

Appendix A: Search Methodology

Appendix A. Search Methodology:

ATYPICAL ANTIPSYCHOTICS – SEARCH METHODOLOGIES

SEARCH #1 (Drug Utilization):

DATABASE & TIME PERIOD COVERED:

PubMed – 6/1/2008-9/9/2009

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name]
AND
drug utilization OR pharmacoepidemiolog* OR utiliz*[tiab] OR utilis* OR use[ti] OR
uses[ti]

NUMBER OF RESULTS: 34

SEARCH STRATEGY #2 (Drug Utilization):

DATABASE & DATES OF COVERAGE:

PubMed – 1966-9/10/2009

paliperidone
AND
drug utilization OR pharmacoepidemiolog* OR utiliz*[tiab] OR utilis* OR use[ti] OR
uses[ti]

NUMBER OF RESULTS: 10

SEARCH STRATEGY #3 (Drug Utilization)::

DATABASE & DATES OF COVERAGE:

PsycINFO – 2008-9/24/2009

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
paliperidone
AND
KW OR TI (drug utilization OR utiliz* OR utilis* OR use OR uses OR
pharmacoepidemiolog*)
Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 366

SEARCH STRATEGY #4a (Anxiety)

DATABASE & DATES OF COVERAGE:

PubMed – 1966-9/24/2009

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*

AND

("Anxiety"[Mesh] OR "Anxiety Disorders"[Mesh] OR "Anti-Anxiety Agents"[Mesh] OR
"Anti-Anxiety Agents "[Pharmacological Action]) OR anxiety[tiab] OR anxious*[tiab] OR
anti-anxiety[tiab] OR antianxiety[tiab]

NUMBER OF RESULTS: 1098

SEARCH STRATEGY #4b (Insomnia)

DATABASE & DATES OF COVERAGE:

PubMed – 1966-9/24/2009

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*

AND

"Sleep Initiation and Maintenance Disorders"[Mesh] OR insomni*[tiab] OR sleep*[tiab]

NUMBER OF RESULTS: 370

SEARCH STRATEGY #4c (Autism):

DATABASE & DATES OF COVERAGE:

PubMed – 1966-9/24/2009

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*

AND

autism OR autistic

NUMBER OF RESULTS: 202

**SEARCH STRATEGY #4d (ADHD):
DATABASE & DATES OF COVERAGE:
PubMed – 1966-9/24/2009**

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*
AND
"Attention Deficit Disorder with Hyperactivity"[Mesh] OR attention deficit disorder[tiab]
OR adhd

NUMBER OF RESULTS: 158

**SEARCH STRATEGY #4e (Anorexia/Bulimia):
DATABASE & DATES OF COVERAGE:
PubMed – 1966-9/24/2009**

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*
AND
"Anorexia Nervosa"[Mesh] OR "Anorexia"[Mesh] OR ("Bulimia"[Mesh] OR "Bulimia
Nervosa"[Mesh]) OR anorexi*[tiab] OR bulimi*[tiab]

NUMBER OF RESULTS: 86

**SEARCH STRATEGY #4f (Tourette Syndrome):
DATABASE & DATES OF COVERAGE:
PubMed – 1966-9/24/2009**

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*
AND
"Tourette Syndrome"[Mesh] OR tourette*[tiab]

NUMBER OF RESULTS: 127

**SEARCH STRATEGY #5:
DATABASE & DATES OF COVERAGE:
PubMed – 1966-10/13/2009**

“Related Article” search on the following:

Leslie, D. L., S. Mohamed, et al. (2009) "Off-label use of antipsychotic medications in the department of Veterans Affairs health care system." Psychiatr Serv 60(9): 1175-81.

NUMBER OF RESULTS: 107

**SEARCH STRATEGY #6 (Original Meds and Original Conditions):
DATABASE & DATES OF COVERAGE:
PubMed – 7/1/2008-10/13/2009**

risperidone OR olanzapine OR quetiapine OR aripiprazole OR ziprasidone OR
"Risperidone"[MeSH] OR "olanzapine"[Substance Name] OR "quetiapine"[Substance
Name] OR "aripiprazole"[Substance Name] OR "ziprasidone"[Substance Name] OR
atypical antipsychotic* OR atypical anti-psychotic*

AND

"Obsessive-Compulsive Disorder"[Mesh] OR "Obsessive Behavior"[Mesh] OR "Stress
Disorders, Post-Traumatic"[Mesh] OR "Personality Disorders"[Mesh] OR
"Dementia"[Mesh] OR "Depressive Disorder, Major"[Mesh] OR obsessive*[tiab] OR
posttraumatic stress[tiab] OR post-traumatic stress[tiab] OR post traumatic stress[tiab]
OR ptsd[tiab] OR personality disorder*[tiab] OR dementia[tiab] OR major depress*[tiab]

NUMBER OF RESULTS: 230

**SEARCH STRATEGY #7 (Original Meds & Original Conditions) :
DATABASE & DATES OF COVERAGE:
PsycINFO – 2008-11/13/2009**

olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole

AND

personality disorder* OR posttraumatic stress disorder OR post-traumatic stress OR
ptsd or dementia OR "major depressive" OR obsessive-compulsive OR obsessive
compulsive or dementia OR ((geriatric OR elderly) AND (agitation OR agitated))

Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 165

SEARCH STRATEGY #8 (Original Meds & New Conditions) :
DATABASE & DATES OF COVERAGE:
PsycINFO --1850-11/18/2009

olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole
AND
anxiety OR anti-anxiety OR antianxiety OR insomnia OR sleep* OR anorexi* OR bulimi*
OR tourett* OR attention deficit disorder OR adhd)
Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 895

SEARCH STRATEGY #9 (New Meds):
DATABASE & DATES OF COVERAGE:
PubMed – 7/1/2008-10/13/2009

paliperidone
NOT
animal* NOT (human OR humans)

NUMBER OF RESULTS: 209

SEARCH STRATEGY #10 (New Meds):
DATABASE & DATES OF COVERAGE:
PubMed – 1966-11/13/2009

iloperidone OR asenapine

NUMBER OF RESULTS: 80

SEARCH STRATEGY #11 (New Meds):
DATABASE & DATES OF COVERAGE:
PsycINFO – 2008-11/18/2009

paliperidone OR iloperidone OR asenapine
Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 85

**SEARCH STRATEGY #12 (Depression):
DATABASE & DATES OF COVERAGE:
PsycINFO – 2008-11/20/2009**

olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole
AND
depression OR depressive
AND
human
NOT
personality disorder* OR posttraumatic stress disorder OR post-traumatic stress OR
ptsd or dementia OR "major depressive" OR obsessive-compulsive OR obsessive
compulsive or dementia OR ((geriatric OR elderly) AND (agitation OR agitated))

Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 137

**SEARCH STRATEGY #13 (Substance Abuse):
DATABASE & DATES OF COVERAGE:
PsycINFO – ~1850-11/20/2009**

olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole
AND
substance abuse* OR drug abuse* OR alcohol abuse OR addict* OR drug dependen*
OR cocaine OR heroin
AND
human

Search modes - Phrase Searching (Boolean)

NUMBER OF RESULTS: 326

**SEARCH STRATEGY #14 (Substance Abuse):
DATABASE & DATES OF COVERAGE:
PubMed – 1966-11/20/2009**

olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole
AND
substance abuse* OR drug abuse* OR alcohol abuse OR addict* OR drug dependen*
OR cocaine OR heroin OR "Substance-Related Disorders"[Mesh]
NOT
animal* NOT (human OR humans)

NUMBER OF RESULTS: 521

SEARCH STRATEGY #15 (Iloperidone & Asenapine):
DATABASE & DATES OF COVERAGE:
Embase – 1972-12/8/2009

iloperidone? or asenapine?

NUMBER OF RESULTS: 222

SEARCH ALERTS (Initiated 12/18/09)

PubMed

atypical antipsychotic* OR atypical anti-psychotic* OR olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole OR paliperidone OR iloperidone OR asenapine

PsycINFO

atypical antipsychotic* OR atypical anti-psychotic* OR olanzapine OR quetiapine OR risperidone OR ziprasidone OR aripiprazole OR paliperidone OR asenapine OR iloperidone

Population Group: Human

Frequency: Monthly, Duration: Six months

Appendix B. Data Collection Forms:

Appendix B. Data Collection Forms:

Short Form Screener

Atypical Anti-Psychotic Drug Review Update
Article Screener
FINAL 12/11/2009

Article ID:

Citation:

1. Research topic(s): **Check all that apply**
- Aripiprazole
 Asenapine
 Iloperidone
 Olanzapine
 Quetiapine
 Paliperidone
 Risperidone
 Ziprasidone
 Entire class
 None of the above (STOP)
2. Condition(s) studied: **Check all that apply**
- Anxiety
 Dementia/severe geriatric agitation
 Depression
 Insomnia
 Obsessive-compulsive disorder
 Personality disorders (DSM IV)
 PTSD
 Substance abuse
 Eating disorder (incl children 17 & under) ..
 ADHD (incl children 17 & under)
 Tourette's (incl children 17 & under)
 None of the above (STOP)
3. Study population: **Circle one**
- Human included 1
 Only animal or cell lines 2 (STOP)
4. Study design: **Circle one**
- Descriptive (historical, editorial etc.) 1 (STOP)
 Non-systematic review 2 (STOP)
 Systematic review / meta-analysis 3 (STOP)
 Case report 4 (STOP)
 Case series 5
 Cohort 6
 Case control 7
 RCT *only* 8
 CCT *only* 9
 Trial + Open label extension 10
 Other design 11
5. Was a placebo used in this study? **Circle one**
- Yes 1
 No 2
6. Total sample size entering study. If not reported then total completing sample size:
Enter # or 999 if no sample reported
-
7. Does article report on the following: **Check all that apply**
- Efficacy
 Safety / Adverse events
 Utilization / Prescribing patterns
 None of the above (STOP)
8. Total duration of study:
For Duration enter # or 999 if not reported.
For Units enter code from below.
-
- | Duration | | Units | |
|----------|-----------|----------|--|
| 01. Hour | 03. Week | 05. Year | |
| 02. Day | 04. Month | 99. NR | |
9. Language of article: **Circle one**
- English 1
 Other 2
 Specify : _____
10. Do you think that this article might be a duplicate or include the same data as another study? **Circle one**
- No 1
 Yes 2
 If YES, ID#: _____
11. Do you think that this article might be part of a large or named trial? **Circle one**
- No 1
 Yes 2
 If YES, trial name: _____
12. Is there a reference that needs to be ordered? **Circle one**
- No 1
 Yes 2
 If YES, Ref #: _____

NOTES:

Detailed Abstraction Form

**Anti-Psychotic Drugs Update Project
Detailed Abstraction Form**

FINAL 05-21-2010

Article ID: _____	Reviewer: _____
First Author: _____	(Last Name Only)
Study Number: ____ of ____	Description: _____
(Enter '1 of 1' if only one)	(if more than one study)

1. **Related Studies Flag:** (ENTER 99 FOR NONE)
ID numbers of articles that contributed data to this form:
_____, _____, _____, _____, _____
2. **Is the study design trial with crossover?** (CIRCLE ONE)
Yes 1
No 2
3. **Was the study described as randomized?** (CIRCLE ONE)
Yes 1
No 2
4. **Treatment Allocation**
 - a. **Was the method of randomization adequate?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9
 - b. **Was the treatment allocation concealed?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9
5. **Were groups similar at baseline regarding the most important prognostic indicators?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9

6. **Is the study described as:** (CIRCLE ONE)
Double blind 1
Single blind, patient 2
Single blind, outcome assessment 3
Single blind, not described 4
Open 5
Blinding not described 8
Not applicable 9
7. **If reported, was the method of double blinding appropriate?** (CIRCLE ONE)
Yes 1
No 2
Double blinding method not described 8
Not applicable 9
8. **Was the outcome assessor blinded?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9
9. **Was the care provider blinded?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9
10. **Were patients blinded?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9
11. **Drop-out rate questions:** (CIRCLE ONE)
 - a. **Was the drop-out rate described and the reason given?**
Yes 1
No 2
Don't know 9
 - b. **Was the drop-out rate acceptable?** (CIRCLE ONE)
Yes 1
No 2
Don't know 9

**Anti-Psychotic Drugs Update Project
Detailed Abstraction Form**

12. Were all randomized participants analyzed in the group to which they were originally assigned? (CIRCLE ONE)

Yes..... 1
 No..... 2
 Don't know..... 9

13. Other sources of potential bias: (CIRCLE ONE)

a. Were co-interventions avoided or similar?

Yes..... 1
 No..... 2
 Don't know..... 9

b. Was the compliance acceptable in all groups? (CIRCLE ONE)

Yes..... 1
 No..... 2
 Don't know..... 9

c. Was the outcome assessment timing similar in all groups? (CIRCLE ONE)

Yes..... 1
 No..... 2
 Don't know..... 9

14. What is the study trial name?
 Enter code or 999 for no name: _____

15. What was the study's setting? (CHECK ALL THAT APPLY)

Multi-center.....
 Single setting.....
 Community practice.....
 Long-term care facilities.....
 VA Healthcare System.....

Other (enter code: _____)..
 Setting not reported.....

16. What was the study's funding source? (CHECK ALL THAT APPLY)

Government.....
 Hospital.....
 Industry.....

Private (non-industry).....
 Other (enter code: _____).....
 Unclear.....
 Not reported.....

17. Did the article include a statement on the role of the funder? (CIRCLE ONE)

Yes..... 1
 No..... 2

18. In what area was the study conducted? (CHECK ALL THAT APPLY)

US.....
 Canada.....
 UK.....
 Western Europe.....
 Eastern Europe.....
 Australia/New Zealand.....
 Asia.....
 Middle East.....
 Latin America.....
 Other Country (spec: _____)..
 Not reported.....

19. What was the percent of male participants? (ENTER NUMBER OR 999)

_____ %

20. What was the racial/ethnic population studied? (Check all that apply)

Caucasian.....
 African Ancestry.....
 Hispanic.....
 Asian/Pacific Islander.....
 Native American.....
 Eskimo/Inuit.....
 Mixed.....
 Other-Not otherwise specified.....
 Not reported.....

**Anti-Psychotic Drugs Update Project
Detailed Abstraction Form**

21. What were reported for the following questions regarding subjects' ages? (Enter number 999 for not reported)

Mean Age _____

Median Age _____

Age Range _____ to _____

22. What were the study's inclusion criteria?

Text: _____

23. What were the study's exclusion criteria?

Text: _____

24. What were the comorbidities reported in the study?

(Check All That Apply)

Anxiety

Dementia/severe geriatric agitation...

Depression.....

Insomnia.....

Obsessive-compulsive disorder

Personality disorders (DSM IV).....

PTSD

Substance abuse.....

Eating disorder (incl children 17 & under) ...

ADHD (incl children 17 & under)

Tourette's (incl children 17 & under)

Enter codes for others: _____ , _____ , _____ ,

_____ , _____ , _____ , _____ , _____ ,

_____ , _____ , _____ , _____ , _____ ,

Units for Q25, Q26, Q27
1. Hour
2. Day
3. Week
4. Biweekly
5. Month
6. Year
7. Not described
8. Not Applicable
9. Not Reported
10. Min
11. Weekly
12. Monthly

25. Run-in period table: (Enter 998 if not described; enter 999 if no run-in.)

Length	Units	Placebo/Medication	How used for randomization?

26. Wash-out period table: (Enter 998 if not described; enter 999 if no wash-out.)

Length	Units	Placebo/Medication	How used for randomization?

27. Time of assessment: When were outcomes measured?

(Enter the number/code in the appropriate box, or circle YES/NO.)

Baseline?	YES / NO	
	Number	Unit
1 st		
2 nd		
3 rd		
4 th		
5 th		
6 th		
7 th		
8 th		
Additional		

Anti-Psychotic Drugs Update Project Detailed Abstraction Form

INTERVENTIONS

33. Enter sample size and intervention data for each arm beginning with placebo or control, then in order of first mention.

Arm/ Group	Sample size	Intervention	Dose	Units	Frequency	Dose Description	Duration of treatment	Units	Co-intervention(s)	
1	_____ N ENTERING	Placebo..... <input type="checkbox"/> Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Quetiapine..... <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/> Code: _____								
2	_____ N ENTERING	Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Quetiapine..... <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/> Code: _____								
3	_____ N ENTERING	Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Quetiapine..... <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/> Code: _____								
	Enter a number for N entering and N completing or enter 999 if not reported	Check box for intervention or enter code(s) from list. Put placebo in first arm.	Enter # or range 998. Not Applicable 999. Not Reported	Enter a number 1. g 2. mg 3. tablets 9. Not Reported	Enter a number 1. Hour 2. Day 3. Week 4. Biweekly 5. Month 6. Year 9. NR	Enter a number 1 Fixed single dose 2 Fixed titration schedule 3 Flexible dose 4 Average final dose 9 Not Reported	Enter a number 997. Variable 998. Not Applicable 999. Not Reported	Enter a number 1. Hour 2. Day 3. Week 4. Biweekly 5. Month 6. Year 8. Not Applic. 9. NR	Enter code(s) or 998. Not Applicable 999. Not Reported	

Anti-Psychotic Drugs Update Project Detailed Abstraction Form

Interventions (continued)

Enter sample size and intervention/exposure data for each arm beginning with placebo or control, then in order of first mention.

Arm/ Group	Sample size	Intervention	Dose	Units	Frequency	Dose Description	Duration of treatment	Units	Co-intervention(s)	
4	_____ N ENTERING	Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/> Quetiapine <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Code: _____							_____	
5	_____ N ENTERING	Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/> Quetiapine <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Code: _____							_____	
6	_____ N ENTERING	Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Olanzapine <input type="checkbox"/> Quetiapine <input type="checkbox"/> Paliperidone <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/>	_____	_____	_____	_____	_____	_____	_____	_____
	_____ N COMPLETING	Code: _____							_____	
	Enter a number for N entering and N completing or enter 999 if not reported	Check box for intervention or enter code(s) from list. Put placebo in first arm.	Enter # or range 998. Not Applicable 999. Not Reported	Enter a number 1. g 2. mg 3. tablets 9. Not Reported	Enter a number 1. Hour 2. Day 3. Week 4. Biweekly 5. Month 6. Year 9. NR	Enter a number 1. Fixed single dose 2. Fixed titration schedule 3. Flexible dose 4. Average final dose 9. Not Reported	Enter a number 997. Variable 998. Not Applicable 999. Not Reported	Enter a number 1. Hour 2. Day 3. Week 4. Biweekly 5. Month 6. Year 8. Not Applic. 9. NR	Enter code(s) or 998. Not Applicable 999. Not Reported	

Note: If there are more than six arms to the study, please print another page for adding arms 7, 8, 9, etc.

**Appendix C. Previously published meta-analyses
on off-label uses of atypical antipsychotics: trials
included**

Appendix C. Previously published meta-analyses on off-label uses of atypical antipsychotics: trials included

Dementia

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)			
	Yury, 2007 ⁹⁶	Ballard, 2006 ⁹³	De Deyn, 2005 ⁹⁵	Schneider, 2006 ⁹⁴
RIS-AUS-05 Brodaty, 2003 ¹²⁷	X	X	X	X
RIS-USA-63 Katz, 1999 ¹²⁸	X	X	X	X
RIS-INT-24 De Deyn, 1999 ¹¹⁸ ; De Deyn, 1998 ²⁶⁵	X	X	X	X
Chan, 2001 ²⁶⁶	X			
Fontaine, 2003 ²⁶⁷	X			
HGGU Deberdt, 2005 ¹²²		X		X
RIS-USA-232 Mintzer, 2004; ¹²⁹ also reported in Colon, 2002		X		X

Quetiapine Efficacy

RCTs (Author, year)	Meta-analysis (Quetiapine)		
	Yury, 2007 ⁹⁶	Ballard, 2006 ⁹³	Schneider, 2006 ⁹⁴
Ballard, 2005 ¹²⁵	X	X	X
5077 US-046 Zhong, 2004 ¹²⁶			X
5077 US-039 Tariot, 2002			X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)		
	Yury, 2007 ⁹⁶	Ballard, 2006 ⁹³	Schneider, 2006 ⁹⁴
HGEU Clark, 2001 ²⁶⁸ ; also reported in Clark, 2001 ²⁶⁹ ; Mintzer, 2001 ²⁷⁰ ; Street, 2000 ¹²⁴	X	X	X
FID-MC-HGAO Satterlee, 1995 ²⁷¹ ; also reported in Street, 2000 ²⁷² ; Street, 2000 ²⁷³		X	X
HGGU Deberdt, 2005 ¹²²		X	X
De Deyn, 2004 ¹²¹		X	X
HGIC Kennedy, 2004			X

Aripiprazole Efficacy

RCTs (Author, year)	Meta-analysis (Aripiprazole)
	Schneider, 2006 ⁹⁴
CN 138-004 Breder, 2004 ¹¹⁹	X
CN 138-005 Streim, 2004 ¹²⁰	X
CN 138-006 Deyn, 2003 ²⁷⁴	X

Obsessive Compulsive Disorder (OCD)

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)	
	Block, 2006 ¹⁷⁶	Skapinakis, 2007 ¹⁷⁷
McDougle, 2000 ¹⁹⁶	X	X
Erzegovesi, 2005 ¹⁹⁴	X	X
Hollander, 2003 ¹⁹⁵	X	X
Li, 2005 ²⁷⁵	X	X

Quetiapine Efficacy

RCTs (Author, year)	Meta-analysis (Quetiapine)		
	Block, 2006 ¹⁷⁶	Skapinakis, 2007 ¹⁷⁷	Fineberg, 2006 ¹⁷⁸
Denys, 2004 ¹⁸⁹	X	X	X
Atmaca, 2002 ¹⁸⁸		X	
Fineberg, 2005 ¹⁹¹	X	X	X
Carey, 2005 ¹⁹⁰	X	X	X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)	
	Block, 2006 ¹⁷⁶	Skapinakis, 2007 ¹⁷⁷
Bystritsky, 2004 ¹⁹²	X	X
Shapira, 2004 ¹⁹³	X	X

Depression

Aripiprazole Efficacy

RCTs (Author, year)	Meta-analysis (Aripiprazole)	
	Arbaizar, 2009 ²⁷⁶	Nelson, 2009 ¹³¹
Berman, 2007 ¹⁴⁰	X	X
Marcus, 2008 ¹³⁹	X	X
Berman, 2008: same study as ¹⁴¹		X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)	
	Nelson, 2009 ¹³¹	Papakostas, 2007 ¹³⁰
Shelton, 2001 ²⁷⁷	X	X
Shelton, 2005 ²⁷⁸	X	X
Corya, 2006 ²⁷⁹	X	X
Thase, 2007 ¹⁶⁰	X	
Thase, 2006 same study as ¹⁶⁰		X

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)	
	Nelson, 2009 ¹³¹	Papakostas, 2007 ¹³⁰
Mahmoud, 2007 ¹⁵⁸	X	
Reeves, 2008 ¹⁵⁶	X	
Keitner, 2009 ¹⁵⁷	X	
Keitner, 2006 not included		X
Gharabawi, 2006 same study as ¹⁵⁹		X

Quetiapine Efficacy

RCTs (Author, year)	Meta-analysis (Quetiapine)	
	Nelson, 2009 ¹³¹	Papakostas, 2007 ¹³⁰
Mattingly, 2006 ¹⁴⁵	X	X
McIntyre, 2007 ⁷⁸	X	
El-Khalili, 2008 ¹³³	X	
Khullar, 2006 not included	X	X
Earley, 2007 same study as ¹³⁴	X	
McIntyre, 2006 same study as ⁷⁸		X

PTSD

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)
	Pae, 2008 ²¹¹
Bartzokis, 2005 ²¹²	X
Reich, 2004 ²¹³	X
Monnelly, 2003 ²¹⁴	X
Padala, 2006 ²¹⁵	X
Hamner, 2003 ²¹⁶	X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)
	Pae, 2008 ²¹¹
Stein, 2002 ²¹⁷	X
Butterfield, 2001 ²¹⁸	X

Risperidone AE

RCTs (Author, year)	Meta-analysis (Risperidone)
	Pae, 2008 ²¹¹
Bartzokis, 2005 ²¹²	X
Reich, 2004 ²¹³	X
Monnelly, 2003 ²¹⁴	X
Padala, 2006 ²¹⁵	X
Hamner, 2003 ²¹⁶	X

Olanzapine AE

RCTs (Author, year)	Meta-analysis (Olanzapine)
	Pae, 2008 ²¹¹
Stein, 2002 ²¹⁷	X
Butterfield, 2001 ²¹⁸	X

Personality Disorder

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)
	Ingenhoven, 2010 ¹⁹⁷
Zanarini, 2001 ¹⁹⁸	X
Soler, 2005 ¹⁹⁹	X
Bogenschutz, 2004 ²⁰⁰	X

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)
	Ingenhoven, 2010 ¹⁹⁷
Koenigsberg, 2003 ²⁰¹	X

Aripiprazole Efficacy

RCTs (Author, year)	Meta-analysis (Aripiprazole)
	Ingenhoven, 2010 ¹⁹⁷
Nickel, 2006 ²⁰²	X

Substance Abuse

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Aripiprazole)
	Amato, 2007 ²⁵⁴
Grabowski, 2004 ²⁵³	X
Levin, 1999 ²⁴⁷	X
Smelson, 2004 ²⁴⁹	X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Aripiprazole)
	Amato, 2007 ²⁵⁴
Kampman, 2003 ²⁴³	X
Reid, 2005 ²⁴⁴	X
Smelson, 2006 ²²⁵	X

Anxiety

Risperidone Efficacy

RCTs (Author, year)	Meta-analysis (Risperidone)
	Ipser, 2006 ⁷⁴
Erzegovesi 2004 ¹⁹⁴	X
Hollander 2003 ¹⁹⁵	X
McDougle 2000 ¹⁹⁶	X

Quetiapine Efficacy

RCTs (Author, year)	Meta-analysis (Quetiapine)
	Ipser, 2006 ⁷⁴
Atmaca 2002 ¹⁸⁸	X
Carey 2005 ¹⁹⁰	X
Denys 2004 ¹⁸⁹	X
Fineberg 2005 ¹⁹¹	X

Olanzapine Efficacy

RCTs (Author, year)	Meta-analysis (Olanzapine)
	Ipser, 2006 ⁷⁴
Pollack 2006 ⁷⁶	X

Appendix D. Evidence Tables

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Mondraty et al.2005¹⁵⁴</p> <p>Eating disorder</p> <p>Olanzapine</p> <p>Location: Australia/New Zealand</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Mean: 25</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: 26 Eligible: 15 Entering: 15 Withdrawn: 0 Lost to follow-up: 0 Analyzed: 15</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Fulfilling DSM-IV criteria for anorexia nervosa</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Chlorpromazine 25-100 mg/days flexible dose for duration not reported vs Olanzapine 5-15 mg/days flexible dose for variable duration</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 46 days</p>	<p>Results: Eating Disorder : Change in BMI at 2 weeks: Olanzapine vs Chlorpromazine - WMD = 0.50 (-1.49 , 2.49)</p> <p>Adverse Events: Chlorpromazine vs Olanzapine Blurring Of Vision And Postural Hypotension: 14.3%(1/7) vs 0.0%(0/8) Sedation: 42.9%(3/7) vs 12.5%(1/8)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Correia Filho et al.2005⁶⁰ ADHD Risperidone Location: Latin America Trial: Not reported Funding source: Hospital, Industry Design: RCT only Setting: Not reported Jadad: 3 Age: Not reported Sex: Mixed Race: African Ancestry, Other-NOS Screened: NR Eligible: NR Entering: 46 Withdrawn: 5 Lost to follow-up: 0 Analyzed: 41 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 6-16, MMR and ADHD, good health</p> <p>Exclusion criteria: PDD, schizophrenia or other psychotic disorder, seizure disorder requiring meds, history of head injury, previous treatment with MPH or risperidone, use of any other psych meds 1 month prior</p> <p>Interventions: MPH dosage not reported for 4 weeks vs Risperidone 0.5-4 mg/days flexible dose for 4 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression</p> <p>Timing of outcome assessment: 7, 14, 21, 28 days</p>	<p>Results: ADHD : Change in SNAP-IV (Total Score) at 4 weeks: Risperidone vs Methylphenidate - WMD = -6.00 (14.75 , 2.75)</p> <p>ADHD : Change in SNAP-IV (Inattention) at 4 weeks: Risperidone vs Methylphenidate - WMD = 1.20 (-1.91 , 4.31)</p> <p>ADHD : Change in SNAP-IV (Hyperactivity) at 4 weeks: Risperidone vs Methylphenidate - WMD = -3.60 (-6.89 , -0.31)</p> <p>ADHD : Change in SNAP-IV (OCD) at 4 weeks: Risperidone vs Methylphenidate - WMD = -1.80 (-5.02 , 1.42)</p> <p>Adverse Events: Methylphenidate Significant Difference Detected Between Baseline And End Point Scores In The SERs Total Scores: 0.0%(0/24) Risperidone Significant Difference Detected Between Baseline And End Point Scores On Any UKU Subscale Scores: 0.0%(0/22)</p> <p>Withdrawals: Methylphenidate vs Risperidone Galactorrhea (Led To withdrawal):0.0%(0/24) vs 4.5%(1/22) Vomiting (Led To withdrawal):4.2%(1/24) vs 0.0%(0/22) Withdrawals:8.3%(2/24) vs 13.6%(3/22) Withdrawals Due To Adverse Events:4.2%(1/24) vs 4.5%(1/22)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Matsunaga et al.2009¹⁷¹</p> <p>OCD</p> <p>Olanzapine, Quetiapine, Risperidone</p> <p>Location: Asia</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 1</p> <p>Age: Mean: 30</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 137 Eligible: 44 Entering: 90 Withdrawn: NR Lost to follow-up: NR Analyzed: 46</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Diagnosed OCD, received treatment >= 1 year at Osaka hospital.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Olanzapine 1-10 mg/days frequency not reported for duration not reported vs Quetiapine 25-100 mg/days frequency not reported for variable duration vs Risperidone 1-5 mg/days frequency not reported for duration not reported vs Control Group</p> <p>Run-in/wash-out period: Run-in: Fluoxetine or paroxetine for 12 week(s). Non-responders were randomized.</p> <p>Comorbidities: Depression</p> <p>Timing of outcome assessment: 365 days</p>	<p>Results: OCD: Insufficient data to calculate an effect size</p> <p>Adverse Events: SSRI+olanzapine, quetiapine or risperidone Increased Appetite: 34.1%(15/44) Increased Body Weight: 27.3%(12/44) Sedation: 6.8%(3/44) Sleepiness: 11.4%(5/44) SSRI+olanzapine, quetiapine or risperidone vs SSRIs (fluvoxamine or paroxetine) BMI Increase > 10%: 50.0%(22/44) vs 15.2%(7/46)</p> <p>Withdrawals: SSRI+olanzapine, quetiapine or risperidone Withdrawals:0.0%(0/44) SSRI+olanzapine, quetiapine or risperidone vs SSRIs (fluvoxamine or paroxetine) Withdrawals Due To Adverse Events:0.0%(0/44) vs 0.0%(0/46)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Moretti et al.2005⁹¹ Dementia/Agitation Olanzapine Location: Western Europe Trial: Not reported Funding source: Not reported Design: CCT only Setting: Long-term care facilities Jadad: 0 Age: Not reported Sex: Mixed Race: Not reported Screened: NR Eligible: 356 Entering: 346 Withdrawn: NR Lost to follow-up: 0 Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: MMSE at least 14 and DSM-IV for dementia. Probable VaD in accordance with the NINDS-AIREN 71-92</p> <p>Exclusion criteria: Normal pressure hydrocephalus. Previous psychiatric illness on central nervous system. Disorders and alcoholism</p> <p>Interventions: Typical antipsychotics 10 drops/day flexible dose for 12 months vs Olanzapine 2.5-7.5 mg/days flexible dose for 12 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 30, 91, 182, 274, 365 days</p>	<p>Results: Dementia : Change in NPI (Total) at 52 weeks: Haloperidol or promazine (typical neuroleptic) vs Olanzapine flexible dose - SMD = 0.38 (0.17 , 0.60)</p> <p>Adverse Events: Typical neuroleptics (Group B) vs Olanzapine (Group A) Anger Episodes: 2.3%(4/173) vs 0.0%(0/173) Angina Pectoris Episode (Never Reported Before): 0.0%(0/173) vs 2.9%(5/173) Death From Complications Of A Thigh Bone Fracture Consequence Of A Fall: 0.6%(1/173) vs 0.0%(0/173) Death From Complications Of Pneumonia: 0.0%(0/173) vs 0.6%(1/173) Death From Myocardial Infarction: 0.6%(1/173) vs 0.6%(1/173) Death From Pulmonary Embolism (Had Suffered From Atrial Fibrillation): 0.6%(1/173) vs 0.0%(0/173) Diagnosed With Diabetes: 1.2%(2/173) vs 1.2%(2/173) Fall: 7.5%(13/173) vs 0.6%(1/173) Hospitalized For Myocardial Infarction: 1.2%(2/173) vs 0.0%(0/173) Inhalation Pneumonia: 1.7%(3/173) vs 0.0%(0/173) Nausea Associated With Anorexia: 19.7%(34/173) vs 0.0%(0/173) Oral Craving With A Weight Increase: 0.0%(0/173) vs 9.2%(16/173) Peripheral Arteriopathy: 0.0%(0/173) vs 0.6%(1/173) Renal Failure: 0.0%(0/173) vs 0.6%(1/173) Total Deaths: 1.7%(3/173) vs 1.2%(2/173) Transitory Sleepiness During Titration Phase: 24.9%(43/173) vs 23.1%(40/173) Weight Increase: 6.9%(12/173) vs 0.0%(0/173)</p> <p>Withdrawals: Typical neuroleptics (Group B) vs Olanzapine (Group A) Withdrawals:0.0%(0/173) vs 0.0%(0/173) Withdrawals Due To Adverse Events:0.0%(0/173) vs 0.0%(0/173)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Prosser et al.2009⁷⁷</p> <p>Anxiety</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 56</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 29</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: 21-55, history of panic attacks, disorder with panic attacks, HAM-A \geq17</p> <p>Exclusion criteria: Other Axis I, history of alcohol and substance abuse 6 month prior, use of antipsychotics 2 month prior, changes in antidepressant or mood stabilizer 2 month prior, other psychoactive meds, a history of adverse reaction to either risperidone or paroxetine</p> <p>Interventions: Paroxetine 30-40 mg/days flexible dose for 8 weeks vs Risperidone 0.125-1 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 3, 7, 14, 21, 28, 35, 42, 49, 56, 63 days</p>	<p>Results: Anxiety : Change in HAM-D-17 at 8 weeks: Risperidone vs Paroxetine - WMD = 0.65 (-4.73 , 6.03)</p> <p>Adverse Events: Paroxetine vs Risperidone Complained Of Adverse Events: 4.3%(1/23) vs 6.1%(2/33)</p> <p>Withdrawals: Paroxetine vs Risperidone Withdrawals:60.9%(14/23) vs 39.4%(13/33)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Savaskan et al.2006⁹⁷</p> <p>Dementia/Agitation</p> <p>Quetiapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting, Inpatients, Hospitalized</p> <p>Jadad: 2</p> <p>Age: Mean: 68</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR Eligible: NR Entering: NR Withdrawn: 8 Lost to follow-up: 0 Analyzed: 22</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: AD, behavioral symptoms > 65</p> <p>Exclusion criteria: Sensitivity to study drugs, medical illness, other antipsychotic</p> <p>Interventions: Haldol 0.5-4 mg/days fixed titration schedule for 5 weeks vs Quetiapine 25-200 mg/days fixed titration schedule for 5 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 35 days</p>	<p>Results: Dementia : Change in NPI (Agitation) at 5 weeks: Haloperidol vs Quetiapine - SMD = 0.06 (-0.78 , 0.89)</p> <p>Dementia : Change in NPI (Total) at 5 weeks: Haloperidol vs Quetiapine - SMD = 0.99 (0.10 , 1.88)</p> <p>Adverse Events: Haloperidol vs Quetiapine Arterial Hypertonia: 9.1%(1/11) vs 0.0%(0/11) EPS: 18.2%(2/11) vs 0.0%(0/11) Gastroenteritis: 0.0%(0/11) vs 9.1%(1/11) Infection Of Unknown Origin: 9.1%(1/11) vs 0.0%(0/11) Reversible Syncope: 0.0%(0/11) vs 9.1%(1/11)</p> <p>Withdrawals: Haloperidol vs Quetiapine Withdrawals Due To Adverse Events:18.2%(2/11) vs 18.2%(2/11)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Suh et al.2006⁹⁸</p> <p>Dementia/Agitation</p> <p>Risperidone</p> <p>Location: Asia</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting, Long-term care facilities</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: 80-99% Female</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 120</p> <p>Withdrawn: 6</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 114</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: >=65 dementia accompanied by behavioral or psychological symptoms of such severity that antipsychotic was warranted, >=4 on FAST, >=8 on Behave-AD, >=3 on any 2 items of CMAI-K</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Haloperidol 0.5-1.5 mg/days flexible dose for 8 weeks vs Risperidone 0.5-1.5 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: No drug for 1 week(s). Patients who completed the wash-out period were randomized. !n Wash-out: No drug for 1 week(s). Patients who completed the wash-out period were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Dementia: Cross over study</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Diniz et al.2009¹⁷³ OCD Quetiapine Location: Brazil Trial: Not reported Funding source: Government Design: RCT only Setting: Single setting Jadad: 2 Age: Mean: 20 Sex: Mixed Race: Not reported Screened: 48 Eligible: 35 Entering: 31 Withdrawn: 13 Lost to follow-up: NR Analyzed: 18 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, OCD, treatment failure to SSRI</p> <p>Exclusion criteria: Substance dependence or abuse, psychosis, suicide risk, pregnant / intending to become pregnant</p> <p>Interventions: Clomipramine 25-75 mg/days flexible dose for 12 weeks vs Quetiapine 50-200 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Run-in: Fluoxetine for 12 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 28, 56, 84 days</p>	<p>Results: OCD : Change in YBOCS (Total Score) at 12 weeks: Quetiapine vs Clomipramine - WMD = -3.60 (9.27 , 2.07)</p> <p>Adverse Events: Clomipramine vs Quetiapine Severe Adverse Events: 0.0%(0/15) vs 0.0%(0/16) Quetiapine 3 Symptoms Of Serotonergic Syndrome (Excessive Sweating, Tremors And Motor Agitation) Leading To Being Dropped: 0.0%(0/16)</p> <p>Withdrawals: Clomipramine 3 Symptoms Of Serotonergic Syndrome (Excessive Sweating, Tremors And Motor Agitation) Leading To Withdrawal:6.7%(1/15) Clomipramine vs Quetiapine Withdrawals:40.0%(6/15) vs 43.8%(7/16) Withdrawals Due To Adverse Events:40.0%(6/15) vs 43.8%(7/16)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Dunner et al.2007¹⁵⁰</p> <p>Depression</p> <p>Ziprasidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 90 Eligible: 64 Entering: 64 Withdrawn: 29 Lost to follow-up: 0 Analyzed: 35</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 21-65, non response to at least 1 course of 4 weeks of antidepressants and MADRS \geq20</p> <p>Exclusion criteria: Psychotic disorder, PTSD, panic, OCD, substance abuse / dependence in past 3 month, history of treatment with atypical antipsychotic fluoxetine, MAO-1 or ECT 6 weeks prior, unstable medical illness, pregnant, breast feeding</p> <p>Interventions: Control Group vs Ziprasidone 40-80 mg/days flexible dose for 8 weeks vs Ziprasidone 80-160 mg/days flexible dose for duration not reported</p> <p>Run-in/wash-out period: Run-in: Sertraline for 6 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Ziprasidone 80mg + Sertraline vs Sertraline - WMD = -1.53 (-2.73 , -0.34)</p> <p>Depression : Change in MADRS at 8 weeks: Ziprasidone 160mg + Sertraline vs Sertraline - WMD = -3.82 (-5.14 , -2.50)</p> <p>Adverse Events: Placebo vs Ziprasidone 160 mg vs Ziprasidone 80 mg Abnormal Thinking: 0.0%(0/21) vs 10.0%(2/20) vs 8.7%(2/23) Abnormal Vision: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Agitation: 0.0%(0/21) vs 25.0%(5/20) vs 21.7%(5/23) Akathisia: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Asthenia: 0.0%(0/21) vs 25.0%(5/20) vs 21.7%(5/23) At Least 1 Adverse Events: 38.1%(8/21) vs 80.0%(16/20) vs 95.7%(22/23) Constipation: 0.0%(0/21) vs 5.0%(1/20) vs 13.0%(3/23) Dizziness: 0.0%(0/21) vs 20.0%(4/20) vs 17.4%(4/23) Dry Mouth: 0.0%(0/21) vs 20.0%(4/20) vs 8.7%(2/23) Headache: 4.8%(1/21) vs 15.0%(3/20) vs 17.4%(4/23) Insomnia: 4.8%(1/21) vs 30.0%(6/20) vs 34.8%(8/23) Nausea: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Required Dose Reduction Or Temporary Discontinuance Due To Adverse Events: 0.0%(0/21) vs 20.0%(4/20) vs 0.0%(0/23) Respiratory Infection: 0.0%(0/21) vs 5.0%(1/20) vs 17.4%(4/23) Somnolence: 9.5%(2/21) vs 15.0%(3/20) vs 21.7%(5/23) Tremor: 4.8%(1/21) vs 10.0%(2/20) vs 21.7%(5/23)</p> <p>Withdrawals: Placebo vs Ziprasidone 160 mg vs Ziprasidone 80 mg Withdrawals:28.6%(6/21) vs 55.0%(11/20) vs 52.2%(12/23) Withdrawals Due To Adverse Events:0.0%(0/21) vs 35.0%(7/20) vs 39.1%(9/23)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Alexopoulos et al.2008¹²⁵</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US, Canada, Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: 63</p> <p>Entering: 63</p> <p>Withdrawn: 7</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 56</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: ≥ 55, MD, failed antidepressants, HAM-D≥20, MMSE > 23</p> <p>Exclusion criteria: Severe or unstable medical illness, dementia, Axis I other than GAD and phobias</p> <p>Interventions: Placebo dosage not reported for 24 weeks vs Risperidone 0.25-1 mg/days flexible dose for 24 weeks</p> <p>Run-in/wash-out period: Run-in: Citalopram only or citalopram plus risperidone for 4-6 weeks. Non-responders or responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 168 days</p>	<p>Results: Depression: Duplicate data</p> <p>Depression: Duplicate data</p> <p>Adverse Events: Placebo+Citalopram vs Risperidone+Citalopram Anxiety: 0.0%(0/31) vs 0.0%(0/32) Appetite Increase: 3.2%(1/31) vs 6.3%(2/32) Constipation: 6.5%(2/31) vs 3.1%(1/32) Diarrhea: 6.5%(2/31) vs 0.0%(0/32) Dizziness: 6.5%(2/31) vs 6.3%(2/32) Dry Mouth: 6.5%(2/31) vs 3.1%(1/32) Dyspepsia: 0.0%(0/31) vs 6.3%(2/32) Fall: 0.0%(0/31) vs 6.3%(2/32) Fatigue: 6.5%(2/31) vs 3.1%(1/32) Headache: 0.0%(0/31) vs 9.4%(3/32) Insomnia: 3.2%(1/31) vs 3.1%(1/32) Lethargy: 6.5%(2/31) vs 0.0%(0/32) Nasopharyngitis: 0.0%(0/31) vs 0.0%(0/32) Nausea: 3.2%(1/31) vs 3.1%(1/32) Peripheral Swelling: 0.0%(0/31) vs 6.3%(2/32) Pruritus: 0.0%(0/31) vs 6.3%(2/32) Seasonal Allergy: 6.5%(2/31) vs 0.0%(0/32) Sensation Of Heaviness: 0.0%(0/31) vs 6.3%(2/32) Somnolence: 3.2%(1/31) vs 3.1%(1/32) Upper Respiratory Tract Infection: 6.5%(2/31) vs 6.3%(2/32) Weight Increase: 6.5%(2/31) vs 6.3%(2/32)</p> <p>Withdrawals: Placebo+Citalopram vs Risperidone+Citalopram Withdrawals:77.4%(24/31) vs 65.6%(21/32) Withdrawals Due To Adverse Events:6.5%(2/31) vs 6.3%(2/32)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Doree et al.2007¹⁴⁹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 20</p> <p>Withdrawn: 3</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 17</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18 - 65, MDD without psychotic features, HAMD \geq 20, CGI \geq 4 despite antidepressants at max dose + \geq4 weeks</p> <p>Exclusion criteria: Bipolar or other Axis I, substance dependence within 6 months, unstable medical condition</p> <p>Interventions: Lithium 600-vario mg/days flexible dose for 8 weeks vs Quetiapine 25-600 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Quetiapine vs Lithium - WMD = -10.90 (-16.47 , -5.33)</p> <p>Adverse Events: Lithium Tremor: 60.0%(6/10) Quetiapine Somnolence: 50.0%(5/10) Quetiapine vs Lithium Serious Adverse Event: 0.0%(0/10) vs 0.0%(0/10)</p> <p>Withdrawals: Quetiapine vs Lithium Mixed State Resulting In Withdrawal:0.0%(0/10) vs 10.0%(1/10) Tremor And Nausea Resulting In Withdrawal:0.0%(0/10) vs 10.0%(1/10) Withdrawals:0.0%(0/10) vs 30.0%(3/10) Withdrawals Due To Adverse Events:0.0%(0/10) vs 20.0%(2/10)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Pollock et al.2007¹⁰⁰ Dementia/Agitation Risperidone Location: Canada Trial: Not reported Funding source: Government, Private Design: RCT only Setting: Single setting Jadad: 5 Age: Not reported Sex: Mixed Race: Caucasian, Other-NOS Screened: 111 Eligible: 106 Entering: 103 Withdrawn: 58 Lost to follow-up: 0 Analyzed: 45 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: AD, vascular dementia, dementia with Lewy bodies, mixed dementia or dementia not otherwise specified, need for hospitalization, >= 3 on agitation items and on psychosis items of NBRBS</p> <p>Exclusion criteria: Schizophrenia, schizoaffective, delusional disorder, psychotic disorder, MR, cognitive deficits, delirium, Parkinson disease, substance dependence / abuse, MDD 6 month prior, >= 12 month CSDD, unstable physical illness, history of intolerance to citalopram or risperidone</p> <p>Interventions: Citalopram 10-40 mg/days flexible dose for 12 weeks vs Risperidone 0.5-2 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 3 days</p>	<p>Results: Dementia : Change in NBRBS (Psychosis) at 12 weeks: Citalopram vs Risperidone - SMD = 0.06 (-0.33 , 0.44)</p> <p>Dementia : Change in NBRBS (Agitation) at 12 weeks: Citalopram vs Risperidone - SMD = -0.11 (-0.50 , 0.28)</p> <p>Withdrawals: Citalopram vs Risperidone Bruising Leading To Withdrawal:1.9%(1/53) vs 0.0%(0/50) Elevated Liver Function Tests Leading To Withdrawal:0.0%(0/53) vs 2.0%(1/50) Gait Disturbance Leading To Withdrawal:1.9%(1/53) vs 6.0%(3/50) Gastrointestinal Bleeding Leading To Withdrawal:0.0%(0/53) vs 2.0%(1/50) Hypoglycemia Leading To Withdrawal:1.9%(1/53) vs 0.0%(0/50) Hypotension Leading To Withdrawal:0.0%(0/53) vs 2.0%(1/50) Ileus Leading To Withdrawal:1.9%(1/53) vs 2.0%(1/50) Infection Leading To Withdrawal:3.8%(2/53) vs 0.0%(0/50) Intracranial Bleeding Leading To Withdrawal:0.0%(0/53) vs 2.0%(1/50) Other Extrapyramidal Symptoms (EPS) Leading To Withdrawal (Other Than Gait Disturbance):1.9%(1/53) vs 6.0%(3/50) Pneumonia Leading To Withdrawal:0.0%(0/53) vs 4.0%(2/50) Psychiatric Worsening: Increased Agitation Leading To Withdrawal:22.6%(12/53) vs 14.0%(7/50) Psychiatric Worsening: Onset Of Depression Leading To Withdrawal:1.9%(1/53) vs 0.0%(0/50) Psychiatric Worsening: Onset Of Psychosis Leading To Withdrawal:1.9%(1/53) vs 2.0%(1/50) Psychiatric Worsening: Readmission Leading To Withdrawal:3.8%(2/53) vs 6.0%(3/50) Psychiatric Worsening: Suicide Attempt Leading To Withdrawal:0.0%(0/53) vs 2.0%(1/50) Sedation Leading To Withdrawal:1.9%(1/53) vs 0.0%(0/50) Seizure Leading To Withdrawal:1.9%(1/53) vs 0.0%(0/50) Withdrawals:52.8%(28/53) vs 60.0%(30/50) Withdrawals Due To Adverse Events:7.5%(4/53) vs 18.0%(9/50)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Rubio et al.2006²¹⁰</p> <p>Substance abuse</p> <p>Risperidone</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Unclear</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: 100% Male</p> <p>Race: Not reported</p> <p>Screened: 124 Eligible: NR Entering: 66 Withdrawn: 4 Lost to follow-up: 0 Analyzed: 62</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Male, 18-65, schizophrenia and SUD for substances other than caffeine and nicotine.</p> <p>Exclusion criteria: Organic or neurological disorder, other psychotic disorder, abnormal labs on ECG</p> <p>Interventions: Other, Zuclopenthixol 10-100 mg/days frequency not reported for 6 months vs Risperidone 3-12 mg/days frequency not reported for 6 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Substance Abuse: Cross Over study</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Gerra et al.2006²⁴⁰</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Professional association</p> <p>Design: CCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex: 80-99% Male</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 67</p> <p>Entering: 67</p> <p>Withdrawn: 34</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 33</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Heroin dependant patients entering methadone and buprenorphine, aggressive personality traits.</p> <p>Exclusion criteria: > 3 month of drugs other than heroin or > 6 month alcohol dependant, severe chronic liver illness, renal diseases, other chronic medical disorders, recent significant weight loss, obesity, endocrinotherapy, immune deficiency. A comorbidity of schizophrenia or bipolar disorder > 60 BDHI.</p> <p>Interventions: SRI and Antidepressant Fluoxetine mean 25.26 (SD 5.9) ; Paroxetine mean 22.5 (SD 6.8) ; Clonazepam mean 5.15 (SD 1.67) for 12 weeks vs Olanzapine mean 12.1 (SD 5.4) for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: OCD, Personality Disorder</p> <p>Timing of outcome assessment: 84 days</p>	<p>Results: Substance Abuse : Change in BDHI at 12 weeks: Olanzapine+Methadone/Buprenorphine vs SSRIs+Clonazepam+Methadone/Buprenorphine - WMD = -10.26 (-11.00 , -9.52)</p> <p>Adverse Events: Fluoxetine/paroxetine and clonazepam vs Olanzapine Overt BDZs Abuse With Severe Sedation And Paradoxical Symptoms That Contributed To Drop-Out: 11.4%(4/35) vs 0.0%(0/32) Paradoxical Effects With Agitation, Increased Irritability, Negativism And The Tendency To Clonazepam Abuse: 20.0%(7/35) vs 0.0%(0/32) Significant Changes Of Glucose Plasma Levels: 0.0%(0/35) vs 0.0%(0/32) Olanzapine Weight Gain =7%: 12.5%(4/32)</p> <p>Withdrawals: Fluoxetine/paroxetine and clonazepam vs Olanzapine Withdrawals:45.7%(16/35) vs 46.9%(15/32)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Gerra et al.2007²¹⁶</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: CCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex: 80-99% Male</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 61</p> <p>Entering: 61</p> <p>Withdrawn: 16</p> <p>Lost to follow-up: 8</p> <p>Analyzed: 35</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Heroin dependant, entering methadone and buprenorphine long-term treatment, SSDS (schizophrenia spectrum disorder) treated with olanzapine or haloperidol.</p> <p>Exclusion criteria: Long lasting period of consumption of drugs, other than heroin (3 months) or prolonged alcohol dependence (6 months), severe chronic liver illness, renal disease, other medial chronic disorders, recent significant weight loss / obesity endocrine and immune deficiency.</p> <p>Interventions: Haloperidol dosage not reported for 12 weeks vs Olanzapine dosage not reported for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: OCD, Personality Disorder</p> <p>Timing of outcome assessment: 84 days</p>	<p>Results: Substance Abuse : Change in Retention Rate at 12 weeks: Olanzapine vs Haloperidol - RR = 2.72 (0.84 , 8.79)</p> <p>Adverse Events: Haloperidol vs Olanzapine Anticholinergic Drugs Prescribed To Treat This Many Pts With Extrapyramidal Symptoms: 15.4%(4/26) vs 0.0%(0/35) Extrapyramidal Symptoms (Akathisia, Dystonia, And Tardive Dyskinesia With Restlessness And Objective Motor Signs, Difficulty In Opening The Eyelids, Torticollis, And Oculogyric Crisis): 26.9%(7/26) vs 0.0%(0/35) Persistent Sedation And Tiredness: 69.2%(18/26) vs 0.0%(0/35) Significant Changes Of Glucose Plasma Levels: 0.0%(0/26) vs 0.0%(0/35) Weight Gain =7%: 0.0%(0/26) vs 17.1%(6/35)</p> <p>Withdrawals: Haloperidol vs Olanzapine Withdrawals:50.0%(13/26) vs 8.6%(3/35)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Green et al.2004²¹⁷</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US, Canada, Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Mean: 16</p> <p>Sex: 80-99% Male</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 263</p> <p>Entering: NR</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: 1</p> <p>Analyzed: 262</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Schizophrenia, schizoaffective, disorder / schizophreniform disorder according to DSM-IV SCID-IV > 2 items of >= 4 or one >= 5 and CGI >= 4 / PANSS</p> <p>Exclusion criteria: Psychotic longer than 5 years. Recovery from initial episode for 6 months or longer. Treated with an injectable depot neuroleptic within 3 month. PSM-IV substance dependence within 1 month.</p> <p>Interventions: Haldol 2-20 mg/days flexible dose for 12 weeks vs Olanzapine 5-20 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 56, 70 days</p>	<p>Results: Substance Abuse: Not all patients had Substance Use Disorder,</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hutchison et al.2003²²³</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Hispanic, Asian/Pacific Islander, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: 75</p> <p>Entering: NR</p> <p>Withdrawn: 8</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 67</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Excellent health, blood alcohol of 0, Audit >= 8, alcohol dependence</p> <p>Exclusion criteria: Pregnant, psychiatric diagnosis on treatment, use of illicit drugs other than MS</p> <p>Interventions: Cyproheptadine 4 mg/days fixed single dose for 4 days vs Olanzapine 5 mg/days fixed single dose for 4 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 5 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Rubio et al.2006²¹¹ Substance abuse Risperidone Location: Western Europe Trial: Not reported Funding source: Design: RCT only Setting: Multi-center Jadad: 1 Age: Mean: 35 Sex: 80-99% Male Race: Not reported Screened: 183 Eligible: 115 Entering: 115 Withdrawn: NR Lost to follow-up: NR Analyzed: 106 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, schizophrenia and SUD for substances other than caffeine and nicotine, according to DSM-IV.</p> <p>Exclusion criteria: Clinically significant organic or neurologic disorder, serious psychotic disorder other than schizophrenia, clinically relevant abnormalities</p> <p>Interventions: Other, Zuclopenthixol 10-50 mg/days flexible dose for 6 weeks vs Risperidone 2-6 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84, 91, 98, 105, 112, 119, 126, 133, 140, 147, 154, 161, 168 days</p>	<p>Results: Substance Abuse : Change in Number of Positive Urine Tests at 24 weeks: Risperidone vs Zuclopenthixol - WMD = 1.69 (0.58 , 2.80)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Sayers et al.2005²¹²</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Single setting, VA Healthcare System</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: 80-99% Male</p> <p>Race: Caucasian, African Ancestry</p> <p>Screened: 170 Eligible: 24 Entering: 24 Withdrawn: NR Lost to follow-up: NR Analyzed: 14</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Schizophrenia and cocaine abuse in last 6 month. 18-60</p> <p>Exclusion criteria: Use of depot meds within 6 month, history of sensitization to haldol or olanzapine or history of NMS, pregnant, lactating, unstable medical problems</p> <p>Interventions: Haldol 5-20 mg/days flexible dose for 26 weeks vs Olanzapine 5-20 mg/days flexible dose for 26 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84, 91, 98, 105, 112, 119, 126, 133, 140, 147, 154, 161, 168 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Withdrawals: Haloperidol Withdrawals:41.7%(5/12)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Smelson et al.2006²¹³ Substance abuse Olanzapine Location: US Trial: Not reported Funding source: Government, Industry Design: RCT only Setting: VA Healthcare System Jadad: 3 Age: Not reported Sex: Race: Not reported Screened: NR Eligible: NR Entering: 31 Withdrawn: NR Lost to follow-up: NR Analyzed: 18 Method of AE assessment: Not applicable</p>	<p>Inclusion criteria: Cocaine dependance and schizophrenia, positive change in baseline craving after cocaine cues</p> <p>Exclusion criteria: Other AXIS I disorders, taking other CNS (central nervous system) meds (medications), history of seizures, pregnant, chronic CNS disease other than schizophrenia</p> <p>Interventions: Haldol 5-20 mg/days flexible dose for 6 weeks vs Olanzapine 5-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 42 days</p>	<p>Results: Substance Abuse : Change in Voris Cocaine Craving Questionnaire (Craving Intensity Scor at 6 weeks: Olanzapine vs Haloperidol - WMD = -6.30 (-17.35 , 4.75)</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Tsuang et al.2002²¹⁴</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: CCT only</p> <p>Setting: VA Healthcare System</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 4</p> <p>Entering: 23</p> <p>Withdrawn: 1</p> <p>Lost to follow-up: 1</p> <p>Analyzed: 3</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Cocaine abusing outpatient with schizophrenia</p> <p>Exclusion criteria:</p> <p>Interventions: Olanzapine 15-20 mg/days frequency not reported for duration not reported vs Haldol 5-10 mg/days frequency not reported for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Withdrawals: Haloperidol Withdrawals:100.0%(2/2)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hussain et al.2005¹⁵¹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: 18</p> <p>Lost to follow-up: 0</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Diagnosed with MDD using DSM-IV criteria</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Paroxetine dosage not reported for duration not reported vs Venlafaxine dosage not reported for duration not reported vs Quetiapine, Paroxetine dosage not reported for duration not reported vs Quetiapine, Venlafaxine dosage not reported for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 21, 42, 84, 182, 365, 730, 1094 days</p>	<p>Results: Depression: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Tariot et al.2006⁹⁴</p> <p>Dementia/Agitation</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center, Long-term care facilities</p> <p>Jadad: 4</p> <p>Age: Mean: 83</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 501 Eligible: 284 Entering: 284 Withdrawn: 103 Lost to follow-up: 1 Analyzed: 180</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: > 64 years old, not bedridden, nursing home residents for >= 2 weeks, diagnosed with DSM-IV AD, presence of psychosis, BPRS scores >=24, CGI-S scores >=4, scores of >= 3 on two or more BPRS items, frequency scores of >= 3 on at least one of the two psychosis items of the NPI-NH, scores of >= 5 on MMSE</p> <p>Exclusion criteria: Other clinically significant medical conditions, history of drug-induced agranulocytosis, acute orthostasis, clinically significant abnormal electrocardiogram, or concurrent other Axis I DSM-IV diagnosis.</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Haloperidol 0.5-12 mg/days flexible dose for 10 weeks vs Quetiapine 25-600 mg/days flexible dose for 10 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 48 hour(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 42, 56, 70 days</p>	<p>Results: Dementia : Change in NPI (Agitation) at 10 weeks: Placebo vs Quetiapine - SMD = 0.25 (-0.05 , 0.54)</p> <p>Dementia : Change in NPI (Agitation) at 10 weeks: Haloperidol vs Quetiapine - SMD = 0.04 (-0.26 , 0.34)</p> <p>Dementia : Change in NPI (Total) at 10 weeks: Placebo vs Quetiapine - SMD = 0.01 (-0.29 , 0.30)</p> <p>Dementia : Change in NPI (Total) at 10 weeks: Haloperidol vs Quetiapine - SMD = -0.31 (-0.61 , -0.01)</p> <p>Adverse Events: Haloperidol vs Quetiapine vs Placebo Abnormal Gait: 10.6%(10/94) vs 3.3%(3/91) vs 3.0%(3/99) Accidental Injury Total: 45.7%(43/94) vs 40.7%(37/91) vs 42.4%(42/99) Agitation: 13.8%(13/94) vs 7.7%(7/91) vs 21.2%(21/99) Convulsion: 0.0%(0/94) vs 4.4%(4/91) vs 0.0%(0/99) Deaths: 7.4%(7/94) vs 2.2%(2/91) vs 4.0%(4/99) Dyspepsia: 4.3%(4/94) vs 0.0%(0/91) vs 4.0%(4/99) Falls: 28.7%(27/94) vs 28.6%(26/91) vs 28.3%(28/99) Fever: 11.7%(11/94) vs 3.3%(3/91) vs 6.1%(6/99) Fractures: 6.4%(6/94) vs 2.2%(2/91) vs 7.1%(7/99) Infection: 5.3%(5/94) vs 14.3%(13/91) vs 5.1%(5/99) Insomnia: 5.3%(5/94) vs 0.0%(0/91) vs 1.0%(1/99) Nonserious Cerebrovascular Event: 0.0%(0/94) vs 1.1%(1/91) vs 3.0%(3/99) Pain: 9.6%(9/94) vs 13.2%(12/91) vs 11.1%(11/99) Pallor: 4.3%(4/94) vs 0.0%(0/91) vs 0.0%(0/99) Pharyngitis: 4.3%(4/94) vs 5.5%(5/91) vs 10.1%(10/99) Rash: 12.8%(12/94) vs 13.2%(12/91) vs 13.1%(13/99) Serious AEs: 16.0%(15/94) vs 11.0%(10/91) vs 12.1%(12/99) Somnolence, All: 36.2%(34/94) vs 25.3%(23/91) vs 4.0%(4/99) Somnolence, Serious: 1.1%(1/94) vs 1.1%(1/91) vs 0.0%(0/99) Urinary Incontinence: 4.3%(4/94) vs 4.4%(4/91) vs 0.0%(0/99) Urinary Tract Infection: 10.6%(10/94) vs 12.1%(11/91) vs 5.1%(5/99) Vomiting: 6.4%(6/94) vs 12.1%(11/91) vs 5.1%(5/99)</p> <p>Withdrawals: Haloperidol vs Quetiapine vs Placebo Somnolence Leading To Withdrawal:3.2%(3/94) vs 1.1%(1/91) vs 0.0%(0/99) Withdrawals:41.5%(39/94) vs 31.9%(29/91) vs 36.4%(36/99) Withdrawals Due To Adverse Events:18.1%(17/94) vs 11.0%(10/91) vs 13.1%(13/99)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For For Active-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Thase et al.2007¹⁴⁸</p> <p>Depression</p> <p>Olanzapine</p> <p>Location: US, Canada</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 44</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 1313 Eligible: 605 Entering: 605 Withdrawn: 146 Lost to follow-up: 18 Analyzed: 441</p> <p>Method of AE assessment: Not applicable</p>	<p>Inclusion criteria: Treatment resistant depression, 18-65 years old, HAM-D-17 \geq22</p> <p>Exclusion criteria: Current / post schizophrenia, other psychotic disorders, PTSD, pregnant or nursing females, post partum depression, MDD with atypical features, paranoid, schizoid, personality disorders, significant medical illness, concomitant medications with primary central nervous system activity except lorazepam with dose up to 4mg / week</p> <p>Interventions: Olanzapine, Naltrexone 6-18 mg/days flexible dose for 8 weeks vs Olanzapine 6-18 mg/days flexible dose for 8 weeks vs Naltrexone 50 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: Fluoxetine for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Olanzapine+Fluoxetine vs Fluoxetine - WMD = -3.40 (-5.35 , -1.45)</p> <p>Depression : Change in MADRS at 8 weeks: Olanzapine+Fluoxetine vs Olanzapine - WMD = -3.70 (-5.60 , -1.80)</p> <p>Depression : Change in MADRS at 8 weeks: Olanzapine vs Fluoxetine - WMD = 0.30 (-1.52 , 2.12)</p> <p>Adverse Events: Fluoxetine vs Olanzapine vs Olanzapine/fluoxetine Deaths: 0.0%(0/206) vs 0.0%(0/199) vs 0.0%(0/200) Dry Mouth: 8.7%(18/206) vs 31.7%(63/199) vs 28.5%(57/200) Fatigue: 7.8%(16/206) vs 14.1%(28/199) vs 14.0%(28/200) Headache: 19.4%(40/206) vs 13.1%(26/199) vs 12.5%(25/200) Hypersomnia: 2.4%(5/206) vs 11.1%(22/199) vs 10.5%(21/200) Increase In Nonfasting Glucose From 140 To <200 mg/dL At Baseline To =200 mg/dL At Endpoint: 0.5%(1/206) vs 1.5%(3/199) vs 2.5%(5/200) Increase In Nonfasting Glucose From <140 mg/dL At Baseline To =200 mg/dL At Endpoint: 3.4%(7/206) vs 3.5%(7/199) vs 1.5%(3/200) Increase In Total Cholesterol From <200 mg/dL At Baseline To =240 mg/dL At Endpoint: 1.5%(3/206) vs 2.5%(5/199) vs 3.5%(7/200) Increase In Triglycerides From <150 mg/dL At Baseline To =500 mg/dL At Endpoint: 0.0%(0/206) vs 0.5%(1/199) vs 0.0%(0/200) Increased Appetite: 5.8%(12/206) vs 30.7%(61/199) vs 32.0%(64/200) Peripheral Edema: 1.0%(2/206) vs 7.5%(15/199) vs 12.0%(24/200) Serious AEs: Bipolar Disorder: 0.0%(0/206) vs 0.0%(0/199) vs 0.5%(1/200) Serious AEs: Pyrexia: 0.0%(0/206) vs 0.0%(0/199) vs 0.5%(1/200) Somnolence: 5.3%(11/206) vs 12.1%(24/199) vs 17.5%(35/200) Tremor: 8.7%(18/206) vs 8.0%(16/199) vs 10.5%(21/200) Weight Increased: 6.8%(14/206) vs 39.7%(79/199) vs 35.0%(70/200)</p> <p>Withdrawals: Fluoxetine vs Olanzapine vs Olanzapine/fluoxetine Withdrawals:19.4%(40/206) vs 36.2%(72/199) vs 26.0%(52/200) Withdrawals Due To Adverse Events:2.4%(5/206) vs 16.1%(32/199) vs 13.5%(27/200)</p>

