



Submission cover sheet

Inquiry into men's suicide rates

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Introduction

I acknowledge the lived experience of mental ill-health and suicidality, including those who have experienced suicidality or survived a suicide attempt, as well as those who have been carers or bereaved as a result of suicide. The impacts of suicide are felt across our whole community. We must listen to and honour the voices of those with lived experiences if we are to achieve meaningful change for the future of our community.

I appreciate the Committee's work in looking at this issue, and hope that the committee's recommendations will lead to an improvement in prevention, intervention, postvention and aftercare services to address this. I also hope to see policy changes that result in improved protective factors, and reduced risk factors, across a broad range of ACT Government programs, aligned with the ACT's Wellbeing Framework.

The ACT Greens believe:

1. Mental health and wellbeing are fundamental to how people experience their lives, engage with others and connect to the broader community.
2. That understanding and responding to mental health must be guided by the social determinants of health, informed by medical models and stage of life transitions, and be trauma informed, culturally responsible and recovery oriented.
3. The ACT should strive for an integrated mental health system that promotes positive mental wellbeing, early intervention, prevention, rehabilitation, suicide prevention and acute care of people affected by mental illness.
4. Mental illness must be de-stigmatised and responded to without judgement.

Factors contributing to suicide rates

Suicide is a leading cause of death for men in Australia. Men aged 55 – 59 years had the highest age-specific suicide rate in Australia in 2023, three times higher than the rate for women aged 55-59 yearsⁱ. Three quarters of all deaths by suicide are men, reflecting the lethality of means used by men.

While it is important to find gender-responsive ways to reduce deaths by suicide for men, we should not assume that women are less likely to attempt suicide. Australian Institute of Health and Welfare data shows that women report having attempted suicide at higher rates than men (28.2% compared to 22.3%) and report having experienced suicidal thoughts at higher rates (75.6% for women and 64.2% for men)ⁱⁱ.

It is also important to note that people who are transgender are far more likely than cisgender people to have experienced suicidal thoughts or attempted suicide. For example, AIHW data shows that the proportion of transgender men who have experienced suicidal thoughts is 90.6%, and for non-binary persons it is 89.9%, compared to 64.2% of cisgender men. The proportion who report that they have at some time in their life attempted suicide is 52.9% for trans men compared to 22.3% for cisgender men.

The needs of people of all genders must be taken into account in the ACT's mental health and suicide prevention plan. Prevention and early intervention programs must be gender sensitive to meet the needs of everyone in our community.

In 2020, an estimated 61% of LGBTIQ+ people reported having been diagnosed with depression and 47% reported having been diagnosed with an anxiety disorder. An estimated 57% reported experiencing high or very high levels of psychological distress within the past 4 weeks.ⁱⁱⁱ

Aboriginal and Torres Strait Islander men experience a disproportionately higher rate of suicide than non-Indigenous men, reflecting their higher rates of experiencing risk factors. They are more likely to have experienced intergenerational trauma. They are more likely to have experienced contact with the justice system, economic inequality, and discrimination or unconscious bias when trying access health or social support services. Their family and kinship relationships and responsibilities are culturally different to those in non-Indigenous families, resulting in different ripple effects from suicide within the community.

Psychosocial risk factors

The most common risk factors in relation to suicide are psychosocial rather than mental health conditions. In 2023, 67.4% of suicides had reported psychosocial risk factors, and 64.0% had reported mental and behavioural disorders^{iv}. The most common psychosocial risk factors are the same for men and women: personal history of self-harm, disruption of family by separation and divorce, problems in relationship with spouse or partner, disappearance and death of family member, problems related to other legal circumstances, other and unspecified problems related to economic inequality, limitation of activities due to disability or chronic health condition^v.

Psychosocial risk factors are social determinants of mental wellbeing, but they are not a mental illness. While we should not pathologise grief, relationship breakdown, unemployment, legal problems, or financial pressures, there are things our community can do to support people experiencing those risk factors, so that they emerge from challenging periods in their life without having experienced acute psychological distress.

