Non-accidental injury of infants by fathers, father-figures and other informal male caregivers: a rapid review of evidence

Commissioned by the National Child Safeguarding Practice Review Panel
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Section 1. Introduction

This review was commissioned by the National Child Safeguarding Practice Review Panel (the Panel), which is responsible for commissioning, supervising and publishing National Child Safeguarding Practice Reviews into cases, or themes, which it considers are complex or of national importance and will lead to national learning.

Non-accidental injury (NAI) in children under one year old is one of the largest groups of cases notified to the Panel (NCSPRP, 2019) and we were asked to conduct a rapid review of the research literature on NAI by fathers and other male caregivers in children aged under one to inform a Review of such cases. Our review was limited to this area, and did not look at other areas such as child sexual abuse or physical neglect.

We conducted two separate but complementary reviews: one looking at the prevalence of, and risk factors for, NAI by fathers and other male caregivers (see Chapter 2) and a second focused on how safeguarding services prevent and respond to non-accidental injury of infants by fathers and other male caregivers – and how their work could be improved (see Chapter 3).

Section 2. Method

This literature review is a rapid systematic review. It has used transparent methods, to integrate the findings of a systematically collected body of diverse quantitative and qualitative research evidence, but is not a full systematic review. Rapid reviews of research evidence have been referred to as part of the family of systematic-type research reviews (Moher et al, 2015). We use new systematic searches of bibliographic databases and the Fatherhood Institute's comprehensive Literature Library (funded by the Nuffield Foundation – Davies et al, 2017) to ensure that this literature review goes beyond widely known studies. Our inclusion criteria and proposed methods were stated in a review protocol prior to starting the review work.

Inclusion criteria for the research review
We set these inclusion criteria for the research review:

- Fathers and other men with a parenting or informal caring role, or closely connected to parental households, including birth, adoptive and foster fathers, stepfathers/mothers' current/former cohabiting/ non-cohabiting/ short-term partners/ boyfriends, foster fathers, grandfathers, older brothers, other male family members (eg uncles, cousins), other male household members (eg lodgers/ flatmates/au-pairs), other 'father figures', and informal male caregivers outside the family/ household - excluding paid childcarers eg childminders and nannies

- Infants aged under one year, or children under two years where we find no evidence on a topic for infants under one – our searches were for literature on children under two years
- 'Non-accidental injury' (NAI) includes deaths (deliberate or consequential killing) and all types of physical abuse (all levels of severity). We excluded emotional abuse, sexual abuse and neglect unless they co-occurred with physical abuse, and we excluded fabricated illness/ Munchausen's Syndrome.
- Safeguarding services: Local authority children's safeguarding services; and any service engaging with family members (children, mothers, fathers, other family members) with the potential to assess or screen for risk and/or implement preventative practices/ early interventions. These include universal (Tier 1) and Tier 2, 3 and 4 services:- antenatal/ postnatal/ health visiting; family and parenting support services; children's centres; early years and childcare services; hospital A&E, GPs and hospital paediatric services; couple relationship support/ parental separation services/ domestic violence services; police and probation services; substance misuse; adult mental health; criminal justice and youth offending services.
- Any working practices and interventions by and for services - organisational factors, management/ supervision, working practices of teams/ practitioners, protocols/ ways of working; screening/ detection (tools/ assessments); multi-agency responses (eg children's and adults services; health and social care services); approaches and discrete interventions in engaging with fathers/ male caregivers, mothers and other family members; and training and support for practitioners/ managers. Including successful and unsuccessful approaches and interventions - those which support effective engagement and those which hinder it
- Empirical research (any quantitative/ qualitative design/ statistics with an explicit research method) including systematic-type research reviews and meta-analysis
    - excluding reviews of legal cases
    - excluding qualitative research, case histories, case series and social science case study research with fewer than 5 individual cases.
- Published in or after 2010
- Published or written in the English language
- All publication types (peer-reviewed journal articles, books – where we could obtain them within our budget - and 'grey literature' such as web-published research reports) and unpublished or interim findings with author-permission.
- UK and international research evidence from European countries, the US, Canada, Australia and New Zealand, whose cultural contexts and systems are most comparable to the UK

Searches

Our new searches of ten bibliographic databases identified UK and international literature in which our topic of interest was sufficiently a focus (in the research aims or findings) for the title or abstract of the publication to include a 'father/ informal male caregiver'-related term and an 'infant'-related term and a 'physical abuse /filicide'-related term (our three 'search concepts'). We also identified relevant studies in a broader literature about child abuse and fathers in the Fatherhood Institute's comprehensive electronic library, which is based on systematic searches (up to 2019) for research about UK fathers, 'father-figures' and grandfathers.

New searches of bibliographic databases
We searched the following electronic bibliographic (library) databases:

Applied Social Sciences Index & Abstracts (ASSIA), British Nursing Index, Cumulative Index to Nursing & Allied Health Literature (CINAHL), National Criminal Justice Reference Service Abstracts (NCJRSA), Social Policy and Practice (includes Social Care Online/ NSPCC Library/ ChildData), Health Management Information Consortium (HMIC), Criminal Justice Abstracts, Social Services Abstracts, APA PsycInfo, Medline, the Campbell Collaboration Library.

These UK-focused and international databases cover a number of academic and professional disciplines (including criminology, social work, social policy, health, medicine and psychology) for peer-reviewed evidence and 'grey literature' on this cross-cutting topic (Clapton,2010; Cooper et al, 2012; McElhinney et al, 2016).

With input from a professional librarian, a sensitive search strategy (see Appendix 1A) was formulated using a combination of free-text keywords and phrases for each of our three 'search concepts' (non-accidental injury/filicide/physical abuse; infants/ children under 2 years; fathers/ informal male caregivers) in Title, Abstract and Keyword fields (taking into account differences in UK and US English and discipline/profession-specific terms), and highly relevant subject headings (database thesaurus terms). Search terms were generated from the researchers' knowledge of synonyms for the three search concepts; existing literature (found in the Fatherhood Institute's electronic library; and through scoping searches in Google) and key policy and practice documents.

Search terms and subject headings were initially tested in APA PsycINFO, CINAHL and SOCIndex. Broad subject headings such as 'Child abuse' and 'Homicide' were tested and omitted to improve precision. Results were limited by publication date from and including 2004 to August 2020, and additional limits to English language and Human populations were applied in databases where these were indexed accurately. We translated the search into each database and equivalent subject headings were applied in each where available.

An additional systematic database search aimed to capture research reviews of quantitative research relating to risk factors for child abuse using free text keywords and phrases in 'all fields' (excluding full texts) in the sociology and social work database SOCIndex. Three further search concepts were devised and tested for 'safeguarding', 'risk factors' and 'research reviews'. These concepts were combined with the other three search concepts (see Appendix 1B). Results were limited by publication date from and including 2004 to August 2020.

All 1439 results from the main systematic database searches were imported to an EndNote library and de-duplicated using a multi-step process developed by Bramer (as cited in Karolinska Institutet University Library, 2017); resulting in 845 unique results. The additional database search for research reviews returned 78 results. These two sets were combined and de-duplicated again, resulting in 901 unique results.

Search of the Fatherhood Institute's extensive electronic library
We conducted a hand-search (in Endnote software) of The Fatherhood Institute's extensive Nuffield Foundation-funded electronic library of keyworded references for UK research and international research reviews relating to fathers, mothers' male partners, grandfathers and fatherhood (dates 1998 to-2019) (see Appendix 1C) to locate literature relating to safeguarding. All the references already keyworded in the library as 'maltreatment' or 'father violence' (on the basis of full text screening) were hand searched. Searches were also carried out using the Endnote search engine to locate studies including any safeguarding terms in their title, abstract or keywords. This ensured that our review of UK research is as comprehensive as possible by finding:

- studies from the additional bibliographic social science databases that were searched for the FI's electronic library in 2014 and 2019
- broader studies of fathers or grandfathers and safeguarding which include relevant content in their full texts, but do not refer specifically to non-accidental injury and infants in their title and abstract (because that is not their key focus), so would not be identified through our new systematic searches.

204 results were identified. These 204 references taken from the FI's library were de-duplicated with the 901 unique results from the new systematic searches to give 512 unique references overall.

Supplementary search methods
We supplemented the above bibliographic searches by identifying grey literature and interim findings through web-searches. During the full text screening phase for the risk factor and safeguarding services reviews, we obtained additional full texts for references in research reviews whose title or abstract included at least two of our three search concepts. Because of the clear lack of focus on fathers in research and practice, and the consequent paucity of evidence identified through the bibliographic searches, we also – in addition to obtaining full texts for references in reviews (as above) – conducted additional professional searches for the safeguarding services review, aimed at mapping relevant interventions (including those with a relatively loose or marginal focus on maltreatment and/or fathers/ mothers' partners), current practice and possible new approaches.

Screening of titles and abstracts
The 512 initial references were screened systematically on title and abstract using our inclusion criteria, which we operationalised into a screening criteria document. We coded the reason for exclusion. Before we began mainstage screening, three reviewers independently screened subsets of references, resolving any discrepancies in screening codes through discussion. This achieved consistency in applying the criteria.

For all references which met our inclusion criteria on the basis of title and abstract, for those references where it was unclear from title and abstract whether or not the study should be included in the review, and for the additional studies we found through our supplementary search methods, we obtained full texts and re-screened these against the same inclusion criteria.

In total, 157 full text references (including 45 research reviews) were screened for the risk factors review (Chapter 2), and 352 for the safeguarding services review (Chapter 3).

Data extraction and synthesis
Informed by issues arising in the Child Safeguarding Practice Review Panel's Review of NAI, we created an analytic framework of themes and issues for each research question, including key sub-categories of interest. Sub-categories included the parental/ family status and other characteristics of perpetrators; the severity and type of NAI (eg homicide; other deaths; severe harm not leading to death; abusive head trauma; lower level physical abuse); type/s of services/ settings/ professional group/s; and types of professional practice and intervention.

We extracted relevant data from the full text papers directly into our analytic framework. We developed the analytic framework iteratively whilst we went through the full texts of papers, and the framework became the basis for our synthesis and report. We created a spreadsheet of the key characteristics and methodological details of included studies so that we could take these into account in our synthesis as described below.

Our thematic synthesis involved describing and interpreting common and contradictory messages across studies, taking into account study differences, quality and relevance to the UK. The research review literature calls this 'narrative synthesis' (Popay et al, 2006) and a 'thematic summary' (Gough, Oliver and Thomas, 2017).

Incorporating study differences, quality and relevance within our narrative
We have considered factors such as when and where studies were conducted; how the study was conducted; study design in relation to the research question (for example use of comparison groups); and study populations and contexts. Consistent with this being a rapid literature review, we have not produced formal quality assessments for individual studies.

References for Introduction and Method

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Chapter 2. Risk Factors Review

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Section 1. Introduction

This chapter reports the **key findings** of our rapid systematic review of evidence from research studies on **risk factors** for non-accidental injury (NAI) of infants (aged under one year) by fathers and other men with a parental or informal caring role ('informal male caregivers'). Details of the findings of individual studies which underlie our conclusions are in Appendix 2.

We address the following research questions:

In relation to **non-accidental injury (NAI) of infants (aged under one year) perpetrated by fathers and other men** with a parental or informal caring role, what do we know from research (published 2010 onwards) about:

- the motivations, psychology, behaviours and life histories of fathers and other informal male caregivers who seriously harm or kill infants for whom they have a parental or caring role, including what leads men to harm?
- the characteristics, social relationships and behaviours of male perpetrators, mothers and families which are **statistically associated** with past or future NAI by fathers and other male caregivers?

We endeavoured through our systematic searches to find evidence that addresses the Panel's key 'risk factor' questions for their Review into non-accidental injury in children under one:

- Is there any discernible difference between **one-off events and sustained abuse**?
- There appears to be a relationship between **domestic abuse and coercive control** and abuse of children. What is the supporting evidence for that and what can be learnt about the possible linkages?
- What can we say about any link between **childhood experiences** and future abusive behaviour?
- Is **poor impulse control** the root of such abuse and if so is that in any way predictable or knowable prior to any abuse occurring?

Our research review is limited to physical abuse, so we exclude findings based on a sample in which more than 15% of the cases are classified as primarily neglect or another type of abuse. We include literature published in 2010 or later, and exclude studies based **solely** on cases occurring before 2000. We limit evidence to European countries, the US, Canada, Australia and New Zealand. We include studies predominantly of infants or of children under 2 years where we found no equivalent data for cases restricted to infants. We include only studies of perpetrators (convicted or suspected); and so exclude findings relating to 'child

abuse potential' and 'child abuse risk' in general populations or socially disadvantaged population groups (eg Rodriguez et al, 2018; Lepistö et al, 2017; Liel et al, 2019). For some sections of our Risk Factors Review, we further limit studies, as detailed in footnotes in Appendix 2.

We found 21 prevalence and 'risk factor' studies (through our systematic searches and supplementary search methods) that meet our inclusion criteria. These are largely quantitative analyses published in the academic criminology, psychology and sociology literatures. Almost all of the relevant evidence is quantitative, mainly based on administrative data (databases and case records), with the remainder deriving from cross-sectional survey data (2 studies) and reviews of published research studies, case series or serious case reviews (3 studies). We found just one study using qualitative interviews with fathers who had perpetrated physical abuse to infants and other young children to provide in-depth psychological profiles. Although the findings were all published in 2010 or later, around a third of the studies analysed samples of cases or convictions stretching back to before 2000 (four studies with cases before 1990). Five studies were of UK cases, and seven studies were of cases in the USA; with the remaining studies analysing cases in Canada, Australia, New Zealand, France, Austria/ Finland, the Netherlands or a multi-country sample.

Our inclusion criteria include physical abuse of infants by non-parental informal male caregivers, such as grandfathers, older brothers, other male relatives, male household members including lodgers, male 'family friends' and male informal babysitters. However, the evidence we found is restricted to fathers (including stepfathers and parents' male partners – see below) as perpetrators. Where non-parental informal caregivers were mentioned as perpetrators in study publications, they were female or, more frequently, the gender was not specified.

Terms

We use the term **infant** to refer to babies aged under one year, to match the Panel's Review of non-accidental injury in children under one. The terms 'infant', 'infancy' and 'baby' are used in some policy, practice and research contexts to refer to children up to two years, although the terms 'infant mortality' and 'infanticide' are generally used in published literature to refer to the child's first year of life.

We use the term **father** broadly to refer to biological and adoptive fathers, foster fathers and stepfathers (parents' cohabiting and non-cohabiting male partners including 'boyfriends'). Similarly, the term 'mother' refers to biological and adoptive mothers, foster mothers and an inclusive definition of stepmothers.

We use quotation marks around the term **stepfather** when reporting findings from individual studies**.** There is often no clear definition of '**stepfather'** in research papers and/or the administrative data analysed. The 'stepfather' category may be restricted to *male cohabiting partners **married to** biological parents* (common in the US context); to *all male cohabiting partners of biological parents* (whether or not married to that parent); or may also include *biological parents' non-cohabiting and short-term/ 'casual' male partners* ('boyfriends'). Some of these men may not have been a 'parental' figure to the child killed,and may have had a minimal relationship with that child (Nobes et al, 2019).

We use the term **physical abuse** as defined in the NICE guideline on child abuse and neglect (2017)[1] (but excluding fabricated illness/ Munchausen's syndrome), except where we state a narrower definition used by researchers for specific studies. Physical abuse may lead to injuries to the infant which we term **non-accidental injury.**

We use the term **infanticide** to refer to homicide (including murder, manslaughter and murder suicide) of infants aged under one year by their parent/s or parent-figure/s (i.e. an age-specific category of filicide) – this includes but is not limited to the specific criminal conviction of infanticide in England and Wales, which applies only to biological mothers. Definitions of 'homicide' (for example, whether manslaughter is included as well as murder) and criteria for included cases differ between studies, datasets/ administrative records and countries; and may be on the basis of police-arrests or investigations, coroner-rulings and/ or court convictions. The cause of death in the included infanticide studies is predominantly physical abuse of infants, with a minority (up to 15% of cases) due to physical neglect.

Abusive head trauma (AHT) is a clinically defined sub-category of non-accidental injury – it is related to **shaking** of young children, which is a major type of physical abuse of infants. In a US general population survey of mothers of babies and toddlers in North Carolina in 2007-08, shaking by the mother or her partner (although rare - 1%[2] reported it) was by far the most prevalent reported abusive behaviour towards infants under 1 year; the only abusive behaviour that did not substantially increase among older babies and toddlers; and primarily reported (by the mothers) not to have harmed the infant (Zolotor, 2011).

We use terms such as **father-perpetrated** and "**killed by fathers"** to refer to cases in which fathers are stated as the **suspected or convicted** perpetrator (usually in administrative returns and case records by police, coroners, social workers or medical practitioners).

We use the past tense when referring to research findings. Each study has a particular place and time. Sub-categories of fathers and risk factors potentially change through the decades.

Section 2. Key findings

The findings in this chapter are based mainly on cases of non-accidental injury that come to the attention of public authorities and medical services (which are likely to involve the more severe end of abusive behaviours) and have an identified perpetrator (convicted or suspect). Unreported cases and cases without an identified perpetrator may involve different father:mother ratios and a different balance of father categories and risk factors. Factors such as perpetrator gender, mental health problems, acrimonious parental relationships, alcohol or drugs use and previous child maltreatment may be associated with the likelihoods of perpetrators being

[1] "*Physical abuse A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child"* (NICE Guideline on Child Abuse and Neglect, 2017, p147) https://www.nice.org.uk/guidance/ng76/resources/child-abuse-and-neglect-pdf-1837637587141.

[2] There may have been under-reporting by survey respondents, due to social desirability factors.

identified or convicted, abuse being brought to the attention of authorities, and medical services reporting injuries as potential abuse.

Scale of identified non-accidental injury of infants by fathers in the UK

Between 2000 and 2015 in England and Wales, eight infants per year on average were killed by a homicidal father (including 'stepfathers') as the convicted principal perpetrator (Nobes et al, 2019)**.** Thirty-one infants in total were killed by fathers **as a result of shaking** over this fifteen year period - these shaking-caused deaths constituted around a quarter of all killings of infants by fathers and by biological fathers; and around a fifth of all killings of infants by 'stepfathers'.

Between 2011 and 2014[3] in England, a **father or mother's partner** (gender not specified) **was an identified perpetrator for around half[4] of Serious Case Reviews of non-fatal severe physical assault** (Sidebotham et al, 2016). The father or partner and the mother acted **jointly** in around two fifths of these father-perpetrated cases. The median child age was three months (range 0-17.5 years, with 75% aged under one year) for this category of Serious Case Reviews. We cite this study because we found no equivalent analysis solely for children aged under one year.

We found no data on the scale of father-perpetrated abusive head trauma (AHT) cases (neither infants nor a broader age-range of children) in the UK.

Fathers vs mothers, and categories of fathers

The published studies we refer to in this section are based on national censuses of all identified cases, or analyses of large-scale samples of cases.

There is **mixed[5] evidence on whether fathers (including 'stepfathers') have outnumbered mothers as perpetrators of infanticide**, and whether biological fathers have outnumbered biological mothers, from UK and international studies (Flynn et al, 2013; Dixon et al, 2014; Martin and Pritchard, 2010; Brown et al, 2019; Mariano et al, 2014; Dawson, 2018; Putkonen et al, 2011; Stöckl et al, 2017). With the exception of one study (in Austria/ Finland), none of these studies show a big difference between the proportions of identified father-perpetrators and identified mother-perpetrators of infanticide, nor between identified biological-father-perpetrators and identified biological-mother-perpetrators (Table 1 in Appendix 2A)**. In the only UK analysis we found**, covering convicted infanticides in England and Wales over the period 1997-2006, infants were more likely to be killed (as the main

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[3] The more recent published analysis of Serious Case Reviews (Brandon et al, 2020) does not include equivalent data on the average age of physical abuse cases.

[4] Based on an analysis of 'non-fatal physical abuse' Serious Case Reviews for which a final report was available at the time of the analysis (Sidebotham et al, 2016). There was no identified suspect in 15% of these Serious Case Review reports (Sidebotham et al, 2016).

[5] Which men are included as 'stepfathers' and therefore as 'fathers' will influence the differing ratios of father-perpetrators to mother-perpetrators, with few studies or administrative data sources giving explicit definitions.

perpetrator) by a father than by a mother in the approximate ratio 2:1 (Flynn et al, 2013).

Parental neonaticides (homicides within 24 hours of birth) were almost exclusively perpetrated by biological mothers (Stöckl et al, 2017 – a systematic review).

Fathers outnumbered mothers as perpetrators of identified abusive head trauma (AHT), both for AHT deaths and across all identified AHT cases, in samples predominantly of infants. **This is a consistent finding** in international data (including one analysis of AHT cases restricted to infants – Scribano et al, 2013), with the fathers: mothers ratio ranging from 2:1 to 10:1 (Wilson, 2018; Brown et al, 2019; Nuño et al, 2015; Scribano et al, 2013; Sieswerda-Hoogendoorn et al, 2013) – Table 2 in Appendix 2A. Biological fathers substantially outnumbered biological mothers in the analysis of AHT cases restricted to infants, and in three of the four AHT studies with a broader age-range which gave this data. We found no data for the UK.

This parental gender imbalance in perpetration of AHT may not apply to shaking of babies which does not come to the attention of public authorities or medical services (eg see Zolotor, 2011). In a survey of 2,500 people aged 14+ years in the general population[6] in Germany**, j**ust over one per cent[7] of male respondents (of whom around three-fifths had their 'own' children) agreed that it is appropriate parenting (rather than potentially harmful) to shake an infant; whereas none stated that it is reasonable to hit or slap an infant (Clemens et al, 2020). Results were similar for female respondents. However, around three-fifths of male respondents with children reported that they had heard of AHT ("shaken baby syndrome"), compared to around three quarters of the women with children (Berthold et al, 2019).

Biological fathers outnumbered 'stepfathers' as father-perpetrators of identified physical abuse in studies exclusively or predominantly of infant cases. This is a consistent finding across nearly all UK and international studies of infanticide, non-fatal physical abuse and AHT (Nobes et al, 2019; Flynn et al, 2013; Brown et al, 2019[8]; Mariano et al, 2014; Martin and Pritchard, 2010; Sidebotham et al, 2016; Wilson, 2018; Scribano et al, 20 13; Sieswerda-Hoogendoorn et al, 2013), and in the two analyses we found of AHT deaths or cases restricted to infants (Nobes et al, 2019; Scribano et al, 2013) - Tables 3, 4 and 5 in Appendix 2A. **In the most recent UK analysis we found,** of infanticides in England and Wales over the period 2000-2015, infants were more likely to be killed by a biological father (as the convicted principal perpetrator) than by a 'stepfather'[9] (as 'main' perpetrator) in the approximate ratio 10:1, with shaking-caused deaths in the ratio 15:1 (Nobes et al, 2019).

In data for England and Wales, this ratio of biological fathers to 'stepfathers' evened out or reversed for father-perpetrated homicide of older babies and pre-school children aged 1 to 5 years (Nobes et al, 2019; Flynn et al, 2013). In UK and international data, biological father-perpetrators were much more likely to have killed

[6] Nationally representative on age and gender (Clemens et al, 2020).

[7] The survey was self-completion but there may have been under-reporting by survey respondents, due to social desirability factors.

[8] This census of 15 Australian cases was the only study we found in which biological fathers did not predominate. Instead, there was an even ratio of biological fathers and stepfathers (Brown et al, 2019).

[9] The 'stepfathers' may have included mothers' non-cohabiting and short-term partners (Nobes et al, 2019).

or caused AHT to an infant than a one year old or a child aged 1-5 years, with the reverse for 'stepfather'-perpetrators (Nobes et al, 2019; Brown et al, 2019; Martin and Pritchard, 2010; Flynn et al, 2013; Scribano et al, 2013) - Tables 3 and 6 in Appendix 2A.

Whilst 'stepfathers' are a minority of father-perpetrators for infanticide (9%[10]) and shaking-caused infant deaths (6%) in England and Wales, reflecting the rarity of stepfathers in infants' lives, **they appear to be over-represented** compared to the prevalence of cohabiting[11] and non-cohabiting[12] stepfathers in the population of **infants**, which is around 2%[13] in the UK. Confounding factors[14] mean we do not know from this data whether there is a causal effect of stepfather status. Other risk factors for paternal infanticide and AHT deaths may be more prevalent among step-families. These include mother age[15], father age, father education, father mental health, family size, family deprivation and whether the mother was cohabiting with the infant's biological father at birth[16].

In a census of recent infanticide cases (2000-2012) in Australia, 'non-custodial' fathers comprised around a fifth of 37 biological father suspects (Brown et al, 2019). We did not find equivalent UK data. This appears to be over-representation compared to the proportion of Australian infants who do not live with both biological parents[17].

Risk factors for fathers' severe physical abuse of infants

Published analyses of serious case reviews in England include **exemplar case studies[18]** of infanticide and physical harm of infants by fathers and other male perpetrators (eg Sidebotham et al, 2016; Ofsted, 2011; Brandon et al, 2012). Poor mental health, young parental age, misuse of alcohol and drugs, past criminal convictions, acrimonious parental relationships and separations, partner violence, previous involvement with public authorities (social services, police, criminal justice),

[10] Our calculation from data in Nobes et al, 2019.

[11] Data from the second Growing Up in Scotland birth cohort (the most recent country-wide birth cohort study in the UK) show that, for the population at large, fewer than 1% of infants at age 10 months (in 2011-12) had a cohabiting stepfather (analysis by Paul Bradshaw, personal communication, December 2020). See Nobes et al, 2019 for similar prevalence in other representative UK datasets. The prevalence is likely to be smaller for younger infants.

[12] Only 1.5% of 10 month old Scottish infants had a resident mother with a non-cohabiting partner who was not the infant's biological father (analysis of Growing Up in Scotland second birth cohort data by Paul Bradshaw, personal communication, December 2020).

[13] Taking into account infants who have no current contact with a father (birth or step) or have had no contact since birth, the estimated % remains around 2%, because fewer than 5% of infants fall into those categories (our estimate from Growing Up in Scotland first birth cohort data for 10-month old infants in 2005-06 – see Anderson et al, 2007).

[14] See Nobes et al (2019) for an analysis for a broader age-range (0-4 years) which controls for father age as a confounding factor.

[15] In the first Growing Up in Scotland birth cohort, only 2% of all mothers had a new cohabiting partner by child age 2 (in 2006-7), but the prevalence was 9% among mothers aged under 20 years (Bradshaw et al, 2014).

[16] In an analysis of 1991-2008 British Household Panel Study data, around 15% of mothers who were not cohabiting at their baby's birth had re-partnered within a year of the birth (Harkness,2018).

[17] In wave 1 of the Growing Up in Australia birth cohort (in 2004), 89% of 0-1 year old children lived with both biological parents (Australian Institute of Family Studies, 2011).

[18] Quantitative data on risk factors in these publications is not broken down specifically for physical abuse by age of child **and** gender of the perpetrator.

poverty and homelessness are mentioned as parental risk factors, alongside prior concerns by practitioners about abuse and neglect in the family. Undoubtedly these issues can play a role as contributory and causal factors in cases of fathers' non-accidental injury of infants.

However, the **quantitative evidence** we found (published from 2010 onwards) on potential risk factors - **specific to father-perpetrators, physical abuse and infants** - is weak. We found no analyses based on a study design suitable for **causal inference**, such as matched comparison groups, or a multi-variable (multivariate) analysis of observational data controlling for confounding variables.

We found eleven **mainly small-scale** quantitative studies (published in 2010 or later) which report **descriptive evidence** about **potential risk factors** among cases of father-perpetrated infanticide, fathers' severe physical abuse of infants, (predominantly-father-perpetrated) AHT, or fathers' shaking of babies. Only two of these studies are of UK cases (Dickens, 2018; Dobash and Dobash, 2012). Much of the evidence is based on fathers as **suspects** for having caused the infanticide or physical abuse (often in administrative records written by doctors, police or coroners). Three included studies are restricted to **convicted** father-perpetrators (Dickens, 2018; Dobash and Dobash, 2012; Adamsbaum, 2010).

The most consistent and well evidenced finding from this set of studies is that **boys have been more prevalent** than girls among victims of **father-perpetrated NAI over past decades, although the difference is small in the one large-scale analysis (Mariano et al, 2014)– around 1.3 boys: 1 girl** *(one large-scale US sample of infanticides stretching back to the 1970s; one small-scale Australian census of infanticides; two very small-scale UK and French samples of fathers' convicted severe physical abuse - Mariano et al, 2014; Brown et al, 2014; Adamsbaum et al, 2010; Dickens, 2018*).

This set of studies **<u>suggests</u> with weak[19] evidence**, on the basis of just one small-scale study in one country for several risk factors (see Appendix 2B for further details) that:-

- **infants in male-perpetrated AHT cases have been younger** than infants in female-perpetrated AHT cases *(multi-country sample of published AHT confessions over several decades, identified in systematic review – Edwards et al, 2020)*
- there is **younger father age** (than for the general population of infants) among relatively recent **AHT cases** (*small-scale census of cases in the Netherlands with 80% father suspects - Sieswerda-Hoogendoorn, 2013*)
- **previous child maltreatment of the victim** is prevalent among recent **father-perpetrated AHT deaths** *(small-scale sample from 32 US states - Wilson, 2018)*
- a substantial minority of relatively recent **AHT cases** have a previously recorded **paternal police history** *(small-scale census of cases in the Netherlands with 80% father suspects - Sieswerda-Hoogendoorn, 2013)*

[19] Our statement about 'weak evidence' relates to the overall evidence base for each risk factor, relative to our research questions for this review. It is not about the quality of individual studies relative to their own research objectives and design.

- **partner violence and couple relationship conflict are <u>not</u> prevalent factors** among recent **father-perpetrated AHT deaths** *(small-scale sample from 32 US states – Wilson, 2018)* – **however, these potential risk factors may be under-reported**; very-small samples of infanticide and NAI cases in the UK, France and the US include father-perpetrated cases in the context of these risk factors[20], for example with coercive control of a partner as the motive, or with an infant injured whilst being carried by the adult victim at the time of violence by their partner (Dobash and Dobash, 2012; Makhlouf et al, 2014; Tiyaggura et al, 2018)
- **convicted father perpetrators of severe physical abuse** of their young child[21] **who have not also harmed adults**[22] have **specific psychological characteristics** compared to **convicted male perpetrators of violence to men** – the child harmers were more likely to have **low self-esteem, anxious attachment styles**, **disengaged coping strategies** (giving up and hopelessness)**, empathy for their victim, moral justification of <u>not</u> using physical discipline**, and **poorer knowledge of appropriate parenting strategies and age-appropriate child behaviour** – this suggests that anger, insecure attachment issues, misinterpretation of their child's behaviour, feelings of rejection by their child, and situation-specific issues override victim empathy at the time of the father's physical child abuse. Yet the child abuse **by this category of father-perpetrators** does not appear to be solely 'parenting gone wrong' – **the child harmers and the adult harmers in this study shared high prevalence of drug use, poor emotional control, heightened anger responses and avoidant attachment styles** *(quantitative and qualitative data from a small-scale UK study interviewing convicted perpetrators – Dickens, 2018).*

These findings would need to be substantiated **in the UK**, using **larger-scale data with representative samples** of father-perpetrated infanticide, physical abuse and AHT cases, and **controlling for confounding variables** to assess the evidence for causal effects. Just one or two further studies in the future could reverse our tentative conclusions.

We found **mixed small-scale evidence** on the prevalence of **fathers' mental health problems and alcohol and drug problems among AHT cases** *(small-scale sample of AHT cases in the Netherlands, and small-scale US sample of AHT deaths - Sieswerda-Hoogendoorn, 2013; Wilson, 2018*). We found no quantitative evidence

[20] Our searches found research reports about partner violence, coercive control in parental relationships and acrimonious parental separations as risk factors for filicides and child maltreatment (eg CAADA, 2014; Green and Halliday, 2017; Barnett, 2020; CAFCASS/Women's Aid, 2017; Jaffe et al, 2014; Women's Aid, 2016). These were primarily about older children, sometimes including toddler case studies (age 1+), and rarely an infant case study. Quantitative analyses restricted their samples to older children or were not disaggregated by child age and/or the gender of the parental perpetrator of the violence towards the child. In Cafcass submissions to Serious Case Reviews involving domestic violence, half of the cases (any child age) involved a perpetrator of severe abuse to a child who was not the alleged perpetrator of the domestic violence (Green and Halliday, 2017).

[21] Fifteen of the 20 children were aged under 18 months, with seven younger than 12 months. It is possible (no data in published paper) that these statistical patterns did not occur among the cases of children aged under one year, who were killed predominantly (6 out of 7) by biological fathers (cf the overall sample, with equal numbers of biological fathers and 'stepfathers').

[22] The child harmers and adult harmers were selected to exclude men who had physically harmed both child/ren and adult/s (including partner/s). This study was not designed to investigate the context of partner violence for NAI of young children.

about mental health problems, drug use or alcohol use as risk factors for father-perpetrated infanticides (those not limited to AHT deaths).

We found **mixed small-scale evidence** about whether infant crying is a substantial trigger for **father-perpetrated infant shaking and AHT** *(small-scale US study of father-perpetrated AHT deaths vs very small-scale US and French samples of father-perpetrated AHT or baby shaking – Wilson, 2018;* Zolotor, 2011; Adamsbaum et al, 2010*)*. Research reviews of studies published prior to 2010 give an evidence base for the role of infant crying in cases of AHT (eg Barr, 2012, 2014), although it appears from the references cited that most of these studies are not specific to fathers.

We found no published quantitative analysis on father-perpetrated infanticide or physical abuse of infants or older babies in the context of **acrimonious partner separations**; nor on the role of **childhood factors and adverse childhood experiences.** In the survey of the general population in Germany, adverse childhood experiences were statistically associated with men's acceptance of shaking a baby as 'reasonable parenting' (Clemens et al, 2020).

It is likely that factors such as fathers' mental health problems, alcohol and drug problems, police records, partner violence and couple relationship conflict are under-reported in medical records, and (to a lesser extent) in social services, police and legal investigations – this may explain the low prevalence or mixed findings for certain risk factors.

A lack of evidence on risk factors

There is a need for more and better-quality studies on the topic of this research review. We found a scarcity of evidence (specific to fathers, infants and physical abuse[23] and published in 2010 or later) to address our broad research questions or the Panel's specific 'risk factor' questions about sustained abuse, impulse control, partner violence, coercive control and childhood experiences. We found mixed weak evidence or no recent evidence (specific to fathers, infants and physical abuse) about the risk factors on which interventions may be based, such as mental health, partner violence, drugs and alcohol, and responses to infant crying. This is despite the high proportion of child maltreatment deaths which are of infants, and the high proportion of AHT cases perpetrated by fathers.

