A System Falling Short

MEN'S EXPERIENCES WITH MENTAL HEALTH AND SUBSTANCE USE SERVICES IN CANADA

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About this report

Most men who need mental health support in Canada never get it. That is not a story about men being hard to reach. It is a story about a system that was not built to reach them. This report draws on national self-reported data from the Movember Institute of Men's Health and Mental Health Research Canada (MHRC). It also draws on population-based linked administrative health data from Ontario held at ICES (formerly the Institute for Clinical Evaluative Sciences) and analyzed by researchers at the Centre for Addiction and Mental Health (CAMH). Together, these sources set out what a system built to reach, respond to, and retain men would look like, structured around the 5R Framework for gender-responsive health systems.

About Movember

Twenty-three years ago, a bristly idea was born in Melbourne, Australia, igniting a movement that would transcend borders and change the face of men's health forever. The movement, known as Movember, united people from all walks of life – sparking billions of important conversations, raising vital funds, and shattering the silence surrounding men's health issues.

Since 2003, this trailblazing charity has challenged the status quo by reshaping men's health research and transforming the way that health services reach and support men.

Powered by a global community of supporters, Movember has raised almost $2 billion CAD, fuelling over 1,320 men's health projects from groundbreaking biomedical research to major global prostate cancer registries. Since expanding into mental health and suicide prevention in 2006, Movember has advocated for earlier recognition of men's mental health challenges and improved clinical responses for men in distress. By empowering men and those around them to act sooner, Movember is helping more men recognize the signs and take action before hitting crisis point.

Movember is committed to redefining the future of men's health by investing in breakthrough research, encouraging healthier behaviours, and championing gender-responsive healthcare that properly addresses the unique needs of all men. By tackling stigma and barriers to support, Movember is working to create a world where all people can live longer, healthier lives. Because better men's health means stronger families, stronger communities and a stronger society.

To learn more, please visit Movember.com.

By improving men's health, we can have a profoundly positive impact on women, families, and society.

Healthier men mean a healthier world.

About the Movember Institute of Men's Health

The Movember Institute of Men's Health was launched in 2023, backed by a landmark $100 million CAD global investment and building on Movember's legacy of funding almost $2 billion CAD in men's health initiatives worldwide since its 2003 inception.

As part of Movember, the world's leading charity changing the face of men's health, the Institute unites experts, communities and partners to accelerate research and translate it into real-world solutions.

Focused on critical issues in men's health such as suicide prevention, mental health, prostate cancer and testicular cancer, the Institute will drive change by improving health services, breaking down cultural barriers that prevent men from looking after their health, building research talent and scaling proven interventions.

Its mission is to improve the health, wellbeing and longevity of men and boys globally by raising the profile of men's health among policymakers and reshaping how health services engage with and support men.

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A note for readers

This report discusses suicide, self-harm, mental illness, and substance use. If you or someone you know needs support, the 9-8-8 Suicide Crisis Helpline is free and confidential, 24/7, in English and French - call or text 9-8-8. In Quebec, call 1-866-APPELLE (277-3553) or text 53 53 53. Indigenous Peoples across Canada can reach the Hope for Wellness Helpline at 1-855-242-3310 or by chat at hopeforwellness.ca. In an emergency, call 9-1-1.

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SECTION 01

Executive Summary

Men's mental health in Canada is less a story of sudden crisis than of needs the system has long left unmet. Men experience disproportionately high rates of substance use problems and account for around 75% of suicide deaths in Canada, yet they reach professional support later and less often than women, usually after concerns have become severe or complex. That pattern is often read as reluctance, but it is better understood as a rational response to a system too few men expect to be accessible, relevant, or effective for them. **Encouraging men to seek help earlier remains important. On its own, it is not enough. The task is to build a system designed to reach, respond to, and retain them.**

This is not a marginal group. The scale of unmet need is large. Mental Health Research Canada estimates that 1.3 million Canadian men over 16, around 1 in 11, have unmet needs for mental health support.[5] In the past year, 12% of men accessed mental health or substance use services and a further 5% needed support but did not reach it, a gap that widens among younger men, of whom 44% did not receive the support they needed and 49% left care before their needs were met.[1]

Encouraging men to seek help earlier remains important. On its own, it is not enough. The task is to build a system designed to reach, respond to, and retain them.

Young men are three to four times more likely than older Canadians to cope with mental health challenges through problematic substance use.[1] In 2024, suicide accounted for nearly 2,900 male deaths.[2] It remains the fourth leading cause of premature death among men.[2]

The barriers do not stop at the door. More than half of men who sought care, 54%, report barriers to receiving effective care, including rushed appointments, difficulty communicating symptoms, feeling dismissed, and a lack of empathy in the encounter.[3] The quality of that first contact shapes what follows: 67% of men who were satisfied with their first healthcare encounter would seek help again, compared with just 26% of those who were not satisfied. **Men are showing up. Whether they come back depends on what happens when they do.**

Ontario's linked administrative data shows what this looks like from inside the system. This analysis uses the terms "males" and "females," reflecting how sex is recorded in administrative health data. Even when a man's mental health problem is already on the record, males are less likely than females to access any care, at one year (14.3% versus 19.0%) and at five years (31.6% versus 41.1%). **More than 85% of males with a mental health problem in Ontario did not access a publicly funded service within a year, so most unmet need is invisible to the system entirely.** When men do reach care, they are more likely to do so through emergency departments than planned outpatient care. The gaps are largest for young men, men in the poorest neighbourhoods, and men in rural and northern communities.

54%

of men who sought care report barriers to receiving effective care

85%

of males with a mental health problem in Ontario did not access a publicly funded service within a year

Unmet need also carries a price. Boston Consulting Group estimates that poor mental health costs Canada more than $200 billion a year in direct and indirect costs, the great majority of it in lost productivity rather than direct health spending.[4] None of this is inevitable. These patterns reflect service designs and system structures that can be changed. What is needed now is not more recognition, but delivery. This report sets out what a health system equipped to respond to and retain men in care could look like and identifies opportunities for provinces and territories to strengthen how care is designed and delivered for men. As Canada develops its first Men and Boys' Health Strategy, there is an opportunity to align federal leadership with provincial and territorial action so that, when men seek care, the system is equipped to meet their needs and keep them engaged.

Central call: Canada's first Men and Boys' Health Strategy, now in development, presents an important opportunity to establish a national commitment to improving men's health. Alongside the development of a national strategy, provinces and territories have an important opportunity to strengthen how their health systems respond to men's mental health and substance use needs, so that when men seek care, services are equipped to respond effectively and keep them engaged.

Recommendation	Key actions
1. Research — make men visible in the data	Publish sex-disaggregated data on mental health and substance use emergency department presentations, follow-up, treatment engagement and outcomes, broken down by age, income and region. Measure whether care is working, not simply whether men are accessing it. Extend independent research access to linked data beyond Ontario to build a clearer national picture of men's pathways through care. Invest in longitudinal research that follows men over time, rather than relying on cross-sectional snapshots.
2. Reach — strengthen non-traditional pathways into care	Fund outreach through workplaces, sports clubs, community organizations and primary care. Run evidence-informed campaigns that normalize help-seeking. Target young men aged 16 to 24, rural and northern communities, low-income neighbourhoods, and Indigenous men.
3. Respond — tailor care to how men present	Train clinicians to recognize how men present in care and how masculine norms can shape help-seeking and engagement. Scale existing evidence-based training rather than developing new programs. Extend this training beyond specialist services to primary care, nursing, pharmacy and emergency staff. Screen opportunistically at high-risk contact points, addressing mental health and substance use together.
4. Retain — design care that keeps men engaged	Offer flexible formats: virtual, evening and drop-in. Guarantee a follow-up pathway after any acute contact. Build in peer support, coaching and proactive outreach when men miss appointments.
5. Relational — design equity-driven policy around men's lives	Address the social and structural factors that shape whether men can access and remain engaged in care. Expand appropriate services in rural, northern and low-income communities; support community-based and non-clinical entry points; resource Indigenous-led, culturally safe care; and strengthen coordination between health services and systems such as housing, employment, justice and education. Recognize the partners, families and friends around men as routes into support and as a consideration in service design.

MEN'S MENTAL HEALTH IN CANADA AT A GLANCE

Finding	Figure
Men's share of suicide deaths in Canada	**around 75%**, nearly 2,900 deaths in 2024
Canadian men over 16 with unmet mental health support needs	**1.3 million**, around 1 in 11
Young men who did not receive the support they needed, and who left care before their needs were met	**44%** and **49%**
Indigenous suicide mortality, against the non-Indigenous population	**two to three times higher** (First Nations, Métis); **nine times higher** (Inuit)
Men reporting barriers to effective care	**54%**
Men who would seek help again after a satisfying first encounter, against those who were not satisfied	**67%** vs **26%**
Ontario males with an identified mental health problem who accessed no publicly funded service within a year	**more than 85%**
Ontario males vs females accessing any service, at one year and at five years	**14.3% vs 19.0%**; **31.6% vs 41.1%**
Ontario males with a mental health problem seeing a psychiatrist within a year, Northwest vs Toronto	**0.8% vs 5.8%**
Annual cost of poor mental health to Canada, all genders	**more than $200 billion**

SECTION 02

Introduction

Men's mental health in Canada is not an emerging crisis. The evidence has been consistent for years and so has the diagnosis: men reach professional support later and less often than women, typically after concerns have become severe or complex, and the pattern is read as reluctance rather than as a byproduct of a system that was not designed for them. What has changed is the opportunity to act on it.

The development of Canada's first Men and Boys' Health Strategy creates an important national opportunity to advance this work. At the same time, many of the changes required sit within provincial and territorial health systems. This report uses Ontario as a case study to examine what happens when men need and enter mental health and substance use services, and what health systems across Canada can learn from those patterns.

"I am on a wait list for therapy. Unfortunately, I have not heard back yet. I don't know how long the wait list is going to be. That's been a big issue for a lot of us, I find. Getting put on a wait list and not knowing when you are going to be able to get that care. I am in an okay headspace, but not everyone is in the headspace where they can wait that long."

MIGUEL, 25-34, ONTARIO

The case for gender-responsive mental health system change is well established. Mental Health Research Canada (MHRC) estimates that 1.3 million (1 in 11) Canadian men over the age of 16 indicated having unmet needs for mental health support.[5] This includes men who reported that their needs were not met through the mental health support they sought out and those who reported that they need help but didn't access care. Young men are three to four times more likely than older generations to cope with mental health challenges through problematic substance use, a pattern that points directly to the need for earlier intervention and better-matched pathways to care.1 The greater challenge is not persuading men to come forward but designing Canada's mental health and addictions system to meet them when they do. This requires an evidence-informed, equity-focused system that delivers timely, accessible, and integrated care while better equipping clinicians to provide gender-responsive services that recognize the unique ways men experience, express, and seek support for mental health and substance use challenges.[1]

The consequences of that design failure are measurable. In 2024, 73,084 men died before the age of 75 in Canada, representing 43% of all male deaths.[2] Suicide remained the fourth leading cause of premature death among men, and in the last year, 30% of young men aged 16 to 24 reported thinking about suicide or planned a suicide attempt.[5] The burden is even greater for Indigenous men: suicide rates are two to three times higher among First Nations and Métis people, and nine times higher among Inuit, than in the non-Indigenous population.[6]

Beyond social and health consequences, unmet mental health care needs also impose a significant economic burden. Boston Consulting Group estimates that the direct and indirect costs of poor mental health in Canada exceed $200 billion annually, comprising roughly $32 billion in direct costs, close to 10% of public health spending, and about $190 billion in indirect costs such as worker downtime and presenteeism.[4] When mental health needs go unmet through our health systems, the consequences do not disappear. They resurface, as *The Real Face of Men's Health* 2025 Canada report set out,[3] as reduced workforce participation, greater strain on families and caregivers, increased pressure on the healthcare system, and lives cut short. Improving the infrastructure of our health systems for men is both a moral and economic imperative. Supporting men before challenges escalate can improve health outcomes, strengthen families and communities, reduce long-term system costs, and contribute to a healthier, more productive Canada.

