

EQUALLY WELL AUSTRALIA POLICY SUBMISSION:

CONSULTATION DRAFT - ADVICE ON THE NATIONAL SUICIDE PREVENTION STRATEGY

OCTOBER 25, 2024

Equally Well Australia

POSITION STATEMENT

There is strong and compelling evidence to indicate that a focus addressing physical illness in the general population; and on the physical health of people with mental health conditions has the potential to make a significant contribution to reducing suicide rates in Australia.

Internationally, a focus on those suffering with physical illness and pain has largely been overlooked in suicide prevention strategy and initiatives. With the development of the National Suicide Prevention Strategy, Australia has the opportunity to lead the world in this respect, by converting this evidence to national, state and local policy and action.

At the very least, the outcome of such a focus would be improved health, less pain and distress for people living with mental health conditions, and reduced pressure on health and hospital services.

EVIDENCE STATEMENT

Given the strong evidence of the direct relationship between physical health and suicide risk, and its dynamic relationship with psychosocial and mental health factors, a focus on physical health and Equally Well² in the Suicide Prevention Strategy appears warranted.

- Australian Bureau of Statistics (2023) cause of death data indicates the suicide risk factor prevalence for natural disease (physical illness) (60.2%) is of same order of magnitude as psychosocial risk factors (68%) or behavioural or mental disorders (64%).⁴
- A 25-year population study of 27,000 suicide cases and 480,000 matched controls found two thirds of suicides of people with a psychiatric illness had a co-existing physical health illness (see Table 1) and that *“the two types of illness interacted significantly with each other to increase suicide risk in all persons.”*⁶

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OPENING STATEMENT

“Not only may the illness lead to suffering, reduced life quality, and loss of societal status and self-esteem (Madva et al., 2018); it may also induce psychological distress (Qin et al., 2014) which exacerbates patients’ risk of taking own life.”¹

Equally Well submits evidence that strongly supports addressing physical illness as a risk factor in the general population and in people living with mental health conditions as an effective suicide prevention strategy.

The standardised death rate of suicide in Australia has stubbornly sat around 11 to 13 per 100,000 population for the last 30 years.³ On the other hand, physical health treatment success has improved remarkably over the same period. For instance cancer mortality in Australia dropped by 32%.⁵ With the increased effectiveness of physical illness and pain treatments over recent decades, the evidence strongly suggests focussing on physical illness and pain has the potential to make a significant contribution to reducing suicide rates in Australia.

Physical health and mental health are connected in a dynamic, bidirectional relationship.^{2,7} Consequently, improving the physical health of people living with mental health conditions is a ‘start now’ and ‘priority reform’ of the Productivity Commission Inquiry into Mental Health,⁸ a priority of the Fifth National Mental Health and Suicide Prevention Plan⁹ and a condition of the National Mental Health and Suicide Prevention Agreement.¹⁰ Poor physical health quadruples psychological distress in Aboriginal and Non-Aboriginal populations.¹¹ Further, access to quality physical health care is a fundamental human right¹² currently being denied to people living with mental health conditions¹³ and thus should also be an end itself for all initiatives addressing individual and community wellbeing.

This submission presents evidence indicating that physical illness risk for suicide is of the same order of magnitude as mental illness and psychosocial risk factors. Further, it highlights the dynamic interaction between psychosocial, mental health, physical health factors and age, with physical illness being the predominant suicide risk factor (along with depression) for people over 45 years of age. As such, we believe addressing physical illness as a risk factor warrants equivalent weighting in evidence-based suicide prevention efforts and policy.

A case-controlled study of suicide in 15 states of the USA of 12.5 million individuals concluded:

“Nearly all physical health conditions increased suicide risk, even after adjustment for potential confounders. Importantly, these data argue that suicide prevention targeted only to patients in behavioural health settings will necessarily miss the majority of individuals at risk for suicide.”¹⁴

Key facts and statistics

- Australian Bureau of Statistics (ABS) cause of death data shows the suicide risk factor prevalence for **natural disease (physical illness) of 60.2%** is the same order of magnitude as psychosocial risk factors (68%) or behavioural or mental disorders (64%).⁴
- The ABS analysis of coroner-referred deaths reported that physical illness is associated with **47% of all suicide deaths**. For people 45 years and over, suicide cause prevalence of physical illness was 59%.¹⁵
- A 25-year population study of 27,000 suicide cases found that physical illness was the **most common association with suicide**: that two thirds of suicides of people with a psychiatric illness had a co-existing physical health illness (see Table 1); and that *“the two types of illness interacted significantly with each other to increase suicide risk in all persons.”*⁶

Physical illness only	33.5%
Psychiatric illness only	14.9%
Co-existing physical and psychiatric illness together	29.9%
Any physical or psychiatric illness	78.3%
No physical or psychiatric illness	21.7%

Table 1: Prevalence of psychiatric, physical illness and comorbid disorders in suicide cases.⁶

- A 5-year retrospective study of 47 million people after diagnosis of severe physical health conditions concluded a *“wide range of physical health conditions...are linked to a higher risk of suicide. One year after diagnosis suicide rate was (for cancer) 21.6/100,000 vs 9.5 in matched controls. COPD was 22.4 vs 10.6 and IHD 16.1 vs 8.8.”*¹⁶
- The ABS analysis of suicide risk factors for the ten years between 2011-2020, showed (five) **physical illnesses and pain was the most common risk factor (41%) after depression (42%)** for people over 45 years of age (see Figure 1).¹⁷

