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Access to mental health care in Canada

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ABSTRACT

There has been ongoing national discourse about barriers to mental health care services in Canada. The purpose of the study is to better understand these barriers, with a focus on Canadians of color. To that end, this study surveyed 1501 adults representative of the general population, collected by the Angus Reid Institute. Over half of the respondents had sought out mental health care and experienced barriers to access. People of color (visible minorities and Indigenous people) had more difficulty accessing care, as did younger adults and those with lower incomes. The most common difficulties were largely structural: long waitlists (62%), financial barriers (58%), lack of resources/professionals in the area (47%), difficulty finding specialists (41%), and difficulty accessing in-person care during the pandemic (34%). Many noted negative experiences with mental health professionals (35%). More English-speaking than French-speaking Canadians reported barriers to care overall. Race/ethnicity was related to difficulties when trying to access mental health care, as many could not find someone of the same group (25% of Black respondents), someone who spoke their preferred language (22% of South Asian respondents), or they had prior negative experiences (50% of Indigenous respondents). We discuss the implications of these findings, including the critical need to increase the supply and diversity of mental health providers across Canada. This study is one of the first to provide quantitative data on the perceived barriers faced by Canadians in accessing mental health care while exploring the role of language, race, and ethnicity as variables that may influence access.

KEYWORDS
Mental health care; barriers to care; access; racism

Introduction

Canada by its own admission, has a problem with the access of its citizens to mental health care services. One in five Canadians experience mental illness in any given year, and by the time Canadians reach the age of 40, half will have experienced a diagnosable mental illness (Smetanin et al., 2011). In 2017, from the 5.3 million persons who reported having needed mental

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health services 3 million, about 57%, had their needs fully met, 1.2 million, about 23%, had their needs partially met, and a staggering 1.7 million (32%) people had their needs entirely unmet (Statistics Canada, 2019). Reasons for partially met or unmet mental health needs, have mainly included a lack of knowledge, financial means, and/or time. Furthermore, the lack of access to a general health care provider, in turn, negatively impacted access to mental health care providers (Statistics Canada, 2019). The purpose of this current study is to better understand the barriers Canadians face, with a specific focus on Canadians of color, to access mental health care professionals and services. Professionals and services for mental health care are available through primary, psychiatric, and community-based care as well as outpatient intensive treatment settings (Moroz et al., 2020).

The COVID-19 pandemic further exacerbated the availability and access to mental health services and negatively impacted the mental health of all Canadians. According to the Mental Health Commission of Canada, the aftermath of COVID-19 revealed how under-resourced the mental health system is and highlighted the existing health and social policies gaps across a wide spectrum of services, from intensive specialized services to prevention to mental health promotion (MHCC, 2020). Based on comparisons of Canadian surveys from 2020 to 2018, self-ratings of mental health among women and youth were particularly negatively impacted (CCHS, 2020; Abelson et al., 2022). Nearly seven out of 10 Canadians, in general, reported being negatively impacted by COVID-19, and by December 2020, two out of five Canadians reported some level of distress in the previous month (Statistics Canada, 2021).

With these increased needs for mental health care, a corresponding response by all mental health stakeholders should be expected. However, these concerns were noted as far back as 2012, and at that time, the Mental Health Strategy for Canada recommended increasing the proportion of the health budget devoted to mental health to 9% by 2022, but this has not occurred (Bartram, 2017; Moroz et al., 2020).

Canada also suffers from systemic racism which results in its racialized (visible minority) citizens and Indigenous peoples receiving poorer quality and experiencing higher barriers to mental health care than White Canadians (MHCC, 2019). Racialized Canadians are subject to societal discrimination, which adversely affects their mental health and well-being (MHCC, 2019; Williams et al., 2022). However, the full extent of this systemic racism is not well-studied or quantified. Although the existence of discrimination against Indigenous and racialized people in Canada has historically been well-documented, only recently has the contemporary impact of this systemic burden started to become part of the national conversation (MHCC, 2020). Additionally, other systems of oppression based on gender,

age, education, place of residence, and socioeconomic conditions also inform observed disparities. These systemic oppressions can also intersect with experiences of racism to further impact access to mental health care.

The situation today is that Canadians die because they do not have access to mental health services, but also because they are racialized people whose access to mental health services is hindered (Lai et al., 2017). As an example, the Saskatchewan Health Authority offered a formal apology for having security officers forcibly remove Samwel Uko, a young Black Canadian from the ED in May 2020, who came to the Regina General Hospital twice on the same day for acute help for a mental health problem. He was found dead in Wascana Lake an hour later. The CEO, in an apology, said staff spent too much time focusing on his identity rather than his care. As a result of tragedies like this, there has been a public outcry from racialized people across Canada, noting a scarcity of providers representative of their communities, particularly those able to treat racial issues (e.g., Soloducha, 2020; Williams, 2021).

