



Predictors of disengagement from treatment in an early psychosis program

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ABSTRACT

Background: Disengagement from treatment is a major concern in psychiatry. This is of particular concern for those presenting for care at their first episode of psychosis (FEP). The purpose of this study is to determine the rate of disengagement from a three year FE treatment program and the predictors of disengagement.

Method: We used a longitudinal cohort design. The cohort consisted of 286 FEP individuals. Measures included assessments of positive and negative symptoms, depression, substance use, premorbid and current functioning, cognition and duration of untreated psychosis. Disengagement from treatment was defined as leaving the program before the 30 months.

Results: At 30 months after treatment, the estimated rate of disengagement from treatment was 31%. Predictors of disengagement were examined via Cox proportional hazards models which revealed that lower ratings on negative symptom scores at baseline (HR = 0.946; CI = 0.909–0.985), a shorter duration of untreated psychosis (HR = 0.997; CI = 0.994–0.999), and not having a family member involved in the program (HR = 0.310; CI = 0.196–0.490) contributed significantly to predicting disengagement from treatment. An examination of those who dropped out at different times revealed that those who dropped out prior to 6 months had significantly greater cannabis ($p < 0.05$) and other drug use ($p < 0.01$).

Conclusions: Engagement in early services may be helped by attending carefully to substance use to prevent early dropout, to those who may have had a short duration of untreated psychosis and to working with families to engage families in the program.

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1. Introduction

It is well known that disengagement from treatment is a major concern in psychiatry. A review of the literature suggests that as many as half of all individuals with schizophrenia that require ongoing treatment are not currently receiving care (Kreyenbuhl et al., 2009). This is of particular concern for those presenting for care at their first episode of psychosis (FEP) as it has been demonstrated that long term treatment can improve symptoms and functioning in individuals experiencing a FEP (Addington et al., 2003b) as well as reduce the likelihood of relapse (Schimmelfmann et al., 2006; Miller et al., 2009). Reported rates of disengagement among FEP individuals vary throughout the literature, however, most studies have reported the number of those who disengage to be between 23% and 30% (Schimmelfmann et al., 2006; Turner et al., 2007; Conus et al., 2010).

The importance of disengagement for service delivery was emphasized when it was identified as one of 24 evidence supported performance measures as essential for evaluating the quality of first episode psychosis services (Addington et al., 2005a). Disengagement is a useful performance measure which can be readily measured and is

typically recorded in routine administrative data bases. A comparison of two Canadian First Episode Psychosis treatment services using a set of performance measures found one year discontinuation rates of 28% and 26% (Addington et al., 2009).

In a recent comprehensive review it was reported that individuals with schizophrenia who disengage from treatment tend to be younger, are male, belong to an ethnic minority, have low social functioning, have an early onset of psychosis, are socially isolated and typically have a co-occurring substance use disorder and/or additional psychiatric illness (Kreyenbuhl et al., 2009).

Research on individuals experiencing a FEP has revealed somewhat similar trends as those displayed in schizophrenia research, however, there is very little research published to date on this topic. To the best of our knowledge four different groups have investigated disengagement with FEP individuals. In a comprehensive chart review from the EPPIC program in Melbourne in a sample of over six hundred patient files it was reported that low severity of illness, forensic history before treatment, having a persistent substance use disorder and living without family were the strongest predictors of disengagement (Conus et al., 2010). Interestingly, consistent results were reported in a subsample of adolescents aged 15–18 which showed that lower severity of illness at baseline, living without family, and having persistent substance abuse during treatment were the strongest predictors of disengagement (Schimmelfmann et al., 2006).

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Secondly in a FE sample ($N=236$) from New Zealand it was reported that unemployment, substance abuse, good health, good social functioning, and higher mean GAF scores were the strongest baseline predictors of service disengagement. They also found that longer duration of untreated psychosis and lower symptom scores were significant univariate factors associated with disengagement (Turner et al., 2007, 2009). One study investigated specifically the impact of cannabis use on treatment drop out, and found that independent of age, race, SES and gender, cannabis use significantly impacted disengagement from treatment (Miller et al., 2009). Lastly, a Canadian study which looked at medication adherence and service engagement in patients enrolled in a program, found that a history of physical abuse, agreeableness, and poor alliance with the therapist were significant characteristics of poor service engagers (Lecomte et al., 2008).

