

increasingly recognised that sedation is not a prerequisite for acute symptom control. Moreover, excessive sedation or 'over-sedation' can interfere with the physician's ability to evaluate the patient and establish an effective therapeutic alliance with them, thus potentially influencing future compliance and treatment outcomes. Over-sedation is also strongly disliked by patients. Thus, achieving control of agitation via rapid calming rather than sedation is becoming an important therapeutic goal. Sedative agents, such as lorazepam, have traditionally been used for the management of acute agitation. However, problems with over-sedation have led to the increased use of intramuscular (IM) antipsychotics – which are easy to administer and provide rapid symptom relief of acute agitation – as a first-line approach in the acute setting. The recent availability of atypical antipsychotics as IM formulations represents a significant step towards meeting the goal of efficacy without over-sedation. Aripiprazole, olanzapine and ziprasidone have demonstrated efficacy in the management of acutely agitated patients with schizophrenia. Indeed, IM aripiprazole has been shown to be equally effective as IM haloperidol with a lower risk of extrapyramidal symptoms. Importantly, calming of acutely agitated patients without excessive sedation is emerging as a significant clinical advantage of IM atypicals over older treatments such as typical antipsychotics or benzodiazepines. Thus, physicians should consider the specific, sedation-independent calming effects of atypicals.

combination therapy versus placebo. Overall, there seems to be evidence for superior efficacy of the combination of antidepressants with cognitive behaviour therapy, especially in certain subgroups of patients.

CS02.02

Psychological treatments combined with drug therapy in bipolar disorder

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There is now a large body of controlled trial research into the efficacy of psychological treatments in unipolar affective disorder, indicating their place in acute treatment and in prevention of relapse and recurrence. In bipolar disorder the evidence is still less strong, but studies are rapidly accumulating. Psychological treatments have been almost always combined with medication. The psychological approaches have included psychoeducation, cognitive therapy (CBT), interpersonal and social rhythm therapy (IPSRT), family therapy. Some approaches have used mixtures of elements, particularly psychoeducation with family or cognitive therapy. Benefits found have included symptom improvement, improvement in social function, relapse prevention and improved adherence to drug regimes. However findings have not been entirely consistent, so that definitive recommendations are still premature. Effects may be weaker than in unipolar disorder. In contrast to unipolar disorder, where the strongest body of empirical evidence favours cognitive therapy for symptom remission and relapse prevention, in bipolar disorder psychoeducationally-based approaches may emerge to be of greater benefit.

Core Symposium: Combined psychopharmacotherapy and psychotherapy

CS02.01

Combination of antidepressants and cognitive behaviour therapy

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The investigation of the comparative efficacy of the combination of pharmacotherapy and psychotherapy versus either modality alone has to consider several methodological issues. Neglect of these methodological aspects can lead to severe pitfalls. Also, the interpretation of the results of such studies should be performed very carefully, considering several aspects. Among others, the following questions have to be addressed:

- Was the study performed in a more psychopharmacology-oriented or more psychotherapeutically-oriented institution?
- Were the patients acutely or chronically ill?
- Were the patients already refractory to pharmacotherapy or psychotherapy prior to inclusion in the study?
- Was the pharmacotherapy performed according to the state of the art?
- Was the psychotherapy performed according to the state of the art?
- Was the pharmacotherapy administered under double-blind conditions, using a placebo control or another kind of control?
- Was the psychotherapy administered in the context of a pseudo placebo control group?
- Was the sample size adequate for a confirmative trial?

Generally it has to be taken into consideration that it is much more difficult to prove efficacy of a combination therapy versus an active mono-therapy than to prove efficacy of a mono-therapy or

CS02.03

The relevance of psychoeducation in the treatment of schizophrenia

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Background and Aims: Due to the multifactorial origin of Schizophrenia, a multidimensional therapeutic approach has become state of the art in our days (APA 2004; DGPPN 2006). Whereas the efficacy of pharmacotherapy has been proven in a great number of studies (Möller 2005), data concerning the efficacy of psychotherapeutic and psychosocial measures are mixed up to now.

Methods: There are many studies about psychoeducation, cognitive behavioural therapy, cognitive remediation, social skills training and other psychotherapeutic interventions, but we don't know exactly if these measures are successful on their own or only in combination with other therapeutic measures. The newest findings in the literature will be screened concerning their efficacy.

Results: Significant results have meanwhile been found concerning the rehospitalisation-rate during the first and the second year after discharge (Pekkala 2004; Pitschel-Walz et al 2006). For the time frame of 5-8 years after discharge in a pooled data analysis, a rehospitalisation rate of 54% among the intervention group and 80% among the control group ($p < .05$) could be found in the long term follow-up studies of Tarrrier et al (1994), Hornung et al (1999) and Bäuml et al (2007).

