9–20.4)) (Jääskeläinen, 2013). Negative and cognitive symptoms frequently impair patient recovery. On the other hand the duration of untreated psychosis shows itself as one of the most important characteristics related with functional prognoses.

F128. THE AGE OF ONSET OF SCHIZOPHRENIA SPECTRUM DISORDERS

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Background: This study characterizes the age of onset of schizophrenia spectrum disorders and summarizes findings regarding a range of clinical and social outcomes, cognition, brain structure, and mortality.

Methods: The review is based on series of systematic and nonsystematic literature searches. We included original articles and systematic reviews looking associations between age of onset and incidence, risk factors, suicides, brain structure and cognition.

Results: The peak age of onset for schizophrenia spectrum disorders is between 20 to 29 years, in where the incidence estimate was among males 4.15 and among females 1.71 per 10,000 person-years. Male gender has been linked with earlier onset age, although among those with family history and cannabis use corresponding gender difference do not exist. Early onset schizophrenia has been linked e.g. with higher familial risk, poor premorbid social adjustment and cannabis use. In adult samples, earlier age of onset associated with worse outcome, regarding hospitalisations, negative symptoms, relapses, social and occupational functioning, and global outcome. Also in childhood and adolescence schizophrenia, earlier onset has been linked with more severe outcomes. Early age of onset has been linked also with larger cognitive deficits and brain alterations. In the few existing studies, later AOO has been linked with a higher suicide rate. In all, the current study found various differences between patients with different age of onset. However, the studies on age of onset are relative heterogeneous on methodology and have given varying results. More good quality studies are needed including patients without restriction due to the age onset.

Discussion: Age of onset is an important characteristic of schizophrenia that could help when examining the origin, genetic mechanism and care of schizophrenia. Understanding factors that influence age of onset in schizophrenia may offer clues to prevent or delay the onset of this debilitating group of disorders.

F129. COMBINED PATTERNS OF TOBACCO AND CANNABIS USE IN ADOLESCENCE AND THEIR ASSOCIATION WITH PSYCHOTIC EXPERIENCES: A LONGITUDINAL ANALYSIS

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Background: There has been increasing concern about potentially causal effects of tobacco use on psychosis, but epidemiological studies have been less robust in attempts to minimise effects of confounding than studies of cannabis use have been. We therefore aim to examine the association of patterns of cigarette and cannabis use with preceding and subsequent psychotic experiences, and compare patterns of confounding across these patterns.

Methods: We analysed repeated measures of cigarette and cannabis use during adolescence in a sample of 5,300 individuals in the Avon Longitudinal Study of Parents and Children birth cohort who had at least 3 measures of cigarette and cannabis use between ages 14–19 years. Cigarette and cannabis use data were summarised using longitudinal latent class analysis to identify longitudinal classes of substance use, and associations between classes and psychotic experiences at 18 years were assessed.

Results: Prior to adjusting for a range of potential confounders, there was strong evidence that early-onset cigarette-only use (4.3%) or early-onset cannabis use (3.2%), and late-onset cannabis use (11.9%), but not later-onset cigarette-only use (14.8%) latent classes were associated with increased psychotic experiences compared to non-users (65.9% (omnibus P<0.001). After adjusting for confounders, the association for early-onset cigarette-only use attenuated substantially (unadjusted odds ratio (OR) = 3.03, 95%CI 1.13, 8.14; adjusted OR = 1.78, 95%CI 0.54, 5.88), whereas those for early-onset (adjusted OR = 3.70, 95%CI 1.66, 8.25) and late-onset (adjusted OR = 2.97, 95%CI 1.63, 5.40) cannabis use were unchanged.

Discussion: Our findings indicate that whilst individuals who use either cannabis or cigarettes during adolescence have an increased risk of developing subsequent psychotic experiences, the epidemiological evidence for this being causal is substantively more robust for cannabis than it is for tobacco.

F130. INCREASED RISK OF PSYCHOTIC DISORDERS IN AFRICAN MIGRANTS TO AUSTRALIA

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Background: Certain migrants groups are at an increased risk of psychosis compared to the native-born population, however these findings relate to certain countries, mainly in Europe and America where the research has been conducted. It is not yet known whether migrants to Australia are at an increased risk for developing a psychotic disorder. This study aimed to determine whether first-generation migrants in a geographically defined catchment area in Melbourne have an increased risk of developing a psychotic disorder.

