THE LANCET
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Supplementary appendix

This appendix formed part of the original submission and has been peer reviewed. We post it as supplied by the authors.

Supplement to: Jongsma HE, Turner C, Kirkbride JB , Jones PB. International incidence of psychotic disorders, 2002–17: a systematic review and meta-analysis. *Lancet Public Health* 2019; **4:** e229–44.

Supplemental Material

List of Supplemental Tables

List of Supplemental Figures

Supplemental Methods

Below is the full PRISMA checklist (Supplemental Table 1).

Supplemental Table 1: PRISMA Checklist

Section/topic	#	Checklist item	Reported on page #
Title			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
Abstract			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2 – abstract
Introduction			
Rationale	3	Describe the rationale for the review in the context of what is already known.	3 - introduction
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3 - introduction
Methods			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	3 - methods
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	3 – methods
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	3 - methods
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Supplemental Table 2
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3 - methods
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	4 - methods
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	4 – methods. Full spreadsheet available online
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	4 - methods
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	4 - methods
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	4 - methods
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within	4 - methods

		studies).	
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	4 – methods, 6- results
Results			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Figure 1
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Table 1
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Supplemental Table 5
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Figures 2-6 / online spreadsheet
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	5 - Results Figures 2-6
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6, Supplemental Tables 14/15
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	6, Supplemental Tables 9-13
Discussion			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	6 - Discussion
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	7 - discussion
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	7/8 - discussion
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	4 – methods and acknowledgements

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Below are the search strategies as used in the PubMed and Web of Science databases.

PubMed

(((((((inciden*[Title/Abstract]) OR epidemiolog*[Title/Abstract])) OR ((((((episod*[Title/Abstract]) OR contact*[Title/Abstract]) OR admission*[Title/Abstract]) OR admit*[Title/Abstract])) AND (((first*[Title/Abstract]) OR 1st[Title/Abstract]) OR hospital*[Title/Abstract]))) OR ((case[Title/Abstract]) AND register*[Title/Abstract])) OR case control*[Title/Abstract]) OR ((((prospectiv*[Title/Abstract]) OR population*[Title/Abstract]) OR communit*[Title/Abstract]) OR survey*[Title/Abstract]))) AND (((((((((schizo*[Title/Abstract]) OR (((psychotic[Title/Abstract]) OR psychosis[Title/Abstract]) OR psychoses[Title/Abstract])) OR bipolar disorder*[Title/Abstract]) OR delusion* disorder[Title/Abstract]) OR ((((((illness*[Title/Abstract]) OR disorder*[Title/Abstract])) AND mental[Title/Abstract]) AND (((severe[Title/Abstract]) OR serious[Title/Abstract]) OR chronic[Title/Abstract]))) OR SMI[Title/Abstract]) OR mani* depressi*[Title/Abstract]) OR chronic psychosis) OR schizoaffective disorder) AND ("2002/01/01"[PDat] : "2017/12/31"[PDat])

Web of science

Supplemental Table 2: Search strategy as used in Web of Science

#19	#18 AND #1 *DocType=All document types; Language=All languages;*
#18	#17 AND #11 *DocType=All document types; Language=All languages;*
#17	#16 OR #15 OR #14 OR #13 OR #12 *DocType=All document types; Language=All languages;*
#16	TI=(prospectiv* or population* or communit* or survey*) *DocType=All document types; Language=All languages;*
#15	TI=(case control*) *DocType=All document types; Language=All languages;*
#14	TI=(case AND register) *DocType=All document types; Language=All languages;*
#13	TI=(inciden* OR epidemiolog*) *DocType=All document types; Language=All languages;*
#12	TI=((first* OR 1st OR hospital*) AND (episod* OR contact* OR admission* OR admit*)) *DocType=All document types; Language=All languages;*
#11	#10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 *DocType=All document types; Language=All languages;*
#10	TI=(schizoaf* disorder) *DocType=All document types; Language=All languages;*
#9	TI=(mani* depressi*) *DocType=All document types; Language=All languages;*
#8	TS=psychosis *DocType=All document types; Language=All languages;*
#7	TI=(SMI) *DocType=All document types; Language=All languages;*
#6	TI=((sever OR serious OR chronic) AND mental AND (illness* OR disorder*)) *DocType=All document types; Language=All languages;*
#5	TI=(delusion* disorder) *DocType=All document types; Language=All languages;*
#4	TI=(bipolar disorder*) *DocType=All document types; Language=All languages;*
#3	TI=(psychotic OR psychosis OR psychoses) *DocType=All document types; Language=All languages;*
#2	TI=(schizo*) *DocType=All document types; Language=All languages;*
#1	PY=(2002-2017) *DocType=All document types; Language=All languages;*

The below Supplemental Table (3) indicates which diagnostic codes were used for which outcome, per diagnostic manual.

Supplemental Table 3: Diagnostic codes by diagnostic manual.

Diagnostic category	ICD-8	ICD-9	ICD-10	DSM-III	DSM-IV
All psychotic disorders	291, 295-299	292.1,293.1 295-298	F20-33	--[1]	292.11/.12, 295-299
Non-affective disorders *	295, 297-299	295,297,298.1-298.9	F20-29	--[1]	295,297,298
Schizophrenia	295	295	F20	295	295.10/.20/.30/60.90
Affective psychotic disorders	296	296, 298.0	F30-33	--[1]	296.x4
Bipolar disorder with psychosis	--[2]	296.0-296.6	F30-31	296.44,296.44I, 296.54C,296.54I, 296.64C, 296.64I	296.04/.44/.54/.64/
Psychotic depression	--[2]	298.0	F32-33	296.34	296.24/.34
Substance-induced psychosis	291	292.1, 293.1	F1X.5	--[1]	292.11,292.12

* The non-affective category in practice included anything that was broader than schizophrenia and did not include any affective disorders. See Supplemental Table 16.

[1] It was not possible to derive these diagnostic categories from the data included in the review

[2] ICD-8 did not differentiate the affective psychoses clearly.

Where citations reported overlapping data from the same study or population, we used the following criteria to determine inclusion in analyses:

(i) data most relevant to the specific outcome and/or exposure under investigation;
(ii) data presented with a corresponding standard error;
(iii) data most closely related to entry criteria for the individual analysis;
(iv) published data;
(v) citations published in the highest impact journal according to Clarivate Journal Citation Reports 2017.

Quality of yield was assessed using the criteria detailed in Supplemental Table 4 below.

Supplemental Table 4: Quality Assessment

Quality criterion	Explanation
Defined catchment area	A clearly defined catchment area was reported. This could be a whole population cohort, or existing boundaries of a municipality or clinical service.
Accurate reporting and reliable source of denominator data	Denominator data was traceable to a reliable source, such as official government statistics.
Population-based case-finding	Cases were identified across the whole population of interest.
Blinding of clinician to demographic variables	In determining a diagnosis, the clinician was blinded to cases' demographic characteristics, such as age, sex and ethnicity
Inclusion criteria clearly stated	Inclusion criteria for the study are listed in such a way that it the study would potentially be replicable.
Leakage study	Leakage methodology was employed to minimise case ascertainment bias. This tends to involve trawling of records of services that are not part of the core study, such as A&E administrative data and police records.

Supplemental results

Study quality

Below are details on study quality by citation. Study quality was scored on seven criteria: having a defined catchment area, reporting an accurate and reliable source of denominator data, conducting population-based case-finding, using standardized research diagnoses, blinding of the clinician to demographic variables, a clear listing of inclusion criteria and conducting a leakage study. The total quality score was used in meta-regression.

Supplemental Table 5: Detailed study quality by citation

First Author (year)	Defined catch-ment area	Accurate denomi-nator	Popu-lation based case-finding	Standar-dised research diagnosis	Blinding to demo-graphic variables	Inclusion criteria	Leakage study	Total Quality Score
Tsuchiya (2002)	1	1	1	0	0	1	0	4
Hanoeman (2002)	1	1	1	0	0	1	0	4
Selten (2002)	1	1	1	0	0	1	0	4
Baldwin (2002)	1	1	1	1	0	1	0	5
Scully (2002)	1	1	1	1	0	1	0	5
Boydell (2003)	1	1	1	1	1	1	1	7
Smith (2003)	1	1	0	0	0	0	0	2
Singh (2003)	1	0	0	0	0	1	0	2
Selten (2003)	1	1	0	0	0	1	0	3
Cantor-Graae (2003)	1	1	1	0	0	1	0	4
Baldwin (2003)	1	1	1	1	0	1	0	5
Proctor (2004)	1	0	0	0	0	0	0	1
Sipos (2004)	1	1	1	0	0	1	0	4
Chien (2004)	1	1	1	0	0	1	0	4
Boydell (2004)	1	0	1	1	1	1	1	6
Veen (2004)	1	1	1	1	1	1	0	6
Singh (2004)	1	1	1	1	0	1	1	6
Sailas (2005)	1	1	0	0	0	0	0	2
Harris (2005)	1	0	1	0	0	1	0	3
Sundquist (2005)	1	1	1	0	0	1	0	4
Nager (2005)	1	1	1	0	0	1	0	4
Laursen (2005)	1	1	1	0	0	1	0	4
Selten (2005)	1	1	1	0	0	1	0	4
Nixon (2005a)	1	0	0	1	1	0	1	4
Qin (2005	1	1	1	0	0	1	0	4
Allardyce (2005)	1	1	1	0	0	1	0	4
Cantor-Graae (2005)	1	1	1	0	1	1	0	5
Baldwin (2005)	1	1	1	1	0	1	0	5
Kennedy (2005a)	1	1	1	1	0	1	1	6
Kennedy (2005b)	1	1	1	1	0	1	1	6
Lloyd (2005)	1	1	1	1	1	1	1	7
Leao (2006)	1	1	0	0	0	1	0	3
Bray (2006)	1	1	0	0	0	1	0	3
Payne (2006)	1	1	0	0	0	1	0	3
Drukker (2006)	1	1	0	0	0	1	0	3
Turner (2006)	1	1	1	0	0	0	0	3
Mahmmood (2006)	1	0	0	1	0	1	0	3
Westman (2006)	1	1	1	0	1	0	0	4
Munk-Olsen (2006)	1	1	1	0	0	1	0	4
Smith (2006)	1	1	0	1	1	1	0	5
Amminger (2006)	1	1	1	1	0	1	0	5
Veling (2006)	1	1	1	1	0.5[1]	1	0	5.5
Morgan (2006)	1	1	1	1	0	1	1	6
Fearon (2006)	1	1	1	1	0	1	1	6
Gould (2006)	1	1	1	1	0	1	1	6
Kirkbride (2006)	1	1	1	1	1	1	1	7
Zipursky (2006)	1	1	1	1	1	1	1	7
Li (2007)	1	1	1	0	0	0	0	3
Schimmelmann (2007)	1	1	0	0	0	1	0	3
Laursen (2007)	1	1	1	0	0	1	0	4
Ajdacic-Gross (2007)	1	1	1	0	0	1	0	4
Andersen (2007)	1	1	1	0	0	1	0	4
Harlow (2007)	1	1	1	0	0	1	0	4
Juvonen (2007)	1	1	1	0	0	1	0	4
Cantor-Graae (2007a)	1	1	1	0	0	1	0	4
Cantor-Graae (2007b)	1	1	1	0	0	1	0	4
Leao (2007)	1	1	1	0	1	1	0	5
Kikbride (2007a)	1	1	1	1	0	1	1	6
Menezes (2007)	1	1	1	1	0	1	1	6
Kirkbride (2007b)	1	1	1	1	0	1	1	6
Stain (2008)	1	0	0	0	0	1	0	2