Appendix D Evidence Tables For For Active-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Zeni et al.2009⁶² ADHD Aripiprazole Location: Latin America Trial: Not reported Funding source: Government, Hospital Design: RCT only Setting: Not reported Jadad: 2 Age: Mean: 8 Sex: Mixed Race: Caucasian, Other-NOS Screened: 710 Eligible: 16 Entering: 16 Withdrawn: 1 Lost to follow-up: 0 Analyzed: 15 Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Age 8-17, diagnosed borderline personality disorder co-morbid ADHD >= 30% improvement in mood symptoms in the previous trial of ARI, SNAP-IV score >=1.5</p> <p>Exclusion criteria: IQ < 70, use of medication besides ARI 10 weeks before entering study, pervasive developmental disorder, schizophrenia, substance abuse, suicidal, hypersensitive to ARI / MPH, pregnancy, acute or chronic disease</p> <p>Interventions: Aripiprazole 5-20 mg/days fixed single dose for 2 weeks vs Aripiprazole, Methylphenidate 5-20 mg/days fixed single dose for 2 weeks</p> <p>Run-in/wash-out period: Run-in: Aripiprazole plus placebo for 12 week(s). Patients who met the study criteria were randomized.</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14 days</p>	<p>Results: ADHD: Cross over study</p>

Appendix D Evidence Tables For For Active-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Verhey et al.2006¹⁰¹</p> <p>Dementia/Agitation</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center, Long-term care facilities</p> <p>Jadad: 3</p> <p>Age: Mean: 70</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: 9</p> <p>Lost to follow-up: 0</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Age >= 60 years, diagnosis of dementia according to DSM-IV, agitation level requiring antipsychotic treatment, no use of antipsychotic treatment within 3 days of inclusion CMAI score >=45</p> <p>Exclusion criteria: Delirium, neurological conditions that could contribute to psychosis or dementia.</p> <p>Interventions: Haloperidol 1-3 mg/days flexible dose for 5 weeks vs Olanzapine 2.5-7.5 mg/days flexible dose for 5 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 3-11 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 35 days</p>	<p>Results: Dementia : Change in CMAI (Agitation) at 5 weeks: Haloperidol vs Olanzapine - SMD = -0.21 (-0.73 , 0.31)</p> <p>Dementia : Change in NPI (Psychosis) at 5 weeks: Haloperidol vs Olanzapine - SMD = -0.03 (-0.57 , 0.50)</p> <p>Dementia : Change in NPI (Total) at 5 weeks: Haloperidol vs Olanzapine - SMD = -0.18 (-0.77 , 0.41)</p> <p>Adverse Events: Haloperidol vs Olanzapine Accommodation Disturbances: 25.0%(7/28) vs 10.0%(3/30) Akathisia: 21.4%(6/28) vs 13.3%(4/30) Asthenia/Lassitude/Fatigue: 78.6%(22/28) vs 60.0%(18/30) Changes Of Sexual Functions: 10.7%(3/28) vs 13.3%(4/30) Concentration Difficulties: 75.0%(21/28) vs 80.0%(24/30) Constipation: 32.1%(9/28) vs 20.0%(6/30) Depression: 71.4%(20/28) vs 56.7%(17/30) Diarrhea: 17.9%(5/28) vs 26.7%(8/30) Dystonia: 14.3%(4/28) vs 13.3%(4/30) Emotional Indifference: 57.1%(16/28) vs 33.3%(10/30) Failing Memory: 100.0%(28/28) vs 96.7%(29/30) Headache: 32.1%(9/28) vs 23.3%(7/30) Hyperkinesia: 14.3%(4/28) vs 20.0%(6/30) Hypokinesia/akinesia: 35.7%(10/28) vs 30.0%(9/30) Increased Dream Activity: 7.1%(2/28) vs 13.3%(4/30) Increased Duration Of Sleep: 42.9%(12/28) vs 63.3%(19/30) Increased Salivation: 25.0%(7/28) vs 13.3%(4/30) Increased Tendency To Sweating: 14.3%(4/28) vs 16.7%(5/30) Micturition Disturbances: 25.0%(7/28) vs 20.0%(6/30) Nausea/Vomiting: 28.6%(8/28) vs 23.3%(7/30) Orthostatic Dizziness: 28.6%(8/28) vs 16.7%(5/30) Palpitations/Tachycardia: 3.6%(1/28) vs 10.0%(3/30) Paraesthesias: 7.1%(2/28) vs 6.7%(2/30) Polyuria/Polydipsia: 17.9%(5/28) vs 16.7%(5/30) Pruritus: 21.4%(6/28) vs 10.0%(3/30) Rash: 21.4%(6/28) vs 13.3%(4/30) Reduced Duration Of Sleep: 32.1%(9/28) vs 36.7%(11/30) Reduced Salivation: 14.3%(4/28) vs 10.0%(3/30) Rigidity: 46.4%(13/28) vs 30.0%(9/30) Sleepiness/Sedation: 78.6%(22/28) vs 60.0%(18/30) Tension/Inner Unrest: 82.1%(23/28) vs 80.0%(24/30) Tremor: 25.0%(7/28) vs 26.7%(8/30) Weight Gain: 25.0%(7/28) vs 20.0%(6/30) Weight Loss: 10.7%(3/28) vs 13.3%(4/30)</p> <p>Withdrawals: Haloperidol vs Olanzapine</p>

Appendix D Evidence Tables For For Active-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Holmes et al.2007¹⁰² Dementia/Agitation Risperidone Location: Not reported Trial: Not reported Funding source: Not reported Design: RCT only Setting: Long-term care facilities Jadad: 3 Age: Not reported Sex: Mixed Race: Not reported Screened: 70 Eligible: 28 Entering: 27 Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Severe probable AD, MMSE <6, NINCDS-ADRDA and CMAI >3 p for at least 6 weeks, nursing home</p> <p>Exclusion criteria: Previous exposure to a cholinesterase inhibitor or had ever received psychotropic drugs of greater than 20mg thioridazine (or its equivalent).</p> <p>Interventions: Other, Rivastigmine 3-6 mg/days fixed titration schedule for 6 weeks vs Risperidone 0.5 mg/days fixed titration schedule for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 42 days</p>	<p>Results: Dementia : Change in CMAI (Agitation) at 6 weeks: Rivastigmine vs Risperidone - SMD = 1.31 (0.47 , 2.15)</p> <p>Adverse Events: Risperidone vs Rivastigmine Any Adverse Event: 33.3%(4/12) vs 60.0%(9/15) Cellulitis: 8.3%(1/12) vs 0.0%(0/15) Chest Infection: 8.3%(1/12) vs 6.7%(1/15) Constipation: 8.3%(1/12) vs 6.7%(1/15) Nausea And Vomiting: 0.0%(0/12) vs 20.0%(3/15) Persistent Agitation: 8.3%(1/12) vs 20.0%(3/15) Skin Rash: 0.0%(0/12) vs 6.7%(1/15) Transient Ischemic Attack: 8.3%(1/12) vs 0.0%(0/15)</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Mondraty et al.2005 ¹⁵⁴ Eating disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Don't know</p>
Correia Filho et al.2005 ⁶⁰ ADHD Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Matsunaga et al.2009 ¹⁷¹ OCD Olanzapine, Quetiapine, Risperidone	Was the study described as randomized? Yes Was the method of randomization adequate? Don't know Was the treatment allocation concealed? Don't know	Were groups similar at baseline? Don't know	How is blinding described? Not described If reported, was the method of double-blinding appropriate? Not applicable Was the outcome assessor masked? Don't know Was the care provider masked? Don't know Were patients masked? Don't know	Was the dropout rate described and the reason given? Don't know Was the dropout rate acceptable? Don't know Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? Yes Was the compliance acceptable in all groups? Don't know Was the outcome assessment timing similar in all groups? Yes
Moretti et al.2005 ⁹¹ Dementia/Agitation Olanzapine	Was the study described as randomized? No Was the method of randomization adequate? No Was the treatment allocation concealed? No	Were groups similar at baseline? Yes	How is blinding described? Open If reported, was the method of double-blinding appropriate? Not applicable Was the outcome assessor masked? No Was the care provider masked? No Were patients masked? No	Was the dropout rate described and the reason given? Don't know Was the dropout rate acceptable? Don't know Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? No Was the compliance acceptable in all groups? Don't know Was the outcome assessment timing similar in all groups? Yes

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Prosser et al.2009 ⁷⁷ Anxiety Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, outcome assessment</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Savaskan et al.2006 ⁹⁷ Dementia/Agitation Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Suh et al.2006 ⁹⁸ Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Diniz et al.2009 ¹⁷³ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Dunner et al.2007 ¹⁵⁰ Depression Ziprasidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Alexopoulos et al.2008 ¹²⁵ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Doree et al.2007 ¹⁴⁹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Pollock et al.2007 ¹⁰⁰ Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Rubio et al.2006 ²¹⁰ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Gerra et al.2006 ²⁴⁰ Substance abuse Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Gerra et al.2007 ²¹⁶ Substance abuse Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Green et al.2004 ²¹⁷ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Hutchison et al.2003 ²²³ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Rubio et al.2006 ²¹¹ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Sayers et al.2005 ²¹² Substance abuse Olanzapine	Was the study described as randomized? Yes Was the method of randomization adequate? Don't know Was the treatment allocation concealed? Don't know	Were groups similar at baseline? Don't know	How is blinding described? Double blind If reported, was the method of double-blinding appropriate? Not described Was the outcome assessor masked? Yes Was the care provider masked? Yes Were patients masked? Yes	Was the dropout rate described and the reason given? No Was the dropout rate acceptable? No Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? No Was the compliance acceptable in all groups? Don't know Was the outcome assessment timing similar in all groups? Yes
Smelson et al.2006 ²¹³ Substance abuse Olanzapine	Was the study described as randomized? Yes Was the method of randomization adequate? Don't know Was the treatment allocation concealed? Don't know	Were groups similar at baseline? Yes	How is blinding described? Double blind If reported, was the method of double-blinding appropriate? Yes Was the outcome assessor masked? Yes Was the care provider masked? Yes Were patients masked? Yes	Was the dropout rate described and the reason given? No Was the dropout rate acceptable? No Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? No Was the compliance acceptable in all groups? Don't know Was the outcome assessment timing similar in all groups? Yes

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Tsuang et al.2002 ²¹⁴ Substance abuse Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Don't know</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? No</p> <p>Was the outcome assessment timing similar in all groups? No</p>
Hussain et al.2005 ¹⁵¹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Tariot et al.2006 ⁹⁴ Dementia/Agitation Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Thase et al.2007 ¹⁴⁸ Depression Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Zeni et al.2009 ⁶² ADHD Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Active-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Verhey et al.2006 ¹⁰¹ Dementia/Agitation Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Holmes et al.2007 ¹⁰² Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Maina et al.2008¹⁶⁷ OCD Olanzapine, Risperidone Location: Western Europe Trial: Not reported Funding source: Not funded Design: RCT only Setting: Single setting Jadad: 3 Age: Mean: 35 Sex: Mixed Race: Not reported Screened: 110 Eligible: 50 Entering: 50 Withdrawn: 7 Lost to follow-up: 0 Analyzed: 43 Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Age >=18, primary diagnosis of OCD, OCD present for at least 1 year prior to study entry. VBOCS total score >=16, non-responders to SRIs</p> <p>Exclusion criteria: A current diagnosis of MDD and/or HAM-D score >=15, schizophrenia or organic brain syndrome or medical illness contra-indicate use of SRI and/or risperidone or olanzapine, pregnant or nursing women</p> <p>Interventions: Risperidone 1-3 mg/days fixed titration schedule for 8 weeks vs Olanzapine 2.5-10 mg/days fixed titration schedule for 8 weeks</p> <p>Run-in/wash-out period: Run-in: SRI monotherapy for 16 week(s). Patients resistant to SRI were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 42, 56 days</p>	<p>Results: OCD : Change in YBOCS (Total Score) at 8 weeks: Olanzapine vs Risperidone - WMD = -0.50 (-3.81 , 2.81)</p> <p>Adverse Events: Risperidone vs Olanzapine Amenorrhoea: 24.0%(6/25) vs 4.0%(1/25) Any Adverse Events: 52.0%(13/25) vs 64.0%(16/25) Diminished Sexual Desire: 0.0%(0/25) vs 4.0%(1/25) Micturition Disturbances: 4.0%(1/25) vs 0.0%(0/25) Nausea/Vomiting: 8.0%(2/25) vs 0.0%(0/25) Orthostatic Dizziness: 12.0%(3/25) vs 8.0%(2/25) Rash: 4.0%(1/25) vs 0.0%(0/25) Rigidity: 8.0%(2/25) vs 0.0%(0/25) Tension/Inner Unrest: 24.0%(6/25) vs 0.0%(0/25) Weight Gain: 16.0%(4/25) vs 52.0%(13/25)</p> <p>Withdrawals: Olanzapine Diminished Sex Desire; Weight Gain Leading To Withdrawal:8.0%(2/25) Risperidone Tension/Inner Unrest; Nausea/Vomiting Leading To Withdrawal:8.0%(2/25) Risperidone vs Olanzapine Withdrawals:12.0%(3/25) vs 16.0%(4/25) Withdrawals Due To Adverse Events:8.0%(2/25) vs 8.0%(2/25)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Rainer et al.2007¹⁰³ Dementia/Agitation Quetiapine, Risperidone Location: Western Europe Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center Jadad: 3 Age: Mean: 55 Sex: Mixed Race: Not reported Screened: NR Eligible: 72 Entering: 72 Withdrawn: 6 Lost to follow-up: 1 Analyzed: 65 Method of AE assessment: Elicited by investigator, reported spontaneously by patient</p>	<p>Inclusion criteria: 55-85 years old, dementia, MMSE score 10-26, have a NPI part I score in sub-items relating to delusions, hallucinations, agitation / aggression</p> <p>Exclusion criteria: Participation in any other drug trial within 4 weeks, hypersensitive to study drugs, chronic disease, use of antipsychotics, seizure, severe cardiovascular disease, asthmatic condition, met NINCDS-ADRDA exclusion criteria.</p> <p>Interventions: Quetiapine 50-400 mg/days flexible dose for 8 weeks vs Risperidone 0.5-4 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 28, 56 days</p>	<p>Results: Dementia : Change in CMAI (Agitation) at 8 weeks: Risperidone vs Quetiapine - SMD = -0.17 (-0.66 , 0.32)</p> <p>Dementia : Change in NPI (Total) at 8 weeks: Risperidone vs Quetiapine - SMD = -0.06 (-0.55 , 0.43)</p> <p>Adverse Events: Quetiapine vs Risperidone All Adverse Events: 57.9%(22/38) vs 44.1%(15/34) Asthenia: 2.6%(1/38) vs 5.9%(2/34) Cerebrovascular Adverse Events: 0.0%(0/38) vs 0.0%(0/34) Conjunctivitis: 0.0%(0/38) vs 5.9%(2/34) Constipation: 5.3%(2/38) vs 2.9%(1/34) Deaths: 0.0%(0/38) vs 0.0%(0/34) Diarrhea: 0.0%(0/38) vs 14.7%(5/34) Fall With Contusion: 2.6%(1/38) vs 0.0%(0/34) Falls Or Fractures Due To Somnolence Or Sedation: 0.0%(0/38) vs 0.0%(0/34) Fatigue: 7.9%(3/38) vs 0.0%(0/34) Femur Fracture: 5.3%(2/38) vs 0.0%(0/34) Insomnia: 5.3%(2/38) vs 2.9%(1/34) Muscle Rigidity: 0.0%(0/38) vs 14.7%(5/34) Sedation: 10.5%(4/38) vs 0.0%(0/34) Serious Adverse Events Of Hallucinations During Hospitalization For Hernia Surgery: 0.0%(0/38) vs 2.9%(1/34) Significant Change From Baseline Blood Pressure Or Pulse Rate: 0.0%(0/38) vs 0.0%(0/34) Somnolence: 5.3%(2/38) vs 0.0%(0/34) Thigh Fracture: 5.3%(2/38) vs 0.0%(0/34) Total Serious Adverse Events: 7.9%(3/38) vs 2.9%(1/34) Treatment-Emergent Extrapyramidal Symptoms Reported As Adverse Events (Extrapyramidal Disorder And Muscle Rigidity): 0.0%(0/38) vs 17.6%(6/34) Urinary Incontinence: 5.3%(2/38) vs 0.0%(0/34)</p> <p>Withdrawals: Quetiapine vs Risperidone Withdrawals:10.5%(4/38) vs 8.8%(3/34) Withdrawals Due To Adverse Events:5.3%(2/38) vs 2.9%(1/34)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Savas et al.2008¹⁶⁸</p> <p>OCD</p> <p>Quetiapine, Ziprasidone</p> <p>Location: Middle East</p> <p>Trial: Not reported</p> <p>Funding source: None</p> <p>Design: CCT only</p> <p>Setting: Single setting</p> <p>Jadad: 0</p> <p>Age: Mean: 19</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 24</p> <p>Withdrawn: 0</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 24</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: OCD without psychotic features, taking study medication and SRIs >= 6 month</p> <p>Exclusion criteria: < 6 month treatment, illness, alcohol or substance abuse dependence, co-morbid psychiatric conditions</p> <p>Interventions: Quetiapine 100-1200 mg/days frequency not reported for 6 months vs Ziprasidone 80-160 mg/days frequency not reported for 6 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 30, 61, 91, 182 days</p>	<p>Results: OCD: Insufficient data to calculate an effect size</p> <p>Adverse Events: Quetiapine vs Ziprasidone Weight Gain: 20.0%(3/15) vs 0.0%(0/9)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Sultzer et al.2008⁸⁹</p> <p>Dementia/Agitation</p> <p>Olanzapine, Quetiapine, Risperidone</p> <p>Location: US</p> <p>Trial: CATIE-AD</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 1</p> <p>Age: Mean: 78</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: NR Eligible: NR Entering: 421 Withdrawn: 77-85% Lost to follow-up: NR Analyzed: NR</p> <p>Method of AE assessment: Not applicable</p>	<p>Inclusion criteria: Had dementia of the Alzheimer's type or probable Alzheimer's disease, delusions / hallucinations / agitation / aggression, had occurred nearly everyday over previous week or intermittently over 4 weeks, at least moderate in severity on BPRS, MMSE score 5-16</p> <p>Exclusion criteria: Patients in skilled nursing homes, taking antidepressants or anticonvulsants for mood stabilization.</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Olanzapine 5.5 mg/days average final dose for 12 weeks vs Quetiapine 56.5 mg/days average final dose for 12 weeks vs Risperidone 1.0 mg/days average final dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 56, 84 days</p>	<p>Results: Dementia : Change in NPI (Total) at 12 weeks: Placebo vs Olanzapine - SMD = 0.15 (-0.11 , 0.40)</p> <p>Dementia : Change in NPI (Total) at 12 weeks: Placebo vs Risperidone - SMD = 0.40 (0.13 , 0.68)</p> <p>Dementia : Change in NPI (Total) at 12 weeks: Placebo vs Quetiapine - SMD = 0.15 (-0.11 , 0.42)</p> <p>Dementia : Change in NPI (Total) at 12 weeks: Olanzapine vs Quetiapine - SMD = 0.02 (-0.27 , 0.30)</p> <p>Dementia : Change in NPI (Total) at 12 weeks: Risperidone vs Quetiapine - SMD = -0.24 (-0.53 , 0.06)</p> <p>Dementia : Change in NPI (Total) at 12 weeks: Risperidone vs Olanzapine - SMD = -0.27 (-0.56 , 0.02)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Placebo vs Olanzapine - SMD = 0.07 (-0.19 , 0.33)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Placebo vs Risperidone - SMD = 0.39 (0.11 , 0.66)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Placebo vs Quetiapine - SMD = 0.16 (-0.10 , 0.42)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Olanzapine vs Quetiapine - SMD = 0.07 (-0.21 , 0.35)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Risperidone vs Quetiapine - SMD = -0.24 (-0.54 , 0.06)</p> <p>Dementia : Change in BPRS (Psychosis) at 12 weeks: Risperidone vs Olanzapine - SMD = -0.27 (-0.56 , 0.02)</p> <p>Dementia : Change in BPRS (Agitation) at 12 weeks: Placebo vs Olanzapine - SMD = 0.28 (0.02 , 0.54)</p> <p>Dementia : Change in BPRS (Agitation) at 12 weeks: Placebo vs Risperidone - SMD = 0.10 (-0.18 , 0.37)</p> <p>Dementia : Change in BPRS (Agitation) at 12 weeks: Placebo vs Quetiapine - SMD = 0.20 (-0.06 , 0.46)</p> <p>Dementia : Change in BPRS (Agitation) at 12 weeks: Olanzapine vs Quetiapine - SMD = -0.09 (-0.37 , 0.19)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Nejtek et al.2008²¹⁸</p> <p>Substance abuse</p> <p>Quetiapine, Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry, Private</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 4</p> <p>Age: Mean: 36</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Hispanic</p> <p>Screened: 651 Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: 14</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 20-50 years old, outpatients, bipolar disorder with or without psychotic features or bipolar II disorder, cocaine or methamphetamine dependence, experiencing hypomanic, manic, or mixed state episodes with YMRS ≥ 9, craving score > 10 on SCQ - 10</p> <p>Exclusion criteria: Inpatients, substance-induced mood disorder, pregnant, a history of special education / mental retardation / dementia, had HIV/AIDS, reactive hepatitis, hepatic cirrhosis or any active liver disease, diabetes, heart disease, central nervous system disease, allergic to study medications, receiving any antipsychotic drugs, had contraindications</p> <p>Interventions: Quetiapine 50-600 mg/days fixed titration schedule for 20 weeks vs Risperidone 0.5-6 mg/days fixed titration schedule for 20 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: OCD, PTSD</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Adverse Events: Quetiapine vs Risperidone Blurred Vision: 2.1%(1/48) vs 6.5%(3/46) Clumsiness: 4.2%(2/48) vs 4.3%(2/46) Constipation: 2.1%(1/48) vs 0.0%(0/46) Daytime Sleepiness: 12.5%(6/48) vs 10.9%(5/46) Decreased Appetite: 6.3%(3/48) vs 6.5%(3/46) Diarrhea: 2.1%(1/48) vs 2.2%(1/46) Difficulty Urinating: 0.0%(0/48) vs 0.0%(0/46) Dizziness: 4.2%(2/48) vs 2.2%(1/46) Dry Mouth: 6.3%(3/48) vs 2.2%(1/46) Headache: 6.3%(3/48) vs 6.5%(3/46) Increase 1.0 BMI Point (Approx 6 lbs): 41.7%(20/48) vs 23.9%(11/46) Increased Appetite: 12.5%(6/48) vs 4.3%(2/46) Increased Perspiration: 2.1%(1/48) vs 2.2%(1/46) Nausea Or Vomiting: 4.2%(2/48) vs 4.3%(2/46) Nervousness: 14.6%(7/48) vs 6.5%(3/46) Palpitations: 0.0%(0/48) vs 0.0%(0/46) Sexual Difficulties: 6.3%(3/48) vs 6.5%(3/46) Skin Rash: 0.0%(0/48) vs 0.0%(0/46) Tiredness, Fatigue: 18.8%(9/48) vs 13.0%(6/46) Tremor: 0.0%(0/48) vs 0.0%(0/46)</p> <p>Withdrawals: Quetiapine vs Risperidone Withdrawals:70.8%(34/48) vs 69.6%(32/46) Withdrawals Due To Adverse Events:0.0%(0/48) vs 0.0%(0/46)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Akerele et al.2007²¹⁵</p> <p>Substance abuse</p> <p>Olanzapine, Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry, Private</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 36</p> <p>Sex: 80-99% Male</p> <p>Race: Caucasian, African Ancestry, Hispanic</p> <p>Screened: 76 Eligible: 29 Entering: 28 Withdrawn: 12 Lost to follow-up: 0 Analyzed: 16</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Diagnosis of schizophrenia or schizoaffective disorder, current cocaine and / or marijuana abuse / dependence , were using marijuana at least twice per week or cocaine at least once per week</p> <p>Exclusion criteria: Physiologically dependent on alcohol or other drugs, had unstable psychiatric symptomatology, unstable medical condition, enzyme function test greater than three times the upper limit of normal. A history of seizures / neuroleptic malignant syndrome, not responded to either olanzapine or risperidone. Positive and negative symptom scale > 30.</p> <p>Interventions: Olanzapine 5-20 mg/days fixed titration schedule for 12 weeks vs Risperidone 3-9 mg/days fixed titration schedule for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 21, 28, 35, 42, 49, 56, 63, 70 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Adverse Events: Olanzapine vs Risperidone Sedation: 57.1%(8/14) vs 78.6%(11/14) Worsening Of Abnormal Movements: 0.0%(0/14) vs 7.1%(1/14)</p> <p>Withdrawals: Olanzapine vs Risperidone Admitted To Inpatient Detox Unit Leading To Withdrawal:0.0%(0/14) vs 7.1%(1/14) Admitted To Inpatient Psych Unit Leading To Withdrawal:7.1%(1/14) vs 0.0%(0/14) Withdrawals:57.1%(8/14) vs 28.6%(4/14) Withdrawals Due To Adverse Events:0.0%(0/14) vs 0.0%(0/14)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Martinotti et al.2009²¹⁹</p> <p>Substance abuse</p> <p>Aripiprazole</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Mean: 40</p> <p>Sex: 80-99% Male</p> <p>Race: Not reported</p> <p>Screened: 112 Eligible: 57 Entering: 57 Withdrawn: 3 Lost to follow-up: 11 Analyzed: 43</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Alcohol use disorders >= 3 years, daily alcohol intake >= 6 units, alcohol dependence, declared commitment to the goal of total abstinence</p> <p>Exclusion criteria: Severe physical illness or mental disorders, regularly taking anticonvulsants, antidepressants or antipsychotics, pregnant, history of severe AE to aripiprazole or naltrexone, previous treated with ARI or NAL.</p> <p>Interventions: Naltrexone 10-50 mg/days fixed titration schedule for 16 weeks vs Aripiprazole 5-15 mg/days flexible dose for 16 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Personality Disorder, Substance Abuse, Eating Disorder</p> <p>Timing of outcome assessment: 14, 56, 112 days</p>	<p>Results: Substance Abuse : Change in Complete Abstinence (Alcohol) at 16 weeks: Aripiprazole vs Naltrexone - RR = 1.05 (0.56 , 1.98)</p> <p>Substance Abuse : Change in Abstinent Days (Alcohol) at 16 weeks: Aripiprazole vs Naltrexone - SMD = 0.13 (-0.39 , 0.65)</p> <p>Adverse Events: Aripiprazole vs Naltrexone Akathisia: 6.9%(2/29) vs 0.0%(0/28) Confusion: 3.4%(1/29) vs 0.0%(0/28) Dizziness: 0.0%(0/29) vs 7.1%(2/28) Euphoria: 6.9%(2/29) vs 0.0%(0/28) Hypotension: 0.0%(0/29) vs 10.7%(3/28) Nausea And Vomiting: 10.3%(3/29) vs 21.4%(6/28)</p> <p>Withdrawals: Aripiprazole vs Naltrexone Withdrawals:75.9%(22/29) vs 75.0%(21/28) Withdrawals Due To Adverse Events:6.9%(2/29) vs 17.9%(5/28)</p>

