

MENTAL HEALTH CARE UTILIZATION OF INDIGENOUS PEOPLES IN CANADA

Bertina Lou, MA

Department of Sociology

Western University

London, Ontario

blou3@uwo.ca

Abstract

The Indigenous mental health crisis in Canada must be contextualized with discussions on race and colonialism within population health research. This research uses nationally representative data from the 2015-2016 Canadian Community Health Survey to investigate the mental health service utilization of Indigenous populations relative to non-Indigenous populations. Preliminary findings suggest an underutilization of mental health services by Indigenous people because although they are more likely than non-Indigenous people to possess characteristics related to an increased likelihood of consulting a mental health professional, findings show that Indigenous peoples access mental health services at similar rates as non-Indigenous peoples.

Résumé

La crise de santé mentale parmi les autochtones au Canada doit se contextualiser avec des discussions sur la race et le colonialisme dans le cadre de la recherche sur la santé des populations. Cette recherche se sert de données représentatives nationales tirées du sondage canadien de santé communautaire afin d'enquêter sur l'utilisation par les autochtones (en comparaison aux allochtones) de services d'aide en santé mentale. Les résultats préliminaires semblent indiquer une sous-utilisation de ces services par les autochtones, et ce parce que, bien que les autochtones sont plus susceptibles d'avoir le profil-type d'individus ayant les traits propres de gens consultant un spécialiste en santé mentale davantage que la moyenne, ces résultats indiquent qu'autochtones et allochtones font un usage comparable des services de santé mentale.

Introduction

As social movements advance in twenty-first century Canadian society, awareness and advocacy have increasingly centered on two important topics: mental health and the challenges faced by Indigenous peoples in Canada (Canadian Mental Health Association [CMHA], 2018; Woods, 2016). Regarding mental health as an issue of public concern, lifetime prevalence statistics state that roughly 21% of Canadians have experienced a mental disorder at some point in their lives (Arboleda-Flórez, 2005). Recognizing that mental health is an important component of health (a fundamental human right), policy experts, researchers, and care providers are making calls for national health care reforms to improve the accessibility of mental health care for all Canadians (Canadian Civil Liberties Association [CCLA], 2017). Within the Canadian population, Indigenous peoples have experienced a long history of marginalization and face distinctive challenges in relation to their mental health and care access (Chandler & Lalonde, 1998; Josewski, 2012; Firestone, 2013; Kant et al., 2013). As such, attention to the historical, cultural, and social contexts shaping the mental health outcomes of Indigenous populations is required for Canadian health reforms to achieve their maximum effect. Canada's first report on population mental health, "Out of the Shadows at Last" by the Standing Senate Committee on Social Affairs, Science and Technology in 2006, entirely neglects to mention race and ethnicity in relation to health outcomes, care access, and treatment (Senate of Canada, 2006). The Mental Health Commission of Canada (established in response to the initial 2006 report) subsequently developed Canada's first Mental Health Strategy in 2012, which lists improving mental health services for ethno-cultural and racialized groups as a priority (Mental Health Commission of Canada [MHCC], 2012). Although the 2012 Mental Health Strategy demonstrates a very shallow engagement with race, it nevertheless represents Canada's first acknowledgement of race as a noteworthy feature in national mental health promotion and policy. The Mental Health Commission's most recent report in 2016 extends previous policy suggestions by not only advocating for the recognition of cultural diversity, but also for an awareness of the "social inequalities and imbalances of power that impact relationships between service providers and service users" (MHCC, 2016). Moreover, it explicitly calls for continuous government efforts to tackle "broader, systemic issues such as discrimination based on ethnicity" (MHCC, 2016). These developments represent a landmark contribution to mental health policy and provide a point of departure for this research.

Contemporary Canadian mental health research should strive to contextualize the mental health of Indigenous peoples with discussions on race and colonialism. Canada's history of colonization produced and

continues to perpetuate large population health disparities through numerous disadvantages, including racism, poverty, and sub-standard living conditions (Richmond & Cook, 2016). Since Indigenous peoples in Canada are far more likely to face structural challenges that can negatively impact their emotional wellbeing, their mental health service access and utilization become crucial to safeguarding and improving their mental health. This current study contributes to both research literature and policy development by exploring the relationship between Indigenous status and mental health service utilization in Canada. It extends previous research on Indigenous care access by investigating, for the first time, the factors associated with mental health care utilization in a nationally representative Canadian sample. Findings of this study provide useful support for the development of health policies that address the particular social contexts and needs of Indigenous peoples in order to decrease barriers to mental health care.

Literature review

The present-day population health of Indigenous peoples in Canada must be examined in relation to a history and legacy of colonization. Colonialism in Canada began in the 1500s, when European settlers first arrived on the east coast with the goal of expanding and exerting their political power in new territories (Feminist Northern Network [FemNorthNet], 2016). For several hundred years, European settlers and Indigenous peoples respectfully co-existed, with each society governing their own affairs while sharing mutually beneficial relationships in the form of military and trade alliances (FemNorthNet, 2016). As non-Indigenous society grew larger and more dominant, however, their shared interactions became characterized by unequal power relations (FemNorthNet, 2016). Indigenous peoples became viewed by colonial settlers as barriers to land settlement and resource extraction and were subsequently coerced into signing treaties that relinquished their land, natural resources, and sense of autonomy (FemNorthNet, 2016). These European documents disregarded Indigenous peoples' systems of governance and lifestyles, which are deeply connected to the land, devastating thousands of distinct Indigenous societies comprised of unique languages, cultures, and group relations (FemNorthNet, 2016). In 1876, the Canadian government passed the highly invasive Indian Act, which consigned Indigenous peoples to specific "reserve" lands and policed their official Indigenous "status," in efforts to assimilate Indigenous peoples into the mainstream Canadian population (McCue, 2011; Henderson, 2006). Government-sponsored residential schools operating in Canada from the 1830s to 1996 also served colonial assimilationist goals by isolating Indigenous children from their families to impose a Chris-