Boonstra (2008)	1	0	0	0	0	1	0	2
Crebbin (2008)	1	0	0	0	0	1	1	3
Farquhar (2008)	1	1	0.5[1]	0	0	1	0	3.5
Pelayo-Teran (2008)	1	0	1	1	0	1	0	4
Castagnini (2008	1	1	1	0	0	1	0	4
Burns (2008)	1	0	1	0	1	1	0	4
Weiser (2008)	1	1	1	0	0	1	0	4
Veling (2008)	1	1	1	1	0.5[1]	1	0	5.5
Kirkbride (2008a)	1	1	1	1	1	1	0	6
Kirkbride (2008b)	1	1	1	1	1	1	0	6
Coid (2008)	1	1	1	1	1	1	1	7
Grant (2009)	0	0	1	0	0	1	0	2
Crebbin (2009)	1	0	0	0	0	1	0	2
Bih (2009)	1	1	1	0	0	1	0	4
Corcoran (2009)	1	1	1	0	0	1	0	4
Osby (2009)	1	1	1	0	0	1	0	4
Valdimarsdottir (2009)	1	1	1	0	0	1	0	4
Harlap (2009)	1	1	1	0	0	1	0	4
Reay (2009)	1	1	0	1	0	1	0	4
Norredam (2009)	1	1	1	0	0	1	0	4
Bogren (2009	1	1	1	0.5[1]	0	1	0	4.5
Kirkbride (2009)	1	1	1	1	0	1	1	6
Coid (2009)	ERRATUM ONLY TO COID (2008)							
Cheng (2010)	1	1	1	0	0	1	0	4
Healy (2010)	1	1	0.5[1]	0	0	1	0	3.5
Bogren (2010)	1	1	1	0	0	1	0	4
Zammit (2010)	1	1	1	0	0	1	0	4
Tseng (2010)	1	1	1	0	0	1	0	4
Zandi (2010)	1	1	1	0	0	1	0	4
Norredam (2010)	1	1	1	0	0	1	0	4
Goodman (2011)	1	1	0	0	0	1	0	3
Cowan (2011)	1	1	0	0	0	1	0	3
Harris (2011)	1	1	0.5[1]	0	0	1	0	3.5
Jorgensen (2011)	1	1	1	0	0	1	0	4
Cheng (2011)	1	1	1	0	0	1	0	4
Kleinhaus (2011)	1	1	1	0	0	1	0	4
Benros (2011)	1	1	1	0	0	1	0	4
Salokangas (2011)	1	1	1	0	0	1	0	4
Schofield (2011)	1	1	1	0	0	1	0	4
Veling (2011)	1	1	1	1	0.5[1]	1	0	5.5
Callaghan (2012)	1	1	0	0	0	0	0	2
Anderson (2012)	1	0	0	0	0	1	0	2
Manrique-Garcia (2012)	1	1	0	0	0	1	0	3
Turola (2012)	1	1	0	0	0	1	0	3
Werbeloff (2012)	1	1	1	0	0	1	0	4
Nosarti (2012)	1	1	1	0	0	1	0	4
Gigantesco (2012)	1	1	0	1	0	1	0	4
Tarricone (2012)	1	1	0	1	0	1	1	5
Kirkbride (2012)	1	1	1	1	0	1	0	5
Hung (2013)	1	1	0	0	0	1	0	3
Peritogiannis (2013)	1	0	1	0.5[1]	1	0	0	3.5
Sutterland (2013)	1	1	1	0	0	0	1	4
Cantor-Graae (2013)	1	1	1	0	0	1	0	4
Kroon (2013)	1	1	1	0	0	1	0	4
Castagnini (2013)	1	1	1	0	0	1	0	4
Hardoon (2013)	1	1	1	0	0	1	0	4
Weibell (2013)	1	1	1	1	0	1	0	5
Cocchi (2014)	0	0	0	0	0	1	0	1
Tortelli (2014)	1	1	0	0	0	1	0	3
Hogerzeil (2014)	1	1	1	0	0	1	0	4
Pedersen (2014)	1	1	1	0	0	1	0	4
Sorensen (2014)	1	1	1	0	0	1	0	4
Munk-Olsen (2014)	1	1	1	0	0	1	0	4
Szoke (2014)	1	1	0	0	0	1	1	4
Bhavsar (2014)	1	1	0	1	0	1	1	5
Omer (2014)	1	1	1	1	0	1	0	5
Lasalvia (2014)	1	1	0	1	0	1	1	5
Veling (2014)	1	1	1	1	0.5[1]	1	0	5.5
Kirkbride (2014)	1	1	1	1	0	1	1	6
Anderson (2015)	1	0	1	0	0	1	0	3

Paksarian (2015a)	1	1	1	0	0	1	0	4
Sorensen (2015)	1	1	1	0	0	1	0	4
Paksarian (2015b)	1	1	1	0	0	1	0	4
Soderlund (2015)	1	1	1	0	0	1	0	4
Medici (2015)	1	1	1	0	0	1	0	4
Carlborg (2015)	1	1	1	0	0	1	0	4
Tsai (2016)	1	1	0	0	0	1	0	3
Chen (2016)	1	1	1	0	0	1	0	4
Latvala (2016)	1	1	1	0	0	1	0	4
Jensen (2016)	1	1	1	0	0	1	0	4
Kuhl (2016)	1	1	1	0	0	1	0	4
Filatova (2016)	1	1	1	0	0	1	0	4
Chiang (2016)	1	1	1	0	0	1	0	4
Nielsen (2016)	1	1	1	0	0	1	0	4
Kendler (2016)	1	1	1	0	0	1	0	4
Levine (2016a)	1	1	1	0	0	1	0	4
Levine (2016b)	1	1	1	0	0	1	0	4
Vassos (2016)	1	1	1	0	0	1	0	4
Sorensen (2016)	1	1	1	0	0	1	0	4
Hollander (2016)	1	1	1	0	0	1	0	4
O'Donoghue (2016)	1	1	1	1	0	1	0	5
Morgan (2016)	1	0	1	1	0	1	1	5
Tarricone (2016)	1	1	0	1	0	1	1	5
Szoke (2016)	1	1	1	0	0	1	1	5
Mule (2016)	1	1	1	1	0	1	1	6
Ramsey (2017)	1	0	0	0	0	1	0	2
Okkels (2017)	1	1	0	0	0	1	0	3
Vikstrom (2017)	1	1	0	0	0	1	0	3
Wang (2017)	1	1	0	0	0	1	0	3
Lin (2017)	1	1	0.5[1]	0	0	1	0	3.5
Marrie (2017a)	1	1	0.5[1]	0	0	1	0	3.5
Marrie (2017b)	1	1	0.5[1]	0	0	1	0	3.5
Hogerzeil (2017)	1	1	1	0	0	1	0	4
Hoeffding (2017)	1	1	1	0	0	1	0	4
Kim (2017)	1	1	1	0	0	1	0	4
Markkula (2017)	1	1	1	0	0	1	0	4
Nielsen (2017)	1	1	1	0	0	1	0	4
Schofield (2017a)	1	1	1	0	0	1	0	4
Schofield (2017b)	1	1	1	0	0	1	0	4
Simon (2017)	1	1	1	0	0	1	0	4
Kirkbride (2017a)	1	1	1	1	0	1	0	5
Kirkbride (2017b)	1	1	1	1	0	1	0	5
Nyberg (2018)	1	1	1	0	0	1	0	4
Barghadouch (2018)	1	1	1	0	0	1	0	4
Richardson (2018)	1	1	1	1	0	1	0	5
Jongsma (2018)	1	1	1	1	0	1	0.5[1]	5.5

[1] A score of 0.5 indicates that this item was met for part of the study, but not the whole study. For instance, in Jongsma et al (2018) a leakages study was carried out in some, but not all catchment areas.

Incidence of psychotic disorders in young people (<40 years old)

Twenty-six citations only described the incidence of psychotic disorder in young people (Supplemental Table 6). This was defined as an upper age limit of 40 years or lower. Seven of these citations included data derived from England, five were derived from Sweden, three each from Australia, Canada and Denmark, two from Israel and one each from Finland, the Netherlands and Switzerland. These studies are described in Supplemental Table 5 below.

The incidence of all psychotic disorders was reported by nine studies [1–9], and varied from 11.78 per 100,000 person-years in one Australian study[1] to 167.0 in men in a second Australian study[2]. The incidence of non-affective disorders was reported in 14 citations[6,7,10–22], and ranged from 21.2 per 100,000 person-years reported in Israel[14] to 138.1 in men refugees in Denmark[13]. The incidence of schizophrenia was reported in 8 citations[6–8,11,21–24], and ranged from 17.3 (95%CI: 15.6-19.2) in England[6,7] to 119.6 (95%CI: 107.4-132.4) per 100,000 person-years in men in Canada[23]. Affective disorders were reported less frequently (three citations[11,15,21]) and varied from 11.3 in Sweden[11] to 15.6 per 100,000 person-years in Denmark[21]. The incidence of bipolar disorder is reported by five citations[6–8,19,22] and varied from 3.2 (95%CI: 2.5-4.1) per 100,000 person-years in England[6,7] to 16.2 in Denmark[19]. The incidence of psychotic depression is reported by four citations[6,8,19,25] and varied from

0.9 (95%CI: 0.6-1.5) in England[6,7] to 10.5 per 100,000 person-years in Finland[8]. Three citations[6,7,26] reported some other form of psychotic disorders. Two citations covering the Schizophrenia and other Psychoses in East Anglia (SEPEA) study reported an incidence of substance induced psychosis of 1.5 (95%CI: 1.0-2.1) per 100,000 person-years[6,7], and a further citation reported an incidence of clinically relevant HoNOS scores of between 11.4 and 25.2 per 100,000 person-years[26].

Supplemental Table 6: Details of citations covering young people (<40 years)

First author (year)	Country	Age range	Outcomes included	Incidence rate per 100,000 person-years (95%CI)
Harris (2005)	Australia	13-25	All psychotic disorders	11.78[1]
Leao (2007)	Sweden	16-34		Not reported. Hazard ratio (HR) for men:
			Non-affective disorders	1.40 (95%CI: 1.31-1.59)
			Affective disorders	0.64 (95%CI: 0.61-0.69)
Leao (2006)	Sweden	20-39	Non-affective disorders	Age-standardised only. Varied from 31 in Swedish women to 123 in 2nd generation Finnish men.
Bray (2006)	Canada	14-24	Schizophrenia	Increase between 1989 and 1998. Women: from 77.1 (90%CI: 42.1-137.7) to 89.9 (90%CI:80.1-100.1). Men: from 66.6 (90%CI: 38.8-113.3) to 119.6 (95%CI: 107.4-132.4)
Amminger (2006)	Australia	15-29	All psychotic disorders	Men: 167.0 Women: 81.0
Ajdacic-Gross (2007)	Switzerland	15-29	Non-affective disorders	Not reported[2]
Stain (2008)	Australia	10-25	HoNOS scores	Coastal: 11.4 Remote: 21.4 Rural: 25.2[1]
Corcoran (2009)	Israel	0-33	Non-affective disorders	21.2
Cheng (2010)	England	17-35	All psychotic disorders	50.0 (44.5-56.2)
Cheng (2011)	England	16-35	All psychotic disorders	50.0 (44.5-56.2)
Kleinhaus (2011)	Israel	0-39	Non-affective disorders	All: 24.7 Men: 30.0 Women: 19.1
Nosarti (2012)	Sweden	16-29	Non-affective disorders	7.0
			Bipolar disorder	2.0
Kirkbride (2013)	England	16-35	All psychotic disorders	All: 42.5 Men: 49.6 Women: 28.4
Anderson (2012)	Canada	14-25	Non-affective disorders	All: 43.6 Men: 84.4 Women: 33.1
Cantor-Graae (2013)	Denmark	0-40	Non-affective disorders	52.8
			Schizophrenia	39.2
			Affective disorders	15.9
Bhavsar (2014)	England	16-35	Schizophrenia	54.6
Paksarian (2015)	Denmark	15-39	Non-affective disorders	77.2
			Schizophrenia	43.4
			Bipolar disorder	16.2
Soderlund (2015)	Sweden	18-30	Non-affective disorders	71.7
			Schizophrenia	30.3
			Affective disorders	11.3
Anderson (2015)	Canada	14-40	Non-affective disorders	Majority population: 55.6 (54.9-56.4) Migrants: 51.7 (49.2-54.4) Refugees: 72.8 (67.1-78.9)
Filatova (2016)	Finland	0-27	All psychotic disorders	93.9
			Schizophrenia	29.3
			Bipolar disorder	9.2
			Psychotic depression	10.5
Hollander (2016)	Sweden	14-40	Non-affective disorders	Overall: 41.9 Majority population: 38.5 Migrants: 80.4 Refugees: 126.4
Kirkbride (2016)	England	16-35	All psychotic disorders	All: 34.0 Men: 44.5 Women: 23.0
Kirkbride (2017)	England	16-35	All psychotic disorders	34.0 (31.5-36.6)
			Non-affective disorders	28.3
			Schizophrenia	17.3 (15.6-19.2)
			Bipolar disorder	3.2 (2.5-4.1)
			Psychotic depression	0.9 (0.6-1.5)
			Substance-induced psychosis	1.5 (1.0-2.1)

Richardson (2018)	England	16-35	See 206	See 206
Barghadouch (2018)	Denmark	18-24	Non-affective disorders	All refugees: 95.8 Men refugees: 138.1 Women refugees: 44.5
Selten (2002)	The Netherlands	15-39	Schizophrenia	All: 19.1 Men: 23.5 Women 14.4

[1] Based on approximate denominator
[2] Reported as 3-year moving averages in graphs only.

Incidence of psychotic disorders in special population groups

Twelve citations reported the incidence of psychotic disorders in a population group with a pre-exiting comorbidity and compared it with a general population cohort[27–38]. These studies are summarised in Supplemental Table 7 below. These citations reported data from Taiwan (n=5), Denmark (n=4), Canada (n=2) and Finland (n=1). Most pre-existing medical conditions investigated increased the risk for a psychotic disorder. The highest relative increase was reported in Danish patients with comorbid substance use (Hazard Ratio [HR] of schizophrenia: 6.04, 95%CI: 5.84-6.26)[38]. The only comorbidity associated with a lower risk of any disorder was Type-1 diabetes in Finland (relative risk [RR] for non-affective disorders: 0.38, 95%CI: 0.25-0.57)[28]. Please note that in the citations originating from the Taiwanese health insurance database it was impossible to differentiate between bipolar disorder with and without psychosis[32–35].

