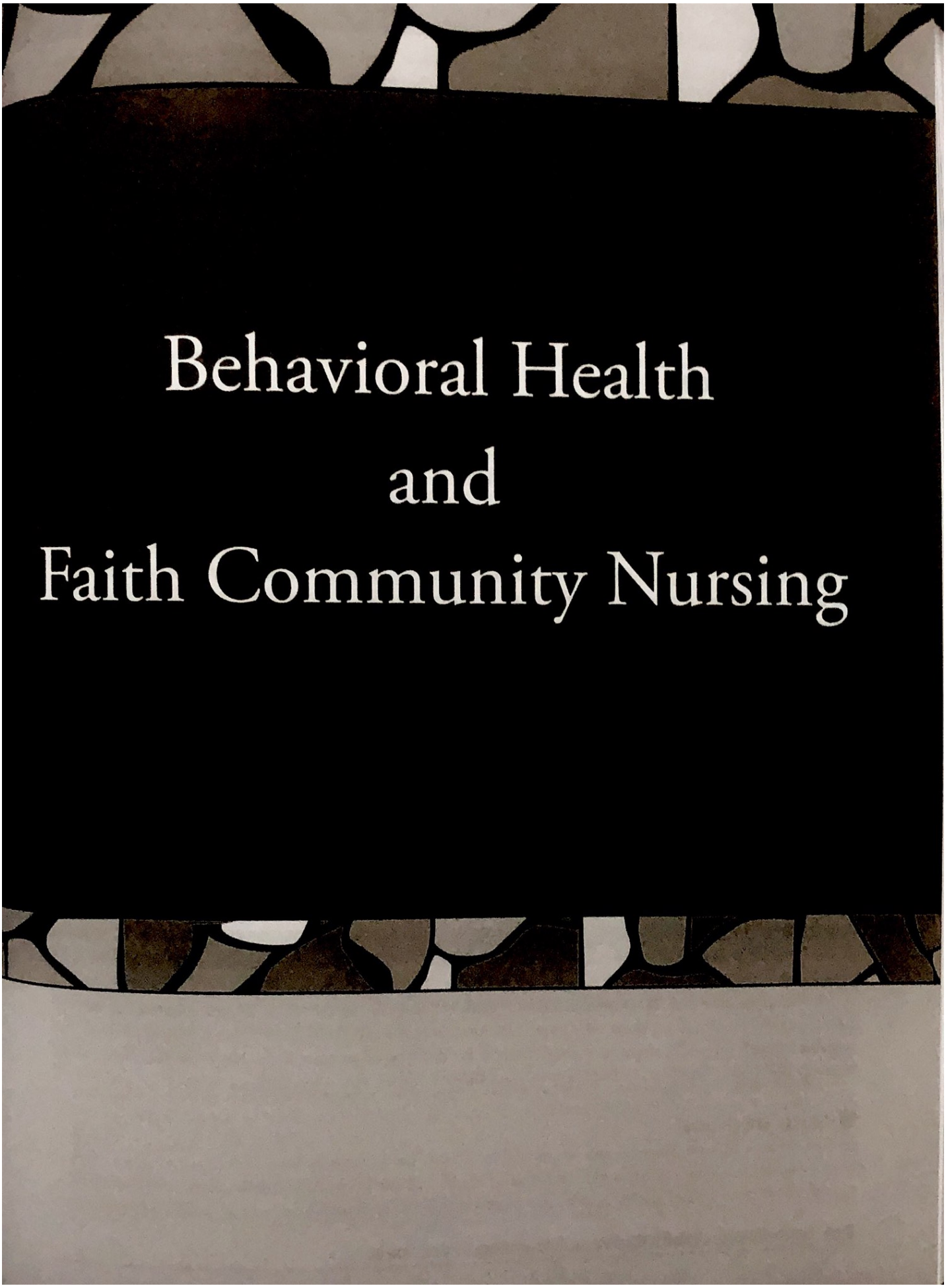

Behavioral Health and Faith Community Nursing

Behavioral Health and Faith Community Nursing

Introduction

2.5 Hours

■ Description

This module addresses the role of the faith community nurse (FCN) in providing behavioral health care in the faith community. It aims to increase the FCN's level of comfort in both educating the faith community about its role and in leading the health team in assessing the needs of the mentally ill.

