Official Language Minority Communities in Canada: Is Linguistic Minority Status a Determinant of Mental Health?

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ABSTRACT

OBJECTIVES: Language has been identified as a determinant of mental health. Within Canada, individuals may speak an official language and still belong within the linguistic minority (Francophones outside Quebec and Anglophones within Quebec). The objectives of this study were to compare mental health problems between minority and majority official language communities, and examine the association between official language minority and mental health problems.

METHODS: Data from the Canadian Community Health Survey, Cycle 1.2 were used to make two comparisons: Francophones to Anglophones within Quebec, and Francophones to Anglophones outside Quebec. Twelve-month and lifetime prevalences of mental disorders (major depressive episode, anxiety disorders, and alcohol/substance abuse/dependence) and mental health indices were compared. Logistic regression analysis examined whether official language minority status was a determinant of mental health.

RESULTS: Mental health between minority and majority language groups was similar. Official language minority status was not a significant determinant of mental health. Self-rated mental health indices varied between groups. In some cases, minority language groups reported lower levels of life satisfaction (minority Anglophones versus majority Francophones), while in other cases more majority Anglophones reported poor life satisfaction and mental health (majority Anglophones versus minority Francophones).

CONCLUSIONS: Overall, few differences were found between language groups, though variations in self-rated mental health indices were observed. In order to better understand the role of context in determining health outcomes, future research should examine mental health problems among official language minority groups provincially to help stakeholders in directing resources and programs to populations in most need.

KEY WORDS: Mental disorders; minority groups; language; prevalence

La traduction du résumé se trouve à la fin de l'article.

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Language has been identified as a determinant of health associated with an individual's health and well-being.¹ Previous research demonstrates that health disparities often exist between individuals who have low proficiency with the dominant language and the general population. For instance, some linguistic minority groups have been shown to have an increased risk for poor mental health.²⁻⁴ However, it should be noted that the relationship between language and mental health outcomes has been inconsistent.⁵⁻⁸ This may be attributed to the fact that research occurring in Canada and the United States has almost exclusively focused on visible minority groups or immigrants as a proxy for language use. Consequently, much less is known about those individuals who do not speak the dominant language yet may not necessarily be members of a visible minority group or part of the immigrant population, or who have no proficiency with the dominant language.

With two official languages in Canada, French- and English-speaking Canadians may belong within a linguistic minority depending on where they reside. Though it has been speculated that health disparities may exist between official language minority and majority groups, very little work has been done to examine this issue, specifically with regard to mental health problems.⁹⁻¹¹ Tempier and colleagues (2010) examined the 12-month prevalences for common mental disorders (major depressive episode (MDE), anxiety disorders, alcohol/substance dependence) among Quebec Francophones, outside-of-Quebec Francophones, and Canadian

Anglophones (overall) using the CCHS 1.2.¹⁰ Canadian Anglophones had a significantly higher prevalence of any mental health problem within the previous 12 months (10%) than outside-of-Quebec Francophones (7.2%), but did not differ significantly from Quebec Francophones (8.7%). No differences were found in prevalence of MDE between groups. However, Anglophones reported a higher 12-month prevalence of anxiety disorders than Francophones outside Quebec (4.9% versus 2.8%) and higher prevalence of alcohol dependence (2.8%) when compared to both Francophones outside Quebec (1.1%) and Francophones within Quebec (1.7%). Prevalence of mental disorders did not significantly vary between Francophone groups for any mental health problem. Although this study included both minority and majority Francophone groups, Anglophones were not stratified by minority/majority status.

Available research so far indicates that health disparities may exist between French- and English-speaking Canadians;^{9,10} how-

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Figure 1. An illustration of the classification of Quebec and Outside-of-Quebec Francophones and Anglophones

ever, the role of *both* language and minority–majority status on mental health and mental health service use has been overlooked. Therefore, the goals of the current study were to compare common mental health problems between official language minority and majority groups in Canada and to investigate whether minority language use is a significant determinant of common mental health problems.