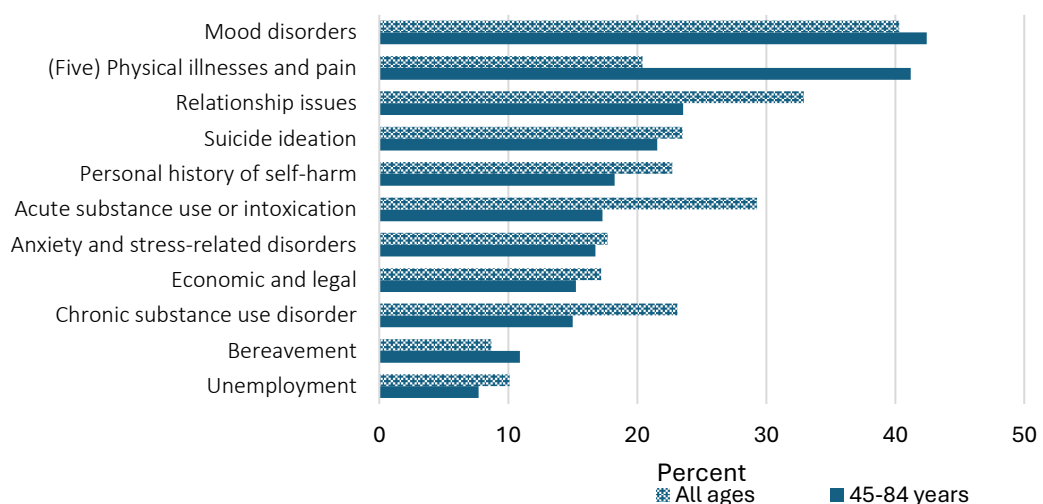


Figure 1: Risk factors proportion of suicides.¹⁷

- The ABS analysis of psychosocial risk factors of coroner-referred deaths indicated that natural disease was **associated with suicide between 40 and 50 percent of time people** under 64 years but became the predominant associated cause of suicide for Australians over 65 years (see Figure 2). It concluded the *‘interaction between psychosocial risk factors with biological and psychological factors is clearly demonstrated’*.¹⁵ Systematic reviews have confirmed the elevated risk of suicide for older adults with physical illness.¹⁸

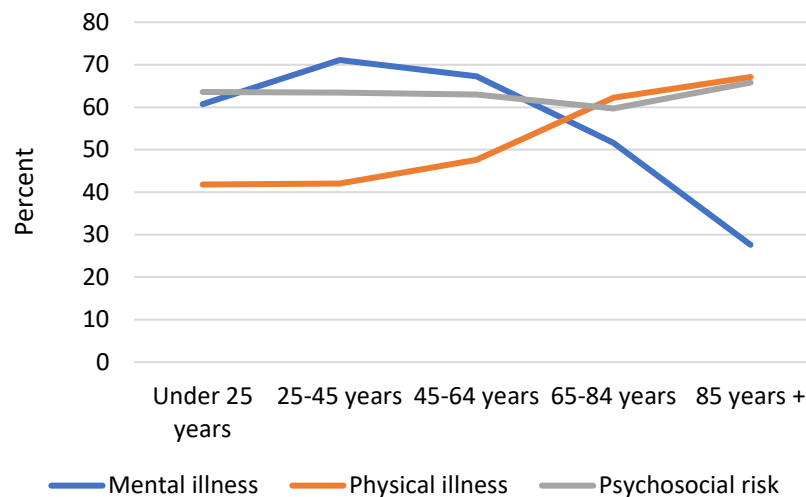


Figure 2: Selected associated cause prevalence by age, coroner-certified suicide deaths, Australia, 2017.¹⁵

- A systematic review and meta-analysis of socioeconomic, psychiatric and physical health risk factors in **midlife** suicides included 62 studies, across 19 countries and concluded: *“midlife suicide is strongly associated with socioeconomic difficulties and physical and psychiatric illnesses that are common in this age population”*.¹
- A retrospective cohort study of 47 million people in the UK concluded that a wide range of physical conditions are linked to a higher risk of suicide. The one-year rate of suicide was **between two and three times higher in patients with physical illness** compared to controls with similar sociodemographic characteristics.¹⁶
- A prospective national cohort study in Sweden of over 7 million people found all psychiatric disorders, COPD, cancer, spine disorders, asthma, stroke, diabetes, ischemic heart disease and specific sociodemographic factors were independent risk factors for suicide during 8 years of follow-up.¹⁹
- A nested, case control national study in Denmark found suicide was significantly more common in individuals with psychiatric illness and physical illness compared with counterparts without physical illness. Suicide risk was particularly elevated when the two types of illness were first diagnosed close in time to each other, regardless which came first.⁶

Contents

OPENING STATEMENT	i
Key facts and statistics	ii
Equally Well.....	2
Broadening current suicide prevention efforts	3
Comments on the draft National Suicide Prevention Strategy	4
Prevention of suicidal distress.....	5
Annotated Bibliography	6
PHYSICAL ILLNESS (NATURAL CAUSES) AS RISK FACTOR	6
COMBINED EFFECTS OF PHYSICAL ILLNESS AND COMORBID MENTAL ILLNESS	16
PAIN AS RISK FACTOR.....	21
Support for people experiencing suicidal thoughts and behaviours, and those who care for them	25
Critical enablers	26
Bibliography	27
Appendix 1 Equally Well Alliance Membership	29

Equally Well

Equally Well aims to improve the quality of life of people living with mental illness by providing equal access to quality health care. By championing physical health as a priority, Equally Well ultimately aims to reduce the life expectancy gap that exists between people living with a mental illness and the general population.

The National Mental Health Commission led the development of Equally Well in Australia to show a commitment to putting the health care of people living with mental illness and the rest of the population on an equal footing.

Based on a clear understanding of the importance of co-design, and co-production with consumers and carers, Equally Well is based on a model of collaborative action and collective impact. To support this a group of key stakeholders including consumers, carers, community managed organisations, primary health networks, public mental health services and professional organisations, has been brought together to regularly monitor, oversee and provide strategic advice to the implementation.

The Equally Well consensus statement commits signatories to acting to deliver:

1. holistic, person-centred approach to physical and mental health and wellbeing
2. effective promotion, prevention and early intervention
3. equity of access to all services
4. improved quality of health care
5. care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. the monitoring of progress towards improved physical health and wellbeing.

The Equally Well National Consensus Statement² has been endorsed by every Australian government, and mental health-related professional college.

Key messages in this submission

Equally Well submits the case to broaden the proposed suicide prevention strategy's evidence base to encompass the principles of Equally Well—[The National Consensus Statement](#) for improving the physical health and wellbeing of people living with mental illness in Australia.

Here, early intervention and prevention for coexisting physical health issues such as chronic pain or problematic alcohol and other drug use with mental health issues need to be considered as suicide prevention interventions, given the evidence that these co-occurring health issues have a role in elevating the suicide risk of individuals.

It is heartening that the draft Strategy has identified the physical health of people living with mental health conditions as focus group. We recommend that the interplay of physical health issues and mental health in elevating suicide risk should be further detailed in the Strategy.

Such action would recognise this element as a protective factor of suicide-related outcomes.

Broadening current suicide prevention efforts

Equally Well supports the intention of the Consultation Draft to:

“The Advice on the National Suicide Prevention Strategy (the Strategy) has been developed by the National Suicide Prevention Office to guide long-term, coordinated suicide prevention activity in Australia. ***It outlines a broadening of current suicide prevention efforts to encompass a truly preventative approach and to strengthen the current support system.*** It describes clear actions that must be taken to reduce the number of people who experience suicidal distress as well as ensure that people who are distressed (and those who care for them) can access high-quality, effective supports that facilitate long-term wellbeing.” Page 5 [Equally Well emphasis].

