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Administration for Children and Families
Office of Family Assistance

National
Responsible
Fatherhood Clearinghouse



NRFC Webinar Series

Healthy Fathers, Healthy Families

Transcript

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Moderator:

- Nigel Vann, Product Lead, National Responsible Fatherhood Clearinghouse

Presenters:

- Craig Garfield, Associate Professor of Pediatrics and Medical Social Sciences, Northwestern University Feinberg School of Medicine
- Albert Pless, Program Manager, Men's Health League, Cambridge Health Department
- Charles Daniels, Founder and CEO, Fathers' Uplift, Inc.

Operator: Good day and welcome to the Office of Family Assistance National Responsible Fatherhood Clearinghouse webinar entitled "Healthy Fathers, Healthy Families." As a reminder, today's conference is being recorded. At this time, I would like to turn the conference over to Nigel Vann. Please go ahead.

Nigel Vann: Thank you very much, and welcome everybody. Good morning, good afternoon. As you see, we're going to be talking about men's health today, "Healthy fathers, Healthy families." We're doing this in anticipation of June being Men's Health Month, as you saw in the announcement for the webinar. There are some significant issues around the life expectancy of men compared to women, and it's particularly relevant for fatherhood programs. A lot of the programs we work with are working with lower income or disadvantaged fathers, and the statistics have showed us that you're much more likely to suffer from poor health if you are in a lower income bracket, and also to suffer from mental health as well as physical health issues. So this is an important topic, and we've got some excellent presenters lined up for you.

Just in terms of what you see on your screen, you see a Chat box on the left there. We invite you to chat there and say hi to each other. If you do have a question for the presenters, please use the Ask a Question box in the bottom right-hand corner of your screen, and then at the end of the webinar, we'll have a Q & A session. As usual, if we don't have time to get to all the questions, then we will post the answers to other questions after the webinar.

The webinar is being recorded, and on our website after the webinar you'll be able to find these slides and a recording, so you can actually hear the audio again. You'll see a transcript, and all the resources that are available on your screen will also be available to you.

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I just want to draw your attention to what we have in the Downloadable Resources box in the center of your screen at the bottom there. You can download the slides from there. You can download a few articles and a Helpful Resources list that includes materials from today's presenters, from the Clearinghouse, and various other sources. There's websites and academic articles on there. I believe you'll find that one very helpful. And then there's various web links as well. There's links to the Clearinghouse site, and there's links to some of our presenters' sites as well.

With that, let me move these slides forward a little bit. This is our standard slide just to introduce you to the Clearinghouse. If you haven't been on one of our webinars before, we have various resources. We're funded by the Office of Family Assistance from the Department of Health and Human Services. We encourage you to go to www.fatherhood.gov if you've not been there.

You can contact us using info@fatherhood.gov, the email address. We have the national call center [1-877-4DAD411 (877-432-3411)] that we encourage fathers to call. We encourage mothers to call. It's particularly good if you need any kind of mediation assistance, and folk on the end of that line are trained mediators. They can also refer you to local resources in your state. We encourage to join us via Facebook [<https://www.facebook.com/fatherhoodgov/>] and Twitter [twitter.com/fatherhoodgov] as well.

Today, we're going to go over a few publications that we have at www.fatherhood.gov that are related to health. And then we're going to hear tips from our three presenters: Craig Garfield, Albert Pless and Charles Daniels. I have their names on another slide, so I'm going to come to that in a minute. You do have the Helpful Resources available for download, and we'll also be doing the Q&A at the end. Again, just a reminder, if you have a question for the presenters, please put it in that Ask a Question box at the bottom. If you put it in the Chat box, we don't always see it.

I'm now going to give you a quick overview of just a few products that we have on the website. We have a project called *Healthy Fathers, Healthy Families*, which is a research brief. And then *Depression Among Urban Fathers with Young Children*, which is also a research brief. We have various tip sheets for dads on ways to look at and help your children avoid accidents. You can find those at the link there on the website [<https://www.fatherhood.gov/content/nrfc-tips-professionals>].

This is just [an] overview, a picture of what the *Healthy Fathers, Healthy Families* research brief looks like. It's hard to read the language there, but it's pointing out that healthy lifestyle habits can lower fathers' and children's risk of becoming overweight or obese, so they can reduce the risk of developing other diseases, such as high blood pressure, diabetes, or cancer — that it can help them improve mental health and mood and increase our chances for living longer.

There's a few tips in there for healthy eating and nutrition and healthy sleep habits. Albert's going to talk to us quite a bit about some of these things in terms of tips to help your children sleep better. This is a handy piece that you could pull out of the brief to share with fathers. You could talk to dads about ways to limit the amount of screen time that their children get, particularly before bedtime. That can be a handheld device. It can be TV. Obviously good to try and avoid having those things in the bedroom. Have a bedroom routine. Keep the household noise down, which can be hard if you a lot of people in the household, if you have people over, but just to help people think about that and ways in which they can help their children prepare better for the next day.

Here's just a shot of what the *Depression* brief looks like, and again you probably can't read all those words there, but the four bullets are pointing out that this was a study that looked at various research that's been done. It's not rocket science

per se, but it points out that fathers are more likely to be depressed if they don't have full-time employment, if they live apart from their children, if they have children with more than two mothers, and if they've been incarcerated. And that fits the bills for a lot of the guys who we find coming into these fatherhood programs. It's not surprising that a lot of practitioners talk about one of the things they really need help with is figuring out how to help guys who come in with some kind of depression or other mental health situation that they need some help with.

It's important to think about how we do that, and we have a few tips in the brief. Certainly, to really pay attention to what fathers are telling you so you can understand that the challenges that they're facing — maybe help them talk with the co-parents, and certainly provide training for all the staff on how to guide conversations, how to look for indicators of depression, but yet to recognize our own limitations. There's only so much we can do, if we're not a trained professional, so to know when to seek support from your colleagues and when to perhaps seek professional services, perhaps be able to find a way to reach out to others ahead of time and develop those research sources there.

We're going to hear in a few minutes from Craig Garfield, but before we do that, we're going to have a poll question, so if I could just pull that up quickly. As usual, we just like to ask each of you to respond to this. It just gives the presenters an idea of who's on the line and what kind of services you're providing, so you can check any of these services that you provide, any health-related services that you're providing.

Do you have curriculum sessions on men's health? Do you have an assessment of physical or mental health? Do you provide tips on healthy eating and nutrition? Or tips for fathers to enhance their children's health? Do you have support groups for fathers of children with special health needs? Do you make any referrals to community health? I'll just give you a few more seconds to respond to that.

[Pause]

While you're doing that, I'm just going to slip back a few slides here. And if we could close the poll now, please. I realize, I thought I had another slide coming up with the presenters' names.

I just wanted to take a brief moment and introduce you to each of the presenters, and then I'll go back and turn it over to Craig. Craig is an Associate Professor in the Departments of Pediatrics and Medical Social Science at Northwestern University's Feinberg School of Medicine. He's also an Attending Physician at the Ann & Robert Lurie Children's Hospital of Chicago. As a practicing physician and scientist, his research is able to focus on improving the health of children and families by understanding the role that parents, particularly fathers, play in the health and well-being of children. He's going to be sharing some information on research he's done and general research that just is really going to set the table for this discussion, I think.

And then he'll followed by Albert Pless, who is the Program Manager for the Men's Health League at the Cambridge Health Department in Cambridge, Massachusetts. He's got over 20 years' experience working in community-based programs in the Greater Boston area. He's directed a nationally-recognized community health worker program for black and Latino men through the Boston Public Health Commission, and he's also facilitated various fathers' groups for the fatherhood program at the City of Cambridge's Center for Families. You can download the bios as well from the Downloadable Resources box, but I just wanted to give you a quick highlight of everybody before we move forward.

