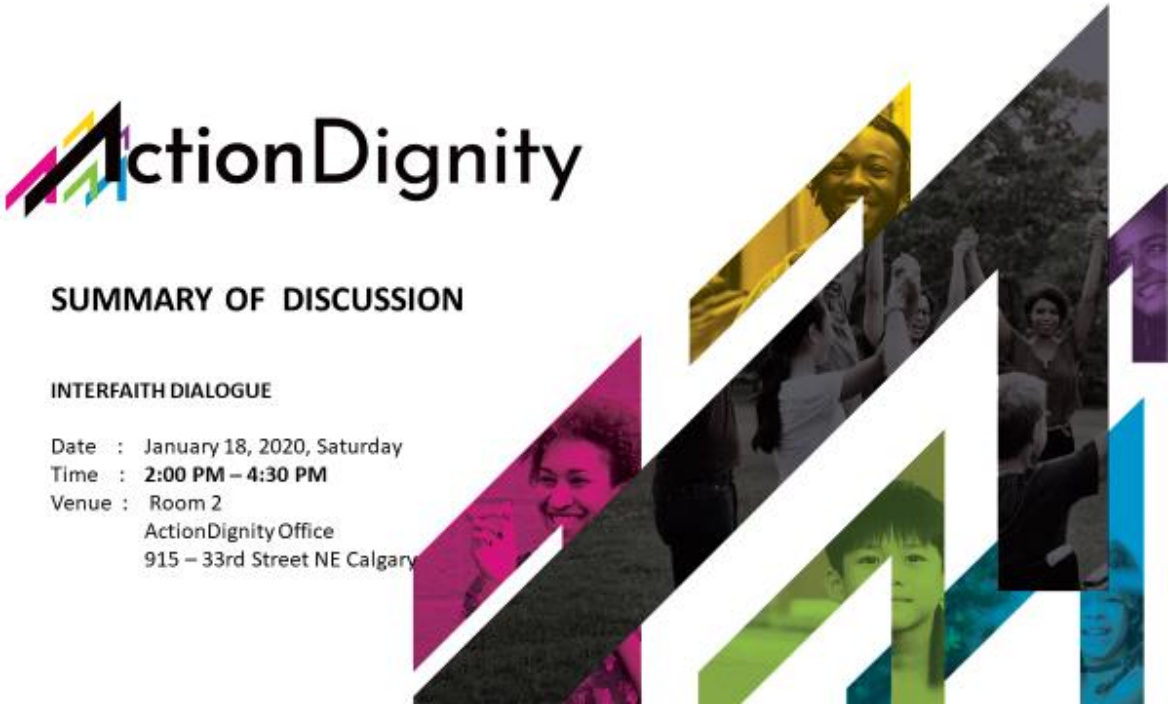

INTERFAITH DIALOGUE

MENTAL WELLNESS AND HEALTHY RELATIONSHIP

INITIATIVES FOR DIVERSITY, INCLUSION & EQUITY (INDIE) FOR ALBERTA NON-PROFITS

Prepared by:

Meriam A. Bravante, Research and Policy Educator

Rubirose R. Ong, INDIE Program Coordinator

INDIE Community Brokers:

Widad Eltahir

Shiraz Boja

Linda Kee

A. Background

The INDIE Interfaith Dialogue came about as a result and as one of the action points of the Focus Groups Discussion on Barriers and Solutions to Access Mental Health Services by Racialized Communities held in early 2019. The communities identified faith leaders as key members of the community in addressing issues and problems with (faith) community members.

INDIE, together with the facilitator, Cesar Cala, organized this event where "members of various faith communities, social service agencies and ethno-cultural communities meet to seek potential ways of working together to address the growing problem of mental health and domestic conflict in our communities."

B. The Dialogue Flow

GUIDE QUESTIONS

OUR STRENGTHS:

On what issues related to mental health and conflict do members reach out to you?
What are we currently doing that can be part of the solutions;
What do we have in our community (our work/practice) that can be part of the solutions?

OUR CHALLENGES:

Where do we need support?
What will help our work be more effective?
What can we do more of? What can we do differently? What can we maybe stop doing

SUPPORTING EACH OTHER:

What help / support do we need from each other; from other groups/communities?

WORKING TOGETHER:

From what you have heard so far, in what areas, in what things can we work together?
What steps can we take that we can do to move us forward in these areas?
Who else do we need to invite?
Who is interested to be part of the next steps?

C. Summary discussion on knowing the landscape:

CURRENT ISSUES

(On what issues related to mental health and conflict do members reach out to you?)

- **Crisis situation**. Many members reach out only when there is a break out. How to catch them before crisis happens?
- **Lack of awareness by people suffering.** It is important to watch out for these people: be they family members, community members (church or otherwise). Sensitivity to mental health is important
- **Shame/stigma in admitting** MH and DV. Example, In Catholic church (and monotheism) there is shame in going to confession.
- **Availability and accessibility of resources.**
- **Fear of secularism and racial and religious prejudice/bias.**
- **Youth** was a common concern in the dialogue:
    - Peer pressure and pressure around house. Parents pushing their children in academics; immigrant youth are more pressured to perform academically compared to non-immigrant peers leading to stress and anxiety
    - Parents are more concerned about their jobs, providing material needs for the family but do not have time to attend school meetings thus not unaware what is happening. Parents should be aware of the changes in their children
    - Acculturation plays a major role. Parents don't adapt as fast as their children to the new culture
    - Understanding the symptoms of depression challenging. It is hard to get the men involved in counselling classes.
    - Negative effect of social media to youth (eg. cyber bullying)
    - Seniors, especially those with language barriers becoming isolated. Perceived prejudice leads to depression.

