Suicide Prevention Australia regularly publishes position statements on priority areas of suicide and self-harm prevention, intervention and postvention in Australia. These foundation documents provide a basis for understanding, discussion, teaching, delivery and research, and reflect the diversity of voices within the sector.

Position statements are not intended to be specific to or limited to policy makers alone, but are instead written with a general cross section of the educated lay public in mind (i.e. broader community, media, and other non government organisations). Suicide Prevention Australia Position Statements therefore represent a starting point for policy and strategy development, while supporting ongoing advocacy work and activities.

These statements are developed in close consultation with community and specialist reference groups and are ratified by the Suicide Prevention Australia Board. They are reviewed biannually with the intention of being reaffirmed, revised or retired. They generally do not refer to issues previously covered by other Suicide Prevention Australia Position Statements or by those currently in the process of being drafted.

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Position Statements can be downloaded from the Suicide Prevention Australia website: www.suicidepreventionaust.org

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To access accurate information about suicide and the portrayal of suicide in the media, please visit: http://www.mindframe-media.info/

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Chronic Illness, Chronic Pain and Suicide Prevention

Guiding principles
• Physical ill-health and mental ill-health are inter-related, which has implications for suicide risk.

• This inter-relationship is little understood although functional impairments and quality of life are known to be greater influencing factors than the type of illness or its prognosis.

• People living with chronic physical conditions, their carers, and their health professionals know best how to manage their care. They are generally resourced and capable to achieve maximum quality of life outcomes, however there is potential for much greater mental health and suicide prevention integration within the physical health care process.

Background
The relationship between physical health and mental health is well established. Research studies and interventions have examined the physical wellbeing of those with a mental disorder although this is yet to be given consistent policy and practice attention. The study of the reciprocal relationship, the mental health of those with a physical disorder, has received even less consideration. This position statement will explore the existing literature on chronic illness and suicide and chronic pain and suicide, linking it with recommendations for improving policy and practice to aid suicide prevention.

Chronic illnesses and pain are overarching terms which encompass a wide variety of conditions. While generalisations are not appropriate, the impact of a chronic physical condition on a person’s wellbeing is the focus of this paper and thus variations in the manifestations of conditions are not explored in depth.

Although recognised as a chronic illness, depression and its relationship with suicidality is not referred to on an individual basis in this position statement as this issue has been previously covered in Suicide Prevention Australia’s position statement Mental Illness and Suicide Prevention.

While a certain level of social and emotional turmoil may be expected to correspond with chronic physical illness and pain, mental distress and suicidality are not inevitable outcomes of physical ill-health and they remain preventable even in those who are elderly or have a terminal illness.
Chronic illness, chronic pain and suicide prevention

Although not evitable, there is a recognised causal link between physical ill-health and mental ill-health. The subsequent contribution of physical illness to suicidality is complex and multifaceted.

Individuals do not become at risk of suicide due to one factor alone; rather risk is generated by a multifarious combination of individual, social and environmental factors. Thus the risk generated by chronic illness or pain will be influenced, mediated and attenuated by many factors. The causes, symptoms, pathology, trajectory, longevity and prognosis for chronic diseases vary greatly and thus the risk of suicide or mental illness does not remain static across illnesses or even within the course of one illness.

Prevalence

Suicide

According to the Australian Bureau of Statistics (ABS) there are between 2000 and 2500 suicide deaths each year in Australia (ABS 2011). Of these deaths, approximately 75% are male and the highest rates are evident in middle and old age. Suicide ideation, suicide attempts and self harm are much more common and are a significant cause of morbidity to the Australian populations. People with mental illness, Aboriginal and Torres Strait Islander people, rural and remote communities, people from low socio-economic backgrounds and sexually diverse communities exhibit higher risk of suicidal behaviour and death by suicide than the general population.