Behavioral health often is used interchangeably with *mental health*. However, there is a difference. Mental health refers to the psychological state of someone who holistically functions at a satisfactory level. Behavioral health emerged in 1979 as an aspect of behavioral medicine promoting individual responsibility in maintaining health and preventing illness by a variety of self-initiated or shared activities. It promotes the well-being of individuals by intervening to address triggers of mental illness, such as substance abuse or the effects of trauma. In addition, the term *behavioral health* is less stigmatized than *mental health*, which may lead to more acceptance of mental conditions by traditional faith communities.

■ Research

Clergy's current beliefs about psychiatric care and the perceived need for treatment vary. In a recent survey conducted among 204 Protestant pastors, a significant number attributed symptoms of depression to "lack of trust in God," and many were reluctant to acknowledge the biological nature of depressive disorders. Another study conducted of Muslim clergy suggested that while imams can recognize the need for psychiatric care, they may be reluctant to make referrals to mental health providers due to concerns about discrimination. These studies reveal that although spiritual leaders are key counselors for religious people, the clergy's current perceptions of psychiatric disorders can lead to avoidance of referral to mental health providers (Ayvaci, 2017).

Additional concerns arise when religious people are hospitalized. In a recent observation study conducted at SUNY Downstate Hospital, Orthodox Jewish patients at the psychiatric inpatient unit faced conflicts between medical and religious practices. For example, inability to pray at accustomed times exacerbated the anxiety of some patients (Ayvaci, 2017).

At the same time, there is a movement among faith communities in the US to initiate programs to develop a supportive environment for those with mental health conditions and their families. Many of the programs are available through the public domain. A good resource for this type of program is the National Association of the Mentally Ill (NAMI) FaithNet. To learn more about NAMI FaithNet, visit www.nami.org/faithnet.

■ Faith Tradition

In both Western and non-Western cultures, mental health care has historically been understood within a religious framework. These religious beliefs could yield positive results, but also led to misunderstandings, such as attributing mental disturbance to evil spirits or demonic possession. Those suffering from mental conditions often were

stigmatized. Secular psychology in the twentieth century brought greater awareness to the understanding of mental health. By the 1980s, psychiatric wards had completely removed any religious influence from the treatment of mental illness. More recent studies recommend therapists change their attitudes from considering religious beliefs harmful to treatment, but it is still true that many therapists do not inquire about religious beliefs. Religious beliefs and practices, particularly in non-Western cultures, have been shown to be a positive influence on the process of human healing, and the psychological benefits of such beliefs and practices have proven valuable to the treatment of both physical and mental health conditions in human beings (Sayeed and Prakash, 2013).

■ Key Terms

Behavioral health: a state of mental and emotional being or choices and actions that affect wellness (Substance Abuse Mental Health Services Administration, 2013)

Caring environment: a faith community environment recognized by the mentally ill as accepting, sympathetic, and well-informed

Inclusion: the active, intentional, ongoing acceptance and welcoming of diversity in employment, service, lifestyles, abilities, denominations, cultural groups, and other communities

Mental health: a state of well-being in which individuals realize their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community. Cultural differences, subjective assessments, and competing professional theories all affect how mental health is defined (World Health Organization, 2014).