Promotion of positive health behaviours

Sports, recreation, arts, and cultural groups improve protective factors in suicidality by increasing social connection. Sports and recreation groups can also promote other behaviours associated with good mental hygiene, such as healthy eating, reduced use of alcohol and other drugs, physical activity, and time spent outdoors.

Reducing risk factors will also improve outcomes. This includes funding programs to prevent childhood physical and sexual abuse, and reduce the prevalence and impact of domestic and family violence. It should include work to reduce ongoing financial pressures related to the rising cost of living and growing economic inequality, as well as acute pressures experienced during a period of unemployment.

Research tells us that suicides by men could be reduced by around one quarter if we could prevent childhood abuse and neglect^{vi}. Childhood abuse (physical abuse and sexual abuse) affects around 18% of women and 11% of men^{vii}. Programs that prevent childhood abuse and neglect will help to slow the increasing demands in our health systems as a result of acute psychological distress, suicidality, or attempts. Improving trauma-informed

services across whole of government — especially in health, social, justice, and education systems — will also assist in managing the impact of abuse across lifetimes.

Inclusion of the impacts of changes to non-health programs on mental health outcomes through the ACT Government's Wellbeing Framework should continue, alongside improvements in quantifying the impacts on health systems. Funding for sports and recreation programs should always fall within the sports and recreation portfolio in the Budget, or for domestic and family violence prevention should fall within the ACT Domestic, Family and Sexual Violence Office funding line, and not the clinical health services portfolio. But it would be valuable to have a health economist in the Office for Mental Health and Wellbeing work in collaboration with Treasury on how they might quantify the slowing of growth in acute mental health crisis services as a result of this kind of preventive work.

Prevention programs

Prevention work adds skills to the mental wellbeing toolbox. Around half of all 16 year olds in Canberra have received Youth Aware of Mental Health prevention training in schools, delivered by MIEACT using resources created by Black Dog. Young people who have participated in the program say that being able to support friends is one of the things they most value about the program. It is important that this work continues, is closely integrated with other Directorate of Education programs for wellbeing, and has funding certainty beyond one or two years in each year's Budget.

In 2023, the highest age-specific suicide rate for men was in the 55-59 years range. In 2018, it was in the 45-49 years range^{viii}. In 2013^{ix} and 2008^x, it was in the 40-44 years range. In 2003, it was in the 30-34 years range, and in 1993 it was in the 20-24 years range^{xi}. This means that for the past 30 years, the age-specific suicide rate for men has been highest among those born in the late 1960s through to the early 1980s. Being able to identify an age cohort who are at higher risk can be helpful in knowing where to deliver preventive programs to have the greatest positive impact.

It is critically important that prevention programs continue to be delivered to young people. ACT Government should add to the age diversity of programs being delivered by commissioning more programs for adult men, such as

workplace program delivery. Menslink's suicide prevention programs delivered in workplaces and sports groups in the ACT are a good example of how this can be achieved, and expanded to a broader age range for adult men.

Integrated mental health and alcohol and other drug services

Impulsivity may play a part in deaths by suicide in men, especially where alcohol is concerned. The integration of mental health with alcohol and other drug services should continue in accordance with the recommendations of coronial inquests. Services such as drug checking at CanTEST, and peer support services, provide opportunities to identify and offer support to people whose psychological distress co-occurs with drug or alcohol use. Alcohol and other drug harm reduction work, including the measures described in the recent Australian National University and Burnet Institute report, *Australian Capital Territory harm reduction cost-benefit analysis*, should receive ongoing funding and expansion to meet community needs^{xii}.

