be customized for clinics and workflows to determine which parts of the MAP program are practical and appropriate. Participation of consumer stakeholders may be essential to delivery of the MAP Program.

T237. PERSON-CENTERED PSYCHOSIS CARE – HOW INCREASING PERSON-CENTEREDNESS IN PSYCHOSIS INPATIENT CARE RELATE TO CARE CONSUMPTION AND WARD BURDEN

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Background: Since person-centered care (PCC) is widely embraced and internationally considered to increase effectiveness and quality of complex health care today this study sets out to investigate its relation to ward level outcomes such as length of hospital stay (LoS), involuntary treatments and ward burden. An educational intervention for staff, using a participatory approach, was created to increase the person-centeredness of the care delivered at four inpatient psychosis wards. 6 conference days spread over a 6 months period with practical work at home wards in-between let participants receive information on, discuss and test the principles of PCC, such as acknowledge patients resources, preferences and experiences, working in partnership with patients to co-create the care plan, and documenting agreements.

Methods: Data for all patients receiving care at the inpatient services during data collection periods before (n = 416) and after (n = 375) the intervention, including LoS, length of involuntary stay (LoIS) as well as number of episodes involving restraints, seclusions and forced injections, were extracted from the clinic registry. During the same data collection periods one staff member per day and ward filled out a VAS rating (1 = no burden – 10 = highest imaginable burden) capturing experienced ward burden (n = 505, 60% response rate vs n = 465, 45% response rate). Mean or median of each variable was used for comparative analysis.

Results: A longer LoS was found after implementation (Md = 21.1, n = 416 vs Md = 26.2, n = 375), U = 85894, p = .014, r = .09. LoIS was shorter after implementation (Md = 10.6 vs Md = 6.6), the difference was however not significant U = 74263, p = .231. Analysis of data on involuntary treatments are underway and will be presented. Ward burden was rated significantly lower after implementation (M = 5.4, SD = 1.94 vs M = 4.5, SD = 2.08), t = 7.5 (968), p <.0005.

Discussion: These findings suggest that relapse occurs frequently for young people who have experienced FEP. This is one of the first studies to find that amphetamine use increases the risk of relapse. Clinical services, especially in Australasia, need to consider how best to manage this co-morbidity in young people with FEP.

T238. RATES AND PREDICTORS OF RELAPSE IN AN AUSTRALIAN FIRST EPISODE PSYCHOSES COHORT

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Background: Clinical and functional recovery is usually achieved after treatment for a first episode of psychosis (FEP). Unfortunately, subsequent relapse remains common, occurring within a year for approximately 30% of individuals and within five years for 80%. What makes someone more likely to relapse remains poorly understood.

Methods: This study is a naturalistic cohort study of young people (15–25 years old) accessing an early intervention in psychosis service in Melbourne, Australia between 1st January 2011 and 31st December 2016. Demographic and clinical predictors of relapse were collected from patient records and analysed using Cox regression analysis.

Results: A total of 1220 young people presented with a FEP during the study period and 37.7% (N=460) experienced at least one relapse during their episode of care. Over half of all relapses resulted in an admission to hospital. Non-adherence to medication, substance use and psychosocial stressors precipitated relapses. Significant predictors of relapse in this sample were a diagnosis of a schizophrenia spectrum disorder or an affective psychotic disorder, amphetamine use, and substance use during treatment.

Discussion: These findings suggest that relapse occurs frequently for young people who have experienced FEP. This is one of the first studies to find that amphetamine use increases the risk of relapse. Clinical services, especially in Australasia, need to consider how best to manage this co-morbidity in young people with FEP.

T239. INDIVIDUAL AND NEIGHBORHOOD PREDICTORS OF OUTPATIENT MENTAL HEALTH SERVICE UTILIZATION AMONG PERSONS WITH SERIOUS MENTAL ILLNESSES

Abstract not included.