METHODS

Data source

The current study used cross-sectional data from the CCHS 1.2 conducted in 2002 by Statistics Canada.^{12,13} The sample includes 36,984 respondents aged 15 years and older. The CCHS 1.2 used a modified version of the World Mental Health-Composite International Diagnostic Interview (WMH-CIDI). The WMH-CIDI is a standardized survey for diagnosing mental disorders based on the definitions and criteria of DSM-IV and ICD-10. Classification of mental disorders in the CCHS 1.2 was partially coded to the DSM-IV and did not support the ICD-10 algorithms. The CCHS 1.2 survey targeted individuals living in private occupied dwellings in the ten provinces and excluded residents from the three territories, Indian Reserves and Crown lands, institutions, and some remote areas, as well as full-time members of the Canadian Armed Forces.¹³

Definition and measurement

Official Language Status

Four comparisons were made: 1) Quebec Francophones to Quebec Anglophones, 2) outside-of-Quebec Francophones to outside-of-Quebec Anglophones, 3) Quebec Anglophones to outside-of-Quebec Anglophones, and 4) Quebec Francophones to outside-of-Quebec Francophones. Official language minority and majority status of the respondents was determined by the following: 1) living in Quebec or outside of Quebec; 2) the language that respondents first learned at home in childhood and can still understand, and 3) the language of conversation, with French respondents being in the Francophone group and English respondents being in the Anglophone group. If a respondent's first language learned at home in childhood and still understood was French or English, then they were classified as Francophone or Anglophone, respectively. If a respondent's first language learned at home in childhood and still understood was neither French nor English, then linguistic status was determined through the languages in which the respondent could converse. Respondents who can converse in English only, English and other (not French), and English and French and other were defined as Anglophone, whereas respondents who could converse in French only, French and other (not English), and French and English and other were defined as Francophone. If a respondent's first language learned at home in childhood and still understood was both French and English, they were originally placed within the minority group within each geographical classification (see Figure 1).

Primary Mental Health Outcomes

Both 12-month and lifetime prevalences were assessed for MDE and anxiety disorders, while only 12-month prevalence was examined for alcohol/substance dependence as the CCHS 1.2 did not collect

data on lifetime prevalence of alcohol/substance dependence. All mental health outcomes were dichotomous. Mental health problems included: Major Depressive Episode (MDE), Anxiety Disorders (AD; included panic disorder, social phobia, and agoraphobia), and Alcohol/Substance Dependence (ASD). The following mutually exclusive categories were derived for 12-month prevalences: No mental disorder or addiction, MDE only, mental disorder only, MDE and AD only, ASD only, ASD with any mental disorder (MDE or anxiety).

Secondary Mental Health Outcomes

Four dichotomous secondary mental health outcomes were also considered: 1) psychological distress (based on the K-10 psychological distress scale)¹⁴, 2) self-rated life satisfaction, 3) self-rated mental health, and 4) self-rated stress.

Statistical analysis

All data were analyzed using STATA software¹⁵ and were weighted using Bootstrap weights through the BOOTVAR¹³ program created by Statistics Canada. A series of chi-squared analyses were conducted in order to compare rates of mental health problems between minority and majority Anglophones and Francophones. To determine whether official language minority status is significantly associated with the presence of mental health problems, a logistic regression model was built with the outcome variable of presence or absence of a mental illness (MDE, social phobia, agoraphobia, panic disorder, or ASD) within the previous 12 months. The main covariates of interest were language status (Anglophone or Francophone) and minority status (official language minority or official language majority). The covariates "province" (Quebec or outside Quebec) "sex", "age", and "immigrant status" were also tested.

RESULTS

Socio-demographic information

Table 1 shows the socio-demographic information for majority Anglophones and minority Francophones outside Quebec and within Quebec. Several noticeable differences were observed. Specifically, a higher percentage of Quebec and outside Quebec Francophones were aged 45 years and older when compared to their Anglophone counterparts. A low proportion of Quebec Anglophones resided in rural areas compared to other language groups (7.6% versus 18.7-25.3%). As well, Quebec Anglophones had a higher proportion of immigrants (46.7% versus 5.8-24.1%) and individuals from a visible minority (34% versus 4.3%-17.7%). Quebec Anglophones had the higher proportion of individuals reporting low income adequacy (14% versus 8.9-11.6%). In contrast, Quebec Anglophones had the lowest proportion of individuals having less than a secondary education (22.7%) while Quebec Francophones had the highest proportion (30.6%).

