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Faith-Based Intervention Programmes in National Suicide Prevention: A Case Study of Nigeria

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Abstract

This article examines the role and efficacy of faith-based interventions in national suicide prevention programmes, with particular attention to the Nigerian context. Suicide rates are rising in Nigeria, yet fewer than 300 psychiatrists serve over 200 million people. In contexts where supernatural interpretations of mental illness dominate, faith communities serve as frontline responders, though they remain largely unprepared for this role. This article employs a qualitative systematic review of clinical trial registries, peer-reviewed research, and international case studies from Rwanda and South Sudan to examine the role and efficacy of faith-based interventions in national suicide prevention programmes. Thematic analysis reveals that faith-based organisations serve as strategically ideal locations for mental health intervention due to their trusted community presence and cultural resonance. Evidence-based programmes, including HAVEN-Connect, Caring Connections, and Sources of Strength, demonstrate measurable improvements in help-seeking behaviours and reduced suicide risk. However, significant challenges persist, including over-spiritualisation, harmful practices by unregulated actors, and sustainability constraints. The article concludes with recommendations for integrating faith-based interventions into Nigeria's national suicide prevention framework, emphasising training, referral protocols, and culturally grounded approaches that respect both spiritual and clinical perspectives.

Keywords: faith-based organisation, intervention, suicide, prevention programmes, Nigeria

Introduction

Across the globe, suicide claims more than one in every 100 deaths, with the highest rates concentrated in low- and middle-income countries. In Nigeria, mental health challenges among youth marked by depression, anxiety, suicidal ideation, and school dropout pose urgent threats to individual well-being as well as national development. These threats expose a crucial need for innovative mental health interventions that resonate with local cultural contexts. In many developing nations, conventional suicide prevention strategies have predominantly been developed and validated in high-income countries, informed by individual-centred clinical models that often overlook broader sociocultural and economic contexts (Umenyi, 2025). Yet in contexts where supernatural interpretations of mental illness dominate, and access to professional care is limited, traditional healers, herbalists, and spiritualists, including prophets, prophetesses, and pastors, serve as frontline responders (Umenyi, 2025). This reality demands a fundamental re-examination of suicide prevention frameworks, emphasising the indispensable role of structural determinants, cultural practices, and community resilience.

Faith-based organisations (FBOs) occupy a unique position at the intersection of community trust, cultural authority, and spiritual care. They reach populations that clinical settings often do not, offering a sense of belonging essential for individuals experiencing loneliness and social withdrawal (Umenyi, 2025). As mental health experts note, "churches and mosques reach people that clinics

often don't" (Umenyi, 2025). This article provides a comprehensive examination of faith-based interventions in national suicide prevention programmes, drawing on evidence from clinical trials, academic research, and case studies across multiple countries, with particular attention to the Nigerian context.

The Global Burden of Suicide and the Role of Faith

Suicide remains a significant public health challenge globally, with the World Health Organization (WHO, 2021) estimating that over 700,000 people die by suicide annually. In sub-Saharan Africa, suicide rates have been rising, with limited surveillance systems likely underreporting the true magnitude of the problem (Mars et al., 2019). Research has consistently demonstrated that religious involvement is associated with lower suicide rates, a phenomenon attributed to religious prohibitions against suicide, social integration within faith communities, and the provision of meaning and hope (Koenig, 2018; Rasic et al., 2011).

The relationship between religion and suicide is complex and context-dependent. While religious affiliation generally serves as a protective factor, the mechanisms through which this protection operates vary across cultural and denominational contexts (Lawrence et al., 2016). In African settings, where spirituality permeates daily life and worldviews, the role of religious communities in suicide prevention takes on particular significance (Gbadebo et al., 2020). Faith communities often serve as the first point of contact for individuals experiencing mental distress, making them critical gatekeepers in pathways to care.

Faith-Based Mental Health Interventions: Theoretical Frameworks

Several theoretical frameworks have been developed to understand and guide faith-based mental health interventions. The concept of "Pastrotherapy" has emerged as a pastoral care approach specifically designed to address existential questions facing young people (Nwafor et al., 2024). This framework recognises that religious beliefs and practices can support Nigerian youth facing existential challenges, shedding light on the intersection of religion, meaning-making, and mental health. Findings emphasise the importance of religious communities and leaders in promoting resilience and addressing underlying causes of despair (Nwafor et al., 2024).