Appendix D Evidence Tables For Head-to-Head Trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Maina et al.2008 ¹⁶⁷ OCD Olanzapine, Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, outcome assessment</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Rainer et al.2007 ¹⁰³ Dementia/Agitation Quetiapine, Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, outcome assessment</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Head-to-Head Trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Savas et al.2008 ¹⁶⁸ OCD Quetiapine, Ziprasidone	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Sultzer et al.2008 ⁸⁹ Dementia/Agitation Olanzapine, Quetiapine, Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Single blind, patient</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Head-to-Head Trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
<p>Nejtek et al.2008²¹⁸ Substance abuse Quetiapine, Risperidone</p>	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Head-to-Head Trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Akerele et al.2007 ²¹⁵ Substance abuse Olanzapine, Risperidone	Was the study described as randomized? Yes Was the method of randomization adequate? Don't know Was the treatment allocation concealed? Don't know	Were groups similar at baseline? No	How is blinding described? Double blind If reported, was the method of double-blinding appropriate? Not described Was the outcome assessor masked? Yes Was the care provider masked? Yes Were patients masked? Yes	Was the dropout rate described and the reason given? Yes Was the dropout rate acceptable? No Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? Yes Was the compliance acceptable in all groups? Yes Was the outcome assessment timing similar in all groups? Yes
Martinotti et al.2009 ²¹⁹ Substance abuse Aripiprazole	Was the study described as randomized? Yes Was the method of randomization adequate? Don't know Was the treatment allocation concealed? Don't know	Were groups similar at baseline? Yes	How is blinding described? Double blind If reported, was the method of double-blinding appropriate? Yes Was the outcome assessor masked? Yes Was the care provider masked? Yes Were patients masked? Yes	Was the dropout rate described and the reason given? No Was the dropout rate acceptable? No Were all randomized participants analyzed? Yes	Were cointerventions avoided or similar? Don't know Was the compliance acceptable in all groups? Don't know Was the outcome assessment timing similar in all groups? Yes

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Bissada et al.2008¹⁵³ Eating disorder Olanzapine Location: Canada Trial: Not reported Funding source: Industry Design: RCT only Setting: Single setting Jadad: 3 Age: Not reported Sex: 100% Female Race: Not reported Screened: 147 Eligible: 76 Entering: 34 Withdrawn: 6 Lost to follow-up: 0 Analyzed: 28 Method of AE assessment: Not reported</p>	<p>Inclusion criteria: DSM-IV criteria for anorexia or nervosa (restricting or binge / purge subtype) including a body index <= 17.5 kg/m2</p> <p>Exclusion criteria: Active suicidal intent, comorbid substance abuse disorder, bipolar disorder, schizophrenia or any other psychotic disorder, organic brain syndromes or dissociative disorders, pregnancy, and failure to use contraception if sexually active</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Olanzapine 2.5-10 mg/days flexible dose for 10 weeks</p> <p>Run-in/wash-out period: Run-in: No drug for 2 week(s).</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Eating Disorder : Change in BMI at 12 weeks: Olanzapine vs Placebo - WMD = 0.15 (-0.80 , 1.10)</p> <p>Eating Disorder : Change in BMI at 12 weeks: Olanzapine vs Placebo - WMD = 0.11 (-0.77 , 0.99)</p> <p>Adverse Events: Olanzapine vs Placebo De Novo Development Of Diabetes Mellitus: 0.0%(0/16) vs 0.0%(0/18) Evidence Of Impaired Glucose Tolerance: 0.0%(0/16) vs 0.0%(0/18) Serious Adverse Events (Extrapyramidal Symptoms, Excessive Sleepiness, Dizziness Or Galactorrhea): 0.0%(0/16) vs 0.0%(0/18)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:12.5%(2/16) vs 22.2%(4/18)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Mintzer et al.2007⁸⁶ Dementia/Agitation Aripiprazole Location: US, Canada, Australia/New Zealand, Latin America, South Africa Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 3 Age: Mean: 56 Sex: Mixed Race: Caucasian, African Ancestry, Hispanic, Asian/Pacific Islander, Other-NOS Screened: 654 Eligible: 487 Entering: 487 Withdrawn: 203 Lost to follow-up: 0 Analyzed: 284 Method of AE assessment: Monitored, other</p>	<p>Inclusion criteria: Diagnosed with AD and delusions / hallucinations. Institutionalized, capable of self-locomotion, MMSE 6-22. NPI-NH score >=6</p> <p>Exclusion criteria: Delirium, amnestic disorder, bipolar disorder, schizophrenia, mood disorder, non-AD, depression with hallucinations / delusions, history of refractoriness to antipsychotics, suicidal ideation, previous participation in aripiprazole trials, pregnancy.</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Aripiprazole 2 mg/days fixed single dose for 10 weeks vs Aripiprazole 5 mg/days fixed single dose for 10 weeks vs Aripiprazole 5-10 mg/days fixed single dose for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56, 70 days</p>	<p>Results: Dementia : Change in CMAI (Agitation) at 10 weeks: Placebo vs Aripiprazole (all doses combined) - SMD = 0.31 (0.10 , 0.52)</p> <p>Dementia : Change in NPI (Psychosis) at 10 weeks: Placebo vs Aripiprazole (all doses combined) - SMD = 0.24 (0.03 , 0.45)</p> <p>Dementia : Change in NPI (Total) at 10 weeks: Placebo vs Aripiprazole (all doses combined) - SMD = 0.16 (-0.05 , 0.37)</p> <p>Adverse Events: Aripiprazole 10 mg vs Aripiprazole 10 mg vs Aripiprazole 2 mg vs Aripiprazole 2 mg vs Aripiprazole 5 mg vs Aripiprazole 5 mg vs Placebo vs Placebo Infection: 5.6%(7/126) vs 5.6%(7/126) vs 7.6%(9/118) vs 7.6%(9/118) vs 4.9%(6/122) vs 4.9%(6/122) vs 4.1%(5/121) vs 4.1%(5/121) Aripiprazole 10 mg vs Aripiprazole 2 mg vs Aripiprazole 5 mg vs Placebo Abdominal Pain: 4.0%(5/126) vs 2.5%(3/118) vs 6.6%(8/122) vs 3.3%(4/121) Abnormal Gait: 4.0%(5/126) vs 1.7%(2/118) vs 7.4%(9/122) vs 0.8%(1/121) Accidental Injury: 19.8%(25/126) vs 29.7%(35/118) vs 23.8%(29/122) vs 19.0%(23/121) Agitation: 10.3%(13/126) vs 11.0%(13/118) vs 7.4%(9/122) vs 16.5%(20/121) Anorexia: 5.6%(7/126) vs 8.5%(10/118) vs 4.9%(6/122) vs 10.7%(13/121) Asthenia: 9.5%(12/126) vs 5.9%(7/118) vs 9.0%(11/122) vs 2.5%(3/121) Back Pain: 6.3%(8/126) vs 5.1%(6/118) vs 3.3%(4/122) vs 3.3%(4/121) Confusion: 4.8%(6/126) vs 2.5%(3/118) vs 7.4%(9/122) vs 4.1%(5/121) Conjunctivitis: 2.4%(3/126) vs 5.9%(7/118) vs 2.5%(3/122) vs 2.5%(3/121) Constipation: 3.2%(4/126) vs 5.1%(6/118) vs 4.9%(6/122) vs 5.0%(6/121) Coughing: 5.6%(7/126) vs 5.1%(6/118) vs 3.3%(4/122) vs 5.0%(6/121) Diarrhea: 8.7%(11/126) vs 5.9%(7/118) vs 6.6%(8/122) vs 5.8%(7/121) Ecchymosis: 8.7%(11/126) vs 8.5%(10/118) vs 4.9%(6/122) vs 9.9%(12/121) Edema: 1.6%(2/126) vs 5.1%(6/118) vs 3.3%(4/122) vs 1.7%(2/121) Edema, Peripheral: 8.7%(11/126) vs 10.2%(12/118) vs 5.7%(7/122) vs 8.3%(10/121) Extremity Pain: 9.5%(12/126) vs 6.8%(8/118) vs 9.0%(11/122) vs 5.8%(7/121) Headache: 7.1%(9/126) vs 4.2%(5/118) vs 4.1%(5/122) vs 3.3%(4/121) Incidence Of Clinically Significant Weight Gain: 4.0%(5/126) vs 6.8%(8/118) vs 4.1%(5/122) vs 5.8%(7/121) Incidence Of Clinically Significant Weight Loss: 11.1%(14/126) vs 10.2%(12/118) vs 13.1%(16/122) vs 14.9%(18/121)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Nickel et al.2007¹⁹¹</p> <p>Personality disorder</p> <p>Aripiprazole</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not funded</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Mean: 22</p> <p>Sex: 80-99% Female</p> <p>Race: Not reported</p> <p>Screened: 52 Eligible: 52 Entering: 52 Withdrawn: 13 Lost to follow-up: 0 Analyzed: 39</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Same as ID 2754</p> <p>Exclusion criteria: Schizophrenia, current use of psychotic medication in previous placebo group, termination of aripiprazole, current psychotherapy, pregnancy, suicide ideation, severe somatic illness, substance abuse</p> <p>Interventions: Placebo dosage not reported for 18 months vs Aripiprazole 15 mg/days fixed single dose for 18 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, OCD</p> <p>Timing of outcome assessment: 182, 365, 547 days</p>	<p>Results: Personality Disorder : Change in SCL-90-R (GSI) at 72 weeks: Aripiprazole vs Placebo - WMD = -16.50 (-20.51 , -12.49)</p> <p>Adverse Events: Aripiprazole vs Placebo Anxiety: 15.4%(4/26) vs 19.2%(5/26) Constipation: 15.4%(4/26) vs 11.5%(3/26) Headache: 34.6%(9/26) vs 30.8%(8/26) Insomnia: 30.8%(8/26) vs 23.1%(6/26) Nausea: 15.4%(4/26) vs 15.4%(4/26) Numbness: 11.5%(3/26) vs 3.8%(1/26) Restlessness: 11.5%(3/26) vs 7.7%(2/26) Significant Weight Change: 0.0%(0/26) vs 0.0%(0/26)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:15.4%(4/26) vs 34.6%(9/26)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Zhong et al.2007⁹² Dementia/Agitation Quetiapine Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 5 Age: Mean: 56 Sex: Mixed Race: Caucasian, African Ancestry, Hispanic, Asian/Pacific Islander, Other-NOS Screened: 435 Eligible: NR Entering: 333 Withdrawn: 118 Lost to follow-up: NR Analyzed: 215 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Institutionalized, diagnosed possible AD or vascular dementia, age \geq 55, ambulatory, agitation that didn't result directly from participants medical condition, PANSS-EC total \geq 14, one of the 5 PANSS-EC items \geq 4.</p> <p>Exclusion criteria: History of schizophrenia, schizoaffective or bipolar disorder, agitation not related to dementia, failure to respond to a prior adequate AAP trial for agitation, unstable medical illness , abnormal ECG results.</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Quetiapine 25-100 mg/days fixed titration schedule for 10 weeks vs Quetiapine 25-200 mg/days fixed titration schedule for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56, 70 days</p>	<p>Results: Dementia : Change in NPI (Agitation) at 10 weeks: Placebo vs Quetiapine (all doses combined) - SMD = -0.03 (-0.27 , 0.21)</p> <p>Dementia : Change in NPI (Psychosis) at 10 weeks: Placebo vs Quetiapine (all doses combined) - SMD = -0.03 (-0.27 , 0.21)</p> <p>Dementia : Change in NPI (Total) at 10 weeks: Placebo vs Quetiapine (all doses combined) - SMD = 0.04 (-0.21 , 0.28)</p> <p>Adverse Events: Placebo vs Quetiapine 100 mg vs Quetiapine 200 mg Any Adverse Events: 80.4%(74/92) vs 80.6%(100/124) vs 84.6%(99/117) Cardiovascular: 4.3%(4/92) vs 1.6%(2/124) vs 5.1%(6/117) Constipation: 1.1%(1/92) vs 5.6%(7/124) vs 6.0%(7/117) Decreased Appetite: 3.3%(3/92) vs 1.6%(2/124) vs 6.0%(7/117) EPS: 5.4%(5/92) vs 4.8%(6/124) vs 6.8%(8/117) Fall: 26.1%(24/92) vs 25.8%(32/124) vs 26.5%(31/117) Gait Abnormalities: 0.0%(0/92) vs 4.8%(6/124) vs 5.1%(6/117) Headache: 3.3%(3/92) vs 5.6%(7/124) vs 3.4%(4/117) Lethargy: 3.3%(3/92) vs 6.5%(8/124) vs 11.1%(13/117) Nausea: 2.2%(2/92) vs 5.6%(7/124) vs 4.3%(5/117) Peripheral Edema: 6.5%(6/92) vs 7.3%(9/124) vs 5.1%(6/117) Sedation: 3.3%(3/92) vs 3.2%(4/124) vs 7.7%(9/117) Serious Adverse Events: 9.8%(9/92) vs 11.3%(14/124) vs 6.8%(8/117) Skin Laceration: 14.1%(13/92) vs 15.3%(19/124) vs 11.1%(13/117) Somnolence: 2.2%(2/92) vs 8.1%(10/124) vs 9.4%(11/117) Upper Respiratory Tract Infection: 4.3%(4/92) vs 4.8%(6/124) vs 5.1%(6/117) Urinary Tract Infection: 7.6%(7/92) vs 16.1%(20/124) vs 7.7%(9/117) Vomiting: 3.3%(3/92) vs 5.6%(7/124) vs 9.4%(11/117) Weight Decreased: 5.4%(5/92) vs 4.0%(5/124) vs 3.4%(4/117)</p> <p>Withdrawals: Placebo vs Quetiapine 100 mg vs Quetiapine 200 mg Withdrawals:34.8%(32/92) vs 34.7%(43/124) vs 36.8%(43/117) Withdrawals Due To Adverse Events:9.8%(9/92) vs 8.1%(10/124) vs 14.5%(17/117)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Armenteros et al.2007⁵⁹ ADHD Risperidone Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Not reported Jadad: 4 Age: Not reported Sex: 80-99% Male Race: Caucasian, African Ancestry, Other-NOS Screened: NR Eligible: NR Entering: 25 Withdrawn: 2 Lost to follow-up: 0 Analyzed: 23 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: ADHD, treated constant does of stimulant for 3 weeks prior, aggressive behavior, AQPA of <= 0, CGI-S >= 4, IQ >=75, normal physical and labs</p> <p>Exclusion criteria: Substance use disorder, unstable illness, history of intolerance or failure to respond to risperidone, suicidal or homicidal</p> <p>Interventions: Placebo dosage not reported for 28 days vs Risperidone 0.5-2 mg/days flexible dose for 28 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14, 21, 28 days</p>	<p>Results: ADHD : Change in CAS-P (improvement = >=30%) at 4 weeks: Risperidone vs Placebo - RR = 1.19 (0.89 , 1.59)</p> <p>Adverse Events: Placebo vs Risperidone Abdominal Pain: 7.7%(1/13) vs 25.0%(3/12) Agitation: 0.0%(0/13) vs 8.3%(1/12) At Least One Adverse Event: 76.9%(10/13) vs 58.3%(7/12) Increased Appetite: 0.0%(0/13) vs 8.3%(1/12) Somnolence: 15.4%(2/13) vs 8.3%(1/12) Vomiting: 23.1%(3/13) vs 16.7%(2/12)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:7.7%(1/13) vs 8.3%(1/12) Withdrawals Due To Adverse Events:0.0%(0/13) vs 0.0%(0/12)</p>

AE=Adverse Event, NR=Not Reported

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Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Bandelow et al.2009⁶⁹</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: Canada, Western Europe, Eastern Europe, Latin America, South Africa</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 5</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: 1054 Eligible: NR Entering: 873 Withdrawn: 188 Lost to follow-up: 9 Analyzed: 473</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65 years old, diagnosed GAD, HAM-A total score \geq 20 with item 1 and 2 scores \geq 2, MADRS total score \leq 16, CGI-S score \geq 4 at enrolment and randomization.</p> <p>Exclusion criteria: Diagnosis of any DSM-IV-TR Axis I disorder other than GAD within 6 months or DSM - IV-TR Axis II disorder, MADRS item 10 score \geq 4, suicide attempt, alcohol abuse</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50-150 mg/days fixed titration schedule for 8 weeks vs Quetiapine 50 mg/days fixed single dose for 8 weeks vs Paroxetine 20 mg/days fixed single dose for 8 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 1-4 week(s). Eligible patents were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 1, 4, 7, 14, 21, 28, 42, 56 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 1.36 (1.17 , 1.59)</p> <p>Adverse Events: Paroxetine vs Placebo vs Quetiapine 150 mg vs Quetiapine 50mg \geq7% Increase In Body Weight At End of Treatment: 4.6%(10/217) vs 2.3%(5/217) vs 6.9%(15/218) vs 4.5%(10/221) Anxiety: 5.1%(11/217) vs 0.5%(1/217) vs 1.4%(3/218) vs 1.4%(3/221) Constipation: 2.8%(6/217) vs 1.4%(3/217) vs 6.0%(13/218) vs 4.5%(10/221) Diarrhea: 5.5%(12/217) vs 4.6%(10/217) vs 3.7%(8/218) vs 3.2%(7/221) Dizziness: 13.4%(29/217) vs 6.0%(13/217) vs 15.6%(34/218) vs 11.8%(26/221) Dry Mouth: 9.7%(21/217) vs 6.0%(13/217) vs 25.7%(56/218) vs 15.8%(35/221) Extrapyramidal Adverse Events: 8.3%(18/217) vs 1.8%(4/217) vs 5.0%(11/218) vs 6.8%(15/221) Fasting HDL Cholesterol =40 mg/dL At End of Treatment: 1.4%(3/217) vs 5.5%(12/217) vs 3.7%(8/218) vs 2.7%(6/221) Fasting Total Cholesterol =240 mg/dL At End of Treatment: 6.5%(14/217) vs 3.2%(7/217) vs 5.0%(11/218) vs 4.1%(9/221) Fasting Triglycerides \geq200 mg/dL At End of Treatment: 3.7%(8/217) vs 2.8%(6/217) vs 8.3%(18/218) vs 3.2%(7/221) Fatigue: 9.2%(20/217) vs 3.7%(8/217) vs 16.5%(36/218) vs 14.9%(33/221) Headache: 17.1%(37/217) vs 18.0%(39/217) vs 12.4%(27/218) vs 16.3%(36/221) Insomnia: 13.4%(29/217) vs 6.5%(14/217) vs 8.7%(19/218) vs 7.7%(17/221) Nasopharyngitis: 6.0%(13/217) vs 3.7%(8/217) vs 2.3%(5/218) vs 3.2%(7/221) Nausea: 24.4%(53/217) vs 9.2%(20/217) vs 11.9%(26/218) vs 11.3%(25/221) Overall Incidence Of Adverse Events: 72.8%(158/217) vs 55.8%(121/217) vs 76.1%(166/218) vs 71.0%(157/221) Sedation: 2.3%(5/217) vs 0.5%(1/217) vs 8.3%(18/218) vs 6.3%(14/221) Sexual Dysfunction: 7.4%(16/217) vs 2.3%(5/217) vs 1.8%(4/218) vs 0.9%(2/221) Somnolence: 11.1%(24/217) vs 4.6%(10/217) vs 25.2%(55/218) vs 21.7%(48/221) Treatment-Related Adverse Events: 58.5%(127/217) vs 34.6%(75/217) vs 65.6%(143/218) vs 58.8%(130/221) Paroxetine vs Placebo vs Quetiapine 50mg Fasting LDL Cholesterol = 160 mg/dL At End of Treatment: 6.5%(14/217) vs 3.7%(8/217) vs 3.2%(7/221) Quetiapine 150 mg Fasting LDL Cholesterol = >160 mg/dL At End of Treatment: 4.1%(9/218)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Barnett et al.2002⁶⁴</p> <p>Anxiety</p> <p>Olanzapine</p> <p>Location: Not reported</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Mean: 18</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 12</p> <p>Entering: 12</p> <p>Withdrawn: 2</p> <p>Lost to follow-up: 3</p> <p>Analyzed: 7</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, social anxiety disorder, DSM-IV of social phobia of, brief social phobia scale (BSPS) >= 20</p> <p>Exclusion criteria: NR</p> <p>Interventions: Placebo 5 mg/days flexible dose for 8 weeks vs Olanzapine 5-20 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: Placebo for 1 week(s).</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 21, 28, 42, 56 days</p>	<p>Results: Anxiety : Change in Brief Social Phobia Scale at 8 weeks: Olanzapine vs Placebo - WMD = -10.60 (-26.09 , 4.89)</p> <p>Adverse Events: Olanzapine vs Placebo Constipation: 14.3%(1/7) vs 0.0%(0/5) Drowsiness: 57.1%(4/7) vs 0.0%(0/5) Dry Mouth: 42.9%(3/7) vs 0.0%(0/5) Headache: 0.0%(0/7) vs 20.0%(1/5) Significant Changes On The BAS Or AIMS: 0.0%(0/7) vs 0.0%(0/5) Thirst: 14.3%(1/7) vs 0.0%(0/5) Weight Gain: 0.0%(0/7) vs 20.0%(1/5)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:42.9%(3/7) vs 40.0%(2/5) Withdrawals Due To Adverse Events:14.3%(1/7) vs 20.0%(1/5)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Brambilla et al.2007¹⁵⁵</p> <p>Eating disorder</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: 100% Female</p> <p>Race: Not reported</p> <p>Screened: 35 Eligible: 30 Entering: NR Withdrawn: 5 Lost to follow-up: 0 Analyzed: 30</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Anorexia nervosa per DSM-IV restricted or bingeing-purging type</p> <p>Exclusion criteria: General medical impairments, endocrine, metabolic and immune alterations (other than those limited to anorexia nervosa), cerebral trauma, epilepsy</p> <p>Interventions: Placebo dosage not reported for 3 months vs Olanzapine 2.5-5 mg/days fixed titration schedule for 3 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, OCD, Personality Disorder</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Eating Disorder : Change in BMI at 4 weeks: Olanzapine vs Placebo - WMD = -0.00 (-0.91 , 0.91)</p> <p>Eating Disorder : Change in BMI at 12 weeks: Olanzapine vs Placebo - WMD = 0.60 (-0.55 , 1.75)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Brambilla et al.2007¹⁵⁶</p> <p>Eating disorder</p> <p>Olanzapine</p> <p>Location: Not reported</p> <p>Trial: Not reported</p> <p>Funding source: Hospital</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: 100% Female</p> <p>Race: Not reported</p> <p>Screened: 20 Eligible: 20 Entering: 20 Withdrawn: NR Lost to follow-up: NR Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Anorexia nervosa according to DSM-IV</p> <p>Exclusion criteria: General medical, neuroendocrine, metabolic, immunologic alterations other than these related to AN, axis I and II psychopathologies other than AN. Axis I and II psychopathologies other than AN</p> <p>Interventions: Placebo dosage not reported for 3 months vs Olanzapine 2.5-5 mg/days fixed titration schedule for 3 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 30, 61, 91 days</p>	<p>Results: Eating Disorder : Change in BMI at 4 weeks: Olanzapine vs Placebo - WMD = -0.20 (-1.44 , 1.04)</p> <p>Eating Disorder : Change in BMI at 12 weeks: Olanzapine vs Placebo - WMD = 0.20 (-1.05 , 1.45)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Brawman-Mintzer et al.2005⁷⁹</p> <p>Anxiety</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: 80-99% Female</p> <p>Race: Caucasian</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 40</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 31</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Age >=18, GAD, HAM-A >=18, CGI-S >=4, Covi > Raskin score despite adequate treatment >= 4 weeks</p> <p>Exclusion criteria: MDD 1 month prior, substance use disorder 6 month prior, bipolar or psychotic disorder</p> <p>Interventions: Placebo dosage not reported for 5 weeks vs Risperidone 0.5-1.5 mg/days flexible dose for 5 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35 days</p>	<p>Results: Anxiety : Change in HAM-A (Total Score) at 5 weeks: Risperidone vs Placebo - WMD = -3.60 (-6.88 , -0.32)</p> <p>Adverse Events: Placebo vs Risperidone Blurred Vision: 0.0%(0/20) vs 15.0%(3/20) Dizziness: 15.0%(3/20) vs 20.0%(4/20) Required Adjunctive Treatment With Anticholinergic Agents: 0.0%(0/20) vs 0.0%(0/20) Somnolence: 15.0%(3/20) vs 45.0%(9/20)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:20.0%(4/20) vs 25.0%(5/20) Withdrawals Due To Adverse Events:5.0%(1/20) vs 15.0%(3/20)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Donahue et al.2009⁷⁶</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 81 Eligible: 44 Entering: 24 Withdrawn: 3 Lost to follow-up: 1 Analyzed: NR</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Diagnosis of SAD and clinically significant public speaking</p> <p>Exclusion criteria: Current contraindications or a history of sensitivity to quetiapine, current regular use of benzodiazepine, tranquilizer or antipsychotic medications, active psychotic/manic/depressed episode, unstable diabetes mellitus, heart disease, neurologic disorder, liver disease</p> <p>Interventions: Placebo dosage not reported for 1 hours vs Quetiapine 25 mg/days fixed single dose for 1 hours</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 1, 2, 3, 4 minutes</p>	<p>Results: Anxiety: Cross over study</p> <p>Adverse Events: Excluded from analysis: Sample size by group not reported</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hirschfeld et al.2006⁷³</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 37</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 838</p> <p>Eligible: 542</p> <p>Entering: 542</p> <p>Withdrawn: 216</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 326</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Outpatients aged 18-65. bipolar I or II disorder, current episode depressed, with a duration between 4 weeks and 1 year, HAM-D score ≥ 2, young mania rating scale score ≤ 12.</p> <p>Exclusion criteria: Diagnosed Axis I disorder other than bipolar disorder within 6 months, history of nonresponse to adequate trial during current episode, substance abuse within 12 months.</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50-300 mg/days frequency not reported for 8 weeks vs Quetiapine 50-600 mg/days frequency not reported for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Anxiety: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Kampman et al.2007²²⁷</p> <p>Substance abuse</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Mean: 47</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 87 Eligible: 72 Entering: 61 Withdrawn: 5 Lost to follow-up: 6 Analyzed: 61</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Aged >= 18 years old, alcohol dependence, have a consecutive 30 days period drinking at least 48 standard drinks, >= 2 days of heavy drinking, >= 3 consecutive days of abstinence, Clinical Institutes Withdrawal Assessment for Alcohol score < 8.</p> <p>Exclusion criteria: Diagnosis of any psychoactive substance dependence other than alcohol or nicotine, current use of psychoactive drugs, taking psychotropic medications, current, severe psychiatric symptoms, severe medical illness, history of seizures or severe head trauma.</p> <p>Interventions: Placebo 50-400 mg/days fixed titration schedule for 12 weeks vs Quetiapine 50-400 mg/days fixed titration schedule for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, OCD, Personality Disorder, PTSD</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Substance Abuse : Change in Complete Abstinence (Alcohol) at 12 weeks: Quetiapine vs Placebo - RR = 4.97 (1.17 , 21.11)</p> <p>Adverse Events: Quetiapine vs Placebo Aches And Pains: 44.8%(13/29) vs 56.3%(18/32) Dry Mouth: 31.0%(9/29) vs 0.0%(0/32) Dysphoria: 31.0%(9/29) vs 21.9%(7/32) Gastrointestinal Complaints: 41.4%(12/29) vs 37.5%(12/32) Headache: 27.6%(8/29) vs 28.1%(9/32) Insomnia: 3.4%(1/29) vs 18.8%(6/32) Lightheaded: 17.2%(5/29) vs 12.5%(4/32) Sedation: 51.7%(15/29) vs 18.8%(6/32) Skin Rash: 10.3%(3/29) vs 3.1%(1/32) Upper Respiratory Tract Infection: 37.9%(11/29) vs 31.3%(10/32)</p> <p>Withdrawals: Quetiapine vs Placebo Withdrawals:20.7%(6/29) vs 25.0%(8/32) Withdrawals Due To Adverse Events:0.0%(0/29) vs 3.1%(1/32)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Nickel et al.2006¹⁹⁰</p> <p>Personality disorder</p> <p>Aripiprazole</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not funded</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 4</p> <p>Age: Mean: 22</p> <p>Sex: 80-99% Female</p> <p>Race: Not reported</p> <p>Screened: 57 Eligible: 52 Entering: 52 Withdrawn: 0 Lost to follow-up: 5 Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Met criteria for borderline personality disorder</p> <p>Exclusion criteria: Schizophrenia, current use of psychotropic medication or psychotherapy, pregnancy, suicidal ideation, current severe somatic illness</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Aripiprazole 15 mg/days fixed single dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, OCD</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Personality Disorder: Duplicate data</p> <p>Adverse Events: Aripiprazole vs Placebo Self-Injury: 7.7%(2/26) vs 26.9%(7/26) Serious AE: 0.0%(0/26) vs 0.0%(0/26) Suicidal Acts: 0.0%(0/26) vs 0.0%(0/26)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Padala et al.2006²⁰³</p> <p>PTSD</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: 100% Female</p> <p>Race: Caucasian, African Ancestry, Mixed</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 20</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 15</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: PTSD, female, 19-65</p> <p>Exclusion criteria: Schizophrenia, bipolar I, unstable illness, suicidality, prior treatment with risperidone, pregnant, nursing, substance abuse / dependency in prior 2 month</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Risperidone 1-6 mg/days flexible dose for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84, 91 days</p>	<p>Results: PTSD: Insufficient data to calculate an effect size</p> <p>Withdrawals: Placebo vs Risperidone Rash Leading To Withdrawal:0.0%(0/9) vs 9.1%(1/11) Withdrawals:33.3%(3/9) vs 18.2%(2/11) Withdrawals Due To Adverse Events:0.0%(0/9) vs 9.1%(1/11)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Pandina et al.2007⁸⁰</p> <p>Anxiety</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 5</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Hispanic, Other-NOS</p> <p>Screened: 453 Eligible: 417 Entering: 417 Withdrawn: 76 Lost to follow-up: 11 Analyzed: 303</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 15-65, GAD, CGI-S ≥ 4, antidepressant, benzodiazepine, buspirone or a combination of an antidepressants plus benzodiazepine or buspirone for at least 8 weeks prior and stable x 4 weeks</p> <p>Exclusion criteria: Pregnancy, suicide risk, serious illness, active substance abuse disorder, history of clozapine, other agents to manage anxiety, other axis I</p> <p>Interventions: Placebo 0.25-2 mg/days flexible dose for 4 weeks vs Risperidone 0.25-2 mg/days flexible dose for 4 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 6 weeks: Risperidone vs Placebo - RR = 0.99 (0.78 , 1.25)</p> <p>Withdrawals: Placebo augmentation vs Risperidone augmentation Withdrawals:21.1%(41/194) vs 23.5%(46/196) Withdrawals Due To Adverse Events:5.2%(10/194) vs 10.7%(21/196)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Pascual et al.2008¹⁹⁴</p> <p>Personality disorder</p> <p>Ziprasidone</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry, REM-TAP Network</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: 80-99% Female</p> <p>Race: Not reported</p> <p>Screened: 127 Eligible: 65 Entering: 60 Withdrawn: NR Lost to follow-up: NR Analyzed: 29</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Borderline personality disorder, 18-45, CGI-5 \geq 4, contraception in females</p> <p>Exclusion criteria: Comorbidity, schizophrenia, drug-induced psychosis, organic brain syndrome, alcohol or other substance dependence, bipolar, mental retardation, major depressive episode</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Ziprasidone 40-200 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 42, 56, 70, 84 days</p>	<p>Results: Personality Disorder : Change in SCL-90-R (GSI) at 14 weeks: Ziprasidone vs Placebo - WMD = 0.18 (-0.35 , 0.71)</p> <p>Adverse Events: Placebo vs Ziprasidone Dizziness: 0.0%(0/30) vs 13.3%(4/30) Gastrointestinal Symptoms: 6.7%(2/30) vs 0.0%(0/30) Headache: 3.3%(1/30) vs 0.0%(0/30) Hyperprolactinemia Not Clinically Relevant: 0.0%(0/30) vs 6.7%(2/30) Minor Sedation: 3.3%(1/30) vs 20.0%(6/30) Movement Disorders, Dystonia, Akathisia, Rigidity Or Hyperkinesia: 0.0%(0/30) vs 0.0%(0/30) Serious Adverse Events: 0.0%(0/30) vs 0.0%(0/30) Significant Changes In Weight Or Blood Pressure: 0.0%(0/30) vs 0.0%(0/30) Treatment-Emergent Adverse Events: 13.3%(4/30) vs 36.7%(11/30) Uneasy Feeling: 0.0%(0/30) vs 10.0%(3/30)</p> <p>Withdrawals: Placebo vs Ziprasidone Withdrawals:46.7%(14/30) vs 56.7%(17/30) Withdrawals Due To Adverse Events:0.0%(0/30) vs 30.0%(9/30) Withdrawals Due To Adverse Events Of Needed Psychiatric Hospitalization:10.0%(3/30) vs 13.3%(4/30) Withdrawals Due To Treatment-Emergent Adverse Events:0.0%(0/30) vs 13.3%(4/30)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Pollack et al.2006⁶⁵</p> <p>Anxiety</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 46 Eligible: 24 Entering: 24 Withdrawn: NR Lost to follow-up: NR Analyzed: 17</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-72 DSM-IV generalized anxiety disorder comorbid depression on dysthymia and other anxiety disorders except for PTSD and OCD if GAD was considered primary by the clinician and patient based on disorder severity and associated distress.</p> <p>Exclusion criteria: Bipolar or psychotic disorders, alcohol or substance abuse or dependence within the last 6 months or those receiving concurrent structured psychotherapies directed at the GAD.</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Olanzapine 2.5-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Fluoxetine for 6 week(s). Symptomatic patients were randomized.</p> <p>Comorbidities: Depression</p> <p>Timing of outcome assessment: 42, 84 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 6 weeks: Olanzapine vs Placebo - RR = 6.67 (0.93 , 47.59)</p> <p>Adverse Events: Olanzapine vs Placebo At Least One AE: 100.0%(12/12) vs 100.0%(12/12) Gained =7% Of Their Body Weight: 16.7%(2/12) vs 0.0%(0/12) Gastrointestinal Distress: 33.3%(4/12) vs 25.0%(3/12) Increased Appetite: 25.0%(3/12) vs 16.7%(2/12) Sedation: 91.7%(11/12) vs 41.7%(5/12) Sexual Dysfunction: 16.7%(2/12) vs 25.0%(3/12) Weight Gain: 58.3%(7/12) vs 16.7%(2/12)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:41.7%(5/12) vs 16.7%(2/12) Withdrawals Due To Adverse Events:33.3%(4/12) vs 8.3%(1/12) Withdrawals Due to Adverse Events: Sedation:33.3%(4/12) vs 8.3%(1/12)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Rothbaum et al.2008²⁰⁷</p> <p>PTSD</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: 80-99% Female</p> <p>Race: Caucasian, African Ancestry, Other-NOS</p> <p>Screened: 91 Eligible: 25 Entering: 25 Withdrawn: 5 Lost to follow-up: 0 Analyzed: 20</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, PTSD due to civilian trauma, CAPS >=50</p> <p>Exclusion criteria: Combat related events</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Risperidone 0.5-3 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: Sertraline for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: Anxiety, Depression</p> <p>Timing of outcome assessment: 56, 63, 70, 84, 98, 112 days</p>	<p>Results: PTSD : Change in CAPS at 8 weeks: Risperidone vs Placebo - WMD = 4.08 (-10.17 , 18.34)</p> <p>PTSD : Change in CAPS at 16 weeks: Risperidone vs Placebo - WMD = -2.35 (-18.69 , 13.99)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:0.0%(0/11) vs 35.7%(5/14) Withdrawals Due To Adverse Events:0.0%(0/11) vs 28.6%(4/14) Withdrawals Due To Adverse Events Of Elevated Liver Enzyme Levels:0.0%(0/11) vs 7.1%(1/14) Withdrawals Due To Adverse Events Of Probable Dystonic Reaction Before Given Drug:0.0%(0/11) vs 7.1%(1/14) Withdrawals Due To Adverse Events Of Tachycardia:0.0%(0/11) vs 7.1%(1/14) Withdrawals Due To Adverse Events Of Visiting ER Twice With Unremitting Chest Pain:0.0%(0/11) vs 7.1%(1/14)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Sheehan et al.2009⁷⁸</p> <p>Anxiety</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: NR Eligible: NR Entering: 111 Withdrawn: 33 Lost to follow-up: 15 Analyzed: 63</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, bipolar I, II or NOS and lifetime panic or GAD, CGI-BP<=4, CGI-S>=4</p> <p>Exclusion criteria: Acute serious or unstable medical illness, antimanic or mood stabilizing medication, substance dependence 6 month prior, psychotic, suicide risk</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Risperidone 0.5-4 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 8 weeks: Risperidone vs Placebo - RR = 0.71 (0.35 , 1.43)</p> <p>Adverse Events: Placebo vs Risperidone Diarrhea: 10.5%(6/57) vs 3.7%(2/54) Dizziness: 3.5%(2/57) vs 5.6%(3/54) Drowsiness: 8.8%(5/57) vs 18.5%(10/54) Dry Mouth: 10.5%(6/57) vs 9.3%(5/54) Fatigue: 3.5%(2/57) vs 3.7%(2/54) Headache: 33.3%(19/57) vs 29.6%(16/54) Insomnia: 5.3%(3/57) vs 3.7%(2/54) Muscle Stiffness, Tension, Aches: 8.8%(5/57) vs 7.4%(4/54) Nausea: 12.3%(7/57) vs 9.3%(5/54) Sedation: 5.3%(3/57) vs 5.6%(3/54)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:36.8%(21/57) vs 50.0%(27/54) Withdrawals Due To Adverse Events:1.8%(1/57) vs 3.7%(2/54) Withdrawals Due To Adverse Events Of Heightened Anxiety And Anger:0.0%(0/57) vs 1.9%(1/54) Withdrawals Due To Adverse Events Of Multiple Symptoms Including Word Slurring, Hair Loss And Fluid Retention:1.8%(1/57) vs 0.0%(0/54)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Simon et al.2008⁶⁶</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry</p> <p>Screened: 101 Eligible: 24 Entering: 22 Withdrawn: 6 Lost to follow-up: NR Analyzed: 16</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Did not receive remission of GAD in >=18</p> <p>Exclusion criteria: <= 7 HAM-A, pregnant / lactating, MD, dysthymia, panic, social phobia, bipolar, psychotic, PTSD, OCD, alcohol or substance abuse / dependence 6 month prior, unstable illness</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 25-400 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: SRI monotherapy for 10 week(s). Non-responders were randomized.</p> <p>Comorbidities: Anxiety, Depression</p> <p>Timing of outcome assessment: 56 days</p>	<p>Results: Anxiety : Change in HAM-A (Total Score) at 8 weeks: Quetiapine vs Placebo - WMD = -2.36 (-7.99 , 3.27)</p> <p>Adverse Events: Placebo+Paroxetine vs Placebo+Paroxetine vs Quetiapine+Paroxetine vs Quetiapine+Paroxetine Diarrhea: 0.0%(0/11) vs 18.2%(2/11) vs 27.3%(3/11) vs 0.0%(0/11) Placebo+Paroxetine vs Quetiapine+Paroxetine Constipation: 18.2%(2/11) vs 0.0%(0/11) Dry Mouth: 0.0%(0/11) vs 27.3%(3/11) Insomnia: 27.3%(3/11) vs 0.0%(0/11) Nausea: 0.0%(0/11) vs 18.2%(2/11) Sedation: 0.0%(0/11) vs 54.5%(6/11) Sexual Dysfunction: 18.2%(2/11) vs 18.2%(2/11) Vivid Dreams: 27.3%(3/11) vs 0.0%(0/11) Weight Gain: 18.2%(2/11) vs 0.0%(0/11)</p> <p>Withdrawals: Placebo+Paroxetine vs Quetiapine+Paroxetine Withdrawals:9.1%(1/11) vs 45.5%(5/11) Withdrawals Due To Adverse Events:9.1%(1/11) vs 36.4%(4/11)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Streim et al.2008⁸⁷ Dementia/Agitation Aripiprazole Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 3 Age: Mean: 59 Sex: Mixed Race: Caucasian, African Ancestry, Hispanic, Asian/Pacific Islander Screened: 330 Eligible: 256 Entering: 256 Withdrawn: 105 Lost to follow-up: 0 Analyzed: 151 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Age 55-95 with AD, had psychotic symptoms for greater than/equal to 1month, institutionalized for more than 4 weeks, have a MMSE score 6-22 and NPI-NH>=6</p> <p>Exclusion criteria: Delirium or schizophrenia, mood disorder, continuous symptoms of psychosis before dementia, psychotic symptoms better accounted for any drug, depression with symptoms of psychosis, non-AD-type dementia, seizure, unstable thyroid pathology, suicide intention, potential to subject to AE, had participated in clinical study</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Aripiprazole 0.7-15 mg/days flexible dose for 10 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 7 day(s).</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56, 70 days</p>	<p>Results: Dementia : Change in CMAI (Agitation) at 10 weeks: Placebo vs Aripiprazole flexible dose - SMD = 0.30 (0.05 , 0.55)</p> <p>Dementia : Change in NPI (Psychosis) at 10 weeks: Placebo vs Aripiprazole flexible dose - SMD = -0.02 (-0.27 , 0.23)</p> <p>Dementia : Change in NPI (Total) at 10 weeks: Placebo vs Aripiprazole flexible dose - SMD = 0.36 (0.11 , 0.61)</p> <p>Adverse Events: Aripiprazole vs Placebo Accidental Injury: 20.6%(27/131) vs 28.8%(36/125) Agitation: 7.6%(10/131) vs 12.0%(15/125) Asthenia: 12.2%(16/131) vs 6.4%(8/125) Cerebrovascular Accident: 0.0%(0/131) vs 0.8%(1/125) EPS-Related Adverse Events: 5.3%(7/131) vs 4.0%(5/125) Ecchymosis: 12.2%(16/131) vs 12.8%(16/125) Potentially Clinically Significant Increases In QTc Interval: 1.5%(2/131) vs 0.8%(1/125) Potentially Significant Low Hemoglobin Levels: 10.7%(14/131) vs 6.4%(8/125) Rash: 9.9%(13/131) vs 12.0%(15/125) Received Medications For Treatment Of Possible EPS: 0.0%(0/131) vs 1.6%(2/125) Serious Adverse Events Of Accidental Injury: 1.5%(2/131) vs 4.8%(6/125) Somnolence: 13.7%(18/131) vs 4.0%(5/125) Total Serious Adverse Events: 12.2%(16/131) vs 13.6%(17/125) Ulcer Skin: 9.2%(12/131) vs 12.0%(15/125) Urinary Tract Infection: 13.7%(18/131) vs 10.4%(13/125) Vomiting: 9.9%(13/131) vs 8.0%(10/125)</p> <p>Withdrawals: Aripiprazole vs Placebo Death During The Study Or Within 30 Days Of Withdrawal:2.3%(3/131) vs 2.4%(3/125) Withdrawals:33.6%(44/131) vs 48.8%(61/125) Withdrawals Due To Abnormal Lab Test Results:0.0%(0/131) vs 0.0%(0/125) Withdrawals Due To Adverse Events:13.0%(17/131) vs 8.0%(10/125) Withdrawals Due To ECG Abnormality Including Prolongation Of The QTc Interval:0.0%(0/131) vs 0.0%(0/125) Withdrawals Due To Weight Loss:0.0%(0/131) vs 0.0%(0/125)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Tramontina et al.2009⁶¹ ADHD Aripiprazole Location: Latin America Trial: Not reported Funding source: Government, Industry Design: RCT only Setting: Single setting Jadad: 5 Age: Mean: 12 Sex: Mixed Race: Caucasian, Other-NOS Screened: 710 Eligible: 43 Entering: 43 Withdrawn: 2 Lost to follow-up: 0 Analyzed: 41 Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Age 8-17, bipolar I or II disorder comorbid ADHD acutely manic or mixed state, clear reports of ADHD symptom onset preceding any mood symptomatology</p> <p>Exclusion criteria: Estimated IQ < 70, use of any medication 4 weeks prior to entering the study, pervasive developmental disorder, schizophrenia, substance abuse, suicide risk, previous use of aripiprazole, pregnancy, chronic diseases</p> <p>Interventions: Placebo 2-20 mg/days flexible dose for 6 weeks vs Aripiprazole 2-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: ADHD : Change in SNAP-IV (Total Score) at 6 weeks: Aripiprazole vs Placebo - WMD = 0.05 (-0.34 , 0.44)</p> <p>Adverse Events: Excluded from analysis: Reflexes Change: 5.6%(1/18) vs 0.0%(0/25) Rhinitis: 27.8%(5/18) vs 64.0%(16/25) Sialorrhea: 72.2%(13/18) vs 52.0%(13/25) Skin Rash: 0.0%(0/18) vs 4.0%(1/25) Slowness Of Thought: 5.6%(1/18) vs 12.0%(3/25) Somnolence: 94.4%(17/18) vs 76.0%(19/25) Suicidal Ideation: 27.8%(5/18) vs 20.0%(5/25) Sweating: 55.6%(10/18) vs 44.0%(11/25) Tiredness: 83.3%(15/18) vs 56.0%(14/25) Tremors: 44.4%(8/18) vs 32.0%(8/25) Vomiting: 27.8%(5/18) vs 20.0%(5/25)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:5.6%(1/18) vs 4.0%(1/25) Withdrawals Due To Adverse Events:5.6%(1/18) vs 0.0%(0/25)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Vaishnavi et al.2007⁷² Anxiety Quetiapine Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Not reported Jadad: 4 Age: Not reported Sex: Mixed Race: Caucasian, Other-NOS Screened: NR Eligible: NR Entering: 15 Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, outpatients, social anxiety disorder, CGI-S\geq4, -BSPS\geq20, negative pregnancy test</p> <p>Exclusion criteria: Bipolar, schizophrenia or other psychotic disorder, mental retardation, pervasive developmental disorder, cognitive disorder due to general medical condition, other anxiety disorder, MDD, history of substance dependence 6 month prior, suicide risk, medical illness, psychotropic medication and history of hypersensitivity to quetiapine</p> <p>Interventions: Placebo 50-400 mg/days flexible dose for 8 weeks vs Quetiapine 50-400 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 21, 35, 56 days</p>	<p>Results: Anxiety : Change in BSPPS at 8 weeks: Quetiapine vs Placebo - WMD = 30.50 (16.86 , 44.14)</p> <p>Adverse Events: Quetiapine vs Placebo Blurred Vision: 10.0%(1/10) vs 0.0%(0/5) Dizziness: 30.0%(3/10) vs 0.0%(0/5) Drowsiness: 50.0%(5/10) vs 0.0%(0/5) Headache: 10.0%(1/10) vs 0.0%(0/5) Nausea: 20.0%(2/10) vs 0.0%(0/5) Sweating: 10.0%(1/10) vs 0.0%(0/5) Swelling: 10.0%(1/10) vs 0.0%(0/5) Thirst: 10.0%(1/10) vs 0.0%(0/5) Tinnitus: 10.0%(1/10) vs 0.0%(0/5)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>McClure et al.2009¹⁹⁸</p> <p>Personality disorder</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 31</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 20</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: 18-60, schizotypal personality disorder</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Risperidone 0.25-2 mg/days fixed titration schedule for 10 weeks</p> <p>Run-in/wash-out period: Run-in: Placebo for 2 week(s). Symptomatically stable patients were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 42, 84 days</p>	<p>Results:</p> <p>Personality Disorder : Change in PANSS (negative) at 12 weeks: Risperidone vs Placebo - WMD = -1.00 (-6.50 , 4.50)</p> <p>Personality Disorder : Change in PANSS (postive) at 12 weeks: Risperidone vs Placebo - WMD = -1.70 (-5.80 , 2.40)</p> <p>Personality Disorder : Change in PANSS (general) at 12 weeks: Risperidone vs Placebo - WMD = -1.80 (-9.68 , 6.08)</p> <p>Withdrawals: Placebo vs Risperidone Galactorrhoea (Leading To Withdrawal):0.0%(0/12) vs 5.3%(1/19) Increase In Suicidal Ideation (Leading To Withdrawal):0.0%(0/12) vs 5.3%(1/19) Withdrawals:25.0%(3/12) vs 42.1%(8/19) Risperidone Withdrawals Due To Adverse Events:10.5%(2/19)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Rappaport et al.2009⁸⁸ Dementia/Agitation Aripiprazole Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center Jadad: 3 Age: Mean: 80 Sex: Mixed Race: Caucasian, African Ancestry, Hispanic, Other-NOS Screened: 150 Eligible: 129 Entering: 116 Withdrawn: 2 Lost to follow-up: 0 Analyzed: 115 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Diagnosed with AD, vascular, or mixed dementia, in healthcare facilities, moderate to severe acute exacerbation of agitated behaviors, able to comply with protocol</p> <p>Exclusion criteria: Other major psychiatric disorders, history of neuroleptic malignant syndrome, seizure, stroke, severe head trauma</p> <p>Interventions: Placebo dosage not reported for 24 hours vs Aripiprazole 5 mg/Not reported average final dose for 24 hours vs Aripiprazole 10 mg/Not reported average final dose for 24 hours</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 2, 4, 6, 12, 24 hours</p>	<p>Results: Dementia: Outcome of interested not reported.</p> <p>Adverse Events: Aripiprazole 10 mg vs Aripiprazole 15 mg vs Aripiprazole 5 mg vs Placebo Agitation: 1.3%(1/78) vs 0.0%(0/13) vs 0.0%(0/12) vs 7.7%(2/26) Any Adverse Event: 52.6%(41/78) vs 69.2%(9/13) vs 50.0%(6/12) vs 30.8%(8/26) Cerebrovascular AE (Acute Stroke) 16 Days After Treatment (Judged Unlikely To Be Treatment-Related): 1.3%(1/78) vs 0.0%(0/13) vs 0.0%(0/12) vs 0.0%(0/26) Clinically Significant Vital Signs Or Electrocardiograms: 0.0%(0/78) vs 0.0%(0/13) vs 0.0%(0/12) vs 0.0%(0/26) Death 24 Days After Treatment (Not Reasonably Linked To Study Medication): 1.3%(1/78) vs 0.0%(0/13) vs 0.0%(0/12) vs 0.0%(0/26) Dementia: 0.0%(0/78) vs 0.0%(0/13) vs 25.0%(3/12) vs 0.0%(0/26) EPS: 0.0%(0/78) vs 0.0%(0/13) vs 0.0%(0/12) vs 0.0%(0/26) Electrocardiogram Change: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Fall: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 3.8%(1/26) Femoral Neck Fracture: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Insomnia: 2.6%(2/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Irregular Heart Rate: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Lethargy: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Pyrexia: 0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Serious AE: 7.7%(6/78) vs 7.7%(1/13) vs 25.0%(3/12) vs 7.7%(2/26) Skin Laceration: 1.3%(1/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 7.7%(2/26) Somnolence: 38.5%(30/78) vs 38.5%(5/13) vs 16.7%(2/12) vs 7.7%(2/26) Vomiting: 3.8%(3/78) vs 0.0%(0/13) vs 8.3%(1/12) vs 0.0%(0/26)</p> <p>Withdrawals: Aripiprazole 10 mg vs Aripiprazole 15 mg vs Aripiprazole 5 mg vs Placebo Femoral Neck Fracture Resulting From A Fall On Wet Floor And Leading To Withdrawal:0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26) Withdrawals:0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 3.8%(1/26) Withdrawals Due To Adverse Events:0.0%(0/78) vs 7.7%(1/13) vs 0.0%(0/12) vs 0.0%(0/26)</p>

