

# Meeting Summary and Recommendations

## Clergy Workgroup on Suicide Prevention and Aftercare

September 28 and 29, 2005

Sponsored by:

The Link's National Resource Center  
for Suicide Prevention and Aftercare  
and

Suicide Prevention Resource Center (SPRC)



SPRC

Education Development Center, Inc.

55 Chapel Street

Newton, MA 02458-1060

Phone: 877-GET-SPRC

Fax: 617.969.9186

[www.sprc.org](http://www.sprc.org)

This report was written by Doreen S. Marshall, PhD LPC, consultant, The Link's National Resource Center for Suicide Prevention and Aftercare, June 2006. SPRC edited and formatted the final document.

We encourage readers to review other documents produced by SPRC that relate to the topic of faith-based communities responding to and preventing suicide, including: *Resource Scan of Faith-Based Materials Addressing Suicide Prevention* [www.sprc.org/library/faithscan.pdf](http://www.sprc.org/library/faithscan.pdf) and *After a suicide: Recommendations for religious services and other public memorial observances* <http://www.sprc.org/library/aftersuicide.pdf>

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## **Workgroup Participants**

Elena Isabel Abatto, Chaplain  
United Chaplains, Assembly of God

Rev. Dr. Gilbert (Budd) Friend-Jones  
Senior Minister, Central Congregational Church

Dr. James T. Clemons, President and Founder,  
Organization for Attempters and Survivors of Suicide in Interfaith Services (OASSIS)  
Minister, United Methodist Church

Gary Delaplane, MA  
Mourning Dove Ministries  
Survivor

Deryck Dursten, Lutheran Minister  
Association for Clinical Pastoral Education (ACPE)  
National Office

Doyle Hamilton, DMin; LMFT  
Director, Roswell First Baptist Church Counseling Center

Dr. Ronald Hamm, Sr., Pastor  
Harvest Chapel Fellowship  
Life Development Institute (Tennessee)

Joanne Harpel, JD\*  
Director of Survivor Initiatives  
American Foundation for Suicide Prevention (AFSP)

Elaine Hoffman, MDiv, LMFT  
Clinical Director for Pastoral Education  
Care and Counseling Center (Georgia)

Rev. Joel Hudson, Episcopal Minister (retired)  
Christ Episcopal Church (Georgia)

Donna Johnson, MA  
Therapist  
The Link's National Resource Center for Suicide Prevention and Aftercare

Wyeuca Bird Johnson, LCSW  
Social worker and Catholic church volunteer  
Survivor

Rev. Dr. Sherry Davis Molock\*  
Associate Professor-Psychology  
George Washington University

Dr. Luis A. Naranjo, Chaplain  
United Chaplains, Assembly of God

Rev. Jim Nixon, Catholic Priest  
St. Catherine's Church (Georgia)

Russell Osmond, Chaplain (retired)  
United States Air Force

Dr. Luis Rivera, Chaplain  
United Chaplains, Assembly of God

Juan J. Saldana, Chaplain  
United Chaplains, Assembly of God

Marti Vogt, Chairperson  
Suicide Prevention Coalition of Georgia  
Volunteer, Perimeter Church

Nancy Yancy, Deacon  
Christ Episcopal Church (Georgia)

Iris Bolton, MA  
Executive Director  
The Link's National Resource Center for Suicide Prevention and Aftercare  
Survivor

Dr. Doreen S. Marshall, LPC  
Consultant  
Suicide Prevention and Aftercare  
Survivor

LaVonne Ortega, MD, MPH  
Prevention Specialist  
Suicide Prevention Resource Center

\*Denotes invited participants who provided insight, yet were unable to attend the workgroup.

*NOTE:* Additional members from other faith groups were invited to participate in the workgroup.

## **Abstract**

A workgroup meeting was held to identify clergy needs related to preventing and responding to suicide in the church community. This paper describes the process of the workgroup and provides a summary of the meeting's content. The purpose of the meeting was to identify the critical elements needed for a competency-based curriculum to train clergy in suicide prevention and response to survivors of suicide. The workgroup provided information about needs, suggested training content and format, and identified possible dissemination strategies. The workgroup also identified action steps to further this project.

## Summary of Key Points

A workgroup comprised of 20 individuals representing clergy, faith-based groups, suicide prevention stakeholders, and survivors of suicide met for over two days to discuss the role of clergy in preventing suicide and responding to suicide. Individuals mainly represented the southeast region of the United States, with the majority of the individuals representing faith groups in Georgia. Clergy and religious leaders in the workgroup mainly represented Christian churches and faith-based groups.