T240. DOES SCHEDULING A POST-DISCHARGE OUTPATIENT MENTAL HEALTH APPOINTMENT INCREASE THE LIKELIHOOD OF SUCCESSFUL TRANSITION FROM HOSPITAL TO COMMUNITY-BASED CARE?

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Background: Scheduling timely appointments for outpatient follow-up care is a discharge planning practice widely accepted as a standard of care for inpatient treatment. Despite these endorsements, however, rates of hospital providers completing these practices vary widely. Timely scheduling of initial outpatient visits following discharge has been associated with improved rates of attending outpatient psychiatric services, although negative findings have also been reported. Nearly all prior studies were single-site case reports that did not use an experimental design and more rigorous research is needed.

In this report, we aimed to examine the association between receiving care transition practices and attending outpatient care after controlling for patient, hospital, and system characteristics in a large cohort of inpatient psychiatric admissions in New York State. We hypothesized that patients for whom hospital providers scheduled a mental health outpatient appointment had a higher likelihood of receiving an initial outpatient psychiatric service following discharge after controlling for the aforementioned covariates.

Methods: This is a retrospective cohort study that used 2012–2013 New York State Medicaid claims data for psychiatric inpatients, who were under 65 years, admitted to an inpatient psychiatric unit with a principal diagnosis of a mental disorder and discharged to the community. The outcome variable was defined as attending to outpatient psychiatric services within 7 and 30 days following discharge from an inpatient psychiatric unit. Scheduling a mental health outpatient appointment as a discharge planning was the primary independent variable. To address the wide range of potentially confounding covariates, propensity scores for regression models were estimated based on patient, hospital, and service system factors.
Results: Before matching by propensity scores, those who had an outpatient mental health appointment scheduled were less likely to be homeless at admission, have a co-occurring substance use diagnosis, and live in large central metro areas, and were more likely to be previously engaged in psychiatric outpatient services. After matching, however, most systematic differences between those who had and those who did not have a mental health outpatient appointment scheduled were substantially diminished (standardized differences of <20%). In the adjusted models including propensity scores, patients who had a mental health outpatient appointment scheduled were more likely to be in treatment in aftercare services compared to patients who did not have an outpatient appointment at both 7 and 30 days following discharge.

Discussion: Scheduling an outpatient mental health appointment increases aftercare attendance following a psychiatric discharge. This effect was noted across all 5 propensity strata, indicating that discharge planning has a positive impact regardless of the presence of other factors highly predictive of failure to attend aftercare appointments.

T241. INCIDENCE AND SOCIO-DEMOGRAPHIC/CLINICAL CHARACTERISTICS OF PSYCHOTIC DISORDERS IN INDIA, NIGERIA AND TRINIDAD: PRELIMINARY BASELINE FINDINGS FROM INTREPID II

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Background: The incidence, presentation, and course of psychotic disorders are highly variable across populations. A recent review noted a lack of evidence from low- and middle-income countries in the global South, where around 85% of the world’s population lives. Robust population-based data from these contexts are needed to better understand the sources of variation in psychotic disorders. INTREPID II is a multi-country programme comprising incidence, case-control, and follow-up studies of psychotic disorders in three diverse catchment areas with populations at risk of ~500,000 in Tamil Nadu (India), Oyo state (Nigeria), and northern Trinidad. Here, using baseline data from the initial 15 months, we present findings on variations in incidence and clinical presentation.

Methods: Baseline recruitment and assessment is ongoing. In each site individuals with an untreated psychotic disorder are identified through a comprehensive case detection system that includes professional, folk, and popular sectors. Inclusion criteria are age of 18–64, resident in catchment area, presence of a ICD-10 psychotic disorder, and no more than one continuous month of treatment with antipsychotic medication prior to the start of case identification. At baseline, detailed data on demographic and clinical characteristics and putative risk factors are collected using established tools.