Finally, our third presenter will be Charles Daniels, who is the Founder and CEO of an organization called Fathers' Uplift in Roxbury, Massachusetts. He's going to tell you a lot more about that, but it's [an] outpatient mental health clinic that's providing some really valuable services in the community. As Charles describes the way he came to this work, he witnessed his mother's struggles as a single parent and started thinking about what might have prevented his father from being active in his life, like, "why isn't my dad here?" What so many dads ask. Charles concluded, well, "What if someone had been there to help him? What if someone could've helped my dad? It might have made a tremendous difference."

So that's a big reason behind why he created Fathers' Uplift, to provide support and therapeutic relationship-building for fathers in low income communities particularly. In Charles' words again, he says, "If we can identify the problems that are preventing men from being in their children's lives, we can find ways to help them work through those problems and remain engaged." So with that, I'm going to take you back to Craig's slides, and I will turn it over to you, Craig. The time is yours.

Craig Garfield: Great. Well, thank you, and welcome, everyone. I think this a wonderful webinar on healthy fathers and healthy families, and something that I'm hoping that the information that we're able to share is something that everyone can take back to their individual environments and communities to improve the health of fathers and families.

As Nigel said, I am a practicing pediatrician here in Chicago. I did my training in Boston, so this is a very Massachusetts-focused group here. But I found that working with families, if you aren't thinking about where the father is, whether they're in the office with you or if they're at home, you're missing an important piece of that family constellation. Whether they're married or not married, fathers are involved with their families, and we'll talk about that in just a little bit.

I just also want to mention two other things. I teach an expectant fathers class here in Chicago for dads who are expecting their babies, and I find that a great source of information for the research and the clinical care that I give. Just this last June, Michael Yogman, also from Boston, and I co-authored the American Academy Pediatrics [report](#) on fathers and pediatricians, which you can find at the AAP website. That really reviews a lot of the information we know about fathers and the role fathers play in families. It's with that perspective that I come to this work.

I want to share with you where things are with fathers. If you think back on this image here on this slide of the typical father of the 1940s or '50s — this is from *The Saturday Evening Post* — you can tell by the look on this guy's face that he is just miserable, and his baby isn't much happier at all. He's tried all the tricks in the book. He's given the baby a bottle, trying to use different toys, rattles, and things like that, and the baby just looks miserable.

If you fast forward to just this past summer — this was *The New Yorker* cover — where you see a man who is totally in control. Not only does he have his three kids, his kids are happy. He's happy, he's buff too, and his kids are eating ice cream. What could be more confident than this father right now? Here we are in 2016. I think that's the background through which fathers are coming into fathering now.

[Music]

Do you all hear that music? Alright, so that was beautiful music. Thank you for whoever included that. I just wanted to give some of the background of how men are coming into fathering this day and what the social media is portraying, and how that might fit in the background of what it is that we're doing out there in working with fathers.

When you look at the numbers of fathers, there's over 70 million fathers in the U.S. today. That includes almost two million single fathers. The biggest growing group of fathers, I should say, are the 2.2 million stay-at-home fathers. This number just keeps on increasing over the years. There's some economic reasons for that, in terms of the employability of men in new economies and things, but there's also a choice that many men are taking to actually be more involved and be stay-at-home fathers as their partner might go out into the workforce and claim some more money.

Another big increase is the number of non-residential fathers. One in six fathers now are non-residential, so these are men who don't live with their child. Some of them have multiple children and may not live with any of them or may live with one, but not with others, and it's where a lot of our services are focused. Yet, 98 percent of non-residential fathers are involved their children to some degree. Typically, this is, if not daily, at least weekly, with that child. They do end up spending less time with their child. They spend less time eating with them, less time involved in child care, and less time playing with their children than resident fathers actually do.

When you think about the impact of becoming a father on men's health, we know that fathers' involvement is increasing. They've actually more than doubled the amount of time that they spend involved in child care, and for many men, this is actually impacting the choices they make in their life. We started on looking at conducting some original research to look at the transition of fatherhood as a lever for change for dads. Would men who typically consider themselves to be indestructible — aren't quite looking much into the future, aren't necessarily going to see the doctor — would becoming a father be something that affects their attitudes and their health behaviors as they take on this new responsibility? Might that be something that actually affects their health and possibly in a positive way?

In order to do that, we first started to look at, "Well, where are we in men's health right now?" We know that a male's life expectancy in 1920, that men were only one year behind in life expectancy compared to females. If you fast forward to 2017, men are actually about five years behind that of women.

It is actually worse for minority male health life expectancy. The life expectancy on average in the U.S. is about 79. It's lower, around 66 to 74, for non-whites in the U.S. That discrepancy and disparity tends to be on the increase. Men are at a greater risk of death than women in every age group with a mortality rate of 1.6 times higher for men compared to women. All this is to say, where we should have been equal or still maybe just a little bit behind, if we had continued in the same direction since the 1920s, men are actually slipping behind, in terms of their health, over the ensuing decades.

When you look at the healthcare system, we know that adolescent males exit pediatric care, where they will have pediatricians and see their pediatricians pretty regularly, but they exit there with limited ties to the healthcare system. For most women, they will see their health practitioner for an annual physical with much more regularity than men do. Yet we do have recommendations for preventative visits and screenings that should be implemented with men, and we'll talk about that in a few minutes.

Most adolescent reproductive health initiatives that work to try and strengthen the health of young people really focus mostly on women and girls, and it's really around the reproductive health and decisions around pregnancy and forming families that most of the initiatives take place. There's less out there for males. We'll hear about a little bit of that in the other presentations. In general, men are less likely than women to have a regular doctor or to attend regular doctor visits. In fact, over a third of men have no regular physician, and 24 percent of men have not seen a physician in the past year. That's setting a bit of the foundation for why we might see fewer men in the healthcare system and that men in general not being as healthy as women over time.

Our group started to think about this. Was fatherhood something like an important social determinate for men's health? We actually wrote a commentary in JAMA for the men's health issue calling it "Fatherhood as a Component of Men's Health." Because when we think about men's health, we typically think about things below the belt. We think about their urologic health, erectile dysfunction, and we don't really think about the bigger picture of health for men.

Just as we know that fathers have an effect on their children, children may in fact have [an] effect on their fathers, and this was a new area of research. Whether this effect was beneficial, detrimental, or neutral, really, we didn't know. When we started our research, what we did was we started talking to fathers, largely minority and non-resident fathers, and asked them, "How did having a child affect their health, their health behaviors, and their attitudes?" We started that research because there wasn't very much out there in the literature, and we started talking to dads to get and hear their story.

What this slide shows you is the result of that question. We started with 35 dads, and we did really intense interviewing with them, asking about that transition of fatherhood. These are dads in Chicago and Milwaukee. We found that about 10 percent said that having a child was a negative experience, 13 percent said it was neutral, but a full 77 percent — so the vast majority of these dads — all said that having a child had a positive effect on their health.

And so when we wanted to dive down a little bit deeper into that, and we asked in the questions, "What were the things that changed for you?" These numbers don't add up to 100. You could answer as many of these as you wanted to. But over a third said that they started to eat better. They started realizing that they're a father now and that there's someone actually watching behaviors. They try to act a little bit better. They try to eat better. They try to exercise more.

Interestingly enough, in the interviews that we did, we had some great quotes of dads saying, "I've got my football. My son's got his football." "I've got my bike. She's got her bike." These are activities that they do together that you can imagine are beneficial for both parents and children.

Dads talked about decreasing their alcohol use, trying to take better care of themselves, and less risk taking, so if they had found themselves on a street corner in a bad position, once they had their kid, they really thought twice about doing that. What we called this overall, was this idea of "being there." When they had not really thought much about their future, now they really told us loud and clear, I want to be there. I want to be there when my child finishes kindergarten. I want to be there when my child graduates eighth grade and when they graduate high school and head into college. It was a real shift, an attitudinal shift for these men that we talked to.

But like many things in research and in science, we wanted to see, well, this was a sample of 35 people — what if we took this to a bigger sample, and we looked at the effect of becoming a father on some of the important indicators for men's health?

