

A Message on . . .

SUICIDE PREVENTION

*Adopted by the Church Council of the Evangelical Lutheran Church in America
on November 14, 1999.*

Each year more than 30,000 persons in the United States take their own life. Suicide is the eighth leading cause of death and the third leading cause among persons who are 15 to 24. More persons die by suicide than by homicide. Each year nearly 500,000 persons make a suicide attempt serious enough to receive emergency room treatment. Millions have suicidal thoughts.¹

These numbers, we know, speak of individuals whose stories and relationships are unique. They speak of persons with whom we live in our families, congregations, neighborhoods, and work places. Some of us have attempted suicide, and others of us have made sure a relative or friend who is threatening suicide gets help. Many of us have mourned and anguished over the suicidal death of a loved one, and others of us will some day experience such unspeakable grief and suffering.

Suicide testifies to life's tragic brokenness. We believe that life is God's good and precious gift to us, and yet life for us—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 so 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 our troubled neighbor.

Increasingly, suicide is being viewed as a serious and preventable public health problem.² Suicide and its prevention are complex and multi-dimensional and need to be approached openly and comprehensively. Suicide prevention requires concerted and collaborative efforts from all sectors of society. 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; rich, middle class, and poor people; 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:

- White males account for nearly three-fourths of all completed suicides.
- While there are four male suicides for every female one, women attempt suicide twice as often as do men.
- The highest suicide rates are found among white men over 50, who represent 10 percent of the population and who are responsible for 33 percent of the suicides. Suicide rates for men over 65 are on the increase after a steady decrease from 1950-1980.
- Since 1950 the suicide rate for young men aged 15-24 has tripled, and for young women, it has more than doubled.
- Although suicide among children is a rare event, there has been a dramatic increase in the reported suicide rate among persons aged 10-14.
- Suicide rates for American Indians and Alaska Natives are well above the national average, with a disproportionate number of suicides among young men.
- Suicide among young African American males, once uncommon, has increased sharply in recent years.
- Suicide rates among some professions, such as police, farmers, dentists, and doctors, have been found to be higher than the national average.
- Attempted suicide rates among youth struggling with questions about their sexual orientation are higher than among others of the same age.
- Nearly 60 percent of all suicides are carried out with a firearm. 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.³

While there is no one cause of suicide, researchers tell us that suicidal behavior is associated with a number of risk factors that frequently occur in combination. These include:

- Clinical depression and other mental illnesses. More than 60 percent of all people who complete suicide suffer from major

depression. If one includes people who abuse alcohol and are depressed, the figure rises to 75 percent. Almost all people who take their own life have a diagnosable mental or substance abuse disorder or both.

- Alcohol and substance abuse. Alcoholism is a factor in 30 percent of all completed suicides.
- Adverse life events. Such events may be confusion about one's personal identity or a feeling of being cut off from others among young people; a family crisis like death or divorce; the loss of one's livelihood, perhaps caused by rural economic crisis, business downsizing, a cutting off of government programs, or addictive behavior; chronic, acute, or terminal illness; or the effects of a natural or social disaster. For most people, adverse life events do not lead to suicidal behavior. They may contribute to suicidal behavior in the context of mental illness and substance abuse.
- Familial factors, such as a family history of suicide, of mental illness and substance abuse, of violence and sexual abuse.
- Cultural or religious factors, such as beliefs that suicide is a noble resolution of a personal dilemma, or the destruction of a people's traditional culture that may lead to feelings of disconnectedness from the past, isolation, and hopelessness.
- Prior suicide attempt, firearm in the home, incarceration, impulsive or aggressive tendencies, and exposure to the suicidal behavior of others (by family members or peers, or through inappropriate media coverage or fiction stories). Suicides among young people

"All persons who express suicidal ideas while exhibiting symptoms of depression, alcohol abuse, drug abuse, or schizophrenia should be evaluated promptly by a qualified health professional." In *Clergy Response to Suicidal Persons and Their Family Members*, ed. David C. Clark (Chicago: Exploration Press, 1993), 183. Clark directs the Center for Suicide Research and Prevention, Rush-Presbyterian-St. Luke's Medical Center, Chicago. This book is a valuable resource for pastors and congregations. In it ELCA pastor and theologian Herbert Anderson writes on "A Protestant Perspective on Suicide."

sometimes occur in clusters and may even become an epidemic. Young people are particularly susceptible to imitating behavior leading to unintended suicide.⁴

Looking at Attitudes

Certain social attitudes form 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 persons 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.

