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Immigrant, refugee, ethnocultural and racialized populations and the social determinants of health

A Review of 2016 Census Data

February 2019

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Acknowledgements

This document is a collaboration between the Mental Health Commission of Canada's (MHCC) Knowledge Exchange Centre (Lara di Tomasso, Lisa Thompson and Bonita Varga), and the Centre for Addiction and Mental Health's (CAMH) Office of Health Equity (Aamna Ashraf, Dr. Kwame McKenzie and Andrew Tuck).

Expert advice and input was provided by subject-matter experts (SMEs). We would like to express deep gratitude to the members of MHCC's Collaborative on Immigrant, Refugee, Ethnocultural and Racialized Mental Health who provided critical input, review and guidance in the development of this document.

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ISBN: 978-1-77318-090-8

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The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this material is made possible through a financial contribution from Health Canada.

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Introduction

As one of the most diverse countries in the world, Canada relies on immigration to enrich and strengthen its social and economic fabric. The most recent Census data from 2016 confirms this demographic picture and its many benefits. Yet a detailed analysis is needed if we are to adequately understand the equity issues emerging in the policies, programs, and services of health-related, social, and economic programs.

It is well documented, for example, that immigrants arrive with better mental and physical health than the Canadian-born population. Yet this “healthy immigrant effect” disappears after five years.¹ Research also shows that immigrant, refugee, ethnocultural, and racialized (IRER) populations are less likely than the Canadian population to seek help with mental health problems (for reasons such as language barriers, access to services, fear, and stigma)² and more likely to use expensive services like emergency rooms if their mental health reaches a crisis point.^{2,3}

Given the federal government’s objective to attract 1.3 million new permanent residents between 2018 and 2021,⁴ it is essential that those in our mental health systems ensure equity of access and outcomes for IRER populations. To identify gaps and develop responses to help mitigate declines in IRER mental health, health systems must have the capacity to collect and use sociodemographic data. Such data will foster health equity in mental health service planning and delivery, as the Mental Health Commission of Canada (MHCC) has recommended in two reports: [Issues and Options](#) (2009) and the [Case for Diversity](#) (2016).

To help achieve these ends, this paper highlights select sociodemographic trends and issues related to IRER mental health and well-being, identified from 2016 Census data⁵ by the MHCC Collaborative on IRER Mental Health. The collaborative prioritized a number of key social determinants that influence mental health, including language, income, education, unemployment and underemployment, discrimination, and hate crimes. This data shows that immigrants experience a range of equity-related issues after settling in Canada – with many having an impact on outcomes related to health and well-being – and it speaks to an increasingly urgent need for action.

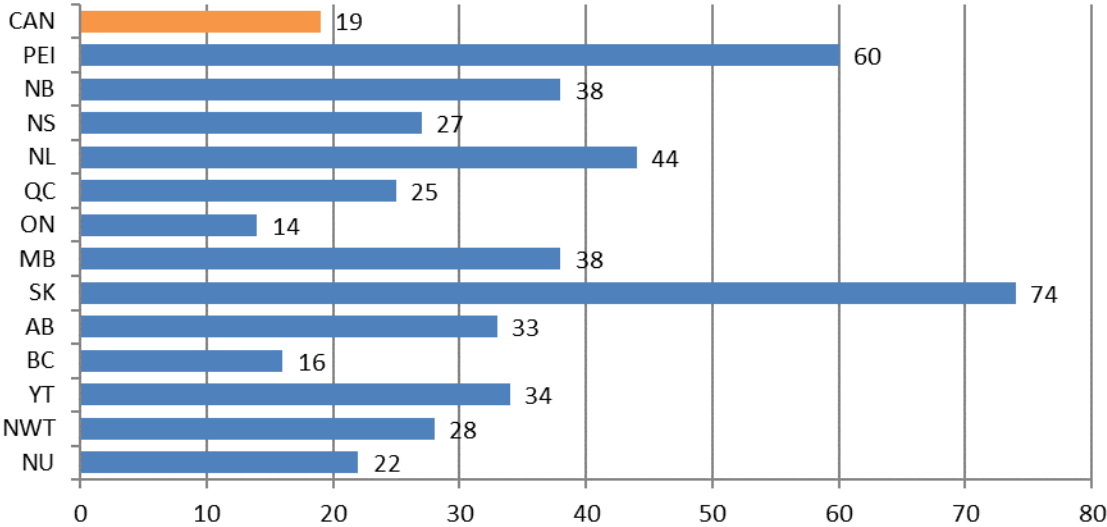
Given that immigrants constitute a growing proportion of the population, health and social service decision makers (at system- and service-levels) would do well to consider these findings as they develop strategies to increase access to culturally and linguistically appropriate services.

Context

A growing immigrant population

Migration accounts for approximately two-thirds of Canada’s population growth and will remain a key driver of growth as the population continues to age and natural replacement rates remain low.⁶ Between 2011 and 2016, the immigrant population increased by 19% (approximately 1.2 million people) with provinces and territories experiencing growth rates of between 14% and 74% (see Figure 1). Saskatchewan (74%), Prince Edward Island (60%), and Newfoundland and Labrador (44%) saw the largest growth rates.

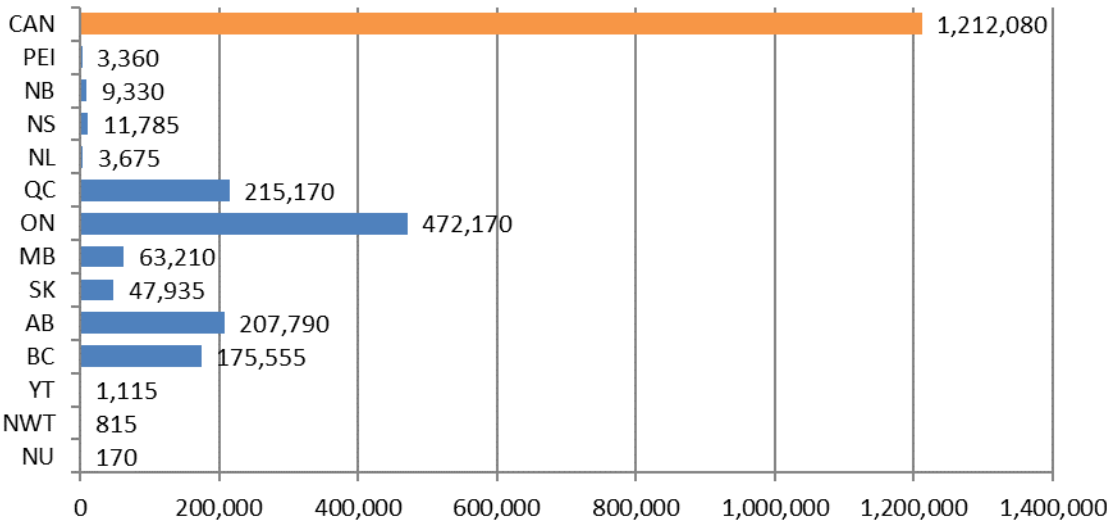
Figure 1. Percentage increase in immigrant population between 2011 and 2016⁷



Highly populated provinces welcomed the largest number of immigrants between 2011 and 2016 (see Figure 2) with 472,170 immigrants arriving in Ontario, 215,170 in Quebec, and 207,790 in Alberta.