### **I. Identified roles of clergy in suicide prevention and aftercare:**

- Provide education re: suicide and mental health
- Foster hope, purpose, and meaning as a protective factor against suicide
- Build an infrastructure and a forum in the church community to support prevention efforts
- Know when to refer to a mental health provider
- Support survivors after suicide and to provide postvention

### **II. Critical elements needed for a competency-based curriculum for clergy**

#### **a. Content—Prevention:**

- Information about the relationship between suicide and mental illness
- Information about warning signs for suicide prevention
- Information about handling suicide-related emergencies in terms of directing individuals to appropriate treatment
- How to approach the issue of suicide and related mental illnesses as more than just a “spiritual problem”
- Information about the process of mental health services and referrals (specifically, what happens when an individual is referred to a mental health provider)
- Information about the relationship between suicide and other high-risk behaviors seen by clergy (e.g. domestic violence, substance abuse, etc)
- Information about how to build collaborative networks with mental health providers.
- Information about resources to share with members of the congregation related to suicide prevention

#### **b. Content—Aftercare:**

- The survivor’s grief experience and stigma
- How (and when) to reach out to survivors following a suicide
- How to appropriately answer questions related to the “after life,” “why”

suicide happens

- Information about short-term and long-term support for survivors (and resources available)
- Information about survivors' risk of mental health issues and suicide
- Exploration of one's own attitudes toward suicide.
- Information about "appropriate language" in order to be sensitive to survivors' needs
- Information related that addressed cultural differences related to suicide and grief

### **III. Suggestions for format**

*Several possible formats were suggested:*

- Seminary-based, provided by associations at conferences or connected to continuing education for pastoral counselors and related groups--either classroom-based or online.
- A video-based training that would involve some "live" interaction so that questions could be answered--include individual stories (both from clergy and survivors) in a video-based format.
- A web-based training developed collaboratively with survivors and mental health trainers that would provide additional resources related to suicide prevention and aftercare.
- A clergy-based resource list to supplement training where clergy could contact others who have had experience responding to suicide in a church setting.

### **IV. Ideas for dissemination**

- Interdenominational groups and interfaith organizations, such as the Emory Interfaith Program.
- Church leaders at the Diocesan or Archdiocesan level, such as those of the Catholic, Episcopal (judicatory) and Methodist traditions.
- Larger churches that are already engaged in large outreach (divorce, grief, etc) efforts, such as Saddleback (California) and Northpoint (Georgia).
- Seminaries and theological institutions regarding the importance of having suicide-related information in their curricula.
- Annual conferences of seminary-based and clergy organizations.
- Pastoral care associations and pastoral counselors.

### **V. Identifying additional stakeholders**

- Stephen Ministries.
- Ministers on college campuses.
- National and state mental health associations as well as national organizations dedicated to suicide prevention (e.g., AFSP) that may have existing relationships with clergy partners.

- Nursing organizations, particularly those with members who are parish/congregational nurses to identify parish stakeholders.
- State coalitions for suicide prevention (e.g., state planners) who can help identify clergy stakeholders.
- The National Council of Churches (contact with the NCC has been initiated by OASSIS).
- Health providers, such as Wellstar Health Systems, that may have clergy and church-related contacts for which they provide services.

## **VI. Next action steps**

- Identify additional key stakeholders in religious and interfaith communities and include them in curriculum development.
- Survey suicide prevention state planning groups and state coalitions to determine whether clergy are actively involved in their state planning efforts.
- Engage in a dialogue with groups who have successfully implemented other outreach training programs in church communities (e.g., Stephen Ministries, Pastoral Counselors).
- Create suicide prevention and aftercare resources specific to clergy needs and make them available via the Suicide Prevention Resource Center website.
- Build a network of “advisors” who could consult with clergy members in the event of a completed suicide in terms of church response.
- Gain additional input from stakeholders who were invited but unable to attend this workgroup meeting for additional insight into this process.

