DISASTERS
POLICY POSITION STATEMENT
NOVEMBER 2021

POSITION

1. Commonwealth, State and Territory Governments budget annually in discretionary funds to respond to need for suicide prevention in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods after a disaster. These funds should be administered without delay through PHNs, Emergency Management Australia or other mechanisms as required to reach those in need.
2. Planning is undertaken to support helplines respond to increasing demands when disasters strike. Additional budgeted discretionary funds should include additional resources for helplines that can be activated as required.
3. Commonwealth, State and Territory Governments fund research into population groups to identify at-risk groups vulnerable to disasters to enable development of evidence-based targeted responses which are tailored to diverse demographic, gender, and cultural needs.
4. Commonwealth, State and Territory Governments invest in rolling out psychological first aid and suicide prevention training to support communities to identify and support individuals at risk. This should begin with investments to build capability among first-responders, community 'gatekeepers' and other frontline workers who work with communities in the immediate aftermath of a disaster.
5. Protective supports, including housing, financial and welfare assistance, put in place during a disaster should be transitioned out in a careful, staged way. This will ensure communities are supported in the medium-term when suicide rates are at risk of increasing.

CONTEXT AND COMMENTARY

Disasters can have negative impacts on overall health and wellbeing, and lead to mental health problems or exacerbate existing conditions. The impacts of disasters are long-lasting and vary depending on the type and nature of the disaster.

From the time the COVID-19 pandemic reached Australia in January 2020 to June 2021, Australia experienced 71 natural disasters (storms, floods, and bushfires) across the country.[1] Research has found people exposed to multiple natural disasters and man-made disasters are at a significantly greater risk of attempting suicide.[2]

Disasters can exacerbate underlying risk factors related to suicide such as financial distress, unemployment, relationship breakdown, domestic violence, social isolation, and can lead to mental health problems placing people vulnerable to suicide.

[1] Disaster Assist. (2021). Australian Disasters, *Department of Home Affairs, Australian Government,* available online: https://www.disasterassist.gov.au/find-a-disaster/australian-disasters#.

[2] Reifels, L., Spittal, M.L., Duckers, M.L.A., Mills, K. & Pirkis, J. (2018). Suicidality Risk and (Repeat) Disaster Exposure: Findings From a Nationally Representative Population Survey, *National Library of Medicine,* 81(2).

Impact of disasters on suicide

Disasters have physical, social and emotional impacts on people and communities who experience them, and last for extended periods of time.[3] The link between suicide in the aftermath of disasters is highly evidenced.[4] Research based in on US data found rates of suicide to increase during the first 3 years post-disaster[5], and another study found increases in suicide rates were seen 2 years post-disaster.[6] Evidence is also found of increases in rates of post-traumatic stress disorder and depression following a disaster.[7]

While evidence concerning the impact of COVID-19 on the community is still emerging, past pandemics such as SARS[8] and The Great Influenza[9] have been linked to increased levels of distress, and previous epidemics has been linked to increased risk of suicide-related outcomes.[10][11] During the SARS epidemic in 2003, the suicide rate in Hong Kong reached an unprecedented high (18.6 per 100,000 people), from previous years (16.5 per 100,000 people in 2002 and 15.3 per 100,000 people in 2001)[12,13].

Economic disasters or crisis are further linked to poor mental health and increases in suicide rates. For example, research has linked the 2007 economic crisis in Europe and North America to an additional 10,000 deaths by suicide.[14] Data reports suicide rates declining in Europe until 2007 and by 2009, a 6.5% increase was witnessed and maintained until 2011.[15] Similar patterns were