Supplemental Table 7: Details of citations covering comorbid population groups

First author (year)	Country	Comorbidity	Outcome of interest	Relative risk (RR) / Incidence Rate Ratio (IRR) / Hazard Ratio (HR)
Qin (2005)	Denmark	Epilepsy	Non-affective disorders	RR: 2.93 (95%CI: 2.69-3.20)
			Schizophrenia	RR: 2.48 (95%CI: 2.20-2.80)
Juvonen (2007)	Finland	Type-1 diabetes	Non-affective disorders	RR: 0.38 (95%CI: 0.25-0.57)
Benros (2011)	Denmark	Autoimmune disorders	Non-affective disorders	IRR: 1.29 (95%CI: 1.15-1.41)
Hung (2013)	Taiwan	Breast cancer	Bipolar disorder	IRR: 2.06 (95%CI: 1.37-3.15)
Chen (2015)	Taiwan	Prostate cancer	Bipolar disorder	IRR: 1.84 (95%CI: 1.25-2.74)
Tsai (2016)	Taiwan	COPD	Bipolar disorder	HR: 2.43 (95%CI: 1.65-3.58)
Lin (2017)	Taiwan	Scabies	Bipolar disorder	HR: 1.86 (95%CI: 1.36-2.54)
Marrie (2017a)	Canada	Immune disorders	Schizophrenia	IRR: 1.32 (95%CI: 1.03-1.69)
			Bipolar disorder	IRR: 1.68 (95%CI: 1.52-1.85)
Marrie (2017b)	Canada	Schizophrenia	Immune disorders	IRR: 1.71 (95%CI: 0.73-4.01)[1]
		Bipolar disorder		IRR: 1.88 (95%CI: 1.35-2.62)[1]
Nielsen (2017)	Denmark	Substance abuse	Schizophrenia	HR: 6.04 (95%CI: 5.84-6.26)
Okkels (2017)	Denmark	PTSD	Non-affective disorders	IRR: 2.34 (95%CI: 1.46-3.53)
			Schizophrenia	IRR: 3.80 (95%CI: 2.33-5.80)
			Bipolar disorder	IRR: 4.22 (95%CI: 2.25-7.13)
Wang (2017)	Taiwan	Asthma	Schizophrenia	HR: 1.40 (95%CI: 1.05-1.87)

[1] This study investigates the relative risk of developing an immune disorder after developing schizophrenia or bipolar disorder. The IRR for bipolar disorder is within three years of an immune disorder diagnosis.

Seven citations reported rates deriving from the army, army conscripts or army veterans[39–45]. These studies are summarised in Table 6 below. A further study used data from the Israeli draft board[46], but considering the universal nature of the Israeli draft (both men and women are drafted into the army), this is included in the main analysis. Three USA-based studies examined the incidence of non-affective disorders (160 per 100,000 combat-years) and bipolar disorder (120) during combat[39], and of schizophrenia in the military (IR: 14.3 per 100,000 person-years[40]). A further USA-based study examined incidence of schizophrenia and bipolar disorder in army veterans[45] (see Table 6). Three Swedish conscript studies examined the effect of various risk factors on the incidence of psychotic disorders. One citation reported the effects of frequent cannabis use on risk of developing non-affective disorders (OR: 2.0, 95%CI: 0.8-4.7), schizophrenia (OR: 3.7, 95%CI: 2.3-5.8) and brief psychosis (OR: 2.2, 95%CI: 1.0-4.7)[41]. Two further citations examined the effects of resting heart rate on schizophrenia (HR for resting heart rate of >82 beats per minute: 1.10 (95%CI: 1.08-1.12) and bipolar disorder (OR: 1.01, 85%CI: 1.00-1.03)[42] and the effects of cardiovascular fitness on non-affective (HR for low fitness: 1.44, 95%CI:1.29-1.61) and other psychotic disorders (HR: 1.41, 95%CI: 1.27-1.56)[44]. A final citation found an incidence of non-affective disorders of 11 per 100,000 person-years and of schizophrenia of 3 among English army personnel[43].

Supplemental Table 8: Details of citations covering the military or army veterans

First author (year)	Country	Army group	Outcome	Incidence rate (95%CI)
Goodman (2011)	USA	Combat (Iraq War)	Non-affective disorders	160[1]
			Bipolar disorder	120
Cowan (2011)	USA	Military	Schizophrenia	14.3
Manrique-Garcia (2012)	Sweden	Conscripts	Non-affective disorders Schizophrenia Brief psychosis	Not reported, examined the influence of cannabis use on psychosis.
Latvala (2016)	Sweden	Conscripts	Schizophrenia Bipolar disorder	Not reported, examined the influence of resting heart rate on psychosis
Turner (2006)	England	Army personnel	Non-affective disorders	11
			Schizophrenia	3
Nyberg (2018)	Sweden	Conscripts	Non-affective disorders Other psychotic disorders	Not reported, examined the influence of cardiovascular fitness on psychosis
Ramsey (2017)	USA	Veterans (Iraqi Freedom, Enduring Freedom, New Dawn)	Schizophrenia	Ranged from 0.05 (0.02 -0.10; women aged 45-64) to 0.47 (0.45-0.49, men aged 18-29)
			Bipolar disorder	Ranged from 1.88 (1.81-1.96, men aged 45-64) to 4.78 (4.63-4.94, women aged 18-29)

[1] per 100,000 combat years

Five citations investigated post-partum psychosis in Scandinavia[47–51]. Three citations contained data from Sweden, and found an incidence of 4.84 per 1,000 person-years[47]. Older maternal age was a risk factor[47,48], as

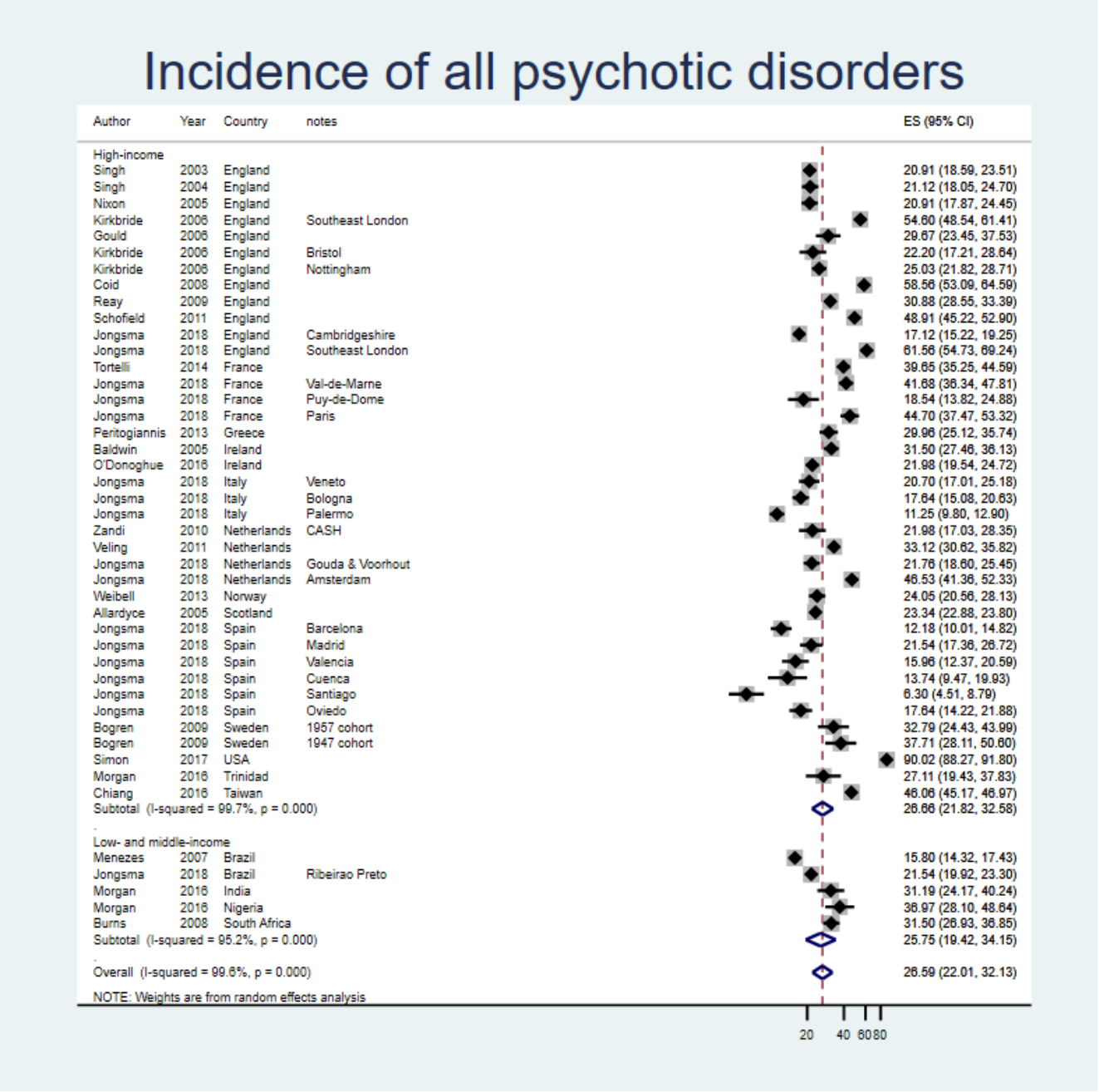
well as being a single mother[48]. Having comorbid diabetes or having a baby with high birthweight lowered risk of developing post-partum psychosis[47], and there was no difference in risk between first-time mothers who conceived naturally and those who used IVF[51]. Two further citations included data from Denmark[49,50]. Both citations looked at any psychiatric contact, although one citation specifically reported the relative risk for schizophrenia (5.65, 95%CI: 3.47-9.20) and bipolar disorder (23.33, 95%CI: 11.52-47.24) in the first thirty days after birth, compared with women in the general population[49].

A final study examined psychotic disorders in incarcerated 15-21 year-olds, and found that during the study period fewer people went to prison in total, increasing the proportion of individuals with a psychotic disorder in prison[52].

Incidence rates pooled by countries' World Bank economic classification.

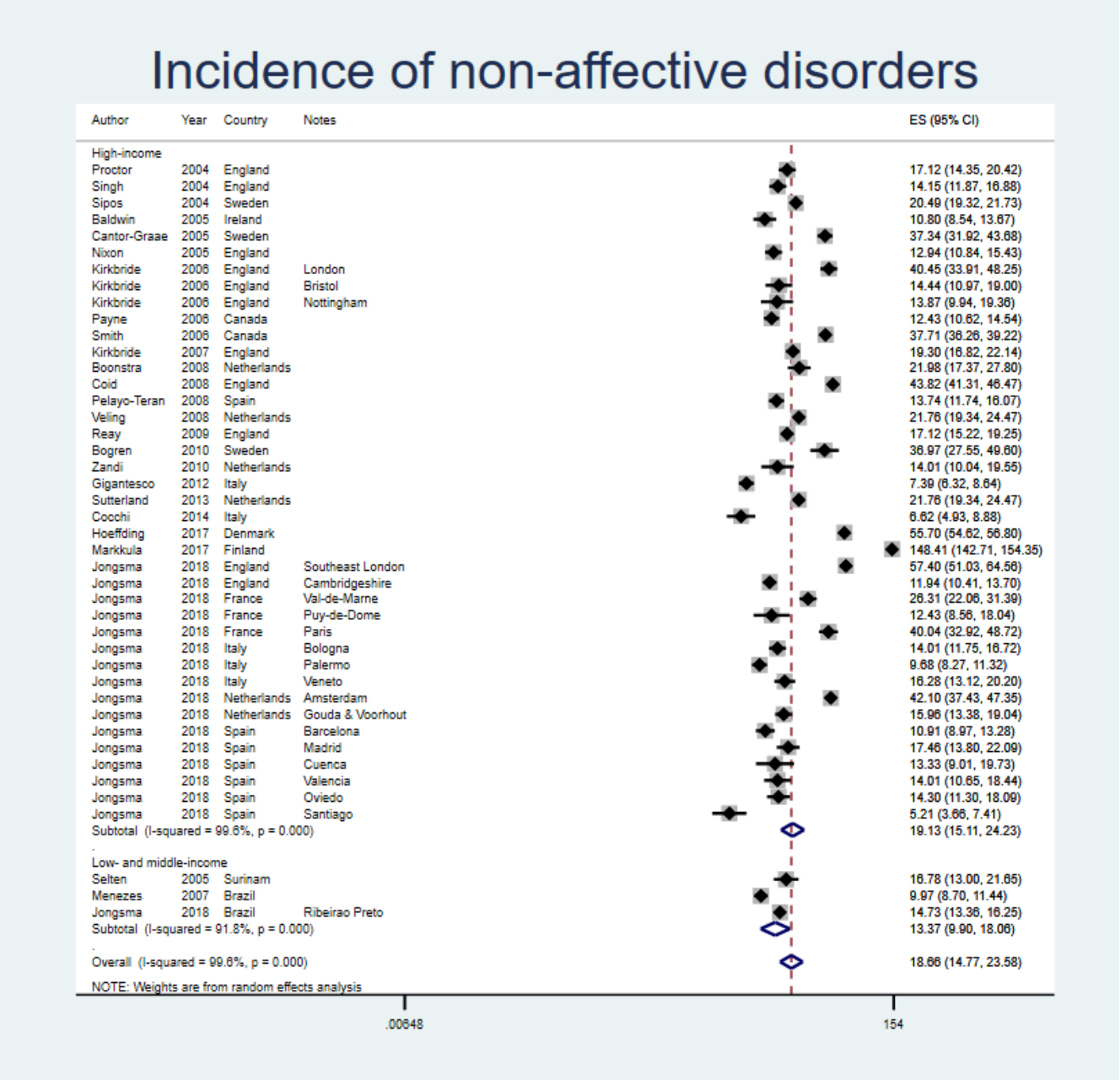
Supplemental Figures 1-4 below group the incidence rates by countries' World Bank Economic Classification (June 2018 edition)[53]. There is little difference in incidence rates between high-income countries and low- and middle-income countries (LMICs), although any formal comparisons are hampered by a lack of studies conducted in LMICs.