Minority Francophones and Anglophones outside Quebec

Prevalences for the mutually and non-mutually exclusive categories were quite similar between linguistic groups for each mental illness category (see Table 2). Within the non-mutually exclusive categories, no statistically significant differences were observed, with the exception of lifetime MDE: minority Francophones had a significantly higher prevalence than Anglophones (13.2% versus 11.4%, $p=0.04$). Within the mutually exclusive mental illness cat-

Table 1. Demographic Information for Francophones and Anglophones Outside Quebec

	Outside Quebec Francophones weighted n = 1,390,980‡		Outside Quebec Anglophones weighted n = 17,115,663§		Quebec Anglophones weighted n = 981,924		Quebec Francophones weighted n = 5,007,719¶	
	%	SE*	%	SE*	%	SE*	%	SE*
Sex (male)	49.9	1.3	49.3	0.13	53.1	2.61	48.4	0.5
Age (years)								
15-24	14.1	1.0	17.0	0.1	19.5	2.0	15.2	0.4
25-44	36.2	1.2	38.7	0.1	39.2	2.8	36.5	0.5
45-64	33.4	1.3	29.7	0.1	28.7	2.7	33.0	0.5
≥65	16.3	0.8	14.4	0.1	12.6	1.5	15.3	0.3
Visible minority	12.0	1.0	17.7	0.4	34.0	3.0	4.3	0.5
Immigrant	21.8	1.3	24.1	0.4	46.7	2.9	5.8	0.6
Marital status								
Married	64.9	1.2	61.7	0.3	59.1	2.9	60.9	1.0
Widow, divorced, separated	13.8	0.8	12.5	0.2	12.2	1.6	13.8	0.6
Single	21.4	1.1	25.6	0.3	28.7	2.7	25.3	0.8
Rural	25.3	1.4	18.7	0.6	7.6	1.2	20.6	1.2
Highest level of education								
<Secondary	27.4	1.2	23.5	0.3	22.7	2.7	30.6	0.9
Secondary	16.2	1.0	20.1	0.4	15.0	2.2	16.3	0.8
Some post-secondary	8.6	0.9	9.0	0.2	7.3	1.7	6.8	0.5
Completed post-secondary	47.8	1.5	47.3	0.4	55.0	3.0	46.3	1.0
Stable employment	53.9	1.4	55.0	0.4	50.6	3.4	49.8	1.0
Low income adequacy†	10.7	0.9	8.9	0.2	14.0	2.2	11.6	0.6

* Standard error.

† Individuals who have low income adequacy based on the following household criteria: <\$15,000 if 1 or 2 people; <\$20,000 if 3 or 4 people; <\$30,000 if 5+ people.

‡ n = 2526, § n = 28,680, || n = 526, ¶ n = 4772.

Table 2. Lifetime and 12-month Prevalences for Mental Health Problems Among Francophones and Anglophones Outside Quebec

	Outside Quebec Francophones weighted n = 1,390,980‡		Outside Quebec Anglophones weighted n = 17,115,663§		Difference (%)	95% CI of Difference		
	%	SE†	%	SE†		Lower	Upper	p-value
Lifetime								
Non-mutually exclusive								
MDE	13.2	0.9	11.4	0.3	-1.80	-3.6	0.0	0.04*
Anxiety disorder	12.5	1.0	11.7	2.7	-0.84	-6.4	4.7	0.41
12 month								
Non-mutually exclusive								
MDE	4.6	0.5	4.8	0.2	0.18	-0.8	1.1	0.70
Anxiety disorder	4.4	0.5	5.1	0.2	0.71	-0.4	1.8	0.22
Alcohol/substance dependence	2.6	0.6	3.3	0.1	0.75	-0.4	1.9	0.28
Mutually exclusive								
No mental illness	90.3	0.8	89.2	0.3	1.10	-0.6	2.8	0.23
MDE only	3.0	0.3	2.7	0.1	-0.29	-1.0	0.4	0.40
Anxiety disorder only	3.0	0.5	3.2	0.1	0.19	-0.7	1.1	0.67
ASD only	2.0	0.5	2.5	0.1	0.48	-0.6	1.6	0.49
MDE and an anxiety disorder	0.8	0.2	0.1	0.1	-0.70	-1.1	-0.3	0.07
ASD and any disorder	0.6	0.2	0.8	0.1	0.17	-0.2	0.6	0.41
Secondary outcomes								
Poor self-rated mental health	7.2	0.6	7.4	0.1	0.11	-1.2	1.5	0.86
Low rated life satisfaction	4.2	0.5	5.3	0.2	1.11	-0.1	2.1	0.05
High self-rated stress levels	3.6	0.5	3.6	0.1	-0.08	-1.1	0.9	0.87
High psychological distress	2.7	0.1	2.6	0.4	-0.16	-0.9	0.6	0.69

* p<0.05.

