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

P. Brazo [1,2], M. Ilongo-Lietout [1], S. Dollfus [1,2]. [1] *Departement of Psychiatry, Centre Hospitalier Universitaire, Caen, France* [2] *UMR 6194 CNRS, Cyceron, Caen, France*

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

E.J. England [1,2,3]. [1] *Department of Primary Care and General Practice, The University of Birmingham, Edgbaston, UK* [2] *National Institute of Health Researcher Development Award Holder, Department of Health, UK* [3] *Laurie Pike Health Centre, Birmingham, UK*

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.2008.01.188 Published online by Cambridge University Press

outcome indicators to the new GP contract and the opportunity for GPs to undertake commissioning of mental health services.

Recently changes to the new GP contract have increased the focus on reliable diagnosis, monitoring and management of chronic mental health problems in primary care. In addition, the new roles, designed to help in the support and management of individuals with mental health problems offer an alternative to traditional ways of managing mental health problems in primary care. These innovative changes have impacted on traditional ways of working and helped promote a more collaborative integrated approach to care of patients with SEMI.

Despite this emphasis on improving organisational relationships and partnership working through the introduction of these new policy initiatives, evidence suggests that the implementation of policy and development of mental health services, has to date been varied. The experience of those working within, and delivering mental health services suggests a rhetoric reality gap between policy formulation, implementation and service organisation and delivery. This has particular implications for people with mental health problems, many of whom have little choice or voice within society and need integrated services.

S27.04

First results of integrated care in Germany

F. Schneider [1], T. Kircher [1], F. Bergmann [2]. [1] *Department of Psychiatry and Psychotherapy, RWTH Aachen University, Aachen, Germany* [2] *Association of German Psychiatrists and Neurologists*

Psychiatric diseases already have a great impact with regard to personal and social impairment and socioeconomic costs. The burden of psychiatric diseases on societies is even expected to grow in the years to come. The WHO for example predicts that Major Depression will be the disease with the most disability-adjusted-life-years (DALY's) by the year 2030 in the industrially developed countries.

New approaches and concepts for the treatment of psychiatric illnesses are therefore needed in research and in care.

A critical point will be the establishment of timely, goal-orientated and scientifically founded therapeutic interventions (e.g. according to national or international treatment guidelines) in psychiatric diseases. Such an improvement of the structures of psychiatric care is to be expected by the new models of integrative care.

The "Integrated care of depression" has been established in the Aachen region in 2006 as a model for a best-practice cooperation of inpatient and outpatient care. The aims of this network are the early detection of depression, the optimization of the treatment, the prophylaxis of relapses and especially the improvement of the transitions between the medical practitioners, other therapists and the hospitals involved.

An improvement of the care of psychiatric diseases will be one major step in the quest to prepare the society for the burden of psychiatric diseases to come in the near future.

Symposium: Common mental disorders in sub-Saharan Africa what lessons for the developed world?

S52.01

What can we learn from the history of psychiatry in Africa?

O. Gureje. *Department of Psychiatry, University of Ibadan, Ibadan, Nigeria*

Alien psychiatrists, most of them from Europe, provided what was known about the mental health and illness of Africans until a few decades ago. Even after departure from the shores of Africa, their views remained dominant among indigenous psychiatrists. Many of those views were based on limited empirical evidence. Some other views, based on well-conducted research, may have been affected by the perennial problem of valid ascertainment of mental and social phenomena. Recent studies, many of them conducted by local scientists, are beginning to offer different perspectives about the nature and profile of mental illness among Africans but are themselves not immune to paradoxes. An examination of both old and new perspectives provides an opportunity to reflect on the challenges of research in psychiatry and how far we still are from achieving consensus.

S52.02

Common mental disorders in sub-Saharan Africa - What lessons for the developed world

F.G. Njenga. *African Association of Psychiatrists & Allied Professions, Nairobi, Kenya*

This symposium will bring together leading mental health specialists from Europe and Africa. It will aim at describing patterns of common mental disorders on both continents and will also seek explanations for any observed differences. The objective of the symposium will be to bring out lessons that can be learnt from the two continents with the expectation that these lessons will not only bring about a better understanding of the mental disorders, but that opportunities for joint research projects between Europe and Africa will be explored, using existing research data from the two continents. The symposium will explore the fields of the psychosis and seek to bring out the current state of the debate on the prognosis of, for example, Schizophrenia in Africa versus Europe as the Africans present the latest findings from their continent. Conversion syndromes, Anorexia Nervosa, drug and substance abuse are all conditions that show patterns that are different in the two continents and pose new and challenging opportunities for collaborative research. Though present on both continents, PTSD and the challenge of HIV/AIDS is greater on the African continent partly due to social, economic and political factors that seem to fuel both. European psychiatrists might value opportunities to hear the state of these conditions in Africa and the way Africa is responding to the challenge.

S52.03

Psychosocial responses to HIV/AIDS pandemic in sub-Saharan Africa

F. Kigozi [1,2]. [1] *Butabika National Psychiatric Referral & Teaching Hospital, Kampala, Uganda* [2] *Uganda Psychiatric Association, Kampala, Uganda*

Epidemiological findings and projections indicate that over two-thirds of all the people now living with HIV/AIDS globally live in Africa, South of the Sahara desert and over 80% of the World's AIDS deaths have been reported in the region and yet Africa has only 22% of the world's population with very limited resources.

The paper outlines the current HIV/AIDS epidemiological status in Sub-Saharan Africa, the common psychiatric presentations as well as the magnitude of the psychosocial effects including that of orphanhood. The Health care systems and the available resources are reviewed as they influence psychiatric responses in the region.

https://doi.org/10.1016/j.eurpsy.2008.01.188 Published online by Cambridge University Press