



Bridging Systems of Care: Experiences of Faith Leaders Supporting Community Mental Health in Worcester, Massachusetts

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Abstract

Amid ongoing workforce shortages in primary and mental healthcare, faith leaders play an important role in supporting individuals with mental health concerns, particularly in culturally diverse urban settings. We conducted semi-structured interviews with 13 faith leaders from diverse religious backgrounds in Worcester, Massachusetts. Interviews explored understandings of mental health, approaches to supporting congregants, and interactions with the healthcare system. Data was analyzed using thematic analysis. Four major themes emerged: (1) faith leaders are approached for a breadth of mental health concerns which are understood to be multifactorial; (2) faith leaders are accessible and complementary resources; (3) faith leaders are vulnerable to burnout; and (4) collaboration with the health system is limited and inconsistent. Ultimately, we describe that faith leaders offer accessible, comprehensive, longitudinal, and coordinated mental health support, though encounter significant challenges including outdated referral resources, lack of formal training, emotional burden, and inconsistent engagement from healthcare systems. Strengthening collaboration through faith leader training programs, updated referral pathways, shared dialogue spaces, and improved cultural and religious competency among clinicians has the potential to improve community mental health by targeting specific, modifiable barriers identified by faith leaders.

Keywords Faith leaders · Mental health · Community health · Clergy · Biopsychosocial model

Background

The current state of mental health in the United States continues to be a significant concern, with 18% of adults reporting symptoms of anxiety and 21% reporting symptoms of depression (Terlizzi & Zablotsky, 2024). Despite growing need, the mental health care system continues to struggle to meet the demand for services. In fact, 149 million people

or about 45% of the U.S. population lives in an area with a shortage of mental health professionals, particularly in rural areas (Kuehn, 2022).

Faith communities, including religious leaders (priests, imams, rabbis, etc.), are one potential resource for addressing gaps in the care of individuals with unmet mental health needs. Though declining overall in the United States, religiosity remains particularly high in racial and ethnic minority and immigrant communities, who often experience disproportionate barriers to mental health care access (Derr, 2016; Giacco et al., 2014; Newberry et al., 2024; Twenge et al., 2016). Evidence suggests that religious participation can improve mental health outcomes, especially in communities historically marginalized by the mainstream health system (Bear et al., 2018; Breland-Noble et al., 2015; Rodríguez-Galán & Falcón, 2018). In response, many faith communities offer services beyond spiritual care, including support for social, economic, legal, and mental health concerns (Mollica et al., 1986).

As articulated by George Engel, the biopsychosocial model is a scientific framework that addresses the missing dimensions of the biomedical model and emphasizes

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the interactions between the biological, psychological, and social dimensions of individuals (Borrell-Carrió et al., 2004; Engel, 1977, 1980). This model offers a helpful framework for understanding the relationship between faith communities and mental health. Faith communities address the social dimensions of health by providing a network of mutual support and safety, particularly for members of marginalized groups. Faith traditions also address the psychological dimensions of health through their emphasis on aligning values and behavior, as well as providing guidance regarding existential questions of humanity that impact mental well-being.

Consistent with the biopsychosocial model, religious beliefs are important for processing life changes and medical illness, especially mental health and end-of-life concerns (Boateng et al., 2024; Tepper et al., 2001). Faith leaders often serve as informal health navigators for individuals in crisis, connecting individuals to resources. Up to a quarter of all U.S. adults seeking support for a mental health disorder report consulting a faith leader (Wang et al., 2003). And, about 90% of faith leaders encourage individuals with depressive symptoms to seek care from a mental health professional (Holleman & Chaves, 2023). Individuals may opt for guidance from faith leaders for several reasons, including concerns that the health system will not consider religious beliefs and coping mechanisms (Peteet, 2019). Faith leaders see themselves as serving community mental health needs through preaching, teaching, and counseling (Lyles, 1992), though many feel ill-equipped to provide specialized counseling and prefer to act as liaisons between their congregants and mental health professionals (Stansbury et al., 2012).

Despite the potential benefits, a longstanding schism exists between faith communities and mental health systems (Koenig, 2015; Pargament & Lomax, 2013). Partnerships between faith communities and health systems have the potential to improve access and engagement with licensed mental health clinicians. This often involves training faith leaders and providing mental health education, which have shown promising results in improving mental health outcomes and reducing stigma (Perez et al., 2025). For example, community-based platforms that train faith leaders to conduct mental health screening and facilitate referrals may be effective in specific settings facing mental health workforce shortages (Iheanacho et al., 2021). When successful, such partnerships are characterized by diverse representation, strong support from faith leaders, multiple communication channels, and reciprocal relationships with equal power dynamics. Unfortunately, most religious communities and health systems lack sufficient collaboration.

