A SUTHERLAND INSTITUTE
POLICY REPORT

How Faith Communities Promote Societal Well-Being and Public Health

Religion and the American Experiment, Volume 2

Written by Samuel J. Abrams

October 2025

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Report Introduction



America is in the midst of a profound health crisis that extends far beyond hospitals, prescriptions, and insurance systems. Rates of chronic disease remain stubbornly high, but the deeper emergency is more than physical. It is emotional, social, and spiritual. We are witnessing a deterioration in the foundations of well-being: Fraying relationships, diminished trust, and a pervasive sense of isolation.

Rates of anxiety and depression have surged across all age groups, but especially among young adults. According to data from the Centers for Disease Control and Prevention (CDC), the percentage of high school students reporting persistent sadness or hopelessness rose from 29 percent in 2011 to over 42 percent by 2021 – a staggering increase in just a decade. Meanwhile, one in two Americans now reports experiencing loneliness, according to the U.S. Surgeon General, who recently declared loneliness a national public health crisis on par with smoking and obesity.

This crisis of belonging cuts across class, race, and geography – but is particularly acute among rising generations. According to the October 2023 Wall Street Journal/NORC poll, more than three-quarters of voters under age 30 believe the country

is headed in the wrong direction. A related survey by the American Enterprise Institute found that over 60 percent of Gen Z feel "deeply disconnected from meaningful community" – despite their near-constant connectivity via digital platforms. Many young adults report that they have few close friends, limited trust in institutions, and little confidence in the future. And yet, paradoxically, they also express a deep yearning for stability, connection, and purpose.

Public health leaders and policymakers have responded with a suite of important interventions, including expanding access to therapy, investing in behavioral health systems, and proposing new forms of economic support. These efforts are necessary and laudable, but insufficient. They miss the relational and moral architecture that undergirds long-term flourishing. In the rush to modernize systems and address symptoms, we have neglected the spiritual foundations of health: Sources of meaning, community, and moral responsibility that have sustained individuals and societies for centuries.

Rising rates of burnout, loneliness, and disaffection make clear that health is not simply a medical issue but also a civic and cultural one. Increasingly, the medical field is beginning to embrace the idea that human beings are not isolated data points or mere biochemical systems. Integrative health programs are expanding in medical schools and health centers nationwide as more practitioners recognize that well-being must be understood holistically – not only as a physical matter, but also as a psychological, social, spiritual, and environmentally influenced one. While there is still much progress to be made, there is growing awareness that we are relational creatures who thrive within networks of belonging and purpose. When those networks erode, our capacity to endure hardship, make ethical choices, and care for others erodes with them.

In that light, the exclusion of religion from mainstream health discourse is both a practical and philosophical mistake. Religious communities offer not only social support, but a coherent vision of the good life – a framework of obligations, practices, and shared narratives that promote resilience, responsibility, and care. They are often first responders to suffering, long-term caretakers of the vulnerable, and sustainers of hope in the face of loss.

In response to this widespread malaise, many policymakers have focused on economic remedies: Expanding access to healthcare, improving mental health infrastructure, and addressing income inequality. All of these matter. But too often, one of the most powerful empirical sources of individual and societal healing is overlooked: Faith and religion.

The Empirical Case for Religion and Health

A growing and increasingly rigorous body of research suggests that active religious practice is one of the strongest predictors of long-term health and well-being. Contrary to the popular assumption that religion is merely a matter of private belief or cultural tradition, numerous studies demonstrate that consistent participation in religious life yields tangible benefits across physical, emotional, and social health metrics.

A recent report from Sutherland Institute notes that religious Americans who regularly attend services are significantly less likely to suffer from depression, more likely to report a strong sense of belonging, and far more engaged in civic and communal life. These findings echo decades of social science research: Religious observance is a public good that improves individual health and strengthens the social fabric.

Women who attended religious services more than once a week have a 33 percent lower risk of dying over a 16-year follow-up period compared to those who never attended.

Perhaps the most striking evidence comes from the Harvard T.H. Chan School of Public Health, where multiple studies show that weekly religious attendance correlates with lower mortality, improved mental health, reduced suicide risk, and better cardiovascular survival across multiple cohorts and settings. Another study published in *JAMA Internal Medicine* found that women who attended religious services more than once a week have a 33 percent lower risk of dying over a 16-year follow-up period compared to those who never attended. These benefits persist even after controlling for factors such as age, income, health status, and social support.