SECTION 03

Data Sources and Methods

This report pairs two kinds of evidence: national self-reported data on what men indicate they need and experience, and population-based linked administrative records in Ontario on what services men actually receive. Ontario serves as a case study to inform equity-focused planning for men and boys across Canada. The self-reported data comes from two national surveys, one conducted by the Movember Institute of Men's Health and one by Mental Health Research Canada.

SECTION 03 — 1

The Real Face of Men's Health Canadian Survey

In January and February 2025, the Movember Institute of Men's Health surveyed 1,502 men in Canada on their experiences of engaging with primary care. The sample was nationally representative. The survey examined men's confidence in understanding their own health, how long they waited before seeking help, their attitudes toward masculine norms and health behaviours, and the quality of their interactions with healthcare providers, including whether they felt listened to, whether providers asked about matters beyond the presenting complaint, and whether they had experienced bias as a man.

Headline findings were published in The Real Face of Men's Health: 2025 Canadian Report. For the present report, further analysis was undertaken on the items relating to help-seeking, barriers to effective engagement, and the influence of the first healthcare encounter on men's willingness to return, including disaggregation by age, cultural background, sexual orientation, and self-reported health condition.

Quotes from this survey are reproduced as published in The Real Face of Men's Health: 2025 Canadian Report. To protect the privacy and confidentiality of participants, names are pseudonyms and identifying information has not been shared.[3]

1,502

men surveyed by the Movember Institute of Men's Health on their experiences of engaging with primary care

SECTION 03 — 2

Mental Health Research Canada's datasets

Findings presented in this report are based on data from MHRC's National Polling Initiative, an ongoing repeated cross-sectional survey designed to monitor the mental health and wellbeing of Canadians since 2020. The survey is conducted online by Pollara Strategic Insights (MHRC's data insights partner) and includes a nationally representative sample of Canadian adults aged 16 years and older. Survey respondents are recruited through an established online research panel, and the final dataset is weighted by age, gender, and region using the latest Canadian census data to ensure representativeness of the Canadian adult population.

The polling initiative combines a consistent set of core questions that enable trend analysis across survey waves with rotating modules that explore emerging mental health issues, service access, and other timely topics. This methodology provides robust, population-level insights that inform research, policy, and practice while allowing MHRC to monitor changes in Canadians' mental health experiences over time.

Quotes included in this report are drawn from an independent qualitative study conducted by Mental Health Research Canada. To protect the privacy and confidentiality of participants, respondents' names and identifying information have not been shared.[25]

SECTION 03 — 3

Ontario administrative health data

Most healthcare encounters in Ontario are covered by a single-payer government insurance program, the Ontario Health Insurance Plan (OHIP), which provides near-universal health coverage to Ontarians. Data on these encounters are held in a database curated at ICES, an independent, non-profit research institute that holds, in trust, data on publicly administered health services within Ontario, and whose legal status under Ontario's health information privacy law allows it to collect and analyze healthcare and demographic data, without consent, for health system evaluation and improvement.

The use of these data in this project is authorized under section 45 of Ontario's Personal Health Information Protection Act (PHIPA) and does not require review by a Research Ethics Board.

The Ontario health data analysis used two complementary approaches to examine men's and boys' access to mental health and addictions services in Ontario, using linked administrative health data held at ICES. First, these data were used to generate nine quarterly indicators of mental health and addictions (MHA) service use across

the Ontario population aged 12 and over between 2014 and 2023, using routinely collected provincial health records. Indicators included MHA hospitalizations, 30-day re-hospitalizations, length of hospital stay, 7-day outpatient follow-up after discharge, emergency department (ED) visits for MHA, ED visits for self-harm, 30-day ED re-visits, ED as first point of contact, and outpatient physician visits. Taken together, these indicators describe what happens within the system, capturing patterns of care among those who engage with services.

The second approach linked responses from the Canadian Community Health Survey (CCHS) and provincial administrative health records to answer the following research question: among males who have a mental health problem, how many seek care at all? Specifically, Ontario male participants aged 12 and over in the CCHS who self-reported or were identified with a prevalent mental health problem were observed through linked administrative health records for up to five years to determine whether they accessed any publicly funded MHA service. This evidence reveals the unmet need that service data alone cannot see.

In both approaches, results were compared between males and females and, among males, stratified by age, neighbourhood income, rurality, and Ontario health region. The Ontario datasets used in this report were linked using unique encoded identifiers and analyzed at ICES.[29]

The Ontario-based study was supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health (MOH) and the Ministry of Long-Term Care (MLTC). This report used data adapted from the Statistics Canada Postal Code^{OM} Conversion File, which is based on data licensed from Canada Post Corporation, and/or data adapted from the Ontario Ministry of Health Postal Code Conversion File, which contains data copied under license from ©Canada Post Corporation and Statistics Canada. This report also used data adapted from Statistics Canada Canadian Community Health Survey – Annual Components 2007-2016 and the Canadian Community Health Survey – Mental Health, 2012.

This does not constitute an endorsement by Statistics Canada of this product. Parts of this material are based on data and/or information compiled and provided by Immigration, Refugees and Citizenship Canada (IRCC) current to 1 November 2025. However, the analyses, conclusions, opinions and statements expressed in the material are those of the authors, and not necessarily those of the IRCC. Parts of this material are based on data and/or information compiled and provided by the Canadian Institute for Health Information (CIHI) and the Ontario Ministry of Health. The analyses, conclusions, opinions and statements expressed herein are solely those of the authors and do not reflect those of the funding or data sources; no endorsement is intended or should be inferred.

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SECTION 04

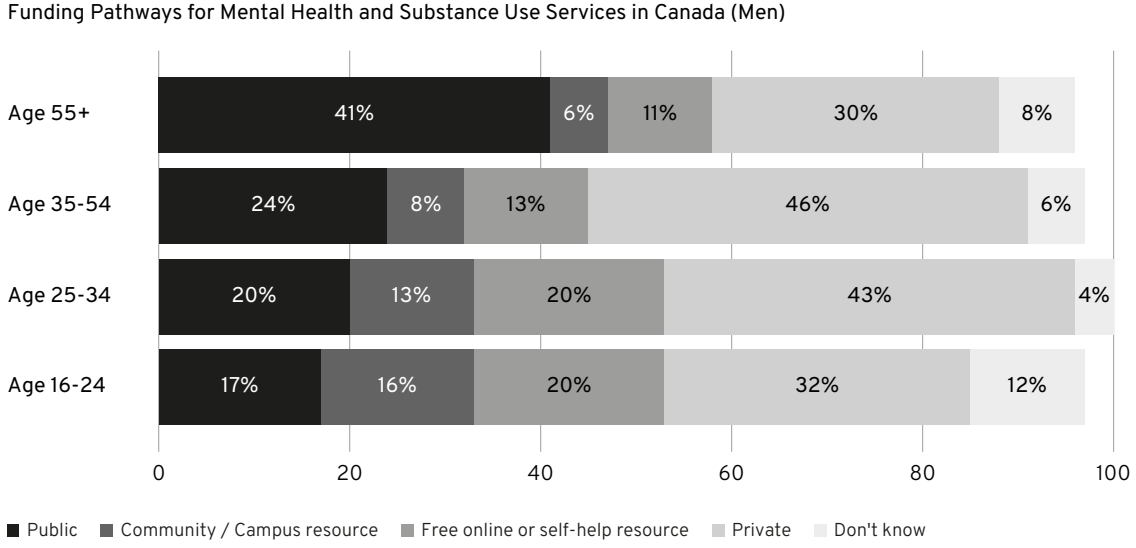
How are Canadian Men Accessing Mental Health and Addiction Services?

Two questions run through the evidence that follows: how many men who need care actually reach it, and how well the system responds once they arrive.

According to MHRC national polling, roughly 1 in 6 Canadian men (17%) needed mental health or substance use support in the past year; of these 12% reached services, but 5% did not. Among younger men, 44% did not receive the support they needed and 49% disengaged from care before their needs were met.[1] Men are seeking help. The system is struggling both to reach those in need and to keep them engaged long enough to achieve meaningful outcomes.

Understanding where men access mental health services shows where to concentrate effort within the system. Among men who did seek support, the settings they used varied: private mental health providers (38%), hospitals (26%), free or self-guided resources (16%), and community-based organizations (11%).[5] These findings challenge the common perception that men are unwilling to seek help. Instead, they suggest that men are engaging with existing services, presenting an opportunity to improve how those services respond to men's unique needs. From a systems perspective, this indicates that gender-responsive mental health care can be integrated within the current healthcare framework, rather than requiring an entirely separate system of care.

FIGURE 1. MHRC NATIONAL POLLING, POLLS 13 TO 28 (JULY 2022 TO MAY 2026)[5]



n = 2,019, Polls 13–28 (July 2022 – May 2026).

SECTION 04 — 1

Men's use of mental health in-person supports versus virtual and AI

"I was living in a smaller outport community. There were no social workers, no mental health doctors. You simply didn't do it. How could you? Now there are other options... online. You don't even have to go to the doctor anymore. But you don't always do it."

DANIEL, 45-54, NEWFOUNDLAND AND LABRADOR

Virtual mental health services are an important access point for younger and underserved Canadians. Use is higher among Canadians under 55 (46%–57%) than those 55 and older (30%–34%), and particularly high among self-identified racialized Canadians (66%), 2SLGBTQIA+ communities (55%), and newcomers (52%).[8]

Artificial intelligence (AI) use for mental health support is also emerging among younger Canadians, reaching 29% among men aged 25–34.[8] These trends highlight the potential of digital services to expand access and engage men less likely to use traditional in-person supports, complementing existing pathways rather than substituting for them.

Term	Definition
Newcomer	An individual who has recently arrived in the country. This includes permanent residents, protected persons and refugees, temporary foreign workers, international students and recent citizens.
Racialized	Persons, other than Indigenous peoples, who are non-Caucasian in race or non-white in colour.
2SLGBTQIA+	This acronym represents Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and additional people who identify as part of sexual and gender diverse communities.