Our systematic searches were extensive but not exhaustive - this is a rapid systematic review rather than a full systematic review. As described in Chapter 1, our searches of eleven bibliographic databases identified literature in which our topic of interest was sufficiently a focus (in the research aims or findings) for the title or abstract of the publication to include a 'father/ informal male caregiver'-related term,

[23] We found and excluded several studies of risk factors for father-perpetrated filicide or physical abuse that did not disaggregate findings for infants. Some of these studies used case control designs, longitudinal datasets, comparison groups and/or multivariate analyses to gain evidence on risk factors, with the analysis for children of all ages. Similarly, we found and excluded analyses of risk factors for infanticide and non-accidental infant injury that did not disaggregate findings according to the gender of the 'parental' perpetrator. Other excluded studies investigated risk factors for 'maltreatment-related deaths' of infants using samples in which a substantial proportion of cases were classified as neglect rather than physical abuse.

'infant'-related term and 'physical abuse /NAI/ filicide'-related term, using an extensive list of synonyms for each of these concepts. We also screened a broader literature about child abuse and fathers in the Fatherhood Institute's comprehensive electronic library (based itself on systematic searches for research about UK fathers, 'father-figures' and grandfathers).

To screen the much larger research literature relating to 'parents' and physical abuse/ NAI/ filicide, or the entire literature relating to physical abuse and homicide of children, so that we could then look for relevant subgroup analyses within full texts, would have been too great a task. We have uncovered additional references (in the bibliographies of included studies) about physical abuse/ NAI or filicide, which potentially include relevant data, but which do not include both a 'father/ informal male caregiver' term and 'infant' term in their title or abstract. There is therefore scope for a full systematic review to extend our work.

Nevertheless, our finding of a lack of research findings specific to fathers and specific to infants is consistent with research reviews on related child maltreatment topics (eg Chamberlain et al, 2019a and 2019b; Christie et al, 2018; Laulik et al, 2013; Cuthbert et al, 2011; De Bortoli, 2012; Ayers et al, 2019; Skinner et al, 2021)[24]. Study authors of several research studies found through our searches (including those we excluded due to a lack of evidence specific to infants or fathers) commented on:

- relatively small sample sizes of cases ('small' in statistical terms), even on national administrative databases, which restrict statistical power and the scope for multivariate analysis controlling for confounding variables
- the lack of data on parental characteristics and risk factors in administrative databases and case records, especially in health services, and particularly on fathers' characteristics and circumstances (eg Kelly, 2020[25])
- the hidden circumstances of physical abuse of infants, who are not able to disclose the abuse or tell their story to authorities or researchers – identification of the gender and other characteristics of the perpetrator and the circumstances of the death or abuse can be challenging, leading to missing data in administrative datasets (eg Nobes et al, 2019; McManus et al, 2015; Nuño et al, 2015) and serious case reviews (Brandon et al, 2020).

Additionally, we found in carrying out this review that quantitative findings in publications are rarely disaggregated by child age and by the gender of the perpetrator, even where the sample is sufficient for finer-grained analysis. In studies

[24] For example, *"A total of 69 papers, including 181,537 participants (of whom 30,482 mothers and 235 fathers had maltreatment histories), investigated the transition to parenthood"* (Christie et al, 2018 abstract - research review on the relationship between childhood history of maltreatment and transition to parenting); "*only three out of the 11 studies considered the impact of paternal personality disorder, with no studies specifically examining father–infant interactions"* (Laulik et al, 2013, p652 - research review on personality disorder and parenting behaviours including physical abuse)*; "Although there is an increased risk of death from male partners after a newborn's first week of life…none of the studies included any information on the male partners*" (De Bortoli et al, 2012, p144 – research review on maternal drug use in pregnancy and child maltreatment).

[25] Kelly (2020) writes (p59) *"It is striking that data describing the father or stepfather are almost entirely absent from perinatal literature, despite the evidence that males are more likely than females to inflict severe or fatal physical abuse" and (p119) " there was almost nothing about the father in perinatal records – not even his name*".

of child maltreatment, findings can differ for father-perpetrated and mother-perpetrated cases[26].

[26] See Brandon et al, 2012 for an account of risk factors for filicide of 5-10 year old children disaggregated by perpetrator gender, showing differences in the characteristics of mother-perpetrated and father-perpetrated cases. In contrast, Ayers et al (2019) write in their research review on perinatal mental health problems and child maltreatment: *"The issue of who perpetrates the abuse is important but not explicitly addressed in many studies. Most studies focused on maternal mental health and child maltreatment, but often did not explicitly consider who was the perpetrator of the abuse and that this may not have been the mother"* (p8).

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Chapter 3. Safeguarding Services Review

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In this chapter we explore what research tells us about safeguarding services' response to non-accidental injury (NAI) of infants (aged under one) perpetrated by fathers and other men with a parental or caring role.

The chapter synthesises evidence from:

- Thirty studies reporting on specific interventions aimed at, or reporting outcomes relevant to, the reduction of non-accidental injuries to infants (eight studies, of which three were from the UK, three from the US, and one each from New Zealand and France) or infant maltreatment (22 studies, of which 11 were from the UK (one of these had also been evaluated in the US, one in Canada and one in the Netherlands), 10 from the US, and one from New Zealand). These are referred to in the chapter and summarised in more detail in Appendix 3.
- Nine studies about the UK child protection/social work system and its engagement with fathers and other informal male caregivers. These are referred to in the chapter and summarised in more detail in Appendix 4.
- An additional 44 'context setting' studies/ reports relating to four key themes: perinatal/universal services (16); child protection/ the Police (ten); 'toxic trio' risk factors (mental health, partner abuse, substance misuse) (18).

There are two sections in this chapter. The first focuses on current practice, and the second on how the safeguarding system might be made more effective in future.

Section 1. Understanding and responding to male caregivers as a risk and resource

In this section, we seek to address two questions:

- How - and how well – does the UK safeguarding system understand and assess the characteristics, psychology, behaviours, relationships, risk and parenting capacity of the male perpetrators? - this includes the perceptions, attitudes, knowledge and skills of service management and practitioners
- How - and how well -– does the UK safeguarding system understand and assess the potential resource and risk of other men with a parental or caring role for the child? - this may apply for example where there is both a birth father and stepfather, or a father and a grandfather, or a current partner and a former partner of the mother.

We have synthesised the evidence we found into three key findings.

Finding 1. Perinatal and other universal services (including specific interventions) do not routinely engage with, or evaluate impact on, fathers

In their 2011-2014 Triennial Review of Serious Case Reviews, the authors (Sidebotham et al., 2016) found, through close inspection of cases of fatal physical abuse (mostly involving babies, and in half of cases, perpetrated by fathers or father-figures), that there were often, prior to the event, "pointers toward some parent or carer risks arising within a vulnerable social context" that had not been recognised or followed up by preventive services. While the tragic event had often been presented as arising 'out of the blue', it frequently did not[27].

Perinatal health services

We found studies relating to 20 perinatal interventions, of which seven had been evaluated in the UK. Eight interventions were abusive head trauma/ shaken baby syndrome (AHT/SBS) prevention programmes. In the largest of two UK-based AHT/SBS prevention programme evaluations, (evaluating a programme called Coping with Crying) father-engagement was low: 34% of the parents who watched the intervention film in hospital, and 32% of those who watched it in the community, were fathers (Coster, 2016): this was considerably lower, for example, than the proportion of fathers in Pennsylvania who signed 'commitment statements' confirming that they would not shake their babies: statements associated with 74% of live births in 2003-13 were signed by at least one parent, and were co-signed by fathers in 70% of cases (Mark S. Dias et al., 2017). The Coping with Crying evaluation reported significant impacts on parents' knowledge and behaviour around infant crying, but – in common with several other studies - the data was not disaggregated by gender of parent, so impact on fathers specifically is unclear. One US intervention, All Babies Cry, stands out as having been evaluated in a way that took account of fathers' disproportionate perpetration of AHT injuries; participants in an RCT reported improvements in parenting knowledge and resilience, and used a wider variety of stress reduction strategies in response to infant crying. Another, Period of Purple Crying, was found to reduce AHT hospital admissions by 35%, but a third, Pennsylvania SBS Programme, reported static or rising hospitalisation rates. In a small French study, more than a third (36%) of fathers were found never to have heard of AHT; 91% of fathers, compared to 81% of mothers, reported having found the information provided during the intervention (a 3-minute talk and leaflet) useful while dealing with infant crying. For more details see Box 1 on page 31 of this report, and Appendix 3.

More widely, we found no evidence suggesting routine engagement with fathers around non-accidental injury, or infant maltreatment more generally, by midwives or other health professionals in universal services in the UK.

For context, midwives see more fathers than any other infant/ children's health, education or social care professional in the UK. Ninety-five per cent of UK couples are in a close relationship as partners or friends at the time of the birth (85% cohabiting), and despite no invitation being extended to expectant fathers, the great majority accompany their pregnant partner to at least one routine antenatal care

[27] We don't know whether these 'pointers' were more or less likely to occur (or occurred at all, in fact) in the father-perpetrated cases.

appointment; 90+ per cent attend scans and the birth (Burgess & Goldman, 2018). Almost all these are biological fathers; a group that outnumbers mothers as perpetrators of AHT. A survey of more than 1,800 men who had become fathers in the previous five years found that almost two-thirds (65%) said healthcare professionals had rarely/never discussed their role during the antenatal period; 56% had rarely/never been addressed by name and only 18% had been asked about their mental health[28]. During the recent Covid-19 pandemic fathers have been routinely excluded from antenatal appointments, early labour and postnatal wards across the NHS[29], but even under normal circumstances, the father has no clinical status in maternity services: in this mother-focused space he has been described as 'not a patient, not a visitor' (Steen et al., 2012). Since he is not, in her view, her patient, a midwife would not routinely assess or refer a father to other specialist preventive or responsive services, as she might a pregnant mother.

The benefits of father-inclusion are recognised sufficiently by policymakers to have brought expectant fathers recently to the point of 'patient-hood' – almost, but not quite. Father-engagement as an expectation was set out in Department of Health/ Public Health England joint pathway for health visiting and midwifery partnerships, for example (DH/PHE, 2018). The Public Health England's Model specification for 0-19 Healthy Child Programme: Health visiting and school nursing services – part of the guidance for local authority commissioners, in whose hands the power now lies to define how perinatal services are delivered (PHE, 2018), also calls for:

> Antenatal visit (mandated) (page 24)
> "From 28 weeks of pregnancy, contact to be made by the health visiting service and an antenatal health promoting visit delivering *comprehensive and holistic assessment of the expectant mother and father's needs*, including:
> • assessing the *mental health and wellbeing of both parents*
> • supporting the *transition into parenthood*
> • promoting health: *providing information and advice* on the Healthy Child Programme, local child health clinics, breastfeeding and nutrition, dental health, postnatal depression, domestic violence and abuse, FGM, home and car safety, vitamins, smoking cessation, prevention of Sudden Infant Death Syndrome, children's centre services and local support networks"

Later in the same specification, it adds this:

> Emotional health and wellbeing of parent and child (page 28)
> "Assessment of mother *(and father, if present)* to be made at antenatal visit. Assessment of *mother, father and baby* to be made at:
> • new baby review
> • 6–8 week visit
> • any contact between service and family
> • one year developmental review
> • 2–2.5 year review (integrated where eligible)"

[28] http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/How-was-it-for-you-UK-results.pdf
[29] https://discoversociety.org/2020/06/22/dad-distanced-the-turbulence-of-new-fatherhood-amidst-a-pandemic/; https://www.dailymail.co.uk/news/article-8950211/Huge-mental-health-toll-Covid-restrictions-mothers-laid-bare-survey.html

(*our italics*).

We found no studies exploring the extent to which NHS health visitors are meeting the expectation to engage with fathers. However, for context, a recent survey of more than 1,000 practising health visitors in the UK by the Institute of Health Visiting (IHV, 2020), suggested strongly that their time is stretched, and it seems likely that this may limit their scope for father-engagement: only a third (34%) of respondents said they were able to offer the mandated antenatal contact[30] to all families; two-fifths (38%) described the care they had provided in the previous year as 'inadequate' or 'poor'.

Notwithstanding Public Health England's guidance for commissioners, fathers may feel marginalized and unacknowledged by health professionals during the perinatal period (Baldwin & Bick, 2017), and report a lack of appropriate information on pregnancy, birth, childcare and balancing work and family responsibilities. Health visitors do not routinely involve fathers and can be perceived by fathers as a service provided "by women, for women" (Baldwin & Bick, 2017). In terms of information-gathering, the Child Health Record standard form allows for the inclusion of the father's name and birth date[31], but there is no provision for a separate address for the father, even though 'split-household' families may be among the most vulnerable.

Reasons for health visitors not engaging with the father/ mother's partner may include this not being required or even suggested to them[32], lack of confidence in ability to engage with men, and workloads not designed to make this easy or even possible (Bateson et al., 2017). It has also been argued that while it is important for healthcare professionals to engage men in the antenatal period, doing so without there being a clearly defined role for them could actually create further distance between them and the pregnancy (Dheensa et al., 2013).

The list of information and advice to be provided through the Healthy Child Programme does not currently include a shaken baby prevention (SBS) programme (PHE, 2018). As we report in Appendix 3, the NHS has recently extended its promotion of ICON, an SBS prevention programme which is so far unevaluated[33], amid concerns about increased prevalence of baby shaking during lockdown[34]. Evidence about AHT prevention programmes' impact on actual rates of infant non-accidental injury has been mixed, and evaluations have often failed to disaggregate results by gender of parent.

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[30] This is the mandated face-to-face visit where comprehensive and holistic assessment with mothers AND fathers is required, according to the PHE guidance (PHE, 2018).

[31] https://www.healthforallchildren.com/wp-downloads/79534v3.02-PCHR.pdf

[32] A senior health visitor who has studied health visiting services' engagement with fathers told us that despite the PHE commissioning guidance, "Fathers are not mentioned in the KPIs set by commissioners and therefore HVs' performance around assessing fathers is not captured or monitored."

[33] In our 'risk factors' review (see Chapter 2) we found mixed evidence (three non-UK studies) for babies' crying as a primary trigger for father-perpetrated infant shaking and abusive head trauma AHT. Research reviews give an evidence base for the role of infant crying in AHT cases (see for example (R. Barr, 2012, 2014)) although it appears from the references cited that most of these studies (nearly all published prior to 2010) are not specific to fathers

[34] A report from the first month of UK lockdown suggested a potential increase in incidence of abusive head trauma in infants during the pandemic, but this was based on very small numbers (Sidpra, 2020).

Systematic reviews (Levey, 2017) have suggested that intensive home visiting has the best evidence of reducing child maltreatment during infancy (see for example the Child First intervention, in Appendix 3), but findings vary, and father-specific evidence is often lacking (let alone evidence about impact on fathers' perpetration of deliberate harm to infants). An evaluation of one US programme, Healthy Families New York, found that when fathers participated, families were four times as likely to remain the programme – which, according to a small RCT, halved the risk of confirmed physical abuse or neglect by mothers (who had already had at least one substantiated child protective services report before enrolment).

Father-focused home visiting enhancements like Dads Matter could be one route towards making such interventions more effective, and there is evidence suggesting that this can bring benefits in terms of improving maternal engagement in interventions, as well as for fathers themselves (CFRP, 2017). The only 'standalone' father-only perinatal interventions we found was Hit the Ground Crawling – which includes provision of information about the dangers of baby shaking. In a small-scale UK evaluation this was found (via self-report) to improve fathers' confidence in caring for a baby, and dealing with a crying baby. For more details about these programmes and their evaluations, see Appendix 3.

Primary care

General practitioners (GPs) are key professionals with responsibility for child safeguarding, as well as being well placed to identify, engage and provide support to fathers in the perinatal period. We found no specific evidence about GPs' involvement in identifying or preventing non-accidental injury to infants (including by men), nor more generally about GPs' responses to men as fathers.

For context, it is likely that primary care clinicians – in common with other health and social care professionals – view mothers as the key/ sole target for family support. Since 2020 it has been expected that GPs should offer a 6-week postnatal check-up to new mothers[35]. However, GPs may fail to implement basic father-engagement techniques, such as offering parenting skills support or screening for perinatal depression (Allport et al., 2019). Men also visit GPs less often than women (Rice et al., 2013), and are less likely to seek help for some conditions, including mental health problems (Banks & Baker, 2013). Even when faced with men experiencing difficulties that may contribute to additional risk to their children (for example around mental illness or substance misuse) GPs may not see these as child safeguarding 'flags' unless the patient himself informs (or reminds) them he is a father.

Although there is no clear (recent) evidence that partner abuse plays a large role in father-perpetrated abuse of infants, it is commonly considered a key risk factor for child maltreatment (see page 13 below) and as such it is interesting to note that a study which explored how general practice understands and responds to links between child safeguarding and domestic violence/ abuse (DVA)[36] (Szillassy et al., 2015) found a worrying lack of knowledge, confidence and partnership working. For

[35] https://www.nhs.uk/conditions/baby/support-and-services/your-6-week-postnatal-check/

[36] The study explored the current content of GP training on DVA and child safeguarding, conducted interviews with 69 GPs, practice nurses and practice managers, and developed and piloted a training course in 11 GP practices across England

example GPs' awareness of the relationship between DVA and child safeguarding was generally low; there was considerable variation in their responses, approaches to the issues, assumptions and perceptions of harm thresholds. Doctors demonstrated a lack of confidence and experience in having conversations about DVA with patients, and most did not see themselves as having a role in contributing to a 'jigsaw' of information about children that was shared between agencies.

Early years services

Early years services, delivered by Children's Centres or state-run/ private nurseries, provide care to some infants, and play an important role in identifying and engaging with families before safeguarding issues are identified. We found no evidence about such services' engagement with fathers on the issue of non-accidental injury to infants, or maltreatment more widely.

For context, like maternity services, early years services provide support mostly to mothers, according to the only national study of family services' father-engagement (published before the period of this review, but included here as reference because of its rare paternal focus), which was commissioned by the then Department for Children, Schools and Families, and found 98% of local authorities agreeing or strongly agreeing that their services were used 'much more' by mothers than fathers (Page et al., 2008). The same study found that with the exception of Children's Centres, which three-fifths (61%) of respondents felt were 'father-friendly', most services aimed at families with infants or young children were felt to be predominantly 'neutral' towards father. More recently, a Parliamentary Inquiry into Parenting and Social Mobility found that support for parents in the UK is patchy, and tends to sideline fathers (APPGs, 2015). An evidence review found that parenting interventions in the UK and around the world mostly ignore fathers in their design and implementation, making minimal efforts to include them in interventions and/or evaluate differential impact between fathers and mothers (Panter-Brick, 2014).

Box 1. Perinatal interventions: we found 20, falling into three groups (see Appendix 2):

Group A. Perinatal couple/ family-targeted: abusive head trauma/ shaken baby syndrome prevention

Two of these, Coping with Crying (Coster, 2016) and Surviving Crying (Bamber, 2019), have been evaluated in the UK. A third, ICON (Smith, 2016), has yet to be evaluated, but we included it in our review because NHS England has promoted elements of the programme during the Covid-19 pandemic (NHSE, 2020); basic information drawing on its content is available on some NHS websites. The other five came from overseas (two from the US and one each from Canada, France and New Zealand). Only two AHT interventions, the Period of PURPLE Crying (Barr & et al., 2018) and Pennsylvania Shaken Baby Syndrome Prevention Programme (Mark S. Dias et al., 2017), were evaluated in ways that show potential direct impact on non-accidental injury to infants: the former study reported a 35% reduction in AHT hospitalisation rates, while the latter reported static or increased incidence during the period studied. Researchers suggested that external factors, including a major economic recession, may have reduced programmes' impact. Half the AHT/SBS programme evaluations provided self-report data specific to fathers, with some finding high proportions (80% or more) of fathers (and mothers) deeming the information they had gleaned from the intervention useful; reporting improved understanding of babies' crying behaviour, and of strategies both to soothe the baby, and calm themselves; and saying that they had remembered programmes' messages about it being "ok to put the baby down in a safe place and walk away" during bouts of excessive crying (see for example (Mark S. Dias et al., 2017; Simonnet et al., 2014). It is worth noting that parents who didn't find it useful (or who didn't attend in the first place) who are the potential perpetrators of AHT – especially if severe abuse is not solely 'parenting gone wrong'. One US programme, All Babies Cry, took note of evidence about fathers' disproportionate perpetration of baby shaking, developing its parent-information carefully to target men (e.g. fathers appeared on screen for 70% of the time in the video content) and designing its evaluation to achieve 70% paternal/ 30% maternal participation. Outcome data suggested effectiveness, but was not disaggregated by parent sex (Morrill et al., 2015).

Group B: Perinatal couple/ family-targeted

This group includes ten interventions, five of which have been trialled in the UK (although in one case the evaluation has yet to be published). None focus specifically on reducing non-accidental injuries, and the level of focus on both child maltreatment and fathers varies widely. For example Family Foundations aims to support new parents' couple relationship via ante- and postnatal classes covering issues like conflict resolution and co-parenting: its declared aim is not to reduce family violence but a US RCT found favourable impacts on this, among mothers and fathers (Feinberg et al., 2016); Healthy Families New York (US) is a home visiting programme targeted at vulnerable families with babies under 3 months; an RCT showed long-term reductions in substantiated child protective services reports, with a later study finding that families where fathers participated, were four times as likely to stay in the programme (McGinnis et al., 2019).

Group C: Perinatal father-targeted

We found two father-targeted perinatal interventions. One, Dads Matter, was designed as an enhancement to run parallel with existing home visiting (mother-targeted) services. Although not designed specifically as an intervention to reduce infant maltreatment, it produced large effect sizes on three paternal measures of child neglect, physical assault and aggression towards child (Guterman, 2018). The other, Hit the Ground Crawling, is a facilitated 2-hour peer mentoring session where recent new and expectant fathers come together to discuss their experiences and concerns, and practise babycare skills, with the aim of building confidence as caregivers. A brief discussion about shaken baby syndrome is included, and in a small evaluation new fathers' self-reported confidence in dealing with a crying baby rose from 61% to 94% (Fraser, 2019).

Finding 2. Child protective services tend to ignore or under-estimate the value of working with fathers to protect infants

As set out in *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*[37], protecting children (including infants) from harm involves multiple agencies. In practice it is social care who are the lead child protection agency and it is no coincidence that the greatest volume of evidence about engagement with fathers by safeguarding services originates from the field of child-focused social work.

Almost a decade ago, a study of 45 serious case reviews where a child had died or been seriously injured, and where a father or father-figure was implicated (Ashley et al., 2011) analysed in forensic detail whether, and in what ways, the father/ father figure was implicated in the injury/ death of the child; how the family were consulted, if at all, in the process of the serious case review; the nature of the presenting concerns in the family (what risk factors had been present); whether the child was subject to local authority safeguarding processes in the period immediately prior to the injury/ death; and whether the father/ father figure was living in the child's household prior to the injury/death. The researcher checked whether there was any evidence that relevant services had engaged with the father in the period preceding the injury/death. He found no clear evidence in *any* of the summary reports, of the father/ father figure having been engaged by agencies *in a way that was directed at his risk to the child*. Furthermore, in three of the cases there was evidence that the child's birth father, no longer living with the child, had raised concerns with children's services about the care his child was receiving, and these concerns had not been adequately responded to.

In our review we found eight subsequent studies, ranging across the entire decade from 2010 to 2020, which provided detailed data about child protection services' approach to engaging with, assessing and intervening with fathers and father-figures – in cases of infant injury and death highlighted in serious case reviews, audits of practice by local authority child protection teams, and studies exploring responses to men already known to be violent. When considered together, the overall picture painted by these studies is one in which services whose role is to protect children, focus almost exclusively on the mother-child dyad. If they consider fathers at all, they position them as marginal to the task of (and ultimately, the responsibility for) caregiving. Mothers, including those who are themselves victims of physical violence and other forms of partner abuse, are seen as almost exclusively responsible for children's safety.

To summarise, researchers found evidence of:

- Social workers lacking in professional curiosity about men in families (Marian Brandon et al., 2020)
- Basic information about men not being gathered, acted on or shared (Ashley et al., 2011; Baynes & Holland, 2012; M. Brandon et al., 2017; Marian Brandon et al., 2020; NSPCC, 2017; Osborn, 2014; Swann, 2015)

[37] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

- The potential risks posed by fathers – biological and otherwise – not being considered or taken seriously (Ashley et al., 2011; M. Brandon et al., 2017; Marian Brandon et al., 2020; NSPCC, 2017; Osborn, 2014; Sidebotham et al., 2016; Swann, 2015)
- Negative assumptions about men's (lack of) availability and/or involvement in their children's lives being commonplace, and underpinning the design and delivery of services and interventions (Bedston et al., 2019; M. Brandon et al., 2017; Sidebotham et al., 2016)
- Fathers not being invited or supported to take part in decision-making and plans to protect their children (Ashley et al., 2011; Baynes & Holland, 2012; NSPCC, 2017; Swann, 2015)
- Mothers being relied upon to provide important information about the men around the child, despite clear evidence that in some circumstances they might not do so, and being expected to take full or disproportionate responsibility for children's safety (NSPCC, 2017; Sidebotham et al., 2016)
- Fathers' concerns about risk posed to their children not being listened to (Ashley et al., 2011; NSPCC, 2017; Osborn, 2014).

Many of these findings drew on evidence not just of social work practice, but of practice across multiple agencies. We have provided a fuller, study-by-study summary of the key findings of the nine 'fathers in child protection' studies referred to above, as Appendix 4[38]. In our review we found evaluations of several multi-agency interventions: see Box 2 on page 35 of this report, and Appendix 3.

Lack of attention to fathers by social workers may result in lost opportunities to prevent father-perpetrated death or injury to infants. As outlined in our Risk Factors Review (Chapter 2 above), there is small-scale evidence (from one US study) suggesting the existence of a history of maltreatment in 29% to 58% of father-perpetrated abusive head trauma deaths, and evidence of past injury in 11% to 40% of these deaths.

Police and criminal justice

Our review found no evidence about Police attitudes, behaviours and/or interventions specific to fathers, nor infants.

For context, Police guidance[39] sets out how officers attending incidents where children are present should act, including identifying any risk factors in order to determine the actions required to safeguard the children; how they should go about referring cases where there are concerns, both internally and externally (for example to health visitors and/or midwives); and that they should discuss their concerns with the child and family as appropriate. The guidance links to clinically evidenced best practice, for example National Institute for Health and Care Excellence guidance *Child maltreatment: when to suspect maltreatment in under18s*[40].

[38] Most of these studies do not focus specifically on perpetration of infant NAI, but rather on child abuse more generally. In our summary here and in Appendix 4 we have tried to synthesise findings wholly or mainly relating to physical abuse, with a particular focus on findings specific to infants.

[39] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/child-abuse/concern-for-a-child/#adult-refusal-to-allow-access-to-a-child.

[40] https://www.nice.org.uk/guidance/CG89.

Guidance also sets out principles for the identification, assessment and management of serial or potentially dangerous domestic abuse and stalking perpetrators[41], stressing that identification and management of serial and dangerous perpetrators should focus both on individuals who pose a significant danger to a single victim, and on those who cause harm to multiple victims. The definition of 'dangerous' includes risks of causing or using psychological and emotional harm, as well as lethal or sub-lethal physical violence. Many of these perpetrators will be fathers, but the guidance makes no mention of risks to children.

In 2014, an HMIC (Her Majesty's Inspectorate of Constabulary) inspection of the Police response to domestic abuse cases found that "even where training is limited, response officers generally make sure that children at the scene are safe and well." This includes checking on children upstairs if the officers are told they are sleeping, and if necessary, ensuring that they are safe if they are at a relative's house. In most forces prompt referrals are made to children's social services where appropriate. In a very small number of forces the HMIC found that referrals to children's social care were not being completed as a matter of course, and raised this with individual forces. The report highlighted several examples of best practice including the following:

> "Durham Constabulary has an established policy of taking positive action around domestic abuse incidents, recognising that when a victim of domestic abuse or violence calls the Police for help for the first time that it is typically the culmination of a series of many incidents, and that domestic abuse and violence can impact on the lives of children and shape their future. The force uses body worn cameras to capture early evidence, which is regularly used to pursue prosecutions where a victim is unwilling or reluctant to support this; in an initiative called 'Through the Eyes of a Child'[42] it has extended the use of BWC to capture the experiences of children and how domestic abuse within a family is seen.
>
> "Footage from BWC is uploaded on to a server by the attending officer. It is there to view as part of how the police investigate and also safeguard vulnerable adults and children. This footage can be viewed by other agencies, like children social care and domestic abuse specialists, who work within Multi Agency Safeguarding Hubs (MASH), and can be used by them to shape their decision making."

More recently, a thematic report looking at Police child protection work across England and Wales between 2014 and 2019 found that where the risk was immediate and obvious, forces usually responded well, but complex or less obvious risks can be missed. It found that: police do not recognise or evaluate risk to children well enough, too often focusing on particular incidents and missing the bigger picture; officers and staff may lack skills, training and experience to investigate effectively or make effective plans to protect the child; supervision is often focused on completing paperwork rather than making better decisions; and there are inconsistencies in information sharing across force and partnership areas.

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[41] http://library.college.police.uk/docs/appref/Serial-dangerous-domestic-abuse-stalking-perpetrators-principles.pdf

[42] https://www.eif.org.uk/resource/think-through-the-eyes-of-the-child-durham-constabulary

We found studies suggesting that there have been efforts to improve the Police's response to partner abuse, for example through a greater emphasis on risk-led assessments (Wire & Myhill, 2018); targeting of 'high incidence' perpetrators (Robinson & Clancy, 2015); and piloting of conditional cautions (Strang et al., 2017); and research aimed at developing a better understanding of perpetrator typologies (Ali et al., 2016). None of these made reference to fathers, or reduction of male-perpetrated infant harm.

Box 3. Multi-agency interventions: We found several interventions, both in the UK and elsewhere, that involved intensive work with families to help them cope with complex problems that might not fit neatly into the remit of one service or type of practitioner – often, but not always, focused on the perinatal period (see Appendix 2).

These interventions may be described as couple- or family-targeted but in fact the way they have been designed, delivered and/or evaluated makes clear that the focus was predominantly on mothers, with little attempt to recognise and/or maximise fathers' involvement, or to evaluate the effectiveness of approaches with fathers. The targeting of the main Family Nurse Partnership evaluation on mothers rather than parent-couples is a case in point (Robling, 2015), as is Newport Family Assessment and Support Service, whose evaluation mentioned fathers but presented scant outcome data, not gender-disaggregated (IPC, 2016). The theories of change behind these programmes are broad enough to allow for father-inclusive versions to be developed, so we took an 'inclusive' view and included them in our review.

Determined commissioners and service providers should be able to develop their own trials of father-inclusive couple/family-focused and/or father-targeted interventions, paying due attention to key issues like staff training, programme recruitment, delivery models and evaluation methods. In this respect there is much learning to be had from the evaluation reports from more father-inclusive and father-targeted interventions (including several from **Group E: Non-perinatal Father-targeted**) and/or supplementary studies relating to others (e.g. (Ferguson, 2016). Careful reading of the studies listed in Appendix 3 could also be instructive, since they offer useful and nuanced insights into fathers' lived realities; the balance of risk and resource they may provide; and the levers social work/ other professionals might pull to engage, support and challenge them as fathers.

Finding 3. Services addressing parental risk factors lack evidence of impact on paternal perpetration of infant harm

There has been widespread acceptance in child protection policy and practice that a 'toxic trio' of factors increase risk, and that these should be considered in children-in-need assessments; the trio being domestic abuse, substance (drug and/or alcohol) misuse and mental health problems. Department for Education figures show that in the year to April 2019, 50% of children-in-need assessments reported the presence of domestic abuse; 43% featured parental mental illness; and drug misuse and alcohol misuse each appeared in 20% of assessments.

A recent systematic review described the evidence for the role of the 'toxic trio' in child protection as "alarmingly weak", and argued that "the dominance of the trio factors, embedded in routine processes and practices, data collection and reporting, and professional mind sets, has crowded out attention to other factors", especially economic factors like housing and employment insecurity, along with parental age, separation and ethnicity, for example (Skinner, 2021). In our Risk Factors Review (Chapter 2) we did not find any clear-cut or robust evidence relating to the 'toxic trio' risk factors for father-perpetrated abuse of infants. There was also a lack of evidence on acrimonious partner separations and father-perpetrated abuse of infants.

Mental health services

Although there is no clear correlation between fathers' mental illness and their risk of infant harm perpetration (as outlined in our Risk Factors Review (Chapter 2), practitioners working in perinatal mental health services may be well-placed to engage with and assess men during their transition to fatherhood – and mental health is, like partner abuse, one of a commonly cited 'toxic trio' of child maltreatment risk factors.

A mixed-method Australian study[43] found that during the perinatal period, first-time fathers experience a strong contrast between positive and negative emotions – being caught between almost overwhelming feelings of love, joy and excitement on one hand, and a heavy weight of responsibility on the other. Researchers found that this juxtaposition of emotional reactions to fatherhood generates considerable stress, and increases the potential risk to new fathers of experiencing psychological distress (Beyondblue, 2015). They split new fathers into three typologies, shaped by their stage in the fatherhood journey:

- 'In the dark' (comprising 10% of new fathers) – expecting their first child, feeling overwhelmed at what lies ahead, and at risk of psychological distress
- 'Trainer wheels' (comprising 12% of new fathers) – first-time fathers whose child is still aged under one year, and want to know more about parenting and feel more involved. They are at the greatest risk of psychological distress, and
- 'The other side' (comprising 78% of new fathers) – the mainstream of experienced fathers, who look back on their inexperience and lack of preparedness from a standpoint of far greater confidence and comfort with their role as father.

[43] Based on a survey of 1,500 fathers, 16 discussion groups and an online forum with 23 new fathers.

The study found that new fathers experience a wide range of challenges as they transition into their new role, with many of these relating to disruption (lack of sleep, teething) or juggling (work and family commitments, finances). Many men try to absorb all this, believing they should 'man up' and get on with their new lives. The result is often high levels of stress – 57% of first-time fathers experience at least moderate stress in their child's first year of life. Most feel they cope well, assisted by their partner and their personal network of family and friends in particular, but around a third (32%) of first-time fathers have low resilience to stress. The outcome of widespread stress and often low ability to bounce back can result in psychological distress; 24% of new fathers scored high for their risk of depression/anxiety, increasing to 39% of first-time fathers with a child aged under one. Only 7% of fathers surveyed experienced a diagnosis during this early stage of fatherhood – suggesting a wide gap between need and service provision (Beyondblue, 2015).

