from a common Normal distribution of treatment effects with an overall SSRI class effect, and the treatment within class heterogeneity. RESULTS: There were 55 eligible studies identified in the systematic review. The relationship between the greatest decrease in YBOCS was behavioural therapy ("exposure and response prevention") showing a decrease of 13.86 (95% CI 3.4 to 24.3) and a second greatest was cognitive-behavioural therapy ("cognitive therapy") with a decrease of 12.62 (95% CI 6.3 to 18.9) and a third greatest was social skills training ("social skills training") with a decrease of 2.49 (95% CI 1.8 to 3.1). CONCLUSIONS: Given consistent effects of social contacts on reduction of negative symptoms and improvement of QoL in schizophrenic patients, social contacts should be used as a therapeutic tool. A higher frequency of social contacts could be obtained by regular therapeutic groups offered to these patients.

PMH10
RELATIONSHIP OF INSIGHT WITH MEDICATION ADHERENCE AND THE IMPACT ON OUTCOMES IN PATIENTS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER: RESULTS FROM A 1-YEAR EUROPEAN OUTPATIENT OBSERVATIONAL STUDY


OBJECTIVES: To estimate the clinical effectiveness of augmentation with either lithium or an AIP in TRD, defined as failure to respond to two or more antidepressants in the current episode of depression. METHODS: Systematic review of CENTRAL, EMBASE, MEDLINE, and PsychNFO was completed in August 2011. Additional data were obtained from manufacturers. Studies were assessed for quality using the Cochrane Risk of Bias Tool. pairwise meta-analysis and random effects meta-analysis (MTE) were undertaken based on intervention type. RESULTS: Of the 3,721 papers found in the literature search, 12 randomised controlled trials (RCTs) were identified; 10 (SSRI + AIP vs SSRI + placebo), one (SSRI vs AIP), and one (SSRI + lithium vs SSRI + placebo). The RCTs included in the primary analyses used fluoxetine as the SSRI and olanzapine as the AIP. Results of the MTE showed a significant difference in favour of lithium vs placebo; OR 0.75 (95% CI 0.57 to 1.0, p = 0.04) and neurectomized vs lithium placebo, OR 0.72 (95% CI 0.53 to 1.0, p = 0.04). However, the results were not significant when the analysis was repeated with a random effects model, OR 1.14 (95% CI 0.77 to 1.69, p = 0.48). CONCLUSIONS: Lithium was not superior to placebo in terms of treatment outcomes, and its use should be considered in the context of other factors.

PMH11
SOCIAL CONTACTS REDUCE NEGATIVE SYMPTOMS, ESPECIALLY EMOTIONAL WITHDRAWAL IN SCHIZOPHRENIA

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OBJECTIVES: In schizophrenia, negative symptoms - especially emotional withdrawal (EW) - represent an important dimension, and are associated to a significant burden. Social contacts are likely to reduce negative symptoms and ameliorate quality of life (QoL) over time. Our objective was to test whether this association was verified in a large cohort of European patients with schizophrenia. METHODS: We used data from the EuroSch study, a longitudinal cohort of 1208 patients with schizo-
v"
OBJECTIVES: Major depressive disorder affects approximately 10-15% of the popu-
lation, with a significant morbidity and mortality. It is one of the leading causes of disability in young adults. A large proportion of the burden can be attributed to treatment-resistant depression (TRD). To understand the prevalence and disease burden of TRD in Western European countries, the US and Canada, a systematic literature search was performed. Two electronic databases and the CRD database were used to retrieve TRD publications in English language from January 2003-October 2013. In total, 6306 abstracts were identified. Predefined selection criteria regarding study design, patient population (age ≥12 years, US; Canada, Germany, Italy, France, Spain or UK; TRD defined as one treatment failure and high symptom severity e.g. MADRS ≥31, or an inadequate response to ≥2 antidepressants) and outcomes of interest were applied. RESULTS: Only seven studies included prevalence and/or disease burden data. Five studies provided previ-
ous estimates which adhered to the strict TRD definition used for this review. Study design and definition of the patient population were critical in determining the prevalence rates, with the highest rates in US employer claims databases (11-15%), higher rates in commercial health insurance databases (29-31%) and the highest rates in a European multicenter study (51-56%). The database studies mainly included employed patients thereby likely underestimating the prevalence, whereas the hospital cohort studies most likely overestimated the prevalence due to a less stringent TRD definition. Inconsistent data were reported regarding treatment outcomes, comor-
bidities, hospitalization and work productivity. There was no information on other outcomes such as health-related quality of life or functioning. CONCLUSIONS: No consistent data were found in the literature from January 2003-October 2013 regarding the epidemiology and disease burden of TRD. To determine the prevalence and disease burden for TRD, further studies are needed.