CURRENT INITIATIVES OF THE FAITH COMMUNITIES

(What are we currently doing that can be part of the solutions?)

Many participants agree that preventative approach to MH and DV is key. These are already embedded in many faith groups. For example in Buddhism, it include practices that are explicit on mindfulness, examine deeper practices beyond just meditation (such as kindness, love, charity, empathic joy) to avoid break out situations. We must be on the look out for the warning signs then reach out instead of waiting for it to break out. Individuals joining churches sometimes show that they are desperate and are trying to look for solutions. Many are self aware that is why they come to church to seek help. This is one advantage of engaging faith-based groups in combatting MH issues. One participant pointed out their practice or teaching that is "directed to the mind" or mental health of students. They see a teacher and seek help on mental health issue but with domestic violence, it is different because there is shame. It is challenging when it comes to openness in dealing/seeking help.

Dealing with stigma especially among youth requires some regular programming, according to some participants. They have "recruited" and held a regular discussion with over a hundred youth and even invited police officers to talk about topics such as drug abuse. Providing them a safe place to share and without the presence of adults/elders was seen as an effective method in addressing the issue. Awareness and education on DV and MH and learning how to talk about it (e.g relationship issues) are considered "aha moments" for some experienced participants.

One participant identified the #metoo movement playing a pivotal role in the increase in the reports on domestic violence (CWES). It is all about believing the victim – that they know that they will be believed, not judged. This explains, according to one participant, the spike in 911 calls. Language is so important. "The words we choose to use makes a huge difference in person receiving those words."

Current initiatives of faith-based communities that they found to be working well are:

1) Workshops on mental health;
2) Discussion forum with youth (drug abuse) – youth invite other youth (drug abuse);
3) Open dialogue with and between children and parents;
4) Engage youth with their interests;
5) Social welfare board in different languages (mental health, First Aid); 6) Sikh Community Kitchen (open to all);
6) Safe spaces for youth, with "no adult policy". They have found out that the number of youth participating increased when there was no elder intervention. Youth share with friends but not parents. Youth invite other youth.

RESOURCES PRESENT IN THE COMMUNITY

Participants identified several resources that are present in the community:

- **Family and counselling services** within the faith traditions
- **Service Providers -** The CCIS (Calgary Catholic Immigration Society) not just for Catholics (a number of programs) Catholic Diocese, Elizabeth Society for pregnant teens; St. Vincent Paul providing food hamper, family assessment and MH needs;
- **Gymnasiums (Muslim, Sikh**). "Positive community engagement is very important. So, we built a gym in our church". The approach is on "what gives me happiness": basketball and emphatic joy.
- **Buddhist temple.** It is open for everyone.
- **Visible leaders of society are standing up.** Leaders are seen as lending out weight.
- **Formal and informal resources for mental health.** Network of Catholic services; University chaplains
- **UofC safe space for students**
- **Bell Let's Talk Campaign**
- **Pool of volunteers around this issue.**

WHERE THEY NEED MORE SUPPORT

One participant shared that mental health and DV stigma/shame/taboo is strongly attached to his community. Small group discussion and informal individual approaches can work. Many agreed that a combination of public awareness building and individualized support may be needed to be able to cater to their specific needs.

Cultural appropriateness of services is needed. Muslim clients will not come to non-Muslim counsellor/service provider. When service provider/faith communities have cultural competency, they will not push their agenda on their clients. Some feels that there is a need to break the misconception about the thing that they do. (eg shelters)

while others want more support to be able to share resources across communities. Others are worried about the fear of secularism, religious and racial bias in the community and 'how do we break through that'? How do we build trust and relationship across political spectrum? Socialization across cultural divides maybe lacking.

Lastly, more funding keeps these programs and initiatives stronger and better.

HOW CAN WE WORK TOGETHER? POSSIBLE ACTIONS:

- Share a list of resources for all faith communities
- Mobilize and share volunteers with shared orientation and grounding in faith-based communities for counselling and providing advice
- Recruit and train leaders
- Build public awareness but support should be to the individual (follow-ups are more direct)
- Awareness should include breaking misconceptions esp with regards to faith
- De-stigmatize seeking help (it's okay to seek help)
- We need culturally appropriate support
- Cultural competency for service providers and faith communities
- Share resources across communities
- Faith-based psychiatrists. Shared resource ID (psychiatrist)
- Hold an Interfaith Day of Mental Health and/or Inter-Faith forum on Mental health – inter-church activities (2-3 faith groups working together)
    - Inter-Faith orientation on Mental Health – simultaneous activity across faiths and communities
- Organize Inter-Faith "pride" parade
- Organize Professional and Ecclesiastical Leaders Conference
- Form faith connectors/brokers who can speak various languages
- Cross Visits among faith communities to share and learn. (e.g visit Sikh Community **Kitchen)**

PARTICIPANTS' REFLECTIONS

There is some excitement/curiosity/optimism on where this dialogue will take the issues and how the participants can work together. There were several participants who emphasized that there were a lot of commonalities across faith groups and servicer providers and it is important to use these commonalities as strengths, take it from there and work together.


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January 18, 2020