

Policies and Programs Affecting Fathers

A State-by-State Report

Jessica Pearson, PhD, Director, Center for Policy Research, Denver, Colorado

Rachel Wildfeuer, PhD Candidate, Research Analyst, Center for Policy Research, Denver, Colorado

Chapter 10: Health and Mental Health

Many studies show gender differences in health status with men at higher risk for mortality and morbidity.¹ The 5.1-year gap in life expectancy for women versus men in 2019 (which increased to 5.4 years during the first half of 2020)² has been attributed to men's propensity to take bigger risks, have more dangerous jobs, die of heart disease more often and at a younger age, be larger than women, commit suicide more often than women, be less socially connected, and avoid doctors.³ Despite these disparities, men aged 18 year or older are less apt to report fair or poor health than adult women (18.2% versus 19.4%).⁴

The health status of parents affects children. A recent study of self-reported parental physical health and child outcomes found that parents' poorer physical health is associated with lower parenting self-efficacy and higher child behavior problems, conferring risks to children that are independent of the depression and anxiety associated with parental physical health problems.⁵ Untreated chronic illness or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.⁶ Parental mental health also matters. Mothers' and fathers' mental health problems are key sources of stress for children and have been linked to worse mental health and more behavioral problems for children during their

1 Vaidya, V., Partha, G., & Karmakar, M. (2012). Gender differences in utilization of preventive care services in the United States. *Journal of Women's Health, 21*(2), 140–145.

2 Arias, E., Tajada-Vera, B., & Ahmad, F. (2021). *Provisional life expectancy estimates for January through June 2020* (Vital Statistics Rapid Release No. 10). U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Retrieved from <https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf>.

3 Shmerling, R. H. (2020). *Why men often die earlier than women*. Harvard Health Publishing. Retrieved from <https://www.health.harvard.edu/blog/why-men-often-die-earlier-than-women-201602199137>.

4 Kaiser Family Foundation. (2021). *Adults who report fair or poor health status by sex*. Retrieved from <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-fair-or-poor-health-by-sex/?currentTimeframe=1&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

5 Poppert-Cordts, K. K., Wilson, Anna C., & Riley, A. R. (2021). More than mental health: Parent physical health and early childhood behavior problems. *Journal of Developmental and Behavioral Pediatrics, 41*(4), 265–271.

6 Shonkoff, J., Garner, A., & The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232–e246.

youth.⁷ Childhood experiences with parental mental health problems correspond with distress in adulthood, regardless of the gender of the afflicted parent.⁸

Finally, parental health insurance coverage plays an important role in child well-being. A Kaiser Family Foundation's research review finds that coverage, whether through Medicaid or private insurance, is associated with improvements in healthcare access and utilization.⁹ A rigorous study in Oregon found that in the first one to two years of Medicaid coverage, people increased their overall healthcare utilization, reported better health, reduced financial strain, and sharply reduced depression versus the control group.¹⁰ Compared to uninsured adults, those with Medicaid coverage are more likely to have a usual source of care, visit a doctor for a checkup, and access specialty care.¹¹ Medicaid coverage for parents also increases health insurance coverage and improves health outcomes for children.¹²

This chapter examines various health, mental health, and health insurance patterns for men for the 50 states and the District of Columbia.

Health Insurance

Lack of Health Insurance Coverage

On the eve of healthcare reform in 2009, the percentage of nonelderly adults aged 18–64 who lacked insurance was 21.1%, while the percentage of poor and near poor adults in the same age group who lacked coverage was 42.5% and 39.1%, respectively.¹³ Although public insurance opportunities for poor and near poor adults expanded dramatically with the passage of the Affordable Care Act (ACA) on March 20, 2010, gaps remain with large differences by state and gender.

According to data on health insurance coverage from the Census Bureau's American Community Survey, 14.5% of nonelderly adult males and 11.4% of nonelderly adult females were uninsured in the United States in 2019.^{14, 15} Nineteen states were above the national percentage of uninsured nonelderly adult males and 31 states, and the District of Columbia, were below. The three states with the highest percentage of uninsured nonelderly adult males in 2019 were Texas (25.9%), Oklahoma (22.8%), and Florida (21.9%). The three states with the lowest percentage of uninsured nonelderly adult males in 2019 were Massachusetts (5.6%), Hawaii (6.2%), and the District of Columbia (6.5%).

7 Meadows, S. O., McLanahan, S. S., & Brooks-Gunn, J. (2007). Parental depression and anxiety and early childhood behavior problems across family types. *Journal of Marriage and Family*, 69(5), 1162–1177.

8 Kamis, C. (2021). The long-term impact of parental mental health on children's distress trajectories in adulthood. *Society and Mental Health*, 11 (1), 54–68.

9 Artiga, S., Young, K., Garfield, R., & Majerol, M. (2015). *Racial and ethnic disparities in access to and utilization of care among insured adults*. Kaiser Family Foundation. Retrieved from <http://kff.org/disparities-policy/issue-brief/racial-andethnicdisparities-in-access-to-and-utilization-of-care-among-insured-adults/>.

10 Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., Schneider, E. C., Wright, B. J., Zaslavsky, A. M., & Finkelstein, A. N. (2013). The Oregon experiment – Effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368, 1713–1722.

11 Paradise, J., Lyons, B., & Rowland, D. (2015). *Medicaid at 50*. Kaiser Family Foundation. Retrieved from <http://kff.org/medicaid/report/medicaid-at-50/>.

12 Wagnerman, K. (2018). *Research update: How Medicaid coverage for parents benefits children*. Georgetown University Health Policy Institute, Center for Children and Families. Retrieved from <https://ccf.georgetown.edu/2018/01/12/research-update-how-medicaid-coverage-for-parents-benefits-children/>.

13 Cohen, R. A., Martinez, M. E., & Ward, B. W. (2009). *Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2009*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201006.htm>.

14 Kaiser Family Foundation. (2021). *Health insurance coverage of men 19–64*. Retrieved from <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-adult-males/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Medicaid%22,%22sort%22:%22asc%22%7D>.

15 Kaiser Family Foundation. (2021). *Health insurance coverage of women 19–64*. Retrieved <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-adult-women/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Medicaid

Medicaid Coverage. Medicaid coverage includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP), or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligible who are also covered by Medicare. In 2019, 12.4% of nonelderly adult males and 16.5% of nonelderly adult females were covered by Medicaid in the United States.^{16, 17} Twenty-three states and the District of Columbia exceeded the national percentage of 12.4% of nonelderly adult males, and 27 states fell below this level. The three states with the highest percentage of nonelderly adult males covered by Medicaid in 2019 were New Mexico (24.7%), West Virginia (20.8%), and New York (19.9%). The three states with the lowest percentage of nonelderly adult males covered by Medicaid in 2019 were Nebraska (5.1%), Texas (5.5%), and Utah (5.6%).

Medicaid Expansion. The ACA expands Medicaid coverage for most low-income adults to 138% of the federal poverty level. States can decide whether to adopt the Medicaid expansion, and there is no deadline for states to implement it.¹⁸ As of November 2021, 38 states and the District of Columbia have adopted and implemented the Medicaid expansion and 12 states have not yet adopted the Medicaid expansion. The average rate of male coverage in the 39 jurisdictions that have expanded coverage stands at 13.6% as compared with 7.6% in the 12 states that have not.