A UK study by the National Childbirth Trust[44] found that almost two-fifths (39%) of new fathers were concerned about their mental health, and lack of support emerged as a key theme in a a recent UK-based qualitative study of first-time fathers (Baldwin et al., 2019), alongside a systematic review in which the authors set out a series of recommendations for how health professionals generally, and health visitors specifically, might better meet fathers' needs (Baldwin & Bick, 2019).

The one study we found of convicted male child harmers (Dickens, 2018) suggested that attending to paternal depression, promoting fathers' involvement in home visits (citing as an example the US-based Dads Matter intervention mentioned in Box 1, on page 35 of this report, and in Appendix 3) and more rigorous referral to child protective services, may be valuable.

Our review found no relevant UK interventions originating in, or drawing systematically on, mental health services (see Box 2, page 38 of this report). The need for more father-responsive perinatal mental health services has been recognised at a national level: in 2018 the NHS announced a Long-Term Plan promising to:

- increase access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis
- extend specialist perinatal mental health services from preconception to 24 (rather than the current 12) months after birth
- expand access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, *couple, co-parenting and family interventions*
- integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience, via maternity outreach clinics, and

[44] During 2013-2014, NCT's Research and Evaluation Department conducted a mixed-methods longitudinal research study of first-time mothers' and fathers' experiences and attitudes during the first two years following the birth of their baby. To understand more about life as a new first-time parent, NCT invited men and women to complete online questionnaires at two time-points: one during their baby's first year (6-9 months), the other one year later (18-21 months), following eight focus groups to inform the survey design. In total, 869 first-time mothers and 296 first-time fathers responded in full to the first questionnaire when their babies were on average eight months old: https://www.nct.org.uk/about-us/media/news/dads-distress-many-new-fathers-are-worried-about-their-mental-health.

- offer fathers/ partners of women accessing specialist perinatal mental health services and maternity outreach clinics an evidence-based assessment for their mental health, and signposting to support as required.

The proposed expansion in NHS perinatal mental health 'offer' seems to remain mother-centric, however, with only fathers whose wives/ partners are accessing mental health services, rather than ALL fathers, being eligible for support. The Royal College of Psychiatrists estimates that 5-10% of fathers experience mental health difficulties during the perinatal period (RCPsych, 2019), but latest evidence suggests mental health support for fathers remains rare (Williams, 2020).

Box 2. Mental health interventions: We found no UK interventions aimed at preventing or responding to fathers' maltreatment of children (including infants), that were based in mental health services (see Appendix 2).

We made an exception to our inclusion criteria to include one intervention trialled in the US, Parent-Child Interaction Therapy (**Group D: Non-perinatal Couple/Family Targeted**), which shows evidence of long-term reduction in physical abuse recidivism, albeit with parents of older children (aged 4 to 12). However, despite being cited as promising in many later reviews, the evaluation (conducted before our 2010 cut-off date) did not disaggregate results by sex of parent, despite more than a third (35%) of participating parent-child dyads including fathers (M. Chaffin et al., 2004).

Partner abuse services

Generally speaking, children living in families affected by partner abuse are reported to be at greater risk of experiencing neglect, physical and/or sexual abuse. An NSPCC prevalence study found that young people experiencing family violence were between 2.9 and 4.4 times more likely to experience physical violence and neglect from a caregiver than those young people not exposed to family violence (Radford et al., 2011). CAADA found that 62% of children exposed to partner abuse were also directly harmed, most often physically or emotionally abused, or neglected; in 91% of cases the perpetrator of the partner abuse (the father in 64% of cases, and the mother in 25% of cases) was responsible for the direct harm to the children (CAADA, 2014). None of this evidence relates specifically to father-perpetrated abuse of infants, although a coalition of organisations and professionals recently signed a joint letter to a key Government minister, calling for a strengthening of focus on babies in new proposed legislation on domestic abuse[45].

Our review found no clear (recent) evidence that partner violence plays a large role in father-perpetrated abuse of infants. If we *were* to assume an association between partner abuse and non-accidental injury to infants, how might we explain it? Some children may be injured whilst trying to intervene in episodes of partner-abuse or, in the case of babies and/or younger children, while being carried by the adult victim at the time of assault (Devaney, 2015). Spousal revenge may be a motive in some cases (Makhlouf et al, 2014); children (including infants) may also be killed in

[45] A letter organised by the First 1001 Days campaign and Institute of Health Visiting and co-signed by interested stakeholders, was due to be sent to Home Office minister Baroness Williams on 2 March 2021.

'collateral' murders (murders related to intimate partner conflict but involving the killing of someone other than the partner) (Dobash & Dobash, 2012)[46]. A more recent study from Norway (excluded from our Risk Factors Review (Chapter 2) because it related to fathers of older children (average age 4.5 years)) found that compared to non-abusive fathers, partner-abusive fathers rated themselves higher on anger, and as more likely to express anger aggressively toward their children. They scored poorly on measures of parental reflective functioning, and often showed limited ability to take the child's perspective; researchers suggested such men may use their awareness of their children's vulnerable emotions to punish or intimidate them (Mohaupt et al., 2019).

Hester's 'three planet model' argued that there are three planets in the safeguarding of children, namely 'child contact'; 'domestic abuse' and 'child protection' (Hester, 2011). Often, she suggested, the three planets do not intersect in their risk assessments, and professionals from each planet (family court professionals, independent domestic violence advisors and social workers respectively) work in silo, coming at cases from their own, often quite different perspectives. On the child protection planet, for example, the tendency has been to place responsibility for protecting the child on the person who is being abused (usually the mother), often with the direct or implicit suggestion that she must leave the relationship, as this is in the best interest of the children. There has been little focus on the perpetrator's behaviour, and very little - or no - accountability placed on him for the harm caused to the child.

Evidence about the impact of interventions aimed at improving outcomes in families experiencing domestic violence and/or substance misuse is mixed and generally weak (for a summary see (Asmussen, 2018)). Many domestic violence perpetrator programmes do not include a fatherhood element, but we found several interventions that do, including Caring Dads (which the NSPCC is no longer offering despite evidence of promising impact, for example social services closing 6% of cases, taking the child off the child protection register or protection plan in 13% of cases, and the child being returned to the parents' care in 3% of cases) and two interventions with a clear father-focus, For Baby's Sake and the Drive Project – the former a perinatal parenting intervention for couples where there is partner abuse. We have included more information about these approaches in Appendix 3, although the studies did not provide evidence of impact on fathers' perpetration of infant harm specifically.

Substance misuse services

In the field of substance misuse prevention, we found two relatively new interventions in the UK, Parents under Pressure and the Family Drug and Alcohol Court, which are working more supportively and assertively with families that may include 'risky' men, and which seem to have the potential to recognise their aspirations to become better partners and fathers while simultaneously putting children's and mothers' safety centre stage. We have included more information

[46] In these collateral murders, a third of which involved infants under the age of 1, the violence was usually directed solely at the child, but the conflict was associated with various forms of anger or resentment of the woman in relation to the child, such as the time/attention spent on the child instead of on the perpetrator; annoyance at childcare duties; and anger/jealousy of children by another man.

about these approaches in Appendix 3, even though the interventions and evaluations focus mostly on mothers, and there is no specific data about impact on fathers' perpetration of infant harm.

As with the partner abuse interventions mentioned above, we have included these because they may be helpful 'touchpoints' for the development of more closely targeted, father-inclusive infant NAI prevention programmes in future.

Box 4. 'Other risk factor' interventions (domestic abuse and substance misuse): We found five interventions (see Appendix 3) that seek in various ways to exploit the potential for direct and indirect work to engage with and influence **domestic abuse perpetrators** not just as husbands/ partners but also as fathers/ father-figures, challenging them to learn non-violent behaviours and ways of thinking partly for the benefit of their children. One, For Baby's Sake, appears in **Group B: Perinatal Couple/Family-Targeted**; the other four (Caring Dads, Community-based Domestic Violence Perpetrator Programmes, the Drive Project and a US-based intervention, Fathers 4 Change) are in **Group E: Non-Perinatal Father-Targeted**. They are not specific to fathers of infants, but none would restrict eligibility for such men. We also found two interventions, Parents Under Pressure (**Group B**) and The Family Drug and Alcohol Court (**Group D: Non-Perinatal Couple/Family Targeted**) exploring new ways of impacting favourably on parental substance misuse. None of these interventions reported impact data specific to non-accidental injury of infants.

Section 2. Improving our response to potential infant maltreatment by fathers and father-figures

In this section we summarise what the evidence from our review suggested about how safeguarding services might be made more effective.

We have synthesised the evidence we found into five themes.

Theme 1. Designing more father-inclusive interventions and research

Working with fathers and testing what works

Most of the interventions in our review were designed to be couple- or family-targeted. In practice, however, while the nomenclature often suggested otherwise through the use of the word *parent*, professionals worked mostly with *mothers*. Even where fathers were invited to be part of, or otherwise involved in, the intervention, they were often side-lined in the evaluation, making it difficult or impossible to assess whether the intervention was effective with fathers[47]. Sometimes it was clear from an evaluation that fathers had been entirely left out of the intervention design, even where the aim of the programme was to influence an outcome where they are disproportionately implicated as possible perpetrators, for example Surviving Crying (Bamber, 2019). There were exceptions to this pattern, such as All Babies Cry (Morrill et al., 2015) and Family Foundations (Feinberg et al., 2016). Sometimes it was clear that programme designers and/or evaluators recognised their failure to build in father-inclusion. Responses to this ranged from reporting father non-participation, to creating 'bolt on' research elements designed to explore fathers' experiences. Programme commissioners could pay more attention to designing new interventions specifically for fathers as well as mothers; to adapting materials and approaches for a paternal audience; and also to 'bringing fathers in' to existing approaches[48], both because of the benefits this might bring in terms of child and other family outcomes (couple-focused interventions tend to be more effective) and because father-engagement can maximise mothers' retention in programmes (CFRP, 2017).

In the one study we found which directly explored child-harming fathers' experiences and beliefs (through interviews with 20 convicted male perpetrators of severe physical abuse to young children ('child harmers'), and a comparison group of adult harmers), the author reported that the 'child harmers' had low self-esteem and anxious and avoidant attachment styles with adults, and suspicious thinking. The author suggested that child harmers' empathy with babies may be overridden at the time of abuse by feelings of rejection by the baby, underpinned by poor understanding and misinterpretation of infant behaviours like crying. It is possible

[47] We took an inclusive approach when deciding whether or not to include interventions in our review, in order to present as broad a view as possible of the range of approaches on which father-inclusive interventions with the potential to impact on infant maltreatment, might be developed; if we had taken a stricter line and insisted on interventions with a clearly enunciated father-inclusive design, delivery and evaluation, the number of interventions in Appendix 3 would have been dramatically reduced.

[48] http://www.fatherhoodinstitute.org/2016/bringing-fathers-in-resources-for-advocates-practitioners-and-researchers/

that fathers with such perspectives and gaps in knowledge could be identified by health professionals within universal services, and be addressed through additional support and/or referral to appropriate mental health professionals - although it is also the case that some risky men may 'pass' as non-risky by 'saying the right things' (Dickens, 2018). For now – until found, through evaluation, not to be effective – such a 'best guess' approach is probably the best idea around.

Our review found evidence from small-scale evaluations, that fathers' experiences can be impacted – including in relation to outcomes relevant to infant maltreatment risk – by universal interventions. We found three interventions, Dads Matter (Guterman, 2018), Hit the Ground Crawling (Fraser, 2010) and the DADS Family Project (Cornille et al., 2006), whose goal was to support *any* father, rather than a father already identified as presenting risk, to make sense of his fatherhood role and build confidence as a hands-on father. These interventions have been evaluated in small-scale, time-limited pilots and suggest favourable outcomes relevant to the reduction of child harm risk. Only one, Hit the Ground Crawling – itself adapted from a US intervention, Boot Camp for New Dads[49] – is based in the UK. To be effective with fathers, interventions do not need to be father-only: couple-based transition to parenthood programmes that target the co-parenting relationship, like Family Foundations, can reduce parents' individual psychological distress, parenting stress, and harsh parenting behaviours, for example (Feinberg et al., 2016).

Making universal services father-inclusive

To attempt to reduce father-perpetrated deaths through a policy of forensically identifying the tiny proportion of fathers or father-figures who might potentially harm their infants, in order to prevent them from doing so, would not be an easy task in a context of equal access to services for fathers and mothers. Such a job is rendered much more difficult by perinatal and other family services' apparent exclusive focus on the mother-child relationship. There is no mandated engagement with fathers in universal perinatal care, and an associated failure to routinely record the details of men not engaged, and to follow them up. This acts as a significant obstacle to comprehensive safeguarding practice. Health professionals operating within a rigorous system that expected and actively pursued engagement with all fathers, might readily identify and flag instances of non-engagement, and these might be viewed as indicative of potential risk (especially, for example, where a father or father-figure was evasive, and/or a mother uncooperative). Such a system could also help build a stronger evidence base around risk factors for fathers' perpetration of infant harm. Current research is hampered by a lack of data in case files, especially about fathers' characteristics and circumstances (see Chapter 2).

The lack of a strong focus on fathers in UK public services is longstanding, and for every step forward in national-level policy guidance, for example Public Health England's inclusion of fathers in its proposed perinatal pathway for health visitors (PHE, 2018), there is a step back, a recent and major one being the National Institute for Health and Care Excellence's omission of key evidence about fathers

[49] Boot Camp for New Dads has been running since 1990 and is now offered in 44 US states, on military bases and in Canada. Although some evaluation data exists, it does not focus on child maltreatment related outcomes (for more information see Appendix 3 and https://www.bootcampfornewdads.org/.

and mothers' partners when developing its new draft guideline for postnatal care[50]. Strong leadership from politicians and key policymakers at a national level would be required to help shift this culture of ambivalence. Recent interest in improving perinatal mental health provision – including, to some extent, fathers' – is encouraging, although even this is focused only on fathers whose partners are experiencing mental health problems, rather than forming part of a universal offer for men in recognition of their transition to fatherhood. The last time the UK government showed a clear commitment to encouraging father-inclusive practice, investing in coordinated research, guideline development and sharing of best practice was in 2008, via the then Department for Children, Schools and Families' *Think Fathers* campaign (Thomas, 2013). More recently, in 2016, the Scottish Government funded *Year of the Dad*[51].

The simple fact of systematically engaging with large number of fathers within universal perinatal services, and opening up lines of communication with them, could provide professionals with opportunities to spot men who seem to be struggling, disengaged or potentially dangerous, and men whose absence is a cause for concern. Almost all the evaluations we found of father-targeted interventions, in the UK and elsewhere, had a focus on reducing violence among men already identified as having perpetrated violence of some form (including partner and child abuse), suggesting that currently, services only start caring about fathers once they are demonstrably problematic.

Local, online and unevaluated interventions

Beyond the interventions listed in Appendix 3, our review found a small number of other UK-based, father-targeted interventions that aim to support men during their transition to fatherhood, and which may directly or indirectly impact on infant maltreatment risk – but which exist outside mainstream services and have not been evaluated[52]. Virtual support via websites and apps[53] is also a growing area but again, we found no impact evaluations – and the lack of one-to-one professional assessment and interaction suggests they should not be overly relied upon.

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[50] The NICE postnatal care guideline, currently under development, is expected to be published in April 2021 https://www.nice.org.uk/guidance/indevelopment/gid-ng10070. Further detail on the omitted evidence is available in the Fatherhood Institute's consultation response (unpublished but available from the authors).

[51] https://www.yearofthedad.org/

[52] These include Dad Matters, an initiative developed by the charity Home Start, which offers antenatal groups for fathers in Greater Manchester: for more information see https://dadmatters.org.uk/antenatal-groups/. Dad Matters has recently expanded into Gloucestershire in a pilot partnership with maternity services: https://homestartnwglos.org.uk/home-start-to-launch-county-wide-project-to-better-support-dads-in-gloucestershire-during-their-childs-early-years/.

[53] Examples include DadsMatterUK, a website which aims to provide information and support for fathers worried about or suffering from depression, anxiety and post-traumatic stress sisorder (PTSD) and signpost them to seek help from their doctors: https://www.dadsmatteruk.org/; The Dads Net, an online community which describes itself as being "for dads who understand that the journey of fatherhood has its ups and downs and once you embark on this journey, life will never be the same" https://www.thedadsnet.com/; and DadPad, which offers a 38 page physical guide, with accompanying app, to support fathers to "gain the confidence and skills necessary to be the very best dad you can be". Dad Pad was created by a social enterprise in Cornwall, with input from NHS clinicians; a neonatal version is also available: https://thedadpad.co.uk/about-us/.

Theme 2. Strengthening the focus on non-accidental injury to infants (including by fathers)

The UK Government has set out clearly, in guidance, how professionals working in a multitude of agencies should be prioritising and working to reduce child maltreatment, including physical injury of infants. However, in our review we found few interventions clearly and explicitly targeted at NAI reduction in the perinatal period, and those that do exist lack a clear father-focus. We found UK evaluations of two universal AHT/SBS prevention programmes, both quite small in scale and designed/ evaluated without considering effectiveness with fathers, despite evidence that they present disproportionate risk. None of the other couple- and family-focused interventions were targeted squarely on reducing maltreatment, rather aiming to provide 'support' of various kinds to vulnerable mothers (and to a greater or lesser extent, their partners) affected by 'toxic trio' risk factors, with an assumption made that alleviating the problems caused by mental illness, partner abuse and/or substance abuse, might result in reduced maltreatment risk to children (including, presumably, but this was often not made explicit, infants).

Such programmes may result in important and life-changing impact but their effects on infant maltreatment are usually unclear, or explored via self-report; they are also, often, driven by a mixture of clinical priorities, competing for practitioners', participants' and evaluators' attention. In some cases evidence of impact is disappointing, as in the case of Family Nurse Partnership (Robling, 2015). A twin lack of focus on child maltreatment reduction, and on father-involvement in the design, delivery and evaluation of the programme, may be partially responsible for the ongoing lack of evidence about 'what works'[54]. Unless maltreatment reduction is defined and communicated as the primary goal of an intervention, efforts to solve that problem may get lost along the way; and we cannot know if interventions are likely to have a useful impact on with potential male perpetrators if they are not delivered to men, and their impact with men specifically evaluated.

To be included in our review, interventions needed to report at least some outcome data of relevance to the reduction of infant maltreatment, but in many cases the measures used were indirect in nature, for example involving parents' self-reporting of parenting stress, confidence or child abuse risk. This is partly a problem of working in a field where it is difficult to objectively measure impact on an individual level (to find out whether a parent is going to kill or harm their child one might train a camera on them 24 hours a day, and even then one might miss the signs of an imminent attack - or momentary 'lapse of reason' - in time to prevent the harm). Attempts to measure population-level impacts of AHT/SBS prevention programmes in the US and Canada have so far produced mixed results (Barr & et al., 2018; Mark S. Dias et al., 2017). This may result in part from programmes not being father-focused or father-inclusive, and if Governments, commissioners and providers of family services wish to explore how best to prevent or reduce infant harm by fathers

[54] In a recent blog referring to a new evaluation of Family Nurse Partnership, published since our review, argues that the programme may need testing and adapting to improve child maltreatment outcomes, but that 'we also need a wider effort to find out what works for children at risk of experiencing maltreatment': https://www.eif.org.uk/blog/worth-the-wait-new-evaluation-data-shows-positive-impacts-of-family-nurse-partnership-on-school-readiness-and-attainment?s=09.

they will need to design and evaluate interventions and approaches that focus on influencing and measuring impact on, relevant and specific outcomes for the population in question (that is, infants).

Theme 3. Using fatherhood as a motivator for change

Changing the most challenging fathers' behaviours is likely to require a blend of approaches aimed at supporting their *intrinsic* motivation to change, while simultaneously activating *extrinsic* motivations to help bring that about. A review conducted for Department for Education which looked at how social workers might best assess the capacity to change of parents whose children were 'on the edge of care', referred to 'turning points' as key to success in delivering behavioural change (Ward, 2014).

A study of perpetrator programmes for fathers who are violent towards their partners described *intrinsic* motivation as being more closely associated with greater long-term behaviour change. Men with greater intrinsic motivation wanted to control their behaviour and change their lives. However these internal motivations often occurred in response to external stimuli: sometimes the men were often motivated by a desire to secure access to their children (hitherto threatened); to avoid losing their children to the care system; or to free their family from the scrutiny of children's services (Stanley et al., 2012). Sometimes the motivation might come from simply becoming a father: a transition which might act as a 'golden moment' when fathers are most readily available for professional interventions, and women most want them involved[55]. This is a period where men's intrinsic motivation to change any unhealthy and/or dangerous behaviours may at its highest. Following the birth of a first biological child, men's crime trajectories have been found to slow, and use of tobacco and alcohol reduce, for example (Kerr et al., 2011).

However, the recent evidence on risk factors (see Chapter 2) points to father-perpetrated harm to infants not being straightforwardly a question of 'parenting gone wrong' (Dickens, 2018), and it must be acknowledged that in some cases, pursuing a strategy of supporting a man to become a better parent may simply be too risky. By systematically assessing men's potential risk early in the antenatal period and being persistent in pursuing and connecting with men in and around families, services would be in a stronger position to take decisions to maximise infants' safety (e.g. via care proceedings) before it is too late.

Theme 4. Developing systematic father-inclusion in child protection practice

Studies exploring how fathers have been engaged and dealt with by child protection agencies, including when things have gone wrong and children have died (see Appendix 3 for more details), suggest several key areas where such work could be improved in ways that could help them identify, remain in contact, and work more successfully with, fathers. These include:

[55] National Fatherhood Initiative: https://www.fatherhood.org/fatherhood/the-golden-moment-to-engage-dads.

- Engaging fathers – being respectful, honest and direct; making clear that you are putting the child's interest first; being flexible, available and reliable
- Finding absent fathers – being persistent, curious and precise; challenging the mother's non-compliance when she is 'gatekeeping' information about father-figures; pursuing as many fathers/father-figures – and other key informants – as are needed to build a complete picture of the child's reality; contacting GPs, who are the most likely to hold information about a father; contacting all other professionals around the child and family and, where necessary, other agencies including the local authority, Child Support Agency, Inland Revenue
- Assessing men – aiming to involve fathers in direct work (if safe) and to support marginalised men to be a better resource for their child; taking time to listen to him and aim to help him develop parenting strategies and ways of dealing with anger; using strengths-based approaches; exploring his role in maltreating or protecting the child, his views on any safeguarding/child protection concerns and what he might have done to prevent the issues occurring, how he perceives the emotional and developmental needs of the child and his views on discipline, aggression, anger and controlling or manipulative behaviour.
- Dealing with violent men – making sure there is a safety plan for the child, mother and practitioner; being clear that violence against the child and its mother is unacceptable; respecting a man's desire to change and try to provide appropriate interventions to help him do so – ideally with a programme that addresses his role as a parent.
- Engaging men in child protection processes – trying to build up a full picture of the case, allowing for the man to be treated fairly, and keeping him involved in child protection plans and conferences.
- Supporting social workers – ensuring practitioners are well supported through supervision and training, because abusive men can be manipulative and couple-work complex and draining; staff need clear guidelines and frameworks to work within, including well-established links with criminal and family courts, probation, voluntary services and the police.

Training for senior and line managers in child protection services, as well as for frontline practitioners, may help improve their understanding of fathers' importance for child and maternal outcomes; challenge negative attitudes; and support them to develop more effective approaches to reaching and responding to men as a risk and resource[56]. Three small-scale evaluations of staff-training-based interventions that took place in the UK in the early part of the 2010s, each aimed at supporting service managers and/or front-line workers to 'think men' when designing, developing, implementing and evaluating services, strategies, approaches and specific interventions, found evidence of positive change; two were focused on training staff within child protection services (CYPNow, 2015; Scourfield et al., 2012) and the other was focused on health visitors (Humphries, 2015).

If child protection services and the Police were known to engage routinely, confidently and systematically with *men as fathers*, this could maximise the potential to identify and respond effectively to *potential child-harming men* (and ensure the

[56] Methods such as motivational interviewing and family group conferences may be helpful: https://lx.iriss.org.uk/sites/default/files/resources/Engaging%20with%20fathers%20-%20men.pdf

safety of any infants, other children and adults around them) and send *non-violent* men (including, but not just, those within the same family) the message that if they were to raise genuine concerns about a mother's new partner, for example, they would be taken seriously.

Theme 5. Improving information gathering/ analysis and assessment

In Chapter 2 we noted that a lack of information and fields about father/ couple 'risk factors' in case records and administrative data systems contributes to the lack of recent research we found on risk factors for father-perpetrated abuse of infants. Midwives routinely gather data from the pregnant woman about her family circumstances, which can include potentially useful information about her partner[57]. This could be improved[58], however, and gathering data directly from the expectant father could allow for more accurate data collection, as well as forming the basis of a one-to-one practitioner-father relationship. Particular efforts could be made to engage directly with him when vulnerabilities in the mother (and/or in the father) are identified: these would include learning difficulties, poor maternal/ paternal mental health, involvement in the criminal justice system, substance misuse, domestic abuse, ambivalence towards the pregnancy (either parent), a transient or chaotic lifestyle, multiple partners (either parent), frequent house moves or overall social isolation (Sidebotham et al, 2016: 56); recent job loss or house repossession (Dickens, 2018).

Birth registration is another 'touch point' at which data on fathers is collected – on 95% of them, in fact, because 95% of new parents register the birth of their baby jointly. Markers of risk that could be identified at this point include birth registration by the mother alone, young age of mother or father, unstable housing or employment (or no employment), mother and father living at separate addresses. While none of these is sufficient on its own to suggest definitive risk, a cluster of such indicators could be useful to responsive services if birth registration data was easily accessible.

In early childhood services it is important that when an infant or young child is registered, these services record, as a matter of routine, the names and contact details of all adults who regularly provide care to that child. Included among them will be biological fathers, and also non-biological fathers/ mothers' boyfriends. Many of these men will not present themselves to the service, but this does not mean they do not exist, nor reduce their potential impact – positive and/or negative – on their children. While it is rare for a woman to have a new partner by the time of the birth, 10% of women who are unpartnered when their first child is born re-partner within the first year (Harkness, 2018). These women are often young and economically

[57] Name, contact details, employment and citizenship status, mental health, some family medical issues and genetic testing. Mothers are asked about substance misuse in the household but not in relation to her partner specifically. There are questions on family violence.

[58] Subjects NOT asked about, which could reveal vulnerabilities significant to the whole family, include the father's mental health, substance use, housing circumstances, welfare benefits, education, disability, diet, exercise and physical health. Space on the form is only available to record the pregnant woman's questions/ comments, and notes on her employment rights and benefits, healthy eating, home safety, parent education, and parent/ infant communication.

vulnerable and – crucially - their new partner is especially likely to be missed by perinatal and other services, since he has entered into a relationship with the mother once the baby is already born, and so will have missed key engagement opportunities. At this early stage such men represent a tiny but minority of all fathers/ father-figures, but a potentially important one for the purposes of the current review[59].

As described above (see pages 36-38 of this chapter, and the Risk Factors Review (Chapter 2)), while evidence on the links between fathers' mental health and father-perpetrated abuse of infants is mixed, it is clear that understanding a father's capacity to care, learn and enjoy his new child will be key to any intervention that aims to assess whether he is safe, and/or to influence his parenting behaviour. To assess fathers' depression, the Edinburgh Postnatal Depression Scale, a standard tool used with new mothers, has been validated for use with fathers. There is no consensus on optimal scores for depression and anxiety, which vary across studies (Cameron et al., 2016; Massoudi et al., 2013). It has also been argued that expression of paternal perinatal depression (PPND) differs from its maternal equivalent, since males tend to display emotional suffering through externalizing and behavioural symptoms rather than typically depressive-like responses. PPND may occur along with other disorders whose symptoms may overlap or mask it, including anxious disorders, abnormal illness behaviour, behavioural acting outs, and addictions. This has led some to suggest that the term PPND be replaced with 'paternal perinatal affective disorder', and that a new scale Perinatal Assessment of Paternal Affectivity (PAPA) be used (Baldoni & Giannotti, 2020). Other tools may also be helpful[60]. Professional consensus on how best to measure parental mental health in the perinatal period is needed, therefore, alongside – perhaps even more importantly - *offence-specific guidance* for father-perpetrated physical abuse of infants, taking into account family, community and individual factors; such guidance has proved valuable in other contexts, including child sexual abuse and partner abuse[61] (Dickens, 2018).

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[59] Children's Centres could make a helpful contribution towards tracking them down. A national evaluation of English Children's Centres found that among women presenting as lone mothers (around 20% of the total) at centres in the most disadvantaged areas, almost four-fifths (77%) said their children were in 'regular' contact with the father (Maisey et al., 2013). Another study found that in the early years, few fathers live apart from their child and their child's mother, and that among those who do, only a tiny percentage are not in regular contact (Haux et al., 2015). Early years providers' father-engagement is generally poor, but could be improved with targeted redesign (Clapton, 2017).

[60] These may include the Gotland Male Depression Scale, Masculine Depression Scale (Magovcevic & Addis, 2008) and Male Depression Risk Scale (Rice et al., 2013) may be helpful, but were not designed for the perinatal period. Clinicians developing a fathers' mental health service in Hampshire report[60] that they are likely to use the four-item Patient Health Questionnaire-4, which has been found to be effective in the general population and with pregnant women (Rodriguez, 2020). We found two studies from outside the UK exploring the development of wider assessment tools for expectant and new fathers. In the US, the Pregnancy Risk Assessment Monitoring System (PRAMS), a joint research project between the state departments of health and the Centers for Disease Control and Prevention, Division of Reproductive Health, was developed in 1987 to reduce infant morbidity and mortality by influencing maternal behaviours before, during, and immediately after pregnancy. Building on this model, researchers are testing a 'PRAMS for dads' system through a pilot involving 500 recent fathers in the state of Georgia (Garfield et al., 2018).

[61] These include, for example, Professor Jane Monckton-Smith's Intimate Partner Homicide Timeline: https://janems.blog/2020/12/18/ipht-training/#more-1171

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Chapter 4. Conclusion

Every child death is a tragedy, and preventable ones even more so. As such, the non-accidental injury of infants by fathers and other informal male caregivers – including those that do not result in death - is a serious cause for concern.

As outlined in both our reviews above, the general lack of attention to fathers in research and practice has made this a challenging review, because one of its effects is a lack of data on which to draw firm and useful conclusions.

On the subject of **scale**, our review found that between 2000 and 2015 in England and Wales, an average of eight infants per year were killed by a homicidal father (including 'stepfathers'). Of these, 31 (25%) were killed as a result of shaking.

Fathers are no more implicated in infanticide than are mothers, but the *types* of infanticide do seem to differ in international data:

- Parental neonaticides (homicides within 24 hours of birth) are almost exclusively perpetrated by biological mothers.

- Fathers outnumber mothers as perpetrators of abusive head trauma (AHT), including those that result in deaths. The great majority of children killed or injured in this way are infants.

Biological fathers outnumber 'stepfathers' among father perpetrators of physical abuse of infants. For older babies and pre-school children (aged 1 to 5 years) the ratio of stepfathers to biological fathers evens or reverses.

Fathers kill more infant sons than infant daughters, although the difference is small.

On the subject of **risk**, overall we found sparse and weak recent evidence on potential risk factors for father-perpetrated infanticide or severe physical abuse of infants, including the risk factors on which interventions are based, such as mental health, partner violence and responses to infant crying (see below). There is a clear need for more research to fill these evidence gaps.

On the subject of **safeguarding services**, we found that a wide range of services, including perinatal and other universal services; mental health services; child protective services, social work and specialist/targeted services; are mostly mother-centric in their approach. They therefore miss opportunities to identify and work with men who may present a danger to infants. Interventions that may have the potential to prevent or reduce harm to infants by fathers tend not to be designed, delivered and/or evaluated with fathers and other male caregivers in mind. Often their aim is to address factors that are theorised to impact on child maltreatment risk, but for which evidence is sparse and weak.

There is, therefore, very limited evidence on 'what works' to prevent non-accidental injury of infants by men – even where, as in the case of interventions aimed at

reducing the prevalence of abusive head trauma/ shaken baby syndrome, it is very clear that fathers are an important target group.

More father-focused and father-inclusive universal and specialist services, with a stronger focus on reduction of non-accidental injury, and on father-engagement as early as possible in the perinatal period, may prove more effective in their prevention of, and response to, male perpetration of harm to infants.

In order to be in a position to deliver maximum impact, such services would need to be underpinned by improved identification, engagement and practice with fathers – and to be evaluated in ways that disaggregate effects by gender.

Appendix 1 – Search strategy

Appendix 1A - New searches of bibliographic databases

The main search was made of three concept sets:

1. **Non-accidental injury/ Physical abuse/ Filicide**
2. **Infants/ Children under 2**
3. **Fathers and informal male caregivers**

These were combined with **AND** before limits were applied.

Principles:

- Free text terms in title/ abstract/ author's keyword (or equivalent fields) but not full text.
- Database-specific subject headings relevant to each concept. Those which are not specific to physical abuse, fathers/ male caregivers (of children) or infants were excluded – for example, child abuse, child neglect, child welfare, violence, crime (eg homicide, assault/ offenders/ perpetrators), men/ male, preschool, early years/ early childhood/ young children, perinatal (ie both antenatal/ postnatal), parents (ie both mothers/fathers).
- Humans limit in selected databases
- Publication Date limit 2004
- English language limit if available

The following syntax for each concept was adapted for different database providers e.g. adjacency, phrase searching, wildcards, hyphenated terms. It was developed in EBSCO databases.

1. Non-accidental injury/ Physical abuse/ Filicide concept

Subject headings / thesaurus / index terms (database-specific): "Physical abuse"; Filicide; Infanticide; "Battered child syndrome"; "Shaken baby syndrome" "

Free text terms:

TI AB KW (author supplied KW).

