June 2025 | **Report**

Randomised controlled trial and implementation and process evaluation

IMPROVING SAFEGUARDING THROUGH AUDITED FATHER-ENGAGEMENT (ISAFE)

Foundations
What Works Centre for Children & Families

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About the Fatherhood Institute

The Fatherhood Institute is a UK charity working to build a society that values, prepares, and supports men as involved fathers and caregivers.

Evidence shows that involved fatherhood has unique and significant impacts on children, mothers, and fathers themselves; improves children's wellbeing and outcomes; and helps progress towards gender equality at home and in the workplace.

Our work focuses on research, policy, and practice. We publish research reviews, take part in new studies, and test promising family interventions; advocate for policy change; produce practice resources; and train practitioners in perinatal, early years, education, and social care services.

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GLOSSARY

Abbreviation/acronym/terms	Description
CASCADE	Children's Social Care Research and Development Centre, Cardiff University
DSA	Data Sharing Agreement
EQ	Evaluation Question
FEQ	Father Engagement Questionnaire
FI	Fatherhood Institute (the delivery partner)
FWER	Family-Wise Error Rate
IPE	Implementation & Process Evaluation
ISAFE	Improving Safeguarding through Audited Father-Engagement
LA	Local authority
OLS	Ordinary Least Square regression method
MoU	Memorandum of Understanding
RCT	Randomised controlled trial
SW	Social worker
ToC	Theory of change

EXECUTIVE SUMMARY

Introduction

Evidence suggests that practitioners in children's social care services fail to adequately and consistently engage, assess, support, and challenge men in families involved with their services (Brandon et al., 2020; Sidebotham et al., 2016; NSPCC, 2017; Ashley et al., 2011; Brandon et al., 2017; Osborn, 2014; Baynes & Holland, 2012). This is despite well-established literature showing fathers' positive impact on children's development and wellbeing (Sarkadi et al., 2008; Keown et al., 2018; Deneault et al., 2021; Cabrera et al., 2007).

In fact, studies show that a number of services, including children's social care, tend to focus on mothers and deprioritise, or sometimes actively exclude, fathers – even when their exclusion leads to potential risks of harm for the child (Baran & Sawrikar, 2024; Brandon et al., 2020; Sidebotham et al., 2016; NSPCC, 2017; Ashley et al., 2011; Brandon et al., 2017; Swann, 2015; Osborn, 2014; Baynes & Holland, 2012). In children's social care, most social work interventions focus on whole families, leaving a significant evidence gap around father-specific approaches.

It is critical that services actively engage with fathers. Without appropriate engagement, basic information about fathers may not be gathered, acted on or shared. This can result in overlooking the potential risks they pose or missing opportunities to include fathers in decisions about protecting their children, identify other risks posed to their children (by mothers and/or other father figures), or support a positive relationship (Strega et al., 2008).

In response to incidents of services' failure to routinely and systematically engage men in families (Dickens et al, 2022; NCSPRP, 2022; DfE, 2008), the Fatherhood Institute and Children's Social Care Research and Development Centre at Cardiff University (CASCADE) developed ISAFE (Improving Safeguarding through Audited Father-Engagement). ISAFE is a training and organisational development programme that aims to improve how local authority children's services (with a focus on child protection) engage with fathers (Scourfield et al., 2024).

The ultimate aim of ISAFE is to better equip social work practitioners to improve child protection. ISAFE intends to achieve this by better identifying the risks that some fathers pose as well as the resources they offer. The intervention, delivered online, includes different key components across two pathways:

- **Practice pathway:** involves two training sessions for social workers on father engagement techniques (modules SW1 and SW2) and an online resource library to encourage ongoing self-led learning and development.
- **Systems pathway:** involves (1) one training session with quality assurance (QA) staff and two audits focused on monitoring father engagement before and after the remaining training sessions, (2) one training session for 'father-inclusion champions' directed at

middle-management social workers, and (3) a webinar delivered to local authority senior leaders to reflect on the training and audits and discuss ways to embed and sustain associated learning.

Objectives

This study was delivered to fill the gap in the robust evidence base available on father-focused interventions in children's social care. The study aimed to:

1. Assess the impact of ISAFE on father engagement practices compared with business as usual.
2. Examine the process of implementing ISAFE in children's services across multiple local authorities and the factors that supported or challenged delivery.
3. Estimate the costs of delivering ISAFE.

Methods

The evaluation included three strands:

1. **Impact evaluation:** conducted using a non-blinded, two-armed cluster randomised controlled trial (RCT). A total of 63 teams across seven local authorities were randomised, resulting in 31 teams in the treatment group and 32 teams in the control group. The intervention was delivered in two cohorts to accommodate capacity within the delivery team – Cohort A included four local authorities and Cohort B included three local authorities.
2. **Implementation and process evaluation (IPE):** conducted to assess the feasibility of delivering ISAFE, the intervention's reach, explore the fidelity and quality of its delivery, and assess the interventions' expected mechanisms of change and any variation in outcomes. Data collected to inform the IPE included: 150 participant responses to a feedback survey after the end of the intervention; interviews with 38 training participants and 10 senior leaders; two focus groups and two interviews with the delivery team at the Fatherhood Institute; interviews with eight fathers working with children's services; and administrative data such as attendance collected by the delivery team.
3. **Cost analysis:** conducted to assess the cost of delivering ISAFE per local authority and participant. Programme implementers provided costs for set-up (one off) and recurring costs for delivering ISAFE.

Outcomes

To assess ISAFE's impact on father engagement practices, the study used an adapted version of the Father Engagement Questionnaire (FEQ). The questionnaire measured multiple self-reported dimensions of father engagement:

1. **Confidence in engaging fathers:** Participants' confidence in engaging fathers (FEQ1 subscale: 'Confidence in Working with Fathers'),
2. **Competence in using father-inclusive strategies:** Participants' competence in using father-inclusive strategies (FEQ2 subscale: 'Competence in Using Engagement Strategies'),
3. **Perceived effectiveness of father-inclusive strategies:** Whether participants perceived father-inclusive strategies as being effective (FEQ3 subscale: 'Perceived Effectiveness of Engagement Strategies')
4. **Use of father-inclusive strategies:** Participants' frequency of use of father-inclusive strategies (FEQ4 subscale: 'Frequency of Strategy Use')
5. **Father-inclusive organisational practices:** Finally, whether father-inclusive strategies are embedded within participants' teams, to reflect cultural changes in organisational practices (FEQ5 subscale: 'Organisational Practices for Father Engagement')

The evaluation covered all the content delivered in the practice pathway (SW1 and SW2 modules and the resources library), as well as two of the key components of the systems pathway (the QA audit training and Champions training). The evaluation did not cover the senior leader webinar.

Findings

Summary of key findings

- ISAFE showed promising results, suggesting that the father-focused intervention improved participants' self-reported confidence and competence in engaging with fathers. The programme also led to improvements in perceptions about organisational practices concerning father engagement, suggesting a shift in participants' team culture around father inclusion.
- There was no significant change in the perceived effectiveness or frequency in using father engagement strategies. Similarly, the study did not find changes in the number of fathers' contact details recorded in participants' case files.
- While the evaluation found statistically significant effects, it is important to note that the magnitude of each effect was very small. Overall, these findings suggest that ISAFE is effective in achieving small benefits in the short term.
- The implementation and process evaluation also found positive results, with the intervention having reached 80% of its total intended audience and 79% of survey respondents that took part in the programme reporting being fairly or very satisfied with the training they received. The intervention was described as a helpful reminder to think more about how social workers could improve their relationships with fathers.
- ISAFE was found to be a relatively low-cost option to achieve small but significant improvements in social workers' confidence, competence, and organisational practice relating to father engagement within children's services.

The evaluation of ISAFE revealed some promising results. The study found statistically significant, though small, improvements in social workers' self-reported **confidence** and **competence** in engaging fathers. Specifically, participants in the intervention group showed improvements on two Father Engagement Questionnaire (FEQ) subscales: 'Confidence in Working with Fathers (FEQ1), and 'Competence in Using Engagement Strategies (FEQ2). This corresponded to increases of 0.206 ($p=.001$) and 0.21 ($p<.001$) in confidence and competence scores (on a 5-point scale) compared to the control group. Furthermore, the programme led to improvement in perceptions about **organisational practices** concerning father engagement with an increase of 0.18 ($p=.032$) in the organisational practices (FEQ5 subscale). These findings translate to Glass's Delta effect sizes of 0.307, 0.334, and 0.243 for the FEQ1 ('Confidence in Working with Fathers'), FEQ2 ('Competence in Using Engagement Strategies'), and FEQ5 ('Organisational Practices for Father Engagement') subscales, respectively.

However, no statistically significant changes were observed in participants' **frequency of using** father engagement strategies (FEQ4) or in participants' **perceived effectiveness** of those strategies (FEQ3) (FEQ4: 0.111, $p=.309$, Glass's Delta: 0.137; FEQ3: 0.135, $p=.069$, Glass's Delta: 0.177). This may reflect the short follow-up period, insufficient time to implement and embed changes, or a mismatch between the strategies measured and those actually used. Secondary outcomes supported these findings: while improvements were seen in self-efficacy (0.227, $p<.001$, Glass's Delta: 0.348) and team culture relating to father engagement (0.179, $p<.05$, Glass's Delta: 0.303), no change was found in the number of fathers' contact details recorded in participants' case files, as self-reported using a survey. This highlights a potential gap between changes in attitudes and observable practice.

Although the evaluation found statistically significant effects, it should be highlighted that the magnitude of the effect was small – on average, the scores increased by 0.21 on a 5-point scale. These observed small effect sizes were statistically significant because of the low variability in the FEQ scores. In other words, participants typically reported similar scores, meaning little variation within the sample, making small differences were significant. Taken together, findings suggest that ISAFE is effective in achieving small benefits in the short term.

Implementation fidelity was generally strong, with some adaptations such as flexible attendance in later cohorts and inclusion of non-social work staff. Attendance reached 80% of the intended audience, although attendance varied across sessions. In the practice pathway, 55% of participants attended both SW1 and SW2 sessions; in the systems pathway, 67% of participants attended the QA audit training, and 54% attended the Champions training. Satisfaction with the training was generally high (79% fairly or very satisfied), especially for QA audit training and the first module of the practice pathway (SW1). Feedback for SW2 was more mixed, partly due to repetition of familiar content like motivational interviewing. The champions training also had mixed success, with participants expressing uncertainty about their roles as a father champion. Finally, there appeared to be very limited use of the resource library among participants within the evaluation timeframes.

Interviewees often described the training as a refresher rather than new learning, noting increased awareness and discussion within teams about engaging fathers, though they acknowledged that the

training sometimes oversimplified the systemic challenges they face – such as high caseloads, poor-quality referrals, and frequent staff turnover. While these limitations of the training might explain the small effect, interestingly, these findings also suggest that fostering intrinsic motivation among social workers to engage fathers may be impactful even without changes in the use of specific strategies, as many participants felt able to apply their existing knowledge and skills to working effectively with fathers. Importantly, this does not mean that interventions on specific strategies or skills for working with fathers do not work.

From a cost perspective, ISAFE was a relatively low-cost intervention, delivered across seven local authorities for a total of £41,058 (approx. £5,865 per local authority, £149 per participant who attended at least one training session). Most costs were associated with staff time for delivery and coordination. Given the modest but statistically significant effects, ISAFE represents a cost-effective way to prompt short-term improvements in key workforce attitudes and organisational practices.

The results suggest that even modest improvements in confidence and team culture may foster more reflective, proactive engagement with fathers – particularly when social workers feel empowered to apply existing knowledge to bolster their engagement with fathers. Participants generally reported applying the training by being more mindful and deliberate in involving fathers, even if they were not using different tools or approaches. This underscores the value of supporting intrinsic motivation and professional reflection, while recognising that more intensive or sustained interventions may be needed to change day-to-day practice.

Findings should be considered alongside limitations to the study. The trial was affected by high staff turnover, which led to participant attrition and challenges in monitoring training attendance. The reliance on self-reported data raises the possibility of response bias, particularly among those who received the training. No objective measures of skill application (e.g. recorded sessions or simulations) were used, and the short follow-up timeframe meant the sustainability of observed effects remains unknown. These issues limit the conclusions that can be drawn about actual changes in practice and longer-term outcomes for children and families.

Despite these caveats, the evaluation makes an important contribution to the limited evidence base on father-focused interventions in child protection. The findings show that brief, well-targeted training can yield measurable gains in practitioner confidence and cultural readiness to engage fathers. However, future research is needed to test whether these early shifts lead to more consistent and impactful practice. In particular, evaluations should explore long-term impact, assess whether refresher training or ongoing support is needed, and capture how father-inclusive practice plays out in real-world interactions and outcomes for families. There would also be value in looking more closely at practitioners across the workforce who engage with children and families and their application of skills during their day-to-day work practice with fathers. Replication of these positive findings would strengthen the evidence base on father engagement training, potentially beyond small, short-term benefits.

INTRODUCTION

Context and rationale for intervention

For several decades, serious case reviews and inquiries into child deaths and serious injuries in the United Kingdom (UK) have highlighted a concerning trend: the failure of social work services to consistently and adequately engage, assess, support, and challenge men in families (Brandon et al., 2020; Sidebotham et al., 2016; NSPCC, 2017; Ashley et al., 2011; Brandon et al., 2017; Osborn, 2014; Baynes & Holland, 2012). This systemic lack of focus on fathers[1] has been repeatedly identified as a critical factor in numerous high-profile child murder cases, including Peter Connelly, Kyrell Matthews, Arthur Labinjo-Hughes, Star Hobson, and Logan Mwangi (see for example: DfE, 2008; Dickens et al, 2022; NCSPRP, 2022). A 2021 report by the National Child Safeguarding Practice Review Panel called for urgent reform to services' response to men (NCSPRP, 2021).

While acknowledging that some fathers can pose a risk to children – evidenced by statistics showing infants are more likely to be killed or injured by fathers than mothers (Davies & Goldman, 2021) – it is crucial to recognise that fathers, like mothers, and paternal relatives can also be important resources for their children. There is a well-established evidence base demonstrating the importance of the role of fathers on children's development and wellbeing (Sarkadi et al., 2008; Keown et al., 2018; Deneault et al., 2021; Cabrera, 2007; Lamb, 2010). As such, it is critical that services actively engage with fathers. Without appropriate engagement, basic information about fathers may not be gathered, acted on, or shared. This can result in overlooking the potential risks they pose or missing opportunities to include fathers in decisions about protecting their children, identify other risks posed to their children (by mothers and/or other father figures), or support a positive relationship (Strega et al., 2008).

Engagement between practitioners and parents more generally within children's social care and child protection may pose challenges as families are typically involved involuntarily, and professionals can therefore be met with parental resistance (Platt, 2012; Forrester et al., 2012). The reasons for limited father engagement are multifaceted, including the attitudes and behaviour of fathers themselves (Gordon et al., 2012; Maxwell et al., 2012a). However, practitioners' beliefs, attitudes, and individual practices, coupled with a lack of emphasis on father-inclusion within local authorities, are considered significant contributing factors (Tully et al., 2018; NCSPRP, 2021). This highlights the need for a shift in perspective across the children's social care workforce who engage with children and families to more effectively engage fathers and other male caregivers, which provided the rationale for a father-focused training and organisational development programme.

[1] In the context of this project, the term 'fathers' includes other male caregivers such as stepfathers, parents' partners, and other significant men in children's lives with caregiving responsibilities.

There is a relatively small evidence base on the effectiveness of interventions that aim to improve how social workers engage with fathers within the child protection context. This is in part due to the limited number of interventions focused on engaging fathers specifically, given that most training and models for social work encompass the whole family (see more under Business as usual). However, this intervention builds on two interventions that showed promise in pilot and feasibility studies including a two-day training course delivered by CASCADE academics (Maxwell et al., 2012b; Scourfield et al., 2012) and a systemic workforce and policy intervention delivered by the Fatherhood Institute (Scourfield et al., 2015). Both evaluations reported improvements in practitioners' self-efficacy working with fathers. Scourfield et al. (2012) found increased self-reported engagement of lower-risk fathers, especially 'own household' fathers, and Scourfield et al. (2015) found increased father participation in case conferences. Swann (2015) conducted research in a London local authority exploring why and how fathers have been excluded from children and family social work and what strategies, methods, conditions, and techniques promote inclusive practice for fathers. The study included participation of practitioners as both researchers and participants as part of a cooperative inquiry supported by 'a before and after' case file audit, which found an increase in fathers identified and assessed.

The wider evidence base on training programmes for social workers is also relevant. For example, there is an extensive evidence base on motivational interviewing, including promising evidence on its relevance in child and family social work (Forrester et al., 2008; Forrester et al., 2012). Forrester et al. (2018) found that intensive, multi-day training primarily focused on motivational interviewing resulted in small improvements in motivational interviewing skills. However, this unfortunately did not translate to any impact on engagement of parents or other child and family welfare outcomes. This raises questions about the relationship between worker skills and outcomes for parents and children, which is a key assumption underpinning the ultimate aims of training for social workers, including this intervention.

Outside the UK, there are other similar initiatives to train professionals, such as The Fatherhood Project and the National Fatherhood Initiative in the US. Non-UK studies have also found promising results for father-focused training in child welfare services (English et al., 2009) and father engagement in parenting interventions (Burn et al., 2019) and parent–child therapy (Klein et al., 2022).

Given the promising but limited evidence base typically made up of single-arm evaluations, this evaluation presented an important opportunity for a robust two-armed experimental design of a father-focused social worker training intervention within the UK child protection context.

Overview of ISAFE

The subsections below provide a summary of the key components of the intervention. More details on the intervention are available in the intervention protocol.[2]

ISAFE (Improving Safeguarding through Audited Father-Engagement) is an online training and organisational development programme designed to enhance how local authority children's services work with and engage fathers. The intervention was developed by the Fatherhood Institute and CASCADE (the Children's Social Care Research and Development Centre, based at Cardiff University).

Target population

ISAFE is targeted at social work practitioners in local authority children's services, including children's trusts. This encompasses professionally registered and qualified children and family social workers as well as trainee social workers, including apprenticeships or those on the Step Up to Social Work programme.[3]

Intervention activities

The ISAFE training is provided in four parts, which are delivered sequentially over approximately three to four months:

- Quality Assurance training designed for quality assurance (QA) staff and a designated 'data champion'. This session provides guidance on auditing father-inclusion in case files and also prepares QA staff to complete a case file audit looking specifically at the quality of information recorded about fathers. A second case file audit is also conducted after all training sessions are delivered.
- Social worker training (two sessions). The first session (SW1) explores the social framing of fatherhood, stereotypes, assumptions, and their impact on fathers' interactions with services. This session includes activities such as considering how attendees' personal experiences with fathers might influence their professional practice and group discussions on gaps in individual and systemic practices. The second session (SW2) focuses on developing practical skills for engaging with fathers, primarily through an introduction to some basic elements of motivational interviewing. Motivational interviewing is a technique designed to strengthen an individual's intrinsic motivation to change by exploring and resolving their ambivalence towards goals and has been tailored to use within UK children's social care contexts (Forrester et al., 2021). Activities include role-playing scenarios and

[2] See: https://foundations.org.uk/our-work/current-projects/isafe-improving-safeguarding-through-audited-father-engagement/

[3] Step up to Social Work is a 14-month, full-time programme for adults to train to become a social worker who do not have a degree in social work. See: https://www.gov.uk/guidance/step-up-to-social-work

case studies to equip attendees with communication and engagement strategies to promote positive interactions with fathers involved in child protection cases.

- Father-inclusion champions training designed for team leaders and senior practitioners and aims to establish them as 'father-inclusion champions' within their teams. The training focuses on equipping champions with the skills to support teamwide inclusive practices, such as using supervision and reflective learning to support practitioners, and to advocate for father-inclusive practices within systems, processes, and daily interactions.
- Senior leaders webinar for senior managers and team leaders. This session reflects on delivering ISAFE and how this has affected LAs. The session also focuses on identifying strategies to embed, sustain, and build upon the intervention. The webinars were out of scope of the trial because it was reasonable to expect that leaders could influence teams in both treatment and control groups. As such, webinars took place after endline data collection to reduce the risk of exposing control group teams to the intervention. The timing also meant this element was only lightly explored through reflections of the delivery team.

Delivery staff

ISAFE is delivered by seven experienced Fatherhood Institute trainers, who have a background in social work, health, or education, and have undergone specific training to deliver the ISAFE intervention. Trainers followed the ISAFE training manual to guide them through delivery and help ensure fidelity to the intervention content.

Delivery format

All ISAFE training sessions are delivered online via Microsoft Teams using PowerPoint slides and interactive exercises. The Fatherhood Institute planned to deliver social worker training sessions to whole teams, including groups of up to 15 participants. To do so, dates were prearranged to hold time in participants' calendars. The Fatherhood Institute provided the senior managers and team leaders with information about the programme, including descriptions of each session and asked them to hold the dates in participants' calendars and promote attendance. Attendees were encouraged to turn on their camera and attend the whole session. Trainers also recorded participant attendance.

Participants are also given access to an online resource library through a password-protected website. This includes a range of resources that participants can access as and when they wished, including short films co-produced with fathers with experience of navigating social care systems, evidence summaries, and examples of best practice for engaging fathers.

Programme theory

As detailed in the programme theory of change (appendix A), the ultimate aim of ISAFE is to better equip social work practitioners to improve child protection, by better identifying the risks that

some fathers pose as well as the resources they offer. It aims to do so by enhancing father engagement through a two-pronged approach: a practice pathway and a systems pathway.

Practice pathway

The two-day social worker training modules (SW1 and SW2) provide the foundation for the practice pathway. This pathway seeks to improve practitioners' knowledge and awareness relating to father engagement, and increase their motivation, confidence, and skills to engage fathers. In turn, this is expected to result in more engagement with fathers and more father-inclusive practice.

Systems pathway

The systems pathway seeks to foster organisational change to support father-inclusive practices. This includes the QA training and case file audits and 'father-inclusion champions' training, as well as the leaders webinar. The QA activities aim to raise awareness of the lack of father inclusion in record keeping, increase motivation to obtain this information, and ultimately improve record-keeping processes to capture information on fathers more consistently (e.g. regular case file audits). The champions training and leaders webinar seek to create team cultures that promote father-inclusive approaches within organisational systems and processes, including better monitoring.

Together, it is hoped that these pathways will enable better identification of risk in families, and better-informed, more assertive decision-making. In some cases, this may lead to greater inclusion, where it is safe, of fathers and/or other male caregivers in child protection plans. In other cases, this may lead to strengthening protective measures against risks posed by fathers, through better understanding the nature of that risk.

The Fatherhood Institute has also recognised that practitioner training on its own can be limited in its effectiveness (e.g. Humphries & Nolan, 2015). Wider system-level changes are typically also required – for example, adapting referral forms to routinely capture fathers' information and setting clear expectations about incorporating fathers as a standard practice through team discussions and supervisions.

Business as usual

Social workers obtain a social work degree approved by Social Work England, which covers work in adult social care as well as with children and families. Newly qualified social workers (NQSWs) also participate in a 12-month employer-led programme in line with the Assessed and Supported Year in Employment (ASYE) framework, where they are assessed using the Child and Family Post Qualifying Standards (DfE, 2018a). All social workers must also complete two pieces of continuing professional development each year to maintain professional registration. While training covers skills like relationship building, communication, and risk assessment, they typically do not include a specific focus on father inclusion.

Furthermore, national policies do not explicitly mandate comprehensive father engagement. While 'Working Together' (DfE, 2018b), the key safeguarding policy document for England, mandates communication with all parents, including fathers, possessing Parental Responsibility under specific circumstances, it lacks explicit directives on actively engaging fathers. This absence of a clear national framework, coupled with the lack of mandatory data collection on father engagement in local authorities' annual Children in Need census returns, contributes to a context where father inclusion within social work practices varies across local authorities and is often minimal.

There are examples of local practice and approaches that focus on engaging fathers and/or parents more generally that can be clearly applied to fathers. Examples include strength-based practice approaches that focus on promoting the value and role of different family members, including the Signs of Safety framework (e.g. Bradford Children's Service, 2023) and the Family Safeguarding Model (Hertfordshire County Council, 2019). Like ISAFE, some of these approaches include motivational interviewing, meaning many social workers were familiar with this technique. In addition to this, best practices for working with fathers have been produced by academic institutions and local authority bodies (Clapton, 2017; Swann, 2015). Other local authorities work with Dads Matter, who deliver parenting groups or courses for fathers rather than training for practitioners. As such, discussions about father inclusion and engagement were likely occurring within local authorities but most would not have experienced specific training for social workers.

Local authorities who signed up to take part in the ISAFE trial were likely already interested in father-inclusive approaches but were not delivering any other father-specific interventions during the trial timeframes.

Evaluation aims and design

The evaluation had three overarching aims, which corresponded to three strands:

1. An impact evaluation using a cluster randomised controlled trial (RCT) to assess the effectiveness of ISAFE on father engagement practices compared with business as usual.
2. An implementation and process evaluation (IPE) to examine the delivery of ISAFE in children's services across multiple local authorities and the factors that supported or challenged implementation.
3. A cost analysis to estimate the costs of delivering ISAFE.

The evaluation protocol outlining the research methods was finalised in April 2023 prior to randomisation and was published on the Foundations website.[4] Table 1 summarises the evaluation timetable, including key data collection points for each strand. The intervention was delivered in two cohorts to accommodate capacity within the delivery team – Cohort A included four local

[4] See: https://foundations.org.uk/our-work/current-projects/isafe-improving-safeguarding-through-audited-father-engagement/

authorities, and Cohort B included three local authorities. As such, randomisation, baseline, and endline measures occurred in two waves, once per cohort.

The evaluation team regularly met with the Fatherhood Institute and Foundations, and sought advice from the ISAFE advisory group set up by the Fatherhood Institute.

Table 1: Key dates in evaluation timetable

Activity	Dates (Cohort)	Strand
Intervention and evaluation protocols published	April 2023	N/A
Baseline survey	A: April–May 2023 B: August–September 2023	RCT
Randomisation	A: May 2023 B: September 2023	RCT
Feedback survey	A: June 2023 B: February 2024	IPE
Endline survey	A: August–September 2023 B: March–April 2024	RCT
Focus groups & interviews with the delivery partner	Focus group 1: July 2023 Focus group 2: January 2024 Interviews: July 2024	IPE
Interviews with training participants	A: July–August 2023 B: May 2024	IPE
Delivery costs shared by the delivery partner with the evaluator	June 2024	Cost analysis

Ethics and data protection

The evaluation's approach to research ethics was reviewed by Ipsos UK's Ethics Group in December 2022, which ensured the evaluation design and data collection approaches were ethical. The evaluation complied with the Government Social Research (GSR) ethical principles and other ethical codes, such as the Social Research Association (SRA) ethical guidelines, the Economic and Social Research Council (ESRC) Research Ethics Framework, and the Market Research Society (MRS) code of conduct.

A Data Sharing Agreement (DSA) and Data Protection Impact Assessment were set up between Foundations, Ipsos UK, and the Fatherhood Institute. The evaluation sought to limit the sharing of

personal data using unique IDs for the impact evaluation. Personal data of staff, stakeholders, and young people, namely contact details, were shared for the purpose of inviting participants to take part in interviews. All personal data was transferred and stored securely.

IMPACT EVALUATION

Methods

The subsections below provide a summary of the key components of the impact evaluation's methodology. Further detail on the impact methodology can be found in the evaluation protocol.[5] The evaluation protocol provides additional detail on the trial design as well as the rationale for decisions on the design.

Impact evaluation questions

The impact evaluation (IE) sought to answer the following questions:

- **Primary analysis:** IE EQ1: What effect on social workers does taking part in ISAFE have on their father engagement practices (measured by the five scales of the Father Engagement Questionnaire), compared to social workers who do not receive the intervention (two months post-intervention)?
- **Secondary analysis:**
    - IE EQ2: What effect on social workers does taking part in ISAFE have on rates of father engagement (measured by the self-reported number of fathers' contact details recorded), compared to social workers who do not receive the intervention (two months post-intervention)?
    - IE EQ3: What effect on social workers does taking part in ISAFE have on their self-efficacy (measured by a scale developed by Scourfield et al., 2012) associated with engaging fathers in child protection assessments, interventions, and safeguarding (intermediate outcome/mechanism), compared to social workers who do not receive the intervention (two months post-intervention)?
    - IE EQ3: What effect does taking part in ISAFE have on organisational/team culture (measured by a scale developed by Scourfield et al., 2012) relating to father engagement (intermediate outcome/mechanism), compared to social workers who do not receive the intervention (two months post-intervention)?
    - IE EQ4: Do outcomes (and experiences) vary by characteristics of social workers (gender, age, ethnicity, experience (i.e. years since qualified))?
    - IE EQ5: Do outcomes vary across teams and/or local authorities?

[5] See: https://foundations.org.uk/our-work/current-projects/isafe-improving-safeguarding-through-audited-father-engagement/

Summary of trial design

Evaluation design	Non-blinded, two-armed cluster RCT.
Primary outcome measures	Father Engagement Questionnaire (FEQ; Jiang et al., 2018), a practitioner-reported measure of father engagement practices with five subscales: • Confidence in Working with Fathers (FEQ1) • Competence in Using Engagement Strategies (FEQ2) • Perceived Effectiveness of Engagement Strategies (FEQ3) • Frequency of Strategy Used (FEQ4) • Organisational Practices for Father Engagement (FEQ5). The evaluation team made slight modifications to fit the study context and cognitively tested the baseline survey through 20 interviews with child and family social workers (further detail provided in the evaluation protocol).
Secondary outcome measures	• Rates of father engagement, measured through survey questions about social workers' caseloads and interactions with fathers[6] • Self-efficacy in working with fathers, assessed using a 10-item scale adapted from Scourfield et al. (2012) • Team culture about working with fathers, evaluated using an 8-item scale developed by Scourfield et al. (2012).
Sample information	Professionally registered and qualified children and family social workers, as well as trainee social workers, including apprenticeships.
Randomisation	Clusters of teams of social workers were randomly allocated to treatment or control using local authorities and team type as strata. Randomisation was conducted in two stages, reflecting the two cohorts of delivery.
Number of clusters	63 teams of social workers across seven local authorities.
Number of participants	426 participants completed the baseline survey, 394 completed the endline survey, and 312 completed both baseline and endline.

[6] Respondents were asked to report the number of children, families/households, and fathers within their current caseload and then indicate the number of fathers who: a) are named in the child(ren)'s case file; b) have known contact details; c) they have engaged with in discussions about parenting, childcare, and their behaviour; and d) attended their most recent meeting. These questions can be found in appendix B of the evaluation protocol (see: https://foundations.org.uk/wp-content/uploads/2024/03/ISAFE-Evaluation-Protocol-1-v2-Feb-2024.pdf).

Data sources and collection methods	Prior to randomisation, all teams were invited to take part in an online survey to capture baseline outcomes, demographics, and other characteristics such as the length of time qualified as a social worker. Endline outcomes were also gathered via an online survey post-intervention.
Data analyses methods	The primary analysis assessed the difference in post-implementation FEQ scores between the treatment and control groups, adjusting for baseline scores and stratification variables. Additional analyses explored treatment on the treated and local average treatment effects, considering factors such as non-compliance and crossovers. Secondary outcomes were analysed using similar regression models. Subgroup analyses, though not powered to detect differences, explored potential impacts across various demographics. Finally, sensitivity analyses considered attrition and missing data, while dosage response analysis examined the relationship between session attendance and outcomes. The analyses were carried out using Stata's cluster robust regression model for analysis of outcomes, with the treatment group indicator as a main effect and baseline measure as the covariate.[7]

Deviations from the evaluation protocol

There were several key deviations from the evaluation protocol, detailed below. There were also several limitations to the trial design, which are detailed in the Discussion section.

Sample size

Sample size estimates assumed a total of eight local authorities, each identifying six teams to take part in the trial, totalling 48 teams (24 in each treatment arm). In practice, only seven local authorities participated in the trial due to a late withdrawal prior to baseline data collection (further discussed in the IPE chapter). The number of social workers per team also varied more significantly than the anticipated average of 11–12, and there was significant staff turnover during the trial period. The evaluation team calculated a minimum detectable effect size (MDES) of 0.26 standard deviation units, assuming attrition yielded approximately 480 participants with outcome data. In practice, 426 participants completed the baseline survey, 394 completed the endline survey, and 312 completed both baseline and endline.

Stratification

At protocol stage, the evaluation team planned to stratify by local authority and within each local authority. However, it was expected that this may use an ordering of social work teams by the associated deprivation rank of their area of operation. Instead, there was more heterogeneity in the teams than anticipated at the protocol stage, and while efforts were made by all partners to identify teams with broadly similar responsibilities, there was likely higher levels of variation than original

[7] No stratification variable was included in the model because of the different stratification descriptions used between the cohorts.

expectations. To avoid the chance allocation of all similar types of teams to one or the other of the trial arms, allocation stratified by both local authority and team. Hence, within each local authority, the teams were also stratified by team type/responsibility. For the first cohort, within each local authority, an odd–even allocation was used with the random start point generated separately for each local authority. The second cohort had fewer team types but more teams per type, so were allocated to treatment based on whether they fell above or below the median random number within the implicit stratum list. The allocation of trial arms to above or below the median itself varied randomly by each stratum, i.e. in one stratum a number less than the median could be treatment, but in another stratum, a number less than the median could be control.

