consequently,even male suicidality decreased on Gotland for the first time. Since than, the "Gotland Study" of educating GPs as a suicide preventive effort in suitable endemic suicide regions has been widely spread and replicated in many countries, regions, and populations of societal transition,, often with positive results. Educating GPs according to the Gotland Model is today considered to be one of the essential measures that should be offered in comprehensive,multimodal and multisectorial national programs of suicide prevention.

S01.05

Substance abuse and suicide risk in schizophrenia

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The literature suggests that nearly 50% of patients with schizophrenia have a co-occurring substance use disorder (SUD), most frequently alcohol and/or cannabis (at a rate about three times as high as that of the general population). Outcomes associated with Comorbid SUD and Schizophrenia are earlier onset of schizophrenia, increased relapses, treatment noncompliance/more side effects, poorer response to antipsychotic medication, more hospitalizations, increased risk for violence, increased medical costs, more affective disturbance. These conditions are also associated with increased suicide risk. The increased suicide risk of substance abusing schizophrenic patients could be the result of a cumulative effect of many factors or events, such as the loss of remaining social control through the consumption of psychotropic substances, noncompliance with antipsychotic medication, presence of paranoia and depression.

Abuse substances worsen both symptoms and prognosis of the illness and are related to higherrelapse rates.

Studies suggest that some of the second-generation (atypical) agents may be helpful for these patients. Some researchers have suggested that the lower incidence of neurologic side effects produced by the atypical antipsychotics, along with the possibility that these agents may be more likely to decrease negative symptoms, make them a logical choice for patients with co-occurring substance use disorder (even though parameters of the metabolic syndrome must be monitored while using these agents).

Joint AEP/ECNP: Psychopharmacological intervention in major psychiatric disorders

JW01.01

Strengths and weaknesses of evidence-based medicine (EBM)

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As medicine and magic began to slowly part ways in the Enlightment era, scientific evidence became the driving force and currency of medicine. As scientific evidence was being defined, the newly established medical schools imparted this knowledge to their students. Those who mastered the evidence, and committed to adhere to it, became physicians who enjoyed public trust and the statutory position that came with it. With some exceptions, the idea that scientific evidence should constitute the only foundation for medical practice has withstood the test of time and the occasional attacks, by well-meaning but naïve individuals as well as charismatic charlatans.

The principal stakeholders of clinical practice - consumers, practitioners, and providers of services and products - are all trying to influence the stream of evidence. The current debate on EBM focuses on what constitutes true scientific evidence, and how best to translate this evidence into clinical practice. The evidence available to the practitioner varies widely in terms of source, quality, and potential for bias, while the relevance of evidence, derived from statistical analyses of data from mega-trials, to the treatment of individual patients is sometimes difficult to grasp.

This presentation will discuss the gap between EBM and clinical practice and ways to bridge the two.

JW01.02

Lessons from the long term bipolar study, balance

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Objectives: To explore the times of onset of response and remission associated with combination therapy in patients with bipolar I disorder.

Methods: Patients who are suitable for long term treatment are initially recruited and treated with the combination of lithium and valproate (as ®Depakote). For a four to eight week run-in period these drugs are given together to assess the tolerability of this combination. At the end of that time patients are randomised to either continue on the combination itself, or lithium alone, or depakote alone

Results: The central problems are patient recruitment and clinician capacity. An update on trial procedures and progress will be presented. The results will be analysed after trial completion later this year

Conclusions: The long term treatment of bipolar disorder is frequently based on polypharmacy. While this approach seems logical, it is not supported by much empirical evidence since industry has hitherto had little interest in studying other than monotherapy. BALANCE has the virtue of being enriched for adherence and tolerability. Whether outcomes are better in combination treatment is a finding that will be eagerly awaited.

Reference

[1]. Geddes, J.G. & Goodwin, G.M. (2001) Bipolar disorder: clinical uncertainty, evidence-based medicine and large-scale randomised trials. British Journal of Psychiatry 178 (suppl. 41), s191-s194

JW01.03

Lessons from schizophrenia study: Eufest

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Background: Most studies comparing second generation antipsychotics with classical neuroleptics have been conducted in more or less chronic schizophrenia patients.

Aims: The aim of the European First Episode Schizophrenia Trial (EUFEST) is to compare treatment with amisulpride, quetiapine, olanzapine and ziprasidone to a low dose of haloperidol in an unselected sample of first episode schizophrenia patients with minimal prior exposure to antipsychotics.

Methods: 500 patients between the ages of 18-40 meeting DSM-IV criteria for schizophrenia, schizoaffective disorder or schizophreniform disorder will be randomly allocated to one year of treatment

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