Submission cover sheet

Inquiry into men's suicide rates

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Submission to the ACT Inquiry into Men's Suicide Rates

Men's suicide is a crisis that requires collaborative and compassionate responses. According to the Australian Bureau of Statistics (2021), men commit three-quarters of all suicides.

EveryMan Australia welcomes the opportunity to contribute to the inquiry into men's suicide rates with a brief submission. As an organisation that directly engages with men at risk of suicide across all our program areas, we would like to take this opportunity to share some insights drawn from our work and advocate for reforms that address the complex drivers of male suicidality.

Our Work

EveryMan is a for-purpose community service provider, and that purpose is to bring effective and professional services to men at risk of exclusion, discrimination and marginalisation, no matter who they are or what they've done.

For the last 25 years we have been developing and delivering an approach for working with men living with high and complex support needs, and with their partners and families. These men often come to us at a time of crisis — facing a combination of mental health issues, AOD, relationship breakdown, family separation, social isolation and loneliness, homelessness and enmeshed long-term, often intergenerational involvement with the mental health, child protection, domestic violence and justice systems related to domestic, family and sexual violence – as victim/survivor or as user of violence.

We use this approach alongside of trauma-informed, DFSV trained and person-centred practice in all our specialist programs, including:

- **Counselling Services:** 25 years of engagement with men of all ages, and with their partners and families, dealing with crises and long-term challenges from every part of a man's life. This program deals with a wide range of matters including mental health crises, use of domestic and family violence, trauma as victim/survivor of child physical and sexual abuse and other forms of violence, addictions, social isolation, relationship breakdowns, loss of children, bereavement – all known contributors to risk of suicide.

- **Men's Accommodation and Support Services:** for men experiencing or at risk of homelessness, 89.47% of whom live with very high and complex support needs. These are related to incarceration, experience of physical and sexual assault (as children and as adults), alienation from healthy family and peer support networks, Acquired Brain Injury, intellectual disability, mental illness, AOD, long histories of support failures by statutory and community services programs - often going back to childhood and often associated with intergenerational involvement with statutory authorities, particularly in relation to child protection and mental health matters.

- **Violence prevention programs:** for men and others using or at risk of using domestic, family and public violence.

Since EveryMan commenced operations in 1998 with what was then a small part-time counselling program, we have supported many men presenting for suicide risk or with suicide risk which was not disclosed during referral or intake. The Men's Accommodation and Support Service which commenced in 2004 has had many clients who presented at referral or later during their support period with suicidal ideation, a number of whom went on to attempt suicide, sometimes successfully. The first client seen in our Working With the Man program was found by the case manager on his first home visit attempting to hang himself in his garage.

In the last two years alone, EveryMan Australia supported at least **68 men who presented with a risk of suicide**.

Key Observations

- **The crises our clients present with are complex and cumulative.** Rarely do the men presenting to our services come with one issue to address or one issue that has triggered suicidality. The risk increases when men experience multiple challenges and trauma events, especially where there are long histories of support failure, a lack of family or social support and a sense of shame when seeking help.

  Social isolation is not a singular phenomenon for our clients, either. Primary drivers include:

  - loss of social/family connections – death of parents, relocation away from family
  - estrangement and alienation – often a consequence of conflict or breakdown related to general family dysfunction or challenges that the client's problem-related behaviour presents to the family find too difficult to manage
  - withdrawal – more commonly associated with mental health conditions like depression where the client disengages from relationships

- **For men who have been socially isolated for a long time, peer groups are often formed from people living in proximity**. For men living in public housing, the pool of people available to form social connections with are often dealing with the same range of life issues as they are and lack the skills needed to establish deeper emotional connection s which are essential to support someone who is becoming suicidal.

  Conversely, for men who have been institutionalised—particularly those exiting prison, social isolation can be replaced with an overwhelming level of contact and supervision. After long periods of restricted interaction and highly structured environments, reintegrating into the community can feel chaotic and destabilising. These men may suddenly find themselves surrounded by multiple services, professionals, and unfamiliar social demands, without the necessary skills or support to manage it all. The rapid shift from isolation to overstimulation can lead to acute distress, a sense of failure or hopelessness, and, in some cases, increased suicide risk.

- **Intervention must be about the whole of the man's life.** Addressing housing, justice involvement, trauma, AOD and relationship loss are as vital as addressing depression or other mental health conditions, but men need to know that the other parts of their life are valued too, that who they are as

people is respected – that they're not just a problem with a person attached. We meet men where they are in life, socially, physically, emotionally and culturally.