The intensity of the mental health crisis for people of color is not receiving the attention it deserves, in part because of the lack of racial data (with respect to both patients and providers), which is only now starting to be collected (Bain et al., 2020; Moyser, 2020). Although many of the demographic variables have been previously studied, no breakdown by ethnicity, race, or language has been described (e.g., McDonald et al., 2017). The resistance to collecting race-based data can be conceptualized as a special kind of systemic racist policy tool that fits under the terminology of *weaponization of policy* (Okun et al., 2019). The term weaponized policy as used in this way refers to a rule or law whose result or (mis-)implementation results in a race-based disparity. Those who administer these policies can be of any race and do not have to have any personal bias for the outcome of the policy enforcement (or non-enforcement) to cause systemic racism.

The lack of collection of data by race by the statistical arm of the government, however, hinders a more thorough analysis in Canada. Without data on the scope of the problem, it is difficult to advocate for more equitable systems, which maintain the status quo. Therefore, this paper seeks to fill gaps in the data on racialized citizens by examining the barriers experienced by Canadians with regard to access to mental health and by breaking down the responses by not only the standard subcategories of location, income, age and gender, language and mental health need but also by ethnoracial group.

Materials and methods

Angus-Reid national survey

Established in 2014, Angus Reid Institute is a national independent research foundation. This data is based on a national Angus Reid online

survey of Canadian adults conducted from February 22–24, 2022. The respondents were members of the online Angus Reid Forum. Survey invitations were sent to randomly selected Angus Reid panelists to ensure a representative sample. All respondents are compensated with a small monetary incentive when completing a survey. Participants were provided informed consent through the terms of service and privacy policy of Angus Reid Forum upon their registration, which outlines the protection of personal information, the purpose and benefits of survey research, compensations, and how to withdraw. This study follows the principles of the Declaration of Helsinki, and anonymized data was provided to the authors by the Angus Reid Institute. The survey included research questions about whether individuals had difficulties accessing mental health care, the types of difficulties people experience, and the types of mental health problems that are most difficult for accessing mental health care.

Participants

The 1501 participants were representative of the general population of Canadian adults, with 236 people of color (unweighted) and 1179 White participants. Among the people of color, 92 identified as Indigenous Canadian, 22 as Black, 38 as South Asian, 41 as East Asian (including Chinese, Taiwanese, Hongkonger, and other East Asian), 18 as Middle Eastern/West Asian, 24 as Latin American, and 87 as other ethnicities or preferred not to answer.

All following numbers are weighted as per the current demographics across all provinces of Canada. Participation was distributed across six provincial regions: British Columbia (13%), Alberta (11%), Saskatchewan/Manitoba (7%), Ontario (38%), Quebec (24%), and Atlantic (7%). Participants identified as male (48%) or female (52%). For education, 37% reported less than or equal to high school, 33% reported some post-secondary/college, and 30% reported university or more. For household income, 28% reported <\$50K, 35% reported more than 50K to <100K, and 27% reported more than 100K.

For race and ethnicity, 6% were identified as Indigenous Canadian, 78% as White, 1% as Black, 2.5% as South Asian, 2.7% as East Asian, 1% as Middle Eastern/West Asian, 1% as Latin American, and 5.7% as other ethnicities or preferred not to answer.

Measures

The first mental health question in the survey read, "How often, if ever, have you had difficulties accessing mental health care when you needed it?"

and participants had six response options (Just about every time, often, sometimes, rarely, never, or not-applicable—have not sought out mental health care). The second question read, "What types of difficulties have you experienced in trying to access mental health care?" and participants had nine response options (financial barriers/too expensive, long waitlists, difficulty finding a specialist, negative experience(s) with mental health professional(s), difficulty accessing in-person care during the pandemic, lack of resources/professionals in the surrounding area, could not find someone of my race/ethnic group, could not find someone who speaks my preferred language, or other/please specify).

In addition to these research questions, the survey also collected several pertinent demographic variables, including the province of residence, language (English or French), gender identity (Male, Female, Other), age (18+, 18–24, 25–34, 35–44, 45–54, 55–64, 65+), education level (less than or equal to high school, some post-secondary/college, university or more), household income (<50K, more than 50K to <100K, 100K+, don't know/rather not say), and race/ethnicity (Indigenous Canadian, White, Black, South Asian, East Asian (Chinese, Taiwanese, Hongkonger, other East Asians), Middle Eastern/West Asian, Latin American, Filipino, specify other ethnicity, and prefer not to answer.

The survey was offered in both English and French, the official languages of Canada. Given that, 98.1% of Canadians can carry a conversation in English or French, and 92.9% speak one of these languages at home, the survey would be accessible to the vast majority of Canadians (Statistics Canada, 2022).

Data analyses

This study relies on a series of analytical techniques to compare response patterns across the three research questions and the demographic variables. Different analytical and statistical methods were used to best utilize the complexity and scope of the current data. Comparisons were made across frequencies and mean levels. The first set of analyses examined frequencies across each of the demographic variables and assessed the statistical significance of any differences. Given the exploratory nature of this study, we did not limit the analysis to a predetermined set of demographic variables. The following set of analyses focused on group differences in mean levels of a specific experience. Across both stages, the analysis, specifically, focused on the covariation between several demographic characteristics and experiences of difficulties in mental health care, the types of difficulties, and the conditions associated with the most difficulties. The demographic variables analyzed include provinces of residence, age groups, language, education

levels, household income levels, ethnic and racial identity, and gender. Contingencies tables were used to examine the frequencies of one variable at varying levels of another variable. Chi-square Independence tests were used to examine differences in the frequencies across levels of demographic variables. *Post-hoc* pairwise z-tests examine whether the observed frequencies differed significantly across demographic variables.

