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# Investigating disparities in mental health care service use among people with mood and anxiety disorders



by Ellen Stephenson and Amélie Fournier

Release date: January 21, 2026



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# Investigating disparities in mental health care service use among people with mood and anxiety disorders

by Ellen Stephenson  and Amélie Fournier 

DOI: <https://www.doi.org/10.25318/82-003-x202600100001-eng>

## ABSTRACT

### Background

The prevalence of mood and anxiety disorders has risen in Canada over the past decade, and a large proportion of affected individuals do not receive professional help. This study aimed to understand how sociodemographic factors, including age, gender, immigrant status, population group, and household income, were associated with mental health care service use among people with mood or anxiety disorders.

### Data and methods

Data from the 2022 Mental Health and Access to Care Survey were used to assess how many of the people who met the criteria for selected mood and anxiety disorders had (1) talked to a health professional about their mental health and (2) received counselling or therapy services in the 12 months before completing the survey. Chi-squared tests and logistic regression models were used to examine demographic differences in mental health service use among those with mood or anxiety disorders.

### Results

Mental health service use among those with a mood or anxiety disorder was lower for youth aged 15 to 24, adults aged 45 and older, men, recent immigrants, and those with household income from \$40,000 to \$79,999, when controlling for other sociodemographic factors. The most frequently cited reasons for not having received counselling or therapy services included both attitudinal and structural barriers.

### Interpretation

Disparities in the use of mental health care services exist beyond differences in the underlying prevalence of mental disorders. Different sociodemographic groups may face attitudinal and structural barriers that can contribute to difficulties in accessing care.

### Keywords

access to health care, mood disorders, anxiety disorders, health inequalities

## AUTHORS

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### ***What is already known on this subject?***

- In Canada, there has been a notable rise in the prevalence of mood and anxiety disorders over the past decade. Despite this increase, half of Canadians with mood, anxiety, or substance use disorders report that they have not received professional mental health care services in the past 12 months.
- Sociodemographic disparities exist in the prevalence of mood and anxiety disorders and mental health care-seeking behaviours. However, studies do not always account for differences in the prevalence of mental disorders when evaluating differences in health care utilization across demographic groups.

### ***What does this study add?***

- Disparities observed in the use of mental health care services by age, gender, immigrant status, and household income could not be fully accounted for by other demographic factors or by differences in the presence of underlying mental health disorders.
- The findings suggest that low perceived need for mental health care among men may be driving the gender differences in the use of mental health care services, whereas removing structural barriers to accessing care may be a more important target for intervention among immigrant populations.

The prevalence of mood and anxiety disorders has increased substantially over the past decade, with prevalence rates in Canada for some disorders doubling from 2012 to 2022.<sup>1</sup> Effective treatments for mood and anxiety disorders include medications and psychological interventions or therapy to manage symptoms and improve an individual's quality of life.<sup>2-4</sup> Nevertheless, many people face challenges when trying to access mental health care services. In 2022, about half of Canadians aged 15 and older who met diagnostic criteria for mood, anxiety, or substance use disorders had talked to a health professional about their mental health in the past year, and one-third had received some form of therapy or counselling.<sup>1</sup> Differences in the prevalence of specific mental health disorders across sociodemographic groups are important to consider when evaluating disparities in mental health care utilization.<sup>5,6</sup> Women tend to be more affected by mood and anxiety disorders and are also more likely to receive care, compared with men.<sup>1,7,8</sup> Younger individuals are more likely to experience mood and anxiety disorders compared with those in older age groups<sup>1</sup> and have been found to be more likely than older adults to receive mental health care services.<sup>8</sup> There are, however, unique challenges that can arise for youth<sup>9</sup> and for adolescents transitioning to adult health care services.<sup>10</sup> For racialized and immigrant populations in Canada, there tends to be a lower reported prevalence of mood and anxiety disorders<sup>1,11,12</sup> and less use of formal mental health care services.<sup>13-16</sup> Findings on income are somewhat mixed, with some studies finding more use of mental health services among higher-income groups<sup>17</sup> and others reporting no consistent association between income or wealth and the use of health services for common mental disorders, including depression.<sup>18</sup>

Recent analyses of disparities in access to care using the 2022 Mental Health and Access to Care Survey (MHACS) have focused specifically on young women and girls<sup>9</sup> and on 2SLGBTQ+ youth.<sup>19</sup> The current study expanded on this

previous work by examining to what extent access to professional support, use of counselling and therapy services, and barriers faced in accessing care differ across age groups. The current study also examined disparities in access to care for multiple racialized groups and by immigrant status. In 2021, immigrants made up almost one-quarter of the Canadian population, and this share is projected to increase to over 30% within the next 20 years.<sup>20</sup> Understanding how to meet the health care needs of newcomers to Canada and how to address specific barriers that immigrants face may become increasingly important.