Medicaid expansion may improve child support outcomes.¹⁹ Research indicates that unmarried mothers with a child support order receive more child support if they live in a state that expanded Medicaid as compared with similar mothers living in a state that did not expand Medicaid. This may be due to the fact that Medicaid expansion, and access to health insurance, reduces noncustodial parents' financial hardship, improves their health outcomes and increases employment, and reduces crime due to substance use disorder treatment. Additionally, custodial parents may be required to work with child support enforcement agencies to receive coverage for themselves and their children.

Table 1 indicates, for each state and the District of Columbia, the percentage of uninsured nonelderly adult males in 2019, the percentage of nonelderly adult males with Medicaid coverage in 2019, and their decision on the Medicaid expansion.



16 Kaiser Family Foundation. (2021). *Health insurance coverage of men 19–64*. Retrieved from <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-adult-males/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Medicaid%22,%22sort%22:%22asc%22%7D>.

17 Kaiser Family Foundation. (2021). *Health insurance coverage of women 19–64*. Retrieved <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-adult-women/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

18 Kaiser Family Foundation. (2021). *Status of state Medicaid expansion decisions: Interactive map*. Retrieved from <https://www.kff.org/medicaid/issue-brief/status-of-state-medicad-expansion-decisions-interactive-map/>.

19 Bullinger, L., & Pratt, E. (2021). *Affordable Care Act's Medicaid expansions and child support outcomes* (Fast Focus Research/Policy Brief No. 50-2021). Institute for Research on Poverty. Retrieved from <https://www.irp.wisc.edu/resource/affordable-care-acts-medicad-expansions-and-child-support-outcomes/#main>.

Chapter 10, Table 1. State Percentages of Adult Males Uninsured and with Medicaid Coverage in 2019 and Medicaid Expansion Decision

| State | Percentage of Uninsured Adult Males (2019) | Percentage of Adult Males With Medicaid Coverage (2019) | Medicaid Expansion Decision |
|----------------|--|---|-----------------------------|
| Alabama | 16.7% | 9.1% | Not adopted |
| Alaska | 18.7% | 14.8% | Adopted |
| Arizona | 17.0% | 15.3% | Adopted |
| Arkansas | 15.1% | 16.3% | Adopted |
| California | 12.5% | 17.8% | Adopted |
| Colorado | 11.4% | 11.5% | Adopted |
| Connecticut | 10.2% | 15.9% | Adopted |
| Delaware | 12.1% | 14.2% | Adopted |
| DC | 6.5% | 19.2% | Adopted |
| Florida | 21.9% | 8.3% | Not adopted |
| Georgia | 21.1% | 6.9% | Not adopted |
| Hawaii | 6.2% | 12.7% | Adopted |
| Idaho | 16.4% | 7.3% | Adopted |
| Illinois | 11.8% | 11.7% | Adopted |
| Indiana | 13.2% | 11.0% | Adopted |
| Iowa | 8.5% | 12.4% | Adopted |
| Kansas | 13.9% | 6.6% | Not adopted |
| Kentucky | 10.3% | 19.0% | Adopted |
| Louisiana | 16.2% | 19.1% | Adopted |
| Maine | 13.4% | 15.0% | Adopted |
| Maryland | 9.7% | 12.7% | Adopted |
| Massachusetts | 5.6% | 17.2% | Adopted |
| Michigan | 10.0% | 16.2% | Adopted |
| Minnesota | 7.8% | 11.5% | Adopted |
| Mississippi | 21.5% | 10.6% | Not adopted |
| Missouri | 15.7% | 7.2% | Adopted |
| Montana | 12.3% | 14.2% | Adopted |
| Nebraska | 12.6% | 5.1% | Adopted |
| Nevada | 17.5% | 11.2% | Adopted |
| New Hampshire | 10.1% | 7.9% | Adopted |
| New Jersey | 12.7% | 10.5% | Adopted |
| New Mexico | 17.2% | 24.7% | Adopted |
| New York | 9.3% | 19.9% | Adopted |
| North Carolina | 18.7% | 7.5% | Not adopted |
| North Dakota | 9.3% | 7.8% | Adopted |
| Ohio | 10.7% | 14.1% | Adopted |
| Oklahoma | 22.8% | 6.6% | Adopted |
| Oregon | 11.7% | 15.8% | Adopted |
| Pennsylvania | 8.8% | 13.9% | Adopted |
| Rhode Island | 6.8% | 17.8% | Adopted |
| South Carolina | 18.7% | 9.1% | Not adopted |
| South Dakota | 15.4% | 5.9% | Not adopted |
| Tennessee | 17.3% | 10.1% | Not adopted |
| Texas | 25.9% | 5.5% | Not adopted |
| Utah | 12.4% | 5.6% | Adopted |
| Vermont | 9.4% | 18.4% | Adopted |
| Virginia | 13.1% | 7.5% | Adopted |
| Washington | 10.6% | 12.7% | Adopted |
| West Virginia | 11.7% | 20.8% | Adopted |
| Wisconsin | 9.7% | 10.1% | Not adopted |
| Wyoming | 16.7% | 5.7% | Not adopted |

Sources: Kaiser Family Foundation. (2021). *Health insurance coverage of men 19–64*. Retrieved from <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-nonelderly-adult-males/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Medicaid%22%22sort%22%3A%22asc%22%7D>.

Kaiser Family Foundation. (2021). *Status of state Medicaid expansion decisions: Interactive map*. Retrieved from <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.



Obesity

Prevalence

Research suggests that fatherhood is associated with an increase in body mass index (BMI) trajectory for both nonresident and resident fathers.²⁰ Children with an overweight or obese father are at a higher risk of becoming obese.²¹ A Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC) data provides the percentage of adult males and females who have a BMI of 30 or higher and are considered obese in each state and the District of Columbia.²² In 2020, the percentage of adult males who were obese in the United States was 31.1% and the percentage of adult females who were obese in the United States was 31.9%. Thirty states had an equal to or higher percentage of adult males who were obese than the national average, and 20 states and the District of Columbia had a lower percentage. The three states with the highest percentage of adult males who were obese in 2019 were West Virginia (41.0%), Kentucky (38.0%), and Iowa (37.6%). The three states with the lowest percentage of adult males who were obese in 2019 were the District of Columbia (18.4%), Colorado (24.1%), and Massachusetts (25.1%).

Physical Activity and Inactivity

Physical activity and healthy eating play a role in preventing obesity.²³ Food quality, and access to healthy food, are discussed in Chapter 9 (Food and Housing) of this report. The United Health Foundation analyzed data from the CDC's 2019 Behavioral Risk Factor Surveillance System (BRFSS) on exercise^{24, 25} and physical inactivity^{26, 27} in each state and the District of Columbia. They defined exercise as the percentage of adults who met the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days. In 2019, the percentage of adult males in the United States who met the federal physical activity guidelines was 25.2% and the percentage of adult females in the United States who met the federal physical activity guidelines was 20.8%. They defined physical inactivity as the percentage of adults who reported doing no physical activity or exercise other than their regular job in the past 30 days. In 2019, the percentage of adult males in the United States who were physically inactive was 24.4% and the percentage of adult females in the United States who were physically inactive was 27.5%. Twenty-four states had a lower percentage of active adult males than the national average of 25.2%, and 26 states and the District of Columbia had a higher percentage. The three states with the highest percentage of active adult males in 2019 were Georgia (29.6%), Montana (29.3%), and New Mexico (29.3%). The three states with the lowest percentage of active adult males in 2019 were Mississippi (17.3%), Oklahoma (17.7%), and West Virginia (18.2%). Thirty-one states had an equal to or higher percentage of

20 Garfield, C. F., Duncan, G., Gutina, A., Rutsohn, J., McDade, T. W., Adam, E. K., Coley, R. L., & Chase-Lansdale, P. L. (2016). Longitudinal study of body mass index in young males and the transition to fatherhood. *American Journal of Men's Health*, 10(6), NP158–NP167.

