who initiated an episode of drug therapy between July 1994 and December 31, 1999. Episodes were required to have a minimum of 6 months of pre-treatment and 12 months of post-treatment data. Episodes were then separated into three time periods: a “closed-access period” prior to October 1997, a “transition period” covering the first 6 months of open access, and an “open access period” for episodes initiated after April 1, 1998. Multivariate regression models were used to estimate the impact of open access on total health care costs and duration of therapy. Cox proportional hazard models were estimated for time to discontinuation. RESULTS: The number of patients re-starting drug therapy or augmenting an existing therapy increased immediately with open access due to increased use of second-generation medications. Episode initiation rates returned to pre-open access levels within 6 months (transition period). Open access significantly reduced total costs primarily due to significant savings in nursing home care ($1700 and $1807 for re-starters and augmenters, respectively). However, drug persistence also declined with open-access: 42 fewer days for re-starters and 33 fewer days for augmenters. Augmenters and re-starters were 16% and 12% more likely to discontinue therapy if their episodes were initiated in the open access period. CONCLUSIONS: The decision to include atypical antipsychotics by the Medi-Cal program resulted in lower persistency of drug therapy and lower total health care costs. Decision-makers and program administrators must use caution in evaluating the impact of open access to new antipsychotic medications on patient outcomes and costs.

ESCITALOPRAM IN THE TREATMENT OF KLEPTOMANIA
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OBJECTIVES: Kleptomania involves stealing items that are not needed or have limited value from shops, strangers and acquaintances. Its prevalence is estimated at 6 per 1000 U.S. adults. Kleptomania appears to account for 5% of shoplifting. No controlled trials of pharmacotherapy for kleptomania have been published. We are conducting the first controlled trial of a medication for kleptomania. METHODS: We are enrolling adults aged 20 and older with kleptomania of 1 year’s duration, meeting DSM-IV criteria and marked by court referral or stealing at least once per week. We exclude individuals with psychotic disorders, alcohol or substance abuse, bipolar disorder or antisocial personality disorder. Subjects receive open-label escitalopram 10mg/day for 4 weeks and if not “much improved,” take 20mg/day for an additional 3 weeks. A “responder” is a patient experiencing at least 50% decrease in the Y-BOCS-kleptomania version (Y-BOCS-K) scale score and a CGI-I score of much or very much improved. Responders are randomized doubleblind to continue for four months on either escitalopram or placebo. RESULTS: We have enrolled 13 patients of a planned 24. Eleven completed the seven weeks of open-label escitalopram; two discontinued. The 11 completers include 9 women with a mean age of 46 years. Nine are employed full-time, one unemployed and one a student. Five are married, three single, three divorced. Ten of the 11 received escitalopram 20mg/day. The completers’ mean Y-BOCS-K scale score decreased from 23.1 (SD 5.1) to 8.6 (SD 7.8) at end of week 7. On a 0–4 scale, the strength of urges to steal decreased from a mean of 2.9 (SD 0.7) to 1.1 (SD 0.8). The mean number of weekly urges to steal decreased from 3.0 (SD 0.6) to 1.6 (SD 1.1). Eight subjects were responders. Of these eight, four relapsed during the 4-month double blind, placebo-controlled phase, but the blind remains unbroken. CONCLUSIONS: Early results suggest a therapeutic effect for escitalopram in treating kleptomania.

MENTAL HEALTH
MENTAL HEALTH—Cost Studies
PMH19
RISK OF REHOSPITALIZATION: OLANZAPINE VERSUS QUETIAPINE
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OBJECTIVE: To compare rehospitalization rates of individuals with schizophrenia who had been treated and discharged on olanzapine or quetiapine from acute care hospitals. METHODS: Using Premier’s PerspectiveTM database—the largest U.S. hospital drug utilization database, rehospitalization status was examined for inpatients with schizophrenia (ICD9-CM: 295.xx) that were successfully treated and discharged on olanzapine (N = 7573) or quetiapine (N = 3368) between January 1999 and September 2001. A successfully treated patient was one who started treatment with olanzapine or quetiapine in hospital and discharged on the same antipsychotic. Time to readmission up to 33 months was analyzed by Kaplan-Meier models. Cox proportional hazard models were used to derive the hazard ratio (HR) for rehospitalization by adjusting potential confounding factors. RESULTS: Overall rehospitalization rate in the study population was 35.3%. After adjusting for potential confounding factors, quetiapine therapy (average daily dose = 356.1 mg) was associated with 25% increased risk of rehospitalization compared to olanzapine (average daily dose = 17.3 mg) (HR = 1.25, 95% confidence interval 1.17–1.34, p < 0.0001). Additionally, younger age, schizoaffective/paranoid diagnoses, higher severity level, and urban hospital location were significantly associated with higher risk of readmission. CONCLUSIONS: This study suggests that olanzapine-treated patients had lower risk of rehospitalization than quetiapine-treated patients. Moreover, certain patient demographic/clinical factors and institution characteristics also influenced hospital readmission.

PMH20
RELATIONSHIP BETWEEN QUETIAPINE DOSE AND LEVELS OF MENTAL HEALTH RESOURCE USE AMONG PATIENTS WITH SCHIZOPHRENIA OR BIPOLAR DISORDER
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OBJECTIVE: Quetiapine’s relatively broad dosage guidelines (150–750mg/day) may result in suboptimal dosing. This study investigated the association between quetiapine dose levels and efficacy as reflected in mental health resource use by patients with schizophrenia or bipolar disorder. METHODS: Patients who initiated quetiapine monotherapy and were treated for at least 4 months were identified in a large health plan database (1999–2002). Use of mental health resources other than quetiapine was measured by charges on all medical claims for mental disorders (ICD-9-CM codes 290.xx–316.xx) and on all prescription claims for other psychotropic medications. Each patient’s first quetiapine prescription was used to identify the target daily dose, because subsequent adjustments may have represented an effect rather than a determinant of health resource use, which was measured in months 2, 3, and 4 of treatment. Regression models controlling for patient differences measured an effect rather than a determinant of health resource use, which was measured in months 2, 3, and 4 of treatment. Regression models controlling for patient differences measured an effect rather than a determinant of health resource use, which was measured in months 2, 3, and 4 of treatment. Regression models controlling for patient differences measured an effect rather than a determinant of health resource use, which was measured in months 2, 3, and 4 of treatment. Regression models controlling for patient differences measured an effect rather than a determinant of health resource use, which was measured in months 2, 3, and 4 of treatment.