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# Informing Practice to Increase the Presence, Involvement and Engagement of Fathers

## A service evaluation of the Nottingham Family Nurse Partnership

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# A Service Evaluation of the Nottingham FNP

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## The Research Team

The team have significant experience of mixed methods research and evaluation of policy and practice with children and families.

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We thank all the fathers who gave permission for their photographs to be taken and who appear on the cover of this report. (See also **Section 3.2.3**)

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# Executive Summary

## A. Background, aims and methodology

The key aim of this evaluation is to inform practice to increase the presence, involvement and engagement of fathers with the Family Nurse Partnership (FNP).

## B. Methodology

A literature review was carried out into what is known about the involvement of fathers with their children and the nature and outcomes of intervention programmes for fathers. The evaluation adopted a mixture of quantitative and qualitative methods. These were:

- A survey of the family nurses and fathers in FNP cases
- Interviews with family nurses and a sample of fathers

This data provided for a profile of the characteristics of the fathers, the meaning and effects of FNP intervention for the men and the dynamics of FNP engagement with them. The collection of data from these different sources strengthened the reliability of the findings by enabling us to, for instance, compare nurses' perspectives with those of fathers and build up a picture of the dynamics and outcomes of engagement of fathers and families.

## C. Sample

Of the 144 active cases in the entire Nottingham FNP caseload, we established that 30 fathers were deemed 'unreachable' or 'reachable but inappropriate for contact'. The most common reason for the latter was that the men were domestic abusers. This left a potential quantitative survey sample of 114 fathers.

In total, 54 out of the 114 questionnaires were returned – a 47% return rate. In surveys of this nature and with such a population this is a respectable return rate even though we might consider it disappointing. However, it was only secured after a great deal of effort, especially by the family nurses who chivvied and encouraged men to return the survey. This has produced a data set that is still large enough to provide a good profile of the fathers and their experiences of the FNP.

### C.1. Nurse interviews

Semi-structured, face-to-face interviews were conducted on two occasions with the eight family nurses to explore their perspectives on the FNP programme and working with fathers and families.

### C.2. Father interviews

We interviewed 24 fathers. The interviews were face-to-face and semi-structured and most took place at the man's home. The ages of fathers interviewed ranged from 17 to 34-years-old. Seven interviewees were aged 19 or under. Fourteen fathers were under 21-years-old, eight aged 22-29 and two fathers were over 30. Four were from BME backgrounds, the remainder were White or White British. Seven of those interviewed had Social Care involvement and in three cases the child was subject to a Child Protection plan.

The interview sample was constructed so that the fathers selected for interview had different levels of engagement in the FNP, so that we could explore why these differences existed. 15 men were cooperative and well engaged with the FNP programme. We could have interviewed more fathers who fitted this profile but did not because at 15 we

reached a saturation point where to interview more men from the same background and who had similar stories to tell would not have advanced our knowledge any further.

Nine interviewed men had minimal or no involvement with the programme. Such men were incredibly difficult to recruit. We ended up feeling glad to have got this many. Most who the nurses tried to enlist on our behalf would not even permit us to contact them to discuss doing an interview. Chasing these men, so to speak, was tantalising and deeply frustrating; mobile phone numbers would rapidly change, or be disconnected and phones go unanswered. Our failure to connect with many of these men was a reflection of that suspicion of officialdom and their precarious, fluid, mobile lifestyles and mirrored the difficulties the nurses have in trying to pin them down and relate to them. What we experienced was nothing compared to the challenges and frustrations the family nurses experience day in day out. But it taught us a lot about the realities of the challenges involved in engaging some 'hard to reach' fathers.

## D. FNP policy and existing research and literature

### D.1. FNP policies, philosophy and fathers

Analysis of FNP policy documents shows that the relationship of the FNP to fathers is ambiguous. At best, fathers are seen as important but secondary to mothers; at worst, they are ignored.

Fathers are sometimes acknowledged in policies but the primary focus is clearly mothers, who it is made clear, along with their babies, are the primary client group for the programme. In many places the policy and programme literature uses gender neutral language, speaking of 'parents' or 'families'. The American home visitation programme on which the FNP is based focused on the mother and baby and systematically excluded fathers from its design and evaluations. FNP policy statements refer in places to fathers and the UK model seems to have at least some intention to involve them. Fathers are included in some of the photographic images, but it is mainly mothers. But when fathers are mentioned it is as a benefit to the mother's capacity to parent rather than the man being a target for the programme and benefiting from it as a carer in his own right.

The ambiguous identity and shadowy presence and absence of fathers is also evident from the data on what the family nurses say about their approach, and some fathers' experiences of the programme.

The policy context is crucial. Fathers are at a significant structural disadvantage from the outset because of how the FNP programme defines the mother as the 'client'.

### D.2. Defining fatherhood and good enough fathering

The sociological literature and previous research on fatherhood and family life show that in general the role of fathers has been transformed over the past 30 years. Fatherhood is no longer defined just in terms of being the breadwinner and providing, men are expected to provide child care and have nurturing relationships with their children and men generally expect this of themselves.

The most compelling reason for the FNP to clarify its policy and practices with fathers and develop the service to them is because generally fathers themselves and their partners define fathering as involving providing direct care for the baby. The men desire and expect to have deep, loving relationships with their children in which they provide hands-on care.

In the UK fathers' involvement with children under five years of age increased from less than 15 minutes a day in the mid 1970s to two hours a day in the late 1990s. The equivalent figures for older children are 15 minutes a day in the mid-1970s to 50 minutes in the late 1990s.

Research evidence suggests that paternal involvement promotes good outcomes for children. A father's engagement with his child is likely to exert direct influences on child

There is no simple or linear relationship between the amount of time men spend with their children and good outcomes for children. The quality of the care provided by fathers to their children is as important as the amount of time spent caring.

Some argue that men still tend to choose to do the more pleasurable aspects of childcare, leaving women responsible for making appointments, covering child sicknesses and housework. In one study by O'Brien (2005) of dual earner couples where mothers worked at least 48 hours a week, in less than 20% of households did men take on the main responsibility for any domestic chores.

The findings of this evaluation show that a significant proportion of the FNP fathers not only provided a lot of direct child care but shared responsibility for making and attending child related appointments.

The active involvement of fathers needs to be proactively promoted for as much time as they are available to care for their child, taking account of work and other circumstances of the family.

The minimum amount of time and quality care by fathers that is needed to produce good outcomes for children is less clear. Nevertheless, some common dimensions of fathering have been found in research to be likely to promote children's well-being.

- caring for the child's physical welfare
- emotional engagement, enabling warm, responsive and sensitive interaction
- listening and talking to the child about their concerns
- encouraging age-appropriate independent action
- monitoring and guiding behaviour to set limits

The FNP programme needs to develop the capacity of fathers to provide quality care in these areas where it is known that fathers impact on children.

Fathering cannot be seen in isolation from all family relationships. When children are parented by more than one person, it is difficult to single out individual relationships as the key determinant in children's lives.

Younger fathers are conventionally defined as 16-25 years. 86% of the fathers in FNP cases were under the age of twenty-five and 38% were less than twenty years old. The literature suggests that the involvement of teenage fathers with their children can be constrained by them being in full-time education or training, or when they have left education having little or no income due to unemployment and no benefits. Maternal and paternal grandparents can have a significant impact on younger father's involvement. Negative perceptions of younger fathers by maternal grandparents can be both a deterrent and a barrier to paternal-engagement. Non-involvement by teenage fathers is often due to the fact that they perceive a barrier between them and their children, rooted in feelings of financial inadequacy, uncertainty about the type of support they should provide, and poor relations between parents and/or maternal grandparents.

The expectations attached to fatherhood within a teenage father's social network can also affect father-involvement substantially. Research indicates that teenage fathers who are expected – by paternal grandparents, family or friends – to play an active role in their children's lives are more likely to become and remain involved.

### D.3. Fathers who are vulnerable or a risk to children

Fathers involved in social care and health interventions can be categorised as resources, as vulnerable, and as risks to their children (Featherstone, 2004). The FNP works with

some families who experience limited social problems and the fathers are a resource to their partners and children by being breadwinners and good carers. More commonly, the men involved in FNP cases are vulnerable due to the presence of several risk factors: poverty, unemployment, low educational attainment, troubled childhoods and fractured relationships with their own parents. This evaluation shows that some of the men are resilient enough to overcome their vulnerability and become good fathers and the FNP is a vital resource in assisting some in doing so.

Studies suggest an association between greater father involvement and a lower risk for child abuse and neglect. The higher fathers' higher sense of effectiveness as a carer the lower the risk, which suggests the need for early intervention and safeguarding work to help men develop a sense of competency and efficacy as fathers.

Research evidence concerning vulnerable and at risk fathers' involvement with their children and health and social care involvement shows the following general patterns:

- Fathers are parenting in ways which does promote safety and well-being but this is often not recognised.
- Fathers presence matters – in terms of economic well-being, social support, and child development.
- Fathers represent dangers to children (and women) which are often not recognised and, even when they are, are often not strategically responded to and services are limited.
- Fathers have unmet needs and require help with developing their parenting capacities but these are often not recognised by professionals or responded to.
- Younger fathers feel that their parenting skills and contribution are not sufficiently recognised by family members or professionals.
- Children and young people often desire to have better relationships with their fathers.

### D.4. Fathers and research into home-visitation programmes

The home-visitation programme on which the work of the FNP is based developed out of work done in America. They were aimed at mothers and babies, fathers are not referred to. These studies found that women who received nurse home-visitation:

> - *Experienced greater informal and formal social support;*
> - *Smoked fewer cigarettes;*
> - *Had better diets;*
> - *Had fewer subsequent pregnancies (if from low-income backgrounds); and*
> - *Had greater participation in the workforce (if from low-income backgrounds.*
>
> *(Olds et al, 1999: 45)*

However, in these studies the nature and outcomes of home-visitation for fathers is unclear.

One study of a home visitation programme in the US that did consider fathers found almost no evidence to suggest that involvement in the programme had affected fathers' parenting. But the study is deeply flawed by the fact that the evidence was gathered using mothers' reports rather than directly measuring fathers' experiences by engaging with the men themselves.

# E. Research findings

## E.1. The approach of the family nurses

A striking feature of the outlook of all the nurses was a belief that there are few, if any, essential differences between what fathers and mothers have to offer and are capable of providing for their children. This means that they in effect regard themselves as promoting equality and democracy in who does what in families. It suggests that in theory it makes no difference to them whether it is fathers or mothers who provide child care and who receives the FNP programme. But the reality is much more complex, as in many cases this value base does not translate into interventions that include work with fathers.

The nurses' view was that "officially" the mother is the FNP client, but they had a commitment to working with fathers. Whatever about the official FNP policy, in practice some nurses are very clear that they wish to promote the role of the father and include them. There was recognition that not enough strategic effort is put into engaging with fathers from the outset, compared to mothers. We heard many positive stories about engaging fathers but there were also many accounts of failures to engage. The nurses have developed a number of strategies for trying to engage fathers and are proactive in bringing some fathers more to the centre of encounters and engaging them more in FNP materials. This does not happen with all fathers, however, and some are relatively ignored and treated as secondary carers and parents and their involvement regarded as at best a 'bonus' rather than as a necessity.

A key finding of this evaluation is that the programme needs to clarify its policy regarding the role of fathers and how FNs should be expected to work with men.

## E.2. The characteristics of the fathers in FNP cases

- 91% of men involved with the programme are the baby's biological father.
- In 60% of cases the father and mother are still in a relationship and 44% of the men currently live with the baby's mother.
- The fathers ranged in age from 17 to 37 years old. 86% were under twenty-five and 38% were less than twenty years old.
- 83% of the men were White British.

While there is diversity in the characteristics of the fathers and in their experiences of the FNP programme, some clear patterns stand out. Fathers involved in FNP cases tend to:

Live in families that are poor, as a result of low pay, living on benefits or the man having no income at all

- Come from families in which their parents separated before they were 10 years old, are part of reconstituted families and have step-fathers and relationships of mixed quality with their biological fathers
- Have low educational attainment and be unemployed
- Be slightly older than the mothers of their children
- Have unplanned pregnancies

There is a need for the FNP programme to systematically gather more information about fathers, such as their employment status.

Approximately half of the fathers were very involved in providing direct care to their children. This was not simply a feature of the men's availability to care if unemployed, but due to their desire to be active fathers.

Of the 144 active FNP cases, 25% were or had been in contact with Social Care. The number of cases where there were Child Protection Plans was 8%. While this is an important indicator of the level of high risk in some of the more acute cases, many more involved families with high support needs who were not involved with Social Care.

## F. Engaging with fathers and the effects of FNP intervention

The family nurses had some contact on home visits with half of the fathers in their cases.

Positively, 58% of the fathers who were present when the nurse visited were there most or all of the time. On the other hand, 46% were present less than half the time and a full 23% were never there. 60% of men's absences were due to him being out at work or education. In 40% of father absences the man was in principle available to be involved.

Little or no effort was made to visit at times after work or college when those fathers were at home. To try and protect staff from over work, the FNP policy locally was not to do evening visits. Some working and in education fathers were very unhappy about being left out of the visits.

- 48% of fathers felt that on visits the nurse involved them as fully as the mother and another 28% felt well involved.
- 26% of fathers did not feel well involved by the FN on home visits, despite him being there.

The family nurses are playing a significant role in helping some men improve their fathering abilities.

Slightly more than half (54%) of the fathers felt that the FNP programme has had a very positive impact on their ability to be a father.

### F.1. Men who were fully engaged and how the programme helped them

A feature of the stories of men who engaged well with the FNP programme was how becoming a father and falling in love with their babies changed them. The men who became actively involved in child care had gained a clear view of their role and responsibilities.

Men's capacity to nurture and their motivation to become involved with their children increases significantly around the time of the birth. The FNP programme worked best with fathers when it capitalised on this emotional energy and helped the man to channel it into active skilled care for his baby. The fact that the FNP programme engaged with some of the fathers during pregnancy was important in helping them to make the transition positively.

Men with whom engagement by the FNP went well felt they were helped in a holistic way. They gained knowledge and confidence around holding the baby, feeding, bathing, communicating, soothing.

In a context where parenthood tended not to be planned and most men entered the pregnancy with a low level of relevant knowledge, these fathers started out lacking confidence. How the FNP helped to build the men's confidence was a vital ingredient of what they liked about the service, and this was not just specific to younger fathers.

The fathers placed a high value on help they received with improving their relationship with their partner and gaining knowledge and understanding of their partner's experience and needs and in resolving disputes about parenting styles.

The men conveyed a strong sense of being in a relationship with the nurse and appreciated the relatively long duration of time the FNs gave them on the visits.

In successful cases of engagement a congruence was found between what the father needed and the nurse offered. The men felt listened to and the FNs respected what they knew, while responding sensitively and knowledgeably to what they did not know.

### F.2. Poor engagement: Fathers who were not included (enough) by FNP

However, there are some significant deficits in how the programme does not engage well enough with some fathers on some aspects of their lives and role, and does not engage with some men at all.

There are many more men considered by the family nurses to be engaged with the baby (70%) than are engaged with the FNP (38%). The programme is not accessing a significant number of fathers who are engaged with the baby.

Some of this non-engagement is legitimate. In 30 of the 144 active FNP cases the fathers were deemed by the FNs to be '*unreachable*' or *'reachable but inappropriate for contact'*, due to being a risk to the mother and/or child.

The FNP faces a real problem in having no programmes in Nottingham to refer known abusive men.

A lack of engagement with fathers is much more of a problem where the man is parenting his child and either wants to learn more about fathering, or opportunities exist or could be made to engage him, but the FN does not do this enough or at all.

A quarter of the fathers believed the programme had a medium to low impact, while 28% felt that it had very little or no impact on their parenting abilities at all.

In some instances this low engagement was straightforwardly due to the fact that the FNs did not do enough to involve the father, such as men who worked outside the home or who were in training or education and the FN did not visit when he was available. And it happened to some fathers who were available and actually around when the FN called but they were not included.

Several fathers were quite clear that the way the service was delivered sent them the message that it was for the mother and that they as fathers were at worst ignored and at best treated as a secondary parent. Men experienced this who came from all age groups, ethnic backgrounds and it affected men who were working, in education or unemployed.

Because, with rare exceptions, the children live with mothers and some fathers are non-resident, and because, whatever the living arrangements, FNs tend to communicate through the mother rather than directly with fathers to set up appointments and remind them of them, this gives mothers significant influence as gatekeepers to the service for men.

But in several cases of low or non-engagement we found that other factors were also present which produces limited engagement. In such instances there often is no simple linear cause and effect relationship that explains limited FNP involvement, such as Good Dad/Bad Nurse. What blocks engagement in particular situations is often a combination of factors:

- The father's level of receptiveness to help
- The (awkward) signals he gives out are perceived as lack of interest or avoidance
- The FN has low expectations of the man and limited understanding of how masculinity is experienced and performed, for instance in how he may be embarrassed at showing feelings, needing help
- He may be confused about the FN's role and lack information about and understanding of the service

- The high support needs of the mother draws the FNs attention away from the father, and the nurse feels she has enough to do working with mother
- The man is regarded as an acceptable father, but is excluded by the FN because he is seen as a risk or irritant to the mother, endangering her capacity to parent well enough
- Because the FN does not communicate directly with the father it is the mother who knows when the FN is visiting and is the family gate-keeper to the service
- The mother keeps the FN to herself and does not want the father involved, and/or does not fully understand that the FNP is for fathers as well as mothers
- Lack of clarity in the FNP programme and organisational policy about working with fathers, which leaves FNs uncertain about their responsibilities to be proactive with men.

In some cases the reasons for low engagement of fathers were a product of the complex interaction between the restricted policy and approach of the FNP, the father's understanding of and ambivalent attitude towards the service and the contribution of mothers, who invariably themselves had high needs. Some mothers either chose to keep the FN to themselves or believed that the service was for mothers and not fathers.

FNs need to inform mothers that the programme is for fathers too. But this again reveals the tensions that arise from the mother being the primary FNP client. Given that the mothers will have been told that the service is primarily for them, it is little wonder that some interpret this as it meaning *only* for them, especially if the FN demonstrates this in practice by not actively including the father.

The mother as the client philosophy and approach affected fathers who were not resident (full-time) with their child and partner because where the mother resides is what is regarded as the family 'home' to be visited. Such fathers were not seen by the FNP unless they happened to be around the home of the mother when the visit was made.

Separated fathers were rarely even seen by the FNP at the times when the men had access to/care of the baby. It is the presence of the child with either (or both) parents rather than any particular residence that should define where and to whom the service is delivered. The service should be equally available to fathers at those times they are caring for the child as it is to mothers when they are. Separated fathers need the programme just as much when they are caring for their child as they do when they are with the mother. In fact the separation can increase their vulnerability and needs for support.

The report shows how the complexities of FNP work are more evident still when issues of risk, safeguarding and the complex needs that some families have are considered.

Some fathers (and mothers) felt ambivalent or did not want FNP involvement because the FN had reported them to Social Care. In some cases this was skilfully worked through by the nurse, while in others resistance persisted.

Then there are fathers who are present in the family but either refuse to engage with the FNP or do so minimally and sometimes in an actively resistant and even hostile manner. Some resistance is passive, where the man slips out of the house or into another room when the FN calls.

Behind very hard to reach men's lack of openness to help is a powerful repudiation of vulnerability and deep distrust of authority figures and probing into their life. At least one man interviewed in the study (one of the two men interviewed in prison) hated the FN and FNP.

Such men's resistance is not simply a product of their awkwardness and personal or moral failings. It is also a function of their previous life experiences. Invariably they have

had poor experiences of authority, the State is experienced as a threat to them and their freedom. The FNP's relationship-based approach is then experienced as invasion, intimidation and control.

Most of the fathers we interviewed had vulnerability factors that were similar to those men who were hard to reach: troubled family backgrounds, leaving home or being thrown out as a young teenager; dropping out of education and having no qualifications and in some instances no income; petty criminality and anti-social behaviour in adolescence and in some instances into adulthood; unplanned pregnancies and unstable relationships with partners. The men who are never reached may differ only in the extremes of how they experience these risk factors, either individually or in combination. The capacities of many of these men to provide care and be responsible fathers are likely to have been significantly adversely affected by their own experiences growing up in difficult and challenging circumstances.

This means that many of the men who engaged positively with the FNP programme did so from a starting-point of high risk of non-engagement and the fact that this did not happen provides the basis for learning not just about how the nurses managed to successfully engage those men but how hard to reach men can be engaged.

A key strategy is for the FNP to develop is to do their utmost to ensure that they do not fulfil the actively resistant men's worst expectations that he will be let down by people, including by being avoided by them. The FNP needs to be as proactive as possible with such men, creating every possible opportunity to meet with them and help them to see what they have to gain from the programme and active fatherhood.

This includes men who are in prison. The imprisoned fathers in this study had a desire to have different lives. They were attempting to acquire a fatherhood identity in very difficult circumstances. This desire to care for their child presents an opportunity for the FNP to relate to and develop them as fathers. We do not wish to oversimplify these cases and the dilemmas FNs face where there are suspicions and concerns that a man may constitute a risk. The crucial thing is that men's desires to be good enough fathers and their capacities are fully understood, assessed and the man is given every opportunity to develop himself as a father, irrespective of where he lives.

### F.3. Help-seeking, men and masculinities

The data reveals that some fathers had problems with help-seeking due to their identities as men and a dominant definition of masculinity which stigmatizes men as 'weak, 'sissies', if they surrender to their need for support. Programmes like the FNP need to help men develop a masculinity based around nurture and a definition of themselves which is comfortable with visibly being a caring man and father and accepting help. Put straightforwardly, the fact that this does not happen in some cases reflects how the FNP does not understand men well enough.

While the FNs have a generally positive and constructive view of men and fathers and what they can contribute to children's lives, the findings suggest that there is significant development work to be done with the FNP workforce if fathers are truly to brought centre-stage.

Enabling FNs to reach a deep understanding of men and masculinities must be at the core of the FNP developing a more uniformly proactive and effective service to all fathers. The same applies to developing deeper understandings of fatherhood and what being a father means to men. As this chapter has shown, not being included by professionals like the FNP transgresses the rights of a child to have a relationship with their father, is painful for some men and regarded by most who are placed on the margins as unjustifiable.

All men who seem unreachable potentially can be engaged. It cannot be known or predicted at the outset who will or might be reachable and who will not. Where there are

signs of avoidance and passive or active resistance and non-engagement by men, FNs need to adopt an approach of creative persistence towards them. We heard examples from FNs of how they do this and some fathers spoke of how, through a mixture of skill, knowledge, charm and persistence, FNs won them round and helped develop them into good fathers.

## G. Recommendations

**Recommendation 1 – Policy Clarification**

The FNP needs to clarify its policies in relation to fathers. The current policy of the mother explicitly being the client is inconsistent with how many families using the service, how they organize gender roles and parenting responsibilities, what many fathers and their partners want and how generally Family Nurses themselves wish to and often try to work. At its worst the '*mother as the client'* policy is exclusionary towards fathers and is therefore sexist. This structural issue is a significant cause of problems in engaging fathers. The Nottingham FNP may wish to reconsider the implications of the FNP being a licensed bought in package from abroad and look at implementing more locally relevant father friendly strategies.

**Recommendation 2 – Understanding fathers and the dynamics of engagement**

The FNP needs to develop and promote among its workforce a much more sophisticated understanding of what enables father engagement and what blocks fuller engagement; how this is sometimes straightforwardly due to the FN's failure to take the man seriously and work with him. But also how it is often a combination of factors:

- FNs low expectations of a particular man, who is perceived as feckless and/or a possible danger/risk;
- The father's apparent receptiveness to receiving help and the avoidant signals he gives out, which is perceived by the FN as lack of interest, but may be role confusion, embarrassment, or lack of understanding of what the service can offer;
- The demands of working with high risk/demanding mothers and feeling challenged enough trying to develop her parenting;
- How the mother gate-keeps the service, keeping it to herself and does not invite or allow her partner in.

**Recommendation 3 – Communicating directly with the fathers**

The fathers' contact details, especially mobile phone numbers, should be gathered by FNs and men should be communicated about appointments the same extent as mothers.

**Recommendation 4 – Letting fathers and mothers know the service is for fathers**

The fathers need to be told time and time again that the service is as much for them as it is for mothers. Mothers also need to regularly be told this. This also needs to be articulated in all policy and practice literature. Photographic images should include fathers to the same extent as mothers.

**Recommendation 5 – Being available when fathers can be home**

The pattern of appointments and visits that would best enable the presence of fathers and their active involvement in sessions needs to be openly negotiated with him. Visiting should occur at times that suit men who are working or in education, balancing this with the need to ensure family nurses are not over-worked and get time off in lieu, and that their safety is ensured through the implementation of lone-worker policies outside of 9am-5pm working hours.

**Recommendation 6 – Provision of emotional support and help with relationships**

Fathers value highly the FNP help with relationships with their partner, as well as developing hands-on parenting skills with their babies. The FNP needs to fully understand and respond to how fathers value the relationship-based approach and that men need help dealing with and showing their feelings and feeling comfortable in so doing.

**Recommendation 7 – Non-resident fathers**

Fathers who are not resident with their partner and baby or separated from the mother need to be seen by the FNP at the times when they have access to/care of the baby. It is the presence of the child with either (or both) parents rather than any particular residence that should define where and to whom the service is delivered. The fathers' 'home' should be defined as being within the scope of the 'home visitation' as well as the home of the mother. The service should be equally available to fathers at those times they are caring for the child as it is to mothers. Separated fathers need the programme just as much when they are caring for their child as they do when they are with the mother. In fact the separation can increase their vulnerability and needs for support.

**Recommendation 8 – Training**

Training to enable family nurses to reach a deeper understanding of men and masculinities must be at the core of the FNP developing a uniformly proactive and effective service to all fathers. The same applies to developing deeper understandings of fatherhood and what being a father means to men. Not being included by professionals like the FNP transgresses the rights of a child to have a relationship with their father, is painful for some men and is regarded by most who are placed on the margins as unjustifiable.

**Recommendation 9 – Making the FNP Father friendly**

The FNP needs to critically review all its programme materials to ensure that they become father focused/friendly. This should include developing facilitators which are attractive to fathers and meet their needs

# 1. The aims and objectives of the evaluation

## 1.1. The aims and methods of the FNP

The Family Nurse Partnership programme 'is offered to first time vulnerable teenage mothers' (Department of Health, 2009, p.8). It is a licensed programme which originated in the United States, with quality and programme measures that are intended to ensure fidelity to the FNP and replication of original research, developed over 30 years in the US. The programme is delivered by specially trained Family Nurses who come from health visiting, midwifery, mental health and other branches of nursing. It does in-depth work with families to achieve change, at the 'intensive, specialist care' end of early intervention and prevention. Each family nurse (FN) has a caseload of no more than 25 families. The FNP team has a supervisor (with a small caseload) providing weekly supervision, learning, management and quality assurance. Nottingham is one 50 LA/PCTs that are currently delivering the programme locally. These local sites are supported by the FNP Central Team, which deals with training, materials, database, research, development, advice and contractual issues (Department of Health, 2009, p.8)

The Nottingham Family Nurse Partnership team is made up of seven family nurses and a supervisor, who also carries a small caseload. The stated aims of the Family Nurse Partnership, in Nottingham which formed the backdrop to this evaluation are to:

- Improve pregnancy outcomes by helping women to engage in good preventative health practices, including getting the most from antenatal care, improving their diet and reducing smoking, alcohol and drugs;
- Improve child development by helping parents provide responsible and competent care;
- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

### 1.1.2. The aims of this evaluation

The key aim of this evaluation is to focus on informing practice to increase the presence, involvement and engagement of fathers with the FNP. It is part of the development work for the national NFP pilot. The starting point for the commissioners of the evaluation was that a consensus of national research is that a significant level of father engagement has a significant positive influence on a child. However, within the delivery of the Family Nurse Partnership it was noted that there were sometimes difficulties engaging fathers. The aims of this evaluation are to:

- Identify which characteristics of fathers are associated with high/low levels of involvement in families with teenage mothers.
- Describe the characteristics of individual fathers in the Family Nurse Partnership - characteristics to include demographics such as employment status, age.
- Identify perceptions of what influences fathers' involvement in the Family Nurse Partnership within Nottingham.
- Develop an action plan to increase fathers' involvement with their child and propose recommendations to inform practice and guide future commissioning.

