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What is the role for child and family services in improving father engagement?

Translating research into practice.

Marek Baran

THE UNIVERSITY
of EDINBURGH

Doctorate in Clinical Psychology
The University of Edinburgh
August 2022
Declaration of Own Work

Name: Marek Baran

Title of Work:

Service-level barriers and facilitators to father engagement in child and family services: A systematic review and thematic synthesis of qualitative studies.

Strategic priorities for implementation of father-inclusive practice in mental health services for children and families: A Delphi expert consensus study

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- I understand that any false claim for this work will be penalised in accordance with the University regulations
- Received ethical approval from the School of Health in Social Science, University of Edinburgh
  OR
- Received ethical approval from an approved external body and registered this application and confirmation of approval with the School of Health in Social Science’s Ethical Committee

Signature:                      Date: 01/08/2022
Acknowledgements

Firstly, a very big thank you to all the experts who took part in the Delphi study – the amount of interest and the sheer enthusiasm of everyone involved kept reminding me how important and meaningful this project really is.

I wish to thank my supervisor, Dr Vilas Sawrikar for his can-do attitude, last-minute availability, giving me the extra push when needed, and - most of all - his faith in my ability to put this all together.

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Last, and by no means least, massive thanks to my wife Iweta for being the kindest, most patient and supportive human being; you made this journey possible and kept me going when things were hard.
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List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>AMPH</td>
<td>Administration and Policy in Mental Health</td>
</tr>
<tr>
<td>CASP</td>
<td>Critical Appraisal Skills Programme</td>
</tr>
<tr>
<td>CFIR</td>
<td>Consolidated Framework for Implementation Research</td>
</tr>
<tr>
<td>FIP</td>
<td>Father-Inclusive Practice</td>
</tr>
<tr>
<td>PICO</td>
<td>Population, Phenomenon of Interest, Context</td>
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</table>
Lay Summary

This thesis contains two papers that explore the issue of father engagement in child and family services. Compared to mothers, very few fathers attend family-based treatments. This is problematic because poor father engagement has serious implications for the effectiveness of family interventions. Research shows that family-based treatments may be more beneficial when both fathers and mothers participate. Although there are many reasons why fathers represent the minority of attending parents, research indicates that father engagement is significantly influenced by the organisational practices of individual services.

The first paper looked at research evidence from different types of family-based services, to identify the main aspects of service delivery that impact father engagement. We systematically reviewed qualitative studies where parents and professionals commented on organisational practices that encourage or discourage father engagement. Results show that practitioner knowledge and attitudes, the clinic environment, advertising and promotion activities, resources, availability of staff training, policies and practice guidelines, and the monitoring and evaluation of father participation, can all substantially influence levels of father engagement.

The second paper is an empirical research study. We asked fifty-six experts in family service provision to fill out three surveys to achieve consensus on key things that either stop or help services to adopt more father-friendly practices. The experts agreed that in order for services to practice in a way that is more father-inclusive, father engagement should be centrally prioritized, encouraged by the service managers, considered in organisational policies and staff guidance, and encouraged by local government and commissioning agencies.
Taken together, this thesis outlines the main organizational barriers and facilitators that impact father engagement and identifies what services should focus on in order to better tackle the barriers and become more father-inclusive. This could help organizations to shape their practice in a way that benefits fathers and, by extension, their children and partners.
Thesis Portfolio Abstract

Background: Fathers are underrepresented in services focused on improving child and family well-being. Despite growing awareness of benefits to father engagement in the last two decades, no significant improvements in this area have been documented. Evidence shows that father engagement is greatly influenced by organizational service provision. However, the understanding of specific service-level factors that impact father engagement is limited, and further information on strategies to overcome barriers to father engagement in services is required.

Aims: This research project had two objectives. The first was to synthesise existing research on service-level barriers and facilitators to father engagement in child and family services. The second objective was to identify the key factors that help or hinder the organizational implementation of Father-Inclusive Practice.

Methods: A systematic review of 23 qualitative studies reporting on barriers and facilitators to father engagement was conducted to distil the key elements of service provision that impact father engagement. An empirical study used Delphi methodology to gather expert opinion on strategic priorities for implementation of Father-Inclusive Practice.

Results and discussion: Father engagement in child and family services was found to be influenced by seven key themes that encompassed a mixture of individual practitioner competence and organizational characteristics. Furthermore, the experts agreed that implementation of father-inclusive practice was more likely to be successful if it is centrally prioritized, encouraged by the service leadership, embedded in policies and staff guidance, and encouraged by government and commissioning agencies. Results highlight the areas of service functioning that should be prioritized in order to create more father-inclusive service environments and emphasize the need for tailored implementation strategies.
Publications

The study reported in chapter 2 is in review:

Baran, M. & Sawrikar, V. Service-level barriers and facilitators to father engagement in child and family services: A systematic review and thematic synthesis of qualitative studies. *Children and Youth Services Review.*

The study reported in chapter 3 is in review. First revisions have been submitted.

Baran, M. & Sawrikar, V. Strategic priorities for implementation of father-inclusive practice in mental health services for children and families: A Delphi expert consensus study. *Administration and Policy in Mental Health and Mental Health Services Research.*
Chapter 1. General introduction

Content and format

This thesis consists of four chapters: a general introduction, a systematic review paper, an empirical research paper, and a general discussion. The general introduction (Chapter 1, current) describes in more detail the rationale, the relationship between the two studies conducted as part of this project, and the overall direction of our project. Chapter 2 presents the systematic review of the existing published literature regarding the service-level barriers and facilitators to father engagement. Its format follows the author guidelines for the Children and Youth Services Review journal, where it was submitted for publication. Chapter 3 presents a Delphi study that was conducted to establish expert consensus on strategic priorities for the implementation of father-inclusive practice. It is written in accordance with the author guidelines for the Administration and Policy in Mental Health and Mental Health Services Research journal. The empirical study was also submitted for publication and is currently under review following the initial revision. Finally, in Chapter 4, contributions of the two research papers in relation to the overall objective of this thesis are discussed.

Context of this research

This thesis is dedicated to the idea of making child and family services more father-inclusive. Fathers are the primary focus, because they represent a target group that tends to be overlooked and underrepresented in services that offer family-based interventions and rarely featured in relevant research (Dadds et al., 2018; Panter-Brick, 2014). The numerous consequences of that are discussed in detail in Chapters 2 and 3. The need for increased father engagement in child and family services has been increasingly discussed in research in the last two decades. The awareness of the issue seems to be growing, but there is little evidence of visible improvements in this area; the problem of poor father engagement remains as significant today as it was thirty years ago (Lechowicz et al., 2019).
Throughout this thesis we emphasize the role, and the responsibility, of child and family services in promoting father engagement. While there are many societal and individual barriers to fathers’ participation in family-based interventions, research indicates that organizations can greatly encourage or discourage father involvement through service delivery, policies, and practices (Panter-Brick et al., 2014; Tully et al., 2018). This suggests that organizations represent an important target for research. More specifically, there is a need for studies that raise service awareness of their role in attracting fathers, generate insights into aspects of service provision that may be important for father engagement, and propose ways of implementing practical changes to enable greater father inclusion.

Finally, the applicability of findings in real-world settings is one of the primary concerns of this project. We recognize that despite growing evidence base and the development of numerous guidelines for father-inclusive practice targeted at child and family services, there is little evidence of these strategies being successfully employed by service providers (e.g., Bennett et al., 2021). This highlights the need for a greater understanding of how evidence-based practice can be efficiently translated into regular use by services.

**Contributions of this research**

This thesis consists of two studies with the aim of investigating these under-addressed issues and taking the initial steps towards bridging the gap between the awareness of, and the implementation of, father-inclusive practice. Firstly, we sought to identify the key elements of service provision that influence father engagement. This was achieved by systematically synthesising global research on father engagement from diverse fields including paediatrics, perinatal care, psychology, and social work. The aim of the systematic review was to draw attention to the areas of organizational practice that are important to consider in order to design services that are more father-inclusive.
Secondly, we intended to build on the findings of the systematic review by investigating the factors that impact the service capacity to successfully address the barriers to engagement experienced by fathers. In other words, the goal was to explore what helps and what hinders organizations from being able to implement father-inclusive practice. An empirical study was conducted to gather expert opinion regarding the strategic priorities for successful implementation of father-inclusive practice.

To aid the effective translation of father engagement and father-inclusive practice research into practice settings, this thesis has been heavily influenced by the implementation science perspective and methodologies. Implementation science offers a range of theories, models and frameworks that provide an a priori structure for assessment and monitoring key contextual factors that influence the initial uptake and use of evidence-based practices (Bauer & Kirchner, 2020). Firstly, throughout both studies, our approach emphasizes implementation science methodology that focuses on understanding barriers and facilitators to father-inclusive service provision. Systematic assessments of barriers and facilitators represent an essential step towards formulating tailored strategies to accelerate the adoption of research into routine practice (Bauer et al., 2015). Secondly, the empirical part of the project employs the use of a specific implementation science framework, i.e., the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), which allows for mapping the empirically derived barriers and facilitators onto a list of theory-based constructs associated with effective implementation. The use of an established framework was considered essential to capture the unique factors influencing the implementation of father-inclusive practice and present those in a way that facilitates subsequent development of tailored implementation strategies.

Fundamentally, we hope that by applying the principles of implementation science to the current research project, the findings can go beyond merely highlighting the practices that
need to change in order for services to become more father-inclusive. We intend for this research to inform the development of practical action points to increase the likelihood of greater father inclusivity being successfully embedded into organizational policies, practices and culture.
Chapter 2. Systematic review

Service-level barriers and facilitators to father engagement in child and family services: A systematic review and thematic synthesis of qualitative studies.

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Prepared in accordance with author guidelines for submission to Children and Youth Services Review (Appendix A)

Word count: 7148
Abstract

**Purpose:** Service-level factors that influence father engagement within child and family services are not well understood due to diversity in research studies and evidence from different contexts. Accordingly, the aim of this systematic review was to identify and synthesise available qualitative evidence across contexts to identify the common service-level barriers and facilitators of father engagement in child and family services.

**Methods:** The following six databases were systematically searched: AMED, EMBASE, Medline, CAB Abstracts, PsycINFO, and Global Health. A screening process conducted by two independent reviewers identified twenty-three eligible qualitative studies. Results from the included studies were synthesised thematically.

**Results:** Thematic synthesis identified five main themes encompassing service-level barriers and facilitators to father engagement: practitioner factors; marketing; resources and information; policies and practice guidelines; and evaluation.

**Conclusions:** The findings show that improving father engagement is putatively dependent on a combination of individual practitioner competence, and an organisational environment that provides the structure and processes to enable effective work with fathers. Addressing the barriers and prioritizing facilitators therefore requires strengthening of the capacity of organizations and practitioners for promoting father-inclusive practice.

*Key words:* systematic review, qualitative methods, service-level, barriers and facilitators, father engagement, child and family services
Introduction

Fathers play a significant role in healthy child development and family well-being (Pruett, 2000). The extent of fathers’ contribution is related to their skill level and confidence in parenting, level of involvement, and their capacity to develop strong attachment with their children (Beardshaw, 2001). To that end, research shows that fathers’ engagement with various child and family services has the capacity to enhance the quality of fathering (e.g., Doherty et al., 2006; Lloyd et al., 2003). However, child and family services that promote parental development and involvement have traditionally placed a greater emphasis on engaging mothers rather than both parents, resulting in fathers being underrepresented and overlooked as potential attendees (e.g., Fabiano, 2007; Scourfield et al., 2014). Evidence shows that this is reflected in organizational policies and practices, which often constitute a significant barrier to father engagement (Panter-Brick et al., 2014). However, reliable information on specific aspects of service provision that may enable or hinder father engagement across child and family services is not readily accessible. To address this, the current study consists of a systematic review of primary qualitative research that reported on service-level barriers and enablers to father engagement in services providing health and social care support to children and families. The aim of the review was to highlight the specific areas of organizational policy and practice that may be important for improving father engagement.

Father involvement is recognized as an important factor for enhancing child and family outcomes (Panter-Brick et al., 2014). Interactions between father and child enhance linguistic, cognitive, and emotional growth among children in infancy (Pruett, 2000), and have the capacity to positively influence children’s mental health, cognitive and social competence, self-esteem, emotional regulation, capacity for empathy and social responsibility, peer relationships and educational achievement during childhood and
adolescence (Goodwin & Styron, 2012; Flouri & Buchanan, 2003; Jeynes, 2015, Sarkadi et al., 2008). Father involvement also has a critical role in supporting the well-being of mothers through promoting health behaviours, reducing parenting stress and the risk of common mental health problems, which, in turn, has a positive effect on the overall family well-being (Alio et al., 2011; Cairney et al., 2003; Firouzan et al., 2018; Fisher et al., 2012; Lancaster et al., 2010; Susin et al., 2012). Therefore, engaging fathers and promoting positive paternal contribution should be a priority for services and organisations aimed at improving child and family well-being.

Services have an important role in fostering positive father-child relationships through direct engagement of fathers as part of family-based interventions. For the purpose of this review, the term ‘service(s)’ refers to any organization operating within the health and social care context and providing services to improve the health and well-being of children and families. We also specify ‘engagement’ as purposeful inclusion of fathers in services with the goal of improving family outcomes, which may include recruiting, enrolling, maintaining active participation of fathers, involving fathers in service development, or integrating fathers in service operations (Selekman & Holcomb, 2021). Research shows that fathers’ attendance of perinatal services can help to develop fathers’ connectedness with the baby and have a positive impact on father-child interactions post-birth (Massachusetts General Hospital, 2017). Other studies show that fathers’ participation in parenting groups and family support services can enhance their confidence, parenting competence and involvement with children, (Doherty et al., 2006; Lloyd et al., 2003; Magill-Evans et al., 2006). Moreover, data from interventions aimed at improving child disruptive behaviours and emotional outcomes show that fathers’ participation in interventions enhances child outcomes (Bagner & Eyberg, 2003; Lundahl et al., 2008). Taken together, the research demonstrates that including fathers as part
of service delivery is directly beneficial to children, fathers, and their partners, and therefore is a key ingredient to building thriving families and communities.

Despite extensive benefits to engaging fathers in service delivery, evidence from home visiting programs, social work, child welfare services, and parenting interventions, suggests that fathers are underrepresented and overlooked as a potential target group across services (Panter-Brick et al., 2014; Sandstrom et al., 2015; Scourfield et al., 2014). For example, a systematic review by Fabiano et al. (2007) revealed that parenting programs are either primarily directed to female participants or fail to consider father involvement altogether. A similar focus on the mother-child dyad and a notable absence of fathers has been highlighted in other reviews of parent-focused interventions (e.g. Magill-Evans et al., 2006; Singer et al., 2007). Consequently, there is risk that the failure to engage fathers in services may translate into diminished outcomes for children and families.

Research suggests that while barriers to father engagement occur at various levels, it is the service provider-level issues such as organizational policy and practice that are particularly important to increasing father involvement in child and family services (Lechowicz et al., 2019; Panter-Brick et al. 2014; Tully et al., 2018). This stems from evidence that father engagement is significantly obstructed by service-level barriers. Some examples from literature include mother-oriented service design and delivery, negative or ambivalent attitudes from health professionals, lack of policies related to father-inclusion, availability of training, or staffing structures (Bayley et al., 2007; Bunting, 2005; Cullen et al., 2011). This recognition has contributed to a growing interest in Father-Inclusive Practice, which is a concept focusing on the development, planning and delivery of services in a way that is more responsive to the needs of fathers (e.g., FaHCSIA, 2009). However, making services more accessible to fathers firstly requires a good understanding of elements of
service provision that may influence father engagement, and extant research in its current state offers limited information into the challenges of father-inclusive service provision.

A significant limitation of the current literature is that the attention to organizational factors influencing father engagement remains scarce and highly fragmented. For instance, research examining barriers to engaging fathers has occurred across different settings, including but not limited to psychology, social work, perinatal services, and paediatrics. Moreover, research into factors influencing father engagement involves narrative papers, including editorials and commentaries (e.g. Carr, 2006; Sarkadi, 2014; Scourfield, 2006), working group reports (e.g. FaHCSIA, 2009; King et al., 2014), and qualitative studies (e.g. Coady et al., 2013; Salinas et al., 2011), many of which are aimed at identification of general barriers and facilitators of involving fathers, often lacking an organizational focus. For example, two studies reviewed factors that influence father engagement in parenting interventions. In their systematic review, Panter-Brick et al. (2014) highlighted a mixture of factors influencing father engagement, which included service provider-level issues. However, the focus of their study was the review of the overall state of the evidence regarding father engagement, with less emphasis on the specific service-level barriers and facilitators. More recently, Lechowicz et al. (2019) conducted a narrative review of father engagement literature, which highlighted a range of clinical practice recommendations for overcoming barriers to including fathers in parenting interventions. However, their approach lacked the rigour of a systematic review, and similarly to Panter-Brick et al. (2014), the focus was limited specifically to parenting programs, without considering wider child and family services. Consequently, there is still a need for a systematic synthesis of the global research into service-level barriers and facilitators to father engagement across services aimed at improving child and family well-being.
A review of qualitative evidence with focus on service-level influences on father engagement is particularly timely considering the growing research interest in this area and a recent increase in qualitative studies that explore this issue. Synthesising qualitative evidence to distil key organisational factors affecting service accessibility has the potential to offer valuable insights for future service design and delivery (e.g. Hirano et al. 2018; Hirayama & Fernando, 2018; Lluch, 2011). Moreover, thematic synthesis represents a particularly appropriate methodological approach for such qualitative synthesis, because of its suitability to bringing together findings across different healthcare contexts to inform service development (Ring et al., 2011; Tong et al., 2012).

In sum, low rates of father involvement in child and family service are a global issue that potentially diminishes the effectiveness of treatments targeted towards children and families. However, the specific elements of organizational policy and practice that promote or hinder father engagement are poorly understood. In this paper, we systematically reviewed qualitative research to distil the key elements of organizational practice that influence father engagement in child and family services. Consistent with previous research (e.g., Morton et al., 2010), the review was conducted on primary qualitative research across different geographic, social, and cultural contexts, and a range of settings, with consideration to the potential variability between disciplines. By synthesising the research, we aim to identify common service-level factors that encourage or discourage father involvement in child and family services to inform recommendations for improving father engagement.

**Method**

**Study design**

This review was guided by frameworks for conducting systematic reviews of qualitative research (Higgins & Green, 2008; Thomas & Harden, 2008). The process included the following steps: development of inclusion and exclusion criteria, systematic search of the
literature, study selection, data extraction, quality appraisal, and a thematic synthesis of the extracted data.

**Search strategy**

A systematic literature search was conducted by the primary author from database inception until February 2022. Six major electronic databases were searched using Ovid: AMED, EMBASE, Medline, CAB Abstracts, PsycINFO, Global Health. The key search terms were developed and grouped according to a modified version of the PICo (Population, Phenomenon of Interest, Context) tool with added qualitative search terms (Lockwood et al., 2015; Methley et al., 2014). The search strategy (Table 1) consisted of the following text words and their variations: fathers, barriers/facilitators, advice, perspective, engagement, child/parent/family interventions, qualitative research.

**Table 1. Ovid databases search**

<table>
<thead>
<tr>
<th>Step</th>
<th>Search terms</th>
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<tbody>
<tr>
<td>1</td>
<td>(parent* adj2 (program* or train* or educat* or promot* or supervis* or skill* or intervent* or group* or support or problem*)).ab,ti.</td>
</tr>
<tr>
<td>2</td>
<td>(child* adj2 (mental health* or psycholog* or service* or mental health service* or welfare or mental wellbeing or mental well-being or mental well-being or well-being)).ab,ti.</td>
</tr>
<tr>
<td>3</td>
<td>(family adj2 (program* or train* or educat* or promot* or supervis* or skill* or intervent* or group* or support or problem* or therap*)).ab,ti.</td>
</tr>
<tr>
<td>4</td>
<td>1 or 2 or 3</td>
</tr>
<tr>
<td>5</td>
<td>(barrier* or hindr* or hinder* or obstacle* or prevent* or stop*).adj3 (participat* or engag* or recruit* or access* or involv* or represent*).ab,ti.</td>
</tr>
<tr>
<td>6</td>
<td>(facilitat* or improv* or enhanc* or increas*).adj3 (participat* or engag* or recruit* or access* or involv* or represent*).ab,ti.</td>
</tr>
<tr>
<td>7</td>
<td>(advic* or advis* or perspectiv* or insight* or theme*).adj3 (participat* or engag* or recruit* or access* or involv* or represent*).ab,ti.</td>
</tr>
<tr>
<td>8</td>
<td>(father* or dad* or patern*).ab,ti.</td>
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<tr>
<td>9</td>
<td>5 or 6 or 7</td>
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<tr>
<td>10</td>
<td>qualitative research/</td>
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<td>11</td>
<td>Focus Groups/</td>
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<td>12</td>
<td>Interviews as topic/</td>
</tr>
<tr>
<td>13</td>
<td>(qualitative or theme* or interview* or focus group* or narrative* or discourse* or narration or meaning* or perspective* or experience* or belief* or percept* or perceive* or view* or opinion* or expectation*).ab,ti.</td>
</tr>
<tr>
<td>14</td>
<td>Nursing Methodology Research/</td>
</tr>
<tr>
<td>15</td>
<td>(content analysis or phenomenol* or grounded theor*).ab,ti.</td>
</tr>
<tr>
<td>16</td>
<td>10 or 11 or 12 or 13 or 14 or 15</td>
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<td>17</td>
<td>4 and 8 and 9 and 16</td>
</tr>
</tbody>
</table>
Inclusion and exclusion criteria

Population: We included studies that focused on fathers, including studies with any participants providing qualitative feedback on father engagement, participation or retention (including, but not limited to: fathers, parents, service providers, health professionals, academic experts). Studies were excluded if they did not comment on issues specific to father engagement. For the purpose of this review, the definition of a father encompassed biological fathers (including separated or non-resident fathers) as well as other father figures, including adoptive fathers, stepfathers and men in the role of a primary caregiver cohabiting with the child’s mother.

Phenomenon of Interest: Barriers and facilitators to father engagement. Studies were excluded if they did not specify factors that either aided or hindered fathers’ engagement, participation, or retention.

Context: Programmes, interventions and services directed at parents or the family, to improve the well-being of children and families. We excluded studies on engagement with services that do not include a parent- or family-focused component. Studies on interventions designed for a single gender (e.g. mother- or father-only groups), and studies that did not focus on any form of service provision were excluded.

Study type: We included primary research using qualitative methods. Mixed methods studies for which qualitative data could be separated were also included. Quantitative research, systematic and other review articles, commentaries, reflective papers, conference proceedings, theses and other grey literature were excluded.

Other: Only studies published in English were considered for inclusion in the review. No restrictions were applied in relation to the country or publication date.
Study selection and quality appraisal

Database search results were imported into Covidence™ and de-duplicated. Study selection was carried out over two stages. Firstly, all titles and abstracts were independently screened by two reviewers against the inclusion criteria. Full texts of all potentially relevant studies were obtained and both reviewers conducted an additional post-screening evaluation of the full-text articles, to exclude any articles that did not contain information on service-level barriers or facilitators to father engagement.

The quality of the included full-text articles was assessed using the Critical Appraisal Skills Programme tool (CASP; Critical Appraisal Skills Programme, 2018), widely considered as an appropriate appraisal tool for qualitative evidence synthesis in Health and Social Care (Hannes & Macaitis, 2012; Dalton et al., 2017). Two raters independently assessed individual studies against the 10-item CASP checklist to assess their trustworthiness, transparency, and relevance. Discrepancies were resolved in discussion between the raters. No studies were excluded based on the CASP results. The assessment of quality was used to determine the general adequacy and methodological rigour, to estimate the relative contribution of included studies.

Data extraction and synthesis

The following characteristics of the included studies were extracted into a purpose-designed Excel form: Author; Country; Study design and data analysis method; Participants/data source; Type of service/intervention. Subsequently, all included articles were imported into NVivo™ software, which was used to organise the papers and assist with the subsequent manual coding of the data from the respective ‘results’ or ‘findings’ sections (Thomas & Harden, 2008). Data extraction was undertaken independently by the primary author (MB).
Data was synthesised using the method of thematic synthesis presented by Thomas and Harden (2008). This was conducted in three stages: (1) line-by-line coding of text, (2) developing descriptive themes, and (3) generating analytical themes (Thomas & Harden, 2008). Following multiple readings of extracted data, the first author conducted line-by-line coding of all findings related to service-level barriers and facilitators to father involvement. Codes were generated using an inductive approach, and subsequently organised under a set of descriptive themes. The descriptive themes of service-level barriers and facilitators were compared and contrasted across all studies, and then unified under higher-order analytical themes with the purpose of addressing the review question. The analytical themes are reported in the results separately for barriers and facilitators, with descriptive themes italicised.