tian curriculum that disparaged traditional Indigenous cultures (Miller, 2012). In these schools, students received an inadequate education in terms of both academic and vocational training (Miller, 2012). They additionally faced excessive punishment, including physical, sexual, and psychological abuse (Miller, 2012). In 2008, the Canadian government acknowledged and issued an apology for its responsibility in these atrocities (Indigenous Peoples Atlas, 2019). The Truth and Reconciliation Commission of Canada was also established that year to document the experiences of residential school survivors and create calls to action for making reparations to Indigenous peoples in Canada (Indigenous Peoples Atlas, 2019).

Canada's colonial history still affects Indigenous communities today. The overrepresentation of Indigenous peoples in correctional and foster care systems, as well as the higher rates of Indigenous educational drop-out, unemployment, poverty, and poor health when compared to the average Canadian population, demonstrate the ongoing consequences of their forced displacement from lands, communities, and traditional cultures (Indigenous Peoples Atlas, 2019; Mitrou et al., 2014). Recent Canadian research on the mental health of Indigenous populations paints a worrisome picture of the disproportionate mental illness and substance misuse challenges that they encounter (Firestone, 2013; Benoit et al., 2016; Webster, 2016; Nelson & Wilson, 2017). Even more concerning are studies demonstrating that, despite a higher prevalence of mental disorders, Indigenous populations are reluctant to consult a service provider about their mental wellbeing (Firestone et al., 2015; McIntyre et al., 2017; Nader et al., 2017). Current literature offers two main explanations for the underutilization of mental health services by Indigenous peoples: the existence of structural barriers (McIntyre et al., 2017; Nader et al., 2017; Bingham et al., 2019) and the cultural incongruence between mainstream mental health services and Indigenous service users (Josewski, 2012; Kant et al., 2013; Firestone et al., 2015).

The structural barriers influencing the mental health service utilization of Indigenous peoples are similar to those impacting their overall health care utilization (Bingham et al., 2019). In a study on the health service use for various illnesses by Indigenous peoples in Alberta, Nader, and colleagues (2017) find minimal service use for mental health conditions compared to other illnesses among Indigenous patients. They report that, in general, health service use is shaped by factors such as patients' insurance coverage, geographical location, and ability to access services (Nader et al., 2017). Similarly, they state that unmet health care needs arise from a lack of available services (e.g., because of long wait times or a completely unserved area) as well as from the inaccessibility of services (e.g., due to distance, transportation, or cost barriers) (Nader et al., 2017). Other research identifies discrimination as a structural barrier to health care access for Indigenous peoples. Studies

find that Indigenous peoples report experiencing pervasive racial discrimination in the Canadian healthcare system, causing some individuals either to strategize ways of avoiding racism before seeking care or to forgo care altogether (Tang & Browne, 2008; Browne et al., 2010). In addition to race-based discrimination, Firestone, and colleagues (2015) find that previous experiences of discrimination due to a mental health problem prevent or delay care-seeking for mental health concerns in urban Indigenous populations. The stigma of mental illness is therefore an additional barrier to the mental health service utilization of Indigenous populations.

The cultural incongruence between mainstream mental health services and the needs of Indigenous service users is another explanation for the underutilization of mental health services by Indigenous peoples. In their systematic review of Indigenous mental health care access in Western countries, McIntyre, and colleagues (2017) find that Indigenous understandings and management of mental health are strongly tied to spirituality. Traditional healers are the most common source of emotional support for Indigenous peoples, who report greater satisfaction from traditional care than from Western medical services (McIntyre et al., 2017). Researchers have proposed that Indigenous health and wellbeing in Canada are affected by social, cultural, and land use (SCLU) factors, such as the amount of household meals consumed from traditional diets and the existence of government regulations on land use (Kant et al., 2013). The most important SCLU factors to Indigenous peoples include strong social ties, a sense of belonging to local community, and access to Indigenous cultural sites (Kant et al., 2013). Research suggests that access to cultural sites as well as the freedom to participate in spiritual activities have the potential to reduce psychological illness for Indigenous peoples (Kant et al., 2013). These factors are therefore crucial to the development of culturally appropriate Indigenous mental health programs and policies (Kant et al., 2013). "Cultural safety," which seeks to decolonize power relations in health services and improve the health status of Indigenous peoples, is gaining momentum in British Columbia's mental health care delivery sector (Josewski, 2012; Hansen, 2019). The expansion of Indigenous mental health treatment models is impeded, however, by prevailing Western neo-liberal and biomedical ideologies that have been proven to be ineffective in addressing the long-standing traumas experienced by Indigenous populations (Josewski, 2012). In Firestone's study on the mental health service utilization of urban Indigenous populations in Canada, 21% of participants reported not consulting a service provider about their mental health concerns because they felt that available services were not culturally appropriate (Firestone et al., 2015). One fifth of participants reported difficulty accessing traditional forms of care, such as a healer, medicine person, or elder (Firestone et al., 2015). The general lack of mental health care suit-

ed to the particular social and cultural needs of Indigenous populations in Canada results in the rise of population health disparities.

