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Evaluating Faith-Integrated Lay Counselling: Outcomes, Challenges, and Implications for Practice

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Abstract
This article purposes to evaluate how congregations can expand mental health support responsibly and effectively by integrating trained lay counsellors into ministry care systems. The current mental health crisis has intensified demands on churches, pastors, and ministry leaders, making accessible, community-based support increasingly necessary. Evidence from task sharing, faith community mental health research, and community-based care models demonstrates that lay led interventions can be effective when implemented within clearly defined boundaries. This article examines the role, benefits, and limitations of lay counselling in ministry settings and proposes a faith-based stepped-care model that aligns congregational support with professional mental health systems. Through a narrative review of interdisciplinary literature, including empirical studies, conceptual analyses, and practice reports from psychology, global mental health, and ministry leadership, this study synthesises key themes to clarify the scope, mechanisms, and boundaries of effective lay counselling. Across the reviewed literature, trained non specialists consistently demonstrate the capacity to provide meaningful early support, particularly where professional services are scarce or financially inaccessible. Lay counselling's distinctive strengths include relational proximity, spiritual credibility, and the ability to identify distress early and facilitate timely referral. The study concludes that a faith-informed stepped-care model that incorporates compassion, comprehensive training, supervision, documentation, and collaboration with professional services provides a promising framework for congregational lay counselling. When approached with humility, accountability, and ethical vigilance, lay counselling can be a scalable and effective part of overall mental health care within church communities.

Key terms: Christian counselling, lay counselling, mental health crisis, ministry settings, pastoral care.

1.0 INTRODUCTION

Defining Lay Counseling in Ministry Contexts

The global increase in mental health crises is increasing pressure on churches, as many people facing mental health challenges turn to pastors first before seeking help from mental health professionals. The importance of this situation is that churches are trusted spaces that many mental health sufferers visit because they do not trust the mental health system, cannot access it, cannot afford it, or fear the stigma associated with formal treatment. Perez et al. (2025) indicate that faith communities already operate across the mental health spectrum. Therefore, the question is not whether the church will encounter mental health issues from congregants, but how the church will address these issues.

The practice of lay counselling is effective when volunteers receive proper training to support counselling efforts within the church. However, these efforts become ineffective when pastors or ministry leaders treat lay counselling as a substitute for counselling from mental health professionals. According to Le et al. (2022), non-specialists can help reduce gaps in access to mental health care when they are supported by training and supervision programs. Therefore, lay counselling remains a complement, rather than a replacement, for pastoral ministry and professional counselling. This paper contends that faith-based lay counselling, which is supervised, ethically guided, and connected to referral systems, can be an effective way to address mental health concerns during crises. Its success depends more on the system responsible for selecting, training, supervising, documenting, and managing helpers' working hours than on the helpers' goodwill. The impact of lay counselling should be seen as part of an implementation strategy within a stepped care framework, rather than as an independent psychotherapy approach.

Lay counselling involves supportive relationships provided by trained but non-licensed church members or ministry volunteers. These helpers typically operate under the authority of pastoral, ministry, or church care teams and offer listening, prayer, encouragement, and practical support for life issues such as grief, family stress, marriage concerns, loneliness, or spiritual distress. While this role differs from professional counselling, lay counsellors do not diagnose, prescribe treatments, offer psychotherapy, or handle severe psychiatric problems. There is a clear distinction between professional counselling, which is regulated through licensure and accountability (Renn et al., 2023), and lay-based, ministry-focused care that follows boundaries rather than clinical authority. A clearer definition is necessary because churches use these terms differently across various care activities. Pastoral counselling typically refers to treatment provided by clergy or ministry staff. Christian counselling can mean either psychotherapy conducted by a Christian therapist or biblical counselling offered within a church. Mentoring focuses on discipleship and life guidance (Barnett et al., 2023). Support groups provide mutual support but may not include individual counselling. Lay counselling occurs in a more informal setting: it is a structured helping relationship offered by trained laypeople, who listen, provide basic psychoeducation, and use referral procedures without assuming a clinical role.

