NCPD 2.5 contact hours

By Veronica Gallo

Identifying Mental Health Needs in the Faith Community

ABSTRACT: *Nearly one in five Americans suffers from a mental health disorder, and mental health issues have escalated during the COVID-19 pandemic. As trusted members of the community, faith community nurses are in a key position to assess mental health needs and take leadership roles in the faith community to address these needs. The aim of this project was to assess the mental health needs of one faith community. Qualitative data with quantitative data from secondary sources were gathered. Analysis revealed three problems for those suffering from mental health disorders: lack of resilience and coping strategies, fear and/or ignorance of mental health disorders, and unfamiliarity with community and health resources.*

KEY WORDS: *community health, faith community nursing, mental health, nursing, substance use, suicide*

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The author declares no conflict of interest.

Accepted by peer review 10/21/2021.

DOI:10.1097/CNJ.0000000000000960

ASSESSING FAITH COMMUNITY MENTAL HEALTH NEEDS

Background and literature review

Nearly one in five American adults suffers from a mental health disorder. Mental health disorders occur in persons of all races, ethnicities, genders, and socioeconomic status (National Institute of Mental Health [NIMH], 2021). People with mental illness are twice as likely to develop cardiovascular and metabolic disorders than the general population, and mental illness has been directly related to suicide and addiction (National Alliance on Mental Illness [NAMI], 2021). In 2020, suicide ranked as the 10th leading cause of death among all age groups in the United States. Among those age 10 to 34, suicide was identified as the third leading cause of death (NIMH, 2021). Furthermore, during the current opioid crisis in the United States, drug overdose deaths have escalated from 17,000 deaths per year in 1999 to more than 70,000 deaths in 2019 (National Institute on Drug Abuse, 2021).

The COVID-19 pandemic, resulting social isolation, economic stress, and lack of access to care have further raised these numbers, especially among vulnerable populations. Suicide rates among African Americans and persons with serious mental illnesses increased during the pandemic (Gordon, 2021). In the first months of the pandemic, 13% of Americans reported beginning or increasing substance use to cope with stress and emotions related to the pandemic (Abramson, 2021). Every state in the United States reported a spike in overdose deaths or other outcomes during the pandemic (American Medical Association, 2021). Experts also agree that the experience of living through the pandemic may lead to chronic mental health symptoms, such as posttraumatic stress disorder (PTSD) or major depressive disorder (Gordon, 2021).

Faith leaders, including faith community nurses (FCNs), are in a unique position to help. They are often the first point of contact for individuals and families facing mental health issues or experiencing crisis (MentalHealth.gov, 2019). Leaders in mental health recognize that faith communities could help to bridge the gap between community care and formal mental healthcare by 1) educating communities and congregations; 2) identifying opportunities to support people with mental illness; 3) connecting individuals and families to services; and 4) promoting acceptance of those with mental health issues (MentalHealth.gov, 2019). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2022) advocates for faith-based and community initiatives aimed at the support of mental health services, substance abuse prevention, and addiction treatment through the provision of training for faith communities and faith-based grant programs and initiatives. As leaders in their faith communities, FCNs are well situated to coordinate and deliver mental health ministries, which may include social support, health education, advocacy, and spiritual care (American Nurses Association [ANA], 2017).

The aim of this project was to assess the mental health needs of both the faith community and the extended community and identify needs for which the nurse

can provide interventions. This project serves as an example of how FCNs might evaluate and advocate for mental health ministries within the faith community. Exempt status was granted by the West Virginia University School of Nursing institutional review board.

METHODS

Defining the community

The faith community of interest is a Catholic church in rural West Virginia with a congregation of 802 active and registered parishioners; the attendance at mass averaged 500 to 600 individuals prepandemic. The parish has an established health ministry team comprised of registered nurses (RN), retired RNs, licensed practical nurses, and social workers. This team provides a variety of annual health screenings and health education classes. A bereavement group is offered twice yearly. Although there is an increase in mental health conditions state and nationwide, no consistent mental health programming was offered.

The city where church is located was also included in this assessment; this provided insight into community assets that support or hinder community health improvement (Rosenbaum, 2013). This information can be used by FCNs to seize opportunities for referral and collaboration, determine gaps in needs or care, or reveal the need for outreach ministries.