Not surprisingly, we find that men value services that value the whole person and offer support in the areas of life that matter to them as individuals – their needs, interests and concerns. What's offered as client-centred approaches from many service providers is experienced by the men mostly as interest in the areas of their lives that impinge on the problem area being addressed, to remove constraints lowering the effectiveness of their interventions. This is an inevitable byproduct of the siloed environments though which they move.

- Service gaps are symptomatic of the absence of a men's policy framework across government. Many services in the ACT are not designed for men who presenting with high and complex support needs that lead to the risk of suicide. In fact, many services are not designed for men at all, relying on generalist support strategies so the service models tend to work best with men who come with less challenging or entrenched presentations. Generalist services mostly advocate within government silos because that's where they work too, and rarely show any awareness of or interest in the impact of this lack of cross-government interest in men per se.
- Men who test the limits of those models are often excluded. This can sometimes continue for years, often because of previous incidents of aggressive behaviours or threats of violence, behaviours which themselves are frequently symptomatic of underlying high and complex support needs. The safety of agency staff and other people is a major consideration when decisions to exclude are made, but the cohort are often highly vulnerable in other ways, and exclusions can exacerbate the risk of harm to self and others.

These exclusions also mean that men with high and complex support needs are often only seen by statutory crisis services, a context where relationships of trust are hard to build when the worker needs to attend the next call. However men in this cohort have to build trust over time, and they need continuity of support to accomplish this. However, there are few choices for men, particularly if they are on low incomes, and many find themselves referred to the agencies that the systems privilege, regardless of their preferences.

EveryMan has had many conversations with men who have told us that they want to be referred to us but the referrers have been disinclined. We don't know what drives this, but we speculate that similar systemic constraints resulted in EveryMan not being informed about or invited to submit to this inquiry.

- **There is little data on the male cohort living with very high and complex needs**. The absence of government policy, whether whole-of-government or silo, means that government lacks institutional champions for men in general, and tends, like the community, to focus on a section that is 'easier to like or harder to blame'. This produces little in the way of gender-specific funding for men, apart from what is allocated for silo purposes, where men access services as an undistinguished part of the general service user pool. This perpetuates a lack of strong, consistent advocacy for men's needs and concerns from the community services sector, as there is no overt and visible policy framework to speak into, and few questions being asked within silos for CSOs to answer.

This is not to say that questions about men's needs are never raised, but their frequency and depth hasn't changed noticeably since the early 90s, when EveryMan Australia commenced operations as Murringu Canberra, or since the 2000's when we were known as Canberra Men's Centre

What we would like to see:

- Understanding of the need to prioritise investment in gender-specialist services that are committed to men per se, not viewed through the silo lens related to their presenting issue
- Government policy frameworks which are curious about the needs of men, particularly those with intersecting high and complex support needs (not just the easier ones or those more likely to attract community sympathy)
- Sustained funding for programs engaging men in early intervention and prevention, without time limits
- Improved collaboration between mental health, housing, justice, and child and family systems

CASE STUDIES

CASE STUDY 1

Background to the referral:

J.D. is a 48-year-old man with a long history of incarceration, chronic mental illness, and substance use and a history of suicide attempts. He was referred to EveryMan's Managed Transition Program in August 2022 by the Justice Housing Program, which deemed him unsuitable for their service due to the complex nature of his presentation, his escalating behaviours and a lack of engagement.

At the time of the referral, J.D. had recently been released on bail following a 7-month incarceration for domestic and family violence charges. He is estranged from his family, has no immediate support network and presents with multiple compounding risk factors including:

- Chronic schizophrenia
- Chronic cirrhosis of the liver
- Polysubstance use (methamphetamine, cannabis, and alcohol)
- History of homelessness and institutionalisation
- Limited insight and intermittent treatment compliance
- Elevated risk of suicide, particularly during periods of instability or disengagement

Request:

The initial request was for transitional housing with case management, as JD has a long history of homelessness, history of incarceration, lack of family support, complex mental health presentation and history of AOD.

Other presenting issues:

J.D. was initially under a Psychiatric Treatment Order (PTO) and linked to Mental Health services, however over time JD's engagement with this service became inconsistent and reactive (despite the PTO) leading to significant deterioration in his wellbeing and increased risk of suicide.

Throughout this time there was inadequate follow-up and minimal contact from Mental Health services despite known risks. No communication with EveryMan when J.D. was eventually admitted to the Adult Mental Health Unit (AMHU). JD was then discharged from AMHU with 10 minutes notice and lacking a plan to ensure JD was safe, willing to engage and comply with his order, despite a history of non-compliance.

