Pan-Canadian Health Inequalities Reporting Initiative

Inequalities in **mental health, well-being and wellness** in Canada

Executive summary

Public Health Agency of Canada
Agence de la santé publique du Canada

Canada

TO PROMOTE AND PROTECT THE HEALTH OF CANADIANS THROUGH LEADERSHIP, PARTNERSHIP, INNOVATION AND ACTION IN PUBLIC HEALTH.

—Public Health Agency of Canada

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Mental health is a public health priority, and it's also one of the most pronounced health inequities in Canada (1). Declining trends in mental health were further worsened by multiple COVID-19 pandemic lockdowns (2,3). As a result, mental health is a common concern among people in Canada.

In this report, the Pan-Canadian Health Inequalities Reporting Initiative (HIRI) uses a holistic approach to understand and describe mental health inequalities by:

- documenting differences in mental health outcomes
- describing the daily living, working and structural conditions that support or harm mental health
- assessing changes over time and tracking which groups have been most impacted

This evidence can guide policy decisions, program design and actions to advance equity in mental health within and across population groups.

Definitions of mental health have evolved over time, reflecting changing societal values, scientific understandings and cultural contexts. Once defined as the absence of mental illness or disorders, mental health is now understood to include emotional, psychological and social well-being.

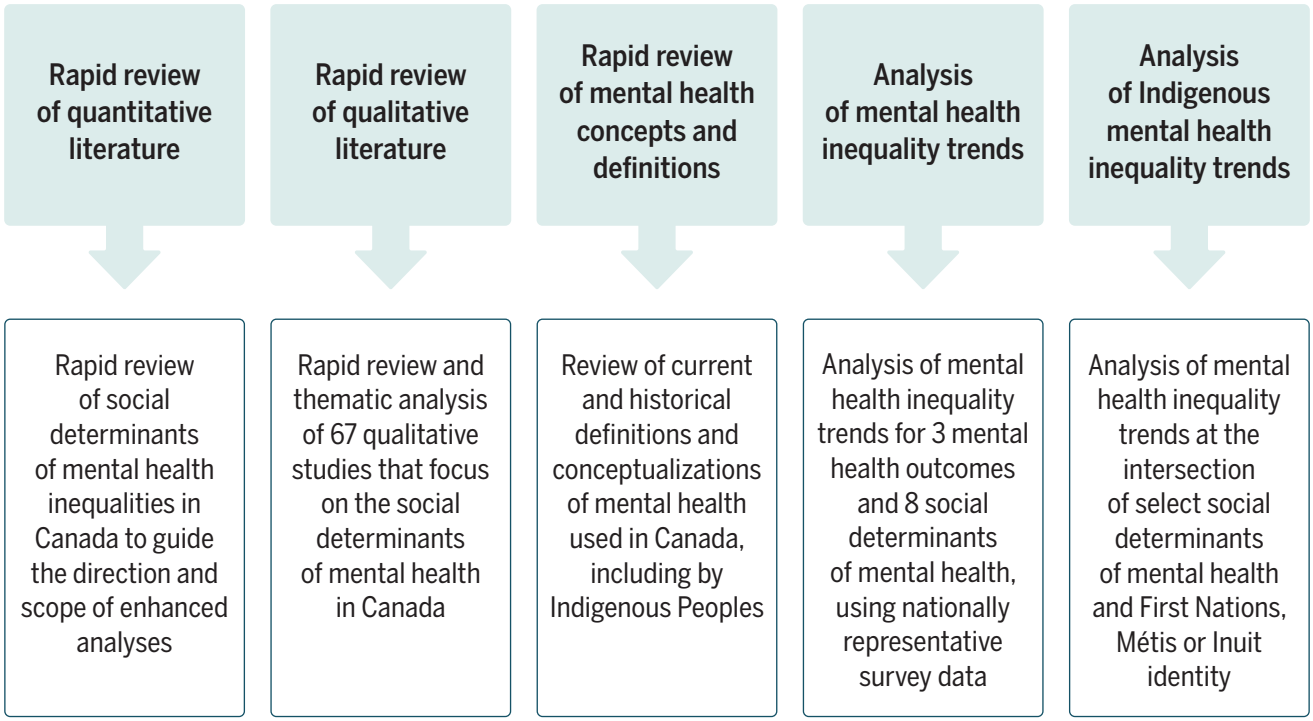
Some groups of people experience significantly worse mental health than others. These same groups are often least able to access quality mental health treatment and support. Such inequalities often reflect broader economic and social differences which are rooted in the unequal distribution of wealth, power and social inclusion (4–8). Identifying mental health inequities, and implementing effective ways to tackle them, requires multi-level, intersectoral efforts that consider:

- the social distribution of mental health
- the populations with the greatest mental health needs
- how current and past systems and structures have resulted in deep-rooted social and health inequality

To understand these complexities, we explore different types of evidence from history, social theory, statistics and people's lived experiences.

We use an intersectional approach to examine the complex nature of mental health inequalities in Canada. Multiple forms of advantage and disadvantage in living conditions and opportunities interact and overlap, producing inequalities in mental health, well-being and wellness. In this report, we include qualitative and quantitative evidence and primary data analyses (Figure 1). This approach considers social and structural factors that contribute to mental health inequalities, and assesses how they have evolved over time.

Figure 1. Types of evidence included in the report



This report includes the unique priorities, worldviews and circumstances of Indigenous Peoples, through ongoing engagement, guidance and input from national Indigenous organizations, including:

- Assembly of First Nations (represented by the First Peoples Wellness Circle)
- Métis National Council
- Inuit Tapiriit Kanatami

Findings

We identify 4 themes (Figure 2) related to the social determinants of mental health, well-being and wellness:

- socioeconomic conditions
- racism, xenophobia, homophobia and other types of discrimination
- social and cultural connection, support networks and community belonging
- access to, quality of, and use of health care services

Figure 2. Approach to combining qualitative and quantitative data

THEME 1
SOCIOECONOMIC CONDITIONS

Various relationships exist between mental health and socioeconomic conditions such as:

- income
- stable and safe housing
- employment status
- working conditions
- education

Trend analyses identified consistent socioeconomic gradients in positive mental health. Between 2007 and 2022, income-related inequalities in life satisfaction and high self-rated mental health narrowed. Meanwhile, the associations between poor mental health and food insecurity, housing insecurity and unemployment persisted or increased.

Mental health is also affected by the cumulative experiences of socioeconomic disadvantage plus discrimination. Discrimination may be based on sex, gender, sexual orientation, race, ethnicity and immigrant status.

Colonialism and ongoing systemic barriers and discrimination have led to a heavier burden of inadequate housing and homelessness among Indigenous people. Similarly, several technical and structural forces have perpetuated racial or ethnic inequalities in occupational mismatch and deskilling. For example, employers may be biased against foreign accents or work experience and accreditation from other countries.

THEME 2

RACISM AND DISCRIMINATION

Members of certain population groups experience more discrimination in Canada. These include people who are Black, racialized, immigrants, 2SLGBTQI+ or Indigenous (9,10). Experiencing racism and discrimination has been consistently linked to depression, anxiety, chronic stress, psychological stress, negative affect, reoccurring negative emotions, and posttraumatic stress, among other outcomes (11,12). Everyday racial discrimination is associated with depressive symptoms among Black people in Canada (13), and anti-Black racism in particular impacts the mental health of youth (14).

Examples of structural determinants of health include racism, sexism, heterosexism, transphobia, xenophobia, religious minority status (e.g., antisemitism or Islamophobia) and colonialism. They all contribute to poor mental health and negatively affect stress levels, perceptions of safety, sense of social connectedness and self-esteem.

Intersecting systems of power and privilege further contribute to unequal material realities and complex social inequalities.

Between 2007 and 2022, inequalities increased between bisexual and heterosexual people with respect to high self-rated mental health and life satisfaction. When looking at the intersection of race and immigration, high self-rated mental health and life satisfaction worsened among all social groups, but disproportionately among some groups, suggesting that inequality has worsened over time.

