translations. RESULTS: Challenges emerged at two levels. a) At the conceptual level, it proved challenging for a linguist to differentiate the distinct but related psychiatric states investigated by the 16 domains present in the questionnaire. b) At the translation level, the formulation had to meet the following requirements: i) accurately convey the concepts and ii) be understandable by the layman. These requirements were all the more crucial in the context of face-to-face diagnostic interviews where mutual and consistent comprehension of terms is essential and may influence the overall results. CONCLUSIONS: The M.L.N.L. translations were produced to ensure concordance with existing translations, conceptual equivalence across and linguistic consistency within languages to facilitate comparison and pooling of data. This was made possible through the close collaboration between linguists and psychiatrists, under the guidance of a coordinating centre. The results of the project suggest promoting similar collaboration when translating other mental health measures in the future.

THE TRANSLATION AND LINGUISTIC VALIDATION OF THE SUBJECTIVE WELL-BEING UNDER NEUROLEPTICS – SHORT VERSION (SWN-S) QUESTIONNAIRE
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OBJECTIVES: The Subjective Well-being Under Neuroleptic – Short version (SWN-S) has been translated into 30 different languages and is currently being translated into further languages. The SWN-S is designed to assess the subjective efficacy of neuroleptic medication. The objective of this study was to produce translations that are comparable and equivalent to the original and other language versions, ensuring the validity and relevance of the translations within the target cultures. METHODS: A standard methodology was employed: two forward translations, a reconciliation of the forward translations, two back translations, back translation review; or an an-country review; linguists’ interviews with five stable patients with schizophrenia in the country and two proofreadings. RESULTS: Numerous cultural and linguistic issues became apparent throughout the translation process, as follows: – The concepts behind some of the English items were unclear to linguists not specialising in schizophrenia. – Terminology was not tested, revealed that amongst the target population, wording was correctly understood. “I find it easy to draw a line between myself and others” was difficult to translate due to numerous possible connotations of this state- ment. After consultation with the developer, an accurate connotation was able to be conveyed. – “Not in control of myself” did not mean “self-control.”” – Rhyming words in the original English were not translated. “It is better to be...” With the highest rating in the original English, the SwN-S has been translated and linguistically validated in 30 languages using a rigorous translation process. A number of cultural and linguistic issues became apparent and were resolved. The measure is now appropriate for use in multinational trials.

MULTITRAIT/MULTIMETHOD ANALYSIS OF THREE GENERIC PRESENCE-BASED HEALTH-RELATED QUALITY OF LIFE MEASURES IN THE NATIONAL HEALTH MEASUREMENT STUDY
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OBJECTIVES: Different generic preference-based health-related quality of life (HRQOL) measures may not yield similar quality-adjusted life expectancy, challenging the meaning of incremental cost-effectiveness ratios in league tables. This study comp- ares corresponding domain scores from different HRQOL measures to evaluate the extent to which they tap into the same or unique constructs. METHODS: The SF-36 (v2), EQ-5D, and HUI-3 were administered to 3844 U.S. adults in the National Health Measurement Study, a cross-sectional random-digit dial telephone survey. Mean domain and preference-based scores were calculated. Convergent and discriminant validity were evaluated by multi-trait multi-method (MTMM) analysis of the three HRQOL instruments across the attributes of physical functioning (SF-36 physical functioning, HUI-3 ambulation, and EQ-5D mobility), mental health (SF-36 mental health, HUI-3 emotion, and EQ-5D anxiety/depression), and pain (SF-36 bodily pain, HUI-3 pain, and EQ-5D pain/discomfort). RESULTS: Mean scale scores of the SF-36, HUI-3, and EQ-5D, respectively, ranged from 50.0 (+ /– 0.37) to 35.4 (+ /– 0.21) to 86.4 (+ /– 0.10) for PCS and MCS; 90.8 (+ /– 0.12) to 97.0 (+ /– 0.28) and 1.35 (+ /– 0.42) to 1.35 (+ /– 0.38). Mean preference-based scores obtained from the SF-36 calculated from the SF-36, HUI-3, and EQ-5D were 0.765 (+ /– 0.144), 0.766 (+ /– 0.275), and 0.838 (+ /– 0.173), respectively (p < 0.001 for Bonferroni- corrected paired t-tests comparing EQ-5D to both SF-36 and HUI-3). The MTMM matrix had average validity and off-diagonal correlations of 0.622 and 0.404, indicat- ing high convergent validity. MTMM analysis also showed 91% of convergent validity correlations to be significantly larger (p < 0.05) than relevant other correlations in the MTMM matrix, providing substantial support for discriminant validity. CONCLU- SIONS: Although the mean preference-based score obtained from the EQ-5D was different from the SF-36 and HUI-3, MTMM analysis demonstrated good support for convergent validity. Further analysis of using analogous domains of these measures. Further analysis is required to better understand how similar elements of different generic HRQOL instruments impact preference-based scores.