† Standard error.

‡ n = 2526.

§ n = 28,680.

egories, no statistically significant differences were found between groups. In addition, no differences were observed in secondary mental health outcomes between language groups.

Francophones and minority Anglophones within Quebec

No statistically significant differences were found for any of the non-mutually exclusive categories (see Table 3). Among the mutually exclusive mental health problem categories, no statistically significant differences were observed, with the exception of the co-morbid “MDE and anxiety disorder only” category where minority Anglophones had a lower prevalence (0.2%) than Francophones (1.1%) (p<0.001). Among the secondary mental health outcome variables, significantly more minority Anglophones (4.3%) reported having low life satisfaction compared to Francophones (2.1%) within Quebec (p=0.02).

Due to the large proportion of immigrant respondents among the Anglophone population in Quebec (46%), a post-hoc analysis was completed to compare rates of mental health problems between immigrant and non-immigrant Anglophone groups within Quebec. Non-immigrant minority Anglophones had a significantly higher prevalence of any mental illness (MDE, AD and ASD) compared to immigrants (11.7% versus 4.6%) (p=0.02). No other statistically significant differences were observed.

Association between linguistic minority status and mental health problems

Table 4 shows the results from the univariate analyses. Although official language minority status was not a significant predictor of mental health problems (OR: 1.18, 95% CI: 0.95-1.45), language

Table 3. Lifetime and 12-month Prevalences for Mental Health Problems Among Francophones and Anglophones Within Quebec

	Quebec Anglophones n = 526§		Quebec Francophones n = 4772		Difference (%)	95% CI of difference		
	%	SE†	%	SE†		Lower	Upper	p-value
Lifetime								
Non-mutually exclusive								
MDE	12.1	2.2	15.1	0.7	3.0	-1.6	7.6	0.24
Anxiety disorder	10.5	1.7	11.4	0.7	0.9	-2.7	4.5	0.64
12 month								
Non-mutually exclusive								
MDE	3.2	0.8	5.1	0.4	2.0	0.2	3.8	0.06
Anxiety disorder	3.2	0.8	4.2	0.4	1.0	-0.8	2.7	0.31
Alcohol/substance dependence	3.8	1.1	2.6	0.3	-1.2	-3.4	1.0	0.87
Mutually exclusive								
No mental illness	91.5	1.7	90.2	0.6	1.3	-2.2	4.9	0.49
MDE only	2.8	0.8	3.3	0.4	0.5	-1.2	2.2	0.59
Anxiety disorder only	2.5	0.7	2.7	0.4	0.2	-1.4	1.7	0.84
ASD only	2.6	1.1	1.8	0.2	-0.7	-2.9	1.4	0.43
MDE and an anxiety disorder	0.2	0.1	1.1	0.2	0.9	0.4	1.3	0.00*
ASD and any disorder	—‡	—	—	—	—	—	—	—
Secondary outcomes								
Poor self-rated mental health	4.2	1.0	5.0	0.4	0.8	-1.2	2.8	0.48
Low rated life satisfaction	4.3	1.3	2.1	0.2	-2.1	-4.6	-0.4	0.02*
High self-rated stress levels	4.2	1.2	3.1	0.4	-1.2	-3.6	1.3	0.25
High psychological distress	2.5	0.8	2.7	0.3	0.2	-1.5	1.8	0.84

* p<0.05.

† Standard error.

‡ Data could not be released due to confidentiality (cell sizes less than n=5).

§ weighted n = 981,924.

|| weighted n = 5,007,719.