Data collection

The study design was altered to include only two timepoints for outcome measures – at baseline and a two-month post-intervention endline survey. This change from the original plan of three surveys (baseline, immediate endline, and three-month follow-up) was made after baseline data collection highlighted response rate challenges. To prioritise achieving a sufficient response rate for endline data, it was agreed that asking respondents to complete two similar surveys in a short space of time risked disengagement and poorer overall response rates. The second survey was then repurposed as a short feedback survey to inform the IPE (discussed in the next chapter). It is possible that following up two months post-intervention instead of three months had implications for outcome maturation, though this decision was in part made to allow the final element of the intervention – the leaders' webinar – to take place.

Analysis

The evaluation protocol originally proposed to deal with missing data using a binary missing variable indicator in the regression model. Given the relatively complex pattern of missing data, instead a multiple imputation approach was carried out using the Multiple Imputation by Chained Equations (MICE) procedure in Stata.

Results

Participants

The real-world context of the evaluation resulted in a sizeable proportion of social workers joining and leaving teams involved in the trial during the study period. This process resulted in a complex pattern of loss-to-follow-up (LTFU). For the purposes of the planned analysis, interest centres on complete case analysis, i.e. with both baseline and endline data available.

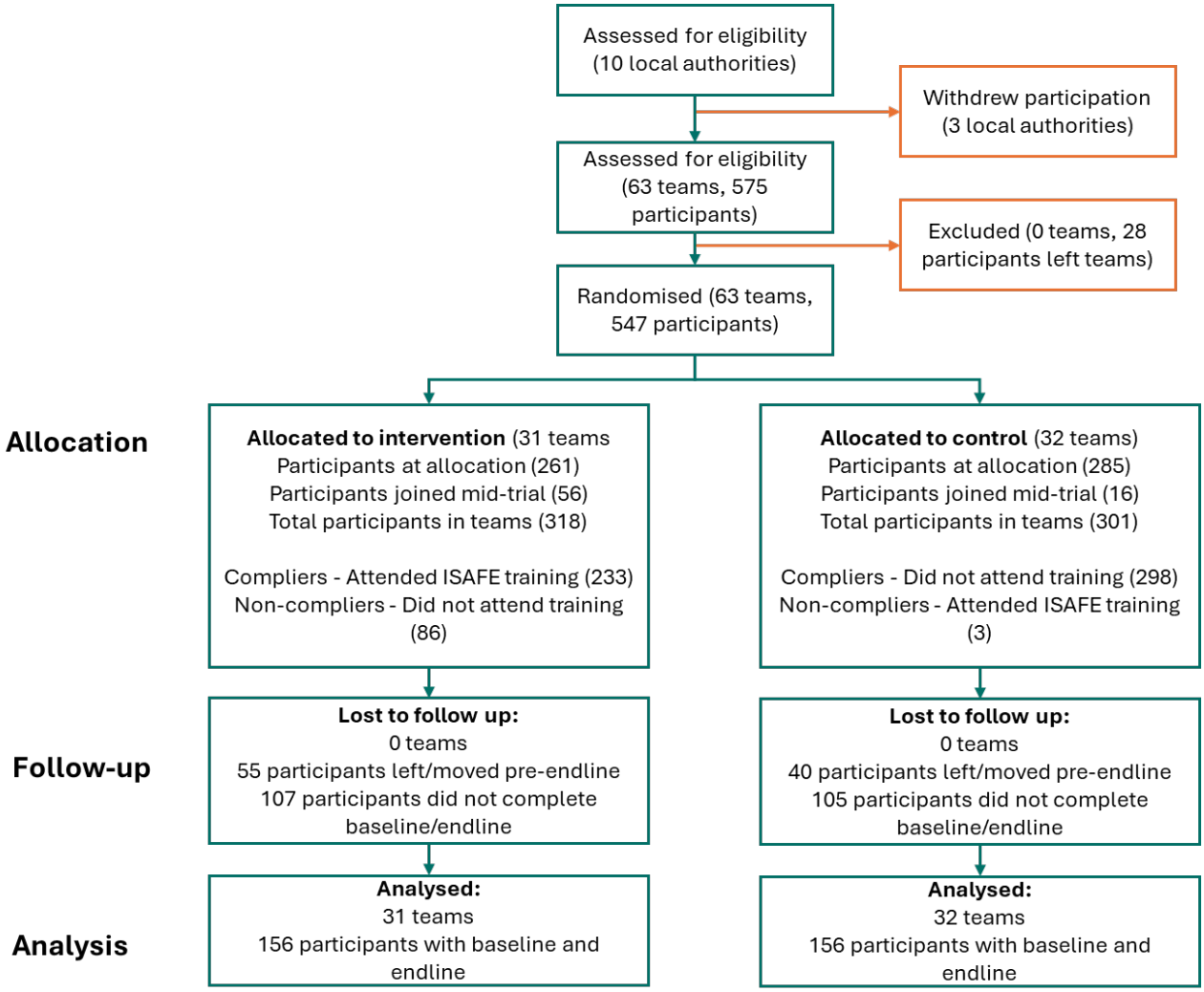
The original sample provided by the local authorities included 575 participants from 63 teams across seven local authorities. Prior to baseline data collection, this was updated to show 28 participants had left teams, meaning 547 participants were eligible to take part. In total, 427 completed the baseline survey and 120 did not. Subsequently, during the trial period, 72 new

participants joined the teams involved in the trial. This resulted in 619 registered in one of the 63 clusters of teams across the seven local authorities at some time during the evaluation period. However, 87 participants also left the local authority or moved teams during the trial pre-endline. As such, 532 participants were invited to complete the endline survey. In total, 509 participants completed baseline and/or endline surveys, and 312 participants completed both.

Of the 63 teams (number of participants = 619) randomised, 32 teams (number of participants = 301) were randomised to the control group and 31 teams (number of participants = 318) were randomised to the treatment group. However, 110 individuals were excluded from the primary analysis as they didn't complete either baseline or endline survey. In total, 82 individuals were excluded as they completed the endline survey but didn't complete the baseline survey. In total, 115 individuals were excluded as they completed the baseline survey but didn't complete the endline survey. A small number of participants with endline data could not be matched to a team and were therefore excluded. A sensitivity analysis, including these individuals where baseline or endline data were unavailable, was conducted.

The final sample included 312 participants with complete data for four of the subscales of the primary outcome (FEQ1 'Confidence in Working with Fathers', FEQ2 'Competence in Using Engagement Strategies', FEQ3 'Perceived Effectiveness of Engagement Strategies', and FEQ5 'Organisational Practices for Father Engagement'), after accounting for loss to follow-up and missing data. This resulted in 156 participants in each group. For the FEQ4 ('Frequency of Strategy Use') outcome, only 268 participants had complete data (Treatment group: n=132, Control group: n=136). This was because the scale looked at frequency of using strategies and the question included an option for respondents to select that they do not currently work directly with fathers. A CONSORT diagram is provided in figure 1 to illustrate the participant flow throughout the study, including the number assessed, randomised, allocated, lost to follow-up, and included in the final analysis. This diagram does not include depiction of FEQ4 outcome where more individuals are missing endline and baseline scores.

Figure 1: CONSORT flow chart (go to accessibility text)



Participant characteristics

Table 2 presents the results of the random allocation across the seven local authorities participating in the study, along with the number of cases included in the primary outcome analysis. The number of teams (included in brackets) randomised was similar across all the local authorities. However, the total number of individuals was notably higher in Somerset (n=102), Surrey (n=105), and Wiltshire (n=136) compared to the other participating local authorities. The Pearson's chi-squared test yielded no statistically significant differences between randomised treatment and control groups within local authorities.

Table 2: Number of participants (and teams) by local authority (randomised and analysed)

Site	Treatment		Control		Total	
	Randomised	Analysed	Randomised	Analysed	Randomised	Analysed
Birmingham	36 (4)	16 (4)	26 (3)	12 (3)	62 (7)	28 (7)
Croydon	30 (4)	20 (4)	29 (4)	15 (4)	59 (8)	35 (8)
Durham	35 (3)	23 (3)	37 (3)	23 (3)	72 (6)	46 (6)
Havering	31 (4)	13 (4)	45 (5)	24 (5)	76 (9)	37 (9)
Somerset	51 (6)	24 (6)	51 (6)	21 (6)	102 (12)	45 (12)
Surrey	59 (8)	34 (8)	46 (8)	25 (7)	105 (16)	59 (16)
Wiltshire	69 (3)	26 (3)	67 (3)	36 (3)	136 (6)	62 (6)
Total	**318 (32)**	**156 (32)**	**301 (32)**	**156 (31)**	**619 (64)**	**312 (63)**

Note: total participants (total teams)

Balance checks

Based on the data available from survey responses, the following key self-reported characteristics were included to check balance between treatment and control group:

- Age
- Gender
- Ethnicity
- Whether had previous training on father engagement
- Number of years as qualified social worker
- Number of children in caseload
- Number of fathers in caseload[8]
- FEQ1 confidence score
- FEQ2 competence score
- FEQ3 effectiveness score
- FEQ4 frequency score
- FEQ5 organisational score

[8] This was self-reported data where participants were asked to provide the number of children in their caseload, from how many families/households, and how many included fathers. These responses could be prone to error given known poorer record keeping on fathers.

- Self-efficacy score
- Team culture score.

To assess the balance between the treatment and control groups, different statistical tests were employed based on the variable type. For continuous variables (age, number of years as qualified social workers, number of children in caseload, number of fathers in caseload, baseline FEQ scores, self-efficacy scores, and team culture scores), balance was tested using two sample t-tests with unequal variances. Balance in binary variables (gender, whether had previous father-focused training) was tested using a z-test. Balance in categorial variable (ethnicity) was tested using Pearson's chi-squared test. Across all these analyses, no statistically significant differences were found between the intervention and control groups, despite the observation that social workers in the treatment group appeared to have a caseload of one additional child on average. Therefore, based on the available characteristics, the data demonstrated no evidence of imbalance between the two groups (table 3).

Table 3: Baseline characteristics by allocated group and balance checks

Characteristic	Treatment group mean	Control group mean	Two-sided test (p-value)
Age	36.86 (n=193)	38.18 (n=204)	0.206
Gender	0.84 (n=219)	0.86 (n=243)	0.648
Previous training	0.29 (n=222)	0.29 (n=241)	0.972
Years as qualified social worker	8.242 (n=190)	8.224 (n=205)	0.981
Children caseload	16.82 (n=168)	15.94 (n=181)	0.219
Father caseload	7.27 (n=168)	7.33 (n=181)	0.889
FEQ1 confidence score	3.57 (n=209)	3.55 (n=218)	0.769
FEQ2 competence score	3.59 (n=209)	3.54 (n=218)	0.488
FEQ3 effectiveness score	3.94 (n=209)	3.90 (n=218)	0.619
FEQ4 frequency score	3.63 (n=191)	3.61 (n=197)	0.817
FEQ5 organisational score	3.76 (n=209)	3.87 (n=218)	0.180
Self-efficacy score	3.49 (n=209)	3.47 (n=218)	0.839
Team culture score	3.91 (n=200)	3.92 (n=198)	0.910

Among the 312 cases with complete data for analysis of the primary outcomes, attrition rates were similar across all seven local authorities. The distribution of participants in the treatment and control groups remained comparable to the distribution at randomisation (see table 4). Although some differences in group sizes were observed between the treatment and control arms within specific local authorities (Havering, Surrey, and Wiltshire), Pearson's chi-squared tests revealed no statistically significant differences in group distribution across the local authorities.

Table 4: Proportion of participants by local authority (randomised and analysed)

Site	Treatment group		Control group	
	Randomised	Analysed	Randomised	Analysed
Birmingham	11%	10%	9%	8%
Croydon	10%	13%	10%	10%
Durham	11%	15%	12%	15%
Havering	10%	8%	15%	15%
Somerset	16%	15%	17%	13%
Surrey	19%	22%	15%	16%
Wiltshire	22%	17%	22%	23%
Total	**100%**	**100%**	**100%**	**100%**

Using the available characteristics, no statistically significant differences were found between the characteristics of participants in the intervention and control groups used for analysis (see tables 5 and 6). Additionally, there were no substantial differences between the characteristics of the allocated groups (table 3) compared to the sample available for analysis (table 5), though the number of children in caseloads was more comparable in the analytic sample and year as qualified social worker was more comparable in allocated sample. Further descriptive statistics on the characteristics of the sample are included in appendix B (tables B1 and B2).

Table 5: Characteristics of sample for analysis by allocated group and balance checks

Characteristic	Treatment group mean	Control group mean	Two-sided test (p-value)
Age	36.51 (n=133)	38.15 (n=129)	0.191
Gender	0.81 (n=149)	0.86 (n=153)	0.226
Previous training	0.30 (n=149)	0.28 (n=149)	0.799
Years as qualified social worker	7.40 (n=142)	8.21 (n=147)	0.332
Children caseload	16.39 (n=128)	16.65 (n=128)	0.767
Father caseload	7.29 (n=128)	7.80 (n=128)	0.310
FEQ1 confidence score	3.53 (n=156)	3.57 (n=156)	0.628
FEQ2 competence score	3.57 (n=156)	3.52 (n=156)	0.494
FEQ3 effectiveness score	3.95 (n=156)	3.87 (n=156)	0.388
FEQ4 frequency score	3.58 (n=140)	3.60 (n=145)	0.855
FEQ5 organisational score	3.77 (n=156)	3.89 (n=156)	0.186
Self-efficacy score	3.44 (n=209)	3.44 (n=218)	0.928
Team culture score	3.90 (n=150)	3.89 (n=143)	0.971

Table 6: Participant ethnicity by allocated group and balance checks

Ethnicity	Treatment group	Control group	Pearson chi² p-value
White	98	111	0.245
Mixed/Multiple	4	5	
Asian	10	3	
Black	36	29	
Other	8	8	

Based on attendance data provided by the Fatherhood Institute, of the 318 participants assigned to the treatment group, 85 (27%) did not attend any training sessions, 71 (22%) attended only one of the two sessions, and 162 (51%) attended both sessions. However, the analytical sample of 156 participants showed a different pattern: 13 (8%) did not attend any training, 36 (23%) attended one session, and 107 (69%) attended both. This discrepancy suggests that a significant portion of the participants who did not attend any training sessions also did not complete the baseline or endline surveys. Without survey data on the characteristics of this group, it was not possible to further explore issues of non-response bias by comparing with the sample for analysis.

Primary outcome analysis

To assess the impact of the ISAFE training programme on the five Father Engagement Questionnaire (FEQ) subscales, a linear regression analysis with clustered standard errors was conducted. This approach accounted for clustering within the teams. The basic model included an intervention status indicator and baseline scores as control variables to enhance the precision of the impact estimator's variance.

IE EQ1: *What effect on social workers does taking part in ISAFE have on their father engagement practices (measured by the FEQ), compared to social workers who do not receive the intervention (two months post-intervention)?*

Overall, ISAFE demonstrated a positive impact on all five FEQ endline subscale scores. However, statistically significant effects were observed only for FEQ1 'Confidence Working with Fathers' ($p=.001$), FEQ2 'Competence in Using Engagement Strategies' ($p<.001$), and FEQ5 'Organisational Practices for Father Engagement' ($p<.05$). FEQ3 'Perceived Effectiveness of Engagement Strategies' ($p=.069$) and FEQ4 'Frequency of Strategy Used' ($p=.309$) did not show statistically significant changes in endline scores.

The estimated impact of ISAFE training corresponded to increases of 0.206 ($p=.001$), 0.21 ($p<.001$), and 0.18 ($p<.05$) in FEQ1 confidence, FEQ2 competence, and FEQ5 organisational scores, respectively, for the treatment group compared to the control group. These findings translate to Glass's Delta effect sizes of 0.308, 0.334, and 0.243 for FEQ1 confidence, FEQ2 competence, and FEQ5 organisational practices, respectively. While these effect sizes are small, they are statistically significant, due to the limited variation observed in FEQ scores. Notably, the effects for FEQ1 confidence and FEQ2 competence reached statistical significance at $p<.001$, exceeding the significance threshold of $p<.05$ established in the evaluation protocol.

Tables 7 to 11 present the clustered Ordinary Least Squares (OLS) estimators of ISAFE's effect on the five FEQ subscales. After accounting for missing data, the sample size available for the OLS regression was 312 observations, with 156 in the intervention group and 156 in the control group for all primary outcomes except FEQ4 frequency. For FEQ4 frequency, the available sample size is 268 with 132 participants in treatment group and 136 participants in control group. As noted in table 5, no differences in observable baseline characteristics were found in the analytical sample.

Table 7: OLS regression results – Basic model – Primary outcome: Endline FEQ1 Confidence in Working with Fathers score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.205***	0.0569	0.091, 0.319	0.001	0.307
Baseline FEQ1 Score	0.453***	0.0384	0.376, 0.530	0.000	
Constant	2.001***	0.1471	1.707, 2.296	0.000	
Number of observations	312				

Table 8: OLS regression results – Basic model – Primary outcome: Endline FEQ2 Competence in Using Engagement Strategies score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.212***	0.0551	0.101, 0.322	0.000	0.334
Baseline FEQ2 Score	0.391***	0.0459	0.299, 0.483	0.000	
Constant	2.276***	0.1696	1.937, 2.615	0.000	
Number of observations	312				

Table 9: OLS regression results – Basic model – Primary outcome: Endline FEQ3 Perceived Effectiveness of Engagement Strategies score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.135	0.0729	-0.017, 0.281	0.069	0.177
Baseline FEQ3 Score	0.392***	0.0417	0.309, 0.476	0.000	
Constant	2.424***	0.1772	2.069, 2.778	0.000	

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Number of observations	312				

Table 10: OLS regression results – Basic model – Primary outcome: Endline FEQ4 Frequency of Strategy Used score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.111	0.1082	-0.105, 0.337	0.309	0.137
Baseline FEQ4 Score	0.338***	0.0529	0.232, 0.443	0.000	
Constant	2.579***	0.2112	2.156, 3.001	0.000	
Number of observations	268				

Table 11: OLS regression results – Basic model – Primary outcome: Endline FEQ5 Organisational Practices for Father Engagement score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.181**	0.0823	0.0165, 0.345	0.032	0.243
Baseline FEQ1 Score	0.320***	0.0439	0.232, 0.408	0.000	
Constant	2.726***	0.1829	2.361, 3.092	0.000	
Number of observations	312				

Secondary outcome analysis

The analysis of secondary outcomes also used the clustered OLS regression method employed for the primary outcomes, as described in the previous section. The basic regression model included

the same control variables to enhance the precision of the impact estimator's variance: an intervention status indicator and baseline scores. Table 12 depicts the available sample size for the OLS regression for the three secondary outcomes after accounting for missing baseline and/or endline data. No differential attrition was found in the treatment and control group participants. This additional attrition in the secondary data can be a cause of non-significant results due to reduced sample size and possibly a bias in results due to differential attrition in unobservable characteristics. A sensitivity analysis with imputed values was conducted to observe the effect of attrition.

Table 12: Sample size available for various secondary outcomes

	Treatment	Control	Total
Father contact detail records	120	118	238
Self-efficacy	156	156	312
Team culture	146	140	286

Overall, ISAFE consistently demonstrated a positive impact across all secondary outcomes, albeit not always statistically significant. Each evaluation question is discussed below.

IE EQ2: *What effect on social workers does taking part in ISAFE have on rates of father engagement, compared to social workers who do not receive the intervention as measured by father contact detail records maintained by a SW?*

Despite positive improvements, table 13 demonstrates that the programme did not significantly affect the average number of father contact details recorded in caseloads (p=.612).

Table 13: OLS regression results – Basic model – Secondary outcome: Endline Father contact details recorded

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.190	0.374	-0.558, 0.940	0.612	0.053
Baseline Father contact details recorded	0.449***	0.065	0.317, 0.580	0.000	
Constant	4.027***	0.479	3.068, 4.986	0.000	
Number of observations	238				

IE EQ3: *What effect on social workers does taking part in ISAFE have on their self-efficacy associated with engaging fathers in child protection assessments, interventions, and safeguarding (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?*

Overall, the programme demonstrated a statistically significant effect on social workers' self-efficacy (p<.001) – see table 14. The estimated impact of ISAFE training corresponds to increases of 0.227 (p<.001) in endline self-efficacy scores for the treatment group compared to the control group. This corresponds to a Glass's Delta effect size of 0.348. The statistical significance level observed for self-efficacy (p<.001) surpassed the pre-established threshold of p<.05 outlined in the evaluation protocol.

Table 14: OLS regression results – Basic model – Secondary outcome: Endline Self-efficacy score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.227***	0.0560	0.115, 0.339	0.000	0.348
Baseline self-efficacy Score	0.467***	0.0479	0.371, 0.563	0.000	
Constant	1.958***	0.1675	1.623, 2.293	0.000	
Number of observations	312				

IE EQ4: *What effect does taking part in ISAFE have on organisational/team culture relating to father engagement (intermediate outcome/mechanism), compared to social workers who do not receive the intervention?*

Overall, the programme demonstrated a statistically significant effect on team culture (p=.011) – see table 15. The estimated impact of ISAFE training corresponds to increases of 0.18 (p<.05) in endline team culture scores for the treatment group compared to the control group. This corresponds to a Glass's Delta effect size of 0.303. The statistical significance level observed for team culture (p=.011) surpassed the pre-established threshold of p<.05 outlined in the evaluation protocol.

Table 15: OLS regression results – Basic model – Secondary outcome: Endline Team culture score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value	Glass's Delta
Intervention	0.179**	0.0684	0.042, 0.316	0.011	0.303
Baseline team culture Score	0.424***	0.0506	0.323, 0.526	0.000	
Constant	2.327***	0.2019	1.923, 2.731	0.000	
Number of observations	286				

Dosage analysis

All participants in the treatment group were invited to attend the two core training sessions (SW1 and SW2). Therefore, the number of sessions attended could be 0, 1, or 2. Table 15 shows the results of a dosage analysis on the five FEQ scores. Attending one additional training session has a larger effect on all primary outcomes except for the FEQ3 effectiveness subscale, for which the magnitude of effect is larger but with a negative sign. However, none of these effects are statistically significant at a p-value of less than 0.05, except for the FEQ1 confidence scale, where the effect is significant at the 5% level.

Table 16: Dosage analysis results of five primary outcome subscales – OLS model

	Number of sessions attended	Coefficient*	Clustered Robust Standard error	95% confidence interval	p-value
FEQ1 confidence	1	0.297	0.193	-0.097, 0.692	0.135
	2	0.396	0.186	-0.017, 0.776	0.041
FEQ2 competence	1	0.294	0.174	-0.061, 0.649	0.102
	2	0.332	0.185	-0.044, 0.710	0.082
FEQ3 effectiveness	1	-0.022	0.257	-0.547, 0.503	0.931

	Number of sessions attended	Coefficient*	Clustered Robust Standard error	95% confidence interval	p-value
	2	-0.107	0.258	-0.633, 0.418	0.680
FEQ4 frequency	1	0.196	0.217	-0.247, 0.639	0.375
	2	0.294	0.217	-0.148, 0.737	0.186
FEQ5 organisational	1	0.046	0.272	-0.508, 0.601	0.866
	2	0.205	0.254	-0.312, 0.723	0.425

*Compared to base level of attending zero training sessions.

Sensitivity analysis

Missing values

Given the presence of missing values in both baseline and endline FEQ scores (82 missing values in baseline for all FEQ scores except FEQ4 frequency,[9] which had 101 missing values, and 115 missing values in endline for all except FEQ4 frequency, which had 148 missing values), a multiple imputation sensitivity analysis was conducted to assess the impact of these missing values. Twenty multiple imputation datasets were generated, addressing the extent of missingness, using the chained equation method, MICE. This method allows for the imputation of different variable types (continuous, binary, etc.) in an iterative manner, starting with the variable with the fewest missing values.

For initiating the chained imputation, simple estimates such as mean, median or mode (depending on the type of the variable) are filled in missing values. The purpose of these initial estimates is to create a complete dataset to start the MICE algorithm. These initial imputations are not meant to be accurate or final; they simply provide a starting point. The MICE algorithm then iteratively refines these imputations based on the relationship between variables and the prediction models defined. A total of 20 datasets were generated by predicting the missing values based on the prediction model defined for variables. Separate imputation was done for the treatment and control group according to the data present in each group. All the baseline and endline FEQ subscales were imputed along with control variables like age group, gender, previous training, total children caseload for a complete case analysis of all the participants lost to attrition. Due to negligible missingness (6 out of 489 participants) in ethnicity, missing values were not imputed for ethnicity. Rather ethnicity was used as independent variables in the prediction model along with

[9] The reason for higher missing values for FEQ4 frequency is due to an option for participants to select 'not applicable' when asked about the frequency of using strategies, e.g. if they did not carry a caseload (with fathers).

team ID and local authority due to the non-existence of variables that predict missingness. The lack of strong predictors of missingness may increase uncertainty in the results; therefore, findings based on these imputed datasets should be interpreted cautiously.

There were similar effect magnitudes observed in both the primary and sensitivity models, which suggests that the missing data did not significantly bias the results, and the interpretation of the primary outcome analysis remains valid. The effect of the intervention in the primary regression model was 0.206, 0.21, 0.13, 0.11, and 0.18 for FEQ1 confidence, FEQ2 competence, FEQ3 effectiveness, FEQ4 frequency, and FEQ5 organisational practices respectively (see tables 7 to 11 above) and the effect of intervention in the sensitivity regression model was 0.18, 0. 184, 0.15, 0.165, and 0.15 for FEQ1 confidence, FEQ2 competence, FEQ3 effectiveness, FEQ4 frequency, and FEQ5 organisational practices respectively (see tables 17 to 21 below). The statistical significance levels remained consistent between the models, except for the FEQ3 effectiveness outcome, which reached significance at $p<0.05$ in the sensitivity analysis. This finding is likely due to the increased sample size for this outcome (approximately a 36% increase) after imputation and the effect in the primary regression model (p-value=0.069) was approaching the significance level of $p<0.05$.

A sensitivity analysis of secondary outcomes yielded different results than the primary regression analysis of secondary outcomes. In the primary regression analysis, the effect of intervention was 0.190, 0.227, and 0.179 for father contact details record, self-efficacy and team culture respectively (see tables 13 to 15 above) and the effect of intervention in the sensitivity regression model was 1.121, 0.193, and 0.207 for father contact details, self-efficacy, and team culture respectively (see appendix B: tables B3–B5. The statistical significance level of father contact details records also improved from p-value = 0.612 to p-value = 0.045, the effect is significant at 5% level with imputed values. However, it should be noted that this variable had a missingness of roughly 51% which means almost 51% of data is imputed for this analysis. Similarly, team culture had a missingness of approximately 41% and self-efficacy had a missingness of roughly 36%. Due to the high level of missingness and non-existence of variables that are predictable of missingness, the results of sensitivity regression analysis should be interpreted with significantly greater care.

Table 17: Multiple Imputation regression estimates – Basic model – Primary outcome: Endline FEQ1 confidence score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.180***	0.061	0.055, 0.305	0.006
Baseline FEQ1 Score	0.471***	0.414	0.387, 0.556	0.000
Constant	1.927***	0.159	1.601, 2.253	0.000
Number of observations	483			

Table 18: Multiple Imputation regression estimates – Basic model -– Primary outcome: Endline FEQ2 competence score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.184***	0.055	0.072, 0.296	0.002
Baseline FEQ2 Score	0.397***	0.043	0.308, 0.486	0.000
Constant	2.251***	0.157	1.929, 2.573	0.000
Number of observations	483			

Table 19: Multiple Imputation regression estimates – Basic model – Primary outcome: Endline FEQ3 effectiveness score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.151**	0.061	0.026, 0.275	0.018
Baseline FEQ3 Score	0.369***	0.044	0.279, 0.459	0.000
Constant	2.500***	0.181	2.132, 2.869	0.000
Number of observations	483			

Table 20: Multiple Imputation regression estimates – Basic model – Primary outcome: Endline FEQ4 frequency score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.165*	0.095	-0.026, 0.357	0.09
Baseline FEQ1 Score	0.317***	0.051	0.213, 0.422	0.000

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Constant	2.611***	0.204	2.191, 3.031	0.000
Number of observations	483			

Table 21: Multiple Imputation regression estimates – Basic model – Primary outcome: Endline FEQ5 organisational score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.149**	0.073	0.001, 0.297	0.048
Baseline FEQ1 Score	0.296***	0.045	0.203, 0.388	0.000
Constant	2.849***	0.185	2.473, 3.225	0.000
Number of observations	483			

Multiple hypothesis testing

Because this study involved testing five hypotheses (for each subscale), increasing the risk of falsely rejecting true null hypotheses (Type I errors), a Romano–Wolf multiple hypothesis correction was conducted. In total, 1,000 bootstrap replications in the method were executed to control for the family-wise error rate (FWER), that is, the probability of rejecting at least one true null hypothesis in the family of hypotheses under test. The Romano–Wolf procedure is particularly valuable because it not only controls the FWER but also provides more statistical power compared to traditional methods like the Bonferroni correction.

The results of the multiple hypothesis testing indicate that all outcomes, except for the FEQ4 frequency outcome, are statistically significant at $p<.05$. Table 22 presents the results of the Romano–Wolf testing. Notably, the Romano–Wolf adjusted p-values for FEQ3 effectiveness, FEQ4 frequency, and FEQ5 organisational practices ($p=.034$, $p=.191$, and $p=.013$, respectively) are lower than the unadjusted p-values from the primary analysis model ($p=.068$, $p=.308$, and $p=.031$, respectively). This suggests a positive dependence among the outcomes of interest, meaning the hypotheses are highly correlated. Methods like Bonferroni correction does not account for this

dependence. The Romano–Wolf method recognises that the tests are not truly independent and adjusts accordingly.

Complier average causal effects

Only three individuals moved from the control to the treatment group during the study, therefore, no complier average causal effect was estimated.

Subgroup analysis

The analysis builds on the impact models to provide further information on how the outcomes vary by the characteristics of social workers and their local authority. The results sit outside of the impact analysis and help to inform how the characteristics of the workforce may influence their current levels of skills, attitudes to and experience of working with fathers. Such information may be helpful in identifying people who may benefit more from training, i.e. score lower on average on the outcome scores relative to their counterparts.

IE EQ4: *Do outcomes (and experiences) vary by characteristics of social workers (gender, age, ethnicity, experience (i.e. years since qualified))?*

IE EQ5: *Do outcomes vary across teams and/or local authorities?*

The analysis found that length of role demonstrated a statistically significant, albeit small, effect on FEQ1 confidence scores ($p<0.05$). For each additional year in role, the average FEQ1 confidence score increased by 0.015 points on a 5-point scale (see table 23).

Other findings related to the FEQ3 effectiveness and FEQ4 frequency, which did not have significant findings overall. We therefore do not advise drawing substantive conclusions based on these findings:

- Both Somerset and Wiltshire showed statistically significant higher FEQ3 effectiveness scores. On average, the FEQ3 effectiveness score was 0.591 ($p<0.000$) points higher in Somerset and 0.309 ($p<0.05$) points higher in Wiltshire on a 5-point scale (see table 24).
- Conversely, Wiltshire exhibited a statistically significant lower FEQ4 frequency score, averaging 0.498 ($p<0.01$) points lower on a 5-point scale (see table 25).
- Individuals in the 60–69 age group had a statistically significant lower average FEQ4 frequency score of 0.755 ($p<0.05$) on a 5-point scale (see table 25). However, this was based on a small sample.

