



Submission cover sheet

Inquiry into men's suicide rates

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Inquiry into Men's Suicide Rate – Submission

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1st August 2025

We are grateful for the opportunity to provide a submission to the Legislative Assembly for the ACT Standing Committee on Social Policy's Inquiry into Men's Suicide Rate.

Our submission focuses specifically on **suicidality and death by suicide among men who are fathers and other caregivers of children aged 0-18 years of age**. We refer to this period as 'early fatherhood' for the purposes of our submission. We acknowledge and appreciate the role of other male caregivers in children's lives and our reference to 'fathers' is also inclusive of other male caregivers. Our submission is informed by our: (a) epidemiological and intervention research into fathers' mental health and suicide, (b) partnerships with community health services working with families of young children, and (c) our own lived experience of fathers' mental health difficulties and suicide.

Our submission will present our research on:

- The extent to which men who are fathers of children aged 0-18 experience poor mental health, suicidality and death by suicide.
- Factors contributing to poor mental health, suicidality and death by suicide among men who are fathers of children 0-18 years.
- Prevention and early intervention approaches targeting fathers' mental health and suicidality.

Our submission will conclude with recommendations for research, policy and practice to prevent and reduce death by suicide among men in early fatherhood.

About Us

The Intergenerational Child & Family Health Group at Deakin University's SEED Centre for Lifespan Research conducts research into the impact of early life stress, adversity and relational trauma on the mental health of children and families across the lifecourse and across generations. Our research also involves developing, trialling, and translating evidence-based prevention, early intervention, and treatment approaches to optimise mental health and family relationships. The research group is led by Professor Rebecca Giallo, whose 13-year program of research has focussed on fathers' mental health in the early years of parenting. Early career research leaders include Dr Alison Fogarty (men's suicide in fatherhood), Dr Monique Seymour (mental health of fathers of children with disabilities and chronic health conditions) and Dr Grace McMahon (mental health of fathers with pre-term infants). Casey Hosking is a PhD student with a Suicide Prevention Australia PhD scholarship to further investigate suicidality among men in early fatherhood.

The Australian Fatherhood Research Consortium is a collaboration of researchers, practitioners and policy makers. We exist to advance the science of fatherhood, inform practice and policy that supports men and their families, and promote healthy inclusion of fathers in family life. The consortium is convened by A/Prof Jacqui Macdonald at Deakin University. The consortium aims to: (1) advance the science of fatherhood; (2) inform practice and policy that supports men and their families; and (3) promote healthy inclusion of fathers in family life.

Poor Mental Health, Suicidality and Suicide among Men in Early Fatherhood

Early fatherhood is a critical life stage to be addressed in the prevention of male suicides in Australia. Suicide is a leading cause of death among young Australian men aged 24-44 years, (Australian Bureau of Statistics, 2020) coinciding with a life stage when many are starting a family or raising children aged 0-18 years. As identified in the National Men's Health Strategy (Commonwealth Department of Health, 2018), early fatherhood is a potentially stressful time that can increase men's risk of poor mental health and/or exacerbate existing mental health issues.

Our Australian research drawing data from the Growing Up in Australia: Longitudinal Study of Australian Children (LSAC) and Men and Parenting Pathways Study (MAPPS) and the Australian Temperament Project Generation 3 Study (ATPG-3) has demonstrated that fathers' mental health difficulties are common and comparable to estimates among mothers. Our research shows:

- About 1 in 10 fathers of young children (0-4 years) experience poor mental health such as depression and anxiety symptoms (Giallo et al., 2012) (Giallo, Wynter, et al., 2023; Macdonald, Greenwood, et al., 2021).
- 1 in 6 fathers report anxiety during the prenatal period and up to 1 in 5 report anxiety during the postnatal period (Leach et al., 2016; Macdonald, Greenwood, et al., 2021)
- Mental health difficulties increase and persist across fatherhood (0-18 years) for 5-7% of fathers (Giallo, D'Esposito, et al., 2014; James et al., 2025).
- Fathers of children with disabilities, chronic health conditions and sleep and settling issues are at increased risk of poor mental health (Monique Seymour et al., 2020; Seymour et al., 2013; Seymour et al., 2014; Seymour et al., 2017a; Seymour et al., 2017b; M. Seymour, R. Giallo, et al., 2020).
- Refugee and migrant fathers were 2-3 times more likely to report psychological distress than Australian-born fathers when their children were 4-5 years of age (Giallo, Riggs, et al., 2017).

- Fathers of children who were unplanned or unintended are at double the risk of depression compared to fathers of planned children (Smith et al., 2023).
- Rates of postpartum mental health problems are 5 to 7 percentage points higher among fathers who report a history of poor relationships with their own mothers and fathers compared to those with positive relationships (Macdonald, Greenwood, et al., 2021).

These estimates of mental health difficulties are likely to be an underestimate of the prevalence in the population due to well established barriers to reporting mental health difficulties among men, including stigma, masculine norms, negative attitudes to help-seeking, and shame (J.A. Macdonald et al., 2022). In smaller studies of help-seeking and clinical samples, estimates of mental health difficulties are much higher. Our research has shown that:

- 1 in 3 fathers accessing a service for support with their partners for couple/coparenting relationship difficulties reported previous or current mental health difficulties (Giallo et al., 2024).
- About 1 in 5 fathers accessing a service for children's sleep and settling issues reported high psychological distress including symptoms of depression, anxiety and stress, fatigue and self-harm ideation (Giallo, Cooklin, et al., 2013).
- 1 in 3 men enrolled in a study to trial different interventions targeting poor mental health in early fatherhood reported clinically significant psychological distress (Giallo et al., 2025).
- 1 in 4 fathers enrolled in the MAPP study report feelings of shame related to their children. This shame is associated with greater likelihood of depression one year later (Misuraca et al., 2024).

It is clear from our research over the last decade that mental health difficulties among men in early fatherhood are common. This is of concern as it is well established that mental health difficulties can increase the risks for suicidality and suicide, particularly among men (Too et al., 2019).