Churches often establish lay counselling through care ministries, recovery groups, structured lay caregiving programs, pastoral counselling teams, premarital or relationship support, grief support, and discipleship relationships. The most appropriate approach assigns helpers to lower- or moderate-risk supportive concerns, while referring higher-risk concerns to licensed workers. Current research on non-specialist mental health efforts confirms that role clarity contributes to higher-quality, more sustainable care models (Barnett et al., 2023). Thus, a church must define what lay counsellors can do and what they must not

attempt, because boundaries protect both the person seeking care and the volunteering church member. Faith-integrated lay counselling, as defined in this paper, is care that uses clear Christian language, values, and practices, along with ethical sensitivity to consent, confidentiality, competence, and referral. Elements of faith integration can include prayer, Scripture, lament, confession, forgiveness, hope, community support, and theological reflection (Baek et al., 2024; Perez et al., 2025). It should not involve intrusive spiritual leadership, oversimplified views of a symptom, anti-medication messages, or suggest that those seeking treatment lack faith. This distinction is important because, for some counselees, spiritual practices can foster trust and meaning, but for others, they might be used to reduce psychological distress, and discussing such practices can be silenced.

The Current Mental Health Crisis and Barriers to Care

The timing of lay counselling is critically important as mental health needs have outpaced formal care capacity. Many Americans face long waitlists, costs, shortages, debt, stigma, and difficulty gaining culturally responsive care. A national study confirms that adults confronting mental health challenges encounter significantly more barriers accessing healthcare than adults without such challenges (Coombs et al., 2021). Such obstacles make churches important entry points for support. Churches cannot solve the crisis, but they can reduce isolation and contribute to appropriate care. Financial strain is particularly significant in the context of mental health treatment. Medical debt has been connected to delays or complete avoidance of mental health care among adults with depression and anxiety disorders (Moon et al., 2024). These findings support non-clinical church support because financial barriers hinder distressed individuals from accessing professional services.

However, these findings also serve as a warning against overconfidence in laypeople's ability to address structural healthcare inequities. The primary ministry goal is to bridge the gap between distressed individuals and proper professional help, not to replace healthcare systems with church volunteers. The national mental health crisis also includes acute episodes that require immediate responses. Anderson et al. (2025) show that nearly one in ten American adults experienced a mental health crisis between 2024 and 2025. This has direct implications for ministry settings. Lay counsellors may face suicidal ideation, domestic violence, psychosis, withdrawal, abuse disclosures, eating disorder behaviours, or severe functional decline. Each situation requires adherence to emergency protocols, awareness of mandated reporting requirements, and proper referrals. The effectiveness of lay counselling partly depends on knowing when not to counsel.

There are not only financial and logistical barriers to accessing care, but also relational and cultural ones. Congregants may worry that a therapist won't respect their religious beliefs, that they will be diagnosed as spiritually deficient, or that family members or other church members will judge them. In many communities, the first person contacted for a marriage crisis, a child with behavioural issues, a family member coping with intense grief, or a community member experiencing depression is still the pastor or a trusted elder. Therefore, ministry leaders are very real gatekeepers. These gatekeepers can either open the door to evidence-based support and care or block it through stigma, misinformation, and over-spiritualisation (Baek et al., 2024; Perez et al., 2025).

One-third of the obstacles is the lack of culturally responsive providers who can recognise mental health signs and symptoms, as well as religious identity. Even when professional services are available, counselees

may hesitate to use them if they feel that prayer, Scripture, church membership, or moral struggles are not relevant. This gap can be narrowed by offering an initial step where lay counselling is provided with spiritual sensitivity, concerns about distress are explored, and the individual is also referred to someone competent for further care when symptoms exceed the scope of ministry. This bridging role is especially important because faith communities can be involved in education, referral, and support, rather than serving as alternatives to clinical systems (Perez et al., 2025). Therefore, cultural and spiritual trust should be viewed by churches as access tools, not treatments.