The next study that we did, we looked at this sample of over 10,000 young men. This is a sample that was collected in the 1990s, and then they went back four times over the ensuing years, and the men in the sample now are in their mid 30s. What we were able to do, and it's a little hard to see on the screen, but if you look at the graph on the bottom line, it says "adolescents, late adolescents, early fatherhood, and late fatherhood." This is essentially four time periods that we broke out in this 20-year sample. We looked at fathers' mental health — what happens when you become a dad to your mental

health. Each time that the study went back and asked questions of the 10,000 men in the sample, they asked them about their mental health.

What we did was we broke it out into resident fathers and non-resident fathers. You can see the graph. The line on top shows this increase in mental health and depressive symptoms scores until zero when a man becomes a father, and then there's this decrease for non-resident fathers. Statistically, that is not significant. The significant one is actually the resident fathers on the bottom here, so these are men who live with their children. They actually are decreasing their depressive symptom scores until becoming a father, and then those first five years after being a father, they actually have this increase here in their depressive symptom scores.

That's really significant if you think about what's happening with children and babies, and they're bonding with the parents knowing that they have a safe, secure attachment. From there, they go and explore the world. If Dad is depressed, that may affect that child's ability to bond and then safely explore the world. A really important time period is that zero-to-five age range.

We did the same kind of a question looking at not mental health, but body mass index. In the same study of over 10,000 men, looked at from adolescence through young adult adulthood, and what we found is that non-resident and resident fathers both increase their BMI, their body mass index, after becoming a father. So here again is this line in the middle that is the transition into fatherhood. You see both the non-resident fathers down here and the resident fathers up in the top. Those lines are increasing. We calculated that to be on average about a three-and-a-half-pound increase for non-resident fathers and a four-and-a-half-pound increase for resident fathers.

That's not taking into account whether they're married or not married. We control for that, so that's an actual — what we call the effect of becoming a father, and you may have heard about the “dad bod.” This is something that people think is attributed to becoming a father. There are real changes. I think that's what this research really shows in men's health as they transition into fatherhood.

What we proposed then in the *Journal of Pediatrics* is that pre-conception care, which is usually considered just for women, is actually something that should be considered for men too. We propose that you can start in the prenatal period with talking with men about their physical health and screening them for their physical and mental health needs, and helping dads understand, or expectant dads understand, that they have an influence on the mother, that they have an influence on the fetus too. That the fetus actually hears Dad's voice when the fetus is inside the mom and will preferentially turn towards Dad's voice once that baby is born. That during the perinatal period, during the pregnancy period, there can be value in attending the obstetric visits as a chaperone. That going to the pediatric visits can be useful to talk about changes in couples' dynamics. To learn something about breastfeeding and the role fathers play in breastfeeding, and making sure that dads are supportive of getting the appropriate immunization.

The post-natal period is a really important time period because finally for many dads, it's like, “Oh, now, I get it. My baby's finally here. Now I understand that I need to know some things.” We can be supportive of that as well and learning about helping dads balance work at home, understanding the roles and responsibilities that dads now have to take on, and still paying attention to their physical and mental health and how they can help the mother and the baby as well.

In general, some tips for fatherhood programs that come from the work that we've done is really recognizing that becoming a father is an important life course event for men, knowing that some dads will realize that sooner rather than

later. For myself, it came literally when the baby was here that I realized, “Wow, I really am a father and need to start thinking about this.” But the dads that we’ve come across both in research and in the office really want to be involved, and our job is to make sure that we find ways to get them involved. Dads are, generally speaking, pretty proactive — they want a task. They want something that they can do and be successful at, so helping them think about that is really important to do. It just may be the wakeup that they’re waiting for.

We want to be able to offer them what they’re looking for because we may have our own ideas of what we think is important, but if they’re looking for something else, whether that’s employment, or housing, or how best to contribute, we need to be sure that we’re offering them that. And at the same time, offering them what we know is important for the child and for the mother as well, so that includes understanding their child in particular — not anyone else’s child, but your unique child and what is unique about your child — so offering tips on age-appropriate care and development, reading to the baby. Play is a great way to get dads engaged, and it’s something that’s very dad-centric. Helping dads to understand their partner and the changes that their partner might be going through, helping their partner with breastfeeding, helping their partner by providing care for the child and hands-on care is really very useful too.

And then making sure that we don’t just forget about Dad and his needs, but he may have very practical needs and concerns about how will he take care of this baby with the hands-on care. And also be concerned about how does he role model to be a good father. I’ve never met someone who says, “I want to be Dad and father to my child.” So how can we help them with that role modeling task that is a big part of how kids see their father growing up.

With that, I’ll end and turn it over to the next speaker, and I’m looking forward to questions at the end of this.

Nigel Vann: Well, thank you very much, Craig. That was great. Yes.

I really liked the point there at the end that we have to give dads what they’re looking for, but then we also have to find ways to talk about other things that may not be the reason they come. I don’t think too many guys come into a fatherhood program thinking about their health. They may be thinking about their child’s health.

Although, as Craig pointed out, they don’t really necessarily know how to do that. We could tell them how important that it is to bond in those early years, but what does that mean? So being able to talk about those things is so important. But I think it’s particularly important, and again with it being Men’s Health Month next month, that we find ways to engage guys in conversations about their own health. You got to take care of your own health before you can do things about children’s health.

With that, I’m going to turn it over to Albert Pless, who’s going to tell us all about his great work with the Men’s Health League to do that very thing in Cambridge. Albert?

Albert Pless: Great. Thanks, Nigel, for that. I also just thank the organizers for this webinar, “Healthy Fathers, Healthy Families.” Once again, it encompasses the 20-plus years of my work, so I feel right at home having this conversation. Also, it’s just really good to follow Craig. Even though I didn’t know Craig, reading his slides and really looking at his work, it’s really a great opportunity to follow him in some ways in terms of building on that message that he put out around the important tips around men’s health. Also, I’m glad I’m actually before Charles Daniels because I’ve heard him speak, and he’s an amazing presenter, so following him would be very difficult, so I think I look forward to his presentation.

Once again, Albert Pless. I run a program in Cambridge at the health department called the Men's Health League. My conversation today with you — I'm going to share with you a model, but it comes from a public health perspective around prevention. It's been running for about nine years now, and really, I think it's a great model of intervention to share around how do we look at men's health, so building on some of what Craig talked about in terms of how do we see this thing in action.

My program, I call it an intervention, focuses on prevention of cardiovascular disease and type 2 diabetes, and particularly with men of color. I talk a little bit about why later, even though a lot of things that we talk about and really address with men of color are really across our races, but there are disparities that exist with men of color. Our programs are designed to do education, particularly around key topics — physical activity and supporting healthy eating.

Those two things are really critical, because a lot of times men — and Craig said it earlier — a lot of times we're socialized to think about certain things around our physical activity. We think we're being physically active, but we may not necessarily be getting the right type of activity. And then also eating, socialized to eat a certain way. A lot that we talk about in that program is educating men on the correct way to eat, portion size, really how to go out and shop and how to really go out and cook healthy meals for them and their families. So this is really important information.

We have two interventions that we do a lot of this work through. One is a program that is really about social support. We call it Fitness Brothers — this whole idea of brotherhood among men, getting men to really connect and bond and feel like they are one in supporting each other. We do a lot of work through competition with that program. Men report time and about how long they've actively worked out. We define anything [as] working out — climbing stairs, taking walks. If you said I parked further away in a parking lot to go to the store, that counts — anything, that counts. We really want to get them using competition.

And then we have a program that's for men who are high risk for heart disease, stroke and diabetes, and then we take them and put them in a 12-week program to teach them around healthy eating, physical activity, education, as well as men's health itself in a broad way. We give them tips along the way for that work. That's really two key programs for us as we're going and doing our work.

I want to just back up to say a lot of work that we do in this project is really done in partnership and collaboration, which I think is something I'll share a little later in the slide around where they're helping those who are doing fatherhood programs like I've done before, and still to this day do now, is that all our work will be done in the collaborative way. I think that's really the way that public health works and operates anywhere.

