Men's Mental Health and Well-being: A Global Imperative

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Introduction

An overview of the statistics on men's mental health internationally shows that men's depression and other mental health problems are under-detected and under-treated all over the world. This can be explained in part due to men's tendency not to seek help. Further, health services appear to have a limited capacity to reach out to men due to their different presentation of symptoms. There may also be a reluctance to do so, with higher levels of substance abuse, anger, withdrawal and challenging behaviours in men than in women. Yet, more than three times as many men as women commit suicide, and the difference increases to up to five times in single men and in older age. The higher suicide rates in men are linked to undiagnosed (and untreated) mental health problems.

This chapter will make recommendations for action in terms of men's mental health to enable states to meet SDG3. Such action will also help countries to meet other SDGs, such as SDG1 and SDG2 (goals to end poverty and hunger) and SDG16 (which requires states to promote peaceful and inclusive societies). The first essential challenge is for men's mental health-related problems to be detected. In addition, it will be crucial for states to create methods for swift referral, as well as treatment models better suited to men. Some suggestions for how such strategies and models might be developed which fit culturally and are effective will be provided in the chapter, with case studies where appropriate. The higher prevalence of substance abuse in men will also be considered; there is often such co-morbidity along with psychosocial disability,[1] with substances

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abused either as a means of self-medication, due to personality propensities, or related to changes in perceived traditional male roles (such as the loss of a job and subsequent lack of employment).

There are five main difficulties in relation to men's mental disorder issues. First, men are under-diagnosed and under-treated. Secondly, men are less likely to seek help than women when it comes to mental health difficulties. Thirdly, it appears difficult for men themselves as well as health professionals to identify their problems as mental disturbances. Fourthly, there is a lack of adequate assessment tools suitable for men's symptomatology. Finally, suitable referral pathways are often unavailable for men who are not used to referring themselves to health services and who do not have adequate language for communicating their mental states. Finally, there is a lack of gender specific treatment and knowledge about the kinds of treatments that are more suitable for men.

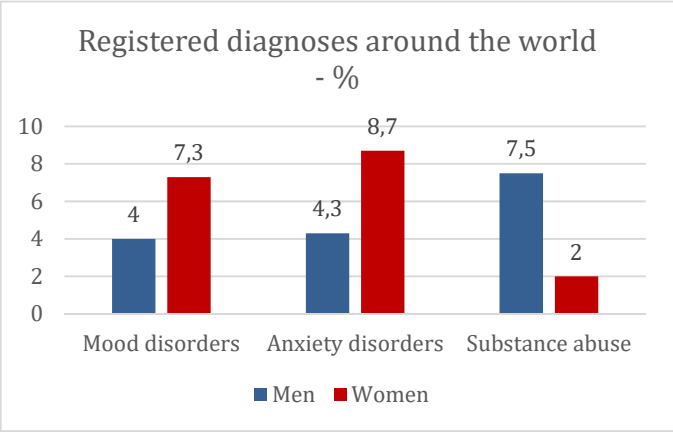
Gender differences

When health, and not least mental health, is the topic, gender-related research and information about it seldom relates to men. A search in PubMed for 'Women AND Psychology' and 'Men AND Psychology' brings up four times as many research articles on psychology containing the word 'women' on its own as articles with the word 'men' only. There are far fewer studies on men and mental health than on women and mental health. However, it is very important to acknowledge that mental health issues can be different for men, which is seldom mentioned. One reason for this might be that the

[1] Wahlbeck, K., Westman, J., Nordentoft, M., & Gissler, M. (2011), Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders, *The British Journal of Psychiatry*, 199, 453-458.

picture is complex. In a study by Zachary *et al*,[2] a consistent 'gender effect' was seen in the prevalence of common mental disorders. Remarkable gender differences were observed in the study, with more than twice as many men diagnosed with substance abuse and twice as many women as men diagnosed with mood and anxiety disorders (see figure 1).

Figure 1



The study also reveals some regional variation, such as in Sub-Saharan-African and North and South East Asian countries, which appear to have lower rates of mental disorders than other regions of the world. This is especially so in English speaking countries[3] – although there are significant difficulties in obtaining data from many low-income countries.

The gender differences shown in Figure 1 above might indicate that there are clear differences in the mental states of men and women. However, the research might also

[2] Zachary, S., Marnane, C., Iranpour, C., *et al* (2014), The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013, *International Journal of Epidemiology*, 476-493.

[3] There are many challenges in obtaining reliable results when measuring mental health, especially in low-resource settings. Worldwide, there are numerous cultural and other barriers against openness about mental disorders, often seen as taboo, and thus they are frequently denied in order to avoid stigmatisation. To ensure accurate reporting when obtaining data, in-country researchers with in-depth knowledge of the culture and traditions of a particular area are essential.

indicate that mental illness in men and women is detected differently, with men more easily diagnosed based on their actions – behaviour such as abuse, violence, and anti-social acts – rather than based on how they feel and express their states of mind. Women are more often diagnosed according to how they feel, and depression and anxiety disorders are diagnoses encompassing states of mind. In general, women are more open about talking about their emotional states of mind.[4]

There also appears to be a gender difference in help-seeking behaviour, with men much more reluctant to seek help from health services, both for physical symptoms, and even more when it comes to mental health difficulties. Very often men visit health care services only when they are urged to, or are sent by their family, employer, or the police. Furthermore, epidemiological and other studies[5] have shown that gender differences in terms of the prevalence of depression are much smaller than the 2:1 ratio which is generally seen upon hospital admission and in attendees at general medical practices. This suggests that men are under-diagnosed with, and under-treated for, depression.

As it has been shown that men of different ages, ethnicities and social backgrounds access physical and mental health services less frequently than women,[6] it is necessary to find new ways for men to access such services to identify and refer the large number of men with depression and other mental health problems for treatment. Therefore there is a need to develop 'male-friendly' primary mental health care services where the barriers to men's access have been addressed. Those barriers have been identified as,

[4] See, *e.g.*, N. Chodrow, (1978), *The Reproduction of Mothering* (Los Angeles: University of California Press); Pollack, W., 'No Man is an Island', in R. Levant & W. Pollack (1995), *A New Psychology of Men*, (NY: Basic Books), pp. 32-57.

[5] Olsen, Lis Raabæk (2006), Measurements of depressive illness and mental distress in the Danish general population, *Danish Medical Bulletin*, Feb, No. 1., Vol.53, pp.101; Madsen, S. Aa. (2013), Mænds skjulte depressioner [Men's Hidden Depressions], *Månedsskrift for Almen Praksis*, 91, 6, pp.537-45.

[6] A. White, R. Hogston, S. Aa. Madsen, S.Aa., *et al* (2011), The State of Men's Health in Europe, The European Commission (Brusselles: DG Sanco Publications).

for example, opening hours, inappropriate information and communication for men, and inaccessible services far away from the workplace.[7]

Depression

According to the World Health Organization (WHO), current predictions indicate that depression is now the leading cause of disease burden globally.[8] This makes it crucial to dig deeper into the causes of the apparent gender disparity in terms of depression. One of the reasons why men appear under-represented in the data on depression is that men may exhibit symptoms not traditionally associated with the illness. In recent decades, more studies have focused on whether men show different symptoms of depression than women. Men often exhibit quite different symptoms that are not typically connected with depression or psychological difficulties at all. In most classification and diagnostic systems, depression is usually defined as a passive and inwardly directed reaction with elements of self-deprecation and guilt feelings.[9] Yet, in men suffering from depression, studies have shown that anger attacks, affective rigidity, self-criticism and alcohol and drug abuse are symptoms that more often occur.[10] In the Gotland Study, Rutz *et al* suggest the existence of such a male-specific syndrome.[11] Startlingly, the

[7] I. Sabaj-Kjær, I. & S. Aa. Madsen (2016), *Manden og lægen*. [The Man and the GP] Copenhagen: Forum for Mænds Sundhed; S. Aa. Madsen (2014), *Mænds sundhed og sygdomme* [Men's Health and Diseases] Copenhagen: Samfundslitteratur.

[8] WHO (2017), Depression and Other Common Mental Disorders: Global Health Estimates (Geneva: World Health Organization). Licence: CC BY-NC-SA 3.0 IGO.

[9] See, *e.g.*, A. Beck, (2008), Beck Depression Inventory (2nd ed.) (Nova Southeastern University Center for Psychological Studies); Beck, A. T., Ward, C. H., Mendelson, M., *et al* (1961), An inventory for measuring depression, *Archives of General Psychiatry*, 4, 561-571; Hamilton, M. (1960), A Rating Scale for Depression, J. *Neurol. Neurosurg. Psychiat*, 23, p.56.

[10] Winkler D., Pjrek E., Kasper S. (2006), Gender specific symptoms of depression and anger attacks, *J Men's Health Gender*, 3: 19-24 & S. Cochran & F. Rabinowitz (2000), *Men and Depression* (New York: Academic Press).