Project design

The multistep community assessment process was derived from accepted community assessment practices, such as defining the community of interest, recording observations of the community, interviewing stakeholders and key informants, reviewing survey findings, and gathering demographic and behavioral statistics from secondary sources (Association for Community Health Improvement [ACHI], 2017; Stanhope & Lancaster, 2019). As the project focus was to assess the community's mental health needs, the assessment paid special attention to mental health indicators. Secondary data were collected from existing open access databases, such as the West Virginia Department of Health and Human Services, Bureau for Behavioral Health, the Centers for Disease Control and Prevention (CDC), and SAMHSA. Data were analyzed and triangulated to identify mental health needs within the community (ACHI, 2017; Stanhope & Lancaster, 2019). Next, needs were examined to identify if interventions would be within the ANA FCN scope of practice and might impact national health initiatives.

Although observations provide important data about the community of interest, direct input from faith community leaders and members is invaluable. Interviews with key informants provide firsthand knowledge to gain insight into community health needs. Key informants typically represent a wide range of people, including community leaders, professionals, and residents (Stanhope & Lancaster, 2019). Informants represented variety within the parish such as family, middle-aged adults, males, females, and single adults. Informants also were chosen because of their leadership roles


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and/or dedication to ministries within the church. Three males and four females were interviewed, ranging in age from 35 to 72 years.

Leaders in mental health recognize that faith communities could help to bridge the gap between community care and formal mental health care.

The FCN conducted interviews by telephone due to COVID-19 restrictions. The interviewing nurse had expertise in qualitative data collection methods. Prior to interviews, the nurse analyzed her personal opinions about interview questions. Informants were asked four questions:

1. Tell me your perceptions of mental health needs in our church and broader community.
2. Tell me what, if any, mental health programs or interventions might be helpful to our church and broader community.
3. What do you see as barriers to mental health programs or interventions in our church or broader community?
4. What do you see as facilitators to mental health programs or interventions in our church or broader community?

Prompts elicited further responses for clarification. Interview notes and interview narratives were recorded as written narratives immediately after each interview. Written narratives were stored in a password-protected computer. To protect the informants' confidentiality, names and identifying information were removed from narratives. Data collection ceased once data saturation occurred and themes and categories became repetitive and redundant (Polit & Beck, 2017).

Written narratives were analyzed using content analysis to determine what mental health issues were of most concern to community members, programs and/or interventions of most interest to community members, and perceived barriers and facilitators related to addressing mental health issues (Hsieh & Shannon, 2005). Results were provided to two respondents to review for accuracy and resonance with experiences (Polit & Beck, 2017).

FINDINGS

Key informant interviews and behavioral health statistics provided data to enlighten this faith community assessment in addition to the observation of the community itself. These results are presented here.

Observation of the community

Observation of the community provided insight into barriers and facilitators of mental health, including available mental health resources and social determinants of mental health (Stanhope & Lancaster, 2019). It was noted that there were mental health resources near the faith community. The faith community, located in the greater downtown area, is within walking distance to the county courthouse, health department, public library, and the county's only homeless shelter. There are two sober-living houses nearby. No acute care hospitals are within city limits; however, the city is host to the county health department, an inpatient mental health hospital, veterans hospital and outpatient clinics, medication-assisted treatment center, and several outpatient mental health facilities. The city is also home to a youth crisis center, the task force on domestic violence, and a women's shelter.

Several substance use recovery programs such as Alcoholics Anonymous, Narcotics Anonymous, and Celebrate Recovery are available. Programs are hosted at various church and community venues, several of which are close to the faith community of interest. The city is also home to a nonprofit organization that provides education, advocacy, and resources to the broader community to promote healthy behaviors. The organization focuses mainly on behavioral health issues such as substance abuse and suicide, and programs are free of charge.

Social determinants of health, such as poverty, have been associated with poor mental health (Burns, 2015). The city has many vacant buildings; several long-standing professional businesses have closed or relocated to newly developed business districts within the county. There are several high-rise, low-income apartment buildings in city limits. Single-family dwellings are a part of the downtown landscape, though many are in disrepair or have been converted into rental units. One downtown section remains a desirable neighborhood for medium- to high-income families. Many residential portions of the downtown area are considered low-income housing and are less desirable.

