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Queensland Mental Health Commission

Consultation Paper:

Development of a whole-of-government Trauma Strategy for Queensland

Trauma-informed approaches to suicide prevention

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What is this research about

The purpose of this research is to understand the current state of knowledge regarding trauma-informed approaches, interventions and/or strategies for suicide prevention across the lifespan. This review seeks to understand what trauma-informed approaches have been implemented to date, how effective and acceptable they are, and whether they have been informed by lived experience involvement or leadership.

The context for this research

Experts in the field of suicidology have emphasized the importance of a trauma-informed approach that understands the prevalence of trauma and its relationship to suicide, recognizes the impact of trauma and the ways a system must be responsive to these needs, avoids retraumatization, and values the feedback of those with lived experience. (Mirick, McCauley, & Bridger, 2023, p. 306).

Over 3,000 people die by suicide in Australia each year (the national age-standardised rate for 2022 is 12.3 deaths per 100,000) [1]. Queensland has the second highest age-standardised rate of suicide (14.4 per 100,000) in Australia [1]. In 2021, 813 people died by suicide in Queensland – this equates to a standardised rate of 15 deaths per 100,000, with males more than three times more likely to die than females [2]. Queenslanders aged 50-54 years experience the highest rate of suicidality (39 deaths per 100,000 for males and 12.8 per 100,000 for females)[2, 3]. Suicide is disproportionately experienced by Aboriginal and Torres Strait Islander people in Queensland, with a standardised rate three times higher than the total state population. Further, for Aboriginal and Torres Strait Islander young people (up to 29 years of age), the suicide rate is three times higher than other age groups. From 2016 to 2018, 24 people who died by suicide were reported as belonging to the LGBTIQ+ community, and this is likely an underestimation [2]. In 2021, one in 10 (8.1%) suicide deaths in Queensland were by people from a non-English speaking background, with 13.3% of all female deaths being of non-English speaking background, compared to 6.4% of all male deaths [2]. Queenslanders who belong to certain occupation groups are at increased risk of suicide, particularly labourers and machine operators/drivers, followed by technicians and trades workers, and suicide is also a known issue for current and ex-serving Australian Defence Force people [2].

In addition to suicide deaths, it is likely that a far greater proportion of Queenslanders also experience suicide-related thoughts, intent and/or behaviours. Although robust data for suicide attempts/ideation in Queensland is not available, it is estimated that there are approximately 16,000 suicide attempts each year [4]. Further, estimates suggest that up to 135 people can be impacted by each suicide death [5], with suicide having a wide reach across the community.

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Other policy evidence summaries in this series have defined trauma and have highlighted the impact of trauma on mental health outcomes for specific population groups. There is a known relationship between lifetime trauma and suicide[6-8], and many studies link childhood trauma with later suicidal ideation [8, 9]. Further, those with lived or living experience of suicidality and/or those who are bereaved by suicide have an increased risk of experiencing trauma [10]. For example, of those Queenslanders who died by suicide between 2016 and 2018, more than one in two males and almost two in three females expressed the intent to take their life, and one in three had engaged in suicide-related behaviour in the past [2]. The interactions people have with services as a result of these experiences have the potential to contribute to exacerbation of existing trauma, or creation of new trauma. Therefore, a trauma-informed approach toward individuals and communities experiencing suicidality can inform suicide prevention efforts and needs to be prioritised.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a trauma-informed approach as one that 'realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" [11] (p. 9). SAMHSA outlines six core principles of trauma-informed practice including: 1) establishing physical and psychological safety; 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice, and choice; 6) taking full account of intersectionality related to cultural, historical, and gender issues [11]. A trauma-informed approach can be applied to all levels of suicide prevention: prevention, intervention and postvention.

The key findings

To inform this report, we conducted a rapid review[1] of peer-reviewed evidence for trauma-informed approaches to suicide across the lifespan. We acknowledge that many suicide prevention practices may include implied elements of trauma-informed care, however for the purpose of this review we were specifically interested in locating evidence for explicit trauma-informed suicide prevention approaches. For details of our review methodology, see Appendix 1.

