

# **The Impact of COVID-19 on Mental Health and Well-Being: A Focus on Racialized Communities in the GTA**

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## Executive summary

The COVID-19 pandemic has resulted in significant inequities in terms of health and social outcomes, and magnified stressors such as increased risk of exposure to and illness from COVID-19, job loss, and housing and food insecurity. These stressors have been particularly felt by already marginalized groups, including those from racialized communities, and there is evidence of accompanying negative mental health impacts. There is a need for increased understanding of how health systems and communities can prepare for the long-term mental health impacts of COVID-19.

The Mental Health Commission of Canada (MHCC) partnered with Wellesley Institute to study the impact of COVID-19 on the mental health and well-being of racialized working-age adults living in the Greater Toronto Area (GTA). The qualitative research focused on experiences of people from racialized communities as well as representatives from community organizations, to explore the pressures people are facing, the mental health supports and services that they need, and ways to support resilience beyond the pandemic, using upstream approaches.

## Key findings

The findings draw from semi-structured interviews with 10 subject matter experts (e.g., representatives from community organizations, researchers) and 22 participants who self-identified as Black, South Asian, or Southeast Asian and lived in the GTA. Interviews were conducted in Punjabi, Tamil, Tagalog, and English.

The findings show that participants experienced pressures (e.g., social isolation) which challenged their mental health and well-being during the first three waves of the pandemic. Despite these challenges, the data reveals a range of personal strategies (e.g., exercise, journaling) that were used to cope with increased anxiety, stress, and feelings of vulnerability and hopelessness resulting from the pandemic.

Community organizations adopted various strategies to meet the increased demand for mental health and related services during the first three waves of the pandemic. The research also uncovered multiple barriers to accessing appropriate mental health supports, including financial barriers, difficulties accessing virtual services, experiences of stigma, cultural and linguistic barriers, and mistrust in systems.

While increased mental health challenges were a common experience, the data also highlighted differences across people's experiences. Public and interpersonal experiences of racism and discrimination were deeply impactful for shaping mental health for some throughout the pandemic. The findings indicate that other social and economic factors were also important for framing experiences of mental health and well-being.

Participants consistently described how the broader factors of work, income, housing and caregiving responsibilities were central to their experiences of pressures during the first year of the pandemic. In instances where pressures specific to COVID-19 (e.g., anxieties around risk of COVID-19) intersected with conditions of job loss, economic and housing precarity and increased caregiving responsibilities, these stressors had the potential to greatly undermine people's mental health and well-being.

The analysis in this report speaks to the relationship between the social determinants of mental health and the effects of systemic and structural racism, which disproportionately position racialized people in work and living situations that increase the risk of acquiring COVID-19, and increase exposure to stressors that negatively impact mental health.

These challenges are not new. Research has documented the role of the broader social determinants of health and systemic racism in shaping mental health for some time, however, COVID-19 has highlighted and magnified these stressors and inequities.

## Recommendations

Action has fallen short on policy and public health interventions that reduce disparities in mental health risk and treatment. Responses to make up for the disproportionate effects of the pandemic on some groups should prioritize mental health services and upstream approaches that address the social determinants of health to reduce inequities in outcomes for racialized communities, in addition to culturally responsive, safe and accessible mental health services.

Some important steps for developing a system response to address mental health inequities include:

- Inclusion and representation of populations with experiences of health disparities in mental health system planning;
- Mental health systems that address racism, as well as the historical and contemporary contexts of colonialism;
- Adequate and sustained funding of community organizations that address the mental health and related needs of members of racialized populations; and
- Solutions that address the role of economic racism in shaping inequitable experiences of COVID-19 and growing gaps in assets held by different groups.

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## Introduction

The COVID-19 pandemic has exposed and amplified long-standing inequities in our society.<sup>1</sup> Emerging statistics demonstrate that COVID-19 infections have disproportionately affected equity-deserving population groups, notably those from low-income and racialized communities in Ontario and the Greater Toronto Area (GTA).<sup>2,3,4</sup> Data from the United States and the United Kingdom also demonstrates that those from racialized populations are more likely to be infected and have negative outcomes (e.g., mortality) from COVID-19.<sup>5</sup> Early reporting showed that racialized groups, comprising just over half the population, made up 83 per cent of reported cases in Toronto.<sup>6</sup>

Contributing to these disparities is the far greater likelihood that racialized individuals live in poverty, engage in precarious yet essential work, and reside in neighborhoods with overcrowded households and inadequate access to health care,<sup>7,8</sup> all of which are thought to increase risk of exposure to COVID-19. Recent research from the Canadian Centre for Policy Alternatives confirms that a larger proportion of racialized households (31 per cent) have faced economic hardship during the pandemic compared to white households (16 per cent) in Canada. The study confirms that racialized workers were over-represented in industry sectors that represented 80 per cent of job losses. Furthermore, the gap in the unemployment rate between racialized and white workers increased during COVID-19 (when compared with 2016 data).<sup>9</sup>

A growing body of evidence also suggests that racialized individuals may experience more substantial consequences of the COVID-19 pandemic on their mental health and well-being. A report by Statistics Canada<sup>10</sup> found that racialized Canadians were experiencing poorer mental health outcomes than non-racialized Canadians. According to the Canadian Mental Health Association,<sup>11</sup> racialized individuals have been more likely to have trouble coping with mental health challenges than the general population (22 per cent vs 14 per cent), since the onset of the COVID-19 pandemic.

Research has also found other social determinants of health to be key drivers of mental health during the pandemic, where factors like job insecurity and lower income are associated with a higher likelihood of depressive symptoms.<sup>12</sup> Polling from the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Use and Addiction has also found high rates of severe symptoms of depression (32 per cent), moderate to severe symptoms of anxiety (45 per cent), and suicidal ideation (12 per cent) among low income respondents.<sup>13</sup>

The GTA was hit harder by the pandemic than any other region in Ontario and consequently endured more restrictive public health measures for the first three waves. The reasons for this experience are complex and due to multiple factors, including population density and the volume of industry, trade and travel in the region. Importantly, areas with relatively high COVID-19 rates (e.g., Peel region) have an over-representation of essential workers in sectors such as manufacturing and retail, in addition to greater representation of racialized groups compared with other areas in the GTA.<sup>14</sup> This reality further suggests the importance of examining the experiences of working-aged adults from racialized communities in the GTA.

The inequalities documented in emerging COVID-19 literature suggest the need for research to better understand how the pandemic has impacted the mental health and well-being of historically disadvantaged populations, including racialized people, in the GTA. While evidence has grown on racial disparities in some health and socio-economic impacts of the pandemic, our knowledge is still limited in understanding how racialized populations cope with related challenges, and what is required to maintain and improve mental health and well-being during and post pandemic. Increased knowledge of experiences from racialized communities is specifically required given the unequal impacts of the pandemic in this region.

Wellesley Institute and the MHCC conducted a research project to explore the experiences of working-age adults from racialized communities during the COVID-19 pandemic, focusing on their challenges and strategies to maintain and improve mental health and well-being, as well as upstream approaches to support mental health.

This research contributes to other work undertaken by the MHCC to build understanding of the determinants of mental health of racialized and low-income people during COVID-19. Outputs in development include a conceptual framework that locates colonialism and structural and systemic racism as root causes of mental health inequities related to unequal access to the social determinants of health. This work brings together research with a particular

focus on areas such as employment, income, housing, food insecurity, and access to health systems and institutions to improve understandings of the unequal impact of COVID-19 on racialized and low-income communities.

Building on this conceptual work, the research team also conducted a qualitative study with three main research questions: i) what pressures are working age, racialized people in the GTA facing and how are they coping since the onset of the COVID-19 pandemic? ii) what mental health supports and services do they need? and iii) how can resilience be supported now and beyond the COVID-19 pandemic using upstream approaches?

Drawing from interviews with research participants who identify as Black, South Asian or Southeast Asian and selected subject matter experts across the GTA, this paper explores how the pandemic has impacted people's mental health and well-being and how these experiences are framed by broader social and economic factors. The findings on the impact of COVID-19 support a body of earlier work that has demonstrated the need for a broad system-wide response to adequately address the mental health and well-being of racialized populations.

## Methods

Qualitative interviews were conducted to explore the experiences and perspectives of two main sample groups: i) participants with lived experience and ii) subject matter expert (SME) participants. Participants with lived experience were included in the sample if they:

- lived in the GTA;
- were between the ages of 18 and 64;
- self-identified as Black, South Asian, or Southeast Asian; and
- spoke Punjabi, Tamil, Tagalog, or English.

This set of inclusion criteria was developed based on the data showing Black, South Asian, and Southeast Asian as the top three racialized groups over-represented in COVID-19 cases in Toronto and Peel, and English, Punjabi, Tamil, and Tagalog as among the most common languages spoken at home for the selected racialized groups.<sup>15</sup>

Interviews with participants from specific racialized communities focused on their general experiences during the pandemic (e.g., pressures and coping strategies), mental health needs related to COVID-19, including social determinants of health (e.g., housing, job, social connection), and the use of informal and formal support for mental health help-seeking.

Subject matter expert participants were included based on their expert knowledge about mental health and well-being in the GTA's racialized communities through their work in service provision, research, and/or policy. Interviews with SME participants focused on identifying gaps in mental health supports and services during COVID-19 and in general, as well as upstream opportunities to build resilience in equity-deserving populations.

A purposive sampling strategy was used to maximize as much as possible, diverse representation of participants within the lived experience group, based on factors such as self-identified ethnoracial identity,<sup>a</sup> gender identity, and age.<sup>16</sup> Purposive sampling was also used to achieve representation of diverse communities and perspectives within the SME group.

For lived experience participant recruitment, researchers posted study and recruitment information on social media and requested that various community agencies (within and outside of researcher networks) disseminate study materials via email lists and newsletters. Individuals interested in participating in the study contacted researchers via email or phone and were screened for their eligibility. For SME interviews, the research team identified potential participants based on their expertise and invited them to participate in the study via publicly available email accounts linked to the organizations where they worked.

