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"If You Prayed More, You Would Feel Better": The Dual Nature of Religion and Spirituality on Black Youths' Mental Health and Access to Care in Canada

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Abstract

This study explores Black Canadian youth's relationship with religion and the impact religion has on their mental health and wellbeing. In addition, we probed promising practices for religious leaders and service providers who want to improve Black youth's access to care. The results of this article draw from a larger study that aimed to explore the barriers and facilitators to mental healthcare for Black youth in Ontario, Canada. 128 (n = 66 youth, n = 35 service providers, n = 27 family and community members; 91% Black, 24% people of colour, 67% white) participants from six regions across Ontario were engaged in 23 qualitative focus groups held virtually between March 2020 and August 2021. Data were analyzed using thematic analysis. Three themes emerged from the data: The stigma and taboo nature of mental illness, the influence of religion and mental health and suggestions to improve care for Black youth. Mental illness is stigmatized in specific ways in Black communities and intergenerational differences exist in how mental illness is conceptualized. In addition, Black Two-Spirit, lesbian, gay, bisexual, transgender, queer/questioning and other diverse or marginalized sexual orientations and gender identities (2SLGBTQ+) youth face additional difficulties in relation to stigma. Religion and religious affiliation stigmatized mental illness yet, both were considered important for inclusion in traditional mental health supports. To improve access to care for Black youth, there is a need for community-practitioner partnerships, incorporating religion into traditional mental healthcare, and increasing mental health awareness in religious and community spaces. This study is among the first to explore the impact of religion on Black youth's mental health, findings can contribute to increased access to affirming and responsive care for this population.

Keywords Religion · Mental health · Canada · African · Caribbean · Black · Youth

Religiosity, spirituality, and mental health are important aspects of cultural diversity that have increasingly gained the attention of policymakers and care providers as important to psychological practice (Parker et al., 2023). Briefly, religiosity is defined as the belief in a higher power, adherence to the 'tenets of a prescribed system of faith' and participation in devotional practices related to that belief system (Mattis & Mattis, 2011, p. 126). Conversely, spirituality is a more loosely defined belief in the sacredness of life and the pursuit of a life of virtue (Mattis & Mattis, 2011, p. 126).

Religion can provide a basis for a shared understanding of how to relate to one's community and impacts individuals sociologically, politically, socially, and psychologically (Mattis & Mattis, p. 125). Thus, religiosity and spirituality may be particularly important during adolescence (Parker, 2010), an important developmental stage which often

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coincides with the emergence of mental health symptomatology (Malla, 2018) and solidified sexual and gender identity (McCann et al., 2020). As a result, understanding the role of religion and spirituality on mental health and care-seeking among adolescents and emerging adults is crucial.

Canada's Black population is significantly younger than their counterparts, with a median age of 29.6 years compared to 40.7 for the population as a whole (Statistics Canada, 2019). Among Canada's 10.5 million Black residents, nearly 86% identify as religious, varying greatly in religious affiliation. 26% of Black Canadians identified as Christian, followed by Catholic (18.1%), Muslim (11.9%) and Pentecostal (8.0%) (Statistics Canada, 2019). The diversity in religious affiliation reflects the ethnocultural diversity of Black Canadians. Black Canadians come from approximately 125 countries of origin and represent nearly 200 ethnic and cultural groups (Statistics Canada, 2022). Some Black Canadians can trace their history in Canada back to the 1800s, while others have immigrated from the Caribbean and Africa in recent waves of migration (Statistics Canada, 2019).

Across these diasporas, the mental health of Black youth in Canada has increasingly gained the attention of communities that have advocated for increased access to care and mental health supports (Francis, 2021). However, little research has focused on the experiences of Black Canadian youth. Black youth in Canada may have unique experiences that differ from their counterparts in other countries with a high level of immigration, such as the United States (US) and the United Kingdom (UK), because of Canada's emphasis on a "multicultural mosaic" (Ferreira & Ross, 2021); Thus, some youth remain strongly affiliated with their cultural communities and religious organizations, and their accompanying social mores, post-immigration. The diversity among Black Canadian youth warrants specific exploration into their understanding of mental health and the strategies they feel should be employed to improve their experiences seeking mental healthcare.

This article provides an overview of how Black youth, their family and community members and service providers in Canada understand and describe Black youth's experiences with their mental health and wellbeing, explicating how Black youth feel about the impact of religion and spirituality. We conclude by sharing suggestions that mental healthcare providers and religious leaders can use to support youth who wish to see religion and spirituality incorporated into their care.

Black Youth and Access to Mental Healthcare

Evidence is limited; however, existing data suggest that Black Canadian youth have disproportionate rates of mental illness compared to their peers. While 20% of youth experience symptoms of mental distress (Malla, 2018), Black youth are affected disproportionately and have experienced increased distress due to the COVID-19 pandemic (Kids Help Phone, 2020). Black youth face additional factors associated with developing mental illness, including a history of colonization, poorer access to resources (Salami et al., 2019), and systemic anti-Black racism (ABR), defined as prejudice, attitudes, beliefs, stereotyping, and discrimination directed at people of African descent (Black Health Alliance, 2018).

Regardless of their ancestry, all Black youth face difficulty accessing the Canadian mental healthcare system (Fante-Coleman & Jackson-Best, 2020; Francis, 2021). While healthcare in Canada is often considered universal, mental health and addictions services are delivered privately and publicly (Canadian Mental Health Association, 2018) in a complicated and disjointed system (Duncan et al., 2018). Canada's mental healthcare system has been criticized as inadequate and inappropriate (Malla, 2018), and Black youth face difficulties accessing care due to structural challenges such as wait times and poor access to mental health service providers as well as barriers related to finances and geographical distance from services (Fante-Coleman & Jackson-Best, 2020). Unfortunately, Black youth also experience ABR within mental healthcare settings, further complicating access to care (Fante-Coleman & Jackson-Best, 2020). Thus, structural barriers to care for Black youth are amplified by a mental healthcare system ill-equipped to address the effects of ABR coupled with a lack of culturally responsive care (Fante-Coleman & Jackson-Best, 2020; Salami et al., 2019).

Religion, Stigma, and Mental Illness in Black Communities

Religion has been an important facet of cultural life in global Black diasporic communities before chattel slavery (Boyd-Franklin, 2010), and historically, mental health and wellbeing were closely aligned with religion and spirituality (Koenig, 2009). Religious organizations are considered particularly influential in African diasporic communities (Brown & Brown, 2003). The church attends to the various needs of its patrons, forming a pillar of the community that is responsive to its emotional, spiritual, physical, and psychological needs (Smith Hatcher et al., 2017). Similarly, in African and Caribbean immigrant communities, religious

organizations are sources of socialization that provide support in new environments and frame community membership (Rose et al., 2020). For Black Muslim youth, the mosque holds similar importance and often delivers programming responsive to its community's needs (Hassan et al., 2021).

