A social message on . . .

Suicide Prevention

Adopted originally by the Church Council of the Evangelical Lutheran Church in America on November 14, 1999. This updated version with contemporary statistics, phrasing, and resource information was adopted November 12, 2021.

****This is the updated, official text but has not yet gone through graphic design. An updated, designed version will be posted shortly.****

Suicide in the United States is a heart-wrenching national crisis.[1] Statistics indicate it is in the top ten of leading causes of death and the second leading cause among people between the ages of 10 and 34. The suicide rate increased by more than 30% between 1999 and 2019.[2] More people die by suicide than by homicide,[3] and it is estimated that slightly more than half of U.S. adults know someone who has died in this way.[4]

In addition to this loss of life and its unspeakable tragedy, there is a much larger proportion of individuals who think about (ideate) and/or attempt suicide. In 2017, nearly 1.5 million emergency department visits were related to suicide ideation or suicide attempts. In 2019, 4.8% of adults aged 18 or older[5] and 18.8% of high school students had serious thoughts of suicide in the past year.[6]

These numbers, we know, speak of individuals whose stories and relationships are unique. They are people in our families, congregations, neighborhoods, and workplaces. Some of us have attempted suicide, and others of us have made sure a relative or friend who speaks of contemplating suicide has gotten help. Many of us have mourned and anguished—often in isolation because of stigma—over the death by suicide of a loved one, while others of us will someday experience this inexpressible grief and suffering.

Suicide testifies to life's tragic brokenness. Christians believe that life is God's good and precious gift to us, and yet life for human beings—ourselves and others—sometimes appears to be hell, a torment without hope. When we would prefer to ignore, reject, or shy away from those who despair of life, we need to recall what we have heard: God's boundless love in Jesus Christ will leave no one alone and abandoned. We who lean on God's love to live are called to "bear one another's burdens, and in this way you will fulfill the law of Christ" (Galatians 6:2). Our efforts to prevent suicide grow out of our obligation to protect and promote life, our hope in God amid suffering and adversity, and our love for the troubled neighbor.

In U.S. society, suicide is increasingly being viewed as a serious and preventable public health problem.[7] Suicide and its prevention are complex and multidimensional and need to be approached openly and comprehensively. Suicide prevention requires concerted and collaborative efforts from multiple sectors of society. When prevention is given priority and used, research tells us there is hope and that we can make a difference.[8]

Let us in the Evangelical Lutheran Church in America contribute to these efforts. With this message, the Church Council encourages members, congregations, and affiliated institutions to learn more about

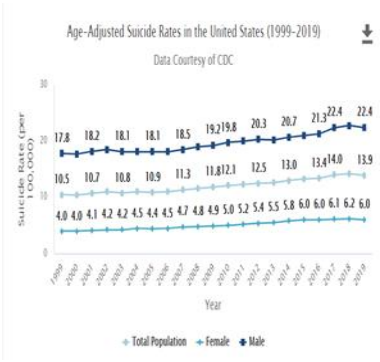
suicide and its prevention in their communities, to ask what they can do, and to work with others to prevent suicide.

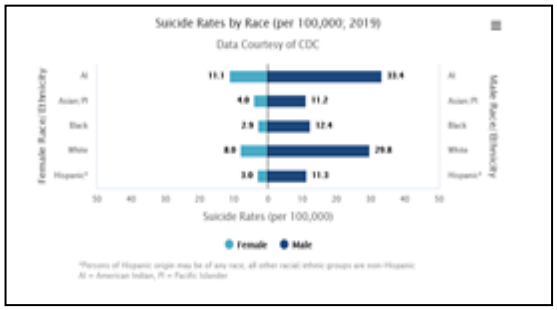
Becoming Aware

Suicide occurs in all social groups. It occurs among young, middle-aged, and older people; men and women; straight and LGBTQIA+; people who are rich, middle class, or poor; all ethnic and religious groups; married and single people; the employed and unemployed; and the healthy and the sick.