Qualitative semi-structured interviews were conducted from February to April 2021. During this time, Ontario announced a third pandemic wave in early February. A provincial emergency was re-established during this period, along with two separate orders that mandated that people not leave their homes except for essential purposes (e.g., work if an essential worker, shopping for essential items). Therefore, all the recruitment efforts and data collection were conducted online or over the phone. At the time of data collection, Canada was in the early stages of vaccine distribution within the population, and many working-aged adults were waiting to receive their first vaccine dose. Ethics approval for the research was granted by the Ryerson University Research Ethics Board in January 2021 (REB #2020-533).

Five researchers from Wellesley Institute and the MHCC conducted interviews with participants in English, Punjabi, Tamil and Tagalog. All SME interviews were conducted in English, and approximately one-third of interviews with lived experience participants were conducted in Punjabi, Tamil, and Tagalog, or a combination of English and one of these languages. Interviews were conducted by telephone or video call (e.g., Zoom).

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<sup>a</sup> Potential participants were asked to self-identify according to various broad ethnoracial categories from established demographic data collection tools – see Measuring inequities in COVID-19: Enhancing socio-demographic data collection. <https://www.healthcommons.ca/project/covid19-sociodemographic-data-collection>



The interviews ranged from 35 to 70 minutes in length. Interviews were audio-recorded and transcribed verbatim by professional transcription companies. Transcripts were analyzed by the project team in NVivo using a thematic analysis approach.<sup>17</sup> Analysis involved an inductive technique where emerging codes were generated in a systematic fashion directly from the data.

The research team first reviewed the data and developed a coding matrix which comprised a list of focused thematic codes. The preliminary list and observations were shared and discussed with the project team. Based on these conversations, the thematic codes were revised and then applied across all transcripts. As analysis progressed, codes were gathered into broader themes, which were organized and refined with ongoing engagement with the data. Project team discussions continued throughout the analysis to corroborate interpretations, identify themes and patterns that reflect the commonalities and differences in participant experiences and perspectives, and resolve points of divergence across the group.

## Results

### Sample description

The sample included 10 SME participants and 22 participants with lived experience. SME participants were service providers representing community health and mental health service agencies serving Black, South Asian, Southeast Asian, and East Asian and other communities across the GTA and researchers who work with racialized communities in areas related to mental health. The sample included seven community health service agencies with representatives in Executive Director, Manager, Director, and frontline service provision positions.

Table 1 summarizes some key sociodemographic characteristics of the lived experience portion of the sample. The majority of lived experience participants were women. While nearly 60 per cent of participants were in their 20s or 30s, 23 per cent were in their 40s and 18 per cent were 50 years or older. Half of the participants self-identified as South Asian, 27 per cent as Southeast Asian and 23 per cent as Black. Among 11 participants self-identified as South Asian, two people spoke Punjabi and three people spoke Tamil during the interviews. Among six participants self-identified as Southeast Asian, three people spoke Tagalog during the interviews. Nearly three in four participants were born outside of Canada.

At the time of the interviews, six participants were unemployed, while the others were employed either full-time (12) or part-time (four). Among those who reported, the household income ranged from under \$15,000 to \$180,000. Four reported household incomes under \$35,000, six reported between \$35,000 and \$60,000, three reported between \$60,000 and \$80,000, and six reported \$80,000 or higher. The number of household members supported by the reported income ranged from one to six, with the average of four.

**Table 1: Sociodemographic characteristics**

Sociodemographic factor	Sample breakdown, N=22 (#) (%)
Gender	Women (16) (72%) Men (5) (23%) Non-binary (1) (5%)
Age	20s (6) (27%) 30s (7) (32%) 40s (5) (23%) 50s/60s (4) (18%)
Ethnic/racial identity	South Asian (11) (50%) Southeast Asian (6) (27%) Black (5) (23%)
Language of interview	English (14) (64%) Punjabi and English (2) (9%) Tamil and English (3) (14%) Tagalog and English (3) (14%)
Born in Canada	No (16) (74%) Yes (6) (27%)
Employment status	Full-time (12) (55%) Part-time (4) (18%) Unemployed (6) (27%)
Household income	Less than \$35,000 (4) (18%) \$35,000-\$60,000 (6) (27%) \$60,000-\$80,000 (3) (14%) More than \$80,000 (6) (27%) Prefer not to say (3) (14%)

## Part I: Experiences of mental health and barriers to accessing supports during COVID-19

The research findings show that participants experienced considerable pressures that negatively impacted their mental health and well-being during the first three waves of the pandemic. As a result, the pandemic was frequently described as a source of stress. At the same time, the data demonstrates that participants held a wide range of formal and informal coping strategies to manage negative mental health impacts during the pandemic and beyond.

The results also suggest that individuals from racialized communities in the GTA who need culturally appropriate, safe, and accessible mental health services continue to experience barriers to receiving this support, such as financial difficulties or a lack of options for service from providers who have shared backgrounds or perspectives.

### Experiences of heightened mental health challenges during the pandemic

All participants in the study described struggling with increased anxiety and mental health challenges since the onset of the pandemic. Various stressors were experienced, including anxiety around acquiring the virus and transmitting it to others, feelings of social isolation, uncertainty around work, income, and the future in general, and difficulties coping with changes throughout the pandemic (e.g., increased caregiving and domestic responsibilities).

A common source of stress for participants, was the experience of feeling socially isolated and disconnected from community and friends,



*Staying home all day, you know, it really affects you mentally, because you are not able to communicate with...not even...say 'hi' to your neighbour or, generally, share some food with your friends and neighbours...no parties, no gatherings, nothing of that sort, so that has a big impact on the generalized South Indian community...That kind of creates a stressful situation on everyone initially.*

(L13, Woman, South Asian, Tamil, 30s)



The quote from this participant, who had just immigrated to Canada in early 2021, expresses the negative effects of limited socializing and in-person gatherings that are important for sense of community and meaning. The restrictions around social interactions may be even more impactful for those who recently left their countries of origin and families to move to Canada. One SME participant working with migrant caregivers described hearing reports of extreme anxiety and feelings of depression, as the effects of social isolation were interacting with other stressors such as delays in permanent resident applications, feeling 'stuck' in their employers' homes during lockdowns (for live-in caregivers), and extended separation from family members in origin countries, such as the Philippines.

Some participants also described challenges with virtual meet-ups, where they struggled with social interactions and building connection with others. As one woman in her 30s articulated, her difficulty with socializing was amplified in the online setting,

“

*I'm an introvert...I didn't really have a strong community before the pandemic as much either but I did have some bond to organizations and some creation of groups that I was part of that was helping a little bit...I was part of a faith group and that was helping me in terms of, you know, the spiritual aspect of my life. But because of the pandemic...it wasn't as meaningful for me when I was virtual because I tend to interact more in person because I'm a very quiet person. So it's part of how I interact is through my expressions and by seeing other people's expressions.*

(L09, Woman, Black, African/Caribbean, 30s)

”

Some participants also expressed stress about the broader state of the world and reported having an awareness of growing inequities and injustice. For example, one participant described concern about how the pandemic would impact other global regions with less capacity to respond,

“


*I'm like, oh my God, like I was consumed with so much that was going on, people were dying and stuff. . .the negative impact that you were seeing around the world [due to COVID] was just so much. Like at one point it was like 'How can God actually let these things happen? I know we have homelessness, we have poverty,' but I'm like, 'This is too much,' right? So just even questioning my Faith, and a lot of stuff. So yeah, it was I think very impactful.*

(L16, Woman, Black, Caribbean, 30s)

”

Knowledge of the suffering caused by the pandemic had a tremendous impact on some people and is described above as questioning the pandemic in the context of other outcomes of inequality (e.g., poverty). While she explained her experience of hopelessness in relation to her faith, other participants offered alternative explanations of the cause and effect of pandemic stressors, as discussed in the following sections.

For some participants, their stress was more connected to concerns around physical health issues for themselves and others, such as feelings of vulnerability associated with potentially acquiring COVID-19. Often these narratives delineated a clear interconnectedness between mental and physical health.




*I was having a really bad time...I had kind of like a breakdown...the level of anxiety in my house has really gone up because both of my parents...they just turned 59 so there's a lot of anxiety in the house concerning that. Also a lot of mental health issues. I do have physical health issues. I have extremely bad asthma...so in combination with my mental health, it has been really, really hard. I haven't been able to really leave my house much because I'm such a high risk in terms of my health.*

(L15, Woman, Black, Caribbean, 30s)



The participant above describes how her worry about family members who were at greater risk of serious illness or death if they were to contract COVID-19, combined with concerns about her own mental and physical health to contribute to her difficulty coping during the pandemic.

Despite variations across the sample in terms of the degree of emotional and mental health challenges, most participants described a range of physical and emotional manifestations of stress, anxiety and depression resulting from or made worse by the pandemic. These included disruptions to sleep, lack of motivation to maintain self-care practices and physical grooming, and difficulty regulating behaviours such as eating and controlling emotions (e.g., crying uncontrollably around their children).



*I found [coping] really, really difficult...And my work suffered and I suffered. I couldn't sleep. I couldn't eat. I lost a lot of weight, you know, to the point where my clothes were hanging off me, which they still do. I had trouble sleeping at night, and I still do. I barely get maybe four, five hours of sleep a night, which for me is quite strange.*

(L02, Man, South Asian, 40s)



Other participants described similar symptoms of distress, and one person described having to resume taking medication after years of effectively managing her anxiety using non-pharmaceutical methods. SME participants explained that they were seeing increases in the use of substances for coping, as well as clients who were struggling to cope with previous experiences of trauma because of the stress brought about by pandemic conditions (e.g., fewer in-person supports). In general, participants described the considerable negative impact that pandemic stressors had on their mental health and well-being.

