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ORIGINAL PAPER

Perspectives on Suicide Prevention Amongst Members of Christian Faith-Based Organizations

Renée Bazley[1] · **Kenneth Pakenham**[1] · **Bernadette Watson**[1]

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Abstract
The purpose of this study was to explore perspectives on suicide prevention held by members of Christian faith-based organizations (FBOs). Eight focus groups were facilitated, and five major themes were identified: perceptions of responsibility, connection to suicidal persons, equipping for suicide prevention, collaboration with professional services, and hope. Overall, Christian FBO members considered suicide prevention to be an important demonstration of their faith and values. They perceived themselves to be currently adding to suicide prevention efforts through spiritual practices and interpersonal skills, but regarded these as insufficient if considered stand-alone responses. They recognized the receipt of suicide prevention training and collaboration with professional services as necessary to be fittingly engaged as a resource for suicide prevention.

Keywords Community · Qualitative research · Suicide · Prevention · Faith-based organizations

With approximately 1 million deaths to suicide occurring annually, a comprehensive, multi-sectoral approach to suicide prevention is required (WHO, 2014). Such a broadening of ownership for suicide prevention allows for previously overlooked community groups to be recruited in suicide prevention efforts. Religious and faith-based organizations (FBOs) are one such group.

Multiple literature reviews suggest that religion and spirituality generally confer a protective factor for suicide (Colucci and Martin 2008; Gearing and Lizardi 2009; Koenig et al. 2001; Stack 1983, 2000; Stack and Kposawa 2011). For example, suicide rates are lower in religious countries and counties (Brenault, 1993; Dervic et al. 2004; Pescosolido and Georgianna 1989; Stack 1983). Religious service attendance has been shown to have a protective effect on suicide amongst US community samples (Kleiman and Liu 2013; VanderWeele et al. 2016). Intrinsic religiosity also serves as a buffer against suicidal behavior amongst mentally ill persons (Caribé et al. 2015; Mosqueiro et al. 2015).

FBOs are significantly heterogeneous, both across and within religions (James 2009). Because of this, examining a single religion in isolation will improve outcome reliability. Moreover, whilst not negating the contribution of other religions, it is the work of Christian FBOs that has been most documented (Clarke and Ware 2015). Christian FBOs are defined in this article as any church denomination, congregation, or place of worship that subscribes to Christian beliefs (Nordtvedt and Chapman 2011).

The Christian position on the morality of suicide is well aired within theological literature (e.g., Aquinas 2010; Augustine 2014; Dublin and Bunzel 1933). However, morality has not impinged upon the willingness of Christians to respond compassionately to other morally contentious issues, such as substance abuse (Brown et al. 2006), incarceration (Johnson 2006), and AIDS (Byamugisha et al. 2002). Perhaps then, moral objection towards suicide need not preclude Christians from contributing to community suicide prevention. Indeed, within Christian literature, clinicians, academics, pastors, and survivors have written evidence-based guides for helping Christian leaders to empathically and practically respond to suicide ideators, attempters, and those beavered by suicide (Biebel and Foster 2009; Mason 2014; Townsend and Bagby 2006). Resources for responding to the stigma of suicide and finding meaning in the aftermath have also been published (Clark 1998; Myers and Fine 2007). Some authors have deliberately approached how to reconcile a Christian faith with the experience of suicide, primarily through the lens of hope (Hunt 2013; Powlison 2011). Lifeline, Australia's foremost national

✉ Renée Bazley
renee.bazley@uqconnect.edu.au

[1] School of Psychology, University of Queensland, Brisbane, Australia

charity providing 24 h access to crisis response care for suicidal persons, was founded by a Christian Reverend and is based on the Christian doctrine of "loving one's neighbor", expressed through effective responding to those at risk of suicide. Australian Christian FBOs such as The Wesley Mission, Anglicare and The Salvation Army all have specific suicide prevention services. Similar services with Christian values exist in America (e.g., Christian Suicide Prevention) and the UK and Ireland (e.g. Samaritans). Marion and Range (2003) identified a collaborative Christian problem-solving style as a buffer for suicidal ideation amongst their public sample of African American women.

Only one experimental study has directly examined the relationship between Christian beliefs and perspectives regarding suicide (Domino and Miller 1992). Correlational findings showed that Christians who scored higher on religiosity tended to perceive suicide as evil, stemming from a lack of religious influence, and a contravention of an individual's prerogative. Participants also gave psychological explanations for suicide, linking it to mental illness, aggression, and abnormal behavior.

In the absence of limited contemporary, qualitative data on Christians' engagement with suicide prevention, this study sought to explore the following research questions: How do Christians engage with the topic of suicide prevention? What role (if any) do Christians perceive for themselves and their communities in responding to suicide?

Methods and Materials

Design

This qualitative study used focus groups to explore Christian perceptions to suicide prevention. Previous research has found focus groups to be well suited for inquiry into various aspects of suicide prevention (e.g., Niner et al. 2009; Poma et al. 2011). Eight focus groups were conducted with 4–8 participants in each group. Participants responded to open-ended questions (Appendix) designed to capture Christian perceptions of suicide prevention. These questions were piloted on four participants (two females and two males, age range 19–55 years) and modifications were made based on their feedback. The questions oriented and refocused the discussion when it became discursive: they were not a stringent guide (Merriam 2009). This study was approved by the institutional ethics committee and informed consent provided by all participants.

Participants

The participants were individuals who resided in the Sunshine Coast, Australia, identified with the Christian faith and were currently attending a Christian church. Recruitment was conducted using convenience sampling. The first author made email contact with the pastors of five churches within the Sunshine Coast region with whom she had an established connection. The decision to use convenience sampling was driven by prior awareness that the churches represented a broad range of sociodemographic variance. At the consent of the pastor, the study was presented to the congregation and interested persons were invited to sign up. All pastors consented for their congregation to take part in the study. Focus group compositions were arranged based on peoples' indicated availability. Group members were notified of their allocation via telephone. This procedure was followed in an iterative fashion per church. In this way, the number of focus groups was driven by the study progression. Data collection was ceased when the collection of new data did not add anything unique to existing data, as per the qualitative research principle of saturation (Glaser & Stauss, 1999). Data saturation was reached with eight focus groups and a total of 47 participants. This meant that Christians from the fifth church were not recruited. Age was the only exclusionary criteria (minimum of 18 years required).

Procedure

Focus groups were conducted based on established focus group protocol (Stewart and Shamdasani 2014). The first author was trained in focus group methodology and received ongoing consultation from an advisor with expertise in qualitative techniques. The focus groups were conducted in September and October 2013. All focus groups were held on the Sunshine Coast, Queensland, Australia. Situating the groups in a church was deliberate to provide contextual cues promoting discussion and exchange of ideas (Braun and Clarke 2013). On arrival at the group, participants received a nametag and provided informed consent. The first author introduced group discussion by orienting participants to her role as a facilitator, and broadly explaining the research intent. All participants contributed to group discussion. Focus groups terminated when group discussion had exhausted all relevant topics and participants had indicated they had no further comments to make. A brief summary of the topics discussed was provided along with opportunity for debrief. Participants also received a handout listing relevant suicide prevention resources.

Data Analysis

The focus groups were audio recorded and transcribed verbatim. The first author coded the transcripts via data immersion, which involved continuous engagement with transcripts and recordings to establish the meaning behind words and phrases. The codes were then categorized into

themes according to their aptitude to capture something common across the dataset. These themes were subjected to inductive thematic analysis as described in Braun and Clarke (2013). Inductive thematic analysis promotes the derivation of data from analysis rather than existing theory. The thematic analysis undertaken employed an iterative process of review, modification, and reappraisal occurring immediately post of the focus groups (November 2013) and 16 months later (March 2015) to further the iteration of the data. Consultation with a qualitative researcher external to the study was sought for confirmation of the analysis, and necessary modifications were made. The consultant and the other authors agreed that the analysis was data-driven and appropriately reflective of the data. Utmost effort was made to promote a reflexive research process during all stages of data collection.

When quotes are provided, participant anonymity is preserved using pseudonyms.

Results

Demographics

Participants' (n = 47) age range was 22–75 years. Of the total, 15 were male and 32 were female. All were currently attending a church on the Sunshine Coast, Queensland, Australia. Nine participants (19%) reported that they had been suicidal at a point in their life; 14 (30%) reported that they had family members or friends who were currently or previously suicidal. 13 participants (28%) reported that they were working (21%), volunteering (4%), or studying (2%) in the field of mental health. Three participants (6%) indicated they had an official leadership role in their church.

Themes

Inductive thematic analysis of the eight focus groups identified five major themes, nine subthemes and 2–4 codes for each subtheme (Table 1).

Table 1 Themes, subthemes and codes from focus Group data exploring christian perceptions of suicide prevention

Themes and Subthemes	Codes
Responsibility	
Being the church	Wholly fulfilling the Christian role Lack of role fulfillment
Compassion	Compassion as early intervention Compassion constrained by self-focus Compassion having a positive impact
Prayer	Prayer as being spiritually combative Prayer increasing sensitivity to God and others Prayer as necessary but insufficient
Connection	
Real relationship	Listening as authentic engagement Care as an important intervention
Barriers to connection	Interpersonal differences Avoidance of connection as wrong Unhelpful problem-solving orientation
Equipping	
The need for equipping	Unpreparedness for crises Unpreparedness for relationships Being unequipped magnifying distressing emotions
The utility of training	Crisis management skills Interpersonal skills Readiness for combating suicide Gatekeeper scope
Collaboration	
Limits of lay Christian help	Threshold of help Not assuming sole responsibility
Partnering with professional services	Being a referral agency Working with existing structures Providing a community scaffold
Hope	Suicide prompted by hopelessness Hope preventing suicide Christians having hope because of God

Theme 1

Responsibility Participants indicated a number of ways in which they felt responsible for suicide prevention, captured in three subthemes: being the church (i.e. wholly fulfilling what it is to be a Christian), compassion (i.e. reaching out to suicidal persons), and prayer (i.e. intentional communication with God).

Being the Church Across the groups, participants often referred to themselves as "the church", explaining that churches are not buildings or institutions, but people who believe in Jesus Christ: thus, "the church" is simply Christians. Participants believed that part of fulfilling their role as Christians meant proactively responding to suicide. As Jenna put it, "in this situation (suicide), the responsibility on the church is to really be the church". This meant not just identifying with but also demonstrating their Christian faith. Examples of what this could look like in the context of suicide prevention included both character attributes (e.g. being inclusive, showing unconditional love) and practical activities (e.g. mentoring, running free community programs). Participants acknowledged existing efforts towards these outcomes but that overall, greater efforts were required. Further, participants indicated that their negligence to be the church had caused suicidal persons to bypass churches as appropriate avenues of help. Participants genuinely believed the church should be a place where suicidal people could receive help. They even suggested that their lack of role fulfillment was responsible for the occurrence of suicide, as worded by Andy: "it's actually a shame that so many suicides happen, because if the church, and I'm talking about the church as a whole, if they be the church, then that shouldn't have happened". Reproach for their irresponsibility towards being the church to date did not overshadow their sense of capacity towards positively impacting suicide prevention.

Compassion Compassion was regarded as an unquestionable responsibility of a Christian. Compassion meant recognizing and responding to the suffering of others. Participants described feeling grieved about people killing themselves and were ardent that compassion be shown towards suicidal persons. Significant discussion was given to the pragmatics for demonstrating compassion to suicidal persons. Participants listed multiple circumstances that could put someone at risk of suicide, and recognized that suicide prevention meant intervening early to prevent risk from increasing. As Elsa explained, "it starts way further, it starts with just being tired of life…we don't have to wait until they're almost down the road and on the edge before we do something". A need to intervene early was regarded as a priority. Participants believed that being actively compassionate to others' suffering would serve to buffer the progression of stressors to suicidal ideation, intent, and behavior, as Kate described, "we're the ones that have got this willingness, because God's given us a will to serve hurting people, and sometimes you have no idea the influence you have on people". The tendency to be excessively self-focused was highlighted as a constraint to this, as summarized by Chelsea, "it's our responsibility as Christians to come alongside these people and not be so caught up in your own world, in your own needs, that you don't see the needs of others". A genuine enthusiasm for showing compassion to suicidal persons was seen across the focus groups.