Chronic diseases

The Australian Institute of Health and Welfare (AIHW) defines chronic medical conditions as those with complex causality, multiple risk factors, long latency periods, prolonged course of illness and functional impairment, however for the purposes of this position statement, any condition which causes enduring distress, impairment or pain to a person is also included. Approximately 33% of Australians aged 25 to 64 report having a chronic disease, most commonly arthritis, asthma and depression (ABS 2010). According to the National Health Survey all people over the age of 85 report at least one long-term condition – this figure includes eyesight and hearing problems. Age is an important factor in chronic disease prevalence with twice as many people in the 55 to 64 age group experiencing a chronic condition compared to those aged 25 to 34 (ABS 2010).

Due to lifestyle and genetic factors which influence their development, chronic illnesses often co-occur. Over 80% of people over the age of 65 have three or more chronic conditions and even 10% of those under 14 experience three or more conditions (AIHW 2006). People living in regional areas experience greater risk factors for the development of chronic diseases, such as smoking and obesity, than those in major cities, and also have less access to health services. This is also true of those living in low socio-economic areas and Aboriginal and Torres Strait Islander people (AIHW 2006).
The prevalence of chronic health conditions is increasing in Australia in line with international trends. The most common chronic conditions in Australia are:

- Ischaemic heart disease (also known as coronary heart disease)
- Stroke
- Lung cancer
- Colorectal cancer
- Depression
- Type 2 diabetes
- Arthritis
- Chronic pain
- Osteoporosis
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Chronic kidney disease
- Oral disease

Some of these conditions are amenable to preventative measures, such as lifestyle changes and health management (AIHW 2011). Although people living with chronic conditions will each be impacted by their illness in different ways, chronic conditions can have psychological outcomes including mental distress and a sense of hopelessness.

**Chronic pain**

Chronic pain is daily pain for three months or more in a six-month period. It is estimated to affect approximately one in five people at one stage throughout their lifetime (Blyth et al. 2001). A report by Access Economics, the University of Sydney Pain Management Research Institute and the MBF Foundation (2007) estimated the cost of pain to the Australian economy to be $34 billion per annum, making it the third most expensive public health problem nationally. Yet chronic pain remains poorly understood and treated.

As well as physical symptoms such as reduced and degenerative mobility and functioning, sleep disturbance, and pain sensations, people experiencing chronic pain are at high risk of depression, anxiety and social isolation. The prevalence of chronic pain conditions increase consistently with age; back pain is the most common, experienced by approximately 14% of Australians (AIHW 2010). Chronic pain often occurs alongside other chronic health conditions although it also has independent causes and symptoms.
Measuring the link between chronic illness, chronic pain and suicide

Measuring the link between chronic illness, chronic pain and suicide is challenging and differs across demographic and geographic groups. An Australian study identified that 21% of people who died by suicide experienced physical health problems which may have contributed to the death (Commonwealth of Australia 2006). A recent report from the United Kingdom conservatively estimated that 10% of people who suicide have chronic illness as an influencing factor (Bazalgette et al. 2011). In a review of suicides, Hughes and Kleespies (2001) found studies estimated the prevalence of physical illness in suicide deaths at 30 to 40%, but found great variances across studies. More recently Kleepies et al. (2009) updated the review and concluded that there is likely an independent association between physical illness and suicide.

Studying the differences between various chronic physical conditions and their impact on suicide risk, Stenager and Stenager (2000) found neurological disorders and cancers clearly increased suicide risk, while the impacts of other disorders were less certain. Additional findings were reported by Goldblatt (2000) who found multiple sclerosis has a particularly high suicide risk. Analysis of survey data in the United States of America (USA) indicated that living with AIDS predicted suicide attempts even when controlling for the presence of mental illness (Goodwin et al. 2003). Elevated risk of suicide has been found for people with cancer, although at varying rates. Suicide rates, eleven times that of the general population, have been found in male pancreatic cancer patients in a large scale study in the USA (Turaga et al. 2011). The first three months after diagnosis is a period of heightened risk and up to 70% of cancer patients report suicide ideation (Robson et al. 2010).