Thus, research to date has suggested a range of different predictors of disengagement from treatment among individuals experiencing a FEP. Not all studies examined the same potential predictors but there were still inconsistencies, for example low severity of illness did not consistently contribute to disengagement. On the other hand substance use in varying degrees consistently played a role in disengagement. Limitations with existing studies are that data was obtained via chart review, samples were small and the programs may have only lasted for 18 months or less and enrolled different diagnostic groups. With the increased attention to early intervention, understanding predictors of disengagement may have important implications for the development of specialty programs for this young population. The purpose of this study is to determine the rate of disengagement from a three year comprehensive treatment program for individuals with a FE of psychosis and identify predictors of disengagement. Potential predictors to be considered will include a range of demographic factors, positive and negative symptoms, general psychopathology, diagnosis, substance use, social functioning, cognition and having a family member involved in treatment. The study will address some of the limitations of current research by using a large FE sample that was attending a three year specialized treatment program and will rely on data from prospective assessments. For the purposes of this study 'disengagement' will be defined as dropping out of treatment before 30 months in treatment.

2. Methods

2.1. Participants

Over a four year period, (Jan 1997 to Dec 2000) 286 (191 males, 95 females) individuals were admitted to the Calgary Early Psychosis Treatment Service (EPTS) a well-established comprehensive program for individuals who are experiencing their first episode of psychosis. This program, which has been well described elsewhere, offers a three year program of psychiatric and case management, a range of group programs, individual therapy and family intervention (Addington and Addington, 2001). EPTS currently serves a population of approximately 1.3 million and includes the majority of potential incidence cases (Jablensky et al., 1992). Participants were excluded if they had a diagnosis of affective psychosis, or a history of neurological disorders, head injury, epilepsy, or did not speak English well enough to adequately complete the assessments. From the potential sample of 286, 20 subjects were excluded who did leave the program early but left because they were moving, usually back to their family home and had been set up with adequate follow-up care in their new place. They were excluded because they did not disengage from treatment but we do not have details on their continued care. The majority of the sample was single (86.3%), with a mean age of 24.5 years ($SD=8.2$). Most had completed grade 12 (60%), lived at home (77.1%), and were Caucasian (76.4%).

Diagnoses were conducted at the initial assessment and then repeated at one year. All participants met DSM-IV criteria for a schizophrenia spectrum disorder or other psychotic disorder as assessed by the Structured Clinical Interview for DSM-IV (SCID-I) (Spitzer et al., 1992; American Psychiatric Association, 2000). See Table 1. Sixty-seven percent were referred as outpatients and 33% as inpatients (Addington and Addington, 2006).

2.2. Measures

The Structured Clinical Interview for DSM-IV (SCID-I) (Spitzer et al., 1992) was used to determine the psychosis diagnoses. Symptoms were assessed with the Positive and Negative Syndrome Scale for Schizophrenia (PANSS) (Kay et al., 1987), and the Calgary Depression Scale for Schizophrenia (CDSS) (Addington et al., 1992). Severity of substance use was assessed with the Case Manager Rating Scale for Substance Use Disorder (CMRS) (Drake et al., 1990). Functioning was assessed with the Premorbid functioning scale (PAS) (Cannon-Spoor et al., 1982), the Quality of Life Scale (QLS) (Heinrichs et al., 1984), and The Global Assessment of Functioning (GAF) Scale (Endicott et al., 1976). Cognition was assessed with a composite score that was derived from a wide range of cognitive tasks that have been described in detail and used in this sample (Addington et al., 2003a, 2005c). Level of insight was rated with G12 on the PANSS. Assessment of the duration of untreated psychosis has been described in detail elsewhere (Addington et al., 2004). Prescribed medication use was recorded using chlorpromazine equivalents. The program was a three year program but discharge planning began in the last 6 months. Therefore disengagement was leaving the program before the end of 30 months. Disengagement was defined as dropping out of the program before 30 months. Individuals were considered to be dropouts when they would not return calls or could not be reached or would not attend appointments for 3 months. Case managers would try to contact patients and family workers of the family. Some patients explicitly refused ongoing care and this was accepted. If neither the patient nor family had been actively involved with the program for 3 months, a letter was sent informing them of the planned discharge unless some contact was made. Some individuals were discharged from the program but were accepted back again within the 3 years. They were not counted as disengaged and continued in the program until the three year anniversary of their admission to the program.

2.3. Procedures

This study received approval from the local ethics committee and all participants signed informed consent. Raters were experienced research clinicians who demonstrated good inter-rater reliability at start up. Reliability to a gold standard was checked every 6 months. Criteria for determining reliability was that the scoring of each item on the PANSS, CDSS and QLS was within one point and there was at least 80% agreement on total scores and subscale scores for all measures. Agreement is calculated as the number of ratings within one point divided by the total number of ratings. The DSM-IV diagnoses were made using the SCID-I by JA and DA. Interrater reliability was

Table 1
SCID diagnoses.

Diagnosis	Baseline $N=266$
Schizophrenia	109 (77.2%)
Schizophreniform	96 (36.6%)
Psychosis NOS	39 (14.7%)
Brief psychotic disorder	9 (3.4%)
Delusional disorder	4 (1.5%)
Schizoaffective	2 (0.8%)

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