This again saw J.D.'s mental health decline and he resumed heavy drinking and substance use, he experienced paranoid delusions and increased withdrawal, he was targeted and threatened by others, and expressed feelings of hopelessness and being unsafe

J.D.'s mental health deterioration and pattern of disengagement significantly increased his risk of suicide, particularly during transitions between services or housing, and following destabilising events such as:

- Substance-induced psychosis
- Loss or theft of property
- Perceived threats
- Lack of family, peer or formal support during hospital discharge
- Feelings of isolation and fear

He has intermittently expressed suicidal ideation to his workers and demonstrated significant risk factors, including isolation, homelessness risk, substance misuse, and chronic illness. His risk is heightened during periods of reduced contact with the statutory authorities involved and and when EveryMan is the sole source of support.

Approach and intervention:

- Regular home visits to support independence and that JD's environment remains stable and secure.
- Collaboration with Directions drug and alcohol service to support JD's substance use via counselling and health check-ups.
- Assertive outreach when JD would disengage, including visiting known locations JD would frequent and speaking with individuals known to JD to assess his wellbeing.
- Coordinate case conferences to escalate concerns related to J.D.'s mental health, substance use, and personal safety, attempting to support JD to comply and follow his care plan.
- Support to identify and apply for long-term housing, such a public housing.
- Support an application to the NDIS.

Outcome:

The lack of collaboration in the case meant that JD's behaviours escalated and eventually led to his reincarceration. The lack of family support and the failure of systems to meet JD's complex needs has meant that he remains incarcerated despite being eligible for early release as there is nowhere for him to go and limited formal supports willing to engage.

CASE STUDY 2

BB was referred to EveryMan's Managed Transitional Program in March 2019 by ACT Corrections after serving a significant sentence in the Alexander Maconochie Centre.

Shortly before being incarcerated, BB experienced the loss of his newborn son just four days after birth. This devastating event fractured BB's world and led to the separation from his partner of ten years. His grief, feelings of isolation and feeling unsupported, exasperated his levels of anxiety and depression. As is common for many men facing compounding challenges, BB began to withdraw further, and his mental health rapidly deteriorated.

Because of his past drug use and complex life circumstances BB was cut off by his family. This rejection reinforced his feelings of being unworthy of love, support and belonging.

BB's mental health remained fragile, limiting his ability to maintain full-time work and further eroding his self-worth. After suffering a breakdown at work, he was unable to recover, highlighting the urgent need for more intensive case management. His attempts to re-engage with the workforce through part-time employment failed when a promised opportunity turned out to be exploitative. This left BB feeling further disillusioned and discouraged.

Despite these obstacles, BB demonstrated a strong desire to improve his life. He completed his parole obligations and graduated from EveryMan's Preventing Violence, Changing Behaviour twelve-week program. He engaged in regular counselling and maintained ongoing mental health support through Interchange Health. In 2022, he was approved for priority housing and eventually signed his occupancy agreement with Housing ACT in February 2025. He had maintained his tenancy and was, by all accounts, trying to hold on.

But recovery does not follow a straight line. For many men like BB, the damage of prolonged social isolation, unresolved trauma, and a lack of meaningful connection can run too deep. In mid-2025, BB ceased contact with support services. Weeks later, he was found dead in his apartment.

BB's death is not just a personal tragedy—it is a societal failure. It reflects what happens when the systems designed to support people in crisis are too stretched, too siloed, or too late, and there is only patchy understanding of what men living with high and complex support needs require in the way of meaningful support. BB needed connection. He needed consistent, coordinated care. He needed a society that understood that men's pain often hides in silence, masked by shame, and reinforced by cultural expectations of stoicism and self-reliance. He needed an organisation which was dedicated to him.

His story underscores the critical need for suicide prevention strategies that prioritise:

- Long-term, wraparound support services
- Compassionate responses to trauma and grief
- Proactive community connection for socially isolated men
- Greater recognition of the cumulative impacts of rejection, poverty, and mental illness

BB tried. He sought help. He did the programs. He held on. But in the end, it wasn't enough. Let's not allow BB's death to become just another number in a devastating national trend. Let it instead compel us to reshape how we care for men in crisis—before it's too late.

Conclusion

EveryMan Australia is committed to working with government and community to ensure no man in the ACT who reaches out is left without help or hope.

We look forward to an opportunity to present at any public enquiry.

Greg Aldridge
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Manager

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Manager

References:

1: Australian Bureau of Statistics. (2021). Causes of death, Australia, available online at: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-selfharm-suicides-key-characteristics.