Substance use may influence the onset and course of psychosis.\(^1\) Ongoing substance use is associated with negative outcomes\(^2\)–\(^4\) but may also be a marker for other factors that affect prognosis, including younger age at onset and male gender.\(^4\) Many young people with psychosis misuse stimulant drugs;\(^5\),\(^6\) however, most of these young people also misuse cannabis,\(^7\) making it difficult to separate the effects of these two drugs. In a large Thai sample, more than half of first admissions with specific diagnoses of methamphetamine psychosis went on to have further episodes of psychosis.\(^8\) We are not aware of any study examining the relationship between stimulant disorders and outcome in young people with broadly diagnosed psychoses.\(^9\) Our study used a large population-based sample of people aged 15–29 years with a first psychosis admission.

### Background

Few studies have examined the impact of stimulant use on outcome in early psychosis. Ceasing substance use may lead to positive outcomes in psychosis.

### Aims

To examine whether baseline cannabis or stimulant disorders and ongoing drug use predict readmission within 2 years of a first psychosis admission.

### Method

Predictors of readmission were examined with Cox regression in 7269 people aged 15–29 years with a first psychosis admission.

### Results

Baseline cannabis and stimulant disorders did not predict readmission. A stimulant disorder diagnosis prior to index psychosis admission predicted readmission, but a prior cannabis disorder diagnosis did not. Ongoing problem drug use predicted readmission. The lowest rate of readmission occurred in people whose baseline drug problems were discontinued.

### Conclusions

Prior admissions with stimulant disorder may be a negative prognostic sign in first-episode psychosis. Drug use diagnoses at baseline may be a good prognostic sign if they are identified and controlled.

### Declaration of interest

None.

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**Baseline period for determination of incident cases**

- Persons 15–29 years with first psychosis admission in study period (\(n = 7772\))
- Not NSW resident (\(n = 437\))
- Diagnostic exclusions (\(n = 56\))
- Death in hospital (\(n = 7\))
- Un-discharged at 2 years (\(n = 3\))
- Included in study, 2-year follow-up data available (\(n = 7269\))

**Study period 2005–2010**

Follow-up period 2005–2012

**Readmitted (\(n = 2715\), 37%)**
- Baseline period for determination of incident cases 2000–2005

**Not readmitted (\(n = 4554\), 63%)**
- Baseline period for determination of incident cases 2000–2005

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(a) admissions where the person was admitted and discharged on the same day;

(b) persons whose usual residence was another country or another Australian state;

(c) persons with organic psychosis or schizotypal disorder as the only psychosis diagnosis;

(d) persons whose index admission ended in death;

(e) persons not yet discharged 2 years after index admission.

The period July 2000 to June 2005 was used as a baseline period for determining incident cases. All participants had no admissions with a psychosis diagnosis for at least 5 years prior to their index admission. Admissions in the baseline period for
non-psychotic conditions (such as mood, anxiety, adjustment or substance disorders) were not excluded, as these conditions frequently precede psychosis.11

We identified readmissions to any NSW public hospital with a primary or additional diagnosis of psychosis within 2 years of discharge from the index psychosis admission. We excluded readmissions due to transfer between hospitals or occurring on the day of discharge of the index admission. Readmission data were available to 30 June 2012.

Measures

Primary and additional diagnoses were made by the treating psychiatrist and extracted from clinical notes by medical record coders. Psychosis was defined by the presence of a primary or additional ICD-10 code diagnosis code for a psychotic disorder, including affective psychoses (mania or depression with psychosis specified) and drug-induced psychosis. Substance-related disorders were identified by diagnosis codes for abuse, dependence, intoxication or poisoning. Drug-induced psychoses were counted as both psychosis and substance use disorder. Amphetamines and cocaine were grouped into a single ‘stimulant’ disorder category. All individual substance diagnoses were recorded; polydrug disorder was recorded only where this was specifically diagnosed (ICD-10 code F19).

Binary variables were constructed to indicate prior hospital admissions with non-psychotic mental health conditions, cannabis disorders or stimulant disorders.


