CHANGING THE CULTURE OF FATHERHOOD

Dads Group

National Implementation Plan

Federal Government Pre Budget Submission

December 2019

Contents

Executive Summary

Dads Group is a leading, national, not-for-profit organisation supporting expecting and new fathers of young children primarily through establishing peer-to-peer groups in collaboration with Hospitals, Allied Health Services, Councils and other community partners. With the view that supporting fathers contributes to addressing broader social issues such as **mental health**, **suicide**, **domestic violence** and **child development**, Dads Group has proven successful in engaging dads — establishing over 70 Dads groups across the nation, engaging thousands of people at face-to-face events and hundreds of thousands through online communities.

After successfully piloting our programs and validating the model of support through research and impact studies we are positioned to scale the impact over the next three years through capacity building programs and leveraging existing services to see the following:

- Grow face-to-face reach and engagement for new and expecting fathers and families (from 5k to 60K)
- Grow education, training, tools, programs and pathways for health practitioners in the perinatal space — Hospitals, Allied Health Services, Councils.
- Increase positive fatherhood messaging and culture change, through influencing workplace cultures and increasing digital reach.

This expansion will see our national presence grow to impact over **60,000** new fathers and families across Australia face-to-face and over **2 million** people through our digital platforms.

The health and wellbeing of men in Australia is recognised as requiring urgent action (Burns et al., 2016). Intentional self-harm is the leading cause of death for those aged between 15 and 44 years, with men accounting for three quarters of these deaths (Australian Bureau of Statistics, 2019). Furthermore suicidality is well-researched and key risk factors have been identified, such as acute stress, depressed mood, unhelpful conceptions of masculinity, and ineffective coping strategies, particularly, withdrawing socially (Proudfoot et al., 2014).

There is a clear need to address these challenging and prevalent societal issues in Australia. The transition to fatherhood which brings a new sense of identity, demands on resources, and responsibilities, is arguably the most opportune point at which to address men's mental health and reduce the risk of suicide and family violence.

- Up to 25% of fathers experience depression in the period 3 to 6 months after having a baby

- 39% of first-time fathers experience high levels of psychological distress in the first year of their child's life.
- 56% of new dads did not seek information or support from any source during stressful times.

Whilst help-seeking in relation to fathering is likely to be low, and Australian men have reported feelings of marginalisation based on services being designed for access by mothers (Rominov et al., 2018), Dads Group's evidenced based peer-to-peer model is having demonstrated impact:

- Almost twice as many dads in the general community reported feeling mostly or always isolated as a parent compared to those who attended Dads Group events.
- 33% of dads in the general community had no idea of places they could go to make friends and talk with other parents compared with 3% of dads who attended Dads Group events.
- 100% of fathers involved in Dads Group would recommend it to other new dads.

Unlike digital-only interventions, community-based programs are an avenue through which individuals can become engaged in a strengths-based environment, reducing isolation. Peer-led support is used to facilitate behaviour change by building trust based on shared lived experiences, role-modelling living well, and engaging others with help available and the broader community — all of which are known protective factors of suicidality.

Through capacity building and leveraging existing services (Maternity Hospitals, Maternal Child Health Services, Allied Health and Councils) Dads Group also equips the existing perinatal workforce with tools, resources and services to have more of a focus on mental well-being and father-inclusivity.

In order to implement this critical national scale-up and impact over 60,000 new fathers and families, Dads Group requires funding of 4.5M over three years. This will enable us to increase staffing, develop key partnerships and increase digital reach and engagement.

Dads Group implementation plans have been carefully developed based on our depth of experience with new fathers through pilot programs, existing research, and key expert contributors from the fatherhood, perinatal, antenatal and mental health spaces.

Key Program Contributors:

Associate Professor Richard Fletcher
The Family Action Centre, Faculty of Health and Medicine, The University of Newcastle.
Richard researches fathers' mental health, attachment, coparenting, rough and tumble play and use of services. He is Principal Investigator of SMS4dads and Stayin on Track for Aboriginal fathers. His book "The Dad Factor: How the Father-Baby Bond Helps a Child for Life" (Finch 2011) has been translated into 5 languages. He is editor of the Fatherhood Research Bulletin.

Dr Alka Kothari
Department of Obstetrics & Gynecology, Redcliffe Hospital, and UQ
Dr Alka Kothari is a leading expert on the psychological impact on fathers of traumatic birth and termination experiences. After observing a culture of 'Forgotten Fathers' she developed a research project that identified that while mental health and other support is available to mothers, the lack of care and engagement with the fathers lead to a wide range of coping mechanisms, including destructive anger and substance abuse. These often resulted in social isolation, guilt, shame, and depression with relationship and family breakdown. *Please refer to Appendix 7. The Forgotten Father.*

For more information or questions about this submission please contact:

Thomas Docking
CEO Dads Group
Ph: 0424 907 249
Email: tom@dadsgroup.org
www.dadsgroup.org.au

Context

Challenges for fathers in Australia

The health and wellbeing of men in Australia is recognised as requiring urgent action (Burns et al., 2016). In Australia, intentional self-harm is the leading cause of death for those aged between 15 and 44 years, with men accounting for three quarters of these deaths (Australian Bureau of Statistics, 2019).

Suicidality is well-researched and key risk factors have been identified, such as acute stress, depressed mood, unhelpful conceptions of masculinity, and ineffective coping strategies, particularly, withdrawing socially (Proudfoot et al., 2014). The ways in which these risk factors affect suicidality are complex and interrelated. Men who report greater social isolation, for example, also report greater psychological distress and self-stigma, and lower personal wellbeing (Burns et al., 2016).

Domestic and family violence is a further societal issue in which men are implicated. Domestic violence includes physical, sexual, emotional and psychological abuse, and family violence is a wider term that encompasses violence between family members as well as intimate partners. In Australia, one in six women have experienced sexual or physical violence (Cox, 2015) and one in four women have experienced emotional abuse by a current or former partner (Australian Bureau of Statistics, 2017).

Children exposed to domestic and family violence are likely to experience maltreatment as a result of diminished parenting capacity and neglect (Campbell & Thompson, 2015) or through direct violence (Horton et al., 2014). Consequently, there can be significant trauma and negative effects for children's cognitive functioning and emotional wellbeing (Kimball, 2016; McTavish et al., 2016).

There is a clear need to address these challenging and prevalent societal issues in Australia. The transition to fatherhood which brings a new sense of identity, demands on resources, and responsibilities, is arguably the most opportune point at which to address men's mental health and reduce the risk of suicide and family violence.

The New Fatherhood Experience

New fatherhood is a time of excitement and joy for most men. In a survey of new fathers in Australia (N = 1379), most reported finding real joy in being a father (89%) and feeling satisfied with their role as a parent (81%; Colquhoun & Elkins, 2015). However, these positive feelings are generally felt in the initial stage after the birth of a child & then decline as fathers have to navigate adapting to a new life and often resuming work.

Fatherhood involves elevated risks that come with life disruption, additional stressors (e.g., sleep deprivation), and new commitments. Fatherhood has become increasingly individualised in the face of societal and household change and that fatherhood is increasingly being challenged by partners and social institutions, such as the media and government (McKelley & Rochlen, 2016; Williams, 2008).

Furthermore, although fathers in Australia today may be more involved in child care than in past decades, recent statistical trends for most families indicate that the time fathers spend in employment remains the same before and after having children (Baxter, 2019).

Many new fathers report not spending the amount of time they wish to with their child (55%) and less than half have reported that it was easy to find someone to talk to when feeling stressed or down (44%; Colquhoun & Elkins, 2015).

Many also report feeling stressed or anxious about needing to be “the rock” in their family (47%) and a high proportion scored highly for risk of depression or anxiety (39%; Colquhoun & Elkins, 2015). Across studies globally, approximately 25% of fathers have been estimated to experience depression in the period 3- to 6-months postpartum (Paulson & Bazemore, 2010).

- ***Up to 25% of fathers experience depression in the period 3 to 6 months after having a baby.***
- ***39% of first-time fathers experience high levels of psychological distress in the first year of their child’s life.***
- ***41% feel overwhelmed by the responsibilities to their family.***
- ***43% of first-time dads saw anxiety and depression after having a baby as a sign of weakness.***
- ***56% of new dads did not seek information or support from any source during stressful times.***

The Impacts on Children & Families

The support of new fathers and prevention of mental ill-health is imperative given the influence fathers can have on their children's development. Historically, warm and involved fatherhood has been associated with a range of positive outcomes, such as school readiness (McWayne et al., 2013), and cognitive, emotional, and social development broadly (Lamb, 2010; Towe-Goodman et al., 2014).

More recently, the father-child relationship has been directly linked to child prosocial behaviour, even when controlling for the influence of mother and teacher relationships (Ferreira et al., 2016). A father's positive beliefs about parenting in early life have also been associated with their child having fewer challenging behaviours in subsequent years (Kroll et al., 2016).

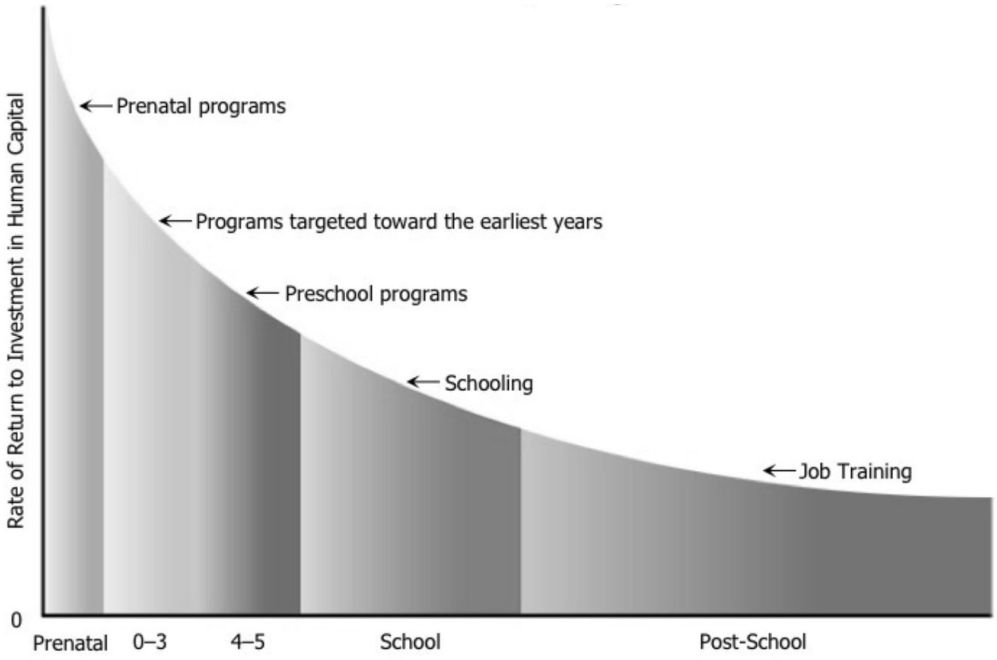
Furthermore, emerging research suggests that rough-and-tumble play, common in father-child interactions, is associated with better social and cognitive outcomes, as well as fewer aggressive behaviours in the child (Anderson et al., 2019; StGeorge & Freeman, 2017). In contrast to these beneficial outcomes, when parental mental ill-health is present, there can be significant social, economic and psychological impacts on families and the capacity for sensitive care may be compromised (van Santvoort et al., 2015).

A report into paternal depression found, after controlling for maternal depression and later paternal depression, having a father who was depressed at 8 weeks postpartum was found to double the risk of behavioural and emotional problems in children at 3.5 years of age[1]. One of the most prevalent behavioural problems - Oppositional Defiant Disorder (ODD) - impacts one in ten children with data showing that those with ODD in childhood/early adulthood have a 90% chance of being diagnosed with a mental illness in their lifetime.[2]

Finally, in relationships where one or both partners have instances of mental health disorder, there is at least a 2x probability of separation or divorce[3] (impact on offspring is highly variable).

[1] Ramchandani P, Stein A, Evans J, et al. Paternal depression in the postnatal period and child development: a prospective population study. *Lancet*
[2] https://www.aafp.org/afp/2016/0401/p586.html
[3] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1662-0

There is also strong evidence to suggest that the earlier the investment in a child's life, the greater the return.



Source: James Heckman, Nobel Laureate in Economics

The Unique Challenges of Supporting Fathers

Help-seeking behaviour is infrequent in men (Yousaf et al., 2015). Indeed, men typically enter services for mental health only when the severity of symptoms, extent of disability, and number of comorbidities becomes highly elevated (Harris et al., 2014).

Help-seeking in relation to fathering, specifically, is also likely to be low. In qualitative research (N = 20), Australian men have reported feelings of marginalisation based on services being designed for access by mothers (Rominov et al., 2018).

Determining ways in which to engage fathers in behaviours that support physical and psychological wellbeing, particularly before concerns become severe, remains a challenge. The culture of most organisations and health programs are unintentionally not supportive of fathers. The unintended consequences of this have significant and lasting economic and social impacts (see table 1 and 2 appendix 6). Traditionally health organisations design programs and models

of care that are based around needs and behaviours of women (who are most often the traditional custodians of family health). In order to improve our paternal engagement the design process requires specific expertise from experienced subject matter experts who have successfully engaged fathers at scale. At a population level, implementation of health programs that have not addressed the specific needs and behaviors of men and more specifically new fathers will continue to reach only a minority of the target demographic.

Fathers also viewed their partner as the gateway to parenting information and expressed preference for informal supports, such as family and friends, rather than formal programs (Rominov et al., 2018).

Why Community-Based Initiatives Work

Community-based programs are an avenue through which individuals can become engaged in a strengths-based environment. For example, peer-led support has been used to facilitate behaviour change by building trust based on shared lived experiences, role-modelling living well, and engaging others with help available and the broader community (Gillard et al., 2015).

The community-based Men's Sheds program in Australia has been used to address social isolation in men and provides another example of effective initiatives (Ballinger et al., 2009; Morgan et al., 2007). Gendered approaches to encouraging help-seeking have been recognised as important (Harris et al., 2014) and community-based groups are well-suited to cater to these needs, providing an inclusive and non-pathologising environment where men build relationships and engage as peers (Morgan et al., 2007).

Such programs may be viewed as a form of "social prescription" (Chatterjee et al., 2018), which help bridge the gap between medical involvement—such as the birthing process in the parenting context—and psychological wellbeing in the community.

Community-based groups also have a role in addressing the broad societal issues men face. Dads Groups aim to help fathers develop supportive social relationships, a sense of purpose, family harmony, and connections to physical and mental health services, all of which are recognised as protective factors against the risk of suicidality (Black Dog Institute, 2018).

Further to this, the act of empowering fathers to develop an identity as a father and embrace this new role is a step towards challenging gender stereotypes as well as strengthening equal and respectful relationships, both of which contribute to the prevention of domestic and family violence (Our Watch, 2015).

The Cost of Doing Nothing

Perinatal depression is costing the Australian economy at least $354 million each year, with the majority of these costs attributable to productivity losses. The direct cost to the health sector alone stands at $79 million, with the highest cost category across all payers and in total being hospital services (Deloittes, 2012).

Stigma, lack of familiarity, poor partner support and significant health service barriers are leading contributors to the low levels of help seeking among Australian parents at risk of or experiencing perinatal mental health challenges (Werner et al 2015; Schmied et al 2016).

Currently, the health system carries the majority of the burden for detection and intervention for perinatal mental health problems for women. No screening of partners currently occurs within the hospital setting. Without significant change to the current model, families will continue to show low levels of help seeking, leading to health system support often only occurring once a crisis point has been reached. Incidents of suicide amongst men are already at a crisis point with the national rate twice the national road toll (ABS 2017).

Dads Groups represent best practice primary prevention of violence in accord with the 'Shared Framework' (OurWatch 2015) which calls for programs that address rigid gender roles and promote male peer relations that emphasise respect for women.

Dads Group Economic Value

"Cost for employers is therefore estimated at $547 million[4] whilst the cost on the healthcare system is an additional $124 million. A total **$671 million** cost just accounting for work absenteeism/presenteeism and healthcare."

Please refer to full article "The Urgent Need to Support New Dads" in Appendix 6.

[4] Formula (171,000 x $3,200)

About Dads Group

What we do

Dads Group promotes positive parenting for Fathers and gives new dads the support and connection they need. As an early intervention approach, Dads Group provides new fathers with positive social relationships and easier pathways to health services if they need them.

Dads Group has four main initiatives:

1. **Community Dads Groups**

   A Dads Group is a gathering of new fathers (fathers during the perinatal and infancy periods; perinatal - conception to 1-2 years post birth: infancy - the state or period of babyhood or early childhood) meeting together weekly with their kids, a coffee, and often a playground. It sounds like a simple formula, but the peer-to-peer approach of Dads Groups create an evidenced based and effective framework for support — something that is often missing from the existing fatherhood experience in Australia. Groups are led by a new father, but usually with the support of a local council worker, especially in the establishment stage. *Click here to watch a short video about Dads Groups.*

   Over 70 Dads Groups have been established around Australia in the last 5 years, with demonstrated impact. The initial findings of a 2019 *University of the Sunshine Coast* research report into the impact of Dads Groups the following have been identified:

   - ***Almost twice as many dads in the general community reported feeling mostly or always isolated as a parent compared to those who attended Dads Group events.***
   - ***33% of dads in the general community had no idea of places they could go to make friends and talk with other parents compared with 3% of dads who attended Dads Group events.***
   - ***Dads who attended Dads Group events were twice as likely to know where they could get help as a parent compared with dads in the general community.***
   - ***Five times as many dads in the general community felt they and their family were not at all connected within their community compared with dads who attended Dads Group events.***

- ***55% of dads in the general community reported never or only a little of the time taking their child to events or gatherings compared with 17% of dads who attended Dads Group events.***

- ***Dads who attend Dads Group events reported feeling that they and their family were connected within the broader community significantly more so than dads generally.***

The impact is also significant for Mothers:

- ***All mothers involved with Dads Group felt at least a little connected within their community, whereas 19% of mothers in the general community felt not at all connected.***

The results of a survey conducted in June 2019, amongst a randomly selected group of 40 participants in Dads Group, aimed at assessing how fathers were benefitting also demonstrated how effective the model is in reaching new fathers:

- ***100% of dads surveyed saying they would recommend becoming a member of a Dads Group to other new fathers.***

The following two vignettes highlight positive benefits of engaging with Dads Group:

M was a newly married, new father from Sweden who recently moved to the Sunshine Coast and connected with a Dad's Group. The multiple transitions, lack of friends and partner relationship challenges which resulted in divorce, could have had disastrous consequences for M. Support for him from other dads through this time was vital. Three years later, M still meets with the group - with a new child from a new marriage.

C, who joined a Dad's Group in Ringwood, was not coping well after a surprise pregnancy of a girlfriend. He was becoming a new dad all of a sudden and his reaction was to run away. After connecting with some new fathers who both understood his feelings and modelled positive responses, he was encouraged to embrace the changes. Strong friendship bonds were formed that helped him adjust to his new reality. The whole Dad's Group were recently at his wedding and celebrating with him the expected arrival of a second child.

Over the past 5 years working with new dads, Dads Group has gained an in-depth working knowledge of new father behaviour and the challenges and opportunities and recognised that the most sustainable way to establish peer support groups is to partner with local councils and existing services. As a result, Dads Group developed the *Engaging Fathers Program* as a way for local councils, maternal child health centres and other health services to support new dads in their local communities.

The program works with services to help identify local community needs, identify peer leaders, train leaders, launch groups and provide a weekly online forum of support as well as ongoing training and workshops.

Leanne Giardina, Coordinator of MCH and Immunisation at Moreland City Council:

"The impact is beyond what we thought. The work is about bringing dads with their children together, giving their partner a break and opportunity to support one another and make new friends. But to see our local dads be a part of setting it all up, owning the direction it goes in, and leading this work is something so wonderful to be a part of and so great to see this community led work happening. Working with Dads Group has been a collaborative, positive and insightful partnership which is building local dad communities in Moreland."

2. Hospital & Maternal Child Health Centre Projects

Most antenatal education classes are presented through a “service-provider lens’, geared to mothers, with minimal focus on mental well-being, father-inclusivity and the support needed during this major life transition.

In collaboration with the Brisbane Metro North Hospital & Health Service, Dads Group has developed a model with the intention of seeing systemic change in the approach and delivery of antenatal and perinatal education and support (see Appendix 8 for details of the project).

The model includes:

- Adapting the content of existing preparation for parenthood programs (PPP) to improve language accessibility and father inclusiveness.
- Establishing a *Peer Educator Mentor* to lead the project and the recruitment and training of *Peer Educators* (people with lived-experience) to deliver the updated education.
- Staff Training (all relevant executive, management and front-line staff trained in: perinatal mental health, research underpinning the model for supporting new fathers, why it benefits their service, and referral pathways.)
- Establishment and delivery of new local Dads Groups, and development of clear pathways from the hospital and existing services.

Launching in 2020, this model will be suitable to be rolled out to maternity hospitals and MCH services across Australia, with the goal of equipping the existing perinatal workforce with tools, resources and services to deliver better outcomes without increasing their workload.

3. Community Events

Dads Group also uses community events to increase awareness of the challenges for new families and to create pathways new fathers to join Dads Groups.

Man With A Pram is a social impact event that brings new fathers and families together with the goal of building awareness and creating stronger local communities. The 2019 Fathers Day event saw 17 different walks happening across Australia with over 1,000 participants.

Parenting Expos are another important entry point for new and expecting fathers, and Dads Group maintains a strong presence across the nation at 9 parenting events (reaching over 100,000 parents). This Dads Group presence provides an important avenue for expecting and new Dads to learn more about how they can be supported during the early stages of their parenting journey.

4. Research, Training, Partnerships & Advocacy

Research — the experiences of new fathers have long been under- researched and community-based programs for new fathers remain to be formally investigated in academic literature. In response, Dads Group have done some preliminary evaluation with the *University of the Sunshine Coast* to better understand the ways in which Dads Group supports outcomes related to men's mental health and domestic and family violence. Currently in progress, this study will capture the intersection between support groups and the changing norms of Fatherhood, providing an important research understanding of community-based programs for fathers. The research will also provide a 'systems' model of Dads Group strategic approach and vision, offering greater insight into the operations and potential for optimising community impact.

Building on this foundational research, Dads Group will form a research and evaluation group, chaired by Associate Professor Richard Fletcher (Founder AFRC and Editor of Fatherhood Research Bulletin). This group's recommendations will underpin all our work and ensure future project deliverables and outcomes will align with international best practice.

Training — Dads Group has developed several programs, including *Dads at Work*, *New Dads Boot Camp,* and *Man with a Plan* to provide practical training to new and expecting Dads. These are delivered both in person and digitally.

Partnerships — Dads Groups works collaboratively with other Father and Family-focused organisations, as well as industry experts and academics to continue to advocate for better outcomes for new fathers.

Impact

Dads Group's evidence based model of engagement and social change is demonstrated by our reach and impact to date outlined below. This reach has been achieved with almost no marketing.

Over 205,000 People Reached

- **200,000** people reached online
- Over **3,000** people engaging in Expos
- Over **2,000** people attending Man with a Pram Events
- **Over 70 Local Dad's Groups** established (**30+ members each)**
- Over **800** Dads Group Events

There are three direct areas of impact:

1.	2.	3.
Mental Health ***Suicide Prevention***	**Family Cohesion** ***Prevention of family violence***	**Child Development** ***Education & the early years***
Supportive social relationships, a sense of purpose, family harmony, and connections to physical and mental health services, all of which are recognised as protective factors against the risk of suicidality. (Black Dog Institute, 2019)	The act of empowering fathers to develop an identity as a father and embrace this new role is a step towards challenging gender stereotypes as well as strengthening equal and respectful relationships, both of which contribute to the prevention of domestic and family violence. (Our Watch, 2015)	The father-child relationship has been directly linked to child prosocial behaviour. (Ferreira et al., 2016)

Dr Ben Lane, University of the Sunshine Coast:

"Supporting new dads also supports their families and ultimately contributes to healthy child development and addressing broader social issues such as isolation."

N, Leader of Glenroy Dads:

"Running the Glenroy Dads Group has quickly brought an active community of local Dads, keen to connect and share experiences. It has been rewarding to build bonds of mateship while creating safe spaces for brand new dads. For us more experienced dads, it is good to offer guidance and ideas to brand new Dads. I know I went through a lot of challenges early on as a new dad, as did some friends, so we are there to let new dads know they have a place to turn to if they get stuck."

A Mum, from Coburg Dads

"It was important to me that D had support from other Dads after F was born. I found myself surrounded by mothers who could share advice, tips and tricks. I noticed early on that the same support didn't naturally come forward for D from other Dads. Dads Group have been important in him building his confidence as a parent, and in supporting him to be a hands on, practical, truly 50% carer for F. I passionately want other Dads to have the opportunities to care for their children in the ways that F has with D - and I believe that Dads Groups can offer the support for new dads to do this."

Dads Group Team & Structure

Dads Group is a registered charity. We have a board, as well as an experienced Industry Advisory Panel.

Industry Advisory Panel

Associate Professor Richard Fletcher
The Family Action Centre, Faculty of Health and Medicine, The University of Newcastle.
Richard researches fathers' mental health, attachment, coparenting, rough and tumble play and use of services. He is Principal Investigator of SMS4dads and Stayin on Track for Aboriginal fathers. His book "The Dad Factor: How the Father-Baby Bond Helps a Child for Life" (Finch 2011) has been translated into 5 languages. He is editor of the Fatherhood Research Bulletin.

Dr Alka Kothari
Department of Obstetrics & Gynecology, Redcliffe Hospital, and UQ
Dr Alka Kothari is a leading expert on the psychological impact on fathers of traumatic birth and termination experiences. After observing a culture of 'Forgotten Fathers' she developed a research project that identified that while mental health and other support is available to mothers, the lack of care and engagement with the fathers lead to a wide range of coping mechanisms, including

destructive anger and substance abuse. These often resulted in social isolation, guilt, shame, and depression with relationship and family breakdown.

Helen Funk
Lead Childbirth Educator, Redcliffe Hospital, QLD
Helen Funk is a midwife with 20 years of experience and the lead Childbirth Educator at Redcliffe Hospital, Queensland. In her role as the coordinator of Childbirth and Parenting Education she was instrumental in the development and facilitation of the Emotional Preparation for Parenthood Session as part of the childbirth class program. Both through working with consumers in the delivery of this education session and in her role as a senior midwife within the antenatal clinic, she is very aware of the value of working with consumers in educating parents about transitioning to parenthood.

Dom Alford
Project Coordinator – Support for Fathers, Relationships Victoria
Dom Alford is the Project Coordinator of Support for Fathers at Relationships Australia Victoria. He has worked in the welfare sector for 12 years across child protection, foster care, parent education and teaching. Dom has experience facilitating fathers' groups, implementing father-sensitive practice and, through the Support for Fathers project, has developed an extensive network and knowledge base of fathers' programs and fatherhood research around Australia. The Support for Fathers project,has officially launched a website with resources dedicated to supporting fathers across Australia. The website can be accessed at www.supportforfathers.com.au.

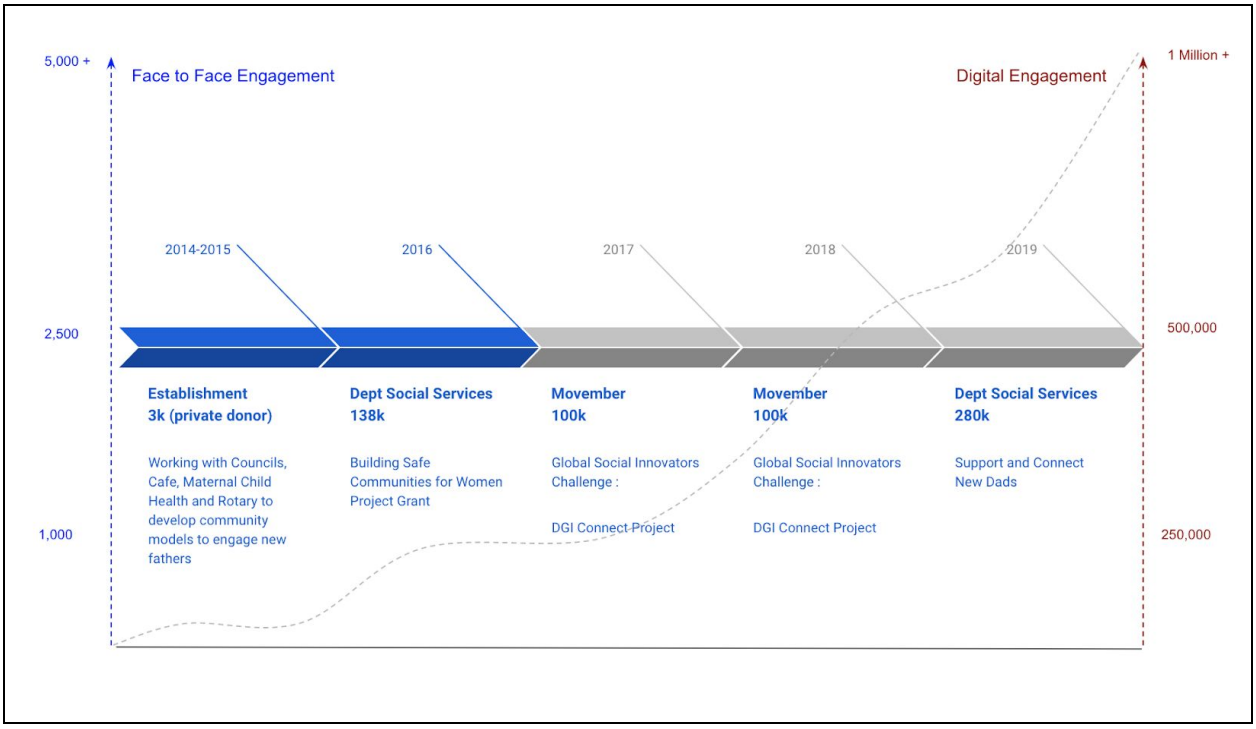
Cameron Just
Managing Director, Pregnancy, Babies & Children's Show
Cameron is an experienced commercial operator, with over 20 year experience working in events and entertainment, now with a strong focus on the early parenthood market.