The objectives, and I said earlier, around behavior change — I think a lot of us who work with fathers and men in general, we know that it's difficult to change behaviors, and that's really in general with anyone if you're trying to change something that's unhealthy. But once again, for men, a lot of things that we've been socialized to do — we're trying to really have them think differently about that. Sometimes it's just really about maybe showing them some other image that they can embrace around a healthy outlook on life.

We also do work around leadership, and this is a crucial piece for us in men's health, because we need models. We need role models. We need men who are out there really doing things that are practicing healthy behaviors. Other men, even young men, even boys, can see a pathway to being healthy. That's really important for leadership. We do that by getting men together, giving them tools and things like that to go out and be models in our community in Cambridge.

And then, finally, we do a ton of community events. Nigel mentioned earlier it's Men's Health Month in June. This is an important time. This is like us and men's health in a playground, a kid in a candy store. I mean, this is our one opportunity during the year that we can just do campaigns like Take Your Loved One to the Doctor Day, or doing things like Healthy Eating During Father's Day Weekend, or things like that, doing cook outs. We do a lot of things in our community. We have men lead a lot of those events and things like that, so this is a really good opportunity, once again, for people to see men doing healthy things.

I think there's still a lot of these myths and misconceptions out there that men are not taking care of themselves and not taking care of their bodies and taking care of their families. I think a lot of what we try to do in an intervention like this, and I know that Craig mentioned some things earlier, and Charles will say some things later, that there are men who are really walking the walk. We really want to make sure that that stuff is highlighted, so we do a lot of raising visibility around men's health. We let our partners be involved in it as well and things like that.

But just a step back again, and some of this you may have heard already with Craig — when we talk about this “why” bucket — why? — clearly, there's some key things around “why us and men's health?” We do our work and stick with it. For me, one of the big things my mentor told me years ago was, “If you're going to stay in this work, you should be trying to put yourself out of a job because your whole focus should be trying to create these models where men are not — you don't need them anymore. The culture's changed. The men are operating a certain way.”

But we still know now that there's these disparities, so we know that men have a lower life expectancy than women. We know that there's different risk factors for men, and they require different interventions. Our program here focuses from a public health perspective around prevention. We look at root causes. There's other interventions, there are other programs that have more interventions. They just go right in and work with a smaller population, versus at public health, we look at more population health. But whatever works, you have to really try that, but there's different interventions we know are out there.

We also know that men of color suffer disproportionately around mortality. We die earlier, and we get sicker earlier, so that's something that's really critical for us to really pay attention to, because some of those same disparities exist as they did 20, 30 years ago. They're just a little masked right now. It may look like some of the numbers have moved, but really on a larger scale they have not, so we have to focus on that.

When we think about some of things that we can do to stay healthy; these things are simple, but really learn how to how to prevent illness, take care of your body, listen to what your doctor's saying to you, follow that, write those things down. Learn to find illness early. A lot of times men — we're stubborn, and a lot times, we really want to wait and wait and wait, and sometimes we don't want to know what that doctor's going to tell us. We shy away from that. But it's like your car. We tell a lot of men in our program, it's like, if you find the illness early, you won't get that knocking noise.

Some simple tips as you heard from probably earlier from Craig — don't smoke, simple things — eat well, exercise [and] avoid stress. I know these are simple things, but sometimes it's about saying “no,” and the men, a lot of times we say “yes,” and then we try to figure it out later. Limit alcohol and just limit that. We don't say don't drink, people drink. But really limit that.

A big one we plug during Men's Health Month is get tested. There's nothing wrong and shameful about finding out something. There's no shame for things, if you die from that. Get tested regularly, look at your regular screens. We give things out regularly throughout the month and year around getting tested for certain diseases and really being on top of that.

We love to show images in our program. This is an image of just healthy, just colorful vegetables, and we let the men know that these are — our nutrition dietitians share with our men the importance of taking in healthy foods, so we share with our men through our programs. This is something that once again, even if you're doing the broader work around fatherhood, it's healthy for men to know that there are healthy options. Even if you're on the go, you can find a salad at any time in one of these local restaurants. You may be going with the kids or really on the move, so eat healthy.

As I said earlier, avoid stress. There's nothing wrong with saying no. In our program and in men's health in general, we use a lot of images. I think it's important for men to see things and visualize what it looks like because a lot of times, we don't really see ourselves. Avoid stress, avoid things that cause stress, and that's an important thing.

But we also know there's incredible barriers, so you just can't tell a man, "Oh, go get healthy, you're going to be fine." We understand there's multiple things, and these are just five of them that really stand away from men being healthy.

One of them is this whole idea of manhood and masculinity and something we fight in the men's health field around this whole idea of what it means to be a man. There's these false images out there we know around avoiding your feelings and things like that. That really is counterproductive when you think about what Craig said earlier around connecting with your primary care because how are you going to be honest with your physician if you're not really feeling the feelings?

It's also challenging navigating these systems. These systems are complex, and I'm not just saying that's a man problem, it's a people problem. But ... we also know that's a barrier, because a lot of times as men, the simplicity of things is what we need. A lot of work that we do in men's health are trying to ease some of those challenges around navigating these systems, which we know are essential for them to really navigate. Also, stress and daily life — once again, I said earlier, I'm just repeating the fact that there's daily stressors that are impacting us; choosing working a second job over maybe going and joining a gym. Those things are real in times of men providing.

Mental health. Once again, same thing around trying to make sure that we're on top of things that are challenging to us. If we need to talk to someone, we should talk to someone, and that's a barrier if we're not doing that.

And then finally, competing priorities. Fathers, kids, both are responsibilities. There's a lot of things that come with being in a place where you're a father or to be responsible for other people in terms of your family. A lot of times, men take on too many things, but the priorities are really challenging for men to navigate that sometimes.

I said earlier - screenings. I can't really emphasize enough the importance of getting screened, getting tested for things that are preventable. A lot of the diseases that men die from, cardiovascular disease is the number one disease, the killer of people out there right now. As men, what we have to understand is that a lot of times, we can look at the results we're getting back from our test, from our physicians. In those tests, we have them telling us things, like either lose weight or make sure that we're below on our cholesterol and things like that. We have to follow those screenings. There's guidelines out there we could follow around that, so we emphasize the importance of screening and getting tested.

Just to follow with some tips as Craig did earlier, in our work for fathers' programs, is talk to dads about the benefits of healthy eating and physical activity. These are things we can just share with them when you're in a small group, build it into the curriculum. Some curriculums have things like this built already into it. If it's not, just add it in. And really do it for themselves and their kids. As Craig said earlier, you cannot just share these things with your kids and families. You have to apply them for yourselves and find ways.

Share information about stress, depression, and other key topics. This is important. Share information. There's things you can get offline. There's things that I share with you on a slide later, you can download. It's really important to get information to fathers.

Ask dads what they think about their health. There's nothing wrong with having a conversation with them. You're not being too invasive. You shouldn't be, just ask them some questions about things that may be prevalent around men's health around, say, diabetes or cardiovascular disease.

Encourage them to support each other in being fathers. It's stressful. I'm a father. We understand there's a lot that comes with us being responsible fathers, but encouraging to support one another. Sharing that brotherhood model is important.

Identify healthcare providers you can refer them to. It's important that you do a landscape and just look at what's around you. Do you know where the local hospital is? You know where the health centers are? Do you know where things are where you can refer them to or build a relationship through? Every man should have a person, but definitely the men [in] the work that we do on fatherhood should have a provider that they are connected to.

As I said earlier, find someone to come in and speak. Guest speakers are really important. Particularly health providers are really important, so they can destigmatize that whole idea of what this doctor looks like, and he's going to come in and say some mean things to me or bad things that I don't want to hear.

And then finally, really encouraging dads to be healthy role models for their kids. This is very important. We are our role models for our kids and we have to practice healthy behaviors so they can see the change that we're trying to go through, so they can adopt some of those healthy behaviors.

I want to share a few different resources.