Research suggests that, for the general Canadian population, mental health service utilization depends on socioeconomic factors as well as indicators of emotional unwellness (Steele et al., 2007b; Pirkis et al., 2001; Jang et al., 2015; Zuvekas & Fleishman, 2008). Regarding socioeconomic factors in care access, income has been studied as a predictor of mental health care utilization (Steele et al., 2007a). Steele and colleagues (2007a) propose that despite the system of universal coverage for mental healthcare provided by medical doctors in Canada, there still remains an inequitable distribution of access to mental health services for low-income populations in need. Studies find a higher prevalence of anxiety and affective disorders among low-income and low-education groups compared to groups with higher income, yet the former are more likely to report “acceptability” barriers to mental health care than the latter (Steele et al., 2007b; Algeria et al., 2000). Acceptability barriers to mental health service utilization include beliefs that services will not be helpful, fears of asking for help, a preference for managing one’s mental health independently, and having language barriers or responsibilities that prevent help-seeking (Steele et al., 2007b). Indicators of emotional unwellness, such as suicidal ideation and poor self-rated mental health, also influence mental health service utilization for the general population (Pirkis et al., 2001). Research on Australian adults who reported suicidal ideation within one previous year shows that these individuals were more likely to use at least one type of mental health service (e.g., outpatient consultations with specialist and non-specialist mental health professionals, hospital-based care, etc.) compared to non-suicidal individuals (Pirkis et al., 2001). Lastly, self-rated mental health is an important predictor of mental health care utilization because it reflects the self-recognition of mental health concerns (Zuvekas & Fleishman, 2008; Jang et al., 2015). Research demonstrates that the likelihood of service use substantially increases when individuals rate their mental health as “fair” or “poor” (Jang et al., 2015). The odds of outpatient visits and medication purchases for mental health treatment, in particular, increase as self-rated mental health worsens (Zuvekas & Fleishman, 2008). This relationship remains even when controlling for diagnosed mental disorders and other sociodemographic variables (Zuvekas & Fleishman, 2008). Interestingly, the increased propensity for treatment as self-rated mental health worsens occurs at a slower rate for non-white individuals than for white individuals (Zuvekas & Fleishman, 2008). Overall, research literature suggests that income and indicators of emotional unwellness are factors associated with mental health service utilization in the general population.

Building upon previous literature on mental health care access, this paper aims to explore the relationship between Indigenous status and

mental health service utilization in the Canadian context. Given the colonial legacies that continue to perpetuate structural disadvantages for Indigenous peoples in Canada, it is all the more crucial that Indigenous individuals experiencing emotional unwellness have access to mental health care. This paper represents a contribution to literature as it explores the care-seeking patterns of Indigenous populations in order to identify potential barriers to care access, which must first be recognized and addressed to grant the possibility of treatment and improved well-being.

Research Hypotheses

Using nationally representative data from the 2015-2016 Canadian Community Health Survey, this study conducts a preliminary descriptive analysis to determine: 1) the factors influencing mental health service utilization for the general population; and 2) the relationship between Indigenous status and mental health service utilization. I hypothesize that factors such as income, thoughts of suicide, and self-rated mental health will be associated with mental health service utilization for the general Canadian population. Consistent with findings in previous literature, I believe that groups with lower income will be less likely to consult a mental health professional while groups that have considered suicide or possess poorer mental health will be more likely to consult a mental health professional than their counterparts. I predict, moreover, that due to the unique barriers that Indigenous service users face when seeking mental health care, the Indigenous population in Canada will be less likely to consult a mental health professional than the non-Indigenous population.

Data and Methods

This study analyzes public use data from the 2015-2016 Canadian Community Health Survey (CCHS), conducted by the Health Statistics Division of Statistics Canada. The CCHS is a cross-sectional survey consisting of “core content” (that is administered to all respondents and does not change year to year), “theme content” (that is administered to all respondents and alternates from year to year), and “optional content” (that is administered only in provinces and territories that select the module, and varies year to year) (Statistics Canada, 2017). The CCHS was first administered in 2001 to collect information related to the health status, health behaviors, and health care utilization of Canadians within the context of their social determinants of health (Statistics Canada, 2017). Since 2007, it has been conducted every year with a minimum sample size of 65 000 respondents (Statistics Canada, 2017). Re-

spondents of the CCHS are individuals aged 12 years and above living in Canada's ten provinces and three territories, excluding those in the Canadian Forces, foster care, institutional dwellings (such as prisons, nursing homes, and hospitals), Indigenous reserves, and select regions of Quebec (Statistics Canada, 2017). Taken together, these exclusions constitute less than 3% of the total Canadian population aged 12 years and above (Statistics Canada, 2017). The CCHS uses the following two sampling frames to select its participants: a frame of telephone numbers from the Canada Child Tax Benefit records (to select youth aged 12 to 17 years) and an area frame for the Canadian population aged 18 and above (Statistics Canada, 2017). The overall response rate of the 2015-2016 Canadian Community Health Survey is 59.5% (Statistics Canada, 2017). Data from the CCHS is primarily used by government agencies to plan, implement, monitor, and evaluate programs to improve public health (Statistics Canada, 2017). It is also used by researchers to conduct population health research as well as by health organizations and the media to raise awareness about health concerns (Statistics Canada, 2017).

The Sample.

The original sample for the 2015-2016 Canadian Community Health Survey consists of 109 659 individuals. Analyses for this study were restricted to individuals aged 25 and over, representing adults who are likely to have completed their education. Individuals with missing data on any variables of interest in the study were also removed from the sample, resulting in a final sample size of 10 416 cases. The data were weighted to represent results at the national level. All analyses were conducted using SPSS in Western University's graduate research laboratory.

Variables.

The main dependent variable of this study is mental health service utilization, measured by the CCHS's variable on whether or not individuals consulted a mental health professional within the past 12 months of responding to the survey. Responses were coded "Yes" or "No."

The independent variable of interest is Indigenous status, which includes respondents who identify as First Nations, Metis, or Inuit in the CCHS. Categories were coded as "Indigenous" (First Nations, Metis, or Inuit respondents) or "Non-Indigenous" (all other respondents).