Our review identified 23 papers for inclusion in this report. This literature is very recent, with papers published between 2019 and 2024. Most of the papers were published in the USA (n=16), with five in Australia, and one each in the UK and Canada. There is notable diversity in the priority population groups and settings for suicide prevention explored in this body of work, as well as the types of study design. Just over half of this body of work is empirical research. This includes two RCTs [13, 14], three retrospective studies [15-17], one cross sectional study [18], one cohort study [19], one case report [20], two mixed methods studies [21, 22], and four qualitative studies/case study reports [23-26]. These studies are complemented by nine recent papers at the expert opinion level of evidence, where authors have produced discussion papers (often supported by client scenarios) of the recommended use of trauma-informed care principles in suicide prevention practice [10, 27-34]. For additional details of the individual papers, see Appendix 2.

[1] "Rapid reviews are a form of knowledge synthesis in which components of the systematic review process are simplified or omitted to produce information in a timely manner." [12]

Involvement of lived experience in study design and authorship

Exploration of the study methods and authorship of the included papers indicates low levels of lived experience involvement and or aspects of leadership in this area of research. The study reports by Bennett et al. describing cultural workshops held in Queensland included participatory elements of design, involvement of First Nations facilitators and artists, and facilitation methods which encouraged participants to set directions of conversation [23, 24]. Several other studies included consultation processes with young people, community members and service user representatives in aspects of study design [22], instrument design [22] and workshop content [14, 21]. None of the conceptual papers indicated any lived experience authorship and were written from clinical standpoints.

Summary of literature findings

We have summarised the included papers according to trauma-informed suicide prevention approaches for specific population groups and/or settings: young people in schools and mental health care settings; adults in mental health care settings; people in rural Queensland; CALD communities; and professions exposed to trauma.

Trauma-informed approaches for young people experiencing suicide-related distress

Young people were the most common demographic group explored in this body of work. Approaches included early intervention and prevention in schools, as well as targeted interventions in crisis care and in the community.

Early intervention/prevention approaches in schools

O'Neill et al. present a practice framework for identifying, engaging and supporting young people with suicide related risk in school communities [33]. This framework encourages school-based mental health and support practitioners to utilise the SAFETY-Acute(A) approach as a strengths-based discussion about the young person's situation and distress. Trauma-informed considerations for using SAFETY-A include identifying the young person's resiliency factors, their current thoughts, feelings and levels of emotional regulation, and the nature of triggering events and interactions for them. Screening for any trauma history is also included and tools such as using a feelings thermometer is also recommended. The framework also encourages a collaborative safety planning process working with the young person and family or other supports to discuss restriction of lethal means, and to identify other protective safety strategies and how and when to connect with them. SAFETY-A also promotes ongoing support for the young person and family, and building trust and connection across these meetings (e.g., daily check ins). Referrals to other specialist providers are recommended for families. The authors highlight the need for school-based practitioners to receive training and supervision in trauma-informed suicide prevention work to improve levels of confidence, and skills in engagement and assessment [33].

Writing in the USA context, Marraccini et al. [30] present the Justice, Equity, Diversity, Inclusion (JEDI) approach for understanding and responding to suicide risk for 'Black boys' in schools [30]. This approach expresses the need to understand the social context of marginalism, racism, intersectionality and systems barriers for Black boys, and how these act to increase involvement in disciplinary processes, experiences of school disengagement, and limit access to effective mental health supports. The JEDI informed approach recommends that schools develop and embed community – family-school partnerships which intentionally promote strengths-based culture and an anti-racist school climate. This includes use of transformative social-emotional learning across the school community as primary prevention. Comprehensive suicide prevention programs should include trauma and JEDI informed screening and risk identification practices, which become the basis for working with young people and families to

understand emotional concerns and distress, improve linkages with mental health supports, complete safety planning, and respond to school-based stressors and engagement barriers in culturally grounded ways [30].