Prayer Participants described prayer as another element of their responsibility to prevent suicide. Prayer meant intentional communication with God, both individually and with other. What made prayer important for the issue of suicide was that it facilitated intercession (i.e. asking God to intervene in the lives of those who are suicidal). Candace described prayer as being spiritually combative: "I think there are a lot of people out there who we can intercede for because prayer is a form of spiritual warfare". Participants talked about the reality of evil, and its strong assignment towards suicidal persons. Prayer was regarded as a spiritual assault against evil. Caleb stated it this way; "it can break off, spiritually, stuff that's making them feel suicidal, like shame, guilt, condemnation..." Participants also talked about how prayer made them more attune to the Holy Spirit, which was considered to be God spiritually active in the world. This attunement was said to provide greater sensitivity to others and thus greater opportunity to identify persons at risk. Participants also regarded prayer as a normative but insufficient response. When recounting her experience of being told about someone's suicidal ideation, Siobhan explained it this way; "…I can pray for her but I don't know what else I can do". Other participants described a lack of knowledge for responding to suicidal persons beyond praying for them.

Theme 2

Connection Participants highlighted the importance of connection with suicidal persons, discussed as per two subthemes: real relationship (i.e. meaningful and authentic connection to suicidal persons) and barriers to connection.

Real Relationship Participants used the phrase "real relationship" to signify their conviction that connection to persons at risk of suicide needed to be interpersonally meaningful and authentic. Participants expressed a desire to show unconditional love to all persons, specifically those contemplating death, and felt that was best facilitated through real relationship with them. A real relationship involved being

present, an idea that participants consistently discussed. Listening not just for conversation but also for opportunity to detect undisclosed suicide thoughts or intent was regarded as essential to being present. Tamasyn described it in this way: "Listening to what they say is not about just letting the words flow over your ears, but really connecting with that person, and reading between the lines as to what they are saying". Listening was also regarded as protective. Participants regarded relationships as a common source of significance for people, and recognized that listening communicated significance, as Michael explained, "when you genuinely listen to someone it's such a powerful thing because a question is powerful; and when that person shares, you're actually saying to them you have value, you have worth, what you've experienced is important to me". Listening and caring were often paired in discussions. Care to participants meant the expression of companionship, being available, providing assistance, and linking into professional support as required. Participants suggested care as a method of intervening in the trajectory of suicidal thinking, with Carlos stating, "I think there's a lot of times that we could actually catch things before the go down there, just because of caring".

Barriers to Connection Participants discussed perceived barriers to connecting with suicidal persons. Many viewed suicide as something fearful and foreign, and therefore perceived difficulty relating to suicidal persons. Alizah expressed it in this way, "I think sometimes we find it difficult to deal with people who have had different experiences to us or who are different to us". Participants agreed that it was not essential to have personal experience with suicide in order to connect with suicidal persons. However, they recognized that a perception of difficulty relating to suicidal persons could cause them to avoid interactions with suicidal persons, something they considered to be harmful for suicidal persons, and unrepresentative of their Christian faith, as said Jude, "then we're just saying you don't matter to me, I don't really care and that's so wrong, as Christians that's so wrong". Participants also talked about unhelpful communication styles with those at risk of suicide. Lorelei expressed the need to problem-solve as such: "Us fix-it people tend to think we need to find an answer, whereas they may not be wanting an answer, they may just be wanting the journey to be smoother". Participants recognized that the perils of a need to problem-solve were two-pronged: misaligned advice that offends or harms, or the inhibition of a response of any kind. Both were regarded as unhelpful for forging genuine connection with suicidal persons.

Theme 3

Equipping Discussion about equipping, being the receipt of suicide prevention knowledge and skills, comprised two subthemes: the need for equipping, and the utility of training.

