COMPOUNDING DISADVANTAGE:

A COMMUNITY REPORT ON THE IMPACTS OF COVID-19 ON IMMIGRANTS LIVING WITH MENTAL HEALTH & ADDICTION DISORDERS

BACKGROUND

Although the COVID-19 pandemic has affected all communities across Canada, immigrants and refugees (referred to as 'immigrants' from here onwards) have shouldered a disproportionate burden of the disease. This health disparity is not surprising, given their structurally marginalized social and economic positions. Further, immigrants and refugees with chronic health conditions, such as mental health and addiction disorders (MH&A), may be particularly vulnerable to the pandemic's negative impacts due to the preexisting debilitating health conditions. There is limited information in this area. This study is a follow up to our first study that looked at the impact of COVID-19 on immigrants and refugee population living with MH&A over a year of COVID-19.

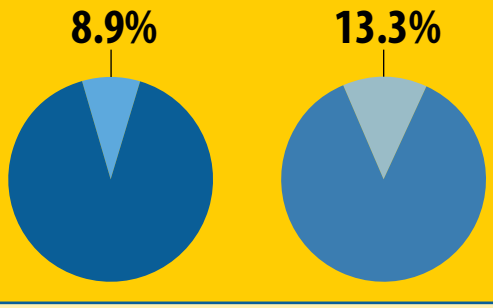
WHAT DID WE DO?

Earlier work from our team looked at the first two waves of COVID-19. Here we present a follow-up retrospective cohort conducted using linked Ontario-based administrative databases to expand the timeframe. The differential impact of COVID-19 over the two years (March 31, 2020, to December 31, 2021) on immigrants and non-immigrants with and without MH&A were examined using multivariate regression while controlling for potential socioeconomic and health-related confounders (e.g., age, sex, income quintiles, living in deprived neighbourhoods, region of origin, region of residence in Ontario, comorbidities, and access to primary care).

WHAT DID WE FIND?

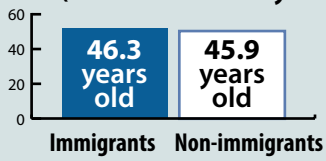
MH&A DISORDERS

222,000 (**8.9%**) immigrants were identified as having **MH&A Disorders** as opposed to 1,047,538 (**13.3%**) non-immigrants.



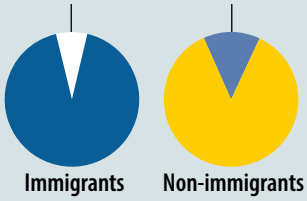
AGE

Immigrants living with MH&A were of **similar age overall** as non-immigrants living with MH&A (**46.3** vs. **45.9** years).



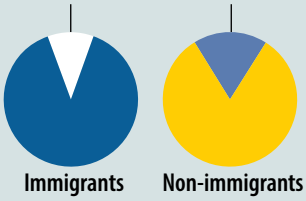
YOUNG ADULTS

Fewer immigrants (vs. non-immigrants) living with MH&A were **young adults**. (**7.5%** vs. **13.5%**)



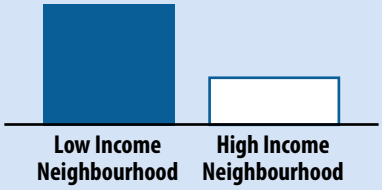
SENIORS

Fewer immigrants (vs. non-immigrants) living with MH&A were **seniors.** (**10.9%** vs. **17.6%**)



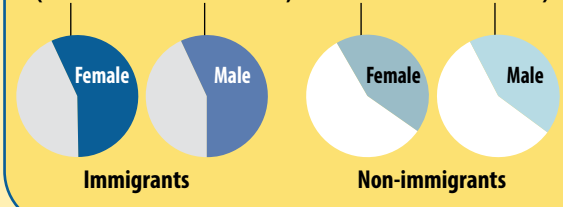
NEIGHBOURHOOD INCOME

Low income neighbourhood are **2.5 times more likely** to be **hospitalized**, admitted to ICU or die from COVID-19.