Model of Friendship: acceptance and friendship; a powerful deterrent to the internalization of the stigma of mental illness by the mentally ill

Multicultural faith community: a faith community comprised of many cultures, such as the deaf, people from diverse countries, and people from distinct regions or heritage

Role of the faith community: a practice of being involved in compassionate care of the mentally ill and advocating to change the stigma surrounding mental illness

Serious mental illness: psychological illness causing significant functional impairments that substantially interfere with life activities

Silence in the congregation: the way congregations of the mentally ill commonly react to mental illness by not publicly acknowledging the condition

Stigma: a mark of disgrace associated with a particular circumstance, quality, or person; persists due to lack of knowledge, portrayal of people by the media, and fear

Reflection

"For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ. For in the one Spirit we were all baptized into one body—Jews or Greeks, slaves or free—and we were all made to drink of one Spirit."
—1 Corinthians 12:12–13

"Dear Lord: Help us to remember that we are all your children and none is to be excluded from your church whether they have physical illnesses, mental illnesses, or any other disability. Give us the wisdom to appreciate all. In Jesus Christ's name. Amen."

"Allah is with those who are of service to others."
—Al Qu'ran 29:70

Learning Outcomes

Upon completion of this module, the participant will be able to:

1. Identify signs and symptoms of mental illness and their spiritual implications.
2. Identify signs and symptoms of behavioral health issues and their spiritual implications.
3. Make appropriate referrals, based on assessment, to behavioral health resources.
4. Create a plan to transform and enhance the current environment of the faith community to ensure an environment recognized as caring by those needing behavioral health services.

Content Outline

Outcome 1

Identify signs and symptoms of mental illness and their spiritual implications.

■ Mental and Behavioral Health Definitions

Key Term: Mental health is a state of well-being in which individuals realize their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community. Cultural differences, subjective assessments, and competing professional theories all affect how mental health is defined.

Key Term: Behavioral health is a state of mental and emotional well-being or choices and actions that affect wellness.

In 2016, the National Survey on Drug Use and Health (NSDUH) estimated that there are 10.4 million adults age 18 or older in the United States with serious mental illness. This represents 4.2 percent of the US adult population (www.nimh.nih.gov/statistics).

Key Term: Serious mental illness is a psychological illness causing significant functional impairments that substantially interfere with major life activities. The NSDUH survey describes serious mental illness as:

- mental, behavioral, or emotional disorder (excluding developmental and substance disorders)
- diagnosed currently or within the past year
- of sufficient duration to meet diagnostic criteria specified within the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM V)*
- resulting in serious functional impairment which substantially interferes with or limits one or more major life activities (NSDUH, 2016)

The *Diagnostic and Statistical Manual of Mental Disorders—5* (2013) lists many mental illnesses. These are the most prevalent diagnoses:

In adults:

- major depression
- schizophrenia
- bipolar disorder
- anxiety disorder
- borderline personality disorder
- antisocial personality disorder

In children:

- attention deficit hyperactivity disorder
- depression
- behavioral disorders

■ Signs and Symptoms of Mental Illness in Adults

The American Psychiatric Association identifies these signs and symptoms as associated with the most prevalent disorders.

Major Depression—serious psychological depression that lasts two or more weeks characterized by a loss of interest or pleasure in almost all activities

- loss of interest in favorite activities
- depressed mood for longer than two weeks
- thoughts of suicide
- feeling hopeless, overwhelmed, or helpless
- withdrawing from social network and family
- difficulty with sleep (too much, too little)

Schizophrenia—characterized by disturbances in thought, perception, and behavior

- delusions
- hallucinations
- lack of concentration, inability to plan, memory problems
- loss of motivation for self-care
- blunted emotions
- social withdrawal

Bipolar Disorder

There are two subtypes of bipolar disorder.