The Need for Equipping Participants indicated that they felt bereft of knowledge and skills regarding suicide. Awareness of the unexpected and confrontational aspects of suicide only increased participants' desire for equipping. Ainsley addressed this using the analogy of an armed robbery; "Have you ever been in a situation, standing in a bank queue or something, and thought, what would I do if a robber came in? How would I react?" The point made was that without training, participants lack preparedness to appropriately respond to suicide. This was important to participants because they valued the sanctity of life and wanted to be able to do what they could to prevent suicide. Others shared their apprehension about their current skills for responding to suicidal disclosure in specific relational contexts, such as Trent, who is a mentor to adolescent boys: "If they came to me and said, "this is going on", I don't know whether I'd have the tools to deal with it". Use of the term "tools" was common, and suggested that participants saw equipping as receiving a set of workable skills that could function to prevent suicide. Being unequipped was also perceived as magnifying the distressing emotions associated with suicide, with Eleanor's comment: "it makes me feel as if I'm drowning". Participants regarded equipping to prevent suicide as crucial for Christians and FBOs to contribute to community suicide prevention.

The Utility of Training Participants discussed how the prospect of training in suicide prevention skills would increase their capacity to manage suicide crisis situations. Notably, whilst they wanted crisis-management skills, they also wanted interpersonal skills, as explained by Josiah; "we need to know the right the right words to say at the right time and the sort of boundaries required. That will be empowering". Participants wanted to prioritize meaningful connection to suicidal persons. Participants also regarded the integration of secular models and Christian principles as essential for suicide prevention, as Mitch explained, "we need training in both the secular and the spiritual side of ways of dealing with this sort of thing. You don't send an army out without training." Reference to an "army" well captured participants' perspective that interested persons be armed with suicide prevention skills and ready to "attend the frontline" when required. Steven expounded on the benefits of this by foreseeing the reach of such training on a community scale: "then you've got all these little warriors out there in society, they would help, be able to stop…" Participants hypothesized that suicide prevention training in churches across communities would have a widespread preventative impact.

Theme 4

Collaboration Collaboration refers to FBOs working with relevant sectors and stakeholders to prevent suicide. Collaboration had two subthemes: limits of Christian lay help, and partnering with professional services.

Limits of Christian Lay Help Participants recognised that as non-professional helpers, they lacked specialist skills, resources and accountability to exclusively respond to suicide, particularly to cases of high risk. Participants described insight into their threshold of assistance, such as Rebekah, who said this of her experience of working with a suicidal adolescent; "when it got to a certain point, I felt out of my depth to be there for this girl. I knew she needed more specialist service". Whilst they wanted to be a resource for suicide prevention, participants were clear that they weren't seeking to substitute for professional services. Part of participants' eagerness to be equipped to prevent suicide meant gaining clarity around the limits to their personal help, enabling them to be effective in what they could do, as Madeline stated, "the bible says you don't have to plant the seed, let it grow, water it, and reap it …you're only part of the chain". To participants, preventing someone from suicide did not mean assuming sole responsibility for them.

Partnering with Professional Services Participants wanted to collaborate with professional services and stakeholders to prevent suicide. They saw this as essential to adequately addressing community suicide prevention. Participants regarded church communities as referral agencies, and wanted to be informed about appropriate professional services to direct suicidal persons towards timely and effective treatment. They also wanted their gatekeeper capacity to be recognised by stakeholders and to support the work of already existing national structures, as Kevin suggested: "working with existing programs—there's structures out there like Lifeline and Beyond Blue, if you could somehow tap into what they are doing and add churches to that…" The addition of churches to existing programs was not seeking to be at odds with or to supersede current suicide prevention strategies. Participants saw themselves as providing both spiritual (i.e. prayer and faith) and practical (i.e. gatekeeper responsibilities) counterparts to a suicide prevention campaign, but also as being uniquely positioned to strengthen the community through the continuation of social welfare programs, community events, and by being an accessible, inclusive, stable support network where people could experience, as Rosie specifically shared, "a sense of community to hold them whilst they make those life adjustments". Participants regarded themselves as providing interpersonal scaffolding for the suicidal person, with priorities of ongoing support, positive reinforcement and community involvement to encourage them to feel valued and purposeful. They wanted policymakers to see that churches were communities of people centralised around a belief system that prioritised people, not religious fundamentalism.