Supplemental Figure 1: Incidence of all psychotic disorders by countries' economic classification



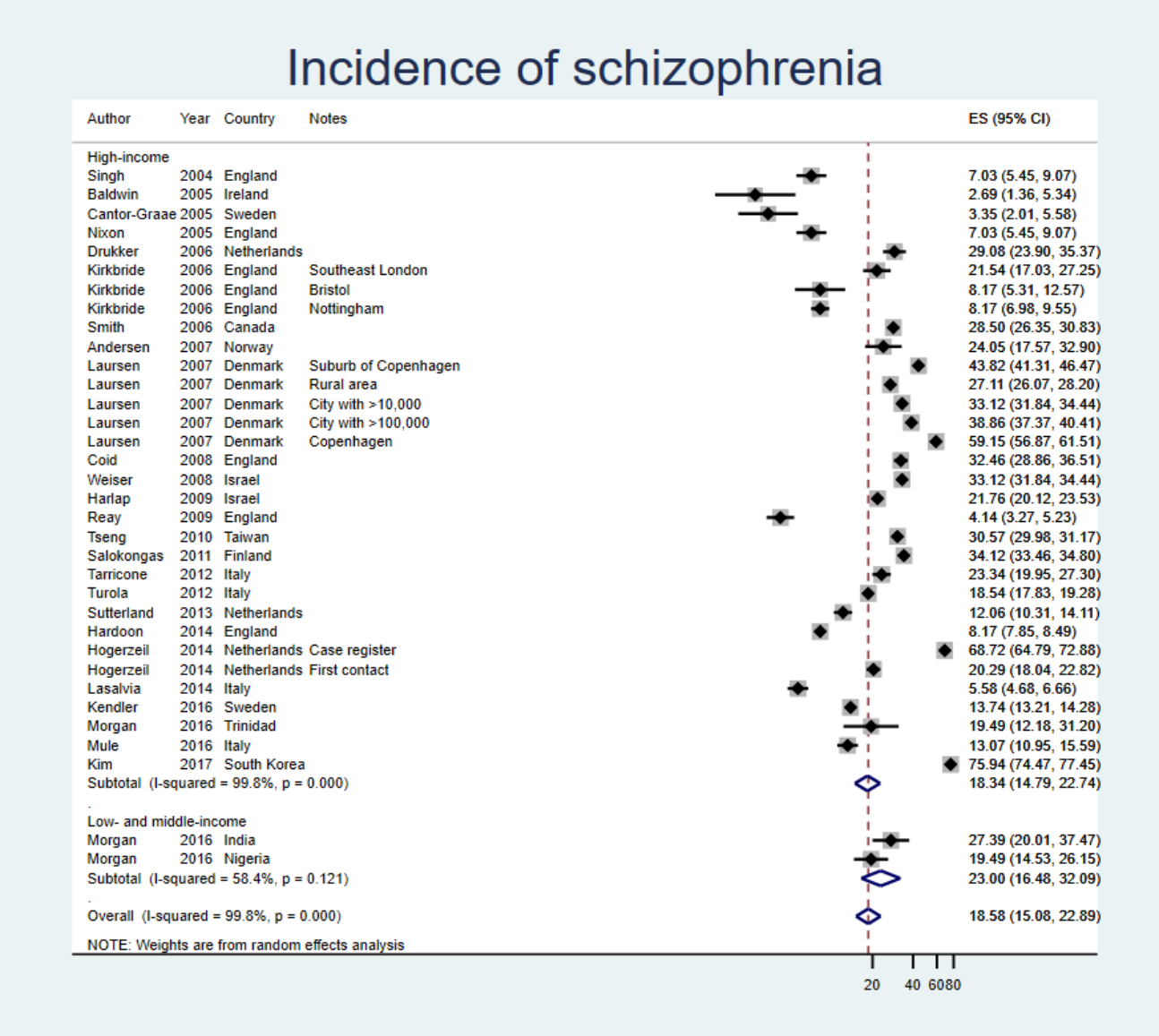
The column 'notes' is used to differentiate estimates resulting from the same citation (but different catchment areas or time periods).

Supplemental Figure 2: Incidence of non-affective psychotic disorders by countries' economic classification.



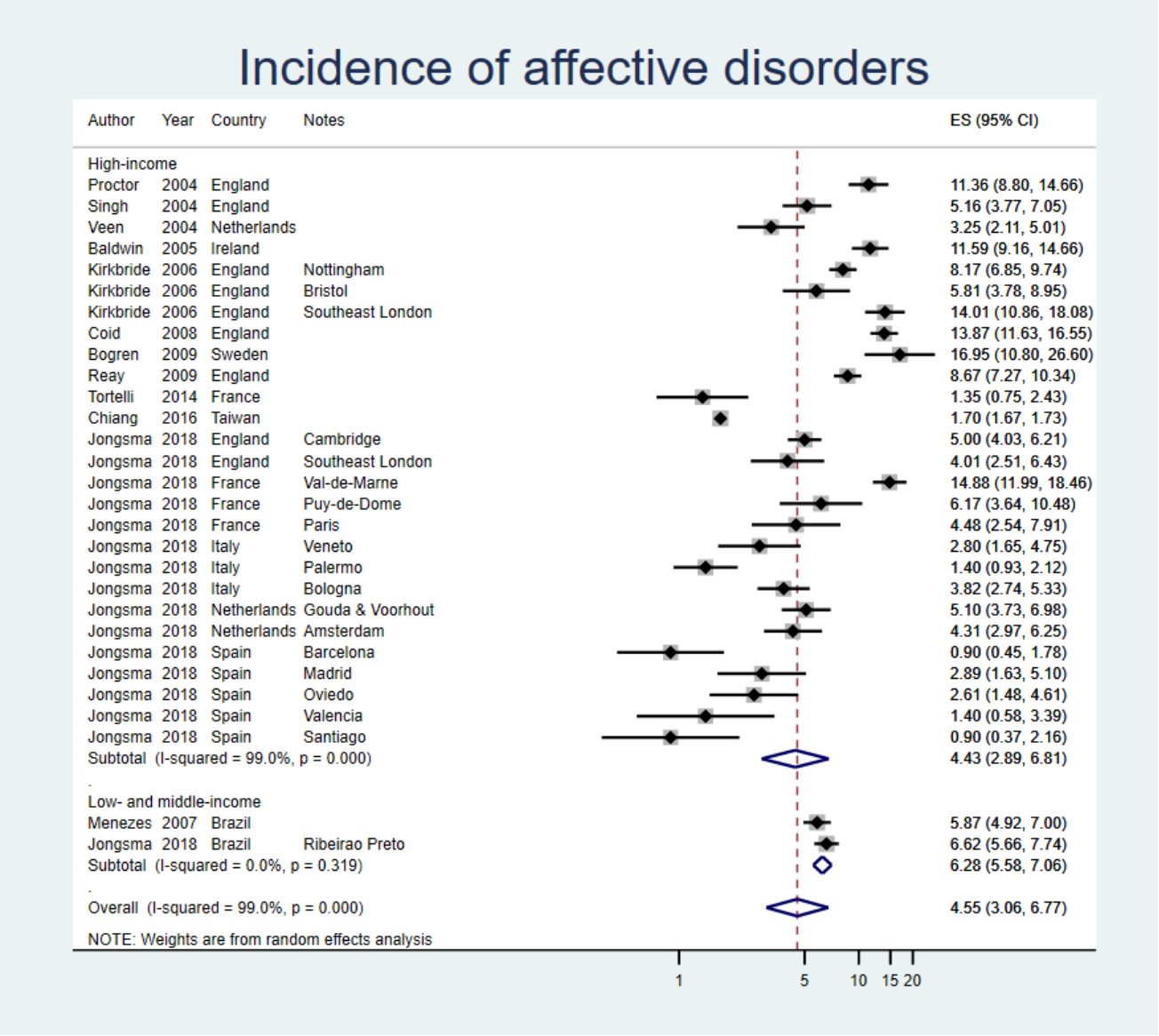
The column 'Notes' is used to differentiate estimates resulting from the same citation (but different catchment areas or time periods).

Supplemental Figure 3: Incidence of schizophrenia by countries' economic classification.



The column 'Notes' is used to differentiate estimates resulting from the same citation (but different catchment areas or time periods).

Supplemental Figure 4: Incidence of affective disorders by countries' economic classification

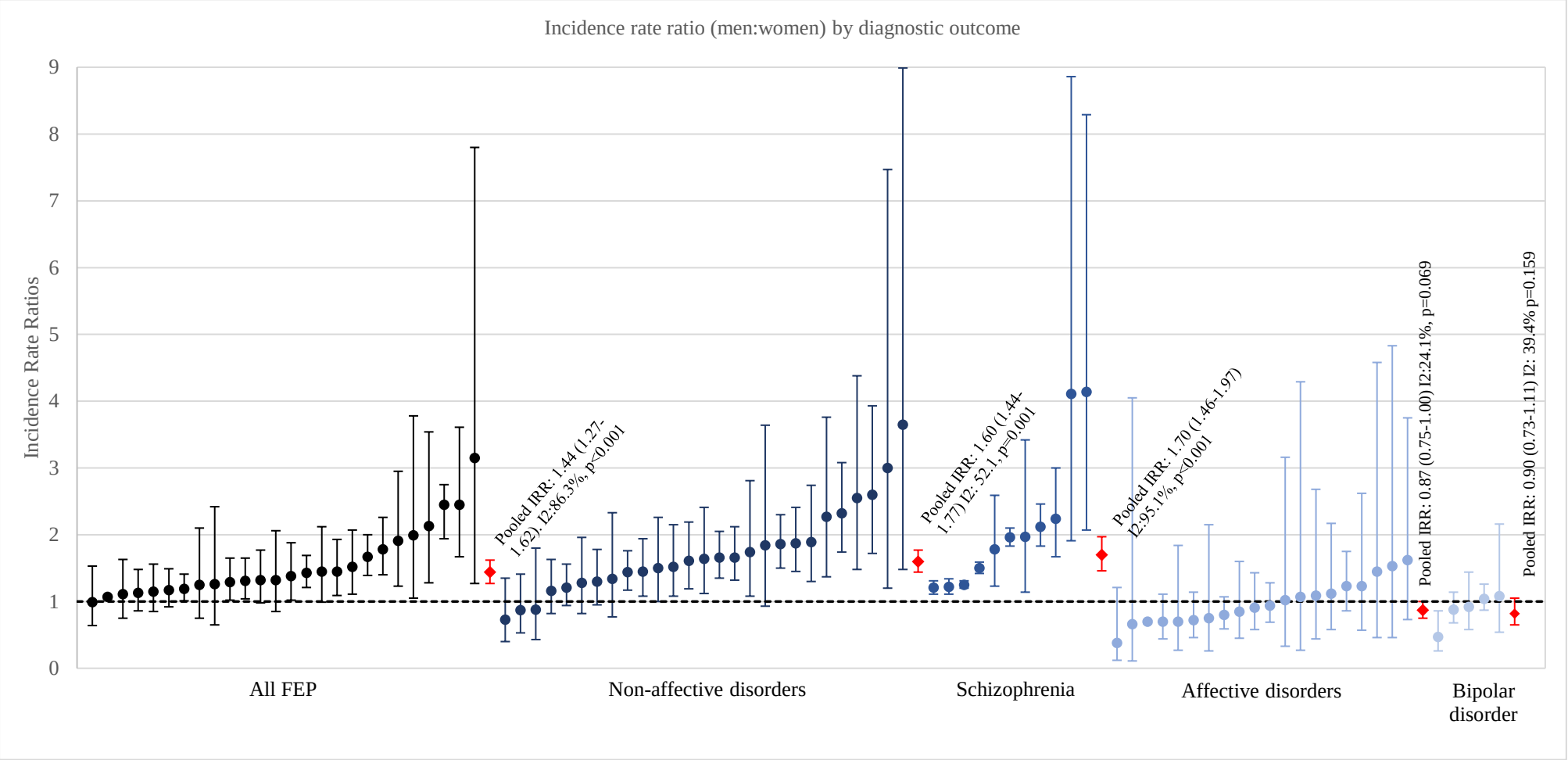


The column 'Notes' is used to differentiate estimates resulting from the same citation (but different catchment areas or time periods).

Incidence rate ratios by sex.

Below is the figure displaying all incidence rate ratios by sex (men : women) for all FEP, non-affective disorders, schizophrenia, affective disorders and bipolar disorder. Insufficient citations were available to pool IRRs for psychotic depression.