Other independent variables include income, thoughts of suicide, and self-rated mental health. The income variable is the total household income variable from the CCHS, coded "Above Median" for respondents with over \$60 000 in total household income and "Below Medi-

an” for respondents with less than \$59 000 in total household income. Thoughts of suicide are measured by the CCHS’s variable on whether individuals had considered suicide within the past 12 months, with responses coded “Yes” or “No.” Lastly, self-rated mental health is measured using the “Perceived Mental Health” variable from the CCHS. Reports of excellent, very good, and good mental health were coded as “Good” mental health, while reports of fair and poor mental health were coded as “Poor” mental health for this study.

Data Analysis.

Analyses began with the construction of frequency distributions for each variable. Cross tabulations and p-values for chi-square tests were then produced for the bivariate relationships between mental health service utilization and the income, thoughts of suicide, and self-rated mental health variables. Additional bivariate descriptive statistics were produced for Indigenous status and the income, thoughts of suicide, and self-rated mental health variables to determine whether Indigenous status holds any significant relationships with these variables. The relationship between Indigenous status and mental health service utilization was subsequently tested. Finally, the income, thoughts of suicide, and self-rated mental health variables were layered into the cross tabulation of Indigenous status and mental health service utilization, with chi-square and p-values generated once again for the multivariate relationship.

Results

Table 1 contains frequency distributions of all the variables in the study. Of all respondents, only a small fraction (8.1%) identifies as Indigenous while the majority (91.9%) do not. Within 12 months before participating in the survey, 38.1% of all individuals reported consulting a mental health professional whereas 61.9% reported not doing so. Most respondents (53.8%) in the sample have a total household income that is above the median Canadian income while the remaining 46.2% of respondents have a total household income below the median Canadian income. Regarding the self-rated mental health of the population, 79% report good mental health whereas 21% report poor mental health. Lastly, 17.1% of the population reported considering suicide within the past year, while 82.9% did not.

Univariate Descriptive Statistics: All Variables.

Table 1. Frequency Distribution of All Variables in Total Population

Variable	Attributes	Percent Frequency
Indigenous Status	Indigenous	8.1%
	Non-Indigenous	91.9%
Consulted Mental Health Professional	Yes	38.1%
	No	61.9%
Total Household Income	Above Median	53.8%
	Below Median	46.2%
Self-rated Mental Health	Good Mental Health	79%
	Poor Mental Health	21%
Considered Suicide	Yes	17.1%
	No	82.9%

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Table 2 demonstrates that individuals with a total household income below the Canadian median are more likely to consult a mental health professional than those with above-median household income. Of all individuals with below-median total household income, 39.8% consulted a mental health professional. This represents a statistically significant difference from the 36.6% of individuals with above-median income who consulted a mental health professional.

Bivariate Descriptive Statistics: Mental Health Service Utilization by Income.

Table 2. Consultation with Mental Health Professional by Total Household Income

Consulted Mental Health Professional	Total Household Income	
	Above Median	Below Median
Yes	36.6%	39.8%
No	63.4%	60.2%
Total	100%	100%
(N)	5609	4807

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square (2-sided Asymptotic Significance) = 0.001 (p<0.01), STATISTICALLY SIGNIFICANT

Bivariate Descriptive Statistics: Mental Health Service Utilization by Thoughts of Suicide.

Table 3. Consultation with Mental Health Professional by Considered Suicide

Consulted Mental Health Professional	Considered Suicide	
	Yes	No
Yes	65.0%	32.5%
No	35.0%	67.5%
Total	100%	100%
(N)	1785	8631

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square (2-sided Asymptotic Significance) = 0.000 (p<0.001), STATISTICALLY SIGNIFICANT

Table 3 shows that thoughts of suicide are associated with mental health care utilization for the general Canadian population. Out of those who had considered suicide within the past year, 65.0% had also consulted a mental health professional. Individuals who had considered suicide are twice as likely as those who had not considered suicide to consult mental health services. This represents both a statistically significant and meaningful difference between the groups.

Bivariate Descriptive Statistics: Mental Health Service Utilization by Self-rated Mental Health.

Table 4. Consultation with Mental Health Professional by Self-rated Mental Health

Consulted Mental Health Professional	Self-rated Mental Health	
	Good	Poor
Yes	29.5%	70.2%
No	70.5%	29.8%
Total	100%	100%
(N)	8225	2191

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square (2-sided Asymptotic Significance) = 0.000 ($p < 0.001$), STATISTICALLY SIGNIFICANT

Table 4 shows, again, a statistically significant and meaningful difference between the mental health consultation of two groups. Individuals with poor self-reported mental health are over 2 times more likely to consult a mental health professional compared to those with good self-rated mental health. The majority of individuals with poor self-reported mental health (70.2%) consulted a professional about their mental health while 29.5% of individuals with good self-reported mental health consulted a mental health professional.

Additional Bivariate Descriptive Statistics: Income, Thoughts of Suicide, and Self-rated Mental Health by Indigenous Status.

The associations between Indigenous status and income, thoughts of suicide, and self-rated mental health were also investigated to determine whether Indigenous status holds any significant relationships with these variables. Results show that Indigenous people are more likely to have a total household income below the median household income in Canada, with 55.8% of Indigenous people having below-median income compared to 45.3% of non-Indigenous people with below-median income. This relationship is statistically significant ($p < 0.001$) and meaningful. Regarding thoughts of suicide, there is no statistically significant relationship between Indigenous status and considering suicide. Virtually the same proportion of Indigenous and non-Indigenous people, at 17.7% and 17.1% of each group respectively, reported considering suicide in the past year. Lastly, Indigenous status holds a statistically significant relationship with self-reported mental health ($p < 0.05$). Indigenous people are more likely to report poor mental health than non-Indigenous peoples, with 24.2% of Indigenous people reporting poor mental health compared to 20.8% of non-Indigenous people. This represents a meaningful difference between the two populations.