(("non accidental*" OR nonaccidental* OR deliberate* OR abus* OR inflict* OR unexplained OR intentional* OR "non natural" OR unnatural OR "un natural") N3 (injur* OR wound* OR mistreatment OR maltreatment OR harm OR trauma* OR death))

(maltreat* OR battering) N3 (injur* OR wound*)

"physical* maltreat*" OR "physical* mistreat*" OR "physical harm"

("non accidental*" OR nonaccidental* OR deliberate* OR abus* OR inflict* OR unexplained OR intentional* OR "non natural" OR unnatural OR "un natural" OR maltreat* OR battering) N3 ("sudden infant death*"OR "sudden unexpected death*" OR "cot death")

"physical* abus*" OR "physical* punish*" OR "physical* child* punish*" OR "corporal punish*" OR "corporal child* punish*" OR "physical* disciplin*" OR "physical* child* disciplin*"

"battering parent*" OR "battering caregiver*" OR batterer OR "shaken baby" OR "battered child*" OR "child battering"

TI AB KW

(Shake OR shaken OR shaking OR Suffocat* OR smother* OR Strangle* OR strangulat* OR Tortur* OR cruelty OR assault* OR ((fire OR fires OR firearm*) NOT firefighter*) OR Battered OR drown* OR poison* OR burn OR burns OR burning* OR scald OR scalds OR scalding* OR fracture* OR bruis* OR beat OR beats OR beaten OR beating* OR hit OR hits OR hitting OR slap OR slapped OR slapping OR smack OR smacked OR smacking OR starv* OR spank OR spanked OR spanking OR ((bite OR bitten OR biting OR bitemark*) NOT animal NOT nail NOT tail))
AND
(abuse* OR abusive OR maltreat* OR mistreat* OR "non accidental" OR nonaccidental OR deliberate OR abusive OR inflicted OR unexplained OR intentional OR "non natural" OR unnatural OR "un natural" OR abusing OR "social work*" OR "social services" OR "child protection" OR "child cruelty" OR "child protective services" OR "social case work")
Filicid* OR Murder* OR homicid* OR kill OR killing* OR kills OR killer* OR killed OR manslaughter OR infanticid* OR neonaticid*
fatal* child* (maltreat* OR abuse OR mistreat* OR harm*)
"maltreatment death"
"abuse death"
"battering death"

All fields (not full text)
"serious case review*" OR "serious safeguarding incident*" OR "serious child safeguarding incident*" OR "fatality review board*" OR "child death review*" OR ""serious child safeguarding case*"

Combine all lines with OR
Apply limit in all fields at the end of this concept:
NOT killer N3 cell at the end of this concept

2. Infants/ Children under 2 concept
Subject headings / thesaurus / index terms (database-specific): Neonatal; Infancy; Infant; Newborn
Free text terms:
TI AB KW
baby OR babies OR infant OR infants OR infancy OR neonat* OR newborn* OR postnatal OR "post natal" OR perinatal OR "peri natal" OR postpart* OR "post part*" OR "post birth" OR postbirth OR "after birth"
"child* under one" OR "child* under 1" OR "child* under age one" OR "child* younger than one" OR "age* 0-1" OR "age* 0 to 1" OR " age* between 0 and 12 months" OR " age* between 0 and 24 months" OR " age* between 0 and 18 months" OR "age* 0-12 months" OR "age* 0-24 months" OR "age* 0-18 months" OR "age* between 0 and 1 years" OR "age* between 0 and 2 years"
("under one year*" OR "under two year*" OR "under 1 year*" OR "under 2 year*" OR "under 12 months" OR "under twelve months" OR "under 24 months" OR "under twenty-four months" OR "under twenty four months" OR "under 18 months" OR "under eighteen months") N5 (age* OR old OR child*)
"child* under two" OR "child* under age two" OR "child* younger than two" OR OR "age* 0 to 2" OR "child* age* 1" OR "age* 0-2" OR "child* age* one" OR "age* one" OR "one year old*" OR "age of one"

"child's first year”
“child’s second year”
“first year of life”
“under-1-year* age-group” OR “under-2-year* age-group”
toddler*
“new father*”
“new parent*”
“first time father*” OR “firsttime father*”
“transition to fatherhood” OR “transition to parenthood”
“pre mobile” OR premobile
“pre-ambulatory child” OR “preambulatory child”

Combine all lines with OR

3. Fathers/ informal male caregivers concept
Subject headings / thesaurus / index terms (database-specific): Fathers; "Adolescent Fathers"; "Single Fathers"; “Father Child Relations"; "Expectant Fathers”; ”Father-infant relations”; “Paternal attitudes”; “Paternal behaviour”; "Father-child relationship"; "Father-daughter relationship"; "Father-infant relationship"; "Father-son relationship"; "Fathers' attitudes"; Husbands; Brothers; (Human males AND Caregivers); (Men AND Caregivers); “Father figures”; “Male caregivers”
Free text terms:
TI AB KW (Author supplied KW)
father* NOT (“founding father*” OR “holy father”)
dad OR dads
“male parent*”
patern* NOT paternalis*
stepfather* OR “step father*”
grandfather* OR “grand-father*” OR granddad* OR “grand-dad*”
“maternal gatekeep*”
“blended famil*”
stepfamil* OR “step-famil*” OR (step N2 famil*)
stepparent* OR “step-parent*”
(“non custodial” OR noncustodial OR “non resident” OR non-resident* OR “non cohabiting” OR noncohabiting) parent*

“separated parent*”
(gay OR homosexual) N3 parent*
“hidden men”
“absent* parent*”

TI AB KW (author supplied KW field)
“both parents”
(Mother* OR parent*) AND (spouse OR partner OR cohabitee)
Husband* OR Boyfriend* OR Expartner* OR exboyfriend* OR “ex-husband*” OR “ex-partner*” OR “ex-spouse” OR exspouse*
“former partner*” OR “former cohabitee” OR “former spouse”
“multiple partners”
Brother OR brothers OR uncle OR uncles

(Men OR male) AND (lodger* OR flatmate* OR babysitter* OR “baby-sitter*” OR aupair* OR “au-pair*”)
(Men OR male) N3 (“family friend*” OR neighbo#r* OR “family member*” OR relative* OR cousin*)
“male carer*” OR “male caregiver*” OR “male guardian*” OR “male primary caregiver*”
men AND “parenting responsibilit*”
“secondary caregiver*”
“male friendly” OR “male inclusive” OR “engaging men” OR “assessing men” OR “working with men”
“male perpetrator*” OR “men as perpetrators”
“male member* of the family”
“men in families”
“men who kill*” OR “men who batter*” OR “men who murder*” OR “men who have kill*” OR “men who have batter*” OR “men who have murder*”

Combine all lines with OR
Combine three concept sets with AND

Appendix 1B – Additional search for research reviews

The additional search for research reviews was made of six concept sets:

1. **Non-accidental injury/ Physical abuse/ Filicide – as above**
2. **Infants/ Children under 2 – as above**
3. **Fathers and informal male caregivers – as above**
4. **Safeguarding**
5. **Risk factors**
6. **Research reviews**

Safeguarding concept
Free text terms:
TI AB
“social services” OR “social care” OR “social work*”
safeguard* OR “child protection”
(maltreat* OR mistreat*)
((deliberate OR serious OR severe OR abusive OR intentional) N6 harm)
(abuse* OR abusive OR abusing)
“social case work”
“abus* behavio#r*”
“child cruelty”
“child protective services”
“abused child*”
“abusive parenting”
“abusive discipline”

‘Risk factors’ concept
Free text terms:
TI AB
“risk profile”

“risk factors”
“risk profiling”
“risk ratio”
“odds ratio”
“correlation coefficient” OR “regression coefficient” OR correlate*
“statistical association*”
“statistically associated”
“statistical determinant*”
“factors associated with”
“predictive factors” OR “factors predicting” OR “predictor variables” OR predictor*
“at risk of”
“protective factor*”
“psychosocial factor*”
demographic*
“perpetrator characteristics”
“causes of”
“patterns of”
background*
history/ histories
antecedents
epidemiologi*
“gender differences”
“longitudinal stud*”
“cross-sectional stud*”
“retrospective stud*”
“panel stud*”
“prospective stud*”
“case comparison”
“case-control” OR “case control”

Research reviews concept

Free text terms:
TI AB
“evidence review”
“(review OR overview) of the literature”
(review OR overview) ADJ (literature OR research OR evidence)

"systematically review" OR "systematic review"

meta-analy* OR metaanaly* OR "meta analysis" OR "meta analytic" OR "meta-analyse"

"research synthesis"

"correlates review"

"systematic synthesis"

"systematic overview"

"systematic evidence assessment"

"literature review"

"review of studies"

"review studies"

"scoping review"

"rapid review"

"rapid evidence assessment"

"narrative review"

"narrative synthesis"

"(bibliographic OR electronic OR literature OR library) databases"

"systematic search"

Concepts combined as follows -

(Fathers/Informal male caregivers OR Infants/Children under 2) AND (Non-accidental injury/Filicide/Physical abuse OR Safeguarding) AND Risk factors AND Research reviews

Appendix 1B - The Fatherhood Institute's Literature Library

The Fatherhood Institute has compiled and maintains a comprehensive online Library of research on fathers and fatherhood in the UK from 1998 to the present day, information from which can be shared with other researchers.

The electronic FI Literature Library[62], held in Endnote software, incorporates keyworded references (with abstracts and full texts where available) for UK[63] research, international research reviews and research methodology papers on fathers, mothers' partners, grandfathers and inter-parental relationships, on any topic. It is based on systematic searches of eleven bibliographic databases[64],

[62] See the FI Literature Library Methodology report (Davies, Goldman and Burgess, 2017) at http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Methodology-PDF.pdf

[63] Based on data collected (fieldwork/ sample) wholly/ partly in the UK, or reporting UK-specific data.

[64] These **eleven bibliographic databases** were searched in 2014 and 2019:

carried out in summer 2014 for the date range 1998-2014, and in autumn 2019 for the date range 2014-19. For these searches, we used a 'father concept' search strategy, with synonyms and related terms (see Davies et al, 2017).

By hand, we systematically screened the titles and abstracts of all search output against inclusion criteria for the FI Literature Library until we were confident that we had identified all the research studies of UK fathers/ fatherhood/ inter-parental relationships. We coded reasons for exclusion. This followed a pilot screen by three researchers of the same references, at the end of which we had achieved over 95% agreement on whether a reference should be included or not.

From 2014, on an ongoing basis, we have added by hand relevant records identified through expert searches and contacts, social media, and organisational alerts and newsletters.

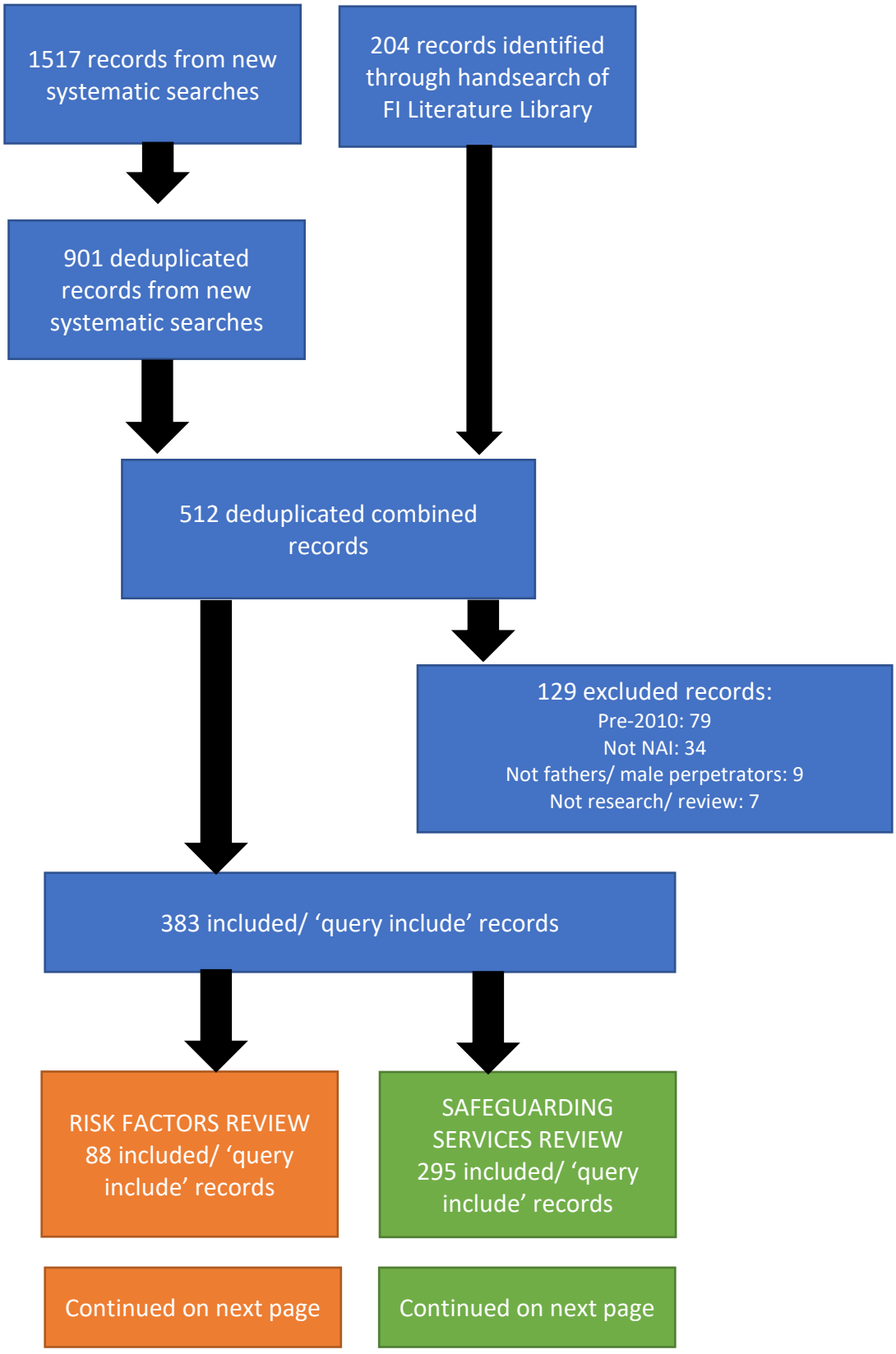
Currently (June 2020), this electronic Library contains 3586 records (UK studies, international research reviews and methodoloy papers).

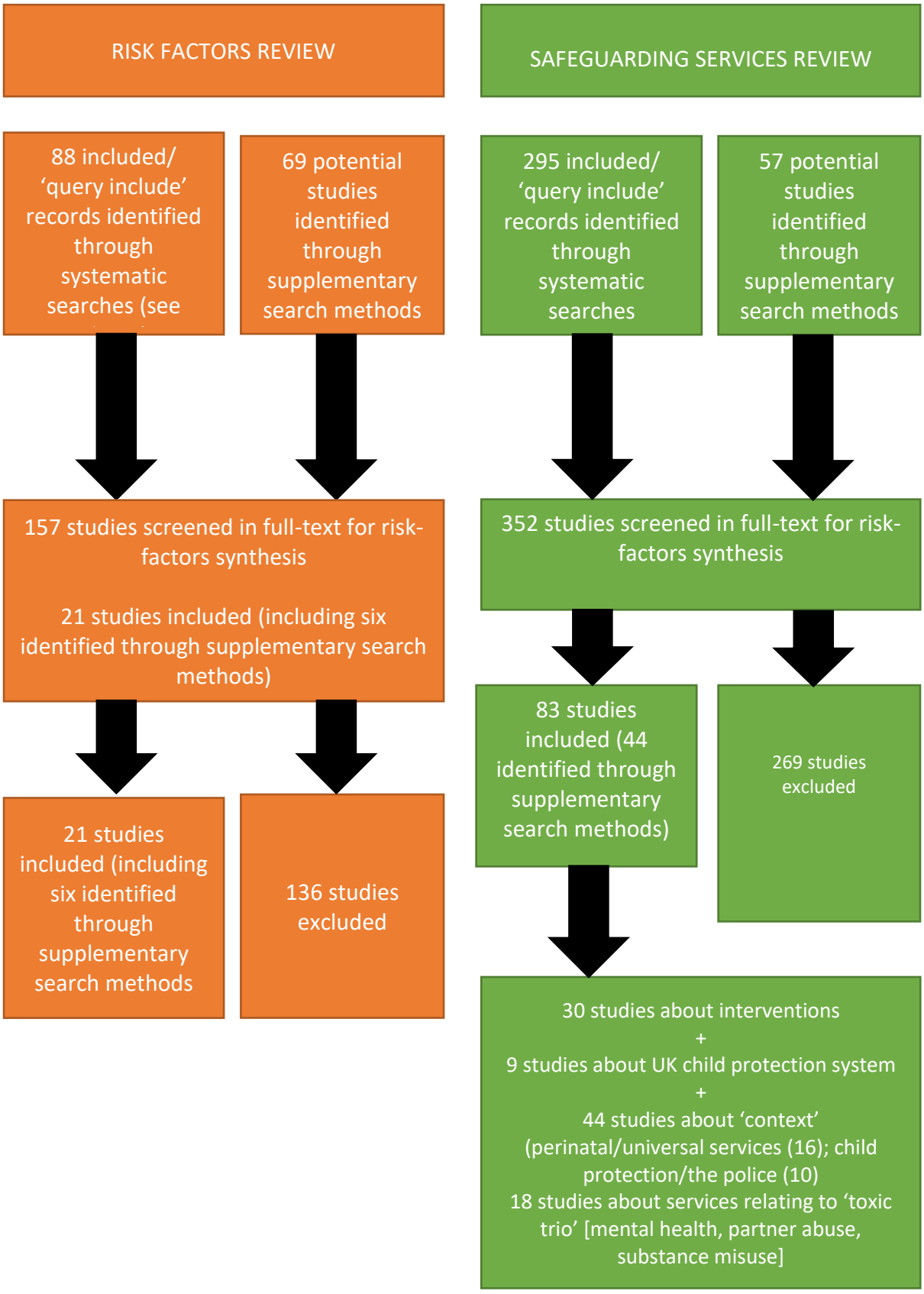
We have categorised records in this Library with a bespoke system of keywords, so that abstracts and full texts can easily be searched. For the purposes of a Nuffield Foundation-funded literature review on fathers in their baby's first year (in progress), we have keyworded 674 UK studies and international research reviews as 'postnatal' - these are the records identified[65]as including evidence on the year following birth. We have keyworded 183 UK studies and international research reviews as 'maltreatment' for any age of child.

Applied Social Sciences Index & Abstracts, PubMed, PsycINFO, Social Policy & Practice, British Nursing Index, British Education Index, Health Management Information Consortium, International Bibliography of the Social Sciences, Zetoc Conference Proceedings, OpenGrey and Ethos (theses).

[65] Identified during the screening process and, subsequently, by searching, in Endnote, ALL FIELDS for records in the FI Literature Library with the terms birth, postnatal, post-natal, postpartum, post-partum, infant, neo-natal, neonatal, paternity leave, parental leave.

Appendix 1C - Flowchart of records through the review




RISK FACTORS REVIEW
SAFEGUARDING SERVICES REVIEW
88 included/ 'query include' records identified through systematic searches (see
69 potential studies identified through supplementary search methods
295 included/ 'query include' records identified through systematic searches
57 potential studies identified through supplementary search methods
157 studies screened in full-text for risk-factors synthesis
21 studies included (including six identified through supplementary search methods)
352 studies screened in full-text for risk-factors synthesis
83 studies included (44 identified through supplementary search methods)
269 studies excluded
21 studies included (including six identified through supplementary search methods
136 studies excluded
30 studies about interventions
+
9 studies about UK child protection system
+
44 studies about 'context' (perinatal/universal services (16); child protection/the police (10)
18 studies about services relating to 'toxic trio' [mental health, partner abuse, substance misuse]

Appendix 2 – Evidence from the risk factor studies

Appendix 2A – Data[66] on fathers vs mothers and categories of fathers

Table 1 – UK and international data[67] - ratios of fathers : mothers[68] as perpetrators (convicted or suspected) of infanticides (child aged under one year)

	Countries/ Sample size	**Years covered by data**	**Fathers : Mothers** (both biological and 'step') **as convicted/ suspected perpetrator**	**Biological fathers: Biological mothers as convicted/ suspected perpetrator**
Flynn et al, 2013	Census of convicted filicide cases in England and Wales - with 161 infants killed	1997 to 2006	2: 1	-

[66] We calculated the ratios in the following tables from data given in research papers, except in a few cases where the authors had included them.

[67] For infanticide and filicide tables in Appendix 2A, and the corresponding synthesis in Chapter 2, we have included only those studies where firstly, all the infant cases are of babies aged under one year; secondly, it is clear that the 'homicides' are predominantly due to physical assault and abuse, with no more than 15% of cases with neglect or 'undetermined' as the primary cause of death; thirdly, the study comprises a census of all cases in that country or a large-geographic-scale sample of cases (i.e. excluding single-centre/ single-local area studies).

[68] Some studies give data on an 'infants killed' base, and other studies on a perpetrators base, with a small proportion of perpetrators killing more than one infant. Some studies give data on fathers only as the main perpetrator (where there are joint perpetrators). Definitions of 'homicide' and included cases (for example whether limited to those with a convicted perpetrator) differ between countries and datasets. Which men are included as 'stepfathers' and therefore as 'fathers' may also influence differing ratios of father-perpetrators to mother-perpetrators, with few data sources having explicit definitions. These issues also apply to other tables in this Appendix.

Brown et al, 2019	Census of filicide cases in Australia - with 90 infants killed	2000 to 2012	1:1	4:5
Dixon et al, 2014	Filicide cases reported to FBI in 32 US states - with 284 infanticides	1995 to 2009	3:2	-
Mariano et al, 2014	Arrests for filicide reported to FBI across US - with 30,714 infants killed	1976 to 2007	1:1	1:1
Dawson, 2 018	Census of filicide cases reported to police in Canada - with 481 infanticides	1974 to 2011	2:3	-
Putkonen et al, 2011	Census of filicide cases in Austrla and Finland – with between 40 and 50 infants killed	1995 to 2005	1:6	-
Martin and Pritchard, 2010	Census of child homicide cases in New Zealand – with 16 infants killed by a parent	2002 to 2006	3:2	4:3
Stöckl et al , 2017	Systematic review of prevalence estimates (five countries[69]	1976 to 2015	Mixed findings on the father – mother ratio	-

[69] Based on country-specific findings which included data post-2000 (see Supplementary Materials for journal paper Stöckl et al, 2017):- Switzerland, Finland, Canada, the US, the UK).

Table 2 –international data[70] - ratios of fathers : mothers as perpetrators (convicted or suspected) of abusive head trauma (AHT)

	Countries/ Years covered by data/ Sample size	Age-range of children	Fathers: Mothers for children of all ages	Fathers: Mothers for infants (aged under 1 year)	Biological fathers: Biological mothers for children of all ages	Biological fathers: Biological mothers for infants (aged under 1 year)
AHT DEATHS						
Wilson, 2018	Census of 99 deaths due to AHT that specified a suspected parental perpetrator, in 32 US states, 2012-2015	All AHT deaths[71] - Median age 0 years (Inter-quartile-range 0-1 years)	10:1	-	7:1	-
Brown et al, 2019	Census of 22 'shaken baby syndrome'	All 'shaken baby syndrome' homicides - Under 5 years,	2:1	-	1:1	-

[70] For abusive head trauma tables in Appendix 2A, and the corresponding synthesis in Chapter 2, we have included only those studies where firstly, the sample of cases is at least 70% infants (aged under 1 year) or the median age is under 1 year; and we have excluded single-centre/ single-local area studies.
[71] 15% were perpetrated by non-parental caregivers.

	homicides by parents[72] in Australia, 2000-2012	with 82% aged under 1 year				
AHT CASES[73]						
Nuño et al, 2015	Nationally representative sample of 1402 AHT cases that specified a suspected parental perpetrator in 44 US states, 2000-2009	All AHT cases[74] - Under 24 months (most between 0-11 months) - Mean age 6 months and median age 3.5 months (Inter-quartile-range 1.5–7.4).	4:1	-	-	-
Scribano et al, 2013	Census of 272 AHT cases (211 cases for infants aged under 1 year) that specified a suspected parental perpetrator in 4	AHT cases with identified suspected perpetrator[75] - Under 60 months, with 76% aged under	6:1[76] (9:1 for sole perpetrators)	6:1[77] (12:1 for sole perpetrators)	4:1 (7:1 for sole perpetrators)	6:1 (7:1 for sole perpetrators)

[72] Includes married and 'de facto' partners of parent, but not stated whether includes parents' non-cohabiting and casual partners.

[73] Mortality rates differed across the studies.

[74] 33% of all AHT cases had an identified suspected perpetrator (parent or other). Of these cases, 17% were perpetrated by non-parental caregivers.

[75] 68% of all AHT cases had an identified suspected perpetrator (parent or other). Of these cases, 13% (11% of infant cases) were perpetrated by non-parental caregivers.

[76] Calculated from Scribano et al, 2013, assuming that all parents' partners were male (gender not specified).

[77] Calculated from Scribano et al, 2013, assuming that all parents' partners were male (gender not specified).

	hospitals across 3 US states, 2004-2009	1 year - mean age 9.4 months				
Sieswerda-Hoogendoorn et al, 2013	Census of 68 AHT cases in which forensic medical expertise was requested by the courts that specified a suspected parental perpetrator in the Netherlands, 2005-2010	All AHT cases[78] - Under 3.25 years, with median age 3.5 months	5:1	-	4:1	-

[78] 81% of all AHT cases had an identified suspected perpetrator (parent or other). Of these cases, 6% were perpetrated by non-parental caregivers.

Table 3 – UK data - approximate ratios of biological fathers : stepfathers as convicted perpetrators of filicide of children of different ages

	Study details	Infants under 1 year (infanticide)	One year old children	Children aged 1-5 years	Children under 5 years	All children up to age 18
Nobes et al (2019)[79] – covering 2000 to 2015	Census of convicted father-perpetrated filicide cases in England and Wales – with 325 children (of any age under 18 years) killed by a father, of whom 122 were infants	10:1	1:1	-	4:1	4:1
Flynn et al (2013)[80] - covering 1997 to 2006	Census of convicted filicide cases in England and Wales - with 195 father-perpetrators (child/ren of any age under 18 years), of whom 101 killed an infant	7:1	-	2:3	-	2:1

[79] Analysis was on basis of infants killed.

[80] Analysis was on basis of perpetrators of infanticide (a few killed more than one child under 1 year).

Table 4 – international data - approximate ratios of biological fathers : stepfathers as perpetrators (convicted or suspected) of infanticides (child aged under one year)

	Country	**Years covered by data**	**Biological fathers : 'stepfathers'** as suspected or convicted perpetrator
Mariano et al, 2014	Arrests for infanticide reported to FBI across US – with 15,000 infants killed by a father	1976 to 2007	26:1
Brown et al, 2019	Census of infanticide cases in Australia - with 44 infants killed by a father	2000 to 2012	5:1 (biological fathers were 80% 'custodial' and 20% 'non-custodial') (on basis of infants killed)
Martin and Pritchard, 2010	Census of child homicide cases in New Zealand – with 9 infants killed by a father	2002 to 2006	8:1

Table 5 – UK and international data - approximate ratios of biological fathers : stepfathers as perpetrators (convicted or suspected) of abusive head trauma

	Countries/ Years covered by data/ Sample size	Age-range of children	Biological fathers : 'stepfathers' for children of all ages	Biological fathers : 'stepfathers' for infants (aged under 1 year)
AHT DEATHS				
Nobes et al, 2019	Census of convicted father-perpetrated filicide cases in England and Wales, 2000-2015– with 31 infants killed by a father in a shaking-caused death	Under 1 year	-	15:1
Wilson, 2018	Census of 90 deaths due to AHT that specified a suspected or convicted father- perpetrator in 32 US states, 2012-2015	All AHT deaths[81] - Median age 0 years (Inter-quartile-range 0-1 years)	3:1	-
Brown et al, 2019	Census of 15 'shaken baby syndrome' homicides by a father[82] in Australia,2000-2012	All 'shaken baby syndrome' homicides - Under 5	1:1	-

[81] 15% were perpetrated by non-parental caregivers.

[82] Includes married and 'de facto' partners of parent, but not stated whether includes parents' non-cohabiting and casual partners.

	Census of 22 'shaken baby syndrome' homicides by parents[83] in Australia, 2000-2012	years, with 82% aged under 1 year		
AHT CASES				
Scribano et al, 2013	Census of 248 AHT cases (190 cases for infants) that specified a suspected 'father/ 'parent's partner' perpetrator in 4 hospitals across 3 US states, 2004-2009	AHT cases with identified suspected perpetrator[84] - Under 60 months, with 76% aged under 1 year - mean age 9.4 months	3:1	6:1 (7:1 for sole perpetrators)

[83] Includes married and 'de facto' partners of parent, but not stated whether includes parents' non-cohabiting and casual partners.

[84] 68% of all AHT cases had an identified suspected perpetrator (parent or other). Of these cases, 13% (11% of infant cases) were perpetrated by non-parental caregivers.

Sieswerda-Hoogendoorn et al, 2013	Census of 57 AHT cases in which forensic medical expertise was requested by the courts that specified a suspected father/ mother's boyfriend perpetrator in the Netherlands, 2005-2010	All AHT cases[85] - Under 3.5 years, with median age 3.5 months	6:1	-

[85] 81% of all AHT cases had an identified suspected perpetrator (parent or other). Of these cases, 6% were perpetrated by non-parental caregivers.

Table 6 – UK data - Proportion of father-perpetrators killing an infant vs other child ages

	% of all father-perpetrators	% of biological-father-perpetrators	% of 'stepfather'-perpetrators
Infants under 1 year	**38%**[86] (Nobes et al, 2019) **52%** (Flynn et al[87], 2013)	**43%** (Nobes et al, 2019) **65%** (Flynn et al, 2013)	**16%** (Nobes et al, 2019) **22%**[88] (Flynn et al , 2013)
Babies aged 1 year	**13%** (Nobes et al, 2019)	**9%** (Nobes et al, 2019)	**30%** (Nobes et al, 2019)
Pre-school children aged 1-5 years		**19%** (Flynn et al, 2013)	**58%**[89] (Flynn et al, 2013)

[86] We calculated these percentages from data given in Nobes et al (2019), confirmed with Nobes in personal communication (2021).
[87] Analysis in Flynn et al (2017) was on basis of father-perpetrators (a few killed more than one child).
[88] The diff between 65% of biological fathers and 22% of 'stepfathers' was stat sig at $p<0.01$ (Flynn et al, 2013).
[89] The diff between 19% of biological fathers and 58% of 'stepfathers' was stat sig at $p<0.01$ (Flynn et al, 2013).

Appendix 2B - Evidence statements - descriptive data on risk factors

We report descriptive quantitative data on potential risk factors from the included[90] UK and international studies that are specific to infants or to a sample predominantly of infants (such as cases of AHT) and specific to father-perpetrators/suspects or to a sample predominantly of father-perpetrators/suspects (such as cases of AHT) in the form of evidence statements below.

As discussed in Chapter 2, the quantitative evidence we found (published from 2010 onwards) on potential risk factors for father-perpetrated filicide and physical abuse of infants is weak[91] and descriptive. We found no analyses based on a study design suitable for causal inference, such as matched comparison groups, or a multi-variable (multivariate) analysis of observational data controlling for confounding variables. These findings would need to be substantiated in the UK, using larger-scale data with representative samples of father-perpetrated infanticide, hysical abuse and AHT cases, and controlling for confounding variables to assess causal effects. Just one or two further studies in the future could reverse our tentative conclusions.

Evidence statement	**Further details of the evidence**	**Brief study details relevant to our research review**
Large-scale evidence (one US study) and small-scale evidence (three studies – UK, France, Australia) for boys having been more prevalent than girls among victims of father-perpetrated NAI over past decades (the father as the convicted or suspected perpetrator)	In a large-scale US sample of infanticides which led to an arrest between 1976 and 2007, boys (56% of all father-perpetrated infanticides[92]) were more likely than girls (44%) to be the victim of an infanticide with a father-suspect - in the ratio 1.3: 1 (Mariano et al, 2014) – see Table 7 below.	**Mariano et al (2014)** – 30,714 cases across US states for which the gender of the suspect was reported to the FBI by participating local and state law enforcement agencies.

[90] For risk factor studies in Appendix 2B, and the corresponding synthesis in Chapter 2, we have included only those studies where firstly, the sample of cases comprises exclusively or mainly children under 18 months, or the median or mean age is under 1 year; secondly, the sample of cases has exclusively or predominantly father-perpetrators; thirdly, it is clear that 'homicides', filicides or infanticides are predominantly due to physical assault and abuse, with no more than 15% of cases with neglect or 'undetermined' as the primary cause of death. In contrast with the studies included in Appendix 2A, we include single-centre studies and single-local-area studies due to the lack of evidence from more robust samples.

[91] [91] Our statement about 'weak evidence' relates to the overall evidence base for each risk factor, relative to our research questions for this review. It is not about the quality of individual studies relative to their own research objectives and design.

[92] We calculated these percentages from data given in Mariano et al (2014). Statistical significance tests **not** carried out.

(Mariano et al, 2014; Brown et al, 2014; Adamsbaum et al, 2010; Dickens, 2018)	This ratio also applied specifically to biological father-suspects, whereas the proportions were even for mother-suspect-infanticides and for 'stepfather'[93]-suspect-infanticides (Mariano et al, 2014). It is not known whether these ratios apply to recent US cases. Not all the arrests led to a conviction - the boys: girls ratio for convicted cases with a father-perpetrator may be different. Additionally (much less robust data), sons were much more prevalent than daughters among victims of father-perpetrated severe NAI in each of three studies (Adamsbaum et al, 2010; Brown et al, 2014; Dickens, 2018). Across the total of 32 cases in these three very small-scale samples in France, Australia and the UK, there were nearly 6 sons to every daughter. This gender pattern in cases of AHT is also noted in a research review of mainly pre-2010 evidence (Barr, 2012).	**Adamsbaum et al, 2010** - a sample of 13 convicted cases of AHT in infants in France in which the father confessed. **Brown et al, 2014** - a census of father-perpetrated infanticides (9 cases) between 2000 and 2009 in the State of Victoria in Australia. **Dickens, 2018** - a sample of 10 convicted biological-father-perpetrators of severe physical abuse of their young child in the UK. Six of the ten children were aged under 12 months, and 9 were aged under 18 months..

[93] It appears that 'stepfathers' were limited in this dataset (US Supplementary Homicide Reports) to those married to the infan t's mother.

