Mental Health
Community Coalition ACT

MHCC ACT Submission to the Inquiry on Men's Suicide Rates

August 2025

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Acknowledgements

Acknowledgement of Country

Mental Health Community Coalition ACT is located on Ngunnawal Country. We acknowledge the Traditional Custodians of the land. We pay our respects to their Elders, past and present. We further acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture and community.

Acknowledgement of mental health lived experience

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

About MHCC ACT

The Mental Health Community Coalition of the ACT (MHCC ACT) is a membership-based organisation which was established in 2004 as a peak agency. It provides vital advocacy, representational and capacity building roles for the Not for Profit (NFP) community-managed mental health sector in the ACT. This sector covers the range of non-government organisations (NGO) that offer mental health recovery, early intervention, prevention, health promotion and community support services.

We advocate for a mental health system that offers people support and belonging within their community.

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Introduction

As the peak body for community mental health in the ACT, MHCC ACT welcomes the opportunity to contribute to the Committee on Social Policy's Inquiry into men's suicide rates.

We acknowledge the grave and persistent issue of suicide among Australian men, who are overrepresented in national suicide statistics. Evidence has shown suicide does not discriminate, and it is a common myth that suicide only affects a small subsection of individuals with a diagnosed mental health condition (National Alliance on Mental Illness, 2020). In fact, any person in the wrong circumstances can be at risk of suicide and the scale of the challenge is indeed much larger than most of us think.

We also express caution at the narrow gender framing of this inquiry, which risks an exclusionary and limited approach to suicide prevention. First Nations youth, women, transgender and non-binary people also experience suicide risk at alarming rates. An effective suicide prevention approach must acknowledge and respond to this complexity.

We stress that suicide is not a single-issue phenomenon - it is systemic, intersectional, and deeply affected by social determinants, trauma, and access to compassionate support. The community requires that the Government act now with the initiatives that will deliver timely high-impact results to reduce the number of people at risk of suicide and the number of communities at risk of bereavement from suicide.

This submission is guided by four central propositions:

1. Suicide prevention must focus on quality of life, not just crisis response.
2. The current system is failing due to over-medicalisation, rigid funding models, and a lack of time, trust, and compassionate engagement.
3. A new model of care must consider early intervention, relational connection, and community-led, non-clinical support.
4. International models such as Scotland's Distress Brief Intervention (DBI) offer scalable, evidence-informed frameworks that should be adapted for the Australian context.

Summary of Recommendations

MHCC ACT calls for decisive action to move from plans to implementation. We recommend:

1. **Implementation of a prevention to postvention suicide ecosystem** that incorporates the suite of services and supports needed to provide a whole-of system response.
2. **Urgent funding for the Scottish DBI program** to address situational distress with rapid, compassionate support.
3. **Expansion of 4MH compassion and suicide training modules** to workplaces, with a focus on high-risk industries, including but not limited to GPs and primary health settings.
4. **Embedding social prescribing practices in primary healthcare**, supported by investment in grassroots community programs.

These recommendations target the most urgent gaps and lay the groundwork for lasting change, ensuring help is timely, accessible, and rooted in compassion.

Suicide in Australia: Data Snapshot

Scale of the Suicide Risk

Suicide remains the leading cause of death among Australians aged 15 to 44 years, with men accounting for around 75% of all suicide deaths each year. In 2023, 3,214 Australians died by suicide- 2,419 of them were men (Australian Insititure of Health and Welfare, 2024). The male suicide completion rate remains consistently around three to four times that of women.

However, while men have higher completion rates, women are more likely to attempt suicide, and LGBTQIA+ individuals have significantly higher rates of suicidal thoughts and behaviours. Young people aged 15–24 are also at increased risk, with suicide being one of the primary causes of death for this cohort. Among Aboriginal and Torres Strait Islander peoples, suicide rates are nearly twice that of the general population, with youth particularly affected (Centre for Population, 2024). It is important that the Legislative Assembly is not seen to encourage exclusionary approaches towards- nor limit its treatment of- this complex social issue, due to a narrow framing of the problem.

Health data indicates that individuals are most at risk within three months of their first suicide attempt, with many occurring in the first month following a hospital discharge (Department of Health, 2022). Yet our current system fails to engage early, respond compassionately, or maintain sustained follow-up. For example, current follow-up mechanisms often fail to engage people effectively—particularly if they do not respond to standard outreach methods like phone calls. **These statistics speak not only to the scope of the crisis but to a systemic failure to offer timely, sustained, and compassionate care.** We need an approach that treats distress as an opportunity for intervention and future prevention, not merely a clinical emergency.

Factors Contributing to Suicide Risk

It is well documented that reasons for suicide are highly individual and can vary from a wide range of risk factors including but not limited to:

- stressful life events,
- trauma,
- existing mental health challenges,
- physical and chronic illness,
- excessive alcohol or substance use,
- and poor living circumstances/ quality of life

In men particularly, the higher rate of suicidality has been linked to greater impulsivity, risk-taking behaviour, and a greater likelihood to choose lethal means- behaviours strongly grounded in traditional views of masculinity. This suicidality is characterised by an immediate and impulsive distress response to an unforeseen acute life event or “breaking point”- usually involving a loss such as unemployment or relationship breakdown that had a severe impact on their sense of identity. Often this event coincided with a loneliness from the disconnection or absence in their usually available support systems (Seidler et al., 2021).

Suicide Prevention Landscape

Over the past decade, Australia has made significant strides in recognising suicide as a public health priority. Below is a rough outline of the substantial work that has been done to understand and prevent the rates of suicide in Australia.

Key Reports and Frameworks:

- Fifth National Mental Health and Suicide Prevention Plan (2017–2022)
- ACT Mental Health and Suicide Prevention Plan (2019–2024)
- Productivity Commission Inquiry into Mental Health (2020)
- National Suicide Prevention Strategy (2020–2023)
- National Mental Health and Suicide Prevention Plan (2021)
- National Mental Health and Suicide Prevention Agreement with States and Territories (2022)
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2025–2035)

Despite the extensive work conducted on suicide prevention in recent years, suicide rates remain unchanged and have in fact increased among Aboriginal and Torres Strait Islander people (Productivity Commission, 2025). This highlights a recurring pattern in our policy landscape: well-intentioned plans without meaningful collaboration and implementation to achieve the progress needed. Action is now overdue.

Progress Requires a New Approach

While awareness has grown and funding has increased, the system remains too clinically oriented, too reactive, and often out of reach for people who need time, trust, and non-medical support to engage. Achieving progress in mental health and suicide prevention outcomes will require a new approach. The Final Advice of the National Suicide Prevention Adviser underscored the importance of "**connected and compassionate care**", framing suicide prevention as the shared responsibility of all levels of government, portfolios, and communities (National Suicide Prevention Office, 2020).

Adopting models of care that are grounded in compassion, time, and trust is both urgent and achievable. **We recommend a shift toward global, community-led innovations such as Scotland's Distress Brief Intervention (DBI) model.** This non-clinical approach brings together compassionate frontline care, rapid follow-up, and support grounded in the realities of distress - not just diagnosis.

A New Model for the Care and Health sector: Distress Brief Intervention (DBI)

Scotland's **Distress Brief Intervention** program offers a powerful, evidence-informed model for early intervention. DBI provides applies a "ask once get help fast" approach over two levels:

Level 1

- Immediate compassionate response by trained frontline workers (police, ED, GPs)

Level 2

- Seamless referral to DBI practitioner in community-based NGO teams within 24 hours
- A 14-day support period focused on problem-solving, distress planning, and connection to ongoing care

Over 75,000 people have accessed DBI since its 2017 pilot (Scottish Government, 2024). Designed to support those presenting to emergency or primary care settings in distress, it integrates healthcare, social care, and NGO support into one holistic system. Evaluations of the DBI program showed 80% of those surveyed felt fairly to completely able to manage distress following a Level 1 interaction, with those engaging fully at Level 2 scoring highest (8 out of 10) on ability to manage distress (Cowie, 2022). A word of caution is that the DBI model is best suited to earlier presentations of distress, as individuals with severe and/or enduring mental needs are most suited to more specialised services.

ACT is well-positioned to adopt this model. Our existing NGO infrastructure, and emerging peer workforce and lived experience leadership can be supported to establish the new model. Improved collaboration between primary, emergency, and NGO sectors is an ideal end state outcome for everyone in the community - for consumers, carers, and workers alike.

Building a Community That Cares

As we work toward building a system that responds in a timely and effective way, it is equally important to adopt a whole-of-community approach - one that fosters a culture of care capable of engaging people before they reach crisis, not only once they present at emergency rooms or call hotlines.

For many men, it has indeed been a chance conversation with someone in their existing social circle that led to necessary help-seeking. This means prioritising developing the crucial soft skills of active listening, compassion, and early recognition of distress within our everyday relationships - with family, friends, colleagues, doctors, and employers. **No one wants to be in a position where someone they care about is struggling alone and feeling unable or lacking the tools to help. These tools must be made accessible and widely understood.**

In Community

Online programs that are evidence-based and evaluated are a valuable resource to support people to access help anonymously, free and at times and ways that suit them. Access is limited to awareness of their availability by the general public.

Many of these exist and we highlight the following examples:

- MindMap - an online navigation tool to services, resources etc. for youth and those supporting them
- myCompass - a free, interactive self-help program from Black Dog Institute designed for adults to build resilience and manage mild to moderate depression, anxiety and stress
- ClearlyMe – a free, evidence-based mental health app to see teenagers through tough times
- Moodgym – an interactive self-help book which helps you to learn and practice skills which can help to prevent and manage symptoms of depression and anxiety
- NewAccess – mental health coaching is a free guided 6 session program for when you are feeling stressed about everyday life issues

MHCC ACT currently delivers the Compassion at Work and Community Suicide Awareness modules under the Connecting with People (CwP) training program, developed by 4 Mental Health (4MH) and under ACT Government funding (expiring in December 2025). These are evidence-based modules providing beginner-friendly education on maintaining compassion and responding safely to suicide risk and safety planning. While in the ACT this is currently delivered to community workers, this could be expanded to primary care, workplaces and the wider community. The more people who are suicide aware and feel equipped to provide a compassionate response and help connect a person to

care, the greater the likelihood of prevention. This training program should be funded to expand into workplaces and the broader community.

In Primary Care

General practitioners are a crucial touchpoint for intervention. They are often the first and sometimes only point of contact for people experiencing mental distress. GPs increasingly support patients with psychological concerns, with 71% reporting mental health as one of the top three reasons for consultations (Royal Australian College of General Practitioners, 2024). While most people who died by suicide had not previously accessed formal mental health care (Tang, et al., 2022), 41% of people had contact with primary care services within 3 months before they died (Mughal, et al., 2023). Given their central role, it is essential that GPs are equipped to recognise and respond to suicidal distress. Tailored training programs such as 4MH's suicide awareness modules for primary care provide practical tools to support early, compassionate intervention.

In Workplaces

Employers should offer more than a single pathway to support as workplace suicide prevention programmes have shown a positive impact on reducing suicide risk (Hallett, Rees, Hannah, Hollowood, & Bradbury-Jones, 2024). A system of intervention could look like well-communicated access to EAPs, education accessible to employees to recognise warning signs of distress and suicidality in themselves and others, trained HR staff who can manage distress and refer to services, provision of information on available services, and trained compassionate peers.

Funding promotion of positive relationships

While we build systems and communities that effectively and compassionately respond to adults in crisis, the prevention of crisis must also be prioritised through the building of positive health behaviours through grassroots community programs. **Focusing on prevention, as heavily detailed in mental health literatures, reduces the need for costly and more traumatic crisis support downstream.**

A good case study is the Melbourne-based Man Cave, providing preventive mental health programs, resources and positive role models for boys and young men, focusing on the role of identity and a healthy sense of masculinity. They are designed to help boys and young men "build heathier relationships with themselves and those around them", for positive shifts in behaviours in the long-run- tackling everything from mental health to domestic violence. Programs are primarily conducted in groups within schools, and create a psychologically safe space to open up among friends in a familiar setting. Top Blokes is a similar intervention program dedicated to positively influencing young boys and men. In an environment where parents are increasingly concerned about their children's wellbeing, adopting a specialised program to the ACT can bring immense relief to our communities.

Whole of System Response

To address suicide effectively, we must move beyond isolated interventions and toward a coordinated ecosystem. We propose a **Whole of System Suicide Prevention Model** that spans the full continuum - from prevention to postvention. Similar to existing constructs of mental health, this model comprises of five support streams from least to most severe suicide presentation:

1. **Social Determinants Stream:**
   At the broadest level, this stream focuses on addressing the social determinants of health

such as poverty, unemployment, housing insecurity, alcohol and substance use and domestic violence that impact a person's quality of life. Improving these conditions requires coordinated action across portfolios like housing, education, justice, and employment. **Suicide prevention must be understood as a whole-of-government responsibility, not only a health issue.**

2. **Community Stream:**
   This stream tackles at a cultural level the erosion of social bonds and loss of connection which have contributed to Australia's loneliness epidemic, costing us around $2.7 billion annually (Mihalopoulos, 2024). **It would include initiatives that focus on rebuilding community connection, belonging, and compassion as key protective factors.** This stream responds to situational distress through proactive interventions, including widespread delivery of the Distress Brief Intervention (DBI) program and better access to online resources and self-help tools. The goal is to reconnect people before they reach crisis. Social prescribing models also work to connect vulnerable people with community activities and groups to lower isolation and increase wellbeing. To date we have had little success in implementing good and consistent models of social prescribing.
3. **Mild to Moderate Stream:**
   This stream targets individuals experiencing early or moderate mental health distress, including mood disorders. This would include:
   - Community mental health providers who support recovery and maintenance of good mental health through the provision of individual and group psychosocial supports
   - Integrated care models that recognise the impact of experiencing compounding issues on a person's wellbeing and recovery
   - Delivery of supports in community by community mental health providers that are not diagnostic or medically driven
   - GP's who are trained to recognise and respond to patients in suicidal distress
   - A Medicare system that facilitates early access to care.
   - Online resources and self-help tools, but with a more intensive focus such online CBT and DBT programs and digital support platform.
   - A mental health hub that includes a range of services for people experiencing distress through to mental illness, and their carers. This would include co-location and integrated care delivered by community and government across the mental health spectrum and include short-stay accommodation and a safe space for people during the day.

   This stream acts as a buffer, preventing escalation into more severe presentations.
4. **Moderate to Severe stream:**

   This stream addresses individuals at significant risk but not yet in acute crisis, and aims to bridge current service gaps with innovations including:

   - A Support Hotline that triages, helps users navigates the complex service system, and connects them with appropriate services, filling the gap between Lifeline and the Access Mental Health Line. While Lifeline provides immediate one-off counselling and Access Mental Health Line responds when a person is in crisis, the Support Hotline serves as a one-stop shop for all support needs for consumer and carer alike.

- Expansion of the HAART Teams to ensure rapid and mobile delivery of our direct intervention crisis service.
- Co-location of a Safe Haven at the Canberra Hospital so individuals can receive compassionate care in an appropriate setting, and reduce negative emergency room experiences that discourage future help-seeking (Rosebrock, et al., 2022).
- Respite care for carers of those in distress but not requiring hospitalisation.
- Respite care or short stay units for people who are in distress and are feeling unsafe but do not need a long-term hospital admission.
- Interdisciplinary community mental health teams that meet with people where they feel safe and focus on de-escalation and psychosocial recovery and not just medication and assessment.