This phenomenon is not new. The long-running Adventist Health Studies at Loma Linda University have repeatedly shown that Seventh-day Adventists, who adhere to a biblically inspired health code that emphasizes plant-based diets, exercise, and abstention from tobacco and alcohol, live six to seven years longer than the general U.S. population. Loma Linda, California – home to a large Adventist population – is one of only five officially recognized global "Blue Zones," regions where people routinely live past 100 in good health.

These patterns are confirmed by nationally representative surveys. The Pew Research Center found that religiously engaged Americans are more likely to report being very happy, more satisfied with their family lives, and more active in volunteerism and charitable giving. Importantly, these trends are not confined to any one religion or demographic group – they hold across diverse faith traditions, from evangelical

Protestants to Orthodox Jews, Muslims, and Buddhists.

The mechanisms by which religion supports health are complex, but increasingly well understood. Scholars generally identify three primary pathways:

1. **Healthy Behavior:** Religious teachings often promote health-enhancing behaviors: Moderation, sobriety, sexual responsibility, and regular rest. They also discourage destructive habits such as substance abuse, reckless driving, or violence. A study in the journal *Drug and Alcohol Dependence* found that religious service attendance is associated with a lower risk of substance use disorders, particularly among adolescents.

2. **Mental Health:** Religious frameworks reduce stress and anxiety by offering coherent worldviews, practices of prayer and meditation, and rituals that provide stability and meaning. Spiritual coping strategies – including prayer, confession, forgiveness, and surrender – correlate with lower levels of cortisol and improved emotional regulation.

3. **Social Support:** Faith communities create deep, structured networks of mutual care and belonging. This social support is not superficial. It includes intergenerational friendships, pastoral counseling, practical assistance, and communal celebration and mourning. Sociologist Linda Waite and others have documented that these strong social bonds are protective against isolation, which the Surgeon General now classifies as a major public health threat.

As the Harvard-Fetzer Institute framework for spiritual well-being has emphasized, religion is not merely belief – it is structure. It creates rhythms and boundaries. It provides identity and accountability, and it anchors individuals in a larger moral narrative that transcends the self. This kind of moral architecture builds resilience, especially in moments of crisis, grief, or uncertainty.

Even secular researchers recognize the implications. In a widely cited editorial in *The New York Times*, public health expert Dr. Tyler VanderWeele argued that "religion may be a miracle drug" for the loneliness and despair that afflict modern life. Unlike pharmaceuticals, religion requires no prescription, has few side effects, and comes with community built in.

Taken together, the empirical record is clear: Religious practice is a robust and underutilized asset in promoting public health. Religion doesn't replace medicine – but it enhances and sustains well-being in ways that no pill or policy alone can achieve.

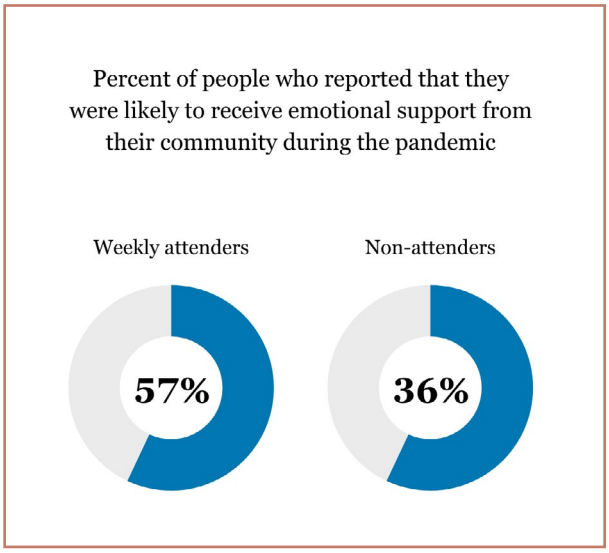
Faith as Mental-Health Infrastructure: A COVID Case Study

The resilience of faith communities was especially evident during the COVID-19 pandemic, when the psychological and social fabric of American life came under intense strain. Amid widespread isolation, school closures, and the breakdown of normal routines, religious congregations across the country stepped up – not as passive observers, but as frontline responders to a sprawling mental health and civic crisis.

According to Sutherland Institute's *Social Benefits of Religion* report, communities with strong religious engagement were significantly more likely to maintain neighborly ties, offer emotional and material support, and reconstitute social life faster than their secular counterparts. While government agencies scrambled to coordinate responses, houses of worship pivoted quickly. Many launched virtual prayer services and counseling sessions, delivered groceries to shut-ins, and organized mutual aid networks long before local relief funds were operational.