Table 22: OLS regression results – Control variables model – Primary outcome: Endline FEQ1 Confidence score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.151	0.066	0.018, 0.284	0.026
Local authority				
Birmingham	0 (base)			
Croydon	-0.127	0.129	-0.386, 0.132	0.331
Durham	0.224	0.117	-0.009, 0.459	0.060
Havering	-0.098	0.127	-0.353, 0.157	0.445
Somerset	0.130	0.132	-0.134, 0.395	0.327
Surrey	0.050	0.133	-0.216, 0.318	0.705
Wiltshire	0.090	0.109	-0.128, 0.310	0.410
Ethnicity				
White	0 (base)			
Mixed/Multiple	0.346	0.266	-0.187, 0.880	0.200
Asian	-0.004	0.104	-0.213, 0.204	0.965
Black	0.063	0.121	-0.180, 0.306	0.606
Other	0.105	0.134	-0.162, 0.373	0.436
Age group				
20–29	0 (base)			
30–39	-0.102	0.090	-0.283, 0.077	0.258
40–49	-0.187	0.107	-0.403, 0.028	0.088
50–59	-0.195	0.112	-0.420, 0.029	0.088
60–69	-0.277	0.307	-0.891, 0.337	0.371

Previous training	.0186	0.0651	-0.111, 0.148	0.776
Female	-0.051	0.114	-0.279, 0.176	0.653
Length in role	0.015	0.006	0.001, 0.0290	.028
Total Children caseload	-0.004	0.004	-0.014, 0.004	0.277
FEQ1 Confidence score baseline	0.423	0.0576	0.308, 0.538	0.000
Constant	2.20	0.298	1.60, 2.79	0.000
Number of observations	197			

Table 24: OLS regression results – Control variables model – Primary outcome: Endline FEQ3 Effectiveness score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.076	0.089	-0.102, 0.255	0.396
Local authority				
Birmingham				
Croydon	-0.000	0.175	-0.351, 0.351	1.000
Durham	0.272	0.171	-.071, 0.615	0.118
Havering	0.169	0.150	-0.130, 0.469	0.264
Somerset	0.591	0.0973	0.396, 0.786	0.000
Surrey	0.169	0.113	-0.058, 0.396	0.142
Wiltshire	0.309	0.126	0.056, 0.562	0.017
Ethnicity				
White				
Mixed/Multiple	0.592	0.312	-0.032, 1.217	0.063
Asian	-0.262	0.147	-0.558, 0.033	0.081

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Black	.078	0.167	-0.256, 0.413	0.640
Other	-0.652	0.285	-1.222, -0.081	0.026
Age group				
20–29				
30–39	-0.073	0.108	-0.290, 0.144	0.503
40–49	-0.027	0.144	-0.316, 0.261	0.850
50–59	-0.007	0. 154	-0.315, 0.300	0.962
60–69	-0.318	0.201	-0.721, 0.083	0.118
Previous training	-0.073	0.103	-0.280, 0.133	0.481
Female	-0.044	0.136	-0.317, 0.229	0.747
Length in role	0.008	0.013	-0.018, 0.035	0.550
Total Children caseload	-0.002	0.006	-0.015, 0.011	0.732
FEQ3 Effectiveness score baseline	0.398	0.056	0.285, 0.510	0.000
Constant	2.270	0.333	1.602, 2.937	0.000
Number of observations	197			

Table 23: OLS regression results – Control variables model - Primary outcome: Endline FEQ4 Frequency score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.103	0.110	-0.117, 0.325	0.353
Local authority				
Birmingham				
Croydon				
Durham	-0.281	0.212	-0.707, 0.144	0.192
Havering	-.307	0.159	-0.626, 0.011	0.058
Somerset	-0.010	0.179	-0.370, 0.348	0.952
Surrey	-0.149	0.191	-0.533, 0.234	0.439
Wiltshire	-0.498	0.150	-0.800, -0.197	0.002
Ethnicity				
White				
Mixed/Multiple	-0.133	0.289	-0.712, 0.445	0.646
Asian	-0.0000	0.148	-0.297, 0.297	0.999
Black	0.092	0.143	-0.194, 0.379	0.522
Other	-.457	0.658	-1.775, 0.860	0.490
Age group				
20–29				
30–39	-0.245	0.132	-0.510, 0.018	0.068
40–49	-0.074	0.147	-0.369, 0.220	0.615
50–59	-0.230	.183	-0.597, 0.137	0.215
60–69	-0.755	0.319	-1.395, -0.115	0.021

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Previous training	0.030	0.111	-0.192, 0.252	0.788
Female	-0.103	0.153	-0.410, 0.203	0.503
Length in role	0.010	0.015	-0.020, 0.041	0.489
Total Children caseload	0.002	0.007	-0.012, 0.018	0.719
FEQ4 Frequency score baseline	0.368	0.0547	0.258, 0.477	0.000
Constant	2.813	0.330	2.152, 3.474	0.000
Number of observations	197			

Discussion

The impact evaluation explored the impact of ISAFE training on social workers' self-reported confidence, competencies, perceived effectiveness and frequency of using father engagement strategies, and organisational practices related to engaging fathers in child protection and parenting decisions. It also looked at the effect on self-reported self-efficacy, team culture, and record keeping as a proxy for father engagement (i.e. the number of recorded contact details for fathers, self-reported by participants).

Overall, the programme demonstrated promising results in enhancing social workers' confidence and competence in father engagement from baseline to endline as measured by the FEQ1 'Confidence Working with Fathers' and FEQ2 'Competence in Using Engagement Strategies' subscales. Furthermore, the programme led to improvement in self-reported organisational practices concerning father engagement from baseline to endline, as measured by FEQ5 'Organisational Practices for Father Engagement' subscale. In other words, social workers felt more confident and competent when engaging fathers and also perceived improvements in their organisation practices relating to father inclusion. It should be noted that the magnitude of each effect was very small. On average, the scores increased by 0.21 on a 5-point scale. These observed small effect sizes were statistically significant likely because of the low variability in the FEQ scores. In other words, participants typically reported similar scores, meaning little variation within the sample, making small differences appear significant. It is also important to note that the evaluation relied on self-reported data, which is a key limitation given that people are prone to cognitive bias (Dunning–Kruger effect) and those with lower competence overestimate their abilities.

These findings were further substantiated by analysing secondary outcomes looking at social workers' self-efficacy, team culture, and record keeping on fathers. While the number of fathers' contact details recorded did not change significantly, there were statistically significant improvements in social workers' self-efficacy and perceptions about team culture relating to father engagement.

There was substantial staff turnover among participants in both the treatment and control group resulting in people not completing the baseline and/or endline survey. Checks using the baseline survey information revealed no evidence to suggest that the pattern of attrition differed systematically between treatment and control group members. It is probable that there were participants in both the intervention and control groups who had less interest in the trial, and were more likely to drop out of the study. For example, a substantial minority of participants in the treatment group (85 out of 318) did not attend any training sessions and, consequently, did not complete either the baseline or endline surveys. This lack of participation resulted in no data being collected for this subgroup. It is possible that these individuals did not anticipate the training would enhance their engagement with fathers. Had they completed the surveys, their responses could have potentially lowered the overall measured impact of the intervention. However, this cannot be definitively assessed due to the absence of personal characteristic data for these non-participating individuals.

The programme did not lead to significant changes in the perceived effectiveness or frequency of use of father engagement strategies (evidenced by scores from the FEQ3 'Perceived Effectiveness of Engagement Strategies' and FEQ4 'Frequency of Strategy Used' subscales). This may be attributed to the time required for the practical application of newly acquired knowledge and skills to manifest in real-world scenarios. In contrast, confidence, competency, and organisational practices are more closely linked to attitudinal shifts, which can be influenced more rapidly, particularly within a light-touch intervention such as ISAFE.

Findings from sensitivity tests were broadly comparable to the main analyses. Sensitivity tests attempted to adjust for missing data using a multiple imputation approach. For the primary outcomes, the sensitivity tests were broadly comparable with the primary outcome analysis. However, for the secondary outcomes, the sensitivity tests showed a greater disparity from the main secondary analysis results, especially for father contact details records, suggest that secondary impacts were underestimated in the main analysis. These sensitivity secondary outcome results should be treated with a degree of caution for two reasons. First, the degree of attrition was relatively greater for the secondary outcomes, especially contact records for fathers, compared to the primary outcomes. Second, and more generally, the imputation can only be as good as the available data used in the imputation and it is possible that influential characteristics exist that affect attrition and outcomes, but relevant data is not available to this study.

The results showed some evidence of promise for short-term outcomes for the intervention, suggesting that ISAFE had a positive impact on participants' confidence and competence in engaging fathers, as well as in positively shifting father-inclusive organisational practices within participants' teams. The relatively small number of local authorities involved and their willingness

to be included in the study means care should be taken when generalising the results to the wider population of social work teams across all local authorities. Ideally, a follow-up study would use a random selection of local authorities for inclusion into the evaluation, which would make generalisation more robust.

IMPLEMENTATION AND PROCESS EVALUATION

Methods

The section below provides a summary of the key components of the IPE methodology. Further detail on the methodology and rationale can be found in the evaluation protocol.[10]

Implementation and process evaluation questions

The IPE sought to answer the following questions:

1. **Mechanisms of change:** To what extent is the ISAFE theory of change validated?
2. **Variation in outcomes:** Do outcomes (and experiences) vary (i) by characteristics of social workers (gender, age, experience (i.e. years since qualified)); and (ii) across teams and/or local authorities?
3. **Fidelity:** To what extent was ISAFE delivered as intended/planned? This will be considered as a whole and a more granular level looking at 1) QA audit training, 2) social worker training, and 3) the role of champions.
4. **Feasibility:** What are viewpoints on the feasibility of implementing ISAFE? What barriers and enablers were encountered, and how were these addressed?
5. **Reach/Dosage:** What is the intervention's reach? How many social workers attended the training? How much of the training did social workers attend?
6. **Quality/Responsiveness:** How acceptable do participants find ISAFE (e.g. contents, number of sessions, online material)? How do participants perceive the quality of ISAFE (e.g. sessions, contents, trainers, training format)? How engaged were participants during the ISAFE training sessions?
7. **Adaptation:** What adaptations have been made to make the programme more acceptable to participants?
8. **Programme differentiation:** Is it viewed as an improvement on services as usual? Is ISAFE seen as a good fit with professional/service norms and with needs of parents, carers and families?

[10] See: https://foundations.org.uk/our-work/current-projects/isafe-improving-safeguarding-through-audited-father-engagement/

Summary of methodology

Evaluation design	The IPE design was mixed methods, including: • **Quantitative data** collected through a feedback survey from training participants and administrative data such as attendance collected by the delivery team • **Qualitative data** including interviews and focus groups with local authority leaders, training participants, delivery team staff, and fathers engaged with children's services.
IPE dimensions	The IPE dimensions used to design the IPE EQs were structured using Humphrey et al.'s (2016) framework from the Education Endowment Foundation's (EEF) implementation and process evaluation handbook. The dimensions include: • Mechanisms of change • Variation in outcomes • Fidelity • Feasibility • Reach/Dosage • Quality/Responsiveness • Adaptation • Programme differentiation.
Sample information	The following groups were sampled for consultation as part of the IPE activities: • **Delivery partner:** All key staff involved in delivering training were invited to take part. • **Local authority senior leaders:** One per local authority signed up for the trial (including three that dropped out pre-randomisation). • **Local authority social workers (including father-inclusion champions/attendees) and QA staff:** - For interviews, treatment group participants were purposively sampled in line with a set of target quotas and invited to take part around three months after the final ISAFE session. - For the feedback survey, all treatment group participants and QA staff received the survey approximately two weeks after the final ISAFE session was delivered. • **Service user fathers:** Social workers acted as gatekeepers to identify fathers currently engaged with children's services who were willing to take part. Father participants were compensated with a £30 voucher to thank them for their participation. Aside from the delivery partner who shared contact details for their team directly, all contact details were securely shared by each local authority.

Data sources and collection methods	The following data collection methods were used: • **Interviews & focus groups with the delivery partner** (n=4): two focus groups and two one-to-one depth interviews. • **Interviews with local authority senior leaders** (n=10). • **Interviews with training participants** (n=38): 30 social workers (including father-inclusion champions/attendees) and eight QA staff. • **Interviews with service user fathers** (n=8). • **Feedback survey of training participants** (n=150): sent two weeks after the end of the intervention.[11] Interviews were conducted virtually using Microsoft Teams or by telephone. Focus groups lasted approximately 90 minutes, staff interviews approximately 60 minutes, and father interviews 30–45 minutes. In addition to this, the following data sources were shared by the delivery team for the IPE analysis: • Training attendance data. • Case file audit results data.
Data analyses methods	The following data analysis approaches were used: • **Interviews:** Interview recordings were transcribed and coded using NVivo qualitative coding software, using a coding framework. A framework analysis was used to examine trends in findings between and across categories of interviewees and local authorities. • **Survey data:** Descriptive analysis of survey data was used to identify key trends in the data. • **Administrative data:** Descriptive analysis of attendance data was used to understand training uptake and case file audit results to complement other data sources. All data sources were triangulated around the IPE questions, identifying key insights, and variations in outcomes and experiences.

Deviations from the evaluation protocol

As set out in the evaluation protocol, the design for the impact evaluation originally included outcome surveys at three timepoints (baseline, immediate follow-up, and a three-month endline). Following challenges in engaging practitioners during the baseline survey, the immediate follow-up survey due to be sent after the end of the training was repurposed to only inform the IPE. The original intention was for the immediate follow-up survey to be sent to both treatment and control groups to capture outcomes, and the treatment group would also be asked questions to inform the IPE. Instead, this timepoint was utilised as a feedback survey sent only to treatment group participants approximately two weeks after the final ISAFE training. The feedback survey asked

[11] A small number of IPE-related questions were also included in the endline survey for participants who did not complete the feedback survey.

questions aligned to the IPE Evaluation Questions (EQ), such as their satisfaction with the training overall and their views on the training's quality. The key rationale for this change was to focus efforts on achieving responses for the endline (for both treatment and control groups) by reducing the overall burden on respondents and local authorities at this timepoint.

In addition to this, the sub-questions within EQ 6 (Quality/Responsiveness) were adapted from the evaluation protocol. In the evaluation protocol, the only sub-question was 'How acceptable do participants find ISAFE (e.g. contents, number of sessions, online material)?'. Additional sub-questions were added to reflect the dimensions this EQ aims to explore, which were omitted in oversight. These include: a) 'How do participants perceive the quality of ISAFE (e.g. sessions, contents, trainers, training format)?'; and b) 'How engaged were participants during the ISAFE training sessions?'

The IPE design possessed some limitations, which are covered within the IPE discussion section.

Findings

This section presents the key findings from the IPE, organised by the IPE EQs. The EQs are ordered sequentially (rather than numerically based on their initial EQ number) to better reflect the stages of designing and delivering the intervention, e.g. starting from the feasibility of delivering ISAFE to the perceived mechanisms and outcomes observed.

Table 26 summarises the key findings against each of the IPE questions. Detailed findings are reported in the sections that follow.

Table 26: Summary of IPE findings

IPE question	Summary of key findings
Feasibility (IPE EQ 4)	• The evidence suggests that implementing ISAFE was feasible. The delivery partner possessed the relevant experience of delivering similar training programmes, recruited sufficient staff and had an appropriate team structure to deliver the programme. • Several barriers during the recruitment and onboarding process, such as delays due to DSAs, were faced but ultimately overcome within the set-up timeframes and did not impact the delivery phase.

IPE question	Summary of key findings
Reach/Dosage (IPE EQ 5)	• In total, 275/345 participants attended at least one of the four training sessions (SW1, SW2, QA audit, and Champions training sessions), showing the intervention reached 80% of its intended participants. • Examining the social worker training attendance, 74% (222/298) of participants attended the SW1 session and 60% (179/298) attended the SW2 session. As a two-part training package, 55% (164/298) of participants attended both sessions, with 25% (73/298) attending just one session. • For the QA audit training, 67% (34/51) of invitees attended the session, while 55% (28/51) attended the Champions training. • Analysis suggests that work commitments (such as needing to go to court), capacity issues and annual leave were the common reasons for non-attendance across the sessions.
Intervention Fidelity & Adaptation (IPE EQ 3 & 7)	• The intervention was delivered more flexibly than initially anticipated in regard to the number of participating teams and who can participate, with no limit on the number of teams (instead an approximate number of participants) and non-social worker participants. • The QA audit session was delivered as intended and sufficiently prepared attendees for the audit exercise. • The SW1 and SW2 sessions were generally delivered as intended, though participant resistance to the training was identified in some sessions. The two training sessions were intended as a two-part training package and participants' views suggested that it was generally seen as a coherent package. • The resource library has had a low usage rate, with 86% (138/150) of survey respondents saying they had not used the resource library. • There is mixed evidence on the implementation of the Champions training. Champion interviewees frequently reported not knowing the expectations of the role or what they needed to do, leading to generally poor implementation. • The intervention was adapted for Cohort B delivery so that a) training sessions were delivered to mixed teams, and b) participants could select which session to take part in, based on learning from Cohort A.

IPE question	Summary of key findings
Quality/Responsiveness & Programme differentiation (IPE EQ 6 & 8)	• Four in five (79%) survey respondents said they were satisfied with the ISAFE programme overall. The survey showed generally positive views on the contents of the training, trainer and format of the training, though participant feedback identified a broader range of views. • Feedback on the QA session was mostly positive, with it seen as informative and well delivered by the trainer. • Participant views on SW1 were generally positive, with the activities during the session seen as impactful and well delivered. SW2 had more varied feedback, with many participants noting they were already knowledgeable about motivational interviewing and the online format not being the most effective for this kind of practical training. • Of the few who had used the resource library, most thought it was a good-quality resource. • Feedback on the Champions training was generally positive, with positive feedback on the quality of discussions. • There was overall positive but varied feedback on whether the ISAFE training was an improvement on services as usual.

IPE question	Summary of key findings
Mechanisms of change (IPE EQ 1)	• For the social worker training within the practice pathway, there is good evidence to suggest that the mechanisms relating to awareness & knowledge and skills & confidence have been realised. For attitudes & practice, the impact evaluation shows the training did not impact participants' frequency of use of strategies; however, the qualitative feedback provided examples of participants becoming more proactive to support fathers within their caseload. There was limited evidence to show practice and family impacts. • For the QA audit training within the systems pathway, the evidence suggests just some of the mechanisms have been validated, with insufficient evidence to show changes at the service level had been implemented. • For the Champions training within the systems pathway, there is insufficient evidence to suggest the mechanisms of change have been realised. Reported uncertainty about how to implement the Fatherhood Champions role is a factor that explains limited evidence to show enhanced adoption for the intervention and ongoing advocacy for father inclusion. Despite this, improvements in team culture on father engagement is suggested to be realised, suggesting other strands of the intervention may have contributed to this. • Key barriers to the effectiveness of ISAFE include: engagement during sessions; perceived simplification of issues; capacity and time restraints; and external referrals not including fathers. Similarly, the key challenges relating to sustainability are staff turnover and the lack of changes to date of systems to embed father-inclusive practice.

IPE question	Summary of key findings
Variation in outcomes (IPE EQ 2)	• The impact evaluation shows a small increase in confidence in engaging fathers for participants with more years of experience in their role. Besides this finding, there was no other statistically significant differences in outcomes between gender, age, experience, or local authority. • In regard to experience of the trial: - Interestingly, more senior personnel were reportedly less satisfied with the training overall than more junior personnel. This may be interpreted in different ways, for example, it may be that they felt they learned less from the training (due to their level of experience) than more junior social workers did. Alternatively, the more senior nature of their role likely means they do not work with fathers directly or regularly (i.e. a team manager) making the training feel less useful or implementable for them. - Local authority-level satisfaction varied considerably. Qualitative data suggested this was due to several key factors, which include receiving similar training to ISAFE recently, disagreement with the contents and its applicability and the perceived level of the training. - Black participants reported being more satisfied and seeing greater improvements in their knowledge, confidence, and skills than White participants. - There was no clear difference in experience based on gender and age.

Feasibility of implementation

IPE EQ 4:

- *What are viewpoints on the feasibility of implementing ISAFE?*
- *What barriers and enablers were encountered, and how were these addressed?*

Delivery partner's viewpoint

General capacity of the delivery partner to implement ISAFE

The delivery partner, the Fatherhood Institute, had previous experience in delivering father-focused training programmes to local authority children's services (referred to as their 'bread and butter' during a focus group with the delivery partner) and possessed in-house knowledge and expertise designing and delivering training focusing on father engagement. This meant the delivery partner had training materials to build upon and adapt for ISAFE.

During the delivery of previous father-focused trainings, the delivery partner would typically work with local authorities on a one-to-one basis to design and deliver bespoke training packages tailored specifically for each local authority. However, with ISAFE, this was the first time they had designed and delivered a single training package across multiple local authorities simultaneously – and in the context of an RCT – with less scope for local adaptations. While this approach to working was new for the delivery partner, it was viewed positively and aligned with their long-term vision around delivering training programmes.

Staff

The Fatherhood Institute is a small organisation with four to five staff members, four of whom were involved in the implementation of ISAFE. To deliver ISAFE, the delivery partner recruited one new staff member and seven new trainers in total. The new staff member was hired to oversee the administration of the programme, including organising the training sessions. Each team member had clear responsibilities over a part of the design and delivery of the programme, such as recruitment of local authorities, training design and delivery, and project management. This lean structure was suggested by the Fatherhood Institute to be an effective approach, as individuals had clear ownership over a specific area of delivery, and this helped drive progress and momentum.

To deliver training, the Fatherhood Institute follows a model which utilises 'associate' trainers who deliver training sessions on its behalf but are not full-time employees. Associates are experienced trainers with expertise within the children's social care sector, with some possessing different subject area expertise (i.e. motivational interviewing). Associates are trained using the 'train-the-trainer' model. In practice, this meant that most sessions in Cohort A were delivered by the Head of Training (who designed the training courses) alongside associate trainers who were being trained and observing sessions. In Cohort B, more sessions were delivered by associate trainers, after they had received training. This model was seen to work well during ISAFE, with generally positive feedback about trainers and their quality of training delivery, as discussed later.

Experience taking part in a trial and evaluation

It was the Fatherhood Institute's first time taking part in a trial of this kind. This meant that many of the steps during set-up and delivery, such as the development of the theory of change and intervention protocol, and working with an evaluation partner and funder, were new organisationally. While this did pose some additional challenges for the implementation of ISAFE (as discussed below), the delivery partner reflected that the set-up phase required a greater amount of administrative and project management time to work through the specifics of the trial, which was not explicit during the bidding phase. The consequence of this was that the delivery partner's capacity was stretched during set-up and the additional capacity requirements were not accounted for within their budget; however, it did not appear to have a material effect on delivery overall.

Despite this, the delivery partner reflected positively on the organisational benefits of taking part in the project and evaluation. The learning and experience helped enhance the team's skill set and has contributed to additional opportunities being generated to take part in trials and contribute to developing the evidence base relating to father inclusion.

Barriers and enablers to implementation

The following subsections detail the key barriers and enablers for the implementation of ISAFE. It is important to highlight that these were in the context of the trial. This means that some of the factors influencing implementation, particularly relating to recruitment and onboarding of local authorities, may not be present when delivering the intervention in a non-trial context in the future.

Recruitment of local authorities

Overall, the process to identify and recruit local authorities to take part in the trial was suggested to be more time-consuming and challenging than initially anticipated. The delivery partner spent a large volume of time identifying warm contacts in prospective local authorities and sharing information about the programme, followed by multiple calls and emails to explain the trial and to seek buy-in, with some local authorities dropping off at different stages. One suggested barrier throughout the recruitment process was the need to communicate the steps and requirements of the trial to local authorities, as this had additional complexity and resource implications for local authorities. For example, the expectation that all teams would need to complete surveys but only half would receive the training required additional explanation. To counter this, the delivery partner prepared a range of materials to share with local authorities, though some difficulties persisted.

Onboarding process

Similar to recruitment, the onboarding process posed additional challenges to implementation. Two key contributing factors were the additional steps and complexity of taking part in a trial compared to simply signing up to an external training course (e.g. randomisation and survey requirements) alongside tight timeframes. After agreeing to take part, participating local authorities had to complete multiple resource-intensive steps (involving different colleagues) including signing the Memorandum of Understanding (MoU) and the Data Sharing Agreement (DSA), and identifying, collating, and sharing the contact details of participating social workers and their teams.

Feedback from both the delivery partner and local authorities recognised the pressures that onboarding placed on all parties. Most communication throughout this process was conducted via email, though it was suggested that telephone or video calls may have been a better approach, particularly to address challenges experienced by local authorities. This may have minimised miscommunications and enabled solutions to be identified sooner. Similarly, the delivery partner reflected that in hindsight they would have spent more time working through the onboarding process to address the challenges experienced by local authorities.

> "If we were to do this again, we might want to put together a much clearer process of sort of onboarding and a sort of review, a review point where we're figuring out is [onboarding] working." – Delivery partner staff

Local authorities dropping out of the trial

In total, three local authorities dropped out of the trial during the onboarding process with each identifying different barriers to participation:

- **Research/trial barrier:** An existing trial was already taking place in the local authority and ISAFE was seen to interfere with the agreement of the existing project. Therefore, the local authority withdrew early into onboarding.
- **Changing context and need:** Multiple compounding reasons led to one local authority deciding to withdraw during onboarding. Of these reasons, the impact of a change of service leadership and a perceived lesser need for help than when they first agreed to take part in the trial led them to withdraw.
- **Perceived incompatibility:** The delivery partner decided that one local authority should not proceed to trial due to consultations with the local authority suggesting that their interpretation of the Safe and Together practice model was at odds with the aims of ISAFE, meaning the delivery partner decided it was not a suitable fit.

Data sharing agreement delays

The process for agreeing the DSA between the delivery partner, evaluation partner, and funder for the trial was also a barrier to implementation. Timelines for the set-up phase were already tight and the DSA, which was initially anticipated to be finalised by December 2022 and shared with Cohort A local authorities soon after, was not finalised until mid-February 2023.

This was seen to have an impact on Cohort A onboarding by shortening timeframes to complete key steps before Cohort A delivery, putting additional pressures on the delivery and evaluation partners and on the local authorities. Though the steps were ultimately completed within these timeframes, it was suggested this process was more complex than anticipated and that it had a knock-on effect on preparations for Cohort A. It was perceived as putting all partners on the back foot, rushing to complete key onboarding tasks within tight timeframes.

Local authority contact detail samples

One of the final steps of onboarding was local authorities sharing the contact details of all trial participants, so that participants could be sent the baseline survey then be randomised (in teams) and have training sessions scheduled into their calendars by the delivery partner (for treatment teams). This process identified that samples received from local authorities often had issues with incorrect contact details and/or outdated teams, either missing current team members or including old team members.

The consequence of this was that additional administrative time was spent throughout the trial by the delivery partner and evaluator working with local authorities collecting correct contact information and identifying new/old members to add or remove from the trial. Unsurprisingly, given known high levels of staff turnover in children's services, teams changed relatively quickly and additional steps to ensure team lists were up to date were required. This includes 'team sample

reviews' conducted with local authorities after the baseline survey in preparation for training and before the endline survey. Though these additional steps helped identify some team changes, additional ad hoc changes regularly happened across both cohorts when changes were identified.

Supporting data collection

To maximise response rates and interview recruitment, the evaluators (with support of the delivery partners) adopted and applied several strategies and techniques to support data collection, including some implemented based on learnings from delivery. Examples of strategies include:

- Timings for data collections were planned around reducing complexity and burden for participants, with no overlap between different methods. For example, this meant that invitations to interview with participants were sent after the endline survey window closed.
- Adopting sampling techniques to build on engagement and momentum. For example, endline survey respondents were asked whether they would be happy to take part in an interview, with those who said yes initially invited, and interview participants asked if they could support with interviews with father recruitment.
- A range of strategies to support survey response rates, including:
    - Regular survey reminders, with different reminders focusing on different motivations, such as the incentive, benefit to the evidence base and their team having the highest response rate.
    - Team response rate breakdowns shared with team managers.
    - Reminders from different stakeholders, including team managers, senior leaders, and the delivery partner.
    - Short-term extensions to achieve target response rates.

Advisory group

The ISAFE advisory group – made up of subject matter experts with backgrounds in children's social care and academia – was identified as a key enabler to implementation by the delivery partner. Particularly throughout the set-up phase, the advisory group regularly met the delivery partner to discuss the design of the programme, review materials, and act as a sounding board for new ideas. This was suggested to be key for the delivery partner, supporting them to maintain momentum and feel reassured about their decision-making. There were additional examples of the advisory group helping implementation, such as identifying warm contacts within prospective local authorities to support with recruitment. The Fatherhood Institute regularly engages advisors as part of its work, which could continue to support the delivery of ISAFE in the future in the event that the ISAFE advisory group is disbanded post-trial.

Support from partners

Support received from other partners was also identified as a key enabler by the delivery partner. This included CASCADE, who provided expertise and input into the design of the materials and weekly meetings with the delivery partner. This also included the advisory group (as discussed

above) and the evaluation partner and funder, particularly in supporting the delivery partner to work through the trial specifics and provide advice and support during delivery.

Reach and dosage

IPE EQ 5:

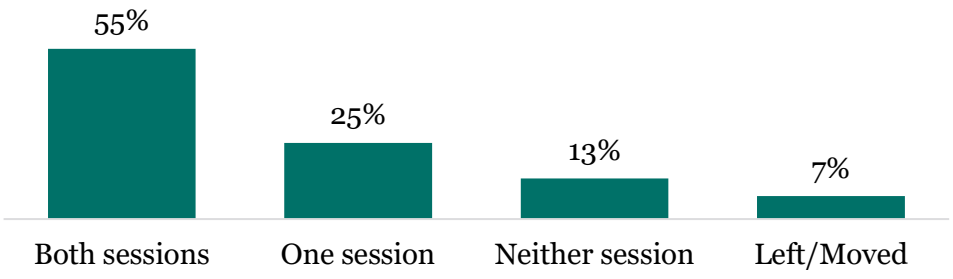
- *What is the intervention's reach?*
- *How many participants attended the training?*
- *How much of the training did participants attend?*

In total, 345 participants[12] were invited to attend one or more of the four ISAFE training sessions, with 275 participants attending at least one session. This includes social work team staff, QA staff and senior management staff. This suggests that the intervention reached 80% of its intended participants.

Social worker training attendance

According to attendance records collated by the delivery partner, 221 participants (74% of all invitees, n=297) attended the SW1 session, and 178 participants (60%) attended the SW2 session. Figure 2 outlines attendance of both SW1 and SW2, showing how many participants attended all, some, or none of the training. It shows that in total, 163 participants[13] (55% of invitees) attended both the SW1 and SW2 sessions in total, while 73 (25%) of participants attended just one of the sessions. As per the intervention protocol, the proportion of participants attending both sessions was lower than the delivery partner initially anticipated (66% – anticipating up to one-third of participants may not be able to attend both sessions).

Figure 2: Attendance across SW1 and SW2 training sessions (link to raw data)



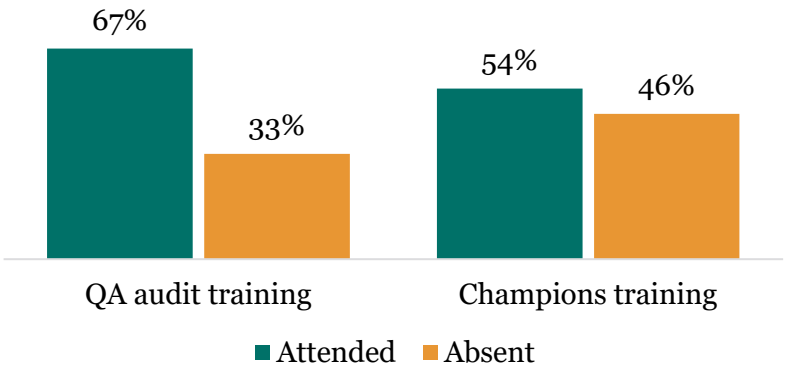
Source: Attendance data. Base: n=297.

[12] Including invitees for the SW1 and SW2 training, QA audit training and Champions training.
[13] Please note, this figure is +1 higher than the figure presented in the impact section due to one control group participant attending the training, which is not included in the impact figures.

QA audit & Champions training attendance

Figure 3 shows the attendance count for the QA audit and Champions training sessions. It shows that 34 participants (67% of invitees, n=51) attended the QA audit training, and 27 participants (54%, n=50) attended the Champions training. During the qualitative interviews, it appeared that some teams did not perceive that all team members who had received an invitation to the training were required to attend the sessions. This meant some teams sent fewer representatives for their team than had been invited to attend. This is a possible contributing factor to both these attendance rates being relatively low.

Figure 3: Attendance count for QA audit & Champions training (link to raw (link to raw data)



Source: Attendance data. Base: n=51 (QA) and 50 (Champions).

Training attendance by cohort

The following differences in attendance across the sessions between Cohort A and B were noted (see appendix B, tables B3–B5):

- **SW1 and SW2:** Cohort B had a notably higher attendance rate (81% vs 70% for SW1 and 70% vs 53% for SW2). This uplift in attendance may be partly explained by the adaptations made to the participant training session allocation process made between Cohort A and B, whereby participants could choose one of three training dates instead of having this assigned to them by the delivery partner (discussed further under fidelity and adaptation).
- **QA audit training:** Cohort A had higher attendance than Cohort B, with 21 of the 29 people invited to the training in Cohort A attending. Cohort B had a lower overall number of invitees (22) and a lower overall number in attendance (13). There was no clear explanation for why this was the case in the qualitative data from interviews.
- **Champions training:** Attendance tended to be lower for the champions training across both cohorts. Again, there was no clear explanation of this from the qualitative data, though it could relate to a perceived lack of clarity or insufficient reflection about the expectations of the role of father-inclusion champions.

