



Submission cover sheet

Inquiry into men's suicide rates

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Submission to ACT Assembly Inquiry into Men's Suicide Rates

**Health Research Institute
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Submission Recommendations

- The ACT Government should audit all the recommendations made in earlier national and local inquiries and reports as they pertain to male suicide, and consider the extent to which they have been implemented locally.
- Provide the resources necessary to ensure accurate and timely data on both completed suicides and attempted suicides in Canberra. This could include data from the health sector, police, community services and others. Urgent consideration should be given to establishing more integrated approaches to data collection and presentation through interactive, real-time dashboards, such as MChart, already being developed in the ACT, and those currently in operation in South Australia.
- Ensure funded suicide prevention activities have the resources they require to complete informative evaluations. This is to ensure every opportunity for systemic learning and improvement is taken. Future suicide prevention funding should be informed by access to a repository of evidence and case studies regarding the impact of strategies already tried.
- Future suicide prevention activities in the ACT might be better targeted through the segmentation of effort into several 'categories,' so as to better organise interventions, responses and consider data/information requirements, as follows:
 - Men who are known to mental health services already
 - those whose suicidality becomes known in the ED
 - those whose suicidality becomes known in primary care (e.g. GP)
 - those whose suicidality becomes known in non-health settings (clubs, schools, social groups etc
 - those whose suicidality is unknown
- Data presented in this report also suggest the need for age and gender-sensitive preventive mental health strategies.
- Stratification of local suicide data by diagnosis and admission frequency underscores the importance of early intervention and more personalised, sustained treatment strategies as part of future suicide prevention efforts. These patterns underscore the urgent need for robust post-discharge pathways.

The Health Research Institute is already working in close cooperation with ACT Health and other partners in relation to innovations such as MChart, which offer the prospect of increased understanding and responsiveness to mental illness and suicidality in the ACT. We would be very pleased to continue and deepen this association, to address this vital area of community concern.

Introduction

Suicide is a tragic and complex public health issue.

In 2023, there were 3,264 deaths by suicide, or 8.9 deaths by suicide each day. The age-standardised suicide rate was 12.0 per 100,000.

Men have a [higher age-standardised suicide rate](#) (18.2 per 100,000) than women (5.9 per 100,000). 75% of people who die by suicide [are men](#).

While men might complete suicide, women [were more likely](#) to be suicidal, with a higher prevalence of suicidal thoughts and behaviours in their lifetime (18.3% compared with 15.0% for men). The 2020–22 National Study of Mental Health and Wellbeing indicates that one in 6 (16.7% or around 3.3 million) Australians aged 16–85 had experienced serious thoughts about taking their own life at some point in their lives. Around 1.5 million or 7.4% of Australians aged 16–85 years had made a suicide plan and around 970,000 or 4.9% had attempted suicide during their lifetime. [Lifeline suggest](#) that as many 54,000 Australians attempt suicide annually. Based on its proportion of the total population, this would mean just under 1000 Canberrans attempt suicide each year.

Nationally, Federal Government [expenditure on suicide prevention](#) has increased since 2013-14, from \$60m to \$150m in 2022-23. As a percentage of total spending on mental health by the Australian Government, suicide prevention now receives 3.2%, an increase from 1.6% a decade ago.

Despite increased attention and resourcing, the rate of suicide in the Australian community has remained stubbornly consistent over the past decade.

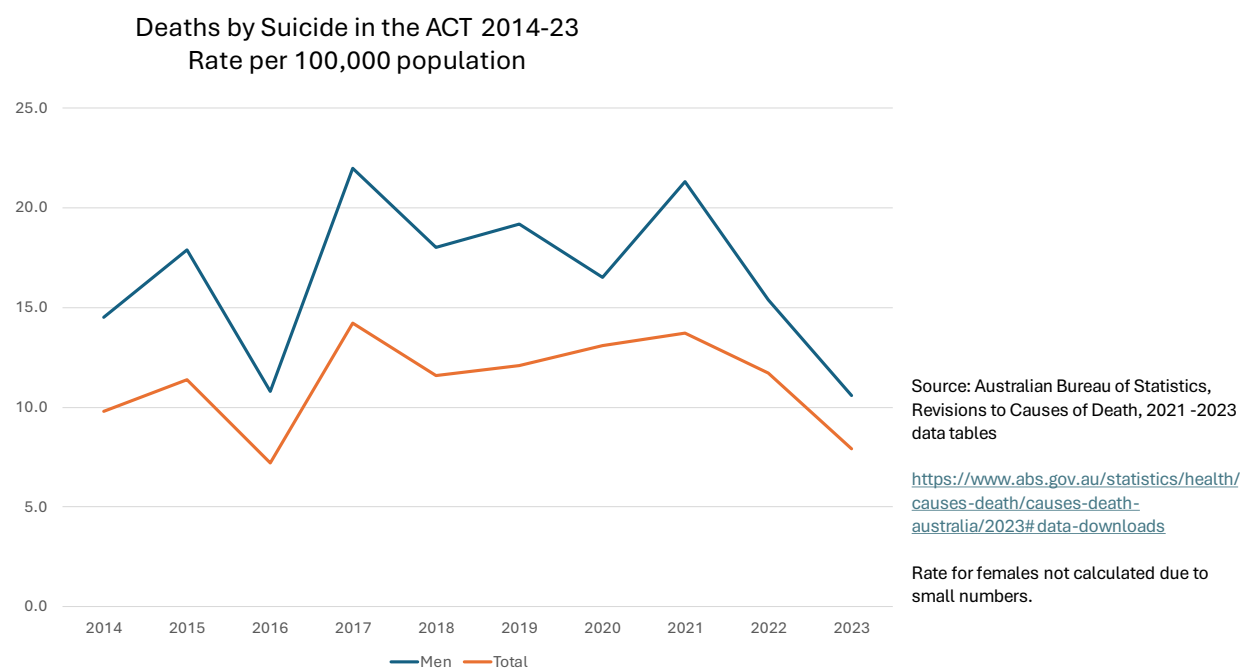
Local ACT data shows some fluctuations in deaths by suicide.

Table 1 Suicide Deaths in the ACT

Year	Males	Females	Total
2014	28	10	38
2015	36	10	46
2016	20	8	26
2017	45	14	59
2018	38	12	50
2019	41	12	53
2020	36	23	59
2021	48	16	64
2022	35	20	55
2023	25	13	38

While absolute numbers of deaths reveal the scale of the tragedies facing individual families, the rate of suicides in the population overall is perhaps a better indicator of trends over time. This is shown in Figure 1.