* The census definition of *immigrant* includes economic and family-class immigrants and accepted refugees.

Figure 2. Number of immigrants that arrived between 2011 and 2016⁸



A growing racialized population

For many reasons, the term *visible minority* is no longer appropriate to describe diverse populations living in Canada. In some cities the majority of individuals may not identify as First Nations, Inuit, Métis, or Caucasian. To acknowledge race as a social construct, this report uses the term *racialized*. The number of people who identified as racialized rose significantly across Canada between 2011 and 2016. Saskatchewan, Nunavut, and Newfoundland and Labrador saw the largest percentage increases at 83%, 77%, and 70%, respectively (see Figure 3). In terms of the number of racialized residents, Ontario, Alberta, and British Columbia saw the largest increases. According to the 2016 Census, Calgary, Winnipeg, and Ottawa, all boast populations where more than one in four people identify as racialized, a rate that jumps to one in two in Vancouver and Toronto (see Figure 4).

Figure 3. Percentage increase in racialized population between 2011 and 2016^{9,10}

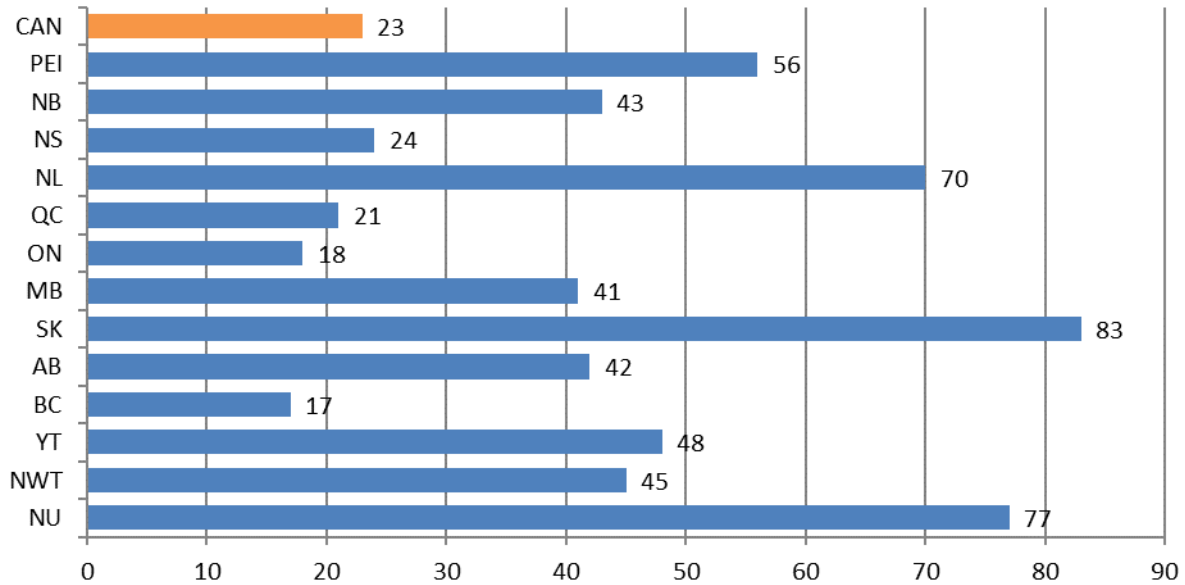
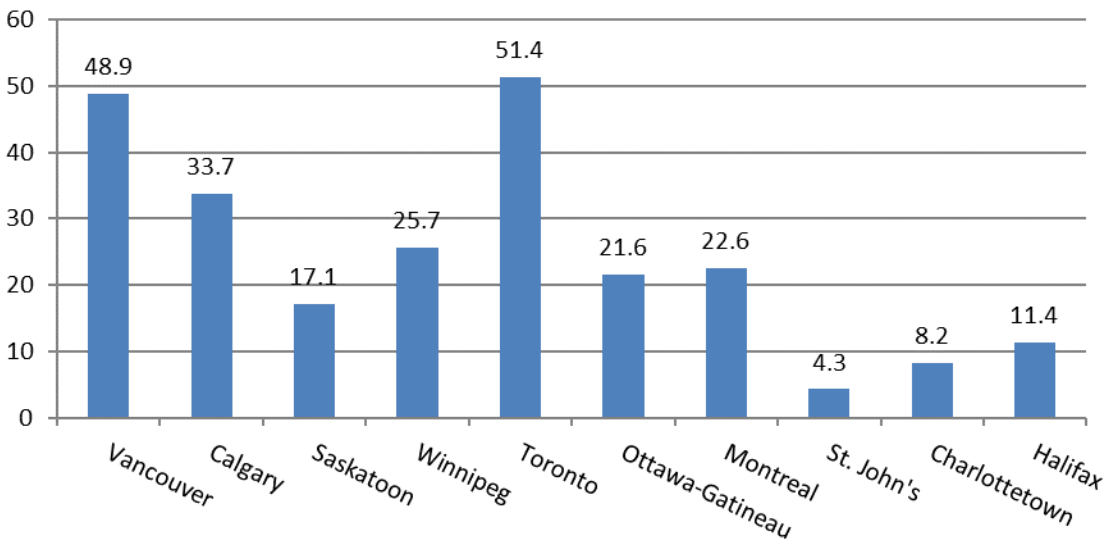


Figure 4. Percentage of population in select census metropolitan areas (CMAs)* that identified as racialized in 2016⁹



* Census metropolitan areas, as defined by Statistics Canada, may be larger than the area under a city's administration, leading to bigger population sizes in the CMAs.