Reasons for non-attendance

The qualitative feedback from participants suggests that they did not attend a training session primarily because they were not available. This was due to either having a court visit for one of their cases that day, being on annual leave, or having limited capacity to attend. A minority of interviewees also mentioned that they did not attend the Champions training as they believed it to be for more senior colleagues, despite being invited. Some interviewees noted that the length of SW1 and SW2 training sessions was an additional factor in why they felt unable to attend, with other responsibilities scheduled during sessions.

> "So I attended those two [SW training sessions], but I couldn't attend the ones before, even though I booked. I had things like court that was booked in, everything clashed. I would have moved anything other than court … [The SW training session] was good, it was just long, and I felt it didn't need to be so long." – Social worker

Intervention fidelity and adaptation

IPE EQ 3 & 7:

- *To what extent was ISAFE delivered as intended/planned?*
- *What adaptations have been made to make the programme more acceptable to participants?*

Participating teams and social workers

During the design of the trial, it was assumed that social worker teams typically had between 10 and 15 members per team and therefore local authorities were initially asked to identify six teams to take part in the programme (meaning between 60 and 90 participants per local authority). In practice, learning from early consultations with local authorities identified that team sizes vary considerably both between and within local authorities (i.e. team sizes varied between 5 to 31 members in Cohort A). As a result, greater flexibility was given to local authorities with selecting their participating teams. Instructions were adapted to instead focus on identifying a group of teams that equalled between 60 and 90 participants in total, rather than being prescriptive on the exact number of teams. This led to the number of teams per local authority varying considerably within the trial (from 6 to 16).

Another assumption during the design phase was that teams were made up of just social workers. However, delivery demonstrated that some local authorities had non-social worker members within their teams. These roles included family support workers, assistants, and subject specialists (such as a mental health specialist) who support social workers with their casework. The delivery partner decided these team members should be given access to ISAFE as the intervention intended to change practice at the team level, and therefore excluding members from the training may undermine this. The impact of this was that 16 non-social worker participants took part in the trial.

Both these examples highlighted that the intervention required greater flexibility than initially anticipated. As discussed later, this key learning played a contributory role to adaptations made during mid-delivery to support implementation.

Training delivery

A copy of the information packs sent to each participating local authority can be found in the intervention protocol appendix X.[14] The information pack explained the ISAFE programme and what each training session entailed.

QA audit training and audit exercise

Feedback from the delivery partner was that, overall, the QA audit training sessions were delivered as initially intended. As the session was focused on local authorities' individual auditing system and processes, the delivery of the session was more tailored to suit the local authority and those in attendance compared to the other training sessions which were more general, though the content was still largely consistent across local authorities. These sessions were attended mostly by QA staff or staff with related responsibilities. Some attendees were senior leaders within the local authority and/or social worker team managers. Generally, both the delivery partner and training attendees thought the correct people attended this training session.

A key intention of the QA audit training session was preparing attendees to conduct the case file audits. The audit exercise was intended to be quick and straightforward to complete, as to not overburden local authorities or lead to disengagement. All local authorities managed to complete both case file audits successfully. Based on the small number of responses from QA staff as part of the feedback survey, most respondents (20/21) reported feeling very or fairly prepared for the case file audits. Interviewees also noted that they left the training understanding how to deliver the audit exercise, with any outstanding questions or uncertainties about the exercise quickly resolved either by colleagues who were also attending the session or by contacting the delivery partner. For the audits themselves, interviewees noted that the first audit was quick and easy to complete, and so took less time than they anticipated. While no feedback was collected from QA staff following the second audit, the delivery partner noted these went ahead as anticipated with no challenges reported.

> "I think it was very simple. I was anticipating the piece of work was going to take much longer, but actually, it was a really simple exercise. It was really quite quick." – QA staff

[14] See:

Social worker training (SW1 and SW2)

As part of the trial, treatment teams were invited to attend the Sw1 and SW2 training sessions. Aside from some challenges with attendance, feedback from the delivery partner suggests that the training sessions were largely delivered as intended.

The SW1 and SW2 sessions were intended to be delivered as a two-part training package for social workers, with the first session focusing on the theory behind issues with fatherhood and the second session looking at applying motivational interviewing techniques specifically with fathers. Feedback from interviewees was generally positive about the extent the training felt like a two-part training package, with the theory of SW1 seen to flow and set up the practical skills focus of SW2.

> "I think it was balanced, because it gave you the theory first to think about it and what professionals are working, and we talked about barriers and gender, and then the second session gave you … this is what you can also use to impact you practice of working with dads." – Social worker

Where feedback was less positive, participants suggested that the training felt imbalanced, and more time should have been spent on the content of SW2 than SW1. SW1 was perceived as 'basic' in terms of contents, containing things that social workers may already know about (such as the evidence and literature explaining the reasons for father exclusion in child protection). Comparatively, some respondents reflected that SW2 introduced techniques that required more time for participants to engage with than available within the session.

> "I think there was a big difference between the first session where I thought, 'That was quite basic' [and] session 2 [where] I think we needed longer to actually really get to grips with some of the techniques … I think that we could have used slightly longer on that because I found that was quite intense." – Social worker

Resource library

All treatment group participants were given login details to the ISAFE resource library to access additional materials and resources relating to father engagement and course contents. This was intended to be used as an additional resource for participants to refer to and continue to enhance their knowledge. Both the feedback survey and qualitative feedback from participants suggested that use of the resource library was low. Only 15% of feedback survey respondents (22 out of 150) had accessed the resource library, most of the time just once (see appendix D, figure D2). The majority (85%) of respondents had not accessed the resource library, with 25% of respondents reporting they were not aware of the resource library at all. The most common reason for not using the resource library was not having time (see appendix D, figure D3), though a small number of respondents also mentioned that they preferred using other sources of information (e.g. speaking to colleagues, online search). Another issue raised by a few interviewees was that they had issues accessing their login details, including delays in receiving these.

> "I think there's not currently space in my job to be doing things that aren't directly going to impact the task list that I have to do. So, I probably would have done it, would have looked at it, if there was a particular issue with engagement with a father or something like that. But, because there isn't, then it's kind of a luxury of doing in my spare time." – Social worker

Champions training and father-inclusion champion role

The evidence suggests mixed success on the implementation of the Champions training and father-inclusion champion role. According to the delivery partner, the Champions training sessions were delivered as intended. Senior social workers with management responsibilities, such as team managers and advanced practitioners, were nominated to attend the session and become champions at the start of the programme. In a few local authorities, additional local authority staff attended the training, such as QA staff and senior leaders. Generally, feedback from the delivery partner and training attendees was that the correct people were invited and attended this session, despite a low attendance rate (27 out of 50, 54%).

Champions are intended to support their colleagues by acting as a specialist and advocate for working with fathers who can support them with their caseload, and take a leadership role in promoting father engagement across the service to drive system change. Feedback from attendees suggests that this was not clearly communicated beforehand with some only finding out about this commitment during the session. Some raised concerns about being assigned this role without consideration for their current capacity or interests, which affected their buy-in. It appeared that this lack of awareness was partly due to leaders not effectively cascading information provided by the Fatherhood Institute to relevant team members.

Although champions felt generally prepared and well suited to perform the role, there were uncertainties about the exact expectations of the role and how it should be performed. Interpretations varied, with some champions providing examples of actively speaking to colleagues across the service about father engagement, while others simply supported colleagues as and when they asked for advice.

> "I talked about it in my management team, just to have those conversations, but I'm not really sure what else I can do. I'm not sure. There's certainly no role in my organisation to do anything about it. I wasn't quite clear as to what the expectation of me was … It wasn't clear what a champion looks like. What would they even look like in a very busy child protection team?" – Social worker

This was recognised by the delivery partner, who reflected that attendees perhaps wanted the training to be more prescriptive in outlining clear responsibilities and expectations of the role. In some cases, this appeared to be desirable given the complex systems they work in, including limited capacity to drive forward the conditions needed to create change.

> "I think they were hoping for something far more prescriptive like 'this is exactly how you do it'. But there's also a bit of a pushback about whether or not they

> have the capacity to take on an additional role so that they could do this well." – Delivery partner staff

Examples of champions being embedded as intended were limited. Most social worker interviewees were unsure who their champion was, tending to say that they would go to their team manager if they needed support with a father regardless. Few social workers and champion interviewees provided examples of champions providing support to social workers. Of the few examples, one champion noted supporting a junior colleague to engage with a father who was currently in prison.

> "I had one colleague who needed to access the voice of a father who was in prison, and I was able to support with that. [They] required some practical help with accessing visit to the prison, and I went along with – because it was a fairly new social worker – so I went along with them to help them ask some quite tricky questions." – Social worker

Local authority leaders' webinars

The purpose of the local authority leaders' webinars was to summarise progress and challenges post-intervention, explore changes to practice and team dynamics, and identify ways to embed, sustain and build on ISAFE. Though taking place after all data collection with local authorities was complete, feedback from the delivery partner was positive on the implementation of the webinars. Sessions consisted of presenting the audit findings and informal discussions about the implementation and legacy of the training. It was not within scope of the trial to understand the impact of the webinars.

Adaptations

Participant training session allocation

In Cohort A, the SW1 and SW2 sessions were intended to be delivered to entire teams and as a result the full team were assigned a designated training session on a fixed date and time. In practice, this did not offer flexibility and resulted in attendance challenges (as discussed in IPE EQ 5). This led to the delivery partner needing to offer several 'mop-up' sessions across the local authorities. After Cohort A, the delivery partner also reflected that in some of the sessions delivered to entire teams, they encountered some challenges due to certain teams' dynamics including a perceived resistance to change. Alternatively, they noted that mixed-team sessions led to richer group discussions as social worker attendees had a broader range of experiences to contribute and reflect on.

> "[By delivering to mixed teams,] you move away from their kind of group dynamics that they bring to the room … [It] steps [people] out of their office group and friendships and probably led to more open discussions and probably slightly more focused, actually." – Delivery partner staff

In response to these reflections from Cohort A, in Cohort B, entire teams were no longer required to attend the same SW1 and SW2 sessions and instead individual social workers were given the option to select a session that suited their availability best. This may have contributed to the higher attendance rates observed for Cohort B (see appendix C).

Quality, responsiveness, and programme differentiation

IPE EQ 6 and 8:

- *How acceptable do participants find ISAFE (e.g. contents, number of sessions, online material)?*
- *How do participants perceive the quality of ISAFE (e.g. sessions, contents, trainers, training format)?*
- *How engaged were participants during the ISAFE training sessions?*
- *Is ISAFE seen as a good fit with professional/service norms and with needs of parents, carers, and families?*
- *Is it viewed as an improvement on services as usual?*

Overall satisfaction with ISAFE

According to a feedback question on overall satisfaction with the ISAFE programme, most respondents (79%) reported that they were fairly or very satisfied (see appendix D, figure D1). To explore this further, figures 5 and 6 show participant responses to the feedback survey, discussed in more detail below (see also appendix D, tables D1–D2).

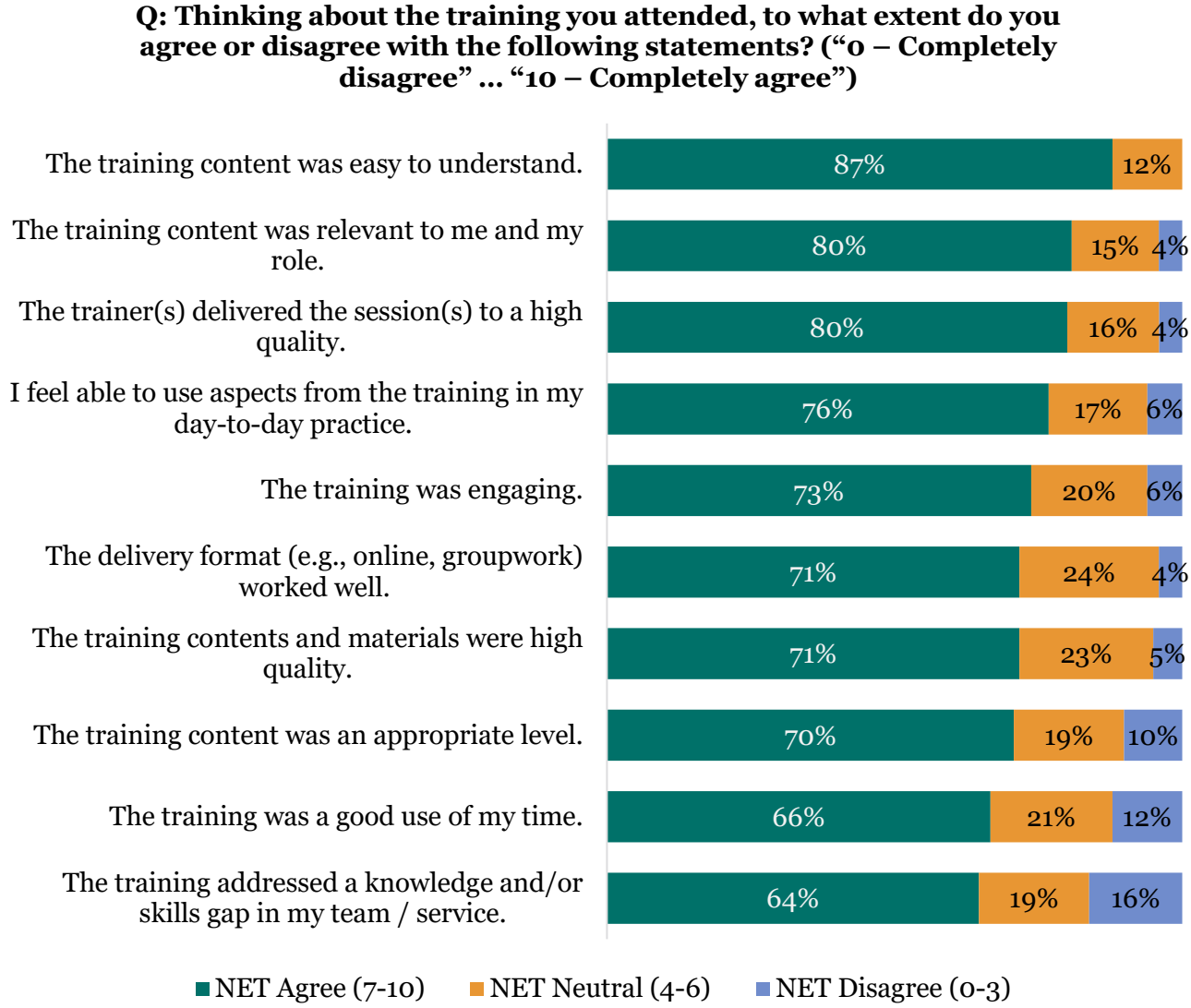
Content of the course – Utility and Relevance

Overall, participants were positive about the utility and relevance of the training. Figure 4 shows that most feedback survey respondents agreed that the training was easy to understand (87%), relevant to their role (80%), applicable to their day-to-day practice (76%), and at an appropriate level (70%). This was echoed when asked about the perceived benefits of the training (see figure 5), with 78% agreeing that the training is very beneficial to their work and 77% reporting that participating in this kind of training is very useful for their job. In terms of quality, 71% agreed that the training content and materials were high quality.

These findings were also mirrored in qualitative interview data, where many recognised the value of attending training on father-inclusive practice and found that the training provided useful in reminding them of best practice. Interviewees mentioned that the training prompted useful discussions within teams and how to enact changes within their systems/teams. Interviewees also expressed that the training was generally pitched at the right level, not being too basic or difficult to understand. In a smaller number of cases, some interviewees felt the training was limited in its applicability to their specific team's work and did not enable discussions within the team on dealing with more specific issues in father engagement within their team – for example, dealing with safeguarding of vulnerable children and barriers to engaging violent/aggressive fathers.

Equally, some participants appeared to disagree with some of the content of the training and the focus specifically on fathers.

Figure 4: Perceptions on the ISAFE training content and quality (link to raw data)



Source: Feedback survey. Base: n=140.

Content of the course – Learning new things

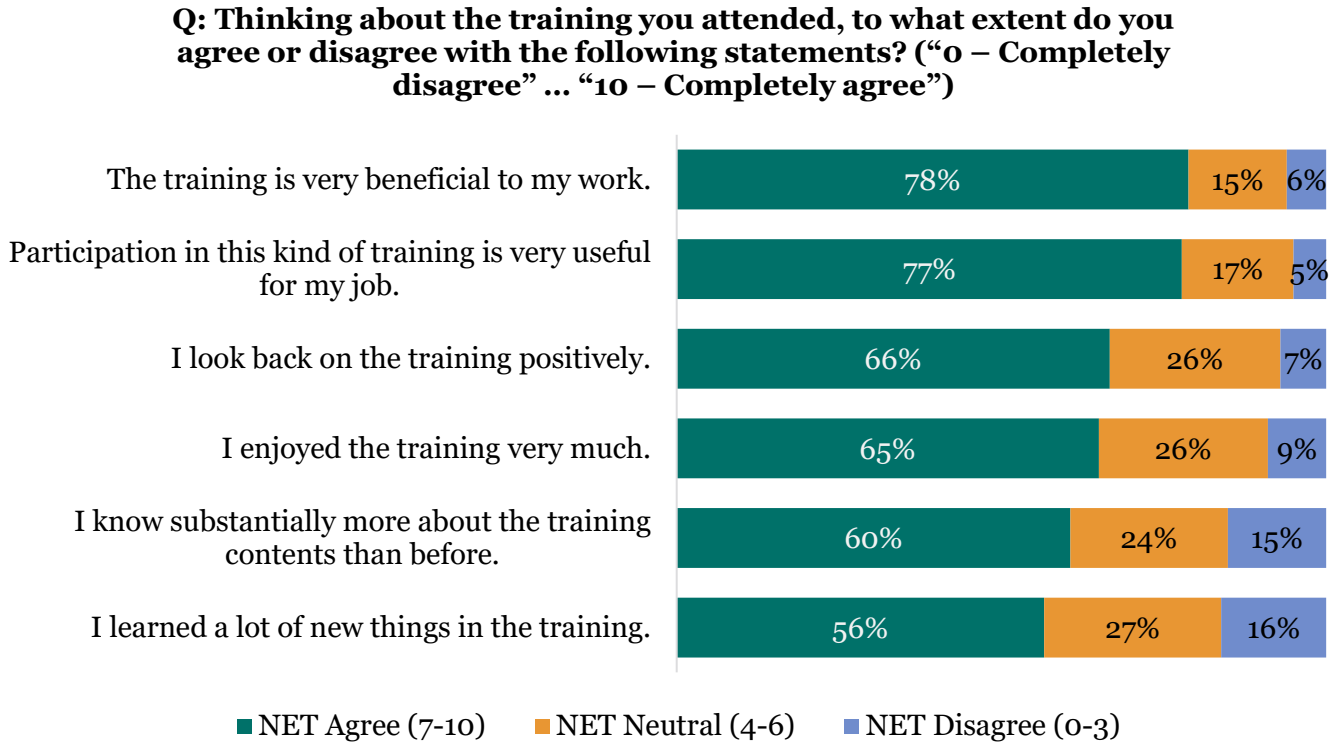
Figure 4 shows 64% of feedback survey respondents agreed that the training addressed a knowledge and/or skills gap in their team/service, while figure 5 shows that 60% agreed that they knew substantially more about the training contents than before and 56% felt that they learned new things from the training. Ultimately, this demonstrates scope for improvement to enhance the value of the content and improve perceptions about the training as a good use of time. This sentiment was echoed in the qualitative interview data, as most interviewees found the training to

cover familiar content to other trainings they had attended in the past, despite these not being father specific. For example, some participants described recently attending training on motivational interviewing and therefore found the SW2 session to be repetitive. Still, many interviewees did highlight new knowledge, such as the effects on men following the birth of their child.

Content of course – Engagement and Enjoyment

Most feedback survey respondents agreed that the training was engaging (73%), and figure 5 shows that about two in three respondents agreed that they looked back at the training positively (66%) and enjoyed the training very much (65%). The qualitative data collected from interviews portrays a more complicated picture with more variation between interviewees. For example, some reported that the training was less engaging because of their familiarity with the content, such as the research on father inclusion in children's social care. Others noted that the online format affected their ability to enjoy or engage with sessions, for example expressing that the role-playing exercises in SW2 would be better face-to-face than virtual.

Figure 5: Perceived value of ISAFE training (link to raw data)



Source: Feedback survey. Base: n=140.

Trainers

Figure 4 shows that the majority (80%) of respondents felt that the trainers delivered the training to a high standard. This is mirrored by the feedback from interviews with most attendees finding

the trainers personable, engaging and well informed on the content. In general, most reflected that the trainers were well informed on the subject matter and able to field more complex questions. However, a small number of interviewees reported that the trainers had less knowledge on their specific team's work, which resulted in them being more likely to disengage. Additionally, it was widely expressed that the trainers handled the risk of disengagement from the online format well.

> "I enjoyed both of them – I thought both of them were really good at keeping the group engaged, and sort of delivering the training and keeping it going. It can be very dry attending training, and to not feel that, with it being virtual training, and for a day, for me demonstrated that they did a good job in providing the training, delivering it, and keeping people engaged." – Social worker/QA staff

Training format

The format of the training was online, with the main SW1 and SW2 trainings occupying two full days. In figure 4, most respondents (71%) agreed that the training format worked well, although a quarter (24%) were neutral on this point. In interviews, some participants were satisfied with the online nature of the training while others expressed that the online format did not work well for them, preventing optimum learning and engagement with the training. Recognising the limited capacity of social workers, this also purportedly made sustained engagement with the online training difficult because social workers could still receive calls, look at emails, and focus on other tasks in the background. It was common for interviewees to report that they found the training too much of a time commitment in their busy work schedule, and they would have preferred multiple shorter sessions instead. As such, the combination of the online format with the length of the training appeared to increase the risk of disengagement.

> "I would have preferred several short sessions. Like I say, just taking up all day of the week is a huge commitment." – Social worker/QA staff

Quality of specific training sessions

QA and audit training

Drawing from qualitative interview data from QA audit training attendees, the training was viewed as informative, valuable, and generally of good quality. Interviewees reported the training was valuable because it showed how to perform the audit exercise they were expected to deliver and also provided suggestions on how their current system could be updated to monitor father inclusion, such as monitoring whether a father's contact details are recorded on the case file. Some interviewees highlighted that the training prompted them to reflect on how their current processes allow poor father inclusion to go underreported.

> "[The training] did cause me to do is start to dig further because sometimes it was just a blank space. So, does that mean that they did come but you forgot to record it or they didn't come? So, then you start going backwards and start looking and then you get to the point of even going back to the assessment stage

> and reading and thinking, 'Oh, the father is not in here at all.' So, it did open up a lot." – Social worker/QA staff

Social worker training

For SW1, interviewees generally indicated that the content of the SW1 provided useful information for social workers. Even though most interviewees were already familiar with some of the content, the training provided an informative refresher for them. Interviewees also reported that the training was at the right level, not being too basic or difficult to understand. Particularly with reference to SW1, interviewees felt that it struck a good mix of academic and practical information.

Interviewees widely expressed that the SW1 and SW2 sessions felt connected and naturally flowed from one to the other. The training order reportedly worked well because the more academic/theoretical and less interactive SW1 session provided an understanding of father-inclusive practice first, and then the SW2 session provided a more practical and interactive understanding.

> "[The SW1 trainers'] presentation was really comprehensive. There was lots of research, lots of evidence, lots of statistics, and that, yes, it made for a learning opportunity. So, for me personally, it was pitched at just the right level. I left the training having learnt and having lots more to think about." – Social worker/QA staff

> "[Talking about SW1] I'm going to say some of it was quite obvious, of course we want to engage with fathers and of course we see their value, but there was also the science underpinning some of that, that was new to me, and that was really interesting because that just helps you think about it slightly differently." – Social worker/QA staff

Based on interviews, the perceived quality of SW2 varied more considerably. Due to many interviewees having previously attended training on motivational interviewing, they felt that this training was less informative. Similarly, others felt where the training offered new techniques, there was limited time to apply these within the training. Despite this, some still appreciated that the training offered an opportunity for reflection on their understanding of father's involvement in their case work.

> "I remember being quite engaged. Within the [SW2] training we had, you know, different discussions. You know, kind of, putting ourselves in clients' shoes, which I always enjoy. And, kind of, you know, reflecting on the importance of fathers' involvement. I think it made everyone a bit more self-aware, like, 'Yes, I should engage fathers a bit more. I should pay attention to that,' yes." – Social worker/QA staff

The online format of the training was another barrier for SW2, because interaction with other interviewees for the role-play and motivational interviewing was sometimes difficult to do virtually.

For example, some people were placed in breakout rooms with interviewees who were not as engaged which then limited their engagement with the exercise and how much they could benefit from the training. Especially due to the in-person and interpersonal nature of social work, some thought SW2 would have been more engaging and impactful in-person. Among interviewees who attended the training online as a team in person, they found this allowed for a good mix of in-person and online engagement.

> "It's not quite the same as being sat in a room with a group of people, and I think you miss out on seeing how other people interact. Because this is so relevant to our practice, and to me, you know, you develop your practice by shadowing other people, seeing other people working." – Social worker/QA staff

Resource library

As outlined in (IPE EQ 3 & 7), usage of the resource library was very low at the time of data collection. However, among the small number of respondents who had used it, reflections were mostly positive, agreeing that it was accessible and easy to understand, relevant to their role, and useful source of information about working with fathers. Only one interviewee provided an example of using the resource library, which helped them prepare for a new case involving a disengaged father.

> "I have access to [the resource library and] noticed that there are a lot of resources that could really help me with [my] new case … the worker that handed over to me had advised me not to bother [inviting the father to] meetings … then during supervision I brought this up and then my manager was like, 'Why not? Just make sure you get the father's view.' Then I said, 'Yes, this is true.' So, I went back to the resource library and … there are a lot of resources how to help make him engage." – Social worker/QA staff

Champions training

Despite the perceived lack of clarity on the champion role, interviewees generally viewed the champions training content as high quality and informative, particularly on how senior staff could embed the learnings in their teams, and on a wider systems level within their area/local authority. The most positive feedback was received by attendees who learned about other team's approaches.

Programme differentiation – ISAFE as an improvement on BAU

Previous training

The evidence collected suggests that most participants have not previously received any training on working specifically with fathers or male caregivers. As shown in figures D5–8 in appendix D, just 3 in 10 (31%) survey respondents had previously received any father-specific training. Of those who had received father-specific training, most had taken part in just one session (46%) or two to three sessions (42%), and half (49%) had received this training in the past 12 months. Looking at how

these training sessions were delivered, sessions were relatively balanced between those delivered internally by colleagues or externally by an external organisation and between being delivered face-to-face or online. External organisations delivering training typically were delivered by councils themselves, Dad's Matter, and universities.

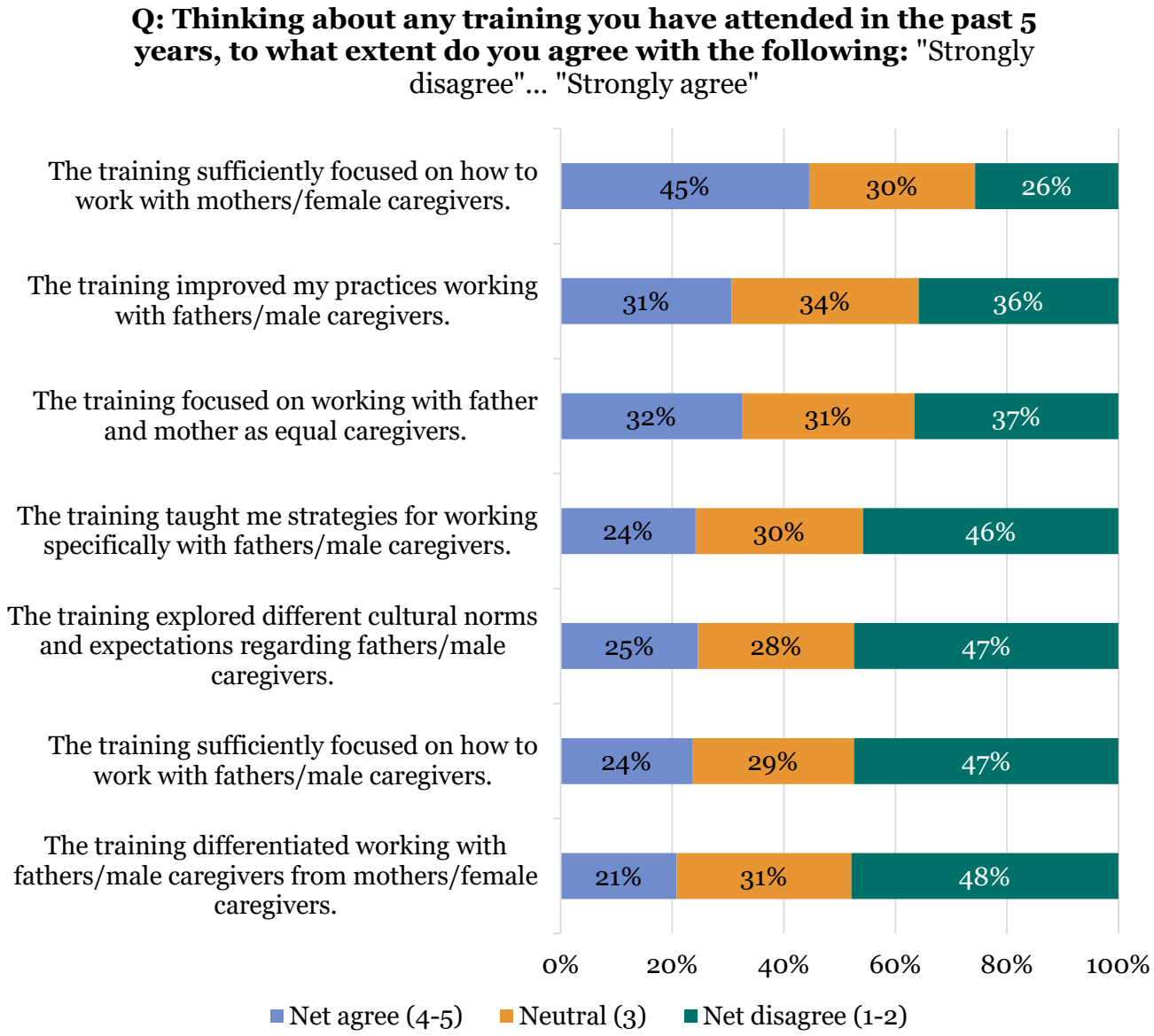
The qualitative data from interviews with participants equally suggested that most had not previously received training on working with fathers, with interviewees frequently noting they had not received training previously or had heard of father-specific training previously:

> "There's not training on engaging with fathers. Even at uni I don't think we had any, to be honest. I just keep fathers and mothers in the same bracket, I don't really differentiate between fathers and mothers. It is what it is, like. I try and engage with both parents." – Social worker/QA staff

Looking more broadly at any previous training survey respondents had received in the past five years and the extent it sufficiently focused on fathers, figure 6 below highlights the following:

- Respondents generally either disagreed or were neutral across each statement, suggesting training generally did not adequately focus on fathers.
- Training was slightly more likely to 'focus on working with fathers and mothers as equal caregivers' (45% of respondents agreed); however, notably fewer agreed that training 'differentiated working with fathers/male caregivers from mothers/female caregivers' (25%), suggesting training may have focused more generally parents rather than recognising their differences.
- Just 3 in 10 (31%) agreed that their 'training sufficiently focused on how to work with fathers/male caregivers', while even fewer thought the 'training sufficiently focused on how to work with mothers/female caregivers' (24%).
- Just one in five (21%) agreed that previous 'training improved my practices working with fathers/male caregivers', suggesting for most training had not led to meaningful change in how they work with fathers.

Figure 6: Views on previous training (link to raw data)



Source: Baseline survey. Base: n=427.

ISAFE training

Many feedback survey respondents and interviewees alike agreed that ISAFE was useful and relevant for their work. As seen in figure 4 above, most respondents (76%) felt able to use aspects of the training in their day-to-day practice. However, fewer respondents (64%) agreed that the training addressed a knowledge or skills gap in their team. Overall, the interview data from attendees suggests that many felt it had the potential to improve services as usual, though this was relative to the work of their team and prior exposure to similar training or content from other sources.

Some interviewees reported that, after attending ISAFE training, they updated their systems so that more thorough data was kept on fathers and how, if, and/or when they had been last engaged.

> "From your audit template, there was a part where it said, 'Could you check to see not only has the father been invited but did they attend?' And normally, it would show from our systems that fathers didn't attend but the part that we didn't do is, have they been invited to be able to attend. So, in the independent reviewing type of meeting that they have, service meeting, we fed that back and it's something that they're going to be now adding to a monitoring form." – Social worker/QA staff

Interviewees who attended the SW1 and SW2 training sessions reported feeling more reflective on their usual practice. For example, interviewees thought more actively about including fathers in their case work, especially when they had not been previously contacted or even known by their team. Some interviewees said that they now spent more time empathising with a father's context, which allowed them to approach their case work in novel ways and reach positive outcomes.

