p=0,002); lower scores at GDS (PS=24,3±0,81 vs NPS=28,3±1,10 p=0,002) Comorbidity for general mediacal conditions, PS and NPS differed significantly in neurologic illness (PS=11,71±2,21 vs NPS=10,21±2,1; p=0,012) AT ADL, PS scored significatively lower (PS: 12,01 ±2,01 vs NPS=15,12±2.10; p=0,032). Regarding temperamental aspects, no statistically significant.

Conclusions: The group PS results characterized by male patients, late onset, higher level of greater in anxious symptomatology, lower scolarity and intellectual disorders: memory and concetration deficit, scores significatively higher in the single subscales of somatization, obsessive–compulsive and psychotic at SCL-90. The subtype with psichotic symptoms presents higher comorbidity for general medical condition, statistically significant for neurologic and severity in disability. Regarding temperamental dimensions, there aren't differences statistically significant.

P23.10

Onset in elderly depressive patients

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Objective: The study aimed to evaluate the symptomatic and temperamental differences in patients with diagnosis of Major Depressive Disorder on the basis of Onset.

Methods: a sample of 105 patients with a DSM-IV diagnosis of Major Depressive Disorder, were divided into two groups on the basis of onset: Early Onset = <60 years(Early Onset=EO, 62 patients) and Late Onset = >60 years (Late Onset= LO, 43 patients). The patients were assessed by means of HAMD+ atypical symptoms, HAMA, GDS, MADRS, CSDD, ADL, AIDL, BADL, QL-Index, SCL-90, MMS and CIRS for Comorbidity with general medical condition.

Results: There was a significant difference in mean age between two groups EO and LO (EO: 55,9±1,8 vs LO: 64,3±2,1; p=0,002). EO differs significantly from LO in basis of sex (EO= female: 39.1% vs male: 10.9%; LO= female: 15% vs male 26% on sample of 105 patients). At HAM-A the items phobias and cognitive disorder differ significantly in two groups: (item 3 EO=2,11±1,12 vs LO= 2,14±1,08 p=0,005; item 5 EO= 1,06±0,59 vs LO=2,42±1,62 p=0,022). At SCL-90, EO scored significatively higher in the total value of subjective symptomatology (EO= 130,11±22,10 vs LO= 79,5±12,81; p=0,011) and in the single subscales of Interpersonal Sensitivity (EO= 11,16±8,05 vs LO=9±5; p=0,005), Depression (EO= 21,31±11,5 vs LO= 12,8±7,11; p=0,004), Anxiety (EO= 16,21±6,20 vs LO=11,5±6,1; p=0,004), Rabies-Hostility (EO=2,12±2,4 vs LO= 6,4±2,1; p=0,012). EO showed total score significatively higher at GDS (EO= 27,1±0,2 vs LO=24,2±1,4; p=0,005). At HAMD the items of initial insomnia, somatic anxiety, hypochondria and atypical symptoms are significantly different between EO and LO (item 5 EO= 1.34±1.12 vs LO= 1.12±0.21 p=0,002; item 11 EO= 2.41±1.01 vs LO= 1.21±1.01 p=0,005; item 15 EO= 2,01±0,48 vs LO= 2.21±1,41 p=0,005; Total Score "atypical symptoms" EO= 1.14±1.10 vs LO= 1.41±0.18 p=0,005). Comorbidity for general medical conditions, EO and LO differed significantly in cardiac illness (EO= 12,72±4,36 vs LO= 21,6±4,2; p=0,005), respiratory illness(EO= 11,70±4,21 vs LO= 18,4±4,2; p=0,005). Regarding temperamental dimensions EO differed from LO in significantly higher scores in Harm Avoidance (EO: 26,4±3,3 vs LO: 24,5±6,2; p=0,002), in Novelty Seeking with subitem NS4 (EO=5,9±1.8 vs LO= 3.2±1.2, p=0.005); and lower scores in Persistence (EO: 2.8±1,2 vs LO: 4.61±1,2; p=0,004).

Conclusions: The Patients with early onset result characterized by an higher level of severity in symptomatology, a greater duration of disorder, depressive and anxious symptomatology. LO presents higher intellectual disorders: memory and concentration deficit, comorbidity for general medical condition, total score "atypical symptoms" and rabies-hostility. Regarding temperamental dimensions EO presents significantly higher scores in Harm Avoidance, Novelty Seeking and lower scores in Persistence.