It was understood at the outset that meeting these aims would require a review of the literature to explore:

- Why involvement of fathers is important
- How engagement in the Family Nurse Partnership would help fathers become involved in bringing-up their child

- what levels of involvement/engagement are considered high enough to have positive significant impact for the child
- what levels of involvement/engagement are considered low and therefore do not have a positive significant impact for the child
- The risks as well as potential benefits of father involvement

The views and experiences of the eight members of the family nurse team and of fathers themselves would also be sought through using quantitative (questionnaire surveys) and qualitative (one to one interviews) research methods (see below). It was accepted that fathers who are known to be violent and at a level of risk where their involvement in the evaluation would place their children and partners, and possibly family nurses in danger would not be included in the study.

### 1.1.3. Fathers and the FNP

Analysis of FNP policy shows that the relationship of the FNP to fathers ambiguous. At best, fathers are seen as important but secondary to mothers; at worst, they are ignored. For instance, agency policy as set out in *The Family Nurse Partnership: A programme of prevention and early intervention. Information for commissioners* (DoH, 2009), suggests that 'Pregnancy and birth [are] a key time – mothers have an instinctive drive to protect their young and first time parents in particular want their child to be healthy and happy and do well in life (p.5), but no mention is made of fathers. In many places the programme literature uses gender neutral language, speaking of 'parents' or 'families'. Some of the photographic imagery contains fathers with mothers and children. There are some of mothers and babies together without a man, and there is at least one photograph of a father and baby alone. Fathers are referred to with respect to the aim of 'Addressing the poorer outcomes for the children of teenage mothers and fathers' (p.9), in response to which the 'FNP [is] offered to young first time parents [and is] known to improve outcomes for this group' (p.9). However, when it comes to presenting 'evidence of benefits for the FNP programme', it all about mothers and children:

> *US research shows positive results from pregnancy through to 28 yrs, across a range of outcomes and for both mother and child, with benefits greatest for young mothers, mothers with low incomes and lowest psychological resources. (p.11)*
>
> *Improves mother's life course and economic self sufficiency (less welfare dependency) (p.11)*
>
> *Benefits those who need it most – greatest effects for young mothers, low income mothers and mothers with lowest psychological resources*
>
> *Benefits are wide ranging, persistent and long lasting*
>
> *Benefits both mothers and children' (p.12).*

The evidence base drawn upon is from USA home visitation programmes on which the FNP is modelled. In the literature review below we show that such programmes make few references to fathers and are focused on mothers and this is replicated in the policy statements. Drawing on the US experience re cost effectiveness: 'Largest cost savings due to reductions in welfare use (mother), increased earnings and increased tax revenue (mother) and less involvement with criminal justice (mother and child)' (p.15).

It is made clear that 'License and fidelity measures ensure replication of research conditions when delivered elsewhere –with successful replication in England' (p.13). It may be, however, that in practice the UK model has at least some intention to be father-centred, which is in part reflected in FNP policy statements. But even when fathers are mentioned it is as a benefit to the mother's capacity to parent rather than the man benefiting from the programme as a carer in his own right. Thus in discussing the anticipated benefits of the programme in the UK it is stated, 'More sustained relationship

with child's father/partner (mother)' (p.21). Here we see how the father is mentioned as a benefit to the mother. On the same page the primary focus of the programme is laid bare: 'most impacts to mothers with low psychological resources or who were poor, unmarried or teens'.

With respect to what is known about implementation of the FNP in England, the language used is mostly about 'families', but a clear reference to fathers is made: 'Engagement with fathers is good. Almost half the fathers and partners had been present for at least one FNP visit' (p.25). In discussing the FNP, the terms 'client' and 'father' are used separately: 'Many clients reported positive changes in their understanding of pregnancy, labour, delivery and their infant' … 'Closer involvement of fathers with infants' (p.26).

A 'typical FNP story' is told from the vantage point of the mother but the father is referred to: *'Her boyfriend became engaged in the FNP and is now involved in the care of his son'* (p.28). Once again, fathers are acknowledged but the primary focus is clearly mothers. A section where service users 'speak for themselves' includes: '*Because we have learnt it together we do it together.*' 19 yr old dad' (p.29). Reference is made to how 'Father involvement is high', with a nice image of a smiling father and baby (p.35), and it is stated that '*'Young fathers show great interest in FNP, and many want to be present for visits or complete the activities'*. Yet the aim of controlled research studies of the FNP is stated to be: 'To assess whether FNP benefits women, children and families over and above usual services and cost effectiveness.' (Department of Health, 2009, p.39).

**The tentative, uncertain approach of the FNP to fathers is further drawn out below in the research findings from family nurses about who is their client and in the review of the literature that follows.**

# 2. Literature review

## 2.1. The changing role of fathers and their impact on children

Public interest in and research on fatherhood and the dynamics of father-child relations have increased dramatically since the 1970s. Historically the focus of researchers into families and child well-being was on mother-child relations. This reflected how mothers were regarded as the primary care-givers, while fathers carried out their traditional breadwinning role. As Cabrera et al. (2000: 127) note, "the constant presence of mothers as children's primary care-givers fostered the implicit assumption that father-child relationships had little impact on children's development". The shift to expanding the study of familial relations to include paternal involvement has been explained by some theorists as a reaction to changes in "family life, gender relations, men's declining wages, and increases in both women's participation in the paid labour force and men's involvement as primary nonmaternal care providers" (Gerson, 1993). As Marsiglio et al. (2000) comment in their review of fatherhood scholarship:

> *At the same time, heated public debates have emerged over numerous issues relevant to fatherhood, including divorce and single parenthood, 'deadbeat dads' and 'androgynous' fathers, welfare reform, teenage pregnancy and nonmarital childbearing, fathers' rights and responsibilities, the definition of the 'family,' and fathers' potentially unique contributions to child development. Discussions of these issues often make reference to serious social problems assumed to arise from the diverse conditions of fatherlessness and father absence (Blankenhorn, 1995; Popenoe, 1996). (Marsiglio et al. , 2000: 1174)*

Research and commentary on fatherhood has focused significantly on father-absence and taken a *deficit* approach to understanding the role of fathers in their children's lives. As Marsiglio et al (2000) suggest, increased attention to fatherhood has in part been driven by a recognition of the risks associated with absentee fathers rather than the impact men have when they are present and the positive outcomes of father involvement. There is now more evidence to suggest that paternal involvement promotes good outcomes for children. The amount and quality of father-child interactions affect individual's well-being during childhood and can also impact upon their future emotional development and life prospects. The negative outcomes associated with a poor father-child relationship are the intergenerational transmission of poverty, low educational achievement, and behavioural and mental health problems. As Cabrera et al (2000) write, "Fathers' emotional investment in, attachment to, and provision of resources for their children are all associated with the well-being, cognitive development, and social competence of young children even after the effects of such potentially significant confounds as family income, neonatal health, maternal involvement, and paternal age are taken into account" (Cabrera et al, 2000: 130). Lamb (1997) argues that a father's engagement with his child is likely to exert direct influences on child development in the same way that the quality of mother-child attachment does.

There is some debate regarding the relationship between the type and level of father involvement and outcomes for children. Marsiglio et al (2000) state that researchers in the area generally focus on "financial support and visitation patterns (especially among non-resident fathers), on one-on-one engagement (e.g., sharing a leisure activity, helping with homework, instructional talks), or on more general indicators of the absence or presence of the father in the home" (Marsiglio et al, 2000: 1182). These measures can, however, be problematic as they do not necessarily provide the researcher with an understanding of the nature of the relationship between fathers and their children. This implies that quantity is equal to quality and therefore produces positive outcomes. Moreover, by using measures such as presence/absence and financial support,

interpretations of positive paternal involvement favour resident fathers with a higher income. These issues are important as they not only reflect the challenges associated with conceptualising father involvement concretely, but also in part help to explain why relatively little is known about the precise relationship between paternal involvement and the development of children, particularly for non-resident fathers, teenage fathers and those who are poor.

Flouri (2005) defines an 'involved father' as one who takes an equal role to the mother in managing them, is interested in their education, who reads to their children, and takes them on outings. Her research shows that father involvement generally resulted in their children experiencing less mental health problems, achieving better educational attainment, and less involvement in anti-social behaviour or with the police. Fathers showing warmth and providing care have been shown to be positively associated with less cognitive delay in children (Bronte-Tinkew et al., 2008).

The question 'what do fathers actually do?' has led researchers to attempt to conceptualise the nature of father 'involvement' and the types of activities fathers engage in with their children. Lamb and Lewis's (2004) work has been influential in distinguishing three areas: the amounts of time fathers spend interacting with, being accessible to, or making arrangements for their children. The latter one is important for showing what level of responsibility men take for children even when they are not present, such as their availability to look after a child who becomes ill at nursery or school. Studies suggest that the amount of time fathers devote to childcare activities has increased over recent generations. In the UK fathers involvement with children under five years of age increased from less than 15 minutes a day in the mid 1970s to two hours a day in the late 1990s (O'Brien, 2005; Fisher et al., 1999). The equivalent figures for older children are 15 minutes a day in the mid-1970s to 50 minutes in the late 1990s. These are of course averages across large samples of men. From family to family some men will be doing less and some much more. Moreover, apparent social class and ethnic differences must be noted. One study suggests that manual workers do the most childcare while men in professional occupations do the least (McDermott, 2008). It has been argued that men still tend to choose to do the more pleasurable aspects of childcare, leaving the hard graft to women (Gatrell, 2007). It is important to distinguish child care from housework and there are suggestions that in general men have not increased their involvement in housework to the same degree as with childcare. In one study by O'Brien (2005) of dual earner couples where mothers worked at least 48 hours a week, in less than 20% of households did men take on the main responsibility for any domestic chores.

As Featherstone (2009, p. 79) notes, it is increasingly argued that a focus on 'time use' as a way of assessing involvement is too restrictive and there is a need for more refined examinations of the nature of fathers' impact on children. The assumption that there is a linear relationship between the amount of time men spend with their children and good outcomes for children is being shown to be simplistic (O'Brien, 2005, p.12). It is the *quality* of care the man provides that is crucial. The minimum amount of time and quality care by fathers that is needed to produce good outcomes for children is less clear. Nevertheless, some common dimensions of fathering have been found in research to be likely to promote children's well-being. Featherstone (2009, p.80), summarises these activities as, warm, responsive and sensitive interaction, monitoring and guiding behaviour to set limits, spending time to listen and talk about the child's concerns, encouraging age-appropriate independent action and caring for the child's physical welfare.

It is important to emphasise that fathering cannot be seen in isolation from all family relationships. There is unlikely to be an utterly unique contribution made by the father which makes the crucial difference. When children are parented by more than one person, it is difficult to single out individual relationships as the key determinant in

children's lives. The father-child relationship may reflect the quality of all relationships within the family (Lewis and Lamb, 2004).

As this evaluation will show, 86% of fathers in FNP cases were under the age of twenty-five and 38% were less than twenty years old. It is important then to give consideration to any particular issues arising for younger fathers, who are conventionally defined as 16-25 years. As this evaluation bears out, the involvement of teenage fathers with their children can be constrained by them being in full-time education or training, or when they have left education having little or no income due to unemployment and no benefits. Maternal and paternal grandparents can have a significant impact on younger father's involvement (Lane and Clay, 2000, Redmond, 1985). The research suggests that in order to ensure that a positive relationship between teenage fathers and their children is sustained, support services need to be provided to teenage fathers from the beginning of the pregnancy. Non-involvement by teenage fathers is often due to the fact that they perceive a barrier between them and their children, rooted in feelings of financial inadequacy, uncertainty about the type of support they should provide, and poor relations between parents and/or maternal grandparents. The relationship between parents often has a significant effect on the level and nature of paternal involvement (Marsiglio et al., 2000; Lamb, 1987), minimising the quality of the time children spend with their parents and this can have more of a negative effect than the quantity of time children spend with their parents (Stafford et al, 2009). Some commentators (Clay and Lane (2001), suggest that non-involvement by teenage fathers can often be influenced not by an unwillingness to engage but by barriers created by the mother. Bunting and McAuley (2004) argue that this perception is largely due to poor relations between parents. In research interviews with both teenage fathers and mothers, Bunting and McAuley (2004) found that whereas teenage fathers would cite the mothers' opposition as a barrier to father-involvement, teenage mothers would cite paternal disinterest.

Negative perceptions of younger fathers by maternal grandparents can be both a deterrent and a barrier to paternal-engagement. In Rhein et al's (1997) review of teenage father's participation in child-rearing, 54% of the fathers cited their partner's mother's resistance and antipathy to them as a barrier to their involvement because they are unwelcome. Fewer teenage mothers had this perception, 39% of their sample identifying maternal grandparent resistance as a barrier to paternal-engagement. Bunting and McAuley (2004) also found that conflict between maternal grandparents and teenage fathers can create a barrier to paternal-engagement. This barrier is largely rooted in maternal grandparents' perception of the relationship between parents as 'either based on commitment or sexual conquest' (Bunting and McAuley, 2004: 299).

The expectations attached to fatherhood within a teenage father's social network can also affect father-involvement substantially. Research indicates that teenage fathers who are expected – by paternal grandparents, family or friends – to play an active role in their children's lives are more likely to become and remain involved. In his study of teenage fatherhood amongst African-Americans, Miller (1997) describes how:

> *the father's family of origin and his peer groups may explicitly indicate to him their respective expectations that he assume the role of father and that any behaviours counter to fulfilling that role will not be tolerated (Miller, 1997: 63).*

In summary, these research findings have a number of significant implications for the FNP:

- Involved fathering produces better outcomes for children
- The quality of the care provided by fathers is as important as the amount of time spent caring

- The FNP needs to proactively promote the active involvement of fathers for as much time as they are available to care for their child, taking account of work and other circumstances of the family
- The programme needs to develop the capacity of fathers to provide quality care in those areas where it known that fathers impact on children:
    - caring for the child's physical welfare
    - emotional engagement, enabling warm, responsive and sensitive interaction
    - listening and talking to the child about their concerns
    - encouraging age-appropriate independent action
    - monitoring and guiding behaviour to set limits

This evaluation was designed in such a way as to try and establish the extent to which the FNP programme engaged with fathers and developed them in these areas.

## 2.2. Fathers who are vulnerable or a risk to children

Fathers involved in social care and health interventions can be categorised as resources, as vulnerable, and as risks to their children (Featherstone, 2004). The FNP works with some families who experience limited social problems and the fathers are a resource to their partners and children by being breadwinners and good carers. More commonly, the men involved in FNP cases are vulnerable due to the presence of several risk factors: poverty, unemployment, low educational attainment, troubled childhoods and fractured relationships with their own parents. This evaluation will show that some of the men are resilient enough to overcome their vulnerability and become good fathers and the FNP is a vital resource in assisting some in doing so.

But as the evaluation will also show, some 25% of the Nottingham FNP cases involved child welfare and safeguarding concerns to the extent that social care were involved with the families, with 8% on child protection plans. It is important then to attend to what is known about fathers who are a risk. Research into the causes and psychology of negative parenting has focussed unduly on the mother to the neglect of men (Peckover and Featherstone, 2007; Strega et al. 2007). Studies into the 'intergenerational transmission' of child abuse have produced some important data on mothers and what works in terms of breaking the cycle of abuse (MacDonald, 2001), but fathers have been consistently ignored. Mayer et al. (2003) argue, 'very little work has been done to investigate the links between fathers and child neglect.' Dubowitz et al. (2000), insist 'Fathers should not be ignored in analyses of the multiple, interacting factors contributing to child maltreatment.' The fathering of men who are known to have been abusive to their partners and/or children has been found to differ from that of non-violent men. They engage more in punitive behaviours and less often in positive parenting behaviours than nonviolent men. However, they were indistinguishable from non-violent men in other aspects of their fathering, such as in the amount of time they spent with their children or in monitoring standards and actions (Perel and Peled, 2008). Abusive fathers have also been found to be rigid and authoritative (Bancroft & Silverman, 2002) and negligent of their basic needs (Sterenberg et al., 1994). Where the relationship with the child's mother has broken down, some abusive fathers use their children as a means for continuing to exert control over their partner and abuse her (e.g., Eriksson & Hester 2001).

Dubowitz et al.'s (2000) important study of fathers and child neglect was based on a sample of 244 families, where interviews and observation took place with 117 fathers. It

found that in low-income communities, many men play important roles in their children's lives even if they do not live in the home. Both the quality of the relationship and father's involvement seem to be more important than the father's biological relationship to the child or where he resides. The study suggested an association between greater father involvement and a lower risk for neglect. Fathers' higher sense of effectiveness as a carer was associated with lower neglect ratings, which suggests the need for early intervention and safeguarding work to help men develop a sense of competency and efficacy as fathers. They suggest that the pressing question 'may be how to encourage fathers to be more involved with their children in ways that are optimally nurturing' (Dubowitz et al., 2000, p.138). Marshall et al. (2001) examined some possible effects of the presence and quality of parent-child interaction of fathers and father figures on the behaviour of young children in a sample of families reported to child protection services. The presence or absence of a father or father figure seemed to make little difference in child behavioural problems at age 4. However, lower levels of aggression and depression were observed for children by age 6 if a father-figure was present in the child's life.

These research findings are not only significant with respect to cases with safeguarding concerns but suggest that attempts to develop healthy father-child relationships and the parenting abilities of all fathers contributes to preventing child welfare problems and maltreatment.

## 2.3. Fathers and health and social care interventions

As has been shown above, a literature on fathers in general and as 'resources' to their children and partners in providing good enough care now exists. However, systematic knowledge about fathers who are vulnerable and a risk to children and how to intervene with them remains limited (Daniel and Taylor, 2005). There is widespread recognition of knowledge gaps surrounding working with fathers and it is now commonly acknowledged that fathers are too often ignored by health and social services providers and that fathers tend to avoid such involvements (McKeown, Ferguson and Rooney, 1998; Ferguson and Hogan, 2004; Milner, 1996; O'Hagan, 1997; Featherstone, 2004; 2009; Scourfield, 2006). Parenting tends to be regarded as synonymous with mothering, and it is with women and to a lesser extent children and young people that professional relationships are formed. The invisibility of fathers is also to be found in research. In evaluating service delivery, even some of the most helpful analyses of policy and practice do not go beyond general comments about "parents" and do not distinguish mothers and fathers. As we will show below, this includes evaluations of home visitation programmes like the FNP. Mothers are regularly referred to while the presence or absence of fathers may not even be remarked upon. This is not because men are never there – they often are – but because of a failure to recognise or evaluate the implications of their presence.

A number of valuable reviews of knowledge about 'what works' in interventions with parents have been conducted in recent years, which also point to an absence of information about fathers and the need for research that includes and focuses on them. The DfES commissioned review *What Works in Parenting Support? A Review of the International evidence* (Moran et al., 2004) gives a high priority to the need for further research which will identify:

> *What aspects of parenting support work are most effective when working with fathers and how programmes may need to be designed to better meet their needs.*

A continuing gap in provision and unwillingness to use services continues to surround 'hard to reach' families who do not willingly engage with any services, which tends to include black and ethnic minority families and also those who are resistant to intervention and often hostile (Carpenter, et al. , 2005, p.44). For good outcomes to be achieved in parenting programmes, it is known that parents have to acknowledge there is a problem, which is often a difficulty in high risk abuse cases and why parenting

programmes are unsatisfactory for such parents. A high priority for further research into such populations and cases has been identified in terms of: "How to retain and engage families in 'high risk' groups in parenting support interventions more successfully and how to ensure better outcomes for these groups more consistently' (Moran et al. , 2004). This is relevant to this evaluation of the FNP programme due to the presence of cases where the babies and in some cases young parents are the subjects of child protection plans, or are looked after.

There is, however, a growing literature on fathers' perspectives and interventions with fathers. In a study of the fathers of teenage mothers Ross et al. (2010) found that the men (who were aged 16–25) felt that their parenting skills and contribution were not sufficiently recognised by family members or professionals. Most of the men were very involved in their child's life and provided support and care to their partner during pregnancy and in early parenthood. Men often felt excluded or judged when accessing maternity and health services, although some reported positive experiences. Some of the fathers felt they lacked skills in basic childcare activities, such as making up bottles, bathing and handling infants, and would have benefited from further guidance and support in the lead up to the birth and immediately after. Some would have liked more support with how to provide effective support to their partners, some of who were depressed (see also, McDonnell and others, 2009). Ferguson and Hogan (2004) in a study of the impact of social work and family support interventions into the lives of 24 fathers, found that men were often ignored by professionals because they were seen as dangerous or feckless. Despite some men being very involved with their children professionals focused on the mother because they assumed she was the primary and often only parent and they had little faith that putting their time and effort into trying to help the men would make them into better fathers. Scourfield (2003) found similar negative assumptions about feckless and dangerous men among child protection professionals in his participant observation study of a social work team in Wales.

Fathers can feel left out of and excluded from involvement in various ways, by being crudely ignored by the professional when present in the home, even the same room, or through guidance and contact by the professional being directed at and through the mother. This can be done unconsciously by workers, who enact uncritically cultural assumptions about gender roles and the secondary nature of fathers in children's lives. Men are very sensitive to picking up these signals and it is clear that professionals can actively compound any hesitancy men have about being involved and are complicit in men opting out (Ferguson and Hogan, 2004; Featherstone, 2009). Men's reluctance to seek help or receive it is now recognised as a significant factor in why services do not engage with them. This is a consequence of how masculinity has traditionally been defined in terms of values of strength, coping and not showing vulnerability or emotions (other than anger). Help-seeking is equated with weakness and being a 'sissy' and men fear being judged as unmanly if they show vulnerability (Kimmel, 1994). Ferguson and Hogan (2004) found that where significant changes occurred in men's parenting capacities, the fathers not only acquired better technical skills to parent, manage anger and so on, but changed aspects of their concept of themselves as men. They were helped to reconstruct their masculinity in significant ways, by moving beyond an identity based on work and sport – what Real (1998) calls 'performance based esteem' - to one where a concept of themselves as nurturers was integrated into their self-identity and manhood.

In summary, research evidence concerning fathers' involvement with their children and health and social care involvement shows the following general patterns:

- Fathers are parenting in ways which does promote safety and well-being but this is often not recognised.
- Fathers presence matters – in terms of economic well-being, social support, and child development.

- Fathers represent dangers to children (and women) which are often not recognised and, even when they are, are often not strategically responded to and services are limited.
- Fathers have unmet needs and require help with developing their parenting capacities but these are often not recognised or responded to
- Children and young people often desire to have better relationships with their fathers.

## 2.4. Fathers and research into home-visitation programmes

The home-visitation programme on which the work of the FNP is based developed out of work done in America. Here we consider what the academic literature on these American programmes says about fathers. As Olds, the originator of such programmes writes, in collaboration with colleagues, home visitation:

> *…was designed to improve three aspects of maternal and child functioning: (1) the outcomes of pregnancy; (2) qualities of parental care-giving (and associated child health and developmental outcomes); and (3) maternal life-course development. (Olds et al. , 1997: 10)*

Home-visitation programmes assumed that there was a direct correlation between the pre- and post-natal experiences of mothers and children's future health and well-being. Home-visitation combines 'human ecology', self-efficacy and human attachment theories of the relationship between social environment and individual behaviour. This triumvirate of theories connects home environment with child outcomes. In doing so it produces a model of the human life-course which roots children's well-being and physical, emotional and behavioural development in positive parenting. Proponents of home-visitation argue that:

> *Many of the most pervasive and intractable problems faced by children and parent s… can be traced to adverse maternal health-related behaviours during pregnancy, compromised care of the child, and stressful conditions in families' homes that interfere with parental and family functioning. (Olds et al. , 1999: 45)*

The solution to these inadequacies in the parenting of young children was regarded as parental education. Home-visitation advocates argued this education could not purely be office-based. The mother's home situation also had an impact on her parenting ability. To substantiate this, a series of longitudinal randomised control trials of home-visitation programmes in Memphis, Tennessee; Denver, Colorado; and Elmira, New York were conducted. These studies found that women who received nurse home-visitation:

- *Experienced greater informal and formal social support;*
- *Smoked fewer cigarettes;*
- *Had better diets;*
- *Had fewer subsequent pregnancies (if from low-income backgrounds); and*
- *Had greater participation in the workforce (if from low-income backgrounds.*

*(Olds et al., 1999: 45)*

However, despite some references to 'good parenting' and 'positive parenting outcomes', the focus of home-visitation is on mothers. Parenting is treated as synonymous with mothering. Fathers were not included in the evaluation studies of the dynamics and outcomes of home-visitation and the home-visitation model proposed by Olds at al makes no allowance for the particular needs of fathers or the nuances of fathering. Most tellingly, the only time fathers are mentioned in Olds' studies in Elmira, Memphis or

Denver is in relation to the needs of mothers. In these studies, fathers are addressed as part of mothers' social support network not in terms of their active caring role and interaction with children.

This reflects the structure of the model of home-visitation developed and evaluated by Olds. The programmes were delivered by nurses and 'Paraprofessionals' which Olds defines as health workers with no formal training in the helping professions (similar to child care and family support workers in UK systems). As their evaluation of the Elmira, Memphis and Denver programmes records, the main substance of nurses' and paraprofessionals' visits was focussed on the mothers' needs:

> *During the home visits [...] the nurses carried out three major activities: (1) they promoted improvements in women's (and other family members') behaviour thought to affect pregnancy outcomes, the health and development of the children, and the parents' life course; (2) they helped women build supportive relationships with family members and friends; and (3) they linked women and their family members with other needed health and human services. (Olds et al., 1999: 49)*

Though the programme – and Olds et al.'s evaluations – make reference to 'other family members', who this refers to is not specified. 'Family members' could include grandparents or siblings, as well as fathers. But regardless of the inclusion of other family members', the mother is still the main client in the intervention.

The apparent exclusion of fathers from home-visitation programme runs contrary to the supposed aim of this approach as a means of ensuring more stable family environments. As Duggan et al. (2004) write in their review of home-visitation programmes with at-risk families:

> *Models that aim to improve child outcomes by improving family functioning imply a focus on multiple family members, not just the mother. Anecdotal evidence suggests, however, that home visiting is provided primarily to mothers, either because the program model calls for a focus on the mother or because the program's implementation system impedes involving other family members in visits. (Duggan et al., 2004: 4)*

The failure to include fathers in home-visitation sessions neglects the role that fathers play in children's lives and development, which was demonstrated in the above review of the literature. It also demonstrates that a stable family environment is being conflated with a positive mothering experience.