Bivariate Descriptive Statistics: Mental Health Service Utilization by Indigenous Status.

Table 5. Consultation with Mental Health Professional by Indigenous Status

Consulted Mental Health Professional	Indigenous Status	
	Indigenous	Non-Indigenous
Yes	40.0%	37.9%
No	60.0%	62.1%
Total	100%	100%
(N)	847	9 569

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square (2-sided Asymptotic Significance) = 0.223 ($p > 0.05$), NOT STATISTICALLY SIGNIFICANT

Table 5 demonstrates that being Indigenous is associated with a greater likelihood of consulting a mental health professional, although the relationship is not statistically significant. Of all Indigenous individuals in Canada, 40.0% consulted a mental health professional within the past year, while 37.9% of non-Indigenous individuals did the same.

Multivariate Descriptive Statistics: Mental Health Service Utilization by Indigenous Status, Controlling for Total Household Income.

Table 6. Consultation with Mental Health Professional by Indigenous Status and Total Household Income

Consulted Mental Health Professional	Total Household Income Above Median		Total Household Income Below Median	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Yes	34.1%	36.8%	44.8%	39.2%
No	65.9%	63.2%	55.2%	60.8%
Total	100%	100%	100%	100%
(N)	375	5 234	473	4 335

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 417

Pearson Chi-Square for Total Household Income Above Median (2-sided Asymptotic Significance) = 0.297 ($p > 0.05$), NOT STATISTICALLY SIGNIFICANT
Pearson Chi-Square for Total Household Income Below Median (2-sided Asymptotic Significance) = 0.018 ($p < 0.05$), STATISTICALLY SIGNIFICANT

Table 6 shows that non-Indigenous people are more likely to consult a mental health professional among persons with above-median total household income, with 36.8% of non-Indigenous people consulting a mental health professional in the past year compared to 34.1% of Indigenous people with above-median total household income who did so. This difference between non-Indigenous and Indigenous peoples with above-median incomes is not statistically significant, however. Among persons with below-median total household income, Indigenous peo-

ples are more likely to consult a mental health professional. This relationship is statistically significant as 44.8% of Indigenous people with below-median income consulted a mental health professional compared to 39.2% of non-Indigenous people in the same income category. Moreover, it is interesting to note that significantly more Indigenous people in the below-median income category consulted a mental health professional compared to Indigenous people in the above-median income category: 44.8% of the former group compared to 34.1% of the latter group did so, representing a meaningful percentage point difference of 10.7%. This trend of greater mental health service utilization by those with below-median income is reflected in the non-Indigenous population as well (although to a lesser degree) as 39.2% of non-Indigenous people with below-median income consulted a mental health professional compared to 36.8% of non-Indigenous people with above-median income.

Multivariate Descriptive Statistics: Mental Health Service Utilization by Indigenous Status, Controlling for Thoughts of Suicide.

Table 7. Consultation with Mental Health Professional by Indigenous Status and Considered Suicide

Consulted Mental Health Professional	Considered Suicide		Did Not Consider Suicide	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Yes	56.4%	65.8%	36.5%	32.2%
No	43.6%	34.2%	63.5%	67.8%
Total	100%	100%	100%	100%
(N)	149	1 636	698	7933

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square for Considered Suicide (2-sided Asymptotic Significance) = 0.021 ($p < 0.05$), STATISTICALLY SIGNIFICANT

Pearson Chi-Square for Did Not Consider Suicide (2-sided Asymptotic Significance) = 0.018 ($p < 0.05$), STATISTICALLY SIGNIFICANT

Table 7 demonstrates that non-Indigenous people are more likely to consult a mental health professional among the population that considered suicide, as 65.8% of non-Indigenous people who considered suicide did so while 56.4% of Indigenous people who considered suicide did so. This difference between non-Indigenous and Indigenous people that considered suicide is both statistically significant and meaningful. Among the population that did not consider suicide, Indigenous people are more likely to consult a mental health professional than non-Indigenous people. Of the Indigenous people who did not consider suicide, 36.5% consulted a mental health professional whereas 32.2% of non-Indigenous people who did not consider suicide did so. This difference between the Indigenous and non-Indigenous people who did not consider suicide is statistically significant. Among Indigenous people who did not consider suicide, 36.5% consulted a mental health professional while among Indigenous people who did consider suicide, 56.4% consulted a mental health professional. This suggests that for Indigenous people, considering suicide increases the likelihood of consulting a mental health professional.

Multivariate Descriptive Statistics: Mental Health Service Utilization by Indigenous Status, Controlling for Self-rated Mental Health.

Table 8 shows that within the population with good self-reported mental health, Indigenous and non-Indigenous people did not consult a mental health professional at vastly different rates. Of Indigenous peoples with good self-rated mental health, 30.8% consulted a mental health professional while 29.4% of non-Indigenous peoples with good self-rated mental health did so. This does not represent a statistically significant difference between Indigenous and non-Indigenous peoples with good self-rated mental health. Among the population with poor self-rated mental health, 68.8% of Indigenous persons consulted a mental health professional while 70.4% of non-Indigenous persons consulted a mental health professional. It appears that among people with poor self-rated mental health, Indigenous peoples are slightly less likely to utilize mental health services, although this relationship is not statistically significant. Among Indigenous peoples, 68.8% of those with poor self-rated mental health consulted a professional while 30.8% of those with good self-rated mental health did so, suggesting that poorer mental health is associated with consulting a mental health professional in the Indigenous population.