In a review Tang and Crane (2006) found high levels of suicide ideation, plans and attempts in people with chronic pain. According to the review, relative to non-pain controls, risk of death by suicide may be double in people who have chronic pain. A large population-based study in Canada found an association between chronic pain and suicide ideation and attempts, regardless of the presence of a co-morbid mental disorder (Ratcliffe et al. 2008). In addition, Van Tilburg et al. (2011) found an association between chronic pain and suicidality in young people, even when controlling for depression.

The correlation between physical illness and suicidality has been found to be stronger in the elderly (Conwell 1997; Hughes & Kleespies 2001), although the risk of depression and subsequent suicidality remains relevant in young people with a chronic illness (Greydanus et al. 2010). Waern et al. (2002) found physical illness may be a stronger risk factor for suicide in men than in women.

Impact of physical health on depression and quality of life

Chronic illness

Chronic physical illnesses are associated with increased likelihood of depression, regardless of type of illness (Pfaff et al. 2009). Depression is a primary risk factor for suicide ideation, attempts and death by suicide. In many cases the risk of suicide in those with a chronic illness is mediated by depression, and has an additive effect on other suicide risk factors (Hughes & Kleespies 2001; Kishi et al. 2001).
Culture and society dictate that health, wellbeing and capability are desired and valued ways of being, and good physical health is necessary to carry out many day-to-day activities. Thus to be unwell or incapacitated can have severe impacts on a person's psychological wellbeing. Townsend (2011) examined how society, rather than illness itself, can disenfranchise those with chronic illness, concluding that as illness ruptures the flow of everyday life, it becomes harder to access social and economic opportunities and people become disadvantaged in comparison to their peers. People living with chronic conditions may have their everyday activities disrupted and their capabilities challenged. While coming to terms with their treatment and prognosis, they also must temporarily or permanently adjust to changes in their activities and lifestyle. This can cause distress and suffering in addition to their physical symptoms.

Physical illness can impact on a person’s quality of life and force them to make lifestyle compromises, which influence their physical, psychological, and social wellbeing (Kristofferzon 2010). Feeling that one's quality of life is poor can contribute to depressive symptoms, especially when combined with weak social support and other adverse conditions (Clark 2009a). Thus, regardless of a particular diagnosis or illness, suicide risk is influenced by the impact an illness has on a person’s quality of life – including their functional abilities, social ties, impairment, sense of control over life, pain and depressive symptoms (Braam et al. 2005; Nicholas et al. 2009; Kishi et al. 2001; Pfaff et al. 2009). Personality and outlook are also relevant factors, as peoples’ perceptions of their health are as important as their actual health when determining risk of suicide ideation (Hughes & Kleespies 2001).

People who are ill, their families and their health professionals often assume that physical illness will lead to a certain level of emotional and psychological distress. This assumption can hinder the disclosure and identification of maladaptive levels of mental distress (Copsey-Spring et al. 2006; Kelly & Turner 2009; Weinberger et al. 2011). This may be more so for the elderly, who receive psychosocial support less often than younger people with similar physical conditions (Ellis et al. 2009). Both help-seeking and distress identification are important to overcome this gap in care. Help-seeking for mental health problems continues to remain relatively low due to stoic attitudes and the stigma of mental illness.

Kishi et al. (2001) found improvements in depressive symptoms reduced suicidality in those with acute physical illnesses, thus highlighting the importance of identifying and treating depression as a means of reducing suicide risk for this cohort.

**Chronic pain**

There is a two-way relationship between pain and psychological factors: psychological factors influence a person’s experience of pain, and reciprocally, pain has an impact on psychological wellbeing. Chronic pain which lasts for a prolonged period can influence emotional, interpersonal and physical functioning, having significant impacts on wellbeing (Turk & Okifuji 2002).