Figure 1 Population Death Rate due to Suicide in the ACT



While recent reductions in both absolute numbers and the rate per population are both welcome, the latest data indicates this is a return to a rate experienced a decade ago.

The Policy Context

There have been numerous major Australian public inquiries into suicide prevention since 2012, including the following:

Table 2 Major Inquiries

Inquiry / Review	Level	Period	Key Focus & Outcomes
Select Committee on Mental Health & Suicide Prevention	Federal	2021	National system recommendations, workforce, early intervention
Productivity Commission Inquiry into Mental Health	Federal	2018–2020	System cost-benefit analysis, broad reform incl. suicide impacts

Inquiry / Review	Level	Period	Key Focus & Outcomes
National Suicide Prevention Adviser – Advice	Federal	2020	Whole-of-government suicide prevention strategy
Royal Commission into Victoria’s Mental Health System	State (Vic)	2019–2021	Victoria-wide mental health reform with strong suicide prevention elements
Royal Commission into Defence and Veteran Suicide	Federal	2021–2024	Veteran/ADF suicide systemic inquiry, 122 recommendations

Each of these inquiries produced multiple recommendations. For example, the Defence Royal Commission included 122 separate recommendations, the House of Representatives inquiry 44. A full audit on the extent to which these recommendations have been actioned would be a useful exercise, in so far as they pertain to suicide in the ACT.

The [National Mental Health and Suicide Prevention Agreement](#) (signed in 2022) and its [Productivity Commission–led final review](#) (due late in 2025) build on earlier inquiry work, aiming to evaluate the suicide prevention system and inform future reforms.

The National Suicide Prevention Office (NSPO)—established in 2021—has driven the development of Australia’s [National Suicide Prevention Strategy 2025-2035](#), which explicitly draws on the Productivity Commission report, Victoria’s Royal Commission, and experience from Defence Royal Commission work and the National Strategy.

In Canberra specifically, several policies or reports have been developed to influence the way our system responds to the challenge of suicide:

1. ACT Mental Health and Suicide Prevention Plan (2019–2024)

Launched in August 2020, this regional plan attempted to align with Australia’s Fifth National Mental Health and Suicide Prevention Plan. It outlined strategic priorities for suicide prevention in the ACT, including early intervention, workforce development, integrated care, and reducing self-harm.

2. ACT LifeSpan Trial

A \$1.545 million trial of the Black Dog Institute's LifeSpan integrated framework ran from 2018 to 30 June 2021 in Canberra. We found no information or evaluation of the impact of this trial. The Office of Mental Health and Wellbeing [has linked](#) the trial to ongoing ACT policy and governance processes, and training (e.g. Connecting with People, Youth Aware Mental Health).

3. ACT Corrective Services Suicide Prevention Framework

This framework sets out trauma-informed suicide prevention practices for clients in custody or community corrections, addressing identification, continuity of care, incident management, and environment. The Youth Suicide review emphasized peer and family early-warning roles and recommended proactive safety planning and respite services.

4. ACT Children & Young People Death Review Committee: Youth Suicide Fact Sheet (2021)

A committee review covering 2017–2019 deaths in people under 25 highlighted systemic gaps—such as inconsistent follow-up, poor risk assessment protocols, and limited service availability—then provided recommendations focused on co-design, assertive outreach, and service evaluation.

[Research demonstrates](#) the links between increased suicidality and poor access to mental health services.

5. Media-reported review (Feb 2021)

A review tabled in the ACT Legislative Assembly reported that youth suicide rose to 5 deaths in 2018 (average had been 1–2 annually), reinforcing the need for systemic improvements across school, health, peer, and family supports.

Suicide and Self Harm in the ACT – What the Data Tells Us

We have collated material provided by local health providers to give a more detailed picture of the nature of suicide-related activity in Canberra.

Emergency Department

Between July 2016 and July 2022, there were a total of 28,709 emergency department (ED) admissions due to suicide or self-harm involving 13,359 unique clients (Table 3). On average, each individual had 2.1 admissions, with the number of admissions per person ranging widely from a single admission to as many as 310. The average length of stay per admission was approximately 388 minutes, though this also varied significantly across individuals—from as short as 5 minutes to extended stays of up to 11,548 minutes (nearly 193 hours).

These figures reflect not only the high demand for suicide and self-harm but also the considerable variation in service use and patient needs within the ED setting.

Table 3: Summary of admission to Emergency Department due to suicide and self-harm across July 2016 – July 2022

Total number of suicide and self-harm admissions (July 2016-July 2022)	The number of unique clients	The range and average of admission for suicide and self-harm per individual	The average of stay for an individual patient	The range of the average of stay for an individual patient
28,709	13,359	Range:1 – 310 Mean: 2.1	387.8 min	5 – 11548 min

A consistent and striking pattern is the predominance of admissions attributable to people without a recorded diagnosis of a mental health disorder and coded as “Other” diagnoses. This “Other” category accounts for the largest share of ED admissions each year—peaking around 2018–2019 and remaining high through 2021–2022 (Figure 2). This dominance may indicate diagnostic ambiguity in acute crisis presentations or limitations in diagnostic coding during ED encounters.

Other notable diagnostic categories include Anxiety, Developmental Disorder, Drug & Alcohol, and Affective Psychosis, though their admission volumes remain substantially lower. The relatively high number of admissions without a recorded diagnosis further highlights challenges in capturing precise clinical information during these critical events.

These trends point to the complexity of suicide and self-harm presentations, often occurring in the context of overlapping or undiagnosed mental health issues. Improved diagnostic clarity and consistency in ED records could enhance the understanding of underlying drivers and inform more targeted intervention strategies.

Across both hospitals in the ACT, females consistently accounted for a higher number of admissions compared to males in every year observed (Figure 3). The disparity is particularly marked at The Canberra Hospital, where female admissions sharply increased between 2016–2017 and 2019–2020, peaking above 2,500, before declining in 2021–2022. Male admissions also rose during this period but remained notably lower than female rates. North Canberra Hospital showed overall lower volumes of ED admissions than The Canberra Hospital but followed a similar gender-based trend.

There is also a proportion of records coded as Unknown/Other or with missing gender data (NA). These patterns suggest both a higher prevalence or likelihood of ED presentation for suicide and self-harm among females, and potentially hospital-specific factors influencing overall admission volumes.