Meeting the mental health needs of IREER populations

Studies show that the rate of health service use is low among people living with mental health problems or illnesses in IREER populations; however, this finding may mask a greater use of more costly, higher intensity services over time, such as those offered by hospitals or forensic psychiatric services.² In many cases mainstream mental health care is inconsistent with the values, expectations, and patterns of immigrants and refugee populations.¹¹ Although mental illnesses have similar symptoms across cultures, the ways people manifest, describe, and interpret symptoms vary across cultures. Similarly, culture influences where people seek help and which treatments they prefer.^{12,13}

A significant body of research demonstrates that early intervention improves outcomes and can reduce costs, which means that addressing the mental health needs of IREER populations, can result in cost savings for the health care system and the economy as a whole.² That said, the evidence also shows that one size does not fit all when it comes to providing mental health services.² While policy makers and system and service planners must work to improve access to timely and culturally and linguistically appropriate mental health services, there is a need to first address the lack of research on how to distinguish the mental health needs of racialized immigrants and refugees from those of racialized populations born in Canada.²

To support evidence-informed decision making, more research is required that explores the myriad differences and distinct needs within immigrant and racialized populations and how these relate to mental health and health outcomes.² While the research indicates that ethnic background and race play a significant role in health status, outcomes, and the quality of care received,,, sociodemographic data are not routinely collected in Canada's health settings.² As a result, the relationship between race and migration (along with other aspects of identity) and access to mental health services and outcomes is not well documented or understood. Only the consistent collection of sociodemographic data – that enables health systems to identify disparities in access and outcomes and develops responses that improve programs and services for all populations – will change the situation. In short, sociodemographic data collection is fundamental to identifying and addressing inequities in health and mental health.¹⁴

The Social Determinants of Health

The circumstances in which people live, work, and grow, along with the wider systems that influence people's lives, are known as the social determinants of health.²

Social determinants can increase or decrease a person's risk of developing a mental health problem or illness and can limit access to timely and appropriate mental health care.² IRER populations in Canada are more exposed to the social determinants that are known to contribute to mental health problems and illnesses.¹¹ In the sections that follow, this report will explore 2016 Census data as it relates to six social determinants of health:

- Language
- Language and the aging population
- Income disparities
- Education and employment income
- Unemployment and underemployment
- Discrimination and hate

Language

Whether or not a person can access mental health services in their language of choice is an indicator of equity in access to mental health services and is central to getting adequate care and treatment.

For mental health services to be accessible it is necessary for service users to be highly proficient in the language in which the service is being offered. A language barrier can be enough to stop newcomers from seeking services, since it could make it difficult for them to navigate the system or convey their feelings, thoughts, and symptoms.¹¹

The number of people who reported having a mother tongue other than English or French has, since 2011,¹⁵ risen to 7,260,080 (about 21% of Canada's population). According to the 2016 Census, 75.5% of those with an immigrant mother tongue lived in one of the country's six largest CMAs: Montreal, Ottawa-Gatineau, Toronto, Calgary, Edmonton, and Vancouver. While most newcomers speak a mother tongue other than the two official languages, many speak some English or French. Among the immigrants who arrived between 2011 and 2016, 106,770 (8.9%) reported not speaking either official language.¹⁵

Unlike the justice system, where interpretation services are mandated, the health system often relies on children, family members and non-medical staff to provide

them.¹¹ Even when these are available in health settings, service providers are often not taught how to use them appropriately.¹¹ Issues pertaining to language barriers that prevent adequate access to health services are particularly complicated for the aging immigrant population, whose first language may not be English or French.

Language and an aging population

In the Greater Toronto Area, seniors are more likely to report poorer (self-rated) mental health if they are a recent immigrant, are racialized, or have a mother tongue other than English or French.¹⁶

Not only is Canada's population aging,^{17,18} as of 2016 the segment that is 65 or older is becoming more diverse,¹⁹ with nearly one-quarter reporting a mother tongue other than English or French.²⁰ In addition, an estimated 1.8 million seniors in the country currently live with a mental health problem or illness,²¹ a number that could reach three million by 2041.^{21,22} Undoubtedly, an inability to communicate with your health care providers due to language barriers or lack of proficient interpretation services, especially if you are living with mental health problems or illnesses (including dementia), can affect comprehension, the ability to convey information and, consequently, the quality of care you receive.

In addition, over half a million people in Canada live with dementia.²² The likelihood of experiencing dementia increases with age, with about 35% of seniors over the age of 90 living with cognitive disorders that include dementia.²¹ For individuals living with dementia, access to linguistically appropriate care is essential since, as research shows, such individuals whose first language differs from that of the host country tend to revert to their mother tongue and have greater difficulty understanding and comprehending the second language they acquired later in life.²³⁻²⁶ Recognizing that the language older Canadians use at home may not be English or French, and that proficiency in second and third languages can deteriorate due to illness, health care systems must make a more concerted effort to address the linguistic needs of its diversifying, aging population.

The number of seniors who speak an immigrant non-official language most often at home grew between 2006 and 2016^{27,28} Table 1 lists the top 10 such languages across Canada, which have changed between 2006 and 2016 as a result of shifting demographics. Tracking this data is important for understanding what is needed regarding workforce planning (i.e., people working with seniors) and interpretation services.

Table 1. The 10 immigrant languages spoken most often at home among all Canadians and seniors (65+) in 2006 versus 2016^{27,28}

	All Canadians 2006	All Canadians 2016	Canadians 65+ 2006	Canadians 65+ 2016
1	Chinese (unspecified) 341,480	Mandarin 462,890	Italian 106,115	Cantonese 111,580
2	Cantonese 300,595	Cantonese 400,215	Chinese (unspecified) 54,440	Italian 93,265
3	Punjabi 278,500	Punjabi 349,140	Cantonese 49,795	Punjabi 62,915
4	Spanish 209,955	Spanish 263,510	Punjabi 33,185	Mandarin 42,385
5	Italian 170,330	Arabic 223,540	German 29,420	Portuguese 36,655
6	Arabic 144,745	Tagalog 213,790	Portuguese 28,355	Spanish 28,450
7	Mandarin 143,385	Persian 143,020	Greek 22,275	Greek 27,340
8	German 128,345	Urdu 128,785	Polish 16,295	Tagalog 25,130
9	Tagalog 119,340	German 120,330	Spanish 15,440	German 20,880
10	Vietnamese 111,440	Russian 116,595	Tagalog 13,835	Arabic 20,535
Totals	3,342,790	3,878,725	537,820	705,265

Income

Low income, particularly when experienced in combination with unemployment, severely limits a person's access to timely mental health services in Canada.

The 2016 Census shows a significant disparity in income between immigrants and non-immigrants. The Census also illustrates that a disproportionate number of immigrant and racialized households qualify as low income.^{*} The median annual income for the immigrant population in Canada is at least \$6,000 less than for non-immigrants.²⁹ This disparity is even more pronounced for newcomers who arrived between 2011 and 2016; their median annual income was \$13,400 less than that of non-immigrants.²⁹ While slightly less pronounced, this same income gap also occurs between racialized and non-racialized populations, with the former group earning \$11,024 less.³⁰ Such income disparities negatively affect people's mental health and reduce their ability to access mental health services, since many interventions, like psychotherapy, require individuals to pay out of pocket.^{31,32} A key part of fostering health equity is therefore expanding access to publicly funded mental health services that are culturally and linguistically appropriate.