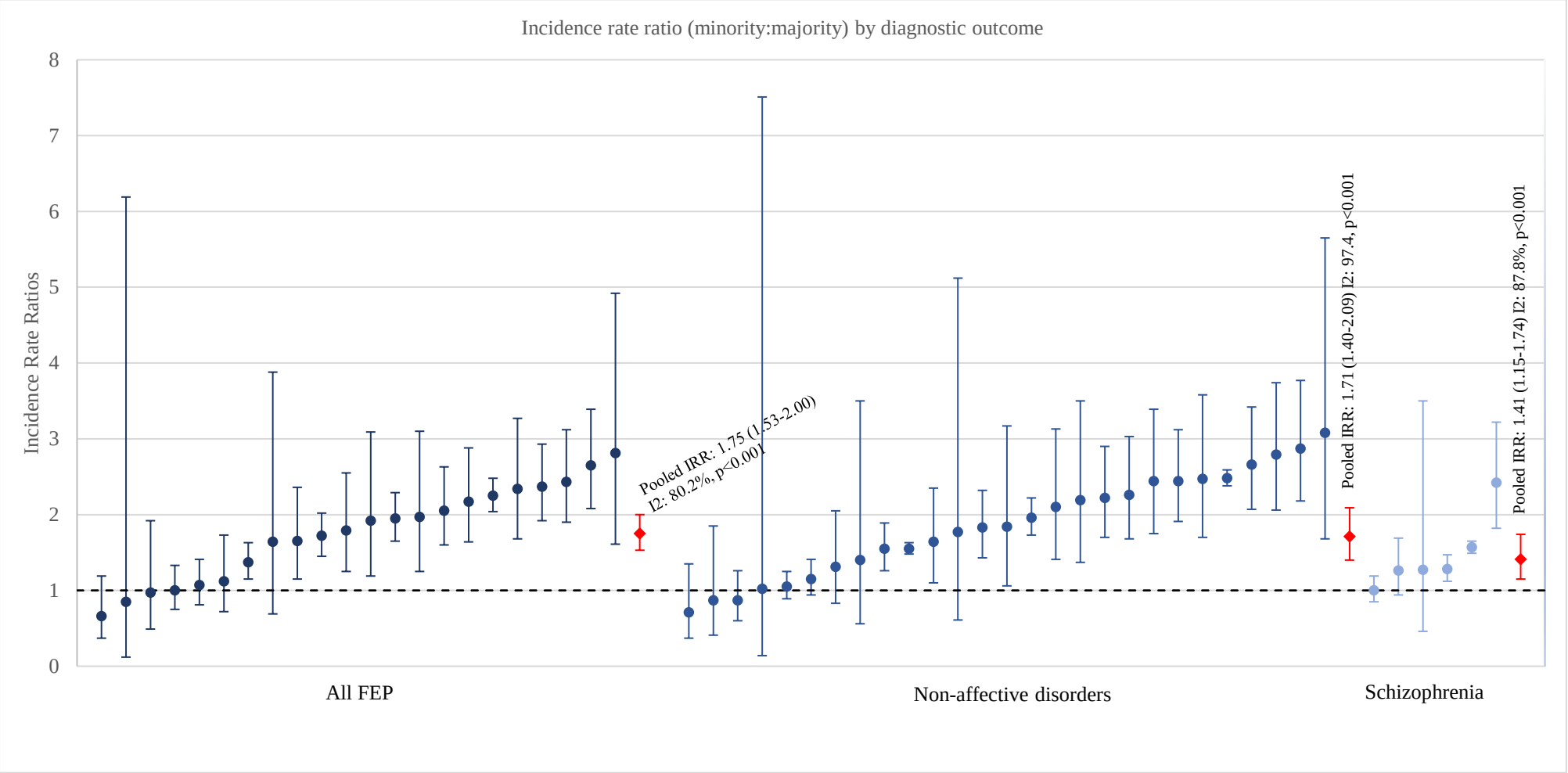
Supplemental Figure 5: Incidence rate ratios (men : women) by diagnostic outcome



Incidence rate ratios by minority status.

Below is the figure displaying all incidence rate ratios (minority : majority) for all FEP, non-affective disorders and schizophrenia. Insufficient citations were available to synthesise results for other diagnostic outcomes.

Supplemental Figure 6: Incidence rate ratio (minority : majority) by diagnostic outcome

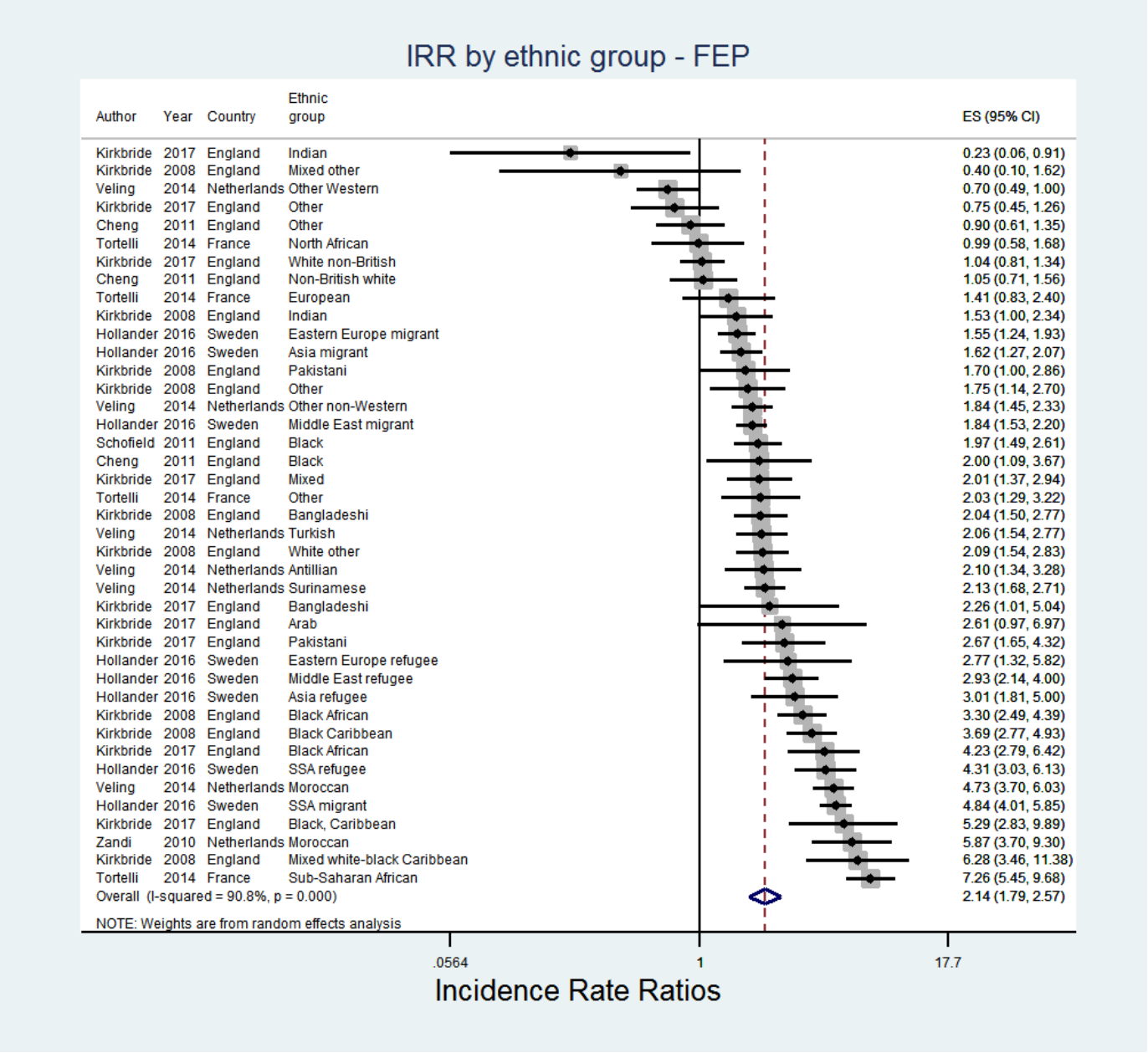


Incidence rate ratios by ethnic group

Grouping all ethnic minorities together to a general minority group masks heterogeneity between ethnic groups. The below forest plots give a detailed overview of which ethnic minority groups in which country are at highest risk of which psychotic disorder.

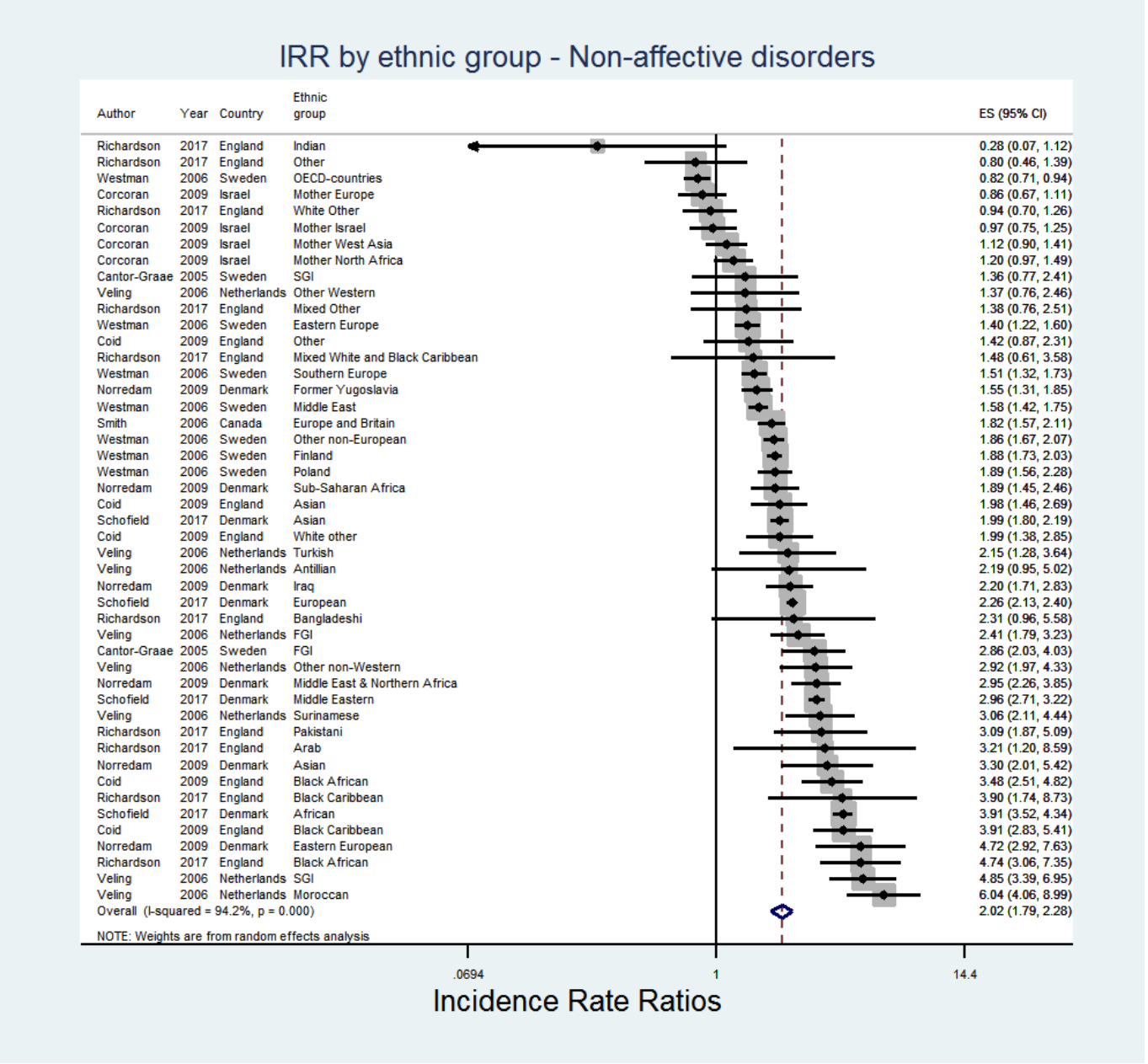
For all psychotic disorders, the highest risk is exhibited by Sub-Saharan African migrants in Paris (IRR:7.26, 95%CI: 5.45)[54], and the Indian population in East-Anglia is the only minority group with a lower risk than the white (British) population (IRR: 0.23, 95%CI: 0.06-0.91; Supplemental Figure 7)[6].

Supplemental Figure 7: Incidence rate ratios by ethnic group, all psychotic disorders.



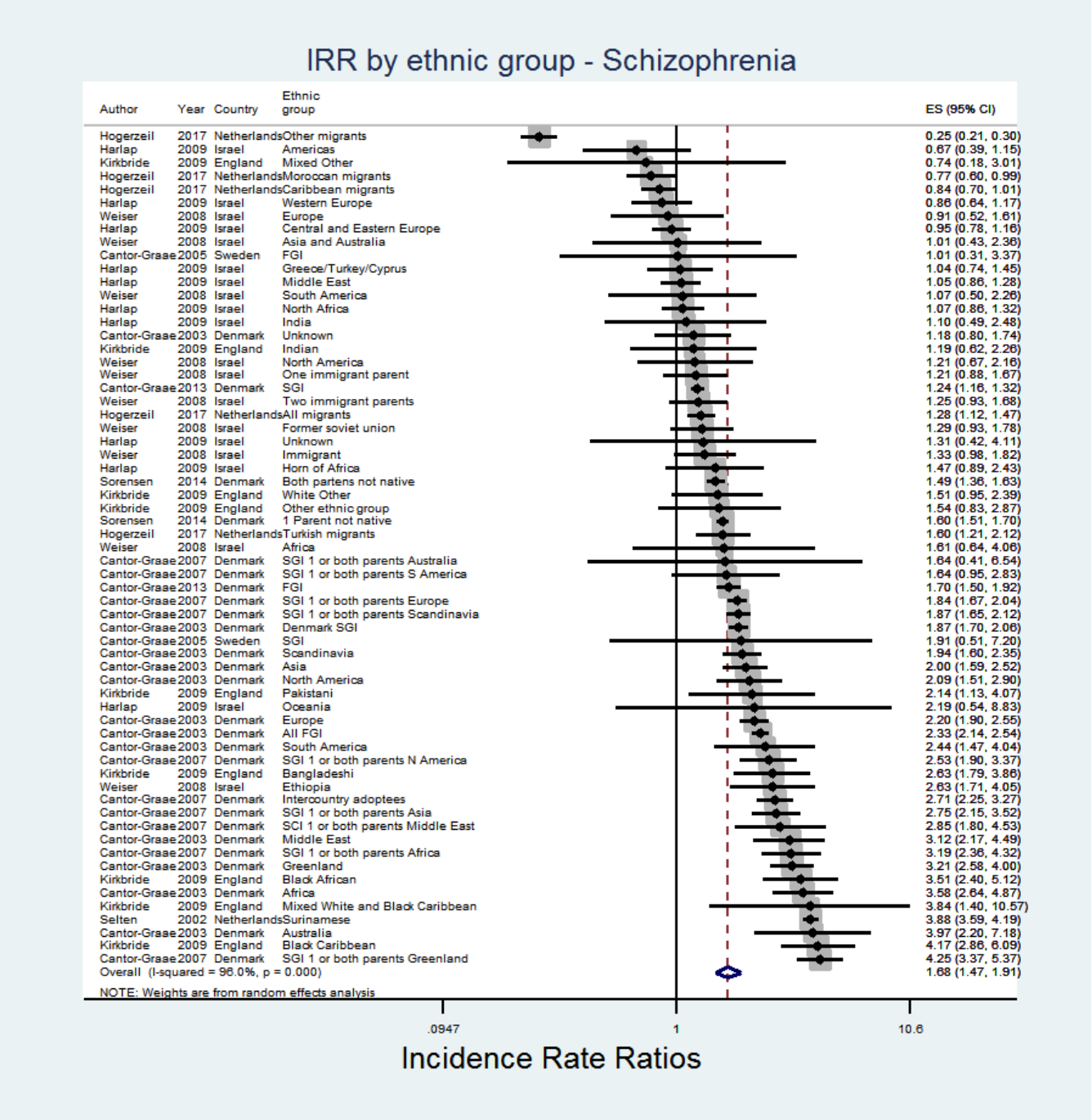
The highest risk for non-affective disorders is exhibited by Moroccan migrants to the Hague in the Netherlands (IRR: 6.04, 95%CI: 4.06-8.99)[55], and the lowest risk by the Indian minority population in East Anglia (IRR: 0.28, 95%CI:0.07-1.12; Supplemental Figure 8)[7].

