



The Real Face of Men's Health

2026 CALIFORNIA REPORT



MOVEMBER® INSTITUTE
OF MEN'S HEALTH
MUSTACHES LOVE RESEARCH



About Movember

A little over 20 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, sparked billions of important conversations, raised vital funds, and shattered the silence surrounding men's health issues.

Since 2003, we have challenged the status quo, supported men's health research, and transformed the way that health services reach, respond to, and retain men in healthcare. We have taken on prostate cancer, testicular cancer, mental health, and suicide prevention with unwavering determination.

We have raised over \$1 billion for men's health, thanks to a passionate community of global Movember supporters. These critical funds have

supported more than 1,300 men's health projects worldwide, including hundreds of advancements in biomedical research and the creation of some of the world's largest prostate cancer registries, built on the real-life experiences of hundreds of thousands of men.

Since taking on mental health and suicide prevention in 2006, Movember has emphasized the importance of better social connections, early recognition of men's mental health challenges, and improving clinician competencies in responding to men in distress.

We want to ensure that more men know what to do when mental health challenges arise, and that their supporters are better prepared to step in when needed. Movember will continue championing new research, cutting-edge treatments, and community programs to promote healthy behaviors in men.

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

*Healthier men mean
a healthier world.*

We advocate for inclusive healthcare systems that are tailored to the unique needs of men, women, and gender-diverse people from wide-ranging cultural backgrounds. In doing so, we hope to create a future where barriers to healthy living are overcome, stigmas are removed, and everyone has an equal opportunity to live a long, healthy life.

About Movember Institute of Men's Health

Building on two decades of investment in men's physical and mental health, the Movember Institute of Men's Health has ambitious goals to improve the quality of life of millions of men worldwide. By uniting global experts in men's health, the Institute aims to accelerate research and translate it into tangible, real-world outcomes.

The Institute aims to raise the profile of men's health with policymakers, ensuring it is prioritized in proportion to its

impact on public health. By focusing on critical areas that include men's mental health, suicide prevention, prostate and testicular cancers, and healthcare that is responsive to the needs of boys and men, the Institute seeks to address the preventable risk factors that contribute to a significant share of male deaths and healthy years of life lost. Through these efforts, the Institute aims to drive sustainable, global progress in men's health. To learn more, please visit movember.com/movember-institute.

Key Contributors

This report was led and written by Clóna Fitzpatrick, Policy and Evidence Director, Movember, with contributions from:

MOVEMBER

- Erin Krummes-Johnson, LCSW, Manager, Men's Health Implementation
- Dr. Bethany Croak, Research Fellow
- Dr. Glen Wiesner, Health Data Lead
- Sophie Eltringham, Health Systems Director

EXTERNAL CONTRIBUTORS

- Dr. Matt Englar-Carlson, Professor of Counseling, California State University, Fullerton

- Dr. Joseph M. Cervantes, Emeritus Professor of Counseling, California State University, Fullerton
- Dr. Daniel Singley, Center for Men's Excellence, San Diego
- Elyse Springer, LMFT, PMH-C, California Chapter of Postpartum Support International
- Dr. Josh Knight, Statistically Speaking
- Alanna Williams, American Institute for Boys and Men

We are also grateful to the men who shared their experiences through our survey, and to the Movember community members who spoke openly about their own health journeys. This report is stronger for their trust.



A Note on Standing Together in Gendered Health

This report is about the health of boys and men in California. Making that focus explicit is not a claim that men's health matters more than the health of women, girls, trans, and nonbinary Californians. It is the opposite: an argument that gendered health inequity, in every direction, deserves attention, evidence, and investment.

Across the state, and the entire United States, men die younger than women, while women spend more of their lives living with illness and disability. Trans and nonbinary Californians face health outcomes that lag behind the general population on almost every measure. None of this is acceptable, and none of it needs to be traded off against the others.

This report draws on data about men's and women's health together to build the

clearest possible picture of where men's outcomes fall short and why. It does not attempt to address the significant and separate work still needed on women's health in California, or the distinct health needs of California's trans and nonbinary communities. We recognize and support the advocates who have spent decades building the evidence base for those issues.

Movember's approach follows the path first cleared by the women's health movement. We aim to stand alongside women's health advocates and LGBTQ+ health advocates in California, not in competition with them, in pursuit of a health system that recognizes gender, in all its forms, as a driver of health outcomes. There is no binary choice in gendered health, and there does not need to be one in gendered health policy.

A NOTE FOR READERS

This report discusses suicide, self-harm, mental illness, and substance use, which some readers may find distressing. If you or someone you know is struggling, support is available.

For free, confidential support 24/7, contact the 988 Suicide and Crisis Lifeline – call or text 988. The Crisis Text Line can also be reached by texting “HOME” to 741741. For non-crisis peer support, California's CalHOPE warmline is available at (833) 317-4673.

Executive Summary

Somewhere in California today, a man will decide to ask for help. He'll find nothing set up to catch him. No provider he can afford, none who will take his insurance. A wait so long the moment passes. He did the hard part and reached out. The system wasn't there to meet him. This report is about closing that gap.

He is not an exception. The scale is large and the causes are concentrated: California men die more than five years earlier than California women. The harm clusters in four areas: chronic disease, overdose, injury, and mental health and suicide. About three in four overdose deaths in the state are among men, as are nearly four in five suicide deaths. Behind those figures sits a wider group who never reach a mortality table at all:

the men living with untreated depression, chronic pain, or addiction that no one caught in time.

When men do reach for help, too often little is waiting for them. The failure here is system-wide, not male-specific. Among insured Californians who tried to book a mental health appointment in the past year, more than half could not find a provider who would take their insurance, and more than half faced excessive waits before being seen. All 58 California counties are projected to face a behavioral-health workforce shortage, most severely in the rural and inland regions where men are already more likely to die prematurely. But men enter that system already less likely to seek help. The men hardest to reach are often the ones a system like this loses.



The barriers do not stop at the door. New primary research with California men finds a second one inside the consulting room. Most report being satisfied with their care, yet the encounter itself tells a different story:

48%

say their practitioner regularly asks about their mental health

58%

hit a communication barrier in the room, most often being rushed or having their symptoms minimized

37%

have left a practitioner after a poor personal connection

14%

(1 in 7) have stopped seeking care altogether

Men are showing up, often after a long delay. The system is too often not built to hear them.

The burden falls hardest on particular groups. Black men in California die prematurely at three times the rate of Asian men, and at a rate 75% higher than non-Hispanic White men. Men in high-risk industries, veterans, men experiencing homelessness, men of color, LGBTQ+ men, and men in rural and inland counties carry a disproportionate share of the harm, at every stage of life. A strategy that only lifts the state average will leave them behind.

None of this is inevitable. California has the scale, the record of innovation, and the political attention to lead the nation on men's health, and momentum is already building: in 2025 the Governor issued an executive order to support boys and young men, an important step, and the first time a California governor has made boys' and men's health an explicit executive priority.

The evidence in this report points to clear, high-yield opportunities on both sides of the clinic door. Inside it, practitioner training such as Men in Mind shows that the quality of the encounter can

be improved with existing workforce and modest investment. Outside it, the opportunity lies with the men who never present at clinical services, and in the moments and settings that reach them: the transition to fatherhood, community and social connection, physical activity and sport, digital health tools, and the workplaces and trusted community spaces where men already gather.

What is needed now is not more recognition but delivery. Recognition changes outcomes only when it is matched by sustained, dedicated funding. Movember calls on California to commit to and resource a coordinated strategy for boys' and men's health, supported by five actions spanning leadership, services, workforce, and evidence.



TABLE 1.0

MOVEMBER'S RECOMMENDATIONS TO THE STATE OF CALIFORNIA

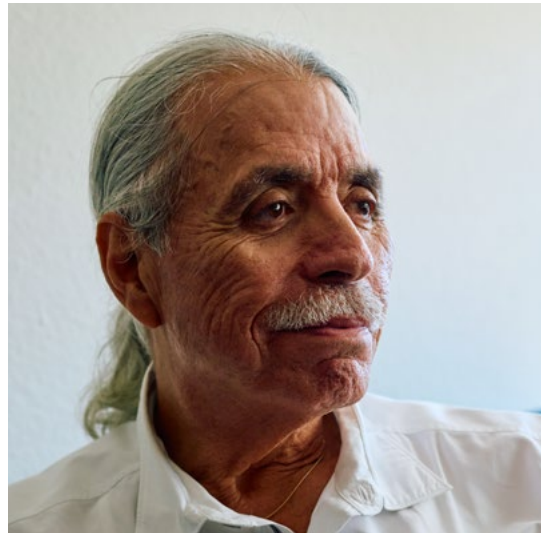
CENTRAL CALL: COMMIT TO AND RESOURCE A COORDINATED CALIFORNIA STRATEGY FOR BOYS' AND MEN'S HEALTH, ONE THAT DRIVES PROGRESS THROUGH CROSS-GOVERNMENT LEADERSHIP, RESPONSIVE SERVICES, A STRENGTHENED WORKFORCE, AND A ROBUST EVIDENCE BASE, SO THAT MORE BOYS AND MEN LIVE LONGER, HEALTHIER LIVES.	
RECOMMENDATION	KEY ACTIONS
1. Develop and resource a California Boys' and Men's Health Strategy	Set clear, measurable targets, for example, reducing male suicide and overdose, with monitoring and reporting built in from the outset. Apply a gender lens across California's major existing investments, including Proposition 1, CalAIM, and the Children and Youth Behavioral Health Initiative. Back the strategy with a costed delivery plan and a pathway that passes funding through to counties. Prioritize the populations and regions carrying the greatest burden.
2. Appoint dedicated, properly resourced state leadership	Appoint a senior leader for boys' and men's health within CDPH or CalHHS, with a dedicated budget line rather than a temporary or unfunded role. Establish a taskforce or advisory group that includes people with lived and living experience. Strengthen, rather than duplicate, existing health-equity work.
3. Invest in community-based, grassroots programs	Scale proven and promising community programs that reach men where they live and work (e.g. fatherhood, social-connection, sport-based, digital, workplace and high-risk-industry programs), with a focus on the populations most disproportionately affected. Fund rigorous evaluation so the most effective approaches can be scaled and replicated.
4. Build a health system and workforce that reaches, responds to, and retains men	Address the behavioral-health workforce shortage in the highest-need regions, where male premature mortality is also highest. Identify and scale proven workforce training programs such as Men in Mind. Equip the perinatal and early-childhood workforce to engage and screen fathers. Promote men's health literacy, built with men, for men.
5. Advance research and close the data gaps	Invest in large-scale, community-led longitudinal research on how, when, and why men engage with their health. Publish routine sex-disaggregated mortality and social-isolation data and establish paternal perinatal mental health surveillance. Bring it together in a single, public men's health data dashboard.

*Healthier men mean healthier families.
Healthier families mean a stronger California.*

Foreword

BECOMING A MAN IN CALIFORNIA: REFLECTIONS ON INDIGENOUS MANHOOD

Dr. Joseph M. Cervantes, Emeritus
Professor of Counseling, California
State University, Fullerton



Growing up in Southern California in the 1950s within the social context of racism and microaggression shaped my thinking and actions in ways that would stir my awareness and understanding of social inequality. My Mexican indigenous and Latino background would not become embodied until years later. The social and racial awakenings of the 1960s left me with lessons that continue to the present: *resiliency* in the face of continuous adversity and racism, and *endurance* of the ever occurring aspects of microaggressions and oppression in my own community.

The 1950s allowed for a strong foundation of manhood which included being responsible, and learning how to navigate boyhood and adolescence with determination and belief in oneself.

I came to understand that I had a mission, an inner calling, but no one to help guide and direct me. Learning to be an indigenous man, yet unaware how to embrace my own wisdom, was daunting in the face of systemic devaluation for cultural beliefs, traditions and diverse communities.

Maintaining one's balance in health, emotionally and spiritually, required regular grounding and validation from one's family and community which I had to learn as a mature adult. Nevertheless, I believed for many years that being self-reliant and independent, namely, rarely asking for directions or assistance, was the expectation toward becoming a mature male from my father's generation and his peers. **To ask for help meant that I would be considered not 'manly enough' or simply culturally inept.**

"To ask for help meant that I would be considered not 'manly enough' or simply culturally inept."



“This was not the history I was going to model.”

My personal evolution into manhood has been inspired by the hardships I have seen with my parents, particularly my father who came with limited financial resources from his home country of Mexico as a fifteen year old boy. He learned how to navigate closed doors due to racial bias and poverty, and become a business owner despite political and economic adversity. Watching him made me aware of social responsibility, and the need to recognize my own brand of manhood as a Mexican male. I remained uncertain about where and how to link the ‘American’ image in me. This awareness also shaped me as a professional committed to working with youth toward promoting equality and personal agency to build responsive and diverse voices of manhood with the next generation.

COVID and the years around it left many young people unable to see how to take the next step from boyhood to manhood. For me, this has meant remaining steady and serving as an anchor, and if needed, to providing a life raft to support distinct ways of being, and accountable citizenship. Now, as I am retired and my children are grown, the push to re-commit to disenfranchised families and youth is all the more relevant given an increased muffling of maturity for young people, and a national crisis of anxiety, depression, and suicide, particularly among transgender youth.

Images from my youth of watching my father work in the various jobs that he performed have arisen again in my awareness. My father tended to rarely complain, and he seemed to always remain competent and successful in his endeavors. **Enduring hardship and long-suffering posture are traits I have admired about my father, but do not serve me as a man or in my personal integration of wellness.** Overworked, limited rest, inconsistent and poor eating habits along with little involvement with our family, likely contributed to early onset diabetes, cancer, and a chronic absence for health checkup. This was not the history I was going to model.

In contrast, a more current realization generated a new metaphor for me to flow like a running spring to help enrich my efforts, and continuously revive freshness and spirit to my sense of personhood and engagements to my community. The importance of health and wellness has become a top priority for me, and not only have I made critical realizations, but also view this awareness as a responsibility to pass on to my family and communities I serve. Being indigenous gave me the confidence to maintain my connectedness to the life forces of Mother Earth while remaining steady and firm, yet flexible to learn from our youth and their communities who have much to teach.

I have come to understand that becoming a man is a dynamic process that evolves over decades, and is regularly tested with change and the expectation to be vigilant, heart-centered, and interpersonally connected.



Contents

	Note on standing together in gendered health	3
	Executive Summary	4
	Foreword	8
	Introduction	12
	California at a Glance	16
SECTION 01	California in US Context	20
SECTION 02	The Scale of Men's Health Inequity in California	23
SECTION 03	Mental Health and Suicide	41
SECTION 04	How California Men Experience the Health System	51
SECTION 05	Injury, Violence and Overdose	58
SECTION 06	Where the Male Health Burden Concentrates	62
SECTION 07	Where the Opportunity Lies	66
SECTION 08	A California Policy Vision for Boys' and Men's Health	78
	References	86

Introduction

California is one of the healthiest states in the country. Total life expectancy at birth was 79.3 years in 2022, the sixth-highest of any US state (1), and the state's age-adjusted suicide rate of 9.6 per 100,000 sits well below the US average of 13.7 (4). In 2024, voters approved Proposition 1, a \$6.38 billion bond and the largest behavioral-health infrastructure investment in California's history, a powerful signal of the state's commitment to the mental health and wellbeing of its people (22).

Like a lot of men, I've spent most of my life showing up, working hard, and carrying the load was just what a man does. You push through stress, ignore warning signs, and tell yourself you'll deal with it later. ... one of the biggest lessons I've learned: later isn't always guaranteed. We tend to prioritize work, family, and responsibilities over our own health until something forces us to pay attention. ... by then, what could have been addressed early may have become much harder to manage.

— Robert, Southern California

Despite these very positive signals, there are areas where the Californian health system is under stress and is still working to fulfill its potential. It sits in the upper-middle of the national distribution on both leading measures of system performance: 20th of 51 jurisdictions on the Commonwealth Fund's 2025 Scorecard on State Health System Performance (2), and 17th on Mental Health America's 2024 State of Mental Health in America (3).

Look under the hood at men specifically and a sharper picture emerges. California men die more than five years earlier than California women on average (1). About one in two male deaths in the state occurs before the age of 75 (4). Nearly four in five deaths by suicide in California are men (4), and the drug overdose death rate has roughly doubled over the past decade, with fentanyl now involved in 86% of opioid overdose deaths (5).

These are not inevitable outcomes. They are patterns that well-designed policy and investment can change.

This report brings that picture into focus. Not to dwell on what is broken, but to make the case for what is possible. Drawing on the best available California-specific data, new primary research with California men, and examples of programs and approaches already making a difference, it sets out a clear evidence base and a practical path forward. California has already signaled its intent. This report sets out what delivering on it would take.



California cannot address men's health without a health equity lens

Men in California are not one group. Race, ethnicity, geography, immigration status, sexual orientation, and disability all shape how long and how well men live. As this report shows, men in the highest-burden rural counties die prematurely at close to three times the rate of men in the state's healthiest counties, and the gap by race and ethnicity is wider still (Section 2.5). These gaps are not the product of biology or individual choice. They reflect differences in access to care, economic opportunity, safe housing, and protection from violence and discrimination, differences created and sustained by systems and policy, and changeable by systems and policy.

A health equity lens means a statewide strategy for boys' and men's health cannot be a single, uniform approach. It means directing attention and resources toward the men carrying the greatest burden: Black men, Hispanic/Latino men, American Indian and Alaska Native men, Native Hawaiian and Pacific Islander men, immigrant men, LGBTQ+ men, veterans, men experiencing homelessness, and men in the rural and inland counties this report identifies as most underserved. California's commitment to men's health will be measured by how well it reaches the men who need it most, not only by how the state performs on average.



CALIFORNIA DATA SOURCES AND THE “MEN’S EXPERIENCES OF CARE AND CONNECTION” SURVEY

This report draws on peer-reviewed and grey literature on men’s health, bringing together findings from the fields of public health, medicine, psychology, and health services research, alongside new analysis conducted specifically for this report.

California data sources: a new lens on state health data. This report synthesizes findings from a comprehensive range of state and national datasets, including the National Center for Health Statistics (NCHS) State Life Tables, NCHS Underlying Cause of Death files, the California Department of Public Health (CDPH), the California Health and Human Services Agency (CalHHS) open data portal, the California Health Interview Survey (CHIS), the Maternal and Infant Health Assessment (MIHA) survey, the California Violent Death Reporting System (CalVDRS), the Department of Health Care Access and Information (HCAI), the California Community Colleges Chancellor’s Office, and the Public Policy Institute of California (PPIC).

The use of this data allows for an examination of mortality and health trends across a sweep of diverse male

subgroups, including trends by race, ethnicity, and geography. This approach surfaces disparities often obscured in aggregate population data, providing the evidence base necessary to design targeted interventions rather than generic policy approaches.

Men’s Experiences of Care and Connection survey. Section 4 of this report draws on the California sub-sample (n = 601) of Movember’s 2025 “Men’s Experiences of Care and Connection” survey, a nationally representative study of over 4,000 US men ages 18 to 69 who had seen a healthcare provider in the past year. The national sample was pre-screened to men actively engaging with the healthcare system, so California findings in this report reflect the experiences of men who showed up, not men absent from the system entirely. This gives California-specific insight into how men are treated once they reach a practitioner: whether they feel heard, whether gateway conversations about mental health and social factors take place, and where practitioner interactions break down.

