Enhancing the Engagement of Immigrant and Ethnocultural Minority Clients in Canadian Early Intervention Services for Psychosis

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The past century has seen significant diversification of the Canadian population.¹ Over 20% of the Canadian population is foreign born, and 20% belong to a racial minority group.² These minority populations add to the fabric of Canadian society and contribute to its economic and social growth. While they often demonstrate significant strengths, as evidenced by the well-documented healthy migrant effect (i.e., immigrants are in better health than native-born populations, at least when they arrive),² it is also well known that these groups face unique challenges within the mental health care system.

The Mental Health Commission of Canada has identified the mental health of immigrants (those who were born outside of Canada), refugees (those who were persecuted in their home country), ethnocultural groups (groups that share common ancestry and cultural characteristics), and racialized groups (a term more commonly used instead of visible minority, stemming from the recognition that race is a social construct³) as a priority.² Broadly speaking, the Canadian mental health care system and service providers have faced challenges in fully engaging immigrant and ethnocultural minority populations,⁴⁻⁷ who are likelier to seek mental health services after long delays⁸ and to drop out prematurely.⁴ This subpar service engagement can have far-reaching consequences for individuals, families, and communities.⁵ It can contribute to inequalities in mental health treatment and outcome between immigrant and ethnocultural minority clients and the general population.⁹⁻¹³

Given its emphasis on improving accessibility and engagement, early intervention (EI) for psychosis is an important context within which the challenges of engaging immigrant and ethnocultural minority clients need to be examined. EI programs aim to provide early, high-quality

treatment to individuals who are experiencing the early stages of psychosis.¹⁴ At its apex, EI embodies a number of core principles, including early identification, high-quality stage-specific interventions, engagement and outreach, family involvement, and conceptions of outcomes that go beyond symptom remission to include social and occupational functioning.¹⁴ EI has been demonstrated to strengthen access to care, reduce treatment gaps, and improve outcomes for individuals with psychosis¹⁴⁻¹⁷: a much-needed development considering that the total cost estimate of schizophrenia in Canada is nearly CAN\$7 billion.¹⁸ Yet, while EI has gained much attention and been buttressed by evidence since its introduction in the 1990s, the EI movement has yet to fully integrate knowledge about the needs of immigrant and ethnocultural minority clients into its models of service provision. This lack of integration is reflected, for example, in poorer outcomes for immigrant and ethnocultural minority clients with psychotic disorders as noted in some international psychosis literature.¹⁹⁻²²

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Understanding the challenges of engaging immigrants and ethnocultural minorities with psychosis is particularly important because the incidence of psychosis is known to be higher among first- and second-generation immigrants compared to the general population in both their home and host countries²³⁻²⁶ and among ethnocultural minority groups as well.^{23,27,28} The incidence is even higher among refugees.²⁹ A recent survey of Canadian EI programs reported that immigrants make up 10% to 66% and visible minorities 10% to 40% of their client population.³⁰ Adding to the challenge is the significant heterogeneity *within* immigrant and ethnocultural populations. Individuals within these groups may vary on a number of characteristics, such as country of origin, time since migration, experiences of trauma and discrimination, availability of family support, race, language, and religion, that affect both their risk for psychosis as well as their interactions with the mental health system. With immigration being an ongoing Canadian reality, EI services need to work to ensure health equity for minority populations.^{4,31} To this end, we aim to highlight the difficulties EI programs may face in engaging immigrant and ethnocultural minorities and discuss opportunities to move forward. Our focus on service engagement in the clinical context is warranted given that EI programs emphasize and dedicate significant resources to achieving client engagement as a means to improved outcomes.