Access to green spaces and recreational facilities has been linked to improved physical and mental health (National Recreation and Park Association, n.d.). One revitalization project is underway in a neighborhood within four blocks of the faith community of interest. This project boasts a community center with a gymnasium that eventually will host after-school and community programs, a community garden, and a playground. No other parks or green spaces are within walking distance of this location. However, several large parks and public walking and biking trails on the city's periphery. The church itself is sizable with a detached social hall. An elementary school and a high school are directly beside the church, as well as several parking lots.

Community action groups and nonprofit agencies can provide help to residents in need at no cost or reduced cost (SAMHSA, 2016). Several commu-

nity action groups offer additional housing to homeless individuals during inclement weather and host food distribution centers for the economically disadvantaged. The city has numerous nonprofit organizations that provide care or services to socioeconomically disadvantaged persons. These include food banks, a senior center, family care centers, and family and pregnancy service organizations; most are within walking distance of the faith community.

Key informant interviews

Three themes emerged from the key informant interviews: 1) we have a problem with mental health, but we don't understand why, 2) knowing our resources and how to cope could help, and 3) stigma, time, and buy-in will affect programming.

We have a problem with mental health, but we don't understand why

Four of the seven community stakeholders interviewed commented about drug use. The epidemic was described in relation to other mental illnesses, traumatic home situations, biological and chemical reasons, and grandparents raising grandchildren of drug-addicted parents. One informant described the epidemic in relation to many of these issues: "Of course, we have a terrible drug epidemic….I'm not sure if it's a result of mental health issues, falling away from the church, poverty, homelessness…."

Five of the seven informants expressed wonder at how and why mental health disorders came to be. One informant described grandparents caring for their grandchildren because their own children suffered from substance use disorder.

> Their adult children are addicted. Their needs are different; they ask, 'What did I do wrong?' There is a lot of guilt over where they went wrong raising their own kids. They are scared to make the same mistakes with grandchildren. I see this a lot in the community health agency that I volunteer in as well….a lot of grandmothers with adolescents in their house that say they 'tried their best' to avoid making same mistakes.

Another informant remarked,

> I wonder if people have lost hope, are not getting what they need out of church. I wonder how we can find out why? I wonder what leads to violence in the schools, lack of family, lack of God in lives…

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Knowing our resources and how to cope could help

Two informants stated that it was difficult to navigate the healthcare system and find resources to help persons and families suffering from mental health disorders. When discussing assisting a parishioner with mental illness to get help, the informant remarked,

> Getting into the healthcare system is a problem! There is no way anyone with serious mental illness can negotiate the system on their own….it's no wonder they turn to drugs and become homeless… But there is no way a person with severe mental illness can do it on their own. They need help to manage and monitor their disease. It's also a problem knowing who to refer people to-–who's good, what resources are out there.

This statement was reinforced by another: "A lot of parishioners have told me they need help dealing with and knowing resources available to them as caregivers and for family members with substance abuse problems."

Informants were asked what mental health programs were needed in the church. All described a need for programming focused on teaching coping skills for various ages and situations. One informant said, "People don't have healthy ways to deal with everyday life. We need something on coping." Five informants remarked on programs needed for youth and adolescent parishioners related to coping and resilience. When discussing the problem of grandparents raising grandchildren, one respondent noted, "We also need stuff for the kids. Support groups or programming to help them deal with their emotions. To help prevent them from making [the] same mistakes as parents."

Another informant remarked,

> ….the youth group…. I think that's important. We had a young friend commit suicide a few years back. It was so hard to have those conversations with my young son at the time. I would have liked help in how to talk to him about that. Maybe someone to offer something like that…..in the schools or in the church.

Informants described the need for additional coping programs and support groups, including focus on caregivers, substance use disorder, PTSD, and grief. Informants explained the need for coping programs to integrate multiple facets of health, including physical, spiritual, and mental. One parishioner described this as a "holistic" approach, whereas others were more prescriptive in their statements. The need to integrate faith and spirituality into coping programs was expressed by one informant:

> Well, hope is key for mental development. How is hope being presented in an environment for kids and adults? That's what God does, that's what the church does (gives hope)…. Premise needs to be tied to God and Jesus and our Catholic faith.