## Coping strategies used to address mental health challenges

Participants described a wide range of strategies that they used to cope with the mental health challenges they faced during the pandemic. These included personal coping strategies such as: going for a walk or engaging in other forms of exercise, activities such as writing in journals, spending more quality time with family, and maintaining social connections. One participant acknowledged her new ability to connect with more people due to the increased use of online meeting platforms,

*[I]t's been tough because I can't see other people...basically I can't give them a hug, can't talk to them and have that face-to-face, actual in-person interaction and listening... But on the other hand, I thought about it and I'm still busy anyways. . .So I'm like, 'If it wasn't COVID, would I really have seen them anyways?' Not all of them. I think I'm able to reach more people and see more people and interact with them even if it's online because of COVID because I don't need to count for the commute time and...if it was in-person I wouldn't be doing as many things. I feel like I can do more because it's online if that makes sense?.*

(L03, Woman, South Asian, 20s)


The data also indicates that informal sources were particularly valuable to people for emotional support during the pandemic. These sources included family members and friends, as well as online community and social groups,

*So there's a lot of the unknowns that kind of keep me up at night. And so my coping strategies have been crying [laughs]. You know, for some people it's helpful, you just kind of got to get everything out and then work your way backwards...And then I started to share and talk as mental health issues became very forefront of conversations, starting to talk to my cousins and my friends about, 'how are you feeling?' And, 'Oh my god. I guess I'm not the only one.'*

(L06, Woman, Black, Caribbean, 40s)

As the participant above described, she found talking about her experiences with those close to her and realizing that these were shared experiences, as well as emotional release, to be helpful tools for managing.

In addition to personal coping strategies and informal sources of support, several participants described seeking and receiving help from formal sources, such as counselling services through work, telephone hotlines, or online supports such as community groups or therapy programs (e.g. web-based cognitive behavioural therapy). One participant reported that mental health support received through work was helpful for easing her anxiety and stress level,




*And again for me it's talk therapy for me is very helpful. And then being able to get something prescribed so I could sleep was the beginning of me being able to come down from my heightened anxiety. . I went ahead and I completed the four sessions and I felt probably by the second session that I felt some relief. Yeah, so I did four sessions and...I felt like I was in a better place.*

(L06, Woman, Black/Caribbean, 40s)




When asked about observed changes in service demand since the onset of the pandemic, SME participants reported a significant increase in formal mental health service needs among racialized individuals and families. A leader of a South Asian community organization noted that “the mental health needs of South Asians is something that has sky-rocketed in the pandemic.” This experience was shared by other SMEs serving different ethno-cultural communities:



*Are we seeing more clients? Definitely! Do we have wait lists? Yes, and that's just one of those things that have been kind of the side effects of Covid and which maybe people didn't – I think the community didn't understand that, you know, this pandemic was going to have mental health repercussions or...it's like we were going to see a rise in addictions within the community.*

(Mental health service provider)




Racialized communities have long advocated for better access to mental health, and the need for these services was described as magnified by the pandemic. In responding to demand, many organizations sought additional funding and adopted various strategies to expand their capacity to meet community needs. These strategies included hiring more staff and mental health specialists, launching virtual counselling programs and hotlines, offering flexible hours, and introducing new programs (e.g., peer support). While describing their work during the pandemic, SMEs highlighted their continuous efforts to provide culturally appropriate mental health services, tailored to meet the needs of various racialized population groups.

## Barriers to accessing mental health supports


### Financial barriers and access in virtual settings

Participants who were able to receive formal mental health support, such as professional counselling, during the pandemic spoke positively about their experience. At the same time, several participants talked about financial difficulties in accessing these supports. For example, the participant quoted below realized while seeking formal help, that her employer-provided health benefits did not cover mental health services and had to pay out-of-pocket for the session. Describing her reliance on free online resources, she highlighted that financial barriers discouraged her from seeking the formal mental health services that she needed,




*...[F]or me, not being covered financially was the biggest reason why I didn't do it or just stopped with one, but I definitely feel like it was helpful to have another – like, a physical or a real person talk to me in real time because, you know, you can read articles; you can watch YouTube videos, but then it's different when you get to talk to someone and they're giving you feedback in real time, and you're able to take action, right there and then, in terms of what you need to do. So, yeah, I think, if it was covered, I definitely would.*

(L12, Woman, South Asian, Tamil, 20s)




In the context of COVID-19, when most mental health supports were provided online or over the phone, many participants also spoke of financial barriers to accessing digital devices or internet services required for virtual mental health supports. SMEs reported that many of their low-income clients were facing difficulties in securing access to a device with sufficient data or a reliable internet connection to join their counselling sessions, which had the potential to result in greater social isolation,



*Many of those folks were afraid to come in to the site to see their provider even if invited to. So that was a big shift in our service delivery and for our clients, the needs really did increase, because there was (an) increase in need for supports especially social supports that they weren't given. Many did not have access to the virtual platforms due to lack of access to internet or the devices needed, so they were really cut off from the service.*

(Lead of Community Health Centre)





The new way of offering virtual mental health supports came with other challenges for many participants. For example, explaining her reason for waiting for the re-opening of in-person services, a participant noted her discomfort accessing virtual sessions,



*I'm not the type of person who enjoys doing that online. I really prefer to engage with somebody in person. So I haven't actually done the extent of therapy that I feel I need because I'm waiting for things to open up or I'm waiting to get to that point where it's like OK, you need to do this online and it's better than nothing. So yeah, you develop your own coping strategies basically.*

(L15, Woman, Black, Caribbean, 30s)



At times, service providers also faced challenges connecting virtually with clients with concerns about security or privacy issues related to attending sessions online or over the phone. As family members were now spending more time at home, some participants had more difficulty securing a private space to freely discuss mental health challenges with counsellors or other peers online. SME participants explained that it was especially difficult to connect with clients who lacked safe spaces for online or telephone sessions.

### **Experiences of stigma**

When describing concerns about accessing mental health supports, a frequently discussed subject was stigma within families and communities around talking about mental health challenges. Participants from different ethnoracial backgrounds highlighted this experience:



*I'd feel more comfortable in an actual office rather than in my own room. I don't know, I feel...my walls are thin...And even one time, I had (...) the therapy stuff open on my computer, because...I was looking through options. And then I went to go to the bathroom—and then I saw my mom there. She was looking. I'm like, 'What are you doing?' And she's, like, 'Why is this open?' I'm just—you know, it's Filipino parents. I feel Filipino parents (...) there's this negative stereotype surrounding therapy, right?*

(L10, Woman, Southeast Asian, Filipino, 20s)





*So I would be sleeping maybe...two straight hours at night. And my husband was just saying maybe you should try something. I didn't know how he would feel about me talking to somebody. . .there's some taboos in our culture about seeking a psychiatrist or a psychologist. . .you being weak, you know, like Black people have been through so much, you can endure, right? So you don't need outside help, you just need to mentally get over it and being in a space knowing that that's not always the case and being okay to reach out and get the help.*

(L06, Woman, Black, Caribbean, 40s)



These quotes describe the stigma experienced by participants in relation to accessing mental health supports, where negative ideas about mental health can deter help-seeking and become internalized to perpetuate shame around needing help to manage mental health challenges

Importantly, the second quote above points to the multiple factors impacting access to mental health supports for Black individuals. These include the broader historical processes and struggles that Black communities have had to endure and reminds us that the stigma experienced around mental health is not a result of some inherent failing of individuals or communities. Instead, this barrier to mental health supports has developed from longstanding inequities and oppressive relations with the colonial institutions that have delivered these services.<sup>18</sup>

### **Cultural and linguistic barriers**

A related barrier that was a consistent theme in the data was the limited availability of, and access to, culturally and linguistically appropriate services. Several SME participants pointed out that the gaps in services designed specifically for members of racialized communities served to discourage individuals from seeking formal mental health supports.

While lack of access or long wait times for affordable mental health services was a common experience, several participants described the dearth of mental health professionals from the same ethno-racial background or lack of culturally specific therapeutic content as a challenge. For example, one South Asian participant highlighted the importance of service providers who understand family dynamics across various ethno-cultural communities. For this participant in her 20s, co-residing with her parents after completing university was a norm, and differed from what she understood as that of the dominant culture. She highlighted the need for culturally appropriate mental health services:

“

*So definitely having...a therapist who can understand and empathize from a culturally sensitive lens would have definitely helped me a lot more and I don't know frankly right now where I could access such a service. . .How we approach relationships within our family, within even our extended family, those types of things, and even conflicts that happen in the household I think that having a more culturally-focused lens could... definitely change the kind of advice [and] support I would be given – rather than just looking at it from a mainstream society.*

(L04, Woman, South Asian, 20s)

”

Many other participants echoed this challenge in finding a mental health service provider who shared or understood their cultural context. Describing her own experience of connecting with mental health services, a Black participant expressed her hesitancy about requesting a Black counsellor. Despite her desire to be served by a Black professional, she found herself in “*an awkward predicament or uncomfortable conversation*,” making her “*weigh [the] pros and cons of what's more important*” in terms of easily accessing any mental health service versus one that will provide a culturally safe approach and environment.

All SME participants spoke of the importance of addressing cultural and linguistic needs in mental health service provision to improve equitable access to mental health services for racialized groups. As noted by one leader of a South Asian community organization, mental health services provided in the GTA were largely seen as having “*a very Eurocentric type of focus*,” and “*models are not designed for South Asian communities*.” Her point was echoed by other SMEs, including those who worked with Black populations:

“

*Well, you know, the assumption in most technologies is that if it works for a mainstream population that it works for everybody else, and that's not the case... people who are of different cultures, some assumptions have to be tested to be proven correct. You can't just assume that because dialectical behavior therapy works for this population, it will work for that population. Often, it doesn't. I mean...just in terms of communication, creating and building a therapeutic relationship, it doesn't...follow necessarily the same logic for African populations as it does for European populations. For a variety of reasons.*