[3] World Health Organisation. (2016). Psychological First Aid For All: Supporting People in the Aftermath of Crisis Events, available online: https://www.who.int/mental_health/world-mental-health-day/ppt.pdf.
[4] Jafari, H., Heidari, M., Heidari, S. & Sayfouri, N. (2020). Risk factors for suicidal behaviours after natural disasters: A systematic review, *The Malaysian Journal of Medicine*, 27(3).
[5] Cartier, K. M. S. (2021), Suicide rates may rise after natural disasters, Eos, 102, https://doi.org/10.1029/2021EO153699.
[6] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, *Journal of Crisis Intervention and Suicide Prevention,* 42(5).
[7] Beaglehole, B., Mulder, R.T., Frampton, C.M., Boden, J.M., Newton-Howes, G. & Bell, C.J. (2018). Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis, *Cambridge University Press.*
[8] Centre for Suicide Research and Prevention. (2017). Number of suicides and suicide rates in Hong Kong, 1997-2016, available online at < https://csrp.hku.hk/wp-content/uploads/2017/09/2017WSPD_slide.pdf.pdf>
[9] Wasserman, I.M. (1992). The impact of epidemic, war, prohibition and media on suicide: United States, 1910-1920, Suicide and Life-Threatening Behaviour, 22(2).
[10] Zortea, T.C., Brenna, C.T., Joyce, M., McClelland, H., Tippett, M., Tran, M.M., Arensman, E., Corcoran, P., Hatcher, S., Heisel, M.J., Links, P., O'Connor, R.C., Edgar, N.E., Cha, Y., Guaiana, G., Williamson, E., Sinyor, M. & & Platt, S. (2020). The impact of infectious disease-related public health emergencies on suicide, suicidal behavior, and suicidal thoughts, *Hogrefe,* available online: https://doi.org/10.1027/0227-5910/a000753.
[11] Farooq, S., Tunmore, J., Ali, W., & Ayub, M. (2021). Suicide, self-harm and suicidal ideation during COVID-19: a systematic review, *Psychiatry Research,* 114228.
[12] Cheung, Y.T., Chau, P.H. & Yip, P.S.F. (2008). A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong, International Journal of Geriatric Psychiatry, 23.
[13] Ibid.
[14] O'Dowd, A. (2014). Economic recession may have caused 10,000 extra suicides, *BMJ,* 348.
[15] Singh, M. (2014). Suicide rate in the U.S. and Europe climbed during Great Recession, *NPR, Public Health,* available online: https://www.npr.org/sections/krulwich/2014/06/11/318885533/suicide-rate-in-u-s-and-europe-climbed-during-great-recession.

witnessed in the United States with an additional 4,750 deaths by suicide linked to the impact of the economic recession.[16]

Research into the impact of the 2009 Black Saturday bushfires in Victoria found 22% of people in high-impact communities reported mental health disorder symptoms at twice the rate of people in low-impact communities.[17] A 10 years on report of the Black Saturday bushfires found 26% of people from high-impact communities were still reporting symptoms of diagnosable mental health disorders (PTSD, depression, and psychological distress) 3-4 years after the bushfires. This was still more than twice as high compared to people from low to no impact communities.[18]

Research indicates that the role of increased social supports to combat risk factors for suicide such as financial distress, unemployment and mental health disorders act as protective factors for suicide and as such, increases in suicide rates immediately after disasters are not commonly experienced.[19] However evidence demonstrates suicide rates can increase years after the disaster which may be attributed to increased disaster supports ending.

Preparing for future disasters

Recent events have demonstrated the need for resources to be available to respond, in real time, to multiple and compounding disasters. The Australian Government should provide discretionary funds through PHNs or other mechanisms to respond to need for suicide prevention in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods, e.g., up to 2-3 years after a disaster.

The World Health Organisation notes that emergency situations such as natural disasters and other humanitarian crises exacerbate the risk of mental health condition, with one in five likely to have a mental disorder such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia. These risks are heightened in older people and marginalised groups.

Mental first aid training for first responders is beneficial. However, research into the impact of disasters shows that providing immediate one-off counselling sessions or debriefing is not effective and may even be harmful.[20] In the immediate aftermath of a disaster it is important that people are not exposed to additional sources of stress, i.e. their immediate needs for shelter, safety and social connection are met.