Methods: This study included an all young people aged between 15 and 24 residing in a geographically defined catchment area of north western Melbourne who presented to the Early Psychosis Prevention and Intervention Centre (EPPIC) between 01.01.11 and 31.12.13. Data pertaining to the at risk population was obtained from the Australian 2011 Census and incidence rates ratios were calculated.

Results: A total of 527 individuals with FEP were included, 393 were Australian-born (74.6%) and 134 (25.4%) were overseas-born. First generation migrants from Kenya (IRR=9.81), Ethiopia (IRR=5.17), Somalia (IRR=3.78), and Sudan (IRR=3.57), had significantly increased risk of having a psychotic disorder. Conversely, first generation migrants from India and China had significantly decreased risk of having psychosis.

Discussion: First-generation migrants from East Africa and the Horn of Africa have significantly high rates of psychosis and they may have experienced factors pre-, during, and post-migration, predisposing them to psychosis.

F131. CHILDHOOD ADVERSITIES IN PEOPLE AT ULTRA-HIGH RISK (UHR) FOR PSYCHOSIS: SYSTEMATIC REVIEW & META-ANALYSIS

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Background: Childhood adversities such as childhood abuse, bullying victimisation, and parental separation have been found to be associated with many psychiatric illnesses, including psychosis. A large body of research has been conducted on individuals at ultra-high risk (UHR) for psychosis, or clinical high risk (CHR)
for psychosis. This review aims to quantitatively summarise (i) the associations between childhood adversities and the UHR state, and (ii) how these adversities may be linked with a higher risk of transition to psychosis (TTP).

Methods: We conducted systematic searches based on PubMed, EMBASE, and PsycINFO databases. We adopted search terms aimed at retrieving studies related to: (1) populations which were at UHR of psychosis, (2) exposure to childhood adversities, and (3) schizophrenia. Studies were eligible as long as they reported information on any form of childhood adversities and recruited participants at UHR of psychosis. Studies that only investigated the level of psychotic symptoms in a cohort or among schizophrenia patients were excluded.

Whenever possible, we conducted meta-analyses to compare, across UHR and healthy individuals: (a) the levels of childhood trauma exposure, (b) childhood bullying victimisation, and (c) parental separation or loss. We conducted a second set of meta-analyses to investigate the effect of childhood trauma on TTP. Whenever allowed by provision of detailed information, we also conducted separate meta-analytic computations for each reported subtype of childhood adversity and trauma. All analyses were conducted in Review Manager 5.3, using inverse variance or Mantel-Haenszel methods (random effects model).

Results: The systematic searches yielded 13 case-control, cross-sectional, and prospective studies from 27 publications, which recorded exposure to childhood adversities among UHR individuals: five of these studies employed longitudinal designs to investigate the conversion rate among UHR. Meta-analytic calculations revealed that, as compared to healthy controls, UHR individuals reported more severe childhood trauma (Random effects Hedges' g = 1.38; 95% CI: 0.92–1.84, Z = 5.92, p < .001), were 5.5 times and 2.5 times more likely to report emotional abuse (OR = 5.54, 95% CI = 1.13–27.20, p = .03) and physical abuse (OR = 2.53, 95% CI = 0.73–8.76, p = .14) respectively. UHR individuals were 3.1 times as likely to report bullying victimisation (OR = 3.09, 95% CI = 2.23–4.30; Z = 6.72, p < .001). However, childhood trauma exposure in general was not significantly associated with psychotic conversion (HR = 1.01, 95% CI: 0.99 - 1.03; Z = 1.51, p = .13), suggesting perhaps that this risk is either mediated by other risk factors or that most specific traumatic experiences may contribute to an enhanced risk of conversion among UHR individuals.