Dads Group Board

Jason McEwan — Chairman
Matt Payne — Director
Haydn Stewart — Treasurer
Thomas Docking — CEO
Kieran Cummins — Secretary
Natalie Peta Rice — Member
Varsha Raghavan — Member

History & Previous Funding

Dads Group has been operating for 5 years, beginning with just one group and growing to over 70, piloting a national rollout model.



Pilot Program Summary of Objectives and Results

The information below provides an overview of the Dads Group's pilot project and evidence of project success and feasibility.

Project Aims:

Through the establishment of Dad's Groups, the aim was to create and implement a framework of support for new dads, scalable throughout Australia.

Progress Against Key Performance Indicators:

Target 1: *Increase in the number of Dads Group groups 10X (to over 30)*

Outcome: 3.7 times above initial target. Since the inception of the program there have been 112 Dad's Groups established throughout Australia.

Target 2: *Increase in the number of new members in groups 10X (to over 3,000)*
Outcome: 1.5 times above the initial target. These groups have 4380 members and there have been 762 events run with the aim of engaging dads.

Target 3: *Increase in the number of strategic partners for project delivery*
Outcome: 28 partners in Event, Program Delivery, Funding and Research

Target 4: *Improve the scalability ratios of the Dads Group methodology to reflect exponential correlation between communities and individuals impacted compared to resource inputs both human and financial*.
Outcome: Exponential impact and group growth from a linear team expansion

Target 5: *Replace seed funding with revenue streams 1-4 to drive operational sustainability*
Outcome: Increased operational sustainability by over the initial $200k seed fund through:

1. *Traditional corporate sponsors:* $60,000 (cash) and $150,000 in-kind.
2. *Fundraising activities:* Implemented at a national level - $15,000.
3. *Program Delivery Revenue:* Dad's Groups programs to Local Councils - $50,000.
4. *Government funding:* Grant from the Dept. of Social Services for $280,000.

Target 6: *Identify strategic global implementation partners*
Outcome*:* Identified and commenced communication process with key strategic partners including Movember, International Government Health and Welfare Departments in over 10 countries, International Perinatal Health Ambassadors. Global strategic partnerships will be developed in the areas of technology, marketing and promotion and global access.

Target 7: *Secure key national ambassadors*
Outcome: Have secured 3 ambassadors to promote the Dads Group initiatives:

1. A key influencer on Instagram and Facebook alias 'DadMum' has 250,000+ followers
2. A key influencer on Instagram and Facebook alias 'Schoollunchbox' and has 79,000+ followers
3. A key government health representative is an ambassador to the medical fraternity and building strategic relationships to develop pathways to new fathers and families.

<u>Evidence for program feasibility, acceptability, accessibility and potential effects for participants:</u>

The following statements are based on the qualitative and quantitative data in the KPIs section above.

- As partnerships have increased in number and focus, the exponential rate of growth of Dads Group has accelerated.
- Program feasibility is enhanced by the formation of multiple dynamic, strategic partnerships (refer Target 3 & 6 above).
- The number of new dads being connected indicates that Dads Group has a high level of acceptance amongst the target population (refer Target 1 & 2 above).
- Facebook is used as a means of communication between dads with the goal of connecting them in person, giving the program a high level of accessibility (refer Target 1 & 2 above).

A detailed analysis of the need and potential effects for participants is detailed in a literature Review – Appendix 5.

Summary of Plans for Scaling & Sustaining Dads Group

Main Goals for Scaling Up

This three-year project proposal outlines the building blocks to scaling nationally as the first steps of the Dads Group expansion. The main goals for scaling up this project are:

1. **Grow face-to-face reach and engagement for new and expecting fathers and families (from 5k to 60K)**
2. **Grow education, training, tools, programs and pathways for health practitioners in the perinatal space — Hospitals, Allied Health Services, Councils.**
3. **Increase positive fatherhood messaging and culture change, through influencing workplace cultures and increasing digital reach.**

Measures of Success

Goal 1. Grow face-to-face reach and engagement (60K)

a. *Engage a greater number of new fathers*
b. *Strengthen reciprocal distribution channels with strategic partners*
c. *Increase the diversity of Dads Groups members*

Goal 2. Develop education, training, tools, programs and pathways for health practitioners in the perinatal space — Hospitals, Allied Health Services, Councils.

a. *Major maternity hospital clusters in all states are approached with co-funded model to incentivise initial implementation*
b. *Implementation of engaging new fathers programs with a maternity hospital partner into each state and territory.*
c. *Co-develop training modules for allied health, local councils and State Government stakeholders seeking to engage new fathers*

Goal 3. Increase positive fatherhood messaging and culture change, through influencing workplace cultures and increasing digital reach.

a. *Increase number and range of strategic program partnerships and strategic ambassadors that champion Dads Group programs and initiatives*
b. *Continue to refine and develop content for online and face-to-face programs*
c. *Digital reach is expanded & increase in the number of new fathers actively engaged through social media*
d. *Enhance the user experience of Dads Group's digital platforms*
e. *Enhance and broaden the mechanisms of positive fatherhood messaging*

Core Features for Scaling Up

The key element in expanding the reach and impact of Dads Group will be scaling-up the organizational capacity to deliver more peer support groups (from 70 to 300). This will be done through training and developing new and existing team members. Our impact scales exponentially, delivering greater capacity for engaging new fathers and enhanced effectiveness of support.

Distribution/Acquisition plan to recruit the targeted number of new Dads

New fathers will be reached through online promotion, partnerships with key organisations and events held in the community. Members of existing Dad's Groups will also play a core role in the recruitment strategy through reaching out to their networks. Key strategic partners will educate the community about the existence and benefits of being a part of a Dad's Group. Dad's Groups State Managers and Leaders will work closely with partners to facilitate the Engaging Fathers Program Package.

For a detailed description of the Engaging Fathers Program Package please see Appendix 2.

Key partnerships Include:	**Other channels for reaching new fathers include:**
● Maternal Child Health Centres ● Hospitals ● Councils ● Local Community Groups ● Not-for-Profits	● Online Advertising ● Social Media ● PR campaigns ● Major events

Expected Barriers and Facilitators to Scaling Up

Expected barriers include recruitment of appropriate personnel, reliance on skill transfer, adaptation of internal management systems and motherhood programs being prioritised over fatherhood programs.

Expected facilitators include Dads Group's unique role as a support for new dads, strong existing partnerships, new ideas through new staff and community uptake due to extensive media exposure.

Details of these barriers and facilitators and the management/mitigation strategies for each are shown in Table 10 in Appendix 1.

Activities for Scaling Up

Structuring for growth will see existing roles expanded and refined with new roles established as follows:

- Leveraging existing services: establish cross organisational collaborative project teams with subject matter experts to validate detailed program design and support implementation
- Research and Evaluation: Establish research and evaluation project team to design and embed effective program evaluation methodology
- Expand and refine the role of executive and operational managers - recruit additional staff to expand these roles.

For a detailed description of roles and the scaling up process please see the organizational structure diagram in the business plan on page 35.

Expected Outcomes from Scaling-Up

Increasing the number and skill base of Dads Group project teams and staff will enable the organisation to forge new service delivery, event, research and funding partnerships. This, alongside the optimisation of digital platforms, will position Dads Group to reach 60,000 new fathers over a three-year period (with the message of the importance of being engaged as a new father with their infants and invitations to participate in programs that will support this).

Key Stakeholders

New Dads, Existing Dads Group members, Dads Group Leaders, Service Delivery partners, Event Partners, Research partners, Funding Partners, Dads Group Staff. *For relationship to scaling up activities please see table in Appendix 4.*

Resources and Infrastructure Required

The primary resources required for this scale up are human resources as detailed below in the business plan. Dads Group requires funding for the tech infrastructure as we establish and expand roles and roll out our national fundraising plan. Dads Group will also require premises for a head office.

Evidence of Demand

The high demand for the Dads Group program is supported by a number of key learnings including;

1. Rapid increased / exponential requests for Dad's Groups to be set up.
2. Set up requests have come about without any paid marketing or promotion and via a website that is rudimentary and has many areas for UX UI improvement.
3. Large target demographic - number of fathers of new babies each year is approximately 250,000.
4. Feedback from participants is overwhelmingly positive*. See preliminary results from University of the Sunshine Coast Research findings on page 13.*
5. Feedback from health industry experts has reflected increased demand.
6. Demand for the innovation comes from the following beneficiaries - Fathers, Mothers, Councils, Maternal Child Health Practitioners, Family support practitioners, NGOs, Hospitals.

Sustainability

The sustainability of scaling up of Dads Group is fundamentally reliant on effective partnerships. The purpose of scaling up the organisational structure is to engage a greater number of these partners and maintain and expand current partnerships.

Co-Investment

Dads Group has benefitted from both cash and in-kind investment from Funding, Event, Program Delivery and Research Partners. In many cases this investment is ongoing and can be leveraged further with the right partnership model.

Collaboration has commenced with the following 28 partners:

Movember, Dept Social Services, Tresillian, Karitane, Bakers Delight, Westfield, Eastland, Eastern Health, Baby Jogger, Child Association of Tasmania, NGALA, Waves of Wellness, Rotary, Toyota, Sunshine Coast University, PCB Expo, Monash City Council, Albury Wodonga Council, City of Stonnington, Salvation Army Capps, City of Moonee Valley, Elwood Playgroup, Uniting Care, City of Glen Eira, City of Moreland, City of Rockingham, City of Vincent, YMCA.

Implementation Plan

Summary

This implementation plan outlines steps Dads Group will take to scale nationally through strategic partnerships. Dads Groups current programs are a proven model of effective engagement with new fathers and represent optimal building blocks for Dads Group to maximise our impact for new fathers and families.

It is estimated that there are over 250,000 new dads or fathers of new infants in Australia each year. Both digital and face-to-face mechanisms of engagement are crucial in reaching and supporting these new fathers. Through collaboration, Dads Group envisions reaching 24% of these new dads in the three-year period and an exponential expansion of this reach into the future.

Strategy for Scaling Up

The key element in expanding the reach and impact of Dads Group will be scaling-up the organisational structure and capacity through increased human resources, alongside establishing a broad reaching marketing and fundraising plan, which will result in increased potential for engaging new fathers and enhanced effectiveness of support.

Structuring for growth will see existing roles expanded and refined and new roles established as follows:

- Refine the organisational roles
- Expand and integrate subject matter experts in both the design and implementation
- Recruit Operational and Strategic Staff for each State allowing State Manager to focus on engagement and relationship management with Dad's Groups, Leaders and State-based partners.
- All roles will be engaged in implementing the national marketing and fundraising plan, particularly the expansion of the fundraising events.

Evidenced-based Approach for Scaling Up

Dads Group will continue to develop initiatives based on the key areas of need and potential impact that have been identified by leading experts. In partnership with other researchers, practitioners and services these may include piloting embedding projects such as:

- Pilot the role of a paternal health medical record.

- Determine the health benefit impact of positive male behaviors, such as weight optimization and smoking cessation, on pregnancy outcomes.
- Establish male-specific guidelines on pre-conception, antenatal, and postnatal care with corresponding training for health care professionals.
- Assess the impact of pre-conception counseling that involves men on maternal, neonatal, and paternal outcomes.
- Explore the paternal contribution and pathophysiological mechanism to offspring health.
- Investigate the effect of obesity, diet, and exercise on sperm epigenetics and the effect on future offspring.
- Determine postpartum paternal health outcomes, such as paternal mental health following normal and abnormal births.

SWOT Analysis

Strengths:	**Weaknesses:**
● Unique organisational focus - no other organisation is doing peer groups for new fathers on a national scale ● 5 years of experience in demographic ● National team - passionate, motivated leaders ● Strong existing partnerships and National Network: AFRC, TFP, RF, TFH, Movember ● Proven peer to peer model and success of ‘Engaging Fathers Program’ ● High existing use of social media platform which is easily expandable ● Strong brand in health and government	● Sustainable funding – future work potentially reliant on cycle-based grants ● Historical research base is low and limited in scope ● The number and strength of health industry connections

Opportunities:	**Threats:**
● Grants ● Fundraising ● Global interest ● Demand is high ● Health industry partnerships	● Lack of funding ● Human resource scarcity ● HR / team attrition ● Competitors growing into the perinatal and infancy group space

Landscape Analysis

For a list of other major organisations established to support fathers in Australia, details of each of their focus areas and their main areas of engagement with the community, please see Appendix 3.

The main points of difference between all organisations listed and Dads Group are:

1. Dads Group specifically supports new fathers in the perinatal and infancy period (first years of fatherhood) when Dads are most vulnerable.
2. Dads Group is the only organisation of this kind utilising a peer-to-peer model of support for new Dads which is a key factor in engaging fathers to combat isolation and depression.
3. Dads Group focuses its action research around gathering data on new fathers, mothers and infants.
4. Dads Group importantly works with local partners, such as Councils and Maternal Child Health Centres, to establish and promote local, face-to-face Dad's Groups.
5. Dads Group co-delivers a globally unique Father's Day event, specifically for new fathers and families.
6. Dads Group's model to connect new fathers can be utilised as a universal transition to fatherhood that can be implemented anywhere in the world.

Project

<u>What Dads Group aims to achieve by 2023</u>

The table below outlines each of the main goals for scaling-up nationally, the sub-goals related to the main goals and the broad Measurables, Metrics and KPIs mapped out to measure the progress of each sub-goal:

Table 1.

Goal 1. Grow face-to-face reach and engagement (60K)		
	Sub-Goal	Measurables, Metrics and KPIs
1a.	*Engage a greater number of new fathers*	Total of 60,000 new fathers are engaged: ● 300 Local Dad's Groups are established with over 30 members each. ● 60,000 are engaged through major partnered events including Man With A Pram and Expos.
1b.	*Strengthen reciprocal distribution channels with strategic partners*	● Partnerships are built and pathways mapped between organisations within the fatherhood landscape. ● Man With A Pram event is positioned as a key on-ramp for engagement of new fathers.
1c.	*Increase the diversity of Dads Groups members*	Local Dad's Groups established in the following diverse communities: ● Defence and ex Servicemen Fathers ● CALD Fathers ● Fly in Fly Out (FIFO) fathers
Goal 2. Develop education, training, tools, programs and pathways for health practitioners in the perinatal space — Hospitals, Allied Health Services, Councils.		
	Sub-Goal	Measurables, Metrics and KPIs
2a.	*Major maternity hospital clusters in all states are approached with co-funded model to incentivise initial implementation*	● All key maternity hospitals in Australia are approached with pilot program outcomes and proposals specific to their region.
2b.	*Implementation of engaging new fathers programs with a maternity hospital*	● Total of 8 maternity hospitals (one in each State / Territory) implement Engaging Fathers Program ● Co-develop specific training modules for each state and territory

	partner into each state and territory.	
2c.	*Co-develop training modules for allied health, local councils and State Government stakeholders seeking to engage new fathers*	● Partnerships are strengthened and built with allied health services in each State / Territory (8) and training module is developed, tested and refined. ● 4 Local Councils in each State / Territory implement Engaging Fathers Program ● State Government stakeholders are engaged and specific training is co-developed
Goal 3. Increase positive fatherhood messaging and culture change, through influencing workplace cultures and increasing digital reach.		
	Sub-Goal	Measurables, Metrics and KPIs
3a.	*Increase number and range of strategic program partnerships and strategic ambassadors that champion Dads Group programs and initiatives are recruited*	● The number of strategic partnerships is increased by 60% per year to see a total of at least 115 new partnerships established by the end of the third year.
3b.	*Continue to refine and develop content for online and face-to-face programs*	● Improvement of content management systems and processes. ● Demonstration of development reviews and updates.
3c.	*Digital reach is expanded & increase in the number of new fathers actively engaged through social media*	● 2,000,000 are connected online and through media. ● Active online engagement increased by 100% per year.

3d.	*Enhance the user experience of Dads Group's digital platforms*	• Dads Group's digital platforms are continuously developed in collaboration with experts and strategic partners. • Platforms are enhanced through user surveys. • Dads Group members report experiencing a high level of satisfaction and high-quality support.
3e.	*Enhance and broaden the mechanisms of positive fatherhood messaging*	• Growth in major community events from 1 to 40 per year. • Distribution of local Dad's Group messaging and promotion is improved.

How Dads Group will achieve these aims

Scaled Up Organizational Structure

Through scaling for growth, Dads Group will increase its capacity and effectiveness. Dads Groups current organisational structure is represented in the diagram below:

The primary scaling up activities include recruiting the following in order to see exponential growth:

- 5 part time State Managers
- 5 part time Operational and Strategic Support staff

This will enable Dads Group to engage multiple volunteer Dad's Group Leaders and mobilise a vast number of other volunteers to extend the reach and impact of the program. Dads Groups scaled up organisational structure is represented in the diagram below:

A detailed description of each role is outlined below in Tables 2,3 & 4

Scaling Up Activities

The table below outlines the main scaling-up activities to be carried out by each role and the measurables, metrics and KPIs set to measure the progress and success of each scaling up activity.

Table 2.

ROLE: CEO/Executive		
Activity	**Description**	**Measurables, Metrics & KPIs**
Vision Casting	• Spokesperson to governments, general public, partners and influencers • Promote positive fatherhood messaging and culture change	• Media Exposure - TV, Radio, Newspaper, Digital • Speaking Engagements

Strategy	● Pursue high-value partnerships for sustainability ● Develop, support and monitor scaled-up engagement strategy ● Utilise new research	● Partner/influencer events ● Government meetings/events ● Regular Managers meetings both face-to-face and via Zoom ● Research partner meetings
Financial Oversight	● Oversee all aspects of Dads Group's finances ● Plan, develop and implement fundraising strategy	Meet fundraising goals: ● Year 1 = $40,000 ● Year 2 = $200,000 ● Year 3 = $300,000
Risk Management Oversight	● Encourage a culture of accountability ● Ensure all staff meet scaling up KPIs ● Ensure risks to ongoing viability are mitigated	● Individual accountability sessions ● Business plan used as reference point at all meetings ● Instigate workplace health and safety plan throughout the organisation

Table 3.

ROLE: STATE MANAGERS x 4		
Activity	**Description**	**Measurables, Metrics & KPIs**
Recruitment	● Advertise, interview and employ local staff	● ·Operational and Strategic staff member recruited by May 2020

Program Implementation	• Connect with new Delivery Partners • Deliver an increased number of Dads Group Engaging Fathers Packages • Train more Dad's Group leaders • Establish more Local Dad's Groups	Engage new Partners • 2020 14 • 2021 22 • 2022 30 Train new Dads Group leaders • 2020 40 • 2021 50 • 2022 60 Establish new Dads Groups • 2020 20 • 2021 50 • 2022 100
Financial Management	• Working with the CEO, • establish and initiate an annual operational Dads Group budget • Plan and undertake local fundraising in line with the national strategy, focusing on MWAP	Meet fundraising goals: • Year 1 = $40,000 • Year 2 = $200,000 • Year 3 = $300,000
Risk Management	• Ensure a safe workplace • Manage and mitigate risks at events	• Implement Dads Group Workplace, Health and Safety plan

Table 4.

ROLE: OPERATIONAL AND STRATEGIC SUPPORT STAFF x 4		
Activity	**Description**	**Measurables, Metrics & KPIs**
Social Media:	• Increase the reach of Dads Groups social media presence and enhance the user experience	Increase social media reach by: • 15% 2020 • 25% 2021 • 40% 2022

Partner Support	• Work with partners to enhance data collection and analysis and Dads Group messaging	• Enhance the platform to collect, analyse and distribute data and messaging by 2021
Program Enhancement:	• Train Dads Group leaders to maximise digital messaging capabilities • Continue to enhance agile digital review process	• Existing Dads Group leaders upskilled by 2021 • All new Dads Group leaders trained on recruitment • ·Improved program development and increased retention rates

Implementation Calendar

The schedule below provides a visual representation of the information included in Tables 2,3 & 4 in Part 5 and details the scaling up activities for each quarter over the three-year period via the following coding:

Preparing		CEO = CEO SMs = State Managers OSS = Operational and Strategic Support Staff
Implementing		
Completion Milestones		

Table 5.

Activity	**Staff**	**2020**				**2021**				**2022**			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Recruit SM x 5	CEO												
Recruit OSS x 5	SMs												
Create SM training program	CEO												
Extended face-to-face training workshops	CEO SMs OSS												
Meet with 2 potential new research partners	CEO OSS												

Pursue high level partnerships for sustainability	CEO												
Develop annual fundraising strategy	CEO SMs												
Implement annual fundraising strategy including MWAP	CEO SMs OSS												
Connect with new program deliver partners and deliver an increased number of Dads Group Engaging Fathers Packages	SMs												
Establish Dads Groups and train Dads Group leaders	SMs												
Increase the reach of Dads Groups social media presence and enhance the user experience	OSS												
Train Dads Group leaders in digital review process	OSS												
Work with industry experts to explore new mechanisms for positive fatherhood messaging and culture change	CEO OSS												

Costs

Table 6.

Maximised Growth and Scale			
Items	**Year 1**	**Year 2**	**Year 3**
Wages: CEO/Executive Full Time	120,000	100,000 Remaining funds raised (20,000)	80,000 Remaining funds raised (40,000)

Wages: State Manager x 5 Full Time	450,000	420,000 Remaining funds raised (30,000)	390,000 Remaining funds raised (60,000)
Wages: Operational and Strategic Support x 5 Full Time	375,000	320,000 Remaining funds raised (55,000)	F280,000 Remaining funds raised (95,000)
Wages: National Fundraising Manager Full Time	80,000 Remaining funds raised (20,000)	60,000 Remaining funds raised (40,000)	40,000 Remaining funds raised (60,000)
Wages: Admin Full Time	72,000	52,000 Remaining funds raised (20,000)	32,000 Remaining funds raised (40,000)
Program Research and Design	52,000 Remaining funds raised (20,000)	46,000 Remaining funds raised (30,000)	46,000 Remaining funds raised (30,000)
Program Implementation	120,000	100,000	80,000
Program Support	70,000	60,000	42,000
Marketing/Promotion	140,000	120,000	100,000
Offices	25,000	25,000	25,000
Events	120,000	100,000	80,000
Flights	45,000	35,000	25,000
Travel (Uber, Taxi, Car Hire)	25,000	15,000	10,000
Accommodation	40,000	30,000	20,000
Accounting	6,000	6,000	6,000

Insurance	5,000	5,000	5,000
TOTAL	1,745,000	1,494,000	1,261,000
TOTAL			**4,500,000**
Fundraising goals: Year 1 = 40,000 Year 2 = 195,000 Year 3 = 325,000 Total =$560,000			

Partnerships

Current Partnerships

The success and scaling up of Dads Group is fundamentally reliant on positive, sustainable and effective partnerships. The purpose of scaling up the organisational structure is to engage a greater number of these partners and maintain and expand current partnerships.

Current partnerships exist in the following areas:

Event Partners

Work with Dads Group to support major events - Expos and 'Man With A Pram'
Provide financial, in-kind and promotional support

Program Delivery Partners

Work on the ground with new dads through 'Engaging Fathers Package'
Dads Group collaborates with these partners to establish new Dad's Groups

Funding Partners

In addition to providing financial support, Funding Partners help Dads Group to be specific with objectives, detailed in implementation planning and accountable in delivery.

Research Partners - Dads Group works closely with Research Partners to expand and enhance research around the journey for perinatal and infancy fathers.

Overview of Dads Groups current partnerships

Table 9.

Partner Type	**Number**	**Organisations**

Event	13	Tresillian, Karitane, Bakers Delight, Westfield, Eastland, Eastern Health, Baby Jogger, Child Association of Tasmania, NGALA, Waves of Wellness, Rotary, Toyota, PCB Expo.
Program Delivery	12	Monash City Council, Albury Wodonga Council, City of Stonnington, Salvation Army Capps, City of Moonee Valley, Elwood Playgroup, Uniting Church, City of Glen Eira, City of Moreland, City of Rockingham, City of Vincent, YMCA.
Funding	2	Department of Social Services Movember
Research	1	University of the Sunshine Coast

Dads Group aims to expand its partnerships to the following levels:

- 50 Event Partners
- 60 Program Delivery Partners
- 3-5 Funding Partners
- 2-3 Research Partners

Future Partnerships

Dads Group would implement a ‘reciprocal distribution channel partnership model’. This decentralised approach would allow:

- Enhanced relationships and greater ownership of Dads Group’s vision by partners
- Facilitated access to wider networks
- An increased focus on train the trainer programs
- Greater number of partnerships particularly with local government
- Greater number of partnerships with organisations in the health sector
- Greater shared leadership of Dads Group activities that engage fathers
- An enhanced feedback loop in preparation for global scalability

APPENDICES

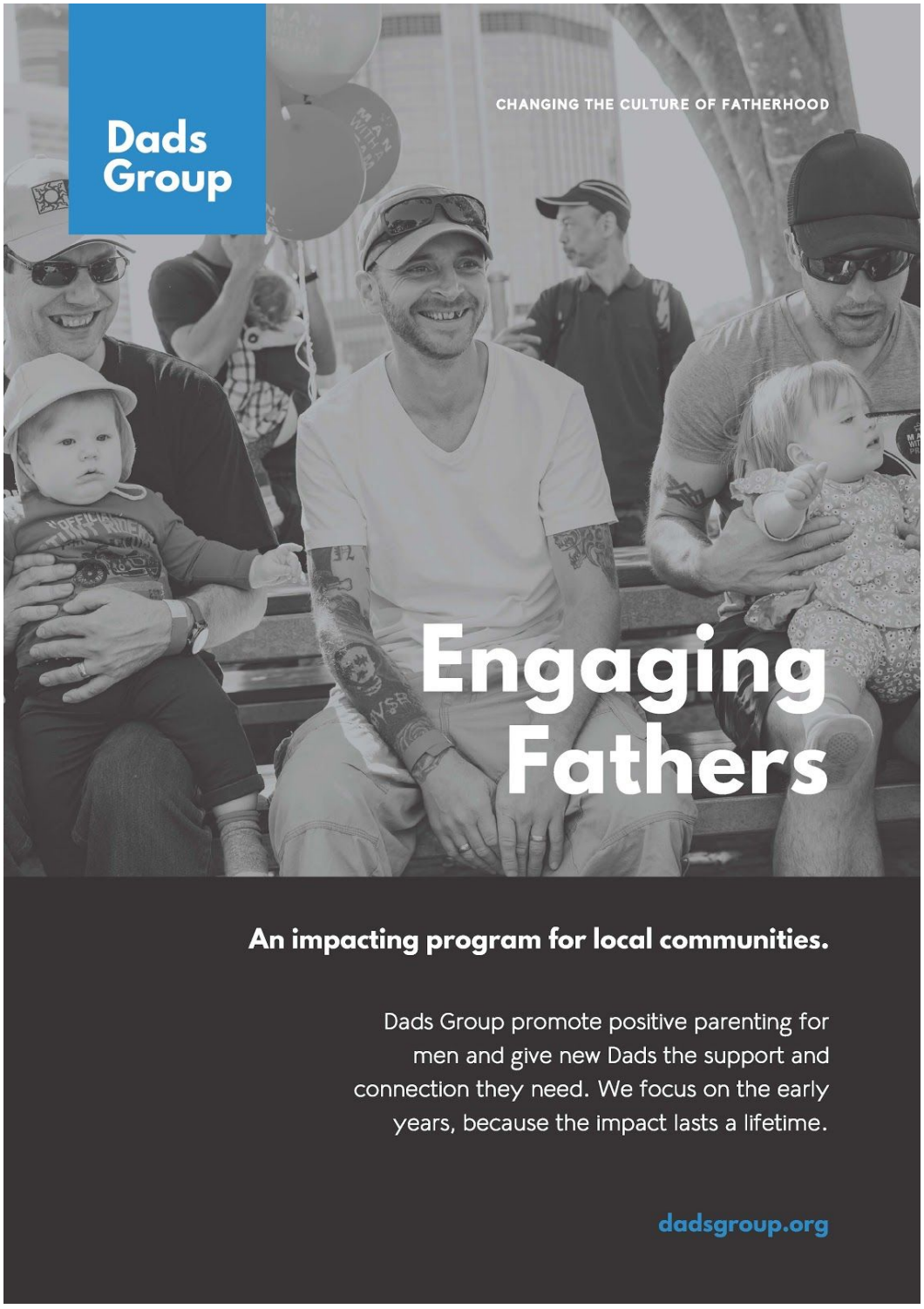
Appendix 1. Barriers & Facilitators

Table 10

Barriers	**Management/Mitigation Strategies**
Recruiting health professionals with the appropriate skill sets e.g. promoting and recruiting, relating well to new Dads etc.	Seek the right people through: ● Current stakeholders ● Health professionals ● Professional development of current SMs
Reliant on skill transfer from CEO to SMs and SMs to OSS – time and energy needed for skill/knowledge transfer of Dads Group while scaling up.	Work together: ● Extended face to face workshop setting ● Regular Zoom meetings ● Use a written training program
Internal program management systems being adapted / upgraded to facilitate scale-up	Strategic focus on upgrading systems: ● Dedicating initial stages of scale-up to system adaptation
Partners prioritizing and funding Motherhood programs over Fatherhood program	Educate potential partners around ‘Helping Fathers, Helping Families’
Facilitators	**Management/Mitigation Strategies**
Research indicates that Dads Group maintains a unique place in the Australian parenting support landscape	Maintain and broaden the role as a peak body for new father programs
Strong existing Event and Program Delivery partnerships	Use positive existing relationships to multiply access to new partners

Recruited staff bring expertise and expansion of ideas to Dads Group	Work with an increasingly open and streamlined management style that invites innovation and discussion of new ideas
Extensive media exposure has led to greater corporate and community participation	Develop a media strategy to harness this interest and support

Appendix 2. Engaging Father's Package



The early stages of fatherhood are a time of acute stress and loneliness for many dads.