S**mall-scale weak evidence (one multi-country sample) for infants in male-perpetrated AHT cases being younger than infants in female-perpetrated AHT cases** (Edwards et al, 2020)	Male perpetrators[94] confessing to AHT of infants were much more likely to have injured a young infant (94% of victims were under six months) than an older infant. In contrast, sole female perpetrators were as likely to have injured an older infant as a young infant (Edwards, 2020). This descriptive pattern would need to be substantiated with data for recent AHT **cases** because the characteristics of published confessed cases of AHT may differ from those of AHT cases overall.	**Edwards, 2020** – a sample of 60 published confessions by sole male perpetrators for AHT for which the age of child[95] and gender of perpetrator was known, identified through a systematic review of research studies and case series from 15 countries[96] published over the period 1971 to 2018 decades in which the AHT occurred?).
Small-scale evidence (one Dutch study) for younger father age (than for the general population of infants) among relatively recent AHT cases (Sieswerda-Hoogendoorn, 2013)	Both fathers' and mothers' ages at the hospital admission of their child[97] for AHT were lower than average Dutch parental ages. Fathers were aged 28 years on average, compared to the mean age of a first child being 32 years for men (Sieswerda-Hoogendoorn, 2013). This finding is not specific to father-perpetrated AHT, but we include it due to	**Sieswerda-Hoogendoorn, 2013** – a census of 89 AHT cases in the Netherlands 2005-2010 for which forensic medical expertise was requested by the courts.

[94] These male perpetrators were biological fathers (the great majority), stepfathers, 'unrelated males' (who may have included non-married cohabiting and non-cohabiting mothers' male partners), and possibly male babysitters (Edwards et al, 2020).

[95] The age of the infant abused may differ from the age reported in the perpetrator's confession.

[96] Around 60% of confessions originated in North America, and around 30% in Europe.

[97] The children had a median age of 3.5 months (maximum age 3 years).

	the predominance of father suspects among cases with an identified suspect[98].	
Small-scale evidence (one US study) for previous child maltreatment to the victim being prevalent among recent father-perpetrated AHT deaths (Wilson, 2018)	Between 29% and 58%[99] of 90 father-perpetrated AHT deaths had a history of maltreatment (abuse, neglect or family violence) of the AHT victim. Between 11% and 40%[100] of these father-perpetrated AHT deaths had evidence of past injury (may have been accidental) to the AHT victim on medical examination. Between 0% and 12%[101] of these father-perpetrated AHT deaths had an open or closed child protection case due to abuse or neglect of the AHT victim or their sibling/s (Wilson, 2018). Previous shaking events occurred in a sample of father confessions of AHT to infants (not all were deaths). In three of these 13 cases, shaking was repeated regularly over a period of time, with	**Wilson, 2018** – a census of deaths due to AHT in 32 US states, 2012-2015 **Adamsbaum et al, 2010** – see above.

[98] Around 80% of the identified suspects were fathers (68% the biological father; 11% a new partner of the mother).

[99] We calculated these percentages on the basis of data given in Wilson, 2018. The 58% applies if all the cases with a recorded history of abuse were father-suspect cases, and the 29% applies if all of the non-father-suspect cases had a recorded history of abuse. 45% of all AHT cases had a recorded history of abuse. Almost 80% of all AHT cases had a father-perpetrator.

[100] We calculated these percentages on the basis of data given in Wilson, 2018. The 40% applies if all the cases with evidence of past injury were father-suspect cases, and the 11% applies if all of the non-father-suspect cases had evidence of past injury. 31% of all AHT cases had evidence of past injury.

[101] We calculated these percentages on the basis of data given in Wilson, 2018. The 12% applies if all the cases with an open or closed child protection case were father-suspect cases, and the 0% applies if all of the non-father-suspect cases had an open or closed child protection case. Nearly 10% of all AHT cases had an open or closed child protection case.

	between 2 and over 30 shaking events confessed by each perpetrator. However, in only two of the 13 cases were previous signs of maltreatment found in children's medical records. (Adamsbaum et al, 2010).	
Small-scale evidence (one Dutch study) for a substantial minority of relatively recent AHT cases having a previously recorded paternal police history (Sieswerda-Hoogendoorn, 2013)	Just under a third[102] of the fathers of a child with AHT had past involvement with the police recorded in their medical records, compared to a mother's past police involvement in only 6% of cases (Sieswerda-Hoogendoorn, 2013). This finding is not specific to father-perpetrated AHT, but we include it due to the predominance of father suspects (80%) among cases with an identified suspect.	**Sieswerda-Hoogendoorn, 2013** – see above.
Small-scale evidence (one US study) that partner violence and couple relationship conflict are <u>not</u> prevalent factors among recent father-perpetrated AHT deaths	In a US study of AHT deaths, a maximum of 7%[103] of 90 father-perpetrated AHT deaths had partner violence noted in records as a contributory or causal factor'. Additionally, there was a record of a partner or parental argument for fewer	**Wilson, 2018** – see above. **Dobash and Dobash, 2012** – an analysis of cases of convicted murders in

[102] We calculated on the basis of data given in Sieswerda-Hoogendoorn, 2013 that a minimum 0% and maximum 49% of the 57 father-suspect cases had this record of past father police involvement. The 49% applies if all the cases with a record of past father police involvement were father-suspect cases, and the 0% applies if none of the cases with a record of past father police involvement were father-suspect cases.

[103] We calculated this percentage on the basis of data given in Wilson, 2018. The 7% applies if all 6 cases with recorded involvement of partner violence were father-suspect cases.

(Wilson, 2018) – **however, these potential risk factors may be under-reported.** **Very small samples of infanticide and NAI cases in the UK, France and the US include father-perpetrated cases in the context of partner violence and couple relationship conflict, for example with coercive control of a partner as the motive, or with an infant injured whilst being carried by the adult victim at the time of violence by their partner.** (Dobash and Dobash, 2012; Makhlouf et al, 2014; Tiyaggura et al, 2018)	than 2% of these deaths, and a similarly tiny proportion of case records noted couple relationship conflict (Wilson, 2018). Of 19 convictions for murder of children by men in the context of partner violence, six cases involved infants under one year (Dobash and Dobash, 2012). Of 15 cases of fatal child abuse of infants by a parent, five cases perpetrated suspect? by fathers (and none by mothers) were described as having a motive of spousal revenge (Makhlouf et al, 2014). Of 13 cases of internal injury to infants during partner violence or argument[104], four cases were stated as perpetrated by the father, and two cases by the mother. In the remaining cases, it was not known whether the mother or father was the perpetrator of the injury to the infant (Tiyaggura et al, 2018). Devaney (2015) also notes cases of babies and younger children being	England, Wales and Scotland (the 'Murder in Britain study). **Makhlouf et al, 2014** – a census of parental homicides 1991-2008 in one area of France. **Tiyaggura et al, 2018** – a sample of cases[105] in the US referred in 2005-2010 by social services or police to medical services for assessment of any injuries for which forensic medical expertise was requested by the courts.

[104]The father was stated as the perpetrator of violence towards the infant's mother in four of the thirteen cases. In other cases, the violence, dispute or 'fight' was described as between the father and mother or more generally as 'family'/ 'domestic' violence.

[105] This was a retrospective analysis of a multi-centre study of children aged under 10 years who were referred to a child abuse paediatrician due to concerns about physical abuse.

	injured whilst being carried by the parent-victim at the time of assault.	
Small-scale evidence (one UK study) for specific psychological characteristics among convicted father perpetrators of severe physical abuse of their young child (who have not also harmed adults) compared to convicted male perpetrators of violence to other men (Dickens, 2018)	The child harmers had lower self-esteem, anxious attachment styles in partner relationships, disengaged coping strategies (giving up and hopelessness); victim empathy[106], and were more likely to justify why physical discipline should not be used with children. Child harmers were more likely to view age-appropriate child behaviours negatively[107], and suggest inappropriate parenting strategies. Adult harmers were more likely to express perceptions of children as "innocent and unknowing". There were no statistically significant differences between the two groups in their level of declared empathy for an unknown child in a road accident; or their expressed views	**Dickens (2018) -** quantitative and qualitative data from a small-scale UK study interviewing convicted perpetrators during 2013-18. This study compared[111] 20 fathers in prison who had been convicted for killing or severely harming[112] their young child[113] in the context of ongoing physical abuse (but had not physically harmed another adult - including their partner) with 46 men in prison who had been convicted for severely harming a male adult[114] (but had not physically harmed a child). It is the only in-depth psychological study of fathers convicted of severe

[106] Child harmers were more likely than adult harmers to report empathy for what their victim had experienced; and more likely to declare empathy for an unknown child being harmed by a male carer.

[107] "One father said *'When he cried, I used to think it was because he hated me, because I was aggressive'…*, or '*baby woke up in a really foul mood…..he urinated and defecated over me….I thought it was deliberate at the time, I felt he didn't really like me, perhaps even hated me on that day, when he cried it was because he wanted to upset me' "* (Dickens, 2018, p97).

[111] Using independent t-tests in a between-groups comparison.

[112] In 15 cases, the child had died.

[113] Fifteen of the 20 children were aged under 18 months, with seven younger than 12 months. Ten of the 20 fathers were biological fathers. It is possible (no data in the published paper) that these statistical patterns did not occur among the cases of children aged under one year, who were killed predominantly (6 out of 7) by biological fathers.

[114] The convicted child harm was. Both groups of men were excluded from the research if they had ever been convicted of violence towards women or had a psychiatric diagnosis at the time of their offence. The adult offenders all had a minimum of two previous violence convictions. The samples are likely to be biased towards those who had experienced remorse and were happy to discuss their offence) because many offenders approached declined to participate.

	on the use of physical child discipline (both groups disapproved of it). Yet the abuse does not appear to be solely 'parenting gone wrong' – the child harmers and the adult harmers in this study shared high prevalence of drug use, poor emotional control, heightened anger responses and avoidant attachment styles. The child harmers' declared empathy with their victims could suggest that anger, insecure attachment issues, misinterpretation of their child's behaviour (involving suspicious thinking and feelings of rejection by their child), and situation-specific issues deactivate empathy at the time of the father's physical abuse. The psychological characteristics were measured at the time of the research[108], once the fathers had bn convicted and were imprisoned, and may have been different at the time of the offence. This quantitative analysis did not control for confounding demographic variables[109].	physical abuse of young children found through our research review.

[108] At the time of the research (whilst in prison), the child harmers were more likely than the adult harmers to report symptoms of depression and anxiety, which may have influenced their reporting of other variables such as self-esteem and suspicion of others.

[109] Child harmers and adult harmers were similar in their education levels, use of drugs before or at the time of their offence, and levels of social support at the time of the offence. Adult harmers were more likely to have drunk alcohol excessively around the time of their offence. The group of child harmers included more white males, and child harmers were lower in socio economic status. The child harmers had a mean age of 38 and the adult harmers a mean age of 34 at the time of their offence.

	That parenting behaviours can be out-of-step with aspired parenting due to poor emotional regulation[110] is noted in a small-scale UK study of fathers of babies who have been violent towards their partner (Domoney and Trevilion 2020).	
Mixed small-scale evidence (three studies) on the prevalence of fathers' mental health problems and alcohol and drug problems among AHT cases (Sieswerda-Hoogendoorn, 2013; Wilson, 2018; Dickens, 2018)	We found no quantitative evidence about mental health problems, drug use or alcohol use as risk factors for father-perpetrated infanticides (those not limited to AHT deaths). A fifth[115] of the fathers of a child with AHT, and a similar proportion of the mothers, had a psychiatric diagnosis in the child's medical records; a third[116] of the fathers had alcohol or drug dependency stated in the records, compared to a mother's alcohol or drug problem in a tenth of cases (Sieswerda-Hoogendoorn, 2013). These findings did not come from an analysis restricted to father-perpetrated AHT, but we report	**Sieswerda-Hoogendoorn, 2013** – see above. **Wilson, 2018** – see above. **Dickens, 2018** – see above.

[110] The fathers were participating in *For Baby's Sake*, a perinatal intervention for parent-couples where the father has been violent. Violence towards their baby is not mentioned in the published paper, and refers to negative parenting behaviours with their older children. One father stated "*Like, where I wanted to be that good person, I wanted to be that good dad, but it was like something was holding onto me and pulling me backwards. I couldn't do it"* (Domoney and Trevillion, 2020, p7).

[115] We calculated on the basis of data given in Sieswerda-Hoogendoorn, 2013 that a minimum 0% and maximum 30% of the 57 **father-suspect** cases had a father's psychiatric diagnosis on their records. The 30% applies if all the cases with a record of the father's diagnosis were father-suspect cases, and the 0% applies if none of the cases with a record of the father's diagnosis were father-suspect cases.

[116] We calculated on the basis of data given in Sieswerda-Hoogendoorn, 2013 that a minimum 0% and maximum 47% of the 57 **father-suspect** cases had father alcohol or drug dependency on their records. The 47% applies if all the cases with a record of father alcohol or drug dependency were father-suspect cases, and the 0% applies if none of the cases with a record of father alcohol or drug dependency were father-suspect cases.

	them here due to the predominance of male suspects (80%) among cases with an identified suspect. However, in a more recent small-scale sample from 32 US states, the perpetrator's mental illness or mood disorder (suspected or diagnosed) was reported as a causal or concurrent factor for only a small proportion (maximum 5%[117]) of father-perpetrated suspect? AHT deaths; there was a record of father's drugs or alcohol use for only a small proportion (maximum 5%[118]) of father-perpetrated suspect? AHT **deaths** (Wilson, 2018). Additional data comes from the very small-scale UK sample of twenty fathers in prison who had been convicted for killing or severely harming their young child[119]. Around half of these fathers had used drugs before or at the time of their offence - a similar level to that in the comparison group of men convicted for physical harm to other men (Dickens, 2018). Child harmers in this UK study	

[117] We calculated this percentage on the basis of data given in Wilson, 2018. The 5% applies if all 5 cases with a record of perpetrator mental illness were father-suspect cases.

[118] We calculated this percentage on the basis of data given in Wilson, 2018. The 5% applies if all 5 cases with a record of perpetrator mental illness were father-suspect cases.

[119] Fifteen of the 20 children were aged under 18 months, with five younger than 6 months. It is possible (no data in the published paper) that drug use occurred predominantly among the cases of children aged 1+ years to 4 years, who were killed predominantly by stepfathers/ parents' partners.

	were less likely than adult harmers to drink alcohol.	
Mixed small-scale evidence (three studies) about whether infant crying is a substantial trigger for father-perpetrated infant shaking and AHT **(**Wilson, 2018; Zolotor, 2011; Adamsbaum et al, 2010)	In a recent small-scale US sample from 32 US states, there was a record of the **baby's crying** as a trigger for the perpetrator's physical abuse for a maximum of 28%[120] (minimum 0%) of father-perpetrated AHT **deaths** (Wilson, 2018). In contrast, the **perpetrator's fatigue and/or the infant's crying** (causing irritation and anger) were mentioned in all fathers' confessions in a very small French sample of 13 convicted cases in which the father confessed (Adamsbaum et al, 2010). In around four fifths of sixteen cases of shaking[121] of their baby by their partner in South Carolina, mothers reported that the trigger was the baby's crying or tantrum/oppositional behaviours, with their partner becoming angry or frustrated in seven cases (Zolotor, 2011). This included shaking of older babies in which tantrums and challenging behaviours	**Wilson, 2018** – see above. **Adamsbaum et al, 2010** – see above. **Zolotor, 2011** – a self-completion survey of US South Carolina mothers of children under 2 yrs in 2008 about a range of 'physical discipline' behaviours.

[120] We calculated this percentage on the basis of data given in Wilson, 2018. The 28% applies if all 25 cases with a record of the baby's crying as a contributory factor were father-suspect cases.

[121] The finding may relate only to those parents who are willing to disclose infant shaking in a survey, and may not apply to cases in which shaking led to the injury of AHT. The mother reported potential harm to the baby in only two of these sixteen cases.

	would be more common than for infants under one year. Research reviews of studies published prior to 2010 give an evidence base for the role of infant crying in cases of AHT (eg Barr, 2012, 2014), although it appears from the references cited that most of these studies are not specific to fathers.	

Table 7[122] – US data for 1976 to 2007 (Mariano et al, 2014) - Proportion[123] of infants killed by child gender

	% of all infants killed by the stated category of parent who were boys	% of all infants killed by the stated category of parent who were girls	TOTAL CASES
Fathers (biological/ 'step')	56%	44%	**15,000**
Biological fathers	56%	44%	**14,454**
Stepfathers	52%	48%	**546**
Biological mothers	53%	47%	**15,696**

References for Appendix 2

See Chapter 2 references, starting on page 20 of this document

[122] We do not include data in this table for the 18 infanticides by a stepmother.

[123] Calculated from data given in Mariano et al (2014). Statistical significance tests **not** carried out.

Appendix 3. Evidence about interventions

Introduction

We found 30 interventions relevant to our research questions. We have divided them into five groups:

A. Perinatal couple-targeted: abusive head trauma/ shaken baby syndrome prevention (n=8)
B. Perinatal couple/ family-targeted (n=10)
C. Perinatal father-targeted (n=2)
D. Non-perinatal couple/family-targeted (n=3)
E. Non-perinatal father-targeted (7).

Information is presented about the design (D) and outcomes (O) of the interventions in the two tables below, using this key:

Design (D)
1 Intervention is focused on infants
2 Intervention is focused on child maltreatment
3 Intervention is focused on key risk factor/s for child maltreatment
4 Intervention is focused on fathers specifically
5 Intervention is focused on families/couples

Outcomes (O)
1 Data about non-accidental injury is provided
2 Data about child maltreatment is provided
3 Data about other relevant outcomes is provided
4 Data specific to fathers is provided

Table 1. Overview of the interventions

Category/ name of the intervention	Has it been evaluated in the UK?	Design Is the intervention designed to target….					Outcomes Does the evaluation provide data on…			
		Infants 1	Non-accidental injury 2	Child maltreatment or risk factors 3	Fathers 4	Families/ couples 5	Non-accidental injury 1	Child maltreatment 2	Other relevant outcome/s 3	Fathers 4
GROUP A. PERINATAL COUPLE-TARGETED AHT/SBS PREVENTION										
All Babies Cry	NO	YES	YES	NO	NO	YES	NO	NO	YES	YES
Auckland SBS Prevention Programme	NO	YES	YES	NO	NO	YES	NO	NO	YES	NO
Coping with Crying	YES	YES	YES	NO	NO	YES	NO	NO	YES	NO

ICON	NO	YES	YES	NO	NO	YES	NO	NO	NO	NO
Pennsylvania SBS Prevention Programme	NO	YES	YES	NO	NO	YES	YES	NO	YES	YES
Period of PURPLE Crying	NO	YES	YES	NO	NO	YES	YES	NO	YES	YES
St Maurice Maternity Hospital	NO	YES	YES	NO	NO	YES	NO	NO	YES	YES
Surviving Crying	YES	YES	YES	NO	NO	YES	NO	NO	YES	NO
GROUP B. PERINATAL COUPLE/ FAMILY-TARGETED										
Child First	NO	YES	NO	YES	NO	YES	NO	YES	NO	NO
Early Head Start	NO	YES	NO	NO	NO	YES	NO	YES	YES	NO
Early Start	NO	YES	NO	YES	NO	YES	YES	YES	NO	YES
Family Foundations	YES	YES	NO	NO	NO	YES	NO	YES	YES	YES

Family Nurse Partnership	YES	YES	NO	YES	NO	YES	YES	YES	YES	YES
For Baby's Sake	YES	YES	NO	YES	NO	YES	NO	YES	NO	YES
Healthy Families New York	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES
Parents Under Pressure	YES	YES	NO	YES	NO	YES	NO	YES	YES	YES
Safe Care	NO	YES	NO	YES	NO	YES	NO	YES	NO	NO
Strengthening Families Salford	NO	YES	NO	YES	NO	YES	NO	NO	NO	NO
GROUP C. PERINATAL FATHER-TARGETED										
Dads Matter	NO	YES	NO	NO	YES	NO	YES	YES	NO	YES
Hit the Ground Crawling	YES	YES	NO	NO	YES	NO	NO	NO	YES	YES
GROUP D. NON-PERINATAL COUPLE/ FAMILY-TARGETED										

Family Drug and Alcohol Court	YES	NO	NO	YES	NO	YES	NO	YES	NO	NO
Newport Family Assessment Support Service	YES	NO	NO	YES	NO	YES	NO	NO	YES	NO
Parent-Child Interaction Therapy	NO	NO	NO	YES	NO	YES	YES	NO	NO	NO
GROUP E. NON-PERINATAL FATHER-TARGETED										
Caring Dads	YES	NO	NO	YES	YES	NO	NO	YES	YES	YES
Community-based Domestic Violence Perpetrator Partnerships	YES	NO	NO	YES	YES	NO	NO	NO	YES	YES
Dad2K	NO	NO	NO	YES	YES	NO	NO	YES	NO	YES
DADS Family Project	NO	NO	NO	NO	YES	NO	NO	NO	YES	YES
The Drive Project	YES	NO	NO	YES	YES	NO	NO	NO	YES	YES

Fathers 4 Change	NO	NO	NO	YES	YES	NO	NO	YES	YES	YES
Strong Fathers	NO	NO	NO	YES	YES	NO	NO	YES	YES	YES

Table 2. Detail about the interventions

NB) Based on our key, we have highlighted IN BLUE below, interventions that are EITHER father-focused OR include father-specific outcome data (or BOTH).

Type and name of intervention	What does the intervention involve?	What's the focus?	Who is it aimed at?	How was it evaluated?	What were the outcomes?	Level of impact evaluation design
GROUP A. Perinatal couple-targeted Interventions aimed at reducing abusive head trauma (AHT)/ shaken baby syndrome (SBS)						
All Babies Cry	All Babies Cry (ABC) is a theory-based infant maltreatment prevention programme designed for use at the maternity bedside and at home. It was developed by injury prevention experts from the Massachusetts Department of Public Health (MDPH) working	To reduce the incidence of abusive head trauma to babies by promoting three protective factors: parents' knowledge of parenting and child development; parental resilience;	First-time parents of newborn babies	US (Massachusetts): Participants were 423 first-time parents (300 (71%) fathers (or, in one case, the mother's nonpaternal male partner) and 123 (29%) mothers) of infants born at either	Parents who received the ABC intervention surpassed control parents in two of the three targeted protective factors (knowledge of parenting and child development and parental resilience). Intervention parents	Quasi-experimental D 1 2 5 O 3 4

	alongside health communications specialists and instructional designers, with the aim of: • developing content that would depict ways for assessing and mitigating parental stress in addition to demonstrations of infant crying behaviour and soothing strategies • designing the media in modules so that it could be easily disseminated to all new parents shortly after birth • appealing to fathers as well as mothers (the development team took care to test the materials with fathers, including via a focus group with fathers who had perpetrated domestic violence; in the ABC self-care module, fathers	and social connectedness.		recruitment site: a level I birth hospital with 1,377 births annually, and a level III birth hospital with 8,362 births annually. One parent per infant was eligible for enrolment. To achieve 70% male participation without overrepresenting single women, fathers and mothers were recruited sequentially (35 fathers, then 15 mothers). A parent was eligible if she or he had no previous children, expected to be living in the same home as their newborn, had to have a caregiving role at least some of the time, could understand and speak either English or Spanish, and had the ability to play a DVD. The ABC intervention comprised (a) an 11-minute overview video for in-hospital use, which introduces topics covered in the take-home	attributed to ABC their use of social connections (the third targeted protective factor) to manage stress. Intervention parents did not use a greater number of stress management strategies than control parents, but at 17 weeks they used a wider variety of such strategies and reported using stress-reduction strategies depicted in ABC because of the programme.	

	appear on screen 70% of the time).			components, and (b) a take-home package comprising a DVD with four brief skills-based modules and a 28-page booklet reinforcing messages in the media programmes. Participants viewed the overview video in the hospital immediately after the baseline interview, and were then given the take-home package. Control participants received usual care, which at one site included one-on-one AHT education with their nurse and state-mandated AHT education (comprising a DVD and handouts). Baseline interviews were conducted at enrolment and via telephone after 5 and 17 weeks. Evaluation measures included a range of quantitative and qualitative behavioural outcomes and		

				assessments, via self-report (Morrill et al., 2015).		
Auckland SBS Prevention Programme	An adapted version of the Dias AHT prevention programme was delivered by nurses or midwives, via: a) a face-to-face conversation with caregivers, following an 8-minute script, one-to-one or in a small group (less than 10); b) supporting materials—educational posters on the walls, pamphlets in English and the option (offered to all) to view Portrait of Promise (a video developed by Dias in the US). The commitment statement was excluded from the programme, which was delivered by trained nurses in the neonatal unit and home visits.	To reduce the incidence of abusive head trauma in babies.	Parents of newborn babies	New Zealand (Auckland): 1800 programme sessions were delivered to, and a pro forma completed for, a total of 2316 parents (1500 mothers and 522 fathers); there were another 276 participants where no pro forma was completed. A total of 150 of participants (6%) were surveyed by telephone a median of 6 weeks later (Kelly et al., 2016).	Among all survey participants, 128 (85%) remembered at least one key message, unprompted; most commonly "It's OK to walk away" (94/150, 63%). When asked, 92% had made a plan for what to do when frustrated and 63% had shared the information with others. Only 98/150 (65%) watched the programme DVD. Many said they already knew about the risks of shaking a baby, but still found the programme highly relevant. Results were not disaggregated by sex of parent.	Pre- and post-intervention survey D 1, 2, 5 O 3
Coping with Crying	The intervention is designed around the delivery of a psycho-educational film, which aims to influence the way all parents of newborn babies react to their infants' crying and other times of stress with their	To reduce the incidence of non-accidental head injuries to babies in the UK and help new parents cope with crying.	Parents of newborn babies	UK: Phase one: in 24 hospitals or birthing units across England, Wales, Scotland and Northern Ireland, the film was shown postnatally in the first few days after	A total of 41,171 parents saw the film during the hospital pilot, 34% of them fathers; and 16,809 in the community pilot, 32% of them fathers.	Quasi-experimental + Qualitative D 1, 2, 5 O 3

	baby. In the film, parents are given information about the dangers of shaking a baby or handling them roughly, and about appropriate coping strategies to use when their baby is crying. Trained staff offer parents the opportunity to discuss the film afterwards.			birth, before discharge from hospital. Phase two: in a range of local pilots including: local authorities; the catchment area for a whole hospital trust; or the area covered by a particular community midwife team or cluster of children's centres. Seven different delivery models emerged, whereby the film was shown: Antenatally (3 models) • within antenatal classes; • at an antenatal clinic; • at home (for example as part of a Family Nurse Partnership visit); Postnatally (4 models): • at a postnatal clinic. • in a postnatal group; • at home in a postnatal visit;	The study found significant impacts on parents' knowledge and behaviour. They were more likely to ask for help, to pass the baby to someone else, to talk to others and to use more soothing strategies to calm their babies. Nearly 20% more parents, in the groups who watched outside the hospital, reported having, at some point, put their babies down in a safe place and walking away when they were finding it hard to cope, when compared with parents who had not watched the film. The study also highlighted differences in impact according to when and where the film was shown. Data was not disaggregated by sex of parent.	

				• at hospital after the birth and before discharge. The pilots were evaluated using a mixed-method, quasi-experimental evaluation design. Qualitative data was collected through focus groups to understand process and experience. Quantitative data was collected based on parents' behaviour, attitude and knowledge change, and matched for comparison to another group that did not see the intervention. In total, over the two phases, 82 mothers and eight fathers attended the focus groups. A survey was conducted with 1,159 parents who had received the intervention, and 1,165 parents in a control group who had not received it, and intervention/control group parents were		

				'matched' using key demographic characteristics (Coster, 2016)		
ICON	The ICON programme delivers its messages (ICON stands for: **Infant** crying is normal and the crying will stop; **Comfort** methods will sometimes help and the crying will stop; **OK** to walk away, if the baby is safe and the crying is getting to you; **Never** ever shake or hurt a baby) through a series of light 'touchpoints' within the first eight weeks of a baby's life via professionals including midwives, health visitors and GPs. At the centre of the intervention is an animated educational film, produced with Public Health England, featuring a stressed father who verbalises his struggle to cope while his baby cries uncontrollably, but remembers the ICON message and is able to calm down. The ICON resources, including information about babies' crying behaviour; key strategies; case studies of children who have	To reduce the incidence of non-accidental head injuries to babies in the UK and help new parents cope with crying	Parents of newborn babies	UK: ICON was developed by a UK health visitor, Suzanne Smith, who visited the teams behind several AHT interventions in the US as part of study tour funded by the Winston Churchill Memorial Trust (Smith, 2016). The resources she has developed are designed to be father-inclusive. The programme has not yet been subject to an evaluation, although it has been used by various clinical commissioning groups and local authorities throughout England. Recently the programme was included in its COVID-19 emergency planning arrangements: all maternity units throughout the country were asked to implement the	N/A	D 1, 2, 5 O n/a

	developed disabilities as a result of having been shaken as babies; and downloadable leaflets, are available for parents and professionals on the ICON website.			hospital-based element of ICON as this is the best time to capture men, even with the restricted visiting arrangements (NHSE, 2020). An as-yet-unpublished evaluation of these arrangements found that about half of maternity units managed to implement ICON and deliver the message and leaflet to both parents in under 10 minutes (Smith, personal communication). The National Institute of Health Research put out a call for proposals to implement and evaluate the ICON programme, in August 2020.		
Pennsylvania Shaken Baby Syndrome Prevention Programme	The Pennsylvania Shaken Baby Syndrome Prevention Programme – a state-wide public health initiative launched in 2003 which was evaluated over the subsequent ten years – is one of the biggest abusive head trauma (AHT) prevention campaigns in the world to	To reduce the incidence of abusive head trauma to babies	Mothers and, whenever present, fathers and father-figures were invited to participate in the intervention.	US: Pennsylvania and five other states. Changes in AHT hospitalization rates in Pennsylvania before and during the intervention, were compared with those in five other states lacking universal parental AHT	In the decade from 2003-2013, almost 1.2 million new parents in the state of Pennsylvania signed 'commitment statements' confirming they would not shake their babies. These represented almost three-quarters (74%) of	Pre- and post-intervention survey + longitudinal data analysis D 1, 2, 5 O 1, 3, 4

	date. The programme, based on an earlier one trialled in the state of New York (M. S. Dias et al., 2005), was built around several key principles: (1) educate parents of all infants; (2) educate especially fathers and father figures; (3) provide information at a consistent time; (4) have nurses deliver the intervention; (5) incorporate multimedia and native languages; (6) administer before infants leave the hospital; (7) have parents sign a commitment statement affirming participation; and (8) require little time from nurses or parents. Before signing the commitment statement, parents of infants born at all maternity units and birthing centres were asked to read a brochure, watch an 8-minute video, and ask any questions of the nurse.			education during the same period. Data were collected from maternity units and birthing centres throughout Pennsylvania from the parents of 1 593 834 infants born on these units from January 1, 2003, to December 31, 2013. Parental behaviour and knowledge were assessed through immediate (n = 16,111) and 7-month post-intervention (n = 146) parent surveys in a per protocol analysis of evaluable parents (Mark S. Dias et al., 2017).	the 1.6 million births during this period (with the ratio of signed statements to live births averaging around 90% from 2006 onwards). Almost all the 'commitment statements' (99%) were signed by mothers, and most (70%) also by fathers. A total of 16,111 parents (21.5% male, 78.5% female) completed the postnatal survey. Despite an overall 74.1% adherence with the intervention, only 20.6% of parents saw the brochure and video and only 5.7% were exposed to the entire intervention. Among the respondents answering individual questions on the postnatal surveys, 91% of mothers and 89% of fathers reported learning a lot about understanding infant crying as normal; 92% of mothers and 89% of fathers about calming their infant, 95% of mothers and 92% of fathers about calming themselves; 85% of mothers and 83% of	

					fathers about selecting other infant caregivers; 95% of mothers and 96% of fathers said that the information would decrease the likelihood of shaking an infant. The 7-month post-intervention survey was completed by 143 respondents; 3 responses were excluded because type-of-parent was unclear; 93 respondents were mothers and 44 fathers. Most mothers (75%) and fathers (80%) reported remembering the information while their child was crying. Calculated AHT hospitalization rates remained static or rose during the intervention for all age ranges compared with the preintervention period in Pennsylvania, and there were no significant differences post vs pre-intervention in Pennsylvania compared with the 5 other states for infants and children aged 0 to 11 or 0 to 23 months, although a significant	

					increase in AHT hospitalization rates in Pennsylvania among children aged 12 to 23 months favoured the comparison states (ratio of IRRs for periods 1 vs 3, 0.6; 95% CI, 0.4-0.9; ratio of IRRs for periods 1 vs 2 + 3, 0.7; 95% CI, 0.5-1.0).	
Period of PURPLE Crying	The Period of PURPLE Crying is a universal abusive head trauma prevention programme involving three doses: a nurse-led discussion while introducing a booklet and DVD during maternity admission; follow-up messaging via telephone and/or home visits post-discharge; and annual community education.	To improve parents' understanding of early increased crying and reduce the incidence of abusive head trauma in babies.	Parents of newborn babies	Canada: With parents of all newborn infants born in British Columbia between January 2009 and December 2016 (n=354,477), nurses discussed crying and shaking while delivering a booklet and DVD during maternity admission (dose 1). Public health nurses reinforced Talking Points by telephone and/or home visits post-discharge (dose 2) and community education was instituted annually (dose 3). (Barr & et al., 2018)	During admission, programme delivery occurred for 90% of mothers. Fathers were present 74.4% of the time. By 2–4 months, 70.9% of mothers and 50.5% of fathers had watched the DVD and/or read the booklet. AHT admissions decreased for <12-month-olds from 10.6 (95% CI: 8.3–13.5) to 7.1 (95% CI: 4.8–10.5) or, for <24-month-olds, from 6.7 (95% CI: 5.4–8.3) to 4.4 (95% CI: 3.1–6.2) cases per 100,000 person-years. Relative risk of admission was 0.67 (95% CI: 0.42–1.07, P=0.090) and 0.65 (95% CI: 0.43-0.99,	Pre- and post-intervention survey + longitudinal data analysis D 1, 2, 5 O 1, 3, 4