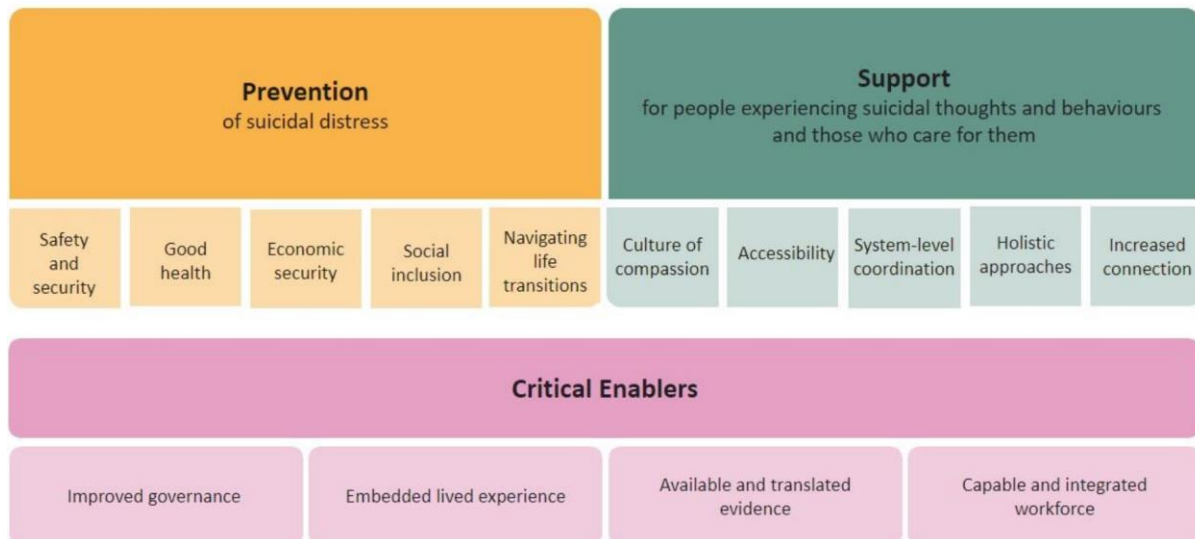
Equally Well proposes that inherent in “broadening current suicide prevention efforts” is the inclusion of interventions to reduce physical health impacts for people living with mental health issues, and the intersectionality of elevated suicide risk and loss of life. Here, early intervention and prevention for coexisting physical health issues such as chronic pain or problematic alcohol and other drug use with mental health issues need to be considered as suicide prevention interventions.

It is therefore very positive to see the Consultation Draft include “clinical factors (for example, mental illness, drug and alcohol use, chronic physical illness)” as individual risk factors to be understood in suicide prevention. (Page 5) As such, to be consistent with this approach, the inclusion of co-occurring chronic physical illness, AOD issues and chronic pain should be included in Table 1: The disproportionate impacts of suicide across population groups in Australia under the *people with mental illness group*. This inclusion would give recognition to the interconnectivity of these health issues in a bi-directional way and the attendant associated higher suicide risk.

Additionally, the option to take a collective impact approach to suicide prevention is supported. This approach recognises the complex ecosystem of suicide prevention, and the myriads of efforts undertaken to support people at most risk and in distress. Taking this collective approach would provide a comprehensive and agile platform for designing the monitoring and reporting mechanism for the Strategy’s ten-year implementation.

Comments on the draft National Suicide Prevention Strategy

The comments provided in this submission are structured upon the three elements of the Strategy:



Not all elements of the Strategy will be addressed in this submission, only those that relate to the work, priority and collective action of Equally Well Australia in achieving equity in health outcomes for people living with a mental health issue and their carers and kin. Reducing death by suicide and distress leading to suicidality are essential to achieving improved overall health outcomes for people. Suicide and suicide risk are inherent in co-occurring mental health and physical health conditions, where the interplay of conditions can increase individual vulnerability and suicide risk.

In this context our comments also acknowledge the role of social determinants, trauma and life experiences that can contribute to an individual's suicidality. However, while acknowledging these and endorsing the holistic person-centred approach that must be embedded in this suicide prevention strategy, our submission will focus on the physical health aspects that play a role in suicidality across communities and for individuals, including those living with mental health conditions.

Equally Well advocates for collective action in how to achieve overall equity of outcomes in health, and we extend this to how gains for people in reducing suicide will be achieved through collective action.

Prevention of suicidal distress

*Describes what is required to reduce the likelihood of suicidal distress arising. This involves strengthening the baseline wellbeing of communities and **better supporting those who are struggling with factors we know can lead to suicidal distress.***

Equally Well supports the goal to better support people who are struggling with factors known to lead to suicidal crisis, in which we strongly advocate that the interplay between mental health and physical illness is recognised and included in suicide prevention strategies. To that end, our comments relate mostly to the ‘good health’ domain as for people with co-existing mental health and physical health issues.

We submit evidence that strongly suggests that focussing on improving the physical health of people at risk of suicide would prove an effective suicide prevention strategy. Further, access to quality physical health care is a fundamental human right¹² currently being denied to people living with mental health conditions¹³ and thus should also be an end itself.

While the underlying suicide rate has been relatively stable for the last 30 years (the standardised death rate in 1993 was 11.9, and in 2023 was 12.3)³, on the other hand physical health treatment success has improved remarkably. For instance cancer mortality in Australia has dropped by 32% over the last 30 years.⁵

The ABS research report of suicide deaths highlights the dynamic interaction between psychosocial, mental health and physical health factors, with physical illness increasing as a factor after 45 years of age. When suicide risk factors are examined for those over 45 years physical health and pain become one of the predominant risk factors.

Poor physical health and chronic pain on mental health and suicidality:

Chronic pain can co-occur with mental illness such as depression can co-occur and have a relational impact where one can impact and exacerbate the other ([Psychiatry.org- Chronic Pain and Mental Health Often Interconnected](https://psychiatry.org-chronic-pain-and-mental-health-often-interconnected)). In turn, depression is recognised as a risk for suicide and interventions to ameliorate chronic pain for people living with mental illness should also be considered a suicide prevention intervention. In 2021 Pain Australia stated:

- chronic pain affects 3.4 million Australians
- 68 per cent of people living with chronic pain are of working age
- suicidal behaviour is two-to three times more likely for people with chronic pain
- one in five Australian adults with severe or very severe pain also experience depression or other mood disorders – four times the rate for people without pain – and one in three have high levels of psychological distress (ABS)
- there are high levels of suicide ideation, plans and attempts in people with ongoing pain, and physical health problems have been implicated in 21 per cent of suicides.