PMH15 PREVALENCE OF METABOLIC SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA ACCORDING TO THE PRESENCE OR ABSENCE OF NEGATIVE SYMPTOMS
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OBJECTIVES: The aim of this study was to estimate the prevalence of metabolic syn-
drome (MS) in patients with schizophrenia according to the presence or absence of negative symptoms. METHODS: A retrospective, cohort study was conducted using electronic medical records from the health provider BSA (Badalona, Spain). All adult outpatients with a diagnosis of schizophrenia were followed for 12 months. Two study groups were defined by the presence or absence of negative symptoms based on the PANSS Marder Negative Symptoms Factor (N1-N4, N6, G7 and G16). MS prevalence was estimated using the NCEP ATP III criteria. Descriptive statistics and logistic regres-
sion analysis were applied. RESULTS: We studied 1,120 patients (mean age: 46.8 ± 13.8 years, male 58%). One or more negative symptoms were present in 52.5% of patients (CTQ scale ≥20). Dyshidriosis (64.7%) and anxiety (38.2%), diabetes in mellitus (19.3%) were the most frequent comorbid conditions. Quetiapine, risperidone and olanzapine were the most common antipsychotic drugs administered. Patients with negative symptoms showed a greater mean number of comorbid conditions than patients without this symptomatology (8.5 and 7.0, respectively; p<0.001). Prevalence of MS was 38.6% (CI: 35.7-41.5%), higher among patients with one or more negative symptoms (43.9% vs. 34.9%, respectively; p=0.002). MS was associated with the pres-
ence of negative symptoms, duration of illness, age, and comorbidity variables (p<0.05). CONCLUSIONS: Further studies are necessary to elucidate the association between the presence of negative symptoms and MS among patients with schizo-
phrenia as well as the underlying mechanisms involved.

MENTAL HEALTH – Cost Studies

PMH16 THE POTENTIAL BENEFITS OF LONG-ACTING ATYPICAL ANTICYPHOTHERAPY IN PATIENTS’ RELAPSE IN BRAZIL
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OBJECTIVES: Buprenorphine/naloxone (BUP/NAL) combination is a well known treatment for opioid dependence. As a chronic relapsing disorder, some patients alternate between periods of on treatment and off treatment. The aim of this study was to compare health care resource utilization and related costs between these two groups. METHODS: Statistical analyses were conducted on a Medicaid insurance claims database (Truven Health MarketScan® Medical Claims Data 2012). Patients with at least two treatment episodes in the first year after the initial filled prescription were identified. The end of a treatment episode was defined as a period of 60 days with no filled BUP/ NAL prescriptions following the theoretical end of the last filled prescription. An ordered logistic regression model was used to analyze the impact of the first treat-
ment episode duration on the number of new episodes in the year following the end of the first episode. Health care resource utilization and related costs during the first year of treatment were compared between the two groups. RESULTS: 2,223 patients were included in the analysis. During the first year, 86% of patients had only one treatment episode, 13% had two and 1% had three. Compared to patients who remained in treatment continuously over 12 months, the multiple treatment episode group had lower medication costs ($2,877) but higher psychi-
atric inpatient costs ($720), non-psychiatric inpatient costs ($420) and emergency room costs ($1,430) over 12 months. Total health care costs over 12 months were $16,585 vs. $15,123, p=0.0004. CONCLUSIONS: Despite lower medication costs, total health care costs over 12 months were higher among patients with multiple treatment episodes compared to patients continuously treated.