Yet statistics indicate that suicide is more prevalent among some groups than others. The following illustrations are not comprehensive but intended to challenge common misunderstanding.[9]

- The accompanying graph indicate statistics broken out by male and female.[10]
- The annual prevalence of serious thoughts of suicide, by U.S. demographic group, are: 4.8% of all adults, 11.8% of young adults aged 18-25, 18.8% of high school students, and 46.8% of lesbian, gay, and bisexual high school students.[11]
- Among adults aged 18 and older, those who report being of multiple (two or more) races (1.5%) have the highest prevalence of suicide attempts and report the highest prevalence of suicidal thoughts (6.9%).[12]
- In 2019, suicide rates were highest for American Indian, non-Hispanic males (33.4 per 100,000), followed by white, non-Hispanic males (29.8 per 100,000), as indicated by the accompanying graph.[13]
- In 2019, firearms accounted for a little over half (50.4%) of all suicides.[14] People living in a household with a firearm are almost five times more likely to die by suicide than people who live in gun-free homes.[15]





There simply is no *one* cause for suicide, yet researchers tell us that suicidal behavior can be associated with a number of *risk factors* that occur in combination. Examples include the following:[16]

- Clinical depression and other mental illnesses. The National Alliance on Mental Illness states that 46% of all people who die by suicide have been diagnosed with a mental health condition and 90% have shown symptoms of a mental health condition.[17]
- Alcohol and substance abuse. Alcoholism is a factor in 30% of all suicides. In 2019, 18.4% of U.S. adults with mental illness also experienced a substance use disorder."[18]
- Significant adverse life stresses when their convergence overwhelms one's ability to cope. Examples include a family crisis such as death or divorce; loss of one's livelihood to a rural economic crisis or business downsizing; chronic, acute, or terminal illness; or the effects of a natural or social disaster.
- Adverse life experiences of social origin. These include social oppressions (racism, sexism, heterosexism, classism, able-ism) and are especially acute after multiple micro-aggressions and/or marginalization among youth (Adverse Childhood Experiences, ACEs).[19]

- Familial factors. These include a family history of suicide, mental illness, substance abuse, violence, or sexual abuse.
- Repeated exposure to suicidal behavior of others. Suicides among young people sometimes occur in clusters and may even become an epidemic. Young people are particularly susceptible to imitating behavior, which may lead to unintended suicide.[20]
- Other common risk factors include prior suicide attempts, easy access to firearms, or barriers to accessing mental health treatment.

Looking at Attitudes

Certain social attitudes present obstacles to suicide prevention. One such set of beliefs says that nothing can be done. "If it's going to happen, it will." "It's not worth trying to help, because these people have such huge problems that nothing can be done." "Suicide has been around forever; we're not going to change that fact." "Let them alone. If they want to kill themselves, that's their business."

Punitive attitudes form another obstacle to suicide prevention. These attitudes are eager to punish suicidal behavior and often blame the living for suicidal deaths. They create an environment in which suicidal behavior is concealed and people with suicidal thoughts are reluctant to talk. Punitive attitudes are a carryover from the time when suicide was considered a crime and an unpardonable sin, and when those who completed suicide were denied Christian burial.

The failure to understand mental health problems such as depression also obstructs suicide prevention. Some misguided attitudes view serious depression as a character deficit, a human weakness, or a rare, untreatable, and permanent condition. These attitudes convey to depressed people that they should "tough it out" or be embarrassed or ashamed by how they feel.

In truth, clinical depression is a disease involving changes in brain chemistry. It is one of the most common diseases and can happen to people who have no apparent reason to "be depressed." Although clinical depression often goes untreated because it is not recognized, people with depression and suicidal thoughts can be helped through effective treatments, especially the combination of medication and therapy. Suicidal behaviors are not inevitable outcomes of depression.[21]

Experts also speak of common false understandings that stand in the way of suicide prevention:

- *Falsehood*: People who talk about suicide rarely actually complete suicide; they are just wanting attention and should be challenged in order to "call their bluff." *The truth is* that people who talk about suicide are serious and may be giving a clue or warning of their intentions. They should not be challenged or invalidated but given assistance in obtaining professional help.
- *Falsehood*: A person who has made a serious suicide attempt is unlikely to make another. *The truth is* that people who have made prior attempts are often at greater risk for dying by suicide.[22] A suicide attempt is a cry for help and a warning that something is terribly wrong and should be taken with utmost seriousness.
- *Falsehood*: The suicidal person wants to die and feels there is no turning back. *The truth is* that suicidal people often feel ambivalent about dying. They often go through a long process in which they try various ways to reduce their profound emotional pain. The balance between their contradictory desires to live and to die shifts back and forth, even up to the time of taking their life.
- *Falsehood*: Most people who take their life have made a careful, well-considered, rational decision. *The truth is* that people considering suicide often have "tunnel vision"—in their

unbearable pain they are blind to available alternatives. Frequently, the suicide act is impulsive. When their suffering and pain are reduced, most will choose to live.

- *Falsehood*: Asking about suicidal feelings will cause one to attempt suicide. *The truth is* that asking a person about suicidal feelings provides an opportunity to get help that may save a life. The listener should ask if the person has formulated a plan and has access to the means to carry it out. If the intent or plan and its means are there, the suicidal person should not be left alone but should be helped to get treatment immediately. (See Immediate crisis resources at end of Helpcard section.)

A Suicide Prevention Helpcard

If someone you know:

- Threatens suicide …
- Talks or writes about having no reason to live, feeling trapped, of being in unbearable pain …
- Appears depressed, sad, withdrawn, hopeless …
- Shows significant changes in behavior, appearance, mood (from being "normal" to being depressed, or the reverse) …
- Abuses drugs, alcohol …
- Deliberately injures themself …
- Says they will not be missed if gone …
- Gives away treasured belongings ...

You can help:

- Stay calm and listen.
- Take threats seriously and ask questions even if the person pushes away.
- Let them talk about their feelings.
- Be accepting—do not judge.
- Ask directly: "Have you been thinking about suicide?"
- Ask how intense and frequent these thoughts are.
- Ask if they have a plan.
- Ask if they have a means to carry out the plan.
- Remove any access to means.
- Don't swear secrecy—tell someone.
- Assure the person that getting help is OK and necessary.
- Seek their cooperation: "Let's keep you safe for now until you're able to see someone."

You cannot do it alone, but accompany the person as they:

- Visit a hospital emergency room.
- Seek mental health services.
- See an understanding friend, family member, or relative.
- Seek a teacher, counselor, family doctor, or member of the clergy as a first contact.
- Call a local or national crisis line.

Immediate crisis resources:

- The National Suicide Prevention Lifeline is 800-273-8255 (available 24 hours, also available for Spanish and the hearing-impaired).

- You can also access the Crisis Text Line by texting HELLO to 741741 or through an online chat at www.suicidepreventionlifeline.org.
- Dial 988 for emergency assistance from the National Crisis Helpline.[23]

Receiving and Giving Help

"The Church," Martin Luther once wrote, "is the inn and the infirmary for those who are sick and in need of being made well."[24] Luther's image of the church as a hospital reminds us of who we are—a community of vulnerable people in need of help; we live by the hope of the gospel and are a community of healing. At the same time vulnerable and healed, we are freed for a life of receiving and giving help. In the mutual bearing of burdens, we learn to be people who are willing to ask for healing and to provide it.

If you are a person who experiences suicidal thoughts you should know that our church community expects, prays, and pleads for you to reach out for help. Talk to someone. Don't bear your hidden pain by yourself. The notion is all too common that you should tough it out and "go it alone." Much of U.S. culture teaches that we are not supposed to be vulnerable. When we are hurting, it teaches that we should conceal it and handle things on our own. In the church, however, we admit that we all share the "need of being made well." There is no shame in having suicidal thoughts or asking for help. Indeed, when life's difficulties and disappointments threaten to overwhelm the desire to live, you are urged and invited to talk with trusted others and draw upon their strength.