(refer: https://treasury.gov.au/sites/default/files/2021-05/171663_painaustralia_0.pdf)

Annotated Bibliography¹

In support of this position, we draw your attention to the strong evidence on the association between physical health of people living with mental health conditions and suicide:

PHYSICAL ILLNESS (NATURAL CAUSES) AS RISK FACTOR

1. Causes of Death Australia: Intentional Self-Harm Key Characteristics

Australian Bureau of Statistics

Canberra, ACT: ABS; 2023 <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#key-statistics>

Summary:

Physical illness (natural disease)* was a risk factor in 60.2% of all suicide deaths between 2019 and 2023.⁴ (compared to 68.7% and 72.9% for mental disorders or psychosocial factors respectively).

Method:

Statistics on the causes of death for Australia, including listing of psychosocial risk factor ICD-10 codes.

Place:

Australia

Data collection period:

2019-2023

Findings:

The types of risk factors experienced by a person can vary across their life. Risk factors more commonly seen in persons in older age groups, such as pain and limitation of activities due to chronic health conditions, are not as common in younger age groups. Similarly, problems related to employment and unemployment are most common in those included in the working age population (defined as 15-64 years).

Cancer, heart disease, hypertensive and musculoskeletal disorders and pain account for 36.8% risk factor people over 45 years of age. Depression accounts for 38.2% risk for this age group. When limitation due to disability is included to the above physical illnesses the risk increases to 51.6%.

**(Natural diseases include all disease and health related conditions with the exclusion of mental and behavioural disorders, injuries, external causes and some terminal conditions (G93, I46, I49, J96). Includes ICD-10 codes A00-E90, G00-R99, U07.1-U07.2, U08-U10.9)*

¹ Much of the body text in this annotated bibliography are direct quotes from the reference article. For simplicity of presentation the quotation marks and page numbers have not been included here. These can be provided upon request.

2. Psychosocial Risk Factors as They Relate to Coroner-Referred Deaths in Australia 2017, Research Paper

Australian Bureau of Statistics

Cat. no. 1351.0.55.062. Canberra: ABS; 2019. Refer Tables 5 and 8

Summary:

Physical illness is associated with 47% of all suicide deaths.¹⁵

For people over 45 years suicide cause prevalence is 59%.

Method:

Psychosocial risk factors were identified in coronial reports including police, pathology and coronial findings and codes from the International Classification of Diseases 10th revision (ICD-10).

Place:

Australia

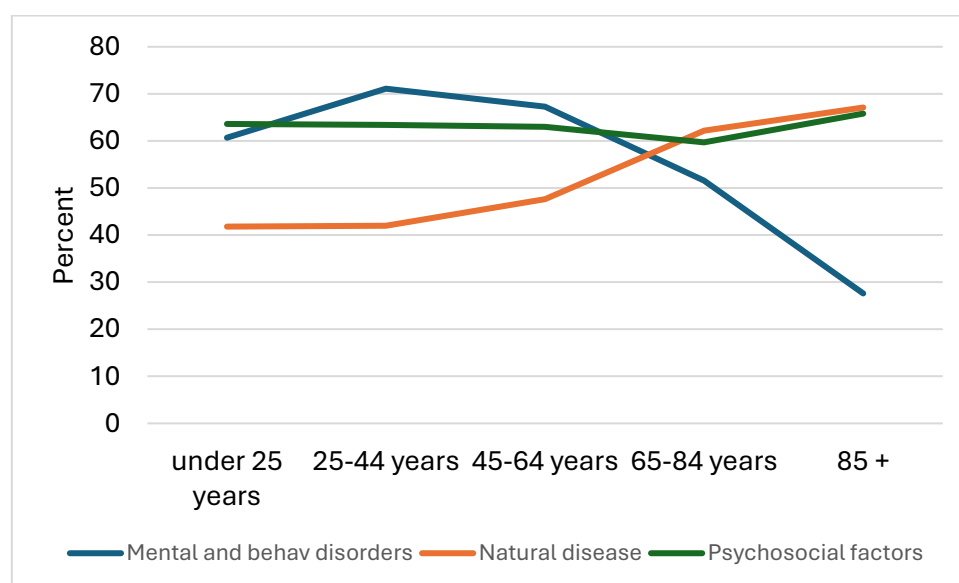
Data collection period:

2017

Findings:

Although the coverage of psychosocial risk factors was consistent for deaths due to suicide for all ages, results show a difference in physical health and mental health risk factors across the lifespan. All-age proportion cause prevalence for natural diseases* was 47.0%. Mental and behavioural disorders was 64.9% and psychosocial risk factors was 62.9%.

For people over 45 years proportion cause prevalence for natural diseases* was 59.0%. Mental and behavioural disorders was 48.8% and psychosocial risk factors was 62.8%.



Selected associated cause prevalence by age, coroner-certified suicide deaths, Australia, 2017.

3. Causes of Death Australia

Australian Bureau of Statistics
ABS Canberra: 2021

Summary:

Five physical illnesses (Ischaemic heart diseases, hypertensive diseases, diabetes mellitus, malignant neoplasms, cardiac arrhythmias) and pain comprise 20% of all age suicides.

For people 45 years and over physical illness and pain become a leading risk (along with depression) comprise 41% of suicides (depression 42%).²⁰

Method:

The risk factors mentioned in the reports on the NCIS are captured as part of the ABS coding process and assigned codes within the framework of the International Classification of Diseases, 10th revision. It is important to note that the capture of information on associated causes of death is reliant on the documentation available for any given death. The information presented reflects information contained within reports available on NCIS at the time of coding and does not necessarily reflect all causes associated with all suicides that have occurred. Risk factors are included and made available as part of the associated causes in the national mortality dataset.