As with other physical conditions, the impact of chronic pain on quality of life and thus mental wellbeing likely mediates the risk of suicide in this cohort and is related with hopelessness (Brennan Braden & Sullivan 2008). In an Australian survey, over 10% of people in all age groups and approximately 80% of young people experiencing chronic pain reported pain interfered with their daily activities (Blyth et al. 2001). A strong association between chronic pain and high levels of psychological distress was reported in this study. Both depression and anxiety disorders are significantly associated with pain conditions, and the presence of these and other co-morbid psychiatric conditions likely mediate suicide risk, with a dose response effect (McWilliams et al. 2004; Brennan Braden & Sullivan 2008). Nicholas et al. (2009) found cognitive variables had a greater influence on depressive symptoms in those with chronic pain than the nature or severity of their pain. Thus depression caused by chronic pain can be amenable to cognitive interventions and treatments.
Chronic pain can differ in physiology from short-term pain caused by tissue damage, with sensations of pain often being felt after the injury or damage has healed. Combined with the complex intersection of physiology and psychology in the manifestations of pain, this can place negative stereotypes and stigma on sufferers of pain (Cohen et al. 2011). This stigma can sometimes pervade the doctor patient relationship in which a patient can feel especially disempowered. Additionally, a lack of understanding regarding the origins of pain can obscure the detection and treatment of co-morbid conditions, including depression (Cheatle 2011).

The interpersonal theory of suicide (Joiner 2008) suggests that habituation to pain can diminish the fear of injury which prevents many vulnerable people from harming themselves even while experiencing suicidality. People with chronic pain may be more susceptible to acquiring the ability to hurt themselves, and thus, when experiencing suicidal thoughts, are at greater risk of suicidal acts.

Traumatic injury

Traumatic injuries are associated with increased risk of psychiatric illness, suicide ideation, attempts and death by suicide. The nature of this association may be causal or may be due to pre-existing factors including aggressive and impulsive behavioural traits, drug and alcohol abuse and suicide attempts as a cause of traumatic injury. Living with a traumatic injury may include decreased functioning and pain which can cause psychological distress and additional psychosocial factors which may increase risk for suicide subsequent to injury.

The link between traumatic injuries and suicide risk also contains similar lifestyle and pain factors as other chronic conditions discussed above. Analysis of longitudinal data exploring the risk of suicide following traumatic injury found male gender, alcohol toxicity at time of injury, increased age until 44 years and disability differentiated those at high risk from those who were not; however injury severity was not a factor which differentiated risk (Ryb et al. 2006).

Suicide risk may be four times greater for people with acquired brain injuries compared to the general population (Teasdale & Engberg 2001). Oquendo et al. (2004) hypothesise that suicide risk following acquired brain injury may be due to pre-existing common risk factors such as aggression and impulsivity, neurological damage reducing inhibitions or the distress caused by the personal impact of the injury. A study by Simpson and Tate (2002) found post-brain injury psychosocial factors had much greater significance for suicide risk than pre-injury factors, and again they found no relationship between severity of injury and suicidality. A later study by the same authors found co-morbid psychiatric problems and substance abuse were significant intervening variables for those with traumatic brain injury who later attempted suicide (Simpson & Tate 2005). Given the heightened tendency for this group to make multiple suicide attempts, the authors recommend the close monitoring of people with traumatic injuries who have made a post-injury suicide attempt.

Considering the high risk of suicide in those with traumatic injuries, professionals who work in rehabilitation and injury care are recommended to receive psychoeducation as the primary means of recognising distress and intervening with this at risk group (Wasserman et al. 2008).

Additional risk factors

Suicide risk is generated by long-term individual, social and environmental factors, impacted by short-term stressors and events. Living with chronic illness or chronic pain can have long-term outcomes on a person’s ability to cope, and can also act as a life stressor which can become a tipping point for underlying distress. In both circumstances, individuals experiencing chronic illness or chronic pain will be at greater risk of suicide if they simultaneously experience other suicide risk factors. Smith et al. (2004) found people who experience chronic pain and additional risk factors, especially a family history of suicide, are at elevated suicide risk. Factors which may disproportionately impact on people with chronic conditions, in comparison to the general population, include lifestyle factors, socio-economic status, co-morbid medical conditions and access to means of suicide.
There is an indirect two-way relationship between health and socioeconomic status, incorporating factors such as lifestyle and socio-environmental determinants, access to health care, employment opportunities and early childhood factors (AIHW 2006). People with chronic physical conditions are more likely to be employed part time, be unemployed or excluded from the workforce than the general population (ABS 2009). Males with a chronic disease are more than twice as likely to be out of the workforce as those without a chronic condition, and absenteeism due to chronic disease amounts to approximately 500,000 days per fortnight (AIHW 2009). Kishi et al. (2001) identified weak social ties and social functioning as independent risk factors for developing suicidal plans while undergoing treatment for acute physical illness. Extenuating circumstances, such as financial stress, relationship breakdown or lifestyle disruption can be a consequence of chronic illness and can precipitate suicidality.