Supplemental Figure 8: Incidence rate ratios by ethnic group, non-affective disorders



The lowest incidence rate ratio for schizophrenia is recorded in migrants to the Netherlands falling under the 'other' category (IRR: 0.25,95%CI: 0.21-0.30)[56] and the highest IRR recorded for a subgroup of migrants is of second-generation migrants to Denmark, where one or both parents originate from Greenland (IRR: 4.25, 95%CI: 3.37-5.37; Supplemental Figure 9 below)[57].

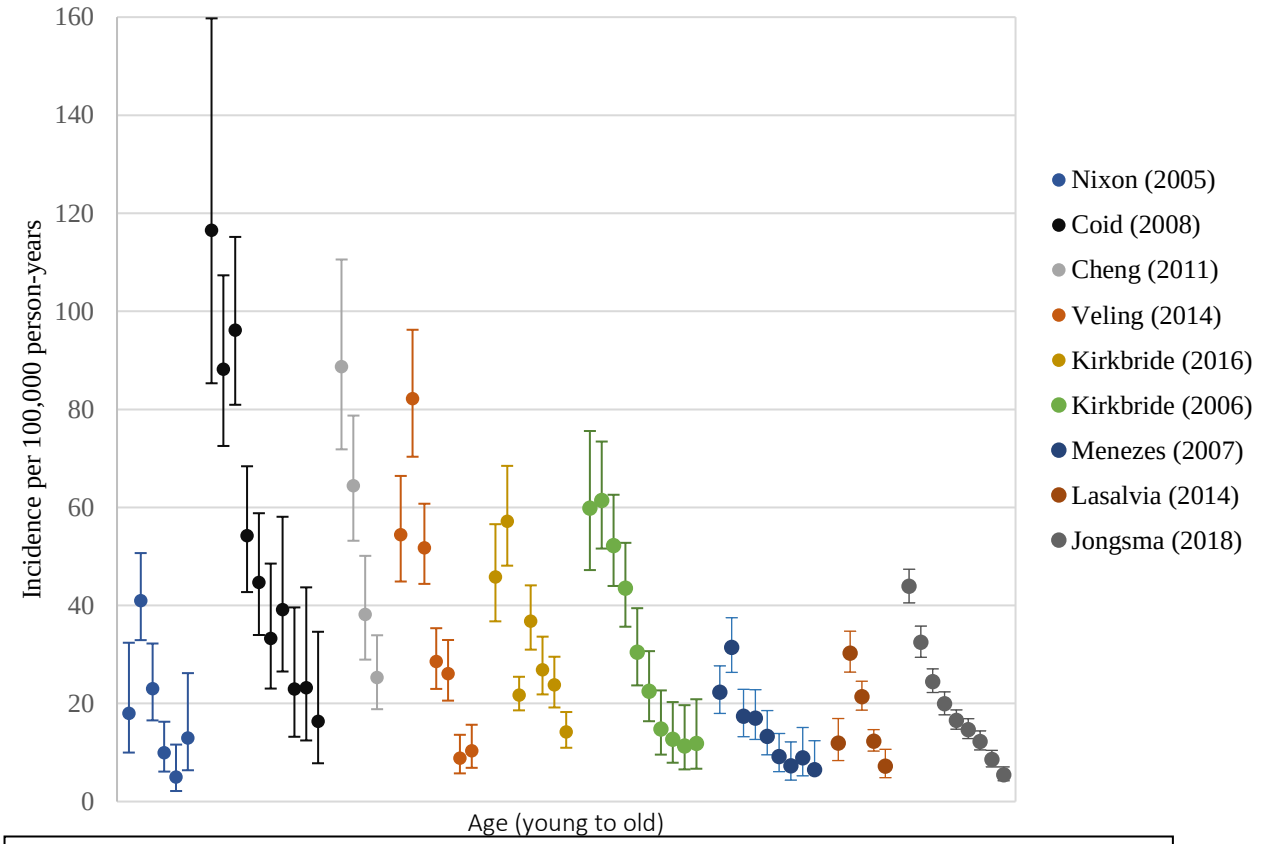
Supplemental Figure 9: Incidence rate ratios by ethnic group, schizophrenia



Incidence by age groups

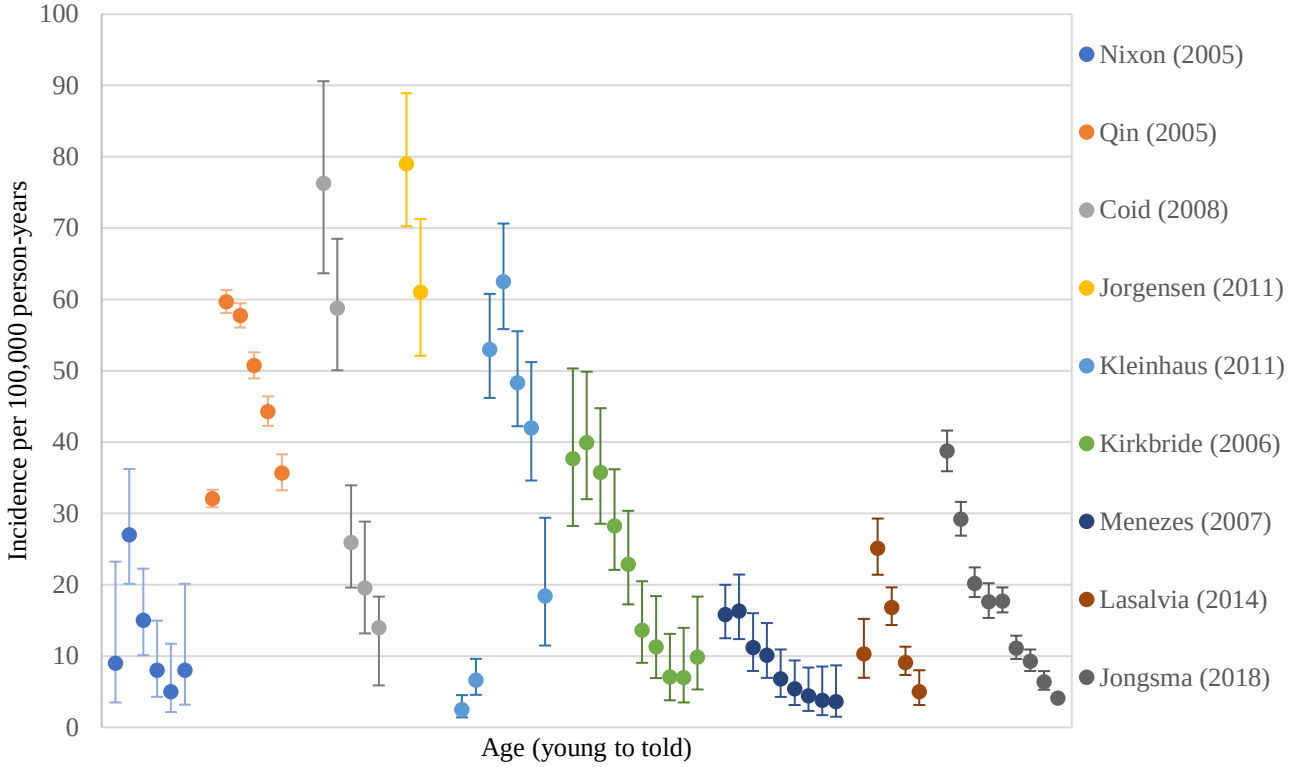
Supplemental Figures 10 to 12 below display incidence rates by age group for all psychotic disorders, non-affective disorders and schizophrenia. Rates are grouped by citation, and ordered from youngest to oldest age group. Overall, incidence appears to be higher in younger age groups.

Supplemental Figure 10: Incidence by age group, all psychotic disorders



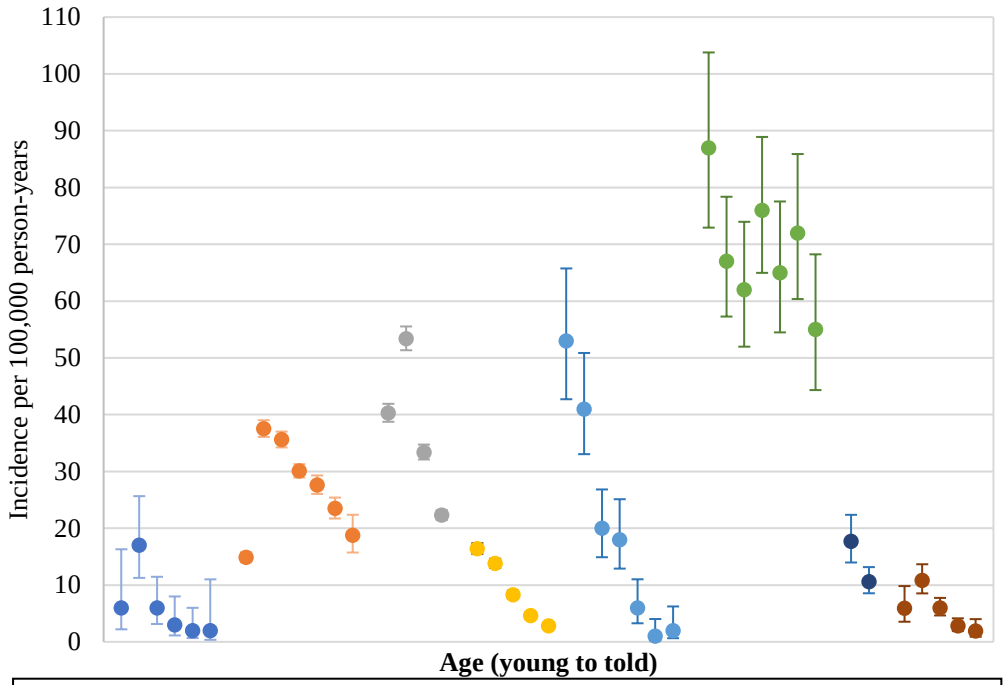
Age groups used are as follows:
Nixon (2005): 16-19, 20-29-, 30-39, 40-49, 50-59, 60-64.
Coid (2008) and Kirkbride (2006): 16-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64
Cheng (2011): 17-19, 20-24, 25-29, 30-35
Veling (2014): 15-19, 20-24, 25-29, 30-34, 35-39, 44-44, 45-49
Kirkbride (2016): 16-17, 18-19, 20-22, 23-35, 26-28, 29-31, 32-35
Menezes (2007) and Jongsma (2018): 18-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64
Lasalvia (2014): 15-19, 20-9, 30-39, 40-49, 50-54

Supplemental Figure 11: Incidence by age group, non-affective disorders



Age groups used are as follows:
Nixon (2005): 16-19, 20-29-, 30-39, 40-49, 50-59, 60-64.
Qin (2005): 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45+
Coid (2008): 18-24, 25-34, 35-44, 45-54, 55-64
Jorgensen(2011): 18-34, 35-44
Kleinhaus(2011): 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39
Kirkbride (2006): 16-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64
Menezes (2007) and Jongsma (2018): 18-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64
Lasalvia (2014): 15-19, 20-9, 30-39, 40-49, 50-54

Supplemental Figure 12: Incidence by age group, schizophrenia



Age groups used are as follows:
Nixon (2005): 16-19, 20-29-, 30-39, 40-49, 50-59, 60-64.
Qin (2005): 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45+
Salakongas (2011): 15-24, 25-34, 35-44, 45-64
Castagnini (2013): 15-24, 25-34, 35-44, 45-54, 55-64
Hogerzeil (2014): 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54
Kirkbride (2007): 16-29, 30-64
Lasalvia (2014): 15-19, 20-29, 30-29, 40-49, 50-54

Meta-regression

Supplemental Tables 9-13 below include both crude and adjusted results of meta-regression for each outcome with study quality (1-7) time period (middle-year of recruitment period) and study design (first contact, a combination, cohort, case register or population register) as exposure variables.

Results by study design are summarised in the main text. No incidence rate (ratio) of any outcome was associated with study quality in a multivariable model. Later citations reported slightly lower incidence rate ratios for minority groups compared with the majority for non-affective disorders (IRR: 0.97, 95%CI: 0.95-1.00) and a slightly lower incidence of affective disorders (IRR: 0.96, 95%CI: 0.92-0.99).