Failure to understand major depression as an illness 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 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, it is a very treatable mental illness. Depressed people cannot treat themselves, but they can be helped by professionals through medication or therapy, or a combination of the two. Suicide is not an inevitable or acceptable outcome of depression.⁵

Experts speak of common misunderstandings that stand in the way of suicide prevention:

- **Myth:** Persons 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 persons who talk about suicide are serious and may be giving a clue or warning of their intentions. They should not be challenged but given assistance in obtaining professional help.
- **Myth:** A person who has made a serious suicide attempt is unlikely to make another. **The truth is** that persons who have made prior attempts are often at greater risk of completing suicide. A suicide attempt is a cry for help and a warning that something is terribly wrong and should be taken with utmost seriousness.
- **Myth:** The suicidal person wants to die and feels there is no turning back. **The truth is** that suicidal persons 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.
- **Myth:** Most people who take their life have made a careful, well-considered, rational decision. **The truth is** that persons 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.
- **Myth:** 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, a plan, and the means are there, the suicidal person should not be left alone but be helped to get treatment immediately, by calling 911 if necessary.

Suicide Prevention Helpcard *

If someone you know:

- threatens suicide
- talks or writes about wanting to die
- appears depressed, sad, withdrawn, hopeless
- shows significant changes in behavior, appearance, mood (either from being “normal” to being depressed or the reverse)
- abuses drugs, alcohol
- deliberately injures himself or herself
- says he or she will not be missed if gone
- gives away treasured belongings . . .

You can help:

- stay calm and listen
- take threats seriously
- let him or her talk about his or her feelings
- be accepting; do not judge
- ask if he or she has suicidal thoughts
- ask how intense and frequent these thoughts are
- ask if he or she has a plan
- ask if he or she has a means to carry out the plan
- don't swear secrecy—tell someone
- assure the person it is okay and necessary to get help . . .

Get help: You cannot do it alone

Accompany the person to your:

- hospital emergency room
- mental health services
- police
- family, friend, relative
- clergy, teacher, counselor
- family doctor
- or call your crisis line

Call your 911 number for emergency assistance or check the inside front cover page of your telephone book for local crisis services. The National Crisis Helpline is 888-784-2433 (1-888-SUICIDE). The National “YOUTH” Crisis Helpline is 800-999-9999.

For information on the nearest ELCA social ministry organization providing non-emergency counseling for suicidal persons, call Lutheran Services in America (LSA), 800-664-3848. You may visit LSA online (www.lutheranservices.org).

* Adapted from The Suicide and Information Center online (www.siec.ca/helpcard.htm).

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.”⁶ Luther’s image of the Church as a hospital reminds us who we are—a community of vulnerable people in need of help; living by the hope of the Gospel, we also 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 persons who are willing to ask for healing and to provide it.

Whoever among us experiences suicidal thoughts should know that the rest of us expect, pray, and plead for them to reach out for help. “Talk to someone. Don’t bear your hidden pain by yourself.” The notion is all-too-common that one should “go it alone”: Persons are not supposed to be vulnerable, and when they are, they should conceal it and handle things on their 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 our desire to live, we are urged and invited to talk with trusted others and draw upon their strength.

When, on the other hand, a loved one talks to us of suicide or we sense that something is seriously amiss, we are called to be our brother’s or sister’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 that we may make matters worse. Yet our responsibility is to listen, to encourage the person to talk, and to get him or her appropriate help.⁷ 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 a person and his or her family.