One study which has taken fathers into account is the review of home-visitation conducted by Duggan et al. (2004). Their study explored the involvement of fathers in visits by paraprofessionals in the Health Start Program (HSP) for at-risk families. The HSP was developed in Hawaii and has been recommended as a best practice model for child abuse prevention by the US Advisory Board on Child Abuse and Neglect and Prevent Child Abuse America. The model combines hospital screening and assessment of all families of newborns and home-visiting of at-risk families. The selection of at-risk families is based on scores from Kempe's Family Stress Checklist (Kempe, 1976) of potential contributory factors in cases of child maltreatment. Families who received a score of 25 or more were invited to take part in the HSP's home-visitation program. Within the program, home visitors would:

> *establish a trusting relationship with parents using empathetic, non-judgemental listening and assisting parents to address existing crises. Once immediate crises are resolved, home visitors are to work to help families build on their strengths to improve family functioning. They are to role model problem-solving skills and help families access needed services. (Duggan et al, 2004: 6)*

The HSP framework is child-centred and not explicitly targeted to the needs of either parent, but appears to address both parents. The study interviewed 730 at-risk families once a year for three years; the impact of the programme was gauged using comparative quantitative analysis of each set of responses. In addition to evaluating the impact of the intervention on mothers, Duggan et al 's study explored the fathers' involvement in the HSP (and factors influencing their involvement) in the following areas: the father's role in parenting; the father's accessibility to their child; the father's engagement with parenting activities; the father's responsibility; the mother's satisfaction with the father's role; and the home visitors' perceived competence in meeting fathers' needs. A problem major with the study however, is that the information used to understand all of these areas of the fathering was gathered from the mothers, not the fathers themselves.

The findings were that fathers participated in home-visits significantly less than mothers. The average number of home visits per year was 13, of which fathers attended between two and four in the first year. Fathers who lived with or saw the mother frequently were more likely to attend than those who rarely saw the mother. Employment, alcoholism and physical abuse towards the mother all had negative impact on the level of participation in home visits by fathers. The researchers presented a number of explanations for the low participation by fathers:

> *First, fathers' decreased participation might have resulted from deliberate decisions on the part of the mother, the home visitor, or both to arrange visits at times and places where the father would be absent. Second, mother or home visitors might have scheduled visits at such times without consciously recognizing that they would exclude the father. Third, fathers might choose not to participate in home visiting. (Duggan et al, 2004: 14)*

The study found almost no evidence to suggest that involvement in the HSP had affected fathers' parenting. The accessibility and engagement of fathers appeared to have more of a correlation with whether the father was violent at the beginning of the home-visitation and whether the couple lived together or saw one another frequently than on the involvement of the HSP. The less violent the father the more he engaged and it was the dynamics of parents' relationship before the HSP intervened which influenced how and whether the fathers' parenting involvement developed. The researchers were undecided about the impact home-visits had. On the one hand they concluded that the home-visits had a positive impact in cases where both accessibility by non-violent fathers who saw their partners frequently and maternal satisfaction with the father's involvement had risen. On the other hand, they were less convinced of the positive impact in cases where the parenting involvement of violent fathers had increased but had not been accompanied by a decrease in violence.

It is important not to read too much into the results of this study concerning the value of home-visitation programmes in promoting positive fathering. The fact that the evidence was gathered using mothers' reports limits the usefulness of its findings as a measure of fathers' experiences. Given that the HSP was focussed on a particular sub-set of families who were judged at-risk to begin with its findings cannot easily be applied to families where these problems do not exist. The use of paraprofessionals could also influence the impact of home-visits on positive parenting outcomes. Findings from randomized controlled trials of different types of visitor suggest that paraprofessional home-visitors may have less impact than nurses (Olds et al, 2002).

In terms of building a picture of the interaction between fathers and home-visitation, existing evidence from the work of commentators such as Olds and Duggan are of limited use. Though each provides important information on the impact of home-visitation generally and on families at-risk of child abuse, they provide little on the nature of fatherhood, men's needs, and the nuances of the relationship between fathers and home-visitation programmes. The programmes and the evaluations of them were shaped

around the needs of mothers, paying little attention to fathers. The nature and outcomes of home-visitation for fathers is unclear.

## 2.5. Conclusion

A key issue for the evaluation is the degree to which the FNP programme and the orientation of the nurses themselves are actively inclusive of fathers. The effectiveness of the FNP is significantly influenced by the skill levels of the practitioners and the quality of the relationships developed. The motivation of the men to acknowledge their role as fathers, engage with the programme and change is also key. The nature of a parenting programme such as this and fidelity of the facilitators to it are crucial factors (Featherstone et al., 2007, p.107). It is not just the length or style of intervention but the quality of the relationship between facilitators and service users that is crucial to achieving good outcomes (Garfield, 2006). Yet the policy context is crucial. Fathers are at a significant structural from the outset because of how the FNP programme defines the mother as the 'client'. The survey of fathers and interviews with nurses and fathers will enable assessment of the extent to which the 'mother as client' policy is implemented and will critically analyse the extent to which the nurses actively involve men in their work, and whether, how and why fathers engage.

# 3. Research Design

The evaluation adopted a mixture of quantitative and qualitative methods. These were:

- A survey of the family nurses and fathers in FNP cases
- Interviews with family nurses and a sample of fathers

The collection of data from these different sources strengthened the reliability of the findings by enabling us to triangulate the data from the informants. For instance, we could compare nurses' perspectives with those of fathers and build up a picture of the dynamics and outcomes of engagement of fathers and families. The research adhered to strict ethical guidelines and the every step has been taken to preserve the anonymity of participants in this report.

## 3.1. Quantitative sources

### 3.1.1. Survey of FNP cases

To meet the aims of the evaluation we needed to gain a profile of the Nottingham FNP cases and the fathers and their families. We gathered systematic data from the family nurses about the number of fathers in their cases, their ethnicity, marital and employment status and the levels of engagement of the fathers with Family Nurses.

### 3.1.2. Survey of fathers

To meet the aim of providing information about the characteristics of fathers in FNP cases we designed a questionnaire and conducted a survey of the fathers. The rigour of the questionnaire was enhanced by it being piloted by the family nurses. It gathered data on the men's circumstances - accommodation, marital status, family background, education, whether in work - attitudes to becoming a father, their relationship with their partner, their experiences of the pregnancy, whether it was planned, the birth, and how fatherhood is working out for them. And it explored how involved they felt by the FNP and the impact of the programme on their fathering. Questionnaires were distributed to all the men using two approaches:

- By the Family Nurses who left the questionnaire for self-completion by the man. This was necessary because for the nurse to have assisted with the completion of questions which were evaluating the man's views on their interventions could potentially have biased the men's responses.
- In the sample of men who were interviewed and had not already filled in a questionnaire (some had and were recruited for the study by consenting on the form to be contacted), researchers went through the questionnaire with the men when they met them to do the interview.

Of the 144 active cases in the entire Nottingham FNP caseload, we established through interviews with the nurses that 30 fathers were deemed 'unreachable' or 'reachable but inappropriate for contact'. In some of these 30 unreachable cases the father's identity was not known to the FNP or, where it was known, he never had any involvement with the baby. In the other cases, where fathers were known to the programme, the main reason for not including them in the study was due to the risk to mother, largely from confirmed or possible domestic abuse. Some such men were living with their partner and baby and the women were seeking to remove the man from her life due to the danger he represented, while in other cases the mother was already living apart from the man. In such cases the Family Nurse had no contact with the father. To have sought to include such men in this evaluation (which was from a practical perspective possible) would have placed the mother (and potentially the baby) at risk and formally engaged with the man about his family for which he was not regarded as safe. A small number of fathers had

current mental health problems which the nurse deemed too severe to allow research contact. Due to the risk it would pose to the mother if we sought to include them in research these 30 fathers were not asked to complete a questionnaire nor approached for interview. This left a potential quantitative survey sample of 114 fathers.

In total, 54 out of the 114 questionnaires were returned – a 47% return rate. In surveys of this nature and with such a population this is a respectable return rate even though we might consider it disappointing. However, even this return rate was only secured after a great deal of effort; men were sent reminders and most important of all the nurses chivvied and encouraged the man to return the survey. This has produced a data set that is still large enough to provide a good profile of the fathers and their experiences of the FNP.

## 3.2. Qualitative sources

### 3.2.1. Nurse interviews

Semi-structured, face-to-face interviews were conducted with the eight family nurses to explore their perspectives on the FNP programme and working with fathers and families. The nurses were interviewed on two occasions, at the beginning of the study, and towards the end.

### 3.2.2. Father interviews

We interviewed 24 fathers. The interviews were face-to-face and semi-structured and most took place at the man's home. Each interviewee was given £20 to cover their time.

The ages of fathers interviewed ranged from 17 to 34-years-old. Seven interviewees were aged 19 or under. Fourteen fathers were under 21-years-old, eight aged 22-29 and two fathers were over 30. The most common ages for fathers interviewed were 17 years old (four fathers), 21 years old (four fathers), 20 years old (three fathers) and 24 years old (three fathers). The age-range of the mothers involved in the interview cases was lower than for the fathers. All the men's partners were between 16 and 20 years old, with nine of them aged 16 and 17 years. This age profile of mothers is to be expected in a service which is focused on first time teenage mothers. The difference in the age of the fathers supports the findings of other studies which indicate that fathers tend to be the older partner in young parent families. Of the 24 fathers interviewed, four were from BME backgrounds. The remainder were White or White British. Seven of those interviewed had Social Care involvement and in three cases the child was subject to a Child Protection plan.

Our interview sample was constructed so that the fathers selected for interview had different levels of engagement in the FNP, so that we could explore why these differences existed. We asked the FNs to rate the current engagement of the fathers with the FNP on a scale of 1 (no engagement) to 5 (very engaged). Fifteen of the fathers we interviewed were regarded by the FNs as above average in their level of engagement with the programme - six of who were given a top score 5 out of 5, five a 3 and three were given a 4. In terms of non-engagement, nine men were given a score of 2 or less for their engagement with the programme by the FNs, six of whom were given a score of one.

We also asked the FNs whether fathers' engagement with the FNP had increased or decreased over time. It had increased for 14 interviewees. Conversely, the level of involvement had decreased for four of those interviewed, while it had stayed low for four interviewees and stayed high for five interviewees. We also asked the FNs to rate the current engagement of the fathers with their child. Lack of engagement with the FNP did not automatically mean low involvement with children. According to the FNs 16 interviewees were highly involved with their child. Fathers who are very involved with the baby are more likely to also be very involved with the FNP. This is indicated by the fact

that, of the 16 interviewees who scored very highly for their involvement with the baby, 13 men were given a score of 3 or more for their involvement with the FNP.

At the outset of the study, 19 of the 24 fathers interviewed were still in a relationship with the baby's mother and in 17 cases the couple actually lived together. This changed as the study progressed, with at least one couple splitting up and one man re-entering the family having been released from prison. Fathers who lived with/were still in a relationship with the baby's mother were more likely to be scored highly for their involvement with the FNP by the FNs. Of the 19 interviewees still in a relationship with the baby's mother, 13 were given a score of 3 or more out of 5 for their involvement with the FNP. Only three of the interviewees still in a relationship with the baby's mother were given a score of 1 or less for their involvement with the FNP.

### 3.2.3. Recruitment of fathers for interviews

The 24 fathers we interviewed were recruited in two ways. From our initial survey of all FNP cases carried out with the nurses, we identified some men and asked the nurse to seek their consent to be interviewed. The second recruitment approach drew from men who consented to be contacted through completion of the questionnaire. We applied certain criteria to the selection of the sample. Gaining a big enough sample size in recruiting fathers for research can be a problem as men can be difficult to engage, but in this study quantity as such was not an issue. We turned down some men who nurses informed us had told them they agreed to be interviewed. This was because our aim was to have a sample that represented all the different types of fathers involved with the FNP, in terms of age, ethnicity, resident and non-resident and, crucially, on a continuum of those who were very engaged with the programme to those who were not. With the enthusiastic assistance of the nurses we were able to recruit a relatively large sub-sample of 15 men who were broadly cooperative with and well engaged with the FNP programme. We could have interviewed more fathers who fitted this profile but did not because we felt that at 15 we reached a saturation point where to interview more men from the same background and who had similar stories to tell would not have advanced our knowledge any further.

In the second half of the study period we put a lot of energy instead into recruiting men who were not thus far well represented in the interview sample: namely fathers who had limited or no involvement at all with the FNP. We had some success in this part of the recruitment drive, in that nine interviewed men were given a score of 2 or less for their engagement with the programme by the FNs. But where we had least success was in recruiting men who had minimal or no involvement. Most of these men simply would not agree to be interviewed and in most cases would not even permit us to contact them. This was in spite of a great deal of hard work by the nurses on our behalf, and with whose support we tried all possible avenues. The nurses gained permission from some mothers who were partners of these men for us to contact the mothers directly to see if we could speak to their partners. This resulted in some telephone conversations with mothers who were literally trying to persuade partners to come to the phone to speak to the researcher about a possible interview, but the men refused even to speak to us. Chasing these men, so to speak, was tantalising and deeply frustrating; mobile phone numbers would rapidly change, or be disconnected and phones unanswered. We sat with nurses as they tried ringing men or, more often, their partners as they had their numbers. One persuaded a father to speak to one of us. It was a Thursday late afternoon and the man agreed to do an interview the following Wednesday. But he wasn't there and could never be found and it turned out that in the short time between the telephone arrangement and the time of the planned interview he and his girlfriend and baby had moved to another city. It is no mere coincidence then that the modest success we did have in this area included the interviews conducted with two men who were in prison. As we discuss later, it is highly unlikely these men would have agreed to be interviewed were it not for the fact that they were incarcerated. The men did of

course consent to be interviewed for the study (and signed consent forms to that effect), but the tenor of their accounts made it clear their deep suspicion and particularly in one case sheer distaste not just for the FNP but for any state services that sought, as they saw it, to intrude into their private lives. This provided important insights into the lived experiences and state of mind of men who live – or try to survive - on the margins: their lack of basic trust and the vested interests they have in avoiding all contact with professionals.

Our failure to connect with many of these men was a reflection of that state of mind and their precarious, fluid, mobile lifestyles and mirrored the difficulties the nurses have in trying to pin them down and relate to them. What we experienced was of course of nothing compared to the challenges and frustrations of making contact that family nurses experience day in day out. But to have gone through this was an important finding for us and taught us a lot about the realities of the challenges involved in engaging some 'hard to reach' fathers.

We were interested in trying to produce an evaluation which included images of the fathers with their children. Previous research has shown that few positive images exist of vulnerable fathers with their children. Working class and black and minority ethnic men are often stigmatised and avoided by the public and health and social care professionals because of their appearance, especially if they have tattoos, skinhead haircuts and other markers that are defined and perceived as 'hard' (Ferguson and Hogan, 2004). We asked the fathers we interviewed if they would agree to be photographed with their child and several agreed and signed a form consenting to the images being used in the report and in training and publications. Several of the men had visible tattoos and we asked them what these meant to them. The general answer was expressed in some way as love for their child, as so many of the tattoos were of the names of their child or the date and time of birth, including clocks which depicted the exact time they were born. These men consented to us taking close-ups of these tattoos and we have reproduced them here (on the front cover) to try and assist a move beyond knee-jerk prejudice and show how they represented the excitement and pleasure of fatherhood and how these fathers have etched their love for their children onto their skin.

### 3.2.4. Analysis

The survey data was extensively analysed using SPSS. All the interviews were audio-taped and then transcribed. Interview transcripts were coded to enable a systematic analysis of the qualitative data. All profiles were stored securely as Word documents. As the researchers coding the interviews were also involved in the data collection, coding checks were carried out for reliability. This procedure helped to clarify the key themes and findings.

# 4. Family nurses' perspectives on their Role

We interviewed all the family nurses on a one-to-one basis on two occasions during the evaluation: at the beginning, in order to obtain information on their cases and to explore their perspectives on their roles; and towards the end of the project, when we also explored their experiences of men who were not engaged with the programme. In this chapter we consider the nurses' professional backgrounds, their understandings of FNP policy, and their attitudes and experiences of specific issues in engaging fathers in the programme. We provide quotes from the data obtained from the family nurses, and to preserve anonymity have not identified who made them.

## 4.1. The approach of the family nurses

The Family Nurses are all highly trained and qualified, coming from a range of healthcare backgrounds, with clinical experience as hospital midwives, community midwives, adult nurses, health visitors, and in one case a lecturer in Nursing. Between the nurses there is considerable local experience across different parts of the city, whilst some have wider work experience outside the city. A number have specifically chosen to work in some way with younger, vulnerable or homeless mothers in the past and joining the FNP was seen as a natural development of that. Consequently, the family nurses are a highly professionally qualified and experienced team. It is clear the nurses are dedicated to the job and the specific nature and needs of the clients. They experience a high level of job satisfaction, as is evidenced by two comments which typify the overall responses:

> *It's brilliant. I really enjoy it. It's everything I thought it would be and I look forward to going to work and I just like the fact that you've got this amazing relationship with your clients and it's a really satisfying job.*
>
> *It's the best job I've ever had.*

The FN role is understood by the nurses to be different in many ways to their previous posts. As a consequence, the nurses have to some extent had to define and redefine their roles and as a team collectively agree on the way to deliver the programme and interact with clients.

> *You've got a professional background and so you've got all the attributes of being a nurse and a midwife but you don't actually put those into play. I don't do any clinical stuff at all.*
>
> *They still have a midwife but they don't have a health visitor. So I do the health role and the new baby role as such – looking at the development of the baby which was very alien to me because I was a midwife and so I've had to learn that role. But my role is with the baby and the mental health of the mother.*
>
> *The training has been immense and you had to almost, not forget the way that you've always worked, but certainly put it aside and work very, very differently. And it's taken a while for all of us to kind of get that into our heads because if you've worked in the one way all your life then to actually work in a very different way, which this programme asks you to do, then it does take a while.*

It becomes clear just how complex the job is once the nurses begin to articulate their experiences of the various roles they have found themselves playing. The role does not just involve developing parenting skills but covers a range of issues, housing, health and education:

> *I deal with housing issues – I may go into a house and I may see the surface but actually I didn't know that they'd got no gas or electricity; they'd got no*

> *food. They might have the stuff for the baby but did they have anything else in the house? You ask the obvious questions about sterilisation of the baby's milk and stuff but that's all you get to know. But now they'll tell me that they've got no gas and they are living in one room upstairs.*
>
> *So I've got one girl who I had to take to the dentist, for example, and she was in a considerably appalling state which I won't go into for confidentiality reasons and I actually could feel this lump in my throat and I was feeling like a mum: 'look at the state that she's got into'. That feeling that she shouldn't be in this state; she's only twenty.*
>
> *One of the sixteen year olds I've got is very motivated and she's got lots of GCSEs but her partner is struggling and he's trying to do some joinery work and he was there one day and I said 'what are you doing here? I thought you were at college'. And he said it was really bad and so I spent quite a long time seeing what his problems were at college and seeing how they could be rectified and how he could help himself and trying to raise his self esteem.*

The role requires the nurses to make a contribution in several areas, in terms of family relationships and the need to help clients improve their lives:

> *Sometimes it's about relationships within families and sometimes they have bad times with the parents so just listening to them really and how can you support them.*
>
> *I think it's looking at the multiple factors impacting on teenage pregnancy and trying to change that cycle of deprivation, yes, ultimately for the baby but also for the parents. You need to do it very holistically and you need to engage them therapeutically because it's a mindset that needs to change.*

Working with teenage mothers is also seen by the nurses as being about promoting change that might disrupt the inter-generational transmission of deprivation and trauma and this causes nurses to consider how they can effectively impact on their service users' lifestyle choices.

> *So if you are going to address something that is maybe three or four generations long then you are going to have to do something that is long term and ultimately looking at not just behaviour change but almost the question of why do we do things the way that we do and have we got other choices?*

The programme adopts an 'empowerment' approach and the FNs are trained in Motivational Interviewing. This involved the FNs in learning to moving beyond a hierarchical medical model of the health professional as 'expert' and advisor, to one where the emphasis is on getting the service user to reflect upon the kinds of choices they make and to choose to make the changes themselves:

> *I think when we first started it was very difficult not to be a midwife because you'd been a midwifes for years and years and suddenly you are saying that you're not a midwife and if a pregnant women is saying she's got this pain or that pain then not to respond to her as a midwife. And it's really, really difficult to do because it's part of your being. A bit like we're asking the parents to change their behaviour and the way that they work so we have to do the same. So there is stuff like 'what do you think it might be and what do you think you might do about it?' Instead of giving her your answers and telling her what to do. So it's trying to get her to find the answers. So getting her empowered to problem-solve her own life rather than us giving her the answers. But it's so hard for midwifes to do that at first because they want to go in and rescue because that's how they've always worked.*

> *I just empower them so that they can go into that building and I will go with them first so they know they can do that. But before, as a midwife, I wouldn't do that.*

This emphasis on a holistic, therapeutic, relationship-based approach makes the work professionally and emotionally demanding, as well as satisfying:

> *It feels like you're a mother figure but you've got to be quite careful about how you manage that. So when we work with the psychologists, particularly with a couple of the girls, because you can actually feel quite overwhelmed with emotion when you are taking them to certain things.*

As this evaluation will show throughout, many of the families had significant personal and social problems. A common tension that came up in the interviews that occurs for nurses is when they have to use their professional judgement and refer families to Social Services and how this conflicts with creating a relationship of trust:

> *Yeah around trust and things and that might have been saveable but then actually referring her to Social Services put an end to that but I think it was the right decision to make. The main reason was there had been three injuries on a non mobile baby – a six month old baby – and for the most recent one the hospital didn't refer it and hummed and erred about it. But I thought about everything that I had seen and so I thought that it does need referring.*

## 4.2. Assumptions about gender, caring and fatherhood

Given that our focus in this study was on fathers, we explored with the nurses their assumptions about gender roles and caring, fathers and their needs**. A striking feature of the outlook of all the nurses was a belief that there are few, if any, essential differences between what fathers and mothers have to offer and are capable of providing for their children**.

The following quotes are typical of the responses:

> *The programme is for parenting predominantly and that is - you can be a good parent whether you're male or female. I can't say what defines a good dad; I suppose it's everybody's experience which is personal to you or them. My definition of a good dad, personally, might be a lot different from someone else.*

> *I think if you've got the father there, I think we deliver it equally and we're not just aiming at the mother but at both of them. I think, in this programme, we do dig quite deep and things are coming out that they've not been able to verbalise before. I'm thinking of a couple who have said that their fathers have been pretty crap and then asking them why did they say that and what have they learnt from that which will make them different as a father. And what makes a good father? We do an activity called 'The Different Hats of Parenthood' – talking about the nurturing role and the caring role; the educator. And you've both got equal partnership within those hats.*

> *I think both parents are capable of doing whatever they chose to do. I think a father is just as nurturing as the mother but it's a very different role and it's in a different way and I'm not stuck on the stereotyping that women stay at home and look after children and men work but I see, as a reality, that that still exists quite a bit and that women have an expectation of themselves that they can do everything and more. They expect that they have to look after their children and they expect that they have to keep the house and they expect that they probably have to get a job on top of all that and they see that as the norm. And many men, but not all, still feel that if they are doing*

*their job they can come back and have some quality time with their kids and that's what it is.*

This outlook of regarding both genders as equally capable of caring can be understood by placing it in the context of major changes in the nature of families and personal life. The 'traditional' family was based on the mother as homemaker and father as breadwinner/provider model. Having children was tied to marriage – which really did mean till death us do part - and births that did not happen within marriage were stigmatised as 'illegitimate'. That traditional order has dissolved since the 1970s and a revolution in how intimate relationships are lived has occurred. More children are born out of wedlock than in it. The women's movement and big increase in mothers' involvement in paid work has resulted in many fathers having to re-evaluate and redefine at least part of their role as carers. Relationships that do not bring satisfaction can be ended and many are. The 'post-traditional family' is a fluid entity which may change over time, as adult relationships end, new partners come in, some with children. The net result is what the sociologist Anthony Giddens (1992) calls the 'transformation of intimacy'. In family relationships, men and women are no longer crudely tied to traditional assumptions about gender roles, are required to negotiate about whether to live together, have children, stay together, who will mind the children, do housework, be the breadwinner, and so on. And as they get older their children also enter the negotiations. Giddens (1998) argues that this has given rise to what he calls the 'democratic family'. He does not mean by this that good negotiations and equality are practised in all families but that a key shift has occurred in the way personal life is lived. Relationships based on trust, openness, and negotiation cannot survive today without there being room for negotiation. Where negotiation is absent, the risk of domestic abuse increases.

Evidence that the FNP works with post-traditional families is not hard to find. As we show below, just 8% of the Nottingham fathers were currently married to the child's mother, while just 74% of the fathers lived with the child's mother, either all or part of the week.

The value base of the family nurses that holds that there are no essential differences between what fathers and mothers have to offer means that they in effect regard themselves as promoting equality and democracy in who does what in families. It suggests that in theory it makes no difference to them whether it is fathers or mothers who provide child care and who receive the FNP programme. But the reality is much more complex, as in many cases this value base does not translate into interventions that include work with fathers.

## 4.3. What is a (good) father?

We also asked the nurses what they regarded as being a 'good father?'.

*I don't know how to answer that really. I think, like mothers, there's a huge spectrum. I suppose you've got good fathers and good partners, don't you. So if you are talking about just being a good father I suppose it's meeting all of those needs for their child in whatever way. So meeting the basic need in that the child is safe and not put at risk; emotionally stable and has food and warmth and all the basic needs.*

The upside of a reluctance to see specific real differences between the mothers' and the fathers' role in parenting is that it avoids reinforcing outdated gender stereotypes and gives fathers a much better chance of being helped, and assisting mothers by them not being expected to be the sole responsible carer. The downside is that if can result in uncertainty about what should be expected of fathers, misunderstandings of masculinity and men and an avoidance or clouding of responses and advice to them.

A key issue that repeatedly surfaced in interviews with the nurses concerned men's emotional lives and responses to the birth and being a father. Two key areas to consider here are (a) the fathers' emotional responses and (b) their own male/fathering role models.

> *There is a part in the programme about 'how did you feel when you first found out about the pregnancy?' and most of them said that they were excited and looking forward to becoming a dad. So you get an insight into how they are feeling and we do leave the facilitators with them and I say to them it's a good idea to fill them in separately and then there's another facilitator to analyse what they've both put down and the girls are often surprised by what the lads put down.*
>
> *I think, in pregnancy, the value of it is shown in how this programme helps in their relationship and if you can get them to focus on their relationship during pregnancy that is important. I think we do that and it is quite evident in a lot of cases that they are thinking about that.*
>
> *The lad who was dealing drugs by the time he was twelve – he has said that the programme has helped him focus on the relationship. They argued a lot to start with but they've realised that their behaviour could be affecting their unborn child and so they are trying to modify their behaviour.*

The lack of positive male role models in many of the fathers' lives poses some dilemmas for the nurses, but does allow them to open up avenues for discussing alternative parenting strategies for dealing with their child and for building a stronger relationship with their partner.

> *Well I just think that if you can get the fathers involved in pregnancy it's quite an important window of opportunity really to discuss good role models. There is a section about what is a good role model and we will also discuss what their parenting role models were. Or if they don't want to discuss it you could say that there is a programme here which puts you in the direction of what good parenting is. And they are usually keen to take it on board – what a good role model of a father is.*

The prior lack of positive role models in the men's' lives provides opportunities to focus on alternative ways of being a father.

> *I think, in this programme, we do dig quite deep and things are coming out that they've not been able to verbalise before. I'm thinking of a couple who have said that their fathers have been pretty crap and then asking them why did they say that and what have they learnt from that which will make them different as a father. And what makes a good father?*
>
> *We do an activity called 'The Different Hats of Parenthood' – talking about the nurturing role and the caring role; the educator. And you've both got equal partnership within those hats. I think we give them the opportunity to understand the importance of their role.*

A small number of the fathers were in prison and were therefore limited in their contact with the child. (As we discuss elsewhere, we did go into prisons to interview two fathers.) There is evidence that even here there are positive signs of good fathering.

