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 the study. 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 9% 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: 23.8, 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 impair 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.

By comparing the timing of the first help seeking attempt initiated in a sample of first episode psychosis participants of an early detection campaign, we aim to investigate if people starting to seek help before psychosis will have shorter delays to care, and if an earlier help-seeking attempt correlates with a lower rate of adverse pathways to care (e.g. police involvement, involuntary admissions).

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 POSP 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 (IQR 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.
Once the first help-seeking attempt was initiated, it took longer to get prescribed an antipsychotic for subjects seeking help before onset compared to those who sought help after (median 245 vs 14 days [0 – 1093], p=0.09). Compared to those who had their first help seeking episode before psychosis onset, the group who sought help after onset had more contacts with the police (64 vs 10), more involuntary admissions (40 vs 6), and same median number of nights spent in a psychiatric hospital six months before STEP enrollment (n=14).

**Discussion:** Timing of first help seeking in early psychosis can be crucial in shaping the individual experience of care. Longer delays in receiving the appropriate treatment and aversive pathways might be associated with help seeking which started only after psychosis onset, compared to first help seeking started before psychosis onset. Tailored interventions are needed to improve psychosis detection and referral of first episodes to specialized services.

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**T243. MENTAL HEALTH SERVICE UTILIZATION IN YOUNG ADULTS REPORTING PSYCHOSIS-LIKE EXPERIENCES**

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**Background:** Psychosis-like experiences (PES) may reflect elevated risk for the onset of serious mental illness, such as a psychotic disorder, as well as negatively impact functioning. Few studies have examined the relation between PEs and mental health service utilization or intent to seek treatment. Characterizing psychosis risk and service utilization among individuals in the peak developmental period for psychotic disorders (~ ages 18–25) may help the field improve psychosis screening tools and reduce the duration of untreated illness.

**Methods:** Participants (N = 439) were individuals between the ages of 18 and 25 years old (M = 20.24) who completed an online survey regarding their mental health experiences. They completed the PRIME Screen with distress and self-reported mental health service utilization throughout their lifetime and for the past two months. Participants were asked how strongly they were considering seeking mental health treatment (Likert-type scale, response options ranging from 1 [“Not at all”] to 5 [“Very much”]). The PRIME Screen symptom total score, total distress score, and specific item responses were used in bivariate correlations and a multiple linear regression model.

**Results:** Approximately a third of the participants (34%) screened positively on the PRIME, mean total score of 16.67 (SD = 14.53). Sixteen percent of participants reported seeking mental health treatment in the past two months, and 38% reported they were currently considering seeking treatment. There were no significant correlations between mental health service utilization in the past two months and PRIME symptom total score (p = .31), or distress total score (p = .32). PRIME total scores and PRIME distress total scores were also not significantly associated with lifetime utilization of mental health services (p = .22 and p = .45, respectively). There were significant relations between how strongly participants were considering seeking mental health treatment and both PRIME symptom total (r = 0.20, p < .01, N = 413) and distress total scores (r = 0.20, p < .01, N = 359). A multiple linear regression model indicated certain PRIME items contributed significantly to this relation (PRIME items 1 [odd/unusual experiences], 3 [thought control], 6 [mind reading], and 12 [concerns with “going crazy”]; all ps < .05). Follow-up analyses showed that distress associated with PRIME items 1, 3 and 12 was significantly higher (all ps < .01) than the mean PRIME distress item score.

**Discussion:** Results suggest that while a third of a college sample of young adults scored positively on the PRIME screen, PEs and related distress were not significantly related to lifetime or current mental health service utilization. Among those not already seeking services, however, both PEs symptom and distress were significantly associated with participants’ intent to utilize mental health treatment. Thus, individuals may experience distressing PE symptoms, but may not do receive mental health services. Higher endorsement of distress with experiences relating to: odd/unusual experiences, thought control, mind reading, and concerns with “going crazy” were more closely associated with intent to seek treatment, suggesting that specific PEs may increase individuals’ desire to address these concerns via mental health services. Findings highlight the need to identify and engage individuals not yet in treatment who have frequent/high level, distressing, and specific PEs.

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**T244. FURTHER EVIDENCE SUPPORTING COORDINATED SPECIALTY CARE FOR EARLY PSYCHOSIS: FINDINGS FROM THE SAMHSA SUPPORTED PENN PSYCHOSIS EVALUATION AND RECOVERY CENTER (PERC)**

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**Background:** The early years following a first episode of psychosis (FEP) present unique opportunities to prevent declines in clinical and social function. Early intervention programs target factors known to be associated with poor long-term outcomes, including longer duration of untreated psychosis, treatment non-adherence, affective symptoms, and cognitive dysfunction. The RAISE trial and other work in the U.S. and internationally spurred congress to fund comprehensive specialty care (CSC) programming across the US through a SAMHSA block-grant set-aside that began in 2015 and was doubled in 2016. As a Pennsylvania recipient of these funds since 2015, the Penn Psychosis Evaluation and Recovery Center (PERC) enrolls individuals age 15–34 who have experienced psychosis onset within two years prior to enrollment. We received complimentary funding in 2018 to provide step-down care to FEP participants, and to expand PERC services to individuals at clinical high risk for psychosis.

**Methods:** PERC services, offered for a minimum of two years, include pharmacotherapy, recovery oriented cognitive therapy and case management, supported employment and education, multi-family group cognitive therapy and psycho-education, peer support, and cognitive remediation. SAMHSA funds are used to provide CSC elements that cannot be supported through available insurance coverage. A comprehensive computerized assessment, conducted at admission and at 6-, 12-, 18- and 24-month follow-up intervals, includes measures from the Pennsylvania FEP Program Evaluation core battery assessing participant-level outcomes (employment and education, hospitalization, criminal justice involvement and risk behaviors, and overall functioning and clinical symptoms), complemented by standardized measures of cognitive insight, sleep quality, and other relevant domains. Systems-level data on outreach efforts, incoming and outgoing referrals, admissions and discharges are also collected. Data collection is integrated into clinical care.

**Results:** To date, PERC has enrolled 202 individuals (mean age=22.2, SD=4.4; 78% male; 56% European-American, 31% African-American, 13% other), of