

**Reflective practice**

As pregnancy and childbirth have become pathologised, those delivering the service have been drawn further towards the medical profession, which as Schön (1991, 22-3) points out, considers itself to be based on theory and to operate in a systematic environment. This leaves non-medical practitioners who might call themselves “professionals” in a situation of looking to a theory to inform practice, but not necessarily having one. This has led to the introduction of reflective practice, which involves workers becoming actively aware of assumptions and constructions that inform their practice (Taylor and White 2009, 35). This is an attempt to navigate the murky waters of the avocational sphere where theory does not or cannot dictate practice.

Bolton (2010, 205-9) suggests that humans store information as narrative. Much of the literature concerning fathers involves stories about them, either as supportive, engaged contributors, or as threatening, dangerous reprobates. Bolton claims that workers can support fathers by helping them take responsibility for the stories, and critically re-examining them. Fletcher (2009, 7) discusses the importance of this process in relation to fathers – stressing the importance of reflective practice, highlighting that simply ‘knowing’ about fathers does not necessarily translate into improved practice.

While reflective practice has many proponents, it relies on the professional to work – it cannot be enforced or policed, and if a practitioner has deep seeded assumptions that they are not interested in examining, challenging those assumptions can be very difficult. If, for example, a health and welfare worker has a strong inherited sense of what constitutes a family, they may consciously or consciously pass this sense on to their clients. Similarly, this research cannot force workers to examine alternative
stories about new and expectant fathers – what it can do is make those stories available, amplifying the ‘quiet voice’ described by King (2005, 34). Workers can incorporate these stories into reflective practice, and challenge some of the assumptions of men examined in the previous section.

**Family-centred care**

An alternative to the dominant paradigms of the medical and feminist models that are present in the health and welfare system does already exist, but is not present in literature concerned with supporting new and expectant fathers. Family-centred care is an approach that views the whole family as the recipient of support or care rather than just the patient (Mitchell and Chaboyer 2010, 154). Family-centred care emerged from pediatric nursing in the 1950’s, in response to concerns regarding the exclusion of parents from pediatric wards in hospitals. This move, away from an approach which viewed parents as having a negative influence on the recovery of their children, required nurses to ‘shift from a professionally-centered view of health care to a collaborative model that recognizes families as central in a child's life and their values and priorities as central in the plan of care’ (Ahmann 1994, 15). It is elsewhere defined as characterised by ‘a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person and in which all the family members are recognised as care recipients’ (Shields 2010, 2629). From a broader perspective, family-centred care is an extension of the move to include patients in their own care, and in the case of babies and children, who are unable to fully participate in their own care, include their families as their representatives (Mitchell and Chaboyer 2010, 154). In certain areas, this model is widely accepted and implemented in policy, however lacks rigorous academic underpinning (Shields 2010, 2630).

Family-centred care has three components, mutual respect, collaboration and support. Mitchell & Chaboyer (2010, 155) explain; ‘Respect is the process of acknowledging and valuing individuals; collaboration is the act of partnering in health care options and support, pertains to acknowledging and assisting with someone’s needs. Workers using a family-centred
model would be able to work with different families as they presented, including step, blended, single, same sex and other non-traditional family types. Coleman (2002, 20) argues in her analysis of family-centred care implementation by nurses, that while workers have a good understanding of the theoretical aspects of family-centred care, this knowledge isn’t necessarily transferred into practice.

The family-centred care model is based on the premise that the family is the most important aspect of physical and psychological health and wellbeing (Mitchell and Chaboyer 2010, 155). This is not necessarily consistent with a whole of family approach, which is simply based on what the participants of this study responded to. For some fathers, this won’t be the case, most evidently in the case of non-residential fathers. This potential inability to work with non-traditional, non-nuclear families extends beyond this example to include same sex and culturally and linguistically diverse families.

A number of studies have demonstrated that in the traditional home of family-centred care, the paediatric ward, workers still focus on the clinical patient and ignore the family (Roets, Rowe-Rowe and Nel 2012). Beyond this, family-centred care still has the potential to become mother focused and exclude fathers – for example this study chastises nurse managers for allowing staff to ignore mothers, but does not mention fathers:

Nurse managers should ensure that all staff who work with children and mothers in the ICU obtain the necessary knowledge and understanding of the identified stressors of the mother, as well as the methods of emotional support. (Roets, Rowe-Rowe and Nel 2012, 628)

That study, titled Family-centred care in the paediatric intensive care unit doesn’t refer to fathers at all, as the aim of the study is to assess emotional support provided to mothers. This is an example of family-centred care not centring on the family at all. Health professionals have been accused of using family-centred care without consideration for the gendered nature of caring within families (Dodd, Saggers and Wildy 2009, 183).

Dodd et al. (2009, 175) explain how a family-centred care model has been shown in disability settings to rely on ideological views of family, confusing the norm with the ideal, and perhaps enforcing the norm or excluding others. This has the potential for workers to impose their own worldviews onto their clients. This is especially pertinent
when looking at family function, and deciding at what point that families become “dysfunctional” and require intervention. They also suggest that upholding an ideal view of families reinforces economic and political norms. Furman (2010, 95-6) adds that working with men in family contexts can lead to a reinforcement of restrictive gender roles. Professionals and services implementing family-centred care need to be aware of the possibility of family-centred care upholding other, less constructive ideals and norms.

Family-centred care has the capacity to include both medical and feminist models of support to new and expectant parents, however Mitchell and Chaboyer (2010, 155) indicate that it works best when a ‘whole of ward’ approach is taken, and Dodd et al. (2009, 178-9) describe some of the challenges in working with this model with other professionals, in particular the barriers raised by professional boundaries and decentralization.

Finally, Dodd et al. (2009, 184) demonstrate that there is a danger that family-centred care can be narrowly interpreted in a way that leaves all the responsibility on families, and ultimately disempowers them. The key phrase in Dodd et al.’s work is family agency – that families should be empowered to take as much leadership as they want, and have the rest provided for them.

The model of family-centred care, while not currently present in the literature concerning new and expectant fathers, has the potential to incorporate both the medical and feminist models and provide support to new and expectant fathers.

**Moving forward**

Two professions that have initiated debate about the importance of engaging fathers for the benefit of their children are midwifery and family work. Burgess and Beardshaw (2005, 53-4), address the antenatal training provided to new and expectant fathers. While they acknowledge that few antenatal educators meet fathers’ needs, they suggest that in this sector at least, there is a significant push to engage fathers. Social workers may benefit from an understanding of the shift in the gender power balance at this crucial point in the life cycle, which may inform the power balance for the remainder. Essentially, Burgess and Beardshaw argue that while women are expected to know intuitively how to parent, men are expected to need teaching. This view,
potentially isolating for new mothers who may not intuitively know how to care for a new child, also unnecessarily disempowers men, who will have their own intuition or expectations. Health and welfare professionals aim to engage fathers in our work with children, we should be aware of these preconceptions and reflect on their impact.

It may be that if men are treated with respect and provided with education that matches their abilities and expectations, they may be less likely to resort to violence or aggression to solve problems. Burgess and Beardshaw (2005, 55) suggest that timely intervention of this kind may have a significant impact on the tendency of frustrated, disempowered parents to shake their babies. They suggest simple tactics such as working with fathers at times that suit them, such as evenings or Saturday mornings, holding group sessions just for fathers, and working with fathers on practical, logical grounds that appeal to their ways of operating. Other suggestions include sports based support groups and practical advice focused on addressing men’s fears, keeping adequate records on fathers, developing strategies aimed at engaging fathers, locating ethic or class minority fathers, develop resources and publications for fathers and implement father specific training for staff.

It is important to make the distinction between the men that workers so often come into contact with, such as those offenders described by Cavanagh and Lewis (1996, 87), and those described by Vernon (2011, 135,141); ‘When Robert Davis discovered his wife was pregnant he had no idea what to do to prepare for fatherhood. Two children later and he realises he still doesn’t...’ The men in Vernon’s book relate their stories of birth and of becoming fathers. Davis describes himself throughout this narrative as variously as ‘forty years old and scared to death,’ ‘scared shitless’ and ‘very apprehensive, nervous and slightly terrified.’ Health and welfare professionals need to be able to isolate Cavanagh and Lewis’s manipulative abuser from the frightened and alone parent – and be aware that at different times they may be the same person. In the delivery room, Davis recounts in tellingly masculine vernacular, ‘I’m a well-built bloke but at that moment I was completely invisible.’

In the area of midwifery, the isolation fathers feel and the emotions they are processing are well documented. There are also many suggestions for addressing some of these issues. Fletcher (2009), from the Engaging Fathers Research Program at the Family Action Centre at the University of Newcastle, suggests that everything family
workers do needs to be rethought or reviewed. In the same way that an entire paradigm shift was required to bring about the women’s liberation movement, the work done with fathers needs to be entirely revaluated. He points out that simply changing the word ‘mother’ to the word ‘parent’ on the advertising for programs has not brought fathers to these programs in droves.

Fletcher argues that while fathers want to be more involved with their children, they are not supported in this by services. While this may run counter to the understanding and experience of most health and welfare professionals, there may be enough cases where it holds true to reassess their perceptions. He recounts examples of a community family services organisation in Victoria which shifted the core principles of the organisation – from ‘family sensitive’ to a model that was also ‘father sensitive’. While logic dictates that ‘family sensitive’ should also be ‘father sensitive’, this example shows that this is not always the case.

One example of this given by Fletcher is the way that current service delivery works best when service users possess a degree of self-awareness and problem-awareness and the ability to discuss personal issues. While some fathers may find this easy, many men will have difficulty internally confronting their problems, let alone bringing them into a public space.

Overseas work is already being done supporting workers in this area - My Daddy Matters Because... is a Canadian project based on the ‘belief that an involved, responsible father provides many positive contributions to the life of their developing children’ (Community Action Program for Children & Canada National Projects Fund 2004). It is a resource aimed a hea lth and welfare professionals who are developing or running father focused programs, and contains information regarding activities, services, resources, and programs that exist for fathers, and a toolkit which includes practical resources for improving father engagement. These include:

- Organisational readiness and assessment checklists
- Ideas for group activities
- Tips for programs
- Recruitment methods
- Time and money savers
Breaking down information into easily accessible toolkits means services looking for support on engaging fathers have clear direction. This toolkit is an excellent resource for services, but is based only on research done with services, not directly with fathers themselves. It is also 10 years old, and does not reflect the changes in literature since then. This is exemplary of the need for ongoing commitment from funding bodies to keep valuable resources such as this up to date.

The United Kingdom’s Fatherhood Institute also produces a toolkit, and a number of resources for working with young, West-African, Somali, Bengali, Muslim and African-Caribbean fathers. They have generalist resources, and resources aimed specifically at maternity professionals, pointing out that ‘no health or family service other than maternity achieves remotely this level of connection with men in their role as carers of children’ (Fatherhood Institute 2012). These resources are evidence based on work with fathers and evaluations of existing programs, and are kept up to date.

The Fatherhood Institute is a charity, funded by foundations, direct donations, government departments, and also by selling fatherhood resources and providing training to other organisations. This sustainable model of supporting services to work with fathers is key to improving father-inclusive practice across the sector.

Working towards father-inclusive practice may include the practical elements listed above, or require a shift in service operating principles discussed by Fletcher (2009), however they will also need to include a new practice model by workers’ as individuals. Fletcher discounts the necessity of male workers to engage with fathers on the grounds that clinical studies have shown it to be ineffective. More than this, it could be argued that the tendency to recruit male workers to work with men disempowers female workers, denying their ability to work with men, and disobliges them of the requirement that they engage the fathers of their clients. Instead, all workers should improve their skills in the area of engaging fathers, as they should improve their skills in working with any group of people. This particularly applies to minority groups of fathers, as it applies to minority groups of any kind. Working with fathers should be seen as a
necessary cultural competency. Fletcher suggests that this view of cultural construct will assist workers to view the problematisation of men as a process that can be addressed, rather than a biological state that cannot be altered. Only by shifting the basis of the way workers think about men can they properly engage with fathers.

Mattock sums up his transformation:

...my vision essentially is about finding practical and meaningful ways to restore fatherhood as a rite of passage and create healthy and supportive pathways for men becoming fathers. That entails changing the culture of fatherhood preparation, changing the politics and culture of men’s involvement in maternity care, contributing to the evolution of ‘healthy masculinity’, creating more safe spaces for men to share their stories and talk about their lives, contributing to the development of mentors and leaders of men and fathers, and taking this vision and work to the wider community with aspiration of creating positive change. (Mattock 2012)

As Curran (2003, 224) points out, ‘Social workers have a professional obligation to promote family well-being by encouraging policy reform and by shaping service delivery.’ Having addressed local and service level concerns, such as service delivery and professional development, all health and welfare professionals need to work to implement change in this area.

This could most obviously involve identifying and addressing and research gaps concerning service delivery for fathers. By engaging in action research, and building on research undertaken in other fields, researchers and workers can create a body of knowledge from which to advocate for increased father engagement. Shapiro & Krysik (2010) suggest that merely increasing the number of articles written about work with fathers is not sufficient – their study found that while the number of articles considering fathers has increased in recent years, the number of studies actually including fathers has remained low. This research addresses this, using a participant driven approach to generate new ways of looking at working with fathers. Health and welfare professionals have access to fathers every day, and can also engage in action research to contribute to the theoretical base that underpins our practice.

A final key element is advocacy, both professional and personal. Health and welfare professionals can have significant impacts on not only their client’s views and beliefs, but on those of their colleagues, friends and families. Male workers can role
model positive gender roles, be engaged fathers and contribute as parents. Female workers can assist the men in both their professional and personal lives to attain their full capacity as men, and as fathers. Strega et al. outline the day to day process this entails:

Children, mothers and fathers suffer when workers fail to engage purposefully with fathers and father-figures. To move toward true inclusiveness in both protecting and supporting children, practitioners need to proactively assess and engage with all significant men in a child’s life, understanding that some may pose risks, some may be assets, and some may incorporate aspects of both. This requires practitioners to hold similar expectations for mothers and fathers, building on their strengths and challenging them to make changes. Workers must not give up on men who disengage or behave abusively until they have done as much as they can to bring about change. (Strega, et al. 2008, 713)

O’Donnell et al. (2005) believe that many of the workers who participated in their study would ‘be eager to explore and re-evaluate their practice with fathers.’ They argue that the persistence of negative images of fathers and their capabilities makes supporting and engaging fathers difficult, noting that this could be remedied with ongoing professional development. This inclination to improve practice is widespread, as Mattock says:

My idea is that if men are appropriately engaged and included in maternity care, we will see better birth outcomes at birth for women and children, less post natal depression, and more involved fathers and supportive partners. (Mattock 2012)

Taylor and Daniel (2000, 13) argue that health and welfare workers ‘particularly because of their direct role in supporting parenting, are in a position either to marginalize or involve fathers’. This is an important role, and is often overlooked. It has been shown that there is a building inertia for change in service delivery to new and expectant fathers, and tools to support that change. This research will explore why these two halves of the solution are not forming a whole.

Research gaps, questions and suggestions

As stated above, the field of providing new and expectant fathers lacks a strong body of rigorous research, although in recent years a number of researchers have greatly increased the body of literature available. This process has left many gaps, especially
Firstly and most obviously, there is a significant lack of research concerning subgroups of fathers; same sex, culturally and linguistically diverse, new migrants, low socioeconomic status, Aboriginal and Torres Strait Islander and rural fathers to name a few. These groups have been identified elsewhere as generally being at risk, and this should be understood to include fathers as well.

It has also been shown that workers have a tendency to view men in a negative light, and to pathologise them and their problems. Despite this, there is a noted lack of consistency in attempts to engage them, or to change their behaviour. This literature review has shown that this is a major barrier to fathers’ engagement in services. This issue can be summarised as a problem with the perception that workers have of fathers, and needs to be better understood.

Finally, the research gap concerning the impact of fathers on their children also needs to be addressed. This is an area that is receiving much attention, as shown in this literature review. One of the most significant understandings that has been highlighted in this review is that fathers and mothers are different, and that it is important that they work together – that parenting is best done collaboratively, not competitively, and by families, not individuals.

For reasons discussed in the following chapter, this research does not require predefined research questions or hypotheses to test, however this literature review will form a significant part of the data used in generating a grounded theory.

**Conclusion**

This literature review has explored the construct of fatherhood, throughout time and culture, examined gender roles and demonstrated that fathers are useful, but require support. It has also examined some of the barriers and supports to father engagement, and provided a framework for assessing solutions using a critical social work perspective. Throughout this, the two themes of medical and feminist exclusion of fathers have been presented. It is concluded that any movement to address the challenges outlined above need to take these opposing themes into account, and that
some elements of reflective practice and family-centred care may be used with a critical social work approach to achieve this.
NO PLACENTAS TO BE PLACED IN THIS FRIDGE/FREEZER
FOR FOOD STORAGE ONLY

THANK YOU
Chapter 3. Methodology

This chapter outlines the key elements of grounded theory as they apply to this study, the process of data collection and analysis and addresses relevant ethical considerations. Critical social work, the underlying perspective for this study, views social work, and all health and welfare provision as socially constructed. Payne (2005, 19) argues that historically the impact of the service users themselves on this construction has been largely ignored. Building on this, Allan (2003, 41) suggests the Foucauldian notion that individuals or groups can resist power oppression through struggle against that power. From this perspective the choice of research method needed an element of power analysis and the ability for the voice of the research participants to be genuinely heard through the research. Thus qualitative in-depth interviewing using grounded theory as outlined by Glaser and Strauss (1967) and Ezzy (2002) was chosen, partly due to the ability of the researcher to include all relevant data as research. This approach was also chosen in response to a lack of pre-existing theory on the topic, as it seeks to create theory from the ground up. It is also partly action research, with the principal researcher both a new and expectant father and a health and welfare professional.

Grounded theory

Developed by Barney Glaser and Anselm Strauss in the 1960s, grounded theory builds on symbolic interactionist perspectives (Ezzy 2002, 7). This approach refute the deductive hypothesis testing of the scientific method, instead relying on data collection and analysis to build a theory. As argued in the literature review, the dominant medical and feminist paradigms aid the implementation of medical and feminist theories which seek to define the role of the father. Using grounded theory in this case does not seek to disprove medical or feminist theories, but to develop a competing or complementary theory based on the data provided by new and expectant fathers and those that work with them. This also avoids the dilemma of aligning primitively with any of the men and masculinities theories that are often defined in response to feminist approaches. Grounded theory allows this research to work within the current context without explicitly opposing any of the current dominant or reactive paradigms, instead taking from them what is relevant and proposing an alternative compromise that acknowledges the subjective truths of all participants.
This is not an anti-deductivist approach, and does not pretend to be developed in isolation. As a new and then expectant father, a mental health social worker and family worker, the primary researcher is profoundly influenced by feminist and medical models. Instead, this acceptance of bias which becomes in grounded theory a reliance on bias, gives insight and creates meaning. As Ratner (2002) states:

“Qualitative methodology recognizes that the subjectivity of the researcher is intimately involved in scientific research. Subjectivity guides everything from the choice of topic that one studies, to formulating hypotheses, to selecting methodologies, and interpreting data. In qualitative methodology, the researcher is encouraged to reflect on the values and objectives he brings to his research and how these affect the research project. Other researchers are also encouraged to reflect on the values that any particular investigator utilizes.” (Ratner 2002)

As Ezzy (2002, 11) warns, the danger of using grounded theory is that the researcher will overemphasise either the theoretical deductions or the inductive theory, the first resulting in an adherence to current theoretical models, and the second in an inability to be explicit about their influence. Theories are instead generated through the process of abduction.

Abduction

Abduction is seen as opposed to deduction or induction, the concept that theories can be generated from data inductively, then tested deductively. Abduction provides the middle path between these approaches, and forms an important element of grounded theory. Abduction ‘elevates grounded theorizing from mere mechanical coding to a creative process. Abduction involves imaginative interpretation while, at the same time, forcing the researcher to seek accountability from the empirical data’ (Pozzebon, et al. 2011).
Figure 9 illustrates the continuum on which abduction lies, between deduction and induction. The process of abduction looks to see which is the best explanation for the data based on the assumption that there will be many possible explanations. This allows the researcher to use the data as it presents itself, and to compare and contrast existing theories with any emergent theories. Given the dominance and inherent value of the current theories dominating the service structure, it would be fruitless to either subscribe to them or refute them entirely. For this reason an abductive approach to grounded theory has been chosen.

**Deviations from grounded theory**

The true grounding of this research is from the researcher’s personal experience as a new and expectant father. This is consistent with the Glaserian approach to grounded theory, that whatever is experienced by the researcher becomes part of the research. It is also consistent with the Straussian approach, with its focus on categories, codes and coding.

Another inconsistency is writing a literature review prior to beginning research, which was required by the course process. This has been mitigated by timing of the researcher’s first experience of receiving service as an expectant then new father. This has ultimately led to a more integrated abductive process as the experience of new and expectant fatherhood, the literature review, data collection and analysis were all
concurrent. In this way, the literature review is simply part of the data, although separated according to convention in the written work.

While some grounded theorists, such as Suddaby (2006, 636), warn against using mixed methods in a grounded theory approach, occasionally quasi-quantitative elements appear in this dissertation. This is actually consistent with grounded theory, which aims to ‘not to make truth statements about reality, but, rather, to elicit fresh understandings about patterned relationships between social actors and how these relationships and interactions actively construct reality’ (Suddaby 2006, 636). These elements have been used to highlight inconsistencies in dialog, or to provide graphical representation of a concept derived from the interview process, again in line with incorporating all possible data.

Grounded theory interviews are often not taped, with the researcher taking notes which forms the first layer of interpretation of the data, and the basis of coding. These interviews were taped to ensure that the researcher was not distracted by the process of note taking, with the interpretation of data taking place on receipt of the transcript. The real strength of this approach is that the real voices of the participants are able to be presented in the results, with the researcher providing context and contrast, and giving structure to their arguments. This also allowed for a form of diarising and reflection as the researcher’s thoughts and responses were also recorded and informed the coding process.

Grounded theory as a research method does not necessarily call for recommendations, however participants in this study were far more interested in discussing what they would like to see than explaining why they thought they were seeing a particular thing. Their responses steered this research towards generating recommendations very early, and from these recommendations a theory began to emerge.

In actual fact, this is not a ‘pure’ expression of grounded theory, and does not attempt to be. Suddaby (2006, 638) notes that there is a fundamentalist element amongst some grounded theorists, with a tendency towards idealism and away from practicality. This research took from grounded theory what worked, and attempted to apply it as consistently as possible. Researchers using grounded theory require ‘a tacit
knowledge of or feel for when purist admonitions may not be appropriate to their research and may be ignored’ (Suddaby 2006, 639). This is not a demonstration of how to do grounded theory, but an attempt to tell the stories of new and expectant fathers.

**Theoretical sampling and recruitment**

In grounded theory, as Ezzy (2002, 74) states, ‘...the units of analysis are sampled on theoretical grounds... this means that the sample is not defined prior to the research but as the theoretical dimensions emerge during the research.’ Glaser and Strauss (1967, 45) suggest that when sampling using grounded theory, the researcher should designate ‘a few principal or gross features of the structure and processes in the situations that he will study.’ In this case, these features included workers who provide a service to new and expectant fathers, and fathers themselves. To distinguish this process from quantitative sampling it is referred to hereafter as recruitment. The recruitment was intended to take place as shown in Figure 10.

![Figure 10 - Example recruitment approach 1](image)

This approach did not prove successful, most likely due to the requirement that workers take the initiative to recruit fathers on behalf of the researcher, for which they had not extrinsic motivation. Only one potential lead was generated this way, which eventuated six months after the data collection and analysis had been completed. An alternative, more direct approach, which proved more successful, is shown in Figure 11.
Flyers were provided to workers and fathers during the interviews to give to other fathers who might be interested – see Appendix 1 – Recruitment Flyer. When the time came to ask, as directed by Glaser and Strauss (1967, 47), ‘what groups or subgroups does one turn to next in data collection? And for what theoretical purpose?’ manager and partners were recruited for comparative analysis. Many of the issues arising from early interviews required a service policy perspective, which could be best provided by managers, and mother focused practice became such a dominating theme that partners also needed to be included.

A total of 31 participants were interviewed in a total of 35 interviews. A number of couples opted to be interviewed together, and a number of fathers, or couples, agreed to be interviewed twice. Nearly all (92%) of the workers or managers interviewed were also parents themselves, however none were new or expectant fathers. Eight fathers or partners (42%) interviewed were also a variety of health or welfare professional, however they were all recruited and identified primarily as fathers or
partners. The average age of the fathers and partners was 37, with the oldest being 50 and the youngest 30. Table 1 outlines the primary roles of participants.

<table>
<thead>
<tr>
<th>Participant Type</th>
<th>Number</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fathers</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Partners</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Workers</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Managers</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Workers were recruited through local networks, initially through the Men and Family Centre, Ballina Byron Family Centre, and NSW Health. One of the ways that participants impacted the research unexpectedly was the high number of managers who volunteered to participate, who gave useful insight into more strategic and operational concerns. Participant occupations are shown in Table 2.

<table>
<thead>
<tr>
<th>Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodyguard</td>
</tr>
<tr>
<td>Carpenter</td>
</tr>
<tr>
<td>Carpet Cleaner / Business Owner</td>
</tr>
<tr>
<td>Coffee Processing Manager</td>
</tr>
<tr>
<td>Craft Maker</td>
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<tr>
<td>Doctor</td>
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<tr>
<td>Engineer</td>
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<tr>
<td>Father Worker</td>
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<tr>
<td>General Practitioner</td>
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<tr>
<td>Homelessness Case Manager</td>
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<tr>
<td>Homelessness Service Coordinator</td>
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<tr>
<td>Juvenile Justice Counsellor</td>
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<tr>
<td>Manager / Speech Therapist</td>
</tr>
<tr>
<td>Midwife</td>
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<tr>
<td>Naturopath / Entertainment Services</td>
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<tr>
<td>Naturopath / Mother</td>
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<tr>
<td>Nurse</td>
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<tr>
<td>Paramedic</td>
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<tr>
<td>Project Manager - Construction</td>
</tr>
<tr>
<td>Service Manager</td>
</tr>
<tr>
<td>Software Programmer</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>
The geographical area chosen for the study, the Richmond-Tweed Main Statistical Area was chosen for geographical convenience and due to its close correlation to the now defunct Northern Rivers Local Health District. Detailed relevant information can be found in Appendix 5- Local Demographics.

Father focused workers and mother focused workers

The workers and managers interviewed can be easily divided into two categories, those who focus on fathers, and those who focus on mothers. The father focused workers include father workers, family workers and men’s workers. The mother focused workers include nurses and midwives. Workers who fit into neither group included GPs, naturopaths, paramedics, counsellors, homelessness workers, social workers and speech therapists. Some fathers who were also service delivery professionals were asked about their work practices in addition to discussing their experience of fatherhood.

Non representative recruitment

A valid criticism of this piece of research is that while recruitment was undertaken according to the principles of grounded theory, due to the issues described below in Accessing fathers (p80), only fathers with a certain level of engagement agreed to be interviewed. In addition to this, expectant fathers were far more likely to have the time and energy to commit to the interview process than new fathers. As Glaser and Strauss (1967, 30) indicate, ‘...the pressure is not on the sociologist to “know the whole field” or to have all the facts “from a careful random sample.” His job is not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behaviour.’ The criticism is not then that the participants are not representative, but that due to restrictions placed on the research by the ethics committee, recruitment of participants was restricted to non-vulnerable populations and to passive recruitment. The theoretical sensitivity required by grounded theory was thereby reduced.

These recruitment strategies, enforced by the ethics committee restrictions, meant that father needed to actively volunteer to participate in the research, either through responding to a flyer or putting their name down on a collection sheet at an antenatal or parent education class. Some classes - specifically courses aimed solely at
fathers had a 90% response rate, while general antenatal classes had closer to a 10% response rate. The result of this is that men who agreed to be interviewed were already actively seeking ways to engage with the process of becoming fathers – they were not only at the antenatal class, but of the fathers of the antenatal class, they were the most likely to agree to participate. This has inevitably skewed the results of this research, however does not necessarily reduce the validity of the outcomes or recommendations. Glaser and Strauss argue that with empirical generalisations are not applicable using grounded theory; ‘Accuracy is not at stake so much as establishing the structural boundaries of a fact: where is the fact an accurate description?’ (Glaser and Strauss 1967, 35). The research reported in this study is an accurate description of the experience of the participants, and is valid in its own right.

Fathers and families with low levels of English literacy were inactively excluded due to the use of English language only recruitment flyers. Aboriginal fathers were actively excluded due to the cultural sensitivities around both fathering and service delivery. Same sex fathers were inactively excluded due to receiving no responses from that group. Single or non-resident fathers were also inactively excluded due to the recruitment methods. Unfortunately, fathers who fail to engage with the service system also did not engage with this research, most likely for the same reasons. Further study may actively identify and access all these groups.

Data collection and analysis

As Data Figure 12 shows, data collection and analysis with grounded theory is not a linear process, but an interdependent process in which every element impacts on the others. Data collection and analysis are integrated, with literature and program reviews and recruitment reshaped by the outcome. There is no final ‘outcome,’ as conclusions are funnelled back into the research process until recommendations are generated.
For this research, each interview was recorded, transcribed and coded as soon as possible. Grounded theory is conducted this way so that all available data can be used to shape resulting interviews, and so follow any themes that are developing in the research. As Ezzy (2002, 63) indicates, ‘examining data right from the beginning of the data collection for ‘cues’ is what makes grounded theory ‘grounded’. This allows for the voice of the participant to inform the shape of the ongoing research. Grounded theory is a blend of these cues and a sophisticated conception of the pre-existing themes in literature.

Interviews took place at a variety of venues, as suited the participant. These included the participant’s home or office, the researcher’s home or office, or a public place. Interviews took on average 55 min, determined by how much new information the participant wished to share.

**Interview process**

The nature of the study was explained to participants, who were asked to relate their experience. Initially questions were based on the researcher’s expectations, they were mainly open questions:

*In general terms what do you think it is that fathers want in the service that they're receiving?*

Questions from then usually attempted to expand or direct a relevant line of questioning, such as this clarification of the social work practice of normalisation:
Interviewee: You know parenting, relationships, we all find them hard. So I like to reinforce that you’re not out there on your own.

Interviewer: So normalisation?

Interviewee: Normalisation of that process.

Interviewer: You find that works?

Many of the participants were so keen to get their story out that few initial questions were required, such as in this example where a father began midway through the research briefing:

Interviewer: Well to start off we’ve spoken to them before birth and then if they’re happy to be reinterviewed afterwards then post birth to see what changed about what they thought they wanted. I think people are often quite clear about things beforehand, and then change a lot afterwards. It’s a life changing experience as you...

Interviewee: Yeah, anything that could be done better.

Interviewer: As a father you think it could be done better?

The subject matter was often very close to the participants’ hearts, and fairly little prompting was required - participants would often speak for 10 minutes without pause. This allowed the participants to guide their interview and as such the research as a whole.

Interviews were recorded on an Apple iPhone using iProRecorder. Transcription was undertaken by Pacific Transcription. Analysis was completed using Nvivo data analysis software to assist with coding and storage of data.

Other data

In line with collection of data using grounded theory, all relevant information that could be included in the research was also used where appropriate. This included calendars of events for local family services, policies and procedures, Facebook conversations with participants, books and articles written by participants, online and traditional media, service publications, and most importantly the experience of the researcher as a new and expectant father. Most often this data was fed back to participants to generate their response, rather than coded directly. As outlined above, the literature review is also considered as data in the grounded theory process.
Open coding and thematic analysis

As workers were easier to recruit than fathers, they formed the bulk of the early interviews, their responses providing the framework for the integrated data collection and analysis. Initial open thematic coding after 10 interviews resulted in 55 themes, which could be grouped into 5 key groups using axial coding:

- Solutions
- Barriers to father engagement
- Theory Informing Practice
- Supports to father engagement
- Father-inclusive Practice

Within these axes, selective coding began to reveal a few early core themes, shown in Table 3.

Table 3 – Early Core Themes

<table>
<thead>
<tr>
<th>Name</th>
<th>No. of Participants who raised the topic</th>
<th>No. of times the topic was raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solutions</td>
<td>9</td>
<td>149</td>
</tr>
<tr>
<td>Service Barriers</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>Cultural Barriers</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td>Fathers need support</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>Mother focused practice</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Work related Barriers</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>Service Supports</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Fathers need to take</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender roles</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

These themes informed later interviews, such as this inquiry regarding work related barriers:

*Interviewer: One of the things that I'm hearing a lot from dads, is 'I couldn't get there because of work. I wanted to be at all the appointments and ultrasounds...’*

*Interviewee: Well I work for myself so that's a big difference.*
Interviewer: You can just move work around, you can work around...

Interviewee: Yeah, well if I wanted I could go to work or don’t go to work I just don’t get paid.

In this way early themes are explored and then tested, sometimes related back to theory for further exploration. Error! Reference source not found. graphically represents the process of coding to develop theory. Figure 13 shows the relationship between interviews, transcription and analysis, allowing the findings of each interview to be fed into the next. This process of constant comparison continued until the end of the research process, into the final draft writing stage. The comparison between different events and process as new data became available formed an important part of the methodological process, in particular the way findings from the research were fed back through the researcher’s experience of new and expectant fathering and receipt of service.

<table>
<thead>
<tr>
<th>DATE OF INTERVIEW</th>
<th>DATE OF TRANSCRIPTION OR ANALYSIS</th>
</tr>
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<tbody>
<tr>
<td>September 2012</td>
<td>May, 2012</td>
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<tr>
<td>October 2012</td>
<td>July, 2012</td>
</tr>
<tr>
<td>November 2012</td>
<td>September, 2012</td>
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<tr>
<td>December 2012</td>
<td>September, 2012</td>
</tr>
<tr>
<td>January 2013</td>
<td>November, 2012</td>
</tr>
</tbody>
</table>

Figure 13 – Relationship between Data Collection and Analysis

Exploring new themes was not always obvious. Often the real meaning behind a narrative would be complex and require multiple attempts at unpacking the meaning.
behind it. One discussion led to an investigation on the way change was understood by the participants, including the use of qualitative analysis tools such as a word search and a stemmed word query. A new theme of change and preparation for change developed, which then split into two more – cultural and service change, and transition for families.

As a result of this, important links and relationships could be established, such as linking this comment:

*After the birth of our first child there was - I know I feel really sorry for the children's father, because I don't think he was at all aware of what the changes were going to be - for him. No idea. At the time there really weren't systems around to support him. Then he - and then certainly it was revealed by the time I checked - just before our second child was born, our relationship ended.*

And this one:

*We were saying, what's your thing as an expectant dad? ... Enjoy it now before it changes. We say well the reality is some of it's true but, hey, it's fantastic - your life's going to change! I'm like, oh mate, your life's going to change.*

This became a central theme which nearly every participant commented on at some stage. This is an example of the process used to explore the data, analysing and reanalysing, comparing to theory, and reflecting on the overlap. It is also an example of hearing the underlying message, not discounting statements because they don’t fit with the dominant ideology, but examining their cause and respecting the places they come from. As Glaser and Strauss describe, when using grounded theory; ‘Since accurate evidence is not so crucial for generating theory, the kind of evidence, as well as the number of cases, is also not so crucial. A single case can indicate a general conceptual category or property; a few more cases can confirm the indication’ (Glaser and Strauss 1967, 30).

Some themes moved from being viewed as challenges to being viewed as strengths. The theme *Mother Focused Practice* began as *Father Exclusive Practice*, coded to *Barriers to Father Engagement*. As it evolved and a deeper understanding of the process was developed, the name changed and the theme moved into a neutral place, splitting some of the coding off to form a new theme – *Family Inclusive Practice* is *Father Include Practice*. This shift in understanding of this concept marked a greater shift in the way the stories of the fathers were interpreted – this theme later became the
overarching finding of the research – that the inclusion of fathers is not at the detriment of service to mothers, or vice versa.

Other themes emerged and then departed, reflecting the interpretation of the data. A key example of this, the early theme Internalised Barriers, grew out of an understanding of research that indicated ‘that fathers often reported the struggle to develop confidence in their parenting and the necessary skills and knowledge’ (Barker, et al. 2011). Given this indication, when fathers responded with statements such as this:

*It's important to have knowledge, but I guess the thing for me if is there's people who have spent their life learning how to do this kind of stuff I'm not going to start telling them how to do their job.*

And this:

*I think they are but not to extent - I don't think we should be put on the same level as mum. That's my own personal thought it's [my partner's] and my moment but it's more her moment because it's such a milestone in the woman's' life. It's such a big epic event and it's such hard work that she has to go to.*

It was easy to view these as internalised sexism, which put men on a lower rung than their partners. As the research continued, it became clear that these beliefs were not only valid, and not in any way related to a lack of self-esteem or confidence, but a clear demonstration of them. This approach to fathering, of supporting a pregnant woman through childbirth, and trusting in the expertise and thoughtfulness of experts, is a sign of confidence and high self-esteem, of clear role definition and a working partnership – a functional family. As a result Internalised Barriers was disbanded and no longer used, mainly replaced by Fathers Provide Support, a theme that emerged from discussing the usefulness of fathers with workers.

Solutions or recommendations that emerged from analysis or suggested by participants were also constructed using grounded theory. Ideas from earlier interviews were fed back to later participants who could comment and provide feedback. In this way concepts were tested with their intended service recipients’ involvement.