FIGURE 2. FORMAT OF MENTAL HEALTH SERVICES USED, IN PERSON VERSUS VIRTUAL, PAST 12 MONTHS, BY DEMOGRAPHIC GROUP. SOURCE: MHRC NATIONAL POLLING, POLL 27 (FEBRUARY 2026)[8]

	Poll 27	Age 16-24		Age 25-34		Age 35-54		Age 55+	
	TOTAL	Men	Women	Men	Women	Men	Women	Men	Women
IN-PERSON SUPPORTS ONLY	54%	51%	53%	48%	46%	55%	42%	70%	66%
VIRTUAL SUPPORTS (alone or with In-Person Supports)	45%	48%	47%	52%	54%	46%	57%	30%	34%

	Poll 27	2SLGBTQIA+		Time in Canada			Racialized Canadians	
	TOTAL	Yes	No	Born in Canada	5 years or less	6+ yrs	Yes	No
IN-PERSON SUPPORTS ONLY	54%	45%	56%	57%	48%*	56%	34%	58%
VIRTUAL SUPPORTS (alone or with In-Person Supports)	45%	55%	44%	43%	52%*	44%	66%	42%

B23Ap27. Were the mental health services you used provided in person or virtually? Virtual services refer to services where a licensed mental health professional provided care using technology (for example, by video, phone, secure messaging, through an app etc.), rather than meeting face-to-face.

Base: IF HAVE USED MENTAL HEALTH SERVICES B15=CODE 1, 3-5 (n=1,103).

☐ Significantly higher than other subgroup

* CAUTION SMALL BASE

FIGURE 3. USE OF AI TOOLS FOR MENTAL HEALTH SUPPORT, PAST 12 MONTHS, BY DEMOGRAPHIC GROUP. SOURCE: MHRC NATIONAL POLLING, POLL 27 (FEBRUARY 2026)[8]

	Poll 27	Age 16-24		Age 25-34		Age 35-54		Age 55+	
	TOTAL	Men	Women	Men	Women	Men	Women	Men	Women
AI SUPPORTS	14%	25%	26%	29%	21%	14%	19%	3%	4%

	Poll 27	2SLGBTQIA+		Time in Canada			Racialized Canadians	
	TOTAL	Yes	No	Born in Canada	5 years or less	6+ yrs	Yes	No
AI SUPPORTS	14%	20%	13%	12%	28%	20%	23%	12%

G17. In the past 12 months, have you used any AI (artificial intelligence) tools to get advice or support for your mental health? Examples include: a chatbot that converses with you about your mood, a mood tracker that gives automated feedback, a virtual assistant offering personalized advice or exercises. Base: Total (n=3,519); Poll 25 (n=4,666).

☐ Significantly higher than other subgroup

* CAUTION SMALL BASE

SECTION 05

Where the System Loses Men

The national data points to a system that struggles to retain men in care, not only to reach them. **The challenge is not only getting men through the door. It is making services relevant and responsive enough to keep them there.** If we are to see meaningful improvements in men's mental health and wellbeing, the system must address these barriers and provide care and supports that better reflect how men experience, access, and engage with mental health and addiction services.[1]

SECTION 05 — 1

How men seek support

Research shows that women are more likely than men to seek support from healthcare professionals (21% versus 15% of men).[9] Help-seeking behaviours also vary across demographic groups. For example, young men who are racialized are less likely to turn to family or friends for support (54% compared with 68% of non-racialized young men) and are nearly twice as likely to not speak to anyone about their mental health (29% versus 15%).[1] In addition, 27% of young men report that they prefer interventions such as coaching, skill building or problem solving as alternatives to one-on-one therapy.[9]

These findings point to two important system challenges. First, services and the settings around them rarely counter stigma or the narrow ideas about how men should cope, so distress often goes unaddressed until it becomes more severe. Second, demographic factors such as race and ethnicity influence how, when, and whether men seek support, underscoring the need for culturally and gender-responsive approaches to care. Addressing these barriers is critical to improving engagement, reducing premature disengagement from services, and ensuring men receive the support they need.

FIGURE 4. FACTORS LEADING TO EARLY END OF CARE[9]

	Poll 27	Age 16-29		Age 30-54		Age 55+	
	TOTAL	Men	Women	Men	Women	Men	Women
Didn't see real-world progress or improvements	15%	15%	14%	18%	15%	13%	15%
Unclear goals or didn't know what to expect from care	13%	18%	14%	19%	12%	10%	10%
Not understood, respected, able to be honest	11%	10%	15%	12%	15%	6%	12%
Did not trust the approach or guidance provided	10%	11%	14%	8%	9%	2%	11%
Sessions were inflexible or scheduling was difficult	9%	13%	13%	13%	9%	2%	5%
No regular check-ins or unclear who to contact	9%	5%	7%	14%	12%	2%	8%
Lacked practical tools, strategies, or ways to track	6%	8%	12%	6%	10%	9%	10%
Had little choice or control over decisions about care	6%	20%	6%	9%	7%	6%	4%
Other	6%	6%	6%	8%	11%	7%	7%
No plan for setbacks or challenges	6%	5%	7%	8%	6%	7%	4%
NA – Care lasted as long as I planned or needed it	51%	41%	43%	39%	51%	64%	63%

B4p27. During your care journey, did you experience any of the following that led you to end care earlier than planned or needed? Select all that apply. Base: accessed mental health services ever.

☐ Significantly higher than other subgroup

* CAUTION SMALL BASE

What happens in the encounter

The evidence also shows that many barriers extend beyond help-seeking and reflect shortcomings within the healthcare system itself. More than half (54%) of men who sought care reported barriers to receiving effective care, including rushed appointments, difficulty communicating their symptoms, feeling dismissed by providers, and a lack of empathetic interactions.[3] These experiences influence future engagement with care: 67% of men who were satisfied with their first healthcare encounter reported they would seek help again, compared with just 26% of those who were dissatisfied. Two in five men (42%) report having experienced a practitioner displaying bias toward them as a man, rising to 58% of First Nations men and 52% of men aged 18 to 34.[3]

International research locates much of this inside the encounter itself, not in the man who initiates it. Studies of doctor and patient interactions find that clinicians often read men's restraint as resilience and, alongside male patients, can jointly play down symptoms because both expect men to tough it out.[10,11] A text analysis of 1.8 million critical care records found that men received systematically less thorough emotional inquiry than women.[12] The effect concentrates where it matters most: mental health practitioners are less willing to treat and refer male patients presenting with suicidality than female patients, with the practitioner's own sense of competence the strongest predictor of that decision.[13]

"Initially, when I was having a crisis, it was surprisingly easier than I thought, but my situation was pretty terrible. I was able to find a doctor who could take me on at that moment and get supports that way. But before then, before I was in crisis, it was hard to be seen or to have anyone take it seriously."

PETER, 35-44, MANITOBA

"Communication is important and I feel that questions regarding your full health concerns and lifestyle are more important than just asking about the immediate concern or issue…I have never had a doctor or healthcare practitioner ask about my mental health."

OLIVER, 35–44, FIRST NATIONS, ONTARIO

SECTION 05 — 3

Why men disengage

Men may be less likely to have consistent relationships with family physicians[14] and may present with physical or behavioural concerns rather than explicitly emotional symptoms,[15,16] increasing the risk that underlying distress is not identified or addressed. Externalizing symptoms such as irritability, risk-taking, substance use or aggression may not fit neatly within dominant therapeutic framings of depression and anxiety, reducing perceived relevance or therapeutic alliance.

Even when men are referred to psychological therapies, they may disengage prematurely[17,18] due to poor connection with the therapist, perceived lack of progress and feeling emasculated by the therapy process. These patterns occur within a broader context of documented barriers to men's healthcare access, including stoicism and self-reliance norms, stigma, poor health literacy, long waiting times, limited-service flexibility, practitioner communication challenges, costs, and culturally unresponsive care.[19]

When early help-seeking attempts are experienced as ineffective, inaccessible or poorly matched, men may withdraw from services altogether. Distress can then escalate untreated, ultimately resulting in presentation to emergency departments at the point of acute distress. Emergency-led care may reflect not reluctance alone, but a mismatch between how services are designed and how men express distress and seek help, a pattern the Ontario analyses in section 7 examine directly.

MASCULINE SOCIALIZATION AND WHAT HAPPENS IN THE ROOM

Masculine socialization shapes both sides of the consultation. Norms such as stoicism, self-reliance and emotional restraint, along with life-stage transitions, influence when men engage with care and how distress surfaces when they do — often somatically, or through externalizing and behavioural signs that don't match the diagnostic prototypes practitioners are trained to recognize. Practitioners' own gender socialization matters too, shaping the encounter as much as anything the patient brings. Where a man's restraint is read as coping, the encounter can quietly confirm his expectation that this is not a place for him. The response is not to correct masculinity but to work with it, engaging men through masculine identity rather than against it — the approach behind gender-responsive practitioner training discussed in Section 8.

SECTION 06

Priority Areas

NOT EVERY GAP IS EQUALLY URGENT. THREE AREAS STAND OUT IN THE NATIONAL DATA, BOTH FOR THE SCALE OF UNMET NEED AND FOR HOW DIRECTLY POLICY COULD ACT ON THEM.

SECTION 06 — 1

Young men

Young men are the clearest priority for service redesign. Men aged 16 to 34 report elevated rates of suicidal ideation, substance dependency, and social isolation.[5] Improving outcomes for young men requires more than increasing access. Services must be gender-responsive, culturally safe, identity-affirming, and designed around the diverse needs and experiences of young men. Given the effectiveness of early intervention in mental health, failure to do so is a critical opportunity foregone**.**

Young men face greater barriers to accessing and staying engaged in mental health care.

- 8% of Canadians aged 16–34 report needing mental health support but not accessing it, compared with 5% of those aged 35–54 and 2% of those 55+.[5]

- 1 in 3 (33%) young men feel mental health support is still framed around weakness rather than being designed with their needs in mind.[1]

Barriers are greater for some groups of young men:

- Indigenous young men: face limited access to culturally safe services, distrust of mainstream systems, and higher substance use.

- 2SLGBTQIA+ youth: are twice as likely to seek support, but also twice as likely to report needing help but not accessing it.

- Racialized young men: are less likely to seek support from family or friends (54% vs. 68%) and nearly twice as likely to speak to no one about their mental health (29% vs. 15%).[1]

These barriers are not abstract. They show up in how young men talk about health long before they reach a service.