					P=0.048) respectively. Researchers concluded that the intervention was associated with a 35% reduction in infant AHT admissions that was significant for <24-month-olds.	
St Maurice Maternity Hospital “Il ne faut jamais secouer un bébé” trial	The intervention involved a short (3 minute) talk about crying and abusive head trauma, given by the maternity department paediatrician, plus a leaflet developed for a Paris regional campaign (“Il ne faut jamais secouer un bébé = One should never shake a baby) developed by the Francilien Resource Centre for Brain Injury	To reduce the incidence of abusive head trauma to babies	Mothers and, whenever present, fathers and father-figures were invited to participate in the intervention.	France: A single-hospital trial ran for a one-month period, during which time 202 babies were born; the parents of 190 babies (94% of the total born) agreed to take part. A total of 186 mothers and 80 fathers completed a pre-intervention survey, and 147 mothers/ 36 fathers completed a follow up survey six weeks later (Simonnet et al., 2014).	Pre-intervention: 27% of mothers and 36% of fathers had never heard of AHT; only around 20% of parents believed baby-shaking was more dangerous than a fall from a changing table. Only 30% of mothers and 28% of fathers said they would put the baby in its bed if the child was persistently crying (this was considered the best response) and they could stand it no longer. Post-intervention: Almost all parents reported that shaking a baby once could kill or lead to permanent impairment. Very high proportions (91% of fathers and 81% of mothers) reported having used the	Pre- and post-intervention survey D 1 2 5 O 3 4

					information provided, mostly during infant crying. Almost half (47% of mothers, 43% of fathers) felt the information should be provided in antenatal classes.	
Surviving Crying	The 'Surviving Crying' intervention includes a website, a printed booklet, and a programme of Cognitive Behaviour Therapy (CBT)-based support sessions delivered to parents by a qualified practitioner.	To reduce the incidence of non-accidental head injuries to babies in the UK and help new parents cope with crying.	Parents of newborn babies	UK: A study was designed to develop and provisionally evaluate a package of support materials for parents of excessively crying babies, including whether the materials might be suitable for use in the NHS. Recruitment involved collaboration with 12 health visitor centres in city, suburban and rural areas of one UK East Midlands NHS Trust. HVs were introduced to the study, definition of 'excessive crying' and materials at briefing workshops and gave written informed consent if they chose to take part. In total, 124 HVs consented to participate. They were invited to visit the study website and	A total of 57 parents provided data; 94% of them were mothers, although five participated as couples. Of the 52 parents who opted to receive the support package, 49 reported using at least one of the three materials (website, booklet, support sessions). They all (100%) rated them as useful or very useful. Data was not disaggregated by sex of parent.	Qualitative D 1, 2, 5 O 3

				provided with log-on information. Where a parent expressed concern about excessive infant crying to a participating HV, the HV gave the parents brief written details about the study and sought consent for contact details to be passed to the research team. The research team then contacted parents to explain the study fully, confirm eligibility and invite them to complete a consent form. Inclusion criteria were (1) a parent of a healthy first or later-born infant aged ≤6 months judged by the parent to be crying excessively; (2) English speaking or supported by an English speaker; (3) living within the study area. Parents who did not meet these criteria were excluded. Because this study aimed to provide an initial evaluation of the Surviving Crying materials there was		

				no control group (Bamber, 2019).		
GROUP B. Perinatal Couple/ Family-targeted interventions						
Child First	The intervention is conducted in the home with the child, parents or other primary caregivers, and other family members. Child First addresses the highest risk families and aims to decrease stress within the family, increase stability, facilitate connection to growth-promoting services, and support the development of healthy, nurturing, protective relationships. Staffing: Each affiliate site has a Child First Clinical Director/ Supervisor and two to six clinical teams, each including a licensed, Master's level Mental Health/Developmental Clinician and Bachelor's level Care Coordinator, both with significant expertise with very young children and vulnerable	The Child First model's Theory of Change is based on scientific research which tells us that **early trauma and adversity lead to biologic changes in the young child that damage the developing brain and metabolic systems, leading to long-term problems** in mental health, learning, and physical health. Child First works from two directions: prevent or ameliorate this damage, and at the same time, enhance the child's development. There are two major strategies that Child First employs to	Child First serves children and their families with the following characteristics: **Age of child**: Prenatal through five years at the onset of services **Target concerns:** Children with emotional/ behavioural or developmental/ learning problems and/or Families with multiple challenges (such as extreme poverty, maternal depression, domestic	US (Bridgeport, Wisconsin); RCT involving 78 children aged 6-36 months randomised to receive Child First, and 79 children to usual care (Lowell et al., 2011).	The Child First Intervention group was 39% less likely than the Usual Care group to be involved with protective services during the 12-month follow-up period (Odds ratio = 4.1 for parental self-report). The Child First Intervention continued to be 33% less likely to be involved with protective services at three-year follow-up (Odds ratio = 2.1 based on child protection records). Outcome data was not reported by sex of parent.	RCT D 1, 3, 5 O 2

	families. They work together in the home with the family. Teams usually carry between 12 and 16 families, such that they are able to complete 12-14 home visits per 40-hour work week. Families receive visits twice per week during the assessment period (first month) and then once a week or more, depending on the needs of the child and family. After assessment, Clinicians and Care Coordinators may visit together or separately, based on the individual family needs. Visits last 1- 1.5 hours and services generally continue for 6-12 months, but may be longer based on individual family needs.	prevent or ameliorate damage due to toxic stress: **Directly decrease the stress experienced by the family** by connecting them to needed services through intensive care coordination. **Provide parent-child psychotherapy to repair the impact of trauma on the child and strengthen the caregiving relationship**, which prevents the biologic changes that lead to long-term damage to the child's developing brain and metabolic systems. There are three major strategies Child First provides to enhance the growth of the caregiver and child: **Build the executive**	violence, substance use, homelessness, abuse and neglect, incarceration, and isolation)			

		capacity, self-regulation, and mental health of the child's parent or caregiver, so that she/he is able and available to nurture the child's development and provide a safe, growth-enhancing environment. **Connect the child and other family members with community services** that stimulate growth and learning. **Provide parent/caregiver guidance and developmental and parenting strategies** that enrich the learning environment and enhance development.				
Early Head Start	Early Head Start is a two-generation early education programme for low-income families with infants and toddlers. Early Head Start programmes	The primary goal is to support child development for children aged under 3, while also supporting parent	Low-income babies and toddlers, and their parents	US; longitudinal study examined programme impacts on child maltreatment, and on short-term child, parent, and family	**Incidence of child maltreatment** • 504 children (18%) involved in the study had either a substantiated child	RCT + Longitudinal D 1, 5 O 2, 3

	are required to follow the Head Start Program Performance Standards, but can adapt to the characteristics of the local community. For instance, Early Head Start programs can provide services through home-based services (weekly 90-minute home visits along with occasional group socialization activities), childcare services (full-day full-year child care, either centre-based or family child care, along with at least two home visits a year) or both.	and family well-being.		outcomes that are linked to longer-term child outcomes, based on state child welfare agency records, for a period of 16 years (1997–2013), of substantiated (confirmed) maltreatment reports and other child welfare involvement for 2,794 children (1,414 in EHS and 1,380 in the control group). Records came from 16 of the 17 EHS sites in the original randomized controlled trial (RCT) of EHS. These 16 EHS sites were located in 15 racially, linguistically, and geographically diverse communities. Researchers linked child maltreatment records to data from the original RCT, which includes comprehensive information about children, parents, and families collected from when children were approximately one year old through	welfare report and/or an out-of-home placement: (73%) of these involved child neglect, 30% physical abuse, and 20% sexual abuse (more than one type of maltreatment was possible for each report). **Preventing child maltreatment** • Participation in EHS led to a long-term reduction in the likelihood that children were involved with the child welfare system, driven by earlier program impacts on parenting and child development. The magnitude of these effects was relatively small. Among children age 2 and their families, those who participated in EHS had better parenting and family outcomes compared to those in the control group. Researchers found that the programme has impacts which led, in	

				grade 5 (age 10-11); they also studied whether EHS prevented children's involvement with the child welfare system from birth to age 15, and if so, what factors might explain how the program was able to have this impact (Green et al., 2014).	turn, to reductions in child maltreatment: Greater parental emotional responsiveness, warmth, and supportiveness Lower levels of parenting stress Less family conflict Improved outcomes were also reported for older children and their families. EHS children were 10 to 22% less likely to be involved with the child welfare system. Other outcomes, including increased knowledge of infant development, reduced use of corporal punishment, and improved family economic stability, were found not to have led to later reductions in maltreatment. Outcome data was not reported by sex of parent.	
Early Start	The intervention uses a social learning model	**Improvements in child health**: Timely	Families where community	New Zealand (Christchurch); RCT	Outcomes at 36-months follow-up	RCT D 1, 3, 5

	approach to home visitation. The critical elements of this model include: a) assessment of family needs, issues, challenges, strengths and resources; b) development of a positive partnership between the family support worker and client; c) collaborative problem solving to devise solutions to family challenges; d) the provision of support, mentoring and advice to assist client families to mobilize their strengths and resources; and e) involvement with the family throughout the child's preschool years.	medical visits for common childhood morbidity; high levels of compliance to immunization and well-child care checks; reductions in hospital visits for preventable childhood morbidity including childhood unintentional injuries and unintentional poisoning; and improvements in home safety and home environment. **Reduction of child abuse**: Reduced agency contact for child abuse and neglect; reduced use of physical punishment; increased awareness of child abuse and neglect issues; effective use of child welfare services. **Improvements in parenting skills**: Parental sensitivity; positive parenting; non-punitive parenting.	nurses have concerns about capacity to care for a child, based on visits undertaken within 3 months of a baby's birth, assessing age of parents; social support; planning of pregnancy; parental substance use; family financial situation; and family violence (concerns present for two or more of these led to referral)	involving 558 families eligible for the trial; of these, 443 (75%) agreed to participate; 220 entered Early Start and 223 the control group. Of the 220 Early Start families, 14 (4%) dropped out. Families were assessed by interview with 'the parent with the greatest involvement with the child (usually the mother)' (Fergusson et al, 2006: 31) at outset, 6, 12, 24 and 36 months, and again at 9 years post-intervention. .	showed that children in the Early Start series had: higher rates of general practitioner contact ($p < .05$); higher rates of well child care ($p < .05$); lower rates of hospital attendance for unintentional injury ($p < .01$); lower rates of parentally-reported child abuse ($p < .01$); greater utilization of preschool education ($p < .05$); more positive and less punitive parenting ($p<.05$); and lower rates of childhood behavioral problems ($p < .05$). No benefits were found for a series of outcomes relating to parental and family circumstances including: maternal depression; family violence; parental substance use; family material conditions; family income and welfare dependence. Outcome data was not disaggregated by sex of parent. Parental adjustment data (based on mother reports) at the start of	O 1, 2, 4

		Supporting parental physical and mental health: Reductions in rates of unplanned pregnancy; early detection and treatment of depression; assistance with mental health and substance use disorders; encouragement to use general practitioner services. **Encouraging family economic and material well-being**: Reducing levels of welfare dependence; encouraging the use of budgeting services; encouraging work force participation; and encouraging forward economic planning. **Encouraging stable positive partnerships**: Reduction of partner violence and partner			the trial found that 50% of 'current male partners' were described as having been in trouble with the law, between 9% and 17% had current problems with alcohol or drugs, between a quarter and a third were described as having problems with aggression, and a similar proportion had assaulted their current partner (Fergusson et al., 2013)	

		conflict; improvements in partner relationships.				
Family Foundations	Family Foundations is a universal perinatal intervention which teaches couples strategies to support their relationship during the transition to parenthood, and to establish positive family routines. Couples attend a series of ante- and post-natal group classes, focusing on co-parental conflict resolution and problem solving, communication, and mutual support strategies. The intervention can be delivered by a range of professionals, including health visitors, midwives, community development workers and parenting support practitioners.	The programme aims to support new parents (mothers and fathers) during the transition to parenthood, with a focus on supporting and coordinating with each other as parent-couples	First-time expectant parent-couples	US RCT involving 399 couples expecting their first child and taking part in 5 antenatal and 4 postnatal group sessions at five urban/ suburban hospitals in three Mid-Atlantic states. Intervention couples attended an average of 6.7 out of 9 classes, facilitated by trained male-female duos. Control group families were mailed written materials on selecting quality childcare, and the stages of child development. (Feinberg et al., 2016) UK The Fatherhood Institute has trialled a UK version of Family Foundations with practitioners in 12 local authorities and has a licence to train practitioners under a	US The study found large effect sizes on three out of four family violence measures, based on parent report. For partner violence and physical parent-to-child violence, measured using the Conflict Tactics Scale and Parent-Child Conflict Tactics Scale respectively, couples who took part in the intervention reported half as many violent incidents as those in the control group. There were no significant moderations of intervention effect by sex of parent. Australia The study found that Family Foundations contributed to enhanced parenting capacity and improved outcomes for their children and was particularly effective	RCT D 1, 5 O 2, 3, 4

				'train the trainer' model (Garratt, 2015) Australia An outcome evaluation using a mixed-methods approach including interviews with parents (14 mothers and two fathers), programme staff (six) and referrers; plus a range of programme data (completed by 24 parents out of 103 who took part in the period studied) (Trew et al., 2019)	with 'high need' parents.	
Family Nurse Partnership	Family Nurse Partnership is an intensive home visiting programme for first-time mothers. Adapted from a US intervention, the UK version involves up to 64 visits by specially trained family nurses: 14 during pregnancy, 28 in the baby's first year and 22 in the second year postpartum. The intervention was delivered in 18 sites across England.	The intervention is informed by theories of human ecology, self-efficacy and attachment, and aims to affect risks and protective factors within each of three domains: prenatal health-related behaviours; sensitive and competent care of the child; and early parental life course.	First-time expectant/new teenage mothers.	UK: RCT involving 1618 first-time mothers, average age 17.9 years; 808 received the intervention plus usually provided health and social care services for pregnant/new mothers; 810 received only the usually provided services. The trial measured a series of primary outcomes: smoking in late pregnancy, birthweight, second	**UK** *Primary outcomes*: No difference found in rate of smoking in late pregnancy between intervention and control arms; no difference in birth weight; no difference in incidence of second pregnancy within two years post-partum; emergency attendances and hospital admissions within 2 years of birth were higher in the intervention group than the control group (81% vs 76.6%).	RCT + Qualitative D 1, 3, 5 O 1, 2, 3, 4

				pregnancy within 2 years postpartum, emergency attendances and hospital admissions. It also measured secondary outcomes relating to the pregnancy and birth; child development concerns and language development; breastfeeding; injuries to/ ingestions by the child; children's centre visits; social services referrals and safeguarding concerns (based on GP records) (Robling, 2015). Netherlands: RCT involving 460 disadvantaged young women pregnant for the first time; 237 were randomised to receive the intervention (VoorZorg, the Dutch version of FNP) and 233 to control (Mejdoubi et al., 2015). .	*Secondary outcomes*: No differences for either maternal or parenting/child outcomes; no statistically significant difference in attendances or admissions for child injuries or ingestions; higher proportion of children in the intervention arm had a safeguarding event recorded in their GP record (13.6%) than those in the control group (8%). Researchers suggested this may have resulted from greater identification of concerns, due to greater professionals contact in the intervention group. The FNP 'client' is the mother, but some engagement with fathers takes place during the intervention. This was not measured in the RCT, but researchers did report that 75.5% of mothers in the trial were closely involved with, or	

					girlfriend of, the baby's father. Most of these fathers (84.5%) were aged 16-24. Almost two-fifths (37%) of the mothers no longer lived with their parent/s; 23% lived with the father of their baby. A small, separate qualitative study including a survey of 54 men in touch with the programme (47% of the original sample) and interviews with 24 of them, found that 54% felt their ability to be a father had changed very positively as a result of the FNP intervention (Ferguson, 2016) **Netherlands** Three years postnatal, 11% of children in the VoorZorg group appeared in child protection service files, compared to 19% of children in the control group.	
For Baby's Sake	For Baby's Sake is a whole family perinatal intervention for couples	The intervention specifically aims to improve the	Expectant parents aged 17 or over by the	UK: Pilot qualitative evaluation with parent/child outcomes	High proportions of participating fathers and mothers suffered	Qualitative D 1, 3, 5 O 2, 4

	where the mother is experiencing partner abuse from the father of the unborn child and this is expected to continue. For Baby's Sake has been developed as a structured, modular programme which is delivered flexibly to meet individual needs. Staff work for up to two and a half years with expectant mothers and fathers as co-parents, whether or not they are together or stay together as a couple. Using a strengths-based model, they work separately but in a coordinated way with both the mother and father to address their complex issues and support lasting behaviour change, alongside managing the risks for each family member, and acting swiftly to address any safeguarding concerns that may emerge. Staff delivering the programme come from a variety of professional backgrounds, including, for example, police, probation, the domestic violence sector, and early years' services. Prior to working with	parenting behaviours of both mothers and fathers, in order to promote healthy development of infants.	time their baby was born, who have identified partner abuse in their relationship, and have expressed a desire to co-parent the infant.	measured on 40 individuals (27 mothers and 13 fathers) at baseline interviews and then again at 1-year (19 mothers and eight fathers) and 2-year (12 mothers and six fathers) post-intervention. Two-fifths (40%) of the women and 38% of the men were first-time parents, and all the families were assessed as experiencing domestic abuse at time of registration. Ten *For Baby's Sake* fathers took part in a separate qualitative study, to aid understanding of how interventions can impact on beliefs and behaviours, provide insights into motivations for engaging with interventions and potentially support future adaptations and refinements to enhance retention (Trevillion, 2020)	from depression, anxiety, PTSD and/or personality disorders; 40% of fathers denied using partner violence, and 60% of mothers denied experiencing it, at baseline. Around 50% of parents were still in the programme after 2 years; dropout rates were higher among fathers. Fathers received fewer parenting sessions than mothers (26% of manualised content vs 36% for mothers). Overall, 67% of completer families did not have social care involvement at the end of the programme; child development outcomes at one- and two-years post sign-up were largely in the normal range. Parent-child interaction data was more mixed, with some families continuing to score in the high-risk range at the end of the evaluation period. In the father-only study, men receiving the intervention had a strong, positive concept	

	families they undertake a significant amount of training which covers topics such as safeguarding, mental illness, parent-infant relationships, and therapeutic skills, alongside specific training on delivering the intervention manual.			(Domoney et al., 2019) (Domoney & Trevillion, 2020)	of what a father is and the ways in which fathers should be involved in their children's lives. They were able to reflect on the challenges of fulfilling this role and were aware of the discrepancy between the idealized view of a father figure and what they were able to provide for their children. In relation to abusive behaviours, men had started to make sense of the ways in which their adverse childhood experiences (ACEs) were impacting on their adult behavior and reported a strong desire to provide different experiences for their own children. Some were able to acknowledge and take responsibility for current abuse and to describe the ways they were beginning to make changes and what had helped them to do so. The study identified four key themes: making sense of violent behaviour; conceptions	

					of fatherhood; an emotional transition; and breaking the cycle.	
Healthy Families New York	Healthy Families New York (HFNY) is an evidence-based home visiting program for expectant and new parents in socioeconomically disadvantaged families at elevated risk for child maltreatment and other adverse outcomes. HFNY makes concerted efforts to promote a father-inclusive culture and increase engagement of fathers in all aspects of home visiting.	The program emphasizes a relational development approach to promote parent–child attachment; foster optimal child and family health, development, and safety; enhance family self-sufficiency; and prevent child abuse and neglect	Expectant parents with an infant under 3 months of age who live in targeted communities that have high rates of teen pregnancy, infant mortality, welfare receipt, and late or no prenatal care	US: **Study 1** RCT involving a subgroup of mothers (n = 104) who had at least one substantiated child protective services (CPS) report before enrolling in the programme. Mothers in the control group were given information about and referrals to other services, not home visiting (Lee et al., 2018). **Study 2** Researchers explored records relating to 4,972 families enrolled in the programme between January 2013 and June 2015, to investigate fathers' participation and its impact (McGinnis et al., 2019).	Study 1: By the child's seventh birthday, mothers in the home visited group were half as likely as mothers in the control group to be confirmed subjects for physical abuse or neglect (AOR = .46, p = .08). The number of substantiated reports for mothers in the control group was twice as high as for those in the home visited group (1.59 vs. 79 p = .02, ES = .44). Group differences were only observed after the child's third birthday, suggesting the possible effect of surveillance in early years. Post-hoc analyses indicate that home visited mothers had fewer subsequent births that may have contributed to less parenting stress and improved life course development for mothers. Study 2	RCT + longitudinal data analysis D 1, 3, 5 O 2, 4

					Information about the father was available for 3,341 families (67%). Among other findings, the study found that when fathers participated in home visiting, families were more than four times as likely to be retained in the programme. Additionally, fathers who were engaged were more likely to live at home with the child and to remain emotionally involved at 6 months.	
Parents under Pressure	Parents Under Pressure is a home-visiting service that aims to provide parenting support to parents who are in treatment for drug or alcohol misuse. The service was developed in Australia and was originally designed for 'multi-problem high-risk families' who have children aged 2–8 years. The programme recognises that parents using substances typically experience problems across multiple domains of family life and	PuP is aimed at supporting parents who face multiple adversities, including dependence on psychoactive drugs or alcohol, by providing them with methods of managing their emotional regulation, and of supporting their new baby's development.	PUP was originally designed for parents of children aged 2-8 but has since been adapted in the UK for use with parents of children aged under 2. The UK RCT studied the impact of the programme on primary caregiver parents of a child/ children under the age of 2.5 years; the parent	UK: RCT with 100 parents (96 of them mothers), of whom 52 received PuP and 48 treatment as usual. Post-intervention data was analysed for 85 participants, and 6-month follow-up data for 75 participants. A separate, self-report evaluation by 166 parents included ten fathers (representing 42% of all fathers who had accessed PuP as primary caregivers). (Hollis & et al., 2018)	UK: PuP parents in the RCT showed reductions in scores reflecting child abuse risk, using a standardised measure. Parents in the control group (who received treatment as usual) those showed an increase in these scores. More PuP families showed a clinical improvement in abuse potential while more control group parents showed a deterioration in terms of potential for	RCT D 1, 3, 5 O 2, 3, 4

	functioning, including child behaviour problems, mental health difficulties, and social isolation. Delivered over 20 weeks, it is a modular, manualised programme that aims to address the complex and multiple problems inherent within these families, within the context of a coherent treatment model. This includes parent and child wellbeing, parent–child interaction and attachment, family relationships, and the broader social environment including the availability of social support.		needed to be receiving treatment for a drug or alcohol problem including opioid replacement treatment, relapse prevention or other treatment programme. If both parents had alcohol or drugs problem, only the mother was assessed (if they were the primary caregiver). Other exclusions also applied.	Australia: RCT involving 64 families with children aged 3-8 and a parent on methadone maintenance – receiving either PuP or standard care.	risk abuse. There was a trend toward improvement in terms of the reduction in legal proceedings (including parenting assessment order through supervision order; special guardianship order; interim care order and care order) for the PuP group. There were also statistically significant improvements in a number of measures relating to parents' capacity to manage their emotions, overall psychological wellbeing and depression, although no differences on parenting stress. In the case study evaluation of fathers on PuP, the ten fathers appeared to show similar characteristics to the wider sample of mothers receiving PuP regarding their demographic profile, emotional wellbeing, and parenting challenges, and mindful parenting. Most had children's services involvement yet most	

					fathers reported low levels of problems and fairly high levels of social support. However, a greater proportion of fathers were in, or had been in, domestically violent relationships, had criminal convictions, and had experienced housing problems and major trauma within the past year compared with mothers. PuP 'completer' fathers received the programme for longer than mothers. Australia: The 22 methadone-maintained parents (of children aged 3–8 years) receiving PuP showed statistically significant improvements across multiple domains of family functioning (Dawe & Harnett, 2007). This included a reduction in rigid parenting attitudes, child abuse potential, and child behaviour problems; these improvements were significantly greater	

					than for the control group.	
Safe Care	Safe Care is a home-based programme for families involved with child protective services – usually focused on families with a preschool-aged child (0-5). It is a structured behavioural skills training program that focuses on concrete caregiving, household management, and parenting skills. It can be delivered as a free-standing intervention or as one component of a broader home visiting service.	Reduction of child abuse and neglect	One maltreating/ neglectful parent per household, with priority given to the primary caregiver.	US (Oklahoma): 2175 parents/ caregivers enrolled in a statewide system of home-based services under contract with child protection services. They were randomised into four groups, in a 2 x 2 cluster experimental design, to test the Safe Care approach against 'service as usual' but to simultaneously test the impact of 'coached' vs 'uncoached' quality control. (Mark Chaffin et al., 2012)	The trial found consistently significant main effects (i.e. lower recidivism rates), especially with clients meeting customary Safe Care inclusion criteria. Clients were 91% female. Outcome data was not disaggregated by gender.	Quasi-experimental D 1, 3, 5 O 2
Strengthening Families Salford	Strengthening Families Salford is an intensive 'early help' service for mothers and/or fathers who have had at least one child removed from the family home and taken into care by the courts. It provides support in three different ways at three different stages in parents' lives after court proceedings. Pathway A is	Strengthening Families aims to improve: · the number of parents and babies able to stay together after the removal of a previous child · the health of parents and babies, including perinatal and infant mental health	Strengthening Families claims to support both parents as they work with a wider range of agencies to deal with practical issues such as housing, work and benefits and as they interact with e.g. education, social	An evaluation of SF by University of Essex was commissioned in 2019 but has yet to be published (SalfordCC, 2020)	Salford City Council figures show that in 2014-19, 15 siblings were born to parents supported by Strengthening Families to keep a child; three children graduated from the programme and started school. Parents being supported by SF report increased contact with children	N/A D 1, 3, 5 O n/a

	for parents in the weeks and months after their child has gone into care, to help them prepare for parenthood in the future. Pathway B is for parents who have had a child removed and are now expecting another. The focus is on pre-birth support in early pregnancy, including through an 8-week Health in Pregnancy and Parenting Programme and, later, the Incredible Years Babies programme, all geared towards supporting parents to make the most of their new window of opportunity for change. Pathway C supports parents from after their baby is born until their child begins school, with the focus on intensive parenting support, early childhood development and school readiness.	· early attachment and bonding, leading to improved child development outcomes · rates of breastfeeding · the number of children ready to start school (school readiness)	services and the police.		who had been removed. No data by sex of parent presented.	
GROUP C. Perinatal Father-targeted interventions						
Dads Matter	Dads Matter is an enhancement to home	Incorporation of fathers into perinatal	Biological parent-couples with no	US: small quasi-experimental time-	Both mothers and fathers in the	Quasi-experimental

	visiting services and is grounded in family systems, co-parenting, stress and social support theories. It is designed to be delivered in parallel with and, when possible, co-equally with those delivered to the mother, beginning at the point of service initiation. It can be flexibly delivered either conjointly or separately, depending upon the assessed nature of each father's role in the family, his and her availability, and the quality of the current relationship, as well as in-person or over the phone if needed. The Dads Matter enhancement does not include specific content on parenting skill training; it complements existing home visiting content and permits adjustment of this content through supervision and training for father inclusion. For example, the Dads Matter modules do not reiterate parent-child attachment skill acquisition for fathers, but rather direct the home visitor to promote father-infant attachment behaviours in ways that	home visiting services	previous child protective services involvement	lagged study in a large metropolitan area in the US Midwest with 24 parent-couple families. Half (12 couples) received the intervention (Dads Matter enhancement to existing home visiting services, which varied in the trial, involving either Parents as Teachers, Early Head Start or a home visiting programme employing the Brazelton Touchpoints parenting curriculum). The comparison group (12 couples) had received standard home visiting services. The trial measured parents' self-report of child abuse/neglect risk; quality of mother-father relationship; and father-involvement, at baseline and four months post-intervention (Guterman, 2018).	intervention group reported favourable changes in all measures of physical child abuse and neglect risk when compared against the comparison group. Effect sizes were in the large range (d scores from −0.75 to −0.9) across all three scales of fathers' self-report of child neglect, physical assault, and psychological aggression toward their child. Smaller but still favourable effect sizes were observed for mothers' self-reported maltreatment indicators (ranging from −0.06 for psychological aggression to −0.5 for physical assault).	D 1, 4, O 1, 2, 4

	emphasize verbal and non-verbal responsivity. The Dads Matter enhancement is delivered by home visitors over four to eight sessions. .					
Hit the Ground Crawling	Hit the Ground Crawling (HTGC) is the UK version of a groundbreaking American antenatal peer-mentoring programme for expectant fathers ('Boot Camp for New Dads'). It involves groups of expectant fathers learning childcare skills and receiving peer support from new fathers, who attend with their babies. The sessions generally last about two hours, and are designed to be informal and relaxed and to provide a space for dads-to-be to discuss their thoughts and concerns with fathers who have recently had their babies ('veteran dads') and to experience, often for the first time, hands-on care of a baby. Although a trained facilitator is present during the session, they do	HTGC aims to increase the confidence levels and involvement of expectant fathers and to raise their awareness of, and participation in, local children and family services. Shaken baby syndrome is a key topic covered within the programme, with facilitators demonstrating the dangers of baby shaking by shaking an egg in box.	First-time expectant fathers, supported by recent new fathers (the 'veterans').	A pilot was delivered in Staffordshire at three sites during the period July 2008 to December 2009. Forty-two first-time expectant fathers across the three sites participated in the pre- and post-session evaluation, the majority of whom were aged 26-40 years, White British, working full-time, living with the mother of their baby. They completed pre- and post-session evaluation forms. Seventeen also undertook in-depth telephone interviews and 23 veteran fathers also completed pre- and post-session feedback about their reasons for	The pre- and post-session evaluations showed improvements in a range of scores designed to explore the fathers' preparedness for fatherhood. Key results included: 'I feel confident in my ability to care for a baby' (98% post-session vs. 81% pre-session) and 'I feel confident dealing with a crying baby' (94% post-session vs. 61% pre-session).	Pre- and post survey and interviews D 1 4 O 3 4

	not work strictly to a formal curriculum, but rather to a list of suggested discussion topics. The session is fundamentally an opportunity for expectant and new fathers to share and reflect on their experiences, and for the expectant fathers to see practical baby care by fathers in action.			participating in HTGC (largely altruistic) and the perceived benefits for expectant fathers (which mirrored the feedback from expectant fathers). (Fraser, 2010) Boot Camp for New Dads, the US programme on which HTGC is based, has no published peer reviewed outcome data, but results compiled in 2012 from more than 2,000 post-Boot Camp evaluations from across the U.S. overwhelmingly supported the positive impact Boot Camp has on its participants, including feeling more confident about becoming a father, creating a parenting team with the baby's mother and bonding with the baby.		
GROUP D. Non-perinatal couple/ family-						

targeted interventions						
Family Drug and Alcohol Courts	FDAC is an alternative, problem solving approach to care proceedings in cases where parental substance misuse is a key factor in the decision by the local authority to bring proceedings. In FDAC, the same judge deals with the case throughout and holds regular court reviews without lawyers present. Parents receive intensive treatment and support from a specialist multidisciplinary team, which is independent from the local authority, and works closely with the court. The court and the team help parents engage with other services to address their wide range of needs. These are the main differences between FDAC and ordinary proceedings, and all are part of the problem-solving and collaborative approach. In ordinary care proceedings, there is no independent multidisciplinary team or judge-led review hearings	Parental substance misuse is a major risk factor for child maltreatment. It features in up to two-thirds of care applications, and parents with substance misuse problems are often involved in repeat care proceedings on subsequent children. FDAC aims to improve outcomes for children by helping parents change the lifestyle that has put their children at risk of harm. It seeks to improve parental substance abuse cessation rates, achieve safer and more sustainable family reunification, and ensure swifter placement with permanent alternative carers when reunification is not possible.	Parents who abuse substances	UK (London) FDAC was piloted in central London between January 2008 and March 2012, originally funded by government departments and three local authorities (Camden, Islington and Westminster). The FDAC pilot was evaluated by a research team at Brunel University, funded by the Nuffield Foundation and the Home Office. The evaluation was conducted in two stages between 2008 and 2013. The main findings are based on 90 families (122 children) who were referred to, and received, the FDAC programme, and the 101 families (151 children) who formed the comparison sample. In both samples parental substance misuse was a key factor in	Substance misuse: more FDAC parents controlled their misuse Rates of substance misuse cessation were higher for FDAC than comparison parents, and the difference reached statistical significance. • 40% of FDAC mothers were no longer misusing substances, compared to 25% of the comparison mothers. • 25% of FDAC fathers were no longer misusing substances, compared to 5% of the comparison fathers (the data on fathers was less complete than for mothers). **Reunited families: higher rate for FDAC families** There was a higher rate of family reunification and substance misuse cessation by FDAC families at the end	Quasi-experimental D 3, 5 O 2, 3, 4

	in which the judge plays a problem solving role and seeks to motivate parents to change. Parents do not talk to judges directly. The distinguishing features of FDAC (Harwin et al., 2011, 2013, 2014) are that: • the judge adjudicates the care proceedings and also holds responsibility for running a specialist treatment court • the judge plays a non-traditional role in order to motivate parents as well as to remind them of their responsibilities • a specialist multi-disciplinary team is attached to the court and coordinates an intervention plan for parents which includes ongoing support and monitoring as well as assessment • parental progress is monitored and supported through regular fortnightly problem-solving therapeutic reviews during which the judge talks to parents and social workers directly; and			initiating the care proceedings. A further 16 families were referred to FDAC but declined the service or were excluded according to the agreed exclusion criteria. The evaluation included follow-up of 24 FDAC and 18 comparison families where children had returned home at the end of proceedings (out of the 32 FDAC and 31 comparison families where reunification had occurred). The initial follow-up was for one year and a smaller number of families were also tracked for up to two more years. There was also a qualitative element to the evaluation, including interviews with parents and professionals and observations of court hearings (Harwin, 2011) (Harwin, 2016)	of proceedings and the difference reached statistical significance. • 35% of FDAC mothers stopped misusing and were reunited with their children, compared to 19% of the comparison mothers. • In each sample, we found variable support for families where parents and children were reunited, prompting questions about how all families can be better supported at this stage. **Child maltreatment: lower rate for FDAC children** The rate of neglect or abuse one year after children returned home was lower for FDAC than comparison parents and the difference reached statistical significance. • Further neglect or abuse of children occurred in six of 24 FDAC families, compared with ten of 18 comparison	

	• parents are advised and supported by parent mentors who have themselves come through similar experiences (including, ideally FDAC).				families (25% v 56%). **Length of proceedings: no quicker in FDAC** • In cases where reunification was not possible, FDAC was not quicker in achieving alternative permanent placement than ordinary proceedings. The mean length of proceedings for both FDAC and the comparison groups was 62 weeks. **Costs of the FDAC pilot** • A costs exercise, conducted at Stage 1 only (not a full cost-benefit analysis), showed that FDAC more than paid for itself, as a result of: shorter court hearings, fewer legal representatives at hearings, fewer contested cases, less use of foster care placements during and after proceedings, and the specialist team undertaking	

					the tasks done by experts in ordinary care proceedings. These findings need to be reviewed in light of the changed context since the completion of Stage 1. **FDAC offered more opportunities to access services** • In addition to receiving the intensive service from the FDAC team, a higher proportion of FDAC mothers (95% v 55%) and fathers (58% v 27%) were offered help from other agencies for their substance misuse. The FDAC families were also more likely to be offered family services than the comparison families (33% v 18%). The family services included intensive family interventions, family therapy, parenting training and practical help. These results were based on 57 FDAC and 82 comparison families tracked to final order in Stage 2. The	

					differences reached statistical significance. **FDAC better able to build on parents' potential to change?** An analysis of case characteristics which predicted outcomes suggest that FDAC might be more effective than the ordinary court with those parents who had fewer problems additional to substance misuse, and therefore may have the greater capacity to change their lifestyle. • The rate of substance misuse cessation and family reunification was higher in the FDAC than in the comparison sample if the case had a low level of child and parent problems (55% [22 of 40] v 16% [9 of 57]). This difference reached statistical significance. • But there was no difference between the samples in the rate of substance misuse cessation and family reunification where there was a higher level of child and	

					parent problems (18% [9 of 50] and 20% [9 of 44]). • None of the cases in either sample were 'easy'. All the families had entrenched and multiple difficulties: parental substance misuse, domestic violence, convictions, and mental health problems. **FDAC's approach deemed more helpful** • FDAC is a service parents would recommend to other parents. Those with previous experience of care proceedings found FDAC to be a more helpful court process that gave them a fair chance to change their lifestyle and parent their child well. • Parents felt motivated by the FDAC team and judges and they valued FDAC's practical and emotional support as well as their treatment intervention.	