There is an urgent need to better understand the extent to which men in early fatherhood experience suicidality and die by suicide. Our recent systematic review and meta-analysis revealed that only 14 studies worldwide have reported on the prevalence of suicidal ideation in fathers of young children (birth-4yrs; (Fogarty et al., 2024). The pooled estimate of suicidal ideation was lower than expected, at 4.2%. We concluded that this was an under-estimation due to major methodological limitations of the identified studies, including (a) the exclusion of males with prior serious mental health problems and/or suicidal ideation, and (b) the lack of suicide specific measures. We identified over 200 articles which included mental health measures with items on suicidal ideation or behaviour but failed to report on this item separately, reflecting the neglect of this field within research.

To address this unmet need, we have conducted the first studies into suicidality and death by suicide among men in early fatherhood in Australia.

- Drawing data from 205 fathers in Ten to Men: The Australian Longitudinal Study on Male Health, we identified that approximately 5% of fathers reported suicidal thoughts, 3% had suicide plans, and less than 1% had attempted suicide in the postnatal period (Giallo, Wynter, et al., 2023).
- Of the 293 fathers who enrolled in a study to trial different interventions targeting mental health difficulties in the early parenting period, 1 in 3 reported suicidal ideation (Giallo et al., 2025).

- In our data linkage study to examine death by suicide among fathers of children (0-18 years), we revealed that **in a 5-year period between 2017-2021 in Victoria, 607 fathers died by suicide** (Fogarty et al., in press). This accounted for 24% of all male suicides in the state during that time. This was equivalent to more than 120 fathers per year. During the critical postnatal period, 47 fathers of infants (<1 year) died by suicide, while 199 fathers of children under four years died during the early parenting period - nearly 40 per year.

Impacts of Fathers' Mental Health Difficulties, Suicidality and Suicide on Families

Fathers' mental health difficulties, suicidality and suicide can have profound and enduring impacts on fathers themselves and their families. Our research highlights the ripple effect across the family system when fathers are struggling with their mental health, including:

- Poor antenatal and postnatal mental health among fathers is associated with higher likelihood of social-emotional, cognitive, language and physical difficulties among children and adolescents ((Le Bas et al., 2025).
- Poor mental health among fathers in the early years of parenting (3-12 months) is associated with increased risk of psychological and behavioural difficulties in children at 8-9 years (Giallo, Cooklin, Wade, et al., 2014).
- Fathers' mental health difficulties spanning 18 years from the first postnatal year were associated with emotional-behavioural difficulties, anxiety and depressive symptoms among their adolescent children (James et al., 2025).
- Poor paternal mental health across the early parenting period from 3-12 months to 8-9 years is associated with parenting difficulties including lower parenting warmth, increased parenting hostility, and decreased parenting consistency (Giallo et al., 2015).
- Fathers' mental health problems are associated with partner mental health difficulties and poorer co-parenting and couple relationship quality (Giallo et al., 2012) (Giallo, D'Esposito, et al., 2014; Macdonald et al., 2020).
- Fathers' poor mental problems, identified preconception or postpartum, are associated with higher levels of anger, lower levels of social support and poorer bonding with infant children (Macdonald et al., 2020) (J. A. Macdonald et al., 2022).
- Fathers' mental health problems are associated with the use of avoidant coping strategies to manage stress including alcohol and substance use, social withdrawal and disengagement from family (Livingston et al., 2021).

Risk Factors for Suicidality and Suicide among Men in Early Fatherhood

There has been much research into the risk factors for poor mental health among men in early fatherhood. In summary, our studies with population-based and clinical samples have identified the following risk factors:

- **Past history:** past history of mental health problems, past history of family violence (Giallo et al., 2024; Giallo, Wynter, et al., 2023; Spry et al., 2018; Thomson et al., 2021)
- **Physical health and lifestyle** poor physical health, limited engagement in self-care behaviour, poor sleep and poor diet (Giallo, Cooklin, et al., 2013; Giallo et al., 2024)(Seymour et al., 2014)(Seymour et al., 2017) (Macdonald, Graeme, et al., 2021).
- **Health literacy and help-seeking:** attitudinal barriers to help-seeking for mental health problems (Giallo, Dunning, et al., 2017; Seymour et al., 2013)
- **Family and social relationship:** young fatherhood (Seymour et al., 2017b); couple relationship difficulties, family separation, partner mental health problems and

inadequate social support (Giallo, Cooklin, & Nicholson, 2014) (Seymour et al., 2013) (Giallo, D'Esposito, et al., 2013; Giallo et al., 2024; Ritorto et al., 2024)(Seymour et al., 2017)

- **Education and employment:** limited access to flexible job conditions and parental leave, high work-family conflict, low educational attainment, and financial difficulties (Giallo, Wynter, et al., 2023) (Cooklin et al., 2015; Cooklin, 2014) (Giallo, Cooklin, & Nicholson, 2014; Giallo, Cooklin, et al., 2013; Giallo, D'Esposito, et al., 2013; Giallo et al., 2024) (Seymour et al., 2017b) (Seymour et al., 2014)
- **Child:** infant prematurity, sleep and self-regulation problems, difficult and reactive temperament, child disability and chronic health conditions (Seymour et al., 2013) (Cook et al., 2017) (Giallo, Cooklin, et al., 2013) (McMahon et al., 2020). (Seymour et al., 2017b) (Seymour et al., 2017b)

Whilst some of these factors may also increase risks for suicidality and death by suicide in early fatherhood, studies investigating this are scarce. Of the studies identified in our recent meta-analysis on suicidality in early fatherhood, none sought to identify risk factors associated with suicidality (Fogarty et al., 2024). Although we did not specifically seek to identify risk factors for death by suicide in our Victorian data linkage study, we did observe that nearly 40% of fathers who died by suicide were not in a relationship at the time of death. This is almost twice the proportion of single-parent households with dependent children recorded in the 2021 Australian Census (AIFS, 2023). Relationship difficulties and breakdowns are a well-established risk factor for suicide among men more generally (Wilson, Mansour, et al., 2025; Wilson, Scott, et al., 2025). Casey Hosking, a PhD student in our team, is undertaking a program of research to explore fathers' perceptions of how and why suicidality develops to inform prevention and early intervention approaches. This work is being funded by a Suicide Prevention Australia PhD scholarship and will be available in the near future.