Figure 2

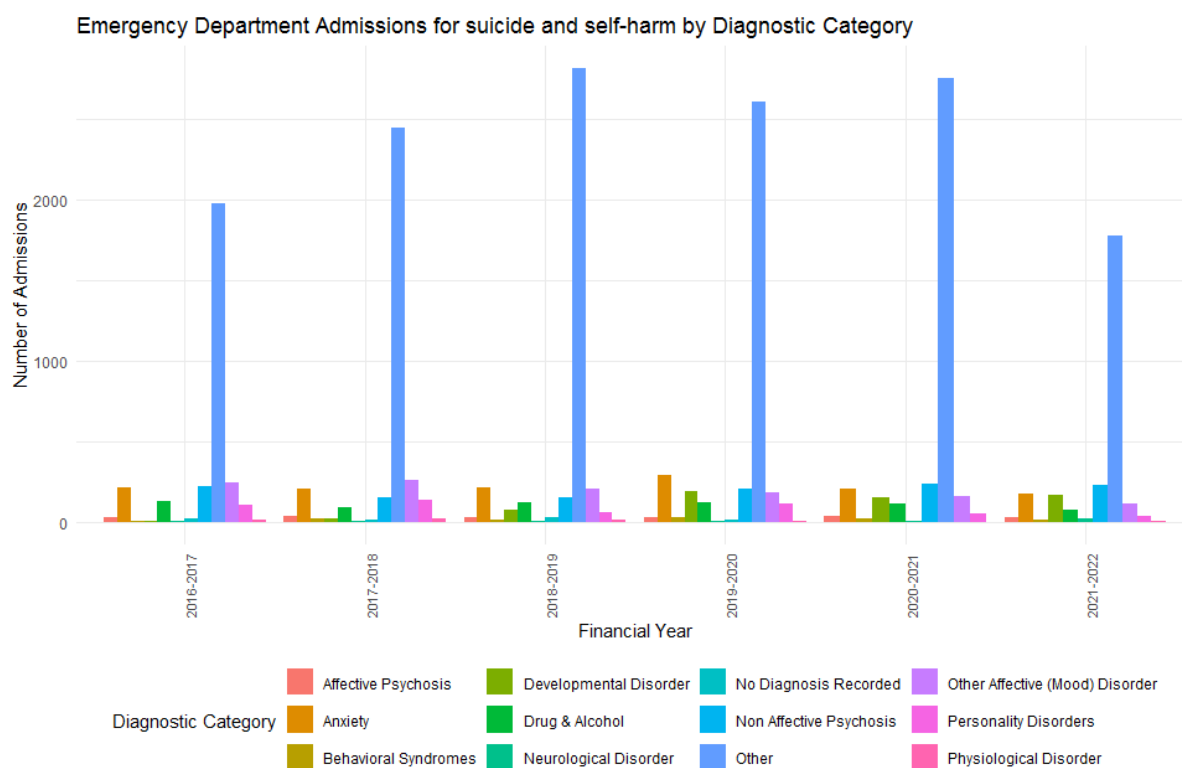
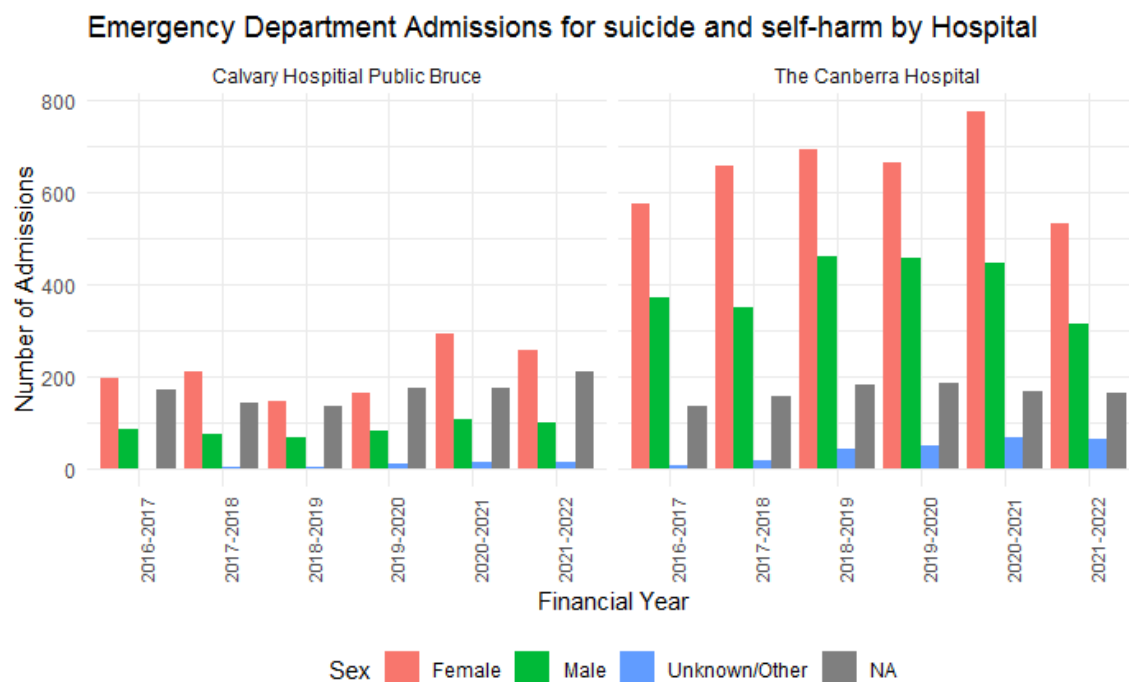
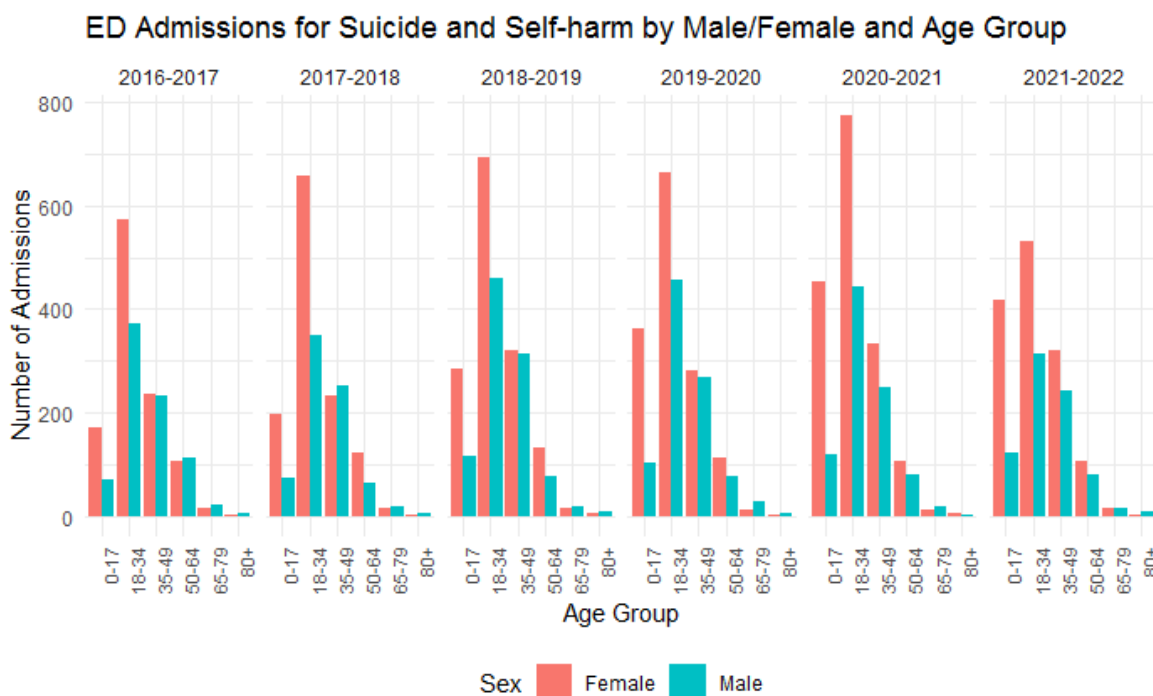