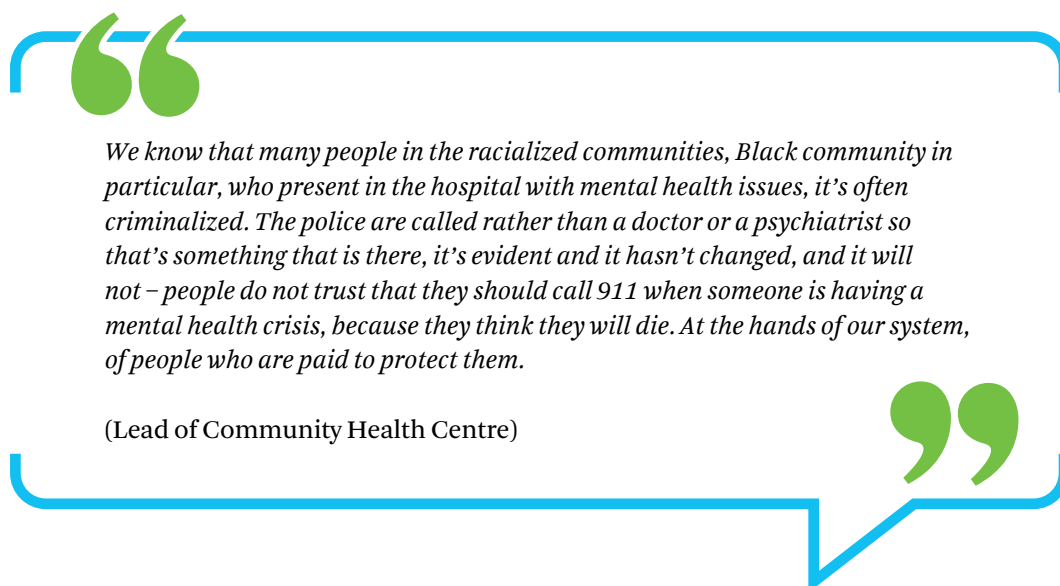
(Academic researcher and policy leader)

”

Service provider participants all reported that they strived to tailor their services to meet the cultural and linguistic needs of specific ethno-cultural groups. Yet, as one of few service providers offering such services to racialized communities, they also acknowledged limited resources available to meet growing needs during the pandemic. Some service agencies had to create new mental health service waitlists for clients since the onset of the pandemic, and others had seen their existing waitlists grow even longer. For a service agency where multiple language services were provided, it was also reported that wait times worsened depending on clients' preferred language, with those waiting for English counselling services waiting less time than people waiting for services in other languages.

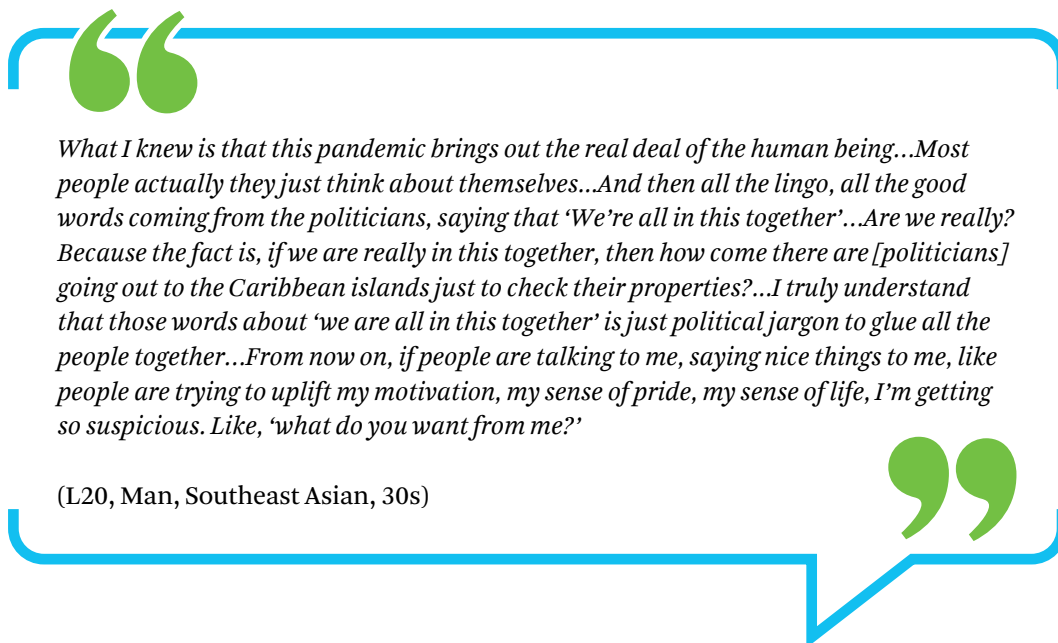
### **Mistrust in systems**

For racialized communities, the lack of trust in systems and institutions was additionally identified as a significant barrier to accessing mental health support. SME participants, in particular, described trust as being a critical factor for historically marginalized communities who have been excluded from accessing health services,



The data from SME participants also spoke to how the mistrust in the health care system can impact access issues to both COVID-19 resources (e.g., vaccines) as well as much needed mental health supports. To address this, various community groups and service providers adopted more community-based, culturally appropriate approaches, such as having multi-lingual health ambassadors or trusted leaders reach out, make connections with, and provide information to members of their communities.

Data from some participants with lived experience also described distrust in the health care system. At the time of data collection, thrombosis (blood clots) was reported as a rare side effect of one of the vaccines. This had received a lot of media attention and was understandably responsible for heightened anxiety around receiving the vaccine. Several study participants described this situation and a sense of skepticism about whether the government could be trusted to protect the population under these uncertain circumstances. Others questioned the accountability of governments and whether they could be trusted to make decisions that were in the best interest of the larger population. As one participant articulated,



*What I knew is that this pandemic brings out the real deal of the human being...Most people actually they just think about themselves...And then all the lingo, all the good words coming from the politicians, saying that 'We're all in this together'...Are we really? Because the fact is, if we are really in this together, then how come there are [politicians] going out to the Caribbean islands just to check their properties?...I truly understand that those words about 'we are all in this together' is just political jargon to glue all the people together...From now on, if people are talking to me, saying nice things to me, like people are trying to uplift my motivation, my sense of pride, my sense of life, I'm getting so suspicious. Like, 'what do you want from me?'*

(L20, Man, Southeast Asian, 30s)

While this example does not speak directly to access issues related to trust, it depicts an underlying sentiment of the cynicism of some study participants, that the social institutions that are in place to serve the public (e.g., health care, political, policing) do not actually represent the interests of the wider public or their communities. This awareness was connected to some participants' feelings of hopelessness and sadness about the world.

The resultant mistrust of those in positions of authority within these systems and in the systems themselves, has been recognized as a considerable deterrent for people from racialized groups in accessing mental health services.<sup>19</sup> The data indicates the potential for mistrust to impact the well-being of individuals who experience disillusionment and detachment from mainstream systems where supports are typically offered. These findings are also illustrated in the following section on racism and discrimination.

## **Part II: Broader social and economic context shaping experiences of mental health challenges**

The research findings in Part 1 describe how participants across ethnoracial populations experienced the negative impacts of the pandemic on their mental health and well-being, how they engaged various strategies and resources to cope with these challenges, as well as the barriers they experienced with respect to accessing appropriate mental health services.

While increased mental health challenges were a common experience, the data also highlighted differences in people's experiences. One theme that emerged was the role of public and interpersonal experiences of racism and discrimination as a deeply impactful social factor in shaping mental health.

Some study participants experienced additional burdens related to other social and economic determinants of health, depending on their roles and locations in the family, work, and society. In general, pressures from changing employment situations, uncertainties around economic and housing security as well as increased family and caregiving responsibilities, had the effect of intensifying the stress and mental health impacts of the pandemic, which was itself a considerable weight for most participants.


The analysis that follows demonstrates the impact of social and economic factors in increasing stressors related to the risk of COVID-19 exposure and other pandemic outcomes (e.g., job losses), and undermining mental health and well-being in general.

These points are revisited in the discussion to make connections with other research, and to make the argument that broader system-level responses that target policies to address social and economic inequities and promote public health and address inequitable access to mental health care for racialized populations, are required.

## Racism and discrimination


A significant theme in the data was the role of racism and discrimination in contributing to negative experiences of mental health throughout the pandemic. In addition to personal accounts of interpersonal and systemic racism experienced by participants, there were several violent public incidents of racism that received media coverage around the time of the study and were identified as potentially impacting the well-being of participants.

During data collection, there was a shooting attack on Asian-Americans in Atlanta, where eight people, mostly women of Asian descent, were killed. This event coincided with greater reporting and awareness of a surge in anti-Asian hate crimes and stigmatization linked to racism, since the beginning of the pandemic in Canada.<sup>20</sup> One SME participant described clients who reflected on personal experiences of discrimination in the context of racist declarations, such those made by former US President Trump, about the origins of the virus,




*So I think one thing that...has been a huge deal...is the anti-Asian racism that's really come up...for many clients...where they're talking about or questioning if an experience [they had], maybe they read online, maybe being a target online or even before lockdown began...that they were concerned if [their experience] was racism, microaggression, that kind of thing. Just because they were...East Asian or Chinese, and...as you would know, like with Trump, there was a lot of conversation or naming it the 'China virus' and all of that. So that was a new thing that really came out.*

(Mental health service provider)



In this context, one South Asian participant who immigrated to Canada in 2012, described his experience of feeling scapegoated for the spread of COVID-19 in the community, especially at the beginning of the pandemic,




*Because we are South Asian, the things we buy are from South Asian stores... In the beginning, COVID came in one of these sites, so people started to look at us strangely. When we go to...[other] stores surrounding it, representing other countries...they would look as though COVID came because of us...So, for me, this was what I was mentally feeling. Like coming this far to settle here [in Canada]...and they think we are the ones who brought COVID...when people realized it is impacting everyone, there was that collective fear at the start.*

(L21, Man, South Asian, Tamil, 50s)




This participant had moved between Canada and his country of origin several times since first arriving in Canada due to difficulties securing employment and residency requirements. This quote suggests his struggles in feeling othered in certain spaces in Canada and the impact that this had on his sense of belonging.

Another example that was frequently described in the data, particularly among interviews with Black participants and SMEs serving Black communities, was the murder of George Floyd, a Black man, by a police officer in Minneapolis in May 2020. Several SME participants described this event as particularly detrimental to the well-being of community members,




*I know the George Floyd incident, murder, had a really debilitating effect on a number of people who are already suffering mental health issues. And hearing the discussions, seeing the – constantly seeing the video play and replay and then that on top of the other things that were happening, it really – it had, as I say, a real negative effect on a number of people.*

(Community Agency Leader)




Participants described experiences of various forms of racism as exacerbating anxieties and mental health issues, especially in the context of the COVID-19 pandemic. As one Black participant shared,



*I'm a frontline worker so I work in the hospital...so for me, the realities of COVID are very real. So I have very heightened anxiety when it comes to large groups. And to know that my circle, my closest circle, is predominately Black, Caribbean and so knowing that we are affected disproportionately and treated, you know, medically not the same as our White counterparts, it heightens my anxiety around being in large groups.*

(L06, Woman, Black, Caribbean, 40s)



This participant's anxiety related to the transmission of the virus was heightened by her knowledge that Black communities are disproportionately impacted by COVID-19 and are additionally discriminated against in health care and other systems.