21 Freeman, E., Fletcher, R., Collins, C. E., Morgan, P. J., Burrows, T., & Callister, R. (2012). Preventing and treating childhood obesity: Time to target fathers. *International Journal of Obesity*, 36, 12–15.

22 Kaiser Family Foundation. (2021). *Adults who are obese by sex*. Retrieved from <https://www.kff.org/other/state-indicator/adult-obesity-bysex/?currentTimeframe=0&selectedDistributions=male&sortModel=%7B%22colId%22:%22Male%22,%22sort%22:%22asc%22%7D>.

23 Division of Nutrition, Physical Activity, and Obesity. (2022). *Causes of obesity*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Retrieved from <https://www.cdc.gov/obesity/basics/causes.html>.

24 United Health Foundation. (2021). *America's health rankings: Exercise – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/exercise/population/exercise_Male/state/ALL?edition-year=2020.

25 United Health Foundation. (2021). *America's health rankings: Exercise – Female, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/exercise/population/exercise_Female/state/ALL?edition-year=2020.

26 United Health Foundation. (2021). *America's health rankings: Physical inactivity – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Sedentary/population/Sedentary_Male_C/state/ALL?edition-year=2020.

27 United Health Foundation. (2021). *America's health rankings: Physical inactivity – Female, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Sedentary/population/Sedentary_Female_C/state/ALL?edition-year=2020.

inactive adult males than the national average of 24.4%, and 19 states and the District of Columbia had a lower percentage. The three states with the highest percentage of inactive adult males in 2019 were Mississippi (35.1%), Oklahoma (31.2%), and Kentucky (31.2%). The three states with the lowest percentage of inactive adult males in 2019 were Utah (17.6%), Washington (18.6%), and Colorado (18.8%).

Table 2 indicates, for each state and the District of Columbia, the percentage of adult males who were obese in 2020, the percentage of adult males who met the federal physical activity guidelines in 2019, and the percentage of adult males who were physically inactive in 2019.

Chapter 10, Table 2. **State Percentages of Obese in 2020, Active in 2019, and Inactive in 2019 Adult Males**

| State | Percentage of Obese Adult Males (2020) | Percentage of Active Adult Males (2019) | Percentage of Inactive Adult Males (2019) |
|----------------|--|---|---|
| Alabama | 37.3% | 20.8% | 28.3% |
| Alaska | 32.6% | 27.4% | 22.1% |
| Arizona | 30.2% | 26.2% | 22.2% |
| Arkansas | 33.9% | 21.8% | 28.1% |
| California | 28.2% | 25.0% | 20.5% |
| Colorado | 24.1% | 28.7% | 18.8% |
| Connecticut | 28.2% | 27.2% | 21.6% |
| Delaware | 35.2% | 26.7% | 24.5% |
| DC | 18.4% | 29.5% | 17.3% |
| Florida | 27.9% | 28.9% | 25.7% |
| Georgia | 32.4% | 29.6% | 26.0% |
| Hawaii | 26.7% | 26.7% | 21.6% |
| Idaho | 32.1% | 23.1% | 23.8% |
| Illinois | 31.1% | 26.0% | 24.4% |
| Indiana | 36.2% | 22.9% | 29.8% |
| Iowa | 37.6% | 19.8% | 27.3% |
| Kansas | 34.9% | 21.9% | 26.2% |
| Kentucky | 38.0% | 18.7% | 31.2% |
| Louisiana | 36.0% | 21.8% | 28.9% |
| Maine | 31.0% | 21.8% | 30.2% |
| Maryland | 30.5% | 26.2% | 21.7% |
| Massachusetts | 25.1% | 22.9% | 25.7% |
| Michigan | 34.4% | 24.2% | 24.9% |
| Minnesota | 31.2% | 26.7% | 20.8% |
| Mississippi | 37.2% | 17.3% | 35.1% |
| Missouri | 32.2% | 20.0% | 29.4% |
| Montana | 28.8% | 29.3% | 19.3% |
| Nebraska | 35.6% | 21.0% | 26.5% |
| Nevada | 30.7% | 21.2% | 24.4% |
| New Hampshire | 31.6% | 27.5% | 19.4% |
| New Jersey | 27.8% | 25.8% | 26.1% |
| New Mexico | 28.9% | 29.3% | 23.7% |
| New York | 26.5% | 25.9% | 24.9% |
| North Carolina | 32.6% | 24.0% | 24.8% |
| North Dakota | 34.5% | 19.7% | 27.8% |
| Ohio | 35.1% | 24.1% | 26.0% |
| Oklahoma | 35.1% | 17.7% | 32.4% |
| Oregon | 28.1% | 26.6% | 23.5% |
| Pennsylvania | 30.9% | 23.2% | 24.3% |

| | | | |
|----------------|-------|-------|-------|
| Rhode Island | 31.3% | 26.6% | 24.5% |
| South Carolina | 32.7% | 25.7% | 26.5% |
| South Dakota | 32.1% | 23.5% | 29.4% |
| Tennessee | 34.4% | 24.3% | 26.7% |
| Texas | 33.5% | 28.2% | 25.0% |
| Utah | 29.9% | 25.5% | 17.6% |
| Vermont | 26.6% | 26.8% | 20.4% |
| Virginia | 31.7% | 25.8% | 23.5% |
| Washington | 28.4% | 26.5% | 18.6% |
| West Virginia | 41.0% | 18.2% | 28.4% |
| Wisconsin | 33.1% | 27.0% | 20.7% |
| Wyoming | 31.0% | 26.6% | 25.6% |

Sources. Kaiser Family Foundation. (2021). *Adults who are obese by sex*. Retrieved from <https://www.kff.org/other/state-indicator/adult-obesity-bysex/?currentTimeframe=0&selectedDistributions=male&sortModel=%7B%22colld%22:%22Male%22,%22sort%22:%22asc%22%7D>.

United Health Foundation. (2021). *America's health rankings: Exercise – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/exercise/population/exercise_Male/state/ALL?edition-year=2020.

United Health Foundation. (2021). *America's health rankings: Physical inactivity – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Sedentary/population/Sedentary_Male_C/state/ALL?edition-year=2020.

Note: Prior data on physical activity and inactivity was used for New Jersey as current data was not available.

Mental Health

Promoting fathers' mental health is important for their children's health and development.²⁸ The risk for male mental health problems increases once they become a father.²⁹ Nonresident fathers report higher depressive symptoms scores at the entry into fatherhood than resident fathers.³⁰ Two recent large-scale, rigorous, federal multi-site demonstration projects that examined the effectiveness of employment programs for disadvantaged noncustodial parents found that approximately one quarter of the 15,695 men who enrolled in the two programs were categorized as depressed at program enrollment when asked about their psychological well-being using a standardized eight-item depression scale (PHQ-8).³¹ Research suggests that, in general, father's mental health is related to increased child internalizing and externalizing behaviors.³² Additionally, father's mental health is associated with parenting behaviors, both positive and negative.³³

Depression

In 2019, the percentage of adult males who reported being depressed in the United States was 13.7% and the percentage of adult females who reported being depressed in the United States was 23.6%.^{34, 35} Twenty-eight states and the District of Columbia were above the national percentage of depressed adult males, and 22 states were below. The three states with the highest percentage of adult males reporting depression in 2019 were West Virginia (21.7%), Alabama (19.3%), and Oregon (18.9%). The three states with the lowest percentage of adult males reporting depression in 2019 were New Jersey (8.0%), Hawaii (10.1%), and California/Nebraska (10.6%).