Results: In the first 15 months, we identified 614 cases (199 in India, 92 in Nigeria, and 264 in Trinidad).

There was wide variation in where cases were identified: In India, 9% via professional services and 91% via the popular sector (i.e., in the community); In Nigeria, 33% via professional services and 63% via the folk sector (traditional and religious service providers); In Trinidad, 98% via professional services.

Further, there were notable variations in incidence and sociodemographic and clinical characteristics. Age-adjusted rates were highest in Trinidad (men: 47.1, 95% CI 39.8–55.4; women: 38.7, 95% CI 32.0–46.3) compared with India (men: 23.0, 95% CI 18.4–28.4; women: 30.2, 95% CI 24.9–36.4) and Nigeria (men: 13.0, 95% CI 9.5–17.2; women: 12.4, 95% CI 9.0–16.6). The proportion with age of onset before 29 years was higher in Trinidad (74%) compared to Nigeria (45%) and India (36%). Among those on whom full data are currently available (n, 327), more in Nigeria were assigned a diagnosis of schizophrenia (63%) than in India (46%) and Trinidad (42%). Median duration of untreated psychosis was longer in India (5.1 years, IQR 1.9–13.6) than in Nigeria (1.5 years, IQR 0.1–4.1) and Trinidad (2.6 years, IQR 0.3–15.2). However, an insidious onset (i.e., gradual emergence of symptoms over several months) was more common in Trinidad (50% of cases) than in India (28%) and Nigeria (14%). Education levels were lower in India (31% completed secondary education or higher) than in Nigeria (74%) or Trinidad (68%). However, the proportion of cases who were married or in a steady relationship was similar in all sites (India: 42%; Nigeria: 38%; Trinidad: 38%), as was the proportion who were unemployed (India: 48%; Nigeria: 55%; Trinidad: 51%).

Discussion: In initial analyses, we found evidence that the incidence and presentation of psychoses varied by site, findings that both further highlight the heterogeneity of psychoses across contexts and challenge assumptions about the basic epidemiology based on findings from the global North. For example, the data from our India site suggest higher rates among women and a later age of onset than commonly supposed. Our findings also show that many people with psychotic disorders in these settings are untreated for long periods, indicating an urgent need to develop more accessible services.

T242. THE TIMING OF FIRST HELP-SEEKING ATTEMPT IN FIRST EPISODE PSYCHOSIS CAN LEAD TO AVERSIVE PATHWAYS TO CARE. RESULTS FROM THE STEP-ED STUDY

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Background: In the U.S., individuals affected by a first episode psychosis endure 74 mean weeks of delay in receiving effective treatment. Facilitating their access to care has become a public health priority. This delay has proven to have adverse consequences both in short and long-term outcomes. Moreover, aversive pathways to care can imperil subsequent engagement with treatment. A better understanding of how a patient’s characteristics might influence interactions with healthcare systems could help tailor early detection interventions and target delays in treatments.

Methods: Participants were recruited starting February 1st, 2014 to January 31st, 2019, to STEP, a Coordinated Specialty Care Program in New Haven, CT. Based on the date of the first help-seeking episode, demographic, clinical, and socioeconomic data were used to compare participants who had their first help-seeking attempt before or after psychosis onset (psychosis onset defined using the POSPs criteria at the SIPS Interview). Chi-square test was used to compare categorical variables; non-parametric or Student’s t test was used to compare the continuous variables.

Results: The sample comprised 168 subjects, the majority of which were male, African American, young adults (mean age was 22.4, SD=3.8), with a median time from psychosis onset to first antipsychotic of 52 days (IQ range, 15 – 196), and had their first help-seeking attempt after psychosis onset (70%). Between the two groups there was no difference in sociodemographic characteristics, in psychosis diagnosis, and in the global assessment of functioning (at baseline and 12 months prior).

Help-seeking attempts made before psychosis onset were mostly initiated by the patients themselves, while attempts made after onset had the family as the prime initiator.