National surveys also illustrate this pattern. Religiously active Americans in a 2021 Pew Research Center survey reported that they were more likely to have received emotional support



from their community during the pandemic (57 percent among weekly attenders vs. 36 percent among non-attenders). Similarly, a Gallup poll from late 2020 showed that only one U.S. demographic group reported no decline in mental health during the pandemic year: Those attending religious services weekly. In fact, their self-reported mental health actually *improved*. The proportion claiming "excellent" mental health rose from 42 percent in 2019 to 46 percent in 2020.

This is not a coincidence. Religious institutions provide a kind of embedded mental-health infrastructure that few other social bodies can

replicate. They offer continuity, purpose, ritual, and intergenerational relationships – all of which protect against anxiety, depression, and social alienation. For millions, the stability of religious life – online or in person – offers a critical lifeline amid chaos.

Religious institutions offer continuity, purpose, ritual, and intergenerational relationships – all of which protect against anxiety, depression, and social alienation.

The role of congregations during COVID extended well beyond psychological support. As sociologist Elaine Howard Ecklund documented, many faith communities served as key nodes in the public-health communication chain, especially among immigrant and minority populations where trust in government institutions can be low. Pastors, imams, and rabbis became de facto health educators – dispelling misinformation, encouraging vaccination, and even hosting pop-up clinics in church basements and synagogue social halls.

For instance, in the Jewish community, Chabad houses across the country expanded their outreach by delivering Shabbat meals to isolated seniors, offering grief counseling, and launching virtual Torah classes that kept communal bonds alive across time zones. In Israel, ultra-Orthodox (Haredi) organizations pivoted from their typical educational work to distribute masks and hygiene kits, and even staffed emergency response centers – despite well-documented tensions between some Haredi communities and the state. The result was a surprising boost in civic cooperation and public health literacy in some of the most religious enclaves.

Similarly, The Church of Jesus Christ of Latter-day Saints mobilized its vast volunteer networks through its *JustServe* platform, connecting thousands of members to pandemic response efforts ranging from food distribution to elder care. Local wards functioned as micro-networks of support, checking in on members through ministering assignments and coordinating aid through established church protocols. Leaders offered both spiritual and psychological reassurance through general conference addresses focused on resilience, faith, and mental health. For many Latter-day Saints, the church's deep bench of community relationships – formalized through ecclesiastical callings – became a mental-health safety net when professional resources were stretched thin.

These actions underscore an often-overlooked fact: Houses of worship are not merely places of personal devotion. They are *civic infrastructure*. They operate as decentralized networks of care, trust, and transmission of values. In doing so, they help bind communities together and offer a crucial buffer against the atomization that characterizes much of modern life.

Sociologist Robert Putnam, whose landmark study *Bowling Alone* chronicled the decline of American social capital, has repeatedly emphasized the unique civic contributions of religious congregations. "Faith communities," he writes, "are arguably the single most important repository of social capital in America." In his later work *American Grace*, co-authored with David Campbell, Putnam



expanded this insight: Religious participation not only fosters trust and altruism among fellow believers, but also increases generosity and civic engagement *across* lines of difference. Those who attend religious services regularly, they found, are more likely to donate to secular charities, volunteer in non-religious settings, and engage in community problem-solving.

In that sense, faith communities are what Putnam calls "moral socializers." They don't simply promote in-group cohesion – they cultivate habits of responsibility, empathy, and public-spiritedness that spill over into broader civic life. During the pandemic, these habits translated into practical action, such as checking on neighbors, delivering meals, supporting the grieving, and sustaining emotional resilience.

The lessons of the pandemic should not be forgotten. As mental health challenges among young people continue to escalate – driven by social media, economic instability, and cultural fragmentation – faith communities offer sustained human connection embedded in shared meaning. They are not a substitute for professional care, but they are a vital complement to it. Where secular systems often struggle to reach the lonely, the ashamed, or the spiritually hungry, religious communities offer a place to be seen, known, and held.

In short, while policymakers debate how to "scale" mental health infrastructure, they should recognize that a scalable solution already exists – quietly, locally, and powerfully – in pews and prayer halls across the country.

Mormonism and Embodied Doctrine

One of the clearest and most rigorously documented examples of religion promoting health through doctrine and daily practice is The Church of Jesus Christ of Latter-day Saints. Latter-day Saints' distinctive health code, known as the "Word of Wisdom", was first revealed in 1833 and outlines a range of divinely inspired health guidelines. Those who commit to following it avoid alcohol, tobacco, coffee, and tea, while building their diet around wholesome grains, fruits, proteins, and vegetables. Though not originally mandatory, the Word of Wisdom became a formal standard of observance in the 20th century and is now considered a key requirement for full participation in Latter-day Saint religious life.

