



# Submission cover sheet

## Inquiry into men's suicide rates

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AMA ACT Submission  
Inquiry into Men's Suicide Rates in the ACT

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### Summary

Men's suicide remains a critical public health issue in the ACT, with complex and multifaceted drivers that demand urgent attention. AMA ACT welcomes the opportunity to contribute to the ACT Legislative Assembly's Inquiry into Men's Suicide Rates, drawing on the clinical insights of its members who work at the frontline of mental health care. This submission is informed by a targeted survey of selected AMA ACT members, who identified a range of systemic, social, and clinical factors contributing to suicide risk among men in the ACT. Key themes emerging from the survey responses include:

- *Mental health conditions* including depression, trauma, and substance use disorders, often compounded by chronic physical illness.
- *Social determinants* including financial stress, relationship breakdowns, social isolation, and cultural stigma around seeking help.
- *Barriers to care* including long wait times for psychiatric and psychological services, financial viability, and limited access to male practitioners.
- *Systemic gaps* including fragmented service pathways, insufficient public mental health resources, and insufficient support for neurodivergent and culturally diverse men.

Clinicians also shared de-identified case examples that illustrate consequences of delayed or inadequate care, and the need for more responsive, integrated, and male-friendly mental health services.

This submission seeks to highlight the lived realities of clinicians and patients, and to inform the Inquiry's understanding of the systemic drivers of male suicide in the ACT. Based on the key themes emerging from the survey, the following goals are suggested:

- Service improvements to expand access and capacity.
- Policy changes to strengthen primary care and mental health funding.
- Community strategies to reduce stigma, promote early intervention, and support families and young men.

## **AMA ACT Submission: Inquiry into Men's Suicide Rates in the ACT**

### **Introduction**

This submission has been created by AMA ACT in response to the ACT Legislative Assembly's Inquiry into Men's Suicide Rates. The purpose is to provide insight from AMA ACT members who regularly care for men at risk of suicide in the ACT. A survey was sent to all AMA ACT members who are general practitioners, psychiatrists, and emergency physicians. Using this data, AMA ACT seeks to highlight systemic challenges, barriers to care, and opportunities for reform based on direct clinical experience and member consultation.

AMA ACT is the peak professional body representing medical practitioners in the Australian Capital Territory. Its membership includes a diverse range of clinicians. AMA ACT advocates for high-quality, accessible healthcare and supports its members in delivering safe, effective, and compassionate care to the ACT community.

Suicide remains a leading cause of death among men in Australia, and the ACT faces unique challenges due to its demographic composition, workforce characteristics, and service landscape. Clinicians in the ACT encounter men at risk of suicide across a range of settings. These clinician's perspectives are critical to understanding the drivers of male suicide and identifying practical, system-level solutions.

This submission draws on the lived experience of AMA ACT members to inform the Inquiry, and to support the development of strategies to reduce suicide risk among men in the ACT.

### **Methodology**

To inform this submission, AMA ACT conducted a targeted consultation with its general practitioners, psychiatrists, and emergency physician members who regularly engage with patients at risk of suicide. The aim was to gather frontline clinical perspectives on the systemic, social, and individual factors contributing to male suicide in the ACT.

An anonymous survey was distributed to these selected AMA ACT members. The survey included six open-ended questions designed to capture insights on:

- Key factors contributing to suicide risk in men.
- Barriers to care encountered in clinical practice.
- Case examples or patterns highlighting system gaps.

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- Suggestions for service, policy, or community-level change.
- Additional reflections or recommendations.
- Willingness to be contacted for follow-up clarification.

12 responses were collected, with representation from each of the three chosen specialities. 7 of the 12 respondents provided contact details for further engagement. The responses received were reviewed and analysed to identify themes and suggestions. De-identified quotes and case examples were extracted to illustrate key points. This qualitative input forms the submission, ensuring it reflects the lived clinical experience of AMA ACT members and the realities faced by men at risk of suicide in the ACT.

### **Key Factors Contributing to Male Suicide in the ACT**

AMA ACT members identified a range of clinical, social, and systemic factors contributing to suicide risk among men in the ACT. These factors include the prevalence of mental health conditions, acute distress situations and barriers to accessing care.

#### 1. Mental Health Conditions

Clinicians cited mental health disorders; particularly major depression, substance use disorders, and trauma related conditions; as primary contributors to suicide risk. These conditions were describe as often being chronic, under-treated, and exacerbated by physical health issues such as chronic pain or illness.