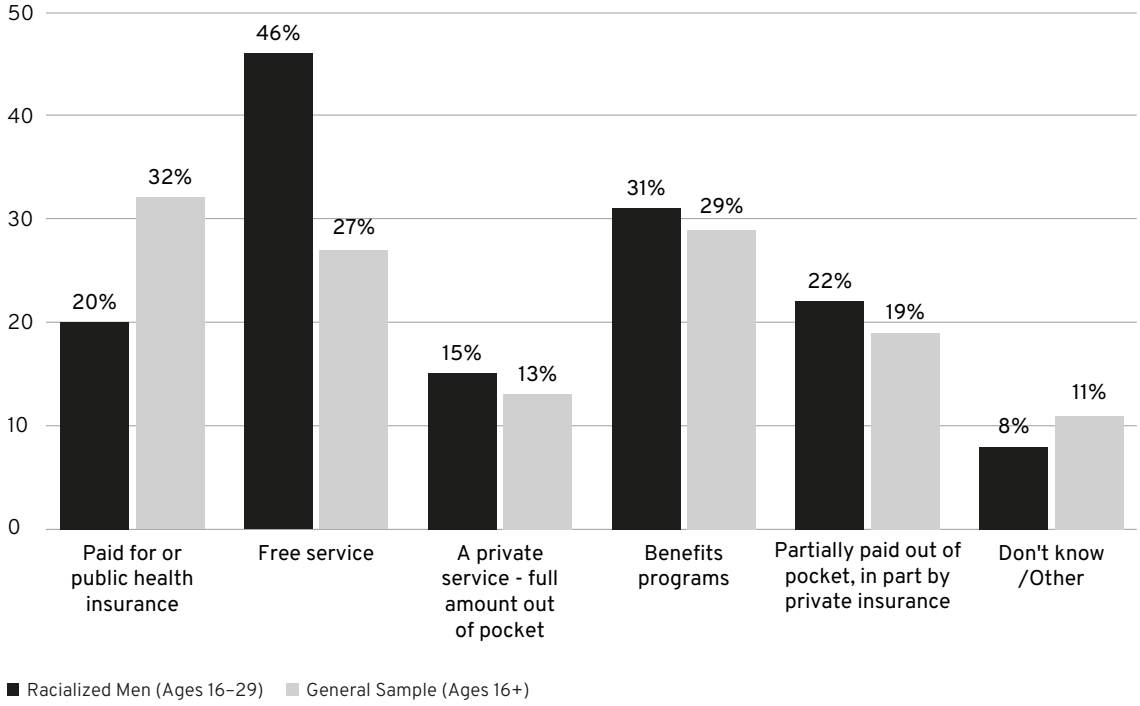
"My male friends will generally be less likely to go seek medical attention if it's not life threatening. Tough it out mentality is a thing even in people who do not try to be super masculine." Owen, 18–24, British Columbia[3]

What follows a first attempt matters just as much.

"The healthcare provider seemed preoccupied and barely made eye contact. My concerns were dismissed quickly, and I left the appointment feeling unheard and frustrated. It was a disheartening experience, making me wary of future healthcare visits." Benjamin, 18–24, Quebec[3]

Nearly half of young men who reach care leave before their needs are met. The encounter above is one reason why.[3]

FIGURE 5. SOURCES OF MENTAL HEALTH SUPPORT FOR RACIALIZED MEN[20]



Racialized men (ages 16–29) n = 153. Overall sample (ages 16+) n = 7,479.

SECTION 06 — 2

Substance use and behavioural addictions

Recognizing how substance use and behavioural addictions (e.g., gambling) intersect is essential for designing responsive men's health services. Figure 6 illustrates that men consume more alcohol and cannabis than other genders, and problem gambling is concentrated among younger men. The implication is direct: care models need to address mental health, problematic substance use, and gambling together for high-risk groups such as young men, rather than treating them as separate presentations.

Cost shapes what treatment is available once a problem is identified. Families carry that cost directly. Movember's survey of Canadian caregivers, most of whom are women supporting a man in their life, captures what that means in practice.

FIGURE 6. DEMOGRAPHIC GROUPS MOST LIKELY TO REPORT PROBLEM GAMBLING AND ASSOCIATED MENTAL HEALTH OUTCOMES (N = 8,803). MHRC – HIGH STAKES: A MENTAL HEALTH PERSPECTIVE ON GAMBLING IN CANADA (2025)[21]

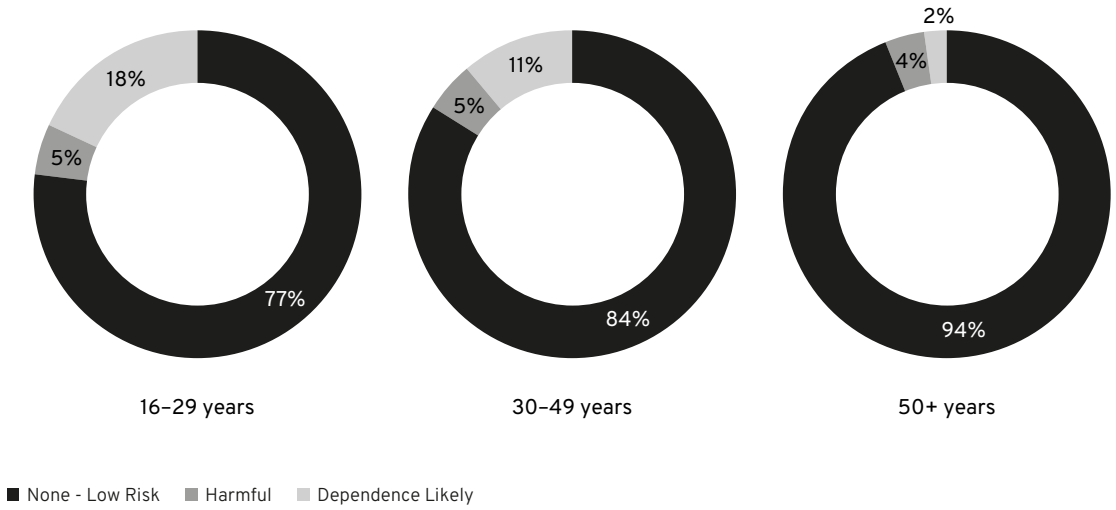
"It makes me angry because the help he needs is too difficult for the average person to receive. There is an opiate crisis in this country and the medication to recover is outside of our financial reach. We've been accumulating a large amount of debt to try and keep up with the cost of medication as it is not covered by private, provincial or federal health benefits."

SOPHIE, 35–44, NEWFOUNDLAND AND LABRADOR[3]

QUOTE FROM MOVEMBER INSTITUTE SURVEY OF 1,366 CANADIAN CAREGIVERS CONDUCTED IN JANUARY AND FEBRUARY 2025 AND REPORTED IN THE REAL FACE OF MEN'S HEALTH.[3]

FIGURE 7. CANNABIS CONSUMPTION (MEN)[20]

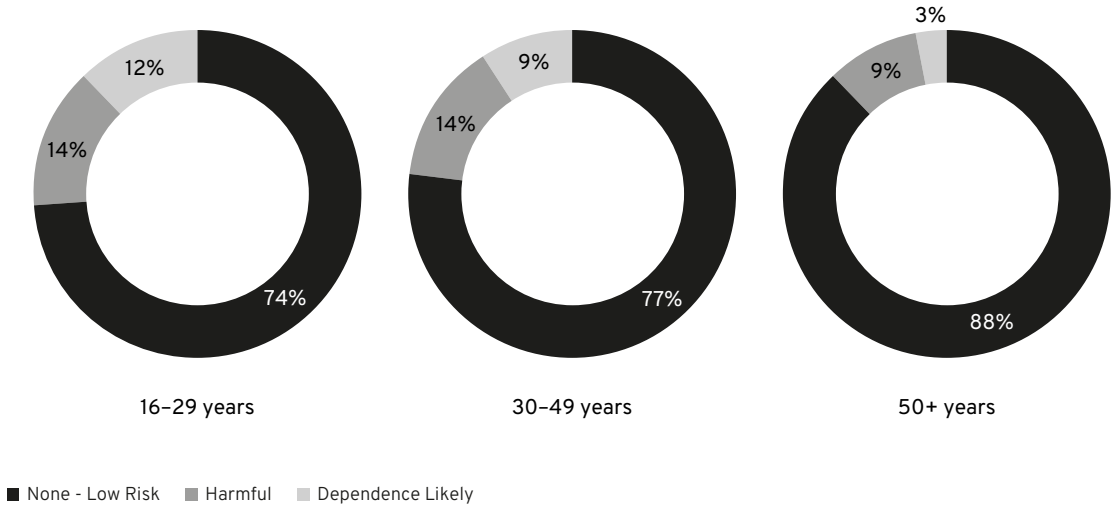
Share of male respondents reporting harmful cannabis use by age group based on self reported CUDIT-R scores



n = 13,642, Polls 13–28 (July 2022 – May 2026).

FIGURE 8. ALCOHOL CONSUMPTION BY AGE GROUP, POLLS 13 TO 28 (JULY 2022 TO MAY 2026)

Share of male respondents reporting harmful alcohol use by age group based on self reported AUDIT scores



n = 13,642, Polls 13–28 (July 2022 – May 2026).
MHRC Polls 13 to 28 (July 2022 to May 2026). Filtered by Men and Age groups (Homepage tab, “Signs of Alcohol Dependency”).

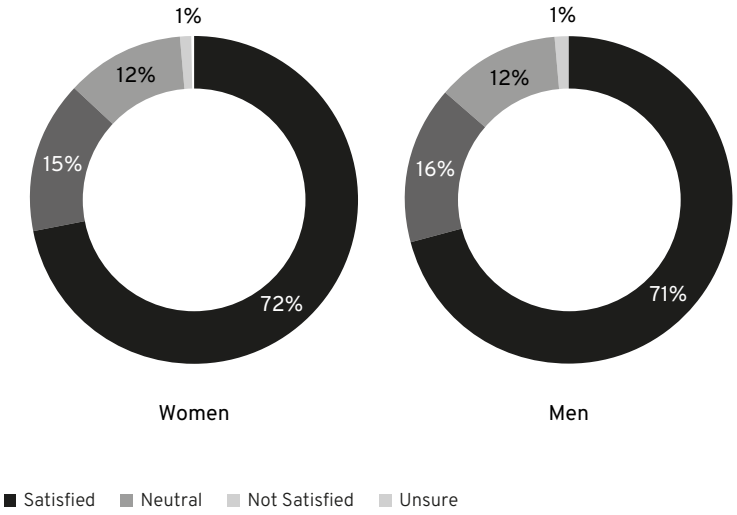
SECTION 06 — 3

Unmet need and satisfaction with care

Among men who accessed services, 70% reported being satisfied with the care they received. Satisfaction tracked income closely: 77% of people earning more than $100,000 were satisfied, compared with only 62% among those earning less than $30,000.[22] This income difference is important when considering men, who may face greater barriers to accessing care and may be more likely to experience problematic substance use. The findings suggest that men's satisfaction with care should not be viewed in isolation from their ability to access timely, affordable and appropriate services.

Those with greater financial resources may have more opportunities to access private or community-based supports (associated with higher satisfaction), while lower-income men may be more reliant on public or free services, where satisfaction is lower. This points to the need for more accessible, affordable and responsive services that can engage men across income levels, particularly those experiencing more severe or complex mental health and substance use needs.