## **Clergy Workgroup on Suicide Prevention and Aftercare**

### **Summary of meeting process**

A workgroup comprised of 21 individuals representing clergy, faith-based groups, suicide prevention stakeholders and survivors of suicide met over two days to discuss the role of clergy in preventing suicide and responding to suicide. With two exceptions, these individuals represented the southeast region of the United States, with the majority of the individuals representing faith groups in Georgia. Clergy and religious leaders in the workgroup mainly represented Christian churches and faith-based groups. Workgroup members were from various racial, ethnic, and age groups. Representatives from three organizations within the National Council for Suicide Prevention (OASSIS, The Link's NRC and AFSP) were also invited to participate. The meeting was facilitated by Doreen S. Marshall, PhD, consultant with assistance from LaVonne Ortega, MD, MPH, of the Suicide Prevention Resource Center.

The workgroup meeting had several purposes. One purpose was to discuss the roles and opportunities for clergy in preventing and responding to suicide. Another purpose was to identify barriers and challenges that clergy face in preventing suicide and responding to suicide. A third purpose of this group was to discuss priorities, possible content, format, and strategies for the dissemination of a competency-based curriculum to train clergy to respond more effectively to those at risk for suicide and to survivors within their congregations. A primary goal of this meeting was to begin a process by which the group could identify training and support needs and strategies to assist suicide prevention efforts in the faith community.

The format of the meeting involved facilitated group discussions in response to a series of questions related to the meeting's goals. Presentations on clergy response to suicide and suicide prevention in the faith community were also included in the meeting's agenda and served to promote discussion as well as to provide information. The meeting closed on September 29<sup>th</sup> with a discussion of possible next steps to further this project.

### **Discussion points summary**

*All points were as noted or expressed by one or more workshop participants.*

#### ***1) What is the role of clergy in preventing suicide?***

The workgroup identified clergy as having the following roles/responsibilities in preventing suicide:

- Provide education to congregations about suicide and mental health
- Foster hope, purpose, and meaning in congregation members as a protective factor against suicide
- Build an infrastructure within the religious community to support both clergy and laity networks that may be involved in prevention efforts
- Provide a forum for discussion of suicide and related mental health issues within the congregation
- Know how and when to refer to a mental health provider
- Gain an understanding of ways to support survivors after suicide and to provide postvention efforts to prevent future suicides

Clergy were identified as having a role in providing education to their congregations about suicide and related mental health issues. Clergy often interact with congregation members about mental health issues, and it is important for clergy to have some

understanding of mental health issues and diagnoses, including common medications used. As leaders of church communities, they believed they have a role in improving communication within the community and in understanding the community's values regarding suicide. Providing a forum for the discussion of suicide and related mental health issues within the church community could help destigmatize seeking mental health assistance in the context of faith. It is important to understand how to communicate about suicide and suicide risk in lay terms as well as to expand the discussion of suicide beyond a theological realm. The group saw this as crucial to becoming a resource that the church community could approach comfortably regarding suicide. Similarly, the group expressed a desire for collaboration with mental health providers in order to feel comfortable referring at-risk individuals to mental health services.

Regarding postvention, many clergy have not had adequate training in responding to survivors of suicide. Several noted they were required to respond and found themselves contacting other clergy who they knew had dealt with suicide for guidance. It is clergy's responsibility to have an understanding of how one's religious traditions have advantages and disadvantages about suicide and communicating messages of hope to survivors. It is also important to be knowledgeable about cultural issues that may affect suicide.

***2) What are the challenges/barriers clergy face in preventing suicide and responding to suicide?***

The workgroup identified several barriers related to their roles in preventing suicide and responding to survivors. Barriers to preventing suicide included:

- Lack of knowledge, particularly regarding how to identify and assist suicidal individuals

- Inaccurate messages regarding the use of medications for depression and related mental/emotional concerns which could lead to suicide
- Stigma about suicide and the fear that talking about it will lead to suicidal behavior
- Lack of access to congregation members who need support around suicide
- Time-competing concerns and a “reactive versus proactive” approach to suicide
- Misperceptions about the church’s perspective on suicide
- Lack of knowledge about how to respond to survivors, unclear expectations from church members after a suicide, and uncertainty about when to intervene with survivors

Clergy generally lack knowledge about how to assist families and individuals when suicidal crises are present. They often do not see mental health intervention as their role, but, rather, want to provide support and linkage to mental health services in the community. There was also an acknowledgment that this group was not typical of most members of the clergy and religious community. The group reported having both more knowledge and interest in addressing suicide in their communities than they felt was typical of their peers.