28 Berns, S. (2021). *Promoting fathers' mental health during children's early childhood*. National Institute for Children's Health Quality. Retrieved from <https://www.nichq.org/insight/promoting-fathers-mental-health-during-childrens-early-childhood>.

29 Fisher, S. D. (2017). Paternal mental health: Why is it relevant? *American Journal of Lifestyle Medicine*, 11(3), 200–211.

30 Garfield, C. F., Duncan, G., Rutsohn, J., McDade, T. W., Adam, E. K., Coley, R. L., & Chase-Lansdale, P. L. (2014). A longitudinal study of paternal mental health during transition to fatherhood as young adults. *Pediatrics*, 133(5), 836–843.

31 Sorensen, E. (2020). *What we learned from recent federal evaluations of programs serving disadvantaged noncustodial parents*. U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation. Retrieved from <https://www.acf.hhs.gov/opre/report/what-we-learned-about-programs-serving-disadvantaged-noncustodial-parents>.

32 Fisher, S. D. (2017). Paternal mental health: Why is it relevant? *American Journal of Lifestyle Medicine*, 11(3), 200–211.

33 Davis, R. N., Davis, M. M., Freed, G. L., & Clark, S. J. (2011). Fathers' depression related to positive and negative parenting behaviors with 1-year-old children. *Pediatrics*, 127(4), 612–618.

34 United Health Foundation. (2021). *America's health rankings: Depression – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Depression_a/population/Depression_Male/state/ALL?edition-year=2020.

35 United Health Foundation. (2021). *America's health rankings: Depression – Female, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Depression_a/population/Depression_Female/state/ALL?edition-year=2020.

Suicide

In 2019, the number of suicide deaths among males per 100,000 population in the United States was 23.4 and the number of suicide deaths among females per 100,000 population in the United States was 6.1.^{36, 37} Thirty-six states were above the national number of suicide deaths among males per 100,000 population and 14 states and the District of Columbia were below. The three states with the highest number of suicide deaths among males per 100,000 population in 2019 were Wyoming (51.3), Alaska (44.0), and Montana (39.3). The three states with the lowest number of suicide deaths among males per 100,000 population in 2019 were the District of Columbia (8.8), New Jersey (13.2), and New York (13.9).

Table 3 summarizes, for each state and the District of Columbia, the percentage of adult males who reported being depressed in 2019 and the number of suicide deaths among males per 100,000 population in 2019.

Chapter 10, Table 3. State Percentage of Adult Males Reporting Depression in 2019 and Suicide Deaths Among Males Per 100,000 Population in 2019

| State | Percentage of Adult Males Reporting Depression (2019) | Suicide Deaths Among Males Per 100,000 Population (2019) |
|---------------|---|--|
| Alabama | 19.3% | 27.2 |
| Alaska | 12.1% | 44.0 |
| Arizona | 12.5% | 31.0 |
| Arkansas | 17.7% | 30.6 |
| California | 10.6% | 18.3 |
| Colorado | 13.6% | 34.6 |
| Connecticut | 10.8% | 18.7 |
| Delaware | 13.1% | 17.1 |
| DC | 17.3% | 8.8 |
| Florida | 13.1% | 24.6 |
| Georgia | 12.3% | 25.2 |
| Hawaii | 10.1% | 25.6 |
| Idaho | 16.7% | 33.2 |
| Illinois | 14.5% | 18.1 |
| Indiana | 14.9% | 24.8 |
| Iowa | 11.4% | 28.0 |
| Kansas | 14.3% | 29.5 |
| Kentucky | 18.3% | 27.6 |
| Louisiana | 17.3% | 25.6 |
| Maine | 18.1% | 33.3 |
| Maryland | 12.1% | 18.4 |
| Massachusetts | 13.6% | 14.4 |
| Michigan | 16.0% | 23.9 |
| Minnesota | 14.4% | 22.9 |
| Mississippi | 14.6% | 25.6 |
| Missouri | 16.3% | 31.3 |
| Montana | 16.3% | 39.3 |
| Nebraska | 10.6% | 26.6 |
| Nevada | 12.5% | 33.6 |
| New Hampshire | 14.7% | 29.9 |
| New Jersey | 8.0% | 13.2 |

³⁶ United Health Foundation. (2021). *America's health rankings: Suicide - Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Suicide/population/suicide_male/state/ALL?edition-year=2020.

³⁷ United Health Foundation. (2021). *America's health rankings: Suicide - Female, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Suicide/population/suicide_female/state/ALL?edition-year=2020.

| | | |
|----------------|-------|------|
| New Mexico | 13.9% | 38.9 |
| New York | 11.5% | 13.9 |
| North Carolina | 15.1% | 21.0 |
| North Dakota | 12.5% | 29.8 |
| Ohio | 14.6% | 25.7 |
| Oklahoma | 16.9% | 34.6 |
| Oregon | 18.9% | 32.7 |
| Pennsylvania | 13.3% | 23.7 |
| Rhode Island | 14.2% | 16.9 |
| South Carolina | 14.2% | 27.9 |
| South Dakota | 12.2% | 34.6 |
| Tennessee | 18.5% | 28.7 |
| Texas | 12.1% | 22.4 |
| Utah | 16.8% | 33.7 |
| Vermont | 16.9% | 26.7 |
| Virginia | 12.5% | 21.5 |
| Washington | 17.1% | 26.7 |
| West Virginia | 21.7% | 29.0 |
| Wisconsin | 15.7% | 23.1 |
| Wyoming | 13.4% | 51.3 |

Sources: United Health Foundation. (2021). *America's health rankings: Depression – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Depression_a/population/Depression_Male/state/ALL?edition-year=2020.

United Health Foundation. (2021). *America's health rankings: Suicide - Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Suicide/population/suicide_male/state/ALL?edition-year=2020.

Note: Prior data on depression was used for New Jersey as current data was not available.

Substance Use

Substance use by fathers impacts children's developmental pathways and risk of substance use.³⁸ Since child support programs do not systematically identify parents with substance abuse disorders, there is limited information on the prevalence of the problem among nonresident parents in the child support program termed "noncustodial parents."³⁹ Most estimates of substance use come from voluntary disclosures that are believed to be serious underestimates due to social stigma, past trauma, and other factors that make individuals unwilling to disclose. Thus, only 3% of more than 10,000 noncustodial parents in eight states who enrolled in the Child Support Noncustodial Parent Employment Demonstration (CSPED) project reported that problems with alcohol or drugs were barriers to them obtaining or keeping a job, a rate that fell far below the 30% and 28% who reported employment barriers due to lack of transportation and having a criminal record, respectively.⁴⁰

Preliminary data from the Office of the Assistance Secretary for Planning and Evaluation reveals that opioid dependence is twice as prevalent among individuals in poverty than individuals with incomes above 200% of the poverty line.⁴¹ Dated, national estimates of alcohol abuse or other drugs among the adult, female, welfare population range from 11% to 27%.⁴² One study that examined non-cash support from nonresidential fathers

38 McMahan, T. J. (2020). Fatherhood, substance use, and early childhood development. In H. E. Fitzgerald, K. von Klitzing, N. J. Cabrera, J. Scarano de Mendonca, & T. Skjøthaug (Eds.), *Handbook of fathers and child development*. Springer.