Independent samples *t*-tests and one-way Analysis of Variance (ANOVA) were used to examine mean level differences across each value of the demographic variables. Independent samples *t*-tests were used to examine mean differences for gender and language. ANOVAs were used to examine differences across categories of age, ethnicity, province, education, and income. Posteriori tests in ANOVA were used to examine each pair of means when an ANOVA test is significant.

The data was balanced and weighted to produce results that were representative of the population of Canadians across ethnoracial group, province, age, gender, and education. Weighted tests were used for all charts and analyses. For comparisons across ethnoracial groups, multiracial, "prefer not to answer," and those groups with <10 respondents were excluded from analyses.

Results

How often, if ever, have you had difficulties accessing mental health care when you needed it?

About half of respondents (48%) had either not sought out mental health care (11%) or never experienced difficulties in accessing mental health care (38%). From the remaining sample who sought out care and reported difficulties (52%), they experienced difficulties *just about every time* (10%), *often* (14%), *sometimes* (17%), and *rarely* (11%). To map the differential experiences of individuals, we examined disaggregated differences across the demographic variables: race/ethnicity, gender identity, age, education level, household income, province of residence, and language.

Race/ethnicity

Comparing White and non-White participants, more people of color sought out care (71 *vs.* 48%; Figure 1a), and those who did had greater difficulty accessing care (Figure 1b).

In terms of specific ethnoracial groups, about 48% of White respondents reported ever seeking out care and having difficulties, compared to other identities, including Indigenous Canadian (69%), Black (67%), Middle Eastern/West Asian (78%), and Latin American (70%). Similarly, from

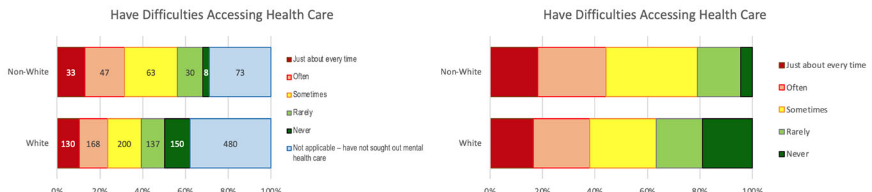

Figure 1. Race related differences in accessing mental health care. (a) The graph on the left shows the sample and proportion of White and non-White respondents who experienced difficulties accessing care and those who have not sought out care; (b) the graph on the right shows the proportion of White and non-White respondents who experienced difficulties accessing care and the frequency of those difficulties.

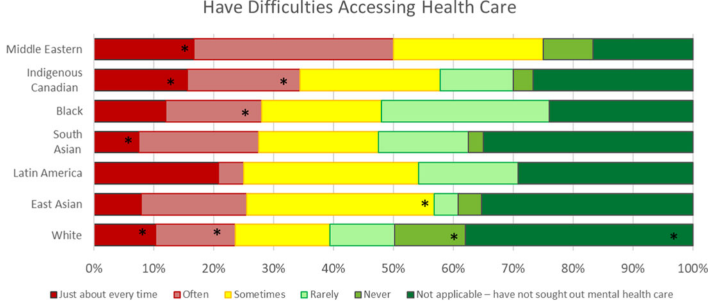

Figure 2. Differences in accessing mental health care by ethnoracial group. *Categories where some comparisons were significant.

respondents who sought out care, White respondents were more likely to never experience difficulties (12%) compared to other identities, such as Indigenous (3%), Black (0%), South Asian (3%), East Asian (2%), Latin American (0%), and Middle Eastern/West Asian (11%), shown in Figure 2.

Ethnicity was related to mean level differences in how often individuals had difficulties accessing mental health care, $F(6,1407) = 4.480$, $p < 0.001$. Specifically, Indigenous and Middle-Eastern people experienced significantly more difficulties in accessing mental health care than White people.

Gender identity

About 60% of women sought out care and reported difficulties, compared to 44% of men. Gender was related to mean level differences in how often individuals had difficulties accessing mental health care $t(1498) = 6.594$, $p < 0.001$. Men were more likely to have not sought out mental health care (45%), compared to women (31%). There was a higher proportion of women (12%) than men (7%) who reported having had difficulties *just about every time* (12 and 7%, respectively) or *often* (17 and 9%, respectively).

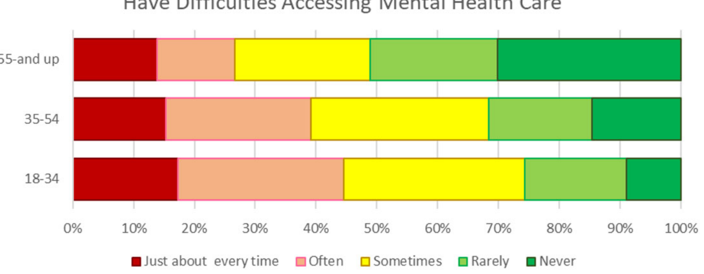

Figure 3. Age related differences in accessing mental health care. *Categories where some comparisons were significant.