The religious and cultural beliefs of the youth's diasporic communities may impact their conception of mental illness. For example, in some countries on the African continent, mental illness is viewed from a communal lens, in addition to biomedical and social structural explanations. This lens is commonly invoked by the term *Ubuntu*, where individuals' mental health struggles are viewed in relation to their broader relationships with others (Edgerton, 1980; Kpanake, 2018). In Islam, there is an awareness that symptoms of mood disorders and anxiety disorders are a cause for concern that warrants additional support, as noted by the prevalence of 'duas' or prayers that can support oneself during these experiences (Al Qahtani, 2021).

Conversely, mental illness has historically been stigmatized and labelled as taboo in many communities (Garssen et al., 2021), and conceptions of 'madness' and mental illness are often rooted in religious imagery, particularly when discussing hallucinations and psychosis (Arthur et al., 2010). For example, a study exploring the perceived causes of mental illness in Muslim outpatient clients found that nearly 43% attributed their symptoms to *Jinn*, supernatural beings in Islamic folklore (Lim et al., 2018). Care seeking for mental illness was also viewed negatively in African American communities, and therapy was seen as something that was only accessed by those who were "sick" or "crazy" (Boyd-Franklin, 2003). Deeply religious people may view therapeutic help as "unspiritual," (Boyd-Franklin, 2010), an association that may be difficult to combat. Instead, African Americans were more likely to rely on coping mechanisms such as prayer (Breland-Noble et al., 2015).

At the same time, psychological practice in Europe, the US, and Canada in the 19th century began to associate religiosity with hysteria and neurosis, signalling a division between religiosity and therapeutic care that would last for more than a century (Koenig, 2009). As a consequence, belief in spirituality and religion was pathologized and, coupled with previous experiences of racism and discrimination, made African Americans less likely to seek out mainstream mental healthcare (Breland-Noble et al., 2015). Black communities, including Muslims (Rivenbark & Ichou, 2020), remain historically marginalized and excluded from mental healthcare. While there is no causal link between religiosity, stigma, and care seeking, it is possible that the alienation of religious African Americans from formal therapeutic care coincided with increased stigma towards formal care seeking for mental distress. Similar barriers may be a factor for Black Canadian youth.

Religiosity's Impact on the Mental Health and Wellbeing of Black Youth

Evidence about religiosity's impact on the mental health and wellbeing of Black youth is conflicting. Research has shown that religion, spirituality, and religious institutions can be facilitators of mental healthcare and positive mental health (Fante-Coleman & Jackson-Best, 2020; Planey et al., 2019). Religiosity and religious affiliation can provide meaning and purpose (Bullock et al., 2012) and a sense of belonging (McCann et al., 2020). In addition, spirituality and faith are associated with improved mental health outcomes (Rodriguez et al., 2021). Among African American youth, religiosity is linked to lower aggression and risky behaviour (Bullock et al., 2012; Gearing & Lizardi, 2009).

Religion and prayer serve as coping mechanisms for life's stressors, particularly for Black youth who face added challenges due to racism (Taggart et al., 2019). Prayer benefits mental and behavioural health (Breland-Noble et al., 2015) and improves psychosocial adjustment (Cotton et al., 2006). Religious affiliation can bridge access to care for youth who may have difficulty obtaining care otherwise. Religiosity has been associated with seeking treatment for mental health challenges among African American youth in the US (Breland-Noble et al., 2015). African Americans seek assistance and guidance from religious organizations and clergy (Taylor et al., 2000). Moreover, religious organizations (Black churches, mosques etc.) are often used as a source of mental health support for populations with inadequate access to care, and these organizations frequently make referrals to traditional mental health supports, such as social workers (Young et al., 2003), particularly for Black youth (Smith Hatcher et al., 2017).

Conversely, religion presents challenges for Black youth. As youth's identities develop during adolescence (Parker, 2010), their religious community's strong ideals and mores can cause tension and hinder care-seeking (Breland-Noble et al., 2015). In their study, the Breland-Noble et al. (2015) found that African American youth in the US had mixed feelings about how religion and spirituality impacted their mental wellbeing. Indeed, youth felt that religious communities relied on spiritual solutions to mental health challenges, which alienated youth seeking traditional forms of care.

Religious affiliation presents more significant challenges for youth who identify as Two-Spirit, lesbian, gay, bisexual, transgender, queer/questioning and other diverse or marginalized sexual orientations and gender

identities (2SLGBTQ+). A religious climate antagonistic to 2SLGTBQ + people was correlated with excessive alcohol use and other risky behaviour among queer youth (Hatzenbuehler et al., 2012). Historical and cultural understandings of religion can lead to tension with self-expression and negative self-perception (McCann et al., 2020). Youth may feel alienated from religious organizations that do not affirm 2SLGBTQ + identities. Conflict between religion, spirituality, and sexual identity, has made 2SLGBTQ + youth wary of religious organizations, but those effects are mediated when youth belong to religious spaces that affirm same-sex relationships (Gattis et al., 2014). However, a dearth of information remains on the spiritual and religious needs of Black Canadian youth. In addition, further attention to the religious and spiritual needs of Black 2SLGBTQ + youth is required.

Evidence also suggests that religion impacts stigma and care-seeking among Black youth. Stigma and shame are prominent barriers to care that are present both among African American (Planey et al., 2019) and Black Canadian youth (Fante-Coleman & Jackson-Best, 2020) as well as youth from other racial and ethnic backgrounds (Bowers et al., 2013). The stigmatization of mental illness was often communicated to youth through caregivers and other members of their social support networks. Planey et al. (2019) identified that stigma, including the fear of being labelled, negative associations with psychotropic medications, and the social perception of mental illness, prevented African American parents from seeking care for their dependents. As African American youth often first sought help through their family and support networks, the perception of stigmatization led to the prevention, delay or cessation of seeking formal therapeutic services (Planey et al., 2019).

Unfortunately, very little research exists on the experiences of Black Canadian youth that considers their ethnoracial, sexual orientation and gender identities in relation to religion, mental health, and access to services. Religious competence is cultural competence (Whitley, 2012) and considering the role of religion and spirituality has gained attention as necessary to combat the underutilization of mental healthcare services (Turner et al., 2019). Moreover, few studies have explored religiosity and cultural responsiveness in mental healthcare provision to Black populations in Canada. Understanding how Black youth conceptualize religion can provide insight into how to meaningfully work with this population and increase access to care.