Theme 5

Hope This theme had no subthemes but rather three codes that reflected the meaning of hope to Christians in the context of suicide prevention. This was because the codes were inter-dependent and did not congregate within a theme, nor did they capture something over-arching in the data. These three codes were: suicide prompted by hopelessness, hope preventing suicide, and Christians having hope because of God. Hopelessness predicting suicide is well established within suicide literature (Abramson et al. 2000). Participants frequently discussed that hopelessness was a major cause of suicide. In response, participants wanted to offer hope to suicidal persons. Diana described such hope as having stabilizing, impermeable qualities, "we can be an anchor for them in their hopelessness". Participants described hope as being a core tenet of Christianity, and attributed their relationship to God as the reason they could offer hope. They regarded God to be the source of their hope, and testified that their confidence in their ability to provide hope to suicidal persons was because of this.

Summary and Integration of Themes

In summary, participants genuinely engaged with the topic of suicide prevention. Given their Christian faith and practice, they considered it to be a responsibility ascribed to them both individually and corporately (i.e., as per their involvement with an FBO). This responsibility appears to function as a motivation factor: the drive for them to utilize their personal and faith community resources to take action against suicide. Connection to suicidal persons serves as the process or interpersonal factor of suicide prevention that facilitates engagement with suicidal persons. Equipping is the training factor, being the need for skills and knowledge to be imparted to Christians to enable them to effectively respond to suicide. Collaboration is the global networking factor, encouraging alliance between FBOs and healthcare organizations as part of a multi-systemic approach to suicide prevention. Finally, hope is the binding factor, which sustains the Christian and the suicidal person and links both to God.

Therefore, in terms of a personal narrative, a sense of responsibility to others drives Christians to use their individual and community resources to show compassion and connect to those at risk of suicide in the community. Skills and knowledge regarding suicide risk assessment

and interpersonal engagement enables them to effectively respond to vulnerable persons as per their needs. Such interaction is infused with a fundamental, God-inspired sense of hope for the vulnerable person and anyone who considers suicide.

Discussion

Implications

The aim of this study was to explore how Christians perceive suicide prevention, and the role they foresee for themselves in a community response to suicide. Findings revealed that Christians perceive suicide prevention to be imperative. Despite literature emphasizing their moral stance towards suicide, perceived immorality of suicide was not discussed among the focus groups. Rather, it appeared that a belief in the sanctity of life compelled Christians to believe suicide was preventable and to assume a part in the campaign against suicide.

In accordance with their faith and practice, Christians described strong attitudes of responsibility, compassion, and willingness to act to prevent suicide. Christians wanted to respond to suicide in appropriate and effective ways. They identified interpersonal skills as requisite but insufficient for suicide prevention, and indicated their desire to receive evidence-based skills and to collaborate with professional services. They regarded Christian churches as both referral agencies and stable communities capable of providing ongoing support for suicidal persons. Together with their doctrine of hope, these findings suggest that Christians are a willing and teachable population that could be a resource for suicide prevention.

The use of focus group methodology was a notable strength of this study, enabling an under-researched population's views on a sensitive topic to be explored. Participants in fact indicated their gratitude for the opportunity to discuss suicide in a safe, honest, and contained environment that made provision for their Christian beliefs to be shared and respected. Whilst diversity in age and gender was present across the groups, young adults (ages 20–40) were few. Perhaps suicide is an issue this age group is unwilling to engage with. A lack of young adults may also reflect the demographic of the churches from which participants were recruited. Importantly, cross-cultural views on suicide were under-represented. This is likely to reflect the predominantly Caucasian populace from which the groups were sampled. Given that generalizability of findings is not the goal of focus groups, the impact of these limitations is marginal.

