years from the initial evaluation. The diagnosis of DS and NDS was made by raters blind to initial categorization using the Schedule for the Deficit Syndrome. Clinical, neurocognitive and social outcome indices were also evaluated.

Results: The follow-up diagnosis confirmed the baseline one in forty-two out of 51 patients with DS (82.4%) and in 35 out of 54 with NDS (79.6%). Clinical, neuropsychological and social functioning characterization of patients with DS also revealed high reproducibility with respect to baseline assessment: anergia and negative dimension, social isolation and neurocognitive impairment (in particular general cognitive abilities and attention impairment) were more severe in patients with DS than in those with NDS. In neither group a significant deterioration of clinical, neurocognitive and social functioning indices was found, in line with previous studies in patients with chronic schizophrenia.

Conclusions: Study findings provide evidence for the long-term stability of Deficit Schizophrenia.

S36.04

Episodic memory in subtypes of schizophrenia

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Some authors observed episodic memory impairments in all the patients with schizophrenia. Others sustained that distinct episodic memory profiles could differentially be expressed across clinical subtypes (Brazo et al. 2002).

Aim: We wanted to investigate whether the different processes of episodic memory (encoding, storage and retrieval) were impaired differently from one clinical subtype of schizophrenia to another.

Methods: Sixty-one schizophrenic patients (DSMIV) were categorized into independent subtypes with the Positive and Negative Syndrome Scale and the Schedule for the Deficit Syndrome as follows : deficit (N=12), disorganized (N=9), positive (N=19) and residual (N=21) subtypes. Sixty-one healthy controls were matched on age, sex and educational level. Episodic memory was explored through the California Verbal Learning Test (CVLT) using all the clues.

Results: Three episodic memory profiles were identified in patients compared to controls : one was characterized by impaired encoding, the second by both impaired encoding and retrieval, the third by no significant impairment. Moreover, these profiles were distributed across all the clinical subtypes and none of them characterized a subtype in particular.

Conclusion: This study isolated similar cognitive patterns across the deficit, disorganized, positive and residual subtypes. The episodic memory heterogeneity was not linked with the clinical heterogeneity of schizophrenia.

Brazo et al. Cognitive patterns in subtypes of schizophrenia. European Psychiatry, 2002 ;17(3):155-162.

Symposium: How to organize integrated care in Europe?

S27.01

Integrated care in Europe - The Dutch model

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Mental health care in the Netherlands generally has been characterized by a relatively high number of hospital beds, and moreover during the last 15 years by an increase of sheltered living accommodation (also beds) in the community – without decreasing significantly the hospitals beds. Psychiatric hospitals have survived and transformed themselves into large organizations providing various forms of out-, day- and inpatient treatment programmes and sheltered living arrangements in a circumscribed geographical catchment areas. Deinstitutionalization has a special meaning in this context: no actual blocking of hospital admissions like in Italy or closing buildings like in the USA but more in the sense of gradually decreasing numbers long stay patients, of shortening duration of admission stay, providing within days a kind of aftercare (continuity of care), extending sheltered living accommodation in the community by independent institutes and outreaching community care. This process of extramuralization seems to be 'frustrated' or maybe 'facilitated' - depending on the eye of the beholder - by recent changes in the organization and financing of mental health care. Not the government but the providers and the insurance companies – and to a lesser extent the client resp family movement – will be decisive for the outcome. This could have far reaching consequences for the ultimate goal of integration of care.

S27.02

Integrated care in Europe - The case of Switzerland

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After the United States Switzerland provides the second most expensive health care system worldwide. Likewise in all other industrialized countries, there is an intensive debate about cost containment. In general care several models are under evaluation not only to reduce costs but also to improve quality of treatment and care in highly fragmented health care systems. These models deal with primary care providers as gate keepers or managed care. There is also a discussion about the introduction of DRGs in inpatient treatment.

There is not a comparable development at present in mental health care. There are few case management models tested, trying to integrate and coordinate a multitude of institutions involved in the treatment and care of chronically mentally ill. The most progressive trial is under consideration at the University of Zurich, where patients after admission to inpatient treatment immediately are referred either to continuing inpatient treatment or to acute day-hospital treatment or to outpatient treatment. This model is the closest on the way to a patient-centered model of treatment in care while the above mentioned models all try to deal with the disadvantages of fragmented institutional care systems.

S27.03

Integrated primary care mental health services in England - Issues in the care of patients with long term mental health conditions

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Mental health is a core issue in primary care and primary care is now becoming a key collaborator in developing and delivering quality mental health care with ongoing, underpinning support from a raft of government policy directives. These include the introduction of new roles into primary care such as Graduate Primary Care Mental Health Workers and the introduction of a number of new quality

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