The workgroup noted that there seems to be a message of “medicines are bad” coming from various members of the church community, likely due to lack of information about the role of medication in treating the biological aspects of depression. This attitude adds to the stigma against addressing depression openly in the congregation, and seems to reinforce a message that people do not need medication but rather, stronger spirituality to treat their mental illness.

Members of the workgroup also discussed that stigma about suicide and suicidal behavior exists in the church community. Reluctance to discuss suicide openly is often due to a fear that doing so will lead to suicidal behavior. They cited historical beliefs and the history of religious perspectives on suicide as contributing to stigma.

Members discussed feeling that they have inadequate access to those members of their church communities who need support around issues of depression and suicide. These members may not see clergy as able to be supportive around mental health concerns. This is likely due to stigma in the church community about mental illness and suicide and misperceptions about the church's views on these issues. Some individual churches may lack a sense of community - contributing to difficulties with accessing those in need. Members expressed interest in serving in a collaborative role with mental health services in supporting individuals who struggle with depression.

Time-competing concerns often make it difficult to address suicide in the church community to the extent workgroup members would like. There was a general acknowledgment that churches often have a reactive approach to addressing suicide and mental health issues. Some members indicated that their interest in addressing suicide in the church grew following the suicide of a member of the church community. These members indicated a sense of uncertainty about appropriate action and a need to seek knowledge about suicide after the experience. Several noted that they sought information from other clergy/religious who they knew had had experience with suicide in the past. A few additional barriers in responding to survivors of suicide were identified:

- The perception that “suicide is a sin” is still active in many churches, making it more difficult for active intervention with survivors. Church members’ views are

sometimes perpetuated in the church community by both clergy and other church members.

- A lack of knowledge about how to respond to survivors of suicide, leading to inadequate response. There are sometimes unclear expectations from the church community as to what their role in supporting survivors should be and this often leads to inaction.
- Uncertainty about the appropriate time to intervene following a suicide for clergy – often leading to inaction.

**3) *What are the opportunities/ resources available to address these barriers?***

The workgroup acknowledged that the role of clergy/religious in a church community provided them with unique opportunities and resources in addressing suicide.

- Clergy/religious have an opportunity for early intervention regarding suicide and related mental/emotional concerns. In many instances, clergy have established relationships with individuals and families prior to the onset of a suicidal crisis.
- Clergy/religious have credibility and influence in the church community, providing an opportunity to address issues of stigma around suicide. The words of clergy are often the first public words following a suicide in the community, and this provides an opportunity to send a message of support for survivors.
- Church members are a “captive audience.” There are opportunities at each service and church function to provide education about suicide and mental health issues. This can be an opportunity to help strengthen the faith of church members, particularly following the tragedy of suicide.

- Church services are generally not “fee-based” or “Monday through Friday.” Members of the workgroup saw this as an opportunity to provide support in conjunction with mental health practitioners, given the accessibility of church services.
- Churches have other outreach programs that are educationally-based. These educational forums (seminars, bible studies, other ministries) often provide a ready venue for congregation education about health issues.
- Church communities are known for their “networks of support.” Churches and religious communities often coordinate “networks of support” through the implementation of various ministries and lay services.

***4) What are the priorities in training clergy to help prevent suicide and to respond effectively to survivors? What information should be included in a competency-based curriculum to train clergy about suicide prevention/postvention?***

Several workgroup members noted they felt their prior training did not prepare them adequately to address suicidal behaviors or to work with survivors of suicide. They were largely unaware of their lack of training in the area of suicide until a member of their church community was suicidal or they learned that a suicide had occurred. Priorities identified for training content in suicide prevention include:

- The relationship between suicide and mental illness
- Warning signs for suicide prevention
- Handling suicide-related emergencies in terms of directing individuals to appropriate treatment

- How to approach the issue of suicide and related mental illnesses as more than just a “spiritual problem”
- The process of mental health services and referrals (specifically, what happens when an individual is referred to a mental health provider)
- The relationship between suicide and other high-risk behaviors seen by clergy (e.g., domestic violence, substance abuse)
- How to build collaborative networks with mental health providers
- Suicide prevention resources to share with members of the congregation

Priorities for training content related to responding to survivors of suicide include:

- The survivor’s grief experience and stigma
- How and when to reach out to survivors following a suicide
- How to appropriately answer questions related to the “after life” and “why” suicide happens
- Short-term and long-term support for survivors (and resources available)
- Survivors’ risk of mental health issues and suicide
- Exploration of one’s own attitudes toward suicide and challenges related to this
- Appropriate language in order to be sensitive to survivors’ needs
- Cultural differences related to suicide and how to address these

***5) What training format would be helpful in order to reach clergy effectively?***

The workgroup discussed several considerations for training formats they believed would help reach clergy effectively. Training should be “faith-specific” but also offer secular resources. Several members noted that reaching out to additional interfaith communities would be important in order to get more feedback about training

considerations. Training should be able to be adapted to the needs of different church groups but maintain a basic core of information. Training that involves scriptural references (to suicide, depression and/or grief) would likely be better received than training that is not connected to scripture.