VALUING HEALTH FROM SCRATCH: THE APPLICATION OF COMMOMSENSE PRINCIPLES TO THE DESIGN OF HEALTH STATE VALUATION METHODS
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This paper applies commonsense principles to determine the basis for selecting any valuation method; at its centre is the concept that health states compete for location within a equivalence across in which full health is assigned the value 1 and dead the value 0. A descriptive health classification system may generate a large of states (972,000 / 18,000 and 245 for HUI3, SF6D and EQ-5D respectively). This argues for a valuation method that can discriminate between states separated by very small value differences. Were all states to have a unique value these differences would be incredibly small (1.03E-6, 5.5E-5 & 0.004 respectively). TTO and SG methods used to calibrate these systems fail a basic credibility test. The numeric output implies a degree of measurement performance unlike any other area of human judgement – even those with more concrete implications (such as controlling the warmth of our environment) which are better understood but that report far cruder measurement properties. A just-noticable difference (JND) of 2 degrees Centigrade is reported when testing human subjects’ response to temperature. If we assume that human judgement “accu- rately” discriminates between health states separated by (say) 5 points on a 0-100 scale then we should expect a limited number (n = 21) of unique value points. Methods that purport to represent health state values with more than this level of accuracy imply a human judgement capacity that lacks supportive evidence. A basic test for any method is whether or not there is evidence that individuals CAN in fact discriminate between adjacent health states separated by such small value differences. Procedures which make minimal assumptions about human judgment are to be pref- erred to those with untested performance characteristics. Spurious “accuracy” in reported values for health states can be avoided by limiting decrements to a maximum of 2 decimal places.

APPLICATION AND FURTHER VALIDATION OF A PATIENT-REPORTED OUTCOME INSTRUMENT: PATIENT SATISFACTION WITH PHARMACEUTICAL CARE QUESTIONNAIRE
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OBJECTIVES: Apply and further validate the Patient Satisfaction with Pharmaceutical Care Questionnaire (PSPQC) in a different pharmacy practice setting. METHODS: Five hundred questionnaires were distributed to patients dropping off a prescription at a high-volume (500 prescriptions/day), 24-hour chain pharmacy, during a 2-week period. Reliability and construct validity of the PSPQC was calculated. RESULTS: The PSPQC was found to be a self-administered questionnaire, and consisted of items that measure patient satisfaction with functional and technical dimensions of pharmacy services, which are represented by Friendship Explanation (FE) and managing therapy (MT) subscales. Patient satisfaction and psychometric properties of the PSPQC were evaluated using SPSS. Pearson’s correlation and Student’s t-test were used, RESULTS: Survey response rate was 24.2% (n = 121). Cronbach’s alpha for FE and MT scales were 0.979 and 0.980, respectively. Mean scale scores for Global, FE, and MT were 2.88 (SD = 1.28), 2.98 (SD = 1.27), and 2.74 (SD = 1.35), respectively. Mean differences in mean scores were 0.24 (P < 0.001), between FE and MT scales, 0.097 (P < 0.001) between Global and FE scales, and 0.15 (P < 0.001) between Global and MT scales. Inter-scale correlation coefficients were 0.938 (P < 0.001) for FE and MT, 0.898 (P < 0.001) for Global and FE, and 0.979 (P < 0.001) for Global and MT. A new validity question “a drug needs to be...” received second highest rating of 3.2, while “Promptness of prescription drug service” received the lowest rating of 2.58, out of the twenty items. CONCLUSIONS: Significantly higher (P < 0.001) overall mean score on MT scale compared to FE scale suggests that patients distinguish between activities related to pharmaceutical care (MT) and friendly service (FE); and, since usually higher scores are expected from patients on familiar items, construct validity was demonstrated. Practicing pharma- cists, in this setting, supported face validity. PSPQC demonstrated external validity, in a high-volume retail pharmacy setting. PSPQC can be used to assess patient-reported quality, in addition to patient awareness, of pharmaceutical care in the community pharmacy setting.

ASSESSING ANXIETY AND DEPRESSION ON AN INTERNATIONAL LEVEL
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OBJECTIVES: Prior to use in an international study, the Generalized Anxiety Disorder Screener (GAD-7) and the Patient Health Questionnaire 9 (PHQ-9) underwent lin- guistic validation into 56 and 24 languages respectively. A rigorous methodology was required to ensure conceptual equivalence and cultural relevance between the different languages and the original US English instruments. METHODS: The translation process was conducted by a specialist in each target country, in collaboration with the developers using the following standardized methodology: (1) two forward translations by professional translators (native speakers of the target language); (2) analysis of the translations by the specialist; (3) backward translation by a native English speaker; (4) comparison of source and backward version and (5) comprehension test on a sample of healthy subjects in each target country. Existing translations were integrated.