- One is — I work on them — it's the health department website. [<http://www.cambridgepublichealth.org>]
- There is an incredible organization called the Men's Health Network [menshealthnetwork.org] that's been around for over 20 years. They have a lot of things — the screening guides, things like that, articles you can read.
- All Pro Dad [allprodad.com]. It's really an NFL-focused initiative by some former NFL players. Good articles, good videos to check out with you and your kids.
- And then finally, just an Eat Right website [eatright.org/resources/for-men] where they just give you some really concrete ways on how to eat healthy, and I think it's important to download some of those things.

Here's my contact information. Feel free to email me offline or whatever just to get information about the work that we're doing or just some tips that I shared earlier. So that's it for me. Thanks, guys.

Nigel Vann: Okay, Albert. Thanks very much. They only give our presenters about 15 minutes here, which is tough to share your wisdom in 15 minutes. I know Albert was a bit nervous about that. You hit that on the dot, Albert. That was perfect.

I'd certainly like to underline some of the resources there that Albert mentioned. I think we've got all these on the Helpful Resources list as well, but I know it's hard sometimes to think about well, "how do we have these conversations with guys?" Well, there are really awesome, good resources there at that Men's Health Network and at the Eat Right website and some of the other things that we have on there because it's just so important to find a way to start these conversations.

Before we go to Charles, we're going to bring up our second poll question here. Just to give you a chance to tell us a little bit more about the work that you're doing. We're just interested — as you think about the fathers who you see as you work with them, which of the three following would you say you see the most often? We're just asking you to check up to three boxes here.

[Pause]

I'm seeing quite a few people go for the first one, stress or depression. Alcohol and substance abuse, we hear that a lot. Yes, it looks like the first three are the ones that you're going for. That doesn't mean we shouldn't be talking about the other things with them though, right?

[Pause]

Okay, well thank you. I'm going to declare "problems with alcohol or other substance abuse" the winner here. In second, you've got chronic stress or depression, and then third, the undiagnosed, untreated mental health. I think if I put money on it, that's where I would have thought we'd end up here. We've got a late run by health insurance, but those are the three that stand out like that.

Thanks very much for that. I will now move the slide over for Charles Daniels to tell us what he's doing. He's doing some fantastic work that deals with quite a lot of the issues that you just mentioned on your poll question. Charles, tell us all about it.

Charles Daniels: Awesome. Thank you, Nigel. Greetings, family from Boston, Massachusetts by way of Atlanta, Georgia. I'm so happy to be presenting. This is a humbling experience.

Today, I'm definitely going to talk about the work that we are doing at Fathers' Uplift, Inc. — we say the nation's first outpatient mental health center, exclusively for paternal and child health and male engagement. Our main goal in our agency is to support dads with overcoming those mental barriers, so they can stay actively engaged in their kids' lives. Our observation within the work that we do, we understand that it's difficult for a man to parent a child or be present for someone else if he is unable to be present for himself.

Oftentimes, a barrier that presents men from being present for themselves are mental health related issues, such as some of the ones that you mentioned in the poll, such as a depression, post-traumatic stress disorder, trauma, and addictions. I'm going to cover a host of those and give you some real-life experiences and the ways in which Fathers' Uplift has been engaging men who are suffering from dual diagnosis, a mental health disorder and a substance abuse-related or addiction to a certain extent.

I want to make sure that you walk away with some concrete tools that you can use that regardless of your position, and regardless of how much time you have to intervene with the men, I truly do believe that some of these tools will be of assistance to you. Thank you, and looking forward to sharing our information.

Now, one thing that we would like to focus on is something called Hasna. When I talked to some of my guys, and I said you need to be like a asna, they're like, "Charles, what are talking about?" Well, in one of our sessions, one of my clients is a 75-year-old grandmother who is still suffering from issues related to her father and how her father abused her, sexually abused her. She was meeting with me in therapy to help her overcome those issues that have been impacting her ability to be present for her kids and also her grandchildren.

I think these experiences of her own father clouded her vision to see how impactful she has been in her kid's life, but issues related to her father have remained present in her life for an extended period of time. She said "Charles, I'm a gardener."

I said, "What's your favorite plant?"

She said, "Well, my favorite plant is a Hasna."

I said, "What is a Hasna?"

She said, "It's a shade plant. It's a plant that grows in the shade."

For me, I thought about the work that we do with our fathers, or men in general, how it's important for us to support them in growing in the shade. They would come to our doors with many issues that have impacted them significantly in the past, but are we going to be the light or the darkness?

I consider some of those negative experiences the shade. Those painful moments. Those moments have interfered with their ability to present in their kids' lives, and have interfered with the ability to be present in their own lives. I was wondering, if we may not be able to erase the darkness completely, but we can contribute to the shade and be the light — so that's the concept on which we're going to talk about it. How can we be the light in the fathers that we are working with? How can we be Hasnas, shade plants, encouraging the people that we are working with to grow in the shade?

Now, when I think about the journey of working with fathers as a mental health outpatient clinic, I'm thinking about the transition into fatherhood. Oftentimes, the lack of support or the lack of know-how as to what that intervention would entail, what the journey of being a father would entail. One thing that we realized in our agency is that many men have been in the position where they're just going through the motions, trying to figure out what it is that's going on.

One of our main clinical interventions is called pre-father care, prenatal care for fathers. Through our years as an agency, we have seen issues such as shame, guilt. Guilt is real big. The majority of our men in our agency, and currently we're serving 50 men, are experiencing a significant amount of guilt. Many of the men that we are serving are working to get reengaged in their kid's life. Much of the issues that they are experiencing are issues that we can't see. Guilt, shame - how do we work with them?

And I feel as if when we're trying to support men in entering fatherhood for the first time, we have to cover issues related to their past, their trauma, what they've experienced, how they see themselves, and more importantly, what do they define as being worthy as a man. That's a complex definition. What makes you worthy? One common denominator that we have seen in men who are transitioning to fatherhood, or men who are reengaging in their kid's life or trying to engage in their kid's life, there's this notion that the more materialistic things that I have, it is combined or connected to the value that I am into society and my own value that I am to myself.

It's very important for us to understand those definitions of what value is. What makes them feel valuable. Is it the cars, the money, the clothes, the good house? Oftentimes, we have found that to be the case. My nice job, the money that I'm making, my ability to have a house, my ability to have clothes on my back — somehow that's connected to their worth as men. I think when we are helping men reengage or transition into fatherhood, those are things that we definitely have to tackle and we have to think about tackling.

We published a book called *Pre-Father Care: Prenatal Care for Fathers* with certain concrete tools that we use as an intervention for our new dads and also dads who are interested in reengaging in their kid's life. We support them in tackling those issues of shame, guilt, embarrassment, pain, and trauma. We'll get to some of those concrete steps, the foundation of some of those steps, through some lived examples.

As you can see, I wanted to make sure that I connect real-life experience to the interventions around mental health work with fathers. I want to start with the story of Javon Taylor, first and foremost, and then I'm going to transition to Luiz Lizardo.

Javon Taylor grew up in a household where his father was actively involved in substance use. He was shooting dope in front of his kids. There was domestic violence in front of Javon. One thing that Javon had [come] to learn about who he is as man is that he had to have a lot of women, and he had to remain in control, and drugs made him valuable. These lessons that have been taught through his observation of those people that he cared about in his life, and his father was his main role model.

When Javon first came to me, he was released from jail. An issue that he had to deal with, first and foremost, before he came into the office, while he was in my office, was what he'd deemed as him being valuable in his life. What does it mean to be worthy as a man? For Javon, the things that made his father worthy, for the things that he felt as if his dad was good enough to provide, he wanted to emulate that. He wanted to be just like that. That was his trophy image of what he needed to be in order to feel adequate.

One thing that we realized with Javon, when he first walked into my office, he said, "Charles, I don't need you to tell me how to parent. I don't need you" — he had two beautiful, young kids — "I don't need you to tell me how to do it. I just need you to listen to me."

One concrete step that we learned from Javon is the importance of validation and not being so quick to try to fix or change or implement a way that they need to be in a parenting setting. What we realize from Javon is that if we start off with lessons that they need to learn, and we have our own image based on what think a man needs to be, and we project that onto them, we will lose that at the beginning at the beginning of the relationship.