For example when discussing a potential model for a support group for new and expectant fathers, participants were asked for feedback on what they thought the group would need to do to attract fathers.
I just think that if you could bring that together to an activity of building something and making something and let things naturally come out as you’re doing something that would be great. So you’re learning skills as well as kind of a by-product of that would be that you’d be sharing your stuff. It felt really healthy, it felt really healthy. I’d be up for more of that for sure.

In this way, consistent with the principles of grounded theory, themes that arose and solutions to issues that arose were fed back to other participants for comment. This process continued until saturation point was reached.

**Saturation point and axial coding**

As the interviews progressed, the saturation point became clearer. Interviews became shorter, questions became more directed, and the focus turned from exploration to the testing of recommendations and potential solutions. Figure 14 shows the interviews growing shorter over time, then becoming longer as solutions are explored, before shortening again as solutions are refined and no new information emerges.

![Figure 14 - Interview length with trend line](image-url)
Figure 15: Polynomial trends of change in axial themes over time.

Figure 15 shows the changes in coding of the five axial themes over time, with polynomial smoothing to clarify the data. Barriers to Father Engagement dominated early interviews, and remained the dominant axial theme until nearly the end of the research, where it was overtaken by Solutions. Discussions regarding theory reduced, while discussions around Supports to Father Engagement increased. This is an example of grounded theory at work – as the research space was explored in conjunction with the participants, the research journey took different paths, first defining the problem, then examining pre-existing strengths, followed by construction and redefinition of the potential solutions. Interestingly, the metatheme of Father-inclusive Practice was fairly constant throughout the interview process, suggesting that this is as important in problem definition as it is in creating and refining solutions.
Figure 16 shows the diminishing rate at which new intersections between themes emerged as constant comparison coding progressed. This is a key indicator of saturation, and it not only shows the rate at which themes are emerging, but also weights themes on their importance. Themes that occur frequently have more intersects. This demonstrates that while in fact more information was emerging from the analysed data, it was simply repeated themes previously explored.

Finally four axial themes were included, as the data settled down after the interviews ceased. At this point, Nvivo, the data analysis program was no longer used other than for reference, as all relevant aspects of the data were written into chapters. The four axial themes were Accessing fathers (p80), Perceptions and cultural constructs (p104), Barriers and supports (p138) and Family, relationships and transitions (p201).

As solutions began to be refined, and no new problems were emerging, it became apparent that saturation point was near. New concepts still arose from time to time – a later interviewee raised the important question of the validity in trying to provide better service to the general population of fathers when there were more important issues requiring attention in specific populations, such as the Aboriginal community. While valid, these points did not provide new information aiding in
understanding service delivery by health and welfare professionals to new and expectant fathers, and as such the data collection element of the research ended, although analysis continued to the day of submission.

Writing and selective coding

In line with the principles of grounded theory the actual writing stage of this research was not linear, but began with a structure informed and reformed as themes emerged from the text. In order to gain greater insights into themes as they emerged, chapters were written and rewritten and discarded or integrated into the final work. As Ezzy (2002, 152) says, ‘Discovery of new meaning and patterns in data involves exploration and experimentation with different combinations of codes... writing involves looking at events and interpretations in a variety of ways until a story emerges from the creative engagement of researcher and participant.’

For this research the writing process significantly comprised the process of selective coding – really making sense of the overriding construction of the data into a grounded theory. This became clear in three steps – firstly the theme that fathers are individuals required a response, the response being that fathers interviewed wanted to be treated like family members. This process led to the metathemes described in the next chapter, which was finally compared with pre-existing theory, as described in Discussion (p221). This follows the directions for coding in grounded theory as outlined by Ezzy (2002, 92).

Moving from this substantive theory to a more formal theory as suggested by Glaser and Strauss (1967, 79) are left for subsequent researchers – the grounded theory identified by this research so neatly dovetails with existing theoretical approaches that a deductive approach may be more appropriate to test the applications of those theories.

Error! Reference source not found. illustrates the process of open, axial and elective coding, with the emergent grounded theory which appeared early, distorting the usual grounded theory approach.
Service Delivery to New and Expectant Fathers by Health and Welfare Professionals

Figure 17 - Simplified graphic illustration of the coding process
All chapters other than the section *The researcher and the research* in Chapter 1 are written in the third person. This is not an attempt to deny the impact of the researcher on the research process, but to ensure that the voices of the participants are heard most loudly, and not dominated by an explicit ‘I’ in the narrative.

Quotations other than in text quotations are in *grey italics*. Quotations from participants have been modified to ensure privacy. Where this has taken place the modified section has been marked with a *[square bracket]*. Where a single quotation has been abridged for clarity, an ellipsis has been used (...) . No change to the intended or potential meaning of the quotations was intentional.

**Ethical considerations**

This research was approved by the Charles Sturt University Human Research Ethics Committee, Office of Academic Governance, with Ethics Approval Number: 2012/047. Participants were all provided with an information sheet and signed a consent form (see Appendix 2, Appendix 3 and Appendix 4). These documents explained that participants understood the purpose of the research, that they were able to withdraw participation at any time and that the information recorded would be confidential and no identifying information would be published. They were also provided with appropriate referrals to counselling services, if necessary.

The most significant ethical consideration for this research was the impact of the interview on the relationship between the interviewee and the health and welfare system. It was thought that this may cause ethical issues if the interview raised concerns that the interviewee had with the service delivery they have received. While this was treated as a real risk, it is the role of critical social workers to encourage service users to be empowered in regard to the service they receive. Interviewing may have uncovered concerns the interviewee had, however this is ultimately the aim of the interview, and is possibly a positive outcome for service if they are able to receive feedback from the participant, although possibly resented by the service provider in question. No significant issues arose during the research regarding this ethical consideration.
Interviewees’ identities have all been protected, with all identifying elements removed from any published material. In addition to these points, the nondirective interviews were non-therapeutic, and contact details for support provided for any therapeutic concerns raised. These concerns included questions about fatherhood that the interview participants had previously not addressed – fortunately there are extensive supports available for fathers in the area covered by the study.

Occasionally, on one of the few interviews with both the father and mother together, a heated topic of discussion would come up. In this example, the couple were discussing supports they might need:

Father: Especially when [she] gets to that point when she needs help. That’s the point when she's most unlikely to go and ask for help. [She] always likes to be seen as the capable one and upbeat and stuff.

Mother: No I don’t.

Father: Yes you do.

Interviewer: We don’t need to go into this if you don’t want to...

Father: No, this is my interview...

Mother: I’m actually interested to hear what he has to say. He doesn’t talk about that sort of thing.

This discussion, like any discussion between two members of a couple, was laden with years of history and previous discussions. In this case, the participants were mature and considerate, and covered an important topic well. This example does indicate the potential for difficult themes to be unpacked and explored in a non-therapeutic research environment.

Overall, the process of interviewing fathers increased their ability to be supported by the service system, as participants often asked the researcher for support in a certain area, which was then referred to another service. A number of fathers participated in parenting programs as a result of referrals from the research process. It would be fair to say that the process of engaging with fathers around the process of having a new baby provided a positive space for them to work through concepts that they might otherwise not have, creating an overall positive impact.
Conclusion

This chapter has detailed the methodology used in this research, describing grounded theory, in particular the use of abduction as a tool for generating theory. The concepts of theoretical sampling and recruitment as they apply to this research have been detailed, with a brief discussion on the impacts of the ethics approval process on the integrity of grounded theory. The data collection and analysis process formed the second part of this chapter, with the process of coding highlighted. This process, alongside the process of abduction, gives validity and meaning to the contents of the next four chapters.
Methodology
Chapter 4. Accessing fathers

This chapter begins with considering barriers to access, then reviews seven approaches either demonstrated by services, employed in the research process, or recommended by participants. During the recruitment stage a number of processes were used to try and recruit fathers for interviews, as detailed above in Theoretical sampling and recruitment (p60). These processes were designed by the researcher both from the perspective of a service deliverer, and a new and expectant father. The approaches employed by the researcher to access fathers are not dissimilar to the approaches which might be used by services for different ends. For this reason the process of trying to access fathers for this research is also included as data, as indicated by the grounded theory process of including all relevant information as data. Workers tended to view accessing fathers as a kind of impossible challenge, as if support they required was beyond the limits of reasonable service delivery. The research process uncovered that new and expectant fathers are hard to find, and even harder to engage.

Barriers to access

When fathers were successfully accessed, they ranged from voluble to verbose, as if a verbal dam had been released, often speaking for ten minutes without a break. Getting to this point however was remarkably difficult – as one father support worker put it:

Where do those guys gather? They don't necessarily - all these pregnant dads don't have one corner of the pub allocated to them

Another father worker, with decades of experience couldn’t help either:

These guys don't gather, that's the thing, so they're all individual and guys aren’t encouraged to gather...

A father, who was also a worker, indicated it would virtually impossible to find new fathers anywhere:

In fact, when you think about it, new fathers frequently are not going to be congregating anywhere because they're going to be at home. They're going to be at work and then home, work and home...

This was supported by another worker, who saw second time fathers as even harder to access:
...their role will be the carer of the second child or third child - so they won't always be there

The proposed tactic of snowballing; asking fathers interviewed to refer other new and expectant fathers they knew proved fairly fruitless, with only one father recruited using this method. The tactic of attending antenatal education sessions also failed to produce significant results, with only a small number of volunteers from each. One participant from these groups mentioned that the fathers that had agreed to be interviewed were not the ones that needed interviewing – insinuating a father prepared to give up their own time to improve overall service delivery was more likely to engage anyway. This theme was repeated a number of times. Some workers suggested that service delivery can only do so much:

...it's like planting a seed. You can have a great seed. This will grow to the most marvellous beautiful little tree that'll produce fruit and rest of it, but if you throw it on the concrete pavement, it's going to die. You need the right soil and the right environment for that to flourish.

A worker suggested that the local area was part of the issue:

Because guys in Byron Shire are either working in hospitality or mobile, it became very difficult to run the post natal classes because guys were busy, they had their baby, they were moving.

This was echoed, but from a different perspective, by a father:

I was a bit worried thinking oh man it's the stereotypical blue collar North Coast dickhead, that's probably what they're thinking of me but I guess they don't know the full story.

On recourse to the statistics, Figure 18 shows a significant variation in professions in the shire. This suggests that other forces are at work, but that they are not well understood, resulting in workers and fathers creating their own explanatory stories for the difficulties in accessing fathers.
Other fathers indicated a lack of knowledge was the heart of the issue. This father, who is a trained and experienced counsellor, highlighted this:

Okay. So when you say workers, I can’t even, I can’t really think of how I would link in with one. I don’t even know at what point...

This father suggested that fear might be preventing men from engaging with services, linked to the social conception of what men are, or what men do (see Gender roles today p18):

...there's a lot of men who are fearful of that formalised kind of thing and say I don't need to do that, I'll work it out - I'm a man, I don't need anything. You're coming up against all of that.

7 (Australian Bureau of Statistics 2011b)
This was echoed by another father:

Yeah, oh definitely, like personally I am kind of a shy person. I will not ask for help unless I’m almost forced to do it, right and that’s not necessarily just a guy thing but to me it feels like it’s the classic a man will drive around two hours lost but the woman will go to the gas station and ask for directions. That in some ways sums me up because I will avoid talking to people, having interaction and how would you plan a service around someone who will avoid you typically at every corner unless you feel comfortable with it?

This question ‘how would you plan a service around someone who will avoid you typically at every corner’ sums up the problem of service engagement for new and expectant fathers. One couple lived literally across the road from the Community Health Centre, and still had not engaged, instead relying on the internet for support:

It’s interesting because I don’t think we would walk over - the physical boundary is so much bigger than like the digital one, because like you feel vulnerable when you - I do anyway, when I talk to somebody or when I ask for help, whereas if I Google something no one knows that I’ve done it, it’s completely anonymous.

Six main approaches to accessing fathers were identified during this research; accessing via mothers, masculine approaches, multimedia, word of mouth, traditional approaches and active recruitment.

Accessing via mothers

It is not surprising that in a system so dominated by providing a service to mothers, that participants were so quick to see mothers as the solution to father engagement. This approach seems to have been adopted for largely practical reasons, however no participant gave an example of this strategy working in isolation to any other. This GP explained why this approach was used:

Well, the reality is - as a GP - 75 percent of your clientele are kids and females. Of the remaining 25 percent who might be male, most of them are elderly, so really your portal of entry [to fathers is] going to have to be through the mothers who are coming in.

A father worker, whose role relied on father engagement, had the same solution:
The place I’m seeing them gather now is at home with their wife. What’s the only way to them if they’ve got all the flyers, everything, what’s the only way to get to them? It’s the wife.

This approach seems to have most value in balanced, resilient relationships, where placing the responsibility of father engagement on the mother would not have a negative impact. One father explained how his experience of the service system was vicariously experienced through his partner:

Interviewee: ...as a father you can quite easily go through the whole experience never coming into contact with any service at all.

Interviewee: Yeah, that’s kind of the trajectory that I think I’m heading on. I think I’m just basically doing what [my partner] tells me to do, you know.

Interviewer: That’s another key thing that all the workers do say, we access fathers if we need to through the mother.

Interviewee: Yeah, but then that still doesn’t discount the other stuff that I need to be conscious of and have an active role in like just planning, the pragmatic aspects of having a baby.

This suggests that focusing on the mother as a conduit for the father may introduce a power dynamic in the couple, on one side increasing pressure on the mother, making her responsible for the father’s engagement, and on the other permitting the father to remain disengaged and subsequently blame any disengagement on the mother. Other power issues are also inherent in this approach – one worker raised the issue of choice:

Would you like that support from him if it was possible? Then she would tell her story. If she said oh not really, I’ve got my mum and I’ve got my dad, they help out, stuff him, well then it’s over pretty much. But if she says no, I want his support, he’s part of this, so it’s about empowering her how to approach him rather than go home and say mate I’m not cooking for you, no more sex, nothing, until you turn up to one of these. That’s probably a deficit model.

This approach could be viewed as problematic if the mother does not want the father involved, or does not relish the predicament of having to bargain for father engagement. Suggesting that women trade sex or food for father engagement is also potentially problematic – rather than empowering the mother to engage the father this may lead to the disempowerment of the mother and the disengagement of the father who resents the resultant relative imbalance.
This applies especially to resistant fathers – those fathers who some workers saw as most important to access.

_How do you access those dads? You can send flyers and brochures home all day and they’ll read it and go yeah that’s probably not for me though._

For these fathers, who can’t be accessed via their partners, or who shouldn’t be, other solutions were explored.

**Masculine approaches**

These solutions worked backward from the common conception of men; as tough, self-conscious, and above all full of prejudice:

_Men work on this subtle thing where we don’t want to openly start talking about our children. If we’re building something it might - the conversation might lead towards that, you know?_

Less subtly, a worker explained the importance of proper brand management for programs working with fathers:

_You’ve got to normalise the process in that this isn’t some wanky tree hugging extra bit just for blokes._

This theme was continued elsewhere, with slightly homophobic undertones:

_I can see how it would work well for some dudes that think it’s a bit gay to go to a class full of dudes sitting round talking about it._

Fathers, and men in general, are seen as being almost prickly and standoffish – something akin to sensitive, and as only engaging when the conditions were right. This father worker explained where an advertisement aimed at promoting father focused programs should be placed.

_Interviewer: …say you’ve got half an A4 ad or …a column in the Echo out near Mandy Nolan’s column…_

_Interviewee: No, right next to the form guide or the footy results._

Not all men read the form guide or the footy results. A potential criticism of this approach to engaging men is that it supports the very issues that prevent men from engaging with services. This idea that men are a certain way, and services can only work with them in that way not only excludes men who don’t subscribe to traditional forms of masculinity (Men’s Health has 7.3 times more readers than Inside Football (Roy
but also perpetuates these stereotypes. Men who would otherwise engage with services might not if they feel obliged to act in a certain way, dictated by conventional norms of masculinity. This barrier to accessing fathers; that masculinity doesn’t ask for assistance, was communicated by this father:

I think it’s up against that whole kind of bloke attitude that we just don’t really talk and we get together with our mates. It’s that kind of formalising anything like that it brings up fear for a lot of blokes I think. I think just because of that independent nature of man I don’t need anything, I’m independent.

Workers who rely on and perpetuate this approach to accessing fathers may be doing a disservice to fathers in the long run. Creating a space where men can leave the social expectations of masculinity may be a more constructive approach than creating a space where these norms are enforced.

There are a number of other issues other than the potential alienation of fathers who don’t subscribe to this paradigm. This partner thought that the usual men’s programs, run at the local health centre after work, missed a key element of father engagement – the child.

I always find with these fatherhood projects and fatherhood things, the fathers go at a time when the child’s asleep. So the child’s not really integrated into the father’s experience. I only say that because I envisage a bunch of fellas standing around talking about football that happened the night before. Whereas if you have a child there you’ve got to watch them interact with other children and you actually have a chance to talk about where your child’s at.

Ultimately, the idea of engaging with men using a masculine approach may be inherently flawed – this father explains that one of the key elements of being a man is not engaging with services.

I’m kind of a bloke in that respect, it’s taken me years to go to the doctor. I finally go and it ends up, you know all the stress you go oh there might be something wrong, there’s nothing wrong with me [laughs].

Alternatively, the masculine approach was also beneficial for one father, who saw fatherhood as a natural state informed by masculinity, and really appreciated the basic level of the fatherhood course he took:
I think that’s the classic bloke… I’m a bloke and you know what? …Yes, I know that I need to do that stuff and that stuff is really important right now. …there’s millions and millions of people who have been here before us. It’s not rocket science. It’s basic stuff. That’s what I think is great for - is the basic stuff. It’s what makes it a lot easier.

Another father was put off by this approach in the same course:

Man some of those guys, there’s some really smart blokes there. There’s some responsible jobs. They’re good for their community; they’re going to be good dads as well. So there’s not one bloke there that I would have thought some of that shit was applicable to.

This highlights the variability in course element that appeal to different fathers, even within a distinctly masculine approach. There is another, more subtle kind of masculine approach. This father worker explained how working with men can be done in a masculine way without alienating men who don’t subscribe to a macho frame of reference:

It was just the language and stuff that was used in the brochures; it was what you do in your spare time and it had somebody knitting… you’re not going to engage guys if you’ve got a photo of knitting …it all relates I think from what the reception is set out like, to the way that I communicate with the guy in terms of building a rapport. I think a lot of that is a large part of why outcomes happen; because the person feels as though they’re relating to somebody that’s walking along that path as well.

This approach speaks to working with men as men, in all the shapes and sizes in which they arrive, not working backward from a dominant stereotype to determine who and what men are. This aspect of a men focused, rather than masculine, approach, may have significant lessons for successfully accessing fathers. This father talks about what connecting with other men meant to him:

I wouldn’t enjoy it if I would read a book. I wouldn’t enjoy the moment, like to be a group to have a joke, as well and to have a talk to this man…

Another father had a similar experience:

It felt like here’s a normal thing that a bunch of blokes get together and they talk as blokes without women about what’s going on for them and it felt really healthy on many levels.

This provides insight into what services need to do to access fathers – not to appeal to the hard, masculine exterior of men, but the underlying insecurities which
they have around fatherhood which they might want to address. While this general concept may be useful for engaging fathers, it doesn’t provide services with specific tools with which to implement this approach.

The general underlying exclusion of women inherent in a masculine approach is also problematic – fathers care about their partners and want to experience the process of new and expectant parenthood with them. This does not mean that all service is provided together; as detailed above men can enjoy women free spaces to interact. What it does mean is that services need to ensure they do not exclude mothers by appealing to fathers, and repeat the mistakes of mother focused practice.

As with accessing fathers via their partners, elements of this masculine approach worked well for some fathers and put other fathers off. This demonstrates that as fathers are not a unified group, and that a number of strategies are required to engage them. One strategy that has the potential to appeal to a number of different fathers is the use of multimedia.

Multimedia

Media in general has not always been kind to new and expectant fathers, portraying them as less than adequate, panicky and inept. This father worker explains:

Yeah, we’re borderline stupid...if you look at the ads and things on TV and media representation of men we’re either stupid or violent. Very, very, very, very few positive images and if you look at most shows ...there’s a whole heap of other shows where women beat the shit out of men all the time. There was an ad on TV where this bloke was doing something wrong and the woman’s got a 14 inch shifter and smacks the guy over the head and everyone laughs.

Of course it shouldn’t be, but if it’s not funny for a bloke to hit a woman, how is it funny for a woman to hit a bloke?

Many participants suggested that multimedia was a way to engage with fathers. One father suggested he would watch a film about fathering, so long as it was funny, and another suggested an iPhone app. It is not clear if this is a reflection of the contemporary trend to move all human communication online, or a realistic method.
of engaging fathers. The key strength of this approach, similar to using mothers, is the ease with which it can be used, both by the service and the service user:

*I think in this day and age most of it could easily be done online. Like you register into the system as giving birth in this area or something like that and you log into your page and there’s all the information available in the area.*

Another father explained that during his depression, he had reached out to friends, but that he would have accessed the internet if he hadn’t had that option:

*Had there not been any of these things available I probably would have just asked more questions of my brother-in-law and my sister. I rang my mate [...] in Newcastle and said mate at the risk of sounding like a dickhead talk me through this. I probably would have spent more time looking on the internet.*

This father explained why it might work – the appeal of engaging with something online seems to be less associated with work (like reading a pamphlet might be) and more with relaxation:

*I've done all the things I need to do - I've done the lawn, I've done all that shit and now I can spend an hour and I can do that fatherly kind of thing and feel good about that. They can go onto their computer and get on and do some research and look for those sorts of things. So I think that would be a good way to do it.*

Again, this father identified not only the ease of access to the internet, but that it holds a kind of intrinsic peacefulness in which fathers would susceptible to engaging with services:

*I think some maybe online answer there is more and more the way to my way of thinking because I know that most men are online these days. It’s a very - it means that they can do that sort of thinking which is a particular kind of caring thinking and that kind of thing in their own time in their own way.*

This idea that using online approaches creates a caring space in men is not generally reflected in the literature. This may reflect the self-directed nature of online and multimedia approaches, or the way that the participants engage naturally and freely with new media. This concept reflects the underlying nature of fatherhood as distinct from masculinity – the need for services to access men in a safe way that recognises their need for comfort. It may be that multimedia has the capacity, due to its interactive
nature, to be accessed by new and expectant fathers at their own pace, when they are ready, and when they feel comfortable.

A multimedia approach also has a significant resource allocation benefit, as one senior manager, who has a family, suggested:

...most of the health service is already consumed by what she called the worried well and look, that's me. That's my family entirely. We don't need probably - we probably need a tenth of the service provision that we've been getting, realistically. Do a lot of it over the phone, a lot of it over the internet. We could do a lot of it ourselves.

The counter to this, regarding the ‘worried well,’ is explained by another manager:

...the worried well also get on the internet and look up and come and tell you in the clinic what they think is wrong... There's a whole group out there who use the internet for health advice, and not very well they use it. But you know, if they set something up that's really appropriate, they could knock off half the people that we see because they'd get their answers there...

One exploratory method of recruiting which was considered was the use of Facebook, which allows specific targeting for advertisers, as shown in Figure 19. This level of detail, targeting only new and expectant fathers in the specific catchment area of the service, allows a level of access never before available. 1 in 5 Australians connect with commercial brands via social networking every week – however no data is available for interaction is health and welfare services (Gilmer 2012).
Facebook has 11,666,040 users who live in Australia, more than half the population (Facebook 2013). From a funding perspective, a service would be charged 16c for each 1000 people who saw their advertisement. Services would need support for such endeavours – many businesses fail to use social media to engage their customers, and services are unlikely to fare any better. Expert commentators point to the difference between traditional broadcast modes of marketing, and the conversational modes of social networking (Khoo 2013). Clearly, there is untapped potential for services to cheaply access a large portion of their target audience online, which should be explored in more detail.

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* (Facebook 2013)
It could be argued that the internet is part of the solution when used correctly, but also part of the problem when used incorrectly. This father explained his frustration around not having adequate support and having to rely on the internet:

…but one of the things I have an issue with kind of is knowing like who to trust and like [my partner’s] been on a big kick of I can eat this, I can’t eat that so we look up everything. Every website has an opinion so how do you trust - like that’s a big thing for me because we are starting to rely on the internet knowing having the resources on the internet that we can trust is a thing. ...because we haven’t had someone to trust that’s been answering the questions and we’ve been using the internet, then we don’t trust anything... Which is a bit disturbing because it makes life difficult and annoying.

This lack of trust in the information on the internet was echoed later on:

The only thing is that reading this stuff on the internet and - I'm always a bit unsure that we've found all the information we need, so when you can talk to a person about that you can know that at least because I guess I have this inherent trust that people will tell me the right information.

This father, despite understanding the resources available on the internet, hadn’t accessed it for support. For another father, it may be that accessing him via his partner is a more viable approach:

Do I think I have enough information? Maybe, like I mean I've gotten information from [my partner] and that's because she's read stuff mostly, so like reasons why you would or wouldn't do certain things, it's all basically come from her. I haven't really done any research on my own which is totally possible, because the internet's there right, the pamphlets are there but nothing's been forced on me.

More traditional forms of media were also raised. This father explained what he saw as the benefits of a video:

I'm just thinking more broadly, in a broader sense for trying to convey important health related information to the broader community then not everyone's literate, for one... I mean maybe if you were to embed that message in a more kind of, in a broader documentary about what the process is about, what to expect, you know. Obviously it would have to be engaging, it couldn't just be a campaign that you've got to be nice to your partner. It would have to be more complex and more interesting than that.

Basic literacy in Australia is generally high, however a 2006 study by the Australian Bureau of Statistics showed that 46% of Australians ‘are considered to lack
the minimum skills required to meet the complex demands of everyday life and work in the emerging knowledge-based economy’ (Australian Bureau of Statistics 2012a). Illiterate fathers may be both the most difficult to access and the most in need of engagement.

Another father thought that a multimedia approach was not sufficient, even from an early intervention perspective – he thought that a societal shift in which people are more engaged with children throughout the lifespan:

*If there was more about those sorts of things and then - and it's ingrained and by the time you leave school you automatically know what happens in a birthing centre and you know what happens during pregnancy not because you've watched a video in a 12 week course but you've been to a birthing centre and you've kind of been a part of something or you've helped out in some way or something like that. Then maybe it would be more ingrained and maybe that's just a societal shift.*

This suggests that as with the two previous approaches, multimedia can be both used and misused when engaging new and expectant fathers and their families. Another approached suggested by workers and fathers is using word of mouth to engage fathers.

**Word of mouth**

Every person interviewed for this research was asked to refer other fathers they thought would be interested. This was originally intended to be the primary mode of recruiting fathers for the study; using a snowballing technique. Only one father was recruited in this way. This may be due to a number of factors:

1. New and expectant fathers are not a cohesive group – often fathers are in pre-existing friendship groups with men either with no children or older children, and are in the process of forming new friendships with other fathers at the same stage in their fatherhood journey. This means that the links between new and expectant fathers are not always strong, and as such are not ideal for communicating information regarding access.
2. Most services provide some reward for participation – this study did not and as such there was no concrete incentive for fathers to participate.
3. New and expectant fathers are busy, and often focusing on their own families and futures, and not necessarily cognisant of the general service system or of the needs of other fathers.

4. Fathers recruited from the study were recruited from father’s groups or antenatal classes, which may have meant that the fathers who were asked to refer other fathers mainly knew fathers from these groups, who had already been approached.

The single father that was referred was referred from a new arrival with the least significant links to the local area, suggesting that the number or quality of community links is necessarily indicative of a person’s ability to access other fathers on behalf of services.

Many fathers in the study only knew about available resources through their friends or family:

*I just got information about this “man course” with [a service provider] from a friend. He had a child just a year ago and he recommended this course to me, so if I wouldn’t have this or if I wouldn’t have this recommendation, I don’t know if I would know or if I would knew about this course. Probably not.*

This worker thought that community leadership was a key element of engaging fathers:

*...it’s about finding the leaders, leaders in - now if you had a bunch of guys that had one year olds like you, you would figure out a way that you could encourage them to access a service because you would probably be a leader for those guys. You would talk to them in a way that doesn’t say you need to go and do this. Fellas, this is what happened for me. You tell your story and you’d have to hope that they go...*

This concept of community leadership was not reflected in the observed interactions of fathers – rather that the network of fathers was too fragmented at the new and expectant stage to develop a leadership structure. This may change for older fathers as their networks solidify around school, children’s sport and childcare. This
approach shouldn’t be ignored, but does need to be better understood – as one father identified the strengths of man to man communication:

I worked with some amazing blokes and learnt really quickly what it was that made me think ‘what a good guy’. I saw these qualities these people had. So even at 30 I was still learning from these people and I thought if I take away 10 per cent of what this guy has taught me I’ve had a result. This bloke and his actions in dealing with people and his confidence, he’s forgotten more than I’ll ever know.

This father worker added some clarity as to why this style of relationship works for men – a comment on the masculine, or more specifically patriarchal tendency to not want to seek help overcome by a filial tendency to seek assistance from patriarchal figure:

It’s like a mentor. It’s for men, at a certain age, it’s hard... to say, all right, what do you want to tell me? Or what is important for me? Probably you have already career and your job and you’re doing pretty good in your job. Why would you just go to person and be open to this person and say, all right, I’m learning again and what do I have to do, please tell me, teach me?

This concept that new and expectant fathers can be accessed through older men is a difficult one to test, and was not covered in this study. As the average age of the participants was 37, it is difficult to see that their own fathers would still be connected to the service system or the experience of new fatherhood to a reasonable extent. A potential solution, relying on new fathers supporting expectant fathers, is proposed in Chapter 7. These concepts of mentoring and friendship networks are covered in more detail in Community supports (p189).

This approach to accessing fathers did not work effectively for this study, and no evidence of it working for other services was observed, however if the strategy were shifted to using mentors rather than peers it may have a greater impact. The next key strategy assessed during the study was the more traditional approach.

Traditional approaches

Traditional approaches are not so much an approach at all, but an expectation that fathers should take responsibility and engage with services themselves. This seemed to be based on the premise that given that workers work well with mothers, the
problem must be with the fathers not wanting to engage, not the failure for workers to engage them. This applied especially to resistant father:

None of those dads are ever going to call you. They’re not. We know that. That’s why they don’t come to our workshops on whatever. Which is a shame isn’t it?

A different worker had this to say:

Well yeah certainly but it’s really hard because they’ve got to want to do it too sort of thing. I mean we can’t go out and say we’re going to run this group this afternoon and say we really want all you new dads and blah, blah, blah. If they don’t want to come we can’t bring them, we can’t force them. We can continue to try to offer and engage and encourage but I’m not sure, maybe you’ll get something out of your research, with how we can actually get them in.

These suggestions usually came from workers who may have been defending the lack of focus on fathers in their practice, or their lack of success in engaging fathers. One program had been successful, relying entirely on referrals from other agencies, such as child protection agencies. This approach worked, but does nothing to address the issue of how to engage with fathers in the first place – ideally before they come to the attention of Community Services. As identified above, if men are not engaging due to a lack of knowledge or to fear, services cannot simply expect them to come knocking on the doors:

We need to empower these guys. So it’s not always about the guys not able to access the service, it’s how does the service access them? Yeah?

Workers who worked at engaging fathers from a traditional perspective often worked for NSW Health, and were usually concerned about funding issues.

I wouldn’t like to see is a lot of money spent on trying to engage those resistant dads. I think there would have to be a process of looking at this is what gets resistant dads in - so what’s the minimum outlay if you like - let’s talk private sector - what’s your cost benefit - your minimum outlay to get those - a large percentage of your resistant dads engaged. What I wouldn’t like to see is a lot of money spent on trying to engage non-engaged dads because it’s not going to go anywhere.
Another worker indicated that even with the required funding, fathers were still unlikely to want to participate without an education program supporting their involvement:

So yes I mean if we had resources - if we had the resources and the ability to do it better I’d certainly want to facilitate that, but again it comes back to the dads and I guess that education needs to start early on to say that if you want to be involved, be involved but be involved as much as you like.

Sometimes these workers had made attempts at engaging fathers by being more flexible, or modifying some aspect of their work practice. When this hadn’t been immediately successful, they reverted to their previous practice:

...we’ve run programs going gee, if we all can’t trip in here at 7 o’clock - seven to nine at night - instead of running it from 11 to 1, we’ll get dads. We don’t get dads.

This often reflected the metatheme of three different levels of father engagement (see p222), in that engaged fathers were accessed without any trouble, or rather did the accessing themselves, disengaged fathers could be convinced, but resistant fathers were not worth the trouble:

What else have we done? We’ve done men’s programs only. So we’ve thought okay, we’ll run a parenting program for - and interestingly the ones who are engaged like you we don’t do anything. We don’t have to do anything to our service delivery; you come along anyway. The [disengaged] dads, when we invite them along, and we say it’s really important that you both come and we make the phone call to dad - so we specifically invite dad and we explain why it’s important to be there, we’ll get them. They’ll come in, generally. The really [resistant] Dads - as I say we’ve tried a whole lot of things and not for a great benefit.

This NSW Health worker didn’t think that the child and baby health nurses should be working towards father engagement, but that other points of service contact would be more beneficial:

You take your baby to the child and baby health nurse, yep, great, tick, done it ...but you know, I actually think there’d be a better context to involve fathers.

This was reflected in the experience of some (but certainly not all) fathers:

...she didn’t pay me much attention at all. She was all speaking to [my partner] and it was the second appointment that [my partner] had
been to. Second? So [my partner] had gone for an initial contact and then I went for the second one. It was just a routine second where she did some sort of Doppler check and took a few - you know bit of blood pressure. Again she didn’t really talk to me at all. So again I guess I did feel a little bit excluded there as well.

Interesting, that father’s partner saw that that worker hadn’t done much to engage with her, either:

Female: But it's not - neither appointments were very personalised towards me either. Like they addressed me but it wasn’t like how are you feeling so much.

Interviewer: So it was quite medical.

Male: Yeah it was quite medical yeah. There was a little bit of that but not much. There was nothing - you know I may as well have not been there.

When fathers were able to go, the partner found this a positive experience:

Interviewer: How about you... has that made a big difference having [your partner] come to those things and being a bit more involved?

Interviewee: Yeah it’s a big difference. It makes me feel really supported and yeah just makes it seem like he’s included and yeah makes me feel better prepared for the birth I think... Especially yeah with it being the first child. Yeah just to feel prepared and supported - for both of us to feel supported somewhere as well. It's good for us both to be at those appointments.

It seemed that while workers, (and partners) usually played down the importance of father involvement in the routine, medical visits, fathers (and partners) found this involvement beneficial. From the worker perspective, it appears that taking only insignificant or token steps to accessing fathers is based more on resource imperatives in an increasingly resource tight environment than a real appreciation of what the benefits or realities of accessing fathers might be. This may also be related to the way workers view fathers, which is explored further in Perceptions and cultural constructs in Perceptions of fathers (p105).

Overall the traditional approaches did not have overall success with accessing fathers. One approach contrasted clearly with the traditional approach and did have
significant success – where workers actively sought out new and expectant fathers and recruited them to their programs.

**Active recruitment**

By far the most successful method for engaging fathers, and one that raised the most controversy, is active recruitment. This was demonstrated in the success of the Building Better Dads program run by NSW Community Health in Bangalow, which recruited fathers after mothers provided their partner’s phone numbers during a midwife visit. Fathers were then phoned a number of times to ensure that they attended the course. This tactic was overwhelmingly successful:

*Interviewee:* [My partner] put my name down for it somewhere and then [the course interviewer] called me.

*Interviewer:* Would you have come otherwise? If you had been given a flyer, do you reckon you would have...

*Interviewee:* I don’t - maybe not. Maybe not.

The validity of this approach was made clear as in neighbouring Lismore, the Building Better Dads program is not run by NSW Health, but by another organisation. This meant that due to privacy concerns, expectant fathers’ phone numbers could not be provided to external organisations, and the organisers of the course have to attend the antenatal classes to recruit fathers, with varying success:

*So it’s double-handling but it’s still potentially access to every dad that goes through there as opposed to losing so many of them because we can’t get their info or whatever. Yeah I don’t think our system will ever be as smooth as [Bangalow] because that’s a great setup.*

Another worker, funded to work with mainly school aged children, used a similar tactic:

*I started at the front fence where the guys wait for their kids to come out so I just go there and hang with them. Sometimes it’s raining - I jump in the car with them and we just yarn.*

A worker who uses active recruitment techniques confirmed that this approach required a fairly persistent style:

*...I just keep pounding them. Most of those people I ring five times to get them in. I know I’ve had to ring you a few times but a lot of guys I ring five times before I get them engaged. Then if they don’t turn up to the first class I get their mates that are doing the same classes to give*
This approach didn’t work for everyone. One father, who admittedly had significant community supports, found the active recruitment approach a bit much:

Interviewer: Why didn’t you go to the fatherhood preparation classes?

Interviewee: Well that's because I was a bit put out by the fact that he just cold called me…and the way he called back twice and it was almost like there was a little bit of pressure there to come along.

Given that some fathers are resistant to cold calling required by the active recruitment approach, what should workers do to access fathers? The same father had a solution – a male nurse who would come and visit the fathers at home, post birth, after hours:

So why can’t we have a male come around like a midwife does for the six weeks? That would be good because then the dad doesn’t have to go out at night. The male nurse or whoever it is could come round and say, how you going mate?

A worker raised a genuine ethical concern, and possibly the main barrier for workers trying to access fathers using any method:

People need a choice. People need choice and so if a father doesn’t want to participate, then that’s okay as well.

