

to guidelines (4). To be eligible for the study, which was approved by the hospital's ethics committee, patients had to be age 15 to 25, live in the catchment area, have an *ICD-10* F2 diagnosis (schizophrenia, schizotypal, and delusional disorders), and have first visited the clinic between November 2009 and October 2010 (intervention group) or between November 2007 and October 2009 (control group). Patients were not eligible if they had experienced multiple episodes of psychosis or had organic psychosis or a substance use disorder. For those who dropped out during the 12-month follow-up, outcome measurements at the last contact were used. We defined disengagement as dropping out during follow-up despite continued need and the team's reengagement attempts. We defined functional remission as working or going to school for at least 16 per week for six continuous months. Outcomes were assessed by a blind rater (SA) using medical records. Analyses were conducted with Mann-Whitney U or Fisher exact tests in SPSS, version 17.0 J.

Of the 55 patients eligible for the intervention group, 40 were excluded (38 had multiple episodes and two had a substance use disorder). Of the 40 patients eligible for the control group, 25 were excluded (23 had multiple episodes and two had a substance use disorder). The 15 patients in the intervention group had a younger age at onset of psychosis and a longer duration of untreated psychosis than the 15 patients in the control group ($p \leq .01$). However, the intervention group had a lower disengagement rate during follow-up (0% versus 33%, $p = .04$) and a lower rehospitalization rate (0% versus 20%, nonsignificant). Five patients in the intervention group were in functional remission at baseline, and all five sustained remission during follow-up. Of the six control group patients in functional remission at baseline, only one sustained remission (two disengaged).

The findings suggest that the intervention may be effective in preventing disengagement. The low disengagement rate in the intervention group may be attributable to the shorter

follow-up period compared with previous studies (2,3) and to the relatively young age of the patients. In addition, all but one patient in the intervention group lived with family, which is characteristic of Japanese culture. We suggest that case managers play a vital role in preventing disengagement because they strengthen ties with users via continuous contact. The study had several limitations. In addition to the small sample, patients were not randomly assigned to the groups and no information on work history was available. We have undertaken a randomized controlled trial of this intervention (5).

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Acknowledgments and disclosures

This study was funded by grant H22-seishin-ippan-015 from the Ministry of Health, Labor, and Welfare. The authors thank Syudo Yamasaki, Ph.D., Naomi Inoue, Ph.D., Nozomu Asukai, M.D., Ph.D., Shigeko Ishikura, M.S.W., Etuko Aono, B.A., Hirohiko Harima, M.D., Toru Wakejima, M.D., and Yuji Okazaki, M.D., Ph.D.

The authors report no competing interests.

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Ethnicity and Service Engagement Among Involuntary Patients

To the Editor: It remains unclear whether ethnicity attenuates service engagement among psychiatric patients (1). The relationship between ethnicity and engagement may be confounded by perceived coercion, illness insight, and severity of symptoms (1–4). However, previous studies of this topic have been cross-sectional (1). Therefore, we examined the relationship between ethnicity, service engagement, perceived coercion, illness insight, and severity of symptoms among 141 involuntary committed patients during a one-year follow-up (5).

Patients involuntarily admitted to three facilities in Rotterdam, Netherlands, between January 2005 and July 2006 were eligible ($N=276$), and 207 patients (118 men, 68%, and 56 women, 32%) were included (75% participation rate). Twenty-eight participants were excluded because the request for the court-ordered admission was rejected and five because of loss to follow-up. We also excluded participants who did not belong to one of three major ethnic groups, leaving a sample of 141 participants: 36 (26%) Antillean-Surinamese patients, 31 (22%) Turkish-Moroccan patients, and 74 (52%) Dutch native patients. Participants and clinicians were interviewed at baseline and after six and 12 months.

Service engagement was assessed with the Service Engagement Scale, a 14-item, clinician-rated measure consisting of statements that assess service engagement. Four subscales assess availability (“When a visit is arranged, the client is available”), collaboration (“The client actively participates in managing his or her illness”), help seeking (“The client seeks help to prevent a crisis”), and treatment adherence (“The client

refuses to cooperate with treatment"). Illness insight was measured with the Schedule of Assessment of Insight-Expanded, perceived coercion with a 15-item questionnaire, and symptom severity with the 24-item version of the Brief Psychiatric Rating Scale. Erasmus University Medical Center's Medical Ethics Committee approved the study, and all participants provided informed consent.