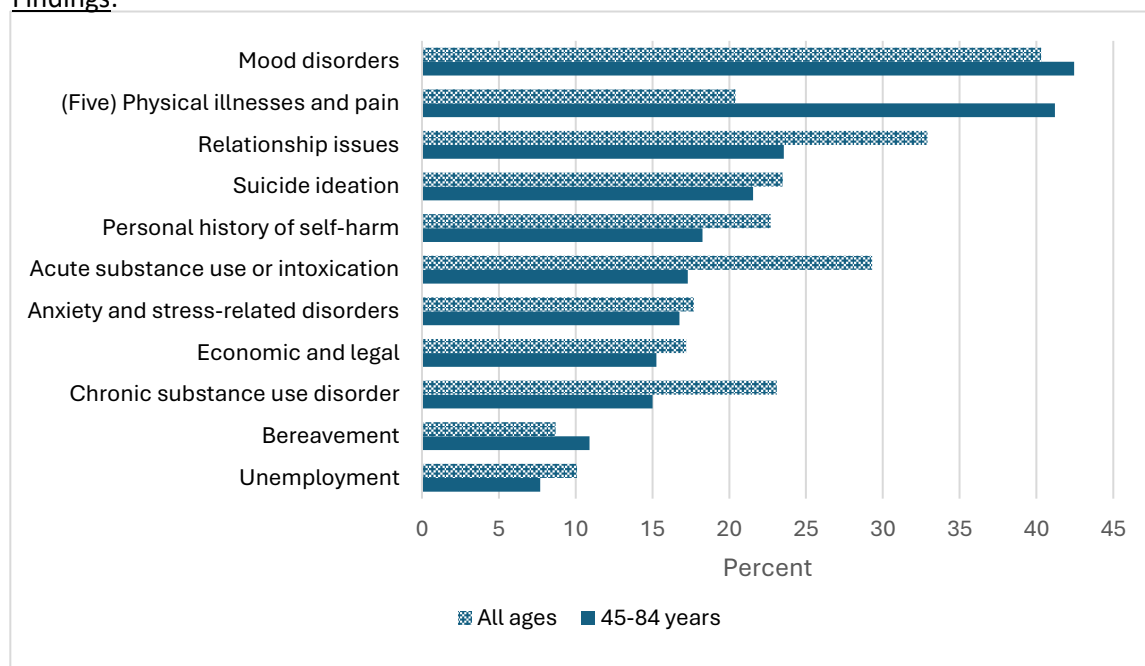
Place:

Australia

Data collection period:

2011-2020

Findings:



4. Risk of suicide after diagnosis of severe physical health conditions: a retrospective cohort study of 47 million people.

Nafilyan V, Morgan J, Mais D, Sleeman KE, Butt A, Ward I, et al.
The Lancet Regional Health–Europe. 2023;25.

Summary:

A wide range of physical conditions are linked to a higher risk of suicide.¹⁶

The one-year rate of suicide was between two and three times higher in patients compared to controls with similar sociodemographic characteristics.

Method:

Retrospective study of 47,354,696 people in England 47 mil alive in 2017.

Linked dataset combining the 2011 Census, death registration records, and the Hospital Episode Statistics (HES). Matched patients to controls from the general population based on socio-demographic factors likely to be associated with suicide rates in the general population.

Data collection period:

Suicides between 1 Jan 2017 and 31 Dec 2021.

Findings:

A diagnosis of severe physical illness is associated with higher suicide risk.

One year after diagnosis (of cancer) suicide rate was 21.6/100,000 vs 9.5 in matched controls. COPD was 22.4 vs 10.6 and IHD 16.1 vs 8.8.

Existing evidence suggests that a wide range of physical health conditions, such as coronary heart disease, cancer, neurological conditions, diabetes, stroke, chronic obstructive pulmonary disease, and osteoporosis, are linked to a higher risk of suicide.^{8–13}

The interaction of physical and mental illness emphasises the importance of collaborative physical and mental health care in these patients.

5. **Major physical health conditions and risk of suicide**

Ahmedani BK, Peterson EL, Hu Y, Rossom RC, Lynch F, Lu CY, et al.,
American journal of preventive medicine. 2017;53(3):308-15.

Summary:

Nearly all physical health conditions increased suicide risk, even after adjustment for potential confounders.¹⁴

Importantly, these data argue that suicide prevention targeted only to patients in behavioural health settings will necessarily miss the majority of individuals at risk for suicide.

Method:

A total of 2,674 individuals who died by suicide.

100 matched cases = total sample 267,400.

Place:

USA

Data collection period:

From 2000 to 2013.

Findings:

In this study, there was a robust association between 17 physical health conditions and suicide.

Seventeen physical health conditions were associated with increased suicide risk after adjustment for age and sex (po0.001) (See table 2).

In addition, having multiple physical health conditions increased suicide risk substantially.

Multimorbidity was present in 38% of cases versus 15.5% of controls, and represented nearly a twofold increased risk for suicide.

Back pain, cancer, chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, HIV heart disease, renal disorder, and stroke all greater than 2 odds ratio.

Studies show that chronic pain, heart disease, chronic obstructive pulmonary disease, stroke, cancer, congestive heart failure, and asthma have all been associated with increased risk for suicide.¹⁵⁻¹⁹

Furthermore, nearly 62% of individuals who died by suicide had a diagnosis of at least one of these conditions in the year before their death.

These data support suicide prevention based on the overall burden of physical health.

6. Risk of suicide and suicide attempts associated with physical disorders: a population-based, balancing score-matched analysis

Bolton JM, Walld R, Chateau D, Finlayson G, Sareen J.
Psychological medicine. 2015;45(3):495-504.

Summary:

Several examined physical disorders were associated with suicide attempts, even after adjusting for comorbidity and mental disorders.²¹

Our results show that people who died by suicide were more than four times more likely to have received a new cancer diagnosis within 3 months of their death, compared to living controls.

Method:

Multivariate conditional logistic regression compared the two groups across physician-diagnosed physical disorders [asthma, chronic obstructive pulmonary disease (COPD), ischemic heart disease, hypertension, diabetes, cancer, multiple sclerosis and inflammatory bowel disease], adjusting for mental disorders and co-morbidity. minimizing sample bias, using physician-based diagnoses, balancing score matching and adjusting for a comprehensive list of confounding mental disorders, this study addressed many limitations of previous work.

Sample:

Individuals who died by suicide (n = 2,100) between 1996 and 2009 were matched 3:1 by balancing score to general population controls (n = 6,300).

Date collection period:

Between 1996 and 2009.

Place:

Manitoba, Canada. Manitoba Health Registry (physical and mental disorder out-patient diagnoses, hospitalization discharge diagnoses, marital status).

Findings:

Physical disorders examined in this study included asthma, chronic obstructive pulmonary disease (COPD), ischemic heart disease, hypertension, diabetes, cancer, multiple sclerosis and inflammatory bowel disease. Cancer was associated with increased risk of suicide [adjusted odds ratio (AOR) 1.40, 95% confidence interval (CI) 1.03–1.91, $p < 0.05$] even after adjusting for all mental disorders.

Women with respiratory diseases had elevated risk of suicide whereas men did not. COPD, hypertension and diabetes were each associated with increased odds of suicide attempts in adjusted models (AORs ranged from 1.20 to 1.73). Women with COPD were at higher risk for suicide.