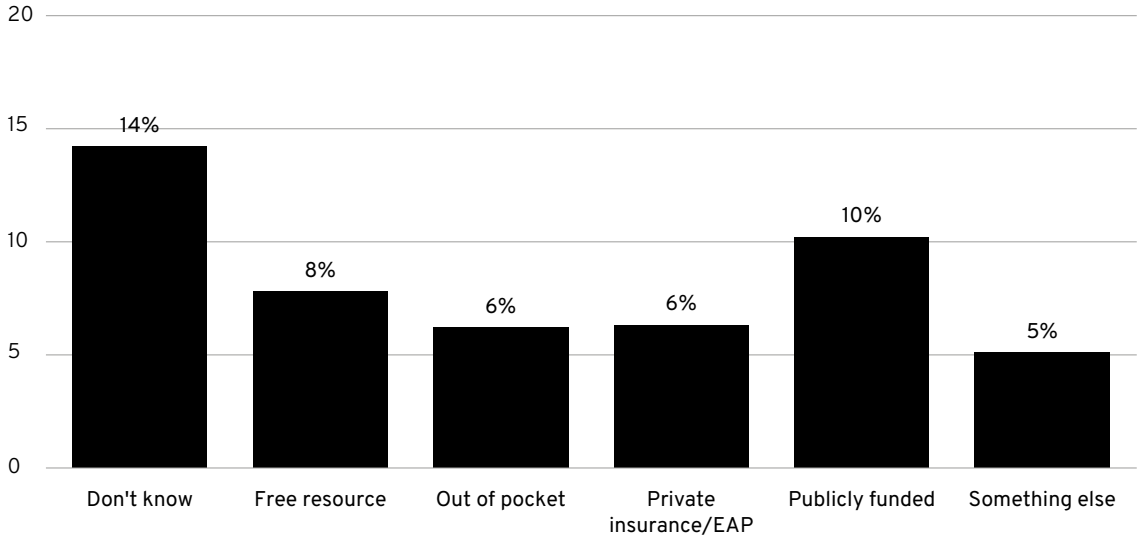
FIGURE 9. SATISFACTION WITH SERVICE BY GENDER, POLLS 13 TO 28 (JULY 2022 TO MAY 2026)[5]



n = 5,960 (2,019 men, 3,941 women), Polls 13–28 (July 2022 – May 2026).

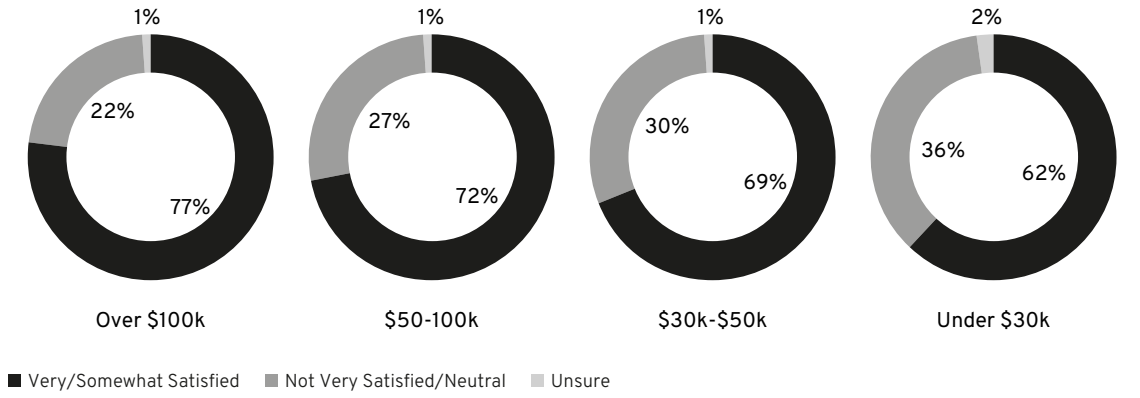
Interpretation: Within each gender, there is almost no difference in satisfaction of care between men and women.

FIGURE 10. MEN'S UNMET NEEDS BY FUNDING TYPE[20]



n = 5,496, Participant Unmet Need by Funding Type (only men). MHRC Poll 13–28 (May 2026).

FIGURE 11. SATISFACTION WITH SERVICE BY INCOME GROUP[22]



n = 2,680, MHRC Polls 13–21 (July 2022 – July 2024).

The highest percentage indicating satisfaction are those in the highest income group (annual income over than $100,000) at 77%. Those in the lowest income group, earning less than $30,000 per year, experience the lowest level of satisfaction with care, 62%. As seen in the figure below, as income group increases, so does satisfaction with support received. This suggests that individuals with higher incomes are more likely to be satisfied with the care and services they access.

What men report about access and satisfaction sets up a harder question that linked service data can answer: once a man's mental health problem is on the record, does the system actually reach him? Ontario's administrative data lets us follow that through.

SECTION 07

The Ontario Case Study: Key Findings

Ontario's linked administrative data lets us observe men as they access the health system and, for men with an identified problem, examine whether they reached care to address it. The findings of this analysis describe a system that is passive in nature and engages men late, through its most acute doors, and least well where need is highest. While these findings are specific to Ontario, they point to questions that health systems across Canada should be asking about how men access, experience and remain engaged in care. Ontario provides a case study of what becomes visible when health-system data is examined through a gender-responsive lens, and an opportunity for other jurisdictions to examine whether similar patterns exist in their own systems.

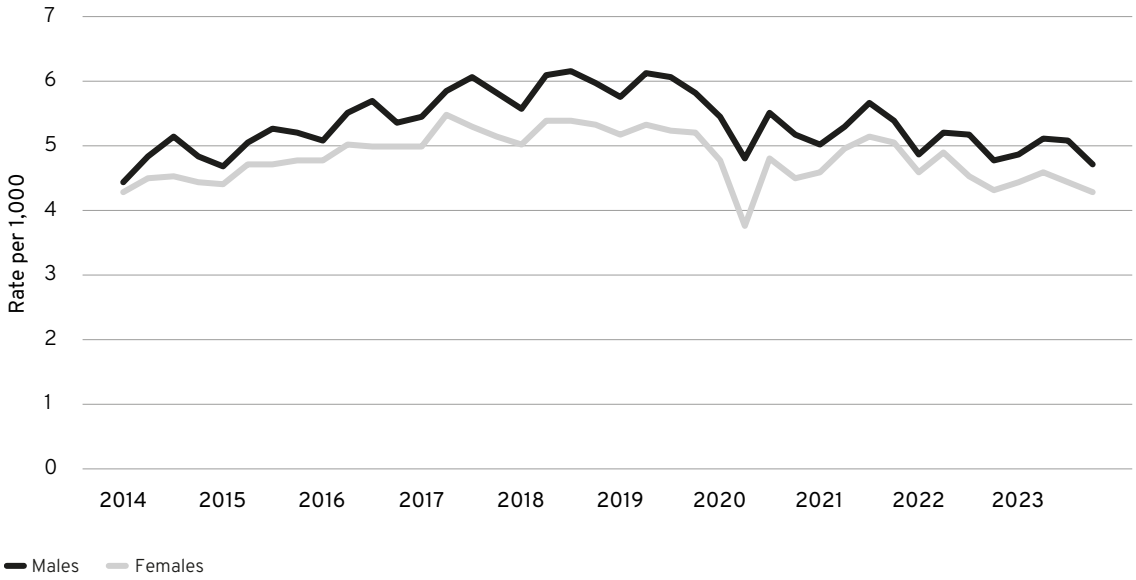
SECTION 07 — 1

Acute and emergency-led patterns of care

Males had higher MHA-related ED visit rates than females throughout 2014–2023, except for self-harm. In Q1 2019, before the pandemic disrupted service use patterns, males visited EDs for MHA reasons at a rate of 5.76 per 1,000 compared with 5.16 per 1,000 for females, approximately 12% higher. By Q1 2023, rates had declined for both sexes but the gap persisted, with males at 4.86 per 1,000 compared with 4.42 per 1,000 for females, approximately 10% higher (Figure 12).

Males were consistently more likely to use the ED as their first point of contact for a MHA problem throughout the observation period, and while this declined over time for both sexes, the gap remained: 28.5% of males in Q1 2014 compared with 25.0% of females, and 25.6% of males in Q1 2023 compared with 22.4% of females. Males also had higher 30-day ED re-visit rates than females across the entire period.

FIGURE 12. QUARTERLY RATES OF MHA-RELATED ED VISITS IN ONTARIO, 2014 TO 2023, BY SEX



Source: linked administrative health data held at ICES. Males and females aged 12+.

Among Ontarians with an identified or self-reported mental health problem, comprising 27,035 males (weighted n=1,909,180) and 27,237 females (weighted n=1,678,553), males were substantially less likely than females to access any psychiatric service, with only 14.3% of males accessing any service within one year compared to 19.0% of females, a gap that persisted and widened at five years (31.6% vs 41.1%) (Figure 13). Where males did access acute care, rates were lower than for females at both one year (2.3% vs 3.4%) and five years (8.4% vs 10.5%), and ED visits rather than hospitalizations were the main driver for both sexes, with risk of hospitalization low for both males and females across both follow-up periods.

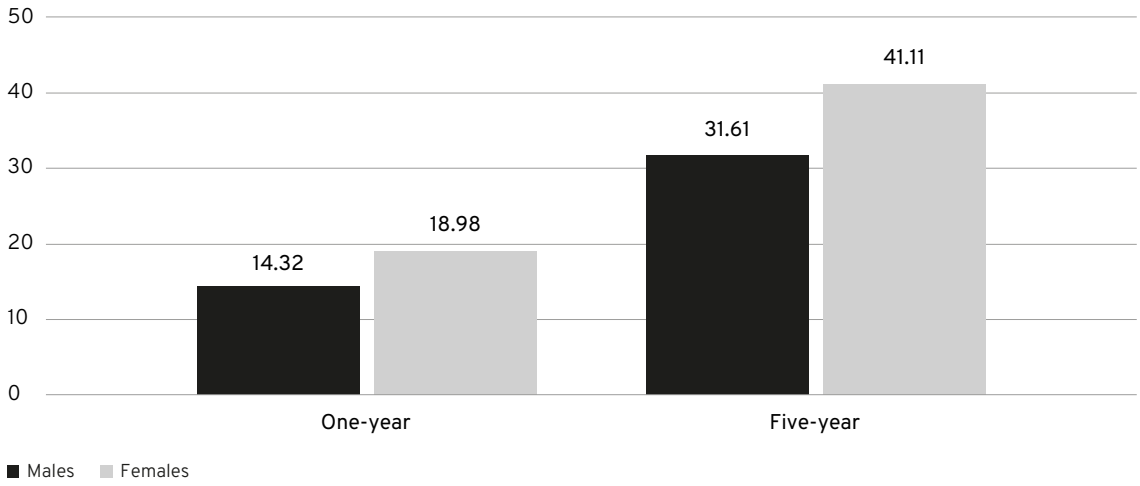
14.3%

of men with an identified mental health problem accessed a psychiatric service within a year

2.3%

of males accessed acute care within a year

FIGURE 13. PROPORTION OF INDIVIDUALS WITH A MENTAL HEALTH PROBLEM ACCESSING ANY PSYCHIATRIC SERVICE, ONE- AND FIVE-YEAR, BY SEX



Source: linked administrative health data held at ICES.
Males n = 27,035 (weighted n = 1,909,180); females n = 27,237 (weighted n = 1,678,553).

The male treatment gap is therefore not a matter of lower need. Even when a mental health problem has been identified, males are less likely to seek and/or receive care. And when they do access services, they are more likely to do so through emergency departments than through planned outpatient care.

THE MEN THE SYSTEM NEVER SEES

More than 85% of Ontario males with an identified mental health problem accessed no publicly funded mental health or addictions service within a year. These men are not waiting for an appointment or lost to follow-up. They are absent from service data altogether, which means reforms that improve care inside services will not reach them. Closing this gap depends on pathways that operate outside clinical settings, and on measuring the men who never arrive as carefully as those who do.