39% of first-time fathers experienced high levels of psychological distress in the first year of their child's life.

41% feel overwhelmed by the responsibilities to their family

43% of first-time dads saw anxiety and depression after having a baby as a sign of weakness.

56% of new dads did not seek information or support from any source during stressful times.

And yet, NO state or nation-wide services exist for fathers that provide the type of proactive and ongoing care a mother receives throughout pregnancy and early parenthood.

Introducing, Dads Groups.

What is a Dads Group?
Dads. Their kids. Coffee. And maybe a playground. It sounds like a simple formula, but Dads Groups provide new fathers with the connection and support they desperately need.

Groups meet weekly, sharing experiences of fatherhood and supporting each other during tough times.

70 Dads Groups

With over 70 groups already established around Australia, Dads Groups are a proven model to engage and support new fathers.

93%

Of new dads surveyed expressed that attending a Dads Group improved their social connections.

100%

Of new dads surveyed said they would recommend becoming a member of a Dads Group to other new fathers.

What impact do Dads Group have?

When Dads are doing well, mums, babies and whole families are supported. Dads Groups directly decrease risk factors associated with mental illness and suicide, contribute to better child development and increase overall family wellbeing.

Mental Health

Suicide Prevention

Supportive social relationships, a sense of purpose, family harmony, and connections to physical and mental health services, all of which are recognised as protective factors against the risk of suicidality.
(Black Dog Institute, 2019)

Family Cohesion

Prevention of Family Violence

The act of empowering fathers to develop an identity as a father and embrace this new role is a step towards challenging gender stereotypes as well as strengthening equal and respectful relationships, both of which contribute to the prevention of domestic and family violence.
(Our Watch, 2015)

Childhood Development

Education & Early Years

The father-child relationship has been directly linked to child prosocial behaviour.
(Ferreira et al., 2016)

The Engaging Fathers Program

After successfully piloting and refining the model of Dads Groups over the last 6 years, we have successfully developed a program called Engaging Fathers, that we run in partnership with local councils and maternal child health services to help them reach families in their local communities.

How does the Engaging Fathers Program work?

1. Identify Community Needs
We meet with your team to identify the specific needs of your community and develop a plan for the most effective way to roll out the program.

2. Identify Leaders & Launch Group/s
Groups are designed to be community led to engage and support fathers and father figures in your community.In partnership with your service DG identify champion local fathers to lead the group, who arrange events for fathers to meet with their babies and create a 'village' that suits the needs of the community.The events occur on weekends at local cafes, parks providing an opportunity for fathers and father figures to have time to bond with their children and share experiences of the highs and lows of early parenting.

3. Training & Support of Leaders
We provide a weekly online forum of support for leaders as well as ongoing training for the group leaders to help them lead the group and increase sustainability.

4. Support & Education for Councils and MCH
We believe in a wholistic model of care, and so we also provide information for councils, MCH workers in how they can better engage fathers and see families doing better.

DG

"Running the Glenroy Dads Group has quickly brought an active community of local Dads, keen to connect and share experiences. It has been rewarding to build bonds of mateship while creating safe spaces for brand new dads. For us more experienced dads, it is good to offer guidance and ideas to brand new Dads. I know I went through a lot of challenges early on as a new dad, as did some friends, so we are there to let new dads know they have a place to turn to if they get stuck."

— Nick, Leader Glenroy Dads

"It was important to me that David had support from other Dads after Frankie was born. I found myself surrounded by mothers who could share advice, tips and tricks. I noticed early on that the same support didn't naturally come forward for David from other Dads. Dads groups have been important in him building his confidence as a parent, and in supporting him to be a hands on, practical, truly 50% carer for Frankie. I passionately want other Dads to have the opportunities to care for their children in the ways that Frankie has with David - and I believe that Dads Groups can offer the support for new dads to do this"

— Mum, from Coburg Dads

"

"The impact is beyond what we thought.

The work is about bringing dads with their children together, giving their partner a break and opportunity to support one another and make new friends. But to see our local dads be a part of setting it all up, owning the direction it goes in, and leading this work is something so wonderful to be a part of and so great to see this community led work happening. We have other organisations promoting this work, referring dads to us and even politicians talking about it! Working with Dads Group has been a collaborative, positive and insightful partnership which is building local dad communities in Moreland."

— Leanne Giardina
Coordinator of MCH and Immunisation at Moreland City Council

Let's chat

We'd love to chat more about partnering to engage Fathers in your local community.

Adam Tardif
adam.tardif@dadsgroup.org
0400 184 068
dadsgroup.org.au

Dads Group

Package Includes:

6 months Facilitated Engaging Fathers Package $4990 ex GST
(Includes One Dads Group)

1. On-site Engaging Fathers Workshop (travel fees may occur)
2. Media Package (Brochures, Posters, Email template, Banner, Facebook Live interviews and promotions, Brochures, Social media posts and Reporting)
3. 7 face to face visits
4. Unlimited remote support (Phone & emails support local from local Dads Group rep)
5. Local group setup for one group (Digital Group Page, and communication channel)
6. Group support (Weekly Conference call)
7. Fundraising support for group sustainability (Eg: one tap donation device for placement in a local coffee shop)
8. Renewal cost $3990 ex GST for an additional 6 months (Must be purchased together with the facilitated package)

Appendix 3. Landscape analysis of major organisations working with fathers

ORG NAME	Function	Approach	Type	Topic	Beneficiary	Geography
Dads Group	**Service & resource provider**	**Service, research & knowledge dissemination**	**Nonprofit**	**Fatherhood for new fathers**	**Dads & Families**	**National scalable to International**
The Fathering Project	Service & resource provider	Service, research & knowledge dissemination	Nonprofit	Fatherhood for school aged children	Families	National
Dads4Kids	Resource provider	Knowledge dissemination	Nonprofit	Fatherhood	Families	Web based
Dads in Distress	Facilitator of support groups	Service provision	Nonprofit	Suicide Prevention amongst Fathers	Dads experiencing separation	National
The Fatherhood Project?	Resource provider & advocate	Service provision	Nonprofit	Fatherhood	Families	National
Men's Health Australia	Resource provider & advocate	Knowledge dissemination & lobbying	Nonprofit	Men's health	Men & boys	National
White Ribbon Fatherhood Program	Service & resource provider	Service provision & knowledge dissemination	Nonprofit	Fatherhood & preventing domestic violence	Families	National

Appendix 4. Dads Group Stakeholders

Stakeholder	Relationship to scaling up activities
New Dads	Target group for engagement through scaling up activities
Existing Dads Group members	Networking with peers to promote Dads Group
Dads Group Leaders	Establishing and supporting new Dads Groups
Service Delivery Partners	Engage new dads and support establishment of new groups
Event Partners	Supporting event implementation - promotion and funding
Research Partners	Expanded research around Dads Group programs and fatherhood
Funding Partners	Financial and strategic support and collaboration
Dads Group Staff	Strategic and operational oversight / implementation

Appendix 5. Literature Review

Supporting evidence for the need to support new fathers with peer support programs.

Title: The changing role of fathers, impacts on the family, and the role of support services
Authors: Mary Gregory, Dr Ben Lane, Dr Nicholas Stevens

1. INTRODUCTION

The word father or dad encapsulates a wide variety of thoughts and meanings. The history of the word father can be traced back to Latin, Greek and Sanskrit influences and the similarity of pronunciation has provided an understanding of the kinship that exists between these somewhat distinct and diverse languages. The English dictionary offers a definition of father as being a male parent or a man who has begotten a child. However, the idea of what it means to be a father encompasses much more than the narrow limits of the definition provided. Indeed, being a father has expanded to fit with changing times and the traditional ideas of fatherhood and of the role of a father are evolving. Central to this evolution is understanding who a father is and can be and that a father may not necessarily be biologically related to his child. Today the definition of father is broadening to recognise other males (or people who identify as male) who are increasingly taking an active role in the lives of their children. This group may include, a grandfather, step-father, foster father, adoptive father, father figures and relatives or friends who serve as an alternate to a biological father in providing care and guidance for a child. This literature review seeks to recognise this evolution of the definition of the term father and how the term is effectively interchangeable with the range of individuals outlined above. With this wider inclusion comes the understanding that there is no longer a single or correct way to be a father as traditional ideals make way for the reality of increasing societal change.

The transition to parenthood is a major life event for both men and women and a time of significant change. Coupled with societal change is the understanding that individuals may struggle in negotiating their new identity as a father, which may have implications for their families. This literature review presents an understanding of how the concept and practice of fatherhood has changed and continues to adapt, driven in part by structural shifts that are impacting modern fathers in a myriad of ways. This review seeks to explore three significant implications of this change and provide an understanding of how the health and well-being of fathers and their children is impacted primarily within the Australian context. The implications discussed include fatherhood and child development, fatherhood and mental health, and fatherhood and domestic violence within the context of the changing role of the father. This is followed by a review of literature pertaining to support seeking behaviours and how community

based support groups which involve play and connection provide a safe space for fathers and their children to facilitate a positive transition to parenthood by enhancing parental well-being, child-parent interaction, social networking, and parental confidence in child rearing.

2. METHODOLOGY

A systematic literature review was conducted in which a comprehensive search of multiple relevant subject databases occurred. The databases which were searched included Google Scholar, Psychnet (APA), ProQuest, JSTOR, SAGE Journals, Taylor and Francis Online, Web of Science, and Psychiatry Online. These searches were conducted in 2019. Both published and unpublished manuscripts were considered, however unpublished research may have been missed if it was not included on the databases. Search terms which were used included father, fathering, fatherhood, father role, paternal, reflexive modernisation, family structures, family complexity, transition to parenthood, transition to fatherhood, child development, father child development, paternal child development, father mental health, paternal mental health, attachment theory, attachment parenting, father child relationship, father sensitivity, father warmth, paternal sensitivity, paternal warmth, father domestic violence, family domestic violence, intimate partner violence, family violence, intimate partner violence child impact, paternal support seeking, father support seeking, parent support seeking, playgroups, parent groups, and father support groups. While no specific review protocol was used the author made every effort to search for published materials that were recent, widely cited, seminal works, or peer-reviewed articles. This review placed a particular emphasis on sourcing relevant articles on new fathers with an Australian focus.

3. FATHERHOOD AND THE CHANGING ROLE OF THE FATHER

There is an historical transformation taking place in society in which rationality, social hierarchies, and tradition are being challenged by a new modernity which has led to a shift in ways of thinking about how individuals relate to society (Beck, 1992). The significance of research regarding transformation in society and modernity is becoming increasingly apparent as the experiences of families are changing, and as the societies around them change as they look to the future. Social theorists including Bauman (2000), Beck, Giddens, and Lash (1994), Beck, Bons, and Lau (2003), and Giddens (1990) have conceptualised this transformation as a process of reflexive modernisation. Beck et al. (2003, p. 3) provide a welcome distinction between what they term a first and second modern society and in doing so they elaborate on the underpinnings of reflexive modernisation:

> Simple modernization becomes reflexive modernization to the extent that it disenchants and then dissolves its own taken-for-granted premises. Eventually this leads to the undermining of every aspect of the nation-state: the welfare state; the power of the legal system; the national economy; the corporatist systems that connected one with the other; and the parliamentary democracy that governed the whole. A parallel process undermines the social institutions that buttressed this state and were supported by it in turn. The normal family, the normal career and the normal life history are all suddenly called into question and have to be re-negotiated.

Giddens (1991) asserts that both structures and associated relationships are changing, and this is forcing individuals to reflect on how to relate to the world, and how and where they fit in this different world. For the purposes of this review it is the re-negotiation of the family structure, the transition to parenthood, and specifically the role of the father that is of particular interest. Family structure trends in Australia have mirrored those in Europe over past decades. That is, fertility rates have declined, and childbearing is occurring later and increasingly outside of a formal marriage (Australian Bureau of Statistics, 2017a). Despite the fact that the Australian population has doubled since the early 1970s, in 2017 there were less marriages than in 1970. The crude marriage rate of 4.6 marriages per 1000 Australian residents in 2017 was the lowest rate ever recorded. Further to this men and women are waiting longer to get married with the median age significantly higher than in the 1970s (Australian Institute of Family Studies, 2017). This has meant that most couples now live together before getting married and this is also a significant increase over pre-marriage cohabitation rates from the 1970s. What this suggests is that these and other changes have prompted evermore complex family structures and relationships over the life course.

The Australian Institute of Family Studies (2016) has sought to analyse and better understand changing family structures and in particular the diversity, complexity and change within children's households. According to the Australian Institute of Family Studies (2016, p. 41) family complexity refers to children living with a single parent or with parent figures who are not biological parents (and also when they are cared for by parents who live in two households, usually post separation), when they live with step- or half-siblings, or with adults other than parents or parent figures. Within the 2015 report a longitudinal analysis identified that two in five children experienced some form of family complexity before they reached the age of 13 with the potential for this to have both positive and negative consequences. Other findings indicated that children were increasingly likely to be exposed to household complexity as they grew due to the cumulative effects of parental relationship collapse which resulted in children being more likely to experience family complexity by living apart from one of their parents. In terms of parental characteristics family complexity was observed to be strongly related to financial wellbeing and

levels of educational attainment with the potential for transference of disadvantage from one generation to the next.

Finding stability within increasingly complex household and family structures, and wider social change is a challenge for all involved. Within this complexity is often the introduction of changes to relationships, family routines, responsibilities and roles and this can be confronting and challenging not only for children but for parents too. Fatherhood and the role of the father has changed considerably over the last half century. Research on fathers and in particular the impact of the father on child development began towards the end of the 1960s and into the 1970s. This led to further research on involvement, and overviews by Lamb (2000) and Paquette, Coyl-Shepherd, and Newland (2013) referenced specific facets or ideal types of the father role that dominated certain periods. Lamb (1987) identified four ideal types as including moral guidance, breadwinning, gender-role modelling and nurturing within the United States. According to Lamb the first period in which moral guidance was the dominant paradigm existed prior to the industrial revolution where fathers were primarily responsible for the moral and educational needs of their children. As the industrial revolution took shape the second period came to be defined by a breadwinning role in which fathers were seen as providers for their families and this ability to provide became the most important characteristic of determining how ‘good fathers’ were defined. Possibly as a result of major world events such as the fall out from the Great Depression and then into the Second World War the third period of the 1930s, 1940s and onward saw a change in the conception of fatherhood. Lamb (2000) pointed to the inadequacy of many fathers being the focus of much literature during this time. As such this period came to be characterised by gender or sex role modelling whereby increasingly the father’s role was to impart on their sons how they were to fit into family life in a positive manner. The fourth period which Lamb referred to as the ‘new nurturant father emerged around the mid-1970s. This period has emphasised active involvement of fathers in the day-to-day care of their children and has become a core facet of active parenting today.

Amidst such archetypal changes (Williams, 2008) has argued that fatherhood has become increasingly individualised in the face of societal and familial change and that fatherhood is increasingly being challenged by partners and social institutions such as the media, and government. As certainty has decreased particularly within labour markets the alignment of fathers with traditional conceptions of fatherhood have become less likely with the literature of Lamb and others pointing to a more involved parenting role for fathers. According to Reilly and Rees (2018) research on fatherhood in indigenous cultures, including Aboriginal and Torres Strait Islander communities is lacking when compared with non-indigenous cultures. It is also important to recognise that while early conceptualisations of fathering roles appear unidimensional and given that typically fathers have been perceived and appraised by their breadwinning capacity, there is in fact a growing recognition of the multiple and significant roles

that fathers perform in raising their children. Although the research of Lamb has over many years focused on the United States, recent Australian census data from 2016 provides a similar depiction of a modern Australian father who is more actively involved in raising his children. For instance, according to the Australian Institute of Family Studies (2018), based on averages of time use estimates reported by parents (with children under 15 years) over the period 2002 to 2015 fathers worked on average, 75 hours a week. Of that, 46 hours was spent on paid work, 16 hours on housework and 13 hours on child care. Mothers were reported to work an average of 77 hours a week with 20 hours spent on paid work, 30 hours on household work and 27 hours on child care. While fathers in Australia today may be more involved in child care than in past decades recent statistical trends for most families indicate that the number of hours that fathers spend in employment remains the same before and after having children (Baxter, 2018, 2019). An increasing number of mothers have returned to the workforce particularly over the past two decades. This has led to changes in the couple parent employment patterns from 1991 to 2016 with a gradual increase in the percentage of households where both parents have worked from 54 percent to 66 percent (Australian Population Census customised reports, 1991-2016). According to the Baxter (2019) it appears that fathers have sought out flexible work arrangements and working from home over part-time work as a means to care for their children and contribute to household work while maintaining full-time employment. The time that families spend together is obviously important in many areas and particularly with regard to relationships. The statistics above indicate that fathers are attempting to reconcile an expanding fatherhood role with increasing time pressure.

Time pressure within Australian families is something that has been examined within the 2004 HILDA survey (Australian Institute of Family Studies, 2007). Within this study parents with children aged under 5 were identified as the most likely to feel time pressure (48% of fathers and 58% of mothers) with the underlying premise being that always or often feeling rushed or pressed for time (time pressure) could be a source of stress for families. When coupled with the parental time use estimates and changing patterns of labour force participation for men and women referred to above there is a thought that families may be spending less time together. This is interesting as trends reported by the Australian Bureau of Statistics (2016) suggest that Australian fathers who spend more time on child care are the most satisfied with their relationships with their children. Further to this, fathers of pre-schoolers, who are completely satisfied with their relationship with their children spend an average of 18 hours per week caring for their children. The least satisfied dads with the same-aged children spent an average of 10 hours per week caring for them (Australian Bureau of Statistics, 2016). The reality is that the involvement and influence of fathers is complex, and the quality of interactions and relationships are seemingly more significant to the health and development of children than is the quantity and duration of interactions. The next section will now explore this topic in greater detail.

4. IMPLICATIONS FOR FATHERS AND FAMILIES

Parents play a fundamental role in the healthy development of their children. Fathers appear to play a significant role in the process of broadening their children's horizons and connecting them to the outside world. Research suggests that such activity is associated with the development of autonomy and risk management as children seek to explore their immediate environments and that this exploration serves to develop a range of physical and social skills, self assertiveness, anger management, and academic and professional success (Fletcher, 2011; Newland & Coyl, 2010; Paquette, 2004; Paquette, Eugene, Dubneau, & Gagnan, 2009). Underlying this exploration and development are the ideas of change referenced in previous sections and so the following sections provide an understanding of implications for fathers and families in the midst of such change. These include, fatherhood and child development, fatherhood and mental health, and fatherhood and domestic violence.

4.1 FATHERHOOD AND CHILD DEVELOPMENT

Research investigating the influence of fathers on child development began around 70 years ago. Since this time researchers have sought to examine fathers' influences on children and the pathways through which those influences have manifested. A significant body of research suggests that fathers perform an important role in the development of their children. The research literature on father involvement and child development has revealed that fathers can and do exert a significant influence on many areas of development in behavioural, emotional, cognitive and social domains. Lamb and Tamis-LeMonda (2004) in their review of fathers' influences on child development provide a historical overview of different types of studies that have been designed to explore this topic. The first, correlational studies in which studies of father involvement targeted links between a father's degree of masculinity, father child relationship quality, and the gendered roles adopted by children. These studies occurred primarily between 1940 and 1970 when the fathers role as a sex-role model was considered to be primary (Lamb & Tamis-LeMonda, 2004). The focus of this research was to assess masculinity in fathers and sons and examine the strength of correlation between the two. What developed from these studies was an understanding that the quality of father-son relationships was more of a mediating variable and subsequently more important than the masculinity of the father (Mussen & Rutherford, 1963; Payne & Mussen, 1956; Sears, Maccoby, & Levin, 1957). Moreover, warm and positive paternal relationships were seen to be of greater benefit to a child's development than the gender characteristics of a father and a similar importance was observed with maternal influence in this regard.

In the 1950s and beyond a second and parallel focus of inquiry began to take shape with studies of father absence. Here single parent families were compared with dual parent families and studies in which father absence was due to other circumstances such as death or work. According to Lamb and Tamis-LeMonda (2004) the focus of these correlational studies was to compare the behaviour and personalities of children raised with and without fathers. Parke (1996), Lamb and Tamis-LeMonda (2004) and Paquette et al. (2013) discuss several of these studies in the US which showed that children (particularly boys) who did not experience the regular presence of a father appeared to encounter more issues with regard to sexual identity, school performance, school drop-out, psychosocial adjustment, self-regulation, and aggression control. Towards the early 1980s studies exploring father absence started to examine in greater depth how divorce and the transition to fatherlessness might influence children's development. Marsiglio, Amato, Day, and Lamb (2000) referenced increasing divorce rates and single parenthood as a catalyst for growing public interest in fatherhood and of the father's contribution to family life and child development. Similarly Dette-Hagenmeyer, Erzinger, and Reichle (2014) surmised that research that adopted a strong focus on the impact of the father on child development was triggered by a growing interest in the effects of father absence. Lamb and Tamis-LeMonda (2004) provide a summary of this research in which it is suggested that father absence is more likely to be harmful because of the many paternal roles that go unfilled or partially filled within single parent families as opposed to simply the absence of a sex-role model. Underpinning this assumption was the recognition that the multiple roles that father's perform are central to understanding how they in turn influence children's development.
While research continued during the 1980s into single parenthood and father absence, other researchers began to study the effects of increased father involvement on children's development (Lamb & Tamis-LeMonda, 2004). Some of these studies identified increased cognitive competence, increased empathy, a greater internal locus of control, and less sex-stereotyped beliefs for children with highly involved fathers (Pleck, 1997; Pruett, 1983, 1985; Radin, 1982; Radin, 1994). Although methodological and conceptual limitations were encountered with these and other studies (Paquette et al., 2013). Flouri and Buchanan (2002a; 2002b) were able to demonstrate increased father involvement as retaining associations with better psychosocial adjustment in children through adolescence and adulthood this association remained even when the mothers involvement was controlled for. Paquette et al. (2013) point to other studies that have found rates of delinquency and internalising and externalising problems in boys to be less, improved mental health and less anti-social behaviours in girls, and increased self-esteem, academic success, and professional success in both boys and girls (Aldous, 2002; Harris, Fursteinberg, & Marmer, 1998; Kosterman, Haggerty, Spoth, & Redmond, 2004; Wenk, Hardesty, Morgan, & Blair, 1994). More recently research has sought to expand on this already extensive body of literature.

Typically from late infancy onward new studies have sought to examine fathering influence at different stages of a child's life course (Jackson, Newsome, & Beaver, 2016). For instance, studies that have focused on the early childhood or preschool period have demonstrated that fathers can have a significant influence on many facets of the development and life trajectory of their offspring during this time. Fathers who are more involved during this stage of their children's life course have been found to have children with stronger capacities for learning and behavioural control (Lamb & Lewis, 2013; McWayne, Downer, Campos, & Harris, 2013; Towe-Goodman et al., 2014). The development of prosocial behaviour may be central to this with the inclination to help, share with and comfort others emerging between the first and second year of life and gradually increasing in variety and frequency during the early childhood period (Zahn-Waxler, Radke-Yarrow, Wagner, & Chapman, 1992). There are several studies indicating an association between children's prosocial behaviour and positive aspects of the parent child relationship (See Ferreira et al., 2016 for a review). While these and other studies have typically focused on the influence of the mother, they have identified parental involvement, responsiveness, connectedness, warmth, sensitivity, parental encouragement of children's emotional expression, and prosocial modelling as contributing to greater prosocial behaviour in their children. In a cross-sectional study investigating the combined associations between mother-, father- and teacher-child relationships, and prosocial behaviour in 168 preschool children results suggested the father-child relationship was directly linked to child prosocial behaviour (Ferreira et al., 2016). There is a thought that the increasing involvement of fathers in family life and within daily family routines coupled with a tendency of fathers to engage in play based activity with their children may help to explain the above link. Furthermore the quality of parenting by fathers rather than the frequency or share of routine care has been suggested as being associated with a lower risk of child behaviour problems (Kroll, Carson, Redshaw, & Quigley, 2016). Within Australia an analysis of the Longitudinal Study of Australian Children (LSAC) reported along similar lines that child behaviour was positively associated with quality of parenting by the father (self-efficacy, good co-parental relationship and warmth), but not with father's contact time, after adjusting for mother's parenting and many other potential confounders (Baxter & Smart, 2011). One area that has been found to be particularly important is the attachment relationship between the father and child, this will now be discussed in more detail.

The parent-child relationship has for several decades been considered as central to personality development (Bowlby, 1969; Erickson, 1963). Attachment theory has evolved as a framework to examine and describe the nature of parent-child relationships (Ainsworth, 1967; Bowlby, 1969/1982). With regard to evolutionary, cultural, and individual perspectives the most relevant functions of an attachment figure for a child is to provide a safe haven and secure base (Grossmann & Grossmann, 2019). Although historically the focus of research has been on the mother as the primary attachment, Palm (2014) and others such as Bretherton (2010), Hoffman

(2011) and Newland, Freeman, and Coyl (2011) have provided contemporary reviews of attachment theory research and practice relating to fathers. From the research findings presented above it appears that a key foundational element of children's early development is the relationships and bonds that they develop with their parents prior to starting school. It has been argued that children who experience their caregivers as being sensitive and responsive to their needs develop internal working models that foster self-worth and competence and the expectation that others will be responsive to them as well (Bowlby, 1979). Previous meta-analytic studies have suggested significant links between paternal sensitivity and child-father attachment (Lucassen et al., 2011; Van IJzendoorn & DeWolff, 1997). Parental warmth is a strong component of sensitivity and an area of research that has also received attention. Evidence from this type of research with young children suggests that the concepts of parental warmth along with sensitivity are crucial to a range of cognitive, social and emotional skills (Bugental & Grusec, 2006).

Baker (2017) has identified links between father-son relationships in ethnically diverse families and boys' cognitive and social development in preschool. A total of 4020 young boys were included in her study which showed that paternal warmth and home learning stimulation (at 24 months) positively predicted cognitive and social emotional skills across three racial groups. In a study of fathers' sensitive parenting and the development of early executive functioning in their children (Towe-Goodman et al., 2014) demonstrated that paternal warmth and sensitivity during free play interactions at 24-months positively predicted children's executive functioning (memory, attention, inhibitory control) at three years of age. As children move beyond the toddler years and into preschool age fathers have become more directly involved in childrearing activities (Black, Dubowitz, & Starr, 1999). Play activity has increasingly been recognised as being a significant component of this involvement (Yeung, 2001). While it is evident that children develop an attachment relationship to their fathers it is engagement through more physical and challenging play that many researchers have focused on (Kazura, 2000; Yeung, 2001). As a result, the manner in which fathers engage in play with their children has been linked to their socio-emotional development. A 2016 UK study investigating early father involvement and subsequent child behaviour at ages 3, 5 and 7 years identified two measures of father involvement (positive parenting beliefs at age 9 months and frequency of creative play at age five years) as being associated with a lower risk of subsequent behaviour problems for boys and girls. Along similar lines Kochanska and Kim (2013) have associated fewer teacher reported externalising behaviour problems and self-reported behaviour problems with a secure child-father attachment. While Boldt, Kochanska, Yoon, and Nordling (2014) have observed greater parent and teacher reported social competence.

Continuing from a social development standpoint Bureau et al. (2017) have explored an association between parental play sensitivity and child social adaptation. Results indicated that of 107 preschool-aged children and their mothers and fathers, both mothers' and fathers' play

sensitivity were associated with child attachment security. Further to this the magnitude of the association between child conduct problems and child-father attachment insecurity was stronger than the corresponding link with child-mother attachment insecurity. This is an interesting point as not only does the research reinforce that a secure father-child relationship influences the development of children's social and emotional skills, it also suggests that the father-child relationship may hold greater influence on child social adaptation. Again, play offers an interesting window in which to understand the father-child relationship and its influence on the many facets of child development. Physical play has been described as the only activity in which fathers are more involved than mothers on a consistent basis (Bronstein, 1984). Interestingly Bourcois (1997) has demonstrated that children with parents who are involved and differentiated (e.g. care role for the mother and play role for the father) present with more highly developed social skills and are better prepared both for competition and cooperation than the children of parents who are both involved but whose roles are more or less interchangeable. With regard to the level of stimulation provided by fathers during play MacDonald (1987) and Paquette (2004) have observed that children who are under stimulated by their fathers during play are likely to be less confident and neglected by their peers. Children who are overstimulated have a higher propensity to have externalised behaviour problems and suffer rejection from their peers.