Conclusions: Psychoeducation has proven as most effective, if relatives were included into the intervention (Pitschel-Walz, Bäuml et al 2001). The newest data concerning psychosocial interventions in general and concerning psychoeducation in particular will be

presented. Consequences for therapy and scientific strategies will be discussed.

CME Course: Networking as a strategy in psychiatry

C17.01

Social network strategies for leading

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How do social networks add value for the work of leaders? What are key network mechanisms? How can you improve the strategic impact of your social capital? This session introduces the idea of 'social capital', along with social network concepts, tools, and strategies. The evidence comes from recent findings about how collaboration in basic research in biotechnology occurs, how firms explore innovative technologies, and on how individuals create professional advantage. The themes focus on how social networks change the terms of value creation, create de facto systems of opportunity and advantage, and extend basic leadership in contested, ambiguous professional settings. The session is interactive, rather than one-way lecture.

Read aheads for the session:

- Hargadon, A. 2006. 'Brokers of innovation.' *Focus*, vol. VIII, no. 1.
 - Uzzi, B and S Dunlap. 2005. 'How to build your network.' *HBR*, December.
- Reprint # R0512B
- Weick, K. 1996. 'Prepare your organization to fight fires' *HBR*, May-June.

Symposium: The WPA presidential global child mental health program

S08.01

The WPA presidential global child mental health program; An overview

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Half of the world's population are children or adolescents. Nearly 5% of them suffer from mental disorders and another five percent have conduct disorders.

Even in highly developed industrialized countries mental disorders in this age are often not recognized nor taken seriously. The situation is made worse by the lack of awareness of the magnitude and severity of the problems caused by mental disorders of children and adolescents by political and health decision-makers, by health professionals and by the general public; and by the fact that health professionals and others involved in child care and development have often only rudimentary knowledge about appropriate methods of prevention and treatment of mental and neurological disorders in childhood and adolescence.

It is for this reason that the World Psychiatric Association (WPA) carried out in collaboration with the World Health Organization (WHO) and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) this unprecedented program.

This program aims at; increasing the awareness of health decision-makers, health professionals and the general public about the magnitude and severity of problems related to mental disorders in childhood and adolescence and about possibilities for their resolution; at promoting the application of measures of primary prevention of mental disorders in childhood and adolescence and of interventions that will contribute to the healthy mental development of children and adolescents; and support to the development of services for children and adolescents with mental disorders and to facilitate the use of effective methods of treatment.

S08.02

Preventive interventions in child and adolescent psychiatry with special reference to school drop-out

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Background and Aims: International studies have demonstrated that the prevalence rates of psychiatric disorders in children and adolescents in population samples vary between 8 and 23 %. Our own school-based study in Germany in a selection-free sample revealed a prevalence of 12.7% in the age-group between 6 and 18. The need for treatment according to international studies is at least 5 %. Over the past 30 years, increasing figures have been described regarding aggressive behavior, alcohol and drug addiction, delinquency, depression, suicidal behavior, obesity, and eating disorders. This underlines the importance of prevention, subdivided in universal prevention addressed to a complete population, and targeted prevention (selective and indicated prevention aiming at groups with increased risk or already identified high-risk groups).

After the discussion of biological, psychological, and psychosocial risk factors and markers of resilience, an overview is given of some established prevention programmes for psychopathological disorders in children and adolescents, followed by the results of three prevention programmes on school drop-out carried out within the WPA Presidential Programme on Child Mental Health in Alexandria/Egypt, Nishnij Novgorod/Russia, and Porto Alegre/Brazil.

Methods: A comparison was made between intervention schools where defined interventions had taken place and control schools where only information was given and no formal interventions had been carried out.

Results and Conclusions: In all three locations, the preventive interventions were successful: The school drop-out rate could be significantly reduced within the course of one year. As school drop-out is associated with many other disorders and disadvantages, this is an encouraging result.

S08.03

Is there a link between slow learning, school failure and delinquency?

P.A. Rydelius. *Karolinska Institutet, Astrid Lindgren's Children's Hospital, Stockholm, Sweden*

In Sweden, CAP (Child and Adolescent Psychiatry) has a history of more than 100 years. The discipline developed out of paediatrics, education, child social welfare and psychiatry in that time order. In similarity to the situation in Switzerland, "school -psychiatry" was established as a branch of CAP with the aim to understand the link between cognition, behaviour and health and to promote health for children with slow learning capacity and mental retardation who in those days were children at a high risk for juvenile delinquency. The first CAP units opened at the end of World War I in the Stockholm Public School system and at the Paediatric Clinic of Norrntull's Children's Hospital, one of