Prevention and early intervention approaches targeting fathers' mental health and suicidality

Despite what we know about the extent to which men experience mental health difficulties in early fatherhood and the impacts on their families, **there is currently no standard of care for routinely engaging fathers about their mental health, or for providing intervention and support in the healthcare system.** We are missing opportunities for prevention and early intervention in universal health care settings where fathers attend with their children and families. This includes maternity care, maternal-child health services, early parenting services, and other early childhood services. **This is in part likely due to a lack of evidence-based prevention and early intervention approaches specifically targeting fathers' mental health and suicidality.**

Our systematic review currently underway [PROSPERO 2024 CRD42024528801] has identified 32 peer-reviewed studies of randomised control trials with data on paternal mental health and adjustment problems including depression, anxiety, anger and aggression. Of these, none reported interventions designed to reduce risk of paternal suicidality.

Recognising the importance of engaging and supporting fathers in the early years of parenting, the NSW Ministry of Health commissioned our team to undertake an Evidence Check to identify and summarise the evidence for father-inclusive practices and interventions that can be delivered in antenatal, birthing and community child health settings from conception until when the child is aged five years (Giallo et al., 2021). We identified only 36 studies published worldwide between 2011-2021, representing four broad types of interventions:

- **Coparenting interventions** focussed on strengthening the co-parenting relationships, father involvement, and/or parent mental health in the perinatal period (n=14 studies)
- **Father-specific intervention components/initiatives embedded into standard care** or interventions that are typically provided to mothers (n=13 studies)
- **Father-focused interventions that were designed for and specifically delivered to men** in early fatherhood (n=6 studies)
- **Professional development and training** in father-inclusive practice for health professionals in the service system (n=3).

Few studies specifically targeted and assessed fathers' mental health outcomes using high quality research designs, and very few interventions were available in Australia. The full review can be found: <https://www.saxinstitute.org.au/evidence-check/effective-interventions-to-increase-father-inclusive-practice-in-community-and-acute-settings/>

Family Foundations (FF) is an example of an evidenced-based program that engages both mothers and fathers in the early years of parenting. FF helps families strengthen their skills to manage stress, communicate well, and work together as a parenting team – pivotal skills needed to promote children's health, wellbeing, and development. The manualised 10-session program is delivered by trained facilitators with an allied health background using discussion-based activities, modelling, and skills practice. Families can receive FF in their own home or via telehealth, or with other families in a group setting. FF is provided flexibly (e.g., weeknights, weekends) to ensure that all parents, co-parents, and caregivers in the family have an opportunity to participate. Our team have been partnering with Holstep Health (formerly, Merri Health), a Victorian-based community health service since 2017 to evaluate the mental health and relationship outcomes for families who have participated in FF. Over the past 8 years, over 500 fathers have participated in FF with a partner/co-parent. Two service-led pilot studies revealed a decrease in fathers' reports of parental conflict and relationship difficulties following participation in FF (Giallo, Fogarty, et al., 2023) (Giallo et al., 2024). See Appendix 1- Policy Brief outlining the findings of the FF pilot studies below. A more recent evaluation with over 200 families was conducted by our team. Results showed that fathers reported a decrease in psychological distress, depressive symptoms and anxiety symptoms at post-intervention and this was maintained at the 6-month follow-up. The report for this evaluation will be available in late 2025. It is worth noting that Prof Giallo has recently been awarded MRFF funding to trial FF with families living in regional and rural areas of Australia. This will provide us with an opportunity to engage fathers and other male caregivers living in regional and rural settings who have even less access to health services and professional support for mental health concerns.

To address the gaps in prevention and early intervention approaches specifically targeting fathers' mental health, our team have partnered with Tweddle Child & Family Health Service to evaluate their Working Out Dads program. **Working Out Dads (WOD) is a facilitated peer support intervention for fathers and other male caregivers of young children (aged 0-4 years) experiencing, or at risk of mental health difficulties.** The manualised six session program consists of: (a) one hour of psychoeducation and group discussion facilitated by a male mental health professional, and (b) a 30-minute group exercise session provided by a qualified personal trainer. Fathers are encouraged to connect with each other between sessions via digital technology (i.e., a WhatsApp group) and access WOD resources (e.g., psychoeducational tipsheets; self-monitoring tools; details of telephone helplines and other services). Pilot evaluations of WOD using single-group non-controlled designs revealed high acceptability to fathers, and significant pre to post decreases in depressive and stress symptoms associated with moderate effect sizes (Giallo et al., 2018; Giallo et al., 2020). See Appendix 2- Research and Policy Brief outlining findings of WOD pilot studies below.

In 2020, Prof Giallo was awarded a MRFF Million Minds Mission Suicide Prevention Grant to assess the effectiveness and cost-effectiveness of WOD. A total of 293 fathers of children aged 0-4 years were recruited and randomly assigned to either WOD or a brief telephone intervention with a maternal-child health nurse (involving a discussion about fathers' mental health, suicide risk assessment and support and referral options). The primary outcome, psychological distress measured by the Kessler-10, and other secondary outcomes including suicidal ideation and social support were assessed at 24-weeks post-randomisation (Giallo et al., 2022). Encouragingly, both intervention groups showed a meaningful reduction in psychological distress, from the clinical range into the normal range at follow-up. While the specific effectiveness of the WOD intervention over the brief phone intervention was not established, these findings demonstrate that participation in either type of support (group or brief health check-in) can contribute to significant improvements in fathers' mental health. This is particularly important given the current lack of targeted mental health support for fathers in the early parenting period. The report for this evaluation will be available in 2025.

There is a prevailing assumption that fathers don't want to engage in services and don't want support for mental health concerns. In both the FF evaluation studies and our WOD trial, father uptake, engagement and satisfaction with the interventions was very high. Many fathers in the WOD trial told us that they had never been asked about their mental health before, and that the study had provided them with an opportunity to talk to someone about their challenges for the first time. Although stigma, cultural norms that discourage help-seeking, and negative attitudes to help-seeking can be obstacles to support for some fathers (Giallo, Dunning, et al., 2017) (Monique Seymour et al., 2020; M. Seymour, R. Peace, et al., 2020), many fathers in our qualitative studies have acknowledged the importance of accessing support and have expressed a strong desire to attend appointments with their children and families (Rominov et al., 2017). Many fathers indicated that they are often unable to attend these appointments that are only offered during business hours due to work commitments, inflexible work hours and limited access to leave.