[16] Reeves, A., Stuckler, D., McKee, M., Gunnell, D., Chang, S. & Basu, S. (2012). Increase in state suicide rates in the USA during economic recession, *The Lancet,* 380(9856).
[17] Gibbs, L., Bryant, R., Harms, L., Forbes, D., Block, K., Gallagher, H.C., Ireton, G., Richardson, J., Pattison, P., MacDougall, C., Lusher, D., Baker, E., Kellett, C., Pirrone, A., Molyneaux, R., Kosta, L., Brady, K., Lok, M., Van Kessell, G. & Waters, E. (2016). Beyond Bushfires: Community Resilience and Recovery Final Report, *University of Melbourne*, Victoria, Australia.
[18] Gibbs, L., Molyneaux, R., Harms, L., Gallagher, H.C., Block, K., Richardson, J., Brandenburg, V., O'Donnell, M., Kellett, C., Quinn, P., Kosta, L., Brady, K., Ireton, G., MacDougall, C. & Bryant, R. (2020). 10 Years Beyond Bushfires Report, *University of Melbourne*, Melbourne, Australia.
[19] De Leo, D., San Too, L., Kolves, K., Milner, A. & Ide, N. (2012). Has the suicide rate risen with the 2011 Queensland floods?, *International Perspectives on Stress & Coping,* 18(2).
[20] Greenberg, N. & Wessely, S. (2017). Mental health interventions for people involved in disasters: what not to do, *World Psychiatry*, 16(3).

Research also shows that serious mental illness, suicidal ideation and making plans for suicide increases as a result of natural disasters.[21] There is evidence that mental illness and suicide rates increase over time after a disaster, with suicide rates reaching the highest level up to two years after the initial disaster.[22] Annual budget planning for disaster suicide prevention responses should include addressing the need for specific postvention support as research indicates suicides are likely to occur in the post-disaster period. Exacerbation of grief can occur in this period and thus increased risk of suicide, it is appropriate postvention support is not provided.

It's well established that helplines have fielded a sizeable increase in help seeking behaviour over the course of successive disasters.[23] Meeting increased demand in a tailored but scalable way is a key element of comprehensive disaster response. A key advantage of helplines in disasters is that they are accessible 24 hours a day 7 days a week and address the need for accessible forms of disaster support. Helplines further provide an opportunity to support people in seeking help at a time when environmental stressors may reduce decision making capacity.

A number of helpline services in Australia currently exist and are engaged with communities. It is generally acknowledged that the more active a support service is in the community prior to disaster – the more trusting people will be accessing the service when the disaster occurs. The COVID-19 pandemic witnessed significant increases in demand for crisis helpline services and these surges in demand during disasters whether economic or natural need to be budgeted for in disaster planning. Services which bridge accessibility challenges during disasters such as digital supports should further be strengthened when disasters strike.

Strengthen communities to support at risk individuals

Many factors contribute to how a person will react to a disaster and their ability to cope, however some common distress reactions that can be expected either immediately or years after a disaster can include feelings of guilt, sadness, anxiety, anger, fear, hopelessness, and helplessness. [24]

Complex reactions associated with disasters include panic attacks, overwhelming anxiety, violence, self-harm and suicide, harmful coping mechanisms (e.g. drugs or alcohol, social withdrawal), prolonged grief, and difficulty sleeping.[25] Risks of psychological distress are further heightened among populations already at-risk of suicide.

Suicide is a complicated and multi-factorial human behaviour and should be understood as more than an expression of mental ill health. A whole-of-government approach to suicide prevention, including in the context of disasters, is required and seeks better cross-portfolio coordination to

[21] Kessler, R. C., Galea, S., Gruber, M. J., Sampson, N. A., Ursano, R. J., & Wessely, S. (2008). Trends in mental illness and suicidality after Hurricane Katrina. Molecular psychiatry, 13(4), 374–384.
[22] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, The Journal of Crisis Intervention and Suicide Prevention.
[23] AIHW. (2021). Mental health services in Australia, *Australian Institute for Health and Welfare,* available online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/covid-19-impact-on-mental-health.
[24] Australian Red Cross. (2020). Psychological First Aid: Supporting people affected by disaster in Australia, Victoria, Australia.
[25] Ibid.

address the social, economic, health, occupational, cultural, and environmental factors involved in suicide prevention.