Results

Literature search

The study selection process is illustrated in Figure 1. The initial electronic database search yielded 470 articles. Following the exclusion of 194 duplicates and 247 ineligible articles after the initial screening of titles and abstracts, 29 full-text articles were sought for retrieval. One full-text article was not available online and attempts at contacting the author were unanswered, leaving 28 full-text articles available for a detailed evaluation. Of those, 23 studies met the criteria for inclusion after the full-text article review. Both the initial screening and full-text article review were conducted independently by two reviewers. The inter-rater reliability was reported using percentage agreement scores jointly with Cohen’s Kappa coefficient (McHugh, 2012). Percent agreement was 89.9% (κ = 0.55) for the title and abstract screening, and 82.1% (κ = 0.49) for the full-text review, indicating a moderate agreement between the two reviewers (Landis & Koch, 1977). Disagreements were resolved by discussion.
Quality assessment

The quality assessment of included studies against the CASP criteria is shown in Table 4 (Appendix B). While the quality of the studies was variable, we opted against assigning numerical scores to individual studies based on their methodological rigour. This is because there is no consensus on the relative weight ascribed to individual CASP items, and therefore using a simple summed score to represent the robustness of each study would not provide a meaningful reflection of the quality of the research. (Critical Appraisal Skills Programme, 2018; Verboom, Montgomery & Bennett, 2016). Rather, the appraisal tool was used as a means of highlighting potential methodological strengths and limitations of each study included in the review. Inter-rater reliability in assessing the quality of included studies was measured using Cohen’s Kappa coefficient ($\kappa = 0.72$) indicating a substantial agreement between two reviewers (Landis & Koch, 1977).

Overall, the quality varied considerably across the twenty-three included studies, with the number of CASP criteria fulfilled ranging from 0-10. Twenty studies included a clear statement of research aims for which qualitative methodology was appropriate, as well as a clear statement of findings; this was absent in the other three studies. Nineteen studies reported data collection procedures that were appropriate for their research goals; the other four studies lacked clarity in their descriptions of data collection. Seventeen studies used an adequate recruitment strategy; the other six studies provided limited rationale regarding the choice of recruitment strategy and its suitability for their research goals. The criteria for appropriateness of research design and sufficient analytical rigour were satisfied by sixteen studies; the remaining seven studies offered limited descriptions of their research design and provided insufficient justification for their methodological approach. Moreover, seven studies did not comment on whether ethical approval was sought and offered no information in relation to maintaining ethical standards. Lastly, all but five studies failed to adequately
consider the relationship between the researcher and the participants. Ultimately, out of total twenty-three studies, twenty-two were considered valuable research; only one study was identified as being of questionable value, as it did not meet any of the other CASP quality criteria (Gilligan et al., 2012). However, all papers were judged to contribute conceptually to the synthesis and were included irrespective of the quality assessment.

Figure 1. PRISMA chart
Characteristics of studies and participants

Table 2 presents a detailed overview of the studies included in the systematic review. Included studies were published between 2005 and 2021, and carried out in the United States (n=7), United Kingdom (n=4), Australia (n=3), Brazil (n=1), Canada (n=1), Mozambique (n=1), New Zealand (n=1), Norway (n=1), Papua-New Guinea (n=1) Sweden (n=1), South Africa (n=1), and across five Pacific nations (Cook Islands, Fiji, Papua New Guinea, Solomon Island, and Vanuatu) (n=1). Among the included studies, father engagement was examined in context of diverse parenting programmes & group interventions (n=9), child welfare and social work services (n=5), services belonging under the umbrella of reproductive, maternal, new-born and child health (n=4), paediatric services (n=2), home visiting service (n=1), preventive primary care (n=1), and in one case, across multiple children’s health, education and social care agencies (n=1).

Three out of twenty-three studies used a mixed methods approach, while the other studies (n= 20) used primarily qualitative research methodologies. Qualitative methods employed by studies included interviews (n=10) and focus groups (n=9), as well as a combination of focus groups and interviews (n=4). Methods of analysis included thematic analysis (n=16) and content analysis (n=3), with a few studies using alternative approaches: constant comparative analysis (n=1), general inductive approach (n=1), interpretive phenomenological analysis (n=1), and an unspecified type of qualitative analysis (n=1).

Studies collected information from a range of samples, including fathers (n=10), mothers (n=1), both parents/caregivers (n=2), healthcare professionals (n=5) and a combination of parents, service providers and community members (5).
<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Country</th>
<th>Study design, Data analysis method</th>
<th>Participants/data source</th>
<th>Service/intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson et al. (2015)</td>
<td>United States</td>
<td>Qualitative: focus groups, Thematic analysis</td>
<td>7 fathers engaged in the services</td>
<td>Early-Childhood Programme (HeadStart / Early HeadStart)</td>
</tr>
<tr>
<td>Barrett et al. (2018)</td>
<td>Australia</td>
<td>Qualitative: semi-structured interviews, Thematic analysis</td>
<td>8 mothers participating in the group intervention</td>
<td>First-Time Parent Groups</td>
</tr>
<tr>
<td>Bayley et al. (2009)</td>
<td>United Kingdom</td>
<td>Mixed methods: focus groups and individual interviews, Thematic analysis</td>
<td>14 fathers engaged in services, 9 professionals and academic experts in parenting programmes or working with fathers</td>
<td>Parenting programmes</td>
</tr>
<tr>
<td>Coady et al. (2013)</td>
<td>Canada</td>
<td>Qualitative: interviews, Thematic analysis</td>
<td>300 fathers engaged in services</td>
<td>Child welfare services</td>
</tr>
<tr>
<td>Davis et al. (2018)</td>
<td>Papua New Guinea</td>
<td>Qualitative: focus groups, Thematic analysis</td>
<td>300 Community members: 155 women (including 78 pregnant mothers) and 145 men (including 64 expectant fathers)</td>
<td>Antenatal care services</td>
</tr>
<tr>
<td>Davis et al. (2016)</td>
<td>International (Cook Island, Papua New Guinea, Solomon Island, Vanuatu)</td>
<td>Qualitative: interviews, Thematic analysis</td>
<td>17 senior maternal and child health policymakers and practitioners</td>
<td>Reproductive maternal and child health services</td>
</tr>
<tr>
<td>Edvardsson et al. (2011)</td>
<td>Sweden</td>
<td>Qualitative: interviews, Content analysis</td>
<td>12 first-time fathers, 12 first-time mothers</td>
<td>Antenatal care services, Child healthcare services</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Methodology</td>
<td>Participants</td>
<td>Services</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Ewart-Boyle et al. (2015)</td>
<td>United Kingdom</td>
<td>Qualitative: semi-structured interviews, Thematic analysis</td>
<td>22 family centre social workers</td>
<td>Children’s social work services</td>
</tr>
<tr>
<td>Frank et al. (2015)</td>
<td>New Zealand</td>
<td>Mixed methods: survey and focus group, General inductive approach</td>
<td>15 fathers</td>
<td>Parenting programmes</td>
</tr>
<tr>
<td>Garfield &amp; Isaaco (2006)</td>
<td>United States</td>
<td>Qualitative: semi-structured interviews, Content analysis</td>
<td>32 fathers engaged in services</td>
<td>Child healthcare services</td>
</tr>
<tr>
<td>Gilligan et al. (2012)</td>
<td>United Kingdom</td>
<td>Qualitative: focus groups, Unspecified qualitative content analysis</td>
<td>70 professionals: children’s services managers and practitioners</td>
<td>A range of children’s services agencies</td>
</tr>
<tr>
<td>Icard et al. (2017)</td>
<td>United States</td>
<td>Qualitative: focus groups, Thematic analysis</td>
<td>17 non-resident fathers with children in foster care</td>
<td>Child welfare services</td>
</tr>
<tr>
<td>Jeong et al. (2021)</td>
<td>Mozambique</td>
<td>Qualitative: semi-structured interviews, Thematic analysis</td>
<td>Mixed sample: 32 mothers, 3 fathers, 1 primary male caregiver, 15 health facility providers, 12 community health providers, 10 external stakeholders</td>
<td>Child healthcare services</td>
</tr>
<tr>
<td>McGirr et al. (2020)</td>
<td>United States</td>
<td>Qualitative: focus groups, Thematic analysis</td>
<td>3 service managers, 11 fathers engaged in services, 5 case managers</td>
<td>Parenting and repeat pregnancy prevention program</td>
</tr>
<tr>
<td>O’Donnell et al. (2005)</td>
<td>United States</td>
<td>Qualitative: focus groups, Constant comparative analysis</td>
<td>34 child welfare service staff</td>
<td>Child welfare services</td>
</tr>
<tr>
<td>Salinas et al. (2011)</td>
<td>United States</td>
<td>Qualitative: focus groups, Thematic analysis</td>
<td>13 fathers engaged in services</td>
<td>Parenting programme (Behavioural parent training)</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Study Design, Methodology</td>
<td>Participants</td>
<td>Service/Program</td>
</tr>
<tr>
<td>--------------------</td>
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<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Sicouri et al.</td>
<td>Australia</td>
<td>Qualitative, Nine focus groups, Thematic analysis</td>
<td>41 fathers</td>
<td>Parenting interventions</td>
</tr>
<tr>
<td>Smythe et al.</td>
<td>Brazil</td>
<td>Qualitative, Participant observation, focus groups and semi-structured interviews, Thematic analysis</td>
<td>61 caregivers (12 fathers and 49 mothers) engaged in the service</td>
<td>Parent group interventions for children with Congenital Zika Syndrome</td>
</tr>
<tr>
<td>Solberg et al.</td>
<td>Norway</td>
<td>Qualitative, Semi-structured interviews, Content analysis</td>
<td>13 fathers engaged in services</td>
<td>Home visiting programme</td>
</tr>
<tr>
<td>Stahlschmidt et al.</td>
<td>United States</td>
<td>Qualitative, Focus groups and semi-structured interviews, Thematic analysis</td>
<td>29 fathers</td>
<td>Parenting interventions</td>
</tr>
<tr>
<td>Warria</td>
<td>South Africa</td>
<td>Qualitative, Interviews, Interpretive phenomenological analysis</td>
<td>3 fathers of children in a residential care facility</td>
<td>Child welfare services</td>
</tr>
<tr>
<td>Williams et al.</td>
<td>England (UK)</td>
<td>Qualitative, Focus groups, Thematic analysis</td>
<td>46 fathers</td>
<td>Preventive primary care services</td>
</tr>
<tr>
<td>Wynter et al.</td>
<td>Australia</td>
<td>Mixed methods, Survey and semi-structured interviews, Thematic analysis</td>
<td>6 midwives</td>
<td>Maternity care services</td>
</tr>
</tbody>
</table>
Thematic synthesis

Descriptive themes representing service-level barriers and facilitators to father engagement were grouped under five broad analytical themes: (1) practitioner factors; (2) marketing; (3) resources and information; (4) policies and practice guidelines; and (5) evaluation. Both barriers and facilitators were represented within each theme except Evaluation, which contained only facilitators to father engagement. Details of the analytical themes and the descriptive sub-themes identified in the process of thematic synthesis are presented in Table 5 (Appendix C).

Service-level barriers to father engagement

Practitioner factors. Fathers, mothers and practitioners all reported that the (i) negative gender-based staff assumptions and attitudes constituted a significant barrier to father engagement, impacting the practitioners’ quality of interaction with fathers who present in services. For example, fathers across multiple contexts interpreted practitioners’ verbal approaches and body language as either unduly harsh or dismissive, which was interpreted as unwelcoming and discouraging from attendance. Practitioners recognized that their gender biases among staff contributed to their low expectations of fathers, minimizing the paternal role, and reinforcing the stereotypes of fathers being the less capable and less involved carers. Moreover, fathers and practitioners alike pointed out that (ii) lack of awareness and understanding of fathers’ needs among healthcare workers is another factor that contributes to poor communication and inadequate treatment of fathers in child and families, creating a barrier to father engagement.

Marketing. Activities aimed at promoting service awareness and access among fathers were highlighted by parents and practitioners as key factors influencing father engagement. Specifically, studies indicated that father engagement may be hampered by (iii)
non-inclusive appointment invitations. Mothers noted that they tend to be the sole recipients of any appointment invitations, which also lack information regarding whether fathers are welcome or expected to attend. This was viewed as not only diminishing the importance of fathers, but also placing mothers in the position of a gatekeeper, which may inadvertently influence fathers’ access to information and, in turn, their engagement with services. Moreover, father engagement was reported to be negatively influenced by (iv) inadequate advertising strategies, such as targeting traditional venues that are not frequently attended by men, or using materials biased towards mothers in their wording and branding. Additionally, (v) gender-neutral advertising messages, such as those indicating ‘parents’ as the target group, were reported as another obstacle to engaging fathers. The rationale was that in public consciousness, the construction of the word ‘parent’ is often indirectly equated to ‘mother’, and therefore its use may inadvertently imply a maternal focus.

Resources and information. There was a general recognition among practitioners and fathers that (vi) inadequate or inflexible timing of service delivery could prevent fathers from being able to utilize services. For example, services available within typical working hours were likely to conflict with fathers’ work schedules, posing a significant barrier to engagement. Policymakers and practitioners reported that (vii) excessive demands on staff were another key barrier to engaging fathers. In many contexts, services were reported to be under-resourced and understaffed, contributing to large caseloads and high stress levels among health workers, limiting their capacity to reach out to fathers. Both practitioners and fathers reported that (viii) mother-orientated environment of many services is a barrier to father engagement. For example, in context of antenatal care services, the physical layout of clinics including large waiting rooms and lack of separate waiting spaces for men and couples was identified as an obstacle to father engagement. Moreover, practitioners recognized that mothers make up the vast majority of attendees, which contributes to the impression of
services as being mother-orientated. Additionally, practitioners reported that (ix) lack of training for staff in engaging fathers was an issue across child and family settings. Inadequate provision of education and training to workforce was reported to impact staff’s capability and confidence to work with men, creating a barrier to father engagement.

**Policies and practice guidelines.** Practitioners highlighted a general (x) absence of specific policies, guidelines, and practice frameworks on father involvement in child and family services, resulting in limited assistance for staff in relation to father involvement, and limited consideration for gender and parenting in workplaces. Furthermore, practitioners and fathers reported that (xi) unfavourable workplace policies represent an obstacle to father involvement, because many have been designed with women and children in mind. Examples of such systemic bias included fathers not being allowed to stay overnight on postnatal wards or being subject to increased scrutiny by child welfare services.

**Service-level facilitators to father engagement**

**Practitioner factors.** Practitioners and fathers reported that health workers’ (i) interpersonal qualities, such as friendly approach, welcoming attitudes and respectful communication, were instrumental in facilitating father engagement. Fathers valued interactions where they received equal quality service as mothers, such as when practitioners showed interest in them, learned their names, complimented them, and talked to them directly, as well as directed questions to both parents.

**Marketing.** Both parents and service providers reported that (ii) outreach activities to raise community awareness regarding men’s role in supporting children and families were a key facilitator to father engagement. Examples of outreach included engaging activists, community leaders and existing community structures (e.g. churches), and delivering educational talks. Thematic synthesis also emphasised the importance of encouraging word-
of-mouth information sharing by men already involved in the services, providing outreach in spaces where fathers are likely to congregate, and delivering mobile outreach clinics to families in more remote areas. Thematic synthesis also highlighted the importance of (iii) advertising strategies that are tailored to the needs of fathers. Examples included using a greater range of advertising media channels, including television, video messages in waiting areas, radio, newspapers and billboards, as well as endorsement by credible figures and organizations. Moreover, the key aspect of this theme was father-friendly content of promotional materials, which should clearly specify fathers as the target audience and include messages that celebrate fatherhood and emphasise fathers’ strengths and their role in improving children’s well-being. This included using a gender-differentiated approach (i.e. referring to ‘fathers and mothers’, as opposite to more generic ‘parents’) in promotional materials, which carries less risk of being misinterpreted as targeting mothers only. Lastly, (iv) direct communication and inclusive appointment invitations were identified by fathers and service providers as facilitators for father involvement. Examples included contact attempts and invitations specifically directed at fathers, addressing them by the name or containing explicit encouragement that they are encouraged to attend.

**Resources and information.** Practitioners and fathers alike emphasised the value of (v) male workers gender-balanced teams in facilitating father engagement, highlighting that presence of male workers may influence the view of services being mother-oriented. Both health workers and fathers reported that a greater (vi) flexibility in timing of programmes and interventions was a facilitator to father engagement. Examples included offering appointments outside of typical working hours to reduce potential conflict with fathers’ work schedule. Moreover, evidence from antenatal context also suggested that increasing the length of appointments would allow more time to address fathers’ needs. Thematic synthesis also highlighted (vii) incentives and rewards as an important facilitator to father engagement.
Examples included offering both material incentives and alternative forms of incentivizing father engagement, such as provision of childcare as part of the intervention, which would allow both parents to be available for the duration of the appointment.

Thematic synthesis indicated that (viii) father-friendly décor and facilities were an important consideration for father engagement. Examples included introducing male-friendly elements such as pictures of men with children, pamphlets aimed at men, provision of hot drinks and entertainment for men such as games or videos. Additionally, practitioners reported that adequate provision of (ix) staff training and development opportunities was a significant enabler of father inclusion. Training was recognized as a way of equipping staff with skills to work effectively with fathers as well as challenging the gender bias and negative stereotypes towards fathers within the workforce.

**Policies and practice guidelines.** Practitioners emphasised the need for (x) father-inclusive policies and top-down guidance on father engagement, which would provide staff with the necessary structure to involve fathers at certain stages with specific strategies. Thematic synthesis also highlighted the importance of (xi) service targets in relation to father recruitment to programmes and interventions, would incentivize a more proactive approach to meet the required minimum father enrolment numbers, enabling greater father engagement.

**Evaluation.** Both fathers and practitioners reported that actively seeking (xii) feedback from fathers via formal and informal feedback mechanisms and responding to it proactively was a significant facilitator to father involvement. Evidence suggested that enabling fathers to share their experience of the service would not only help build rapport, but also help organizations gain a better understanding of fathers’ needs, thus inspiring a more effective and inclusive service provision. Furthermore, thematic synthesis emphasised (xiii) monitoring father enrolment and retention as an important facilitator to father engagement,
with the rationale that monitoring numbers of fathers engaged in the service could help identify patterns of attendance and help to modify aspects of service accordingly.

**Discussion**

The aim of this systematic review was to synthesise the qualitative literature on the service-level barriers and facilitators to father engagement in child and family services. This review was the first to systematically identify and synthesise qualitative evidence related to aspects of service provision that impact father engagement across a range of contexts. We identified eleven specific service-level barriers and thirteen service-level facilitators to father engagement and generated seven overarching analytical themes. Thematic synthesis generally revealed that father engagement can be either enhanced or hindered by practitioner knowledge and attitudes, advertising and promotion activities, commitment of resources (which included the clinic environment and access to training for practitioners), workplace policies and practice guidelines, and the capacity to monitor and evaluate father participation. Our analysis suggests that all the identified themes could either enhance or diminish father engagement depending on their presence or absence.

Consistent with previous reviews (Lechowicz et al., 2019; Panter-Brick et al., 2014), our synthesis highlighted that at the service level, father engagement is influenced by a complex mixture of both organizational and practitioner-level factors, and that these are highly interdependent. For example, practitioner knowledge and attitudes towards fathers can likely be shaped by the top-down organizational policies, procedures, and guidance (Fletcher et al., 2014; Lechowicz et al., 2019). However, the opposite may also be true, as practitioners’ skills and competencies may have an impact on the development of organizational strategies for father-inclusive service provision (Burn et al., 2019). Although further research is required to explore the interaction between practitioner-level and organizational factors and identify priority areas for father engagement, previous studies
(e.g., Glynn & Dale, 2015; Tully et al. 2018) show that both practitioner competence and organizational support are strong predictors of father attendance rates. Therefore, we suggest that to enable greater father engagement, equal attention should be given to improving both the practitioner-level and organizational aspects of service provision.

Relatedly, although extant research evidence and our own findings are consistent in highlighting the importance of both practitioners and organizational support in promoting father engagement, this is not always reflected in practice recommendations. While some practice guidelines emphasize both the role of practitioners and the top-down support for father engagement (e.g. Fatherhood Institute, 2013), others appear to focus primarily on enhancing practitioner competence in attempts of improving father-inclusive practice in services, with less emphasis on organizational factors (e.g. Fletcher, 2008; Clapton, 2017). Burn et al. (2019) argued that enhancing practitioner competencies in father engagement offers a way of influencing organizational practices without necessarily requiring the involvement of service leadership. However, other studies show that even well-intentioned practitioners may be restricted in their capacity to effectively engage fathers if the structural barriers remain unaddressed (Humphries & Nolan, 2015; Tully et al., 2018). Consequently, we suggest that there is a need for practice recommendations that maintain a greater focus on bringing about changes at the organizational level.

Regarding practitioner-level factors, our review highlighted that practitioner attitudes and behaviour that hinder father engagement can be a product of either limited awareness of fathers’ needs, or negative gender-based assumptions. The latter finding converges with the previous research (e.g., Pfitzner et al., 2015; Storhaug, 2013) confirming widespread prevalence of a deficit model of fatherhood within child and family services, which promotes the view of men as inadequate or less competent in their parental role (Lloyd, 2001; Panter-Brick, 2014). Relatedly, our thematic synthesis suggests that adequate staff training
potentially represents one way of addressing the issues of staff awareness and attitudes, which largely confirms the extensive benefits of father-inclusive practice training highlighted by previous studies (e.g., Humphries & Nolan 2015).

In terms of organizational support for father engagement, our review outlines several areas of importance. Firstly, the thematic synthesis supports existing research in emphasising the role of internal processes, such as gathering and acting on fathers’ feedback, and routinely monitoring levels of father engagement (e.g., Dadds et al., 2018). Moreover, our results confirm previous findings regarding importance of raising community awareness, targeted advertising, and sustained effort in including fathers in communication (Lechowicz et al., 2019). Additionally, our review also converges with previous research regarding the importance of the sufficient availability, and adequate allocation of resources, such as time, manpower and facilities, and their impact on the services’ capacity to engage fathers (e.g., Bateson et al., 2017). Lastly, we note the key importance of organizational policies and procedures in influencing father engagement. Considering that policies provide a framework and structure that informs organisational practice, many factors discussed above may be contingent on the presence of policies and procedures that emphasize father engagement. Consequently, it appears that addressing specific individual aspects of service provision, such as the organisational policies that guide service delivery, could potentially have a knock-on effect on other areas of organizational functioning (e.g., resource allocation, training provision, or marketing strategies) and their impact on father engagement.

Overall, the current review highlights a comprehensive list of service-level features, which represent targets for improvement in the interest of enhancing father engagement. The findings reinforce the need for implementation of service-focused strategies and clinical practice guidelines that address the identified barriers to father engagement. Nevertheless, we acknowledge that implementing strategies to improve father inclusion in practice has been
difficult to achieve. Even though numerous practice guidelines for father engagement have been developed in the last decade (e.g., Clapton, 2017; Fatherhood Institute, 2013; Lechowicz et al., 2019), their adoption is not yet consistently evident in practice (Bateson et al., 2017; Bennett et al., 2021). Addressing this research-to-practice gap may benefit from methods rooted in the emerging field of implementation science, developed to understand, and influence how evidence-based practice can be efficiently translated into regular use by services (Brownson et al., 2012). Accordingly, further research should draw from the principles of implementation science to explore what makes father-inclusive practice difficult to achieve and identify practical solutions to the successful embedding of father-inclusive practice in services.

Strengths, Limitations and Direction for Future Research

The most significant strength of our review is the generalizability of its findings. By examining factors influencing father engagement across a diverse array of specialisms and service settings, our research offers insights that are valuable internationally and relevant in various healthcare systems. Moreover, by taking into consideration the perspectives of service users (fathers, mothers, community members) and a wide range of service providers, our findings capture a balanced view of factors that impact father engagement. An additional strength of our study is the robustness of our study selection and quality assessment procedures, which were carried out independently by two reviewers, helping to minimize the risk of overlooking pertinent research.