> "But I think [ISAFE] just made me … ask things in a slightly different way around, rather than saying, 'Well, I've noticed that this is going wrong and that's going wrong,' rather than that say, 'Right, tell me how we got to this point, how are we going to help?' And I think that was really powerful particularly in this dad that I'm working with because the social worker's relationship has broken down with this dad so badly he won't work with them. I've taken that add on … that has really worked for him." – Social worker

> "So let's say a family that I'm working with now … I didn't even know his first name really … But now we are working with the whole family, including the dad, and he's more involved. He's basically every step of the way, even one of the children lives with him now. So it's a whole 360 regards to dad's involvement comparing where we were last year." – Social worker

Experiences of fathers

The evaluation included interviews with a small number of fathers who receive support from a participating social worker to better understand their experiences and whether they noticed any differences in how they work with their social worker in the past six months (approximately when the social worker would have received the first training session).

Overall, the interviews were ultimately too limited to identify examples of social workers changing their practice as a result of ISAFE (this may be due to sampling, with father participants tending to have a better relationship with their social worker to begin with). However, fathers identified several key examples of best practice either that they had experienced or suggested social workers should follow to best support fathers:

- **Both parents should be valued equally, regardless of the context:** Those with more positive experiences highlighted that their social worker valued their input and role as a parent equally to the mother of their children, while those who had less positive experiences perceived themselves to be less valued. In practice, this means the father should be involved in all communications and decision-making, even when they do not have custody or when the parents are not together:

  "If there's two parents, the father needs to be heard as well on his point of view … they need to sort of listen more. The person [without custody] still needs to be heard the exact same way as someone who has got full custody." – Father

  "[My social worker] is more of a neutral professional or social worker [between me and the mother of my child], as they should be." – Father

- **Open and honest communication and relationships:** Developing a relationship based on trust and open and honest communication was seen as crucial by fathers, even if this means being involved in difficult conversations. A key component of this was social workers listening to the father and making their point of view feel respected; failing to do this often is perceived as antagonistic to the father.

  "Just be honest with them, I think. Tell them what's going on and try and obviously pick out the truth from the untruth sometimes, because that's very difficult, but, you know, just generally be straight up and honest, good or bad, whatever that might bring." – Father

  "[My social worker] understands, like, and she knows how to [listen] … She knows how to talk without sounding threatening." – Father

- **More recognition of the father's role and perspective:** Similar to above, social workers recognising what role the father can have in their child's life was suggested to be key to improving their confidence and driving positive action:

  "[My social worker] was acknowledging the fact that I could raise a baby on my own, which was reassuring." – Father

- **More support and resources tailored for fathers:** One father suggested there is a lack of resources tailored towards fathers, contributing to feeling unsupported. They suggested more should be available specifically for fathers, as this would have helped them in their journey:

  "Men need to have a bit more [support and resources] than they have, I think. Or maybe it does exist out there, but I was never given the resources or told about what I could do with it [which I would have valued]." – Father

Mechanisms of change

IPE EQ 1: *To what extent is the ISAFE theory of change validated?*

Mechanisms of change are the processes that are anticipated to happen in intervention participants to link a theory of change's activities to the intended outcomes (Kazdin, 2006). Within the ISAFE theory of change, three sequential overarching stages of mechanisms (awareness & knowledge; skills & confidence; attitudes & practices) were hypothesised to be required before practice and family impacts were anticipated. Due to the length of the trial, most practice and family impacts were not anticipated to be realised during the trial. Instead, the earlier mechanisms (awareness & knowledge; skills & confidence; attitudes & practices) were expected to be evidenced and provide an indication about whether the theory of change held true. It is important to note that the evidence relies on self-reported questions about applying skills rather than testing of skills, for example through real or simulated practice.

In the following section, we examine the evidence against each of the mechanisms and some of the in-scope impacts as presented within the theory of change. This analysis is presented under the practice pathway (social worker training package) and systems pathway (QA audit training and Champions training). Mechanisms associated with the local authority leaders webinars is out of the scope of the trial due to the webinars taking place after all data collections.

Practice pathway

The practice pathway encompasses the social worker training package, intending to influence the impact of individual social workers and how they work with fathers.

Social worker training

The evidence against each of the hypothesised mechanisms below suggests that the theory of change for the social worker training has been validated; however, there is generally insufficient evidence to demonstrate either the practice impacts or family impacts.

There is good evidence to suggest that each mechanism relating to increasing awareness and knowledge has been realised, with the survey and interview data supporting this conclusion. The evidence collected for the mechanisms relating to skills and confidence also support this. While participants regularly highlighted that they did not learn new skills or that their confidence was low, the impact analyses demonstrated the training had an impact and was found to motivate participants. Examining the mechanisms under attitudes and practice, the impact analyses and qualitative data indicates these have been realised. Examining the practice impacts or family impacts, the qualitative data does not provide sufficient evidence to assess whether these mechanisms have yet been realised.

Awareness and knowledge

The evidence collected suggests that each of the practice pathway mechanisms relating to awareness and knowledge have been realised. To support this, survey data, revealed in figure 7, shows that most respondents self-reported an overall increase in their knowledge since taking part in ISAFE in following:

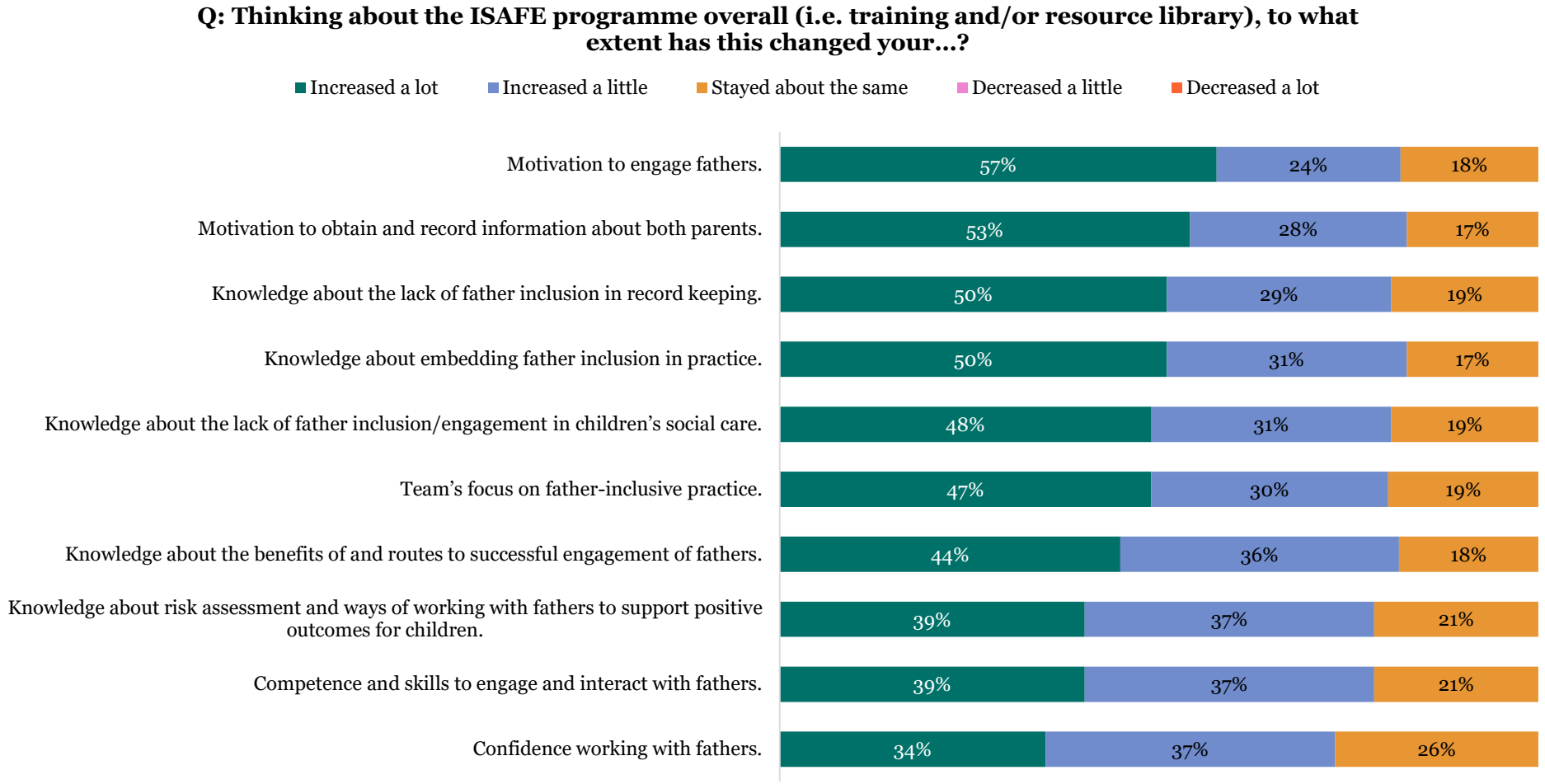
- **Knowledge about the lack of father inclusion and engagement:** 79% of respondents reported an overall increase in their knowledge, with half (50%) reporting that their knowledge 'increased a lot'.
- **Knowledge about the benefits of and routes to successful engagement of fathers:** 79% of respondents reported an overall increase, with 44% reporting their knowledge 'increased a lot'.
- **Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children:** 77% of respondents reported an overall increase, with 39% reporting their knowledge 'increased a lot'.

The qualitative feedback with attendees generally supports these findings and helps contextualise these further. A common reflection by interviewee was that, as a result of the training, they better understood the issues and challenges around father engagement within children's social care. The focus of SW1, focusing on both the systems-level barriers and their own personal practices, was suggested to be particularly impactful on highlighting the extent of the issue, with key activities, such as reflecting on their own relationship with their father and how this impacts their practices:

> "Based on my own bias, my own storyline, where you think men are macho, you know, why should we be speaking to a man and, you know, the cultural aspect of engaging with fathers, for me, it's resonated with my background and I thought, 'Oh no. The fathers have to be spoken to, whatever it is.' Because that fear of, you shouldn't be doing this, you shouldn't do that. But now I know, they should be there, they should be part of their families' lives." – Social worker

> "I think as a manager … my team have always been pretty good about inclusion of fathers. But it's interesting and I think the information we received on the first day regarding our own relationships with our father has a great bearing on how we include fathers in the assessments." – Team Manager

Figure 7: Participant changes as a result of taking part in ISAFE (link to raw data)



Source: Feedback and endline survey. Base: n=228.

Similarly, the videos of fathers discussing the challenges they have faced working with social workers during SW1 was also suggested to be particularly insightful:

> "I was really struck by the experiences of the fathers, and that really helped me to, kind of, put myself in their shoes and think, 'Okay, this is how they are experiencing this situation and their involvement with social services.' Unfortunately, across the board, it was really quite negative and that I think was the most powerful plea. That's the biggest thing that stuck with me out of that entire training." – Social worker

The training was suggested by some to be effective at highlighting the benefits of engaging fathers, both for the father and family, and providing approaches to successfully engaging sessions. The SW1 was seen to challenge attendees' assumptions and biases towards fathers and their desire to be involved, while the SW2 session built further on this by exploring how resistive behaviour may be interpreted differently and overcome.

> "I think [SW1 is] where I got the information about how fathers wanted to be included and of course because the world of social work is predominantly female, fathers do struggle to feel involved." – Social worker

> "[My key takeaway from the SW2 training was] understanding the nature of the resistance. Yes. Why are they resisting?" – Social worker

Another common theme was that the training reiterated the importance of considering fathers within the context of their wider family, even if engagement has previously been difficult. Several interviewees noted that their main takeaway from the training has been ensuring fathers are involved throughout all processes, even if it is challenging.

> "[The training] definitely has made me even more aware than what I was before about the need to engage fathers and their wider family as part of our assessment process, as part of the support and as part of support services for mums and dads. Trying to keep them engaged is difficult … I think it's just trying to keep them engaged and trying to warn them of the importance of coming to meetings." – Social worker

Not all interviewees stated that the training led to an increase in their knowledge. Some key themes limiting this are:

- **Experience:** Experienced practitioners were often already familiar with the content and key messages of the training, limiting the extent that their knowledge increased. This was clearest when interviewees frequently regarded the training as a refresher on things they already know.

> "It's what you already know, but it's hearing it again, and hearing it externally. It's just the inclusion side of things, and what it means to be involved in an

assessment for me particularly. Some parents are absent for their own choice." – Social worker

- **Overlap with other trainings:** Some interviewees reported taking part in other training sessions that overlapped with ISAFE, meaning parts of the training felt duplicative. Examples include: training focusing on engaging abusive or absent parents, parents with complex needs, and motivational interviewing.

  "I wouldn't say it wasn't helpful, but I think some of it was quite repetitive because my team, about two months ago, had just done an intensive trainin g… and some of the learning that we found ISAFE crossed over to the training that we'd done. And it was about working with perpetrators and domestic violence. And some of those ways of working where you're finding it hard to work with fathers." – Social worker

- **Perceived gaps in the training:** It was suggested that the training focused too extensively on the father and the role of the practitioner. It was suggested that this meant the training missed the nuance and complexity of working with complex families, while other factors such as practitioner safety and the role of the mother were underexplored.

  "The overarching issue I had with it … was that [it suggested] we weren't engaging dads or bothering to and that we should be seeing that we should do that and we shouldn't just focus on the mums, etc. It wasn't digging into some of the reasons and it was talking about some barriers that dads might face to be engaged fully and the difference in terms of their motivations and their status and masculinity and things." – Social worker

  "There are multiple complexities [underpinning father engagement], it's not the unwillingness of practitioners, it's also about their safety as well, and 'At what point do we step into children's lives?' … in some situations fathers don't even know that they've got children. Then there's also the issue of the father rejecting the child and blame as well." – Social worker

Motivation, skills, and confidence

The evidence supports that participation in ISAFE led participants to having **increased motivation to engage fathers**. The realisation of this mechanism is suggested by the survey data, as shown in figure 6, where four-fifths (80%) of respondents reported an overall increase in their motivation, with most of these respondents (57%) reporting their motivation 'increased a lot'.

The qualitative feedback from attendees equally supports that this mechanism has been realised. Interviewees frequently reported that one of their key takeaways from the training was a renewed motivation to ensure the fathers in their caseload are included where possible, even if the father is resistant or they have a difficult relationship.

> "It's made me think of ways to more positively frame [the challenging fathers I work with] which is useful in terms of motivation … because it helped me think about how I can frame it to other parents and it fits with the family networks that we're meant to achieve through signs of safety so it had resonance there. It's helped me think about the accountability that I need to give workers and really question and give a proper rationale of why they weren't involved if they're not." – Team manager

Increased motivation was suggested to be an immediate change following the training, though one attendee suggested that this motivation and focus on fathers reduced over time:

> "I think it's just bringing it back to the forefront really, so whenever I'm having those discussions, or it had at the very early onset of that training, it's sort of filtered away now. But I would say probably for the first four months that was the theme that was going on during supervision, during conversations that I've had with social workers about casework. That, you know, 'Let's look at how we can get fathers better engaged in this circumstance.' And what I'm doing is dropping in and out of it because sometimes it's needed and sometimes it isn't." – Team manager

The impact evaluation found that ISAFE led to participants **having improved competence and skills to engage and interact with fathers**. This is additionally supported by the survey findings, with 76% of respondents reporting an overall increase in their competence and skills, with 39% reporting this 'increased a lot'. This suggests that this mechanism was realised in most participants as a result of ISAFE, though the extent of increase varied.

The qualitative feedback from attendees highlights a more nuanced picture that may help interpret these findings. Interviewees regularly reported that the training didn't lead to them learning new skills or feeling more competent per se, but rather it enhanced their current skill set. As most participants were qualified social workers with experience working in the field, they often felt they already possessed the necessary skills and competency to work effectively with fathers.

> "I welcomed it as a point to have discussions. I didn't necessarily feel like I was learning any new skills, maybe some new information but no new skills … because I think for the most part you were talking to people that had a general understanding." – Social worker

Instead, participants often viewed the training as reiterating the importance of applying skills, that sometimes may be overlooked or deprioritised when working with a challenging case:

> "I don't know if it's given me many additional skills, but it has given me a prompt to use the skills that I did have, I think. So I think it's more of a reminder of the importance. I think subconsciously I knew that I should have been doing better … I don't feel like it gave me much that I didn't know in terms of the skill and how to apply that, I think I probably already had that." – Social worker

An exception to this was for early careers social workers still developing their skills. It was suggested for this cohort the training was most effective:

> "No, I wouldn't say [my skills improved] personally … but I think as a whole for new practitioners, I think it's a little bit of a part of the jigsaw puzzle of what really working with families is about and how to get the best out of those assessments. You know, alongside other assessment tools and strategies." – Social worker

Another factor which may help understand this mechanism was that some participants were familiar with motivational interviewing already, as discussed earlier. This meant they reported gaining little from these sessions:

> "I think the motivational interviewing day was teaching social workers old tricks. It was really we knew everything, I think by the end of day two, a lot of my team had lost the will to live." – Social worker

The impact evaluation found that ISAFE led to participants having **improved confidence working with fathers**. This is additionally supported by the survey findings, with 71% of respondents reporting an overall increase in their confidence working with fathers, with 34% reporting their confidence 'increased a lot'. This suggests that ISAFE led to improved confidence in most participants.

The interview feedback from training attendees helps contextualise this further. While increased confidence wasn't discussed by all interviewees, some reported that it had increased since taking part in the training. Others highlighted that their confidence was not low pre-training, and this wasn't a barrier to working with fathers. Instead, for them, the training prompted them to think about how they can proactively engage the father, even if previous social workers had not engaged the father or had poor relations with them.

> "I think, for me personally, I think I have become more confident, a bit more, with working with fathers … because I've had fathers swearing at me and, you know, that sort of thing. It's just not because of the nature of the job, you can't let it prevent you from continuing to work with fathers. Especially those who are not present in their family home." – Social worker

> "I don't feel there was a general feeling of anyone being underconfident working with fathers. It's more about making sure it's firmly on their radar, because like I say, if you inherit a file that's silent on the father, it's very easy to run with what you've got when you're so busy." – Social worker

In addition to this, it was suggested that increases in confidence didn't necessarily mean just for working with fathers. Some interviewees reported they felt more confident working with the whole family, including mothers who put up barriers to fathers being involved:

> "Well, interestingly I suppose it's almost – I know we're specifically talking about fathers here – but it's almost changed the way that I work with mothers. Because I think quite often I would just say, 'Oh yes, okay. Fair enough. You've had this experience with the father. You don't want them involved. Okay, fine.' But I'm challenging them now." – Social worker

Similar to this, a few interviewees suggested their confidence increased in their own practices as a result of taking part in the training, even if their team hadn't previously promoted a culture of father inclusion:

> "It's not like I was … not confident to speak with fathers … It was more within my workplace. But before I wasn't really confident because, like I said, I would follow … the lead of social workers [who neglect the role of the father]. But this training gave me, like, reassurance that what I was feeling and thinking about working with families was correct." – Social worker

Attitudes and practice

To help explain what improved engagement looks like in practice, several interviewees suggested that, to them, it meant being more proactive in engaging fathers and removing barriers to engagement. Common themes raised included:

- **Offering different modes of contact:**

  > "Since doing the training I definitely [have been] contacting fathers sooner, rather than it necessarily just being a telephone conversation. I will always [offer], a Teams or a face-to-face [either] in the office or at their house … And you get more information from fathers, and they understand my role a bit better." – Social worker

- **Booking appointments outside fathers' working hours:**

  > "For example I had a father who was working, but finishing work late, maybe around 6 and would be home around 7, but at the same time I finished work at 5.20 so I had to make an appointment to call him around 7 when he's at home. So for me that was, like, part of including him in the training, just to be flexible and obviously take my time off that I would have spent working and talking on the phone with him." – Social worker

- **Involving both parents at the earliest stage, rather than just the primary caregiver:**

  > "Initially, to make the initial visit I would just call the primary carer and then get that perspective, and then call the absent parent, usually. But I took a different approach and called them both at the same time, then explained to the absent

> parent that I would be in touch, but I've not seen them yet, essentially, but this is what we're doing to, kind of, include them from the first instance rather than when I've already got some information, and then call them. And that's stuck with me since, to be fair, it's something I saw worked so kept doing it." – Social worker

- **Not giving up on fathers who are immediately resistant to involvement:**

> "If they say, 'I don't want to engage with you. I don't want to see you. I don't want you to come and visit my house. I don't consent to an assessment,' it's quite easy to then say, 'Oh, well they didn't consent.' But actually, if you're a bit more persistent and try and build the relationship with dads and men who are involved in children's lives, they bring a lot to the table in terms of support and looking at who the networks are around children, who can to keep them safe, who can support." – Social worker

In addition to this, several team managers suggested they had noticed a difference in their team's attitudes and practices in relation to fathers:

> "Yes, definitely more engaging. More engaging, they include fathers more in support if they're not in a relationship with the mother. So, definitely, fathers are being included much better." – Team manager

> "I think before the training there was a certain amount of dismissal of dads, I'll be honest, of, 'Oh, well, we can't find them, we haven't got the number for them so we'll have to give up,' you know, rather than, 'Actually, no, if we ask his mum or her mum and his brother we might be able to find this dad.' It's about being a bit more curious isn't it." – Team manager

This mechanism is covered less by the qualitative evidence from participants. While interviewees highlighted that they were making more of a concerted effort to ensure fathers were engaged and assessments included details about the fathers, little evidence was collected to suggest that this data was being analysed more frequently.

> "All of my social workers now include fathers in all assessments and if they can't then they will evidence what extent they've gone to to try and include fathers. They know if they don't, they're getting the assessment back." – Team manager

Practice impacts

The evidence does not provide sufficient support to demonstrate that ISAFE led to **higher-quality risk assessments of fathers**. Relying just on the qualitative feedback from attendees, limited evidence was captured to show that ISAFE impacted the quality of risk assessments.

The evidence provides some limited support that ISAFE led to **better identification of resources associated with fathers**. The only source of evidence is participant qualitative feedback, whereby only a few interviewees discussed this mechanism, so it should be considered indicative at best. Where it was discussed, this was because the training prompted them to reframe their thinking of the father towards what role they can have on their child and family:

> "When we work with families in [my] team, we see families in crisis, we're often trying to safeguard children in all different aspects and fathers can sometimes get lost within that. And I think it's just about considering [whether] we [are] identifying [the father as] a further safety network for this child? [Even] if they might not live with dad, they might not have seen dad for a few months; however, he could be a really significant safe person." – Social worker

Family impacts

The evidence does not provide sufficient support to demonstrate that ISAFE led to **better support for father–child relationships**. Relying on the qualitative feedback from participants and fathers, limited evidence was captured to demonstrate this impact had yet been realised as a result of the ISAFE training. From the limited number of interviews with fathers, it was not possible to identify any change in social workers' practices that could be attributed to taking part in ISAFE that may have impacted the father–child relationship.

Systems pathway

The systems pathway encompasses the QA audit training and Champions training (and the local authority leaders webinar which is out of the scope of the trial and therefore not covered), intending to lead to sustainable, systems-wide changes within local authorities to complement and embed the practice changes underneath the practice pathway.

QA audit training

The evidence against each of the hypothesised mechanisms below suggests that just some of the theory of change for the QA audit training has been validated, with insufficient evidence to demonstrate that local authorities change their auditing processes as a result of ISAFE.

While the evidence suggests ISAFE improves knowledge about the lack of inclusion of fathers in record keeping and increases motivation to ensure they are included, there is insufficient evidence to show QA staff learning new skills to improve their auditing processes or embedding new systematic approaches.

Awareness and knowledge

The evidence supports that participation in ISAFE led participants to having **increased knowledge about the lack of father inclusion in record keeping**. The realisation of this mechanism is suggested by the survey data, as shown in figure 6, where 78% of respondents

reported an overall increase in their knowledge, with 50% reporting their knowledge 'increased a lot'.

The qualitative feedback from participants additionally supports this. In addition to the themes discussed relating to improvements in knowledge for the practice pathway, participants also suggested that the presentation of their local authorities audit results was highly impactful. It was seen to help visualise the extent of the issue in record keeping:

> "I think what stuck out to me, and I can visualise the spreadsheet that was shown to us about conferences, were fathers were invited and those who attended and how there was such a difference in that. So, I think that data is stuck in my head, you know, because I was quite surprised that actually, we do invite fathers but they just don't attend, but yet we don't have their details on the system, so how does that all work then?" – Social worker

> "I really liked that they showed some of the statistics and they show the baseline from the first round of audits that had been done. And I was able to actually identify [my local authority], even though it was anonymised from the audit. And as [other interviewee] said, we didn't fare well." – QA Staff

Motivation, skills, and confidence

The evidence supports that participation in ISAFE led participants to having **increased motivation to obtain information about both parents**. The realisation of this mechanism is suggested by the survey data, as shown in figure 6, where 80% of respondents reported an overall increase in their motivation, with 53% reporting their motivation 'increased a lot'. This suggests that most participants' motivation increased as a result of ISAFE.

The qualitative evidence additionally provides some supportive evidence. In addition to the evidence discussed within the practice pathway relating to motivation by social worker participants, some team managers suggested their team's increased motivation was leading to fathers being more regularly included within their assessments and case file:

> "I think it has [been impactful] for my whole team … because every assessment I sign off now, fathers are included. Whether it's in-person or the extent to how they've tried to involve fathers, so definitely, I think it has impacted." – Team manager

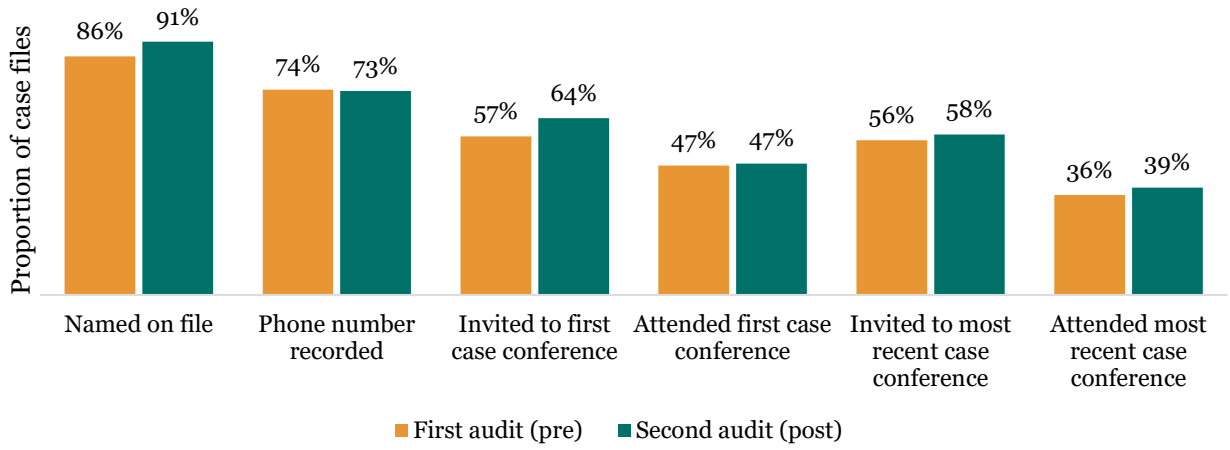
The evidence does not sufficiently demonstrate that ISAFE led to **increased ability to embed processes for father-inclusive record keeping**. Relying just on a limited number of qualitative interviews with participants, QA staff suggested that while the QA audit session primarily focused on how to conduct the audit exercises and also discussed how they could change their own systems, participants did not suggest it increased their abilities to embed processes within their systems. While some reported looking further into their own process following the training, none reported that their ability to do so changed as a result of ISAFE.

Attitudes and practice

Despite some examples of individual staff implementing changes, the evidence does not sufficiently demonstrate that ISAFE led to **improved processes for father-inclusive record keeping at a system level and more systematic data collection being embedded**. It does, however, provide some limited evidence that **regular father-inclusion audits were being conducted**.

The case file audit data, as shown in figure 8 and broken down further in appendix D, aligns with the findings from the impact evaluation. While there were improvements in some measures, such as the proportion of fathers named on the case file and invited to the first case conference, other measures remained fairly consistent, such as the proportion of case files with the father's phone number recorded and attendance at first case conferences. Similarly, when looking at the audit data at the LA level (presented in appendix D), there is significant variation across the LAs, with some showing improvements between the audits, while others had no change and even declines for some measures. Notably, the case file audit clearly demonstrated the gap between information recorded on mothers relative to fathers.

Figure 8: LAs combined average for the proportion of audited case files with the father (link to raw data)



Source: QA audit results data

Although based on a limited number of interviews with QA staff, examples of local authorities regularly auditing on father inclusion in record keeping was identified. In one local authority, a monthly review of father inclusion had been implemented, while in another, discussion about father inclusion was suggested to now be part of QA moderation meetings.

> "I review it on the first of the month. We've got new families coming in all the time. So I renew it on the first of the month, now, to look at which children do not have a relationship to their father laid out on our system, so that we can keep on top of that. And it's just that continuing prompting to the social workers, that, actually, 'If he's not even on the file, what are you doing with him? How do you

> even know what his name is? Do you know how to spell his name?' Those really, really basic things." – QA Staff

There was limited evidence to demonstrate that local authorities had improved processes for record keeping and more systematic data collection had been embedded as a result of ISAFE. Generally, where improvements in record keeping were identified, this tended to be driven by social workers themselves and team managers reminding social workers that assessments need to include fathers, rather than any changes at the local authority level on record-keeping processes.

Champions training

The evidence against each of the hypothesised mechanisms below does not sufficiently validate the theory of change for the Champions training, with generally limited or insufficient evidence to demonstrate that each mechanism of change has been realised. However, the evidence does suggest that team culture (practice impact) had improved as a result of the intervention.

While the evidence does suggest knowledge on embedding father inclusion increased as a result of ISAFE, the feedback from Champions training attendees suggested only a few had learned skills to embed this within their teams. This perhaps explains why there was limited supporting evidence to suggest Fatherhood Champions were ongoing advocates for fathers in their teams and helping embed the intervention. Despite this, the evidence suggests team culture towards father-inclusive practice had improved, suggesting that other strands of the intervention, such as the social worker training, had resulted in this impact being realised.

Awareness and knowledge

The evidence provides some support that ISAFE led to **increased knowledge about embedding father inclusion in practice**. Of the limited number of interviews with Champions training attendees, it was suggested their knowledge on supporting father inclusion within their team increased as a result of participating in the training.

> "Obviously it's the team that are going out to families all day every day. I don't do nearly as much of that as they do, so it was absolutely stuff that they could effect in their day-to-day role, but really relevant to me as well, from that slightly different perspective of being able to make some changes and to support them to." – Champions training attendee

In addition to this, this is supported by figure 6, which, while sent to all participants and not just those that attended the Champions training, shows that 81% of respondents reported an overall increase in knowledge, with 50% reporting their knowledge 'increased a lot', suggesting most felt their knowledge had increased.

Motivation, skills, and confidence

The evidence does not suggest that ISAFE led to **improved skills to support culture change in the team**. Relying on qualitative data from Champions training attendees, no interviewees reported having improved skills to support culture change and, as discussed in the Intervention fidelity and adaptation (IPE EQ 3 & 7) section, a common piece of feedback from participants was that they felt unclear on how to perform the Fatherhood Champions role to lead culture change within their team and local authority.

Attitudes and practice

The evidence shows some support that ISAFE led to an **ongoing focus on father-inclusion advocacy**, however there was limited evidence to show whether Champions were enabling an **enhanced adoption of/support for intervention** within participating local authorities.

While only involving a small number of interviewees, the qualitative evidence identified several examples where Fatherhood Champions/team managers were actively advocating for their team to ensure fathers were included in their assessments and practice.

> "I think all of my social workers now include fathers in all assessments and if they can't then they will evidence what extent they've gone to to try and include fathers. They know if they don't, they're getting the assessment back." – Team manager/Father-inclusion champion

> "I think I push more. I'm wanting to engage the father more. And when I'm doing supervisions with my team now, if I'm asking, 'So what did father have to say?' And they're like, 'Father wasn't at the home visit.' I'm definitely saying, 'Did you ring him and let him know that you visited and what were his views?' So I'm working on incorporating father a lot more." – Team manager/Father-inclusion champion

However, there was insufficient evidence to show that Fatherhood Champions were enhancing adoption of the intervention more broadly. As discussed previously, regular feedback from Champions was that they were unclear of the expectations of the Champions role and as a result many did not know what they needed to do to embed culture change within the local authority.

Practice impacts

The impact evaluation found that ISAFE led to an **improved team culture on father engagement**. This is additionally supported by the survey data, where 77% of respondents reported an overall increase in their team's focus on father-inclusive practice, with 47% reporting it 'increased a lot'.

Similar to this, the qualitative feedback suggests this mechanism has been realised. Several interviewees identified that, as a result of the training, the team overall had become more focused

on father engagement. This was best illustrated by the team discussing father inclusion more regularly, with both team managers and social worker participants suggesting they had noticed a real difference.