> *She takes the baby to see him and she tries to get to see him as much as she can. It was funny because I was visiting her last week and he rang while I was there and she got the phone to the baby's ear – and the baby is six months old – and she said 'say hello to daddy' and the baby was chattering away and you could hear him talking to the baby over the phone and so baby was squealing with delight, so he must recognise the voice. And every time she visits she does take him with her.*

## 4.4. Are fathers *really* FNP clients?

A key question we faced time and time again in this evaluation was just who is the FNP programme for; who is, or are, the client(s) of the FNP? The dominant response was that the mother is the FNP client, though at times nurses spoke of "the family".

> *[If the mother isn't there] I'd make another appointment when they were all there because the mother is my client and that's the start off point.*

> *I would think mostly mum because the mother is still our client and the mother is the one that you are having most discourse with and the one that you are having your visits with. The dad might be there at every visit, or at some visits but if he was there then I would give it to both of them and say that this is for them. But I would think that mostly it's the mum because she will mostly spend more time with the baby than the father and so will know most of these things. But with some couples they will certainly do it together and they will tell you the next time.*

However, there was a recognition by the nurses that this is not straightforward, as typified by the following:

> *I think it depends on which angle you are coming from because we write it up as the child's life record and so, in effect, the child becomes the client and it's about the development of children. But I think it's a little bit fuzzy and I think it might use some more definition.*

We completely agree. A key finding of this evaluation is that the programme needs to clarify its position regarding the role of fathers and how FNs should be expected to work with men. The nurses view was that "officially" the mother is the client, but as already shown, they had a commitment to working with fathers.

One dilemma this faces nurses with is how to respond to the father when the mother is absent from the visit. Although we were told this did not often happen, it raises very starkly the ambiguous role of the programme in supporting fathers and family, as currently configured in FNP policy.

> *I think mostly you would probably make another appointment. If it was me and he said that she'd had to go to the doctors with the baby or something like that then I would sit and chat to him for ten minutes and find out what was happening and if there had been any issues from the previous visit I might follow them up so I might say 'how did you get on at housing or such and such?' So I would have that kind of conversation with him but I possibly wouldn't deliver any of the programme to him.*

In some such cases the father himself would indicate that he assumed the visit would need to be rescheduled. This was sometimes re-enforced by the mothers, especially those who similarly regard child care as principally their responsibility. However, there were occasions where the absence of the mother was able to be turned into a positive encounter:

> *I would carry on with the visit as much as I could. I have done that before. If there is only the dad there I would carry on the visit because he is normally part of that child's life and he is doing exactly the same thing as the mother is doing and some of the stuff*

> *I can think of the last visit I did where she was actually in the house for five minutes but she had to go out for a driving lesson and she forgot to tell me. So I did all the normal health things with the baby like weighing the baby and I asked about his feeding and the dad could give me all that information. I asked about the sleeping and then we went on to the Family Nurse Partnership stuff and I did as much as I could but there were some forms that*

*had to have information about her that he didn't know like GCSEs etc. But the actual work and worksheet instead of leaving them for the dad I left them for the mum and I asked him to give her the gist of what we'd been talking about.*

Notwithstanding how some such opportunities are taken to engage positively with fathers and deliver the programme directly to them, there was further recognition of an underlying bias toward the mother and baby.

*We don't force ourselves on the lads as much as we force ourselves on the girls, if that makes sense. We don't insist that he's got to be there because he's part of that family unit and he should be involved because that's how families are built etc. The dad is on the sideline as far as the programme goes. In all the facilitators there is work for them but we don't put as much emphasis on the dads as we do on the mums – rightly or wrongly.*

*Some just don't want to be involved. I haven't asked him. I don't particularly make a point of it because I don't want the girl to feel that it's something that he should be doing. I don't want to put pressure on her or on him. But if he is there I will ask him what he thinks and sometimes he will give an opinion, but he'll soon back off into the kitchen again. He's a very shy lad and I don't know whether it's to do with that or not.*

There was recognition that not enough strategic effort is put into engaging with fathers from the outset, compared to mothers:

*I think you could get the lads signed up at the same time as the girls and you give them the same. You work round them and you encourage them more to be at visits – every visit and not just occasional ones – and you are more flexible. I take mums to the library but I don't take the dads. Why don't I take the dads? I don't know. Because I see the mum, as you say, as the primary carer and that's the one that I'm working with – rightly or wrongly. If there wasn't a mum around on that day then I would probably take the dad.*

The sources of this avoidance of fathers is not only systemic in the sense of FNP policy, but also is due to skill levels and what professionals feel comfortable doing, their 'personalities':

*Well, for example, if he's there and he obviously wants to keep out of the way a family nurse might not try to involve him. I suppose it depends on your personality as well and what your communication skills are like. Some might not feel able to go and say come and have a look at this. I probably would. But we haven't got a demand on us to involve the fathers.*

## 4.5. Failing to engage fathers

While we heard many positive stories about engaging fathers there were also many accounts of failures to engage. We analyse the different levels of engagement at various points in this report and here we shall deal mainly with the availability of the FNP to working fathers. One of the clear contradictions is how nurses helping to get a father into employment means that he cannot be as available to parent his child or potentially to avail of the programme. The following exchange shows this:

*FN: But that's ok. But if he said that he really wanted to be part of the visits so could I come at five o'clock then I would.*

*Interviewer: What if he said seven o'clock?*

*FN: No. You try and work around him as much as you can but ...*

There was recognition among the FNs that men are often forced to take second place by various professionals throughout the process of childbearing and child rearing.

> *That's where the family nurse comes in, I think, because we encompass the whole family. I think the dads get left out generally and they are very surprised when we involve them as well because they feel that it's all been centred around the mother and not around them and so they are surprised when they get us asking them questions about what they think. And they sometimes have problems in their own upbringing that they didn't realise or they've put aside.*

Other examples of what FNs said included:

> *Yeah. I mean what I could do is say when are you not at work and I'll come when they are both there. But it does tend to cut them out of the programme and there's no way around that unless we worked evenings but the programme is not prepared to let us do that.*
>
> *No, I don't think the flexibility is there to include that. I suppose if you wanted to involve the fathers more then maybe work evenings but do we want to be doing that? Is somebody going to be paying us unsocial hours? I don't know whether we have the time or the resources to include fathers more at weekends and evenings really.*

This restriction can be for some very good and acceptable reasons:

> *... because there is nobody really to liaise with to let them know that we are safe or whatever.*
>
> *we're flexible in the way that we can do later visits if they are necessary but you've got to have some kind of agreements really for safety – so who is going to track you if you go to do a seven o'clock visit in the Meadows? Who is going to know that you got out of there safely? So that is left for somebody else in the team who is off duty to do that. So there is the safety element.*
>
> *The nurses all work more hours than they should do but you've got to have some kind of boundaries and some kind of safety net. If we wanted to do a seven o'clock visit once a month or once every now and then we would not say no to it, but it would be how we could do that in a safe way?*

However, this is not just an issue for the FNP to resolve – as responsibilities are held more widely – for example with employers and training agencies.

> *And, as much as possible, you try and keep it nine to five for your own wellbeing and, I guess, it's not something that I thought about with dads but I've got one dad who is looking at apprenticeships and actually one of my clients herself is on an apprenticeship where she is working and she leaves the house at eight in the morning and doesn't get in until six in the evening. To be honest I'm only seeing her when she happens to have a day off because at six in the evening she is too tired. But one of the things that I have brought up is that, as part of the apprenticeship, could this be fitted in somewhere because it is a learning experience as well. So I don't know whether we could put forward a case for that.*

Working with men and understanding masculinities is not straightforward, yet we were told that the FNP has not provided any specific training on how to work with men and fathers.

> *No, not that I've come across yet anyway. We would broach it and we would discuss it in training. But I can't think of any formal training.*

## 4.6. Family nurses' strategies for engaging fathers

Whatever about the official FNP policy, in practice some nurses are very clear that they wish to promote the role of the father and feel 'passionate' about trying to include them:

> *Yes and why are they disengaged? We don't know if it's a relationship thing or if they are frightened? We don't know why they are disengaged because we don't get a chance to talk to them. If you were able to get involved with them - I've always had quite a passion about that and I've always included them in everything I do because they are part of that child's life and they need to be there.*

> *And those girls really need them. I mean the girl that I've just seen has got a partner who is quite involved in the baby's life but goes out at nine o'clock in the morning and comes back at half past nine at night and leaves this poor girl on her own and she's got one baby and is pregnant again.*

The levels of engagement with fathers is diverse, with some fully involved to the same extent as the mother, to at the other extreme cases in which the father is deliberately excluded for safety reasons. The nurses have developed a number of strategies for trying to engage fathers. We were given many examples of how nurses needed to be proactive in pulling the fathers more to the centre of encounters and engaging them more in FNP materials. This includes the team discussing the suitability of the Programme materials for fathers and how they present them:

> *And we actually had a conversation yesterday about giving the dads a folder so that it's theirs and they've got all their worksheets in one folder instead of mixing them up with the girls. So the dads have their own identity and if for some reason that relationship breaks down you can still include them because they can have their own folder and can be seen perhaps separately.*

Some of the fathers pose very difficult challenges for the nurses, coming as they do from troubled backgrounds, experiencing depression, substance misuse, poverty, unemployment, criminality and violence. The FNs are aware that they can have some impact through engaging these men in a positive relationship, sometimes for the first time in the man's life.

> *He was adopted at the age of six because his mother was alcoholic. She was in care for most of her childhood. They met and decided to get married within about six months of meeting each other and she got pregnant more or less straight away. They've both got huge issues and he's on medication for depression. He also has an alcohol problem which he is trying to rectify. But he's there at every visit and I would say that I've got the same relationship with both of them*

There was awareness among the FNs of how they can support men to feel they are important and valued and are making a contribution to raising their child and supporting the mother. This engagement needs to be sensitively handled:

> *I think sometimes they feel as if they are intruding as well. So he ran. I think if I'd done it another way and tried to encourage him to talk a bit then he might have got involved because he might have realised that it was something that he wanted. It's a bit like the ones who stay in the kitchen for a few weeks or months or even all the pregnancy and then suddenly they will come out when the baby's there and they'll listen.*

We came across much evidence that the nurses had some empathy with the men, providing positive reinforcement and encouragement to them in their role as fathers.

> *Because you are there to praise the mums but the dads almost need it more: they need a bit more encouragement and a lot of nurturing in themselves. But*

*I kept on and on involving him and asking him questions and his opinions and now he's great.*

*I was talking about singing nursery rhymes to the baby and they said they've never experienced that when they were younger and they felt embarrassed so I asked if they wanted to stand up and do the scarecrow song – no chance! So I said that I would stand up and do it and if I could do it then they could. So we all did the scarecrow song and they were laughing really but the baby was really loving it. It was a great visit actually and just from seeing how well the baby responded to the singing increased his confidence.*

*I think it was just the familiarity and the fact that I said that he was doing a good job. But I know that he is quite down a lot of the time and he's always quite thankful when he's engaged with the programme.*

There was also a recognition amongst the nurses that it is sometimes difficult to uncover the complexities in the fathers attitudes and relationships. Sometimes this means recognising the differential perspectives of the mother and father.

*Because he works full time. If I just took what [partner] said about him on face value I wouldn't think that he was very involved with his daughters but if I talk to him more broadly about his involvement then he does do quite a bit but just not as much as she would like. Because he works full time and he's providing financially. I have seen him interact with them but he does quickly pass them on to [mother] but I have seen him play with them and I've seen him undress them and I've seen him feed one of them. But her concern is that he often comes back from work and gets changed and goes out and doesn't really do anything at all for them. So it's partly about her feelings of being abandoned as well rather than he's not doing anything with his daughters.*

*Well they tend to walk out of the room; they tend to think that's women's business. So I will try to get them into the discussion and say 'there's a bit here for you – what do you think about that one?' Even if it's only one little question – like the lad who shouted at me down the road who said something about, I was asking the mum a question and he started to butt in and she said 'you don't have to answer it' and I said 'no let's have his point of view'. And it was something about how he'd been parented and his views and how it was going to affect his bringing up of his son. So any opportunity to get them involved.*

The broad role of the Family Nurse allows them at times to see their responsibility as supporting fathers (and of course mothers) to adopt a more inclusive family perspective on childrearing.

*I had a lad the other day and he was going to the dentist so I said that his daughter will have to go to the dentist one day so tell her what it's like. So just bringing them into the conversation so that they don't feel that they are on the outside. I don't think it's just the young lads but all dads probably feel a bit out of it around pregnancy and delivery because they are not the centre of attention, are they?*

*And I've one who when the man is there it's causing a bit of tension with the other female members of the family as well from the different generations. So I see my work as including them to bring relationships together and to support the family and to support the child in an inclusive way.*

This role offers possibilities for engaging with the families more broadly, and in ways that promote equality in relationships.

*One of the important things was the attachment between mother and child but as the job becomes more and more defined you realise that you were working with an extended family – dads and grandparents – and it's very much about the attachment processes within that family. So I was interested in supporting parents to get that as right as they could get it.*

*Anything from the fact that the girls are emotionally up and down due to the pregnancy and the guys can't cope with it because they don't understand it and so we might discuss that.*

*So I try to explain what is expected in an equal relationship. Sometimes the blokes really have no idea of what is expected in an equal relationship because they've never seen it either.*

*We do leave the facilitators with them and I say to them it's a good idea to fill them in separately and then there's another facilitator to analyse what they've both put down and the girls are often surprised by what the lads put down.*

Our findings suggest that a core outcome of the FNP programme when it did include fathers was to help men to progress along a developmental path to being good enough fathers, including practising equality in their relationship with their partner.

## 4.7. Conclusion

The findings support the analysis in **Chapter 1** of what is said about fathers in FNP policy in that fathers have a peculiar presence and at the same time an absence in FNP work. The nurses regard the mother as the client because this is their understanding of FNP policy. They are broadly committed to working with fathers and feel it has real benefits for children, partners and the men themselves. However, this leaves the Family Nurses struggling to fit men into the philosophy of the mother as main client. The Nurses generally try to work with fathers and sometimes do so very effectively. But they will also treat fathers as secondary carers and parents and at the same time regard their involvement as a 'bonus' rather than as a necessity. More worryingly, this tension leads the nurses to sometimes ignore fathers and just work with the mother. The dynamics of these engagements with fathers will be drawn out in further detail later in the report.

# 5. The characteristics of fathers in FNP cases

In this chapter we report on the results of the survey work which provides a profile of the characteristics of the fathers in FNP cases. Firstly, we consider the findings from a small-scale survey of the Family Nurses in which we gathered basic data about all their cases. Where necessary, figures have been rounded up to the nearest whole number so in some cases may not total 100%.

## 5.1. Introduction to the characteristics of the fathers

At the beginning of the project, the Nottingham Family Nurse Partnership (FNP) had a total of 152 cases on record. As the research progressed eight families were removed from the programme entirely because either the baby was taken into care, the family moved out of the area, or the family returned to health visiting. That left us an active sample of 144 families.

Information on the characteristics of all the 144 active FNP cases was gathered from the Family Nurses using case information grids completed by the Nurses in interviews with the researchers early on in the study. Basic data was gathered on:

- whether the man was the biological father;
- the father's ethnicity;
- the relationship status of the parents;
- father's employment/education/training status;
- the men's level of involvement with both the child and the FNP; and
- whether their involvement with the FNP had changed over time.

These findings provided us with the nurses' perspectives on basic characteristics for the total number of active FNP cases.

### 5.1.1. Paternity

The majority of men involved with the programme are the baby's biological father (91%). In 60% of cases the father and mother are still in a relationship and 44% of the men currently live with the baby's mother. One father was deceased, one father lived outside Nottingham and two fathers were in prison at the outset of the study.

### 5.1.2. Fathers' age

The age range of fathers involved with the FNP ranges from 17 to 37 years old with the majority in their late teens or early twenties. 86% of fathers were under the age of twenty-five and 38% were less than twenty years old, while 4% were over thirty when the research was conducted.

### 5.1.3. Fathers' ethnicity

The men are predominantly White British, with 17% of the total sample of 144 from Black or Minority Ethnic (BME) backgrounds.

### 5.1.4. Fathers employment status

Twenty-five per cent of fathers were in either full - or part-time employment. This was higher than the percentage out of employment (20%). 17% of fathers were not in employment, education or training at the time of study. Only 6% of fathers were involved in some form of training according to the Family Nurses, though this could be reflective of the fact that the majority of men were over school-leaving age.

The Family Nurses did not know the educational/employment status of 32% of fathers. In a small number of cases there was no father present or known about for the FN to ask about, but in the majority this information potentially was available. This findings reflects a pattern of the FNP not being proactive in gathering information about and some fathers, which in some cases also resulted in non-engagement with them.

### 5.1.5. Social care involvement

Of the 144 active FNP cases, 25% were or had been in contact with Social Care. The number of cases where there were Child Protection Plans was 8%. While this is an important indicator of the level of high risk in some of the more acute cases, many more cases involved families with high support needs who were not involved with Social Care.

### 5.1.6. Fathers' engagement

Family Nurses were asked to rank fathers on both their engagement with the child and with the FNP between 0 and 5, with five as the highest and were asked whether the level of engagement with the FNP had increased, decreased or stayed the same over the period of the FNP involvement. According to the nurses, fathers' levels of involvement with the baby were scored as:

- Very highly involved: 4-5 55%
- Reasonably involved: 3 15%
- Not really involved: 0-2 30%

And for engagement with the FNP:

- Very highly involved: 4-5 25%
- Reasonably involved: 3 13%
- Not really involved: 0-2 62%

It is very clear here that there are many more men considered to be engaged with the baby (70%) than are engaged with the FNP (38%) – in fact almost twice as many. Clearly, the programme is not accessing a significant number of fathers who are engaged with the baby.

The fathers' engagement with the FNP had also increased in a significant number of cases (28%). In 38% of the cases the level of engagement had stayed the same (though this could be high or low engagement) and in 19% it had decreased since the family had first become involved with the FNP.

> *Many of the fathers are not permanently resident with their partners and children and where the parents are not living together the fathers' level of engagement with the FNP is lowest (See Table 5.1). This compares with those who are living together who have a range of levels of engagement, but with a pattern of generally higher levels. This reflects in part how it is easier to engage a father if he is resident with the mother and child. However this seems also to reflect the fact that the FNP home visitation programme is focused on the home of the mother, who are considered the primary clients of the programme, so that when fathers are not present they are not pursued to their own homes. This is an issue of FNP policy that requires consideration at a strategic level and it will be returned to throughout this report.*

| Engagement with FNP | Living together? | |
|---|---|---|
| | No | Yes |
| **Low: 0-1** | 65% (30) | 30% (19) |
| **Medium: 2-3** | 15% (7) | 33% (21) |
| **High: 4-5** | 20% (9) | 37% (23) |
| **Total** | 100% (46) | 100% (63) |

**Table 5.1 – Level of Engagement with FNP and Living Arrangements**

One thing that became very clear to us in the research process was how well the Family Nurses knew the families on their case loads. This is not to say that they could know everything there is to know of course; the identities of some fathers were unknown to them, for instance. However, this data based on Family Nurses experiences and perceptions of their cases provided us with a reliable general picture of the characteristics of the fathers and their families and quite a robust indicator of levels of engagement by fathers. This data therefore provides a useful overall profile of the men, their families and FNP work.

## 5.2. Characteristics of fathers in the questionnaire sample

Having outlined the basics of the family nurses' perceptions and experiences of the fathers, we now begin to outline the findings from the survey we conducted of the fathers themselves. As discussed above, 30 fathers from the 144 FNP cases were not asked to complete a questionnaire nor approached for interview, which left a potential quantitative survey sample of 114 fathers. 54 out of the 114 questionnaires were returned – a 47% return rate.

The findings from the survey provide a reasonably robust profile of fathers involved in the FNP; however, some limitations to the data should be noted. The data is biased towards the fathers who are more engaged with the FNP. The more cooperative the fathers were with the FNP, the more likely they were to cooperate with the research. For the most part the fathers who did not engage with the FNP did not engage with the research either. The small number of exceptions to this included the two men in prison who were interviewed and completed questionnaires. This does not mean that the research tells us nothing about engagement strategies with reluctant fathers. Nine of the 24 fathers who were interviewed had relatively low levels of engagement with the programme. It is also crucial to remember that the fathers involved were engaged in the research at a point when the resistance that some had previously showed had been worked on by the nurse, with at least some success. Some of these previously reluctant men were still ambivalently attached to the FNP programme, while some were now fully engaging and securely attached. It is important to stress that some men engaged willingly with the programme from the outset of contact during pregnancy.

This data also provided us with a base for analysing the more in-depth information gathered during face-to-face interviews with fathers and Family Nurses.

### 5.2.1. Ethnicity

Of the men who completed questionnaires, 87% were White/White British, while 13% were from BME backgrounds. This means that questionnaires were completed by a smaller proportion of men from BME backgrounds than were in the entire 144 active cases (17%). The ratio of White/White British to BME respondents to questionnaires was significantly higher than the ratio of White/White British to BME men in the total active cases.

### 5.2.2. Age Range

The age range of the fathers in the survey was from 17 to 33 years old, with 61% aged 21 or less. Almost a third of respondents (30%) were teenage fathers aged 19 or less. 17% of respondents were over 25. The age range of the mothers in the questionnaire sample was 16 to 21 years old and narrower than that of the fathers, which is to be expected given that the FNP is targeted at teenage women (see Table 5.2). This finding is similar to other studies on teenage parents which found that fathers were usually older than their partners (Miller, 1997; Lane and Clay, 2000). It is clear there are a number of instances of older (and in a small number of cases significantly older) men with young women, but this is not a dominant pattern.

Respondents were also asked to provide the date of birth of their children. This could then be compared with the date the survey was completed to give the baby's age. Both the date of birth and the date of completion of the survey were provided by 39 respondents. All of the babies – whose ages were known - were less than 15 months old at the time of the survey. The majority of babies (80%) were one year old or less and over a quarter (28%) were 6 months old or less when the survey was completed. The remaining 20% were between 13 and 15 months old.

| | | **Age of Mother** | | | | | |
|---|---|---|---|---|---|---|---|
| **Age of Father** | | **16** | **17** | **18** | **19** | **20** | **21** |
| | **17** | 2 | 1 | 0 | | 1 | |
| | **18** | | 2 | | 1 | | |
| | **19** | | 2 | 3 | 3 | 1 | |
| | **20** | 1 | 1 | 3 | 1 | | |
| | **21** | 1 | 2 | 8 | 5 | 3 | |
| | **22** | | 1 | 2 | 1 | 1 | 1 |
| | **23** | | | | 1 | 2 | |
| | **24** | | | 1 | 1 | | 1 |
| | **25** | 2 | 1 | | | 1 | |
| | **26** | | | | 1 | 1 | |
| | **27** | | 1 | | 2 | | |
| | **28** | | | 1 | | | |
| | **30** | | | 1 | | | |
| | **31** | | | 1 | | | |
| | **34** | | 1 | | | | |

**Table 5.2 - Ages of mothers and fathers in the Nottingham FNP**

### 5.2.3. Accommodation

We inquired about the living arrangements of the family.

- 67% were living in permanent accommodation;
- 29% were in temporary accommodation;
- 4% were in crisis or emergency accommodation.

The majority of families (86%) live in rented accommodation – either from private landlords (43%) or through the local council or a Housing Association (43%).

There was considerable unease for some men about their living arrangements.

- 46% were really happy with their accommodation;
- 54% were less satisfied;
- 39% felt their accommodation was just OK;
- 15% were not happy at all.

Of those who are "not happy at all" the most common reason for their dissatisfaction was that the accommodation was too small for their family.

## 5.3. Fathers' relationships with their partners

In our survey, three-quarters of the fathers (74%) lived with the child's mother, either all or part of the week. A significant minority of fathers (24%) lived with one or both of the paternal grandparents. Two of the respondents were in prison when they completed the questionnaire, two were in foster care and one lived alone. Of those who did not live with the child's mother, 19% said that they intended to live together in the future while 4% said that they do not intend to.

In most of the 54 sample cases the man was the biological father of the child (85%). A minority had other children, though none lived with children from other relationships. Of those respondents with other children, the majority see these children at least once a fortnight. Only one respondent said that he sees his other children once a month. Two of the questionnaire respondents with other children have no contact with them.

Previous studies of fatherhood (Marsiglio et al. , 2000; Lamb, 1987) underline that the relationship between younger parents can have a significant effect on the level and nature of paternal involvement. As the FNP home visitation programme is shaped around the needs of the mother and child (Olds, 1986) and the mothers are the primary point of contact for the Family Nurses, the relationship between the mother and father can have a substantial effect on the fathers' experiences of the programme and indeed whether the men get the opportunity to experience it at all.

Similarly, whether the couple were originally planning to have a baby or not can have an impact on how the man initially felt about being a father. The questionnaire also included questions on the dynamics of the fathers' relationship with the mother, both before and after the pregnancy.

Just 4 (8%) of the fathers were currently married to the child's mother. When we asked about marriage in interviews with the men, some laughed reflecting perhaps a view that the question, like marriage itself, was rather old fashioned.

The nature of the relationship at the time of conception:

- 4% were married
- 46% were in a steady relationship
- 26% were cohabitating
- 11% were in a casual relationship
- 4% were not in a relationship with the baby's mother
- 2% were just friends
- 52% had been together for at least a year

In terms of how fathers felt the pregnancy had affected their relationship with the mother:

- 30% said it was just as good afterwards
- 28% said it brought them closer together
- 24% said it was more difficult but they stayed together
- 4% said it broke them up

Similar findings were revealed for the impact on the relationship of the presence of the baby:

- 33% said the relationship was just as good
- 2% said the relationship was just as bad
- 35% said the baby had brought them closer together
- 13% said it was more difficult but they stayed together
- 4% said it broke them up
- 2% said they broke up but got back together
- 2% had not yet had their baby

Given that in just 4% of cases the relationship broke during or because of the pregnancy it is clear that nearly all of these men had made a commitment to their partner and being a father. Importantly, there are those who felt that the relationship had become more difficult but the couple had stayed together – 24% during the pregnancy and 13% after the birth. Interviews with the fathers showed that several fathers found the support with their relationship given by the family nurse very valuable and a significant number of couples in struggling relationships were helped to become more stable.

An important finding from this survey and the interviews with the fathers is how much they valued the help the nurses gave with their relationship with their partner. Had it not been for this FNP support, relationship breakdown is very likely to have occurred in many more cases.

## 5.4. Getting Pregnant

For 57% of the fathers, the pregnancy had not been planned, and we inquired into their contraceptive behaviour at the time the pregnancy happened. Of those 57%:

- 48% were using contraception at least some of the time;
- 30% were not using contraception at all;
- 22% claimed the mother become pregnant when the contraception failed.

In terms of their current behaviour, 72% said that the couple were now using contraception at least some of the time, and 22% of fathers said that it was not themselves who were using contraception. This is also indicated by the fact that the most common form of contraception used was the combination pill.

Some 76% of the fathers said that they discovered their partner was pregnant as soon as she did the test. Though the pregnancy was unplanned for many of the fathers, 37% of respondents said that they were very happy when they heard the news. However, 17% were unsure or worried when they found out that they were going to be a father. Two of the fathers said that they were unhappy or did not want to be a father when they heard the mother was pregnant.

We need to treat this with some caution because the figures do not capture the men who did not complete questionnaires, many of who did not engage with the FNP. This means

that the actual number of fathers of children in FNP caseloads who did not want to be a father appears to have been higher because some of them were never involved in the pregnancy and some who were left before the birth or soon after.

