tence and increased health care costs in older adults with demen-
tia in a managed care setting. Health status assessments
completed at enrollment had the potential to identify enrollees at
higher risk for nonadherent behaviors and poor health related
outcomes.

PMHS8
IMPROVEMENT IN PERSONAL AND SOCIAL FUNCTIONING
IN SCHIZOPHRENIA PATIENTS TREATED WITH RISPERIDONE
LONG ACTING INJECTION: 6-MONTH RESULTS FROM e-STAR
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OBJECTIVE: To evaluate the effectiveness of risperidone
long-acting injection (RLAI) treatment on personal and social
functioning in patients with schizophrenia enrolled in the
electronic-Schizophrenia Treatment Adherence Registry (e-
STAR) from six countries (Canada, Czech Republic, Denmark,
Netherlands, Slovakia, Sweden) that collected Personal and
Social Performance (PSP) data. METHODS: e-STAR is an inter-
national, long-term, prospective, observational study of patients
with schizophrenia who commence RLAI. Data are collected
retrospectively for one year and prospectively every three months
for two years. Personal and social functioning is measured using
the PSP scale which evaluates four areas, socially useful activities,
personal and social relationships, self-care, and disturbing and
aggressive behaviour. Pooled results presented are based on data
from patients who have completed their six-month follow-up
visit. RESULTS: To date, 1831 are enrolled in e-STAR from
the six countries, 1232 patients who have been followed for at
least 6 months are included in this analysis. Mean age was
38.4 ± 12.5 years, 58.6% were male and mean time since diag-
nosis was 9.6 ± 11.6 years. At 6 months, 95.5% of patients are
still on RLAI. The mean PSP score significantly improved from
48.0 ± 17.3 at baseline to 64.2 ± 15.2 at 6 months (p < 0.001).
Improvement in PSP was similar for patients hospitalized at
baseline versus those who were ambulatory patients (PSP score
increased by 17.2 and 16.1, respectively, p < 0.001 for both).
Furthermore, significant improvement in PSP was seen as soon as
the first assessment after RLAI treatment at three months.
CONCLUSION: These 6-month interim results indicate that personal
and social functioning as measured by the PSP improved with
risperidone long-acting injection treatment in patients with
schizophrenia.

PMHS9
HEALTH RELATED QUALITY OF LIFE IN PATIENTS TREATED
WITH ANTIPSYCHOTIC DRUGS: RESULTS AT BASELINE FROM
THE COMETA STUDY
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OBJECTIVE: To measure adherence and persistence in patients
undergoing antipsychotic treatment and their impact on costs
and health-related quality-of-life (HRQoL). METHODS: A
naturalistic, prospective, multicentre cohort study, named
COMETA, was begun in subjects aged 18–40 years, diagnosed
with schizophrenia or schizoaffective disorder 10 years before
the enrolment. Subjects were enrolled and observed for up to
52 weeks in psychiatric centres throughout Italy. Sociodemog-
ographic, clinical, HRQoL, and data on resource use were
collected. RESULTS: Six-hundred-sixty-one patients (mean age
31.1 ± 5.6, 65.4% male) with schizophrenia (86.5%) or schizo-
affective disorder (13.5%) were enrolled in 86 centres during
2006–2007. Most patients had primary/secondary level
education (51.9%), and were single (85.9%). A total of 56.6% of
the subjects received help for their disease from relatives/friends,
37.3% of patients were employed, 10.3% were students. The
PANSS (Positive and Negative Syndrome Scale) mean + SD score
was 86.1 ± 27.4. The CGI-S (Clinical Global Impression Severity)
mean + SD score was 4.27 ± 1.1. The GAF (Global Assessment
of Functioning) mean + SD score was 54.3 ± 13.8. Ninety
days prior, patients were treated with olanzapine (32.5%), ris-
eridone (31.5%), haloperidol (18.3%), aripiprazole (14.4%),
quetiapine (12.4%) and clozapine (11.2%). Thirty percent of the
patients took >2 different drugs (up to 5) in that period. Regard-
ing HRQoL, 68.7% of patients reported problems on the
anxiety/depression-domain of the EQ-5D, 52.3% on usual activi-
ties, 37.7% on pain/discomfort, 21.4% on mobility and 16.8%
on self-care. The EQ-5D Visual Analogue Scale score was
63.6 ± 17.8 (mean ± SD). The SF-36 Physical-Summary-Score
was 47.3 ± 9.4 and the Mental Summary Score was 39.0 ± 9.6.
CONCLUSION: Improvement of patients’ well-being is an
important objective of antipsychotic treatment. Baseline charac-
teristics of this schizophrenic cohort show that there is ample
space for improvement. Future analyses will focus on the rela-
tion between adherence with therapy, symptomatology,
costs, and quality of life.