Diabetes was associated with an elevated risk of suicide attempts.

Physical and mental disorder diagnoses are dependent on treatment seeking, and are therefore probably an under-representation of the true population prevalence given discrepancies.

7. The Association Between Physical Illness/Medical Conditions and Suicide Risk

Pompili M, Forte A, Berman AL, Lamis DA.

The International Handbook of Suicide Prevention 2016. p. 133-48.

Summary:

An increased risk of suicide is related to medical illnesses characterized by poor prognosis, chronic pain, mobility impairment, limits to autonomy, cognitive impairment, and social stigma.²²

Method:

Book chapter – overview of international literature.

Focus on multiple sclerosis (MS), epilepsy, Huntington's disease, cancer, HIV, end-stage kidney disease, diabetes mellitus, and stroke.

Sample:

NS

Date collection period:

NA

Place:

International

Findings:

Evidence from the literature also highlights the key role of primary care physicians in identifying depression comorbidity and other suicide risk factors that are often overlooked by general practitioners.

Screening for suicidal ideation and depression among individuals with physical illness should be part of routine clinical care.

8. A systematic review of physical illness, functional disability, and suicidal behaviour among older adults

Fässberg MM, Cheung G, Canetto SS, Erlangsen A, Lapierre S, Lindner R, et al.
Ageing and mental health. 2016;20:166-94.

Summary:

Functional disability, as well as a number of specific physical illnesses, was shown to be associated with suicidal behaviour in older adults.¹⁸

Method:

Systematic review of 65 studies exploring the link between a variety of physical illnesses and functional disabilities and suicidal behaviours.

Sample:

People over 64 yrs.

Data collection period:

NS

Findings:

While somewhat divergent results were obtained for studies focusing on physical illness per se, results were more consistent regarding functional disability and certain specific physical conditions, including malignant diseases, neurological disorders, male genital disorders, arthritis/arthrosis, COPD, and liver disease.

Studies were subsequently classified as population-based, register based, clinical cohort, or post-mortem.

In studies from four continents, poorer self-rated health was associated with wish to die.

The findings of this review suggest that greater attention to, and expertise in suicide prevention is needed in specialty medical settings. Interventions involving specialty medical providers, particularly oncologists and neurologists, need to be developed.

9. Functional disability and death wishes in older Europeans: results from the EURODEP concerted action

Fässberg MM, Östling S, Braam AW, Bäckman K, Copeland JR, Fichter M, et al.
Social Psychiatry and Psychiatric Epidemiology. 2014;49(9):1475-82

Summary:

Functional disability was independently associated with death wishes in older adults.²³

Method:

Data from 11 population studies on depression in persons aged 65 and above were pooled, yielding a total of 15,890 respondents.

Date collection period:

NA

Findings:

Functional disability was associated with death wishes and this relationship remained also after adjusting for depressive symptom score.

Several case–control studies have demonstrated that physical illness is associated with increased suicide risk [7–13]. Record linkage studies utilising hospital registers [14, 15] and prescription registers [16] lend further support to the association between physical illness and suicide.

10. Factors relating to high psychological distress in Indigenous Australians and their contribution to Indigenous–non-Indigenous disparities.

McNamara BJ, Banks E, Gubhaju L, Joshy G, Williamson A, Raphael B, et al.
Australian and New Zealand Journal of Public Health. 2018;42(2):145-52

Summary:

Poor physical health is associated with a 4 times increase in psychological distress for Indigenous and Non-Indigenous Australians.¹¹

Method:

45 and up study.

Sample:

250,000 residents of NSW.

COMBINED EFFECTS OF PHYSICAL ILLNESS AND COMORBID MENTAL ILLNESS

11. Sociodemographic, psychiatric and somatic risk factors for suicide: a Swedish national cohort study.

Crump C, Sundquist K, Sundquist J, Winkleby MA.
Psychological medicine. 2014;44(2):279-89.

Summary:

All psychiatric disorders, COPD, cancer, spine disorders, asthma, stroke, diabetes, ischemic heart disease and specific sociodemographic factors were independent risk factors for suicide during 8 years of follow-up.¹⁹

Method:

National prospective cohort study.

Sample:

7,140,589 Swedish adults followed for 8 years for suicide mortality.

2,508 women (0.07% of all women) and 6,213 men (0.18% of all men) suicides.

Date collection period:

2001-2008

Place:

Sweden

Findings:

This large national cohort study found that all psychiatric disorders, COPD, cancer, spine disorders, asthma, stroke, diabetes, ischemic heart disease and specific sociodemographic factors (including unmarried status and non-employment) were independent risk factors for suicide during 8 years of follow-up.

Chronic obstructive pulmonary disease (COPD), cancer, spine disorders, asthma and stroke were significant risk factors among both women and men (1.4–2.1-fold risks) whereas diabetes and ischemic heart disease were modest risk factors only among men (1.2–1.4-fold risks).

Among those who died from suicide, 29.5% of women and 21.7% of men had a health-care visit within 2 weeks before the suicide, and 57.1% of women and 44.9% of men had a health-care visit within 13 weeks before the suicide.

12. Combined effects of physical illness and comorbid psychiatric disorder on risk of suicide in a national population study

Qin P, Hawton K, Mortensen PB, Webb R.

The British Journal of Psychiatry. 2014;204(6):430-5.

Summary:

Suicide was significantly more common in individuals with psychiatric illness and physical illness compared with counterparts without physical illness.⁶

Suicide risk was particularly elevated when the two types of illness were first diagnosed close in time to each other, regardless which came first.

Method:

Based on the national population of Denmark, individual-level data were retrieved from five national registers. Nested case-control design.

Data were analysed using conditional logistic regression.

Sample:

Entire pop of Denmark - on 27,262 suicide cases and 468,007 gender- and birth-date matched living controls.

Date collection period:

1981-2006

Place:

Denmark

Findings:

The two types of illness interacted significantly with each other to increase suicide risk in all persons (test of interaction: $\chi^2 = 265.96$, $P < 0.0001$) in men and women separately ($\chi^2 = 178.00$, $p < 0.0001$ for men; $\chi^2 = 169.51$, $p < 0.0001$ for women).

Our findings support previous evidence of high comorbidity of^{1-3, 21} mental and physical health problems and a strong correlation³⁴ between physical symptoms and psychological distress. (Watson D, Pennebaker JW. Health complaints, stress, and distress: exploring the central role of negative affectivity. *Psychol Rev* 1989; 96: 234-54.)