> "I think [the training] has just prompted some much more open discussions. The teams then went away and said, 'Well, actually, now I want to think about Mr and Mrs so-and-so, and I want to think about [their children], because I've noticed that.' Or they'll go out on a visit and come back and say, 'That was really interesting, because actually, that dad was very passive,' or, 'That dad wasn't, and that dad was really hands-on.' That's been really interesting." – Social worker

However, as mentioned earlier, it was suggested by a few interviewees that the impact on team culture and practice was strongest immediately after the training – as illustrated by more discussions about fathers during regular meetings – though it had become less regular as time passed since the training, suggesting the impact may not be permanent.

Barriers to the effectiveness of ISAFE

As highlighted throughout previous sections, the evaluation identified several barriers limiting the effectiveness of ISAFE. To summarise some of these key barriers:

- **Engagement during sessions:** As discussed within the section on Quality/responsiveness (IPE EQ 6 & 8), participant feedback suggested the length of the training sessions (particularly SW1 and SW2) and the online format made maintaining focus more challenging. Some reported themselves or others losing focus and/or completing other tasks during the training as consequence.
- **Perceived oversimplified view on the challenges around father engagement:** The training was suggested to oversimplify a complex issue by focusing on what the practitioner can do differently. Some thought it neglected the complexity of working with fathers who may be perpetrators of abuse and/or antagonistic to social workers and that social worker or family safety can be the reason why the father isn't included:

  > "[The training] wasn't digging into some of the reasons [for why we don't engage fathers] and it was talking about some barriers that dads might face to be engaged fully and the difference in terms of their motivations and their status and masculinity and things. That was interesting but the fundamental reason we usually have to do this is around domestic abuse … It would have been helpful if we'd [discussed] rational decision-making about when to include and when to not and what would be our lines." – Social worker

  Similarly, it was suggested that the training didn't sufficiently address how to deal with mothers who do not want the father to be involved even though there is no reported abuse or mistreatment by the father. This left some participants being inadequately prepared to manage these conversations.

- **The barriers ISAFE aims to tackle are difficult to overcome:** Some barriers, particularly those relating to the father's ability or willingness to engage, were not seen as being sufficiently addressed by the training to be overcome in practice. This may have resulted in practitioners being unable to apply the training to practice regardless of the training's impact on them. As shown in figure D4 in appendix D, the most common barriers to engaging fathers relate to their caregiving responsibilities, responsiveness to the practitioner, the other parent not wanting them to be involved, and fathers' behaviour challenges.

- **Social worker time and capacity restraints:** Ability to implement the training was limited by the time and capacity pressures that social workers face. It was suggested that engaging fathers to the same extent as the mothers could effectively double the workload per case, as they would have to repeat conversations twice.

  > "I think the difficulty I've had is probably, it's about capacity. I think that's probably been my struggle with it previously, is perhaps I'd avoid speaking to someone who's not the primary caregiver. Which is more often than not, the mum. Because I want to avoid having duplicate conversations … It's like doing twice the work almost." – Social worker

  Related to this, training suggestions to include fathers, such as calling fathers outside working hours in the evenings, were viewed as excessively adding to participants' workloads.

- **New referrals:** Referring organisations, such as schools, may not include any information on the father in their referral, either because they don't have this information themselves or because they did not see it as relevant. This was seen as a barrier to implementing the training, as it makes it difficult to involve fathers in decision-making from the start.

  > "When we create a child's electronic file, the information that we use to create that is taken from the initial referral. So if dad isn't on that initial referral, he is not on the child's file. So that file then gets created, somebody makes a decision about whether or not we're going to accept that child in for an assessment … And at that point of making that decision, you know nothing about the child's father … We're just missing that, at that very first stage about do we even need to be involved, we're not considering dad." – QA staff

Sustainability

Two main challenges to the sustainability of the impacts of the training were identified:

1. **Staff turnover:** Team members who received the ISAFE training leaving their team or local authority and are replaced by new members risks the difference to individual participants and team culture being weakened or lost over time. Some team managers and

senior staff did outline approaches they planned to counter this, though they still recognised this challenge:

> "What needs to happen, though, is that, as new people come in … it's about setting out very clear expectations about how we work with fathers from day one, and making sure they understand not just that it's expected, but why. It's all very well and good somebody telling you to do something, but if you don't understand why, then it's not so easy to effect, is it? So, that is the bit that needs to happen, and I don't know whether or not we need to devise some formal training around that for new starts." – Team manager

2. **Changes to systems:** As discussed earlier, there was limited evidence to show whether a local authority had changed its record-keeping processes to embed father inclusion, which was regarded as key to embedding father inclusion in practice. One local authority suggested they were considering how this would look, though at the time of interview had not yet made this change:

> "I think training is helpful to keep it at the forefront of our mind and a discussion, but actually, there needs to be things built in. So, for example, we were talking about, at the point of it coming in, you don't accept a referral that doesn't have the name of the father on it. That kind of thing, like, contact details of the father have to be included, so that we're able to make the initial phone calls and engage them. So, it's stuff like that, that I think would make the real difference. I don't think it's about a lack of willingness or wanting to, but it's about the systems generally favour the involvement with mothers." – QA staff

Variation in outcomes

IPE EQ 2: *Do outcomes (and experiences) vary (i) by characteristics of social workers (gender, age, ethnicity, experience (i.e. years since qualified)); and (ii) across teams and/or local authorities?*

The impact evaluation examined whether outcomes varied among social workers with different characteristics (gender, age, experience) and across teams and local authorities. These findings are included under 'Subgroup analyses' in the impact evaluation chapter. In addition, analysis of feedback survey data and qualitative interviews revealed some noteworthy variations in experiences and perceived impact (see appendix D, tables D3–D4). Please note that these are not statistically significant differences and in most cases involve underpowered samples and therefore should be interpreted with caution.

Regarding **gender**, male survey respondents reported greater increases in awareness, knowledge, skills, and confidence compared to females. This trend was also reflected in satisfaction levels, with male participants reporting higher satisfaction with the training than females. Qualitative data suggested that male attendees generally perceived the training more positively, praising the

trainers and engaging format, while female attendees expressed more mixed views, with some critiquing the online format and lack of novel content.

Concerning **age**, older survey participants reported slightly lower satisfaction levels with ISAFE than younger participants. This could be attributed to older participants viewing the training as a refresher course because they already perceived themselves to know the content, while younger participants might have gained more from the training because it was more likely to feature new content or learnings. However, it is important to note that these are trends observed in the data and not statistically significant differences.

Regarding **ethnicity**, Black survey participants reported greater increases in awareness, knowledge, skills, and confidence, compared to White participants. A similar trend was seen in satisfaction levels, with both groups having higher average satisfaction compared to White participants. Qualitative data appears to support this, with Black participants more regularly praising the quality of the trainer and their delivery of the course than other groups.

Regarding **experience/role**, more experienced social workers, such as advanced practitioners and team managers, reported lower satisfaction levels compared to their less experienced counterparts. This difference potentially stemmed from a perception that the training content was too basic and lacked new information relevant to their experience level. In contrast, trainee or apprentice social workers found the training more beneficial, likely due to their limited prior exposure to the concepts covered.

Across **local authorities**, satisfaction with ISAFE varied considerably. Lower satisfaction levels were linked to factors such a recent exposure to similar training and perceptions of the training being too basic. These findings highlight the importance of considering local context and prior training experiences when implementing such interventions.

Looking **across teams**, some differences in experiences were observed. For instance, Children with Disabilities teams reported higher satisfaction levels and perceived greater impact on their motivation and confidence in engaging fathers compared to Assessment and Child Protection teams. This suggests that the relevance and impact of such training might differ depending on the context and dynamics of the families they work with and their role as their social worker, and the specific challenges they may experience working with fathers.

Discussion

The Implementation and Process Evaluation explored the intervention's feasibility, reach, fidelity, quality, mechanisms of change, and variation in outcomes. **The evaluation found implementing ISAFE was feasible with the delivery partner's experience, capacity, and team structure facilitating this application.** ISAFE was broadly successful in reaching its intended audience, although typical barriers experienced by social workers prevented greater engagement. Overall, the intervention reached 80% of its intended audience. However, attendance varied across different sessions of the practice pathway, with approximately 55% of participants

attending both SW1 and SW2 modules. Attendance for sessions in the systems pathways also varied, from 67% of all invitees to the QA audit training to 55% for the Champions training session. Work commitments (such as needing to go to court), capacity issues, and annual leave were the common reasons for non-attendance across the sessions.

ISAFE was delivered more flexibly than initially anticipated. Instead of restricting participation to a fixed number of teams and to social workers only, the intervention was delivered to a flexible number of teams and included non-social workers. Besides these adaptations, **evidence suggests the content of ISAFE's sessions was delivered with fidelity**. The practice pathway (SW1 and SW2 sessions) was delivered as intended. Within the systems pathway, the QA audit session was delivered with high fidelity and evidence suggests the training sufficiently prepared attendees for the audit exercise. However, there was mixed evidence on the implementation of the Champions training. Champion interviewees frequently reported not having knowledge about expectations of the role or what they needed to do, leading to generally poor implementation. Finally, the resource library had a low usage rate, with 86% (138/150) of survey respondents saying they had not used it.

Four in five (79%) survey respondents said they were satisfied with the ISAFE programme overall. Across the practice and system pathways, the evidence suggests that participants generally viewed ISAFE as a well-delivered, high-quality training. Views about the practice pathways were broadly positive, with many recognising the value of attending training on father-inclusive practices. However, participants held different views about the value of the SW1 and SW2 sessions, with some participants viewing the training package as balanced, while others felt they were already knowledgeable about motivational interviewing (covered in SW2). Some participants also suggested that the practical training in SW2 might be more effective in-person, rather than delivered online. Views about the systems pathways were mixed between the QA audit session and the Champions training. While both sessions were seen as high quality, informative and well delivered, there was a perceived lack of clarity on the champion's role. Overall, the evidence of champions being embedded across teams was limited.

The IPE contributes further evidence to demonstrate that ISAFE realised some of its intended impact, especially with respect to social workers' awareness, knowledge, motivation, skills, and attitudes towards engaging fathers. The long-term aim of ISAFE is to realise practice and family impacts (e.g. through higher-quality risk assessments of fathers, and improved support for father–child relationships) – however, these changes were not anticipated to be captured by the evaluation due to its limited duration. Instead, three stages of change were anticipated to be realised during the trial. First, the training was expected to impact social workers' awareness and knowledge of fathers' impact and the importance of father inclusion. Second, the training was expected to improve participants' motivation to engage with fathers, as well as improve their skills and confidence in effectively engaging with fathers. Third, the training was expected to change attitudes towards father-inclusion practices.

The evaluation finds there is good evidence to suggest the mechanisms of change relating to these three stages were validated. In practice, the evidence shows that

participants felt more aware and knowledgeable about the importance of father inclusion following the training. The training also proved to be effective in improving participants' motivation to engage with fathers, although the duration of this effect is unclear. Looking at skills, while participants' views about gaining specific skills was mixed in interviews, the training was viewed as an effective way to enhance social workers' skill set. Finally, the evidence pointed towards a general improvement in teams' attitudes towards father inclusion.

While these three underpinning stages were realised, **as anticipated**, **the evaluation did not find sufficient evidence to suggest ISAFE led to higher-quality risk assessments of fathers, nor led to better identification of resources associated with fathers**. The limited duration of the trial prevented the collection of sufficient evidence to support these mechanisms. This means there was not enough evidence to observe changes in father-inclusion practices nor changes in father–child relationships or families.

The evidence gathered to assess the mechanisms of change driven by the systems pathway was more mixed. The systems pathway intended to achieve improvements in routine collection and analysis of data about fathers; enhanced support for social workers; and stronger leadership around, and advocacy for, teamwide father-inclusive approaches. To achieve this, the training offered a QA audit session to improve father recording practices and a Champions training session to embed father inclusion across teams.

Looking at the QA audit training, the evaluation found that ISAFE improved knowledge about the lack of inclusion of fathers in record keeping and increased motivation to ensure fathers are included. However, **there was insufficient evidence to show that QA staff effectively improved their auditing processes or embedded new systematic approaches.** This was evidenced by mixed trends in father-inclusion practices from the audit of case file data. Even if father-inclusive record practices were not embedded systematically, **there was some limited evidence to show that regular father-inclusion audits were conducted**.

The evidence about the Champions training showed **some support that ISAFE led to an ongoing focus on father-inclusion advocacy**. However, there was limited evidence to show whether Champions were enabling an enhanced adoption of/support for intervention within participating local authorities. Interestingly, while the evaluation found limited evidence on the effectiveness of the role of Champions, there was good evidence to suggest that ISAFE improved teams' culture on father engagement. Taken together, it suggests that the positive impact realised by ISAFE on organisational culture may have been driven by sessions within the practice pathways, instead of the Champions training.

The evaluation found a number of barriers which are likely to have limited ISAFE's effectiveness in changing father engagement practices. These range from more minor factors, such as the format of the training (the duration or the online delivery), to more lasting, systemic barriers, which ISAFE aims to tackle but that are inherently more difficult to overcome: these ranged from difficulties in working with complex family cases, to fathers' willingness to engage. These barriers, although

tackled within the intervention, were seen as not always sufficiently addressed by the training to be overcome in practice.

Finally, some limitations should be discussed. Interviews with participants typically took place around three months after the last ISAFE training session. This meant that some participants struggled to recall elements of the training. Although a range of views were gathered across local authorities and from different roles of participants (e.g. social workers, team managers, QA staff), the views shared with the evaluation team may not have been representative of all participants' views and experiences. Due to social workers acting as gatekeepers, only service-user participants with positive relationships were likely identified. This means their views are unlikely to be representative of fathers' experiences, especially due to the small sample size.

COST ANALYSIS

Methods

The subsections below provide a summary of the key components of the cost analysis methodology. Further detail on the cost analysis methodology can be found in the evaluation protocol.[15]

Cost analysis question

How much does it cost to deliver ISAFE?

Data collection

To answer the research question, the evaluator requested programme costs from the delivery partner in June 2024. The collected costs data included both one-time set-up costs and recurring costs. Costs were broken down by the following:

- Staff time for delivering ISAFE.
- Any costs associated with recruiting and training staff.
- Any costs related to training (e.g. use of video call platforms (Zoom, phone calls) and stationery).
- Any other overheads including facilities and equipment costs.

Data management and analysis

All cost data was collated on an Excel spreadsheet by the delivery partner and shared with the evaluator. Using the cost data, descriptive analysis was performed to identify and answer the research question, this includes using additional analyses to estimate the costs to deliver ISAFE by a) local authority, b) cohort, and c) treatment team.

Results

How much does it cost to deliver ISAFE?

Table 26 details the total costs to deliver ISAFE, including costs during the set-up and delivery phases. It shows that in total, it cost £41,058 to deliver ISAFE, with £8,111 (20%) of the total cost spent during the set-up phase and £32,947 (80%) during delivery.

[15] See: https://foundations.org.uk/our-work/current-projects/isafe-improving-safeguarding-through-audited-father-engagement/

Examining the individual cost types, it highlights the following:

- Staff time for delivering the programme was the highest individual cost at £27,147 in total. This accounted for around 66% of the total cost and was spent during the delivery phase. In interviews, the delivery partner reflected that the project required more staff time than originally anticipated and budgeted for, especially in relation to recruiting local authorities (see below) and project management.
- Staff recruitment and training for one new staff member and seven new trainers cost £5,000 in total. This accounted for 12% of the total cost of the programme. £2,000 of this cost was spent during set-up, while the remaining £3,000 was spent during delivery.
- Recruiting the local authorities, including the three that did not proceed, cost £4,000 in total, accounting for 10% of the total cost of the programme. £1,200 of this cost was spent during the project set-up phase, while the remaining £2,800 was spent during the delivery phase.
- Overhead costs, which include equipment costs, totalled £3,721, representing 9% of the total costs, used during the set-up phase.
- The remote platform for delivering ISAFE cost £1,190 in total (3% of the total costs), used during the set-up phase.

Table 2426: Breakdown of cost types per set-up and delivery periods

Cost type	Set-up	Delivery	TOTAL
Staff time for delivery, including admin	-	£27,147	£27,147
Recruiting and training staff (1) and trainers (7)	£2,000	£3,000	£5,000
Recruiting 10 LAs (including 3 dropouts)	£1,200	£2,800	£4,000
Overheads including equipment costs (laptops/phones)	£3,721	-	£3,721
Remote platform delivery cost	£1,190	-	£1,190
Total costs	**£8,111 (20%)**	**£32,947 (80%)**	**£41,058 (100%)**

Source: data provided by the delivery partner in June 2024

Table 27 breaks down the cost to delivery ISAFE by local authority, cohorts, and treatment team. It shows that delivering ISAFE cost:

- £5,865 per local authority
- £23,462 for Cohort A
- £17,596 for Cohort B

- £1,324 per treatment team
- £149 per participant who attended at least one training session (either SW1, SW2, Audit and/or Champions training)

Table 2527: Breakdown of cost types per local authority, cohorts and treatment team

Cost type	LA (n=7)	Cohort A (n=4)	Cohort B (n=3)	Treatment team (n=31)	Participant who attended 1 or more sessions (n=275)
Staff time for delivery, including admin	£3,878	£15,513	£11,634	£876	£99
Recruiting and training staff (1) and trainers (7)	£714	£2,857	£2,143	£161	£18
Recruiting 10 LAs (including 3 dropouts)	£571	£2,286	£1,714	£129	£15
Overheads including equipment costs (laptops/phones)	£532	£2,126	£1,595	£120	£4
Remote platform delivery cost	£170	£680	£510	£38	£14
Total costs	**£5,865**	**£23,462**	**£17,596**	**£1,324**	**£149**

Source: data provided by the delivery partner in June 2024

Discussion

Delivery phase costs comprised 80% of total costs, while set-up costs represented 20% (£32,947 and £8,111 respectively, out of a total programme cost of £41,058). Staff time for delivery, including administrative costs, was the highest expenditure at £27,147 (66% of the total). This was followed by recruiting and training one staff member and seven trainers, costing £5,000 (12%). Recruiting local authorities cost £4,000, and overheads, including equipment costs (laptops and phones), amounted to £3,721, and the remote platform delivery cost £1,190. These costs were spread proportionally across all seven local authorities and 31 treatment teams. Unfortunately, cost

data was provided in aggregate at the end of the intervention by the breakdowns outlined above, meaning further analysis to disaggregate costs is not possible.

Coupled with the impact evaluation findings, this suggests that ISAFE is a relatively low-cost option to achieve small but significant improvements in social workers' confidence, competence, and organisational practice relating to father engagement within children's services.

CONCLUSIONS

The ISAFE intervention, designed to enhance father engagement within child protection services, demonstrated promising results, particularly considering its relatively low cost. The RCT revealed a small but statistically significant positive impact on three out of five primary outcomes related to participant confidence and competence in father engagement (FEQ1 & FEQ2) and led to reported improvements in organisational practices concerning father engagement (FEQ5). However, no significant change in the frequency or perceived effectiveness (FEQ3 & FEQ4) of father engagement strategies was detected. Although the evaluation found statistically significant effects, it should be noted that the magnitude of the effect was small – on average, the scores increased by 0.21 on a five-point scale. These observed small effect sizes were statistically significant because of the low variability in the Father Engagement Questionnaire (FEQ) scores. This suggests that ISAFE is effective in achieving small benefits in the short term. The positive shift in these primary outcomes perhaps underscored a key aspect of the training: fostering intrinsic motivation among social workers to engage fathers was impactful even without changes in the use of specific strategies. This could relate to the measure used, such as that the Father Engagement Questionnaire strategies being tested did not resonate with participants – this should be further explored in future research. This observation was further substantiated by the IPE, which suggested that ISAFE's impact was predominantly driven by social workers' proactive efforts to involve fathers rather than their application of specific techniques learned during the training.

Despite the promising results of the study, some limitations are worth highlighting. First, the trial is based on self-reported survey and interview data, which may mean a greater risk of bias. Participants within the treatment group may have self-reported more positively due to receiving the training, regardless of its impact on them, meaning effect sizes may be even smaller or there may be no actual effect. Second, the evaluation did not test practitioners' retention or application of skills (e.g. through practice session recordings or simulations), which may find different results to the self-reported data. In addition to this, a key limitation of the trial was its inability to assess the long-term sustainability of these positive changes due to its restricted timeframe. Future research could explore the need for refresher sessions or ongoing support to embed these practices more deeply.

The ISAFE trial substantially adds to a relatively small evidence base on the effectiveness of interventions that aim to improve how social workers engage with fathers within the child protection context, specifically within the UK. Building on promising pilot and feasibility studies (Maxwell et al., 2012b; Scourfield et al., 2012; Scourfield et al., 2015), this is the first full RCT and evaluation of a father-focused social worker training intervention, and by showing an effect on most primary outcome subscales, should prompt further research within this and related areas of focus. The findings of the trial show similarities to other trials focusing on similar areas of practice, such as Burn et al. (2019) which focused on parenting interventions. Burn et al., like ISAFE, suggested that the training may have its greatest impact through practitioners demonstrating more proactive behaviour prompted by the training, rather than any specific techniques learned. As

above, this raises the question about whether the training offer should refocus towards encouraging proactive behaviour in practitioners rather than focusing on learning new skills and techniques, especially given the relatively light touch nature of the intervention. Equally, it would likely be more fruitful when combined with a greater focus on supporting local authorities to implement organisational changes instead, which may better support the sustainability of any training impacts (discussed further below).

Focusing on specific aspects of the intervention, the two-day social worker training, as part of the practice pathway and a cornerstone of the intervention, was perceived as effective despite some limitations highlighted through participant feedback. While some social workers perceived the training as oversimplifying complex issues or presenting already familiar concepts, it was seen as effective at prompting participants to be more proactive in engaging fathers. The SW1 session was regarded as particularly impactful by attendees because it used engaging and thought-provoking activities and discussions to present the evidence base on the barriers fathers face. The response to the SW2 session was more varied. Many participants were already knowledgeable about motivational interviewing beforehand, and this led to some reporting that the training was too basic for them, while others reported disengaging from the session. This was particularly acute in LAs which recently received training in motivational interviewing and/or actively follow this approach. Similarly, some reported that not enough time was spent on applying the techniques discussed during the session, which is likely a contributing factor to limited evidence of participants applying motivational interviewing in practice following the training. These findings are consistent with the wider literature on the limited impact of even more intensive and in-person motivational interviewing training on practitioners' skills and parental engagement (Forrester et al., 2008; Forrester et al., 2018). Based on this, plans for future delivery should consider whether training on techniques such as motivational interviewing are likely to lead to the desired changes to practitioner practices. If SW2 is to continue to focus on motivational interviewing, future delivery may benefit from being targeted at local authorities that do not already follow this approach, delivering different versions of the session tailored to attendees' familiarity with the approach, such as offering advanced versions of the training focusing on aggressive fathers and/or a more intensive training programme, rather than a one-day session.

Examining the systems pathway, designed to complement the practice pathway by fostering organisational change, revealed a more nuanced picture. The QA audit training, while successful in improving record-keeping practices at the individual practitioner level, did not translate into substantial changes in service-level processes or quality assurance mechanisms within the timeframe of the study. This suggests that achieving systemic change requires a more comprehensive and extended approach (a similar finding to Scourfield, 2012). Future iterations may benefit from a more comprehensive training offer, including a greater focus on implementing changes recommended by the programme. The Champions training, intended to cultivate 'father-inclusion champions' within teams to drive cultural change, faced challenges due to a lack of clarity regarding the role's expectations and responsibilities. This ambiguity hindered the champions' ability to effectively advocate for and implement father-inclusive practices. Interestingly, the IPE indicated that positive shifts in team culture surrounding father engagement were more pronounced in teams where all members participated in the social worker training, suggesting that

collective learning experiences might be more effective in fostering cultural change compared to interventions targeting specific individuals. Future iterations of the Champions training could benefit from a more structured approach, clearly outlining expectations, providing practical guidance, and engaging a wider range of staff (including senior leaders) to promote broader buy-in and facilitate more impactful cultural shifts towards father-inclusive practices. Despite some positive evidence in terms of team culture, key barriers to father engagement were not actively tackled at an organisational level as part of or as a result of ISAFE within the trial timeframes. For example, the absence of changes to forms or record-keeping systems could hinder social workers' efforts to change their practice. This is even more critical in the context of high turnover, which was evident during the trial, as the effects may be short-lived. Nonetheless, given the low cost of ISAFE, the Fatherhood Institute should consider adapting ISAFE based on the findings from this trial.

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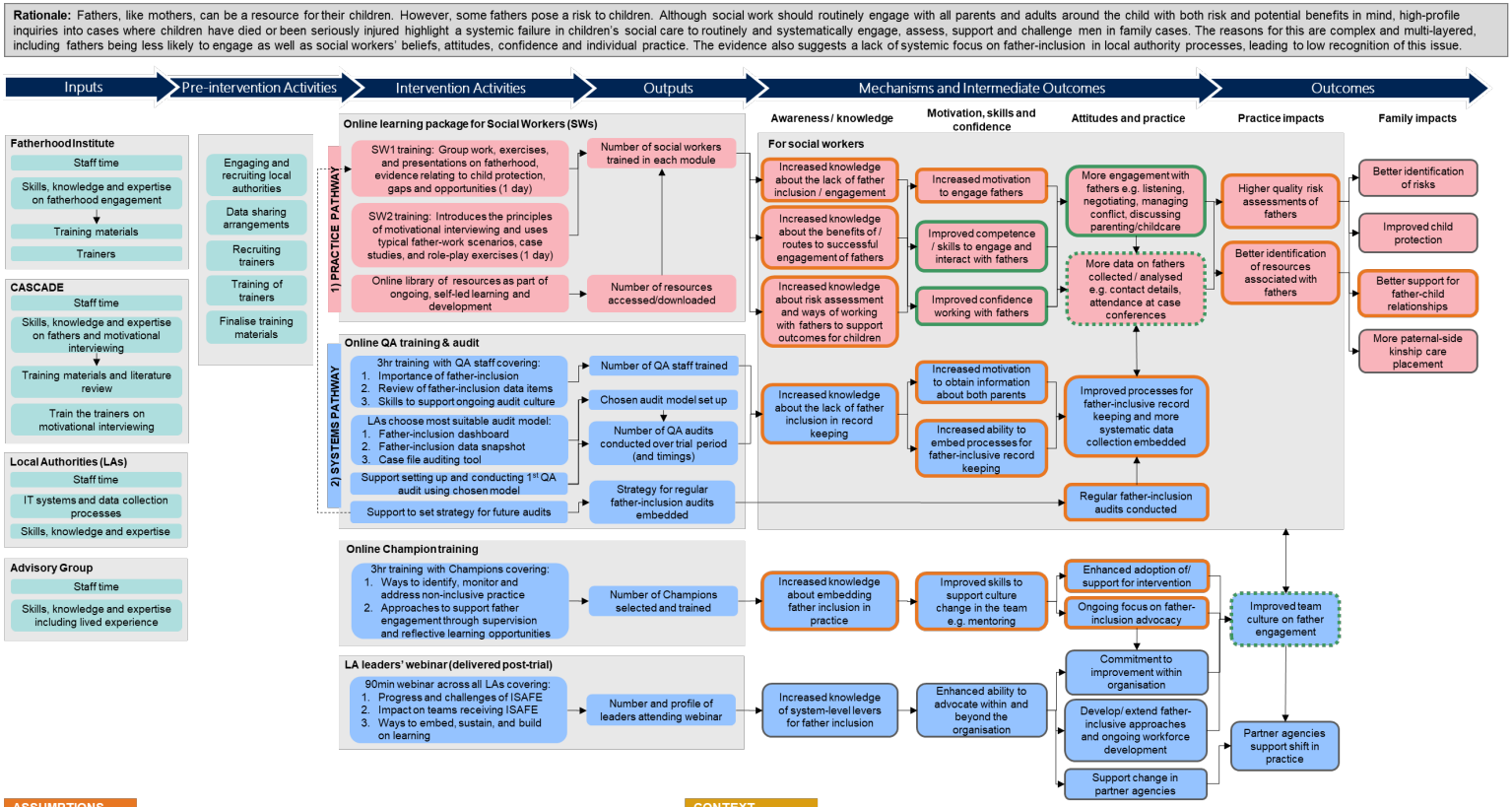
APPENDICES

Appendix A: ISAFE theory of change (go to accessibility text)



Appendix B: Additional impact evaluation tables

Table B1: Descriptive characteristics for full sample (including those with missing baseline/endline)

Characteristics	Number of observations	Mean	Standard deviation	Minimum	Maximum
Age	397	37.54	10.40	20	68
Female	462	0.85	0.35	0	1
Previous training	463	0.29	0.45	0	1
Years as qualified social worker	445	8.14	7.44	1	45
Children caseload	349	16.40	7.17	0	50
Father caseload	349	7.30	3.88	0	30
FEQ1 confidence score (base)	427	3.56	0.69	1.55	5
FEQ2 competence score (base)	427	3.57	0.68	2	5
FEQ3 effectiveness score (base)	427	3.92	0.76	2	5
FEQ4 frequency score (base)	388	3.62	0.86	1	5
FEQ5 organisational score (base)	427	3.82	0.80	1	5
Self-efficacy score (base)	427	3.48	0.68	1	5
Team culture score (base)	398	3.92	0.63	1.55	5

Table B2: Descriptive characteristics for analytical sample

Characteristics	Number of observations	Mean	Standard Deviation	Minimum	Maximum
Age	262	37.32	10.21	21	66
Female	302	0.84	0.36	0	1
Previous training	298	0.29	0.45	0	1
Years as qualified social worker	289	7.81	7.09	1	34
Children caseload	256	16.52	7.17	0	50
Father caseload	256	7.55	3.99	1	30
FEQ1 confidence score (base)	312	3.55	0.71	1.55	5
FEQ2 competence score (base)	312	3.54	0.69	2	5
FEQ3 effectiveness score (base)	312	3.91	0.78	2	5
FEQ4 frequency score (base)	285	3.59	0.86	1	5
FEQ5 organisational score (base)	312	3.83	0.80	1	5
Self-efficacy score (base)	312	3.44	0.69	1	5
Team culture score (base)	293	3.90	0.62	1.5	5

Table B3: Multiple Imputation regression estimates – Basic model – Secondary outcome: Endline Father contact detail records

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.121**	0.532	0.024, 2.217	0.045
Baseline father contact detail records	0.533***	0.091	0.348, 0.719	0.000
Constant	3.060***	0.608	1.825, 4.294	0.000
Number of observations	483			

Table B4: Multiple Imputation regression estimates – Basic model – Secondary outcome: Endline self-efficacy score

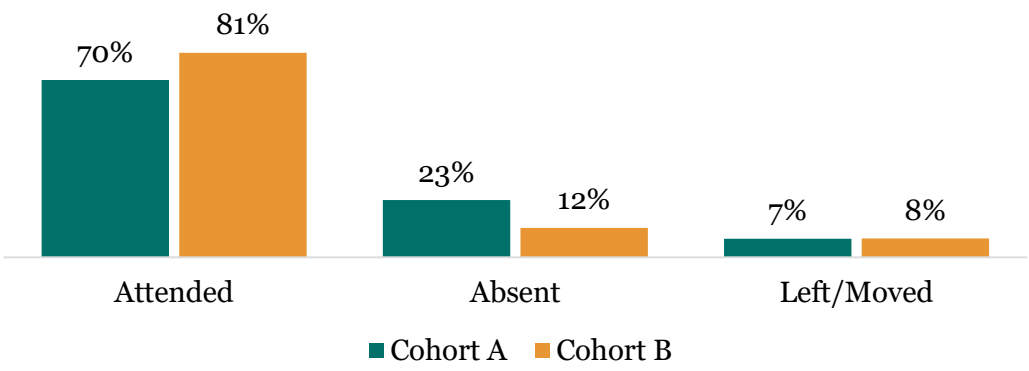
	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.193***	0.056	0.078, 0.308	0.002
Baseline self-efficacy score	0.488***	0.047	0.391, 0.585	0.000
Constant	1.887***	0.168	1.545, 2.229	0.000
Number of observations	483			

Table B5: Multiple Imputation regression estimates – Basic model – Secondary outcome: Endline team culture score

	Coefficient	Clustered Robust Standard error	95% confidence interval	p-value
Intervention	0.207***	0.061	0.083, 0.331	0.002
Baseline team culture score	0.442***	0.048	0.343, 0.540	0.000
Constant	2.228***	0.195	1.831, 2.625	0.000
Number of observations	483			

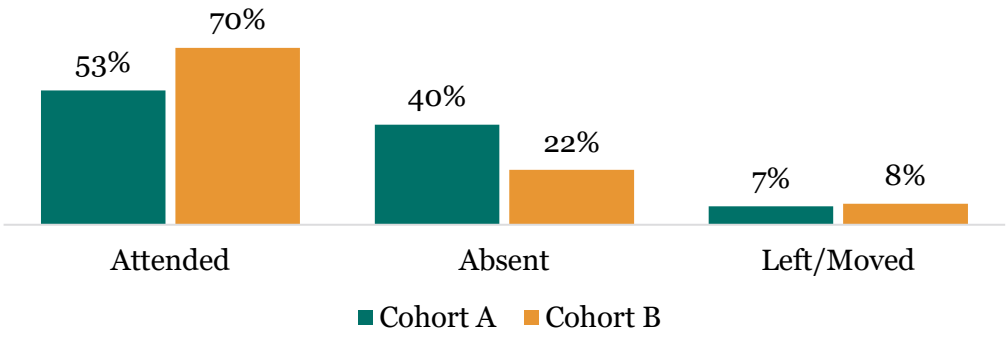
Appendix C: Training attendance data

Figure C1: Attendance for SW1 training session, by cohort (link to raw data)



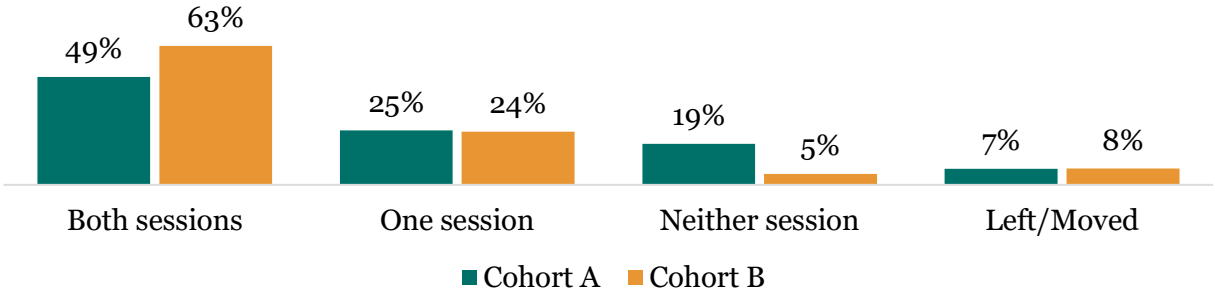
Source: Attendance data. Base: n=297 (Cohort A=177; Cohort B=120).