Low income is a social determinant of health that strongly interacts with others like food insecurity and housing. There is a clear link between low income, financial insecurity, poverty, and mental illness.^{†11,33,38} Even *perceived* low-income can affect people's access to primary health care³⁷ – which is significant since primary care physicians deliver up to two-thirds of all mental health services in Canada.³⁹ Longitudinal research from the U.S. has showed that reductions in income levels over

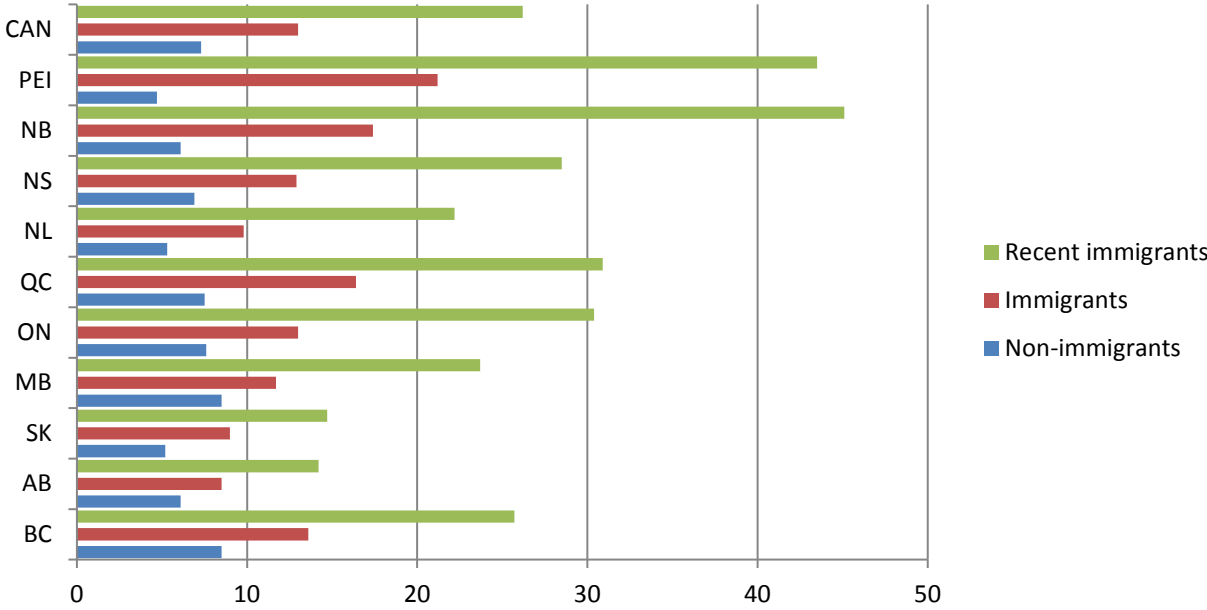
* Statistics Canada uses a LICO-AT (low-Income cut-offs, after tax) measure, which refers to an income threshold below which economic families or persons not in an economic family would likely have devoted a larger share (20% or more) of their after-tax income than average to the necessities of food, shelter, and clothing.⁷

† See, for example, the *Hamilton Spectator's Code Red Hamilton* series.

a three-year period raises the risk of mood, anxiety, or substance use problems significantly.⁴⁰ The study also found that increases in household income over the same period did not appreciably change the likelihood of a mental health problem or illness.⁴⁰

In 2015, the 9.2% of Canadians fell below the LICO-AT threshold.⁴¹ Yet, a larger percentage of immigrants (13%) and racialized Canadians (16.4%) fell below this threshold than did non-immigrant (7.3%) or non-racialized Canadians (7.1%; see figures 5-7).^{7,42} In fact, the proportion of the racialized population living below LICO-AT in any province is at least twice⁷ – and in some cases ten times – that of the non-racialized population.⁴² That said, low-income rates across immigrant generations vary greatly for racialized and non-racialized Canadians.⁴²

Figure 5. Percentage of population in low income after tax (LICO-AT) by immigration status for Canada and provinces⁷



* Statistics Canada does not apply LICO-AT to the territories. The existence of substantial in-kind transfers and sizeable barter economies or the consumption of one’s own production (such as product from hunting, farming, or fishing) could make the interpretation of low-income statistics more difficult in these situations.⁴²

Figure 6. Percentage of population in low income after tax (LICO-AT) by immigration status for select CMAs⁷

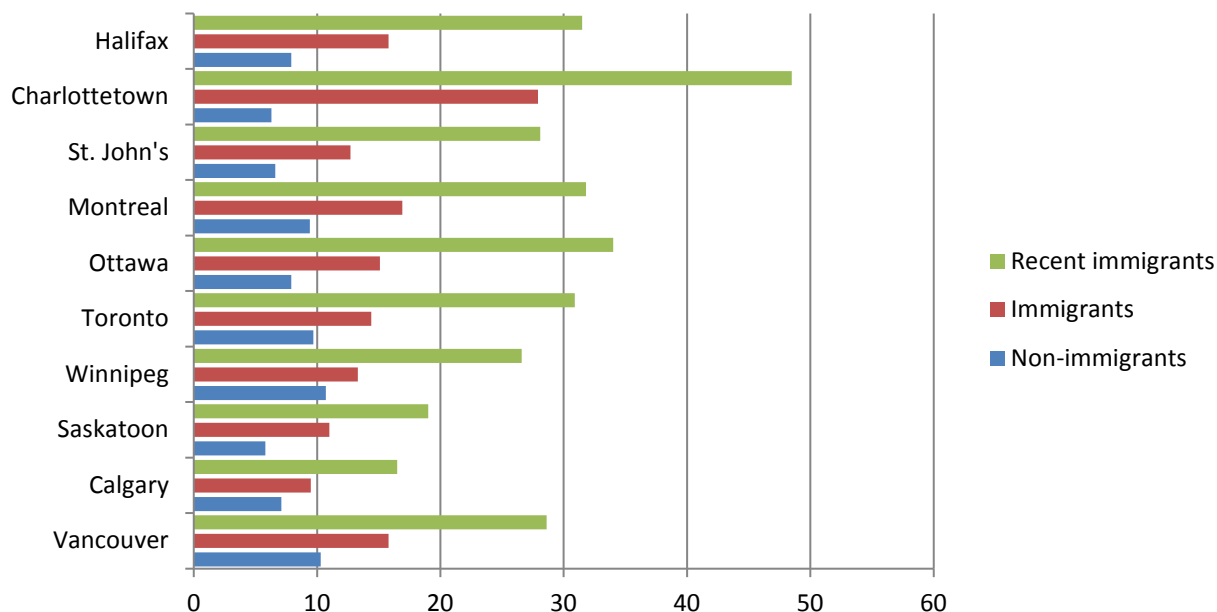
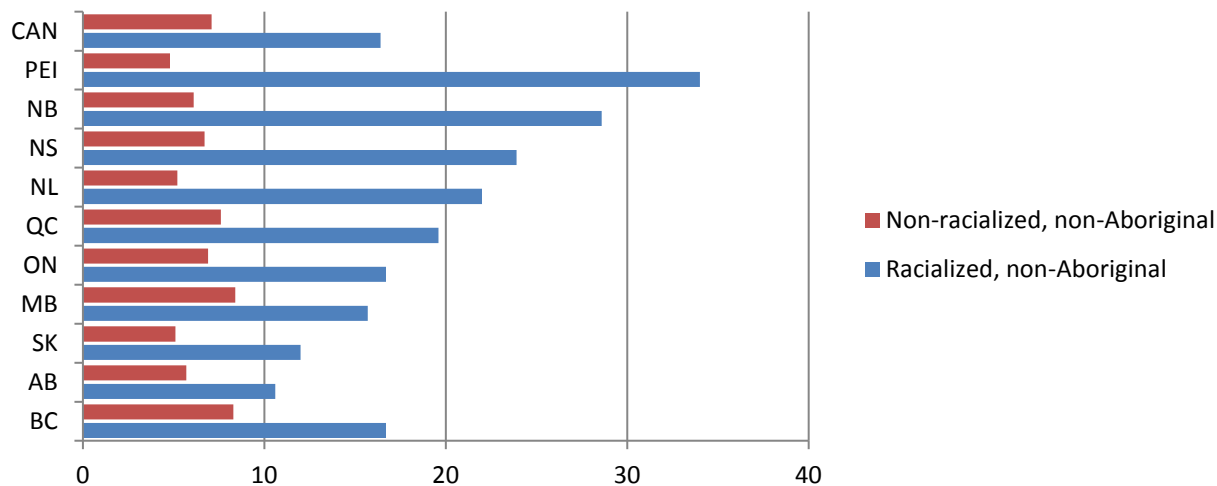