The presence of certain contextual factors in the study must be noted. The facilitator had prior established relationships with some of the participants. Ideally, this increased the integrity of the data by promoting honesty and openness. However, it may have made participants feel allegiant to the facilitator and prompted socially desirable responses. Whilst facilitating the focus groups, the first author became aware that despite efforts to clearly outline study objectives, some participants believed that direct action following the focus groups would be taken. At times this may have more forcibly encouraged conversation towards action in the service of suicide prevention.

Suggestions for Suicide Prevention Initiatives in FBOs

Strengthening the community's capacity for suicide prevention is part of a multi-componential approach to the increasing prevalence of suicide worldwide (WHO, 2014). Whilst several community organizations have received suicide prevention training, FBOs are yet to be targeted. A sizeable multidisciplinary literature describes the successful public health-related activities of FBOs (Asomugha et al. 2011; Barnes and Curtis 2009; Clarke and Ware 2015; DeHaven et al. 2004; WHO, 2008). They have traditionally outworked their social service mission independent to mainstream, government-funded health promotion initiatives. However, with enthusiasm for recruiting FBOs in the pursuit of community health outcomes at an all-time high (Duff and Buckingham 2015), it is important that their suitability for suicide prevention be examined.

A significant finding from this study is that members of Christian FBOs would like to receive suicide prevention training. Gatekeeper training (GKT) is the prevailing format for community suicide prevention training (Mann et al. 2005; Isaac et al. 2009). A gatekeeper is intended to provide linkage to community channels of help, both formal and informal, for those at risk (Synder 1971). Whilst GKT has been recommended for those occupying formal leadership roles within an FBO context (WHO, 2014), opportunity to receive training has not been extended to lay FBO members. Given that members primarily power FBOs' social service delivery, and have extensive community reach through layered social networks, this is an oversight. Providing training for all interested members of FBOs is likely to be more effective at establishing a gatekeeper presence within the community. Regarding GKT content, exercising ethical integrity when working with FBOs, as described in detail elsewhere (Campbell et al. 2007) and sensitivity to Christian teachings and practices would be important. It could also be worth considering whether the presence or absence of Christian faith in the facilitator is of importance to trainees. Finally, training should target interpersonal skills, given that Christians showed insight into their interpersonal weaknesses, and felt these were significantly impacting upon their response to persons at risk of suicide.

This study also revealed that Christian FBO members desire to be better networked with professionals and organizations specializing in suicide prevention. Establishing communication pathways between Christian FBOs, health professionals, and relevant agencies that encourage exchange of information, referrals, training and support groups would facilitate increased networking. Further, a more intentional partnership between Christian FBOs and existing national suicide prevention structures could promote strategic and systematic utilization of this community group in population-based interventions (e.g., initiatives partnering professionals with FBOs to provide GKT).

Examples of different faith groups working together to achieve improvements in community health exist (Tomkins et al. 2015). Core religious values like purpose and meaning could support interlinkage amongst FBOs within and across faith contexts in the service of strengthening communities against suicide. To this end, an important practical consideration is increasing communication amongst FBO networks.

Given the widespread presence of Christian FBOs at community, state, national, and international levels, the prospect of equipping them to prevent suicide has potential for community suicide prevention. Yet, resources for formative investigations are few. Future research could use this study to create semi-structured questionnaires for use among focus groups within Christian FBOs. Data could alternatively be developed into a quantitative survey for distribution amongst Christian FBOs within a community. These measurement tools would promote increased and systematic exploration of Christian FBO members' perspectives on suicide prevention, enabling better determination of their role in responding to this issue.

Appendix

Prepared Questions for Focus Groups

1. Tell me your thoughts about whether Christian churches can be used as a resource to prevent suicide?
2. How do you think Christian churches can help to prevent suicide?
3. Is there anything unique that Christian churches can offer when it comes to preventing suicide in the community?
4. Are there strengths that Christian churches possess that would help them to prevent suicide?
5. What might make it difficult for Christian churches to be a resource for suicide prevention?
6. How do you think these difficulties could be overcome?
7. How can Christian churches and mental health professionals work together to prevent suicide?
8. Is there anything that we have not covered that you feel is important to mention?

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