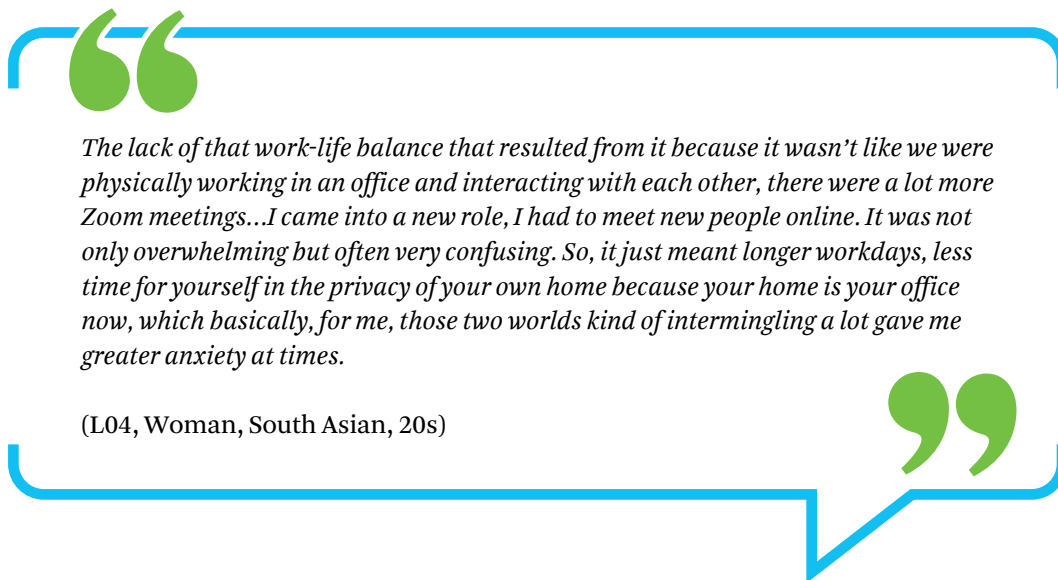
Other participants described general experiences of racism at work and elsewhere as negatively impacting their sense of well-being. For example, one Black participant in her 30s described her process of increased reflection, stimulated in part by the international Black Lives Matter movement, about the impact of internalized racism and

microaggressions at work, which had a substantial impact on her mental well-being. Experiences of racism and discrimination were described as contributing to a heightened sense of vulnerability and undermined many participants' sense of belonging and security.

### Work conditions during the pandemic

Experiences in the labour market varied, with some participants recognizing their relative advantage in being employed in jobs with good work conditions (e.g., stable, well-paid, or able to work remotely), and others experiencing greater precarity in their work situations.

Participants who continued to work from home described increased anxiety caused by remote work and related difficulties, such as problems balancing work and personal responsibilities in the home. Some participants shared experiences of starting new positions during the pandemic and detailed difficulties that came from connecting with colleagues virtually and learning the role and work context in the remote work environment,



Participants who were able to maintain employment still struggled with the impacts of working remotely during the pandemic, which resulted in anxiety and stress for some.

Working participants also described the pressure to adjust to changing conditions throughout the pandemic, often without adequate support (e.g., internet expenses, childcare support, health benefits including paid sick days) or solutions for appropriate workspaces from their employers who were also adapting. One participant highlighted the potential financial challenges of accessing high-speed internet to facilitate remote work,



“

*I guess in terms of just having to figure out my work situation that's been hard because...it's not so easy to concentrate when I'm at the home environment. I live with the others in the house so sometimes it's hard to get into that space. . .The internet [was] a big requirement for one of the jobs I applied for so it was kind of tricky getting the high quality internet that they were looking for, especially considering that my finances weren't the best.*

(L09, Woman, Black, African/Caribbean, 30s)

”

Many participants who maintained stable and remote employment throughout the pandemic acknowledged that despite some pressures, they were in the privileged position of not having to worry about their safety or economic security.

In contrast, other participants described the extreme stress of occupying jobs that were less secure and more vulnerable to the negative impacts, future and immediate, of the pandemic. As one South Asian participant expressed,

“

*I'm extremely worried all the time, that what if I lose my job? How am I going to manage things, like the kids' expenses? They are growing. And—there are no jobs out there. How will we manage?...So, it is a worry, [I'm] extremely worried, believe me. It's not only that I'm worried for this current year, 2021, what about after that? What if there is another recession? Because we have seen the recession of 2008, 2009; that was so scary. So, I'm still afraid of that recession.*

(L07; Woman, South Asian, Punjabi, 40s)

”

The participant quoted above worked in a sector that is highly reliant on government funding for retaining their workforce, and felt anxiety that she would lose her job if the economy were to decline. Her personal experience of struggles during the previous 2008 recession caused her a lot of worry about the impact on her family were the pandemic to lead to a similar situation. This observation speaks to her heightened sense of vulnerability to economic shocks as a single mother in a precarious job, and substantial worry about future financial security.

Another South Asian participant in his 50s described the stress associated with working in a low paying contract job without benefits such as childcare, extended health and pension benefits. Because of this, he was forced to seek dental care outside of Canada for a lower cost whenever he visited his home country of origin,



*[I]n my work, though it is full-time, they do not give me health benefits. So, when we go back home, eyecare and dental is fully accessed there. We did not go back home – for two years...Here, if you go to dental, that is it – one month salary goes to a one-day doctor's visit [laughs]. So, we have these challenges...Once COVID is done, we must go back home, and get this done as a main priority.*

(L21, Man, South Asian, Tamil, 50s)



The results speak to the need for better health care coverage for workers during and following the pandemic. Many SME participants pointed out that the pandemic has highlighted the need for benefits such as extended health care coverage, paid sick days, and pensions to protect workers. The experience of racialized workers in precarious positions highlights how the lack of these protections can greatly increase the risk of disease and perpetuate social and economic inequity; a reality that preceded 2020, but was exacerbated by pandemic conditions.

These examples underscore the added stress experienced by people working in jobs throughout the pandemic where there is considerable insecurity in terms of the future status of such positions or where the pay and benefits do not sufficiently meet financial or health needs.

Several study participants who were essential workers spoke of the risk that they and their family members experienced in continuing work outside the home during the pandemic, through their participation in frontline work. For participants, such as one hospital worker, the knowledge of increased risk of acquiring COVID-19 at work, and possibly transmitting the virus to loved ones, greatly diminished their sense of well-being.

Similarly, one young South Asian woman detailed working in a relatively low-paid job in an environment where she interacted with members of the public as part of her role. She expressed anxiety over potentially acquiring the virus through interactions with large numbers of people and difficulty in maintaining safe social distance in the workplace.

In addition, many SME participants detailed the precarious and often risky work experiences of racialized workers in their communities - many of whom worked as service, health care, long-term care, warehouse, and factory workers. These participants described workplaces that did not offer adequate protections and workers who were at greater risk of exposure due to the virus as a result of job requirements,



*So we heard the stories first hand from folks who said that they had a co-worker who they knew who had COVID...the workplace did not offer any protection and...they couldn't afford not to go, because they were not paid if they missed an hour of work, so they did go to work so that they can pay their rent, to have somewhere to live and buy food and just the necessities of life. So the workplace in some cases was one of the biggest factors around driving the case numbers up. Workplaces as well as transit where many of these folks had to take crowded transit buses to the workplaces. Many of them to multiple workplaces because they had more than one job to support themselves.*

(Lead of Community Health Centre)



Another SME participant echoed the concern about lack of sick days for racialized workers in precarious employment as it also discouraged them from testing for COVID-19 when needed. Citing the over-representation of racialized workers in health and long-term care settings, this participant also highlighted higher risks of COVID-19 infections for these workers and their contacts.

The data also presented heightened stress and anxiety among those who had family members or were themselves laid off during the pandemic. Among the research participants, six reported being unemployed at the time of interviews and many others shared experiences of job loss within their families. Several other participants had been laid off during the pandemic and had managed to regain employment in different jobs. These participants spoke to the significant distress associated with job loss during the pandemic. One Southeast Asian participant who had lost his job for several months described the conflict that he had with his partner because of this stressor and continual close contact under lockdown,



*Then I was unemployed. I stayed at home. It was from October to February. It had an effect on my intimate relationship with my partner, of course. Because the thing is that when you stay at home, and then you meet the same person again and again, and everyday is just like Groundhog Day. The same kind of thing that's happening every day. So, then we had an argument, a lot of arguments, and then I got very sensitive of everything that he said.*

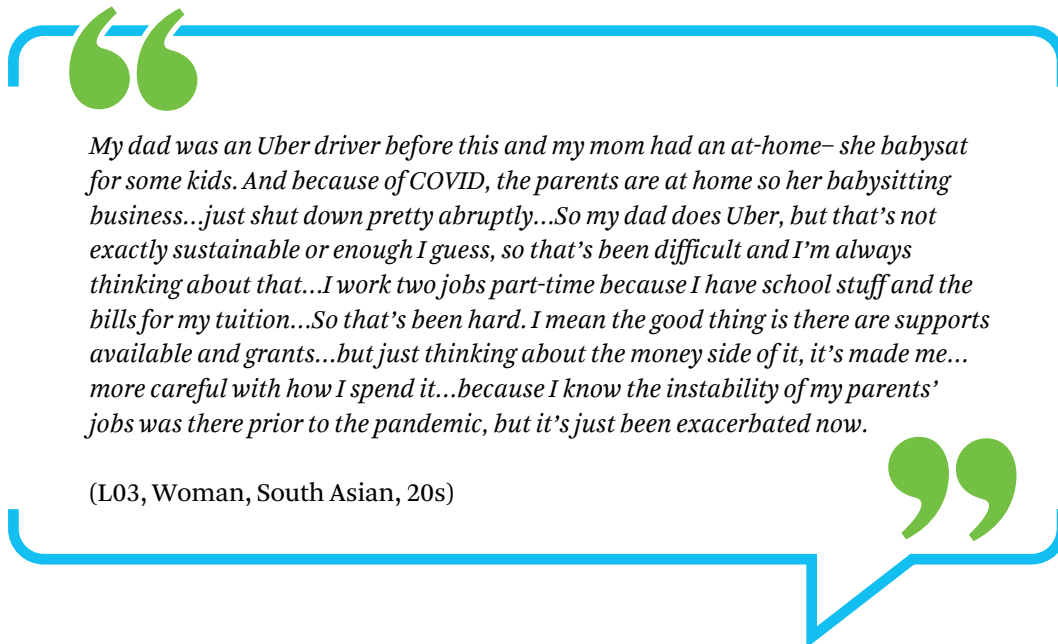
(L20, Man, Southeast Asian, 30s)



Not surprisingly, given that the study sample is made up of working-aged adults, the pressures stemming from work during the pandemic was an important theme in the data. Participants described changed work conditions as a source of stress, navigating the risk of exposure to the COVID-19 virus at work, and the pressure of loss of employment and income due to the pandemic.