Even when fathers can attend appointments, **our research shows that fathers often feel marginalised when accessing services with their children and families.** Universal health services such as maternity care, maternal-child health services and early parenting centres are generally designed with mothers and children in mind. In interviews with fathers, they share that they are rarely engaged by health professionals when attending appointments with their children, and they feel in the periphery or "in the background" (M. Seymour, R. Peace, et al., 2020; Watkins et al., 2024). Our research with maternity and maternal-child health service staff suggests that this may be in part due to service constraints (e.g., fathers are not clients of the service) and workforce gaps (e.g., lack of training, knowledge and confidence to engage fathers; (Rominov et al., 2018; Small et al., 2025; Wynter et al., 2021). Our research with maternity care professionals found that although they recognised the importance of engaging fathers and they had a strong desire to, they did not feel they had the knowledge, skills or confidence to work with fathers and engage them about their mental health concerns (Rominov et al., 2018),

Lived Experience Reflection

After the birth of our second child, my partner experienced significant mental health issues including depression, anxiety, irritability, frustration and anger. Across his childhood from birth to 18 years of age, he had a father with mental health difficulties and alcohol dependence. He also directly and indirectly witnessed intimate partner violence in the home, and his own life and the lives of other members of his family were put at risk. Stigma and other negative attitudes to help-seeking have been barriers to accessing professional support for these traumatic experiences. Although my partner did not experience mental health difficulties after

the birth of our first child, it is likely that his earlier life experiences of family violence in the home and reluctance to seek support were risk factors for mental health difficulties after the birth of our second child. As the primary caregiver for our two children, he attended all maternal and child health service appointments with my children and any family doctor appointments. Not once was he ever asked by a health professional about how he was managing or coping as a parent. These were missed opportunities to engage my partner about his mental health and offer support options at a time when he may have been more open to it. As his mental health difficulties worsened and he became worried about the potential impacts on his family, he eventually saw a general practitioner. It took great courage for him to overcome significant attitudinal barriers and stigma to make an appointment and express that he was experiencing mental health difficulties. Even in this appointment, the general health practitioner did not ask for much information about his experiences and underlying risk factors. He was subsequently prescribed medication, which helped to relieve symptoms of frustration, irritability and anger at the time. Routinely engaging with fathers about their mental health in universal health care settings may identify fathers at risk of, or currently experiencing mental health difficulties and offer support options in the critical early years of fatherhood. For some, this may be the first time they have ever been asked about their mental health.

Recommendations for Policy, Research and Practice

Policy, research and practice are deeply interconnected in effectively supporting fathers' mental health and reducing suicidality. Evidence-based policy relies on high-quality research and evaluations, and these guide investment in services that work. In turn, practice plays a crucial role in implementing and testing these approaches on the ground, generating real-world insights that can inform research priorities and policy development. A coordinated approach is needed to drive meaningful and sustained improvements in mental health outcomes for fathers and their families.

Policy

Promoting the mental health of men in early fatherhood was briefly acknowledged in the Australian Government's National Men's Health Strategy (Commonwealth Department of Health, 2018). Given our research in Victoria indicating that men in early fatherhood make up a quarter of all male suicides (Fogarty et al., in press), this is not enough. Policy around suicide prevention must include father specific efforts, including:

- Ensuring **fathers are explicitly recognised as priority populations across key mental health and suicide prevention policies at a state/territory and national level**. Such policies and frameworks include: the *National Mental Health and Suicide Prevention Plan*; the *National Men's Health Strategy 2020-2030*; and the *National Children's Mental Health and Wellbeing Strategy*. Fathers remain largely invisible in policy design and implementation. There is an opportunity to engage fathers in the co-design of such policies and frameworks.
- There are specific **opportunities to address the mental health care needs of fathers in parental leave and workplace policies**. Fathers require better access to leave following the birth of a child, and additional leave when there are birth complications, following miscarriage and neonatal death, and when their children or partners are unwell. Not only would this allow them to be available to support their families, but it would reduce barriers to accessing mental health support (e.g., services only available during business hours). However, even when leave entitlements exist, many fathers face barriers to taking these up due to societal norms and workplace expectations which discourage leave-taking or part-time work due to enable dual caretaking. Strategies

are needed to address both societal attitudes and workplace cultures that implicitly or explicitly penalise fathers for prioritising caregiving and mental health.

- Strengthening the visibility of fathers in national and state/territory policies and frameworks would create a policy imperative for **the provision of more inclusive, father focussed service development**. This will drive the development and implementation of prevention and early intervention approaches in the universal health care system that are inclusive and responsive to the needs of fathers. This may include service development, the redesign of existing services, and investment in workforce development.

Research

Research into men's mental health and suicidality in early fatherhood is still largely neglected, and compared to research focussed on mothers, is still in its infancy. To effectively support fathers, targeted research and evaluation are needed to guide policy and service development. The following research priorities aim to address current evidence gaps and inform scalable, father-inclusive approaches:

- **Identification of key drivers of suicidality** among fathers from preconception through the antenatal, postnatal and later parenting periods. This research should examine psychosocial risk factors and suicide risk trajectories to better understand which fathers are most at risk and when risk may be heightened.
- **Investigate under-researched risk factors** for suicidality in men, including brain injury, concussion, Chronic Traumatic Encephalopathy (CTE), to understand the mechanisms and prevalence of these risks.
- Given the lack of research in the field, **qualitative research is needed to develop a better understanding of the lived and living experience** of suicidality in early fatherhood. This can provide powerful insight into how fathers experience, and what has supported them to move through or beyond, suicidality within the context of parenthood.
- **Understand the experiences and risks for diverse and vulnerable groups** of fathers. For example, young fathers (<24 yrs), culturally diverse fathers, Aboriginal and Torres Strait Islander fathers, fathers and other male caregivers in LGBTIQ+/rainbow families, solo-parent fathers, separated fathers, fathers not living with their children, fathers in prison, fathers raising children with disabilities and chronic health conditions and fathers living with disabilities and chronic health conditions themselves.
- **Data linkage** represents an underutilised resource for understanding health service contacts and other events leading up to suicide attempts and deaths. Linking administrative data from health, ambulance, police, court, and social services can help identify critical intervention points and improve prevention strategies. Data linkage could also be used to better understand the longer-term impact of death by suicide on bereaved children and families.
- Conduct **comprehensive and robust evaluations** of a range of intervention approaches, recognising that one size does not fit all. This includes assessing the effectiveness of existing community-based interventions, as well as building the evidence-base for other intervention models, such as WOD and brief assessment/intervention approaches that could be delivered in the universal health care system such as antenatal and postnatal care, maternal and child health services, and early parenting settings.
- Support continued Victorian Government investment in father-focused peer support programs, but ensure this is accompanied by **high-quality evaluations** to assess impact and inform future service development.