The long-term health effects associated with Latter-day Saint religious practices are both measurable and well-documented. Research from Utah, where The Church of Jesus Christ has its highest concentration, consistently demonstrates that members of the church experience significantly lower rates of smoking-related illnesses, alcohol-related diseases, and substance abuse, as well as longer life-expectancies, when compared to both national and state populations.

These studies collectively demonstrate that religiously motivated health behaviors – particularly abstention from tobacco, alcohol, and other harmful substances – can have a significant impact on long-term physical well-being. Latter-day Saints' emphasis on healthful living, embedded in communal and spiritual life, contributes measurably to positive public health outcomes. Together, these findings underscore the ways that sustained religious practice helps drive long-term health outcomes: Healthy individual behaviors pursued with social support from the community.



But the church's approach to health goes well beyond abstention. At its core, Latter-day Saint doctrine embraces a holistic theology of embodiment. The human body is not simply a vessel for the soul – it is part of the soul. As Doctrine and Covenants 88:15 states, "The spirit and the body are the soul of man." This duality reflects the Latter-day Saints' broader emphasis on physical stewardship, moral agency, and personal responsibility. Health is not merely a biological condition, but a spiritual discipline, intimately tied to one's covenantal responsbilities and divine potential.

This theological framework helps explain the consistency and durability of Latter-day Saints' health behavior. Rather than relying on external enforcement or public messaging, Latter-day Saints' health norms are internalized through covenantal promises made by the individual, reinforcement given by the ecclesiastical structure, and support offered by the broader community. From early adolescence, Latter-day Saint youth participate in health-promoting programs like Personal Progress and Duty to God, which tie physical discipline to spiritual growth. Weekly church meetings, family home evenings, and temple recommend interviews reinforce accountability while offering pastoral and peer support.

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Moreover, emphasis in The Church of Jesus Christ on preparedness and community resilience also aligns closely with public-health goals. Latter-day Saints are encouraged to maintain emergency food storage, develop self-reliance skills, and participate in mutual aid through organized ministering programs. During the COVID-19 pandemic, these systems were rapidly activated to deliver care and resources at scale. The Church of Jesus Christ Humanitarian Services arm coordinated over 1,000 COVID-19 response projects across 150 countries, offering everything from PPE and food kits to mental-health resources and vaccination campaigns.

The durability of these efforts rests in a cultural logic that prioritizes health as a communal covenant. Latter-day Saint theology places immense value on "the sanctity of the ordinary" – on building strong families, honoring the body, and seeing daily actions as eternal in consequence. This grounding yields what sociologist Armand Mauss and others have described as essentially voluntary discipline through sacred framing – an internalization of health norms not through fear or shame, but through love, purpose, and responsibility.

In short, the Latter-day Saint community exemplifies how moral narrative, institutional consistency, and theological depth can produce robust health outcomes – without coercion or top-down mandates. The case of The Church of Jesus Christ of Latter-day Saints challenges prevailing assumptions in health policy that behavior change must be engineered externally. Religion, rather, can empower individuals to make better health choices *because* they are part of a story bigger than themselves.

Jewish Wisdom on Wellness and Wholeness

Like The Church of Jesus Christ, Judaism also offers a deep and enduring framework for integrating spiritual and physical well-being – one that spans ancient law, ritual practice, and contemporary theology. Far from separating body and soul, Jewish tradition views health as a sacred obligation, interwoven with religious life, communal ethics, and divine purpose.

At the Core

Jewish law *(halakha)* is filled with explicit and implicit imperatives related to health. The commandment *"venishmartem meod lenafshoteichem"* – "you shall greatly guard your lives" (Deuteronomy 4:15) – has long been interpreted by rabbinic authorities as a mandate for self-care and bodily preservation. It underpins rabbinic prohibitions against dangerous behavior and establishes a religious basis for modern health interventions, from vaccination to mental health treatment. Similarly, the principle of *pikuach nefesh* – the obligation to preserve life – overrides nearly all other commandments in Jewish law, including Sabbath restrictions. In other words, health is not a secular concern grafted onto Jewish life; it is a core religious value.