Why We Should be Concerned

Access to Care

Individuals from immigrant and ethnocultural minority groups may be reluctant to seek mental health care in their new country¹⁰ for varied reasons, including difficulty in navigating the system, lack of information or resources, stigma toward mental illness, inadequacies of services, or a preference for alternative treatment options.⁹ Thus, individuals from these groups may experience longer treatment delays and access the formal mental health system only after other avenues are exhausted, often via difficult pathways. This is evinced by Canadian studies of pathways to care (the contacts people make on their journey to EI). African, Afro-Caribbean, Asian, and other ethnic minority individuals are likelier to be referred from the emergency room than to enter EI services as outpatients.^{17,32,33} Black-Caribbean individuals are also more likely to have been referred from inpatient units because of decreased general practitioner (GP) involvement and fewer total contacts with the mental health care system.¹⁷ In a recent Ontario study, 40% of immigrants did not have physician follow-up in the 30 days following the first diagnosis of a psychotic disorder, with lower rates of follow-up for African and Caribbean minorities.³⁴ Furthermore, some European literature suggests that the duration of untreated psychosis is longer in ethnic minority clients.^{21,35} Taken together, these studies suggest that ethnic minorities and migrants may have a more challenging time accessing specialized care for a

first episode of psychosis. They also tend to access EI via adverse pathways to care, which represent abrupt, traumatic experiences for individuals and increased costs for the health care system.

Sustained Engagement and Disengagement

In some EI settings, it has proven difficult to sustain the engagement of immigrant and ethnocultural minority clients and their families.^{36,37} Engagement entails more than just periodic contact; it involves other aspects of care such as medication adherence, participation in therapy, and the uptake of available services.¹⁶ While patient engagement can be generally challenging (with 20% to 40% of clients tending to disengage prematurely from EI services³⁸), it is even more difficult to achieve with immigrant and ethnocultural minority clients.

Canadian research investigating disengagement (defined as rates of dropping out of care³⁸) among immigrant clients in EI programs has had varying results. One study suggests that immigrant clients have higher disengagement rates than nonimmigrants,³⁹ and another showed no difference.⁴⁰ Furthermore, the drivers of disengagement have been shown to vary between immigrant and visible minority subgroups.⁴⁰ Poorer service engagement among immigrant and ethnocultural minorities may be a function of their perceptions of services (as culturally or linguistically incompatible) and their larger struggles with racism, social integration, and acculturation. To optimize engagement, providers must acknowledge that these issues likely play a role in reducing their clients' ability and willingness to engage with care.

Previous research (albeit not from Canada) suggests that immigrants may be less adherent to⁴¹ and racial minorities less satisfied with medications.⁴² Beyond medication, though, EI services provide a number of psychosocial services. The benefits of psychotherapy,⁴³ family interventions,⁴⁴ social work support, vocational training, and occupational therapy⁴⁵ have been demonstrated in general EI populations, but little is known about the immigrant and ethnocultural minority experience with these services. Research outside the EI context suggests that the uptake and completion of psychological interventions (therapy, substance use treatment, etc.)⁴⁶⁻⁴⁸ and family interventions⁴⁹ is lower among ethnic minorities. The reasons for this remain unclear: some suggest that it is due to dissatisfaction with services, while others have found that immigrants are actually more satisfied with mental health services than nonimmigrants.⁵⁰ Given this, the paucity of research examining minority group engagement in specific interventions offered by EI services represents a notable knowledge gap. Such an understanding is essential to inform the design of programs and interventions that can produce better outcomes through better engagement.

What May Contribute to These Concerns

As discussed above, EI literature considers access to care and sustained engagement as distinct concepts. However, for

the purposes of this section, we have conceptualized service engagement as both access to care and sustained engagement because the issues discussed below may apply to both processes.

Stigma

Stigma toward mental illness exists in numerous countries and cultures, and it has been documented as one of the strongest barriers to seeking help for mental health issues, including psychosis.⁵¹⁻⁵³ While stigma is pervasive, it is particularly strong in certain communities,⁵⁴ including the Black-African community.⁵⁵ This may be attributable to a variety of reasons, including variation in explanatory models of psychosis and views on what treatments are considered acceptable.^{56,57}

Language Barrier

Immigrants in Canada come from over 200 countries,⁵⁸ and many do not speak English or French fluently, making language a potentially significant barrier to achieving optimal service access and engagement. Outside of the EI literature, a number of Canadian studies identify language as a barrier to accessing and engaging with mental health services, suggesting that language is an important consideration in efforts to increase engagement and outcomes.^{9,59,60} Work outside of Canada also suggests that a mismatch in language between clinician and client contributes to delay in accessing care and to reduced treatment participation.⁶¹⁻⁶³

Some EI services have ready access to interpreters, translators, or other tools to enhance communication in situations of language mismatch. Unfortunately, these resources are neither widely nor uniformly offered across the country at both tertiary care centers and community clinics.