Together, these two strands of evidence pair the hard facts of mortality and health-system data with the lived healthcare experiences of California men themselves.





California

at a glance: the men's health key numbers

THE HEADLINE GAP

5+ YEARS

California men die more than five years earlier than California women

1 IN 2

male deaths happen before age 75

4

areas carry the harm: chronic disease, overdose, injury, and mental health and suicide

THE WARNING SIGNS WE MISS BEHIND MALE SUICIDE

52%

of men who died by suicide had a recorded mental health problem; nearly half had none. For many, the warning signs were life events, not a diagnosis: a job loss, a relationship breakdown, a health crisis



WHERE MEN ARE OVER-REPRESENTED IN DEATH

4 IN 5

suicide deaths are men

3 IN 4

overdose deaths are men

4 IN 5

homicide victims are men





WHEN MEN REACH FOR HELP, IT IS TOO OFTEN NOT THERE

ONLY 48%

of men say their practitioner regularly asks
about their mental health

37%

of men have left a practitioner after a poor
personal connection

14%

of men have stopped seeking care altogether
after a poor experience

ALL 58

counties face a behavioral-health workforce shortage,
worst in the rural and inland regions where male premature
mortality is highest



THE BURDEN FALLS HARDEST ON SOME MEN

3X

Black men die prematurely at three times the rate of Asian men, and at a rate about 75% higher than that of White men

3X

a man in the highest-burden rural county is nearly three times as likely to die prematurely as a man in the healthiest

1.6M

Veterans: the largest veteran population of any state, with suicide rates well above those of other men

WHERE THE OPPORTUNITY LIES

1 IN 5

new fathers experience a perinatal mental health disorder, making the transition to fatherhood a key window to reach men

15%

lower risk of all-cause mortality in men who are regularly physically active, compared with men who are inactive

\$6.38B

Proposition 1, California's largest-ever behavioral-health investment, not yet shaped by a gender lens to reach the men who carry much of the burden



SECTION 01

California in US Context

CALIFORNIA MEN LIVE LONGER THAN MEN IN MOST US STATES. HOWEVER, THEY STILL DIE MORE THAN FIVE YEARS EARLIER THAN CALIFORNIA WOMEN, AND WITHIN CALIFORNIA THAT GAP WIDENS FURTHER IN RURAL AND INLAND COUNTIES.

Life expectancy

In 2022, the most recent state-level data available, California’s male life expectancy ranked eighth in the US (1). As recently as 2018 and 2019, it ranked first, representing a decline relative to other states (6). This, however, is a marked improvement on the situation 30 years ago when the state ranked 23rd (7).

A range of factors has contributed to this improvement over the last 30 years, among them pioneering policy achievements such as tobacco control (started in 1988) (8) and air

quality regulation (the early 1980s to mid-1990s). These policies acted on cardiovascular, respiratory, and cancer mortality, which together accounted for much of the mortality burden of that era. This track record offers reason to expect that more recently introduced policies can continue that progress in today’s health environment.

Despite California’s relatively high national standing, California men, on average, live 5.4 fewer years than women (1). This gap matches the US national average.

TABLE 1.1 LIFE EXPECTANCY AT BIRTH BY SEX, CALIFORNIA VS UNITED STATES (2022)

	CALIFORNIA	UNITED STATES	GAP (CA – US)
Total population	79.3 years (rank 6 of 51)	77.5 years	+1.8
Male	76.7 years (rank 8 of 51)	74.8 years	+1.9
Female	82.1 years (rank 4 of 51)	80.2 years	+1.9
Sex gap (F – M)	5.4 years	5.4 years	0.0

Data note:

Ranks are for the 50 states plus the District of Columbia. Life expectancies are rounded; rankings are based on unrounded figures. (1)

Cross-state US context

Male life expectancy varies by nearly eight years across US states, from 69.5 years in Mississippi to 77.4 years in Massachusetts in 2022 (1). California, at 76.7 years, sits near the top of that distribution.

California's position near the top reflects relatively favorable performance on many of the leading drivers of male premature mortality, including drug overdose, suicide,

accidental injury, cardiovascular disease, and conditions related to economic and social disadvantage.

However, further sections will show that the remaining gap between California and the seven states that outperform it on male life expectancy (Massachusetts, Utah, Hawaii, New Jersey, Minnesota, New York and Connecticut) is driven by those same causes.





SECTION 02

The Scale of Men's Health Inequity in California

CALIFORNIA MEN DIE PREMATURELY AT NEARLY TWICE THE RATE OF CALIFORNIA WOMEN. THE MALE PREMATURE MORTALITY RATE RANGES ALMOST THREE-FOLD ACROSS COUNTIES, FROM 252 PER 100,000 IN SAN MATEO TO 700 IN LAKE. IN EVERY CALIFORNIA COUNTY, MALE RATES EXCEED FEMALE RATES.

Premature mortality: about one in two California male deaths happen before age 75

Movember's 2025 Real Face report highlighted that 53% of all male deaths in the United States in 2023 occurred before age 75 (9). California performs slightly better than that national figure: in 2024, the share was 50.2% (4). That is a low bar, given how the United States as a whole compares with other OECD nations (9).

The statewide age-adjusted male premature mortality rate (deaths under 75 per 100,000) is 405, against a female

rate of 224, representing a male-to-female ratio of 1.81 (4). Put plainly, California men die prematurely at almost twice the rate of California women.

These deaths are not randomly distributed. They concentrate in particular places, at particular stages of life, and among particular groups of men. The rest of this section maps where, because understanding where the burden falls is the starting point for changing it.



Leading causes of death for California men

For California men, the three leading causes of death are heart disease, cancer, and accidents. On the third of these, men bear a disproportionate toll.

OVERALL MORTALITY

For men in California, the leading causes of death broadly mirror the national picture. Heart disease, cancer, and accidents (unintentional injuries) top

the list for the state overall, followed by cerebrovascular diseases (i.e. stroke), diabetes, chronic lower respiratory disease, Alzheimer’s disease, chronic liver disease and cirrhosis, suicide, and renal disease (4).

TABLE 2.1 TOP 5 CAUSES OF DEATH IN CALIFORNIA MEN AND WOMEN (OF ALL AGES) IN 2024

CAUSE OF DEATH	MALE RATE (PER 100,000)	FEMALE RATE (PER 100,000)	M:F RATE RATIO (%)*
Diseases of heart	178.6	138.2	129%
Malignant neoplasms	160.3	149.9	107%
Accidents (unintentional injuries)	67.7	26.3	257%
Cerebrovascular diseases	40.3	49.2	82%
Diabetes mellitus	32.3	24.1	134%

Data notes:

Causes of death are defined using the CDC ICD-10 113 Cause List and the “15 Leading Causes of Death” framework; data were filtered to ensure mutually exclusive categories and prevent double counting of underlying causes.

*A value above 100 means men die from this cause at a higher rate than women (4).

When looking at the top five causes in Table 2.1, the difference between men and women is moderate for four of them. Accidents are the striking exception: men die at two and a half times the rate of women, a gap made all the more notable by how common a cause of death this is.

PREMATURE MORTALITY

The leading causes of premature mortality, deaths before age 75, closely resemble the overall leading causes, though they occur at lower rates. Four of the five causes are common to both,

with cerebrovascular disease exchanged for chronic liver disease and cirrhosis in the premature picture. This is largely explained by the majority of deaths under 75 occurring in the 10 years before the cut off, which produces substantial overlap in the underlying diseases.

TABLE 2.2 TOP 5 CAUSES OF PREMATURE DEATH AMONG CALIFORNIANS, 2024

CAUSE OF DEATH	MALE RATE (PER 100,000)	FEMALE RATE (PER 100,000)	M:F RATE RATIO (%)*
Cancer	86.6	82.8	105%
Heart disease	83.1	36.8	226%
Accidents (unintentional injuries)	62.3	20.4	305%
Diabetes mellitus	19.3	11.7	165%
Chronic liver disease and cirrhosis	17.8	10.0	178%

Data notes:
Data represents deaths before 75 years of age. Causes of death eligible for inclusion were those in the CDC ICD-10 113 Cause List and '15 Leading Causes of Death' list to prevent double counting of causes.
*A value above 100 means men die from this cause at a higher rate than women. (4)

What changes markedly when looking at deaths in this age group is the comparison with women. Men are notably overrepresented across every one of these causes except cancer,

where the rates are close to equal. The largest disparities are seen for heart disease and accidents, with mortality rates more than twice and three times those of women, respectively.

Geographic variation: a coastal-state success that masks a male health gap

Within California, premature mortality among men varies dramatically across the 58 counties, and the pattern broadly follows urbanization. The five counties with the highest age-adjusted male

premature mortality rates are all rural, non-metropolitan counties concentrated in the Northern and Sierra region (Alpine, Modoc, Lake, Siskiyou and Del Norte) (Table 2.3.1).

TABLE 2.3.1 TOP AND BOTTOM 5 CALIFORNIA COUNTIES BY MALE AGE-STANDARDIZED PREMATURE MORTALITY RATE (ASMR PER 100,000), 2020 TO 2024

GROUP	COUNTY	NCHS URBANIZATION	MALE ASMR (95% CI)
Highest	Alpine †	NonCore (Nonmetro)	900 (608–1,268)
	Modoc †	NonCore (Nonmetro)	725 (614–849)
	Lake	Micropolitan (Nonmetro)	700 (662–739)
	Siskiyou	NonCore (Nonmetro)	683 (635–733)
	Del Norte	Micropolitan (Nonmetro)	675 (620–732)
Lowest	Placer	Large Fringe Metro	317 (307–328)
	Mono †	NonCore (Nonmetro)	277 (229–331)
	Santa Clara	Large Central Metro	257 (252–261)
	Marin	Large Fringe Metro	253 (241–265)
	San Mateo	Large Fringe Metro	252 (245–259)

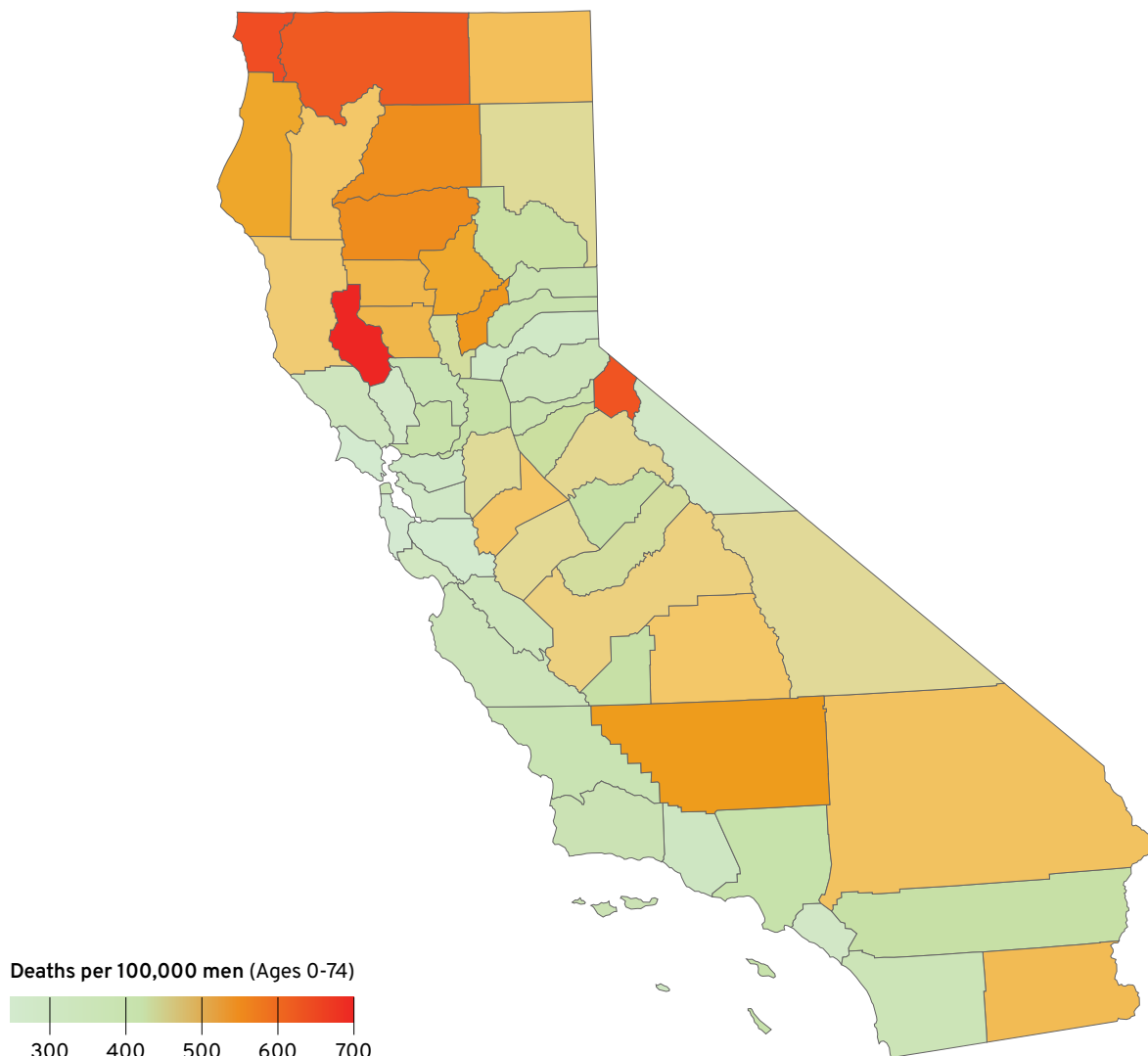
Data notes:

Data represents pooled deaths 2020 to 2024 by California county × sex × 10-year age band, age-standardized to the US 2000 standard population. † = high-variance small county (≥8 suppressed male age bands). Note: due to small sample sizes this data uses pooled years of mortality which incorporates part of the COVID pandemic, this data can be used for comparison, but the 2024 state level data is better for current benchmarking.(4)

The picture at the other end is equally clear. Four of the five counties with the lowest male premature mortality rates are metropolitan: San Mateo, Marin, and Santa Clara in the Bay Area, and Placer

near Sacramento. The gap between the highest and lowest is stark. A man in Lake County is nearly three times as likely to die prematurely as a man in San Mateo (700 versus 252 per 100,000) (4).

FIGURE 2.1 AGE-ADJUSTED MALE PREMATURE MORTALITY RATE (DEATHS < 75) BY COUNTY, 2020 TO 2024



Source:

CDC WONDER Underlying Cause of Death 2018-2024 (Single Race), all-cause deaths < 75, pooled 2020-2024. Age-standardized to the US 2000 standard population, ages 0-74 (under-5 denominator from US Census Vintage 2024). Recomputed from source; reliable counties match the report to ~0. High-variance small-population counties (≥ 8 suppressed age bands or very wide CI), point estimates unstable: Alpine, Colusa, Mariposa, Modoc, Mono, Plumas, Sierra. Color scaled to reliable counties (250-700); higher-rate counties shown at the scale maximum.

The gap between men and women tells the same story. In rural Northern California, men are not just dying prematurely at higher rates than the state average. They are dying prematurely at dramatically higher rates than the women living in the same communities. In Trinity County, the gap between male and female premature mortality is 326 per 100,000, roughly 80% wider than the statewide gap of 181 (4). In rural Northern California, men bear a disproportionate share of the burden of premature death.

TABLE 2.3.2 TOP AND BOTTOM 5 CALIFORNIA COUNTIES BY THE MALE-FEMALE GAP IN AGE-STANDARDIZED PREMATURE MORTALITY RATE (ASMR PER 100,000), 2020 TO 2024

GROUP	COUNTY	NCHS URBANIZATION	MALE ASMR (PER 100,000)	FEMALE ASMR (PER 100,000)	M-F GAP
Highest	Trinity †	NonCore (Nonmetro)	582	256	326
	Siskiyou	NonCore (Nonmetro)	683	378	305
	Modoc †	NonCore (Nonmetro)	725	422	303
	Lake	Micropolitan (Nonmetro)	700	404	296
	Imperial	Small Metro	559	284	275
Lowest	Kings	Small Metro	461	337	124
	Marin	Large Fringe Metro	253	130	123
	Lassen	Micropolitan (Nonmetro)	518	399	119
	San Mateo	Large Fringe Metro	252	137	115
	Santa Clara	Large Central Metro	257	146	111

Data notes:
Data represents pooled deaths 2020 to 2024 by California county × sex × 10-year age band, age-standardized to the US 2000 standard population. † = high-variance small county (≥8 suppressed male age bands). (4)

The counties with the smallest gap between men and women fall into two very different groups. In San Mateo, Marin, and Santa Clara, the gap is narrow because both men and women have low rates. In Lassen and Kings, it is narrow for the opposite reason: women are dying prematurely at unusually high rates (4). A narrow gap is not automatically good news.

WHAT IS CONSISTENT ACROSS ALL 58 CALIFORNIA COUNTIES IS THIS: MEN DIE PREMATURELY AT HIGHER RATES THAN WOMEN EVERYWHERE. ONLY THE SIZE OF THAT GAP VARIES.

Data note: small-county estimates

Small-population counties have wide confidence intervals around their rates. Alpine County's point estimate is 900 per 100,000 (95% CI 608 to 1,268) based on twelve male premature deaths over the 2020 to 2024 pool (4). The cross-county contrast reported in this section excludes

these small counties: among counties with stable rates, the highest-to-lowest ratio is approximately 2.8-fold (Lake 700 versus San Mateo 252). Including Alpine would widen the range to 3.6-fold. Where small-county rates are presented in Tables 2.3, the source notes flag the cells affected.



The age dimension: where in the life course male mortality concentrates

Health inequities do not emerge suddenly in adulthood. They accumulate across the life course, with different risks becoming prominent at different stages of life. For California men, four periods stand out as particularly important: adolescence, young adulthood, midlife, and older age.

Premature death does not strike evenly across a man’s life. Table 2.4 shows where the gender gap is widest, where it narrows, and what share of all male premature deaths falls at each life stage. The gap between men and women is widest in youth, but the sheer number of premature deaths is concentrated in mid and later life.

TABLE 2.4 MALE PREMATURE MORTALITY BY LIFE STAGE IN CALIFORNIA: MALE-TO-FEMALE DEATH-RATE RATIO AND SHARE OF TOTAL MALE PREMATURE DEATHS, 2020-2024

LIFE STAGE	AGE	M:F DEATH-RATE RATIO	SHARE OF MALE PREMATURE DEATHS
Adolescence & young men	15–24	2.72	3%
Early adulthood	25–44	2.36	15%
Mid-life	45–64	1.78	41%
Older men	65–74	1.63	40%

Data notes:
Statewide data pooled 2020–2024, all-cause deaths under 75. Note that shares are rounded and do not sum to 100%; the remainder falls among boys aged 0–14, who are not covered in this section. (4)

ADOLESCENCE AND YOUNG MEN (15–24)

Adolescence is the period when many lifelong health behaviors are established. Mental health conditions commonly emerge during these years, educational trajectories are formed, and social norms around masculinity begin to shape help-seeking behavior. Young men are navigating education, friendships, risk-taking, and the first steps toward adulthood. It is also when health habits, help-seeking behaviors, and attitudes toward mental health take shape and often stick.

The mortality numbers at this stage are stark. Young men die at 2.7 times the rate of young women,

the widest gender gap of any life stage. Yet because death is relatively rare at these ages, this group accounts for only around 3% of all male premature deaths (4). The deaths that do occur are almost entirely external: injury, suicide, and homicide. Homicide is the leading cause of death among young Black men in California, highlighting the disproportionate burden of violent victimization experienced by this population (4, 16).

But mortality captures only the most visible edge of the burden. For most adolescent boys, the health story of these years is not death but the conditions that take root during them. Rates of anxiety, depression, and psychological distress are rising sharply in this generation (10–12), and at their most severe these struggles are reflected in suicide now ranking among the leading causes of death for adolescent boys. Many are exposed to violence and injury, as victims or as witnesses. Others disengage from school or fall behind academically, narrowing the opportunities that protect health across the rest of the life course. Early initiation of alcohol and other substances is common at this stage and can set patterns that persist for decades. And for the current generation, social media has added a distinct layer of pressure: it can deepen isolation even as it appears to connect, and it intensifies body-image concerns and constant social comparison in ways earlier cohorts never faced. These pressures rarely appear in a mortality table, but they shape the trajectory of a young man's health long before they ever show up as a cause of death.

“In my youth, I faced bullying from my peers based on my size and appearance. Although the bullying ended after high school, I internalized these experiences through self-hatred and kept it quiet for many years. I remained silent for so long because of the cultural concept of masculinity, which told me that by expressing these feelings I was weak and that I would be judged poorly by my friends.”

— Maxwell, Southern California





The small share of deaths should not obscure the stakes. This is the highest-leverage stage for prevention. The habits and norms formed here shape the decades

that follow. What shifts the trajectory is not a young man deciding to try harder, but the removal of the fear that made silence feel compulsory in the first place:

“After overcoming the fear of being shunned and shamed for those difficult emotions, I have found much more stability, especially after reaching out and receiving professional help in therapy. Through this experience, I have found hope and a path in life.”

— Maxwell, Southern California

CALIFORNIA POLICY OPPORTUNITY

SCHOOL-BASED MENTAL HEALTH SERVICES, MENTORING PROGRAMS, YOUTH SPORTS SUCH AS MOVEMBER GAME CHANGERS IN SAN DIEGO, AND EARLY INTERVENTION INITIATIVES THAT NORMALIZE HELP-SEEKING AMONG BOYS, EXTENDED THROUGH DIGITAL MENTAL-HEALTH LITERACY TOOLS, MODERATED ONLINE PEER COMMUNITIES, AND CULTURALLY AFFIRMING DIGITAL PLATFORMS SUCH AS BROTHER BE WELL.

EARLY ADULTHOOD (25–44)

Early adulthood is one of the most significant periods of transition in a man's life. Having moved through education and into the workforce, men are forming lasting relationships, establishing independent identities, and, for many, becoming fathers. At the same time, men in this age group face a distinct set of challenges. Suicide rates climb, drug and alcohol harms rise

sharply with overdose chief among them, and many grow increasingly vulnerable to loneliness and social disconnection as the ready-made structures of school and early friendship fall away.

These pressures are reflected in the mortality data. Men in this age group die at 2.4 times the rate of women, and this life stage accounts for around 15% of all male premature deaths (4). Roughly three quarters of California's overdose deaths are male, a ratio of about 3 to 1 (Section 5.4). For many men in this age group, overdose is not a background risk. It is the leading threat to their lives.

But this life stage also carries real opportunity. The transition to fatherhood is one of the most powerful moments of openness to change in a man's life. Research consistently shows it is a window when men are more willing to seek help, change habits, and engage with health services they would otherwise avoid (Section 7.1). It deserves to be treated as a health intervention, not just a parenting one (13).

I moved to the Bay Area, a stressful job, some anxiety issues that I had largely ignored for years came to a head – and I was diagnosed with OCD. It was extremely tough to deal with until I found my psych ... Exercise, meditation, and talking with people have all been vital.

— Brian, Bay Area

CALIFORNIA POLICY OPPORTUNITY

WORKPLACE MENTAL HEALTH INITIATIVES, FATHERHOOD PEER SUPPORT AND MENTAL HEALTH INITIATIVES, APPRENTICESHIP-BASED WELLBEING PROGRAMS, COMMUNITY-BASED SOCIAL CONNECTION PROGRAMS, AND TARGETED OUTREACH THROUGH COLLEGES AND TRADE SCHOOLS, ALONGSIDE TELEHEALTH AND APP-BASED ACCESS TO MENTAL-HEALTH CARE, AND FATHER-FOCUSED DIGITAL SUPPORTS.



MID-LIFE (45–64).

This is often when life's pressures converge. Many men are navigating peak career demands and financial responsibilities, while also caring for children and aging parents. A time when health risks such as cardiovascular disease, diabetes and cancer begin to rise. For some, relationship breakdown and social isolation after divorce or separation add another layer of difficulty.

I was dealing with high anxiety & deep depression that led to alcohol addiction. Masking my issues became impossible, but the fear and embarrassment of seeking help was in control ... Family support, and their deepest love and understanding was instrumental in getting me through my darkest times.

— Dane, Southern California

The causes shift at this stage. Heart disease and cancer overtake overdose and injury as the dominant killers. The gap between men and women narrows to about 1.8 to 1, but it remains substantial, and the absolute toll is the largest of any life stage. Roughly 41% of all male premature deaths occur between the ages of 45 and 64 (4).

Many of the men in this group work in construction, agriculture, and transport, industries with some of the highest rates of suicide and overdose in the country (Section 6.1). They are among the hardest to reach through clinical services. But they are reachable through the workplace, and that is where targeted intervention needs to go.

Midlife also represents a critical window for prevention. Most major causes of premature mortality, including heart disease, diabetes and many cancers, can be significantly influenced through earlier intervention and supportive policy. The opportunity for policy is clear: investing in prevention, screening and earlier engagement during this stage of life has the potential to reduce the gender gap in health outcomes and save lives.

CALIFORNIA POLICY OPPORTUNITY

WORKPLACE MENTAL HEALTH INITIATIVES, TARGETED HEALTH CHECKS FOR CARDIOVASCULAR, METABOLIC AND CANCER RISK, AND COMMUNITY-BASED SOCIAL CONNECTION PROGRAMS, SUPPORTED BY WEARABLES AND REMOTE MONITORING FOR THESE CONDITIONS AND TELEHEALTH HEALTH CHECKS DELIVERED THROUGH THE WORKPLACE.

OLDER MEN (65–74)

Retirement, bereavement, declining mobility and chronic illness can all reduce opportunities for meaningful social participation. For many, it also means the gradual loss of the structures, routines, and relationships that kept them connected and well. Around 40% of all male premature deaths occur between 65 and 74, meaning that the 45 to 74 range accounts for roughly four in every five male premature deaths (4). Chronic disease dominates for both sexes at this stage, and the gap between men and women narrows to about 1.6 to 1. It does not close.

Two risks deserve particular attention. Suicide rises again in this group, particularly among non-Hispanic White men. And social isolation emerges as a serious health threat in its own right. Retirement removes the workplace, often the primary social structure in a man's life and the most reliable point of contact with care. Without it, many men quietly disappear from view.

Veterans are over-represented in this group and carry a disproportionate share of both risks (Section 6.2). The strongest lever here is community connection.



CALIFORNIA POLICY OPPORTUNITY

COMMUNITY CONNECTION PROGRAMS, LATE-LIFE SUICIDE PREVENTION, VETERAN-FOCUSED OUTREACH, AND POST-RETIREMENT STRATEGIES TO MAINTAIN CONTACT WITH CARE, INCLUDING TELEHEALTH TO SUSTAIN CONTACT AFTER RETIREMENT, REMOTE MONITORING, TECHNOLOGY-ENABLED SOCIAL-CONNECTION PROGRAMS, AND VETERAN TELEHEALTH PATHWAYS. PROPOSITION 1'S \$1.065 BILLION ALLOCATION FOR SUPPORTIVE HOUSING FOR VETERANS IS DIRECTLY RELEVANT TO THE OLDER VETERANS (22).





MEN 75 AND OVER

For men 75 and over, as with the 65-74 age group, the great majority of deaths are from chronic disease, chiefly heart disease, cancer, and dementia (4).

As a father and a grandfather, I have increased my way of thinking about staying healthy – including regular exercise and maintaining a specific schedule of medical check-ups ... I sincerely hope that this way of thinking and living my life sets an example for our entire family.

— Stu, Bay Area

Chronic disease dominates the mortality picture, but mental health remains a distinct and often overlooked concern at this age. Men aged 75 and older have the highest suicide rate of any age group in the United States, concentrated among non-Hispanic White men (4).

The drivers are particular to late life: chronic illness and pain, declining independence, bereavement, and the isolation that follows the loss of mobility and lifelong ties (14). The impacts on quality of life can accumulate quietly and can be overlooked as mental-health concerns. Men of this age are more frequently in contact with health professionals when compared to younger men. Although this point of contact is infrequently a mental-health professional this is a potential pathway that already exists. Veterans, over-represented among the oldest men, again carry a disproportionate share of this risk.

THE BURDEN WE CANNOT FULLY COUNT

This report has focused on premature mortality because it is the most complete and consistent data available. But deaths tell only part of the story. Behind every mortality statistic is a larger, less visible group of men: the young man who survives a serious workplace injury but never fully recovers, the father who spends years living with untreated depression, the older man who withdraws from life long before it ends. None of them appear in a mortality table. But the harm to them, their families, and their communities is real and often lifelong.

In routinely collected health data, non-fatal illness and injury only show up if a man seeks care and receives a diagnosis,

and men, young men in particular, are less likely to do either. What we can measure is a floor, not a full count. Some of it can be raised, workplace injury is comparatively well captured through workers' compensation, but illness and injury outside work leave far less of a trace, and the true burden runs well above what these systems record.

Any strategy built only on mortality data will systematically underinvest in the years where prevention matters most and where the greatest number of men are slipping through unnoticed. These patterns are distinctly male, shaped by norms that both encourage risk-taking and stoicism and condition society to overlook them. A strategy that takes men's health seriously has to set out to change that.



The race and ethnicity dimension

Race and ethnicity draw the sharpest dividing line in California's health picture. New research tracking California death records from 2019 to 2024 finds that Asian Californians live, on average, to 85.5 years whereas Black Californians live to 73.4 years (15). That is a gap of more than 12 years. It is wider than the difference between California's average life expectancy and that of the worst-performing state in the country. Hispanic Californians (81.1 years) and non-Hispanic White Californians (79.9 years) sit between those two extremes.

The pandemic made these gaps worse, and they have not closed. By 2024, Black and Hispanic Californians still had life expectancies nearly one and a half years below where they stood before COVID-19. That is more than twice the recovery deficit experienced by non-Hispanic White Californians (0.63 years lost). The gap in life expectancy between Black and White Californians grew from 5.7 years before the pandemic to 6.5 years in 2024. The communities that

were already furthest behind fell further behind still, and have not recovered(15).

For men specifically, looking at premature death before age 75, the racial and ethnic gap is just as stark. Black men in California die prematurely at a rate of 689 per 100,000, more than three times the rate for Asian men (208 per 100,000) and about 75% higher than the rate for White men (394 per 100,000) (Table 2.5) (4). The next highest rates fall on American Indian and Alaska Native (AIAN) men (607 per 100,000) and Native Hawaiian and Pacific Islander men (589 per 100,000), both well above the statewide male average of 374 (4). Because each of these groups makes up less than half a percent of California's men, their small absolute death counts mean they are sometimes aggregated into an "other" category which can obscure the scale of the issue.

Two causes of death sit behind much of this disparity, and both are covered in detail later in this report.

A caveat applies to the AIAN figure: racial misclassification on death certificates means American Indian and Alaska Native deaths are frequently recorded as another race. The CDC estimates this understates non-Hispanic AIAN death rates by roughly a third, compared with about 3% for

Hispanic and Asian populations. The 607 reported here should therefore be read as a floor. Adjusted for that undercount, AIAN male mortality in California would approach or exceed the Black male rate, consistent with national data placing AIAN mortality above every other group.

The first is homicide. Homicide rates among Black men in California reach 32.7 per 100,000, underscoring the disproportionate burden of violent victimization faced by this population. That is five times the rate for White men and eighteen times the rate for Asian men. Black men make up roughly six percent of California’s male population but accounted for 29% of male homicide deaths in 2024 (4,16). The second is drug overdose. Black and American Indian/Alaska Native Californians carry the highest fentanyl-related overdose death rates in the state (5). Black men died from overdose at nearly twice the rate of non-Hispanic White men during the pandemic-era peak (17). The systems meant to protect Californians are not reaching everyone equally.

TABLE 2.5 CALIFORNIA AGE-STANDARDIZED MALE PREMATURE MORTALITY RATE (DEATHS UNDER 75 PER 100,000) BY RACE, POOLED 2020 TO 2024

RACE/ETHNICITY	MALE ASMR (95% CI)	RATIO VS ASIAN MALE	M:F RATIO	% OF MALE POP.	MALE DEATHS (2020–24)
Black, non-Hispanic	689 (681–698)	3.3	1.64	5.6%	25,503
American Indian/Alaska Native, non-Hispanic	607 (577–639)	2.9	1.49	0.4%	1,655
Native Hawaiian/Pacific Islander, non-Hispanic	589 (558–621)	2.8	1.45	0.4%	1,447
White, non-Hispanic	394 (391–396)	1.9	1.68	33.0%	111,913
Hispanic or Latino (any race)	360 (358–363)	1.7	1.88	42.2%	76,709
Two or more races, non-Hispanic	316 (306–326)	1.5	1.61	3.2%	3,899
Asian, non-Hispanic	208 (206–211)	1	1.83	15.1%	21,700
All California men (total)	374 (372–375)	1.8	1.77	100%	242,845

Data notes:

Data represent pooled deaths 2020 to 2024 by Sex × Single Race 6 x Hispanic origin × Ten-Year Age Groups, age-standardized to the US 2000 standard population and restricted to ages under 75 (4).

Rows may not sum to the total due to deaths with unknown or not-stated race/ethnicity.

Pooled 2020–2024 rates are not directly comparable with the single-year 2024 figures in Section 2.1.



SECTION 03

Mental Health and Suicide

MENTAL HEALTH, AND MALE SUICIDE IN PARTICULAR, IS PERHAPS THE DEFINING AREA OF NEED FOR ACTION ON MEN'S HEALTH IN CALIFORNIA. THE STATE HAS RESPONDED WITH THE LARGEST BEHAVIORAL-HEALTH INVESTMENT IN ITS HISTORY; HOW THAT INVESTMENT WILL REACH THE MEN WHO MOST NEED IT IS THE OPEN QUESTION.

Scale of the unmet need and access issues

Men's mental health need in California is large, and much of it goes unmet. Based on national data, approximately three million California men, almost one in five adult men, experience a mental illness in a given year (18). Men are also less likely to be treated for it: national data from 2022 found that men with serious mental illness received treatment considerably less often than women, 59% versus 71% (18).

Data on access to appropriate mental health care show a long-standing shortfall in availability. The best available evidence comes from a 2011 to 2014 pooled analysis of the California Health Interview Survey (CHIS), which found that approximately 77% of Californians with a mental health need received no care, or care that fell short of accepted standards (19). That

estimate is several years old; however, more recent survey work shows no sign that access has improved. CHIS data from 2015 to 2020 estimate that close to two thirds of adults with a mental illness received no treatment at all. The later estimate counts whether any treatment was received, not whether care met accepted standards, so the two figures cannot be read as a trend (20).

Survey evidence from California points to the systemic barriers that compound the difficulties men already face. The 2024 California Health Care Foundation (CHCF) California Health Policy Survey, a representative statewide sample of 3,431 adults, found deep dissatisfaction with the mental health system and wide support for reform (21). Two in three Californians (67%) said local treatment for serious mental illness needs to improve, 42% of them calling the change needed "significant." Eighty-one percent ranked better access to mental health care as an extremely or very important priority for state government, on par with reducing overall health-care costs (21).

For those trying to actively navigate the system, the roadblocks are concrete:

- **Insurance.** Among insured California adults who tried to book a mental health appointment in the past 12 months (n = 623), 52% struggled to find a provider who would accept their coverage, against just 14% for physical health care (21).

GAY AND BISEXUAL MEN: NEED IS NOT EVENLY DISTRIBUTED ACROSS MEN. ANALYSIS OF THE 2023 CALIFORNIA HEALTH INTERVIEW SURVEY FOUND THAT LGBT ADULTS IN CALIFORNIA WERE NEARLY THREE TIMES AS LIKELY AS NON-LGBT ADULTS TO HAVE EVER SERIOUSLY THOUGHT ABOUT SUICIDE, 48% AGAINST 17% (95). THAT FIGURE COVERS LGBT ADULTS OF ALL GENDERS. AMONG CISGENDER GAY AND BISEXUAL MEN, THE FIGURE WAS 36% (95). CALIFORNIA IS HOME TO HUNDREDS OF THOUSANDS OF CISGENDER GAY AND BISEXUAL MEN, AND THIS IS ONE OF THE FEW MEASURES ON WHICH THE STATE'S DATA SPEAKS TO THEM DIRECTLY.



77%

received no care,
or care that fell short of
the accepted standards

- **Delays.** Among all who sought mental health treatment over the same period (n = 703, regardless of insurance status), 55% faced excessive waits before being seen (21).

These figures cover all California adults, not men specifically. Difficulty finding a provider who accepts coverage and long delays mean that men in California, who already face distinct barriers to care, are often disconnected from care at the very first point of contact.



Suicide

In 2024, 4,022 Californians died by suicide, a rate of 9.6 per 100,000, roughly 30% below the national rate of 13.7 (4). The gap holds for men specifically: California’s male rate of 15.3 per 100,000 was roughly 30% lower than the national figure of 22.3.

While the suicide rate among men in California is substantially lower than the national average, the proportion of deaths in men, relative to women, is essentially identical to the national picture. Of California’s 4,022 suicide deaths in 2024, 3,175 were among men, nearly four in five (79%) of the total. The pattern closely tracks the national picture, where men accounted for about 80% of suicide deaths (38,977 of 48,824) (4). This four-to-one ratio has remained

stable over time, in California and nationally alike.

Two readings of the age pattern point in different directions, and both matter for prevention. The male suicide rate climbs with age, from 12.1 per 100,000 at ages 15 to 24 to 31.1 per 100,000 at 75 and older, by far the highest of any age band.

As a share of mortality, however, the pattern inverts. Suicide accounts for about 16% of all male deaths at ages 15 to 24 but only about 0.5% at 75 and older, because deaths from other causes accumulate far faster with age (4). Suicide is therefore a leading cause of death among young men, even as older men die by suicide at the highest absolute rates.

TABLE 3.1 SUICIDE RATES BY AGE BAND AND AS A PERCENTAGE OF ALL DEATHS IN THE AGE BAND

AGE BAND	MALE SUICIDE RATE (PER 100,000)	% OF ALL MALE DEATHS
15–24	12.1	16.1%
25–44	18.4	9.4%
45–64	21.3	3.4%
65–74	21.9	1.2%
75+	31.1	0.5%

Data notes:
California resident males, 2024. Rates are crude age-specific rates; shares are male suicide deaths as a percentage of all-cause male deaths in the age band.(4)

Risk also differs by race and ethnicity, and the California ranking broadly matches the national one. Within California, the highest suicide rates are among American Indian or Alaska Native residents at 17.5 per 100,000 and White residents at 17.1 per 100,000. White and Hispanic residents account for the

largest number of suicide deaths, 57% and 25% respectively, reflecting the demographics of the state. This race and ethnicity data is not published by sex; however, because almost 80% of suicide deaths in California are among men, the overall figures strongly reflect male trends.

Where Proposition 1 Reaches Men, and Where It Doesn't

Approved by California voters in March 2024, **Proposition 1** is a two-part measure that reformed the state's Mental Health Services Act and authorized a \$6.38 billion general obligation bond to build behavioral-health treatment and residential facilities and to fund supportive housing for veterans and others experiencing or at risk of homelessness with behavioral-health needs. That bond is not, at face value, a male-targeted intervention (22). It

contains no sex-disaggregated allocation or target. The closest it comes to reaching men specifically is the \$1.065 billion for permanent supportive housing for veterans with behavioral-health needs (covered in Section 6.2), but that is veteran-targeted, not male-targeted. Because California's veteran population is overwhelmingly male, however, this carve-out functions as a de facto lever for reaching men, even though it was not designed as one.

The warning signs we are missing

MOST COMMON CONTRIBUTING CIRCUMSTANCES AMONG MEN WHO DIED BY SUICIDE

The circumstances most common among men who died by suicide in the most recent national surveillance period (2022 NVDRS data, the most complete multi-state release available at the time of writing) are summarized in Table 3.2.

TABLE 3.2 MOST COMMON CONTRIBUTING CIRCUMSTANCES AMONG MEN WHO DIED BY SUICIDE, US NVDRS 2022 (APPROXIMATE SHARES)

CIRCUMSTANCE	% OF MEN WHO DIE BY SUICIDE*
Mental health condition (any diagnosis)	45%
Crisis in past or upcoming 2 weeks#	30%
Intimate-partner problem	24%
Physical health problem (rises sharply with age)	20%
Alcohol problem^	18%
Other substance use problem (excludes alcohol)^	16%
Job problem	8%
Criminal or legal problem	7%
Financial problem	6%
Family relationship problem	6%

Notes:

* Percentages are not mutually exclusive. More than one circumstance may be present in a single death; therefore, percentages do not sum to 100%.

Refers to a stressful event occurring within the two weeks before or after the death. The stressor event could include issues listed elsewhere in the table (for example, legal or financial problems) and indicate an acute, time-limited stressor rather than a chronic condition.

^ Alcohol problem and other substance use problem refer to identified ongoing problems with alcohol or substance use. They do not necessarily indicate intoxication at the time of death.



TABLE 3.3 CALIFORNIA MALE SUICIDE DECEDENTS, 2022 (CALVDRS)

CIRCUMSTANCE	% OF MEN WHO DIE BY SUICIDE*
Mental health problem	52%
Recent or impending life crisis	21%
Physical health problem	18%
Alcohol problem or dependence	17%
Current or former intimate partner problem	17%
Non-alcohol substance use problem	17%
Financial and/or job problem	12%
Death of a friend, family member, or intimate partner	6%

Notes:

* Percentages are not mutually exclusive. More than one circumstance may have been present for a single decedent; therefore, percentages do not sum to 100.

† Circumstance data are derived from CalVDRS enhanced surveillance records for suicides occurring in 32 participating California counties and may not be representative of all suicide deaths occurring statewide. (23)



One of my lowest points was June 2024, when I had legitimate suicidal ideation to take my own life.

But through that faith, my commitment to daily grounding practices — working out, reading books, and especially breathwork meditations — and most importantly, my relationships with my family and friends who supported me no matter what, I persevered.

— Acusio, Southern California

California findings were broadly consistent with national NVDRS data. Mental health problems, recent life crises, physical health problems, substance use problems and relationship difficulties were among the most common contributing circumstances in both datasets. Compared with national male suicide decedents, California recorded a somewhat higher prevalence of mental health problems (52% vs 45%) and lower levels of recent crises (21% vs 30%) and intimate-partner problems (17% vs 24%). Nonetheless, the overall pattern

was similar, highlighting the importance of mental health, acute life stressors, physical health conditions, substance use and relationship difficulties as common contributing circumstances associated with male suicide.

Three patterns deserve attention. First, financial, job, and criminal-legal problems are more common contributing circumstances among men who died by suicide than among women, while intimate-partner problems and recent crises are common in both sexes (16). Second, physical health problems become a far more common circumstance with age, particularly among men aged 65 and over. Third, only around 45% of men who died by suicide nationally, and 52% in California, had a documented mental health diagnosis, meaning around half had none on record. This could point to one of two things: that existing diagnostic frameworks are not detecting mental illness before suicide, and/or that men's suicide often follows complex life stressors in the apparent absence of mental illness (16,24).

The circumstances behind most male suicides are life events: a job loss, a relationship breakdown, a court date, a new health diagnosis. They surface in a doctor's waiting room, a workplace, a courtroom, a housing office. That is where early intervention has to happen. For the close to half of men who do have a mental health diagnosis, that existing contact with services is itself a route to deliver help. Taken together, this points to a set of key moments that should trigger support, both inside and outside the formal healthcare system.

For California, this means two things. First, practitioner training in primary and general medical care needs to equip

THE ALEC MODEL, ASK, LISTEN, ENCOURAGE ACTION, AND CHECK IN, DEVELOPED BY R U OK? AND USED IN MOVEMBER CONVERSATIONS, GIVES LAY PEOPLE A SIMPLE, STRUCTURED WAY TO START AND SUSTAIN THESE CONVERSATIONS (25).



clinicians to recognize and respond to these precipitating circumstances, not only to formal psychiatric diagnoses. Second, the people men are most likely to encounter in a crisis, from construction supervisors to probation officers to emergency physicians, need the skills to act on what they are seeing. This is true further upstream too: friends, family, and coworkers are usually the first to notice when a man is struggling, often long before any clinician does.

California's cultural and geographic diversity, from tightly networked immigrant communities to rural counties with few services, makes this lay response especially valuable: community trust travels through relationships a formal health system cannot always reach on its own. Neither response works in isolation: community-level trust is what brings men into contact with

services in the first place, and a health system equipped to respond is what makes that contact count. The warning signs are there. Building a system capable of seeing them requires both.

HEALTHCARE CONTACTS BEFORE SUICIDE

Most people who die by suicide have had recent contact with the healthcare system. A large US population analysis, which included 5,894 people who died by suicide across eight integrated health systems between 2000 and 2010, found that approximately 83% had a healthcare contact in the year before death, 48% within the four weeks before, and 22% within the week before (26). Most of those contacts were in primary or general medical care, not in mental health specialty settings: 64% made a primary care visit and 62% a medical specialty visit in that year with no mental health diagnosis recorded, against 29% who had an outpatient mental health visit. In the four weeks before death, only 24% had a visit coded with a mental health diagnosis at all. Men made up 77% of that sample (n = 4,534), and recent visits were most common among women and older adults, meaning men were the group least likely to have been seen shortly before death (26).

A systematic review of the international literature found that, on average, around 31% of people who died by suicide had contact with mental health services in the 12 months before death, while the share with a primary care contact was consistently higher (80% in the 12 months before death) (27). Men are considerably less likely than women to have had any mental health contact before suicide, and more likely to have had primary care contact only (27).

WHAT IS ALREADY WORKING: REACHING MEN BEFORE CRISIS. SEVERAL PROGRAMS ARE BUILT TO ENGAGE MEN WHO NEVER PRESENT AT CLINICAL SERVICES. MAN THERAPY, AVAILABLE NATIONALLY INCLUDING IN CALIFORNIA, USES HUMOR AND SELF-GUIDED TOOLS FOR WORKING-AGE MEN, AND A CDC-FUNDED RANDOMIZED TRIAL FOUND HIGHER RATES OF PROFESSIONAL HELP-SEEKING AMONG USERS (96), THOUGH NO ADVANTAGE OVER THE COMPARISON SITE ON DEPRESSION AND SUICIDAL IDEATION (97). THE YBMEN PROJECT OPENS MENTAL-HEALTH CONVERSATIONS WITH YOUNG BLACK MEN THROUGH PRIVATE SOCIAL-MEDIA GROUPS, WITH EVALUATION SHOWING FEWER DEPRESSIVE SYMPTOMS AMONG PARTICIPANTS (98). MINDMOVES DELIVERS FREE MENTAL-HEALTH AND SUICIDE-PREVENTION CONTENT TO STUDENT ATHLETES, A MODEL CALIFORNIA'S LARGE UNIVERSITY AND COMMUNITY-COLLEGE SYSTEMS ARE WELL PLACED TO SCALE FOR YOUNG MEN (99).

Workforce shortage and geographic mismatch

California's behavioral-health workforce shortage is severe and concentrated in precisely those communities with the highest mortality and unmet need. The Department of Health Care Access and Information (HCAI) maintains a Supply and Demand Modeling dashboard for the behavioral-health workforce at county and regional level (28). Its 2025 modeling finds that every one of California's 58 counties is projected to face an overall behavioral-health workforce shortage, with statewide supply meeting only about 62% of projected demand. The shortage is deepest in three regions: the San Joaquin Valley, the Inland Empire and desert, and the far north (Northern & Sierra), where modeled supply covers only about 47%, 51% and 58% of demand respectively.

In the largest role category, non-prescribing licensed clinicians (the workforce that provides the bulk of psychotherapy, counseling, and case management), statewide supply of roughly 80,900 meets only about 59% of the 136,200 in projected demand, a gap of approximately 55,300 providers.

The geographic mismatch matters because the regions HCAI flags as most severely short-staffed, the San Joaquin Valley and the far north, are also home to the rural counties with the highest male premature mortality documented in Section 2.3. The overlap is real but uneven: among the high-mortality far-north counties, Lake stands out, with modeled supply meeting only about a third of demand, and Plumas and Siskiyou each sit near half; Modoc, by contrast, is close to the state average. This is where California's men's health problem falls hardest: several of the counties with the highest male premature mortality are also among the worst-served by the behavioral-health workforce that might mitigate that loss.

62%

of projected behavioral-health
demand met by supply





SECTION 04

How California Men Experience the Health System

CALIFORNIA MEN ARE SHOWING UP. ONLY AROUND HALF SAY THEIR PRACTITIONER REGULARLY ASKS ABOUT THEIR MENTAL HEALTH, MORE THAN HALF HIT A BARRIER ONCE THEY ARE IN THE ROOM, AND ONE IN SEVEN HAS STOPPED SEEKING CARE ALTOGETHER AFTER A POOR CONNECTION.

Health status and healthcare usage

This section presents core findings from Movember 2025 “Men’s Experiences of Care and Connection” survey (n = 601), the California sub-sample of the US Real Face dataset (US n = 4,126) (9). The US sample was pre-screened to include only men who had a healthcare interaction in the past 12 months, so findings reflect men actively engaging with the healthcare system.

Two-thirds (67%) of these men reported having at least one physical or mental health condition (9). Across the sample, 59% reported a physical health

condition and 22% a mental health condition. This is the engaged-patient population: men who have experience navigating the California health system in the past year. Findings from this section should be read in that context. The picture they describe is the picture for men who are engaging, not the picture for men who are absent from the system entirely.

Before turning to what these men encounter, it is important to recognize the men who are absent. National data underlines how large that engagement gap is. In 2019, US men averaged 2.73 office-based physician visits per person compared with 3.66 for women, a statistically significant difference in how often men engage with the system at all (29).

Men who do engage are not necessarily engaging early. Sixty-two percent of US men wait more than six days after symptoms appear before seeing a physician. Nearly a third wait over a month, and 17% delay care for six months or longer (9).

This is not a uniquely California problem, and it is not new. What follows is what happens next: what these men encounter once they reach a practitioner, why it breaks down, and what a system built to hold onto them would look like.

59%

of men reported a physical health condition

22%

of men reported a mental health condition



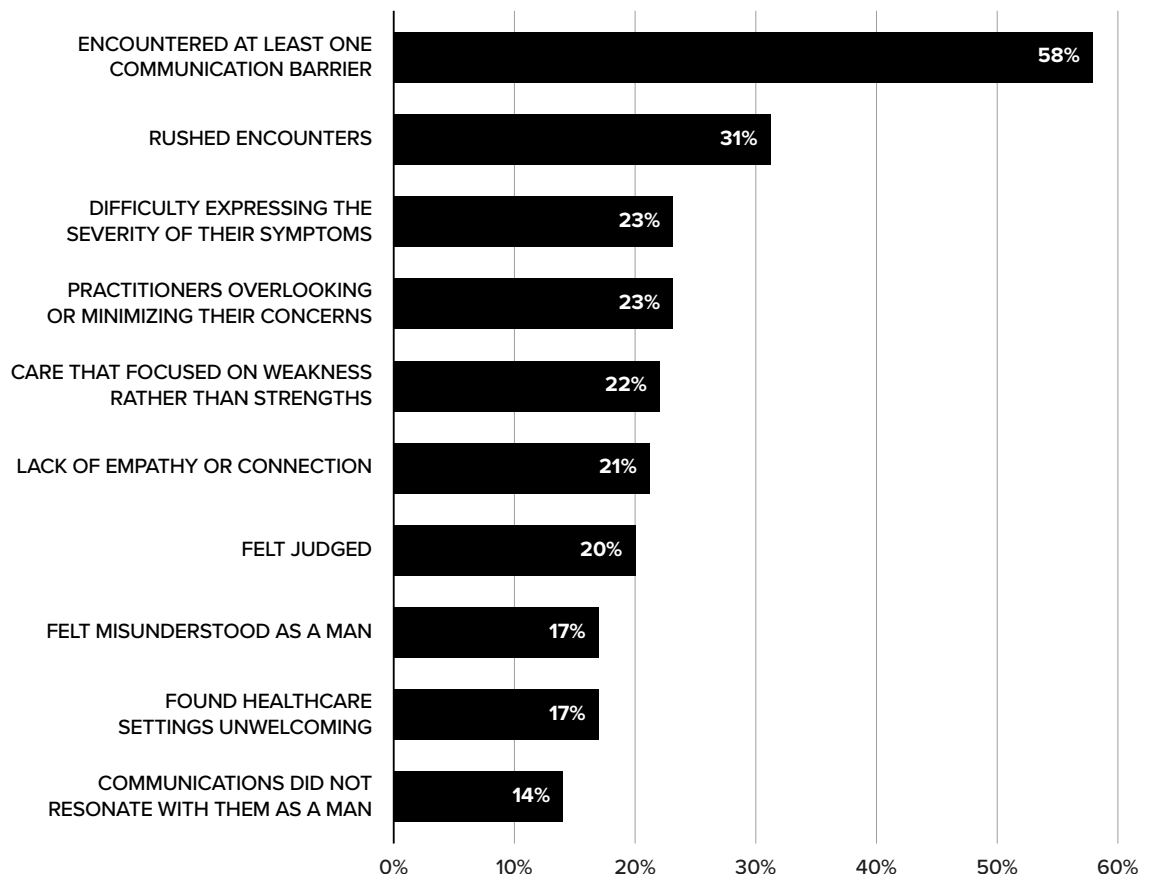
What happens once men are in the room

The barriers California men describe are not about stigma or reluctance to engage. They are about what happens once men are in the room.

In the past 12 months, more than half of California men (58%) encountered at least one communication barrier in their healthcare interactions (9). Rushed encounters were the most common, affecting nearly a third of men (31%). Close behind were difficulty expressing

the severity of their symptoms and practitioners overlooking or minimizing their concerns, both at 23%, followed by care that focused on weakness rather than strengths (22%) and a lack of empathy or connection (21%). One in five felt judged. Smaller but still substantial proportions felt misunderstood as a man (17%), found healthcare settings unwelcoming (17%), or felt that communications did not resonate with them as a man (14%).

FIGURE 4.1 IN THE PAST 12 MONTHS, WHAT BARRIERS HAVE YOU FACED IN RELATION TO EFFECTIVE COMMUNICATION WITH HEALTHCARE PROVIDERS?



Two of those barriers point at the same failure from opposite ends. Difficulty expressing symptom severity and practitioners overlooking or minimizing concerns affect nearly a quarter of men each. These men are engaged with the system, they showed up, and they are leaving without having been heard.

The conversations most likely to surface that unmet need are not happening reliably. Only 48% of California men reported that their practitioner often or always asks about their mental health, and just 37% about male-specific health issues (9). Questions about other health concerns and about a man's personal or social life were reported only around half the time.

These are the gateway conversations that open the door to mental health and substance use risk, and in a population pre-screened for having attended an appointment, they are the exception rather than the rule. The touchpoints exist. The conversations do not.

When connection fails, men leave, and the window to re-engage them closes. More than a third of California men (37%) have left a practitioner due to poor personal connection, and the consequences vary: 23% switched to someone else, but 14% stopped seeking care entirely. A further 21% have felt like leaving without acting on it (9). These are not men on the margins of the system, they are men who were engaged enough to show up. When they disengage, they do not typically find their way back through the front door. They return through emergency departments, or not at all.

None of this registers in the satisfaction data: 94% of these men say they are satisfied with their care, and over 90% agree that they felt heard and involved in decisions. However, patients are rarely positioned to judge a practitioner's technical performance, so satisfaction ratings track what they can readily assess, namely courtesy, rapport, and whether they felt listened to, rather than whether specific clinical behaviors took place (30).

Long wait times, finding the right providers ... Not knowing where to start is enough of an obstacle to delay treatment. For men who are already reluctant to ask for help, those barriers can be enough to keep them from seeking care altogether.

— Robert, Southern California



Why the encounter breaks down

The barriers in 4.2 are not random friction. They follow a pattern that the international research describes directly.

Studies of doctor-patient interactions find that clinicians often read men's symptoms through an assumption of stoicism, rather than on clinical need alone, and that male doctors and male patients can jointly, and often unintentionally, play down symptoms because both expect men to "tough it out" (31,32). Clinicians rate stoic patients as more respectable, which rewards silence over help-seeking rather than correcting for it (32). An analysis of 1.8 million clinical care records found men received systematically less thorough emotional inquiry than women (33).

The effect compounds at the point where it matters most. Mental health

practitioners have been shown to have a significantly lower willingness to treat and refer male patients presenting with suicidality than female patients, with the practitioner's own self-perceived competence the strongest predictor of that decision (34).

That last finding locates the problem precisely. A man arrives carrying norms about self-reliance that make it hard to say how bad it is. He meets a practitioner whose training never equipped them to hear it and who reads his restraint as resilience. Both are behaving reasonably given what they have been taught. The encounter fails anyway. This is not a problem of individual clinical skill or of individual male reticence. It is a problem of what the system has equipped either party to do.