- **Tailoring and evaluation of WOD** which is an acceptable and meaningful program to support men in the critical early years of fatherhood. Ongoing evaluation is critical to building the evidence for WOD. An important next step is to understand how well WOD meets the diverse needs of fathers in our communities such as migrant and refugee fathers, Aboriginal fathers, young fathers, fathers and other male caregivers in LGBTIQ+/rainbow families, fathers of children with disabilities and chronic health conditions, and fathers who have experienced childhood adversity and trauma.

Practice

Early fatherhood is an opportune time for prevention and early intervention for poor mental health, suicidality and death by suicide. Fathers often attend child-focused services with their family, and for many, it is the first time since childhood that they have had regular contact with any healthcare provider. Our research demonstrates that fathers are very amenable to help at this time, and want to be asked about their mental health by professionals (Rominov et al., 2018). This is a “window of opportunity” to address mental health at a time when fathers are motivated to make changes that could benefit their children and families. Greater investment in a range of father-inclusive approaches is needed, including:

- Approaches within the universal health care system that **routinely engage fathers** about their mental health and wellbeing, such as during perinatal visits and the ‘age and stage visits’ in maternal and child health settings. This may require a redesign of services to ensure that they are more inclusive and responsive to the needs of fathers and overcome barriers to access. For example:
 - Renaming of Maternal and Child Health Service to Family and Child Health Service so that it is more inclusive of fathers, male and other caregivers
 - Fathers are considered clients of the service
 - Ensuring that fathers are invited and involved in first-time parents groups
 - Offering father specific programs (fathers groups)
 - Offering after hours appointments to engage working fathers who do not have access to flexible working conditions and leave.
- **Targeted interventions** for men experiencing mental health difficulties or at risk of mental health difficulties in early fatherhood, with a focus on accessibility (e.g., after hours, schedule telehealth/phone check-in), cultural safety, and stigma reduction.
- **Support services for fathers at critical transition points**, including the postnatal period, following a child’s health/development diagnosis, or when navigating complex family needs. This includes support services for fathers in crisis, for example post-separation/divorce.
- **Bereavement support for children and families** across the life course following death by suicide. While few studies have examined child outcomes following paternal suicide, losing a parent to suicide is a known risk factor for mental health problems and risk of suicide in adulthood (Guldin et al., 2015; Melhem et al., 2008). Thus, comprehensive bereavement and mental health support for children and families following paternal suicide is crucial in helping to mitigate long-term intergenerational impacts.
- **Workforce Development.** Perinatal and early childhood services have been designed with mothers and children in mind. Our research has revealed that health professionals are interested in expanding their role to ensure that fathers’ mental health is prioritised (Rominov et al., 2017). Professional development and support for health professionals and the organisations in which they are embedded is needed to make a meaningful change in how services are delivered, and to overcome the barriers to engaging with and supporting fathers in the universal health care system.

- **Strengthening pre-service education** to equip the future workforce to support fathers' mental health. There is a critical opportunity to embed content on father-inclusive practice and men's mental health into the training of future health and social care professionals, including nursing and midwifery, social work, counselling, and psychology programs. Education should build knowledge of the unique mental health needs and help-seeking barriers faced by fathers, and men, along with developing the skills needed to engage fathers sensitively and effectively. This will build a shift in long-standing service cultures that have often excluded or neglected fathers, and build a workforce that is confident in supporting the mental health and wellbeing of all parents.

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Appendix 1: Policy Brief on Family Foundations

Policy Brief 1

Family Foundations: Strengthening families during pregnancy and the early years in Australia



Translating evidence from the Family Foundations Project into policy and practice

What is Family Foundations?

Family Foundations (FF) is an evidence-based family intervention designed to strengthen coparenting relationships, reduce parental conflict, and promote parent mental health during pregnancy and the early years of parenting. FF is for families experiencing stress, health and wellbeing difficulties, and challenges in their family relationships including disagreements, arguments, and conflict.

FF helps families strengthen their skills to manage stress, communicate well, and work together as a parenting team – pivotal skills needed to promote children’s health, wellbeing, and development. The manualised 10-session program is delivered by trained facilitators with an allied health background using discussion-based activities, modelling, and skills practice. Figure 1 shows an overview of the FF content and approaches. Families can receive FF in their own home or via telehealth, or with other families in a group setting. FF is provided flexibly (e.g., weeknights, weekends) to ensure that all parents, co-parents, and caregivers in the family have an opportunity to participate.

FF was developed by Prof Mark Feinberg at Penn State University, and has been evaluated extensively in the United States.^{1,71} Figure 1 shows the outcomes of FF for children and families demonstrated through randomised controlled trials. Follow-up studies have shown that FF can lead to long-term sustainable change in parent and family functioning that promotes children’s health and wellbeing many years after the intervention has been delivered.