- bipolar I (mania, then depression) • bipolar II (depression, then hypomania)

Depression in bipolar disorder has some or all of the symptoms of major depression. Manic episodes will have some of the following symptoms:

- increased energy and over-activity
- elevated mood: feeling high, full of energy, invincible
- long periods of not sleeping
- irritability
- rapid thinking and speech
- lack of inhibitions: reckless spending, hypersexuality, risky behavior
- delusions of grandeur (feeling all-powerful, superior)
- lack of insight: inability to see episode as a sign of illness

Anxiety Disorder—excessive and unrealistic worry over a period of at least six months

- restlessness
- fatigue
- difficulty concentrating
- irritability or explosive anger
- muscle tension
- sleep disturbances
- personality changes, such as becoming less social
- possible phobic disorders (fear of certain objects, situations)
- panic attacks (sudden, intense periods of fear or feelings of doom)

Post-traumatic stress disorder (PTSD) represents anxiety caused by circumstances or events that threaten a person's physical well-being. The traumatic event is re-experienced with fear or feelings of helplessness or horror and may appear in dreams or in recurrent thoughts.

Borderline Personality Disorder—a pervasive pattern of instability in interpersonal relationships, self-image, and marked impulsivity beginning by early adulthood

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- identity disturbance: marked and persistent unstable self-image or sense of self
- impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- recurrent suicidal behavior, gestures, threats, or self-mutilating behavior

- affective (mood) instability
- chronic feelings of emptiness
- inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, recurrent physical fights)
- transient, stress-related paranoid ideation or severe dissociative symptoms

Antisocial Personality Disorder—a condition in which a person has a long-term pattern of manipulating, exploiting, or violating the rights of others; behaviors often are criminal in nature.

- witty and charming disposition
- flattery and manipulation of others' emotions
- repeated violation of the law
- disregard of the safety of self and others
- problems with substance abuse
- frequent lying, stealing, fighting
- little or no remorse for actions
- frequent anger, arrogance

■ Signs and Symptoms of Mental Illness in Children

Major Depression—exhibits the same symptoms as those seen in adults

- sadness, a feeling of hopelessness, mood changes
- complaints of physical illnesses (e.g., recurring stomachache) that do not respond to treatment
- thoughts of death and suicide

Attention Deficit Hyperactive Disorder (ADHD)—exhibits inattention, hyperactivity, or impulsivity in specific ways

- constant motion
- squirming and fidgeting
- inability to listen
- difficulty playing quietly
- talking incessantly
- interrupting and intruding on others
- not finishing tasks
- frequent distraction

Behavior Disorders—involve patterns of behavior that are hostile, aggressive, and disruptive for a period of more than six months; not developmentally age-appropriate

- harming or threatening self, others, or pets
- damaging or destroying property
- lying or stealing
- poor performance in school, skipping school
- early smoking, drinking, or drug use
- early sexual activity
- frequent arguments and tantrums
- hostility toward authority figures

■ Substance-Induced Disorders in Adults or Children

Research has shown a strong relationship between Adverse Childhood Experiences (ACEs), substance abuse disorders, and behavioral problems. The neurodevelopment of a child can be disrupted when exposed to chronic stressful events, leading to impairment in the ability to cope with negative or disruptive emotions (https://www.samhsa.gov/capt/). Includes disorders related to:

- alcohol
- cannabis
- hallucinogens
- opioids
- sedatives and hypnotics
- anxiolytics
- stimulants

These disorders share some common symptoms:

- substance taken in larger amounts than intended
- increased activity to obtain the substance
- recurrent failure to fulfill major role at work, home or school
- abandoned social, occupational, and recreational activities
- use in situations considered risky
- sleep difficulty or restlessness
- nervousness, anxiety, irritability, anger, aggression (APA, 2013)

Opioids have been used to modify pain since the beginning of history. However, the World Health Organization has declared opioid addiction a widespread epidemic (2014). The US is trying to organize its public health community to tackle the epidemic. Public stigma and stereotypes have been identified as barriers to treatment that occur when the general population endorses stereotypes and discriminates against people labeled with a behavioral health disorder. Collaboration is essential for success in prevention of opioid overdose deaths. Medical personnel, emergency departments, first responders, public safety officials, mental health and substance abuse treatment providers, community-based organizations, public health, and members of the faith community all bring awareness, resources, and expertise to address this complex and fast-moving epidemic. Pain management and pain control for chronic conditions is essential. The FCN is in an ideal position to educate healthcare consumers about monitoring pain control in order to provide improved pain control options and to prevent abuse of prescription drugs and addiction (Corrigan and Nieweglowski, 2018). The FCN should also provide education related to stereotypes and stigma in faith communities in order to facilitate recovery for parishioners who may be addicted.

