Dear Committee members,

1) My name is Mark Layson, and I have had 30 experience as an emergency service practitioner and pastoral carer in local communities. I served as a NSW Police officer from 1991-1997, a NSW Firefighter from 1997-2002, an ordained Anglican pastor between 2001-2019, a volunteer chaplain with NSW Ambulance from 2012 to the present, and as an aged care chaplain since 2020. These occupations have put in me in the frontline as part of at-risk communities (first responders) and in contact with mentally, emotionally, physically and spiritually distressed people. I have worked on the frontline of bushfires and currently work in two high risk groups (aged-care and paramedics) during the COVID-19 pandemic. I am currently undertaking doctoral research to develop a holistic model that prevents negative wellbeing impacts from morally significant trauma exposure.

2) This submission highlights four important emerging factors that I believe require attention to help increase the response and prevention capacity in relation to suicide in Australia;
   i. The emerging role of moral injury and other parallel paradigms in suicidality,
   ii. The impact of these paradigms in relation to natural disasters such as bushfires and pandemics, particularly for high risk communities,
   iii. Recruiting and training of multi-disciplinary teams to enact holistic preventative strategies,
   iv. The need to measure primary outcomes for program efficacy over the easier measurement of secondary outcomes

3) **Moral Injury:** Suicide is often linked to other mental health conditions such as depression and PTSD (Beyond Blue Ltd., 2018, p. 64). Underlying factors in these conditions can include shame, social isolation and anger. An emerging construct known as moral injury is shedding new light on the emotions of guilt and anger and the resultant social isolation. Recent research in the military has revealed moral injury, which can arise from betrayal by leaders or personal moral compromise, impacts on suicidality(Jamieson et al., 2020). Moral injury is related to trauma, including natural disasters such as bushfires, and COVID-19 (Australian Senate Education and Employment References Committee, 2019; Phoenix Australia & Canadian Centre of Excellence -PTSD, 2020). The advent of moral injury raises the possibility that the underlying moral nature of traumatic and significant events can lead to lasting psychological, biological, spiritual, behavioural and social impacts (Litz et al., 2009). Other parallel moral models in civilian contexts include moral distress (Grimell & Nilsson, 2020) and perceived injustice (Sullivan et al., 2014). Understanding and applying insights from these models may aid in early detection, diagnosis, treatment and recovery across the general population and at-risk groups such as first responders. The committee may wish to consider further the impact of moral injury, moral distress and perceived injustice as causal elements in suicidality.

4) **Disasters:** The twin natural disasters of the 2019-20 bushfires and the COVID-19 pandemic have brought public discussions of vulnerability, mortality and culpability to a new level over the last year and a half. There has been a large amount of literature produced in the last 12 months about the impact of moral injuries associated with COVID in health workers (Čartolovni et al., 2021; Gaitens et al., 2021; Greenberg et al., 2020; Lai et al., 2020; Mortillaro, 2020). However, there has been little research on its role in the negative mental health associated with bushfires. It is worth noting though that the public discussion on both COVID the bushfires proffered increasingly negative moral evaluations that find fault in individual civic leaders or societal factors (Thomas et al., 2020). This negative moralising can lead to a deeper distress than caused by the actual trauma itself as it dwells on anger, guilt etc. As a result, it is

reasonable to believe that many feel the fires are the result of various bureaucratic and political betrayal. Research has suggested that when natural disasters or traumas are linked to injustice there are deeper and longer lasting mental and physical impacts (Trost et al., 2015). This is particularly so in the high-risk communities such as first responders. With the possibility of ever-increasing bushfires due to climate change the committee might consider that research into the link between moral distress, natural disasters and moral resilience is urgently needed.

5) **Holistic preventative strategies:** The terms of reference notes the importance of considering "the roles, training and standards for all health and allied health professionals who contribute to mental health care, including peer workers, that are required to deliver quality care at different levels of severity and complexity, and across the spectrum of prevention, early intervention, treatment and recovery support." While the committee is considering this issue through a mental health lens, the mental health lens requires a broader holistic understanding of human functioning. Currently, the mental health model is based on a biopsychosocial model that excludes spirituality/religiosity and existential angst. Additionally, many psychologists who work in the mental health field often have no training or background in spiritual or religious concerns (Burkman et al., 2019). Much research on moral injury contends that spiritual and religious beliefs must be addressed in many morally loaded traumas, even for those who profess no overt religion (Nieuwsma, 2015; Sedlar et al., 2018; Smith-MacDonald et al., 2018). As a result, the development of a biopsychosocial-spiritual model for early intervention and response may be of enormous benefit (Cenkner et al., 2020; Hodgson & Carey, 2017; Katerndahl, 2008; Saad et al., 2017). A multifaceted model such as this entails the need to utilise of a broad range of practitioners that includes psychologists, peer supporters, chaplains, pastoral carers, social workers, families and more. Currently, many emergency organisations have such teams, however, they can often poorly communicate between disciplines due to traditional inter-professional grievance (Avgoustidis, 2008) or no current mechanisms to allow inter-disciplinary collaboration. The committee may wish to consider how to incorporate a holistic biopsychosocial-spiritual model in the training of multi-disciplinary wellbeing teams.

6) **Rigorous measurement**: Many mental health programs do not measure their efficacy in reducing suicide, instead opting to measure secondary outcomes such as the reduction of stigma. The terms of reference mention the need to consider "effective system-wide strategies for encouraging emotional resilience building, improving mental health literacy and capacity across the community, reducing stigma, increasing consumer understanding of the mental health services, and improving community engagement with mental health services" While this is true, the link between the listed activities such as reducing stigma may not directly correlate to a reduction in suicide. Recent Canadian research found that stigma reduction and mental health literacy encouraged by one program did NOT reduce suicide (Côté et al., 2021). The committee may wish to consider the need for mental health programs and research to measure the efficacy of programs by the primary outcome of suicide reduction, as well as secondary outcomes such as reducing stigma.

I submit this letter in the hope that these insights will help in our shard goal of suicide reduction.

Kind regards,
Mark Layson

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