Evidence of Effectiveness

Research on task sharing provides the strongest foundation for evaluating lay counselling. Task sharing equips non-specialists to contribute to selected areas of mental health support (Le et al., 2022). While lay counselling within ministries is not identical to public health task-sharing efforts, both depend upon trained helpers. Systematic implementation research demonstrates that task-sharing interventions are feasible when they appropriately attend to provider characteristics, organisational support, stigma, and community context (Le et al., 2022). Such findings support lay counselling efforts, but only in churches where counselling is intentionally designed. It is imperative to exercise caution when evaluating evidence. The majority of research on task sharing focuses on structured interventions in public health, educational institutions, or community settings, rather than on informal, church-based counselling services. Consequently, it cannot be conclusively stated that all church lay counselling ministries are efficacious. Instead, these studies elucidate overarching principles: roles are precisely delineated, training programs are competency-based, supervision is accessible, fidelity is closely monitored, and referral mechanisms are established (Barnett et al., 2023; Le et al., 2022). Churches that designate their counselling services as lay counselling should refrain from asserting the efficacy based on evidence from more rigorous programs unless they embed these essential implementation features.

The U.S. study also suggests that non-specialists can be valuable within a care program. Barnett et al. (2023) examined training techniques for non-specialist mental health providers in the United States and other countries. The study showed that training, feedback, supervision, and competency monitoring can enhance non-specialists' ability to provide care. While volunteer training can benefit churches, volunteers should not be trained as if they are therapists. Even brief training may help churches when limitations are recognised and when the church does not try to operate as an inpatient or outpatient mental health facility. Faith communities provide advantages that secular systems often cannot easily replicate. These include relational trust, shared language, community experience, a sense of belonging, spiritual meaning, and ongoing contact over time.

A scoping review shows that faith communities can collaborate with mental health systems in areas such as education, referrals, support, and service delivery (Perez et al., 2025). These strengths are important because mental distress is rarely just cognitive or emotional; it also affects identity, belonging, hope, shame, family relationships, and spiritual interpretation. Churches are especially well-positioned to address these aspects. The most that can be reasonably concluded from the literature is that the effectiveness of faith-integrated lay counselling depends on the context. It appears to be most helpful for mild to moderate issues such as distress, adjustment challenges, grief, loneliness, relationship conflicts, spiritual struggles, and ambivalence about seeking help. Conversely, it is likely to be less effective or even potentially harmful in situations involving active crises, severe mental illnesses, complex trauma therapy,

abuse cases, or psychiatric evaluations (Anderson et al., 2025). This conditional view is more justified than outright dismissals of lay counselling or accusations of overstepping scholarly boundaries.

Table 1. Strengths and Limitations of Lay Counseling in Ministry Settings

Component	Ministry Strength	Major Risk	Best Practice
Access	Low-cost and relationally available	Volunteers may exceed competence	Use intake screening and referral pathways
Trust	Shared faith increases openness	Spiritual authority may pressure counselees	Emphasize consent and confidentiality
Support	Ongoing community reduces isolation	Boundaries can become blurred	Set session limits and supervision rules
Theology	Scripture offers hope and meaning	Proof-texting can minimize suffering	Integrate Scripture with careful listening
Referral	Churches can guide people into care	Poor referral systems delay treatment	Maintain professional referral networks

The table demonstrates that lay counselling succeeds by leveraging relational and spiritual strengths but falters if these are disconnected from proper structure. The key factor is not volunteer enthusiasm but effective ministry governance. Research on implementation highlights how training, supervision, and organisational factors influence the effectiveness of non-specialist care (Barnett et al., 2023). Neglecting these elements could lead to unsafe ministry practices. Conversely, a church that thoughtfully develops these components can provide meaningful early support.

Outcomes in Ministry Settings

A thorough assessment of effectiveness should include outcomes relevant to the ministry context. Firstly, it involves early engagement, where lay counsellors serve as the initial safe contact for someone who might not otherwise disclose their issues. A congregation member may feel comfortable talking to a trained lay counsellor due to familiarity and spiritual credibility. This initial connection can reduce feelings of secrecy and guide individuals toward appropriate support. Therefore, lay counselling is effective when it lowers the help-seeking barrier and encourages the person to express distress before it worsens (Perez et al., 2025).