By the same token, when a loved one talks to us of suicide or we sense that something is seriously amiss, we are called to be our sibling's keeper. The experience may be frightening, and we may want to deny or minimize the suicidal communication. We may want to shy away because we feel unprepared to help someone with suicidal thoughts or think we may make matters worse. Yet our responsibility is to listen, encourage the person to talk, and find them appropriate help.[25] Beyond the crisis situation, we will want that person to hear the healing comfort of the gospel and receive the care of the congregation. That care might, for example, involve creating an ongoing support network for the person and their family or training members in how to provide mental health first aid.

Pastors have unique opportunities to minister with suicidal people, in part because many people are more willing to approach clergy than other caregivers. Chaplains in hospitals and nursing homes, colleges and universities, the military, and prisons, as well as counselors in church agencies, are called upon to counsel people experiencing suicidal thoughts. Besides safety, the primary concern is to explore the suffering that motivates the person's thoughts and behavior and to comfort the person in their anguish.

Drawing upon pastoral wisdom, pastors may seek to discern to what extent the person's suffering is spiritual or has other sources. They will refer (and often accompany) suicidal people to professional health care and mental health providers for other forms of intervention and assistance. The pastoral response will bring God's word to bear on the situation with compassion, competence, and willingness to collaborate with other care providers.

When a suicide does occur, congregations and pastors minister to the bereaved and deceased through Christian burial and loving support. Funerals are not occasions to condemn or idealize an act of suicide. Rather, they are times to proclaim that suicide and death itself do not place one beyond the communion of saints. Because of Christ's death and resurrection for us, we entrust a troubled person to God's love

and mercy with the promise that "whether we live or whether we die, we are the Lord's" (Romans 14:8). Pastors and congregational leaders need to offer intentional and sensitive care—best practices[26]—for the congregation, friends, family, and loved ones of the deceased for some time. Part of that care is to encourage efforts to become part of a support group for survivors.[27]

Preparing to act for prevention

Suicide prevention is broader than responding to a crisis situation. Prevention efforts aim to reduce or reverse risk factors and to enhance protective factors before vulnerable people reach the point of danger. They often combine with efforts to prevent drug and alcohol abuse as well as violence.[28] Proactive efforts include:

- Administering effective and appropriate clinical care for mental, physical, and substance-abuse disorders.
- Providing easy access to a variety of clinical interventions and support for those seeking help.
- Restricting access to highly lethal methods of suicide.
- Developing family and community support groups.
- Seeking support from ongoing medical and mental health care relationships.
- Learning skills in problem-solving, conflict resolution, and de-escalating disputes.
- Teaching cultural and religious beliefs that discourage suicide and support self-preservation instincts.
- Training others how to help someone.[29]

What more can we do in our congregations and communities to prevent suicide? The following ideas are intended to stimulate discussion, reflection, and action:

Let us first recognize that the day-to-day preaching, teaching, and living of the Christian faith in congregations contribute to suicide prevention in indirect yet significant ways. In the community of the baptized, we come to know that we belong to God and to one another. There we give thanks to God for life and for our new life in Christ, and we are empowered to persevere during adversities and to hope in God when all else fails. We learn that human life is a sacred trust from God and that "deliberately destroying life created in the image of God is contrary to our Christian conscience."[30] We are equipped to empathize with others in their suffering and joy and are prepared to act for their well-being. We are given a reason to live, forgiveness to start anew, and confidence that neither life nor death can separate us from "the love of God in Christ Jesus our Lord" (Romans 8: 38). How, we might ask, do we do such ministry better?

How can your congregation find ways to learn about and talk about suicide prevention? When discussing love for others in confirmation classes or in adult education, could we talk about what to do if a friend hints at suicide? How does our congregation ensure that all members are known and none is invisible? How do we become more attentive to changes in a person's participation that may indicate personal distress or depression? How do we strengthen the bonds of community with people going through stressful periods in their lives and with older people living alone so they do not feel isolated and abandoned? Might we begin or further develop congregational health ministries, such as a parish nurse program or Stephen Ministry?[31]

How do we honor the vocations of members who are social workers, psychologists, doctors, nurses, counselors, and other caregivers, and who often work with people contemplating suicide? How do we find ways to assure anyone caring for or helping someone with suicidal thoughts that they are not

responsible when "saving a life" does not happen? We also can draw upon wisdom from these caregivers, and upon survivors and advocates for suicide prevention, to educate other members about suicide. How can these become part of our congregational life?

