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Self-perceived mental health and mental health care needs during the COVID-19 pandemic

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Self-perceived mental health and mental health care needs during the COVID-19 pandemic

Throughout the pandemic, various public health measures have been implemented across the country, impacting employment, schooling, family relationships and leisure. For some individuals, these measures, in combination with fears associated with the risks stemming from COVID-19, have contributed to feelings of greater stress, anxiety and loneliness, which in turn, may have an impact on overall mental health and perceived mental health care needs. Health care delivery changed within most jurisdictions during the pandemic, including shifts in the delivery of in-person services and greater reliance on care provided virtually or by telephone. These mitigation strategies to contain the spread of COVID-19 and changes to the availability and accessibility of health care may have had various effects on Canadians' mental health and the care they received.

After a brief pause respecting lock downs and public health, the Canadian Community Health Survey (CCHS) resumed collection in September 2020 with telephone surveys only. The 'Methodology' section highlights the data validation undertaken to better understand the impacts of this methodology change.

This article examines CCHS data on self-perceived mental health and mental health care needs before the pandemic (October to December 2019) and during the second wave of the pandemic in the fall of 2020 (September to December 2020).

Perceived mental health declined compared to pre-pandemic, particularly for females

In the fall of 2020, close to two-thirds (63.9%) of Canadians aged 12 and older reported positive mental health (excellent or very good).

Compared to data collected during the fall of 2019, the proportion of Canadians reporting positive mental health declined slightly in 2020. This change is mainly attributed to a decline for females from 63.0% to 59.9%. Over the same period, the proportion of males reporting positive mental health remained stable (Table 1).

When looking at changes in positive mental health by age group, Canadians aged 50 to 64 were the only age group where a significant decline was observed between the fall of 2019 and the fall of 2020. The proportion of those reporting positive mental health remained similar between both periods for all other age groups. Compared to other age groups, the proportion of young adults aged 18 to 34 reporting positive mental health was consistently lower during both periods.

Residents of Quebec (69.8%) were more likely to report positive mental health compared to all other regions during the fall of 2020. Across all regions, the reported positive mental health remained consistent with the figures from the fall of 2019.

While estimates of the population reporting very good or excellent mental health can indicate how many Canadians are in a state of positive well-being and emotional stability, the other end of the self-perceived mental health spectrum (fair or poor) is often correlated with symptoms of mental disorders or distress (Mawani and Gilmour, 2010). In the fall of 2020, the proportion of the population reporting fair or poor mental health increased among females (from 9.1% in 2019 to 11.7% in 2020), and among those aged 35 to 49 (8.2% to 11.1% respectively) and those aged 50 to 64 (7.0% compared to 9.7%).

While there was no regional statistical differences when comparing positive mental health status between the fall periods of 2019 and 2020, there was an increase in the percentage of Quebec and Ontario residents who indicated a poor or fair mental health status between 2019 and 2020 (from 4.6% in 2019 to 7.4% in 2020 for Quebec, and from 9.7% in 2019 to 12.1% in 2020 for Ontario).

Table 1
Self-perceived mental health, by age, sex, and provincial region, Canada excluding the territories, October to December 2019 and September to December 2020

	Excellent or Very Good Mental Health		Fair or Poor Mental Health	
	2019 (October to December)	2020 (September to December)	2019 (October to December)	2020 (September to December)
	percent			
Overall	65.8	63.9*	8.9	10.5*
Sex				
Male	68.7	68.1	8.6	9.2
Female	63.0	59.9*	9.1	11.7*
Age groups				
Aged 12 to 17	72.1	67.1	6.6[E]	9.0
Aged 18 to 34	56.4	57.5	14.2	14.9
Aged 35 to 49	66.0	63.4	8.2	11.1*
Aged 50 to 64	70.4	64.9*	7.0	9.7*
Aged 65 and older	71.3	70.4	5.0	5.6
Geographical Regions				
Atlantic provinces	61.7	63.0	11.0	11.9
Quebec	72.1	69.8	4.6	7.4*
Ontario	64.7	61.9	9.7	12.1*
Prairie provinces	64.4	63.0	10.1	10.1
British Columbia	62.2	61.0	10.9	11.1

[E] use with caution
* significantly different from reference category ($p < 0.05$))

Note: Atlantic provinces include residents of Newfoundland and Labrador, Prince Edward Island, Nova Scotia and New Brunswick. Prairie provinces include residents from Manitoba, Saskatchewan and Alberta.
Source: Canadian Community Health Survey, October to December 2019 and September to December 2020.

A previous study through a crowdsource initiative at Statistics Canada found that some groups designated as visible minorities, immigrants, Indigenous people and sexual minority reported higher rates of discrimination during the COVID-19 pandemic (Statistics Canada, 2020a). Statistics Canada has also reported that LGBTQ2+ Canadians may be particularly vulnerable to negative impacts from the pandemic (Prokopenko & Kevins, 2020), and some population groups have experienced greater consequences to their economic well-being (Statistics Canada, 2020b). The disproportionate impacts to diverse groups may have a greater effect on their perceived mental health.