Prior work has established that faith leaders are frequently consulted for mental health concerns and that

partnerships with health systems can reduce stigma and improve engagement (Campbell, 2021; El Malmi et al., 2024; Humam et al., 2023). Several studies have documented how faith leaders perceive their role in community mental health and collaborating with mental health professionals (Fitzgerald & Vaidyanathan, 2023; Leavy, Loewenthal, & King, 2007; Young et al., 2003). However, less is known about the day-to-day experiences of faith leaders who provide mental health support within their communities, including both the opportunities and burdens associated with this role. Similarly, there is a need to better understand system-level barriers that limit collaboration between faith communities and healthcare systems in real-world settings. While a substantial body of research has examined religion and mental health, much of the literature focuses on specific populations or geographic regions. This study contributes to the literature by examining the perspectives of faith leaders across multiple traditions within a single multicultural urban community and identifying practice-relevant barriers and opportunities at the intersection of faith communities and the formal healthcare system.

The objectives of this study are (1) to better understand the experiences of faith leaders in supporting individuals with mental health concerns; (2) to identify opportunities to facilitate collaboration between health system services and local religious organizations in supporting individuals with mental health concerns; and (3) to generate recommendations for clinicians and health systems to engage patients in spiritually sensitive mental health care.

Methods

Setting and Participants

The setting for this study was Worcester County in central Massachusetts, primarily focused on the city of Worcester. The city is a multicultural community of about 207,000 people, within a county of approximately 862,000 as of 2020 (*US Census - Worcester County, MA, 2020*). Worcester is a diverse city with a 23% foreign-born population and 372 reported religious communities (*US Census - Worcester County, MA, 2020; Worcester County, Massachusetts - county membership report, 2020*). About 45% of the total population is affiliated with a religious organization, and the most common religious denomination is Catholicism, followed by Protestantism, Judaism, Islam, and Buddhism (*Worcester County, Massachusetts - county membership report, 2020*). For this study, we sampled faith leaders purposively across religious traditions (Protestantism, Catholicism, Judaism, Islam, and Buddhism). Participants were

identified through the personal connections of the authors and through a local interfaith organization. Identified participants were contacted via email. If there was no response after at least 1 month, we sent a reminder via email or directly called the organization's office. We aimed to enroll about 15 participants.

Data Collection

Semi-structured interviews were conducted in person or virtually by the authors. Interviews took place between July 2024 and November 2024. Interviews were conducted by two researchers. The interview guide, which is included as [Appendix A](#), focused on the definition of mental health, prevalence of mental health concerns, resources available through the religious organization, and recommendations for improved community-level mental health care. Interviews were recorded and transcribed verbatim using Microsoft Teams. Transcripts were reviewed and checked against the audio recordings for accuracy by the researchers, and any identifying information was removed.

Ethics Statement

This study was approved by the UMass Chan Medical School IRB (# S-00001807). Using a consent factsheet, participants were informed about the purpose of the study, benefits and risk of participation, and the voluntary nature of participation. A waiver of written consent was granted by the IRB because participation posed no more than minimal risk to the participants. In a procedure approved by the IRB, participants were presented with the approved consent factsheet, and verbal consent was obtained by the researcher before the interview.

Analysis

Transcripts were managed using Atlas.ti, version 25 software (<https://atlasti.com/>). We applied thematic analysis because of its flexibility to adequately capture the broad experiences of faith leaders of various religious backgrounds (Braun & Clarke, 2006). We aimed to elucidate the themes relevant to our primary objectives using an inductive, semantic approach. We were interested in the prevalence of faith leader engagement, the spectrum of services offered, the level of training among faith leaders, the comfort level and challenges of faith leaders, and opportunities for the health system to better support faith communities. The analytic approach involved the six steps of familiarization of data, generation of codes, combining codes into themes, reviewing themes, defining themes, and reporting findings. Two authors iteratively

developed and tested the thematic framework. Uncertainties in analysis were resolved through regular meetings, and themes were reviewed and approved by all the researchers.