Pastors have unique opportunities to minister with suicidal persons, in part because many people are often 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 suicidal persons. Their concern is to explore the suffering that motivates the person’s thoughts and behavior and to comfort the person through his or her anguish. Drawing upon their 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 persons 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 their loving support. Funerals are not occasions either to condemn or idealize an act of suicide, but 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 14:7). Pastor and congregation need to offer intentional and sensitive care for the family and loved ones of the deceased for some time and offer them the opportunity to become part of a support group for survivors.⁸

Preparing to Act

Suicide prevention is broader than responding to a crisis situation. Prevention efforts also aim to reduce or reverse risk factors and to enhance protective factors before vulnerable persons reach the point of danger. They go together with efforts to prevent drug and alcohol abuse as well as violence.⁹ "Protective factors include:

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help seeking.
- Restricted access to highly lethal methods of suicide.
- Family and community support.
- Support from ongoing medical and mental health care relationships.
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts."¹⁰

What can we do in our congregations and communities to prevent suicide? The following is 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.”¹¹ We are equipped to empathize with others in their suffering and joy and are prepared to act for their wellbeing. 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 things better?

When discussing love for others in confirmation classes, 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 are 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 persons going through stressful periods in their lives and with older persons 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?¹²

How do we honor the vocation of members who are social workers, psychologists, doctors, nurses, counselors, and other caregivers who often work with suicidal persons? How do we find ways to assure them that when a person they are helping takes his or her life, they are not responsible for not “saving a life”? We also can draw upon these caregivers as well as upon survivors and advocates for suicide prevention to help educate other members about suicide.

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? We can join with other churches and community groups to help ensure that adequate treatment resources are available. What about our schools? Is suicide prevention a 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?¹³

What about the firearms in our homes? Most gun owners reportedly keep a firearm in their home for “protection” or “self-defense,” yet 83 percent of gun-related deaths in these homes are suicide, often by someone other than the gun owner.¹⁴ Are our homes really safer with guns in them?, we might ask.

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 persons at risk for suicide to obtain needed substance abuse and treatment services?¹⁵

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?¹⁶ How are our seminaries preparing pastors to minister with suicidal persons? Should suicide prevention be a part of continuing education for rostered persons? 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?

The Church Council urges 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, calling upon this church’s educational and advocacy programs to make suicide prevention an important concern in their ministries. It directs the Department for Ecumenical Affairs 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 welcomes the Surgeon General’s call for a comprehensive national strategy for suicide prevention.¹⁷

Before we go in peace from worship to serve the Lord in the trials and joys of the coming days, we receive the 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 sing. We are not alone, abandoned, and without hope. The Lord’s name is “‘Emmanuel,’ which means, ‘God is with us’” (Matthew 1:23).

National Suicide Prevention Organizations

American Association of Suicidology (AAS)

4201 Connecticut Avenue, NW, Suite 408
Washington, DC 20008

Phone 202-237-2280
E-mail info@suicidology.org
Website www.suicidology.org

American Foundation for Suicide Prevention (AFSP)

120 Wall Street, 22nd Floor
New York, New York 10005

Phone 888-333-2377 (Toll-free)
Phone 212-363-3500
E-mail inquiry@asfp.org
Website www.afsp.org

Depression and Bipolar Support Alliance

730 North Franklin Street, Suite 501
Chicago, Illinois 60610-7224

Phone 800-826-3632 (Toll-free)
Facsimile 312-642-7243
Website www.dbsalliance.org

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, Virginia 22201

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
Mailstop K65, 4770 Buford Highway NE
Atlanta, Georgia 30341-3724

Phone 770-488-4362
E-mail ohcinfo@cdc.gov
Website www.cdc.gov/ncipc/ncipchm.htm

National Institute of Mental Health (NIMH)

6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, Maryland 20892-9663

Phone 301-443-4513
Facsimile 301-443-4279
E-mail nimhinfo@nih.gov
Website www.nimh.nih.gov

