disorder have not been investigated, despite its potential relevance in this disorder, given its high cardiovascular and metabolic comorbidities and the encouraged maintenance of social rhythms in its management. This study aimed to explore the effectiveness of an adjunctive walking program in the acute treatment of bipolar disorder.

Methods: The sample consisted of a retrospective cohort of in-patients at a private psychiatric hospital with a primary diagnosis of bipolar disorder, who were admitted from January 2004 to December 2005. All patients were invited to participate in a 40-min walking group that took place on weekdays. Those who reliably attended the walking group (participants) were compared against those who never attended (nonparticipants), using the Clinical Global Impression (CGI) scales and the 21-item Depression Anxiety Stress Scales (DASS).

Results: The participants ($n = 24$) and nonparticipants ($n = 74$) were comparable in age, length of stay, bipolar subtype distribution, and baseline CGI and DASS measures, except for a lower DASS stress subscore for the participants (19.4 vs. 25.3, $P = 0.049$). The groups did not differ in their discharge CGI scores, but participants showed significantly lower scores on DASS (23 vs. 44.6, $P = 0.005$) and all its subscales (depression 7.2 vs. 13.7, $P = 0.048$; anxiety 6.6 vs. 13.8, $P = 0.002$; stress 9.2 vs. 17.1, $P = 0.01$) at the time of discharge.

Conclusions: Physical activity may have an adjunctive therapeutic role in bipolar disorder. Further investigation with randomized controlled trials is warranted.

The utility of the Clinical Global Impression Scale in the clinical setting

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Background: The Clinical Global Impression (CGI) scale is an established outcome measure in psychopharmacology research and has been applied to specific disorders, including schizophrenia, anxiety disorders, depression and bipolar disorder. Its simplicity and ability to transcend diagnostic boundaries support its utility in the general clinical setting. This study was conducted to test the validity of the CGI in a private psychiatric in-patient setting.

Methods: Consecutive admissions ($n = 786$) to a private psychiatric hospital from January 2004 to December 2005 were studied. Retrospective data were collected on four outcome measures that were routinely administered at admission and discharge. These were the self-rated 21-item Depression Anxiety Stress Scales (DASS-21) and the Mental Health Questionnaire (MHQ-14), and the clinician-rated CGI and Health of the Nation Outcome Scales (HoNOS). In relation to the CGI, only the severity (CGI-S) and global improvement (CGI-I) subscales were used. Comparative statistical analyses were performed.

Results: The numbers of completed CGI ratings were 624 admission CGI-S, 614 discharge CGI-S and 610 CGI-I. The admission and discharge CGI-S scores were correlated ($r = 0.40$), and the indirect improvement measures obtained from their differences were highly correlated with the direct CGI-I scores ($r = 0.71$). The CGI-S categories reflected similar trends in scores on the other three measures, and the CGI-I showed parallel changes with improvement on HoNOS.

Conclusions: The CGI-S and CGI-I are comparable to other measures of illness severity and improvement. They appear to be valid instruments in the private psychiatric in-patient setting.

Alzheimer's disease, delusions and cognitive decline

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Background: The authors reviewed studies published between 1992 and 2005 that reported on the prevalence and phenomenology of delusions in Alzheimer's disease (AD), as well as any relationship with cognitive decline.

Methods: The terms 'delusions, cognitive and Alzheimer's disease/dementia' were used to search the PubMed and PsychINFO databases. Empirical investigations and reviews were included in our report but were dependent upon quantitative data on the above factors being available.

Results: Data from a meta-analysis show that the overall prevalence for delusions in AD is 36%. There is, however, a broad range of reported prevalence rates across studies, from 9% to 70%. Variations in prevalence rates are because of methodological differences, such as inconsistent consideration of neuroleptic use, participants being included at various stages of AD and failure to consider other neuropsychiatric symptoms. One study did address factors that lead to inconsistent findings and subsequently reported that 34% of a sample of patients with AD were found to experience delusions and that these patients were at a higher risk of

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