[11] See Rutz, W. (2001), Preventing suicide and premature death by education and treatment, *Journal of Affective Disorders*, Vol.62, Issue 1-2: 123-129; Rutz, W,, von Knorring, L,, Pihlgren, H,, Rihmer, Z, & Wålinder J. (1995), Prevention of male suicides: lessons from Gotland study, *The Lancet*, Vol.25, Issue 345, p.524.

study showed that education and training of general practitioners about depressive illness resulted in a statistically significant reduction in the number of female suicides, but left the rate of male suicides almost unaffected. These experiences led to the development of the Gotland Male Depression Scale[12] which lists some of the symptoms or states of mind more often seen in men which are quite different from those traditionally associated with depression (see Box 1).

Box 1

- Acting out, aggressiveness
- Low impulse control
- Anger attacks
- Irritability
- Tendency to blame others and to be implacable
- Low stress threshold
- Restlessness
- Risky and socially unacceptable behaviour
- Abuse, especially alcohol
- General dissatisfaction with oneself and one's own behaviour

Other researchers in the field have used the term "masked depression" to designate male symptoms.[13,] Such research forms part of the psychological studies on gender-specific conditions in societal and cultural connection, such as work and family roles and responsibilities, and in socialisation and development (with mothers being the first attachment and identification figure for both boys and girls). In the gender roles that historically men have adopted, it has been important to keep fear and emotions at bay in order to be able to act, defend, fight, toil for food, and hunt. This has led to a channelling of emotional problems into anger, avoidance and self-reflection, disregard for one's own

[12] Zierau F., Bille A., Rutz W., & Bech P. (2002), The Gotland Male Depression Scale: a validity study in patients with alcohol use disorder, *Nord J Psychiatry*, 56(4): 265-71.
[13] S. Cochran & F. Rabinowitz (2000), *Men and Depression* (New York: Academic Press) & Pollack, W. (2005) 'Masked men', in G. Good, & G. Brooks (ed.), *The new handbook of psychotherapy and counselling with men* (2005) 203-216 (San Francisco: Wiley).

condition, and non-communication of feelings. Boys and men therefore have encountered pressure to conform to social norms encapsulated by beliefs such as 'big boys don't cry', 'beware of weakness', 'you must be able to take care of yourself', and 'it's important not to be dependent on others'.

In this connection, men appear to have difficulty in defining and expressing their internal condition and feelings. This has led to a focus on the specific reactions and state-patterns set out in Box 2 below, which, together with those mentioned previously, are seen more often in men than women.

Box 2[14]

- Withdrawal from relationships
- Over-involvement with work
- Denial of pain
- Rigid demands for autonomy
- Rejection of getting help

When such states as 'acting-out', substance abuse and/or withdrawal symptoms are predominant, the man's suffering is very often not identified and, therefore, their depression remains untreated. Magovcevic and Addis[15] have developed *The Masculine Depression Scale* as an instrument for detecting men with depression with (*inter alia*) traditional, externalising and withdrawal symptoms.

Post-natal depression

One distinct disorder in many countries which affects men as well as women is not even recognised as existing in the male gender – namely, perinatal mood disorder. This is often also called post-natal or post-partum depression. Whilst the impact of women's

[14] See *e.g.*, *ibid*, and Madsen (2013), *op cit.*, nt.5.

[15] Magovcevic, M. M. & Addis, M. E. (2008), The Masculine Depression Scale: Development and Psychometric Evaluation, *Psychology of Men and Masculinity*, 9, 117-132.

transition to parenthood has been recognised and acknowledged for several decades, with many mental health studies focusing on psychiatric and psychological perinatal suffering in women, men's transition to parenthood has not been met with much attention. However, men's transition to fatherhood can have a major psychological impact on men's lives, identities and states of mind. This can also lead to mental disturbances which are, essentially, a feature of perinatal depression. Perinatal mood depression, as measured by the Edinburgh Postnatal Depression Scale (EPDS),[16] affects approximately 10% to 14% of women.[17] A growing number of studies on post-partum depression in women also take note of the father's psychological well-being. Meta-analyses of studies around the world[18] report rates of 7% to 10% in men suffering from perinatal mood disorders, with the highest rates in the US (approaching 13%).[19] However, the importance of raising awareness of men's post-partum depression has been emphasised in research which has found that paternal depression has a specific and detrimental effect on children's early behavioural and emotional development.[20,]

All in all, it seems that when statistics on depression (and possibly other mental disturbances too) show a twofold higher prevalence in women than in men, it might well be that this is not a proper reflection of the concrete situation. Rather, it may be that depression in half of the men and other mental disorders are not detected and consequently not treated.