Cultural Barriers

Cultural differences may result in clients having different explanatory models than those of the service provider.⁶⁴ Clients who do not feel understood or feel judged may be less inclined to engage in their own care.⁶³ Such cultural barriers are more likely to affect engagement if service providers are unable to adequately explore cultural identity or unwilling to elicit or consider alternative models of illness.⁶⁵

Barriers in Effectively Working with Families

Families play a major role in promoting medication adherence and service engagement and in improving the outcomes of EI.⁶⁶ Family involvement is a key predictor of client functioning and reduces relapse risk.^{67,68} Despite this, there is often limited involvement of families in mental health care and suboptimal uptake of family interventions, when offered.⁶⁹ In general, engaging families can be difficult due to concerns about confidentiality, time limitations, and so on. Clinicians in the Canadian health care system, which has traditionally privileged a focus on the individual patient,

may struggle to effectively engage families of immigrant and ethnocultural minority clients who may be more culturally predisposed to being more intimately involved in making decisions for their ill relatives. In addition, factors that impede the engagement of individual patients also serve as barriers to family engagement. These include linguistic differences, differences in families' explanatory models for the illness, lack of familiarity with the health care system, and possibly financial constraints that hinder caregiving. Furthermore, refugees and newcomers may often be living alone and have a limited social support network. Little is known about the extent to which family interventions, which are otherwise well recognized as being useful, are accessible to, acceptable to, and effective for families of immigrant and ethnocultural minority clients.

How We Can Address These Challenges

To enhance the engagement of immigrant and ethnocultural minority populations, service providers require tools, training, and research. Some of these tools are already in use and simply require further dissemination.

In regards to EI specifically, not all evidence-based interventions¹⁴ have been validated in all populations. As mentioned earlier, immigrant and ethnocultural minority populations comprise heterogeneous subpopulations: while each group is unique, most interventions have core elements that could be helpful for multiple groups,⁷⁰ particularly with meaningfully planned cultural adaptation. For example, cognitive behavioural therapy for psychosis (CBTp) has demonstrated efficacy in the general first-episode psychosis population,⁴³ and research suggests that cultural adaptation of CBTp is possible and could enhance client engagement and outcomes.⁷¹⁻⁷³ Similarly, family interventions have been shown to be effective in improving engagement⁴⁴ and clinical and functional outcomes.^{74,75} There have been promising efforts to implement culturally adapted family interventions⁷⁶ as they have demonstrated benefit across cultures.⁷⁷ Our recommendation would be for EI services to offer culturally adapted interventions where evidence is available. Where such evidence is not available and evidence-based interventions that have not been adapted/validated are offered, clinicians must make additional efforts to continuously assess patients and families' goals, needs, and experienced and perceived benefits and harms of offered interventions.

The recommendations below are applicable across the spectrum of evidence-based first-episode psychosis interventions and are relevant in addressing both issues of access to care and sustained engagement.

Personalized Care

The principles upon which the EI movement was founded⁷⁸—flexibility, emphasis on therapeutic alliance and engagement, personalized care, and openness to issues around identity, illness models, and worldviews—hold

equal or even more relevance for addressing the challenges faced by immigrant and ethnocultural minority populations. In addition, EI services should integrate into their training and service delivery reflexivity/reflective practice⁷⁹ and cultural humility.⁸⁰

When working with immigrant and ethnocultural minority clients, clinicians should be open to clients seeking support from nonmedical sources, such as religious or spiritual groups. It may also be beneficial for clinicians to encourage patients or help them to restore or foster connections to their own cultural communities and resources. Support for this comes from the ethnic density hypothesis^{81,82} (that members of ethnic minority groups may have better mental health when they live in neighborhoods with higher proportions of people of the same ethnicity) and from research on the resilience-enhancing benefits of community belonging and a positive ethnic identity.⁸³ This would also facilitate shared discussions about the potential negative outcomes of such efforts, for example, if the views of a religious/spiritual group regarding mental health treatment suggested disengaging from treatment.