Research on mood and anxiety disorders and unmet mental health care needs is sometimes limited to people who have been able to access the care needed to receive a clinical diagnosis.<sup>21-23</sup> By looking specifically at those who met diagnostic criteria for a mood or anxiety disorder based on their symptoms within the past 12 months, differences in the underlying prevalence of these disorders across sociodemographic groups are controlled for, while people who face challenges in receiving a formal diagnosis are also included. This will show whether disparities in health care utilization exist beyond established demographic differences in the prevalence of these disorders and provide insights that can support efforts to improve access to care.

## **Methods**

### **Data source**

This study used data from the 2022 MHACS, conducted by Statistics Canada from March 17 to July 31, 2022.<sup>24</sup> The MHACS was administered by interviewer-assisted electronic questionnaire to 9,861 individuals aged 15 and older living in the 10 provinces (response rate = 25%). The survey sample was selected from those who completed the 2021 Census long-form

questionnaire and excluded individuals living on First Nations reserves and settlements, full-time members of the Canadian Forces, and people living in institutional residences. The target population was stratified by age group (15 to 24, 25 to 44, 45 to 64, and 65 and older), by gender, and by population group, oversampling for four racialized groups (South Asian, Black, Chinese, and Filipino).<sup>24</sup>

## Measures

### Sociodemographic characteristics

The survey collected demographic information, including age, gender, country of birth, year of arrival in Canada (for immigrants), and population group. It is important to note that although the MHACS collected data on multiple racialized groups, the analyses focused on four oversampled groups, namely the South Asian, Black, Chinese, and Filipino populations. Data from non-oversampled racialized groups, including people belonging to multiple racialized groups, were aggregated into a single category, “other racialized groups,” in the final analyses. Separate population groups were created for Indigenous respondents (i.e., First Nations, Métis, or Inuit [Inuit]) and for non-racialized, non-Indigenous respondents. Given the sample size, it was not possible to report results separately for distinct Indigenous groups. These results should also be interpreted with caution given that some Indigenous people were excluded from the survey’s coverage (e.g., First Nations people living on reserve or people living in Inuit Nunangat).

Previous studies have found that mental health outcomes for immigrants to Canada vary based on the length of time they have been living in Canada.<sup>25,26</sup> When possible, respondents who were born outside Canada were split into two groups: recent immigrants (less than 10 years in Canada) and long-term immigrants (10 years or more in Canada).

Data on total household income from all sources for 2020 were obtained from tax records linked through the 2021 Census disseminated file.

### Mood and anxiety disorders

The MHACS employed a modified version of the World Health Organization Composite International Diagnostic Interview (WHO-CIDI) to identify individuals presenting with mood disorders (major depressive episode, bipolar disorder types I and II, and hypomania) or anxiety disorders (generalized anxiety disorder and social phobia) within the 12 months before completing the survey.<sup>27</sup> While this classification does not constitute a clinical diagnosis, the WHO-CIDI is a widely recognized and standardized tool used to evaluate mental disorders in population-based surveys, aligning with the criteria outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Although a fifth edition of the DSM (DSM-5) was introduced in 2013 and a text revision (DSM-5-TR) was published in 2022, a revised version of the

WHO-CIDI was not available during the data collection period. The DSM-5-TR introduced some minor changes in the diagnostic criteria for the mood and anxiety disorders measured in the current study.<sup>28,29</sup>

### Mental health care service use

Two measures of mental health care service use were considered. First, respondents were grouped based on whether they had consulted with a professional or used a professional service in the 12 months preceding the interview to address issues related to emotions, mental health, or the use of alcohol or drugs. The professionals included in this category are psychiatrists, family doctors, general practitioners, psychologists, nurses, social workers, counsellors, and psychotherapists. Professional services also encompassed hospitalization and online therapy. The second outcome went beyond simply consulting a professional and included only those who reported having received therapy or counselling. Respondents were asked, “During the past 12 months, did you receive the following kinds of help because of problems with your emotions, mental health or use of alcohol or drugs?” “Counselling, therapy, or help for problems with personal relationships” was one of the response options. Respondents who reported that they had not received this type of service were asked whether they felt they needed it and could select from a list of reasons why they felt they had not received it. Those who reported that they felt they needed this type of support were classified as having a perceived need for counselling or therapy.