AE=Adverse Event, NR=Not Reported

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Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Schulz et al.2008¹⁹⁵</p> <p>Personality disorder</p> <p>Olanzapine</p> <p>Location: US, UK, Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 385 Eligible: 314 Entering: 314 Withdrawn: 119 Lost to follow-up: 17 Analyzed: 175</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, DSM-IV for personality disorder and DSM-IV for borderline personality disorder by DIPD-IV, ZAN-BPD = q at randomization</p> <p>Exclusion criteria: Schizophrenia, schizoaffective disorder, schizophreniform disorder, bipolar I, delusional disorder by DSM-IV Axis I, major depressive disorder, bipolar II, substance dependence within 3 month, actively suicidal PTSD, panic disorder, OCD BMI < 17, cluster A personality disorder.</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Olanzapine 2.5-20 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56, 70, 84 days</p>	<p>Results: Personality Disorder : Change in SCL-90-R (GSI) at 12 weeks: Olanzapine vs Placebo - WMD = -0.04 (-0.31 , 0.23)</p> <p>Adverse Events: Olanzapine vs Placebo Aggression: 0.6%(1/155) vs 1.3%(2/159) Agitation: 0.6%(1/155) vs 0.0%(0/159) Alcoholism: 0.6%(1/155) vs 0.0%(0/159) Anxiety: 4.5%(7/155) vs 5.0%(8/159) Appetite Increased: 17.4%(27/155) vs 7.5%(12/159) Deaths During Study: 0.0%(0/155) vs 0.0%(0/159) Depressed Mood: 0.0%(0/155) vs 0.6%(1/159) Drug Misuse: 0.6%(1/155) vs 0.0%(0/159) Dry Mouth: 7.1%(11/155) vs 3.8%(6/159) Exacerbation Of Borderline Personality Disorder Symptoms: 0.0%(0/155) vs 1.3%(2/159) Fatigue: 10.3%(16/155) vs 7.5%(12/159) Headache: 14.8%(23/155) vs 11.3%(18/159) Impulsive Behavior: 0.6%(1/155) vs 0.0%(0/159) Incidence Of Treatment-Emergent Abnormal High Levels Of Prolactin At Endpoint: 19.4%(30/155) vs 8.8%(14/159) Insomnia: 2.6%(4/155) vs 6.3%(10/159) Nausea: 4.5%(7/155) vs 7.5%(12/159) Participants With >=1 Treatment-Emergent Adverse Event: 65.8%(102/155) vs 56.6%(90/159) Sedation: 11.6%(18/155) vs 1.3%(2/159) Self-Injurious Ideation: 0.6%(1/155) vs 0.0%(0/159) Self-Mutilation: 0.6%(1/155) vs 0.0%(0/159) Serious AE: 3.9%(6/155) vs 5.7%(9/159) Somnolence: 12.9%(20/155) vs 4.4%(7/159) Suicidal Ideation: 5.8%(9/155) vs 2.5%(4/159) Treatment-Emergent Weight Gain =7% Of Baseline: 32.9%(51/155) vs 2.5%(4/159) Weight Decrease: 0.0%(0/155) vs 0.6%(1/159) Weight Increased: 17.4%(27/155) vs 2.5%(4/159)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:48.4%(75/155) vs 38.4%(61/159) Withdrawals Due To Adverse Events:11.0%(17/155) vs 11.3%(18/159)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Paleacu et al.2008⁹³ Dementia/Agitation Quetiapine Location: Israel Trial: Not reported Funding source: Industry Design: RCT only Setting: Not reported Jadad: 3 Age: Not reported Sex: Mixed Race: Not reported Screened: 44 Eligible: 40 Entering: 40 Withdrawn: 12 Lost to follow-up: 1 Analyzed: 27 Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: AD with BPSD, age > 50, MMSE < 24, NPI > 6 on any item</p> <p>Exclusion criteria: Other types of dementia, malignancy, heart disease, women of child-bearing potential, alcohol or drug abuse</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 50-300 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Dementia : Change in NPI (Agitation) at 6 weeks: Placebo vs Quetiapine - SMD = -0.48 (-1.11 , 0.15)</p> <p>Adverse Events: Quetiapine vs Placebo Akathisia: 0.0%(0/20) vs 5.0%(1/20) Confusion Urinary Tract Infection: 5.0%(1/20) vs 0.0%(0/20) Diarrhea: 0.0%(0/20) vs 5.0%(1/20) Dizziness: 0.0%(0/20) vs 5.0%(1/20) Dry Mouth: 5.0%(1/20) vs 0.0%(0/20) Edema: 0.0%(0/20) vs 5.0%(1/20) Elevated Systolic Bp (190/90): 5.0%(1/20) vs 0.0%(0/20) Falls: 0.0%(0/20) vs 10.0%(2/20) Headaches: 5.0%(1/20) vs 0.0%(0/20) Parkinsonism: 5.0%(1/20) vs 5.0%(1/20) Sedation: 5.0%(1/20) vs 0.0%(0/20) Tremor: 0.0%(0/20) vs 5.0%(1/20)</p> <p>Withdrawals: Quetiapine vs Placebo Withdrawals:40.0%(8/20) vs 25.0%(5/20) Withdrawals Due To Adverse Events:5.0%(1/20) vs 5.0%(1/20)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Linehan et al.2008¹⁹⁶</p> <p>Personality disorder</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: 100% Female</p> <p>Race: Caucasian, African Ancestry, Hispanic, Native American, Other-NOS</p> <p>Screened: 44 Eligible: 24 Entering: 24 Withdrawn: 8 Lost to follow-up: 0 Analyzed: 16</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Borderline, personality disorder according to personality disorder and conducted clinical interview for DSM-IV (SCID-II), borderline personality disorder for inappropriate anger on the SCID II, OAS-M irritability subscale ≥ 6.</p> <p>Exclusion criteria: Schizophrenia, bipolar I, schizoaffective disorder, major depressive disorder with psychotic features or other psychotic disorder, mental or seizure disorder, substance dependence in the past 6 month according to DSM-IV, self inflicted injury in the 8 weeks prior, pregnant, breast feeding or planning to be pregnant.</p> <p>Interventions: Placebo 2.5-15 mg/days flexible dose for duration not reported vs Olanzapine 2.5-15 mg/days flexible dose for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, Personality Disorder, Substance Abuse, Eating Disorder</p> <p>Timing of outcome assessment: 49, 98, 147 days</p>	<p>Results: Personality Disorder: Insufficient data to calculate an effect size</p> <p>Adverse Events: Olanzapine vs Placebo Dizziness: 133.3%(16/12) vs 66.7%(8/12) Muscle Stiffness: 166.7%(20/12) vs 83.3%(10/12) Severe Nervousness: 0.0%(0/12) vs 83.3%(10/12) Sexual Dysfunction: 66.7%(8/12) vs 0.0%(0/12) Significantly Distressing Or Incapacitating Sedation: 83.3%(10/12) vs 16.7%(2/12) Weight Gain: 183.3%(22/12) vs 116.7%(14/12)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:33.3%(4/12) vs 33.3%(4/12)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Loebl et al.2008²³⁶</p> <p>Substance abuse</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: 100% Male</p> <p>Race: Caucasian, African Ancestry</p> <p>Screened: 89 Eligible: 31 Entering: 31 Withdrawn: NR Lost to follow-up: NR Analyzed: 14</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Men, 18-60, cocaine dependence, using cocaine ≥ 1 every other week</p> <p>Exclusion criteria: Schizophrenia, bipolar disorder, MDD, HIV, head trauma with loss of consciousness, unstable medical condition</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Risperidone 1-2 mg pills daily fixed titration schedule and 25mg injection biweekly fixed dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression, Substance Abuse</p> <p>Timing of outcome assessment: 7, 14, 21, 35, 49, 63, 77 days</p>	<p>Results: Substance Abuse : Change in ASI (Drug Composite) at 12 weeks: Risperidone vs Placebo - WMD = -0.03 (-0.09 , 0.03)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:60.0%(9/15) vs 50.0%(8/16) Withdrawals Due To Adverse Events:0.0%(0/15) vs 12.5%(2/16)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Anton et al.2008²²⁰ Substance abuse Aripiprazole Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center Jadad: 3 Age: Mean: 47 Sex: Mixed Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS Screened: 691 Eligible: 295 Entering: 295 Withdrawn: 75 Lost to follow-up: 25 Analyzed: 195 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 21-65 years old, alcohol dependence, presents at 3 visits with negative breathalyzer results and abstain from alcohol before randomization score < 8 on Clinical Institute Withdrawal Assessment for Alcohol Revised</p> <p>Exclusion criteria: Substance abuse on drugs other than cocaine and opiates with exception of marijuana abuse within past year, pregnant, axis I or II disorder, high suicidal risk, allergy to aripiprazole taking an investigational agent within past month.</p> <p>Interventions: Placebo 27.4 mg/days average final dose for 12 weeks vs Aripiprazole 2-30 mg/days fixed titration schedule for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 28, 56, 84 days</p>	<p>Results: Substance Abuse : Change in Complete Abstinence (Alcohol) at 12 weeks: Aripiprazole vs Placebo - RR = 0.50 (0.29 , 0.88)</p> <p>Substance Abuse : Change in Abstinent Days (Alcohol) at 12 weeks: Aripiprazole vs Placebo - SMD = -0.13 (-0.36 , 0.10)</p> <p>Adverse Events: Aripiprazole vs Placebo Anxiety: 12.8%(19/149) vs 2.7%(4/146) Clinically Significant Alt Elevations (Alt [sgpt]=3x Upper Limit Of Normal): 3.4%(5/149) vs 0.0%(0/146) Clinically Significant Ast Elevations (Ast [sgot]=3x Upper Limit Of Normal): 2.7%(4/149) vs 1.4%(2/146) Death: 0.0%(0/149) vs 0.0%(0/146) Diarrhea: 6.7%(10/149) vs 5.5%(8/146) Disturbance In Attention: 9.4%(14/149) vs 2.1%(3/146) Dizziness: 7.4%(11/149) vs 7.5%(11/146) EPS-Related AE: Akathisia: 6.0%(9/149) vs 0.7%(1/146) EPS-Related AE: Dyskinesia: 1.3%(2/149) vs 0.0%(0/146) EPS-Related AE: Tremor: 3.4%(5/149) vs 2.7%(4/146) EPS-Related AEs: 9.4%(14/149) vs 3.4%(5/146) Fatigue: 24.2%(36/149) vs 6.8%(10/146) Headache: 20.1%(30/149) vs 24.0%(35/146) Increased Appetite: 5.4%(8/149) vs 2.7%(4/146) Insomnia: 21.5%(32/149) vs 11.0%(16/146) Nausea: 6.7%(10/149) vs 6.8%(10/146) Restlessness: 18.1%(27/149) vs 2.7%(4/146) Serious AE: 2.7%(4/149) vs 2.7%(4/146) Serious AE: Accidental Overdose: 0.0%(0/149) vs 0.7%(1/146) Serious AE: Atrial Fibrillation: 0.0%(0/149) vs 0.7%(1/146) Serious AE: Cellulitis: 0.7%(1/149) vs 0.0%(0/146) Serious AE: Chest Pain: 0.7%(1/149) vs 0.0%(0/146) Serious AE: Migraine: 0.7%(1/149) vs 0.0%(0/146) Serious AE: Overdose (Not Accidental): 0.0%(0/149) vs 0.7%(1/146) Serious AE: Thrombosis: 0.7%(1/149) vs 0.0%(0/146) Serious AE: Worsening Alcoholism: 0.0%(0/149) vs 0.7%(1/146) Somnolence: 16.8%(25/149) vs 5.5%(8/146) Treatment Related AE: 81.2%(121/149) vs 61.6%(90/146) Used Anticholinergic For Potential EPS: 2.7%(4/149) vs 0.0%(0/146)</p> <p>Withdrawals: Aripiprazole Anxiety Leading To Withdrawal:3.4%(5/149) Insomnia Leading To Withdrawal:6.7%(10/149) Restlessness Leading To Withdrawal:2.7%(4/149) Aripiprazole vs Placebo Withdrawals:40.9%(61/149) vs 26.7%(39/146)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Grabowski et al.2000²³³ Substance abuse Risperidone Location: US Trial: Not reported Funding source: Government Design: RCT only Setting: Not reported Jadad: 4 Age: Not reported Sex: Mixed Race: Caucasian, African Ancestry, Hispanic Screened: 193 Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Risperidone 2 mg/days fixed single dose for 12 weeks vs Risperidone 4 mg/days fixed single dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Guardia et al.2004²²⁴</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 5</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 60</p> <p>Entering: 60</p> <p>Withdrawn: 19</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 41</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: DSM-IV for alcohol dependence disorder age 18 - 60</p> <p>Exclusion criteria: Pregnancy, breast feeding, severe organic disorder, AST or ALT > 150 units /l, severe psychiatric disorders or psychotic disorders, bipolar I, severe major depressive disorder with suicidal risk, severe personality disorder, other current substance abuse or dependence disorder (except for nicotine) that was not in sustained remission, and less than 5 or more than 30 days since the last drink.</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Olanzapine 5-15 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56, 70, 84 days</p>	<p>Results: Substance Abuse : Change in Abstinent Days (Alcohol) at 12 weeks: Olanzapine vs Placebo - SMD = -0.35 (-0.86 , 0.16)</p> <p>Adverse Events: Olanzapine vs Placebo Amenorrhea: 3.4%(1/29) vs 3.2%(1/31) Anxiety: 3.4%(1/29) vs 12.9%(4/31) Appetite Increase: 24.1%(7/29) vs 9.7%(3/31) Constipation: 10.3%(3/29) vs 9.7%(3/31) Decreased Sexual Desire: 3.4%(1/29) vs 12.9%(4/31) Delayed Ejaculation: 3.4%(1/29) vs 6.5%(2/31) Depression: 6.9%(2/29) vs 9.7%(3/31) Dizziness: 0.0%(0/29) vs 9.7%(3/31) Drowsiness: 17.2%(5/29) vs 16.1%(5/31) Dry Mouth: 10.3%(3/29) vs 6.5%(2/31) Erection Difficulty: 3.4%(1/29) vs 6.5%(2/31) Hypokinesia: 3.4%(1/29) vs 3.2%(1/31) Itching: 3.4%(1/29) vs 0.0%(0/31) Loss Of Energy: 6.9%(2/29) vs 12.9%(4/31) Motor Tension: 0.0%(0/29) vs 9.7%(3/31) Muscle Stiffness: 3.4%(1/29) vs 0.0%(0/31) Orthostatic Hypotension: 3.4%(1/29) vs 12.9%(4/31) Photosensitivity: 6.9%(2/29) vs 3.2%(1/31) Tremor: 3.4%(1/29) vs 3.2%(1/31) Weight Gain: 31.0%(9/29) vs 12.9%(4/31)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:41.4%(12/29) vs 22.6%(7/31) Withdrawals Due To Adverse Events:0.0%(0/29) vs 3.2%(1/31)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hamilton et al.2009²³⁰ Substance abuse Olanzapine Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Single setting Jadad: 4 Age: Mean: 33 Sex: 100% Male Race: Caucasian, African Ancestry Screened: NR Eligible: 48 Entering: 52 Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Age >= 18, cocaine dependence according to DSM-V, active use of cocaine within 30 days by urine test or self report</p> <p>Exclusion criteria: Currently receiving antipsychotic medication, current DSM - IV diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder. current active psychotic symptoms, hallucinations, remarkably disorganized speech, history of bipolar disorder, major depressive disorder by hypersensitivity to olanzapine serious unstable medical illness.</p> <p>Interventions: Placebo 2.5-20 mg/days flexible dose for 16 weeks vs Olanzapine 2.5-20 mg/days flexible dose for 16 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Depression, OCD, PTSD</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56, 70, 84 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Adverse Events: Olanzapine vs Placebo Abdominal Pain: 13.0%(3/23) vs 20.0%(5/25) Akathisia: 39.1%(9/23) vs 28.0%(7/25) Amnesia: 21.7%(5/23) vs 4.0%(1/25) Any Side Effect: 100.0%(23/23) vs 96.0%(24/25) Articulation Impairment: 17.4%(4/23) vs 20.0%(5/25) Asthenia: 26.1%(6/23) vs 16.0%(4/25) Blepharitis: 8.7%(2/23) vs 4.0%(1/25) Chest Pain: 8.7%(2/23) vs 28.0%(7/25) Constipation: 26.1%(6/23) vs 40.0%(10/25) Dizziness: 21.7%(5/23) vs 16.0%(4/25) Dry Mouth: 69.6%(16/23) vs 44.0%(11/25) Euphoria: 13.0%(3/23) vs 12.0%(3/25) Increased Appetite: 87.0%(20/23) vs 60.0%(15/25) Muscle Twitching: 30.4%(7/23) vs 28.0%(7/25) Neck Rigidity: 26.1%(6/23) vs 28.0%(7/25) Non-Aggressive Behavior Changes: 26.1%(6/23) vs 28.0%(7/25) Peripheral Edema: 8.7%(2/23) vs 4.0%(1/25) Postural Hypotension: 52.2%(12/23) vs 28.0%(7/25) Rash: 8.7%(2/23) vs 4.0%(1/25) Somnolence: 73.9%(17/23) vs 56.0%(14/25) Stuttering: 17.4%(4/23) vs 20.0%(5/25) Tachycardia: 8.7%(2/23) vs 20.0%(5/25) Tremor: 17.4%(4/23) vs 20.0%(5/25) Weight Gain: 69.6%(16/23) vs 64.0%(16/25)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hutchison et al.2006²²⁵</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government, Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian</p> <p>Screened: 154 Eligible: 78 Entering: 64 Withdrawn: 13 Lost to follow-up: 0 Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Excellent health - DSM - IV for alcohol dependence</p> <p>Exclusion criteria: Psychiatric diagnosis (bipolar disorder, schizophrenia, bulimia, anorexia nervosa) psychological disorder, recurring pharmacotherapy, endorsed current use of illicit drugs other than marijuana, or tested positive for the use of illicit drugs</p> <p>Interventions: Placebo 2.5-5 mg/days fixed single dose for 12 weeks vs Olanzapine 2.5-5 mg/days fixed titration schedule for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 56, 84 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:18.2%(6/33) vs 22.6%(7/31)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Kampman et al.2003²³¹</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Native American</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 30</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 27</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: \$100 worth of cocaine use in prior month, age 18-60 cocaine dependency</p> <p>Exclusion criteria: Substance dependency besides nicotine and alcohol, severe alcohol dependence, psychosis, dementia, use of other psychotropic medications, unstable medical illness, history of hypersensitivity to olanzapine</p> <p>Interventions: Placebo 2.5-10 mg/days fixed titration schedule for 11 weeks vs Olanzapine 2.5-10 mg/days fixed titration schedule for 11 weeks</p> <p>Run-in/wash-out period: Run-in: Psychosocial treatment for 1 week(s). Eligible participants were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84 days</p>	<p>Results: Substance Abuse : Change in ASI (Drug Composite) at 12 weeks: Olanzapine vs Placebo - WMD = 0.03 (-0.03 , 0.09)</p> <p>Adverse Events: Olanzapine vs Placebo Medication Related Serious AE: 0.0%(0/15) vs 0.0%(0/15)</p> <p>Withdrawals: Olanzapine vs Placebo Withdrawals:13.3%(2/15) vs 6.7%(1/15)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Levin et al.1999²³⁵ Substance abuse Risperidone Location: US Trial: Not reported Funding source: Government Design: RCT only Setting: Not reported Jadad: 3 Age: Not reported Sex: Mixed Race: Caucasian, African Ancestry, Hispanic Screened: NR Eligible: 14 Entering: 14 Withdrawn: 4 Lost to follow-up: 0 Analyzed: 10 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Cocaine dependence</p> <p>Exclusion criteria: Alcohol, opiate or sedative dependence, MD on dysthymia, axis I disorder requiring treatment</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Risperidone 1-6 mg/days frequency not reported for 12 weeks</p> <p>Run-in/wash-out period: Run-in: Placebo for 2 week(s).</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63, 70, 77, 84, 3, 7 days</p>	<p>Results: Substance Abuse : Change in Reduction in Use (Urine) at 6 weeks: Risperidone vs Placebo - WMD = 0.10 (-0.22 , 0.42)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Lile et al.2008²²⁸ Substance abuse Aripiprazole Location: US Trial: Not reported Funding source: Government Design: CCT only Setting: Single setting Jadad: 1 Age: Not reported Sex: 80-99% Male Race: Caucasian, African Ancestry Screened: 12 Eligible: 12 Entering: 24 Withdrawn: 6 Lost to follow-up: 0 Analyzed: 12 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Cocaine dependence, no other psychiatric diagnosis</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 10 days vs Aripiprazole 15 mg/days fixed single dose for 10 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Adverse Events: Aripiprazole Extrapyramidal Symptoms During Maintenance: 8.3%(1/12)</p> <p>Withdrawals: Aripiprazole Withdrawals:50.0%(6/12) Withdrawals Due To Adverse Events:8.3%(1/12)</p>