*“Mental health conditions—namely major depression, being chronic and difficult to treat.”*  
*“Mood disorders, substance abuse disorders, social isolation.”*

Clinicians noted that male suicide may sometimes be impulsive and intertwined with substance use, making it difficult to distinguish between intentional acts and misadventure. They suggested that this ambiguity can affect both the accuracy of statistics and the design of prevention strategies.

*“Male suicide may be impulsive but lethal... means statistics may be hard to interpret.”*

#### 2. Distress

Respondents highlighted the impact of acute distress, particularly in middle-aged men. Causative examples of acute distress included relationship breakdowns, financial pressure, custody disputes, and social isolation. These situational stressors were cited to often intersect with mental health vulnerabilities, increasing suicide risk.

*“Middle-aged men at high rates of situational distress - marriage breakdown, childcare custody issues.”*  
*“Financial pressures/uncertainties, and chronic health challenges.”*

#### 3. Barriers to Accessing Care

Clinicians identified a range of barriers that prevent men at risk of suicide from accessing timely and effective care in the ACT. These barriers are both systemic and cultural, and are suggested to contribute significantly to delayed intervention and poorer outcomes.

- a. **Stigma:** A recurring theme was the role of stigma and cultural expectations around masculinity, which discourage men from seeking help or expressing emotional distress. Clinicians associated this stigma with delayed intervention and underutilisation of available services.

*“Society often says it’s important for men to bottle up or suppress feelings - which leads to further distress.”*

*“Men sometimes need to be strongly encouraged to get help.”*

*“Adjust services to be more welcoming of men. The current system is a little skewed to helping those more capable of expressing emotions and providing a narrative (capabilities often found more in women).”*

Certain occupations were identified as an additional stigmatising factor. Military personnel, police officers, and public servants were noted as having elevated risk due to workplace culture, exposure to trauma, and limited access to tailored support.

*“Military and police culture can be inhibiting to getting help.”*

*“Police and military can have high suicide rates.”*

- b. **Care Availability:** Clinicians also highlighted broader systemic factors, including underfunding of mental health services, lack of visibility of men’s mental health organisations, and limited support for neurodivergent individuals.

*“No public support services for neurodivergent in the ACT.”*

*“Underfunding of mental health and addictions services.”*

*“Many neurodivergent/gender divergent males have no way of accessing the correct form of support when the specialists can't do more than tell someone they are anxious or depressed.”*

*“Apparent broader community denial of the social factors contributing to suicide in men.”*

- c. **Long wait times:** A consistent theme was the difficulty in accessing psychiatric and psychological services, with wait times often extending for months.

*“Referral difficulties to psychiatrists—long wait times, difficult for GPs to access to discuss clinical situation.”*

*“Mainly the delay in being able to see new patients—can be many months.”*

*“It (the need for mental health services) is only increasing and the services available are already being overburdened.”*

- d. **Affordability and service gaps:** The cost of private mental health care was cited as a major barrier. Public services were described as under-resourced and difficult to navigate, leaving many men without viable options.

*“Failure to have access to affordable inpatient facilities, rehab, detox.”*

*“Public health system is completely useless in regards to supports.”*

- e. *System accessibility:* Several respondents described fragmented referral pathways and ineffective crisis response systems, including dismissive interactions with crisis lines and limited options for care. These experiences were suggested to discourage future help-seeking.

*“Poor experiences when I have called crisis lines with the patient in the room... the service is dismissive and clunky.”*

*“Limited admission options—for therapy and treatment.”*

### **Case examples**

Clinicians provided several de-identified case examples and observations that illustrate critical failures and gaps in the current system of care for men at risk of suicide in the ACT. These examples highlight the consequences of delayed access, fragmented services, and missed opportunities for intervention.

#### **1. Delayed Access to Specialist Care**

One clinician described the case of a man in his 30s with chronic pain and major depression. Despite multiple attempts, the GP was unable to secure a timely referral in Canberra. The patient eventually travelled to Sydney for care, but no communication was received from the specialist. The clinician wrote:

*“Access to specialised care is a huge issue in Canberra... I believe this was the catalyst on a background of chronic major depression that resulted in his planned suicide.”*

#### **2. Missed Opportunities for Intervention**

Another case involved a middle-aged man with a history of suicide attempts following a relationship breakdown. Despite multiple prior interactions with mental health services regarding suicidal behaviour, the patient died by suicide in a violent and deliberate manner. The clinician reflected on whether protective measures such as admission could have prevented the outcome.

*“Given the determination of this man to suicide, I think more protective measures - by way of admission - may be helpful to intervene.”*

#### **3. Vulnerable Populations**

Clinicians highlighted systemic neglect of high-risk groups, including Aboriginal men in custody, military cadets, and AFP officers. These populations often face cultural and institutional barriers to accessing mental health care, and their needs are not adequately addressed by current services.