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

Fixing this means acting on the layers that shape the encounter, not on the men inside it. Three layers matter, and they work only together.

A workforce equipped to respond.

The evidence set out above is not that practitioners lack care or skill. It is that competence in engaging men is a taught capability, and it is largely not taught. Movember's Men in Mind is a continuing professional development program for mental health practitioners, delivered across five self-paced modules, that trains clinicians to apply a considered lens to how men present, examine their own assumptions, and use strengths-based strategies and screening tools for men's depression and suicidality.

In a randomized controlled trial of 587 Australian practitioners, confidence to work with suicidal men rose from 47% before training to 81% afterwards (35). The Australian Government has since funded the next stage: Men in Mind is expanding from mental health specialty settings into primary care, with three new courses for GPs, nurses, and pharmacists rolling out nationally in 2026. That expansion matters here, because the consultations described in 4.2 are overwhelmingly primary and general medical ones, not specialty mental health. The program is now being adapted for a US audience, with testing already underway in California. The pilot will partner with a small number of California providers and put approximately 500 California-based mental health practitioners (pre-licensed and licensed) through the training, gathering outcome data to build the evidence base for wider US rollout.

Movember's

Men in Mind

is a continuing professional development program for mental health practitioners

Services and system leaders that coordinate around how men present.

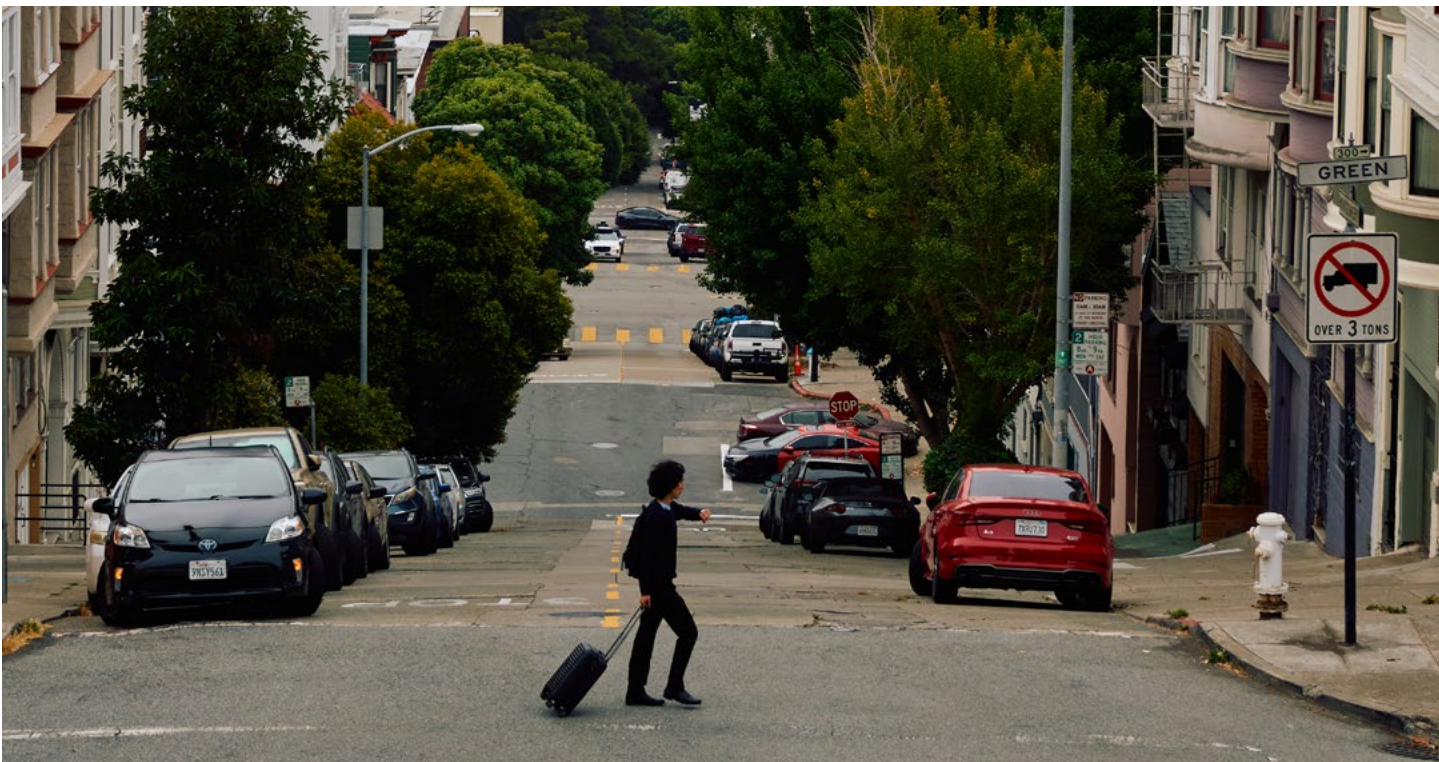
Training a practitioner changes one encounter. Changing the pathway changes whether the encounter happens at all, and whether anything follows it. The men who drop out are not lost to the system by choice, they are lost to a system with no mechanism for noticing they went. Service design, referral pathways, and the accountability measures that sit above them all determine whether a well-trained practitioner is working with the grain of the system or against it.



WHAT IS ALREADY WORKING: MEETING MEN WHERE THEY ARE. WHERE THE SYSTEM REACHES INTO TRUSTED COMMUNITY SPACES, IT CLOSES THE CONNECTION GAP RATHER THAN WAITING FOR MEN TO RETURN. IN THE LOS ANGELES BARBERSHOP BLOOD PRESSURE STUDY, PAIRING CLINICAL PHARMACISTS WITH BARBERS ACROSS 52 BLACK-OWNED BARBERSHOPS LOWERED SYSTOLIC BLOOD PRESSURE SUBSTANTIALLY MORE THAN BARBER-DELIVERED EDUCATION ALONE, WITH RESULTS SUSTAINED AT 12 MONTHS; CALIFORNIA'S CUT HYPERTENSION PROGRAM (36) IS EXTENDING THE MODEL IN THE BAY AREA (37). WITHIN THE FORMAL SYSTEM, THE UNIVERSITY HOSPITALS CUTLER CENTER FOR MEN IN CLEVELAND CONSOLIDATES SPECIALTIES IN ONE LOCATION AND ASSIGNS EACH MAN A NAVIGATOR TO GUIDE HIM THROUGH CARE, ADDRESSING DIRECTLY THE RUSHED, DISCONNECTED ENCOUNTERS DESCRIBED ABOVE (38). MOBILE SCREENING UNITS THAT BRING PROSTATE, COLORECTAL, AND LUNG CHECKS TO WHERE MEN LIVE AND WORK EXTEND THE SAME PRINCIPLE TO EARLY DETECTION.

Men equipped to navigate it. The third layer is the one men themselves hold. Difficulty expressing symptom severity affects nearly a quarter of California men, and no amount of practitioner training substitutes for a man able to say what is wrong and press when he is not heard. Movember is testing this population-level approach in Australia through a Men's Health Literacy campaign, funded by the Australian Government's Department of Health and Aged Care, designed to build men's clarity and confidence about what care involves, when to seek it, and how to navigate the system before they reach the consultation room.

A well-trained clinician needs a man willing and able to say what is wrong. A confident, well-informed man needs a practitioner with the skill to hear it. Both need a system that connects the two and notices when the connection fails. California's opportunity is to build all three at once.





SECTION 05

Injury, Violence and Overdose

THE CATEGORY THAT DRIVES THE MALE / FEMALE PREMATURE MORTALITY GAP NATIONALLY HAS THREE DISTINCT SUB-STORIES IN CALIFORNIA. HOMICIDE AND TRANSPORT INJURY ARE BOTH BELOW THE US AVERAGE; THE OVERDOSE CRISIS IS THE DOMINANT DRIVER OF THE PAST DECADE'S MALE MORTALITY ACCELERATION, AND AROUND THREE IN FOUR OVERDOSE DEATHS ARE MALE.

For both accidents and drug overdoses, men die at approximately three times the female rate (4). Together with suicide, this category accounts for most of the male disadvantage in premature mortality. The two are not always distinct: many

overdose deaths, particularly among men with untreated mental illness or chronic pain, are difficult to cleanly separate from suicide, and the same men driving the suicide crisis often reappear in the overdose data.

SECTION 05 – 1

The male share of injury, violence and overdose

The category is sharply male-skewed across all three drivers, and the male share is similar across them. In 2024 in California, approximately three in four drug overdose deaths, four in five homicide victims, and three in four motor-vehicle transport deaths were male (4). The unintentional-injury category

collectively is the third leading cause of death for California men and the leading category for men aged 18 to 44.

The remainder of this section takes the three drivers in order: homicide and firearm violence, transport and other unintentional injury, drug overdose.

SECTION 05 – 2

Violence and homicide

California's age-adjusted homicide rate of 5.1 per 100,000 in 2023 sits below the US average and below that of most large states (4). Approximately 70% to 75% of California homicides involve a firearm, below the national firearm share of homicide.

The largest internal disparity in California male homicide victimization is by race. Homicide rates among Black men in California reach 32.7 per 100,000, five times the rate for White men and eighteen times the rate for Asian men. Black men made up roughly 6% of California's male population but accounted for 29% of male homicide deaths in 2024 (4,16).

Transport and other unintentional injury

Motor-vehicle and other transport deaths in California totaled 4,760 in 2024, of which approximately three in four were male (4).

Transport injury is the leading cause of unintentional-injury death among California men through their early twenties. From age 25 onward, drug overdose overtakes it as the dominant unintentional-injury category (see Section 5.4), although transport remains

a major contributor to working-age male mortality throughout the life course.

Other unintentional-injury mechanisms (drowning, falls, fire and occupational injury) are also strongly male-skewed in California but are not analyzed individually in this report. Nationally, men account for approximately 80% of drowning fatalities and the substantial majority of fatal occupational injuries.



Drug overdose

Drug overdose is the dominant driver of the past decade's acceleration in male premature mortality in California (4). As mentioned in section 5.1, approximately three in four of the drug overdose deaths recorded in 2024 were male. The age-adjusted overdose death rate peaked at 27.9 per 100,000 in 2023 (39), roughly double the rate a decade earlier, before declining in 2024 as the national decline outpaced California's, meaning the relative position of California men has, at least temporarily, worsened (4).

WHAT IS ALREADY WORKING:
THE COMMUNITY RESPONSE TO OVERDOSE OVERLAPS WITH THE MENTAL-HEALTH AND CONNECTION PROGRAMS IN SECTION 7, INCLUDING THE NATIONAL COMPADRES NETWORK'S CÍRCULOS DE HOMBRES, WHICH OPERATE AT CALIFORNIA SITES AND WORK WITH MEN ON SUBSTANCE MISUSE AND MENTAL HEALTH IN TRUSTED CULTURAL SETTINGS (41). ADDITIONALLY, SYSTEMIC HARM-REDUCTION EFFORTS HAVE PROVEN HIGHLY EFFECTIVE; THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES' NALOXONE DISTRIBUTION PROJECT HAS SUCCESSFULLY DISTRIBUTED MILLIONS OF KITS ACROSS THE STATE, RESULTING IN HUNDREDS OF THOUSANDS OF REPORTED OVERDOSE REVERSALS (42).

Synthetic opioids, chiefly fentanyl, drive both the rise and the partial reversal (17). Fentanyl is implicated in approximately 86% of California opioid overdose deaths, and CDPH data show synthetic-opioid deaths beginning to fall through 2024 (5). Polydrug deaths involving fentanyl plus a stimulant now make up a substantial share of overdose mortality, and these frequent combinations complicate treatment because medications for opioid use disorder do not address stimulant use.

The impact of overdose mortality is not located in a narrow age band: male fentanyl deaths under age 75 distribute roughly equally between the 25 to 44 and 45 to 64 bands, with the relative male disadvantage sharpest in the younger group. Policy targeting therefore needs to span the full 25 to 64 male working-age range (40).

A decade ago California's opioid overdose profile was White-majority and prescription-driven; CDPH now reports American Indian/Alaska Native and Black/African American Californians at the highest fentanyl rates (5), reflecting unequal exposure to the more recent, more lethal wave of synthetic-opioid supply rather than any difference in underlying risk. Kiang et al. independently confirm this pandemic-era shift (17).



SECTION 06

Where the Male Health Burden Concentrates

THE MORTALITY AND TREATMENT-ACCESS PATTERNS DESCRIBED IN SECTIONS 2 TO 5 ARE NOT EVENLY DISTRIBUTED ACROSS THE MALE POPULATION. THREE COHORTS CARRY A DISPROPORTIONATE SHARE OF THE BURDEN: MEN IN HIGH-RISK INDUSTRIES AND OCCUPATIONS, VETERANS, AND MEN EXPERIENCING HOMELESSNESS. EACH COHORT HAS A DISTINCT POLICY LEVER ATTACHED TO IT.

High-risk industries and occupations

90%
of the construction workforce
are men, followed by 89%
in the mining sector and 69%
in the agricultural sector

Suicide rates vary sharply by industry, and the sectors carrying the highest rates are among the most heavily male. The most recent national figures, from the National Vital Statistics System, are summarized in Table 6.1 (43). Notably, these industries are often male-dominated: in California, men constitute 90% of the construction workforce, 89% of mining workers and 69% of agricultural workers (101).

TABLE 6.1 MALE SUICIDE RATE BY INDUSTRY, US, 2021

INDUSTRY	SUICIDE RATE (PER 100,000 MALE WORKERS)
Mining, quarrying, oil and gas extraction	72.0
Construction	56.0
Other services (except public administration)	50.6
Agriculture, forestry, fishing and hunting	47.9
Arts, entertainment, and recreation	47.9
All male workers	32.0

California’s economic geography means some male-dominated industries like construction and agriculture are concentrated in particular regions of the state. These are the same regions identified in Section 2.3 as having the highest male premature mortality rates

and in Section 3.4 as having the most severe behavioral-health workforce shortages. Industry-occupation overlay against premature mortality and workforce shortage is therefore a useful targeting tool available to California’s prevention infrastructure.

**WHAT IS ALREADY WORKING:
PEER SUPPORT IN MALE-DOMINATED SETTINGS.
SOME COMPANIES AND GROUPS IN HIGH-RISK
INDUSTRIES HAVE STARTED INITIATIVES TO
FOCUS ON MENTAL HEALTH:**

- **Employer-led investment.** Bechtel committed \$7 million to the American Foundation for Suicide Prevention to bring suicide-prevention programming to 500,000 US construction workers, and CEOs of major contractors have formed an advisory council to drive an industry-wide response (44).
- **Industry coalitions.** The Construction Industry Alliance for Suicide Prevention offers free peer-support frameworks, toolbox talks, and anonymous screening tools to any contractor or union, with regional counterparts like Oregon's Construction Suicide Prevention Partnership (45,46).
- **Union-based programs.** North America's Building Trades Unions hosts a task force on opioids and suicide prevention, and individual unions offer member services. Union-affiliated wellness coalitions have also emerged in several places, including St. Louis and New Mexico, offering peer support and confidential navigation to members and families. Because union programs travel with the worker across employers, they can reach men that employer-tied benefits miss (47, 48, 49).
- **Government action.** Washington State's HB 2492, passed in 2026, requires all state-registered construction apprenticeship programs to provide behavioral health and wellness training beginning in 2027, embedding the training at the point of workforce entry. At the federal level, USDA's Farm and Ranch Stress Assistance Network funds farm crisis helplines, agricultural behavioral health counseling, and peer support networks for farmers and ranchers (50, 51).

SECTION 06 – 2

Veterans

California is home to approximately 1.6 million veterans, the largest veteran population of any US state (52). Veteran suicide mortality runs substantially above the rate for non-veteran men of similar age. The most recent VA National Veteran

Suicide Prevention Annual Report places the age-adjusted suicide rate among male US veterans at approximately 1.5 times the non-veteran male rate, with California's veteran-specific figure published in the same series (53).



WHAT IS ALREADY WORKING:
INTEGRATED CARE FOR VETERANS. VETERANS HEALTH ADMINISTRATION SITES THAT BRING UROLOGICAL, PRIMARY, AND MENTAL-HEALTH CARE TOGETHER MODEL THE JOINED-UP APPROACH THIS REPORT CALLS FOR (54). AT SCALE, THE MILLION VETERAN PROGRAM IS ONE OF THE COUNTRY'S LARGEST HEALTH-RESEARCH EFFORTS (55), AND THE DEPARTMENT OF DEFENSE PROSTATE CANCER RESEARCH PROGRAM DIRECTS DEDICATED FEDERAL INVESTMENT THAT CALIFORNIA'S 1.6 MILLION VETERANS CAN BE CONNECTED TO (56).

Two California-specific points are worth surfacing. First, Proposition 1 directs \$1.065 billion to permanent supportive housing for veterans with behavioral-health needs (22). The allocation is veteran-targeted rather than male-targeted, but it reaches a heavily male population, and it is the closest the bond comes to a men's health investment. Second, with roughly 1.6 million veterans, California carries a larger share of this risk in absolute terms than any other state.

SECTION 06 – 3

Homelessness

California recorded 187,084 people experiencing homelessness on a single night in January 2024 according to HUD's 2024 Annual Homeless Assessment Report, the largest state count of any US state and approximately 24% of the US total of 771,480 (the highest US count since HUD began this enumeration in 2007) (57). California also had the highest unsheltered rate (not in emergency shelter, transitional housing, or a safe haven program) of any state at 66%.

The majority of California's homeless adult population is male, with 69% of all participants in the UCSF Benioff Homelessness and Housing Initiative's California Statewide Study of People Experiencing Homelessness (CASPEH) identifying as male and 64% of those ages 18-24 (58,59).

MORTALITY OUTCOMES AMONG PEOPLE EXPERIENCING HOMELESSNESS

The Los Angeles County Department of Public Health publishes the most detailed homeless-mortality data in the state. LA County's most recent report, covering 2024 deaths and released in March 2026, found 2,208 deaths among people experiencing homelessness in LA County, an age-adjusted mortality rate of 2,994 per 100,000, approximately 4.2 times the LA County overall rate (60).



SECTION 07

Where the Opportunity Lies

THIS SECTION MAPS WHERE THE LEVERAGE SITS. THE WORKPLACE AS A SETTING FOR HEALTH INTERVENTION WAS COVERED IN SECTION 6. BEYOND IT, THERE ARE OTHER AREAS IN WHICH COMMUNITY-BASED INTERVENTION HAS BEEN SHOWN TO BE EFFECTIVE: FATHERHOOD, COMMUNITY CONNECTION, PHYSICAL ACTIVITY, AND TECHNOLOGY. EACH CARRIES EVIDENCE THAT IT SHIFTS MALE MENTAL AND PHYSICAL HEALTH AT POPULATION SCALE.

They are not the only routes to engage California men in their own health, but they are among the highest-yield ones,

particularly for the majority of men who do not present at clinical services.

SECTION 07 – 1

Fatherhood: A Critical Window in Men's Health

This section was developed with Dr. Daniel Singley, psychologist, early fatherhood researcher, and founder of the San Diego-based Center for Men's Excellence, and Elyse Springer, marriage and family therapist and a founding board member of the California Chapter of Postpartum Support International.