Figure 7. Percentage of population in low income after tax (LICO-AT) by (non-Aboriginal) racialized status for provinces and territories⁴²



Regardless of how long particular immigrants have been in Canada (or where they live), in 2015 they were more likely than non-immigrants to live below the LICO-AT threshold (see figures 5 and 6). While the percentage of immigrants living with low-incomes is similar across provinces, greater fluctuations by province exist for people who arrived between 2011 and 2016.⁵ With specific racialized populations, the percentages of those living below the LICO-AT threshold ranges widely, from 6.3% for Filipino Canadians to

more than 25% for Arab, West Asian, and Korean Canadians.⁴² While the data does not provide reasons for these differences, it indicates that a one-size-fits-all approach is inadequate to meet the needs of different populations. The percentage of racialized populations living below LICO-AT decreases in relation to the time lived in Canada. In several provinces (N.B., N.S., N.L., Que.), however, the percentage of second generation racialized Canadians living below LICO-AT is lower than first and third generation groups.⁴²

Two-thirds of immigrants in any given year between 2000 and 2012 experienced chronic low-income* (i.e., lasting five years or longer).⁴³ While chronic low-income among immigrants did improve over that time,⁴³ it did not rise as quickly as for the Canadian-born comparison group.⁴³ The highest rates of chronic low-income are experienced by immigrants over 65, at 30% among those in Canada for 20 years or less and 50% among more recent immigrants.⁴³

Education and employment income

Research suggests that when mismatches occur between education and occupation levels, higher rates of depression and mental illness can occur.^{44,45}

In general, immigrant populations have higher levels of education and are more likely to have post-secondary degrees than people born in Canada. Nearly half (44%) of those who immigrated between 2011 and 2014 hold a bachelor's degree, and more than 15% hold a master's, doctorate, or medical degree (see Table 2). These trends are in large part due to the six selection factors used in the federal skilled workers program (the points system). The second highest proportion of all immigrants admitted to Canada in 2016⁴⁶ entered under this program, which awards the most points to graduate degree holders.⁴⁷

Yet, despite these higher levels of education, immigrants earn less on average than people born in Canada. Immigrants working full time in 2015 earned less than non-immigrant Canadians with the same degree (see figures 8 and 9). Recent immigrants with the highest post-secondary education rates earned the least among full-time workers.⁴⁸ Women, whether immigrant or non-immigrant, earn less than their male counterparts across all categories, making recently arrived immigrant women among the lowest income earners in Canada.^{48,49}

* This study uses an *adjusted* low-income measure (LIM): the national LIM multiplied by a city-specific factor for differences in the cost of basic necessities.⁴³

Based on available Census data, it is difficult to determine if people are employed in the professions they are trained for or are in jobs that are commensurate with their education levels and experience. It is likely that a high proportion of recent immigrants work in “survival jobs” that do not reflect their education or related pay levels.^{50,51} Strict regulations and other barriers to credential recognition make it more difficult for some to find work in their fields, specifically, lawyers, engineers, physicians, and other regulated health professionals. These obstacles are probable influences on the observed differentials in median incomes between immigrant and non-immigrant populations. To this extent, overqualification, defined as employment in an occupation below an individual’s skill or experience level,^{52, 53} is prevalent among immigrant populations in Canada.⁵³ Still, although overqualification is negatively associated with life satisfaction, this association weakens over time spent in Canada.⁵³

Figure 8. Median employment income earned by immigration status and highest degree earned for full-time workers in 2015⁴⁸