Table 8. Consultation with Mental Health Professional by Indigenous Status and Self-rated Mental Health

Consulted Mental Health Professional	Good Self-rated Mental Health		Poor Self-rated Mental Health	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Yes	30.8%	29.4%	68.8%	70.4%
No	69.2%	70.6%	31.2%	29.6%
Total	100%	100%	100%	100%
(N)	642	7 583	205	1 986

Source: 2015-2016 Canadian Community Health Survey, Annual Component
N = 10 416

Pearson Chi-Square for Good Mental Health (2-sided Asymptotic Significance) = 0.440 ($p > 0.05$), NOT STATISTICALLY SIGNIFICANT

Pearson Chi-Square for Poor Mental Health (2-sided Asymptotic Significance) = 0.631 ($p < 0.05$), NOT STATISTICALLY SIGNIFICANT

Discussion

I initially hypothesized that, in the general population, factors like income, thoughts of suicide, and self-rated mental health would be associated with mental health service utilization. Based on previous literature, I predicted that groups with lower income would be less likely to consult a mental health professional than those with higher income. This hypothesis was not supported by findings, which show that Canadian individuals with below-median total household income are more likely to consult a mental health professional than those with above-median total household income. Although this is surprising if one assumes that low-income populations face economic barriers to accessing mental health services, previous research does show that low levels of household income are also associated with several lifetime mental disorders and suicide attempts, which are associated with increased mental health

service utilization (Sareen et al., 2011). Other hypotheses at the start of this study regarding the general population were that groups that have considered suicide or possess poorer mental health would be more likely to consult a mental health professional. These predictions were supported by this study's findings.

While conducting additional analyses of the associations between Indigenous status and income, thoughts of suicide, and self-rated mental health, findings showed that Indigenous people are more likely to have a total household income below the median Canadian income than non-Indigenous people. Moreover, similar proportions of Indigenous and non-Indigenous people report having considered suicide in the past year. Indigenous people are more likely, however, to report poor mental health than non-Indigenous people.

Regarding the relationship between Indigenous status and mental health service utilization, I initially hypothesized that the Indigenous population in Canada would be less likely to consult a mental health professional than the non-Indigenous population due to the unique barriers they face in mental health care. The findings that have been summarized in this section thus far show that: 1) having a low income or poor self-rated mental health increases the likelihood of consulting a mental health professional for the general population; and 2) Indigenous populations are more likely to have low income and poor mental health compared to non-Indigenous populations. Given these two sets of findings, one expects that Indigenous people would be more likely than non-Indigenous people to consult mental health services in Canada. A bivariate analysis of mental health service utilization by Indigenous status (in **Table 5**) shows that, although being Indigenous is associated with a slightly greater likelihood of consulting a mental health professional, the relationship is not statistically significant. Because Indigenous people consulted with a mental health professional at a similar rate as non-Indigenous people despite being more likely to have low income and poorer mental health, this outcome suggests the potential underutilization of mental health services by Indigenous people in Canada. This possibility is consistent with previous literature describing the low rate of mental health service utilization of Indigenous people due to structural and cultural barriers.

When the relationship between Indigenous status and mental health service utilization is further investigated by controlling for income, thoughts of suicide, and self-rated mental health, a more complex reality emerges.

Controlling for total household income in the relationship between Indigenous status and mental health service utilization reveals a statistically significant relationship between Indigenous status and consulting a mental health professional for populations with below-median total household income. This relationship, which shows that Indigenous

peoples with below-median income are more likely to consult a mental health professional than non-Indigenous peoples with below-median income, demonstrates that Indigenous class differences in mental health consultation are hidden by the bivariate relationship between Indigenous status and mental health consultation. Among individuals with above-median income, there is no statistically significant difference between the mental health consultation of Indigenous and non-Indigenous individuals. This might be because, although Indigenous peoples are generally more likely to report poor self-rated mental health, class position provides health-protective resources to mitigate the effects of poor mental health for individuals with above-median income (Callan et al., 2015). The higher propensity of low-income Indigenous peoples to consult a mental health professional might imply circumstances of greater stress associated with this status, or the existence of programs targeting this under-resourced population. Additionally, outcomes show that both Indigenous and non-Indigenous peoples with below-median total household income are more likely to consult a mental health professional than their counterparts with above-median income. This finding is consistent with outcomes in the general population showing a greater proportion of mental health utilization in lower-income groups compared to higher-income groups.

When controlling for thoughts of suicide in the relationship between Indigenous status and mental health service utilization, there is a statistically significant difference in the relationship between Indigenous status and mental health service utilization for both people who considered suicide and people who did not consider suicide in the past year. Results show that Indigenous peoples are less likely than non-Indigenous peoples to consult a mental health professional when they have considered suicide. However, Indigenous peoples are more likely than non-Indigenous peoples to consult a mental health professional when they have not considered suicide. Because thoughts of suicide are associated with the decreased propensity to consult a mental health professional for Indigenous populations, it may suggest stigma within Indigenous culture regarding thoughts of suicide. This demonstrates that although the bivariate relationship between Indigenous status and mental health consultation is not statistically significant, it conceals information with respect to Indigenous rates of service utilization by thoughts of suicide. Having thoughts of suicide is an important factor that differentiates the rates of service utilization between Indigenous and non-Indigenous groups. Furthermore, when comparing across groups that considered suicide and groups that did not consider suicide, a higher proportion of both Indigenous and non-Indigenous individuals consulted a mental health professional if they considered suicide. Consistent with outcomes in the general population, this finding demonstrates a greater proportion of mental health service utilization by those who

have considered suicide compared to those who have not.