Beyond the research there exists a special quality in the child-father relationship that is distinct from the child-mother attachment. The research above suggests that fathers offer their children a secure base from which to play and explore and it is within this exploration that boundaries are tested, relationships negotiated, and skills developed. The involvement and influence of fathers on the development of their children is significant particularly when cast in the complimentary light of a mother's role. As Lamb and Tamis-LeMonda (2004, p. 11) assert, there is no single father's role to which all fathers should aspire. Rather, a successful father, as defined in terms of his children's development, is one whose role performance matches the demands and prescriptions of his sociocultural and familial context.

4.2 FATHERHOOD AND MENTAL HEALTH

The transition to parenthood is a major life transition and a complex stage of life that requires physical, psychological, social and spiritual adjustments (Baker, 2017; Roy, Schumm, & Britt, 2014). Previous sections have discussed significant changes to social, economic, and family structures and subsequently to the very idea of what it means to be a father. As the concept of fatherhood and the role of a father have changed so too have the expectations of society. In Australia it is estimated that 800,000 new fathers (father or carer of a child aged under five years) experience a variety of challenges as they move into fatherhood with many of these relating to disruption (lack of sleep, teething) or juggling (work and family commitments, finances) (Beyond Blue, 2014). According to Beyond Blue (2014) 57% of first time fathers report

experiencing moderate stress in their child's first year of life, as do 46% of expectant fathers. For many fathers these expectations and the transition to fatherhood are managed well however for some fathers there may be an increased vulnerability to psychological distress during this time. While research in this area from the maternal perspective has been well recognised, the paternal perspective has not enjoyed the same level of attention (Bartlett, 2004). However, over the past decade research has increasingly sought to better understand fathers' mental health during the early parenting years and how this has related to their children's wellbeing and development. In addition to this, research has also increased regarding the health benefits of parenting for men.

Fathers' mental health can have a significant impact on child development. Research alluded to in previous sections has highlighted the benefits to children whose fathers are sensitive and supportive. In contrast there can be significant social, economic and psychological impacts on families where parental mental illness is present and sensitivity and support may be compromised (Goodyear, McDonald, von Doussa, Cuff, & Dunlop, 2018). Research indicates that psychiatric disorders of parents are associated with an increased risk of developmental and psychological difficulties in their children (Ramchandani & Psychogiou, 2009). A 2010 meta-analysis of 43 studies suggested that one in ten fathers reported depression in the postnatal period (Paulson & Bazemore, 2010). Within Australia there have been significant and large studies that have sought to better understand the mental health difficulties of fathers during the postnatal period and beyond. The Longitudinal Study of Australian Children (LSAC) has provided a rich data source for some of these studies with participating fathers numbering in the thousands. For instance, in a 2012 study of over 3,000 fathers approximately 9% of fathers reported symptomatic or clinical psychological distress. Fathers within this study had 1.38 increased odds of psychological distress compared with the Australian adult male population (Giallo et al., 2012). A 2014 study of psychological distress in Australian fathers involved 2,470 fathers and used data from LSAC. The researchers identified that 8% of fathers reported moderate distress during the first postnatal year and that this increased over time (Giallo, D'Esposito, Cooklin, Christensen, & Nicholson, 2014). More recently a 2016 parenting survey of 2600 parents of which 1044 were fathers identified that while the majority of fathers were doing well and feeling supported, one in five fathers had experienced depression and/or anxiety since having children (Parenting Research Centre, 2017). Further findings revealed that fathers who were not in full-time paid work, and fathers who had a child with a medical condition or learning difficulty were also more likely to have poorer mental health and fathers with poorer mental health were less likely to feel effective as a parent. In contrast research supports the idea that fathers with better mental health may be more likely to engage in positive parenting practices and to provide more co-parental support than their counterparts with poorer mental health (Baxter & Smart, 2011).

Evidence indicates that suicide is one of the leading causes of death in postpartum women (Oates, 2003). Suicide has been identified as the leading cause of maternal death within 12 months of giving birth (Ellwood & Dahlen, 2016). The suicide rate of new fathers however is unknown as this is an area of research that is lacking in Australia. According to the (Australian Bureau of Statistics, 2017b), which is the primary source of national suicide data the rate of male deaths by suicide has increased from 16.4 in 2007 to 19.1 in 2017. While these numbers can be broken down into age, states and territories, and co-morbidities they do not reveal more detailed life circumstances such as whether the person who died was a father, if they were in a family unit, or how many dependent children they had. What is evident from Australian research is that relationship stress and family breakdown as acute life stressors raise the risk of suicide (Cantor & Slater, 1995). Furthermore, males were identified as being particularly vulnerable to suicide where interpersonal conflict was present during the separation phase. For separated males' significant predictors have been identified as including lower education, separation related shame and stress from legal negotiations, especially relating to property and financial issues (Kolves, Ide, & De Leo, 2010). With regard to child rearing, fatherhood and associations with suicide there is a paucity of research.

While some research suggests that parenthood is a protective factor against suicide (Denney, 2010; Qin & Mortensen, 2003), little is known about why some parents attempt suicide or whether there are situations in which parenthood is protective. In recent years a study involving parents who had recently attempted suicide identified that parenthood could be a risk factor for suicide among parents with high parenting stress with 61.4% of respondents reporting scores within the clinical range for overall parenting stress (Cerel, Frey, Maple, & Kinner, 2016). Within this study parents who identified parenting as an impetus for a suicide attempt endorsed significantly more symptoms of depression, and significantly higher levels of stress related to dysfunctional parent-child interactions, and a trend toward overall parenting stress compared with parents who did not report parenting as an impetus for the attempt.

Psychological distress and in particular depression and anxiety can be associated with a wide range of additional factors. Several studies on postpartum depression in fathers have shown a direct correlation between paternal and maternal depression scores with one study identifying maternal depression as the strongest predictor of paternal depression in the postpartum period (Goodman, 2004; Kamalifard, Payan, Panahi, Hasanpoor, & Kheiroddin, 2018; Paulson & Bazemore, 2010). Additional psychosocial factors such as quality of the marital relationship, parenting distress and perception of parenting efficacy have also been associated with paternal depression (Burgess, 2006; deMontigny, Girard, Lacharite, Dubeau, & Devault, 2013; Schumacher, Zubaran, & White, 2008). As has a previous history of depression and poor social support (Habib, 2012; Schumacher et al., 2008). Research on fatherhood and social connections commissioned by Movember (2019) identified that whilst some fathers reported

having close friends and strong friendships that could insulate them from the above stresses there was also an acknowledgment that some fathers lost friends when they became fathers or contact was not to the extent that they wanted due to family and work commitments taking precedence. Further to this a significant group of fathers were identified (16%) who reported that they could not, or would not, talk to a friend about problems they were finding it hard to cope with. Interestingly more than half of this specific group continued to report satisfaction with the quality of their friendships reinforcing the idea that pre-existing friendships may not always serve as an accepted outlet for fathers to discuss their problems. Research by (Beyond Blue, 2014) on men's social connectedness highlighted a relatively normalised experience of social disconnection for men in Australia. An experience which when compared with other social issues such as depression and anxiety was seen as being relatively unimportant by men themselves. The research conducted by (Beyond Blue, 2014) identified a lack of social support and loneliness as being complex and significant issues for men in their middle years and pointed to clear associations with mental health issues. In the midst of these findings however was a recognition that many men reported wanting a greater openness with their friends and to be able to discuss their personal problems. For these men, lacking the skills or tools to initiate these conversations, or understanding how to respond when a friend opened up to them were significant obstacles.

Problems with alcohol and drugs are also associated with paternal depression within the literature (Burgess, 2006; Schumacher et al., 2008). Research from 2016 which reviewed 11 studies provided evidence that paternal alcohol consumption during preconception or during pregnancy has an impact on pregnancy health, on maternal alcohol consumption during pregnancy, on fetal outcomes and on infant health outcomes (McBride & Johnson, 2016). According to (Yang & Kramer, 2012) there is a large body of research linking paternal alcohol consumption to the well-being of their children. These studies have shown that fathers' alcohol dependence is associated with their children's problems in cognition and academic performance, externalising and internalising behaviours, and alcohol and illicit drug use (Assanangkornchai, Geater, Saunders, & McNeil, 2002; Giglio & Kaufman, 1990; Harter, 2000; Korhonen et al., 2008; Weinberg, 1997). Other factors include the negotiation of changing societal norms for fathers as a process where fathers may have difficulty with their new role as a father. Moreover, fathers may have little idea what their role will be in the postpartum period and this is described as adding to feelings of uncertainty and anxiety (Beyond Blue, 2014; Price-Robertson, 2015). Sleep disruption is an area that has been acknowledged as requiring more evidence-based interventions for fathers in Australia. Cook (2016) in a study of 102 fathers identified that fathers of unsettled infants reported greater anger towards their infant and increased depressive symptoms by 4 months infant age.

In general, parent psychological distress is associated with children's psychological distress and problematic behaviour (Hughes, Devine, Mesman, & Blair, 2019). Australian research asserts that this potential impact can also have an intergenerational impact whereby children may develop an increased awareness of their parent's symptoms, feel burdened with caring responsibilities and may develop their own mental health conditions through a combination of genetic and environmental influences (Goodyear et al., 2018). With regard to child temperament research has shown that children of depressed parents generally display more difficult temperamental characteristics (Bruder-Costello et al., 2007) and longitudinal studies indicate that difficult child temperament is associated with depression in the child later in life (Block, Gjerde, & Block, 1991; Caspi, Moffitt, Newman, & Silva, 1996; van Os, Jones, Lewis, Wadsworth, & Murray, 1997). The negative repercussions of parental depression are pervasive and the impact that the above factors have on family relationships is significant. The next section will now explore domestic violence in the context of those relationships.

4.3 FATHERHOOD AND DOMESTIC AND FAMILY VIOLENCE

Domestic and family violence (DFV) has been described as a serious, pervasive, global social problem and a chronic and destructive aspect of family life in Australia (Cox, 2015; World Health Organization, 2013). For women who experience violence, more than half have children in their care (National Crime Prevention, 2001). DFV has been defined within The National Plan to Reduce Violence Against Women and Their Children 2010-2022 as acts of violence that occur between people who have or have had, an intimate relationship, it is an ongoing pattern of behaviour aimed at controlling a partner through fear, and can be both criminal and non-criminal (Council of Australian Governments, 2009). In addition to this domestic violence includes physical, sexual, emotional and psychological abuse, and family violence is a wider term that encompasses violence between family members as well as intimate partners. Women are overwhelmingly the victims of DFV with men being the primary perpetrators of physical and mental harm (World Health Organization, 2013). The prevalence of DFV within Australia is well documented. According to (Cox, 2015) around one in six women have experienced sexual or physical violence by a current or former partner. While one in four women have experienced emotional abuse by a current or former partner (Australian Bureau of Statistics, 2017c). For Aboriginal and Torres Strait Islander women the rates of violence are noted to be higher, with poorer outcomes when compared to non-Indigenous women (Al-Yaman, Van Doeland, & Wallis, 2006; Olsen & Lovett, 2016). Almost 40% of women have continued to experience violence from their partner while temporarily separated (Australian Bureau of Statistics, 2017c) and on average, one woman a week is murdered by her current or former partner (Bryant & Bricknall, 2017). Statistics show that domestic violence has a negative impact on a woman's health with intimate partner violence being recognised as a leading contributor to illness, disability and premature death for women aged 18 to 44 years (Ayre, Lum On, Webster, Gourley, & Moon,

2016). As a result of intimate partner violence women are five times more likely than men to require medical attention or hospitalisation (Mouzos, 1999). Societal impacts are far reaching with a report by (KPMG, 2016) estimating that violence against women is estimated to cost the Australian economy $22 billion a year. DFV is a complex issue with significant individual, community, and social costs. While it is acknowledged that violence in the family can be perpetrated by either member of a couple, this review primarily focuses on male violence against women as evidence shows that patterns of violence are gendered and that a greater proportion of women than men experience fear and severe injury within intimate relationships with their partners.

Statistics within Australia show that many young people are exposed to DFV that is noted to impact them in a number of ways. Children who experience DFV within their households are more likely to suffer maltreatment as a result of diminished parenting capacity and neglect (Campbell & Thompson, 2015) or through direct violence (Horton et al., 2014) and a growing body of research indicates that these two issues must be considered together. Bunston, Pavlidis, and Cartwright (2016) point out that DFV is different to other forms of violence to which children may be exposed, as it occurs within their most intimate relationships and within their most intimate space, their homes. Underpinning this is the understanding that DFV has been found to be the leading cause of homelessness for women and their children in Australia (AIHW, 2017). The research evidence suggests that the majority of children experiencing DFV display significant negative impacts to their cognitive functioning and emotional wellbeing in comparison to children who are not experiencing DFV (Kimball, 2016; McTavish, MacGregor, Wathen, & MacMillan, 2016). Furthermore, children living with DFV have an increased likelihood of experiencing other forms of child abuse such as physical abuse, sexual abuse and neglect at the hands of a perpetrator of family violence (Price-Robertson, Rush, Wall, & Higgins, 2013). Lanius, Bluhm, and Frewen (2013) assert that this increased risk correlates with negative mental health outcomes in children and adolescents.

For children who are impacted early in life the stress of parent and family dysfunction has been identified as posing a risk to their adaptive functioning such as emotional regulation, executive functioning, and social engagement (McCollum & Ostrosky, 2008). It also appears that the earlier that children are exposed to violence in their lives, the greater their difficulties appear (Holt, Buckley, & Whelan, 2008). With regard to attachment the inability of a parent to provide a consistent, safe and responsive environment for a young child increases the probability that a child will develop insecure attachments (Bunston et al., 2016). As children become secondary victims of DFV they begin to frequently exhibit adjustment difficulties, in particular externalising and internalising problems (Binder, McFarlane, Maddoux, Nava, & Gilroy, 2013; Blair, McFarlane, Nava, Gilroy, & Maddoux, 2015). In addition to externalising and internalising disorders, impairment associated with exposure to DFV among children has been noted to

include a wide range of social, emotional, and behavioural problems, as well as relationship and academic problems (Gilbert et al., 2009; Graham-Bermann, Castor, Miller, & Howell, 2012). (Slep & O'Leary, 2005) argue that family violence including both intimate partner violence and parent-to-child violence is perhaps highest when children are young. This is especially concerning given that this concentration of individual and family risk during the transition to parenthood period occurs when children are most vulnerable (Feinberg et al., 2016).

For fathers who are perpetrators of DFV, research suggests that they are more likely to express anger aggressively toward their children and overuse physical forms of discipline when compared with other fathers (Fox & Benson, 2004; Francis & Wolfe, 2008). They are more likely to score poorly on measures of parental reflective functioning (Mohaupt & Duckert, 2016; Stover & Kiselica, 2014) and there is a greater probability that they will have poor parenting skills due in part to their sense of entitlement and overly controlling behaviour (Bancroft & Silverman, 2002; Harne, 2011; Scott & Crooks, 2007). Furthermore, they are more likely to hold unrealistic expectations for their children as well as a poor understanding of child development (Fox & Benson, 2004; Harne, 2011). A recent qualitative and quantitative study of 36 participants in Norway found that partner-abusive men displayed difficulties in understanding their children's feelings and intentions and that their underdeveloped relational skills and traditional masculinity values were detrimental to their fathering practices (Mohaupt, Duckert, & Rangul Askeland, 2019). The underdevelopment of relational skills appeared to contribute to their problems with creating safe relationships with their children and as their children developed a will of their own these relationships appeared to worsen.

The research evidence regarding effective interventions that decrease women's and their children's exposure to DFV has grown over recent years. In a recent literature review of strategies for the prevention of intimate partner violence during the childbearing years (Sinnott & Artz, 2016) noted several important findings. These included a disproportionate focus on making females responsible for not becoming victims of violence in the family, as well as a significant lack of research on the prevention of intimate partner violence perpetration in males, particularly fathers. The review called for a better understanding of the underlying factors that contribute to male violence and a greater emphasis on interventions that targeted preparing men for the challenges of fatherhood. Indeed, several studies have suggested that fathering may be the most effective way to engage perpetrators of DFV who would like to parent in a manner which is different to how they themselves were fathered (Featherstone & Peckover, 2007; Stanley, Graham-Kevan, & Borthwick, 2012; Stover & Morgos, 2013). The availability of these and other supports and the willingness of perpetrators and fathers in general to seek out supports and engage are of critical importance. The next section will now explore this topic in more detail.

5. SUPPORT SEEKING AND SUPPORT GROUPS

Previous sections have outlined the cognitive, emotional, and social benefits for children who experience positive child-father relationships. Equally, active and involved fathering that is both sensitive and responsive has been discussed as being associated with a more secure child-father attachment. The involvement and influence of fathers with regard to child development, mental health, and domestic violence are three areas that have been discussed as presenting significant challenges towards achieving the above outcomes particularly during the transition to fatherhood period. It is worth remembering that not only do fathers have an increased vulnerability to mental health issues during this time but the risk of family violence including both intimate partner violence and parent-to-child violence is perhaps highest when children are young (Slep & O'Leary, 2005). Higher levels of fatigue during the perinatal period can also be a significant concern for new fathers and this has been linked with irritability and low mood, interpersonal difficulties, decreased tolerance and patience with children, and a lack of concentration at work (Giallo, Rose, Cooklin, & McCormack, 2013). Rominov, Giallo, Pilkington, and Whelan (2018) list other challenges as including a perceived low competency with infant care skills, and an inability to pursue personal interests and social friendships due to pressure on free time, as examples. These and other challenges serve to highlight the importance for fathers to be sufficiently supported not only in their role as a father but in relation to their mental health and general well-being. As has also been mentioned, fathers today are experiencing multiple changes and challenges that were either not present or different for previous generations. To return to the thoughts of (Giddens, 1991) the negotiation of this change to various structures and associated relationships is forcing individuals and fathers in particular to reflect on the way of the world, how they relate to it, and how and where they fit in it.

Research evidence indicates that despite these challenges the majority of fathers in Australia continue to positively influence their children's well-being and development. One of the ways in which fathers have been able to bolster this influence and build parenting capacity has been by seeking out support both formally through child and family health services and perhaps to a lesser degree informally via community based supports such as playgroups. However, maximising this engagement has been limited by several factors such as a lack of father focus by support services and an inadequate understanding of men's experiences and needs around support particularly during the perinatal period and first years of a child's life (Rominov et al., 2018). Beyond Blue (2014) have described support seeking by fathers as a minority action taken by new fathers. In addition to this, key findings from their study suggest that new fathers tend to seek help or information reactively and that they rely upon their partner to be a conduit for advice and direction. Furthermore, fathers in this study reported a general lack of satisfaction with their engagement with professionals and with the availability of father-specific support and advice. A previous Australian study by (Berlyn, Wise, & Soriano, 2008) found that positive father

engagement was most likely to occur in situations where the facilitator was male and a father also, was liked and trusted, and created discussion by sharing personal experiences. In contrast, fathers reported feeling invisible to experts and alienated by a highly structured program format, ultimately there was a preference for informal, peer discussions and more involved program activities. Barriers to fathers support seeking have also been explored from the perspective of women and findings indicate that having groups as female spaces, dad's as a minority, and female gatekeeping have all served to also limit fathers from seeking support (Barrett, Hanna, & Fitzpatrick, 2018).

Community based intervention for fathers that increase well-being at the individual and family level is a strategy that has been explored and used as a means to enhance child-father relationships. Furthermore, community based parent support groups have been examined as a way of supporting fathers who may be struggling through parenthood with a view to reducing the burden on the individual and their families and improving a range of positive outcomes for their children. As fathers' involvement with their children has increased greater emphasis has been placed on the role of child and family services that support and promote father involvement. Barrett et al. (2018) provide a brief review of support groups for first time parents in Australia, they discuss a long history for these groups which over time have primarily been facilitated by child and family health nurses. They discuss the purpose of these groups as facilitating a positive transition to parenthood by enhancing parental well-being, child-parent interaction, social networking, and parental confidence in child rearing.

Research evidence indicates that social support especially benefits the health of mothers and fathers as well as the well-being of their children (McConachie et al., 2008). Peer support has been described as one way in which support and validation can be provided and community programs that seek to connect new parents with one another to form support networks can and do provide an important function during the early stages of parenting (Jackson, 2011). Traditionally community playgroups that are parent led and supported playgroups that are led by a professional or facilitator have served this purpose as well as enhancing children's early learning within Australian communities. A comparative review of 2015 Australian Early Development Census data indicated that nationally 35.5% of children attended playgroups prior to school (Gregory, Sincovich, Harman-Smith, & Brinkman, 2017). Statistics around fathers attendance at playgroups are limited but father's do not appear to attend community based playgroups to the same extent as mothers in Queensland (Playgroup Queensland, 2018). Of this population playgroup attendance was noted to be higher in regional and remote areas of Australia than for children living in metropolitan areas. In addition, playgroup attendance increased incrementally for children living in less socio-economically disadvantaged communities from 26% in the most to 44% in the least disadvantaged communities. The informal nature of community playgroups has seemingly fit well with Aboriginal and Torres Strait

Islander cultural beliefs and practices by encouraging wider family involvement and seeking to incorporate values about the importance of community and diversity (Bond, 2009). Williams, Berthelsen, Viviani, and Nicholson (2016) provide a brief overview of positive associations between playgroup attendance and children's stronger learning competence, increased social-emotional functioning, and improvements in language, cognition, and behaviour skills. With regard to improved parental outcomes from playgroup participation they point to several studies which support associations such as a greater understanding about early child development, decreased social isolation, and access to peer support (Jackson, 2006, 2013; Shulver). Playgroups provide a safe space for children to engage in unstructured play with other children of a similar age and they continue to reach many parents and children across Australia. Previous sections have discussed the importance of play with regard to a father's role, involvement, and influence and according to Gregory et al. (2017) the importance of play for children's development is both significant and undeniable. As play is such an important part of a father's role, targeting of support groups and support services towards play-based less formal activities appears to make sense.

6. CONCLUSION

The literature contained in this review presents a narrative of unending change and negotiation for fatherhood. The transition to parenthood is viewed as a critical time for fathers and their children and a time in which vulnerability is shared and experienced in equal parts. The evolution of the role of a father to incorporate greater involvement and influence in children's lives and development is reinforced and there exists an understanding that support groups and services for fathers have not evolved to meet this change and the needs of fathers. Fathers can play an important role in child development in providing experiences and skills that are different to those a mother can provide. Moreover, research evidence suggests that where fathers can offer their children a secure base from which to play and explore there is opportunity for boundaries to be tested, relationships negotiated, and skills developed. In addition to this there is evidence to suggest that the quality of father-child interactions outweigh the duration of interactions and that there are benefits for children that exist across a range of developmental outcomes. As a result of change this review acknowledges implications for fathers and families. The prevalence of poor mental health among fathers and domestic and family violence among families is both significant and concerning within Australia and particularly during the transition to parenthood. With this in mind there is a clear need for support groups and services that are capable of meeting the needs of families and more specifically fathers during this time. As play is such an important part of a father's role, targeting of support groups and support services towards play-based and less formal activities appears to make sense.

References

AIHW. (2017). *Specialist Homelessness Services 2016–17*. Retrieved from Canberra: https://whiteribbon.org/2WDrP6u

Ainsworth, M. D. (1967). *Infancy in Uganda: Infant care and the growth of love*. Baltimore, MD: John Hopkins University Press.

Al-Yaman, F., Van Doeland, M., & Wallis, M. (2006). *Family violence among Aboriginal and Torres Strait Islander peoples*. Retrieved from Canberra:

Aldous, J., & Mulligan, G.M. (2002). Fathers' child care and children's behaviour problems. *Journal of Family Issues, 23*(624-647).

Assanangkornchai, S., Geater, A. F., Saunders, J. B., & McNeil, D. R. (2002). Effects of paternal drinking, conduct disorder and childhood home environment on the development of alcohol use disorders in a Thai population. *Addiction, 97*, 217-226.

Australian Bureau of Statistics. (2016). Census of Population and Housing: Australia Revealed, 2016. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/2024.0

Australian Bureau of Statistics. (2017a). *3301.0 - Births, Australia, 2017*. Retrieved from Canberra:

Australian Bureau of Statistics. (2017b). *3303.0 - Causes of Death, Australia, 2017*. Retrieved from Canberra:

Australian Bureau of Statistics. (2017c). *Personal Safety Survey 2016*. Retrieved from Canberra: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0

Australian Institute of Family Studies. (2007). *A snapshot of how Australian families spend their time*. Retrieved from Melbourne, Victoria: https://aifs.gov.au/sites/default/files/publication-documents/familytime.pdf

Australian Institute of Family Studies. (2016). *The Longitudinal Study of Australian Children Annual Statistical Report 2015.* Retrieved from Melbourne:

Australian Institute of Family Studies. (2017). *Marriage rates in Australia*. Retrieved from Canberra: https://aifs.gov.au/facts-and-figures/marriage-rates-australia

Australian Institute of Family Studies. (2018). Work and family. Retrieved from https://aifs.gov.au/facts-and-figures/work-and-family

Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). *Examination of the burden of disease of intimate partner violence against women in 2011*. Retrieved from Sydney: http://bit.ly/2W1LzfV

Baker, C. E. (2017). Father-son relationships in ethnically diverse families: Links to boys' cognitive and social emotional development in preschool *Journal of Child and Family Studies, 26*, 2335-2345. doi:10.1007/s10826-017-0743-3

Bancroft, L., & Silverman, J. G. (2002). *The batterer as parent: Addressing the impact of domestic violence on family dynamics*. Thousand Oaks, California: Sage Publications.

Barrett, N., Hanna, L., & Fitzpatrick, O. V. (2018). Barriers to first time parent groups: A qualitative descriptive study. *Nursing Health Science, 20*, 464-471.

Bartlett, E. E. (2004). The effects of fatherhood on the health of men: A review of the literature. *The Journal of Men's Health & Gender, 1*, 159-169.

Bauman, Z. (2000). In *Liquid Modernity*. CambriDads Groupe: Polity Press.

Baxter, J. (2018). *Fathers and work: A statistical overview*. Retrieved from Canberra: https://aifs.gov.au/sites/default/files/4_fathers_and_work_1905.pdf

Baxter, J. (2019). *Fathers and work: A statistical overview*. Retrieved from Australia: https://aifs.gov.au/aifs-conference/fathers-and-work

Baxter, J., & Smart, D. (2011). *Fathering in Australia among couple families with young children*. Retrieved from Canberra:

Beck, U. (1992). *Risk society: Towards a new modernity*. New Delhi: Sage.

Beck, U., Bons, W., & Lau, C. (2003). The theory of reflexive modernization: Problematic, hypotheses and research programme. *Theory, Culture and Society, 22*(2), 1-33.

Beck, U., Giddens, A., & Lash, S. (1994). *Reflexive Modernisation: Politics, Tradition and Aesthetics in the Modern Social Order*. CambriDads Groupe: Polity Press.

Berlyn, C., Wise, S., & Soriano, G. (2008). *Engaging fathers in child and family services: Participation, perceptions and good practice*. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1728594

Beyond Blue. (2014). *Healthy Dads? The challenge of being a new father*. Retrieved from Australia: https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0313-beyondblue-healthy-dads-full-report.pdf?sfvrsn=6f0243ea_0

Binder, B., McFarlane, J., Maddoux, J., Nava, A., & Gilroy, H. (2013). Children in distress: Functioning of youngsters of abused women and implications for child maltreatment prevention. *Journal of Child Care Practice, 19*(3), 237-252. doi:10.1080 /13575279.2013.785935

Black, M. M., Dubowitz, H., & Starr, R. H. (1999). African American fathers in low income, urban families: development, behavior, and home environment of their three-year-old children. *Child Development, 70*(4), 967-978.

Blair, F., McFarlane, J., Nava, A., Gilroy, H., & Maddoux, J. (2015). Child witness domestic abuse: Baseline data analysis for a 7-year study. *Pediatric Nursing, 41*(1), 23-29.

Block, J. H., Gjerde, P. F., & Block, J. H. (1991). Personality antecedents of depressive tendencies in 18 year olds: A prospective study. *Journal of Personality and Social Psychology, 60*, 726-738.

Boldt, L. J., Kochanska, G., Yoon, J. E., & Nordling, J. K. (2014). Children's attachment to both parents from toddler age to middle childhood: Links to adaptive and maladaptive outcomes. *Attachment & Human Development, 16*, 211-229. doi:10.1080/14616734.2014.889181

Bond, C. (2009). Starting at strengths . . . an Indigenous early years intervention. *Medical Journal of Australia, 191*(3), 175-177.

Bourcois, V. (1997). Modalite´s de pre´sence du pe`re et de´veloppement social de l'enfant d'aˆge pre´scolaire. *Enfance, 3*, 389-399.

Bowlby, J. (1969). *Attachment and loss. Vol 1: Attachment*. New York: Basic Books.

Bowlby, J. (1969/1982). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London, UK: Tavistock Publications.