P23.11

Gender differences in geriatric depression

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Objective: To evaluate gender differences both in symptomatic and temperamental aspects, comorbidity with general medical condition in elderly depressive patients.

Methods: a sample of 61 female (F=58.1%;mean age 62.4±1.2) and 44 males (M=41.9%;mean age 66.1±1.1) consecutively admitted in the Center for the study of Depression Disorder in elderly people of the Psychiatric Clinic of the University of Parma with a DSM-IV diagnosis of Major Depressive Disorder, were assessed by means of HAMD+ atypical symptoms, HAMA, GDS, MADRS, CSDD, ADL, AIDL, BADL, QL-Index, SCL-90, MMS and CIRS for Comorbidity with general medical condition.

Results: At HAM-A the items of subjective tension, phobias and cognitive disorder differ significantly in two groups: (item 2 F=1.23±1.10 vs M=1.01±0.42 p=0,032; item 3 F=1.71±1.11 vs M= 1.10±1.05 p=0,002; item 5 F=1,02±0,89 vs M=2,72±1,52 p=0,044). At SCL-90, female patients scored significatively higher in the total value of subjective symptomatology (F=128,14±45,30 vs M=88,5±22,59; p=0,012) and in the single subscales of Obsessive–compulsive (F=18,22±7,32 vs M=8,17±2,4; p=0,018), Interpersonal Sensitivity (F=12,18±9,07 vs M=10±5; p=0,002), Depression (F=22,36±10,5 vs M=15,8±7,2; p=0,002), Anxiety (F=19,41±8,22 vs M=12,5±7,2; p=0,005), Rabies-Hostility (F=2,5±4,4 vs M=8,4±2,3; p=0,026). Women showed total score significatively higher at GDS (F=28,1±0,4 vs M=23,2±1,6; p=0,005). At HAMD the items of initial insomnia, somatic anxiety, hypochondria, weight loss, insight are significantly different between female and male patients (item 5 F=1.24±1.11 vs M=1.21±0.22 p=0,012; item 11 F=1.81±1.21 vs M= 1.20±1.02 p=0,005; item 15 F=1,01±0,49 vs M=2,22±1,51 p=0,011; item 16 F=1,22±0,29 vs M=2,32±1,21 p=0,005; item 17 F=1,61±0,21 vs M=3,21±1,01 p=0,002). Comorbidity for general medical conditions, male and female patients differ significantly in cardiac illness (F=21,72±5,96 vs M=16,8±4,4; p=0,001), respiratory illness(F=21,72±5,96 vs M=16,8±4,4; p=0,001) and endocrinologic illness (F=21,72±5,96 vs M=16,8±4,4; p=0,001). AT TCI, temperamental dimensions such as Harm Avoidance (HA1:fear of uncertainty vs confidence F=4.22±1,0 vs M=2.21±1,2; p=0,010) Reward Dependence total (F=16,6±1,8 vs M=12,1±4,3;p=0,007) and single items RD1 (sentimentality vs insensitivity: F=4,4 ±1,5 vs M=3,6±2,3;p=0,002), RD3 (attachment vs detachment: F=4,7±1,1 vs M=2,1±1,4;p=0,005) were all over-representedin female patients. Character differs between F and M: almost all dimensions of Self directedness were significantly higher in M than in F (Self directedness tot, F: 18,8±2,8 vs M: 26,8±5,2; p=0,001. Purposefulness vs lack of goal direction, F: 2.1±1. vs M: 2.5±1.0; p=0.002. Self-acceptance vs self-striving, F: 2.1±1. vs M: 3.2±1.2, p=0.002) and Cooperativeness (C total: F=26,32±3,1 vs M=15±4.3; p=0,025) was significantly reducted in male patients.

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Conclusions: These results suggest that the two groups different in symptomatology and temperamental aspects. In particular, female patients present an higher level of severity in symptomatology and in temperamental aspects for all dimensions temperamental. Male patients present character features significantly higher in all dimensions of Self directedness and reducted cooperativeness. Male patients present higher comorbidity for general medical condition.