Daily Jewish practices also cultivate a holistic ethic of balance, embodiment, and mindfulness. Ritual handwashing *(netilat yadayim)* before meals and upon waking promotes hygiene while imbuing bodily actions with spiritual intention. Dietary laws *(kashrut)* discipline consumption and elevate the act of eating into a mindful ritual. The rhythm of prayer – *shacharit*, *mincha*, *maariv* – encourages stillness, reflection, and physical awareness multiple times per day.



A Sacred Refuge

Perhaps no institution embodies Jewish health wisdom more fully than the Sabbath. Modern Jewish theologian Abraham Joshua Heschel, in his classic work *The Sabbath*, described it as a "cathedral in time"; a sacred refuge from the relentless demands of labor and consumption. Heschel argued that the Sabbath is not a luxury but a spiritual and physical necessity: A weekly reset that guards against burnout, overwork, and alienation. Today, as digital life collapses boundaries between work and rest, studies in neuropsychology increasingly affirm what Heschel intuited. Periods of structured rest improve cognitive function, emotional regulation, and nervous system recovery.

The physiological and psychological wisdom embedded in Sabbath observance has drawn interest even from secular health professionals. The concept of *tech Shabbat*, promoted by author Tiffany Shlain, encourages individuals (Jewish or not) to unplug from digital devices for 24 hours each week, echoing ancient Jewish patterns of rest and renewal. What Judaism has long framed as a mitzvah – a sacred obligation or commandment – modern science now sees as a public-health imperative. This idea has gained public traction outside the Jewish community.

Life in the Community

Moreover, Jewish tradition connects wellness not just to individual behavior but to community structure. Contemporary research on Haredi (ultra-Orthodox) populations in Israel illustrates this powerfully. Despite lower socioeconomic status and limited access to certain public services, Haredi Jews report high levels of subjective well-being, emotional resilience, and communal satisfaction. Formal studies have revealed that Haredi neighborhoods showed stronger social cohesion and greater mental health outcomes compared to nearby secular areas.

This apparent paradox is explained in part by social capital: Haredi life is deeply structured by shared rituals, extended family networks, communal norms, and frequent acts of mutual aid. Religious observance in these communities is lived collectively, not atomized, which enhances both emotional support and existential meaning. As sociologist Samuel Heilman has noted, Haredi Judaism constructs a dense moral world where each individual's well-being is seen as integrally tied to the community's spiritual and material health.

That communal ethos extends across Jewish denominations and diasporas. Programs like *Bikur Cholim* (visiting the sick), *chevra kadisha* (sacred burial societies), and communal cooking or childcare during times of illness reflect a longstanding ethic of relational care that predates modern social work. In this way, Judaism offers not just a theology of wellness but a practice of wholeness. This practice is grounded in the dual convictions that: (1) the human body is a vessel for divine service, and (2) healing is both a spiritual and communal responsibility.

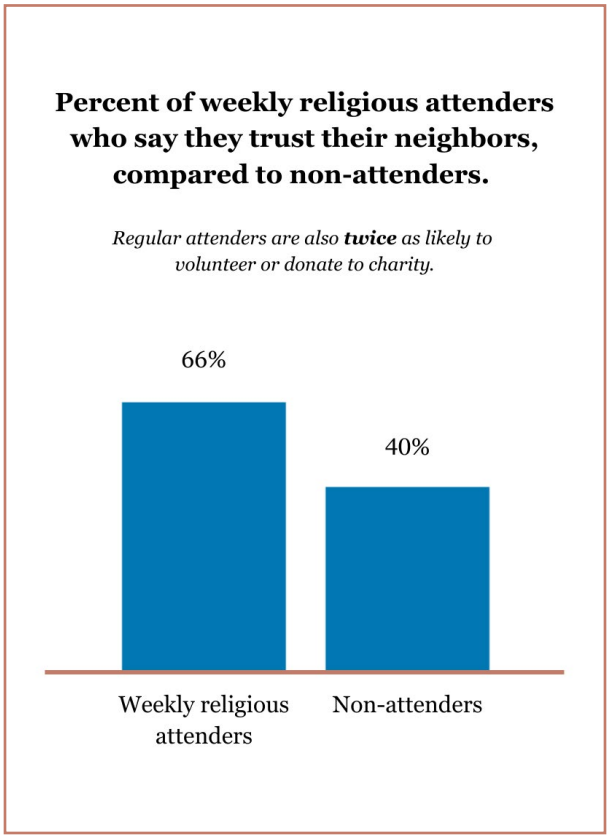
The Meaning of Health in Jewish Tradition

Contemporary Jewish thinkers have sought to reclaim and deepen these connections. Rabbi Elliot Dorff, a leading scholar in Jewish medical ethics, has argued that Judaism provides a uniquely integrative bioethics that affirms medical intervention while grounding it in humility, dignity, and the sacredness of life. In his work *Matters of Life and Death*, Dorff notes that Judaism not only permits but *requires* us to engage in healing; this is a core value.