Bretherton, I. (2010). Fathers in attachment theory and research: a review. *Early Child Development and Care, 180*(1-2 Emerging topics on father attachment: Considerations in theory, context and development), 9-23. doi:https://doi.org/10.1080/03004430903414661

Bronstein, P. (1984). Differences in mother's and father's behaviours toward children: A cross cultural comparison. *Developmental Psychology, 20*(6), 995-1003.

Bruder-Costello, B., Warner, V., Talati, A., Nomura, Y., Bruder, G., & Weissman, M. (2007). Temperament among offspring at high and low risk for depression. *Psychiatry Research, 153*, 145-151.

Bryant, W., & Bricknall, S. (2017). *Homicide in Australia 2012-2014: National Homicide Monitoring Program report*. Retrieved from Canberra: https://aic.gov.au/publications/sr/sr002

Bugental, D. B., & Grusec, J. (2006). Socialization theory. In N. Eisenberg (Ed.), *Handbook of child psychology: Vol 3. Social, emotional, and personality development* (pp. 366-428). New York, NY: Wiley.

Bunston, W., Pavlidis, T., & Cartwright, P. (2016). Children, family violence and group work: Some do's and don'ts in running therapeutic groups with children affected by family violence. *Journal of Family Violence, 31*, 85-94. doi:10.1007/s10896-015-9739-1

Bureau, J. F., Martin, J., Yurkowski, K., Schmiedel, S., Quan, J., Moss, E., . . . Pallanca, D. (2017). Correlates of child–father and child–mother attachment in the preschool years. *Attachment & Human Development, 19*(2), 130=150. doi:10.1080/14616734.2016.1263350

Burgess, A. (2006). The costs and benefits of active fatherhood: Evidence and insights to inform the development of policy and practice.

Campbell, A. M., & Thompson, S. L. (2015). The emotional maltreatment of children in domestically violent homes: Identifying gaps in education and addressing common misconceptions: The risk of harm to children in domestically violent homes mandates a well-coordinated response. *Child Abuse & Neglect, 48*, 39-49. doi:doi:10.1016/j.chiabu.2015.08.009

Cantor, C. H., & Slater, P. J. (1995). Marital breakdown, parenthood, and suicide. *Journal of Family Studies, 1*(2), 91-102.

Caspi, A., Moffitt, T. E., Newman, D. L., & Silva, P. A. (1996). Behavioral observations at age 3 years predict adult psychiatric disorders: Longitudinal evidence from a birth cohort. *Archives of General Psychiatry , 53*(11), 1033-1039.

Cerel, J., Frey, L. M., Maple, M., & Kinner, D. G. (2016). Parents with suicidal behavior: Parenting is not always protective. *Journal of Child and Family Studies, 25*, 2327-2336. doi:10.1007/s10826-016-0377-x

Cook, F., Giallo, R., Petrovic, Z., Coe, A., Seymour, M. & Cann, W. (2016). Depression and anger in fathers of unsettled infants: A community cohort study. *Journal of Paediatrics and Child Health, 53*(2), 131-135. doi:https://doi.org/10.1111/jpc.13311

Council of Australian Governments. (2009). *National plan to reduce violence against women and their children*. Retrieved from Canberra:

Cox, P. (2015). *Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey*. Retrieved from Sydney: http://anrows.org.au/publications/horizons/PSS

deMontigny, F., Girard, M. E., Lacharite, C., Dubeau, D., & Devault, A. (2013). Psychosocial factors associated with paternal post-natal depression. *Journal of Affective Disorders, 150*(2013), 44-49.

Denney, J. T. (2010). Family and household formations and suicide in the United States. *Journal of Marriage and Family, 72*, 202-213. doi:10.1111/j.1741-3737.2009.00692.x.

Dette-Hagenmeyer, D. E., Erzinger, A. B., & Reichle, B. (2014). The changing role of the father in the family. *European Journal of Developmental Psychology, 11*(2), 129-135.

Ellwood, D., & Dahlen, H. (2016). FactCheck: Is suicide one of the leading causes of maternal death in Australia? *The Conversation*.

Erickson, E. H. (1963). *Childhood and society (2nd Ed.)*. New York: Norton.

Featherstone, B., & Peckover, S. (2007). Letting them get away with it: Fathers, domestic violence and child welfare. *Critical Social Policy, 27*(2), 181-202.

Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: Effects on coparenting, parenting, family violence, and parent and child adjustment *Prev Science, 17*, 751-764. doi:10.1007/s11121-016-0674-z

Ferreira, T., Cadima, J., Matias, M., Vieira, J. M., Leal, T., & Matos, P. M. (2016). Preschool children's prosocial behavior: The role of mother–child, father–child and teacher–child relationships. *Journal of Child and Family Studies, 25*(6), 1829-1839.

Fletcher, R. (2011). *The Dad factor: How father-baby bonding helps a child for life*. Sydney: Finch Publishing.

Flouri, E., & Buchanan, A. (2002a). Father involvement in childhood and trouble with the police in adolescence: Findings from the 1958 British cohort. *Journal of Interpersonal Violence, 17*, 689-701.

Flouri, E., & Buchanan, A. (2002b). What predicts good relationships with parents in adolescence and partners in adult life: Findings from the 1958 British cohort. *Journal of Family Psychology, 16*(186-198).

Fox, G., & Benson, M. (2004). Fox, G., & Benson, M. In R. D. M. Lamb (Ed.), *Conceptualizing and measuring father involvement*. Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers.

Francis, K. J., & Wolfe, D. A. (2008). Cognitive and emotional differences between abusive and non-abusive fathers. *Child Abuse and Neglect, 32*(12), 1127-1137.

Giallo, R., D'Esposito, F., Christensen, D., Mensah, F., Cooklin, A., Wade, C., . . . Nicholson, J. M. (2012). Father mental health during the early parenting period: results of an Australian population based longitudinal study. *Social Psychiatry and Psychiatric Epidemiology, 47*(12), 1907-1916.

Giallo, R., D'Esposito, F., Cooklin, A., Christensen, D., & Nicholson, J. M. (2014). Factors associated with trajectories of psychological distress for Australian fathers across the early parenting period. *Social Psychiatry and Psychiatric Epidemiology, 49*(12), 1961-1971.

Giallo, R., Rose, N., Cooklin, A., & McCormack, D. (2013). In survival mode: Mothers and fathers' experiences of fatigue in the early parenting period. *Journal of Reproductive and Infant Psychology, 31*, 31-45.

Giddens, A. (1990). *The consequences of modernity.* CambriDads Groupe: Polity Press.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age.* New York: Stanford University Press.

Giglio, J. J., & Kaufman, E. (1990). The relationship between child and adult psychopathology in children of alcoholics. *International Journal of Addiction, 25*, 263-290.

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. L. (2009). Recognising and responding to child maltreatment. *Lancet, 373*(9658), 167-180.

Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing, 45*(1), 26-35.

Goodyear, M., McDonald, M., von Doussa, H., Cuff, R., & Dunlop, B. (2018). Meeting the intergenerational needs of families where a parent has a mental illness. *Journal of Parent and Family Mental Health, 3*(2). doi:https://escholarship.umassmed.edu/parentandfamily/vol3/iss2/1/

Graham-Bermann, S. A., Castor, L. E., Miller, L. E., & Howell, K. H. (2012). The impact of intimate partner violence and additional traumatic events on trauma symptoms and PTSD in preschool-aged children. *Journal of Traumatic Stress, 25*(4), 393-400.

Gregory, T., Sincovich, A., Harman-Smith, Y., & Brinkman, S. (2017). *The reach of Playgroups across Australia and their benefits from children's development: A comparison of 2012 and 2015 AEDC data*. Retrieved from South Australia:

Grossmann, K. U., & Grossmann, K. E. (2019). Essentials when studying child-father attachment: A fundamental view on safe haven and secure base phenomena. *Attachment & Human Development*, 1-6. doi:https://doi.org/10.1080/14616734.2019.1589056

Habib, C. (2012). Paternal perinatal depression: An overview and suggestions towards an intervention model. *Journal of Family Studies, 18*(1), 4-16.

Harne, L. (2011). *Violent men and the risks to children: The need for change*. Bristol: Polity Press.

Harris, K. H., Fursteinberg, F. F., & Marmer, J. K. (1998). Paternal involvement with adolescents in intact families: The influence of fathers over the life course. *Demography, 35*, 201-216.

Harter, S. L. (2000). Psychosocial adjustment of adult children of alcoholics: a review of the recent empirical literature. *Clinical Psychology Review, 20*, 311-337.

Hoffman, J. (2011). *Fathers factors: What social science research tells us about fathers and how to work with them*. Retrieved from Canada: http://www.fira.ca/cms/documents/211/FatherFactorsFinal.pdf

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: a review of the literature. *Child Abuse & Neglect, 32*(8), 797–810.

Horton, E., Murray, C. E., Garr, B., Notestine, L., Flasch, P., & Johnson, C. H. (2014). Provider perceptions of safety planning with children impacted by intimate partner violence. *Children and Youth Services Review, 42*, 67-73. doi:10.1016/j.childyouth.2014.03.016

Hughes, C., Devine, R. T., Mesman, J., & Blair, C. (2019). Parental well-being, couple relationship quality, and children's behavioral problems in the first 2 years of life. *Development and Psychopathology*, 1-10. doi:10.1017/S0954579419000804

Jackson, D. (2006). Playgroups as protective environments for refugee children at risk of trauma. *Australian Journal of Early Childhood, 31*, 1-5.

Jackson, D. (2011). What's really going on? Parents' views of parent support in three Australian supported playgroups. *Australasian Journal of Early Childhood, 36*(4), 29-37.

Jackson, D. (2013). Creating a place to 'be': unpacking the facilitation
role in three supported playgroups in Australia. *European Early*
Childhood Education Research Journal, 21, 77-93.

Jackson, D. B., Newsome, J., & Beaver, K. M. (2016). Does early paternal involvement predict offspring developmental diagnoses? *Early Human Development, 103*, 9-16. doi:10.1016/j.earlhumdev.2016.07.001

Kamalifard, M., Payan, S. B., Panahi, S., Hasanpoor, S., & Kheiroddin, J. B. (2018). Paternal postpartum depression and Iis relationship with maternal postpartum depression. *Journal of Holistic Nursing and Midwifery, 28*(2), 115-120.

Kazura, K. (2000). Father's qualitative and quantitative involvement: An investigation of attachment, play, and social interactions. *The JOurnal of Men's Health Studies, 9*(1), 41-57.

Kimball, E. (2016). Edleson revisited: Reviewing children's witnessing of domestic violence 15 years later. *Journal of Family Violence, 31*, 625-637.

Kochanska, G., & Kim, S. (2013). Early attachment organization with both parents and future behavior problems: From infancy to middle childhood. *Child Development, 84*, 283-296. doi:10.1111/j.1467-8624.2012.01852.x

Kolves, K., Ide, N., & De Leo, D. (2010). Suicidal ideation and behaviour in the aftermath of marital separation: Gender differences. *Journal of Affective Disorders, 120*(1), 48-53.

Korhonen, T., Huizink, A. C., Dick, D. M., Pulkkinen, L., Rose, R. J., & Kaprio, J. (2008). Role of individual, peer and family factors in the use of cannabis and other illicit drugs: a longitudinal analysis among Finnish adolescent twins. *Drug and Alcohol Dependence, 97*, 33-43.

Kosterman, R., Haggerty, K. P., Spoth, R., & Redmond, C. (2004). Unique influence of mothers
and fathers on their children's antisocial behaviour. *Journal of Marriage and Family, 66*(3), 762-778.

KPMG. (2016). *The cost of violence against women and their children in Australia*. Retrieved from Canberra: https://bit.ly/2wzVWxC

Kroll, M. E., Carson, C., Redshaw, M., & Quigley, M. A. (2016). Early father involvement and subsequent child behaviour at ages 3, 5 and 7 years: Prospective analysis of the UK millennium cohort study. *PLos ONE, 11*(9). doi:10.1371/journal.pone.0162339

Lamb, M. E. (1987). Introduction: The Emergent American Father. In M. E. Lamb (Ed.), *The Father Role: A Cross-cultural Perspective* (pp. 1-26). Hillsdale, NJ: Lawrence Erlbaum.

Lamb, M. E. (2000). The history of research on father involvement. *Marriage and Family Review, 29*(2), 23-42.

Lamb, M. E., & Lewis, C. (2013). Father-child relationships. *Handbook of father involvement: Multidisciplinary perspectives, 2*, 119-135.

Lamb, M. E., & Tamis-LeMonda, C. S. (2004). The role of the father: An introduction. In M. E. Lamb (Ed.), *The role of the father in child development* (pp. 1-31).

Lanius, R. A., Bluhm, R., & Frewen, P. A. (2013). Childhood trauma, brain connectivity, and the self. In J. D. Ford & C. A. Curtois (Eds.), *Treating complex traumatic stress disorder in children and adolescents. Scientific foundations and therapeutic models*. New York, NY: The Guildford Press.

Lucassen, N., Van IJzendoorn, M. H., Volling, B. L., Thamer, A., Bakermans-Kranenburg, M., J., V., F. C, & Tiemeier, H. (2011). The association between paternal sensitivity and infant–father attachment security: A meta-analysis of three decades of research. *Journal of Family Psychology, 25*(6), 986-992.

MacDonald, K. (1987). Parent–child physical play with rejected, neglected and popular boys. *Developmental Psychology, 23*(5), 705-711.

Marsiglio, W., Amato, P. R., Day, R. D., & Lamb, M. E. (2000). Scholarship on fatherhood in the 1990s and beyond. *Journal of Marriage and Family, 62*, 1173-1191.

McBride, N., & Johnson, S. (2016). *Fathers and alcohol. Implications for preconception, pregnancy, infant and childhood health outcomes*. Retrieved from Australia:

McCollum, J. A., & Ostrosky, M. (2008). Family roles in young children's emerging peer related social competence. In W. H. Brown, S. L. Odom, & S. R. McConnell (Eds.), *Social Competence of Young Children: Risk, Disability, and Intervention* (pp. 31-59). Baltimore, MD: Paul H. Brookes Publishing.

McConachie, H., Hammal, D., Welsh, B., Keane, B., Waterston, T., Parker, L., & Cook, M. (2008). Wellbeing of new mothers. *Community Practitioner: The Journal of the Community Practitioners' & Health Visitors' Association, 81*(3), 19.

McTavish, J. R., MacGregor, J. C. D., Wathen, N., & MacMillan, L. (2016). Children's exposure to intimate partner violence: an overview. *International Review of Psychiatry, 28*(5), 504-518.

McWayne, C., Downer, J. T., Campos, R., & Harris, R. D. (2013). Father involvement during early childhood and its association with children's early learning: A meta-analysis. *Early Education and Development, 24*(6), 898-922.

Mohaupt, H., & Duckert, F. (2016). Parental reflective functioning in fathers who use intimate partner violence: Findings from a Norwegian clinical sample. *Nordic Psychology, 68*(4), 272-286. doi:https://doi.org/10.1080/19012276.2016.1162107

Mohaupt, H., Duckert, F., & Rangul Askeland, I. (2019). How Do Men in Treatment for Intimate Partner Violence Experience Parenting their Young Child? A Descriptive Phenomenological Analysis. *Journal of Family Violence*, 1-13. doi:https://doi.org/10.1007/s10896-019-00083-x

Mouzos, J. (1999). *Femicide: An overview of major findings, No. 124*. Retrieved from Canberra:

Movember. (2019). *Global research report of male social connection: Fatherhood and social connections*. Retrieved from Australia:

Mussen, P. H., & Rutherford, E. (1963). Parent-child relations and parental personality in relation to young children's sex-role preferences. *Child Development, 34*, 589-607.

National Crime Prevention. (2001). *Young people and domestic violence: National research on young people's attitudes and experiences of domestic violence*. Retrieved from Canberra:

Newland, L. A., & Coyl, D. D. (2010). Fathers' role as attachment figures: An interview with Sir Richard Bowlby. *Early Child Development and Care, 180*(1-2), 25-32.

Newland, L. A., Freeman, H. S., & Coyl, D. D. (2011). *Emerging topics on father attachment.* New York, NY: RoutleDads Groupe.

Oates, M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British Medical Bulletin, 67*, 219-229.

Olsen, A., & Lovett, R. (2016). *Existing knowleDads Groupe, practice and responses to violence against women in Australian Indigenous communities: State of knowleDads Groupe paper*. Retrieved from Alexandria, NSW:

Palm, G. (2014). Attachment theory and fathers: Moving from “being there” to “being with”. *Journal of Family Theory and Review, December 2014*, 282-297. doi:DOI:10.1111/jftr.12045

Paquette, D. (2004). Theorizing the father–child relationship: Mechanisms and developmental outcomes. *Human Development, 47*, 193-219.

Paquette, D., Coyl-Shepherd, D. D., & Newland, L. A. (2013). Fathers and development: new areas for exploration. *Early Child Development and Care, 183*(6), 735-745.

Paquette, D., Eugene, M. M., Dubneau, D., & Gagnan, M. N. (2009). Do Fathers have a specific influence on childrens develoment? In D. Dubeau, A. Devault, & G. Forget (Eds.), *La paternite au 21e siecle*. Quebec: PUL.

Parenting Research Centre. (2017). *Parenting Today in Victoria: Report of Key Findings*. Retrieved from Melbourne:

Parke, R. D. (1996). *Fatherhood*. CambriDads Groupe: Harvard University Press.

Paulson, J., & Bazemore, S. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression. *JAMA, 303*(19), 1961-1969. doi:10.1001/jama.2010.605

Payne, D. E., & Mussen, P. H. (1956). Parent-child relations and father identification among adolescent boys. *Journal of Abnormal and Social Psychology, 52*, 358-362.

Playgroup Queensland. (2018). *Annual report 2017-2018*. Retrieved from Brisbane, Queensland:

Pleck, J. H. (1997). Paternal involvement: Levels, sources and consequence. In M. E. Lamb (Ed.), *The role of the father in child development (3rd ed., pp. 66–103, 325–332)*. New York: Wiley.

Price-Robertson, R. (2015). *Fatherhood and mental illness: A review of key issues, CFCA Paper No. 30*. Retrieved from Canberra:

Price-Robertson, R., Rush, P., Wall, L., & Higgins, D. (2013). *Rarely an isolated incident: Acknowledge the interrelatedness of child maltreatment, victimisation, and trauma (CFCA Paper No. 14)*. Retrieved from Melbourne:

Pruett, K. D. (1983). Infants of primary nurturing fathers. *Psychoanalytic Study of the Child, 38*, 257-277.

Pruett, K. D. (1985). Children of the fathermothers: Infants of primary nurturing fathers. In E. G. J. D. Call, & R. L. Tyson (Ed.), *Frontiers of infant psychiatry (Vol. 2, pp. 375–380)*. New York: Basic Books.

Qin, P., & Mortensen, P. B. (2003). The impact of parental status on the risk of completed suicide. *Archives of General Psychiatry, 60*, 797-802. doi:10.1001/archpsyc.60.8.797

Radin, N. (1982). Primary caregiving and role-sharing fathers. In M. E. Lamb (Ed.), *Nontraditional families: Parenting and child development (pp. 173–204)*. Hillsdale, NJ: Erlbaum.

Radin, N. (1994). Primary-caregiving fathers in intact families. In A. E. G. A. W. Gottfried (Ed.), *Redefining families: Implications for children’s development (pp. 11–54)*. New York: Plenum.

Ramchandani, P. G., & Psychogiou, L. (2009). Paternal psychiatric disorders and children's psychosocial development. *The Lancet, 374*(9690), 22-28.

Reilly, L., & Rees, S. (2018). Fatherhood in Australian Aboriginal and Torres Strait Islander communities: An examination of barriers and opportunities to strengthen the male parenting role. *American Journal of Mens Health, 12*(2), 420-430.

Rominov, H., Giallo, R., Pilkington, P. D., & Whelan, T. A. (2018). Getting Help for Yourself is a Way of Helping Your Baby:" Fathers’ Experiences of Support for Mental Health and Parenting in the Perinatal Period. *Psychology of Men & Masculinity, 19*(3), 457-468.

Roy, N. R., Schumm, W. R., & Britt, S. L. (2014). *Transition to parenthood.* New York: Springer.

Schumacher, M., Zubaran, C., & White, G. (2008). Bringing birth related paternal depression to the fore. *Women & Birth, 21*, 65-70.

Scott, K., & Crooks, C. (2007). Preliminary evaluation of an intervention program for maltreating fathers. *Brief Treatment and Crisis Intervention, 7*, 224-238.

Sears, R. R., Maccoby, E. E., & Levin, H. (1957). *Patterns of child rearing*. Evanston, IL: Peterson.

Shulver, W. (2011). *Parenting groups as sources of social capital: Their patterns of use and outcomes for Aboriginal and non-Aboriginal mothers of young children*. Retrieved from Adelaide, Australia: http://theses.flinders.edu.au/public/adt-SFU20111101.205019/

Sinnott, T., & Artz, S. (2016). Literature review of strategies for the prevention of intimate partner violence during the childbearing years. *International Journal of Child, Youth and Family Studies, 7*(3/4), 324-342.

Slep, A. M. S., & O’Leary, S. G. (2005). Parent and partner violence in families with young children: Rates, patterns, and connections. *Journal of Consulting and Clinical Psychology, 73*, 435-444.

Stanley, N., Graham-Kevan, N., & Borthwick, R. (2012). Fathers and domestic violence: Building motivation for change through perpetrator programmes. *Child Abuse Review, 21*(4), 264-274.

Stover, C., & Morgos, D. (2013). Fatherhood and intimate partner violence: Bringing the parenting role into intervention strategies. *Professional Psychology: Research and Practice, 44*(4), 247.

Stover, C. S., & Kiselica, A. (2014). An initial examination of the association of reflective functioning to parenting of fathers. *Infant Mental Health Journal, 35*(5), 452-461.

Towe-Goodman, N. R., Willoughby, M., Blair, C., Gustafsson, H. C., Mills-Koonce, W. R., & Cox, M. J. (2014). Fathers' sensitive parenting and the development of early executive functioning. *Journal of Family Psychology, 28*, 867-876.

Van IJzendoorn, M. H., & DeWolff, M. (1997). In search of the absent fathers: Meta-analysis of infant–father behavior. *Child Development, 68*, 604-609.

van Os, J., Jones, P., Lewis, G., Wadsworth, M., & Murray, R. (1997). Developmental precursors of affective illness in a general population birth cohort. *Archives of General Psychiatry, 54*, 625–631.

Weinberg, N. Z. (1997). Cognitive and behavioral deficits associated with parental alcohol use. *Journal of Amercian Academic Child and Adolescent Psychiatry, 36*, 1177-1186.

Wenk, D., Hardesty, C. L., Morgan, C. S., & Blair, S. L. (1994). The influence of paternal involvement on the well-being of sons and daughters. *Journal of Marriage and Family, 56*, 229-234.

Williams, K. E., Berthelsen, D., Viviani, M., & Nicholson, J. M. (2016). Participation of Australian Aboriginal and Torres Strait Islander families in a parent support programme: Longitudinal associations between playgroup attendance and child, parent and community outcomes. *Child: Care, health and development, 43*(3), 441-450.

Williams, S. (2008). What is Fatherhood? Searching for the reflexive father. *Sociology, 42*(3), 487-502.

World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Retrieved from Geneva:

Yang, S., & Kramer, M. S. (2012). Paternal alcohol consumption, family transition and child development in a former Soviet country. *International Journal of Epidemiology, 41*(4), 1086-1096.

Yeung, J., Sandberg, J., Davis-Kean, P., & Hofferth, S. (2001). Children's time with fathers in intact families. *Journal of Marriage and the Family, 63*, 136-1154. doi:10.1111/j.1741- 3737.2001.00136.x

Zahn-Waxler, C., Radke-Yarrow, M., Wagner, E., & Chapman, M. (1992). Development of concern for others. *Developmental Psychology, 28*(1), 126-136. doi:10.1037//0012-1649.28.1.126

Appendix 6. Supporting New Fathers is Good for the Economy

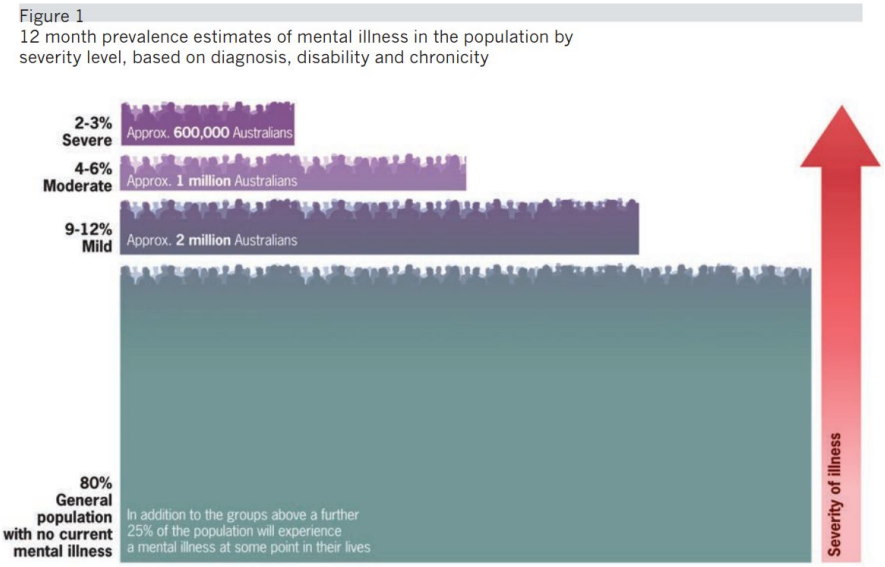
According to the national mental health report, approximately 20% of Australians are living with a mental illness each year.

Furthermore, Beyond Blue indicates that 14% of men are living with anxiety or depression each year with up to 10% of new dads struggling with depression post the birth of a child[5]. But these statistics aren't just limited to Australia - they're global. The UK's National Childbirth Trust claims 38% of new dads are concerned about their mental health[6].

The Movember Foundation also reports that fathers with mental health problems around the time of the birth of their child are up to 47 times more likely to be considered at risk of suicide than at any other point in their lives.[7]

These statistics are alarming and will not improve without adequate support both in preventative and post-'diagnosis' initiatives.

Table 1:



Source: National Mental Health Report 2013

[5] https://www.panda.org.au/info-support/how-is-dad-going
[6] https://www.nct.org.uk/about-us/media/news/dads-distress-many-new-fathers-are-worried-about-their-mental-health
[7] https://uk.movember.com/story/view/id/11858/new-movember-research-into-fatherhood-social-connections?tag=mental-health

There is not only a cultural and community need to support those with anxiety and depression but, according to KPMG, a “clear economic case for improving the mental health and wellbeing of all Australians."

Mental ill-health costs employers an average of **$3,200 per employee** with mental health illness per annum in absenteeism and presenteeism[8] with an estimated 40% of those with depression and 18% of those with anxiety taking time off work with a loss of 35 days and 27 days respectively per annum[9].

Furthermore, it is estimated that the average healthcare resources required for those with anxiety or depression is **$725 per person** per annum (including consultation, medication and - in more severe cases - hospitalisation).

Let’s break this down more succinctly.

In 2018 there were 315k babies born. Of these, an estimated 42%[10] were born to first time parents. That’s 132k new mums and 132k new dads in 2018. From 2014-2018 there were ~1.5 million babies born.

So, how many new dads are out there (i.e. of children under 5)? For the period 2014 to 2018 you’re looking at **647,000 new dads**.

Research suggests up to 10%[11] of these fathers (i.e. 65,000) will suffer from depression post the birth of their child.

We also know that lifetime prevalence of anxiety and depression in men is ⅕ and ⅛ respectively which equates to a 62:38 ratio of anxiety to depression. Therefore, in addition to 65,000 new dads suffering from depression, a further 106,000 will likely be suffering from anxiety. That’s 171k new dads suffering from anxiety or depression.

Cost for employers is therefore estimated at $547 million[12] whilst the cost on the healthcare system is an additional $124 million. A total **$671 million** cost just accounting for work absenteeism/presenteeism and healthcare.

[8] https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf
[9] https://journals.sagepub.com/doi/pdf/10.1177/0004867417710730
[10] https://embryology.med.unsw.edu.au/embryology/index.php/Australian_Statistics
[11] 10% based on PANDA statistics for new dads; up to 14% for all men
[12] Formula (171,000 x $3,200)

Then there's the worst possible outcome. Suicide. The average age of a new dad is approximately 31. At this age, risk of suicide is at it's highest, with approximately 35/100,000[13] taking their own life (compared to women at 8/100,000 at the same age).

This implies 226 new dads will take their life every year. The total cost (mostly present value of future earnings[14]) comes in at ~$974k per person, totalling **$220 million**… per year.

That's an estimated grand total of **$891 million** every year of economic cost resulting from anxiety and depression in new dads every year - from just three factors.

Importantly, these direct costs are conservative as they do not include the economic cost in other categories such as through lost income tax and social security payments.

The above is a review of the direct economic costs. How about the indirect costs such as impact of anxiety and depression on the family?

A Medical Journal of Australia study[15] found a threefold increase in depression, anxiety and substance dependence in the offspring of people with a depressed parent, compared with those whose parents had no diagnosis.

