Secondly a randomized controlled trial was conducted to see whether patients who use Bias Blaster experience less social anxiety after 12 weeks compared to those who don't use Bias Blaster.
Results: Social anxiety occurs in more than half of patients with a first episode of psychosis.
Patients reported giving a speech or speaking in public (10,07%); acting or performing in front of others/an audience (8,38%); going to parties or other social gatherings: 42,68 (7,35%); entering a room when others were already present (6,79%) and suggesting/proposing a request to others (6,33%) as the most fearful situations which were included in the serious game. 80 patients were included in the trial of which 40 received treatment add on using Bias Blaster. First results show significant improvement in patient using Bias Blaster
Discussion: Social anxiety is a major problem in patient with first episode psychosis. Using Bias Blaster, a serious game patients can play whenever they want, seems to be a cheap and approachable intervention with great results.

S283. Person centered psychosis care (PCPC) in an inpatient setting: the implementation process and staff experiences

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Background: Persons with schizophrenia-spectrum disorders might benefit from increased involvement in the care process. To this end, integrated care models have been successfully implemented in outpatient settings. We wanted to develop an inpatient care model inspired by integrated care. Further, we wanted to include central components of person-centered care (as defined by the Gothenburg Center for Person-centered Care) including a focus on the patient's narrative, the creation of partnership between staff and patient, and an agreement between staff and patient concerning the care. The present research project, Person Centered Psychosis Care (PCPC), aims to develop, implement, and evaluate an inpatient care approach that utilizes aspects of integrated care as well as person-centered care. In the present study we will describe the PCPC staff educational intervention, the implementation process that followed, and staff experiences of the intervention and implementation.
Methods: Employing a participatory design, the PCPC staff educational intervention involved one third ($n = 40$) of the staff working at four wards at a clinic providing inpatient care for persons with schizophrenia-spectrum disorders. Facilitators with previous experience in the implementation of person-centered care in somatic settings served as coaches. During six full day workshops, staff learned to apply theoretical concepts of both integrated care and person-centered care to their everyday ward situation and worked in groups to develop ward-level projects with the aim of stimulating patient involvement. Service users took part in the educational intervention. Staff who participated in the educational intervention transferred their new skills to their fellow staff members who had not taken the course. Together they created and tested new approaches to care tasks. This means that all ward staff became involved in the implementation process.
Results: A purposeful sample of staff members (both with and without course participation, $n = 20$) were asked to participate in focus group interviews to relate their experiences of the PCPC staff educational intervention, the transfer to those staff members who did not take the course, and of the implementation process. Focus group interviews with staff are ongoing. The interviews are recorded, transcribed verbatim, and thematically analyzed. Results regarding the implementation process will be presented, with a focus on barriers and facilitators to change.
Discussion: Findings from the focus group interviews will shed light on staff members' experiences of the education intervention, as well as the experiences of staff members who participated in transfer activities but not in the course itself. It is our expectation that the participatory design will facilitate long lasting behavior change in staff, resulting in patients feeling more involved in their care. Future studies will report on patient outcomes (empowerment and care satisfaction) as well as ward level outcomes. If the PCPC-intervention shows positive outcomes for patients and staff, it might be a model that other psychiatric care providers can use to enhance patient involvement and satisfaction with care.

S284. What drives the higher incidence of psychosis in London compared to Palermo?

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Background: Incidence of psychosis seems to be lower in Italy than in other European countries (Tansella *et al.* 1991; Lasalvia *et al.* 2012, Tarricone *et al.* 2012); however there are no studies comparing the incidence of psychotic disorder in Northern and Southern Europe.
Methods: Incidence and socio-demographic data on all psychotic patients presenting for the first time to the mental health services of Palermo were collected over a period of three years.
Palermo incidence rates were compared to South London rates obtained from the AESOP study (Kirkbride *et al* 2006). South London rates were reanalyzed excluding people aged 16-17 years and substance related psychoses. Second generation migrants (people who were born in UK belonging to ethnic minorities) were also excluded to make the sample comparable since migration in Palermo referred to people who were not Italy born. The term migrants was used in the present analysis to indicate non-native born British and Italians respectively.
Incidence rates of overall psychosis, schizophrenia, affective psychoses and other non-affective psychoses were compared in Palermo and in South London by indirect standardization (by age and gender and then by age, gender and migration) to take into account the differences in the population structures between sites. Standardized morbidity ratios (SMRs) and their reciprocal of overall psychoses, schizophrenia, other non-affective psychoses and affective psychoses were calculated.
Results: During the study period two hundred and four patients affected with a first episode of psychosis (FEP) were ascertained in Palermo. South London cases were 195. Standardized incidence rates of overall psychoses were 16.9 (95% CI 14.7-19.4) per 100,000 per year in Palermo and 36.8 (95% CI 31.8-42.3) in South London. Migrants had an increased risk of developing a psychotic disorder both in Palermo OR: 3.12 (95% CI 1.89-4.93) and in London OR: 2.9 (95% CI 2.15-3.93). After standardizing by age and gender the risk of psychosis was significantly higher in South London compared to Palermo for all psychoses 1/SMR = 2.18 (95% CI 1.98-2.39) and for each diagnostic category. After standardizing also for migration the difference in risk of overall psychoses between Palermo and London decreased: 1/SMR = 1.39 (95% CI 1.23-1.56) and no differences in risk were found any longer between Palermo and South London for schizophrenia and other non affective psychoses; there was however an increased risk of affective psychoses in South London compared to Palermo 1/SMR = 3.31 (95% CI 2.52-4.21). This result confirms that migration explains the majority of the difference in incidence rates between Southern Italy and London.
Discussion: This is the first epidemiological study of psychosis ever carried out in Sicily and one of the few from Southern Europe. The risk of psychoses was higher in South London when compared to Palermo. However no significant differences were found in rates of schizophrenia and other non-affective psychoses after taking into account the different proportion of migrants in the two sites suggesting that migration might explain the majority of the difference in the risk of psychosis. However, it did not explain all the difference as there was still an excess of affective psychoses in South London. Further studies are needed to explore the role of other risk factors (Mediterranean diet, vitamin D, social fragmentation, drug use) in influencing the risk of psychosis.

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