Results

A total of 29 faith leaders were invited to participate in the study. Of those contacted, 13 faith leaders accepted the invitation and completed interviews, representing several religious traditions including Christianity, Islam, Judaism, and Buddhism, as shown in [Table 1](#). The sample reflected diverse backgrounds and years of experience in religious leadership.

Thematic analysis identified four themes: (1) faith leaders are approached for a breadth of mental health concerns which are understood to be multifactorial; (2) faith leaders are accessible and complementary resources; (3) faith leaders are vulnerable to burnout; and (4) collaboration with the health system is limited and inconsistent. An overview of themes and subthemes is provided in [Table 2](#).

Faith Leaders are Approached for a Breadth of Mental Health Concerns Which are Understood to be Multifactorial

Faith leaders are approached by congregants for a variety of reasons, chief among them depression, anxiety, substance use disorder, grief and loss, interpersonal conflict, and distress about current events. These leaders serve a unique role by having "open doors" for communication. Unlike a standard visit to a primary care clinician or mental health care practitioner, there are no fifteen-, thirty-, or sixty-minute appointment slots. Faith leaders play a different role for each congregant, shifting according to the needs of whoever is approaching. Notably, nearly every faith leader mentioned "depression and anxiety" as the first reason why they were approached by someone. Most of these faith leaders are not licensed or certified as mental health practitioners. Faith leaders report that many members of their communities

Table 1 The religious traditions of local faith leaders invited and interviewed

Religious Tradition	Invited	Interviewed
Protestant	15	6
Catholic	5	2
Muslim	2	2
Jewish	4	2
Buddhist	1	1
Hindu	2	0
Total:	29	13

Table 2 Summary of the major themes and selected subthemes identified by thematic analysis

Identified themes and subthemes
Faith leaders are approached for a breadth of mental health concerns which are understood to be multifactorial
<i>Relational and cultural factors</i>
<i>Psychological and biological understandings</i>
<i>Spiritual understandings</i>
Faith leaders are accessible and complementary resources
<i>Trusted supporters</i>
<i>Providers of spiritual and pastoral care</i>
<i>Health-system navigators</i>
<i>Reduce stigma in community</i>
Faith leaders experience vulnerability to burnout
<i>Emotional and personal burdens</i>
<i>Limits of training and expertise</i>
<i>Personal boundaries</i>
Collaboration with the health system is limited and inconsistent
<i>Building connections</i>
<i>Poor referral resources</i>
<i>Mistrust in the health system</i>
<i>Cultural and religious competency</i>

address their mental health needs within their faith communities rather than through formal treatment systems. Often, these needs were addressed in one-on-one meetings with the leader, each having different rules on how to address mental health concerns. For example, one faith leader stated:

“I won’t visit somebody more than twice about the same issue, especially in one year’s time. If they need that kind of ongoing care, then I try to help them find a therapist” (Participant 11).

When asked to define the term “mental health,” faith leaders described it as arising from biological, psychological, social, and spiritual factors. Every faith leader interviewed shared the belief that mental health was made up of multiple components of a person’s life. For example, one participant eloquently shared:

“My view is most aligned with the biopsychosocial spiritual model. So, it’s the addition of that the human being is made up of that biological element...the mental health aspect, and then the social context...The spiritual is that individual relationship that a person will have with God. So, it’s a bridge between all those components together” (Participant 13).

Faith leaders believed that the presence of mental health concerns often dominates the time they spend with their congregants, leading to concerns about the volume of congregants that need counseling, meetings, or support.

Many faith leaders view the role of their religious group as helping congregants process suffering and find meaning

through religious teachings, while simultaneously recognizing that spiritual practices alone are not sufficient substitutes for medical care. As one leader stated:

“Spiritual practices are not the kind of substitute for medication and treatment that help regulate the chemicals in the brain. Spiritual practice can be part of that, but it’s not instead of it” (Participant 11).

Faith leaders sometimes referred to mental health as the processing of life experiences and finding purpose in one’s place in the world. One faith leader explained:

“I also think that sometimes those with different challenges, whether they’re mental health or regular health or family dynamics or more, sometimes look for answers, and so the spiritual or religious texts and context can sometimes help provide comfort or consolation or just empathy in certain ways” (Participant 3).

Faith leaders see their role in the lives of their congregants as ones that listen and provide empathy through open dialogue. Faith leaders also incorporate spiritual and religious context to congregants’ mental health concerns, often using religious texts, prayers, or meditations to provide a crucial layer of support and understanding. Most also recognized the impact of trauma on a person and their mental health.