National Mental Health Association (NMHA)

2001 N. Beauregard St. Street
12th Floor
Alexandria, Virginia 22314
Phone 800-969-NMHA (Toll-free)
Phone 703-684-7722
Website www.nmha.org

National Organization for People of Color Against Suicide

4715 Sargent Rd., NE
Washington, D.C. 20017
Phone 866-899-5317
E-mail nopcas@onebox.com

**The Organization for Attempters and Survivors of
Suicide in Interfaith Services (OASSIS)**

4541 Burlington Place, NW
Washington, DC 20016
Phone 202-363-4224
E-mail jamestclemons@aol.com
Website www.oassis.org

SAVE - Suicide Awareness Voices of Education

Minneapolis, Minnesota 55424-0507
Phone 952-946-7998
E-mail save@winternet.com
Website www.save.org

Suicide Prevention Advocacy Network USA (SPAN USA)

5034 Odins Way
Marietta, Georgia 30068
Phone 888-649-1366 (Toll-free)
E-mail act@spanusa.org
Website www.spanusa.org

Yellow Ribbon Suicide Prevention Program

P.O. Box 664
Westminster, Colorado 80036-0644
Phone 303-429-3530
E-mail ask4help@yellowribbon.org
Website www.yellowribbon.org

**Most state health or disease control and prevention departments
have resources on suicide prevention and mental health.**

Endnotes

1. The information on reported suicides comes from official 1997 United States data, the most recent available. An average of 84 suicides occur each day. The number of suicides is certainly higher. Suicide deaths sometimes go unreported for reasons of concealment and insurance, and some accidents are camouflaged suicides. Homicide deaths are around 20,000 a year. The data on attempted suicide is found in *U.S. Public Health Service, The Surgeon General's Call to Action to Prevent Suicide* (Washington, D.C., 1999), p.1.
2. The United States Senate and the House of Representatives have passed an identical resolution that “recognizes suicide as a national problem and declares suicide prevention to be a national priority”(U.S. Senate Resolution #84, May 6, 1997, and U.S. House of Representatives Resolution #212, October 9, 1998). The United States Surgeon General has for the first time recognized suicide as a preventable public health problem. In his *Call to Action* of July 28, 1999, the Surgeon General introduced a blueprint for addressing suicide—Awareness, Intervention, and Methodology (research)—(AIM) as an essential step toward a comprehensive national strategy for suicide prevention. The report emphasizes the role of faith leaders and communities in preventing suicide. It is available online (www.surgeongeneral.gov/library/calltoaction). Suicide Prevention Advocacy Network USA (SPAN USA), founded and directed by ELCA members Elsie and Jerry Weyrauch, has led the grass-roots effort calling for such a national strategy. To contact SPAN USA, see the information given at the end of this message.
3. These statistics on suicide come from information provided in the Surgeon General's report and accompanying documents as well as by the suicide prevention organizations listed at the end of this message. Their information relies on official United States data from 1996 and earlier. Contact or visit the web pages of these organizations for more data on suicide. On attitudes toward persons who are gay and lesbian, see “An Open Letter from the Bishops of the Evangelical Lutheran Church in America,” March 22, 1996, and the resolution “Human sexuality/Homosexuality,” adopted by the 1991 Churchwide Assembly (CA91.7.51). On gun control, see the resolution on “Community Violence—Gun Control” adopted by the 1993 Churchwide Assembly (CA93.6.10). The Churchwide Assembly resolutions are available online (www.elca.org/dcs/elca_actions.html).
4. This summary of risk factors draws especially from research findings from the National Institute of Mental Health and from the American Foundation for Suicide Prevention. For more information on risk factors, contact or visit the web sites of these and other organizations listed at the end of this message or consult the Surgeon General's report.
5. For more on depression contact or visit the web sites of the organizations listed at the end of this message. You also may refer to David Clark's book mentioned on page three. For information on the Lutheran Network on Mental Illness/Brain Disorders, contact Disability Ministries, Division for Church in Society, 800-638-3522 ext. 2710.
6. “Lectures on Romans.” Edited by Hilton C. Oswald, *Luther's Works*, Vol. 25 (St. Louis: Concordia Publishing House, 1972), p. 263.