Drug overdose is the method of suicide most often reported by those with chronic pain and a suicide plan or previous attempt (Smith et al. 2004). The availability of drugs as a means of suicide and the habituation of drug administration for controlling pain may lead to higher levels of intentional and unintentional overdoses in this patient group (Cheatle 2011).

**Co-morbidities**

In addition to the link between physical illness and depression, there is a reciprocal relationship between other mental disorders and physical illnesses which can have cumulative negative impacts. People living with mental illnesses have higher rates of tobacco smoking and drug and alcohol abuse than the general population which contribute to physical ill-health and greater impairments. [Please see the Suicide Prevention Australia position statement Alcohol, Drugs and Suicide Prevention for more information].

Co-morbid mental and physical illnesses are a risk factor for increased disease severity due to non-compliance, increased morbidity, help-seeking complications and poor self management (Clarke & Currie 2009; Muller 2009; Prince et al. 2007). Furthermore, side effects from antipsychotic and antidepressant medications, including weight gain and lethargy, contribute to physical ill-health and psychological distress and demonstrate the complexity of the relationship between physical and mental conditions.

The 2010 National Survey of People Living with Psychotic Illnesses analysed the physical health of people with psychosis (Commonwealth of Australia 2011). Survey respondents had higher rates of all chronic physical conditions measured when compared to the general population, except for cancer. Heart conditions, diabetes, severe headaches or migraines and epilepsy showed the greatest variance from the general population. Nearly one third of respondents reported chronic pain conditions and nearly half were obese. The burden of physical ill health on those living with psychotic illness is substantial, and can have profound detrimental impacts on their management of their illness. Considering the higher rates of suicide in this population group, additional health burdens may generate extra risk, although these burdens are often preventable and treatable.

In a study of Australians with multiple co-morbidities, Walker (2007) found that those with three or more chronic health conditions are more likely to be older, female, living alone, obese or from lower socio-economic backgrounds than were the rest of the adult population. Perceptions of quality of life are negatively affected by having two or more co-morbid conditions, especially when one condition is of a psychiatric nature (Baumeister et al. 2005). The dose response nature of chronic illness and pain experiences suggests that those with two or more co-morbid conditions are at increased risk of suicide, especially if these conditions greatly impact their functional abilities.

**Elderly suicide**

Elderly people, particularly those in the 75 and older age group, have consistently high suicide rates in many countries. There is a greater association between physical health and depressive symptoms in the elderly than across the age span, especially when measuring functional impairment (Braam et al. 2005; Pfaff et al. 2009). A case control study from Sweden found serious physical illness was more likely to predict suicide in people over the age of 75 than in those under that age of 75 (Waern et al. 2003).