What in our community, we should ask, are the cultural and social dynamics that lead to isolation and hopelessness? How do we address them? What are the resources in our community to respond to suicidal behavior? Do members know how to access them? Can we join with other churches and community groups to ensure that adequate treatment resources are available? What about our schools? Is suicide prevention part of their programs that focus on mental health, substance abuse, aggressive behavior, and coping skills? Are there peer-counseling or ministry programs in our schools and congregations?[32]

For decades, over half of U.S. suicide deaths involved firearms. Up to 70% of military and veteran suicide deaths are due to self-inflicted firearm injuries. Often, gun-related deaths in homes with firearms involve someone other than the gun owner. [33] Can we ask whether our homes are really safer with guns in them? Congregations also can be a part of community efforts to improve firearm safety practices, such as providing information on safely storing firearms inside and outside the home.[34] Have these concerns been approached in our congregations?

How do we counter the stigma often associated with mental illness? Should not the crucial role of untreated depression in suicidal behavior be an important consideration in debates on insurance coverage for mental illnesses? What might we do as citizens to promote accessible and affordable mental health services to enable all people at risk for suicide to obtain needed substance-abuse treatment services?[35]

We can encourage, use, and learn from suicide prevention programs in our social ministry organizations and at our colleges and universities. What, we should ask, could our church-related day schools do to prevent suicide? How are our seminaries preparing pastors to minister with people who have attempted suicide or harbor serious suicidal thoughts? Should suicide prevention be part of continuing education for rostered people? Could we create opportunities at events for youth, women, and men, and in our camping and retreat programs, to learn about suicide and its prevention?

Conclusion

In adopting this message on behalf of the whole ELCA, the Church Council urges the churchwide office and the synods to support members, congregations, and affiliated institutions in their efforts to prevent suicide. It directs the governing bodies of churchwide units to evaluate their programs in light of this message. It calls upon this church's educational and advocacy programs to make suicide prevention an important concern in their ministries. It directs the Ecumenical and Inter-Religious Relations team in the Office of the Presiding Bishop to share this message with churches with whom we are in full communion and to express our willingness to work with them to prevent suicide. The Church Council affirms and encourages all who work toward a comprehensive national strategy for suicide prevention.

Often, as members of this church, we go in peace from worship to serve the Lord in the trials and joys of the coming days, hearing words such as this benediction: "The Lord bless you and keep you. The Lord make his face shine on you and be gracious to you. The Lord look upon you with favor and give you peace." "Amen," we reply. We are not alone, abandoned, or without hope. The Lord's name is "'Emmanuel,' which means, 'God is with us'" (Matthew 1:23).

Resources

National Suicide Prevention Organizations (as of 2021)