Javon taught me the importance of building the therapeutic relationship, first and foremost. If you can't do anything else within 30 minutes, 10 minutes, an hour, five, 15 minutes, you can validate. You can validate. You can let that man know that you see him for who he is, not from what he's been impacted by, not from his criminal record, not from what he doesn't have. That's what Javon taught us. I think a concrete step that you should take away from here is the importance of validating and suppressing the need to fix or to teach in such a point before the relationship is actually developed. We have to put a stop sign on that.

With Luiz Lizardo, he taught me a lesson simply that we have to stop making assumptions about men and why they're not engaged in their kid's life. When I first met Mr. Luiz Lizardo, he was one of the dads who would be on the corner drinking, and he was really down and out. He was addicted to opiates. He was also drinking. He would be in a corner nodding off. He was homeless. He was at his lowest point.

Luiz got a referral to my office one day, and what we found out with Luiz, we found out the reason why he was on the corner drinking. Now, I imagine we would have jumped to the assumption that Luiz didn't want to be a good father because he's on the corner drinking, or he's using opiates. That wasn't the case with Luiz.

Luiz was drinking to numb the feeling that he had when his daughter was driving in a vehicle with her mother one day on the highway, and her mother was texting, and the car had rolled off of the road, and everyone made it out of that accident, except for Luiz's daughter. She died in a car wreck. Luiz had embedded in his mind the last time that he'd buried his daughter. He had to dress her and put her in the casket the last time that he'd seen her. The first thing that we said to Luiz was, "Hey, Luiz, man. I see why it is that you're drinking. I see what you're trying to escape." Luiz started to cry.

Lesson from Luiz, you definitely have to be very careful not to make assumptions about why a man isn't engaged. We have explore and extrapolate, if we have the time. If we don't have the time, some of us who are only engaging with men for five to 10, 15 minutes, we can validate and make a necessary referral. If they don't make a referral, continue to validate and understand that change may not happen with you, it may happen with someone else, but we cannot be the darkness contributing to that father not being able to change. Validate and show him love too. From that, my situation with Luiz, I understood that we could not make assumptions about men and why they're not involved. Oftentimes, they care.

I'm going to transition to my study that we've done that was approved by Simmons College School of Social Work's IRB recently. What I found was I did a narrative, a qualitative study on 10 fathers, assessing how they saw themselves as men and what was valuable to them. Many of these men were not engaged in their kids' lives. So these are 10 dads who were trying their best to be engaged in their kids' lives, but they [weren't] in their kids' lives.

We wanted to understand how they see fatherhood, how do they see themselves and what is valuable to them. What we found out was substance use was a real big issue for them, and they understood the problem that the addiction was, but the fact of the matter was, is that simply because they were using substances didn't mean that they didn't want to be in

their kid's life. As you can see, here are some of the words. This is a word cloud and some of the common words that stood out in their narrative.

They talked about their experiences with their own father, their mother. They also talked about the daughter. So the larger words are the words that were more prevalent in the narratives that were key and that were caught by the analysis from NVivo, which is a computer software that quantifies and quantitates the data. Their sons, they also thought their sons were very important. If you look at some of the larger words, these dads are not in their kids' lives, but they're talking about their daughters. They're talking about their sons. They're also talking about their experiences with their own parents.

What does that mean? We have to dispel the notion that just because fathers are absent doesn't mean that they don't care. A father who is absent from our study of 10 dads, they care. They are just unable to care enough about themselves to get past those images that have been embedded in them to be present for the kids in their life. Matter of fact, one father said, "Charles, my kid would do better with me not in his life because I'm such a mess-up." That's how much he valued his child - that he didn't want to put his stuff onto his kid by being present.

Another repeating theme — life, the decisions that they made in their past. Similar things that stood out when they were talking about the addiction are the same things that stood out when they were talking about their meaning as a father and what was valuable to them. Their kids, the lessons that they learn from life, and they regretted the years that they passed from not being engaged in their kid's life. They were so filled with guilt that they couldn't reengage.

The one thing that I would like for you to take away is that I want us to understand that we can be the light, but we may not be able to erase the darkness. That's a fundamental point that every practitioner should take away from this call. Guess what? You don't have to erase the darkness. We have to learn how to co-exist with the pain. Our goals shouldn't be to rectify. Our goals shouldn't be to fix. Our goals should be able to help that father co-exist with what he's experienced so that pain doesn't end up controlling his life.

As a mental health clinic, we understand that in order for us to make sure that we're not contributing to darkness in that child's life, we have to check our own perceptions of what we think a father should be. The goal isn't to make the father the father that we want to him to be. The goal is to make the father the father that *he* wants to be.

Another thing is, some of these common points that we think men should be, those things that society teaches us — that we need to be strong, that we need to be providers, that we need to be money makers, we need to be tough, these cultural myths — we need to throw those out the window. We have to engage in a partnership with men where they are able to create their own definitions of what they want to be for their children. That doesn't necessarily require them having the greatest things in life, the things that they may not be able to get. They can get those things. But how can the things that they're able to get be the greatest things to them, not what society tells them what great needs to be? Either we can be a part of what society tells them that what great needs be, or we can be different. We can let them shape their own definition of what they need to be, so they can get back in their kid's life.

We've got be very careful about that and understand that when put our own stuff, our own definitions onto men, we are pushing them away from their kids.

You have a fundamental responsibility to partner with that father, validate him, be the light by validating him, playing on his strengths, even though you may not agree with him drinking. You may not agree with him using. You may not agree with him that he's not in his kid's life, or he has a history of violence. But how can you see his strengths? Oftentimes, people are engaged in painful experience because they cannot see their light.

We have to put that in front of their faces, so they can see it themselves. We got to externalize the problem from them, because they're not the problem. The problem is the problem. Stop blaming these guys for a problem. We have to reframe and remain positive relentlessly, even though it may be hard to remain positive and withhold the judging. Thank you so much. My 15 minutes have concluded. That's it for me, Nigel.

Nigel Vann: Thank you very much, Charles. Yes. I'm sorry we have to limit you to 15 minutes. I know you could have shared a lot more wisdom, but yeah. We've got a good 15 minutes now for some Q&A, so if you haven't asked a question yet and have it, please do submit it. I do have quite a few questions here, so we can certainly kick-start our little conversation here, and again, what we don't get to we will post answers to on the website after the webinar.

Actually, Craig, I'd like to get back to you first. We've actually got a question about this, and I had noticed it as well. I hadn't looked at your graph on the fathers and mental health close enough before, but it's very interesting as this person points out, that if you look at the graph for the non-resident dads, it goes up. In fact, maybe we can go back to that slide. It goes up before pregnancy and before the birth and then it goes down right where the — so if you're non-resident dad on the top, you get more depressed prior to the birth, and then you become less depressed after the birth.

But if you're a resident dad, you become less depressed. I guess you're excited about the birth. I guess you're more likely to be involved. But then as you deal with the reality of having the child in the home, you start being a bit more depressed. Now, the non-resident dad is still significantly more depressed throughout this, and they're a lot of the guys who we see in these fatherhood programs. But I just wondered if you can talk a little bit more to the dynamic of what's going on there, particularly for non-resident dads, if you could.

Craig Garfield: Yes. Sure. It's a great question, and that's a great pickup. For purposes of the presentation, I just focused on the resident fathers because when you actually analyze the data, you get significance only for the resident fathers, and that's probably because we had more resident fathers than non-resident fathers. That's a more statistical answer, and a statistical reason for that [was] the sample size was smaller for the non-resident fathers.

But I think the point is a big one, and we actually mentioned it in this paper, which I think Nigel has given as one of the downloadable resources, because it's clear there are two different trajectories. The non-resident fathers are increasing, and they are always at a higher point than the resident fathers. We can't just say, "Well, do this for all men." There are different things going on for non-resident fathers compared to resident fathers.

When we looked at the data, it was the resident fathers that were significantly different. Yes, they do decrease. We don't know if that's because they're — if things are going really well, they're going to be resident and more likely to be married, maybe things are going really good. Their depressive symptoms are decreasing. Then the baby comes along, and there is a lot of stress when a baby comes out. There's a lot of change in roles and responsibilities, and we're trying to balance those different responsibilities.