Supplemental Table 9: Meta-regression all FEP

	Psychotic disorders, overall incidence				Incidence rate ratio by sex				Incidence rate ratio by minority status			
Exposure	*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[4]	
	β (95%CI)	p-value	β (95%CI)	p- value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value
Study quality[1]	0.94 (0.78-1.14)	0.53	0.96 (0.80-1.11)	0.52	1.06 (0.95-1.20)	0.29	1.01 (0.85-1.20)	0.95	1.04 (0.52-2.07)	0.83	--	--
Time period[2]	0.99 (0.98-1.01)	0.42	0.99 (0.97-1.01)	0.18	1.00 (0.99-1.01)	0.92	1.00 (0.98-1.01)	0.59	0.99 (0.95-1.02)	0.45	--	--
Study design												
First contact	Reference		Reference		Reference		Reference		Reference		Reference	
Combination	0.78 (0.21-2.87)	0.71	0.40 (0.09-1.73)	0.21	0.94 (0.55-1.62)	0.83	0.79 (0.31-2.03)	0.61	--	--	--	--
Cohort	--	--	--	--	--	--	--	--	--	--	--	--
Case register	--	--	--	--	--	--	--	--	--	--	--	--
Population register	--	--	--	--	0.73 (0.47-1.12)	0.14	0.71 (0.36-1.38)	0.291	1.31 (0.68-2.51)	0.40	--	--

[1] Ranged from 1 – 7 [2]Measured as middle year of recruitment [3]Adjusted for other variables in model (study quality, time period, study design) [4]Insufficient observations available
Effect sizes in **bold** are statistically significant (p<0.05)

Supplemental Table 10: Meta-regression non-affective disorders

	Non-affective disorders, overall incidence				Incidence rate ratio by sex				Incidence rate ratio by minority status			
Exposure	*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[3]	
	β (95%CI)	p-value	β (95%CI)	p- value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value
Study quality[1]	1.04 (0.86-1.25)	0.66	1.11 (0.95-1.30)	0.18	1.02 (0.90-1.15)	0.786	1.02 (0.89-1.16)	0.80	1.03 (0.79-1.34)	0.83	0.82 (0.83-1.06)	0.12
Time period[2]	1.00 (1.00-1.00)	0.94	1.00 (1.00-1.00)	0.568	1.00 (0.99-1.01)	0.926	1.00 (0.99-1.02)	0.77	0.99 (0.98-1.01)	0.55	**0.97 (0.95-1.00)**	**0.03**
Study design												
First contact	Reference		Reference		Reference		Reference		Reference		Reference	
Combination	0.74 (0.21-2.59)	0.63	1.07 (0.19-2.78)	0.76	--	--	--	--	--	--	--	--
Cohort	--	--	--	--	--	--	--	--	0.79 (0.35-1.81)	0.57	**0.43 (0.20-0.92)**	**0.03**
Case register	0.98 (0.28-3.42)	1.00	1.08 (0.6.01)	0.616	--	--	--	--	--	--	--	--
Population register	**5.31 (2.21-13.27)**	**0.001**	**9.64 (2.92-31.82)**	**<0.001**	--	--	--	--	0.72 (0.37-1.43)	0.34	**0.42 (0.22-0.83)**	**0.01**

[1] Ranged from 1 – 7 [2]Measured as middle year of recruitment [3]Adjusted for other variables in model (study quality, time period, study design)
Effect sizes in **bold** are statistically significant (p<0.05)

Supplemental Table 11: Meta-regression schizophrenia

	Schizophrenia, overall incidence				Incidence rate ratio by sex				Incidence rate ratio by minority status			
Exposure	*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[4]	
	β (95%CI)	p-value	β (95%CI)	p- value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value	β (95%CI)	p-value
Study quality[1]	0.82 (0.64-1.05)	0.11	1.00 (0.77-1.30)	0.99	1.16 (0.93-1.46)	0.17	1.10 (0.66-1.83)	0.59	1.36 (0.94-1.97)	0.08	--	--
Time period[2]	0.99 (0.98-1.01)	0.40	0.99 (0.8-1.01)	0.29	1.01 (0.99-1.03)	0.57	1.02 (0.94-1.10)	0.52	1.00 (0.99-1.03)	0.40	--	--
Study design												
First contact	Reference		Reference		Reference		Reference		Reference		Reference	
Combination	0.63 (0.13-2.24)	0.31	0.45 (0.09-2.31)	0.33	1.10 (0.29-4.17)	0.87	2.06 (0.05-84.01)	0.58	0.57 (0.21-1.60)	0.15	--	--
Cohort	**3.10 (1.12-8.53)**	**0.03**	**3.27 (1.06-10.12)**	**0.04**	0.84 (0.40-1.76)	0.59	0.71 (0.13-3.76)	0.56	0.45 (0.15-1.29)	0.08	--	--
Case register	**3.12 (1.33-7.29)**	**0.01**	**3.95 (1.22-12.83)**	**0.02**	0.68 (0.38-1.25)	0.18	0.79 (0.11-5.57)	0.72	--	--	--	--
Population register	**2.50 (1.36-4.55)**	**0.004**	**2.54 (1.24-5.21)**	**0.01**	1.13 (0.61-2.10)	0.64	1.18 (0.29-4.91)	0.73	0.65 (0.25-1.67)	0.19	--	--

[1] Ranged from 1 – 7 [2]Measured as middle year of recruitment [3]Adjusted for other variables in model (study quality, time period, study design) [4]Insufficient observations available
Effect sizes in **bold** are statistically significant (p<0.05)

Supplemental Table 12: Meta-regression affective psychotic disorders

	Affective psychotic disorders, overall incidence				Incidence rate ratio by sex			
Exposure	*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[3]	
	β (95%CI)	p-value	β (95%CI)	p- value	β (95%CI)	p-value	β (95%CI)	p-value
Study quality[1]	1.04 (0.77-1.39)	0.80	1.31 (0.94-1.84)	0.11	**1.15 (1.07-1.24)**	**0.001**	1.12 (0.92-1.35)	0.26
Time period[2]	0.96 (0.91-1.00)	0.06	**0.96 (0.92-0.99)**	**0.02**	1.00 (0.99-1.02)	0.66	1.00 (0.98-1.02)	0.80
Study design								
First contact	Reference		Reference		Reference		Reference	
Combination	--	--	--	--	--	--	--	--
Cohort	--	--	--	--	--	--	--	--
Case register	2.58 (0.28-23.95)	0.39	6.64 (0.71-62.09)	0.09	--	--	--	--
Population register	--	--	--	--	**0.76 (0.65-0.88)**	**0.001**	0.91 (0.57-1.46)	0.67

[1] Ranged from 1 – 7 [2]Measured as middle year of recruitment [3]Adjusted for other variables in model (study quality, time period, study design)
Effect sizes in **bold** are statistically significant (p<0.05)

Supplemental Table 13: Meta-regression bipolar disorder with psychosis

	Bipolar disorder with psychosis, overall incidence				**Incidence rate ratio by sex**			
Exposure	*Crude association*		*Adjusted association*[3]		*Crude association*		*Adjusted association*[4]	
	β (95%CI)	p-value	β (95%CI)	p- value	β (95%CI)	p-value	β (95%CI)	p-value
Study quality[1]	0.82 (0.59-1.15)	0.24	0.95 (0.71-1.26)	0.69	0.96 (0.72-1.57)	0.77	--	--
Time period[2]	1.00 (0.98-1.02)	0.89	1.00 (0.1.00-1.02)	0.13	0.99 (0.93-1.04)	0.76	--	--
Study design								
First contact	Reference		Reference		Reference		Reference	
Combination	2.08 (0.52-8.35)	0.28	2.45 (0.63-9.51)	0.18	1.13 (0.19-9.46)	0.79	--	--
Cohort	--	--	--	--	--	--	--	--
Case register	2.64 (0.66-10.59)	0.16	2.40 (0.61-9.50)	0.20	1.34 (0.24-7.35)	0.54	--	--
Population register	**4.08 (2.19-7.59)**	**<0.0001**	**4.53 (2.41-8.51)**	**<0.0001**	--	--	--	--

[1] Ranged from 1 – 7

[2]Measured as middle year of recruitment

[3]Adjusted for other variables in model (study quality, time period, study design)

[4]Insufficient observations available

Effect sizes in **bold** are statistically significant (p<0.05)

Small study effects

The below table (13) details results of the Egger's test for small study effects, where the number of studies included in the analysis is at least ten. Funnel plots of all analyses are displayed below (Figures 9-13). Orange lines in the Figures corresponds to Egger's test for funnel plot asymmetry. A negative coefficient indicates that smaller studies produce smaller outcomes, and a positive coefficient indicates that smaller studies produce larger outcomes.

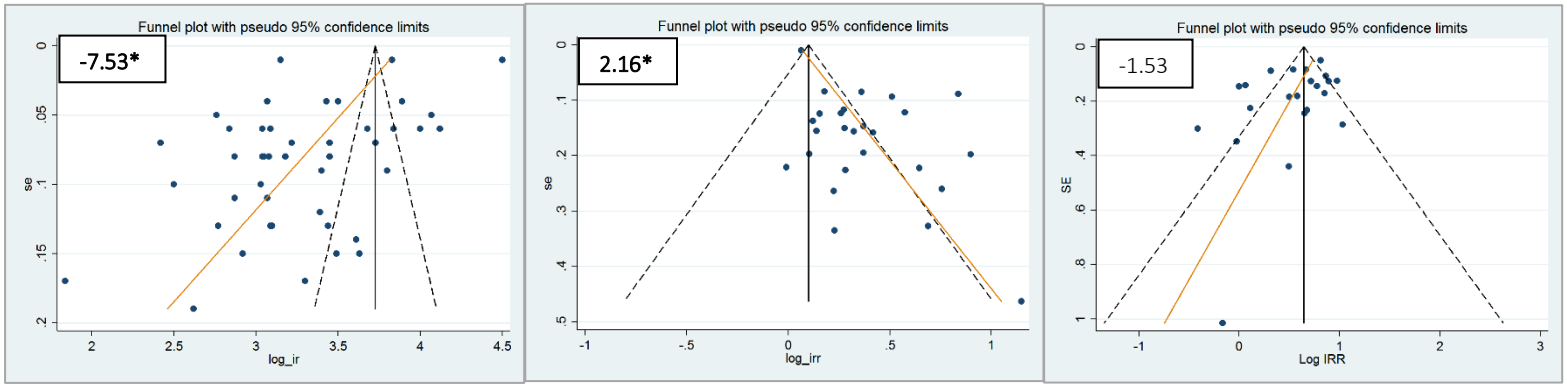
Supplemental Table 14: Egger's test for small study effects

Outcome	***N***	**Bias (β)**	**Standard error**	**p-value**
All FEP				
Overview	44	**-7.53**	**3.14**	**0.02**
By sex	26	**2.16**	**0.44**	**<0.0001**
By minority status	22	-1.53	0.89	0.10
Non-affective disorders				
Overview	43	**-14.55**	**2.46**	**<0.0001**
By sex	27	0.05	0.76	0.95
By minority status	28	-0.79	1.57	0.62
Schizophrenia				
Overview	34	**-11.78**	**5.52**	**0.04**
By sex	11	2.97	1.74	0.12
By minority status	6	--	--	--
Affective disorders				
Overview	29	**7.72**	**1.60**	**<0.0001**
By sex	20	**0.90**	**0.24**	**0.001**
Bipolar disorder				
Overview	24	**-14.67**	**2.69**	**<0.0001**
By sex	5	--	--	--

Estimates in **bold** are statistically significant (p<0.05) and provide evidence of small study effects.

Supplemental Figure 13: Funnel plots for all FEP

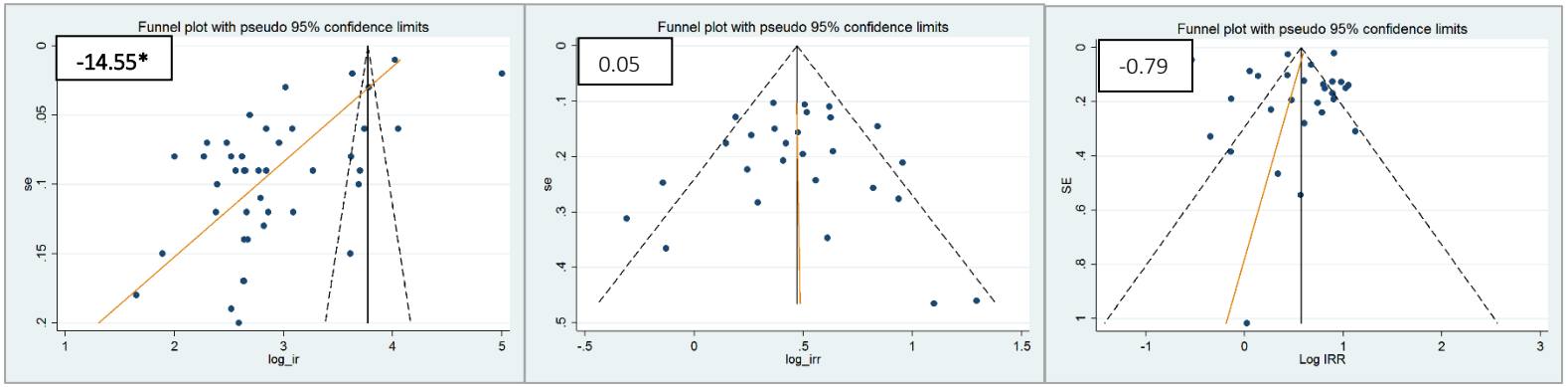
a. Overall incidence **b. IRR by sex** **c. IRR by minority status**



The orange line represents Egger's coefficient, and corresponds to the bias (β) in Supplemental Table 10. Coefficients in ***bold**** *are statistically significant (p<0.05)*