39 Antelo, L., & Waters, A. (2019). *Illicit substance use and child support: An exploratory study*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy. Retrieved from <https://aspe.hhs.gov/sites/default/files/private/pdf/262081/ChildSupportSubstanceUseNoncustodialFathers.pdf>.

40 Cancian, M., Guarin, A., Hodges, L., & Meyer, D. R. (2018). *Characteristics of participants in the Child Support Noncustodial Parent Demonstration (CSPED) evaluation*. Institute for Research on Poverty. Retrieved from <https://www.irp.wisc.edu/resource/csped-final-characteristics-of-participants-report/>.

41 Ghertner, R., & Groves, L. (2017). *The opioid epidemic and economic opportunity* (Draft Working Paper). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

42 Kirby, G., & Anderson, J. (2000). *Addressing substance abuse problems among TANF recipients: A guide for program administrators*. Mathematica Policy Research. Retrieved from <https://mathematica.org/publications/addressing-substance-abuse-problems-among-tanf-recipients-a-guide-for-program-administrators>.

found that 14% of the fathers in the study were currently misusing drugs and/or alcohol.⁴³ In another study of 296 noncustodial parents who enrolled in a job program conducted in three judicial districts in Tennessee, 13% reported problems with drugs or alcohol at program entry.⁴⁴ Anecdotal estimates of the prevalence of substance abuse disorders among noncustodial parents provided by child support experts ranged between 15% and 40%.⁴⁵

Information on the prevalence of substance use problems among low-income fathers also comes from records maintained by Responsible Fatherhood (RF) programs. Data compiled on 31,867 fathers who enrolled in one of 40 RF programs that were funded in 2015 by the Office of Family Assistance within the U.S. Department of Health and Human Services' Administration for Children and Families, found that 27% of participants reported having substance abuse or mental health problems that might make it "a little" or "a lot" harder for them to find or keep a good job. For the 11,074 fathers who were incarcerated and participated in the RF program within three to nine months of their release, this was reported by 48%.⁴⁶

Opioid Crisis

Research analyzing data from the 2017 National Survey on Drug Use and Health found that although men were significantly less likely than women to report opioid use, they were significantly more likely to report opioid misuse and to misuse prescription opioids primarily to feel good or get high. Additionally, men were significantly more likely than women to meet DSM-IV criteria for opioid dependence.⁴⁷

In February 2018, the National Academy for State Health Policy (NASHP) highlighted several state strategies for combating the opioid crisis that have showed promising results: track opioid prescribing, invest in harm reduction, build capacity for medication-assisted treatment (MAT), engage corrections, and ensure access in rural areas.⁴⁸ The states that have pursued one or more of these approaches were Florida, Massachusetts, New Mexico, Rhode Island, and Virginia.

Overdose Deaths. In 2019, the rate of male opioid overdose deaths in the United States was 21.7 per 100,000 population and the rate of female opioid overdose deaths in the United States was 9.3.⁴⁹ Twenty-five states and the District of Columbia were above the national rate of male opioid deaths, and 25 states were below. The three states with the highest rate of male opioid overdose deaths in 2019 were Delaware (62.4), West Virginia (54.7), and the District of Columbia (52.0). The three states with the lowest rate of male overdose deaths in 2019 were Nebraska (3.9), Hawaii (4.6), and South Dakota (5.1).

43 Kane, J. B., Nelson, T. J., & Edin, K. (2015). How much in-kind support do low-income nonresident fathers provide? A mixed-method analysis. *Journal of Marriage and Family*, 77(3), 591–611.

44 Davis, L., Pearson, J., & Thoennes, N. (2018). *Evaluation of the Tennessee Parent Support Program*. Center for Policy Research. Retrieved from <https://centerforpolicyresearch.org/wp-content/uploads/EvaluationofTennesseeParentSupportProgram.pdf>.

45 Antelo, L., & Waters, A. (2019). *Illicit substance use and child support: An exploratory study*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy. Retrieved from <https://aspe.hhs.gov/sites/default/files/private/pdf/262081/ChildSupportSubstanceUseNoncustodialFathers.pdf>.

46 Avellar, S., Stanczyk, A., Aikens, N., Stange, M., & Roemer, G. (2020). *Who enrolls in Responsible Fatherhood Programs? Data snapshot of clients at program entry* (OPRE Report 2020-84). U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation. Retrieved from <https://www.mathematica.org/publications/who-enrolls-in-responsible-fatherhood-programs-data-snapshot-clients-at-program-entry>.

47 Silver, E. R., & Hur, C. (2020). Gender differences in prescription opioid use and misuse: Implications for men's health and the opioid epidemic. *Preventative Medicine*, 131, 105946.

48 Purrington, K. (2019). *Tackling the opioid crisis: What state strategies are working?* National Academy for State Health Policy. Retrieved from <https://www.nashp.org/tackling-the-opioid-crisis-what-state-strategies-are-working/>.

49 Kaiser Family Foundation. (2021). *Opioid overdose deaths by sex*. Retrieved from <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-sex/?dataView=2¤tTimeframe=0&sortModel=7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Table 4 summarizes, for each state and the District of Columbia, the rate of male overdose deaths for in 2019.

Chapter 10, Table 4. **State Male Opioid Overdose Death Rate per 100,000 in 2019**

| State | Male Opioid Overdose Death Rate per 100,000 (2019) | State | Male Opioid Overdose Death Rate per 100,000 (2019) |
|---------------|--|----------------|--|
| Alabama | 11.6 | Montana | 8.4 |
| Alaska | 15.4 | Nebraska | 3.9 |
| Arizona | 26.2 | Nevada | 14.4 |
| Arkansas | 8.7 | New Hampshire | 39.8 |
| California | 11.6 | New Jersey | 42.0 |
| Colorado | 13.1 | New Mexico | 26.4 |
| Connecticut | 48.9 | New York | 22.1 |
| Delaware | 62.4 | North Carolina | 25.9 |
| DC | 52.0 | North Dakota | 6.3 |
| Florida | 26.7 | Ohio | 43.3 |
| Georgia | 11.2 | Oklahoma | 8.7 |
| Hawaii | 4.6 | Oregon | 10.2 |
| Idaho | 8.3 | Pennsylvania | 35.8 |
| Illinois | 25.2 | Rhode Island | 34.4 |
| Indiana | 26.5 | South Carolina | 23.8 |
| Iowa | 7.1 | South Dakota | 5.1 |
| Kansas | 8.1 | Tennessee | 31.6 |
| Kentucky | 32.1 | Texas | 7.2 |
| Louisiana | 17.5 | Utah | 15.0 |
| Maine | 38.1 | Vermont | 27.6 |
| Maryland | 50.8 | Virginia | 20.1 |
| Massachusetts | 44.3 | Washington | 13.9 |
| Michigan | 25.2 | West Virginia | 54.7 |
| Minnesota | 10.3 | Wisconsin | 22.2 |
| Mississippi | 11.5 | Wyoming | 10.3 |
| Missouri | 25.8 | | |