*“I used to provide a clinic for remandees and prisoners... military cadet... AFP officers.”*

*“The differences in the ACT population... include a high number of public servants... and unique bodies including the AFP, ADFA and Duntroon. Police and military can have high suicide rates.”*

#### 4. Legal and Social System Intersections

Some clinicians noted that men involved in family violence orders or legal disputes often experience compounding stress and stigma, with little support available to navigate these challenges constructively.

*“Men arrested at (his) workplace after AVO or FVO delivered.”*

*“(No) Social support in DV cases.”*

*“Actual evidence and fair separation processes. Stronger sentencing for violence.”*

*“Despite being rare, false accusations and dealing with the legal system are very much geared against innocent men.”*

### **Opportunities for Change**

Clinicians identified a range of service, policy, and community-level changes that could significantly reduce suicide risk among men in the ACT. These suggestions reflect both practical frontline experience and broader systemic insights.

#### 1. Service

Clinicians suggested expanding capacity in mental health services, particularly in psychiatry, psychology, and neurodivergence support. They expressed a need for more male practitioners. Enhanced integration and coordination across services to reduce fragmentation and improve continuity of care was also suggested. The development of mobile outreach teams and specialised suicide prevention services to engage men in the community were recommended.

*“Increase capacity for specialised services... particularly psychiatry and psychology.”*

*“A specialised suicide outreach service, more mobile community teams.”*

#### 2. Policy

Increased funding for primary care, enabling longer consultations and better mental health support in general practice was suggested. There were recommendations of clearer referral pathways and reduced barriers to accessing specialist care. Increased support for GP training in mental health assessment and management was suggested. There were recommendations for education and community-based programs to support early intervention and awareness.

*“ACT Government increase funding... stop taxing and constraining primary care.”*

*“Improve scope of practice for GPs and health professionals.”*

#### 3. Community

Clinicians expressed the need to address stigma in help-seeking and mental illness perception. Several respondents emphasised the need to shift societal narratives and reduce shame around emotional vulnerability. Clinicians highlighted the importance of supporting boys and young men early in life, particularly in developing emotional literacy, resilience, and access to appropriate care.

*“Stigma about mental health and illness remains a societal problem.”*

*“We don’t support young men to be able to reach out and get help... this just carries on through their lives.”*

*“Improving young men/adolescent boys’ self-esteem, willingness to talk about feelings.”*

*“Encouragement of male high school students to take up psychology/MH disciplines.”*

#### 4. Legal

Clinicians called for recognition of the impact of legal and social systems, including family law and criminal justice, on men’s mental health. They highlighted the importance of fair and evidence-based processes in cases involving family violence and separation.

*“Actual evidence and fair separation processes. Stronger sentencing for violence.”*

### **Conclusion**

Men’s suicide in the ACT is a complex and deeply concerning issue that demands a coordinated, compassionate, and informed response. Through this submission, AMA ACT has sought to amplify the voices of clinicians who witness the impacts of systemic gaps, cultural stigma, and service limitations on the lives of men at risk.

The insights gathered from general practitioners, psychiatrists, and emergency physicians reveal that men in the ACT face significant barriers to accessing timely, appropriate, and affordable mental health care. These barriers are compounded by societal expectations around masculinity, under-resourced public services, and a lack of tailored support for vulnerable populations. AMA ACT urges the Inquiry to consider the lived realities presented in this submission and to prioritise reforms that strengthen primary care, expand mental health service capacity, and foster a culture of openness and support.

## **Appendix**

### Survey Questions

1. From your clinical perspective, what are the key factors contributing to suicide risk in men in the ACT? (Consider patient demographics, mental health conditions, social determinants, access to care, etc.)
2. Have you encountered any specific barriers to care that affect men at risk of suicide in your practice? (E.g. stigma, long waiting times, cultural or geographic challenges, referral difficulties)
3. Can you briefly describe any cases or patterns you've seen that highlight gaps or failures in the current system of care for men at risk of suicide? (Please do not include any identifying information)
4. What change at a service, policy, or community level do you believe could make the most difference in reducing suicide risk among men? (This could include workforce capacity, models of care, outreach, prevention strategies, etc.)
5. Is there anything else you would like to share regarding male suicide in the ACT or suggestions for inclusion in the AMA ACT submission?
6. Optional: Would you be open to a brief follow-up call or email if we need to clarify or expand on anything you've shared? If yes, please provide preferred contact details: