Submission to the Final Review of the National Mental Health and Suicide Prevention Agreement

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Introduction

The purpose of this brief paper is to ask for a rethink of what problem we are trying to solve and to rethink goals and expectations in the context of the limitations of today's social, economic and cultural factors and the realities of human life. This is not intended to be detailed paper with a thorough analysis of reliability of data sources, but more an overview of a larger picture that aims to illustrate the enormously complex problem of mental health and suicide in our society and globally.

We are not alone

The Australian Government has been criticised for a flawed mental health and suicide prevention agreement that is not fit for purpose. The challenges Australian government face with mental health are not entirely unique to Australia. Australia does have some unique risk factors such as remote rural communities, multi-cultural communities and Aboriginal and Torres Strait Islander people, but Australia's problems with suicide and mental illness are essentially a shared global problem.

Suicide rates in developed countries vary and whilst some countries like Germany (Suicide Prevention Germany, 2025) and New Zealand (Mental Health Foundation of New Zealand, 2025) show a decline in suicide. However, the overall suicide rates across developed countries have not declined significantly in the last ten years and the incidence rates of suicide over this period have fluctuated.

Some examples

- In New Zealand. 538 people died by suspected suicide in the 2021/22 financial year (from July 2021 to June 2022), less than the 607 reported for 2020/21 and 628 reported in 2019/20. Note: This shows suicide rates have decreased but not in some groups (Mental Health Foundation, 2025).

- In the USA, suicide rates for females and males have increased since 2002 (CDC, 2025).

- In the UK, the suicide rate in 2023 was the highest since 1999, while also being the highest rate for males since 1999 and the highest rate for females since 1994 (Office for National Statistics, 2023).

These countries use the same psychotropic medications, the same psychiatric model of mental health, the same therapeutic modalities, similar social services and similar standards of education and training for health care professionals and have access to the same scientific and social sciences research.

These countries have similar human rights and ethics regarding the treatment of people with mental illness. These countries share similar social and economic challenges such as inequality, increasing poverty, increasing cost of living, rising health care costs, increased costs in welfare services, an ageing population, lower birth rates, and the health and economic inequalities in multi-cultural and diverse populations.

Despite several developed countries setting Zero Suicide goals none of them successfully reduced suicide to zero or have come anywhere close to achieving zero. These countries like Australia have struggled to significantly reduced the prevalence of anxiety or depressive disorders. If any country had made significant progress in reducing suicide, then they surely would be a best practice model for Australia to follow.

Setting realistic goals and expectations about suicide

Medicine and health are fundamental rights of every citizen. We must help those in need. Our health care workforce save lives every day and help people live better lives, but it is not perfect, and we know many people do not receive the care they need for a myriad of reasons already well researched.

Instead of blaming our mental health system policies and plans for failing to improve the mental health of our citizens and save more people from suicide, why not take a step back and look at the problem from a global perspective and ask what is the problem we are trying to solve, and is it realistic?

“The “promise” of Zero Suicide presumes that most, if not all, suicides can be prevented by excellent health care (Mokkenstorm, 2016). It is argued that by setting a goal of zero suicide creates more distressed health care providers working with patients at risk (Mokkenstorm, et al 2016). Critics also argue that Zero Suicide will enhance the guilt felt by those bereaved by suicide, because the expectation of zero suicide is unrealistic (Mokkenstorm, et al 2016).

According to the AIHW, significant proportion of people who die by suicide have contact with the health system in their last year of life, but overall 49% of 15–64-year-olds who died by suicide **did not have** any contact with the hospital (emergency department (ED) presentation or hospital separation) (AIHW, 2025).

We know that some people who commit suicide do not come for help, and we know mental illness is under reported because people don’t come forward for help.

It is ethically and morally right for society to help those we can. But is it ethical to set unrealistic goals and pour money into unachievable outcomes diverting resources

away from more achievable change that the public and health care sector will more likely support?

Zero suicide is an unrealistically framed goal that rejects the realities humanity face locally and globally. We know we can do better, and we know people in health care want things to be better. Let's be honest and realistic about what we can achieve. How the suicide goal is framed will determine whether all stakeholders believe it, support it and commit to it.

Realistic goals mean happier healthy health care workers

Unrealistically poorly defined goals without sufficient support, resources and governance put pressure and more distress on those who are responsible for delivering them but do not control the outcome. The wrong goals drive the wrong behaviour and increase risk of burn-out in employees, but realistic co-designed goals will motivate people to support leadership, and it protects people's mental health (Sijbom, 2019).

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