Mirick and colleagues have applied the SAMHSA principles to both prevention and postvention in schools [10, 32]. Mirick et al. [10] explain how schools can best prepare to receive and respond to disclosures of suicide (for example, through explorations of suicide within the school curriculum). This can include trauma-informed training for teachers, and open communication throughout the school community about the timing of any suicide and/or trauma content within the classroom, when students may disclose experiences with suicide. In addition, Mirick et al. [32] describes important processes that can reduce stigma, promote school community cohesion, safety and empowerment in responding to the loss of a young person to suicide. The SAMHSA principles can help guide activities in promoting healthy grieving, commemoration, and reducing risk of contagion for other distressed students and other adverse outcomes. Providing education and trauma-informed supports across the school community is also promoted, including forms of mutual support. Helping students to identify their needs, and decide about things such as time away from school, returning to class, and forms of support needed, helps them to feel empowered and heard [32].

Lastly, a suicide prevention intervention based on trauma-informed yoga has been used to support high school students living in a rural area with significant social and health disadvantage [22]. This program engaged students with trauma histories in bi-weekly yoga sessions as a part of their physical education, and to teach yoga practices as a means for coping. Pre and post test results indicated significant impacts in reducing anxiety symptoms, and improved identification of personal strengths and emotional functioning. Some reduction in depressive symptoms were also recorded, while some students reported improved awareness of bodily feelings (interoception) after the program [22]. The authors recommended further programs and research for effectiveness.

Group homes for young people

Two studies, drawing on the same sample, have explored the impact of trauma-informed group homes for youth [16, 17]. The group homes were based on a modified version of the evidence-based, Teaching-Family Model, where professionally trained staff (family-teachers) lived with the youths and provided psychoeducation (pro-social skills, relationship building, motivation skills, self-government, problem solving and moral/spiritual development). Staff were trained in aspects of trauma-informed care. Based on staff reports, Tyler et al. [16] found a significant reduction in self-injurious incidents (including self-destructive behaviour, suicidal ideation and suicide attempts) in the first month, followed by a non-significant reduction over the remaining 11 months. The same trends were found by Tyler et al. [17], although the initial reduction was non-significant.

Targeted interventions for young people in crisis care

Various studies and discursive papers had a focus on supporting young people experiencing suicide-related crisis. This included a focus on emergency department care, as well as general crisis response practice.

Three papers describe using the SAFETY-A approach in this context [18, 28, 34]. This is single session, strength-based and family-focused CBT intervention which engages the young person and family in care planning, which features exploring stressors, triggers, strengths and undertaking safety planning. There is a focus on ensuring links between follow up care and the initial ED visit. In one study Giles et al. [18] combined this approach with a trauma-informed Care Process Model for screening trauma experiences, identifying resilience, symptoms, coping skills and likely areas of trauma therapy. This intervention showed promising results for 30 young people receiving the care

model including effective strengths-based responses, identification of relevant trauma, assisting young people to articulate their feelings (via feelings thermometer). All participant young people and families generated a care (including safety) plan, with improved linkage to trauma focused assessment, and existing or new care providers [18]. Asarnow et al. provide further guidance on the use of SAFETY-A model in their description of trauma-informed care planning [28].

Tunno et al. [34] includes SAFETY-A in offering a model of trauma-informed care throughout acute care provision. This is based on using six non-sequential steps of practice. These include 1) adopting a trauma-informed therapeutic stance; 2) establishing and promoting physical and psychological safety; 3) recognising signs of traumatic stress exposure; 4) mobilising youth, family and community strengths to support resilience; 5) conducting a trauma-informed therapeutic assessment and acute intervention; and 6) conduct ongoing trauma-informed monitoring and care. Tunno et al. emphasise the essential collaborative nature of working with young people, caregivers and family units if possible, and recommend building trauma-informed organisations and service systems which embed high quality practice and supports for young people, families and providers [34].