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Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Newton et al.2008²³⁹</p> <p>Substance abuse</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 30</p> <p>Sex: 80-99% Male</p> <p>Race: Caucasian, African Ancestry, Hispanic</p> <p>Screened: NR Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: 16</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Methamphetamine dependant, not seeking treatment, aged 18-45, had normal physical examinations, EKG's and clinical lab assessments.</p> <p>Exclusion criteria: History of asthma, pregnancy, prior adverse reaction to methamphetamine or aripiprazole, history of seizure disorder, head trauma, dependent on other drugs (except nicotine), other axis I psychiatric disorder</p> <p>Interventions: Placebo dosage not reported for 14 days vs Aripiprazole 15 mg/days fixed single dose for 14 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14 days</p>	<p>Results: Substance Abuse : Change in BDI at 2 weeks: Aripiprazole vs Placebo - WMD = 3.62 (-4.29 , 11.53)</p> <p>Adverse Events: Aripiprazole vs Placebo At Least One AE: 87.5%(7/8) vs 75.0%(6/8) Restlessness: 37.5%(3/8) vs 0.0%(0/8) Severe AE: 25.0%(2/8) vs 12.5%(1/8) Tremor: 50.0%(4/8) vs 25.0%(2/8)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:0.0%(0/8) vs 0.0%(0/8)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Reid et al.2005²³²</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Multi-center, VA Healthcare System</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Hispanic, Other-NOS</p> <p>Screened: 135 Eligible: 68 Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Standardized MDD CREST study inclusion criteria</p> <p>Exclusion criteria: Clinically significant medical condition, standardized MDD CREST study exclusion criteria</p> <p>Interventions: Placebo 2 tablets/days fixed single dose for 8 weeks vs Olanzapine 5-10 mg/days fixed titration schedule for 8 weeks vs Valproate 800-1500 mg/days fixed titration schedule for 8 weeks vs Other, Carnitine + Carnitine + CoQ 10 200+500 mg/days fixed single dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Substance Abuse : Change in ASI (Drug Composite) at 8 weeks: Olanzapine vs Placebo - WMD = 0.02 (-0.23 , 0.27)</p> <p>Adverse Events: Carnitine+CoQ10 vs Olanzapine vs Placebo vs Valproate Abdominal Pain: 12.5%(2/16) vs 5.6%(1/18) vs 6.3%(1/16) vs 27.8%(5/18) Anxiety: 0.0%(0/16) vs 0.0%(0/18) vs 0.0%(0/16) vs 11.1%(2/18) Arthralgia: 6.3%(1/16) vs 5.6%(1/18) vs 6.3%(1/16) vs 11.1%(2/18) Asthenia: 12.5%(2/16) vs 5.6%(1/18) vs 12.5%(2/16) vs 11.1%(2/18) At Least One AE: 75.0%(12/16) vs 83.3%(15/18) vs 93.8%(15/16) vs 83.3%(15/18) Back Pain: 12.5%(2/16) vs 11.1%(2/18) vs 0.0%(0/16) vs 16.7%(3/18) Body Pain: 6.3%(1/16) vs 16.7%(3/18) vs 6.3%(1/16) vs 5.6%(1/18) Diarrhea: 6.3%(1/16) vs 5.6%(1/18) vs 25.0%(4/16) vs 33.3%(6/18) Dizziness: 6.3%(1/16) vs 16.7%(3/18) vs 31.3%(5/16) vs 5.6%(1/18) Dry Mouth: 18.8%(3/16) vs 0.0%(0/18) vs 0.0%(0/16) vs 11.1%(2/18) Dyspepsia: 0.0%(0/16) vs 5.6%(1/18) vs 18.8%(3/16) vs 11.1%(2/18) Ecchymosis: 12.5%(2/16) vs 0.0%(0/18) vs 12.5%(2/16) vs 0.0%(0/18) Fever: 0.0%(0/16) vs 0.0%(0/18) vs 12.5%(2/16) vs 11.1%(2/18) Flu Syndrome: 12.5%(2/16) vs 11.1%(2/18) vs 18.8%(3/16) vs 11.1%(2/18) Headache: 25.0%(4/16) vs 22.2%(4/18) vs 18.8%(3/16) vs 27.8%(5/18) Insomnia: 12.5%(2/16) vs 11.1%(2/18) vs 25.0%(4/16) vs 11.1%(2/18) Myalgia: 12.5%(2/16) vs 0.0%(0/18) vs 6.3%(1/16) vs 0.0%(0/18) Nausea: 12.5%(2/16) vs 0.0%(0/18) vs 31.3%(5/16) vs 5.6%(1/18) Somnolence: 18.8%(3/16) vs 44.4%(8/18) vs 25.0%(4/16) vs 38.9%(7/18) Thirst: 18.8%(3/16) vs 0.0%(0/18) vs 0.0%(0/16) vs 11.1%(2/18) Olanzapine vs Placebo vs Valproate Vomiting: 5.6%(1/18) vs 12.5%(2/16) vs 0.0%(0/18)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Smelson et al. 1997²³⁴ Substance abuse Risperidone Location: US Trial: Not reported Funding source: Not reported Design: CCT only Setting: Single setting Jadad: 0 Age: Not reported Sex: 100% Male Race: Not reported Screened: NR Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Recently cocaine-withdrawn patients, met DSM-IV criteria for cocaine dependence, admitted to a locked inpatient substance abuse treatment program</p> <p>Exclusion criteria: History of opiate, barbiturate, benzodiazepine, marijuana or alcohol dependence, met DSM-IV criteria for a concurrent Axis I disorder, currently taking medication that could effect the central nervous system, history of seizures, cognitive impairment, head trauma, Beck Depression Inventory>16</p> <p>Interventions: Control Group vs Risperidone 1-4 mg/days flexible dose for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7 days</p>	<p>Results: Substance Abuse : Change in Reduction in Use (Self Report) at 4 weeks: Risperidone vs Placebo - WMD = 4.40 (-2.68 , 11.48)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Smelson et al.2004²³⁷ Substance abuse Risperidone Location: US Trial: Funding source: Government, Industry Design: RCT only Setting: Single setting, VA Healthcare System Jadad: 3 Age: Mean: 41 Sex: Race: Not reported Screened: NR Eligible: NR Entering: 35 Withdrawn: 3 Lost to follow-up: 0 Analyzed: 32 Method of AE assessment: Reported spontaneously by patient</p>	<p>Inclusion criteria: Met DSM-IV criteria for cocaine dependence, reported using at least 6g of cocaine in the past month, responded to cue-exposure with increased craving</p> <p>Exclusion criteria: Met DSM-IV criteria for an additional Axis I disorder, history of alcohol, opiate, barbiturate, benzodiazapine or marijuana dependence, taking medication that could affect central nervous system, history of seizures</p> <p>Interventions: Placebo dosage not reported for 2 weeks vs Risperidone 1-2 mg/days flexible dose for 2 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:12.5%(2/16) vs 5.3%(1/19) Withdrawals Due To Adverse Events:0.0%(0/16) vs 5.3%(1/19)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Stoops et al.2007²²⁹</p> <p>Substance abuse</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: CCT only</p> <p>Setting: Single setting</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry</p> <p>Screened: NR</p> <p>Eligible: 8</p> <p>Entering: NR</p> <p>Withdrawn: 0</p> <p>Lost to follow-up: 0</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Current crack cocaine users</p> <p>Exclusion criteria: Not for any other current psychiatric diagnosis</p> <p>Interventions: Placebo dosage not reported for 7 days vs Aripiprazole 10 mg/days fixed single dose for 7 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Tiihonen et al.2007²³⁸</p> <p>Substance abuse</p> <p>Aripiprazole</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Hospital</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 1</p> <p>Age: Mean: 36</p> <p>Sex: Mixed</p> <p>Race: Caucasian</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 53</p> <p>Withdrawn: 2</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 17</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Aged 18 - 65, amphetamine/ methamphetamine dependence recent and accustomed intravenous amphetamine / methamphetamine use.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 20 weeks vs Aripiprazole 15 mg/days fixed single dose for 20 weeks vs Other, Methylphenidate 18-54 mg/days fixed titration schedule for 20 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 140 days</p>	<p>Results: Substance Abuse : Change in Proportion of amphetamine-positive urine screens at 20 weeks: Methylphenidate vs Placebo - RR = 2.25 (0.85 , 5.92)</p> <p>Substance Abuse : Change in Proportion of amphetamine-positive urine screens at 20 weeks: Aripiprazole vs Placebo - RR = 0.11 (0.01 , 1.92)</p> <p>Adverse Events: Placebo vs Aripiprazole vs Methylphenidate Transient Ischemic Attack (Attributed To Continued Amphetamine Use): 0.0%(0/17) vs 5.3%(1/19) vs 0.0%(0/17)</p> <p>Withdrawals: Aripiprazole Withdrawals:10.5%(2/19) Placebo vs Aripiprazole vs Methylphenidate Ransient Increase Of Liver Enzymes (Attributed To Recently Started HIV Medications) And Withdrawn:0.0%(0/17) vs 5.3%(1/19) vs 0.0%(0/17) Withdrawals Due To Adverse Events:0.0%(0/17) vs 10.5%(2/19) vs 0.0%(0/17)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Voronin et al.2008²²¹</p> <p>Substance abuse</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: University</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 4</p> <p>Age: Mean: 27</p> <p>Sex: 80-99% Male</p> <p>Race: Caucasian, African Ancestry, Native American</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 30</p> <p>Withdrawn: 0</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 30</p> <p>Method of AE assessment: Elicited by investigator</p>	<p>Inclusion criteria: Aged 21-65, alcohol dependence, non treatment seeking.</p> <p>Exclusion criteria: Current DSM-IV criteria for drug dependence except nicotine, other major DSM-IV Axis I disorders, psychoactive medication or substance abuse (except marijuana), past history of alcohol-related medical illness, liver enzymes \geq 2.5 times above normal, or significant health problems.</p> <p>Interventions: Placebo dosage not reported for 8 days vs Aripiprazole 5-15 mg/days fixed titration schedule for 8 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 6, 8 days</p>	<p>Results: Substance Abuse : Change in Complete Abstinence (Alcohol) at 1 weeks: Aripiprazole vs Placebo - RR = 1.67 (0.48 , 5.76)</p> <p>Adverse Events: Aripiprazole vs Placebo Constipation (Mild): 20.0%(3/15) vs 0.0%(0/15) Constipation (Moderate): 6.7%(1/15) vs 0.0%(0/15) Constipation (Severe): 0.0%(0/15) vs 0.0%(0/15) Day Time Sleepiness (Mild): 33.3%(5/15) vs 73.3%(11/15) Day Time Sleepiness (Moderate): 40.0%(6/15) vs 13.3%(2/15) Day Time Sleepiness (Severe): 26.7%(4/15) vs 0.0%(0/15) Feeling Depressed (Mild): 0.0%(0/15) vs 13.3%(2/15) Feeling Depressed (Moderate): 0.0%(0/15) vs 6.7%(1/15) Feeling Depressed (Severe): 0.0%(0/15) vs 0.0%(0/15) Nervousness (Mild): 40.0%(6/15) vs 0.0%(0/15) Nervousness (Moderate): 6.7%(1/15) vs 13.3%(2/15) Nervousness (Severe): 0.0%(0/15) vs 0.0%(0/15) Trouble Sleeping (Mild): 33.3%(5/15) vs 40.0%(6/15) Trouble Sleeping (Moderate): 46.7%(7/15) vs 0.0%(0/15) Trouble Sleeping (Severe): 6.7%(1/15) vs 6.7%(1/15)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:0.0%(0/15) vs 0.0%(0/15) Withdrawals Due To Adverse Events:0.0%(0/15) vs 0.0%(0/15)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Merideth et al.2008⁶⁸ Anxiety Quetiapine Location: Not reported Trial: D1448C00010 Funding source: Not reported Design: RCT only Setting: Multi-center Jadad: 2 Age: Not reported Sex: Race: Not reported Screened: NR Eligible: NR Entering: 854 Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: DSM-IV diagnosis of GAD, HAM-A total score ≥ 20 with item 1 and item 2 scores ≥ 2, CGI-S ≥ 4, MADRS ≤ 16</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Escitalopram 10 mg/days frequency not reported for 8 weeks vs Quetiapine 150 mg/days frequency not reported for 8 weeks vs Quetiapine 300 mg/days frequency not reported for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 4, 56 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 1.46 (1.21 , 1.76)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Bandelow et al.2007⁷⁰</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: Not reported</p> <p>Trial: D1448C00011</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 873</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50 mg/days frequency not reported for 8 weeks vs Quetiapine 150 mg/days frequency not reported for 8 weeks vs Paroxetine 20 mg/days frequency not reported for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 4, 56 days</p>	<p>Results: Anxiety: Duplicate data</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4469)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Katzman et al.2008⁷⁴</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: D1448C00012</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 433</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: HAM-A <= 12, MADRS <= 16, CGI-S <= 3 after 4-8 weeks open-label and 12-18 weeks stabilization of quetiapine XR treatment</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 52 weeks vs Quetiapine dosage not reported for 52 weeks</p> <p>Run-in/wash-out period: Run-in: Antipsychotics for 26 week(s). Patients who met the study criteria were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: Anxiety: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Joyce et al.2008⁷⁵ Anxiety Quetiapine Location: US Trial: D1448C00009 Funding source: Industry Design: RCT only Setting: Multi-center Jadad: 2 Age: Not reported Sex: Race: Not reported Screened: NR Eligible: NR Entering: 710 Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50 mg/days frequency not reported for 8 weeks vs Quetiapine 150 mg/days frequency not reported for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 56 days</p>	<p>Results: Anxiety : Change in HAM-A (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 1.02 (0.85 , 1.21)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Chouinard et al.2007⁷¹</p> <p>Anxiety</p> <p>Quetiapine</p> <p>Location: Not reported</p> <p>Trial: D1448C00011</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 873</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Paroxetine 20 mg/days frequency not reported for 8 weeks vs Quetiapine 50 mg/days frequency not reported for 8 weeks vs Quetiapine 150 mg/days frequency not reported for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 56 days</p>	<p>Results: Anxiety: Duplicate data</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>van den Broek et al.2008¹⁹³</p> <p>Personality disorder</p> <p>Quetiapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 24</p> <p>Withdrawn: 8</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 16</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: DSM-IV diagnosis of borderline personality disorder</p> <p>Exclusion criteria: Schizophrenia, current major depression, bipolar disorder, substance dependence</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 200-600 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56, 70 days</p>	<p>Results: Personality Disorder: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hamner et al.2000²⁰⁸</p> <p>PTSD</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 38</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: PTSD with psychotic features</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 5 weeks vs Risperidone 2.5 mg/days average final dose for 5 weeks</p> <p>Run-in/wash-out period: Run-in: Placebo for 1 week(s). Patients who met the study criteria were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: PTSD: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hutchison et al.2001²²⁶</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Mean: 23</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: 26</p> <p>Entering: 26</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Reported drinking >=2 times/week, >= 3 drinks / occasion (2 for women), age >= 21 years old</p> <p>Exclusion criteria: Reported ever having received treatment for alcohol problems, have history of cardiac illness, reported hearing loss, were taking medications contraindicated for concurrent use with olanzapine, breath alcohol level >0</p> <p>Interventions: Placebo dosage not reported for 2 days vs Olanzapine 5 mg/days fixed single dose for 2 days</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 1, 7 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Gaskill et al.2001¹⁵⁷</p> <p>Eating disorder</p> <p>Olanzapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: CCT only</p> <p>Setting: Single setting</p> <p>Jadad: 0</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 46</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Control Group vs Olanzapine 1.25-15 mg/days flexible dose for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: Eating Disorder: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Anton et al.2006²²² Substance abuse Aripiprazole Location: US Trial: Not reported Funding source: Not reported Design: RCT only Setting: Multi-center Jadad: 2 Age: Not reported Sex: Mixed Race: Not reported Screened: NR Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: NR Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Medically stable, alcohol dependant, outpatients</p> <p>Exclusion criteria: Other substance abuse</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Aripiprazole <=30 mg/days frequency not reported for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 84 days</p>	<p>Results: Substance Abuse: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Ballard et al.2008¹⁰⁴ Dementia/Agitation Risperidone Location: UK Trial: DART-AD Funding source: Private Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 5 Age: Mean: 67 Sex: Mixed Race: Not reported Screened: NR Eligible: NR Entering: 165 Withdrawn: 62 Lost to follow-up: 26 Analyzed: 77 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Living in a nursing or residential home, NINCDS/ADRDA probable or possible AD, MMSE score > 6 or severe battery impairment score > 30, taking >= 10mg chlorpromazine equivalents of a typical neuroleptic or >= 0.5mg daily of risperidone</p> <p>Exclusion criteria: Suffered from any physical condition that would increase suffering if participate, taking thioridazine and showing a prolonged QTc on electrocardiogram</p> <p>Interventions: Placebo dosage not reported for 12 months vs Olanzapine, Quetiapine, Respidone dosage not reported for 12 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 30, 91, 182, 365 days</p>	<p>Results: Dementia: Not a comparison of interest</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Zanarini et al.2007¹⁹²</p> <p>Personality disorder</p> <p>Olanzapine</p> <p>Location: Not reported</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 451</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: 18-65 years old, diagnosis of DSM-IV BPD</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Olanzapine 2.5 mg/days frequency not reported for 12 weeks vs Olanzapine 5-10 mg/days frequency not reported for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 84 days</p>	<p>Results: Personality Disorder : Change in Zanarini Rating Scale (Response Rate) at 12 weeks: Olanzapine 2.5mg/d vs Placebo - RR = 1.04 (0.86 , 1.26)</p> <p>Personality Disorder : Change in Zanarini Rating Scale (Response Rate) at 12 weeks: Olanzapine 5-10mg/d vs Placebo - RR = 1.28 (1.08 , 1.51)</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Mintzer et al.2006⁹⁵ Dementia/Agitation Risperidone Location: US Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 3 Age: Mean: 83 Sex: Mixed Race: Caucasian, African Ancestry, Hispanic, Asian/Pacific Islander, Other-NOS Screened: 560 Eligible: 473 Entering: 473 Withdrawn: 117 Lost to follow-up: 1 Analyzed: 354 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: >= 55 years old, residents of nursing homes or long-term care facilities, mobile, met the criteria for psychosis of AD, in need of treatment with an atypical antipsychotic, scored >=2 on any item of the BEHAVE-AD psychosis subscale, MMSE 5-23</p> <p>Exclusion criteria: Recently treated with neuroleptic injections, had other medical conditions that diminish cognition, had other psychiatric disorders that produce psychotic symptoms, patients with epilepsy, cancer, unstable medical conditions</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Risperidone 0.5-2.5 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: Placebo for 1-16 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56 days</p>	<p>Results: Dementia : Change in BEHAVE-AD (Agitation) at 8 weeks: Placebo vs Risperidone - SMD = 0.04 (-0.16 , 0.23) Dementia : Change in BEHAVE-AD (Psychosis) at 8 weeks: Placebo vs Risperidone - SMD = 0.17 (-0.02 , 0.36) Dementia : Change in BEHAVE-AD (Total) at 8 weeks: Placebo vs Risperidone - SMD = -0.01 (-0.21 , 0.18)</p> <p>Adverse Events: Placebo vs Risperidone Agitation: 6.7%(16/238) vs 8.1%(19/235) Any Adverse Event: 63.9%(152/238) vs 74.5%(175/235) Death: 0.0%(0/238) vs 0.9%(2/235) Edema-Related: 4.6%(11/238) vs 5.1%(12/235) Extrapyramidal Symptoms-Related: 3.4%(8/238) vs 8.5%(20/235) Fall: 12.6%(30/238) vs 11.1%(26/235) Glucose-Related: 2.1%(5/238) vs 1.7%(4/235) Hematoma: 5.0%(12/238) vs 3.4%(8/235) Injury: 10.5%(25/238) vs 9.4%(22/235) Insomnia: 5.9%(14/238) vs 5.5%(13/235) Potentially Prolactin-Related: 0.0%(0/238) vs 0.0%(0/235) Serious Adverse Event: 13.0%(31/238) vs 14.0%(33/235) Somnolence: 4.6%(11/238) vs 16.2%(38/235) Stroke: 0.4%(1/238) vs 0.4%(1/235) Tardive Dyskinesia: 0.0%(0/238) vs 0.0%(0/235) Transient Ischemic Attack: 0.0%(0/238) vs 1.3%(3/235) Urinary Tract Infection: 10.1%(24/238) vs 9.4%(22/235)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:24.8%(59/238) vs 25.1%(59/235) Withdrawals Due To Adverse Events:10.1%(24/238) vs 10.6%(25/235)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Lohoff et al.2010⁸¹</p> <p>Anxiety</p> <p>Ziprasidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: 73 Eligible: NR Entering: 62 Withdrawn: 12 Lost to follow-up: 3 Analyzed: 47</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: >18 years old, meet DSM-IV criteria for GAD, have treatment failure of ≥ 1 adequate trial of an SSRI, SNRI, BZ, or combination HAM-A total score ≥ 16, CGI-S score ≥ 4</p> <p>Exclusion criteria: Had a history of mania, bipolar disorder, schizophrenia, other psychotic disorders, had a history within 6 months of panic disorder, PTSD, major depression, OCD, social phobia, acute stress disorder, substance abuse, or other psychiatric diagnoses that may interfere with assessment, had clinical significant abnormalities, pregnant</p> <p>Interventions: Placebo 20-80 mg/days flexible dose for 8 weeks vs Ziprasidone 20-80 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Anxiety : Change in HAM-A (Total Score) at 8 weeks: Ziprasidone vs Placebo - WMD = -2.80 (-10.71 , 5.11)</p> <p>Anxiety : Change in HAM-A (Total Score) at 8 weeks: Ziprasidone vs Placebo - WMD = 2.83 (-2.26 , 7.92)</p> <p>Adverse Events: Placebo vs Ziprasidone Any Adverse Event: 85.7%(18/21) vs 87.8%(36/41) Blurred Vision: 0.0%(0/21) vs 4.9%(2/41) Constipation: 14.3%(3/21) vs 9.8%(4/41) Depression: 0.0%(0/21) vs 9.8%(4/41) Dermatitis: 9.5%(2/21) vs 0.0%(0/41) Diarrhea: 14.3%(3/21) vs 7.3%(3/41) Dizziness: 4.8%(1/21) vs 17.1%(7/41) Drowsiness: 28.6%(6/21) vs 51.2%(21/41) Dry Mouth: 9.5%(2/21) vs 31.7%(13/41) Excitement: 4.8%(1/21) vs 14.6%(6/41) Headaches: 28.6%(6/21) vs 19.5%(8/41) Insomnia: 9.5%(2/21) vs 29.3%(12/41) Nausea: 9.5%(2/21) vs 14.6%(6/41) Stimulation: 19.0%(4/21) vs 43.9%(18/41) Tachycardia: 0.0%(0/21) vs 2.4%(1/41) Vivid Dreams: 0.0%(0/21) vs 4.9%(2/41) Weight Gain: 9.5%(2/21) vs 7.3%(3/41) Weight Loss: 4.8%(1/21) vs 2.4%(1/41)</p> <p>Withdrawals: Placebo vs Ziprasidone Withdrawals:9.5%(2/21) vs 31.7%(13/41) Withdrawals Due To Adverse Events:0.0%(0/21) vs 12.2%(5/41)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Brodaty et al.2005⁹⁶ Dementia/Agitation Risperidone Location: Australia/New Zealand Trial: BEHAVE-AD Funding source: Industry Design: RCT only Setting: Multi-center, Long-term care facilities Jadad: 2 Age: Not reported Sex: 80-99% Female Race: Caucasian, Other-NOS Screened: NR Eligible: 93 Entering: 93 Withdrawn: NR Lost to follow-up: NR Analyzed: 72 Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Alzheimer disease, vascular dementia, age >=55, FAST>=4, MMSE<=23, CMAI >= 4 on at least 1 aggressive item, 3 on at least 2 aggressive item, 2 on at least 3 aggressive item, at least 2 items on BEHAVE-AD psychosis subscale.</p> <p>Exclusion criteria: Medical or neurological conditions other than dementia, psychiatric disorder, MD preceding 6 months, neuroleptic drugs.</p> <p>Interventions: Placebo dosage not reported for 12 weeks vs Risperidone 0.05-2 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Run-in: No drug for 1 week(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 28, 56, 84 days</p>	<p>Results: Dementia : Change in BEHAVE-AD (Psychosis) at 12 weeks: Placebo vs Risperidone - SMD = 0.36 (0.13 , 0.59)</p> <p>Dementia : Change in BEHAVE-AD (Total) at 12 weeks: Placebo vs Risperidone - SMD = 0.46 (0.23 , 0.69)</p> <p>Dementia : Change in CMAI (Agitation) at 12 weeks: Placebo vs Risperidone - SMD = 0.37 (0.14 , 0.59)</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Bissada et al.2008 ¹⁵³ Eating disorder Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Mintzer et al.2007 ⁸⁶ Dementia/Agitation Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Nickel et al.2007 ¹⁹¹ Personality disorder Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Zhong et al.2007 ⁹² Dementia/Agitation Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Armenteros et al.2007 ⁵⁹ ADHD Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Bandelow et al.2009 ⁶⁹ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Barnett et al.2002 ⁶⁴ Anxiety Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Brambilla et al.2007 ¹⁵⁵ Eating disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Brambilla et al.2007 ¹⁵⁶ Eating disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Brawman-Mintzer et al.2005 ⁷⁹ Anxiety Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Donahue et al.2009 ⁷⁶ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Hirschfeld et al.2006 ⁷³ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Kampman et al.2007 ²²⁷ Substance abuse Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Nickel et al.2006 ¹⁹⁰ Personality disorder Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Padala et al.2006 ²⁰³ PTSD Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Pandina et al.2007 ⁸⁰ Anxiety Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Pascual et al.2008 ¹⁹⁴ Personality disorder Ziprasidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Pollack et al.2006 ⁶⁵ Anxiety Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Rothbaum et al.2008 ²⁰⁷ PTSD Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Sheehan et al.2009 ⁷⁸ Anxiety Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Simon et al.2008 ⁶⁶ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Streim et al.2008 ⁸⁷ Dementia/Agitation Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Tramontina et al.2009 ⁶¹ ADHD Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Vaishnavi et al.2007 ⁷² Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
<p>McClure et al.2009¹⁹⁸</p> <p>Personality disorder</p> <p>Risperidone</p>	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
<p>Rappaport et al.2009⁸⁸</p> <p>Dementia/Agitation</p> <p>Aripiprazole</p>	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Schulz et al.2008 ¹⁹⁵ Personality disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Paleacu et al.2008 ⁹³ Dementia/Agitation Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Linehan et al.2008 ¹⁹⁶ Personality disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Loebl et al.2008 ²³⁶ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Anton et al.2008 ²²⁰ Substance abuse Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Grabowski et al.2000 ²³³ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Guardia et al.2004 ²²⁴ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? No</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Hamilton et al.2009 ²³⁰ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Hutchison et al.2006 ²²⁵ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, patient</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Kampman et al.2003 ²³¹ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Levin et al.1999 ²³⁵ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Lile et al.2008 ²²⁸ Substance abuse Aripiprazole	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Newton et al.2008 ²³⁹ Substance abuse Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Reid et al.2005 ²³² Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Smelson et al.1997 ²³⁴ Substance abuse Risperidone	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Single blind, outcome assessment</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Smelson et al.2004 ²³⁷ Substance abuse Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Stoops et al.2007 ²²⁹ Substance abuse Aripiprazole	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Tiihonen et al.2007 ²³⁸ Substance abuse Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Voronin et al.2008 ²²¹ Substance abuse Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Merideth et al.2008 ⁶⁸ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Bandelow et al.2007 ⁷⁰ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Katzman et al.2008 ⁷⁴ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Don't know</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Joyce et al.2008 ⁷⁵ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Chouinard et al.2007 ⁷¹ Anxiety Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
van den Broek et al.2008 ¹⁹³ Personality disorder Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Hamner et al.2000 ²⁰⁸ PTSD Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Hutchison et al.2001 ²²⁶ Substance abuse Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Gaskill et al.2001 ¹⁵⁷ Eating disorder Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Don't know</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Anton et al.2006 ²²² Substance abuse Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Ballard et al.2008 ¹⁰⁴ Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Zanarini et al.2007 ¹⁹² Personality disorder Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Mintzer et al.2006 ⁹⁵ Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Placebo-controlled trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Lohoff et al.2010 ⁸¹ Anxiety Ziprasidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Brody et al.2005 ⁹⁶ Dementia/Agitation Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Keitner et al.2009¹⁴⁵</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Mean: 20</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 246</p> <p>Eligible: 97</p> <p>Entering: 97</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 94</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Depressed, failed current antidepressant trial. MADRS \geq15, 18-65</p> <p>Exclusion criteria: Bipolar I or II, psychotic features, suicide risk, substance abuse / dependence, mod illness or seizures, ECT, pregnant or breast feeding, taking herbal meds</p> <p>Interventions: Placebo dosage not reported for 4 weeks vs Risperidone 0.5-3 mg/days flexible dose for 4 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants for 5 week(s). Non-responder or partial responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28 days</p>	<p>Results:</p> <p>Depression : Change in HAM-D (% Remitted) at 4 weeks: Risperidone vs Placebo - RR = 1.95 (0.88 , 4.33)</p> <p>Depression : Change in HAM-D (% Responder) at 4 weeks: Risperidone vs Placebo - RR = 1.49 (0.83 , 2.68)</p> <p>Depression : Change in MADRS (% Remitted) at 4 weeks: Risperidone vs Placebo - RR = 2.13 (1.11 , 4.08)</p> <p>Depression : Change in MADRS (% Responder) at 4 weeks: Risperidone vs Placebo - RR = 1.65 (0.97 , 2.80)</p> <p>Adverse Events: Placebo vs Risperidone \geq7% Increase From Baseline Weight: 0.0%(0/33) vs 3.1%(2/64) Abdominal Gas: 6.1%(2/33) vs 0.0%(0/64) Any Adverse Events: 81.8%(27/33) vs 84.4%(54/64) Constipation: 9.1%(3/33) vs 12.5%(8/64) Dry Mouth: 3.0%(1/33) vs 14.1%(9/64) Fatigue: 6.1%(2/33) vs 0.0%(0/64) Headache: 15.2%(5/33) vs 9.4%(6/64) Increased Appetite: 0.0%(0/33) vs 15.6%(10/64) Insomnia: 9.1%(3/33) vs 3.1%(2/64) Tired: 6.1%(2/33) vs 0.0%(0/64) Weight Gain: 3.0%(1/33) vs 3.1%(2/64)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:21.2%(7/33) vs 15.6%(10/64)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Mahmoud et al.2007¹⁴⁶</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 5</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Hispanic, Other-NOS</p> <p>Screened: 463 Eligible: 274 Entering: 274 Withdrawn: 33 Lost to follow-up: 9 Analyzed: 232</p> <p>Method of AE assessment: Elicited by investigator, reported spontaneously by patient</p>	<p>Inclusion criteria: 18-65, antidepressant monotherapy \geq 4 weeks, MDD, CGI-S \geq4</p> <p>Exclusion criteria: Pregnancy, suicide risk, serious illness, active substance or alcohol use disorders, current TCA (tricyclic antidepressant), MAO-I (monoamine oxidase inhibitor), mood stabilizer, antiepileptic, ADHD or narcolepsy medications</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Risperidone 0.25-2 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants for 4 week(s).</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42 days</p>	<p>Results: Depression : Change in HAM-D (% Remitted) at 6 weeks: Risperidone vs Placebo - RR = 2.29 (1.22 , 4.30)</p> <p>Depression : Change in HAM-D (% Responder) at 6 weeks: Risperidone vs Placebo - RR = 1.57 (1.10 , 2.23)</p> <p>Adverse Events: Placebo vs Risperidone Any Treatment-Emergent Adverse Event: 54.1%(72/133) vs 44.7%(63/141) Arthralgia: 2.3%(3/133) vs 1.4%(2/141) Back Pain: 2.3%(3/133) vs 0.0%(0/141) Constipation: 2.3%(3/133) vs 3.5%(5/141) Death During The Study: 0.0%(0/133) vs 0.0%(0/141) Diarrhea: 3.8%(5/133) vs 2.1%(3/141) Disturbance In Attention: 0.0%(0/133) vs 2.1%(3/141) Dizziness: 2.3%(3/133) vs 3.5%(5/141) Dry Mouth: 0.8%(1/133) vs 5.0%(7/141) Dyspepsia: 3.0%(4/133) vs 2.1%(3/141) Fatigue: 0.0%(0/133) vs 3.5%(5/141) Headache: 14.3%(19/133) vs 8.5%(12/141) Hypertension: 2.3%(3/133) vs 0.0%(0/141) Insomnia: 1.5%(2/133) vs 4.3%(6/141) Lethargy: 2.3%(3/133) vs 0.7%(1/141) Nasopharyngitis: 3.0%(4/133) vs 2.1%(3/141) Nausea: 4.5%(6/133) vs 1.4%(2/141) Peripheral Edema: 0.8%(1/133) vs 2.8%(4/141) Sinusitis: 3.0%(4/133) vs 1.4%(2/141) Somnolence: 1.5%(2/133) vs 5.0%(7/141) Upper Respiratory Tract Infection: 2.3%(3/133) vs 0.0%(0/141) Weight Gain: 1.5%(2/133) vs 4.3%(6/141)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:12.0%(16/133) vs 18.4%(26/141) Withdrawals Due To Adverse Events:2.3%(3/133) vs 5.7%(8/141)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Maina et al.2008¹⁶⁷</p> <p>OCD</p> <p>Olanzapine, Risperidone</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not funded</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Mean: 35</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 110 Eligible: 50 Entering: 50 Withdrawn: 7 Lost to follow-up: 0 Analyzed: 43</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Age >=18, primary diagnosis of OCD, OCD present for at least 1 year prior to study entry. YBOCS total score >=16, non-responders to SRIs</p> <p>Exclusion criteria: A current diagnosis of MDD and/or HAM-D score >=15, schizophrenia or organic brain syndrome or medical illness contra-indicate use of SRI and/or risperidone or olanzapine, pregnant or nursing women</p> <p>Interventions: Risperidone 1-3 mg/days fixed titration schedule for 8 weeks vs Olanzapine 2.5-10 mg/days fixed titration schedule for 8 weeks</p> <p>Run-in/wash-out period: Run-in: SRI monotherapy for 16 week(s). Patients resistant to SRI were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 28, 42, 56 days</p>	<p>Results: OCD : Change in YBOCS (Total Score) at 8 weeks: Olanzapine vs Risperidone - WMD = -0.50 (-3.81 , 2.81)</p> <p>Adverse Events: Risperidone vs Olanzapine Amenorrhoea: 24.0%(6/25) vs 4.0%(1/25) Any Adverse Events: 52.0%(13/25) vs 64.0%(16/25) Diminished Sexual Desire: 0.0%(0/25) vs 4.0%(1/25) Micturition Disturbances: 4.0%(1/25) vs 0.0%(0/25) Nausea/Vomiting: 8.0%(2/25) vs 0.0%(0/25) Orthostatic Dizziness: 12.0%(3/25) vs 8.0%(2/25) Rash: 4.0%(1/25) vs 0.0%(0/25) Rigidity: 8.0%(2/25) vs 0.0%(0/25) Tension/Inner Unrest: 24.0%(6/25) vs 0.0%(0/25) Weight Gain: 16.0%(4/25) vs 52.0%(13/25)</p> <p>Withdrawals: Olanzapine Diminished Sex Desire; Weight Gain Leading To Withdrawal:8.0%(2/25) Risperidone Tension/Inner Unrest; Nausea/Vomiting Leading To Withdrawal:8.0%(2/25) Risperidone vs Olanzapine Withdrawals:12.0%(3/25) vs 16.0%(4/25) Withdrawals Due To Adverse Events:8.0%(2/25) vs 8.0%(2/25)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Savas et al.2008¹⁶⁸ OCD Quetiapine, Ziprasidone Location: Middle East Trial: Not reported Funding source: None Design: CCT only Setting: Single setting Jadad: 0 Age: Mean: 19 Sex: Mixed Race: Not reported Screened: NR Eligible: NR Entering: 24 Withdrawn: 0 Lost to follow-up: 0 Analyzed: 24 Method of AE assessment: Not reported</p>	<p>Inclusion criteria: OCD without psychotic features, taking study medication and SRIs >= 6 month</p> <p>Exclusion criteria: < 6 month treatment, illness, alcohol or substance abuse dependence, co-morbid psychiatric conditions</p> <p>Interventions: Quetiapine 100-1200 mg/days frequency not reported for 6 months vs Ziprasidone 80-160 mg/days frequency not reported for 6 months</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 30, 61, 91, 182 days</p>	<p>Results: OCD: Insufficient data to calculate an effect size</p> <p>Adverse Events: Quetiapine vs Ziprasidone Weight Gain: 20.0%(3/15) vs 0.0%(0/9)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Bauer et al.2009¹³⁶</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada, Western Europe, Eastern Europe, Australia/New Zealand, South Africa</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: 572 Eligible: NR Entering: 493 Withdrawn: 66 Lost to follow-up: 3 Analyzed: 424</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65 yrs old, diagnosed MDD, outpatients, HAM-D total score \geq 20. HAM-D item I score \geq 2, inadequate response during current episode to antidepressants.</p> <p>Exclusion criteria: Any DSM-IV Axis disorder other than MDD. DSM-IV Axis II disorder, duration of current MDD episode > 12 month or < 4 weeks from enrollment, substance abuse, clinically significant medical illness, HAM-D item 3 score \geq 3, require psychotherapy, received quetiapine > 25mg/day for insomnia within 7 days before randomization, lack of quetiapine response.</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 50-150 mg/days fixed titration schedule for 6 weeks vs Quetiapine 50-300 mg/days fixed titration schedule for 6 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 14 day(s). Eligible patents were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Quetiapine vs Placebo - RR = 1.42 (1.03 , 1.94)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Quetiapine vs Placebo - RR = 1.22 (1.01 , 1.48)</p> <p>Adverse Events: Placebo vs Quetiapine 150 mg/d vs Quetiapine 300 mg/d \geq7% Increase In Body Weight At End of Treatment: 1.2%(2/163) vs 4.2%(7/167) vs 4.3%(7/163) Clinically Relevant HDL Shifts To Elevated Values (\leq40): 4.3%(7/163) vs 1.8%(3/167) vs 6.1%(10/163) Clinically Relevant LDL Shifts To Elevated Values (\geq160): 11.0%(18/163) vs 16.2%(27/167) vs 12.3%(20/163) Clinically Relevant Prolactin Shifts To Elevated Values (Males \geq20, Females >30): 1.8%(3/163) vs 1.2%(2/167) vs 2.5%(4/163) Clinically Relevant Shifts Glucose To Elevated Values (\geq126): 2.5%(4/163) vs 2.4%(4/167) vs 6.7%(11/163) Clinically Relevant Shifts Tot Cholesterol To Elevated Values (\geq240): 8.6%(14/163) vs 21.0%(35/167) vs 15.3%(25/163) Clinically Relevant Triglycerides Shifts To Elevated Values (\geq200): 3.1%(5/163) vs 11.4%(19/167) vs 12.9%(21/163) Constipation: 3.7%(6/163) vs 4.2%(7/167) vs 10.4%(17/163) Dizziness: 7.4%(12/163) vs 11.4%(19/167) vs 9.2%(15/163) Dry Mouth: 6.7%(11/163) vs 20.4%(34/167) vs 35.6%(58/163) Fatigue: 3.1%(5/163) vs 13.2%(22/167) vs 14.7%(24/163) Headache: 9.8%(16/163) vs 9.0%(15/167) vs 8.0%(13/163) Nasopharyngitis: 6.1%(10/163) vs 3.0%(5/167) vs 3.1%(5/163) Nausea: 6.1%(10/163) vs 5.4%(9/167) vs 5.5%(9/163) Sedation: 4.3%(7/163) vs 9.6%(16/167) vs 12.9%(21/163) Somnolence: 3.1%(5/163) vs 16.8%(28/167) vs 23.3%(38/163)</p> <p>Withdrawals: Placebo vs Quetiapine 150 mg/d vs Quetiapine 300 mg/d Withdrawals:11.0%(18/163) vs 12.6%(21/167) vs 18.4%(30/163) Withdrawals Due To Adverse Events:3.1%(5/163) vs 6.6%(11/167) vs 11.7%(19/163)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Cutler et al.2009¹³⁴</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 5</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: 912</p> <p>Eligible: NR</p> <p>Entering: 612</p> <p>Withdrawn: 138</p> <p>Lost to follow-up: 32</p> <p>Analyzed: 370</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: 18-65 years old, diagnosed MDD, HAM-D total score ≥ 22, HAM-D item 1 score ≥ 3 at enrollment and randomization</p> <p>Exclusion criteria: DSM-IV AXIS I/II disorders duration of current MDD ≥ 12 months or ≤ 4 weeks, inadequate response to at least 6 weeks of treatment with 2 or more classes of antidepressants during current episode, clinically significant medical illness, psychotic feature</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 50-150 mg/days fixed titration schedule for 6 weeks vs Quetiapine 50-300 mg/days fixed titration schedule for 6 weeks vs Haldol 60 mg/days fixed single dose for 6 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 7-28 day(s). Eligible patients were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Quetiapine vs Placebo - RR = 1.43 (1.03 , 2.06)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Quetiapine vs Placebo - RR = 1.51 (1.20 , 1.91)</p> <p>Adverse Events: Duloxetine 60 mg/d vs Placebo vs Quetiapine 150 mg/d vs Quetiapine 300 mg/d $\geq 7\%$ Increase In Body Weight: 0.7%(1/151) vs 0.0%(0/157) vs 2.0%(3/152) vs 3.3%(5/152) Abnormal Dreams: 2.6%(4/151) vs 0.6%(1/157) vs 6.6%(10/152) vs 2.0%(3/152) Clinically Important Elevated Glucose (≥ 126 mg/dL) at endpoint: 0.7%(1/151) vs 0.6%(1/157) vs 2.0%(3/152) vs 3.9%(6/152) Constipation: 11.3%(17/151) vs 6.4%(10/157) vs 5.9%(9/152) vs 8.6%(13/152) Decreased Appetite: 5.3%(8/151) vs 0.6%(1/157) vs 3.3%(5/152) vs 0.0%(0/152) Diarrhea: 10.6%(16/151) vs 6.4%(10/157) vs 4.6%(7/152) vs 2.6%(4/152) Dizziness: 16.6%(25/151) vs 10.8%(17/157) vs 14.5%(22/152) vs 19.1%(29/152) Dry Mouth: 18.5%(28/151) vs 8.9%(14/157) vs 33.6%(51/152) vs 38.2%(58/152) Dyspepsia: 5.3%(8/151) vs 3.2%(5/157) vs 3.9%(6/152) vs 5.3%(8/152) Fatigue: 6.6%(10/151) vs 0.0%(0/157) vs 2.6%(4/152) vs 5.3%(8/152) Headache: 17.9%(27/151) vs 10.2%(16/157) vs 10.5%(16/152) vs 9.2%(14/152) Hyperhidrosis: 7.3%(11/151) vs 0.6%(1/157) vs 0.0%(0/152) vs 0.0%(0/152) Increased Appetite: 2.0%(3/151) vs 1.9%(3/157) vs 5.9%(9/152) vs 3.9%(6/152) Insomnia: 14.6%(22/151) vs 7.0%(11/157) vs 1.3%(2/152) vs 1.3%(2/152) Irritability: 0.0%(0/151) vs 4.5%(7/157) vs 1.3%(2/152) vs 5.9%(9/152) Nausea: 35.8%(54/151) vs 9.6%(15/157) vs 10.5%(16/152) vs 5.3%(8/152) Pollakiuria: 5.3%(8/151) vs 1.3%(2/157) vs 3.3%(5/152) vs 2.0%(3/152) Sedation: 15.9%(24/151) vs 5.1%(8/157) vs 38.8%(59/152) vs 36.8%(56/152) Somnolence: 12.6%(19/151) vs 7.0%(11/157) vs 24.3%(37/152) vs 27.0%(41/152) Upper Respiratory Tract Infection: 4.0%(6/151) vs 7.0%(11/157) vs 2.0%(3/152) vs 2.6%(4/152) Vision Blurred: 2.6%(4/151) vs 1.9%(3/157) vs 5.3%(8/152) vs 5.3%(8/152)</p> <p>Withdrawals: Duloxetine 60 mg/d vs Placebo vs Quetiapine 150 mg/d vs Quetiapine 300 mg/d Withdrawals:30.5%(46/151) vs 21.0%(33/157) vs 34.2%(52/152) vs 25.7%(39/152) Withdrawals Due To Adverse Events:13.2%(20/151) vs 4.5%(7/157) vs 19.7%(30/152) vs 15.1%(23/152) Withdrawals Due To Of Death:0.0%(0/151) vs 0.0%(0/157) vs 0.7%(1/152) vs 0.0%(0/152)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>de Geus et al.2007¹⁶⁹</p> <p>OCD</p> <p>Quetiapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 2</p> <p>Age: Mean: 36</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 39</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 36</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: 18-65 years old, primary OCD. Y-BOCS total score ≥ 18 or 12 if only obsessions or compulsions present, failure to respond to previous or current treatment ($\leq 35\%$ improvement)</p> <p>Exclusion criteria: Significant depressive symptoms (HAM-D Score ≥ 15), bipolar disorder, anxiety disorder, schizophrenia or other psychotic conditions, substance abuse, personality disorder, stroke, organic mental disorders, central nervous system disorders.</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50-300 mg/days fixed titration schedule for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 56 days</p>	<p>Results: OCD : Change in YBOCS at 8 weeks: Quetiapine vs Placebo - RR = 3.91 (0.94 , 16.33)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Garakani et al.2008¹³²</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 41</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 114</p> <p>Withdrawn: 29</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 87</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65 years old, diagnosis of unipolar major depression without psychotic features, MADRS score > 15 at both screen and baseline</p> <p>Exclusion criteria: Received an antidepressant for the current episode or within 2 weeks of entering the study, a history of treatment -refractory depression (failure to respond to adequate trials), primary diagnosis of any eating disorder / psychotic disorder / delirium / dementia / bipolar / OCD, any Axis II disorder that would interfere with the study, substance abuse, positive urine toxicology screen.</p> <p>Interventions: Placebo 25-100 mg/days flexible dose for 8 weeks vs Quetiapine 25-100 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 8 weeks: Quetiapine vs Placebo - RR = 0.87 (0.67 , 1.13)</p> <p>Adverse Events: Fluoxetine + placebo vs Fluoxetine+ quetiapine Anxiety: 12.3%(7/57) vs 7.0%(4/57) Dizziness And Lightheadedness: 12.3%(7/57) vs 17.5%(10/57) Dry Mouth: 8.8%(5/57) vs 12.3%(7/57) Fatigue: 7.0%(4/57) vs 8.8%(5/57) Gastrointestinal Symptoms (Nausea, Diarrhea, And Constipation): 22.8%(13/57) vs 14.0%(8/57) Headache: 12.3%(7/57) vs 5.3%(3/57) Muscle And Joint Pain: 7.0%(4/57) vs 3.5%(2/57) Sedation: 7.0%(4/57) vs 26.3%(15/57)</p> <p>Withdrawals: Fluoxetine + placebo vs Fluoxetine+ quetiapine Withdrawals:19.3%(11/57) vs 28.1%(16/57)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Kordon et al.2008¹⁷⁰ OCD Quetiapine Location: Western Europe Trial: Not reported Funding source: Industry Design: RCT only Setting: Multi-center Jadad: 3 Age: Not reported Sex: Mixed Race: Not reported Screened: NR Eligible: NR Entering: 40 Withdrawn: 10 Lost to follow-up: NR Analyzed: 30 Method of AE assessment: Reported spontaneously by patient, observed</p>	<p>Inclusion criteria: Aged 18-65, diagnosis of OCD, Y-BOCS \geq 18, treated with an SRI \geq 12 weeks and non-responders (< 25% improvement in Y-BOCS)</p> <p>Exclusion criteria: Known intolerance or lack of response to quetiapine, a psychotic disorder, substance abuse, organic brain disease, epilepsy, known HIV infection, significant and unstable renal, cardiovascular, hepatic, hematologic, or endocrine conditions.</p> <p>Interventions: Placebo 100-600 mg/days flexible dose for 12 weeks vs Quetiapine 100-600 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Personality Disorder</p> <p>Timing of outcome assessment: 14, 28, 42, 56, 70, 84 days</p>	<p>Results: OCD : Change in YBOCS at 12 weeks: Quetiapine vs Placebo - RR = 2.11 (0.61 , 7.24)</p> <p>Adverse Events: Quetiapine vs Placebo Abdominal Pain Upper: 15.0%(3/20) vs 25.0%(5/20) Apathy: 15.0%(3/20) vs 10.0%(2/20) Constipation: 25.0%(5/20) vs 5.0%(1/20) Diarrhea: 5.0%(1/20) vs 25.0%(5/20) Disturbance In Attention: 25.0%(5/20) vs 5.0%(1/20) Dizziness: 15.0%(3/20) vs 5.0%(1/20) Dry Mouth: 50.0%(10/20) vs 15.0%(3/20) Dyspepsia: 35.0%(7/20) vs 5.0%(1/20) Fatigue: 85.0%(17/20) vs 65.0%(13/20) Headache: 35.0%(7/20) vs 55.0%(11/20) Hyperhidrosis: 30.0%(6/20) vs 50.0%(10/20) Increased Appetite: 15.0%(3/20) vs 15.0%(3/20) Influenza-Like Illness: 5.0%(1/20) vs 30.0%(6/20) Nasopharyngitis: 5.0%(1/20) vs 20.0%(4/20) Nausea: 10.0%(2/20) vs 20.0%(4/20) Nightmare: 10.0%(2/20) vs 10.0%(2/20) SAE: Cramps In Lower Abdomen: 0.0%(0/20) vs 5.0%(1/20) SAE: Headache: 0.0%(0/20) vs 5.0%(1/20) SAE: Increased Cardiac Enzymes: 5.0%(1/20) vs 0.0%(0/20) SAE: Orthostatic Collapse: 0.0%(0/20) vs 5.0%(1/20) Subjects With At Least 1 AE: 95.0%(19/20) vs 100.0%(20/20) Subjects With At Least 1 Drug-Related AE: 95.0%(19/20) vs 55.0%(11/20) Subjects With At Least 1 Drug-Related SAE: 5.0%(1/20) vs 10.0%(2/20) Subjects With At Least 1 SAE: 5.0%(1/20) vs 15.0%(3/20) Vertigo: 45.0%(9/20) vs 25.0%(5/20)</p> <p>Withdrawals: Quetiapine vs Placebo Withdrawals:30.0%(6/20) vs 15.0%(3/20) Withdrawals Due To Adverse Events:20.0%(4/20) vs 5.0%(1/20)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Matsunaga et al.2009¹⁷¹</p> <p>OCD</p> <p>Olanzapine, Quetiapine, Risperidone</p> <p>Location: Asia</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 1</p> <p>Age: Mean: 30</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 137 Eligible: 44 Entering: 90 Withdrawn: NR Lost to follow-up: NR Analyzed: 46</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Diagnosed OCD, received treatment >= 1 year at Osaka hospital.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Olanzapine 1-10 mg/days frequency not reported for duration not reported vs Quetiapine 25-100 mg/days frequency not reported for variable duration vs Risperidone 1-5 mg/days frequency not reported for duration not reported vs Control Group</p> <p>Run-in/wash-out period: Run-in: Fluoxetine or paroxetine for 12 week(s). Non-responders were randomized.</p> <p>Comorbidities: Depression</p> <p>Timing of outcome assessment: 365 days</p>	<p>Results: OCD: Insufficient data to calculate an effect size</p> <p>Adverse Events: SSRI+olanzapine, quetiapine or risperidone Increased Appetite: 34.1%(15/44) Increased Body Weight: 27.3%(12/44) Sedation: 6.8%(3/44) Sleepiness: 11.4%(5/44) SSRI+olanzapine, quetiapine or risperidone vs SSRIs (fluvoxamine or paroxetine) BMI Increase > 10%: 50.0%(22/44) vs 15.2%(7/46)</p> <p>Withdrawals: SSRI+olanzapine, quetiapine or risperidone Withdrawals:0.0%(0/44) SSRI+olanzapine, quetiapine or risperidone vs SSRIs (fluvoxamine or paroxetine) Withdrawals Due To Adverse Events:0.0%(0/44) vs 0.0%(0/46)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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<p>McIntyre et al.2007⁶⁷ Anxiety, Depression Quetiapine Location: Canada Trial: Not reported Funding source: Industry Design: RCT only Setting: Single setting Jadad: 3 Age: Not reported Sex: Mixed Race: Not reported Screened: 73 Eligible: 58 Entering: 58 Withdrawn: 22 Lost to follow-up: 2 Analyzed: 34 Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, major depression, HAM-D 17 >= 18, CGI-S >=4, HAM-A >= 14, treated with single SSRI/venlafaxine at a therapeutic dose >= 6 weeks</p> <p>Exclusion criteria: Substance abuse / dependence 6 month prior, antipsychotic or benzodiazepines 7 days prior, P450 inhibition / induces 14 days prior, pregnant, breast feeding, risk of suicide</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50-600 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Anxiety: Insufficient data to calculate an effect size Depression : Change in HAM-D (% Remitted) at 8 weeks: Quetiapine vs Placebo - RR = 1.78 (0.53 , 5.97) Depression : Change in HAM-D (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 2.00 (0.76 , 5.26)</p> <p>Adverse Events: Quetiapine vs Placebo Anxiety: 0.0%(0/29) vs 10.3%(3/29) Constipation: 13.8%(4/29) vs 0.0%(0/29) Dizziness: 20.7%(6/29) vs 24.1%(7/29) Dry Mouth: 44.8%(13/29) vs 13.8%(4/29) Dysuria: 10.3%(3/29) vs 3.4%(1/29) Flu-Like Symptoms: 6.9%(2/29) vs 10.3%(3/29) Headache: 13.8%(4/29) vs 27.6%(8/29) Increased Appetite: 17.2%(5/29) vs 20.7%(6/29) Increased Dreaming/ Nightmares: 13.8%(4/29) vs 0.0%(0/29) Increased Weight (Based On Pt's Perception): 34.5%(10/29) vs 10.3%(3/29) Insomnia: 0.0%(0/29) vs 31.0%(9/29) Irritability/Restlessness: 13.8%(4/29) vs 17.2%(5/29) Nausea: 3.4%(1/29) vs 10.3%(3/29) Other AE: 41.4%(12/29) vs 41.4%(12/29) Pain: 10.3%(3/29) vs 13.8%(4/29) Sedation/ Somnolence/Lethargy: 86.2%(25/29) vs 48.3%(14/29)</p> <p>Withdrawals: Quetiapine vs Placebo Withdrawals:37.9%(11/29) vs 44.8%(13/29) Withdrawals Due To Adverse Events:27.6%(8/29) vs 6.9%(2/29) Withdrawals Due to Adverse Events: Increase Irritability:0.0%(0/29) vs 3.4%(1/29) Withdrawals Due to Adverse Events: Increased Appetite, Increased Irritability And Sedation/Somnolence/Lethargy:3.4%(1/29) vs 0.0%(0/29) Withdrawals Due to Adverse Events: Sedation/Somnolence/Lethargy:20.7%(6/29) vs 3.4%(1/29) Withdrawals Due to Adverse Events: Weight Gain And Fatigue:3.4%(1/29) vs 0.0%(0/29)</p>

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<p>Vulink et al.2009¹⁷²</p> <p>OCD</p> <p>Quetiapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 249</p> <p>Eligible: 143</p> <p>Entering: 76</p> <p>Withdrawn: 0</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 66</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Age >= 18, OCD, YBOCS>=17 or 11 if only obsessions and compulsive were present</p> <p>Exclusion criteria: Use of antipsychotics or SRI's at effective dose for at least 8 weeks, MDD, or HAM-D 17>=17, pregnant or nursing, women not on contraception, organic mental disorder, epilepsy, central nervous system disorder or stroke within last year, bipolar, schizophrenia or other psychotic disorders, subrelated disorder within 6 months, personality disorder, tics or Tourette's, any clinically significant acute or unstable medical condition, allergy to quetiapine, behavioral or cognitive therapy 3 month prior, suicide risk</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Quetiapine 50-450 mg/days fixed titration schedule for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: Anxiety, Depression</p> <p>Timing of outcome assessment: 14, 21, 28, 42, 56, 70 days</p>	<p>Results: OCD : Change in YBOCS (Total Score) at 10 weeks: Quetiapine vs Placebo - WMD = -3.80 (-6.72 , -0.88)</p> <p>Adverse Events: Placebo vs Quetiapine Concentration Problems: 10.8%(4/37) vs 7.7%(3/39) Dizziness: 10.8%(4/37) vs 23.1%(9/39) Dry Mouth: 13.5%(5/37) vs 33.3%(13/39) Headache: 35.1%(13/37) vs 25.6%(10/39) Increased Appetite: 10.8%(4/37) vs 17.9%(7/39) Muscular Pain: 16.2%(6/37) vs 5.1%(2/39) Nausea: 37.8%(14/37) vs 5.1%(2/39) Palpitations: 10.8%(4/37) vs 7.7%(3/39) Sexual Problems: 43.2%(16/37) vs 41.0%(16/39) Sleeplessness: 29.7%(11/37) vs 0.0%(0/39) Somnolence: 56.8%(21/37) vs 84.6%(33/39) Sweating: 27.0%(10/37) vs 12.8%(5/39) Tremor: 27.0%(10/37) vs 15.4%(6/39) Weight Gain: 21.6%(8/37) vs 53.8%(21/39)</p> <p>Withdrawals: Placebo vs Quetiapine Withdrawals:5.4%(2/37) vs 20.5%(8/39) Quetiapine Withdrawals Due To Adverse Events:17.9%(7/39)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Weisler et al.2009¹³⁷</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 5</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: 1075 Eligible: 723 Entering: 723 Withdrawn: 127 Lost to follow-up: 85 Analyzed: 511</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, output, MDD, HAM-D item 17>=22, HAM-D item 1>=2</p> <p>Exclusion criteria: Other axis I disorders during prior 6 month, Axis II impacting status, current MDD episode > 12 months or <4 weeks, inadequate response to adequate antidepressants treatment with >= 2 classes of antidepressants, medical illness, suicide or homicide risk</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 50 mg/days fixed titration schedule for 6 weeks vs Quetiapine 50-150 mg/days fixed titration schedule for 6 weeks vs Quetiapine 50-300 mg/days fixed titration schedule for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 4, 7, 14, 28, 42 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Quetiapine vs Placebo - RR = 1.27 (0.89 , 1.82)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Quetiapine vs Placebo - RR = 1.58 (1.24 , 2.02)</p> <p>Adverse Events: Placebo vs Quetiapine 150mg vs Quetiapine 300mg vs Quetiapine 50mg Any Adverse Event: 67.9%(125/184) vs 87.1%(155/178) vs 87.7%(157/179) vs 80.2%(146/182) Back Pain: 2.2%(4/184) vs 5.6%(10/178) vs 5.0%(9/179) vs 1.6%(3/182) Constipation: 2.7%(5/184) vs 8.4%(15/178) vs 8.9%(16/179) vs 7.1%(13/182) Death: 0.0%(0/184) vs 0.0%(0/178) vs 0.0%(0/179) vs 0.0%(0/182) Diarrhea: 8.7%(16/184) vs 6.2%(11/178) vs 3.4%(6/179) vs 6.6%(12/182) Dizziness: 5.4%(10/184) vs 10.7%(19/178) vs 10.6%(19/179) vs 8.8%(16/182) Dry Mouth: 8.7%(16/184) vs 37.1%(66/178) vs 41.3%(74/179) vs 22.0%(40/182) Dyspepsia: 2.7%(5/184) vs 5.6%(10/178) vs 2.8%(5/179) vs 2.2%(4/182) Fatigue: 4.3%(8/184) vs 7.9%(14/178) vs 6.1%(11/179) vs 6.0%(11/182) Headache: 14.7%(27/184) vs 13.5%(24/178) vs 14.5%(26/179) vs 12.1%(22/182) Increased Appetite: 3.8%(7/184) vs 5.1%(9/178) vs 4.5%(8/179) vs 4.4%(8/182) Insomnia: 7.6%(14/184) vs 6.7%(12/178) vs 6.7%(12/179) vs 4.9%(9/182) Irritability: 3.8%(7/184) vs 5.6%(10/178) vs 3.4%(6/179) vs 6.0%(11/182) Myalgia: 1.6%(3/184) vs 7.3%(13/178) vs 2.2%(4/179) vs 4.4%(8/182) Nausea: 6.0%(11/184) vs 8.4%(15/178) vs 8.9%(16/179) vs 7.7%(14/182) Sedation: 6.0%(11/184) vs 35.4%(63/178) vs 30.7%(55/179) vs 26.9%(49/182) Somnolence: 10.9%(20/184) vs 19.7%(35/178) vs 29.1%(52/179) vs 18.1%(33/182) Vomiting: 2.2%(4/184) vs 2.2%(4/178) vs 6.7%(12/179) vs 1.6%(3/182)</p> <p>Withdrawals: Placebo vs Quetiapine 150mg vs Quetiapine 300mg vs Quetiapine 50mg Withdrawals:27.2%(50/184) vs 30.9%(55/178) vs 33.0%(59/179) vs 26.4%(48/182) Withdrawals Due To Adverse Events:6.0%(11/184) vs 14.0%(25/178) vs 19.0%(34/179) vs 8.2%(15/182)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Berman et al.2009¹²⁹</p> <p>Depression</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 45</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Native American, Other-NOS</p> <p>Screened: 1147 Eligible: 349 Entering: 349 Withdrawn: 48 Lost to follow-up: 5 Analyzed: 296</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: 18-65 years old, diagnosed major depressive episode >= 8weeks, inadequate response to previous antidepressants</p> <p>Exclusion criteria: Had received antidepressant with an adjunctive antipsychotic for > 3 weeks, psychosis, previously not tolerate any study antidepressants</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Aripiprazole 2-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Aripiprazole vs Placebo - RR = 1.43 (0.96 , 2.12)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Aripiprazole vs Placebo - RR = 1.75 (1.30 , 2.35)</p> <p>Adverse Events: Aripiprazole Akathisia: Mild: 11.3%(20/177) Akathisia: Moderate: 5.1%(9/177) Akathisia: Severe: 1.7%(3/177) Aripiprazole vs Placebo Akathisia: Total: 18.1%(32/177) vs 3.5%(6/172) Clinically Significant Weight Gain (=7%) At Endpoint: 4.5%(8/177) vs 1.2%(2/172) Constipation: 5.6%(10/177) vs 3.5%(6/172) Diarrhea: 5.6%(10/177) vs 7.6%(13/172) Dizziness: 5.1%(9/177) vs 2.9%(5/172) Fatigue: 9.0%(16/177) vs 4.7%(8/172) Headache: 8.5%(15/177) vs 8.1%(14/172) Insomnia: 8.5%(15/177) vs 5.2%(9/172) Nausea: 4.0%(7/177) vs 5.8%(10/172) Restlessness: 12.4%(22/177) vs 3.5%(6/172) Serious AE: Arterial Occlusive Disease: 0.0%(0/177) vs 0.6%(1/172) Serious AE: Suicidal Ideation: 0.6%(1/177) vs 0.0%(0/172) Somnolence: 5.6%(10/177) vs 0.6%(1/172) Upper Respiratory Tract Infection: 7.3%(13/177) vs 7.6%(13/172) Vision Blurred: 7.3%(13/177) vs 1.7%(3/172)</p> <p>Withdrawals: Aripiprazole Withdrawal Due To Akathisia:1.1%(2/177) Aripiprazole vs Placebo Withdrawals:16.9%(30/177) vs 13.4%(23/172) Withdrawals Due To Adverse Events:6.2%(11/177) vs 1.7%(3/172)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Chaput et al.2008¹³¹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Mean: 23</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 40 Eligible: 24 Entering: 22 Withdrawn: NR Lost to follow-up: NR Analyzed: 15</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: MD, HRSD >= 20, CGI-S >=4, 2 classes of antidepressants</p> <p>Exclusion criteria: Suicide risk, pregnant, breast feeding, not on birth control for 3 month prior, bipolar, schizophrenia, personality disorder, panic, anxiety, OCD, somatoformor organic mental disorder, anorexia, bulimia, substance abuse, other psychotropics, unstable medical illness</p> <p>Interventions: Placebo 12.5-200 mg/days flexible dose for 12 weeks vs Quetiapine 12.5-200 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Run-in: Lithium for 3 week(s). Non-responders were randomized. !n Wash-out: No drug for 8 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 21, 28, 42, 56, 70, 84, 98 days</p>	<p>Results: Depression: Only data on placebo group reported</p> <p>Adverse Events: Quetiapine/CBT vs Placebo/CBT Dry Mouth: 36.4%(4/11) vs 9.1%(1/11) Gastrointestinal Discomfort: 18.2%(2/11) vs 27.3%(3/11) Headache: 36.4%(4/11) vs 9.1%(1/11) Insomnia: 45.5%(5/11) vs 18.2%(2/11) Labile Hypertension: 9.1%(1/11) vs 9.1%(1/11) Mild Akathisia And Muscle Rigidity: 0.0%(0/11) vs 9.1%(1/11) Nausea: 18.2%(2/11) vs 18.2%(2/11) Somnolence: 63.6%(7/11) vs 9.1%(1/11)</p> <p>Withdrawals: Quetiapine/CBT vs Placebo/CBT Possible Anomaly Detected At The Week 10 Electrocardiogram That Was Ultimately Found To Be A False Positive Result Leading To Withdrawal:9.1%(1/11) vs 0.0%(0/11) Withdrawals:9.1%(1/11) vs 54.5%(6/11) Withdrawals Due To Adverse Events:0.0%(0/11) vs 0.0%(0/11)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Diniz et al.2009¹⁷³</p> <p>OCD</p> <p>Quetiapine</p> <p>Location: Brazil</p> <p>Trial: Not reported</p> <p>Funding source: Government</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 2</p> <p>Age: Mean: 20</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: 48 Eligible: 35 Entering: 31 Withdrawn: 13 Lost to follow-up: NR Analyzed: 18</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65, OCD, treatment failure to SSRI</p> <p>Exclusion criteria: Substance dependence or abuse, psychosis, suicide risk, pregnant / intending to become pregnant</p> <p>Interventions: Clomipramine 25-75 mg/days flexible dose for 12 weeks vs Quetiapine 50-200 mg/days flexible dose for 12 weeks</p> <p>Run-in/wash-out period: Run-in: Fluoxetine for 12 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 28, 56, 84 days</p>	<p>Results: OCD : Change in YBOCS (Total Score) at 12 weeks: Quetiapine vs Clomipramine - WMD = -3.60 (9.27 , 2.07)</p> <p>Adverse Events: Clomipramine vs Quetiapine Severe Adverse Events: 0.0%(0/15) vs 0.0%(0/16) Quetiapine 3 Symptoms Of Serotonergic Syndrome (Excessive Sweating, Tremors And Motor Agitation) Leading To Being Dropped: 0.0%(0/16)</p> <p>Withdrawals: Clomipramine 3 Symptoms Of Serotonergic Syndrome (Excessive Sweating, Tremors And Motor Agitation) Leading To Withdrawal:6.7%(1/15) Clomipramine vs Quetiapine Withdrawals:40.0%(6/15) vs 43.8%(7/16) Withdrawals Due To Adverse Events:40.0%(6/15) vs 43.8%(7/16)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Reeves et al.2008¹⁴⁴</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 23</p> <p>Withdrawn: 5</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 18</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: 19 - 60, MDD and suicidal ideation despite treatment with up to 2 antidepressants for >= 3 weeks. MADRS >= 25, suicidal subscore >=4</p> <p>Exclusion criteria: Psychotic features, other major psychiatric diagnosis, pregnant or lactating</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Risperidone 0.5-2 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 4, 7, 14, 21, 28, 42, 56 days</p>	<p>Results: Depression : Change in MADRS (Total Score) at 8 weeks: Risperidone Augmentation vs Placebo Augmentation - WMD = -7.11 (-9.88 , -4.34)</p> <p>Adverse Events: Placebo vs Risperidone Bad Taste: 0.0%(0/12) vs 25.0%(3/12) Delayed Ejaculation: 25.0%(3/12) vs 0.0%(0/12) Diarrhea: 25.0%(3/12) vs 16.7%(2/12) Dizziness: 8.3%(1/12) vs 16.7%(2/12) Dry Mouth: 0.0%(0/12) vs 58.3%(7/12) Headache: 91.7%(11/12) vs 16.7%(2/12) Heartburn: 16.7%(2/12) vs 8.3%(1/12) Increased Appetite: 16.7%(2/12) vs 8.3%(1/12) Insomnia: 25.0%(3/12) vs 8.3%(1/12) Nausea: 25.0%(3/12) vs 16.7%(2/12) Somnolence: 8.3%(1/12) vs 16.7%(2/12)</p> <p>Withdrawals: Placebo vs Risperidone Withdrawals:41.7%(5/12) vs 8.3%(1/12)</p>