For Individuals with physical illness and a subsequent psychiatric disorder, there was an attenuation of suicide risk when psychiatric treatment followed shortly after physical illness.

Suicide risk concurs with evidence that physical and psychiatric comorbidity is strongly associated with high levels of distress, worsening of quality of life³⁸⁻⁴⁰ and prognosis of physical illness.

13. Interactions between psychiatric and physical disorders and their effects on the risks of suicide: a nested case-control study

Chang CF, Yeh Mk, Chien WC, Chung CH, Li TT, Lai ECC.

Annals of the New York Academy of Sciences. 2020;1462(1):79-91.

Summary:

Our findings indicate that poor physical health and psychiatric illness are individually associated with a high risk of suicide, and that a bidirectional association may exist between some psychiatric and physical disorders. We found that patients with psychiatric illness had higher suicide risk compared with those with neither physical nor psychiatric illness and the risk increased substantially in patients with both psychiatric and physical illnesses.²⁴

Method:

Compiled results from three major databases, including the National Health Insurance Research Database (NHIRD), Household Registration Database, and the National Register of Deaths. Examined the isolated and interaction effects of psychiatric and physical disorders on the risk of suicide.

Sample:

55,630 suicide cases aged 20–110 years, incidence density sampling approach, we selected 222,520 controls matched by age, sex, and residence area.

Date collection period:

2000 to 2012

Place:

Taiwan

Findings:

Psychiatric and physical disorders cooccurred in 40.7% of the suicide cases. Most physical disorders were independently associated with higher risks of suicide, regardless of psychiatric comorbidity.

Results demonstrated that both psychiatric and physical disorders were significant risk factors for suicide and the two types of disorders significantly interacted with each other, increasing the suicide risk in all individuals.

In addition, we found that most physical disorders were independently associated with higher risks of suicide, regardless of psychiatric comorbidity. These findings indicate that the higher risk of suicide may be associated with the severity of disease and/or overall health status, highlighting the need for clinicians to pay greater attention to those with multiple disorders or severe psychiatric conditions.

There is evidence of a bidirectional biological linkage between psychiatric disorders and physical illness.²⁶

Findings warrant attention to high suicide risk and preventive treatments in patients with both psychiatric and physical illnesses.⁶⁸ Bridging the gap between physical and psychiatric medicine is of critical importance for reducing suicide risk,⁴ especially for patients with a history of psychiatric illness.

14. Risk of self-harm and suicide in people with specific psychiatric and physical disorders: comparisons between disorders using English national record linkage

Singhal A, Ross J, Seminog O, Hawton K, Goldacre MJ.

Journal of the Royal Society of Medicine. 2014;107(5):194-204.

Summary:

All psychiatric illness and some physical illness had high Risk Ratio (RR) for suicide.²⁵

Method:

Retrospective cohort studies using a linked dataset – incl each psychiatric and physical condition and a reference Cohort of Hospital Episode Statistics (HES). We further subdivided the results by whether the first episode for self-harm was within one year of admission to hospital or after a longer interval.

Sample:

52 mill in 2001, 56 mill 2011.

All admissions and day cases (did not include A& E or GP in Individuals with selected psychiatric or physical conditions) were compared with a reference cohort constructed from patients admitted for a variety of other conditions and procedures.

Date collection period:

1999–2011

Place:

National Health Service (NHS) hospitals in England.

Findings:

The psychiatric illnesses studied (depression, bipolar disorder, alcohol abuse, anxiety disorders, eating disorders, schizophrenia and substance abuse) all had very high RRs (> 5) for self-harm.

Of the physical illnesses studied (Table 2), (*Authors note: Only a limited range of physical illnesses included in this study*) epilepsy, asthma, migraine, psoriasis, diabetes mellitus, eczema and inflammatory polyarthropathies were associated with an increased risk of self-harm.

Many chronic physical illnesses are also associated with an increased risk of both self-harm and suicide. (*Authors note: Study did not analyse risk of co-morbidity mental illness and physical illness.*)

15. Midlife suicide: a systematic review and meta-analysis of socioeconomic, psychiatric and physical health risk factors

Qin P, Syeda S, Canetto SS, Arya V, Liu B, Menon V, et al.

Journal of psychiatric research. 2022;154:233-41.

Summary:

Midlife suicide is strongly associated with socioeconomic difficulties and physical and psychiatric illnesses that are common in this age population.¹

Method:

The first systematic review of studies of midlife suicide.

This systematic review and meta-analysis was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Metanalysis (PRISMA) guidelines. Our systematic search found 62 research articles on midlife suicide that were published between 1990 and 2019. Nineteen high-income countries. Finally, all studies included in the meta-analysis were of good quality; and no significant publication bias was detected.

Sample:

People aged 35–65 years old.

Findings:

A strong association of physical illness and midlife suicide is evident.

Midlife suicide is strongly associated with socioeconomic difficulties and physical and psychiatric illnesses that are common in this age population.

This study indicates a substantial proportion of midlife suicide decedents (27.3%) having a physical illness. While middle adulthood is generally a period of good physical health, certain physical illnesses (e. g., heart disease, diabetes, cancer, musculoskeletal disease) emerge at this life stage and often persist through late adulthood.

Future investigations should consider the interactions between risk factors.

PAIN AS RISK FACTOR

17. Physical pain–suicidality association in adults: A meta-analysis

Rignanese M, De Filippi M, Salmè E, Madeddu F, Calati R.

European Psychiatry. 2021;64(S1):S580-S1.

Summary:

Adults with pain more likely to report any suicidal outcome apart from death.²⁶

Method:

28 studies were included in this work.

Sample:

Pubmed (until March 2020).

Conclusions:

Starting from a meta-analysis published by Calati and colleagues in 2015

Results suggested that adults with physical pain are more likely to report any form of suicidal outcome, except for death.

18. The impact of physical pain on suicidal thoughts and behaviors: Meta-analyses

Calati R, Bakhiyi CL, Artero S, Ilgen M, Courtet P.

Journal of psychiatric research. 2015;71:16-32.

Summary:

Physical pain is a consistent risk factor for suicidal thoughts and behaviours.

Method:

Meta-analyses 31 included studies. Participants with a pain related physical condition versus participants without it.

The main aim of this meta-analysis was to evaluate the extent to which suicidal thoughts and behaviours differed in individuals with and without physical pain.

Sample:

MEDLINE and PsycINFO (May 2015).

Date collection period:

1993-2014

Place:

Studies from US, Can, Aus, Japan, Finland, Korea, UK.

Findings:

Individuals with physical pain were more likely to show lifetime DW, both current and lifetime SI, SP, SA, and to die by suicide.