Age

Younger respondents sought out care and reported more difficulties compared to middle-age and older respondents. Age was related to mean level differences in how often individuals had difficulties accessing mental health care, $F(5,1498) = 64.957$, $p < 0.001$. The highest proportion was about 18–35 year olds (67%), then 35–54 year olds (59%), and the lowest proportion was among respondents aged 55 and older (33%). There were significant differences across the age groups on whether they ever sought out care and experienced difficulties [$F(2, 1498) = 68.666$, $p < 0.001$]. About half of adults aged 55 and older (52%) reported to not have sought out mental health care, compared to 26% of 18–34 year olds and 31% of 35–54 year olds. More younger adults (aged 18–34) and middle-aged adults (aged 35–54) than older adults (aged 55 and older) reported having had difficulties *just about every time* (13, 11, and 7%, respectively), *often* (20, 16, and 6%, respectively), and *sometimes* (22, 20, and 11%, respectively), shown in Figure 3.

Other findings

There were no significant differences in whether respondents ever sought out mental health care based on their education level [$F(2,1498) = 0.950$, $p = 0.382$]. However, respondents with some post-secondary or college reported difficulties finding mental health care *just about every time* (13%) compared to respondents with less than high school or university (9 and 8%, respectively). Household income was related to mean level differences in how often individuals had difficulties accessing mental health care, $F(5,1498) = 4.323$, $p = 0.013$. Individuals with household incomes <$50k reported having had difficulties *just about every time* (12%) and often (16%) compared to those with household incomes between $100k and $100k (9 and 12%, respectively), and those with over $100k (9 and 11%, respectively).

Similarly, language was related to mean level differences in how often individuals had difficulties accessing mental health care $t(1499) = -2.324$, $p = 0.020$. English-speaking respondents sought out care and reported difficulties more than French-speaking respondents (54 and 43%, respectively). For the province of residence, the highest proportions of respondents (56%) who sought out care and reported difficulties were from Ontario and Atlantic Canada. The analysis of variance showed the province of residence did not result in mean level differences in how often individuals had difficulties accessing mental health care, $F(5,1495) = 1.308$, $p = 0.258$.

What types of difficulties have you experienced in trying to access mental health care?

For those who sought out care and reported difficulties (52%), the most common difficulties include *long waitlists* (62%), *financial barriers/too expensive* (58%), *lack of resources/professionals in surrounding area* (47%), and *difficulty finding specialist* (41%), as shown in Figure 4. Other difficulties listed were having *negative experiences with mental health professionals* (35%), *difficulty accessing in-person care during pandemic* (34%), could not

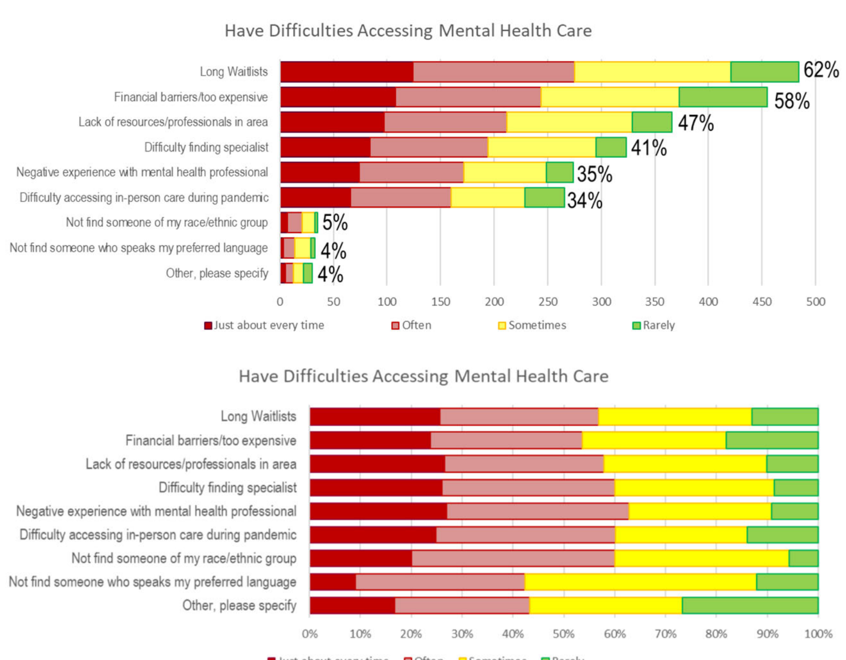

Figure 4. Difficulty accessing mental health care by barrier type. (a) The top graph shows the entirety of the data organized by the difficulty level of access to mental health care with the reasons for the greatest difficulty at the top. Participants could select more than one reason. The x-axis is the number of Canadians surveyed (total 1501). (b) The bottom graph shows the same data trends for each category proportionally to compare how often each particular issue is being experienced, by those who endorsed that particular barrier.

find someone of my race/ethnic group (5%), could not *find someone who speaks my preferred language* (4%), or other, please specify (4%), as shown in Figure 4. For those who selected *other*, participants mentioned issues with insurance (being told by insurer they are not in need of treatment or gatekeeping who is a qualified therapist, quality of coverage is limited), lack of LGBTQ + services or providers, medical professional (GP) gatekeeping medication, access to care/services, or not believing symptoms are real, lack of knowledge of mental health, disorganization of physicians, business hours of services, personal challenges (willingness, capacity to seek care), and limited specialized services (youth, men).