Fatherhood is one of the most powerful and underutilized entry points into men's mental and physical health. It is a period when men are often motivated to make changes in their lives, interacting with healthcare and family-serving systems, and experiencing substantial biological, psychological, relational, and social changes. Recent research has shown clear and unique ways that fathers struggle during this transition, yet utilization of the related screening and interventions remains largely neglected by clinicians, administrators, policy, and legislation in this area.

Discussions about parenting, caregiving, and family wellbeing are often framed through the very real challenges faced by mothers, including disproportionate caregiving responsibilities, mental load, and longstanding inequities associated with the "second shift." While these

concerns remain important, responding to them fully means recognizing fathers and non-gestational parents as part of the same family system: supporting fathers strengthens the support available to mothers and children rather than competing with it. There is now an opportunity to widen the lens from mothers and babies to a family systems approach that includes fathers and all co-parents.

FATHERS ARE SOCIETALLY EXPECTED TO PROTECT AND PROVIDE BUT NOT TO PARTNER EQUALLY IN PARENTHOOD.

"Rather than being seen as parents navigating their own transition to health," says Elyse Springer, "fathers are seen in context as being in support of mothers and babies, with an unintended lack of systemic care for their own experience." Fathers are often recognized for what they bring to mothers and children. They are also parents navigating their own transition to parenthood, and recognizing both adds to the picture rather than detracting from it. Traditional assumptions that fathers are primarily providers and protectors remain deeply embedded across healthcare, behavioral

health, public health, and parent education systems despite substantial changes in how families function and how fathers participate in caregiving, yet the research literature tells a different story.

Fatherhood is a developmental transition sometimes called “patrescence,” the father’s counterpart to the better-studied matrescence that mothers undergo. Research from Dr. Darby Saxbe and colleagues at the University of Southern California has shown that fathers experience measurable changes in neurobiology, hormones, caregiving behavior, identity, and mental health. Fathers experience changes in testosterone, cortisol, caregiving-related neuroendocrine systems, and brain regions associated with attachment, emotional regulation, and caregiving (13). These changes are most pronounced among fathers who are actively engaged in the day-to-day care of their children. Everyday caregiving contributes to the

biological, psychological, and relational adaptations that accompany the transition to fatherhood. Caregiving is not just something fathers do; it is part of what shapes them as parents.

Mental health changes are part of this transition. Across studies, research finds close to 20% of all new fathers experience some type of perinatal mental health disorder. A nationwide cohort study of new Canadian fathers revealed that 22.4% experienced comorbid depression and anxiety symptoms at some point during the first year postpartum, with 13.2% of those fathers experiencing comorbidity during the second year postpartum (105).

Approximately one in ten fathers experiences depression during pregnancy or the first year following the birth of a child (103), with rates increasing substantially between four and six months postpartum. Anxiety and related disorders are also common, including generalized anxiety disorder, obsessive-compulsive disorder, and panic disorder. Protective factors also shape this picture. A supportive partner relationship, social connection, and practical support during the perinatal period are associated with better paternal mental health, pointing to concrete opportunities for prevention.

One of the strongest predictors of paternal postpartum depression is maternal postpartum depression, highlighting that perinatal mental health is a family systems issue. The perinatal period also offers a unique opportunity to support the entire family. During this time, families have frequent contact with healthcare providers across multiple settings, creating natural opportunities to identify concerns, engage fathers, and connect families with appropriate care. Building father-inclusive approaches

Dr. Daniel Singley encourages fathers, partners, clinicians, and birth educators alike to recognize what the research now shows: that while it is important for new fathers to protect, provide, and sacrifice for those they love, making the transition to parenthood as healthy as possible also means fathers hearing, and being given permission, to let others protect them, provide for them, and sacrifice for them in their own time of need.



into the services families already access can strengthen outcomes for fathers, mothers, and children.

The perinatal period offers an important opportunity to better understand and support fathers' mental health. As research on paternal perinatal mental health continues to expand, so does the understanding of how fathers experience and express psychological distress (61). Fathers experience emotional distress in ways that can include irritability, anger, emotional withdrawal, substance use, compulsive behaviors, physical complaints, risk-taking, and increased

work involvement, in addition to more traditional symptoms of depression and anxiety (64). Continued refinement of screening approaches, workforce training, and father-inclusive models of care will improve recognition of these experiences (64). Research also identifies several factors that support positive paternal mental health, including supportive partner relationships, strong social connections, practical support, and active involvement in caring for an infant (107, 108). Strengthening these protective factors creates meaningful opportunities to improve outcomes for fathers, mothers, children, and families.



The true scope of paternal perinatal mental health problems is likely much larger than prevalence estimates suggest. Fathers are rarely screened. Most screening tools were developed using maternal populations. Men often express distress differently than women, with symptoms appearing as irritability, anger, emotional withdrawal, substance use, compulsive behaviors, somatic complaints, risk-taking, or excessive work involvement. Men are also less likely to seek healthcare generally and mental healthcare specifically. Together, these realities create a population that is systematically under-screened, under-identified, and undertreated.

THIS PATERNAL PERINATAL MENTAL HEALTH EQUITY GAP IS PARTICULARLY RELEVANT IN CALIFORNIA.

California has made substantial investments in maternal and child health through the Birthing Care Pathway, Comprehensive Perinatal Services Program (CPSP), Enhanced Care Management (ECM), Transitional Care Services (TCS), CalWORKS Family Stabilization, First 5 California initiatives, community-based fatherhood programs, maternal mental health screening requirements, and maternal mental health

quality measures. California has built one of the strongest maternal mental health infrastructures in the country.

Fathers are present throughout these systems. They attend prenatal appointments, childbirth classes, pediatric visits, family support programs, and public benefit programs. Yet fathers remain absent from screening protocols, referral pathways, outcome measurement, workforce training, and quality improvement efforts. Their inclusion is typically tied to the impact they have on mothers and children rather than recognition of their own health, adjustment, and developmental needs.

The result is a system that recognizes fathers as influential to family health but not as individuals whose own mental health, relationship functioning, identity development, and adjustment to parenthood warrant systematic attention.

California does not need to build an entirely new system as fathers are already present within existing systems, California's task is to make fathers visible and to consider ways to address the resources and culture of the system to address fathers' unique needs.



Where fathers already appear in California systems

California already operates the systems, programs, and policy infrastructure needed to reach fathers. The task is to extend it.

TABLE 7.1.1 PERINATAL AND FAMILY-SERVING SYSTEMS FATHERS ALREADY MOVE THROUGH

VEHICLE	WHAT IT IS
<u>Comprehensive Perinatal Services Program (CPSP), CDPH (65)</u>	Enhanced prenatal and postpartum health, nutrition, education, and psychosocial services for eligible Medi-Cal members. Enhanced perinatal services alongside obstetric care for Medi-Cal pregnancies.
<u>Birthing Care Pathway, DHCS (66)</u>	CalAIM framework standardizing the perinatal care journey across pregnancy and postpartum.
<u>Enhanced Care Management and Community Supports, DHCS (67)</u>	CalAIM care management and wraparound supports for high-need Medi-Cal members.
<u>Pregnancy and Postpartum Transitional Care Services, DHCS (68)</u>	Care coordination supporting transitions across pregnancy and the first year postpartum for eligible Medi-Cal members.
<u>CalWORKs (including Family Stabilization, CDSS) (69)</u>	Cash assistance, employment services, and intensive support for CalWORKs families facing barriers to employment. Cash aid and intensive crisis support for low-income families with children

TABLE 7.1.2 FATHERHOOD-SPECIFIC PROGRAMS

VEHICLE	WHAT IT IS
<u>First 5 California Fatherhood Initiative (70)</u>	Proposition 10-funded father engagement work in early childhood settings.
<u>Supporting Father Involvement, CDSS/OCAP (71)</u>	Evidence-based program strengthening father engagement.
<u>Project Fatherhood, Children's Institute (72)</u>	A Children's Institute peer-support group program for fathers in Los Angeles.

TABLE 7.1.3

THE MATERNAL MENTAL HEALTH PRECEDENT THE REPORT ASKS THE STATE TO EXTEND TO FATHERS

VEHICLE	WHAT IT IS	STATUS
<u>AB 2193 (2018) (73)</u>	Requires specified prenatal and postpartum care practitioners to offer or conduct maternal mental health screening and plans to maintain a maternal mental health program	Enacted, mandatory
<u>AB 3032 (2018) (74)</u>	Requires hospitals with perinatal units to run a maternal mental health education program	Enacted, mandatory
<u>AB 1936 (2024) (75)</u>	Requires maternal mental health programs to include one screening during pregnancy and one during the first six weeks postpartum	Enacted, mandatory
<u>AB 2581 (2024) (76)</u>	Directs Healing Arts boards to consider maternal mental health in continuing education	Enacted, permissive
<u>Knox-Keene, Health and Safety Code § 1367.625 (77)</u>	Statutory basis for the plan-level maternal mental health program	In force
<u>HEDIS Postpartum Depression Screening and Follow-Up, NCQA (78)</u>	National quality measure that makes screening count toward plan accountability	Active measure

No equivalent statewide screening requirement or widely adopted quality measure exists for paternal perinatal mental health. That gap is the opening.

TABLE 7.1.4

FEDERAL REFERENCE POINTS

VEHICLE	WHAT IT IS
<u>Dads Matter Act of 2025 (79)</u>	Bipartisan bill to promote father engagement and improve maternal health outcomes
<u>National Responsible Fatherhood Clearinghouse (80)</u>	Federal hub for fatherhood programs and resources



Community and connection

Community is one of the most important, and overlooked, influences on health. While formal healthcare services treat illness, communities help prevent it. They shape whether people feel connected, supported, valued, and able to navigate life's challenges. Strong communities provide great opportunities for social connection, practical support, shared identity, and a sense of belonging - all factors that are recognized as important determinants of physical and mental health (81,82).

“I always tell people I have my work family and my biological family, and each places expectations and demands on your time. What comes with experience and maturity is knowing that achieving balance is ever more important. Listen to your body and mind, seek help from peers, family and the resources available, and restore balance between work, play and rest.”

— Jibran, Bay Area

Community comes in many forms. It may be built around family, neighborhoods, faith groups, sports clubs, workplaces, volunteer organizations, online networks, or shared cultural experiences. In California, community is reflected in the state's diversity. The experience of community in Los Angeles differs from that of the Central Valley, the Bay Area, Tribal Nations, the Inland Empire, or rural Northern California. For many Californians, community is strengthened through cultural traditions, immigrant and multilingual networks, local organizations, schools, and civic institutions that provide connection, support, and a sense of belonging.

Community connection is not experienced equally across California. Historical and ongoing inequities related to race, income, housing, education, transportation, and access to supportive services shape the opportunities for participation and belonging. At the same time, many communities that have experienced historical racism, exclusion, and disinvestment have developed strong social and cultural assets that support health and wellbeing, including extended family networks, faith communities, mutual aid traditions, cultural organizations, and community-led institutions. Across California, these networks have served as important sources of resilience, belonging, and support. Improving health outcomes therefore requires not only addressing barriers to participation, but recognizing, strengthening, and investing in community assets that already exist.

This place, it gave me a support system. It's a place where you know they've got you if you need it.

— Kobe, Mentor, San Diego (UWEAST)

I want to grow into a man who leads by example, showing others the best options and helping them make the right choices.

— Participant, San Diego (UWEAST)

At the same time, social and economic pressures can weaken community connections. Housing affordability pressures, long commuting times, economic insecurity, geographic mobility, relationship breakdown, and changing patterns of work can all reduce opportunities for meaningful social interaction. In California, these pressures can be particularly acute. High housing costs may force people away from established support networks, while large geographic distances and lengthy commutes can make it harder to sustain regular

community participation. In some rural parts of California, geographic isolation, dispersed populations, limited transportation, and fewer opportunities for organized community activities can make it more difficult to build and maintain regular social connections. These challenges may be compounded by limited access to health and behavioral health services, increasing the importance of strong local community networks (83).

When community connections are weakened or disrupted, the health consequences can be significant. Social isolation and loneliness are increasingly recognized as important public health challenges (84). While loneliness affects people of all ages and genders, evidence suggests that men may be particularly vulnerable to its consequences because of differences in friendship patterns, help-seeking behaviors, and societal expectations around self-reliance and emotional expression (81).

Viewed through this lens, strengthening community is more than a social objective— it is a preventive health strategy and an essential component of public health infrastructure. Policies and programs that create opportunities for connection, participation, purpose, and belonging can support mental wellbeing, promote healthy aging, strengthen resilience during periods of transition, and contribute to better health outcomes for California men across the life course.

WHAT IS ALREADY WORKING: THE SANCTUARY OF HOPE, LOCATED IN THE MANTUARY IN SOUTH LOS ANGELES; MIS CUATES, BY THE LATINO LEADERSHIP COUNCIL IN ROSEVILLE; BLACK MALE CIRCLE, PROVIDING RESTORATIVE JUSTICE FOR OAKLAND YOUTH AND NUMEROUS ORGANIZATIONS OFFERING HEALING CIRCLES FOR MEN, INCLUDING NAMI CONTRA COSTA AND PEACEFUL WARRIORS, FOR MEN OF COLOR, AND YOUNGGOOD? IN LOS ANGELES.



Physical activity and sport

Unlike interventions designed to address a single primary health outcome, physical activity is a multi-outcome intervention. The WHO identifies benefits spanning cardiovascular, metabolic, musculoskeletal, cognitive, and mental health, as well as reductions in all-cause mortality, while the American College of Sports Medicine recommends exercise because it simultaneously improves cardiorespiratory, musculoskeletal, and neuromotor fitness and overall health (85,86,100).

The 2018 US Physical Activity Guidelines Advisory Committee Scientific Report, on which the current federal recommendation of 150 to 300 minutes per week of moderate-intensity activity (or 75 to 150 minutes of vigorous activity) rests, summarizes an inverse dose-response relationship between physical activity and all-cause mortality across age and sex (86). Analyses of the National Health Interview Survey show that regular leisure-time physical activity, compared with inactivity, is associated with a 15% lower risk of all-cause mortality in men (HR 0.85, 95% CI 0.82–0.89) and a 24% lower risk in women (HR 0.76, 95% CI 0.73–0.80), with men reaching maximal benefit around 300 minutes per week (102). An umbrella review covering 16 systematic reviews finds a 19 to 30% all-cause mortality reduction and a 25 to 34% cardiovascular mortality reduction at guideline-level activity in older adults (87).

On mental health specifically, the evidence is now as strong as for physical health. Schuch et al.'s 2016 meta-analysis of randomized controlled trials found a large effect of exercise on depression (SMD 1.11, 95% CI 0.79 to 1.43) (93). A separate prospective cohort meta-analysis (Schuch et al. 2018, *American Journal of Psychiatry*) demonstrated that higher levels of physical activity are associated with 17% lower odds of developing depression (pooled adj OR 0.83, 95% CI 0.79 to 0.88) across 49 prospective cohorts (88). The mechanistic literature points to biochemical pathways, but the practical implication is straightforward: physical activity is one of

WHAT IS ALREADY WORKING:
SPORT-BASED PROGRAMS ARE INCREASINGLY BEING USED TO IMPROVE BOTH PHYSICAL AND MENTAL HEALTH AMONG BOYS AND MEN. MOVEMBER'S GAME CHANGERS PROGRAM, CO-CREATED WITH YOUNG MEN THROUGH THE MAKING CONNECTIONS INITIATIVE, USES SPORT AS A PLATFORM FOR BUILDING MENTAL HEALTH LITERACY, EMOTIONAL SKILLS, AND HELP-SEEKING BEHAVIORS, WITH A US PILOT LAUNCHING IN SAN DIEGO IN 2025 (89). WITHIN THE HEALTHCARE SYSTEM, UC SAN DIEGO HEALTH HAS IMPLEMENTED EXERCISE IS MEDICINE ACROSS ITS PRIMARY CARE CLINICS, EMBEDDING ROUTINE PHYSICAL ACTIVITY ASSESSMENT, COUNSELING, AND REFERRAL INTO CLINICAL PRACTICE (90). EARLY EVALUATIONS FOUND HIGH PATIENT ACCEPTANCE AND INCREASED CONFIDENCE TO ENGAGE IN REGULAR PHYSICAL ACTIVITY, DEMONSTRATING THE FEASIBILITY OF INTEGRATING EXERCISE PROMOTION INTO ROUTINE HEALTHCARE. TOGETHER, THESE INITIATIVES ILLUSTRATE COMPLEMENTARY APPROACHES TO INCREASING PHYSICAL ACTIVITY WHILE SUPPORTING BOTH PHYSICAL AND MENTAL HEALTH ACROSS CALIFORNIA.

the few interventions that protect against both incident and recurrent depression at a population level.

California is particularly well positioned to leverage physical activity as a public health strategy. The state's climate, extensive parks and trail systems, coastline, and strong network of community recreation programs create opportunities for year-round participation. However, these opportunities are not distributed equally.

Communities experiencing poverty, neighborhood disinvestment, limited recreational infrastructure, transportation barriers, or disability often face greater obstacles to participation despite carrying a disproportionate burden of chronic disease and poor mental health. Expanding equitable access to safe, affordable, and culturally relevant opportunities for physical activity therefore represents both a health promotion and health equity priority.

SECTION 07 – 5

Advances in Technology that Benefit California Men's Health

California is often described as the birthplace, and a leading global hub, of digital technology. With Silicon Valley at its center, the state has played a major role in shaping the personal computing era, the rise of the internet, and today's advances in artificial intelligence. Advances in digital platforms, next-generation artificial intelligence, and integration of digital health information and wearables position technology as an appealing medium for closing gaps in service and support (91). Technology applications for men's health are particularly appealing because they meet men where they are - at home or work, on their phones, computers, and social media, or on the go - they lower barriers to care and reach audiences who might not connect with traditional health services. Men are no longer required to go to health services for information or support - it is available on demand 24 hours a day in their hands.

Integration of technology into men's health as extensions of existing health providers and as standalone mediums is rapidly changing. Most health providers in California have some digital footprint, offer virtual or telehealth services along with traditional in-office services, have partnerships with HIPAA-compliant and CMS-integrated online or app-based health providers, and increasingly integrating wearables (e.g., passive devices like smart watches/digital trackers, smart rings, smart patches, continuous glucose monitors, etc.). These technologies can overcome help-seeking and medical data collection barriers that can impact men's engagement in traditional health systems and care delivery. Integration of technology for sensitive services such as behavioral health, sexual health, urinary symptoms, and erectile dysfunction care help by making care feel easier for some men to start.