The prevalence of physical conditions in the elderly makes the identification of suicide risk in this age group challenging. Additional suicide risk factors such as depression and loneliness, combined with co-morbid physical conditions which reduce functioning, may be more useful indicators (Conwell & Thompson 2008). Impairment of daily living activities, pain and threats to autonomy and personal integrity play pivotal roles in mediating the link between physical illness and suicidality in the elderly (Conwell et al. 2011). Elderly people are less likely to disclose emotional distress and prefer to visit a general practitioner (GP) than a mental health professional (Conwell & Thompson 2008). Social support can help protect the elderly against suicide risk.
Experts in late-life suicide recommend a combination of universal, selective and indicated strategies to reduce the risk generated by physical conditions and other risk factors. These include addressing issues related to becoming dependent on others in old age such as: making better use of psychiatry treatment for the elderly including diagnosis and intervention; increasing awareness and training of risk factors among professionals; treating physical symptoms; and utilising social and community resources to improve quality of life indicators (Erlangsen et al. 2011). Hirsch et al. (2009) identify happiness as a protective factor for elderly people with chronic physical conditions, recommending treatments focus on identifying and enhancing sources of happiness as a means of reducing suicide risk. Reaching out to those who do not seek medical or psychological help, and interventions for older men are also prioritised (Lapierre et al. 2011). GPs are in a unique position to detect elderly depression and take a lead role in suicide prevention in this age group (Pfaff et al. 2009).

**Protective factors and prevention**

Chronic illness and chronic pain generate lifestyle changes and compromises that can disrupt the activities, goals and outlook of a person living with a chronic physical condition. To mediate the impacts of these changes, personal and social supports, practical infrastructure and quality health care need to be available and accessible to people developing or living with a chronic condition.

The ability to cope can attenuate some negative psychological impacts of chronic illness or pain (Kristofferzon 2010). Coping, stress management skills and resilience are bolstered by access to resources, a sense of coherence and optimism about one’s situation and feelings of self-efficacy. Self-efficacy describes a person’s confidence in their ability to manage their illness and can have positive impacts on emotional wellbeing and outlook. The support of family, friends, carers and the community are important to the wellbeing of a chronically-ill person, but are reliant on an individual’s ability to seek and benefit from this support (Goldblatt 2000).

The concept of self-care empowers a patient to help manage their own symptoms or recovery and reduces the burden on the health care system. Self-care is reliant on resources, support and networks which must be incorporated into policy models of self-care. Expecting individuals to care for themselves and drive their own recovery, without providing the infrastructure, knowledge and support required, can place unnecessary pressure on those with chronic conditions. Furthermore, it may lead to the perpetuation of health inequalities and the attribution of personal responsibility for care which can contribute to blame and stigma (Vassilev et al. 2011). An empowering and understanding relationship between health professionals, the community and those living with chronic conditions helps share the burden more evenly. Carers and loved ones also need a supportive infrastructure as well as knowledge and practical resources to support the social, health and self-care needs of a person living with a chronic condition. This concept needs to be incorporated into the overall primary and acute health care needs of a population.

As the link between chronic physical condition and suicide is often mediated by depression, the detection, treatment and management of depression is a principle means of preventing suicide in this cohort (Kishi et al. 2001). Encouraging help-seeking, community education, training of GPs and primary health professionals on the
risks generated by physical ailments (Robson et al. 2010), routine screening (Greydanus et al. 2010) and ongoing monitoring of those at risk is recommended. Furthermore, professionals who provide treatment for depression and other mental illnesses require training to be aware of the potential impact of physical health problems on a person’s risk of suicide. The underlying causes of depression need to be addressed and programs put in place to prevent depression resulting from physical impairment. These include social and practical supports to reduce the negative day-to-day impacts of living with a chronic condition.

To mediate the impact of chronic conditions on an individual’s quality of life, personal and social supports, practical infrastructure and quality health care need to be provided. The prevention, identification and treatment of psychological distress need to be prioritised alongside physical treatment.

Carers and family
The impacts of chronic illnesses can extend beyond the individual with the illness. Family, friends and carers can invest time, resources and emotional support which can have huge beneficial outcomes for the person with the illness but also can have costs. Cummins et al. (2007) found carers of those with a disability, mental or physical illness experienced very low levels of wellbeing and had multiple life stressors which impacted on their own physical, mental and emotional health. This has negative outcomes for their own lifestyles and also their caring ability.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) found that young siblings of children with chronic illnesses are at risk of behavioural, mental and physical health problems which, unaddressed, can increase the risk of longer-term mental health problems (RANZCP 2011). This may not be true for all siblings, but even those who do not play a caring role may be impacted by disruptions to their family life caused by illness in a sibling.