### Statistical analyses

The percentage of the population who met diagnostic criteria for mood or anxiety disorders was estimated and compared by gender, age group, immigrant status, population group, and income level using Rao-Scott chi-squared tests, with additional pairwise comparisons between proportions made using z-tests. Next, the percentage of the population who had consulted a professional and the percentage of the population who had received therapy or counselling were estimated across the same sociodemographic characteristics. Separate estimates of mental health service use were reported for the overall population of Canadians and for the subpopulation of Canadians who met diagnostic criteria for a mood or anxiety disorder.

Logistic regression models were used to assess the combined effect of multiple demographic factors (age, gender, immigrant status, population group, and household income) on the use of mental health services among people who met criteria for a mood or anxiety disorder. Two models were fit to the data: one for having talked to a health professional about their mental health and one for having received counselling or therapy services.

Perceived need for counselling or therapy and the most common reasons for not having received counselling or therapy services were compared across sociodemographic groups to better understand any observed disparities in mental health service use.

The analysis incorporated survey weights, bootstrap weights, and a variance adjustment factor to accommodate the MHACS design. All statistical analyses were performed using SAS software version 9.4.<sup>30</sup>

## Results

Among those aged 15 and older living in Canada, the 12-month prevalence of mood and anxiety disorders varied based on age, gender, immigrant status, and population group (Table 1). Differences were also observed for both measures of mental health service use across these sociodemographic characteristics (Table 1). Women were more likely than men to have met diagnostic criteria for a mood or anxiety disorder, to have talked to a health professional about their mental health, and to have received counselling or therapy for mental health problems. Similarly, youth aged 15 to 24 were more likely to have met diagnostic criteria for a mood or anxiety disorder

compared with those aged 25 to 44 and those aged 45 and older. They were also more likely to have talked to a health professional about their mental health and to have received counselling or therapy for mental health problems compared with those aged 45 and older.

The prevalence of mood or anxiety disorders, professional consultation, and receipt of counselling or therapy was significantly lower for recent immigrants (less than 10 years in Canada) and long-term immigrants (10 years or more in Canada) compared with people who were born in Canada, and among the South Asian, Chinese, and Filipino populations relative to the non-racialized, non-Indigenous population (Table 1). Although Black people were less likely to have used mental health care services than non-racialized, non-Indigenous people, there was no significant difference between these groups in terms of the proportion who met diagnostic criteria for a mood or anxiety disorder (Table 1).

**Table 1**  
Prevalence of mood and anxiety disorders and mental health care service use among Canadians aged 15 and older by selected sociodemographic characteristics

	Met the criteria for a mood or anxiety disorder			Consulted a health professional			Received counselling or therapy		
	%	95% confidence interval		%	95% confidence interval		%	95% confidence interval	
		from	to		from	to		from	to
<b>Total</b>	15.4	14.6	16.3	16.8	15.9	17.7	14.5	13.6	15.4
<b>Age group</b>									
15 to 24 <sup>†</sup>	29.1	26.9	31.5	23.3	21.1	25.6	21.2	19.1	23.4
25 to 44	19.4 *	17.6	21.4	22.9	21.0	25.0	20.6	18.8	22.6
45 and older	9.1 *	8.1	10.2	11.2 *	10.2	12.4	8.9 *	7.9	9.9
<b>Gender</b>									
Men+ <sup>†</sup>	11.4	10.3	12.6	12.0	10.9	13.2	10.2	9.2	11.4
Women+	19.3 *	18.0	20.7	21.4 *	20.1	22.8	18.5 *	17.3	19.9
<b>Immigrant status</b>									
Born in Canada <sup>†</sup>	17.6	16.4	18.8	19.3	18.2	20.6	17.2	16.1	18.4
Living in Canada less than 10 years	11.0 *	8.9	13.5	7.8 *	6.0	10.3	6.7 *	5.1	8.7
Living in Canada 10 years or more	10.3 *	8.8	12.0	11.5 *	10.1	13.2	8.3 *	7.1	9.7
<b>Population group</b>									
South Asian	11.7 *	9.8	14.0	11.5 *	9.5	13.9	10.4 *	8.5	12.6
Chinese	8.7 *	7.1	10.8	9.4 *	7.6	11.5	7.8 *	6.2	9.6
Black	14.6	12.2	17.4	13.7 *	11.5	16.3	10.8 *	8.8	13.1
Filipino	10.1 *	8.0	12.6	9.8 *	7.7	12.2	7.1 *	5.3	9.4
Other racialized groups	16.6	13.5	20.2	15.6	12.7	19.2	11.1 *	8.7	14.1
Indigenous	23.0	15.8	32.1	20.9	14.7	28.7	21.0	14.6	29.1
Non-racialized, non-Indigenous <sup>†</sup>	16.1	15.0	17.3	18.1	17.0	19.4	15.8	14.7	17.0
<b>Household income</b>									
\$39,999 or less <sup>†</sup>	16.6	13.9	19.8	18.2	15.5	21.2	14.6	12.2	17.4
\$40,000 to \$79,999	13.9	12.1	16.0	14.9	13.1	16.9	12.6	10.9	14.5
\$80,000 to \$149,999	15.6	14.2	17.1	17.2	15.7	18.8	14.8	13.4	16.4
\$150,000 or more	16.1	14.5	17.9	17.5	15.9	19.3	15.7	14.1	17.4