Mental health crisis and distress response services

The PACER service, providing the combined skills of mental health clinicians, paramedics, and police for mental health crisis response, should be permanently resourced and expanded to meet the level of need in the community. This includes better supporting carers and family members through integration with mental health respite or short stay residential care, and improved resourcing for follow-up community mental health services. Recognising that psychosocial risk factors are reported in relation to suicide more frequently than mental illness, it is important that ACT Government resources programs that can address these causes when a person is experiencing psychological distress. Trials of Distress Brief Support in Victoria and Queensland are expected to provide an Australian context, building on the successful Distress Brief Intervention program in Scotland that began in 2016. The ACT Office for Mental Health and Wellbeing has already given some consideration to how such a program could be implemented in the ACT. These programs can support a person through the initial period of distress, and build resilience skills for future occurrences of

psychosocial risk factors. They work by providing a person with non-clinical support for a two to three week period to manage the drivers of their distress, and connection to long term supports^{xiii}.

Culturally safe services for First Nations people

Closing the Gap for Aboriginal and Torres Strait Islander men in our community requires services that are trauma-informed and culturally safe. These services are best designed and delivered by Aboriginal and Torres Strait Islander people, such as by Aboriginal Community Controlled Health Organisations like Winnunga Nimmityjah and Thirrili. This is consistent with respect for the right to self-determination.

The mental health support needs of Aboriginal and Torres Strait Islander people in the ACT, and services that could be commissioned, have been considered by the Office for Mental Health and Wellbeing during the previous term of the Assembly. This information could inform recommendations that address the needs of Aboriginal and Torres Strait Islander men.

Any other issues

In a city the size of Canberra, a small change in the actual number of deaths by suicide within a particular demographic, such as gender, from one year to the next may appear as a large proportional change. This proportional impact becomes more pronounced for intersectionality, such as the difference in the population overall compared to men, and then to Aboriginal and Torres Strait Islander men, or men aged 55 – 59 years. It is therefore important to consider both qualitative and quantitative data in assessing which programs might produce improvements in outcomes within the ACT.

It can be difficult to distinguish between suicide attempts and accidental deaths without a coroner's report, which is why data on causes of death takes several years to be collated and analysed at a population level.

Investment in prevention and early intervention takes time to demonstrate a change in the trajectory of increased service needs. It may be years between exposure to prevention programs and exposure to the psychosocial risk factors that test the effectiveness of the prevention work. There is also a

compounding factor in some prevention programs that helps to build resilience at a whole of community level, as seen in the Youth Aware of Mental Health program. Around half of all Year 9 and 10 students in the ACT complete the program over several years. Because the program includes awareness building and help-seeking skills, young people who have completed the program are able to support their peers who may not have had the opportunity to participate. These positive ripple effects take time to build up, but can have lasting effects at a population level.

The combination of time taken to ensure data accuracy, and time required for a program to begin to produce a measurable change in outcomes, means that investment needs to be for more than a one or two year period. Programs that have already been resourced as a trial or pilot, and have been independently evaluated as successful, should be funded as ongoing services for the ACT community and expanded to meet the actual level of need.

- i <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-australia>
- ii <https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/lgbtqiasb-people>
- iii <https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness>
- iv <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#risk-factors-for-intentional-self-harm-deaths-suicide-in-australia>
- v <https://www.abs.gov.au/statistics/research/psychosocial-risk-factors-they-relate-coroner-referred-deaths-australia#results-special-topic-suicide>
- vi <https://theconversation.com/recruiting-more-mental-health-workers-wont-stop-suicides-preventing-child-abuse-and-neglect-will-171110>
- vii <https://www.abs.gov.au/media-centre/media-releases/1-7-australians-have-experienced-childhood-abuse>
- viii <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2018#intentional-self-harm-key-characteristics>
- ix <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010>
- x <https://www.abs.gov.au/ausstats/abs@.nsf/Products/6B3EE404901565F8CA2576F600124E28?opendocument>
- xi [https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/4410D945E6F9BF2FCA256F6A00735523/\\$File/3309055001_1993%20to%202003.pdf](https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/4410D945E6F9BF2FCA256F6A00735523/$File/3309055001_1993%20to%202003.pdf)
- xii https://www.act.gov.au/_data/assets/pdf_file/0008/2864285/ACT-harm-reduction-cost-benefit-analysis-harm-reduction-review-final-report-March-2025.pdf
- xiii <https://www.health.vic.gov.au/mental-health-reform/recommendation-27>