The second aspect concerns relational stabilisation. While a lay counsellor is not expected to handle complex psychiatric symptoms, they can still help a person stay connected with a supportive community until professional help is accessible. This stabilisation may include listening, identifying immediate needs, reducing shame, mobilising safe, practical supports, encouraging the scheduling of medical or counselling appointments, and establishing a simple plan for the next steps. Reducing isolation is a significant achievement in ministry, as social disconnection can heighten distress, whereas a sense of community can boost engagement and motivation to seek clinical assistance.

One additional measure is referral completion. Lay counselling should not be judged solely by the temporary relief felt by the counselee after a session. It should also be assessed based on the actions the counselee takes afterwards, such as contacting a licensed counselling service, attending a support group, meeting with a doctor, or accessing crisis resources. This is important because task-sharing models tend to be most effective when non-specialists handle only a subset of tasks within a broader service pathway,

rather than trying to address every issue (Renn et al., 2023). Churches can follow up with clients to determine whether they connected with the referred professional, whether referral details were shared, whether consent was obtained for follow-up, and whether the counselee successfully engaged with the recommended care.

Strengths and Weaknesses of Lay Counselling

The main strength of lay counselling is its accessibility. Many individuals prefer to speak with a trusted church member before reaching out to a therapist. This is especially true in communities where there is stigma around mental illness or limited access to professional services. Research on Korean American church leaders and members shows how churches can serve as vital support systems while also highlighting barriers to seeking help (Baek et al., 2024). Lay counselling thus acts as a bridge from distress to treatment by lowering the barrier to getting help.

Another key strength is spiritual integration. Christian counselees often view suffering through aspects of sin, meaning, hope, forgiveness, calling, and God's presence. Professional counsellors may address these elements with spiritually skilled practitioners, but many believers prefer care that explicitly respects faith. Lay counsellors might incorporate prayer, Scripture, lament, confession, encouragement, and community support. Research on faith and community initiatives shows that spiritually credible support can boost engagement, especially when formal services seem distant or impersonal (Perez et al., 2025). Therefore, these approaches are particularly relevant for community members whose struggles include spiritual dimensions.

Lay counselling has limitations. Lay counsellors risk causing unintentional harm by downplaying symptoms, making false promises of confidentiality, giving overly simplistic spiritual solutions to complex issues, or discouraging clients from seeking professional help. Le et al. (2022) explain that stigma, unclear roles, inadequate supervision, and systemic barriers can reduce the effectiveness of such counselling. These risks may manifest in ministry settings as unsolicited advice, boundary breaches, victim-blaming, or ignoring danger signals. Good intentions alone are insufficient. Providing effective support necessitates competence, humility, and accountability.

Volunteer burden is another concern. Lay counsellors absorb painful stories without always having appropriate emotional support. A scoping review of task-sharing impacts shows that non-specialist providers experience growth, pride, stress, and burnout (Sangraula et al., 2025). Churches must therefore care for those who care. Good supervision includes debriefing, spiritual care, workload limits, case consultation, and permission to step back. Any ministry that uses volunteers but fails to support them eventually weakens both helper and counselee.



Figure 1. A Stepped-Care Model for Lay Counselling in Churches

This model highlights the importance of timing and clear role definition. Lay counselling is most effective early in the course of distress, offering support, stabilisation, encouragement, and referrals to prevent further isolation. However, it is less suitable for cases requiring diagnostic work, trauma treatment, or crisis intervention. Research on task-sharing supports stepped care models, as they align with provider skills and client needs (Renn et al., 2023). Therefore, churches should view lay counselling as a component of a broader continuum of care rather than a standalone solution.

The stepped care model begins before the individual session. The church defines a care pathway, specifies the concerns lay counsellors may address, and clarifies when immediate escalation is needed. The intake process should ask about safety, ongoing treatments, medication concerns, abuse risk, substance use, suicidality, and support needs. It is not a diagnostic assessment but a triage tool to determine if lay counselling is suitable or if other interventions are necessary. This approach aligns with the task-sharing philosophy, which holds that non-specialists should perform only tasks for which they've been trained (Barnett et al., 2023; Le et al., 2022).