Despite these strengths, several limitations of our review are noted as potential directions for future research. Firstly, although we recognized the generalizability of the barriers and facilitators as a key strength of our review, it can also be interpreted as a limitation. The services and interventions reported in the studies included in the review vary greatly with regards to their geographical location, cultural and political context, and the type
of clientele and healthcare professionals involved. As a result, our review does not capture the context-specific nuances associated with specific services, which may present an obstacle to those interested in developing tailored policies requiring significant awareness of the local setting. In such cases, localized research focusing on the needs of the community and taking into consideration local service context may be indicated. Secondly, our decision to focus on peer-reviewed empirical qualitative research necessitated that we exclude grey literature from our systematic search. While we believe that this reduced the risk of including studies lacking scientific rigour, we recognize that the exclusion of grey literature could have not only led to the omission of potentially relevant data, but also increased the potential for publication bias. Introducing a carefully controlled grey literature search limited to unpublished qualitative research could have potentially minimised any inadvertent bias in derivation of analytic themes.

By focusing on the service-level barriers and facilitators to father engagement, our review offered limited insight into external factors that may influence father-inclusive service provision. For example, there is evidence that government support for father engagement through national and local policies is an important driver that can either facilitate or hinder the organizational commitment to father engagement (Page et al., 2008), yet this is not addressed in our findings. Consequently, narrowing our search terms to service-level factors may have created an impression that the extent of father engagement in services is dependent solely upon the services, their leadership, and practitioners, without reporting other influences that may determine the functioning of organizations. Therefore, future research is required to explore, and establish priorities with regards to, both internal and external factors that influence organizational readiness and capacity for provision of father-inclusive practice.
Conclusions

In summary, this review highlights multiple interacting barriers and facilitators to father engagement that occur at the level of organizational structure, policies and procedures, as well as the individual practitioner. Although we found many parallels with the existing research of father engagement in parenting interventions, the results extend the previous research by providing a set of factors influencing father engagement that are not context specific and applicable to a wide range of service settings. The identification of a wide range of barriers to father engagement emphasizes the need for effective strategies and ways in which these barriers could be addressed. Overall, the findings of this review imply that initiatives to address the problem of father engagement should target both the individual practitioners and the organizational structures in their capacity to deliver father-inclusive practice. This could be of particular interest to researchers, health professionals and policymakers, who are encouraged to use this review to inform the development of targeted strategies to improve father engagement. Meanwhile, we recognize that creating father-inclusive services requires a better understanding of factors that influence the service capacity to take practical steps towards father inclusion. Implementation science holds promise for ensuring that emerging strategies are successfully implemented in practice.

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Chapter 3. Empirical Project

Strategic priorities for implementation of father-inclusive practice in mental health services for children and families: A Delphi expert consensus study.

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Abstract:

Objective: The aim of this study was to investigate expert consensus on barriers and facilitators to the organizational implementation of Father-Inclusive Practice (FIP) in child and family services to establish strategic priorities for implementation.

Methods: An international panel of 56 experts in child and family service provision and father inclusion were surveyed using the Delphi technique. Three online questionnaires were used to gather opinions and measure experts’ levels of agreement in regard to factors that enable or hinder the organizational implementation of FIP. Survey design, analysis and interpretation was guided by the Consolidated Framework for Implementation Research (CFIR).

Results: Consensus was achieved for 46.4% (n=13) statements. Eight barriers and five facilitators were identified as strategic priorities to organizational implementation of FIP. The key factors were related to the following CFIR themes: leadership engagement, access to information and knowledge, implementation climate, structural characteristics, networks and communication, client needs and resources, external policies and incentives, and reflecting and evaluating.

Conclusions: The study findings suggest that issues related to central prioritization, top-down organizational processes and external policy context should represent priority areas for implementation. Our results prioritise methods for improving FIP by highlighting the key areas of organizational practice to be addressed by tailored implementation strategies.

Key words: Delphi method, barriers and facilitators, father-inclusive practice, implementation, organizational context, child and family services.
Introduction

Research indicates that fathers are underrepresented in services that provide psychological interventions aimed at improving outcomes for children and families (Dadds et al., 2018; Panter-Brick et al., 2014). Low levels of father engagement are observed in a range of contexts, including child welfare services (Gordon et al., 2012; Maxwell et al., 2012), paediatric psychology (Phares et al., 2005), and targeted treatments for childhood mental health and developmental disorders (Fabiano, 2007; Bögels & Phares, 2008; Flippin & Crais, 2011, Meadan et al., 2013). The extant research emphasises the importance of organizational efforts in improving rates of father engagement in child and family services, with recommendations promoting father-inclusive practice (FIP) in service design and delivery (see Lechowicz et al., 2019 for a review). However, low levels of implementation of FIP recommendations by organisations around the world have significantly restricted improvement in father participation in treatment (Cullen et al., 2011; Fletcher et al., 2014,).

To address this, the current study examined expert consensus on barriers and facilitators to the organizational implementation of FIP in child and family services using Delphi methodology. For the purpose of the current study, the term child and family service(s) encompasses organizations that provide programmes and interventions aimed at supporting the mental health and well-being of children and families.

Research evidence is consistent in showing that father involvement and active engagement with their child can significantly benefit child development, including cognitive development, social competence, academic achievement, levels of happiness and psychological well-being (Pears et al., 2013; Majdandžić et al., 2013; Pougnet et al., 2011; Feldman, Bamberger, & Kanat-Maymon, 2013; McBride, Schoppe-Sullivan, & Ho, 2005; Flouri & Buchanan, 2003). The increasing awareness of fathers’ potential to influence child well-being has led to greater recognition of the need to engage fathers in child and family
mental health services for improving treatment outcomes (e.g., Maxwell et al., 2012). Indeed, greater, and longer-lasting improvements in child disruptive behaviour and emotional outcomes have been observed in interventions attended by fathers and mothers compared to those that included mothers only (Bagner & Eyberg, 2003; Lundahl et al., 2008). However, evidence from studies where parents’ attendance is reported suggests that fathers are engaged in family-based interventions much less frequently than mothers (Duhig, Phares, & Birkeland, 2002; Fabiano, 2007; Lazar, Sagi, & Fraser, 1991). This suggests that treatment effectiveness may be putatively diminished because of poor father engagement.

Difficulties in engaging fathers in child and family services are reported to be linked to multiple barriers. Personal and practical factors such as work commitments, availability of childcare, fathers’ own reluctance and beliefs about help-seeking, or maternal gatekeeping have been highlighted as potential obstacles (Salinas, Smith & Armstrong, 2011; Tully et al., 2017). Moreover, father engagement appears further complicated by cultural and societal attitudes towards fatherhood predicated on a deficit model that promotes the view of men as inadequate or less competent in their parental role (Hawkins & Dollahite, 1997). Importantly, evidence suggests that some of the most significant barriers to father engagement in family-based interventions may be related to practitioner-level and service-level issues affecting service provision (Panter-Brick et al., 2014; Tully et al., 2018). Lack of experience working with men, or ambivalent or negative staff attitudes towards fathers that prevent practitioners from effective encouragement of father involvement, are examples of practitioner-level barriers that hinder father engagement (Centre for Urban and Community Research, 2004; Russell et al., 1999). Service-level barriers relate to the lack of organizational commitment to father-inclusion, often exemplified, but not limited to, mother-oriented approaches and resources, absence of policies related to father-inclusion or biases in policy orientation, lack of adequate guidance for staff, or poor training availability (Bayley, Wallace & Choudhry,
2009; Cullen et al., 2011; Fletcher et al., 2014). Taken together, research suggests that changes to organizational structure and practice can improve fathers’ engagement within services that provide mental health support for children and families (Panter-Brick et al., 2014).

Father-Inclusive Practice (FIP) is the term that has been used to describe the organizational commitment to “support men in their role as fathers, actively encourage their participation in programs, and to ensure that fathers are appropriately and equally considered in all aspects of service delivery” (FaHCSIA, 2009, p. 9). FIP represents a significant step towards addressing the barriers to effective father engagement, with guidelines of implementation at both the practitioner- and organizational level to make child and family services more attractive, relevant, and accessible to fathers as prospective attendees (Panter-Brick et al., 2014; Tully et al., 2018). A comprehensive summary of key father-inclusive practice recommendations has been presented by Lechowicz and colleagues (2019) in a recent narrative review, where FIP-related recommendations were categorised into six broad themes: effective engagement of both parents, tackling the institutional bias and the ‘deficit-model’ of fathering, increasing the awareness of interventions among fathers, ensuring father-inclusive program content and delivery, increasing organizational support for father-inclusive practice, and provision of father-engagement training.

Despite these conceptual developments in FIP, little research exists evaluating the implementation of strategies targeting the structural, organizational barriers to father-involvement (Glynn & Dale, 2015; Tully, et al., 2018). This is particularly problematic because organizational factors are known to have a key role in determining how practitioners encourage or discourage father involvement (Cullen et al., 2011). Lechowicz et al. (2019) suggest that top-down, service-level strategies that emphasise father inclusion may enable practitioners to engage fathers more effectively, whereas lack of that support from the
organisation constitutes a major barrier to father involvement (Glynn & Dale, 2015). It could therefore be argued that in absence of appropriate implementation of FIP by organisations, practitioners may find it difficult enacting father-inclusive practices.

Greater understanding of barriers and facilitators to implementing organizational support for FIP is needed. In related lines of implementation science research, studies have adopted specific frameworks for investigating barriers and facilitators of implementation to understand the context and processes that underpin successful adoption of research into real-world settings (e.g., Hanssen et al., 2021; Taba et al., 2012; Smith et al., 2019). One such framework applied in healthcare research is the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), which provides standardized contextual determinants of implementation. The CFIR has been extensively applied to evaluate factors that influence the implementation process, highlighting its utility in conducting in-depth exploration of key variables that may either facilitate or hinder adoption of evidence-based guidelines within healthcare (Kirk et al., 2016). Notably, few studies using the CFIR framework have adopted Delphi methodology to assess factors influencing implementation (e.g., Havers et al., 2019, Strike et al., 2019). The usefulness of Delphi method in this context lies in ranking the importance of the various determinants of implementation based on consensus of experienced groups of experts. This helps establish a list of strategic priorities for implementing evidence-based guidelines into practice (e.g., Hackett, Masson & Phillips, 2006; Havers et al., 2019; Mahoney et al., 2017; Yap et al., 2014; Sharpe et al., 2020).

The aim of the current study was to establish expert consensus on the barriers and facilitators that are most relevant to organizational implementation of FIP in child and family services, using Delphi methodology. The consensus was formed based on the opinions of a panel of experts in research and practice of family-focused interventions or promotion of father engagement. The use of CFIR allowed the grouping of the barriers and facilitators
highlighted by experts into broader categories provided by the framework, to provide a
standardized list of implementation determinants of FIP. This offered benefits in terms of
greater scientific rigour and a more systematic approach to the analysis and interpretation of
the results. Establishing key determinants that influence the organizational support for FIP
was expected to help narrow down a list of strategic priorities that aid the translation FIP into
practice. As the study utilized the Delphi method, which is an exploratory technique that does
not lend itself to hypothesis testing (Birko, Dove & Özdemir, 2015), there were no a priori
predictions regarding study outcomes.

Method

Design & Procedure

Guided by the Delphi method, we conducted three iterative survey rounds to gather
and aggregate responses with the aim of establishing a collective agreement among a group
of selected experts (Hasson, Keeney & McKenna, 2000, Jones & Hunter, 1995). Three
iterations are considered sufficient to reach consensus, enabling adequate reflection on group
responses, and helping to attain stability in responses (Iqbal & Pidon-Young, 2009; Linstone
& Turoff, 1975). Survey rounds were conducted between April 2021 and September 2021.
Identified experts were directly invited to take part in the study via email. An information
sheet was sent with the email, providing an outline of the aims of the research, selection
criteria, the extent and timing of expected involvement, as well as the voluntary nature of
participation. Identified experts were requested to click on a link to the Statement of Consent
if they were interested in taking part in the study prior to starting the first survey. Experts
were then directed to an online survey where they were required to complete a questionnaire
battery assessing sociodemographic questions, followed by Round 1 survey questions.
Demographic information included questions regarding experts’ age, gender, country of
residence, occupation, current role, type of involvement and years of experience in work
related to father engagement or child and family service provision. Details of the Delphi survey rounds can be found in the ‘Description of Delphi survey rounds and measures’ section below. Responses to the online survey were collected using the Qualtrics online survey platform. Data for this study were collected following the ethical guidelines provided by the University of Edinburgh Human Research Ethics Committee (Appendix E).

**Participant recruitment**

Recruitment for the study consisted of purposive and snowball sampling (Hasson et al., 2000; Skulmoski, Hartman & Krahn, 2007). Delphi method relies on recruitment of a panel of informed individuals, commonly referred to as experts (McKenna, 1994). For the purpose of the current study, subjects were considered experts by reason of their knowledge and experience with the issues under investigation, capacity and willingness to participate; sufficient time to participate in the Delphi, and effective communication skills (Skulmoski et al., 2007). Overall, to be eligible for this study, experts were required to be above 18 years of age, English speakers, actively involved in formal research, practice or activism concerning the inclusion of fathers in healthcare settings, or delivery of programmes or interventions aimed at improving outcomes for children and families. Experts were identified through a range of means, from professional contacts of the research team, online searches of individuals who were associated with institutions within the area of interest or had authorship of articles relevant to the study, and by directly contacting multiple relevant institutions and professional networks. Contacted individuals were also asked to either nominate or pass study information on to other relevant professionals.

Fifty-six experts provided consent to participate in the study and answered the demographic questionnaire items. Of the 56 experts, 46 responded to Round 1 survey (82.14% response rate) and the same number (46) completed Round 2 survey (82.14%). Only
the 46 individuals who completed Round 2 were invited to take part in Round 3, and of those, 44 completed the Round 3 questionnaire (95.65% response rate).

**Description of Delphi survey rounds and measures**

A summary of the Delphi method used in the current study is presented in Figure 1. In Round 1, experts were presented with seven open-ended questions asking for their views regarding the extent, to which selected organizational features of father-inclusive practice are implemented in child and family services, and the factors that may either hinder or support their implementation (Appendix F). Selected FIPs were drawn from the best practice guidelines of father engagement in family-based interventions (Panter-Brick et al., 2014, p. 1206). Participants were given a window of 3 - 6 weeks for the completion of the first survey. The qualitative data gathered was analysed thematically to develop specific items for questionnaires used in the subsequent survey rounds.

The second survey round (Round 2) commenced five weeks after completion of the Round 1 survey window. Participants received a questionnaire with 28 statements presenting potential barriers and facilitators to organizational implementation of father-inclusive practice (Appendix G). Experts were asked to indicate the extent to which they agree whether each statement constituted a barrier or a facilitator to the implementation of father-inclusive practice, on a seven-point Likert scale (‘Strongly disagree’, ‘Disagree’, ‘Somewhat disagree’, ‘Neither agree nor disagree’, ‘Somewhat agree’, ‘Agree’, ‘Strongly agree’). Seven-point Likert scale was optimal for the current study due to its high reliability, validity and discriminating power, and evidence of previous successful adoption in studies using Delphi methodology (Preston & Coleman, 2000; Walsh et al., 2018). Responses to Round 2 survey were collected within a 3-week window.

Survey Round 3 was conducted two weeks after the completion of the Round 2 response collection. Round 3 represented the evaluation phase (Iqbal & Pipon-Young, 2009),
whereby experts were provided with a summary of the information gathered in Round 2 and asked to reflect and reassess their initial judgments (Hsu & Sandford, 2007). Survey questions in Round 3 were the same statements as presented in Round 2. However, alongside each statement, experts were provided with a reminder of their individual reply from Round 2, and the aggregated ratings of other panel members (Appendix H). The experts were invited to re-evaluate their original responses in light of the group feedback and given the option to either maintain or adjust their previous rating. Experts had three weeks to complete Round 3.

**Figure 2.** Summary of the Delphi process
Data collection and analysis

Anonymized data was exported from Qualtrics™ to IBM SPSS Statistics 25 for analysis at the completion of each round. Descriptive statistics were used to summarize demographic information gathered in Round 1. Analysis of the free-text responses to questions in Round 1 was subsequently supported by NVivo™. The process of converting responses from open-ended questions in Round 1 into items for Rounds 2 and 3 combined inductive and deductive thematic analytical approaches, which were carried out over two successive stages. This was done to ensure that the development of items for latter rounds captured themes relevant to father-inclusive practice. The process of thematic analysis followed Braun and Clarke’s (2006) six-phase framework, undertaken collaboratively between two researchers (MB & VS). Any differences were resolved through discussion. In the first inductive stage of analysis, phrases relating to the factors influencing implementation of father inclusive practice were coded as either barriers or facilitators, or both depending on the narrative source, and captured into descriptive themes. In the second stage of analysis, themes that had been derived in stage 1 were subsequently mapped onto the implementation determinants specified by the CFIR, and thus grouped under the five major domains that constitute the CFIR framework: intervention characteristics, outer setting, inner setting, characteristics of individuals, and process) (Appendix I). The five domains describe different categories of factors that may influence implementation: ‘Intervention characteristics’ refer to the features of the interventions offered by the organization; ‘Inner Setting’ encompasses the characteristics of the implementing organisation; ‘Outer Setting’ refers to external influences on implementation such as the wider context or environment; ‘Characteristics of Individuals’ relates to beliefs, knowledge and personal attributes of those involved; and ‘Process’ includes the specific implementation activities (Damschroder et al., 2009).
One theme (Remote service provision) could not be mapped on existing CFIR constructs; thus, an additional construct (Intervention Modality) was added to the CFIR domain of ‘Intervention Characteristics’. Altogether, 28 barriers and facilitators were represented in 17 CFIR constructs (Appendix J). The identified barriers and facilitators were paraphrased into the 28 individual questionnaire items used in Rounds 2 and 3.

Descriptive analysis of individual levels of agreement to items was used to establish consensus among experts from responses collected in survey round 3. Consensus was assumed to have been reached if >70% of experts agreed (summative of agree and strongly agree) with an individual statement at the end of round 3. This criterion of consensus follows methods used in previous Delphi studies (e.g., Vernon, 2009; Vogel et al., 2019; Veugelers et al., 2020; Walsh et al., 2018). Barriers and facilitators were reported separately, with their associated consensus levels. Statements that achieved consensus of >70% at the end of Round 3 were identified as the strategic priorities to the organizational adoption of father-inclusive practice in child and family services.

Results

Demographic information

Table 3 summarises the demographic characteristics of the participants included in the analysis. The sample included experts from the United Kingdom (67.9%), United States (12.5%), Canada (12.5%), Australia (5.4%) and Belgium (1.8%). Of the 56 experts that took part, 33 (58.9%) participants identified as female and 23 (41.1%) as male. The average age of participants was 50.7 years (SD = 12.9). Those who identified primarily as research and academic professionals represented the largest group in the expert panel (28.6%, n=16), followed by services managers and those in leadership roles (19.6%, n=11), practitioner psychologists (19.6%, n=11), and family support workers and coordinators (14.3%, n=8). In terms of professional experience, a large proportion of participants reported involvement in
direct clinical work (60.7%, n=34), while 37.6% (n=21) indicated being involved in indirect clinical service provision, particularly service leadership and managerial roles. Nearly half of all experts (44.6%, n=25) reported engagement in academic work and 19.6% (N=11) identified as pursuing activities related to consultancy, campaigning, and policymaking. Of all experts, 44.6% (n=25) indicated fulfilling multiple professional roles that simultaneously covered several types of professional experience (e.g., both direct clinical and academic work). The length of time working in the relevant fields ranged from 1 to 60 years, with average years of experience of 18.57 (SD = 11.15).

**Table 3.** Characteristics of the participants included in the analysis

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>58.9%</td>
</tr>
<tr>
<td>Male</td>
<td>23</td>
<td>41.1%</td>
</tr>
<tr>
<td>Years of relevant experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>5</td>
<td>8.9%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>11</td>
<td>19.6%</td>
</tr>
<tr>
<td>11-20 years</td>
<td>25</td>
<td>44.6%</td>
</tr>
<tr>
<td>21-30 years</td>
<td>10</td>
<td>17.9%</td>
</tr>
<tr>
<td>30+ years</td>
<td>5</td>
<td>8.9%</td>
</tr>
<tr>
<td>Current role</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Academic/researcher</td>
<td>16</td>
<td>28.6%</td>
</tr>
<tr>
<td>Practitioner psychologist</td>
<td>11</td>
<td>19.6%</td>
</tr>
<tr>
<td>Manager/service lead</td>
<td>11</td>
<td>19.6%</td>
</tr>
<tr>
<td>Family Support Worker/Coordinator</td>
<td>8</td>
<td>14.3%</td>
</tr>
<tr>
<td>Nurse/Health Visitor/Midwife</td>
<td>5</td>
<td>8.9%</td>
</tr>
<tr>
<td>Project Worker/Coordinator</td>
<td>3</td>
<td>5.4%</td>
</tr>
<tr>
<td>Family Therapist</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Type of involvement with the target area</td>
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<td></td>
</tr>
<tr>
<td>Direct client work (clinical/support)</td>
<td>34</td>
<td>60.7%</td>
</tr>
<tr>
<td>Research/Academic</td>
<td>25</td>
<td>44.6%</td>
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<tr>
<td>Indirect work (managerial/leadership/administrative)</td>
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<td>37.5%</td>
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<tr>
<td>Consultancy/Campaigning/Policymaking</td>
<td>11</td>
<td>19.6%</td>
</tr>
<tr>
<td>Other: training, capacity-building</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>Std. dev.</td>
</tr>
<tr>
<td>Age (in years)</td>
<td>50.7</td>
<td>12.9</td>
</tr>
</tbody>
</table>

**Consensus analysis**

Tables 7 and 8 (appendix K and L) report the statements relevant to barriers and facilitators along with their associated levels of agreement. At the end of Round 3, 13 out of
the 28 (46.4%) statements achieved consensus (>70% agreement) to be considered key strategic priorities for the organizational implementation of father-inclusive practice in child and family services. This included 8 of the 21 statements representing barriers, and 5 of the 7 statements representing facilitators. Consensus was not obtained for the remaining 18 statements.

**Barriers to implementing FIP**

Seven out of eight barriers that reached consensus were associated with constructs belonging to the *Inner Setting* domain. Two of those barriers were related to *access to knowledge and information*. The experts agreed that lack of clear service protocols to adequately engage fathers, and lack of training and education for the workforce, were significant barriers to the implementation of FIP. Another barrier that met consensus was related to *leadership engagement*, highlighting that according to most of the experts, lack of leadership support for FIP was one of the key factors impeding its organizational adoption. Furthermore, experts were also in agreement that lack of centralized guidance, i.e., leaving the decision whether or not to engage in FIP in the hands of an individual professional, was an important structural characteristic of an organisation that hinders implementation. The other three barriers that achieved high consensus rates were related to aspects of the *Implementation Climate* construct: *Relative Priority, Goals and Feedback* and *Compatibility*. That is, the experts agreed that lack of strategic prioritization of FIP, absence of service targets and key performance indicators related to FIP, and the view of FIP as creating excessive burden for staff, were important barriers to FIP implementation. The only other barrier that met consensus was associated with the *Outer Setting* construct of *Patient Needs and Resources*. Experts were in agreement that the limited awareness of fathers’ needs within services is a major obstacle to the organizational implementation of FIP.
Thirteen statements did not meet expert consensus as key strategic priorities for FIP implementation. These included all three statements belonging to the *Characteristics of Individuals* domain, such as practitioners’ lack of confidence in engaging fathers, assumptions and stereotypes about fathers’ role availability or interest, or assumptions of FIP not leading to improved outcomes. Furthermore, eight statements related to the Inner Setting also did not meet consensus. For instance, none of the statements associated with resource availability (insufficient time due to competing demands, lack of gender diversity in staff teams, insufficient financial resources, limited staff availability) reached consensus to be considered a key barrier to FIP implementation. Other Inner Setting barriers that did not reach consensus threshold included: lack of awareness of FIP guidelines and recommendations, inadequate data systems, organizational resistance to change, and lack of organizational incentives and rewards. Lastly, two barriers that did not meet consensus were related to belonged to the *Outer Setting* domain. There was no agreement on the lack of incentives from authorities being a high-priority barrier to implementation of FIP.

Furthermore, no consensus was reached regarding the statement that a drive towards gender-neutrality was a barrier to the organizational adoption of FIP in child and family services.