### Income loss and economic insecurity

In the context of income loss and potential economic insecurity, several participants pointed out the importance of the Canada Emergency Response Benefit (CERB). Many SME participants stressed the importance of CERB in providing income supports to members of racialized communities who had experienced loss of employment. One younger South Asian participant described her family's experience around income loss during the pandemic,



The economic stressors stemming from her parents' loss of income and job stability during the pandemic was a source of worry for this participant and her family. In the face of having to pay tuition fees and contribute to household finances, the role of CERB and the Canada Emergency Student Benefit (CESB) in providing income support was key. However, these programs were time-limited and did not provide ongoing security for people experiencing future uncertainty. Some SMEs also explained that some of their clients had difficulty accessing CERB due to restrictions placed on eligibility for the benefit.

Many SME participants described their changing role in providing basic necessities, such as food, for community members. In the narrative below, one community organization that had always provided meals for socialization and food security, found that during COVID-19 this role had intensified as clients struggled due to greater economic hardship,

“

*So basically we don't have onsite programs like we used to. But with the community kitchen what we have done to maintain food security is we have a cook who cooks here. And then we package up meals and send them out...so the people who were depending on us for food you know, because of their health, their mobility. If you lost your job you're more vulnerable now too. So we're making sure that our participants have food to eat...And we also give them a weekly food hamper...food security has been a big part of what we're doing.*

(Mental health service provider)

”

Other SME participants explained that their organizational role had expanded beyond the provision of traditional mental health services (e.g., counselling) during the pandemic to include services to address other needs.

“

*We are funded to do mental health services, right? So that's why partnerships have been so important...to get some technology to folks...to get some food to folks. We've also done partnerships to get PPE [Personal Protective Equipment]...[for people] when they are out and about in the community.*

(Mental health service provider)

”

The struggle to deal with the effects of income loss, such as food insecurity, was similarly described by several participants with lived experience. As the participant below articulates, rising food costs combined with reduced and insufficient incomes meant that they and members of their community were reliant on food banks to get by during the pandemic.

“

*I struggled. I went to the food bank for help. Despite this, it was still very challenging... There are many people who are struggling, and it is hard to see this...More than me, those on social assistance, our Tamil people and other immigrants get \$850 or \$900, but after rent, during COVID, food is very expensive. So, they go to one food bank today and then another tomorrow – wherever they are giving food and then another day and so on.*

(L22, Man, South Asian, Tamil, 40s)

”

Difficulty paying for housing in addition to food expenses, was also described by SME participants as a common experience during the pandemic. These accounts are consistent with reports at the time that food insecurity for racialized communities and low-income groups in Toronto had increased to unprecedented levels.<sup>21</sup>

Taken together, these findings on work and income security during COVID-19 suggest that while all participants experienced increased distress linked to changed work conditions, those who lost their jobs or were facing greater economic precarity for themselves and family, experienced added pressures on mental health related to their material well-being. Several participants also voiced anxiety around a lack of savings that could function as a safety net for their families, given what they felt was an uncertain economic outlook.

One SME participant pointed to the broader detrimental impact of the pandemic on racialized and low-income groups with respect to depletion of savings and other resources,



This quote highlights that without significant policy changes, the unequal impact of the pandemic will be the burden of largely racialized, low-income communities in its potential to heighten their already disproportionate experience of economic inequities.

## Housing and living conditions

### The blurring of work and other roles and access to physical space

Housing and living conditions were also a key part of the broader context that participants described as influencing their experiences of COVID-19 and their ability to manage changes related to the pandemic. As the findings above demonstrate, participants experienced struggles around the blurring of private and public space within the home due to remote work or socializing online, and some described difficulties practicing self-care in addition to work and other functions in their home spaces,

“

*And then, there is a stress because...like a lot of people, I'm also using my dining table as my computer desk, as my office. So, the dining table means it's right in front of the kitchen. So, even though I'm sitting at home, my main priority is to focus and to feed a family and children, and at that time, my own meals are missing...while at work, there is a lunch hour, there is a 15-minute tea break or you go around the block and you really feel happy.*

(L07, Woman, South Asian, Punjabi, 40s)

”

Several participants described how the intensity of sharing physical space with others placed increased stress on their relationships, especially with family members,

“

*With my Dad, we're not that close, and we've kind of grown apart throughout the years. So spending more time with my Dad, it's kind of weird. Because I'd always be in school and when I would see him, it'd kind of be a more positive experience. But now that we're constantly in front of each other and in each other's face, it's not the best thing, because we're both used to having more of that space.*

(L08, Woman, Southeast Asian, Filipino, 20s)

”

Loss of employment combined with the mobility restrictions of the pandemic lockdown placed a strain on relationships for some, especially when cohabitation was involved. For the participant above, the increased time spent with her father heightened existing communication and interpersonal issues. At the same time, many study participants described relationships with family and friends with whom they lived as a considerable source of support.

There was a range in the degree to which people's living environments allowed them to perform multiple functions within their home and take the space they needed, with some people having access to an entire basement for their work, online, and other roles. In contrast, some struggled to support their children and family members as well as fulfill other roles in their home spaces, due to overcrowding and other constraints. In these situations, living spaces were sometimes associated with greater vulnerability to COVID-19.

Several participants expressed worry about the potential to transmit the virus to their family members due to close living quarters and difficulty social distancing given the available space in their homes,



*So I told [my boss], I'm like 'Hey, someone in my house tested positive.' He was like 'OK you obviously can't come into work,' even though I got a negative result. And then a week later I got a negative again so then I could go to work, but by that time everyone in [my brother-in-law's] house, so his parents, his three siblings had got COVID as well, and my sister...I was so scared because I sleep in the room with my grandma and she's 70 so I was so scared. She's older.*

(L03, Woman, South Asian, 20s)



This example highlights the complexity of living arrangements for some families, where multiple families in different homes can share responsibility for caregiving and domestic duties. In these cases, the risk of transmitting the virus within networks increases due to the mobility of family members within the community for work and other purposes. The knowledge of this reality was especially stressful for the participant quoted above.

### **Housing precarity**

Several participants also experienced pressures around housing security and the threat of eviction, as has been a public concern during the pandemic,



*So this new owner just wants to renovate everything and turn it into a condo-style unit. And I think they use as an excuse my kids [being] at home and making noise... and we were threatened because they thought that...I wouldn't say anything. If they tell me to move, I'll move. But I didn't. I fought back and I won...and they stopped threatening me with eviction. Yeah, so it's a very stressful—I think my mental capacity got compromised during those times."*

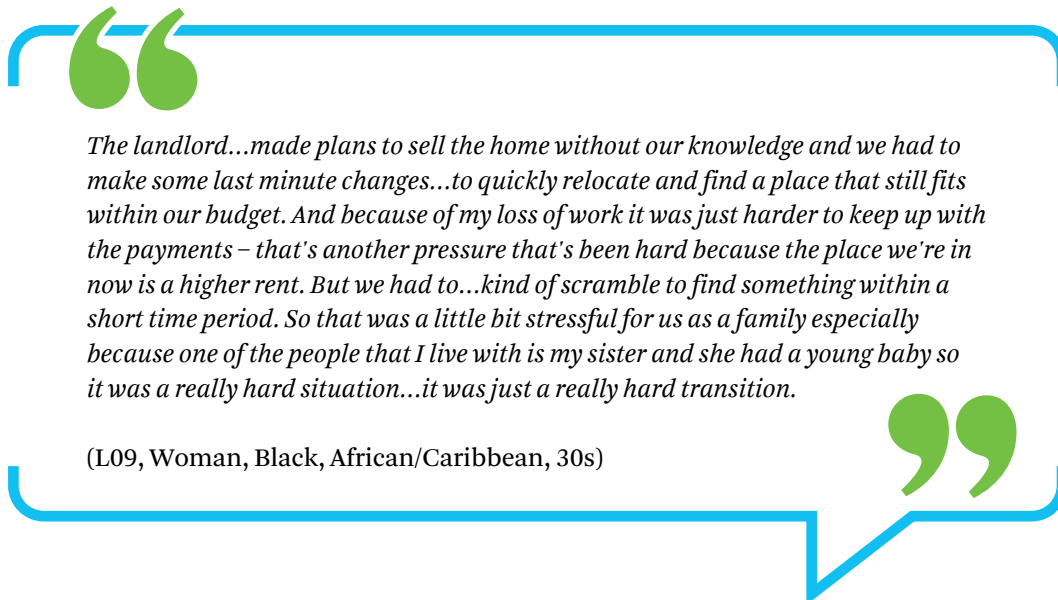
(L14, Woman, Southeast Asian, Filipino, 40s)



This Filipino participant had been laid off from her job at the beginning of the pandemic and had not been employed since that time. According to her description of the experience, the job loss, the significant stress of looking after her two children who she described as having complex needs, as well as responding to the threat of 'renoviction' from her landlord, had together taken a substantial toll on her mental health.