PMHS60
HEALTH STATUS AND WORK-RELATED OUTCOMES OF
PATIENTS WITH ANXIETY DISORDERS AND DEPRESSION
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OBJECTIVE: To determine the association between various
levels of comorbid anxiety and depression with health-related
quality of life and work-performance. METHODS: Patients from
an anxiety disorders program clinic completed the SF-36, Work
Limitations Questionnaire, Work Productivity and Activity
Impairment Questionnaire, Endicott Work Productivity Scale,
and Work Performance Scale. The Beck Anxiety Inventory (BAI)
and the Beck Depression Inventory (BDI) were used to determine
the severity of anxiety and depression, respectively. Patients
were categorized as lowBAI/lowBDI, highBAI/lowBDI, highBAI/
lowBDI, and highBAI/highBDI. The influence of severity of
anxiety/depression on the eight SF-36 scales, the SF-36 PCS and
MCS, and each work-performance instrument scale score was
determined using ANOVA with Scheffe post-hoc analyses. Mul-
tivariate linear regression assessed the combined association
of BAI and BDI on SF-36 and work-performance scales, controlling
for patient demographics. P values of <0.05 were statistically
significant. RESULTS: Ninety-one patients provided complete
SF-36, BAI and BDI. Of these, 61 were employed. There were no
differences in demographics between groups. Post-hoc analy-
sis indicated that lowBAI/lowBDI patients had significantly
higher MCS (41.2 ± 10.9) compared to highBAI/lowBDI
(MCS = 29.9 ± 8.3), lowBAI/highBDI (MCS = 23.7 ± 15.8),
and highBAI/highBDI (MCS = 17.4 ± 9.9). The difference
between highBAI/lowBDI and lowBAI/highBDI were not signifi-
cant. High BAI/high BDI was significantly different than the other groups (p < 0.01). This pattern was similar for social function, role emotion, mental health. Physical-related SF-36 domains were generally not different between groups. The difference in work-performance scale scores followed the same general pattern of less impairment with low BAI/low BDI (for example, WPAI-Percent Impairment While Working scale 0.22 ± 0.3) and high BAI/high BDI (WPAI Percent Impairment While Working 0.77 ± 0.2), p < 0.01. Other work scales followed a similar pattern. BDI routinely was more significant in regression models compared to BAI. CONCLUSION: Comorbid anxiety and depression greatly impair patients. Clinicians and researchers should measure the presence and severity of both mental illnesses when assessing their influence on health-related quality of life and work-performance.

PMH61

PATIENT PREFERENCES IN THE THERAPY OF ADHD—A DISCRETE CHOICE EXPERIMENT

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OBJECTIVE: While the clinical efficacy of drugs for ADHD is widely studied in clinical trials (usually randomised controlled trials, RCTs), patient preferences with regard to their treatments are not well understood and therefore considered to a less extent. Aim of this study therefore was to explore the patients' perceptions of an "ideal treatment" for ADHD. METHODS: Examination of the state of the art as reported in the literature was followed by a qualitative study with four focus groups consisting of 6–8 parents of ADHD-patients each. In a subsequent quantitative study phase, data was collected in an online or paper-pencil questionnaire for parents of patients and patient (age >14 years) themselves. It included sociodemographic data, treatment history and actual treatment and patients' preferences of therapy characteristics using direct measurement (23 items on a 5-point Likert-scale) as well as a discrete-choice-experiment (DCE, 8 pairs with 6 characteristics). RESULTS: N = 213 questionnaires were filled; most of them by the parents of patients (79% by the mothers, 9% by the fathers). Most of the patients were male (83%) and most of them (83%) had actual medical treatment of ADHD. Direct measurement showed "good emotional quality of life," "no addiction on medication," "improvement of concentration capability," and "few side effects" in the first places. In the DCE, alternatives with "better social quality of life (friendships etc. possible)", "better emotional quality of life (disease not all of the time mentally present)" and "longer duration of medication effect" were more likely to be chosen, giving thus similar results. CONCLUSION: This unique study demonstrates that it is possible to obtain valid and robust information from patients on what constitutes relevant patient outcomes. Such information should play a critical role in appraisal of treatment alternatives by HTA bodies.