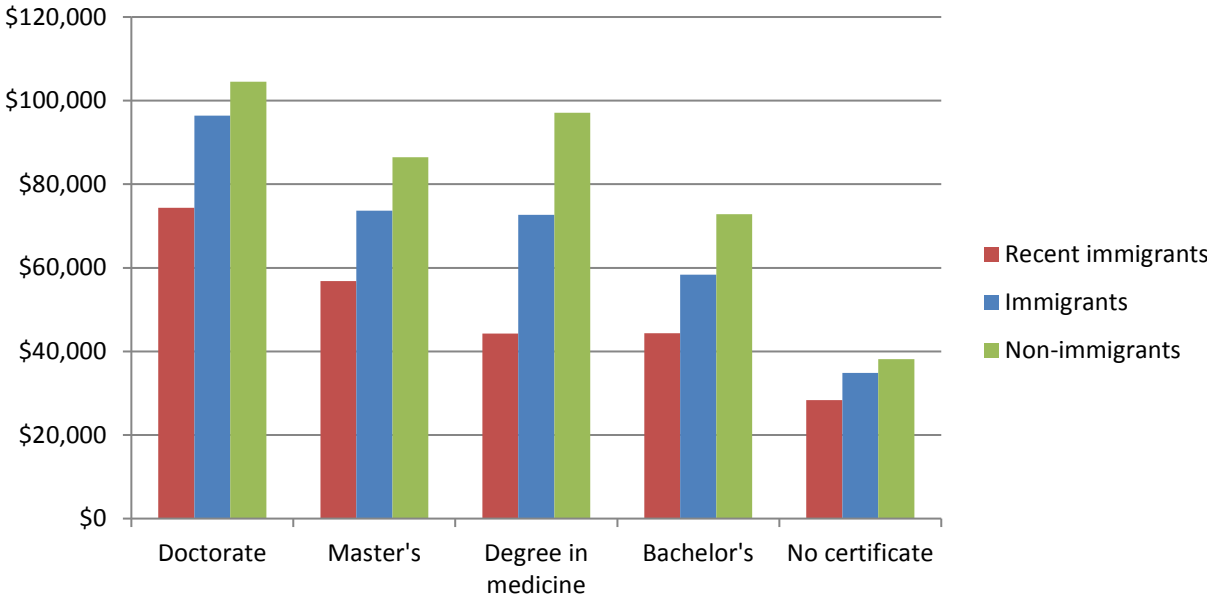


Figure 9. Median employment income earned by immigration status and highest degree earned for full-time workers in 2015 by sex⁴⁸

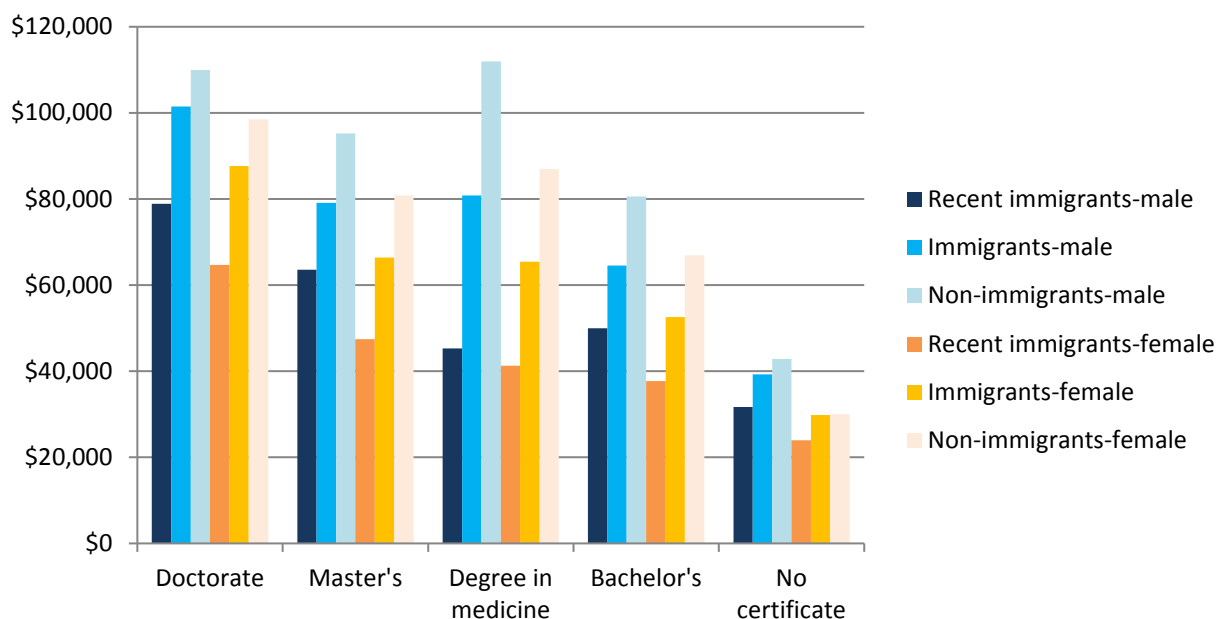


Table 2. Percentage of population based on immigration status with select earned degrees (Age 15+)⁵⁴

	No degree	Bachelor's degree or higher*	Master's degree, doctorate, or earned medical degree
Non-immigrant	18.78%	19.64%	4.46%
Immigrant	17.38%	32.53%	10.40%
Recent immigrant	14.94%	44.16%	15.25%

Unemployment and underemployment

Unemployment and poor-quality employment are particularly strong risk factors for mental health problems and illnesses. But the causal relationship between unemployment and mental health is complex, since people dealing with mental health issues are more likely to be unemployed.^{40,55,56}

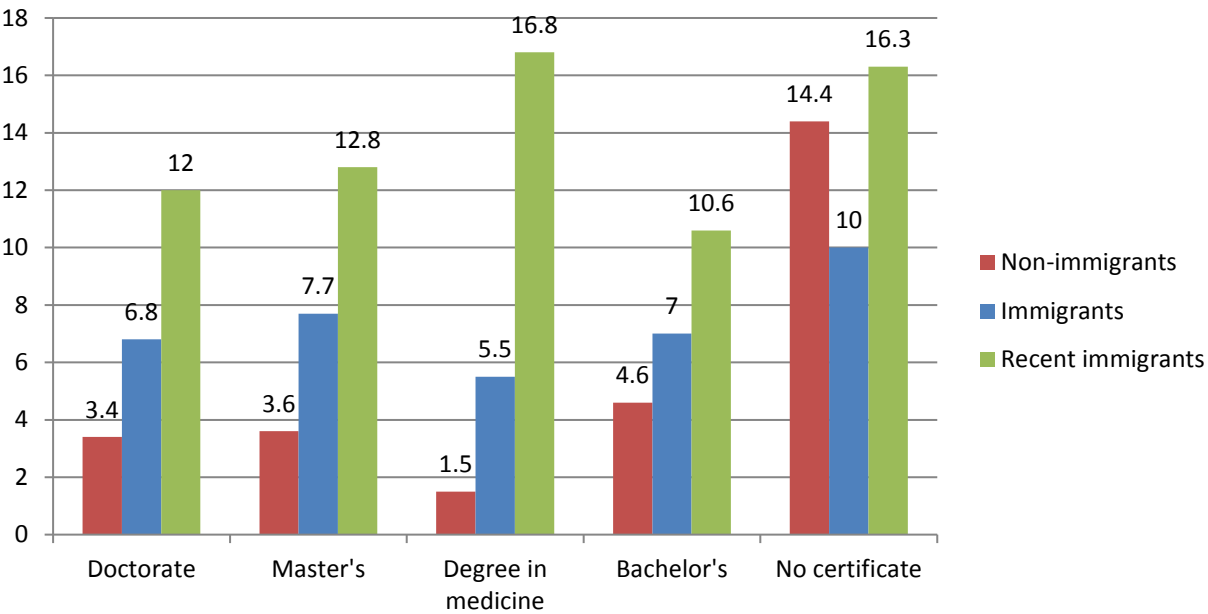
Precarious employment situations, such as fluctuating unemployment, low wages, underemployment, and undesirable employment due to insecure job markets, may have a detrimental effect on mental health.⁵⁷⁻⁵⁹ When, on the other hand, employment is

* Bachelor's degree or higher refers to the Statistics Canada category "University certificate, diploma or degree at bachelor level or above."

meaningful, worthwhile, and challenging, it is an important part of overall health and wellbeing, contributing to financial security, positive social interactions, and personal growth and development.