[16] J. Cox & J. Holden (2003), *Perinatal Mental Health: A Guide to the Edinburgh Post-natal Depression Scale* (London: Gaskell).

[17] Cox J., Connor, Y., & Kendell R. (1982), Prospective study of the psychiatric disorders of childbirth, *Br J Psychiatry*, 140, 111-117.

[18] Paulson, J. F. & Bazemore, S. D. (2010), Prenatal and postpartum depression in fathers and its association with maternal depression, *Journal of the American Medical Association*, 303, 1961-1969; Cameron, E., Sedov I. & Tomfohr-Madsen, L. (2016), Prevalence of Paternal Depression in Pregnancy and the Postpartum: An updated meta-analysis, *Journal of Affective Disorders*, 206, 189–203.

[19] There are studies included from four continents, but none are from Africa. Although there is a fast-growing body of research on men and perinatal depression around the world, there still are very few studies from low-income countries.

[20] Junge, C., Garthus-Niegel, S., Slinning, K., *et al* (2016), The Impact of Perinatal Depression on Children's Social-Emotional Development: A Longitudinal Study, *Matern Child Health J* 10.1007/s10995-016-2146-2; Paulson J., Dauber S. & Leiferman J. (2006), Individual and Combined Effects of Postpartum Depression in Mothers and Fathers on Parenting Behaviour, *Pediatrics*, 118, 659-668; Ramchandani, P., Stein, A., Evans, J. & O'Connor, T. (2005), Paternal depression in the postnatal period and child development: a prospective population study, *The Lancet*, 3652: 2201-2205.

Suicide

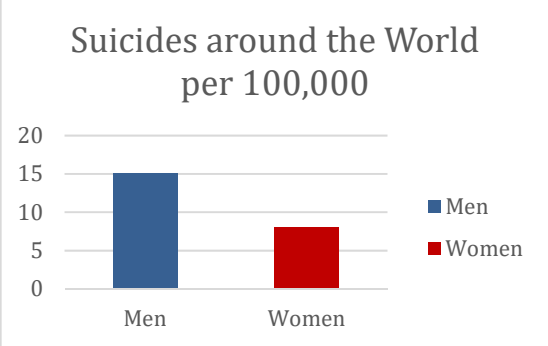
The UN Secretary-General Report, 'Progress towards the Sustainable Development Goals', states that "[t]he most common [mental disorders] are anxiety and depression, which, not infrequently, can lead to suicide. In 2012, an estimated 800,000 people worldwide committed suicide, and 86% of them were under the age of 70. Globally, suicide is the second leading cause of death among those between the ages of 15 and 29".[21] Women globally are considered to have higher prevalence rates of mood and anxiety disorders – around twice as high as men – and thus more suicides should be expected in women. However, suicide rates reveal a paradox; the WHO identifies in its report, 'Preventing suicide: a global imperative',[22] that globally, men's suicide rate is 15 per 100,000, whereas it is around half that for women (namely, 8 per 100,000). This inconsistency is an eye-opener, further revealing the complexities of men's mental health. Plainly, a gender perspective is essential in understanding mental health data.

With meeting SDG3 in mind, SDG target 3.4 requires states to, "[b]y 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being").[23] There are only two indicators associated with target 3.4, and one is the suicide mortality rate (indicator 3.4.2).[24] Figure 2 below shows the suicide rate per 100,000 in the population according to the WHO's 2014 report. The figure suggests that approximately double the amount of men commit suicide than women on average globally. However, as the WHO remarks, we must read these figures cautiously: "…since suicide is a sensitive issue, and even illegal

[21] United Nations (2016), *Progress towards the Sustainable Development Goals*, Report of the Secretary General, United Nations, Economic and Social Council 2016 session, 3 June 2016, E/2016/75.
[22] World Health Organization (2014), *Preventing suicide: a global imperative* (Geneva: World Health Organization).
[23] UN-GA (2015*), A/RES/70/1*, *Transforming our world: the 2030 agenda for sustainable development* (Geneva: United Nations).
[24] The other is indicator 3.4.1: the "[m]ortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease".

in some countries, it is very likely that it is under-reported. In countries with good vital registration data, suicide may often be misclassified as an accident or another cause of death. Registering a suicide is a complicated procedure involving several different authorities, often including law enforcement. Moreover, in countries without a reliable registration of deaths, suicides simply go uncounted".[25] Together with studies from countries with reliable vital registration data,[26] this suggests that men commit suicide around three times as often as women.