The use of sporting programs and other outlets were also described by many as a way to facilitate groups on coping. Although one described the use of sports leagues, such as volleyball or basketball, another summarized this by stating,

> I guess maybe a series that would incorporate mental wellness with other activities…yoga, essential oils, cooking, knitting, so people feel like they are coming away with another skill or something. Integrate those with mental health.

Stigma, time, and buy-in will affect programming

Key informants were asked what barriers and facilitators existed regarding the faith community and mental health programming. Analysis of written narratives revealed that stigma, time, and buy-in would hinder or help participation in programming. Five of the seven individuals interviewed identified stigma as a barrier. Discussions of stigma related to fear of judgment or labeling by others, feelings of weakness if they attend mental health programming, and general avoidance of mental health discussions. Perhaps one summarized it best: "The stigma is a barrier. People are afraid of what people will think of them."

Three individuals described time as a barrier to programming, stating that programs would need to be offered at times that were convenient to target audiences and would contain valuable information. One noted,

> It's so hard to get people out of their homes to come to things. It's got to be worthwhile….I mean, it's so hard. What is the best time? People work during the day and in the evening there are so many activities. Childcare can be a barrier too.

Three of the seven informants described buy-in as a potential barrier or facilitator of mental health programming. "For something to work, you're going to have to have the cooperation of all important players—clergy, teachers, etc. They have to see a need, everyone must be a supporter even if they are not a contributor. Need buy-in."

Another participant described how buy-in could be improved by involving influential members in the church. "Getting the right people involved…. it's terrible to say, but people are willing to do things when they see the right people involved."

Behavioral health statistics

Data were gathered from government and organization websites to identify indicators of community mental health. Indicators included geography and ethnicity, presence of mental illness, incidence of suicide, experience of trauma, poverty and homelessness, and substance use disorder, including alcohol and illicit drugs. These data provide insight into barriers and facilitators to mental health in the surrounding community. The FCN must be able to integrate global and environmental factors into the assessment process (ANA, 2017). All of West Virginia lies within the Appalachian region. Appalachians have disproportionately higher rates of mental health problems when compared with the U.S. population (American Psychiatric Association [APA], 2018). West Virginia ranks number one in the United States for incidence of depression with nearly 22% of the population having been diagnosed with depression. West Virginia had the highest percentage of adults reporting symptoms of anxiety or depression in a survey conducted by the U.S. Census Bureau during the pandemic (National Center for Health Statistics, 2022). West Virginia ranks among the top 10 states for suicide, with a rate of 21.1 per 100,000 persons. Suicide is the second leading cause of death for persons ages 15 to 34, and the fourth leading cause for persons ages 35 to 54. In West Virginia, nearly one person dies by suicide every 22 hours (American Foundation for Suicide Prevention [AFSP], 2021).

Experience of trauma is associated with negative mental health outcomes; West Virginians' experience of trauma is high. Adverse childhood experiences (ACEs) are on the rise among West Virginians. Adverse childhood experiences are events that occur in children up to age 18: violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Trauma also can include an unsafe or unstable environment, lack of bonding, growing up in a household with substance misuse, mental health problems, parental separation/divorce, or incarceration of family member (CDC, 2019). A recent study of adults in West Virginia found that over half of the state's residents had experienced at least one ACE in their lifetime, whereas one in seven reported experiencing four or more ACEs (Adverse Childhood Experiences Coalition of West Virginia, n.d.). Presence of ACEs correlates with negative physical and mental health outcomes, including depression and substance use (APA, 2018; CDC, 2019).

Substance use is prevalent in the community. Of the 55 counties in West Virginia, the county of interest ranked fourth in alcohol dependence diagnosis and fifth in alcohol-related diagnosis.

Binge drinking in a month's time was reported by 8% of county residents, compared with 10% of state residents. Underage drinking (among persons aged 12 to 20) in the county was higher than in the rest of the state, with reports of 37.1% respondents and 26.2% of respondents, respectively. Binge alcohol use among adolescents was also higher among county residents than the state as a whole (31.0% vs. 20.1%). Furthermore, a higher percentage (7.3%) of county residents age 12 to 20 reported that they needed treatment for alcohol use but were unable to get it in the past year when compared with the state as a whole (5.3%; Bureau for Behavioral Health, 2016).