					• Professionals thought that FDAC's Trial for Change approach (support to parents with close monitoring by the court) provided a fair and transparent test of capacity to change. This made it more likely that parents would, if relevant, accept the decision that children could not return to their care. • Meeting the new 26-week timescale for care proceedings is a challenge for all courts, and there is a particular challenge for the problem-solving approach of FDAC. The concern is that the court is less likely to be the main arena for testing parental capacity to change. Yet our findings about the strengths of FDAC arise from the unique combination of a specialist team attached to the court and motivation and oversight provided by FDAC	

					judges. The impact of a reduced role for the court is uncharted territory.	
Newport Family Assessment and Support Service	FASS provides intensive assessment and support to families on the brink of care or where the plan is for a child's rehabilitation to home, in a two-stage process. The first, lasting 2-4 weeks and including up to 4 sessions per week, aims to 'grip' the family, focusing on exploring, in depth, their history, strengths and challenges. Workers are trained in motivational interviewing and aim to support caregivers – fathers as well as mothers – to develop 'internal motivation' to change. Stage 2, lasting up to around 10 months, involves the delivery of a support package including a combination of therapeutic and practical approaches.	The aim is to develop *internal* motivation to change, rather than *external* (for example requirements set out in Child Protection plans), and to support families with a combination of therapeutic (e.g. work to improve relationship functioning) and practical (e.g. housing advice, parenting tips) approaches	43% of FASS families had 'toxic duo' issues (often domestic abuse plus either substance abuse or mental health); 37% of referred families included at least one parent who had been abused or neglected as a child	UK: Evaluation of the experiences of 30 families in receipt of FASS services over an 18-month period (IPC, 2016)	A small-scale evaluation found that 48% of families supported by FASS, many on the brink of their child being put into care, reported positive outcomes, including the child being able to stay at home. Evaluators contrasted this with data from "another less deprived part of the UK where no such service exists", where they found that only 21% of families in need had such positive outcomes from their social care intervention No data by sex of parent was available, but several case studies suggested a potentially useful focus on supporting fathers/ mothers' partners.	Qualitative D 3, 5 O 3
Parent-Child Interaction Therapy	Parent-Child Interaction Therapy attempts to teach parents – including those with a history of child maltreatment - specific	PCIT was designed to help parents cope with children displaying challenging	Dyads made up of a physically abusive parent plus their physically abused	US: 110 parent-child dyads where the parent had physically abused the child (aged 4-12). Non-	Recipients of PCIT had less than half the rate of re-report for physical abuse as those in a standard community-	RCT D 3, 5 O 1

	skills and practices, with the aim of changing their parental behaviour and reducing any child abuse recidivism. Therapists observe parent-child dyads through a one-way mirror and coach the parent to develop specific skills, through a radio microphone.	behaviours, but it has also been adapted for parents with a history of child maltreatment, to prevent recidivism.	child (other parents and siblings may take part as collateral partiipants).	abusive parents and non-abused siblings were eligible as collateral participants but did not provide data. Dyads were randomised to receive one of three interventions: PCIT; an enhanced version of PCIT; or the standard community parenting programme intervention. The PCIT intervention was composed of three modules, and the duration and sequencing of the modules was designed so that the overall structure and duration of the program would be comparable to the standard community group model to which it was being compared. The first module consisted of a six-session orientation group, focused on increasing parent motivation for active participation. Parents who did not pass the	based parenting group (After 850 days, 19% recurrence compared to 49%). PCIT was more impactful than the enhanced version of PCIT. More than a third (35%) of participants were fathers, but the results were not disaggregated by gender – so we cannot report on the intervention's effectiveness with men.	

				motivational enhancement group requirements (n=2) repeated the group once before starting PCIT. A manualized collateral safety and skill-building group was provided for the children, which ran concurrently with the motivational enhancement parent module. Following the motivational enhancement orientation module, parents began a 12–14 session course of PCIT. Like standard PCIT, the version of PCIT used in this study was conducted in clinic-based, individual parent–child dyad sessions. PCIT itself consists of two phases. The first phase, Child Directed Interaction (CDI), focuses on teaching relationship enhancement skills and establishing a daily positive parent–child interaction		

				time. The first phase consists of a single didactic session followed by five to six live-coached parent–child dyad sessions. Parents are coached to ignore minor child misbehaviour; to follow their child's lead in a play interaction; to avoid criticism, sarcasm, or other negative behaviours; and to increase use of labelled praise, reflection, imitation, description, and enthusiasm. Daily homework practice logs were assigned to encourage practice of these skills. The second phase of PCIT, Parent-Directed Interaction (PDI), focuses on teaching command-giving skills and a behavioural discipline protocol for using time-out to obtain child compliance. The second phase also consists of a single didactic session followed by five to six		

				live-coached parent–child dyad sessions. PCIT was developed for children presenting with disruptive behaviour disorders. Modifications to standard PCIT were made to address special issues related to physically abusive families. For example, during the CDI, drills and role plays were used to redouble emphasis on identifying appropriate child behaviour and responding with specific praise, a behaviour that many physically abusive parents reported was foreign and difficult for them. In standard PCIT, mild corporal punishment may be used if children refuse to comply with time-out. This was not used with physically abusive parents. Nonviolent back-ups and strategies to prevent non-compliance with time-out were taught instead (e.g., depending on age and		

				parental self-control, strategies such as contingent loss of special rewards, time-out in a barrier room or holding chair). Following completion of PCIT, parents and children participated in a four-session follow-up group program. These groups were less structured and focused on any skill implementation problems parents might discuss or other issues parents would choose to raise. The main purpose of the follow-up group was to structure the PCIT intervention to be of the same 6-month duration as the standard community parenting group intervention. During this phase, children attended a concurrent manualized support group that focused on teaching social skills. In the enhanced PCIT version, individualized enhanced services		

				(such as additional home visits, marital and/or family psychotherapy, etc) were added, with particular attention to services targeting parental depression, current substance abuse, and family, marital, or domestic violence problems. The 'standard' community intervention had three phases: a six-session orientation module; a 12 session parenting skills group; and a 12-session anager management group (M. Chaffin et al., 2004).		
GROUP E. Non-perinatal father-targeted interventions						
Caring Dads	Caring Dads: Safer Children is a parenting programme for domestically abusive fathers, developed in Canada by Scott and Crooks (2004) and	The primary commitment of Caring Dads is to the safety and wellbeing of children. The programme uses men's role as	Fathers who have abused or neglected a child/ children or exposed them to domestic abuse; or are deemed to	UK: Study 1: The programme was evaluated based on delivery in five sites located in mostly urban areas of	**Study 1** The evaluation considered the impact of the intervention on fathers, their children and partners, and found promising evidence that the programme can	Quasi-experimental D 3, 4 O 2, 3, 4

	evaluated in the UK by NSPCC. The Caring Dads programme includes three elements: group work with fathers, partner engagement and coordinated case management. To be eligible for CDSC, the fathers must: • have abused or neglected their children, exposed them to domestic abuse, or be deemed to be at high risk for these behaviours • currently care for or have contact with their children • be sufficiently motivated to attend group sessions; and • have some, however limited, acknowledgement of their abusive behaviour. Eligible fathers attend a two-hour weekly session, usually facilitated by a male and female worker, for 17 weeks. During this time, the programme sets out to achieve four major goals: 1. To develop sufficient trust and motivation to engage men in the	fathers to motivate them to change their abusive behaviour and reduce the risk of them further harming their children.	be at high risk for these behaviours.	England, Wales and Northern Ireland in 2010-2014. Over two-thirds of referrals to the programme came from social services; other referrals came from the Children and Family Court Advisory and Support Service (CAFCASS), probation and health services. Over the whole period of the evaluation, 6% of fathers had self-referred. The percentage of fathers self-referring decreased from 8% during the first few years to 2% during the final year of the evaluation. All fathers who started the first session of the programme were invited to participate in the evaluation. Of these, 334 (97% of the total) agreed to take part, and 185 (54%) provided post-intervention data (apart from one father, who refused, the others had dropped out or been asked to leave during the	contribute to reducing risks to children, including evidence of sustained change among some fathers. Researchers found that: • Fathers and partners reported fewer incidents of domestic abuse post-programme • Potential risks to children appeared to reduce as fathers generally found being a parent less stressful and interacted better with their children after they had attended the programme (improvements in the fathers' total parenting stress, parent–child dysfunctional interaction and perceptions of a difficult child were all sustained six months post-intervention – although these figures are based on only 27% of the overall sample, so may not be generalisable). • Qualitative data provided illustrations of how the programme can bring about positive improvements in the	

	process of examining their fathering. 2. To increase men's awareness of child-centred fathering. 3. To increase men's awareness of, and responsibility for, abusive and neglectful fathering, and 4. To consolidate learning, rebuild trust, and plan for the future.			programme); 49 (14%) also provided follow-up data. Some partners and children also provided pre, post and follow-up data. Measures included: the Parenting Stress Index 3rd Edition Short Form1 (PSI); the Parental Acceptance and Rejection Questionnaire (PARQ); the Controlling Behaviours Inventory (CBI); the Strengths and Difficulties Questionnaire (SDQ); the Adolescent Wellbeing Scale; and the Adult Wellbeing Scale. Qualitative interviews also took place with fathers' family member, and practitioners, and fathers' case records were analysed (NSPCC, 2016). Study 2: Information was collected in relation to 38 fathers who completed the programme in eight groups in five different	fathers' behaviour. However, some fathers did not change sufficiently despite completing the programme • Sustained improvements in the fathers' behaviour appeared to contribute to increased feelings of safety and wellbeing within their families. • CDSC practitioners reported being able to influence decision making about children, either by providing evidence of the fathers' learning or highlighting additional safeguarding concerns. • The programme provided opportunities to explain to fathers exactly what change they needed to make, and to gain more understanding of the current risk fathers posed to their families. • Case notes indicated an improvement in children's circumstances for nearly half (48%) of fathers who completed CDSC, usually as part of a coordinated cross-	

				local authority sites. Data was collected at three time intervals: start of the programme (T1), end of the programme (T2) and six months post-programme (T3). The main forms of data collection were: Face-to-face interviews with fathers Interviews with partners or ex-partners Standardised questionnaires completed with fathers Interviews with referring practitioners and social workers Interviews with programme facilitators, Interviews with practitioners involved in partner contact Interviews with team managers and parenting coordinators. Analysis of the data yielded findings on process and outcomes of the groups participating in the evaluation (Hood et al., 2015).	agency plan. In 6% of cases, social services had closed the case and/or recorded no safeguarding concerns; in 13% of cases the child was removed from the child protection register or plan; in 3% the child was returned to parents' care. • In a small minority of cases (3%) staff detected a deterioration in the father-child relationship and/or an increase in abusive behaviour, and were able to act accordingly, for example by strengthening the child protection plan. • Contact with the father's family and working alongside other agencies involved was found to be essential for the safe delivery of the group work programme. **Study 2** *Findings about process* Attrition from referrals to men starting the group ranged from 59% to 37%, mostly as a result of fathers not engaging with the	

				Canada: Study 3 studied 98 fathers who completed the Caring Dads programme in Canada (Scott & Lishak, 2012).	screening process. On average, two thirds of men who started in the first three sessions went on to complete the programme. Group dynamics were characterised by an emerging 'core' of fathers who attended consistently and developed a rapport with each other and with facilitators. These fathers were generally motivated to engage with the material, and contribute actively to dialogue and discussion. Facilitators sometimes wondered how far to go in challenging abusive attitudes and partner-blaming. Facilitators generally felt able to deliver the programme as set out in the manual. Groups did not work as instructional sessions, in the manner of a parenting course, but rather through dialogue and discussion. Due to time constraints, there were limited opportunities to	

					do one-to-one work with fathers. □ Communication with referrers was variable and Caring Dads was not always integrated into the wider safeguarding process. There were similar problems with partner contact, which was only organised consistently in one of the sites. □ Facilitators were from a mixture of probation and social work backgrounds. Clinical supervision was helpful in resolving differences in professional approach, particularly around managing group dynamics and challenging individuals. *Findings about outcomes* □ Analysis of questionnaires with fathers was hindered by the small sample of paired pre- and post- measures and poor internal consistency of data. The results showed no significant changes in father involvement, parenting alliance,	

					parenting scales, or children's strengths and difficulties. □ Analysis of interviews with fathers established concerns at T1 particularly in relation to emotional unavailability, psychological boundaries, and undermining of the children's relationship with their mother. Responses at T2 suggested that fathers had shifted to same extent towards more appropriate attitudes and parenting practices during the course of the programme, particularly in terms of emotional responsiveness. □ Analysis of feedback from referrers showed that the most common risk factors at the point of referral were emotional abuse, parental conflict, fathers not taking responsibility for their children, and minimisation of concerns. Indications were that fathers found it easier to demonstrate appropriate interactions with their children than	

					to apply a child-centred approach to other aspects of their fathering role. Positive outcomes were noted in over half of cases where fathers were being considered as full-time carers for their children. Study 3: found evidence that the programme has potential to promote positive change in fathers' parenting and co-parenting, but no evidence of change in aggression after completing the programme.	
Community-based Domestic Violence Perpetrator Partnerships	Project Mirabal (Kelly & Westmarland 2015) reports that since 1989, the UK has seen a steady growth of Domestic Violence/Abuse Perpetrator Programmes (DVPPs/ DAPPs). These have focused on individual and group work behaviour change programmes for male perpetrators of violence towards female partners and ex-	Teaching perpetrators of partner and/or family violence to adopt non-violent behaviours, whilst simultaneously ensuring that the safety of victims remains paramount	Male perpetrators of partner and/or family violence	The main study was built around two core strands of data collection, locating DVPPs in their wider contexts and operationalising the six measures of success developed in the pilot study drawing on 70 interviews with men on programmes, women whose (ex) partners were on a	The study found remarkable reductions in physical and sexual violence against women: 30% of women whose husband/partner entered the programme reported having been made to "do something sexual" they did not want to do in the three months beforehand; that was reduced to zero a year later.	Multi-method longitudinal study D 3 4 O 3 4

	partners (survivors). Integral to this is a package of support for survivors provided by an Integrated Support Service (ISS). The precise nature of the programme may vary by area, but a Respect accredited programme has safety of victims and children as its aim and focus, and can contribute to this aim in a range of unique ways: 1. Carry out assessments of risk and programme suitability 2. Make proactive contact with partners, ex-partners, new partners and others who may be at current or recent risk from the individuals referred; 3. Offer support, information and advocacy as needed to those partners 4. Carry out individual or group work or a combination of the two with perpetrators able and willing to engage with the DVPP; 5. Carry out joint risk and case management between programme workers and partner support workers;			DVPP, DVPP staff and funders. The first two were particularly important for women, underlining that ending violence and abuse is a necessary, but insufficient, requirement for safety and freedom. 1. An improved relationship underpinned by respect and effective communication. 2. Expanded 'space for action' for women which restores their voice and ability to make choices, whilst improving their well-being. 3. Safety and freedom from violence and abuse for women and children. 4. Safe, positive and shared parenting. 5. Enhanced awareness of self and others for men, including an understanding of the impact that domestic violence has had on their partner and children.	Similarly, women reporting having a weapon used against them reduced from 29% to zero. Those who said they were slapped, punched or had something thrown at them reduced from 87% to 7%. Far fewer women reported being physically injured after the programme (61% before compared to 2% after), and the extent to which children saw or overheard violence also dropped substantially, from 80% to 8%. The study did not provide data about fathers' violence against children, but explored many of the subtleties of life in a violent household, including aspects relating to parenting. Fewer children were found to be scared of the perpetrator, and worried about the safety of their mother, for example. The study also found that programmes were more effective for men who entered them *with an*	

	6. Contribute to inter agency risk management and safety planning to protect victims and/or children; 7. Co-locate with children's social workers to assist with risk assessment, case management, engagement with parents, assess parenting capacity etc. 8. Provide specialist reports of current and potential risk from individual clients referred to the programme by family courts, children's services and safeguarding, MARAC or others 9. Provide assessments of likely risk of harm to children on contact visits, to inform court decisions; 10. Improve skills, confidence and knowledge of other frontline agencies in responding to perpetrators.			6. For children, safer, healthier childhoods in which they feel heard and cared about. The study used a range of quantitative and qualitative approaches, including use of surveys, programme data and interviews with perpetrators, (ex) partners, children and staff. The interventions group (DVPP participants and their families, from 12 DVPP projects) were compared with a comparison group receiving survivor/ victim-only support via Freedom Programmes (13 sites); however, researchers concluded that differences between the two groups were too great (for example in 40% of comparison group families, fathers had no contact with their children, vs 16% in the intervention group; decision-making about child	*interest in change within existing relationships* (our italics), than for those who, after a length of separation and limited or no communication with ex-partners, had made a legal application for child contact. Group work, the length and depth of programmes, and the nuanced understandings of gender that underpinned the work, were found to be important, enabling the men to be self-reflective and question their assumptions about masculinity in relationships and parenting. Overall, the researchers concluded that perpetrator programmes can allow men who are ready to choose to stop using violence and abuse in relationships to take steps – some big steps, some tiny – towards change.	

				contact also differed, with the family court or children's services tending to have more influence for the intervention group; couples in the intervention group were also more likely to still be together – this was true in nearly half of cases pre-programme and a third post, vs 13% and 9% in the comparison group) and so did not report data from the comparison group. Recruitment of men was more successful than women, with 64 men and 48 women taking part in the baseline interview. There was a high degree of sample attrition with 36 men (56%) men and 26 women (54%) completing the second interview. More than half the men (20/36) at second interview had had limited/ no contact with their		

				child/ren since baseline.		
Dad2K	Dad2K is an augmented version of the Parent-Child Interaction module of SafeCare (see above), which has been shown to be independently effective for reducing risk and improving parenting in prevention populations, and which pilots suggested might be effective with fathers. Researchers designed Dad2K to maximise engagement with fathers and reduce reliance on verbal interaction with the course provider, by using online content and activities to teach and model target skills, supported by live, face-to-face practice with the home visit practitioner.	Reduction of child physical abuse and neglect	Fathers at risk of maltreating children aged 2-5 ('at risk' being defined as exhibiting two of four factors: low education level; low household income; unmarried; young age at time of first child's birth)	US (large southern city): RCT with 99 male caregivers, mostly from deprived and/or high-risk families (including teen father and Early Head Start programmes); 51 were randomised to the intervention and 48 to control. Dad2K fathers participated in six home visiting sessions and were invited to complete the module between baseline and second assessments (8 weeks later). Control group fathers received parenting materials at three timepoints during the study. The trial measured parent-child interaction satisfaction, parenting skills and child maltreatment behaviours (Self-Brown et al., 2017)	A significant main effect emerged indicating decreases for both groups in psychologically aggressive behaviours. No significant group by time findings emerged for child maltreatment behaviours. Father intervention completers endorsed high satisfaction ratings for the programme and demonstrated significant improvements in targeted father-child interaction skills.	RCT D 3, 4 O 2, 4
DADS Family Project	The DADS (Dads Actively Developing Stable Families) Family Project is an eight-session parenting	The aim of the programme is to help fathers develop new attitudes	Fathers (no specific sub-group)	DADFP was evaluated with a cohort of 63 imprisoned fathers. Of	Fathers self-reported improved scores in three out of eight scales namely 'permitting self-	Quasi-experimental D 4 O 3, 4

	intervention with modules aimed at supporting fathers to develop: • Self • Safety and Sensitivity • Play Skills • Communication Skills • Stress Management Skills • Effective Discipline Skills • Experiential Skills. The goals for each father include: recognition of his potential positive impact on his children; improvement in his attitude of wanting to be an equal parent; development of a personal model of fatherhood as a "generative" dad; an understanding of the meaning and strategies for establishing a safe, secure, predictable, and reliable home environment; an appreciation of the value of play for children and strategies for playing; and improvement of skills of communication, stress management, and	towards parenting, and learn parenting skills.		these, 46 took part face-to-face in live sessions in three different prisons, and 17 took part remotely via video conferencing. Fathers took part in four x 3-hour sessions. Impact was assessed by fathers' self-report using a total of 45 items; of these, 40 fitted into the following eight sub-scales: Encouraging Verbalization, Fostering Independence, Permitting Child's Self-Expression, Avoiding Harsh Punishment, Non-Punishment, Avoiding Strictness, Encouraging Emotional Expression, and Change Orientation (Cornille et al., 2006).	expression', 'avoiding harsh punishment' and 'no physical punishment'. Changes were more significant in the distance learning group, but researchers suggest that pre-existing differences may have accounted for some of these changes.	

	discipline. The curriculum utilizes a self-efficacy model to enable fathers to lower anxiety, experience a sense of accomplishment, and maintain high level of effort. Fathers learn from and support one another in a context that allows for building trust and promoting community spirit.					
The Drive Project	The Drive intervention is a perpetrator programme aimed at high risk, high harm and/or serial domestic abuse perpetrators. Drive implements a whole-system approach using intensive case management alongside a coordinated multi-agency response, working closely with victim services, the police, probation, children's social services, housing, substance misuse and mental health teams. Drive focuses on reducing risk and increasing victim safety by combining disruption, support and behaviour-change interventions alongside the crucial protective work by victim	Drive targets perpetrators of domestic abuse to improve outcomes for victims and children. The key objectives are to: reduce the harm caused to victims and children; reduce the number of serial perpetrators of domestic abuse; reduce the number of repeat and new victims; and intervene earlier to safeguard families living with high-risk, high-harm domestic abuse.	High-risk, high-harm perpetrators (94% male) were identified via the MARAC referral pathway for associated victims-survivors.	The Drive Project was piloted in three areas across England and Wales (Essex, South Wales and West Sussex) from April 2016 to October 2019 with the aim of reducing the number of child and adult victims of domestic abuse by deterring perpetrator behaviour. The study explored what happened during the ten or so months of intervention to 506 perpetrators who were randomly selected to the Drive cohort, and whether change was sustained during the twelve months after they completed Drive. Findings were	The study found that the Drive perpetrator intervention was reducing the use of abusive behaviours, increasing safety for victims and children, and doing so to a greater degree than in cases where only victim-targeted support is provided. The data showed a more sustainable impact on safety when Drive is present. Key findings include: • The number of Drive service users using each type of domestic violence and abuse (DVA)	RCT D 3 4 O 3 4

	services. Drive has been developed to knit together existing services, complementing and enhancing existing interventions.It is run by a partnership between Respect, SafeLives and Social Finance. The costs of the three-year pilot were met by a combination of local funding from police and crime commissioners, local authority budgets, the Home Office Police Innovation Fund and philanthropic grants from Lloyds Bank Foundation for England and Wales, The Tudor Trust and Comic Relief. Work can be carried out in direct contact with the service user, or where this is not possible, indirectly. Drive's direct contact one-on-one work is a bespoke offer rather than a standard programme delivered to each service user. However, themes of direct work included: • Relationship building to cultivate and sustain engagement in behaviour change work;			generated from a randomised control trial and draw on qualitative and quantitative data from a range of sources including monitoring data; interviews with practitioners, Drive service users and associated victims-survivors; case note analysis; police and Multi-Agency Risk Assessment Conference (MARAC) data to establish findings and cross-check them from a range of perspectives including victim-survivors, professionals and service users. The 506 (of 5096) service users who were randomly allocated to Drive for a ten-month period. • Drive associated victims-survivors. Outcomes data was available for 196 victims-survivors whose perpetrators were on Drive and who were themselves	behaviour reduced substantially. For example physical abuse reduced by 82%; sexual abuse reduced by 88%; harassment and stalking behaviours reduced by 75%; and jealous and controlling behaviours reduced by 73%. • For both the Drive-associated victims-survivors group and the victims-survivors in the control group, IDVAs perceived a significant or moderate reduction in risk in over three quarters of cases over the period of the intervention. The overall	

	• Work on impulse control and emotional regulation; • Working with past trauma as a route to developing empathy and acknowledging of the impact of abuse especially for service users with children; • Partnership working with social workers enabling a level of service user engagement that had not previously been possible as well as changing the perspectives of the social workers involved in relation to their understanding of the dynamics of abuse in the case; • Step-down work after the normal ten-months of intervention when more time was needed to consolidate change and/or to ease the transition to greater self-reliance. Indirect work includes information sharing, institutional advocacy and co-ordinating multi-agency action to heighten risk awareness and the ability to respond. Responses include disruption activity focusing on the perpetrator and/or risk			engaging with an IDVA. • A control group of 610 victim-survivors who were engaging with IDVAs. • MARAC data for 184 Drive service users and 1,139 control group perpetrators for site 2. • Police data for 149 Drive service users and 173 control group perpetrators for site 2. • Qualitative interviews with practitioners (N=88), service users (N=30) and victims-survivors (N=19), where N is the number of interviews. • In-depth analysis of 30 Drive case manager case notes. Children and Young People's Services were involved with 20% of cases and under half of service users (43%) were reported as having 'current legal proceedings' in relation to Criminal and Civil Justice involvement at intake.	trend was a reduction in risk for both groups, with a stronger reduction for Drive associated victims-survivors, and IDVAs assessed risk 'permanently eliminated' at the point of case closure in almost 3 times as many cases for victims-survivors in the Drive associated group (11%) compared to those in the control group (4%) • Drive victim-survivors were more likely (82%) to experience a moderate or significant reduction in risk than their control counterparts (78%).	

	management activity to protect the victim-survivor. Indirect work was generally much more common than direct work with service users. Findings from the analysis of case managers' recorded actions showed that indirect work accounted for 84% of case managers' activities and direct work accounted for 16% in both Year 2 and 3. There was less indirect work in Year 1 as the multi-agency links required for this had not embedded to the same extent at that stage.			9% of service users were recorded as living with the victim. 63% of the Drive service users had one or more needs. 34% had 3 or more needs. Case managers assessed service users for: drugs and alcohol misuse, housing issues, unemployment, mental health issues, financial issues, children and family issues, parenting capacity issues, social isolation and poor physical health. Of those service users engaging with Drive case managers, the most likely to engage were those with financial difficulties (61%), poor physical health (62%) and mental health difficulties (51%). Drive case managers interviewed often described service users with no additional needs as some of the hardest to engage due to a lack of available 'levers' or	• MARAC data shows that Drive helped to reduce high-risk perpetration including by serial and repeat perpetrators, and this was sustained for a year after the case was closed. Drive service users appeared at MARAC less often (mean= 2.7 times) than perpetrators in the control group (mean= 3.3 times). This difference was statistically significant. • Police data for a matched sample in Year 2 of the pilot showed perpetration of DVA offending had reduced by 30% for Drive service users	

				incentives to elicit engagement. (Hester et al., 2019)	recorded in the 6 months after the intervention compared to 6 months before, where the control group were reported as perpetrating DVA at the same level. • The proportion of Drive service users with recorded police DVA incidents continued to fall more than a year after the intervention, whereas in the control group it began to rise after 12-months post-intervention. • Case note analysis shows significant risk reductions were achieved without making direct contact with the service user – by working with the victim-survivor and through multi-	

					• agency disruption activity focusing on preventing abuse. • A degree of statutory involvement, for example from police, probation or social services, was found to be a key factor in engaging service users. Where other agencies are not involved with the service user and/or the victim-survivor is not in contact with the IDVA, it was found to be extremely challenging to engage the service user and manage risk effectively. Researchers defined around 10% of Drive service users as having 'children and parenting issues'. Roughly a third of service users with a	

					defined need relating to parenting capacity or their relationship with a child/ children, engaged with case managers. Areas of need more closely associated with engagement included poor physical health (61%), financial difficulties (61%) and mental health problems (51%). At the midpoint 25% of those service users with high need around parenting capacity were engaged with the programme; 14% were partially engaged and 58% not engaged. Those with high need around relationship with children had the highest level of non-engagement of all need categories (67%). Especially for service users with children, working with past trauma was a route to acknowledging the impact of abuse and developing empathy with their children. The positive aspiration to be a better parent	

					was a common theme in service user narratives. 26 of the 28 service users interviewed across the three years had children and within the wider sample (n=212), service users with children were more likely to engage – of those service users who at least partially engaged, 70% had children. Where the information was available, 32% of those service users interviewed had ongoing child protection proceedings. Similarly, within the wider sample, the service users who engaged were more likely to have child protection involved – 64% of the 212 service users with child protection concerns engaged with Drive case managers. Multi-agency work with children's social services was particularly notable in Years 2 and 3. This ranged from relatively simple activities like enhanced information	

					sharing and Drive engagement being written into the child protection plan, through to detailed partnership working including joint visits, shared and/or coordinated actions/tasks and close communication between social workers and Drive case managers.	
Fathers 4 Change	Fathers for Change has both individual and coparenting components. It begins as an individual intervention for fathers of children (under 10 years) with a history of IPV, defined as threatened or actual sexual or physical violence against an intimate partner, and co-occurring substance abuse. The Fathers for Change intervention includes 14 topics delivered in 60-minute sessions of individual and dyadic treatment over approximately 4 months. The intervention combines attachment, family systems, and cognitive behavioral theory with the	Fathers for Change was developed to help men who abuse sustances and perpetrate family violence – to reduce transmission of IPV across generations	Fathers who have threatened or used violence (and who recognize the impact of their violence and interparental conflict on their children) – and who abuse substances.	US (Florida): Study 1: 35 men were referred to the study by the courts or the Department of Children and Families (DCF) after either an arrest for domestic violence or drug related charges or a call for an investigation to DCF due to these co-occurring issues; 28 met criteria based on initial phone screening and 24 agreed to participate. Of those, 21 attended the initial research assessment and signed informed consent and two were excluded following further assessment.	Study 1: F4C fathers were more likely to complete treatment (67% vs. 33%, p=.10); they also showed a trend toward greater reduction in violence that continued following treatment. Not only did men reduce their violence, but they also reported less violence by their partners. Reductions in substance abuse for the F4C and IDC groups were comparable. In videotaped interactions with their children, F4C men showed less intrusiveness during free-play interactions and more consistency of style post	RCT D 3, 4 O 2, 3, 4

	goals of: (1) cessation of violence and aggression; (2) abstinence from substances; (3) improved coparenting; (4) decreased negative parenting behaviors; and (5) increased positive parenting behaviours. Following assessment, treatment begins with individual-focused sessions, followed by coparenting-focused sessions and ending with restorative parenting sessions. Coparents are invited to an initial individual session with the therapist when the program begins and again just before the coparent session segment. These sessions are used to help the mother: (1) feel comfortable with the therapist in advance of coparent sessions; (2) understand the program and its goals; (3) be prepared for the coparent sessions; and (4) be able to talk openly with the therapist about her concerns in the relationship and assure it is safe to engage in conjoint sessions. Once it			The remaining 18 fathers were randomised to receive either Fathers for Change (F4C) or Individual Drug Counselling (IDC) (C. S. Stover, 2015) Study 2: A more recent trial evaluated a modified version of the intervention implemented with a residential treatment program for 44 substance abusing men. Interviews were conducted at baseline and follow-up to assess the impact of the intervention on anger, hostile thinking and emotion regulation problems. Focus groups were also conducted with the participants to gain further insight into their needs as fathers and their recommendations for interventions that they would find helpful (C. S. Stover et al., 2018) Study 3: More recently again, F4C was compared to a	intervention, compared to IDC. Study 2: Results indicated a high prevalence of anger-related thoughts at baseline that significantly decreased at follow up; there were also significant reductions in affect regulation problems. A very high proportion of participants (84%) completed the programme in its entirety and were highly satisfied with the content. Study 3: Fathers in F4C had greater reductions in emotion dysregulation and less substance use following discharge than men in the PE group. F4C was more effective in reducing affect dysregulation; both showed reductions in partner abuse. Study 4: In the initial 2.5 years of implementation, 207 fathers were referred for F4C, with a 70%	

	is determined to be safe for conjoint coparent sessions, mothers can participate in up to six sessions with the father. The final phase of restorative parenting includes the father and his child. Mothers are invited to participate in one of these final phase sessions when deemed appropriate and clinically indicated by the therapist. The areas of focus for each of the three phases of Fathers for Change are: (1) abstinence from aggression and substance abuse; (2) coparenting communication; (3) parenting/father–child relationship. The focus is on the paternal role throughout treatment, both in terms of the father–child and the coparenting relationships. The central premise is that the focus on men as fathers and increasing their feelings of competence and meaning within their parenting role, will provide motivation to change maladaptive			parenting education program (PE) called Dads 'n' Kids, in a randomized trial. Sixty fathers were randomized to F4C or PE (C. S. Stover et al., 2019). Study 4: Most recently, clinicians from six community mental health agencies were trained to offer F4C to child protection involved families through a state-wide initiative in Connecticut. In this initiative, F4C was implemented as part of a larger Intimate Partner Violence Family Assessment Intervention Response which includes assessment of all members of the family, safety planning, treatment for mothers and fathers and case management services. Each family is assigned a clinician and family navigator team. The clinician provides F4C or other clinical treatment	completion rate. Pre-post assessments revealed significant reductions in IPV and children's exposure to conflict based on both fathers and mothers' reports. Fathers reported significant reductions in affect dysregulation and hostility from pre to post intervention. These changes were associated with reductions in IPV post-intervention. Importantly, fathers also reported significant reductions in PTSD, depression and anxiety symptoms. Mothers who were co-parents of participating fathers also reported improved mental health symptoms in their children.	

	patterns that have led to use of aggression and substances to control negative feelings. In the coparenting phase, communication practice is focused on coparenting issues (e.g., visitation exchanges; different views of discipline) but not intimate partner-related issues (e.g., sex, jealousy). Participation of the coparent, while encouraged, always depends on the therapist's assessment of safety and on the mother's own wishes to participate. The restorative parenting sessions are designed to assist fathers in talking with their children about the mistakes they have made and building more positive relationships with their children. These include sessions with the father and child together where he can talk with his child about his past behaviors in an age-appropriate way, share some of the coping skills he has learned, see the therapist model appropriate parent management techniques,			needed by the mother and father and the family navigator assists with case management, connection with other services, and advocacy (Carla Smith Stover et al., 2020).		

	and engage in child-directed play activities.					
Strong Fathers	Strong Fathers is a psychoeducational and skills-building group for men with a history of domestic violence, referred by child welfare services. It was developed in the US state of North Carolina, In groups, the men learn parenting techniques and talk with each other about good ways of fathering and caring for their families. The Strong Fathers curriculum incorporates, over 20 sessions, information and activities from similar programs as well as from evidence-based therapeutic models. Sessions focus on, among other things, fathers' childhood experiences, general parenting styles, domestic violence and its impact on child development, and stress management. Where possible, the programme was delivered by a mixed-gender team, to model male/ female collaboration.	The intervention aims to help men relate in safe and caring ways to their children, partners, and other family members, and become strong fathers who provide time and support; model non-violence and respect to their children; and show their children that they care and want safety for them and their mothers.	Fathers whose child/ children are in receipt of child welfare services, and who did not have a protective order preventing contact with the child/ children.	US (North Carolina) Study 1: 43 fathers who participated in six groups run by Family Services Inc – a non-profit in Winston-Salem, North Carolina – completed reflective logs as they progressed through the programme (Pennell et al., 2013). Study 2: The sample was 53 fathers who enrolled in the programme in 2009-2012, from the first six groups in Winston-Salem and the first two groups in Durham (NC); 47 of these participated in the evaluation. Data came from participants' goal-setting worksheets and weekly parenting logs, and from county administrative reports on child maltreatment (Pennell et al., 2014)	Study 1: 24 out of 43 fathers (56%) completed the programme; 13 partially completed it; six did not. Their participant logs provided rich data about the fathers' goals and experiences. Study 2: As part of the programme, fathers set their own goals. These fitted into four main themes: Caregiver of their children (87%); Role Model of respectful relationships with women (72%); Reclaiming their personhood and affirming the personhood of mamily members (58%), and Provider for their families (58%). Session by session, the 47 participants were asked to assess their progress towards these goals. Their written self-reflections identified that by the time they left the group, more than half the men realized	Qualitative D 3, 4 O 2, 3, 4

	The group was structured to support the men in setting their own goals, assessing their progress in achieving these goals, and sharing their accomplishments and challenges with the other participants. The men's self-reports on goal achievement could then be checked against child protection assessments.			Study 3: Researchers studied child protection records for 177 fathers enrolled on the programme in 2010-2015, to explore pre- and post-intervention reports to child protection services (Pennell, 2015).	the Provider and Care-giver goals; less than one-third achieved the Role Model goal, and only three men reached the Personhood goal. Men's statements about their progress on the goals were consistent with child protection outcomes. Before entering the programme, the families of 32 of the 53 sample had been reported to CP, and 18 of these had a CP finding (either substantiated child maltreatment or in need of services). Most (16) of the 18 families with a finding during the pre-period had household domestic violence cited as a contributory factor to the need for child protection intervention. After the men entered the group, only four of their families had CP findings: three findings emerged during the men's time in the group and one afterwards; researchers suggest the need for CP interevention might	

					have resulted from the men's participation. Only four out of the 53 families were reported in the post-period. Study 3: Among the 104 men (59% of the total) whose families had been reported to child protection services at some point in a three-year period on either side of participation in the programme (two years before and one year after enrolment), 35 (20%) were reported both pre- and post-programme. Almost a third (53: 30%) of men had 'child protection findings' (i.e. investigated reports that resulted in a determination of substantiated child maltreatment) pre-enrolment on the programme; this fell to 16 (9%) post-programme.	