85%

of Ontario males with an identified mental health problem accessed no publicly funded mental health service within a year

SECTION 07 — 2

Males are less likely than females to access care overall

Among Ontarians with a prevalent mental health problem, only 14.3% of males accessed any psychiatric service within one year, compared to 19.0% of females, a gap that persisted and widened at five years (31.6% vs 41.1%). For acute care specifically, one-year access was 2.3% for males compared to 3.4% for females, rising to 8.4% vs 10.5% at five years. For outpatient care, one-year access was 13.2% for males compared to 17.2% for females (five-year: 29.1% vs 38.0%), with lower rates for males across both general practitioner (GP) visits (one-year: 10.5% vs 13.1%; five-year: 25.2% vs 32.8%) and psychiatrist visits (one-year: 4.2% vs 6.0%; five-year: 9.4% vs 12.8%).

At the population level, males had outpatient visit rates of 17.68 per 1,000 in Q1 2019, with females consistently higher throughout 2014–2023, and the absolute difference widening notably during 2020 and 2021, when the rise in outpatient visits was largely driven by increased access among females. Males also had consistently lower 7-day outpatient follow-up rates after hospital discharge than females throughout the observation period (28.11% vs 30.82% in Q1 2019).

SECTION 07 — 3

Young adult men are a high-risk group

Males aged 18–44 carry the highest burden of acute service use. At the population level, males aged 18–24 had the highest MHA hospitalization rates (2.62 per 1,000 in Q1 2019) and, alongside those aged 25–44 (2.04 per 1,000), the highest ED visit rates. The highest 30-day ED re-visit rates were concentrated in those aged 25–64, while re-hospitalization rates were highest among those aged 18–24 (15.26%) and 25–44 (14.75%).

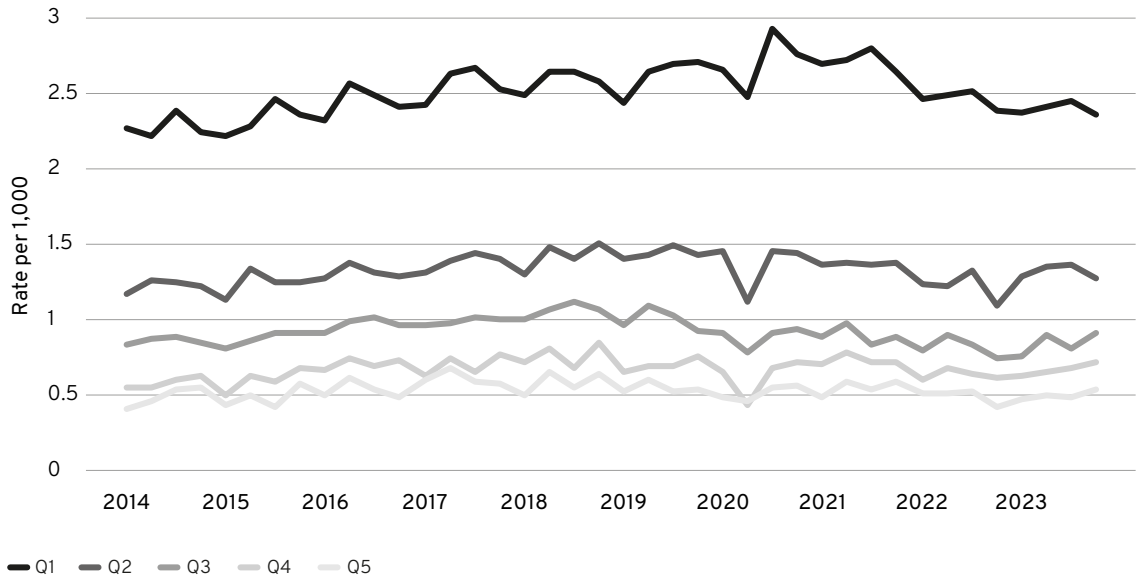
Among males with an identified mental health problem, overall psychiatric service use and GP visits followed a U-shaped pattern by age, highest in male adolescents aged 12–17 (one-year: 28.2%; five-year: 47.5%) and older adults aged 65 and over (one-year: 19.1%; five-year: 39.3%), and lowest among working-age men aged 18–24 (one-year: 10.8%; five-year: 27.2%). ED visits and psychiatrist visits declined with increasing age. The combination of high acute service use at the population level but low overall service engagement among working-age men with identified problems suggests that males aged 18–64 who do reach acute services are not transitioning to sustained MHA outpatient care.

Strong socioeconomic gradient

Across nearly all indicators, rates were highest among males living in the lowest income neighbourhoods. At the population level, a clear inverse income gradient was observed for hospitalizations, ED visits, self-harm presentations, and ED re-visits, with rates decreasing with each successive income quintile. Hospitalization rates among males in the lowest income neighbourhoods were 2.54 per 1,000 in Q1 2019, compared with rates that decreased progressively across each higher income quintile (Figure 14).

Among males with an identified mental health problem, any service use at one year was 18.0% in the lowest income quintile compared with 11.7% in the highest income quintile, a gap that widened at five years (36.6% vs 26.5%). The gradient was steepest for acute care (one-year: 4.0% in Q1 vs 1.7% in Q5; five-year: 12.0% vs 5.3%), reflecting the concentration of acute presentations among the most deprived. GP access followed a similar pattern (one-year: 12.8% Q1 vs 8.5% Q5; five-year: 29.1% vs 20.9%), as did psychiatrist access (one-year: 5.5% Q1 vs 3.3% Q5; five-year: 12.4% vs 8.5%) (Figure 15).

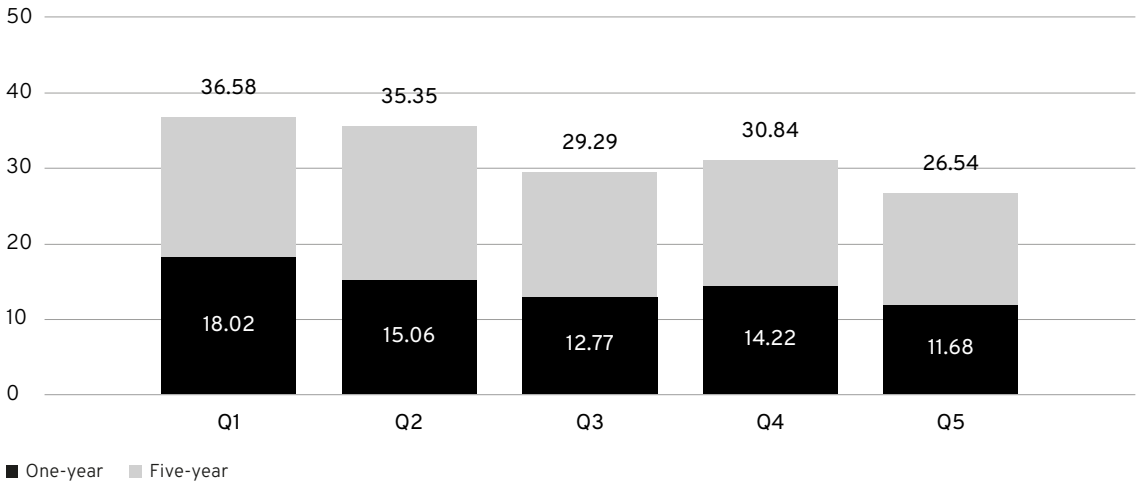
FIGURE 14. QUARTERLY RATES OF MHA-RELATED HOSPITALIZATIONS AMONG MALES IN ONTARIO, 2014 TO 2023, BY NEIGHBOURHOOD INCOME QUINTILES



Q1 = lowest income quintile; Q5 = highest.

Source: linked administrative health data held at ICES.

FIGURE 15. PROPORTION OF MALES WITH A MENTAL HEALTH PROBLEM ACCESSING ANY PSYCHIATRIC SERVICE, ONE- AND FIVE-YEAR, BY NEIGHBOURHOOD INCOME QUINTILE

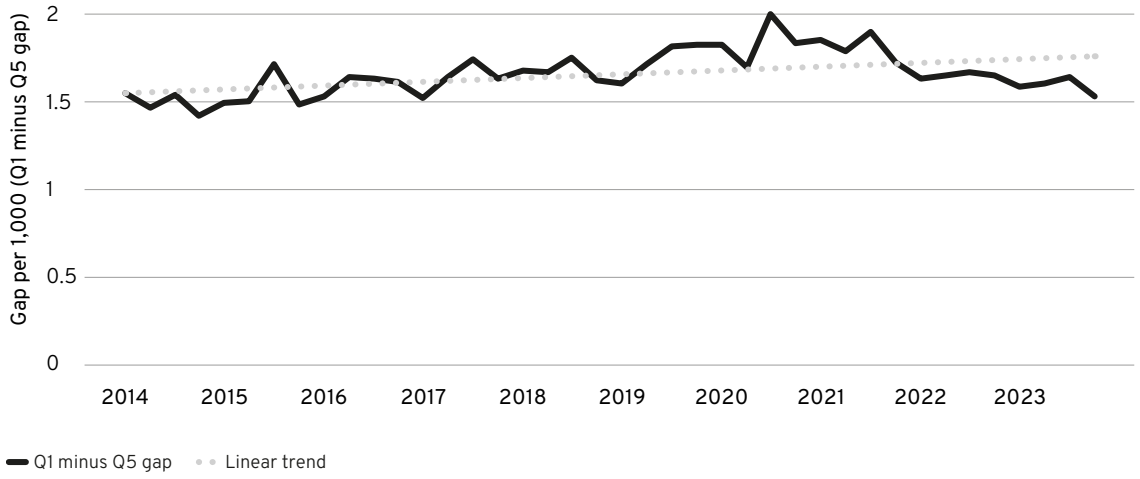


Q1 = lowest income quintile; Q5 = highest.

Source: linked administrative health data held at ICES.

Importantly, the income gap in hospitalization rates at the population level has not narrowed over the decade. The absolute difference between Q1 and Q5 has fluctuated between approximately 1.4 and 2.0 per 1,000 throughout 2014–2023, with a modest upward trend in the most recent years and a notable spike in Q3 2020 as the poorest neighbourhoods bore a disproportionate share of the pandemic-related surge in acute care (Figure 16).

FIGURE 16. ABSOLUTE GAP IN MHA-RELATED HOSPITALIZATION RATES BETWEEN THE POOREST AND LEAST POOR NEIGHBOURHOOD INCOME QUINTILES AMONG MALES IN ONTARIO, 2014 TO 2023



Q1 = lowest income quintile; Q5 = highest.

Source: linked administrative health data held at ICES.

SECTION 07 — 5

Rural and northern inequities

Geography compounds disadvantage, particularly in northern Ontario. At the population level, ED visit rates were highest in the sparsely populated Northwest, followed by the Northeast, while 7-day outpatient follow-up rates were consistently lower in rural and northern regions and highest in Toronto. Among males with an identified mental health problem, overall psychiatric service use was lowest in the Northwest (one-year: 10.8%; five-year: 25.2%), compared with Toronto which had the highest rates (one-year: 17.0%; five-year: 35.8%). This was driven almost entirely by lower outpatient access in the Northwest (one-year: 7.4%; five-year: 21.2%) compared with Toronto (one-year: 16.1%; five-year: 32.0%), and particularly lower psychiatrist access (one-year: 0.8% Northwest vs 5.8% Toronto; five-year: 3.8% vs 13.5%). Conversely, males in the Northwest and Northeast were more likely to access acute care than those in southern regions: one-year acute care rates were 4.0% in the Northwest and 2.6% in the Northeast, compared with 1.9% in Central Ontario, suggesting that in the absence of accessible outpatient services, men in northern regions are reaching the point of acute distress before receiving care.