Faith Leaders are Accessible and Complementary Resources

Across varying faith traditions, leaders reported serving as a frequent first point of contact for individuals experiencing emotional distress. As one participant explained:

“Clergy are often the first stop for people who are related to the church. They would rather talk to someone like me than to go to see somebody like you” (Participant 9).

Another leader described their role:

“I’m like a triage agent. To a certain extent, I’m free. So, I’m an easy stop for people” (Participant 9).

Faith leaders described offering individual meetings, spiritual counsel, prayer, and, when possible, assistance with navigating formal health services. Several emphasized their ability to integrate theological perspectives with secular counseling. As the first point of contact for individuals seeking mental health care, faith leaders are in a unique

position to gather important information from someone who may not go to a trained mental health practitioner. There is a sense of community within larger faith traditions that allows congregants access to faith leaders to speak about what they are experiencing.

It is not just one-on-one meetings that are offered by these communities. Most include community groups that meet weekly or biweekly, support groups, and a gathering space with weekly meetings for the entirety of the congregation. Individuals in need of support from their faith communities can seek it out in an approach that may work best for them.

Several faith leaders also maintain referral lists of mental health practitioners that they use for individuals they believe need more professional support than a faith community can offer. Such lists have been compiled over time and passed on, often containing contact information for therapists and counselors that other congregants have found helpful.

When making the decision to refer, faith leaders discuss their own scope of practice. Because many of them do not have professional mental health training, recognizing their scope of practice is an important part of their care for congregants who approach them with mental health concerns. One leader described their approach:

“I to some extent feel like being a rabbi is not dissimilar to parts of being an EMT, where people invite you into their homes and lives in their most vulnerable moments. And it’s not my job to diagnose, it’s my job to support or to triage outside if it’s beyond the scope of what the community can handle” (Participant 3).

If there are situations with unstable patients, or patients who pose a threat to themselves or someone else, faith leaders will get authorities involved or facilitate emergency care.

However, the scope of practice for faith leaders extends beyond simple referral. One faith leader described driving congregants to detox facilities and maintaining ongoing contact:

“I’ve physically driven congregants to detox...And you just hope they stick it out and they do the full 30 days. But you know, then they might leave and not finish the program. And then it’s just like, yeah, it’s just discouraging when you love people and care about people, watch them suffer like that” (Participant 6).

Several faith leaders described actively working to reduce stigma around mental health in the communities. Such stigma may stem from generational differences, alongside an unfamiliarity with why faith leaders are seeing rapid increases in concerns about anxiety and depression from their congregants. To many, speaking out about mental

health has been a relatively new phenomenon, one that has become important to some communities. One participant articulated the importance of openly discussing mental health:

“I think as pastors, preachers, faith leaders, I think we have to talk about it...a key part of our work is not only exegeting the scriptures, but exegeting our people in their world, in the world they live in, and then helping them learn how to follow Jesus in what they’re facing. So that involves, we’ve got to talk about our emotions” (Participant 12).

As one participant noted:

“I think that it has required clergy to become far more savvy about the nature of mental health issues and to learn how to integrate the theoretical and the strategic kind of aims of mental health interventions with various theological systems” (Participant 1).

Another faith leader describes a new event at their congregation, formatted as a panel discussion with faith leaders and mental health professionals from within the congregation, created to address the stigma of mental health concerns. This leader found that having this panel discussion with the congregation’s robust involvement was well received.

Faith Leaders Experience Vulnerability to Burnout

Participants highlighted the emotional toll of supporting congregants in crisis, particularly in the absence of formal training. A rapid increase in individuals coming to faith leaders for mental health concerns adds to this toll, with faith leaders feeling overwhelmed at times. Faith leaders also expressed the heavy emotional burden of talking with these individuals for prolonged periods of time. One leader described:

“We tend to be healers...Mental health, especially, it’s so tragic. Really tragic...It seems to afflict extraordinary people, you know, extraordinary...So often, it’s really when they’re well, they’re beautiful and lovely, smart, funny, really. So, yeah, it’d be nice to be able to do better treating them” (Participant 10).

For many, there was a moral obligation for continued follow-up with these people, even if they were not connected to other mental health resources. Alongside this level of care, there is also “on-the-job learning” done by the faith leaders for their congregants.