Figure C2: Attendance for SW2 training session, by cohort (link to raw data)



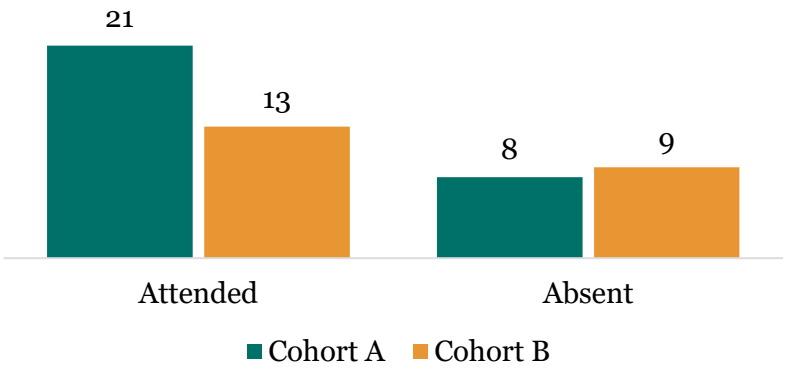
Source: Attendance data. Base=297 (Cohort A=177; Cohort B=120).

Figure C3: Attendance of SW1 & SW2 sessions, by cohort (link to raw data)



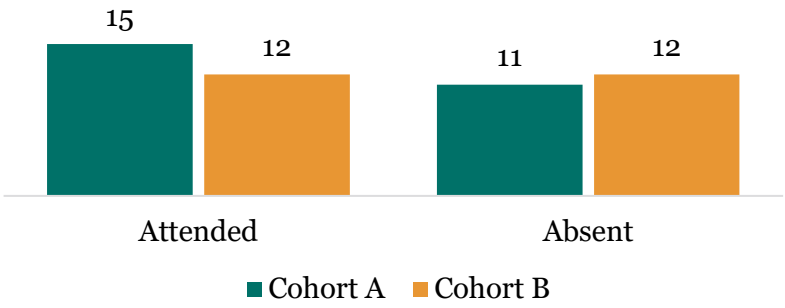
Source: Attendance data. Base: n=297 (Cohort A=177; Cohort B=120).

Figure C4: Attendance for QA and Audit training session, by cohort (counts) (link to raw data)



Source: Attendance data. Base=51 (Cohort A=29; Cohort B=22).

Figure C5: Attendance for Champions training session, by cohort (counts) (link to raw data)

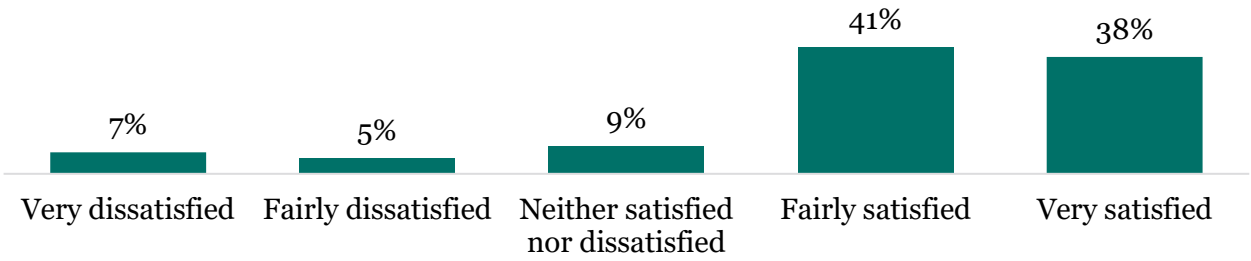


Source: Attendance data. Base: n=50 (Cohort A=26; Cohort B=24).

Appendix D: Additional survey data

Figure D1: Overall satisfaction with the ISAFE training programme (link to raw data)

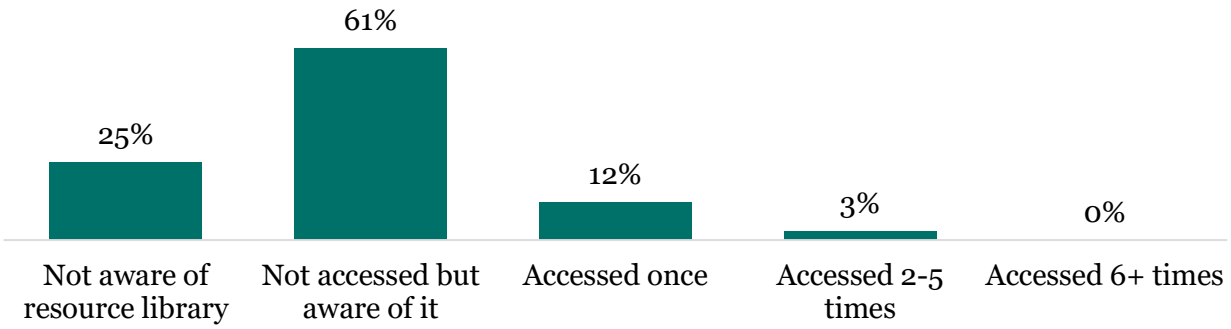
Q: How satisfied were you with the training you attended?



Source: Feedback & endline surveys. Base: n=228.

Figure D2: Use of the resource library (link to raw data)

Q: You should have been given an account for the ISAFE resource library to access in your own time. How many times would you estimate that you have accessed the library so far?

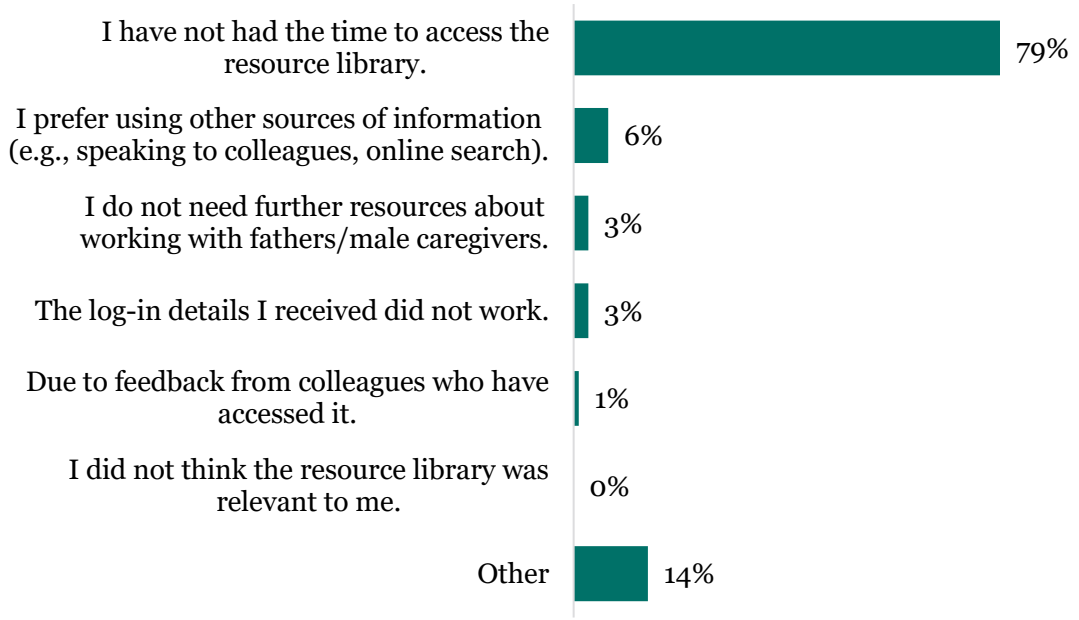


Source: Feedback survey. Base: n=150.

Among those who had accessed the resource library (n=22), respondents generally agreed that it was relevant to them and their role, complemented the training, provided a useful source of information about working with fathers, and was accessible and easy to understand. Most also agreed they intended to refer to it in the future.

Figure D3: Reasons for not using the resource library (link to raw data)

Q: Thinking about the ISAFE resource library, why have you not accessed it more? Please select all that apply.



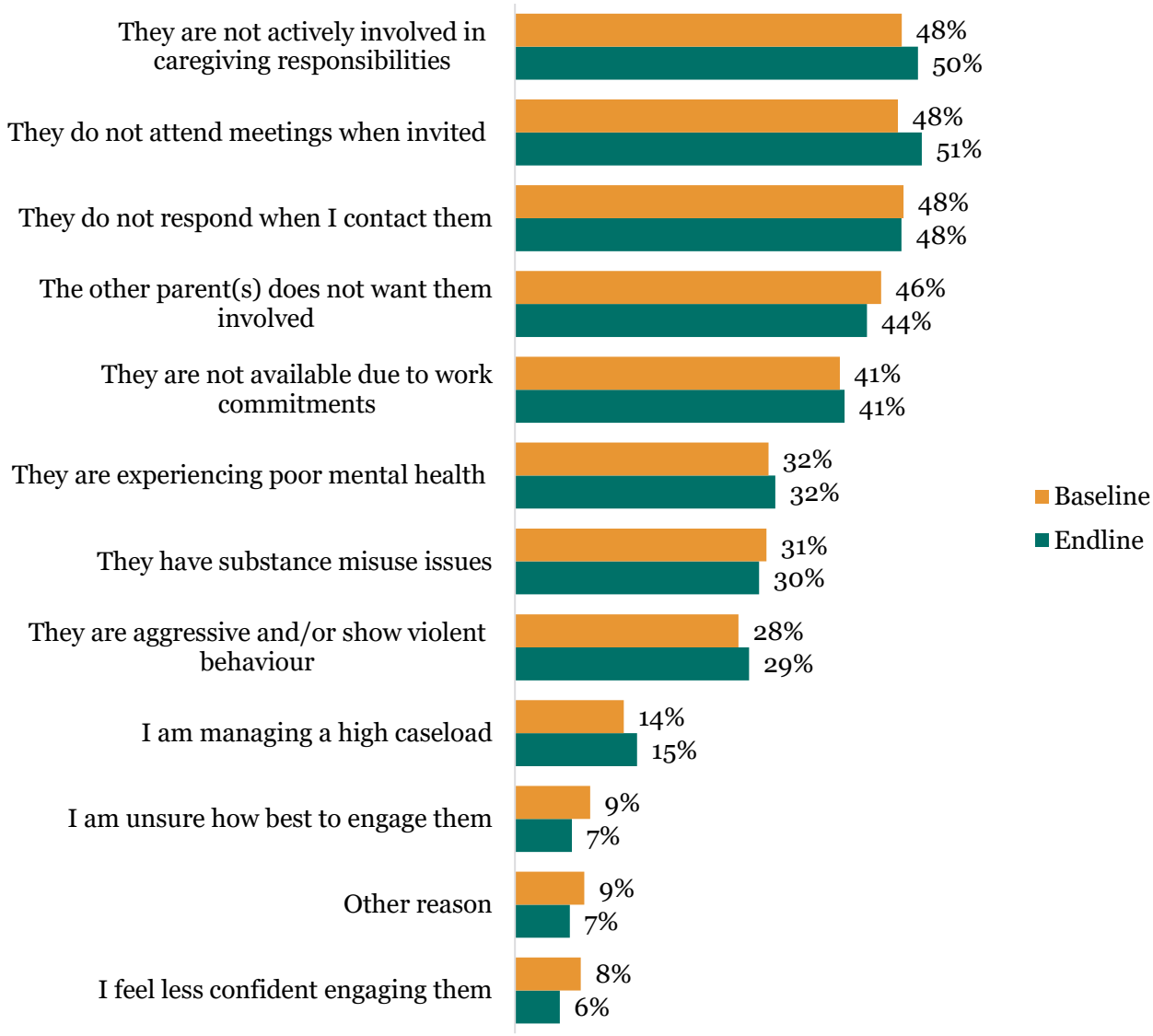
Source: Feedback survey. Base: n=109.

The reasons provided in open-ended response for 'other' included:

- Accessing other resources
- Not needing the resource to date/so far (too soon after login)
- Waiting for the link/access details
- Being on leave, including sick leave.

Figure D4: Barriers when working with fathers (link to raw data)

Q: Thinking about your current caseload, what, if any, barriers do you face when working with fathers and similar male caregivers? Please select all that apply.



Source: Baseline survey (Base: n=427) and Endline survey (Base: n=394).

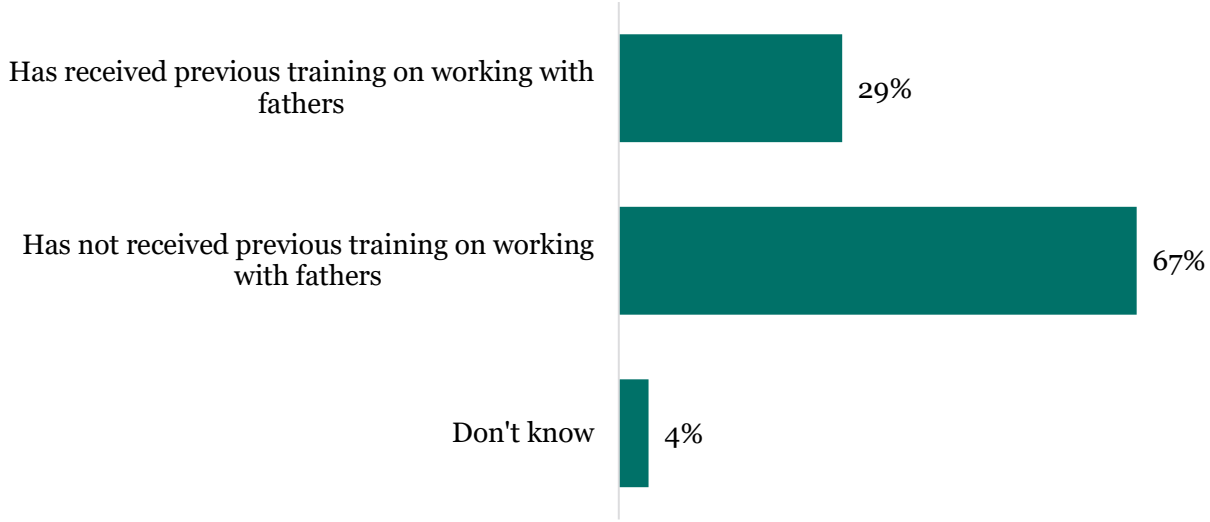
The reasons provided in open-ended response for 'other' included:

- Father in prison or bail conditions restrict contact
- Not having their contact details
- Father's location (including living abroad)
- Domestic abuse and/or safeguarding concerns.

Figure D5: Previous training on working with fathers/male caregivers

(link to raw data)

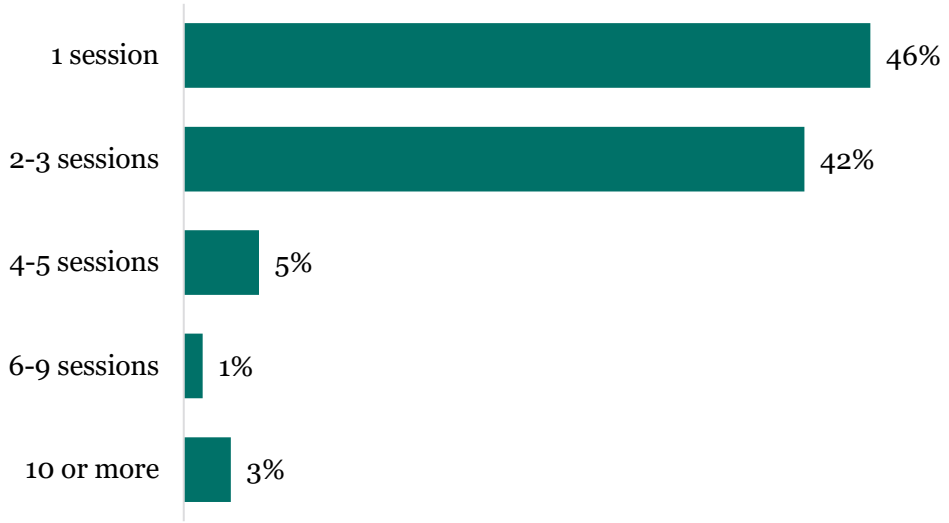
Q: Except for ISAFE, have you ever attended previous training on working specifically with fathers/male caregivers?



Source: Baseline survey (Base: n=427), Feedback (Base: n=49) and Endline survey (Base: n=66).

Figure D6: Number of previous training sessions on working with fathers/male caregivers (link to raw data)

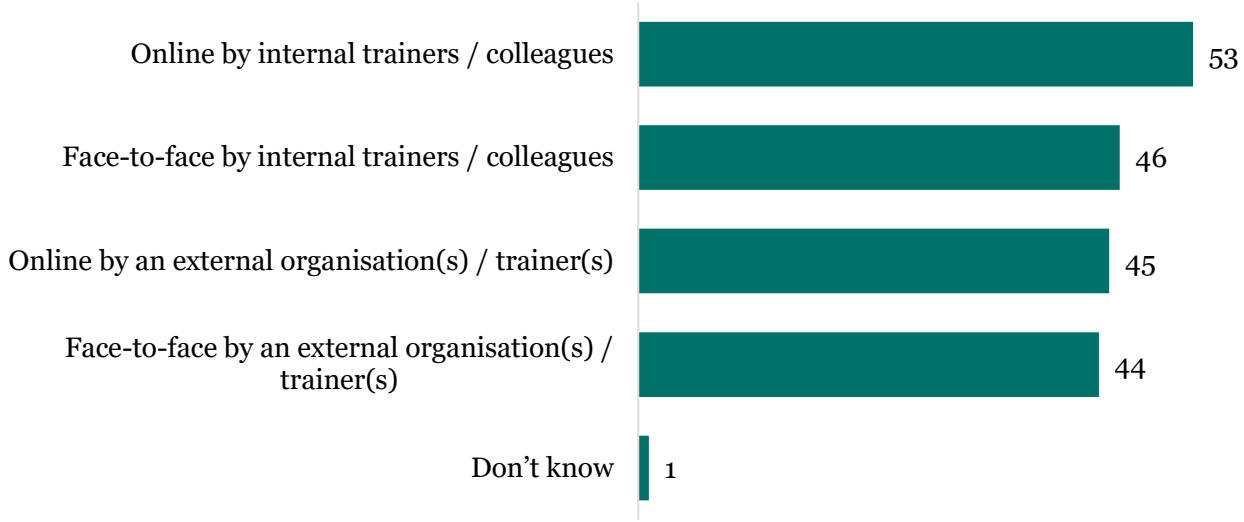
Q: Thinking about the training specifically on fathers/male caregivers (but not including ISAFE), roughly how many training sessions have you attended?



Source: Baseline survey, Feedback survey and Endline survey – respondents who have received previous training on working with fathers (Base: n=157 (117 + 16 + 24)).

Figure D7: How previous training sessions on working with fathers/male caregivers were delivered (link to raw data)

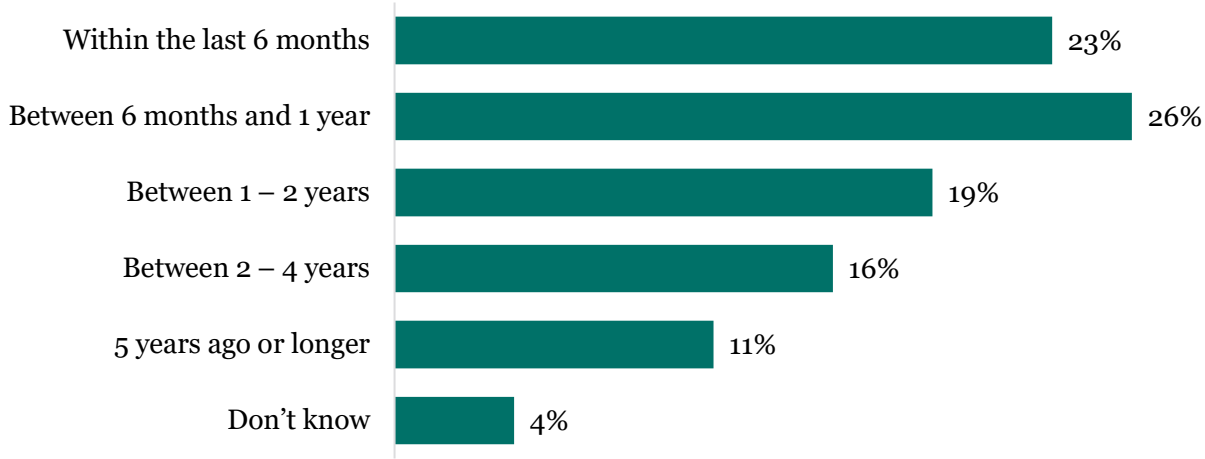
Q: Thinking about the training specifically on fathers/male caregivers (but not including ISAFE), how was this training delivered? Select all that apply.



Source: Baseline survey, Feedback survey and Endline survey – respondents who have received previous training on working with fathers (Base: n=157 (117 + 16 + 24)).

Figure D8: How previous training sessions on working with fathers/male caregivers was delivered (link to raw data)

Q: Thinking about the training specifically on fathers/male caregivers (but not including ISAFE), when did the most recent training take place?



Source: Baseline survey, Feedback survey and Endline survey – respondents who have received previous training on working with fathers (Base: n=157 (117 + 16 + 24)).

Table D1: Perceptions on the ISAFE training content and quality

Q: Thinking about the training you attended, to what extent do you agree or disagree with the following statements? ("0 – Completely disagree" … "10 – Completely agree")

Statement	0 - Completely disagree	1	2	3	4	5	6	7	8	9	10 - Completely agree	I don't know	Net Disagree (0-3)	Net Neutral (4-6)	Net Agree (7-10)
The training content was easy to understand.	0	0	0	0	1	6	10	20	35	25	42	1	**0 (0%)**	**17 (12%)**	**122 (87%)**
The training content was relevant to me and my role.	0	3	2	1	4	4	13	13	33	20	46	1	**6 (4%)**	**21 (15%)**	**112 (80%)**
The trainer(s) delivered the session(s) to a high quality.	0	1	2	2	1	7	14	16	30	31	35	1	**5 (4%)**	**22 (16%)**	**112 (80%)**
I feel able to use aspects from the training in my day-to-day practice.	3	2	2	1	1	9	14	21	31	23	32	1	**8 (6%)**	**24 (17%)**	**107 (76%)**
The training was engaging.	0	2	4	3	2	12	14	17	31	20	34	1	**9 (6%)**	**28 (20%)**	**102 (73%)**
The delivery format (e.g. online, groupwork) worked well.	1	1	1	3	5	11	18	18	20	28	33	1	**6 (4%)**	**34 (24%)**	**99 (71%)**
The training contents and	0	1	0	6	1	11	20	20	28	21	31	1	**7 (5%)**	**32 (23%)**	**100 (71%)**

Statement	0 - Completely disagree	1	2	3	4	5	6	7	8	9	10 - Completely agree	I don't know	Net Disagree (0-3)	Net Neutral (4-6)	Net Agree (7-10)
materials were high quality.															
The training content was an appropriate level.	3	3	3	5	5	8	14	19	26	20	33	1	**14 (10%)**	**27 (19%)**	**98 (70%)**
The training was a good use of my time.	3	4	4	6	3	11	15	16	28	14	35	1	**17 (12%)**	**29 (21%)**	**93 (66%)**
The training addressed a knowledge and/or skills gap in my team/service.	4	7	4	7	5	10	12	22	27	19	22	1	**22 (16%)**	**27 (19%)**	**90 (64%)**

Source: Feedback survey. Base: n=140.

Table D2: Perceived value of participation in the ISAFE training

Q: Thinking about the training you attended, to what extent do you agree or disagree with the following statements? ("0 – Completely disagree" … "10 – Completely agree")

Statement	0 - Completely disagree	1	2	3	4	5	6	7	8	9	10 - Completely agree	I don't know	Net Disagree (0-3)	Net Neutral (4-6)	Net Agree (7-10)
The training is very beneficial to my work.	1	1	2	5	2	6	13	22	24	17	46	1	**9 (6%)**	**21 (15%)**	**109 (78%)**
Participation in this kind of training is very useful for my job.	1	2	0	4	3	11	10	22	23	23	40	1	**7 (5%)**	**24 (17%)**	**108 (77%)**
I look back on the training positively.	1	1	1	7	6	12	18	15	25	20	33	1	**10 (7%)**	**36 (26%)**	**93 (66%)**
I enjoyed the training very much.	1	1	2	8	8	11	17	22	25	18	26	1	**12 (9%)**	**36 (26%)**	**91 (65%)**
I know substantially more about the training contents than before.	3	5	7	6	6	10	18	21	20	24	19	1	**21 (15%)**	**34 (24%)**	**84 (60%)**
I learned a lot of new things in the training.	4	4	7	8	4	11	23	16	21	18	23	1	**23 (16%)**	**38 (27%)**	**78 (56%)**

Source: Feedback survey. Base: n=140.

Table D3: Attendee satisfaction with ISAFE, by participant characteristics

Q: Thinking about the ISAFE programme overall (i.e. training and/or resource library), to what extent were you satisfied or dissatisfied with it? ("Very dissatisfied" … "Very satisfied")

Category	Subgroup	Very/fairly satisfied (%)	Total respondents
Gender	Female	139 (76%)	184
	Male	29 (91%)	32
	Prefer not to say	11 (92%)	12
Age	21-30	42 (78%)	54
	31-40	51 (78%)	65
	41-50	33 (79%)	42
	51-65	19 (73%)	26
	Prefer not to say	34 (83%)	41
Ethnic group	White	98 (77%)	127
	Asian/Asian British	13 (81%)	16
	Black/African/Caribbean/Black British	33 (83%)	40
	Mixed/multiple ethnic groups	-	<10
	Other ethnic group	-	<10
	Prefer not to say	32 (82%)	39
Role	Advanced practitioner & senior social worker	41 (76%)	54
	Social worker	39 (80%)	49
	Newly Qualified SWs (less than 2 years) & Trainees/Apprentices	52 (85%)	61
	Team Manager/Assistant TM	23 (70%)	33
	Non-SW role (Assistant, Family support or subject specialist)	-	10
	Other (QA)	13 (76%)	17
	Unknown	-	<10
LA	Birmingham	23 (88%)	26
	Croydon	21 (78%)	27
	Durham	25 (83%)	30
	Havering	18 (75%)	24
	Somerset	26 (70%)	37
	Surrey	34 (69%)	49
	Wiltshire	32 (91%)	35

Category	Subgroup	Very/fairly satisfied (%)	Total respondents
Team type	Assessment team	31 (76%)	41
	Child Protection/Child in Need/Looked After Children team	116 (81%)	144
	Children with Disabilities team	17 (77%)	22
	QA	15 (75%)	20
	Unknown	-	<10
Total		179 (79%)	228

Source: Feedback & endline survey. Base: n=228.

Table D4: Number (and proportion) reporting mechanisms of change increased a little or a lot, by participant characteristics

Q: Thinking about the ISAFE programme overall (i.e. training and/or resource library), to what extent has this changed your…? ("Decreased a lot" … "Increased a lot")

Characteristic	Sub-group	Knowledge about the lack of father inclusion/engagement in children's social care	Knowledge about the benefits of and routes to successful engagement of fathers	Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children	Knowledge about the lack of father inclusion in record keeping	Knowledge about embedding father inclusion in practice	Motivation to engage fathers	Motivation to obtain and record information about both parents	Competence and skills to engage and interact with fathers	Team's focus on father-inclusive practice	Confidence working with fathers	Total respondents
Gender	Female	142 (77%)	145 (79%)	140 (76%)	144 (78%)	148 (80%)	146 (79%)	145 (79%)	138 (75%)	140 (76%)	130 (71%)	184
	Male	28 (88%)	27 (84%)	26 (81%)	26 (81%)	26 (81%)	27 (84%)	29 (91%)	26 (81%)	26 (81%)	25 (78%)	32
	Prefer not to say	10 (83%)	9 (75%)	9 (75%)	9 (75%)	10 (83%)	10 (83%)	9 (75%)	10 (83%)	10 (83%)	8 (67%)	12
Age	21-30	41 (76%)	42 (78%)	40 (74%)	39 (72%)	40 (74%)	44 (81%)	40 (74%)	38 (70%)	42 (78%)	37 (69%)	54
	31-40	51 (78%)	53 (82%)	51 (78%)	53 (82%)	54 (83%)	50 (77%)	53 (82%)	51 (78%)	51 (78%)	49 (75%)	65
	41-50	32 (76%)	32 (76%)	31 (74%)	31 (74%)	35 (83%)	34 (81%)	34 (81%)	30 (71%)	28 (67%)	29 (69%)	42
	51-65	23 (88%)	23 (88%)	23 (88%)	23 (88%)	22 (85%)	22 (85%)	23 (88%)	23 (88%)	22 (85%)	21 (81%)	26

Characteristic	Sub-group	Knowledge about the lack of father inclusion/engagement in children's social care	Knowledge about the benefits of and routes to successful engagement of fathers	Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children	Knowledge about the lack of father inclusion in record keeping	Knowledge about embedding father inclusion in practice	Motivation to engage fathers	Motivation to obtain and record information about both parents	Competence and skills to engage and interact with fathers	Team's focus on father-inclusive practice	Confidence working with fathers	Total respondents
	Prefer not to say	33 (80%)	31 (76%)	30 (73%)	33 (80%)	33 (80%)	33 (80%)	33 (80%)	32 (78%)	33 (80%)	27 (66%)	41
Ethnicity	White	91 (72%)	93 (73%)	91 (72%)	93 (73%)	96 (76%)	95 (75%)	95 (75%)	89 (70%)	90 (71%)	88 (69%)	127
	Asian/Asian British	13 (81%)	14 (88%)	14 (88%)	14 (88%)	14 (88%)	12 (75%)	13 (81%)	13 (81%)	13 (81%)	11 (69%)	16
	Black/ African/ Caribbean/ Black British	39 (98%)	39 (98%)	38 (95%)	39 (98%)	38 (95%)	39 (98%)	39 (98%)	39 (98%)	37 (93%)	37 (93%)	40
	Mixed/ multiple ethnic groups	-	-	-	-	-	-	-	-	-	-	<10
	Other ethnic group	-	-	-	-	-	-	-	-	-	-	<10
	Prefer not to say	34 (87%)	32 (82%)	29 (74%)	30 (77%)	33 (85%)	34 (87%)	33 (85%)	32 (82%)	32 (82%)	25 (64%)	39
Role	Non-SW role	-	-	-	-	-	-	-	-	-	-	10

Characteristic	Sub-group	Knowledge about the lack of father inclusion/engagement in children's social care	Knowledge about the benefits of and routes to successful engagement of fathers	Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children	Knowledge about the lack of father inclusion in record keeping	Knowledge about embedding father inclusion in practice	Motivation to engage fathers	Motivation to obtain and record information about both parents	Competence and skills to engage and interact with fathers	Team's focus on father-inclusive practice	Confidence working with fathers	Total respondents
	Newly Qualified SWs & Trainees/ Apprentices	50 (82%)	54 (89%)	52 (85%)	50 (82%)	51 (84%)	54 (89%)	53 (87%)	51 (84%)	51 (84%)	49 (80%)	61
	Social worker	38 (78%)	38 (78%)	37 (76%)	36 (73%)	41 (84%)	38 (78%)	36 (73%)	35 (71%)	33 (67%)	32 (65%)	49
	Advanced practitioner & senior social worker	44 (81%)	44 (81%)	43 (80%)	46 (85%)	46 (85%)	45 (83%)	46 (85%)	44 (81%)	46 (85%)	43 (80%)	54
	Team Manager/ Assistant TM	28 (85%)	27 (82%)	25 (76%)	28 (85%)	28 (85%)	28 (85%)	28 (85%)	26 (79%)	27 (82%)	24 (73%)	33
	Other (QA)	10 (59%)	9 (53%)	9 (53%)	10 (59%)	8 (47%)	8 (47%)	10 (59%)	9 (53%)	9 (53%)	7 (41%)	17
LA	Birmingham	22 (85%)	24 (92%)	24 (92%)	24 (92%)	26 (100%)	25 (96%)	25 (96%)	23 (88%)	23 (88%)	22 (85%)	26
	Croydon	25 (93%)	22 (81%)	20 (74%)	22 (81%)	21 (78%)	22 (81%)	22 (81%)	21 (78%)	22 (81%)	20 (74%)	27

Characteristic	Sub-group	Knowledge about the lack of father inclusion/engagement in children's social care	Knowledge about the benefits of and routes to successful engagement of fathers	Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children	Knowledge about the lack of father inclusion in record keeping	Knowledge about embedding father inclusion in practice	Motivation to engage fathers	Motivation to obtain and record information about both parents	Competence and skills to engage and interact with fathers	Team's focus on father-inclusive practice	Confidence working with fathers	Total respondents
	Durham	25 (83%)	29 (97%)	26 (87%)	27 (90%)	28 (93%)	27 (90%)	27 (90%)	26 (87%)	27 (90%)	25 (83%)	30
	Havering	23 (96%)	24 (100%)	24 (100%)	23 (96%)	24 (100%)	24 (100%)	24 (100%)	24 (100%)	24 (100%)	21 (88%)	24
	Somerset	21 (57%)	19 (51%)	21 (57%)	19 (51%)	21 (57%)	20 (54%)	20 (54%)	21 (57%)	20 (54%)	18 (49%)	37
	Surrey	35 (71%)	35 (71%)	32 (65%)	38 (78%)	37 (76%)	36 (73%)	37 (76%)	32 (65%)	36 (73%)	30 (61%)	49
	Wiltshire	29 (83%)	28 (80%)	28 (80%)	26 (74%)	27 (77%)	29 (83%)	28 (80%)	27 (77%)	24 (69%)	27 (77%)	35
Team type	Assessment team	32 (78%)	33 (80%)	31 (76%)	31 (76%)	34 (83%)	35 (85%)	34 (83%)	31 (76%)	36 (88%)	29 (71%)	41
	Child Protection/ Child in Need/ Looked After Children team	117 (81%)	118 (82%)	115 (80%)	119 (83%)	121 (84%)	118 (82%)	117 (81%)	114 (79%)	110 (76%)	107 (74%)	144

Characteristic	Sub-group	Knowledge about the lack of father inclusion/engagement in children's social care	Knowledge about the benefits of and routes to successful engagement of fathers	Knowledge about risk assessment and ways of working with fathers to support positive outcomes for children	Knowledge about the lack of father inclusion in record keeping	Knowledge about embedding father inclusion in practice	Motivation to engage fathers	Motivation to obtain and record information about both parents	Competence and skills to engage and interact with fathers	Team's focus on father-inclusive practice	Confidence working with fathers	Total respondents
	Children with Disabilities team	19 (86%)	19 (86%)	18 (82%)	17 (77%)	19 (86%)	20 (91%)	20 (91%)	18 (82%)	19 (86%)	18 (82%)	22
	QA	11 (55%)	10 (50%)	10 (50%)	11 (55%)	9 (45%)	9 (45%)	11 (55%)	10 (50%)	10 (50%)	8 (40%)	20
	Unknown	-	-	-	-	-	-	-	-	-	-	<10
Total		180 (79%)	181 (79%)	175 (77%)	179 (79%)	184 (81%)	183 (80%)	183 (80%)	174 (76%)	176 (77%)	163 (71%)	228

Source: Feedback & endline survey. Base: n=228.