7. See “Suicide Prevention Helpcard” on page six. Congregations are encouraged to copy this helpcard for use as a bulletin insert or to post on a bulletin board. They also may download this page at www.elca.org/dcs/suicide_prevention.html and adapt it with local information.
8. The American Foundation for Suicide Prevention (AFSP) maintains a current national directory of survivor support groups. For information on contacting the AFSP see the listing of organizations at the end of this message. “Survivor” refers to one who is a remaining family member or loved one of someone who has completed suicide. The Church’s vital ministry with survivors goes beyond the scope of this message. Helpful resources for this ministry include: *Mourning After Suicide*, Lois A. Bloom (Cleveland: The Pilgrim Press, 1986), a booklet for survivors; *Andrew, You Died Too Soon: A Family Experience of Grieving and Living Again*, E. Corrine Chilstrom (Minneapolis: Augsburg Fortress, Publishers, 1993); and *My Son . . . My Son . . . A Guide to Healing After Death, Loss, or Suicide*, Iris Bolton with Curtis Mitchell (Atlanta: Bolton Press, 1996). That book includes a list of things that may be comforting to survivors and one of the things that may be less helpful, pp. 110-111.
9. See the “Message on Community Violence,” adopted by the ELCA Church Council in 1994. 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.
10. The Surgeon General’s *Call to Action*, p. 10. The report cautions: “Existing suicide research is strongest in the identification of risk factors, particularly mental and substance abuse disorders, less developed in categorizing protective factors, and only beginning to analyze the mutual interactions among risk and protective factors” (p. 5).
11. “Message on End-of-Life Decisions,” adopted by the ELCA Church Council in 1992, p. 4. The message summarizes a Christian perspective on death and dying (p. 2) and offers guidance for difficult decisions at the end of life.
12. The Division for Church in Society has information for finding out more about parish nurse programs and other congregational health ministries online (www.elca.org/dcs/healthmin.html). For information on Stephen Ministries, go online (www.stephenministries.com) or phone 312-428-2600.
13. For information on peer ministry resources, adult training, youth retreats, camps, and support, contact: National Peer Ministry Training Center, Augsburg Youth and Family Institute, Campus Box #70, 2211 Riverside Ave., Minneapolis, MN 55454-1351, phone 612-330-1598, or go online (www.peerministry.org).
14. “Suicide Facts,” American Foundation for Suicide Prevention online (www.afsp.org).

15. "This church commits itself to the public policy goals of . . . health maintenance and care . . . as fundamental rights of every citizen. . . ." "Implementing Resolution for Human Rights Social Statement," Lutheran Church in America, 1978. The Evangelical Lutheran Church in America is presently involved in a study process on health and health care that will lead to a proposed social statement being considered at the 2003 ELCA Churchwide Assembly. For more information, contact the Division for Church in Society, 800-638-3522, ext. 2716.
16. The Division for Higher Education and Schools has an online listing of resources on violence prevention, grief, and suicide (www.elca.org/dhes/schools/violence.html).
17. See endnote two. It is encouraging to note that in Finland, the first country in the world to implement a nationwide suicide prevention project, the suicide frequency decreased by nine percent in the first decade of the project. "National Suicide Prevention Project a Success," STAKES, Press Release, March 4, 1999. The Evangelical Lutheran Church of Finland cooperated with the project from the beginning and has played an important role in its implementation. "Congregations have constituted one of the three most active local actors. Especially in crisis and relatives' group activities, congregations and parishes have played a major role." Maila Upanne, Jari Hakanen, Marie Rautava, *Can Suicide be Prevented? The Suicide Project in Finland 1992-1996: Goals, Implementation and Evaluation* (Helsinki: STAKES, 1999), pp. 120-2.



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