At baseline, patients from ethnic minority groups were younger than Dutch native patients (Antillean-Surinamese, 31.2 ± 9.9 years; Turkish-Moroccan, 27.0 ± 7.1 ; and Dutch native, 42.9 ± 15.8 years; $F=20.25$, $df=2$ and 138 , $p<.001$). Larger proportions of the ethnic minority groups had a psychotic disorder (Antillean-Surinamese, 92%, $N=33$; Turkish-Moroccan, 90%, $N=28$; and Dutch native, 66%, $N=49$; $\chi^2=12.66$, $df=2$, $p=.002$). No significant between-group differences were found in service engagement, illness insight, perceived coercion, and symptom severity. Mixed-model regression analyses showed a significant increase in engagement during follow-up (time $\beta = -1.34$, $SE=.28$, $p<.05$; time² $\beta = -.05$, $SE=.02$, $p<.05$). Better illness insight was correlated with greater engagement ($\beta = -.91$, $SE=.17$, $p<.05$). Over the follow-up period, engagement deteriorated among patients with more severe symptoms ($\beta = -.05$, $SE=.06$; by time $\beta = .02$, $SE=.01$, $p<.05$) and among patients with high levels of perceived coercion, although this effect became weaker over time (perceived coercion $\beta = .10$, $SE=.06$; by time $\beta = .05$, $SE=.02$, $p<.05$; by time² $\beta = -.004$, $SE=.002$, $p<.05$). No significant relationship was found between ethnicity and the course of engagement during follow-up.

This prospective study showed that ethnicity per se was not related to service engagement among involuntarily committed patients, either at baseline or during follow-up. The increase in engagement during follow-up was related to better illness insight and coincided with less perceived coercion and severity of symptoms.

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Acknowledgments and disclosures

This work was supported by the Dutch national research grant organisation, ZonMW, grant number 100-002-004. The authors thank Niels Mulder for his contribution to the study and analysis.

The authors report no competing interests.

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Medication Adherence Among Patients With Comorbid Diabetes

To the Editor: Medication nonadherence is a significant issue for patients with diabetes and serious mental illness (1). Determining the causes of nonadherence is challenging. In a study of veterans with schizophrenia, adjusted analyses found that adherence to medication for a comorbid general medical condition was worse than adherence to antipsychotic medication (2). In this study, we explored whether adherence to diabetes medications is correlated with adherence to psychiatric medications among veterans with comorbid diabetes and serious mental illness.

We analyzed 2008-2011 pharmacy data for 319 veterans with diagnoses of both diabetes and serious mental illness (defined as bipolar disorder or schizophrenia). For one year before each patient's study enrollment, we calculated the medication possession ratio (MPR)—that is, the percentage of days during the study year on which filled prescriptions were available for all hypoglycemic medications and for all psychiatric medications (antipsychotics and mood stabilizers).

The mean MPR for psychiatric medications was 72%, compared with 79% for hypoglycemic medications. A modest linear correlation was observed between MPR rates for psychiatric and hypoglycemic medications (Pearson correlation coefficient, $r=.26$, $p<.001$). A scatterplot showed clustering effects at high and low MPR levels, but otherwise there was substantial discordance in rates of adherence between the medication classes. Among the 173 patients with good adherence to psychiatric medication (defined as an $MPR \geq 80\%$), 73% ($N=126$) had good adherence to hypoglycemic medication. Among the 200 patients with good adherence to hypoglycemic medication, 63% ($N=126$) had good adherence to psychiatric medication. Among the 119 patients with poor adherence to hypoglycemic medications (defined as an $MPR < 80\%$), 60% ($N=72$) had poor adherence to psychiatric medication. Among the 146 patients with poor adherence to psychiatric medication, 49% ($N=72$) had poor adherence to hypoglycemic medication ($p<.001$ for all).

Only 126 of the 319 patients (39%) were adherent to both classes of medication, which is consistent with previous research (2). No data were available on patients' reasons for adherence or nonadherence to either type of medication. A previous study found that nonadherence to psychiatric medication was influenced by perceptions of stigma (3). However, if stigma was a major driving force behind nonadherence to psychiatric medication in this study, we would have observed much higher average MPRs for