Other considerations for the training format include:

- A seminary-based training, either provided by associations at conferences or connected to continuing education for pastoral counselors and related groups. These trainings could be either classroom-based or online.
- A video-based training that involves some “live” interaction so questions could be answered. Workgroup members felt it would be important to include individual stories (both from clergy and survivors) in a video-based format.
- A web-based training developed collaboratively with survivors and mental health trainers to provide additional resources on suicide prevention and aftercare.
- A clergy resource list to supplement training so clergy could contact others who have had experience responding to suicide in a church setting.

***6) How could a competency-based curriculum help address clergy’s challenges to responding to suicide?***

Additional training could help address several challenges related to responding to suicide. First, training would likely increase the confidence of clergy in dealing with suicidal persons as well as supporting survivors. Second, by receiving such training, clergy may be encouraged to incorporate discussions of suicide and mental illness into their daily activities, not only when a crisis occurs. Members also noted that understanding the relationship between suicide and other issues in which the church is

already involved in outreach (e.g., substance abuse, domestic violence, at-risk youth programs, grief ministries) could facilitate identifying those at risk for suicide and provide opportunities for education. Having more information would likely reduce fear and address clergy reluctance to be proactive in addressing suicide.

***7) What groups/organizations could help disseminate training information to clergy regarding responding to suicide? What are the priorities for disseminating information?***

The workgroup discussed several ways to disseminate training information to clergy regarding responding to suicide in their congregations. Several groups and organizations that could assist with dissemination in training materials were identified. The group acknowledged it would be important for individual clergy members to know the needs of their community regarding suicide and adapt information accordingly. The ideas generated regarding general dissemination of training materials are:

- Provide a curriculum to interdenominational groups and interfaith organizations, such as the Emory Interfaith Program.
- Approach church leaders at the Diocesan or Archdiocesan level, such as those of the Catholic, Episcopal (judicatory) and Methodist traditions, about utilizing the information.
- Provide a curriculum to larger churches that are already engaged in large outreach efforts, such as Saddleback (California) and Northpoint (Georgia). These churches tend to have outreach programs for other issues (e.g., divorce, grief).
- Engage in a dialogue with seminaries and theological institutions on the importance of having suicide-related information in their curriculum. Such

training could also be provided at annual conferences of seminary-based organizations.

- Engage pastoral care associations and pastoral counselors to provide a “bridge” between clergy training and mental health-related training.

***8) How might we reach stakeholders who are not connected to already identified organizations or to those who have unique needs in responding to suicide?***

- Engage groups such as Stephen Ministries in assisting with the identification of additional clergy stakeholders.
- Engage ministers on college campuses, given the support for suicide prevention on college campuses provided by the Garrett Lee Smith Memorial Act.
- Engage national and state mental health associations as well as national organizations dedicated to suicide prevention (e.g., AFSP) that may have existing relationships with clergy partners.
- Engage nursing organizations, particularly those with members who are parish/congregational nurses to identify parish stakeholders.
- Engage the support of state coalitions for suicide prevention (e.g., state planners) who can help identify clergy stakeholders. This is particularly important given the objectives of the National Strategy for Suicide Prevention and of many state suicide prevention plans.
- Engage the National Council of Churches (NCC), who received a draft of a resolution calling on the group to address the issue of suicide with their constituents. This group represents several church denominations. Contact with the NCC has been initiated by OASSIS regarding this resolution.

- Engage health providers who may have clergy and church-related contacts for whom they provide services.

The workgroup identified some limitations of the current process. First, the representatives that attended this meeting were mostly affiliated with Christian churches and interfaith groups. More information is needed from other religious groups before a training can be developed that would meet the specific needs. Engaging different groups in dialogue about suicide prevention could pose a challenge given theological differences among these groups. However, in order for competency-based training to meet the needs of various groups, representatives from those groups need to be included in the development process. The group was uncertain as to what process might engage representatives from other religious faiths (e.g., Islamic traditions).