Intersecting experiences of discrimination, childhood trauma and homophobia affect the mental health of people who are 2SLGBTQI+. Those who are bisexual or transgender may face unique challenges and discrimination, including biphobia and transphobia, even within 2SLGBTQI+ communities. Their access to support networks can be very limited amid increased risks of different forms of violence.

THEME 3

SOCIAL AND CULTURAL CONNECTION, SUPPORT NETWORKS, AND COMMUNITY BELONGING

Sense of community belonging or attachment to, identification with, and acceptance within a person's social environment is a well-established determinant of health. It's strongly associated with mental health (15). People thrive when they feel a sense of attachment, support and identification with the people and places around them. Community belonging can be considered an outcome of positive mental health.

Social and cultural connection, support networks, and community belonging are influenced by racial discrimination, gender inequities and social exclusion. Between 2007 and 2022, gaps in high self-rated mental health and life satisfaction widened between those reporting a strong versus a weak sense of community belonging.

There are 2 populations that face intersecting barriers to acceptance and connection within social environments: recent immigrants, or newcomers, and 2SLGBTQI+ people. Newcomers often found belonging within their ethnocultural communities, but had difficulty fully integrating into larger society because of language barriers, employment issues and discrimination. Newcomers who identified as 2SLGBTQI+ highlighted their social isolation. Social support groups and community organizations were crucial in fostering a sense of community belonging and acceptance. They also helped reduce feelings of loneliness and depression.

Climate change increasingly disrupts daily life for all individuals in Canada, negatively impacting social and cultural connection. This can cause distress, anxiety and grief over loss of land and natural disasters, and exacerbating food insecurity. First Nations, Inuit, and Métis in rural communities are particularly vulnerable. Environmental changes threaten their cultural practices and livelihoods, making it crucial to address climate change as a determinant of mental health.

THEME 4

ACCESS TO, USE OF, AND QUALITY OF HEALTH CARE SERVICES

There are significant challenges with access to and quality of mental health care services across Canada. These challenges are not limited to rural and remote regions. Qualitative research identifies ways that sexism, heterosexism, homophobia, racism and stigma related to mental illness contribute to poor experiences with care. For example, 2SLGBTQI+ people lack affirming care options. Transgender and nonbinary people describe having their gender identity challenged by care providers. Wait times for mental health care, particularly for specialized care, are long, even for individuals at risk of substance use.

Greater unmet need for mental health care was reported by people who:

- identify as female
- are gay, lesbian or bisexual
- are immigrants
- are racialized

The stigma experienced by people who use substances or who have serious mental illnesses hinders their ability to get treatment. Some groups reported specific experiences of stigma, double standards and lack of cultural sensitivity when seeking mental health and substance use treatment and support. These included women, transgender people and Indigenous people.

Discussion and implications

This report describes the influence of structural determinants of health and interlocking systems of power on mental health inequalities in Canada. Its findings support holistic, whole-of-society approaches that can address persisting mental health inequalities. This can be accomplished through intersectoral collaboration and concerted actions of public health and mental health sectors. Partners from the education, employment, housing and social services sectors are key. These sectors play a crucial role in addressing the social and structural determinants that influence mental health outcomes.

We propose 5 main areas for action:

- broadening understandings of mental health, well-being and wellness
- integrating equity as a priority in mental health care
- partnering across sectors
- employing universal policies alongside targeted interventions
- filling data gaps and continuous health equity monitoring

Broadening understandings of mental health, well-being and wellness

To include diverse systems of knowledge, perspectives and relationships, we must emphasize broader and more culturally and socially inclusive understandings of mental health. For example, qualitative evidence has shown that categories used to identify problems, measure outcomes, and develop interventions may not fit newcomers or racialized people. This is because psychological research has predominantly been based on Western, middle class, educated participants (16,17). Public health and health systems must consider diverse factors that affect mental health. These include historical injustices for Indigenous Peoples and stressors associated with immigration. By emphasizing holistic understandings of mental health, policies and interventions can be tailored to specific communities and their unique challenges.