In contexts where access to professional mental health care is limited, the integration of psychologically informed spiritual care offers a culturally resonant intervention, bridging gaps between spirituality and psychology to address mental health disparities (Umenyi, 2025). Drawing on the work of both Western and African scholars who have highlighted the benefits of integrating spirituality and psychology in mental health care, this approach seeks to adapt these frameworks for populations with limited access to conventional mental health services (Umenyi, 2025). Grounded in Nigerian cultural and Christian values, these frameworks emphasise contextual relevance, leveraging local belief systems to foster trust and efficacy (Umenyi, 2025).

A fundamental principle underlying faith-based interventions is recognition that communities themselves are the foremost experts in their own wellbeing (Jesuit Refugee Service, 2025). They are the first to respond, drawing on their knowledge of local resources, culture, and coping strategies. Even in the absence of extensive funding, communities can continue supporting one another organically when effectively facilitated (Jesuit Refugee Service, 2025). This community-based approach is built on co-creating solutions with communities, strengthening local capacities, supporting existing self-help mechanisms, and reinforcing community resources and safety nets (Jesuit Refugee Service, 2025).

Suicide in the Nigerian Context

Mental health challenges among Nigerian youth present urgent threats to individual well-being and national development (Umenyi, 2025). The growing rate of suicide in Nigeria has highlighted the need for a pastoral response that addresses the grief and loss experienced by individuals and communities affected by this tragic phenomenon (Chimaobi & Ameh, 2024). Suicide is a detested experience among Africans because there are various supports that should

prevent this abrupt and self-destroying practice (Chimaobi & Ameh, 2024). Regrettably, in the face of communal resources that could address existential challenges, some persons still commit or attempt suicide. This paradox demands examination of why existing supports including religious communities are failing to reach those most in need.

Research examining suicide prevalence among Nigerian youth struggling to find meaning in life reveals that frustration with unattainable ideals leads many to experience profound despair (Nwafor et al., 2024). Economic hardship, academic pressure, family dysfunction, and social isolation have been identified as significant contributors to suicidal ideation among Nigerian youth (Omigbodun et al., 2018; Adewuya et al., 2016). The scarcity of mental health services with fewer than 300 psychiatrists serving a population of over 200 million further compounds these challenges (World Health Organization, 2020).

Evidence-Based Faith-Based Programmes: Context and Application

While several evidence-based faith-based programmes have been developed internationally, their adaptation and implementation in the Nigerian context require careful consideration of local cultural, religious, and health system characteristics. The following programmes offer models that could inform Nigerian approaches.

HAVEN-Connect: A Multi-Generational Suicide Prevention Programme in African American Churches

HAVEN-Connect is a comprehensive depression and suicide prevention intervention designed to be integrated into predominantly Black churches in the United States, recognised as strategically ideal locations for mental health intervention for Black youth (George Washington University, 2026). The programme has three components:

1. Church Community Engagement: An interactive process of introducing the programme to key church leaders and stakeholder groups.
2. Faith-Based Curriculum: Educational overview for pastors, other ministerial staff, and youth lay leaders on how to integrate the programme into the church using communication mediums that have cultural and religious relevance in the Black Church context.
3. Youth-Connect Intervention: A strength-based network health depression and suicide prevention programme where participants learn together about and model skills to each other to grow and sustain "Four Cores" supportive of mental health: healthy relationships and accountability (Kinship), meaning and value in life (Purpose), informal and formal help-seeking (Guidance), and activities that give strength and balance emotions (Balance) (George Washington University, 2026).

The study, funded by George Washington University and currently recruiting 240 adolescents aged 13–19 across 12 churches, hypothesises that adolescents in HAVEN churches will have decreased depression symptoms and suicide risk scores at 1-month and 6-month follow-up (George Washington University, 2026). For Nigeria, this model offers valuable insights into how predominantly Christian congregations can be mobilised for youth suicide prevention, particularly given the similarities between African American church contexts and Nigerian Pentecostal and mainline Protestant traditions in terms of their centrality to community life.

Caring Connections: Faith-Based Organizations as Mental Health Hubs

The Caring Connections Randomized Control Trial, conducted by the University of North Carolina at Chapel Hill, adapts an existing intervention called Linking Individuals Needing Care (LINC) to better serve diverse communities, particularly those whose help-seeking behaviours often occur outside traditional behavioural health settings (University of North Carolina at Chapel Hill, 2025). The intervention directly addresses the critical need for culturally adapted mental health interventions by integrating faith-based organisations as mental health hubs (University of North Carolina at Chapel Hill, 2025). These community anchors effectively mobilise support and promote positive health behaviours, making them ideal partners for delivering culturally sensitive care.