Two further papers provide similar levels of guidance to Tunno et al.'s approach and describe how SAMHSA's approach and principles to trauma-informed care guide support for young people. An overview by Mirick et al. provides practical strategies across all six principles [31]. The principle of safety means that practitioners need significant skills in ensuring psychological safety, avoiding restrictive practices only focused on physical safety. Practitioners should also manage their own fear and anxieties on risk to maximise collaboration with young people and promote their choices. Psychological safety also promotes safe environments such as waiting rooms, clinical spaces and actions of first responders. For the principles of trust and transparency, it is important to facilitate clear informed consent, and build trust by having clear and transparent boundaries on confidentiality and information sharing. The third principle of peer support is achieved by connecting young people to peer support opportunities, and practitioners should become familiar with local peer services and programs to provide effective support for young people in suicide related distress. Collaboration and mutuality is SAMHSA fourth principle. Here Mirick et al. highlight the need to intentionally collaborate with young people and families to dress safety, reduce access to lethal means, identify preferred forms of support. Practitioners should maintain fidelity with collaborative practices of safety planning, through their own learning and training. The principle of empowerment, voice and choice means practices of checking in, asking permissions, gaining client perspectives and acting on input. This should use a strengths-based, non-shaming approach which sees behaviours as adaptive responses of client agency. This approach acknowledges and works from lived experience. The last principle - cultural, historical and gender issues - encourages practitioners to learn how the person's culture shapes the trauma response and expression of suicidality. It requires awareness of impacts of marginalisation and discrimination - impacts of white privilege, systemic racism, homophobia, and colonisation impacts for first nations, LGBTIQ+ and migrant communities - including distrust in service use. The authors recommend more integrated trauma-informed approaches to suicide prevention and a paradigm shift away from coercive interventions [31]. The paper by Adams et al. [27] recommends similar use of these principles, using a trauma-informed crisis intervention model, to provide support and stabilisation for young people in suicide-related distress. This includes enhanced organisational supports for practitioners [27]. Similarly, Fialkowski et al. [29] describe the use of a trauma-informed care framework to a young

person admitted to hospital, highlighting how this can address the effects of trauma, and promote recovery and resilience.

A qualitative study of family caregivers perspectives in their experiences of supporting young people access care in crisis is provided by Inscoe et al. [25]. Carers involved in this study highlighted the traumatising aspects of ED care including poor trauma awareness on the part of staff, high waiting times and poor information provision. A trauma-informed approach from their perspective would include: increased skills and capability in offering trauma aware support, improved carer involvement and information across care, better education and emotional support for the young person and families, and assisting in navigating complex service systems [25].

An Australian, Child and Adolescent Mental Health Service-based study by Palfrey et al. was one of the few therapeutically-focused studies in the review [19]. This study evaluated the impact of a trauma-focused cognitive behaviour therapy program for children and young people and their parents/ guardians which features education and parenting skills, relaxation skills, emotional regulation skills, cognitive coping processing and skill building, and working with trauma narratives. Results of the program indicated significant improvements in post-traumatic stress disorder (PTSD) symptoms and general mental health of young people [19].

Trauma-informed practices in adult mental health services

Three papers explored trauma-informed practices for adults. A UK study raises the importance of staff in adult, inpatient psychiatric care having trauma-informed processes and skills promoting safety. Nikopasch et al. [15] reports on a four year project developing team capacity and skills for a unit team. These included developing a Team Formulation approach using The Power Threat Meaning Framework and staff training in psychological stabilisation practices. There was also some engagement with consumers feeding back on what was important for the team to understand and think about within Team Formulation. Evaluation of Unit records overtime indicate that the program was successful in achieving significant reductions in reported self-harm, seclusion and restraints [15]. A case study report by Winkler et al. [20] also describes the importance of using SAMHSA's trauma-informed care principles for avoiding re-traumatisation, shifting staff attitudes, reframing clinical formulations of distress and more compassionate care practices towards consumers experiencing high distress on psychiatric units. Trauma-informed care can transform care experiences for consumers and staff providing them [20]. Similarly, in their conceptual paper, Mirick et al. [10] provide two case study examples of using SAMHSA's trauma-informed principles to support adults in two settings and at two levels of suicide prevention (intervention and postvention). They explain how the principles can be applied to an adult with a history of sexual assault requiring hospitalisation for suicidality, particularly surrounding avoiding re-traumatisation. In the second example, an adult seeking support following a loved one's suicide, can be supported through therapeutic services that specifically recognise a suicide death as traumatic and understand the impact of trauma on the individual.

