of patients with schizophrenia. RESULTS: 1208 patients with schizophrenia were included in the study and followed for 2 years. Mean GAF scale score at baseline was 51.34 (SD: 36.06) ranging from 11 to 98. MCID values retrieved from the anchor-based approaches were 2.92 and 3.8, for within- and between-patient methods, respectively, when using CGI as external criterion. MCID values retrieved from the distribution-based approaches were 0.89 and 1.26, for within- and between-patient methods, respectively, when using CGI as external criterion. MCID values obtained from the distribution-based approaches were 1.47, 1.70 and 0.71 when conducting the analysis using standard error measurement approach, standard deviation approach and effect size, respectively. CONCLUSIONS: As in many MCID analyses, although the objective is to provide a unique threshold value, the different methods produce a variety of MCID values. MCID values retrieved in the present study are very disparate, ranging from 2.92 to 11.70. As anchor-based measure are generally preferred to distribution-based measures, we suggest using 4 as the MCID for GAF, reflecting the smallest difference that clinicians would deem important. MCID estimates may help clinicians and researchers design future studies and interpret treatment effect.

PMH3
BURDEN ASSOCIATED WITH AGITATION IN SCHIZOPHRENIA
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OBJECTIVES: Clinical management of agitated patients with schizophrenia is a common objective in inpatient units and other settings. Being defined as a state characterized by motor restlessness, excitement, and mental tension, agitated patients may become a threat to others, act out violently, and also lead to suicidal thoughts and behaviors. The purpose of this study is to describe the agitated schizophrenia population. METHODS: We worked on data from a large longitudinal cohort of patients suffering from schizophrenia, including a battery of questionnaires every 6 months for up to 24 months. Patients with a positive and negative syndrome scale (PANSS) Excited Component higher than 14 and a score of 4 or higher on at least one item, were identified as agitated patients. Agitated status of patients was considered as variable over 2 years, pathways of agitated patients were explored. Bivariate analyses were conducted to compare agitated patients with others in terms of severity of symptoms (PANSS total or subscale), CGI, quality of life and resource utilization. RESULTS: 5% of patients were identified as agitated at baseline. This rate was very stable at 6, 12, 18 and 24 months. Agitated patients were found to have more severe symptoms (PANSS total 60.9 vs. 48.9; p<0.0001), higher agitation (CAF: 39.9 vs. 51.99 p<0.0001), and more side effects (AIMS: 4.15 vs. 2.66 p=0.07). For each type of service, resource use was consistently higher for agitated patients when compared to others. No difference was found in terms of quality of life or depression level. CONCLUSIONS: Our study suggests that agitated patients with schizophrenia form a stable population overtime with a high clinical burden. Research on management of agitated is of key importance in schizophrenia.

PMH4
COMPARATIVE EFFECTIVENESS IN TERMS OF TREATMENT DISCONTINUATION OF ORODISPERSIBLE VERSUS STANDARD ORAL OLANZAPINE TABLETS IN NON-ADHERENT PATIENTS: RESULTS FROM A 1-YEAR EUROPEAN OUTPATIENT OBSERVATIONAL STUDY
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OBJECTIVES: Non-adherence is common in the treatment of patients with severe mental illness. Different formulations have been developed in an effort to improve medication adherence. The aim of this study is to explore whether there is a differential impact of different formulations of olanzapine orlawa (OD) or standard oral tablets (SO) for the treatment of non-adherent patients with schizophrenia or bipolar disorder. METHODS: This post-hoc analysis included 266 non-adherent patients diagnosed either with schizophrenia or bipolar disorder from an observational study (n=927) that measured the proportion of patients who discontinued treatment for any reason with olanzapine OD or SO formulations over a 1-year period. Non-adherence was defined as having a baseline rating from 0 to 4 in the Medication Adherence Rating Scale (MARS). Treatment discontinuation was defined as discontinuing or adding a new antipsychotic to the index medication. A Kaplan Meier estimation of time to medication discontinuation was calculated. A Cox regression model adjusting for covariates was fitted to study the effect of baseline treatment on time to discontinuation. RESULTS: Patients treated with OD (n=177) vs. SO (n=89) were more severe as measured by the Clinical Global Impression scale (CGI) (3.63 [SD 1.53] vs. 4.0 [SD 1.16], p < 0.0001) at baseline. During the 1-year follow up period the Kaplan Meier graph showed that patients treated with OD were less likely to discontinue treatment (11% vs. 27%, p=0.01). A Cox regression showed that patients taking OD had a significantly lower risk of discontinuing their baseline medication compared to patients taking SO (hazard ratio: 0.35, 95% CI: 0.15-0.80). CONCLUSIONS: Treatment discontinuation was low with both olanzapine formulations; however the use of the orodispersible formulation in non-adherent patients with schizophrenia or bipolar disorder was associated with a significantly lower treatment discontinuation rate over a 1-year period.