Workers need to consider both fathers’ right not to receive service, and the potential impacts of receiving or not receiving the service. This becomes more problematic when the service is funded to increase outcomes for somebody other than the father – either specifically the child or the mother. What is identified is the need for a practice approach that can be flexible in delivery, without allowing workers to focus overly on babies, mother or fathers.

Participant solution – information kit

Through the process of assessing barriers, interview participants were asked to provide feedback on what they thought might be a way to overcome them. These suggestions were then fed back to later participants to comment on, and participant solutions were generated. Fathers interviewed often related that they did not have enough information early enough to make a decision about key aspects of their
Understanding Service Delivery to New and Expectant Fathers by Chris Maylea

pregnancy, such as courses available, which hospitals offered what, until after these decisions had to be made. They would often gain this information from friends rather than the service system (see Friends and family p191). Fathers were surprised at the disorganisation of the service system:

*I'm surprised that you don't get an agenda at the start of your first pregnancy. Just a really clear outline of what events are to follow. That would be useful, put it on the fridge.*

They also identified that they would be more involved if they had better information:

*If there was some kind of flowchart that just showed me what the appointments, when they were coming up and what the purpose was then I probably, my attendance probably would be higher, I'd say.*

This indicated a gap in the way accessing fathers was viewed – not as a lack of effort on behalf of the fathers, but as a lack of information provided to them. The need for a local resource was identified, rather than general parenting or pregnancy information:

*...if you've got some rough guide to the path that you're go on and how that fits into the local community in the area whether that's a booklet or something I think that would be really beneficial for everybody around here. Well I certainly would have found it very helpful.*

This worker had already approached a manager in the service system with a similar idea, which had not come to fruition:

*...it’s something I’d still love to see happen, is like a dad’s resource pack that is given to expectant dads at the hospital.*

Having identified the need, fathers were asked what would get them to actually read it:

*...kind of like those men’s magazines how they offer stuff as well - like you know might have gadgets and stuff - the latest gadgets and the latest apps and that kind of technical, practical stuff in there like how to make a cot and those sorts of things and make it look like something that’s got - that’s not pink and womanly and like a Cleo magazine.*

This idea of practical concepts as being immediately attractive was repeated:

*If you made it look like there was a whole lot of practical other stuff in there that was really going to be practical it probably would work. I’d probably open it and have a look.*
Humour was also offered as an incentive to get fathers to interact with it:

I think if it had some humour on it, some kind of a cartoon, or some kind of a caption that would not look like your typical doctor's office... if you want to have somebody to pick it up, it's got to be eye-catching, with some kind of a sports figure, or a cartoon figure, something that I guess guys would - not all guys are going to be drawn to that stuff, but I think if it would be different, you'd have guys picking that stuff up faster...

At a certain point it became clear that two packs were needed, one provided by the GP at the first GP appointment, and another provided by the hospital on discharge after birth – fathers simply couldn’t think clearly about what would happen post birth during pregnancy:

Interviewer: When you bring the baby home, do you know who's going to support you then...?

Interviewee: No. No, I don't really know what's happening with that yet. I don't think we've worked that far.

This worker, who had developed similar packs in the past, supported this method:

I think your idea of getting it earlier is a good one. I think the take home one is a really good one too. I think timing wise, that just works. There's that separation there of services.

This simple solution was seen as addressing significant gaps raised by the fathers in this study, important gaps that the service system wasn’t filling. As this father says:

...you are making some big, big decisions and in a way they’re not actually really decisions that I have made because they’re not informed, I’m just going with what I think is kind of the default position.

Finally, some fathers suggested this pack could be more accessible online:

I think in day and age most of it could easily be done online. Like you register into the system as giving birth in this area or something like that and you log into your page and there's all the information available in the area.

One father even suggested an app, for mobile phones. This information kit would ideally link in with one off information sessions for fathers (see p134). This participant solution has addressed some of the barriers to father engagement raised above.
Conclusion

Six major approaches to accessing fathers were identified during this research; accessing via mothers, masculine approaches, multimedia, word of mouth, traditional approaches and active recruitment, with a participant derived information pack presented as a possible solution. The inclusion of the difficulties accessing fathers for this research as data gave an added insight into the challenges and opportunities that health and welfare workers face at the early stages of engagement.

Three levels of father engagement were present in discussions with participants regarding access, mainly regarding the different strategies which might work with different participants – a consensus was held that engage fathers access themselves with little encouragement, while resistant fathers would need an extreme amount of force. The participant solution of an information pack would have the most significant potential impact on disengaged fathers who would engage if they knew how.
Chapter 5. Perceptions and cultural constructs

A key element of understanding why fathers don’t access services, or why services don’t access fathers, is to understand the perceptions that workers have of fathers. The overriding theme that dominates this chapter is that there are as many different types of fathers as there are men having babies – every father is unique, and any attempt to create, or even investigate, a generalised approach to working with fathers needs to negotiate this. A response to this, including the social work principle of individualisation is explored in Chapter 8.

In order understand the way different key players in the arena interact, the perceptions of fathers and workers are examined from the perspectives of fathers, their partners, workers and managers. This allows an insight into the discourse surrounding service delivery to new and expectant fathers, and addresses the prejudice which supports some of the most significant allegations made about different groups. It also highlights the different priorities that these groups have – for instance Figure 20 and Figure 21 demonstrate the different conceptions of fathers as caregivers between the two main groups. This chapter also includes an analysis of culture change in services as perceived by the participants.

Fathers are individuals

Fathers become fathers in different ways. One father, who at 41 had found himself expectant by accident, communicated his unease regarding the way other fathers were so keen to have children:

*Mate I worried in that - when we were doing the dad's course the first day we were there, the first or second day and they're going round and blokes are there going 'oh yeah me and me wife couldn't wait to have children and we were dying to have children.'*

*I'm sitting there going shit I'm the only bloke here who didn’t go into it reluctantly but was like oh man this isn't really what I planned. I just - because I was 41. I was 41 years by myself. I've been busy. That's the way it was whereas other blokes have this different attitude."

When one father was asked how we could access fathers, he replied:

*There's so many different types of men... I don't think there's any simple answer.*

Other fathers responded the same way:
So, whatever you design for dads, in your situation, probably like any other medical service, it’s not just catering for one person or one type of person. You’ve got so many different types of people, that what works for someone might not work for someone else.

Many workers understood this:

Each client is individual. So I don’t tend to assume that a client wants anything until I hear what they do want and I try to keep that across the board. So to answer what it was, in very general terms, I really would hesitate to offer an idea as to what fathers want... I think there needs to be an understanding that a father’s role can be completely fluid.

Despite this claim to accept that fathers are different, there a clear theme of perceptions of fathers, sometimes straying into a prejudice against fathers, often emerged.

Perceptions of fathers

The first perception that became clear was the way fathers were categorised by workers and fathers, into three main groups. One expectant father, also a health professional, was quite candid about the binary nature of fathers he worked with:

It depends on your clientele too. We all know what sort of clientele there is out there. You get your good ones and you get your bad ones.

A senior manager had a less binary perspective which supported a graded model of father engagement:

People are really receptive to service, they want it, they expect it. Whereas in other places, with lower, more disadvantaged - it’s not even on their agenda.

She went on to argue the case for a graded model:

Because it’s also a completely different engagement strategy. What works in Bangalow won’t work in Casino. You have to use a different way to engage more disadvantaged and more at risk groups in anything that you do. …it’s very different populations. Very, very different.⁹

Engaged fathers were seen in a certain light:

⁹ Average taxable income for Byron Shire in 2009 was $33,011 compared with $31,048 in Casino in the same year, only a 6% difference. See Appendix 5- Local Demographics for more information and Local community (p180) for more responses regarding perceptions of the local community.
We’ve done men’s programs only. So we’ve thought okay, we’ll run a parenting program for - and interestingly the ones who are engaged like you we don’t do anything. We don’t have to do anything to our service delivery; you come along anyway.

And a father who identified as engaged:

If someone who we think knows what they’re doing tells us we’re doing it wrong, we’ll change it. We’ll do it differently.

Disengaged fathers were viewed as being involved with services only under pressure:

The [disengaged] dads, when we invite them along, and we say it’s really important that you both come and we make the phone call to dad - so we specifically invite dad and we explain why it’s important to be there, we’ll get them. They’ll come in, generally.

And a father identified this middle group:

Obviously, then there’s a grey zone who could be persuaded one way or the other...

While disengaged fathers were seen as being too hard to work with altogether:

The really [resistant] Dads - as I say we’ve tried a whole lot of things and not for a great benefit.

This conversation led to discussion regarding disengaged fathers as opposed to resistant fathers:

....they're the ones who probably need most of the help, but they're the ones who are probably least likely to seek it and the least likely to accept it. But they're the ones where the risk is. ...They're the ones who obviously need probably more of the resources channelled towards them, because they're the ones where the kids are at risk. But they're the ones ...who're probably least likely to voluntarily access those services and to listen to anything anyway.

By limiting the scope of the research to disengaged fathers, it became more realistic:

...you need a very special trick up your sleeve to engage them ...how you engage those guys, yeah, that’s a Nobel Peace Prize.

Beyond this categorising of fathers, a general sense of the perceptions of fathers by workers emerged. Figure 20 and Figure 21 show the focus which service providers (workers and managers), and parents (fathers and partners) gave to four areas, Fathers
care about their children, Fathers need to take responsibility, Fathers provide support and Fathers need support.

Service providers were much more likely to view fathers as requiring support, and much more likely to suggest that they needed to take responsibility, than were parents. They were significantly less likely than parents to view fathers as providing support or to suggest that fathers care about their children. Parents, in contrast, saw
fathers as primarily providing support and caring about their children. This comparison indicates the way service providers predominately perceive fathers.

**Fathers care about their children**

The fathers in this study, while not necessarily representative, were sensitive, caring, and dedicated. This father was interviewed when his daughter was 14 days old:

> There's nothing like it - to find out we had a little girl. No matter how she came out, it was the best feeling in the world. There's nothing that will beat it. There's nothing really negative that I have to say about the process.

One expectant father, who had two older children, shared this:

> Yes, it's a lot of hard effort and it's not an easy job but it's fulfilling, especially when they're older and you get to do so much with them. The one thing you could never change, it's awesome. I love being a dad.

This father still had 5 months to go to the birth of his child, and what is most touching is not his infinite love for his unborn baby, but the anxiety and loss he communicates as he waits for that love to grow.

> The thing that I'm probably most conscious of is right now I don't feel attached to the baby emotionally, and I find that, I used to find that a little bit of a concern. Because you know you want to bring a baby into this world, feel really, really passionate and in love with it. I don't have those feelings yet.

Another expectant father, who had teenagers from a previous relationship, was far more relaxed:

> I've got a really good respect with my kids. I get angry when I have to but at the end of the day you love them and you'd do anything for them. You just want them to succeed. Of course you're going to do whatever you can for them.

This father was more excited, but still confident:

> The fact that it's a boy, I think, is special and has a [new] bond with father-son. I had a good relationship with my - and still do - with my father. So, I want to do it, I guess, from the beginning, have that initial desire to be with him, even when he's young and crying and can't speak and those kind of things where it's still, he doesn't know yet how special it is, but I'll know how special it is to have that begin bond with him from the get-go.
Workers never suggested that fathers didn’t care about their child, but they also never took it into account. It is assumed that this perception of fathers necessarily has a significant impact on the way they provide them service.

Fathers need to take responsibility

Workers were much less likely to present a caring depiction of fathers, instead suggesting that fathers should take more responsibility, and get more involved:

_We’ll facilitate the fathers to be involved as much as want to; if they’re here they’ll be involved, if they’re not they won’t obviously... if we had the resources and the ability to do it better I’d certainly want to facilitate that, but again it comes back to the dads and I guess that education needs to start early on to say that if you want to be involved, be involved but be involved as much as you like._

This theme was repeated over and over:

_I think the dads, they sometimes need to speak up a bit more in things like antenatal classes and talk about their role._

And over:

_So the answer is no. Unless the father turns up at a visit and asks questions and participates in a visit, then there’d be no - we don’t say - we don’t spend a lot of time on the phone trying to convince the woman to bring the partner in._

An experienced midwife with a strong commitment to father focus practice reported that she had never seen an expectant father attend an antenatal class without the expectant mother present:

_Interviewer: Do dads ever come by themselves?_

_Interviewee: No, I don’t think I’ve ever had a dad come by themselves without - if mum wasn’t able to come that night - no._

She was quite convinced about this:

_I don’t think we’d ever get that. I don’t think we ever would have had a dad without a mum... Yeah, that would be very unusual - I’m sure. I probably could say 100 per cent sure that no dad would come - alone._

A week later a father who participated in this research attended her class when his partner was unable to attend:
Interviewee: ...I guess the next five weeks of the course with [the midwife] is going to be those bits. Because I’m going on Thursday, [my partner’s] not, [my partner’s] going to Sydney.

Interviewer: Do you know [the midwife] told me she has never seen a single father there by themselves?

Interviewee: Well I’m going to be the first one [laughs]...Well it's going to happen on Thursday. Well because it's an important - I think it's an important lesson you’d be mad to miss, one of us. I’m going to do the same, I'm just going to record it for [my partner].

When this father was reinterviewed with his partner after the birth, he outlined the impact of attending those classes:

Mother: I didn't even know he wasn’t there. I was trying to concentrate on not moving while the epidural was happening. My contractions were not giving up at all. You know they were constant...

Father: I was so prepared. I was really prepared for it which was great. Because [of the midwife] in the antenatal/prenatal classes ...I was so prepared for it and that’s what happened on the day.

A worker from the local men and family centre, a father himself, explained the benefits of fathers taking responsibility for their own engagement:

I think the more proactive I’ve become in engaging as a father and more proactive in asserting what my values are and what I want in life, the more fulfilling my life’s been, the less I’ve had - the less I’ve – resent’s a strong word but the less I’ve had conflict I guess in my own relationship because I’m more satisfied and taking control of my own experience.

Perhaps as a result, he had a particularly hard line on men taking responsibility:

It’s like well mate, you know, you don’t have - you know, we’re not going to come running after you if you leave. Some guys will cross their arms and say oh this is bullshit when we do a relaxation. So we do a 10 minute relaxation when we’re in the group. This is bullshit; I’d prefer to have a smoke. We say well it’s invitational, nobody has to do anything; so if you want to go outside and have a ciggie while we do this no worries, all we ask is you don’t interrupt us while we do it.

This seemed to come from a different place than from the other workers. Mother focused workers - nurses and midwives - were likely to suggest that fathers should take responsibility as a defence for not engaging them properly, father focused and whole of family focused workers seemed to suggest that men should engage from an
empowerment perspective. These two approaches are in effect coming from opposite directions. This same worker indicated the positive impacts men could experience:

I think there’s a lot of guys that are just going along and are being guided and almost resenting what’s happening for them in terms of how much involvement they have and so on. If they become proactive or take responsibility and actually say these are my values and this is what I would like to be doing and I’m going to actually take charge in my life to actually make that happen, it’s phenomenal.

So I think that’s big for a lot of the guys here as well; is that I can just keep blaming my partner and saying oh they’re f-ing this and does this and this is why I did this to her and so on. It’s like well the more responsibility that they take the more they realise wow this is - there’s a lot of things happening for me internally and as soon as I stop blaming everyone else for what’s happening, then my anger levels go down because it’s either get angry at myself or have understanding for my own experience.

Compare that to this response, from a maternal focused worker:

I mean we can’t go out and say we’re going to run this group this afternoon and say we really want all you new dads and blah, blah, blah. If they don’t want to come we can’t bring them, we can’t force them.

A father worker had some insight into why this might attitude might be so prevalent:

I think generally there’s a lot of negative perceptions around men, their willingness to engage, their ability to engage and I think that really shapes and informs the way that things happen. I think that services and supports have become so shaped around women because of that and I think there’s a bit of fear around engaging men and working with men.

Another father worker had a slightly different theory:

I think women have a protective thing and I think they’re protecting their child from the father. Because historically we haven’t been that good, we’re likely to drop the baby or do - sell the baby or give the baby away if we’re not happy, back 100 years. Those genetic memories are passed through from generation to generation.
This suggests that the ‘protective thing’ that workers may have for the children they care for may extend to excluding fathers from service, or at least not actively seek them out. This father had a succinct answer to that dilemma:

...you can’t just assume that every bloke’s a drunken wife-beater.

Others saw the need for fathers to take responsibility as more of a tragedy than an abnegation of their own responsibility to attempt to engage them, especially with resistant fathers:

We get the super-engaged and enthusiastic dads that come along to the group and the dads that we’d love to see come along - more of those guys come along; we don’t see as many of those as we’d like.

And that getting them in the door was a real triumph, rather than a risk:

...We had some what we’d say really disengaged dads in there …We had a couple of guys that were sort of I guess if you like not very sociable, so disengaged not in terms of enthusiasm or positive parenting but disengaged just because they’re socially a little bit awkward as guys. So for them it was like this might be an opportunity for me to be able to connect with other blokes...

The father focused workers put the responsibility on fathers to engage for the good of the father – the maternal focused workers put the responsibility on fathers to make their admittedly very difficult work easier. One father focused worker balanced this dichotomy with clarity:

I think the dads need to step up and take responsibility, but I also think there’s more work that can be done within the system to actually engage and support dads. So it’s that midpoint where yeah, dads actually want to - need to step up, but also they need to be met.

Fathers provide support

The single topic on which all study participants could agree on was the capacity of fathers to act in a supporting role to their partners. Often this was seen as a role that fathers undertook during the pregnancy, birth and breastfeeding stages of parenthood:

...so for me right now, just she’s doing the job and I’m - or she carries the baby and she’s doing the birth, so right now, I’m just supporter part and when the baby is there, we see how we go, so that’s a reason, maybe, I’m talking about to be a supporter right now. After the birth, I don’t know, we see how we go.
This change of role led this father to feel excluded during pregnancy, although he was confident that he would be able to be more involved after the birth:

> It does feel like you're just a bit of a third wheel during the pregnancy, like there's not much you can do. You like take up the slack and that, do as much for her as you can, but at the end of the day she's the one that's struggling with it. Once it's out then you can kind of step in a bit more which will be good.

Interestingly, this father differentiated between the role of supporter (husband) and parent (father):

> I'm here and I would or love to step in and to be a part of the family and as well, not just to support her any more for her. Just as well to be a father.

This expectant father, only four months into pregnancy, described his unexpected journey into support person:

> ...that's what I'm starting to realise now. Even now, when [my partner's] at a kind of place where things are harder for her to do just with the sickness and fatigue and stuff it's like I find myself getting away from that, you know, how would you call it? Screwing things up kind of mentality, you know what I mean?

> it is interesting timing because I am starting to become more aware of myself thinking oh, well, we've just got to be understanding of her situation and we've got to work as a team now. Yeah, so that's probably a natural thing, I think that comes along.

Couples seemed to be on a journey from the individual to the family sphere. Understanding this, a grounded theory needed to undertake to provide for the family unit and the individuals within it, especially for fathers who need support to provide support. This father, with more pre-existing family and community support, was more prepared for the role:

> She's going to have a lot of times where I'm going to need to do things for her that she's not going to be able to do because she's nursing, or she's tired, or she's just worn out.

Fathers and their partners saw this support role as natural, and crucial. This idea of the support role being a ‘natural thing’ was also echoed in this sentiment aimed at fathers who didn’t provide support:

> ...imagine the poor women that have men that are absolutely useless. Then you've got two babies that you're looking after. They're the ones
that I feel sorry for because they've just got such a hard job ahead of them when they've got a partner that doesn't want to get involved and doesn't realise that they need to help.

This father identified the support role of the father as just as essential as the role of the mother, but in a different way:

Interviewee: I guess what you're trying to do, to involve the father as well rather than just thinking about the mother. They've got that feeling and they don't know what they're going to expect or what they're in for as well, because it's a team effort; it's not just the individuals. It takes two to bring up a kid, doesn't it? It's a bit hard trying to bring kids up by yourself.

Interviewer: What do you think the benefits are to including the father?

Interviewee: I don't know. It's probably just getting the father involved in it more, it would be more fulfilling for the father. They're getting more out of it as well, so they're not pushed to the side and just thinking it just takes a mother, which it does to do a lot of things, but we do a lot of things as well.

This indicates a shift in the way workers need to think about the way fathers provide support – moving away from the idea that they exist solely to support the mother for her benefit, towards and understanding that the process of providing that support is also beneficial for the father. This role of support in for new and expectant fathers seemed to change as they children grew older:

I see that as a real necessity because I didn't have my father around when I was young. That's one thing which I'd never do to my kids, not be around for them, I always said that. I wouldn't just get up and leave them and have nothing to do with them because it definitely affects kids, especially young kids. You need to have that role of a father figure.

Fathers in this study saw themselves as part of a family unit that provided support to itself, not as a one way energy exchange. This role changed over time, as detailed in Transition (p209). This father, with teenage children from a previous relationship, saw this change in roles from supporter to co-parent as relating to the mechanics of breastfeeding:

I reckon it starts once the baby stops breastfeeding...

This father was more to the point:
I reckon if a baby is shitting itself or peeing 10 times a day I think it’s really unreasonable to expect somebody to do the 10 nappy changes a day. I reckon there’s no excuse. You’ve got to get in there and get your hands dirty and get your technique down and do whatever.

The biology of childrearing meant that fathers provide support during pregnancy and early childhood, either to their partners or directly to their children. Partners also felt more supported and responded positively to fathers undertaking this role:

Interviewer: How about you - has that made a big difference having [your partner] come to those things and being a bit more involved?

Interviewee: Yeah it’s a big difference. It makes me feel really supported and yeah just makes it seem like he's included and yeah makes me feel better prepared for the birth I think...

Another partner saw the roles of supporter (husband) and parent (father) as complimentary:

... just helping, just helping me and doing everything together like, you know, not just me doing it obviously, but taking turns or like I said with the feeding thing, trying to - if I can, he can do like one of the feeds. At least I have a rest. It's again good for him to do the - have some bonding as well with the baby so he doesn’t I suppose feel left out in a way. I know he'll want to be interactive in that way. Then obviously bathing together. Just doing it all together as a little, you know, new little family unit really. Having that little connection.

Although this father worker saw the two roles as contradictory, or at least inconsistent:

...they get the confidence and they get somebody actually giving them permission to be a father. Because up until that point you kind of don’t have permission to be a dad, it's mum this, mum that, you as your support role delivering a baby, you as the guy going to get the money.

With this couple who were interviewed both before and after the birth, there was some initial tension around this role definition during the first interview:

Him supporting me and the family but also obviously me involving him and making sure that he's involved with all the tasks and things, so that he doesn’t like I said, feel left out. That he's, you know, I've just been at work all day and I'm just the provider and you've been doing stuff and hanging out.

Which had shifted to something else during the second interview:
I think I was always quite maternal anyway. Paternal. So no, I’m loving the experience...

...But most of the time it seems that you know I get her when she’s crying and it’s changing a nappy. Whereas [my partner’s] got the power of the boob and that just settles her you know. So you kind of start going oh God, I’m not really good for much. Do you know what I mean? So hence why we’re looking at hopefully getting expressing happening. But you know, I’m big enough to realise that that’s just the way it is.

Workers were also quick to acknowledge that fathers were able to provide support, and that their positive impact could be invaluable to securing healthy outcomes for mothers and babies:

...it’s not just about the dads, it’s about the benefits that come for mum, like from the dad being more engaged and feeling like he’s got clearer idea about his role and how to be in that role and therefore he’s got a better way of communicating with her around her needs and how they’re going to do this together.

Most often, when the importance of father engagement was raised, it was in terms of support provided and potentially increased outcomes for mothers and babies – not outcomes for the fathers themselves:

....when it comes to breastfeeding, they can do - they can be settling the baby after it’s had its feed. They can be bathing the baby, they can be massaging the baby. There’s a lot of ways for them to have a lot of contact with their babies...

...you can do this, you can do that, you can do the other. Even things like - you know when you try and put a flailing baby to a breast, arms go every which way, sometimes dads just holding onto the little hands while mum puts their baby on, is one thing that they can do to be very supportive.

This theme emerged a number of times:

Well certainly the outcomes improve for the kid because it’s much more efficient to have both parents working on the same page than only working with a mother who then tries to go home and explain what we’ve explained to her to the father. So the outcomes definitely are better; absolutely. Much better outcomes for the kid to see Mum and Dad engaged in the same process of the system than Mum.

And was also identified by a number of managers:

What would the benefits be? Well, obviously there’d be more equity around role responsibility for a start. Around taking more responsibility
of that kind of stuff. But I also think that it would be better for the development of the child. Obviously that’s got to be paramount, hasn’t it, realistically, to have both parents involved in that kind of stuff?

The complementary roles of support (husband) and parent (father) were also recognised by workers and managers:

Dads get to spend more time with the baby in that initial stage and they develop a relationship that then continues on. I think it supports the mum during that difficult first few weeks and supports them through that. It also brings about an understanding in three months’ time when mum is sleep deprived and starts to crack up emotionally and physically, he’s got more of an understanding of what she’s been going through...

One worker, a fathers rights activist, agreed on the importance of fathers supporting their partners, but proposed that the importance of this is actually as much to do with the healthy psyche of the father as it is the direct support provided, essentially suggesting that the two roles of support (husband) and parent (father) are intertwined:

...it’s all interconnected in terms of the way that services are delivered to women and to couples. I think there’s a really strong connection to the outcomes for - and men are included in that... this is something that’s not original, but the man is the last bastion there for his partner, in terms of that he’s got a really important role there to play and support her, emotionally and psychologically.

If that right is taken - if that role is taken away from him, and care is provided to her without choice, that sets up a massive dynamic in their relationship. It takes away from his role at birth, in terms of what he actually gets to experience in terms of bonding and connection with his partner, with his child.

If a woman feels that a man has let her down at birth, that’s a wound that gets carried forward into that relationship, and will either heal - because of through love and healing and trust and rebuilding - or it won’t. This is where the system has a massive role to play in terms of supporting as much as it can the man’s role, so that he can play that effectively and providing the best care to the woman obviously. I’m all for women centred care, I think that’s the way it should be.

A manager responsible for a team of workers working in the early childhood arena identified the distinction between support for a pregnant woman, and support for the child the pregnant woman was carrying – essentially combining the two roles into one of parent:
...that support role during pregnancy - make sure she’s getting plenty of sleep and put up with the mood swings and take her out and make her feel special because she doesn’t like her body shape and all that sort of stuff, I think it needs to change there. I was really, as a woman, really lucky. I had a partner who said you need to sleep because our baby needs you to sleep. So that’s parenting. There wasn’t you poor dear. It was hold on; you need to sleep for my child. If it doesn’t start before birth then it sure as hell should be starting at birth. So the parenting should be starting at birth.

This manager identified the contradiction in the perception of fathers as useful and providing support, and the expectation that fathers should take responsibility:

Look when you talk about birth and the next five years, the woman might have the baby and she might stay at home and look after it. But by gosh she likes it when the husband comes home at night, can give her an hour’s peace and quiet to go and have a bath or a shower and have a little bit of free time. So I don’t think we’re good at acknowledging the importance of men but yeah they are important.

Health and welfare professionals interviewed in this study often expressed this duality, of acknowledging the importance of fathers, but excluding (or failing to include) them from service. Many workers, mainly father workers, did identify that fathers need support to engage, and often identified areas that support could be targeted. A broader, more gendered view of this is explored in Gender roles (p201) below.

Fathers need support

Fathers most often initially identified practical issues as the areas they would most like support in – although would often latter identify issues around communication or relationships which they hadn’t initially seen. This father identified some gaps in the support he was provided:

Well I think, to be honest with you I guess there’s a lack of information out there. The one thing that I noticed with the classes, and I said to [my partner] the other day, I said are we actually going to do any kind of practical stuff while we’re doing breathing techniques and being the supportive partner. She goes no, I don’t think so and supposedly we don’t and I’m actually surprised at that. I thought that would be part of the program.

This highlights a lack of support for fathers, and the willingness of this particular father to engage in support if it was provided. His approach was not unique – when asked, he fully comprehended the support he would need, and had identified where to find it:
Is that it's going to be a learning curve; I think I'll be quite natural at it. I think it's important that I do the Becoming Better Dads (sic), even though I have done a lot of that stuff already. But it'll be just great to refresh and I suppose I'll learn stuff that I didn't know.

He highlighted the practical communication and parenting skills he would like support with:

> I think there just needs to be, I don't know, there needs to be some kind of information out there as to - I suppose how to get - how to communicate with kids I guess is what it comes down to. Because we're seeing a lot of our friends with kids who have real issues at the moment and it all comes down to communication and boundaries and all that kind of thing.

As did this father:

> I would sign up if there was a course for how to deal with the terrible two's I'd put my name down.

Another father knew where to access support if he felt his depression returning:

> If I felt like that again I'd go to the doctor and talk to him about it and then try to get a referral to see a counsellor, because I found talking to the counsellor was the best thing for me.

Some workers identified that some fathers had always been trying to be more involved, but that workers have not always encouraged this:

> ...there's always been fathers who've been interested in learning different ways and I've always tried to do things to try and assist them but the way the service is provided generally, no. They don't really get a look in unless the practitioner allows them a look in.

Another father identified midwives as potential supports for breastfeeding advice:

> ...you spend a day at hospital after the birth, you spend pretty much all that time recovering and trying to get the baby on the boob and if it doesn't work I'll be saying to the midwife what do I do now?

Another father was looking for support to be more involved with his partner, and share some of her load:

> What am I interested in? I guess I hear a lot about how this affects - like pregnancy affects women but like for me, for instance, like ways to help her with that. Being part of it instead of - like a lot of the times she feels alone in it because it's happening to her and it's not
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happening to me. So how do I not make myself a part of that but just involve myself in that, I guess. That would be good.

His previous attempts at accessing support hadn’t been overly successful:

...because we haven’t had someone to trust that’s been answering the questions and we’ve been using the internet, then we don’t trust anything...

For others, they’d missed out in other areas, such as finance:

I think maybe the one thing that we could have had a bit more help in is financial advice. That was - that’s the one struggle that I’ve had is financially...

Even those who had medical training identified parenting as an area they might like support with:

Just with my work, I’m quite confident even if I had to deliver this bub that I’ve got no problems there at all. But it’s the after-fact - that’s where I would struggle. But until that happens - and I’ve had a little bit of hands-on now practising, I think everything should be fine.

Some workers identified that fathers need support, such as this manager:

...it’s an important time in a family's life, whether they’re becoming a family for the first time, whether they’re moving from a couple to a family, or whether they're extending their family.

Other workers saw men, and in particular fathers, with a history of solving problems with violence as requiring support:

...the guys that we engage with who are generally some of the more violent guys in society. They don’t want to be violent people; they don’t want to be seen as violent; they don’t want a relationship that involves violence.

Father workers were also quick to highlight the need for more interventions for fathers:

I think there’s a clear role to also support men at birth and give them the opportunity to be present, be active, engage, to bond, to nurture, to protect - do all of the things that we’re actually expecting the men to do but not - we’re giving guys very little preparation to play this role.

He explained that due to the historical shift in fatherhood, men having children today are lacking in support from their fathers:
I think men need to be met and engaged and supported. ...over the last few generations, ...men have been pushed further and further out. So what we've got now is this dynamic where the norm is that men are on the out, and don’t know how to play their role. So in terms of generational sharing - like what was it like for you? How did you do it? ...that's a massive link that's been lost. We’re rebuilding that now. Most dads don't have the chance to talk to their dad about what was it like for you? They weren’t there.

Another father worker reinforced this:

...men have had not great role models for a number of generations, as far as the hands on approach and communication between partners approach goes. Health professionals have a lot of the problem to bear for that because we don't really - a lot of us are middled aged, middle class women. That's just - I’m not - that's not a slant, that's just the way it is. Their model of care has been father is primary wage earner, and mother is primary care giver and that model's a very comfortable model for a lot of people.

He went on to explain how he had developed his support service in response to a lack of support for fathers:

...it came out of what I perceived as a need to support dads through the birthing process and to give them a leg up to become fathers. Started off, I don’t know, six years or so ago now maybe when I started looking at research around what’s available for dads. What courses, ante-natal classes for dads, types of support around the country and internationally... a research project with a number of people going through ante-natal classes looking at what they wanted as far as fathers works go.

Then looked at the global research into the role of fathers and interventions to support fathers and then put the course together basically as a result of that. ...it was supposed to be a cycle, a mentorship cycle as much as anything else where you taught guys about parenting, and then brought them back in after they’d had their babies to look at them developing relationships with each other, so there was mutual support. Then bringing some of those dads back in to run the class or to be involved in the class with their baby, as a cyclic thing.

...it’s evolved to a point where now I run three classes... to run through a set of competencies with guys’ information, knowledge and give guys the skills and competencies to spend time with their kids and be a good partner and father.
This same worker also explained the response he received in the industry when he made the case that fathers need support:

...She said... Jesus men have got a lot of problems that need fixing. I said no, men aren’t broken, there’s nothing wrong with us, it’s the same paradigm as it is for women, we just need to be supported to be better that’s all. She looked at me with this strange - and laughed, thought that was quite funny.

This midwife had a personal commitment to seeing more support for fathers:

I think probably on a more personal note, like why I’m really, really I’m pro it [support for fathers], is that for me, my - I’ve got two children. Certainly after the birth of our first child there was - I know I feel really sorry for the children’s father, because I don’t think he was at all aware of what the changes were going to be - for him. No idea. At the time there really weren’t systems around to support him... just before our second child was born, our relationship ended.

What emerged from these interviews is not only that fathers need support around relationships, parenting and transitions, but that health and welfare workers are appropriately placed to provide it:

I think right from the outset you’ve got nine months to work with people, not just about their child rearing but their own health practices as well… We’ve got that eight month or so, seven month period after people are diagnosed with pregnancy, for want of a better - we should be working with them psychologically, financially, emotionally, spiritually and practically to teach them how to be parents.

The motivation behind this was also a commonly shared theme:

Because at the end of the day anything that is as important as being a parent needs new skills, but we just think people will fall into it and become good parents without really teaching them how to communicate with each other. What sort of a parent do you want to be?

Despite this common understanding, the gaps that are identified are significant:

How do you want to do this? How do you want to manage your finances? How do you want to bring up your kids? How do you want to discipline your child? Do you want to breast feed? Where do you want to live? How much money, blah, blah, blah? None of those things are being discussed, we’re just leaving that up to couples to fall over and then wondering why at the end of the day they make mega mistakes.

Fathers care about their children and they do need to take responsibility for their own engagement, however workers do need to ensure that they are providing support
that allows for this engagement. Fathers are also undervalued for the support they do provide, and often misconstrued regarding their motives – they provide support as part of a family unit, and workers and services need to shift the focus from just mothers or just babies, and take into account that whole family unit. One of the main supports and barriers to fathers taking responsibility for their own engagement, was the way they viewed workers.

**Perceptions of workers**

The main negative perception of workers was also the main positive perception – one of knowledge and power. Fathers were both disempowered by the knowledge and experience of workers, and respected and relied upon it. Even minor inconveniences demonstrate this imbalance:

*That if you want to go to a medical appointment or a radiologist appointment you're going to have to, because we have to wait. There's quite a significant waiting list, isn't there? So you'd have to go when they tell you.*

Other issues caused more volatile responses – often due to the intense emotional reaction people felt when transitioning to parenthood, managing a range of their own emotions:

*I started getting real angry and I had to walk out of there because I was that close to actually punching him... Oh mate, he was so rude. He was the same bloke who delivered me when I was a kid.*

This partner suspected that workers were resistant to working with men:

*There's almost a little bit of a taboo around support for fathers anyway I think.*

Still more fathers just felt ignored:

*Well he just didn't talk to me - he spoke to [my partner] and basically assessed [my partner]and it was all about [my partner]and I just kind of sat there and felt like a third leg basically. There wasn't a lot of acknowledgement at all that I was really even in the room. So I guess yeah I felt excluded there.*

Others were more understanding, even supportive of workers not giving them too much attention:

*In a perfect world it would be like that but I understand that human nature and characters and people make mistakes or circumstances are...*
what they are. Someone's on the back end of a 12 hour shift, they've just had a couple of wankers previously and it's like going into a casualty department at four o'clock in the afternoon on a shift changeover or something.

This father indicated that he were not concerned with the service they received, so long as the service his partner received was high quality:

*I don’t give a shit to be honest. I don’t care if people ignore me all day. I don’t take it personally. So the guy’s a busy man, he’s got a tough job. As long as the lady who’s doing the hard work feels comfortable with him then good. That’s it.*

*I won’t lose one minute’s sleep over somebody giving me a spray and that’s the same with the doctor. If he’s too busy to acknowledge me then I don’t mind. It’s not because he’s going oh look at this loser or something like that. There’s nothing like that for me. I don’t take anything, what anybody says personally because they don’t know me.*

However if the service that was delivered to the partner was problematic, this he had no problems advocating on her behalf:

*Yeah then I’d have no qualms in saying hang on a minute and I’d have no qualms in saying I’ll just stop you there mate, hang on a sec.*

When this concept was explored, his father had good insight into where his approach came from:

*...I don’t think we should be put on the same level as mum. That’s my own personal thought [and] it’s [my partner’s] and my moment but it’s more her moment because it’s such a milestone in the woman’s life. It’s such a big epic event and it’s such hard work that she has to go to.*

*... I understand if some doctor is a bit blunt with me, no worries mate just don’t be blunt with the lady doing all the hard work. She might take it more personally.*

This attitude may be associated with more traditional gender roles and parenting styles, but holds and important point for service delivery. As this father one, ‘some blokes might be a bit more needy than others.’ As discussed above, in Fathers are individuals (p104), workers need to understand where fathers are at in order to work with them. Some fathers will need support to engage, others will not – either because they have made an informed choice not to engage, or because they will engage themselves. What was consistent, is that fathers want services to engage not solely with them, but with them as part of a family.
This father saw the issue as system based, rather than individual:

Interviewer: Do you think that it was worse for you as a father? Do you think you were more excluded, or do you think the whole system was just...