## 5.5. Fathers' education, employment and criminal record

Existing research suggests that the education and employment status of fathers can have a significant impact on their relationship with their children. This problem is particularly acute for younger fathers. Evidence from research by Bunting and McAuley (2004) indicates that non-involvement by teenage fathers is often due to the fact that they perceive a barrier between them and their children. This perceived barrier can be rooted in feelings of financial inadequacy and uncertainty about the type of support they should or can provide.

In terms of levels of education, 35% of the fathers had no qualifications at all, while 28% of all respondents to the questionnaire had five or more GCSEs, and 19% had a higher education qualification (e.g. NVQs, B-Tech). On the other hand, few of the respondents (15%) were still in education or on a training course. Although evidence from the questionnaire provides information on the number of respondents with five or more GCSEs, a weakness is that it does not provide us information on the grades received. This is an important point as it means we do not have systematic data on whether the reported qualifications were of a high enough standard to provide entry to employment or training. We know that in some cases it did not, but because several men did not provide information on their grades we have no systematic evidence. From the interviews with the men we know that in many cases the GCSEs they had were either low grades or they did not even know what grades they got.

While the majority of the fathers were not in education, employment or training, a third (32%) of questionnaire respondents were in paid employment. As already pointed out, two fathers were in prison at the time of the study.

The main sources of income of the fathers were earnings from paid employment (30%) and Jobseekers' Allowance (28%). The majority of the men had very low incomes. Some fathers had no income at all due to their age and the fact they were living at home with their parents. The income data we gathered was for the family unit of mother, father and baby and so includes the mother's income, which was from benefits in the vast majority of cases. The largest proportion of fathers (40%) fell into the very low income bracket with a self-reported net weekly of between £100-150, while 37% of fathers were on a net weekly income of £150-£300. Interviews with the fathers showed that their lack of spending power routinely prevented them from buying their children (or partners) any presents or "little luxuries" and sometimes rendered them unable to buy their children even essential items forcing them to borrow and rely on family. This was a source of great regret and pain to them.

## 5.6. Fathers' family history

The survey gathered data on the men's family backgrounds and childhoods and paid particular attention to the men's relationship with their own father, whether they had any siblings and whether their siblings had children of their own. Previous research suggests that the attitudes and actions of a young father's family – particularly the paternal grandparents – can have a significant impact on their own experience of and attitude towards fatherhood. For example, in his study of teenage fatherhood amongst African-Americans, Miller (1997) describes how "the father's family of origin and his peer groups may explicitly indicate to him their respective expectations that he assume the role of father and that any behaviours counter to fulfilling that role will not be tolerated" (Miller, 1997: 63). This is supported by findings from the survey, with 48% of respondents stating that their own mother and 30% stating that their own father were really important influences on their own attitude to fatherhood and fathering. All of the men

surveyed had siblings, with 70% having stepbrothers or stepsisters. A significant proportion of our sample then grew up in reconstituted families. Just over half of the men's parents were still together (56%). In 69% where the men's parents' relationship had ended this occurred before they were ten years old. This compares with 25% whose parents' relationship broke down when the men were in their teens and 6% whose parents' relationship broke down when they were over the age of 20. Three men's fathers were deceased and one man's mother had died. 11% of respondents had been in care and one father was in foster care at the time of the study.

The highest proportion of men had at least two siblings – including stepbrothers/sisters – and a minority of the fathers had no stepsiblings (30%). The number of respondents whose siblings did not have children (46%) was only slightly lower than the percentage of respondents whose siblings had children (52%).

In terms of the men's relationship with their own father:

- 50% "We were very close"
- 30% "I got on with my father but were not too close"
- 2% (1) "We didn't get on very well"
- 8% (4) "I used to know my father but have no contact now"
- 10% (5) "I have never known my father".

Thus 80% of the fathers in the 54-case sample had reasonable relationships with their own fathers, and mostly positive ones. It is unfortunate that we were unable to find out more about the characteristics of the fathers who did not engage with the FNP. We hypothesise below from the interview data that the quality of father-son relationships for men who would not engage is poorer and that these difficult relationships were mirrored in the lack of trust and attachment of the men to services like the FNP.

However, there does seem to be a hint here that many of the men are not coming into fatherhood with very strong or positive images of fatherhood themselves and this would seem to be an important issue for the type of support they might need. We develop these findings on the nature of being a father in the next section.

## 5.7. Being a father

The questionnaire asked about the men's experiences of being a father and their relationship with the Family Nurse herself. The purpose of these questions was five-fold, to provide an understanding of:

- the men's knowledge of fatherhood before becoming a father;
- their previous knowledge of birth control and pregnancy;
- what the men actually do in caring for their child;
- the men's skill levels and confidence in their own capabilities as a father; and
- whether their and their partners' view of themselves as a father had changed over time.

As well as providing an insight into how the men view themselves, the responses to these questions also give an indication of the men's support needs.

The views on their own knowledge of pregnancy prior to the conception were very evenly distributed, with 25% for each of "very good", "adequate", "poor" and "very poor". This points to a broad lack of information and preparation for pregnancy for young men.

The men were asked to rate between one and ten their knowledge of being a parent when they left school. This was based on a study by Lowenthal and Lowenthal (1997)

which stated that the inclusion of good parenting classes in high school curricula could have a positive impact on adolescents' experiences of parenthood. Grouping the responses as Low (1-4), Average (5-7) and Good (7-10) gives a response set as:

- Low - 40%
- Average - 25%
- Good - 35%

This is an important finding. So many of the men became fathers soon after leaving school and this is an important indicator of the starting-points of the men when the FNP began working with them. Of course it raises questions about the role of schools in preparation for fatherhood – which was beyond our remit. However, this aspect was explored in another local project (Ayoola, Gates and Taylor, 2010)

## 5.8. The father's role

In an attempt to develop on from the previous section we wanted to look into what the men saw as important elements of fatherhood, so we asked them to rank between one and 10 the value they placed on activities such as: earning and providing; protecting the child from danger; feeding, soothing and changing; educating about right and wrong; playing; and doing housework. We grouped their scores with 0-2 as least valuable, 3-5 as fairly valuable, 6-8 as quite valuable and 9-10 as most valuable. The aspects of parenthood considered most valuable by the highest proportion of fathers were, in order:

- protecting (93%),
- educating about right and wrong (72%)
- earning and providing (65%).
- practical care tasks (feeding, soothing and changing) (56%)

For these fathers, their response differs slightly from the findings of Clay and Lane (2000) and Rhein et al. . (1997) in their studies of young parents, where fathers were found to be more likely to value providing financial support, protection and moral guidance than practical care. This is a quite interesting and possibly encouraging finding. The high number of fathers rating protecting and educating so highly could well be a positive outcome which reflects in part the impact of the FNP.

In attempting to measure the amount of direct care fathers provided to their children we followed the approach of O'Brien (2005) who assessed how involved a father was according to the number of times he engaged in particular practical care activities. This is regarded as a more reliable measure of activity than simply quantifying the amount of time spent doing child care and it also provides insights into how much of particular activities are done. Based on the understanding that a baby would need to be fed between six and eight times in a 24 hour cycle, O'Brien's study used the number of times respondents said they fed, changed, dressed or soothed their child as a means of giving a robust indication of how involved fathers were. Our questionnaire adapted this framework by asking respondents to provide a figure for how many times they engaged in practical care tasks with their baby. We regrouped responses so that a score of 0-2 was classed as not very engaged, 2-3 was classed as moderately engaged, 4-6 was classed as quite engaged and 6 or more was classed as very engaged.

The responses for the number of times men said they fed, changed, dressed, soothed and played with the baby on a typical day were:

- 23% fed the baby more than four times
- 47% change the baby more than four times
- 45% soothe the baby more than four times

- 77% feed the baby three or fewer times

At the other end of the scale:

- 53% change the baby less than three times
- 55% soothe the baby less than four times

This suggests that around half of the men in the survey sample were very engaged in providing direct care for their children. We show below that some men clearly attributed some of this level of activity and the quality of care they provided to FN involvement.

The issue of the extent to which the men take responsibility for child care was addressed by asking respondents how often they arranged and attended medical or other care related appointments with the baby ('always, sometimes, never'). Just two% of men said that they always took the baby to medical appointments alone, while 28% said they went sometimes on their own. Some 80% said that they attended appointments at least sometimes with their partner, and seven% said that they never attended the baby's medical appointments with their partners.

In addition, respondents were asked to estimate how much time in total they spent doing things with the baby on a typical day. Two thirds of men (63%) claimed they spent at least 5 hours a day doing things for and with the baby, compared with 11% who said they never do things with the baby. Respondents were also asked if the amount of time they spent with the baby had changed over the time the FNP had been visiting. Some 41% of men felt that they spent more time looking after the baby now compared to since the period immediately after the baby was born, 11% felt that they spent less and 35% felt they spent about the same. If the amount of looking after had changed, respondents were asked to give a reason for this. One of the reasons was that they now had a full-time job so had less time to spend looking after the baby. Overall, the increased engagement of 41% of the fathers has to be seen as encouraging. It may be down to their growing confidence at handling a newborn baby, but as we shall show, many men felt that the FNP had impacted positively on that.

Analysis of the relationship between arranging appointments, attending appointments and practical care tasks, shows some very interesting results. For example, of the men who said they only sometimes arranged medical appointments, 19% said that they fed the baby at least five times a day while 31% said that they fed the baby less than twice a day; 19% of those who sometimes arranged appointments said that they changed the baby at least seven times a day while 24% said that they changed the baby less than two times; 19% said that they soothed the baby at least nine times a day, while 13% said that they soothed the baby less than twice a day; and 56% said that they played with the baby at least nine times a day while 13% said that they played with the baby less than twice a day.

This might indicate that taking responsibility for arranging appointments might not be a particularity good indicator of father's involvement in practical care. When we talked to fathers, often there was an assumption – and agreement with the mother – that appointments were something either they did together, or that the mother took full responsibility for. This was possibly as an extension of a presumed caring role for mothers, but the data suggests a more complex picture, with one pattern being of roles, responsibilities and tasks being negotiated by fathers and mothers in some households.

The findings also suggest that there may be some justifiable reasons why fathers do not spend a lot of time with their children, fathers who work long hours being the obvious one. Another circumstantial factor concerns men who do not live with their partners and who because they are not present every night to take part in bathing and changing the baby for bed and are not there in the morning to feed and dress the child, are actually less able to provide regular practical care on a daily basis. The interviews with fathers

showed that men vary in this; some of the fathers who are living apart ensured that they were there in the evenings and mornings, while some others were less likely to do so.

Levels of engagement by fathers is related to the physical accessibility of the child. In what we call 'fractured' families, where the couple have split up and there is acrimony and sometimes court proceedings and social care involvement, in some cases the men are allowed none or very restricted access to their child. Where there is evidence of or high suspicion of domestic abuse or other violence this is of course justified. But as we show in the analysis of the qualitative data, this was not always the case.

While O'Brien (2005) has developed this model of time spent as a means of gauging father involvement, other research has questioned the link between positive fathering and the quantity of time fathers spend with their children (Cabrera et al. , 2000). It is important to emphasize that there is no evidence linking the amount of paternal involvement per se with desirable outcomes. For example, fathers who are better off financially spend less time with their children than do low-income fathers; however it is argued (Levy-Shiff and Israelashuili, 1988) that more affluent fathers may have more constructive and positive interactions with their children. Likewise, research has indicated (Russell, 1983; Elder et al., 1985) when fathers feel pressured involuntarily into child care or parental roles because of job loss while their partners maintain employment, children do not benefit and sometimes suffer because some such fathers parent harshly. In light of these factors it is important to use the findings on the amount of time fathers spend with the baby cautiously as they do not give a full picture of the quality of care provided and the dynamics of the father's relationship with the baby. Once again the interview data with the fathers and Family Nurses proved valuable in enabling us to interpret some of these issues for FNP cases.

Seen through the men's perception however, we can see a very positive stance on their own relationships.

*79% considered themselves to have a 'brilliant' relationship with their child*

*17% described their relationship with the baby as 'good'.*

*4% said that they had 'good days and bad days'*

We explored the men's assumptions and beliefs about gender and caring responsibilities by asking whether they believed there were any things one parent was better at or more suited to than the other. This is a tricky question – and responses might well reflect the difficulty many have (including many professionals) in defining what a "what a fathers is", as distinct from a mother. The fathers' responses were:

- 50% felt that both mothers and fathers had equal capabilities
- 48% believed there were things mothers could do that fathers couldn't
- 41% believed there were things fathers could do that mothers couldn't

Examples of specifically mothers' capabilities– apart from one dad who replied with the obvious "breastfeeding" - included emotional support for the baby and 'knowing what the baby wants'. The particular capabilities fathers' were regarded as having included, playing, roughhousing, football, taking risks. Where we followed this up in the the interviews with fathers some showed this to include a belief that men had more of a role in playing outside with children, but the difference in perceived gender roles here were rather minimal. Overall, the father's assumptions and values were broadly in favour of active parenting.

However, despite this view that mothers and fathers have equal parenting capabilities the extent to which this translated into engagement in all practical parenting tasks is questionable. Evidence from the questionnaire indicates that of those who view fathers and mothers' capabilities as the same only 36% feed the baby four or more times daily and only 36% soothe the baby four or more times daily. This compares with 60% who

feed the baby less than three times daily and 64% who soothe the baby less than three times daily.

The final aspects of 'being a father' explored how the men rated themselves (on a scale of 0-10) as fathers and what elements of fatherhood and fathering they felt they still needed to learn more about. We regrouped these somewhat crudely as 9-10 being a very good farther, 6-8 good and 0-5 ok or poor, which gave the following:

- 29% considered themselves as a very good father
- 44% saw themselves as a good father
- 10% saw themselves as an OK or poor father

Evidence from the questionnaire also suggests that attendance at Family Nurse's visits had an impact on how involved fathers were in practical care and how the men viewed themselves as fathers. This is explored further in the following section.

In terms of what elements of fatherhood and family life the men felt they still need to learn more about (see Table 5.3), physical child care skills was the area where most felt that they needed to learn 'a lot' more. At the same time, almost half those surveyed felt they had nothing to learn about this. The need to learn 'a bit' more was evident for quite high proportions of fathers in the areas of communication with the child, taking responsibility for child care, and supporting the mother. As we discuss later with respect to the impact of the FNP, a feeling that they had nothing to learn could be either because the FNP had a big impact and had taken the man as far as he needed to go in learning, or because the man felt he had learned all he needed already before the FNP got involved.

| | **I need to learn a lot more** | **I need to learn a bit more** | **nothing more to learn** |
|---|---|---|---|
| **Physical care** | 35% | 30% | 45% |
| **Communication** | 5% | 55% | 20% |
| **Responsibility** | 13% | 40% | 32% |
| **House work** | 13% | 17% | 52% |
| **Support mother** | 11% | 50% | 19% |
| **Relationship** | 11% | 41% | 28% |

**Table 5.3 – What fathers feel they still need to learn**

## 5.9. Experiences of the Family Nurse Partnership

The final section of the questionnaire looked into the men's experiences of the FNP: how involved the men felt they were in the Family Nurse visits, the impact of the Family Nurse visits on the men's fathering and the impact on their relationship with the baby's mother.

In terms of the attendance of fathers at visits by the Family Nurse:

- 26% were present all the time
- 32% were present most of the time

- 6% were there about half the time
- 13% were there less than half of the time.
- 23% were rarely or never there

This means that 74% of fathers were not present at all of the FN visits, which is a high threshold against which to evaluate levels of engagement. A positive finding is that some 58% of the fathers were present most or all of the time. On the other hand, 46% were present less than half the time and a full 23% were never there. One trend is clear: whereas 20% (8) gave no reason for not being there, 60% (23) said that they were absent due to being at work or education.

In addition to work and education preventing them from being there (and less significant due to the small numbers and individual idiosyncrasies):

- 2 fathers said that they don't want to attend Family Nurse appointments because they do not see any point in it as it is not what they should be doing.
- 2 did not live with the mother (in one case the mother was in foster care at the time of the study).
- 1 said that he wanted to be there but the Family Nurse doesn't involve him so he didn't see the point.
- 1 who attended Family Nurse visits less than half the time said that he would like to attend visits more but the baby's mother does not want him there.
- Another – who was rarely at the Family Nurse appointments, said he did not participate because he was "shy".

More worryingly perhaps, of those who were not able to attend the FNP programme due to work and training commitments, 75% actually lived with the mother and all considered themselves to be brilliant fathers. However when these fathers were asked to evaluate their own abilities as a father the picture is a little different. On a scale of 1 (poor) to 10 (Excellent):

- 28% judged themselves OK (5-6)
- 20% Judged themselves good (7-8)
- 52% judged themselves excellent (9-10)

There seems then to be a sizeable number of fathers who would seem to admit to themselves that although they feel brilliant fathers, they might still be in some need of support to develop as fathers. The interviews with a sub-sample of these men showed that generally they were critical of the FNP for not making efforts to include them by visiting at times that fitted with their work pattern.

The interviews with the fathers, the findings from which we discuss in detail later, are helpful in interpreting these findings. Most men, whether in work or out, felt that a role as the breadwinner and provider was a vital dimension of their being a "good father". Some were deeply conflicted about how this took them away from seeing a lot of their babies and caring for them. So, being a working man can be responsible for a father's self-assessment as being good or excellent and not working a reason for some regarding themselves as 'just ok'. Equally, some fathers who were working or in education/training rated themselves lower because they felt they needed to develop their knowledge and skills as fathers. **The findings show however that such men are not receiving this kind of help from the FNP and are not seen as a high priority for intervention.**

In terms of the impact of the Family Nurse on fathers' attendance at appointments, just 4% said that they would like to be at the appointments but the Family Nurse does not involve them. This sentiment was also expressed in response to the question of how involved the men felt during the Family Nurse visits. The majority of the men felt

involved or very involved in the Family Nurse visits, with 80% giving a score of 6-10 (10 representing completely involved). Just 6% gave a score of less than 3. However, the fact that 20% rated the extent to which the FN gets them involved at 5 or less is a significant proportion. Once again, these findings need to be seen in the context of the biased nature of this sample in that the findings reflect an over-representation of the more co-operative fathers in the 54 men in our survey sample. When we discuss later the views of men who did not feel involved, or who were not involved at all, we provide stronger evidence of the failures in engagement and some of the challenges of working with these men, especially those who are hard to reach.

We also explored the extent to which the men felt that the Family Nurses involved them as much as they did the baby's mother (0 indicating that they did not feel as involved at all compared to the mother and 10 as feeling as involved as the baby's mother). The fathers responded:

- 2% felt like they were not involved at all, giving a score of 0-2
- 18% felt modestly involved compared to the mother, giving a score of 3-5
- 29% felt well involved, giving a score of 6-8
- 51% felt fully involved as much as the baby's mother, giving a score of 9-10

The fact that 51% of fathers felt the nurse involved them as fully as the mother and another 29% felt well involved is a significant finding and must been seen in the context of a service that is strategically mother-centred and a sample of men who were broadly speaking cooperative. How best to interpret such findings – is it appropriate to describe this as the relative neglect of fathers, for instance? Much depends on one's starting point; if expectations of father involvement are low then 48% of men feeling as involved by the nurse as their partner is a good finding. However, if the starting point is an aspiration to treat fathers the same as mothers – as it is for the FNP staff team as articulated by the nurses - then this gap between aspiration and practice is problematic. We expand on this issues below.

Finally, this section asked whether the men felt that their fathering abilities had changed as a result of the Family Nurse visits and whether they felt their partners perceived their fathering capabilities differently as a result of the FNP. The respondents were asked to rank on a scale of 0-10 the impact of the Family Nurse on their:

- core parenting skills in practical terms (feeding, changing, getting up in the night),
- emotional and communicative skills (teaching the baby things, talking to the baby, taking the baby out)
- relationship with the baby's mother (their understanding of what support the mother needed and how the men could talk about their own feelings and needs)

The results were:

- 23% felt the programme had had a huge impact (9-10)
- 33% felt there was a medium to high impact (6-8).
- 27% of fathers felt it had a medium to low (3-5) impact.
- 6% felt the FNP programme had very little impact (1-2)
- 11% felt it had no impact at all (0)

A total of 56% of the fathers felt that their ability to be a father has changed very positively as a result of the family nurse visits, while a quarter believed it had a medium to low impact. Some 44% felt that it had little or no impact at all as a result of the programme. Clearly then, the FNP home-visitation programme has had little effect on the

fathering of some men. In some cases this was due to the service being seen as failing to meet the men's needs, or a dislike of the approach of the FN. But for others a more subtle interpretation is required. The division between those who believe the Family Nurse visits had a substantial impact on their fathering abilities and those who believe it had a low impact can in part be explained by the fact that some men claimed that they knew a lot about being a father before (through caring for relatives, for instance) and therefore the FNP added little to their abilities. This is evident in the considerable variation in what it was that the nurses had impacted upon. A significant proportion of fathers believed that the sessions had had no impact on some activities but did have an impact on others. Often a father would record a high impact for one activity (for instance, feeding), and a low or nil impact for another, (for instance, comforting the child). In terms of overall patterns:

- 21% rated the impact of the Family Nurse on feeding from 8-10, while 20% gave a score of 0.
- 20% rated the impact of the Family Nurse on holding from 8-10, while 31% gave a score of 0.
- 22% felt that the FNP Programme had had a significant impact on their relationship (giving a score of 8-10), 23% felt that the sessions had had no impact at all (score of 0).
- 39% of men felt that the Family Nurse programme had had a significant impact (scoring 8-10) on their understanding of what support the mother needs.

These findings help to show the extent of the positive impact of the FNP on men's fathering skills. But the extent to which the Family Nurse visits impacted upon the men's fathering is called into question by the relationship between the father's involvement in FNP visits and their involvement in parenting tasks. For example, 71% of respondents who said they attended Family Nurse visits at least sometimes said that they fed the baby less than three times a day and 49% who said that they attended visits at least sometimes said that they soothed the baby less than three times a day. This could suggest that the correlation between engagement in practical care tasks and attendance at Family Nurse visits is not a strong as it might be given that helping parents learn about practical care of their baby is part of the aims of the FNP. On the other hand, there is a strong correlation between how the men saw themselves as fathers and their attendance at Family Nurse visits. 67% of respondents who attend Family Nurse visits at least sometimes gave their fathering abilities a score of at least 8. Relatively low scores in some fathering activities may reflect the availability of the men and how the couple have negotiated child care roles and responsibilities.

The division between those who believed the Family Nurse visits had a substantial impact on their fathering abilities and those who believed it had a low impact can in part be explained by the fact that some men felt that they knew a lot about being a father before and therefore the FNP added little to their abilities. Perceived impact has to be seen in the context of the men's starting-points.

This dual interpretation for the low scores attributed to the perceived impact of the Family Nurse visits could also be used to explain the range of responses for the effect of the sessions on the men's relationship with the baby's mother, which shows a similar pattern:

- 21% claimed FNP had a huge effect (9-10);
- 26% claimed FNP had medium to high effect (6-8);
- 23% felt FNP had a low to medium effect (3-5);
- 6% FNP had a low effect (1-2);
- 24% felt FNP had no effect (0)

Overall, the FNP had a significant impact on men's relationship with their partners, a finding borne out by interviews. The largest difference here is those fathers who felt the Family Nurse has had no impact on their relationship. In these 11 cases, 8 had indicated that their relationship was as good or better as a result of the birth of the baby. Here "no effect" needs to be seen as a positive finding as there was no effect to make.

However, a significant proportion of men felt that the Family Nurse programme had had a significant impact on their understanding of what support the mother needs.

- 24% felt the programme had a huge impact (9-10);
- 35% felt the programme had medium to high impact (6-8);
- 30% felt the programme had a low to medium impact (3-5);
- 0% felt the programme had a low impact (1-2);
- 11% felt the FNP had no impact (0)

The perceived impact of the Family Nurse on how the men communicated their feelings was also quite mixed:

- 20% felt the FNP had a huge impact (9-10);
- 26% felt the FNP had medium to high impact (6-8);
- 26% felt the FNP had a low to medium impact (3-5);
- 15% felt the FNP had a low impact(1-2);
- 13% felt the FNP had no impact (0)

Some 50% of fathers felt that the baby's mother viewed their abilities as a father as being better as a result of the Family Nurse visits. The perceived impact of the Family Nurse on how the men communicated their feelings was also quite mixed, with 54% giving a low rating between 0 -5 and 46% giving a higher rating of 5-10. It can be seen as positive that almost half the men admitted they had been helped emotionally by the Family Nurse given the difficulty young men often have in exposing and communicating their feelings.

In addition, whilst only 53% of fathers felt that the baby's mother viewed their abilities as a father better as a result of the Family Nurse visits, more positively, 40% felt they were just the same. An issue here is the 7% (4 cases) who felt they were seen as worse as a father as a result of the Family Nurse.

Overall, the fathers who responded to the questionnaire were satisfied with the support they had been given by the Family Nurse, and on the whole they thought of themselves as "good dads". This was reflected in the final part of the questionnaire where the men were asked to rate their fathering abilities from 0 (Poor) -10 (Excellent). Here 46% of respondents gave their abilities a score of 8 or more and none of the respondents gave themselves a score less than 5. Though this is of course a subjective assessment, it does show that generally this sample of men involved with the FNP are now broadly confident in their fathering abilities and enjoy being a father.

## 5.10. Summary

We accept that this survey initially seemed a little daunting especially for the nurses who had to administer it to some of the fathers. However, our analysis has indicated how important it was to obtain this rich data from the set of fathers. We have been able to identify a number of key characteristics here which have complemented our qualitative data in interviews with the Family Nurses and parents.

# 6. The dynamics of engaging with fathers

## 6.1. Introduction

A key aim of this evaluation is provide for learning and development about how the FNP can effectively engage fathers. Engagement is a product of the interaction of the characteristics of the father – his temperament and openness to receiving support; the attitude and needs of the mother; the FN's approach and the perceived relevance and suitability of the FNP programme. Within the sample of 24 men we interviewed there were different patterns of engagement. As was pointed out earlier in the report, 15 of the interviewed fathers were well engaged with the FNP programme. But even within this sub-group there were different 'pathways' to full participation. Some men engaged with the FN and the programme straightaway and from a positive starting point the relationship grew and deepened over time. Some other fathers were much more suspicious, fearful, cynical and uncooperative at the outset and their participation in the programme only came with time and effort by themselves and the nurses. This includes some men who initially rejected the FN and only cooperated with the programme after another FN was introduced. A referral to social care by the original nurse was one reason why this rejection occurred. Nine of the 24 fathers interviewed either engaged in a minimal way with the programme, or not at all and the particular issues around these men are addressed in the second half of the chapter. To draw out the various dimensions of engagement and non-engagement of fathers with the FNP two levels of analysis are adopted in what follows: data on what the men said about outcomes of the programme for them – if and how it developed them as fathers; and what the findings show about the process of engagement and what it was about the men and/or how the FNP worked with them which secured their ultimate cooperation, or failed to.