Source: Kaiser Family Foundation. (2021). *Opioid overdose deaths by sex*. Retrieved from <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-sex/?dataView=2¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Grant Funding. The 21st Century Cures Act established the State Targeted Response to the Opioid Crisis grant program (the STR grant program) to address the increased need for opioid treatment services. Through this program, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded almost \$1 billion to states over a two-year grant period (May 2017 through April 2019) and states were required to use these funds to expand access to evidence-based treatment, especially medication-assisted treatment (MAT); reduce unmet treatment needs; and reduce opioid overdose-related deaths through the provision of prevention, treatment, and recovery support services. The U.S Department of Health and Human Services, Office of Inspector General examined how much of each state's award remained unspent

at the end of the second year of the grant period and determined the percentage of each state's grant award expenditures by category during the first 18 months (treatment, prevention, recovery support, administration).⁵⁰ All but six states requested a no-cost extension to allow them to spend their funding for up to 12 months beyond the original end date for the project. Overall, 31.3% of the grant funds were unspent at the end of the second year of the grant and nine states spent less than half their grant allocation. West Virginia had the highest percentage of unspent funding (65.9%), and Missouri had the lowest (2.7%). Overall, 65% of the grant funds that were spent during the first 18 months were devoted to treatment, 17% to prevention, 13% to recovery support, and 4% to administrative costs. Forty-five states and the District of Columbia reported that more than half their expenditures went to treatment services, two states spent more than half on prevention, and one state spent more than half on recovery support services. Nineteen states exceeded the 5% administrative spending cap.

Table 5 summarizes, for each state and the District of Columbia, the percentage of their grant funding left unspent at the end of the second year of the grant period and the percentage that was spent on prevention, treatment, recovery support, and administration during the first 18 months of the grant period.

Chapter 10, Table 5. **State Opioid Crisis Grant Funding Unspent and Spent**

| State | Percentage of Funds Unspent | Percentage Spent on Prevention | Percentage Spent on Treatment | Percentage Spent on Recovery Support | Percentage Spent on Administration |
|---------------|-----------------------------|--------------------------------|-------------------------------|--------------------------------------|------------------------------------|
| Alabama | 8.1% | 8.9% | 85.6% | 2.9% | 2.6% |
| Alaska | 48.8% | 31.4% | 33.3% | 35.2% | 0.0% |
| Arizona | 50.6% | 24.0% | 73.0% | 0.0% | 2.9% |
| Arkansas | 60.9% | 23.1% | 46.6% | 14.7% | 15.6% |
| California | 49.8% | 34.7% | 63.6% | 0.0% | 1.6% |
| Colorado | 21.7% | 20.3% | 76.3% | 3.2% | 0.3% |
| Connecticut | 11.6% | 29.7% | 44.9% | 23.8% | 1.6% |
| Delaware | 63.6% | 0.2% | 91.9% | 0.0% | 7.9% |
| DC | 47.9% | 9.9% | 87.2% | 0.5% | 2.3% |
| Florida | 11.4% | 1.5% | 91.7% | 3.5% | 3.3% |
| Georgia | 27.8% | 20.2% | 52.1% | 14.3% | 13.3% |
| Hawaii | 40.4% | 9.9% | 80.1% | 10.0% | 0.0% |
| Idaho | 5.8% | 6.1% | 65.8% | 26.1% | 2.0% |
| Illinois | 28.4% | 14.6% | 81.1% | 1.2% | 3.1% |
| Indiana | 53.1% | 29.2% | 60.5% | 0.0% | 10.3% |
| Iowa | 24.6% | 22.2% | 72.7% | 0.0% | 5.1% |
| Kansas | 6.7% | 12.9% | 81.4% | 4.6% | 1.2% |
| Kentucky | 37.1% | 24.2% | 55.5% | 14.4% | 5.9% |
| Louisiana | 54.2% | 16.7% | 62.7% | 8.7% | 11.9% |
| Maine | 28.5% | 22.9% | 74.9% | 2.0% | 0.2% |
| Maryland | 41.1% | 28.6% | 69.2% | 1.4% | 0.8% |
| Massachusetts | 19.1% | 12.7% | 8.5% | 74.1% | 4.7% |
| Michigan | 44.0% | 32.2% | 53.0% | 7.8% | 7.0% |
| Minnesota | 26.7% | 23.8% | 53.5% | 13.2% | 9.5% |
| Mississippi | 28.4% | 9.5% | 86.0% | 1.0% | 3.5% |
| Missouri | 2.7% | 4.9% | 83.3% | 7.8% | 3.9% |
| Montana | 54.8% | 21.5% | 54.7% | 12.3% | 11.5% |
| Nebraska | 56.4% | 54.5% | 37.0% | 0.0% | 8.5% |

50 Office of Inspector General. (2020). *States' use of grant funding for a targeted response to the opioid crisis* (OEI-BL-18-00460). U.S. Department of Health and Human Services. Retrieved from <https://oig.hhs.gov/oei/reports/oei-BL-18-00460.pdf>.

| | | | | | |
|----------------|-------|-------|-------|-------|-------|
| Nevada | 32.9% | 13.2% | 81.7% | 0.0% | 5.1% |
| New Hampshire | 44.7% | 39.1% | 54.5% | 6.4% | 0.0% |
| New Jersey | 44.5% | 3.5% | 43.1% | 48.8% | 4.6% |
| New Mexico | 12.7% | 22.2% | 63.1% | 10.5% | 4.2% |
| New York | 25.6% | 18.6% | 46.6% | 31.6% | 3.3% |
| North Carolina | 9.1% | 12.8% | 80.3% | 6.2% | 0.7% |
| North Dakota | 10.4% | 24.8% | 59.3% | 10.4% | 5.5% |
| Ohio | 23.0% | 21.1% | 76.2% | 0.0% | 2.7% |
| Oklahoma | 15.3% | 32.6% | 54.9% | 5.0% | 7.5% |
| Oregon | 44.8% | 26.1% | 63.5% | 8.0% | 2.4% |
| Pennsylvania | 26.6% | 15.7% | 65.4% | 14.6% | 4.3% |
| Rhode Island | 28.6% | 22.7% | 35.4% | 35.4% | 6.4% |
| South Carolina | 5.4% | 17.4% | 62.0% | 16.6% | 4.0% |
| South Dakota | 46.4% | 79.3% | 7.5% | 2.7% | 10.5% |
| Tennessee | 9.8% | 18.3% | 71.8% | 7.0% | 2.9% |
| Texas | 47.9% | 9.5% | 52.3% | 30.3% | 7.9% |
| Utah | 14.5% | 11.6% | 73.7% | 10.0% | 4.6% |
| Vermont | 63.6% | 25.8% | 24.1% | 37.2% | 12.8% |
| Virginia | 4.6% | 24.9% | 53.8% | 17.7% | 3.6% |
| Washington | 30.0% | 15.1% | 71.8% | 8.2% | 5.0% |
| West Virginia | 65.9% | 18.4% | 70.7% | 8.9% | 1.9% |
| Wisconsin | 40.0% | 11.8% | 63.6% | 18.4% | 6.1% |
| Wyoming | 17.7% | 8.9% | 84.1% | 6.7% | 0.4% |

Source: Office of Inspector General. (2020). *States' use of grant funding for a targeted response to the opioid crisis* (OEI-BL-18-00460). U.S. Department of Health and Human Services. Retrieved from <https://oig.hhs.gov/oei/reports/oei-BL-18-00460.pdf>.