The pattern of unemployment among non-immigrants, immigrants, and recent immigrants is similar across all levels of education (see Figure 10), with recent immigrants experiencing the highest rates of unemployment, and non-immigrants experiencing the lowest.⁶⁰ The main exception is for those who have no certificate, diploma, or degree or else have a certificate in the trades. In all such cases, immigrants have lower rates of unemployment than non-immigrants.⁶⁰ In 2016, unemployment in Canada was relatively low at 7.7%.⁶¹ While immigrants had this same rate of unemployment,⁶⁰ for racialized populations it was 9.2%.⁶² Those without any certificate (i.e., without a high school diploma) had the highest rates of unemployment.⁶⁰ Recent immigrants (arriving between 2011 and 2016) with a doctorate are 3.5 times more likely to be unemployed than non-immigrants with the same level of education (see Figure 10).

Figure 10. Percentage of unemployed Canadians age 15 and older by immigration status and highest degree earned⁶⁰



Research with immigrant and racialized populations indicates that unemployment and precarious employment significantly impact mental health.⁶³⁻⁶⁶ One of these studies shows that when unemployment occurs soon after arrival, it greatly influences mental health and well-being.⁶³ A second study concludes that high rates of neighbourhood unemployment take a psychological toll on first generation immigrants, more so than

on non-immigrants living in the same neighbourhood.⁶⁴ Precarious employment status is likely to be more of a burden for immigrant women, especially among those who are racialized.⁶⁵ Immigrant women in such situations report numerous emotional and mental health symptoms, including insomnia, anxiousness, panic attacks, a sense of helplessness, and continuous feelings of stress.^{65,66}

Discrimination and hate

Discrimination is a key determinant of mental health, and it impacts immigrant and racialized populations^{8,64-68} in many ways, including socially inflicted trauma (indirect or witnessed), social inequality, and inadequate, inappropriate, or degrading medical care.^{67,68}

Canadian longitudinal data⁶⁹ reveals an association between perceived discrimination and a deterioration of self-reported mental health for immigrants after arrival. Not only can discrimination weaken mental health for immigrant and racialized populations, it can also discourage help-seeking behaviours.^{11,70,71} When immigrants and racialized populations have experienced discrimination or have the perception (or expectation) of discrimination in accessing services, they are less likely to look to the health care system for help;^{11,70,71} instead, they may opt for non-medical services for their mental health concerns.⁷⁰

Reported hate crimes in Canada

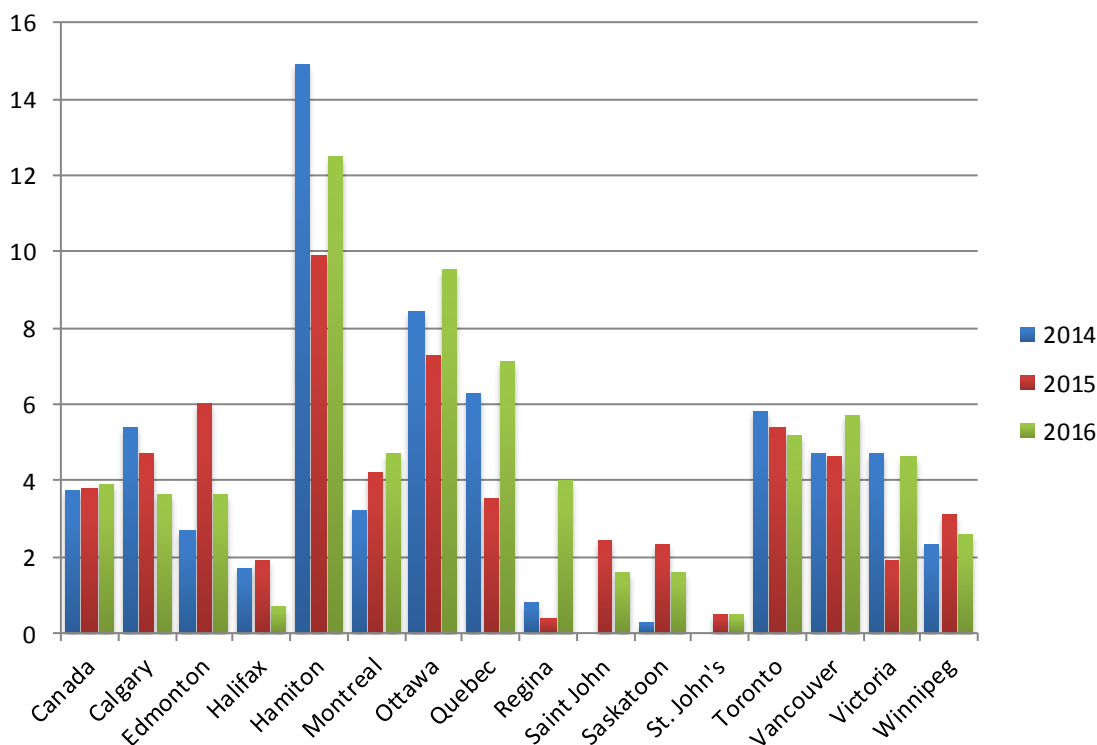
Rates of discrimination and hate crimes are difficult to understand and measure, especially because of under-reporting and a lack of uniformity in data sources.⁷² While police services collect and report on hate crimes, the reports are limited by the number of cases that are directly reported, which is likely lower than the rates of occurrence.^{72,73} Statistics Canada asks Canadians to self-report discrimination and victimization in hate crimes through its General Social Survey.⁷⁴⁻⁷⁶ This annual survey provides at least some understanding of who the targets of these behaviours are as well as the general patterns and trends over time.⁷²

Yet there are marked differences across the country's biggest CMAs regarding the prevalence and motivations for hate crimes. From 2014 through to 2016, the number of hate crimes reported to police was approximately 4 per 100,000 people nationally. However, the rates are either lower or higher than this in different CMAs (see Figure 11), ranging from less than one case per 100,000 in Halifax and St. John's to 12.5 per 100,000 in Hamilton.⁷³

Although the percentage of reported hate crimes for the country remained stable from 2014 to 2015 and 2015 to 2016, some CMAs saw dramatic changes.⁷³ Those that are smaller may have greater swings from year to year because overall numbers are low. For instance, reported hate crimes in Edmonton increased by 122.2% between 2014 and 2015 (rising from 36 to 81 incidents) but dropped by 40% between 2015 and 2016.⁷²

In Quebec City, reported hate crimes decreased by 44.4% from 2014 to 2015 (from 50 down to 28 incidents) and increased by 102.9% from 2015 to 2016, with 57 crimes per 100,000 in 2016.⁷³ Such changes may reflect actual changes in the number of hate crimes from one year to the next or a change in desire to report.