Interviewee: The whole system - the system that we eventuated being with in that structure, for want of a better word, I remember going to some of their classes, like breastfeeding classes and all the types of classes. It was very, very focused on the mother, which is fair enough.

Another father, who experienced a comedy of errors as a result of a badly timed baby, also viewed the problem as systemic:

Okay. Do you want to just give us a minute and I’ll come and speak to you in a sec. Here’s your little daughter... I don’t blame her. I just think it’s just that part of the system. We were unfortunate that we happened to be having a caesarean section at changeover of shifts... I guess they kind of felt bad but at the end of the day they’re under the system.

This extended to a partner’s response to the food she was provided in hospital:

I know it’s a public system and everything else and it was great. But the only thing that freaks me out is the food scenario. It’s like you’re feeding your baby - especially if you’re breastfeeding, you want to nourish your baby - and they give you shit food. We didn’t eat anything. It made me sick.

These fathers were even more damming:

As a service system we don’t seem that well set up to manage that, and to deal with that. I think that probably extends to fathers throughout the system.

And:

I can just see now that it’s not really - the whole system is kind of failing the father basically.

Other fathers, who either had different priorities or different experiences, had very different reports:

We went up to the hospital, so they had a tour there, which was pretty informing. Really good and actually, the whole - the midwives in - at first, we went to Murwillumbah and I was really impressed about the whole service, actually,

This view of workers as high quality professionals was echoed elsewhere, and formed a significant part of the respect fathers had for workers. This father, referring to
other fathers who wanted to be more involved in the process, felt the workers should be allowed to do their job without interference:

*I understand where you're coming from and it's important to have knowledge, but I guess the thing for me if is there's people who have spent their life learning how to do this kind of stuff I'm not going to start telling them how to do their job.*

Nearly all fathers and partners had very complimentary responses to service they received. This is a typical comment:

*It made me feel more confident because she was just so calm and so I thought oh if things go - not go pear shaped but I think whatever scenario we can throw out this woman will have dealt with it. It looks like she's been around the block a few times so she's delivered a few babies. So I thought yeah that's good.*

As is this:

*From the get-go though every interaction I've had either with the course that [a father worker] ran, the ante-natal course, [the midwife],[the obstetrician], I've gone into it really open-minded and I didn't have any pre-conceived ideas but it's just been positive. I haven't come away from anything and gone no this is fucked. I haven't come away from anything and gone I'm wasting my time.*

For most parents, the service they received outweighed the negatives - these positive responses, while less targeted than the negative responses, demonstrate the excellent service that is being provided.

Clearly the perceptions of workers and father are not consistent across the board. They do raise two main questions, which are explored in this research. Firstly, what can workers do to assist fathers in taking responsibility for their own engagement, and secondly, what can workers learn from positive experiences fathers have had to address some of the concerns raised by their negative experiences. These two questions are really one – what barriers are present and what supports are available (see Barriers and supports p138), and how can they be addressed or improved?

**Gendered workers**

Another important perception of workers was not directly related to their capacity to provide service, but the assumption that a worker of a certain gender would be more appropriate or more relevant than a worker of another gender. When this was further explored, it was often less about gender itself, and more about the experience...
of living in that gender. This is particularly relevant to this research due to the predominance of women in health and welfare roles in the region, as illustrated in Figure 22. Public hospital social workers in the region were 92% female. In addition to this, 71% of women working in this sector in this region were over 40, with 46% over 50 (Australian Bureau of Statistics 2012c).

![Gender of Workers Chart]

*Figure 22 - Workers in healthcare and social assistance sector in Richmond Tweed*

10 (Australian Bureau of Statistics 2013)
This issue was often raised by research participants. This father, for example, first stated that a fatherhood course needed to be run by a male, before qualifying that statement:

*Interviewer*: Do you think that somebody who didn’t have kids or a mother could run the course? Do you think that would be as effective?

*Interviewee*: No. Definitely not the mother. It has to be a male.

*Interviewer*: What about a man without kids?

*Interviewee*: Can be a bit tricky. Can be a bit tricky, I think, because to trust the person or - it’s the same, like, 21 year old guy will try to sell you insurance, life insurance, and he never worked before. Just coming from the high school. All right. What do you know about life? ...I think can be a bit tricky. Some guys can definitely can do this, but in general, I’m probably a bit - might be a bit careful of this.

This same father was asked the same question of a traditionally female worker role:

*Interviewer*: How would you feel about having a male midwife?

*Interviewee*: I think my partner would have big problems with this.

*Interviewer*: How would you feel?
Interviewee: I think it would be the same, but would be a bit strange.

Interviewer: Because of the privacy aspect or - what is it that...

Interviewee: The emotions, the feelings and it’s all a bit different.

Interviewer: ...What if it was a midwife who hadn’t had children? Would that be the same as a man?

Interviewee: No, because at this point, a midwife is trusted person and I think she is more to - she needs - if she has a good education or good training and she’s pretty professional, I think that would be all right...

For this father at least, there was a conflict between knowing that experienced workers could provide a high level of service, and an expectation that men would work better with men and women with women. Other fathers were less specific, just preferring one gender over another:

I know that guys can be uncomfortable in general with going to the doctor. I prefer a female doctor anyway...

This father felt comfortable with somebody with their own experience of childbirth:

I think, at this stage, it’s been nice to have our midwife, who’s had five kids, being able to say, I’ve had experience. I’ve done it.

Or somebody with their own experience of fatherhood:

I think having a guy being able to say, this is what I did with my wife and it worked brilliantly, something to think about. It would probably stick in my head a little bit stronger, too.

This father felt that the information provided by an experienced worker was validated by that experience:

...his fathering history is pretty interesting. The fact that his first daughter was left with him by her mother ... So he's got an incredible history as far as child rearing and I respect that immensely - you know to be thrown in that situation. So I guess I was really interested in hearing his information

Others were surprised at the high level of service provided by workers in roles traditionally occupied by a different gender:

Interviewer: Do you remember what having a male midwife was like?

Interviewee: He was actually really good. Because she was so long in birth, it changed over from a female midwife to the male who came in
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for the last four or five hours. He was actually more helpful than the female was... But he was really good. I couldn’t believe how good he was. He was twice as good as the female midwife.

Interviewer: Did your partner feel the same way about him?

Interviewee: Yes, we both did... well at first I thought, oh no, a male midwife. I was just really surprised at how well he was and more caring. He was actually asking me questions and stuff where the other female midwife, everything was just spoken to my partner.

Some workers agreed that competent workers could provide father-inclusive practice:

...in Health and Community Services, it’s stacked with women. I think there are some great women. Like the gift is when there’s a great woman there, who is actually father-inclusive. Gets the importance of dad’s role, wants to support dad and can work with the female partner to actually facilitate better outcomes. That’s golden. When it happens, that’s the best outcome.

This initial reaction – ‘oh no, a male midwife’ was quickly overcome by the midwife’s skill and demonstration of whole of family practice. This view, that competence can overcome gender, wasn’t shared by some of the workers interviewed:

They can’t go anywhere else for this [course] and this is a really rare rite of passage opportunity and I think it’s going to be most effective if experienced dads run this, for that reason.

This theme was usually linked to mentoring. This conversation began a series of discussions on mentoring with other participants:

I think that’s part of the big picture in terms of what men need and how we actually achieve that is creating more opportunities for mentoring. Like I call it mentoring, I think there’s a really strong mentoring element to it. It’s not only an education, it’s not only support but there’s mentoring element to it as well, like we’re kind of taught we’re sharing your experiences as well, we’re drawing on our experiences. We’re not just drawing on knowledge, we’re not just drawing on our practice but we’re drawing on our experience, like which I think has a lot of value.

From this perspective, competence blends with personal experience to create a fully rounded service delivery system. This perspective was born out of a group work mentality:

...in the context of men’s work in a men’s group I think the power of the group comes from when other men share their experiences too. So
I think, like, I really like to participate in the groups. I don’t - one thing I don’t think works well at all - I try and very quickly disarm the notion that I’m the expert in the room. I don’t want to be the expert, I don’t try to be the expert so I’ll try and walk the line between being I guess, the facilitator and the educator and a participant

Another father worker who ran fatherhood groups had a similar perspective:

I think that’s what they get out of it, I think they get somebody connecting with them, a male who has children, connecting with them and giving them permission to be fathers.

For this worker, communicating with fathers wasn’t something that could be taught, but it could be learned:

How do you talk to dads? You don’t learn that at uni. I learnt that from the ground up, from the grassroots working in trades, drinking in pubs, playing football, whatever, all that stuff.

This manager explained the gender divide not so much in terms of competence, and more in terms of focus:

...we have a male psychologist and two female psychologists. When I look at their notes and this is just reflecting, the male will often have stuff in there about Dad. Yeah? Or even if it’s only stuff about their relationship there will be more there than in the female psychs. That’s not intentional on their part. It is reflective of their training I think but it’s also reflective of their feminist/non-feminist stuff.

This female manager had a different perspective based on her own experience:

I had a male midwife when I had my first child and that was fine. I thought that was really good because I knew [my partner] wasn’t comfortable in a hospital setting. With the male midwife I can still remember sitting there in my little cocoon of pain but feeling quite relaxed because I knew that [my partner] was comfortable with [the male midwife]. ...he was comfortable with that guy and being able to say what’s happening now. Whereas when you get into labour ward and you’ve got two female midwives and it’s a female dominated area I think men can feel a little bit lost.

Ultimately this theme raised so many conflicting responses that this father worker seemed to have the most convincing answer:

It's too much of a grey area of knowing whether men want to talk to men, men want to talk to women, women want to talk to men,blah, blah. I've had a mix of the whole lot and as far as I'm concerned that practitioner if you're getting empathy you're latching on.
Male health and welfare professionals need to be able to work with women, and female health and welfare professionals need to be able to work with men. The solution to this quandary may be found in working with the whole family, rather than individuals within the family unit (see Chapter 8).

**Service culture change**

When workers were asked about the father-inclusive nature of the services they provided, they would often immediately communicate how much of an improvement services are today, when compared to previously:

...the whole baby health started out as a - it did have a mother-baby focus. It didn’t even have a mother-child focus, it had a mother-baby focus. When things were started out, they needed to have that because they were doing basic hygiene and feeding and stuff like that, because child death was a huge issue when they started out, about 90 years ago.

This was often followed by an explanation of how much better fathers had it these days:

I think the partners are well received and well accepted in the birthing suite; it’s not like 40 years ago when they sat outside and smoke cigars and paced that floor. We certainly embrace dads to be being in the birthing suite and give them jobs and get them to rub backs and hands, and all that sort of stuff, and involve them in the labour, involve in the care of the woman, and really get them to participate in what’s going on.

Other workers were less convinced that the improvements were significant:

I think that we’re kidding ourselves that it’s changing, but I still think at the core of it men are still seen - there’s some fluff around the edges like the odd double bed, but 95 per cent of the stuff is still female.

Other workers seemed to come from the perspective that services were simply reflecting a larger social culture change, recognising that father involvement is a process that requires the support of fathers and the community:
Years ago I did mid in 1978 and mums used to - we talked about mums bonding with babies but we didn't ever think about dads bonding with babies in those days. But certainly there have always been the dads that were very hands-on and I would have said yes they bonded with their babies back in the '80s sort of thing. But now it's quite a common term to talk about dads bonding with babies.

There was also a recognition of how much work there was still left to do:

So we need to change - I believe we need to change the training of all health professionals from the very beginning about not being child-or mother child - all the research in the ‘60s and ‘70s and ‘80s was about mother-child interaction.

But a tendency to view this cultural change as impossible with current staff:

So we’ve got a workforce who are - and still our training institutions - but predominantly our workforce who are in their 40s and 50s or older who have come through that period of time, really difficult to change their focus to family.

Inconsistent with the trend, this GP saw including fathers as an extension of a generalist shift in medicine:

General practice training when I went through and I went early ...is very heavily about patient autonomy, patient choice, communication skills, removing that old-fashioned the doctor's got the power and all that kind of stuff. It’s more and more in general practice training embracing, look, this is the way we should be doing it after decades of being a bit heavy-handed and a bit patronising and patriarchal.

On the other side, some workers definitely saw the potential in change, or rather the change ongoing in the service culture:

Yeah I think it's gradually making inroads. I think the positives are coming out and certainly there are some dads that are starting to engage more

And others were working passionately for it:

Positive images, positive messages, keep them coming, keep them coming. We're talking about changing a culture here. It's going to take 50 years. Two generations probably.
This idea of long term cultural change in services is important an context for all health and welfare workers trying to provide better service to new and expectant fathers. It is a contested context, with some key figures arguing that little improvement has been made, and others suggesting that much of the work is already done. What was most promising was the organic drive towards a whole of family model already present in the field. Workers and services understood the value of fathers, and wanted them to be included – but not at the expense of the mother. Ultimately the workers and managers interviewed in this research agreed that there was more to do – what differentiated them was whether they were prepared to do it.

**Participant solution – information sessions**

The perceptions of fathers by workers and the barriers posed by outdated service cultures are not necessarily easily overcome, and will require significant ongoing reflective practice. The perceptions of workers by fathers may be more easily overcome – much of the negative perception was based on expectation management and misinformation. As participants were asked to provide feedback on how this could better occur, a model of an information session formed.

Most of the fathers in this study were recruited from father education and support groups or antenatal classes (see Non representative recruitment p63), and many of them identified the benefit of these groups. Over time, these discussions identified two main components, the support they received from these groups, and the information that was provided. Many fathers were put off by the idea of a group of men sitting around and sharing their stories, others had the information and didn’t want to be talked down to. In response, the idea of separating the excellent work done in these groups into two separate programs arose. A single information session, explaining the service structure in the local area, available supports and a basic timeline up until birth. This would not necessarily need to be for fathers only – however fathers identified as having less access to information than mothers did. The second key benefit fathers found in a group situation was the support of other men. This is explored below in on page 197.
This session would expand upon and complement the information kit (see p100), giving fathers and opportunity to ask questions and workers an opportunity to manage expectations. Many fathers identified that any program that would interest them would have to include practical skills:

...the whole program is pretty interesting...starting with the relationship, how it will affect our relationship with my partner, going over financial aspects ...I handle a baby, how I work with the nappies. What kinds of nappies are used ...how I bath the baby? How I clean the baby,

Many of these things are covered in antenatal education, and this information session was not conceived to duplicate those classes. For some fathers, what was key to the success of the fatherhood courses wasn’t practical at all:

It was more just knowing to not look at how you were raised as a child as wrong but I guess not to necessarily fall into the footsteps of how your father raised you. Do you know what I mean? To not necessarily say no, that can’t be the way, but to potentially do it different. I guess that was the biggest thing. Just basics as well.

Note the inclusion of practical skills on the end; ‘just basics as well,’ reinforcing the importance of these elements. While the concept of these information sessions was well received, there were some elements that fathers found valuable that cannot be compacted into a one off session. For fathers seeking this extra layer of support, a group approach was viewed as preferable (see p197).

Conclusion

Chapter 5 has explored the perceptions of workers and new and expectant fathers and cultural constructs of providing service delivery. It has been suggested that while new and expectant fathers are a diverse group, workers have a tendency to attribute behaviour demonstrated by resistant fathers to all fathers. Workers often fail to view fathers as clients in themselves, but as nearly superfluous and often problematic appendages to mothers. Workers often saw this as the fault of fathers, and saw the changes in the culture of their service as having moved to a point of acceptance for fathers. Some workers did have a more sympathetic view, and these were often viewed by fathers as having a positive influence.

The model devised by the participants which most addresses these issues is that of an information session, building on the Information Kit (p100) and leading to the
Support Group (p197). Ultimately, this chapter provides insight into some of the supports and barriers to father engagement which are explored in the next chapter.
Perceptions and cultural constructs
Chapter 6. Barriers and supports

By fully appreciating what is working in regards to providing service to new and expectant fathers, health and welfare professionals can address identified issues that are not working. This chapter presents data relating to Service barriers, Service supports, Cultural supports and barriers, Work related supports and barriers, Knowledge supports and barriers, Community supports and finally Academic and textual supports and barriers. While the service supports and barriers are of most immediate relevance for health and welfare professionals, the importance of the cultural and community influences should not be underestimated. Ultimately, workers should understand the multifarious complexity of what assists or prevents a father in receipt of support from their service if they hope for that support to have a positive impact.

Service barriers

Workers often responded that fathers were welcome to receive any service – claiming that nothing the service was doing was actively preventing them from receiving service, while acknowledging that they would be happy to adapt their service to better include and support fathers if they could. This section outlines how fathers are excluded from services, from the perspective of both workers and fathers. The different ways fathers were excluded included barriers around mother focused practice, physical aspects, time, system, policies and risk. Many participants raised funding either as a barrier or as justification for barriers, which is explored below.

Mother focused practice

This theme emerged early, and was consistent to the end. Participants either believed mothers should be the focus, or that mothers received too much focus, but all agreed on the current state of affairs:

There is no men's health service for men having babies, there's a women's health service for women having babies, ...maternity services for women having babies.

There was no argument about this from workers delivering the service:
When I bring my social emotional questionnaires, I’m basically focusing on the mother, I’m asking the mother the questions. The father may be in the room.

Fathers were also cognisant of the status quo:

I think there needs to be something specifically advertised as For Fathers or Dads Are Welcome or I mean, I just want - there’s one play group in [a local town] and it’s advertised - it’s actually advertised as For Mums and it’s actually for both, but it’s advertised that it’s for mothers, so it’s just an example of that kind of unintentional exclusion.

Participants’ responses have been divided between workers and managers, and fathers and partners, to demonstrate the variety of views of mother focused practice. The key theme is that of agreement that the system currently focuses on mothers, but conflict over how much there should be.

Workers and Managers

This manager, responsible for postnatal workers, explained the reality of the current service environment:

It’s always predominantly been focused on the mother, yeah. From the way they look at it starts with mother - if you read their progress notes - read their progress notes because I read a lot of them - breastfeeding well, mother’s breasts are tender. Had some mastitis. Height, weight, head circumference of the baby. Very little about Dad. It might say supportive partner. It might say unsupportive partner. So again Dads, in that progress - in that mindset - Dad is an adjunct to the mother.

It never says Dad coping well or Dad having difficulties. Dad struggling; needing support. Never. It might say Mum’s struggling; needing more support, unsupportive partner. It never looks at Mum and Dad struggling with their new role as parents together, needs some support. That sort of language is never there. Never there.

Another manager, responsible for a team of midwives, confirmed this:

...the service that we provide to dads is - it’s really incidental and ad hoc depending on whether the father asks any questions because we are focused on that - on the woman.

And later:

No, so there’s nothing like that which would encourage or facilitate partners to come...But again it’s all women focused and it’s hard to do that with budgetary restraints.
One worker seemed to describe mothers as having some kind of supernatural ability when it came to caring for their children:

…it comes to the old saying, mum knows - mum knows when bub is crook. Just not feeding right or just not sleeping right. Mums always - they don’t tend to panic, but they always seem to know if something is not right.

A GP confirmed that she had been trained to be mother focused, but admitted some potential faults:

…the way I’ve been trained is to talk to mum - listen to the mum’s story about the child is the best story historically. It’s probably a bit old-fashioned to think that. The dad probably has a side that’s different from the mum…

This often occurred during interviews – a worker would acknowledge that there was a potential issue with mother focused practice. Other times, it was acknowledged that it existed, but was supported, usually on biological grounds. Fathers were often tokenistically included, if at all:

…there’s not greater focus on dads, and I guess there never has been. I mean you can do the traditional get the dad to cut the umbilical cord at birth and all that same old stuff, change the first nappy so they get the mucky poo, and all of that fun stuff. But really it’s very woman focused and I guess that’s understandable considering the woman is having the baby, the pregnancy...

A father worker critiqued this approach:

The problem is social workers, family workers, thinking oh I work with the mum and the kids and that’s the family. It doesn’t matter - you know if the dad wants to come along to the sessions or not that’s okay. What we’re trying to do is change their mind about what is important. We want them to believe that the dads are important...

Any possibility of changing this approach to better involve fathers faced major barriers:

I guess as midwives we are very - it's woman focused and I think we tend to lose sight of the fact it's a couple having a baby, not a woman having a baby, and if there wasn’t a couple there probably wouldn't be a baby. So I think there would be a portion of staff that would struggle with fully inclusive involvement of a father as far as double beds and staying over and participating in the care of the baby in that first couple of days, and there would be a large portion of midwives who'd just go that’s wonderful.
This was echoed by another manager, who identified the issue as a problem with basic training:

*Our [workers] are predominantly midwife trained. So the focus of their training - and whether we all like it or not we can do as much post work and post research as we like but our basic core training of where we started colours our values a little bit.*

This has ramifications beyond father involvement:

*So our [workers] are predominantly midwives so they’re female focused; they’re mother focused. They’re actually more mother than child focused. [They] are missing all sorts of child protection issues because they’re really focused on supporting this mum. She’s doing the best she can; she really loves her kid, all that, that’s all fantastic but she’s not keeping her kid safe. The child’s not safe whether it’s her or Dad or whatever. I think [workers] are very - and our other staff - are very mother-focused. So they’re not family-focused. They’re mother-focused.*

This reflects a base understanding of what mothers are, what fathers are, and how mothers and fathers relate to babies. This NSW Health worker explained how it is seen as normal for fathers to be separated from their newborns, but unacceptable for mothers:

*...when a mother goes to theatre to have a caesarean, she should have a nurse with her so that the baby can stay with her. Because it’s unacceptable for a baby, when she goes back up the ward to be stitched, it’s unacceptable for the mother to be separated from the baby. But the dad’s not allowed into that theatre, so it’s fine for the dad to be separated for long periods of time from his baby, but it’s not okay for the mother. She’s not breast feeding, it’s just the way we see maternity services; all of our policies are about the mother’s rights and mother’s needs.*

This tendency to focus on mothers was seen to be consistent right to the top of the Health system, as another NSW Health worker, a father himself, explained:

*I think that organisationally at senior bureaucracy level the paradigm is still mother is primary care giver and I see it all the time. I find it extremely frustrating that we’re still seen as secondary in the arena of bringing up kids when there’s a bucket load of research showing that kids need dads and kids do better with an engaged communicating father than they do without one.*

*...But 98 per cent of our services, 97, somewhere like that are to mums. There is no - if you look at all of the policies within health and*
education, in particular health, the ones I’m aware of around breast feeding and around maternity, they’re all about the mother’s rights.

This policy focus was seen to be reflective of societal values:

Well if you look at the data, 97/98 per cent of our child and family services occasions of services are to mums. Now that’s - there’s no way of knowing if that was around the other way, 98 per cent of occasion services was dads, if that would last for more than eight seconds before there was a massive outcry.

What became evident, despite this suggestion that society favoured mother focus practice, was that workers wanted to be seen to be father-inclusive:

If my staff heard this they’d be most unhappy. They’ll say oh of course we think about Dads.

Even when they were demonstrably not:

The first thing they ring is the mother.... They all have on their intake form, they’ll have mother’s mobile, father’s mobile. They will do mother’s mobile every time; every time. Every single time.

This manager summed up the predicament – the issues with mother focused practice can only be addressed when all parties work together:

....I think that there has to be a recognition of the differences in roles and the - you cannot get away from the fact that the woman’s got to give birth, the woman’s got to carry it and all of those things. Men have a different role. I think you can’t say they’re the same. I don’t think we can say it’s the same thing.

...There is a middle ground and it needs to come from both directions. Men need to understand that and women need to understand that and professionals need to go there.

This calls for a practice approach that requires workers to include the whole family, and then listen to what the families want, rather than imposing their particular practice approach, which has been shown is most commonly mother focused practice. Fathers and partners also agreed on the current dominance of this paradigm, but had varying perspectives on what that meant.
Fathers and Partners

Fathers and partners had as diverse views on mother focused practice as workers, but with a significantly different twist – their support for mother focused practice was a strengths based model, focusing on the virtue of the mother, rather than the deficit of the father. This father explained that the priority for him wasn’t his involvement, but the support available for his partner:

I guess the most important thing is the health, for me, of the baby and [my partner]. I’m really - as far as the actual birth goes, I mean I’m pretty thick skinned, I’m not too concerned about how I’m treated. I’m going to be there but their priority, for me - and I just want it to go smoothly. If I can be there to help [my partner] do that that’s great, but at the end of the day I’m going to honestly put it in the hands of people who know what they’re doing. If they’re calling - I’m going to let them call the shots, so I guess that’s what it comes down to.

There was no disagreement about the experience that fathers felt, in that they were excluded, only disagreement in if this was a problem or not. This father also felt that a mother focused approach was appropriate:

All right, so the radiologist and the doctor - the radiologist, it’s all about the mum, and getting the mum into position, and just going about their business. ...they’re not necessarily rude or anything, they’re just really focussed on the mum and the baby. ...it’s pretty mum focussed, and baby focussed. Not much love for dad.

Another father had a similar experience at the radiologist:

They stick you in the corner, and pretty much shut up.

This mother picked up on the focus on her from the workers:

[For my partner] there was no, hey are you surviving? Are you getting your needs met? Are you feeling part of the family? ...Whereas they asked me how I was doing, whether I was coping, getting me to fill out forms.

This father seemed to take mother focused practice into his relationship, although with some input from him:

I probably would defer to the first one, just letting her decide and knowing that she’s going to ask me if she wants my opinion, but she’s also not the kind of personality that’s going to override any kind of
Another father though that even though the workers complimented him on being in the birthing suite, and were very accommodating, other fathers, who didn’t have his skills, would be problematic in that environment:

*In labour, the fact that - they were accommodating to have me there and present and they complimented it which was great. ...I’m guessing there would be cases where there would be guys that are pretty much rendered useless in the birthing suite.*

This seems to suggest that fathers who are better prepared for the birthing process specifically and parenthood in general are easier to engage in those environments. Taking this one step further, workers who engage with fathers, and prepare them for high stress environments such as the birthing suite, are actually making their own job easier. Midwives who adequately prep fathers are going to have better births, maternal child health nurses who engage fathers around shaking babies and Sudden Infant Death Syndrome are going to be caring for healthier babies.

This father, who had only just discovered he was pregnant, posed this question about the role of workers in father engagement:

*What it comes down to me is it really the role of the midwife to perform that function? Is it? Or is their primary role to I guess support the safe and healthy arrival of the child? It’s really what is the primary function of that role?*

Another father, also a worker, echoed this sentiment:

*Does the health service have a role in engaging the partner to try and minimise the circumstances that can lead to PND and shaken baby? I guess if you’re looking at a - I think in theory, yes. But how do you achieve that in practice? I don’t know.*

Services often excluded fathers by employing mother focused practice, however fathers did not necessarily feel disadvantaged by this, and in many cases supported it. This theme of mother focused practice persists throughout the other barriers to father engagement, in that physical, time related, systemic and risk barriers all disadvantaged fathers more than mothers. These are explored below.
Physical barriers

A local hospital which provided service to many of the fathers in the study, and whose staff participated actively in the research, did not allow fathers to stay overnight after the baby was born. One father told me he planned to sleep in his van outside the hospital if they wouldn’t let him sleep inside.

Then other guys were going oh I can’t stay at the hospital on the first night and other guys were chiming in going yeah - I’m really disappointed.

This dad found it particularly hard to leave his partner and newborn child:

[After the birth] I had to come home... and I get that as well, because you’ve got these precious things that might not be - I get that’s around safety, because I’m also studying sexual abuse and stuff. But that was another biggie for me. That was so hard.

Other dads weren’t put out by the process at all, even this dad who had originally thought he might be:

Yeah, it didn’t bother me. Because it had been such a long labour, and emotional...I was quite happy to come home.

One of the staff at the hospital explained why having fathers stay overnight would actually make their job easier:

None of our other rooms are geared for partners staying, which is unfortunate because that would be a really great way to get dads involved if they were included in everything, if they stayed with their partner. It really would make our job a lot easier.

...in the middle of the night they’d be getting up to the baby first before they hit the buzzer to call the midwife in to check on the baby. They would be changing nappies and doing all that stuff; taking the baby - if someone's independently breastfeeding they'd be picking the baby out of the cot and giving it to the mother to breastfeed. So it would be well received I believe in the unit.

I mean the bonding and relationships that they're establishing straight from birth you can see that. You can see - I have worked [at another hospital] ...they had rooms that accommodated fathers and you’d see your dads up in the middle of the night nursing their kids, and doing the - putting them to sleep, pacing the floor, and just being together with their child and just loving it. So yeah so it does have clear benefits as far as support for their partner, bonding with their baby, and just knitting together as a family unit; you can really see it.
In response to investigation as to why fathers couldn’t stay, the recurring theme of funding barriers emerged:

*Then well if we don't have the facilities we don't have rooms that are big enough to accommodate another bed or a double bed like they do at [another hospital]. So those are the barriers to doing something like that. I'm fully supportive of that sort of thing and really looking at a family unit rather than a women and a baby. I mean it would be a wonderful initiative to have.*

This physical barrier – the physical exclusion of fathers in the day of their child’s life, demonstrates the significant issues faced by fathers who do want to engage, who do try and take responsibility for their own engagement with support.

**Time related barriers**

Most time related barriers revolved around work. Fathers were generally working, and many found that this prevented them from accessing services. This father saw this process as fairly normal:

*...she will organise the appointment and I will have to plan around her and it's just the nature of I think the way the service works, I think there's just the expectation that you have to go when there's availability.*

Others blamed it on their employer, rather than the service provider:

*I suppose I could have insisted on the day off, but at the end of the day I know that my work, even though they're very forward thinking, would have gone ‘do you really need to be there for that, is that really that important?’*

This was repeated elsewhere:

*There's this whole culture within the film industry is you're so privileged to be working in it. Then you shouldn't question what time you're going to finish or question overtime and blah, blah, blah.*

And again:

*But now they want to change our rosters, ...which is ridiculous, but that's what they're going to do. Once again, I've already told our work that once this comes in, they've just ruined my family life. So it's impacted greatly. Well, I won't have a family life, basically.*

This barrier is recognised by workers:
I would say that it’s a very low percentage of men that are involved in coming to clinic. Obviously that’s because they’re working through the day, the clinics are held in the day, so they don’t have access to that… and we don’t have after hours.

This worker identified it as the main barrier to providing a service to new and expectant fathers:

Number one is probably is the availability of that access. So if you’re talking about men that are working, it can’t be something that’s available during working hours...

This was echoed elsewhere:

It comes back to their resources and their ability to be here at the time that things are happening.

Fathers and their partners are forced to work around a service system that operates on its own time, despite recognising the barriers they are erecting. One senior manager put this succinctly:

...if somebody works it will be the father and the reality is we work in office hours, so the reality is that you’re going to get the mother and not the father.

And then went on to explain:

I mean, there’s not a lot of community-based care that’s provided after hours anyway. ... a lot of it is provided in office hours. That’s just a systems issue, really. It’s a cost issue and a safety issue...

This defence, that the barriers posed to father engagement were systems issues, was also common.

Systemic barriers

A couple who were interviewed before and after the birth of their child were astonished that at the moment of birth, which happened to coincide with a shift change, their midwives swapped shift. At the end of a 24 hour labour, in the middle of a caesarean section, the father describes this scenario:

But the weirdest thing of the whole thing was that literally as I’m showing her to [my partner], this woman comes up in a mask and goes I just thought this might be a good time, but I’m your new midwife.

Despite this quirk of the system, he managed to keep a sense of humour about it:
Maybe there's babies that are born at changeover - it's like taxis. You know? When you want a taxi, you can't get one.

Other fathers tried to make the most of it, but struggled:

…it was like a logistical nightmare of - because they have a system, and we had shared care, so in the end we just had to kind of run with it, and it wasn't a pleasurable experience. It wasn't memorable. But for - we just tried to make the best out of it as what we could.

... we kind of wish we'd had a bit more knowledge. I wish we'd had a bit more care and not - it's not a production line...

...I have to regulate the testosterone. I want to instigate a law suit, just not for money, just to educate the system that you can't do this to women. You can't because of the long term ramifications and impact on the next generation, who will suffer greatly.

Another key factor, closely linked to the systemic barriers, and often intertwined, is that of policy.

Policy

As highlighted in Systemic barriers (p147) and Funding barriers (p152), the government its bureaucratic functions were often seen as accountable for barriers to access for fathers. The most obvious application for policy makers would be an adoption of the National framework for father-inclusive practice for early intervention and family-related services (Family Action Centre 2005). The Principles for Father-Inclusive Practice in Early Intervention and Family-Related Services within this framework are:

- Group work with fathers
- Recruiting fathers to early childhood health centres
- Talking to males about violence
- Engagement skills for working with antenatal dads
- Working with Indigenous fathers, uncles, pops, brothers
- Using play with fathers in a multicultural setting
- Raising staff awareness and acceptance of fathers

At a state level, this has not yet happened, as this NSW Health worker explains:

The Ministry of Health has no strategic direction around fathers or men's health, so that's another thing. We can't suddenly just go, that's it, we're going to reorientate everything to be directed towards men's health or to fathering when there's no strategic direction coming out
Another manager responded to this approach with some hesitation:

... there are a lot of policies around that sit on a shelf and gather dust that aren’t implemented all that well. Certainly it will fluctuate within communities as to how well people will still engage even if you put it out there.

This manager responded to a question about the acknowledged tendency of NSW Health policies to have little impact at the local level:

I suppose the other thing the ministry could look at is putting a policy statement out, or a procedure statement out, about the importance to include - because that always jolts people. Like, I can bang on, time and time again and say, you've got to do this, you've got to do this, no, no. But if New South Wales had a policy about the importance of fathering. ...Then that would be a bit of a strategic direction around the fact that then we have to look at ways to make fathers be more inclusive.

Ultimately discussions about policy directive efficiency are futile when there is no policy directive to begin with. Other policy implications of note raised by participants include home birthing and natural birthing:

They should be putting more research into home birthing, natural birthing. So it can become more accepted because there’s still a lot of controversy around natural birthing.

Others, such as this worker, wanted a more coercive approach:

I would certainly then look at those people doing long term parenting courses. So if you want to get your child family payment, ...for people having their first child, no matter what age they are, they want to get their parenting payment then they run through a series of parent support classes.

This worker argued for a peak body that would guide father-inclusive practice from where it is now to where he thought it should be:

...a peak fatherhood body collaborating with the peak health bodies... [That] not only endorses the policy but puts some resources behind the education around the policy, like the delivery of it and putting it into practice, not just paying lip service to it.

Participants were clear that the policy and systemic issues were contributing to the barriers to father engagement, but there was little in terms of action that was picked
up by this research, with the exception of a few father workers who were largely ignored by the establishment.

Risk

Risk of physical or sexual violence was often posed as a barrier. This father worker saw it as mainly a social construct:

*I just think that’s the world we’re in at the moment. It’s very risk focused and it’s very fear based…*

This family worker also saw the problem as constructed:

*I have had an outright ban put on the doing home visits to certain families by management, that I reckon I could have quite happily negotiated safely in their household. I’ve got several of those types of families.*

Note the use of the phrase, ‘those types of families,’ loaded with connotation. This extended to men as perpetrators of child abuse:

*…there’s a whole website on keeping them safe*. Policies that - New South Wales health policies and procedures and so forth, and then what I can get myself into big trouble with, with line manager and my staff, is a major issue for me.

A manager explained the position from a service perspective, as a justification for why all men were physically excluded from the service:

*So you’re working for the health service, you’ve got to do risk assessments, you’ve got to consider the OH&S components of things, so we’d have to screen - fairly closely screen who we have stay and whether that would be seen as discrimination - obviously we’re not going to let someone who’s got a history of domestic violence or drug use or who is a risk to our staff and other patients.*

Another manager raised risk when discussing time related barriers:

*Then there’s issues around worker safety at night, because it does present different issues.*

A program coordinator explained how workers might work differently with men based on their experience in working with men who use violence to solve problems:

*Whereas [a particular worker] hasn’t really had experience with - working with some dads that have got a pretty big DV issues,*

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traumatic pasts, violence, anger - pretty - so it could be a bit confronting for her I would think...

A slightly less direct barrier is the need to assess risk to the mother, which can’t be done with the father present:

*My first home visit, I’ve usually got mother and father - if there’s a father on the scene, I’ve usually got mother and father so that then, you never screen for domestic violence in the presence of another adult or a child who can talk, ever.*

This process caused fathers to be excluded so the domestic violence assessments could be conducted. These service barriers around risk were sometimes conceived as discriminatory towards men:

*If you look at men's health policies they're around men behaving badly, about our obesity, our cardiac, our violence, all of these things.*

Other examples were clearly discriminatory, such as this local family centre with only two male workers:

*I think it's an organisation policy. I'm not allowed to work with any perpetrators of domestic violence.*

The worker explained why this discrimination might occur:

*It's very much - from that women studies family's model ...it is run by women who have had 20 to 30 years background working in family work settings. So they're very old school. [The male focused programs were separated from the main centre partly because] some of the male clients found it uncomfortable going to a place where it was all women and there was domestic violence counselling, [unclear] domestic violence. You know - feeling like a victim even though you haven't done anything.*

This father worker saw the problem as not related to service discrimination, but a problem with the current health of masculinity:

*This is the health of - the current health and state of masculinity. Why is there so much war? Why is there so much violence, abuse, sexual abuse, all that shit? That's, to me, it's all indicators of an unhealthy man.*

From a solution focused perspective, this manager, whose agency works with men in court mandated programs to manage their violence, explained the use of the invitational approach in managing risk:
...we use the invitational approach... if you don’t want to be involved then you don’t have to be involved.