Table 4. Results From the Univariate and Multivariate Logistic Regression Analyses With Presence of a Mental Illness Within the Previous 12 Months as the Outcome Variable

Factor	OR	SE	95% CI for OR		p-value
			Lower	Upper	
Univariate analyses					
Linguistic minority status (Minority = 0)	1.18	0.13	0.95	1.45	0.13
Language (Anglophone = 0)	0.88	0.05	0.79	0.98	0.02*
Age	0.97	0.01	0.969	0.97	0.00
Sex (male = 0)	1.16	0.0595	1.05	1.28	0.00
Immigrant status (immigrant = 0)	1.95	0.16	1.65	2.29	0.00
Province (Quebec = 0)	1.11	0.08	0.97	1.28	0.11
Multivariate analysis: Final model					
Linguistic minority status (Minority = 0)	1.04	1.25	0.82	1.32	0.76
Language (Anglophone = 0)	0.88	0.06	0.77	1.02	0.08
Age	0.97	0.01	0.97	0.98	0.00*
Sex (male = 0)	1.21	0.06	1.09	1.34	0.00*
Immigrant status (immigrant = 0)	1.82	0.16	1.54	2.17	0.00*

* p<0.05.

status was a significant predictor with Francophones less likely to have a mental illness (OR: 0.88, 95% CI: 0.79-0.98). Sex, age, and immigrant status were all significantly associated with the presence of a mental illness. Specifically, women (OR: 1.16, 95% CI: 1.05-1.28), younger individuals (OR: 0.97, 95% CI: 0.96-0.97), and non-immigrants (OR: 1.95, 95% CI: 1.65-2.29) were more likely to have a mental health problem. Province of residence (Quebec versus outside Quebec) was not a significant predictor of mental health problems (OR: 1.11, 95% CI: 0.97-1.28).

Table 4 also shows the results from the final multivariate model. Although official language minority status was not significant at the univariate level, it was retained in the model as it is one of the main covariates of interest. The model indicates that when controlling for sex, age, and immigrant status, language use (French or English) is no longer significant. The interaction between language use and official language minority-majority status was also tested and was found to be non-significant. Because both linguistic minority status and language status (and the interaction between the two independent variables) were non-significant, we concluded that official language minority-majority status does not predict the presence of a mental illness within the previous 12 months and we did not proceed any further.

DISCUSSION

For common mental health problems in populations outside of Quebec, minority Francophones were found to have a significantly higher lifetime prevalence of MDE than majority Anglophones. In Quebec, Francophones had significantly higher rates of co-morbid "MDE and anxiety disorder only" than minority Anglophones (0.83% versus 0.13%) within the 12-month mutually exclusive categories.

Overall, mental disorder prevalences between official language minority and majority groups appear to be more similar than different. As well, official language status was not a significant determinant of mental health problems. This contrasts with previous work which has shown that individuals with poor language proficiency have higher rates of depression, anxiety, and substance abuse compared to those with good to excellent language proficiency.²⁻⁴ However, in these studies participants had at least limited English skills and data collection took place in the United States where there is a pre-eminence of English as an "official language". In contrast, the current study was unable to assess English or French language proficiency and took place in Canada where two official languages exist. One may also refer to previous research which has

examined minority status, in general, and mental illness. Such research reveals an inconsistent association between minority status and mental illness.^{5-8,16} Therefore, it is perhaps not surprising to observe minimal differences between our language groups of interest.

A potential explanation for a lack of difference between official language groups within Quebec is the proportion of Anglophone immigrants. Nearly half of the minority Anglophones interviewed were immigrants; therefore, we conducted mental health comparisons between immigrant and non-immigrant Anglophones in order to determine whether differences exist in mental health between these groups. A significant difference for 12-month prevalence of "any mental illness" was found between immigrant and non-immigrant Anglophones within Quebec. A large body of research has examined the "healthy immigrant effect" in Canada wherein immigrants have been shown to be healthier than Canadian-born residents when they arrive in Canada, largely due to the extensive physical and mental health screening process necessary in order to enter the country.¹⁷⁻²² Therefore, it may be the case that differences between minority and majority official language groups in Quebec, and majority and minority Anglophones are confounded by the "healthy immigrant effect".

Self-reported mental health and well-being indicators were also examined (self-rated mental health, self-rated life satisfaction, self-rated stress levels, and psychological distress levels) in order to better understand how respondents view their own health, information that may not be otherwise captured through diagnostic screening measures.²³ The results from our secondary mental health outcomes analyses indicated that some self-rated indicators of well-being may, in fact, vary between groups. In some instances, minority language groups reported lower levels of life satisfaction (minority Anglophones versus majority Francophones), while in other instances more majority Anglophones reported poor life satisfaction and mental health (majority Anglophones versus minority Francophones). Thus, both minority and majority Anglophones reported lower levels of life satisfaction when compared to their Francophone counterparts. However, it is unclear whether official language groups differ in their perceptions of well-being across regions. In other words, do Anglophones/Francophones in Quebec and outside Quebec have similar perceptions of their mental health and well-being? Contextual and cultural environmental factors found within Quebec may differ from those of the rest of Canada²⁴⁻²⁶ and these factors may play a strong role in determining an individual's mental health experiences. Future research should examine differences in mental health outcomes between Francophones within and outside Quebec, and Anglophones within and outside Quebec in order to determine whether minority language status or contextual variables may better account for variations in mental health functioning.