Research shows that, for the offspring of a depressed parent, they would face 3x[16] the probability of mental health disorders. Taking Beyond Blue headline statistics would mean, children with a depressed parent would have a:

- 45% probability of experiencing depression in their lifetime; a
- 79% probability of experiencing anxiety in their lifetime; and
- In any twelve-month period, an 18% chance of experiencing depression, a 43% chance of experiencing anxiety or a 51% probability of experiencing depression or anxiety or both[17]

So, purely taking those 65,000 new dads with depression, taking today's birth rate they will have, on average, 1.77 children each. That's 115,000 children. Of those children, 58,650 will experience anxiety or depression or both in any twelve-month period in adulthood.

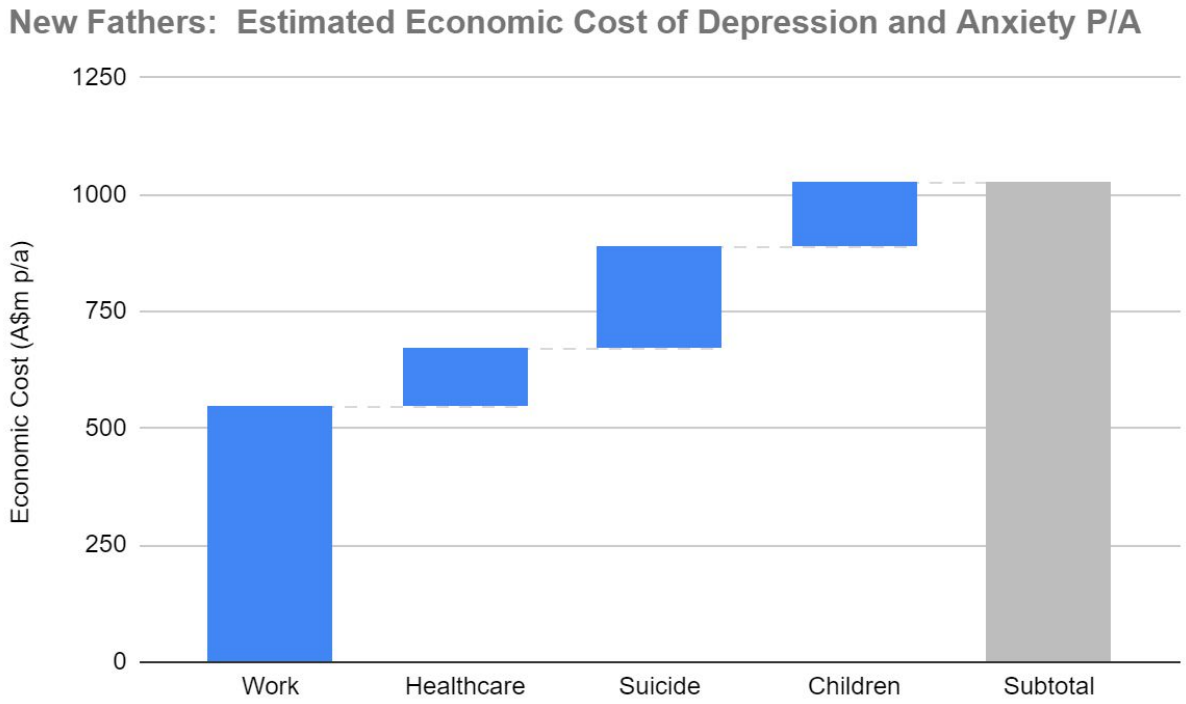
This comes in at **$153 million** for work and hospital cost in any one year. There is also the increased probability of suicide (9x and 3.4x more likely for men and women respectively who

[13] https://menslink.org.au/wp-content/uploads/2013/10/KPMG-Economic-cost-of-suicide-in-Australia-Menslink.pdf
[14] https://menslink.org.au/wp-content/uploads/2013/10/KPMG-Economic-cost-of-suicide-in-Australia-Menslink.pdf
[15] https://www.mja.com.au/journal/2013/199/3/children-whose-parents-have-mental-illness-prevalence-need-and-treatment#0_i1115817
[16] https://www.psychiatrictimes.com/major-depressive-disorder/outcomes-children-depressed-parents/page/0/1
[17] https://www.beyondblue.org.au/media/statistics

suffer from anxiety). Purely accounting for the 'additional' children suffering from anxiety in their lifetime[18] as a result of parental depression we would see an additional **$38 million** per annum in economic cost of suicide in the next generation. So - quite conservatively - an added economic cost of $191 million or (**~$137 million** if you were looking at estimated present value).

This equates to direct costs of $891m per annum on fathers and $137m per annum on children; totalling **$1.03 billion per annum**. This is the direct (and conservative) cost of anxiety and depression in new dads on the economy. Or, per capita, $6,023 per new dad suffering from anxiety or depression per year.

Table 2:



Source: See footnotes (Beyond Blue, KPMG et al). Compiled and estimated by Charlie Nave (Granite Bay Capital) 2019

It is clear that urgent action needs to be taken early (i.e. at the earliest stages of parenthood) to break this cycle of generational anxiety and depression.

These findings are supported by a report into paternal depression which found, after controlling for maternal depression and later paternal depression, having a father who was depressed at 8 weeks postpartum was found to double the risk of behavioural and emotional problems in children at 3.5 years of age[19]. One of the most prevalent behavioural problem - Oppositional

[18] Beyond Blue data (26.3% standard). 3x (79%). Difference (53%)
[19] Ramchandani P, Stein A, Evans J, et al. Paternal depression in the postnatal period and child development: a prospective population study. *Lancet*

Defiant Disorder (ODD) - impacts one in ten children with data showing that those with ODD in childhood/early adulthood have a 90% chance of being diagnosed with a mental illness in their lifetime.[20]

Finally, in relationships where one or both partners have instances of mental health disorder, there is at least a 2x probability of separation or divorce[21] (impact on offspring is highly variable).

What We Can Do

Approximately one quarter (23%) of dads felt isolated when they became a father and one fifth of fathers say that the number of close friends they had decreased in the 12 months after becoming a father[22]. This decrease in social engagement directly leads to an increase in instances of anxiety and depression.

However, there are solutions - specifically the importance of social participation and community.

Multiple reports highlight a substantial link between social isolation and anxiety and depression with other findings identifying social participation (membership in community groups and other organisations) as having a positive impact on reducing instances of isolation, anxiety and depression[23].

Whilst there are thousands of active mum's groups being established every year there is still very little community support for new dads.

It is essential, as a pillar of overarching mental health initiatives, that more focus is directed towards prevention of mental health instances in new fathers.

Just as mothers have an extensive and well established network of end-to-end support (perinatal, postnatal, maternal child health, mum's group); it is important, now more than ever, to expand similar end-to-end support networks specifically targeted at new fathers.

This will, undoubtedly, have a considerably positive economic impact - but far more than that - a considerable intangible impact of stronger relationships between the father, their partner and his children.

[20] https://www.aafp.org/afp/2016/0401/p586.html
[21] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1662-0
[22] https://cdn.movember.com/uploads/images/News/UK/Movember%20Fathers%20%26%20Social%20Connections%20Report.pdf
[23] https://journals.sagepub.com/doi/full/10.1177/0004867417723990

Appendix 7. The Forgotten Father

The forgotten father in obstetric medicine
A Kothari, K Thayalan, J Dulhunty, and L Callaway

Review Article

Obstetric Medicine

Obstetric Medicine
0(0) 1–9

DOI: 10.1177/1753495X18823479
journals.sagepub.com/home/obm

SAGE

The forgotten father in obstetric medicine

A Kothari[1,2], K Thayalan[1,3], J Dulhunty[1,4] and L Callaway[1,5]

Abstract

The role of fathers prior to conception, during pregnancy, and in the post-partum period has generally not been a key consideration for Obstetric Physicians. However, this view may need challenging. This paper outlines the key importance of fathers in all phases of obstetric medical care. We review the contribution of paternal factors such as genetics, health, and lifestyle to fetal development, pregnancy complications, and maternal and neonatal wellbeing. The role of fathers in complex care decisions during pregnancy is also reviewed. Postpartum, fathers have a substantial role in shaping the future of the family unit through encouraging breastfeeding and creating a supportive environment for motherhood. This review proposes areas for future research and recommends an evidence-based change in practice in obstetric medicine that focuses on recognizing the role of fathers in the pregnancy journey.

Keywords

Fathers, men's health, preconception

Introduction

Childbirth traditionally has had a focus on the mother and child, almost to the exclusion of paternal participation. With the phenomenon of male partners being increasingly welcomed into antenatal classes and the birth suite,[1] this paper explores health care practitioner considerations for the father. This includes the preconception, antenatal, childbirth, and post-partum periods, with a particular focus on key issues for the obstetric physician.

Preconception

A core component of obstetric medicine is to provide preconception care to women with complex medical conditions. In practice, this includes a detailed history, physical examination, and appropriate investigations.[2] A holistic approach comprises interventions that aim to identify and modify biochemical, behavioral, and social risks factors.[2]

Men's preconception health is a novel and equally important consideration for health practitioners with a wide spectrum of benefits.[2,3] Paternal health is critical in fetal developmental programming and can influence the health of future generations through polygenic inheritance.[4] The social wellbeing of the father is also critical in providing a healthier environment for the mother and baby unit. This is reinforced by the Centre for Disease Control's (CDC) preconception recommendations for men to address concerns related to nutrition, medical, mental and sexual health history, toxins, environmental exposures, and violence through consultation with their health practitioner prior to fathering a child.[2,5]

Better planning and support

Preconception care by health practitioners that involves male partners is critical in facilitating the quality of information available to couples when planning a pregnancy. With over half of pregnancies being unplanned, the CDC recommends that all couples develop a reproductive life plan.[5] Preconception counseling for men results in better preparation for parental responsibilities and improved reproductive outcomes for women by encouraging positive perinatal care choices, health-seeking behaviors, and supportive maternal health decisions. Women whose partners were involved in the pregnancy were 1.5 times more likely to receive prenatal care, and women who smoked reduced their cigarette consumption by 36% more when compared to women without partner involvement. Additionally, significantly more women breastfed their child when partners attended the intervention class (74%) compared to those whose partners did not (41%).[6,7]

Sperm quality

Improved overall health enhances men's biologic and genetic contributions to conception with improved sperm quality. Whilst literature on maternal exposures and risk of epigenetic changes is long standing, recent animal and epidemiological studies on various

[1]University of Queensland, Brisbane, Australia
[2]Department of Obstetrics and Gynaecology, Redcliffe Hospital, Brisbane, Australia
[3]Department of Obstetrics and Gynaecology, The Royal Brisbane and Women's Hospital, Brisbane, Australia
[4]Medical Administration, Redcliffe Hospital, Brisbane, Australia
[5]Department of Obstetric Medicine, The Royal Brisbane and Women's Hospital, Brisbane, Australia

Corresponding author:
A Kothari, Department of Obstetrics and Gynecology, Redcliffe Hospital, Anzac Avenue, Redcliffe, Queensland 4020, Australia.
Email: alka.kothari@uq.edu.au

contaminants, nutrition, and lifestyle-related conditions suggests a paternal influence on the offspring's future health.[8] These phenotypic outcomes have been attributed to DNA damage or mutations and environmentally induced functional changes of the genome. These changes may be driven by epigenetic components, accumulation of epigenetic changes from chronic exposures, or persistent and heritable modifications to the epigenome demonstrated by transgenerational effects. The effects of environmental insults are not necessarily equal and there is a suggestion of the existence of epigenetic windows during sperm development where DNA methylation, histone modification and non-coding RNAs result in a non-genetic transfer of paternal environmental information.[8]

Advanced paternal age

Advanced paternal age modifies the epigenetic integrity of the sperm and is associated with increased rates of spontaneous miscarriage and child morbidity.[8] A retrospective analysis of 17,000 intrauterine inseminations found that the clinical pregnancy rate was 12.3% for men below the age of 30 years, and declined to 9.3% for men over the age of 45 years. There was a corresponding increase in the risk of miscarriage from 13.7% to 32.4%.[9] In addition, when compared to younger fathers of 25 to 29 years, advanced paternal age (>45 years) is associated with an increased risk of adverse pregnancy outcomes. These include a 19% increase in the risk of low birth weight (odds ratio [OR]=1.19, 95% confidence interval [CI] 1.09–1.29),), an increase in preterm birth of 13% (OR = 1.13, 95% CI: 1.05–1.22) and a 29% increase in the risk of very preterm births (OR = 1.29, 95% CI: 1.15–1.44) with a substantial (48%) increase in the risk of late stillbirth (OR = 1.48, 95% CI: 1.04–2.10).[9,10]

As with other cellular processes, the ability to reprogram the epigenome declines with advancing years. This results in premeiotic damage to spermatogonia that can introduce new point mutations into the gene pool.[8] These point mutations can in turn lead to birth defects, neuropsychiatric diseases and an increased risk of malignancy. However, the risks of advancing paternal age are not routinely discussed in prenatal counseling.[11]

Exposures

Paternal preconception exposure to environmental and occupational factors including heat, radiation and endocrine disruptors are important determinants of sperm quality. Male preconception exposure is associated with poor outcomes including birth defects, malignancies and other developmental concerns.[12-17] Interestingly, paternal exposure is associated with longer gestational age and larger birth weight. Peri-conception occupational exposure to organic solvents, even in one parent, was associated with an increased risk of having a child with anencephaly (OR= 2.97, 95% CI: 1.36–6.52).[16] In addition, occupational exposures to phthalates in the father was associated with an increased risk of developing a peri-membranous ventricular septal defect (PmVSD) (OR = 1.6, 95% CI: 1.0–2.4) and pulmonary valve stenosis (OR= 2.4, 95% CI 1.1–5.2). Similarly, paternal exposure to alkylphenolic compounds had an increase in the risk of developing PmVSD (OR = 1.5, 95% CI: 1.0–2.2).[14] Exposures to herbicides from residential use contributed to a significantly increased risk of astrocytoma (OR = 1.9, 95% CI: 1.2–3.0).[13] Furthermore, a recent systematic review and meta-analysis concluded that occupational exposure to pesticides in parents has a statistically significant association for the occurrence of astroglial brain tumors in their offspring (OR= 1.30, 95% CI: 1.11–1.53).[18]

When assessing a couple's combined fertility, the exposure to toxins from environmental and occupational exposures must be quantified in both partners. The Longitudinal Investigation of Fertility and the Environment (LIFE) study assessed various chemical classes and the effect of overall fecundity through time-to-pregnancy (TTP) and fecundability odds ratios (FORs). There were significant reductions ranging from 17% to 31% in a couple's fecundity where partners had elevated concentrations of heavy metals, organic pollutants, environmental phenols and phthalates on urine and blood analysis. Increased levels of lead in the male partner's blood was associated with a reduction in couple fecundity (FOR= 0.83, 95% CI: 0.70, 0.98), and similarly so for tetrahydroxy benzophenone (FOR= 0.69, 95% CI: 0.49–0.97) and monomethyl phthalates (FOR = 0.81, 95% CI: 0.70, 0.94). In particular, male partners' chemical concentrations were consistently more often associated with diminished couple fecundity than female partners' concentrations.[19]

Furthermore, a quarter of fathers are likely to take prescription drugs in the three months prior to conception.[20] Although the limited data from small studies provides reassurance that paternal drug exposure is not an important risk factor for adverse pregnancy outcomes, large and longer term follow-up studies are necessary to evaluate the risk of rare outcomes, such as birth defects, and long-term effects on the offspring.[20,21] Table 1 delineates the effect of some drugs on semen quality, sperm motility, and infertility.

Other exposures, including radiation and certain infections, may affect male factor infertility. Data on paternal Zika virus infection have suggested that although spermatogonia are probably the main target, the seminal vesicles and prostate are also likely to be infected for prolonged periods of time.[27] Therefore, the World Health Organization (WHO) recommends abstinence or safe sexual practices for at least six months after potential exposure to Zika virus.[28]

Health behaviors

Male health and lifestyle factors define the paternal genome with the potential to affect male fertility and offspring health. Exposure to tobacco contributes to oxidative damage to the sperm DNA and results in a dose-dependent increase in the incidence of mutations in the sperm from 5.3% in nonsmokers to 19% in irregular smokers and 33% in daily smokers, thus contributing to infertility.[29] Smoking is also associated with an increased risk of aneuploidy and structural defects, impaired long-term health of the offspring and serious public health and socio-economic implications for future generations.[29,30]

In addition to health issues for the father, paternal obesity is a major risk factor for chronic diseases in offspring. Obesity in fathers is associated with preterm birth and impaired spermatogenesis with lower rates of fertility and pregnancy success.[15,31] Recent studies have explored the inter-generational and trans-generational epigenetic effects in the sperm cells and offspring.[8] The paternal influence is dependent on the body mass index and the transfer of preconceptional environmental influences through the sperm epigenome.[8,32] Therefore, weight optimization in fathers prior to conception is an area that needs to be prospectively studied in terms of the impact on child health.

Paternal mental health

Lifestyle stressors and paternal experience across the lifespan can induce germ cell epigenetic reprogramming and impact the offsprings' hypothalamic-pituitary axis stress regulation. This has the potential to influence neuropsychiatric disease risk as well as rates of mutagenic oxidized DNA. This effect is reversed with meditation and yoga, highlighting the contribution of lifestyle and social habits on sperm DNA integrity and consequent offspring health.[32] A recent interventional study evaluating the effects of exercising in humans reported positive epigenetic changes in the sperm cells after a three-month period of physical exercise.[33] DNA methylation changes occurred in the genes related to diseases such as schizophrenia, Parkinson's

Table 1. Medications associated with male factor infertility.

Drug class	Medication	Mechanism contributing to infertility
Specific Serotonin Reuptake Inhibitors (SSRI)[22]	Combination SSRI Buproprion Sertraline Fluoxetine Escitalopram	Altered testosterone levels Decreased sperm motility Spermicidal effect (in vitro)
	Paroxetine	Sperm DNA fragmentation Erectile dysfunction Difficulties in ejaculation
Calcium Channel Blockers (CCB)[22]	Diltiazem Nifedipine Non-specified or mixed CCB	Decreased sperm motility and viability in vitro (dose-dependent) Sperm structural changes in head and tail regions Altered sperm binding
Alpha-adrenergic blockers[22]	Tamsulosin Alfuzosin	Antegrade ejaculation Anejaculation Reduced sperm concentration and motility
5-alpha-reductase[23] inhibitors	Finasteride Dutasteride Propecia	Decreased sperm count, semen volume, sperm concentration and sperm motility.
Anti-epileptics[22]	Carbamazepine Valproate Phenytoin	Abnormal sperm morphology Reduced motility Low sperm count Reduced testicular volume
Anti-retrovirals[22]	Saquinavir	Decreased sperm motility (in vitro) Negative effect on essential fertilization mechanisms
	Highly Active Anti-Retroviral therapy	Neuropathy and lipodystrophy Reduced sperm motility Reduced ejaculate volume Increased rates of abnormal sperm morphology
Antibiotics[24]	Tetracycline	Reduction in the sperm motility, number of live spermatozoa, sperm counts, and increased abnormal sperm morphology (animal studies) Reduced sperm motility (in vitro)
Chemotherapy[25]	Cyclophosphamide	Oligospermia or azoospermia (longstanding/permanent)
Anabolic steroids[26]		Oligospermia and azoospermia Abnormal sperm morphology
Phosphodiesterase inhibitors[22]	Sildenafil	Improvement in semen motility, but negative effect on oocyte fertilization

disease, cervical cancer, and leukemia, although it remains to be determined if these changes are inherited by future generations.[33] Furthermore, the results of prospective cohort studies demonstrate the positive association between paternal stress in the antenatal and postnatal period and offspring behavioral dysfunction.[34–36] On the Strengths and Difficulties Questionnaire (SDQ), children of 4 to 5 years whose fathers had early depressive symptoms were more likely to score above the 90th percentile in terms of behavioral difficulties (OR = 3.34, 95% CI: 3.06–3.65) and had a low development and wellbeing score (OR = 2.70, 95% CI: 2.44–2.98).[34] In addition, maternal and paternal depression affects child development differently. Early paternal depression was more strongly associated with hyperactivity problems in boys, although it had a stronger association with emotional problems in girls. Therefore, interventions for detection and treatment of depression in fathers at risk are likely to be justified.[34]

Table 2. Examples of paternal interventions and factors shown to positively impact outcomes for the father, mother, or child.

Reference	Study type	Subjects (number)	Country	Intervention	Findings
Antenatal:					
Martin et al.[6]	Longitudinal cohort study	Women and their partners (5404)	USA	Nil (observational)	Women whose partners were involved in pregnancy care were 1.5 times more likely to receive prenatal care and those women who smoked reduced cigarette consumption by 36%
Denham et al.[33]	Longitudinal cohort study	Young healthy men with no previous structured exercise (24)	Australia	Three-month exercise intervention program	Epigenetic changes in sperm cells after involvement in a physical intervention program (DNA methylation at CpG sites in genes associated with a wide range of diseases such as schizophrenia, Parkinson's disease, cervical cancer and leukemia)
Tunc et al.[70]	Longitudinal cohort study (baseline control)	Men with known male factor infertility (45) compared to fertile controls (12)	Australia	Daily multivitamin/antioxidant supplement for three months	Increased overall sperm DNA methylation and decreased DNA damage with antioxidants. No change in morphology and motility
Håkonsen et al.[71]	Pilot cohort study	Males with a BMI 33–61 kg/ m^2 (43)	Denmark	14-week residential weight loss program	Weight loss was associated with an increase in total sperm count, semen volume, testosterone, serum hormone binding globulin (SHBG) and anti-Mullerianhormone (AMH).
Charandabi et al.[72]	RCT	Spouses of pregnant women with gestational ages of 24–28 weeks followed up until six weeks postpartum (126)	Iran	A two-weekly lifestyle-based training session lasting 60–90 min	The intervention group had a significant decrease in depression and anxiety scores at eight weeks after the intervention, as well as postnatal depression scores
Li et al.[73]	RCT	Expectant fathers – first pregnancy (87)	Taiwan	Four-hour birth education program providing information on labor and delivery and suggestions to assist women in labor and relaxation techniques	Significantly decreased anxiety in fathers in the intervention group
Diemer et al.[74]	RCT	Partners of primaparous and multiparous women (83)	USA	Father-focused discussion in perinatal classes	No effect on paternal stress levels in the antenatal period, but increased paternal coping and support seeking behaviors
Matthey et al.[75]	RCT	Couples in their first pregnancy (199)	Australia	Antenatal psychosocial intervention session on empathy	Reduction of postpartum distress at 6 weeks postpartum in mothers with low self-esteem and increased awareness in the men regarding their partners' needs

(continued)

Table 2. Continued

Reference	Study type	Subjects (number)	Country	Intervention	Findings
Postnatal:					
Wolfberg et al.[7]	RCT	Partners of women who were booked in to give birth (51)	USA	A 2-h class on infant care and breastfeeding compared to a class on infant care only	Significant improvement in breastfeeding initiation rates
Alio et al.[10]	Retrospective cohort study	755,334 fathers classified into age brackets:<20 years, 20–24 years, 25–29 years, 30–34 years, 35–39 years, 40–45 years, and >45 years	USA	Nil (observational)	Fathers aged 25–44 years of age had lower risk of children with low birth weight and partner with preterm labor compared to those aged <25 years and >44 years; fathers of advanced paternal age (>45 years) had a 48% increased risk of late stillbirth
Deutsch et al.[76]	Longitudinal cohort study	Children 10–11 years of age (40)	USA	Nil (observational)	Children who experience intimate parental relationships and have fathers who contribute a high proportion of the caretaking that is attentive, firm, and emotionally involved have higher self-esteem than other children
Cox et al.[77]	Longitudinal cohort study	Married couples at three months post-partum (38)	USA	Nil (observational)	Sensitive, warm, and appropriate interactions of fathers with their 3-month-old babies resulted in secure attachment of the babies to their fathers
Easterbrooks et al.[78]	Longitudinal cohort study	20-month-old children and their parents (75)	USA	Nil (observational)	The extent of fathers' involvement was related to toddler development in qualitative attitudes, such as behavioral sensitivity. Positive parenting attitudes and behaviors contributed to toddlers being more securely attached and competent at a problem-solving task
Koestner et al.[79]	Cross-sectional study	31-year-old subjects (37 men and 38 women)	Canada	Nil (observational)	Paternal involvement at age 5 was a significant predictor of empathic concern for others at age 31
Goncy et al.[80]	Longitudinal cohort study	Adolescents in grades 7 to 12 (9148)	USA	Nil (observational)	Shared communication and emotional closeness to fathers had an impact on adolescent alcohol use, above and beyond maternal involvement
Cookston et al.[81]	Longitudinal cohort study	Adolescents in grades 7 to 12 (2387)	USA	Nil (observational)	Father involvement was a significant predictor of adolescent depressive symptoms. Considerable stability was observed in the relation between father involvement and child adjustment

RCT: randomized controlled trial.

This issue becomes increasingly important as the transition to fatherhood involves numerous stressors associated with fundamental shifts in roles and relationships.[37] Psychological morbidity for fathers' peaks in the perinatal period from conception to one-year post-partum with a significant prevalence of depression (5–10%) and anxiety (5–15%).[38] A recent updated meta-analysis has suggested that rates of depression are highest in the 3 to 6 months post-partum (13%, 95% CI: 7.2–22.3).[39]

The primary period of increased paternal depressive symptoms is in the child's formative first five years of life.[36] Whilst the reported paternal postpartum depression rates are about half the maternal rate, this is likely to be biased due to underreporting by men.[36] Paternal mental health and wellbeing is also important due to the buffering effect of maternal stress on child development.[40,41] This suggests a role for routine paternal screening and interventions. In addition, there is evidence to show that postpartum educational programs are more effective when they involve both partners.[42,43] This is particularly important after severe adverse events such as postpartum hemorrhage and shoulder dystocia, where men are often bystanders and generally ignored.[44]

Antenatal

Pre-eclampsia. Pre-eclampsia is a significant contributor to maternal and neonatal morbidity and mortality worldwide.[45] It is a disease caused by complex pathophysiological mechanisms including genetic, environmental, and epigenetic factors. A recent emerging theory has suggested that a failure of the adaptation of the maternal cardiovascular system may lead to impaired uterine perfusion, resulting in end-organ damage and inadequate trophoblast invasion.[46] In addition, it has also recently been recognized that pre-eclampsia is a "couple's disease". The male partner has been classified as the "dangerous partner" due to passing on genes that may adversely affect the pregnancy outcome.[47] Men who previously fathered a pregnancy complicated by pre-eclampsia are twice as likely to contribute to pre-eclampsia in a pregnancy with another woman.[47] The only meta-analyses exploring paternal factors investigated the contribution of anti-paternal human leucocyte antibodies (HLA) and suggested that human leukocyte antigen G (HLA-G) expressed on the invading cytotrophoblast is important for the maternal adaptation of the placental vessels.[48] A shorter duration of exposure to seminal fluid is responsible for an increased risk of developing pre-eclampsia.[47] This is also demonstrated by an escalated risk of pre-eclampsia in pregnancies conceived as a result of ovum donation in azoospermic partners and after a short duration or a single act of unprotected intercourse.[49,50] The paternal antigens evoke a maternal immune reaction and prolonged exposure to the seminal fluid results in maternal mucosal tolerance. This protective effect is lost when there is an increased inter-pregnancy interval, even with the same partner. This increased duration is a higher risk factor for pre-eclampsia than a new partner.[51] Additionally, the use of barrier contraceptives increases the incidence of pre-eclampsia, while oral sex acts as another mechanism to increase maternal mucosal tolerance to paternal antigens decreasing the risk of pre-eclampsia.[51–53] The risk of pre-eclampsia is lower with Asian paternity, although discordance of parental ethnicity increases the risk.[54]

Furthermore, studies on paternal family history of genetic thrombophilia, hypertension, and cardiovascular disease reflect genes passed through the feto-placental unit via the father, which are associated with a number of adverse pregnancy outcomes.[48] This may be through single-nucleotide polymorphisms in the paternally expressed insulin-like growth factor (IGF2), which is responsible for trophoblastic invasion and placental function.[48] Likewise, there are several other possible pathways by which certain viruses, such as cytomegalovirus (CMV) and herpes virus, bacterial, fungal, and parasitic infections, have the potential to contribute to adverse pregnancy outcomes and, more specifically, to pre-eclampsia.[47] Herpes, in particular, is associated with an increased risk of developing pregnancy-induced hypertensive disorders.[55] CMV is known to have a major reservoir in the male urogenital system and could change the cytokine levels in seminal fluid. This would adversely affect the partner-specific mucosal tolerance and impair aspects of cyto trophoblast function, including decreased HLA-G expression and alterations in IGF2.[47,48]

Whilst a significant effort is made by obstetric physicians to recognize and treat women at high risk of pre-eclampsia, there is no routine approach to identify pregnancies fathered by a higher risk partner. Furthermore, there appears to be a significant gap in the level of counseling provided to both male and female partners on current and future pregnancy risks specific to shared medical histories. Simple interventions like providing written information such as the CDC factsheet (2018) on "Information for men" may provide an opportunity to intervene by engaging prospective fathers prenatally.[5]

Stillbirth. Worldwide, more than 2.7 million babies are stillborn each year.[56] Stillbirth is associated with significant and variable grief reactions from both parents and their families, resulting in an ongoing strain on interpersonal relationships.[56] The consequences of stillbirth can also negatively affect subsequently born children.[56] Even in higher income countries, support services focus on the mother and the impact on fathers is less well described, with most literature recording second-hand accounts from women regarding their partner's reaction.[57] Qualitative findings demonstrate that fathers display a classical grief response, but their experiences often relate to the expectations of being the "strong one", with particular prominence of grief suppression, increased substance use, employment difficulties, and financial debt compared to mothers.[56] Men appear to struggle with anxiety and depression, as well as possible post-traumatic stress disorder (PTSD) following stillbirth, but are reported to have lower rates of these complications compared to mothers.[57] The sense of grief and loss can be so overwhelming for fathers that they may choose not to participate in the birth of their stillborn baby.[58] Healthcare providers need to be conscious of providing counseling that takes men's needs into account.[59]

Evidence-based guidelines for the care of families after a stillbirth recommend the development and implementation of meaningful, non-pharmacological care strategies, which includes attending to the needs of the father.[60]Appropriate training is required for all staff involved in providing care to reduce the psychosocial impact of stillbirth and assist parents in developing resilience.[56,61] The importance of the social role of fathers in supporting their partner in difficult circumstances requires recognition and further encouragement.[62,63] In pre-conception counseling, emphasis should be provided towards caring for fathers who have experienced adverse pregnancy outcomes, as they may be hesitant to embark on another pregnancy. Anxiety levels in fathers increase after a fetal loss (15.6% had PTSD), especially when there is a greater inter-pregnancy interval.[57] In a pregnancy subsequent to fetal loss, fathers experience significant levels of anxiety and PTSD in the antenatal period, although these remit after the birth of a live baby.[57] While at all time points fathers' symptom levels appear lower than those of mothers, this is an area requiring further research and increased acknowledgement of its unique manifestations.[57]

Post-partum period

Breastfeeding

Breastfeeding has been shown to provide immediate and long-term benefits for both mother and children. Despite this, breastfeeding

rates remain suboptimal and the reasons include a lack of knowledge and support from the immediate family and the larger community, conflicting information, mechanical issues, complications, and logistics.[64] While social and behavioral change made breastfeeding more acceptable in public areas, the role of the father is often ignored as a potential promoting factor.[65] In addition, health professionals and broader care services often fail to engage fathers in supporting breastfeeding. In a 2013 Puerto Rican study of 84 volunteer fathers, the majority (88%) wanted their partners to breastfeed.[66] Contrastingly, some fathers had negative views and attitudes with 17% perceiving that breastfeeding is detrimental to breast health and 26% of the belief that it impacts breast appearance.[66] Furthermore, 7% of fathers reported feelings of jealousy and separation from the baby with the breastfeeding experience, which was identified as an important reason for the early discontinuation of breastfeeding.[66]

Sherriff et al.[67] delineated a model of father support in breastfeeding with the focus areas of enhancing knowledge, promoting a positive attitude, involvement in decision-making, and practical and emotional support towards breastfeeding. This model highlights entry points for practitioners to develop meaningful strategies to proactively engage fathers from different backgrounds in supporting breastfeeding.[67] Fathers with lower levels of education, lower disposable household income, or those not on paternity leave during the infant's first year of life were significantly less likely to have partners who breastfeed despite the cost benefits involved.[68] The published literature highlights increased rates of breastfeeding associated with paternal education and further research about how to best engage men in this process is required.[68,69]

Conclusion

As the emphasis in obstetric medicine increasingly shifts from the mother and child to the whole family unit, the integration of men's health as a part of preconception, pregnancy, and postpartum services is critical. Given that men's role in this journey has been largely neglected, it may be time for obstetric physicians to embrace the opportunity to more consciously provide health care to fathers. The research into the role of men in pregnancy health and long-term infant outcomes is less prominent than for women. There is very little evidence-based information to guide care for men at this critical time of their lives. Some paternal interventions shown to positively impact maternal–child outcomes are summarized in Table 2. Undoubtedly, this is an important challenge for the obstetric medicine community.

