an update on the economic costs related to nonadherence to antipsychotics. METHODS: A systematic MEDLINE search for the years 1995–2004 was conducted to identify published English-language articles on the economic impact of medication nonadherence in schizophrenia. A manual search was also performed using the references of retrieved articles to identify additional studies. For a study to be included, the direct healthcare costs or the inpatient days related to nonadherence must have been specifically assessed or estimated. We extracted data on nonadherence rate, relapse rate, and inpatient days based on the identified studies, and derived the daily hospital costs for schizophrenia in 2001 from National Inpatient Sample of Healthcare Cost and Utilization Project. We then extrapolated the data to national level to obtain an estimate on the inpatient costs related to nonadherence to antipsychotics. RESULTS: A total of 7 studies were identified and assessed according to their study design, measurement of medication nonadherence, study setting, and cost outcome results. Although adherence measures varied across studies, all the studies reviewed showed that nonadherence to antipsychotic drugs was related to an increase in hospitalization rate, hospital days or hospital costs. Based on the results from selected studies, we estimated that the national rehospitalization costs related to nonadherence to antipsychotics ranged approximately from $609 million to $979 million in year 2001. CONCLUSIONS: There is a consensus in the literature that poor adherence to antipsychotic medications was associated with higher risk of relapse and rehospitalization and higher hospitalization costs. Future investigations need to search more effective interventions targeting specifically to nonadherent patients to improve patient outcomes and reduce health care costs.

PMH45 DURATION OF ANTIPSYCHOTIC SWITCHING PROCESS IN THE NATURALISTIC TREATMENT OF SCHIZOPHRENIA

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OBJECTIVES: To assess the duration of antipsychotic switching process in the naturalistic treatment of schizophrenia. METHODS: This post hoc analysis used data from a randomized, open-label, one-year trial of olanzapine, risperidone, and typical antipsychotics in the treatment of schizophrenia (N = 664), in which switching of antipsychotics was permitted, when clinically warranted. No suggestions were provided to clinicians as to which switching strategy to use or how long the switch process should last. The number of overlapping days between antipsychotics during each switch was calculated for all switching episodes in the study (N = 217), by antipsychotic type (typical, atypical), and by specific atypical antipsychotic (olanzapine, risperidone). RESULTS: Most of the switching between antipsychotics (58.5%) was abrupt, with complete discontinuation of the previous antipsychotic the same day or a day after the start of the new antipsychotic. Abrupt switching was most prevalent between the 2 atypical antipsychotics (75.9%), and least prevalent when switching from any typical to atypical antipsychotics (47.0%). The next most prevalent switching strategy involved cross titration lasting 1–7 days (16.0%). CONCLUSIONS: Abrupt switching appears to be the most prevalent antipsychotic switching strategy. Abrupt switching was previously found to provide outcomes comparable to other antipsychotic switching strategies in the treatment of schizophrenia.

THE MISSION IS REMISSION—HEALTH ECONOMIC CONSEQUENCES OF ACHIEVING REMISSION WITH ANTIDEPRESSANT TREATMENT FOR DEPRESSION

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OBJECTIVE: Depression is a prevalent psychiatric disorder associated with impaired patient functioning and reductions in health-related quality of life (HRQL). The present study describes the impact of depression on patients’ HRQL and assesses the impact of antidepressant treatment on HRQL. METHODS: A total of 447 patients were recruited at 56 primary care centres to this naturalistic longitudinal observational study. Patients over 18 years with depressive symptoms, and who initiated a new antidepressant therapy were included in the study. Data on patients’ socio-demographics, daily activity and quality-of-life (EQ-5D) were collected using questionnaires completed during outpatient GP visits for a follow-up period of 6 months. Disease severity was assessed with the Clinical Global Impressions Severity scale (CGI-S). Regression analysis was employed to analyse the determinants of quality-of-life in depressed patients. RESULTS: The mean EQ-5D utility score at baseline was 0.47 (0.44–0.49). Milder cases of depression reported a health utility of 0.60, whereas moderately and severely depressed patients reported utility values of 0.46 and 0.27 respectively (p < 0.001). At end of follow-up the average utility in the sample was 0.69 (0.67–0.72), corresponding to an increase in utility by 0.23 over 6 months (p < 0.0001). Our regression model showed that, all else equal, patients who were on sickleave were associated with 10% lower utility (p < 0.0001). Moreover, increased disease severity (assessed with CGI) was associated with decreased health-related quality of life. By treating the patient to achieve clinical remission is associated with higher quality of life and the presence of co-morbidity is associated with decreased quality-of-life. CONCLUSIONS: Depression has a substantial impact on health-related quality of life of the patient. Our results indicate that antidepressants are associated with significant improvement in EQ-5D index score over a course of 6 months. Self-reported patient valuations are important outcomes for cost-effectiveness analysis of new antidepressant compounds.