Disaggregated differences across the demographic variables: province of residence, language, gender identity, age, education level, race/ethnicity, and household income were examined to explore the types of difficulties associated with accessing mental health care.

Race/ethnicity

Race and ethnicity were related to mean differences in the types of difficulties people experience when trying to access mental health care. Specifically, there were significant differences in experiences in finding someone of the same race/ethnic group [$F(6,724) = 12.572$, $p < 0.001$] and finding someone who speaks a preferred language [$F(6,724) = 4.201$, $p < 0.001$]. Black Canadians (31%) were significantly more likely to report barriers associated with not finding someone of their race/ethnic group compared to other identities, including Indigenous (2%), White (2%), and Latin American (6%), as shown in Figure 5a. East and South Asians (21%)

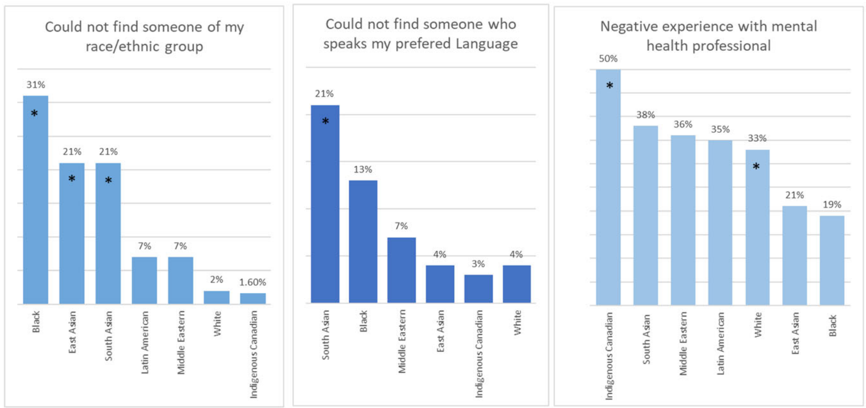

Figure 5. Race, language, and therapist barriers to mental health care by ethnicity. (a) Ethnoracial group and therapist concordance. (b) Ethnoracial group and language preference. (c) Ethnoracial group and previous negative experiences. These tables show which ethnoracial groups had the most difficulty navigating selected barriers. *Indicate significance found in one or more category comparisons.

also reported barriers related to finding someone of their race/ethnic group more than Indigenous and White people. South Asians (21%) were significantly more likely to report not finding someone who speaks their preferred language than other identities, including Indigenous, White, East Asian, and Latin American, as shown in Figure 5b.

Indigenous Canadians (69%) reported more financial barriers than other groups, including respondents who identified as Black (63%) and South Asian (67%). Indigenous people (50%) reported experiencing negative experience(s) with mental health professionals more than White (33%), and East Asian (21%), as shown in Figure 5c.

Provinces of residence

Across the sample, 58% of Canadians reported financial barriers as a type of difficulty. The province of residence was related to mean differences in the types of difficulties individuals experience when accessing mental health care. Specifically, there were significant differences in experiences of financial barriers [$F(5,771) = 2.619$, $p = 0.023$] and negative experiences with mental health professionals [$F(5,771) = 2.487$, $p = 0.030$]. This barrier was significantly lower in Quebec (49%), compared to other provinces including Alberta (67%), and Ontario (62%). Similarly, the difficulty of negative experience(s) with mental health professional(s) was significantly lower in Quebec (25%), compared to other provinces including Alberta (42%) and Ontario (39%). Other provinces (British Columbia, Atlantic, Saskatchewan/Manitoba) were not significantly different from each other.

Language

The language was related to mean level differences in the types of difficulties people reported, specifically, financial barriers [$t(775) = 3.95$, $p < 0.001$] and negative experiences with professionals [$t(774) = 3.245$, $p < 0.001$]. In line with the provincial findings, more English-speaking Canadians than French-speaking Canadians experienced financial barriers (61 and 42%, respectively) and negative experience(s) with mental health professionals (38 and 22%, respectively).

Gender identity

Gender was related to mean level differences in the types of difficulties people reported, specifically, financial barriers [$t(774) = -5.069$, $p < 0.001$], long waitlists [$t(774) = -2.987$, $p = 0.003$], negative experiences with professionals [$t(774) = -3.424$, $p < 0.001$], and not finding someone who speaks preferred language [$t(774) = 2.213$, $p = 0.027$]. Although women sought out care and experienced more difficulties in general than men, there were

three types of difficulties that were significantly different. Women experienced more difficulties than men due to financial barriers (66 and 48%, respectively), long waitlists (67 and 56%, respectively), and negative experience(s) with mental health professionals (40 and 28%, respectively). However, men were significantly more likely than women to report difficulties associated with finding someone who speaks their preferred language (6 and 3%, respectively).