Rationale, Aim, and Research Questions

The Pathways to Care (PTC) research project, led by Black Health Alliance, intended to explore the barriers and facilitators to accessing mental healthcare for Black youth in Canada. Upon an initial exploration of the data and multiple discussions between the PTC team and the Youth Action Committee (YAC) members, we were led to explore religion and spirituality as additional dimensions of mental health and wellbeing. Religion is an important aspect of culture for many Black youth in Canada who have varied diasporic experiences. Understanding how youth do or do not incorporate religion and spirituality into their practices is important to ensure that service providers and religious leaders know opportunities for incorporating religion into care. Thus, our research questions are (1) How do Black youth understand, describe, and discuss mental illness? What factors impact Black youth's mental wellbeing in relation to religion from the perspective of family and community members and service providers? (2) How does religion impact Black youth's mental health and wellbeing? And (3) What implications exist for mental health practitioners and religious leaders who wish to provide culturally responsive care that considers religiosity and spirituality for Black Canadian youth?

Method

The PTC project is a five-year community-based participatory research (CBPR) project that aims to understand the access needs of Black youth in the mental healthcare system. A partnership between five community-based organizations, the project was heavily rooted in CBPR (Flicker et al., 2007). As a CBPR project, we worked with numerous community stakeholders and committees to drive the overall research project. The PTC project is foremost community driven, action-oriented and exploratory, thus a generic qualitative approach not bound by specific theoretical assumptions was followed (Kahlke, 2014). Nevertheless, our work is partly informed by the social constructionist tradition (Charmaz, 2008) to inform how we view how religion and culture shapes the experiences of mental illness for Black youth. In particular, how youth's experiences of religion and culture are shaped under 'particular conditions' such as familial histories of racism and colonization (Charmaz, 2008, p. 402).

The PTC study was conducted via focus groups to elicit information about participants' attitudes towards mental health and illness and perceptions around access to care in the mental healthcare system in Ontario. Focus groups were ideal for this study because they foster communal

meaning-making among participants, allowing findings to be affirmed by others (Carey & Smith, 1994). The study took place in six regions in southern Ontario: Ottawa, Toronto and the Greater Toronto Area (GTA), Hamilton, Waterloo and Kitchener, London, and Windsor.

Twenty-three focus groups took place between May 2020 and August 2021. Except for Toronto and Windsor, three focus groups with Black youth, family and community, and service providers were facilitated in each region. In Toronto, additional focus groups were done with service providers, 2SLGBTQ + Black youth, Black youth with experiences in the justice system, and PTC's YAC. In Windsor, an additional focus group with Black Francophone youth took place. Specific focus groups were conducted with the additional youth communities so that further research could be undertaken with historically marginalized communities. Although attention was placed on specific demographics within these additional focus groups, these same demographics of youth were also found amongst the larger participant sample. For example, one closed focus group was offered for Black 2SLGBTQ + youth. However, Black 2SLGBTQ + youth appear as participants in other non-closed focus groups as well.

Social Location of Authors

As the authors of this manuscript, we are a collaboration of Black contributors who all have an expressed interest in the mental health and wellbeing of Black youth in Canada. Some of us (TFC, MB, AC, and FJB) are staff members of the PTC project, while KA is a member of PTC's YAC. As a CBPR project, writing this article as a collective was an intentional choice to ensure the voices of youth were heard and amplified throughout the PTC project.

We all identify as Black and, more specifically, are members of the Afro-Caribbean and African American diaspora in Ontario. Members of our collaboration also identify as 2SLGBTQ+. We come from various experiential backgrounds, including academia, direct service provision to Black youth, and being young people ourselves. Our religious and spiritual identities vary, including Christianity, Islam, and Atheism. We also range from identifying ourselves as devout and practicing to secular and non-practicing. During the analysis and writing phases of this article, the research team met bi-weekly to engage in reflexive discussions that explored our experiences, biases and assumptions related to religion and mental health to locate our research work within the same "world" and "framework" that we would be theorizing (Eakin, Robertson, Poland, Coburn & Edwards, 1996, p. 158).

The research team discussed personal and familial experiences with religion and mental health, our judgments of religion's usefulness to mental healthcare and experiences of how religion intersected with culture and their experiences of racism. Given our diverse backgrounds, how these realities were shaped and influenced by our levels of religiosity, our opinions of religion, and our notions of youth mental health experiences were also considered. Moreover, we carefully appraised how our experiences and motivations informed the results of this article, ensuring the results remained focused on participants' perspectives (Finlay, 2002) and provided a critical analysis.

Participants

The PTC team conducted 23 focus groups involving 128 focus group participants. Thirty-seven (37) participants were from Toronto and the Greater Toronto area, 17 participants from Ottawa, 20 participants from Hamilton, 11 participants from London, 21 participants from Kitchener-Waterloo, and 22 from Windsor. We spoke to 66 youth, 35 service providers, and 27 family and community members. See Table 1 for further details and focus group signifiers.

Participants ranged in age from 14 to 67 years old, most of whom (n = 85, 65.4%) self-identified as female. 22.3% (n = 22.7%) identified as male, 0.78% (n = 1) identified as gender-fluid, 12 (n = 9.2%) participants did not respond, and 0% of participants identified as non-binary. Participants were able to choose multiple identities and one participant (0.78%) identified as male and third-gender, and as female and trans, respectively. For more information, see Table 2. The majority of respondents (n = 85, 66.4%) identified as heterosexual, one (0.8%) respondent identified as asexual, nine (6.8%) as bisexual, six (4.5%) as gay, two (1.6%) as lesbian, one (0.8%) as pansexual, six (4.5%) as queer, 4 (3.0%) as questioning. 18 (13.6%) of respondents did not respond. For more information see Table 3.

Youth participants (n = 66) ranged in age from 14 to 31 (M = 23.22, SD = 4.74), family and community (n = 27) 21–67 (M = 39.39, SD = 13.10), and service providers (n = 35) were between 27 and 54 (M = 37.36, SD = 7.9). Most participants identified as Black (n = 95, 91.3%), while 24% (n = 25) were people of colour, and 6.7% (n = 7) identified as white (see Table 4). Regarding religious identity, 52% of participants identified with Christianity, 20% with Islam, 11% with a Personal Belief System, 3% as Atheist, and 11% with Agnosticism. For questions about gender identities, sexual orientation, religious identity, race, and ethnicity, participants were able to provide multiple responses.