<sup>†</sup> reference category

\* significantly different from reference category (p < 0.05)

**Notes:** Men+ include men and boys, as well as some non-binary people. Women+ include women and girls, as well as some non-binary people. Other racialized groups include groups that each made up less than 2% of the population (e.g., Arab, Latin American, Southeast Asian, West Asian, Korean, and Japanese), people belonging to multiple racialized groups, and people belonging to racialized groups not included elsewhere. The sample size did not allow further disaggregation. Indigenous people include First Nations people living off-reserve, Métis, and Inuk (Inuit). The sample size did not allow further disaggregation.

**Source:** Mental Health and Access to Care Survey, 2022.

When the analysis was limited to the subpopulation who met criteria for a mood or anxiety disorder (Table 2), differences by age, gender, and immigrant status remained statistically significant for both measures of mental health care service use ( $p < 0.05$  for all chi-squared tests). Results by racialized group showed a significant difference for having received counselling or therapy ( $\chi^2_{(6)} = 14.4, p = 0.025$ ), but not for having consulted a health professional ( $\chi^2_{(6)} = 8.6, p = 0.196$ ). This significant effect was largely driven by a significant difference in the proportion of people who had received counselling or therapy services between Black people (33.1%) and non-racialized,

non-Indigenous people (48.7%). Household income was associated with having talked to a health professional about mental health ( $\chi^2_{(3)} = 8.2, p = 0.042$ ), but not with having received counselling or therapy services ( $\chi^2_{(3)} = 4.4, p = 0.221$ ). A higher proportion of people in the lowest household income category (\$39,999 or less) had consulted a health professional about mental health compared with those in the second-lowest category (\$40,000 to \$79,999).

When all these sociodemographic factors were considered together in a single regression model, age, gender, immigrant status, and household income were uniquely associated with the

**Table 2**  
Mental health service use in the past 12 months among those who met diagnostic criteria for a mood or anxiety disorder