Discussion: To date, this is the first meta-analysis that quantitatively summarises the associations between childhood adversities and TTP, and between specific abuse subtypes and the UHR state or TTP. Overall, our findings support the association between childhood adversities (trauma and bullying) and the UHR state; however, these adversities alone may not be sufficient to cause a UHR individual to develop frank psychosis. Most studies did not adjust for potentially confounding variables such as cannabis use, gender, education level, age, comorbid psychiatric disorders and other unmeasured variables such as socioeconomic status, urbanicity, genetic risk, and PTSD symptoms. The current review supports the need to screen for childhood adversities among the UHR population and to provide treatment accordingly, which may improve patients’ engagement with their treatments and result in better clinical outcomes.

F132. IDENTIFICATION OF PATIENTS WITH RECENT ONSET PSYCHOSIS IN KWAZULU NATAL, SOUTH AFRICA: A PILOT STUDY WITH TRADITIONAL HEALTH PRACTITIONERS AND DIAGNOSTIC INSTRUMENTS

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Background: There is considerable variation in epidemiology and clinical course of psychotic disorders across social and geographical contexts. To date, very little data is available of low- and middle-income countries (LMICs). Obtaining valuable evidence from under-represented regions such as Sub-Saharan Africa holds the promise of advancing our knowledge and understanding of psychosis and will provide a strong basis for redressing inequities in service provision for people with psychotic disorders living in LMICs. Many patients in these countries remain undetected and untreated, partly due to lack of formal health care facilities. This study in rural South Africa aimed to investigate if it is possible to identify patients with recent onset psychosis in collaboration with traditional health practitioners (THPs).

Methods: We developed a strategy to engage with THPs. Key to the collaboration between psychiatry, THPs and the local community, was the building of trust by recognizing and acknowledging local authorities, mutual respect for health constructs, taking time to find common ground, and adaptation of the procedures to sociocultural norms. Fifty THPs agreed to collaborate and were asked to refer help-seeking clients with recent onset psychosis to the study. At referral, the THPs rated probability of psychosis (“maybe disturbed” or “disturbed”). A two-step diagnostic procedure was conducted, including the self-report Community Assessment of Psychotic Experiences (CAPE) as screening instrument, and a semi-structured interview using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Accuracy of THP referrals, and test characteristics of the THP rating and the CAPE were calculated.

Results: In six months, 149 help-seeking clients were referred by THPs, of which 44 (29.5%) received a SCAN DSM-IV diagnosis of psychotic disorder. The positive predictive value of a THP “disturbed” rating was 53.8%. Test characteristics of the CAPE were poor.

Discussion: This pilot study in rural South Africa found that it is possible to identify patients with recent onset psychosis in collaboration with THPs. THPs not only grasped the concept of psychosis, they recognized “being disturbed” as a condition that is often difficult to treat and for which collaboration with psychiatric mental health care might be beneficial. By contrast, the CAPE performed poorly as a screening instrument. Collaboration with THPs is a promising approach to improve detection of patients with psychosis in LMIC.

F133. ARE WE UNDERESTIMATING THE INCIDENCE OF PSYCHOTIC DISORDER? ESTIMATES FROM POPULATION-BASED HEALTH ADMINISTRATIVE DATA FROM ONTARIO, CANADA

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Background: Recent incidence estimates from population-based health administrative data in Ontario suggest an incidence rate of non-affective psychosis of 55.6 per 100,000 person-years in the general population. However, early psychosis intervention (EPI) programs across the province estimate that the treated incidence of first-episode psychosis is in the range of 12 to 13 per 100,000 per year, which corresponds to frequently cited estimates of the incidence of schizophrenia. This discrepancy between population-based estimates of incidence and the treated incidence reported by EPI programs suggests that there may be additional cases of psychotic disorder receiving services elsewhere in the health care system. Our objective was to estimate the incidence of non-affective psychosis in the catchment area of an EPI program, and compare this estimate to the EPI-treated incidence of psychotic disorder.

Methods: We constructed a retrospective cohort of incident cases of non-affective psychosis in the catchment area from 1997 to 2015 using linked population-based health administrative data. Cases were identified by the presence either one hospitalization with a primary discharge diagnosis of non-affective psychosis, or two outpatient physician billings with a diagnosis of non-affective psychosis occurring within a 12-month period. We estimated cumulative incidence proportions of non-affective psychosis for the total sample meeting our case definition using denominator data obtained from the census. Using admission ratios from the EPI program (# admitted/# referred), we correct our population-based incidence estimate to yield an estimated “true incidence” of non-affective psychosis.