■ Implications of Mental Illness on Spirituality

Spirituality and faith may be influenced by the signs and symptoms of mental illness in the following ways:

- Isolation, withdrawal from family and community, leading to feelings of being alone and abandoned.
- Frustration with emotional pain, leading to a distance between the individual and God, particularly when prayers go unanswered (Koenig, 2005).

Key Term: Stigma is a mark of disgrace associated with a particular circumstance, quality, or person; persists due to lack of knowledge, portrayal of people by the media, and fear. Hallucinations and delusions present in the psychotic state may lead certain mentally ill individuals to believe that God is talking to them, and to interpret biblical readings erroneously (Simpson, 2013).

Outcome 2

Identify signs and symptoms of behavioral health issues and their spiritual health implications.

■ History of the Church's Care for People with Mental Illness

Understanding the issues that form barriers to ministering to people with mental illness requires first understanding the history of the church's involvement in the care of people with mental illness.

- Historically, religious beliefs often influenced the misunderstanding of mental illness.
- People with mental illness were often characterized by religious leaders as possessed by demons or evil spirits.
- Before the modern era, concern about demons and evil spirits led to fears that mental illness was contagious. This, in turn, led to confinement, exorcism, or death (Koenig, 2005).
- In spite of these concerns, history shows that major religious traditions throughout the world have been at the forefront in providing care for the mentally ill and emotionally vulnerable (Koenig, 2005).
- Many of the breakthroughs in caring for people with mental illness have been championed by members of religious organizations crusading for change (Koenig, 2005).
- Congregations that have turned a blind eye to mental illness have led many families to leave the faith community (Rogers et al., 2012). "The data give the impression that mental illness, while prevalent within a congregation, is also nearly invisible" (Stanford, 2012).
- Families of people with mental illness would like the church community to provide assistance with the issues they face.
- Data indicate that the faith community often overlooks the needs of the mentally ill.

■ Barriers to Effective Ministry

Amy Simpson calls mental illness the "no-casserole" disease (2013). She paints a picture of families dealing with mental illness watching their congregation deliver casseroles and offer support and help to the physically ill while the mentally ill suffer in silence.

Key Term: Silence in the congregation is the way congregations of the mentally ill commonly react to mental illness by not publicly acknowledging the condition. This silence toward families affected by mental illness is often the main barrier to church involvement. Families themselves may be silent due to the stigma that still exists. Congregations are uninvolved in many instances due to lack of knowledge of the signs of mental illness. The portrayal in the media regarding those with mental illness—such as perpetrators of mass shootings—may also cause the congregation to be hesitant in reaching out to the mentally ill.

Faith-based providers have been found to be reluctant to collaborate with formal health services due to:

- lack of demand from the community
- financial limitations
- lack of specialized training (Ayvaci, (2017)

Critical Thinking

What have you seen happen to the spirituality of people who have been diagnosed with mental illness?

Outcome 3

Make appropriate referrals, based on assessment, to behavioral health resources.

■ Appropriate Assessment

The **goals of the assessment** of a faith community member who has presented with signs and symptoms of mental illness are to:

- keep the person safe
- refer to the appropriate level of care

An appropriate assessment includes the following (Kitchener et al., 2009):

1. Assess for threat of harm to self or others.

- Do not be afraid to ask the question, "Are you thinking of hurting yourself or others?"
- If the answer is yes, do not leave the person alone. (See Appendix C for appropriate questions if the answer is yes.)