Illicit drug use among state and county residents also was examined. The county reported nearly 110 more drug-related diagnoses in a year than the state average and ranked fifth out of 55 counties for drug-related diagnoses (Bureau for Behavioral Health, 2016). The rate of drug overdose deaths for residents of West Virginia was more than double that for the United States with rates of 57.8/100,000 and 21.7/100,000, respectively, and the state leads the nation in overdose deaths (CDC, 2021). The county in which the church is located is among 21 counties that had 10 or more overdose deaths in 2018; overdose deaths in the county are expected to increase in upcoming years (West Virginia Department of Health & Human Resources, 2019).

Homelessness is an indicator of mental health, whereas homelessness is often preceded by mental health difficulties (Sharma & Aggarwal, 2020). A 2015 county report on homelessness revealed 74 sheltered homeless persons. Homeless rates in the county were higher than that of the state by 2%. Also, 40% of the county's homeless individuals reported mental illness or chronic substance abuse (Bureau for Behavioral Health, 2016). The reported number of individuals served by the West Virginia Coalition against Domestic Violence in 2012 was 29 sheltered individuals and 715 nonsheltered individuals. Nearly 13% of those individuals were identified as having a mental health disability, whereas 44% of individuals served identified substance misuse as contributing to abuse (Bureau for Behavioral Health, 2016).

DISCUSSION

Synthesis of findings and identification of needs

Qualitative and secondary data were triangulated to determine needs (Stanhope & Lancaster, 2019); qualitative data included recorded observations and themes derived from interviews, whereas secondary data included behavioral statistics from government and other organizational sources. Data were compared and contrasted; similarities were further analyzed to reveal needs. Three needs were identified: 1) lack of resilience and coping strategies; 2) fear and/or ignorance of mental health disorders (including substance use disorder); and 3) unfamiliarity with community and health resources for those suffering from mental health disorders. Needs were then analyzed to determine if interventions might fit within the ANA FCN Scope of Practice (2017) and faith-based community mental health initiatives (MentalHealth.gov, 2019).

Social determinants of health, such as poverty, have been associated with poor mental health.

Lack of resilience and coping strategies

Coping is defined as conscious ways to deal with stressors, whereas resilience is defined as a mechanism of defense against mental hardship. Resilience provides mental health protection, promotion, and recovery; it allows individuals and communities to adapt to adversity across the lifespan (Davydov et al., 2010). Lack of resilience and poor coping skills have been related to mental health disorders, such as anxiety and depression (CDC, 2019; Davydov et al., 2010). Notably, there is a high incidence of depression in West Virginia, as 22% of the population is diagnosed with depression and persons from Appalachia suffer disproportionately from depression and anxiety (APA, 2018).

Negative coping strategies were prevalent in the community. The county reported an increased incidence of underage drinking in comparison with the state as whole, along with higher rates of illicit drug use, overdose (Bureau for Behavioral Health, 2016), and suicide (AFSP, 2021). A high percentage of West Virginians have suffered ACEs. Building resilience through the development of protective factors promotes positive well-being and healthy development in this population (Adverse Childhood Experiences Coalition of West Virginia, n.d.).

Findings also pointed to a need for coping strategies. The theme, *Knowing our resources and how to cope could help* emerged from the interviews. Respondents remarked that coping strategies were needed for a variety of populations and situations among parishioners and community members. Observations of the community revealed resources to help with coping, yet interview findings revealed that many parishioners were unaware of resources and/or how to access them.

Fear and/or ignorance of mental health disorders

Fear and/or ignorance of mental health disorders was a second problem identified. *Stigma, time, and buy-in will affect programming* was a theme revealed after analysis of stakeholder and key informant interviews. Stigma is the fear, stereotyping, and prejudice that often result from misconceptions about mental illness (Corrigan & Watson, 2002). National trends in care-seeking behaviors may also support the stigma of mental illness. Less than half of

individuals with a mental health disorder receive care each year, and the average person suffering from mental illness delays treatment for up to 11 years from onset of symptoms (NAMI, 2021).

Nearly all informants identified a need for programming on substance use disorders and underlying causes, as revealed by the theme, *We have a problem with mental health, but we don't understand why.* The staggering number of drug overdoses in the county also points to a need for more education on substance use disorders and causes. Regarding drug overdose deaths, the community of interest ranks higher than most counties within the state (CDC, 2021).