Among groups designated as a visible minority (68.1%), a higher proportion reported positive mental health compared to non-visible minorities (62.6%). Some visible minority groups, including South Asian (70.2%), Filipino (74.2%) and Arabic (75.4%) were more likely to report positive mental health compared to non-visible minorities during the fall of 2020. All other groups designated as a visible minority did not have a statistically significant difference compared to the non-visible minority population.

During the fall of 2020, recent immigrants living in Canada for less than 10 years since immigration were more likely to report positive mental health (74.2%) in comparison to established landed immigrants (65.5%), and Canadian-born (62.5%).

Indigenous people (53.2%) were less likely to report positive mental health compared to non-Indigenous people (64.3%) during this 2020 reference period. During the same period, 46.9% of First Nations people living off reserve reported positive mental health which was lower than for non-Indigenous people. At 59.2%, the proportion of Métis reporting positive mental health was not statistically different from non-Indigenous people. Due to low sample size, the estimate for Inuit living outside of Inuit Nunangat is not released.

A much lower proportion of LGBTQ2+ Canadians (lesbian, gay, bisexual, transgender, queer or Two-Spirit or persons reporting another non-binary gender or minority sexual identity) aged 15 and older reported positive mental health during the fall of 2020. Compared to LGBTQ2+ Canadians, non-LGBTQ2+ Canadians were 1.5 times more likely to report positive mental health (39.9% vs. 64.6% respectively).

Perceived need for mental health care

Individuals may have a need for mental health care in the form of counselling, therapy, medication, information, or other types of care, for help with their emotions, mental health disorders and their use of alcohol or drugs. Given the impact of the COVID-19 pandemic on the mental health of Canadians, understanding how these needs are being met across Canada, and the perceived barriers to meeting the required care is especially important.

During the fall of 2020, almost one in five Canadians (18.1%) aged 12 and older reported that they needed some help with their mental health in the past year. Among those who perceived a need, slightly more than half (55.0%) felt their needs were fully met (i.e., they received some form of care or help and did not report needing additional care). The remaining (45.0%) felt that their needs were either unmet (i.e., some care was needed but none was received) (22.5%), or only partially met (i.e., some care was received but was not sufficient) (22.5%).

One in four Canadians aged 18 to 34 reported a need for mental health care

While Canadians aged 18 to 34 were less likely than other age groups to report excellent or very good mental health during the fall of 2020, they were also the most likely to indicate they had a need for mental health care in the past year (Table 2). Among the 18 to 34 year olds who perceived a need for mental health care, 53.0% reported their need was unmet or partially unmet. This was a higher proportion of unmet need compared to all age groups except those aged 35 to 49. Compared to any other age groups, seniors aged 65 and older were less likely to report a perceived need for mental health care (7.4%).

Table 2
Perceived need for mental health care, by age group, Canada excluding territories, September to December 2020

	Had a perceived need for mental health care in the past year	Perceived need unmet or partially unmet
	percent	
Overall	18.1	45.0
Aged 12 to 17	17.1	39.8
Aged 18 to 34	25.5	53.0
Aged 35 to 49	21.8	46.5
Aged 50 to 64	15.4	34.5
Aged 65 and older	7.4	33.1

Source: Canadian Community Health Survey, September to December 2020.

An individual may report requiring different types of care for their mental health, and the degree to which these types of care are met, also vary. It's not unlikely that individuals will report needing an array of concurrent types of mental health care services to meet their needs. Among those who perceived a need for mental health care, 75.6% indicated that it was for counselling or therapy, 44.0% reported a need for information, 44.4% reported a need for medication and 6.2% reported other needs. Just over half of those requiring counselling or therapy (51.0%) had their needs met, 70.8% had their needs for information met and 87.0% had their needs for medication met. Among those who indicate they needed other types of care, 93.6% had their needs met.

There are multiple reasons why people may not get the help that they need for their mental health. In the fall of 2020, 78.5% of people with unmet or partially unmet mental health care needs reported personal circumstances as a barrier. Examples of personal circumstances include a lack of knowledge as to where to get help, not being able to get around to get help (or simply not bothering to get help), employment-related barriers (e.g., not being able to leave work), income related barriers, fear of what others would think, lack of trust in the health care system, and lack of insurance coverage. Further, one-quarter (25.5%) reported that they prefer to manage the need on their own, and 20.9% reported that features of the health care system such as language problems or the service care not being readily available constituted a barrier to their care needs. Respondents could report multiple barriers for their unmet or partially met mental health care needs.