PMH62

ASSESSING THE VALIDITY OF DERIVING CLINICAL DEMENTIA RATING (CDR) GLOBAL SCORES FROM INDEPENDENTLY OBTAINED FUNCTIONAL RATING SCALE (FRS) SCORES IN VASCULAR DEMENTIA AND MIXED VASCULAR DEMENTIA PATIENTS

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OBJECTIVE: The functional rating scale (FRS) and clinical dementia rating (CDR) scale are two different tests used to assess the severity and progression of dementia. Although the FRS covers more domains and requires less time to administer than the CDR, the CDR categorizes severity of dementia while the FRS does not. The purpose of this research was to calculate the agreement between the FRS and CDR scales and to determine if they could be used interchangeably for diagnosis of disease severity in vascular dementia (VaD). METHODS: Inpatients and outpatients diagnosed with VaD/mixed VaD were evaluated using the FRS and CDR scales. The tests were administered independently by two separate raters. Since the FRS contains all of the domains that are rated in the CDR, CDR scores were extracted from the corresponding FRS domains and used to derive global scores of severity. FRS-derived global scores were then compared to original CDR global scores by a weighted kappa analysis to measure concordance. RESULTS: A total of 28 VaD/mixed VaD patients were involved in the study. In the patient population, 60.7% were males and average age was 78.6 ± 7.7 years. Average MMSE score was 19.9 ± 4.8 while mean Hachinski score was 8.1 ± 2.8. The modal value obtained for both the FRS-derived CDR scores and original CDR scores was 2; in both groups scores ranged from 0.5–3 with 43% of patients diagnosed in category 2 (moderate dementia). The weighted kappa analysis showed substantial concordance (kappa = 0.75) between FRS-derived CDR and original CDR-global scores. CONCLUSION: These results suggest that FRS scores can be used to derive global scores that are in agreement with those produced by the validated CDR method. This serves as a powerful tool since it allows for easy comparison of the diagnostic distribution, natural history and treatment outcomes of individuals with dementia.

PMH63

PATIENT REPORTED MEASURES AS QUALITY ASSURANCE TOOLS IN CNS CLINICAL TRIALS

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OBJECTIVE: Signal detection and, ultimately, regulatory approval depend on high-quality, valid and reliable data. The subjective rating scales utilized in CNS clinical trials may be vulnerable to spurious ratings and intentional or unintentional manipulation of ratings by investigators at screening or baseline visits. The objective of this study was to evaluate the feasibility of utilizing a patient reported outcome as a quality assurance measure for evaluation of the quality of a clinician rated primary efficacy measure in a CNS clinical trial. METHODS: A proprietary ratings surveillance system was utilized in a multi-center, double blind, randomized, placebo-controlled clinical trial in which the Hamilton Anxiety Rating Scale (HARS) was the primary efficacy measure. The patient rated Beck Anxiety Inventory (BAI) was added to the baseline visit for quality assurance purposes. Based on published guidelines of the expected relationship between HARS and BAI scores, a computer program flagged aberrant ratings and three flags with the same rater triggered a teaching intervention. The ratings surveillance system was intended both to detect aberrant rating patterns and to deter intentional inflation of ratings in order to qualify subjects. RESULTS: The clinical trial is ongoing. 91 pairs of HARS and BAI ratings have been examined from the randomization visit. 61/91 (67%) pairs were flagged for discordance, in most cases (79%) due to disproportionately high HARS scores compared to the BAI. In 8 cases, the BAI was under 10 with the HARS 22 or greater. In 11 cases, there were at least 3 flags for the same rater and the pattern of discordance was considered to be of sufficient clinical significance to warrant a teaching intervention. CONCLUSION: Use of