Table D5: Father engagement in participants' caseload

	Control		Treatment	
	Baseline average (as a % of total fathers)	**Endline average (as a % of total fathers)**	**Baseline average (as a % of total fathers)**	**Endline average (as a % of total fathers)**
Total children	16.6	17.2	16.6	18.6
Total families	10.4	10.7	9.7	11.7
Total fathers	7.8	7.7	7.4	8.4
Is the father(s)/male caregiver(s) named in the child(ren)'s case file?	7.3 (94%)	7.2 (93%)	6.9 (94%)	8.0 (95%)
Are the contact details (i.e. telephone number) for the father(s)/male caregiver(s) known?	6.9 (89%)	6.9 (90%)	6.6 (89%)	7.5 (90%)
Is the father(s)/male caregiver(s) living with the child(ren)?	4.1 (53%)	4.3 (56%)	3.8 (51%)	4.3 (52%)
Have you engaged these fathers/male caregivers in discussions about parenting and childcare?	4.9 (64%)	5.5 (71%)	4.8 (66%)	5.4 (64%)
Have these fathers/male caregivers attended their most recent meeting?	3.3 (43%)	3.8 (49%)	3.4 (46%)	3.9 (46%)

	Control		Treatment	
	Baseline average (as a % of total fathers)	Endline average (as a % of total fathers)	Baseline average (as a % of total fathers)	Endline average (as a % of total fathers)
Are these fathers/male caregivers the main (or equal) contact for their family/household?	2.9 (37%)	3.4 (44%)	2.8 (38%)	3.3 (39%)
Is the father(s)/male caregiver(s) not living with the child(ren) but their whereabouts/home address is known?	3.8 (49%)	4.0 (53%)	4.1 (56%)	4.7 (56%)
Have you engaged these fathers/male caregivers in discussions about parenting and childcare?	3.5 (45%)	4.1 (53%)	3.9 (52%)	4.7 (56%)
Have these fathers/male caregivers attended their most recent meeting?	2.2 (29%)	2.8 (36%)	2.5 (34%)	3.1 (37%)
Does the father(s)/male caregiver(s) display behaviours which put	2.7 (35%)	2.9 (38%)	2.8 (38%)	3.6 (43%)

	Control		Treatment	
	Baseline average (as a % of total fathers)	Endline average (as a % of total fathers)	Baseline average (as a % of total fathers)	Endline average (as a % of total fathers)
their child(ren) at risk of harm?				
Have you discussed with these fathers/male caregivers about their behaviour that is putting their child(ren) at risk of harm?	2.4 (30%)	2.6 (34%)	2.7 (37%)	3.3 (39%)
Have these fathers/male caregivers attended their most recent meeting?	1.7 (22%)	1.7 (22%)	1.9 (26%)	2.0 (24%)

Source: Baseline survey and endline surveys – respondents who completed both surveys. Base: n=255.

Appendix E: QA audit results

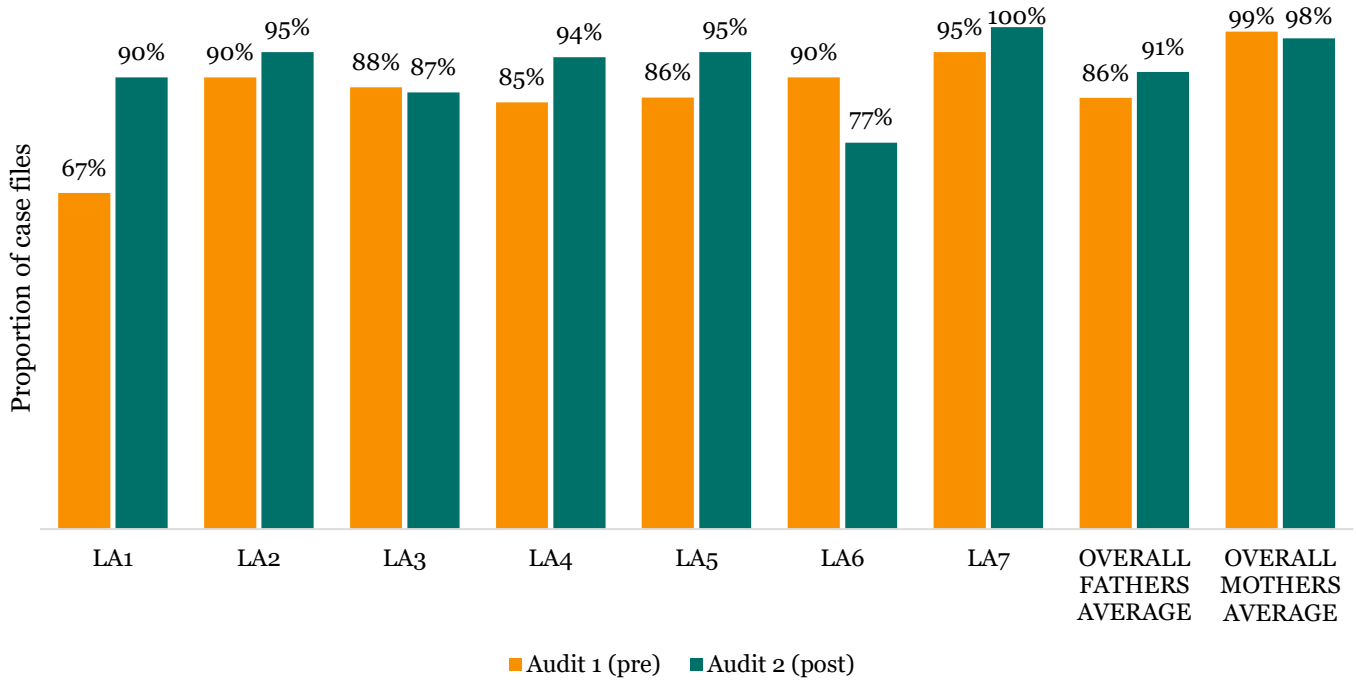
As part of the ISAFE intervention, QA staff were asked to complete a case file audit exercise at two timepoints using the ISAFE audit tool. The first audit took place before the ISAFE intervention (pre) and the second audit was scheduled for after the final ISAFE training session (post). The results of the audits were anonymously presented back to LAs during the LA Leader webinars.

Audits consisted of randomly selecting 20 case files from treatment team participants and recording the following information:

1. Percentage of a) fathers and b) mothers who are named on case files
2. Percentage of a) fathers and b) mothers for whom there is a phone number
3. Percentage of a) fathers and b) mothers invited to the initial case conference
4. Percentage of a) fathers and b) mothers attending to the initial case conference
5. Percentage of a) fathers and b) mothers invited to the most recent case conference
6. Percentage of a) fathers and b) mothers attending to the most recent case conference.

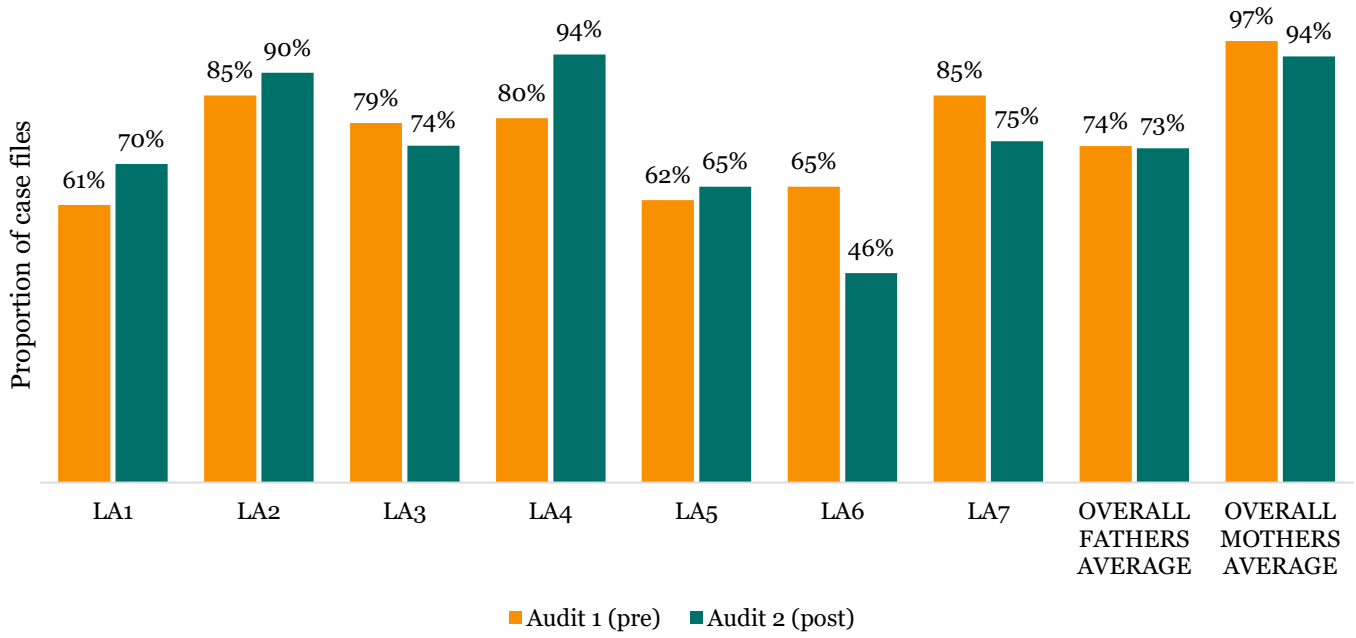
Below outlines the results of each of these by LA and then overall average for fathers and mothers. The data was collated and provided by the Fatherhood Institute.

Figure E1: Proportion of audited case files with the father named on the file (link to raw data)



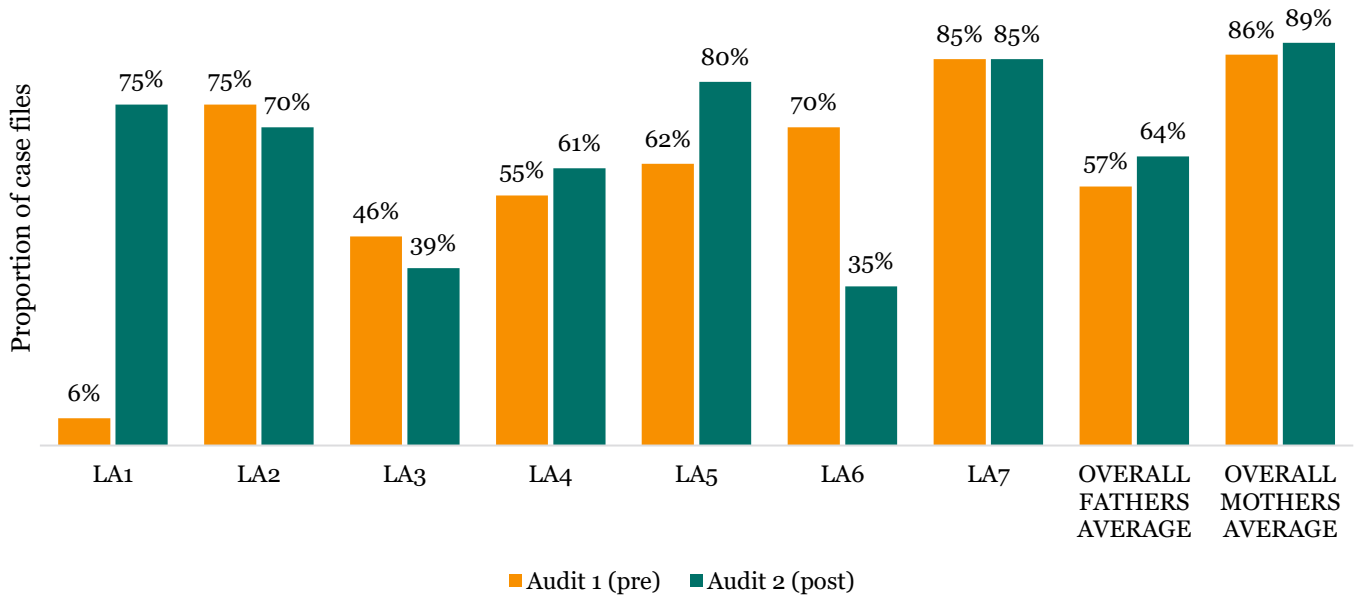
Source: QA audit results data

Figure E2: Proportion of audited case files with the father's contact number on the file (link to raw data)



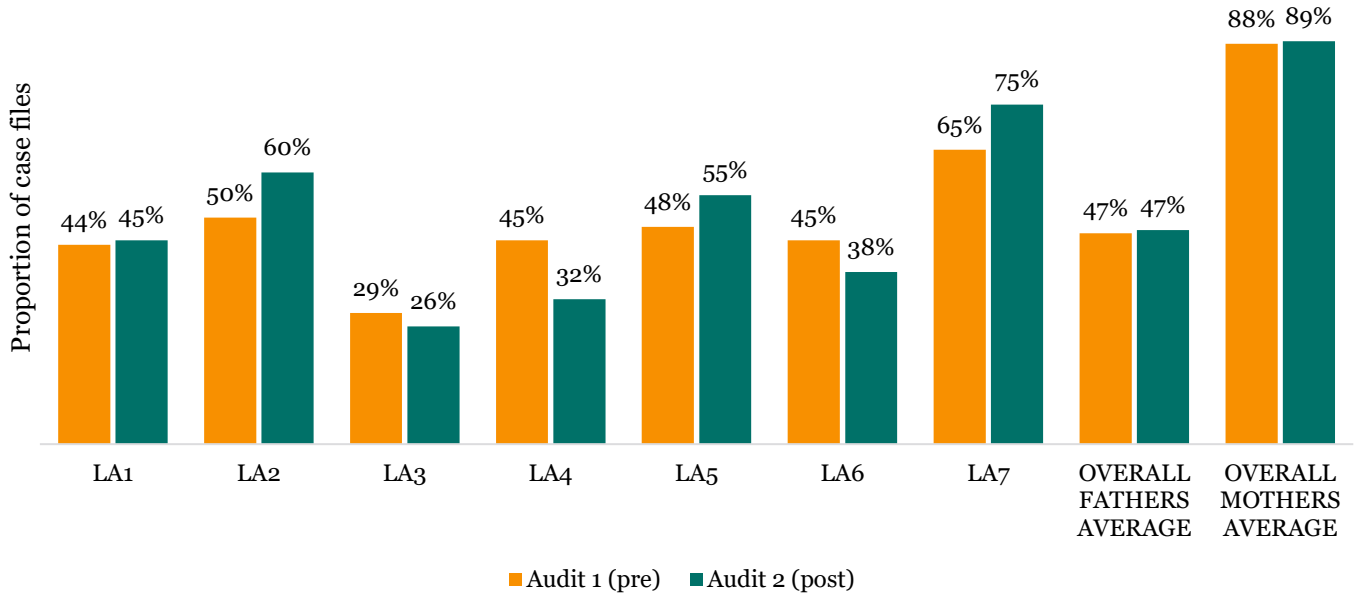
Source: QA audit results data

Figure E3: Proportion of audited case files with the father invited to the first case conference (link to raw data)



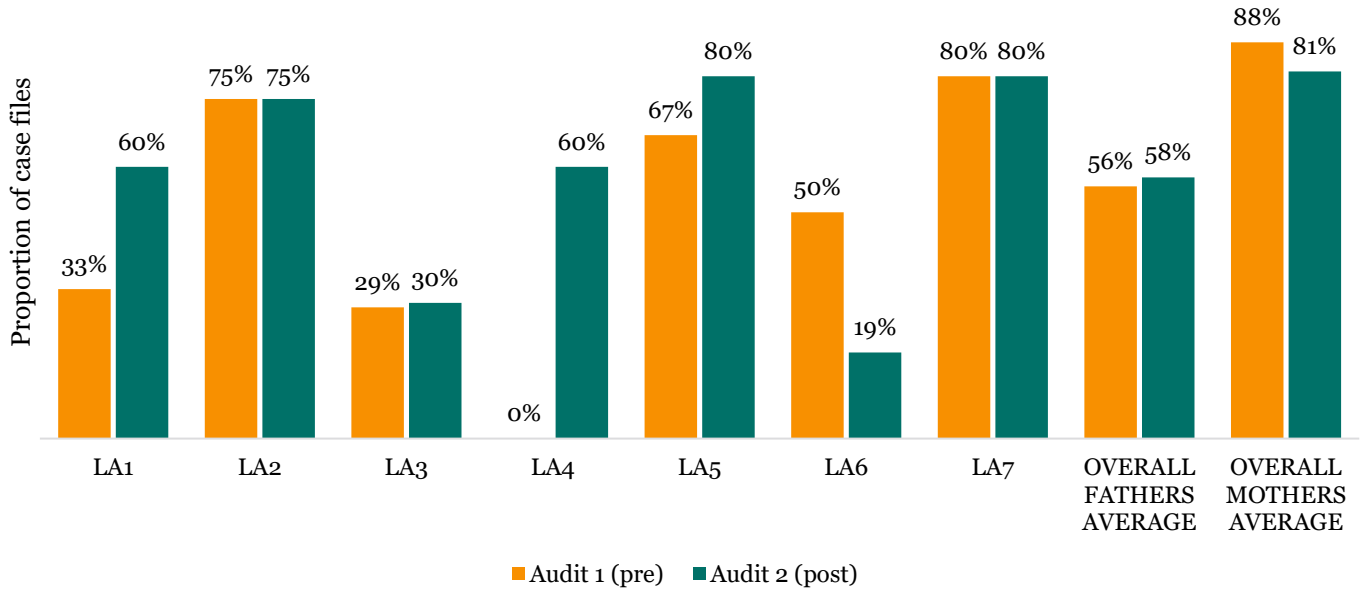
Source: QA audit results data

Figure E4: Proportion of audited case files with the father attending the first case conference (link to raw data)



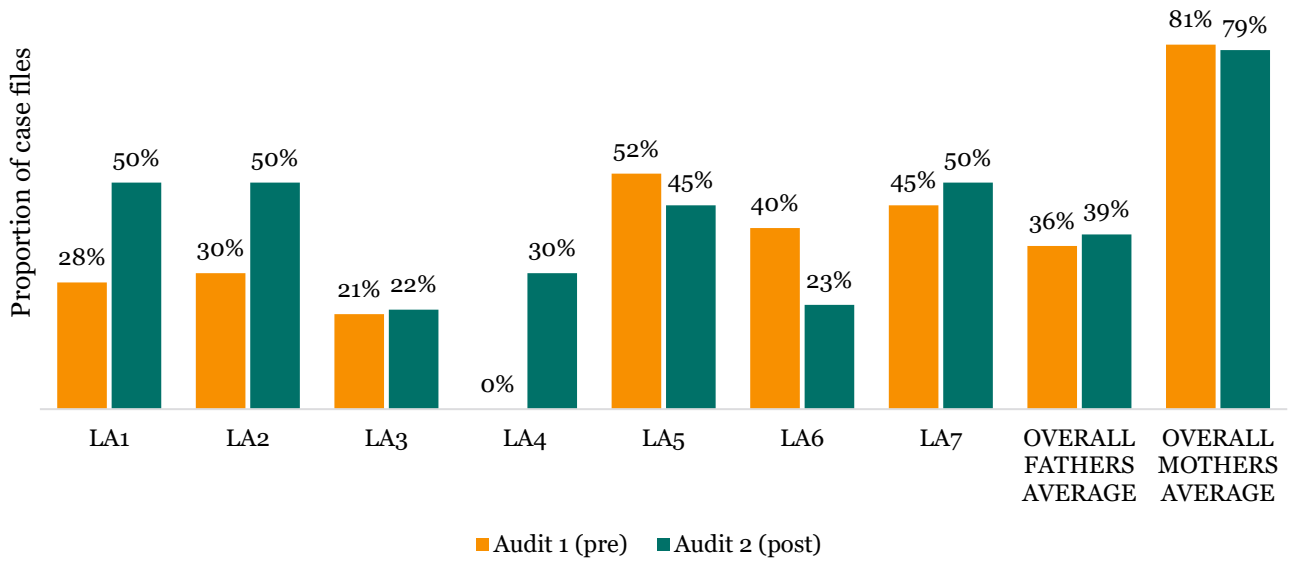
Source: QA audit results data

Figure E5: Proportion of audited case files with the father invited to the most recent case conference (link to raw data)



Source: QA audit results data

Figure E6: Proportion of audited case files with the father attending the most recent case conference (link to raw data)



Source: QA audit results data

Appendix F: Accessibility text

Figure 1: CONSORT flow chart

The image is of a CONSORT (Consolidated Standards of Reporting Trials) flow chart, depicting the flow of participants (and local authorities) through the ISAFE trial. The CONSORT flow chart illustrates the different stages of the trial, starting from local authorities being assessed for eligibility to participants' being included within the final analysis. The flow chart can be broadly divided into four sections: eligibility & randomisation, allocation, follow-up and analysis.

Eligibility & randomisation

- Assessed for eligibility: 10 local authorities
    - Proceed with participation: 7 local authorities
    - Withdrew participation: 3 local authorities
- Assessed for eligibility: 63 teams and 575 participants
    - Proceed with participation: 63 teams and 547 participants
    - Excluded: 0 teams and 28 participants who left teams
- Randomised: 63 teams and 547 participants

Allocation

- Allocated to intervention: 31 teams
    - Participants at allocation: 261
    - Participants joined mid-trial: 56
    - Total participants in teams: 318
    - Participants that attended ISAFE training: 233
    - Participants that did not attend training: 86
- Allocated to control: 32 teams
    - Participants at allocation: 285
    - Participants joined mid-trial: 16
    - Total participants in teams: 301
    - Participants that did not attend training: 298
    - Participants that attended ISAFE training: 3

Follow-up

Lost to follow up for intervention:

- 0 teams
- 55 participants left/moved pre-endline
- 107 participants did not complete baseline/endline outcomes

Lost to follow up for control:

- 0 teams
- 40 participants left/moved pre-endline
- 105 participants did not complete baseline/endline outcomes

Analysis

Analysed from intervention:

- 31 teams
- 156 participants with baseline and endline outcomes

Analysed from control:

- 32 teams
- 156 participants with baseline and endline outcomes

Click here to return to main report.

Appendix A: ISAFE Theory of Change

This image shows the Theory of Change of the ISAFE intervention. A Theory of Change is a visual explanation of how and why a desired outcome(s) from an intervention are expected to happen. It maps out the causal pathways from activities to outcomes to better understand, and test, the mechanisms underpinning the intervention. The ISAFE theory of change includes two pathways, the practice pathway and the systems pathway, with the different sessions of the intervention sitting underneath these pathways. The theory of change shows the following:

Rationale

Fathers, like mothers, can be a resource for their children. However, some fathers pose a risk to children. Although social work should routinely engage with all parents and adults around the child with both risk and potential benefits in mind, high-profile inquiries into cases where children have died or been seriously injured highlight a systemic failure in children's social care to routinely and systematically engage, assess, support and challenge men in family cases. The reasons for this are complex and multi-layered, including fathers being less likely to engage as well as social workers' beliefs, attitudes, confidence and individual practice. The evidence also suggests a lack of systemic focus on father-inclusion in local authority processes, leading to low recognition of this issue.

Inputs

- Fatherhood Institute
    - Staff time
    - Skills, knowledge and expertise on fatherhood engagement
    - Training materials
    - Trainers
- CASCADE
    - Staff time
    - Skills knowledge and expertise on fatherhood engagement
    - Training materials and literature review
    - Train the trainers on motivational interviewing
- Local Authorities (LAs)
    - Staff time
    - IT systems and data collection processes
    - Skills, knowledge and expertise
- Advisory group
    - Staff time
    - Skills, knowledge and expertise including lived experience

Pre-intervention activities

- Engaging and recruiting local authorities

- Data sharing arrangements
- Recruiting trainers
- Training of trainers
- Finalise training materials

Intervention activities, outputs, mechanisms and intermediate outcomes & outcomes, by pathway

1) PRACTICE PATHWAY

Online learning package for Social Workers (SWs)

Intervention activities:

- SW1 training: Group work, exercises, and presentations on fatherhood, evidence relating to child protection. gaps and opportunities (1 day)
- SW2 training: Introduces the principles of motivational interviewing and uses typical father-work scenarios, case studies, and role-play exercises (1 day)
- Online library of resources as part of ongoing, self-led learning and development

Outputs:

- Number of social workers trained in each module
- Number of resources accessed/downloaded

Mechanisms and intermediate outcomes:

- Awareness / knowledge
    - Increased knowledge about the lack of father
    - inclusion / engagement
    - Increased knowledge about the benefits of/ routes to successful engagement of fathers
    - Increased knowledge about risk assessment and ways of working with fathers to support outcomes for children
- Motivation, skills and confidence
    - Increased motivation to engage fathers
    - Improved competence / skills to engage and interact with fathers
    - Improved confidence working with fathers
- Attitudes and practice
    - More engagement with fathers e.g. listening. negotiating, managing conflict, discussing parenting/childcare
    - More data on fathers collected / analysed e.g. contact details, attendance at case conferences

Outcomes:

- Practice impacts
    - Higher quality risk assessments of fathers
    - Better identification of resources associated with fathers
- Family impacts
    - Better identification of risks
    - Improved child protection
    - Better support for father-child relationships
    - More paternal-side kinship care placement

2) SYSTEMS PATHWAY

Online QA training & audit

Intervention activities:

- 3hr training with QA staff covering: 1. Importance of father-inclusion 2. Review of father-inclusion data items 3. Skills to support ongoing audit culture
- LAs choose most suitable audit model: 1. Father-inclusion dashboard 2. Father-inclusion data snapshot 3. Case file auditing tool
- Support setting up and conducting 1" QA audit using chosen model
- Support to set strategy for future audits

Outputs:

- Number of QA staff trained
- Chosen audit model set up
- Number of QA audits conducted over trial period (and timings)
- Strategy for regular father-inclusion audits embedded

Mechanisms and intermediate outcomes:

- Awareness / knowledge
    - Increased knowledge about the lack of father inclusion in record keeping
- Motivation, skills and confidence
    - Increased motivation to obtain information about both parents
    - Increased ability to embed processes for father-inclusive record keeping
- Attitudes and practice
    - Improved processes for father-inclusive record keeping and more systematic data collection embedded
    - Regular father-inclusion audits conducted

Online Champion training

Intervention activities:

- 3hr training with Champions covering: 1. Ways to identify, monitor and address non-inclusive practice 2. Approaches to support father engagement through supervision and reflective learning opportunities

Outputs:

- Number of Champions selected and trained

Mechanisms and intermediate outcomes:

- Awareness / knowledge
  - Increased knowledge about embedding father inclusion in practice
- Motivation, skills and confidence
  - Improved skills to support culture change in the team e.g. mentoring
- Attitudes and practice
  - Enhanced adoption of support for intervention
  - Ongoing focus on father- inclusion advocacy

Outcomes:

- Practice impacts
  - Improved team culture on father engagement

LA leaders' webinar (delivered post-trial)

Intervention activities:

- 90min webinar across all LAs covering: 1. Progress and challenges of ISAFE 2. Impact on teams receiving ISAFE 3. Ways to embed, sustain, and build on learning

Outputs:

- Number and profile of leaders attending webinar

Mechanisms and intermediate outcomes:

- Awareness / knowledge
  - Increased knowledge of system-level levers for father inclusion
- Motivation, skills and confidence
  - Enhanced ability to advocate within and beyond the organisation
- Attitudes and practice
  - Commitment to improvement within organisation
  - Develop/extend father- inclusive approaches and ongoing workforce development
  - Support change in partner agencies

Outcomes:

- Practice impacts

- Partner agencies support shift in practice

Assumptions

- (Delivery) SWs need distinct father engagement training to achieve outcomes.
- (Delivery) SW teams and wider LA staff have the willingness, capacity and resources to engage in the training.
- (Delivery) Trainers deliver training of a sufficient quality to achieve outputs.
- (Delivery) Staff continuity/ retention sufficient to support training delivery.
- (Theory) Increase in awareness/knowledge/ skills confidence lead to improved motivation to engage fathers (and practice).
- (Theory) Better father engagement by social workers leads to better outcomes for children in social care (there is limited evidence to support this, though there is evidence to demonstrate the reverse of this).
- (Delivery) Data collection contains relevant and quality data on father engagement to support case file review processes.
- Performance management in local areas supports the delivery of systems change regarding fathers engagement.

Context

- Enabling factors:
    - Ability to show good practice in response to National Safeguarding Panel Report
    - Acknowledged need to reduce looked-after-children rates
    - Low baseline of father engagement so good potential for progress
    - Good practice to show Ofsted
    - Avoidance of negative publicity around lack of attention to fathers in isolated cases of child death
- Inhibiting factors:
    - Traditional assumptions about gender in practitioner culture
    - Fear of aggressive men and lack of services to refer to
    - Very high percentage of domestic abuse on caseloads
    - Very high staff turnover & lack of time for training

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