- **American Association of Suicidology (AAS)** | Phone: 202-237-2280 | Email: info@suicidology.org | Website: www.suicidology.org
- **American Foundation for Suicide Prevention (AFSP)** | Phone: 888-333-2377 (toll-free) | Phone: 212-363-3500 | Email: info@asfp.org | Website: www.afsp.org
- **Depression and Bipolar Support Alliance** | Phone: 800-826-3632 (toll-free) | Fax: 312-642-7243 | Website: www.dbsalliance.org
- **National Action Alliance for Suicide Prevention** | Phone: 202-572-3737 | Website: theactionalliance.org/about-us
- **National Alliance for the Mentally Ill (NAMI)** | Phone: 800-950-6264 (toll-free) | Phone: 703-524-7600 | Website: www.nami.org
- **National Center for Injury Prevention and Control** | Division of Violence Prevention, Centers for Disease Control and Prevention | Phone: 770-488-4362 | Email: ohcinfo@cdc.gov | Website: www.cdc.gov/ncipc/ncipchm.htm
- **National Council on Suicide Prevention** | Phone: 1-800-273-TALK (8255)| Website: www.thencsp.org
- **National Institute of Mental Health (NIMH)** | Phone: 301-443-4513 | Email: nimhinfo@nih.gov | Website: www.nimh.nih.gov
- **National Mental Health Association (NMHA)** | Phone: 800-969-NMHA (toll-free) | Phone: 703-684-7722 | Website: www.nmha.org
- **Suicide Awareness Voices of Education (SAVE)** | Email: save@save.org | Website: www.save.org
- **Suicide Prevention Ministry** | Website: suicidepreventionministry.org
- **Yellow Ribbon Suicide Prevention Program** | Phone: 303-429-3530 | Email: ask4help@yellowribbon.org | Website: www.yellowribbon.org
- Miscellaneous websites with useful links: **Suicide Prevention Resource Center**, resources by state (www.sprc.org/states); **American Foundation for Suicide Prevention** resources for underrepresented communities (afsp.org/mental-health-resources-for-underrepresented-communities) and LGBTQ suicide prevention (afsp.org/stronger-communities-lgbtq-suicide-prevention); **Lutheran Services in America** (www.lutheranservices.org).

Note: Most state health or disease control and prevention departments also have resources on suicide prevention and mental health.

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Endnotes

[1] In 2019 suicide deaths numbered 47,511. See "Leading Cause of Death in the United States," Centers for Disease Control and Prevention, accessed Sept. 28, 2021, https://www.cdc.gov/nchs/nvss/leading-causes-of-death.htm

[2] See Pamela L. Owens, Kimberly W. McDermott, Rachel N. Lipari, et al., "Emergency Department Visits Related to Suicide Ideation or Suicide Attempt, 2008-2017," Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, www.hcup-us.ahrq.gov/reports/statbriefs/sb263-Suicide-ED-Visits-2008-2017.pdf. From 1999 to 2019, the national suicide rate increased 32%—from 10.5 to 13.9 per 100,000 individuals, with an average of 130 suicides each day in 2019. See Holly Hedegaard, Sally C. Curtin, and Margaret Warner, "Suicide Mortality in the United States, 1999-2019," National Center for Health Statistics Data Brief, no. 398 (DOI: dx.doi.org/10.15620/cdc:101761). It should be noted that suicide deaths sometimes go unreported for reasons of concealment and insurance and that some accidents are camouflaged suicides.

[3] "Leading causes…" https://www.cdc.gov/nchs/nvss/leading-causes-of-death.htm

[4] William Feigelman, Julie Cerel, John L. McIntosh, et al., "Suicide Exposures and Bereavement Among American Adults: Evidence From the 2016 General Social Survey," *Journal of Affective Disorders* (February 2018): 1-6 (DOI: 10.1016/j.jad.2017.09.056).

[5] See "Key Substance Use and Mental Health Indicators in the United States: Results From the 2019 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, HHS publication no. PEP20-07-01-001, NSDUH Series H-55, accessed Aug. 25, 2021, www.samhsa.gov/data.

[6] See Asha Z. Ivey-Stephenson, Zewditu Demissie, Alexander E. Crosby, et al., "Suicidal Ideation and Behaviors Among High School Students—Youth Risk Behavior Survey, United States, 2019," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, August 2020, www.cdc.gov/mmwr/volumes/69/su/su6901a6.htm?s_cid=su6901a6_w (DOI: dx.doi.org/10.15585/mmwr.su6901a6). It should be added that many of these individuals go untreated due to stigma, lack of social support, and disparities in access to mental health care.

