METHODS: M-NCAS data were collected from nursing staff ratings of nursing home patients diagnosed with dementia (N = 281), in a randomized double-blind clinical trial comparing risperidone to placebo (RIS-AUS-5 trial). For each item nurses rated the extent to which they agree the target patient exhibits the behavior (agree, partially agree, doubtful/unsure, don’t agree) and the extent to which the behavior is difficult to cope with (very easy, easy, difficult, very difficult). Exploratory factor analyses were performed separately for “agree” and “cope” scales to determine if empirically and conceptually valid subscales exist. Internal consistency reliability was assessed via Cronbach’s alpha. Correlations with the BEHAVE-AD and Cohen-Mansfield Agitation Inventory were examined to evaluate construct validity.

RESULTS: Factor analysis resulted in identification of 3 agree subscales (difficulty, attention seeking, autonomy) and 5 cope subscales (predictability, self direction, neediness, job satisfaction, affect). Total scores were internally consistent, with alphas of 0.74 for the agree scale and 0.95 for the cope scale. Internal consistency reliability was also acceptable for the 3 agree subscales (0.69, 0.77, 0.57) and for the 5 cope subscales (0.89, 0.86, 0.83, 0.86, 0.79). The M-NCAS agree and cope total scale scores correlated most highly with the BEHAVE-AD aggressiveness and anxiety/phobia subscales (r = 0.36, r = 0.35; r = 0.43, r = 0.35 respectively; p < 0.001) and the CMAI verbal/non-aggression and aggression subscales (r = 0.45, r = 0.32; r = 0.34, r = 0.31, p < 0.001), indicating adequate construct validity.

CONCLUSIONS: The 32-item M-NCAS is an internally consistent and valid scale for capturing both dementia-specific behaviors and nursing perception of job burden associated with those behaviors. The M-NCAS provides detailed item-level as well as subscale-level data.

Mental Health—Health Policy Presentations

Labor Supply of Poor Residents in Metropolitan Miami: The Role of Depression and the Co-Morbid Effects of Drug Use

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About 1 in every 20 employees experience depression in the U.S. A recent study estimated that in 1990 the economic costs of depression amounted to $43 billion, with absenteeism alone contributing $12 billion.

OBJECTIVES: The study used 1996–1997 data collected in crime-ridden and low-income neighborhoods of Miami, Florida to 1) examine the relationship between depression and employment; 2) conditional on being employed, estimate the effect of depression on annual weeks worked; 3) examine the robustness of the model estimates to the co-morbid effects of drug use.

METHODS: The labor supply measures included employment in past 30 days and number of weeks worked in past 12 months. The analysis estimated a univariate probit model of employment as well as a bivariate probit model of depression and employment, which accounted for the possible correlation between the unobserved determinants of depression and employment. The annual weeks worked specification was estimated by a standard Tobit and an instrumental variable Tobit model, which, besides the censoring of the observations, accounted for the possible endogeneity of depression.

RESULTS: Results indicate that depressed individuals had a 0.18 lower probability of employment relative to non-depressed individuals in the univariate probit model and a 0.15 lower probability in the bivariate model. Both standard and IV Tobit models found that depression significantly reduced the number of annual weeks worked by 8 weeks. Co-morbid drug use significantly contributed to the estimated effects of depression.

CONCLUSIONS: Prevention and/or treatment of mental health problems such as depression may yield economic benefits by promoting employment and enhancing labor supply. While expansion of mental health services may be particularly beneficial to the unemployed, employers may find it economically efficient to allocate more resources to stress management training and job redesign.

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Impact of Primary Payer Type on Access to Antidepressant Pharmacotherapy Among Patients Diagnosed With Depression

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OBJECTIVE: This study was designed 1) to investigate the impact of primary payer type on access to antidepressant pharmacotherapy among patients diagnosed with depression; 2) to identify predictors of antidepressant pharmacotherapy, prescription for an SSRI or an SNRI, and psychotherapy among patients diagnosed with depression.

METHOD: Data from 1999 National Ambulatory Medical Care Survey (NAMCS) was used for this analysis. Odd ratios (OR) and 95% confidence intervals (CI) were used to investigate the impact of primary payer type on access to antidepressant pharmacotherapy and to elucidate the factors predictive of receipt of antidepressants, an SSRI or an SNRI, and psychotherapy among patients diagnosed with depression.

RESULTS: Among estimated 19,445,888 patients diagnosed with depression in 1999, 74.0% were prescribed with antidepressant pharmacotherapy, 56.7% were prescribed an SSRI or SNRI and 40.8% received psychotherapy. Medicaid beneficiaries (7.8%) were 70%
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less likely to receive antidepressant pharmacotherapy (OR = 0.30, 95% CI = 0.16–0.56) and 80% less likely to receive an SSRI or SNRI (OR = 0.20, 95% CI = 0.10–0.40) but nearly twice more likely to receive psychotherapy (OR = 2.93, 95% CI = 1.44–5.94), compared to patients covered by private insurance (67.6%). Patients lived in the south were the least likely to receive antidepressant pharmacotherapy, an SSRI or SNRI and psychotherapy, compared to other regions (northeast, west and midwest). Other factors predictive of receipt antidepressant pharmacotherapy include patients 50 to 64 years old (patients 30 to 49 as reference) and female gender. Other factor predictive of receipt of psychotherapy included self-report depression as a reason for office visit and duration of the encounter.

CONCLUSION: Among patients diagnosed with depression, factors affecting the pattern of prescribing antidepressant pharmacotherapy and psychotherapy include a patient’s age, gender, type of insurance coverage, self-report of depression and region lived in. Further research is required to discern the reasons for these observed effects.

CLINICAL COMPARABILITY OF SCHIZOPHRENIA PATIENTS SERVED AT TWO PUBLIC SETTINGS: VETERANS AFFAIRS (VA) AND NON-VA MEDICAID

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Differences between Veterans Affairs (VA) and non-VA Medicaid patients with schizophrenia may limit the ability to generalize study results from one group to the other.

OBJECTIVE: This study assessed the clinical comparability of patients with schizophrenia in these two populations (VA and Non-VA Medicaid), after adjusting for important background characteristics.

METHOD: Baseline data from the U.S Schizophrenia Care and Assessment Program, (US-SCAP), a prospective, naturalistic study of schizophrenia, with a total of 223 VA patients were matched with Non-VA Medicaid patients (N = 1,428), using propensity scores calculated based on patients’ characteristics (gender, age, race, age at illness onset, and study site). Using standard measures, the matched pairs (N = 217) were compared on 28 parameters of clinical symptomatology, level of functioning, quality of life, alcohol and drug abuse, depression, concurrent medical conditions, prior hospitalization, medication adherence, and work status.

RESULTS: VA and Non-VA Medicaid patients did not significantly differ on 26 of the 28 studied parameters. For two-thirds of the parameters, the magnitude of the difference between the groups was less than 10%.

CONCLUSIONS: Current findings suggest clinical comparability of VA and Non-VA Medicaid patient groups, with potential generalizableability of clinical findings from one group to the other, after adjustments for background characteristics.