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<p>Marcus et al.2008¹²⁷</p> <p>Depression</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 44</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Native American, Other-NOS</p> <p>Screened: 1151 Eligible: 381 Entering: 382 Withdrawn: 57 Lost to follow-up: 0 Analyzed: 324</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: 18-65 years old, major depressive episode > = 8weeks, inadequate response to previous antidepressants</p> <p>Exclusion criteria: Previously reported Berman 2007</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Aripiprazole 2-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Aripiprazole vs Placebo - RR = 1.67 (1.10 , 2.54)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Aripiprazole vs Placebo - RR = 1.86 (1.28 , 2.72)</p> <p>Adverse Events: Aripiprazole vs Placebo Akathisia: 25.7%(49/191) vs 4.2%(8/190) At Least 1 AE: 80.6%(154/191) vs 63.2%(120/190) Clinically Significant Weight Gain (=7% From Double-Blind Baseline): 3.1%(6/191) vs 0.0%(0/190) Constipation: 5.2%(10/191) vs 2.6%(5/190) Deaths: 0.0%(0/191) vs 0.0%(0/190) Fatigue: 9.9%(19/191) vs 3.7%(7/190) Headache: 8.9%(17/191) vs 10.5%(20/190) Insomnia: 7.3%(14/191) vs 1.6%(3/190) Nausea: 5.2%(10/191) vs 4.2%(8/190) Restlessness: 9.4%(18/191) vs 0.5%(1/190) Serious AE: Cellulitis (Deemed Not Related To Study Medication): 0.5%(1/191) vs 0.0%(0/190) Somnolence: 6.8%(13/191) vs 3.7%(7/190) Suicide-Related AE During Double-Blind Randomized Phase: 0.0%(0/191) vs 0.0%(0/190) Tremor: 6.3%(12/191) vs 2.6%(5/190)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:15.2%(29/191) vs 14.7%(28/190) Withdrawals Due To Adverse Events:3.7%(7/191) vs 1.1%(2/190)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Dunner et al.2007¹⁵⁰</p> <p>Depression</p> <p>Ziprasidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 90</p> <p>Eligible: 64</p> <p>Entering: 64</p> <p>Withdrawn: 29</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 35</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 21-65, non response to at least 1 course of 4 weeks of antidepressants and MADRS \geq20</p> <p>Exclusion criteria: Psychotic disorder, PTSD, panic, OCD, substance abuse / dependence in past 3 month, history of treatment with atypical antipsychotic fluoxetine, MAO-1 or ECT 6 weeks prior, unstable medical illness, pregnant, breast feeding</p> <p>Interventions: Control Group vs Ziprasidone 40-80 mg/days flexible dose for 8 weeks vs Ziprasidone 80-160 mg/days flexible dose for duration not reported</p> <p>Run-in/wash-out period: Run-in: Sertraline for 6 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Ziprasidone 80mg + Sertraline vs Sertraline - WMD = -1.53 (-2.73 , -0.34)</p> <p>Depression : Change in MADRS at 8 weeks: Ziprasidone 160mg + Sertraline vs Sertraline - WMD = -3.82 (-5.14 , -2.50)</p> <p>Adverse Events: Placebo vs Ziprasidone 160 mg vs Ziprasidone 80 mg Abnormal Thinking: 0.0%(0/21) vs 10.0%(2/20) vs 8.7%(2/23) Abnormal Vision: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Agitation: 0.0%(0/21) vs 25.0%(5/20) vs 21.7%(5/23) Akathisia: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Asthenia: 0.0%(0/21) vs 25.0%(5/20) vs 21.7%(5/23) At Least 1 Adverse Events: 38.1%(8/21) vs 80.0%(16/20) vs 95.7%(22/23) Constipation: 0.0%(0/21) vs 5.0%(1/20) vs 13.0%(3/23) Dizziness: 0.0%(0/21) vs 20.0%(4/20) vs 17.4%(4/23) Dry Mouth: 0.0%(0/21) vs 20.0%(4/20) vs 8.7%(2/23) Headache: 4.8%(1/21) vs 15.0%(3/20) vs 17.4%(4/23) Insomnia: 4.8%(1/21) vs 30.0%(6/20) vs 34.8%(8/23) Nausea: 0.0%(0/21) vs 20.0%(4/20) vs 4.3%(1/23) Required Dose Reduction Or Temporary Discontinuation Due To Adverse Events: 0.0%(0/21) vs 20.0%(4/20) vs 0.0%(0/23) Respiratory Infection: 0.0%(0/21) vs 5.0%(1/20) vs 17.4%(4/23) Somnolence: 9.5%(2/21) vs 15.0%(3/20) vs 21.7%(5/23) Tremor: 4.8%(1/21) vs 10.0%(2/20) vs 21.7%(5/23)</p> <p>Withdrawals: Placebo vs Ziprasidone 160 mg vs Ziprasidone 80 mg Withdrawals:28.6%(6/21) vs 55.0%(11/20) vs 52.2%(12/23) Withdrawals Due To Adverse Events:0.0%(0/21) vs 35.0%(7/20) vs 39.1%(9/23)</p>

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<p>Alexopoulos et al.2008¹²⁵</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US, Canada, Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 4</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: 63</p> <p>Entering: 63</p> <p>Withdrawn: 7</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 56</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: >= 55, MD, failed antidepressants, HAM-D>=20, MMSE > 23</p> <p>Exclusion criteria: Severe or unstable medical illness, dementia, Axis I other than GAD and phobias</p> <p>Interventions: Placebo dosage not reported for 24 weeks vs Risperidone 0.25-1 mg/days flexible dose for 24 weeks</p> <p>Run-in/wash-out period: Run-in: Citalopram only or citalopram plus risperidone for 4-6 weeks. Non-responders or responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 168 days</p>	<p>Results: Depression: Duplicate data</p> <p>Depression: Duplicate data</p> <p>Adverse Events: Placebo+Citalopram vs Risperidone+Citalopram Anxiety: 0.0%(0/31) vs 0.0%(0/32) Appetite Increase: 3.2%(1/31) vs 6.3%(2/32) Constipation: 6.5%(2/31) vs 3.1%(1/32) Diarrhea: 6.5%(2/31) vs 0.0%(0/32) Dizziness: 6.5%(2/31) vs 6.3%(2/32) Dry Mouth: 6.5%(2/31) vs 3.1%(1/32) Dyspepsia: 0.0%(0/31) vs 6.3%(2/32) Fall: 0.0%(0/31) vs 6.3%(2/32) Fatigue: 6.5%(2/31) vs 3.1%(1/32) Headache: 0.0%(0/31) vs 9.4%(3/32) Insomnia: 3.2%(1/31) vs 3.1%(1/32) Lethargy: 6.5%(2/31) vs 0.0%(0/32) Nasopharyngitis: 0.0%(0/31) vs 0.0%(0/32) Nausea: 3.2%(1/31) vs 3.1%(1/32) Peripheral Swelling: 0.0%(0/31) vs 6.3%(2/32) Pruritus: 0.0%(0/31) vs 6.3%(2/32) Seasonal Allergy: 6.5%(2/31) vs 0.0%(0/32) Sensation Of Heaviness: 0.0%(0/31) vs 6.3%(2/32) Somnolence: 3.2%(1/31) vs 3.1%(1/32) Upper Respiratory Tract Infection: 6.5%(2/31) vs 6.3%(2/32) Weight Increase: 6.5%(2/31) vs 6.3%(2/32)</p> <p>Withdrawals: Placebo+Citalopram vs Risperidone+Citalopram Withdrawals:77.4%(24/31) vs 65.6%(21/32) Withdrawals Due To Adverse Events:6.5%(2/31) vs 6.3%(2/32)</p>

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<p>Doree et al.2007¹⁴⁹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 20</p> <p>Withdrawn: 3</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 17</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18 - 65, MDD without psychotic features, HAMD \geq 20, CGI \geq 4 despite antidepressants at max dose + \geq4 weeks</p> <p>Exclusion criteria: Bipolar or other Axis I, substance dependence within 6 months, unstable medical condition</p> <p>Interventions: Lithium 600-vario mg/days flexible dose for 8 weeks vs Quetiapine 25-600 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Quetiapine vs Lithium - WMD = -10.90 (-16.47 , -5.33)</p> <p>Adverse Events: Lithium Tremor: 60.0%(6/10) Quetiapine Somnolence: 50.0%(5/10) Quetiapine vs Lithium Serious Adverse Event: 0.0%(0/10) vs 0.0%(0/10)</p> <p>Withdrawals: Quetiapine vs Lithium Mixed State Resulting In Withdrawal:0.0%(0/10) vs 10.0%(1/10) Tremor And Nausea Resulting In Withdrawal:0.0%(0/10) vs 10.0%(1/10) Withdrawals:0.0%(0/10) vs 30.0%(3/10) Withdrawals Due To Adverse Events:0.0%(0/10) vs 20.0%(2/10)</p>

AE=Adverse Event, NR=Not Reported

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Gerra et al.2006²⁴⁰</p> <p>Substance abuse</p> <p>Olanzapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Government, Professional association</p> <p>Design: CCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex: 80-99% Male</p> <p>Race: Not reported</p> <p>Screened: NR Eligible: 67 Entering: 67 Withdrawn: 34 Lost to follow-up: 0 Analyzed: 33</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Heroin dependant patients entering methadone and buprenorphine, aggressive personality traits.</p> <p>Exclusion criteria: > 3 month of drugs other than heroin or > 6 month alcohol dependant, severe chronic liver illness, renal diseases, other chronic medical disorders, recent significant weight loss, obesity, endocrinotherapy, immune deficiency. A comorbidity of schizophrenia or bipolar disorder > 60 BDHI.</p> <p>Interventions: SRI and Antidepressant Fluoxetine mean 25.26 (SD 5.9) ; Paroxetine mean 22.5 (SD 6.8) ; Clonazepam mean 5.15 (SD 1.67) for 12 weeks vs Olanzapine mean 12.1 (SD 5.4) for 12 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: OCD, Personality Disorder</p> <p>Timing of outcome assessment: 84 days</p>	<p>Results: Substance Abuse : Change in BDHI at 12 weeks: Olanzapine+Methadone/Buprenorphine vs SSRIs+Clonazepam+Methadone/Buprenorphine - WMD = -10.26 (-11.00 , -9.52)</p> <p>Adverse Events: Fluoxetine/paroxetine and clonazepam vs Olanzapine Overt BDZs Abuse With Severe Sedation And Paradoxical Symptoms That Contributed To Drop-Out: 11.4%(4/35) vs 0.0%(0/32) Paradoxical Effects With Agitation, Increased Irritability, Negativism And The Tendency To Clonazepam Abuse: 20.0%(7/35) vs 0.0%(0/32) Significant Changes Of Glucose Plasma Levels: 0.0%(0/35) vs 0.0%(0/32) Olanzapine Weight Gain =7%: 12.5%(4/32)</p> <p>Withdrawals: Fluoxetine/paroxetine and clonazepam vs Olanzapine Withdrawals:45.7%(16/35) vs 46.9%(15/32)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Berman et al.2007¹²⁸</p> <p>Depression</p> <p>Aripiprazole</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 4</p> <p>Age: Mean: 45</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Native American, Eskimo/Inuit, Other-NOS</p> <p>Screened: 1044</p> <p>Eligible: NR</p> <p>Entering: 362</p> <p>Withdrawn: 31</p> <p>Lost to follow-up: 7</p> <p>Analyzed: 320</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Diagnosed major depressive episode ≥ 8 weeks, inadequate response to antidepressant, ($< 50\%$ reduction in depressive symptoms severity), HAM-D-17 ≥ 18</p> <p>Exclusion criteria: Delirium, dementia, amnesic, cognitive disorder schizophrenia, bipolar disorders, OCD, PTSD, personality disorders, psychotic symptomatology, allergy, participated ARI trial within past month, drug abuse, received antipsychotic and antidepressant for ≥ 3 weeks etc.</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Aripiprazole 2-20 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Aripiprazole vs Placebo - RR = 1.65 (1.08 , 2.53)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Aripiprazole vs Placebo - RR = 1.41 (1.01 , 1.98)</p> <p>Adverse Events: Aripiprazole vs Placebo $\geq 7\%$ Weight Gain: 7.1%(13/184) vs 1.1%(2/178) Akathisia: 22.8%(42/184) vs 4.5%(8/178) At Least One AE: 81.0%(149/184) vs 61.8%(110/178) Continuing Akathisia: 10.3%(19/184) vs 0.0%(0/178) Diarrhea: 3.3%(6/184) vs 5.6%(10/178) Dry Mouth: 3.3%(6/184) vs 6.2%(11/178) EPS-Related AEs: 27.2%(50/184) vs 9.6%(17/178) Fatigue: 6.0%(11/184) vs 3.4%(6/178) Headache: 6.0%(11/184) vs 10.7%(19/178) Insomnia: 7.6%(14/184) vs 2.2%(4/178) Nausea: 2.7%(5/184) vs 5.1%(9/178) Non-Akathisia EPS-Related AEs: 4.3%(8/184) vs 5.1%(9/178) Restlessness: 14.1%(26/184) vs 3.4%(6/178) Serious AE: Cellulitis And Staphylococcal Abscess: 0.0%(0/184) vs 0.6%(1/178) Serious AE: Contusion And Physical Assault: 0.0%(0/184) vs 0.6%(1/178) Serious AE: Exostosis: 0.0%(0/184) vs 0.6%(1/178) Serious AE: Pneumonia: 0.5%(1/184) vs 0.0%(0/178) Serious AE: Staphylococcal Cellulitis: 0.5%(1/184) vs 0.0%(0/178) Serious AEs: 1.1%(2/184) vs 1.7%(3/178) Suicidal Ideation: 0.0%(0/184) vs 1.1%(2/178) Upper Respiratory Tract Infection: 8.2%(15/184) vs 3.9%(7/178) Vision Blurred: 6.5%(12/184) vs 1.7%(3/178)</p> <p>Withdrawals: Aripiprazole vs Placebo Withdrawals:13.0%(24/184) vs 10.1%(18/178) Withdrawals Due To Adverse Events:3.3%(6/184) vs 2.2%(4/178)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Montgomery et al.2008¹²⁰</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Not reported</p> <p>Trial: D1448C00002</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 612</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Not reported</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Duloxetine 60 mg/days frequency not reported for 6 weeks vs Quetiapine 150 mg/days frequency not reported for 6 weeks vs Quetiapine 300 mg/days frequency not reported for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 42 days</p>	<p>Results: Depression: Duplicate data</p> <p>Depression: Duplicate data</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Zheng et al.2007¹³⁰</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Asia</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 1</p> <p>Age: Mean: 25</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 37</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: Diagnosed with MDD without psychotic symptoms, HAM-D score ≥ 18, BPRS item 4 score ≤ 4, item 11 score ≤ 3, had been treated unsuccessfully with ≥ 2 different types of antidepressants for ≥ 6 weeks</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Antidepressant 26.7-28 mg/days flexible dose for 4 weeks vs Quetiapine, Antidepressant 50-200 mg/days flexible dose for 4 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 56 days</p>	<p>Results: Depression : Change in HAM-D (% Remitted) at 4 weeks: Quetiapine vs Placebo - RR = 8.44 (1.17 , 60.94)</p> <p>Depression : Change in HAM-D (% Responder) at 4 weeks: Quetiapine vs Placebo - RR = 2.90 (1.13 , 7.47)</p> <p>Adverse Events: Quetiapine + antidepressants Somnolence: 25.0%(5/20) Quetiapine + antidepressants vs Antidepressants AEs: All Mild To Moderate In Intensity: 40.0%(8/20) vs 35.0%(7/20)</p> <p>Withdrawals: Quetiapine + antidepressants vs Antidepressants Withdrawals:10.0%(2/20) vs 5.0%(1/20) Withdrawals Due To Adverse Events:0.0%(0/20) vs 0.0%(0/20)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Mattingly et al.2006¹³³</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 40</p> <p>Withdrawn: 8</p> <p>Lost to follow-up: 0</p> <p>Analyzed: 32</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Outpatients aged 18-65 years old, a primary diagnosis of major depression who were not psychotic, baseline HAM-D 17 \geq 20 following a \geq 6 weeks SSRI or SNRI treatment, HAM-D item I score \geq 2 had failed \geq 1 r-week trial of clinically appropriate dose of another antidepressant</p> <p>Exclusion criteria: Met DSM-IV criteria for substance abuse within 3 months, a history of clinically significant disease, had participated in a clinical trial in the past 90 days, had a known intolerance or lack of response to quetiapine, received mood stabilizers, other antipsychotics or antidepressants other than SSRIs or SNRIs \geq2 weeks</p> <p>Interventions: Placebo 200-400 mg/days flexible dose for 8 weeks vs Quetiapine 200-400 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: SRI monotherapy for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 42, 56 days</p>	<p>Results: Depression : Change in HAM-D (% Remitted) at 8 weeks: Quetiapine vs Placebo - RR = 2.83 (0.73 , 10.98)</p> <p>Depression : Change in HAM-D (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 2.12 (0.89 , 5.05)</p> <p>Adverse Events: Placebo vs Quetiapine Dry Mouth: 0.0%(0/14) vs 11.5%(3/26) Fatigue: 14.3%(2/14) vs 26.9%(7/26) Headache: 35.7%(5/14) vs 26.9%(7/26) Sedation/Insomnia: 7.1%(1/14) vs 7.7%(2/26)</p> <p>Withdrawals: Placebo vs Quetiapine Withdrawals:21.4%(3/14) vs 19.2%(5/26) Withdrawals Due To Adverse Events:14.3%(2/14) vs 0.0%(0/26)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Datto et al.2008¹³⁹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Not reported</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 776</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: MADRS <= 12, CGI-S <= 3</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for Up to 52 weeks vs Quetiapine 50-300 mg/days flexible dose for Up to 52 weeks</p> <p>Run-in/wash-out period: Run-in: Quetiapine for 12 week(s). Stable patients were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: Depression: Insufficient data to calculate an effect size</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4493)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Denys et al.2006¹⁷⁴ OCD Quetiapine Location: Not reported Trial: Not reported Funding source: Not reported Design: RCT only Setting: Not reported Jadad: 2 Age: Not reported Sex: Race: Not reported Screened: NR Eligible: NR Entering: NR Withdrawn: 9 Lost to follow-up: NR Analyzed: NR Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Patients with primary OCD according to DSM-IV criteria</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Control Group vs Quetiapine dosage not reported for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 70 days</p>	<p>Results: OCD: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Hussain et al.2005¹⁵¹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 1</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: 18</p> <p>Lost to follow-up: 0</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Diagnosed with MDD using DSM-IV criteria</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Paroxetine dosage not reported for duration not reported vs Venlafaxine dosage not reported for duration not reported vs Quetiapine, Paroxetine dosage not reported for duration not reported vs Quetiapine, Venlafaxine dosage not reported for duration not reported</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 21, 42, 84, 182, 365, 730, 1094 days</p>	<p>Results: Depression: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>El-Khalili et al.2008¹²⁴</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: OPAL D1448C00003</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 310</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18 - 65 years old, DSM-IV diagnosis of MDD, HAM-D total score ≥ 22, HAM-D item 1 score ≥ 2</p> <p>Exclusion criteria: Any DSM-IV Axis I disorder other than MDD within 6 months prior to enrollment, any DSM-IV Axis II disorder significantly impacting psychiatric status, duration of current MDD episode > 12 months or < 4 weeks, substance abuse, history of inadequate response to an adequate treatment with ≥ 2 classes of antidepressants</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 150-300 Not reported/Not reported flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Depression: Duplicate data</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4469)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>AstraZeneca2008¹⁴⁰</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US, Canada, Western Europe, South Africa</p> <p>Trial: AMETHYST</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 19</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 776</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Age 18-65, with DSM-IV diagnosis of MDD together with an acute depressed episode confirmed by MINI, have a current episode of depression ≥ 4 weeks and < 12 months in duration, HAM-D total score ≥ 20, HAM-D item 1 score ≥ 2, MADRS score ≤ 12, CGI-S score ≤ 3</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo 50-300 mg/days flexible dose for 52 weeks vs Quetiapine 50-300 mg/days flexible dose for 52 weeks</p> <p>Run-in/wash-out period: Run-in: Antipsychotics for 26 week(s). Patients who met the study criteria were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 364 days</p>	<p>Results: Depression : Change in MADRS (Total) at 52 weeks: Quetiapine vs Placebo - WMD = -1.88 (-1.91 , -1.85)</p> <p>Adverse Events: Placebo Serious AE Leading To Death (Hypertension): 0.3%(1/385) Placebo vs Quetiapine "drug-Related Ae": 28.3%(109/385) vs 33.0%(129/391) ≥ 15 bpm Increases In Heart Rate: 6.5%(25/385) vs 10.2%(40/391) $\geq 7\%$ Increase In Weight: 2.9%(11/385) vs 5.4%(21/391) AE Potentially Related To Neutropenia Or Agranulocytosis: 0.0%(0/385) vs 0.0%(0/391) AE Potentially Related To Qt Prolongation: 0.0%(0/385) vs 0.0%(0/391) AEs Potentially Related To Nausea And Vomiting: 10.9%(42/385) vs 4.9%(19/391) Anxiety: 2.6%(10/385) vs 1.3%(5/391) Any AE: 60.5%(233/385) vs 62.9%(246/391) Arthralgia: 2.3%(9/385) vs 4.9%(19/391) Back Pain: 2.6%(10/385) vs 3.8%(15/391) Blood Pressure Increased: 0.5%(2/385) vs 2.3%(9/391) Constipation: 0.3%(1/385) vs 2.0%(8/391) Decreases ≥ 20 Millimeters Of Mercury In Orthostatic Systolic Blood Pressure: 6.2%(24/385) vs 11.5%(45/391) Diarrhea: 6.8%(26/385) vs 5.4%(21/391) Disturbance In Attention: 0.0%(0/385) vs 0.0%(0/391) Dizziness: 4.4%(17/385) vs 6.6%(26/391) Dry Mouth: 1.6%(6/385) vs 3.6%(14/391) Dyspepsia: 0.0%(0/385) vs 0.0%(0/391) Edema Peripheral: 0.0%(0/385) vs 0.0%(0/391) Fatigue: 2.6%(10/385) vs 4.3%(17/391) Headache: 11.4%(44/385) vs 6.9%(27/391) Incidence Of Syncope: 0.0%(0/385) vs 0.8%(3/391) Increased Appetite: 0.0%(0/385) vs 0.0%(0/391) Increases ≥ 15 Bpm In Supine Pulse: 19.2%(74/385) vs 28.1%(110/391) Insomnia: 14.8%(57/385) vs 5.6%(22/391) Irritability: 3.1%(12/385) vs 0.8%(3/391) Lethargy: 0.0%(0/385) vs 0.0%(0/391) Musculoskeletal Pain: 1.3%(5/385) vs 2.0%(8/391) Myalgia: 1.3%(5/385) vs 2.3%(9/391) Nasopharyngitis: 6.5%(25/385) vs 7.2%(28/391) Nausea: 9.9%(38/385) vs 3.6%(14/391) Pain In Extremity: 2.1%(8/385) vs 1.5%(6/391) QTcF Values ≥ 450ms: 2.6%(10/385) vs 2.6%(10/391) Restlessness: 0.0%(0/385) vs 0.0%(0/391) Sedation: 0.3%(1/385) vs 2.6%(10/391) Serious Ae, All: 2.1%(8/385) vs 2.0%(8/391) Sinusitis: 2.3%(9/385) vs 3.1%(12/391) Somnolence: 0.0%(0/385) vs 3.8%(15/391) Tx Emergent Shift From < 3 To ≥ 3 Metabolic Risk Factors: 12.7%(49/385) vs 17.6%(69/391) Upper Respiratory Tract Infection: 4.2%(16/385) vs 3.8%(15/391)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>AstraZeneca2008¹⁴¹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US, Eastern Europe, Latin America</p> <p>Trial: SAPPHIRE</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 66</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 338</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 224</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Age >=66, DSM-IV diagnosis of MDD confirmed by MINI. HAM-D total score >=22, HAM-D item 1 score >=2 at both enrollment and randomization.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo 50-300 mg/days flexible dose for 9 weeks vs Quetiapine 50-300 mg/days flexible dose for 9 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 28 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 63 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 9 weeks: Quetiapine vs Placebo - RR = 2.48 (1.70 , 3.62)</p> <p>Depression : Change in MADRS (% Responder) at 9 weeks: Quetiapine vs Placebo - RR = 2.11 (1.63 , 2.71)</p> <p>Adverse Events: Placebo vs Quetiapine "drug-Related Ae": 39.5%(68/172) vs 62.7%(104/166) >=7% Weight Decrease: 1.2%(2/172) vs 0.0%(0/166) >=7% Weight Increase: 0.6%(1/172) vs 0.0%(0/166) AE Potentially Related To Diabetes (Blood Glucose Increased In Patient Who Was Being Treated For Type II Diabetes Prior To And During The Study): 0.0%(0/172) vs 0.6%(1/166) AE Potentially Related To Suicidality: 0.6%(1/172) vs 0.6%(1/166) AEs Potentially Related To Qt Prolongation, Neutropenia/Agranulocytosis, Syncope, Sexual Dysfunction, Or Cerebrovascular Accidents (Eva): 0.0%(0/172) vs 0.0%(0/166) Abdominal Pain Upper: 2.3%(4/172) vs 3.0%(5/166) Any AE: 61.0%(105/172) vs 80.7%(134/166) Asthenia: 0.6%(1/172) vs 3.6%(6/166) Back Pain: 1.2%(2/172) vs 2.4%(4/166) Clinically Important Shift To Low Neutrophil Count At End of Treatment: 0.0%(0/172) vs 1.2%(2/166) Constipation: 2.3%(4/172) vs 6.0%(10/166) Diarrhea: 7.0%(12/172) vs 5.4%(9/166) Dizziness: 15.1%(26/172) vs 19.3%(32/166) Dry Mouth: 10.5%(18/172) vs 20.5%(34/166) Dysgeusia: 0.6%(1/172) vs 2.4%(4/166) Edema Peripheral: 2.3%(4/172) vs 0.0%(0/166) Extrapyramidal Disorder: 0.6%(1/172) vs 3.6%(6/166) Extrapyramidal Symptoms (EPS) Through The End Of The Study: 2.3%(4/172) vs 9.0%(15/166) Fatigue: 4.1%(7/172) vs 7.8%(13/166) Headache: 16.3%(28/172) vs 21.1%(35/166) Hypertension: 2.3%(4/172) vs 1.2%(2/166) Hypotension: 0.0%(0/172) vs 2.4%(4/166) Hypothyroidism: 0.0%(0/172) vs 0.0%(0/166) Insomnia: 5.8%(10/172) vs 7.8%(13/166) Nasopharyngitis: 3.5%(6/172) vs 1.2%(2/166) Nausea: 4.7%(8/172) vs 5.4%(9/166) Pain In Extremity: 1.2%(2/172) vs 2.4%(4/166) Sedation: 1.2%(2/172) vs 4.8%(8/166) Serious AE Leading To Death: 0.0%(0/172) vs 0.0%(0/166) Serious Ae, All: 1.2%(2/172) vs 2.4%(4/166) Somnolence: 8.1%(14/172) vs 33.1%(55/166) Tachycardia: 2.3%(4/172) vs 1.2%(2/166) Treatment-Emergent Clinically Important Triglyceride Values: 5.8%(10/172) vs 13.9%(23/166) Treatment-Emergent Hypothyroidism Based On Clinically Important High Thyroid-Stimulating Hormone (Tsh) Values In Combination With Clinically Important Low Thyroxine (T4) Values: 0.0%(0/172) vs 0.0%(0/166)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>AstraZeneca2007¹³⁵</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: PEARL</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 19</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 446</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 344</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65 years old, DSM-IV diagnosis of MDD, confirmed by MINI, have been on treatment with an antidepressant ≥ 6 weeks, HAM-D total score ≥ 20, HAM-D item 1 score ≥ 2 at both enrollment and randomization.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 50-150 mg/days fixed titration schedule for 6 weeks vs Quetiapine 50-300 mg/days fixed titration schedule for 6 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 0-14 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 42, 56 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 6 weeks: Quetiapine vs Placebo - RR = 1.58 (1.15 , 2.19)</p> <p>Depression : Change in MADRS (% Responder) at 6 weeks: Quetiapine vs Placebo - RR = 1.58 (1.15 , 2.19)</p> <p>Adverse Events: Quetiapine 150 mg vs Placebo Shift To A Clinically Important High Glucose Level: 0.7%(1/148) vs 0.7%(1/148) Quetiapine 150 mg vs Quetiapine 300 mg vs Placebo "drug-Related Ae": 70.9%(105/148) vs 74.0%(111/150) vs 35.1%(52/148) $\geq 7\%$ Increase In Weight: 0.7%(1/148) vs 8.0%(12/150) vs 2.0%(3/148) A Potentially Clinically Important Shift To Qt Prolongation (≥ 60 Ms): 0.7%(1/148) vs 0.0%(0/150) vs 0.0%(0/148) A Shift From Normal To A Clinically Important Low Neutrophil Count: 0.7%(1/148) vs 0.0%(0/150) vs 0.7%(1/148) AEs Potentially Related To Diabetes: Polyuria With Thirst: 0.0%(0/148) vs 0.0%(0/150) vs 0.7%(1/148) AEs Potentially Related To Diabetes: Thirst Alone: 0.0%(0/148) vs 0.0%(0/150) vs 0.7%(1/148) Abdominal Distension: 0.7%(1/148) vs 2.0%(3/150) vs 0.7%(1/148) Abdominal Pain Upper: 0.7%(1/148) vs 0.0%(0/150) vs 2.7%(4/148) Abnormal Dreams: 2.7%(4/148) vs 2.7%(4/150) vs 1.4%(2/148) Aes Potentially Related To Diabetes: Thirst Alone: 0.0%(0/148) vs 0.7%(1/150) vs 0.0%(0/148) Agranulocytosis: 0.0%(0/148) vs 0.0%(0/150) vs 0.0%(0/148) Akathisia: 1.4%(2/148) vs 2.7%(4/150) vs 0.7%(1/148) Anxiety: 3.4%(5/148) vs 2.7%(4/150) vs 0.7%(1/148) Any AE: 82.4%(122/148) vs 86.7%(130/150) vs 66.9%(99/148) Arthralgia: 2.7%(4/148) vs 2.0%(3/150) vs 0.0%(0/148) Back Pain: 2.0%(3/148) vs 4.0%(6/150) vs 0.0%(0/148) Chills: 1.4%(2/148) vs 2.0%(3/150) vs 0.7%(1/148) Constipation: 7.4%(11/148) vs 10.7%(16/150) vs 3.4%(5/148) Decreased Appetite: 2.7%(4/148) vs 2.0%(3/150) vs 0.7%(1/148) Depression: 4.1%(6/148) vs 0.7%(1/150) vs 0.7%(1/148) Diarrhea: 6.8%(10/148) vs 6.7%(10/150) vs 6.8%(10/148) Disturbance In Attention: 2.0%(3/148) vs 2.7%(4/150) vs 2.7%(4/148) Dizziness: 11.5%(17/148) vs 14.0%(21/150) vs 5.4%(8/148) Dry Mouth: 35.1%(52/148) vs 44.0%(66/150) vs 8.8%(13/148) Dyspepsia: 1.4%(2/148) vs 2.7%(4/150) vs 2.0%(3/148) Extrapyramidal Symptoms (Akathisia, Cogwheel Rigidity, Drooling, Extrapyramidal Disorder, Psychomotor Hyperactivity, Restlessness, Tremor, Hypertonia): 3.4%(5/148) vs 8.0%(12/150) vs 3.4%(5/148) Fall: 2.0%(3/148) vs 0.7%(1/150) vs 0.7%(1/148) Fatigue: 15.5%(23/148) vs 6.7%(10/150) vs 4.7%(7/148) Gastroenteritis Viral: 0.0%(0/148) vs 1.3%(2/150) vs 2.0%(3/148) Gastroesophageal Reflux Disease: 0.7%(1/148) vs 2.0%(3/150) vs 0.0%(0/148) Headache: 14.2%(21/148) vs 7.3%(11/150) vs 13.5%(20/148) Hyperhidrosis: 3.4%(5/148) vs 2.0%(3/150) vs 0.7%(1/148) Hypersomnia: 2.0%(3/148) vs 2.0%(3/150) vs 0.0%(0/148)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>AstraZeneca2008¹⁴²</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: OPAL</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 310</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 219</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18 -65 years old, MDD confirmed by the MINI and DSM-IV, have a HAM-D \geq 22, HAM-D item1 score \geq 2 at both enrollment and randomization</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo 50-300 mg/days flexible dose for 8 weeks vs Quetiapine 50-300 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 0-28 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 56, 70 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 8 weeks: Quetiapine vs Placebo - RR = 1.39 (0.97 , 1.98)</p> <p>Depression : Change in MADRS (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 1.29 (1.05 , 1.59)</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4490)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>AstraZeneca2007¹³⁸</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Canada, Western Europe, Asia, Latin America, South Africa</p> <p>Trial: AMBER D1448C00004</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 18</p> <p>Sex: Mixed</p> <p>Race: Caucasian, African Ancestry, Asian/Pacific Islander, Other-NOS</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 471</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 223</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: 18-65 years old, DSM-IV diagnosis of MDD, HAM-D score >=22, HAM-D item 1 score >=2</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 9 weeks vs Quetiapine 50-300 mg/days flexible dose for 9 weeks vs Escitalopram 10-20 mg/days flexible dose for 9 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 7-28 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 14, 56, 70 days</p>	<p>Results: Depression : Change in MADRS (% Remitted) at 8 weeks: Quetiapine vs Placebo - RR = 1.01 (0.75 , 1.37)</p> <p>Depression : Change in MADRS (% Responder) at 8 weeks: Quetiapine vs Placebo - RR = 1.18 (0.97 , 1.45)</p> <p>Adverse Events: Escitalopram vs Placebo vs Quetiapine "drug-Related Ae": 67.5%(106/157) vs 51.6%(81/157) vs 79.6%(125/157) Abdominal Distension: 3.2%(5/157) vs 2.5%(4/157) vs 2.5%(4/157) Abdominal Pain: 3.8%(6/157) vs 3.2%(5/157) vs 4.5%(7/157) Abdominal Pain Upper: 3.2%(5/157) vs 3.8%(6/157) vs 5.7%(9/157) Akathisia: 3.2%(5/157) vs 0.6%(1/157) vs 1.3%(2/157) Anxiety: 4.5%(7/157) vs 2.5%(4/157) vs 7.6%(12/157) Any AE: 80.9%(127/157) vs 72.6%(114/157) vs 86.6%(136/157) Arthralgia: 0.6%(1/157) vs 3.2%(5/157) vs 5.1%(8/157) Chills: 0.6%(1/157) vs 0.6%(1/157) vs 3.2%(5/157) Constipation: 8.3%(13/157) vs 4.5%(7/157) vs 12.7%(20/157) Cough: 3.2%(5/157) vs 1.3%(2/157) vs 3.2%(5/157) Deaths: 0.0%(0/157) vs 0.0%(0/157) vs 0.0%(0/157) Decreased Appetite: 3.2%(5/157) vs 1.9%(3/157) vs 2.5%(4/157) Diarrhea: 12.1%(19/157) vs 7.0%(11/157) vs 12.1%(19/157) Dizziness: 18.5%(29/157) vs 14.0%(22/157) vs 33.8%(53/157) Dry Mouth: 14.0%(22/157) vs 8.3%(13/157) vs 38.2%(60/157) Dyspepsia: 3.2%(5/157) vs 5.7%(9/157) vs 7.6%(12/157) Dyspnea: 0.6%(1/157) vs 2.5%(4/157) vs 3.2%(5/157) Extrapyramidal Disorder: 9.6%(15/157) vs 5.1%(8/157) vs 8.3%(13/157) Fatigue: 8.9%(14/157) vs 5.1%(8/157) vs 12.1%(19/157) Gastroenteritis: 0.6%(1/157) vs 3.2%(5/157) vs 1.9%(3/157) Headache: 31.2%(49/157) vs 31.2%(49/157) vs 26.1%(41/157) Hot Flush: 4.5%(7/157) vs 1.3%(2/157) vs 3.2%(5/157) Hyperhidrosis: 7.6%(12/157) vs 5.7%(9/157) vs 5.1%(8/157) Hypersomnia: 1.3%(2/157) vs 0.6%(1/157) vs 5.7%(9/157) Increased Appetite: 1.9%(3/157) vs 3.8%(6/157) vs 7.0%(11/157) Influenza: 1.9%(3/157) vs 2.5%(4/157) vs 5.1%(8/157) Insomnia: 14.6%(23/157) vs 14.0%(22/157) vs 14.0%(22/157) Irritability: 5.1%(8/157) vs 5.1%(8/157) vs 5.7%(9/157) Musculoskeletal Stiffness: 1.9%(3/157) vs 1.9%(3/157) vs 3.2%(5/157) Myalgia: 7.6%(12/157) vs 3.8%(6/157) vs 7.0%(11/157) Nasal Congestion: 0.0%(0/157) vs 0.6%(1/157) vs 2.5%(4/157) Nasopharyngitis: 4.5%(7/157) vs 5.7%(9/157) vs 1.3%(2/157) Nausea: 29.9%(47/157) vs 19.1%(30/157) vs 21.7%(34/157) Pain In Extremity: 3.8%(6/157) vs 0.6%(1/157) vs 1.9%(3/157) Palpitations: 5.1%(8/157) vs 3.8%(6/157) vs 3.8%(6/157) Paraesthesia: 2.5%(4/157) vs 1.3%(2/157) vs 2.5%(4/157) Rash: 0.6%(1/157) vs 0.0%(0/157) vs 3.2%(5/157) Restlessness: 1.9%(3/157) vs 0.6%(1/157) vs 2.5%(4/157) Sedation: 5.1%(8/157) vs 3.2%(5/157) vs 10.8%(17/157)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Vulink et al.2007¹⁷⁵</p> <p>OCD</p> <p>Quetiapine</p> <p>Location: Western Europe</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Single setting</p> <p>Jadad: 3</p> <p>Age: Not reported</p> <p>Sex: Mixed</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 76</p> <p>Withdrawn: 12</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 64</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Diagnosed DSM-IV OCD</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 10 weeks vs Quetiapine <=450 mg/days frequency not reported for 10 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: days</p>	<p>Results: OCD: Duplicate data</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Earley et al.2008¹²²</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US, Canada, Western Europe, Asia, South Africa</p> <p>Trial: Amber D1448C00004</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: 660 Eligible: NR Entering: NR Withdrawn: NR Lost to follow-up: NR Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Same as # 4497</p> <p>Exclusion criteria: Any other DSM-IV Axis I disorder within 6 month, any DSM-IV Axis II disorder impacting psychiatric status, current MDD episode >= 12 month or < 4 weeks, substance abuse, HAM-D item 3 score >= 3</p> <p>Interventions: Placebo dosage not reported for 8 weeks vs Quetiapine 50-300 mg/days flexible dose for 8 weeks vs Escitalopram 10-20 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Wash-out: No drug for 28 day(s). Patients still eligible after washout were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42, 56 days</p>	<p>Results: Depression: Duplicate data</p> <p>Depression: Duplicate data</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4497)</p>

Appendix D Evidence Tables For Augmentation trials
Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>El-Khalili et al.¹²¹</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: US</p> <p>Trial: pearl D1448C00006</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 446</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Same with #4495</p> <p>Exclusion criteria: Any DSM-IV Axis I disorder other than MDD within 6 month, any DSM-IV Axis II disorder impacting psychiatric status, current MDD episode > 12 month or < 4 weeks, HAM-D item 3 score >= 3, substance abuse, significant medical disease</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Quetiapine 150 mg/days frequency not reported for 6 weeks vs Quetiapine 300 mg/days frequency not reported for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 28, 42 days</p>	<p>Results: Depression: Duplicate data</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4495)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Katila et al.Nove¹²³</p> <p>Depression</p> <p>Quetiapine</p> <p>Location: Not reported</p> <p>Trial: sapphire D1448C00014</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Mean: 66</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 338</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored, reported spontaneously by patient</p>	<p>Inclusion criteria: ≥ 66 years old, DSM-IV diagnosis of MDD, HAM-D total score ≥ 22, HAM-D item I score ≥ 2, outpatient</p> <p>Exclusion criteria: MMSE ≤ 25, dementia or mild cognitive impairment, DSM-IV Axis I disorder other than MDD within 6 months, any DSM-IV Axis II disorder impacting psychiatric status, current depressive episode < 4 weeks or > 12 months, HAM-D item score ≥ 3, history of inadequate response to 6 weeks treatment with ≥ 2 classes of antidepressants.</p> <p>Interventions: Placebo 500-300 mg/days flexible dose for 9 weeks vs Quetiapine 50-300 mg/days flexible dose for 9 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56, 63 days</p>	<p>Results: Depression: Duplicate data</p> <p>Adverse Events: Excluded from analysis: Duplicate data (4494)</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Gharabawi et al.2006¹⁴⁷</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 274</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Monitored</p>	<p>Inclusion criteria: Adult outpatients with DSM-IV MDD, had an incomplete response to \geq 8 weeks of antidepressant treatment</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo 0.25-2 mg/days average final dose for 6 weeks vs Risperidone 0.25-2 mg/days flexible dose for 6 weeks</p> <p>Run-in/wash-out period: Not reported</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 42 days</p>	<p>Results: Depression : Change in HAM-D (% Remitted) at 6 weeks: Risperidone vs Placebo - RR = 2.03 (1.10 , 3.75)</p> <p>Depression : Change in HAM-D (% Responder) at 6 weeks: Risperidone vs Placebo - RR = 1.44 (1.03 , 2.01)</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Thase et al.2007¹⁴⁸</p> <p>Depression</p> <p>Olanzapine</p> <p>Location: US, Canada</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Multi-center</p> <p>Jadad: 3</p> <p>Age: Mean: 44</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 1313</p> <p>Eligible: 605</p> <p>Entering: 605</p> <p>Withdrawn: 146</p> <p>Lost to follow-up: 18</p> <p>Analyzed: 441</p> <p>Method of AE assessment: Not applicable</p>	<p>Inclusion criteria: Treatment resistant depression, 18-65 years old, HAM-D-17 \geq22</p> <p>Exclusion criteria: Current / post schizophrenia, other psychotic disorders, PTSD, pregnant or nursing females, post partum depression, MDD with atypical features, paranoid, schizoid, personality disorders, significant medical illness, concomitant medications with primary central nervous system activity except lorazepam with dose up to 4mg / week</p> <p>Interventions: Olanzapine, Naltrexone 6-18 mg/days flexible dose for 8 weeks vs Olanzapine 6-18 mg/days flexible dose for 8 weeks vs Naltrexone 50 mg/days flexible dose for 8 weeks</p> <p>Run-in/wash-out period: Run-in: Fluoxetine for 8 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 7, 14, 21, 28, 35, 42, 49, 56 days</p>	<p>Results: Depression : Change in MADRS at 8 weeks: Olanzapine+Fluoxetine vs Fluoxetine - WMD = -3.40 (-5.35 , -1.45)</p> <p>Depression : Change in MADRS at 8 weeks: Olanzapine+Fluoxetine vs Olanzapine - WMD = -3.70 (-5.60 , -1.80)</p> <p>Depression : Change in MADRS at 8 weeks: Olanzapine vs Fluoxetine - WMD = 0.30 (-1.52 , 2.12)</p> <p>Adverse Events: Fluoxetine vs Olanzapine vs Olanzapine/fluoxetine Deaths: 0.0%(0/206) vs 0.0%(0/199) vs 0.0%(0/200) Dry Mouth: 8.7%(18/206) vs 31.7%(63/199) vs 28.5%(57/200) Fatigue: 7.8%(16/206) vs 14.1%(28/199) vs 14.0%(28/200) Headache: 19.4%(40/206) vs 13.1%(26/199) vs 12.5%(25/200) Hypersomnia: 2.4%(5/206) vs 11.1%(22/199) vs 10.5%(21/200) Increase In Nonfasting Glucose From 140 To <200 mg/dL At Baseline To =200 mg/dL At Endpoint: 0.5%(1/206) vs 1.5%(3/199) vs 2.5%(5/200) Increase In Nonfasting Glucose From <140 mg/dL At Baseline To =200 mg/dL At Endpoint: 3.4%(7/206) vs 3.5%(7/199) vs 1.5%(3/200) Increase In Total Cholesterol From <200 mg/dL At Baseline To =240 mg/dL At Endpoint: 1.5%(3/206) vs 2.5%(5/199) vs 3.5%(7/200) Increase In Triglycerides From <150 mg/dL At Baseline To =500 mg/dL At Endpoint: 0.0%(0/206) vs 0.5%(1/199) vs 0.0%(0/200) Increased Appetite: 5.8%(12/206) vs 30.7%(61/199) vs 32.0%(64/200) Peripheral Edema: 1.0%(2/206) vs 7.5%(15/199) vs 12.0%(24/200) Serious AEs: Bipolar Disorder: 0.0%(0/206) vs 0.0%(0/199) vs 0.5%(1/200) Serious AEs: Pyrexia: 0.0%(0/206) vs 0.0%(0/199) vs 0.5%(1/200) Somnolence: 5.3%(11/206) vs 12.1%(24/199) vs 17.5%(35/200) Tremor: 8.7%(18/206) vs 8.0%(16/199) vs 10.5%(21/200) Weight Increased: 6.8%(14/206) vs 39.7%(79/199) vs 35.0%(70/200)</p> <p>Withdrawals: Fluoxetine vs Olanzapine vs Olanzapine/fluoxetine Withdrawals:19.4%(40/206) vs 36.2%(72/199) vs 26.0%(52/200) Withdrawals Due To Adverse Events:2.4%(5/206) vs 16.1%(32/199) vs 13.5%(27/200)</p>

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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Nemeroff et al.2004¹⁴³</p> <p>Depression</p> <p>Risperidone</p> <p>Location: US</p> <p>Trial: Not reported</p> <p>Funding source: Industry</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: 241</p> <p>Withdrawn: 23</p> <p>Lost to follow-up: NR</p> <p>Analyzed: 218</p> <p>Method of AE assessment: Not reported</p>	<p>Inclusion criteria: Inpatients or outpatients aged 18-85 years old, DSM-IV diagnosis of MDD, 17-item HAM-D score \geq 20, failed to respond to 1-3 antidepressants other than citalopram or escitalopram given at least 6 weeks.</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 24 weeks vs Risperidone dosage not reported for 24 weeks</p> <p>Run-in/wash-out period: Run-in: Citalopram for 4-6 week(s). Non-responders were randomized.</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 168 days</p>	<p>Results: Depression : Change in Proportion of patients that relapsed at 24 weeks: Risperidone + Citalopram vs Placebo +Citalopram - RR = 1.04 (0.82 , 1.31)</p>

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Evidence

Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Zeni et al.2009⁶²</p> <p>ADHD</p> <p>Aripiprazole</p> <p>Location: Latin America</p> <p>Trial: Not reported</p> <p>Funding source: Government, Hospital</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Mean: 8</p> <p>Sex: Mixed</p> <p>Race: Caucasian, Other-NOS</p> <p>Screened: 710 Eligible: 16 Entering: 16 Withdrawn: 1 Lost to follow-up: 0 Analyzed: 15</p> <p>Method of AE assessment: Monitored, elicited by investigator</p>	<p>Inclusion criteria: Age 8-17, diagnosed borderline personality disorder co-morbid ADHD \geq 30% improvement in mood symptoms in the previous trial of ARI, SNAP-IV score \geq1.5</p> <p>Exclusion criteria: IQ < 70, use of medication besides ARI 10 weeks before entering study, pervasive developmental disorder, schizophrenia, substance abuse, suicidal, hypersensitive to ARI / MPH, pregnancy, acute or chronic disease</p> <p>Interventions: Aripiprazole 5-20 mg/days fixed single dose for 2 weeks vs Aripiprazole, Methylphenidate 5-20 mg/days fixed single dose for 2 weeks</p> <p>Run-in/wash-out period: Run-in: Aripiprazole plus placebo for 12 week(s). Patients who met the study criteria were randomized.</p> <p>Comorbidities: Anxiety</p> <p>Timing of outcome assessment: 7, 14 days</p>	<p>Results: ADHD: Cross over study</p>

Appendix D Evidence Tables For Augmentation trials
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Citation and Study Information	Eligibility, Interventions, Outcomes	Results, Adverse Events, and Withdrawals
<p>Kim et al.2007¹²⁶</p> <p>Depression</p> <p>Aripiprazole</p> <p>Location: Not reported</p> <p>Trial: Not reported</p> <p>Funding source: Not reported</p> <p>Design: RCT only</p> <p>Setting: Not reported</p> <p>Jadad: 2</p> <p>Age: Not reported</p> <p>Sex:</p> <p>Race: Not reported</p> <p>Screened: NR</p> <p>Eligible: NR</p> <p>Entering: NR</p> <p>Withdrawn: NR</p> <p>Lost to follow-up: NR</p> <p>Analyzed: NR</p> <p>Method of AE assessment: Not applicable</p>	<p>Inclusion criteria: MDD, incomplete response to at least one historical treatment and one prospective treatment</p> <p>Exclusion criteria: Not reported</p> <p>Interventions: Placebo dosage not reported for 6 weeks vs Aripiprazole 2-20 mg/days frequency not reported for 6 weeks</p> <p>Run-in/wash-out period: Run-in: Antidepressants plus placebo for 8 week(s).</p> <p>Comorbidities: None</p> <p>Timing of outcome assessment: 42 days</p>	<p>Results: Depression: Insufficient data to calculate an effect size</p>