Other Substances

The CDC reports that men are more likely to drink alcohol, to binge drink, and to have an alcohol use disorder than women. Additionally, the CDC notes that male alcohol use is associated with injury, violence, and other harms (including suicide and cancer) and that alcohol may affect men's sexual and reproductive health.⁵¹ Parental drinking problems have been linked to negative effects in children including externalizing behaviors, internalizing problems, lower academic and cognitive performance, and mental disorders. Households with parents who abuse alcohol are often chaotic and have higher levels of antisocial behaviors and domestic violence.⁵² Parental alcohol use is also a predictor of adolescent alcohol use both directly (by being exposed to alcohol use) and indirectly (through its compromising effects on parenting behaviors such as parental monitoring and discipline).⁵³

Studies have also established the connection between exposure to parental smoking and childhood asthma and rhinitis,⁵⁴ and that parental smoking increases cigarette consumption levels among adolescents. Having a cohabitant mother who smokes increases the number of cigarettes smoked by children by around 18.7%, while having a cohabitant father who smokes increases the number by around 12.1%. Accordingly, quitting smoking by parents and grandparents before children become adolescents appears to be a powerful means

51 Centers for Disease Control and Prevention. (2020). *Excessive alcohol use is a risk to men's health*. U.S. Department of Health and Human Services. Retrieved from <https://www.cdc.gov/alcohol/fact-sheets/mens-health.htm>.

52 Park, S., & Schepp, K. G. (2015). A systematic review of research on children of alcoholics: Their inherent resilience and vulnerability. *Journal of Child and Family Studies*, 24, 1222–1231.

53 Latendresse, S. J., Rose, R. J., Viken, R. J., Pulkkinen, L., Kaprio, J., & Dick, D. M. (2008). Parenting mechanisms in links between parents' and adolescents' alcohol use behaviors. *Alcoholism: Clinical & Experimental Research*, 32(2), 322–330.

54 Thacher, J. D., Gruzieva, O., Pershagen, G., Neuman, Å., Wickman, M., Kull, I., Melén, E., & Bergström, A. (2014). Pre- and postnatal exposure to parental smoking and allergic disease through adolescence. *Pediatrics*, 143(3), 428–434.

to both reduce smoking rates among adolescents and the number of cigarettes smoked by smokers. More to the point, the visibility of smoking among parents appears to exert a stronger influence on the prevalence of smoking and consumption levels than exposure to smoking prevention campaigns at school.⁵⁵

Excessive Drinking. Excessive drinking is defined as the percentage of adults who reported binge drinking (five or more drinks for men and four or more drinks for women on one occasion in the past 30 days) or heavy drinking (15 or more drinks for men and eight or more drinks for women per week). According to CDC data, the percentage of adult males in the United States who reported excessive drinking in 2019 was 22.7% and the percentage of adult females in the United States who reported excessive drinking in 2019 was 14.1%.^{56, 57} Twenty-five states and the District of Columbia had a higher percentage of adult males who reported excessive drinking than the national average and 25 states had a lower percentage. The three states with the highest percentage of adult males who reported excessive drinking in 2019 were North Dakota (29.9%), Wisconsin (28.6%), and South Dakota (28.0%). The three states with the lowest percentage of adult males who reported excessive drinking in 2019 were Utah (15.0%), Alabama (17.3%), and Maryland (17.7%).

Cigarette Smoking. According to CDC data, in 2019 17.1% of adult males and 13.5% of adult females in the United States reported smoking (currently smoke every day or some days).⁵⁸ Twenty-eight states had an equal to or higher percentage of adult males who reported smoking than the national average and 22 states and the District of Columbia had a lower percentage. The three states with the highest percentage of adult males who reported smoking in 2019 were West Virginia (24.4%), Mississippi (24.2%), and Louisiana (24.1%). The three states with the lowest percentage of adult males who reported smoking in 2019 were Utah (10.0%), California, (12.7%), and Washington (13.6%).

Table 6 summarizes, for each state and the District of Columbia, the percentage of adult males who reported excessive drinking in 2019 and the percentage of adult males who reported smoking in 2019.



55 Escario, J.-J., Wilkinson, A. V. (2015). The intergenerational transmission of smoking across three cohabiting generations: A count data approach. *Journal of Community Health, 40*(5), 912–919.

56 United Health Foundation. (2021). *America's health rankings: Excessive drinking – Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/population/ExcessDrink_Male_C/state/ALL?edition-year=2020.

57 United Health Foundation. (2021). *America's health rankings: Excessive drinking – Female, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/population/ExcessDrink_Female_C/state/ALL?edition-year=2020.

58 Kaiser Family Foundation. (2021). *Adults who report smoking by sex*. Retrieved from <https://www.kff.org/other/state-indicator/smoking-adults-by-sex/?currentTIframe=1&sortModel=%7B%22colld%22:%22Male%22,%22sort%22:%22asc%22%7D>.

Chapter 10, Table 6. State Percentage of Adult Males Who Reported Excessive Drinking and Smoking in 2019

| State | Percentage of Adult Males Who Reported Excessive Drinking (2019) | Percentage of Adult Males Who Reported Smoking (2019) | State | Percentage of Adult Males Who Reported Excessive Drinking (2019) | Percentage of Adult Males Who Reported Smoking (2019) |
|---------------|--|---|----------------|--|---|
| Alabama | 17.3% | 22.4% | Montana | 27.9% | 16.7% |
| Alaska | 21.4% | 19.0% | Nebraska | 27.1% | 15.7% |
| Arizona | 22.0% | 17.4% | Nevada | 22.4% | 17.5% |
| Arkansas | 19.2% | 21.7% | New Hampshire | 23.1% | 17.1% |
| California | 23.1% | 12.7% | New Jersey | 19.1% | N/A |
| Colorado | 22.4% | 15.1% | New Mexico | 21.5% | 18.3% |
| Connecticut | 20.9% | 13.7% | New York | 21.9% | 14.2% |
| Delaware | 23.2% | 15.8% | North Carolina | 18.8% | 20.7% |
| DC | 28.8% | 16.1% | North Dakota | 29.9% | 18.1% |
| Florida | 21.2% | 15.7% | Ohio | 23.6% | 21.6% |
| Georgia | 20.9% | 19.0% | Oklahoma | 18.1% | 21.1% |
| Hawaii | 25.1% | 15.2% | Oregon | 23.6% | 15.4% |
| Idaho | 23.3% | 16.8% | Pennsylvania | 22.3% | 18.2% |
| Illinois | 27.2% | 17.0% | Rhode Island | 23.8% | 15.3% |
| Indiana | 21.4% | 21.2% | South Carolina | 25.3% | 19.5% |
| Iowa | 27.7% | 17.9% | South Dakota | 28.0% | 18.8% |
| Kansas | 24.0% | 16.4% | Tennessee | 20.1% | 20.9% |
| Kentucky | 21.7% | 22.1% | Texas | 25.2% | 18.2% |
| Louisiana | 27.6% | 24.1% | Utah | 15.0% | 10.0% |
| Maine | 23.8% | 19.9% | Vermont | 24.1% | 16.5% |
| Maryland | 17.7% | 14.2% | Virginia | 20.8% | 15.3% |
| Massachusetts | 24.7% | 14.5% | Washington | 18.8% | 13.6% |
| Michigan | 23.5% | 20.2% | West Virginia | 18.6% | 24.4% |
| Minnesota | 26.0% | 16.3% | Wisconsin | 28.6% | 17.2% |
| Mississippi | 20.9% | 24.2% | Wyoming | 23.4% | 18.9% |
| Missouri | 22.5% | 20.6% | | | |

Sources: United Health Foundation. (2021). *America's health rankings: Excessive drinking - Male, United States*. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/ExcessDrink/population/ExcessDrink_Male_C/state/ALL?edition-year=2020. Kaiser Family Foundation. (2021). *Adults who report smoking by sex*. Retrieved from <https://www.kff.org/other/state-indicator/smoking-adults-by-sex/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Male%22,%22sort%22:%22asc%22%7D>.