## 6.2. Fully engaged fathers: How the FNP helped them and why they engaged

### 6.2.1. A passion for caring: the transformative effect of love and becoming a father

Men's levels of motivation to care for their babies is a crucial factor in whether they engage with professionals and in how approachable professionals perceive them to be. Becoming a father involves a developmental transition for men through which they experience intense emotions, face many new challenges and adjust to new responsibilities. A developmental transition involves a 'qualitative shift in perceptions of oneself and the world' and behavioural shifts that can be observed by others (Hawkins et al, 1995, p.43). Parenthood represents just such a developmental transition for men and women. Following Erikson's theory of psycho-social development, the primary developmental task of adulthood is learning to care for others (Erickson, 1963). Erickson labelled this process 'generativity'. Generativity, or care, is defined as an interest in establishing and guiding the next generation. For Erikson, nurturing one's off-spring is the primary focus of this energy, although generativity can also be achieved by investing in other productive, creative or altruistic endeavours that make the world a better place for the next generation to live in (Hawkins et al, 1995, p.44). Following Hawkins et al. (1995), we can see the importance of the awakening of generativity in FNP fathers' lives and the potentially crucial role of the FNP in enabling men to make a developmental transition to fatherhood that maximises their capacity to take on a definition of themselves as carers and perform it well.

A feature of the stories of men who engaged well with the FNP programme was how becoming a father and falling in love with their babies changed them.

> *I used to be a bit stupid when I was out. ... Getting into trouble. Used to be out with my mates and I used to drink when I used to go out sometimes, but I don't do any of that any more ... Once he was born I just didn't seem to do any of that any more, or want to do it anymore. I don't know what ... well it must have been him being born that changed it, but I just stopped. There's no other reason that I stopped apart from when he was born, it just didn't happen anymore, I just didn't want to go out and do that.*
>
> *(Father 18 years; child 7 months; ethnicity, WB)*

The men who became actively involved in child care had gained a clear view of their role and responsibilities.

> *I want to be there to buy him stuff. That is why I am doing a course so I can get a job. I wasn't really bothered but as soon as she got pregnant I decided I needed to sort myself out. I had no money coming in. You can't do that when you are on benefits. I would put myself a 9 [out of 10 as a father] because I play with him all the time. Play football. I'd be a bit too soft I suppose. I'd let him off when he did naughty things. I read books with him.*
>
> *I want to help him learn new stuff, playing, feed and bath him. Take him out. He always listens to me- might be because he is a boy. I let Laura have a lie in at weekends because she has had him all week. I used to smoke but I stopped when Laura got pregnant. I just want to live with Jake but at the moment I spend as much time as I can.*
>
> *(father 18 yr old, 15 month baby; ethnicity WB)*

Many men spoke of their confusion, feeling 'scared but excited' when they learned they were going to become fathers. Men's capacity to nurture and their motivation to become involved with their children increases significantly around the time of the birth. Like all parenting fathering involves a form of 'univocal reciprocity', a 'type of moral norm that encourages individuals to engage in social exchanges with others without expecting to receive direct or immediate reciprocation' (Marsiglio, 1995, p.83). Professionals need to capitalise on this emotional energy and help the man to channel it into active skilled care for his baby. The fact that the FNP programme engaged with some of the fathers during pregnancy was important in helping them to make the transition positively. Men commented on how they did not know what fatherhood would be like. One 20 year old father typifies the pattern of those men whom fatherhood had settled down. He was expelled from school, and subsequently spent three months in a young offenders institution for breaching his anti-social behaviour order. He says that he has changed, and noted the irony that now he is an adult local children today terrorize him as he used to others.

> *I was stupid before. When you have a kid, it hits you, tells you what is best. I'm so glad to be a dad instead of hanging out on street corners. It's changed my life.*
>
> *(20 yr old, child 11 months, WB)*

This father rates himself as eight or nine out of ten as a father, as he feels that to give himself a ten would be 'cocky'. "I feel like a good dad".

For one father of a 15 month old son there was regret that the child came too late to settle him down and keep him out of trouble. At the time of the interview he had been out of prison for just three weeks, having served a 16 month sentence for burglary, which began in the last two months of his partner's pregnancy. He was not allowed out to attend the birth. During the first 7 months of the pregnancy however, he attended all the scans. but he did not recollect any personal engagement with midwives or other professionals. 'Midwives, don't remember any. The scans, I was there, all times'.

> *I used to be a bad boy but because of my circumstances I'm not now. If I'd had him before I'd committed the offence it would not have happened. He would have been first and I would have wanted to be with him.*

Although he had only had sporadic contact with his son during the first 14 months of his life, he was now trying to commit to him:

> *Being a dad, I have built a good bond with him since I came out. I saw him once a week for 14 months when I was in prison, it was not enough but what could I do? As a father there's no better. I probably put myself an 8 [out of 10 as a father]. I come from a massive family so I am used to kids. It's a happy relationship. I'll feed him, change nappies, put him to bed. All that. [partner] has more of a bond because I was not here early on - he wasn't here to see me on a regular basis. But he is getting used to it now.*

As we will show later in the report, imprisoned fathers in this sample had markedly more fractured and difficult childhoods than non prison men, through experiencing domestic violence and their parent's relationship ending, their own fathers being in prison, poor educational attainment, poverty and unemployment. The father in the latter case felt that it was not too late for the baby to provide a new motivation for him to stay out of prison. Leaving prison had allowed the generative energy that had been released in him to find expression in direct care and commitment to his son and partner. This finding is supported by other studies of prison fathers for whom generative fathering becomes a key goal in their lives (Walker, 2010). Like all those cases where positive engagement of men occurred, the family nurse had begun to work with him to help him channel this motivation and achieve his goal of being a good father.

### 6.2.2. The totality of support by the FNP

A key message to come through from men with whom engagement by the FNP went well was that they felt they were helped in a holistic way. The intervention did not just cover developing the men's parenting skills but several areas of their lives. This holistic approach is exemplified by 'Shaun', a 19 year old Mixed White British Caribbean father of a 12 month old daughter who spoke very highly of the FN, who he feels gets him completely involved in her visits and just as involved as the mother. Shaun scored the FN a 10 out of 10 for the impact she has had on his knowledge and skills in feeing the baby, listening to the baby and weaning the baby, and an 8 for playing.

Shaun relayed to us a vivid example of how the Family Nurse advised them about the kinds of reading books with soft play surfaces to get for the baby and other soft toys. He saw no FN impact on developing his skills at holding the baby, getting up in the night, and teaching the baby things. This was because he felt he knew them already. He clearly has learned a great deal of practical things about child care and explained how he happily fills in the Family Nurse's worksheet exercises between visits. Shaun believes the FN has had a hugely positive impact (10 out of 10) on his relationship with his partner, helping them to resolve arguments and differences about many issues, including parenting styles. When asked about what it was about how the FN relates to him that was so effective he emphasized her reliability, how she always carries through on promises she makes - for instance, in helping him find possible college courses; how well she listens, and the generous amounts of time she gives them – often up to 2 hours on a visit. He said he really likes her. And he smiled when he said it.

Another good illustration of the totality of help the fully engaged fathers' felt they received is Kyle, a 20 year old White British father of an 11 month old son. Kyle spoke highly of the FN: "she makes sure we're ok". He rates her as "Really important, the main thing". Interestingly, the FN's perspective in the interview with us was that Kyle was not engaging well with her or the programme, that he seemed tentative, never spoke and was in and out of the room/house. Yet according to Kyle: "The Family Nurse is great with [child's name], weighing him, playing, and doing fun things like handprints". When she

is there, he says he stays in the room, and feels included in what goes on. "She talks to me, helps me out". She has shown him how to play with the baby, but he was less reliant on her for help with feeding and changing because he had experience with his friends and sibling's children.

> *She has helped when playing with and talking to the baby, showing us games and activities, like showing us how to encourage him to walk. … She has helped me understand that [partner] needs a break, and how to avoid post natal depression.*

While feeling helped with developing some parenting skills Kyle felt that in and of himself, "she has not really helped me". He regards himself as having more to learn:

> *I need to learn more about the washing and clothing of the baby, as at the moment [partner] does all of that, because if I wanted to take him on away for a few days, I'd need to know that.*

### 6.2.3. Learning the practical skills of child care

These brief portraits of Leon and Kyle with whom effective engagement with the FNP programme occurred, typify how this sub-sample of high engaging men were helped to gain knowledge and confidence around a myriad of parenting skills: holding the baby, feeding, bathing, communicating, soothing. The men often in effect reflected back to us aspects of the FNP programme as they had learned it.

Irrespective of their age at the time of the pregnancy, several of the men who engaged well with the FNP felt in some ways unprepared for the role of fatherhood. This is an important part of the context for why the work that was done with them during the pregnancy was so vital and had a significant impact.

> *Yeah it was kind of weird, obviously you've got this little baby and you're holding it, and you don't want to drop it, you don't want to drop her. Yes, she [Family Nurse] teaches about that yeah, before [baby's name] was born she brought a baby round, a fake baby, and she was telling us how to hold it and stuff like that, yeah. (18 yr old; child 7 months, WB)*

Regarding the specifics of what they learned from the family nurse, the following quotes were typical:

> *Just looking after [child] in general really. Knowing when she's ill, knowing the sad face, the happy face, the bored face, stuff like that really, it's been good. … She's told us that obviously they don't like, they can tell when you're angry by your voice, by your facial impressions, and she can tell when you're like trying to communicate happy with her by your facial impressions and the sound of your voice if you know what I mean.… she also let us know what sound is for what, I can't explain it, like sounds for the feelings, she's feeling, does that make sense? … sounds, like she would make a different kind of sound in how she's feeling, obviously besides the crying. When she's happy she makes like a high pitched voice, and chuckles to herself and that. (18 yr old; child 7 months, WB)*

> *The bathing and playing stuff was really good, I also feel I have a good idea how [daughter] is doing from day to day. … I never read bedtime stories, or did dad-kiddie things, I'm much better now. (31 yr old, child 13 months, WB)*

This last quoted father, Steve, is impressed by the speed of the FN's response when he asks for help and her willingness to assist them with a broad range of things:

> *I have texted [FN] and got a reply back the same day, to do with her formula feeding and things, it's really good to know that she's there. … [The FN] also*

> *helped us a lot when [partner's name] was pregnant, sorting out finances and telling us what we are entitled to, that was a massive help.*

Steve's relationship with and reliance on the FN surprised him as he has experience of rearing a child from a previous relationship. That baby was conceived shortly after his release from prison and was born when he was 17. Now 31, Steve is self-critical of his lack of involvement with that child's early life due to his own immaturity. His level of child care knowledge was really poor before he met his current partner, and has improved significantly through the pregnancy and during the first year of his youngest child's life. He attributes this to the help they have received from their own mothers, and gave "top marks" to the family nurse. Steve still rates himself as under-achieving, at a 6 out of 10 as a father, because he has not stuck at things to make their lives better.

> *I would give myself a couple more points if I had a job at the mo, but I sit here doing the nursery runs, so I think 6 is about right.*

Interestingly, Steve feels he learns a lot by watching and talking to his partner, as she shares the lessons she has learned from the family nurse.

> *I watch [partner] and I learn the things she knows, so I suppose it may help [partner] as she teaches me too, and that is supposed to be a good thing isn't it. … The thing is, you don't even realize what you have learned, only now do you think, "how did I know that?", and you realize it'd be from a chat with the family nurse. That is clever, it seems casual, but you are learning loads.*

This is an important finding in showing the way fathers do not simply learn from direct professional instruction, but acquire new skills and knowledge as a result of learning from their partners. On a home visit, the nurse could perceive such a man as a quiet, disengaged father and regard them as not participating and may be unaware of the level and amount of knowledge being imparted via the mother. This is an interesting dimension for the FNP to take into account as it provides a more realistic account of their impact on families like this. At the same time, as we this report shows, there can be no substitute for direct engagement with the man, as some sit their silently not taking in much or even anything, and some mothers are not good mentors. There are also fathers who are absent from visits due to work or not knowing about the visit, who are unhappy with having to try and pick things up from mothers and want more direct involvement from the FNP. As one working father put it,

> *As I said before I miss out on [FN] visits, but I do pick up on small bits when I get home, not everything.*

While the eagerness of some men to learn shines through, it is important to emphasize that the fathers were not passive, empty vessels into who the FNP programme was simply poured. Most had clear views about the areas they needed help with and those that they didn't. This does not of course mean that their self-assessments were always right. It is in the very nature of health and social care work sometimes for there to be differing views about what family members need. What it does point to is the importance in successful cases of engagement of a congruence being created between what the father needed and the nurse offered. The men felt listened to and the FNs respected what they did as well as what they did not know. As was shown in discussing the survey findings, and is evident in the above cited cases, some men felt that the FNP had no impact at all on some fathering skills because they did not need any help to develop them. Some broadly satisfied service users rejected those aspects they did not need or agree with and the FNs were able to accept this, except where there were concerns about risk and/or referral to social care, which we discuss later in the report.

### 6.2.4. Building confidence, acceptance and promoting a positive father identity

In a context where parenthood tended not to be planned and – as the survey findings also showed – most men entered the pregnancy with a low level of knowledge of

pregnancy and parenting, these fathers started out lacking confidence. How the FNP helped to build the men's confidence was a vital ingredient of what they liked about the service, and was not just specific to younger fathers.

> *She has said I'm doing really well, and that I'm a good dad lots of times. She is not judgmental, even when I talk about drinking …, she is dead good with us. (31 yr old; child 13 months, WB)*

> *She has helped me see the family unit really. To be here. She has helped me to talk to people and get things out. I used to get very stressed. But now I can talk to people about it. She helped me try to stop smoking. She got me into [support group], gave me a kick up the arse. (21; child 12 months; WB)*

> *She is really nice, I feel really comfortable talking to her, unlike doctors and that. I feel confident talking to her about personal or confidential stuff. (28 yr old; child 14 months, WB)*

> *This was not always the case for this last quoted father who remarked, 'I would not normally go out and get help, I would usually deal with it myself.' But he now feels that the FN has made it clear that she is there for him, as well as his partner. He classes the FN as his 'first port of call' if he has a problem.*

> *'I think she thinks I am a good dad, she always says it to [partner]' (28 year old, child 14 months, WB).*

### 6.2.5. Help with the men's relationship with their partner

Given that the majority of the men were new to pregnancy and some were very inexperienced with women, and certainly pregnant women, they really welcomed help with improving their knowledge and understanding of their partner's experience and needs. This was manifested in frequent mentions by the men of 'hormones'.

> *Oh yes, she [FN] was telling me obviously the mood swings [partner's name] got when she was pregnant, she was telling me to stick by her and that, and that obviously it's natural because they're all over the place at the minute when they're pregnant aren't they. (18 year old; child 7 months; WB)*

Not surprisingly, the pregnancy and having a baby placed strain on many relationships. Even where the men felt the relationship had flourished through the pregnancy and with the baby's presence, the fathers really valued the help they got from the FNs with their relationship with their partner and negotiating roles, clarifying differences and seeking agreement on parenting styles.

One working father, who was critical of the FNP for not doing more to involve him by visiting at times that fitted in with his work routine, felt that the highest area of impact the FN had had was in providing help with his relationship with his partner:

> *I'd say for that a 7 [out of 10], because it was a lot on how it would be before [baby] was born, and after [baby] was born, and then she did a lot of work on postnatal depression, coping you know together as a couple, and how we'd cope together looking after a child. She did a bit of work on that, I do give her that credit, she was pretty good with that, got some good leaflets and information on depression especially, because I was looking into that quite a bit, you know, because obviously I didn't want anything like that to happen with [partner]. (24 yr old; child 3 months, WB)*

One 31 year old father, who has prior experience of fathering his other children from a previous relationship, used the family nurse as a conduit for telling his teenage partner about his experiences and the advice he can give. The FN enables his views to be communicated in a safe way which avoids the couple arguing:

> *Because I have had kids before, I have a certain amount of knowledge about looking after them. But [partner] is only young, and I just want to help her out and tell her what she is doing wrong. Obviously this will cause problems in the house, because we would argue about it. … I can tell the family nurse I think something could be done differently, or ask her to focus on something for [partner's] benefit. It means I can offer or use my experience, but without putting [partner's] nose out of joint in the process.*

Although he says that most of the services provided are for his partner' benefit, the FN

> *'does make a difference. She gives me advice on stopping drinking, and looking for a job. … Even though I knew stuff before, from my last kids, I have forgotten so much. I used to think I knew it all, but I have been learning stuff from the family nurse all over again' (31 yr old; child 13 months, WB).*

This trust has developed even though social care have been involved and the family know that the FN is in regular contact with them about them.

### 6.2.6. Generous time given and a meaningful relationship

Viewed on their own, each of the areas covered above were significant contributory factors in assisting the men with their fathering. But it is in how these various dimensions combined that was truly powerful for the men. A striking thing was how the men conveyed a sense of being in a relationship with the nurse.

> *She is like a mother or a guidance person, it's a nice thing to have. She'll come up, weigh [child], check her over, have a chat and tell us what is going on at this stage in her life. (31 yr old; child 13 months, WB)*

> *She's kind of weird in a way, like she don't just cover that job, if you know what I mean, what she's meant to do, she kind of covers different things. I like her, I think she's a good person, but yeah she kind of covers everything. Like she helps me out, she helps [partner] out, obviously not like what she's not allowed to do, but I mean she helps, she just helps us out really. (18 yr old; child 7 months, WB)*

> *She's been really helpful in all sorts of ways. She does involve me. We look forward to her coming. (20 yr old; child 8 months; WB)*

The following portrait of a father we are calling Keith is representative of this totality of care by the FN, how it was valued and its impact.

Keith was 17 at the time of the interview. His girlfriend Mary (21) became pregnant two months after they started going out, it was unplanned. Their son James is 9 months. Keith officially lives with his own mother and Mary and James live in a rented house. They have future plans to live together when he is older. He has no income whatsoever, no benefits because of his age, and relies entirely on handouts from his mother. Mary's income (from benefits) supports their child. He feels guilt at not being able to buy anything for his son and is longing to change that. He has no formal qualifications, has never worked or gone to college. He dropped out of school at 14 and attended fitfully until leaving before he was 16. Very soon after he learned that he was to become a father. He has never worked. He had problems with anger and being verbally abusive at school (never physically, he says) and went on an anger management course which helped him greatly. Keith was scared when he heard of the pregnancy expecting fatherhood to be "really hard". It has turned out easier that he expected. This is largely because he loves it. Some bits are hard, but these concern how love and comfort cannot cure all, such as when he cannot find any way of relieving his son's distress from teething. He scored himself highly on every measure of father involvement. The only thing he won't/can't do is change soiled nappies; wet ones are okay but soiled one make

him wretch. This does not mean he never has the child on his own – he had him for a whole weekend once – but that he has to go through with all nappy changing and finds it very hard. His son is "my life". He gets huge pleasure from fatherhood and even from simply looking at his son for hours. Before becoming a father he spent much of his time out with his mates, and playing football. He has calmed and settled down now. He found it very hard at first and gave in to the feelings of wanting to be out and free. But he has learned to be responsible and what his priorities are. He says his partner finds it even harder than he does to have to stay home with the baby and sacrifice her social life. Her friends, some of who have babies, come round to the house. Keith's friends also come over and they get involved with the baby too. His own mother is very helpful with the baby and he is close to his father now, much more so than he was in the past. He intends to have a more active involvement with his son than his father did with him - to "be there for him" - because his dad was out of the house so much working. Keith is at Mary's everyday and spends several nights a week there. Keith was generally very positive about the Family Nurse and how she has helped him, from right through the pregnancy and since the birth. He is always there when she visits and feels that she gives him the same amount of time and attention as the child's mother. She always lets the Mary know when she is calling and never has direct prior contact with him. He thought it probably would be good if FNs made direct contact with fathers too. He gave vivid examples of how the FN has implemented the programme to help him, including leaving worksheets, which he says he reads/completes. During the pregnancy the nurse helped him a lot to develop a better routine, not to stay up so late and to be more organised, which prepared him well for fatherhood. He strongly valued the books the FN gave him to read during the pregnancy as he knew nothing about babies or parenting. He trusts the FN and put great emphasis on how much she has helped him to understand his partner (who has had some post natal depression), deal with his own feelings, helped them as a couple to communicate and work things out in their relationship and about how best to parent their son. He has learned a huge amount, having initially been frightened to even hold the baby as he was so small and vulnerable. He scored himself highly on his fathering abilities (8 out of 10), only failing to award himself a 10 because he doesn't live with his son all the time and so cannot do everything, and because "nobody's perfect".

## 6.3. Poor engagement: Fathers who were not included (enough) by FNP

There are men with whom the FNP is not involved, either because of the father's absence from the family and child care, or where the man is involved with his family but has made it clear that he does not want any involvement and actively avoids it. When FNs make genuine efforts to contact such men they cannot be criticized for their non-engagement of them because they are effectively shut out by the fathers and/or their partners. A lack of engagement with fathers is much more of a problem where the man is parenting his child and either wants to learn more about fathering, or opportunities exist or could be made to engage him, but the FN does not do this enough or at all. The sub-group of men we consider in this section had some low level involvement with the FNP. In some instances this low engagement was straightforwardly due to the fact that the FNs did not do enough to involve the father. This happened to some men who worked outside the home or who were in training or education and the FN did not visit when he was available on his time off or in the evenings. And it happened to some fathers who were available and sometimes actually around when the FN called but they were not included.

**A crucial finding here – and this was apparent in interviews with the nurses themselves - is that because the FNP programme regards the mother as the primary client, fathers are left out of service provision or provided with a limited service. This philosophy and approach particularly affected fathers who**

**were not resident (full-time) with their child and partner who were not seen by the FNP unless they happened to be around when the visit was made. In some cases, as was intimated in Chapter 4 and we show in this chapter, the reasons for low engagement of fathers were more complex, and a product of the interaction between the restricted policy and approach of the FNP, the father's understanding of and ambivalent attitude towards the service and the contribution of mothers, who invariably themselves had high needs.**

### 6.3.1. The mother as primary client and the neglect of the father

Although we have already shown in this report that the FNP is doing some very good work with fathers, we found significant evidence of fathers being marginalized by the FNP. The core structural reason for this, as the report has already shown, is that the FNP fundamentally regards the mother as the primary client, so it is with mothers that relationships are always formed. The FNs then have to fit fathers into the service/case, which is done with different degrees of enthusiasm. Several fathers in the study were quite clear that they regarded the service as being for the mother and that they as fathers were at worst ignored and at best treated as a secondary parent. Men experienced this who came from all age groups, ethnic backgrounds and it affected men who were working, in education or unemployed.

> *They should involve the father more and want to see them all the time, just like they do the mothers. (17 yr old; child 6 months; WB)*

> *[The nurse could] tell the fathers they were needed at the meetings, like when [nurse's name] encouraged me to stay in the house. Men need to be told that the nurses are there for them too. Blokes will not know this on their own. (33 yr old; child 4 months; WB)*

> *Try to get us [fathers] more involved with activities basically. Like I mentioned earlier about it, like an evening time appointment so I'm able to receive information and be there when the family nurse is there and be able to hear information myself, not off [my partner] and ask any questions I want to ask. Sometimes I say "[partner's name], oh when's the family nurse coming?" She says, "oh tomorrow", and I say well can you ask her this. I've said that a few times. (24 yr old; child 6 months; WB)*

This last quoted father, Paul, is devoted to his child.

> *Basically she's my life, she's everything to me, I would do anything I could to get what she needs… She's probably the most important thing to me in my life at the moment, as well as [partner], because it's created a family, we've started a family, it's our own family, and you look forward to seeing them every day, it's what's most important to you.*

Paul would like to be able to spend more time with his baby but accepted that he was the breadwinner and had little choice. He felt pained by the FNP's lack of inclusion of him. This even occurred on the rare occasions he was present during visits, during the pregnancy and in the six months since the baby was born. He rated the extent to which the FN included him compared to his partner as 'I would say about 5 [out of 10]'.

> *Most of the questions were based around [partner] and [child]. I just like took a back seat really, it was more like checking up on [child] and stuff, not much was about me as a father.*

Paul's strongly held view was that the FNP should be committed to visiting at times when working fathers can be present. Time-off in lieu of visiting beyond 5pm should be part of the organization's policies:

> *I'm not trying to dictate, but say like they have mornings off, like two mornings off a week, but then do two evenings instead. I don't know, it might*

> *work then. But then that way the fathers are there, you know they're home from work, and then they get, I can get to spend the time with the family nurse and [child], and be able to get involved with the work and everything, and all the information I need to know.*

The dynamics of how the marginalization of fathers occurs can be further appreciated through the experience of Lee, who is White British and was 18 at the time of interview. His partner Jane, now 17, became pregnant shortly after Lee left school. He became a father at 17 and their son, Alfie, is now 15 months old. He was 'scared' at first when the unplanned pregnancy was discovered, but soon committed himself to it and Jane and settled into looking forward to the birth. Lee could not be sure exactly how the FN was assigned in the first place, but he recalls her early involvement.

> *She came round when [Alfie] was born and talked with [Jane] really. I was there. She was talking about how to handle him. Telling us how to understand the faces he did, how to feed him, I was listening but don't think I was involved a lot. She was actually quite good when he was first born but now he is older she has hardly seen [Jane] and I have hardly been there because I am in training. I was just wanting to play with him [laughs].*

Lee spoke of how the pregnancy changed him and how during the pregnancy he became highly motivated to be an involved father:

> *I want to be there to buy him stuff. That is why I am doing a course so I can get a job. I wasn't really bothered but as soon as she got pregnant I decided I needed to sort myself out. I had no money coming in. You can't do that when you are on benefits. I would put myself a 9 [out of 10 as a father] because I play with him all the time. Play football. I'd be a bit too soft I suppose. I'd let him off when he did naughty things. I read books with him.*
>
> *I want to help him learn new stuff, playing, feed and bath him. Take him out. He always listens to me - might be because he is a boy. I let [Jane] have a lie in at weekends because she has had him all week. I used to smoke but I stopped when [Jane] got pregnant. I just want to live with [Alfie] but at the moment I spend as much time as I can.*

Here we have a classic statement from this father of what in this report we are characterizing as the awakening of men's 'generativity', an energy, drive, capacity to care for the next generation that is released in pregnancy and after birth. It is crucial that health and social care professionals recognize the developmental changes men can go through in this transition to fatherhood and do all they can to connect into the man's generative energies to help him develop an identity as an active father and acquire the knowledge, skills and application to perform it well. It is in the gap between the awakening of men's generativity and the absence of proactive involvement by the FNP that the failure to properly engage motivated fathers arises and is exposed.

This awakening can also be seen in Lee's account of his response at the birth.

> *When the baby came out I was holding my tears in because her mum was there and I didn't want them to see. I was so proud that I'd made a baby. I was a bit worried at first, and didn't know what to do. How to change a nappy. They told me at the hospital when I went to visit after [Alfie] was born.*

Here Lee exemplifies the depths of the emotions he experienced on becoming a father and the fear of showing tears and feelings that some younger men in particular in our study expressed. This is juxtaposed with his deep feelings of pride at 'making a baby' and his lack of knowledge of how to handle the child or what to do with it. The couple were living apart, each with relatives due to their young ages and lack of money. In part, Lee was relatively ignored by the FN because he was not always present on visits due to

them living apart and him doing a training course. He finds his absences from his child difficult to cope with: 'I do struggle with not being there at night times'. But even when he was present on FNP visits he felt that the service was not meant for him, but the mother.