Recruitment

PTC staff members recruited participants using convenience sampling and local liaisons with solid connections

Table 1 Focus Groups by Region

Focus Group Number	Focus Group Type [Signifier]	Location	Date	Participants	Regional Total
1	Service Providers [SP1]	Toronto	May 28th, 2020	4	37
2	Service Providers [SP2]	Toronto	June 23rd, 2020	3	
3	Family and Community [FC3]	Toronto	July 16th, 2020	5	
4	Black Youth [BY4]	Toronto	July 28th, 2020	7	
5	Black Youth (2SLG-BTQ+) [2SLGBT+BY5]	Toronto	July 30th, 2020	6	
6	Black Youth (PTC Youth Action Committee) [YC6]	Toronto	August 26th, 2020	6	
7	Black Youth (Youth in the Justice System) [YJ7]	Toronto	December 8th, 2020	6	
8	Family and Community [FC8]	Ottawa	December 10th, 2020	4	17
9	Service Providers [SP9]	Ottawa	December 15th, 2020	9	
10	Black Youth [BY10]	Ottawa	December 17th, 2020	4	
11	Black Youth [BY11]	Hamilton	March 16th, 2021	7	20
12	Service Providers [SP12]	Hamilton	March 25th, 2021	8	
13	Family and Community [FC13]	Hamilton	March 29th, 2021	5	
14	Black Youth [BY14]	KW	April 6th, 2021	12	21
15	Service Providers [SP15]	KW	April 12th, 2021	3	
16	Family and Community [FC16]	KW	April 22nd, 2021	6	
17	Black Youth [BY17]	London	June 3rd, 2021	5	11
18	Service Providers [SP18]	London	June 10th, 2021	4	
19	Family and Community [FC19]	London	June 22nd, 2021	2	
20	Black Youth [BY20]	Windsor	June 29th, 2021	5	22
21	Service Providers [SP21]	Windsor	June 30th, 2021	4	
22	Family and Community [SP22]	Windsor	July 6th, 2021	5	
23	Black Youth (FR) [BY23]	Windsor	August 26th, 2021	8	

Table 2 Gender of Participants

	Service Providers (n = 35)	Family and Community (n = 27)	Black Youth (n = 66)	Total (*N* = 128)		
Gender Identity	n	n	n	*N*	**Percent (%)**	**Percent of Cases (%)**
Girl/Woman	28	18	39	85	**65.4**	**66.4**
Boy/Man	3	4	22	29	**22.3**	**22.7**
Transgender	0	1	1	2	**1.5**	**1.6**
Gender Fluid	0	0	1	1	**0.8**	**0.8**
Third Gender	0	0	1	1	**0.8**	**0.8**
No Response	4	4	4	12	**9.2**	**9.4**
Total	**35**	**27**	**68**	**130**	**100.0**	**101.6**

to their respective communities. Participants who were not recruited through community liaisons were contacted via e-mail through connections with mental health organizations and through social media. Except for PTC's YAC members, researchers did not have a prior relationship with participants.

All participants received a phone call from PTC's Researcher (TFC) prior to the focus groups to ensure they met the inclusion criteria and understood the purpose of the focus groups. As well, the research team provided potential participants information about the length of the sessions, the subject matter, participants' right to free and informed consent, and strategies for ensuring their anonymity via Zoom. Researchers provided potential participants with the demographic survey and informed consent form via email. Each participant was provided an honorarium of 40 CAD for their

Table 3 Sexual Orientation of Participants

	Service Providers (n = 35)	Family and Community (n = 27)	Black Youth (n = 66)	Total (*N* = 128)		
Sexual Orientation	n	n	n	*N*	Percent (%)	Percent of Cases (%)
Asexual	0	1	0	1	0.8	0.8
Bisexual	2	0	7	9	6.8	7.0
Gay	1	0	5	6	4.5	4.7
Lesbian	0	0	2	2	1.5	1.6
Pansexual	0	0	1	1	0.8	0.8
Queer	1	2	3	6	4.5	4.7
Questioning	0	2	2	4	3.0	3.1
Straight	26	18	41	85	64.4	66.4
No Response	5	5	8	18	13.6	14.1
Total	35	38	69	132	100.0	103.1

Table 4 Race of Participants

Race of Participants	*N*	Percent (%)
Person of Colour	25	24.00
Black	95	91.30
White	7	6.70
Not Sure	1	1.00
Total	128	123.10

time and knowledge. Participants received the entire honorarium if they attended any part of the session. As the aim of the project was to determine access needs in six regions across the province with perspectives from Black youth, service providers and family and community members, focus groups took place when enough participants had been recruited to ensure multiple perspectives.

Focus groups were conducted with Black youth, service providers, and family and community members, respectively. Except for Black youth, service providers and family and community members did not have to self-identify as Black. However, they did need to live or work in the region of interest and have a specific focus on the mental healthcare access needs of Black youth. Youth participants needed to live in an area of interest, self-identify as Black and self-identify as youth.

When determining eligibility for participation in the youth focus groups, participants were able to self-identify as youth in consideration of r the diverse determinants that can impact a person's life stages, including intersectional identities and varying access to resources. This method allows a participant to identify, based on lived experience, whether they were youth or not. Lei and South (2016) write that as Black youth age, they are more likely than white youth to stay in their childhood home and are more likely to return home sooner if they do move out. Living independently is generally viewed as a significant step in the transition from youth to adulthood which may help to explain why Black people self-identify as 'youth' into their late twenties and early thirties. Ethical approval was obtained from the Community Research Ethics Office (Project #154).

Data Collection and Analysis

Focus groups were facilitated by PTC's Researcher, except for the Francophone Black youth focus group in Windsor, which PTC's Bilingual Health Promoter facilitated. Sessions took place over Zoom, which allowed participants to use a pseudonym and keep their camera off to support confidentiality and anonymity. Focus groups lasted between 65 and 123 min, with an average of 106 min, and had between two and 12 participants. Questions were semi-structured and created in partnership with the YAC to ensure their interests were explored. Focus group questions probed community perceptions of mental health and illness, accessing mental healthcare, and potential improvements to Ontario's mental healthcare system. Although focus group questions focused primarily on access to care, participants discussed cultural perspectives on mental health, including religion. Focus groups questions for the Black youth focus groups can be found in Appendix A.

The PTC Researcher and consultants transcribed interviews with the assistance of Otter.ai, a transcription software. PTC's Researcher also analyzed data using thematic analysis in Nvivo (QSR International, 2020), where findings were organized into codes and themes and refined until they formed a cohesive 'story' (Braun & Clarke, 2006).

Findings were corroborated through member-checking done with every focus group participant. Member-checking was conducted via email which allowed participants to share their feedback in a manner that allowed the researcher to keep track of what was being shared and what gaps, if any, arose. Summaries that highlighted the findings from their specific focus group and the overall project were provided to participants with requests for feedback to ensure the findings reflected their experiences.

During manuscript preparation the authors revisited the existing codes with the research questions in mind and discussed how the themes should be organized. In keeping with a generic qualitative approach, no specific theoretical application was used. Instead, the authors used an inductive approach to provide a rich description of how participants interpreted and constructed their experiences (Kahlke, 2014). Codes and themes were re-examined and the research team reflexively and critically contemplated each quotation in relation to the subject matter, researcher perspectives and usefulness to the community. Though analysis used a generic approach, the authors also considered familial power dynamics, Black communities' experiences of racism and colonialism and the intersecting experience of multiple identities as those were priorities for the PTC project.

