2004. At the same time important changes took place in the service delivery. This might affectlong term outcome. Denmark is a fairly small and uniform country so dissemination of knowledge, formally as well as informally, spread quickly.

Aim: To describe changes in mental health service delivery, during the 10 years from 1995-2004. To compare delivery of services between the different centers in the study such as beds available, and outpatient services available. To compare basic features as DUP between the centers, and to look at use of services in terms of use of beds, and use of outpatient services between the centers.

Results: During the years of the investigation a growing political and public interest was directed towards First Episode Psychosis. Three large investigations, TIPS, OPUS and DNS were initiated and two of those were initially financed by the ministry of health, whereas they were initially rejected for funding from the Danish medical research council.

A lot of local publicity was attached raising awareness of detection and intervention in these years. This affects of course Treatment as Usual (TAU). Comparison of outcome between the centers participating in DNS show no great differences pointing to a consensus of best practise.

W02.05

Treatment as usual (tau) in the first episode psychosis (fep) with focus on continuity and compliance. The danish national schizophreniaproject

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Very few research projects describe the clinical routines and every day treatment procedures, and correlate these to the outcome.

Objectives: To determine the possible correlation between continuity of treatment and compliance and to register its impact on psychopathology and social functioning.

Method: Patients with first episode of F2 diagnosis in The Danish National Schizophrenia Project (N= 269) were consecutively included during a two years period to be followed up for five years. Data were collected concerning social functioning, psychopathology, continuity of relationship in treatment, treatment conditions, medication, psychotherapy, compliance and social support and training.

Results: 50% has no shift of primary treatment person in the first two years. Continuity was lower in the metropolitan areas, and especially if the patients had substance abuse. Protecting factors seems to bee continuity, female gender, rural area and psychotherapy.

Symposium: Are there schizophrenia subtypes?

S36.01

What psychopathology tells us about the nature of schizophrenia?

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Psychopathological symptoms are the hallmark characteristics in all schizophrenia constructs all along the history since non-clinical domains have never been included in any of the major diagnostic criteria systems applied to schizophrenia.

Despite the critical importance of the DSM system in psychiatric nosology, a problem that is still not completely solved is clinical heterogeneity of patients, which it is not the exception but the rule. The magnitude of the problem is well illustrated by an example: There are 25 different combinations of characteristic symptoms (Criterion A), 5 schizophrenia subtypes and 9 longitudinal courses for 'DMS-IV-TR' schizophrenia disorder. Taken together, 1125 different clinical forms are possible for the same diagnosis.

Categorical approach to the assessment of symptoms and syndromes/disorders should be supplemented by dimensional analyses both at clinical and research levels. In fact, treatments for schizophrenia patients are mainly selected by their predominant symptoms and not exclusively by their diagnoses.

S36.02

Deteriorating/no deteriorating cognitive subtypes within schizophrenia

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Cognitive impairment has been at the forefront of schizophrenia research and clinical interest for the last 2 decades. The prevailing clinical impression is that individuals who meet criteria for schizophrenia also suffer from easy observable and at times severe cognitive impairment. However, when large populations of schizophrenics undergo classic psychological testing, the normal distribution of their composite scores is "shifted to the left" only moderately. There exist a very large overlaps between patients and controls in terms of cognitive scores regardless of the tests employed. An hypothesis that would reconcile the clinical observations with the research data on large population would suggests that the quality and degree of cognitive impairment that cognitive impairment in schizophrenia is heterogeneous both in quality and severity and that some subgroups of individuals perform within or above normal range on all aspects of cognition. Adding to this heterogeneity is the fact that for some individuals the cognitive impairment is static while for others it is progressively declining.

Since different aspects of cognitive impairment might have different biological substrate, investigating and sub-typing cognitive impairment could be essential to finding a therapeutic remedy.

S36.03

Longitudinal stability and long-term outcome of schizophrenia deficit and nondeficit subtypes

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Background and Aims: The concept of Deficit Schizophrenia (DS) is considered one of the most promising attempts to reduce heterogeneity within schizophrenia. Few prospective studies tested its longitudinal stability and ability to predict clinical features and outcome at five years follow-up.

Methods: In the present study 51 patients with DS and 43 with Nondeficit Schizophrenia (NDS), previously included in an Italian Multicenter Study on Deficit Schizophrenia, were reassessed after 5

https://doi.org/10.1016/j.eurpsy.2008.01.184 Published online by Cambridge University Press

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

D. Wiersma. *Department of Psychiatry, University Medical Center, University of Groningen, Groningen, The Netherlands*

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

W. Rössler. *Department of General and Social Psychiatry, Psychiatric University Hospital, Zurich, Switzerland*

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

https://doi.org/10.1016/j.eurpsy.2008.01.184 Published online by Cambridge University Press