Training, Supervision, and Ethical Safeguards

Training should include listening skills, confidentiality, informed consent, crisis recognition, suicide screening, abuse reporting, trauma awareness, cultural humility, and biblical care. Training should teach volunteers how to avoid diagnosing and how to avoid replacing licensed clinicians. Reviews of non-specialist training show that quality benefits from practice, feedback, and support (Barnett et al., 2023). Churches should not appoint lay counsellors simply because of maturity, kindness, or respected community roles. Character matters, but competence must be developed.

It is crucial that volunteers not only attend lectures on listening skills or ethics but also actively practice their skills through role plays, case vignettes, crisis simulations, and supervised exercises. Certain skills, such as reflective listening, obtaining permission for spiritual interventions, recognising red flags, documenting contacts—including referrals—and seeking supervision, are best learned through hands-on experience. Barnett et al. (2023) highlight the importance of active practice, constructive feedback, and ongoing quality support within training for non-specialists. Therefore, churches should move away from one-time workshops as the only preparation for providing sensitive care.

Supervision is fundamental to ethical lay counselling. Supervisors may be pastors with counselling training, licensed Christian counsellors, or ministry leaders collaborating with professional consultants. Mobile supervision studies indicate that lay counsellors appreciate accessible support when handling complex issues. Although ministry practices differ, the core principle remains: lay counsellors require regular consultation, documentation review, and approval before escalating concerns. Without supervision, lay counselling risks becoming isolated advice rather than structured guidance.

Ethical safeguards require documented policies and procedures. Churches ought to implement intake forms, recordkeeping systems, referral systems, abuse-reporting systems, and session-limits systems. Although these procedures may seem procedural, they are vital for protecting vulnerable individuals and safeguarding the ministry environment. Research demonstrates that organisational structures significantly influence the acceptance and practicality of task-sharing interventions (Le et al., 2022). Sole reliance on informal warmth is inadequate for creating a secure ministry setting.

Crisis procedures should be clearly documented. When someone is actively suicidal, has made a credible threat to harm, is a child or elder at risk of abuse, faces domestic violence, is experiencing psychosis, is intoxicated and poses a risk of violence, or is in a medical emergency, it is necessary to go beyond basic lay counselling. The protocol should include emergency contact numbers, local crisis resources, and pastoral or professional contacts. Counsellors should be trained to stay with the individual in imminent danger, contact emergency services, and document all actions taken. During these moments, the focus is on rapid referral and safety measures rather than ongoing counselling.

Biblical and Theological Reflection

The theological foundation for lay counselling is rooted in the church's identity as a priestly community. First Peter 2:9 refers to believers as a royal priesthood and a holy nation. This does not imply every Christian becomes a professional counsellor; rather, it signifies that the entire church participates in ministries of witness, mercy, intercession, and care. The priesthood of all believers grants lay counselling theological significance and suggests that church care should not depend solely on pastors.

Galatians 6:2 exhorts believers to bear one another's burdens. Emotional and relational challenges within the body of Christ are genuine. Bearing burdens entails showing presence, patience, honesty, and support. The broader context also emphasises the importance of self-awareness, which entails humility and accountability. This context promotes compassionate care while curbing arrogance and overreach. Lay counselling should shoulder burdens without assuming all solutions.

2 Corinthians 1:3-4 describes God as the Father of compassion and the God of all comfort, who comforts believers so they can comfort others. This is a ministry of mercy received, not expertise possessed. Such a theology values testimony, empathy, and encouragement. Comfort is not the same as clinical treatment, however. The passage rightly supports lay spiritual companionship while allowing space for specialised care needs. Wise churches honour both prayer and professional referral.

A Christian approach to lay counselling must balance compassion with acknowledgement of limits. The church is called to care deeply but also to recognise creaturely boundaries. Mental illness encompasses biological, psychological, social, spiritual, and environmental aspects. Recent research on access barriers

and crises highlights that many forms of distress require assistance beyond a single helper or institution (Anderson et al., 2025; Coombs et al., 2021). Theologically, referral should not be viewed as a failure; instead, it can be an act of neighbourly love.