Trauma-informed, arts-based programs in Rural Queensland

The value of group learning programs to assist community members and families to process grief, loss and trauma from losing young people to suicide was described in two papers by Bennett and colleagues. They examined key trauma-informed processes of group facilitation and the drivers of change and growth for participants attending a cultural workshop program held in rural Queensland (Warrick). The workshops utilised specialist cultural content, and immersive storytelling relating to trauma experienced by First Nation's people. Facilitation processes of holding

space – being with, hearing, sharing feelings and co-creating meanings - helped participants to process and integrate the effects of trauma and loss into new personal meanings [23]. The authors highlight the unique cultural space of the workshops to enable expression and a place to grieve and share. Trauma-informed cultural level workshops can play an important role given gaps in accessing therapy for most people and the significance of responding to trauma in relational and cultural ways [23, 24].

Trauma-informed programs for CALD communities

Only one study explored an approach for CALD communities. Hahm et al. [14] tested the impact of an approach for Asian American women with histories of interpersonal trauma. Through a 2-arm RCT, women were allocated to the Asian Women's Action for Resilience and Empowerment (AWARE) program or a waitlist-control. The intervention included a face-to-face, 8-week trauma-informed and gender- and culture-specific group psychotherapy program, along with daily text messages containing stories from women of the same background. While there were significant short-term reductions in suicidal ideation and intent associated with participating in the program, this was also the same for those in the control group, and therefore further research is needed to understand the impact of this program on suicidality. Of note, however, was a reduction in depressive symptoms among women in the intervention group who had PTSD, compared to those in the control group.

Trauma-informed approaches for professions exposed to trauma

Three studies explored trauma-informed approaches for occupational groups who are exposed to trauma due to the nature of their work, specifically doctors [13, 26], and firefighters [21]. Taylor et al. [13] conducted a single arm, pilot RCT to explore the impact of an 8-week trauma-informed personalised yoga program for junior doctors. However, there were no differences over time between or within the intervention and control group (who received group fitness) in suicidal ideation. Reduced burnout was found for both groups, along with increased compassion satisfaction within the yoga group. Further, yoga participants reported their intervention to be more beneficial for their mental and physical health than those in the control group. In a follow-up qualitative interview study with the same participants, Taylor et al. [13] identified various benefits of trauma-informed personalised-yoga, including that it offered junior doctors a therapeutic alliance, time to check-in/self-reflect, could help to reduce anxiety/rumination, and had a positive impact on symptoms of physical pain.

In a mixed-methods study, Hendrix et al. [21] explored a mindfulness intervention for firefighters. Participants attended three training sessions in MindShield, a trauma-informed, mindfulness-based intervention, with a focus on creative protective cognitive strategies to address PTSD. While suicidality data were collected at baseline, the study did not directly assess the impact of the intervention on suicide or other related outcomes. Qualitative data from focus groups with a subset of participants indicated that the intervention is feasible and acceptable – and participants reported using it more in their personal lives rather than while on duty. Participants also offered suggestions for how MindShield could be improved, through strategies such as alterations to length of training, more inclusion of firefighters in the training presentation, adding a tangible tool to use when in crisis, addressing privacy concerns, and providing training to domestic partners too.

Key knowledge gaps

Despite a notable increase in authors discussing trauma-informed suicide prevention approaches in recent years, there are some significant gaps in this body of knowledge, including:

- An overall lack of high-quality and lived-experience informed studies, with trauma-informed approaches being a relatively new area of focus in suicide prevention work;
- Limited understanding of how the existing literature may apply to the Australian, and more specifically Queensland, context;
- Lack of evidence for population groups with higher rates of suicide in Queensland, such as people living in rural and remote areas, people of Aboriginal and Torres Strait Islander background, and culturally and linguistically diverse communities;
- Lack of attention to postvention (more focus on prevention and intervention), which is a critical component of suicide prevention given the high likelihood of experiencing trauma after a suicide death.