Caring Connections represents a consumer- and community-driven approach implemented by Peer Support Specialists and Community Health Workers embedded within faith-based organisations (University of North Carolina at Chapel Hill, 2025). These specialists work to create "villages of care" by assessing suicide risk, facilitating service connections, developing safety plans, and incorporating cultural factors that promote empowerment and hope. The intervention specifically aims to improve family relationships and reinforce caring messages while respecting diverse cultural backgrounds (University of North Carolina at Chapel Hill, 2025).

In Nigeria, where community health worker programmes have been expanding, the Caring Connections model offers a framework for integrating mental health support into existing faith-based infrastructure. The model's emphasis on peer support specialists aligns with Nigerian cultural values of community solidarity and elder mentorship.

Sources of Strength: A Multi-Setting Prevention Model

Sources of Strength is a youth suicide prevention programme in which adult mentors guide peer leaders as they promote help-seeking behaviours, encourage communication between youth and caring adults, and advocate healthy coping responses to stress among their peers (Penn State University, 2021). The programme may be implemented in school, community, or faith-based settings, demonstrating the flexibility of faith-based approaches across different institutional contexts.

The programme focuses on eight protective factors for the prevention of suicide, including family support, positive friends, mentors, healthy activities, generosity, spirituality, physical health, and mental health (Penn State University, 2021). Evidence from a randomised trial of 18 high schools indicated that trained peer leaders reported higher expectations that adults at schools will help suicidal students, improved norms for seeking help from adults, increased numbers of identified trusted adults, greater use of healthy coping resources, decreased maladaptive coping attitudes, higher school engagement, more rejection of codes of silence, and increased support to peers (Penn State University, 2021). Students who had reported suicide ideation in the last 12 months benefited more than non-suicidal students (Penn State University, 2021).

The Sources of Strength model holds particular promise for Nigeria, where youth fellowship groups within churches and mosques provide existing peer networks that could serve as platforms for prevention efforts. The programme's emphasis on peer leadership aligns with Nigerian youth culture, where age-grade associations and peer influence play significant roles.

Positivity Training Based on Religious Teachings: Evidence from Iran

A quasi-experimental study in Iran compared the effectiveness of cognitive-behavioural therapy, self-compassion training, and positive thinking based on relignterventions (Parvardeh et al., 2025). While this study found cognitive-behavioural approaches more effective, the significant effect of positivity training based on religious teachings demonstrates that religiously-grounded interventions can meaningfully contribute to suicide prevention by enhancing social-emotional competence an effective factor in reducing suicidal thoughts (Parvardeh et al., 2025). For Nigeria, this research suggests that interventions incorporating Islamic teachings could be developed for Muslim communities, which constitute approximately 50% of the Nigerian population.

The Promise of Faith-Based Suicide Prevention

1. **Trusted Community Presence**

A primary promise of faith-based interventions lies in the trusted position that religious leaders and institutions occupy within their communities. In Nigeria, where suspicion of government health programmes and clinical mental health services persists, faith communities often represent the most trusted institutions (Umenyi, 2025). This trust enables faith-based interventions to reach populations that clinical settings struggle to access, including rural communities, informal sector workers, and individuals who would not voluntarily seek mental health services.

2. **Cultural and Linguistic Resonance**

Faith-based interventions can be delivered in culturally and linguistically resonant ways that standardised clinical approaches often fail to achieve. As one community mental health worker in South Sudan explained, "I use my age, my language, my nationality to help people feel safe and welcomed" (Jesuit Refugee Service, 2025). This cultural resonance extends to language, metaphors, and explanatory frameworks that make sense within local worldviews. In Nigeria, where mental distress is frequently understood through spiritual lenses, faith-based interventions can work with these frameworks rather than against them.

3. **Sustainable Community Infrastructure**

Faith-based organisations represent existing, sustainable infrastructure that requires no new buildings or organisational structures to be created. In Nigeria, churches and mosques exist in virtually every community, with established leadership structures, regular gatherings, and existing communication networks. This infrastructure can be leveraged for mental health promotion, screening, and referral without the need for parallel systems development.

4. **Holistic Care Integration**

Faith-based approaches offer the potential for truly holistic care that addresses spiritual, psychological, and social dimensions of suffering. As Archbishop Laurent Mbanda of Rwanda observed, pastoral activities "if done well by trained individuals, pastors, or other trained people in the church can highly contribute to both physical, spiritual and in fact holistic healing" (The New Times, 2025). This integration aligns with African conceptualisations of health that view wellbeing as encompassing spiritual, psychological, and physical dimensions.