Psychological first aid addresses social, psychological, and practical support for people experiencing distress from disasters, and is a recommended approach in supporting people in the aftermath of a trauma or disaster.[26,27] Psychological first aid is recognised to be best delivered as a community-based activity[28], and is endorsed by the World Health Organisation. It is widely used by governments in disaster preparedness and can be delivered by both lay and professional helpers.[29,30]

Communities can be strengthened to respond to disasters by supporting at risk individuals by completing training in support roles (e.g. psychological first aid) prior to a disaster. Both disaster responders and broader communities (e.g. education based settings, community touchpoints) need to be equipped with the skills and knowledge needed to support those most vulnerable in their communities. Touch points in the community must have ground level supports available that they can refer vulnerable people to. Ensuring continuity of care during times where people are at risk of suicide is critical in preventing suicide.

In addition to rolling psychological first aid, Governments should continue to support specific suicide prevention capability building in communities. Evidence-based suicide prevention training can support frontline workers, community 'connectors' and 'gatekeepers' to identify, monitor and respond to future suicides risks that emerge in communities impacted by disasters. Specific suicide prevention capability can build on and complement mental health literacy and psychological first-aid training programs.

Need to target populations at risk

Disasters impact people who are marginalised (such as Aboriginal and Torres Strait Islander peoples, LGBTQI communities, people from culturally and linguistically diverse communities, young people, people with disabilities, people who live in rural and remote areas and veterans), frontline workers and first responders more significantly than the general population. For those already experiencing disadvantaged circumstances, disasters can create divides between socioeconomic status.

Addressing the social determinants of health that are impacted by disasters is crucial in disaster preparedness. To enable effective suicide prevention responses to disasters, we need to know who is already at high risk before a disaster occurs (such as those who are socioeconomically disadvantaged, experience discrimination and stigmatisation, and are already at risk of suicide) and prepare necessary targeted supports.

For example, young people can respond to disasters in a multitude of ways. Specifically, research informs that young people reactions to disasters can include both internalising and externalising behaviour problems, highlighting the need for a developmental perspective in when designing and

[26] World Health Organisation. (2011). New psychological first aid guide to strengthen humanitarian relief, News release, available online: https://www.who.int/news/item/21-10-2011-new-psychological-first-aid-guide-to-strengthen-humanitarian-relief.
[27] Phoenix Australia. (2021). Psychological First Aid, *Phoenix Australia*, Victoria, Australia.
[28] Ibid.
[29] Ibid.
[30] Ibid.

implementing targeted suicide prevention disaster responses.[31] Following a disaster, young people are much less likely to actively seek out professional support. [32,33] As such, providing assertive outreach to vulnerable youth, with a focus on increasing social connection, normalising behavioural responses and providing safe spaces for young people to explore their experiences are critical.

Research into Australian population groups at risk of suicide due to disasters is urgently needed, along with research into how best to communicate with those groups using approaches that have a gendered lens tailored to demographic needs.

[31] Rubens, S.L., Felix, E.D. & Hambrick, E.P. (2018). A meta-analysis of the impact of natural disasters on internalizing and externalising problems in youth, *Journal of Traumatic Stress*, 31: 332-341.s

[32] Magaard, J.L., Seeralan, T., Schulz, H. & Brütt, A.L. (2017). Factors associated with help-seeking behaviour among individuals with major depression: A systematic review, *PLOS ONE,* 12(5).

[33] Black Dog Institute. (2020). Mental Health Interventions Following Disasters, available online: https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/mental-health-interventions-following-disasters-black-dog-institute-february-2020.pdf?sfvrsn=0.