P24. Health economics

P24.01

Guidelines for economic evaluation of treatments for major depression

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Objective and method: Our previous research proved cost-utility analysis (CUA) to be the most adequate of the 3 economic evaluation subtypes in examining psychiatric treatment. Since Major Depression is the psychiatric disorder with the largest societal costs, we checked the relevant medical literature vol. 1987–1998 in order to develop guidelines for future research.

Results: Only 3 methodologically comprehensive trials were found, 2 of them dealing with major depressive patients. The following variables turned out to be most important for calculating the cost-utility ratio, expressed in incremental $ / incremental Quality-Adjusted Life-Year:

direct costs including therapist hours, medication and blood tests (all easy to calculate),

indirect costs such as for travelling and patient time (transportation, waiting and visiting time – usually 60–80% of an average hour of pay per hour),

the utility value p (quality of life while being depressed): between 0,3 and 0,7 (reasonably pessimistic/optimistic – 'sensitivity analysis'),

discount rates (different in each country, e.g. 0–5%).

Conclusion: Although it is perfectly possible to evaluate psychiatric treatment by CUA without special economic knowledge there is a considerable lack of appropriate studies which can only partly be explained by the fact that consideration of a treatment's cost-utility must be based on results of methodologically comprehensive *clinical* studies including comparison treatment/placebo.

P24.02

The economic burden of schizophrenia in Russia

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Objectives: This study tried to estimate the annual total costs of schizophrenia in Russia in 1998.

Methods: The cost-of-illness study was based on a prevalence approach. Costs were expressed in 1998 values.

Summary of the results obtained: The overall monetary burden of schizophrenia in Russia was estimated to be Roub.8.1 billion (US$0.8 billion). The direct (medical) costs were Roub.3.4 billion (42% of total costs), or 5% of the annual health care budget, or 0.1% of gross domestic product. Inpatient care costs accounted for 95% of the direct costs while drug therapy costs accounted for only 1.8%. The indirect (societal) costs were caused mainly by work disability. The mean total costs per capita were Roub.5800. However the study revealed the cost heterogenety of schizophrenia population.

Conclusions: In light of the huge burden of schizophrenia more attention should be directed at cost-effective psychopharmacotherapy, the management of "high cost" service users, and community psychiatry.

P24.03

Healthcare utilization in patients with treatment resistant depression

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Objective: Recent studies indicate that as many as 20% of depressed patients are resistant to traditional antidepressant treatments. This study utilized a national healthcare database to characterize healthcare utilization of patients with treatment-resistant depression.

Methods: Depression-diagnosed adults with at least 8 weeks of adequate antidepressant dosing were selected. Patients were classified as treatment-resistant (n=1,697) and those without evidence of treatment resistance (n=3,639) for comparison.

Results: Treatment-resistant patients are at least twice as likely to be diagnosed with bipolar disorder, comorbid anxiety disorders, and substance-related disorders ($p<0.01$). Treatment-resistant patients were at least twice as likely to be hospitalized (depression and non-depression related), had 41% more outpatient visits ($p<0.01$), and used 2 to 3 times more psychotropic medications ($p<0.01$). Treatment resistant depression was associated with higher total health care costs ($41,475/yr vs $5,318/yr; $p<0.01$).

Conclusions: Treatment-resistant depression is costly and is associated with extensive use of health care services. These findings underscore the importance of effective long-term treatment for patients with treatment-resistant depression.

P24.04

Costs for evidence-based care of patients with schizophrenia

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The Swedish National Board of Health and Welfare has recently issued evidence-based national practice guidelines for the care of persons with schizophrenia. They recommend a community-oriented care based on multidisciplinary outpatient teams with integrated, small nursing units and complementary acute beds in wards with no more than six beds each. We estimated the total annual cost for healthcare according to the recommended guidelines by appraising and comparing the resources such care would necessitate with the actual costs for current resources in Uppsala County (225,000 inhabitants 18 years and older). Mental healthcare according to the guidelines would necessitate 6.8 psychiatrists (64 % increase), 6.9 psychologists and 20.7 rehabilitation workers (e.g. occupational therapists, social welfare officers) per 105 inhabitants. Furthermore, the number of beds in small nursing units would have to be raised to 20.9 per 105 inhabitants, enabling a reduction of acute beds in hospital wards to 10.7 per 105 inhabitants. In conclusion, the total annual cost for care according to the guidelines was estimated to 5.2 million euro per 105 inhabitants, which is 24 percent in excess of the current annual cost.

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