The pattern is not confined to Ontario. In the most remote communities the gap is not only in specialist access but in whether anything exists for men at all.

A 0.8% CHANCE OF SEEING A PSYCHIATRIST

Among males in northwest Ontario with an identified mental health problem, 0.8% saw a psychiatrist within a year, against 5.8% in Toronto. At five years the figures were 3.8% and 13.5%. Northern men were correspondingly more likely to reach acute care: one-year acute care rates were 4.0% in the Northwest and 2.6% in the Northeast, against 1.9% in Central Ontario. Where outpatient care is hard to reach, the emergency department becomes the default.

0.8%

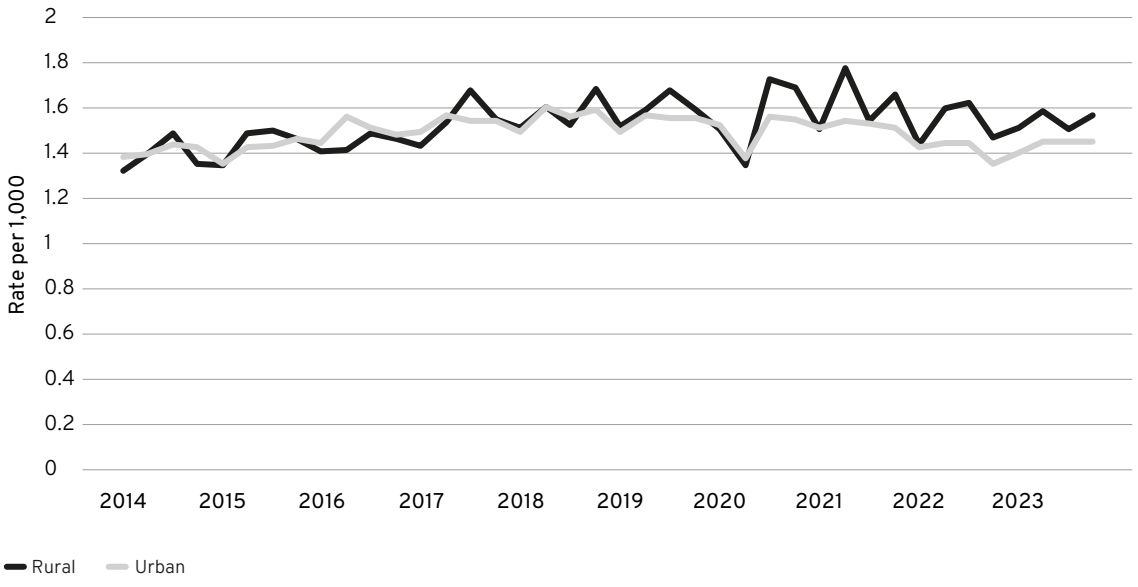
of Ontario males with an identified mental health problem saw a psychiatrist within a year

Rural males also had lower overall outpatient access than urban males (one-year: 9.6% vs 13.8%; five-year: 23.1% vs 30.0%), and substantially lower psychiatrist access in particular (one-year: 1.6% rural vs 4.6% urban; five-year: 4.7% vs 10.2%). Population-level hospitalization rates in rural areas remained elevated relative to urban areas after the pandemic, even as urban rates declined (Figure 17).

"There are a lot of women programs, a lot. We're good. There are sewing groups, and cooking groups, and pregnancy groups, AA [Alcoholics Anonymous] groups, NA [Narcotics Anonymous] groups, whatever. But not for the men. There is literally nothing available for men. They are just left to try and deal with it themselves."

SARAH, 40, INUIT HEALTH AND WELLNESS WORKER, NUNAVIK[3]

FIGURE 17. QUARTERLY RATES OF MHA-RELATED ED VISITS AMONG MALES IN ONTARIO, 2014 TO 2023, BY RURALITY



Source: linked administrative health data held at ICES.

Outpatient care patterns and the COVID-19 shift

Outpatient MHA visits rose sharply during the COVID-19 pandemic (2020–2022), coinciding with a rapid shift to virtual care, before declining into a blended model. The absolute gap between male and female outpatient rates widened during this period, suggesting females accessed expanded virtual care at higher rates than males. Among males at the population level, outpatient visits were highest in those aged 25–44 (17.68 per 100 in Q1 2019), followed by those aged 45–64 (14.01 per 100), 18–24 (13.13 per 100), 12–17 (10.20 per 100), and 65 and over (7.49 per 100). Among males with an identified mental health problem, outpatient use was lower than for females both for GPs (one-year: 10.5% vs 13.1%; five-year: 25.2% vs 32.8%) and psychiatrists (one-year: 4.2% vs 6.0%; five-year: 9.4% vs 12.8%), consistent with the population-level finding that the outpatient gap is not explained by differences in identified need.

SECTION 08

Recommendations

Building a system that reaches, responds to, and retains men

Improving men's mental health and substance use outcomes will require action across jurisdictions, with different levels of government bringing different levers to the challenge. Provinces and territories have a direct opportunity to strengthen how health systems reach, respond to, and retain men in care, while the federal government can support this work through national leadership, stronger data and evidence, shared learning, and the development of Canada's first Men and Boys' Health Strategy.

The Ontario findings in this report provide a case study of what becomes visible when men's pathways through the health system are examined in detail. They offer an opportunity for Ontario to act on identified gaps in service delivery, while providing a framework for other provinces and territories to examine whether similar patterns exist in their own systems.

The following recommendations reflect Movember's evidence-based contribution to strengthening mental health and substance use care for men and boys across Canada. They are intended to inform federal, provincial, and territorial action, including the development of Canada's first Men and Boys' Health Strategy, and are not a statement of government policy.

These recommendations are organized around the 5R Framework: Research, Reach, Respond, Retain, Relational. Published in The Lancet Public Health by Professor Paul Galdas (University of York), Associate Professor Zac Seidler (Movember Institute of Men's Health), and Professor John Oliffe (University of British Columbia), it is the first system-level design tool for gender-responsive health systems for men.[23] The framework moves men's health beyond temporary pilots and fragmented programs toward coherent system design, and its five domains map directly onto the challenges documented in this report: men who are invisible in the data, never reached, poorly responded to when they do present, lost to follow-up, and underserved by policy that overlooks the relationships and conditions shaping their lives.

The call to action

For provinces and territories: The evidence from Ontario points to an opportunity to strengthen how health systems serve men across the continuum of mental health and substance use care. Provinces and territories should examine men's pathways through their own health systems and use that evidence to build more gender-responsive services:

- Reaching men before needs escalate to crisis;
- Equipping the health workforce in recognizing and responding to how men present;
- Strengthening pathways from acute to ongoing care; and
- Designing services that keep men engaged.

Ontario has an immediate opportunity to lead this work by acting on the gaps identified in this report.

For the federal government: Canada's first Men and Boys' Health Strategy can help accelerate this work by establishing men's mental health and substance use as a national priority, strengthening the evidence base, supporting shared learning across jurisdictions, and enabling promising approaches to be evaluated and scaled across Canada.

To accelerate this work, Movember invites federal, provincial, and territorial governments to partner with the Movember Institute of Men's Health to better understand, at a population level, how, when, and where men in Canada are using healthcare services.

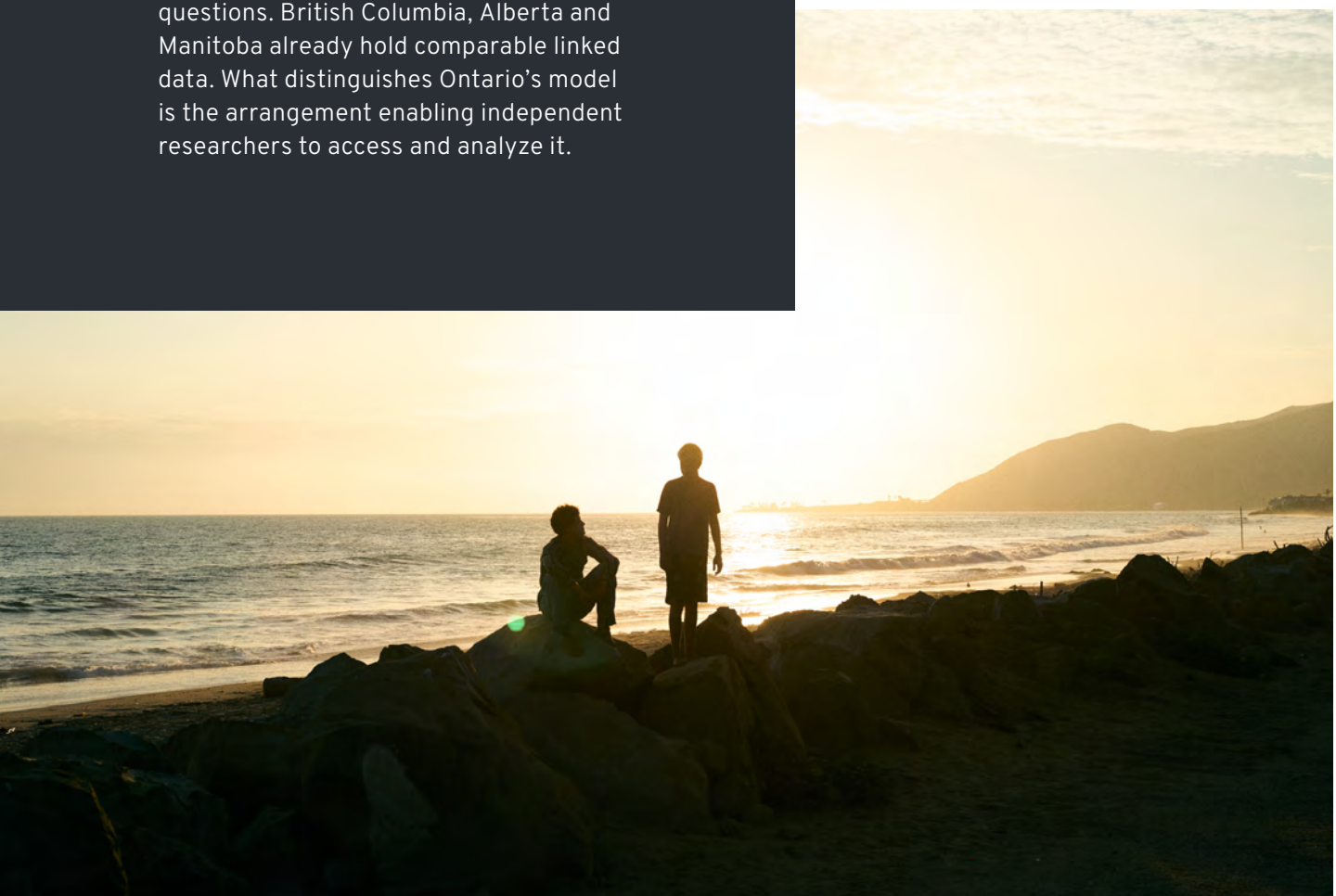
1. Research: make men visible in the data

Without better data, men are invisible in policy. Sex-disaggregated reporting is inconsistent across Canadian jurisdictions, which makes it difficult to know whether investment is reaching men or working for them. Nor is the data we do have designed to follow men over time, so pathways through care can only be inferred from cross-sectional snapshots. Without it, there is no way to tell whether the changes that follow are working. We recommend:

1. Collecting and reporting sex-disaggregated data on emergency department presentations, re-presentations, follow-up rates, and treatment engagement.
2. Publishing this reporting routinely and publicly, disaggregated by age, income, and region, so governments and communities share a common view of progress and gaps.
3. Evaluating the impact of male-responsive interventions on re-attendance, admission, and suicide risk, rather than measuring participation alone.
4. Extending independent research access to linked administrative data beyond Ontario, so men's pathways through care can be examined in other jurisdictions.