Appendix D Evidence Tables For Augmentation trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Keitner et al.2009 ¹⁴⁵ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Mahmoud et al.2007 ¹⁴⁶ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Maina et al.2008 ¹⁶⁷ OCD Olanzapine, Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Single blind, outcome assessment</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Savas et al.2008 ¹⁶⁸ OCD Quetiapine, Ziprasidone	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Bauer et al.2009 ¹³⁶ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Cutler et al.2009 ¹³⁴ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Appendix D Evidence Tables For Augmentation trials
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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
de Geus et al.2007 ¹⁶⁹ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Garakani et al.2008 ¹³² Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Kordon et al.2008 ¹⁷⁰ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Matsunaga et al.2009 ¹⁷¹ OCD Olanzapine, Quetiapine, Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
McIntyre et al.2007 ⁶⁷ Anxiety, Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Vulink et al.2009 ¹⁷² OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Weisler et al.2009 ¹³⁷ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Berman et al.2009 ¹²⁹ Depression Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Chaput et al.2008 ¹³¹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Diniz et al.2009 ¹⁷³ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Reeves et al.2008 ¹⁴⁴ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? No</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Marcus et al.2008 ¹²⁷ Depression Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Dunner et al.2007 ¹⁵⁰ Depression Ziprasidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Alexopoulos et al.2008 ¹²⁵ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Yes</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? No</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Doree et al.2007 ¹⁴⁹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Gerra et al.2006 ²⁴⁰ Substance abuse Olanzapine	<p>Was the study described as randomized? No</p> <p>Was the method of randomization adequate? No</p> <p>Was the treatment allocation concealed? No</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Berman et al.2007 ¹²⁸ Depression Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Yes</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Montgomery et al.2008 ¹²⁰ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Zheng et al.2007 ¹³⁰ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Open</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? No</p> <p>Was the care provider masked? No</p> <p>Were patients masked? No</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Mattingly et al.2006 ¹³³ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Datto et al.2008 ¹³⁹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Denys et al.2006 ¹⁷⁴ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Hussain et al.2005 ¹⁵¹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
El-Khalili et al.2008 ¹²⁴ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
AstraZeneca2008 ¹⁴⁰ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
AstraZeneca2008 ¹⁴¹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
AstraZeneca2007 ¹³⁵ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
AstraZeneca2008 ¹⁴² Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

AE=Adverse Event, NR=Not Reported

Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
AstraZeneca2007 ¹³⁸ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Yes</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Vulink et al.2007 ¹⁷⁵ OCD Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Earley et al.2008 ¹²² Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
El-Khalili et al. ¹²¹ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Katila et al.Nove ¹²³ Depression Quetiapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Gharabawi et al.2006 ¹⁴⁷ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Thase et al.2007 ¹⁴⁸ Depression Olanzapine	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Yes</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? No</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Nemeroff et al.2004 ¹⁴³ Depression Risperidone	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? No</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

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Appendix D Evidence Tables For Augmentation trials
Quality

Study	Treatment allocation	Groups similar at baseline?	Blinding	Dropouts	Other sources of potential bias
Zeni et al.2009 ⁶² ADHD Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Not described</p> <p>If reported, was the method of double-blinding appropriate? Not applicable</p> <p>Was the outcome assessor masked? Don't know</p> <p>Was the care provider masked? Don't know</p> <p>Were patients masked? Don't know</p>	<p>Was the dropout rate described and the reason given? Yes</p> <p>Was the dropout rate acceptable? Yes</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Yes</p> <p>Was the compliance acceptable in all groups? Yes</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>
Kim et al.2007 ¹²⁶ Depression Aripiprazole	<p>Was the study described as randomized? Yes</p> <p>Was the method of randomization adequate? Don't know</p> <p>Was the treatment allocation concealed? Don't know</p>	<p>Were groups similar at baseline? Don't know</p>	<p>How is blinding described? Double blind</p> <p>If reported, was the method of double-blinding appropriate? Not described</p> <p>Was the outcome assessor masked? Yes</p> <p>Was the care provider masked? Yes</p> <p>Were patients masked? Yes</p>	<p>Was the dropout rate described and the reason given? Don't know</p> <p>Was the dropout rate acceptable? Don't know</p> <p>Were all randomized participants analyzed? Yes</p>	<p>Were cointerventions avoided or similar? Don't know</p> <p>Was the compliance acceptable in all groups? Don't know</p> <p>Was the outcome assessment timing similar in all groups? Yes</p>

Appendix F. Excluded Studies:

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Reject Descriptive:

1. Postmarket Drug Safety Information for Patients and Providers. FDA Public Health Advisory; [cited 2009 Dec 12]; Available from: <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm>.
2. Alanen HMF-S, H. Fialova, D. Topinkova, E. Jonsson, P. V. Soerbye, L. W. Bernabei, R. Leinonen, E. Use of antipsychotic medications in older home-care patients. Report from nine European countries. *Aging Clin Exp Res*. 2008 Jun;20(3):260-5.
3. Alanen HMF-S, H. Noro, A. Leinonen, E. Use of antipsychotic medications among elderly residents in long-term institutional care: a three-year follow-up. *International Journal of Geriatric Psychiatry*. 2006;21(3):288-95.
4. Bagepally BSP, O. Nonsignificant weight gain with atypical antipsychotics in men with Alzheimer's Disease: an important result of the CATIE-Alzheimer's disease study. *Am J Psychiatry*. 2009 Sep;166(9):1063-4; author reply 4-5.
5. Barbarich-Marsteller NCK, Walter H. 'An Open Trial of Olanzapine in Anorexia Nervosa': Reply. *Journal of Clinical Psychiatry*. 2005 May, 2005;66(5):655-6.
6. Barbui CC, A. Nosé, M. Patten, S. B. Stegagno, M. Burti, L. Amaddeo, F. Tansella, M. Off-label and non-classical prescriptions of antipsychotic agents in ordinary in-patient practice. *Acta Psychiatrica Scandinavica*. 2004;109(4):275-8.
7. Blier P. Atypical antipsychotics for mood and anxiety disorders: safe and effective adjuncts? *J Psychiatry Neurosci*. 2005 Jul;30(4):232-3.
8. Blier PS, S. T. Potential mechanisms of action of atypical antipsychotic medications in treatment-resistant depression and anxiety. *J Clin Psychiatry*. 2005;66 Suppl 8:30-40.
9. Bloch MHL-W, A. Kelmendi, B. Coric, V. Bracken, M. B. Leckman, J. F. A systematic review: Antipsychotic augmentation with treatment refractory obsessive-compulsive disorder: Corrigendum. *Molecular Psychiatry*. 2006 Aug, 2006;11(8):795.
10. Bronskill SEA, G. M. Sykora, K. Wodchis, W. P. Gill, S. Shulman, K. I. Rochon, P. A. Neuroleptic Drug Therapy in Older Adults Newly Admitted to Nursing Homes: Incidence, Dose, and Specialist Contact. *Journal of the American Geriatrics Society*. 2004;52(5):749-55.
11. Callaly TT, Tom. Patterns of use of antipsychotic medication in a regional community mental health service. *Australasian Psychiatry: Publication of The Royal Australian and New Zealand College of Psychiatrists*. 2000;8(3):220 - 4.
12. Carroll BJ. Aripiprazole in refractory depression? *J Clin Psychopharmacol*. 2009 Feb;29(1):90-1; author reply 2-3.
13. Cleare A. Adjunctive aripiprazole improves symptoms in antidepressant refractory major depressive disorder. *Evid Based Ment Health*. 2008 Nov;11(4):111.
14. Dawes J. Chemical straightjackets in a care home near you. *Br J Community Nurs*. 2008 Jul 4;13(7):301-Unknown.
15. Duggal HSS, Ira. Letter to the Editor: Ziprasidone and Hypomania. *CNS Spectrums*. 2005 Aug, 2005;10(8):606.
16. Erman MK. Is it a sleeping pill? *Primary Psychiatry*. 2008 Jan, 2008;15(1):34-6.

17. Gardner TJK, T. R. Human laboratory and neuroimaging studies in substance use disorders: developing new treatment approaches. *Am J Drug Alcohol Abuse*. 2007;33(6):765-7.
18. Gill SSS, Dallas Rochon, Paula A. Atypical Antipsychotic Drugs, Dementia, and Risk of Death. *JAMA*. 2006 February 1, 2006;295(5):495-a-6.
19. Haw CS, J. A survey of off-label prescribing for inpatients with mild intellectual disability and mental illness. *J Intellect Disabil Res*. 2005 Nov;49(Pt 11):858-64.
20. Haw CY, Graeme Stubbs, Jean. Guidelines on antipsychotics for dementia: Are we losing our minds? *Psychiatric Bulletin*. 2009 Feb, 2009;33(2):57-60.
21. Health Canada CADRMP, Marketed Health Products Directorate,. Important drug safety information:RISPERDAL(risperidone) and cerebrovascular adverse events in placebo-controlled dementia trials— Janssen-Ortho: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/medeff/risperdal_hpc-cps-eng.pdf; 2002 Contract No.: Document Number|.
22. Jaffe A, B. Levine, Jerome. Antipsychotic medication coprescribing in a large state hospital system. *Pharmacoepidemiology and Drug Safety*. 2003;12(1):41-8.
23. Keenan K. Antipsychotics in disruptive behavior disorders and ADHD. *J Am Acad Child Adolesc Psychiatry*. 2005 Oct;44(10):969-70; author reply 70-1.
24. Keks NAA, Kylie Hope, Judy Krapivensky, Natalie Culhane, Christine Tanaghaw, Amgad Doherty, Peter Bootle, Anne. Use of antipsychosis and adjunctive medications by an inner urban community psychiatric service. *Australian and New Zealand Journal of Psychiatry*. 1999;33(6):896-901.
25. Kerrsens CJP, Y. A. L. Vulnerability to neuroleptic side effects in frontotemporal dementia. *European Journal of Neurology*. 2008 Feb, 2008;15(2):111-2.
26. Khazaal YC, A. Khan, R. Zullino, D. Quetiapine dosage across diagnostic categories. *Psychiatr Q*. 2009 Mar;80(1):17-22.
27. Kopecek MM, P. Novak, T. Sedative effects of low-dose risperidone in GAD patients and risk of drug interactions. *J Clin Psychiatry*. 2006 Aug;67(8):1307-8; author reply 8-9.
28. Kozaric-Kovacic D. Pharmacotherapy treatment of PTSD and comorbid disorders. *Psychiatr Danub*. 2009 Sep;21(3):411-4.
29. Kuehn BM. FDA panel issues mixed decision on quetiapine in depression and anxiety. *JAMA*. 2009 May 27;301(20):2081-2.
30. Lakey SLG, Shelly L. Sales, Anne E. B. Sullivan, Jean Hedrick, Susan C. Psychotropic use in community residential care facilities: A prospective cohort study. *The American Journal of Geriatric Pharmacotherapy*. 2006;4(3):227-35.
31. Leiderman DBS, S. Montgomery, A. Bloch, D. A. Elkashef, A. LoCastro, J. Vocci, F. Cocaine Rapid Efficacy Screening Trial (CREST): a paradigm for the controlled evaluation of candidate medications for cocaine dependence. *Addiction*. 2005 Mar;100 Suppl 1:1-11.
32. Liperoti R. Starting a conventional antipsychotic increases risk of death more than an atypical antipsychotic in elderly people with dementia. *Evid Based Ment Health*. 2009 May;12(2):58.
33. Mauri MCR, Francesca Beraldo, Scilla Volonteri, Lucia S. Ferrari, Veronica M. Fiorentini, Alessio Invernizzi, Giordano. Patterns of clinical use of antipsychotics in

hospitalized psychiatric patients. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*. 2005;29(6):957-63.

34. Menaster M. Use of olanzapine in anorexia nervosa. *J Clin Psychiatry*. 2005 May;66(5):654-5; author reply 5-6.
35. Mintzer JE. 'Significance of findings in aripiprazole for treatment of psychoses in Alzheimer dementia': Reply. *The American Journal of Geriatric Psychiatry*. 2008 Jul, 2008;16(7):614.
36. Nakajima SS, Takefumi Watanabe, Koichiro Kashima, Haruo Uchida, Hiroyuki. Potential risks of adjunctive use of atypical antipsychotic drugs for the treatment of depression. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*. [doi: DOI: 10.1016/j.pnpbp.2009.12.023]. 2010;34(2):435-6.
37. Nishtala PSM, A. J. Bell, J. S. Chen, T. F. Determinants of antipsychotic medication use among older people living in aged care homes in Australia. *Int J Geriatr Psychiatry*. 2009 Aug 10.
38. No authorship i. International Addictions Infoline. *Journal of Psychoactive Drugs*. 2004 Sep, 2004;36(3):403-5.
39. Norris MLS, W. Buchholz, A. Henderson, K. A. Challenges Associated with Controlled Psychopharmacological Research Trials in Adolescents with Eating Disorders. *J Can Acad Child Adolesc Psychiatry*. 2007 Nov;16(4):167-72.
40. Nose M. No significant difference between olanzapine and placebo for improvement in borderline personality disorder symptoms. *Evid Based Ment Health*. 2009 Aug;12(3):89.
41. Nunes EVD, S. Fischman, M.W. Risperidone for cocaine dependence: an early phase II clinical trial. 1999 [updated 1999; cited 4/9/10]; Available from: <http://clinicaltrials.gov/ct2/show/NCT00000317>.
42. Raivio MML, Jouko V. Strandberg, Timo E. Tilvis, Reijo S. Pitkala, Kaisu H. Neither Atypical Nor Conventional Antipsychotics Increase Mortality or Hospital Admissions Among Elderly Patients With Dementia: A Two-Year Prospective Study. [Article]. *American Journal of Geriatric Psychiatry*. 2007;15(5):416–24.
43. Rijcken CAB, G. J. Slooff, C. J. Beuger, P. J. Tanja, T. A. de Jong-van den Berg, L. T. Off-label use of antipsychotics in the community pharmacy: the sex differences. *Pharmacopsychiatry*. 2003 Sep;36(5):187-91.
44. Rochon PAS, Therese A. Bronskill, Susan E. Gomes, Tara Sykora, Kathy Wodchis, Walter P. Hillmer, Michael Kopp, Alexander Gurwitz, Jerry H. Anderson, Geoffrey M. Variation in Nursing Home Antipsychotic Prescribing Rates. *Arch Intern Med*. 2007 April 9, 2007;167(7):676-83.
45. Rosenheck RAL, Douglas L. Sindelar, Jody L. Miller, Edward A. Tariot, Peter N. Dagerman, Karen S. Davis, Sonia M. Lebowitz, Barry D. Rabins, Peter Hsiao, John K. Lieberman, Jeffery A. Schneider, Lon S. for the Clinical Antipsychotic Trial of Intervention Effectiveness Alzheimer's Disease investigators,. Cost-Benefit Analysis of Second-Generation Antipsychotics and Placebo in a Randomized Trial of the Treatment of Psychosis and Aggression in Alzheimer Disease. *Arch Gen Psychiatry*. 2007 November 1, 2007;64(11):1259-68.
46. Spettigue WB, Annick Henderson, Katherine Feder, Stephen Moher, David Kourad, Kader Gaboury, Isabelle Norris, Mark Ledoux, Sheila. Evaluation of the efficacy and safety of olanzapine as an adjunctive treatment for anorexia nervosa in adolescent

- females: a randomized, double-blind, placebo-controlled trial. *BMC Pediatrics*. 2008;8(1):4.
47. Spier SA. Use of atypical antipsychotics: observations from clinical practice. *J Clin Psychiatry*. 2006 Mar;67(3):490-1.
 48. Suh GH. The use of atypical antipsychotics in dementia: rethinking Simpson's paradox. *Int Psychogeriatr*. 2009 Aug;21(4):616-21.
 49. Traynor K. FDA advisers wary of expanding quetiapine use: clinicians air concerns about metabolic effects, tardive dyskinesia. *Am J Health Syst Pharm*. 2009 May 15;66(10):880, 2.
 50. Trifiro GS, E. Brignoli, O. Sessa, E. Caputi, A. P. Mazzaglia, G. Antipsychotic prescribing pattern among Italian general practitioners: a population-based study during the years 1999-2002. *Eur J Clin Pharmacol*. 2005 Mar;61(1):47-53.
 51. Tsai AC. Unclear clinical significance of findings in adjunctive aripiprazole for major depressive disorder: comments on article by Marcus et al. *J Clin Psychopharmacol*. 2009 Feb;29(1):91-2; author reply 2-3.
 52. Westenberg HG. Recent advances in understanding and treating social anxiety disorder. *CNS Spectr*. 2009 Feb;14(2 Suppl 3):24-33.
 53. Wheeler A. Atypical antipsychotic use for adult outpatients in New Zealand's Auckland and Northland regions. *N Z Med J*. 2006;119(1237):U2055.
 54. Yatham LNK, S. H. Lam, R. W. Advances in treatment of mood and anxiety disorders: focus on atypical antipsychotics. *Bipolar Disord*. 2003;5 Suppl 2:5-6.

Reject, Non Systematic Review:

1. Ahearn EPK, A. Connor, K. M. Davidson, J. R. Pharmacologic treatment of posttraumatic stress disorder: a focus on antipsychotic use. *Ann Clin Psychiatry*. 2003 Sep-Dec;15(3-4):193-201.
2. Aman MGB, C. Turgay, A. Risperidone effects in the presence/absence of psychostimulant medicine in children with ADHD, other disruptive behavior disorders, and subaverage IQ. *J Child Adolesc Psychopharmacol*. 2004 Summer;14(2):243-54.
3. Asnis GMK, S. R. Henderson, M. Brown, N. L. SSRIs versus non-SSRIs in post-traumatic stress disorder: an update with recommendations. *Drugs*. 2004;64(4):383-404.
4. Assal FvdM, M. Pharmacological interventions in primary care: hopes and illusions. *Front Neurol Neurosci*. 2009;24:54-65.
5. Ballard CC, A. Chitramohan, R. Aarsland, D. Management of agitation and aggression associated with Alzheimer's disease: controversies and possible solutions. *Curr Opin Psychiatry*. 2009 Nov;22(6):532-40.
6. Ballard CGG, S. Cummings, J. L. Brodaty, H. Grossberg, G. T. Robert, P. Lyketsos, C. G. Management of agitation and aggression associated with Alzheimer disease. *Nat Rev Neurol*. 2009 May;5(5):245-55.
7. Bandelow B. The medical treatment of obsessive-compulsive disorder and anxiety. *CNS Spectr*. 2008 Sep;13(9 Suppl 14):37-46.
8. Baune BT. New developments in the management of major depressive disorder and generalized anxiety disorder: role of quetiapine. *Neuropsychiatr Dis Treat*. 2008 Dec;4(6):1181-91.

9. Bellino SP, E. Bogetto, F. Efficacy and tolerability of pharmacotherapies for borderline personality disorder. *CNS Drugs*. 2008;22(8):671-92.
10. Bishara DT, D. Howard, R. J. Abdel-Tawab, R. Expert opinion on the management of behavioural and psychological symptoms of dementia (BPSD) and investigation into prescribing practices in the UK. *Int J Geriatr Psychiatry*. 2009 Sep;24(9):944-54.
11. Bobo WVS, R. C. Fluoxetine and olanzapine combination therapy in treatment-resistant major depression: review of efficacy and safety data. *Expert Opin Pharmacother*. 2009 Sep;10(13):2145-59.
12. Bobo WVS, R. C. Olanzapine and fluoxetine combination therapy for treatment-resistant depression: review of efficacy, safety, and study design issues. *Neuropsychiatr Dis Treat*. 2009 Jul;5(3):369-83.
13. Boulton DB, A. Royzman, K. Patel, C. Berman, R. Mallikaarjun, S. Reeves, R. The pharmacokinetics of standard antidepressants with aripiprazole as adjunctive therapy: studies in healthy subjects and in patients with major depressive disorder. *J Psychopharmacol*. 2008 Oct 2.
14. Broadway JM, Jacobo. The many faces of psychosis in the elderly. *Current Opinion in Psychiatry*. 2007 Nov, 2007;20(6):551-8.
15. Brooke NSW, M. Salzman, C. Atypical uses of atypical antipsychotics. *Harv Rev Psychiatry*. 2005 Nov-Dec;13(6):317-39.
16. Brown ES. Management of comorbid bipolar disorder and substance abuse. *J Clin Psychiatry*. 2006 Aug;67(8):e05.
17. Burke ADT, P. N. Atypical antipsychotics in the elderly: a review of therapeutic trends and clinical outcomes. *Expert Opin Pharmacother*. 2009 Oct;10(15):2407-14.
18. Carvalho AFC, J. L. Castelo, M. S. Lima, M. C. Augmentation strategies for treatment-resistant depression: a literature review. *J Clin Pharm Ther*. 2007 Oct;32(5):415-28.
19. Carvalho AFM, J. R. Cavalcante, J. L. Augmentation strategies for treatment-resistant depression. *Curr Opin Psychiatry*. 2009 Jan;22(1):7-12.
20. Cheng-Shannon JM, J. J. Pataki, C. McCracken, J. T. Second-generation antipsychotic medications in children and adolescents. *J Child Adolesc Psychopharmacol*. 2004 Fall;14(3):372-94.
21. Chouinard G. The search for new off-label indications for antidepressant, antianxiety, antipsychotic and anticonvulsant drugs. *J Psychiatry Neurosci*. 2006 May;31(3):168-76.
22. Citrome L. Quantifying risk: the role of absolute and relative measures in interpreting risk of adverse reactions from product labels of antipsychotic medications. *Curr Drug Saf*. 2009 Sep;4(3):229-37.
23. Conn DKM, R. Use of sleep-promoting medications in nursing home residents : risks versus benefits. *Drugs Aging*. 2006;23(4):271-87.
24. Daiello LAB, M. T. Hoffmann, V. P. Kennedy, J. S. Pharmacotherapy of Behavioral and Psychological Symptoms of Dementia: A Review of Atypical Antipsychotics. *Consult Pharm*. 2003 February 1;18(2):138-52, 55-7.
25. Davidson JR. Pharmacologic treatment of acute and chronic stress following trauma. 2006. *J Clin Psychiatry*. 2006;67 Suppl 2:34-9.

26. Davidson JR. Pharmacotherapy of social anxiety disorder: what does the evidence tell us? *J Clin Psychiatry*. 2006;67 Suppl 12:20-6.
27. Davidson JR. First-line pharmacotherapy approaches for generalized anxiety disorder. *J Clin Psychiatry*. 2009;70 Suppl 2:25-31.
28. De Lucas Taracena MTR, F. Montañés. El uso de los nuevos antipsicóticos atípicos en el síndrome de Gilles de la Tourette Use of new atypical antipsychotics in Tourette's syndrome. *Anales de Psiquiatría*. 2005 Dec, 2005;21(7):331-9.
29. Deberdt WGS, Alan Ahl, Jonna Meyers, Adam L. Landbloom, Ronald. Effect of olanzapine on cognition during treatment of behavioral and psychiatric symptoms in patients with dementia: A post-hoc analysis. *International Journal of Geriatric Psychiatry*. 2008 Apr, 2008;23(4):364-9.
30. Denys D. Pharmacotherapy of obsessive-compulsive disorder and obsessive-compulsive spectrum disorders. *Psychiatr Clin North Am*. 2006 Jun;29(2):553-84, xi.
31. Denys DF, N. Carey, P. D. Stein, D. J. Quetiapine addition in obsessive-compulsive disorder: is treatment outcome affected by type and dose of serotonin reuptake inhibitors? *Biol Psychiatry*. 2007 Feb 1;61(3):412-4.
32. Diaz-Marsa MGB, S. Tajima, K. Garcia-Albea, J. Navas, M. Carrasco, J. L. Psychopharmacological treatment in borderline personality disorder. *Actas Esp Psiquiatr*. 2008 Jan-Feb;36(1):39-49.
33. Dodd SB, M. Olanzapine/fluoxetine combination for treatment-resistant depression: efficacy and clinical utility. *Expert Rev Neurother*. 2008 Sep;8(9):1299-306.
34. Elkashef AV, F. Hanson, G. White, J. Wickes, W. Tiihonen, J. Pharmacotherapy of methamphetamine addiction: an update. *Subst Abus*. 2008;29(3):31-49.
35. Fava MW, S. R. Thase, M. E. Baker, R. A. Tran, Q. V. Pikalov, A. Yang, H. Marcus, R. N. Berman, R. M. Metabolic assessment of aripiprazole as adjunctive therapy in major depressive disorder: a pooled analysis of 2 studies. *J Clin Psychopharmacol*. 2009 Aug;29(4):362-7.
36. Finkel S. Pharmacology of Antipsychotics in the Elderly: A Focus on Atypicals. *Journal of the American Geriatrics Society*. 2004 Dec, 2004;52(12):S258-S65.
37. Frye MAS, I. M. Bipolar disorder and comorbid alcoholism: prevalence rate and treatment considerations. *Bipolar Disord*. 2006 Dec;8(6):677-85.
38. Gao K. Antipsychotics in the treatment of comorbid anxiety in bipolar disorder. *Psychiatr Times*. 2007;24(5):68-9.
39. Gao KM, D. Gajwani, P. Calabrese, J. R. Efficacy of typical and atypical antipsychotics for primary and comorbid anxiety symptoms or disorders: a review. *J Clin Psychiatry*. 2006 Sep;67(9):1327-40.
40. Gao KS, D. V. Calabrese, J. R. Atypical antipsychotics in primary generalized anxiety disorder or comorbid with mood disorders. *Expert Rev Neurother*. 2009 Aug;9(8):1147-58.
41. Gareri PDF, Pasquale De Fazio, Salvatore Marigliano, Norma Ibbadu, Guido Ferreri De Sarro, Giovambattista. Adverse effects of atypical antipsychotics in the elderly: A review. *Drugs and Aging*. 2006 2006;23(12):937-56.
42. Goodwin GF, W. Arango, C. Baumann, P. Davidson, M. de Hert, M. Falkai, P. Kapur, S. Leucht, S. Licht, R. Naber, D. O'Keane, V. Papakostas, G. Vieta, E. Zohar, J. Advantages and disadvantages of combination treatment with antipsychotics ECNP

- Consensus Meeting, March 2008, Nice. *Eur Neuropsychopharmacol.* 2009 Jul;19(7):520-32.
43. Green AI. Schizophrenia and comorbid substance use disorder: effects of antipsychotics. *J Clin Psychiatry.* 2005;66 Suppl 6:21-6.
 44. Greenaway ME, D. Focus on Aripiprazole: A Review of its use in Child and Adolescent Psychiatry. *J Can Acad Child Adolesc Psychiatry.* 2009 Aug;18(3):250-60.
 45. Hamner MBR, S. Emerging roles for atypical antipsychotics in chronic post-traumatic stress disorder. *Expert Rev Neurother.* 2005 Mar;5(2):267-75.
 46. Hamner MBR, S. Frueh, B. C. Treatment-resistant posttraumatic stress disorder: strategies for intervention. *CNS Spectr.* 2004 Oct;9(10):740-52.
 47. Hanley MJK, G. A. Quetiapine: treatment for substance abuse and drug of abuse. *Am J Health Syst Pharm.* 2008 Apr 1;65(7):611-8.
 48. Hindmarch I. Cognitive toxicity of pharmacotherapeutic agents used in social anxiety disorder. *Int J Clin Pract.* 2009 Jul;63(7):1085-94.
 49. Hoffman EJM, S. J. Anxiety disorders: a comprehensive review of pharmacotherapies. *Mt Sinai J Med.* 2008 May-Jun;75(3):248-62.
 50. Ishak WWR, M. H. Gotto, J. G. The effectiveness of atypical antipsychotic medications in depressive disorders. *Curr Psychiatry Rep.* 2004 Dec;6(6):422-4.
 51. Ivanov IC, A. Treating pediatric patients with antipsychotic drugs: Balancing benefits and safety. *Mt Sinai J Med.* 2008 May-Jun;75(3):276-86.
 52. Jeste DVB, D. Casey, D. Meeks, T. Salzman, C. Schneider, L. Tariot, P. Yaffe, K. ACNP White Paper: update on use of antipsychotic drugs in elderly persons with dementia. *Neuropsychopharmacology.* 2008 Apr;33(5):957-70.
 53. Kalapatapu RKS, C. Update on neuropsychiatric symptoms of dementia: antipsychotic use. *Geriatrics.* 2009 May;64(5):10-8.
 54. Karila LG, D. Weinstein, A. Noble, F. Benyamina, A. Coscas, S. Blecha, L. Lowenstein, W. Martinot, J. L. Reynaud, M. Lepine, J. P. New treatments for cocaine dependence: a focused review. *Int J Neuropsychopharmacol.* 2008 May;11(3):425-38.
 55. Kaufer DI. Pharmacologic treatment expectations in the management of dementia with Lewy bodies. *Dement Geriatr Cogn Disord.* 2004;17 Suppl 1:32-9.
 56. Kenna GA. Rationale for use of aripiprazole for alcohol dependence treatment. *Drugs Future.* 2003;28:1227-35.
 57. Kenna GAM, J. E. Swift, R. M. Pharmacotherapy, pharmacogenomics, and the future of alcohol dependence treatment, Part 2. *Am J Health Syst Pharm.* 2004 Nov 15;61(22):2380-8.
 58. Kenna GAN, D. M. Mello, P. Schiesl, A. Swift, R. M. Pharmacotherapy of dual substance abuse and dependence. *CNS Drugs.* 2007;21(3):213-37.
 59. Khan A. Current evidence for aripiprazole as augmentation therapy in major depressive disorder. *Expert Rev Neurother.* 2008 Oct;8(10):1435-47.
 60. Kirshner HS. Controversies in behavioral neurology: the use of atypical antipsychotic drugs to treat neurobehavioral symptoms in dementia. *Curr Neurol Neurosci Rep.* 2008 Nov;8(6):471-4.
 61. Kosten TRK, T. A. New medication strategies for comorbid substance use and bipolar affective disorders. *Biol Psychiatry.* 2004 Nov 15;56(10):771-7.
 62. Lee JWB, E. Sherwood Perantie, Dana C. Bobadilla, Leonardo. A comparison of single-item Visual Analog Scales with a multiitem Likert-type scale for assessment of

cocaine craving in persons with bipolar disorder. *Addictive Disorders & Their Treatment*. 2002;1(4):140-2.

63. Littrell KHP, R. G. Wolf, N. M. Olanzapine: a 5-year perspective. *Expert Rev Neurother*. 2006 Jun;6(6):811-21.

64. Maina GA, Umberto Pessina, Enrico Salvi, Virginio Bogetto, Filippo. Antipsychotics in obsessive-compulsive disorder. *Current Psychiatry Reviews*. 2005 Nov, 2005;1(3):293-301.

65. Mathew SJC, J. D. Gorman, J. M. Management of treatment-refractory panic disorder. *Psychopharmacol Bull*. 2001 Spring;35(2):97-110.

66. McNeal KMM, R. P. Lukacs, K. Senseney, A. Mintzer, J. Using risperidone for Alzheimer's dementia-associated psychosis. *Expert Opin Pharmacother*. 2008 Oct;9(14):2537-43.

67. Mendez MF. Frontotemporal dementia: therapeutic interventions. *Front Neurol Neurosci*. 2009;24:168-78.

68. Mitchell JEdZ, M. Roerig, J. L. Drug therapy for patients with eating disorders. *Curr Drug Targets CNS Neurol Disord*. 2003 Feb;2(1):17-29.

69. Nelson JCM, R. Baker, R. A. Carlson, B. X. Eudicone, J. M. Pikalov, A. Tran, Q. V. Berman, R. M. Effects of aripiprazole adjunctive to standard antidepressant treatment on the core symptoms of depression: A post-hoc, pooled analysis of two large, placebo-controlled studies. *J Affect Disord*. 2009 Aug 4.

70. Nelson JCP, A. Berman, R. M. Augmentation treatment in major depressive disorder: focus on aripiprazole. *Neuropsychiatr Dis Treat*. 2008 Oct;4(5):937-48.

71. Nemeroff CB. Use of atypical antipsychotics in refractory depression and anxiety. *J Clin Psychiatry*. 2005;66 Suppl 8:13-21.

72. Ostacher MJS, G. S. Update on bipolar disorder and substance abuse: recent findings and treatment strategies. *J Clin Psychiatry*. 2006 Sep;67(9):e10.

73. Pae CUS, A. Patkar, A. A. Masand, P. S. Aripiprazole in the treatment of depressive and anxiety disorders: a review of current evidence. *CNS Drugs*. 2008;22(5):367-88.

74. Papakostas GIS, R. C. Use of atypical antipsychotics for treatment-resistant major depressive disorder. *Curr Psychiatry Rep*. 2008 Dec;10(6):481-6.

75. Pederson KJR, J. L. Mitchell, J. E. Towards the pharmacotherapy of eating disorders. *Expert Opin Pharmacother*. 2003 Oct;4(10):1659-78.

76. Philip NSC, L. L. Tyrka, A. R. Price, L. H. Augmentation of antidepressants with atypical antipsychotics: a review of the current literature. *J Psychiatr Pract*. 2008 Jan;14(1):34-44.

77. Pies R. Should psychiatrists use atypical antipsychotics to treat nonpsychotic anxiety? *Psychiatry (Edgmont)*. 2009 Jun;6(6):29-37.

78. Potvin SS, E. Roy, J. Y. Clozapine, quetiapine and olanzapine among addicted schizophrenic patients: towards testable hypotheses. *Int Clin Psychopharmacol*. 2003 May;18(3):121-32.

79. Powers PSB, H. Pharmacotherapy for eating disorders and obesity. *Child Adolesc Psychiatr Clin N Am*. 2009 Jan;18(1):175-87.

80. Powers PSS, C. Available pharmacological treatments for anorexia nervosa. *Expert Opin Pharmacother*. 2004 Nov;5(11):2287-92.

81. Preti A. New developments in the pharmacotherapy of cocaine abuse. *Addict Biol.* 2007 Jun;12(2):133-51.
82. Ravindran AVdS, T. L. Ravindran, L. N. Richter, M. A. Rector, N. A. Obsessive-compulsive spectrum disorders: a review of the evidence-based treatments. *Can J Psychiatry.* 2009 May;54(5):331-43.
83. Ravindran LNS, M. B. Pharmacotherapy of PTSD: premises, principles, and priorities. *Brain Res.* 2009 Oct 13;1293:24-39.
84. Rosa ARF, C. Torrent, C. Comes, M. Cruz, N. Horga, G. Benabarre, A. Vieta, E. Ziprasidone in the treatment of affective disorders: a review. *CNS Neurosci Ther.* 2008 Winter;14(4):278-86.
85. Rowe DL. Off-label prescription of quetiapine in psychiatric disorders. *Expert Rev Neurother.* 2007 Jul;7(7):841-52.
86. Sartorius NF, W. W. Gjerris A. Kern U. Knapp, M. Leonard B. E. Lieberman, J. A. Lopez-Ibor J. J. Van Raay B. Twomey E. Kupfer, D. J. Angst J. Cassano G. B. Crow T. J. Freeman H. Gelder M. G. De Girolamo G. Katschnig H. Lader M. H. Leon C. A. Mak F. L. Maj M. Metzler H. Y. Offord D. Okasha A. Parker G. Remschmidt H. Rutter M. Simon G. E. . The usefulness and use of second-generation antipsychotic medications: Preface. *Current Opinion in Psychiatry.* 2002 May 7;15(SUPPL. 1):S1-S51.
87. Saunders EFS, K. R. Personality trait dimensions and the pharmacological treatment of borderline personality disorder. *J Clin Psychopharmacol.* 2009 Oct;29(5):461-7.
88. Scahill LE, Gerald Berlin, Jr Cheston M. Budman, Cathy Coffey, Barbara J. Jankovic, Joseph Kiessling, Louise King, Robert A. Kurlan, Roger Lang, Anthony Mink, Jonathan Murphy, Tanya Zinner, Samuel Walkup, John. *Contemporary Assessment and Pharmacotherapy of Tourette Syndrome. NeuroRX.* 2006;3(2):192-206.
89. Schoevers RAV, H. L. Koppelmans, V. Kool, S. Dekker, J. J. Managing the patient with co-morbid depression and an anxiety disorder. *Drugs.* 2008;68(12):1621-34.
90. Schruers KK, K. Luermans, J. Haack, M. J. Griez, E. Obsessive-compulsive disorder: a critical review of therapeutic perspectives. *Acta Psychiatr Scand.* 2005 Apr;111(4):261-71.
91. Schulz S. The promise of atypical anti psychotics for borderline disorders. Presented at the 155th annual meeting of the American Psychiatric Association. Philadelphia, Pa; May 18-23,2002.
92. Shelton RC. Treatment-resistant depression. Are atypical antipsychotics effective and safe enough? . *Current Psychiatry Reviews.* 2006;5(10):31-44.
93. Shelton RC. Augmentation strategies to increase antidepressant efficacy. *J Clin Psychiatry.* 2007;68 Suppl 10:18-22.
94. Stigler KAP, Marc N. Posey, David J. McDougle, Christopher J. Weight Gain Associated with Atypical Antipsychotic Use in Children and Adolescents: Prevalence, Clinical Relevance, and Management. *Pediatric Drugs.* 2004;6(1):33-44.
95. Thase MET, M. H. Nelson, J. C. Fava, M. Swanink, R. Tran, Q. V. Pikalov, A. Yang, H. Carlson, B. X. Marcus, R. N. Berman, R. M. Examining the Efficacy of Adjunctive Aripiprazole in Major Depressive Disorder: A Pooled Analysis of 2 Studies. *Prim Care Companion J Clin Psychiatry.* 2008;10(6):440-7.

96. The Royal College of Psychiatrists. Atypical Antipsychotics and Behavioral and Psychiatric Symptoms of Dementia. 2007 [updated 2007; cited 04/09/10]; Available from: <http://www.rcpsych.ac.uk/pdf/BPSD.pdf>.
97. Trifiro GS, E. Gambassi, G. Use of antipsychotics in elderly patients with dementia: do atypical and conventional agents have a similar safety profile? *Pharmacol Res.* 2009 Jan;59(1):1-12.
98. Trivedi MHT, M. E. Fava, M. Nelson, C. J. Yang, H. Qi, Y. Tran, Q. V. Pikalov, A. Carlson, B. X. Marcus, R. N. Berman, R. M. Adjunctive aripiprazole in major depressive disorder: analysis of efficacy and safety in patients with anxious and atypical features. *J Clin Psychiatry.* 2008 Dec;69(12):1928-36.
99. Trivedi MHT, M. E. Osuntokun, O. Henley, D. B. Case, M. Watson, S. B. Campbell, G. M. Corya, S. A. An integrated analysis of olanzapine/fluoxetine combination in clinical trials of treatment-resistant depression. *J Clin Psychiatry.* 2009 Mar;70(3):387-96.
100. Turgay A. Treatment of comorbidity in conduct disorder with attention-deficit hyperactivity disorder (ADHD). *Essent Psychopharmacol.* 2005;6(5):277-90.
101. Vollm B. Assessment and management of dangerous and severe personality disorders. *Curr Opin Psychiatry.* 2009 Sep;22(5):501-6.
102. Weber JL-W, K. A. Scott, L. J. Aripiprazole: in major depressive disorder. *CNS Drugs.* 2008;22(10):807-13.
103. Wisniewski SRC, C. C. Kim, E. Kan, H. J. Guo, Z. Carlson, B. X. Tran, Q. V. Pikalov, A. Global benefit-risk analysis of adjunctive aripiprazole in the treatment of patients with major depressive disorder. *Pharmacoepidemiol Drug Saf.* 2009 Oct;18(10):965-72.
104. Wood JGC, J. L. Delap, C. M. Heiskell, K. D. Beyond methylphenidate: nonstimulant medications for youth with ADHD. *J Atten Disord.* 2007 Nov;11(3):341-50.
105. Zhu AJW, B. Timothy. Pharmacologic Treatment of Eating Disorders. *Canadian Journal of Psychiatry.* 2002;47(3):227.

Rejected, Case Report:

1. Arana-Lechuga YS-E, O. de Santiago-Trevino, N. Castillo-Montoya, C. Teran-Perez, G. Velazquez-Moctezuma, J. Risperidone treatment of sleep disturbances in Tourette's syndrome. *J Neuropsychiatry Clin Neurosci.* 2008 Summer;20(3):375-6.
2. Barzman DG, Beth Delbello, Melissa. Quetiapine for chronic motor Tic disorder. *The American Journal of Psychiatry.* 2004 Jul, 2004;161(7):1307.
3. Ben Djebara MW, Y. Schupbach, M. Hartmann, A. Aripiprazole: a treatment for severe coprolalia in "refractory" Gilles de la Tourette syndrome. *Mov Disord.* 2008 Feb 15;23(3):438-40.
4. Berkowitz AL. Ziprasidone Therapy in Elderly Patients with Psychotic Mood Disorders and Parkinson's Disease. *Psychiatry.* 2006 Nov, 2006;3(11):59-63.
5. Cohen JAP, J. M. Adolescent weight loss during treatment with olanzapine. *J Child Adolesc Psychopharmacol.* 2004 Winter;14(4):617-20.

6. Cole SAS, Rehan Shea, William P. Sedler, Mark Sablosky, Marilyn Jyringi, Darlene Smith, Angela. Ziprasidone for agitation or psychosis in dementia: Four cases. *International Journal of Psychiatry in Medicine*. 2005 2005;35(1):91-8.
7. Constant ELB, L. Seghers, A. Aripiprazole is effective in the treatment of Tourette's disorder. *Int J Neuropsychopharmacol*. 2006 Dec;9(6):773-4.
8. Curtis ARR, R. W. The treatment of psychogenic excoriation and obsessive compulsive disorder using aripiprazole and fluoxetine. *Ann Clin Psychiatry*. 2007 Jul-Sep;19(3):199-200.
9. Czarnecki KK, N. Josephs, K. A. Parkinsonism and tardive antecollis in frontotemporal dementia--increased sensitivity to newer antipsychotics? *European Journal of Neurology*. 2008 Feb, 2008;15(2):199-201.
10. da Rocha FFC, H. Successful augmentation with aripiprazole in clomipramine-refractory obsessive-compulsive disorder. *Prog Neuropsychopharmacol Biol Psychiatry*. 2007 Oct 1;31(7):1550-1.
11. Dennis KLG, D. Bremer, J. Olanzapine use in adolescent anorexia nervosa. *Eat Weight Disord*. 2006 Jun;11(2):e53-6.
12. Desseilles MM, F. Aripiprazole diminishes cannabis use in schizophrenia. *J Neuropsychiatry Clin Neurosci*. 2008 Winter;20(1):117-8.
13. Duggal HS. Ziprasidone for maladaptive behavior and attention-deficit/hyperactivity disorder symptoms in autistic disorder. *J Child Adolesc Psychopharmacol*. 2007 Apr;17(2):261-3.
14. Ehrt UF, Friederike Aarsland, Dag. Respiratory Dyskinesia as Discontinuation Effect of Risperidone. *Journal of Clinical Psychopharmacology*. 2005 Dec, 2005;25(6):609.
15. Fernando AC, G. Chronic insomnia secondary to chronic pain responding to quetiapine. *Australas Psychiatry*. 2005 Mar;13(1):86.
16. Fountoulakis KNI, A. Siamouli, M. Koumaris, V. Kaprinis, G. S. Successful treatment of anorexia with a combination of high-dose olanzapine, fluoxetine and mirtazapine. *Int J Clin Pharmacol Ther*. 2006 Sep;44(9):452-3.
17. Fountoulakis KNS, M. Kantartzis, S. Panagiotidis, P. Iacovides, A. Kaprinis, G. S. Acute dystonia with low-dosage aripiprazole in Tourette's disorder. *Ann Pharmacother*. 2006 Apr;40(4):775-7.
18. Friedman SA, T. A. Oumaya, M. Rouillon, F. Guelfi, J. D. Aripiprazole augmentation of clomipramine-refractory obsessive-compulsive disorder. *J Clin Psychiatry*. 2007 Jun;68(6):972-3.
19. Gentile S. Quetiapine-fluvoxamine combination during pregnancy and while breastfeeding. *Arch Womens Ment Health*. 2006 May;9(3):158-9.
20. Ginsberg DL. Quetiapine effective for chronic motor tics. *Primary Psychiatry*. 2004 Aug, 2004;11(8):22.
21. Ginsberg DL. Aripiprazole Augmentation for Treatment-Resistant Depression. *Primary Psychiatry*. 2005 Jun, 2005;12(6):26-7.
22. Gupta NB, D. Does risperidone reduce concomitant substance abuse in cases of schizophrenia? *Can J Psychiatry*. 2001 Nov;46(9):862-3.
23. Hansen L. Olanzapine in the treatment of anorexia nervosa. *Br J Psychiatry*. 1999 Dec;175:592.

24. Heinrich TWB, Lee A. Schneider, John. Torsades de Pointes Associated With Ziprasidone. *Psychosomatics*. 2006 June 1, 2006;47(3):264-8.
25. Hounie ADM, A. Sampaio, A. S. Mercadante, M. T. [Aripiprazole and Tourette syndrome]. *Rev Bras Psiquiatr*. 2004 Sep;26(3):213.
26. Huther RG, C. Mirisch, S. Bauml, J. Forstl, H. Choreatic symptoms during and after treatment with paliperidone and escitalopram. *Pharmacopsychiatry*. 2008 Sep;41(5):203-4.
27. Inoue KT, Hisashi Aoki, Tatesuke Kaiya, Hisanobu Nishimura, Yukika Nishida, Atsushi Kajiki, Naomi Yokoyama, Chika Takeda, Masatoshi Okazaki, Yuji. The Report That Olanzapine had an Effect in PTSD. *International Medical Journal*. 2006 Dec, 2006;13(4):265-7.
28. Inta DE, Susanne Zink, Mathias. Aripiprazole monotherapy for Tourette syndrome accompanied by obsessive-compulsive symptoms. *German Journal of Psychiatry*. 2008 2008;11(3):123-5.
29. Karam-Hage MG, N. Olanzapine in Tourette's disorder. *J Am Acad Child Adolesc Psychiatry*. 2000 Feb;39(2):139.
30. Kellner M. Aripiprazole in a therapy-resistant patient with borderline personality and post-traumatic stress disorder. *Pharmacopsychiatry*. 2007 Jan;40(1):41.
31. Kikukawa S. Effectiveness of aripiprazole in treatment of adults with attention deficit disorder and restless legs syndrome. *Int J Neuropsychopharmacol*. 2008 May;11(3):439-40.
32. Koelsch D. Olanzapine as an add-on therapy in post-traumatic stress disorder (PTSD). *German Journal of Psychiatry*. 2007 2007;10(2):50-2.
33. Laks JM, Roberto Marinho, Valeska Engelhardt, Elias. Use of aripiprazole for psychosis and agitation in dementia. *International Psychogeriatrics*. 2006;18(02):335-40.
34. Leey JS, Belinda Murphy, Patrick Antimisariis, Demetra Miles, Toni. Quetiapine-induced dystonia and agitation in Parkinson disease with dementia: A case report. *Journal of the American Geriatrics Society*. 2009 May, 2009;57(5):918-9.
35. Mehler-Wex CR, M. Kirchheiner, J. Schulze, U. M. Atypical antipsychotics in severe anorexia nervosa in children and adolescents--review and case reports. *Eur Eat Disord Rev*. 2008 Mar;16(2):100-8.
36. Misra LKK, L. Fuller, W. Treatment of inhalant abuse with risperidone. *J Clin Psychiatry*. 1999 Sep;60(9):620.
37. Mobascher AM, J. Schlemper, V. Winterer, G. Malevani, J. Aripiprazole Pharmacotherapy of Borderline Personality Disorder. *Pharmacopsychiatry*. 2006;39(03):111-2.
38. Ozbulut OE, Murat Guler, Ozkan Gecici, Omer. Tardive dyskinesia with ziprasidone and citalopram use in an elderly female patient. *Psychogeriatrics*. 2008 Jun, 2008;8(2):96-7.
39. Padala PRL, D. Petty, F. Bhatia, S. C. Adjunctive aripiprazole in combat-related posttraumatic stress disorder. *Ann Pharmacother*. 2007 Oct;41(10):1744.
40. Pae CU. Potential utility of aripiprazole monotherapy for the treatment of major depressive disorder comorbid with obsessive-compulsive disorder. *Psychiatry Clin Neurosci*. 2009 Aug;63(4):593.