Several described struggles with setting boundaries and a sense of personal inadequacy when confronted with severe or complex mental health concerns. Some have learned that to effectively care for their congregants, they must have their own modes of self-care. One participant explained:

“I have to maintain and manage my own mental and spiritual health in order to be a good pastor to people. So, I have to prioritize time for my own prayer life and spend time with my loved ones and exercise. If I don’t do that, then I’m not effective as a pastor” (Participant 11).

Many faith leaders also recognize the incongruence between the needs of their congregation and their own training. Another faith leader candidly admitted:

“To be honest, I mean that is the most honest answer I can give you because I think sometimes, I feel ashamed because I don’t have the training, so I obviously wouldn’t approach myself for me...I don’t know what to do. I don’t know what to say because I didn’t have the training” (Participant 7).

Other faith leaders shared a similar sentiment that gaps in knowledge can sometimes leave them feeling ill-equipped and more vulnerable to burnout.

Collaboration with the Health System is Limited and Inconsistent

Faith leaders expressed a strong desire for greater collaboration with healthcare providers but described current partnerships as inconsistent and underdeveloped. The referral lists that some faith providers maintain are often outdated. Many leaders noted that a compilation of resources into a reference document for faith leaders, with names and contacts of mental health professionals currently accepting new patients, would be helpful for their practice. Additionally, faith leaders were interested in pursuing mental health training programs on their own to gain some level of professional certification and credibility. Many were open to “red flag” training for themselves and their congregants, to act as bridges between individuals in acute mental health crises and professionals.

One faith leader explained a need for better collaboration:

“One way to help the situation is to have therapists reach out to faith leaders, reach out to community leaders, to learn more about how certain things are understood in that context, especially with the demographic of their clients” (Participant 13).

Another leader emphasized the bidirectional importance of this collaboration, describing the need for educational opportunities:

“You know, kind of connecting the faith aspect and saying, look we recognize there’s some things here that definitely impact a personal spiritual well-being. I think that would go a long way” (Participant 2).

Several participants noted the frustration of inconsistent engagement from healthcare systems. One leader described this tension:

“And one of the takeaways was like, oh, we need to go engage the faith leaders around mental health here in the city. And I chuckled because, um, there’s this swinging pendulum that goes back and forth where, uh, you know, we don’t want the, we don’t want the faith leaders involved in the conversation” (Participant 12).

Participants noted gaps in cultural and religious understanding among clinicians, which limited trust and coordination. Several suggested that clinicians initiate outreach to local faith leaders to build mutual understanding and shared approaches. One faith leader noted that another issue faced by congregants seeking professional help was that the mental health professionals they encountered were not spiritual or religious. The leader described a rift between the experiences of the congregant and the therapist, from which a therapeutic alliance could not properly form. If the therapist was unable to connect to the individual’s culture or religion, then the individual would not feel heard, seen, or listened to.

One leader explained:

“So, they’re missing a very important element of cultural competency. Instead of understanding the culture of the person that they’re sitting in front of, they superimpose whatever they believe onto their client, whether that is their own religious belief, cultural beliefs, or values” (Participant 13).

Another emphasized:

“It’s not just about being Muslim, it’s about like how you give mental health therapy in a way that actually informed by principles of our religion?” (Participant 8).

Lastly, faith leaders expressed that they are intertwined with the mental health of the local community and would be happy to be used as a resource. Many faith leaders described

seeing dozens of congregants per week to discuss mental health challenges. The volume of those individuals is significant in the community, and some leaders believe it would benefit the community if they were included in conversations about mental health in Worcester.

Discussion

Our study of faith leaders across diverse religious traditions revealed four key themes regarding their role in mental healthcare. Faith leaders reported addressing primarily depression, anxiety, substance use, grief, and interpersonal conflict, and articulated a biopsychosocial understanding of mental health while recognizing that spiritual practices complement rather than replace professional support. Participants are self-described as accessible, often no-cost first points of contact who provide counseling, spiritual guidance, and referrals, as well as reducing stigma, while recognizing challenges associated with a limited scope of practice, difficulty referring congregants, and vulnerability to burnout. And, though interested in collaborating with health systems, faith leaders described current partnerships as limited and inconsistent, calling for bidirectional engagement including updated referral resources, mental health training for faith leaders, and improved cultural and religious competency among clinicians.