[7] This is true in both governmental and private sectors. The U.S. Congress declared suicide prevention a national priority in the late 1990s (U.S. Senate Resolution #84, May 6, 1997, and U.S. House of Representatives Resolution #212, Oct. 9, 1998). Along with others, ELCA members Elsie and Jerry Weyrauch, who lost their daughter Terri to suicide, led grassroots efforts through the Suicide Prevention Advocacy Network USA (SPAN USA—which has since merged with the American Foundation for Suicide Prevention) to create congressional and executive branch awareness of suicide (obamawhitehouse.archives.gov/champions/suicide-prevention/the-suicide-prevention-action-network-%28span-usa%29). Along with other advocacy groups, SPAN USA's efforts helped spur the first "Surgeon General's Call to Action to Prevent Suicide," in 1999

(sprc.org/sites/default/files/migrate/library/surgeoncall.pdf). It also helped frame the first U.S. National Suicide Prevention Strategy in 2001 (pubmed.ncbi.nlm.nih.gov/20669520/).
In 2021, an updated "Surgeon General's Call to Action" focused on implementing what we know about suicide prevention (www.hhs.gov/sites/default/files/sprc-call-to-action.pdf). The National Strategy also was updated in 2012 (www.ncbi.nlm.nih.gov/pubmed/23136686).

[8] Psychotherapies aimed at addressing suicidal thoughts and behaviors can reduce reattempts and even brief interventions that support continuity of care and organize support for the individual are beneficial. See "Brief Suicide Intervention Preventions in Acute Care Settings May Reduce Subsequent Suicide Attempts," National Institute of Mental Health, Sept. 16, 2020, www.nimh.nih.gov/news/research-highlights/2020/brief-suicide-prevention-interventions-in-acute-care-settings-may-reduce-subsequent-suicide-attempts. Further, research is showing that interventions that build healthier family and peer relationships, as well as efforts that support social connections to schools and other community organizations in youth, reduce the risk for suicidal thoughts and behaviors in young adulthood. See "Preventing Suicide: A Technical Package of Policy, Programs, and Practices," Centers for Disease Control and Prevention, www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

[9] These statistics come from recent surgeons general's reports and accompanying documents as well as from suicide prevention organizations listed at the end of this message. Such information relies on official United States data. Contact or visit the web pages of these organizations for updated data.

[10] Between 1999 and 2019, suicide rates have trended upward for both men and women (10.5 to 13.9 per 100,000 people). Death by suicide has been consistently higher among men (17.9-22.4 per 100,000) than women (4.0-6.0 per 100,000).

[11] See "Suicide," National Institutes of Mental Health, accessed June 30, 2021, www.nimh.nih.gov/health/statistics/suicide.

[12] Ibid.

[13] Ibid.

[14] See the Web-based Injury Statistics Query and Reporting System, http://www.cdc.gov/injury/wisqars/index.html.

[15] See "What the Data Says About Gun Deaths in the U.S.," Pew Research Center, Aug. 16, 2019, www.pewresearch.org/fact-tank/2019/08/16/what-the-data-says-about-gun-deaths-in-the-u-s/.

[16] This summary of risk factors draws especially from research findings of the National Institute of Mental Health and American Foundation for Suicide Prevention. For more information on risk factors, contact or visit the websites of these and other organizations listed at the end of this message.

[17] See Deborah M. Stone, Thomas R. Simon, Katherine A. Fowler, et al., "Vital Signs: Trends in State Suicide Rates—United States, 1999-2016 and Circumstances Contributing to Suicide—27 States," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, June 8, 2018 (DOI: dx.doi.org/10.15585/mmwr.mm6722a1).

[18] Ibid. The average delay between onset of mental illness symptoms and treatment is 11 years.

[19] See "Adverse Childhood Experiences, Overdose, and Suicide," Centers for Disease Control and Prevention, www.cdc.gov/injury/priority/index.html.

[20] See Madelyn S. Gould and Alison M. Lake, "The Contagion of Suicidal Behavior," National Center for Biotechnology Information, www.ncbi.nlm.nih.gov/books/NBK207262/.

[21] For more information concerning medical depression, visit the websites of the organizations listed at the end of this message.