Notes: Prior data on excessive drinking was used for New Jersey as current data was not available.

Due to limited data, information on smoking was not provided for New Jersey.

For smoking data, the percentages are weighted to reflect population characteristics.

Conclusions

Children do best when they have parents who are physically and mentally healthy. Gender patterns on physical and mental health for non-elderly adults consistently find men disadvantaged relative to women. Poor and near poor individuals fare worse than the not poor. And unmarried men experience worse health outcomes than those who are married. Taken together, low-income, non-resident fathers may be presumed to have particularly deleterious physical and mental health characteristics.

A significant component of the negative health picture for low-income men pertains to their lower rates of health insurance coverage. People without insurance coverage have worse access to care than people who are insured. Studies repeatedly demonstrate that uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. As a result, they are more likely to be hospitalized for avoidable health problems, to experience declines in their overall health, and to have higher mortality rates than those with insurance.

A key strategy to address the problem is to extend ACA and Medicaid coverage to low-income fathers. Gaining health insurance improves access to health care and diminishes the adverse effects of having been uninsured. A comprehensive review of the literature on the effects of ACA Medicaid expansion finds that expansion led to positive effects on access to care, utilization of services, the affordability of care, and financial security among the low-income population. Medicaid expansion is associated with increased early-stage diagnoses rates for cancer, lower rates of cardiovascular mortality, and increased odds of tobacco cessation.

One possible way to reach uninsured nonresident fathers and try to engage them in health insurance coverage is through the child support program. Federal law requires every child support order to include medical support for the children covered in the order. Medical support can be private health insurance from an employer or the health insurance marketplace, public health care coverage from Medicaid or the Children's Health Insurance Program (CHIP), or payment towards healthcare costs. Thus, when establishing new child support orders, child support workers determine whether either parent has access to affordable, private health insurance from an employer to which the children covered in the order might be added. Lacking a private insurance option, they ensure that children covered on the order who qualify are enrolled in Medicaid or the CHIP program. One logical extension of that process would be to have child support workers determine whether both the custodial and the nonresident parent in new and modifying child support cases have private health insurance coverage. Finding none, child support workers could be instrumental in referring uninsured parents to navigators at the Medicaid agency and/or the health insurance marketplace to help them procure coverage. Since health insurance status for children and adults change over time (e.g., very young children covered by Medicaid at case establishment may roll off as they age), child support workers should check on insurance coverage for children and adults at every stage of case processing. To facilitate the process of determining insurance status, child support agencies should maintain electronic interfaces between the automated systems for the child support program, the Medicaid and CHIP agency, and the health insurance exchange.



Other ways to improve the health status of nonresident fathers and their children would be to develop two-generation programs dealing with nutrition, exercise, smoking, and substance use. One example is the Healthy Dads, Healthy Kids (HDHK) program which is an evidence-based, community-based healthy lifestyle program that improved health outcomes and behaviors in overweight fathers and their children in Australia.⁵⁹ Although not specifically targeted to men or fathers, the CDC funds 16 state recipients through the State Physical Activity and Nutrition (SPAN) program to implement evidence-based strategies at state and local levels to improve nutrition and physical activity.⁶⁰

A third approach to improving father health and strengthening father-child relationships is to incorporate fatherhood in various human services treatment programs. This is being done by ForeverDads, which is a nonprofit community-based organization funded by the Ohio Commission on Fatherhood that operates in six rural counties in Ohio. Focusing on fathers in substance use disorder treatment programs in both residential and community-based settings, ForeverDads uses fatherhood programming to improve father engagement, motivation, and outcomes.⁶¹ Combining classes on fatherhood with substance use treatment is perceived to promote positive treatment outcomes as well as enhancing parenting skills and rekindling relationships with children.⁶²

Impaired physical and mental health, and substance abuse disorder create obstacles to secure gainful employment among affected individuals. Parental problems with substance abuse and mental health are some examples of the types of adverse childhood experiences (ACEs) among children that are linked with chronic health problems, mental illness, and substance abuse that follow children into their adulthood. About 61% of adults surveyed across 25 states reported that they had experienced at least one type of ACE, and nearly one in six reported they had experienced four or more types of ACEs.⁶³ Among the chief strategies to prevent ACEs are the enhancement of primary care to individuals and the provision of family-centered treatment for substance use and disorders. Extending health insurance coverage and treatment to low-income, nonresidential fathers, would further these prevention efforts and result in better outcomes for affected fathers and their children.

59 Morgan, P. J., Collins, C. E., Plotnikoff, R. C., Callister, R., Burrows, T., Fletcher, R., Okely, A. D., Young, M. D., Miller, A., Lloyd, A. B., Cook, A. T., Cruickshank, J., Saunders, K. L., & Lubans, D. R. (2013). The 'Healthy Dads, Healthy Kids' community randomized controlled trial: A community-based healthy lifestyle program for fathers and their children. *Preventive Medicine*, 61, 90–99.

60 Division of Nutrition, Physical Activity, and Obesity. (2021). *State Physical Activity and Nutrition (SPAN) program*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Retrieved from <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/span-1807/index.html>.

61 DeLisle, D., Selekmán, R., & Holcomb, P. (2021). *Case study of father engagement in substance use disorder treatment programs: ForeverDads*. Mathematica. Retrieved from <https://www.mathematica.org/publications/case-study-of-father-engagement-in-substance-use-disorder-treatment-programs-foreverdads>.

62 Garfield, C. F., Clark-Kauffman, E., & Davis, M. M. (2006). Fatherhood as a component of men's health. *JAMA*, 296(19), 2365–2368.

63 Centers for Disease Control and Prevention. *Preventing adverse childhood experiences*. Fast Facts. Retrieved from <https://www.cdc.gov/violenceprevention/aces/fastfact.html>.

Fatherhood Research & Practice Network

About the FRPN

The Fatherhood Research & Practice Network (FRPN) was created and operated by Temple University and the Center for Policy Research through funding by the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation from 2013-2019 (OPRE grant #90PR0006). FRPN promotes rigorous evaluation of fatherhood programs, disseminates information to fatherhood practitioners and researchers, and catalyzes system-level changes that support father engagement and equity. Visit www.frpn.org for an extensive library of resources for practitioners, researchers, and policymakers.

Policies and Programs Affecting Fathers: A State-by-State Report was prepared with the support of the Center for Policy Research in Denver, Colorado. Thanks are extended to Jay Fagan, Professor Emeritus of Social Work at Temple University; Johan Dellgren, Student at Pomona College; Jane Venohr, Research Associate and Economist at the Center for Policy Research; Christopher Brown, President, National Fatherhood Initiative; and various subject matter and policy experts with whom we consulted in the course of developing this report.

To the best of our knowledge, the information we provide is current as of report publication and/or the date indicated in the report and table sources. Nevertheless, since state policies and programs continually evolve, there are inevitable changes and developments that we have not captured. The views expressed in the report are those of the authors.

©2022. Center for Policy Research, Denver, Colorado. Suggested citation: Pearson, J., & Wildfeuer, R. (2022). Policies and Programs Affecting Fathers: A State-by-State Report. Center for Policy Research and Fatherhood Research & Practice Network.