**Facilitators to implementing FIP**

The experts reached consensus on five facilitators of FIP. Three of those belonged to the *Inner Setting* domain. Firstly, experts agreed that practices such as allowing and encouraging team discussions and reflection regarding FIP can be a major facilitator to organizational implementation of FIP. Moreover, experts recognized a need for greater access to knowledge and information about FIP among staff, as provision of education and training for staff was recognized as a key enabler of FIP. Another facilitator that met consensus was related to the services having explicit goals for introducing FIP, which could be achieved through introduction of relevant targets and key performance indicators that guide service
delivery. Furthermore, one facilitator that met the consensus threshold was associated with the *External Policies and Incentives* construct of the *Outer Setting* domain. That is, experts agreed that greater recognition of the importance of FIP by the authorities and commissioners is a significant facilitator of FIP. Finally, one statement that met expert consensus as a key facilitator of FIP belonged to the *Implementation Process* domain and related to the importance of having clear measures to monitor the provision of FIP.

Only two facilitators did not reach the necessary consensus level to be considered a strategic priority for the organizational implementation of FIP. One of the statements was related to the *Implementation Process* domain and highlighted that enlisting champions for father inclusion was not viewed as a key priority for implementation of FIP in services. The second statement that did not attract high levels of agreement was related to the *Intervention Characteristics* domain. More specifically, increasing remote service provision was not highlighted as a key enabler of FIP.

**Discussion**

The current study examined barriers and facilitators to organizational implementation of father inclusive practice (FIP) within services that provide interventions to improve the mental health and well-being of children and families. The purpose was to establish areas of strategic priority for future FIP implementation. Our results indicated 8 barriers and 5 facilitators considered as implementation priorities. These were arranged across the relevant domains and constructs of the CFIR implementation framework. Most belonged to the Inner Setting domain reflecting issues of central prioritization of FIP. By contrast, the factors not identified as priority varied across multiple CFIR domains, representing practitioner-level, service-level, and external influences.

Our results suggest that one of the key overarching themes that hinders the organizational implementation of FIP is lack of central prioritisation and provision to support
FIP. This result replicates and extends previous research findings that highlighted the critical importance of organizational support to greater father-inclusivity (e.g., Glynn & Dale, 2015; Tully et al., 2018). Notably, lack of leadership support, centralized guidance, and performance monitoring were identified as key barriers to implementing FIP. These findings converge with previous research, which emphasize the instrumental role of leadership in implementing new initiatives by facilitating buy-in among staff and ensuring that new processes are integrated into practice (Li et al., 2018). Conversely, research shows that leadership that is reluctant to partake in the implementation process or neglects to hold staff accountable can undermine the implementation of evidence-based practices (Lodge et al., 2017; Omer, 2012). Indeed, high staff autonomy was found to be a major barrier in our analysis, alongside previous studies, adding to evidence that without centralized guidance regarding implementing new evidence-based practices, staff may be resistant in adopting father-inclusive practice (e.g. Berta et al., 2005; Lodge et al., 2017).

Relatedly, our findings highlighted that successful implementation of FIP depends on the compatibility between FIP and the existing work processes. Experts agreed that implementing FIP is likely to be hampered in environments where it is perceived as an extra burden. Indeed, new initiatives that don’t align with the organizational norms, ways of working, and perceived needs, have less likelihood of being adopted (Greenhalgh et al., 2004). This is emphasised for initiatives viewed as complex or difficult to implement (Greenhalgh et al., 2004). While the issue of compatibility is related to lower-level operational context, it is possible that top-down influences such as effective leadership may offer ways of fostering more positive attitudes towards implementation (Aarons, 2006).

Furthermore, our study identified the lack of organizational awareness of fathers’ needs as a major obstacle to FIP implementation. This echoes the view of Rollins (2020), who recognized father awareness as the first step towards greater father-inclusivity in
services. Research suggests that awareness of fathers’ needs is a factor that can be potentially addressed by adequate staff education (e.g. Humphries & Nolan, 2015; Rollins, 2020). This corresponds with our findings, which also emphasised the strategic importance of staff education and training for FIP implementation. Consequently, our results are supportive of the view that FIP training provision represents one potential strategy to remedy the lack of organizational father awareness. Moreover, our outcomes align more generally with previous research that highlights the multi-level benefits of staff training in enhancing father-inclusivity and improving organizational practices in services (e.g. Burn et al., 2019, Humphries and Nolan, 2015; Scourfield et al., 2012, Scourfield et al., 2015).

The experts in our study were explicit about top-down organizational facilitators for implementing FIP, many of them reflecting ways of addressing implementation barriers. For instance, organizational encouragement of discussion and reflection on father-inclusive practice was recognized as important for implementation. This converges with previous findings that intra-organizational communication can impact the implementation of evidence-based practice (e.g. Harvey, Jas & Walshe, 2015, McCullough et al., 2015). More specifically, the evidence suggests that establishing systems and processes to facilitate communication about new initiatives (in this case, FIP), and utilizing various communication channels to encourage dialogue about the new initiative among staff, can contribute to implementation success (Harvey et al., 2015; Stevens et al., 2014; Vamos et al. 2017). Secondly, service targets and key performance indicators were recognized as important facilitators to FIP, suggesting that setting targets in relation to FIP has the potential to boost implementation success. In line with this, the results also highlighted that monitoring and auditing the implementation of FIP putatively encourages good practice among staff in healthcare contexts (Stevens et al., 2014; Yamada et al., 2017). Lastly, we hypothesise that the organizational willingness to implement targets and monitoring to enhance FIP may be
dependent on the external policy context. Service targets and performance indicators often reflect local and national priorities that exist in the form of regulations and guidelines (Davies et al., 2021; Mendel et al., 2008). Our findings add to the evidence that systems-level support for FIP from external bodies (government and commissioners) represents an important facilitator to FIP, which may directly impact the services’ motivation to adopt new initiatives (Greenhalgh et al., 2004).

By contrast to areas identified as priority for implementation, our findings indicated that practitioner-level issues such as staff’s assumptions or confidence in engaging fathers are arguably less of a priority for the successful implementation of FIP. These findings somewhat contrast previous research emphasising practitioners in improving father engagement (e.g., Burn et al., 2019; Hecker, 1991; Wolins, 1983; Vetere, 2004). It is important to note that the lack of recognition of practitioner-level issues as a priority area is reflective of the opinion and the characteristics of the current expert sample, 40% of whom did not identify as frontline clinical staff. While some caution should be exercised when drawing inferences from this finding, the results are clear in suggesting that focusing solely on improving individual practitioner skills without putting in adequate organizational support and addressing challenges associated with external policy and social context, might not lead to improved father inclusivity. Furthermore, our results show that, contrary to findings from previous studies (e.g., Bach-Mortensen, Lange & Montgomery, 2018; Li et al., 2014), factors associated with availability of resources, such as time constraints, staffing and financial limitations, might hold relatively less strategic importance for FIP implementation. In light of our findings, we hypothesise that organizational implementation of FIP may be less resource-intensive than previously assumed. Additionally, it is possible that putting in place effective top-down strategies and processes may in fact help with adequate allocation of existing resources to facilitate implementation.
Taken together, our findings emphasise numerous interrelationships that exist between factors influencing FIP provision. We identified potential contingencies between systems-level influences, top-down organizational guidance and prioritization, leadership support, lower-level organizational processes, and practitioner competencies. Our results therefore reinforce the notion that many implementation determinants are interdependent and work synergistically to influence implementation (Li et al., 2018; Sarkies et al., 2020). Taking that into consideration, we suggest that successful organizational implementation of FIP relies on accurately identifying these interrelationships and taking them into account when coordinating future FIP implementation efforts.

**Limitations and future research directions**

Several limitations should be considered for future research. We recruited a very diverse sample of experts working within different systems and policy contexts to gain a wide-ranging perspective on the issue of implementation of FIP. While this increased the generalizability of our findings, one potential limitation of this approach was the possibility that barriers and facilitators may differ significantly depending on the local and national context, impacting the experts’ levels of agreement on the key factors. Therefore, one consideration for future research should be to focus on assessments of factors affecting FIP provision that target a particular service type, locality, or professional group, which could offer more context-specific insights.

Although previous research identifies snowball sampling as a valid method of identifying expert populations in Delphi studies (e.g. Skulmoski et al., 2007), we have found that applying this sampling method in the current study may have led to the inclusion of some non-experts in the sample. While the years of relevant experience reported by the sample was high (18.5), it ranged from 1 to 60, which indicates that those at the lower end may have had a more limited expertise in relation to child and family service provision. This could have
influenced the robustness of our data, and therefore should be carefully considered by future research involving expert samples. This challenge could be possibly remedied by introducing more stringent minimum inclusion criteria in relation to the participants’ experience.

Due to the need to rapidly convert open-ended responses into questionnaire items, the processes of inductive coding, derivation of themes and their matching to CFIR framework in the Round 1 thematic analysis, were not done independently by the members of the research team. Although thematic analysis was not a specific aspect of our study, non-independence in coding might have introduced potential bias, thus impacting the reliability of the analysis. Allowing more time and introducing procedures to assess the inter-rater reliability would help to mitigate this risk of bias.

Although the recruited sample of experts was balanced in terms of variety of professional experience, some experts may have had a limited exposure to certain aspects of child and family service provision, such as the direct clinical work. Therefore, future research using expert samples should consider the extent to which expertise of the participants matches the focus of the study.

Pinpointing the key determinants of implementation is merely the first step towards enabling greater father-inclusivity and requires further research to identify and select appropriate implementation strategies to address the identified barriers and facilitators. This is another limitation of this approach: determinant frameworks such as the CFIR, provide insight into factors influencing implementation, but do not specify the mechanisms of change or provide support for carrying out the process of implementation. Therefore, future research should build on these findings by determining and matching discrete implementation strategies to address the CFIR-based contextual factors. This could be achieved by utilizing a range of process models designed to guide the translation of research into practice (see Nilsen, 2015 for a review), including the Expert Recommendations for Implementing Change
(ERIC) compilation, which has been specifically designed to complement the CFIR framework in tailoring the implementation process (Waltz et al., 2019). Finally, due to the descriptive nature of the CFIR framework, the current study offers limited insight into the possible synergistic relationships between the factors that influence the organizational implementation of FIP. Future research should address this by exploring further how the individual barriers and facilitators interact to influence the implementation of organizational practices to aid father inclusion.

**Conclusions**

By establishing expert consensus on strategic priorities among the factors that enable or obstruct the organizational adoption of FIP, we provided an evidence base of the key priorities that should be considered by services aiming to enhance their father-inclusive practice. From the evidence, it was clear that more attention should be given primarily to the top-down organizational processes and practices to improve the service-level provision of FIP. The findings of this study should inform the identification and selection of appropriate implementation strategies to address the existing service-level challenges to FIP.

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Chapter 4. General Discussion

In this thesis, we sought to 1) bring attention to the organizational influences on father engagement in child and family services, and 2) narrow down the strategic priorities for implementation of father-inclusive practice. Two studies were conducted in attempt to address the research objectives.

Chapter 2 presents a systematic synthesis of the global evidence base on barriers and facilitators to father inclusive practice. This systematic review was necessary to unify the
knowledge of factors that are important for father engagement across a range of service contexts. The results were consistent in showing that the way services are set up and delivered has significant implications for father engagement. The themes identified in the review provided a clear list of factors that should be addressed by services that have the ambition to attract more fathers. We view the systematic review as the foundation for the empirical project described in the subsequent chapter. The review provided clarity regarding service-level factors that influence father engagement. While this was an important step towards encouraging organizational change, further work was required to stimulate the uptake of father-inclusive practice in child and family services.

Chapter 3 describes an empirical study, which focused on the issue of the implementation of father-inclusive practice. By gathering expert opinion regarding the main barriers and facilitators to organisational provision of father-inclusive practice, we were able to narrow down the contextual features that are instrumental to creating service environments that attract and benefit fathers. Ultimately, the results show that organizations where father engagement is considered and encouraged by leadership, embedded in top-down guidance, and reinforced externally, are more likely to successfully address the barriers typically experienced by fathers.

**Synthesising outcomes across studies**

There are many parallels between the results of our two research projects. Although the first study explored organizational determinants of father engagement and the other on factors influencing the implementation of father-inclusive practices, both studies emphasize the importance of the organizational characteristics and service design. Moreover, both studies reinforce the view that having appropriate systems in place can not only enhance father attendance, but also enable practitioners to better implement father-inclusive practice guidelines. Another common theme was staff training in engaging fathers, which was
recognized in both studies as instrumental for adopting more father-inclusive practices and thus making services more accessible to fathers. Furthermore, while the results of both studies acknowledged the role of practitioners in encouraging father engagement, the findings support the view that staff attitudes and behaviours can be potentially shaped by workplace policies and practices.

**Implications for organisational practice**

This research is rooted in the principles of implementation science. Throughout this thesis we emphasize the need to intensify the efforts to implement Father-Inclusive Practice in services and the results provide preliminary indication with regards to the areas where the implementation efforts should be focused. By analysing the unique barriers and facilitators to the implementation of FIP through the lens of the CFIR framework, this research has helped to recommend changes necessary to increase the uptake of FIP in services. Following from the empirical findings, we propose a tentative model to summarize the key recommendations and to detail the practice implications of this research in an easily accessible format (Figure 3).
Figure 3. Father-Inclusive Practice recommendations and implications for service providers.

**Implementation of Father-Inclusive Practice**

<table>
<thead>
<tr>
<th>Organisational-level recommendations</th>
<th>Process-level recommendations</th>
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| 1. Foster leadership engagement and support  
Strong leadership that recognizes the importance of father-inclusive practice and adopts a supportive stance towards FIP is vital to ensuring the overall organisational commitment to father inclusion | 1. Enable access to knowledge and information  
Provide staff training and continued professional development opportunities in relation to FIP |
| 2. Establish guiding frameworks  
Inserting clear guidance around FIP into service policies, guidelines and protocols can help to shape staff practices, ensuring that FIP is reflected in organisational processes | 2. Build service capacity for effective communication  
Provide spaces for discussion and encourage team reflection on father engagement and father-inclusive practice |
| 3. Set goals and expectations  
Introducing targets and key performance indicators in relation to father engagement can provide extra incentive for practitioners and management | 3. Introduce effective evaluation and monitoring mechanisms  
Introduce systems and processes to monitor the service provision of FIP and measure the outcomes relating to father engagement |

<table>
<thead>
<tr>
<th>External support recommendations</th>
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</table>
1. Enhance service awareness of fathers’ needs  
There is a need for external initiatives that raise awareness of the importance of father engagement across services  
2. Solicit support from wider systems  
The uptake of FIP is more likely if it aligns with local and national policies and is supported externally by government and commissioning agencies | 4. Ensure compatibility between FIP and existing practices  
Integrate father-inclusive practices in staff’s responsibilities in a way that doesn’t result in excessive burden for practitioners |
This model outlines elements of service functioning that represent priorities for improving father-inclusive practice, divided between three core areas: organisational-level, process-level and external support. This division was partly inspired by Rummier and Brache’s (1990) framework for improving organisational performance, according to which improvement typically occurs at three levels: organisational-level, process-level, and individual performer level (the latter being of less relevance to the findings of the current research). This framework was adjusted to include the category of external influences, which was identified in our research as one of the key determinants to implementation of FIP.

Firstly, the organisational-level recommendations are aimed at influencing change at the highest level of service provision: generating shifts in service design and structure, creating frameworks that determine the functioning of the service, and adjusting top-down expectations and responsibilities assigned to teams and individuals. These recommendations, i.e., leadership engagement and support, establishing guiding frameworks, and setting goals and expectations provide the foundation for father-inclusive practices to occur. Secondly, process-level recommendations outline the tasks, processes and practices that should be undertaken by the service to build organizational capacity for father-inclusive practice. The results of the current research indicate four key action points that are considered important for improving FIP at the process level: providing opportunities for staff training in father inclusion, encouraging team discussion and reflection regarding father engagement, introduction of FIP evaluation and monitoring, and ensuring compatibility with existing job plans and practices to reduce staff burden. Lastly, the model recognizes the pivotal role of external support in influencing father-inclusive practice in services. This is reflected in recommendations that outline the need for extra-organisational influences in order to foster FIP: external initiatives to raise awareness of fathers’ needs and the importance of father engagement; and external support from local government and commissioning agencies.
Results of the empirical study indicate that the three areas are intricately contingent on one another and mutually influential in the implementation of FIP. While all three areas represent important targets for implementation efforts, empirical study findings repeatedly emphasize the key role of top-down organisational processes, while recognizing the impact of external influence on adoption of FIP. Changes at the higher organizational level are likely to inspire and drive process-level improvements and external support has the capacity to influence service provision at both organizational and process levels. Therefore, we tentatively suggest that efforts to improve father-inclusive practice may yield better outcomes when they are incentivized externally, as well as focused on targeting leadership, policies and protocols, and top-down directives in the first instance. Further research exploring the interconnection between the three areas described in the model could provide further clarity regarding relationships between included elements.

Taken together, addressing the key recommendations from this research may promote more inclusive practice by mitigating the barriers and leveraging the facilitators to father engagement. This could potentially contribute to more fathers taking part in, and benefitting from, service provision. However, while this research provides preliminary indication as to what the priority areas for improving father engagement are, it is limited in providing advice on how they should be best approached. Therefore, there is still a need for development of context-specific, practical, and actionable implementation strategies that would enable services to address the recommendations identified in this research (Perry et al., 2019). Future studies could build on the findings of the current project by deriving context-specific implementation strategies to directly influence FIP implementation efforts and consequently promote father-inclusive organizational culture across child and family services.
General conclusion

Father engagement in child and family services has grown from an area of a relatively low perceived significance to a major consideration for service providers. The benefits of father engagement are increasingly discussed in research, calls for greater father inclusion have become more widespread, promotion of father engagement appears to be more evident in many national policies, and numerous guidelines are formed with the purpose of generating a shift in organizational culture to encourage father engagement. While these changes are not yet consistently evident in practice, the current research project has generated insight on the recommendations across different levels of service provision to adopting greater father-inclusivity. It is our hope that the clear directions outlined in this thesis will help to bridge the gap between the knowledge about father inclusivity and its application in child and family service settings.
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Appendices

Appendix A

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• **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about Methodology and Materials. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**

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## Appendix B

### Table 4. CASP analysis for all studies included in the systematic review

#### Supplementary information

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<th>Study</th>
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1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?
# Appendix C

Table 5. Themes and subthemes describing barriers and facilitators to father engagement

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<th>Analytical theme</th>
<th>Barriers (sub-themes)</th>
<th>Facilitators (sub-themes)</th>
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<td>Practitioner factors</td>
<td>Negative gender-based staff assumptions and attitudes</td>
<td>Interpersonal qualities</td>
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<td>Lack of awareness &amp; understanding of fathers’ needs</td>
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<tr>
<td>Marketing</td>
<td>Non-inclusive appointment invitations</td>
<td>Outreach activities to raise community awareness</td>
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<td></td>
<td>Inadequate advertising strategies</td>
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<td>Gender-neutral advertising messages</td>
<td>Advertising strategies</td>
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<td>Resources and information</td>
<td>Inadequate or inflexible timing</td>
<td>Male workers and gender-balanced teams</td>
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<td>Excessive demands on staff</td>
<td>Flexibility in timing</td>
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<td>Mother-orientated environment</td>
<td>Incentives and rewards</td>
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<td></td>
<td>Lack of training for staff</td>
<td>Father-friendly décor and facilities</td>
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<tr>
<td>Policies and practice guidelines</td>
<td>Absence of father-focused policies, guidelines and frameworks</td>
<td>Father-inclusive policies and top-down guidance</td>
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<td></td>
<td>Unfavourable workplace policies</td>
<td>Targets</td>
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<tr>
<td>Evaluation</td>
<td>N/A</td>
<td>Feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring father enrolment and retention</td>
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</table>

a Anderson et al. (2015)  
b Barrett et al. (2018)  
c Bayley et al. (2009)  
d Coady et al. (2013)  
e Davis et al. (2018)  
f Davis et al. (2016)  
g Edvardsson et al. (2011)  
h Ewart-Boyle et al. (2015)  
i Frank et al. (2015)  
j Garfield & Isaaco (2006)  
k Gilligan et al. (2012)  
l Icard et al. (2017)  
m Jeong et al. (2021)  
n McGirr et al. (2020)  
o O’Donnell et al. (2005)  
p Salinas et al. (2011)  
q Sicouri et al. (2018)  
r Smythe et al. (2019)  
s Solberg et al. (2022)  
t Stahlschmidt et al. (2013)  
u Warria (2021)  
v Williams et al. (2012)  
w Wynter et al. (2021)
Appendix D

Author guidelines for submission to Administration and Policy in Mental Health and Mental Health Services Research

Submission guidelines

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General Contents

The aim of Administration and Policy in Mental Health and Mental Health Services is to improve mental health services through research. This journal primarily publishes peer-reviewed, original empirical research articles. The journal also welcomes systematic reviews. Please contact the editor if you have suggestions for special issues or sections focusing on important contemporary issues. The journal usually does not publish articles on drug or alcohol addiction unless it focuses on persons who are dually diagnosed. Manuscripts on children and adults are equally welcome. Topics for articles may include, but need not be limited to, effectiveness of services, measure development, economics of mental health services, managed mental health care, implementation of services, staffing, leadership, organizational relations and policy, and the like. Please review previously published articles for fit with our journal before submitting your manuscript.

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- Authors should avoid citing their own work in a way that could reveal their identity.

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Authors should refer to the Publication Manual of the American Psychological Association (6th edition) as a style guide for the abstract, main body of the manuscript, tables, figures, and references.

The references should adhere strictly to the APA style. Authors are responsible for all information in a reference, since accurately prepared references help establish credibility as a careful researcher.

Tables and figures should be placed at the end of the article, one table or figure per page. Use short, descriptive titles and subheads.

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QUALITATIVE METHODS are appropriate when the research question calls for an exploratory or descriptive level of inquiry. This often occurs when relatively little is known about the topic under investigation. Qualitative methods are generally used for hypothesis generating, rather than hypothesis testing. Submissions to the journal that use qualitative methods must:

1. Communicate a clear study purpose, rationale, significance, and research question(s).

2. Provide rationale for the use of qualitative methods and describe the study methodology.

3. Thoroughly describe details for the qualitative research methods employed (e.g., study design, sampling strategy, data collection, and step-by-step data analysis).

4. Describe the measures of study rigor operationalized in the qualitative procedures. Be sure to refer to measures of rigor specific to qualitative research (i.e., credibility, 

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dependability, confirmability, and transferability) rather than measures of rigor used for quantitative research (i.e., validity, reliability, objectivity, and generalizability).

5. Report results from the qualitative inquiry, complete with data.

6. Include study limitations in light of the study findings and conclusions.

7. Discuss how the manuscript makes a novel contribution both to the literature on qualitative research and to the substantive area in the field of inquiry.

More information on qualitative data collection, analysis, and reporting can be found in the following:


- Watkins DC. Qualitative research: The importance of conducting research that doesn’t ‘count.’ Health Promotion Practice 2012; 13(2): 153-158.


MIXED METHODS are appropriate when the research question calls for the use of both qualitative and quantitative inquiry. The journal is guided by John Creswell’s 2008 definition of mixed methods: “Mixed methods research is a methodology for conducting research that involves collecting, analyzing, and integrating (or mixing) quantitative and qualitative research (and data) in a single study or a longitudinal program of inquiry. The purpose of this form of research is that both qualitative and quantitative research, in combination, provide a better understanding of a research problem or issue than either research approach alone.” Submissions to the journal that use mixed methods must:

1. Communicate a clear study purpose, rationale, significance, and research question(s).

2. Provide rationale for the use of mixed methods.
3. Fit the definition of mixed methods research by collecting and analyzing data, integrating the findings, and drawing overall interpretations using both qualitative and quantitative approaches or methods.

4. Thoroughly describe the qualitative and quantitative methods (e.g., theory or methodological framework, study design, sampling, data collection, and data analysis procedures) used.

5. Describe the measures of study rigor operationalized in the qualitative and quantitative procedures. Be sure to refer to measures of rigor specific to qualitative research (i.e., credibility, dependability, confirmability, and transferability) and the measures of rigor specific to quantitative research (i.e., validity, reliability, objectivity, and generalizability).

6. Report results from the qualitative and quantitative inquiry, complete with data.

7. Include study limitations and in light of the study findings and conclusions.

8. Describe how the quantitative and qualitative data were integrated (i.e., “mixing”) and how it helped achieve the goals of the study.

9. Discuss how the manuscript makes a novel contribution both to the literature on mixed methods research and to a substantive area in the field of inquiry.

IMPORTANT NOTE: Submissions that do not show integration or discuss how they make a novel contribution to the mixed methods literature will be returned to the author(s).