...they say oh I’m made to be here and we say okay, you know, no worries; we’re not making you be here. So for us we take the approach of saying it’s great that you’re here, pat yourself on the back, it’s cool, well done to get in here...

...there’s no authority or pointing the finger stuff happening. So I think that’s why we don’t get a lot of violence here. I mean obviously there’s been occasions where somebody’s fired up but there’s been no situation that I’m aware of that anyone’s been hurt by somebody.

Despite attracting men with a history of violence to their service, this might explain why the invitational approach works with these men and might not with others:

...the guys that we engage with who are generally some of the more violent guys in society. They don’t want to be violent people; they don’t want to be seen as violent; they don’t want a relationship that involves violence.

This suggests that these men, while clearly posing a risk to others, are actually in a prime position to receive service. A final barrier around risk is for men escaping violence – while refuges and support services exist for women, nothing is available for men:

I suppose that that kind of correlates with all sorts of family violence, domestic violence. We’ve had a few, maybe one or two where the actual perpetrator is a female and you know, you don’t expect that. Also so - doesn’t really cater for - it’s hard to fight - well there’s no refuges for men, or men with children.

This barrier to providing service to new and expectant fathers due to their propensity to physical or sexual violence or other systemic barriers was often linked to another systems level barrier – a lack of resources.

Funding barriers

Funding, or more accurately the lack of it, was not raised as a specific barrier, but as a reason that other barriers were not overcome. Many participants (N=13) identified
funding as an issue, however this was raised by a barrier to service primarily by workers, as shown in Figure 28.

Surprisingly, fathers were more likely to raise funding as an issue than managers, and no partners mentioned funding as a barrier at all. When funding was raised as an issue, the blame was easily apportioned:

*I think that basically comes down to once again the Government. These nurses are so run off their feet that they don’t have time. Not only are they seeing you but they’re seeing five others at one time. They’re in and out running around. It comes for - facilities like the hospital - it’s that old, it’s run down.*

This system wide lack of resources was seen as both the problem, and the reason for the problem:

...*I think we’re really underdoing it terms of resources. I think we need to commit a lot more time and focus and energy to looking at ways at how we do it and you know, engaging with more dads around what their needs are and how we meet them.*

Funding wasn’t just about not enough money – it was often about who was responsible for paying for what. This father worker had some strong feelings about this:

*[NSW Health] with their limited funding they meet their mandate. They prepare couples for birth. They don’t prepare them to be parents. They don’t prepare them to be involved fathers or engage them on that*
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level. [FaHCSIA] don’t get involved, so they’re waiting here to when families walk out of the hospital with the baby to do anything.

In addition to this, funding is also about what the money is paying the service to do – and what it cannot do. This manager explained:

*Because you've got a service that’s funded to do a specific thing, that has to report to the ministry about how many babies you saw, how many were [unclear], that kind of stuff, that’s the focus of the program. So it’s really hard to shift a whole program, with all these people who have been trained, to do something completely different.*

This level of complexity in understanding was not reflected in many participant’s understanding. There seemed to be a general acknowledgment that there was not enough money to fund the health system, and that nobody was to blame, except the government, and even then many participants would confuse different levels of governmental responsibility. Nobody linked the need for higher taxes to pay for increased services.

The requirement for more funding was mainly general – few participants had specific capital or program based plans, and when they did they were usually based on existing services in neighbouring regions:

*For places like [one local hospital] it’s going to take a refurbishment of the unit to make it as good as [another local hospital]. So that’s your main barrier; I think dollars and cents…*

Or on expanding current support, such as paid parental leave:

*In a society as rich and as organised as Australia, there’s absolutely no reason when we only have one to two kids across a working life of 40 years, that they can’t make provisions for both mums and dads to have 12 months leave, provided in some share basis with both. So that we can really learn how to be parents together.*

Often the question wasn’t ‘is investing in supports for fathers a good thing?’ by ‘is investing in supports for fathers better than other competing priorities?’ This manager responded to the first question:

*Yes. Categorically yes. That’s a different question. Is it worth investing in fathers? Do you get a costing of it? Yes you do. Is it a good thing to invest in fathers? Do you get a benefit at the other end? Yes you do. Is it more worth investing in fathers than the benefits you would get from investing that same dollar into another area of the health service? Oh that’s a tricky question.*
Specifically, lack of funding was identified in main key areas; education and basic services. In addition to this, there was a distinct flavour of despair – as if funding was the panacea to all of the health service’s problems, but that it would never be addressed. Another, less distinct theme of potential savings via early intervention was also present.

**Education**

Generally any activity without clear benefits which directly linked to program key performance indicators were seen to be lacking in funding. A key example of this is education for workers, identified in Moving forward (p45) as a way to address issues identified in the literature. A number of participants saw education for workers as a necessary step towards father engagement:

> I would love to say education, but there's just no money for education. You don't have the time off the road or off the ward to have education.

Another father identified the same issues:

**Interviewer:** ...So why do you think in that environment health and welfare professionals do so commonly block out the new dads?

**Interviewee:** Maybe that's just the way they've been taught and they haven't changed the way they're teaching.

Even when provided with material and the requirement to complete the study, this worker found that he was expected to complete it in his own time, due to funding restrictions:

> ...they give you information and study and all that, but you've got to go and do it in your own time. To me that's - you're at work; that's where you should be learning. You can't just say, here's a course to do; go and do it in your own time. Not only are you spending that ten hours a day at work; you're then expected to go and - two hours in your own time.

Another worker pointed out the difficulty in changing a culture in which many of the workers are of an older generation. She explained why this was the case:

> There’s not the support or encouragement for the younger nurses to actually do the training because it’s another full - another 12 months full time graduate course to be a child and family health nurse...

> It’s a 12 months postgraduate course and with the costs and stuff like that, plus getting relief - if you’re employed, particularly by the department, you don’t get relief and you don’t - there’s not a lot of scholarships around and there’s not enough support for the younger
ones to even consider taking it up. I’ve got one girl here who has done one subject this year and I’m hoping she’ll continue to another subject next year, but because she needs financial assistance, I’m not even sure whether she’ll complete.

A manager echoed this issue, and linked it to the challenge of changing culture in programs that work with families:

A lot of the child and family health nurses trained a long time ago. I mean, we don’t have a child and family health nurse under the age of 42. They’re not training any new child and family health nurses across the state, because it’s a nursing degree plus postgraduate quals in child and family. Last year, one person in the whole of New South Wales trained.

Even when that training is completed, it is not necessarily family or father focused. Consider this quote from the website of the Bachelor of Midwifery at the local university:

Midwifery is a woman-centred ancient practice of attending women during their childbearing experiences. Midwifery is founded on respect for women and on a strong belief in the value of women’s work of bearing and rearing each generation. (Southern Cross University 2012)

Even ignoring the use of the phrase ‘women’s work’ in 2012, this statement illustrates the impact of training on service delivery. From a different approach this manager made this comment about the Not-For-Profit sector attempting to provide the same service as the public sector but for less money, and subsequently lacking the skills required to do the job – both on the ground and at a governance level:

That’s probably who you need to go and talk to about what to do with clients because they’re too complex and our workers don’t have the skills to do that. So, while that’s great, there’s real governance and the NGOs have to get a whole lot better at their governance and their training and that kind of stuff.

Some services do have some money for education around father involvement. A worker who had previously conducted father engagement workshops explained how popular they were with services that could afford them:

I’ve seen workshop junkies. We used to do workshops in Newcastle, quite a lot in Newcastle but other places, down in Sydney and Canberra. We’d turn up to deliver our engaging fathers workshop in Canberra and here’s these two Newcastle people, the same service they were there for turned up for that for the same workshop we gave them in Newcastle. They became workshop junkies.
If a service is funded to see a certain number of babies, and nothing in either their funding agreement or policies and procedures indicates that including fathers is necessary, it should come as no surprise when that service doesn’t respond by training workers in whole of family practice. What was more surprising is how many participants saw funding impinging on basic services – restricting the core business of the service.

Basic services

The difficulty of delivering essential service in a resource poor environment was often used as justification for not attempting to engage fathers. What is most telling about this is how much it suggests that fathers are seen as completely superfluous to the process of having a child. This manager of an antenatal unit explained:

No, so there’s nothing like that which would encourage or facilitate partners to come. From time to time you do see the father in his work gear come in and he’s obviously taken half an hour off work and come in, which is wonderful and well accepted and well received by the midwives. But again it’s all women focused and it’s hard to do that with budgetary restraints.

Simply to have an evening clinic, which might address some time related barriers, was seen as prohibitively expensive.

I think in the first instance money. It costs extra money to have an evening clinic. I think that would be the first consideration from my bosses.

Another manager explained this as if it were self-evident:

Well [she is] a manager - we’re managers trying to manage incredibly scarce resources...

When probed about why one very successful program in a neighbouring area was not adopted in this manager’s area of responsibility, funding was again the reason:

He did that before resources got so tight and things got so bad that he could actually do that. Now, if I - that wouldn’t be a look-in.

This overwhelming certainty that not only was there not enough money to run the current health and welfare system, but there would be less in the future, seemed to have a paralysing effect on suggestions for further father engagement. One manager took this one step further, proposing a dismantling of universal health care and focusing on a targeted model which would provide a better service for vulnerable families:
I really believe in targeted services for those who really need them and I think at some point we’ve really got to look at, as a community, about what we do and who we do it with, you know? Where we put our resources. Should I really be providing - universal child and family health nursing services? ...Could that be got at the chemist or somewhere, when there’s a whole lot of people out there who don’t even - we can’t even find on their first home visit. You know what I mean? Who aren’t home when we call, who don’t answer their phones, who deliberately avoid our contact. So it’s a bit of a question in terms of, you know, you always end up seeing the worried well - I’m not saying they don’t need any support but maybe it’s a different level. I don’t know.

This approach was based on the reality of living a service system unable to support itself – a funding system not capable of sustaining basic services.

That there’s not enough service to go around anymore... so we really need to start looking at how we’re doing it. I actually think there’s different methodologies for providing different services.

No argument was given regarding the potential benefits of investing in father involvement, however the potential cost/benefit didn’t seem to add up:

But is that a good use of public money when there’s kids sitting at Cabbage Tree Island\(^\text{13}\) whose parents can’t get into town or are too hard to access?

With this background, many participants had extremely despairing views of the funding landscape, both current and in the future.

Despair

The language people used to discuss funding was powerless and defeatist. This worker used the word ‘cut’ as if it were a physical action:

But once again, how are you going to provide all that? You’ve got no money for health as it is. Then they want to cut you even more.

Often, following a long diatribe regarding all the issues that required addressing, the inertia was halted by the idea of funding, and the impossibility of funding any solutions:

\(^{13}\) Cabbage Tree Island is an Aboriginal community and former Aboriginal reserve and station.
Of course there is. There’s a huge need for it. There’s a huge need for a lot of things out there, which - just not going to happen.

This solution was proposed in the same breath as it was defeated:

Extra money to run an afterhours clinic, extra to run a weekend clinic with penalty rates and that sort of stuff. So it’s not likely to happen anytime.

This comment from a father worker was particularly relevant, given the similarities of his proposals and the recommendations from this research:

I was only asking for 200 grand over three years to deliver more Building Better Dads programs and develop the resource packs and that was knocked back. So I even got a meeting in Canberra with the Parliamentary secretary for Community Services, Julie Collins to sit down, have a chat about that and talk about the value of that, what that might be and why it’s worthy of support. I got told it wasn’t a good time to ask the Government for money...

Again and again funding was cited as a major barrier to providing a service to fathers, and men in general:

Men’s health policies I’ve been involved in writing for a number of years and supporting the federal men’s health policy and things like that. But unfortunately it’s still seen as a financial issue that if we support men it’s going to cost money and that’s not good.

This despairing view of supporting fathers - that due to funding restrictions, no solution will be sustainable – leaves little hope for improving the way services work with new and expectant fathers. Some participants had a slightly more positive approach, focusing on the savings to be gained by involving fathers rather than on the costs (see Savings p159).

Savings

Managers were especially likely to raise the savings to the health and welfare system that could be realised by working more closely with fathers. This manager linked father involvement to reduced hospital stays and a reduction in intervention at birth:

For a vaginal birth 24 to 48 hours after birth and for a caesarean 72 hours. So yeah of course with pressure on beds we encourage that...
And again, although not directly related to fathers, the savings realised by having more responsive and flexible support in the caseload model could also be realised by involving fathers:

The cost savings with that model are that they do have reduced Caesar rates, so cost of a Caesar $5000 for example, cost of a normal vaginal $2000 for the health service. They're just made-up figures but it's a reduced number. The evidence shows that there's reduced epidural rates in caseload models of care, so then no anaesthetist, no epidural equipment or insertion. There's dollar savings there as well. Models of care - midwifery led models of care are demonstrated to be a lot cheaper than mainstream models of care for that reason.

A father worker had also drawn the same conclusion, around supporting parents through crisis to reduce separations:

How much we pay in supporting parents benefits, billions of dollars a year, 54 per cent of relationships break up, when they interview women they say it’s because he was useless... So if we change that to where he's useful, then right there there's the potential benefits down the track of paying social welfare and - to both parents, which is what happens - and all the court costs and family courts. There's 10s and 10s of millions and billions of dollars going into this break-up scenario.

If you get parents more aware of what they're doing, then you are in all likelihood going to decrease those sorts of things happening. Marital stress or relationship stress and it's just the right thing to do. If you're going to have babies you've got to do something about making sure they're growing properly.

Savings were generally assumed, with little concrete cost benefit analysis:

I understand that the health system is consumed and budget - and constrained budgetary wise. That's why my point is I think there needs to be an early intervention focus and collaboration between Families and Heath. Priority given to it and less priority given to putting bandaids on things - ineffective bandaids - anyway down the track. Where basically we’re throwing bandaids at issues here that just keep rolling and costing money and cost people’s lives, basically. There’s so much of that it’s not funny. So I think re-prioritisation of an amount of funding that would deliver something somewhat effective, down this end.

While the basis for these claims are supported by empirical evidence – see Fathers are useful (p26) in the literature review, the savings are implied, or expected, rather than proved. They are however, significant:
...I see that as early intervention to preventing these issues down the track. So if you're going to try and nail some of the - if you look at all the fatherhood research... they're more likely to be homeless without a father. They're more likely to be teen pregnant in their teens. They're more likely to be school dropouts. They're more likely to be drug and alcohol users. These are all things that we throw millions and millions and millions of dollars at but way down here.

However the barriers were also well recognised:

Early intervention. This is the problem, because it's economically driven and it is politically driven. Politics is interested in outcomes now. It's interested in what it can achieve now, into ticking the boxes and saying, we've done this now. That's the thing. This isn't going to deliver quick results but it will deliver long term results. That's what we need, is some long term vision to go if we actually invest in this now and in this way and heavily - it needs heavy investment - we will actually set ourselves up for - there'll be more couples that stay together. There'll be healthier kids with better health and social outcomes.

The potential savings are just that – potential. This area requires further investigation.
Service supports

Many fathers and partners identified ways that they had been supported, by services. This section examines the themes raised relating to the ways fathers were supported successfully by services, rather than the support they received or the impact this support might have had. This theme is loosely divided into practical skills, worker experience, trust and rapport, creating a safe space, high quality service delivery, father-inclusive practice, and whole of family practice. Many of these supports apply to all fields of health and welfare practice, however a repeated here for their particular insight into providing service to new and expectant fathers.

Practical skills

Many fathers identified that practical skills were appreciated, and many workers suggested that the key to providing more in depth services was to assist fathers practically in the first instance. This father explained how he engaged around breastfeeding and housework, which led to a deeper understanding of his partner’s experience:

I think it’s given me some more detailed descriptions on - besides just helping out with feeding, or doing stuff around the house while she’s having to do the nursing for a while... a basic understanding of what she’ll be going through, as well - bodily changes and just being able to give the baby what it needs at the beginning, especially those first few weeks, where it’s going to be pretty full on and all that kind of stuff. So, yeah, it’s been - it’s given me good insight to what she’s - what she’ll be going through - and both of us, as well.

This father experienced the same process:

I think it’s just helped get my expectations of what I’m excited about and what to get ready for. Some of the - really, I've delved into the practical side of - we did breastfeeding this week, so, that was helpful to know what my wife will be going through

This father had a similar experience, finding advice about basic elements of fatherhood – maintaining marital relations and interacting with his child – particularly useful:

What else did I get out of it? Some practical stuff. Things like foreplay and floorplay was really interesting... floorplay is literally getting down on the ground with your child, but foreplay with your wife, you know, if you want to maintain a healthy relationship, and sexually active relationship... Doing all the cleaning, and all that sort of stuff...
As did this father:

...that all sounds pretty good like stuff you need, changing the baby, washing a baby, all that sort of stuff and a few pointers how to get by basically. Yeah, I think he spells it out that it’s a tough gig but you’ll love it and that’s it.

Each of these examples indicates the direct connection between providing practical skills for fathers and an improvement of their capacity to support their partners and their children in non-practical ways.

Worker experience

Many fathers and partners held the health and welfare professionals they worked with in high esteem, which contributed to their likelihood of engaging with them. One father explained:

...they’ve seen so many different cases and each person is individual and they can relate to that individual situation and go this is what you need to do. As opposed to the advice of someone who’s been doing it for three years and giving a general suggestion of maybe this will work.

This was particularly likely to come up with older workers, contrasting with the identification of older workers as barriers to father support due to traditional practice mindsets (see Service culture change p132). This father saw that experience as positive:

...because she’s a bit of an older lady too she was just nothing seemed like it was a problem. It made me feel more confident because she was just so calm and so I thought oh if things go - not go pear shaped but I think whatever scenario we can throw out this woman will have dealt with it. It looks like she’s been around the block a few times so she’s delivered a few babies. So I thought yeah that’s good. I didn’t want someone walking in with the text books still under their arm.

This theme of the experienced midwife as calm, confident and in control seemed to relax the tension this father had around the birth of his child, taking him back to simpler times in his religious studies class:

I had a great woman, [a midwife], and she must be in her 60s, late 60s, still doing it and she’s doing the night shift. She was great. She was so black and white. She reminded me of a religious studies teacher. She was really regimented but she was really sweet. We actually got on really well and she just gave me some really good pointers.
This concept of ‘regimented’ doesn’t fit with the importance of treating fathers as individuals, or positive culture change. It did seem to fit well with those receiving service:

*I guess it’s just comfortable with the fact that people that are going to be there at the hospital have done it thousands, hundreds of thousands of times...*

This is important for health and welfare professionals – sometime fathers will need to feel in control and in charge – other times, when they are afraid and out of their depth, they will need somebody to step in and take control, and tell them what to do. In this scenario, a mentoring type support is not necessarily ideal. These fathers identified somebody who could not be less like them – a matron-like figure, as the person who provided the highest level of support.

**Trust and rapport**

On a similar vein many fathers identified that trust and rapport were key factors in providing high quality service, which was also identified by workers as a key factor to success. Sometimes that trust was in a profession as a whole:

*I definitely have trust in the doctors that - like I'm assuming it's going to be doctors or midwives or whoever that have the information they need and they'll present it to us in a way that we can make a good decision. It'll obviously be somewhat biased but I think we have enough opinions of our own that we'll take those into account.*

Other times it was professional respect for an individual:

*I knew the obstetrician, because I do lists for them anyway as an anaesthetist. So I knew the obstetrician as well. Then when we came into the hospital when [my partner] was in labour, I knew the midwives who were with us, and then I knew the obstetrician.*

Or mutual professional trust and respect that made the process a positive experience:

*Then when [my partner] went to have the epidural, I knew the anaesthetist anyway quite well. Then when she needed the Caesar, it was the same anaesthetist and obviously we knew the obstetrician and I knew all the theatre staff, so it was a very positive experience because at all times they knew who I was. They knew that I was a health professional - I was a doctor - and so they would talk to me as part of the conversation. But they also knew me personally. It wasn’t a stranger who was simply this woman’s partner.*
One worker identified the safety in trusting a professional, in absolving themselves from the decision making process, and handing responsibility over to somebody else.

*I really get that there’s a lot - there’s a certain amount of safety in trusting a professional. That’s where I think that desire comes from to think okay, I’m putting - I believe I’m making the right choice in putting the care of my partner and child, in good care.*

This worker identified rapport as the single most important factor in working with new and expectant fathers:

*So I’d say that’s a big thing; it’s just rapport. I mean there’s a lot of research that says over 50 per cent - well, you know, a large part of the impact is the relationship so it’s not necessarily if I’m using CBT or narrative [therapy] or whatever, it’s the relationship and the rapport that I build with my client that is one of the most I guess prominent contributing factors to change.*

Contradicting the positive concept of a matronly woman as an ideal support, or perhaps complementing it, is the idea of a mentoring like support person.

*I think a lot of that is a large part of why outcomes happen; because the person feels as though they’re relating to somebody that’s walking along that path as well.*

These may simply be complementary roles – fathers need different types of support from different people. Lastly, this worker identified that while it is important, building trust takes time, and sometimes fathers are lost to service before it can be established:

*I need to build that rapport before I start going - again this is my way of working. There needs to be some sense of rapport before I can start to challenge. But there are instances where we don’t really get past first base.*

One of the ways in which an environment in which to build trust can be created is by creating a safe space for men to engage in.

**Safe space**

This idea of a safe space was usually raised by father workers, who saw mainstream services as having a kind of stigma attached to them for fathers. This manager explained how important it was to his service to be father friendly:
...still every now and again... I’ll see a guy walk past and you can see him sort of looking at the sign and he’s scoping the place out and it’s that thing about is it safe to go in here; yeah will I be made a fool or will I feel shame and so on for asking for help.

When asked, he described why the nature of the space was so important:

…it’s just about normalising men engaging men’s services and creating a safe way of doing that. So I don’t think, at the moment, the way we do those, in general, like there’s a lot of work to be done to make it more safe for men to access men’s services and make them more father inclusive and father friendly.

This idea of safety is not often raised in relation to providing service to new and expectant fathers, and if it is, it is the physical safety of the workers that is in question (see Risk p148). This concept was further unpacked:

We try and deliberately make our space here not necessarily blokey, but we don’t have a lot of posters in the waiting area of women smelling flowers and rubbing their pregnant bellies and stuff.

Another worker identified the importance of both group and individual support time for fathers:

...built into that budget was time, like knowing, expecting that there were going to be some vulnerable men who came along to that group was allowed for some time and space outside of that for those facilitators to give them one-on-one support and engagement with the view of referring them on to other services and supports.

And tried to make the space comfortable:

...having it there at the [local men’s support centre] was a big bonus. Having a comfortable setting, having your tea, coffee, pizza - we provided those things just to make it feel more welcoming, the little perks I guess.

This father explained what made a safe space for him:

I know that I just value the time that I have with other males, other fathers in [my home town]. I just value and I get a lot out of it and I guess, you just feel like it’s a safe space …It’s just about wanting to spend more time with other dads, other fathers and yeah, that isn’t a public environment or a child’s birthday environment or something like that, so - yeah. I guess, just those deeper conversations that you have with fathers, as well. Not just superficial talk. Getting into the more - getting into more D&M territory with dads. Like, I find that valuable as well, so rather than just the small talk.
Others responded well to the efforts workers went to in order to make the shared birthing space safe:

*So I actually thought it was good. It was a lot of condensed information in one but completely thorough as well. It gave us an opportunity to feel safe and personable I guess in the space that we were going to use for birthing.*

This concept of a safe space for men to engage with services was very important for those men with the insight to identify it. It should be considered a key aspect of improving the service delivery provided to new and expectant fathers by health and welfare professionals.

**Indefinably high quality service**

Another key aspect of good service delivery was a kind of indefinable quality in practice. This was often identified as ‘just nice’:

*...when we did the ultrasound both times really nice guys, both of them. Very relaxed, as in relaxed in terms of not being too clinical, it was - made both of us feel comfortable.*

Or just ‘lovely’:

*...she was great. She did the first bath with us. She came here for the first check at home and she was lovely.*

Or ‘100% awesome’:

*So far - and [my partner] said the same thing -so far he’s been 100 per cent awesome. Obviously we’re paying for a private service, but we’re actually getting the service, and that’s what we went for.*

Or ‘pretty cool’:

*Yeah, so he was pretty cool. He was really good actually, just talked normal to me and just I wasn’t sure what to expect and that was really good. Like okay, this dude’s cool, it’s no worries.*

Others were even less well defined as like ‘a good mechanic’:

*...she was just very - there was no - she wasn’t trying to hide any facts, she was just upfront and we talked quite normally about it. I guess that’s what it comes down to, is just talking normally. It’s hard to find, it’s like finding a good mechanic, someone that’s not going to just talk jargon to you and stuff that you don’t understand. Speak in layman’s terms and I guess that’s what she did, she spoke in layman’s terms.*
This has been included in the research not as an explanation of how to improve service, but as a recognition of the way workers who make an effort are appreciated by fathers.

**Father-inclusive**

The two final aspects of service supports should in truth be viewed as one. Practice that includes fathers without excluding mothers provides support to the whole of the family. When fathers responded to father-inclusive practice, it was because they were treated with respect and equality. When asked what he got out of the fathering course, this father responded:

> Probably that dads can be great parents, instead of just supporting the mother and being like a secondary carer. You’re definitely equal, in different ways, like in your relationship, but you’re definitely an equal part of it.

Others really responded well to being included:

> I can’t remember any point where I thought, I’m - what I’m doing here? Just paying or what’s my reason here, to be here. No, I think it was - I was always welcome to join the meeting

Even at the most basic level of human politeness:

> …they direct their speech towards you rather than just straight to [my partner] and sort of get you involved. But the midwife, she’s really nice. She was sort of speaking to me and asking me questions as well...

And noticed the difference between when they were, and when they weren’t included:

> I probably felt more included at the birth centre, natural birth centre. I guess, there was - I guess they place more value on birth preferences and fathers being an active participant in the birth and being an important person at the birth.

None of these fathers identified wanting replace the mother, reduce the service that was provided to them, or in any way detract from that service. These fathers all wanted, and appreciated when they received, respect. They wanted service provided to the whole of their new families, not just one member. This worker, along the lines of themes raised in Fathers need to take responsibility (p109) saw a danger in father-inclusive practice at the expense of whole of family practice:
Instead of spending a lot of time in saying men are marginalised, men need to take more active - all those things - we need to say our culture and our system need to set up families; need to set it up as a family is the important thing.

This father would probably have agreed with her:

So I'm there for her to help and support her and do anything she wants something but I don't need - some blokes might be a bit more needy than others but I don't know. I don't need someone to go and how are you feeling about it...? Listen dude I'm good, just worry about the lady on the bed.

This father’s perspective, that the service should be focused on his partner, reflects a whole of family approach - whole of family practice isn’t about mother’s rights or father’s rights, but about a whole of family approach, and allowing families to decide what that looks like.

Whole of family

This worker explained that including the whole family in the service provided is actually not that difficult; and should be a key focus of the service provided:

...it is a critical management of the patient, but you do engage the family of whoever is there as well. Take, for instance, having a bub. Mum is the main focus at the time until you're ready to deliver. Then once bub is out, everyone engages. You get dad to cut the cord, so he feels he's there. You ask if there’s a camera there and take your photos and make a note of the time. So everyone becomes involved. If there are other children, they come in and hold little bub's hand and touch him.

Other workers were aware that they should be doing more about working with the whole family:

I guess that’s all we’re supposed to be doing, as well. Like, strengthening the family, looking at those causes...

But workers at the same service recognised that they were not:

Probably very limited experience with that Chris. We deal with families. Yeah we primarily focus on the adults per se, so as a by-product that the children are there or are present, but we don’t really specialise in providing extra-curricular services.

A manager at another service recognised the importance of a whole of family approach, but acknowledged that the service had lost sight of this:
I don’t know whether we’ve lost or we lose focus that it’s a couple and a family that are going on the journey or not. So and it’s an important time in a family’s life, whether they’re becoming a family for the first time, whether they’re moving from a couple to a family, or whether they’re extending their family.

This father raised the issue of tokenism in including fathers in discussions about childbirth and parenting and of being aware of the stereotypes:

...stereotypically like men are thought of as strong and manly and doing all these things, but that’s never - like fighting for your family is but being part of these discussions is not. It’s more just like a figurehead kind of right?

When asked what image would get him to pick up a book on fatherhood, he responded:

I would have more thought it has to be not just the father and child, but more family image... Yeah, not just the dad. Where you've got a family. So two parents but with the father holding the child so it’s a family shot but with the father holding the child. So they're relevant to that situation...

This manager of a maternity ward also identified this as a key area for improvement:

I'm fully supportive of that sort of thing and really looking at a family unit rather than a women and a baby. I mean it would be a wonderful initiative to have.

A midwife from that ward pointed out the absurdity of the mother focused approach:

That they’re the mum, dad family, sort of thing. So I don’t see why [the fathers] shouldn’t be involved... it’s just how family units are and that’s what they are. It's just them to be inclusive.

She went on to explain that this is not always as easy as it sounds:

...we are looking for the best outcome for baby, mum, dad and family. We say there’s quite a few players in there and at times they will be at conflict.

She had also seen other, more whole of family focused models:

...when I was in the neonatal intensive care at Sweden. They had a completely different attitude. They were like, ‘it’s their babies.’ They have a beautiful thing of dads with preemie babies at 28 weeks - in their double bed, in their room. That was the family's room.
This idea of the baby belonging to the family should also be considered a key element of whole of family practice. It was a senior manager at NSW Health who most succinctly summarised this theme, which was consistent throughout the research, between workers, managers, fathers and partners, that whole of family practice is what everybody is after:

*I think we need to be engaging families rather than fathers. I think we need to be using the word families, you know. We need to be engaging families better and whoever is in that family, so be it, if it’s a dad, great, if it’s a mum, that’s great, if it’s two mums whatever, or two dads or whatever. Particularly those as risk families, we need to be engaging them better.*

This reconciliatory stance emerged as a productive middle ground when considering service delivery to new and expectant fathers by health and welfare professionals – that whole of family practice is father-inclusive practice.
Understanding Service Delivery to New and Expectant Fathers by Chris Maylea

Cultural supports and barriers

Cultural implications in this context refers to organisational or social culture, not ethic or nationalistic. Cultural reasons were often cited as the underlying reasons that service or other barriers existed. These were often seen to be intertwined with media representations, but were often more subtle, representing deep, unconsidered and unchallenged prejudices. It was also often seen as an overwhelming barrier, something beyond influence:

...it's that whole thing of society changing its media role models and those sorts of things. It's a big difficult thing.

Not only beyond influence, but also the most dominant barrier:

Barriers to dads accessing our services? I would say well the general culture of society I think is a massive barrier that any service faces...

Cultural and funding barriers alternated as insurmountable barriers to father inclusion. Culture was cited as why fathers didn’t engage with the health service, and funding was cited as why the health service didn’t engage with fathers. From this understanding it becomes important to understand both of these factors in order to address the exclusion of fathers, or their failure to take responsibility. Sometimes, however, it became obvious that funding had nothing to do with the way fathers were excluded; for example this father worker pointed out the impact that language can have on the way father’s roles are defined:

...mothers are the primary care giver, which I find is a term like saying you’re a half caste. You know, it's a term that should have been banned a long time ago, or you’re a lunatic, you’re an abo, all these terms thankfully have been banned these days... But you're still allowed to use terms like primary care giver which explicitly - and the underlying meaning is that there is a secondary care giver. Now if you're secondary you’re nowhere near as important as a primary, that’s just life. So dads are being told on a constant basis subliminally and consciously and unconsciously that we are less important than mothers. Now you can't go on telling someone they're less important without consequences.

This father saw market forces at work:

...I think in advertising you know the father is generally displayed as the bumbling fool these days. That's definitely the stereotype these days. [Unclear] mum's in charge, he's the bumbling idiot who doesn't
know anything and that’s the media stereotype these days. It’s kind of reversed. So I don’t know how to change that - advertising is always going to just do whatever sells.

A worker highlighted the consumer aspect of market culture:

...there’s an over-prioritisation towards capitalist culture and consumer culture. So between managing work commitments and consumer culture, and also too by and large, the nuclear families are breaking down more and more. There’s less family structure - well extended family structure around. So most parents are doing it solo. I don’t see that as a healthy thing.

He went on to talk about where some intervention might be useful, viewing fathers as victims of their own internalised discrimination, a result of a less cohesive society:

...when blokes get to their late 30s a lot of it's too late - like they’re so set. A lot of this stuff should be just in school. A lot of this stuff we should be more involved with babies and old people and all those things in school and learning about how a society and a community works rather than just white man’s history and some calculus and some chemistry and get out of here.

This father worker saw it starting even earlier than school – in the home:

...if our partner doesn’t expect us to do a lot, like if she does the dishes and cooks every night and doesn’t expect us to do it, we'll sit there and watch TV every night and let her do it. Because that's the way we're tuned, that's the way men are programmed, that's what we are. Because our mothers programmed us and that's what they did, and their mothers programmed their sons and that's what they did. That's the way we're programmed and my wife programs my son just the same. Expects my daughter to cook but him not to...

This father summed the whole process up succinctly:

Yeah if there was more of a societal shift then this whole me needing to go to a course to find out how to fold a nappy at the age of 40 you know might not... need to happen...

A father only recently arrived in Australia suggested that this might be related to an Australian cultural phenomenon:

...what I’ve heard and maybe experienced a little bit, just my wife’s told me a lot about Aussie guys and they’re not the ones that would want to come together and talk about stuff, or they’re just not as open, or not as forthcoming...
Some fathers found their own internal cultural shift, of viewing themselves as important, quite profound:

...society just doesn’t - at least the communities I’ve been a part of, not that they shy away from this but it’s never been mentioned that men are hugely important in this process... I could have thought of that but I didn’t because it’s just not the way that society has thought of things and therefore me, because I’ve never put real time into thinking about it.

That father had experienced that shift as a result of service provided by a worker, again demonstrating the significant impact workers can have on fathers. He went on to explain how the worker approached the subject:

...his whole mentality, the way that he approaches it I think is important and refreshing because you see the other side. He kind of comes at it almost not like opposing ideas but yeah, but in a lot of ways he does and it’s like I finally see the other side of the debate kind of, you know? At least now I have the option to decide...

This shows that not only can health and welfare professionals have a positive impact, but that for some fathers at least, they are looking for this kind of support through this challenging period. A worker, who was also a father, explained how fathers might feel uncomfortable in the role the dominant culture expects of them:

I do realise that most dads do feel like they’re not really part of the process. Just the act of being a father, they can sometimes - a lot of dads spend so much time in their job earning money for the family, getting tired and stressed with their job, they don’t get the same type of time and relationship building with their kids. I feel like a lot of dads being almost a bit marginalised in their family, because they’re so busy outside. It’s almost through no choice of their own, providing for their family.

They don’t get the same depth of relationship they get with the kids that mum does, because mum’s usually around more. I suspect that a lot of dads probably don’t have that kind of depth of relationship that mums do. They don’t have the same level of understanding of their kids and the ability to manage behaviours and things, so I think I do have a bit more of a knowledge of that.

One father worker thought that simply looking at the cultural influences on fatherhood wasn’t sufficient, but that a complete review of masculinity was required:

I think we’re calling for a radical cultural shift around men and masculinity, really... So isolating a target group like expectant dads and trying to effect change there is probably not going to hit the mark
because, I guess - well, there’s all layers to this. There’s the constructs that we’ve got in our culture and society around us, around who men are, how they are and therefore how we engage with them, how we support them.

When asked what was required to enact this kind of societal change, he identified that despite the work going on, interconnectivity was missing:

I think there’s a hell of a lot of great work happening out there but it’s happening in so many isolated ways that the net effect of that is there’s no connectors, there’s nothing that’s really bridging the gaps on a big scale. It’s bridging gaps in communities or in places or in organisations but it’s not bridging the social and cultural gaps that we need to effect a larger scale change.

Another father worker saw a similar solution to the same problem:

...cultural change requires structural and organisational change and societal change and policy change.

Ultimately cultural barriers were viewed as the underlying cause to father disengagement, as also being the cause of the funding barriers described above, and the most difficult barrier to overcome. This was tempered by examples such as those above, of workers themselves enacting cultural change through positive service delivery, usually with no injection of extra funds.

Not all cultural impacts were negative – many participants identified cultural influences that supported father engagement – this father explained how the media had influenced his desire to have a strong emotional connection to his unborn child, despite not necessarily feeling overly connected at that point:

I’ve seen it on movies and Hollywood kind of says that it’s the right thing to do so that’s the only connection I have, but I don’t even know that, I don’t have any real emotional, desperate to the, the blood tests or - for no good reason, just because I didn’t really make the connection. I don’t really see myself as being part of that role, part of that scene.