WHY THIS ANALYSIS WAS ONLY POSSIBLE IN ONTARIO

This report was only possible because Ontario's linked administrative data held at ICES allowed men's pathways through care to be examined in detail. Most provinces and territories cannot yet answer the same questions. British Columbia, Alberta and Manitoba already hold comparable linked data. What distinguishes Ontario's model is the arrangement enabling independent researchers to access and analyze it.



2. Reach: strengthen non-traditional pathways into care

Reach means meeting men where they are, not where the system expects them to appear. This analysis found that over 85% of males with a mental health problem accessed no publicly funded service within a year. The majority of unmet need is therefore invisible to the health system entirely, and recommendations focused on improving care within services will not touch this group. We recommend:

1. Expanding outreach and pathways into care through workplaces, sports clubs, community organizations, and primary care, rather than relying on men to present to clinical settings.

2. Using evidence-informed public-facing campaigns to normalize help-seeking among men, tailored to masculine norms and framed around strength, agency, and connection, and around what good care can do rather than around vulnerability. These campaigns should provide clear, accessible information about available supports and how to access them.

3. Prioritizing approaches designed with populations where barriers are greatest, including young men aged 16 to 24, men in rural and northern communities, men in the lowest-income neighbourhoods, and Indigenous men.

REACHING MEN OUTSIDE THE CLINIC: WHAT ALREADY WORKS IN CANADA

Reach recommendations often stall on the question of what a non-clinical pathway actually looks like. Canada already has working examples, several with published evaluations behind them.

Buddy Up, from the Centre for Suicide Prevention and delivered through CMHA Alberta, is a peer-based men's suicide prevention campaign co-designed with men and focused on workplaces. It engaged 1,410 workplace champions across 452 organizations in 2024.[3] In a feasibility study of campaign users, 95% of 48 survey respondents felt more confident talking with men about mental health and suicide.[26]

Men's Sheds Canada runs more than 130 sheds across ten provinces. Evaluations report improved self-rated health, reduced social isolation and better mental wellbeing, including for older men in rural communities.[3]

Movember Ahead of the Game delivers mental fitness workshops to young men aged 12 to 18 through community sports clubs, with Australian evaluations showing improved mental health literacy and greater intention to seek and provide help.[27]

These models are established and evaluated. What is missing is sustained funding to scale them and to connect them to clinical pathways.

3. Respond: tailor care to how men present

Men's contact with the health care system is often brief and may not be repeated. What happens in that encounter can determine what follows: 67% of men satisfied with their first healthcare encounter would seek help again, compared with 26% of those who were not. Responding well requires both a workforce equipped to recognize how men may present and the routine application of that expertise at the points where men actually interact with the health system. We recommend:

1. Building a gender-responsive workforce by:
    a. Training clinicians to recognize atypical or externalizing symptoms of mental distress, including irritability, anger, aggression, substance use, risk-taking, and somatic complaints.
    b. Including education on how social norms around masculinity can shape help-seeking, emotional expression, communication, and engagement with care.
    c. Extending this training beyond specialist mental health services

MEN IN MIND: BUILDING A WORKFORCE EQUIPPED TO ENGAGE MEN

Movember's Men in Mind is a world-first, evidence-based online continuing professional development program, developed by the Movember Institute of Men's Health. The eight-hour, self-paced, five-module program is designed for mental health practitioners (i.e., psychologists, psychiatrists, counsellors, mental health nurses, social workers, and peer workers) to equip them to better engage men, recognize the distinct ways distress presents in men, and reduce premature disengagement from care. A randomized wait-list controlled trial found it significantly improves practitioners' confidence and competence when working with male clients.[24] A follow-up study one year on found these gains were sustained, with 78% of practitioners reporting confidence to engage suicidal men — closely comparable to the 77% recorded at three months.[28]

Recognizing that most men never reach a mental health clinic, Movember has extended the program into primary care. Men in Mind for Primary Care offers three short, profession-specific courses for general practitioners, nurses, and pharmacists — the clinicians men are likely to turn to. Each runs around 2.5 hours, is accredited or endorsed by the relevant professional body, and built for the realities of a short consultation. Development and rollout are funded by the Australian Government. Men in Mind is also integrated into the Tasmanian Government's Suicide Prevention Strategy, establishing both the program's efficacy and a viable model for co-funded government partnership.

The same model could be applied in Canada, extending training across provincial and territorial mental health, primary care, and community health workforces.

to the practitioners men are most likely to encounter, including family physicians, nurses, pharmacists, and emergency department staff.

2. Identifying, disseminating, and scaling evidence-based programs that have demonstrated improvements in practitioner confidence and competence, rather than developing new training from scratch.

3. Building gender-responsive practice into key points of contact, using opportunistic screening when men present with injury, particularly assault- or alcohol-related injury, recurrent emergency department attendance, self-harm, or other high-risk behaviours, and incorporating brief, validated tools designed for men, such as the 7-item Male Depression Risk Scale.

4. Screening for mental health and substance use together. Young men are three to four times more likely than older Canadians to cope with mental health challenges through problematic substance use; treating these as separate presentations risks missing men who present with one while experiencing both.

4. Retain: design care that keeps men engaged

Many services get men through the door and then lose them to follow-up. Retention fails when engagement is treated as one-time compliance rather than a relationship the service is responsible for sustaining. The Real Face of Men's Health found that more than half of men have wanted to leave, or have left, a healthcare practitioner because of a lack of personal connection, and that a substantial share of those men stopped going back altogether rather than switching to someone else.[3] In Ontario, men are less likely than women to receive outpatient follow-up within seven days of hospital discharge, and nationally, 49% of young men left care before their needs were met. We recommend:

1. Making care easier to stay in by offering flexible formats, including virtual, evening, and drop-in care, to accommodate working-age men and reduce practical barriers to continued engagement.

2. Actively preventing disengagement by providing proactive outreach when men miss follow-up appointments, rather than relying on them to independently re-engage with services, and by building in peer support, coaching, and structured follow-up, which can improve men's adherence to treatment and satisfaction with care.

3. Strengthening transitions from acute to ongoing care by establishing clear follow-up pathways after acute contact. Ontario data shows that men who reach emergency departments are not consistently moving into sustained outpatient care, making the transition from acute to planned care a critical point for intervention.

5. Relational: design equity-driven policy around men's lives

Men's ability to access and remain engaged in appropriate care is shaped by social, geographic, cultural, and economic conditions. Where a man lives, what he earns, and who is around him do more to determine his pathway through care than any clinical decision made once he arrives. We recommend:

1. Strengthening access to appropriate services in rural, northern, and socioeconomically deprived communities, where men may rely more heavily on emergency care.

2. Supporting community-based and non-clinical entry points, including primary care, workplaces, and community organizations, that can connect men with appropriate services.

3. Resourcing Indigenous-led services and culturally safe care developed and delivered by Indigenous governments and organizations.

4. Strengthening coordination between mental health and substance use services and other systems that can affect men's health and engagement in care, including housing, employment, justice, and education.

5. Recognizing partners, children, friends, workmates, and other relationships around men as potential routes into support and important considerations in the design of care.

SECTION 09

Conclusion

Men in Canada are not absent from the mental health and substance use system by choice. They are absent because too little of it has been built with them in mind. Some 1.3 million men have unmet needs for support. More than half of those who sought care report barriers to receiving effective care. And whether a man returns after his first encounter depends heavily on how that encounter goes: 67% of those satisfied with it would seek help again, against 26% of those who were not.

Ontario's linked administrative data shows what these challenges can look like from inside a health system. Even among men already identified as having a mental health problem, most access no publicly funded service within a year, and those who do reach care are more likely to arrive through an emergency department than a planned appointment. This burden is also not evenly shared. Young men, men in low-income neighbourhoods, men in rural and northern communities, and Indigenous men face the steepest barriers. The income gap in acute service use has not narrowed in a decade. The outpatient gap widened during the pandemic.

None of these patterns is fixed. These patterns reflect service designs, clinical and system structures, all of which can be changed. Ontario has an immediate opportunity to act on the gaps identified in this report, while other provinces and territories can examine men's pathways through their own health systems and identify where similar gaps exist. The opportunity is to build gender-responsive care into existing health systems rather than create new ones. That means making men visible in the data, strengthening the pathways that bring them into care, and equipping the workforce to recognize and respond to how men present. It also means improving transitions and follow-up, and designing services that keep men engaged once they arrive. And the benefits do not stop with men. When men's needs go unmet, the strain falls on the partners, families and caregivers around them — most of them women.

Canada's first Men and Boys' Health Strategy creates a complementary national opportunity to accelerate this work. Federal leadership can strengthen the evidence base, support shared learning across jurisdictions, help identify and scale promising approaches, and maintain a sustained national focus on improving health outcomes for men and boys. Together, action within provincial and territorial health systems and national leadership can move gender-responsive care from isolated programs and promising practice toward lasting health-system change.

Men are showing up. The system needs to be built to meet them.

Glossary of acronyms and abbreviations

Acronyms are spelled out at first use in the text. They are collected here for reference.

Acronym	Definition
2SLGBTQIA+	Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and additional people who identify as part of sexual and gender diverse communities.
5R Framework	A system-level design tool for gender-responsive health systems, structured around five domains: Research, Reach, Respond, Retain, and Relational.
AI	Artificial intelligence.
CAMH	Centre for Addiction and Mental Health.
CCHS	Canadian Community Health Survey.
CIHI	Canadian Institute for Health Information.
ED	Emergency department.
GP	General practitioner.
ICES	The legal name of the independent, non-profit research institute that holds Ontario health data in trust, formerly the Institute for Clinical Evaluative Sciences.
MHA	Mental health and addictions. Used throughout the Ontario analysis to describe services, hospitalizations and emergency department visits relating to mental health or substance use.
MHRC	Mental Health Research Canada.
MLTC	Ontario Ministry of Long-Term Care.
MOH	Ontario Ministry of Health.
OHIP	Ontario Health Insurance Plan.
PHIPA	Personal Health Information Protection Act (Ontario).
Q1 to Q5	Neighbourhood income quintiles, from Q1 (lowest income) to Q5 (highest income). Where Q1 to Q4 appear alongside a year, for example Q1 2019, they denote calendar quarters.

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