When self-rated mental health is controlled for in the relationship between Indigenous status and mental health service utilization, no statistically significant relationships emerge. This suggests that the main relationship between Indigenous status and mental health service utilization does not change within each category of self-rated mental health. In other words, Indigenous and non-Indigenous peoples with poor mental health access services at similar rates, and Indigenous and non-Indigenous peoples with good mental health access services at similar rates. The bivariate relationship between Indigenous status and mental health consultation does not conceal additional information in relation to categories of self-rated mental health. Similar to trends in the general population, there is a greater proportion of mental health service utilization by Indigenous and non-Indigenous peoples who report poor self-rated mental health compared to those who report good self-rated mental health.

Conclusion

Through investigating the relationship between Indigenous status and mental health service utilization, while accounting for correlates of mental health service utilization such as income, thoughts of suicide, and self-rated mental health, this study produces important findings regarding disparities in health care. Research outcomes show that Indigenous and non-Indigenous populations in Canada use mental health services at similar rates. This suggests an underutilization of services by Indigenous populations, however, given that they are more likely to experience poor self-rated mental health than the non-Indigenous population and are also less likely to consult a mental health professional than the non-Indigenous population if they have considered suicide.

Limitations of this study include the recoding of the CCHS's original total household income variable into two categories of "Above" and "Below" the median Canadian income. Collapsed categories result in more nuanced information being lost during analyses, which may have otherwise been available with more categories of the variable. Other limitations are related to the nature of the CCHS's data. The CCHS is cross-sectional and therefore depends on the accuracy of its participants' memories. The time frame applied to certain questions asked in this study (e.g., consultations with a mental health professional and considerations of suicide) extend up to one year prior to when the survey was conducted, which make responses prone to memory error. The sensitive nature of the questions asked (e.g., on the topic of suicide) can also impact the willingness of respondents to report (or truthfully report) information. Lastly, the CCHS excludes populations living on In-

digenous reserves, which might impact findings if this population disproportionately experiences low-income, thoughts of suicide, or poor mental health.

New directions for research should involve qualitative inquiry into the statistical outcomes observed in this study. For example, an inquiry into the potential stigma that exists around considering suicide for Indigenous populations would explain this study's findings and aid in the development of more culturally appropriate mental health services. Next steps for quantitative research involve including additional variables, such as age, sex, marital status, and educational level, in analyses of the relationship between Indigenous status and mental health care utilization. It would also be important to employ inferential statistics to explore this relationship, since this study simply uses preliminary descriptive statistics.

Notwithstanding its limitations, this study provides a useful contribution to Canadian population health literature. It suggests that mental health services for Indigenous populations must be developed with the recognition of population-specific needs and within the context of cultural safety. The equitable access to, and utilization of mental health services by Indigenous populations is central to advancing overall population health in Canada.

References

- Alegria, M., Bijl, R.V., Lin, E., Walters, E., & Kessler, R.C. (2000). Income differences in persons seeking outpatient treatment for mental disorders: a comparison of the United States with Ontario and the Netherlands. *Arch Gen Psychiatry* 57(4):383-391.
- Arboleda-Flórez, J. (2005). The Epidemiology of Mental Illness in Canada. *Canadian Public Policy* 5.
- Benoit, A. C., Cotnam, J., Raboud, J., Greene, S., Beaver, K., Zoccole, A., Brien-Teengs, Balfour, L., Wu, W., & Loutfy, M. (2016). Experiences of Chronic Stress and Mental Health Concerns among Urban Indigenous Women. *Archives of Women's Mental Health* 19(5).
- Bingham, B., Moniruzzaman, A., Patterson, M., Distasio, J., Sareen, J., O'Neil, J., & Somers, J.M. (2019). Indigenous and Non-Indigenous People Experiencing Homelessness and Mental Illness in Two Canadian Cities: A Retrospective Analysis and Implications for Culturally Informed Action. *BMJ Open* 9(4).
- Browne, A. J., Smye, V. L., Rodney, P., Tang, S. Y., Mussell, B., & O'Neil, J. (2010). Access to Primary Care From the Perspective of Aboriginal Patients at an Urban Emergency Department. *Qualitative Health*

Research 21 (3): 333-348.

- Callan, M., Kim H., & Matthews, W. (2015). Predicting Self-Rated Mental and Physical Health: The Contributions of Subjective Socioeconomic Status and Personal Relative deprivation. *Frontiers Research Foundation* 1(1):1415.
- Canadian Civil Liberties Association. (2017). The Current State of Mental Health in Canada. Retrieved November 30, 2019 from <https://ccla.org/current-state-mental-health-canada/>.
- Canadian Mental Health Association. 2018. "Mental Health in the Balance: Ending the Health Care Disparity in Canada." Retrieved November 30, 2019 from <https://cmha.ca/ending-health-care-disparity-canada>.
- Chandler, M. J. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's first nations. *Transcultural Psychiatry* 35(2): 191-219.
- Feminist Northern Network. (2016). Colonialism and its Impacts. *Resource Development in Northern Communities: Local Women Matter* #3. Ottawa: Canadian Research Institute for the Advancement of Women.
- Firestone, M. (2013). *Our Health Counts - Unmasking Health and Social Disparities among Urban Aboriginal People in Ontario*. University of Toronto, Canada. ProQuest Dissertations Publishing.
- Firestone, M., Smylie, J., Maracle, S., McKnight, C., Spiller, M., & O'Campo, P. (2015). Mental Health and Substance Use in an Urban First Nations Population in Hamilton, Ontario. *Canadian Journal of Public Health*. Retrieved November 17, 2019 from <https://link-galegroup-com.proxy1.lib.uwo.ca/apps/doc/A449316307/AONE?sid=lms>.
- Hansen, H. (2019). Cultural safety training raises the bar for our mental health providers. *First Nations Health Authority*. Retrieved December 17, 2019 from <https://www.fnha.ca/wellness/sharing-our-stories/cultural-safety-training-raises-the-bar-for-our-mental-health-providers>.
- Henderson, W. B. (2006). Indian Act. *The Canadian Encyclopedia*. Retrieved March 23, 2019 from <https://www.thecanadianencyclopedia.ca/en/article/indian-act>.
- Indigenous Peoples Atlas of Canada. (2019). The Road to Reconciliation. Retrieved December 16, 2019 from <https://indigenouspeoplesatla->

sofcanada.ca/article/the-road-to-reconciliation/.