A proxy measure of ongoing problem drug use was constructed for individuals who had contact with community mental health services or were readmitted to hospital for any reason after their index admission. This proxy measure could not be constructed where a person had no further contact with NSW hospital or community services following their index admission. New South Wales in-patient and community mental health services collect diagnoses and periodic ratings using the Health of the Nation Outcomes Scales (HoNOS).13 Ratings are made by the treating clinician (case manager or psychiatrist). Ongoing drug problems were defined as present if, during the follow-up period, the person had either (a) any diagnosis of a substance use disorder in hospital or community records or (b) at least one completed HoNOS with a score of 2 (‘Loss of control of drinking or drug-taking’), 3 (‘Marked craving or dependence’) or 4 (‘Incapacitated by alcohol and drug problems’) on the HoNOS Problem Drinking or Drug-taking Scale (i.e. HoNOS Item 2). HoNOS does not distinguish the type of substance used. A threshold score of 2 or more was chosen to define problem substance use, in keeping with expert clinician ratings of ‘clinically significant’ problems on the HoNOS.14 Baseline and ongoing drug diagnosis and HoNOS measures were combined to create a composite variable with three possible values: no drug problem (baseline or ongoing), drug problem ceased (drug diagnosis at index admission but no ongoing problem) and drug problem ongoing (drug problem in ongoing measure, with or without drug diagnosis at index admission).

Analysis

Statistical analyses were undertaken using Stata v11 SE for Windows. Univariate Cox regressions were conducted on candidate variables. Proportional hazards assumptions were tested by visual examination of log–log survival plots and by testing for significant interactions when each variable was entered as a time-based covariate. Variables of interest, with univariate P < 0.2, and which satisfied proportional hazards assumptions, were entered into a multivariate Cox regression. This model was stratified on local mental health service, because observations may have been correlated within health services due to local population or resource factors. Two variables failed proportional hazards assumptions and were therefore included as stratiﬁers rather than covariates: (a) admission to a non-specialised mental health unit; and (b) psychosis as a comorbid diagnosis rather than a primary diagnosis for the index admission. The distribution of deviance residuals was examined to identify multivariate outliers.

Differences between people with and without ongoing service contact were examined using binary logistic regression. The proxy measure of ongoing drug problems was analysed for the subset of participants for whom the measure was available, using the same Cox regression method described above.

Results

There were 7269 persons aged 15–29 who had a first admission in the study period (Table 1). Two-thirds (66%) were male and only 24% were aged under 20. The most common diagnoses at first admission were schizophrenia or delusional disorders (36%) and drug-induced psychosis (22%). Thirty per cent had a comorbid cannabis disorder and 16% a comorbid stimulant disorder. One

| Table 1 Characteristics of study group and readmission rate within 2 years of first admission with a diagnosis of psychosis |
|--------------------------------------------------|---------------|----------------|---------------|
| Gender                                           | n (%)         | % readmitted   | (95% CI)       |
| Gender                                           | n (%)         | % readmitted   | (95% CI)       |
| Male                                             | 4810 (66)     | 39 (38–40)     |               |
| Female                                           | 2459 (34)     | 34 (32–35)     |               |
| Age group, years                                 |               |                |               |
| 15–19                                            | 1736 (24)     | 42 (40–43)     |               |
| 20–24                                            | 2718 (37)     | 37 (36–39)     |               |
| 25–29                                            | 2815 (39)     | 34 (32–36)     |               |
| Diagnosis                                        |               |                |               |
| Schizophreniaa                                   | 2602 (36)     | 42 (40–44)     |               |
| Schizoaffectiva                                   | 343 (5)       | 41 (35–48)     |               |
| Affective psychosisb                             | 939 (13)      | 28 (25–31)     |               |
| Brief psychosis                                  | 919 (13)      | 38 (35–42)     |               |
| Drug-induced psychosis                           | 1570 (22)     | 36 (33–38)     |               |
| Other psychosisc                                 | 896 (12)      | 36 (33–40)     |               |
| Baseline drug diagnoses                          |               |                |               |
| Cannabis                                         | 2197 (30)     | 41 (38–43)     |               |
| Stimulants                                       | 1162 (16)     | 38 (35–42)     |               |
| Prior care                                       |               |                |               |
| Prior admissionsd                                | 1177 (16)     | 42 (38–45)     |               |
| Prior cannabis                                   | 645 (9)       | 41 (36–43)     |               |
| Prior stimulants                                 | 372 (5)       | 46 (39–53)     |               |
| Person                                           |               |                |               |
| Migrant                                          | 1332 (18)     | 35 (32–38)     |               |
| Rural residence                                  | 3013 (41)     | 39 (37–41)     |               |
| Most disadvantaged                               | 3183 (44)     | 39 (38–41)     |               |
| a. Includes delusional disorder.                 |               |                |               |
| b. Mania or depression where psychosis specified. |               |                |               |
| c. Includes other non-organic psychosis (ICD-10 code F29) and psychosis not otherwise specified (F29). | | | |
| d. Prior admissions for mental healthcare but not prior psychosis diagnosis. | | | |
| e. Readmission rate 37.35% (95% CI 37.33–37.38). | | | |
in six (16%) had prior admissions for mental health or substance-related problems but without a psychosis diagnosis.