Taken together, the Jewish tradition articulates a powerful alternative to fragmented models of health. It affirms that spiritual and physical well-being are not opposites but partners – that health is not merely the absence of illness, but the presence of meaning, connection, and covenant. In a secular world increasingly hungry for purpose and community, Jewish wisdom on wellness offers both ancient insight and practical guidance.

Social Capital, Trust, and Civic Health

The connection between religious participation and civic trust is not just cultural folklore – it is a well-documented empirical reality. Research from the American Enterprise Institute's Survey Center on American Life consistently shows that religiously observant Americans are more likely to trust others, engage in community service, and participate in democratic life. According to AEI's Survey on Community and Society, 66 percent of weekly religious attenders say they trust their neighbors, compared to just 40 percent of non-attenders. Regular attenders are also twice as likely to volunteer or donate to charity – religious and secular.



This civic orientation is part of what social scientists call social capital: The network of trust, reciprocity, and norms that bind people together and support cooperative institutions. As Robert Putnam argues in *Bowling Alone*, houses of worship are among the most powerful generators of this capital. In *American Grace*, Putnam and David Campbell expand this idea, showing that religiously observant Americans are not only more engaged in their own communities, but also more altruistic toward others – across lines of faith and ideology. Religious Americans, they argue, are simply better neighbors.

Sutherland Institute reinforces these findings in its 2024 report, The Social Benefits of Religion, arguing that faith communities are among the most effective mediating institutions in American life. This critical research shows that religiously affiliated Americans are significantly more likely to: (1) feel connected to a broader purpose, (2) have someone they can rely on in a crisis, and (3) believe they can improve their communities. Crucially, these effects are most robust not from private belief alone, but from active participation in congregational life – what the Sutherland report describes as a form of structured belonging.

This has enormous implications for public health, particularly during periods of crisis. A growing body of interdisciplinary research confirms that social trust and civic cohesion are among the strongest predictors of health outcomes, especially in emergencies. In a 2021 BMJ study of 177 countries,

researchers found that higher levels of societal trust were associated with significantly lower COVID-19 mortality rates, even after controlling for income and healthcare access; a 2021 *Lancet* study found similar trends. In the U.S., counties with strong religious infrastructure – defined by church attendance, volunteer rates, and community service – reported faster vaccine adoption, lower death rates, and quicker returns to social stability.

These benefits are not accidental. Faith communities often function as civic infrastructure, providing not only spiritual support but also practical assistance, public health messaging, and social accountability. During the COVID-19 pandemic, religious leaders played a pivotal role in encouraging preventive health behaviors, countering misinformation, and maintaining morale – especially in communities with low institutional trust. Black churches, Catholic parishes, and Orthodox synagogues became distribution sites for food, masks, and even vaccines, building on decades of local trust and relational capital.

Moreover, the health-enhancing effects of religious community extend beyond pandemics. Studies in the *Journal of Religion and Health* and Health Affairs show that individuals with high levels of congregational involvement report better mental health, lower levels of loneliness, and greater resilience in the face of trauma or economic hardship. In short, research regularly confirms that religiosity and social capital are mutually reinforcing – with each enhancing the other's protective effects on well-being.

Put simply: Trust saves lives. It enables public health coordination, increases adherence to treatment protocols, and fosters mutual responsibility. In a country where institutional trust is declining, religion remains one of the last strongholds of relational reliability and moral commitment.

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In this light, religion is not a "nice to have" feature of civil society – it is a foundational asset, as essential to people's well-being as good government itself. Faith communities cultivate not only private virtue but public good. They reinforce the ties that make democratic life and public health possible. Ignoring or marginalizing religion or public expression of faith is not only unwise; it is self-destructive.

Recognizing Religion's Risks and Rewards

It is essential to acknowledge that not all religious expression promotes health or human flourishing. While the empirical record overwhelmingly shows that active religious participation is correlated with positive outcomes, there are notable exceptions. Religion, like any powerful social force, can be harnessed for healing or harm.

Harmful expressions of religion include sectarianism, spiritual abuse, authoritarian control, the stigmatization of mental illness, and the rejection of medical science. In some instances, religious teachings may be invoked to justify silence around trauma, discourage the use of psychiatric medication, or treat suffering as a form of divine punishment. These dynamics can alienate vulnerable individuals, delay diagnosis, and contribute to poor health outcomes, particularly in cases involving depression, addiction, or domestic violence.