Results

The purpose of this study was to provide insight into diverse Black Canadian youths' relationship with religion, mental health and care-seeking from the perspectives of Black youth, family and community members and service providers. An additional aim was to identify implications for mental health practitioners and religious leaders who wish to increase access to culturally responsive care for Black Canadian youth. The following quote encapsulated many of the findings:

> "…About religion? And, I agree completely, because it can be so horrible… Sometimes when people don't have the money or access to mental health, we try to use religion as the proxy but I also think that religious leaders can be a great resource in normalizing and talking to people about mental health– if they wo*uld stop talking about praying to solve it– to say this is a real thing."* (FC8, Ottawa, Amelia)

Three themes emerged from the focus groups: stigma of mental illness, how religion influences Black youth's mental health, and implications for practice for service providers and religious leaders. Further, these discussions involved cultural (mis)understandings of mental illness as taboo, madness, a curse, and a heavily stigmatized condition. Additionally, delineated are the challenges 2SLGBTQ + Black youth experience when reconciling their faiths with their mental wellbeing. Participants discussed some of the positive impacts of religion, namely its role in caring for one's mental health and how it serves as a social and cultural pillar in many Black communities. Participants expressed concern when explaining how barriers rendered mental healthcare inaccessible, making some individuals rely on religion as a proxy instead of a complement to optimal mental health. The findings highlight potential strategies religious leaders and mental health practitioners can employ to bridge the gap between religion, spirituality, and mental healthcare. The subsequent sections outline these three themes in more detail.

The Stigma and Taboo Nature of Mental Illness

Mental health and illness stigmatization manifest in unique ways within the Black community. Stigmatization of mental illness and the notion that it occurs due to personal failings are intertwined with Black culture, resulting in a reluctance to discuss mental health and mental illness for fear of being negatively labelled and ostracized. Individuals were labelled and felt defined by their illness or symptoms. One participant reflected:

> "Mental health I think has its stigma with Black people. It doesn't matter how old you are, I think people don't want to talk about mental health. They think mental health, they think 'oh you think that I'm crazy or bipolar or I'm schizophrenic'…I think mental health is a BIG issue with Black people." (YJ7, Toronto, Ramona)

Ramona's quote highlights that the perceived severity of different mental illnesses impacted the level of stigmatization, where bipolar disorder or schizophrenia were more negatively viewed, however, it resulted in the stigmatization of all mental illnesses. Ultimately, the way Black communities, including youth, discuss or avoid discussing mental health and illness served as a barrier to accessing timely and culturally safe healthcare and social support.

Intergenerational Conceptions of Mental Illness

Participants articulated similarities and differences regarding the way participants and other older family members conceptualized mental illness. In many ways, Black youth had similar beliefs to older family members, which youth attributed to how understanding of mental illness was passed down and socialized between generations. Lack of faith, insufficient prayer, and believing one was cursed, or 'mad' were cited as reasons for mental illness. Participants recognized conceptualizing mental illness in this way could lead to a failure to notice and appropriately treat mental illness. For instance, one participant explained:

> "I think when it comes to religious communities and this goes back to our parents' generation, I know a lot

> of people around my age group that think the same way. So…basically I was saying my parents had their issues, but I know a lot of people my age as well that are also religious in general who kind of like, blame mental health on a lack of faith and they say if you prayed more, you would feel better." (BY11, Hamilton, Safa)

At the same time, intergenerational differences in conceptualizing mental health were apparent in the phrases used to describe mental illness and how discussions of mental illness were received by older family members. Black youth noted when they showed symptoms or discussed their mental health challenges, their symptoms would be minimized, and they were accused of having 'gone mad' or being cursed. One respondent said:

> "I think that's the problem like we may be going through it ourselves and not even know that we are going through it, just because of the biases. …You know generational stuff where they blame mental illness on somebody's 'mad', because they are cursed or whatever." (FC3, Toronto, Sherry)

Though the reasons given for mental illness were similar between generations, it appears that the conversation about mental illness was different. The experience of having existent mental health concerns ignored and demonized creates a space where mental health conditions are stigmatized, and any further expression of mental health issues may be silenced.

Black 2SLGBTQ + Youth and Religion

Further to the discussions surrounding the cultural (mis) understandings of Black youth and their experiences with mental healthcare, Black 2SLGBTQ + youth experience an added layer of difficulty when navigating mental health services. Youth experience stigmatization due to intergenerational misunderstandings and the lack of acceptance of their sexual orientation and gender identities. Two things arise from this experience; in one instance, Black youth are having their mental health concerns dismissed and attributed to the complexities of their sexual orientation and gender identities. Black youth's mental health concerns go unaddressed because the stigma surrounding their intersectional identities is targeted. Youth are told once they "handle" their diverse gender and sexual identities, they will be relieved of their mental health concerns. In the other instance, Black youth are misdiagnosed with mental illness solely due to their sexual orientation and gender identities. Black neurotypical youth may be labelled as mentally ill because they disclosed being 2SLGBTQ+. Explaining how mental illness can be attributed to one's identity, a participant stated:

> "Like people have these associations, like it's the demons, it's the devil, it's this, it's that. And when people automatically hear that you are queer within the Black community, they automatically associate that with mental illness." (2SLGBT+BY52S, Toronto, Shawn)

The direct link between the intergenerational misunderstandings of mental health among Black communities and their taboo nature directly affects Black 2SLGTBQ + youth regardless of whether they are experiencing mental health challenges.

The Influence of Religion on Mental Health

Religion and faith are cultural cornerstones for many African, Caribbean, and Black (ACB) communities; organized religion commonly serves as a point of social connection, and a means to foster resilience in the face of challenges. Moreover, organized religion and personal spirituality and practice can enhance mental health outcomes by helping youth cope with stressful situations and facilitating the formation of strong community-based social networks. When mental healthcare is inaccessible due to financial constraints, accessibility issues, or religious discrimination, religion can also instill hope and act as a proxy for culturally safe care.

At the same time, culture and organized religion stigmatized mental illness. For participants, religion's ability to catalyze social connections and support individuals through difficult times was contrasted with the entrenched cultural norms of religions, which stigmatized mental illness and discouraged professional treatment in favour of faith-focused activities. When they discussed the harmful effects of using religion as a proxy for care. Participants described the way that religion was used to discourage seeking care:

> …So I grew up Christian, and some of my family members when they would hear that I'm like going to therapy or I'm having…depression or anxiety. They would say like to me, "oh, that doesn't really make much sense. Like, all you have to do is pray or you're not praying enough or you're not having faith in God," or "God has a plan" and stuff like that…It didn't actually help me not have depression or anxiety, like I would pray but it wouldn't fix it right away. (BY17, London, Sasha)

Here, a respondent shared the dysphoric experience of engaging in therapeutic activities to support their mental

health, while at the same time feeling shame for not relying on their religion to attain support. Even when faith may not be effective in increasing mental wellness, the stigma associated with using clinical supports still existed, due to the role that religion played in their lives.