2. Listen nonjudgmentally. Use empathetic listening skills—open-ended questions, clarification, restating with an open and inviting presence, listening to tone of voice, and nonverbal clues. Avoid giving unhelpful advice, such as "Pull yourself together."

3. Give reassurance and information.

- Do not make promises you cannot keep.
- If people are hallucinating or delusional, they may not be able to understand information. This can be offered after the person has been treated and is in touch with reality.
- Reassure with statements validating the person's feelings, such as "I know you believe the visions are real. I will help keep you safe."
- Assist in contacting the individual's therapist, if the person is not able to do so due to mental state.

4. Encourage appropriate professional help. For those experiencing suicidal or homicidal ideation:

- Contact the therapist.
- Accompany the person to the local hospital emergency room for evaluation.
- If you cannot persuade the person to go to the ER, file a mental detention order with the local sheriff's department.

For those experiencing panic attacks, fear of dying, or extreme distress:

- Monitor physical symptoms as well as mental and emotional symptoms.
- Be aware that people experiencing a panic attack may think they are having a heart attack, especially if this is their first panic attack. In this case, refer a person having chest pain to the emergency room or call 911.
- If the individual has had panic attacks previously, ask what has worked to relieve an attack in the past, and provide assistance.

For those experiencing symptoms suspected to be signs of substance abuse:

- Try to get individuals to a safe place.
- Do not argue if they show signs of intoxication. This is one argument you will not win.
- Do not let the person drive or engage in activity that could cause harm to themselves or others.
- Contact Alcoholics or Narcotics Anonymous as a resource.
- If unable to manage the situation, or if the person becomes aggressive, keep yourself and others safe by isolating the person in any way possible.
- Contact law enforcement for assistance and describe the situation, including the substance being used if it is known.

For those experiencing exacerbation of mental illness without aggression:

- Encourage the person to seek counseling.
- Provide local resources and help make an appointment.

For those who are aggressive:

- **Keep yourself safe. Take all threats seriously.**
- **De-escalate the situation.**
  - √ Stay calm.
  - √ Use a calm tone of voice.
  - √ Use nonthreatening language.
  - √ Allow the person to pace if needed.
  - √ Do not involve law enforcement unless absolutely necessary as the situation may escalate; if you involve law enforcement, be sure to fully describe the behavior you are observing.
  - √ Sometimes passing the person off to another member of the health team or the spiritual leader may help de-escalate the situation if the person is directing anger toward you personally.

Critical Thinking

What barriers in the faith community have you seen interfere with ministering to people living with mental illness?

■ Cultural Considerations

Key Term: A multicultural faith community is a faith community comprised of many cultures, such as the deaf, people from diverse countries, and people from distinct regions or heritage. In a multicultural faith community, it is appropriate to ask the faith community member the following questions, all of which give the faith community member a feeling of respect about the referral.

- What would you like for your provider (psychiatrist, psychologist, social worker, or therapist) to know about your religious or spiritual beliefs and practices?
- What forms of healing are practiced in your religion?
- Is there a spiritual leader or healer you would find helpful while you are receiving care?

Culture-related questions that may be helpful in assessing the needs of the faith community member include:

- What do you call your complaint or condition?
- What do you think caused this?
- What do you think will happen because of this condition?
- What do you think about getting a diagnosis and treatment from a mental health professional? How will this affect your life?

Outcome 4

Create a plan to transform and enhance the current environment of the faith community to ensure an environment recognized as caring by those needing behavioral health services.

Families with members suffering from mental illness would like to experience an accepting, sympathetic, and well-informed community. In this type of community, they will be in a situation to express their feelings and share their experiences in a nonthreatening environment without fear of rejection or condemnation (Swinton, 2000).