One father worker described the media response to the introduction to a program aimed at supporting fathers:

...it’s been happening for seven years and it’s now in capital cities around Australia and some regional areas, but when I launched it up here, I think because I was - because of the male factor, the media grabbed it completely. So first of all I did an interview with ABC North Coast ...
So I did a story with the Northern Star. The morning the Northern Star article ran I got phone calls from the Daily Telegraph, Sunrise - oh, the phone just went off. I just got all this interest in the fact that I was doing - I think because of the male factor, that I was doing it, which I thought was great - unexpected but great.

This has clearly identified a number of ways that culture can act as a support or a barrier to family engagement. This idea of culture, explored from a service perspective above in Service culture change (p132), and intertwined into other supports and barriers, such as service related (p138 & 163) and work and knowledge related (p178) below, is a key element to understanding how service delivery to new and expectant fathers by health and welfare workers can be improved.
Work related supports and barriers

Work is a common theme – both as a barrier and a support. Many fathers found that their work prevented them from engaging by preventing them from being present at important events, while others found that it gave them increased service knowledge, or skills to plan and negotiate the challenges of childbirth and early years parenting. The initial way new and expectant fathers usually explored the concept of work was financial security, however on deeper examination this was only one part of the impact this professional side of their lives had on their parenting.

Fathers were much more likely to raise work as a factor in discussions as either a support or a barrier to their engagement with services, as shown in Figure 29, raising the issue twice as often as their partners, and 18.4 times more often than front line workers. Interestingly, managers had a higher focus on work as an impact on new and expectant fathers than their front line staff – perhaps due to the difficulty some managers experience themselves with a work-family balance. Figure 29 highlights the different understanding of the importance of work between the different groups of participants.

![WORK - RELATIVE FOCUS](image)

Figure 29 - Work - relative focus as a support or barrier

Fathers viewed work as a support as often as they raised it as a barrier (raised 76 times as a support and 72 as a barrier), but was not raised as a support by workers at all. Figure 30 shows the focus that fathers and partners had on the concept of work as a support to father engagement.
Figure 30 - Work as a support - relative focus

Figure 31 shows the relative focus on work as a barrier to engagement, again with fathers and partners raising the issue as a barrier more than workers, although managers were quick to recognise this barrier.

Figure 31 - Work as a barrier - relative focus

What these figures show is that workers don’t fully understand the importance of work either as a support or as a barrier to engaging in their services, and that when they do consider it, they view it as a barrier. This could indicate that workers are missing key aspects of family systems, and failing to negate the potential negative issues, and failing to use the positives.
Fathers felt an expectation to work, and to provide financial security. This is consistent with the gender roles covered in the literature review (see Gender roles today p18). Some fathers worried about not being able to balance their work and family commitments:

*I still don’t know how we’re going to make ends meet because I don’t earn much at [my current job] and we’ve got a block of land at Pottsville and we’re about to start building ... But I haven’t looked out what’s going to happen with that. There’s better paying jobs than what I’m doing now but it just means working more, so it’d be nice to squeeze this out for a year and then when things get a bit tighter...*

Others were getting all the work they could handle, but still not making ends meet:

*I work 50 hours a week and we run two small businesses and still don’t have a whole lot of money.*

This new father went on to explain how having a child had changed things:

*...Yeah because we’d always had this thing where if I was working, [my partner] could have a bit of time of or not worry. Then when my work would run out, just naturally [my partner] would take up the slack. Another father had had a wakeup call when he lost his job:

*Then suddenly I broke the finger and there was no work, there was no money rolling in and then suddenly we were having to - that was when we started buying all the stuff for the baby and I had that moment of clarity where I went oh man, you know? Like - then it sort of started sinking in that if come April [if I don’t get a certain job], here I am with somebody dependent on me, or two people dependent on me. What am I going to do for a career again?*

Fathers often felt the expectation of social pressure unbalancing their natural tendency towards involved fatherhood:

*Then I was telling that to a friend who was a woman and she said to me no, no it’s your job to go out and earn the money and that’s your role and all that sort of thing. I went okay right. So it was kind of going against my natural thing which was wanting to be as close to this baby as I can and really wanting to spend time with it in the early years and all those sorts of things.*
Others had based their whole life plan around the financial aspects of having a child:

_The reason why we’re having a child so late is because I just - financially it just hasn’t been, in my eyes, feasible. We’ve moved up here, it was a big decrease in money coming in the bank and still now I’m going oh, this is going to be tough._

These couples often associated financial security with confidence:

_I feel like I’m comparatively in a good position because I look at myself in comparison to my friends who I imagine, I just imagine what their position would be if they got pregnant and a lot of them probably wouldn’t be financially robust enough to be able to go into it with confidence._

Others, despite not owning their own house, or having a lot of money, still managed to feel confident and secure:

_[I’m] a counsellor at [a juvenile justice centre] and I’m just, it’s not that expensive to live out here. We made the transition from the city down to small town and rent is cheap. Financially I feel like I’m happy to do it and it’s, as a man it just feels, it makes you feel good about your situation._

The financial aspect was only part of the way work impacted on how new and expectant fathers in the study. Other ways included confidence around parenthood, understanding of how to engage with services, and the ways that they engage with these services. During the data collection process, while investigating the link between previous experiences and preparation for fatherhood, an interesting theme developed – while fathers often spoke about the impact of their previous exposure to children as a factor, they were often unconscious of the impact their professional lives had on their personal. This couple, both naturopaths, were an example, as they responded to a question about how their professional lives had impacted their birth:

_Mother: So what should we have done? Had herbs put in the bath?_

_Father: Well we did._

_Mother: Oh shit we did._
This father, an engineer, saw the difference in terms of his relationship with his partner, and her different worldview influenced by her professional training:

"It’s creative solving problems...my partner, she’s a graphic designer, so she’s pretty creative and sometimes I have to bring her down and bring her back... I always just solve one problem and then, to the next problem... I never thought about this one, but yeah, I think it’s a point of my job or it’s a thing of my job, what I use, as well, to my life."

Note the phrase ‘I never thought about this one’; reflecting the naturopaths above who were unaware of this side of the potential impacts of work on parenting. When the link was clearer, the potential impacts were more obvious:

Interviewee: I’m fortunate because she does know a lot of stuff just because of her background.

Interviewer: What’s her background?

Interviewee: She’s an early childhood teacher, she’s a director at a centre so she knows a lot of stuff about babies,

This father saw the impact of his profession as having positive implications for communication with his partner:

"I’m a counsellor, so I talk to people about emotions and all that kind of stuff so I have to be able to be comfortable thinking about it and talking about it."

Another father saw his background in international security as also having positive implications for communication with his partner:

"...observational skills with people are pretty good. I can read people really good. I pick up on a lot of stuff I think that others don't. Also with my partner I’m able to read how things are going with her, whether I can see whether she’s stressed or unhappy or she's - when she comes in I can tell if she’s having a good day or a bad day."

He also saw it has giving him skills to negotiate the service system, and to empathise with health and welfare professionals:

"...this is another reason why I think I’ll enjoy the [a security related job] because if some guy stands there and calls me a dickhead I don’t take it personally. I won’t lose one minute's sleep over somebody giving me a spray and that's the same with the doctor."

Taking this to the extreme, one father, also a healthcare provider, explained the preferential treatment he received:
I think in a situation like mine though, it can also be skewed the other way because my experience... I worked at the hospital. Every area of service delivery regarding antenatal care and then the delivery, I work in it anyway. So the midwives knew me because I came to epidurals. The anaesthetists knew me because I work with them every day. The theatre staff knew me because that’s where I work. So I think my experience was actually a very positive experience. It’s going to be a bit skewed, because people knew who I was and they knew - if you’re part of the team so to speak, then you get preferential treatment if that makes sense.

When prompted, he unpacked this even further:

The minute you’re a health professional - and I think being a doctor, it’s rammed up even more - you’re going to be always more included whether it’s because people are going to include someone who has a knowledge of what’s going on, or whether they’re simply worried about being seen to do the right thing in front of a fellow professional. I think it’s a bit of both. But I think if fathers had a greater knowledge of labour and the birth and of the process and they threw a bit of jargon in that sort of twigged the midwives, oh, this person knows what they’re talking about. That might make them be more inclusive, I guess, because they’re thinking, oh, this person actually knows quite a lot. I need to include them in the process. Then they’ll probably get asked, what work do you do? Are you a health professional?

Yet another father, a paramedic, and his partner, a GP, also felt comfortable in their imminent birth process:

I’ve delivered at least three and come in when there’s a new bub there and - at least 15, 20 others.

However even that level of preparation left gaps in knowledge:

Just with my work, I’m quite confident even if I had to deliver this bub that I’ve got no problems there at all. But it’s the after-fact - that’s where I would struggle. But until that happens - and I’ve had a little bit of hands-on now practising, I think everything should be fine.

A social worker, partnered to another social worker, used his rights based stance to ensure he and his partner received the service they wanted:

...having worked within this field, you know you’ve got rights and you know that health services, they’ve got to take your decisions into consideration. It’s got to be based around your wants, your needs, so yeah, I guess, we just kept on reinforcing what we wanted and I guess, the midwife helped reinforce that...

Another father found support at work of a less practical kind:
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So two of the blokes that were there went through pregnancy and giving birth and we all got on really well. So there was a lot of sharing and support in that work environment so it was quite natural and easy with all those people.

This worker explained how her husband’s work as a farmer had helped with father engagement, but warned from professional experience against forcing fathers into unwanted contact with their children:

....my children were born from mid to late ‘80s and we were in a situation where we had a farm so [my partner] was at home all the time and I was back at work. I came back to work when [my son] was only three months old but my husband was always a hands-on person with the kids right from birth. He just created the daily activities on the farm around the demands of the kids. So there are people that will be able to do that and he was happy to do that. Whereas there are the others where unfortunately it’s forced on them for whatever reason and they’re not into bonding with the children.

What emerged from the research is that work positively impacts on fathers in diverse and significant ways. For health and welfare professionals, it is important to understand the complex environment this creates – the service provided to social workers should be different to the support provided to a paramedic. All fathers asked about this were able to find strong positive impacts their work had on their capacity to father, although work and work related skills were not always seen as supports – many fathers found that work was a major barrier to them engaging with services and the parenting process. This was also often cited by workers as a reason fathers were difficult to access (see Barriers to access p80 and Time related barriers p146).

Interestingly, it was often things that some fathers saw as strengths, which others saw as barriers. This father didn’t see the flexibility of running his own business as an advantage:

..I've got my own business and I'm working mainly overseas. I'm going overseas from time to time. Work there and try to bring a few projects with - to here and working here on the computer or having a few telephone conferences and this will be a bit tricky in the first time, because I want to spend more time here, instead of going overseas.

Nor did this one:
This is a busy time of year, too, so December/January, when the baby's born. It's going to be a little tough... I don't want to be all business when the baby's born. I want to be able to be around.

Other couples chose service providers based entirely on the basis of proximity to the father’s workplace. This couple chose a hospital 95km away:

Interviewee: So we actually went to the Gold Coast Hospital because it’s...

Interviewer: Gold Coast or John Flynn?

Interviewee: No, it’s the Gold Coast like in Southport because it's five minutes from my work.

Other fathers worked beyond the realm of conventional service delivery:

The classic situation is my service in the army when I was in there full-time. You go overseas with guys for five or six months. I didn't have kids at the time when I was in the army, but a lot of those guys who did have kids would endure five or six months of being away from their family. I don’t know how you do that. Then they'd come home and after five or six months of having someone else do your cooking and your cleaning and not having to worry about anything domestic, because you’re outside the wire all the time.

Although returning to domestic life had singular difficulties:

Then suddenly you're thrown back in your family where your kids hardly know you. Suddenly you've gone from this high-level heavily involved, stressful, dangerous work to being at home where kids are screaming at you and you don’t really know how to manage it. You've been given six weeks of leave or two months of leave. What a lot of these guys end up doing is they end up going back to work after one or two weeks. They can't even handle it at home, because it’s so stressful for them compared to what they've been doing.

The only time workers see fathers in this situation is when they are in this challenging transitional process – something that would significantly inhibit a father’s ability to engage with services.

Sometimes work was a straightforward barrier – while some couples had chosen to have their babies at hospitals they worked at because they felt comfortable, others felt differently:

Interviewer: You’re affiliated with doctors at Mullumbimby in what way?

Interviewee: I work there. I’m a doctor that works there...
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Interviewer: Yeah, I've had [two doctors] have both been supervisors of mine. So I don't think I'd want them to deliver my baby if I was to be there.

A manager shared the stress of having her personal life cross into her working life:

My last child was delivered by [another manager] and every time I sit with him in a meeting, I think, oh Christ, I hope he doesn't remember me. It's quite confronting ... it's like, oh my God, I'm sitting in a meeting with somebody who delivered my child.

For service providers, the problem of the working father was often repeated, and impacted significantly on services they were able to access, not just relating to Barriers to access (p80) and Time related barriers (p146), but to the whole family unit. This worker described why working fathers meant women left hospital earlier:

A lot of the women like to get back to their own environment if they've got some kids at home they certainly love to get back and be with their kids and get the family back together. A lot of women have financial constraints and they need to get home so their partner can get back to work and not be looking after the kids.

Work plays a significant part in the lives of new and expectant fathers, for a range of reasons including confidence around parenthood, understanding of how to engage with services, and the ways that they engage with these services. The interaction between fathers and work goes beyond financial security, and should be well understood by health and welfare professionals to ensure that they are interacting with fathers appropriately on this important topic.
Knowledge supports and barriers

Some fathers and partners found a level of support from their work, particularly in regard to the skills it provided them in their journey to fatherhood. Others were less prepared:

*I don’t know how to change a nappy, I don’t read, I don’t know how to stop a baby crying, I really just wouldn’t know what to do with it other than hold it if somebody gave me a baby. I do have a bit to learn I think.*

The ability to change a nappy seemed to be a key indication of preparedness:

*I’d never changed a nappy. Neither had [my partner]. They taught us how to change a nappy. How to wash him. I think I would have liked somebody visiting us every day because, you know it’s like, ‘what’s happening?’*

Parents often reflected on their mindset going into parenthood:

*...sometimes when I think back I think we were a wee bit naive going into parenthood thinking that everything would be okay.*

This worker, also a father, explained the isolation he felt when fatherhood didn’t turn out to be what he had expected:

*I know when my partner was pregnant and when our first one was really young, most of the dads I knew said oh it’s great, you know it’s brilliant. I felt really not disenfranchised but really isolated when that wasn’t my experience of it. It wasn’t until down the track I said to some of these dads over a beer you told me it was going to be really cool and it’s a fucking nightmare. “Oh yeah no I guess we’d forgotten about it or we didn’t want to tell you or something.” So I was kind of always - I say to people now in the spirit of support it is bloody hard and that’s normal. I don’t mean it’s bloody hard but it is normal pull yourself together. I mean yeah it’s really hard on you.*

This is an area of concern for workers – if the community supports fathers have are creating unhelpful expectations, workers are uniquely placed to rectify this. This worker related the journey some parents went on as their knowledge and skills increased:

*...three of the dads in there or two said they were close to resorting to physical punishment when they started the program. It was – ‘I don’t know what else to do.’ ‘I’m going to end up having to spank them’ -

No-one tells you how much it’s going to hurt when it happens. Like the birthing process. But then I think that applies to the whole process in general.*
and they had older children. ‘I just can’t handle it.’ By the end of the program they felt that they didn’t need to do that anymore.

A different worker explained the gaps in this identified area:

Most of the father courses are one hour; if you can teach a bloke how to be dad in one hour yet it takes 120 hours to learn how to drive a Holden Barina, then I’m off the planet.

Ultimately, fatherhood is hard, but without the knowledge supports in place, it can be much harder:

No-one tells you how much it’s going to hurt when it happens. Like the birthing process. But then I think that applies to the whole process in general.

Conversely, fathers who did have some level of knowledge from experience were much more confident:

...the thing is I actually have had a little bit of experience. I lived with two single mums for close on six years and they were reasonably young kids, so we’re talking two for one of them, and the other one was even younger, then obviously through their growing up period. ...As far as though the understanding kids, I think I’ve got a good understanding of them and will be a good parent in that respect.

This is consistent with the metatheme that fathers need to be better understood (p224). Workers need to be aware of fathers’ previous experience and knowledge when providing them a service, and match the service they provide to the expertise of the father. This will often require an understanding of not only the father’s experience, but also what other community supports they might have that will fill any remaining gaps.
Community supports

This theme of local community supports for fathers was widespread, with 19 of the participants raising the concept, most usually in relation to their own family, friends or community groups. Fathers and partners were much more likely to view their community supports as important than workers or managers. Only 1 worker and 1 manager raised the topic, compared to 14 out 15 fathers and 3 out of 4 partners.

Local community

The area the research was undertaken is a transient area – 49% of individuals in target area in the age range of the participants lived outside of the target area at the previous census – the highest in the state for a non-metropolitan area (Australian Bureau of Statistics 2012c). Only one of the fathers interviewed was originally from the area. Despite this apparent dislocation of people and place, many participants suggested that the local area had a culture of supporting fathers:

Interviewer: Where are you doing your - what area?

Interviewee: Mullumbimby and Brunswick Heads.

Interviewer: So there’s kind of a cultural...

Interviewee: More of a - more an accepted culture of dads looking after kids.

Many participants identified this influence:

But I think in this area it’s a progressive area, it’s a bit more laid back this whole Northern Rivers area. I don’t see that there would be too much resistant to including dads more in whatever way we can.

This was extended to a kind of holistic positive environment – a kind of positive energy:

I think from an environment perspective you can’t beat it. In Byron you’ve got the calm waters, you’ve got the lighthouse to walk up to, all the wildlife and everything else right there at your disposal so I think if that doesn’t sort of help you then things are pretty serious. To be around a positive environment’s always a good thing, so that was the big step forward for me.

Others saw this as less of a positive image:

...my opinion was just the polar opposite and I was a bit worried thinking oh man it’s the stereotypical blue collar North Coast dickhead,
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that’s probably what they’re thinking of me but I guess they don’t know the full story.

Outside of the alternative lifestyle area of the Northern Rivers, in Casino, the alleged Beef Capital of Australia\(^{14}\) (George 2000), a change to a more father accepting culture was reported:

*I think it’s more acceptable to sit in the break room at work and talk about your kids in a positive way, not derogative, wife and kids, pains in the arses type stuff. Some of them even had this thing of - one guy in particular sticks in my memory. His wife had gone back to work. It was easier for him to bring the kids into me after work. So he used to bring them. When he knocked off after the meatworks, he’d bring the children in to me.*

This idea of a community that supports fathers is worthy of further research to explore where this concept comes from and how it can be supported elsewhere.

The church

For those who identified as religious or churchgoing, this also played a big part in how they related to fatherhood:

*We don’t have a lot of young families [in our church], except our family, who has two kids herself - my sister-in-law. So, that’s good that they’ve been through it and they’re still going through it, but there are dads in the church that are really good to have; have a lot of wisdom and experience.*

This support wasn’t limited to the Sunday service:

*Interviewee: Well, there’s two older guys that I look up to that I would count as mentors, I guess, that I’m able to meet on a pretty regular basis, just for coffee, or something, or in between and after church and things like that.*

*Interviewer: You met them through the church?*

*Interviewee: Yeah, yeah. They’re really wise and helpful and have got experience and pretty much everything. So, I really can gain a lot from them, but they’re all obviously, a generation older than myself, as well.*

This mentoring concept is explored in more detail Chapter 7. Another father, a GP himself, identified that he would access the church for a particular kind of support:

*One would be a GP. The second would be the community childhood nurses, because I guess they know where all the services are. Where

\(^{14}\) A title contested by the Queensland City of Rockhampton (The Age 2006)
Barriers and supports

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else? Maybe go to our church for practical support but obviously not professional support.

One other father who didn’t identify as church-going, still highlighted to role these community minded groups can play – in this extreme example saving his life:

Interviewee: Yes and I was really down. I tried to commit suicide and there was no one there for me. I was going through the middle of committing suicide and this bloke from the church drove past and pulled up and saw what I was doing and spoke to me and took me up here to the hospital. If it wasn’t for him...

Interviewer: You knew him through the church, did you, already?

Interviewee: No, I didn’t. I didn’t know him from a bar of soap.

For service providers, understanding the supports fathers bring with them enables the service that is provided to be tailored to the individual, not the service. This is especially poignant when regarding religious or church based supports, which may not fit within the service provider’s own worldview.

Friends and family

Friends and family composed the most significant factor in community supports for fathers and their partners. Participants identified the notion of the family, and the father’s role in the family, as also a strong support for father engagement:

I thought that was the whole idea of having kids, that you involve them and it’s a family thing.

Another father put it a different way:

So then you’re responsible for something, and I think one of the greatest needs of humans is to be part of a community, and that’s a very small community that you can be a part of. It’s a basic human need.

Perhaps related to the transient nature of the population, many fathers didn’t have close family nearby, and would instead rely on friends:

We don’t have the mother-in-law around. [My partner’s] family are in Sydney. My sister’s in [unclear ] with her family. So we don’t have a huge network to fall back on but what we have is [My partner’s] got other friends, close friends who have just had kids. There’s about four of them all having a baby within nine months of each other.

The importance of having people in this role was fairly universally recognised:
Man, if you didn’t have a parent, or just someone else that could come over and give you that relief, it’d be horrible.

And how useful it could be when it was available”

Well, we had the support of [my partner’s] mum when we got home which was really good. So we - I bounced off her. How do I do this? As simple as cleaning the nappy - that helped because that was - she was just here 24/7 for the first week or so, wasn’t it?

However this didn’t always work out:

...that whole family system’s gone out the window I reckon - for us anyway. Traditionally the grandmother comes and looks after the child. We don’t have that - we tried it maybe once or twice in the last two years.

Often in the absence of traditional family roles, other family members would step in:

She's really close to my sister. My sister has had four kids and my sister is going to be there to support her as well so if I go look this is a bit much for me, I need a break my sister will be there. At the same time if my sister or [my partner] decide that is hold be there and I’m being a bit of a dickhead my sister will be able to pull me into line anyway and say, ‘look, get with the programme.’

This would also often have a big impact on the way people accessed service. This father’s partner consulted their friends about their baby dropping, rather than a health professional:

So yesterday when she thought the baby had dropped she rang around all the girls and asked. She rang the first two and I said ring the next one. She said why they might say the same - maybe they won’t. Let’s find out. Ring my sister as well. So get four different opinions if need be and then we’ll decide which one is right. As it was they all said something very similar.

Many were making decisions based solely on advice from friends:

We’ve heard from friends that Mullumbimby has this and Tweed has that, we’ve heard from the doctor in the Gold Coast Hospital saying Gold Coast Hospital has this, Robina has this, Tweed has this kind of thing.

Father would find these groups anywhere:

I’m in the music industry doing DJ’ing and there’s a bunch of us DJs that all know each other. Also I guess I’ve let the surfing and a few of those
other kind of things slip because for the past four years I've been working in an office of four men or five men or up to six men at a time.

Or just organically:

Traditionally, we've been hard at work, and then surf a lot. So, it's not like we actively go out, and have dinner parties with new people all the time, and that can be hard, sometimes. So we're just organically growing our little circle of friends, and that good, more realistically.

But those circles of friends are highly valued when they were present:

I've got a lot of close mates and friends and a lot of friends who have just had babies or are due a couple of months after us. So I've got them to talk to and a good relationship with a lot of older people as well who've had kids. I've got a pretty good network of friends and really close, good friends.

And the risks of not having them were well recognised:

...yeah, the support network is very thin and it doesn't seem very - I was going to say not very strong, but it just doesn't seem like there's enough of it, especially for her to be home alone and with the fear of postnatal depression and things like that. Yeah, we need to start like getting involved in the community more just to meet people to try and find those links.

Importantly for health and welfare professionals, the community supports that fathers have available dictate not only what support services they need, but how they chose and use those services.

One father had joined a football team, in which five of the six players fell pregnant at the same time. The team wrote a book about the experience, called One Got Past the Keeper, by Fertile FC (Young, et al. 2011). That father felt that this community support experience should be offer to all fathers:

Maybe everybody should get six blokes together and write a book. It was bloody helpful.

When probed about this, what was useful was the manner in which the support was provided:

Well I think the way it worked was because the guys weren't telling me what to do and how to have my baby and how to react. They were just telling me their story.

It was almost to the point where they weren't giving advice. The most experienced dad - there's a line in the book where - he didn't give
advice to anybody. He was, you work it out yourselves boys because every birth and everything is different. Then he'd tell his stories about his childhood and we'd just listen and work it out that way.

So it’s that sort of whole lead by example sort of thing. You’ll not tell somebody how to do it but just show them by example I suppose. So maybe some way where you can just hear the experience of other dads.

This approach was often raised as preferable to fathers – less of a traditional support service approach, and more of a mentoring approach to supporting fathers. This mentoring aspect, which is a form of community support, is explored in the next chapter.

Academic and textual supports and barriers

Academic and textual supports are included here mainly due to their absence. Many fathers used academic and textual supports such as parenting books and DVDs, however these were not usually seem to influence the way they interacted with services. Fathers were also much less likely to engage with this material than their partners, and when they did it was usually at their partner’s request. This father, a GP, was an exception:

Interviewer: Where would you source your information from?

Interviewee: We would do it - that's a good question. There was one particular author that we used.

Interviewer: Who was it?

Interviewee: Robin Barker.

Interviewee: Amongst certain circles, it's like the unofficial bible, the baby and then the toddler stage. She seems to have a reasonably good respected opinion amongst the profession anyway. Then we'd use, I guess, websites. You'd go to professional websites and then look at the list of references they've got and things like that.

Another father, an engineer, also read a book, to give more context to the information provided in the antenatal class:

I've read up on it a bit. I read a father book and in the antenatal class they went through it briefly but it still gives you a bit more of an idea.

This father explains why he preferred the course over an equivalent book:

I think I wouldn’t - I wouldn’t enjoy it if I would read a book. I wouldn’t enjoy the moment, like to be a group to have a joke, as well and to
have a talk to this man, as well, to hear the feelings or the emotions from other men in this course.

This partner shed some light on why fathers weren’t reading books about parenting:

…it was very much aimed at me. In fact [my partner] hasn’t even looked at it yet and I just put it in [his] bedside drawer so that you will but it was very - it’s aimed at the woman.

This theme of mother focused practice emerges in the support literature available to fathers. For a mother focus of a different kind, this father was put off by the content of the videos available:

…they said the whole orgasm video while giving birth is just - it put them off a bit so you don’t need to see it.

Many fathers left the book reading side of things to their partners:

…so we know we have this list of - because [my partner’s] read a book or two, we have this kind of list of things that we need to acquire just like the minimal.

Another father was fairly dismissive of a friends attempt to use parenting literature:

He armed himself with that American woman’s book, where you schedule everything every 15 minutes, and it has turned out to be a fucking disaster, because him and his wife, who are not very natural kind of people, have set themselves up with this expectation that they’re going to be able to control their kid. And they can’t control their kid, and they’re freaking out. She’s two, and still, he’s like - I saw him the other day, and he’s like - oh fucking 30 pound fucking handbrake, you know. I’m like, what? You don’t love her? It’s just a kid, man.

One partner was particularly keen to get her partner to get into the book:

Interviewee: Or we’ve got - there’s that great Baby Love book to - it’s meant to be really good...

Interviewee: So there’s sections in here that I want [my partner] to read...

Interviewer: So what do you want [your partner] to read?

Interviewee: There’s sections in here, there’s my little post it notes. What have I put in here? Not women’s business.

Interviewer: You don’t want him to read the women’s business?
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Interviewee: No not women’s - no but I’ve actually got breathing in here for the labour, so he can understand the breathing and obviously assist me along if I’m too fast or whatever. Then there’s a chapter on the new arrival which talks about all sorts of goodies.

Interviewer: What sort of goodies? What did you get from that book that you want [your partner] to get?

Interviewee: It’s got things like - just the basics for head shape, lumps and bumps, just basic for nappy content, mucous, you know, sticky eye, all this kind of thing. So he understands what’s happening with baby as well. Wrapping the baby obviously; the placenta. You know, circumcision, that whole discussion.

Her partner responded to this topic in his interview:

Interviewer: What kind of books are you reading?

Interviewee: I haven’t done a lot of reading, [my partner’s] been doing most of the reading and I’ll be honest with you. So it’s a matter of…

Interviewer: Are you a reader, would you read…?

Interviewee: I’m a reader but it’s more - I’ve got to admit I finish work, come home and the last thing I’m doing, and should be at this stage, I should be picking them up and reading them. I’ve got seven weeks to go and I guess now is the time and I’ll refer with [my partner] and say what are the important things that I need to be reading do you think? She’ll bookmark and this is a good thing, and [our antenatal instructor] showed us some stuff that - articles that should be read and the couple that I read were important.

In summary, fathers in this study did not respond positively or negatively to academic or textual supports. Some workers engaged with the literature around fathers, but not many. Again, this worker is the exception:

We use the invitational approach. I don’t know if you’re aware of Alan Jenkins’ work - Alan Jenkins lives in Adelaide; he’s written a couple of books. I don’t know if we’ve copies here. Invitations to Responsibility was his first book and then his second one is called Becoming Ethical and basically he calls it the invitational approach and a lot of his work is based on a narrative - sort of coming from a narrative context.

Only one other worker even mentioned an academic author, source or approach:

Olds and Perry were the two researchers that the whole of Families First was basically based on. Olds did a lot of research on - this is going over a 30 year period now, and he’s proved that frequent home visiting by nurses actually increases the engagement with health services, increases engagement with education, reduces drug and alcohol use, reduces contact with juvenile drug use and jail.
These two workers who did use theory to inform practice were not demonstrably driven by it, but similarly to the other workers, worked with fathers intuitively from experience, or on the basis of supposition. This worker was asked why some midwives were opposed to including fathers, particularly if feminist theory, necessary to reclaim women’s ownership of birth from male doctors, was now excluding fathers:

*I don’t think they’re necessarily influenced by theory - by this theory at all unfortunately. I think it would be great if they were, maybe. I think it’s more power control from professionals. It’s a lot of ownership. There was some colleagues who had a lot of ownership over the mother and the baby.*

This lack of theory in worker’s practice is not surprising given the lack of relevant theory available to them – something that this research hopes to address. This is indicative of the themes raised in How workers work / how practitioners practice (p41), regarding the difference between a profession and an avocation. With a strong theoretical base on from which to build practice, workers have a much better chance of positively engaging fathers.

Participant solution – support groups

Having previously isolated the information session from the fatherhood group model, participants identified the need for support groups in the community. This concept of a support group as distinct from a course arose from fathers who didn’t feel as if they needed teaching, but still valued the interaction with other men in similar situations. This expectant father was highly educated, and felt he could access the information he needed, but found something extra in the group environment:

*I wouldn’t enjoy it if I would read a book. I wouldn’t enjoy the moment, like to be a group to have a joke, as well as to have a talk to this man, as well, to hear the feelings or the emotions from other men in this course. It’s - I think it’s pretty helpful.*

Another father explained what would get him involved in a group environment:

*I mean if I was really going to be motivated to go along to one of those forums it would be to network with other people that are in a similar place in life.*

Those fathers that did do it, responded well to it:

*It felt really good. It felt like a really good thing that ...course. It felt like here’s a normal thing that a bunch of blokes get together and they talk*
Through discussion with fathers about their barriers to accessing these types of services, and how much they valued what they got out of them, a concept of building, or creating something while bonding with other new and expectant fathers arose:

I just think that if you could bring that together to an activity of building something and making something and let things naturally come out as you’re doing something that would be great. So you’re learning skills as well as kind of a by-product of that would be that you’d be sharing your stuff. It felt really healthy, it felt really healthy. I’d be up for more of that for sure.

This idea of not forcing conversation, but allowing it to come out naturally, appealed to the men. This father explained:

It’s that kind of formalising anything like that it brings up fear for a lot of blokes I think.

Fathers also wanted to hear from other fathers, not just teachers – even if those teachers were fathers themselves:

...if you have guys come back if they’ve already had a kid, but people who have had kids and been in that situation, about maybe techniques and things that they did that were beneficial and helpful for them...

This combination of learning from other fathers in an informal environment resonated with all of the fathers who provided feedback. The one idea that really sold the program was building something for their child – a bassinette, a cot or a bed, depending on where their children were up to developmentally:

I like the building the cot idea because you’re not going there to be told how to be a good dad. You’re going there to build something for your child that’s it. In that act you’re being a good dad. You just learn by osmosis.

This provided an excuse to join the group, a safe reason to discuss their children and families. Through further discussion this idea became more concrete; a co-facilitated support group, 6 weeks in length, for new and expectant fathers. One facilitator would be a carpentry professional, the other a family worker. This father
explained why having somebody driving the conversation, but not dominating it, would be a useful experience:

*He made really good points that I would have never thought of because society just doesn’t - at least the communities I’ve been a part of, not that they shy away from this but it’s never been mentioned that men are hugely important in this process.*

This demonstrates why this group needs to be facilitated at all – in order to make these points. The facilitator would need to ensure that they were facilitating, and not leading the group:

*I found just being around other blokes who are going through the same thing and seeing people from all different walks - like going through the same kind of experiences and just hearing them talk about it and just being in that felt really comforting on some level.*

This model, a group of new and expectant fathers getting together to build something for their children was developed through discussion with fathers about what they wanted in terms of service delivery. A linked, but perhaps more transferable concept for working with fathers, is mentoring (see p215).

**Conclusion**

The barriers and supports to father engagement in health and welfare services have been segmented into service, cultural, work, knowledge, community and academic and textual areas. The service barriers to supporting new and expectant fathers have been explored from the perspectives of mother focused practice, physical, time related, systemic, risk related and funding barriers. There is clearly much work to be done, however there was also a significant level of support available for many fathers, and many fathers were supported to interact with the service system.

The dominant metatheme in this chapter is that of mother focused practice. This mode of practice was so entrenched that supporting the mother was generally seen as the main reason for the service delivery, with any service delivered to fathers as either incidental or only useful in relation to the potential of the father to provide support to the mother. A secondary metatheme is that not only do fathers provide support to their partners and their children, but that they need support themselves, and that they are not currently getting it. The assumption that fathers don’t need support is evident is much of the responses from workers in this chapter – although often also present in the
responses from fathers, or father workers. In addition to this, workers would often focus on the barriers for father engagement while not acknowledging the supports.

The service supports detailed above for new and expectant fathers are many and varied. They included practical worker skills, experience level, trust and rapport, creating a safe space, quality of service, and father-inclusive and whole of family supports. What is clear is that there is a lot of support available for fathers, and that they are accessing it, although there is still much capacity for improvement. This research does highlight a potential path to improvement – that of fathers being better supported through a whole of family approach, as discussed Chapter 8.

What has been consistently demonstrated through this research is that workers are often aware of the barriers to father engagement, but do not acknowledge or utilise the available supports. For example workers did not focus on fathers caring about their children, the skills that they might bring from work or personal experience, or the value their communities might provide. Conversely, they also did not notice when these supports were absent, and did not move to address them. This demonstrates that workers who better understand fathers can better work with them and their whole families. Workers often overlooked the roles fathers play in their families, and the support that they might need as individuals, distinct from their role as supporters. This assumption, that fathers don’t need support is discussed in Chapter 8.
Chapter 7. Family, relationships and transitions

For health and welfare professionals to provide high quality support to new and expectant fathers, they need to have highly developed understanding of the forces impacting on those fathers within their family system. This chapter aims to build on the understanding of providing services explored in the previous chapters to give an insight into areas not traditionally included in service delivery. Three main elements inform these forces for the fathers in this study; gender roles, the relationship they had with their partners, and their transitions from manhood to fatherhood.

Gender roles

Gender roles were a key factor in how fathers related to fatherhood. Those fathers who were most comfortable with traditional gender roles were also most comfortable with traditional service to fathers. Much of this topic has already been covered in Fathers provide support (p112) and Mother focused practice (p138), and as such this mainly focuses on fathers and their partners perceptions and negotiations of gender roles, and how these are interpreted by workers with the aim of providing increased an insight into this process. This expectant father spoke about his role in the relationship:

It means, as well, we carry a role, an important role, in this relationship. It means I have got, as well, if I go working, but nevertheless maybe I want to be at home or I have to carry the weight that means I have to earn money to get the whole show running.

Another father felt trapped in the role his gender, and his culture, had assigned him:

I'm only going to be able to have two weeks off which is - I mean I'd love to be and in the real world I'd love to be - I'd love to be a home dad, I'd love the roles to be reversed. Whereas I've got to take on the responsibility...

Other couples had negotiated roles for themselves in domestic chores:

She loves cooking and she's a good cook and the first time I tried to cook, which I used to do all the cooking in my previous relationship, she was shoulder surfing me and correcting me and I went that's it, you're cooking now. So she does all the cooking and I just do all the cleaning.

And in parenting:
I mean she's already said she'll be getting up doing the feeding and if need be one of us will be going into a special room because I'll still be working.

Even to the point of identifying that the mother's role is to care for infants, and that the father will have a more involved role later:

...when the baby is older, when he's up and cutting about and there's more of that traditional - he's running around now and he's got more energy to burn then that's probably where I'm going to step up a bit more and enjoy it a bit more.

This negotiation process is important for workers to understand. If families decide to operate a certain way, workers need to not only understand that approach, but also respect it. This father, from further west, thought the local culture there had a significant impact on the gender roles in his community:

...certainly in my area... the women are very good at staying connected, but I think the men don’t tend to maybe get together on their own as much or that kind of thing, so - because it's more about traditional kind of roles, gender roles out there.