Integrating equity as a priority in mental health care

Prioritizing and integrating equity in mental health care involves bridging the gap between public health and mental health care. We identified 4 categories of functions where public health and mental health care can work together to advance equity in outcomes:

- coordinating care: improving access to mental health care as part of integrated health and mental health care
- expand perspectives by applying a population health approach to clinical practice
- identify and address inequalities in mental health through strengthened health promotion and disease prevention
- collaborate around policy, training and research to address inequities in mental health.

Partnering across sectors

Partnering across sectors to address upstream factors can increase opportunities and positive outcomes for mental health, well-being and wellness. Public health can tackle some mental health inequalities. However, most measures that directly influence the social determinants of health flow from the health system, community organizations, civil society and other government sectors and stakeholders (18).

- Partnerships should be coordinated in a whole-of-society approach. Individual and community engagement can reveal the needs for and barriers to mental health. Meaningful and sustained engagement and collaboration with Indigenous peoples from the very early stages is particularly important. Indigenous partners should determine the priorities and set the agenda. Partners across sectors can work collaboratively in support of those goals.

Our findings highlight the need for interventions to address the cumulative effects of the structural determinants of health that have resulted in persisting inequities. These include determinants such as income, employment, racism, community belonging and access to health care.

The Health in All Policies (HiAP) approach advocates that every government sector and department should systematically apply a holistic view of health to their decision-making processes. Collective Impact is a structured, cross-sector approach that brings together diverse partners to tackle complex issues collaboratively. It could be used by public health and mental health organizations to address mental health inequities.

Employing universal policies and interventions with targeted interventions

Our findings show declines in high self-rated mental health across multiple groups. These declines persist across income levels, employment status, and levels of food insecurity.

Our findings also show a narrowing of mental health inequalities over time. This has been driven by worsening rates in the reference (most advantaged) groups. This is referred to as 'levelling down'.

These findings suggest a need for targeted interventions to support the most disadvantaged groups. They also point to a need for universal mental health interventions to improve mental health outcomes generally. A combination of universal and targeted interventions can help ensure that everyone has the necessary resources to support their mental health.

Filling data gaps and monitoring ongoing health equity

National health surveys must be expanded to:

- gather better and more accurate data on racism, race and ethnicity
- include questions about diagnosed mental health conditions and mental health symptoms
- gather more comprehensive population data on:
  - sociodemographic factors (sexual orientation, gender)
  - social determinants of health (housing insecurity, exposure to climate change)
  - mental health outcomes

Cultural sensitivity would be improved by adding explicit definitions of subjective concepts and providing survey questions in different languages.

There is a need for periodic detailed reporting on the magnitude and trends of health inequalities and their determinants to:

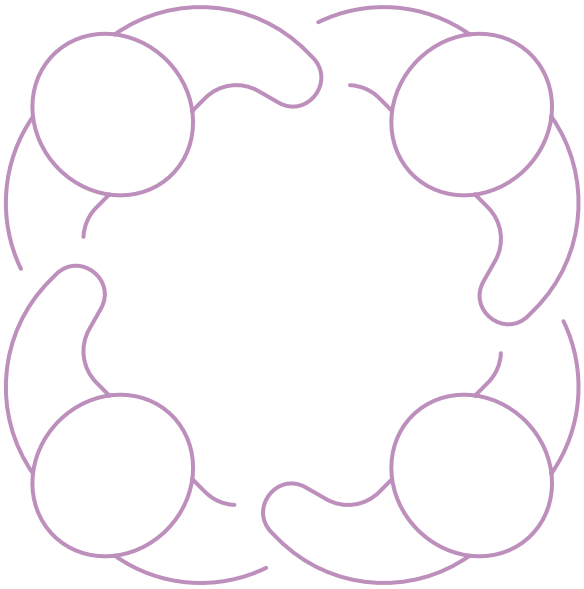
- inform policy and program decision-making to reduce health inequalities
- monitor progress
- facilitate collaborative action across jurisdictions (19)

Conclusion

There is a critical need for an integrated, multifaceted approach to mental health. This approach must be rooted in understanding the broader social determinants and systemic inequalities that shape mental health, well-being and wellness. This report emphasizes a whole-of-society strategy. It calls for collaboration between public health, different government departments, the health systems, the education and housing sectors and community organizations. Policies and frameworks like HiAP and Collective Impact help us address interwoven factors that contribute inequalities in mental health. Ultimately, this approach promises to reduce current inequalities and build a healthier and more resilient society for future generations.