Another Black participant described losing her housing very unexpectedly and the difficulty in finding affordable rental housing in the middle of a pandemic, when she had also been struggling to find employment,



This example demonstrates the way that factors such as threats to housing security interconnect with pressures of job loss and income insecurity to create highly stressful environments for people, marked by limited control and choice over environments. In this case, the participant managed to find housing for herself and her family but was still struggling to find employment and faced uncertainty in terms of being able to generate adequate income.

### Informal caregiving responsibilities

During data collection, school was being delivered online, and many in-person, non-essential services were cancelled (e.g., community social programs). A consequence of these emergency lockdown measures was that public programs that provide support for parents and informal caregivers by sharing responsibility for care were unavailable. This meant that many participants were left with the full responsibility of caring for and educating their children, some of whom had complex needs.

Among participants with young and school-aged children, the impact of lockdown and school closure was particularly significant on their mental health and well-being as they were juggling their work and increased caregiving responsibilities at home. Many parent participants reported feeling guilt as they were consistently unable to perform their job duties sufficiently or to adequately support their children with their online education. Consequently, the increased caregiving role worsened participants' experience of sleep problems, depression, and anxiety.

Many public analyses have detailed that caregiving is a fundamentally gendered phenomenon, with women taking primary responsibility for unpaid caregiving in addition to paid work in Canadian society.<sup>22</sup> Women in low-income households have fewer support and economic resources than those in higher income brackets and face greater difficulty following protective public health measures, such as social distancing. In addition to shouldering the responsibility of caring for children during the pandemic, many women participants were also providing care or support to aging parents. Several women who were single parents or had less family support struggled to maintain their caregiving roles in addition to other responsibilities,

“

*God bless my little one because I have my biological son, and then I have two [that I am caring for] from my extended family...So one [of my sons] is on the Autism spectrum...So it was very time consuming. But I tried to work with the teachers as much [as possible]...And then the other two I had to check in. To just make sure they were staying online...Yeah, I had to always start [my work] later. Sometimes if I didn't sleep I will get up early. So like for the admin piece of it I would just do those at 3:00am, 4:00am. And then I'd touch base with the clients and stuff, and then meetings here and there that we had.*

(L16, Woman, Black, Caribbean, 30s)

”

The quote from this Black participant in her 30s describes her experience caring as a sole parent for three children, in addition to working directly with low-income people in her job. The requirements placed on her to fulfill these roles were extremely taxing, especially because she lacked outside support for her caregiving duties which included educating her child with additional support needs. The participant described the huge toll that this took on her health, which included insomnia and physical health problems stemming from stress.

Other participants echoed that their caregiving responsibilities had increased, along with their anxiety around contagion connected to these roles,

“

*We're living, yeah with my parents. We're in the basement, we have separate living quarters. I know the care has changed in terms of me constantly checking in and making sure that, you know, hands are washed, we're following protocols if anybody's coming over. You know, it's, the anxiety in the house is very heightened, the precaution is heightened but the anxiety is equally heightened.*


(L06, Woman, Black, Caribbean, 40s)

”


## Role of intersecting social and economic factors in shaping experiences

The findings presented thus far point to how living and work conditions intersect with the complex role of informal caregiving and responsibility to others, to increase the risk of acquiring and transmitting COVID-19, as well as heightening stress for participants (e.g., through increased social contact with others or inability to adequately social distance). For some participants, this placed a considerable strain on them in terms of fulfilling all of their roles and maintaining their mental health and well-being.<sup>b</sup>

For example, one South Asian participant described the pressures of being a single mother responsible for educating her children from home for the duration of the pandemic because of her concerns about risk due to underlying health issues,



*Being a single mother, I have so many challenges. Like, I live in a basement, right? It's really hard to stay inside all the time during the COVID situation. There are times I feel so lonely and emotional, right? My health has some more impacts because I am a diabetic person, so I have to have more awareness for that . . . I have a responsibility for my kids, right? . . . So I'm not sending him to school, so this is a really big issue for me. And definitely financially, I'm suffering because my job place is closed. So there, you know, I can say there is so many complications. Some feel, sometimes like I'm sitting inside, I'll feel so depressed, right?*



(L05, Woman, South Asian, 50s)

This participant described the intersecting roles of housing conditions, loss of work, and lack of support for her caregiving responsibilities as framing her struggles with mental health during the pandemic.

Several participants described the experience of shared living quarters with multi-generational family members and the stress of having younger family members performing frontline work in the community cohabit with parents and grandparents who were more vulnerable due to age and other health conditions. This fear was described by one SME participant as common among community members with whom they worked,

<sup>b</sup> As described in Part 1 of our research findings, familial connection was at the same time experienced as a significant source of comfort and coping for most study participants.



*Those that are going out [to work] on a daily basis. And concern about you know are they bringing home that sickness to their families. That was a constant burnout for many people we talked to as well. They were concerned always. They're out there, but you know they're trying to stay safe. But especially those who were in the nursing and long-term care homes that were concerned especially at the beginning when they didn't have proper PPE, et cetera. So there's so much anxiety...I mean, even using those words is not enough. Folks are terrified...COVID is something that terrifies a lot of people, but many of us who have the luxury of working from home comfortably where we have multiple rooms to self-isolate, it's very different from someone who knows that they live in a one-bedroom or a bachelor apartment and cannot isolate from their loved ones.*

(Community Agency Leader)



This observation highlights how the increased risk of exposure in the workplace (and in travel to work) can work in synergy with living conditions to increase the risk of COVID-19 transmission. The quote demonstrates that this knowledge can greatly impact the well-being of individuals navigating such circumstances. In instances where COVID-19-related pressures combined with conditions of economic and housing precarity, these stressors work together to create the potential for significant negative mental health impacts.

Study participants described the broader factors of work, income, housing and living conditions, and informal caregiving responsibilities as central to their experiences of pressures during COVID-19. The findings presented here point to how these factors can work in synergy to increase the risk of exposure to COVID-19 and create barriers to mental health and well-being.

## Discussion

The potential mental health and well-being impacts of the global pandemic raised early alarm bells for many professionals, researchers, and advocates. With the adoption of widescale public health measures (e.g., lockdowns) and considerable uncertainty in terms of the response and effectiveness of health and other systems to emerging needs, experts drew attention to the possible mental health consequences for populations and sub-groups.<sup>23</sup> The disproportionate impact of the pandemic on racialized communities has also been identified as necessitating specific responses to address the potential for inequities in mental health outcomes.<sup>24,25</sup>

This research illustrates the mental health struggles that individuals from racialized groups in the GTA experienced during the first three waves of the pandemic. Participants described increased anxiety and distress in relation to various dimensions of the pandemic, including struggles with social disconnection and fear around contracting the virus.

The findings also point to how experiences of racism and discrimination and lack of access to the social determinants of health and mental health services can interact to increase the risk of COVID-19 transmission and negatively impact the mental health of racialized individuals disproportionately compared to other groups.

### The diverse experiences of study participants

The findings demonstrate diversity in the experiences of study participants during the pandemic and in related pressures impacting well-being. The research sample was diverse in terms of socioeconomic factors. Several participants enjoyed a relatively high level of security in their work and living conditions. The findings point to the potential role of intersecting dimensions of identity – race, class, gender, ability, age – in framing experiences before and during the pandemic, as well as coping with mental health challenges. There was also complexity in the sources of distress across the sample, such as through increased COVID-19 risk or interpersonal issues stemming from work situations or cohabitation with relatives and other community members.

Another example of heterogeneous experiences is that while over 70 per cent of the sample was comprised of immigrants to Canada, there was a considerable range in when people arrived. Those who arrived more recently described experiences of social isolation (e.g., lack of connection to others, experiences of discrimination that impeded a sense of belonging). However, due to the study design, it is not possible to compare the degree of social isolation across the sample. Other sources have identified recent newcomers as experiencing significant challenges during COVID-19,<sup>26</sup> in part due to support needs around social integration, including an increase in isolation experienced by those without social networks.<sup>27</sup>

### Racism, discrimination and inequitable access to the social determinants of health

This study also demonstrates the substantial impact that pressures related to the social and economic determinants of health – racism and discrimination, work, income, housing, and support with education and informal caregiving – had on many participants during the first three waves. Our analysis highlights the relationship between the social determinants of mental health and the effects of systemic and structural racism, which disproportionately positions racialized people in work and living situations that increases the risk of acquiring COVID-19 in addition to increasing socioeconomic stressors that negatively impact mental health. The analysis presented in this paper points to how these factors have the potential to interact to negatively impact mental health.

### Link to stress about COVID-19 risk and outcomes

Study participants, including SMEs, described economic precarity and employment loss as significant contributors to mental health challenges experienced during the pandemic. There are clear links between financial insecurity and unemployment conditions and negative mental health, including depression and anxiety.<sup>28</sup> We know that racialized groups in Canada have experienced disproportionate unemployment outcomes and financial insecurity due to COVID-19.<sup>29</sup> In August 2020, Statistics Canada found that South Asian (17.8 per cent) and Black Canadians (16.8 per cent) had substantially higher rates than the general unemployment rate of 10.9 per cent.<sup>30</sup>

The over-representation of racialized groups in low paid employment and other precarious living conditions has been identified as a fundamental cause of the disproportionate burden of COVID-19 risk,<sup>31,32</sup> and negative economic outcomes during the pandemic for some groups.<sup>33</sup> The Black Health Alliance identifies systemic anti-black racism as underpinning inequitable access to decent living conditions and increased risk for negative outcomes associated with COVID-19, including mental health outcomes. Key social areas that they identify as being sites of systemic racism are employment conditions, income and income security, housing, food security, education and transportation.<sup>34</sup>

The social determinants of health (e.g., housing conditions where self-isolation is possible) are known to impact the risk of COVID-19 transmission. Some participants in this study were acutely aware of this reality and described the stress they experienced due to social and economic conditions that increased their exposure to the virus and other negative outcomes, such as unemployment, related to the pandemic. Furthermore, the findings depict how systemic racism and its potential impact on experiences of COVID-19 (e.g., one participant's knowledge of anti-Black racism within the health care system) can potentially increase stress and negatively impact mental health and well-being.