Thirty-seven per cent of persons were readmitted with psychosis within 2 years. The risk of readmission was highest immediately following the index admission; 17% of participants were readmitted within 90 days (representing 45% of those who were readmitted).

Table 2 shows the results of univariate and multivariate Cox regression. In univariate comparisons, readmission at 2 years was significantly more likely in males (hazard ratio (HR) 1.21, 95% CI 1.11–1.31) and in younger individuals. The highest rate of readmission (42%) was for people with an index diagnosis of brief psychosis within 2 years. The risk of readmission was highest in males (hazard ratio (HR) 1.21, 95% CI 1.11–1.31) and in younger individuals. The highest rate of readmission (42%) was for people with an index diagnosis of brief psychosis (HR = 0.85, 95% CI 0.77–0.93), drug-induced psychosis (HR = 0.83, 95% CI 0.75–0.92), and atypical psychosis (HR = 0.83, 95% CI 0.75–0.97).

The results of multivariate analysis differed slightly: after controlling for other variables, affective, brief and atypical psychoses were associated with lower risk of readmission than schizophrenia, but drug-induced psychosis was associated with a higher risk (HR = 1.13, 95% CI 1.04–1.24). Baseline cannabis disorder was no longer associated with readmission. Findings regarding stimulants were unchanged in the multivariate analysis: prior stimulant disorders predicted readmission (HR = 1.36, 95% CI 1.12–1.66) but a baseline stimulant diagnosis did not. There was no relationship between readmission and migrant status, rural location or residing in more disadvantaged localities.

Examining multivariate outliers, 80 participants (1.1%) had deviance residuals greater than 2.5 standard deviations (s.d.), but none greater than s.d = 3.0. These individuals did not differ significantly from other participants on age, gender, diagnosis group, rate of substance use or year of admission, but they were more likely to have had their index admission outside a specialist mental health unit. Index admission occurred outside a specialised mental health unit for 1068 persons (15% of the study group). These admissions were more common in rural hospitals, and were not excluded from the study in order to avoid systematic under-representation of rural residents. Sensitivity analysis was conducted by refitting the multivariate Cox regression model after removing this group; the risk of readmission for brief psychosis was slightly reduced, and now differed significantly from that for schizophrenia (HR = 0.84, 95% CI 0.74–0.96) in the revised model. The model was otherwise unchanged.

Sensitivity analysis was conducted on the effects of different methods for dealing with tied observations within a Cox regression. There was no significant difference between exact and approximate methods; the results presented used the Efron approximation.

A total of 31% of participants had no further contact with NSW community mental health or in-patient services in the 2 years after their index admission, and therefore had no diagnostic or HoNOS information for ongoing care in the study period. People with no ongoing service contact were more likely to be younger, to have an index diagnosis of brief (odds ratio (OR) 1.39, 95% CI 1.01–1.91), drug-induced (OR = 1.27, 95% CI 1.02–1.58) or atypical/unspecified psychosis (OR = 1.49, 95% CI