Religion as Important to the Individual

Religion was an integral factor in participants' mental health, but they had diverse views on the importance of religion and mental healthcare. Some participants relied solely on prayer and faith to cope with mental health challenges and during times of hardship, while others perceived both mental healthcare and religion as essential aspects of caring for their mental health every day. On the subject of using religious practices as coping mechanisms, a youth participant stated:

> "I was gonna say that I find that prayer has been actually the most effective thing for me. In handling… those days especially since Covid." (YC6, Toronto, Ashley)

Acknowledging their need for balance between clinical and spiritual supports for their mental health care, another participant continued:

> "I think it's important if that's a part of your lifestyle you should definitely incorporate it and find a way to make it a very healthy part of your day-to-day life and make sure that it is helping you with your mental health but that's not the end all be all solution and it's important to get treatment beyond that…" (BY11, Hamilton, Safa)

Ultimately, the results underscored the personal role that religion, spirituality, and personal practice play in caring for Black youth's mental health. Though consensus was reached regarding the importance of spirituality in maintaining optimal mental health, Black youth recognized that incorporating these elements with clinical mental health treatments was necessary to maximize mental wellness.

Religion as Important to Community

Community and family values are integral aspects of Black identities and numerous religions. For many Black communities, religion fosters and sustains long-term social connection and emotional support amongst diverse individuals, fundamental for ensuring optimal mental health. A participant commented:

> "I think religion does a great job at forming a community – a strong link – people feel supported and where you really feel like you can talk to a lot of different people but I don't know it's kind of hard for me – I'm trying to think – for me at least I met somebody at this church that I went to and she was a leader the community and she did a lot of volunteer work and I did volunteer work with her in high school and she was the first person ever in church that I heard talk about self-love." (BY11, Hamilton, Dante)

Religion's ability to foster a safe space where individuals can speak freely, receive social support, and hold discussions was emphasized. Due to the high degree of reverence and influence religious leaders possess, they are well-positioned to normalize mental illness through their theological approach and integrate messaging highlighting mental health literacy and treatment in places of worship.

Improving Care for Black Youth

Respondents expressed an inclination towards incorporating spirituality into mental healthcare in two ways: strengthening the religious and spiritual lens through which mental health practitioners may be able to work and improving the mental health literacy of faith leaders.

Mental Health Practitioners

Mental health practitioners having a specific faith-based skill set would allow service providers to use spirituality and religion, where appropriate, to provide care to clients who request this allowing them to better support Black youth. Participants commented on encouraging practitioners to have some knowledge of various religions and spiritualities that would allow them to better connect with youth upon request. In particular, service providers noted that religion and spirituality were important to clients and that they had to be able to navigate that. When explaining the value in understanding the diversity in spiritual beliefs, one participant expressed:

> "Mental health is definitely something that everyone has, because it's your mind and how it's moving and thinking and working…Whereas spiritual health, I think you have to have some spiritual connection with someone, somebody, some God… Even if they don't say, you know, I'm a Christian, or I'm a Muslim, or, you know, whatever that is, they still, you know, may say, thanks to the higher up. So, in terms of that, I think that they collide best when you understand that, just because you're having a mental health issue, doesn't mean that whoever that spiritual person is that you worship has been taken away or has forgotten about

you, is what I always have to remind people." (SP15, Kitchener-Waterloo, Miranda)

Another participant stressed the legitimacy of clinical and non-clinical care options:

"I think if we are looking at holistic approaches…It's talking about recognizing that faith is very central to a lot of people, ingrained within their culture… There's informal and formal therapeutic approaches [and] that is a very great informal therapeutic approach. As a clinician you should be able to recognize it as helpful, beneficial and just as good as something else that you're recommending." (SP2, Toronto, Aisha)

However, participants were also aware that incorporating religion into care was an individual decision:

"I think just keeping in mind that religion to everybody is something different, even if they're practicing under the same umbrella, the way they practice, personally, and what their own personal journey is, it differs from everybody…Obviously, it differs from people who aren't religious. So, I always feel like it's an individual decision." (FC13, Hamilton, Anita)

In this same regard, letting Black youth guide the conversation surrounding the incorporation of their faith into their mental healthcare builds Black youths' capacity to take control of their mental health supports. This creates a space for individualized care, which could mitigate the possibility of negative experiences for the client and increase the likelihood of a client returning for longer-term care. A service provider commented on the need for client initiative when broaching the topic of religion:

"So the first thing I'll say is, let them take the lead, let them take the lead, let them open up that chapter. You know, not forcing it on clients, you know, I mean, they, they have the right, you know, right to, to decide what they want. So, the first thing I'll say is, you know, allow them to take the lead, and explore with them, don't assume, let them say what it is to them. Because there are some people who have had a negative experience with spirituality." (SP15, Kitchener-Waterloo, Nina)

Creating space for trauma-informed individualized care allows Black youth to not only reach out for clinical mental health support that is affirming of their faith, but community-centric care that is equally affirming of their mental health concerns.

Religious Leaders

Participants discussed viewing religious and spiritual figures as prominent leaders in their communities. They are influential and trusted members of their communities, often taking on supportive roles. An opportunity was highlighted for faith leaders to directly engage with their communities to reduce the experience of stigma among Black communities through discussions of mental health and illness. One participant suggested:

"If anything truly needs to happen, that conversation needs to happen in the church realistically speaking, or the mosque. 'Cause I feel like that's where a lot of people's ideas and values come from. So, I feel if you had a pastor or whoever, leading the church or whatever, say that it's okay to be a person of God and still be dealing with mental health issues and it doesn't make you any less a person, I think that would be a really good start." (2SLGBT+BY5, Toronto, Shawn).

A more nuanced discussion surrounded the need for additional resources and professional development of religious leaders so they may adequately support Black youth and connect them to available supports. Specifically, participants mention building the capacity of religious leaders and establishing consistent relationships between faith-based leaders and mental health providers. When emphasizing the necessity for increasing mental health education for religious communities, one participant asserted:

"…For that we have to 'edumacate'…yes that's a word today. 'EDUMACATE', the religious communities that we are dealing with illnesses and it must be treated as such or should be treated as such." (FC3, Toronto, Nat).

Building on the need for increased education, another participant focused on religious leaders' skills, and said:

"So empowering the spiritual leaders to be able to know what mental health is and the appropriate way to handle it when somebody confides in them regarding some mental, mental health struggle." (SP15, Kitchener-Waterloo, Nina)

There are many opportunities that religious and spiritual communities can leverage to benefit Black youths' mental health. However, a desire for safety within religious and spiritual spaces and increased education and training for religious leaders was emphasized by participants.