	Consulted a health professional			Received counselling or therapy		
	%	95% confidence interval		%	95% confidence interval	
		from	to		from	to
<b>Total</b>	51.4	48.1	54.7	46.6	43.3	50.0
<b>Age group</b>						
15 to 24 <sup>†</sup>	49.2	44.2	54.2	44.5	39.6	49.6
25 to 44	56.4	50.8	61.8	51.9	46.2	57.6
45 and older	46.5 <sup>‡</sup>	40.4	52.7	41.2 <sup>‡</sup>	35.3	47.2
<b>Gender</b>						
Men+ <sup>†</sup>	42.4	37.1	47.9	40.2	34.9	45.8
Women+	56.4 <sup>*</sup>	52.4	60.4	50.1 <sup>*</sup>	46.0	54.3
<b>Immigrant status</b>						
Born in Canada <sup>†</sup>	53.5	49.6	57.2	49.4	45.6	53.2
Living in Canada less than 10 years	34.2 <sup>*</sup>	25.1	44.7	30.5 <sup>*</sup>	21.8	40.9
Living in Canada 10 years or more	45.1	37.1	53.4	36.5 <sup>*</sup>	29.0	44.8
<b>Population group</b>						
South Asian	46.9	37.3	56.8	41.6	32.6	51.2
Chinese	40.7 <sup>*</sup>	31.1	51.2	36.2 <sup>*</sup>	26.9	46.7
Black	41.1 <sup>*</sup>	32.4	50.5	33.1 <sup>*</sup>	25.3	41.9
Filipino	38.4 <sup>*E</sup>	27.1	51.2	36.4 <sup>E</sup>	25.3	49.1
Other racialized groups	46.9	36.5	57.6	37.9	27.9	49.0
Indigenous	F	F	F	F	F	F
Non-racialized, non-Indigenous <sup>†</sup>	53.3	49.2	57.5	48.7	44.6	52.9
<b>Household income</b>						
\$39,999 or less <sup>†</sup>	60.5	50.6	69.5	54.5	44.6	64.0
\$40,000 to \$79,999	43.6 <sup>*</sup>	36.2	51.3	41.4 <sup>*</sup>	34.1	49.1
\$80,000 to \$149,999	53.2	47.9	58.3	46.8	41.3	52.3
\$150,000 or more	51.3	45.6	57.0	47.3	41.5	53.1

<sup>E</sup> use with caution

<sup>F</sup> too unreliable to be published

<sup>\*</sup> significantly different from reference category ( $p < 0.05$ )

<sup>†</sup> reference category

<sup>‡</sup> significantly different from people aged 25 to 44 ( $p < 0.05$ )

**Notes:** Men+ include men and boys, as well as some non-binary people. Women+ include women and girls, as well as some non-binary people. Other racialized groups include groups that each made up less than 2% of the population (e.g., Arab, Latin American, Southeast Asian, West Asian, Korean, and Japanese), people belonging to multiple racialized groups, and people belonging to racialized groups not included elsewhere. The sample size did not allow further disaggregation. Indigenous people include First Nations people living off-reserve, Métis, and Inuk (Inuit). The sample size did not allow further disaggregation. Respondents with missing data on either the health outcome or sociodemographic variable were excluded. The resulting sample sizes for the analyses presented in this table ranged from 1,228 to 1,278.

**Source:** Mental Health and Access to Care Survey, 2022.

use of mental health care services among those with a mood or anxiety disorder (Table 3). Adults aged 25 to 44 who met diagnostic criteria for a mood or anxiety disorder were more likely to have talked to a health professional about their mental health than youth aged 15 to 24 (odds ratio [OR] = 1.38). Women who met diagnostic criteria for a mood or anxiety disorder had 1.90 times higher odds of having talked to a health professional about their mental health and 1.60 times higher odds of having received therapy or counselling relative to men who met the same diagnostic criteria. Relative to people who were born in Canada, people who immigrated to Canada within the past 10 years and who met diagnostic criteria for a mood or anxiety disorder were less likely to have talked to a health professional about their mental health (OR = 0.39) or to have received counselling or therapy services (OR = 0.43). Compared with people with a household income of \$39,999 or

less, those with a household income from \$40,000 to \$79,999 who met diagnostic criteria for a mood or anxiety disorder were less likely to have talked to a professional about their mental health (OR = 0.45) or to have received counselling or therapy services (OR = 0.53).

As shown in Table 4, perceived need for counselling or therapy services was higher among women compared with men ( $\chi^2_{(1)} = 11.6, p < 0.001$ ). The most common reasons cited for not having received counselling or therapy among those who perceived a need for it were a preference for managing alone (37.9%), help not being readily available (33.0%), not being able to afford to pay (31.9%), being too busy (30.5%), and not knowing how or where to get this kind of help (27.7%). Compared with people aged 25 and older, youth aged 15 to 24 were more likely to report that they did not know how or where to get this kind of help (Table 5).