Families and carers need to be supported. This safeguards their own wellbeing but also has positive implications for those they care for.

Policy and practice context
The National Chronic Disease Strategy 2005 provides national direction to chronic disease prevention and care in Australia. Its principles include:

1. Adopt a population health approach and reduce health inequalities.
2. Prioritise health promotion and illness prevention.
3. Achieve person centred care and optimise self-management.
4. Provide the most effective care.
5. Facilitate coordinated and integrated multidisciplinary care across services, settings and sectors.
6. Achieve significant and sustainable change.
7. Monitor progress.
The strategy acknowledges the mental health implications of chronic physical conditions, specifically as they relate to disease complexity, progression and management. It also promotes the incorporation of both physical and mental wellbeing into care planning.

According to the National Pain Summit, many people with chronic pain are either receiving ineffective treatment which is costly for them and the health system or they are undertreated (National Pain Summit 2010). For this reason and as the National Chronic Disease Strategy does not incorporate the specific needs of those living with chronic pain, in 2010 a consortium of stakeholders developed a National Pain Strategy. The Strategy is intended to provide guidance to governments, practitioners, researchers and consumers and aims to improve the quality of life for people experiencing pain (National Pain Summit 2010). The objectives outlined in the Strategy are yet to be recognised within federal and state chronic disease policy frameworks, and there remains a shortage of initiatives focusing on prevention across the health spectrum, early intervention, integration of health care and self-management for chronic pain. Accordingly, this is overarched by the unequal consideration of chronic pain alongside other chronic conditions.

In 2011 the Australia Productivity Commission recommended the establishment of a National Disability Insurance Scheme (NDIS) to provide for the costs of support and tailored care for individuals who acquire a disability or have a traumatic injury. The Federal Government has committed to build a NDIS as part of wider disability reform. In its early stages of development, it is not yet clear what the implications of this will be for Australians living with chronic illness and pain that result in disability, although its potential to provide more accessible care and support is evident.

Living is for Everyone, the Department of Health and Ageing's suicide prevention framework recognises physical health and its relationship to suicide, although few programs are funded which address this issue directly. The Fourth National Mental Health Plan aims to improve linkages and partnerships between services for better mental and physical illness identification, referral and treatment. The role of GPs and the importance of coordinated care pathways and greater understanding are highlighted. Under the recently expired Council of Australian Governments (COAG) National Action Plan on Mental Health 2006 to 2011, the physical health of people with a mental illness was recognised as a priority and funding was provided for GP referral and access programs in Australian Capital Territory. The recently released draft 10-Year Roadmap for Mental Health reform contains provisions for improving holistic primary health care for people with co-morbid mental and physical health conditions.

While policy, research and understanding of the relationship between physical and mental health are lacking, service provision and practice lag even further behind (Clark 2009). Notwithstanding the valuable day-to-day support and treatment provided by primary health networks, chronic illness care and mental health services to many Australians living with chronic conditions, direct psychological support is not prioritised. Fund rebates through Medicare provide psychological services for patients with chronic physical conditions if it is thought that this treatment will assist in improving their physical condition. The rebates are limited to five allied services, including physiotherapy, dietetic and other allied services, per calendar year. Additional psychological services are available to holders of a Mental Health Treatment Plan provided by a GP. Despite these initiatives and the attention given in policy rhetoric to the prevention of mental distress and suicide, this issue has received little direct State, Territory or National funding attention. The prevention and treatment of physical and mental ill-health are still seen as separate goals and outcomes which underestimate their interrelationship (Prince et al. 2007). National policy and funding is required to integrate both spheres and ensure care is comprehensive, best practice, person centred and sustainable.