PMH17 ANALYSIS OF ‘REVOLVING DOOR’ PATIENTS IN OPIOID DEPENDENT PATIENTS: THE IMPACT OF TREATMENT DISCONTINUATION ON RELAPSE RATES AND HEALTH CARE COSTS IN THE US PUBLIC HEALTH INSURANCE CLAIMS
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OBJECTIVES: To quantify the economic burden of schizophrenia relapse in
the USA. The economic burden of schizophrenia relapse in Canada and the US from January 2011-2012 was estimated. Conclusions: The economic burden of schizophrenia relapse in the USA was $11.59-17.97119 billion. Treatment with atypical LAIs reduced hospitalization and related costs by 37% compared to oral antipsychotics. Further studies are needed to confirm these results.

PMH18 TREATMENT COST COMPARISON: PALIPERIDONE PALMATITE VERSUS RISPERIDONE LONG ACTING IN BRAZIL
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OBJECTIVES: To compare the treatment cost of paliperidone palmitate (PP) versus risperidone long acting (R-LA) both indicated for the treatment of schizophrenia in Brazil. METHODS: In Brazil, both (PP and R-LA) long acting 2nd generation antipsychotics are approved for the treatment of schizophrenia. Published literature shows that: PP is more effective than R-LA in relapse prevention, therefore, a budget impact analysis was performed. Yearly treatment costs were calculated for an average dose of 37.5 mg per patient in the case of R-LA and 75 mg in the case of PP. The two initial treatment doses were considered for: PP, 150 mg on the 1st day and 100 mg on the 2nd day, and for R-LA 21 daily oral supplementation with 3 mg of risperidone, accord-
ing to dosing intervals defined in the product label. Prices were gathered from the official price list (CMED – Apr 16). RESULTS: PP has the lowest cost of treatment, at $6989 for Non-TRD patients during the first year - against R-LA $8,165 – and for TRD $11,359 for the 2nd year (R-LA has $17,971). Treatment with PP compared to R-LA may bring important savings to the payers (HMOs or Government), with potential to reduce the cost of treatment by 30% in the 1st year, and 37% in the 2nd year - allowing a higher number of patients to be treated at the same budget level. CONCLUSIONS: Although both molecules, PP and R-LA, have demonstrated similar efficacy, PP offers further cost saving for the major private health care system compared to R-LA. In addition, PP offers advantages that can have additional value for public and private payers alike such as a monthly injection and no need for cold chain. PP can therefore be considered a cost-saving therapeutic option for schizophrenia compared to R-LA.

PMH19 COSTS OF EMPLOYEES WITH TREATMENT-RESISTANT DEPRESSION BASED ON A CANADIAN PRIVATE CLAIMS DATABASE
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OBJECTIVES: To investigate the cost of Treatment-Resistant Depression from a private payer perspective in Canada. METHODS: An employer-sponsored benefits plan data-
base (2011/2012) was used to define a cohort of Non-TRD and TRD claimants. TRD claimants were defined as those on their third antidepressant monotherapy, or combination antidepressant therapy, or antidepressant augmented with lithium, thyroid hormone or an antipsychotic medication. The cost of prescription medica-
tion utilization, short-term disability (STD), and long-term disability (LTD) benefits for employees was calculated (2011 and 2012 SCAN) for both Non-TRD and TRD groups. Descriptive statistics were used to characterize the cohort of claimants and employees, as well as resources and costs for employees. RESULTS: There were 55,324 and 61,028 employee claimants in 2011 and 2012, respectively. 717 (1.3%) were Non-TRD claimants, 4,744 (8.4%) were Non-TRD and 80 (0.1%) were Non-TRD claimants in 2011 and 2012, respectively. In 2011, the medication costs for treating depression was $774 per TRD employee claimant compared to $303 per Non-TRD employee claimant. STD costs were $6,263 for TRD (n=79) and $5,855 for Non-TRD (n=276). LID costs were $13,598 for TRD (n=80) and $12,272 for Non-TRD (n=119). In 2012, the medication costs for treating depression per TRD employee claimant was $794 compared to $293 for Non-TRD claimants. STD costs were $7,832 for TRD (n=80) and $6,468 for Non-TRD (n=276). LID costs for TRD (n=89) and $12,901 for Non-TRD (n=121). CONCLUSIONS: Claimants identified with TRD had higher medication, STD and LTD costs than those with Non-TRD. Limitations include lack of diagnostic information for claimants and small sample sizes for STD and LTD subgroups.