> *When she makes appointments she always calls [Jane]. She never rings me. Sometimes she comes when I am training. I don't know why. When I finish training I am knackered. I have only been there a couple of times when she was at my house. I have never gone to [my partner's] house when FN is there. Obviously [Jane] has lots of paperwork and I'll just be sitting there listening to them. The FN is for her really she has given me a couple of pieces of paper asking what he has done and what I'd rate myself as a father.*

The pattern of appointments and visits that would best enable Lee's presence and involvement appears not to have been negotiated with him by the FN. Lee takes some responsibility for not being more proactive in trying to get the FN to recognize him as a father and represent what needs he had for support. But as a young man only recently out of school, he did not know how to ask for help and felt awkward about doing so:

> *I think I was embarrassed really because I didn't really know anything and was learning all the stuff. I don't think she helped me get over being embarrassed, I can't remember. She was more focussed on [Jane]. She didn't involve me a lot. I guess I could involve myself more saying can I do this but I am actually embarrassed to butt in. If he [Alfie] was born now I'd be a bit more pushy. I don't think I was bothered because I was young.*

Lee is reflective here, identifying the challenges he faced as a young man struggling to find a voice and a way into what he experienced as women's world of baby care. He identifies how he has since grown in skill and confidence as a father, but does not regard this as being due to the FNP programme. However, not all the responsibility for this lack of engagement can be placed on the FNP. According to Lee, his partner did not always see the FNP programme as one in which they should jointly engage.

> *[Jane] didn't actually ask me if I wanted to be there so I didn't bring it up because it is more for girls, like the woman involves her more than they involve me. She gives her loads of paperwork to do and I don't get none. I don't know what it's for. We have no other professionals involved now or ever.*

Because, with rare exceptions, the children live with mothers and some fathers are non-resident, and because, whatever the living arrangements, FNs tend to communicate through the mother rather than directly with fathers to set up appointments and remind them of them, this gives mothers significant influence as gatekeepers to the service for men. Lee implies that Jane was prone to keeping the nurse to herself and that in any event they did not communicate as a couple about what his place and role in FN sessions should be. As we have already shown, for some other men in our interview sample, the FN was highly valued because she helped the couple to communicate and negotiate mutual understandings of feelings and roles. But this does not seem to have happened in Lee's case. The comment 'it is more for girls' seems to suggest that his own concept of gender and parenting roles supports his father-absence from full responsibility for child care and for involvement with the FNP. But this gendered assumption is also a reflection of the reality of what he has experienced in the 15 months since he became a father, that services are 'more for girls, like the [FN] involve her more than they involve me'. It is the responsibility of health and social care professionals to explain to fathers (and mothers) who the service is for and to demonstrate father inclusion through deeds.

The absence of good engagement practice in Lee's and some other cases went beyond the FNP and was part a wider systemic failure to effectively include fathers right from the start. As Lee explains:

*When he was first born [Jane] was taking a shower in the hospital and he was crying and I didn't know what to do so I said [to a nurse] can you help me and she just took him off me and fed him. She didn't involve me. She could have told me before he was born what to do I didn't get any help with anybody at all. At school [Jane] went to [educational institution for pregnant mothers] and got loads of support but me I got nothing. I always got a welcome at [Jane's school]. It's all girls but most of the dads have left them on their own. That is basically all the help I have had.*

### 6.3.2. Minimal engagement as a co-creation of different factors

The case study of Lee illustrates how so far as the father was concerned, and the mother to some extent too, the FN was not proactive enough in involving or developing him as a father, despite his desire to be as good a one as possible. But in several cases of low or non-engagement we found that other factors were also present which produces limited engagement. In such instances there is no simple linear cause and effect relationship that explains limited FNP involvement, such as Good Dad/Bad Nurse. What blocks engagement in particular situations is often a combination of factors:

- The father's level of receptiveness to help
- The (awkward) signals he gives out are perceived as lack of interest or avoidance
- The FN has low expectations of the man and limited understanding of how masculinity is experienced and performed, for instance in how he may be embarrassed at showing feelings, needing help
- He may be confused about the FN's role and lack information about and understanding of the service
- The high support needs of the mother draws the FNs attention away from the father
- The man is regarded as an acceptable father, but is excluded by the FN because he is seen as a risk or irritant to the mother, endangering her capacity to parent well enough
- Because the FN does not communicate directly with the father it is the mother who knows when the FN is visiting and is the family gate-keeper to the service
- The mother keeps the FN to herself and does not want the father involved, and/or does not fully understand that the FNP is for fathers as well as mothers
- Lack of clarity in the FNP programme and organisational policy about working with fathers, which leaves FNs uncertain about their responsibilities to be proactive with men.

A case that illustrates well the complex interactions between these variables is that of Mike who was 21 when interviewed. Mike lived with his 19 year old girlfriend, 'Rose' and their 7 month old baby. Mike is Black British and Rose is white British. They have been together for about 4 years. Both partners were present during the research interview, in which they identified a lack of engagement of Mike by the FNP:

*Mike: We were referred by our midwife. It was about 4 months into the pregnancy. It is really for... I don't know- just to try and help us out I suppose. I am at work most of the times she comes – I am only there for about 1 in every 4 [FN visits] really. She has come in an evening but not much. So I don't see her much. I would like to be here more but it is sometimes nice to come home and relax after work and not spend an hour with a nurse. I do want to be here more often because I miss out on what she tells us. She always contacts [Rose] to arrange visits.*

*Rose: I never really say we needed [Mike] there. I didn't know I could do that. Because I thought it was all for mums really. When he has been here he has just sat there.*

*Mike: Even when I am here she [FN] doesn't really bring me in. She aims the questions at Rose not me. I feel like I am sat here and am nothing to do with it really. It is all about Rose and the baby. A lot of the sheets are about mother and baby. There is the odd sheet I have to fill out but the majority ain't. She leaves me things to do but I don't always do them, some I think are a bit too personal.*

*Rose: Like some are about what I eat in the day or when I smoke and I don't want to go out and in the middle of [place] and pull a sheet out when I am having a fag.*

Here we have a father who feels marginalised by the FNP because they visit when he cannot be there and ignore him when he is. Mike claims to want to be involved, but would like it to happen at a time when he isn't feeling tired. If it is true that the FN is not including him in the sessions when he is present then clearly primary responsibility for excluding him lies with the FNP. Yet he has some responsibility for the situation too in how uncomfortable he is with how 'personal' some of the programme is, resists opening himself up and seems unmotivated to work hard at it. In addition, his partner has contributed to the situation in that she claims not to have known the service is for fathers too, so she hasn't included him or challenged the FN to do so. This shows the importance of FNs informing mothers that the programme is for fathers too, but again reveals the tensions that arise from the mother being the primary FNP client. Given that the mothers will have been told that the service is primarily for them, it is little wonder that some interpret this as it meaning only for them, especially if the FN demonstrates this in practice by not actively including the father.

### 6.3.3. The FNP's safeguarding children role and (not) working with fathers

The complexities of FNP work are more evident still when issues of risk and the complex needs that some families have are considered. As was shown in chapter 5, some fathers in the total sample of FNP cases were deliberately not worked with by the FN because of the degree of risk they were thought to represent to the child and mother. It was not ethically appropriate to include any of these men in the evaluation, because seeking to engage with them would have required the FN to negotiate our access to them, which would have placed the FN at risk by being brought into contact with them and it would have legitimized the man's role in the family in a manner which was regarded by the FN as unsafe for his partner and child. This does not mean that no fathers who were a cause for concern were included in the evaluation. Seven of the fathers who were interviewed for the evaluation had Social Care involvement and in three cases the child was subject to a Child Protection Plan. The aim of this section is not to deal with the FNP's safeguarding role and the involvement of fathers in its entirety, but to consider some aspects of such fathers not being (fully) engaged with by the FNP. Other aspects of fathers and safeguarding are included in other sections of the report.

In triangulating the data from what fathers, mothers and FNs told us in research interviews there was often consensus where fathers who felt positive about the FNP and how it had helped them had FNs who had similarly positive views about those fathers and how constructively they had used the programme. But in some situations there were differences in perspective between FNs and family members. This occurred in some of the sample cases where there were concerns for the safety and welfare of the children. Fathers constitute risks and/or are a resource in caring for their children and for their partner (Featherstone, 2009). One core tension to emerge here is that a father who is viewed as caring adequately for his child can be viewed with suspicion and deliberately

not fully included by the FNP. This is due to the risk he represents to the mother, diminishing her capacity to care well enough for the child.

Raymond is 19 and his partner, Gloria, is 20. Their baby daughter, Samantha is 5 months old and was not planned.. They live in a social housing property. They had spoken about having children but had not wanted one at that time. They get about £210 a week in benefits, most of which goes on bills. They manage by making sure Samantha's needs come first. They are finding it very stressful trying to make ends meet. Raymond is unemployed and has few qualifications, but is beginning to take up voluntary work in order to get some experience to be better placed to get a job. Raymond did not have a stable father figure in his early years, and was raised by his mother.

Raymond found out about the pregnancy when he was 18 and still at college based in another city. 'I wanted to be with [Gloria] and didn't want to miss any of the pregnancy. So I left.' This has left him more vulnerable to not getting paid work.

> *I was very heavily involved when she was pregnant. I made sure she didn't do too much by doing as much as I could. I went to all the scans. I was there sitting next to [her] reassuring her.*

After the birth Raymond found it hard at first getting up every 3-4 hours but it got easier as his daughter got older and more settled and was going longer between feeds. The professionals Raymond encountered did not involve him much.

> *They were mainly focussed on [Gloria]. [The Family Nurse] was one of the only ones that got involved with me. [The other professionals] involved me very little. I didn't know how involved I was going to get. I was disappointed in some way as I was not as involved as I wanted to be. I just wanted a bit more guidance of what to do.*

Raymond picked up most of what he knows from some of his mum's friends or just picked it up for himself:

> *I learned myself really by just figuring out what to do. [Gloria] has helped me. Like how to hold her. I have big hands and she is so small. I didn't want to hurt her. And burping her, rubbing her back, I didn't want to hit her too hard. It has turned out brilliant and brought us closer together.*

Raymond says he does a lot for and with his daughter, and in the interview both parents agreed they share the roles: "we both help, it is a joint work". Whilst he loves Samantha and doesn't regret having her, he would not recommend it at such a young age and without the qualifications to get work and provide. Raymond and Gloria say he shares the childcare with her and he feels he is a really good dad. The main problem he has is that he can't provide as much as he wants to.

> *I feed her and change her in the day, we just share. Mostly I push the buggy! I enjoy every second of it. Now I would score me as a ten [out of 10], I would like to provide but at the moment I can't.*

So whilst Raymond might push the buggy, Gloria organises the doctor and health centre visits herself and this is their agreed way of dividing up the jobs. Raymond exudes love for Samantha:

> *Raymond: I was really excited when she was born but couldn't believe it. I was only 18. I was so excited I could not take my eyes of her.*
>
> *Gloria: He was more excited than I was!*

Raymond had some concern about his role and how to do it properly, but seems proud of his achievements as a father.

> *I'm worried that I won't do a good job. But as it turns out, I am.*

Both Raymond and Gloria initially felt quite positive about the involvement of the Family Nurse, but some issues began to surface as they talked about specifics. The Family Nurse takes them through the facilitator sheets and Raymond says he feels she has worked with him more than any other professional has.

> *She helped with all the services, to get in touch with people. She helped me to get involved with … the children's centre, asking how I am coping and how do I think I could improve.*

However, from his perspective the FN visits mainly focus on Samantha and the mother.

> *Raymond: She mainly goes through Gloria. I am mostly here – I am only not there if I have appointments with the doctor and so on. It is mainly about Samantha. We have let her know I would not be there sometimes, but Gloria is still happy to go ahead.*
>
> *Gloria: Because she doesn't mind [Raymond] not being there, I can fill in the paperwork. I think she feels I understand more than he does.*
>
> *Raymond: She does say she doesn't mind one of us being here, either me or Gloria. Gloria was still willing to go ahead with it.*

The FN visits last an hour to hour and a half and although Raymond felt the FN did involve him more than any other professional he had encountered, he still had concerns.

> *Raymond: I just want to be more involved with it. Though she includes me the most of anyone else, I'm not as involved as I should be. Most of the paperwork is down to Gloria – if it was half and half it would be ok but it's like 80% Gloria. Most of the sheets are for the mother. There's a few for the dad.*
>
> *Gloria: It sometimes says this is for the dads but most of it is for the mum. I think she feels I understand more.*

Raymond worries that the FN sees him as childish and both he and Gloria feel some animosity since the FN got social workers involved and has now done so on two occasions, but for reasons that had no foundation, they claim.

The FN's position in the research interview was clear: she did refer them to social care twice due to concerns about complex needs that could develop into child neglect. She regards Raymond as a good father, but as immature and demanding on his partner, who is an extremely vulnerable young mother. It seems that while the FN has a relationship with the father and has put effort into working with him, the relative lack of attention given to the father is part of a strategy to provide as much support as possible to a highly vulnerable young mother, who was seriously abused by her own parents, and to a degree is still at some risk of being harmed by them. His care of the baby is regarded as acceptable, but it is the risk he poses to the mother's already tenuous parenting capacity which is a cause for concern and the justification for concerns about him as well as the mother, and of course the child. The complexity then is that a man who is a resource in providing good enough direct care for his child, is also a risk to the child's well-being because of the demands he makes on the mother.

From the FN's perspective an approach which seeks to protect the mother from the father while seeking to develop her parenting is legitimate because of her vulnerability. But from the father's perspective it is not fair. As was shown earlier in the report, fathers who fully engaged valued the help they received with their relationship with their partner. What is not clear, as it was beyond the scope of this evaluation, is what efforts were being made by social care to try to change the father and improve how he relates to his partner.

### 6.3.4. The marginalization of fathers because they do not live in the 'home'

In some cases, the provision of a service to fathers also decreases, stops or never begins when the man does not live in the family home. This is compounded further when there are safeguarding concerns and social care involvement. In the FNP approach, 'home' equates to where the mother lives. Because the FNP home visitation programme is explicitly aimed at mothers the likelihood of the father being excluded is all the greater when he does not live in the family home with the mother and child. Family Nurses know this and in some respects feel very curtailed and uncertain about what they can legitimately do for fathers because of the mother-as-primary-client policy. In some cases where the man is regarded as a risk to the child and/or mother and no longer lives in the family home the FN is relieved to not have involvement with him. But the reduction or withdrawal of a service from the father is much more problematic in cases where there are concerns about the risk the man represents and he is no longer living at 'home' but is still having contact with his child.

Matt is 19 years old, unemployed and estranged from his 18 year old ex-girlfriend, Rebecca. They never lived together but have been separated for 4 weeks since the relationship broke down. Their son, Jack, is 3 months old and has lived with Rebecca in a mother and baby hostel since birth. Matt lives with his mother. They had been together for 18 months before they planned to have a baby, and were together throughout the pregnancy and for two months after the birth. Rebecca has been known to social workers for many years. There is now a child protection plan in place due to an incident of marks being found on Jack. Some 3 weeks previously he was found with scratches on his head, which Rebecca claims happened when he rolled off the bed. Matt doubts this as the baby does not have the capability to role. Matt has been told by social workers that he can see his son two days a week. This is an increase from one day a week after the incident happened. If he wants more access he has to go to court. He said that he is not regarded as a suspect re the incident, or a possible risk to his son and does not know what social workers think of him. The restriction of access may be due to the fact that the couple argue and the risks to the child from that. Matt claims that Rebecca physically attacked him (Matt), tried to strangle him and he called the police. She is having anger management and counselling, he says. They have argued and fought a lot since the baby was born because they have different views about how to care for him and both want to do different things. Matt said the FN spoke up for him at meetings and helped him get another day of contact per week with his child. Social workers did interview him and assess his parenting capacities, but they do not have any contact with him now other than at case conferences and core group meetings. Their focus is on the child's mother.

Matt presented himself as a fully involved father and rated himself as a 10 in his fathering abilities. On closer examination this applied to the times he did spend with his child, which was difficult at the hostel because he was not allowed to go into Rebecca's bedroom and so they had no private family space and he had to be with his child in the play room. His son and Rebecca would also visit with him at his mother's home. In the two months after the birth before the relationship broke down he only spent the night with his child twice, at his mothers. He has bathed him twice in his life, both on these same nights.

Matt's own father passed away when Matt was aged 2. He claimed the pregnancy was planned and his desire to have a baby was to be able to be the kind of father to his son that his father never got the chance to be with him, or he never had the chance to experience. His stepfather came on the scene when he was 4 and they have had a good relationship. Being a good father amounts to "being there for the child". Although Jack was planned, Matt says he was still shocked ("a good shocked") to find out about the pregnancy. He attended all of the scans and most of the antenatal meetings and felt that the services included him. He was happy to take on fatherhood and passionately described holding his son 10 minutes after his birth: "It was like being introduced to the

most important person in your life, I would do anything for him." He described the experience of being apart from his son since the separation as one of "a black hole". He said that he expected to lose some of the freedoms he had before the birth, but does not miss having a laugh or messing around with his friends, because he now has fun with his son. He would rather spend money on his son than going out. He has strong views on what he considers to be the differences between the role of mother and father, and despite describing a strong bond with his son, he maintains that the mother has more opportunity to bond with the child (womb time, breastfeeding, etc) and so has a stronger bond than the father. He sees the role of a father as a duality, combining the financial responsibility of being a provider and providing direct care and love, to ensure that his son knows he is there for him. When pushed to choose which is most important, he stated that the financial security enabled more family activities, and was therefore more significant. However this was seen as having a cost that reduces quality time with his son.

Matt emphasised how much he had had to learn from the experience of doing parenting. He values the FN quite highly. First contact with the FNP was around five months into the pregnancy, and they had one visit a week up to the time of birth. When the couple were together the FN did used to let him know directly by phoning him when she was coming to visit and did not just tell the mother. He always was present when the FN called and felt completely involved, to the same extent as she involved the mother. He feels the FN taught him a lot and gave some very good examples of activities that illustrate his son's developmental stages and him being shown how to play with him. These were mediated using sheets, leaflets and activity packs. The levels of impact on fatherly tasks were varied, and low scores tended to illustrate that the knowledge was pre-existing. He described helpful areas such as communication, play, and developmental activities, as well as a supporting role for the couple during the pregnancy. Since the relationship breakdown he has had some contact with the FN, largely about issues arising from the separation, like him getting to see his child, attending the case conferences etc. The FN has continued to visit the mother and baby but has not visited him as a father, ie when he has his son, and he feels that is not right. He is therefore not learning about parenting from the FN any more. An improvement he suggested was that in the case of parents who are separated, it would be beneficial for the father to have family nurse visits during the periods the child spends with him.

Matt currently sees himself as a father who does everything he can for his son, rating himself ten out of ten, while acknowledging that his current situation of restricted access does not allow him to be such a father as much as he wishes. He feels that he has a bit to learn about communication with Jack and Rebecca, as well as how to cook, iron etc. He wants to be "the best dad in the world" and hopes to give Jack the best life he can imagine, and do his best to protect and take care of him.

This case is illustrative of how the FNs have to seek to extend their involvement beyond the mother and child's designated home as far as possible if they are to work with fathers. This father clearly felt well supported by the FN, but was very aware of how what he was receiving was limited because he was no longer in daily contact with his child and (ex-) partner. Like so many men in this study, such fathers learn from the experience of being fathers, 'doing' fatherhood in everyday actions and relationships. The FNP needs to revise its policies to ensure that FNs remain involved with separated fathers at those times when they are caring for their children, so that they may benefit from the FNP programme and continue to develop their fathering abilities.

### 6.3.5. Gender and masculinities in FNP work

The cases cited in this chapter vividly illustrate the influence of gender in FNP work. All aspects of FNP work are influenced by definitions of motherhood/femininity and fatherhood/masculinity. The programme is primarily oriented towards helping women become better / good enough mothers. As we have been showing, we found that the

failure by the FNP to have an active policy of working with fathers is very influential in creating patterns of low or non-existent work with men.

Another aspect to this are the problems with help-seeking that men experience due to dominant definitions of masculinity and their identities as men (O'Brien, et al, 2005). In traditional definitions of masculinity it is seen as the binary opposite of femininity. So being a man requires repudiating any signs of what is regarded as feminine: 'sissy stuff' (Kimmel, 1995). Where femininity is recognized in men it is equated with being gay, a marginalized and stigmatized manhood. Homophobia and the fear of being perceived to be gay is a key influence on men's identities and behaviours. Help-seeking and public displays of emotion such as crying are equated with the feminine and avoided by (some) men. Within this world-view, for some men having a relationship with professionals like FNs threatens their deep sense of who they are as men. Recent work on masculinity is showing that while this dominant ideology of masculinity is something that all men have to reckon with, not all men are the same, there are different masculinities (Connell, 2005). This helps to explain why some fathers are more receptive to the help of the FNP than others. Programmes like the FNP are - or should be - attempting to help men develop a masculinity based around nurture and a definition of themselves which is comfortable with visibly being a caring man and father and accepting help.

Put straightforwardly, the fact that this does not happen in some cases reflects how the FNP does not understand men well enough. This is in part related to the FNP being a totally female workforce, but this lack of understanding of men is not unique to women. There can be no certainty that male workers would understand their own gender and relate to men any better. The research evidence on gender matching in welfare work is mixed, showing that some men are more comfortable being vulnerable with female workers because they do not wish to show the tender, vulnerable side of themselves to (professional) men, while others prefer male professionals because they feel that there is more common understanding (Arendell, 1997). Male staff – and especially men who have not done the personal development work which would enable them to recognize the impact of traditional masculinity on them – are at risk of colluding with traditional values of mothers-as-natural-carers and men-as-emotionally-illiterate-non-nurturing-breadwinners. The same applies to female staff.

We have already shown in this report that the FNs have a generally positive and constructive view of men and fathers and what they can contribute to children's lives. However, the data suggests that there is significant development work to be done with the FNP workforce if fathers are truly to brought centre-stage. Not only are mothers still privileged, but father's behaviours and attitudes are mis-interpreted and sometimes poorly understood. The above case of Lee is a good example of this in how he recognizes that he was passive at first when in the presence of the FN and gave out signals of uncertainty and disinterest because he did not know what was expected. But these were perceived by the FN as lack of interest or avoidance. Our findings suggest that while FNs generally have the values, there is a knowledge and skills deficit in relation to working with men. Enabling FNs to reach a deep understanding of men and masculinities must be at the core of the FNP developing a more uniformly proactive and effective service to all fathers. The same applies to developing deeper understandings of fatherhood and what being a father means to men. As this chapter has shown, not being included by professionals like the FNP transgresses the rights of a child to have a relationship with their father, is painful for some men and regarded by most who are placed on the margins as unjustifiable. This finding is supported by other research. Fletcher and Visser (2008), found in their study of Family Relationship Centres in Australia that some staff had stereotypical views of men as emotionally non-expressive and disinterested. They argue that the promotion of 'self-reflective capacities' which enable professionals to routinely examine their own assumptions, beliefs and experiences of men and fathers needs to be a central part of developing the skills of the children and families workforce.

## 6.4. Actively non-engaged fathers: working with highly resistant men

### 6.4.1. Hostile, defensive men who will not engage

As this report has been showing, some fathers are not engaged with by the FNP because they are not part of the child's life and cannot be reached. Some are part of the child's life but are not worked with due to the risks they represent to the child and mother. In some such cases the FNP rightly does not work with men because they also represent a danger to professionals. Then there are fathers who are present in the family but either refuse to engage with the FNP or do so minimally and sometimes in a resistant and even hostile manner. This section deals with the latter fathers. As was pointed out earlier in the report, accessing non-engaged men as part of the evaluation proved extremely difficult. These men turned out to be as reluctant to engage with us as researchers as they appear to be with health and social care professionals. We seem to have experienced something of the kind of resistance that FNs regularly face, albeit just a fraction of what they do. This gave us some invaluable lived experience of the challenges and frustrations FNs have to face: the chasing, unanswered phone-calls, disconnected phones, abortive visits and so on.

This means that we were much less successful at recruiting men who were not engaged with the FNP for the study than we would have liked. On the other hand, it left us feeling relieved to have managed to access what we did. Nine of the 24 men we interviewed were given a score of 2 or less out of 5 for their engagement with the programme by the FNs, six of whom were given a score of one. Not all of these men were resistant non-engagers. Some were working fathers or in education or training who were not present when the FN visited. These men's experiences have already been covered in the report. Others were fathers who were known to be part of the family and who were occasionally around during FN visits but who were on the margins of involvement. Some of these types of situation and men's experiences have also been covered in the report. Our focus here is on resistant and hostile men who are actively non-engaged with the FNP. By active non-engagement we mean men who seem determined to avoid the service. They try not to be there when they know the FN is calling, and disappear upstairs or out the door if they do happen to be there when she calls.

Because we had such problems recruiting them for the study, men who are totally and actively non-engaged with the FNP remain something of a mystery. But not totally so. Despite – and as it turned out, because of - their antipathy towards the FNP and desire to have nothing to do with it, a couple of such men did agree to be interviewed.

'James' is 20 and his partner 'Hannah' 18. Their baby is 4 months old. The research interview took place in prison where James had been for three months. He was convicted of drugs offences and expects to serve 11 months in total. They had been going out just a few weeks before Hannah got pregnant. He 'always stood by her during the pregnancy'. He became sexually active from the age of 16 or 17. Using condoms 'doesn't always run through your head. I have used them, but fuck knows why I didn't'. He hadn't been drinking – but was probably using cannabis. 'At that time I was smoking it all the time'. The pregnancy was a 'shock'.

> *I'm not one of those who would just fuck off. Most of my time I've grown up without my dad and I know how horrible it is to grow up like that. I knew I wanted to stick by her and that. I didn't want my daughter to grow up without a dad. Just because I have doesn't mean I have to.*

James' relationship with his mother was 'alright' until he got to his teenage years. 'I started rebelling and that'. He stopped listening to her and she couldn't control him – she'd ground him and he'd run off. His mum did the best she could for them. They moved a lot during his childhood (about 6 or 7 places) and he doesn't know why. He

says he never asked and she never explained why they made all the moves. She hasn't visited him in prison but does see his daughter every week or so. He has had telephone contact with his mum from prison but no contact of any kind with his dad.

James does have some contact with his father but not since he came into prison. His father has been in prison many times for theft etc – 'he's a twat'. **'**Dad's been in and out of my life all of the time, mostly because he was in prison'. As a child he did visit his father in prison sometimes, but there were long gaps when he didn't see him. He remembers visiting him in prison as a little boy and feeling upset that he only got to see him for a short time. He missed him and felt sad.

He did attend school, but would get excluded from lessons because he: 'couldn't be arsed with it'. He sat some GCSEs and got Ds and Es, but can't recall how many. He has never had a job but does odd-jobs for £10. The Job Centre annoyed him because they wouldn't help out. He did get 2 weeks' benefits but missed appointments so they stopped his money. 'They think that it's their money that they are fucking giving to you. It's fucking not'.

At the time James began going out with Hannah he had been kicked out of his mum's and was staying at his mates. He moved in with Hannah for 3 days per week and then ended up staying there. He was on an electronic tag and community order for a burglary offence and was allowed to stay at Hannah's for the birth. They were cohabiting full time from half way through the pregnancy.

Having his daughter 'was one of the best feelings ever'. The pregnancy helped his relationship with Hannah, made it stronger. Sometimes they'd argue 'when hormones got in the way and that'. 'It was good to see my daughter born. It is one of the best experiences you'll ever see'. Fatherhood both thrilled and scared him: 'It's just mixed emotions. You start thinking I've got to grow up and start doing thinks for [Hannah] and my daughter'.

In the five weeks he was at home before imprisonment he contributed to baby care:

> *We'd both be caring for the baby together, sometimes I'd do it, sometimes she would. [Hannah] would do a bit more than me. She'd do nappy changes and that and we'd both be doing bottles and cleaning up and that, waking up and feeding her. I'd hold the baby a lot, take her out sometimes.*

He said he knew quite a lot about being a parent (7 out of 10) at the time he met Hannah. He believes that mothers have a stronger bond with babies because they give birth to them and can always sense when there's something wrong with them. As to where this leaves the father, they 'have to get that bond with their child, whereas mothers instantly have it'. Fathers get it by 'being there and letting the child know who you are'. He doesn't feel that mothers should go out and earn straightaway, but fathers should – because 'it's something you need to do for your child, provide for it'.