Next-generation architectures in AI therapy and coaching apps, such as The Path, Ash and Sonia, reject aimless venting for time-boxed, outcome-driven sessions that actively challenge blind

WHAT IS ALREADY WORKING:
BROTHER BE WELL IS A CALIFORNIA BASED CULTURALLY AFFIRMING MULTIMEDIA MENTAL HEALTH AND WELLNESS PLATFORM FOR BOYS AND MEN OF COLOR (AGES 13+) (94). IT PROVIDES PREVENTION AND EARLY-INTERVENTION EDUCATION THROUGH STORIES, ARTICLES, PODCASTS, VIDEOS, AND EXPERT CONVERSATIONS. THE PLATFORM ALSO INCLUDES IMMERSIVE VIRTUAL-REALITY EXPERIENCES WITH MUSIC TO SUPPORT MINDFULNESS AND MOOD. IT OFFERS PATHWAYS AND TOOLS FOR INDIVIDUALS, SCHOOLS, AND COMMUNITIES.

spots using proprietary models and compounding memory (92). By replacing passive text boxes with real-time voice-to-voice interaction and proactive check-ins, they act as actionable on-demand tools for health and wellness. This structured setup appeals to men by shifting the focus from passive emotional venting toward objective, strategic problem-solving. Further, when harm to self and others is assessed, immediate support via direct transfer to 988 crisis lines and human services can be achieved. These tools work best as an on-ramp into care rather than a substitute for it, particularly for men managing acute distress or high-risk presentations where sustained in-person psychological support and clinical judgment remain essential.

SECTION 07 – 6

The programs reinforce each other

The strongest community-level programs rarely operate in isolation. Sports clubs, fatherhood groups, and peer support programs naturally overlap, sharing participants, venues, and the same underlying social fabric. Where they do, whether that is fathers playing sport together, or peer groups organized around physical activity, their effects compound. Digital tools extend the same fabric rather than replacing it, carrying these connections between meetings and reaching men who are not yet in the room.

The same logic extends to the relationship between community and health system: programs that build trust and connection at the community level make it more likely that men will seek help, and more likely that health professionals trained to respond will have something meaningful to offer when they do. California's program design should take this seriously: interventions deliberately built at these intersections (community, clinical, and digital alike) are likely to yield more than the sum of their parts.



SECTION 08

California Policy Vision for Boys' and Men's Health

CALIFORNIA HAS THE SCALE, THE AMBITION, AND THE PUBLIC-HEALTH TRACK RECORD TO LEAD THE NATION ON BOYS' AND MEN'S HEALTH. THE RECOMMENDATIONS BELOW SET OUT HOW THE STATE CAN TURN THAT POTENTIAL INTO SUSTAINED, MEASURABLE ACTION.

In July 2025, the Governor signaled this intent, issuing an executive order to support young men and boys and to address mental-health stigma and rising suicide rates. The order drew broad support across health, education, and advocacy organizations, a notable degree of cross-sector consensus that the problem is real and action is overdue, and it sits alongside real momentum already underway. In March 2026, the Governor convened state and community leaders to confront the crisis facing boys and men. The California Department of Public Health has released its Behavioral Health Services Act (BHSA) Population-Based Prevention Plan, a statewide framework to prevent suicide, overdose, and self-harm that now includes commitments relevant to boys and men. And the Department's Office of Suicide Prevention has addressed the issue directly, publishing a March 2026 data brief on sex as a risk factor for suicide and convening an April 2026 statewide Community of Practice on suicide prevention approaches for boys and men that drew on Movember's Real Face of Men's Health among its

guiding sources. This report is designed to build on that foundation, not to restart it. The concern it responds to is not direction but delivery: recognition only changes outcomes when it is matched by sustained, dedicated funding. The agenda below sets out how California can turn shared intent into well-resourced, measurable, and durable action across the whole life course, for boys and men of every age, not only at the youth end.

Men's health does not sit within a single department. The drivers of male premature mortality, including suicide, overdose, chronic disease, injury, and social isolation, cut across health, behavioral health, housing, veterans' affairs, labor, corrections, and education. Improving men's health therefore requires coordinated action across government, not a single program. The recommendations that follow are organized around one central call: that California commit to and resource a coordinated strategy for boys' and men's health, supported by five actions spanning leadership, services, workforce, and evidence.

The central call

Commit to and resource a coordinated California strategy for boys' and men's health: one that drives progress through cross-government leadership,

responsive services, a strengthened workforce, and a robust evidence base, so that more boys and men live longer, healthier lives.

RECOMMENDATION 1

Develop and resource a California Boys' and Men's Health Strategy

A coordinated, evidence-based state strategy should guide investment across leadership, workforce, service design, research, and health promotion. To carry real weight rather than stand as a statement of intent, it should be tied to a clear policy agenda and a budget or legislative ask, the levers that give a strategy teeth in a system where funding sits with the legislature and delivery sits with counties. It should:

- Set clear, measurable targets (for example, reducing male suicide and overdose) and embed monitoring and reporting from the outset.
- Apply a gender lens across California's major existing investments, including Proposition 1's behavioral-health reforms, CalAIM, and the Children and Youth Behavioral Health Initiative, so that men's heightened risks are reflected in how these programs are designed and delivered. This is an immediate step that can be taken through existing programs rather than requiring new ones, needing only a gender lens applied to what California already funds.
- Be backed by a costed delivery plan that spells out what the funding would achieve, for example outreach to the men who never present at services, training that equips practitioners to engage and respond to men more effectively, and a pathway that passes funding through to counties to seed and scale dedicated local men's-health initiatives. The scale of the ask should be calibrated to the budget cycle.
- Prioritize the most disproportionately affected populations and regions identified in this report, including men of color, Indigenous men, veterans, men in high-risk industries, men experiencing homelessness, LGBTQ+ men, and rural and inland communities.
- Build on and connect existing California strategies and programs that already intersect with men's health, including the California Tobacco Prevention Program, Striving for Zero: California's Strategic Plan for Suicide Prevention, the state's alcohol- and other-drug prevention initiatives, the California Violence Intervention and Prevention (CalVIP) program and CDPH's Violence Prevention Initiative, and the Office of Health Equity's work to reduce disparities in underserved communities.
- Adopt a whole-family lens in service design and policy, recognizing that mothers, fathers, partners, and children influence one another's



wellbeing and outcomes. Across California's family-serving systems, fathers are currently recognized mainly for the impact they have on mothers and children, not as individuals whose own mental

health, relationship functioning, and adjustment to parenthood warrant systematic attention in their own right. A strategy that closes that gap strengthens outcomes for fathers, mothers, and children alike.

RECOMMENDATION 2

Appoint dedicated, properly resourced state leadership

Movember calls for the appointment of a dedicated senior leader, a Senior Advisor or Associate Director for Boys' and Men's Health within the California Department of Public Health or the California Health and Human Services Agency, supported by a taskforce or advisory group to guide the strategy. The gold-standard version is a role that is properly mandated, empowered, and institutionalized, with a dedicated budget line in the host office rather than a temporary or unfunded appointment. The most durable form of this is a standing budget request; a flexible advisory role within an executive office may also offer a near-term route worth exploring.

This role would not duplicate or compete with existing health-equity work. It would strengthen it, ensuring that the experiences of boys and men, including those from communities already facing the greatest health disadvantages, are systematically included in how California designs, funds, and evaluates its health programs. The taskforce should include people with lived and living experience alongside sector partners, and should oversee the strategy's governance, deliverables, timeframes, and evaluation. Just as investment in women's health leadership has delivered measurable returns for California families and communities, investment in men's health leadership would benefit not only men themselves but their partners, children, and caregivers.

RECOMMENDATION 3

Invest in community-based, grassroots programs

Scale proven and promising community programs that reach men where they live and work (e.g. fatherhood, social-connection, sport-based, digital, workplace and high-risk-industry programs), with a focus on the populations most disproportionately affected. This should include:

- Focused investment in priority populations and regions, including men of color, Indigenous men, veterans, men in high-risk industries, rural and inland communities, men experiencing homelessness, and LGBTQ+ men.
- Using the transition to fatherhood as an entry point for men's health engagement. California does not need to build an entirely new system to do this: fathers are already present within the Comprehensive Perinatal Services Program, Birthing Care Pathway, Enhanced

Care Management, Transitional Care Services, CalWORKs Family Stabilization, and community-based fatherhood programs. The task is to make fathers visible within systems that already reach them, not to build parallel ones.

- Developing father-inclusive public awareness campaigns that normalize paternal mental health challenges, reduce stigma, and increase awareness of available supports, building on the goals reflected in the federal Dads Matter Act and California's existing fatherhood initiatives.
- Establishing a funding pathway through which promising early-intervention programs can demonstrate effectiveness through rigorous evaluation, so the most effective approaches can be scaled and replicated.



Build a health system and workforce that reaches, responds to, and retains men

Strengthen the capacity and capability of the workforce men are most likely to encounter, and design services around how men actually engage with care:

- Address the behavioral-health workforce shortage in the highest-need regions (Northern & Sierra, the Inland Empire, and the San Joaquin Valley), where male premature mortality is also highest.
- Grow and diversify the workforce men are most likely to trust, including by expanding the pipeline of male providers in behavioral health, a gap raised repeatedly in the state's own workforce discussions and one the current Workforce Education and Training (WET) plan does not yet address through a gender lens.
- Implement proven models: identify, disseminate, and scale evidence-based interventions that equip the health workforce to better reach, respond to, and retain men in care, including Men in Mind, Movember's world-first CPD program for mental-health practitioners, shown through gold-standard randomized controlled trial to improve practitioners' confidence and competence in engaging help-seeking men.
- Equip the perinatal and early-childhood workforce to confidently engage and screen fathers for mental-health concerns, incorporating father-inclusive screening, education, referral, and follow-up pathways into pediatric, obstetric, family medicine, NICU, primary care, and community-based settings. Existing maternal screening infrastructure provides a foundation that can be expanded to include fathers and non-gestational parents, and paternal perinatal mental health should be built into graduate education, workforce development, continuing education, and healthcare professional training, so the workforce is equipped to identify paternal distress and apply the tools shown to be effective for dads.
- Promote uptake of screening, prevention, and existing services among men, including through health-literacy efforts built with men, for men.

RECOMMENDATION 5

Advance research and close the data gaps

California cannot manage what it does not measure. A stronger evidence base, built on better data and a clearer understanding of how, when, where, and why men engage with their health, is essential to designing services and policy that reach and retain men. The state should:

- Invest in large-scale, longitudinal research, community-led and developed with sector partners, to build the evidence base on how, when, where, and why men engage with their health, and use it to advance policy, practice, and standards of care for boys and men.
- Connect and integrate existing data and records across services, within and beyond the health system, so men's journeys through care can be tracked, the points where they drop out identified, and self-care and help-seeking better supported.
- Establish state-level surveillance of paternal perinatal mental health, parallel to the maternal PRAMS system and ideally integrated into the California Health Interview Survey, and expand quality improvement, population health, and accountability efforts more broadly to include paternal mental health, paternal engagement, and family wellbeing outcomes. What is not measured is unlikely to improve.
- Publish routine sex-disaggregated reporting in CDPH's suicide, overdose, migrant, and homelessness mortality and morbidity series, alongside sex-disaggregated estimates of social isolation, building an empirical base that informs future work and identifies cost-saving opportunities. Extend that reporting to sexual orientation and gender identity, where the mandate and the standards already exist but publication does not.
- Fund evaluation that links participation in California-funded community programs to downstream health outcomes, not only participation counts, building the evidence base for what works and for whom.
- Bring this together in a single, public men's-health data dashboard that tracks key indicators by sex, region, and population over time, giving departments, counties, and the public a shared view of progress.

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



SUMMARY OF RECOMMENDATIONS

#	RECOMMENDATION
—	Central call: Commit to and resource a coordinated California strategy for boys’ and men’s health.
1	Develop and resource a California Boys’ and Men’s Health Strategy, tied to a budget and policy agenda.
2	Appoint dedicated, properly resourced and mandated state leadership.
3	Invest in community-based, grassroots programs focused on high-burden populations.
4	Build a health system and workforce that reaches, responds to, and retains men.
5	Advance research and data, including a unified men’s health dashboard.

California has a unique opportunity to lead nationally: the largest and most diverse population in the country, a public-health record that has repeatedly set the national standard, and political attention already turned toward boys and men. The same qualities that make the challenge complex make California the right place to meet it:

what works here, across communities this varied, can work anywhere. Men of color, Indigenous men, immigrant men, Veterans, LGBTQ+ men, and men experiencing poverty, homelessness, or incarceration face compounding health disadvantages, underserved by programs not designed with their needs in mind. Embedding a gender lens across all major health and human-services strategies is essential to reaching them. The opportunity now is to deliver, and to show the rest of the country what a coordinated commitment to boys’ and men’s health can achieve.

Healthier men mean healthier families. Healthier families mean a stronger California.

References

1. Arias E, Xu J, Tejada-Vera B, Bastian B. U.S. state life tables, 2022. National Vital Statistics Reports. 2025;74(12):1–18. doi:10.15620/cdc/174620
2. Radley D, Kolb K, Collins S. 2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities [Internet]. The Commonwealth Fund; 2025. (The Commonwealth Fund). Available from: <https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance>
3. Mental Health America; 2024. (Mental Health America). Available from: <https://mhanational.org/research-reports/2024-state-mental-health-america-report/>
4. Centers for Disease Control and Prevention (National Center for Health Statistics). CDC WONDER [Internet]. CDC WONDER; 2026. National Vital Statistics System, Mortality 2018-2024 on CDC WONDER Online Database. Available from: <http://wonder.cdc.gov/ucd-icd10-expanded.html>
5. California Department of Public Health (Substance and Addiction Prevention Branch). Opioid-Related Overdose Deaths in California, 2023. California Department of Public Health; 2025. (California Department of Public Health).
6. Arias E, Xu J, Tejada-Vera B, Bastian B. U.S. State Life Tables, 2019. National Vital Statistics Reports. 70(18).
7. National Center for Health Statistics. U.S. Decennial Life Tables for 1989-91, Volume 1, Number 1: United States Life Tables [Internet]. National Center for Health Statistics. (National Center for Health Statistics). Available from: https://www.cdc.gov/nchs/data/lifetables/life89_1_1.pdf
8. Pierce J, Shi Y, McMenamin S, Benmarhnia T, Trinidad D, Strong D, et al. Trends in Lung Cancer and Cigarette Smoking: California Compared to the Rest of the United States. Cancer Prevention Research (Philadelphia). 2019;12(1):3–12. doi:10.1158/1940-6207.CAPR-18-0341
9. Movember Institute of Men's Health. The Real Face of Men's Health: 2025 United States Report [Internet]. Movember Institute of Men's Health; 2025. (Movember Institute of Men's Health). Available from: <https://us.movember.com/>
10. Mojtabai R, Olfson M, Han B. National trends in the prevalence and treatment of depression in adolescents and young adults. Pediatrics. 2016;138(6):e20161878. doi:10.1542/peds.2016-1878
11. Racine N, McArthur B, Cooke J, Eirich R, Zhu J, Madigan S. Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. JAMA Pediatrics. 2021;175(11):1142–50. doi:10.1001/jamapediatrics.2021.2482
12. Twenge J, Cooper A, Joiner T, Duffy M, Binau S. Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005-2017. Journal of Abnormal Psychology. 2019;128(3):185–99. doi:10.1037/abn0000410
13. Saxbe D, Rossin-Slater M, Goldenberg D. The transition to parenthood as a critical period for adult health. American Psychologist. 2018;73(9):1190–200. doi:10.1037/amp0000376
14. Conwell Y, Van Orden K, Caine E. Suicide in Older Adults. Psychiatric Clinics of North America. 2011;34(2):451–68. doi:10.1016/j.psc.2011.02.002
15. Schwandt H, Currie J, von Wachter T, Kowarski J, Woolf S. The failure of life expectancy to fully rebound to prepandemic levels. JAMA. 2025;334(10):915–8. doi:10.1001/jama.2025.10439
16. Forsberg K, Sheats K, Blair J. Surveillance for Violent Deaths - National Violent Death Reporting System, 50 States, the District of Columbia, and Puerto Rico, 2022. MMWR Surveillance Summaries. 2025;74(5):1–42.
17. Kiang M, Acosta R, Chen Y, Matthay E, Tsai A, Basu S, et al. Sociodemographic and geographic disparities in excess fatal drug overdoses during the COVID-19 pandemic in California: A population-based study. Lancet Regional Health - Americas. 2022;11:100237. doi:10.1016/j.lana.2022.100237
18. National Institute of Mental Health. Mental illness [Internet]. 2024. Available from: <https://www.nimh.nih.gov/health/statistics/mental-illness>
19. Tran T, Wallace J, Ortega A. Unmet need for mental healthcare among California adults [Internet]. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515380/>



20. California Health Care Foundation. Mental Health in California: Waiting for Care [Internet]. Oakland, CA: California Health Care Foundation; 2022 Jul. (California Health Care Almanac). Available from: <https://www.chcf.org/resource/mental-health-california-almanac/>
21. Joynt J, Catterson R, Alvarez E. The 2024 CHCF California Health Policy Survey [Internet]. California Health Care Foundation; 2024. (California Health Care Foundation). Available from: <https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/>
22. California Department of Health Care Services. Behavioral Health Transformation, Proposition 1: Behavioral Health Services Act (SB 326) and Behavioral Health Infrastructure Bond Act (AB 531) [Internet]. 2024. Available from: <https://www.dhcs.ca.gov/services/MH/Pages/Behavioral-Health-Transformation.aspx>
23. California Department of Public Health (Injury and Violence Prevention Branch). California Suicide and Self-Harm Trends in 2022 [Internet]. Sacramento, CA: California Department of Public Health. (California Violent Death Reporting System (CalVDRS)). Available from: <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/21-22SuicideandSelf-HarmDataBrief.pdf>
24. Rice S, Fallon B, Aucote H, Moller-Leimkuhler A. Development and preliminary validation of the Male Depression Risk Scale: Furthering the assessment of depression in men. *Journal of Affective Disorders*. 2013;151(3):950–8. doi:10.1016/j.jad.2013.08.013
25. Movember. ALEC Conversation Strategy [Internet]. Movember Conversations. Available from: <https://conversations.movember.com/en/ALEC/>
26. Ahmedani B, Simon G, Stewart C, Beck A, Waitzfelder B, Rossom R, et al. Health care contacts in the year before suicide death. *Journal of General Internal Medicine*. 2014;29(6):870–7. doi:10.1007/s11606-014-2767-3
27. Stene-Larsen K, Reneflot A. Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. *Scandinavian Journal of Public Health*. 2019;47(1):9–17.
28. Department of Health Care Access and Information. Supply and Demand Modeling for California's Behavioral Health Workforce, 2025 update [Internet]. California Department of Health Care Access and Information (HCAI); 2025. (California Department of Health Care Access and Information (HCAI)). Available from: <https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-californias-behavioral-health-workforce/>
29. Ashman J, Santo L, Okeyode T. Characteristics of Office-based Physician Visits by Age, 2019 [Internet]. Hyattsville, MD: National Center for Health Statistics; 2023 Apr. (National Health Statistics Reports). Available from: <https://stacks.cdc.gov/view/cdc/125462> doi:10.15620/cdc:125462
30. Ferreira D, Vieira I, Pedro M, Caldas P, Varela M. Patient Satisfaction with Healthcare Services and the Techniques Used for its Assessment: A Systematic Literature Review and a Bibliometric Analysis. *Healthcare (Basel)*. 2023;11(5):639. doi:10.3390/healthcare11050639
31. Seymour-Smith S, Wetherell M, Phoenix A. "My Wife Ordered Me to Come!": A Discursive Analysis of Doctors' and Nurses' Accounts of Men's Use of General Practitioners. *Journal of Health Psychology*. 2002;7(3):253–67. doi:10.1177/1359105302007003220
32. Hale S, Grogan S, Willott S. Male GPs' views on men seeking medical help: a qualitative study. *British Journal of Health Psychology*. 2010;15(4):697–713. doi:10.1348/135910709X479113
33. Markowitz D. Gender and ethnicity bias in medicine: a text analysis of 1.8 million critical care records. *PNAS Nexus*. 2022;1(4):pgac157. doi:10.1093/pnasnexus/pgac157
34. Almaliah-Rauscher S, Ettinger N, Levi-Belz Y, Gvion Y. "Will you treat me? I'm suicidal!" The effect of patient gender, suicidal severity, and therapist characteristics on the therapist's likelihood to treat a hypothetical suicidal patient. *Clinical Psychology & Psychotherapy*. 2020;27(3):278–87. doi:10.1002/cpp.2426
35. Seidler Z, Wilson M, Toogood N, Oliffe J, Kealy D, Ogrodniczuk J, et al. Pilot evaluation of the Men in Mind training program for mental health practitioners. *Psychology of Men & Masculinities*. 2022;23(2):257–64. doi:10.1037/men0000383
36. Victor R, Lynch K, Li N. A cluster-randomized trial of blood-pressure reduction in Black barbershops. *New England Journal of Medicine*. 2018;378(14):1291–301. doi:10.1056/NEJMoa1717250
37. Roots Community Health. Cut Hypertension Program. Available from: <https://cuthypertension.org/>