Figure 1: Overview of the FF content and skills, approaches and intended outcomes for families

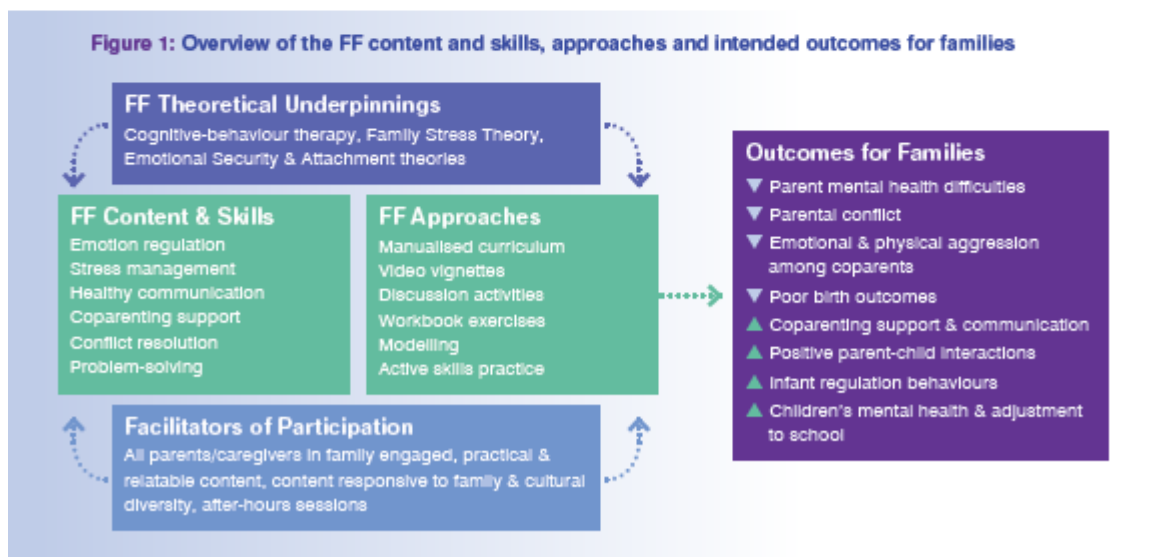


Figure 2: History of Family Foundations In Australia

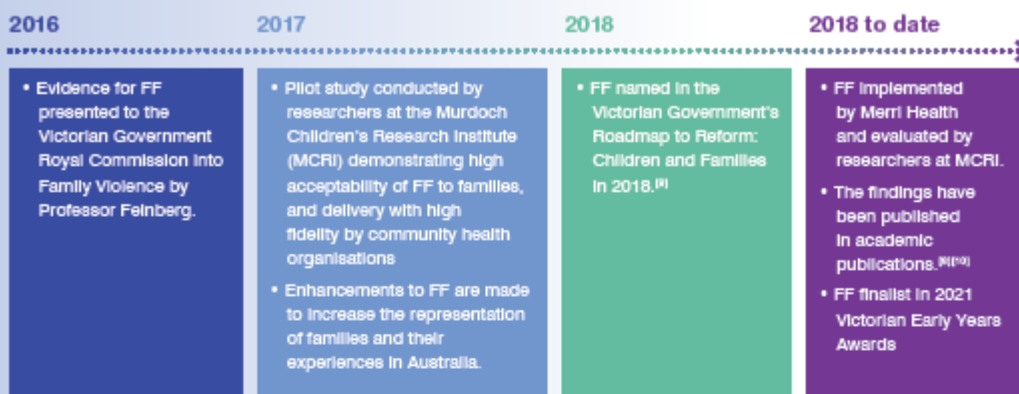


Figure 3: Examples of FF materials



Building an evidence base for Family Foundations in Australia

A total of 343 families received FF between 2018 and 2021. Over 80% of these families received FF delivered via telehealth during the COVID-19 pandemic.

- Common reasons why families took up FF included:
 - To improve their communication
 - To engage in fewer arguments, disagreements and conflict with each other
 - To work better together as a parenting team
- The majority of families:
 - Were in a heterosexual relationship (98%). Remaining families were single parent's accompanied by a parenting partner (e.g., grandparent), or were in a same-sex relationship
 - Had a baby in the last 12 months (83%), and a small number were pregnant with their first child

Figure 4: Number of parents experiencing difficulties enrolled in FF



Family engagement in FF

- The majority of families (**78%**) **completed** all 10 sessions.
- On average, families who partially completed FF attended 4 sessions. Common reasons for not completing FF included (a) difficulties finding the time due to stressful life circumstances and work commitments, and (b) difficulties engaging all parenting partners in the program.
- ~**85%** of the FF content was **delivered** to families **as planned**.
- The majority of families (**>75%**) were **highly satisfied** with the content, activities, home-visits, and telehealth sessions. Parents reported that the most important topics were managing conflict, communication, and listening skills

Experiences of parents who completed FF

“ Our parent coaches set up a safe environment that was fun, engaging, respectful, and no judgements. ”

“ It’s really great that it’s delivered in the home. It’s made it so much easier - don’t think we would have done it otherwise. ”

“ Being online has made it easier and more accessible - some nights we have been struggling to get the baby down, so it made more flexible for us. ”

Outcomes of participation in FF for families

Families reported statistically significant and meaningful changes in their coparenting relationships, mental health and parenting following FF.



Mothers reported:

- ▼ depressive, anxiety and stress symptoms
- ▼ parental conflict
- ▼ harsh parenting behaviour
- ▼ infant sleep and crying problems
- ▲ coparenting behaviour
- ▲ confidence in parenting
- ▲ warm parenting behaviour



Fathers reported:

- ▼ parental conflict
- ▼ harsh parenting behaviour
- ▼ infant crying problems
- ▲ confidence in parenting



Parenting is really trying on the relationship. The program is designed to help you look at what are the pressure points and how could you make them more manageable as a family and develop some common language around how you approach things.



It’s been super helpful & potentially saved us.



It would get heated in front of the children, and we didn’t realise how much it could affect them. That has changed a lot now, we talk to each other.

I really appreciated that we could take the time as a couple to reflect on our relationship and celebrate the parts we value and excel in but recognise the areas we know need improvement.



Future development and evaluation of FF

Ongoing evaluation is critical to building the evidence for FF. Merri Health will continue to partner with researchers at MCRI to assess outcomes for families 6 months after receiving FF. The results of this evaluation are due in 2024. An important next step is to understand how well FF meets the diverse needs of families in our communities including migrant and refugee families, LGBTQI+ families, Aboriginal families, young parents, families living in regional and rural areas, and families of children with disabilities and chronic health conditions. We are seeking funding to work in partnership with community organisations to further evaluate and enhance FF.