Discussion

This article explored Black Canadian youths' perspectives and understandings of mental health and illness. It also sought to understand the impact of religion on Black youths' mental wellbeing and identify suggestions to increase access to care. Religion and mental health were chosen as a site of inquiry because of their importance in diasporic communities (Smith Hatcher et al., 2017). This study demonstrates stigma's central role in impacting youth's mental health. Moreover, religion can be a direct facilitator or barrier to Black youth's mental wellbeing. Participants suggested supportive strategies to improve Black youths' safe access to mental healthcare.

Stigmatization of Mental Illness in Black Youth

This article's findings underline that mental illness continues to be a source of stigmatization for Black Canadian youth. Like Black youth in other countries, mental illness remains taboo to discuss openly with their family and community. The taboo nature of mental illness was similar for youth of Caribbean and African descent and not dissimilar from the experiences of Black people in the UK (Bard et al., 2021) and Jamaica (Arthur et al., 2010), highlighting a similarity across the diaspora beyond the Canadian context.

In this study, youth discussed how religion was often invoked as an explanation for their mental illness. For example, mental illness was attributed to not engaging enough in prayer or being 'cursed,' which discouraged youth from speaking openly about their mental health challenges. Stigma also varied based on the perceived severity of certain mental illnesses. For instance, though still stigmatized, anxiety and depression were more acceptable than mental illnesses that presented as psychosis (e.g., bipolar disorder, schizophrenia). Those were more likely to be attributed to spiritual causes (Arthur et al., 2010) and associated with violent behaviour. The way mental illness was discussed profoundly impacted youth who felt that these conceptualizations were unhelpful and contributed to their struggles. Youth felt isolated and feared discussing their mental health or asking for help.

Mantovani et al. (2017) found that among African and Caribbean people in the United Kingdom, beliefs about the spiritual causes of mental illness carried implicit notions about the moral failings of the person experiencing mental distress. The associated stigma and feelings of shame delayed care-seeking from formal mental healthcare and made it more likely that individuals solely accessed spiritual supports that may be inadequate to address their needs (Mantovani et al., 2017). Moreover, the beliefs one has about their mental illness affects their health outcomes (Bard et al., 2021). Thus, the discussion of mental health and wellness must work to eliminate negative conceptions about all forms of mental illness.

Stigma may influence the discussions between family members of different generations. Stigma contributes to the lack of discussion about mental illness in Black communities (Hays & Aranda, 2016) in the same way it would impact older adults from other cultural backgrounds (Conner et al., 2010); however, the authors identified that older Black adults in the US were more likely to internalize stigma and less likely to endorse seeking care when compared to older white adults. While there was little data that explored generational differences concerning mental health illness between younger and older Black people, it is possible that older Black people may have a limited (de Toledo Piza Peluso & Sergio Luis, 2004) or different (Bard et al., 2021) understanding of mental health and wellbeing than their younger counterparts or may have had little access to a mental healthcare system in their countries of origin (Arthur et al., 2010).

Moreover, some communities with longer histories within North America have experienced outright exclusion from or discrimination within the mental healthcare system, leading them to be wary of this kind of intervention (Conner et al., 2010). Many participants noted their family members dealt with similar challenges but went untreated and undiagnosed due to stigma and poor access to care. If family or community members are unsure of the symptoms and causes of mental illness or fear stigma, that could cause a delay in Black youth seeking appropriate treatment.

Being 2SLGBTQ+complicated the attribution of the cause of mental illness, as youth's sexual orientation was considered the cause of their mental illness, a similar occurrence to 2SLGBTQ+youth of other backgrounds in the US (McCann et al., 2020). Youth in our study described biases attributed to "folk stories" from older family members, findings consistent with African American youth's experiences (Breland-Noble et al., 2015). Black 2SLGBTQ+Muslim youth also navigate the challenges of homophobia and transphobia in similar ways to Christianity, a shared experience in many monotheistic religions (Chadee et al., 2013).

Religion, Community and Black Youths' Experiences of Mental Illness

Religion had a profound impact on Black youth's mental health and is intertwined with youth's cultural experiences. However, religion's impact on mental health was ambiguous (i.e., it was a facilitator and barrier). When youth professed to their caregivers and other family members, they were experiencing challenges with their mental wellbeing, they would be encouraged to use prayer as a remedy. Youth

expressed frustration at the overreliance on religion and attribution of mental illness to a lack of prayer and adherence to religious practices, similar to African American youth (Breland-Noble et al., 2015).

At the same time, religion and spirituality served as a meaningful way to process and cope with mental illness. Religion is deeply personal, and youth develop their own relationship with religion akin to Fowler's fourth stage of development (Parker, 2010). In the fourth stage, which occurs in adolescence, youth begin to understand their relationship with faith differently from what their community, culture, or religion has told them about faith and spirituality (Parker, 2010). Among our sample, youth had to determine how to leverage faith for their own wellbeing and saw it as something positive while recognizing faith alone may be insufficient to address their mental health needs fully. Youth rejected the idea that mental illness was caused by a lack of faith or by spiritual forces and prayer alone was the solution. Instead, they saw prayer as a tool for better wellbeing. Thus, incorporating religion into care but not relying solely on faith and religiosity is a path to providing adequate care.

Religious organizations are important links to social and emotional support (Campbell & Littleton, 2018), particularly when Black youth face challenges accessing care due to financial, geographical, and discrimination-related barriers (Fante-Coleman & Jackson-Best, 2020). Religious organizations were seen as trustworthy spaces for Black youth to seek support, and clergy were regarded as trusted sources of advice, findings echoing Taylor et al. (2000). The positive impact religion exerts on mental health has been documented among African-American youth (Taylor et al., 2000; Breland-Noble et al., 2015). Moreover, organized religion and personal spiritual practice can enhance mental health outcomes by helping youth cope with stressful situations and forming strong community-based social networks (Samuel, 2015). Service use increased African-American youth who believed that their faith communities were supportive of their accessing mental healthcare (Planey et al., 2019). Given the positive role of religious affiliation among Black youth, it is an important site to consider for intervention. For instance, Black Muslim youth may prefer seeking care in religious spaces (Hassan et al., 2021). To ensure they are equipped to assist youth, religious communities should understand symptoms of all mental illnesses as well as mental health first aid.

Black 2SLGBTQ + Youth and Mental Health

Due to the pervasive societal and internalized stigma faced by Black 2SLGBTQ + youth due to their intersecting identities, mental health issues are common and accessing care remains burdensome. This study's findings delineate the fraught role spirituality, organized religion, and places of worship play in the lives of Black 2SLGBTQ + youth. Participants expressed frustration due to their mental health struggles being erroneously attributed to their gender identities and sexual orientation. Participants felt that love, acceptance, and mental health support from their religious and Black communities was conditional upon 'addressing' their sexual orientation and gender identities. Numerous studies have corroborated the existence of homophobia and transphobia within some Black religious institutions. Richards (2018) cites Levy's academic work on the relationship between religion and homosexuality, noting Black churches actively encouraged congregation members to adopt traditional gender and family roles (Levy, 2014, as cited in Richards et al., 2018, p.124).