| Table 2 Cox regression analyses of readmission within 2 years of first admission with psychosis (persons aged 15–29, n = 7269) |
|---|---|---|---|---|---|---|
| **Diagnosis** | **n** | **HR** | **95% CI** | **P** | **HR** | **95% CI** |
| Schizophrenia | 2602 | 1.00 | – | <0.001 | 1.00 | – |
| Schizoaffective | 343 | 0.98 | 0.82–1.17 | 0.80 | 0.97–1.04 |
| Affective psychosis | 939 | 0.61 | 0.53–0.69 | 0.80 | 0.73–0.89 |
| Brief psychosis | 919 | 0.91 | 0.80–1.02 | 0.80 | 0.73–0.89 |
| Drug-induced psychosis | 1570 | 0.83 | 0.75–0.92 | 1.13 | 1.04–1.24 |
| Other psychosis | 896 | 0.85 | 0.75–0.97 | 0.81 | 0.71–0.92 |
| **Baseline drug diagnoses** | | | | | | |
| Cannabis | 2197 | 1.15 | 1.06–1.25 | <0.001 | 1.06 | 0.97–1.16 |
| Stimulants | 1162 | 1.05 | 0.95–1.16 | NS | 1.02 | 0.90–1.14 |
| **Prior care** | | | | | | |
| Prior admissions | 1177 | 1.18 | 1.07–1.30 | <0.001 | 1.22 | 1.08–1.37 |
| Prior cannabis | 645 | 1.11 | 0.97–1.26 | NS | 0.97 | 0.82–1.14 |
| Prior stimulants | 372 | 1.30 | 1.11–1.51 | NS | 1.36 | 1.12–1.66 |
| **Person** | | | | | | |
| Migrant | 1332 | 1.11 | 1.00–1.22 | NS | 1.04 | 0.93–1.16 |
| Rural residence | 3013 | 1.10 | 1.02–1.19 | NS | 1.03 | 0.86–1.24 |
| Most disadvantaged | 3183 | 1.13 | 1.04–1.22 | <0.001 | 1.07 | 0.95–1.21 |

HR, hazard ratio; NS, not significant.

a. Reference group.
b. Includes delusional disorder.
c. Mania or depression where psychosis specified.
d. Includes other non-organic psychosis (ICD-10 code F28) and psychosis not otherwise specified (F29).
e. Not significant (P > 0.05).
f. P for overall model <0.001.
is the more important issue.3,4,17 are consistent with those suggesting that ongoing substance use nor stimulant diagnoses at baseline predicted readmission after people following a first admission for psychosis. Neither cannabis of 7.3 million persons to examine the risk of readmission in young outcomes.15,16 We have used health-system data for a population with psychosis is associated with negative prognostic factors. However, there is increasing evidence that comorbid drug use in people with psychosis is associated with better neurocognitive performance, fewer negative symptoms, fewer neurological soft signs and more positive symptoms.26,27

Three explanations have been proposed for these findings. First, cannabis may have direct neuroprotective effects.27 Second, Meuser et al.28 have proposed that this effect is mediated through social competence, whereby more ‘socially oriented patients with serious mental illness are more likely to come into contact with drugs and subsequently develop substance use disorder’ (p. 726). Third, these findings may reflect varying degrees of personal vulnerability: psychosis in the absence of substance use is likely poor outcome.2,18 Some of the apparent association between baseline cannabis use and adverse outcome may be due to confounding of cannabis disorders with other factors which predict readmission, namely, being younger, male and having a primary diagnosis of schizophrenia. Baseline use of cannabis or other drugs may also be a predictor of ongoing drug use.

Stimulant disorders and readmission
Stimulant disorders at baseline were not associated with readmission, but hospital admissions with stimulant disorders prior to the index admission were. The finding is consistent with evidence that the risk of developing drug-related psychosis after prolonged drug use is greater for stimulants than for cannabis,19 and with sensitisation models of the interaction between stimulant use and psychosis.20,21 Prior stimulant-related admissions are likely to be indicators of severe or enduring stimulant use, since most people with stimulant misuse or dependence are not admitted to hospital. Severe stimulant disorders may also be associated with misuse of a wider range of substances, including heavier or more sustained cannabis use. However, the same association was not found for prior cannabis use disorders.

Ongoing drug use
We found that people with ongoing problem drug use had a rate of readmission nearly a third higher than people with no drug use. An association between ongoing drug use and poor outcome is not surprising, however our findings help to quantify the scale of this effect in a representative population-based sample, and underline the significant personal and health system impacts of ongoing drug use.