38. University Hospitals Cutler Center for Men, Cleveland, Ohio. Available from: <https://www.uhhospitals.org/services/mens-health>
39. Garnett M, Minino A. Changes in drug overdose mortality and selected drug type by state: United States, 2022 to 2023 [Internet]. NCHS Health E-Stats; 2025. (NCHS Health E-Stats). Available from: <https://www.cdc.gov/nchs/data/hestat/drug-overdose/drug-overdose-2022-2023.htm> doi:10.15620/cdc/174578
40. California Legislative Analyst's Office. Brief on California overdose mortality among working-age adults, 2024 [Internet]. California Legislative Analyst's Office; 2024. (California Legislative Analyst's Office). Available from: <https://lao.ca.gov/>
41. National Compadres Network. Círculos de Hombres (Men's Circles) [Internet]. Available from: <https://nationalcompadresnetwork.org/misson-purpose-history/>
42. California Department of Health Care Services. Naloxone Distribution Project [Internet]. 2025. Available from: https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
43. Sussell A, Wiegand R, Ridenour M, Marsh S. Suicide rates by industry and occupation, National Vital Statistics System, United States, 2021. MMWR Morbidity and Mortality Weekly Report. 2023;72(50):1346–50. doi:10.15585/mmwr.mm7250a2
44. Construction Dive. Construction leaders form executive council on suicide prevention [Internet]. 2024. Available from: <https://www.constructiondive.com/news/suicide-prevention-construction-bechtel-afsp/730231/>
45. Construction Industry Alliance for Suicide Prevention. CIASP [Internet]. Construction Industry Alliance for Suicide Prevention. Construction Industry Alliance for Suicide Prevention (CIASP). Available from: <https://www.preventconstructionsuicide.com/>
46. Construction Suicide Prevention Partnership, Lines for Life. Construction Suicide Prevention Partnership [Internet]. Lines for Life. Construction Suicide Prevention Partnership (CSPP). Available from: <https://www.suicide-stops-here.org/>
47. International Union of Painters and Allied Trades District Council 11. IUPAT District Council 11 [Internet]. International Union of Painters and Allied Trades District Council 11. Mental Health Awareness. Available from: <https://www.iupatdc11.com/ourwork/mentalhealthawareness>
48. New Mexico Building and Construction Trades Council. NM Building Trades Wellness [Internet]. New Mexico Building Trades Wellness Coalition. New Mexico Building Trades Wellness Coalition. Available from: <http://nmbtwellness.org/>
49. North America's Building Trades Unions. NABTU Opioid and Suicide Prevention Task Force [Internet]. Available from: <https://nabtu.org/home-page/cpwr-covid-19/nabtu-opioid-taskforce-opioid-resources/>
50. Washington State Legislature. Substitute House Bill 2492: Providing behavioral health and wellness training for building and construction trade apprenticeships (Chapter 14, 2026 Laws of Washington). Washington State Legislature, 2025-26 Regular Session [Internet]. Washington State Legislature; 2026. Available from: <https://app.leg.wa.gov/bills/summary?BillNumber=2492&Year=2025>
51. U.S. Department of Agriculture (National Institute of Food and Agriculture). USDA National Institute of Food and Agriculture [Internet]. U.S. Department of Agriculture. Farm and Ranch Stress Assistance Network (FRSAN) Program. Available from: <https://www.nifa.usda.gov/grants/programs/farm-ranch-stress-assistance-network-frsan-program>
52. US Department of Veterans Affairs (National Center for Veterans Analysis and Statistics). Veteran Population (VetPop) and State Summaries. US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics [Internet]. US Department of Veterans Affairs. Available from: https://www.va.gov/vetdata/veteran_population.asp
53. US Department of Veterans Affairs (National Center for Veterans Analysis and Statistics). 2024 National Veteran Suicide Prevention Annual Report [Internet]. US Department of Veterans Affairs; 2024. (US Department of Veterans Affairs). Available from: <https://www.va.gov/vetdata/>
54. Fenstermaker M, Paknikar S, Rambhatla A, Ohl D, Skolarus T, Dupree J. The state of men's health services in the Veterans Health Administration. Current Urology Reports. 2017;18(11):73. doi:10.1007/s11934-017-0733-4
55. US Department of Veterans Affairs. Million Veteran Program [Internet]. 2025. Available from: <https://www.mvp.va.gov/>
56. Congressionally Directed Medical Research Programs (US Department of Defense). US Department of Defense [Internet]. US



- Department of Defense; 2025. Prostate Cancer Research Program. Available from: <https://cdmrp.health.mil/pcrp/>
57. US Department of Housing and Urban Development. 2024 Annual Homeless Assessment Report (AHAR) to Congress: Part 1, Point-in-Time Estimates of Homelessness [Internet]. US Department of Housing and Urban Development; 2024. (US Department of Housing and Urban Development). Available from: <https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf>
 58. Kushel M, Perry E, Craig R, Schneidemann M, Duke M. Health and Homelessness in the California Statewide Study of People Experiencing Homelessness (Toward Thriving). UCSF Benioff Homelessness and Housing Initiative; 2025. (UCSF Benioff Homelessness and Housing Initiative).
 59. Kushel M, Moore T. Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness (CASPEH) [Internet]. UCSF Benioff Homelessness and Housing Initiative; 2023. (UCSF Benioff Homelessness and Housing Initiative). Available from: <https://homelessness.ucsf.edu/CASPEH>
 60. Los Angeles County Department of Public Health. Lives Lost: Mortality Trends and Prevention Opportunities for People Experiencing Homelessness in Los Angeles County, 2024. Los Angeles County Department of Public Health; 2026. (Los Angeles County Department of Public Health).
 61. Berg R, Solberg B, Glavin K, Olsvold N. Instruments to identify symptoms of paternal depression during pregnancy and the first postpartum year: A systematic scoping review. *American Journal of Men's Health*. 2022;16(5). doi:10.1177/1557988322114984
 62. Addis M, Mahalik J. Men, masculinity, and the contexts of help seeking. *American Psychologist*. 2003;58(1):5–14. doi:10.1037/0003-066X.58.1.5
 63. Seidler Z, Dawes A, Rice S, Oliffe J, Dhillon H. The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*. 2016;49:106–18. doi:10.1016/j.cpr.2016.09.002
 64. Schöch P, Hölzle L, Lampe A, Hörtnagl C, Zechmeister-Koss I, Buchheim A, Paul JL. Towards effective screening for paternal perinatal mental illness: A meta-review of instruments and research gaps. *Frontiers in Public Health*. 2024;12:1393729. doi:10.3389/
 65. California Department of Public Health (Center for Family Health D of M Child and Adolescent Health). California Department of Public Health [Internet]. California Department of Public Health. Comprehensive Perinatal Services Program (CPSP). Available from: <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx>
 66. California Department of Health Care Services. DHCS Birthing Care Pathway [Internet]. Available from: <https://www.dhcs.ca.gov/CalAIM/Pages/BirthingCarePathway.aspx>
 67. California Department of Health Care Services. Enhanced Care Management (ECM) and Community Supports [Internet]. Available from: <https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx>
 68. California Department of Health Care Services. Pregnancy and Postpartum Transitional Care Services (TCS) Policy FAQs [Internet]. Available from: <https://www.dhcs.ca.gov/calaim-transforming-medi-cal/pregnancy-and-postpartum-transitional-care-services-tcs-policy-faqs/>
 69. California Department of Social Services. California Department of Social Services [Internet]. California Department of Social Services. CalWORKs (California Work Opportunity and Responsibility to Kids), including Family Stabilization [Internet]. Available from: <https://www.cdss.ca.gov/calworks>
 70. First 5 California (California Children and Families Commission). First 5 California [Internet]. First 5 California. First 5 California Fatherhood Initiative (Stronger Starts). Available from: <https://www.first5california.com/en-us/professionals/>
 71. California Department of Social Services (Office of Child Abuse Prevention). California Department of Social Services, Office of Child Abuse Prevention (OCAP) [Internet]. California Department of Social Services. Supporting Father Involvement. Available from: <https://www.cdss.ca.gov/inforesources/ocap/about-ocap/supporting-father-involvement>
 72. Children's Institute. Project Fatherhood [Internet]. Los Angeles, CA: Children's Institute. Available from: <https://www.childrensinstitute.org/project-fatherhood-2/>
 73. California Legislature. Assembly Bill 2193: Maternal mental health (Chapter 755, Statutes of 2018). California Legislature, 2017-18 Regular Session [Internet]. California Legislature; 2018. Available from: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2193

74. California Legislature. Assembly Bill 3032: Maternal mental health conditions (Chapter 773, Statutes of 2018). California Legislature, 2017-18 Regular Session [Internet]. California Legislature; 2018. Available from: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB3032
75. California Legislature. Assembly Bill 1936: Maternal mental health screenings (Chapter 815, Statutes of 2024). California Legislature, 2023-24 Regular Session [Internet]. California Legislature; 2024. Available from: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1936
76. California Legislature. Assembly Bill 2581: Healing arts: continuing education: maternal mental health (Chapter 836, Statutes of 2024). California Legislature, 2023-24 Regular Session [Internet]. California Legislature; 2024. Available from: https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2581
77. California Legislature. California Health and Safety Code Section 1367.625 (Knox-Keene Health Care Service Plan Act of 1975): maternal mental health program. California Health and Safety Code, Division 2, Chapter 2.2 [Internet]. California Legislature. Available from: https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.625.&lawCode=HSC
78. National Committee for Quality Assurance. HEDIS, National Committee for Quality Assurance [Internet]. National Committee for Quality Assurance; 2021. Postpartum Depression Screening and Follow-Up (PDS-E). Available from: <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/postpartum-depression-screening-and-follow-up/>
79. United States Congress. Dads Matter Act of 2025 (S. 2131, 119th Congress). 119th Congress (2025-2026) [Internet]. United States Congress; 2025. Available from: <https://www.congress.gov/bills/119th-congress/senate-bill/2131>
80. U.S. Department of Health and Human Services (Administration for Children and Families) of FA. U.S. Department of Health and Human Services [Internet]. U.S. Department of Health and Human Services. National Responsible Fatherhood Clearinghouse (NRFC). Available from: <https://www.fatherhood.gov/>
81. Holt-Lunstad J, Smith T, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspectives on Psychological Science*. 2015;10(2):227–37. doi:10.1177/1745691614568352
82. World Health Organization. Determinants of health [Internet]. 2024. Available from: <https://www.who.int/news-room/questions-and-answers/item/determinants-of-health>
83. California Department of Health Care Access and Information. Rural Health Presentation, November 2024 [Internet]. Sacramento, CA: California Department of Health Care Access and Information (HCAI); 2024 Nov. (California Department of Health Care Access and Information (HCAI)). Available from: <https://hcai.ca.gov/document/rural-health-presentation-november-2024/>
84. Office of the U.S. Surgeon General. Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community [Internet]. U.S. Department of Health and Human Services; 2023. (U.S. Department of Health and Human Services). Available from: <https://www.hhs.gov/surgeongeneral/priorities/connection/index.html>
85. World Health Organization. Physical activity [Internet]. 2024. Available from: <https://www.who.int/news-room/fact-sheets/detail/physical-activity>
86. Physical Activity Guidelines Advisory Committee. 2018 Physical Activity Guidelines Advisory Committee Scientific Report [Internet]. Washington, DC: U.S. Department of Health and Human Services; 2018. (U.S. Department of Health and Human Services). Available from: <https://odphp.health.gov/our-work/nutrition-physical-activity/physical-activity-guidelines/current-guidelines/scientific-report>
87. Fukushima N, Kikuchi H, Sato H, Sasai H, Kiyohara K, Sawada S, et al. Dose-Response Relationship of Physical Activity with All-Cause Mortality among Older Adults: An Umbrella Review. *Journal of the American Medical Directors Association*. 2024;25(3):417–30. doi:10.1016/j.jamda.2023.09.028
88. Schuch F, Vancampfort D, Firth J, Rosenbaum S, Ward P, Silva E, et al. Physical Activity and Incident Depression: A Meta-Analysis of Prospective Cohort Studies. *American Journal of Psychiatry*. 2018;175(7):631–48. doi:10.1176/appi.ajp.2018.17111194
89. Laureus Sport for Good Foundation USA, Movember. Laureus Sport for Good Foundation USA [Internet]. Laureus Sport for Good Foundation USA. Movember Invests \$750,000 into Laureus Sport for Good Programs in Chicago and New York City. Available from: <https://laureususa.com/news/movember-invests-in-laureus-usa/>



90. Dayao J, Duffy C, Cristiano A, Kallenberg G, Linke S. Implementation and evaluation of Exercise is Medicine in primary care clinics within a large academic health system. *Family Medicine and Community Health*. 2024;12(1):e002608. doi:10.1136/fmch-2023-002608
91. Coelho J, Pecune F, Micoulaud-Franchi J, Bioulac B, Philip P. Promoting mental health in the age of new digital tools: Balancing challenges and opportunities of social media, chatbots, and wearables. *Frontiers in Digital Health*. 2025;7:1560580. doi:10.3389/fdgth.2025.1560580
92. Dig Deep, Inc. The Path: AI Therapy Designed for Outcomes, Not Engagement [Internet]. Available from: <https://www.thepath.ai/>
93. Schuch FB, Vancampfort D, Richards J, Rosenbaum S, Ward PB, Stubbs B. Exercise as a treatment for depression: A meta-analysis adjusting for publication bias. *Journal of Psychiatric Research*. 2016;77:42–51. doi:10.1016/j.jpsychires.2016.02.023
94. Mental Health California. Brother Be Well [Internet]. Available from: <https://brotherbewell.com/>
95. Padilla-Frausto DI. Lesbian, Gay, Bisexual, and Transgender (LGBT) Adults' Mental Health, Access to Care, and Unmet Need for Care in California [Internet]. Los Angeles, CA: UCLA Center for Health Policy Research; 2025 Sep. Available from: <https://healthpolicy.ucla.edu/our-work/publications/lgbt-adults-mental-health-policy-brief-2025>
96. Gilgoff J, Wagner F, Frey J, Osteen P. Help-seeking and Man Therapy: the impact of an online suicide intervention. *Suicide and Life-Threatening Behavior*. 2023;53(1):154–62. doi:10.1111/sltb.12929
97. Frey J, Osteen P, Sharpe T, Mosby A, Joiner T, Ahmedani B, et al. Effectiveness of Man Therapy to reduce suicidal ideation and depression among working-age men: a randomized controlled trial. *Suicide and Life-Threatening Behavior*. 2023;53(1):137–53. doi:10.1111/sltb.12932
98. Watkins D, Goodwill J, Johnson N, Casanova A, Wei T, Allen J, et al. An online behavioral health intervention promoting mental health, manhood, and social support for young Black men: the YBMen project. *American Journal of Men's Health*. 2020;14(4):1557988320937215. doi:10.1177/1557988320937215
99. Movember, Opendorse. MindMoves [Internet]. Movember; 2024. Mental health programming for collegiate athletes. Available from: [https://us.movember.com/story/movember-](https://us.movember.com/story/movember-mindmoves-mental-health-programming-for-collegiate-athletes)
[mindmoves-mental-health-programming-for-collegiate-athletes](https://us.movember.com/story/movember-mindmoves-mental-health-programming-for-collegiate-athletes)
100. Garber CE, Blissmer B, Deschenes MR, Franklin BA, Lamonte MJ, Lee IM, et al. Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults. *Medicine & Science in Sports & Exercise*. 2011;43(7):1334–59. doi:10.1249/MSS.0b013e318213fefb
101. U.S. Census Bureau. Sex by Industry for the Civilian Employed Population 16 Years and Over, California [Internet]. American Community Survey 1-Year Estimates, Table C24030. Washington, DC: U.S. Census Bureau; 2023. Available from: <https://data.census.gov/>
102. Ji H, Gulati M, Huang TY, Sehl MV, Kwan JE, Frank-Spraker AL, Merz CNB, Cheng S. Sex differences in association of physical activity with all-cause and cardiovascular mortality. *Journal of the American College of Cardiology*. 2024;83(8):783–793. doi:10.1016/j.jacc.2023.12.019
103. Cameron EE, Sedov ID, Tomfohr-Madsen LM. Prevalence of paternal depression in pregnancy and the postpartum: an updated meta-analysis. *Journal of Affective Disorders*. 2016;206:189–203. doi:10.1016/j.jad.2016.07.044
104. Wain KF, Daley MF, Coca Perrailon M. Temporal association between maternal depression and paternal postpartum depression. *American Journal of Preventive Medicine*. 2025;68(6):1061–71. doi:10.1016/j.amepre.2025.02.014
105. Dennis CL, Marini F, Dol J, Vigod SN, Grigoriadis S, Brown HK. Paternal prevalence and risk factors for comorbid depression and anxiety across the first 2 years postpartum: a nationwide Canadian cohort study. *Depression and Anxiety*. 2022;39(3):233–45.
106. Saxbe DE, Edelstein RS, Lyden HM, Wardecker BM, Chopik WJ, Moors AC. Fathers' decline in testosterone and synchrony with partner testosterone during pregnancy predicts greater postpartum relationship investment. *Hormones and Behavior*. 2017;90:39–47.
107. Saxbe D, Martínez-García M. Cortical volume reductions in men transitioning to first-time fatherhood reflect both parenting engagement and mental health risk. *Cerebral Cortex*. 2024;34(4):bhae126. doi:10.1093/cercor/bhae126
108. Feinberg ME. The internal structure and ecological context of coparenting: a framework for research and intervention. *Parenting: Science and Practice*. 2003;3(2):95–131. doi:10.1207/S15327922PAR0302_01



MOVEMBER® INSTITUTE
OF MEN'S HEALTH
MUSTACHES LOVE RESEARCH