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Appendix 4. Evidence from reviews of child protection practice

Study	Sample	Challenges highlighted	Practice pitfalls identified	Solutions suggested
(Ashley et al., 2011) Chapter 7: Serious case reviews: what do they conclude in terms of risky fathers? (Sean Haresnape)	45 serious case reviews involving death or serious injury of a child/ children and where a father/ father-figure was implicated	Working across agencies to clarify what voluntary agreements exist with parents, and who is responsible for monitoring them Need for staff to recognise partner abuse as a child safeguarding issue; to understand why and how to engage with fathers and assess their roles in families; to know how to work with reluctant, evasive and 'hard to reach' families; and to listen to the wider family	Over-reliance on SCRs, which represent a fairly small number of cases, to shape social work practice Failure by agencies to address fathers/ father figures in ways that address risk to the child Failure to respond to concerns raised by non-resident fathers Failure to keep good records of who did what, when and why – and to what effect Inconsistent practice in the use of written agreements. Variation in the thresholds applied in relation to domestic abuse.	There should be a full assessment of both the child's parents/ carers, including meeting and interviewing 'absent' parents Agencies should endeavour to engage with the fathers and father figures and examine their roles in the child's life Vulnerable mothers' new partners/ boyfriends, once known about, must be assessed as to his impact on and risk he may pose to the children Agencies should listen to non-resident fathers who may no longer be providing care for their children and involve them in decisions. Their views should be recorded and any reasons for not engaging with them made clear to them Children's Social Care should complete core assessments of families where serious partner abuse is identified. This should include assessment of the strengths and weaknesses of all carers Agencies should consider using specific standardised assessment tools for assessing the impact of domestic violence on children. Social workers should seek detailed information held by other agencies working with both parents.

			Inconsistent practice in sharing concerns re domestic abuse.	All voluntary agreements with parents by any agency should be properly documented, with clarification as to who has agreed them, monitoring, timeframes and contingencies Agencies should listen and record on file, information provided by the wider family and community that may assist in understanding the child's situation. This may include information that is provided by people who are hostile or who have a particular interest in their view being heard. Information given where possible should be checked and verified with others and recorded. Practitioners should consider the use of recording strategies that highlights the specific impact of significant events on the child; this may be the impact of domestic violence or the consequences of many changes of address. This information should be clearly accessible and draw on historical accounts. Develop and enforce strict record-keeping protocols, including chronologies. Where there are concerns for a child resulting from domestic abuse this should be shared with all relevant agencies. Where this has not been possible this should be recorded and reasons given. Agencies should develop clear and agreed protocols setting out when domestic abuse would trigger a referral to children's social care. This should take account of agreed indicators of harmful behaviour and the pattern of cumulative effect of incidents on the child. The joint working protocol should reflect the importance of changes in the circumstances of the child and family that may have the effect of heightening risk e.g. when families move, the effects of parental separation.

				Universal health services should ensure background history about both parents is gathered at the ante natal stage. Consideration should be given to routinely using genograms for this purpose Other key issues re domestic abuse to be agreed include: use of MARAC, assessment of all carers, strategy discussions, response to non-compliance with a CP plan, investigating domestic abuse, safety planning for DVA victim and child, risk to staff Children's social care and partner agencies should consider the training needs of their workforce in relation to working with risky fathers.
(Baynes & Holland, 2012) *Social work with violent men: a child protection file study in an English local authority*	40 child protection case files open in an English local authority in 2007; these involved 63 men and 71 children who were the focus of the child protection concerns	High levels of reported violence amongst the men in the study generally, irrespective of whether this was the issue that triggered the initial child protection meeting; many men had a previous history of violence Huge variety in case characteristics, ranging from a one-off incident to 20-year partner violence histories Differing response types from subgroups of fathers, e.g. fathers co-resident with mother were in closer contact with staff, but less likely to be responsive, than non-residents	Failure to engage with men before initial CP meeting (>1/3 no contact with anyone, 60% no contact with social worker) Continued lack of engagement by services, and non-attendance by men Failure to gather data systematically, including even basic information Undifferentiated approach to assessing 'parents' Higher standards of record-keeping around violence to children, than violence to women (the latter more 'sanitised');	Training and assessment tools need to keep pace with increased recognition of significance of domestic violence More research needed about interventions for violent men Need to recognise violent men's heterogeneity Need to identify and gather information about all men in children's lives (not just fathers) as soon as possible in the CP process More research needed about how to safely include violent men in CP meetings

		Risks of provoking further violence by engaging with men	tendency to attribute some blame for male violence, to women.	
(Osborn, 2014) *Working with fathers to safeguard children*	Audits of 20 child protection case files in each of six local authorities to look at approaches to fathers	Need to overcome a 'cultural blindspot' to working with fathers – that fathers are less important than mothers. Fathers exist and have impact, for good or ill. We need to accept this and work with it to achieve the best child outcomes. When fathers leave families, their involvement with children (the 'index' child and/or others) rarely ceases. This can be a good and/or bad thing.	Failing to work with both parents – which is inefficient and less effective Ignoring the fathers who are not in our line of vision. Men whose risky or negative behaviour is not challenged, are unlikely to change Gender-neutral approaches, e.g. referring to 'parents' instead of 'mothers and fathers' leave men off the hook Failing to see fathers as a risk and/or resource, and to address each of these assertively. This may include not listening to and/or assessing fathers outside the mother's home Placing unfair burdens on mothers by ignoring/ sidelining fathers and assuming she is/ should be the 'chief parent'. This may even involve making it her responsibility to	Father inclusion can be improved when: • the father's engagement is presented from the start as expected and important • professionals proactively seek the men out, explaining why they want to meet and acknowledging their role as a parent or carer and their expert knowledge about and concern for their child and family • forms requiring information from parents are designed with an assumption that the father's views are required and not just those of "the parent" • fathers are signed up systematically at the outset when the child is registered; and are pro-actively included • fathers' needs, including their mental health, are regularly assessed • services regard interventions as being as much for dads as for mums and proactively enable them to attend • the benefits to their child of fathers' participation are emphasised repeatedly. Systematisation is key – from data collection through to assessment, guidelines on inclusion/exclusion for conferences, use of interventions and evaluation. Organisations should create a clear and explicit culture of father-inclusion unless there are exceptional circumstances

			protect the child from his violence	
(NSPCC, 2017) *Hidden men: learning from serious case reviews*	Analysis of case reviews published since 2008 (an unspecified number) which highlighted the issue of professionals not identifying and/or assessing key men, such as fathers, mothers' partners, involved in the care of children who died or suffered harm.	Men play a very important role in children's lives and have a great influence on the children they care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers / female carers. From NSPCC's analysis of these case reviews, two categories of 'hidden' men emerged: • men who posed a risk to the child which resulted in them suffering harm • men, for example, estranged fathers who were capable of protecting and nurturing the child but were overlooked by professionals. The briefing was based on case reviews published since 2008, which highlighted the issue of professionals not identifying and/or assessing key men, such as fathers, mothers' partners, involved in the care of children who died or suffered harm.	**Lack of information sharing between adults' and children's services** Professionals involved with men who are fathers (such as substance misuse workers and probation officers) do not tend to share information about potential risks with other professionals supporting the children and partners of those men. This may be because they are unaware the men have contact with their children. Consequently, practitioners depend entirely on parents to share this information, which they may or may not do. **Relying too much on mothers for essential information** Professionals sometimes rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their	**Identifying the men in the child's life** • During pregnancy and after birth, make active enquiries about the child's father, the mother's relationships and any adults in contact with the child. Record these details. • Identify and carry out checks on any new adults who have significant contact with vulnerable children. Always clarify who the members of a household are each time you visit a family. • Be aware that some individuals will have a number of aliases. Try to find out what these are and carry out checks accordingly. You might also receive names which are incorrectly spelt. Make sure you carry out checks which allow for different spellings of a surname. • In an assessment, always put the child's needs before those of an adult. • It can be difficult to get mothers to open up and discuss their partners' involvement in their children's lives. Supervisors should support practitioners to find ways to engage with mothers and build trust. • Supervisors also need to offer guidance and training on working with fathers / male carers, monitor fathers' engagement with services and evaluate how effective direct work with them is. **Involving fathers** • From the very beginning, emphasise to parents how crucial the father's role is to the child's wellbeing. • Encourage fathers to attend ante-natal appointments and classes. Make appointments for times convenient to them (such as evenings). • Involve fathers and male carers in assessments. Ask them directly about risky behaviours such as drug and alcohol use and offer them services based on their needs.

		In these case reviews, children died or suffered serious harm in a number of different ways: • physical and sexual abuse by the mother's partner • killed by a father with mental health problems.	children. Professionals do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in them missing crucial information and failing to spot inconsistencies in the mother's account. **Not wishing to appear judgmental about parents' personal relationships** Professionals can be reluctant to judge the decisions parents make about their personal and sexual relationships. However this is to ignore the risks that might be posed to children by men who are in short-term, casual relationships with the mothers. **Overlooking the ability of estranged fathers to provide safe care for their children** Failing to identify and/ or engage with fathers ignores their fundamental importance in a child's emotional and psychological	• Make sure fathers and male carers (including those who are not directly involved in mothers' and children's lives) know about concerns relating to their child. Consult them about plans, invite them to child protection conferences and include them on core groups. **Men as protectors** • Estranged fathers / ex-partners may be able to give crucial information about a mother and her children. Likewise, the siblings of an at-risk child can give insights into family dynamics and important people in their lives. • Explore the potential of estranged fathers to offer protective care and stability

			development. When a vulnerable child's needs are not being met by their mother, an estranged father may be able to provide the protection and stability that the child needs.	
(Swann, 2015) *Breaking down barriers: developing an approach to include fathers in children's services*	Audits of 70 local authority case files involving fathers, and interviews with 10 social workers	Fathers being excluded from the social work task because: • Children and family social work is one of the few institutions to confront the perversities and abuses of traditional gender and power relations. Paternal alienation is a response to that male abuse. • The profession has been blind to father involvement as a defence against hegemonic masculinity, gender and power relations. • Local authorities have colluded over decades in silence,	Failure to include information about fathers in case files Failure to invite fathers to case conferences Failure to record/take account of fathers' parental responsibility Failure to involve fathers in assessments.	Fathers can be included in social work assessments and interventions where: • There is a whole system approach. • We identify and then continually re-identify how covert power and gender relations influence our behaviour in practice. (The author also proposes that we need to identify and then continually re-identify how covert race, sex and class relations influence our behaviour in practice). • We are all open to learning and be ready to act on that learning. • Social workers and managers, throughout the organisation, collaborate in developing practice by challenging the blindness and silence through regular dialogue about the challenges of father inclusion. • Social workers' anxieties are contained. • Social workers and managers are given permission to be afraid and describe the fear preferably in supervision. • Senior management authorise staff to focus on this activity. • Data over father inclusion is collected and targets set. • A senior manager leads a long-term collaborative project. The same senior manager is offered psychoanalytical supervision.

		blind to the abuse caused by men. • This blindness has been mirrored in government departments, inspections and academic organisation. • This blindness means abusive men are not held to account, whilst abused women and children remain at risk, perpetuating the cycle of abuse. • The blindness will continue to recur risking repeating a pattern of harm to children and women. • This blindness has contributed to the continued marginalisation of fathers. • From a financial perspective, local authorities are missing opportunities for children to be placed with fathers or paternal extended families thereby saving		• There is a long-term, (ten to fifteen years), strategic commitment and a realignment of resources to meaningfully address domestic violence.

		millions of pounds a year in foster placement and residential costs.		
(Sidebotham et al., 2016) Pathways to harm, pathways to protection: a triennial review of serious case reviews 2011-2014	293 serious case reviews relating to incidents involving death or serious injury of children, which occurred in the period 1 April 2011- 31 March 2014; including 175 SCRs for which there were published final reports	Across all SCRs, fathers (17%) and father figures (10%) were, when combined, more likely to be the source of harm than mothers (23%). Both parents were deemed responsible in 12% of cases. Infants appeared in reports predominantly to be healthy, with no particular vulnerabilities. In the 48 cases where a child (73% of them aged less than 2) had died from fatal physical abuse, the suspected perpretrator was the biological father (29% of cases) or a non-biological father/ mother's partner (23%). In the 28 cases involving deliberate/ overt filicide, the perpetrator was usually a biological parent – either the mother herself, or the biological father. In several cases, there appears to have been a trigger event, often a court case around	There is a danger in assuming that simply because children appear to be healthy and adapted, and don't stand out from their peers, they are necessarily free of any maltreatment. This is particularly so when there are known parental risks, or disrupted home circumstances. Failure to take proper account of parental risk factors, including age; domestic abuse (including coercive control); restrictions on fathers' contact with child. Accepting mothers' assurances about minimal risk from fathers/ father-figures. Failure to recognise and take account of coercive control by partners after separation. Tendency of police to focus (usually effectively) on addressing individual	The authors make a range of recommendations for how services might improve their identification of, and intervention with, at-risk children, based on the SCRs. These draw on family histories where father-involvement and/or lack of it, were often key to the death/injury. In some cases, SCRs themselves made recommendations about improving father-engagement; and this theme is mentioned more broadly several times by the report authors. Key practice 'learning points', many of which may be read as applying to fathers' as well as mothers' roles, include: • Very young babies are particularly vulnerable; premature babies, babies with a low birth weight and/or requiring initial (or in some cases lengthy) special care baby unit nursing, and babies born with neonatal abstinence syndrome may pose challenges to their parent(s) over and above the considerable demands of any new-born infant. • Disability may also be a factor, so professionals caring for disabled children and their families should consider the possibility of maltreatment in their assessments of the child • Young, unsupported parent(s) can face additional pressures and challenges in their caring roles.

		residence or contact, which preceded, or was preceded by, the murder.	incidents of domestic abuse. This carries the risk of harm-to-infants (and harm-to-women) carrying on for long periods of time.	• A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaging with parenthood provides an opportunity to explore with that parent, their feelings towards the child and any risks that this might pose (NB: the paragraphs leading to this point refer specifically to *maternal* ambivalence. Given that the report authors acknowledge the relatively high incidence of fathers' and father-figures' perpetration of harm throughout their report, it seems likely that their use of 'parent' in this recommendation is intended to widen the proposed change in approach to include supporting men who may be feeling ambivalent about a pregnancy/new baby.)
				
				• A wide range of factors in the parents' backgrounds may raise potential risks to the child. These include:
				  • Domestic abuse
				  • Parental mental health problems
				  • Drug and alcohol misuse
				  • Adverse childhood experiences
				  • A history of criminality, particularly violent crime
				  • Patterns of multiple, consecutive partners
				  • Acrimonious separation
				  • These factors appear to interact with each other, creating cumulative levels of risk the more factors are present
				
				• Domestic abuse is always harmful to children:

				• Any evidence of domestic abuse in a relationship in which there are children should prompt a careful consideration of the harms those children are suffering and how they can be effectively protected • Domestic abuse should not be seen solely in terms of violent incidents, but consideration should be given to the ongoing contexts of coercive control and the impact of these on the parent and children • Professionals should not rely on victims of domestic abuse to act for their own or their children's protection • Controlling behaviour may continue to pose risks to mothers and children, even following separation. • Any parental separation carries the potential for harm to the children involved; this is particularly the case where there is acrimony in the separation: • Family law courts should consider the impact on the child of any contested proceedings, contact arrangements, or parental allegations and counter-allegations: the children will always be victims in such battles, and their rights and needs should always come before those of either parent • Acrimonious separation and contested proceedings may be warning indicators of possible future serious or fatal harm to the children

				• Parental mental health problems should not be seen, in and of themselves, as necessarily harmful to children, but:
				  • Where there are indicators of an escalation in the severity of mental health problems, any indicators of delusional thought patterns towards the children, or where a parent expresses thoughts of self-harm, or of harming her or his children, these should be taken seriously and should prompt an urgent consideration of the safety of the child
				  • Where parental mental health problems co-exist with other risk indicators, particularly domestic abuse, but also including drug or alcohol misuse, or social isolation, this should prompt a further assessment of the child's safety. The authors state that in most cases involving a male perpetrator, there were paternal mental health problems and either 'known violent behaviour' or a previous criminal record
				
				• Any bereavement, loss, or threat of loss may lead to increased parental vulnerability and stress, which may be a trigger point for harm to a child
				
				• Insecure and inappropriate housing causes additional stress to families, and can adversely impact on the health and wellbeing of any children.

				• Families who appear to have a transient lifestyle or families from abroad, with few geographical or social connections, may be particularly vulnerable.
				
				• Professionals should be alert to the social networks available to parents with whom they are working
				  • Where a family appears to be socially isolated, this should prompt an appraisal of the safety and wellbeing of the children in that family
				  • Where extended family is available it is essential not to make assumptions about how supportive they may or may not be
				  • Immigrant families may find themselves particularly isolated due to the lack of shared language and/or culture
				  • Social isolation may be deliberate: in one case a mother changed the child's name by deed poll, and moved house, in order to avoid the birth father.
				
				Other key themes include:
				
				The need to focus on the voice of children and families. The authors point out that family members might be covering up abuse or neglect. "Balancing parental support, building on resilience and progress, while maintaining an attitude of respectful uncertainty is a challenge. Treating parents with openness and respect allows professionals to build a trusting relationship within which challenge can be made." (p14)

				Communication and information sharing. "Effective communication requires practitioner skills and a culture that promotes information sharing as well as clear systems and guidance that enables information to be critically appraised and used to guide decision making and planning. Information received must be triangulated and verified and child protection agencies must feedback promptly to referrers and others participating in safeguarding." (p15) **Assessments and thresholds**. "Children's social care assessments need to be planned, comprehensive and timely and involve all professionals working with the family. Opportunities for improvement were identified in adequately appraising relevant information, minimising delays, and improving clarity in the assessment processes. Professionals tended to see assessment as a one-off event rather than an ongoing process, relying at times on a single visit and single sources of information. This made it difficult to keep an open mind to different explanations for any presenting feature. This included cases where abuse was discounted for a particular concerning presentation, which should not be taken as confirming that the child had not suffered or would not suffer serious harm." (p15) **Reluctance to take responsibility**. "Professionals often hung back expecting others to act, or passed on information thinking their responsibility ended at that point. Assumptions could be made about the actions or views of others, including those of parents or carers, without checking them out first." (p16) In their practice briefing drawing on the same 175 cases, Brandon et al (2016) highlighted that one in four (24%) of the fatal SCRs related to children who

				had died from fatal physical abuse; nearly three-quarters (73%) of these children were under two years old. In the majority of cases, the cause of death was a severe non-accidental head injury, from suspected shaking or shaking impact injuries. On first inspection, many of these deaths seemed to arise 'out of the blue' in an otherwise unremarkable family, only known to universal services. However, close inspection reveals **there were often pointers toward some parent or carer risks**: "Most notable are the risks presented through situations of domestic abuse, particularly when this is in a context of a young or immature mother, or one who has ambivalent feelings to her child, and perhaps exacerbated through a transient or chaotic lifestyle with multiple partners, frequent house moves or overall social isolation" (p56). **It is this combination of multiple risks, coming together in a family with a young infant, which provides health and other practitioners with opportunities for recognition of risk and preventive intervention**, the authors claim.
(M. Brandon et al., 2017) *Counting fathers in: understanding men's experiences of the child protection system*	Interviews with 35 men relevant to child protection cases in three local authorities, contextualised with an audit of 150 case files (50 in each of the three LAs), and focus groups with social work professionals	Without good quality, consistent information about them, men can remain a 'shadowy' group – and this makes it difficult (or impossible) to make decisions about them as a risk or resource for their child. The range of challenges faced by fathers in the CP system was striking. They included: • Poor health: Well over half the 35	Assumptions about fathers' non-involvement in children's lives, which may mask reality. Case file audits identified 139 men in a parental or caregiving role in the lives of the 150 children. Although they were more mobile than mothers, fathers tended to remain involved post-separation (39 out of 139 (28%) were no longer in contact with their child one year on).	**Building a full picture of men's lives as fathers** Child protection assessments of men tend to lack depth and context, the authors claim. In order to assess and evaluate the balance of resource and risk of harm a father figure may present, social workers need to understand men's lives as fathers. They should seek the fullest picture possible of the background, relationship dynamics, wellbeing, and current circumstances of the child's father or father figure. Social workers and the multi-agency team need to be curious about men's lives, their perspectives and narratives. What they learn should inform a shared approach which takes account of the benefits to the child's wellbeing fathers may bring, as well as any harm they may pose.

		men had significant illness, disability or other impairments, including mental health problems and substance misuse • Poverty: Most of the fathers were living economically precarious lives, with reduced access to work and benefits, and growing debt • Relationship and housing issues: Men were continually balancing conflicting demands, for example trying to maintain their income, meet children's needs and manage contact with children from other relationships. When relationships broke down, it was fathers rather than mothers who left the shared home.	Failure to keep good quality, consistent records. Men may be linked in different ways to the child protection concern, ranging from being held fully or partly responsible, to being seen as a protective (or partly so) factor. Such distinctions are important. In many cases lack of information in case files suggested that men's positions remain unknown. Assumptions (among social workers, fathers, mothers and others) about the primacy of mothers' relationship with children (this was found to underpin men's agency (or lack of it) as fathers in their relationships, and in their dealings with the authorities. Tendency to settle for 'passive inclusion' of men in the CP system, rather than reaching for 'active involvement' (which can be transformative).	**Working relationships with fathers: pursuing active rather than passive involvement** Negotiation and support may be needed to enable men to participate more fully in the work to protect the child. Similarly, men may need support to stay involved with their child. Active involvement is part of a strengths-based approach where honest communication about child protection concerns does not preclude recognising the positive contributions a father can, or could make. **Bringing organisations into step to support better practice** Engaging fathers should be seen as everyday practice in child protection. Better engagement may require organisations to tackle structural and cultural barriers to fathers' involvement. This includes challenging deep rooted assumptions about gender and parenting, where the father-child relationship is often seen as secondary and where the child protection system tends to prioritise mothers over fathers. Workers need confidence that managers will support them in this and managers themselves need to challenge risk-averse, procedurally driven culture and practice. These actions should be considered part of local authorities' duties under the Equality Act 2010. The study authors call for **a more gender-differentiated approach to work with families, whereby services are designed and/or adapted to respond supportively to each parent**. This should be reflected in policy documents and guidance, and routine paperwork (for example letters being written to mothers and fathers separately). They mention several key areas in need of attention: *Access to the law*: "Social workers, as the lead professionals in child protection, need better knowledge and understanding of how and when fathers might need access to the law. Local authorities we worked

		Partner abuse was a factor in many men's stories and there are tensions between taking this seriously as a factor in child protection, and acknowledging both the existence of female-male violence, and the differential consequences perpetration has for fathers vs mothers. Less than half (15) of the 35 men were found to be exercising some degree of agency as fathers, and more than half (18) were 'largely resigned' from this. Factors affecting men's agency as fathers included: • Formative figures and events (positive and negative) from the past, which may need working through • Work-life balance and the meeting (or not) of societal expectations around fatherhood – underpinned by assumptions about the primacy of motherhood		alongside were mostly overlooking the potential to use the current exemptions and legal resources under the LASPO Regulations (Legal Aid, Sentencing & Punishment of Offenders Act 2012) to strengthen child protection plans or to enable fathers to access legal representation. We found examples where fathers were disadvantaged in relation to Child Arrangement Order applications in cases where the mother's care was deemed unsatisfactory but the case had not reached the Section 31 threshold." *Dealing with domestic violence and abuse*: "Child protection policy and practice guidance (and that of other public agencies, including the Police service) needs to be reviewed in the light of increasing evidence that although most domestic violence and abuse is committed by men against women, a significant minority of men are victims of abuse from their female partners. The complexity of DVA means that more sophisticated assessments procedures and training are needed for social workers and other professionals (Ali et al., 2016). *The range of interventions offered where there is DVA needs to reflect what is known about the greater variety of causes, types, degrees and consequences of abuse on all family members. Programmes for addressing men's DVA are often limited or reliant on short-term funding. A more proactive approach is needed for men who have lost more than one child to public care, who often but not always, have offending histories related to domestic violence. This group of men present complex combinations of vulnerabilities and risk factors, and both pose, and face, the greatest rehabilitative challenges **(our italics)**.* Currently such men are offered fewer services than mothers who have experienced recurrent care proceedings. Where fathers are incorrectly held responsible for DVA, this may delay or even rule out the possibility of otherwise viable fathers taking on the care of their children.

		• Ambivalence about the child (sometimes related to circumstances of the child's conception and other ensuing relationship complexities) • Quality/intensity of the father-child relationship correlated with strength of his agency in dealing with the authorities. Other factors were persistence, sense of entitlement and quality of agency. Differing perceptions of time between men and social workers – the 'when and how' of social workers' inclusion of men in fact-finding, assessment and so on – can disrupt/ undermine men's confidence in the CP system. There is a need for persistence and flexibility in relationship building with men, including around timing of meetings for example.		

		Most fathers experienced or perceived 'unfair treatment' based on their gender, in terms of, for example, responses to their emotions (anger); handling of allegations or concern about partner-abuse and harm to children; and recognition/ evaluation of their parenting. In focus groups, social workers and managers also recognised much of this. Working relationships between men and social workers were hindered by mutual scepticism, and organisational and attitudinal factors (for example capacity of social workers to 'tolerate' men's emotions, be flexible and reliable) contributed to success. Fathering is contextually sensitive, being affected by the CP system, social workers' actions and the individual father's own life events – all of which act to open and/or close the gate to father-involvement.		
(Bedston et al., 2019)	25,498 *recurrent* birth parents – 38% of them	Parents who enter recurrent sets of care proceedings represent a	The authors refer to a common assumption that fathers will be 'hidden' to	The researchers sought to build on existing research about trends and patterns in mothers' (re)appearances

Linked lives: Gender, family relations and recurrent care proceedings in England	fathers – whose data appeared *more than once* in records from the Children and Family Court Advisory and Support Services, covering care proceedings in England, 2008-2018. Just over a quarter (27.1%) of these fathers had a youngest child aged up to 4 weeks in care proceedings, and another 26% had a youngest child aged 4-51 weeks.	group of 'high risk' adults whose children are deemed to be suffering, or likely to suffer, significant harm. Previous research has shown that a sizeable proportion of increased 'demand' for family court time is generated by local authorities "bringing the same mothers back". In the decade from 2008-2018, an estimated 29% of mothers entered a recurrent set of care proceedings after previous appearances before the family courts – typically with a child aged less than one. But little is known of the fathers	the family justice system; instead their findings highlight the prominence of couple-hood as a key feature of recurrence, and the general visibility of fathers. In relation to "lone recurrent mothers" returning to the family courts (Type 5) a substantial but comparatively small proportion of fathers do remain unidentified: Type 5 mothers made up 18% of recurrent mothers.	in care proceedings, to better understand fathers' (re)appearances, and parents' family relationships. They uncovered a five-fold typology of family relations between mothers, fathers and children as they navigated repeated sets of care proceedings - each characterized by parents' gender as well as distinctive life-course positions of the parents and children. They found that **a substantial proportion of fathers (more than three-quarters) are 'visible' in care proceedings, and that the majority of those who return to court do so with the same partners and children**, as part of either a recurrent family (Type 1: same partner, same child; this accounts for 41% of recurrent fathers) or recurrent couple (Type 2: same partner, new child; this accounts for 36% of recurrent fathers). The authors suggest that to date, interventions have predominantly followed an individual-centered, mother-focused approach, commonly involving a bespoke, holistic service through a trusted key-worker model; they argue that their findings support **the need for whole-family, couple-focused and father-inclusive work**, that may well incorporate or adapt elements of existing interventions aimed at mothers.
(M. Brandon et al., 2017; Marian Brandon et al., 2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017*	368 serious case reviews relating to incidents where children died or suffered serious injury (2014-2017), and an in-depth analysis of a subset of 278 of these. There		Over-emphasis on mother-child dyad Lack of professional curiosity about men in children's lives, and consequent lack of in-depth assessment of fathers/ father figures/ mothers' partners	The authors report (pp68-70) that SCRs "often demonstrate a failure to consider all the significant figures in the family context and the roles they play in family functioning and dynamics. The invisibility of men in parental roles or the issue of absent fathers persists in this sample, echoing previous national reviews (Bailey et al, 2010; Brandon et al, 2012; Sidebotham et al, 2016)". They refer to a continued "dearth of information" about men in SCRs, and say that the primary focus of health professionals and social workers continues to be on the needs, circumstances and perspectives of the mother - even in established

	was also a more focused analysis of 63 final reports looking at a range of themes, including neglect.			relationships when the mother's partner has a major role in looking after the children. In one example, where the children were having overnight stays with their father: '…there was no expectation or requirement, for an in-depth assessment of Father's parenting capacity and assessment within his own home environment.' A similar lack of assessment is found when mothers form new relationships. In the same case, when facial bruising of the mother was identified during pregnancy this failed to trigger an assessment of her new partner to determine whether he presented any risk of harm to the unborn child. The authors state that "such lack of professional curiosity or interest in fathers and partners, not only potentially leaves women and children vulnerable, it can also leave fathers themselves feeling alienated, forgotten and their role in bringing up their children dismissed". The difficulty in engaging with fathers is exacerbated when a personal history of social care makes them uncomfortable or fearful of childcare professionals, the authors add. "If there is a lack of support to enable men to get their voices heard, a comprehensive understanding of the child's life is not always possible. The father in the case quoted above had held significant information about the possible abuse of his daughter at the hands of her mother and current partner, 'including photos of bruises to P… on his mobile phone'. He told the review that he had feared, at the time, sharing these with social workers because of his own personal experiences of the care system." The authors refer to factors from previous studies that can encourage fathers to become engaged with childcare services and enable them to get their voices heard, including rescheduling appointments and home

				visits to enable them to be present, and addressing communications to both parents. They add that "during the antenatal and postnatal period there is still a culture among professionals that the primary focus is on the needs and circumstances of mothers. This needs to be addressed so that father figures are included and that the contribution they make, the stress they experience and the risks they present are properly understood and addressed." Although the focus of the report is on cases involving neglect, its recommendations cover similar ground to previous triennial reviews, for example: the need for better cooperation and information sharing across agencies, including the police; the creation of systems, processes and strategies that ensure it is not left to individual judgement whether to show sufficient and appropriate interest in fathers and father-figures; improved supervision of key staff

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