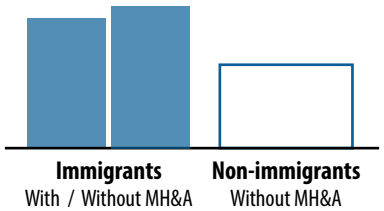
GENDER

Similar gender proportion of females and males between immigrants and non-immigrants with MH&A. (**56.9%** vs. **57.1%**, **43.1%** vs. **42.9%**)



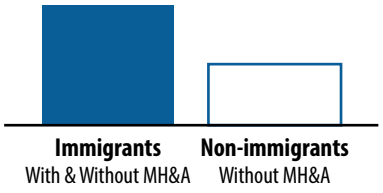
DIAGNOSIS

Immigrants living with and without MH&A (vs. non-immigrants without MH&A) were **52%** and **66% more likely** to be **diagnosed** with COVID-19.



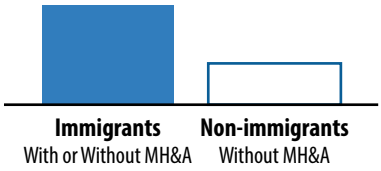
HOSPITALIZATION

Immigrants living with and without MH&A (vs. non-immigrants without MH&A) were almost **twice more likely** to be hospitalized.



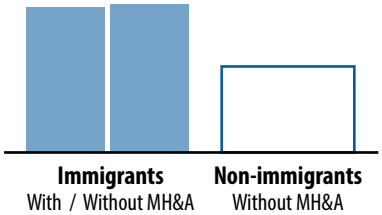
ICU ADMISSIONS

Immigrants living with or without MH&A (vs. non-immigrants without MH&A) were about **2.3 times more likely** to be admitted to ICU.



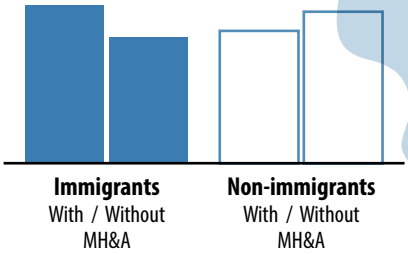
MORTALITY

Immigrants living with or without MH&A (vs. non-immigrants without MH&A) were **63%** and **67% more likely** to die from COVID-19.

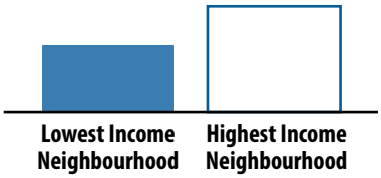


VACCINATION

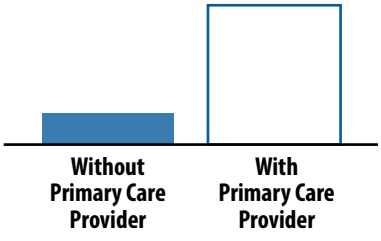
Although COVID-19 **vaccination** among **immigrants living with MH&A** (vs. non-immigrants without MH&A) was 3% more it was **17%** and **14% less** among immigrants without MH&A and non-immigrants with MH&A respectively.



Those living in the **lowest-income neighbourhoods** were about **37% less likely** to receive **COVID-19 vaccination** compared to the highest-income neighbourhoods.



Those without a **primary care provider** were **78% less likely** to receive **vaccination.**



RECOMMENDATIONS

1. Incorporate Targeted Upstream Interventions for Marginalized Populations

COVID-19 recovery efforts and future crisis responses must prioritize upstream interventions that address the social, material, and clinical needs of structurally and clinically marginalized populations. This includes financial aid, food security, housing subsidies, employment assistance, paid sick leave, and childcare support, especially for those with preexisting chronic health conditions like mental health and addiction issues.

2. Enhance Culturally Specific Outreach and Care

Targeted, culturally specific outreach and education are essential to increase COVID-19 vaccination uptake. Recruiting and training community ambassadors, especially those with international medical training, can effectively disseminate culturally and linguistically appropriate health information. These ambassadors can facilitate community forums to address public health guidelines and provide a platform for questions, fostering better understanding and trust within communities.

3. Expand Community-Based Outreach for COVID-19 Vaccination

Host community-based outreach pop-up COVID-19 vaccine clinics in accessible locations, such as faith-based organizations, settlement agencies, and ethnic food stores, to increase accessibility for marginalized groups. This approach helps ensure that vaccines and health services reach underserved populations in familiar and trusted environments.

4. Improve Access to Comprehensive Primary Care

Health systems should prioritize proactive efforts to connect individuals, particularly vulnerable populations, to comprehensive, interprofessional, team-based primary care. Ensuring that patients are enrolled in family health teams, which do not follow a fee-for-service model, can facilitate access to a range of health services and improve health outcomes. Expanding access to such care models is crucial for promoting vaccination and mitigating poor outcomes, especially during pandemics.

Acknowledgements:

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