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Manuscript Preparation

Title Page

The title page should include:

- The name(s) of the author(s)

- A concise and informative title

- The affiliation(s) and address(es) of the author(s)

- The e-mail address, and telephone number(s) of the corresponding author

- If available, the 16-digit ORCID of the author(s)

Abstract

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

- Purpose (stating the main purposes and research question)

- Methods

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- Results

- Conclusions

Keywords

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For more information or if you have further questions about submitting to this journal you may contact the editor:

- Leonard Bickman, Ph.D
  e-mail: Leonard.Bickman@vanderbilt.edu

EIC website

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DataCite

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教程

Nature Research Editing Service

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・英語で執筆する際のよくある間違いに関する英語のチュートリアルを参照する。
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英語トピックページ

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ICMJE, Defining the Role of Authors and Contributors.

Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

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- providing transparency on re-use of material and mention any unpublished material (for example manuscripts in press) included in the manuscript in a cover letter to the Editor;
- making sure disclosures, declarations and transparency on data statements from all authors are included in the manuscript as appropriate (see above).

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  All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

  **Example: CRediT taxonomy:**

  - Conceptualization: [full name], ...; Methodology: [full name], ...; Formal analysis and investigation: [full name], ...; Writing - original draft preparation: [full name, ...]; Writing - review and editing: [full name], ...; Funding acquisition: [full name], ...; Resources: [full name], ...; Supervision: [full name], ...

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- Informed consent
Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

The Editors reserve the right to reject manuscripts that do not comply with the above-mentioned guidelines. The author will be held responsible for false statements or failure to fulfill the above-mentioned guidelines.

Competing Interests

Authors are requested to disclose interests that are directly or indirectly related to the work submitted for publication. Interests within the last 3 years of beginning the work (conducting the research and preparing the work for submission) should be reported. Interests outside the 3-year time frame must be disclosed if they could reasonably be perceived as influencing the submitted work. Disclosure of interests provides a complete and transparent process and helps readers form their own judgments of potential bias. This is not meant to imply that a financial relationship with an organization that sponsored the research or compensation received for consultancy work is inappropriate.

Editorial Board Members and Editors are required to declare any competing interests and may be excluded from the peer review process if a competing interest exists. In addition, they should exclude themselves from handling manuscripts in cases where there is a competing interest. This may include – but is not limited to – having previously published with one or more of the authors, and sharing the same institution as one or more of the authors. Where an Editor or Editorial Board Member is on the author list they must declare this in the competing interests section on the submitted manuscript. If they are an author or have any other competing interest regarding a specific manuscript, another Editor or member of the Editorial Board will be assigned
to assume responsibility for overseeing peer review. These submissions are subject to the exact same review process as any other manuscript. Editorial Board Members are welcome to submit papers to the journal. These submissions are not given any priority over other manuscripts, and Editorial Board Member status has no bearing on editorial consideration.

Interests that should be considered and disclosed but are not limited to the following:

**Funding:** Research grants from funding agencies (please give the research funder and the grant number) and/or research support (including salaries, equipment, supplies, reimbursement for attending symposia, and other expenses) by organizations that may gain or lose financially through publication of this manuscript.

**Employment:** Recent (while engaged in the research project), present or anticipated employment by any organization that may gain or lose financially through publication of this manuscript. This includes multiple affiliations (if applicable).

**Financial interests:** Stocks or shares in companies (including holdings of spouse and/or children) that may gain or lose financially through publication of this manuscript; consultation fees or other forms of remuneration from organizations that may gain or lose financially; patents or patent applications whose value may be affected by publication of this manuscript.

It is difficult to specify a threshold at which a financial interest becomes significant, any such figure is necessarily arbitrary, so one possible practical guideline is the following: “Any undeclared financial interest that could embarrass the author were it to become publicly known after the work was published.”

**Non-financial interests:** In addition, authors are requested to disclose interests that go beyond financial interests that could impart bias on the work submitted for publication such as professional interests, personal relationships or personal beliefs (amongst others). Examples include, but are not limited to: position on editorial board, advisory board or board of directors or other type of management relationships; writing and/or consulting for educational purposes; expert witness; mentoring relations; and so forth.

Primary research articles require a disclosure statement. Review articles present an
expert synthesis of evidence and may be treated as an authoritative work on a subject. Review articles therefore require a disclosure statement. Other article types such as editorials, book reviews, comments (amongst others) may, dependent on their content, require a disclosure statement. If you are unclear whether your article type requires a disclosure statement, please contact the Editor-in-Chief.

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**Summary of requirements**

The above should be summarized in a statement and included on a **title page that is separate from the manuscript** with a section entitled “Declarations” when submitting a paper. Having all statements in one place allows for a consistent and unified review of the information by the Editor-in-Chief and/or peer reviewers and may speed up the handling of the paper. Declarations include Funding, Competing interests, Ethics approval, Consent, Data, Materials and/or Code availability and Authors’ contribution statements. **Please use the title page for providing the statements.**

Once and if the paper is accepted for publication, the production department will put the respective statements in a distinctly identified section clearly visible for readers.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

When all authors have the same (or no) competing interests and/or funding it is sufficient to use one blanket statement.

**Examples of statements to be used when funding has been received:**

- Partial financial support was received from […]
- The research leading to these results received funding from […] under Grant Agreement No[...].

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• This study was funded by [...] 
• This work was supported by [...] (Grant numbers [...] and [...])

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• No funding was received to assist with the preparation of this manuscript.
• No funding was received for conducting this study.
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• **Financial interests:** Author A received a speaking fee from Y for Z. Author B receives a salary from association X. X where s/he is the Executive Director.
  
  **Non-financial interests:** none.

• **Financial interests:** Author A and B declare they have no financial interests. Author C has received speaker and consultant honoraria from Company M and Company N. Dr. C has received speaker honorarium and research funding from Company M and Company O. Author D has received travel support from Company O.
  
  **Non-financial interests:** Author D has served on advisory boards for Company M, Company N and Company O.

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• The authors have no competing interests to declare that are relevant to the content of this article.
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Research involving human participants, their data or biological material

Ethics approval

When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

Retrospective ethics approval

If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval usually cannot be obtained and it may not be possible to consider the manuscript for peer review. The decision on whether to proceed to peer review in such cases is at the Editor’s discretion.

Ethics approval for retrospective studies

Although retrospective studies are conducted on already available data or biological material (for which formal consent may not be needed or is difficult to obtain) ethics
approval may be required dependent on the law and the national ethical guidelines of a country. Authors should check with their institution to make sure they are complying with the specific requirements of their country.

**Ethics approval for case studies**

Case reports require ethics approval. Most institutions will have specific policies on this subject. Authors should check with their institution to make sure they are complying with the specific requirements of their institution and seek ethics approval where needed. Authors should be aware to secure informed consent from the individual (or parent or guardian if the participant is a minor or incapable) See also section on **Informed Consent**.

**Cell lines**

If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

It is recommended that authors check the [NCBI database](https://www.ncbi.nlm.nih.gov) for misidentification and contamination of human cell lines. This step will alert authors to possible problems with the cell line and may save considerable time and effort.

Further information is available from the [International Cell Line Authentication Committee](https://www.iclac.org) (ICLAC).

Authors should include a statement that confirms that an institutional or independent ethics committee (including the name of the ethics committee) approved the study and that informed consent was obtained from the donor or next of kin.

**Research Resource Identifiers (RRID)**

Research Resource Identifiers (RRID) are persistent unique identifiers (effectively similar to a DOI) for research resources. This journal encourages authors to adopt RRIDs when reporting key biological resources (antibodies, cell lines, model organisms...
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**Plasmid:** mRuby3 plasmid  **RRID:** Addgene\_104005

**Software:** ImageJ Version 1.2.4  **RRID:** SCR\_003070

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The World Health Organization (WHO) definition of a clinical trial is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes". The WHO defines health interventions as "A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions" and a health-related outcome is generally defined as a change in the health of a person or population as a result of an intervention.

To ensure the integrity of the reporting of patient-centered trials, authors must register prospective clinical trials (phase II to IV trials) in suitable publicly available repositories. For example [www.clinicaltrials.gov](http://www.clinicaltrials.gov) or any of the primary registries that participate in the [WHO International Clinical Trials Registry Platform](http://www.who.int/clinicaltrials/trialsearch). The trial registration number (TRN) and date of registration should be included as the last line of the manuscript abstract.
For clinical trials that have not been registered prospectively, authors are encouraged to register retrospectively to ensure the complete publication of all results. The trial registration number (TRN), date of registration and the words ‘retrospectively registered’ should be included as the last line of the manuscript abstract.

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- Observational studies ([STROBE](https://www.strobe-statement.org))
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- Diagnostic/prognostic studies ([STARD](https://www.stard-initiative.org)) and ([TRIPOD](https://www.tripod-statement.org))
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- Animal pre-clinical studies ([ARRIVE](https://www.arrive-statement.org))
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- Economic evaluations ([CHEERS](https://www.cheers-statement.org))
Summary of requirements

The above should be summarized in a statement and placed in a ‘Declarations’ section before the reference list under a heading of ‘Ethics approval’.

Examples of statements to be used when ethics approval has been obtained:

- All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).

- This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date../No. ...).

- Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

- The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

- Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.

- This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

- This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this...
Examples of statements to be used when no ethical approval is required/exemption granted:

- This is an observational study. The XYZ Research Ethics Committee has confirmed that no ethical approval is required.

- The data reproduced from Article X utilized human tissue that was procured via our Biobank AB, which provides de-identified samples. This study was reviewed and deemed exempt by our XYZ Institutional Review Board. The BioBank protocols are in accordance with the ethical standards of our institution and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.

Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic
Informed consent for publication should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort meaning.

Exceptions where it is not necessary to obtain consent:

• Images such as x-rays, laparoscopic images, ultrasound images, brain scans, pathology slides unless there is a concern about identifying information in which case, authors should ensure that consent is obtained.

• Reuse of images: If images are being reused from prior publications, the Publisher will assume that the prior publication obtained the relevant information regarding consent. Authors should provide the appropriate attribution for republished images.

Consent and already available data and/or biologic material

Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.

Data protection, confidentiality and privacy

When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made aware what kind of (personal) data will be processed, how it will
Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found

here. *(Download docx, 36 kB)*

Summary of requirements

The above should be summarized in a statement and placed in a ‘Declarations’ section before the reference list under a heading of ‘Consent to participate’ and/or ‘Consent to publish’. Other declarations include Funding, Competing interests, Ethics approval, Consent, Data and/or Code availability and Authors’ contribution statements.

Please see the various examples of wording below and revise/customize the sample

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statements according to your own needs.

Sample statements for "Consent to participate":

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior to the interview.

Sample statements for "Consent to publish":

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

Sample statements if identifying information about participants is available in the article:

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

Images will be removed from publication if authors have not obtained informed consent or the paper may be removed and replaced with a notice explaining the reason for removal.
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Appendix E

Ethical approval document including empirical study proposal

University of Edinburgh, School of Health in Social Science
Research Ethics, Integrity and Governance

The forms required when seeking ethical approval in the School of Health and Social Sciences have now been merged into this single electronic document. The sections you are required to complete will depend on the nature of your application. Please start to complete the form from the beginning and proceed as guided. On completion the entire document should be submitted electronically to your section’s ethics administrator using the email addresses detailed on the final page.

Applications submitted without appropriate documentation will be returned.

Please work your way through this form, reading the questions and accompanying information carefully. Sections highlighted in yellow are mandatory, so you must answer all the questions in these sections.

Aside from the mandatory questions you won’t always need to answer all of the questions in the form. Section 1 “your project details” includes a set of filter questions that determine the rest of the questions you need to answer. Please read the notes carefully to make sure you answer the right questions. The notes contain hyperlinks so you can jump directly to the relevant section.

Sections highlighted in yellow are mandatory. These must be completed for every application.

Section 1: Introduction
Section 2: Your project details
Section 3: Description of the research
Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participants or data subject information and consent
Section 7: Confidentiality and handling of data
Section 8: Security sensitive material
Section 9: Copyright
Section 10: Good conduct in collaborative research
Section 11: Good conduct in publication research
SECTION 1: Introduction

This is a:
- New application for ethical approval – first submission ☑
- A resubmission following reviewer comments □
- A resubmission with requested amendments □

Please select your School:
- ☑ School of Health in Social Science

Please select your subject area
- □ CPASS
- ☑ Clinical Psychology
- □ Nursing Studies

It is each researcher's responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS. [https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance](https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance)

If the project requires any of these, these need to be secured prior to submitting this application.

Please tick the relevant box before proceeding:

- I have checked and this project does not require Sponsorship, Caldicott, R&D and/or IRAS approval ☑

- My project requires Sponsorship □ Sponsorship letter attached □
- My project requires Caldicott approval □ Caldicott approval letter/e-mail attached □
- My project requires R&D approval □ R&D approval letter/e-mail attached □
- My project requires IRAS approval □ IRAS approval letter/e-mail attached □

External Research Ethics Approval

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Please state the name of the review body and the current status of your application (for example, submitted, approved, deferred, or rejected)? Please include any known submission/approval timelines.

No additional approval needed.
SECTION 2: Your project details

2.1 Project details

Your name: Marek Baran

Please enter your project title: Examining barriers and facilitators to the implementation of evidence-based father-inclusive practice in Child and Family services: A Delphi consensus study.

Proposed Project Start Date: 01/01/2021
Proposed Project End Date: 01/10/2022

Q1. Are you a member of staff or a student?

☐ Staff member

Supplementary questions for staff members only:

List the names and institutions of any Co-Investigators working with you on the project.

N/A

☒ Student

Supplementary questions for students only:

What type of student are you?

Doctral student – Clinical Psychology

Please provide your course title or programme name

Doctorate in Clinical Psychology

Who is your supervisor?

Dr Vilas Sawrikar

Q2. Please indicate any external ethical guidance your project has to adhere to. For example, the British Psychological Society (BPS), the British Academy, the British Association of Sport and Exercise Sciences (BASES)

British Psychological Society (BPS)
2.2 Participants

Q3. Will you be collecting or generating any new data (including autoethnographic writings)?

☐ Yes
☐ No

Q4. Will you be extracting, re-coding or using existing data that contains sensitive information (i.e., identifiable information)?

☐ Yes
☒ No

If the answers to both Q3 and Q4 are ‘no’ you are not required to complete:

Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participant or data subject information and consent
2.3 Security-Sensitive Material

Q5. Does your research project fit into any of the following security-sensitive categories?
☐ Your research project is commissioned by the military.
☐ Your research project is commissioned under an EU security cell.
☐ Your research project involves the acquisition of security clearances.
☐ Your research project concerns groups which may be construed as terrorist or extremist

If you answer ‘yes’ to any of the questions above you must complete Section 8 Security Sensitive Material. You must answer all questions in the section.

2.4 Good Conduct in Collaborative Research

Q6. Will your research project involve collaborative work?
☐ Yes
☒ No

Selecting “Yes” to this question means you must complete Section 10 “Good conduct in collaborative research” later in the form. You must answer all questions in the section.

2.5 Project Funding

Q7. Is funding required for your research project? (To be completed by staff only)

Please Indicate how the project will be financially supported.

N/A

2.6 Knowledge Exchange and Impact

Q8. Will there be any knowledge exchange and impact activities associated with this project? (To be completed by staff only)


2.7 Consultancy Potential

Q9. Could your research project lead to potential consultancy activities in the future? (To be completed by staff only)


Page 4
SECTION 3: Description of the research

Q10: Please use the box below to describe your research; including a background summary, rationale, research questions and hypotheses, methodology, procedures. If you have identified ethical considerations that are not addressed in other parts of the form, please outline and discuss them here.

Background information

Services providing family interventions for child mental-health consistently observe that very few fathers attend these interventions, especially compared to mothers (e.g. Bögels & Phares, 2008; Fippin & Crais, 2011; Panter-Brick et al., 2014; Phares et al. 2005). Poor father engagement has serious implications on the effectiveness of family interventions, which in most cases are more beneficial when both fathers and mothers participate (Bagner & Eyberg, 2003; Lundahl et al., 2008). We also know that fathers, who are actively engaged in their children’s lives, can have a very positive effect on the child’s development, conduct and well-being (Bayley et al., 2009).

There are a number of reasons why fathers don’t seem as likely to participate in parent-focused interventions. These include e.g. issues around traditional gender roles, work commitments, stigma around help-seeking, or simply being unaware of the availability of interventions (Bayley et al., 2009; Dolan, 2014; Salinas et al., 2011; Walters et al., 2001). However, big part of the responsibility for poor engagement of fathers also lies with health service management and inadequate implementation of father inclusive practices (Panter-Brick et al., 2014). In other words, services are often seen as not doing enough to involve fathers, or being too ‘mother-oriented’ in terms of their programme content, delivery and advertising. To help health services better engage fathers, previous research has recommended that services employ practices such as ensuring that advertising targets both parents, making the content of interventions more relevant to fathers, or making extra effort to contact both parents at intake (Bayley et al. 2009; Sicouri et al. 2018; Lechowicz et al. 2019). However, there is no evidence that these recommendations are being widely implemented.

Rationale

Gaining a better understanding of what influences the adoption of these father-inclusive practices by health services would highlight common implementation barriers and identify priorities for change. No previous research has explored the factors that may influence the implementation of father-inclusive practices in services that provide parent-focused interventions for child mental-health.

To address this gap in research, the present study aims to explore the barriers and facilitators to implementing father-inclusive practice, by seeking the opinion of experts in the field of family interventions and father involvement. Disseminating the insights from such study could incentivize organizations to make improvements in how father involvement is approached. This is likely to increase fathers’ participation, which in turn would have a positive effect on the outcomes of children and the families that seek professional support for child mental health.

Research question

What are the barriers and facilitators to the implementation of father-inclusive practice by services providing family interventions for child mental health?

Methodology

The study will use Delphi methodology, which involves deployment of two or more sequential surveys, commonly referred to as rounds, to gather a broad range of opinions from a group of experts in a systematic way, with a goal of establishing a group consensus or divergence of opinion. A key characteristic of the Delphi method is that it uses the information gathered in the first survey round to construct the questionnaires deployed in the subsequent rounds. The rationale behind employing the Delphi method for the purpose of the current study, is that it would provide a unique means to gather opinion and establish a level of agreement between specialists regarding the
importance of factors that influence the provision of father-inclusive practice by services. The outcome could highlight the priority areas for potential improvement, giving a clear focus to future policy considerations.

The Delphi method applied in the current study will use an exploratory sequential mixed-methods design. This type of design employs a combination of qualitative and quantitative methods in a sequence of phases, where the data collected in the initial "exploratory" qualitative phase provides the content for subsequent quantitative data collection. The structure of the Delphi framework provides a unique and robust way of integrating both qualitative and quantitative methods. The study will employ three survey rounds, commonly used in traditional Delphi designs, with the rationale that three iterations generally help to attain stability in the responses. Following each round, the information will be collected, analysed, and used to form the basis for the questionnaires used in subsequent rounds.

The first-round questionnaire will involve open-ended questions to provide respondents with the opportunity to freely express their opinion, which is conducive to generating new ideas and helps with identification of issues to be addressed in the following rounds. The questions will ask about participants’ view of organizational practices that have been linked to father-inclusivity, with the aim to gather initial insights into what may be the factors that either encourage or hinder the implementation of these practices. A copy of the proposed questionnaire items to be used in the first survey round has been attached to this application (Appendix 1). The questions are structured in a way to elicit a broad range of participants’ views about barriers and facilitators to a range of organizational practices known to influence father inclusivity, which then could be explored further in rounds 2 and 3.

Data obtained in the first round will be then analysed using qualitative content analysis, which is a commonly recommended method for the interpretation of the qualitative stages in Delphi studies. This will allow to qualitatively synthesise the responses into closed-ended questions, which will form the basis of the subsequent questionnaires in the second and third rounds of the study.

In the second-round survey, participants will be presented with a range of potential barriers and facilitators that might affect the implementation of practices that encourage father inclusivity. Items will be presented on a 5-point Likert scale, and respondents will be asked to indicate their level of agreement with each item. The aim of the second round will be to measure the consensus, i.e. the level of agreement between the respondents on individual questionnaire items. As the content of the questionnaires used in round 2 is entirely dependent on the answers gathered in the first-round questionnaire, it is not possible to predict the exact number and content of the questions. However, please refer to Appendix 2 for examples of some anticipated second-round questionnaire items that include the dimensions that we are hoping to look at.

The third-round questionnaire will closely resemble the survey used in the second round. Minor changes may be applied based on the comments collected in the second round, but in general the questionnaire is expected to proceed largely in the same format as the second-round survey. The key difference is that in the third iteration, participants will be invited to consider their answers from round 2 in the light of the group response and given the opportunity to change their opinions. As is the case in the second round, we are unable to predict the content and the number of the items in this questionnaire, but please refer to Appendix 3, which includes examples of questions we are hoping to include, and their expected format.

Recruitment:

The sample will be recruited both within the UK and internationally. The researcher will focus on recruiting suitable individuals from local authorities and third-sector organizations in the UK (e.g. Stirling Council, The City of Edinburgh Council, The Centre for Parent and Child Support – South London & Maudsley) that provide child and family interventions, including but not limited to: Raising Children with Confidence, Empowering Parents – Empowering Communities, The Incredible Years, and Triple P. Other key organizations will include charity organizations (both UK-based and international) such as the Fatherhood Institute, Fathers Network Scotland, Shared Parenting Scotland, as well as university departments (UK and international). Part of the sample, particularly the individuals involved in the academia and some of the front-line family intervention providers, will be identified via the researcher’s and the research supervisor’s established networks.
Individuals who meet the inclusion criteria for the project (please refer to section 5, Q23) will be identified primarily via online searches, word of mouth, and by contacting target organizations via telephone and/or email to identify potential candidates.

In cases where recruitment will take place by contacting a target organization, please refer to Appendix 4 & 12 for an example of an advertising email and study information leaflets to be sent to organizations during the recruitment phase. In cases where the prospective participants are to be approached directly, this will be done via telephone, email, or social media (e.g. Facebook). An example of the content of the direct recruitment email and/or a social media message to be sent to participants at this stage is presented in Appendix 5.

The recruitment will proceed over a 3-week period, during which we aim to actively send out recruitment messages via email to individuals and organizations, as well as via social media, to gather at least 25 participants. Recruitment messages will be sent out together with information sheets and consent forms. The contacted individuals will be requested to indicate their agreement to participate in the study by returning a signed consent form to the researcher. Those who consent to participate in the study will be sent the Round 1 survey invitations immediately after they return their completed consent form. Participants will be actively sought and approached during these initial 3 weeks, and may start the study at different time points during that period. At the end of the initial 3-week recruitment period no more participants will be allowed to join the study. From that point, all participants will be given 3 more weeks to respond to the Round 1 survey. This means that an individual respondent will have a minimum of 3 weeks to complete the survey if he/she is recruited at the end of the recruitment period, or as long as 6 weeks if recruited at the very beginning of the recruitment period.

Please note that the participant information sheet (Appendix 6) and the consent form (Appendix 7) will be shared again with participants via Qualtrics at the beginning of the Round 1 of the study. Also, from the moment of first contact with prospective participants, the researcher will remain contactable to provide any extra information regarding any non-confidential details of the study.

Procedure:

In summary, the study will involve responding to an online survey administered over three rounds. The rounds will be delivered at varying intervals. The surveys will be shared with all participants at the same time, and all will be given a timeframe of maximum of three weeks to respond. Round 1 will be an exception to that, because of the addition of the initial recruitment period, which will give participants up to extra 3 weeks at the beginning. The first-round questionnaire will be designed to take approximately 30 minutes to complete, which has been considered a reasonable survey length for a Delphi study (Iqbal & Pippin-Young, 2009). The second and third-round questionnaires will be relatively briefer and are expected to take a maximum 10 minutes each to complete. An analysis of responses will take place after each survey round to form the basis for the questions included in the questionnaire in the subsequent round. Participants will be sent up to three email reminders for each round, at 6 days, 12 days, and 18 days from the invitation to each round. A separate debrief form will be provided after each survey round. A detailed breakdown of the procedure is presented below.