These findings suggest that the function of faith leaders in community mental health closely resembles that of primary care. Primary care practices serve four key roles in the healthcare system: (1) timely access to care with minimal barriers; (2) comprehensive care addressing a broad range of patient concerns; (3) longitudinal care that maintains relationships over time; (4) coordinated care that integrates services across primary care providers and specialists (Jimenez et al., 2021; Starfield et al., 2005). Notably, the themes identified by faith leaders in this study show significant overlap with these functions. Faith leaders often serve as accessible first points of contact for individuals experiencing mental distress, particularly in underserved populations where systemic barriers limit healthcare access. Following initial contact, they provide holistic support integrating spiritual, emotional, and social components, maintain longitudinal relationships that build the trust needed to address sensitive concerns, and facilitate referrals to mental health professionals when appropriate. Viewing faith leaders through this lens recasts the collaboration problems described not as vague partnership failures, but as predictable breakdowns analogous to the well-documented challenges primary care clinicians often face when coordinating with mental health specialists. Recognizing these parallels may help clarify the role faith leaders play in community mental health, helping

policymakers and health systems identify where targeted collaboration efforts could be most effective.

Consistent with prior research, faith leaders define mental health as a reflection of biological, psychological, social, and spiritual well-being (El Malmi et al., 2024; Holleman & Chaves, 2023; Moore et al., 2022). Previous studies similarly demonstrate that faith leaders often function as both spiritual counselors and informal mental health advocates, operating at the intersection of religious and health systems (Campbell, 2021; Fitzgerald & Vaidyanathan, 2023; Lyles, 1992; Stansbury et al., 2012; Young et al., 2003). Our findings propose that faith leaders often serve as “first responders” for mental health concerns in the community, despite significant barriers. This aligns with a recent study describing faith leaders as supporting a “wide but not comprehensive” range of mental health issues while struggling with role boundaries (El Malmi et al., 2024).

Our study also found burnout from the emotional toll to be a prominent theme among faith leaders. This finding also is well-supported by extensive literature describing compassion fatigue, exhaustion, depersonalization, and inability to function due to intense workloads, unrealistic expectations, and the pressures of caring for a congregation (Abernethy et al., 2016; Chandler, 2010; Clarke et al., 2022; Foskett et al., 2004). Participants in our study also described gaps between the mental health needs presented by congregants and their own training, which may further contribute to stress and feelings of inadequacy. Concurrently, many faith leaders described actively working to reduce mental health stigma within their communities through open dialogue and educational activities. Such efforts have increasingly been recognized as an important contribution of faith communities to public mental health (Campbell, 2021; Murthy, 2015; Roberts-Eversley et al., 2025).

Faith leaders in our study consistently expressed interest in collaborating with healthcare systems, yet described existing partnerships as sporadic, informal, and difficult to maintain. This observation aligns with prior research indicating that while faith leaders are often willing to collaborate with clinicians, effective partnerships are frequently limited by inconsistent communication, unclear referral pathways, and limited mutual familiarity between institutions (Fitzgerald & Vaidyanathan, 2023). Our study suggests that these challenges may reflect greater structural barriers rather than a lack of interest from either group. Addressing these barriers may require relatively modest but intentional interventions, including regular communication channels, shared educational opportunities, and accessible referral resources. Sustainable partnerships will likely depend on mutual recognition of the complementary roles played by faith leaders and clinicians in supporting community mental health.

Our study extends the literature by clarifying the mental health role faith leaders already occupy. Participants described routinely supporting individuals with significant psychological distress, often before they seek professional care. They also identified structural barriers to collaboration with healthcare, including outdated referral lists, limited access to clinicians able to address religious concerns, and inconsistent engagement from health systems. Whereas prior studies have focused on factors that support successful partnerships, our findings highlight barriers that prevent those partnerships from forming. By drawing on perspectives from multiple religious traditions within one multicultural city, this study captures the shared experiences that are common to faith leaders from different communities.

Implications for Research and Practice

In many communities, faith leaders are already functioning as accessible caregivers for addressing depression, anxiety, grief, substance use, and crises. This care often happens before congregants contact formal mental health services. Because this work is largely invisible to health systems, failure to create basic referral infrastructure and bidirectional relationships not only limits access to care but also transfers clinical risk and emotional burden onto faith leaders who lack formal training and support.

Our findings offer an agenda for partnering with faith leaders to address their community's mental health needs. Given faith leaders' role as first contacts for those with mental health concerns, licensed health professionals may look to provide brief education and consultation regarding informal assessment and referral treatment. To emphasize the compatibility and mutual support of religious and secular care of those with mental health needs, faith leaders and licensed health professionals should appear together in community meetings or educational activities. Additionally, clinicians should approach mental health topics with humility and sensitivity when patients describe symptoms in spiritual or non-medical terms.