Conversely, we found that the best outcome (as measured by hospital readmission) occurred in people with baseline substance diagnoses but no ongoing substance use problems. Several studies have found that young people with psychosis who cease substance use have better outcomes than those who have never used substances.22–24 A recent meta-analysis of this issue concluded that further and larger studies were needed.22 Our findings add further evidence on this issue. An association between substance use and positive outcome in psychosis may seem counterintuitive, since substance use in people with psychosis is associated with negative prognostic factors including younger age, male gender and social disadvantage. However, there is increasing evidence that comorbid drug use in psychosis is also associated with better neurocognitive performance, fewer negative symptoms, fewer neurological soft signs and more positive symptoms.26,27

Discussion
It is clinically important to identify factors which predict outcome in first-episode psychosis, and especially to identify prognostic factors which may be influenced by intervention. Some studies have found that substance use at psychosis onset predicts poorer outcomes.5,25,17 We have used health-system data for a population of 7.3 million persons to examine the risk of readmission in young people following a first admission for psychosis. Neither cannabis nor stimulant diagnoses at baseline predicted readmission after controlling for age, gender and diagnostic subtype. Our findings are consistent with those suggesting that ongoing substance use is the more important issue.3,4,17

Cannabis disorders and readmission
We found univariate associations between baseline cannabis and outcome; however these were no longer significant after controlling for age, gender and diagnostic subtype. Our findings are consistent with studies reporting that baseline cannabis use did not predict poor outcome.2 Some of the apparent association between baseline cannabis use and adverse outcome may be due to confounding of cannabis disorders with other factors which predict readmission, namely, being younger, male and having a primary diagnosis of schizophrenia. Baseline use of cannabis or other drugs may also be a predictor of ongoing drug use.
to reflect greater genetic or developmental diathesis in the person affected, whereas cannabis or other drugs may precipitate psychosis in individuals with less intrinsic vulnerability.29,30 Our findings cannot distinguish between greater social competence and lesser personal vulnerability as explanations for positive outcome in former drug users with psychosis, and further research on this question is needed. The association between ongoing substance use and worse outcome is inconsistent with cannabis having a neuroprotective effect in psychosis.

Regardless of the mechanism, our findings underline an important and hopeful clinical message. Young people with first-episode psychosis and comorbid substance disorder may have the best outcomes, provided that substance disorder is properly managed.

Other findings
After controlling for other variables, the risk of readmission for people with an index diagnosis of drug-induced psychosis was higher than for those with an index diagnosis of schizophrenia. This is consistent with studies questioning the predictive validity of drug-induced psychosis diagnoses.31,32 In a study of persons with diagnoses of cannabis-induced psychosis, nearly half were subsequently diagnosed with schizophrenia and 77% had further psychotic episodes.33

The association between ongoing problem drug use and readmission was not constant over time; cessation of problem drug use appeared to be associated with a reduced risk of early readmission (within 90 days of discharge from index admission). Early and late relapse or readmission may be influenced by different processes and risk factors.34 This issue warrants further study.

Limitations
The scale and population coverage of administrative data-sets can complement clinical studies by allowing an examination of issues such as stimulant misuse which may be otherwise confounded by other clinical or personal variables in smaller clinical samples. However, routinely collected administrative data also have a number of limitations.

First, we have not captured all incident cases of psychosis in NSW because we have used hospitalisation data to define incidence. More than 80% of people seen by specialised early psychosis services are admitted early in their illness.35,36 Those not admitted have longer duration of psychosis, less social disadvantage and greater likelihood of mania.36,37 However, they do not differ in their prevalence of positive symptoms or the likelihood of problem substance use.37 Our findings underestimate the total number of young people with psychosis, and our sample omitted some young people with better social support and/or a less acute onset.

Second, we do not have follow-up information on all study participants. Thirty-one per cent of participants had neither a readmission to hospital nor a contact with NSW community mental health services. Thirty-one per cent of participants had neither a readmission to hospital nor a contact with NSW community mental health services.

Finally, our proxy measure of ongoing drug use was imprecise. It combined data from in-patient and community diagnoses with a clinician rating of problem substance use derived from the HoNOS. The HoNOS is not a diagnostic instrument and does not distinguish the type of drug used.

Clinical implications
Cannabis or stimulant disorders at first hospital admission with psychosis may not be negative prognostic signs. Young people with substance comorbidities may have both the best and worst of outcomes, depending on whether problematic substance use is discontinued. It is critical to screen and offer intervention for drug use in early psychoses. Admissions with stimulant disorder diagnoses prior to the first psychosis admission were associated with worse outcome. This suggests that it is important not only to identify current substance use at first admission with psychosis but also to obtain a detailed history of the type, severity and duration of past substance use.

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Cannabis and stimulant disorders and readmission 2 years after first-episode psychosis
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