PMH5
MINIMUM CLINICALLY IMPORTANT DIFFERENCE IN THE CALGARY DEPRESSION SCALE FOR SCHIZOPHRENIA
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OBJECTIVES: No Minimum Clinically Important Difference (MCID) for the Calgary Depression Scale for Schizophrenia (CDSS) has been reported yet. This scale, ranging from 0 to 27, assess the level of depression in schizophrenia. The objective of this study was to generate a MCID for the CDSS, based on a longitudinal cohort of patients with schizophrenia. METHODS: Two methods exist to assess MCID in scales such as CDSS: the anchor-based approach (comparison of the change in CDSS score and Clinical Global Impression (CGI) within- and between-patients), and the distribution-based approach (comparison between the change in PRO scores and some measure of variability, including standard error measurement approach, standard deviation approach, effect size). Both methods were implemented in a longitudinal cohort of patients with schizophrenia. RESULTS: 1208 patients with schizophrenia were included in the study, and followed for up to 2 years. The mean CDSS score at baseline vs. follow up was 6.08 (SD: 4.57), ranging from 0 to 27. Eight anchor-based approach were 0.89 and 1.26, for within- and between-patient methods, respectively. CONCLUSIONS: As in many MCID analyses, although the objective is to provide a unique threshold value, the different methods produce a variety of MCID values. Since all MCID values retrieved in the present study were in the same order of magnitude, we therefore suggest using 1.3 as the MCID for CDSS, reflecting the smallest difference that clinicians would deem important. MCID estimates may help clinicians and researchers design future studies and interpret treatment effect.

PMH6
EVOLUTION OF DEPRESSIVE STATUS IN PATIENTS WITH SCHIZOPHRENIA: AN ANALYSIS OF PATIENT TRAJECTORIES
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OBJECTIVES: The majority of studies on depression among patients with depression reports means or percentages which obscure changes in depressive status over time. Trajectory description analysis may provide a more nuanced picture of the evolution of depression, applicable to study patients with schizophrenia. METHODS: We used data from a longitudinal cohort of 1208 patients with schizophrenia and DSM-IV criteria for depression. Values from the Calgary Depression Scale for Schizophrenia (CDSS) questionnaire every 6 months for up to 2 years. Several cut-points were used, to distinguish patients with and without depression. Depression rates were calculated at each visit, independently, and depending on the patient’s previous status. RESULTS: Rates of depression at the baseline visit were 39.7% and 20.2%, when considering cut-points of 3 and 6, respectively. Among the 477 and 243 patients considered as depressive at baseline, 41.8% and 59.5% changed status after 6 months when considering cut-points of 3 and 6, respectively. Similarly, among the 724 and 958 patients considered as non-depressive at baseline, 18.2% and 9.9% changed status after 6 months. These results were relatively stable over time, when considering each pair of successive visits. Additionally, analyses also showed that the proportion of patients labeled as these trajectories over time. CONCLUSIONS: Trajectory analysis allowed us to detect different groups of patients, with specific characteristics and different trajectories. Our larger sample size allowed identifying levels of various characteristics at baseline and over time as being associated with each trajectory.

PMH7
EVOLUTION OF PRESENCE OF PREDOMINANT NEGATIVE SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA
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OBJECTIVES: Patients with schizophrenia often remain symptomatic with predomin- ant negative symptoms (PNS) despite receiving antipsychotic therapy. Several definitions of PNS are published in literature. This study is to compare evolution of patients with and without PNS over time, and to explore the predictive status of PNS in terms of quality of life, depression and resource use, considering several definitions. METHODS: Fifteen definitions of PNS were retrieved from literature, out of which 3 were applied in a longitudinal cohort of patients with schizophrenia (N=1208). Clinical characteristics, depression, functioning, medication, quality of life and resource utilization were assessed at baseline and at 6 months, and compared between subgroups of patients (with/out PNS at baseline and at 6 months). Reasons of PNS status change were described for each definition. Regression models were used to explore the predictive status of PNS in terms of quality of life, depression and resource use. RESULTS: According to the 3 definitions used, severity of positive symptom significantly increased in patients with PNS at baseline but not at 6 months. Negative symptoms decreased to a lesser extent. Furthermore, functioning, depression, medication, quality of life and resource utilization evolution were not consistent across definitions. According to all the definitions, PNS status at baseline was associated with change from baseline in terms of depression, quality of life, number of GP visits and number of hospitalization days, when adjustments were taken into account. CONCLUSIONS: Our study suggests that PNS status at a specific time point is associated with depression, quality of life and resource utilization evolution at 6 months. Results also show that patients with PNS at a specific time point not showing PNS 6 months later are not associated with better outcomes. This confirms that schizophrenic patients with PNS form a severe population, and required further analyses.

PMH8
FUNCTIONAL IMPAIRMENT AND COGNITIVE DYSFUNCTION IN DEPRESSED PATIENTS IN SOUTH-KOREA: RESULTS OF PERFORM-K
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