Figure 2



Furthermore, in some countries there is a high prevalence of the elderly committing suicide, such as in Europe where elderly men commit suicide five times as often as women of the same age.[27] In comparison, in China and Greenland it is younger people who most often commit suicide (young women in the former, and young men in the latter).

Suicide is generally considered to be an act arising out of intense mental suffering. The much higher rate of suicides in men are, amongst other things, likely to be due to a lack of detection of men's mental suffering. Suicide risk in men also arises from psychosocial and/or economic pressure, as well as problems related to age, such as the loss of a

[25] *Ibid.*
[26] White, *et al* (2011), *op cit.*, nt.6.
[27] *Ibid.*

partner, loss of reduced functional capacities, and loss of employment.[28] Although these stressors also apply to women, research suggests that such negative social determinants have an increased negative impact on men's physical and mental health.[29] Suicide prevention in men can be strengthened through better detection of depression in men, in combination with improved social factors such as reduction of poverty, unemployment, and improvement in access to health care. Thus, both mental health treatment and social changes are needed to reduce suicide rates in men.

The burdens

In its 2012 report, 'Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level', the WHO emphasises that untreated mental disorders are a heavy burden globally.[30] Burdens arising from men's mental disturbances are violence, sexual abuse and intimate partner violence, as well as alcohol and drug abuse, in which men are more often the offenders, perpetrators and abusers. These disturbances cost lives, cause illness and disabilities, and increase mental health problems not only in the person who is abused, but also in the wider family.

In addition, men's mental health problems often arise from trauma. As men form the majority of the workforce globally and tend to undertake much more manual labour than women, they are more at risk of workplace accidents which can cause injury. This means they will require time off work, with associated reduced self-esteem, not to mention increased stress and anxiety about supporting their families. Furthermore, men are much more likely than women to be conscripted into the military, with the

[28] Suicide rates for men increased in the years after the economic crisis in 2008.
[29] Madsen (2014), *op cit.* nt.7.
[30] WHO (2012), *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*, Report by the Secretariat (Geneva: World Health Organization).

higher risk of post-traumatic stress disorder (PTSD). Such risk is higher in lower-income countries compared with high-income countries, and especially prevalent in post-conflict areas. Trauma can also produce various physical illnesses related to unhealthy living, which are a heavy health burden, especially in low and middle-income countries (LMICs) with little access to professional mental health workers.[31]

Men's violence against women is a very serious worldwide problem. However, it should also be recognised that intimate partner violence is a phenomenon occurring between people in intimate relationships - heterosexual and/or same-sex relationships - and that domestic violence can also take place against men, including emotional, sexual and physical abuse and threats of abuse. This is still not well recognised, or accepted as a real problem, about which there have been very few studies.[32]

It is well known that differences in life expectancy are immense for people with a mental disorder diagnosis. The decrease in life expectancy that poor mental health causes is marked. Those diagnosed with a mental illness have a two to three times higher mortality rate than the general population.[33] There is a gender disparity in this increased mortality rate, however: men with mental disorders live twenty years less than the general population, measured as life expectancy from the age of fifteen, than women, who live fifteen years less than others.[34] Plainly, the causes of this difference warrants further investigation.

[31] Atwoli, L. Stein, D. Koenen, K. & McLaughlind, K. (2015), Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences, *Curr Opin Psychiatry*, 28(4), 307-311.
[32] See, *e.g.*, Hines, D. & Douglas, E. (2010), Intimate Terrorism by Women against Men: Does it Exist?, *Journal of Agress Confl Peace Res*, 2,3, 36-56; Barber, C. (2008), Domestic violence against men, *Nursing Standard*, 22, 51, 35-39; and Kumar, A. (2012), Domestic Violence against Men in India: A Perspective, *Journal of Human Behavior in the Social Environment*, 22, 3, 290-296.
[33] Wahlbeck *et al* (2011), *op cit.*, nt.1. This study covers men and women treated at a psychiatric hospital in the Nordic countries, and it is not possible to predict if this is an international trend. However, most of the data on mental health related to gender is very much alike around the world.
[34] *Ibid.*