Figure 11. Hate crimes per 100,000 persons: Canada and select CMAs (2014, 2015, 2016)⁷³



What motivates hate crimes and who is affected?

The most common type of hate crime is motivated by race or ethnicity.⁷³

In 2014, there were 611 ethnically or racially motivated hate crimes committed in Canada; in 2015, there were 641 reported incidents, and in 2016, there were 666. Black Canadians reported the highest number of crimes in each of these years (see Figure 12).

Self-report survey data suggests that non-immigrant Canadians experience greater levels of violent victimization^{*} than immigrants,^{74,75} and Canadian-born individuals who are members of a racialized population have a much higher rate of self-reported violent victimization than racialized immigrants.⁷⁵ While the reasons for this higher number of reports are not clear, both racialized Canadians and immigrants report less satisfaction about the actions of police.^{74,75} Over half the immigrants (53%) who reported being victims of a crime did not report it to police,⁷⁴ but three-quarters did not believe the crime was motivated by hate.⁷⁴ When they did report a crime, immigrants had a lower opinion (55%) of police action compared to non-immigrants (28%).⁷⁴ Racialized Canadians were less likely than non-racialized Canadians to say police were approachable and easy to talk to and twice as likely to report an experience of discrimination when dealing with the police (in the five years before the survey).⁷⁵

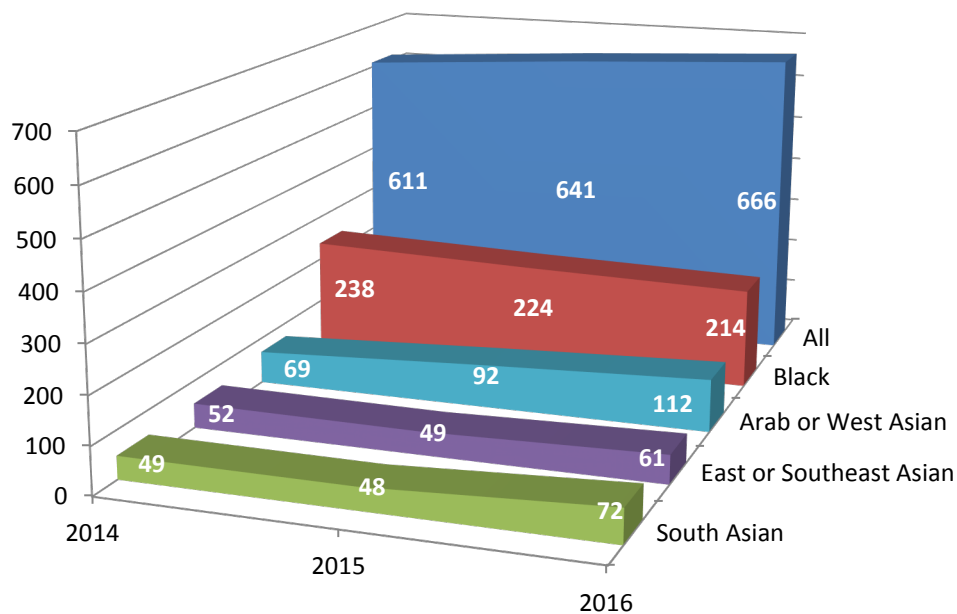
Hate crimes reported to the police that targeted Black Canadians have decreased each year since 2012. Since 2013, however, the number targeting Arabs[†] and West Asians[‡] has increased.⁷³ Police services also document motivation by sexual orientation and religion. Religiously motivated hate crimes predominantly target Jewish and Muslim Canadians,⁷³ and self-reported victimization rates indicate that non-Christians are more likely to be victims of discrimination than Christians.⁷⁶

* This includes sexual assault, robbery, and physical assault.⁷⁴

† The term *Arab* is used by Statistics Canada in their visible minority category and reports; it is based on the *Employment Equity Act*.⁷⁷

‡ The term West Asian is used by Statistics Canada in their visible minority category and reports as follows: “West Asian (e.g. Iranian, Afghan, etc.).”⁷⁷

Figure 12. Hate crimes in Canada by motivation type race or ethnicity (select groups)⁷³



Conclusion

Ensuring IRER populations have equitable access to mental health services requires action on the social determinants of health, a focus on mental health promotion and illness prevention, and a commitment to developing culturally responsive, safe, and accessible services and systems that meet their needs.²

Using 2016 Census data, this paper demonstrates that IRER groups continue to experience a range of equity issues that can impact their mental health and wellbeing, including discrimination, underemployment, and low-income. The rapid growth of IRER populations in all parts of the country presents provinces and territories with a responsibility to provide equitable health and mental health services to meet their needs. One approach the jurisdictions can take is to create population-based plans that tailor service development to their wider demographic imperatives.¹¹ To do so, services and systems must first collect sociodemographic data at the point of accessing services to identify gaps and inequities in health-care access and outcomes and to develop and track service system responses.¹⁴

In light of the ongoing issues outlined in the paper, the MHCC plans to examine progress on the key recommendations in the [Issues and Options](#) report. In partnership with the Centre for Addiction and Mental Health, the MHCC will review federal, provincial, and

territorial policy documents to identify governmental priorities for improving the experiences of IRER groups (in relation to the social determinants of health) and increasing access to more culturally safe and competent mental health services.

This policy scan will also identify areas of progress as well as opportunities where activities to enhance supports for IRER mental health and wellbeing can be strengthened. In addition, it will provide insights to assist decision makers on where best to focus their efforts.

The Canadian government's immigration targets will invariably bring greater diversity. Some projections suggest that, by 2036, between 24.5% and 30%⁷⁸ of people living in Canada will have been born elsewhere. Fostering and supporting the physical and mental health of all newcomers, and ensuring that all people living in Canada can access equitable, quality mental health services to support them to live satisfying, hopeful and contributing lives, are drivers of Canada's social and economic vibrancy. Ultimately, the settlement, integration, and success of newcomers is a shared responsibility across jurisdictions.

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