Moreover, religious institutions that fail to balance pastoral care with doctrinal teachings can encourage climates of fear and shame, especially around sexuality, gender identity, or mental illness. These environments can impede honest dialogue about suffering or doubt. In such settings, individuals may



feel isolated or spiritually defective for experiencing distress, leading to what researchers call "negative religious coping."

Psychologist Kenneth Pargament, one of the leading scholars in the psychology of religion, has developed a widely used framework to distinguish between positive and negative religious coping mechanisms. According to Pargament, *positive religious coping* involves trust in a benevolent God, seeking spiritual support, and finding meaning in adversity. This style has been linked to lower levels of anxiety and depression, greater resilience, and faster recovery from illness. In contrast, *negative religious coping* – such as seeing suffering as divine punishment, feeling abandoned by God, or religious disengagement – correlates with higher levels of psychological distress, poorer physical health, and even higher mortality rates.

These findings underscore an important truth: *The impact of religion on health is not determined solely by belief, but also by context, interpretation, and community norms*. Faith becomes health-enhancing when it is open, compassionate, and integrated with contemporary understandings of medical science and mental well-being.

This is where institutional pluralism and accountability matter. Religious institutions that foster open dialogue, welcome pastoral counseling, and partner with health professionals can be vital allies in addressing the spiritual and emotional dimensions of suffering. Initiatives like Interfaith America and FaithNet through NAMI (National Alliance on Mental Illness) have pioneered models of faith-based mental health education, reducing stigma while respecting religious autonomy.

Meanwhile, theological educators and clergy training programs are increasingly emphasizing trauma-informed pastoral care and spiritual first aid – equipping religious leaders to respond with empathy and competence to a range of health challenges. This growing field recognizes that faith leaders are often the first responders to emotional and psychological crises, particularly in underserved or religiously observant communities.

Importantly, recognizing religion's risks is not an argument against its inclusion in public health – but a call for its thoughtful integration. We must engage faith communities as *partners*, not as threats. The alternative – secularizing health discourse entirely – ignores the lived reality of millions of Americans for whom health, hope, and healing are inextricably bound up with spiritual life.

While faith institutions have distinct and unique features that set them apart from other civic institutions, they remain civic institutions that require both trust and transparency. Rather than exclude religion from the health domain, public systems should work with religious networks to deliver care, promote resilience, and respond to suffering – while protecting against abuse or misinformation.

In short, the task is not to secularize health, but to equip and empower religious institutions to contribute positively to health. When rooted in love, humility, and truth, religious traditions can be not only sources of private comfort, but pillars of connection, purpose, and care in a fragmented world.

Policy and Civic Recommendations

If religion demonstrably enhances health, trust, and civic well-being, then it should no longer be viewed as a private or tangential concern in public life. Rather, it must be understood and leveraged as a public asset, while respecting the reasonable and constitutional limits on the influence of government and public policy in the realm of religion.

Too often, religious communities are excluded from strategic planning in public health, social services, and education – not because they lack impact, but because they are misunderstood or misclassified as purely sectarian. In reality, faith-based institutions are among the most effective and enduring civic intermediaries in American life. They are place-based, trusted, multilingual, and intergenerational – and uniquely positioned to provide care, moral guidance, and community.

To that end, policymakers, educators, and health professionals should:

- ***Recognize and fund partnerships with faith-based institutions in mental health, addiction recovery, and elder care.***

Faith-based organizations (FBOs) provide a disproportionate share of America's care infrastructure, particularly for underserved and marginalized populations. Groups like Catholic Charities USA, Lutheran Services in America, and Jewish Family Services offer counseling, housing support, addiction treatment, and hospice care – often at scale and with decades of experience. According to a 2016 Baylor University study, religious organizations contribute more than $1.2 trillion annually to the U.S. economy, much of it through health and human services. Federal, state, and local governments should expand funding streams and formal partnerships to support these initiatives, especially in areas where government capacity is limited or public trust is low.

- ***Support campus ministries and religious student groups that foster identity and connection.***

Young adults today are experiencing unprecedented levels of loneliness, anxiety, and spiritual disorientation. Research from Springtide Research Institute shows that nearly 70 percent of Gen Z feel isolated, yet those with strong religious or spiritual ties report significantly higher levels of belonging and purpose. Campus ministries, Hillel chapters, Chabad Centers, Newman Centers, Muslim Student Associations, and Latter-day Saint Institute's of Religion provide more than worship services – they offer mentoring, mental health referrals, service opportunities, and community support. Public and private universities should protect and promote these groups as vital contributors to student well-being.

