O8.3. CLINICAL AND FUNCTIONAL OUTCOMES IN YOUNG ADULTHOOD OF CHILDREN WITH PSYCHOTIC SYMPTOMS: A LONGITUDINAL TWIN COHORT STUDY

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Background: Childhood psychotic symptoms, such as hallucinations and delusions, are relatively common and have been shown to increase risk of psychotic disorders in adulthood. However, less is known about their association with other forms of psychopathology and more broadly with social and occupational functioning during the crucial transition to adulthood. Using a prospective genetically-sensitive birth cohort we investigated associations between age-12 psychotic symptoms and a range of mental health problems and functional outcomes at age 18.
Methods: Data from utilized from the Environmental Risk (E-Risk) Longitudinal Twin Study, a birth cohort of 2,232 twins born in 1994–1995 in England and Wales, followed to age 18 with 93% retention. Childhood psychotic symptoms were assessed in private interviews at age 12. At age 18, interviews were conducted to assess psychopathology, social and occupational functioning, physical health, quality of life, risky and offending behaviors.
Results: Children with psychotic symptoms were at greater risk of psychotic phenomena, depression, anxiety, and suicide attempts or self-harm in young adulthood than children without such symptoms. They were also more likely to be obese, smoke cigarettes, be lonely, already have children, and report a lower quality of life at age 18 compared with their unaffected peers. These associations held when controlling for sex, age-5 IQ, other psychopathology at age 12, and family environment.
Discussion: In our genetically sensitive cohort, we showed strong evidence of continuity between early psychotic symptoms in childhood and persistence of psychotic phenomena to young adulthood. Psychotic symptoms in childhood are also important risk markers for a wide range of non-psychotic disorders and poor functional outcomes and therefore should be carefully assessed and treated to prevent adverse consequences in adulthood.

O8.4. THE EFFECT OF EARLY MEDICATION DISCONTINUATION ON LONG-TERM CLINICAL OUTCOME IN FIRST EPISODE PSYCHOSIS

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Background: Clinical decision to dis/continue antipsychotics in patients remitted from first-episode psychosis is important. Existing short-term evidence suggests that patients who discontinued antipsychotics had more relapses. Data on long-term outcomes are lacking; with only one open-label study suggesting better long-term recovery outcome in patients who had early medication discontinuation. We examined the long-term effect of early medication discontinuation in year 2 following first-episode remission for patients with no residual psychotic symptoms.
Methods: We followed-up 178 first-episode psychosis patients who participated in a 1-year randomized controlled trial (RCT) on medication discontinuation. Patients were randomized into receiving either a medication maintenance group or a placebo discontinuation group. After the RCT, all patients received usual psychiatric care. Poor long-term clinical outcome was defined as a composite of persistent psychotic symptoms, a requirement for clozapine, or suicide.
Results: There were no differences between patients who were included (n=142) and excluded (n=36) from the study with regard to their baseline demographics, clinical and functioning. At 10 years, more patients in the early discontinuation group (35/89, 39%) had poor clinical outcome than patients in the maintenance group (19/89, 21%) (P<0.01). Relapse during the RCT has partly mediated the significant relationship between early medication discontinuation and poor outcome at 10-year.
Discussion: Whether to discontinue medication following successful treatment of first episode psychosis is a difficult clinical decision. In first episode psychosis with a full initial response to antipsychotic treatment, continued need for medication is important for the first three years after starting treatment, to prevent relapse, and decrease the risk for a poor long-term outcome.

O8.5. SCHIZOPHRENIA AND BIPOLAR DISORDER DIAGNOSIS PATTERNS: REAL-WORLD EVIDENCE FROM US CLAIMS DATABASES

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Background: Schizophrenia and bipolar disorder (BD) are typically understood as separate and non-concurrent psychiatric disorders both in the clinical setting and in the DSM-V and ICD-10 classification systems. However, patients may experience both mood and schizophrenia symptoms simultaneously. Several studies have shown overlap between schizophrenia and BD symptoms, which may lead to diagnostic confusion. Additionally, molecular studies have confirmed that schizophrenia and BD share susceptibility genes. This study explored diagnosis patterns of patients with schizophrenia and/or type I bipolar disorder (BD-I) diagnoses in a real-world setting.
Methods: This was a retrospective cohort study using Truven MarketScan® Commercial, Medicaid, and Medicare Supplemental databases from the study period 01/01/2012 and 06/30/2016. Patients were considered to have a diagnosis of schizophrenia if 1 inpatient claim or 2 outpatient claims for schizophrenia were identified within a selected identification period (01/01/2013 and 06/30/2015). BD-I was defined in an analogous way, and the following five mutually exclusive cohorts were defined: 1) schizophrenia (SCZ) alone (cohort I): newly diagnosed with schizophrenia alone (e.g., met the claims-based diagnostic criteria for schizophrenia, but not for BD-I), 2) BD-SCZ (cohort II): met BD-I criteria only in the year prior to meeting the schizophrenia criteria, 3) SCZ-BD (cohort III): met schizophrenia criteria only in the year prior to, or on the same day as, meeting BD-I criteria, 4) BD-SCZ-BD (cohort IV) met BD-I criteria both in the year before and the year after meeting the schizophrenia criteria, and 5) BD alone (cohort V): newly diagnosed with BD-I alone (e.g., met the claims-based diagnostic criteria for BD-I, but not for schizophrenia). Descriptive statistics are reported for all cohorts.
Results: Of the 63,725 patients in the final analytic sample, 11.5% (n=7,336) had schizophrenia alone (cohort I), 7.7% (n=4,909) had a dual diagnosis (cohorts II-IV), and 80.8% (n=51,480) had BD-I alone (cohort V). The dual diagnosis patients included 1.0% (n=615) with BD-SCZ (cohort II), 2.8% (n=1,794) with SCZ-BD (cohort III), and 3.9% (n=2,500) with BD-SCZ-BD (cohort IV). Patients with different diagnosis patterns significantly differed in age, gender, and insurance type (p<.001). Considering the dual diagnosis cohorts, 927 received both diagnoses on the same day. Of those occurring on the same day, the majority (n=753) were on claims from the hospital/emergency department setting.