**Table 3**  
Adjusted odds ratios for the association between sociodemographic characteristics and mental health service use among people who met diagnostic criteria for a mood or anxiety disorder

	Consulted a health professional			Received counselling or therapy		
	Adjusted odds ratios	95% confidence interval		Adjusted odds ratios	95% confidence interval	
		from	to		from	to
<b>Age group</b>						
15 to 24 <sup>†</sup>	1.00	...	...	1.00	...	...
25 to 44	1.38 *	1.00	1.91	1.35	0.98	1.86
45 and older	0.88	0.62	1.25	0.84	0.59	1.20
<b>Gender</b>						
Men+ <sup>†</sup>	1.00	...	...	1.00	...	...
Women+	1.90 *	1.42	2.54	1.60 *	1.18	2.16
<b>Immigrant status</b>						
Born in Canada <sup>†</sup>	1.00	...	...	1.00	...	...
Living in Canada less than 10 years	0.39 *	0.22	0.67	0.43 *	0.25	0.76
Living in Canada 10 years or more	0.75	0.48	1.19	0.65	0.40	1.05
<b>Population group</b>						
South Asian	1.09	0.67	1.77	1.05	0.65	1.69
Chinese	0.63	0.37	1.07	0.65	0.38	1.11
Black	0.77	0.48	1.23	0.66	0.41	1.06
Filipino	0.76	0.41	1.41	0.85	0.44	1.62
Other racialized groups	0.91	0.52	1.58	0.80	0.45	1.41
Indigenous	0.94	0.39	2.28	1.33	0.57	3.07
Non-racialized, non-Indigenous <sup>†</sup>	1.00	...	...	1.00	...	...
<b>Household income</b>						
\$39,999 or less <sup>†</sup>	1.00	...	...	1.00	...	...
\$40,000 to \$79,999	0.45 *	0.27	0.76	0.53 *	0.32	0.90
\$80,000 to \$149,999	0.67	0.42	1.06	0.66	0.41	1.05
\$150,000 or more	0.64	0.39	1.05	0.70	0.43	1.14

... not applicable

<sup>†</sup> reference category

\* significantly different from reference category ( $p < 0.05$ )

**Notes:** Men+ include men and boys, as well as some non-binary people. Women+ include women and girls, as well as some non-binary people. Other racialized groups include groups that each made up less than 2% of the population (e.g., Arab, Latin American, Southeast Asian, West Asian, Korean, and Japanese), people belonging to multiple racialized groups, and people belonging to racialized groups not included elsewhere. The sample size did not allow further disaggregation.

Indigenous people include First Nations people living off-reserve, Métis, and Inuk (Inuit). The sample size did not allow further disaggregation. Respondents with missing data on either the health outcome or sociodemographic variable were excluded. The resulting sample sizes for the analyses presented in this table ranged from 1,228 to 1,278.

**Source:** Mental Health and Access to Care Survey, 2022.

**Table 4**  
**Perceived need for counselling or therapy among those who had not received it and met diagnostic criteria for a mood or anxiety disorder**

	Perceived need for counselling or therapy		
	%	95% confidence interval	
		from	to
<b>Total</b>	29.6	25.6	33.9
<b>Age group</b>			
15 to 24 <sup>†</sup>	29.9	24.1	36.4
25 to 44	35.5	28.0	43.8
45 and older	22.7	16.7	30.1
<b>Gender</b>			
Men <sup>†</sup>	20.9	15.9	27.0
Women <sup>+</sup>	35.4 *	29.9	41.3
<b>Immigrant status</b>			
Born in Canada <sup>†</sup>	31.5	26.6	36.8
Immigrant	24.7	18.7	31.9
<b>Population group</b>			
Part of a racialized group	27.3	21.8	33.6
Non-racialized, non-Indigenous <sup>†</sup>	30.4	25.3	35.9
<b>Household income</b>			
\$39,999 or less <sup>†</sup>	23.8 <sup>E</sup>	13.6	38.2
\$40,000 to \$79,999	25.4	17.1	35.8
\$80,000 to \$149,999	36.8	30.0	44.1
\$150,000 or more	25.5	19.3	33.0

<sup>E</sup> use with caution

<sup>†</sup> reference category

\* significantly different from reference category (p < 0.05)

**Notes:** Men+ include men and boys, as well as some non-binary people.

Women+ include women and girls, as well as some non-binary people. Because of the small sample sizes, some categories were combined to create two groups for each variable. The analysis by population group excluded Indigenous people because they were not asked the racialized group question and the sample size was too small to report a separate estimate for Indigenous people. Respondents with missing data on either the health outcome or sociodemographic variable were excluded. The resulting sample sizes for the analyses presented in this table ranged from 654 to 691.

**Source:** Mental Health and Access to Care Survey, 2022.

## Discussion

The findings from this study show that sociodemographic characteristics affect access to mental health care services. Although the prevalence of mood and anxiety disorders was higher among certain groups—women; youth; non-racialized, non-Indigenous people; and people born in Canada—this higher prevalence of mental health disorders did not fully explain the difference in the use of mental health care services observed across these sociodemographic groups.