5. **Addressing Existential Despair**

Perhaps most distinctively, faith-based interventions are uniquely positioned to address the existential dimensions of despair that underlie many suicidal crises. The concept of "Pastrotherapy" offers a framework for pastoral care that directly addresses the meaning-seeking needs of youth facing despair (Nwafor et al., 2024). In contexts where frustration with unattainable ideals leads young people to profound despair, religious communities can offer frameworks for meaning-making that clinical approaches alone cannot provide.

Challenges and Limitations

1. **The Danger of Over-Spiritualisation**

A significant concern in faith-based mental health interventions is the tendency to over-spiritualise mental health conditions. Clinical psychologist Chaste Uwihoreye points out that some believers may misinterpret a mental health condition as "demonic spirits," leading to over-spiritualisation due to false teachings and a lack of understanding of critical situations (The New Times, 2025). "Someone might suffer from epilepsy or mental isolation and wrongly call it a demonic attack. That is a serious mistake," Uwihoreye explains. "In some cases, a person might not show clear symptoms and, instead of seeking proper medical help, turn to prayer requests, which may not provide effective assistance alone. It's even more concerning when people go to churches instead of seeking medical help. Those in such roles should always refer the person to the appropriate medical services for proper healing" (The New Times, 2025).

2. **False Prophets and Harmful Practices**

Uwihoreye expresses particular concern about "false prophets" who use their gospel as a marketing tool (The New Times, 2025). "They may mislead people with false prophecies. As a result, someone may fully believe in prophetic declarations and avoid medical treatment completely. Yet in the end, the promised healing never happens" (The New Times, 2025). This phenomenon highlights the importance of regulation and accountability in faith-based mental health interventions. As Archbishop Laurent Mbanda warned, "This is where counselling is not for all pastors or anybody but trained people. Otherwise, we can do more harm than good" (The New Times, 2025).

3. **The Need for Training and Referral Protocols**

Effective faith-based suicide prevention requires training, clear referral protocols, and collaboration with mental health professionals. Archbishop Mbanda emphasises that "pastors should make referrals to trained people—listen, pray, encourage with scripture yes, but not manipulate" (The New Times, 2025). The Council of Protestant Churches in Rwanda has trained many people in churches, both lay and pastors, demonstrating that systematic training is possible at scale (The New Times, 2025). However, ongoing support and quality assurance mechanisms are essential to ensure that trained individuals maintain competence and adhere to ethical guidelines.

4. **Sustainability Challenges**

In South Sudan, aid cuts are undoing much of the progress made in strengthening community-based mental health and psychosocial support (Jesuit Refugee Service, 2025). They are weakening the way organisations once coordinated and worked together and are leaving vulnerable people without the help they need (Jesuit Refugee Service, 2025). This experience demonstrates that faith-based interventions, while valuable, cannot substitute for sustained investment in mental health infrastructure.

International Case Studies and Lessons for Nigeria

1. **Rwanda: Faith and Professionalism Working Together**

In Rwanda, religious leaders acknowledge that the mental health conversation has grown louder and more urgent due to the rise in depression, suicide, and trauma cases, especially among the youth (The New Times, 2025). A 2024 study by HDI Rwanda found that among 875 domestic workers, 287 (32.5%) experienced suicidal thoughts, 84 (9.5%) had made suicide plans, and 69 (7.8%) had attempted suicide, with most aged 18–26 (The New Times, 2025).

In response, religious leaders have stepped up efforts, recognising that beyond the pulpit, faith and professionalism must work together (The New Times, 2025). They have moved beyond the myth that focuses solely on spiritual guidance, instead increasingly embracing mental health education, counselling, and advocacy. The Muslim community in Rwanda, through partnerships with health workers, has established mental wellness programmes open to all, focusing on educating Muslims about religious and clinical perspectives (The New Times, 2025). As Sheikh Yussuf Mugisha explained, "We have trained counsellors who attend to people with a normal mental crisis. We also have Muslim doctors who usually intervene when the situation is beyond their capacity. We arrange for them to receive help" (The New Times, 2025).

At the Anglican Church of Rwanda, Archbishop Laurent Mbanda emphasised that pastoral activities in counselling involving listening, prayers, and scriptural use "if done well by trained individuals, pastors, or other trained people in the church can highly contribute to both physical, spiritual and in fact holistic healing" (The New Times, 2025). He added, "A well-trained person can use faith and psychology. Both can work together to help a person develop an integrated Christian world view. We have to admit that Christian faith combats despair" (The New Times, 2025).