Figure 3



Considering the age groups of patients, females still consistently represent the majority of admissions, particularly in the 15–34 age group (Figure 4). The highest number of admissions occurred among females aged 15–34, with a notable peak in 2020–2021, followed by a decrease in the following year. Males also show elevated admissions in this age group, though consistently lower than females. Admissions for both sexes taper off in older age groups, with very low counts observed in individuals aged 65 and over. The data reveal a clear concentration of self-harm and suicide-related ED visits among young females, suggesting a demographic at particularly high risk. This trend highlights the need for age- and gender-sensitive preventive mental health strategies.

Figure 4



A notable trend across the years is the consistently higher number of admissions among females, particularly in the 18–34 age group, where conditions like Anxiety, Other Affective (Mood) Disorders and Personality Disorders appear prominently.

In contrast, males show a more distributed pattern across age groups, with Drug & Alcohol and No Diagnosis Recorded being more prevalent in older age brackets. Over time, there is a visible increase in the number of admissions, especially among younger females, suggesting a growing mental health burden in this demographic.

Building on the observed age and sex distribution of ED admissions for suicide and self-harm, a consistent and striking pattern emerges: females—particularly those aged 18–34—consistently exhibit the highest rates of presentation across the years.

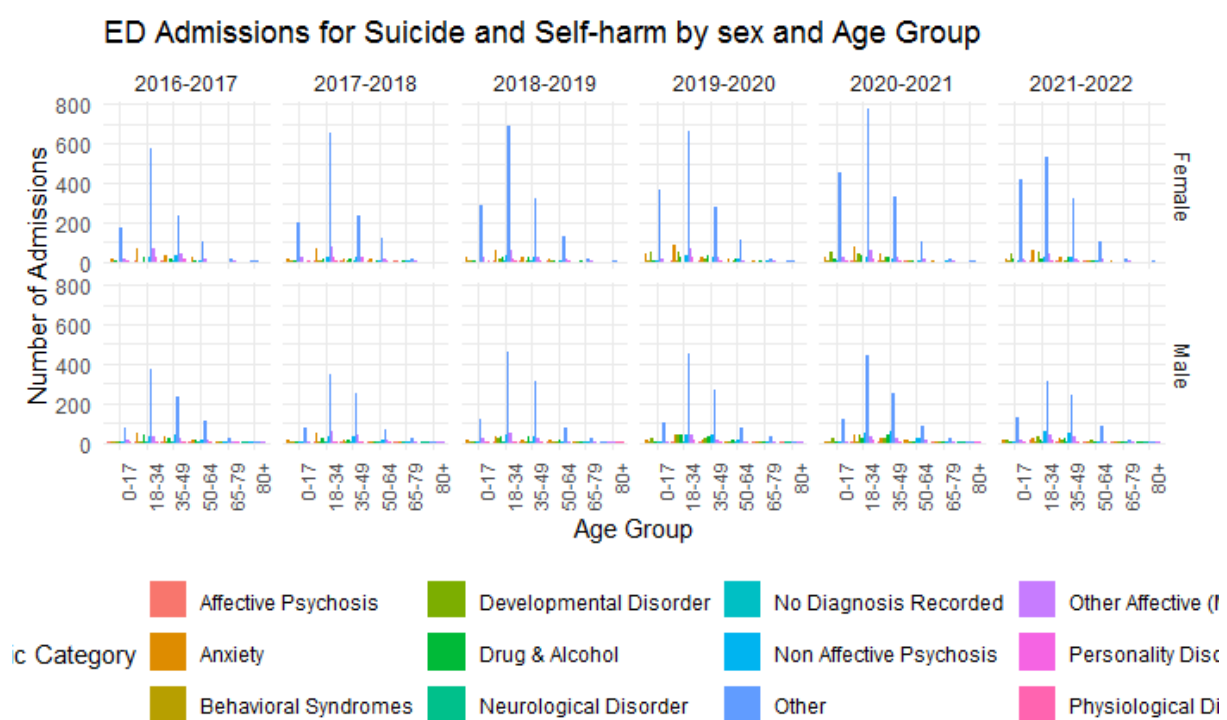
While the majority of admissions were for individuals with no known history of mental health disorders, females with recorded diagnoses are disproportionately affected by conditions such as Anxiety, Other Affective (Mood) Disorders, and Personality Disorders—these being among the most frequently documented categories in their presentations (Figure 5). This suggests that young adult females are not only at greater risk of suicidal and self-harming behaviours but are also more likely to present to emergency services for issues related to mood and emotional regulation.

In contrast, males show a more evenly distributed pattern of admissions across age groups, with higher representation among those aged 18–34 and 35–49.

