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Disengagement in immigrant groups receiving services for a first episode of psychosis

Anika Maraj^a, Franz Veru^a, Laura Morrison^a, Ridha Joobar^{a,b}, Ashok Malla^{a,b}, Srividya Iyer^{a,b,1}, Jai Shah^{a,b,*}

^a Prevention and Early Intervention Program for Psychoses, Douglas Mental Health University Institute, Department of Psychiatry, McGill University, Montréal, Quebec, Canada

^b ACCESS Open Minds, Douglas Mental Health University Institute, Montreal, Quebec, Canada

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ABSTRACT

Objective: Although early intervention (EI) programs for psychosis invest in clients remaining engaged in treatment, disengagement remains a concern. It is not entirely clear whether immigrants are likelier to disengage. The rates and predictors of disengagement for immigrant vis-à-vis non-immigrant clients in a Canadian EI setting were analyzed.

Method: 297 clients were included in a time-to-event analysis with Cox Proportional Hazards regression models. Immigrant status (first- or second-generation immigrant or non-immigrant), age, gender, education, substance abuse, family contact, social and material deprivation and medication non-adherence were tested as predictors of service disengagement.

Results: 24.2% (n = 72) of the clients disengaged from services before completing two years. Disengagement rates did not differ between first-generation immigrants (23.3%), second-generation immigrants (22.7%) and non-immigrants (25.3%). For all clients, only medication non-adherence predicted disengagement (HR = 3.81, 95% CI 2.37–6.14). For first-generation immigrants, age (HR = 1.17, 95% CI 1.02–1.34) and medication non-adherence (HR = 2.92, 95% CI 1.09–7.85) were significant predictors. For second-generation immigrants, material deprivation (HR = 1.03, 95% CI 1.00–1.05) and medication non-adherence (HR = 11.07, 95% CI 3.20–38.22) were significant.

Conclusion: Disengagement rates may be similar between immigrants and non-immigrants, but their reasons for disengagement may differ. Medication adherence was an important predictor for all, but the role of various sociodemographic factors differed by group. Sustaining all clients' engagement in EI programs may therefore require multi-pronged approaches.

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1. Introduction

Early intervention (EI) service paradigms (Malla et al., 2007; Nordentoft et al., 2014) have contributed to improving the clinical and functional outcomes (Malla et al., 2007; Iyer et al., 2015; Lal and Malla, 2015; Anderson et al., 2015) of psychosis. A key strength of EI is the priority it places on keeping clients engaged, which is reflected in its service design and goals (Birchwood, 2014; Iyer et al., 2015). Despite these advances, disengagement from EI programs remains a concern, with typically reported rates of disengagement being 20–40% (Turner et al., 2007; Conus et al., 2010; Doyle et al., 2014; Malla et al., 2007; Stowkowy et al., 2012). Certain characteristics, such as low socioeconomic status, substance misuse or poor family support have been associated with increased risk of disengagement. Reasons for

disengagement include dissatisfaction with services, feeling that services do not meet their needs, lack of trust, poor insight, and stigma (Lal and Malla, 2015). Although time to disengagement from EI services is less frequently reported, there may be periods of higher risk for disengagement such as early in and/or towards the end of treatment (Conus et al., 2010). Thus, time-to-disengagement is an important factor to examine (Lal and Malla, 2015; Turner et al., 2007; Conus et al., 2010; Doyle et al., 2014; Malla et al., 2007; Stowkowy et al., 2012). Variables such as family involvement and substance use may also differ between individuals who disengage early versus later in the course of receiving EI (Stowkowy et al., 2012).

Immigrant populations have a higher risk of developing a psychotic disorder as compared to non-immigrants (Bourque et al., 2011; Cantor-Graae and Selten, 2005), yet immigrants are less likely to access mental health care (Kirmayer et al., 2007; Whitley et al., 2006; Edge and Newbold, 2013; Thomson et al., 2015). Immigrants face extensive challenges in accessing care (Thomson et al., 2015), and two recent studies suggest that they are at a greater risk for disengaging from EI services (Ouellet-Plamondon et al., 2015; Abdel-Baki et al., 2015). It is therefore

* Corresponding author at: PEPP-Montréal, Douglas Institute, Wilson Pavilion, 6875 LaSalle Boulevard, Montreal, Quebec H4H 1R3, Canada.

E-mail address: jai.shah@mcgill.ca (J. Shah).

¹ Senior authors with equal contributions.

important to establish if indeed immigrants are at greater risk of disengagement from EI services, and to examine potential drivers of service disengagement among immigrants.

Many EI services make significant efforts to keep clients engaged in treatment. It is unclear whether current engagement efforts are effective or if they differentially impact certain client groups. This makes understanding the reasons for disengagement and how they vary across different client sub-groups crucial (Nordentoft et al., 2014).

1.1. Aims and objectives

We aimed to evaluate the rates and early predictors of service disengagement among non-immigrant and immigrant clients at an EI for psychosis service in Montréal, Canada. We sought to examine similarities and differences in these factors across non-immigrants, first-generation and second-generation immigrants. Additionally, given the important intersection of immigrant and visible minority status, we also sought to investigate these issues across visible minority groups.