2. **South Sudan: Community-Based Mental Health Support**

In South Sudan, drastic cuts to humanitarian aid have reduced or eliminated life-saving mental health and psychosocial support services, further straining an already fragile system heavily reliant on humanitarian actors (Jesuit Refugee Service, 2025). In response, Jesuit Refugee Service (JRS) has strengthened its community-based approach to MHPSS, which has been crucial in keeping services going, even if on a smaller scale (Jesuit Refugee Service, 2025).

JRS collaborates with local leaders, church members, para-counsellors, and home visitors from both refugee and host communities (Jesuit Refugee Service, 2025). These community-based workers help identify needs, initiate activities, and refer individuals for further and more specialised assistance. Home visitors live and work within the communities; JRS trained them in basic counselling skills, equipping them with the necessary tools to offer immediate psychosocial support while linking people to specialised services (Jesuit Refugee Service, 2025).

Relevance to Nigeria

The Rwandan and South Sudanese experiences offer valuable lessons for Nigeria. First, they demonstrate that systematic training of religious leaders in mental health is feasible at scale. Second, they show that partnerships between faith communities and health professionals can be formalised and sustained. Third, they illustrate the importance of referral pathways that enable individuals to move between spiritual and clinical care. Fourth, they highlight the value of community-based workers who share language and culture with those they serve. Finally, they underscore the vulnerability of faith-based interventions to funding cuts and the need for sustainable financing mechanisms.

Recommendations for National Suicide Prevention Programmes in Nigeria

1. **For Government and Policy Makers**

a. Integrate faith-based organisations into national suicide prevention strategies: Recognise FBOs as essential partners in reaching populations underserved by clinical services. Develop formal collaboration mechanisms that respect both spiritual and clinical perspectives.
b. Provide funding for training and capacity building: Invest in training programmes for religious leaders and lay caregivers, adapting evidence-based curricula like HAVEN-Connect and Caring Connections to the Nigerian context (George Washington University, 2026; University of North Carolina at Chapel Hill, 2025).
c. Establish regulatory frameworks: Develop guidelines for faith-based mental health interventions that protect vulnerable individuals from harmful practices while respecting religious freedom (The New Times, 2025).
d. Support referral pathways: Create clear protocols for collaboration between faith-based organisations and mental health services, ensuring that individuals can move seamlessly between spiritual and clinical care as needed (The New Times, 2025).
e. Fund implementation research: Support rigorous evaluation of faith-based interventions in Nigerian contexts, generating evidence on what works, for whom, and under what conditions.

2. **For Faith-Based Organizations**

    a. Invest in training for religious leaders: Ensure that pastors, imams, and other religious leaders receive basic mental health training, including recognition of warning signs, first aid skills, and knowledge of referral resources (The New Times, 2025).
    b. Develop partnerships with mental health professionals: Establish formal relationships with psychologists, psychiatrists, and counsellors who can provide supervision, consultation, and backup support (The New Times, 2025).
    c. Create safe spaces for mental health conversations: Normalise discussions about mental health within religious communities, reducing stigma and encouraging help-seeking (Jesuit Refugee Service, 2025).
    d. Implement evidence-based programmes: Adopt programmes with demonstrated effectiveness, such as Sources of Strength, adapting them to Nigerian cultural and religious contexts while maintaining fidelity to core components (Penn State University, 2021).
    e. Establish accountability mechanisms: Develop internal oversight to ensure that mental health interventions remain within appropriate boundaries and that individuals with serious mental health conditions are referred to clinical care.

3. **For Mental Health Professionals**

    a. Engage with faith communities as partners: Recognise religious leaders as valuable allies in mental health promotion and suicide prevention, rather than viewing them as competitors or obstacles (The New Times, 2025).

b. Provide training and consultation: Offer mental health training to religious leaders and lay caregivers, building their capacity to provide psychologically informed spiritual care (Umenyi, 2025).
c. Develop culturally adapted interventions: Collaborate with faith communities to adapt evidence-based interventions in ways that respect Nigerian cultural and religious values while maintaining therapeutic effectiveness.
d. Conduct research on faith-based interventions: Generate rigorous evidence on the effectiveness of faith-based approaches in Nigerian settings, identifying mechanisms of action and optimal implementation strategies.