Among males with mental health diagnoses, Drug & Alcohol-related disorders are more commonly observed. This may reflect a greater tendency toward substance-related crises in this population.

Importantly, across both sexes and all age groups, the majority of ED admissions for suicide and self-harm involve individuals without a recorded mental health diagnosis. This highlights a significant gap in identification or documentation of underlying mental health conditions and underscores the need for improved screening, assessment, and follow-up care during ED encounters to better address the needs of this high-risk group.

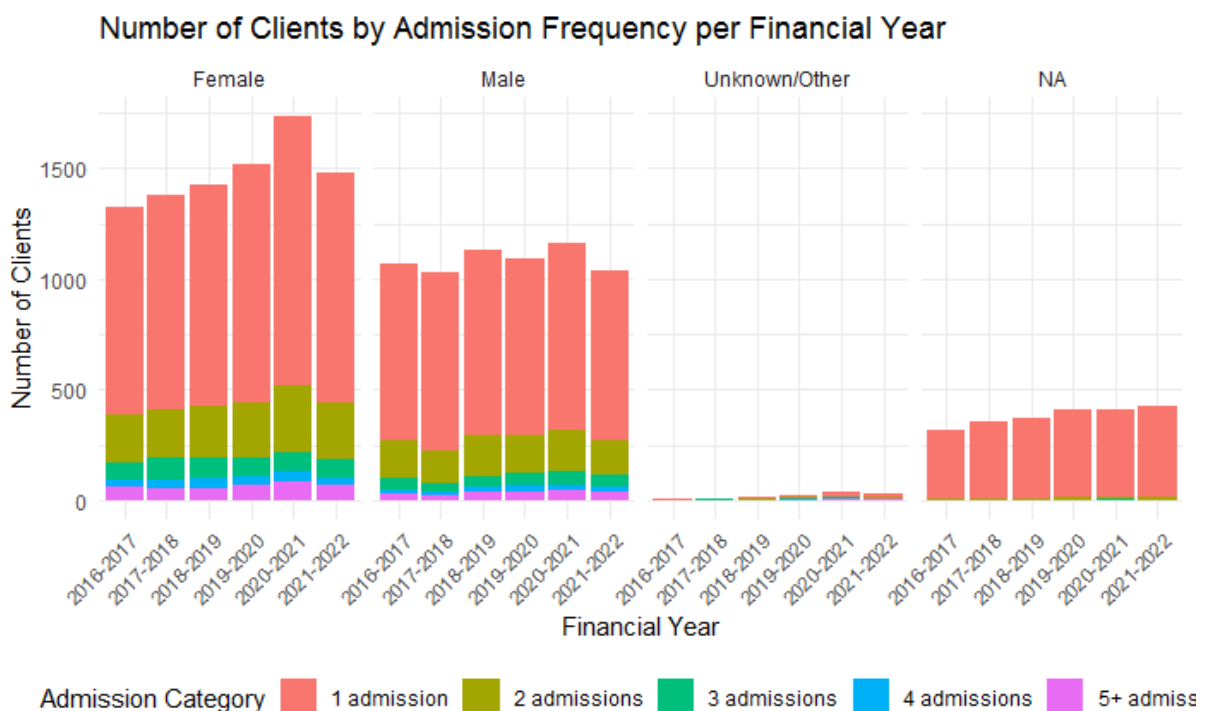
Figure 5



Extending the analysis of demographic and diagnostic patterns of ED admissions for suicide and self-harm, another concerning trend becomes apparent when examining the frequency of presentations over time. Across both sexes, most clients each year had one admission (Figure 6). There is a notable higher number of individuals with two admissions, especially among females.

The repeated admissions suggest the presence of a growing group of individuals experiencing persistent or poorly managed mental health difficulties. The overall upward trajectory in total ED visits may reflect escalating psychological distress in the community, heightened awareness, or improved access to acute care. However, it also signals potential shortcomings in long-term management and continuity of care.

Figure 6

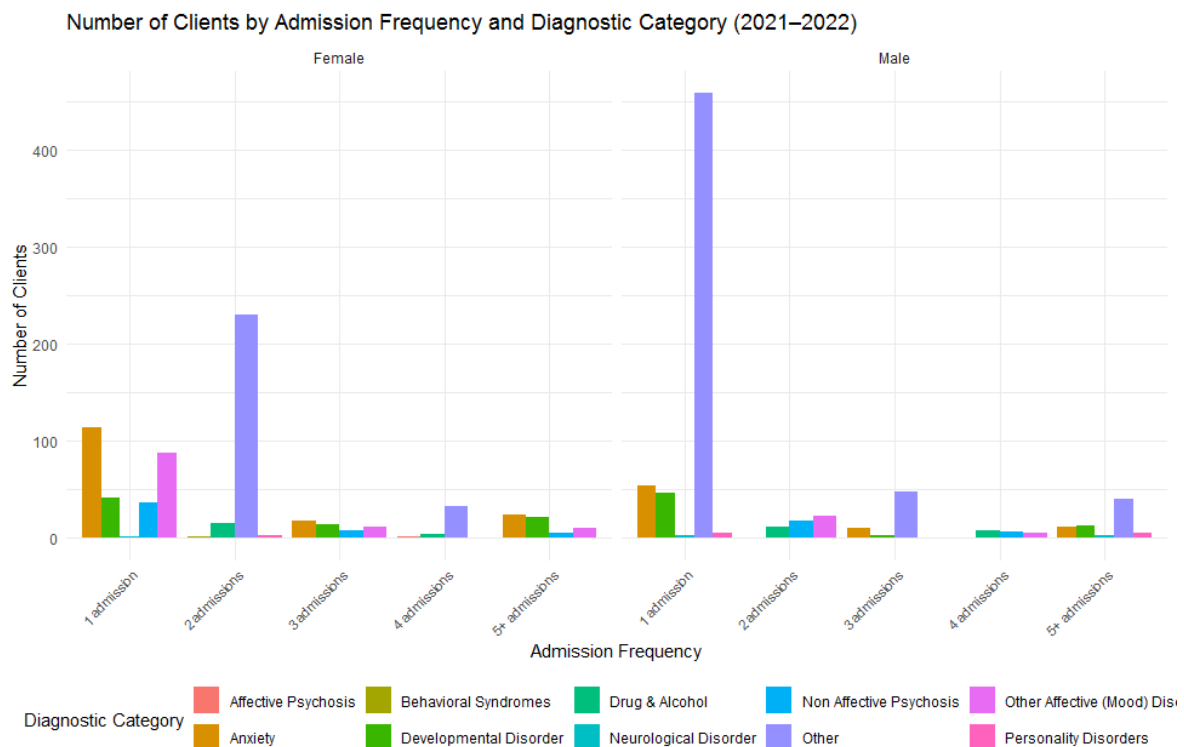


A closer look at diagnostic profiles by sex and admission frequency reveals important nuances (Figure 7). Among females, while the largest proportion of admissions continues to involve individuals with no recorded history of mental health disorders after first admission, Anxiety and Other Affective (Mood) Disorders are the most commonly documented conditions among those with one admission.