Suggestions for further research and health care delivery

- Establish male-specific guidelines on pre-conception, antenatal, and postnatal care with corresponding training for health care professionals.
- Assess the impact of pre-conception counseling that involves men on maternal, neonatal, and paternal outcomes.
- Explore the paternal contribution and pathophysiological mechanism to offspring health.
- Determine the health benefit impact of positive male behaviors, such as weight optimization and smoking cessation, on pregnancy outcomes.
- Investigate the effect of obesity, diet, and exercise on sperm epigenetics and the effect on future offspring.
- Pilot the role of a paternal health medical record.
- Determine postpartum paternal health outcomes, such as paternal mental health following normal and abnormal births.
- Explore evidence-based interventions and maternal–paternal factors that may reduce the psychosocial cost of stillbirth.
- Develop training models for healthcare professionals to optimize support for families who have had a difficult pregnancy, stillbirth, or bereavement from a fetal or neonatal death.

Acknowledgements

The authors would like to acknowledge and thank Jane Orbell-Smith, Health Librarian, Redcliffe and Caboolture Hospitals, Queensland, Australia, for assistance with the literature search and data management.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Guarantor

AK

Contributorship

This is an invited review paper for the journal and forms a part of higher degree (AK). The literature search and manuscript writing were undertaken by AK and KT. LC and JD provided expert review of the draft. All authors approved the final version of the manuscript.

ORCID iD

A Kothari http://orcid.org/0000-0002-9816-3734

References

1. Draper J. Men's passage to fatherhood: an analysis of the contemporary relevance of transition theory. *Nurs Inq* 2003; 10: 66–77.
2. Posner SF, Johnson K, Parker C, et al. The National Summit on Preconception Care: a summary of concepts and recommendations. *Matern Child Health J* 2006; 10: 199–207.
3. Kotelchuck M and Lu M. Father's role in preconception health. *Matern Child Health J* 2017; 21: 2025–2039.
4. Magnus P, Gjessing HK, Skrondal A, et al. Paternal contribution to birth weight. *J Epidemiol Community Health* 2001; 55: 873.
5. Centers for Disease Control and Prevention. Preconception care. *Information for men*, https://www.cdc.gov/preconception/men.html (2018, accessed 10 May 2018).
6. Martin L, McNamara M, Milot A, et al. The effects of father involvement during pregnancy on receipt of prenatal care and maternal smoking. *Matern Child Health J* 2007; 11: 595–602.
7. Wolfberg AJ, Michels KB, Shields W, et al. Dads as breastfeeding advocates: results from a randomized controlled trial of an educational intervention. *Am J Obstet Gynecol* 2004; 191: 708–712.
8. Soubry A, Hoyo C, Jirtle RL, et al. A paternal environmental legacy: evidence for epigenetic inheritance through the male germ line. *BioEssays* 2014; 36: 359–371.

9. Belloc S, Cohen-Bacrie P, Benkhalifa M, et al. Effect of maternal and paternal age on pregnancy and miscarriage rates after intrauterine insemination. *Reprod Biomed Online* 2008; 17: 392–397.
10. Alio A, Salihu H, McIntosh C, et al. The effect of paternal age on fetal birth outcomes. *Am J Mens Health* 2012; 6: 427–435.
11. Harlap S, Paltiel O, Deutsch L, et al. Paternal age and preeclampsia. *Epidemiology* 2002; 13: 660–667.
12. Agricola E, Gesualdo F, Carloni E, et al. Investigating paternal preconception risk factors for adverse pregnancy outcomes in a population of internet users. *Reprod Health* 2016; 13: 37.
13. Wang C, Zhan Y, Wang F, et al. Parental occupational exposures to endocrine disruptors and the risk of simple isolated congenital heart defects. *Pediatr Cardiol* 2015; 36: 1024–1037.
14. Smarr MM, Grantz KL, Sundaram R, et al. Parental urinary biomarkers of preconception exposure to bisphenol A and phthalates in relation to birth outcomes. *Environ Health* 2015; 14: 73.
15. Houfflyn S, Matthys C and Soubry A. Male obesity: epigenetic origin and effects in sperm and offspring. *Curr Mol Biol Rep* 2017; 3: 288–296.
16. Aguilar-Garduño C, Lacasaña M, Blanco-Muñoz J, et al. Parental occupational exposure to organic solvents and anencephaly in Mexico. *Occup Environ Med* 2010; 67: 32–37.
17. Shim YK, Mlynarek SP and van Wijngaarden E. Parental exposure to pesticides and childhood brain cancer: U.S. Atlantic coast childhood brain cancer study. *Environ Health Perspect* 2009; 117: 1002–1006.
18. Van Maele-Fabry G, Hoet P and Lison D. Parental occupational exposure to pesticides as risk factor for brain tumors in children and young adults: a systematic review and meta-analysis. *Environ Int* 2013; 56: 19–31.
19. Buck Louis GM, Barr DB, Kannan K, et al. Paternal exposures to environmental chemicals and time-to-pregnancy: overview of results from the LIFE study. *Andrology* 2016; 4: 639–647.
20. Engeland A, Bjørge T, Daltveit AK, et al. Effects of preconceptional paternal drug exposure on birth outcomes: cohort study of 340 000 pregnancies using Norwegian population-based databases. *Br J Clin Pharmacol* 2013; 75: 1134–1141.
21. Begg EJ. Prescribing in pregnancy and lactation. *Br J Clin Pharmacol* 2008; 65: 627–628.
22. Brezina PR, Yunus FN and Zhao Y. Effects of pharmaceutical medications on male fertility. *J Reprod Infertil* 2012; 13: 3.
23. Amory JK, Wang C, Swerdloff RS, et al. The effect of 5α-reductase inhibition with dutasteride and finasteride on semen parameters and serum hormones in healthy men. *J Clin Endocrinol Metab* 2007; 92: 1659–1665.
24. Hargreaves CA, Rogers S, Hills F, et al. Effects of co-trimoxazole, erythromycin, amoxycillin, tetracycline and chloroquine on sperm function in vitro. *Hum Reprod* 1998; 13: 1878–1886.
25. Meistrich ML, Wilson G, Brown BW, et al. Impact of cyclophosphamide on long-term reduction in sperm count in men treated with combination chemotherapy for Ewing and soft tissue sarcomas. *Cancer* 1992; 70: 2703–2712.
26. Torres-Calleja J, González-Unzaga M, Decelis-Carrillo R, et al. Effect of androgenic anabolic steroids on sperm quality and serum hormone levels in adult male bodybuilders. *Life Science Weekly* 2001; 68: 1769–1774.
27. Barzon L, Lavezzo E and Palù G. Zika virus infection in semen: effect on human reproduction. *Lancet Infect Dis* 2017; 17: 1107–1109.
28. World Health Organization. *Prevention of sexual transmission of Zika virus: interim guidance update*. Geneva, Switzerland: WHO, 2016.
29. Beal MA, Yauk CL and Marchetti F. From sperm to offspring: assessing the heritable genetic consequences of paternal smoking and potential public health impacts. *Mutat Res* 2017; 773: 26–50.
30. Dior UP, Lawrence GM, Sitlani C, et al. Parental smoking during pregnancy and offspring cardio-metabolic risk factors at ages 17 and 32. *Atherosclerosis* 2014; 235: 430–437.
31. Moss J and Harris K. Impact of maternal and paternal preconception health on birth outcomes using prospective couples' data in Add Health. *Arch Gynecol Obstet* 2015; 291: 287–298.
32. Soubry A. POHaD: Why we should study future fathers. *Environ Epigenet* 2018; 4: dvy007.
33. Denham J, O'Brien BJ, Harvey JT, et al. Genome-wide sperm DNA methylation changes after 3 months of exercise training in humans. *Epigenomics* 2015; 7: 717.
34. Fletcher RJ, Feeman E, C G, et al. The effects of early paternal depression on children's development. *Med J Aust* 2011; 195: 685–689.
35. Kvalevaag AL, Ramchandani PG, Hove O, et al. Paternal mental health and socioemotional and behavioral development in their children. *Pediatrics* 2013; 131: e463–e4e9.
36. Garfield G, Duncan G, Rutsohn J, et al. A longitudinal study of paternal mental health during transition to fatherhood as young adults. *Pediatrics* 2014; 133: 836–843.
37. Cabrera N, Tamis -LeMonda CS, et al. Fatherhood in the twenty-first century. *Child Dev* 2000; 71: 127–136.
38. Darwin Z, Galdas P, Hinchliff S, et al. Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY). *BMC Pregnancy Childbirth* 2017; 17: 45.
39. Cameron EE, Sedov ID and Tomfohr-Madsen LM. Prevalence of paternal depression in pregnancy and the postpartum: an updated meta-analysis. *Journal of Affective Disorders* 2016; 206: 189–203.
40. State of Queensland (Queensland Health). Queensland mothers and babies 2014 and 2015: report of the Queensland Maternal and Perinatal Quality Council. 2017.
41. Khan L. Fatherhood: the impact of fathers on children's mental health. *Briefing*. Centre for Mental Health, 2017, pp. 1–13.
42. Morgan M, Matthey S, Barnett B, et al. A group programme for postnatally distressed women and their partners. *J Adv Nurs* 1997; 26: 913–920.
43. Kim P and Swain JE. Sad dads: Paternal postpartum depression. *Psychiatry (Edgmont (Pa: Township))* 2007; 4: 35.
44. Locock L and Alexander J. Just a bystander'? Men's place in the process of fetal screening and diagnosis. *Soc Sci Med* 2006; 62: 1349–1359.
45. Ghulmiyyah L and Sibai B. Maternal mortality from preeclampsia/eclampsia. *Semin Perinatol* 2012; 36: 56–59.
46. Thilaganathan B. Pre-eclampsia and the cardiovascular–placental axis. *Ultrasound Obstet Gynecol* 2018; 51: 714–717.
47. Dekker G, Robillard PY and Roberts C. The etiology of preeclampsia: the role of the father. *J Reprod Immunol* 2011; 89: 126–132.
48. Katsi V, Felekos I, Siristatidis C, et al. Preeclampsia: what does the father have to do with it? *Curr Hypertens Rep* 2015; 17: 60.
49. Saito S and Sakai M. Th1/Th2 balance in preeclampsia. *J Reprod Immunol* 2003; 59: 161–173.
50. Wang JX, Knottnerus A-M, Schuit G, et al. Surgically obtained sperm, and risk of gestational hypertension and pre-eclampsia. *Lancet* 2002; 359: 673–674.
51. Trogstad LI, Eskild A, Magnus P, et al. Changing paternity and time since last pregnancy: the impact on pre-eclampsia risk. A study of 547 238 women with and without previous pre-eclampsia. *Int J Epidemiol* 2001; 30: 1317–1322.
52. Koelman CA, Coumans AB, Nijman HW, et al. Correlation between oral sex and a low incidence of preeclampsia: a role

for soluble HLA in seminal fluid? *J Reprod Immunol* 2000; 46: 155–166.
53. Galaviz-Hernandez C, Arámbula-Meraz E, Medina-Bastidas D, et al. The paternal polymorphism rs5370 in the EDN1 gene decreases the risk of preeclampsia. *Pregnancy Hypertens* 2016; 6: 327–332.
54. Caughey AB, Stotland NE, Washington AE, et al. Maternal ethnicity, paternal ethnicity, and parental ethnic discordance: predictors of preeclampsia. *Obstet Gynecol* 2005; 106: 156–161.
55. Gibson CS, Goldwater P, MacLennan A, et al. Fetal exposure to herpesviruses may be associated with pregnancy-induced hypertensive disorders and preterm birth in a Caucasian population. *BJOG* 2008; 115: 492–500.
56. Burden C, Bradley S, Storey C, et al. From grief, guilt pain and stigma to hope and pride – a systematic review and meta-analysis of mixed-method research of the psychosocial impact of stillbirth. *BMC Pregnancy Childbirth* 201; 9.
57. Turton P, Badenhorst W, Hughes P, et al. Psychological impact of stillbirth on fathers in the subsequent pregnancy and puerperium. *Br J Psychiatry* 2006; 188: 165–172.
58. Cacciatore J. Psychological effects of stillbirth. *Semin Fetal Neonatal Med* 2013; 18: 76–82.
59. Cacciatore J, Erlandsson K and Rådestad I. Fatherhood and suffering: a qualitative exploration of Swedish men's experiences of care after the death of a baby. *Int J Nurs Stud* 2013; 50: 664–670.
60. Peters MDJ, Lisy K, Riitano D, et al. Caring for families experiencing stillbirth: evidence-based guidance for maternity care providers. *Women Birth* 2015; 28: 272–278.
61. Lisy K, Peters MDJ, Riitano D, et al. Provision of meaningful care at diagnosis, birth, and after stillbirth: a qualitative synthesis of parents' experiences. *Birth* 2016; 43: 6–19.
62. Badenhorst W, Riches S, Turton P, et al. Perinatal death and fathers. *J Psychosom Obstet Gynaecol* 2007; 28: 193.
63. Badenhorst W, Riches S, Turton P, et al. The psychological effects of stillbirth and neonatal death on fathers: systematic review. *J Psychosom Obstet Gynaecol* 2006; 27: 245–256.
64. Zakarija-Grković I, Šegvić O, Vučković Vukušić A, et al. Predictors of suboptimal breastfeeding: an opportunity for public health interventions. *Eur J Public Health* 2016; 26: 282–289.
65. Yourkavitch JM, Alvey JL, Prosnitz DM, et al. Engaging men to promote and support exclusive breastfeeding: a descriptive review of 28 projects in 20 low- and middle-income countries from 2003 to 2013. *J Health Popul Nutr* 2017; 36: 43.
66. García-Fragoso L, Jiménez D, Ortiz N, et al. Father attitudes and knowledge about breastfeeding. *Bol Asoc Med P R* 2013; 105: 37–40.
67. Sherriff N, Panton C and Hall V. A new model of father support to promote breastfeeding. *Community Pract* 2014; 87: 20–24.
68. Flacking R, Dykes F and Ewald U. The influence of fathers' socioeconomic status and paternity leave on breastfeeding duration: a population-based cohort study. *Scand J Public Health* 2010; 38: 337–343.
69. Mitchell-Box KM and Braun KL. Impact of male-partner-focused interventions on breastfeeding initiation, exclusivity, and continuation. *J Hum Lact* 2013; 29: 473–479.
70. Tunc O and Tremellen K. Oxidative DNA damage impairs global sperm DNA methylation in infertile men. *J Assist Reprod Genet* 2009; 26: 537–544.
71. Håkonsen LB, Thulstrup AM, Aggerholm AS, et al. Does weight loss improve semen quality and reproductive hormones? Results from a cohort of severely obese men. *Reprod Health* 2011; 8: 24.
72. Charandabi SM-A, Mirghafourvand M and Sanaati F. The effect of life style based education on the fathers' anxiety and depression during pregnancy and postpartum periods: a randomized controlled trial. *Community Ment Health J* 2017; 53: 482.
73. Li HT, Lin KC, Chang SC, et al. A birth education program for expectant fathers in Taiwan: effects on their anxiety. *Birth* 2009; 36: 289–296.
74. Diemer GA. Expectant fathers: influence of perinatal education on stress, coping, and spousal relations. *Res Nurs Health* 1997; 20: 281.
75. Matthey S, Kavanagh DJ, Howie P, et al. Prevention of postnatal distress or depression: an evaluation of an intervention at preparation for parenthood classes. *J Affect Disord* 2004; 79: 113–126.
76. Deutsch FM, Servis LJ and Payne JD. Paternal participation in child care and its effects on children's self-esteem and attitudes toward gendered roles. *J Fam Issues* 2001; 22: 1000–1024.
77. Cox MJ, Owen MT, Henderson VK, et al. Prediction of infant–father and infant–mother attachment. *Dev Psychol* 1992; 28: 474–483.
78. Easterbrooks MA and Goldberg WA. Toddler development in the family: impact of father involvement and parenting characteristics. *Child Dev* 1984; 55: 740–752.
79. Koestner R, Franz C and Weinberger J. The family origins of empathic concern: a 26-year longitudinal study. *J Pers Soc Psychol* 1990; 58: 709–717.
80. Goncy EA and Van Dulmen MHM. Fathers do make a difference: parental involvement and adolescent alcohol use. *Fathering* 2010; 8: 93–108.
81. Cookston J and Finlay A. Father involvement and adolescent adjustment: longitudinal findings from Add Health. *Fathering* 2006; 4: 137–158.

Appendix 8. Brisbane Metro North Hospital & Health Service, Grant Application & Project Overview

Expression of Interest - 2019 LINK and SEED Innovation Fund
LINK and SEED Application Form (Final)
Application LNKSEE00732019 From Mrs Helen Funk
Form Submitted 28 Nov 2019, 1:11pm AEST

Proposal Details

*** indicates a required field**

Project Summation

1. What type of innovation funding are you applying for? *
◉ LINK ○ SEED

2. Please provide the LINK/SEED application number issued to you with your Expression of Interest *
LNKSEE00732019
(e.g. LNKSEE00xx2019)

3. Define the problem *
Most new mothers and fathers do not seek mental health support when they need it. 100 new dads in Queensland are affected by postnatal psychological distress each week (QLD Health 2019). 75% of women experiencing symptoms do not seek help (Schmied et al, 2016).

Most antenatal education classes are presented through a “service-provider lens’, geared to mothers, with minimal focus on mental well-being, father-inclusivity and the support needed during this major life transition.

The Emotional Preparation for Parenthood (EPP) Program established at Redcliffe Hospital for expectant parents has improved awareness of the emotional challenges experienced during this major life transition (Perinatal Mental Health & Wellness (PMHW) Project, 2017), with a key component being a trained Peer Educator co-facilitating the session with a midwife.There remains however a lack of language accessibility, father inclusivity in the program design and delivery, and a lack of focus on community connections. Further peer educators are needed within MNHHS.

Recently surveyed fathers in a current MNHHS project (Funk, 2019) are seeking more information on their role as a father, relationship changes, mental health and available supports. Mothers have local council and Child Health organised groups but there are no specific father support groups available locally.
Must be no more than 200 words.
Refer back to your EOI. What is the current challenge that you have identified and are seeking to address?

4. Detail the solution *
Outcome 1. Strengthening a preparation for parenthood program (PPP) including peer education and father inclusivity through networking and knowledge-sharing

Partnering with an expert Perinatal Peer Educator and the nationally focused Dads Group Inc. (DGI) the content of the existing EPP program will be reviewed by consumer experts to become more language accessible and father inclusive with stronger community connections. The midwife will co-facilitate the new antenatal PPP with a peer educator, whilst a Dads Group Leader will contribute remotely to the session via zoom link.

Outcome 2. Enhance access to ongoing mental health support for new fathers through partnership with DGI.

Through this project, DGI will establish sustainable fathers groups within MNHHS, thus providing an early intervention approach for new fathers building positive social relationships and easier pathways to health services. Dads Groups are male-led, supportive and engaging environments with trained peer leaders, aimed at reducing isolation for new

dads, promoting positive parenting for men and preventing family violence. These groups encourage help-seeking behaviour by addressing gender stereotypes and normalising the lived experience of mental health challenges for new and expecting fathers.

Outcomes 3. Enhance the sustainability of the embedded Peer Educator model within a PPP through partnership with PANDA

With support from an informal partnership with the national non-government organisation PANDA (Perinatal Anxiety & Depression Australia) a sustainable identification, recruitment and training program for Peer Educators will be developed by the expert Perinatal Peer educator and project officer. This aims to support embedding Peer Educators in MNHHS maternity services to co-facilitate the PPP.

For sustainability of the PPP, a peer educator mentor role will be developed and embedded. The mentor will support all elements of the program including ongoing supervision for the peer educators, which is standard best practice for peer workers within the health system.

Must be no more than 300 words.

Again, refer back to your EOI as a starting point. What outcomes are you hoping to achieve? What are the activities, actions, interventions that will deliver the improvement outcome/s you are seeking to achieve?

5. Key outcome success measures *

Outcome 1.

A. A group of confident peer educators are successfully co-facilitating PPP at Redcliffe, RBWH and Caboolture Hospitals.

Quantitative: 6 -10 peer educators co-facilitating the PPP.

Qualitative: At least 85% of peer educators report feeling confident in their roles and understanding of perinatal mental health (PMH) challenges.

B. Midwives working in antenatal education have improved mental health literacy.

Quantitative: 15 - 20 midwives are working with peer educators in PPPs.

Qualitative: At least 85% of midwives facilitating PPPs with peer educators report feeling confident in their roles and understanding of PMH challenges.

C. Midwives have increased capacity to respond appropriately and supportively to perinatal mental health issues in clinical settings.

Qualitative: At least 85% of midwives self-report feeling improved confidence in conversing with families about PMH challenges.

D. Expectant parents have improved mental health literacy and confidence in help seeking.

Quantitative: Between 4-5000 expectant parents are supported through access to a peer educator and fatherhood expert during PPPs.

Qualitative: At least 80% of expectant parents report substantial understanding of mental health challenges and confidence in help seeking.

Outcome 2.

A. Fathers who have attended Dads Groups have increased parenting confidence, improved social connections and wellbeing.

Quantitative: 5 new Dads Groups have been established with an average of 30-50 new fathers in each group

Qualitative: At least 80% of Dads Group participants report increased parenting confidence and social connections.

Outcomes 3.

A. A Peer Educator Mentor Role has been developed and implemented.

Quantitative: A Peer Educator Mentor has been recruited, trained and is active in the role.

B. A sustainable identification, recruitment and training process of Peer Educators is established.

Evaluation: This outcome will require commitment from the MNHHS which can't be guaranteed. Throughout the program we will focus on relationship development and support systems to embed the pathways.

Must be no more than 300 words.
How will you provide credible and reliable justification for the success of your activities? What might be your qualitative and Quantitative success measures?

6. WAU impact compared to current practice (WAU - Weighted Activity Units) *

This project will not directly increase additional WAU as expectant parents are already attending the existing antenatal childbirth and parenting education curriculum at each of the three sites (RBWH, Redcliffe and Caboolture). This proposal adds value to an existing session within the antenatal education classes and enhances current experiences for expectant parents attending those classes.

There is potential scope for an increase in the number of expectant parents who will attend antenatal classes at both Redcliffe and Caboolture. However, the RBWH classes as they currently operate are at capacity.

The implementation of Dads groups will not attract WAU. There are however social benefits (improvement in mental wellbeing) which may result in a reduction in future need of mental health services. The Dads groups will not be self-sustaining, however the plan is for DGI to seek ongoing grants from local leaders, councils, businesses and community organisations to support their ongoing monetary requirements.

Must be no more than 200 words.
Is the activity sustainable ie pays for itself post funding?

7. Staffing *

The expected timeframes for the DGI Program Leader & Support person, Peer Educator and Project Officer are detailed on the attached spreadsheet document, with shared involvement across the 12-month period being evident.

In kind support will be required by relevant Caboolture and RBWH midwives and management to undertake a once-off, half-day training workshop around the PPP content and co-facilitation practices.

In kind support will be required from the Coordinator of antenatal education for each MNHHS maternity service to review revised PPP content and adapt overall curriculum to enable the inclusion of the PPP. The coordinator and other childbirth educator midwives will assist with orientating and supporting the Peer Educator trainee when co-facilitating the class in the initial phases. They will also provide in-kind support for the promotion and marketing of Dads Groups being established.

Midwives and doctors working with expectant and new parents in the antenatal and postnatal periods will be educated through existing inservice opportunities about the PPP and Dads Groups. With this new knowledge gained it is hoped midwives and doctors will provide support to promote the PPP and Dads Groups during antenatal appointments, on the postnatal ward, home visits, and other OPD appointments including lactation clinic appointments.

Must be no more than 200 words.
What is the anticpated workload impact on affected people? (Consider the project team and also staff covering for project actitiies from within the work unit)

8. Blockers *

1. Potential blockers to strengthening the PPP including peer education and father inclusivity may be:

● The successful recruitment of 6-10 peer educators relies on appropriate candidates and their willingness and skill to participate. Engaging with the PANDA Champions program will help to mitigate.

● Scheduling conflicts for peer educators around family responsibilities. Good communication with class coordinators and rescheduling or use digital alternatives will help to mitigate.

● Midwives facilitating the PPP being unsupportive of the peer education element. Midwives may be challenged by program content, possibly stemming from their own lived-experiences. Clinical supervision and training would help to mitigate.

2. Potential blockers to enhancing access to ongoing mental health support for new fathers may be:

● If local fathers, government and other bodies were unwilling to partner long-term. Dads Groups thrive and survive through ongoing support from local council, businesses and community organisations. Developing relationships throughout the project will help to mitigate.

3. Potential blockers to enhancing the sustainability of the embedded Peer Educator in the PPP may be:

● If the organisation chose not to budget for the peer educator and mentor roles. The development of strong working relationships with decision makers will help to mitigate.

Must be no more than 200 words.
What factors or which roles have you identified that have the most potential to derail your project?

9. Enablers

1. Enablers to strengthen the peer educator role are:

● Engaging with staff across the organisation, helping them to understand the value of collaborating with peer educators and consumer experts using high level evidence.

● Collaborating with an existing, experienced peer educator to support and train new recruits and relevant staff.

● Development of Champions at RBWH & Caboolture to support program uptake.

2. Enablers to enhance access to ongoing mental health support for new fathers are:

● Using Dads Group Inc. to provide high quality training and support for local fathers to become a Dads Group Leader.

● Developing ownership and motivation for MNHHS staff to enthusiastically promote Dads Groups by educating them about the research and contextual needs for supporting new fathers.