- ***Include spiritual questions in health surveys and patient intake forms.***

Just as health professionals inquire about diet, exercise, and family history, they should also ask about the spiritual background and religious affiliation

that are empirically linked to coping strategies, health outcomes, and treatment preferences. The Joint Commission already recommends spiritual assessments as part of holistic care, and leading medical institutions like the Cleveland Clinic and Mount Sinai have integrated chaplaincy and spiritual support into patient services. Yet such practices remain uneven and underutilized. Institutionalizing these questions – respectfully and without coercion – allows clinicians to better understand the patient as a whole person, not merely a body in need of treatment.

- ***Encourage interfaith collaborations around health education, food access, and youth development.***

Religious pluralism is not a barrier to cooperation – it is a wellspring of civic innovation. In cities across the U.S., interfaith coalitions are already tackling pressing health challenges. Organizations like Interfaith America bring together diverse communities to fight hunger, provide mental health training, and lead vaccination outreach. These collaborations model civic trust and respect, while often reaching populations that are culturally or linguistically isolated from mainstream services. Public health agencies should partner with and fund these efforts as part of their broader strategy to build community resilience.

- ***Protect religious liberty while expecting accountability and transparency in faith-based service provision.***

Finally, any serious integration of religion into civic life must be grounded in constitutional protections and public accountability. Religious liberty ensures that faith communities can operate according to their beliefs; public funding, however, rightly comes with expectations of fairness, non-discrimination, and program transparency. Fortunately, these goals are not in conflict. Numerous successful partnerships – such as the President Obama's Faith-Based and Neighborhood Partnerships Initiative or the SAMHSA Faith-Based and Community Initiatives Office – have demonstrated that religious groups can deliver public goods without compromising either conscience or compliance.

In sum, rather than marginalizing religion in civic planning, policymakers should pursue a twofold approach: (1) empower faith communities to serve, and (2) equip public systems to collaborate intelligently and ethically. In doing so, we move toward a model of public health and civic engagement that honors both pluralism and partnership – recognizing that the spiritual and the social are not separate spheres, but deeply interconnected dimensions of human flourishing.

Conclusion: A New Health Covenant

In our fractured and anxious age, Americans are searching not only for better health but for flourishing – a life marked by meaning, connection, and purpose. As Arthur Brooks has observed and declared, happiness is not about getting what you want, but about wanting what you have – and knowing why you want it. True well-being is not simply a matter of physical metrics or medical interventions. It is about cultivating a sense of belonging and gratitude, of living in harmony with others, and of seeing one's life as part of a greater story. Faith communities excel at fostering this holistic form of flourishing.

Public institutions alone cannot meet these deeper human needs. Governments can build hospitals and fund mental health programs. They cannot provide the moral narratives, rituals of belonging, and transcendent visions of the good life that faith traditions offer. *Religious communities – synagogues, churches, mosques, temples – remain among the few enduring places where body, mind, and spirit are integrated into a coherent path of care and purpose.*

As Rabbi Jonathan Sacks wrote in *The Great Partnership*, "Science takes things apart to see how they work. Religion puts things together to see what they mean." In a society increasingly defined by technological acceleration and the fragmentation of digital life, this "putting together" is urgently needed. Artificial intelligence, for all its power, cannot provide wisdom, virtue, or love. Algorithms may optimize healthcare systems, predict disease, and even offer therapeutic chat-bots, but they cannot teach us why life is worth living or how to be a good neighbor. As AI becomes more prominent in medicine and public health, the role of religious communities as custodians of meaning and moral orientation will only grow more vital.

Religion is not a relic. It is a living source of resilience, relationship, and responsibility. By healing the body, mind, and spirit together, religious institutions offer a vision of health far deeper than any prescription pad – or algorithm – can write. *Flourishing is built not just on success or material security but on faith, family, friendship, and meaningful work. Faith traditions offer all of these in abundance, creating the scaffolding of a truly good life.*

The question is not whether faith should be part of public health – it is already there, acting quietly and effectively. The real question is whether we, as a society, will rediscover what our ancestors knew instinctively: A healthy society requires not just medicine or money, but meaning. A renewed partnership between faith communities and public health systems will not merely treat illness, but cultivate human thriving. It will remind us that to be healthy is not only to survive, but to live with hope, purpose, and joy.

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