### **Impact on mental health and well-being**

Both SME participants and those who identified as South Asian, Southeast Asian or Black detailed the occurrence of the pandemic with elevated levels of racism and stigmatization, which was described as having a considerable psychic and emotional burden for many people. This has been acknowledged both internationally<sup>35</sup> and in Canada,<sup>36,37</sup> for its implications for the health and social inclusion of people from racialized groups. Participants grappled with experiences of interpersonal racism, and described how public incidents of violence by the police and individuals, as well as a heightened awareness of systemic racism, had negatively impacted the mental well-being of some members of racialized communities.

Other research points to how systemic racism operating through discriminatory policies over generations (e.g., race-based housing discrimination, unequal access to medical services), is a source of chronic stress and a foundational cause of disparities in both mental health outcomes and health care access.<sup>38,39</sup> A related outcome of historical discriminatory policies and practices is deep mistrust in the systems that uphold these.<sup>40</sup>

Higher rates of chronic stress can also be attributed to higher levels of exposure to negative social determinants of health, such as lower-income, unemployment, racism, job stress and substandard housing – all of which are disproportionately experienced by immigrant, racialized, ethno-cultural and refugee (IRER) groups, and can undermine mental health.<sup>41</sup> At the same time, as evidenced by the sample in this research, there is variability in experiences of mental health based on a diversity of factors. Many participants in this study described the multiple social and economic stressors they faced as undermining their mental health and well-being.

### **Barriers to accessing mental health services**

Despite the heightened need for mental health services during the pandemic, the study also uncovered barriers to accessing these supports.

Cultural and linguistic barriers to services, such as gaps in representation from mental health professionals from shared ethno-racial backgrounds and a lack of culturally safe and tailored mental health supports were identified throughout the data. Although culturally-specific mental health supports were acknowledged as crucial by all service provider participants, most described a lack of organizational capacity to meet these needs. A 2021 study of COVID-19 in priority neighbourhoods with high representation from racialized groups (e.g., South Asian communities) in Brampton found that while over half of respondents reported experiencing extreme to moderate stress and needing increased mental health services, almost one-third reported facing barriers in accessing these services.<sup>42</sup>

Financial barriers were experienced by several study participants in need of mental health counselling services. Access to mental health services is easier for people with higher incomes or private or workplace insurance.<sup>43</sup> Additional themes included internalized stigma associated with mental health services as a barrier to access, and mistrust in systems such as healthcare due to historical and ongoing experiences of racism and exclusion. Research conducted by the Black Health Alliance on COVID-19 in Toronto also identifies mistrust, stigmatization, and anti-

black racism as central to people's experiences and interactions with the health care system, and thus as major barriers to equitable access to services and outcomes.<sup>44</sup>

These findings are consistent with previous research that shows that despite high levels of stress experienced by IRER communities, these groups tend to access mental health services less often.<sup>45</sup> A 2016 report for the Mental Health Commission of Canada, *The Case for Diversity: Building the Case to Improve Mental Health Services for IRER Populations* highlights similar gaps as those outlined in the current report.<sup>46</sup> Barriers identified in this research are service accessibility (e.g., cultural compatibility), patient-provider interaction, circumstantial challenges (e.g., financial barriers), language, stigma and fear (e.g., around potential negative repercussions of accessing supports, like involvement from child protective services).

In this light, the call to improve mental health services for racialized populations in Canada is not new. However, it acquires a renewed urgency given this study and other work detailing experiences of mental health and well-being throughout the pandemic.

### **Developing a system response to address the mental health and well-being of racialized populations**

Despite prior calls to develop a system response that focuses on policy and public health interventions aimed at mental health promotion and illness prevention, in addition to those targeted at mental health service improvement for IRER populations,<sup>47</sup> action has fallen short on these approaches to reduce disparities in mental health risk and treatment.

The research findings clearly demonstrate that action to build the psychological resilience of communities must start with upstream efforts to address existing inequities. The pandemic provides an opportunity to rebuild health systems and better respond to mental health needs equitably. This could include improving the representation of populations with experiences of health disparities in health systems planning.<sup>48</sup> Additionally, mental health systems that confront racism and engage with the historical and contemporary contexts of colonialism and experiences of mental health problems are required.<sup>49</sup>

The pandemic as a magnifier of inequality drives home the urgency of addressing the social and economic determinants of health, with a particular focus on intersecting factors such as race, gender, class, and ability, which underpin inequities in mental health and well-being. While income security interventions such as CERB were a welcome relief for many people who lost work and income during the pandemic, the program was discontinued in 2021 and many workers and low-income people, such as those with precarious immigration status were not able to access these crucial income security benefits.<sup>50</sup>

Data from interviews with SMEs indicate the need for economic opportunity and social mobility for racialized groups with historical and current experience of segregation in various arenas, including the labour market, housing, neighbourhood and related services, and education. This is consistent with recent work that analyzes the significant role of economic racism in shaping inequitable experiences of COVID-19 in Canada and supports the need to address growing gaps in assets held by different groups in society.<sup>51</sup>

As the findings indicate, community organizations struggled to extend and adapt services to meet a wide range of member needs beyond traditional mental health services during the pandemic. Other sources have also highlighted the expanded role of community organizations in providing health, social and economic supports (e.g., PPE, social programs, grocery drop-off) in Toronto.<sup>52</sup> Adequate and sustained funding is imperative to support organizations representing racialized communities to build resilience and respond to mental health needs during future emergencies.

Investment in community-driven supports, including those provided by non-profits and faith-based organizations, can also help overcome some barriers to services by reducing unmet needs and mistrust in the health care system. Specific actions include increased counselling services and efforts to improve access to services for diverse groups, including interventions to reduce stigma.<sup>53</sup> In addition, community-based programs to improve social connectedness<sup>54</sup> with evidence-based interventions such as targeted, culturally-adapted programs and therapies have an important role in increasing equity in mental health service.<sup>55</sup>



The MHCC's Mental Health Strategy for Canada identifies a key strategic priority as increasing responses to better address the mental health needs that arise for people who experience disparities in access to appropriate mental health programs and services because of a number of factors such as socio-economic status, ethno-cultural background, and experience of racism and other forms of discrimination. Recommendations for tackling disparities outlined in the strategy include: expanding use of cultural safety standards by mental health organizations, increasing support for IREER community organizations in addressing local mental health needs in collaboration with the broader system, and developing and implementing community-led mental health plans in all jurisdictions to address the mental health needs of IREER groups.<sup>56</sup>

Finally, these findings point to the need for policy options that transcend sectoral boundaries and mobilize whole-of-government approaches to address the problem of racialized inequities in mental health. While intersectoral approaches have previously been proposed to address access to mental health services for diverse groups and complex health and social issues,<sup>57</sup> the pandemic has renewed calls to mobilize these approaches to address inequity in experiences since early 2020. Funding approaches, policy development, and decision-making that cut across health services and social sectors (e.g., housing, income security) to prioritize mental health promotion and prevention, as well as treatment, are crucial.<sup>58</sup>

### Study limitations

While this paper offers important insights into the experiences of individuals from racialized communities in the GTA during the pandemic, it is important to recognize that there are limitations with any research of this nature.

The recruitment strategy involved disseminating study information through networks and relied on people to contact the research team to express interest. As such, there were some gaps in representation in the study sample. For example, participants who identified as male or non-binary are under-represented, and those who identified as Black and male are not represented. While the research team attempted to reach members of these groups directly through established networks, this strategy had limited success, and the response rate may be reflective of broader gender differences in acknowledging and articulating struggles with respect to mental health. There is related evidence of the unequal effects of COVID-19 on young Black men in the UK, and consequent calls for government commitment and tailored interventions to support the mental health of this group.<sup>59</sup>

The study focused on the experiences of individuals from specific racialized groups and did not include the perspectives of Indigenous Peoples living in the GTA. Recent research indicates that this group has also faced considerable inequities since the beginning of the pandemic, including disproportionate economic hardships.<sup>60</sup> Additionally, the research does not represent the experiences of members of the LGBTQ2S+ community. While some participants did identify as part of this community, the sample was not adequately inclusive to generate data to represent specific challenges faced by this heterogeneous group.

The sample may also represent people who were comfortable discussing issues related to mental health versus individuals dealing with greater challenges during the pandemic who avoided self-selecting into the study because of the topic, or because they faced competing demands that made participation challenging (e.g., additional caretaking of family members). The same could be the case for SME participants, where competing demands in community work and personal lives may have prevented some from participating in the study.

These gaps point to important areas for future research, and also highlight the inability of qualitative research to fully represent the diversity of existing perspectives and experiences within one study. Nonetheless, the findings offer rich insights into the lived experiences of residents from communities across the GTA. There was considerable diversity within and across groups and our analysis attempts to illustrate this heterogeneity and the depth of diverse experiences. There are also many shared observations and experiences detailed in this report, which speak to some notable commonalities that require further attention in responses to social vulnerabilities exposed through the pandemic. The findings support the proposition that qualitative methods are the best for providing in depth understanding of the social experiences and implications of the pandemic.<sup>61</sup>



## Conclusion

The goal of this research has been to explore the pressures and mental health challenges of racialized individuals in the GTA, and this paper sheds light on the lived experience of people in real-time during the pandemic. This research was possible due to the unique language skills and the project team members' connections with community networks. The findings are grounded in the perspectives and experiences of members of racialized communities that have been disproportionately impacted by the pandemic and support the work of community organizations and groups toward change that address the social and economic inequities that underpin health outcomes.

As a follow up to this research, Wellesley Institute and the Mental Health Commission of Canada will produce an additional brief that identifies specific policy areas and interventions to address inequitable access to mental health services and the social and economic determinants of mental health. In light of the recent platform commitment of the federal government to establish a new mental health funding transfer to provinces and territories of \$4.5 billion over five years,<sup>62</sup> there is a real opportunity to ensure that funding meets the needs of racialized populations.

The pandemic recovery response should have equity as the underlying objective.<sup>63</sup> This includes prioritizing mental health services and upstream approaches that address the social determinants of health to reduce inequities in outcomes for racialized communities, in addition to culturally responsive, safe and accessible mental health services.<sup>64</sup> New investments in prevention and mental health promotion that address socioeconomic inequities, social isolation, and other stressors are needed to build resilience for future emergency events.

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