3. Enablers to enhance the sustainability of the Peer Educator role are:

● Support current midwives, management and executive at Redcliffe who have worked with a peer educator since 2012, to become champions, supporting the other two sites.

● A video-recording of the PPP class to train newly recruited peer educators in the future.

● Support an ongoing informal partnership with relevant MNHHS staff and PANDA to maintain a recruitment pathway for peer educators.

What will you need to do to achieve the project outcomes? Who or what needs to be in accord with your project intent in order for it to be successful?

10. How can this idea be sustained beyond the funded time? *
The PPP will require a commitment from the RBWH and Caboolture to fund the role of peer educators at their sites. Redcliffe currently reimburses their peer educator as a paid volunteer via an external vendor process. Invoices are signed by the peer and the midwife at the completion of each session, then submitted to the maternity unit manager. The current cost for the peer educator to co-facilitate the EPP class at Redcliffe is approximately $4,500/year. A similar number of classes are delivered at both the RBWH and Caboolture sites, therefore we expect that the cost to be comparable.

Additional ongoing costs will include:

● Peer educator mentor role:

○ provision of peer supervision 6 x 4hr sessions per year across MNHHS at a minimum

○ delivery of staff training if required

○ future training for newly recruited peer educators as required

Whilst we are unable to guarantee that the RBWH and Caboolture will choose to fund the role into the future, we will focus on relationship development with relevant decision makers, ensuring we communicate clearly the social and financial benefits of supporting families in this way. We will highlight how the PPP and Dads groups aligns with the MNHHS Strategic Plan 2016-2020, focusing on:

Objective 1: To always put people first

Strategy 1.1: Partner with patients and their carers and families to improve the patient experience.

During this project, Dads Group Inc. will be pursuing funding relationships with local councils in order to sustain the Dads Groups established through LINK funding. Dads Group Inc. approaches local councils with an Engaging Father's Program package, which 15 other councils around Australia have already purchased. Dads Groups also has existing funding relationships at multiple levels of government and philanthropic bodies and will continue to pursue these diverse avenues for project sustainability.

Must be no more than 300 words.
Please be specific. What is needed for the project deliverables to be continued beyond project funding? What resourcing costs will need to be met? What business changes would be necessary for this inititaive to be embeded as Business As Usual? What stakeholders need to be engaged for this to be a success long term?

Funding Request

*** indicates a required field**

Labour Budget

What will your project be seeking as a budget for labour resources?

Labour resources	Labour budget
Project Officer - Midwife (0.4	$45,867.00
DGI Program Lead (124 days)	$49,600.00
DGI Program Support (29 days)	$8,700.00
DGI training Facilitator Stipend (volunteers)	$2,000.00

DGI Admin	$1,500.00
DGI Research and Evaluation	$3,600.00
Project Peer Educator/Mentor	$14,800.00
Newly trained peer educators class delivery - approx. $140 per session for final 2-3 months of project	$1,680.00
	Must be a dollar amount.

Non labour Budget

What will your project be seeking as a budget for labour resources?
If no non-labour budget requested, please indicate NIL / $0.00 against the first line entries

Non labour resources	Non labour budget
DGI Promotion, Marketing and Printing	$4,000.00
DGI Dads group Catering - Coffee etc	$12,500.00
Peer Educator training expenses - printing manuals etc.	$500.00
Videoing of PPP class to be used for training of peer educators	$3,500.00
	Must be a dollar amount.

Budget Totals

Total Expenditure Amount
$148,247.00
This number/amount is calculated.
This figure should equal the total amount of LINK or SEED funding requested.

Funding Timeframe

Is the funding request for the full 12 months? *
◉ Yes ○ No ○ Other:

Contact details

*** indicates a required field**

Contacts

Primary contact person *
Mrs Helen Funk

Position held in MNHHS *
Project Nurse Manager/Clinical Midwife
This is the name of the Project Lead and key contact for project.

Primary Phone Number *
0413 276 837
Please include Australian area code

Primary Email *
helen.funk@health.qld.gov.au
Must be a QHealth email address

Executive Director / Executive Sponsor *
Alanna Geary
Please enter name and title of Executive Director of Project location / Executive Sponsor

Business Manager's name *
Tracey Palu

Business Manager's email *
tracey.palu@health.qld.gov.au
Must be a Queensland Health email address

Business Manager's phone number *
(07) 3646 0279
Must be an Australian phone number.

Is your Business Manager aware of this application? *
◉ Yes ○ No
It is important to engage early with your Business manager to ensure accuracy of funding information and support for funding management

Idea Proposed

*** indicates a required field**

1. Project Outputs

Before responding to this section, please review your project proposal, issue and solution, from your successful EOI.

1. Inclusions: What is 'in scope' for the project? *
1. Establish Peer Educator Mentor Role:

● Develop role description

● Recruit appropriate candidate within first month

2. Adapting PPP content

● Adapt existing EPP content to improve language accessibility and father inclusiveness by August 31 2020

3. Recruitment and Training of Peer Educators

● 6-10 people with lived-experience recruited and trained as peer educators. Refine current role description
● The PPP class videoed and used during training
● Delivery of the training program:
○ 4 x 4.5hr face-to-face sessions
○ Recruits mentored & supervised to co-facilitate two PPP classes
● Completed by Mar 31 2021

4. Staff Training
● All relevant executive, management and front-line staff trained in:
○ Overview of the project, its impact and benefits to service
○ Value of peer educators
○ Research underpinning model for supporting new fathers
○ How they can support this project
○ Referral pathways
● Completed by Sept 30 2020

5. Delivery of PPP
● New recruits independently co-facilitate PPP class across 3 sites
● DGI representative attends the PPP class via a zoom providing a father focus and information on newly established Dads Groups in Metro North.
● Apr-June 2021

6. Establishment and Delivery of new Dads Groups.
● Run DGI events and information sessions to engage new fathers
● Determine five sites across Metro North to establish Dads' Groups
● Potential Dads Group leaders are identified and training provided.
● Support the local leaders to establish the group with marketing and promotion
● Groups established by Mar 2021.

7. Sustainability
● maximise potential for sustainability by:
○ strong relationship development with decision makers throughout project
○ grow partnerships with local leaders, council, business and community organisations throughout project

8. Evaluation
● Survey development and completion
● Focus groups
● Data analysis
● Dissemination of findings
● Ongoing throughout project

Must be no more than 300 words.
Activities planned for and 'in scope' for the project should be: Specific, Measurable, Achievable, Realistic, and completed within a specific Timeframe. (For example, you may be proposing to run a series of ten week programs in North Lakes, providing tailored exercise plans and health and nutrition education. Patients are identified as having diabetes and chronic kidney disease as well as other health comorbidities. The model is building on the positive outcomes from a similar clinic run elswhere in Brisbane).

2. Exclusions: What is 'out of scope' for the project? *

1. Other sites: Only Redcliffe, RBWH and Caboolture maternity services will be supported to implement the PPP. Requests from other sites or services to participate will not be supported.

2. Other midwives: Midwives not involved with antenatal education at one of the 3 sites will not be supported to participate in any direct PPP training. Education of other midwives will occur through regular scheduled inservices across MNHHS that currently occur.

3. Development of additional Dads Groups: groups located beyond the MNHHS geographical boundaries will not be supported within the scope of the project.

4. Expansion of RBWH antenatal class schedule: Currently the RBWH dedicates only 35-40 minutes to emotional preparation for parenthood content in their antenatal classes. It is beyond the scope of this project to ensure the inclusion of the full 2 hour PPP class in the RBWH antenatal class schedule, however the RBWH may choose to do so.

Must be no more than 200 words.

Out of scope are activities beyond the agreed project plan. They may be activities that will impact on the project at some stage (consider recording as project Risks). They typically suggest changes that will impact directly on the approved project charter/plan, the type and extent of work, the cost, the time schedule or the deliverables.

3. What are the project's dependencies? *

● Establish Peer Educator Mentor Role
○ Defining the scope and responsibilities of the role.
○ Supporting the capacity of the identified candidate to participate in the program.
● Recruitment and Training of Peer Educators
○ Defining the scope and responsibilities of the role.
○ Developing the training program content.
○ Identifying recruitment pathways and process
○ Design effective interview process
● Antenatal Educator Training
○ Relationship development focussed on familiarisation with project aims.
○ Developing the training program content.
○ Scheduling appropriate timing to deliver training enabling staff to access
● Adapting EPP content through consultation with peer and fatherhood experts
○ Familiarisation of existing content for DG leader.
○ Coordinating appropriate working schedule.
● Delivery of PPP across 3 sites
○ Adaptation of EPP content.
○ Training of peer educators, midwives and staff.
○ Coordination with ante-natal education coordinator at each site.
● Establishing and Delivery of Dads Groups
○ Training of MNHHS staff around Dads Group programs.
○ Promotion of Dads Group.
○ Recruitment and communication with potential participants.
○ Locating appropriate venues for groups.
● Pursue sustainability of Dads Groups
○ Setting meeting with local councils
○ Draw on Dads Groups existing funding relationships and program materials

● Evaluation
○ Developing all relevant survey tools and focus group questions
○ Completing a HREA and obtaining ethical approval
○ Distribution of surveys and undertaking of focus groups
○ Data analysis
○ Completing a report & disseminating findings

Must be no more than 300 words.
Dependencies are any project tasks, events or situations that are either dependent on the previous completion of a task or on which a task is dependent on. It is the relationship between two separate activities within one larger project. (For example, task dependencies for the implementation of an on-line training program for staff, would be the prior planning, development, and user testing of the new program).

Implementation

4. Please outline how this project will address the needs of, and provide benefits to MNHHS clients and other stakeholders? *
Staff learning or growth:

Peer educators sharing experiences creates space for health professionals to reflect on their own experiences. Midwives who have participated in the current EPP at Redcliffe have reported an improved ability to connect, understand and communicate with expecting and new parents about emotional wellbeing as a result.

Improved client experience:

The Clinical Practice Guidelines Pregnancy Care (Department of Health, 2018) recommendation is that if psychological preparation for parenthood is included as part of antenatal education, positive effects on women and partners' mental health postnatally will occur.

As recommended in the PMHW project, people with lived experience of perinatal mental illness and recovery can provide a valuable contribution to the work of mental health promotion, prevention and early intervention in the perinatal period, through co-facilitating universal psychoeducation such as the EPP program (PMHW Project, 2017). Peer Educators sharing their own stories of recovery, gives voice to what experiences mean for an individual, rather than the clinical analysis based on measurable factors alone.

Collaborating with fatherhood experts to adapt existing EPP to be more language accessible, fathers are expected to feel more included and empowered to participate in the perinatal journey, influencing child development, family cohesion and the gendered drivers of violence against women. Simple support strategies will enhance their overall experience.

New Evidence of Improvements in areas not previously measured:

The following improvements will be determined through completion of surveys undertaken during the project:

● Improved social connections and engagement for fathers
● Improved fatherhood confidence
● Improved mental health literacy for expectant parents
● Improved confidence in help seeking for expecting and new parents.
● Improved mental health literacy of other MNHHS midwives working in role of childbirth and parenting educators.
● Role satisfaction and confidence of peer educators
● Improved father inclusivity within MNHHS maternity services

Must be no more than 300 words.

Be specific. How will the project change and improve current services or care? What will be the benefits for internal processes, staff learning and growth, improved stakeholder experience and operational efficiency? Benefits might directly relate to current KPI's or provide new evidence of improvements in areas not previously measured or monitored effectively.

5. How do you plan to scale your innovation idea? *
Peer support groups are successful across other sectors and this initiative could be adapted for other health specialities.

The peer educator role has the potential to be utilised in a variety of contexts. It is a timely initiative in regards to best practice peer-to-peer support which positions this project to be scalable across different teams and services both within MNHHS and other HHSs. The videoing of a PPP class including role plays for training purposes for this initiative could then be utilised for training purposes across other HHSs.

The PPP implemented for this initiative could be implemented at other HHS and similar both within Queensland and Australia wide. The expert perinatal Peer Educator could act as consultants to enable this.

Dads Group Inc will be seeking to replicate successful program outcomes with Maternity Services in other hospitals using a similar funding approach. The operational efficiencies and learnings of this project would shape the design and scaling of these future programs.
Must be no more than 250 words.
If you scale an idea you make it greater in size, amount, or extent than it used to be. For MNHHS this could mean expanding your successful initiative to other teams, streams, specialties, work sites, health services etc.

6. Implementation challenges: Describe the challenges associated with implementing your idea successfuly. *
1. Relationship between midwives/health professionals and peer educators:

● Managing perceived or real hierarchy in the workplace.

● Communication and behaviour expectations will be highlighted, including respective roles and responsibilities, using the MNHHS Capability Framework.

● Rapport building activities will be included during training.

● Combined supervision sessions will be facilitated by the project officer and peer mentor throughout the entirety of the project.

● Clear governance structure will be demonstrated.

2. ‘Buy in’ from RBWH and Caboolture staff at all levels:

● Change management principles will be utilised to ensure buy in from RBWH and Caboolture staff; using ‘Resistance to Change’ analysis tool and ‘Communicating for Change’ tools as resources.

● Focus on developing a genuine culture of collaboration.

● Ensure our team effectively receives and appropriately responds to feedback.

3. Recruiting suitable peer educator candidates:

● By using PANDA’s existing Champions program, the recruits have already self-identified as being willing and able to share their story.

● Recruitment will be supported by the existing highly experienced peer educator, who deeply understands the requirements of the role, to identify suitable candidates.

● Regular peer supervision will be mandatory for peers participating in the project, with a clear pathway to clinical support described.

4. Multiple sites:

● Recognising that each site will be using different processes, therefore flexibility and project adaptation will be necessary.

● Difficulty in identifying champions at each site to support implementation.

5. Effective collaboration between multiple contributing entities:

● Strong relationships already exist between the Qld Health applicant, the existing perinatal peer educator and DGI.

● Clear guidelines created outlining the roles and responsibilities of each contributor

● Developing a clear communication strategy for project progression: weekly update ZOOM meetings.

● Comprehensive monthly meetings scheduled for a full review of all aspects of the project.

Must be no more than 300 words.
Provide specific examples and be realistic. Typically project implementation challenges may involve any or all of the following: maintaining team focus and engagement; ensuring well defined/understood project goals and objectives; managing milestones and deadlines; finding and using the right project management/governance tools; managing scope creep; managing miscommunication and differing agendas, managing risk; ensuring appropriate team skills available; dealing with opposition or adversity to change.

7. Related Projects

We are not aware of any other activities or similar projects occurring across MNHHS that may impact on this project's implementation.

Must be no more than 200 words.
List any other activities you are aware of that are occuring across MNHHS and that are similar to, or may impact on, this project's implementation.

Implementation context

*** indicates a required field**

Implementation Risk

9. What are the key project risks? *

1. Resourcing:

● Recruiting enough suitable peer educators

● Recruiting enough suitable Dads Group Leaders

2. Budget

● Unforeseen costs not identified within the proposed budget

3. Technology

● Failure of the ZOOM platform when including a DGI representative at the PPP class

4. Staff resistance to change

● Perception of increased workload required of midwives

● Midwives, management and executive having to understand the importance of father inclusivity and engagement which has not historically been part of their core business or service provision

● Possible mind set change required to effectively work with peers in a hospital maternity setting

5. Systems

● RBWH and Caboolture will need to develop a remuneration process for the peer educators if the program is to continue beyond June 2021.

6. Multiple sites:

● Project officer and peer mentor ability to adapt to each site's particular processes and requirements

7. Post project sustainability

● Reliant on each site's willingness to fund peer educators and a peer mentor beyond the project.

● Reliant on each site being willing to train midwives and peer educators in an ongoing way.

● Reliant on community support to sustain the operation of the Dads Groups.

8. Recruitment of Dads Groups participants

● Father's / men have historically been difficult to engage in health programs. While Dads Group Inc has a proven model of engagement this project will test the model in a new context (hospitals) and therefore involve a level of risk.

Must be no more than 300 words.
Give brief examples. Risks can include or be associated with: Budget; Resourcing; Stakeholders; Technology, Systems; Access; Location; Change; Operational silos; Communications; Policies, Political; Organisational; Project complexity; Competing priorities; as well as those as yet unknown risks.

10. What are the risks associated with not proceeding with this project? *
Perinatal depression is costing the Australian economy at least $354 million each year, with most of these costs attributable to productivity losses. The direct cost to the health sector alone stands at $79 million with the health sector cost the highest cost category across all payer and in total was hospital services. (Deloittes, 2012).

Stigma, lack of familiarity, poor partner support and significant health service barriers are leading contributors to the low levels of help seeking among Australian parents at risk of or experiencing perinatal mental health challenges (Werner et al 2015; Schmied et al 2016).

Currently, the health system carries the majority of the burden for detection and intervention for perinatal mental health problems for women. No screening of partners currently occurs within the hospital setting. Without significant change to the current model, families will continue to show low levels of help seeking, leading to health system support often only occurring once a crisis point has been reached. Incidents of suicide amongst men are already at a crisis point with the national rate twice the national road toll (ABS 2017).

Lack of engagement of fathers and high levels of psychological distress experienced by fathers have been shown to have significant and negative impacts on child development, family cohesion, family violence and wellbeing of mothers (Lamb & Tamis-leMonda, 2004. White Ribbon Aus 2019.) Conversely positive father-child relationships have been directly linked to child pro-social behaviour, while supportive social relationships, family harmony and connection to mental health services are all recognised as key protective factors against suicide (Ferreira et al 2016; Black Dog Institute 2018).

Dads Groups represent best practice primary prevention of violence in accord with the 'Shared Framework' (OurWatch 2015) which calls for programs that address rigid gender roles and promote male peer relations that emphasise respect for women.

Must be no more than 300 words.
What might deteriorate or suffer in terms of community health outcomes if nothing is done to address the issue you have identified, in the short, medium, or long term?

Implementation Details

N.B. Only complete Start and End dates if they are planned to be different to the standard commencement date of 1st July and completion date of 30th June. Requests for a lesser timeframe will need to be considered by the LINK/SEED Assessment panel.

Start Date

By default all LINK and SEED Projects will commence on the 1st July of the funding round year. Only complete if a different start date is proposed.

End Date

By default all LINK and SEED Projects will conclude on the 30th June of the funding round year. Only complete if a different end date is proposed.

11. Key Stakeholders: List all key stakeholders, or stakeholder groups, relevant to progressing the project and who have indicated their readiness to participate in a project that will include business change. *

Director of Nursing, Redcliffe

Director of Nursing & Midwifery, RBWH

Director of Nursing & Midwifery, Caboolture

Business Manager of MNHHS

Dads group Inc. - Founder

Perinatal Peer Educator Expert

Metro North Perinatal Mental Health Team Leader

Assistant Director of Social Work, Redcliffe

PANDA (Perinatal Anxiety and Depression Australia) - Community and Training Programs Coordinator

Childbirth and Parenting Educator midwives

Others consulted in preparation of this application include:

Business Manager for Women's and Newborn Services - RBWH

Director of Nursing, Navigation & Innovation Strategy

Please also identify any others who have been consulted in the preparation of this application.

Does this project require ethics approval? *

◉ Yes ○ No

If YES or unsure, please liaise with your local Human Research Ethics Committee (HREC) to determine ethics applicability. Ethics are moral principles that govern a person's behaviour or the conducting of an activity. Research governance, including the ethical review of research, refers to the processes to ensure that research in Metro North Hospital and Health Service is conducted according to the appropriate regulatory, ethical and scientific standards.

Partnership Tool

*** indicates a required field**

Planning Tool

LINK applicants please complete the Partnership Planning Tool and specific questions.

Additionally, you could use these resources to guide you in the development of your partnership.

- The Collective Impact assessment tools and resources provide greater in-depth analysis and discussion of partnering which may be helpful for longer-term and sustained collaborative work
- The Vic Health Partnership analysis and checklist can help you assess your readiness to work together.

1. Goal and Purpose. What are the agreed common goal/s and purpose of this project partnership? *

People with lived experience sharing their story in a work setting with no perceived power imbalance, reduces stigma and also supports understanding of mental health issues for the health professionals. This leads to improved communication, identification of issues, and effective interventions offered by these health professionals within other settings. (PMHW Project, 2017).

Implementing this program through training and mentoring other peer educators to work within MNHHS, supports positive organisational culture and safety by improving mental health literacy amongst health professionals, therefore more empathy for patients as well as co-workers, whilst committing to providing high-value care.

The three formal partners of this initiative share the following common objectives of the partnership:

● to improve mental health literacy of parents and staff
● to improve father inclusivity
● to improve social connections for fathers
● to train peer educators to co-facilitate the PPP
● to improve the wellbeing of fathers so they can better support their partners and children
● to improve language accessibility for expectant parents
● to work together in partnership to improve the wellbeing of families who access maternity services in MNHHS
● to engage with consumers to design and implement a new program to improve health service delivery within maternity services
● to demonstrate successful collaboration between tertiary health services, peer educators and community organisations

Must be no more than 250 words.
What is your shared understanding of the objectives of the partnership? What common approaches and interests do the partners share? Define the outcomes you want to achieve together, centred on patients/consumers, communities, carers and families? How will the partnership add value for the community and consumers?

2. Partnering. Describe how your project alliance/s will work. What will each partner contribute in terms of shared resources, i.e. time, personnel, IP, material or facilities? *

There are significant opportunities for mutual learning and exponential impact through the partnership between MNHHS, the Perinatal Peer educator and Dads Group Inc. All teams bring to the project complementary expertise and the staff involved have expressed a dedication to expanding their knowledge base in order to enhance the experience of new and expecting fathers engaging with ante and perinatal services. Staff will maintain open lines of communication through both zoom calls and face-to-face meetings throughout

the project duration and will utilised shared planning tools to ensure effective co-implementation.

Both external parties bring to the project, experience and resources around peer-to-peer facilitation of health promotion programs including content developed during prior project implementation. Staff will work closely to adapt this content to the antenatal PPP context.

Any new content developed within this project remains the property of Queensland Health and the partnering bodies, co-jointly. If any external body requests access to the content after the completion of the project appropriate processes via MNHHS would be followed. Any intellectual property created prior to the beginning of the project will remain the property of its creator beyond the project. The results of the project will be shared in a final project report, at appropriate conferences and forums and if appropriate published in relevant journals.

Must be no more than 250 words.
Describe how partners plan to share ideas, influence and power to achieve the goal? How will you share ownership and recognition of the outcomes? What opportunities will there be for staff to cross traditional boundaries between agencies (reaching out and reaching in)?

3. Organisational support. Is there management support, recognition and reward for partnership and reciprocity? *

The MNHHS would build on the PMHW Project partnership experience and lead the way in partnering with an external consumer led organisation and embedding perinatal peer educators as standard practice. Whilst consumer and carer representatives are widely used across the health system, including the increasing role of Health Consumers Qld in service improvement, the role of peer workers is undergoing necessary further development. (Peer Workforce Development Framework, 2019)

Peer support workers are used within hospital mental health settings, however there is no history of peers using their lived experience to deliver preventative and early intervention strategies directly for clients beyond the existing perinatal peer educator at Redcliffe.

Within maternity services, postnatal support for mothers has been recognised as very important, resulting in a variety of government funded and community services, including child health. Postnatal support for fathers however, has historically been overlooked. The proposed model would be the first of its kind, linking hospital, peer and community services across the perinatal journey with a focus on fathers.

For Dads Group the partnership represents an important opportunity to engage more fathers and working with MNHHS would add significant prestige and further validate Dads Group’s efforts in health promotion.

Must be no more than 200 words.
What is the history of relations between partners? How might the partnership add prestige to partners individually as well as collectively?

4. Planning and decision making. How will project partners demonstrate their equal involvement in planning and setting priorities for project activities? *

In terms of the decision-making hierarchy, while the project will be highly participatory, there will be a clear hierarchy to ensure clarity and progress with decision making. The identified MNHHS Project Executive sponsor will hold the governance for the project and the MNHHS Project Officer will take the leading role in the oversight of project implementation.

The following key project team activities with compulsory attendance (remote or face-to-face) will ensure equal involvement and priority setting: Workshops, Planning sessions, Specific learning sessions, co-developing/collaboration sessions.

Partners will utilise shared budgets, project timelines (attached) and scheduled meetings outlined under Question 5.

The primary issues requiring consideration and expertise to ensure this project is effectively implemented include:

- understanding of the lived experience of mental health challenges.

- understanding of the existing structures, content and processes around perinatal services in the hospital context.

- understanding of new and expecting father behaviour and effective engagement of men within health promotion programs.

- effective implementation of multi-dimensional, partnership based projects.

MNHHS and Dads Group Inc are appropriately placed to ensure a comprehensive understanding of and expertise in the above issues given the experience and proven success of:

- The EPP program at Redcliffe with Peer Educators who has lived experience of mental health challenges.

- Over 70 active Dads Groups around Australia successfully engage new and expecting fathers in peer-to-peer health promotion programs.

- Both MNHHS and Dads Group's staff with a history of effectively managing partnership based project implementation across a variety of settings.

Must be no more than 250 words.
What diversity and variety of perspectives and disciplines are available across partners to ensure a comprehensive understanding of issues? What mechanisms are planned, or in place, to ensure participatory decision-making?

5. Capability. What skills and commitment are partners bringing to the project that are necessary for successful project delivery *

The project team includes:

1. a midwife, highly experienced in childbirth education and a long term keen interest in perinatal mental health promotion and support for families.

2. a perinatal peer educator with:

○ 8 years of experience in consumer and carer representation at national, state and local levels,

○ 10 years of experience in peer support work

○ 7 years of experience in perinatal peer education

○ 9 years of experience working across government and community sectors

3. DGI Executive engagement:

○ 5 years NGO Chief Executive

■ Experience in new father peer education and support groups

■ Community Development

■ Media and Campaign Execution

○ 15 years in Commercial and Business Strategy

■ Government Relations

■ Commercial Partnerships

■ Sponsorships

■ General Management

■ Tech Design and Program Implementation

■ Stakeholder Engagement

The project officer will be responsible for maintaining regular and clear communication with the relevant staff of each site involved including:

● Weekly ZOOM meetings to:
○ update each partner on progress
○ ensure timelines are on track
○ manage issues as they arise
● Comprehensive monthly meetings to achieve as above and also:
○ confirm responsibilities of each partner for the following month
○ strategise alternative approaches to achieve project goals if necessary

The DGI representative will be responsible for ensuring the active participation of DGI staff in project decision making, as well as the necessary logistics and liaison with parties regarding the establishment of Dads Groups.
Must be no more than 250 words.
What capacity and potential do the partners have to achieve the objectives? What understanding has been reached regarding roles, responsibilities and expectations? What responsibility will partners be taking for communicating within their own organisations and networks?

6. Enabling systems. Are administrative, communication and decison-making systems simple, functional and as clear as possible *
The lead (or backbone) organisation will be MNHHS with an identified MNHHS project executive sponsor along with the MNHHS project officer, with the project executive sponsor holding governance.

MOU's will be established between each of the partnering organisations and MNHHS. These will clearly articulate:

● the roles and responsibilities, accountability of partner organisations
● the reporting lines for every staff member involved in the initiative must be clearly articulated and communicated, with
○ contact points for communication
○ use of multimedia aspects for these points of contact

The Project officer will hold responsibility for:

● development of a project plan articulating all aspects of proposal
● obtaining ethical approval to undertake project
● undertaking evaluation of all aspects of the project initiatives
● weekly zoom meetings with partnering organisations
● comprehensive monthly project meetings
● measuring KPI, research components and provide routine reports

In terms of the protocols, standards, forms and mechanisms for engaging fathers in the hospital context and providing pathways to ongoing engagement with fathers in Dads Groups, it will be necessary to co-develop these project elements in partnership during the project to ensure they are relevant and effective.
Must be no more than 200 words.
What are the lines of communication? What are the common processes in place across agencies for referral protocols, service standards, consent forms, data collection, and reporting mechanisms? Who will have the role as the 'backbone' organisation? How are you managing project governance?

Certification and Feedback

*** indicates a required field**

Expression of Interest - 2019 LINK and SEED Innovation Fund
LINK and SEED Application Form (Final)
Application LNKSEE00732019 From Mrs Helen Funk
Form Submitted 28 Nov 2019, 1:11pm AEST

Certification

I certify that to the best of my knowledge the statements made within this application are true and correct.

I understand that if the complete proposal is approved for funding, we will be required to accept the terms and conditions outlined in a Contract document (LINK) or Letter of Approval (SEED).

I, the applicant, agree *
◉ Yes ○ No

Applicant Feedback

Before you review your second stage application and click the **SUBMIT** button, please take a few moments to provide some feedback.

Please indicate how you found the second stage application process: *
○ Very easy ○ Easy ◉ Neutral ○ Difficult ○ Very difficult

How long did it take you to complete this second stage of the application?
several days

Please provide us with any suggestions about improvements and/or additions to the overall LINK/SEED process.
Clearer communication at initial information session or early emails outlining the differences with completing this 2nd submission compared with the initial EOI submission would be beneficial. It was realised late that this 2nd submission was more extensive particularly with the additional link funding questions & so the increased time taken to complete this wasn't initially factored in. However its now completed thankfully with the assistance of the partnering organisations!!

Thank you again for your interest in the LINK/SEED Innovation funding program.

Dads
Group

For more information or questions about this submission please contact:

Thomas Docking
CEO Dads Group
0424 907 249
tom@dadsgroup.org
dadsgroup.org.au