Age

Age was related to mean level differences in how often individuals had difficulties accessing mental health care, $F(5,1498) = 64.957$, $p < 0.001$. Younger adults (aged 18–34) and middle-aged (aged 35–54) were more likely to seek care and experience difficulties than older adults (55 and older). There were several types of difficulties more common in younger age groups. Age was significantly related to mean differences in experiencing financial barriers [$F(2,774) = 5.968$, $p = 0.003$], negative experiences with mental health professionals [$F(2,774) = 11.043$, $p < 0.001$], difficulties accessing in-person care during the pandemic [$F(2,774) = 6.687$, $p = 0.001$], finding someone who speaks their preferred language [$F(2,774) = 8.771$, $p < 0.001$], and finding someone of their race/ethnic group [$F(2,774) = 3.407$, $p = 0.034$]. Younger adults experienced more difficulties due to financial barriers (65%) compared to middle-aged (57%) and older adults (50%). Younger and middle-aged adults experienced more barriers than older adults, specifically due to negative experience(s) with mental health professionals (38, 41, and 21%), difficulty accessing in-person care during the pandemic (40, 35, and 24%), and finding someone who speaks their preferred language (5, 5, and 1%). Younger adults experience more difficulties finding someone of their race/ethnic group (8, 3, and 0%).

Household income

Income was significantly related to mean differences in experiencing financial barriers [$F(2,774) = 3.968$, $p = 0.019$] and negative experiences with mental health professionals, [$F(2,774) = 3.327$, $p = 0.036$]. Canadians who made <$50k were more likely than those making over $100k to report specific types of difficulties, financial barriers (66 and 54%), and negative experience(s) with mental health professionals (42 and 31%).

Education level

There were no significant differences in education level and the types of difficulties reported.

Discussion

Access to mental health care

This study used a cross-sectional nationally representative sample to examine the barriers to accessing mental health care professionals and services faced by Canadians. Specifically, this study was to better understand the barriers Canadians of color face when accessing mental health care professionals and services. Being racialized also intersects with multiple systems of oppression based on gender, socioeconomic conditions, geographic location, age, and education. Indeed, research indicates that compounding marginalized identities can have an increased deleterious impact on mental health (Williams et al., 2023).

When asked directly, Canadians give a clear response: There are substantial barriers to finding mental health care in Canada, including financial barriers, long wait times, no available specialists, language or cultural barriers, geographic barriers, and lack of knowledge about where to go (e.g., Moroz et al., 2020). Moreover, circumstances including geographic location, age, language, and race are influencing the size and severity of these barriers. About half of Canadians, including two-thirds of young adults, report difficulties accessing mental health care when they need it. A quarter even says it happens often or just about every time. Women are significantly more likely than men to have experienced these difficulties, owing to the fact fewer men seek out mental health care in the first place (Slaunwhite, 2015). Older Canadians are nearly twice as likely as those under 55 to say they have never sought out mental health care. These disparities also highlight the underlying influence of systemic oppression based on gender and age.

Amongst those who have experienced difficulties accessing mental health care, our data shows that the most common are structural—notably financial barriers and long waitlists due to a lack of local resources/professionals.

Financial barriers

Two-thirds of lower-income respondents reported experiencing financial barriers, compared to just over half of higher-income respondents (McDonald et al., 2017). Given that outpatient mental health is largely not covered by the government health care system, it is unsurprising that income was positively correlated to one's ability to obtain care. This state of affairs guarantees that Canadians who are the most disadvantaged will suffer the most from lack of care as provincial health plans do not include mental health care until a patient's illness becomes so severe that an intensive program or inpatient care is required. Outpatient therapy can prevent

many of the crises that bring patients to emergency departments, where the care is the most invasive and expensive. There have been concerns about spending more tax dollars on health care, as many Canadians believe that taxes are already comparatively high for the health services which they can access, even if in the long-run preventative care will save money (Williams, 2022). There is ample research demonstrating how to provide mental health services without corresponding increases in costs, but there has not been an adequate push for implementation (Naeem et al., 2017). Given Canada's placement among the top 10 wealthiest nations per capita, it is hard to understand why there is so little funding for mental health.

Canadians tend to believe the United States, their closest neighbor, has a problematic health care system that leaves the most critically ill and impoverished unserved. This misperception has created widespread complacency in Canadian consumers, physicians, and policymakers about critical access issues in Canada (Vogel, 2020). Our southern neighbor actually has an excellent health provisory care system, notably with wait times that are shorter and more accessible specialists (McIntyre & Chow, 2020; Papanicolas et al., 2019; Williams, 2022). An efficient public insurance plan covers over a third of the US population and this plan includes lower income Americans who are covered through Medicaid (fully 25% of the population). Leaving about 8% of Americans remaining uninsured for various reasons including personal choice. Further, in 1996 the US expanded health care to require public and private plans to cover mental health care by passing the Mental Health Parity Act, which required mental health care coverage at the same level as physical health. This addition resulted in only a modest and negligible rise in insurance costs. As a well-resourced, compassionate, and progressive nation, there have been calls for Canada to do the same (Tasca et al., 2018; Williams, 2022).