Others were impacted by their own history, which they rejected:

Interviewee: That's really disappointing to me, because I thought - but no, I'm into smashing the patriarchy, you're kidding me. My father was - he worked in a foundry, 12 hour shifts and stay at home mum with five kids. That was kind of nuts. That's impacted on me.

Interviewer: So they had a traditional model... I guess you're kind of, not rebelling against that, but you're refusing that.

Interviewee: Yeah, I'm completely declining that. Then I’d see it was like [my partner] wants to go to work, she wanted to - two weeks later she was doing her masters...

This father identified the cues he was taking from the media, and the disconnection he felt from the lack of role during his pregnancy:

I've seen it on movies and Hollywood kind of says that it's the right thing to do so that's the only connection I have, but I don't even know that, I don't have any real emotional, desperate to the, the blood tests or - for no good reason, just because I didn't really make the connection. I don't really see myself as being part of that role, part of that scene.
This partner was looking to the future – following a discussion on how her partner was playing a supporting role to her during pregnancy, she raised the shift in gender roles from supporter (husband) to parent (father):

Interviewer: Where do you want to end up do you think?
Interviewee: Equal parents definitely. Definitely.
Interviewer: Yes. Where do you see that happening?
Interviewee: When? I mean probably straight away really. I’d like it straight away.
Interviewer: You start working towards it straight away?
Interviewee: Yes definitely.

Another partner, with one young child and another one on the way, described this successful period of transition into different roles:

We never had gender roles, ever. It was this unspoken thing as soon as...Since [our child has] come along, just automatically we just fell in...and it just - it works and there’s no resentment around it. Just as long as things get done and our family’s happy, who cares who does it? ...Everything we do is for the love of our family... It doesn't matter and we don't take ourselves too serious so I think that works.

Just as long as things get done and our family's happy, who cares who does it?

Some workers saw it as their role to assist new parents in defining gender roles by preparing them for some of the difficult concepts they might have to adjust to in the future:

...when I do the antenatal class - around breastfeeding ...about, what impact do you think this will have on your relationship? ...there’s a question of - around breastfeeding - who owns the breast? Does the baby? The mum? Dad? Or society?

There was also an understanding of how gender roles can be constructed by methods other than biology:

...when dads aren’t around it becomes gender because the woman is there. ...maybe not gender, but by role she becomes the expert very quickly.

This senior manager, whose partner had stayed at home when she returned to work, also critiqued the biological determination of gender roles in parenting:
You can't really change gender equity. But you know, the other thing is, you know, I think that - it's the subject of your PhD, but you could actually take the concept a whole lot further and say that services aren't actually set up for people, you know, people who work. I mean, in my home I've been the primary breadwinner since most of my children were six months old and I've always worked full-time and my partner's always worked part-time. So what you're talking about is completely foreign to me because he was the one who did all that stuff.

This father worker saw a traditional family culture as leading to more traditional roles for parents, such as the disciplinarian father:

I think that in a traditional family there's a stereotype that the more disciplinary side of things it does tend to fall more towards dads.

And also had a more traditional approach to his own parenting, while recognising that both parents needed to operate in both roles:

I think generally guys do perform a slightly different role than women do. I'm a single dad as well and I have two daughters that live with me half the time and with their mum half the time. You know we do - I don't find myself quite as nurturing as their mum but I'm far more fun.

And critiquing those fathers that tried to operate in both roles at the same time:

Really like dads who almost over-parent because of that lack of - both of these fathers I'm thinking of the mothers aren't in the children's lives and they over mother them.

The complex and contradictory space in which fathers, especially single fathers, need to negotiate to determine their parenting roles was summed up by this complex and contradictory statement:

I do think a child needs to be nurtured and needs to be supported and challenged. Support and challenge is what I think we all need basically but children need that in typically males and females. That's why dads are so important because they tend to give kids that. However I think a father's job is very fluid and should be flexible so I don't really like stereotypes...

The fathers interviewed for this research were largely still in the process of defining their parenting roles – mostly still in the support (husband) role and wanting to move toward the parent (father) role, but restricted by the main feature of gendered roles in parenting – biology.
Biology

I think that there has to be a recognition of the differences in roles and the - you cannot get away from the fact that the woman’s got to give birth, the woman’s got to carry it and all of those things. Men have a different role. I think you can’t say they’re the same. I don’t think we can say it’s the same thing.

The physical nature of pregnancy, and to a lesser extent of breastfeeding, formed many parenting roles early on. Some study participants raised it as a significant element, others played it down:

*I think it does - hormones obviously play a part - physiologically that’s probably different; it plays a part. It doesn’t have to play as much a part as what it does. Both partners, often, will use it as an excuse or use it as a reason to rationalise the role that they’re choosing to have in the family whether it’s actively or not - and often I don’t think it is - but they will use that as an excuse.*

This was particularly controversial when the question of hormones were raised. Most participants were happy to acknowledge the gendered nature of pregnancy, not all were happy with the idea of hormonal changes impacting one mothers’ (or fathers’) behaviour or parenting style. This very experienced early childhood worker had this to say:

*I will say there is an element of hormone but there is also - that can be managed very, very well. So you get a lot of mums - I heard one mum the other day saying I can’t possibly leave my baby. I couldn’t possibly leave my baby, she needs me; I couldn’t possibly leave my baby. Well that’s just crap I’m sorry.*

She also recognised the complex forces at play:

*Absolutely it’s bio-psychosocial. There is a biological element of course there is. Absolutely there is. They give you a baby and you just got blah. You’re set up to - I remember before I had my child going to a wedding, we were very – [my baby] was overdue so I was like this - going to this wedding in a hideous blue, taffeta dress and something very emotional happened. I looked down and I went oh my God, I’ve got milk everywhere. What is this crap? This is so not me. That’s biological.*

One father found his own behaviour unconsciously changing due to what he saw as a biological evolutionary drive to find a cave with his iPad:

*I’ve just had this very faint kind of awareness about what I’ve been doing at times. Like I’ve noticed I’ve been a bit more proactive with looking for houses... on my iPad... normally I would just leave house...*
moving to the eleventh hour. I wouldn’t really be concerned about the kind of house that I live in …that seems to have changed and I think that probably has to do with the fact that she feels sick all the time and is tired and I probably have some, I don’t know evolutionary drive to find a cave that’s going to do the job.

This same father identified challenges with working well with his partner’s changes in hormonal states:

I’m thinking one of the biggest challenges that we’ve had that I haven’t talked about is the – [my partner’s] not listening - but the change and I guess the natural change in the woman’s emotional state and not being conscious of that.

If you’re not conscious of that enough then you’re not prepared with the level of empathy that you need, you have to respond with in that situation and you can get yourself into all kinds of strife and cause stress on your relationship.

He went on to explain how important communicating this information to new fathers should be:

So the main thing that I would hammer is just to prepare men for that reality that, at least this is in my realm, I don’t really know much about this whole process because I haven’t worked in this environment or anything. But I’ve gathered I’m not on my own on this one.

But that learning this lesson himself might actually have strengthened his relationship:

I wasn’t prepared enough. Like I was, I heard it was like emotions all round are volatile but I wasn’t aware of how much it impacts on you. When I started to actually realise what was going on then I had a bit of a shift and I think I’m trying to become a little bit more resilient and she’s becoming more resilient as a result.

And that there was the potential for a more significant impact for more vulnerable families:

...if you were to have a, in the context of I guess relationships where men, both partners are more prone to domestic violence then that would probably be even more important.

Perhaps most importantly for health and welfare professionals, that father identified that he hadn’t been provided with the information that would have been helpful for him to negotiate the biological changes in his relationship – although who
should take responsibility for that is a more complex question (see Fathers need to take responsibility p109):

...that aspect of it needs to be covered, I'm not sure if it is normally in mainstream, but certainly the pamphlet that [my partner] brought home and I had a quick flick through didn't have anything about that.

The importance of biology in parenting role negotiation should not be underestimated when providing a service to new and expectant fathers, especially from a whole of family framework. A final element to understanding this is timing – while fathers often didn’t come into contact with a health or welfare professional until nearly the end of pregnancy, they reported struggling with issues around their partner’s mood changes long before that. This area, one of the few relevant areas with empirical research foundations, should be further explored from a father’s perspective to provide more useful understanding for health and welfare professionals.

Relationship with partner

A major factor in understanding fathers, and being able to provide an appropriate service to them, is understanding their relationship with their partner. If the relationship is strong, negotiated and positive, service can be provided successfully to the whole couple. If the relationship is not cohesive, it may be necessary to work on that aspect first, or to work with the father separately to support his inclusion. Many fathers remarked on how the strength of their relationships gave them confidence to parent:

I’ve got a pretty good relationship with my partner ...we are pretty - already pretty good in talking and sharing moments and let out our emotions.

This was often expressed in practical examples:

...we’ve had the conversations the whole way along about all the finances. It's not like anything’s changed so much it's just made me realise that I don’t have to feel such a heavy burden... nothing essentially changed apart from this weight had lifted that I was bearing all this responsibility.

And also when the relationship lacked that strength:

When [my partner] got pregnant she was always looking to have a family. She just hadn’t found the right guy to have a family with and I was a bit sort of - when she said I’m pregnant I just felt like oh I'm
trapped here. She’s got me a beauty this chick. I don’t want to be with her and have children, it’s too early for me...

Although through the experience of two miscarriages, that couple did strengthen their relationship and become comfortable in their roles as parents:

...anything that I’ve felt uncomfortable about, if I bring it up to talk about it with [my partner] then it’s fine.

Another example of a relationship in trouble was given by this father:

...when that all went pear shaped I learnt really quickly the value of good communication. It wasn’t there. That was one of the primary factors regardless of whether we were meant to be together or whatever. The good communication wasn’t there so the relationship deteriorated.

He explained how a service provider had helped him work on this element of communication in his relationships:

...this is what happened in my previous relationship and this is why I think it happened. I spoke about this with [my counsellor] as well and he said you can’t go wrong with this attitude. As long as you lay your cards out on the table someone can’t fault with it.

Another father had a similar experience:

we’ve probably grown even closer, and built - we’ve actually gone and worked on our relationship with a counsellor, and even something that [my building better dad’s worker] said a couple of weeks ago is, the best kids - you turn out the best kids when you’ve got the most love in the parents. So, parents who are getting on really well, most of the time produce more stable children. That really hit home to me. So I thought, well what’s something that I can do to become a better person, work on my relationship, get prepared? That was definitely one of those things.

Over a long term relationship the impact became even more profound – this couple were asked about their birthing experience:

Mother: We just did all that ourselves.

Father: The thing with us - because we’ve been together for 20 years, I think we just formed a real sort of bond between us so it became this real...

Mother: That’s all we needed.

Father: Yeah, we just felt strength in each other so we just trusted that everything was going to be okay.
The relationship between the father and his partner is something few workers mentioned in a positive way – usually it was a reason fathers were not present, or not involved. This manager explained how this can negatively impact the relationship the father has with the child:

...there's the unexpected pregnancy where dads aren't in a particularly strong relationships with the mums. They go through the birth experience and mum’s got some personality problems. The relationship breaks down and therefore the relationship between the dad and the infant slowly starts to break down.

This antenatal instructor explained how separation can mean fathers miss out on the antenatal classes:

Then teenage dads usually come, they usually come along. Who doesn't come? It’s usually if there's relationship breakdown - where there's relationship breakdown.

A father worker explained why he covered basic breastfeeding and nappy changing in his class:

...your partner is not expecting to be taught a skill about how to be a parent from you, that’s just unexpected. So you come home, and that’s why I teach [unclear] in the course, you come home and start explaining about breast feeding and expressing and you start talking about post natal depression and you show her how to change a nappy, suddenly her expectations of you as a co-parent go through the roof. It changes the dynamics of that relationship and for me that’s a big reason of why I do those things. I think it’s changing the dynamics and expectations between parents will change the way we parent.

These provide examples of the complexity of the relationships between new and expectant parents, the potential negative impacts of poor relationships, and the potential positive impacts when workers provide appropriate support and interventions. One of the key elements of these interventions is timing, an element that requires an understanding of the journey new and expectant fathers take, during one of the most significant transition periods in their lives.

**Transition**

The process of transition for new and expectant fathers can be viewed into four main stages, fathers who are expecting their first child, fathers with newborns, fathers expecting their second or subsequent children and fathers with newborns and older children. Fathers tended to have similar ways of relating to their fatherhood at each
stage, beginning with naïveté and confidence with each expectant child, and moving towards a tired elatedness or occasionally a tinge of resentment after the child’s arrival. Figure 32 details the four main transitional stages, which are explored in the following sections.

![Figure 32 - Four main transitional stages](image_url)

**Expecting a first child**

Fathers in early stages of pregnancy were often keen to demonstrate they knew vaguely what to expect. Most often this revolved around how difficult life with a baby would be:

...you’re preparing yourself for the inevitable which is you’re going to have to take on more responsibility and do more and you’re developing your stress resilience skills. Because you’d think that things would become much more stressful after the birth, hey?

This was a common theme:

I’ve gotten so used to living my life and our life together, it’s like me, us and the transition from that to baby and then us and me is going to be, yeah, it’ll just be a learning experience. It’ll be good. Like I’m excited, but at the same time scared a little bit...

Many parents were using the opportunity to work on their relationship:

So that period, that nine month period is like I guess it’s a good sort of graduated introduction into parenthood. So yeah, getting that first bit right is critical, for sure. We were just saying the other day, actually to be completely honest with you, that we’ve got to get our shit together now and stop arguing now, before the baby arrives... So it’s like a
practice period, so yeah that totally resonates with me. You’ve got to get it right from the start.

Some, usually older, fathers felt that they were ‘ready’:

That was always one of my big fears that as soon as you have a baby your life is kind of predetermined from here until the kids are fully grown and fully functional and independent. But now that I’ve gotten a lot of the things that I want to do out of the way I feel more comfortable doing it.

This expectant father saw the transition as happening ‘with a bang’:

I’m kind of fortunate in the sense that I’m kind of aware of what is at stake, what’s going to - that it is going to be a change. I guess I’m just waiting, you know, seven weeks then bang, the change is going to happen.

But felt quite confident that his experience would meet his expectations:

I guess that’s the difference you know, I think a lot of blokes in particular just aren’t aware that there’s going to be that big change and when it comes it’s a bit of a shock.

Although after the birth was quite able to relay the changes in his personality as a result of having a child:

I’m not a particularly patient person and I guess I’ve seen that as being something that I’ve actually probably learnt. Do you know what I mean? I’ve got a pretty short temper as far as just being frustrated easily. I guess that’s probably the biggest thing I’ve learnt.

And still held onto his confidence in himself:

I’ve just suddenly got patience. So I guess that’s the biggest lesson. Everything else I guess, like I said to you originally, I’d had an inkling. Because I’d been around mums with kids. Natural instincts just kicked in pretty well. Do you know what I mean? We knew that patterns were just going to work themselves out, you can’t force them into place.

This father wasn’t ready for a child when his girlfriend fell pregnant the first time, and in a way embodies the transitional phase of a man turning into a father:

Then she had a miscarriage and so I was a bit like ooh, dodged a bullet there and then - but I got to know her better then. I saw her under pretty shitty conditions of your girlfriend having a miscarriage, saw
how upset she was and how much pain she was in and everything. Then a few months later she got pregnant again and that time I had my head around it. I’d spoken with my family about it and I was thinking yeah, I can do this. If I’m going to have a kid this could be the person to do it with and there’s worse people out there than me who have got children, so I thought I can do this, I can do this.

Then we lost that one as well. At the end of that one I actually felt a bit sad because I’d sort of lost a - I had my head around it by then. Then straight away she got pregnant again and this is the one we’re about to have now. So by the time, it was probably what I needed, the progression to sort of get me into it. By the time the third one come round I’d gone full circle.

Other fathers were more prosaic about their expectations of transitioning into fatherhood:

I’m wondering how we’re going to fit in a baby with the schedule we have right now, but we’re going to have to, so...

There was always a recognition that there was a payoff at the end:

I’ve been on my own for a long time and being able to get used to that independence and now being able to have our whole system wrecked pretty much, about what we’re used to with the schedule and space and freedom. We know that, that’s a part of getting ready for a family and getting ready to have their life changed. Everybody I’ve talked to that has a good family - good relationship, they said, it’s the best thing. Even though it changes a lot of stuff, they wouldn’t trade it for the world.

And even with a fairly combative approach, an expectation of more children to come:

So, I think it’ll be a lot of getting used to new experiences with late nights and early mornings and just wrecking our schedule kind of thing. So, you just adjust and your parents say, you just do it, when it happens. So, we’ll fight through it and get used to it and get ready for another one.

This long term view was unique to first time expectant fathers, when compared to fathers after their first birth. This expectant father was already thinking about schooling.:...

...when the child’s developing and getting older I guess the hardest parts that I’m going to be looking at and the bits that I have the lack of knowledge in, is when it comes to the schooling and choosing your schools and all that kind of thing.
After the arrival of the first child

Fathers who had already had their children were less far sighted, less enthusiastic, some even judgemental of their pre-fatherhood expectations:

_We also said we're going to still do all that stuff and the baby will just come with us. We were so naive._

Although warm and loving towards their children, who they cherished:

...a lot of parents start to resent their kids because they can't do this and they can't do that. [Our son] just enriches everything that we do. He comes out on date nights with us.

Expecting a second child

Parents of more than one child had an even less romantic view of parenting:

_Then they start crawling and then walking, and it's like you're trying to contain a tiger. Then the second stage you're talking about, it ramps up even more because suddenly you've got mum looking after the baby full-time._

_I could still do things. If I needed to go out and exercise, I could still go out and do that, because it was one on one. If I'm going to go out and do anything now, it's going to be two on one. You've got a toddler who runs amok and a baby who's got an unpredictable sleep cycle - he's breastfeeding every couple of hours - it's impossible to go and do anything._

Another father had a similar experience:

_She's gone through that period of trying to become independent and there's also the issue of the new sister on the scene. That's creating a lot of jealousy, so I'm having to be more authoritarian with her, as well, so that's another change._

The naïveté sometimes seen in first time parent was occasionally present in those parents expecting their second:

_I think for the second, I think I'm pretty up-skilled. I think that side doesn't faze me._

For others it was expressed as a lack of obsessiveness:

_Well, I've got to say; it's totally different for your second child, isn't it? There's not that obsession and stuff like that. I - we've already contacted the [hospital] and [my partner's] seen the midwife twice... it's a really nice feeling. It's like I'm flat out and I'm busy and [my son]_
This expectant father, with teenagers from a previous relationship, was straightforward and realistic, without the zeal of first time fathers:

*It probably will change between our relationship with me and [my partner]. We’re used to having so much time together. We know that we’re not going to be able to do half the things that we do because we’re going to have this little kid.*

**After the arrival of the second or subsequent children**

Both the naivété and the confidence soon evaporated - for those fathers second time fathers who had their second child, such as this father with a two year old and a newborn, the period of transition continues:

*I think families that previously cope with one child will then start to become extremely stressed with the second.*

Although he did also relate the shift in roles towards a more equal, albeit traditional, equilibrium:

*...the older [our eldest] gets, the more engaged I become with him. I engage with him better when we can go outside and do physical things compared to when he wants to sit and draw in a book or do painting... I’ll do it, but it’s really painful for me to do that whereas I’d rather just go outside and pick oranges with him or do the garden or kick the ball or throw him around or...*

This resonates with the traditional role of fathers as attending to the family outside the home, whereas the mother attends to the inside. This father explained the way he expected the roles to become more equal over time:

*It seems like, to me, there’s a struggle between those two - between [my partner] and [our eldest] - whereas he will come to me now preferentially. I think for this stage while [our youngest] is so dependent on [my partner] - until he becomes more independent - that’s the way it will be. Then I guess once [our youngest] is one or two or three or whatever, the dynamic will blend back again to being equal mum and dad*  

For this worker, years later, relating his own experience of being a young father, this equilibrium had emerged:
...we were just parents straight up so it’s almost now as our kids are getting a bit older and we are going oh there’s a bit of space... Whereas I think older parents sometimes it’s almost a deficit of becoming a parent - is that they lose all this time. Whereas for us I think as our kids are getting older we’re going oh spare time.

This nature of the period of transition is important for workers providing services to understand. Fathers in this study were enthusiastic and confident prior to the birth of their first child, then exhausted and elated immediately after. Those expecting with children under two were overworked and focusing on the everyday, and having little understanding of the change a second child would bring. Workers, with their experience of the transition process are ably placed to positively support this process, and to take into account the timing of their interventions. This manager explained how much support dads received in the antenatal classes:

...antenatal classes... do look at what it's going to be like for the dads a little bit. They cover... changes at home, what's going to be different, new baby in the house, that sort of stuff, and that's relevant to both the mother and the father.

For this father worker, the service system wasn’t doing enough to work with fathers in what he saw as a crucial time – particularly relevant is the idea that because new and expectant fathers are particularly open to receiving service:

That is the window - prime, prime, prime window. That window is a really key time in a man’s life, where he is open to change, where he's transitioning into something that's going to be life changing. Most dads head down that track, wanting to be the best dad they want - can be.

Ultimately one message rang out for new and expectant fathers – and one message that health and welfare professionals should both understand and constructively address:

You need to know that it’s going to be hard. It might not be hard for everybody which is great. But for a lot of us it’s character building.

**Participant solution – mentoring**

Responding to this message, participants noted that while a support group (see p197) would address some of this difficulty, the negotiation of gender roles, relationships and transitions, would require a response with more longevity, and that for reasons explored in Funding barriers (p152) it would need to be community based. Based on the same premise as the support group; that in general father are not always
eager to be told what to do, but may learn better through peer relationships, mentoring has been identified as a potentially useful support strategy. This goes some way to give context to the perception of Gendered workers (p126). One example of an attempt at setting up a mentoring approach to service delivery was found, a course that later morphed into the Building Better Dads Program, eventually shedding the mentoring aspect in favour of an information and support group format. This advertisement was published in a local calendar of events:

THE NEW AND EXPECTANT DADS MENTORING PROGRAM

This program supports men through this time of change in their partner and values the man’s new role. Initially for expectant and new fathers. Mentors that have recently had a new baby share their knowledge with expectant and first time dads. The training programs cover essentials such as: Sex & romance, baby safety, sleep, caring for new mothers, looking after yourself, teamwork in parenting, finance, balancing work and family, Post Natal Distress and more...

Each group will create an ever widening circle of mentors over the next decades until we have a mentoring culture for fathers of all ages in our communities.

The concept of mentoring was raised a beneficial by a number of fathers, especially relating to the benefit of shared experience. This is relevant to health and welfare professionals, particularly midwives and maternal child health nurses, given the disproportionate number of women in those professions (see Gendered workers p126).

This father explains why mentoring is so appealing for new and expectant fathers:

It’s like a mentor. It’s for men, at a certain age, it’s hard to, probably, to not believe to be [unclear] to say, all right, what do you want to tell me or what is important for me? Probably you have already [your] career and your job and you’re doing pretty good in your job. Why would you just go to person and be open to this person and say, all right, I’m learning again and what do I have to do, please tell me, teach me? So I think from this perspective, it’s good that there is a person who has got the knowledge, the experience to bring this over and as well, here, to educate you. What you have to do with your partner, with your child, with your baby.

This concept that because fathers are at a certain stage in their life, a stage where they are no longer learners, but teachers themselves, they require an approach that respects their prior knowledge. This father explains that the lessons he learns from his brother, are conversational, not didactic:
The support that I have is just basically just through role modelling and just through experience. I see, for example, my brother who is like a replication of me he’s just much older, we’re exactly the same. He is completely obsessed with his children, like he just loves them to pieces, so I think that - we’ve had conversations and we had conversations about it.

This father chose his mentors based on his assessment of the outcome – their children:

Basically I’m just looking at my mates and looking at whose kids seem to be - or who seems to be doing a decent job and you just ask them, you know, how? A mate whose kids are really impressive, he said oh yeah, we just follow this book that I got. I’ll give you a read of it.

Fathers seemed to seek out mentors with the same energy they avoided the mainstream service system. When they found one they liked, they were highly valued:

I made it my mission to take as much as I could out of this bloke. He must have got sick of working with me. I was constantly asking him questions, picking his brain but I think it worked. So it made me come back to the North Coast and whatever the North Coast can throw at me I’d do standing on my head.

And when it wasn’t present, was sorely missed:

I think there’s a really lack of that father to father engagement and mentoring and where the opportunity’s there for a man to ask another dad who’s walked the path before...

This father, with children from a previous relationship, saw himself as a mentor to others, based on his life experience:

I know I’ve helped out a lot of friends who have actually gone through breakups and stuff as well. I know what it’s like so I tell them to come around and just listen to them because that’s all basically you need, someone to talk to, someone who’s going to sit there and listen, that’s what it’s about.

This father wanted to see the mentoring branch into a cultural change role as well, and lead groups of fathers, not just work on a father to father basis:

So yeah, I guess, yeah, I guess mentoring, but also leadership as well. I think it’s - it would be good to identify potential fathers that could lead those kind of groups as well and drive it a bit.

This worker explained how his experience of fatherhood had given an empathy for fathers he worked with that he didn’t have before:
I didn’t have kids at the time when I was going through all that stuff, so I couldn’t relate to it as clearly. I think now I’d be so much more supportive. I think back then if I had someone who came in and said, oh, kids are screaming, I’d say, “you’re a dad. Just harden up. It’s your responsibility.” But now I can understand.

One worker explained his vision for mentoring in the future; for a community based support network for fathers:

I think that that real father-to-father type of - and I think that’s part of the big picture in terms of what men need and how we actually achieve that is creating more opportunities for mentoring. Like I call it mentoring, I think there’s a really strong mentoring element to it. It’s not only an education, it’s not only support but there’s mentoring element to it as well, like we’re kind of taught we’re sharing your experiences as well, we’re drawing on our experiences. We’re not just drawing on knowledge, we’re not just drawing on our practice but we’re drawing on our experience, like which I think has a lot of value.

Finally a different worker explained the simplicity of the process – all mentors are really doing is sharing their own stories, and trusting their own experiences:

I was running a male mentor program at the time with the [family centre]. He had this way of getting us guys to just jump up in front of like hundreds of people and telling what we’ve found. It scared the hell out of us initially and then I realised that all we have to do is tell them what we’ve seen, what we’ve noticed. That’s all he was encouraging us to do.

How this mentoring solution would be implemented is not clear – it is not necessarily within the scope of the health service, and would require at least an initial investment. The potential benefits to fathers are significant, as well as the savings to the health system if support can be provided by the community rather than government funding. It is also debateable if the role of the health and welfare services is to provide services outside their traditional arena, such as assisting families to negotiate gender roles, relationships and life transitions.

Conclusion

Chapter 7 explored three areas not usually considered the domain of traditional service delivery; gender roles, relationships and the transition from manhood to fatherhood, with particular attention to the impact that health and welfare professionals can have on these areas. The aspects of gender roles and relationships provide insight into how service delivery can positively impact these realms while
working with fathers as part of a whole family. The concept of increasing the capacity of fathers to mentor other fathers was developed through discussion with participants. The next chapter discusses main findings and the metathemes emerging from them.
Chapter 8. Discussion

The challenge of developing a grounded theory to improve the service delivery to new and expectant fathers by health and welfare professionals is in the incorporation of the many competing discourses that emerged from the available data – mainly from the literature and from the interviews. These include the medical and feminist hegemonies currently dominating the literature and practice as described in Chapter 2, the metathemes emergent from the coding process, and other theories which might also be applicable. The aim of participant led research provided the grounding for a theory to help workers improve their practice. Workers and fathers reported that fathers were excluded from service. Workers, responding to this, suggested that the solution was not to shift the focus to the father directly, but to the whole of the family. The grounded theory principle of abduction (see p56) prompted the exploration of a Whole of Family Approach, which is the emergent grounded theory from this research.

Glaser and Strauss (1967, 29-30) suggest that ‘Whether or not there is a previous speculative theory, discovery gives us a theory that “fits or works” in a substantive or formal area (though further testing, clarification or reformulation is still necessary), since the theory has been derived from data, not deduced from logical assumptions.’ Glaser and Strauss acknowledge that grounded theories can be strengthened through the use of existing theories:

A discovered, grounded theory, then, will tend to combine mostly concept and hypotheses that have emerged from the data with some existing ones that are clearly useful. (Glaser and Strauss 1967, 46)

This chapter will discuss six meta themes emerging from the interview data and define and demonstrate the applicability of a whole of family approach, with elements borrowed from existing theories highlighted in Chapter 2, including Critical social work, Reflective practice and family centred care.

Metathemes

From the analysis of interview data presented in the previous chapters six metathemes have been identified. These are: Fathers are men who have babies; three levels of father engagement; fathers need to be better understood; fathers need and provide support; and mother focused practice and work. By addressing the metathemes, and using them to build a grounded theory, this research can avoid targeting individual
issues raised in the previous chapters, and instead take a view of the data which identifies the competing forces at play which result in numerous different issues. This is not to suggest that the metathemes are necessarily the underlying cause of the issues identified, but that understanding them holds the key to addressing underlying causes for each of those issues.

**Fathers are individuals**

Sometimes when research areas lack full and comprehensive analysis, it is useful to begin by stating the obvious. This theme, that there are as many types of fathers as there are men who are having babies, began in the first interview and was present until the last. Glaser and Strauss (1967, 30) urge grounded theorists to be unconcerned with questions such as ‘everybody knows it, why bother to write a book.’ This enables the obvious to be helpfully restated – fathers are individuals, and the service system should address them as such, rather than as a cohesive group with identical attributes.

The responses that led to this theme are explored further in *Fathers are individuals* (p104). What emerged as this process continued was that there are even more types of fathers than there are men who are having babies, as each father plays a different role to different people (most noticeable in *Fathers provide support* (p112), *Work related supports and barriers* (p178) and *Gender roles* (p201), and that these roles change considerably at different points on their journey to fatherhood (see *Transition* p209).

**Three levels of father engagement**

With nearly complete disregard to the above metatheme, fathers can be loosely grouped into three levels in regard to their engagement with the service system; resistant, disengaged, and engaged.
Engagement with the service system was often viewed by workers as synonymous with engagement with their role as a father – this is not always the case and not assumed by this model. More consistently with the previous metatheme, fathers often migrate between different stages of engagement during the process, while others stay at the same level. Some fathers are all three levels at once – perhaps engaged at home, disengaged at work, and resistant with workers. Some fathers were resistant to NSW Health staff and well engaged with family workers. Despite this demonstrated opposition to classification, the three levels of father engagement are as follows:

**Engaged**

These fathers are already looking to be as involved as possible with the services provided to their family. They will be in the birthing suite as the primary support person, they will attend all antenatal and early childhood appointments and classes, ultrasounds and other elements of service delivery. In addition to this they will seek out further services, such as fathering specific courses, calm or natural birthing classes. These fathers will take time off work to be involved in the service system. They are open to support and feedback, but will also make complaints, or raise issues with specific points of service.
Disengaged

Disengaged fathers would like to be better fathers, and would like to be supported to be better fathers, but either through negative previous experience or a lack of understanding of the service system, they are unable to engage. They will often engage if accessed appropriately, or if supported to engage within a pre-existing social group. These fathers often do not understand fully the importance of their roles as fathers or supporters to their partners, and may see the process as ‘owned’ by either the mother or the service provider.

This group, through grounded theory, became the target group for recommendations for this study, on the basis that engaged fathers already accessed support, and that services needed to learn how to access easy fathers before attempting to access the more difficult resistant ones.

Resistant

No resistant fathers participated in this study – by definition they would be resistant to participation in a father themed activity. These fathers don’t go to any appointments or classes, and are often completely invisible to the service system. This group is most often associated by workers with low socioeconomic status and drug and alcohol use. Many workers commented on this group, often at length.

Having determined the cohort of fathers that recommendations of this research would be focused on, it became clear that workers (and some fathers) were associating these resistant fathers with the disengaged fathers – mistaking confusion and exclusion for defiance (see Perceptions of fathers p105).

Fathers need to be better understood

Throughout the process of exploring workers’ perceptions of fathers, it became clear that these perceptions were not always consistent with the way fathers viewed themselves. This is not to suggest that there is a single set of criteria that workers need to understand in order to understand fathers, but that workers in this study did not make the effort to understand fathers they were working with, instead focusing on the mother or the baby.

One of the key examples of this is the focus by father on the way fathers felt about their children, essentially missing from workers’ perceptions (see Perceptions and
cultural constructs (p104), in particular Fathers care about their children (p108) and Fathers need to take responsibility (p109).

Workers would often claim that services to fathers had improved over time (see Service culture change p132) but admit that they were not really providing a service to fathers at all, unless they asked for it (see Mother focused practice p138). This lack of insight into the ways fathers do or don’t interact with services is a major way in which they are excluded (see Service barriers (p138) in particular Systemic barriers (p147).

Finally, there was a lack of understanding about the process described in Transition p209) regarding the journey to fatherhood. This journey is well described in many other texts, including one written by a participant of this research (Young, et al. 2011). Despite the information needed to better understand fathers being readily available in largely non-empirical and qualitative formats, that understanding isn’t reaching workers. This highlights a gap not in individual workers, but in the service system in general.

Fathers need and provide support

Part of understanding fathers is understanding the way they provide support to their children and partners. This metatheme emerged initially as two axial themes, and is explored in detail in Perceptions of fathers (p105). It emerges again as a metatheme in Service supports (p163) in relation to service interactions, and in relation to different ways fathers support mothers, children and families in Gender roles (p201) and Relationship (p207).

Mother focused practice

This metatheme persisted throughout the research process. Mothers were often referred to as the ones ‘having the baby,’ ‘doing the work’ or just ‘the client.’ This is explored in detail in Mother focused practice (p138), but also dominated other areas such as Accessing via mothers (p83), Physical barriers (p145), Cultural supports and barriers (p173) and Knowledge supports and barriers (p187). The perceptions of gender that lead to mother focused practice is explored in Gender roles (p201) and Biology (p205).
**Work**

Contemporary parenting and childbirth seemed to be dominated by the balance between work and family life. While not always a concern of health and welfare workers, work has a significant impact on fathers’ interactions with services, from the skills they obtained, or relationships formed at work or the money gained from working, (Work related supports and barriers p178 and Knowledge supports and barriers p187), or perhaps most importantly how to find fathers (Accessing fathers p80 and Time related barriers p146).

**A whole family approach**

The emergent metathemes all lead towards a whole of family approach to improving service delivery to new and expectant fathers by health and welfare professionals. As identified above, all fathers are different, presenting challenges for workers to identify ways to provide appropriate service. This is even more challenging when working with a whole family, as workers are faced with more variables, and more variation in those variables. This challenge is the strength of a whole of family approach, as working with a family as a whole empowers the family to make their own decisions about receiving service. Incorporating a key element of Family-centred care (p45), that families should be provided with agency, means that rather than workers constantly providing direction, families can make their own decisions and request the service that best suits them.

Furman (2010, 94) explains that men’s challenges are often universal – and ‘part of the drama of human existence.’ Acknowledgement of this and support for men to understand this was a key factor to the success of support provided to men in in this research. A whole of family approach addresses this with the social work principle of individualisation, described as ‘seeking to understand the unique constellation of factors in each client’s stressful situation’ (Maas 1976).

This same aspect also addresses the metatheme of fathers needing support (p225), in that rather than suggesting that fathers should be coerced into engaging with services or abandoned if they resist, it provides opportunities for those families to engage to access services they need, as they need them. Abandoning mother focused practice, which has been shown to be a major barrier (see p138) in favour of a whole of family approach, would create an environment of expectation of father inclusion.
This shift from the mother to the whole family would also help workers better understand fathers. A whole of family approach would encourage contact with fathers, helping workers forge relationships based on understanding, and overcoming some of the negative perceptions demonstrated by some workers in this study (see p105). This is distinct from a father-inclusive approach as proposed by the Family Action Centre (2005) or Lamb (2007) in that it acknowledges that one of the key aspects to understanding a father is to understand his context in terms of his relationships with his family. As highlighted in Chapter 7, understanding a father’s family, relationships and process of transition is key to providing a high level of service. Perhaps most importantly, the fathers in this study didn’t want to be the focus of service, just receive what service was necessary. A whole of family approach allows the worker to incorporate all these aspects into providing service.

Conversely, understanding a whole family also enables workers to manage problematic behaviour better, make more accurate child protection reports, support survivors of violence and identify any other gaps or issues that may require support. This may mean earlier identification of problems which could reduce their impact, as well as an ability to manage and support a family to use its strengths.

The metatheme of fathers needing as well as providing support is also incorporated into whole of family practice. When workers work with a whole family, that family is more able to provide support to itself - fathers who are committed to an unborn child are more able to provide support for it. Fathers who attend more ultrasound visits are more likely to have a stronger bond with their child (Slade, et al. 2009), and mothers in this study reported feeling well supported when their partners attended, however workers and managers often played down the need for fathers to attend medical pregnancy appointments (see Fathers provide support p112). This example illustrates the virtuous cycle of supporting fathers in their own right, and not just including them as supports to mothers, the defining feature of a whole of family approach.

Lamb (2007) states that ‘Active fatherhood is a pent-up resource and we need to find a way to liberate that resource.’ Workers need to be wary of imagining they are doing fathers a service by including them in a solely supportive role, unless that has been negotiated with the whole family. As Pemberton and Locke (1971, 96) state, ‘By
representing forms of exploitation as forms of benevolence, the exploiters bemuse the exploited into feeling at one with their exploiters, or into feeling gratitude for what (unrealized by them) in their exploitation, and, not least, into feeling bad or mad even to think of rebellion.’ This implication of exploitation is present in mother focused practice, but absent in a whole of family approach. When fathers were provided service for their own benefit rather than for the benefit of somebody else, they were more likely to provide support to others.