Many studies have found that women are more likely than men to seek medical care.<sup>7,31,32</sup> Consistent with this broader literature, the current study found that women were more likely than men to have consulted a health professional about their mental health and, more specifically, to have received counselling or therapy services. Women may be more likely

than men to recognize and acknowledge mental health problems, leading to a proactive approach in seeking professional help.<sup>32,33</sup> Consistent with this explanation, the current study found that women were more likely to report a perceived need for counselling or therapy services than men. Addressing the gender disparity in the use of mental health services may require changes in men’s attitudes toward seeking care. For example, other research has found that men are more likely to report barriers to care that are related to their perceptions of mental health issues and the usefulness of health care services, whereas women are more likely to report availability or accessibility issues such as a lack of transportation or child care.<sup>34</sup> In Canada, access to mental health care specialists often requires a referral, and many services require patients to pay out of pocket. This can create additional barriers for those who feel a need for help and are trying to access care.

**Table 5**  
**Barriers to accessing therapy or counselling among those reporting a need**

	Preferred to manage yourself			Help was not readily available			Couldn't afford to pay			Too busy			Didn't know how or where to get this kind of help		
	%	95% confidence interval		%	95% confidence interval		%	95% confidence interval		%	95% confidence interval		%	95% confidence interval	
		from	to		from	to		from	to		from	to		from	to
<b>Total</b>	37.9	30.1	46.4	33.0	25.6	41.3	31.9	24.6	40.2	30.5	23.7	38.3	27.7	21.2	35.2
<b>Age group</b>															
15 to 24 <sup>†</sup>	50.2 <sup>E</sup>	38.5	61.9	29.8 <sup>E</sup>	19.9	42.1	38.2 <sup>E</sup>	27.2	50.5	37.6 <sup>E</sup>	26.6	50.2	40.7 <sup>E</sup>	29.4	53.2
25 and older	32.9 <sup>*</sup>	23.4	43.9	34.3	25.1	44.9	29.3	20.7	39.8	27.6	19.6	37.3	22.3 <sup>*</sup>	15.1	31.6
<b>Gender</b>															
Men+ <sup>†</sup>	44.6 <sup>E</sup>	30.4	59.8	25.4 <sup>E</sup>	14.0	41.7	20.0 <sup>E</sup>	10.8	34.1	35.3 <sup>E</sup>	23.0	49.9	34.1 <sup>E</sup>	21.6	49.2
Women+	35.4	26.4	45.6	35.8	26.9	45.7	36.3	27.3	46.3	28.7	20.8	38.3	25.3	18.0	34.3
<b>Immigrant status</b>															
Born in Canada <sup>†</sup>	39.9	30.8	49.8	32.4	24.3	41.7	30.8	22.6	40.3	28.7	21.1	37.8	26.8	19.6	35.6
Immigrant	29.1 <sup>E</sup>	18.7	42.3	36.0 <sup>E</sup>	21.3	54.0	35.1 <sup>E</sup>	21.7	51.4	37.1 <sup>E</sup>	24.1	52.4	30.6 <sup>E</sup>	18.8	45.5
<b>Population group</b>															
Part of a racialized group	35.8 <sup>E</sup>	25.9	47.0	30.1 <sup>E</sup>	19.7	43.0	28.5 <sup>E</sup>	19.6	39.3	31.8 <sup>E</sup>	22.0	43.6	35.2 <sup>E</sup>	24.5	47.5
Non-racialized, non-Indigenous <sup>†</sup>	35.8	26.7	46.1	35.6	26.5	45.8	33.5	24.5	43.9	28.8	20.9	38.3	25.7	18.1	35.0
<b>Household income</b>															
\$149,999 or less <sup>†</sup>	38.2	29.1	48.2	35.6	26.9	45.4	33.4	24.8	43.2	29.4	21.4	38.8	27.7	20.2	36.7
\$150,000 or more	36.9 <sup>E</sup>	23.8	52.2	25.3 <sup>E</sup>	14.5	40.4	27.8 <sup>E</sup>	16.2	43.3	33.9 <sup>E</sup>	21.2	49.4	27.4 <sup>E</sup>	16.9	41.3

<sup>E</sup> use with caution

<sup>†</sup> reference category

<sup>\*</sup> significantly different from reference category (p < 0.05)

**Notes:** Men+ include men and boys, as well as some non-binary people. Women+ include women and girls, as well as some non-binary people. Because of the small sample sizes, some categories were combined to create two groups for each variable. The analysis by population group excluded Indigenous people because they were not asked the racialized group question and the sample size was too small to report a separate estimate for Indigenous people. Respondents with missing data on either the health outcome or sociodemographic variable were excluded. The resulting sample sizes for the analyses presented in this table ranged from 196 to 205.