What does this research mean for policymakers

At present, there is limited, high-quality evidence to guide the implementation of trauma-informed approaches to suicide prevention in Queensland. However, there is useful theoretical and conceptual information about how to apply trauma-informed principles across suicide prevention, intervention and postvention.

Trauma-informed approaches, as indicated in the conceptual papers, require systems, organisations, services and practitioner-level capacity building to raise trauma awareness, better recognise trauma experiences in communities, consumers, families and staff, respond effectively from integrating knowledge in policy and practices, and intentionally avoid re-traumatisation. The implications for policymakers in the context of developing a whole-of-government trauma strategy must be anchored in highly relational approaches which will require people affected by trauma and suicide to define practices of psychological safety and physical safety.

At the same time, trauma-informed suicide prevention requires significant and meaningful levels of authentic engagement and collaboration between people with lived and living experience of suicide, peer communities and practitioners. Activity should be properly resourced and designed as a psychologically safe activity that can inform suicide prevention efforts. This approach will be needed at the point of care and support, in organisational planning and service development, and in research.

Importantly, consideration of the characteristics of the population groups must be taken into account. It would be important to acknowledge interconnectedness within and between groups, noting that many elements of contemporary suicide prevention strategies will have overlap with approaches for specific population/lifespan groups discussed in other policy evidence summaries included in this series, and also that by addressing trauma at these upstream stages there is likely to be a positive downstream impact on suicide prevention efforts.

Creating a statewide trauma-informed approach to suicide must be inclusive of *Every life: The Queensland Suicide Prevention Plan 2019-2029 [4].* The Plan acknowledges the complex interplay of factors that lead to suicide, and recognises that suicide prevention requires a whole-of-government and whole-of-community approach. Any recommendations for reform should align with the Plan's four action areas: building resilience; reducing vulnerability; enhancing responsiveness; working together. Consideration should be made towards understanding what this means at the point of care. For example, within a trauma-informed approach a so called 'difficult person'

is best conceptualised as 'a person in difficulty'. At the same time, difficulties with service engagement are often not a conscious individual choice but the function of a convergence of multiple, complex, and intertwined adaptive processes in response to distress triggers, socioeconomic and personal circumstances driving suicidality. Previous negative experiences with care providers can also shape the person's help seeking. The work of the individual worker, service and organisation is to identify key issues, potential barriers, and potential enablers in collaborative discussion with the person. This could fit alongside the Plan's action area of: 'enhancing responsiveness'.

Options for reform

With the focus of this paper being on trauma-informed approaches to suicide prevention across the lifespan, the options for reform here are broadly aimed across systems. Other papers included in this series have focused on trauma and specific population groups, and have provided options for reform at that level. Given the known association between trauma and suicide, we recognise that many of the options for reform for specific population groups discussed in the other papers are also likely to have a positive impact on reducing suicide.

Through the principles of co-design and collaboration, the following options for reform are recommended:

1. Taking a whole of community approach to suicide prevention (i.e., beyond the mental health sector) which was coming through in many of the papers in this review, e.g., school-based approaches. This would include building upon trauma-informed practice and organisational development in different systems, including education, criminal justice, police and first responders, housing, family welfare, mental health and relationship counselling, to maximise integration of trauma-informed considerations, identification and support for people experiencing suicide-related distress.

2. Services and systems should adopt a defined and transparent trauma-informed approach. For example, a number of the papers included in this review describe the adoption and implementation of SAHMSA's six principles of trauma-informed care.

3. Ensuring that trauma-informed approaches are applied to all levels of suicide prevention - prevention, intervention and postvention - particularly given the potential for experiencing suicide-related distress and/or the loss of a loved one to suicide to be traumatic experiences.

4. Capacity building among staff and services (both in the health sector and more broadly, e.g. schools). This would include training in trauma-informed care, suicide prevention, and an understanding of the bidirectional relationship between trauma and suicide. Broad training would be relevant for all staff, followed by identification of staff and services where more specific trauma-informed suicide prevention training would be beneficial (i.e., 'gatekeepers' and those referring people to support services, and practitioners working directly with people experiencing suicide-related distress). This may include creative technologies and media to convey key learning.