Given the high rates of burnout reported in our study, clinicians who care for faith leaders should explicitly inquire about the emotional burdens of the role. It may be helpful to regard faith leaders as first responders in the community who are at risk of primary and secondary trauma and the consequent toll this trauma has on physical and mental health. Licensed clinicians and health systems should include faith leaders in the design of mental health programs and design referral pathways and ongoing communication policies in ways that strengthen partnerships with faith leaders (Wilson et al., 2024). Further, advocating for the emotional and mental health support for faith leaders is important work. SAMHSA and The Partnership Center

report for strengthening clergy wellbeing is a helpful summary and resource ("Strengthening the mental health and wellbeing of tomorrow's faith leaders in theological educational settings," 2023), but broader support and recognition is needed. Creating shared dialogue spaces between clinicians and faith leaders could also reduce mistrust and increase collaboration, with faith leaders providing insights from almost daily mental health conversations in the community. Scotland's "Community Chaplaincy Listening" program offers a relevant model. This initiative integrates chaplains into primary care, providing 4–8 short-term listening sessions by trained volunteers for individuals experiencing grief, loss, loneliness, stress, and unemployment (Snowden et al., 2023). While different from traditional pastoral care, this program addresses our finding that people often seek spiritual advisors for mental health concerns before or alongside trained professionals. This program is reminiscent of the role of community health workers, though focusing on the intersection of mental health and spirituality.

Existing system-level interventions could improve communication and care simply if faith leaders are made aware of them. For example, such training resources already exist at no cost, including the American Psychiatric Association's "Mental Health: A Guide for Faith Leaders" and SAMHSA's quick-reference guide ("[Everyone Can Play a Role in the Conversation about Mental Health](#),"; [Mental Health: A Guide for Faith Leader](#)). Most faith leaders interviewed in this study were unaware of these resources. Wide distribution of these materials could improve basic mental health literacy and referral information. In addition, despite our study identifying lack of referral resources as a primary barrier, a recent review suggests that few partnerships offer bidirectional referrals (Perez et al., 2025). While any partnership can be beneficial, our work suggests that ineffective, absent referral processes are a dominant stressor for faith leaders. A simple, regularly updated list of mental health professionals accepting new patients would enable faith leaders to more effectively connect individuals to professional care.

It is important to note that the interplay between faith leaders and mental health extends well beyond the scope of our study. Future research should assess the impact of faith leader training programs on referral rates and mental health outcomes among congregants. Additional qualitative research might explore patient perspectives on coordination between healthcare providers and faith communities. Population studies with broader representation of religious and cultural communities would strengthen the existing literature with additional data, perspectives, and insights. Finally, developing and testing collaborative models that integrate primary care, mental health services, and faith-based support deserves consideration.

Limitations

The principal limitation of this study is that leaders were surveyed in only one state, so our findings may not generalize to all communities. The leaders who agreed to participate in our study may have been already interested in mental health or actively engaged in counseling their congregants and therefore may have been more open to collaboration with formal treatment systems than the typical faith leader. Our study also captured the opinions of leaders in the faith community, but not the congregants themselves who may have had additional insights to offer. Additionally, we were unable to recruit faith leaders from explicitly Black or immigrant communities. Our challenges in recruiting from these communities may indicate especially poor relations between those communities and representatives of organized medicine such as ourselves, though we cannot be certain.

Conclusion

This study describes faith leaders across diverse traditions as trusted first points of contact for mental distress. Faith leaders offer accessible, comprehensive, longitudinal, and coordinated support while recognizing that spiritual practices complement rather than replace professional mental health care. Given the significant barriers these leaders face, including outdated referral resources, limited formal training, emotional burden, and inconsistent healthcare engagement, strengthening collaboration through targeted training programs, updated referral pathways, and improved cultural and religious competency among clinicians would meaningfully improve community mental health care.

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Author Contributions JD is the corresponding author. JD and KP served as co-first authors with equal contributions. DM is the senior author. All authors (JD, KP, DM) designed the study. JD and KP conducted the interviews and performed the qualitative analysis. All authors contributed substantially to the manuscript and approved the final version. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Declarations

Competing Interests The authors declare no competing interests.

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