- Jang, Y., Yoon, H., Chiriboga, D.A., Molinari, V., & Powers, D.A. (2015). Bridging the Gap Between Common Mental Disorders and Service Use: The Role of Self-Rated Mental Health Among African Americans. *The American Journal of Geriatric Psychiatry* 23(7):658-65.
- Josewski, Viviane. (2012). Analysing 'Cultural Safety' in Mental Health Policy Reform: Lessons from British Columbia, Canada. *Critical Public Health* 22(2):223-34.
- Kant, S., Vertinsky, I., Zheng, B., & Smith, P.M. (2013). Social, cultural, and land use determinants of the health and well-being of Aboriginal peoples of Canada: A path analysis. *Journal of Public Health Policy* 34(3): 462-476.
- Mccue, H.A. (2011). Reserves. *The Canadian Encyclopedia*. Retrieved March 23, 2019 from <https://www.thecanadianencyclopedia.ca/en/article/aboriginal-reserves>.
- McIntyre, C., Harris, M.G., Baxter, A.J., Leske, S., Diminic, S., Gone, J.P., Hunter, E., & Whiteford, H. (2017). Assessing Service Use for Mental Health by Indigenous Populations in Australia, Canada, New Zealand and the United States of America: A Rapid Review of Population Surveys. *Health Research Policy and Systems* 15 (65): 1-17.
- Mental Health Commission of Canada. (2012). Changing directions, changing lives: The mental health strategy for Canada. Calgary, AB. Retrieved November 30, 2019 from https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf
- Mental Health Commission of Canada. (2016). Advancing the Mental Health Strategy for Canada: A Framework for Action (2017-2022), Ottawa, ON. Retrieved November 30, 2019 from https://www.mentalhealthcommission.ca/sites/default/files/2016-08/advancing_the_mental_health_strategy_for_canada_a_framework_for_action.pdf.
- Miller, J.R. (2012). Residential Schools in Canada. *The Canadian Encyclopedia*. Retrieved December 16, 2019 from <https://www.thecanadianencyclopedia.ca/en/article/residential-schools>.
- Mitrou, F., et al. (2014) Gaps in Indigenous Disadvantage Not Closing: A Census Cohort Study of Social Determinants of Health in Australia, Canada, and New Zealand from 1981-2006. *BMC Public Health*, 14. 1: 201-201.

- Nader, F., Kolahdooz, F., & Sharma, S. (2017). Assessing Health Care Access and Use among Indigenous Peoples in Alberta: A Systematic Review. *Journal of Health Care for the Poor and Underserved* 28(4):1286–1303.
- Nelson, S.E. & Wilson, K. (2017). The Mental Health of Indigenous Peoples in Canada: A Critical Review of Research. *Social Science & Medicine* 176:93–112.
- Pirkis, J.E., Burgess, P.M., Meadows, G.N., & Dunt, D.R. (2001). Suicidal Ideation and Suicide Attempts as Predictors of Mental Health Service Use. *Medical Journal of Australia* 175(10):542–45.
- Richmond, C.A.M. & Cook, C. (2016). Creating Conditions for Canadian Aboriginal Health Equity: The Promise of Healthy Public Policy. *Public Health Reviews* 37(1):2.
- Sareen, J., Afifi, T., McMillan, K., & Asmundson, G. (2011). Relationship Between Household Income and Mental Disorders: Findings From a Population-Based Longitudinal Study. *Arch Gen Psychiatry* 68(4):419–427.
- Senate of Canada. (2006). Out of the Shadows at Last. Retrieved November 30, 2019 from https://sencanada.ca/content/sen/committee/391/soci/rep/rep02may06part1-e.htm#_Toc133223000.
- Statistics Canada. (2017). Canadian Community Health Survey, 2015–2016: Annual Component. Version updated September 2019. Ottawa.
- Steele, L.S., Dewa, C.S., Lin, E., & Lee, K. (2007a). Education Level, Income Level and Mental Health Services Use in Canada: Associations and Policy Implications. *Healthcare Policy* 3(1):96–106.
- Steele, L., Dewa, C., & Kenneth Lee. (2007b). Socioeconomic Status and Self-Reported Barriers to Mental Health Service Use. *The Canadian Journal of Psychiatry* 52(3):201–6
- Tang, S.Y. & Browne, A.J. (2008). Race Matters: Racialization and Egalitarian Discourses Involving Aboriginal People in the Canadian Health Care Context. *Ethnicity & Health* 13(2):109–27.
- Webster, P.C. (2016). Canada's Indigenous Suicide Crisis. *The Lancet* 387(10037):2494–2494.
- Woods, J. (2016). Public opinion of indigenous people in Canada improving: survey. *The Globe and Mail*, June 8. Retrieved December

14, 2019 from <https://www.theglobeandmail.com/news/politics/public-opinion-of-indigenous-people-in-canada-improving-survey/article30346252/>.

Zuvekas, S.H. & Fleishman, J.A. (2008). Self-Rated Mental Health and Racial/Ethnic Disparities in Mental Health Service Use. *Medical Care* 46(9):915.