Social support and open discussions about mental health are elusive for Black 2SLGBTQ + youth who experience marginalization and social exclusion from most faith-based spaces, society at large, and Black cultural spaces, where open mental health discussions are already scarce (though this is changing, as evidenced by the establishment of Black Mental Health Day in 2020) (TAIBU Community Health Centre, n.d.).

Ultimately, the current study's findings suggest that despite the systemic homophobia and transphobia regularly experienced by Black 2SLGBTQ + youth, religion and spirituality remain fundamental aspects of their lives and an important factor in achieving mental wellness. When mental health service providers engage with 2SLGBTQ + youth, it is vital to acknowledge the cultural diversity in the acceptance of 2SLGBTQ + communities. However, it is also important to note nuances among cultures; multiple Indigenous nations, for example, did not historically stigmatize 'same-gender' relationships, which may be a product of Christianization and Western colonization (Robinson, 2020).

Implications

Research participants shared the challenges they experienced in religious spaces and their hope for improved mental health support from religious organizations and mental health practitioners. In this regard, several implications emerged. Suggestions included improving the capacity of religious leaders to assist with mental health challenges, increasing the religiosity lens of mental health practitioners, and expanding their knowledge of Black youth who may hold multiple marginalized identities.

Mental health awareness among faith-based leaders should be improved. Resources and professional development sessions would create opportunities for further education and increase capacity to better navigate mental health

challenges youth may experience. Catholic leaders have shown promise in this regard as they have focused on community-based mental health education in support of stigma reduction and intervention surrounding misconceptions of the origins of mental illness (Aramouny et al., 2020). Generally, faith-based leaders enjoy a high level of trust within their community and are viewed as frontline mental health providers (Stull et al., 2020). Furthermore, the collaboration between mental health practitioners and religious leaders has been documented as an aid to clients' access to mental healthcare (Burns & Tomita, 2015). These collaborative efforts should be leveraged to increase discussions about mental illness among their congregations to aid in stigma reduction and bridging the gap between religious organizations and evidence-based mental healthcare.

Where warranted, religion and spirituality should be incorporated into mental healthcare practice. The practice of assessing a client's religious background during clinical assessment exists and the benefits of these practices has been documented (Burns & Tomita, 2015). Educating mental health practitioners regarding the diversity of faiths among Black youth should increase their understanding and improve the level and the quality of support they can provide to Black youth who request religiosity be incorporated into their care. Moreover, Drew et al. (2021) suggest that practitioners who aim to incorporate religion into their practice in an affirming and responsive manner should aim to focus on the universality of faith and recognize that all faiths are equal, akin to the sixth stage of FDT.

Resources focused on religious literacy and awareness of referral opportunities would ensure Black youth are connected to the appropriate services if they require additional support. Though many youth had positive sentiments about incorporating religion into care, it is possible that not all Black youth would wish to incorporate religion into their therapeutic practice. Mental health practitioners should be mindful of letting Black youth initiate incorporating religion into their mental healthcare, being careful to avoid any bias or undue influence on youth.

Black youth are not a homogenous group. Religious practice and accessing mental healthcare services are individual experiences, fluctuating from person to person. Moreover, due to the historic harm Black 2SLGBTQ+youth have endured from many religious communities, a concerted effort must be made to centre these groups. Both identity affirming spaces and historically oppressive environments should be transparent in this process (Barnes & Meyer, 2012). Direct accountability, open conversations, safety measures, and further research must be undertaken surrounding the homophobia and transphobia Black 2SLGBTQ+youth have experienced directly from faith-based communities, spaces, and leaders. There is a need for community-based practices and consistent and ongoing research to improve mental healthcare praxis. Promising practices should be drawn from academic literature, input from religious organizations, and youth themselves, and used as a foundation to encourage nuanced discussions about Black youth's experiences navigating mental healthcare systems. Any initiatives that intend to increase the capacity of Black youth are most beneficial when engaged alongside fundamental understandings of the impact of anti-Black racism, the experiences of homophobia and transphobia, and recognition of the social and structural determinants of health.

Limitations

Despite best efforts, this study had limitations. As a qualitative study, the results are not intended to be generalized. However, many cultures and ethnicities are represented under the umbrella term 'Black' that may not have been adequately represented in our sample, including Afro-Latinx and Black Indigenous folks. This article explored the impact of religion on mental health and wellbeing. However, most participants practiced either Islam or Christianity, and there was a lack of meaningful representation of other religions. Thus, results may not apply to all Black youth. Recruitment was a challenge initially, and some participants were eventually recruited with the assistance of community liaisons, youth who were harder to reach or not actively engaged with community liaisons may not have participated. Many other forms of recruitment were used in addition to liaisons to ensure young people from all backgrounds were included in the study.

Some topics could have been further explored in this article. For instance, there was a lack of information about solutions to the unique challenges faced by 2SLGBTQ+youth and a lack of discussion about religion's impact on addiction and substance use, which can be expanded upon significantly. There was also a lack of discussion about how communities can better support Black youths' mental health and wellbeing from a faith-based lens. After family members and friends, communities are next to notice any challenges youth may experience, and the broader community has a significant impact on youths' experience of their mental health and wellbeing (Fante-Coleman & Jackson-Best, 2020).

Lastly, the geographical focus of this article is Ontario, Canada. Though there were six regions focused upon for the overall research project, some regions were not represented by quotations in this article. Further research should explore the experiences of youth from across Canada beyond the six regions that were of interest in this study. To date, most 2SLGBTQ+mental health and addictions research is focused on White populations. Thus, there is a

dearth of Black-specific studies, especially those focusing on Black trans populations. Furthermore, research explicating the relationship between faith, religion, and Black 2SLGBTQ + communities specifically is rare, with much of this research centring on White populations or other racial identities. Increased attention should be paid to the disparities of mental health issues amid common challenges such as gender dysphoria, hormone replacement therapy, surgery, and medical care costs.

Conclusion

Awareness of mental health as an integral aspect of maintaining wellbeing has increased in Canada. However, little attention has been paid to the mental health experiences of Black youth. As is the case for many communities, religion is a cultural facilitator that supports Black youth's mental wellness; however, religion's impact on Black youth's mental health has not been explored extensively. Focus group data from Black youth were analyzed and provided insight into how culture shapes differences in intergenerational understandings of mental health and illness. Moreover, discussions centered on the impact religion has on Black youth's mental health and the heavily stigmatized nature of mental illness partially rooted in cultural misunderstandings. Black youth shared their perspectives on potential strategies religious leaders and mental health professionals can employ to provide culturally safe care. Religious leaders, mental health professionals, and Black communities need to collaborate to strengthen mental health initiatives and advocate for youth-led longitudinal research to explain why religion plays a pivotal role in Black youth's mental health.

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