Once participants have expressed interest in participating in this research project by responding to the service email (Appendix 4) or the direct recruitment message (Appendix 5), and completing the consent form (Appendix 7), they will be sent a Round 1 invitation via email. The message will contain the instructions to begin Round 1 of the study by following a hyperlink to the Qualtrics platform. On accessing the Qualtrics link to Round 1 survey, participants will be presented with the following documents, in this order: participant information sheet (Appendix 6), consent form (Appendix 7), demographic information sheet (Appendix 8), the Round 1 Delphi questionnaire (Appendix 1), and Round 1 debriefing form (Appendix 9). The forms will be presented sequentially, requiring participants to complete one before moving on to the next, with no option to skip any of the content. Participants will be free to respond to the survey immediately after they receive the link. Following the initial 3-week recruitment period, participants will be given another three weeks to complete Round 1. During those three weeks completion rates will be monitored daily, and the individuals who take longer to finish the survey will be sent up to three reminder
emails at 6, 12 and 18 days from the invitation email, to encourage participation. At the end of the three-week period, questionnaires will be closed, and the researcher will proceed to analyse the received responses, which will be synthesised into closed-ended questions to be used in the Round 2 of the Delphi survey. Three weeks will be allocated for this process, making it a total of 6 weeks dedicated to Round 1 procedures.

The Round 2 of the Delphi study will proceed similarly to the first. Participants will be sent a link to the Qualtrics platform via email at the 3-week mark from the Round 1 final response deadline. On accessing Qualtrics via the provided link, participants will be presented with the Round 2 Delphi questionnaire (Appendix 2), followed by a Round 2 debriefing form (Appendix 10). From the moment of the Round 2 invitation email receipt, three weeks will be allocated for the participants to complete the Round 2 survey, followed by a further two weeks for the responses to be analysed by the researcher. Again, during the three weeks allocated for questionnaire completion, the researcher may send up to three reminder emails, at 6, 12 and 18 days from email invitation, to encourage participation.

The third round of the study will closely resemble the second round. Participants will be asked to complete the same questionnaire as they did in Round 2, but this time next to each question they will also be able to see their previous reply and the average reply of the other participants from Round 2. They will then be asked if they want to keep or change their answer from the second round. Participants will be sent a link to the Qualtrics platform via email two weeks from the Round 2 final response deadline, and will have 3 weeks to complete the survey. On accessing Qualtrics via the provided link, participants will be presented with the Round 3 Delphi questionnaire (Appendix 3), followed by a final debriefing form (Appendix 11). Up to three email reminders may be sent to participants during that time, at 6, 12 and 18 days from their receipt of Round 3 invitation email. Please note that the Round 3 debrief form will conclude the whole study and no further input will be required from the participants past that point. The data gathered in all three surveys will then enter the analysis stage.

Please note that due to the requirements of the Delphi method, participant responses will have to be linked across two time points, between Round 2 and Round 3. This is to ensure that each participant’s responses collected in Round 2 could be reflected back to the same individual in Round 3, as required by the standard Delphi procedure. In this way, participants can revise their former answers in light of the replies of others, with the chance that the group will converge towards a “consensus” (Rowe & Wright, 1999). Please refer to the Data Management section below for specific details of how we envisage to achieve this while respecting participants’ confidentiality.

Ethical considerations:

Data management:

As the study will use the Qualtrics platform, all information will be collected and initially stored on Qualtrics during periods of information gathering (approximately 3 weeks from the start of each round). After each round is concluded, the researcher will download the data from Qualtrics, to be saved directly onto a password-protected network drive provided by the University. Please note that the researcher will go through a rigorous process of deidentifying the data, so that any identifiable elements (e.g. email addresses) are stored on a secure password protected university drive, in a file that’s separate from all the other data such as demographic information or Delphi questionnaire responses. The file with email addresses will only be accessible to the research team."

On completion of the Round 1 questionnaire, each participant will be assigned a randomly generated unique code, by which they will be referred to henceforth for the purpose of data collection and storage, e.g. when recording information in data spreadsheets. All data gathered for the purpose of the study will be stored for a period of 5 years, according to the University of Edinburgh data retention schedule.

In terms of personal data collection, participants will be asked to provide only basic demographic details that will enable the researcher to adequately describe the sample in the research paper. These include: age, gender, country of residence, occupation, current role, type of involvement in child and family work (research, clinical/support, consultancy, other), whether they work with families directly or indirectly, and years of experience. Please see
Appendix 8 to see the format in which the demographic questions are expected to be presented in the study.

Participants will be asked to provide their email address on the consent form (Appendix 7), and email will be used as the primary means of communication between the researcher and participants from the moment they are obtained (following the completion of Round 1 survey) to the end of the study. The use of emails will be required for the researcher to be able to link participant responses between Round 2 and round 3, as described below.

Please note that the study will be pseudonymised. This means that participant responses to the Delphi questionnaire obtained via Qualtrics (specifically in Round 2 and 3, but not in Round 1) will be identifiable and traceable to specific participants by the research team only, and only during the data collection phase. The rationale for allowing the link between participant email addresses and their responses to Round 2, 3, is that the researcher needs to ensure that the individual responses to items from Round 2 can be reflected back to the same respondent in Round 3. This is essential for the study to adhere to the standard Delphi procedure, and the only way of achieving this outcome is by allowing the researcher to make the connection between the respondent and his/her answers in the latter two rounds. In practice, this will be achieved through the following process:

Individual email addresses will be obtained on completion of the study consent form by the participants at the start of Round 1. Once email addresses are obtained, these will be saved on a password-protected network drive provided by the University, in a separate file from all the other information gathered at this stage.

In Round 2, to ensure that survey responses to the second Delphi questionnaire can be linked to individual respondents at a later stage, the researcher will generate separate Round 2 Qualtrics surveys for each participant. The content will be the same for all, but by sending separate surveys to their target email addresses, the researcher will be able to track the responses to the email address that they were received from. In effect, each participant will have their dedicated survey identifiable (through its hyperlink) by the researcher via the email address associated with it. For the duration of the data collection phase, the researcher will keep a record of each unique survey hyperlink, it’s associated email addresses, and – once collected – also the survey responses associated with that hyperlink. This will be stored on a password-protected excel sheet separately from all other data gathered up to this point.

Individual responses to Round 2 questionnaire will be considered when preparing the Round 3 surveys. In Round 3 of the Delphi questionnaire, participants will receive the same questions as in Round 2, but most importantly, each questionnaire item will also include a brief statement to remind each participant of the answer they gave to that same item in the previous round. To append this individualized statement to each questionnaire, again each participant will be sent a separate survey that will include the information on their own scores from the previous round. The individual surveys will be linked to individual email addresses in the same way as in the previous round.

Please note the final responses collected from Qualtrics and saved onto the University network drive will be completely deidentified. Immediately after the completion of Round 3, the information on individual email addresses will be deleted from password protected storage, to ensure that there are no records linking questionnaire data to individual email addresses.

It is expected that the risk of linking participant responses between two time points will be minimal. The study will not collect sensitive personal data, and the only information that can be linked to individual participants will be their opinions.

References:


SECTION 4: Potential risks to participants and researchers

Q11. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☐ Yes
☒ No

If “yes” state the types of risk and what measures will be taken to deal with such problems.

Q12. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes
☒ No

If “yes” give details and outline procedures to be put in place to deal with potential problems.

Q13. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes
☒ No

If “yes” - Give details and outline procedures to be put in place to deal with potential problems.

Q14. Does your research project involve the investigation of any illegal behaviour or activities?

☐ Yes
☒ No

If “yes” - Give details of any illegal behavior or activities you may investigate.

Q15. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☐ Yes
☒ No

If “yes” - Indicate the likelihood of disclosure and the procedures to be followed if you become aware that a child has been or may be at risk of harm.

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Q16. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes
☒ No

*If “yes” - Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.*

Q17. Could participation in this research adversely affect participants and others associated with the research in any other way?

☐ Yes
☒ No

*If “yes” - Describe the possible adverse effects and the procedures to be put in place to protect against them.*

Q18. Is this research expected to benefit the participants, directly or indirectly?

☐ Yes
☒ No

*If “yes” - Give details of how this research is expected to benefit the participants.*

The research is unlikely to benefit the individuals taking part in the study. However, the outcome may provide a basis for future service improvements that may benefit a specific target demographic (fathers, families).

Q19. Will the true purpose of the research be concealed from the participants/data subjects?

☐ Yes
☒ No

*If “yes” - Explain what information will be concealed and why.*

Q20. Will participants/data subjects be debriefed at the conclusion of the study?

☒ Yes
☐ No

*If “no” – Why will participants/data subjects not be debriefed?*
Q21. At any stage in this research could researchers’ safety be compromised, or could the research
induce emotional distress in the researchers?
☐ Yes
☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on
project and travel insurance prior to project commencement.

☒ I agree
☐ I do not agree
☐ Not applicable
SECTION 5: Participants and data subjects. For autoethnographic research also include those who may feature in your writings.

Q22. How many participants or data subjects are expected to be included in your research project?

The expected sample size for this study will be 25 experts or more. This adheres to the common recommendations for Delphi sample sizes, and similar participant numbers have been recruited by the majority of other studies utilizing Delphi methodology (e.g. Ludwig, 1997; Turoff, 2002).

The researcher will aim to initially approach 50 experts with the offer to participate in the study, with the anticipation that approximately half of the contacted individuals will agree to take part, adding up to a total of 25. In case the response from the 50 individuals does not satisfy the required number, the researcher will continue to identify further individuals to ensure that the study has sufficient data subjects.

References:


Q23. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

Inclusion criteria:
To be considered for inclusion in the study, the individual must be a professional belonging to at least one of the following categories:
- Current employees of local government and third sector organizations, currently involved in provision of family interventions aimed at improving child well-being, either directly or in managerial or supervisory capacity
- Researchers and academics, actively engaged in research concerning parent-focused interventions aimed at improving child well-being, as well as the topic of father-inclusive practices.
- Current employees of third-sector organizations actively involved in campaigning, policy-making and consultancy to advance the provision of father-inclusive practices.

Exclusion criteria:
- Non-English speakers.
- Individuals under 18 years of age

Q24. Are any of the participants or data subjects likely to be under 16 years of age?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q25. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes
☑ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q26. Are any of the participants or data subjects likely to be known to have additional support needs?
☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q27. In the case of participants with additional support needs, will arrangements be made to ensure informed consent?
☐ Yes
☒ No

If “yes” – What arrangements will be made?

If “no” – Please explain why not
The study requires input from professionals currently working in a range of capacities. It is unlikely that individuals selected from this population will present with additional support needs that will require changes to be made to the content or design of the study. Due to remote nature of the study, all individuals who take part are expected to be able to access and utilize electronic documents and online survey software.

Q28. Are any of the participants or data subjects likely to be physically or mentally ill?
☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q29. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harm in other ways?
☐ Yes
☒ No

If “yes” - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

Q30. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted
☐ Yes
☑ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q31. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q32. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?

☐ Yes
☒ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q33. Describe how the sample will be recruited.

The sample will be recruited both within the UK and internationally. The researcher will focus on recruiting suitable individuals from local authorities and third-sector organizations in the UK (e.g. Stirling Council, The City of Edinburgh Council, The Centre for Parent and Child Support – South London & Maudsley) that provide child and family interventions, including but not limited to: Raising Children with Confidence, Empowering Parents – Empowering Communities, The Incredible Years, and Triple P. Other key organizations will include charity organizations (both UK-based and international) such as the Fatherhood Institute, Fathers Network Scotland, Shared Parenting Scotland, as well as university departments (UK and international). Part of the sample, particularly the individuals involved in the academia and some of the front-line family intervention providers, will be identified via the researcher’s and the research supervisor’s established networks.

Individuals who meet the inclusion criteria for the project (please refer to section 5, Q23) will be identified primarily via online searches, word of mouth, and by contacting target organizations via telephone and/or email to identify potential candidates.

In cases where recruitment will take place by contacting a target organization, please refer to Appendix 4 & 12 for an example of an advertising email and study information leaflets to be sent to organizations during the recruitment phase. In cases where the prospective participants are to be approached directly, this will be done via telephone, email, or social media (e.g. LinkedIn, Facebook). An example of the content of the direct recruitment email and/or a social media message to be sent to participants at this stage is presented in Appendix 5.

The recruitment will continue until at least 25 individuals indicate their agreement to participate in the study by responding to the recruitment messages. Once a sufficient number of individuals have offered
to take part, the study will move on to the data collection stage described in detail in the section below.

Please note that further relevant documents including the participant information sheet (Appendix 6) and the consent form (Appendix 7) will be shared with target individuals at the beginning of the Round 1 of the study. Also, from the moment of first contact with prospective participants, the researcher will remain contactable to provide any extra information regarding any non-confidential details of the study.

Q34. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes
☒ No

*If “yes” - What benefits will be offered to participants and why?*
Section 6: Participant or data subject information and consent

Q35. Will written consent be obtained from all participants or data subjects?

☒ Yes
☐ No

If “yes” – attach participant information sheet and consent form
If “no” – explain why not and how consent is obtained (e.g. orally), and/or if consent cannot or should not be sought for some reason, please provide a clear case and rationale for this

Please see the attached participant information sheet and consent form (Appendices 6 and 7).

Q36. Have you made arrangements to tell participants what information you will hold about them and for how long?

☒ Yes
☐ No

If “yes” - what arrangements have been made?

As outlined in the section 10 of the participant information sheet (Appendix 6), data will be retained for a period of 5 years and in accordance with the University of Edinburgh data retention schedule.

Q37. Have you made arrangements to tell participants whether you will disclose the information to other organisations?

☒ Yes
☐ No

If “yes” - What arrangements have been made?

Please refer to the information outlined in the sections 8 and 9 of the Participant Information Sheet (Appendix 6):

“The results of this research will be written up as a doctoral thesis. There is also the possibility that this work may be written up as a presentation or article for publication in peer-reviewed conferences and journals, and disseminated in the form of poster presentation and research summary among services that may benefit from the information. In any publication and/or presentation, all reports will only contain aggregated summary information, which will be fully anonymized. No individual personal details will be reported.”

“If the study is published, the anonymized data may be made available to the third parties. Your information will not be identifiable when written up, published, or presented. For instance, publications of findings will report aggregated responses to the survey. In the case of needing to include an excerpt from your survey response, personal and identifying information will be deleted prior to the findings of the study becoming publicly available.”

Q38. Have you made arrangements to tell participants whether you will combine that information with other data?

☐ Yes
☐ No

If “yes” - What arrangements have been made?

Q39. In the case of children participating in the research, will the consent or assent of parents be obtained?

☐ Yes
☒ No

If “yes” - Explain how this consent or assent will be obtained

If “no” – Please explain why you won’t be obtaining consent
Not applicable – the research will not involve children’s participation.

Q40. Will the consent or assent of children participating in the research be obtained?

☐ Yes
☒ No

If “yes” - Explain how this consent or assent will be obtained

If “no” – Please explain why not
Not applicable – the research will not involve children’s participation.

Q41. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?

☐ Yes
☒ No

If “yes” – What arrangements will be made?

If “no” – Please explain why not
Not applicable – only participants proficient in English will be selected for the purpose of this research.

Q42. Does the activity involve using cookies or tracking individual’s activity on a website or the Internet in general?

☐ Yes
☒ No

If “yes” – Describe the arrangements, you have put in place to obtain informed consent for the use of these tools?
SECTION 7: Confidentiality and handling of data

Q43. What information about participants/data subjects will you collect and/or use?

Participants will be asked to provide only basic demographic details that will enable the researcher to adequately describe the sample in the research paper. These include: age, gender, country of residence, occupation, current role, type of involvement in child and family work (research, clinical/support, consultancy, other), whether they work with families directly or indirectly, years of experience. Please see Appendix 8 to see the format in which the questions will be asked in the study.

Moreover, the Delphi survey questions will record the participants’ expert opinion on barriers and facilitators to father inclusive practice in health services.

Q44. Will you collect or use NHS data?

☐ Yes
☒ No

If “yes” – what NHS data will you collect or use?

Q45. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff who have access completed the mandatory data protection training on the self-enrolment page of Learn?

Data protection training on the Learn page.

Q46. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)

☐ Yes
☒ No

If “yes” – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

If you answered “no” to this question, please skip Q56 and continue answering the rest of the questions.

Q47. Please indicate how your research is in the public interest:

☒ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other
Q48. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

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<tr>
<th>Risk</th>
<th>Likelihood of risk manifesting</th>
<th>Severity of harm</th>
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<tbody>
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<td>Remote</td>
<td>Possible</td>
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<tr>
<td>Identifiable due to data linkage</td>
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<td>Identifiable due to low participant numbers</td>
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<td>Identifiable due to geographical location</td>
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<td>Identifiable due to transfer of data</td>
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<td>Identifiable due to access of data</td>
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<td>Insert more rows as appropriate</td>
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</tbody>
</table>

Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm.

No other risks anticipated.

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

We anticipate the study to carry relatively low risk levels, as it will neither involve handling of any sensitive data, nor present any risk to participant’s health and well-being. There exists the possibility of participants being identifiable due to low participant numbers, and the fact that some of them will be recruited using existing networks. To minimize the risk of identification, participant’s responses to the questionnaire will be fully anonymized, and kept separately from any personal details. All data will be stored confidentially in a password-protected, secured network on University of Edinburgh's servers, as well as on Qualtrics survey software. Only the researcher and his supervisor will have access to it.

The following steps will be taken to ensure the anonymity and confidentiality of the participants’ data:

As the study will use the Qualtrics platform, all information will be collected and initially stored on Qualtrics during periods of information gathering (approximately 3 weeks from the start of each round). After each round is concluded, the researcher will download the data from Qualtrics directly onto a password-protected network drive provided by the University. Please note that the researcher will go through a rigorous process of deidentifying the data, so that any identifiable elements (e.g. email addresses) are stored on a secure password protected university drive, in a file that’s separate from all the other data such as demographic information or Delphi questionnaire responses. The file with email addresses will only be accessible to the research team. Outside of the necessary transfer of data from the Qualtrics system to the University network drives, no transfers of data will take place at any point of the research process.

All data gathered for the purpose of the study will be stored for a period of 5 years, according to the University of Edinburgh data retention schedule.
In terms of personal data collection, participants will be asked to provide only basic demographic details that will enable the researcher to adequately describe the sample in the research paper. These include: age, gender, country of residence, occupation, current role, type of involvement in child and family work (research, clinical/support, consultancy, other), whether they work with families directly or indirectly, and years of experience. Please see Appendix 8 to see the format in which the questions will be presented in the study.

Participants will be asked to provide their email address on the consent form (Appendix 7), and email will be used as the primary means of communication between the researcher and participants from the moment they are obtained (prior to the completion of Round 1 survey) to the end of the study. The use of emails will be required for the researcher to be able to link participant responses between Round 2 and round 3, as described below.

Please note that the study will be pseudonymised. This means that participant responses to the Delphi questionnaire obtained via Qualtrics (specifically in Round 2 and 3, but not in Round 1) will be identifiable and traceable to specific participants by the research team only, and only during the data collection phase. The rationale for allowing the link between participant email addresses and their responses to Round 2 & 3, is that the researcher needs to ensure that the individual responses to items from Round 2 can be reflected back to the same respondent in Round 3. This is essential for the study to adhere to the standard Delphi procedure, and the only way of achieving this outcome is by allowing the researcher to make the connection between the respondent and his/her answers in the latter two rounds. In practice, this will be achieved through the following process:

Individual email addresses will be obtained on completion of the study consent form by the participants at the start of Round 1. Once email addresses are obtained, these will be saved on a password-protected network drive provided by the University, in a separate file from all the other information gathered at this stage.

In Round 2, to ensure that survey responses to the second Delphi questionnaire can be linked to individual respondents at a later stage, the researcher will generate separate Round 2 Qualtrics surveys for each participant. The content will be the same for all, but by sending separate surveys to their target email addresses, the researcher will be able to track the responses to the email address that they were received from. In effect, each participant will have their dedicated survey identifiable (through its hyperlink) by the researcher via the email address associated with it. For the duration of the data collection phase, the researcher will keep a record of each unique survey hyperlink, its associated email addresses, and—once collected—also the survey responses associated with that hyperlink. This will be stored on a password-protected excel sheet separately from all other data gathered up to this point.

Individual responses to Round 2 questionnaire will be considered when preparing the Round 3 surveys. In Round 3 of the Delphi questionnaire, participants will receive the same questions as in Round 2, but most importantly, each questionnaire item will also include a brief statement to remind each participant of the answer they gave to that same item in the previous round. To append this individualized statement to each questionnaire, again each participant will be sent a separate survey that will include the information on their own scores from the previous round. The individual surveys will be linked to individual email addresses in the same way as in the previous round.

Please note the final responses collected from Qualtrics and saved onto the University network drive will be completely deidentified. Immediately after the completion of Round 3, the information on individual email addresses will be deleted from password protected storage, to ensure that there are no records linking questionnaire data to individual email addresses.

It is expected that the risk of linking participant responses between two time points will be minimal. The study will not collect sensitive personal data, and the only information that can be linked to individual participants will be their opinions.

The information regarding data management will be conveyed to all participants in Sections 9 and 10 of the Participant Information Sheet (Appendix 6):

"Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. Your responses to the questionnaires will be pseudonymized for the duration of the
study, which means that only the researcher and his supervisor will know who provided the data. In practice, your questionnaire data will be linked to your email address by a unique, randomly generated code, which the researcher will use to identify your dataset. This is important for the study, as we want to be able to know which responses from different survey rounds come from the same person. Please note that once the responses to the final survey are collected, any records of your individual email address will be immediately deleted. Your answers from different surveys will remain linked by the unique code, but without the email address information, this data will no longer be linkable to your person in any way. Your email address will be stored in a separate folder to your survey responses. Email addresses will be deleted from our systems following the completion of the 3rd survey. Your data will only be viewed by the researcher and his supervisor. All electronic data will be stored on a password-protected, secure network drive provided by the University of Edinburgh. Your consent information and your demographic details shared in the first questionnaire will be kept separately from your survey responses to minimise the risk of data linkage. This study has been approved by the University of Edinburgh School of Health in Social Science Research Ethics Committee. This means that we are responsible for looking after your information and using it in accordance with the University of Edinburgh data protection guidelines. The findings from this study containing fully anonymized data will be written up and submitted by the researcher to the University of Edinburgh as part of doctoral thesis. If the study is published, the anonymized data may be made available to the third parties. Your information will not be identifiable when written up, published, or presented. For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research."

“All the information that you submit via the online survey software will be downloaded directly onto password-protected, secure network drive on University of Edinburgh’s servers. This will be done immediately after each survey round is closed. Only the researcher and his supervisor will have access to it. Furthermore, only aggregated, non-identifiable data will be used in the write up of the doctoral thesis. Your emails will be deleted after the collection of data from the third survey. All anonymised data will be stored securely in its electronic form for a period of 5 years and then deleted permanently from the online server.”

Q49. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes
☒ No

If “yes” - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q50. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☐ Yes
☒ No

If “yes” - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.

Q51. Will feedback of findings be given to your research project participants or data subjects?

☒ Yes
If "yes" - How and when will this feedback be provided?

Participants who are interested in knowing the outcomes of the study will be able to access a 1-page summary of the study’s results by either (i) requesting it from the supervisor (Vilas Sawrikar) or (ii) via the Edinburgh University’s Research Explorer website. The 1-page summary will be available by the third quarter of 2022 and can be accessed by searching the research project title “Examining barriers and facilitators to the implementation of evidence-based father-inclusive practice in child and family services: A Delphi consensus study.” Participants will be made aware of the above in Section 8 of the Participant Information Sheet (Appendix 6).

If "no" - Please provide rationale for this.

Q52. How do you intend to use/disseminate the results of your research project?

The current study will be written up and submitted as part of the Doctorate of Clinical Psychology thesis at the University of Edinburgh. Following the submission, steps will be taken to adjust the content according to the guidelines for submission for publication to a range of reputable academic journals, which may include: Journal of Child and Family Studies; Health Services Research; The International Journal of Health Services; Journal of Child Health Care.

Participants who are interested in knowing the outcomes of the study will be informed that they will be able to access a 1-page summary of the study’s results by either (i) requesting it from the supervisor (Vilas Sawrikar) or (ii) via the Edinburgh University’s Research Explorer website.

The results of the study will also be shared with the services taking part in the data collection, as well as other organizations engaged in advocacy for father-inclusive practice. For local services, this may include delivering presentations at service meetings. Otherwise, provision of a web-link with the write-up of research findings will be considered.

The researcher will also seek opportunities to deliver presentations about the outcomes of the study at any relevant conferences and events that become available after the project has been successfully completed. Moreover, an article describing the outcome of the study will be submitted to the BPS Clinical Psychology Forum for potential publication.
SECTION 8: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q53. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes
☒ No

If “yes” - Please tick ‘Yes’ to indicate that you agree to store all documents on that file store

Q54. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes
☒ No

If “yes” - Please tick ‘Yes’ to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q55. Will your research involve visits to websites that might be associated with extreme, or terrorist, organisations?

