of these agents for the treatment of AD. Prof. Cefalu expressed that the high level of cholinesterase inhibitor discontinuation among AD patients remains a problem and that withdrawal may be associated with acceleration of cognitive and physical decline. Therefore, it is important to educate family members, caregivers, and patients (when appropriate) regarding the risks and benefits of these pharmacological treatments prior to initiating therapy.

There are a few topics that correspond across all of these guidelines. The use of atypical antipsychotics has been associated with an increased risk of death that is related to vascular disease in elderly patients with dementia. Also, the CATIE study suggested that the adverse effects that are associated with these agents may offset the advantages in the efficacy of atypical antipsychotic drugs in AD patients [Schneider LS et al. *N Engl J Med* 2006]. Therefore, they should only be used after careful assessment of the risks and benefits. These guidelines all agree that the use of NSAIDS, statins, and estrogen are no longer recommended due to their lack of efficacy and safety. The presenters all stressed the importance of early detection and the need for disease-modifying therapies.

Suicide Risk Factors and Prevention

In 2006, the suicide rate was 11.2 people/100,000 (n=33,000), averaging 1 person every 16 minutes and exceeding the rate of homicide (6.2/100,000) in the United States [Centers for Disease Control and Prevention. www.cdc.gov/ncipc/wisquars/default.htm.]. Paula Clayton, MD, American Foundation for Suicide Prevention, New York, NY, discussed possible risk factors and suicide prevention strategies at the APA Annual Meeting. Mental disorders, past suicide attempts, symptomatic precursors, genetic factors, sociodemographics, and environmental factors have been shown to play a role in suicide. Mental illness is the number 1 risk factor for suicide, and psychological autopsies and interviews with family members and caregivers after a suicide have shown that 90% of victims of suicide have 1 or more mental disorders at the time of death [Harris & Barraclough. *Br J Psychiatry* 1997]. Schizophrenia, unipolar depression, and bipolar disorder are associated with the highest short-term risk [Tidermalm et al. *BMJ*, 2008]. Acute anxiety, psychic pain, and panic attacks during an acute depressive episode are also linked to higher rates of suicide [Lewis LM et al. *Suicide & Life Threat Beh* 2007].

In a study by Lewis and colleagues, the use of no-harm contracts as a prevention method was shown to have little efficacy [Fawcett et al. *AJP* 1990]. Therefore, other prevention tools are needed. Prof. Clayton pointed out that method restriction is the best strategy for patients who are at risk. Bridge barriers and netting, as well as increased firearm restriction, have been the best methods of prevention, according to Prof. Clayton, because bridgeside phones and signs have not impacted suicide rates thus far. Time delays that are associated with these prevention methods allow the suicidal patient to change his mind, resolve the preceding conflict or stressor, detoxify if there are contributing substances that lead to an attempt, and seek professional help.

Medications, such as antidepressants and lithium therapy, are also helpful tools in the prevention of suicide. Although only 20% of medicated depressed patients are adequately treated with antidepressants, Prof. Clayton stressed that lithium therapy is underutilized and that the use of this treatment in combination with psychotherapy should be encouraged for at-risk patients. Prof. Clayton concluded that early detection and treatment for mental disorders, method restriction, and responsible reporting on the part of the media to avoid sensationalizing suicide are currently the best practices for prevention.