Long waitlists due to lack of resources/professionals

Long wait times were experienced in a combined category ("just about every time" and "often"), with 55% of all survey respondents indicating this as a barrier. The barriers linked to a lack of resources are a part of the architecture of the structural barriers that mental health care seekers face (McDonald et al., 2017). Scholars have noted increasingly long wait times for mental health care in Canada (Barua & Moir, 2019). There are long waits for general and surgical medical services as well, and the stress of unmet medical needs exacerbates mental health concerns (e.g., Barua et al., 2014; Eimontas et al., 2022). Barua and Moir (2019) have noted that "Waiting for treatment has become a defining characteristic of Canadian health care." (p. iii).

The latest information from the Canada Institute for Health Information (CIHI, 2022) on wait times for mental health care before COVID-19 found that in 2019–2020, half of Canadians were required to wait up to 1 month for local ongoing counseling services, while one in 10 waited more than four months. This however does not consider if the client requires acute care services (i.e., suicidal) or services from a psychologist or psychiatrist. Children's Mental Health Ontario (2020) found that for many regions, including Toronto, the wait for youth services is from 600 to 900 days. The situation is, unfortunately, worse for youth and children than for those older than 18 in some jurisdictions, punctuating the need for more counselors, particularly for children, as there are not enough professionals to service all (Liddy et al., 2020; Loebach & Ayoubzadeh, 2017; Mikail & Nicholson, 2019; Viberg et al., 2013). Current strategies to increase access to mental health care have been unsuccessful (Beaulieu & Schmelefske, 2017; Moroz et al., 2020).

Notably, as late as 2022, the Canadian Psychology Association has denied accreditation for a large class of psychology professionals (PsyD graduates from non-university programs), over the pleas of provincial registration boards and the PsyD schools themselves. South of the border, this category of professionals supplies the US with over half of their psychology workforce in much-needed mental health indications. The outcome has been to make it more difficult for Canadians to find mental health care. This burden falls disproportionately on racialized Canadians as it is racialized students who gravitate to the PsyD programs given the barriers that keep them from entering Ph.D. programs (Faber et al., in press). As such, this type of policy is an example of weaponization because it disproportionately denies diverse mental health professionals to visible minority Canadians suffering from mental health issues as 85% of current providers in Canada are White (Brisset et al., 2014; Thomson et al., 2015). Notably, Francophones reported fewer barriers as compared to Anglophones, and this may be due in part to Quebec producing more accredited PsyDs through their university programs (CPA, 2018).

Negative experiences in mental health care

Although the overall data indicate that Canadians find long waitlists and financial barriers as the most daunting impediments to mental health care when the overall data is graphed by group proportions, other interesting trends emerge. Among those who indicated that "negative experiences" with their mental health provider were a reason for not finding mental health care services, the aggregate of the two highest categories ("just about every time" and "often") indicates that 63% of respondents found this to be

a notable impediment Given that mental health care providers are trained to build rapport and have healing interactions with their clients, it is lamentable that so many people in need of mental health care report bad experiences. This finding could indicate a lack of empathy by mental health care providers. Consider the case of Samwel Uko, who was twice turned away from the Regina General Hospital while explaining he was experiencing a mental health crisis, and later found dead. If mental health professionals have empathy, they would understand that, as the CEO said in his apology, "it is possible to care for someone without [even] knowing their name" (Issa, 2020).

New research is urgently needed to determine why Canadians seem to be having so many poor interactions with their mental health care providers, and to unearth the impediments to creating a strong therapeutic alliance (e.g., Tasca et al., 2018). There is a racial component to this finding as well, given that negative experiences posed a notable barrier for Indigenous and Middle Eastern participants, and as such, it could indicate a need for more clinician training in building rapport, connection, and empathy, especially when working with diverse clients (e.g., Jones et al., 2021; Miller et al., 2015).

Racial barriers to mental health

Racial breakdowns of who is seeking mental health care reveal that White Canadians are seeking health care significantly less often than other racialized groups. Middle Easterners, Indigenous Canadians, and Black people are on the other end of the spectrum and seek mental health care more frequently, with South and East Asians and Latin Canadians falling in the middle. This finding was unexpected, given that all communities of color have hesitations and stigma around mental illness and help seeking, more so than White Canadians, and most have had a pattern of underuse of mental health care in the past (e.g., Cénat et al., 2021; Chiu et al., 2018; Grace et al., 2016; Singla et al., 2018; Zhang et al., 2019). The fact that these groups are now seeking more mental health care, despite stigmas, may communicate a level of desperation to find relief from suffering that transcends social norms. Communities that have been suffering for decades are experiencing worsening mental health in the aftermath of COVID-19.