Opportunities for policy and practice in Australia

FF has a strong evidence base as an intervention to strengthen parent mental health and family relationships in the critical early years of children's lives. A key next step is to make FF available to more families with young children in Australia.

Critical success factors for a model of scale-up led by community health organisations include:

- **Implementation support** provided by a lead organisation with experience and success in embedding FF into its service. This includes support to: (a) set up models for delivery, clinical governance, and quality assurance; (b) identify and select a suitable workforce to deliver FF; (c) establish partnerships and referral pathways; (d) monitor intervention fidelity; and (e) problem-solve barriers and challenges to implementation.
- **Workforce capacity building initiatives**, including (a) training provided by an accredited FF trainer; (b) opportunities for ongoing individual supervision and support; and (c) a Community of Practice for peer supervision and learning.
- **Community health organisation commitment** to providing FF outside of business hours (e.g., weeknights and weekends) to maximise opportunities for all parents, coparents and caregivers within the family to participate in FF.
- **Models of implementation** that involve a shared workforce between organisations and flexible co-delivery options to: (a) overcome workforce availability issues, particularly in regional and rural areas; and (b) enhance responsivity to the needs of socially and cultural diverse families. This may include bicultural workforce; staff experienced in working with LGBTQI+ families; staff with experience in supporting families with mental health difficulties, substance use concerns, and past histories of trauma; and staff with experience in working with children with disabilities and chronic health conditions.
- **Commitment to a common evaluation framework** for FF and partnership with researchers in Australia to monitor outcomes for families and children, maintain integrity and fidelity, and identify opportunities for intervention and service improvements.

For more information

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This policy brief has been put together by the Family Health & Wellbeing Team in the Intergenerational Health research group at the MCRI and Merri Health.

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Research and Policy Brief

Working Out Dads:

Strengthening men's mental health
in early fatherhood in Australia



Translating evidence from the Working Out Dads trial into policy and practice

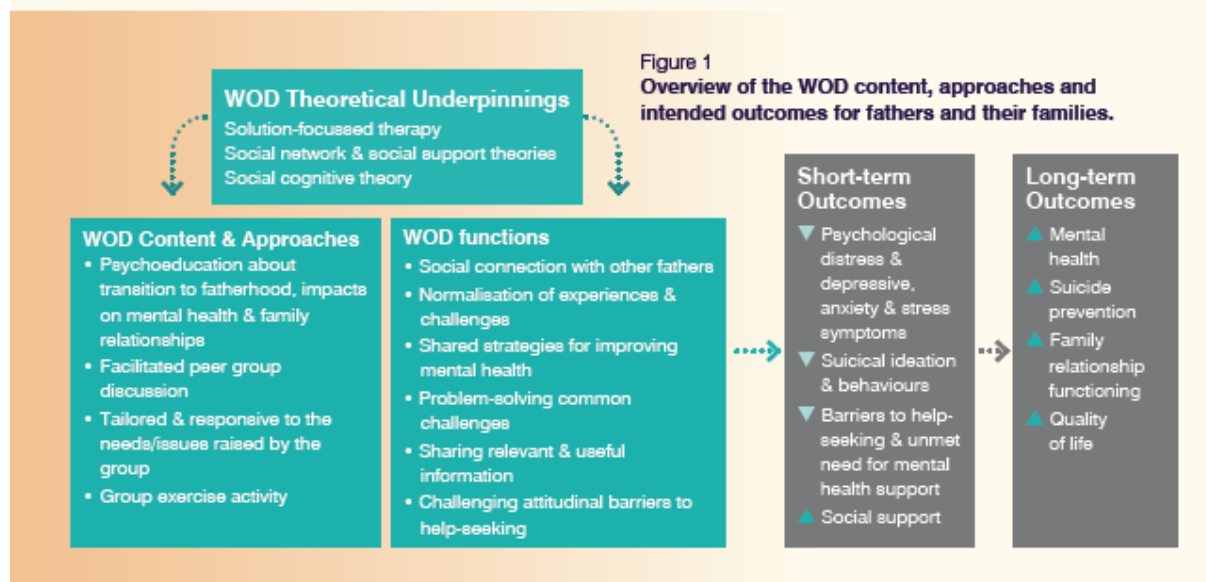
What is Working Out Dads?

Working Out Dads (WOD) is a facilitated peer support group intervention designed to promote the mental health and wellbeing of fathers in the critical early years of their children's lives. WOD is for fathers and other male caregivers of children aged 0-4 years who are experiencing high stress, health and wellbeing difficulties, and/or challenges with parenting and family relationships. It was developed by Tweddle Child & Family Health Service in Victoria.

Over a 6-week period a small group of 6-10 fathers come together to share their experiences of early fatherhood, changes in family relationships, parenting challenges, managing stress, and ways to promote their health and wellbeing. The six sessions are manualised and delivered by trained facilitators with an allied health background. Each session consists of:

- One hour of psychoeducation and discussion
- A 30-minute group exercise session provided by a qualified personal trainer.

Between sessions, fathers can connect with each other via a moderated online group chat, and access the WOD resources such as tipsheets and information about other supports for fathers via SMS.



Why was Working Out Dads developed?

In Australia, 1 in 10 men report mental health difficulties such as stress, anxiety and depression, and poor physical health in early fatherhood.^{1,2,3}

Without effective early support, these difficulties can worsen over time,⁴ and have negative impacts on families.^{5,6,7}

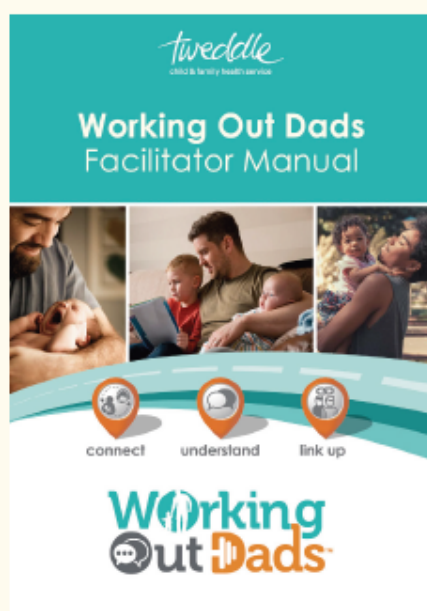
Mental health difficulties can also increase the risk of suicide.^{8,9}

The importance of promoting men's health in early fatherhood has been emphasised in Australian health policies and clinical guidelines such as the National Men's Health Strategy¹⁰ and Australian Perinatal Mental Health Clinical Practice Guidelines.¹¹

Despite this, there is currently no routinely provided care for fathers or any other male caregivers in the health care system (e.g., maternity care; perinatal services; maternal and child health care). There are also no evidence-based interventions specifically targeting fathers' mental health in the early years of parenting.