Unfamiliarity with community and health resources

Although the reluctance to admit that one has a mental health illness is one barrier to receiving care, lack of familiarity with community mental health resources is another barrier. Observation of the community revealed a variety of mental health resources; despite this, faith leaders and parishioners identified a lack of knowledge regarding resources available.

Navigating mental health in communities can be difficult and daunting, and often faith communities are reluctant to embrace mental health ministries because of stigma. Yet, for persons of religious backgrounds, mental health support provided by the church is typically well received because the church communicates in terms familiar to parishioners and is seen as a safe space (Rogers & Stanford, 2015). In their role as a leader within their faith communities, FCNs can advocate for and provide mental health programming. Advocacy requires the FCN to be knowledgeable of the needs of the community and provide evidence to support the existence of those needs.

Nursing implications

The role of the FCN is sometimes misunderstood; however, the ANA (2017) has provided scope of practice guidelines. Standards one and two of the FCN nursing practice focus on assessment and identification of diagnoses. Part of the assessment process includes collection of data, which can include demographics, social and health disparities, and various other aspects. Examples of how such data can be gathered and used in the diagnosis of mental health needs were demonstrated in this project. Data for the state and city in which the community was housed were gathered to gain understanding of facilitators and barriers to mental health in the broader community. As leaders in population health, FCNs must be prepared to deliver interventions "to an entire population, to those from the faith community, the family, and the individual" (ANA, 2017, p. 34).

Faith community nurses also serve as leaders within the community by influencing decision-making entities within the church to establish practices and programs that improve community member health outcomes (ANA, 2017). Data, such as that presented in this project, can inform church leaders with clear evidence of need for mental health ministries. This evidence can be presented to faith communities that are reluctant to host mental health ministries, demonstrating why such programs are needed and how the faith community, under the guidance of the FCN, can positively impact the health and well-being of congregants.

It is also important to note, as seen in this assessment, that the presence of community mental health resources does not equate with access of resources. Multiple community mental health resources were identified in the city, yet informant interviews revealed that finding resources and navigating the mental healthcare system was daunting. It is within the FCN scope of practice to coordinate care delivery for persons experiencing mental health issues. As coordinator of care, the FCN "communicates with healthcare consumer, family, interprofessional team, and community-based resources to effect safe transitions in continuity of care" (ANA, 2017, p. 57). MentalHealth.gov (2019) also has indicated that faith leaders can facilitate access to care by connecting parishioners to mental health resources. To effectively advocate for resource utilization, FCNs must know what resources are available in their community and the barriers and facilitators to accessing resources (ANA, 2017).

Limitations

One limitation of this project was the inability to perform a congregational needs survey. A congregational survey had been conducted in October 2019, but did not yield a high number of results representative of the congregation; therefore, data were not used. Because of the focus on one congregation in one rural community, the needs identified in this project may not be applicable to other faith communities.

CONCLUSION

This assessment was done between January and April 2020. The COVID-19 pandemic had not fully taken hold in the United States and stay-at-home orders and social distancing guidelines were just beginning. The pandemic's impact on mental health continues to become evident. Experts agree that mental health conditions in relation to the pandemic have and will continue to escalate. New stressors have been introduced, yet traditional means and resources for coping with stress and anxiety are largely unavailable (Clay, 2020; Weiner, 2020). Now more than ever, FCNs must heed the call to action and work toward establishing mental health ministries within their faith communities. Through these services, the FCN can provide social support, health education, coordination of care, resource utilization, advocacy, and spiritual care to address the specific mental health needs of his/her congregation and extended communities (ANA, 2017). Future work will focus on identifying, implementing, and evaluating evidence-based interventions for identified needs.

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Web Resources

- **Faith Community Nurse Network** https://www.fcnntc.org
- **Faith Community Nursing Scope and Standards of Practice/ANA** https://www.nursingworld.org
- **MentalHealth.gov Local Organizations With Mental Health Expertise** https://www.mentalhealth.gov/talk/community-conversation/services
- **Westberg Institute for Faith Community Nursing** https://westberginstitute.org/faith-community-nursing.html

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