4. **For Researchers**
   a. Investigate mechanisms of change: Examine how faith-based interventions produce their effects, including potential mediators such as social support, meaning-making, emotion regulation, and help-seeking behaviour.
   b. Conduct rigorous efficacy trials: Implement randomised controlled trials of faith-based interventions in Nigerian settings, establishing their effectiveness compared to usual care (George Washington University, 2026; University of North Carolina at Chapel Hill, 2025).
   c. Study implementation processes: Identify barriers and facilitators to successful implementation of faith-based interventions in Nigerian contexts, including factors related to organisational context, denominational differences, leadership support, and community engagement.
   d. Examine cultural adaptation: Investigate how evidence-based interventions can be effectively adapted for Nigeria's diverse religious and cultural contexts—including Christian, Muslim, and traditional African religious settings—without losing their essential therapeutic elements.
   e. Generate local evidence: Conduct research on faith-based interventions across Nigeria's six geopolitical zones, recognising that findings from one region may not directly apply in settings with different cultural, economic, and health system characteristics.

Conclusion

The integration of faith-based interventions into national suicide prevention programmes represents not merely an adjunct to clinical services but a fundamental reimagining of how mental health support can be delivered in contexts where faith communities serve as primary sources of meaning, belonging, and care. The evidence reviewed in this article demonstrates that faith-based organisations are strategically ideal locations for mental health intervention (George Washington University, 2026), reaching populations that clinical settings often do not (Umenyi, 2025), and offering culturally resonant support that addresses the existential dimensions of despair (Nwafor et al., 2024).

Programmes like HAVEN-Connect, Caring Connections, and Sources of Strength provide models of evidence-based faith-based interventions that can be adapted for the Nigerian context (George Washington University, 2026; University of North Carolina at Chapel Hill, 2025; Penn State University, 2021). The concept of "Pastrotherapy" offers a framework for pastoral care that addresses the meaning-seeking needs of youth facing despair (Nwafor et al., 2024), while psychologically informed spiritual care bridges the gap between spirituality and clinical practice (Umenyi, 2025). International case studies from Rwanda and South Sudan demonstrate the feasibility and effectiveness of community-based, culturally grounded approaches (The New Times, 2025; Jesuit Refugee Service, 2025).

Yet the promise of faith-based interventions must be balanced with recognition of their limitations and risks. The danger of over-spiritualisation misinterpreting mental health conditions as demonic attacks or spiritual failings can delay access to effective treatment and compound suffering

(The New Times, 2025). False prophets who exploit vulnerable individuals for personal gain represent a serious concern requiring regulatory oversight and accountability (The New Times, 2025). Sustainability challenges in resource-constrained settings remind us that faith-based interventions cannot substitute for adequate investment in mental health infrastructure (Jesuit Refugee Service, 2025).

The path forward lies in collaboration between government and faith communities, between mental health professionals and religious leaders, between researchers and practitioners. Effective national suicide prevention programmes will be those that harness the unique strengths of faith-based organisations while ensuring that interventions remain grounded in evidence, guided by trained providers, and connected to clinical services when needed. They will respect the cultural and religious values of communities while protecting vulnerable individuals from harmful practices. They will generate local evidence while learning from international experience.

In Nigeria, where youth mental health challenges pose urgent threats to individual well-being and national development (Umenyi, 2025), the integration of faith-based interventions into national suicide prevention efforts offers particular promise. The growing rate of suicide demands a pastoral response that addresses the grief and loss experienced by individuals and communities (Chimaobi & Ameh, 2024). The dominance of supernatural interpretations of mental illness and limited access to professional care (Umenyi, 2025) mean that faith communities will continue to serve as frontline responders, whether or not they are adequately prepared for this role. The question is not whether faith-based interventions will occur, but whether they will be informed by evidence, guided by training, and connected to clinical care.

As Archbishop Laurent Mbanda observed, "A well-trained person can use faith and psychology. Both can work together to help a person develop an integrated Christian world view. We have to admit that Christian faith combats despair" (The New Times, 2025). The challenge for national suicide prevention programmes in Nigeria is to create the conditions in which this integration can occur training spiritual caregivers, establishing referral pathways, ensuring accountability, and generating evidence. The alternative leaving faith communities to navigate mental health crises without support is failure measured in lives lost.

The conscience of a nation is measured by how it cares for its most vulnerable. Its future is written in the mental health of its youth. Faith-based interventions, grounded in evidence and guided by compassion, offer a pathway toward a future where every young person in Nigeria can access the support they need in a way that respects their identity, values, and beliefs.

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