In contrast, males exhibit a higher overall proportion of those with no history of mental health diagnoses compared to females. The higher concentration of psychiatric diagnoses among males with frequent admissions may reflect differences in help-seeking behaviour, symptom manifestation, or underlying social determinants.

This stratification by diagnosis and admission frequency underscores the importance of early intervention and more personalised, sustained treatment strategies. Individuals presenting with recurrent admissions and complex mental health profiles—especially those with escalating needs—would benefit from integrated care approaches, consistent follow-up, and strengthened links to community and ambulatory mental health services to prevent cycling through emergency care.

Figure 7

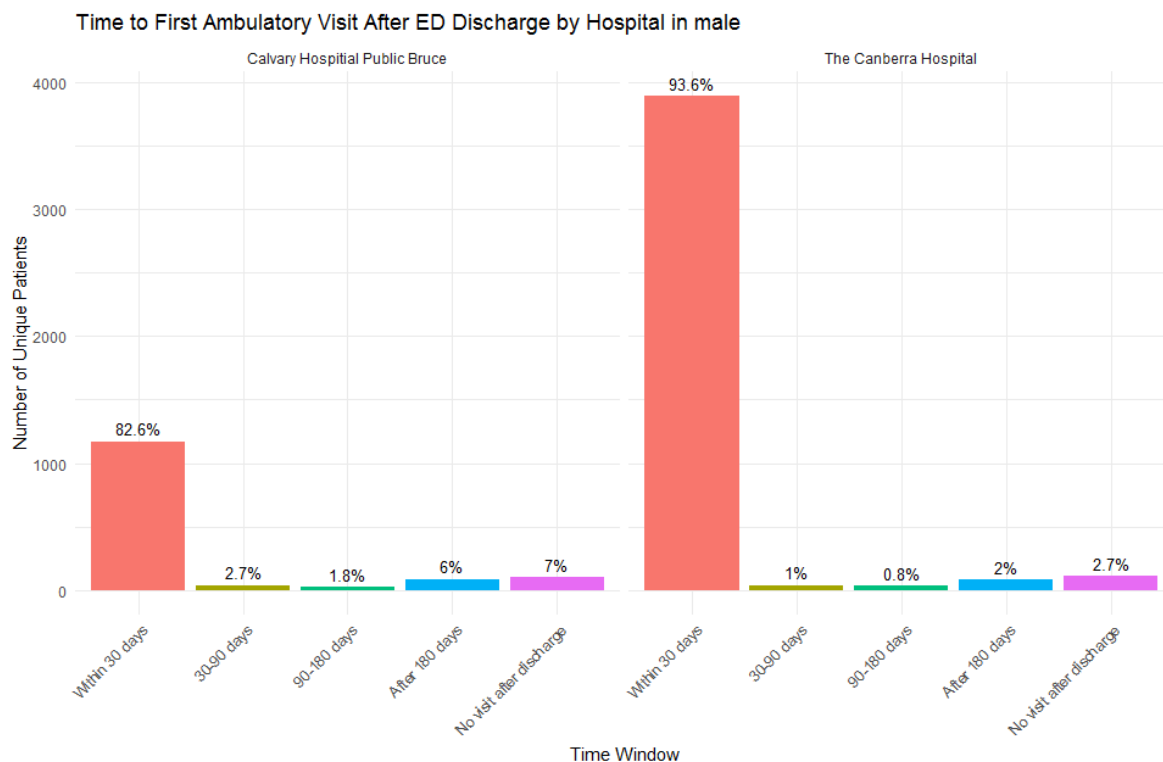


These patterns underscore the urgent need for robust post-discharge pathways. Enhanced coordination with community-based and ambulatory mental health services is essential to ensure that individuals—particularly those with recurrent ED presentations—receive timely follow-up, sustained support and proactive care. Without these measures, the healthcare system risks reinforcing a cycle of crisis-driven interventions rather than addressing the root causes of distress among high-risk populations.

A comparison between the two hospitals reveals significant differences in the timeliness of follow-up care (Figure 8). At The Canberra Hospital, 93.6% of male patients had an ambulatory visit within 30 days of ED discharge, suggesting a responsive and well-coordinated outpatient system. In contrast, North Canberra Hospital recorded a lower but still substantial rate of 82.6%, suggesting some room for improvement in ensuring prompt follow-up.

Notably, North Canberra Hospital also had a higher proportion of patients who experienced delays or received no follow-up at all: 7% of male patients had no visit post-discharge, compared to just 2.7% at Canberra Hospital. These disparities may reflect differences in service integration, resource allocation, or patient engagement practices between the two facilities.