☐ Yes
☒ No

If “yes” - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please acknowledge that you understand this risk by ticking ‘Yes’

☐ Yes
☐ No

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convenor of the University’s Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please acknowledge that you accept this by ticking ‘Yes’

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking ‘Yes’

☐ Yes, I have contacted my School’s Research Ethics Officer
☐ No, I have not contacted my School’s Research Ethics Officer
Section 9: Copyright

Q56. Does your project require use of copyrighted material?

☐ Yes
☒ No

If “yes” please give further details
Section 10: Good conduct in collaborative research

Q57. Does your project involve working collaboratively with other academic partners?

☐ Yes
☒ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

If "no" - Please explain why there is no formal agreement in place?
Not applicable – the project will not involve any partner collaboration.

Q58. Does your project involve working collaboratively with other non-academic partners?

☐ Yes
☒ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

If "no" - Please explain why there is no formal agreement in place.
Not applicable – the project will not involve any partner collaboration.

Q59. Does your project involve employing local field assistants (including guides/translators)?

☐ Yes
☒ No

If "yes" - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If "no" - Please explain why there is no formal agreement in place.
Not applicable – the project will not involve local field assistants.
Q60. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☐ Yes
☐ No

If “no” - Please explain why care will not be taken

Q61. Have you reached agreement relating to intellectual property?

☐ Yes
☐ No

If “no” - Please explain why you have not reached agreement
Section 11: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University’s guidance on integrity.

By ticking yes, you confirm that full consideration of the items described in this section will be addressed as applicable

☐ Yes
☐ No
Subsequent to submission of this form, both the applicant and their supervisor should review any alterations in the proposed methodology of the project. If the change to methodology results in a change to any answer on the form, then a resubmission to the Ethics subgroup is required.

The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

ALL forms should be submitted in electronic format. Digital signatures or scanned in originals are acceptable. The applicant should keep a copy of all forms for inclusion in their thesis.

| Marek Baran   | Applicant’s Name | Applicant’s Signature | 09/11/2020 | Date signed |

| Vilas Sawirkar | Supervisor’s Name | 09/11/2020 | Date |

*NOTE to Supervisor: Ethical review will be based only on the information contained in this form. If countersigning this check-list as truly warranting all ‘No’ answers, you are taking responsibility, on behalf of the HSS and UoE, that the research proposed truly poses no ethical risks.

**ISSUES ARISING FROM THE PROPOSAL**

\[\text{Not required for staff applications}\]
Recruitment
- Directly targeting potential participants via LinkedIn is potentially intrusive
- If services identify potential individuals is there a potential for individuals to feel obliged to take part in the research and how will they be assured that they are not required to?
- Following recruitment messages, if potential participants contact the researcher, the researcher has email addresses in advance of potential participants having full information about the study. It would be better to have a link to the survey information and consent (with provision to leave an email address) that can be sent with recruitment messages

Data management
- Clarify whether excel sheet with emails will also be stored on university drives and accessed via VPN. This should not be stored on a personal laptop.

Q27: Explain why arrangements will not be made for ASN. This excludes hearing/sight impaired so a rationale should be given

Information sheet
- The information sheet should have complete inclusion criteria so that potential participants can ensure that they meet these before submitting personal data (email address). The inclusion criteria should include good understanding of written English (as 'no' was checked in question 29)
- More detailed information should be provided on how participants withdraw, for example, emailing the researcher. At which point will non-response be considered withdrawal? For example, if participants do not respond to three reminders for survey one, will their data be withdrawn at that point, or will they continue to receive communications about survey 2?
- State explicitly at which point participants will no longer be able to withdraw their data
- 7: as well as possible benefits, what are possible risk (or if there are none, state this)
- 9: participants may not understand pseudonymised. State that only the researcher and supervisor will have access to full data and data will be fully anonymised before becoming publicly available. With the qualitative data there is a high possibility of disclosive identifiers due to sample size. How will this be addressed? Will any part of the qualitative data be made public (i.e. through open access or published excerpts)? If so, how will the researchers ensure that an individual cannot be identified by their service or other professionals in the area? This also pertains to section Q37
- Make clear how study parts will be linked following deletion of emails (i.e. code)
- There is some repetition in sections 9 and 10. Consider editing to increase the chance that participants will read through carefully
- It is mentioned in the ethics form, that the researcher will be contactable about questions (Q33). Contact details should go on the info and debrief sheet

Consent form
- State explicitly that participants can withdraw at any stage of the research, i.e. that completing parts 1 and 2 does not oblige the participant to complete part 3
- In the survey, ensure that there is tick box for each consent item.
- Have a specific separate statement making sure that the participant is aware that they will be audio recorded only and that they agree to this.

Debrief 1
- Nightline is for student only. Resources need to be appropriate to the participant group
- Only an office phone number is given for the supervisor. Provide email.
- Paragraph at end is incomplete

The applicant should respond to these comments in section below.

Signature:  Position:  Ethics and Integrity Lead  Date: 21.1.21
**APPLICANT’S RESPONSE (If required)**

**Recruitment**
- Directly targeting potential participants via LinkedIn is potentially intrusive.
  - Considering that LinkedIn is potentially intrusive, I have removed this from recruitment options.
- If services identify potential individuals is there a potential for individuals to feel obliged to take part in the research and how will be they be assured that they are not required to?
  - I have added extra statements to the provisional service email template (Appendix 4), direct recruitment message template (Appendix 5) and the service flyer (Appendix 12) to highlight the voluntary nature of the project.
- Following recruitment messages, if potential participants contact the researcher, the researcher has email addresses in advance of potential participants having full information about the study. It would be better to have a link to the survey information and consent (with provision to leave an email address) that can be sent with recruitment messages.
  - In an answer to this feedback, I have made the following adaptations to the recruitment process:
    - The study information sheet and consent form will be included in the recruitment messages (both direct messages and service emails) either in the form of an attachment or a hyperlink. I have opted for using attachments as opposite to links to an online platform in this initial contact, as sometimes people might be reluctant to open links from unknown sources. The information sheet and consent form will only be made available via a hyperlink in cases where I am unable to attach the documents (e.g. recruitment via social media).
    - Edited the prospective messages in line with the changes – see Appendix 4 & 5.
    - Edited the relevant sections of the participant information sheet to reflect the above change.

**Data management**
- Clarify whether excel sheet with emails will also be stored on university drives and accessed via VPN. This should not be stored on a personal laptop.
  - The statement has been altered to reflect that emails will also be kept on a secure drive. “Please note that the researcher will go through a rigorous process of deidentifying the data, so that any identifiable elements (e.g. email addresses) are stored on a secure password protected university drive, in a file that’s separate from all the other data such as demographic information or Delphi questionnaire responses. The file with email addresses will only be accessible to the research team.”

**Q27: Explain why arrangements will not be made for ASN. This excludes hearing/sight impaired so a rationale should be given.**
- Added the following statement as a response to Q27: “The study requires input from professionals currently working in a range of capacities. It is unlikely that individuals selected from this population will present with additional support needs that will require changes to be made to the content or design of the study. Further, due to remote nature of the study, all individuals who take part are expected to be able to be able to access and utilize electronic documents and online survey software.
  In the case of additional support needs related to sight impairment, the researcher may be able to make individual adjustments to e.g. the size, contrast or the spacing of the written content involved in this study on participant request. Moreover, this study is not expected to disadvantage those with a hearing impairment, as there is neither any audio content involved, nor an expectation for participants to communicate verbally.”
- Also added the following sentence to the recruitment emails (Appendix 4 & 5): “In case you have any
**Information sheet**

- The information sheet should have complete inclusion criteria so that potential participants can ensure that they meet these before submitting personal data (email address). The inclusion criteria should include a good understanding of written English (as “no” was checked in question 29).

  - Add the following section to the information sheet to outline the inclusion criteria:

    "Who can participate in this research?
    This research is open to participate for anyone who is:
    - Over 18 years old
    - Has a good understanding of written English
    - Is involved in at least one of the following:
    - Any aspect of delivering family interventions for child mental health
    - Work to promote the inclusion of fathers in healthcare settings
    - Research concerning family interventions and/or father-inclusive practice
    You have been invited to participate in this study as we believe you meet the above criteria."

- More detailed information should be provided on how participants withdraw, for example emailing the researcher. At which point will non-response be considered withdrawal? For example, if participants do not respond to three reminders for survey one, will their data be withdrawn at that point, or will they continue to receive communications about survey 2?

  - In light of this feedback, we have decided to go ahead with the following approach:

    Non-participation will not be counted as withdrawal. This is because participants who e.g. didn’t complete round one, may still be able to offer valuable input in rounds 2 and 3. In the case that participants do not complete a survey round, we will assume that they are still active in their participation and they will receive notices for future survey rounds.

    If participants want to withdraw from the study, they will have to indicate this to the researcher via email, who will then no longer send the participant future emails requesting participation in later survey rounds.

  - The following information has been added to the information sheet to make the terms of withdrawal clearer:

    "You can withdraw from the study by emailing the researcher directly at M.Baron@ans.ed.ac.uk. You will then no longer receive future emails requesting your participation in survey rounds. Unless you request to withdraw via email, it will be assumed that you are happy to continue your involvement in this research, even if you don’t participate in one of the 3 surveys. This means that if you don’t respond to e.g. Round 1 within given timeframe, you will still be invited to take part in Rounds 2 and 3, and will continue to receive communication from us about the study until its completion."

- State explicitly at which point participants will no longer be able to withdraw their data.

  - We have carefully considered the issue of data withdrawal, and have come to the following conclusion:

    Although the participants can withdraw from the study at any point, we are unable to withdraw all of their data. This is because the data, e.g. from Round 1 will be deidentified – there will be no personal information associated with participants’ answers, therefore we will be unable to trace the answers to specific respondents. Moreover, their deidentified responses will be used for analysis to inform future survey rounds (rounds 2 and 3 are contingent on information gathered in round 1, so the information from round 1 will be inevitably used to inform the content of the latter rounds). This means that for example, at the time of round 2, participants’ responses from round 1 would have been already translated into round 2 questions. Thus, even if we had a way of tracing individual answers to Round 1 (which we do not), deleting this data once the study has begun would still not be feasible in this case.
However, we will be able to trace and identify data from Rounds 2 and 3, as the questionnaires will be constructed in a way to allow us linking the answers to participants. As such, data from Round 2 and 3 can be withdrawn, and we will enable the participants to do it on request.

- **Added the following statement to the information sheet to make the above clear to prospective participants:**
  “If you choose to withdraw from the study, you can also request to withdraw some of your data submitted in response to the survey rounds, by emailing the researcher, at M.Buran@ums.ed.ac.uk, albeit please note that our ability to withdraw data is limited.

- **You will be able to withdraw only your responses to Round 2 and 3. Withdrawing this data after you have completed the study will remain possible only until the deadline for Round 3 responses. This is because at that point all individual email records will be deleted so that survey answers cannot be traced to individual participants. Once your email address is deleted, it will not be possible to locate your individual responses, as these will be completely anonymized.

- **It will not be possible to withdraw your responses to Round 1 at any point, because they are anonymized from the start, and the setup of that first survey gives us no way of tracing who the individual answers belong to.**

- **7:** as well as possible benefits, what are possible risk (or if there are none, state this)
  - **Added the following sentence under section 7 of information sheet:** “We do not anticipate that the study will present any risks to anyone involved.”

- **9:** participants may not understand pseudonymised. State that only the researcher and supervisor will have access to full data and data will be fully anonymised before becoming publicly available. With the qualitative data there is a high possibility of disclosing identifiers due to sample size. How will this be addressed? Will any part of the qualitative data be made public (i.e. through open access or published excerpts)? If so, how will the researchers ensure that an individual cannot be identified by their service or other professionals in the area? This also pertains to section Q5?
  - **Revise the above point – Published findings will only report aggregated responses to the survey. To ensure that these do not include any disclosing identifiers, the researcher will go through the rigorous process of de-identifying the data collected. This will be done in the following steps:**
    - Email addresses will be deleted from the secure network drive after the deadline for Round 3 questionnaires.
    - Any personal identifiable identifiable information from responses collected in Qualtrics will be removed before being saved on the secure network drive.
    - Survey responses stored on Qualtrics will be deleted immediately after the de-identified data has been saved on the secure network drive.

Removal of the personal identifiable information from responses prior to storing them on the university drive should also protect the participants’ confidentiality in case of open access requests. In line with this, please see the amendment below:

- **Added a statement to section 9 of the information sheet to replace the use of “pseudonymized”, and address the concern of identifiable data being made public:** “All information collected about you will be kept strictly confidential. Only the researcher and his supervisor will have access to full data, and data will be fully anonymized before becoming publicly available. For instance, publications of findings will report aggregated responses to the survey. In the case of needing to include an excerpt from your survey response, personal and identifying information will be deleted prior to the findings of the study becoming publicly available”.

- **Make clear how study parts will be linked following deletion of emails (i.e. code)**
  - If you are unsure whether the existing statement in section 9 explained this adequately, I have slightly changed the wording of this part to clarify the process of de-identification of data.
“For the duration of the study, your questionnaire data will be linked to your email address by a unique, randomly generated code, which the researcher will use to identify your dataset. This is important for the study, as we want to be able to know which responses from different survey rounds come from the same person. Please note that once the responses to the final survey are collected, any records of your individual email address will be immediately deleted, thus your email address will no longer be linked to the unique code at the end of the final survey round. However, your anonymized answers from different surveys will remain linked by the unique code, without the email address information. As such, data will no longer be linkable to you in any way after the final survey round is complete.

- There is some repetition in sections 9 and 10. Consider editing to increase the chance that participants will read through carefully.
  - Removed repetitive statements as suggested.

- It is mentioned in the ethics form, that the researcher will be contactable about questions (Q33). Contact details should go on the info and debrief sheet.
  - Updated the info sheet and all 3 debriefing forms with my contact details as required.

Consent form
- State explicitly that participants can withdraw at any stage of the research, i.e. that completing parts 1 and 2 does not oblige the participant to complete part 3.
  - Added a separate point in the consent sheet to add this statement: “I understand that completing the first or the second round of the study does not oblige me to continue participating in the whole study.”

- In the survey, ensure that there is tick box for each consent item.
  - Done as suggested. Please see the updated consent form.

- Have a specific separate statement making sure that the participant is aware that they will be audio recorded only and that they agree to this.
  - This statement doesn’t seem relevant to this study; we’re not seeking to gather any data that would require anything beyond participants’ written answers to the survey questionnaires. At no point will there be a need for recording audio.

Debrief 1
- Nightline is for student only. Resources need to be appropriate to the participant group.
  - Removed Nightline information from all 3 debrief forms.

- Only an office telephone number is given for the supervisor. Provide email.
  - Added email address for the supervisor in all 3 debrief forms, and also the information sheet where the email was missing too.

- Paragraph at end is incomplete
  - Removed the paragraph – not relevant, was left there accidentally.

ADDITIONAL CHANGES MADE SINCE THE FIRST ETHICS SUBMISSION:

- Timing of the three rounds: Having discussed this in supervision, we decided to make an amendment to the timeframes of the three survey rounds. This is to increase the chances of successful initial recruitment. The changes are as follows:
  - The initial plan was that the prospective participants would be first contacted to express the interest in the study, and once we have enough numbers, they would all be sent the invitation to
participate in Round 1 of the study. The concern with this approach was that participants could be less likely to engage with the research if there is too long of a period between first contact and the beginning of the first survey. Moreover, in case of significant dropout at that stage, it would then be too late to seek new participants, as the study would already be in motion. Instead, we now aim to allow an extra 3-week period at the beginning of the study specifically for the purpose of gathering participants. Recruitment messages will be sent out together with information sheets and consent forms. Those who consent to participate in the study will be sent the Round 1 survey invitations immediately after they return their completed consent form. Participants will be actively sought and approached during these initial 3 weeks, and may start the study at different time points during that period. At the end of the initial 3-week recruitment period no more participants will be allowed to join the study. From that point, all participants will be given 3 more weeks to respond to the Round 1 survey (as was the case in the original recruitment plan). This means that an individual respondent will have a minimum of 3 weeks to complete the survey if he/she is recruited at the end of the recruitment period, or as long as 6 weeks if recruited at the very beginning of the recruitment period.

- The period for Round 2 questionnaire data analysis and Round 3 questionnaire preparation has been reduced from 3 weeks to 2 weeks. It was decided that 2 weeks will be sufficient for this process, and the reduction of waiting time between questionnaire may have a positive effect on participant engagement.
- The rest of the study procedure will remain as per the original proposal.
- The above changes are reflected in Section 3 of this ethics form, and in the Section 2 of the participant information sheet.

Signature: Marek Boran

Date: 19/02/2020

CONCLUSION TO ETHICAL REVIEW (if required)

The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for favourable opinion from Clinical Psychology ethics committee.

Signature:

Position: Ethics and Integrity Lead

Date: 28.2.21
AMENDMENT/S: REQUEST FOR APPROVAL

Signatures:

Date:

CONCLUSION TO ETHICAL REVIEW OF AMENDMENT

The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has therefore been approved.

Signature:

Position:

Date:

Acronyms / Terms Used
NHS: National Health Service
SHSS: School of Health in Social Science
IRAS: Integrated Research Applications System
Section: The SHSS is divided into Sections or subject areas, these are; Nursing Studies, Clinical Psychology, C-PASS.

Ethics Administrators

Nursing Studies: nursing@ed.ac.uk

Counselling, Psychotherapy and Applied Social Science: CPASS.ethics@ed.ac.uk

Clinical Psychology: Submitting.Ethics@ed.ac.uk

MA in Health, Science and Society:
Appendix F

Round 1 survey questions

1. **In your view, how much is father-inclusive practice considered by the services in organizational policies, recruitment, and support of staff and clients?** (We are looking for your expert opinion on what helps or hinders services from adequately considering fathers in their policies, recruitment and support)

2. **In your opinion, how much consideration is given by services to the timing, the place, and the format (e.g. online, face to face, group) of programmes and interventions to include fathers as well as mothers?** (Can you please elaborate on what you think the barriers and facilitators are for organizations to tailor their service delivery to fathers' needs?)

3. **What is your view on whether organizations provide sufficient resources to ensure reaching both fathers and mothers as part of service delivery?** (Please include your thoughts on what you think could stop services from reaching fathers? What do you think would help services to better reach fathers?)

4. **What is your opinion on whether services take sufficient steps to ensure that both mothers and fathers are informed about the importance of participation in family interventions, and benefits to children?** (Can you please elaborate on what you think the barriers and facilitators are for services to share this information with fathers as well as mothers?)

5. **To your knowledge, to what extent is data collection on parents who use services (e.g. monitoring of attendance, participation, and referrals)**
disaggregated by sex? (Please elaborate on what you think stops organizations from recording the gender of the parents who use their services, and what could help with improving this practice?)

6. In your opinion, how much emphasis do services put on training their practitioners to build skills to positively engage fathers? (Can you please elaborate on what you think the barriers and facilitators are for organizations to provide training for their practitioners to better engage fathers)

7. What is your view on whether services provide sufficient resources to audit their father-inclusive practice and implement change toward greater father-inclusivity? (Can you please elaborate on what you think the facilitators and barriers are for services to audit their father-inclusive practice and implement changes?)

8. In addition to your previous answers, do you have any other comments about what may help or hinder services from implementing organizational practices to better include fathers? Please share below.
Appendix G

Round 2 survey questions

Part 1: Please rate your agreement whether you think the following factors hinder child and family services from being more inclusive to fathers. (Rated on a 7-point Likert Scale: Strongly Disagree (1) Disagree (2) Somewhat Disagree (3) Neither agree nor disagree (4) Somewhat Agree (5) Agree (6) Strongly Agree (7)).

1. Lack of training and education for the workforce on how to improve father inclusion
2. Organizations lacking sufficient financial resources to adequately fund father-inclusive practices
3. Lack of clear protocols that would help staff to adequately engage fathers
4. No rewards offered from service leadership for staff to be more inclusive of fathers in their practice
5. Services having limited awareness of fathers’ needs and how to address them
6. Limited staff availability due to inflexible working hours
7. Father-inclusive practices not being incentivized by the authorities and/or commissioners
8. Father-inclusive practices being viewed as creating additional work, resulting in excessive burden for staff
9. Lack of leadership’s commitment, engagement, and support for father-inclusive practice
10. Staff’s assumptions and stereotypes about fathers’ role, availability or interest in child and family interventions
11. Lack of confidence among child and family professionals in engaging dads
12. General organizational culture of resistance to change and reluctance to introduce new initiatives
13. No centralized guidance, i.e., father-inclusive practice being left at individual professional’s discretion
14. Lack of gender diversity in the staff teams, e.g., disproportionate percentage of female practitioners
15. Inadequate data recording systems, which don’t allow for storing and collating information that could enhance father inclusion
16. Reluctance to focus attention on fathers' needs because of the drive for child and family services to be gender-neutral
17. Father inclusive practices not being linked to service targets or key performance indicators
18. Lack of awareness of father-inclusive practice guidelines and recommendations
19. Father inclusion not being recognized as a strategic priority by services
20. Staff not having enough time for activities related to father-inclusive practice due to other competing demands
21. Staff’s assumptions that implementing father-inclusive practices will not lead to improved outcomes or increased father engagement

Part 2: Please rate your agreement whether you think the following factors enable child and family services to be more inclusive to fathers. (Rated on a 7-point Likert Scale:
Strongly Disagree (1) Disagree (2) Somewhat Disagree (3) Neither agree nor disagree (4)
Somewhat Agree (5) Agree (6) Strongly Agree (7)).

