tions, reflecting differences in early time points and in illness severity levels. For schizophrenia patients with at least moderate symptom severity, the lack of at least 14–23% improvement on the PANSS total score at two weeks is an optimal predictor of subsequent non-response following eight weeks of treatment. This early response threshold appears to be an important clinical marker of subsequent non-response to antipsychotic therapy.

**PMH7**

**CLINICAL AND FUNCTIONAL IMPROVEMENTS IN PATIENTS WITH SCHIZOPHRENIA TREATED WITH RISPERIDONE LONG ACTING INJECTION: INTERIM RESULTS FROM OBSERVATIONAL STUDIES CONDUCTED IN AUSTRALIA, BELGIUM AND THE UNITED STATES**

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**OBJECTIVE:** To evaluate the 12-month clinical and functional outcomes in patients with schizophrenia who received RLAI treatment and were enrolled in the electronic-Schizophrenia Treatment Adherence Registry (e-STAR) in Australia and Belgium, and the Schizophrenia Outcomes Utilization, Relapse, and Clinical Evaluation (SOURCE) in the United States.

**METHODS:** e-Star and SOURCE are long-term, prospective, observational studies of patients with schizophrenia who commence RLAI treatment. Data are collected both retrospectively and prospectively and clinical effectiveness was measured by the Clinical Global Impression Severity (CGI-S) scale and patient functioning was measured by the Global Assessment of Functioning (GAF) scale.

**RESULTS:** Seven hundred sixty-nine patients (Australia = 493, Belgium = 163, USA = 113) with 12-months of follow-up data were included. Australia had significantly younger patients than Belgium and the United States (mean ages: Australia = 38.6, Belgium = 41.6, USA = 43.5; p < 0.0003). Time since diagnosis (in years) was significantly higher in the United States than Australia and Belgium (USA = 17.6, Australia = 11.6, Belgium = 9.8; p < 0.0001). United States patients had significantly higher baseline GAF scores than the Australian and Belgian patients (USA = 50.9, Australia = 42.7, Belgium = 43.1; p < 0.0001). Despite baseline differences, GAF and CGI-S scores significantly improved from baseline in all three countries. CGI-S scores significantly decreased by 0.8 (p < 0.001), 1.08 (p < 0.001) and 0.83 (p < 0.001) points and GAF scores significantly increased by 12.7 (p < 0.001), 14.8 (p < 0.001), and 11.1 (p < 0.001) points in Australia, Belgium, and the United States respectively. **CONCLUSION:** This interim analysis from the two observational studies shows that despite differences in patient characteristics among countries, treatment with RLAI resulted in significant improvements in disease severity and patient functioning in patients with schizophrenia from all three countries.

**PMH8**

**TREATMENT DURATION FOLLOWING INITIATION ON ATYPICAL ANTIPSYCHOTICS AMONG SCHIZOPHRENIA PATIENTS WITH VERSUS WITHOUT A METABOLIC SYNDROME**

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**OBJECTIVE:** To assess differences in treatment duration and resource utilization following initiation on atypical antipsychotics among schizophrenia patients with versus without metabolic syndrome who were treated at the Veteran Health Administration.

**METHODS:** We used electronic medical records data for October 2002–August 2005 from a large Veterans Integrated Service Network (VISN16) to identify schizophrenia patients who were initiated on an atypical antipsychotic and have undergone metabolic monitoring in the 180 days prior to medication initiation. Those found to have a metabolic syndrome (MetSyn+) were compared to those without (MetSyn–) on patient characteristics, treatment duration, medication adherence per medication possession ratio (MPR), and resource utilization in the 1-year post medication initiation. Kaplan-Meyer (K-M) estimation compared the difference in treatment duration. A Cox proportional hazard regression was used to compare all-cause medication discontinuation, controlling for group differences at baseline.

**RESULTS:** A minority of schizophrenia patients who have undergone metabolic monitoring was found to have a metabolic syndrome (83 of 593, or 14.0%). The MetSyn+ and MetSyn– groups did not significantly differ on baseline characteristics except that the MetSyn+ group had a higher rate of non-VA adherence. Adherence (MPR) during the year following medication initiation was higher for the MetSyn+ group (81% vs. 68%; p = 0.031). K-M estimators (log-rank test p = 0.471; Wilcoxon test p = 0.512) and a Cox model (p = 0.671) indicated lack of statistically significant group difference in all-cause medication discontinuation.

**CONCLUSION:** Among schizophrenia patients who have undergone metabolic monitoring, those with a metabolic syndrome and those without do not appear to differ on treatment duration and resource utilization following initiation on an atypical antipsychotic medication in the Veterans Health Administration.

**PMH9**

**RETENTION RATES FOR ORAL AND DEPOT ANTIPSYCHOTIC MEDICATIONS OVER ONE YEAR IN ONTARIO, CANADA**

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**OBJECTIVE:** Continuous treatment is an important goal in the management of schizophrenia. Retention rate is a well-recognized global measure of effectiveness that integrates patients' and clinicians' judgment of efficacy, safety and tolerability. Furthermore, all-cause discontinuation was used as a primary outcome measure in a large effectiveness study (Clinical Antipsychotic trial of Intervention Effectiveness or CATIE). The current study utilized longitudinal claims data from Ontario Drug Benefit (ODB) recipients in Ontario, Canada to compare retention rates for typical and atypical antipsychotic medications with different formulations.

**METHODS:** Longitudinal data were obtained for ODB recipients that were initiated on antipsychotic therapy in July 2006. ODB recipients were followed from their first claim for the specific target drug to their last claim in a 12-month period. Rates of retention were determined throughout and up until 12 months. Descriptive analyses were performed. Retention rates were reported for depot (long-acting injectable) risperidone; oral atypical antipsychotics including olanzapine, risperidone, and quetiapine; orally disintegrating tablet formulations of risperidone and olanzapine; oral typical antipsychotics (pooled); and depot typical antipsychotics (pooled). **RESULTS:** From July 2006–June 2007, 12-month retention rates were lowest with oral typical (29% of recipients), depot typical antipsychotics (30%), and risperidone orally disintegrating formulations (30%). Retention rates for oral atypical antipsychotics were 41% for olanzapine, 46% for risperidone and 50% for quetiapine. Retention on risperidone long-acting injectable were the highest with 73% of recipients retained over 12-months.

**CONCLUSION:** Retention rates were lowest