Mother and child visit him in prison every week, for about 90 minutes. 'All you can really do is talk and hold your daughter and that'. He describes it as rows and rows of tables so there is no privacy. He looks forward to seeing them both on the visits, but finds it very restrictive. 'You can't play, but fucking hell, you've got to use your imagination. I talk to her and she babbles back'. He feels that she does recognise him as her father, she cries when she is leaving. They have a 'storybook dads' scheme in the prison where he did a recording onto a cd and mother plays it so that the child will know his voice. His partner likes to see him but the horrible thing is leaving. He rates the quality of his relationship with his daughter as 'good'. 'It can't be brilliant because I'm in this place'. His relationship with his partner has improved since the birth, it's brought them closer together. He plans to use condoms when he gets out as he's 'happy with the way it is at the moment, just the 3 of us'.

This is his first time in prison and 'it's pretty shit'. He has done a parenting course that lasted a week – 'basic things like whether we think smacking is right, child rights, that sort of stuff'. His plans on release are to get a job. He doesn't want to make the same mistake as his dad, keeping coming back to prison. 'I changed before I came in, thinking about my daughter and my missus'.

Regarding his views on fatherhood he says becoming a father has changed him for the better:

> *I think I'll be alright. It's made me realise this ain't the life and that. Because I need to look after her and I can't do it in here'. [His daughter will help him to stay out of prison] because I don't want to come back here.*

However, he fully expects to be a father in the community without the assistance of the FNP. His attitude to the FN and the programme was totally negative and hostile:

> I think I've met her about twice. She wrecks my head. She's just too nosy. She just asks questions that aren't relevant really. Things that have nothing to do with her. I used to just go out or I'd be at probation. I just don't like her and I'm not bothered if she knows I don't like her. I don't even get why she comes round. … She tried to give me leaflets and something to fill out, but I don't know if I done it. She gave them to me and told me what I had to do with them and that's it. I didn't fill them in. She's just a head wrecker. She's like she's part of the relationship. She wants to know too much.
>
> **Interviewer**: Is there nothing you feel you have needed help with as a dad?
>
> **Father**: Nope! … I don't like her. She just annoys me, the shit she asks about. She may think it's relevant, I don't.

James took every opportunity he could during the interview to be critical of the FNP. Thus, he doesn't know what income his partner and child get and says he doesn't talk to her about how she manages financially.

> *Ask the woman who put you on to this [FN]. She's as nosy as fuck. She is, she's too nosy. Hannah was saying to me the other day, she asks what I spend it on. It's not on is it!'*

He kept repeating how the FN regarded herself,

> *like she's part of the relationship. She wants to know too much. Like daily activities and stuff like that. Like trying to tell Hannah about bottles and shit like that, stuff we already know. … Just her being there. She just wants to know too much.*

He believes that the FN saw him once with the baby, but he had to go out to probation. 'She said hello and that was it'. He said she did not encourage him to stay and he said he would not have stayed even if he had nowhere to go.

What he might regard as being relevant 'is how to spot illnesses and that. She tried to talk to us about smoking around the baby when we already know that. She just talks about things I already know'. He doesn't feel his partner is getting anything out of the FN: 'she irritates Hannah as well'. He has not received any FNP leaflets in prison.

When asked what advice should our report give about how the family nurses should work with fathers and families, he replied:

> *The Family Nurse should do things that are relevant instead of being part of the relationship. She just wants to be too involved and that. She needs to chill out a bit. I think the Family Nurse's job is to be there for the baby and mother but she's not, she's just trying to be part of the relationship. What they do should be about weighing the baby and that. I don't think she has*

> *any right asking [partner] what she does with money. She can't help me with the things I've got to do. If she's gonna be there, be there for the baby's sake, not the relationship's sake.*

Given his hostile attitude towards the FNP he was asked why he agreed to do the research interview:

> *I didn't. Didn't. I didn't know until you got here. Obviously [FN] didn't explain that properly because she thought it was something to do with parenting.*

It was gently pointed out to him that the interview *has* been about parenting and him as a father. What he seemed to mean was that he was not expecting the interview to have such a strong association with the Family Nurse. He signed all the consent forms at the end of the interview and made it clear that he was happy for his views to be used.

This is a man who we believe would never have agreed to be interviewed were he in the community and who would not be engaging with FNP. He provides some insights into hard to reach men and what lies behind their lack of openness to help, their repudiation of vulnerability and their deep distrust of authority figures and probing into their life. His petulant, disgusted stance towards the FNP's relationship-based approach showed how professional interest in him is experienced as invasion, intimidation and control. His opposition to the FN and the FNP programme was visceral. His body language expressed this. For the last third of the (2 hours 20 minutes) interview he was sullen in mood and slumped in the chair, often lying with his head on his arm on the table, only becoming animated when expressing hostility towards the nurse. We accept that prison is clearly a miserable experience for him and talking about it may have depressed him further. But his hostile tone and life history suggests a deeply defended self which reflects his attachment problems and the absence of loving relationships in his childhood and young adulthood.

Such men's resistance is not simply a product of their awkwardness and personal or moral failings. It is also a function of their previous life experiences. Invariably they have had poor experiences of authority, the State is experienced as a threat to them and their freedom. James has internalised the values that the State and all professionals associated with it are to be mistrusted and to be kept at a distance. This is compounded by acute disappointments in family relationships, in particular in James' case his loss from his father being a recidivist prisoner. And his sadness and anger with himself for beginning to visit on his own child what his father did to him. To risk having a relationship with a caring professional has become too much too bare.

Resistance then, has a variety of origins. It is rooted in past experiences of adversity and what are experienced as oppressive encounters with the law and health and social care professionals. It is also about past intra-familial relationships and how these adults' own attachment patterns manifest in how they relate to professionals. Given this, it is important that the FNP does not take this kind rejection too personally. Men with such an outlook tend not to discriminate. They hate most if not all professionals. Yet it is through experiencing a consistent, caring professional relationship that they may be helped to repair and overcome these patterns and there is hope (Trevithick, 2003). The challenge, of course, is how to get the men to begin to engage to a point where they can experience the benefits of such a relationship.

A key strategy is for the FNP to develop is to do their utmost to ensure that they do not fulfil the man's worst expectations that he will be let down by people, including by being avoided by them. The FNP needs to be as proactive as possible with such men, creating every possible opportunity to meet with them and help them to see what they have to gain from the programme and active fatherhood. This includes men who are in prison.

### 6.4.2. The FNP and fathers in prison

Men in prison who are the fathers of children on the FNP programme need to be offered the programme. Ideally, this needs to be done by them being visited by the FN, preferably at a time when the mother and child are visiting. Imprisoned fathers need to be engaged with in similar ways to fathers in the community. As our analysis of fathers who appreciated the FNP programme showed, they engage so well because they feel respected and valued. This is communicated to them through the generous amounts of time the FNs spend with them and the totality of care that is provided. If visiting men in prison is not possible then the FNP should ensure that they get the FNP facilitators. The FN can also try to arrange to talk to the father on the phone and could take him through the work sheets.

These are not absolutes and the desirability of the father being encouraged to use the FNP programme must always rest on a risk assessment of him. In another case in the sample a man we shall call Dave was in prison at the time he was interviewed for the research. Dave had never engaged with the FNP and the FN had never met him as he went to prison before she became involved in the family. He committed the offence before his partner – here called Elaine - got pregnant and the couple only knew that she was pregnant one week before he went to jail.

The FN was concerned because Elaine, with whom she had a close working relationship, spoke about feeling controlled by him through endless telephone calls. He was a long-term prisoner due to a conviction for serious violence and the FN was using strengths based approaches and motivational interviewing techniques which are at the heart of the FNP programme and the therapeutic relationship with this mother to enable her to come to an understanding of the kind of relationship she was in with this man and whether she wishes it to continue.

Dave was visited weekly in prison by his child, Jake and Elaine and spoke passionately about how much it meant to him.

> *Jake knows who I am. When he sees me in the visiting room he puts his arms out to me. … Jake's not really that bothered with the toys he just plays with me. He messes about when I hold him, like he'll pull on my lips. He gives us a kiss and that. It's good man, it keeps me going.*

But the time they get together is short.

> *At first them leaving used to be horrible. I've got used to it. I got so happy when I first saw him. It was horrible holding him when he was born. He was so skinny. There was no meat on him. Now I can hold him better because he's older. It's like I've grown up now since I've had [him].*

Dave was not allowed to attend the birth. He knew his partner had gone into labour. 'I was crying to tell you the truth because I wasn't there'. When Jake was born he felt jealous of him because of how Elaine used to do things for him:

> *I used to hate it lie because I used to have Elaine to myself. I was jealous of him. I did love him, but now I've got used to him. Now it's both of them – I felt pushed out when he was born.*

He regards all jails as being the same,

> *you don't have any privacy. You are allowed to hug and kiss them'. 'I'd be a good dad I know I would. I wouldn't want to Jake to grow up without things, like I did with my mum.*

Dave doesn't believe there are any differences between what mothers and fathers can offer children. 'Apart from breast feeding it's the same'.

> *When I got this sentence I thought she's not going to wait. But when I got sentenced she said she would wait and loves me more than anything in this world. Losing your freedom is a big punishment but if they gave me this sentence and said I could spend it with [partner and child] I wouldn't mind. Even if I could have one night with them.*

He expressed ignorance about the FNP:

> *I don't really know anything about it to be honest with you. I just know that she helps her and that … I just know she comes round and helps her with stuff, to get into college. She helps her sort out things. I've spoken to the nurse once and that was about you.*

If he was living in the community he would not regard the FNP programme as necessary for him or his partner:

> *To be honest with you, if I was out I wouldn't want them there. I don't think Elaine would either. She only needs them because I'm not there.*

When asked what he felt about possibly having the FNP contact him in prison, he replied: 'It's hard to say. I've never really had anything like that so I don't know what to think'. But he was pessimistic about its value:

> *No-one can help me really when I'm in jail. My aunty and dad give me advice. But I'm powerless in jail. I can't do the things I would like, take him to the park, swimming, the things I want to do with them.*

Dave admits to feeling possessive towards Elaine and scared that she will not wait for him: 'I always accuse her of having someone in the house and that's what we argue about.' He knows what it is like to have an unhappy childhood and wants something different for his own child:

> *My childhood wasn't good really. I always used to get beat up by my mum. My mum was mad, she was in hospital for 3 years.*

Dave was excluded from school at 13 and placed on a crime diversion programme and was never made to attend school. He can read, but not write. He intends to do a literacy course in prison. He worked as a labourer when he was 17-18 and was then unemployed. He described himself 'as living all over the place'.

He feels that he is changing and becoming a father is central to that:

> *Being a father has definitely changed me. When I was in my last prison I used to fight every day. But since [my son] was born I've stopped. First thing that comes into my mind is my son. I've only had one fight here in the 6 months I've been here – a guy hit me in mouth with a snooker ball and me and my mates battered him. Then they split us up.*
>
> *I'm proud of being a dad. When I see [my child] and he smiles at me, it hurts me so much and when I hold him, it hurts me so much. I love him so much. I've got pictures of him all over my pad, I think about him every night. I speak to him on the phone every day. He laughs and goes "goo go gaga".*

These men have a desire to have different lives. They are attempting to acquire a fatherhood identity and may have at least partially succeeded in some aspects of this in what are very difficult circumstances. These findings are supported by other research into fathers who are in prison or have been released and men in other marginalised situations (Walker, 2010; Ferguson and Hogan, 2004). This generativity and desire to care for their child presents an opportunity for the FNP to relate to and develop them as fathers. We do not wish to oversimplify these cases and the dilemmas FNs face where there are suspicions and concerns that a man may constitute a risk and having to balance whether and how to include fathers with protecting and developing mothers and

the child. The crucial thing is that men's desires to be good enough fathers and their capacities are fully understood, assessed and the man is given every opportunity to develop himself as a father, irrespective of where he lives.

### 6.4.3. Working with passively resistant fathers

Some fathers in the sample were resistant towards the FNP programme, but in a much more passive way than those discussed above. Their attachment to the FNP was ambivalent, characterised by love and hate, with some appreciation of the service, laced with criticism and unhappiness with it. The ambivalence was mutual, as FNs sometimes had mixed feelings towards these fathers and could take or leave them, sometimes preferring to leave them.

Michael Morgan is 17 and white British, his partner Victoria 16 and their son Robbie is 6 months old. They live with Michael's parents in social housing. This is Michael and Victoria's permanent accommodation and they are satisfied with it but want to get a place of their own when they are older and can afford it. Michael and Victoria began living together before Victoria got pregnant at the age of 15. They were in a relationship for 2 years before the pregnancy happened. The pregnancy was unplanned. She fell pregnant when the condom must have split. On learning of the pregnancy Michael was "scared and happy", fearing telling his parents, but they were soon supportive; and of the responsibility of fatherhood. They say the pregnancy and the birth have not affected their relationship, which is as good as it always has been. Michael attended the birth. He rates his level of knowledge about being a parent at 5 out of 10 during the pregnancy and is 8 now. Fatherhood is turning out well for him. He enjoys his son very much and describes the quality of his relationship with him as "brilliant" and is actively involved in his care. His son means "everything" to him. "I love him", "he makes me smile". Victoria described him as "a brilliant dad". On a typical day he feeds him twice, changes him three times, dresses him once or twice, and sooths him 3 times. He could not put a figure on how often he plays with him because it is 'all the time'. Michael never takes sole responsibility for medical or other appointments, but always accompanies his partner to them.

Michael saw no significant difference between the roles of mother and father. On balance he would prefer to be working because the benefits of having money outweigh the loss of more contact with his child. He placed a high value on earning and providing. He dropped out of school at 15, a year before his official leaving date. He has no qualifications and has never worked. He has no income at all as he not entitled to Job Seekers Allowance until he reaches the formal date for him to leave college. They get a weekly 'family' income via child benefit and child tax credits of £50-100. He has been in trouble with the law, cautioned by the police and involved with the youth offending social work service for a theft he says he didn't commit. He gave a vivid account of how fatherhood has changed him, settled him down; how, on our terms, it has changed his internal world and awakened his generativity. He can barely explain it to himself but he has no desire to hang out with his mates like he used to do all the time and rarely goes out. Some friends visit him and his son is involved in these visits and the sociality. This, then, was another young father articulating how the focus of their pleasure has shifted from external activities to their child.

When the FN visits he is there less than half the times. He felt that when he is present the FN gets him involved only to a level of 5 out of 10. She gets much more involved with his partner than with him and he essentially regards it as a mother-centred service and was critical of it on that basis. He feels that the FN has withdrawn from him since the baby was born six months ago, having been more involved with him during the pregnancy. That said, he identified several areas in which the FN had made some impact on him, where he learned from her about parenting. Feeding the baby got a 7 out of 10 for impact, bathing the baby also a 7 and holding the baby a 5. Communicating with the

baby – talking, listening, teaching the baby things – all got 6s. Weaning the baby only got a 1 because he didn't agree with the nurse's advice to give the baby toast, including the crusts. He and Victoria were very clear that they like to do things their own way. Changing nappies, getting up in the night and going out with the baby all got 0s, mainly because he knew them already – he had past experience of looking after his nephews and nieces. He was positive about how the FN had helped him to understand his partner's support needs (a 7) and she had helped with his relationship with Victoria (a 5). Communication about his own feelings and needs scored a 0, because he feels FN hasn't done it. Overall he rates his fathering abilities as an 8:

> *Because I think I could do a bit better, particularly at helping out more, particularly paying for things which I can't do because I don't have a job.*

He also feels he has a bit more to learn about physical care of children and communication skills and taking responsibility. But he felt these things would come with experience, while acknowledging that new knowledge is needed as children grow and progress through developmental stages.

In the research interview, the FN expressed frustration and irritation towards him, complaining that 'his father gets more involved than he does'. There was clearly some mutual antipathy, as both Michael and the FN regarded the other as not doing enough. According to the FN, Victoria is hard to engage and she has 'enough on trying to work with her'. This suggests that Michael's feeling that the Nurse has withdrawn from him since the birth has some accuracy. This young father's efforts and achievements do not seem to have been sufficiently acknowledged. He seems under-appreciated and feels it. Part of the problem in communication between this father and the FN is his location in an apparently caring but somewhat smothering family. When asked about housework he said he doesn't do any because his mother does it all and won't let him. It would take a significant effort and we suspect considerable support for this young father to emerge as a distinct individual within this family. The striking thing about him is his youthfulness and how well he has made the challenging transition to fatherhood. He clearly has found the FNP intervention helpful in some respects, but is resentful of their lack of attention towards his needs as a father. He is an important resource for his child and partner and it is in their interests for the FNP to engage proactively and fully with him. The challenge for the FNP is how to work effectively with someone who is a committed father, and yet still a dependent son.

### 6.4.4. Hard to reach men: a summary

Crucially, most of the fathers we interviewed had vulnerability factors that were similar to those men who were hard to reach: troubled family backgrounds, leaving home or being thrown out as a young teenager; dropping out of education and having no qualifications and in some instances no income; petty criminality and anti-social behaviour in adolescence and in some instances into adulthood; unplanned pregnancies and unstable relationships with partners. The men who are never reached may differ only in the extremes of how they experience these risk factors, either individually or in combination. As so little is known about these men in terms of direct contact with them, we cannot assume that non-engagement or resistance by the fathers is indicative of any pathological irresponsibility. The capacities of many of these men to provide care and be responsible fathers are likely to have been significantly adversely affected by their own experiences growing up in difficult and challenging circumstances. On the basis of what the mothers tell them, the family nurses have some real concerns about hard to reach men's parenting capacities. What is clear is that whatever these men do they do it without outside support. A key point is that this means that many of the men who engaged positively with the FNP programme did so from a starting-point of high risk of non-engagement and the fact that this did not happen provides the basis for learning not just about how the nurses managed to successfully engage those men but how hard to reach men can be engaged.

### 6.4.5. From avoidance to engagement: Strategies for engaging (resistant) fathers

All men who seem unreachable potentially can be engaged. It can't be known at the outset who will or might be reachable and who will not. Where there are signs of avoidance of the nurse and passive or active resistance and non-engagement by men, FNs need to adopt an approach of creative persistence towards them. Some fathers spoke of how, through a mixture of skill, charm and persistence, FNs won them round:

> *In the beginning I would go up and hide in the bedroom, so I did not have to speak to her, but after a couple of times we spoke, and she was a lovely lady, and it was dead easy to get on with her.*
>
> *(31; child 13 month old; WB)*

This father had all the risk factors for non-engagement. He was abused as a child by his own father, has had significant problems with addictions and social care are still involved with the family. The FN managed to get him to engage by stressing that the service was for him and not just his much younger partner. Once he began to engage he felt the benefit and a virtuous cycle of engagement became established, where he the more he engaged the more value he experienced and the higher his motivation to be involved with the FNP.

Another good example of a father who initially felt very unsure of the FN is Ron, whose daughter is six months old. He too has a history of significant drug misuse and there is social care involvement. He met his 17 year old partner when she was still in care. He rates the FN's involvement with him compared to the mother at 3 out of 10. Yet for him this is an improvement as he used to always leave the room or the house when she called. He rates the family nurse as 'quite important' as a source of learning, compared to social workers, whom he dislikes strongly, due to his family history. He is there for most of the FN visits, but still sometimes he will leave the room. Sometimes this is because he is told that the nurse wants to talk to his partner, 'especially about how young she is'. Even though the nurse asks him to stay for the meetings, he will often go out. This self-exclusion arises in part from his assumptions about gender roles and tendency to leave child care responsibility with the mother. But it is beginning to change, as the nurse continues to encourage him to stay in the room. He feels that this has had an impact in helping him to hold the baby, and made him a better father by 'telling me it's ok to pick her up'. The FN does answer his questions and helps him to get to grips with picking up 'a dead small baby with my massive hands'. He has literacy problems and finds the facilitator sheets the nurse leaves difficult to read, so he will leave his partner to complete them. His advice to the FNP programme is that:

> *[nurses could tell the fathers they are needed at the meetings, Like when [FN] encouraged me to stay in the house.*

These examples show how family nurses have a repertoire of tactics that they use to encourage men to become involved. As we have argued in this report, this must include always letting the man know that he matters and ensuring his partner knows this and that the FNP programme is for fathers and not just mothers. The great resource the FNs have to work with in engaging fathers is the baby. The most successful interventions manage to appeal to the men's interest in caring for their baby and their desire to have the best for their child. The ideal to aim for is that fathers matter so much that they are routinely seen by the FNP even when mothers are not at home for the visit. This already happens in some cases, but as the report has been showing, there is scope for the engagement of fathers, when alone or with their partners, to occur much more. As one father happily put it: 'The Family Nurse will still come and see [child's name] and myself even if [partner] has an appointment or has to go somewhere.'

# 7. Findings and recommendations

## 7.1. Overview of findings

Analysis of FNP policy documents shows that the relationship of the FNP to fathers is ambiguous. At best, fathers are seen as important but secondary to mothers; at worst, they are ignored.

In many places the policy and programme literature uses gender neutral language, speaking of 'parents' or 'families'. The American home visitation programme on which the FNP is based focus on the mother and baby and systematically excluded fathers from its design and evaluations. FNP policy statements refer in places to fathers and the UK model seems to have at least some intention to involve them. But when fathers are mentioned it is as a benefit to the mother's capacity to parent rather than the man being a target for the programme and benefiting from it as a carer in his own right.

### 7.1.1. The characteristics of the fathers

The characteristics of the fathers in Nottingham FNP cases can be summarised as follows:

- 91% of men involved with the programme are the baby's biological father.
- In 60% of cases the father and mother are still in a relationship and 44% of the men currently live with the baby's mother.
- The fathers ranged in age from 17 to 37 years old. 86% were under twenty-five and 38% were less than twenty years old.
- 83% of the men were White British.

While there is diversity in the characteristics of the fathers and in their experiences of the FNP programme, some clear patterns stand out. Fathers involved in FNP cases tend to:

- Live in families that are poor, as a result of low pay, living on benefits or the man having no income at all;
- Come from families in which their parents separated before they were 10 years old, are part of reconstituted families and have step-fathers and relationships of mixed quality with their biological fathers;
- Have low educational attainment and be unemployed;
- Be slightly older than the mothers of their children;
- Have unplanned pregnancies;
- Approximately half of the fathers were very involved in providing direct care to their children.

**This evaluation has highlighted the need for the FNP programme to systematically gather more information about fathers, such as their employment status.**

### 7.1.2. Family Nurse visits

The family nurses have had at least some contact on home visits with about a half of the fathers in their cases.

- Positively, 58% of the fathers who were present when the nurse visited were there most or all of the time. On the other hand, 46% were present less than half the time and a full 23% were never there. 60% of men's absences were due to him being out at work or education.

- 48% of fathers felt that on visits the nurse involved them as fully as the mother and another 28% felt well involved.

**The findings show that the family nurses are playing a significant role in helping some men improve their fathering abilities.**

Just over half (54%) of the fathers felt that the FNP programme has had a very positive impact on their ability to be a father.

### 7.1.3. Limitations

**However, there are some significant deficits in how the programme does not engage well enough with some fathers on some aspects of their lives and role, and does not engage with some men at all.**

A quarter of the fathers believed the programme had a medium to low impact, while 28% felt that it had very little or no impact on their parenting abilities at all.

There are many more men considered by the Family Nurses to be engaged with the baby (70%) than are engaged with the FNP (38%). **The programme is not accessing a significant number of fathers who are engaged with the baby.**

Some of this non-engagement of fathers is legitimate. In 30 of the 144 active FNP cases the fathers were deemed by the Family Nurses to be '*unreachable*' or *'reachable but inappropriate for contact'*. Unreachable men were either never on the scene or were but now have no contact with the baby or partner. The main reason for the men who were reachable but it was not deemed appropriate for the FNP to do so was domestic abuse.

**The FNP faces a real problem in having nowhere in Nottingham to refer known abusive men.**

## 7.2 Recommendations

**Recommendation 1 – Policy Clarification**

The FNP needs to clarify its policies in relation to fathers. The current policy of the mother explicitly being the client is inconsistent with how many families using the service, how they organize gender roles and parenting responsibilities, what many fathers and their partners want and how generally Family Nurses themselves wish to and often try to work. At its worst the *'mother as the client'* policy is exclusionary towards fathers and is therefore sexist. This structural issue is a significant cause of problems in engaging fathers.

The Nottingham FNP may wish to reconsider the implications of the FNP being a licensed bought in package from abroad and look at implementing more locally relevant father friendly strategies.

**Recommendation 2 – Understanding fathers and the dynamics of engagement**

The FNP needs to develop and promote among its workforce a much more sophisticated understanding of what enables father engagement and what blocks fuller engagement; how this is sometimes straightforwardly due to the FN's failure to take the man seriously and work with him. But also how it is often a combination of factors:

- FNs low expectations of a particular man, who is perceived as feckless and/or a possible danger/risk;
- The father's apparent receptiveness to receiving help and the avoidant signals he gives out, which is perceived by the FN as lack of interest, but may be role confusion, embarrassment, or lack of understanding of what the service can offer;
- The demands of working with high risk/demanding mothers and feeling challenged enough trying to develop her parenting;
- How the mother gate-keeps the service, keeping it to herself and does not invite or allow her partner in.

**Recommendation 3 – Communicating directly with the fathers**

The fathers' contact details, especially mobile phone numbers, should be gathered by FNs and men should be communicated with about appointments to visit to the same extent as mothers.

**Recommendation 4 – Letting fathers and mothers know the service is for fathers**

The fathers need to be told time and time again that the service is as much for them as it is for mothers. Mothers also need to regularly be told this. This also needs to be articulated in all policy and practice literature. Photographic images should include fathers to the same extent as mothers.

**Recommendation 5 – Being available when fathers can be home**

The pattern of appointments and visits that would best enable the presence of fathers and their active involvement in sessions needs to be openly negotiated with him. Visiting should occur at times that suit men who are working or in education, balancing this with the need to ensure family nurses are not over-worked and get time off in lieu, and that their safety is ensured through the implementation of lone-worker policies outside of 9am-5pm working hours.

**Recommendation 6 – Provision of emotional support and help with relationships**

Fathers value highly the FNP help with relationships with their partner, as well as developing hands-on parenting skills with their babies. The FNP needs to fully understand and respond to how fathers value the relationship-based approach and that men need help dealing with and showing their feelings and feeling comfortable in so doing.

**Recommendation 7 – Non-resident fathers**

Fathers who are not resident with their partner and baby or separated from the mother need to be seen by the FNP at the times when they have access to/care of the baby. It is the presence of the child with either (or both) parents rather than any particular residence that should define where and to whom the service is delivered. The fathers' 'home' should be defined as being within the scope of the 'home visitation' as well as the home of the mother. The service should be equally available to fathers at those times they are caring for the child as it is to mothers. Separated fathers need the programme just as much when they are caring for their child as they do when they are with the mother. In fact the separation can increase their vulnerability and needs for support.

**Recommendation 8 – Training**

Training to enable family nurses to reach a deeper understanding of men and masculinities must be at the core of the FNP developing a uniformly proactive and effective service to all fathers. The same applies to developing deeper understandings of fatherhood and what being a father means to men. Not being included by professionals like the FNP transgresses the rights of a child to have a relationship with their father, is painful for some men and is regarded by most who are placed on the margins as unjustifiable.

**Recommendation 9 – Making the FNP Father friendly**

The FNP needs to critically review all its programme materials to ensure that they become father focused/friendly. This should include developing facilitators which are attractive to fathers and meet their needs.

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