pose a substantial burden in terms of indirect costs, much of which is attributable to loss of employment. We present a new approach to assess the cost-effectiveness of Risperidone Vs Haloperidol, using employability as an outcome measure. METHODS: A decision analytic cost-effectiveness model was developed to compare the two treatments over a one-year period including all direct medical costs and the number of employable persons as a measure of effectiveness. A measure of executive functioning, the Wisconsin Card Sort Test (WCST), was used as an intermediate endpoint from which employability was modeled. A Monte-Carlo procedure, using WCST sampling distributions from clinical trials, simulated the WCST score distribution for a cohort of 10,000 patients. A clinically stable patient, with a Positive and Negative Syndrome Scale (PANSS) score increase of at least 20% and a WCST-Category score of ≥3.5 was assumed to be employable. Sensitivity analysis was performed for key values. RESULTS: The base case per-patient cost of Risperidone and Haloperidol was $5,967 and $4,622 respectively and the number of employable persons was 3,258 (32.58%) and 2,517 (25.17%) respectively. Risperidone remained cost increasing and had higher number of employable persons over all the ranges used in the sensitivity analysis. The base case incremental cost-effectiveness ratio for Risperidone was $14,507 for each additional employable person. The incremental CE ratio ranged from a high of $100,000 to a low of $3,000 per employable persons when the rates of clinical stability for Risperidone and Haloperidol therapy were varied. CONCLUSION: Gains from earning rates for employed schizophrenics, savings in informal caregiver costs and other intangible positive effects could justify an incremental cost of $14,507 for each additional employable person prescribed Risperidone.

CLINICAL ASSESSMENT OF QUALITY OF LIFE AMONG SCHIZOPHRENIA PATIENTS WITH DEFICIT SYNDROME
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OBJECTIVE: To determine whether persons with deficit syndrome exhibit lower quality of life than do their counterparts. METHODS: Participants were drawn from the U.S. Schizophrenia Care and Assessment Program (SCAP). Trained assessors collected baseline data. Baseline QLS was used (n = 781; mean = 56) and was modeled as a linear function of covariates, including demographic, clinical, medication adherence, and site variables. Presence of deficit syndrome was assigned based on proxy methods using clinical data collected at the baseline assessment (Kirkpatrick B., et al., 1993). RESULTS: Modeling revealed that deficit syndrome had a negative impact of 4.7 points (p < .001) on quality of life score (range 0–120), suggesting that persons with deficit syndrome may experience a significantly lower quality of life than their non-deficit counterparts, all else equal. Those having higher hallucinations/delusions scores (p < .001) exhibited lower QLS scores and those with higher functioning scores (GAF; p < .001) exhibited higher QLS scores. The presence of insurance other than Medicare or Medicaid (as compared to no insurance) revealed a positive relationship to QLS score. Significance was achieved on one site variable and indicated a negative relationship. Weak evidence was obtained (p = .0587) indicating a positive association between higher education level and QLS score. CONCLUSIONS: Findings suggest that persons with deficit syndrome experience lower quality of life than those who are non-deficit. The result is expected given the use of clinical assessment of quality of life and is contrary to the expectation of higher self-reported quality of life for persons with deficit. Although the clinical and functional scores are significant, the impact of deficit syndrome is at least five times greater than that of hallucinations/delusions. The interpretation of significance on the insurance and site variables is less clear and may suggest that the observed variation is a result of an unobserved mediating process, such as selection or differential access.

APPLICATION OF THE RASCH MODEL TO THE SF36 MENTAL HEALTH 5 ITEM SCALE (MH5)
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OBJECTIVES: To verify whether the SF36 Mental Health 5 item scale (MH5), an instrument commonly used in mental health research, fulfills criteria of unidimensionality and invariant measurement specified by item response theory (IRT). METHODS: As part of a survey of health care needs among university students in Geneva, Switzerland, 1257 respondents (64% of eligible persons) filled the MH5 (version 2). Each item was scored on a 5-level frequency scale (“never” to “all of the time”). We analyzed these data using both the traditional method (summative scoring), and the polytomous one-parameter IRT (or Rasch) model. RESULTS: In traditional analysis, the MH5 scale performed as expected (single factor, Cronbach alpha 0.85, mean 67.1, standard deviation 17.6, range 0–100). Rasch analysis revealed the good fit of all item characteristic curves. Threshold locations for feeling “nervous” (mental health logits: −3.2, −0.7, 2.0, 3.3), “down in the dumps” (−4.0, −1.7, 0.4, 1.5), “calm and peaceful” (−3.0, −0.6, 0.9, 6.0), “down-hearted and blue” (−4.2, −1.6, 1.0, 3.0), and “happy” (−3.1, −0.9, 0.7, 4.2) were all ordinal, consistently with theory, and spread widely over a span of 10.2 logits. While classic MH5 scores and Rasch-based scores were closely correlated (r = 0.98), their relationship was S-shaped: the intervals, in mental health logits, between MH5 scores 0–10, 10–20, etc., up to 90–100 were: 2.23,
RESPONSIVENESS TO CHANGE OF THE SF-36 IN RAPOLO, A LONGITUDINAL STUDY OF RHEUMATOID ARTHRITIS PATIENTS TREATED WITH ETANERCEPT

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OBJECTIVES: To evaluate the responsiveness of the SF-36 subscales, the generic physical (PCS) and mental (MCS) components of the SF-36, and the SF-36 Arthritis-Specific Health Index (ASHI) to changes in disability measured by the Health Assessment Questionnaire (HAQ) in RAPOLO. METHODS: We identified 388 participants from RAPOLO, a longitudinal, observational study of RA, who had repeated measures of arthritis specific function (HAQ and ASHI) and general function (SF-36). We categorized patients into three groups according to HAQ score—(1) stable, (2) declined (increase in HAQ score > of 0.25) and (3) improved (a decline in HAQ score of > 0.25). For each group we calculated Guyatt’s statistic—a measure of responsiveness to change. The larger the absolute value of Guyatt’s statistic, the greater the responsiveness to change. RESULTS: Cohort is 79% female; mean disease duration is 13.2 yrs; mean age is 55 yrs. There were 286 participants who had no change in HAQ score. Guyatt’s statistic ranged between 0.04 to 0.17 (Social Functioning). There were 52 participants who declined. The Guyatt’s statistics for the SF-36 ranged from 0.11 (Role Emotional) to 1.88 (Role-Physical). There were 46 participants who improved in HAQ score. Guyatt’s statistic ranged from 0.14 (Mental Component Summary Score) to 1.58 (Role-Physical). CONCLUSIONS: Statistics less than 0.3 indicate no responsiveness to change, statistics > 0.5 reflect responsiveness to change. The physical subscales of the SF-36, the PCS, and the ASHI were moderately to highly responsive to change in HAQ score. The emotional subscales were not responsive to change in disability.

CORRELATION OF A GENERIC HEALTH-RELATED QUALITY OF LIFE QUESTIONNAIRE AND SELF-ADMINISTERED RHEUMATOID ARTHRITIS DISEASE ACTIVITY INSTRUMENT

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BACKGROUND: Health-related quality of life (HRQOL) measures have been used to study the impact of disease activity in patients with rheumatoid arthritis (RA). The objective of this study was to evaluate the correlation between SF-36 scales, physical function (PF), role physical (RP) and bodily pain (BP) and Rapid Assessment of Disease Activity in Rheumatology (RADAR). METH-