Second, a key component to the development of a competency-based curriculum is the partnership between religious affiliates and those who can provide technical assistance on implementing trainings, such as clergy and other professionals experienced in suicide prevention and postvention. The group noted that SPRC and related consultants would be important technical resources in assisting with the adaptation and implementation of a training curriculum.

The group also discussed cultural competency in terms of the curriculum development. In particular, it would be important to have resource information available for non-English speaking church communities. A recommendation was made to provide resource information in Spanish that can be shared in Hispanic churches. “Training the trainers” within these church communities could help address the issue of suicide in a way that mental health services may not, as few seek mental health assistance due to

stigma. While the discussion of cultural competence was not limited to Hispanic churches, the experiences of several workgroup members from these churches underscored the need in the local Hispanic community. In addressing suicide in the church, there is a need for overall sensitivity to, and awareness of, cultural differences.

### **Recommendations for next steps**

The meeting closed with the identification of several action steps to further the development of a competency-based curriculum for suicide prevention and aftercare for clergy and the religious community:

- Identify additional key stakeholders in the religious and interfaith communities and include them in curriculum development based on the needs of those communities.
- Survey suicide prevention state planning groups and state coalitions to determine whether clergy are actively involved in their state planning efforts.
- Engage in dialogue with groups who have successfully implemented outreach training programs in church communities (e.g., Stephen Ministries, Pastoral Counselors).
- Create suicide prevention and aftercare resources specific to clergy needs and make them available via the Suicide Prevention Resource Center website.
- Build a network of “advisors” who could consult with clergy members in the event of a completed suicide in terms of appropriate church response.
- Gain additional input from stakeholders who were invited but unable to attend this workgroup meeting for additional insight into this process.

In summary, the workgroup process yielded several recommendations toward addressing the training needs of clergy regarding suicide prevention and aftercare. Despite the noted limitations, this process was an important first step toward addressing suicide in the church community and preparing clergy members to adequately respond.

## **Appendix A: Meeting Agenda**

### **Clergy Workgroup Meeting**

#### **The Link's National Resource Center for Suicide Prevention and Aftercare (NRC) and The Suicide Prevention Resource Center (SPRC)**

**Wednesday, September 28, 2005**

- 1:00 Welcome and introductions  
Overview of workgroup purpose and tasks  
Doreen S. Marshall, PhD  
LaVonne Ortega, MD, MPH SPRC  
Iris Bolton, MS
- 1:30 Clergy response to suicide: An Overview  
Doreen Marshall, PhD
- 2:00 Workgroup Task #1:  
What is the role of clergy in preventing suicide?  
What are the challenges/barriers clergy face in preventing suicide and responding to suicide?  
What are the opportunities and resources available to address these barriers?
- 2:45 Break (15 min)
- 3:00 Suicide Prevention & The Faith Community  
LaVonne Ortega, MD MPH SPRC
- 3:30 Workgroup Task #2  
What are the priorities in training clergy to help prevent suicide and to respond effectively to survivors?  
What information should be included in a competency-based curriculum to train clergy about suicide prevention/postvention?  
What training format would help in order to reach clergy effectively?
- 4:15 Group Discussion
- 5:00 Day summary and setting Thursday's agenda
- 5:30 Meeting concluded for day

**Thursday, September 29, 2005**

- 9:00 Welcome and summary of previous day meeting and information  
Overview of day's tasks and schedule
- 9:30 Workgroup Task III  
What are the unique challenges clergy face in responding to survivors of suicide and suicide attempters?  
How could a competency-based curriculum help address these challenges?  
How might we reach those stakeholders who are not connected to existing organizations, or those who have unique needs in responding to suicide?
- 10:30 Break (15 min)
- 10:45 Workgroup Task IV  
What groups/organization could help disseminate information to clergy regarding responding to suicide?  
What stakeholders should this information be disseminated to?  
What are the priorities for disseminating information?
- 11:15 Group Discussion
- 11:45 SPRC's role in meeting the needs of clergy related to suicide  
Future directions: Discussion and plans  
LaVonne Ortega, MD MPH  
Doreen S. Marshall, PhD  
Iris M. Bolton, MS
- 12:30 Meeting conclusion