Individuals with physical pain were more likely to report both current and lifetime SI Participants with physical pain were more likely to have both a current and a lifetime history of SA Individuals with physical pain of any severity were more likely to die by suicide.

Moreover, the comorbidity evaluation is crucial since the presence of multiple physical and psychiatric disorders seem to confer a consistent increase in suicide risk.

19. The relationship between physical pain and suicidal thoughts and behaviors in adolescents: A meta-analysis.

De Filippi M, Rignanese M, Salmè E, Madeddu F, Calati R.
European Psychiatry. 2021;64(S1):S580-S.

Summary:

Adolescents with physical pain were more likely to report SI.²⁷

Method:

16 included studies, (CMA, version 3).

Sample:

PubMed

Place:

NA

Findings:

We started from a systematic review published by Hinze and colleagues in 2019 and we searched on PubMed (January 2019 - June 2020) studies comparing rates of suicidal outcomes (Suicidal Ideation, Suicide Plan, Attempt, Self-Harm: SI, SP, SA, SH) in individuals with any type of physical pain (head, back, neck, chest, stomach, abdomen, muscle, joint, arthritis) vs. those without it. Data were analysed with Comprehensive Meta-Analysis software.

20. Chronic pain and suicide risk: a comprehensive review

Racine M.

Progress in Neuro-Psychopharmacology and Biological Psychiatry. 2018;87:269-80.

Summary:

We found robust evidence that chronic pain, regardless of type, was an important independent risk factor for suicidality.²⁸

Method:

Comprehensive review.

Findings:

Several clinical practice guidelines highlight the importance of considering chronic pain as a potential risk factor for suicidality (American Psychiatric Association, 2003; National Collaborating Centre for Mental Health, 2011; Magellan Health Services, 2014; Wasserman et al., 2012). Likewise, the World Health Organization (WHO) has acknowledged chronic pain as an individual key risk factor for suicide (World Health Organization, 2010, 2014).

The present comprehensive literature review supports prior reviews and meta-analyses (Fishbain, 1999; Tang and Crane, 2006; Fishbain et al., 2014; Calati et al., 2015) evidencing that chronic pain is a key individual risk factor for suicidality and death by suicide.

A large number of these factors are amenable to change through targeted intervention, highlighting the importance of comprehensively assessing chronic pain patients at risk for suicide, while also incorporating a suicide prevention component into chronic pain management programs.

Support for people experiencing suicidal thoughts and behaviours, and those who care for them

Describes what is required to have an effective support system: compassion, accessibility, coordination, connection, and a holistic approach to reducing suicidal distress. To provide high-quality support, these components must operate in each part of the support system and across the system as a whole.

In terms of the elevated suicide risk for people with mental health issues and co-existing physical health issues, addressing the need for holistic approaches that understand and address the interplay between both and suicide risk, the need for seamless connected care for people with complex mental health and health needs and for accessible early intervention are imperative. We note that section 2.2 (page 19) addresses the mental health and physical health interplay which is supported as a priority in the Strategy.

As such, a system or approach to support needs to include early and effective screening and interventions. With the recognised effect from diagnostic overshadowing of mental health conditions upon physical health, and the resultant delayed diagnosis and deferred intervention can leave people with chronic health conditions that could have been addressed earlier in the course of illness. Health consequences such as chronic pain or AOD misuse problems are known not only to be associated with suicide risk but are also bi-directional in developing a mental health issue.

These systems of support or approaches rely upon prevention and early intervention, and here the health literacy of the broad health and social service workforce plays an essential role. Understanding the interplay of mental health and physical health conditions in elevating suicide risk in primary care and community health settings will be a key suicide prevention enabler.

Critical enablers

Describes the governance, lived and living experience involvement, data and evidence shifts, and workforce that are needed to implement and sustain the more coordinated, better-quality, and more effective suicide prevention system outlined in earlier sections of the Strategy.

The collective impact approach outlined in the Strategy, referencing the collective impact model used by New Zealand for suicide prevention (page 58), is supported as in its design it accounts for the ecosystem in which the changed outcome is to be achieved. In this way, the collective experience, knowledge and breadth of stakeholders and system organisations can contribute individually but with a common goal and purpose. The added benefit of having a governance and reporting that also reflect not only the ecosystem dynamics but the diversity of measures from individuals, communities, organisations and systems allows both a system perspective and a more tailored view of how outcomes and progress are tracking.

Similarly, Equally Well Australia has adopted a collective impact model, as achieving equity of health outcomes for people with mental health issues requires efforts at different levels with multiple players. We have used new linked data¹³ to enable a more granular analysis of the premature mortality of people with mental health issues who accessed mental health care. Exploring new data sources and elevating lived experience research needs to be a crucial element of the Strategy to monitor and inform the new national approach it advocates for.

This holistic approach to strategy design also echoes the holistic approach strategies call for in designing services and supports for people by people. In the collective impact model, lived experience experts and voices lead and participate in design, development, evaluation and reporting. It is welcomed therefore, that the proposed Strategy also embeds lived experience across each element of the strategy.

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Appendix 1 Equally Well Alliance Membership

The Equally Well Alliance, formally the Equally Well Implementation Committee, is a collective of people and organisations representing consumers, carers, professional colleges, Aboriginal and Torres Strait Islander organisations, Primary Health Networks, peak bodies, community managed organisations, private health providers and government. Currently, members include:

Dave Peters (Co-Chair)	Lived Experience (Consumer) Representative
John Allan (Co-Chair)	Department of Health Queensland
Adrian Armitage	Australian College of Mental Health Nurses
De Backman-Hoyle	Lived Experience (Carer) Representative
Shay-Lee Coulson	Aboriginal and Torres Strait Islander Representative
Jackie Curtis	Mindgardens
Lyn English	Lived Experience (Consumer) Representative
Rachel Fishlock	Gayaa Dhuwi (Proud Spirit) Australia
Rachelle Foreman	Brisbane North Primary Health Network
Vinay Lakra	Royal Australian & New Zealand College of Psychiatrists
Kim Schultz*	Australian Government Department of Health
Rachel Earl*	National Mental Health Commission
Ingrid Hatfield	Mental Health Australia
Caroline Johnson	Royal Australian College of General Practitioners
Vicki Langan	Neami National
Russell Roberts	Charles Sturt University
Keir Saltmarsh	Safer Care Victoria, Victoria Government
Grant Sara	NSW Health
TBA	Australian Private Hospitals Association

*Please note representatives from the Australian Government have recused themselves from the preparation and endorsement of this submission due to a potential conflict of interest.