Identification of patients with recent onset psychosis in Kwazulu Natal, South Africa

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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 TPP. 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 Psychic 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 psychoses 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.