This concept of working with whole families to increase their support capacity also relates to their resiliency. Goldenberg & Goldenberg (2008, 11-2) highlight the importance of resiliency, suggesting that it can be impacted by a small number of factors including internal belief systems, organisational processes and communication/problem solving processes. Fathers are crucial these elements, but so are all family members. If workers engage in a whole of family approach, they are including all family members in these processes and aiding family resilience.

Many of the barriers presented to father engagement related to the metatheme of mother focused practice. This is one of the key strengths of a whole of family approach, in that it is not in combat with mother focused practice, instead incorporating it and broadening it to include the whole family.

The mother can still be the main focus in a whole of family approach, if that is what the family decides – something many study participants indicated (see p143). This variation in approaches to receiving service is addressed by a whole of family approach in that it gives agency to the family to indicate where support is required, and at what times. Families may decide to focus on mothers during pregnancy and childbirth, then
the mother and child during breastfeeding, then the father if the mother goes back to work. Instead of the inflexibility of mother focus practice, a whole of family approach allows for the variety of family structures and dynamics to be accounted for a different parts of the transition to parenthood.

This removes the exclusionary aspect of mother focused practice, such as the exclusion of fathers from ante-natal wards, or the failure to interact with fathers at all, while still ensuring the focus on those family members at the appropriate times. In addition to this, a whole of family approach appreciates that providing fathers with skills to assist mothers reduces the support that needs to be provided by the worker, resulting in an overall reduction in resources.

The final metatheme of work is also addressed in a whole of family approach. While there are a significant number of men not in the labour force caring for their own children (1602 in the target area at the last census), all of the fathers interviewed, and most new and expectant fathers are in some kind of work or looking for work (Australian Bureau of Statistics 2012c). A whole of family approach acknowledges that work will make engaging with working parents more difficult, but that the effort required to overcome work related barriers is well worth the extra resources. A whole of family approach also understands, as informed by this research, that work brings as many supports for new and expectant fathers as it has barriers, something overlooked by most workers in this study (see p178).

The support provided by work is also often overlooked – a number of fathers in this study had medical training, knew how to deliver a baby or build a cot, as a result of their work experience and training. A whole of family approach incorporates a strengths based approach as described by Healy (2005, 151) which acknowledges these capacities.

Working with the whole of a family is not a new concept in health and welfare provision, as shown in Family-centred care (p45), and also seen in mental health (Meldrum 2012), mediation and counselling (Positive Solutions 2011) and family violence (J. Cavanagh 1998). Despite this, it is nearly absent from the practice seen in these interviews or in the literature reviewed. It is occasionally referred to in father-inclusive literature, but is used as an equivalent term for father-inclusive practice, ignoring the inherent issues in simply including fathers into mother focused practice.
It is argued that the competing discourses of medical and feminist models of providing care are the reason that a whole of family model has been so absent in this case. Not only have the medical and feminist discourses excluded fathers and other family members, the reaction to these discourses – father-inclusive practice, has been reactionary and focused on dislodging and delegitimising these approaches. Figure 36 illustrates the division between the opposing hegemonies.

A whole of family approach includes father-inclusive practice, in that it includes all family members, feminist approaches, in that it acknowledges and supports the ownership of the female body and experience by the female, and the medical, in that it appreciates the importance of sound clinical practice. These are all incorporated in a whole of family approach, however they are provided to the family within a family agency model described in family-centred care, and mitigated by a critical social work perspective which acknowledges the importance of individual and social change. Added to this is the principle of reflective practice. Fletcher (2009, 7) discusses the importance of reflective practice, indicating that simply ‘knowing’ about fathers does not necessarily translate into improved practice. This is adopted by the whole of family approach in order to mitigate the effect of worker prejudice highlighted by Dodd et al. (2009, 175)
in relation to family-centred care. While family-centred care is based on mutual respect, collaboration and support, it doesn’t have a strong tradition of reflective practice which would help workers to appreciate their own biases and work with families despite them.

Taylor and Daniel (2000, 12) suggest that ‘practitioners can be paralysed by a fundamental gap between the rhetoric and the reality in engaging fathers in their children’s care.’ This is consistent with the findings of this research, that workers say they want to engage fathers, yet recognise that they don’t. Taylor and Daniel argue that this results in mother focused practice, the loss of fathers as an asset, and the omission of managing fathers as a potential risk. It is suggested that a reflective practice approach, as outlined in Reflective practice (p44), would address the identified gap between workers claiming that they engage fathers or work with whole families, and actually doing to.

Grounded finding of this research is that the model of care that participants wanted to receive, and that some workers wanted to provide, was not father-inclusive at the expense of mothers or children, but a whole of family approach which legitimately includes fathers. This combines the medical and feminist themes that currently dominate the field, both respecting the knowledge and experience of the medical staff and ensuring ownership of the female body rests with the female. It adds to both of these approaches by also providing the father, and any other key players, with a voice. No key player loses respect, and all share power, as shown in Figure 37.
A whole of family approach in practice

A whole of family approach *sounds* convincing – possibly the process of abduction generates theories that look as though they should work, without significant evidentiary base. For this reason, this section addresses specific issues raised in the research process with whole of family approach to demonstrate its potential.

One of the key barriers to providing service to men is the reality of their problematic behaviour – behaviour expected, and even permitted by the exclusionary process of mother focused practice. A whole of family approach expects fathers to care about their children (see p108), requires that they take responsibility (see p109), and views them as both recipients and providers of support (see p112 and p118).
expectation without punitive measures has roots in the demonstrated efficiency of the invitational approach used by a number of research participants.\textsuperscript{15}

This requires practitioners to hold similar expectations for mothers and fathers, building on their strengths and challenging them to make changes. Workers must not give up on men who disengage or behave abusively until they have done as much as they can to bring about change. (Strega, et al. 2008, 713)

Some men will be beyond the capacity of some workers to engage— as will some women. The key aspect of a whole of family approach is that it expects involvement of all family members, and does not actively work to exclude them or consistently focus on a single member.

Some services will be best delivered in a men-only or women-only environment. A whole of family approach does not mean that all parties need to be included in all aspects of service. Some elements, such as mentoring, will be best delivered with only fathers present. Others, such as routine medical check-ups, may only require the mother, or one parent to accompany the child. A whole of family approach does mean, for example, that for these medical appointments, services will not always contact the mother automatically, but that they will check to see which parent to contact to make appointments. It also means that the support needs of the other parent would be assessed, not just the presenting parent. Mothers in the study reported significant focus from workers on their post-natal mental health— something not reported by fathers.

A detrimental mental health impact that was reported by fathers was the challenge in negotiating a work-life balance. Workers would often identify working hours as a barrier for fathers to receive service, but would identify that as a problem with the fathers, not with the service (see Time related barriers p146). These are typical examples of work-family conflict, which has been defined as having three components:

1. Time based
2. Strain based
3. Behaviour based

\textsuperscript{15} The invitational approach, developed specifically for men who are violent and abusive, is not a key aspect a whole of family approach, but uses similar principles of responsibility to enhance involvement. For more information see Invitations to responsibility: the therapeutic engagement of men who are violent and abusive (Jenkins 1990)
In addition to blaming the fathers for their nonattendance at inconvenient appointments, there was little support evident, or understanding on behalf of the support providers, of the negative mental health impact this conflict could entail:

*Even for fathers with other children, a new baby often results in increased demands associated with infant care, sleep disruption and the need to renegotiate the balance between work, parenting, family roles and responsibilities. (Giallo, et al. 2012, 1912-3).*

This understanding of challenges faced by fathers builds on the whole of family approach that understands that fathers need support in their own right, as legitimate participants in their pregnancy, birth and parenting process. As Matthey et al. (2009, 36) point out, providing service after hours or weekends might not always increase father engagement, health and welfare services need to work with the work-family balance of working fathers, rather than against it.

A whole of family approach also includes elements of the father-inclusive practices that have previously been presented as alternatives to the medical and feminist models. Workers can access tools to conduct audits such as *Engaging Men – a father friendly agency audit* to assess the friendliness of their service. This is an example of one of the checklists from that audit:

- lack of male staff or male-friendly staff
- not invited or made to feel welcome
- absence of visual pointers that men belong
- inflexibility of hours of operation or event
- clinical or intimidating environment
- suspicious, judgemental or deficit approach
- bias against men in favour of women
- lack of validation of importance of father role
- patronizing manner
- ‘pushy women’
- jargon that marginalizes and dis-empowers
- boring monologues & programs
- lack of assistance while ‘on hold’
This tool comes from a father-inclusive perspective, but is not consistent with a whole of family approach – it is language such as ‘bias against men in favour of women’ and ‘pushy women’ which may exclude women, children and pro-feminist workers. Workers need to work with their communities to engage fathers in a relevant manner, not simply assume that all men have a list of things they don’t like, or that there is a list of things that can be ticked off to ensure father involvement. A better approach was suggested by this manager:

*I think there needs to be a change in the pattern in the culture of, ‘Are you coming in for an appointment? Will that be you and dad? Yeah, is your partner able to come in as well? That’d be great; it’d be lovely to see you as a family.’ Not, ‘we’d love to see dad’ because ... our language reflects our values. If we change our language our values change.*

This is an excellent example of a whole of family approach as opposed to father-inclusive practice.

**Participant solutions**

Four participant generated responses to the issues raised in chapters 6 to 10, an information kit to assist in accessing fathers, information sessions to manage expectations and provide information, a support group to address some barriers and engage some supports, and a mentoring program to assist fathers with negotiating gender roles, relationships and the transition from manhood to fatherhood. These responses form a chain, linking one to another and keeping fathers engaged, ending with an approach that allows fathers to provide support to other fathers – see Figure 38.
These responses correlate with the metatheme of three levels of father engagement (p222). In a way, they critique this metatheme as proposed by some participants, that a father is forever fixed at a certain engagement level. Figure 39 details this relationship: fathers who attend information sessions may shift from resistant to disengaged with the correct information and expectation management, and disengaged may move to engaged through attending a support group. Only engaged fathers would be willing and capable of mentoring other fathers. This reconceptualises levels of father engagement not as static states, but as stages on a journey which all fathers travel.
Understanding Service Delivery to New and Expectant Fathers by Chris Maylea

delivery to new and expectant fathers. This is a process of discussing with local fathers their needs, fears and expectations and developing with them a program to address their needs, not the needs of the service system. Involving fathers and their families in the service that they receive is at the heart of a whole of family approach.

Both generalist workers and father specific workers were guilty of assuming that their own experience, either of parenting or accessing services, qualifies them to speak on behalf of all fathers. Fathers who are involved should not be treated as if they are capable of speaking on behalf of all fathers. This doesn’t mean that including them should be considered futile – representation is necessary, but does not absolve other workers from actively pursuing a whole of family approach. Matthey, et al. (2009, 39) found that while having male workers helped men identify with services, what was more important for service delivery was that a worker of either gender can relate well to men. Asking and involving fathers reduces the potential that the service fathers are looking for are confused with a general concept of ‘what fathers want.’

The discrepancy between what fathers identified as their unmet needs before and after receiving service demonstrates again the individuality of fathers as a group, and the need for workers to work with fathers to ensure that their services respond to the variety of need in the families they provide service to. A whole of family approach isn’t just about including the whole family, but also letting the family lead the service delivery process.

Conclusion

In this chapter metathemes arising from the data, a whole family approach and a practical perspective using the solutions proposed by research participants have been discussed. The whole of family approach has been generated through a process of abduction during the data collection and analysis stage, and has been presented here as a response to many of the barriers currently facing father involvement. This approach incorporates the medical and feminist models which currently dominate practice, combining them with aspects of father-inclusive practice. This is further combined with elements borrowed from critical social work, reflective practice and family-centred care. This produced both a model for explaining the barriers to father engagement and
critiquing the current system, and for whole of family practice. The final chapter covers implications for research, policy and practice.
Understanding Service Delivery to New and Expectant Fathers by Chris Maylea
Chapter 9. Conclusion

This chapter concludes the dissertation, examining the objectives and research questions presented in Chapter 1, highlighting limitations, presenting implications for policy, practice and theory, suggesting areas for further research and finally summarising the research process.

Research objectives and questions

This research could be said to have achieved its aim of improving the service delivery provided to new and expectant fathers simply by stimulating debate around the topic and by encouraging workers, managers, fathers and partners to reflect on the topic. It also has the potential to contribute the grounded theory to practice with subsequent positive changes to the service delivered.

More specifically, the research objectives were to discover the kind of services health and welfare professionals deliver to new and expectant fathers; why new and expectant fathers receive minimum services or excluded from some services; and to suggest strategies improve service delivery to them. These objectives have been achieved, as fathers discussed their experience of receiving service and workers explained why fathers were often excluded or received reduced services. The main strategy to address this was proposed as a whole of family approach, a fundamental shift away from a mother focused approach which resulted in exclusion for fathers. In addition to this, participant solutions were proposed as strategies for workers to implement.

Three research questions were initially developed to guide the early stages of the data collection process, with emergent themes guiding later interviews. As the grounded theory process took over, issues such as accessing fathers, service barriers, perceptions of workers and fathers, and the importance of family, relationships and identity became axial themes on which further interviews were conducted. As the research developed further, a pattern emerged of metathemes that were present in all other areas of providing practice. In this conclusion, it is not useful to see how these initial research questions have been answered, but how the complexity of the data responded to these initial prompts.
The first two questions referred to the way fathers felt about the service they received and what workers felt they should receive. No clear answer emerged from this question, instead leading to the metatheme that fathers are individuals who have varied service needs and engage with services in a variety of ways.

This in turn answered the third initial research question, about what fathers want, in that it is different for every father – fathers need to be provided service based on their needs and abilities, not as a homogenous group. This guiding question led to the participant solutions, and also supports to father engagement, although the diversity of responses meant that the main response requested by fathers was diversity. This question had such a variety of responses that it became clear that no pattern was going to emerge. Instead, a pattern that did emerge was that workers had few skills in accessing fathers, and often didn’t know what to do with them when they did engage. This highlighted the need for a new paradigm that didn’t just focus on mothers.

Following this, workers were asked what they thought fathers were provided with. A number of workers believed that fathers were being provided with the same level of service that mothers were – which is largely true, in that fathers were provided with mother focused practice which excluded them.

The final question asked if the answers to the above questions fit into the paradigms explored in the literature review, or if an overhaul of the conceptualisation of service delivery to new and expectant fathers is required. Father-inclusive practice comes the closest to addressing the concerns raised by fathers and father workers, however as discussed in Chapter 8, it has the same potential to alienate as mother focused practice. The proposed solution, a whole of family approach, addresses the issues raised above, building on the existing theories explored in the literature review.

Grounded theory built on these questions, providing tools for answering them. The participant led, flexible yet rigorous nature of the process developed answers to these questions that could only have come from the data, such as a whole of family model.

**Implications for policy**

As cited in Chapter 1, Skene (1998, 132) claims that ‘government policy, employment conditions, child-care provisions and the conservative attitudes of
professionals, employers and sections of the community’ have prevented fathers from engaging. As shown in Chapter 2, fathers in health and welfare policy are viewed either as perpetrators of abuse, or as non-residents seeking custody, with little attention to those fathers who are not abusive and living with their children.

This research has used a grounded theory approach as detailed in Chapter 3 to view fathers as they are, rather than using the filters of abuse or non-residents to inform the research. This is a major implication for policy in itself, that policy makers need to better understand fathers, not view them as isolated special interest groups, but as members of families.

This research highlighted policy as a major barrier for engagement with new and expectant fathers (see p148), particularly in regard to managing risk, and providing education to workers. The most obvious place to begin addressing this is an adoption of the National framework for father-inclusive practice for early intervention and family-related services (Family Action Centre 2005). Despite being father-inclusive, they also incorporate many aspects of whole of family practice indicated in this study.

A second consideration for policy is that many of the cultural issues presented in Chapter 5 were attributed either to outdated policies or a lack of progressive policies. Managers especially highlighted their inability to move on initiatives supporting fathers without policy change from above. Examples of this include organisational policies which prevent workers engaging with perpetrators of domestic violence (p151), or a lack of direction around home birthing (p149). Further research and advocacy is required in the policy sphere to advocate for fathers, or as one author refers to it, “DADvocacy” (Mattock 2012).

Implications for practice

The most significant implication for practice is the potential of the whole of family approach in addressing the issues presented by the data. This approach, building on lessons learned in nursing from family-centred care, with ongoing development and research, could incorporate fathers into the service provided to new and expectant families. The potential benefits of this are not limited to fathers, with grandparents, step-parents, siblings and other key family members also benefiting.
Workers also stand to benefit – as argued above, families providing support to each other ultimately means decreased reliance and resource drain on the workers directly. For workers and services, this is the appeal of a whole of family approach over a father-inclusive approach. Rather than running extra services provided to fathers who are too diverse to be engaged by any particular tactic, a shift in practice away from mother focused and towards the family incorporates these fathers into existing practice. What remains, of course, is empirical testing of the approach and further development of the model.

The implementation of this model requires a training package that can be developed in accordance with the principles of a whole of family approach developed in this thesis, which could then be applied in relevant services.

In addition to this, the participant solutions of an information kit (p100), information sessions (p134), support groups (p197) and mentoring (p215) provide a simple to implement model that addresses a number of significant issues raised in the research. These solutions would require adoption and resource provision by the local health and welfare system, but could incorporate a number of existing resources into a cohesive system to reduce overall costs.

Theoretical Implications

The current theoretical environment is one of conflict and unconstructive debate. The two dominant paradigms of medical and feminist service do not interact with each other, instead building layers of knowledge on opposing ontologies which uphold their basic assumptions about best practice. Father-inclusive practice, the third player in this two-party system, attempts to justify the usefulness of fathers according to either of the dominant paradigms, or attacks them for aspects core to their belief (risk aversion, women’s rights etc.) A whole of family approach, instead, acknowledges the importance of risk, the importance of a woman’s ownership of her body, and other key aspects of both approaches. This has significant theoretical implications if it can provide a middle ground in which to incorporate aspects of both theoretical stances.

Limitations

The main limitations of this study were highlighted in Chapters 2 and 3 – that any piece of research is limited by transferability and that this research has little or no
transferability to diverse ethnicities, sexualities, family types or any community other than the target group. It is based on literature which is written entirely in English and mainly written in Australia, and the research itself has been conducted by a researcher trained nearly exclusively at English speaking Australian institutions which teach Western schools of thought.

It also relies on a qualitative technique not widely accepted outside of sociological circles and dependant on interpretation. The immersive nature of the researcher in the research process, which gives unparalleled insight into the data, also leaves scientific objectivity behind, which makes promotion of these research findings difficult outside of sociological circles, even into evidenced-based or clinical social work practice.

Despite this, it is a beginning in the process to fill the gaps identified in research analysing service delivery to new and expectants, particularly in regard to research which presents the voices of participants as its key finding. The subjective methods chosen are the only way to attain this. The next step in this process is research to build on this.

Further research

This research raised more questions than it answered, as is to be expected in such a nascent field. Some of the key areas raised are detailed below.

Longitudinal Study

Some of the key points raise in this research relate to change, both regarding service and cultural change, and the transition to new parenthood undergone by parents. These aspects of change are crucial to understanding fatherhood – an inherently fluid and dynamic state.

A longitudinal study which followed a smaller number of expectant fathers through their journey would provide insight into ways services could assist fathers at different points in their journey. The experience of fatherhood is integral to the experience of receiving service delivery. Fathers who are experiencing stress or trauma need a modified service, and savings can be found in ensuring fathers who are travelling well are only provided with the service they need.
Services required

While this research generated participant solutions, it did not catalogue a detailed list of services required or requested by fathers. This would be a useful topic for further research, although a challenging one, as many fathers interviewed in this study were not aware of what types of services existed or those that might potentially exist.

In addition to this, no participants were fully aware of all the services currently available, which should be a starting point for any further research looking at service delivery.

Overcoming barriers

Chapter 6 details barriers and supports to working with new and expectant fathers, but does not examine in depth approaches to overcoming these barriers, or how to use these supports, other than through participant solutions and a whole of family approach. Further research into barriers and the potential of supports to overcome them would aid in the practical application of the findings of this research. In addition, any other research of this kind conducted in other areas would refine or increase generalisability of this research.

Genealogy

Another key area for exploration of change over time is that of the culture of services. By clearly mapping the cultural history of service to fathers by health and welfare professionals, a debate can be usefully held regarding future directions. Much of the animosity held by father workers and father activists is around past behaviour by workers in the service system which is no longer prevalent. Most of the workers in this study at least claimed progressive approaches to father engagement, and many demonstrated progressive practice. This was not echoed in the understanding of practice by father workers, who tended to view more traditional health and welfare professionals as part of the problem than the solution. An understanding or recognition of how far services have come might assist in covering the remaining ground in partnership rather than conflict.

Ideally this genealogy would also look forward to develop a set of shared goals which all levels of the service system could work towards in a way consistent with other
frameworks, strategic plans and policy documents. This would ask the ‘miracle question’ – to identify how an ideal service system would be configured in five years’ time.

**Power analysis**

A key element present in the metathemes but largely absent from the analysis in this research is an understanding of the use of power by workers when providing service to new and expectant fathers. Further investigation into this topic could cover the role of workers as collaborators in consensus situations, other roles as persuader or broker between conflicting elements of service or family. Most importantly, what role are workers, playing and what roles can they play, in dissensus situations, such as when domestic violence or child abuse is present?

**Using online approaches**

Many fathers suggested engagement strategies using the internet, as explored in Masculine approaches (p85). The efficacy of this approach needs to be better understood and workable models developed for technology poor health and welfare agencies.

**Community and culture change approaches**

In the same way that a policy debate fell outside the terms of reference of this research, the need for community and cultural change around attitudes to fathers has been identified but requires further exploration. This research should consider who are the key actors in this change, and potentially examine other community cultural change campaigns to generate recommendations.

**Savings**

Many participants pointed out the potential savings generated from early intervention in father (see Savings p159), particularly the question, ‘is investing in better support for fathers an overall cost benefit for the state?’ Cowan et al. (2009, 677) discuss how complex this question can be: ‘We know that one meeting was not sufficient to produce positive results. We know that 11 to 16 meetings with a total of 32 hours were effective. We do not have systematic information about the time point at which additional hours stop producing positive gains.’ Policy makers, funding bodies and program designers need concrete data to make these decisions.
If advocates for delivering better support to fathers want to convince policy makers of these savings, there needs to be quantitative data to back this up. This may in fact be the answer to further policy development – in similar approaches that have been undertaken regarding cigarette smoking and alcohol abuse, early intervention for fathers may save the state money – but only if the cause and effect can be proven.

**Diverse groups**

As detailed in Non representative recruitment (p63) this research actively or inactively excluded same sex families, culturally and ethnically diverse families, Aboriginal communities, and disengaged fathers. These groups need specific, appropriate and targeted research to provide services with the culturally appropriate tools to engage with them as families.

**And all the rest...**

The one thing that was not in short supply in regards to providing service to new and expectant fathers was good ideas with unproven potential. This is an excerpt from a Facebook conversation with a participant:

*Chris, you’ve really got me fired up with your million dollar question: how do we engage the dads who don’t come to ante natal classes or engage with other services? I’m turning it over. My thinking yesterday is around a grassroots fatherhood campaign. Going to where the expectant dads are and recruiting advocates on the ground. Pubs, football clubs, employers, supermarkets, shopkeepers, and the like. I suspect community acknowledgement and engagement with a man who is navigating the rite of passage to fatherhood could really make a difference. Perhaps informal community-based 'groups' for expectant dads to check out might work too. The Men & Family Centre used to have a Mobile Men’s Shed that was out on the road, assisting men and informing men about services. Something like this for expectant dads could really work!*

There are many more of opportunities for further research, pilot programs and other areas of investigation on this topic. Participants were eager to improve the service delivery and gaps were identified easily. Understanding service delivery to new and expectant fathers has only just begun in a from a research perspective, and there are many more opportunities for further research.
Summary and conclusion

Following the researcher’s experience as a new and expectant father, and a health and welfare professional, early investigation into the main barriers to supporting fathers were identified as the result of mother focused practice. A review of the literature was undertaken in Chapter 2, which identified the conflict between the medical and feminist hegemonies which dominate service to new and expectant families. This included a genealogy, an analysis of gender roles, the supports and barriers to engaging fathers, and a review of the pre-existing aspects which might support a grounded theory.

Chapter 3 detailed the grounded theory methodology with reference to abduction, theoretical sampling and the data collection and analysis process. The processes of grounded theory coding and theory generation as they applied to this research were also covered.

The following chapters, Accessing fathers, Perceptions and cultural constructs, Barriers and supports and Family, relationships and transitions present the results of the data collection and analysis process, systematically presenting the data from which the grounded theory of a whole of family approach emerged.

This is developed in Chapter 8, which discusses the process in which the feedback from participants regarding the provision of service to families rather than individuals in the family group was used to develop a whole of family approach. The application of the approach to practice was explored, with a discussion of the implication of the participant solutions as a potential model for deriving service responses.

The concluding chapter re-examined the research questions, and considered implications for policy, practice and theory, as well as some of the limitations of the research and areas for further study. It has been shown that this research filled significant research gaps, addressed the research question using the proposed methodology, and provided a grounded theory for use in practice. This research has demonstrated the potential for new and expectant fathers to receive better support from health and welfare workers, and the potential benefits from providing this support.

Overall, the research has shown the kind of and inadequacy of services delivered to fathers by health and welfare professionals, identified the causes of such a
phenomenon and suggested some strategies. Most fathers are vulnerable and supportive individuals, with varying levels of engagement, who are largely misunderstood by the service system – mainly due to the focus by both medical and feminist models of care on providing service exclusively to mothers. It has been argued that this is not an appropriate model of care, and that it is not the most effective or efficient model for supporting healthy families. This conflict between the feminist and masculine ideals was resolved by participants suggesting a whole of family approach, which was further developed by the researcher and has the capacity to resolve the issues raised by the research.
References


Conclusion


Clark, E. 1817. *Tales at the fire side; or, A father and mother's stories*. Printed by and for P. Norbury.


Fleming, J. 2007. “‘If we get the mums and kids in, we are doing well’: father absence in the context of child welfare. A review of the literature.” Children Australia 32 (3): 13-20.


Conclusion


Conclusion


Jenkins, A. 1990. *Invitations to responsibility: the therapeutic engagement of men who are violent and abusive.* Adelaide: Dulwich Centre Publications.


Conclusion


Conclusion


Appendices

Appendix 1 – Recruitment Flyer

Improving Service Delivery for New and Expectant Fathers

Are you a new or an expectant father?
I’d like to find out your story.

I am conducting research as part of a doctoral thesis. The research is aimed at gathering information that will be used to inform service delivery by health and welfare professionals. The interviews will gather your stories and experiences and analyse these to look at ways health and welfare professionals work better with new and expectant fathers.

Interviews will take approximately one hour, and any information which might be used to identify any participant or any other person will be removed.

Contact Chris on
0439 463 255
chrismaylea@counsellor.com
Consent Form

Improving Service Delivery for New and Expectant Fathers

Please tick:

☐ I am consenting as a willing participant in this research, conducted by Chris Maylea, contactable on 0439 463 255, a DSW candidate at Charles Sturt University who is supervised by Manohar Pawar, who can be contacted on (02) 6933 2497.

☐ I understand that this research is aimed at gathering information that will be used to inform service delivery by health and welfare professionals. I understand that my interview responses will be analysed using Grounded Theory, and will be published in a Doctoral Thesis which will be available to all participants. I understand that I am expected to honestly share my experience of the service delivery received by health and welfare professionals.

☐ I understand that these interviews will take approximately one hour, and will be digitally recorded and later transcribed. I understand that I am free to withdraw my participation in the research at any time, and that if I do I will not be subjected to any penalty or discriminatory treatment. The purpose of the research has been explained to me and I have read and understood the information sheet given to me and I have been given the opportunity to ask questions about the research and received satisfactory answers.

☐ The purpose of the research has been explained to me, including the potential risks and or discomforts associated with the research. I have read and understood the written explanation given to me and I have been given the opportunity to ask questions about the research and received satisfactory answers.

☐ I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published in any part of this research. I understand that if I reveal any criminal or potentially criminal act the interviewer may be compelled by law to report this act.

Charles Sturt University's Ethics in Human Research Committee has approved this study.
I understand that if I have any complaints or concerns about this research I can contact:

Executive Officer
Ethics in Human Research Committee
Academic Secretariat
Charles Sturt University
Private Mail Bag 29
Bathurst NSW 2795

Phone: (02) 6338 4628
Fax: (02) 6338 4194

Name: ........................................................................
Signature: ........................................................................
Date: ........................................................................

www.csu.edu.au
CRICOS Provider Numbers for Charles Sturt University are 00066G (NSW), 01697G (VIC) and 02950F (ACT). ABN 83 678 765 551
Appendix 3 - Information Sheet for Fathers and Partners

Information Sheet

Improving Service Delivery for New and Expectant Fathers

Thank you for participating in this research to improve service delivery to new and expectant fathers by health and welfare professionals. Your participation is greatly appreciated and will assist in better service delivery in the future.

This research is being conducted by Chris Maylea, a Doctor of Social Work candidate at Charles Sturt University. Chris is supervised by Dr Manohar Pawar, PhD, who can be contacted on (02) 6933-2497 for comment. Chris can be contacted on 0439 463 255 if you have any questions.

CSU is a community that embraces diversity and nurtures individual growth. At CSU we value economic, social and environmental sustainability. CSU gives back to the local community by providing an excellence in our courses and the businesses that arise from them.

The research is aimed at gathering information that will be used to inform service delivery by health and welfare professionals. The interviews will gather your stories and experiences and analyse these to look at ways health and welfare professionals work better with new and expectant fathers. This will be published in a Doctoral Thesis which will be available to all participants. You are expected to honestly share your experience of the service delivery received by health and welfare professionals.

Interviews will take approximately one hour, and will be digitally recorded and later transcribed, with your consent. Any information which might be used to identify any participant or any other person will be removed. A professional transcription agency may be used to transcribe the original recording. No participants or individuals, including health and welfare professionals, will be able to be identified based on published data. Where transcripts are required to be provided for peer review, names and identifying data will be removed.

If you feel troubled in any way by recounting your experience of service delivery, please speak with your GP about arranging counselling or other support for yourself. Other counselling services include Lifeline Australia 13 11 14, Mental Health Australia 1300 78 99 78 or the Lismore Men & Family Centre at 1 Club Lane, Lismore NSW 2480 (02)6622 6116. Due to the potentially invasive nature of in depth interviews, please advise the interviewer if you are suffering from a mental illness, have experienced significant trauma or loss related birth or parenting, or feel that this interview process may have a negative impact on your health or wellbeing.

You are able to withdraw from the research at any time prior to submission of the thesis. Please only continue with this study if you feel entirely comfortable in doing so, and don’t hesitate to ask any questions if there is anything you don’t understand or would like clarified.

NOTE: Charles Sturt University’s Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Office of Academic Governance
Charles Sturt University
Panorama Avenue
Bathurst NSW 2795

Tel: (02) 6338 4628
Fax: (02) 6338 4194

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Sincerely

Chris Maylea
cmaylea@postoffice.csu.edu.au

www.csu.edu.au
Appendix 4 - Information Sheet for Workers and Managers

Information Sheet

Improving Service Delivery for New and Expectant Fathers

Thank you for participating in this research to improve service delivery to new and expectant fathers by health and welfare professionals. Your participation is greatly appreciated and will assist in better service delivery in the future.

This research is being conducted by Chris Maylea, a Doctor of Social Work candidate at Charles Sturt University. Chris is supervised by Dr Manohar Pawar, PhD, who can be contacted on (02) 6933-2497 for comment. Chris can be contacted on 0439 463 255 if you have any questions.

CSU is a community that embraces diversity and nurtures individual growth. At CSU we value economic, social and environmental sustainability. CSU gives back to the local community by providing an excellence in our courses and the businesses that arise from them.

The research is aimed at gathering information that will be used to inform service delivery by health and welfare professionals. The interviews will gather your stories and experiences and analyse these to look at ways health and welfare professionals work better with new and expectant fathers. This will be published in a Doctoral Thesis which will be available to all participants. You are expected to honestly share your experience of the service delivery provided to fathers.

Interviews will take approximately one hour and will be digitally recorded and later transcribed with your consent. All information which might be used to identify any participant or any other person will be removed. A professional transcription agency may be used to transcribe the original recording. No participants or individuals, including health and welfare professionals, will be able to be identified based on published data. Where transcripts are required to be provided for peer review, names and identifying data will be removed.

If you feel troubled in any way by recounting your experience of service delivery, please speak with your GP about arranging counselling or other support for yourself. Other counselling services include Lifeline Australia 13 11 14 or your organisation’s Employee Assistance Program. Due to the potentially invasive nature of in depth interviews, please advise the interviewer if you are suffering from a mental illness, have experienced significant trauma or loss related to this birth or any other, or feel that this interview process may have a negative impact on your health or wellbeing.

You are able to withdraw from the research at any time prior to submission of the thesis.

Please only continue with this if you feel entirely comfortable in doing so, and don’t hesitate to ask any questions if there is anything you don’t understand or would like clarified.

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The Executive Officer
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Charles Sturt University
Panorama Avenue
Bathurst NSW 2795

Tel: (02) 6338 4628
Fax: (02) 6338 4194

Sincerely

Chris Maylea
cmayle01@postoffice.csu.edu.au

www.csu.edu.au

CRICOS Provider Numbers for Charles Sturt University are 00009F (NSW), 010120 (ACT), and 080775 (ACT). ABN 41 000 705 508.
Appendix 5- Local Demographics

The area chosen for the study, the Richmond Tweed area, falls within the Northern NSW Local Health District. It stretches from the Gold Coast border town of Tweed Heads to the Evans Head in the south, and west to Bonalbo. It includes a variety of communities, including rural farming centres of Kyogle and Casino, the alternative lifestyle centres of Nimbin and Mullumbimby, tourist resorts of Ballina and Byron Bay, and the Aboriginal communities of Tabulam, Box Ridge and Cabbage Tree Island.

![Richmond Tweed area detail map](image.png)

Figure 40 - Richmond Tweed area detail map\textsuperscript{16}

Richmond Tweed is serviced by the NSW Health system, however residents often use the Gold Coast and Brisbane hospitals and health systems, especially for complex medical issues that cannot be addressed at the local base hospitals. The proximity to these regions is evident in Figure 41.

\textsuperscript{16} (Australian Bureau of Statistics 2011b)
Figure 41 - Richmond Tweed Area location map

Table 4 - People - Richmond Tweed

<table>
<thead>
<tr>
<th>People</th>
<th>227,619</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>110,592</td>
</tr>
<tr>
<td>Female</td>
<td>117,027</td>
</tr>
<tr>
<td>Median age</td>
<td>44</td>
</tr>
</tbody>
</table>

Table 5 – Families - Richmond Tweed

<table>
<thead>
<tr>
<th>Families</th>
<th>61,409</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average children per family</td>
<td>1.8</td>
</tr>
<tr>
<td>Average people per household</td>
<td>2.4</td>
</tr>
<tr>
<td>Median weekly household income</td>
<td>$865</td>
</tr>
</tbody>
</table>

17 (Australian Bureau of Statistics 2011b)
18 (Australian Bureau of Statistics 2012c)
19 (Australian Bureau of Statistics 2012c)
As shown in Figure 42, Richmond Tweed has a proportionately high number of couple families without children, and one parent families.

![Family Composition - Richmond Tweed Area](image)

**Figure 42 - Family composition - Richmond Tweed Area**

This may be as a result of the significant difference in age comparison compared to the national distribution, show in Figure 43. This suggests both an aging population, and a population where families are having children later.

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20 (Australian Bureau of Statistics 2012b)
Figure 43 - Age comparison

Figure 44 shows that Richmond Tweed also has a higher number of single fathers than the national average.

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21 (Australian Bureau of Statistics 2012c)
In addition to these demographics, it is also transient area – 49% of individuals in target area in the age range of the participants lived outside of the target area at the previous census – the highest in the state for a non-metropolitan area (Australian Bureau of Statistics 2012c). Within this age range, wealthier individuals were more likely to be transient.

In the geographical area considered in this research, there are a number of programs and services specifically aimed at fathers, including:

- The Men and Family Centre (Men & Family Centre 2012)
  - Dads & Kids Playgroup
  - Building Better Dads
  - Parenting for Dads
- NSW Health
  - Building Better Dads
- Beer and Bubs (Beer and Bubs 2012)
  - Childbirth education for dads at the pub
- The Fatherhood Project (Fatherhood Project 2012)
  - Building Better Dads Program
  - Indigenous Fathers Program
  - New Dads Getting it Together!
  - The Fatherhood Festival
- Ballina-Byron Family Centre (Ballina-Byron Family Centre 2012)
  - Fella’s Family Project
- Interrelate (Interrelate 2012)
  - Personal Counselling
  - Family Counselling
  - Family Dispute Resolution
  - Programs:
    - Being a Dad—assists fathers become more effective parents
    - Positive Parenting —positive communication and other parenting techniques

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22 (Australian Bureau of Statistics 2012c)
- Challenge of Disciplining your Children — ideas for positive discipline
- Ideas for Parenting Teens — how to effectively communicate & set boundaries with your teenager
- Parents not Partners — for separated parents in conflict over parenting issues
- Building Connections — helping separated parents have strong healthy relationships with their children