Supplemental Figure 14: Funnel plots of non-affective disorders

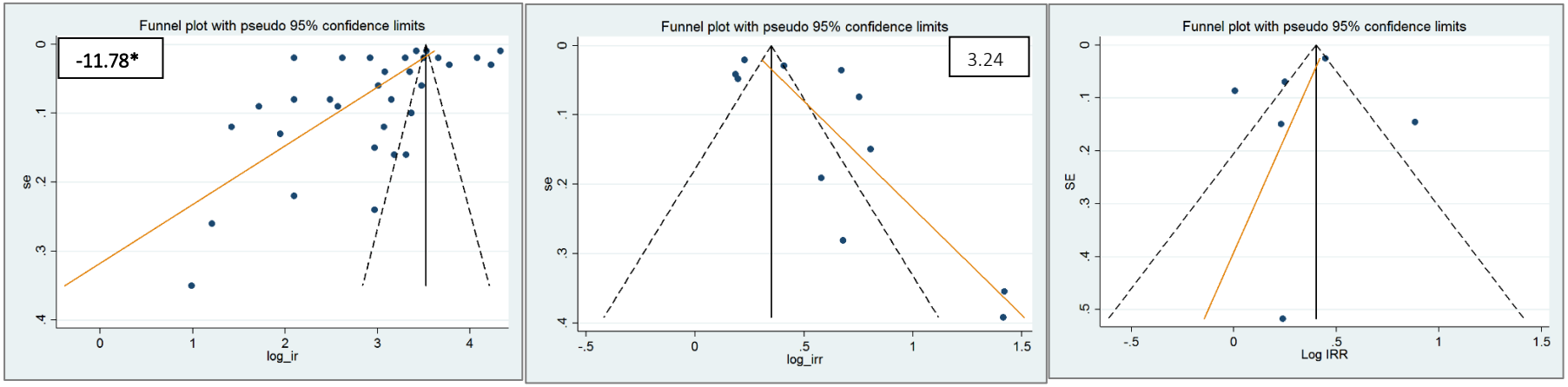
a. Overall incidence **b. IRR by sex** **c. IRR by minority status**



The orange line represents Egger's coefficient, and corresponds to the bias (β) in Supplemental Table 10. Coefficients in bold are statistically significant (p<0.05)*

Supplemental Figure 15: Funnel plots of schizophrenia

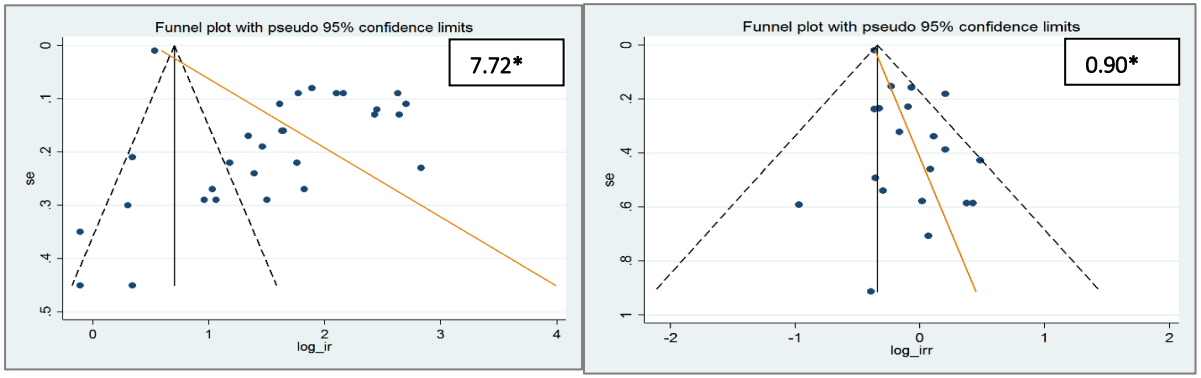
a. Overall incidence **b. IRR by sex** **c. IRR by minority status**



The orange line represents Egger's coefficient, and corresponds to the bias (β) in Supplemental Table 10. Coefficients in ***bold**** *are statistically significant (p<0.05). No Egger's test was computed for IRR by minority status (insufficient observations).*

Supplemental Figure 16: Funnel plots of affective psychotic disorders

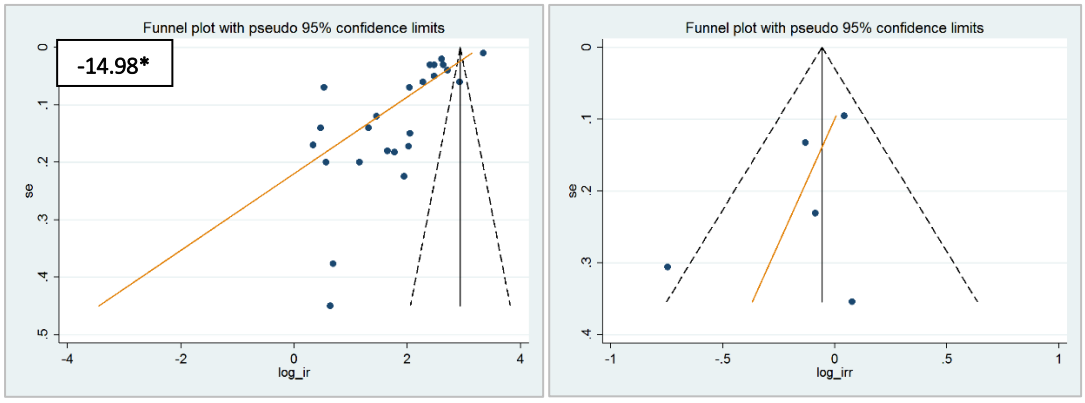
a. Overall incidence **b. IRR by sex**



The orange line represents Egger's coefficient, and corresponds to the bias (β) in Supplemental Table 10. Coefficients in ***bold**** *are statistically significant (p<0.05)*

Supplemental Figure 17: Funnel plots of bipolar disorder

a. Overall incidence **b. IRR by sex**



*The orange line represents Egger's coefficient. Coefficients in **bold** are statistically significant (p<0.05). No Egger's test was computed for IRR by sex (insufficient observations).*

In *post-hoc* sensitivity analyses, we repeated Egger's test by study type, to test our initial hypothesis that this could explain strong evidence of small study effects (Supplemental Table 15). Whilst study type appeared to explain some of the small study effects, some evidence of it remained, particularly within first contact studies.

Supplemental Table 15: Sensitivity analyses: Egger's test by study type

Outcome	Study type	*N*	Bias (β)	Standard error	p-value
All FEP	First contact				
Overview		43	**-7.43**	**3.21**	**0.03**
By sex		24	0.01	0.91	0.99
By minority status		21	-0.87	1.07	0.43
All FEP	Population register				
Overview			Insufficient observations		
By sex					
By minority status					
Non-affective disorders	First contact				
Overview		39	**-8.75**	**1.97**	**<0.0001**
By sex		27	0.05	0.76	0.95
By minority status		23	-0.53	1.09	0.63
Non-affective disorders	Population register				
Overview			Insufficient observations		
By sex					
By minority status					
Schizophrenia	First contact				
Overview		21	-7.19	4.00	0.09
By sex		5	**3.89**	**0.67**	**0.01**
By minority status		n/a			
Schizophrenia	Population register				
Overview		7	33.67	74.79	0.67
By sex		n/a			
By minority status		n/a			
Affective disorders	First contact				
Overview		28	**7.46**	**1.63**	**<0.0001**
By sex		19	0.18	0.42	0.68
Affective disorders	Population register				
Overview			Insufficient observations		
By sex					
Bipolar disorder	First contact				
Overview		15	**-8.94**	**2.46**	**0.03**
By sex		n/a			
Bipolar disorder	Population register				
Overview		7	**-25.41**	**7.11**	**0.02**
By sex		n/a			

Estimates in **bold** are statistically significant (p<0.05) and provide evidence of small study effects.

Non-affective psychotic disorders

Supplemental Table 16 below gives an overview of the exact diagnoses included in the broad 'non-affective psychotic disorders' category.

Supplemental Table 16: Exact diagnoses included in the non-affective psychotic disorders category.

First author (year)	Diagnostic manual	Outcomes included	Diagnostic codes
Hanoeman (2002)	DSM-III-R	Schizophrenia, schizophreniform disorder	None given
Proctor (2004)	ICD-10	Non-affective disorders	F20-F29
Sipos (2004)	ICD-9 & ICD-10[1]	Non-affective disorders	F20-F29
Leao (2007)	ICD-9 & ICD-10	Non-affective disorders	F20-F29
Cantor-Graae (2005)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder	297.1, 298.9, 298.9
Qin (2005)	ICD-8 & ICD-10	Non-affective disorders	F20-F25, F28/F29
Westman (2006)	ICD-9 & ICD-10	Non-affective disorders	F20-F29
Leao (2006)	ICD-9 & ICD-10	Non-affective disorders	F20-F29
Munk-Olsen (2006)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Payne (2006)	Not stated	Schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, psychosis NOS	None given
Kirkbride (2007)	ICD-10	Non-affective disorders	F20-F29
Coid (2008)	DSM-IV	Non-affective disorders	295.xx, 297.xx, 298.8, 298.9
Boonstra (2008)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychosis, delusional disorder, psychosis NOS	None given
Corocran (2009)	ICD-10	Non-affective disorders	F20-F29
Harlap (2009)	ICD-10	Non-affective disorders	F20-F29
Reay (2009)	ICD-10	Non-affective disorders	F20-F29
Kirkbride (2009)	ICD-10	Non-affective disorders	F20-F29
Bogren (2010)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychosis, delusional disorder, psychosis NOS	None given
Zammit (2010)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Bogren (2009)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychosis, delusional disorder, psychosis NOS	None given
Jorgensen (2011)	ICD-10	Non-affective disorders	F20-F29
Kleinhaus (2011)	ICD-10	Non-affective disorders	F20-F29
Benros (2011)	ICD-10	Non-affective disorders	F20-F29
Cowan (2011)	ICD-9	Schizophrenia, schizoaffective disorders, schizophreniform disorder	295.x
Manrique-Garcia (2012)	ICD-8 & ICD-10	Schizophrenia, substance-induced psychosis, delusional disorder, acute and transient psychosis, other non-organic psychosis, psychosis NOS	F20, F125/F127, F22, F23, F28, F25
Nosarti (2012)	ICD-8 & ICD-10	Schizophrenia, schizotypal disorder, acute and transient psychosis, schizoaffective disorder, other non-organic psychosis, psychosis NOS	F20, F21, F23.1/23.2, F25, F28, F29
Anderson (2012)	Not stated	Schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychosis, psychosis NOS	None given
Sutterland (2013)	ICPC	Schizophrenia, schizophreniform disorder, schizoaffective disorder, brief psychosis, psychosis NOS	None given
Cantor-Graae (2007)	ICD-8 & ICD-10	Schizophrenia, schizotypal disorder, delusional disorder, acute and transient psychosis, psychosis NOS.	F20-F23, F29
Weibell (2014)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychosis, psychosis NOS	295.3, 295.7, 295.4, 297.1, 298.9, 298.9
Kirkbride (2015)	DSM-IV	Non-affective disorders	295.xx, 297.xx, 298.8, 298.9
Paksarian (2015)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Paksarian (2015)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Soderlund (2015)	ICD-10	Non-affective disorders	F20-F29
Anderson (2015)	ICD-10	Non-affective disorders	F20, F25
Szoke (2016)	DSM-IV	Non-affective disorders	295.xx, 297.x, 298.x
Kendler (2016)	ICD-9 & ICD-10	Non-affective disorders	F20-F29
Hollander (2016)	ICD-10	Non-affective disorders	F20-F29
Kirkbride (2016)	ICD-10	Non-affective disorders	F20-F29
Hoeffding (2017)	ICD-8 and ICD-10	Non-affective disorders	F20-F29

Veling (2006)	DSM-IV	Schizophrenia, schizoaffective disorder, schizophreniform disorder	None given
Tarricone (2012)	ICD-10	Non-affective disorders	F20-F29
Singh (2004)	ICD-10	Non-affective disorders	F20-F29
Kirkbride (2006)	DSM-IV	Non-affective disorders	295.xx, 297.xx, 298.8, 298.9
Turner (2006)	ICD-10	Non-affective disorders	F20-F29
Menezes (2006)	DSM-IV	Non-affective disorders	295.10-.90, 297,1, 298.8, 298.8
Kirkbride (2007)	ICD-10	Non-affective disorders	F20-F29
Szoke (2014)	DSM-IV	Non-affective disorders	None given
Lasalvia (2014)	ICD-10	Non-affective disorders	F20-F29
Cocchi (2014)	ICD-10	Non-affective disorders	F20-F29
Jongsma (2018)	ICD-10	Non-affective disorders	F20-F29
Kim (2017)	ICD-10	Non-affective disorders	F20, F25
Kirkbride (2017)	ICD-10	Non-affective disorders	F20-F29
Markkula (2017)	ICD-10	Non-affective disorders	F20-F29
Nyberg (2018)	ICD-8 & ICD-10	Non-affective disorders	F20, F22, F24, F25, F28, F29
Okkels (2017)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Richardson (2018)	ICD-10	Non-affective disorders	F20-F29
Schofield (2017)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Schofield (2017)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Barghadouch (2018)	ICD-10	Non-affective disorders	F20-F29
Vikstrom (2017)	ICD-8 & ICD-10	Non-affective disorders	F20-F29
Norredam (2009)	ICD-10	Non-affective disorders	F20-F29
Norredam (2010)	ICD-10	Non-affective disorders	F20-F29

[1] For all citations including more than one version of the ICD manual, codes referring to the most recent manual are given (in all cases: ICD-10).

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NB: some studies are also referred to in the body of the main article, and these are included in the reference list at the end of the main article (references up until #60 in Table 1).

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