If implemented successfully, these recommendations can lay the groundwork for more equitable, inclusive and responsive approaches to mental health equity.

To effectively tackle the challenges posed by mental health inequalities, it's essential to consider structural determinants, historical contexts and collaboration across sectors.



References

1. Public Health Agency of Canada (PHAC). Key Health Inequalities in Canada: A National Portrait [Internet]. Ottawa, ON; 2018. Available from: **www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf**.

2. Stephenson E. Statistics Canada. 2023 [cited 2023 Oct 11]. Mental disorders and access to mental health care. Available from: **www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00011-eng.pdf**.

3. Guerrero MD, Barnes JD. Profiles of mental health and their association with negative impacts and suicidal ideation during the COVID-19 pandemic: A Canadian perspective. Heal Reports. 2022;33(8).

4. Health Canada. First Nations Mental Wellness Continuum Framework. Ottawa, ON; 2015.

5. Alianait Inuit-specific Mental Wellness Task Group. Alianait Inuit Mental Wellness: Action Plan [Internet]. Inuit Tapiriit Kanatami; 2007. Available from: **http://docplayer.net/18015067-Alianait-inuit-mental-wellness-action-plan-prepared-by-alianait-inuit-specific-mental-wellness-task-group.html**.

6. Métis National Council. Métis Vision for Health [Internet]. 2022. Available from: **www.metisnation.ca/uploads/documents/3-1)Me%CC%81tis%20Vision%20for%20Health-July%2012%20update.pdf**.

7. Government of Canada. The human face of mental health and mental illness in Canada. Minister of Public Works and Government Services Canada Ottawa, Ontario, Canada; 2006.

8. Patel V. The right to mental health. Lancet [Internet]. 2023 Oct 21 [cited 2023 Nov 23];402(10411):1412–3. Available from: **https://linkinghub.elsevier.com/retrieve/pii/S0140673623022419**.

9. Cotter A. Experiences of discrimination among the Black and Indigenous populations in Canada, 2019. Juristat Can Cent Justice Stat. 2022;(85).

10. Nangia P. Discrimination experienced by landed immigrants in Canada. RCIS Working Paper No. 2013/7. 2013.

11. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0138511.

12. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. Vol. 389, The Lancet. 2017.

13. Cénat JM, Kogan C, Noorishad PG, Hajizadeh S, Dalexis RD, Ndengeyingoma A, et al. Prevalence and correlates of depression among Black individuals in Canada: The major role of everyday racial discrimination. Depress Anxiety. 2021;38(9).

14. Salami B, Idi Y, Anyieth Y, Cyuzuzo L, Denga B, Alaazi D, et al. Factors that contribute to the mental health of Black youth. C Can Med Assoc J. 2022;194(41).

15. Michalski CA, Diemert LM, Helliwell JF, Goel V, Rosella LC. Relationship between sense of community belonging and self-rated health across life stages. SSM - Popul Heal. 2020;12.

16. Henrich J, Heine SJ, Norenzayan A. The weirdest people in the world? Behav Brain Sci. 2010;33(2–3):61–83.

17. Kirmayer LJ. Peace, conflict, and reconciliation: Contributions of cultural psychiatry. Vol. 47, Transcultural Psychiatry. Sage Publications Sage UK: London, England; 2010. p. 5–19.

18. World Health Organization, Finland Ministry of Social Affairs. Helsinki Statement Framework for Country Action: Health in All Policies [Internet]. Geneva; 2014. Available from: **https://iris.who.int/handle/10665/112636**.

19. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P. WHO European review of social determinants of health and the health divide. Vol. 380, The Lancet. 2012.