Key Term: Role of the faith community is a practice of being involved in compassionate care of the mentally ill and advocating to change the stigma surrounding mental illness.

Rather than being a place where a stigma around mental illness persists, faith communities can seek to be supportive. ***Key Term: Caring environment*** is a faith community recognized by the mentally ill as accepting, sympathetic and well-informed. Several models have met with success in changing the culture of faith communities to one that provides resources, support, and acceptance. For persons living with psychosis, religious and spiritual spaces are a readily available resource that can support recovery and community inclusion. However, these resources are often underutilized in treatment planning.

Critical Thinking

What behavioral health resources are available in a faith community and in the external community to support a person with mental illness?

An in-depth qualitative analysis explored the construction of community through faith spaces, religion, and spirituality for persons with psychosis. This grounded theory study revealed three themes: (a) creating community and increasing resilience through religion and spirituality; (b) identifying barriers to engaging in religion and spirituality; (c) facilitating inclusion in faith spaces (Virdee et al., 2016). Faith spaces provided an environment in which the whole person was embraced, enabling a more coherent sense of self. These findings have implications for faith community nurses to enhance the social and spiritual experience of persons living with behavioral and mental health issues. Education provided to faith community leaders and members can reduce the stigma and stereotyping. ***Key Term: Inclusion*** is the active, intentional, ongoing acceptance and welcome of diversity in employment, service, lifestyles, abilities, denominations, cultural groups, and other communities.

Key Term: Model of Friendship is acceptance and friendship; a powerful deterrent to the internalization of the stigma of mental illness by the mentally ill.

- This type of friendship is modeled on the relationships of Jesus: unconditional acceptance (John 4:9) and solidarity with the poor and the marginalized (Matthew 9:10).
- Swinton's basic model for the church emphasizes education about friendship as Jesus demonstrated: seeking out information regarding the need for advocacy and empowerment of the mentally ill, formulating a plan for church involvement, and developing relationships with other community agencies (2000).

Critical Thinking

Can a nonbehavioral health professional adequately assess a mental health issue for referral? Explain your answer.

Creating Caring Congregations (Mental Health Ministries, 2018) is a five-step program that includes education of the faith community regarding mental illness; commitment to the intentional care and support of those with mental illness; welcoming those with mental illness as full members of the faith community as well as providing support and advocacy.

Pathways to Promise (www.pathways2promise.org) offers a toolkit for mental health ministries that includes national resources, monthly activities focusing on mental health issues, and suggestions about how to be welcoming to those who suffer from mental illness. It includes tools needed to start and maintain a ministry focusing on people with mental illness. This model includes education, community, hospitality, service, and advocacy.

Standards of Professional Performance for Faith Community Nursing

All standards of care will apply to faith community nursing practice. In connection with behavioral health, the FCN will be heavily involved in the assessment of the client and the church culture, education and advocacy to reduce stigma, appropriate referral, and resource utilization.

Standard 1. Assessment

The faith community nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.

Competencies

The faith community nurse:

- Collects pertinent data, including but not limited to demographics, social determinants of health, health disparities, and physical, functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual/transpersonal, and economic assessments in a systematic, ongoing process with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
- Recognizes the importance of the assessment parameters identified by World Health Organization (WHO), Healthy People 2020, or other organizations that influence nursing practice.
- Integrates knowledge from global and environmental factors into the assessment process.
- Elicits the healthcare consumer's values, preferences, expressed and unexpressed needs, and knowledge of the healthcare situation.
- Recognizes the impact of one's own personal attitudes, values, and beliefs on the assessment process.
- Identifies barriers to effective communication based on psychosocial, literacy, financial, spiritual, religious, and cultural considerations.
- Assesses the impact of family dynamics on healthcare consumer health and wellness.
- Engages the healthcare consumer and other interprofessional team members, in culturally sensitive data collection related to health and wholeness.
- Prioritizes data collection based on the healthcare consumer's immediate condition or the anticipated needs of the healthcare consumer or situation.
- Uses evidence-based assessment techniques, instruments, tools, available data, information, and knowledge relevant to the situation to identify patterns and variances.
- Applies ethical, legal, and privacy guidelines and policies to the collection, maintenance, use, and dissemination of data and information.
- Recognizes the healthcare consumer as the authority on their own health by honoring their care preferences.
- Documents relevant data accurately and in a confidential manner and accessible to the interprofessional team when applicable.