To address this unmet health care need in Australia, Tweddle Child & Family Health Service developed WOD in collaboration with Andrew King.¹² WOD was informed by Tweddle's survey of fathers attending their service who said that they wanted to:

- a) meet other fathers to share their experiences,
- b) find out ways to promote their mental health and wellbeing and find out ways to promote their mental health and wellbeing, and be the best fathers they can for their families, and
- c) do something active such as physical exercise.



Building an evidence base for Working Out Dads in Australia

WOD is the only rigorously evaluated intervention specifically targeting fathers' mental health in Australia.

Since 2016, two service evaluations with 112 fathers living in metropolitan Melbourne have been conducted.^{13,14} More recently, a randomised controlled trial to assess the effectiveness and cost-effectiveness of WOD with 293 fathers living in metropolitan and regional Victoria was conducted.¹⁵

This trial was supported by funding from the Australian Government Medical Research Future Fund Million Minds Mission (targeted call for Suicide Prevention). A summary of the evidence across these three studies is provided opposite.

Father engagement in WOD

- Since 2016, over 250 fathers have received WOD. The majority were born in Australia, English-speaking and had a high school education or higher.
- About 1 in 3 fathers who enrolled to participate in WOD reported clinically significant mental health difficulties and suicidal ideation before starting the program.
- The majority of fathers (~70%) completed all 6 sessions. Common reasons for not attending sessions included travelling, being busy at work, and illness in the family.
- Approximately 90% of the WOD sessions were delivered as planned.
- The majority of fathers (>75%) were highly satisfied with the content, activities, and how it was delivered.

Experiences of fathers who have completed WOD

“Overall a really great experience. I really would like to continue in a similar program if any are available. The facilitator was great and was great being amongst like-minded people.”

“It was a feeling of belonging. So many ideas that were shared were simple yet effective.”

“Group discussion and sharing helps me understand that I am not alone on the road of fatherhood.”

“Just knowing that there are other dad's out there going through the same stuff that I am. It's hard to open up to 'normal mates' sometimes. But in this facilitated session it felt very easy to talk about these kind of issues.”

Outcomes of participation in WOD

Service evaluations of WOD with 112 fathers using pre-post and follow-up designs^{13,14} have found:

- ▼ Stress symptoms
- ▼ Depressive symptoms
- ▼ Anxiety symptoms
- ▲ Increased perceived social support

In the randomised controlled trial of WOD with 293 fathers, WOD was compared to a brief telephone intervention (mental health check + referral) with a maternal and child health nurse.

Fathers in both interventions reported a decrease in mental health difficulties (using the Kessler Psychological Distress Scale), with overall psychological distress scores moving from the clinical to non-clinical range.

Exploring stress and how it impacts our lives individually as well as fatherhood. Getting us to explore that stress and discuss new ways of looking at it as a group was fascinating.



The main thing I took from the course is the knowledge that other dads have similar struggles to my own, and that we are not alone or unique in some of our thoughts and feeling towards fatherhood. It was an opportunity to be supported and heard.



Prior to this study though, if I had any suicidal thoughts they were related to not coping with the change of being a dad and the stress of the new work/relationship with my partner. This program has had a profound effect on me.



Future development and evaluation of WOD

WOD has shown to be a meaningful program to support men in the critical early years of fatherhood. Ongoing evaluation is critical to building the evidence for WOD. An important next step is to understand how well WOD meets the diverse needs of fathers in our communities such as migrant and refugee fathers, Aboriginal fathers, young fathers, LGBTQIA+ fathers, fathers of children with disabilities and chronic health conditions, and fathers who have experienced childhood adversity and trauma. Continual improvements will be made to WOD to ensure that it is meeting the needs of fathers.

Opportunities for research, policy and practice In Australia Enacting policy directions

Despite the acknowledgement of fathers' mental health in Australian policy, they continue to be neglected in the health care system. Public investment in support for fathers is critical. This should include investments in:

- **Approaches in the universal health care system** to routinely engage with fathers about their mental health and wellbeing.
- **Targeted interventions** for men experiencing mental health difficulties or at risk of mental health difficulties in early fatherhood.
- **Future research to identify and build the evidence for WOD** and other intervention

strategies such as brief assessment and intervention approaches that could be delivered in the universal health care system.

Workforce capacity building Initiatives

Perinatal and early childhood services have been designed with mothers and children in mind. Our research has revealed that health professionals are interested in expanding their role to ensure that fathers' mental health is prioritised. Training and support for health professionals and the organisations in which they are embedded is needed to make a meaningful change in how services are delivered, and to overcome the barriers to engaging with and supporting fathers in the universal health care system.

Wider dissemination of WOD

WOD is a promising and unique intervention addressing an unmet health care need in Australia. Tweddle is committed to enhancing access to the WOD program such that more fathers across Australia may benefit from evidence informed care and improved health and wellbeing outcomes. Tweddle commits to developing and delivering training to other health and care professionals (including access to the detailed program manual) to facilitate this, and ensure that program fidelity supporting the ongoing effectiveness of this program is maintained. This would be provided on a cost recovery / fee for service basis, whilst opportunities for advocating for public funding continues.

For more information about Working Out Dads, please contact Tweddle Child & Family Health Service on (03) 96891577 or email tweddle@tweddle.org.au.

This policy brief has been put together by researchers from the Intergenerational Health Research Group at the Murdoch Children's Research Institute, the SEED Centre for Lifespan Research in the School of Psychology at Deakin University, and Tweddle Child & Family Health Service.

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