5. Design/re-design of suicide prevention services to avoid re-traumatisation – this would include considerations around elimination of restrictive practices (i.e. seclusion/restraint); shifts in language; ensuring policies/guidelines are trauma-informed. This may include taking a targeted approach at an organisational level to explain how the principles of trauma-informed practice can guide responses to

specific groups. For example, when working with an adult with a history of sexual assault, police responding to people in suicidal crisis within a community setting, or at the time of emergency department attendance following a suicide attempt. All three areas are opportunities for a nuanced approach to avoid re-traumatisation and promote safety: making sensitive revisions in (for example) the use of uninvited touch and conscious awareness of distress triggers, and rebalancing power in decision making.

6. Draw from multi-agency and interprofessional contributions – inclusive of leadership contributions from people with lived experience toward statewide trauma-informed suicide prevention. This would include effective engagement and partnership with lived experience leaders and organisations in planning trauma-informed suicide prevention activities, including the funding, development and sustaining of peer support models, and community led workshops and education initiatives.

References

1. Australian Bureau of Statistics. *Causes of Death*. 2022; Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release.
2. Leske, S., Adam, G, Catakovic, A, Weir, B, Kõlves, K, *Suicide in Queensland: Annual Report*. 2022: Brisbane, Queensland.
3. Griffith University. *The Queensland Suicide Register*. 2023; Available from: https://www.griffith.edu.au/griffith-health/australian-institute-suicide-research-prevention/research/qsr.
4. Queensland Mental Health Commission, *Every life: The Queensland Suicide Prevention Plan 2019-2029*. 2019, Queensland Mental health Commission Queensland.
5. Cerel, J., et al., *How many people are exposed to suicide? Not six.* Suicide and Life-Threatening Behavior, 2019. **49**(2): p. 529-534.
6. Angelakis, I., E.L. Gillespie, and M. Panagioti, *Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis.* Psychol Med, 2019. **49**(7): p. 1057-1078.
7. Angelakis, I., J.L. Austin, and P. Gooding, *Association of childhood maltreatment with suicide behaviors among young people: A systematic review and meta-analysis.* JAMA Network Open, 2020. **3**(8): p. e2012563-e2012563.
8. Zatti, C., et al., *Childhood trauma and suicide attempt: A meta-analysis of longitudinal studies from the last decade.* Psychiatry Res, 2017. **256**: p. 353-358.
9. Wiebenga, J.X., et al., *Suicide ideation versus suicide attempt: Examining overlapping and differential determinants in a large cohort of patients with depression and/or anxiety.* Aust N Z J Psychiatry, 2021. **55**(2): p. 167-179.
10. Mirick, R.G., J. McCauley, and J. Bridger, *Integrating trauma-informed principles into suicide prevention, intervention, and postvention* Practice Innovations, 2023. **8**(4): p. 305-316.
11. Substance Abuse and Mental Health Services Administration, *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. 2014: Rockville, MD:.
12. Tricco, A.C., et al., *A scoping review of rapid review methods.* BMC Medicine, 2015. **13**(224).
13. Taylor, J., et al., *Personalised yoga for burnout and traumatic stress in junior doctors.* Postgraduate medical journal, 2020. **96**(1136): p. 349-357.
14. Hahm, H.C., et al., *Feasibility, preliminary efficacy, and safety of a randomized clinical trial for Asian Women's Action for Resilience and Empowerment (AWARE) intervention.* The American journal of orthopsychiatry, 2019. **89**(4): p. 462-474.
15. Nikopaschos, F., et al., *Trauma-Informed Care on mental health wards: the impact of Power Threat Meaning Framework Team Formulation and Psychological Stabilisation on self-harm and restrictive interventions.* Frontiers in psychology, 2023. **14**: p. 1145100.
16. Tyler, P.M., et al., *Youth Needs at Intake into Trauma-Informed Group Homes and Response to Services: An Examination of Trauma Exposure, Symptoms, and Clinical Impression.* American Journal of Community Psychology, 2019. **64**(3-4): p. 321-332.