The order of these experiences by race is furthermore a reflection of historical racial hierarchies in Canadian society. The less power held as a people, the more one might need mental health care, due to the traumatizing impact of oppression (Blendon & Casey, 2019; Holmes et al., 2016; Williams et al., 2022). In regard to the difficulty of access for those seeking care, a similar story is being told by trends in the data. White Canadians

have the least difficulty accessing health care and Middle Eastern, Indigenous, South Asian, East Asian, and Black Canadians have the most difficulty, respectively (e.g., Cénat et al., 2021).

Types of difficulties in accessing care

When given the opportunity to choose "race of provider" as a barrier among several possible barriers, people from some ethnic groups explicitly chose this option as a reason for being unable to access health care. Of those who indicated that a barrier to mental health care was "not being able to find a provider of their ethnic group or race," a quarter identified as Black, with the percent for East and South Asians hovering around one in five. In contrast, under 2% of those reporting this reason as a barrier were White and Indigenous Canadians.

The scope of this problem is hard to measure due to a lack of data about the composition of the mental health workforce. If one cannot measure a situation or condition, one cannot demonstrate that it exists, which leaves one open to claims that the issue is not important. If the systemic racism harming racialized Canadians cannot be measured, then policymakers can act as if it does not exist and plausibly decline to create initiatives or legislation to remedy the issue. As such, this underscores the importance of collecting racial data not only of patients but providers as well.

Within the category "could not find someone who speaks my language," under 3% of those who considered this a barrier identified as White and Indigenous Canadians, while the percentage for Black Canadians (10%) and South Asians (23%) indicated language as a barrier for racialized groups were much higher. This underscores the importance of producing more providers who are fluent in languages other than English and French, particularly for Asian and Black Canadians. Furthermore, culturally-responsive providers are needed to provide a range of essential services, not limited to working in different languages. Weaponized policy barriers in Canada also selectively and discriminatorily prevent the small pool of qualified clinical psychologists who are fluent in a language other than French or English from taking their qualifying exams in their native language (e.g., College of Psychologists of Ontario, 2019; Quebec Office of the French Language, 2022) depriving entire linguistic cohorts of mental health providers. Unlike in other professions, there is no potential for competition; English or French only speakers cannot provide the best mental health services for these Canadians. The only thing linguistic discrimination in mental health does is deprive entire ethno-linguistic groups of much needed services from empathetic providers.

Negative experiences with healthcare professionals were one of the most frequently mentioned barriers to mental health care for all Canadians; however, this category can also represent racial animosity. This may be why we find Indigenous and some racialized Canadians (Middle Eastern and South Asian) reporting higher levels of negative interactions as a barrier than White Canadians. However, in this category, some racialized Canadians (those identifying as Black and Hispanic) reported similar levels to White Canadians, while East Asians reported negative experiences as less of a barrier. Studies have also indicated that while East Asians in Canada uniquely have a lower prevalence of mood and anxiety disorders, which may explain their low use of mental health services, contradictorily, they have a low self-rated mental health and the highest level of unmet needs (Chiu et al., 2018). These findings are likely to be explained in that East Asians may experience or report lower levels of interpersonal issues due to the cultural emphasis on harmonious interactions, colorism, and their "model minority" status (Blendon & Casey, 2019; Zhang et al., 2019). Findings for Black participants are also consistent with a recent study that found that more than half of Black Canadians reported being treated unfairly when receiving hospital care or other medical services (Cénat et al., 2022).

Limitations and future research

No territories were included in this study, where perhaps the most pronounced difficulties in accessing care might be found. Future surveys should ensure the inclusion of First Nations, rural and institutionalized persons, as the mental health needs of these groups are important as well. The relatively small size of each of the ethnoracial groups is a study limitation. Also, the survey was only offered in English and French, which could have excluded some immigrants who do not speak either language.

Future studies should collect data on cultural constructs, such as acculturation, to help contextualize findings. Other facets of identity also play a role in mental health care access (e.g., sexual and gender minority identity) as well as treatment expectations, which should be examined as well.

Conclusion

This study is one of the first to provide quantitative data on the perceived barriers Canadians are experiencing in their attempts to access mental health care while including language, race, and ethnicity as selectable options that may influence access. Access to mental health care is unacceptably difficult. In Canada, nearly everyone suffers from a lack of access, as indicated by this study and others. Many do not realize how long

the wait times are until they need care for themselves or their loved ones (Vogel, 2020).

Lack of access for people of color is of particular concern. Because there has been no data on which ethnic groups are being underserved and why, there has been no policy remedy. The injustice which is the lack of any specific policy remedy for Canada's racialized population (30% of the Canadian population) is compounded over years of inaction and over the generations that have had to bear the systemic burden of increased barriers. This existing structure for the provision of mental health was originally created to advantage White Canadians over all other racialized groups (De Los Reyes & Uddin, 2021; Dupree & Kraus, 2022; Williams, 2019). Every week that goes by without the necessary data being collected perpetuates the historic injustices (Cénat et al., 2022).

Increased funding for mental health care is essential to remove financial barriers to wellness. There is also a critical need to prioritize the production of more mental health care providers, with more racially and linguistically diverse providers graduating from training programs, along with more culturally-informed training of existing providers.

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