Cultural and Congregational Factors

Culture influences whether lay counselling feels secure. Some congregations highly value privacy, causing individuals to avoid sharing their struggles. Others may spiritualize symptoms, viewing depression as a sign of weak faith. Certain immigrant and minority churches offer strong communal support but face stigma around professional mental healthcare. Research among Korean American church communities highlights church leaders as key gatekeepers who need better mental health literacy and referral skills (Baek et al., 2024). Therefore, lay counselling must directly address cultural factors.

Operational requirements should be regarded as equally important as cultural competence, beyond just demonstrating a kind attitude. Counsellors need training on how race/ethnicity, immigration history, gender, socioeconomic stressors, and family norms influence help-seeking behaviour. In certain communities, distress might be expressed through physical symptoms, family conflicts, prayer requests, or feelings of shame rather than clinical terminology. However, research on Korean American church communities shows that congregants can be a valuable resource for support, though there is a need for improved mental health literacy and referral-readiness within these groups (Baek et al., 2024). Therefore, churches should educate lay counsellors to ask culturally sensitive questions, avoid assumptions, and recognise cultural stigma that may prevent individuals from accepting professional help during crises and recovery, thus protecting dignity, trust, and safety.

Church size influences the experience: smaller churches foster a close-knit community but may lack privacy, whereas larger ones have specialised care teams but less personal connection. Rural churches often have limited referral options, while urban churches encounter diverse cultural needs and high expectations. Research on faith-community partnerships indicates that working with mental health professionals enhances a congregation's ability to support members (Perez et al., 2025). It is wise for churches to proactively establish local referral networks rather than wait for a crisis. Being prepared is more ethical than improvising in emergencies.

Reasoned Judgment on Effectiveness

Lay counselling is effective when evaluated by the appropriate standard. It should be distinguished from psychotherapy, psychiatry, or crisis intervention, and instead regarded as early support, spiritual care, and relational stabilisation. Under this framework, the evidence supports its effectiveness. Studies on task-sharing indicate that non-specialists can effectively increase access to care when their roles are well-structured and supervised (Renn et al., 2023). Additionally, incorporating spiritual and relational resources within ministry settings boosts engagement.

However, lay counselling is inappropriate as an initial response to active suicidality, psychosis, severe substance dependence, abuse emergencies, eating disorders, or trauma with complex backgrounds. Such approaches are also unsuitable if volunteers lack proper training or if churches have not established referral networks. The strongest evidence indicates that the advantages of such models should be

balanced against potential risks (Le et al., 2022). The most justified conclusion is that lay counselling constitutes one element within a comprehensive ecological model of care.

The importance of each component influences ministry choices. Although access is vital, safety takes precedence. While spiritual care is essential, role clarity becomes more crucial during severe symptoms. Volunteer compassion is valuable, but supervision is key to ensuring program sustainability. Research indicates that programs must safeguard both helpers and care recipients (Sangraula et al., 2025). Therefore, the church should prioritise investing in screening, training, supervision, and referral systems.

Implications for Practice

This evidence has several practical implications. Churches should have a written scope of care statement outlining the role of lay counsellors, the issues they address, and those they do not handle, including confidentiality, referral procedures, and supervision. This statement should be shared with counselees before starting care. A clear scope prevents role confusion within the church and ensures that counselees do not mistakenly believe they are receiving professional counselling when they are not (Barnett et al., 2023; Renn et al., 2023).

Churches should set up referral networks before starting or expanding lay counselling. Potential partners include licensed professional counsellors, marriage and family therapists, psychologists, psychiatrists, medical providers, crisis centres, domestic violence agencies, addiction treatment programs, and community mental health clinics. However, having a simple referral list isn't enough. Leaders must know which professionals are culturally responsive, affordable, trauma-informed, and willing to collaborate effectively with faith communities (Perez et al., 2025).

Churches must ensure support for volunteers. When a counsellor encounters stories of abuse, sorrow, betrayal, addiction, or discouragement, they need proper backing. This can include de-briefing rooms, prayerful care, balanced caseloads, and adequate rest in churches. Burnout isn't solely a ministry issue—it's also about how caregivers are cared for. Exhausted and unsupported helpers are more prone to give poor advice, overstep boundaries, or disengage. Therefore, supporting providers is a key part of ethical care (Sangraula et al., 2025).