Prevention

In order to improve men's mental health, it is obvious that prevention is needed. However, there are very few examples of goal-directed mental health prevention programmes for men. The exception to this poor state of affairs is the Men's Shed movement around the world.[35] A 'Men's Shed' is an open, autonomous and friendly place where men can come together for a variety of self-decided activities such as handicraft work, gardening, physical training, painting, and cooking. Men's Sheds are open to men of all ages and backgrounds. The movement began in Australia in the 1990s and spread to Europe and America more recently. Men's Sheds have been shown to have a positive impact on men's mental as well as physical health.[36]

Conclusion and recommendations

It is time for the world to recognise that in order to meet SDG3, gender differences in terms of mental health must be addressed. Governments and health professionals must develop detection, referral and treatment models better suited to men. Men use health services less, and tend to be reluctant to take their health issues seriously or to look after their health properly. The barriers to help-seeking observed in men are often related to a culture of masculinity, such as male embarrassment arising from a perception of emasculation. Indeed, this may result in additional stigma for men with mental health issues than for women.[37]

[35] B. Golding (2015), *The Men's Shed Movement: The Company of Men* (Illinois: Common Ground Publishing).
[36] See Lefkowich, M., Richardson, N. & Robertson, S. (2015), If we want to get men in, then we need to ask men what they want: Pathways to Effective Health Programming for Men, *American Journal of Men's Health*; online pii: 1557988315617825. [Last accessed 4 April 2017]; P. Flood & S. Blair (2013), *Men's Sheds in Australia: Effects on Physical Health and Mental Well-Being* (Hawthorne: UltraFeedback Pty Ltd.).
[37] Although there has been no research on this.

To meet SDG3, states have a duty to create mental health policies and treatment strategies which take into account gender differences. The duty of states under target 3.5 of SDG3 to "strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" requires policy and treatment initiatives which recognise the prevalence of substance abuse in men (often a method of self-medication) and the connection between alcohol abuse and depression. In addition, men are more often victims of violence than women, and of severe traffic and workplace accidents. Their higher involvement in military conflicts can also cause severe trauma, making PTSD more prevalent than in women. National policies need to recognise this and prepare for it.

Clearly, mental health policies must include prevention strategies which take account of gender differences. The Men's Shed movement has been shown to have a supportive and positive preventive effect on men's mental and physical health. States should also prioritise as a matter of urgency much more extensive prevention of men's suicides – especially in older men. The scaling up of the Men's Sheds initiative in countries where it exists currently ought to assist with this. It is recommended that similar initiatives are rolled out and piloted in LMICs (with culturally appropriate adaptations), and their efficacy carefully researched.

Furthermore, in order to meet SDG3, the under-detection of men's mental health problems must be recognised as a reality, both in national health strategies as well as at the international level. More research on the symptoms of male mental health issues is necessary, both in high-income countries and LMICs. To help reduce the current global mental health treatment gap, governments need to develop appropriate screening tools to detect the 50% of male depression that remains undiagnosed. Earlier detection of men's depression through the development of identification programmes and evidence-based strategies is essential. In line with states' responsibilities under target 3.8 of SDG3

to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes", the stress of having a young family (particularly on the birth of a first child) should be recognised not only for women, but also for men. The fact that men, too, can suffer from perinatal depression, should be widely disseminated information. Thus, men should be included in pre-natal preparation courses and screening programmes, with the goal of identifying the 7% to 10% of new fathers who suffer from perinatal depression.

Further, culturally sensitive screening instruments suited to men's depression and other mental health problems in men should be devised for them, especially for those in vulnerable groups such as older or single men. Also crucial is for GPs and other mental health service professionals to receive training on understanding men's mental health, and to improve their engagement and communication with male patients. Furthermore, populations in general and mental health professionals in particular need to understand that men as well as women can be the victim of violence and psychological and emotional abuse from their intimate partner, with mental health consequences. The development of specialised education programmes on men's mental health and the integration of modules on gender and men's mental health into the training syllabi of all health courses is essential in this regard. In addition, the development of training protocols and short training courses on men's mental health which targets the existing service providers in the health, allied health, and community sectors is imperative.

Target 3.7 of SDG3 also requires states to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". There is a stark lack of appropriate treatment services for men worldwide. This is, of course, interlinked with a failure to detect men's disturbances, as well as insufficient

engagement and communication strategies. To address the under-treatment of men's mental health problems, it will be important for states to develop 'male-friendly' primary mental health care services that provide flexible opening hours (and in particular which provide later opening hours after work). They should also have the capacity to be offered in workplace settings and in more accessible community settings. Only if a comprehensive, multipronged and multidisciplinary approach is taken to men's mental health in terms of research, policy and treatment will states be able to meet the requirements of SDG3.

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