For the non-resident fathers, we don't have a good explanation of why they would have a decrease after having the baby. It might be that there's stress in the relationship up to the point of becoming the dad, and they may actually change in their relationship after becoming the father. It's not clear. We don't have enough data there, but we make a strong point in the paper that for non-resident fathers, that's the most important time to be checking in on them because that's when their symptoms are going to be the highest, and that's the important time to get them in and maybe actually, you could get some benefit for the entire family, should that non-resident dad seek services that Charles was just talking about too. I hope that answers the question.

Nigel Vann: Absolutely. Yes. That's very interesting, I think. In fact, Charles, perhaps you could say a little bit about the work that you're doing with guys prenatally now. You've got a new project that's doing that, right?

Charles Daniels: Absolutely. Under the services of a mental health clinic, we offer several services. Some of those are individual therapy, group therapy, couples therapy, and family therapy. What we realized with the prenatal care piece, is that it's important for us to encourage men from the outset, when we know that they are expecting a child, to make sure that they get the appropriate screenings. Some of the screenings that we think men should get are the pre-diabetes screen — which is very important — thyroid screenings, also vitamin deficiency screenings. I think there are several symptoms that are similar in depression as opposed to some of these other health diagnoses that I mentioned before, such as thyroid issues [and] diabetes issues.

We need to make sure that when fathers are presenting symptoms of depression that it's not a physical issue. I think encouraging them to get connected to appropriate health care, their primary care physician. If they don't have one - which some of our dads may not have one because they're homeless - we have to connect them to health insurance and connect them and show them how to get connected to a primary care physician. It's like teaching a young man how to brush their teeth. We can't assume that every young man knows how to brush their teeth when no one ever taught them.

When I think about the importance of prenatal care for dads, I'm thinking about making sure that physically, if there's depression in a mental health setting, we need to make sure physically that the depression isn't connected to a physical condition, first and foremost. Once we get the physical issues situated, and we understand that they have checked in with their physician, and they got some of these screenings done, we need to begin to deal with and explore some of those underlying feelings that they have regarding fatherhood.

For example, Nigel, one of my fathers is an attorney for the city of Boston, and he came to me and said, "Charles, I need some pre-father care." What he meant was, "Charles, I am scared as hell. I don't know what to do. I don't what to expect. Although I am a lawyer, I am scared. I never had a child in my life. I don't know where to start."

But there was also some guilt there. There was also some shame there, related to how he was fathered when he was a kid. How will we know, if we never took time to explore those issues with him? So those are some of things that we use within the modalities of treatment that we provide and some of the things that we provide as we are doing it.

[Pause]

Charles Daniels: Hello? Hello?

Nigel Vann: I'm sorry, I committed the cardinal sin of talking while muted. I'm sorry about that. I was starting to ask a question to you, Albert. Somebody was asking in reference to the Fitness Brothers and the Fit for Life programs, whether you found any determinates of health and social determinates of health, or anything might act as a barrier to men's health that you hadn't expected. If so, what kind of solutions you might be able to offer to those problems.

Albert Pless: Certainly. What we found — it's interesting with those two programs, because a lot of what happens is— just well briefly, because of the purpose of the call, is that we do everything in group settings. We found that this method allows us to really get them into feel[ing] connected to each other in doing this work, because a lot of issues that happen around men's health are issues around trust. Our program's a lot more men of color-engaged, and that's really our target population for a lot of our programs, particularly that Fit for Life program. But what we found was that one of the challenges that came out in that program was the idea of the fact that how were these men [unintelligible] — was the health system we were ushering them into, was it culturally competent? Did it understand them as men of color and some of the barriers and challenges that they went through, or were going through? A lot of what it forced us in our work — and in Men's Health League, we work in a larger health system — is really to look at the health system we were ushered into, and to really try to have some great conversations around cultural competency. That's one of the things that we found as a result of doing this kind of work together with these men in these settings, that they were not trusting this health system that we were ushering them into. So it opened up a larger conversation around addressing the social determinates of health once again from the health system that we are currently operating in.

Nigel Vann: Thank you. We have a question about home visiting. This is an area where I think we can get a lot more involved with dads, and I certainly encourage fatherhood programs to work with home visiting programs. I've done a bit of training myself with home visitors, and you often hear that it's harder to involve the dads in those visits, just to get him to stay in the same room. I'm just wondering if anybody might have a tip — for anybody who's doing home visiting. What are some effective ways that might be able to make those opportunities more important for dads, so they can engage the dads in the conversation?

Craig Garfield: Well, Nigel, I can tell you — we actually here at Northwestern University have funding — Darius Tandon and myself who — He has a really good mother-baby curriculum for mental health of supportive mothers, and we just got funded to start to try and use text messaging to help mothers follow up on some of the work from the home visiting visits, some of the homework pieces that they have, particularly around the mother-baby curriculum. We got funded to actually include fathers now, again, regardless of marital status, to think about how we could be texting messages out to them.

One of things that we're talking about in a group is, how much do we focus messages on dads helping Mom, and how much do we focus messages on Dad's help for Dad's self. I think that's an interesting point that we're at now in the field is, there's value in helping Dad, because it helps kids, and it helps Mom, but there's also value in helping Dad, because it helps him as a man. And I think one of the things that's exciting about this webinar in particular is that focus on the health of the man, which I think is a missed conversation sometimes.

Charles Daniels: I would also add, Nigel —

[voices overlapping]

Nigel Vann: Great. Thank you.

Charles Daniels: I'm sorry. Could I —

[voices overlapping]

Nigel Vann: Go ahead Charles. Go ahead.

Charles Daniels: Okay. Yep. One thing that we realized in our work — and we go into the homes. We're actually certified as an outpatient home-based clinic for the state of Massachusetts, as well as a school-based outpatient clinic, so we take our mental health services to schools for our young dads, as well as to the home for our fathers. One thing that we realized with home visits and engaging men, and we have over 50 dads that we're working with right now, is that we have to reach out to them aggressively. I mean, sometimes you may talk to them, and they may schedule an appointment, or they may not show up. That cannot be end all, be all. That can't be the last attempt.

I think one thing we recognized with our work with fathers, we have to do a little bit more reaching out as opposed to some of the work with the women. And how I know is because we have clinicians who are therapists, and one way of approaching — [here] is just a sidebar conversation, Nigel — one approach to working with men in our agency, we understand that we have to have therapists who are mothers and females on our staff to engage women, particularly during conflict in relationships. In the state of Massachusetts, it seems as if it's easier to reconcile your differences with the woman, as opposed to go through the court. The court is a painstaking process. One of our goals at our clinic is to make sure that we have Mom engaged to a certain extent, so we can help them reconcile their differences.

But back to the question about how do we engage men during the home visits — we have to continue to reach out to them, continue to call them until we get them. We may have to schedule appointments outside of the home, rather than have conversations with them and get to know them a little bit more prior to getting involved in their families. I think when it comes to men, it's about trust, making sure that that trusting relationship is there, and setting that foundation and letting them know that hey, this isn't a one-time thing, I'm not going to quit after one attempt. I'm going to keep going. They're going to be very helpful for them.

Nigel Vann: Absolutely. Yes. Give me —

Albert Pless: Nigel, can I?

[voices overlapping]

Nigel Vann: Go ahead, Albert.

Albert Pless: I just want to add a resource there, because once again this is where I know folks on the line, really, it's called Baby University. I'm going a little selfishly, it's here in Cambridge, but it's a parenting program piloted after the Harlem Children's Zone program in New York. It has a really strong dads, fathers component to it. They have a really nice model, a contact person you can reach out to him. It's a — you can Google search Baby University, Cambridge. [\[https://www.cambridgema.gov/DHSP/programsforfamilies/babyuniversity\]](https://www.cambridgema.gov/DHSP/programsforfamilies/babyuniversity) But I'm pretty sure that contact person would give a really good way about their home visiting program. It's a really nice model, about five years old right now.