2.0 CONCLUSION AND RECOMMENDATIONS

Conclusion: Lay counselling represents a vital and increasingly necessary dimension of congregational care within contemporary Christian ministry. As churches confront rising mental health needs, lay-driven pastoral support offers an accessible and relationally grounded complement to professional clinical services. Its significance is especially evident in contexts where access to licensed care is limited by financial constraints, geographic barriers, time pressures, or concerns regarding trust and cultural fit. In such settings, trained lay counsellors provide a timely, compassionate presence that can reduce distress, strengthen resilience, and reinforce the communal bonds that characterise healthy ecclesial life.

Yet the effectiveness of lay counselling depends on more than proximity or goodwill. Research consistently demonstrates that lay counselling produces the most positive outcomes when counsellors operate within clearly defined roles, receive structured and ongoing training, and participate in supervision that ensures ethical integrity and accountability. Without such preparation and oversight, well-intentioned efforts can

inadvertently introduce risks that compromise both care recipients and the ministry's credibility. Consequently, churches must develop governance frameworks grounded in ethical standards, confidentiality protocols, and established referral pathways to licensed professionals. These structures not only safeguard congregants but also enhance the legitimacy and sustainability of lay counselling as a ministry practice.

A theological rationale for lay counselling emerges from biblical motifs of burden-bearing, priestly intercession, and Spirit-empowered consolation. These themes affirm the legitimacy of shared pastoral responsibility while simultaneously acknowledging human finitude and the need for specialised expertise. The most faithful and effective model of congregational care reflects this dual recognition: churches cultivate internal capacities for relational support while collaborating with mental health professionals to ensure safety, competence, and continuity of care. Such an approach honours both the communal nature of Christian discipleship and the complexity of contemporary mental health challenges.

Recommendations: Future research should continue to examine the empirical effectiveness of lay counselling across diverse ecclesial, cultural, and socioeconomic contexts, with particular attention to longitudinal outcomes and the mechanisms that contribute to positive change. Scholars should also investigate which training competencies most reliably predict effective lay counselling practice, as well as the structural features that support sustainable collaboration between churches and mental health professionals. Additional inquiry into ethical decision-making, liability reduction, and crisis management would further strengthen the field and provide clearer guidance for ministry practitioners. These fields of study, such as empirical outcomes, competency development, and risk management, offer promising avenues for interdisciplinary research.

The policy implications for churches are equally significant. Congregations should adopt formal governance structures that define the scope of practice, confidentiality expectations, documentation procedures, and referral protocols for lay counsellors. Establishing minimum training standards and ongoing supervision requirements can help ensure that lay counselling ministries operate with both theological integrity and professional prudence. Churches should also cultivate partnerships with local mental health providers to facilitate timely referrals and collaborative care. These institutional commitments, such as developing governance structures and strengthening community partnerships, are essential for sustaining safe and effective ministry.

For ministry leaders, the practical task is to construct systems that balance compassionate accessibility with disciplined safeguards. This involves clarifying the theological rationale and operational boundaries of lay counselling, investing in comprehensive training, ensuring regular supervision, and maintaining robust referral networks. Leaders must also promote congregational awareness of the ministry's purpose and limitations, thereby reducing stigma and encouraging appropriate utilisation. These practices, such as defining ministry scope, ensuring supervision, and strengthening referral pathways, enable churches to offer care that is both compassionate and responsible.

When well-organised, faith-based lay counselling shows great promise as a form of contextualised pastoral care that is clearly structured, thoroughly trained, properly supervised, culturally sensitive, and integrated with professional mental health systems. Its effectiveness decreases when it turns into informal therapy,

spiritualized oversimplification, or unsupervised advice. The key question for churches is not whether lay counselling should exist, but how it can be practised in ways that honour the church's pastoral mission while following ethical mental health standards. Such carefully designed models of care are a valuable contribution of the church to the well-being of individuals, families, and communities.

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