2. Methods

2.1. Study population

This is a prospective study that included all clients who entered PEPP-Montréal between January 2003 and July 2012; met program eligibility criteria (aged 14–35 years; and were diagnosed with affective or non-affective psychosis with <1 month of previous antipsychotic treatment); consented to assessments and had complete data for the variables of interest. Exclusion criteria were not having organic brain damage, pervasive developmental disorder, an IQ below 70, epilepsy or substance-induced psychosis (Iyer et al., 2015). PEPP-Montréal is publicly funded and the sole program in its catchment for youth with first-episode psychosis, making its patient sample representative of the surrounding population. Treatment is provided for two years, and comprises intensive case management and psychosocial (e.g., family psychoeducation) and medical management (Iyer et al., 2015). This is part of a larger study approved by the Research Ethics Board at the Douglas Mental Health University Institute. Rigorously trained research staff were responsible for all data collection, with repeated checks and other means to ensure high-quality data.

2.2. Service disengagement

Service disengagement was defined as having no clinical contact for at least three consecutive months (Anderson et al., 2013) (i.e., no clinic or community appointments with the psychiatrist and/or case manager and not responding to phone calls). Time to disengagement was recorded as the time from program entry to the first month (of the three consecutive months) of no contact. Clients who moved or were transferred were censored as of that time and were not considered to have disengaged. Clients who completed the two-year program were censored at 24 months.

2.3. Sociodemographic and baseline data

Sociodemographic variables that were previously shown to be important for predicting disengagement were recorded, including age, gender (female/male), education level (completed/did not complete high school), substance use diagnosis based on the Structured Clinical Interview for DSM-IV (yes/no), and family contact with the treatment team (yes/no). Social Deprivation Index (SDI; combines 3 indicators from the Canadian census: the proportion of the population aged 15 and over living alone, the proportion of the population aged 15 and over who are separated, divorced or widowed, and the proportion of single-parent families) and Material Deprivation Index (MDI; combines 3 indicators from the Canadian census: the proportion of the population

15 years and over without a high school diploma (or equivalent), the employment to population ratio for the population 15 years and over, and the average income of the population aged 15 years and over) (Gamache et al., 2010) were used as proxies for socioeconomic status (SES) and were included as continuous variables based on centiles ranging from 0 to 100, with higher scores indicating higher levels of deprivation. Medication adherence during months one to three of treatment was included as a putative early predictor of disengagement. It was reported as a dichotomous variable with “adherent” defined as taking medication as prescribed for at least 75% of the time during all three months and “non-adherent” defined as taking medication as prescribed <75% of the time for any of the first three months (Jordan et al., 2014; Cassidy et al., 2010).

2.4. Immigration and visible minority status

Individuals born outside Canada were coded as first-generation immigrants. Those born in Canada with at least one parent born outside Canada were coded as second-generation immigrants. Those born in Canada with both parents born in Canada were coded as non-immigrants (Anderson et al., 2015; Statistics Canada, 2013a). Visible minority status was self-reported; options were based on Statistics Canada’s classification (Statistics Canada, 2013b) of Caucasian, Black, Asian (includes Chinese, South Asian, Filipino, South-East Asian, West Asian, Korean, Japanese), Aboriginal or Other (Latin America, Arab, multiple). The small number of individuals who identified as Aboriginal ($n = 4$) were excluded given their unique historical contexts and internal migration patterns.

2.5. Data analysis

Descriptive statistics are presented as proportions for count data and as means with standard deviations (SD) for continuous data. Independent sample t -tests (for continuous variables) and Pearson Chi-squared tests (for dichotomous variables) were used to assess group differences between clients who completed treatment and clients who disengaged before the two year timepoint. Pearson Chi-squared tests with post-hoc adjusted residual calculations (for dichotomous variables) and one-way ANOVAs with Tukey post-hoc tests (for continuous variables) were used to assess group differences between non-immigrants, first-generation and second-generation immigrants.

Kaplan-Meier time-to-event curves were plotted for each immigrant group to demonstrate the rate and pattern of disengagement. Log-rank test assessed differences between groups. Cox Proportional Hazards regression analysis was used to determine the predictive value of the selected sociodemographic and baseline variables on disengagement for all clients and for each immigrant sub-group. Post-hoc time-to-event and Cox Proportional Hazards regression analyses were carried out with visible minority status replacing immigration status. Results are presented as hazard ratios (HR) with 95% confidence intervals (CI). All analyses were performed using SPSS software, version 20.

3. Results

Table 1 presents key clinical and sociodemographic characteristics for the sample ($N = 297$) of PEPP clients included in this study. 208 (70.0%) had non-affective psychosis, 88 (29.6%) had affective psychosis, and 1 (0.3%) was missing a main diagnosis. The median duration of untreated psychosis was 15.1 weeks (range 0–1011.6).

3.1. Completers vs. disengagers

Of the 297 included clients, 72 (24.2%) disengaged with an average time to disengagement of 13.3 (SD = 5.7) months. Compared to those who remained engaged, a higher proportion of those who disengaged

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