This tier focuses on timely de-escalation and person-centred response.

5. **Crisis Stream:**

This final stream provides acute response for individuals in suicidal crisis and will create a more effective emergency response that ensures safety for both consumer and carer. It will oversee the development of a **short-stay unit** that engages the person in crisis even if they are ineligible for a hospital bed and does not discourage their help seeking.

It supports more **assertive aftercare** in the form of follow-up that begins at the first point of contact i.e at the hospital, and strong post-crisis pathways to prevent disengagement. Ideally, follow-up services will be co-located at the hospital. Often, individuals discharged from hospital following a suicide attempt are told they will be contacted by aftercare services but due to their distressed state, they may not retain this information or feel connected when a stranger calls days later. By building that connection early, follow-up becomes more meaningful, and the likelihood of ongoing engagement improves. Aftercare must start with a human connection at the moment of crisis to truly support long-term recovery.

This stream ensures no person is turned away or left unsupported during or after crisis.

References

Australian Insititure of Health and Welfare. (2024). Retrieved from https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/suicide-deaths

Centre for Population. (2024). *Mortality trends - deaths of despair*. Retrieved from https://population.gov.au/sites/population.gov.au/files/2024-10/mortality_trends_-_deaths_of_despair.pdf

Cowie, D. J. (2022). *Evaluation of the Extended Distress Brief Intervention Programme.* Scottish Government.

Department of Health. (2022). *Prioritising Mental Health, Preventative Health and Sport.* Retrieved from Budget 2021-22: https://www.health.gov.au/sites/default/files/documents/2021/05/prioritising-mental-health-and-suicide-prevention-pillar-2-suicide-prevention.pdf

Hallett, N., Rees, H., Hannah, F., Hollowood, L., & Bradbury-Jones, C. (2024). Workplace interventions to prevent suicide: A scoping review. *PLOS One*.

Mihalopoulos, L. E. (2024). The loneliness epidemic: a holistic view of its health and economic implications in older age. *Medical Journal of Australia*.

Mughal, F., Bojanić, L., Rodway, C., Graney, J., Ibrahim, S., Quinlivan, L., . . . Kapur, N. (2023). *Recent GP consultation before death by suicide in middle-aged males: a national consecutive case series study.* British Journal of General Practice.

National Alliance on Mental Ilness. (2020, September). *5 Common Myths About Suicide Debunked.* Retrieved from https://www.nami.org/stigma/5-common-myths-about-suicide-debunked/

National Suicide Prevention Office. (2020, December). *National Suicide Prevention Adviser Final Advice.* Retrieved from https://www.mentalhealthcommission.gov.au/nspo/projects/national-suicide-prevention-adviser-final-advice

Nutmeg Hallett, H. R.-J. (2024). Workplace interventions to prevent suicide: A scoping review. *PLOS One*.

Productivity Commission. (2025, June). *Mental Health and Suicide Prevention Agreement Review - Interim Report.* Retrieved from https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf

Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M., & Shand, F. (2022). Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation. *Crisis*.

Royal Australian College of General Practitioners. (2024). *Reasons people are seeing their GP*. Retrieved from Health of the Nation: https://www.racgp.org.au/health-of-the-nation-1/chapter-1-patient-interactions-and-health-trends/reasons-people-are-seeing-their-gp

Scottish Government. (2024, November). *Enhanced support for people in emotional distress*. Retrieved from https://www.gov.scot/news/enhanced-support-for-people-in-emotional-distress-2/

Tang, S., Riley, N., Arena, A., Batterham, P., Calear, A., Carter, G., . . . Helen Christensen. (2022). People Who Die by Suicide Without Receiving Mental Health Services: A Systematic Review. *Frontiers in Public Health*.

Zac E Seidler, M. J. (2021). *"Eventually, I Admitted, 'I Cannot Do This Alone'": Exploring Experiences of Suicidality and Help-Seeking Drivers Among Australian Men.* Retrieved from https://doi.org/10.3389/fsoc.2021.727069

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