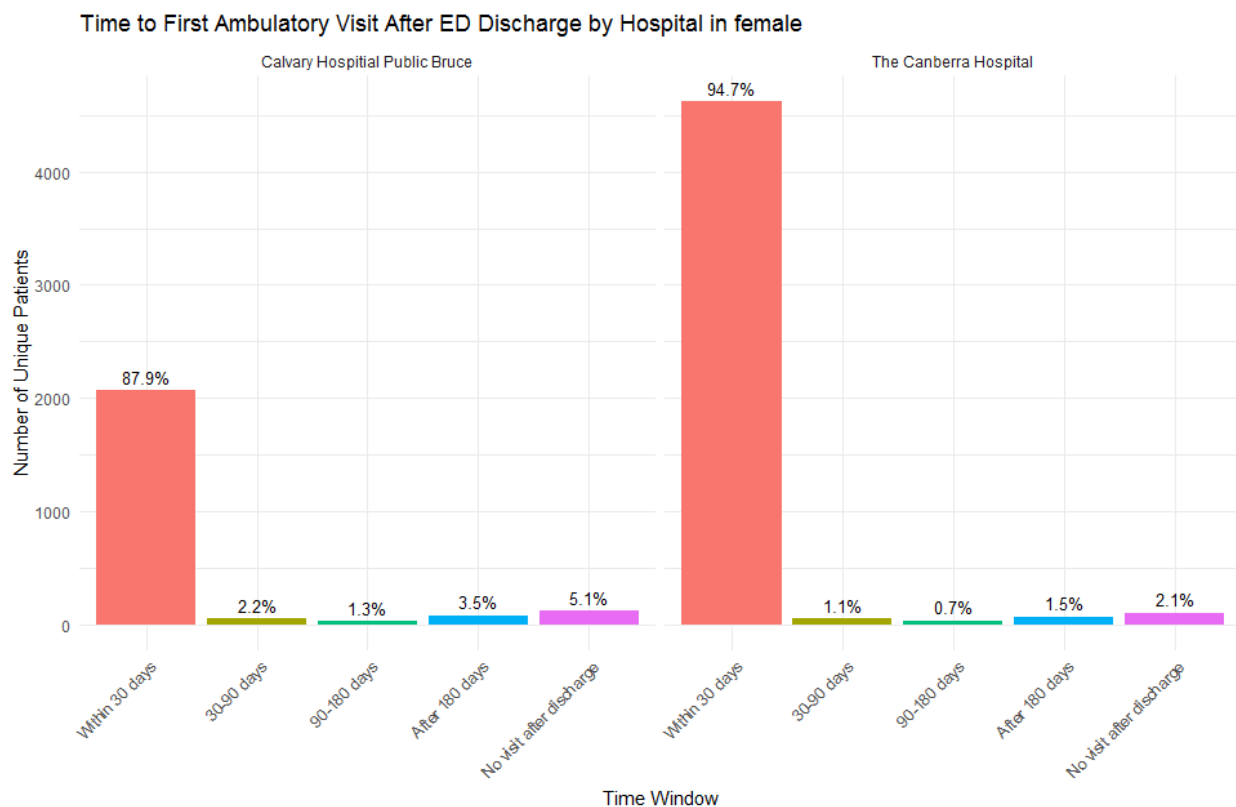
Figure 8



Among female patients (Figure 9), The Canberra Hospital demonstrated similarly strong performance, with 94.7% receiving follow-up within 30 days—further affirming the hospital’s effective transition-of-care practices. North Canberra Hospital followed closely with 87.9%, yet the gap remains notable. Moreover, a higher percentage of North Canberra’s patients experienced delayed follow-ups: 2.2% were seen between 30–90 days, 1.3% between 90–180 days, and 3.5% only after 180 days. The percentage of female patients at North Canberra who had no follow-up (5.1%) shows the same trend points toward less consistent continuity of care compared to Canberra Hospital.

These findings highlight the critical role of discharge planning and outpatient coordination in achieving timely care transitions—especially for female patients, who may present with more complex or layered mental health needs. Closing these service gaps through improved integration and resource targeting can help mitigate relapse risks and reduce preventable ED returns.

Figure 9



Barriers and Enablers to Suicide Prevention

Overall, there is a danger that suicide prevention activities can become too generic or lack specific focus. A recent publication¹ encouraged planners to be much more alert to the different ‘types’ of suicide which exist in the community, even suggesting more than thirty such types exist. Designing interventions depends on understanding the problem you are attempting to fix.

Future suicide prevention activities in the ACT might be better organised and targeted through the segmentation of efforts into several ‘categories’, so as to better organise interventions, responses and consider different data/information requirements, as follows:

- Men who are known to mental health services already
- those whose suicidality becomes known in the ED
- those whose suicidality becomes known in primary care (e.g. GP)
- those whose suicidality becomes known in non-health settings (clubs, social groups etc)
- those whose suicidality is unknown

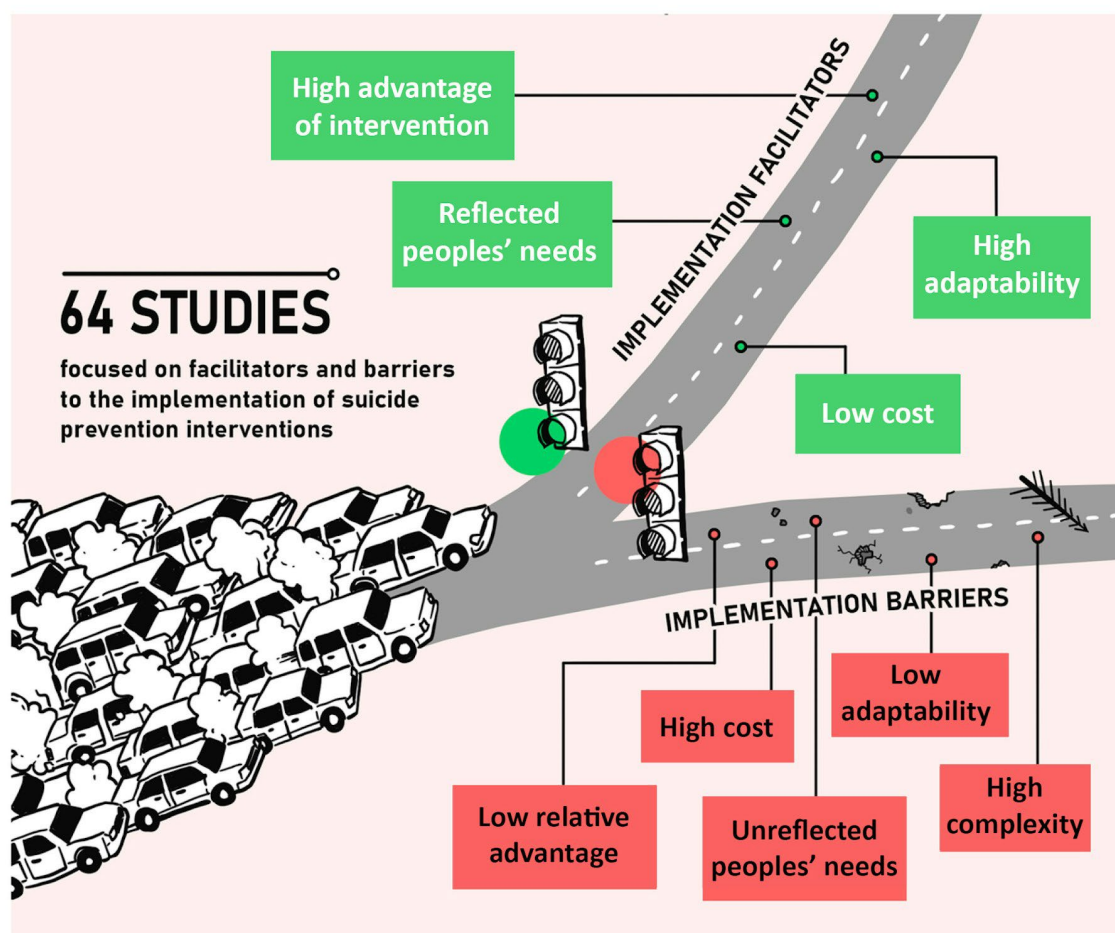
¹ Tatz C, Tatz S. The sealed box of suicide. The Contexts of Self-Death. Switzerland: Springer Nature. 2019.