[22] Research indicates that repeated attempts reduce the fear of dying and increase tolerance for pain, resulting in greater likelihood of successive attempts. See Kimberly A. Van Orden, Tracy K. Witte, Kelly C. Cukrowicz, et al., "The Interpersonal Theory of Suicide," *Psychological Review* (April 2010): 575-600.

[23] The Federal Communications Commission (FCC) designated 988 as the new three-digit number for the National Suicide Prevention Lifeline on July 16, 2020. The National Suicide Hotline Designation Act of 2020 was signed into law on Oct. 17, 2020, requiring phone service providers to transition to 988. The National Suicide Prevention Lifeline took effect on July 16, 2022. A national transition period is underway toward complete national activation.

[24] See Martin Luther, "Lectures on Romans," *Luther's Works* (*LW*), vol. 25, ed. Hilton C. Oswald (St. Louis: Concordia Publishing House, 1972): 263.

[25] A handy reference can be created from the "helpcard" on page TBD. Congregations are encouraged to copy this card for use as a bulletin insert or to post it on a bulletin board.

[26] For best practices for messaging about suicide prevention in the aftermath of a suicide death in the community, see Timothy Doty and Sally Spencer-Thomas, "The Role of Faith Communities in Suicide Prevention: A Guidebook for Faith Leaders," sprc.org/sites/default/files/migrate/library/2010FaithLeaderGuideBookweb.pdf, or David Litts, "After a Suicide: Recommendations for Religious Practices & Other Public Memorial Observances," sprc.org/sites/default/files/migrate/library/aftersuicide.pdf. These resources include recommendations for religious services and other public memorial observances.

[27] The American Foundation for Suicide Prevention (AFSP) maintains a current national directory of survivor support groups (afsp.org/find-a-support-group). "Survivor" refers to anyone whose loved ones have completed suicide. Detailing the church's vital ministry for survivors lies beyond the scope of this message. However, a few helpful resources include: Corrine Chilstrom's *Andrew, You Died Too Soon: A Family Experience of Grieving and Living Again* (Minneapolis: Augsburg Fortress, 1993) and Iris Bolton and Curtis Mitchell's *My Son … My Son … A Guide to Healing After Death, Loss, or Suicide* (Atlanta: Bolton Press, 1996).

[28] See the ELCA social message "Community Violence" (Chicago: Evangelical Lutheran Church in America, 1994), www.elca.org/socialmessages. Other acts of violence are sometimes connected with the self-violence of suicide. The message addresses our society's "atmosphere of violence," of which suicide is part.

[29] For instance, the national coalition of Suicide Prevention Ministry offers trainings to congregations, both in person and virtual (www.suicidepreventionministry.org).

[30] See the ELCA social message "End-of-life Decisions" (Chicago: Evangelical Lutheran Church in America, 1992), 4, www.elca.org/socialmessages. The message summarizes a Christian perspective on death and dying (page 2) and offers guidance for difficult decisions at the end of life.

[31] Suicide Prevention Ministry has developed a program model for congregations; visit www.suicidepreventionministry.org. Information on Stephen Ministries can be found at www.stephenministries.com, or phone 312-428-2600.

[32] For information on peer ministry resources, adult training, youth retreats, camps, and support, email the Ministry Training Leadership Center (www.peerministry.org) at peermin@peerministry.org.

[33] See "Learn the Facts," American Foundation for Suicide Prevention, www.afsp.org.

[34] Faith communities can become aware of local laws and resources for temporary storage of firearms due to suicide risk, as well as risk related to substance use and domestic violence (these three problems often co-occur). See the community page at Prevent Firearms Suicide, preventfirearmsuicide.efsgv.org/interventions/community/. Faith community leaders should also be aware of ERPO (Extreme Risk Protection Order) laws; see "Extreme Risk Protection Orders," Giffords Law Center to Prevent Gun Violence, giffords.org/lawcenter/gun-laws/policy-areas/who-can-have-a-gun/extreme-risk-protection-orders/.

[35] See the ELCA social statement *Caring for Health: Our Shared Endeavor* (Chicago: Evangelical Lutheran Church in America, 2003), www.elca.org/socialstatements.