There are several strengths to the current study. First, this study is one of the first of its kind to investigate mental health problems among official language minority communities (OLMC). Second, by using the CCHS 1.2, we were able to access a large, nationally representative Canadian sample, which allowed us to gain a wide perspective into the mental health problems among OLMC across Canada. Third, the CCHS 1.2 contains an array of variables targeting multiple areas of mental health problems. Despite these strengths, there are several limitations to the current study worth

noting. First, the analyses were limited to the variables available within the CCHS 1.2 data source. Second, one must consider that the results are based on self-report data and that the reported mental disorder diagnoses were not determined or confirmed by a mental health professional. Another limitation is the way in which minority-majority Francophone and Anglophone groups were classified. No consistent definition was provided in the research literature as to how Anglophone and Francophone groups should be defined. Although every effort was made to ensure the appropriate classification of each respondent, the lack of specific questions regarding official language use limited our ability to directly assess language usage, which has the potential to produce a misclassification bias.

In summary, the current study is important because it is the first of its kind to examine common mental health problems among Canada's OLMC. Understanding how language and minority status may influence the presence of mental health problems may aid in redirecting resources and developing policies and programs towards areas wherein health disparities exist. Although our results indicate that very few differences exist between official language minority and majority groups, this knowledge remains extremely important to many key stakeholders, including patients, health care providers, administrators, and the health care system. Future research should examine the provincial and socio-cultural contexts in which Francophones and Anglophones are situated while paying special attention to particularly vulnerable groups, such as official language minority immigrants and women. By doing so, it may be ensured that official language minority communities in Canada are well served in the areas they need most.

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RÉSUMÉ

OBJECTIFS : On sait que la langue est un important déterminant de la santé mentale. Au Canada, il est possible de parler une langue officielle tout en appartenant à une minorité linguistique (c'est le cas des francophones hors Québec et des anglophones du Québec). Les objectifs

de notre étude étaient de comparer les problèmes de santé mentale des communautés de langue officielle minoritaire et majoritaire et d'examiner les associations entre le statut de minorité de langue officielle et les troubles de santé mentale.

MÉTHODE : Nous avons utilisé les données de l'Enquête sur la santé dans les collectivités canadiennes, cycle 1.2, pour faire deux comparaisons : entre les francophones et les anglophones du Québec, et entre les francophones et les anglophones hors Québec. Nous avons comparé les prévalences de certains troubles mentaux (accès dépressif majeur, troubles anxieux et toxicomanie/dépendance à l'alcool ou à d'autres substances) et les indices de santé mentale, sur 12 mois et sur toute la vie. Par analyse de régression logistique, nous avons cherché à déterminer si le statut de minorité de langue officielle était un déterminant de la santé mentale.

RÉSULTATS : La santé mentale des groupes linguistiques minoritaires et majoritaires était semblable. Le statut de minorité linguistique officielle n'était pas un déterminant significatif de la santé mentale. Les indices de la santé mentale autoévaluée variaient d'un groupe à l'autre. Dans certains cas, des groupes linguistiques minoritaires ont déclaré des niveaux inférieurs de satisfaction de vivre (anglophones minoritaires par rapport aux francophones majoritaires), tandis que dans d'autres, les anglophones majoritaires ont été plus nombreux à déclarer de faibles niveaux de satisfaction de vivre et de santé mentale (anglophones majoritaires par rapport aux francophones minoritaires).

CONCLUSIONS : Globalement, nous avons observé peu de différences entre les groupes linguistiques, mais des écarts dans les indices de la santé mentale autoévaluée. Pour mieux comprendre le rôle du contexte dans la détermination des résultats sanitaires, les recherches futures devraient porter sur les troubles de santé mentale au sein des minorités de langue officielle à l'échelle provinciale afin d'aider les acteurs du milieu à orienter les ressources et les programmes vers les populations qui en ont le plus besoin.

MOTS CLÉS : troubles mentaux; minorités; langage; prévalence