Standard 5A. Coordination of Care

The faith community nurse coordinates care delivery.

Competencies

The faith community nurse:

- Organizes the components of the plan.
- Collaborates with the consumer to help manage health care based on mutually agreed-upon outcomes.
- Coordinates implementation of a whole-person-centered plan of care with particular emphasis on the spiritual needs of diverse populations.

- Manages a healthcare consumer's care in order to maximize independence and quality of life in accordance with mutually agreed upon outcomes.
- Engages healthcare consumers in self-care to achieve preferred goals for quality of life with attention to mind, body, and spirit.
- Assists the healthcare consumer to identify options for care.
- Communicates with the healthcare consumer, family, interprofessional team, and community-based resources to effect safe transitions in continuity of care.
- Advocates for the delivery of dignified and whole-person humane care by the interprofessional team.
- Documents the coordination of care.

■ Standard 12. Education

The faith community nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.

Competencies

The faith community nurse:

- Identifies learning needs based on nursing knowledge and the various roles the nurse may assume and the changing needs of the population.
- Participates in ongoing educational activities related to nursing and interprofessional knowledge bases and professional topics and spiritual care.
- Mentors nurses new to their roles for the purpose of ensuring successful enculturation, orientation, and emotional support.
- Demonstrates a commitment to lifelong learning through self-reflection and inquiry for learning and personal growth.
- Seeks experiences that reflect current practice to maintain and advance knowledge, skills, abilities, attitudes, and judgment in clinical practice or role performance for faith community nursing.
- Acquires knowledge and skills relative to the role, population, specialty of faith community nursing, setting, and global or local health situation.
- Participates in formal consultations or informal discussions to address issues in nursing practice as an application of education and knowledge.
- Identifies modifications or accommodations needed in the delivery of education based on healthcare consumer and family members' needs.
- Shares educational findings, experiences, and ideas with peers.
- Supports acculturation of nurses new to their roles by role modeling, encouraging, and sharing pertinent information relative to optimal care delivery.
- Facilitates a work environment supportive of ongoing education of healthcare professionals.
- Maintains a professional portfolio that provides evidence of individual competence and lifelong learning.

■ Standard 16. Resource Utilization

The faith community nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible.

Competencies

The faith community nurse:

- Assesses healthcare consumer care needs and resources available to achieve desired outcomes.
- Assists the healthcare consumer in factoring costs, risks, and benefits in decisions about treatment and care.
- Assists the healthcare consumer in identifying and securing appropriate services to address health and spiritually related needs across the healthcare continuum.
- Delegates in accordance with applicable legal and policy parameters.

Appendix A

■ Quiz on Mental Illness

Circle Y or N for each statement.

1. Mental illness only affects people in poverty.	Y	N
2. Many of the homeless have a form of mental illness.	Y	N
3. People with mental illness are violent.	Y	N
4. Only non-Christians experience mental illness.	Y	N
5. Mental illness results because people are sinful or evil.	Y	N
6. There is no effective treatment for mental illness.	Y	N
7. People will avoid the subject of mental illness due to fear of the mentally ill.	Y	N
8. Medication is a useful form of treatment for mental illness.	Y	N
9. Many view mental illness as weakness.	Y	N
10. Most faith communities are open and welcoming to the mentally ill.	Y	N

1. N; 2. Y; 3. N; 4. N; 5. N; 6. N; 7. Y; 8. Y; 9. Y; 10. N.