Community Outreach

Using early identification initiatives targeted at specific communities (e.g., multilingual pamphlets in GPs' offices, posters in community centres, liaising with religious leaders) can aid in promoting early help seeking for minority populations. Earlier help seeking would increase opportunities for immigrant and ethnocultural minority individuals experiencing a first episode of psychosis to be referred to an EI program with fewer and less traumatic contacts.

Interpreters and Translation Resources

Some EI services have readily available interpreters, which can help bridge the language gap between clinician and clients. Alternatives include technology-assisted interpretation (eg, telephonic or video interpretation) for services that do not have access to interpreters or if an interpreter is not available in the required language. Importantly, working with interpreters is not a skill that comes naturally to most; it is something that requires training and practice.⁸⁴ Increasing the availability of this fundamental/basic training for EI service providers could substantially improve the experience of linguistic minority clients receiving care in EIP programs. More resources should be dedicated to interpretation, which may be most efficiently coordinated at a national policy level.^{85,86}

Cultural Brokering

The ability to contextualize the clients' distress within their cultural norms is essential for improving therapeutic alliance and optimal management. This can be a daunting task when faced with a variety of clients from different cultural

backgrounds. Fortunately, there are tools that can aid in the process. First, cultural consultation services and cultural brokers exist to help bridge the cultural divide between service providers and clients. They provide greater insight and understanding of the client's cultural context and experience of the illness, enabling more accurate diagnosis and enhanced management.^{87,88} Second, the *Diagnostic and Statistical Manual of Mental Disorders* has introduced the Cultural Formulation Interview (CFI).⁸⁹ The CFI is an evidence-based tool that helps clinicians to conduct culturally appropriate assessments and provides guidance in making culturally informed diagnoses and treatment plans.⁸⁹ The extent to which EI services integrate such tools appears to be unfortunately limited.

Family Intervention Training

Within psychiatry, working with families has many benefits,⁹⁰ yet family interventions are underused.⁶⁹ Research on family psychoeducation has provided some insight into what makes family interventions successful. Notably, interventions must be considerate of time and location, brief interventions and bibliotherapy must be offered, and service providers must consider both single- and multifamily groups.⁶⁹ In addition, the content of family groups may need to be adapted to better meet the needs of culturally diverse families.⁶⁹

To offer family support more effectively and to the greater satisfaction of families, EI staff may need ongoing training, supervision, and/or opportunities to work with more experienced staff.⁶⁹ Specific strategies in this regard could be active family outreach, staff responsiveness to family needs, and family-inclusive shared decision making.⁹¹ EI staff also need to be sensitized to the importance of family involvement in promoting better outcomes and to the varying cultural norms around the role of the family. Finally, the definition of *family* may need to be expanded to include other trusted, supportive members in patients' networks such as friends, community members, and peer support workers to enable patients not in contact with their families to also benefit from the known benefits of family interventions.

Research

The extensive gaps in the literature regarding the experiences and outcomes of immigrant and ethnocultural minorities in Canadian EI services necessitate focused service and evaluation research on this topic. Ideally, such research should integrate both quantitative and qualitative methods, so that the extent of the problem of engagement is understood as well as its experience from the point of view of those whom we are seeking to engage.

Policy and Practice Guidelines

The EI movement has traditionally generated and promoted adherence to progressive, evidence-informed service

guidelines and fidelity scales.^{30,92} Incorporating strategies for the engagement of immigrant and ethnocultural minority clients and their families into these guidelines and scales (e.g., availability of interpreters, culturally adapted interventions) is an important avenue for the advancement of universal engagement.

Conclusions

While much remains unknown, existing research indicates that EI services may not be providing equitable care to immigrant and ethnocultural minority clients and families. Their pathways to and experience of care may be difficult and disengaging, and they arguably contribute to poorer outcomes. The EI movement brought about a paradigm shift in the philosophy of and approach to the provision of care for psychosis. It now needs to extend its transformational impetus to ensuring that *all* those in need are adequately served. Doing so requires efforts at the level of individual service providers and EI programs in terms of better training and the wider deployment of best practices, as well as at the systemic level in terms of more focused research and policy.

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