The survey findings show that most Canadians appear to have maintained what they perceive to be very good or excellent mental health in the fall of 2020 during the second wave of the pandemic although certain groups, such as women, people aged 35 to 64, as well as Quebec and Ontario residents reported a significant decline in mental health as seen in the increase in the proportion reporting fair or poor mental health in the fall of 2020 compared to the same period in 2019.

Methodology

This article uses data from the Canadian Community Health Survey (CCHS) collected in September to December 2020. Data collected in October to December 2019 is used as reference for the mental health of Canadians prior to the pandemic.

Although data for both years are from the Canadian Community Health Survey, the 2020 cycle of the survey had some differences. In March 2020, the CCHS collection was paused and did not resume until September 2020— at which point the collection periods transitioned from 3 month periods to five week periods. In person interviews were halted for the CCHS and collection was only completed via telephone interview.

Some bias was discovered in the 2020 cycle of CCHS, which is likely attributed to the limitations to survey collection in the pandemic, including the decreased response rate and the use of telephone interviews only. Based on weighted estimates, results show that respondents interviewed during the pandemic (September to December 2020) appear to have slightly higher educational attainment and they were slightly more likely to own their place of residence compared to previous cycles.

As was done for previous CCHS cycles, for the 2020 data, survey weights were adjusted to minimise any potential bias that could arise from survey non-response; non-response adjustments and calibration using available auxiliary information were applied and are reflected in the survey weights provided with the data file. Extensive validations of survey estimates were also performed and examined from a bias analysis perspective. Despite these rigorous adjustments and validations, the higher non-response increases the risk of a remaining bias as well as increasing the magnitude with which such a bias could impact estimates produced using the survey data.

In order to better understand how the 2020 survey limitations could affect the comparability with previous cycles, similar changes were applied to the 2019 file and weights were adjusted to see how the estimates would be affected. In order to do this, the response rates for 2020 were calculated by collection period and were applied to the 2019 data, removing respondents collected after the 2020 response rates were reached. We also removed the respondents for which the data was collected through in-person interviews from the last three collection periods of 2019. Through analyzing this file, we have seen that it has similar shifts in person level characteristics to those observed in the 2020 data. Also, some variables had statistically significant differences when comparing the 2019 file with the adjusted 2019 file. Due to the shifts in person level characteristics and the limitations. Users are advised to use the CCHS 2020 data with caution, especially when creating estimates for small sub-populations or when comparing to other CCHS years. Note, the 2019 data presented in this article is from the regular 2019 file.

The symbol E next to an estimate indicates that the coefficient of variation for this estimate is between 15.1% and 35.0% and the quality is marginal. Users should interpret these results with caution.

In this article, the term ‘Indigenous peoples’ refers to First Nations people living off reserve, Métis, and Inuit living outside of Inuit Nunangat. Indigenous peoples were identified on the basis of their self-reported answer to “Are you an Aboriginal person, that is, First Nations, Métis or Inuk (Inuit)? First Nations includes Status and Non-Status Indians.” The CCHS does not collect data on reserves. Consequently, the results discussed for First Nations people exclude those living on reserves, as well as Indigenous peoples in the Territories or remote northern regions of the provinces which includes Inuit Nunangat.

All reported differences are statistically significant with a p-value of less than 0.05. Bootstrap weights were used for significance tests.

The term ‘visible minority’ refers to Canadians designated as visible minorities as per the definition in the *Employment Equity Act*. The act defines minorities as “persons other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.” Visible minority groups include: South Asian; Chinese; Black; Filipino; Latin American; Arab; Southeast Asian; West Asian; Korean and Japanese.

The term ‘LGBTQ2+’ refers to persons who are lesbian, gay, bisexual, transgender, queer, Two-Spirit, or persons reporting another non-binary gender or minority sexual identity. While members of these communities differ in the types of challenges and discrimination that they face depending on where they fall on the spectrums of sexual orientation and gender, this article groups them together due to small sample size. Respondents were included in the LGBTQ2+ population on the basis of self-reported sexual orientation (lesbian, gay, bisexual, or another minority sexual identity such as asexual, pansexual or queer), sex at birth and gender identity (transgender, including respondents with non-binary identities like genderqueer, gender fluid or agender). The analysis on LGBTQ2+ excludes proxy interviews.

Barriers were grouped based on suggested categories described by Sanmartin et al. (2002) and used in the article by Sunderland and Findlay (2013). Personal circumstances includes the following response categories: didn’t know where to get the kind of help needed, respondent has not got around to it, job interfered, respondent did not have confidence in health care system, could not afford to pay, insurance did not cover, afraid of what others would think, and ‘other’. Features of the health care system includes the following response categories: help was not readily available and language barriers. The third category was the respondent preferred to manage the need on their own.

Respondents could have reported more than one type of need and/or barriers, so estimates for these indicators are not exclusive within the population (they can add to more than 100%).

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