1. Services nominating champions committed to improving father inclusion
2. Services introducing targets and key performance indicators related to father-inclusive practice

3. Services providing more emphasis on remote treatment provision in efforts to better engage dads

4. Greater recognition of the importance of father-inclusive practice by the authorities and service commissioners

5. Services actively encouraging team discussion and reflection about implementing father-inclusive practice

6. Services introducing clear measures to monitor their provision of father-inclusive practice

7. Services providing opportunities for staff education and training on father-inclusive practice

Please use the space below if you would like to add further comments in relation to any of the questionnaire items.
Appendix H

Round 3 survey questions

Instructions included the following paragraph (including the table):

“Below each question you will see feedback on how all participants responded, and you will be given a reminder of your own response from the previous round. This will take the format of a table - please see the example below: “

<table>
<thead>
<tr>
<th>Your previous rating was:</th>
<th>Overall percentages from Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

Part 1: Please rate your agreement whether you think the following factors hinder child and family services from being more inclusive to fathers. (Rated on a 7-point Likert Scale: Strongly Disagree (1) Disagree (2) Somewhat Disagree (3) Neither agree nor disagree (4) Somewhat Agree (5) Agree (6) Strongly Agree (7))

1. Lack of training and education for the workforce on how to improve father inclusion
2. Organizations lacking sufficient financial resources to adequately fund father-inclusive practices
3. Lack of clear protocols that would help staff to adequately engage fathers
4. No rewards offered from service leadership for staff to be more inclusive of fathers in their practice
5. Services having limited awareness of fathers’ needs and how to address them
6. Limited staff availability due to inflexible working hours
7. Father-inclusive practices not being incentivized by the authorities and/or commissioners
8. Father-inclusive practices being viewed as creating additional work, resulting in excessive burden for staff

9. Lack of leadership’s commitment, engagement, and support for father-inclusive practice

10. Staff’s assumptions and stereotypes about fathers’ role, availability or interest in child and family interventions

11. Lack of confidence among child and family professionals in engaging dads

12. General organizational culture of resistance to change and reluctance to introduce new initiatives

13. No centralized guidance, i.e., father-inclusive practice being left at individual professional’s discretion

14. Lack of gender diversity in the staff teams, e.g., disproportionate percentage of female practitioners

15. Inadequate data recording systems, which don’t allow for storing and collating information that could enhance father inclusion

16. Reluctance to focus attention on fathers' needs because of the drive for child and family services to be gender-neutral

17. Father inclusive practices not being linked to service targets or key performance indicators

18. Lack of awareness of father-inclusive practice guidelines and recommendations

19. Father inclusion not being recognized as a strategic priority by services

20. Staff not having enough time for activities related to father-inclusive practice due to other competing demands

21. Staff’s assumptions that implementing father-inclusive practices will not lead to improved outcomes or increased father engagement
Part 2: Please rate your agreement whether you think the following factors enable child and family services to be more inclusive to fathers. (Rated on a 7-point Likert Scale: Strongly Disagree (1) Disagree (2) Somewhat Disagree (3) Neither agree nor disagree (4) Somewhat Agree (5) Agree (6) Strongly Agree (7))

1. Services nominating champions committed to improving father inclusion
2. Services introducing targets and key performance indicators related to father-inclusive practice
3. Services providing more emphasis on remote treatment provision in efforts to better engage dads
4. Greater recognition of the importance of father-inclusive practice by the authorities and service commissioners
5. Services actively encouraging team discussion and reflection about implementing father-inclusive practice
6. Services introducing clear measures to monitor their provision of father-inclusive practice
7. Services providing opportunities for staff education and training on father-inclusive practice

Please use the space below if you would like to add further comments in relation to any of the questionnaire items.
Appendix I

Figure 4. An overview of the CFIR framework used in the current study. Coloured boxes represent the constructs used to group the inductively derived barriers and facilitators to Father-Inclusive Practice.
### Table 6

A summary of proposed barriers and facilitators to the implementation of father-inclusive practice identified in Round 1 survey, grouped by the corresponding CFIR domains and constructs

<table>
<thead>
<tr>
<th>CFIR Domain</th>
<th>CFIR Construct</th>
<th>Descriptive inductive themes</th>
<th>Barrier</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Intervention modality</td>
<td>Remote service provision</td>
<td>-</td>
<td>Services providing more emphasis on remote treatment provision in efforts to better engage dads</td>
</tr>
<tr>
<td>characteristics</td>
<td>External policy and incentives</td>
<td>External incentives from authorities and commissioners</td>
<td>Father-inclusive practices not being encouraged or incentivized by the authorities and/or commissioners</td>
<td>Greater recognition of the importance of father-inclusive practice by the authorities and service commissioners</td>
</tr>
<tr>
<td>Outer setting</td>
<td>Drive for a gender-neutral approach to parent engagement</td>
<td>Reluctance to focus attention on fathers' needs because of the drive for child and family services to be gender-neutral</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Patient/client needs and resources</td>
<td>Lack of awareness of fathers’ needs</td>
<td>Services having limited awareness of fathers’ needs and how to address them</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Inner setting</td>
<td>Structural characteristics</td>
<td>High level of staff autonomy / lack of centralization.</td>
<td>No centralized guidance, i.e. father-inclusive practice being left at individual professionals’ discretion</td>
<td>-</td>
</tr>
<tr>
<td>Networks and</td>
<td>Promoting dialogue within services</td>
<td>-</td>
<td>General organizational culture of resistance to change and reluctance to introduce new initiatives</td>
<td>Services actively encouraging team discussion and reflection about implementing father-inclusive practice</td>
</tr>
<tr>
<td>communication</td>
<td>Organizational culture</td>
<td>Workplace culture resistant to change</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Implementation climate: compatibility</td>
<td>Burden associated with FIP implementation</td>
<td>Father-inclusive practices being viewed as creating additional work, resulting in excessive burden for staff</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Inadequate health data systems</td>
<td>Inadequate data recording systems, which don’t allow for storing and collating information that could enhance father inclusion</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Implementation climate: relative priority</td>
<td>Strategic prioritization of FIP</td>
<td>Father inclusion not being recognized as a strategic priority by services</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Implementation climate: org. incentives and rewards</td>
<td>Internal incentives from leadership</td>
<td>No rewards offered from service leadership for staff to be more inclusive of fathers in their practice</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Implementation climate: goals and feedback</td>
<td>Targets and key performance indicators</td>
<td>Father-inclusive practices not being linked to service targets or key performance indicators</td>
<td>Services introducing targets and key performance indicators related to father-inclusive practice</td>
<td>-</td>
</tr>
<tr>
<td>Readiness for</td>
<td>Leadership commitment to FIP</td>
<td>Lack of leadership’s commitment, engagement, and support for father-inclusive practice</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>implementation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix J**
<table>
<thead>
<tr>
<th>leadership engagement</th>
<th>Readiness for implementation: available resources</th>
<th>Time constraints</th>
<th>Staff not having enough time for activities related to father-inclusive practice due to other competing demands</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Availability of funding</td>
<td>Organizations lacking sufficient financial resources to adequately fund father-inclusive practices</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workforce diversity</td>
<td>Lack of gender diversity in the staff teams, e.g. disproportionate percentage of female practitioners</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff availability</td>
<td>Limited staff availability due to inflexible working hours</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Readiness for implementation: access to information and knowledge</td>
<td>Education and training</td>
<td>Lack of training and education for the workforce on how to improve father inclusion</td>
<td>Services providing opportunities for staff education and training on father-inclusive practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Awareness of FIP guidelines and recommendations</td>
<td>Lack of awareness of father-inclusive practice guidelines and recommendations</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clear protocols for FIP</td>
<td>Lack of clear protocols that would help staff to adequately engage fathers</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Characteristics of individuals</td>
<td>Knowledge and beliefs about intervention</td>
<td>Staff’s assumptions and stereotypes about fathers’ role, availability or interest in child and family interventions</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of outcome expectancy</td>
<td>Staff’s assumptions that implementing father-inclusive practices will not lead to improved outcomes or increased father engagement</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Lack of confidence in engaging fathers</td>
<td>Lack of confidence among child and family professionals in engaging dads</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>Engaging: champions</td>
<td>Establishing FIP champions in services</td>
<td>Services nominating champions committed to improving father inclusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflecting and evaluating</td>
<td>Measures to monitor the provision of FIP</td>
<td>Services introducing clear measures to monitor their provision of father-inclusive practice (could also be – goals and feedback / reflecting and evaluating)</td>
<td></td>
</tr>
</tbody>
</table>
**Table 7.** Number of responses and percentage agreement (strongly agree/agree) to Round 3 survey items relating to barriers to FIP

<table>
<thead>
<tr>
<th>CFIR Domains</th>
<th>CFIR Constructs</th>
<th>Barriers to father-inclusive practice</th>
<th>SD</th>
<th>D</th>
<th>SwD</th>
<th>N</th>
<th>SwA</th>
<th>A</th>
<th>SA</th>
<th>%A</th>
<th>Consensus achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outer setting</strong></td>
<td>Patient/Client needs and resources</td>
<td>Services having limited awareness of fathers’ needs and how to address them</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>25</td>
<td>9</td>
<td>77.3%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Access to knowledge and information</td>
<td>Lack of clear protocols that would help staff to adequately engage fathers</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>23</td>
<td>10</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Leadership engagement</td>
<td>Lack of leadership’s commitment, engagement, and support for father-inclusive practice</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>20</td>
<td>12</td>
<td>72.7%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Structural characteristics</td>
<td>No centralized guidance, i.e., father-inclusive practice being left at individual professional’s discretion</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>17</td>
<td>15</td>
<td>72.7%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Goals and feedback</td>
<td>Father inclusive practices not being linked to service targets or key performance indicators</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>22</td>
<td>10</td>
<td>72.7%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Access to knowledge and information</td>
<td>Lack of training and education for the workforce on how to improve father inclusion</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>16</td>
<td>15</td>
<td>70.5%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Compatibility</td>
<td>Father-inclusive practices being viewed as creating additional work, resulting in excessive burden for staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>22</td>
<td>9</td>
<td>70.5%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Relative priority</td>
<td>Father inclusion not being recognized as a strategic priority by services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>17</td>
<td>14</td>
<td>70.5%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td>Self-efficacy</td>
<td>Lack of confidence among child and family professionals in engaging dads</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>14</td>
<td>16</td>
<td>68.2%</td>
<td>No</td>
</tr>
<tr>
<td>of individuals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Access to knowledge and information</td>
<td>Lack of awareness of father-inclusive practice guidelines and recommendations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>20</td>
<td>8</td>
<td>63.7%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td>Knowledge and beliefs</td>
<td>Staff’s assumptions and stereotypes about fathers’ role, availability or interest in child and family interventions</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>12</td>
<td>8</td>
<td>19</td>
<td>61.4%</td>
<td>No</td>
</tr>
<tr>
<td>of individuals</td>
<td>about intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Compatibility</td>
<td>Inadequate data recording systems, which don’t allow for storing and collating information that could enhance father inclusion</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>17</td>
<td>10</td>
<td>61.4%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Outer setting</strong></td>
<td>External policy and incentives</td>
<td>Father-inclusive practices not being incentivized by the authorities and/or commissioners</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td>14</td>
<td>11</td>
<td>56.8%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Available resources</td>
<td>Staff not having enough time for activities related to father-inclusive practice due to other competing demands</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>16</td>
<td>9</td>
<td>56.8%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Available resources</td>
<td>Lack of gender diversity in the staff teams, e.g. disproportionate percentage of female practitioners</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>18</td>
<td>52.3%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Inner setting</strong></td>
<td>Organizational culture</td>
<td>General organizational culture of resistance to change and reluctance to introduce new initiatives</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>13</td>
<td>16</td>
<td>6</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Inner setting</td>
<td>Available resources</td>
<td>Organizations lacking sufficient financial resources to adequately fund father-inclusive practices</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>17</td>
<td>11</td>
<td>9</td>
<td>45.5%</td>
<td>No</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>----</td>
<td>---</td>
<td>-------</td>
<td>----</td>
</tr>
<tr>
<td>Inner setting</td>
<td>Organizational incentives and rewards</td>
<td>No rewards offered from service leadership for staff to be more inclusive of fathers in their practice</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>13</td>
<td>10</td>
<td>13</td>
<td>5</td>
<td>40.9%</td>
<td>No</td>
</tr>
<tr>
<td>Inner setting</td>
<td>Available resources</td>
<td>Limited staff availability due to inflexible working hours</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>14</td>
<td>9</td>
<td>9</td>
<td>41%</td>
<td>No</td>
</tr>
<tr>
<td>Characteristics of individuals</td>
<td>Knowledge and beliefs about intervention</td>
<td>Staff’s assumptions that implementing father-inclusive practices will not lead to improved outcomes or increased father engagement</td>
<td>0</td>
<td>4</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>4</td>
<td>31.8%</td>
<td>No</td>
</tr>
<tr>
<td>Outer setting</td>
<td>External policy and incentives</td>
<td>Reluctance to focus attention on fathers’ needs because of the drive for child and family services to be gender-neutral</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td>8</td>
<td>1</td>
<td>20.5%</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: Items presented in descending order of strength of agreement
SD = Strongly agree, D = Disagree, SwD = Somewhat Disagree, N = Neither agree nor disagree, SwA = Somewhat Agree, A = Agree, SA = Strongly Agree, %A = Percentage agreement
### Appendix L

**Table 8.** Number of responses and percentage agreement (strongly agree/agree) to Round 3 survey items relating to the facilitators to FIP.

<table>
<thead>
<tr>
<th>CFIR Domains</th>
<th>CFIR Constructs</th>
<th>Barriers to father-inclusive practice</th>
<th>SD</th>
<th>D</th>
<th>SwD</th>
<th>N</th>
<th>SwA</th>
<th>A</th>
<th>SA</th>
<th>%A</th>
<th>Consensus achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner setting</td>
<td>Networks and communication</td>
<td>Services actively encouraging team discussion and reflection about implementing father-inclusive practice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>24</td>
<td>18</td>
<td>95.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Inner setting</td>
<td>Access to knowledge and information</td>
<td>Services providing opportunities for staff education and training on father-inclusive practice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>17</td>
<td>25</td>
<td>95.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Process</td>
<td>Reflecting and evaluating</td>
<td>Services introducing clear measures to monitor their provision of father-inclusive practice</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>23</td>
<td>17</td>
<td>90.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Outer setting</td>
<td>External policy and incentives</td>
<td>Greater recognition of the importance of father-inclusive practice by the authorities and service commissioners</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>18</td>
<td>20</td>
<td>86.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Inner setting</td>
<td>Goals and feedback</td>
<td>Services introducing targets and key performance indicators related to father-inclusive practice</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>24</td>
<td>10</td>
<td>77.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Process</td>
<td>Champions</td>
<td>Services nominating champions committed to improving father inclusion</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>25</td>
<td>5</td>
<td>68.2%</td>
<td>No</td>
</tr>
<tr>
<td>Intervention characteristics</td>
<td>Intervention modality</td>
<td>Services providing more emphasis on remote treatment provision in efforts to better engage dads</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>9</td>
<td>23</td>
<td>3</td>
<td>59.1%</td>
<td>No</td>
</tr>
</tbody>
</table>

*Note: Items presented in descending order of strength of agreement*

*SD = Strongly agree, D = Disagree, SwD = Somewhat Disagree, N = Neither agree nor disagree, SwA = Somewhat Agree, A = Agree, SA = Strongly Agree, %A = Percentage agreement*
Appendix M

Participant information sheet

THE UNIVERSITY OF EDINBURGH
School of Health in
Social Science

Examining barriers and facilitators to the implementation of father-inclusive practice in child and family services: an expert consensus study.

PARTICIPANT INFORMATION SHEET

1. What is this research about?

You are being invited to take part in our research, which is seeking to explore the factors that affect the inclusion of fathers in services that provide programmes and interventions to improve outcomes for children and families. We know from previous research that fathers are significantly less likely to participate in family-focused interventions in general, but recent evidence also suggests that the engagement of fathers can be influenced by the way the services operate. Research recommends many helpful organizational practices for improving father engagement. However, we know very little about whether these recommendations are translated into practice by individual services, and what may help or hinder their implementation.

The present study seeks to obtain your expert opinion on the barriers and facilitators to the implementation of father-inclusive practice in child and family services.

2. What is involved in this research?

This study will employ the Delphi technique, a widely used method of gathering group consensus from a panel of knowledgeable persons. The Delphi process involves completing three different online questionnaires at three different time points (referred to as Rounds).

- **Round 1: After you confirm your interest**
  You will be asked to complete the first questionnaire as soon as you confirm your interest in taking part in the study. You will be sent a link to an online survey. The deadline to complete the survey will be between 3–6 weeks from the moment you receive the link. In the survey, first you will be asked to enter some basic demographic information. Then you will be asked to respond to some general open-ended questions asking about your opinion on factors that affect the provision of father-inclusive organizational practices. This is expected to take a maximum of 30 minutes of your time. A short debrief form will follow, with a summary of Round 1 and brief information on next steps.

- **Round 2: Three weeks after Round 1 response deadline.**
  Your answers (and those from the other experts) from Round 1 will be summarized and formulated into a series of more specific questions that you will be asked to respond to. This will take place 3 weeks after the deadline to complete Round 1. You will be sent an email which will include an online link to the second survey. This survey is expected to take less than 10 minutes to complete. Again, you will be provided with a short debrief form to summarize Round 2.
Round 3: Two weeks after Round 2 response deadline

Two weeks after the Round 2 deadline, you will be sent another email with an online link to the third (and final) survey. You will be asked to complete the same questionnaire as you did in Round 2, but this time next to each question you will also be able to see your previous reply and the average reply of the other participants from Round 2. You will then be asked if you want to adjust your answer from the second round. Again, this survey is expected to take less than 10 minutes to complete.

A more detailed written debrief, which will provide further details of the study’s aims, methods, and clinical relevance, will be provided following completion of the Round 3 questionnaire.

You may be sent up to 3 reminder emails to complete each survey.

Prior to participation in the study, you will be asked to give your consent via an online consent form. When consenting to this study, you will also be asked to provide us with your email address. There are three reasons why we need it: to send you the online survey links, to potentially send you reminders to complete each survey within 3 weeks; and to be able to link your answers from different rounds, which is important for the study. Your email address will not be used for any other purpose.

Your email address will be stored securely and separately to your survey responses and will be deleted immediately after you have completed the final survey. This means that all data collected will remain anonymous when analysed. Only the researcher and his supervisor will have with access to this information.

It is okay to decline to provide your email address if you are not comfortable giving out this information. However, this means that you will not be able to take part in the surveys, and any data you might have shared up until that point will be deleted and will not be used within the study.

3. **Who is conducting this research?**

This research project is being conducted by Marek Baran, Trainee Clinical Psychologist at The University of Edinburgh’s School of Health in Social Science. Dr Vilas Sawrikar is supervising this project. This study has been approved by the University of Edinburgh School of Health in Social Science Research Ethics Committee.

4. **Who can participate in this research?**

This research is open to participate for anyone who is:

- Over 18 years old
- Has a good understanding of written English
- Is involved in at least one of the following:
  - Delivering programmes or interventions to improve outcomes for children and families.
  - Work to promote the inclusion of fathers in healthcare settings
  - Research concerning family interventions and/or father-inclusive practice

You have been invited to participate in this study as we believe you meet the above criteria.
5. Do I have to take part in this research project?

No. Participation in this study is voluntary. You can ask questions about the research before deciding whether to participate. While we would greatly value your participation in the study, if you do not wish to take part in answering any of the three surveys, you do not have to. If you do agree to participate, you may withdraw yourself from the study at any time without giving a reason, and without any disadvantage to yourself.

You can withdraw from the study by emailing the researcher directly at M.Baran@sms.ed.ac.uk. You will then no longer receive future emails requesting your participation in survey rounds. Unless you request to withdraw via email, it will be assumed that you are happy to continue your involvement in this research, even if you do not participate in one of the 3 surveys. This means that if you don’t respond to e.g. Round 1 within given timeframe, you will still be invited to take part in Rounds 2 and 3, and will continue to receive communication from us about the study until its completion.

If you choose to withdraw from the study, you can also request to withdraw some of your data submitted in response to the survey rounds, by emailing the researcher, at M.Baran@sms.ed.ac.uk, albeit please note that our ability to withdraw data is limited.

- You will be able to withdraw only your responses to Round 2 and 3. Withdrawing this data after you have completed the study will remain possible only until the deadline for Round 3 responses. This is because at that point all individual email records will be deleted so that survey answers cannot be traced to individual participants. Once your email address is deleted, it will not be possible to locate your individual responses, as these will be completely anonymized.

- It will not be possible to withdraw your responses to Round 1 at any point, because they are anonymized from the start, and the setup of that first survey gives us no way of tracing who the individual answers belong to.

6. What are the possible risks and disadvantages of taking part?

Aside from giving up some of your time, we do not expect that there will be any risks or costs associated with taking part in this study. However, in the event you become upset or distressed because of your participation in the research, and you would like to talk to someone about any distress, you can contact your local GP. For further information you can also visit Anxiety UK: https://www.anxietyuk.org.uk/, or call Samaritans: 116 123.

7. What are the possible benefits of taking part?

We cannot guarantee that you will receive any benefits from this research; however, through participation you may increase your own awareness of organizational practices that influence father engagement. Your participation will help us investigate the factors that influence the provision of father-inclusive practice by child and family services, and the outcome has the potential to help organizations shape their policies and practices in a way that encourages father involvement, ultimately benefiting the families that seek this type of support. We do not anticipate that the study will present any risks to anyone involved.
8. What happens when the research project ends?

The results of this research will be written up as a doctoral thesis. There is also the possibility that this work may be written up as a presentation or article for publication in peer-reviewed conferences and journals and disseminated in the form of poster presentation and research summary among services that may benefit from the information. In any publication and/or presentation, all reports will only contain aggregated summary information, which will be fully anonymized. No individual personal details will be reported. If you are interested in knowing the outcomes of the study, you will be able to access a 1-page summary of the study’s results by either (i) requesting it from the supervisor (Vilas Sawitkar) or (ii) via the Edinburgh University’s Research Explorer website. The 1-page summary will be available by the third quarter of 2022 and can be accessed by searching the research project title ‘Examining barriers and facilitators to the implementation of evidence-based father-inclusive practice in Child and Family services: A Delphi consensus study’.

9. Will my taking part be kept confidential?

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. Only the researcher and his supervisor will have access to full data, and data will be fully anonymized before becoming publicly available. For instance, publications of findings will report aggregated responses to the survey. In the case of needing to include an excerpt from your survey response, personal and identifying information will be deleted prior to the findings of the study becoming publicly available.

For the duration of the study, your questionnaire data will be linked to your email address by a unique, randomly generated code, which the researcher will use to identify your dataset. This is important for the study, as we want to be able to know which responses from different survey rounds come from the same person. Please note that once the responses to the final survey are collected, any records of your individual email address will be immediately deleted, thus your email address will no longer be linked to the unique code at the end of the final survey round. However, your anonymized answers from different surveys will remain linked by the unique code, without the email address information. As such, data will no longer be linkable to you in any way after the final survey round is complete.

Your consent information and your demographic details shared in the first questionnaire will be kept separately from your survey responses to minimise the risk of data linkage.

This study has been approved by the University of Edinburgh School of Health in Social Science Research Ethics Committee. This means that we are responsible for looking after your information and using it in accordance with the University of Edinburgh data protection guidelines.

The findings from this study containing fully anonymized data will be written up and submitted by the researcher to the University of Edinburgh as part of doctoral thesis. If the study is published, the anonymized data may be made available to the third parties. Your information will not be identifiable when written up, published, or presented.

For general information about how we use your data go to:
https://www.ed.ac.uk/records-management/privacy-notice-research.
10. What happens to the data provided?

All the information that you submit via the online survey software will be downloaded directly onto password-protected, secure network drive on University of Edinburgh’s servers. This will be done immediately after each survey round is closed. Only the researcher and his supervisor will have access to it. Furthermore, only aggregated, non-identifiable data will be used in the write up of the doctoral thesis.

All anonymised data will be stored securely in its electronic form for a period of 5 years and then deleted permanently from the online server.

11. Who do I contact if I have a concern about the study or wish to complain?

For any queries about the details this study, please contact the researcher, Marek Baran on M.Baran@sms.ed.ac.uk.

If you have a concern about any aspects of this study, please contact the supervising researcher of this study, Dr Vilas Sawtikar: or +44 (0) 131 651 3919, who will do his best to answer your query. The researcher will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

If you would like to discuss this study with someone independent of the study, please contact:

Dr Susanah C. Johnston: Phone: +44 (0)131 6503 901
Email:

If you wish to make a complaint about the study, please contact:

Matthias Schwannauer, the head of school and professor of clinical psychology.

Phone: +44 (0)131 651 3954
Email: headofschool.health@ed.ac.uk

If you wish to make a formal complaint about this study, please follow the link for more information: https://www.ed.ac.uk/university-secretary-group/complaint-handling-procedure/procedure?بطلid=jwAR3JcVV34xX14Zt3IamSoKeSi3HB0-Vx7uixKZABwwe10UeFkiqHT2I38Y
Appendix N

Participant consent form

Exercising barriers and facilitating the implementation of evidence-based father-inclusive practice in child and family services: A Delphi consensus study. Version 1: 07/12/2020

THE UNIVERSITY OF EDINBURGH
School of Health in
Social Science

Participant Consent Form

Exercising barriers and facilitating the implementation of father-inclusive practice in child and family services: an expert consensus study.

PLEASE CHECK EACH BOX IF YOU ACCEPT EACH STATEMENT BELOW:

☐ I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I agree to participate voluntarily. I understand that I am free to withdraw from the study at any point, without giving any reason, and without adverse consequences or academic penalty.

☐ I understand that completing the first or the second round of the study does not oblige me to continue participating in the whole study.

☐ I understand research data collected during the study may be looked at by project researchers from the University of Edinburgh. I agree to give permission for these individuals to access my data.

☐ I agree to the use of my anonymised data in future research projects.

☐ I agree to the anonymised data that I provide being reported in dissertations and published in scientific journals in the future.

☐ I agree to take part in the above study.

Your email address (required):
Appendix O

Demographics form

Examiner barriers and facilitators to the implementation of evidence-based father-inclusive practice in child and family services: A Delphi consensus study. Version 1: 07/12/2020

Demographic Information:

1. What is your age?
   - <Input age or choose from drop-down menu>

2. How do you describe yourself?
   - Male
   - Female
   - Prefer not to answer
   - Other

3. Country of residence:
   - <Input manually or choose from drop-down menu>

4. Occupation:
   - Academic staff
   - Clerical staff
   - Nurse
   - Social worker
   - Psychologist
   - Family therapist
   - Manager
   - Other (specify): ________________

5. Current role: ____________________

6. Type of involvement in child and family service provision and/or father engagement work (tick all that apply):
   - Research / Academic
   - Clinical / Support – direct (e.g. first-line workers)
   - Clinical / Support – indirect (e.g. management, administrative)
   - Consultancy / Campaigning / Policy-making
   - Other (please specify): ____________________

7. How long have you worked in roles related to child and family service provision and/or father engagement?
   - Less than 6 months
   - 6 to 12 months
   - 1 to 3 years
   - 4 to 6 years
   - 7 years or more
5. Are you proficient in English?

- Yes
- No