(in past four weeks, yes/no), and comorbid diagnosis of substance use disorder (yes/no). **RESULTS:** The average annual mental health cost was highest for patients who attempted suicide (yes $46,024, no $15,865), followed by patients with psychiatric hospitalization in the past six months (yes $37,329, no $12,229), patients with arrests (yes $31,081, no $15,655), prior violent behaviors (yes $18,778, no $16,113), and those with comorbid substance use disorder (yes $19,034, no $15,038). **CONCLUSIONS:** Crisis-prone patients, particularly those with a recent suicide attempt or psychiatric hospitalization tend to incur substantial mental health costs. Findings also suggest that patients who are involved in the criminal justice system also accrue high costs within the mental health delivery system.

MH3

SUPPORT FOR CLASSIFICATION OF DEPRESSION OUTCOMES INTO LONGITUDINAL PATTERNS: EVIDENCE FROM A POPULATION-BASED STUDY OF THE ELDERLY

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OBJECTIVE: To examine the longitudinal relationship between depression outcomes and subsequent functional disability (FD) in the non-institutionalized elderly. **METHODS:** Secondary data analysis was performed using the population-based Assets and Health Dynamics of the Oldest Old (AHEAD) cohort (age ≥70 years). Depression was considered present if four or more depressive symptoms were reported on the modified Center for Epidemiological Studies-Depression Scale (CES-D). CES-D scores from baseline, two-year and five-year follow-up allowed the characterization of seven distinct patterns of depression (plus never depressed): remittent, endogenous, emergent, remitting persistent, recurrent, emerging persistent and persistent. FD was operationalized as the ability to perform six activities of daily living (ADL) and five instrumental ADL. The subsequent impact of depression patterns on FD scores (at two, five and seven-year follow-up) over time was analyzed using mixed-effect regression models. **RESULTS:** Of the 8222 initial respondents, 57% were considered ineligible. Among the remaining 3476 respondents, half were never depressed. Pattern-based FD mean (SD) scores were: remittent 1.4 (2.4) (n = 166); endogenous, 1.4 (2.2) (n = 136); recurrent, 2.03 (2.6) (n = 63); emergent 1.2 (2.2) (n = 332); remittent persistent 1.9 (2.5) (n = 64); recurrent 2.0 (2.6) (n = 103); emerging persistent 2.1 (2.6) (n = 108) and persistent 2.1 (2.5) (n = 144). After adjusting for age, gender, and comorbidity, and baseline FD, all patterns had significantly more FD than those never depressed, with the exception of the remittent pattern. Compared to an emergent pattern, emerging persistent (difference = 0.69 (0.19), p < 0.001) and persistent pattern (difference = 0.49 (0.15), p < 0.001) had higher mean FD over time. **CONCLUSIONS:** The elderly with depression have more FD compared to those never depressed, but FD can improve with the remission of depression. Important differences in FD scores between depression patterns were observed (i.e. effect sizes >0.5), providing health outcomes-based support for a pattern-based classification of longitudinal depression.

MH4

EFFECT OF SECOND-GENERATION ANTIDEPRESSANT DISCONTINUATION ON DEPRESSIVE RELAPSE IN ADULT PATIENTS WITH BIPOLAR DEPRESSION

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OBJECTIVES: There are almost no data addressing antidepressant's long-term prophylaxis use that both establishes the mood stability and delays depressive episodes in patients with bipolar disorder. This study concentrated on the question that whether patients who continued taking antidepressant beyond 6 months after depressive remission are less likely to have depressive relapse than patients who discontinued early, with a focus on modern second-generation antidepressant medications. **METHODS:** A total of 589 bipolar subjects were identified with interested antidepressant use after a depressive remission, followed by at least 6-months of continuous enrollment in a national managed care plan between January 1998 and December 2002. Duration of pharmacotherapy was defined based on the computerized diagnosis and pharmacy records. A Cox proportional hazard model was developed to predict time from depressive remission to next depressive relapse with continuous antidepressant use either longer or shorter than 6 months. Propensity score method with greedy matching was employed in addition to further balance the observed background covariates and baseline disease severity between comparison groups. **RESULTS:** The Kaplan-Meier estimate of the sample from propensity score matching showed that time to 50% survival with continuation and discontinuation groups were 16.5 months and 6.8 months respectively. The log-rank homogeneity test of survival curves indicated a significant difference (p < 0.05). The Cox model identified a significantly lower risk of depressive relapse among those who continued antidepressant treatment beyond 6 months after remission than those who discontinued treatment within 6 months, with a statistically significant hazard ratio of 0.61 (95% CI: 0.42–0.88). **CONCLUSIONS:** This study suggests the potential adverse outcome of removing an antidepressant treatment after depressive remission in patients with bipolar disorder. Given the concerns regarding a risk of switching into mania by antidepressant use, an optimal prophylaxis treatment after depressive remission should balance risks between depressive relapse and manic switch.