**Source:** Mental Health and Access to Care Survey, 2022.

The pattern of results for immigrants to Canada showed that they had both a lower prevalence of mood and anxiety disorders and a lower prevalence of mental health service use overall. This finding is generally consistent with the “healthy immigrant effect,” a theory that suggests that immigrants have better health outcomes than non-immigrants because the migration process selects for healthier individuals and that this advantage disappears the longer they spend living in Canada.<sup>35</sup> However, findings for a healthy immigrant effect in the context of mental health outcomes have been mixed<sup>25,36,37</sup> and may reflect a reporting bias among respondents from different cultural backgrounds. Nevertheless, the lower rate of mental health service use in the immigrant population observed in the current study was not fully accounted for by the reduced prevalence of mental health disorders. Immigrants and non-immigrants with mood and anxiety disorders reported similar levels of perceived need for counselling and therapy services, so a lack of perceived need for professional help does not explain the difference in service use between these two groups. Instead, structural barriers may explain why mental health care service use is lower among immigrant populations. Efforts to improve the uptake of mental health care services among immigrants may need to focus on helping newcomers to Canada learn where and how to access the services they may need.<sup>38</sup> For those accessing care, cultural competency among care providers can be important to delivering effective treatments to a diverse population.<sup>39,40</sup>

Finally, youth aged 15 to 24 had a higher prevalence of mood and anxiety disorders compared with the other age groups, but youth with a mood or anxiety disorder were less likely than those aged 25 to 44 to have talked to a health professional or to have received counselling or therapy services. This finding is consistent with other Canadian research using administrative health data that showed youth are underrepresented among those accessing mental health care services. One possibility is that youth may face additional barriers associated with the transition from child to adult health care systems.<sup>10</sup> They may benefit from additional support or guidance on where to get the kind of help they need.

### Limitations

While this study provides valuable insights into the associations between sociodemographic factors and mental health care, some limitations should be acknowledged.

First, the measures of mental health care service use are based on only a few questionnaire items and capture a broad range of health care interactions. In addition, this study did not examine the intensity of services received, the type of counselling or therapy service provider, or insurance coverage, which may have been related to disparities in health service use across sociodemographic groups.

Second, the analysis focused primarily on people who met criteria for specific mood and anxiety disorders. Although these are among the most common types of mental disorders,<sup>1,41</sup> there are other mental health diagnoses that were not captured in the current study. In addition, the MHACS used criteria from the fourth edition of the DSM to determine the prevalence of mood and anxiety disorders, and this may have produced slightly different results than if DSM-5 criteria had been applied.<sup>28,29</sup>

The MHACS had a relatively low response rate of 25%, heightening the risk of selection bias. Sampling weights were used to account for potential non-response bias, but there may still be some bias that was not fully accounted for by those weights. The lower statistical power associated with small samples limited the ability to detect group differences in some analyses. It was not possible to consider all the factors that may be related to mental health and health care service use. Instead, the analysis was limited to the demographic variables that had a larger number of observations and could produce reasonable-quality estimates. For example, analysis of intersectional identities can be especially important when evaluating inequalities in health and health care,<sup>42,43</sup> but this was beyond the scope of the current investigation. Several of the measures

used in this study captured events that happened during the COVID-19 pandemic. The pandemic affected many aspects of people's lives, including the availability of health care services, lifestyle behaviours, mental health, employment, and income support policies,<sup>44-46</sup> all of which could limit the generalizability of the current findings. Future research will need to assess whether similar patterns continue to exist over time.

### Conclusion

The current study adds to the understanding of disparities in mental health care service use in Canada by highlighting some of the differences in service use for people with mood and anxiety disorders based on their age, gender, population group, immigrant status, and household income. Future research is needed to better understand how and why these differences exist and what steps can be taken to reduce these inequalities. Investigating the underlying mechanisms involved in these disparities is an important next step. There are often complex intersections with systemic barriers and individual characteristics that may influence mental health care service use.

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