17. Tyler, P.M., et al., *Evaluating social skills training for youth with trauma symptoms in residential programs.* Psychological trauma : theory, research, practice and policy, 2021. **13**(1): p. 104-113.
18. Giles, L., et al., *Implementation of a Trauma-Informed Suicide Prevention Intervention for Youth Presenting to the Emergency Department in Crisis.* Evidence-Based Practice in Child and Adolescent Mental Health, 2021. **6**(3): p. 343-353.
19. Palfrey, N., R. Ryan, and R.E. Reay, *Implementation of Trauma-specific Interventions in a Child and Adolescent Mental Health Service.* Journal of Child and Family Studies, 2023. **32**(6): p. 1722-1735.
20. Winkler, O., et al., *Shifting to Trauma-Informed Care in Inpatient Psychiatry: A Case Study of an Individual with Dissociative PTSD Undergoing EMDR Therapy.* Case reports in psychiatry, 2023. **2023**: p. 8161010.
21. Hendrix, E.W., et al., *Mindfulness-based Interventions to Improve Relational and Mental Health of Firefighters: A Mixed Methods Feasibility Study.* Clinical Social Work Journal, 2023. **51**(4): p. 401-414.
22. Davis, L., A. Aylward, and R. Buchanan, *Trauma-Informed Yoga: Investigating an Intervention for Mitigating Adverse Childhood Experiences in Rural Contexts.* Educational studies, 2022. **58**(4): p. 530-559.
23. Bennett, J., et al., *Transforming Trauma through an Arts Festival: A Psychosocial Case Study.* Social Sciences, 2023. **12**(4).
24. Bennett, J., et al., *Connecting Us Back to Ourselves: Aesthetic Experience as a Means to Growth after Trauma.* Social Sciences, 2024. **13**(1).
25. Inscoe, A.B., et al., *Trauma-informed care for youth suicide prevention: A qualitative analysis of caregivers' perspectives.* Psychological trauma : theory, research, practice and policy, 2022. **14**(4): p. 653-660.
26. Taylor, J., et al., *How junior doctors perceive personalised yoga and group exercise in the management of occupational and traumatic stressors.* Postgraduate medical journal, 2022. **98**(1161): p. e10.
27. Adams, C.R., J.M. Blueford, and J.F. Diambra, *Trauma-Informed Crisis Intervention.* Journal of Professional Counseling, Practice, Theory, & Research, 2022. **49**(2): p. 91-107.
28. Asarnow, J.R., et al., *Suicide, Self-Harm, & Traumatic Stress Exposure: A Trauma-Informed Approach to the Evaluation and Management of Suicide Risk.* Evidence-based practice in child and adolescent mental health, 2020. **5**(4): p. 483-500.
29. Fialkowski, A., et al., *Trauma-Informed Care for Hospitalized Adolescents.* Current pediatrics reports, 2022. **10**(2): p. 45-54.
30. Marraccini, M.E., et al., *A Trauma-and Justice, Equity, Diversity, and Inclusion (JEDI)-informed approach to suicide prevention in school: Black boys' lives matter.* School Psychology Review, 2023. **52**(3): p. 292-315.
31. Mirick, R.G., J. Bridger, and J. McCauley, *Trauma-Informed Clinical Practice with Clients with Suicidal Thoughts and Behaviors.* Smith College Studies in Social Work, 2022. **92**(3): p. 169-184.
32. Mirick, R.G., J. Bridger, and J. McCauley, *Trauma-Informed School-Based Postvention Services: Support to Students Following a Suicide Death.* Clinical Social Work Journal, 2024. **52**(1): p. 3-11.
33. O'Neill, J.C., et al., *Implementing Trauma Informed Suicide Prevention Care in Schools: Responding to Acute Suicide Risk.* Evidence-Based Practice in Child and Adolescent Mental Health, 2021. **6**(3): p. 379-392.
34. Tunno, A.M., et al., *A Trauma-Informed Approach to Youth Suicide Prevention and Intervention.* Evidence-Based Practice in Child and Adolescent Mental Health, 2021. **6**(3): p. 316-327.