[There is also research](#) which indicates a link between increased suicidality and associated physical illness, particularly [among the elderly](#). This research may help further target future suicide prevention efforts.

Further research should be undertaken to assess the extent to which other groups often recognised as vulnerable to suicidality, such as Aboriginal and Torres Strait Islander people and first responders, are also at risk here in Canberra.

Such efforts also be more clearly guided by reference to the barriers and enablers already identified by groups like [Lifeline](#). As shown in Figure 10 below, these factors are already well understood and can guide the shape of more tailored approaches to suicide prevention in the ACT going forward.

Figure 10 Barriers and Enablers in Suicide Prevention Activities

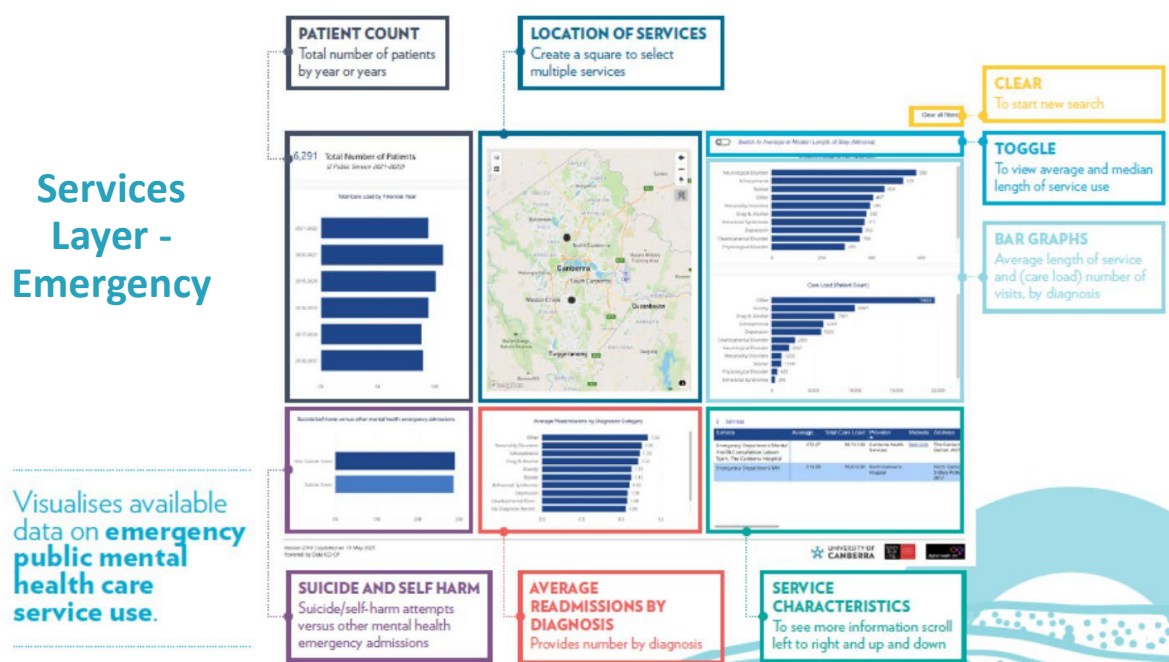


Dashboards and MChart

A key step in better responding the challenge of suicidality in Canberra would be the establishment of a more integrated approach to data management and monitoring across key areas of the health system. [South Australia already](#) offers several 'dashboards' which give line of sight understanding about the operation of inpatient, emergency and ambulance services, in real time.

Such a system would significantly enhance overall system responsiveness in cases of suicide and attempts. Some of the necessary infrastructure for such a system has already been started in Canberra. Working with ACT Health, the Capital Primary Health Network and others, we have developed the MChart mental health navigation tool for planners, using Canberra as a demonstration site. Figure 11 below shows a screenshot of one of 8 layers of information available to MChart users, this one focusing on ED services, and showing information (bottom left) regarding suicide and attempts. More information about MChart is [available here](#).

Figure 11 MChart Suicide Information



Impact Analysis

The evaluation of suicide prevention activities could be further enhanced with new techniques in impact analysis. Our Global Impact Analytics Framework (GIAF) presents a taxonomy, glossary and associated measurement tools for impact analysis of implementation research, using an onto-terminological approach and which focused on the process of implementation.

We have developed the GIAF to be 'fit for purpose' for any phase of implementation research: the pre-implementation (initiation); early implementation (maturity); or later implementation (evolution) once the original implementation research project is completed. The GIAF includes a toolkit relevant to any sector impacted by the research (e.g., research, education, employment, policy and practice, market, population and society). The GIAF has already been used in ten countries, including in relation to [Movember's](#) multinational impact assessment of programs to support the mental health of veterans and first responders. More information about the GIAF is [available here](#).

Conclusion

Suicide is a stubborn problem to address. Increased awareness and community concern regarding the issue has not translated in sustained reductions in either completed or attempted suicides.

Proper analysis requires long term data collection and trend analysis. Rates bump around from year to year.

Increased research does suggest increasing confidence in the effectiveness of some prevention activities. Activities should not occur unless dedicated resources have been set aside from the start for well organised evaluation, contributing to an ongoing repository of knowledge about what works, to be shared.

The Health Research Institute has very strong and close relationships with ACT Health, other government agencies, and Capital Primary Health Network. We believe, through MChart and other projects, there is scope to further deepen these relationships specifically to improve Canberra's response to suicidality. This may be through ongoing data sharing and the establishment real time dashboards, coordinated reporting, analysis, policy development and impact evaluation.

We would welcome the opportunity to explore this work further with the Assembly and Government.