The assumption that people with chronic conditions will experience inevitable levels of distress masks the true incidence of depression and maladaptive coping which some people experience. When not detected, this can escalate into suicide risk. However, in reality, many health professional are not adequately trained to recognise or respond to mental health conditions in the same way that they are to physical illness. Similarly, mental health professionals are not trained to understand the implications of physical health conditions on mental health. This hampers access to holistic and coordinated care provision for those in need.
The effectiveness of psychological interventions for improving the prevention and treatment of lifestyle-related chronic illness is supported by a strong evidence base (Toumbourou 2010). Treating co-morbid mental illness is highly effective for improving the quality of life for people living with cancer, diabetes, heart disease and HIV/AIDS (Prince et al. 2007). [Please see the Suicide Prevention Australia Position Statement Mental Illness and Suicide for more information on the evidence base of treatment for depression and other mental health conditions]. Therefore, immediate investment in improved training, targeted and integrated services and increased psychological treatment access is warranted.

The regular interface between a person with a chronic condition and health services offer an opportunity for psychological intervention but also may contribute to further distress for an individual. Reliance on medical care can, in some cases, reduce autonomy and self-efficacy. However, if managed effectively, this can be a positive experience. Focusing treatment on individual condition management can isolate those with chronic conditions and increase their burden. In comparison, it may be recommended to maintain person-centred treatment in primary health but replace a symptom management approach with community-based interventions for wellbeing and illness management, such as lifestyle factors (Vassilev et al. 2011). This also increases the focus on illness prevention and health promotion.

Conclusion
This position statement has given an overview of the prevalence and features of the inter-relationship between physical ill-health and mental ill-health and subsequently with suicide. It is clear that greater policy attention is needed and service provision must be improved in this area.
Recommendations

- More research is needed into the factors that influence the relationship between physical ill-health and mental ill-health. Routine suicide and suicide-attempt data should record physical health conditions and their possible influences allowing for greater understanding of risk.

- The promotion of healthy lifestyles and reducing the burden of physical health conditions needs continued investment.

- The psychological impacts of physical conditions need to be given equal attention to physical symptoms in treatment and prevention. Collaborative care models and integrated care pathways need to be resourced, trialled and universally available.

- Interventions to prevent and mitigate the negative psychological impacts of physical conditions need to be designed, implemented, evaluated and researched. This includes the resourcing of personal and social supports, compassionate and quality psychosocial support programs, practical assistance and psychiatric care.

- The social and functional impacts of physical ill-health are amenable to preventative and management measures; practical, emotional and in some cases financial support needs to be available to those with a chronic condition and their carers.

- Carers and loved ones need a supportive infrastructure as well as knowledge and practical resources to support the social, health and self-care needs of a person living with a chronic condition. This concept needs to be incorporated into the overall primary and acute health care needs of a population.

- Existing crisis services, including online, telephone and face-to-face support are well positioned to recognise chronic physical conditions as causes of psychological distress. Protocols for referral and collaboration between these services, individuals, carers and other health and medical services must be strengthened.

- Innovative treatment options, including online and technological initiatives, must be trialled to establish their effectiveness for self-care support.

- The National Disability Insurance Scheme is to be supported and its benefits for people living with chronic conditions maximised.

- Targeted training of all health professionals and care staff on the two-way relationship between physical and mental health is recommended. Integrated care needs to be prioritised and easily accessible.

- Population-based approaches to chronic illness prevention and treatment, including community level initiatives, can complement individual care and improve health outcomes while reducing psychological distress.

- Suicide Prevention Australia recommend that chronic pain be recognised in national health policy as a condition requiring targeted investment for prevention and treatment. When taking this approach, policy makers and governments need to attend to the psychological impacts of chronic pain as a matter of priority.
References


Australian Bureau of Statistics, 2009, Chronic Conditions & Workforce, Brisbane ABS.


Australian Institute of Health and Welfare, 2006, Chronic Disease and Associated Risk Factors in Australia Cat No, PHE 81.

Australian Institute of Health and Welfare, 2009, Chronic Disease and Participation in Work, Cat No. PHE 109, Canberra: AIHW.

Australian Institute of Health and Welfare, 2011, Key Indicators of Progress for Chronic Disease and Associated Determinants: Data Report, Cat. No. PHE 142, Canberra: AIHW.


Department of Health and Ageing, 2007, Living is for Everyone Framework, DoHA.