Nigel Vann: Oh, that's great. Actually, Albert, could put that information in the Chat box on the left-hand side there, so people can see that?

Albert Pless: Yep. I sure can.

Nigel Vann: Yep. Great. Thanks. There's a couple of questions that have come in around staff training, and I'm just wondering if any of you could offer some tips on how you might prepare staff. We're talking staff of a general fatherhood program who aren't necessarily trained to talk about health issues, but how might you — have you got any tips for programs to encourage or support their staff, one, to have these conversations with dads, and then secondly, to be able to practice healthy lifestyles themselves as models? Anyone got any thoughts on that?

Charles Daniels: Yeah. I have one thought, Nigel. Prior to founding Fathers' Uplift, I did some work in a substance abuse clinic with fathers, and I have also done some work with the Department of Children and Families. I've had experience in the community working with men.

One common theme that we found when working with staff who are engaging men: there are some fears there. There are some preconceived notions about the men, and there's also some experiences that the staff may have with their own fathers, or men in their lives, that if they are not addressed in your agency — if you're not discussing these issues and setting some boundaries to be able to address these issues, or a safe space with supervision where [supervisors] could support staff in figuring out these issues, and developing a plan to engage men when they feel as if they're triggered, for someone to step in or for them to step out or take — whatever the case may be.

I feel as if, oftentimes the issue is, when it's engaging men, is that people's stuff — what they haven't dealt with themselves — interferes with their ability to engage men. From my work with men, men can sense that. Particularly fathers who are not engaged, they can sense stuff when it's not necessarily them, when it's other people's stuff. I feel as if that's a good training process or a good conversation starter for leaders and companies to make it natural for people who are under them or who are partnering with them to have a safe space, a time throughout the week, for them to be able to talk about what's going on with them. And there's also EAP resources, so it doesn't interfere with their relationship with men.

One thing, in general, that I just make sure that my staff understands is that you have to be honest with where you are with men in your life, with men who you have experienced issues with in the past. If we are not honest with that, it's going to interfere with the work. I feel that sometimes we try to keep that in the closet, and we don't discuss it. When it comes to trainings or being able to engage men more effectively, that stuff has to be checked at the door. It can't be left in the closet.

Nigel Vann: Absolutely. Yes. You remind me that a lot of the training I did in the early days to help folk get ready for this work, we always had the staff do the same things that they're going to have the dads do in their program. I think most fatherhood curricula encourage those conversations where you really get to that moment where a guy can talk about his relationship with his own father openly, and I've always thought about it as taking off the mask of masculinity. We open ourselves up to that, and that's what bonds a group, so I think that's a great point, Charles. You made me think about an activity that I saw a few years ago, also in Massachusetts — you guys must be healthy there. This was at a conference in Massachusetts, and John Badalament and Haji Shearer — I'm sure those of you in Massachusetts know those guys — they did a session on nutrition and had everybody in there think about and talk about

in pairs what they learned from their father about eating, and what they're trying to teach their kids about eating. Again, if you do that as a practitioner, then you can do that with a father.

Anything else on that from Craig or Albert? Any more thoughts on the staff training piece?

Craig Garfield: The only thought that I wanted to share — I think Albert and Charles brought up these great points of ... the dad wanting to really present material things as an indication of love and commitment. What I really try and stress with the dads I see is that it really is just about their time. It's about putting the time in with that child, whether that's reading to the kids or just spending time on the floor playing with them, talking with them, walking with them. The research is very clear that the language that dads use is very different than that of moms, and that kids benefit, children benefit from that different type of language. If you think about how a mom describes a street scene versus a dad, the dad may point out different things on that street, and all that helps to build the language of the child, and all that helps to build that child up to be better and more ready for school when school starts.

I think when dads hear that, they understand that it's not about bringing in a new toy, going out to a new fast food restaurant or something like that. It really is about spending time on the ground with that kid doing whatever the dad wants to do because if the dad's excited about doing it, the kid will pick up on that too.

Nigel Vann: Yes. I got a research question here, which Albert, perhaps you can respond to this or Craig.

[Pause]

"Do you know of any studies that have been done that are looking into first-time fathers of foster and adopted children, in terms of depression?" Albert or Craig, are you aware of any of those?

Albert Pless: No. I'm not aware. Maybe Craig is.

Nigel Vann: Nope.

Craig Garfield: Yes. It's a great question, and it's a really important population. I think part of the issue is access to those families in particular, and then ... being able to follow them through. I know that Michael Yogman and I spent a lot of time in the *American Academy of Pediatrics* report talking about fathers and mental health, and we stress the fact that we have so much more to learn. We need to learn about foster families and adoptive families. We need to learn about same-sex families as well, military families, teen fathers, grandparents that come back in and have the responsibility of raising the child. So there's a lot of great work to be done. I just encourage those of you out there in position to do that to help support those initiatives.

Nigel Vann: Okay. We've got about two minutes left here. I do want to give each of you a chance just for one final thought, so you just think about that for a minute. I realize we've not gotten to all the questions. We had a real flood of questions here at the end, so we will, as I said, I'll share these questions that we didn't get to with the presenters and get some responses from them, and then when we post the other webinar materials, we will post those as well.

In a minute, you're going to have a survey that we're going to ask you just to complete to tell us what you thought about the webinar, any tips for how we might improve these, any tips for future topics. Let me give each of the presenters just a chance for one quick final thought. How about we start with Albert. We'll go in alphabetical order, so "A" for Albert.

Albert Pless: Yes. That's why I'm glad my dad — I'm a junior, so I'm glad I'm always "A" starting. [laughs] I just [unintelligible]. I appreciate the opportunity to really talk about my program. Also, it's really good to be on the webinar with you, Craig and Charles. I mean, I think [we're] learning a lot from what they're doing.

I would just say, I think we're still journeying through this work around engaging men and healthy behaviors and in these fathers that we're working with. I would just say that continue to look at the research. Craig made a good point: there's populations of men that we have not had access to in terms of data, so I will continue to really have us just understand that we have a lot more work to do. But thanks for the opportunity, and I really look forward to learning more about the work that folks are doing.

Nigel Vann: Okay. Thanks Charles [*sic*]. I always liked it if they went by last name in alphabetical order because that always gave me time to think about things before I got there. I guess that would be Charles next, if I'm going in alphabetical order then. Charles, a final thought for everyone. What would you leave them with?

Charles Daniels: Yes. Final thought is that these dads care. I think reframing this notion that they don't care if they're absent can changing into, well, how can you care if you're too hurt to care? I think that helps us perceive the situation a little bit more differently. My takeaway point for everyone is to remember that no matter what the father is doing or engaging, he cares. The question is, does he know how to care? Does he know how to be present, if he can't really care for himself? Thank you so much, Nigel. That's my takeaway.

Nigel Vann: Okay. Really appreciated, Charles. I love your perspective and particularly learning about Hasna. That's one thing I really learned from this webinar. Yes, so Craig, you get the final word.

Craig Garfield: Great. I think it's been a wonderful little hour or so here with everyone, and I've learned a lot coming away from it. My main takeaway is to really see that dad as a person, as an individual who wants to be involved but isn't quite sure what to do, and to draw them out. That even if it's just something as simple as acknowledging them in the room where a lot of times, we may not actually do that. Probably the biggest takeaway is that thriving parents lead to thriving kids, and if we can help parents to thrive, ultimately that does help the child as well and helps the whole family. Thank you all for your attention today.

Nigel Vann: Yes. Wonderful. No. I really appreciate you all. You made some great points there, and this is what this work's all about. It's about seeing guys for who they are and helping them get engaged in the conversation. At some point, we won't have fatherhood programs. We'll have family programs that cater for the whole family and realize that dads are a part of that, but until then keep up the good work, everybody. Thank you very much, and everyone have a good day. Speakers, you can stay on the line, if you'd like to have a chat at the end here. Don't forget to do the Survey Monkey when it pops up.

Operator: This does conclude today's conference. We thank you for your participation. You may now disconnect.

[End]