41. Peters BdH, L. Remission of schizophrenia psychosis and strong reduction of obsessive-compulsive disorder after adding clozapine to aripiprazole. *Prog Neuropsychopharmacol Biol Psychiatry*. 2009 Sep 18.
42. Prakash RP, A. Munda, S. Bagati, D. Quetiapine effective in treatment of inappropriate sexual behavior of lewy body disease with predominant frontal lobe signs. *Am J Alzheimers Dis Other Demen*. 2009 Apr-May;24(2):136-40.
43. Preskorn SH. Multiple medication use presenting as Parkinson's dementia complex: A message from Titanic. *Journal of Psychiatric Practice*. 2008 Jan, 2008;14(1):45-54.
44. Ritchie BN, M. L. QTc Prolongation Associated With Atypical Antipsychotic Use in the Treatment of Adolescent-Onset Anorexia Nervosa. *J Can Acad Child Adolesc Psychiatry*. 2009 Feb;18(1):60-3.
45. Sarkar RK, J. Kruger, S. Aripiprazole augmentation in treatment-refractory obsessive-compulsive disorder. *Psychopharmacology (Berl)*. 2008 May;197(4):687-8.
46. Sattar SPB, S. C. Olanzapine for cocaine cravings and relapse prevention. *J Clin Psychiatry*. 2003 Aug;64(8):969.
47. Sattar SPG, Kathleen Bhatia, Subhash Petty, Frederick. Potential use of olanzapine in treatment of substance dependence disorders. *Journal of Clinical Psychopharmacology*. 2003 Aug, 2003;23(4):413-5.
48. Scahill LB, J. Leckman, J. F. Martin, A. Sudden death in a patient with Tourette syndrome during a clinical trial of ziprasidone. *J Psychopharmacol*. 2005 Mar;19(2):205-6.
49. Schmidt SK. Quetiapine: A New Adjunctive Medication in Addictions Treatment. *Journal of Addictions Nursing*. 2006 2006;17(1):65.
50. Sokolski KNB, B. J. Quetiapine for insomnia associated with refractory depression exacerbated by phenelzine. *Ann Pharmacother*. 2006 Mar;40(3):567-70.
51. Thomas NS, P. Russell, S. Angothu, H. Tardive dyskinesia following risperidone treatment in Tourette's syndrome. *Neurol India*. 2009 Jan-Feb;57(1):94-5.
52. Tranulis CP, S. Gourgue, M. Leblanc, G. Mancini-Marie, A. Stip, E. The paradox of quetiapine in obsessive-compulsive disorder. *CNS Spectr*. 2005 May;10(5):356-61.
53. Valerius GB, N. C. Schaerer, L. O. Langosch, J. M. Quetiapine in the Treatment of Rapid-Cycling Bipolar II Disorder With Comorbid Anxiety and Social Phobia. *Pharmacopsychiatry*. 2005 Sep, 2005;38(5):225-6.
54. Van den Eynde FN, K. H. De Saedeleer, S. van Heeringen, C. Audenaert, K. Olanzapine in Gilles de la Tourette syndrome: beyond tics. *Acta Neurol Belg*. 2005 Dec;105(4):206-11.
55. Wang TSC, Y. H. Shiah, I. S. Combined treatment of olanzapine and mirtazapine in anorexia nervosa associated with major depression. *Prog Neuropsychopharmacol Biol Psychiatry*. 2006 Mar;30(2):306-9.
56. Weintraub DH, Howard I. Presentation and management of psychosis in Parkinson's disease and dementia with Lewy bodies. *The American Journal of Psychiatry*. 2007 Oct, 2007;164(10):1491-8.
57. Yao YCC, P. H. Hsiao, M. C. Liu, C. Y. Effective treatment of premenstrual violence in major depression: augmentation with aripiprazole. *Chang Gung Med J*. 2008 Jul-Aug;31(4):402-6.

58. Yasuhara DN, T. Harada, T. Inui, A. Olanzapine-induced hyperglycemia in anorexia nervosa. *Am J Psychiatry*. 2007 Mar;164(3):528-9.
59. Yumru M, Eren Ozen M, Savas HA, Selek S. Long-acting injectable risperidone for control of agitation in dementia. *J Clin Psychiatry*. 2006 Oct;67(10):1651-2.

Rejected due to Other Design (Open label):

1. Rapaport MHG, G. M. Canuso, C. M. Mahmoud, R. A. Keller, M. B. Bossie, C. A. Turkoz, I. Lasser, R. A. Loesch, A. Bouhours, P. Dunbar, F. Nemeroff, C. B. Effects of Risperidone Augmentation in Patients with Treatment-Resistant Depression: Results of Open-Label Treatment Followed by Double-Blind Continuation. *Neuropsychopharmacology*. 2006;31(11):2505-13.

Rejected, Foreign Language:

1. Baño MDM, J. A. Agujetas, M. López, M. L. Guillén, J. L. Eficacia del antipsicótico olanzapina en el tratamiento del abuso de cocaína en pacientes en mantenimiento con metadona Interacción en los niveles plasmáticos Olanzapine efficacy in the treatment of cocaine abuse in methadone maintenance patients: Interaction with plasma levels. *Actas Españolas de Psiquiatría*. 2001 Jul-Aug, 2001;29(4):215-20.
2. Boulin MM, S. Serot, D. Martin, P. Alizon, B. Vailleau, J.L. [Prescribing practices of second generation antipsychotics in hospital units]. *Therapie*. 2005;60(6):567-72.
3. Bret PB, F. Bret, M. C. Jaffre, A. [Use of atypical antipsychotics in Charles Perrens psychiatric hospital (Bordeaux) analysis of prescribing practices for Amisulpride, Clozapine, Olanzapine and Risperidone]. *Encephale*. 2002 Jul-Aug;28(4):329-42.
4. Bret PB, M. C. Queuille, E. [Prescribing patterns of antipsychotics in 13 French psychiatric hospitals]. *Encephale*. 2009 Apr;35(2):129-38.
5. Casas Brugué MG, M. Gibert, J. Bobes, J. Roncero, C. Octavio, I. Risperidona en el tratamiento de pacientes psicóticos con abuso y dependencia de opiáceos Risperidone in the treatment of psychotic patients with opiate abuse and dependence. *Actas Españolas de Psiquiatría*. 2001 Nov-Dec, 2001;29(6):380-5.
6. Cath DCM, G. de Jonge, J. L. van Balkom, A. J. [Antipsychotics in the treatment of Tourette disorder: a review]. *Tijdschr Psychiatr*. 2008;50(9):593-602.
7. Chitaya NND, D. S. Tiuvina, N. A. [Peculiarities of neuroleptic syndrome in women treated with typical and atypical neuroleptics]. *Zh Nevrol Psikhiatr Im S S Korsakova*. 2009;109(3):37-43.
8. Drozdov ES. [Rispolept (risperidone) efficacy in the treatment of patients with schizophrenia and psychoactive drug dependence]. *Voen Med Zh*. 2002 Jul;323(7):46-52.
9. Dulz BW, Amelie. Zur medikamentösen Anxiolyse bei Borderline-Patienten About the treatment of borderline patients with neuroleptics: Effects and side effects. *PTT: Persönlichkeitsstörungen Theorie und Therapie*. 2003 Nov, 2003;7(4):253-62.

10. Dumortier GC, W. Stamatiadis, L. Saba, G. Benadhira, R. Rocamora, J. F. Aubriot-Delmas, B. Glikman, J. Januel, D. Tolérance hépatique des antipsychotiques atypiques Hepatic tolerance of atypical antipsychotic drugs. *L'Encéphale: Revue de psychiatrie clinique biologique et thérapeutique*. 2002 Nov-Dec, 2002;28(6):542-51.
11. Forlenza OVC, E. Diniz, B. S. [The use of antipsychotics in patients with dementia]. *Rev Bras Psiquiatr*. 2008 Sep;30(3):265-70.
12. Fremaux TR, J. M. Chevreuril, C. Bentue-Ferrer, D. [Prescription of olanzapine in children and adolescent psychiatric patients]. *Encephale*. 2007 Mar-Apr;33(2):188-96.
13. Haupt MS, A. Schwalen, S. Behandlungseffekte auf Verhaltensstörungen, psychotische und somatische Symptome bei Patienten mit Demenz: Ein Vergleich zwischen Melperon und Risperidon Pharmacological effects in the treatment of behavioural and somatic symptoms of dementia: A comparison between risperidone and melperone. *Nervenheilkunde: Zeitschrift für interdisziplinäre Fortbildung*. 2004 2004;23(9):539-44.
14. Iglesias Garcia CSM, S. Alonso Villa, M. J. [Ziprasidone as coadjuvant treatment in resistant obsessive-compulsive disorder treatment]. *Actas Esp Psiquiatr*. 2006 Jul-Aug;34(4):277-9.
15. Martinez Martinez LOF, M. R. Pineiro Corrales, G. [Mortality in patients with dementia treateds with atypical antipsychotics (olanzapine, quetiapine and ziprasidone).]. *Farm Hosp*. 2009 Jul 1;33(4):224-8.
16. Martinez Raga JD-A, J. Job, A. Knecht, C. C. Cepeda, S. San, L. Perez-Galvez, B. [Post-traumatic stress disorder and substance use disorder: treatment intervention]. *Vertex*. 2005 Nov-Dec;16(64):412-7.
17. Mehler-Wex CR, S. Warnke, A. [Aatypical antipsychotics in child and adolescent psychiatry--indications apart from schizophrenia]. *Z Kinder Jugendpsychiatr Psychother*. 2005 Jul;33(3):159-68.
18. Montecchi FM, M. Marinucci, S. Gambarara, M. Diamanti, A. Risperidone nel controllo dei sintomi negativi nell'anoressia nervosa in adolescenza Risperidone in the control of negative symptoms in anorexia nervosa in adolescents. *Minerva Psichiatrica*. 1998 Dec, 1998;39(4):205-9.
19. Morant AM, F. Hernandez, S. Rosello, B. [Pharmacological treatment with risperidone in children with behavior disorders]. *Rev Neurol*. 2001 Aug 1-15;33(3):201-8.
20. Orlandi VOR, Camilla Bersani, Giuseppe. L'impiego di neurolettici atipici in pazienti con doppia diagnosi di schizofrenia e abuso di cannabis: Dati clinici con olanzapina Atypical antipsychotics in patients with schizophrenia and comorbid cannabis abuse: Clinical data with olanzapine. *Rivista di Psichiatria*. 2004 Sep-Oct, 2004;39(5):356-64.
21. Pelland CT, J. F. [Atypical antipsychotic efficacy and safety in managing delirium: a systematic review and critical analysis]. *Psychol Neuropsychiatr Vieil*. 2009 Jun;7(2):109-19.
22. Scholten MRS, J. P. [Suicidal ideations and suicide attempts after starting on aripiprazole, a new antipsychotic drug]. *Ned Tijdschr Geneesk*. 2005 Oct 8;149(41):2296-8.

23. Vilalta-Franch JL-P, S. Garre-Olmo, J. Turon-Estrada, A. Pericot-Nierga, I. [Mortality rates in patients with Alzheimer's disease treated with atypical neuroleptic drugs]. *Rev Neurol*. 2008 Feb 1-15;46(3):129-34.
24. Wittmann M, Hausner H, Hajak G, Haen E. Antipsychotic Treatment of Dementia After Publication of New Risks. *Psychiatr Prax*. 2009 Sep 1.
25. Wobrock TDA, R. Falkai, P. [Pharmacotherapy of schizophrenia and comorbid substance use disorder. A systematic review]. *Nervenarzt*. 2008 Jan;79(1):17-8, 20-2, 4-6 passim.
26. Yildiz A. [Benzodiazepines, typical and atypical antipsychotics in the management of acute agitation: a review]. *Turk Psikiyatri Derg*. 2003 Summer;14(2):134-44.
27. Zhao HZ, Ying. [Untitled] Risperidone in treatment of Tourette syndrome. *Chinese Mental Health Journal*. 2003 Jan, 2003;17(1):30.

Reject due to Focus:

1. Angelucci FB, S. Gravina, P. Bellincampi, L. Trequatrini, A. Di Iulio, F. Vanni, D. Federici, G. Caltagirone, C. Bossu, P. Spalletta, G. Delusion symptoms and response to antipsychotic treatment are associated with the 5-HT_{2A} receptor polymorphism (102T/C) in Alzheimer's disease: a 3-year follow-up longitudinal study. *J Alzheimers Dis*. 2009 May;17(1):203-11.
2. Bergh SE, Knut. The withdrawal of antipsychotics and antidepressants from patients with dementia and BPSD living in nursing homes--An open pilot study. *International Journal of Geriatric Psychiatry*. 2008 Aug, 2008;23(8):877-9.
3. Coley KCF, T. J. Kim, E. Ammerman, D. K. Scipio, T. M. Saul, M. I. Kim, M. S. Whitehead, R. Ganguli, R. Predictors of aripiprazole treatment continuation in hospitalized patients. *J Clin Psychiatry*. 2008 Sep;69(9):1393-7.
4. Segal-Trivitz YB, Y. Goldburt, Y. Sobol-Havia, D. Levkovitch, Y. Ratzoni, G. Comparison of symptoms and treatments of adults and adolescents with borderline personality disorder. *Int J Adolesc Med Health*. 2006 Apr-Jun;18(2):215-20.

Rejected due to Topic (Not off-label use of atypicals):

1. Becker PM. Treatment of sleep dysfunction and psychiatric disorders. *Curr Treat Options Neurol*. 2006 Sep;8(5):367-75.
2. Becker PMS, M. Treatment of sleep dysfunction and psychiatric disorders. *Curr Treat Options Neurol*. 2009 Sep;11(5):349-57.
3. Brown ESN, V. A. Perantie, D. C. Rajan Thomas, N. Rush, A. J. Cocaine and amphetamine use in patients with psychiatric illness: a randomized trial of typical antipsychotic continuation or discontinuation. *J Clin Psychopharmacol*. 2003 Aug;23(4):384-8.
4. DelBello MG, S. Phenomenology and epidemiology of childhood psychiatric disorders that may necessitate treatment with atypical antipsychotics. *J Clin Psychiatry*. 2004;65 Suppl 6:12-9.

5. Dresser RF, J. Off-label prescribing: a call for heightened professional and government oversight. *J Law Med Ethics*. 2009 Fall;37(3):476-86, 396.
6. Fossey JB, C. Juszczak, E. James, I. Alder, N. Jacoby, R. Howard, R. Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster randomised trial. *BMJ*. 2006 Apr 1;332(7544):756-61.
7. Gruber-Baldini ALS, Bruce Zuckerman, Ilene H. Simoni-Wastila, Linda Miller, Ram. 'Treatment of dementia in community-dwelling and institutionalized Medicare beneficiaries': Erratum. *Journal of the American Geriatrics Society*. 2007 Oct;55(10):1697.
8. Haliburn J. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *Australian and New Zealand Journal of Psychiatry*. 2005 Jul, 2005;39(7):639-40.
9. Hansen RAG, Gerald Lohr, Kathleen N. Gaynes, Bradley N. Carey, Timothy S. Efficacy and Safety of Second-Generation Antidepressants in the Treatment of Major Depressive Disorder. *Annals of Internal Medicine*. 2005 September 20, 2005;143(6):415-26.
10. Hay P. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *Australian and New Zealand Journal of Psychiatry*. 2004 Sep, 2004;38(9):659-70.
11. Huang C-CS, I. Shin Chen, Hsing-Kang Mao, Wei-Chung Yeh, Yi-Wei. Adjunctive use of methylphenidate in the treatment of psychotic unipolar depression. *Clinical Neuropharmacology*. 2008 Jul-Aug, 2008;31(4):245-7.
12. Huang WFL, I. C. Patterns of sleep-related medications prescribed to elderly outpatients with insomnia in Taiwan. *Drugs Aging*. 2005;22(11):957-65.
13. Jindal RDT, Michael E. Treatment of insomnia associated with clinical depression. *Sleep Medicine Reviews*. [doi: DOI: 10.1016/S1087-0792(03)00025-X]. 2004;8(1):19-30.
14. Kenna GAM, J. E. Swift, R. M. Pharmacotherapy, pharmacogenomics, and the future of alcohol dependence treatment, part 1. *Am J Health Syst Pharm*. 2004 Nov 1;61(21):2272-9.
15. Kerssens CJP, Y. A. L. 'Vulnerability to neuroleptic side effects in frontotemporal dementia': Erratum. *European Journal of Neurology*. 2008 Jun, 2008;15(6):640.
16. Lenze EJP, B. G. Shear, M. K. Mulsant, B. H. Bharucha, A. Reynolds, C. F., 3rd. Treatment considerations for anxiety in the elderly. *CNS Spectr*. 2003 Dec;8(12 Suppl 3):6-13.
17. McKeith IGD, D. W. Lowe, J. Emre, M. O'Brien, J. T. Feldman, H. Cummings, J. Duda, J. E. Lippa, C. Perry, E. K. Aarsland, D. Arai, H. Ballard, C. G. Boeve, B. Burn, D. J. Costa, D. Del Ser, T. Dubois, B. Galasko, D. Gauthier, S. Goetz, C. G. Gomez-Tortosa, E. Halliday, G. Hansen, L. A. Hardy, J. Iwatsubo, T. Kalaria, R. N. Kaufer, D. Kenny, R. A. Korczyn, A. Kosaka, K. Lee, V. M. Lees, A. Litvan, I. Londos, E. Lopez, O. L. Minoshima, S. Mizuno, Y. Molina, J. A. Mukaetova-Ladinska, E. B. Pasquier, F. Perry, R. H. Schulz, J. B. Trojanowski, J. Q. Yamada, M. Diagnosis and management of dementia with Lewy bodies: third report of the DLB Consortium. *Neurology*. 2005 Dec 27;65(12):1863-72.

18. Mitchell JEP, C. B. Myers, T. Wonderlich, S. Combining pharmacotherapy and psychotherapy in the treatment of patients with eating disorders. *Psychiatr Clin North Am.* 2001 Jun;24(2):315-23.
19. MTACooperativeGroup. A 14-Month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder. *Arch Gen Psychiatry.* 1999 December 1, 1999;56(12):1073-86.
20. Roberts DCSV, Gary. Atypical neuroleptics increase self-administration of cocaine: An evaluation of a behavioural screen for antipsychotic activity. *Psychopharmacology.* [10.1007/BF00426397]. 1983;82(1):135-9.
21. Trivedi MHF, Maurizio Wisniewski, Stephen R. Thase, Michael E. Quitkin, Frederick Warden, Diane Ritz, Louise Nierenberg, Andrew A. Lebowitz, Barry D. Biggs, Melanie M. Luther, James F. Shores-Wilson, Kathy Rush, A. John the, Star D. Study Team. Medication Augmentation after the Failure of SSRIs for Depression. *N Engl J Med.* 2006 March 23, 2006;354(12):1243-52.
22. Uthman OAA, Jibril. Comparative efficacy and acceptability of pharmacotherapeutic agents for anxiety disorders in children and adolescents: a mixed treatment comparison meta-analysis. *Current Medical Research and Opinion.* 2010;26(1):53-9.
23. Valenstein MM, J. F. Austin, K. L. Greden, J. F. Young, E. A. Blow, F. C. What happened to lithium? Antidepressant augmentation in clinical settings. *Am J Psychiatry.* 2006 Jul;163(7):1219-25.
24. Vandereycken W. Neuroleptics in the short-term treatment of anorexia nervosa. A double-blind placebo-controlled study with sulpiride. *The British Journal of Psychiatry.* 1984 March 1, 1984;144(3):288-92.
25. Voyer PV, René Mengue, Pamphile Nkogho Laurin, Danielle Rochette, Louis Martin, Lori Schindel Baillargeon, Lucie. Determinants of Neuroleptic Drug Use in Long-Term Facilities for Elderly Persons. *Journal of Applied Gerontology.* 2005 Sep, 2005;24(3):179-95.
26. Wurthmann CK, Eckhard Lehmann, Erlo. Side effects of low dose neuroleptics and their impact on clinical outcome in generalized anxiety disorder. *Progress in Neuro-Psychopharmacology and Biological Psychiatry.* [doi: DOI: 10.1016/S0278-5846(97)00035-3]. 1997;21(4):601-9.
27. Zerbe KJ. Eating disorders over the life Cycle: Diagnosis and treatment. *Primary Psychiatry.* 2003 Jun, 2003;10(6):28-9.
28. Ziedonis DMS, David Rosenthal, Richard N. Batki, Steven L. Green, Alan I. Henry, Renata J. Montoya, Ivan Parks, Joseph Weiss, Roger D. Improving the Care of Individuals with Schizophrenia and Substance Use Disorders: Consensus Recommendations. *Journal of Psychiatric Practice.* 2005;11(5):315-39.

Rejected due to Condition:

1. Risperidone treatment of autistic disorder: longer-term benefits and blinded discontinuation after 6 months. *Am J Psychiatry.* 2005 Jul;162(7):1361-9.
2. First drug to treat irritability associated with autism. *FDA Consum.* 2007 Jan-Feb;41(1):4.

3. Accardo P. Risperidone in children with autism and serious behavioral problems. *J Pediatr*. 2003 Jan;142(1):86-7.
4. Adetunji BM, M. Osinowo, T. Williams, A. Risperidone for the core symptom domains of autism. *Am J Psychiatry*. 2006 Mar;163(3):551; author reply -2.
5. Adli MW, Katja Baethge, Christopher Pfennig, Andrea Stamm, Thomas Bauer, Michael. Olanzapine in the treatment of depression with psychotic features: A prospective open-label study. *International Journal of Psychiatry in Clinical Practice*. 2008 Sep, 2008;12(3):202-9.
6. Ahuja NP, N. Mackin, P. Lloyd, AJ. Olanzapine-induced hyperglycaemic coma and neuroleptic malignant syndrome: case report and review of literature. *J Psychopharmacol*. 2010 January 1, 2010;24(1):125-30.
7. Akhondzadeh ST, H. Mohammadi, M. R. Mohammadi, M. Nouroozinejad, G. H. Shabstari, O. L. Ghelichnia, H. A. A double-blind placebo controlled trial of piracetam added to risperidone in patients with autistic disorder. *Child Psychiatry Hum Dev*. 2008 Sep;39(3):237-45.
8. Alessi NE. Ziprasidone in autism. *J Am Acad Child Adolesc Psychiatry*. 2003 Jun;42(6):622-3.
9. Alexander W. American psychiatric association. P T. 2008 Jun;33(6):364-7.
10. Aman MB, J. Smedt, G. D. Wapenaar, R. Binder, C. Pharmacotherapy of disruptive behavior and item changes on a standardized rating scale: pooled analysis of risperidone effects in children with subaverage IQ. *J Child Adolesc Psychopharmacol*. 2005 Apr;15(2):220-32.
11. Aman MG. Management of hyperactivity and other acting-out problems in patients with autism spectrum disorder. *Semin Pediatr Neurol*. 2004 Sep;11(3):225-8.
12. Aman MGA, L. E. McDougle, C. J. Vitiello, B. Scahill, L. Davies, M. McCracken, J. T. Tierney, E. Nash, P. L. Posey, D. J. Chuang, S. Martin, A. Shah, B. Gonzalez, N. M. Swiezy, N. B. Ritz, L. Koenig, K. McGough, J. Ghuman, J. K. Lindsay, R. L. Acute and long-term safety and tolerability of risperidone in children with autism. *J Child Adolesc Psychopharmacol*. 2005 Dec;15(6):869-84.
13. Aman MGH, J. A. McDougle, C. J. Scahill, L. Tierney, E. McCracken, J. T. Arnold, L. E. Vitiello, B. Ritz, L. Gavaletz, A. Cronin, P. Swiezy, N. Wheeler, C. Koenig, K. Ghuman, J. K. Posey, D. J. Cognitive effects of risperidone in children with autism and irritable behavior. *J Child Adolesc Psychopharmacol*. 2008 Jun;18(3):227-36.
14. Andersohn FMDS, Niklas B. P. H. Weinmann, Stefan M. D. Willich, Stefan N. M. D. M. P. H. Garbe, Edeltraut M. D. PhD. Priapism Associated With Antipsychotics: Role of [alpha]1 Adrenoceptor Affinity. [Report]. *J Clin Psychopharmacol*. 2010;30(1):68-71.
15. Anderson GMS, L. McCracken, J. T. McDougle, C. J. Aman, M. G. Tierney, E. Arnold, L. E. Martin, A. Katsovich, L. Posey, D. J. Shah, B. Vitiello, B. Effects of short- and long-term risperidone treatment on prolactin levels in children with autism. *Biol Psychiatry*. 2007 Feb 15;61(4):545-50.
16. Aparasu RR, Bhatara V, Gupta S. U.S. national trends in the use of antipsychotics during office visits, 1998-2002. *Ann Clin Psychiatry*. 2005 Jul-Sep;17(3):147-52.
17. Aparasu RRB, Vinod. Datapoints: Antipsychotic Prescribing Trends Among Youths, 1997-2002. *Psychiatr Serv*. 2005 August 1, 2005;56(8):904-.

18. Ashcroft DMF, Martin Lockett, Joanne Chapman, Stephen R. . Variations in prescribing atypical antipsychotic drugs in primary care: cross-sectional study. *Pharmacoepidemiology and Drug Safety*. 2002;11(4):285-9.
19. Barnett MA, T. Alexander, B. Perry, P. A regional comparison of developing diabetes among VA patients exposed to typical and atypical antipsychotics relative to corticosteroids and proton pump inhibitors. *Ann Clin Psychiatry*. 2006 Jan-Mar;18(1):1-7.
20. Barnett MJP, P. J. Alexander, B. Kaboli, P. J. Risk of mortality associated with antipsychotic and other neuropsychiatric drugs in pneumonia patients. *J Clin Psychopharmacol*. 2006 Apr;26(2):182-7.
21. Berk MB, S. Trandafir, A. I. A comparison of olanzapine with haloperidol in cannabis-induced psychotic disorder: a double-blind randomized controlled trial. *Int Clin Psychopharmacol*. 1999 May;14(3):177-80.
22. Berwaerts JC, A. Herben, V. van de Vliet, I. Chang, I. van Hoek, P. Eerdeken, M. The effects of paroxetine on the pharmacokinetics of paliperidone extended-release tablets. *Pharmacopsychiatry*. 2009 Jul;42(4):158-63.
23. Bogart GTC, B. Safety and Efficacy of Quetiapine in Bipolar Depression (November) (CE). *Ann Pharmacother*. 2009 Oct 6.
24. Bondolfi GE, C. B. Bertschy, G. Zullino, D. Vermeulen, A. Baumann, P. The effect of fluoxetine on the pharmacokinetics and safety of risperidone in psychotic patients. *Pharmacopsychiatry*. 2002 Mar;35(2):50-6.
25. Boon-Yasidhi VT, J. Suwanwattana, C. Soising, L. Risperidone in the treatment of autistic Thai children under 4 years of age. *J Med Assoc Thai*. 2002 Aug;85 Suppl 2:S784-9.
26. Bostwick JRG, S. K. Ellingrod, V. L. Antipsychotic-induced hyperprolactinemia. *Pharmacotherapy*. 2009 Jan;29(1):64-73.
27. Briskman ID, R. Barak, Y. Treating delirium in a general hospital: a descriptive study of prescribing patterns and outcomes. *Int Psychogeriatr*. 2009 Sep 29:1-4.
28. Brown ED, D. L. McElroy, S. L. Keck, P. E. Adams, D. H. Degenhardt, E. Tohen, M. Houston, J. P. Olanzapine/fluoxetine combination vs. lamotrigine in the 6-month treatment of bipolar I depression. *Int J Neuropsychopharmacol*. 2009 Jul;12(6):773-82.
29. Bushe CS, Michael Peveler, Robert C. A review of the association between antipsychotic use and hyperprolactinaemia. *Journal of Psychopharmacology*. 2008 Mar, 2008;22(2):46-55.
30. Caicedo CW, S. H. Risperidone improves behavior in children with autism. *J Fam Pract*. 2002 Nov;51(11):915.
31. Campbell NB, Malaz Ayub, Amir Fox, George Munger, Stephanie Ott, Carol Guzman, Oscar Farber, Mark Ademuyiwa, Adetayo Singh, Ranjeet. Pharmacological Management of Delirium in Hospitalized Adults – A Systematic Evidence Review. *Journal of General Internal Medicine*. [10.1007/s11606-009-0996-7]. 2009;24(7):848-53.
32. Canitano R. Self injurious behavior in autism: clinical aspects and treatment with risperidone. *J Neural Transm*. 2006 Mar;113(3):425-31.
33. Canitano RS, V. Risperidone in the treatment of behavioral disorders associated with autism in children and adolescents. *Neuropsychiatr Dis Treat*. 2008 Aug;4(4):723-30.

34. Capone GTG, Parag Grados, Marco Smith, Brandon Kammann, Heather. Risperidone use in children with Down syndrome, severe intellectual disability, and comorbid autistic spectrum disorders: A naturalistic study. *Journal of Developmental and Behavioral Pediatrics*. 2008 Apr, 2008;29(2):106-16.
35. Cascade EK, A. Findling, R. Use of antipsychotics in children. *Psychiatry (Edgmont)*. 2009 Jun;6(6):21-3.
36. Castberg IS, E. Spigset, O. Quetiapine and drug interactions: evidence from a routine therapeutic drug monitoring service. *J Clin Psychiatry*. 2007 Oct;68(10):1540-5.
37. Centorrino FC, Stephanie L. Talamo, Alessandra Fogarty, Kate V. Guzzetta, Francesca Saadeh, Mark G. Salvatore, Paola Baldessarini, Ross J. Hospital use of antipsychotic drugs: Polytherapy. *Comprehensive Psychiatry*. 2008 Jan-Feb, 2008;49(1):65-9.
38. Chavez BC-B, M. Rey, J. A. Role of risperidone in children with autism spectrum disorder. *Ann Pharmacother*. 2006 May;40(5):909-16.
39. Chavez BC-B, M. Sopko, M. A., Jr. Rey, J. A. Atypical antipsychotics in children with pervasive developmental disorders. *Paediatr Drugs*. 2007;9(4):249-66.
40. Chen CHC, C. C. Huang, M. C. Dose-related exacerbation of obsessive-compulsive symptoms with quetiapine treatment. *Prog Neuropsychopharmacol Biol Psychiatry*. 2008 Jan 1;32(1):304-5.
41. Chue PE, R. Long-acting formulations of atypical antipsychotics: time to reconsider when to introduce depot antipsychotics. *CNS Drugs*. 2007;21(6):441-8.
42. Çitil DYS, Engin Karlidağ, Rifat Unal, Süheyla. Ziprasidone-induced hyperprolactinemia: A case report. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*. 2008 Apr, 2008;32(3):905-6.
43. Citrome L. Paliperidone: quo vadis? *Int J Clin Pract*. 2007 Apr;61(4):653-62.
44. Citrome LJ, A. Levine, J. Allingham, B. Robinson, J. Relationship between antipsychotic medication treatment and new cases of diabetes among psychiatric inpatients. *Psychiatr Serv*. 2004 Sep;55(9):1006-13.
45. Cobaugh DJE, A. R. Booze, L. L. Scharman, E. J. Christianson, G. Manoguerra, A. S. Caravati, E. M. Chyka, P. A. Woolf, A. D. Nelson, L. S. Troutman, W. G. Atypical antipsychotic medication poisoning: an evidence-based consensus guideline for out-of-hospital management. *Clin Toxicol (Phila)*. 2007 Dec;45(8):918-42.
46. Cobo Gomez JVF, G. Coronas, R. Benito, N. Barbero, J. D. Domenech, C. Garcia-Pares, G. Combination of aripiprazole and other psychopharmacological treatments in resistant and multi-resistant patients. *Curr Drug Saf*. 2008 Sep;3(3):210-5.
47. Cohen SAF, B. J. Khan, S. R. Khan, A. The effect of a switch to ziprasidone in an adult population with autistic disorder: chart review of naturalistic, open-label treatment. *J Clin Psychiatry*. 2004 Jan;65(1):110-3.
48. Cohrs SM, A. Neumann, A. C. Jordan, W. Ruther, E. Rodenbeck, A. Improved sleep continuity and increased slow wave sleep and REM latency during ziprasidone treatment: a randomized, controlled, crossover trial of 12 healthy male subjects. *J Clin Psychiatry*. 2005 Aug;66(8):989-96.
49. Cohrs SR, A. Guan, Z. Pohlmann, K. Jordan, W. Meier, A. Ruther, E. Sleep-promoting properties of quetiapine in healthy subjects. *Psychopharmacology (Berl)*. 2004 Jul;174(3):421-9.

50. Conley RRK, D. L. Drug-drug interactions associated with second-generation antipsychotics: considerations for clinicians and patients. *Psychopharmacol Bull.* 2007;40(1):77-97.
51. Conley RRK, D. L. Gale, E. A. Olanzapine response in treatment-refractory schizophrenic patients with a history of substance abuse. *Schizophr Res.* 1998 Sep 7;33(1-2):95-101.
52. Corbett RG, L. Shipley, J. E. Shukla, U. Strupczewski, J. T. Szczepanik, A. M. Szewczak, M. R. Turk, D. J. Vargas, H. M. Kongsamut, S. Iloperidone Project, Team. Iloperidone: Preclinical profile and early clinical evaluation. *CNS Drug Reviews.* 1997 Sum, 1997;3(2):120-47.
53. Correll CU. Antipsychotic use in children and adolescents: Minimizing adverse effects to maximize outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2008 Jan, 2008;47(1):9-20.
54. Correll CUK, J. M. One-year incidence rates of tardive dyskinesia in children and adolescents treated with second-generation antipsychotics: a systematic review. *J Child Adolesc Psychopharmacol.* 2007 Oct;17(5):647-56.
55. Correll CUK, John M. Malhotra, Anil K. Risks From Antipsychotic Medications in Children and Adolescents--Reply. *JAMA.* 2010 February 24, 2010;303(8):730-.
56. Corson AHB, J. E. Posey, D. J. Stigler, K. A. McDougle, C. J. A retrospective analysis of quetiapine in the treatment of pervasive developmental disorders. *J Clin Psychiatry.* 2004 Nov;65(11):1531-6.
57. Crockford DNF, G. Barker, P. Risperidone, weight gain, and bulimia nervosa. *Can J Psychiatry.* 1997 Apr;42(3):326-7.
58. Cubells JF. Beyond irritability and aggressive behavior: does risperidone improve adaptive behavior in autistic spectrum disorders? *Curr Psychiatry Rep.* 2007 Apr;9(2):132-3.
59. Curtis LHM, Leah E. Ostbye, Truls Hutchison, Steve Dans, Peter E. Wright, Alan Krishnan, Ranga R. Schulman, Kevin A. Prevalence of Atypical Antipsychotic Drug Use Among Commercially Insured Youths in the United States. *Arch Pediatr Adolesc Med.* 2005 April 1, 2005;159(4):362-6.
60. Dan AB, Rahul Grover, Sandeep. Neuroleptic malignant syndrome with use of quetiapine in mental retardation. *Psychiatry and Clinical Neurosciences.* 2009 Apr, 2009;63(2):255-6.
61. de Millas WH, Christian. Treatment of alcohol hallucinosis with risperidone. *The American Journal on Addictions.* 2007 May-Jun, 2007;16(3):249-50.
62. Dean AJM, B. M. Marshall, R. T. PRN sedation-patterns of prescribing and administration in a child and adolescent mental health inpatient service. *Eur Child Adolesc Psychiatry.* 2006 Aug;15(5):277-81.
63. Deeks EDK, Gillian M. Spotlight on olanzapine/fluoxetine in acute bipolar depression. *CNS Drugs.* 2008 2008;22(9):793-5.
64. Del Paggio D. Psychotropic medication abuse in correctional facilities. *The Bay Area Psychopharmacology Newsletter.* 2005;8(1).
65. DelBello MPC, K. Welge, J. A. Adler, C. M. Rana, M. Howe, M. Bryan, H. Vogel, D. Sampang, S. Delgado, S. V. Sorter, M. Strakowski, S. M. A double-blind, placebo-controlled pilot study of quetiapine for depressed adolescents with bipolar disorder. *Bipolar Disord.* 2009 Aug;11(5):483-93.

66. Dew REH, D. Acute dystonic reaction with moderate-dose ziprasidone. *J Clin Psychopharmacol.* 2004 Oct;24(5):563-4.
67. Dinca OP, M. Spencer, N. J. Systematic review of randomized controlled trials of atypical antipsychotics and selective serotonin reuptake inhibitors for behavioural problems associated with pervasive developmental disorders. *J Psychopharmacol.* 2005 Sep;19(5):521-32.
68. Dlugosz HN, H. A. Paliperidone: a new extended-release oral atypical antipsychotic. *Expert Opin Pharmacother.* 2007 Oct;8(14):2307-13.
69. Dopheide JA. Paliperidone: An improvement over risperidone? *Am J Health Syst Pharm.* 2008 Mar 1;65(5):401.
70. Duggal HS. Letter to the editor: Ziprasidone for maladaptive behavior and attention-deficit/hyperactivity disorder symptoms in autistic disorder. *Journal of Child and Adolescent Psychopharmacology.* 2007 May, 2007;17(2):261-3.
71. Duggal HS. Possible neuroleptic malignant syndrome associated with paliperidone. *J Neuropsychiatry Clin Neurosci.* 2007 Fall;19(4):477-8.
72. DuMouchel WF, David Yang, Xionghu Mahmoud, Ramy A. Grogg, Amy L. Engelhart, Luella Ramaswamy, Krishnan. Antipsychotics, Glycemic Disorders, and Life-Threatening Diabetic Events: A Bayesian Data-Mining Analysis of the FDA Adverse Event Reporting System (1968-2004). *Annals of Clinical Psychiatry: The official Journal of the American Academy of Clinical Psychiatrists.* 2008;20(1):21 - 31.
73. Einarson AB, Rada. Use and safety of antipsychotic drugs during pregnancy. *Journal of Psychiatric Practice.* 2009 May, 2009;15(3):183-92.
74. Endicott JP, B. Gustafsson, U. Schioler, H. Hassan, M. Quetiapine monotherapy in the treatment of depressive episodes of bipolar I and II disorder: Improvements in quality of life and quality of sleep. *J Affect Disord.* 2008 Dec;111(2-3):306-19.
75. Endicott JR, K. Minkwitz, M. Macfadden, W. A randomized, double-blind, placebo-controlled study of quetiapine in the treatment of bipolar I and II depression: improvements in quality of life. *Int Clin Psychopharmacol.* 2007 Jan;22(1):29-37.
76. Englisch SE, C. Inta, D. Weinbrenner, A. Peus, V. Gutschalk, A. Schirmbeck, F. Zink, M. Clozapine-induced obsessive-compulsive syndromes improve in combination with aripiprazole. *Clin Neuropharmacol.* 2009 Jul-Aug;32(4):227-9.
77. Feldman PDH, L. K. Deberdt, W. Kennedy, J. S. Hutchins, D. S. Hay, D. P. Hardy, T. A. Hoffmann, V. P. Hornbuckle, K. Breier, A. Retrospective cohort study of diabetes mellitus and antipsychotic treatment in a geriatric population in the United States. *J Am Med Dir Assoc.* 2004 Jan-Feb;5(1):38-46.
78. Feroz-Nainar CR, M. Risperidone and late onset tics. *Autism.* 2006 May;10(3):302-7.
79. Feroz-Nainar CS, P. Roy, M. Risperidone induced oedema in a child with learning disability and autism. *Autism.* 2006 May;10(3):308-10.
80. Fido AA-S, S. Olanzapine in the treatment of behavioral problems associated with autism: an open-label trial in Kuwait. *Med Princ Pract.* 2008;17(5):415-8.
81. Findling RL. Atypical antipsychotic treatment of disruptive behavior disorders in children and adolescents. *J Clin Psychiatry.* 2008;69 Suppl 4:9-14.
82. Findling RLM, N. K. Gracious, B. L. O'Riordan, M. A. Reed, M. D. Demeter, C. Blumer, J. L. Quetiapine in nine youths with autistic disorder. *J Child Adolesc Psychopharmacol.* 2004 Summer;14(2):287-94.

83. Findling RLMDK, Ralph E. M. D. Sallee, Floyd R. M. D. PhD Carson, William H. M. D. Nyilas, Margaretta M. D. Mallikaarjun, Suresh PhD F. C. P. Shoaf, Susan E. PhD Forbes, Robert A. PhD Boulton, David W. PhD Pikalov, Andrei M. D. PhD. Tolerability and Pharmacokinetics of Aripiprazole in Children and Adolescents With Psychiatric Disorders: An Open-Label, Dose-Escalation Study. *Journal of Clinical Psychopharmacology*. 2008;28(4):441-6.
84. Findling RLR, M. D. O'Riordan, M. A. Demeter, C. A. Stansbrey, R. J. McNamara, N. K. A 26-week open-label study of quetiapine in children with conduct disorder. *J Child Adolesc Psychopharmacol*. 2007 Feb;17(1):1-9.
85. Flanagan SRE, E. P. Sandel, E. Managing agitation associated with traumatic brain injury: behavioral versus pharmacologic interventions? *PM R*. 2009 Jan;1(1):76-80.
86. Fombonne E. Risperidone improves restricted, repetitive, and stereotyped behaviour in autistic children and adolescents. *Evid Based Ment Health*. 2006 Feb;9(1):6.
87. Fountoulakis KNG, Heinz Panagiotidis, Panagiotis Kaprinis, George. Treatment of bipolar depression: An update. *Journal of Affective Disorders*. 2008 Jul, 2008;109(1):21-34.
88. Gabriel A. Changes in plasma cholesterol in mood disorder patients: does treatment make a difference? *J Affect Disord*. 2007 Apr;99(1-3):273-8.
89. Gagliano AG, E. Pustorino, G. Impallomeni, C. D'Arrigo, C. Calamoneri, F. Spina, E. Risperidone treatment of children with autistic disorder: effectiveness, tolerability, and pharmacokinetic implications. *J Child Adolesc Psychopharmacol*. 2004 Spring;14(1):39-47.
90. Gencer OE, F. N. Miral, S. Baykara, B. Baykara, A. Dirik, E. Comparison of long-term efficacy and safety of risperidone and haloperidol in children and adolescents with autistic disorder. An open label maintenance study. *Eur Child Adolesc Psychiatry*. 2008 Jun;17(4):217-25.
91. Ghanizadeh A. Does risperidone improve hyperacusia in children with autism? *Psychopharmacol Bull*. 2009;42(1):108-10.
92. Gimenez SC, S. Romero, S. Grasa, E. Morte, A. Barbanoj, M. J. Effects of olanzapine, risperidone and haloperidol on sleep after a single oral morning dose in healthy volunteers. *Psychopharmacology (Berl)*. 2007 Mar;190(4):507-16.
93. Gjerden PS, L. Bramness, J. G. Prescription persistence and safety of antipsychotic medication: a national registry-based 3-year follow-up. *Eur J Clin Pharmacol*. 2010 Jun 3.
94. Gobert MDh, W. Prevalence of psychotropic drug use in nursing homes for the aged in Quebec and in the French-speaking area of Switzerland. *International Journal of Geriatric Psychiatry*. 2005;20(8):712-21.
95. Goodnick PJ. Higher than Physician's Desk Reference (US) doses on atypical antipsychotics. *Expert Opinion on Drug Safety*. 2005;4(4):653-68.
96. Gorwood P. Meeting everyday challenges: antipsychotic therapy in the real world. *Eur Neuropsychopharmacol*. 2006 Sep;16 Suppl 3:S156-62.
97. Goto MY, Reiji Kakihara, Shingo Shinkai, Koji Yamada, Yasuhisa Kaji, Kyoko Ueda, Nobuhisa Nakamura, Jun. Risperidone in the treatment of psychotic depression. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*. 2006;30(4):701-7.
98. Haberfellner EMaR, Hans b. Weight gain during long-term treatment with olanzapine: a case series. *International Clinical Psychopharmacology*. 2004;19(4):251-3.

99. HALL DAA, PINKY GRIFFITH, ALIDA SEGRO, VICKI SEEBERGER, LAUREN C. MOVEMENT DISORDERS ASSOCIATED WITH ARIPIRAZOLE USE: A CASE SERIES. *International Journal of Neuroscience*. 2009;119(12):2274-9.
100. Hamann JaR, Andras b Auby, Philippe c Pugner, Klaus d Kissling, Werner a. Antipsychotic prescribing patterns in Germany: a retrospective analysis using a large outpatient prescription database. *International Clinical Psychopharmacology*. 2003;18(4):237-42.
101. Haney MS, R. Controversies in translational research: drug self-administration. *Psychopharmacology (Berl)*. 2008 Aug;199(3):403-19.
102. Hasnain MV, W. V. Baron, M. S. Beatty-Brooks, M. Fernandez, A. Pandurangi, A. K. Pharmacological management of psychosis in elderly patients with parkinsonism. *Am J Med*. 2009 Jul;122(7):614-22.
103. Hazell P. Drug therapy for attention-deficit/hyperactivity disorder-like symptoms in autistic disorder. *J Paediatr Child Health*. 2007 Jan-Feb;43(1-2):19-24.
104. Henderson DCC, P. M. Borba, C. P. Daley, T. B. Nguyen, D. D. Cagliero, E. Evins, A. E. Zhang, H. Hayden, D. L. Freudenreich, O. Cather, C. Schoenfeld, D. A. Goff, D. C. Glucose metabolism in patients with schizophrenia treated with olanzapine or quetiapine: a frequently sampled intravenous glucose tolerance test and minimal model analysis. *J Clin Psychiatry*. 2006 May;67(5):789-97.
105. Hien L, T. T. Cumming, Robert, G. Cameron, Ian, D. Chen, Jian, S. Lord, Stephen, R. March, Lyn, M. Schwarz, Jennifer Le Couteur, David, G. Sambrook, Philip, N. . Atypical Antipsychotic Medications and Risk of Falls in Residents of Aged Care Facilities. *Journal of the American Geriatrics Society*. 2005;53(8):1290-5.
106. Hirschfeld RMA. 'Does olanzapine have any antidepressant effect?': Dr Hirschfeld replies. *The American Journal of Psychiatry*. 2006 Oct, 2006;163(10):1839.
107. Hollander EW, S. Swanson, E. N. Chaplin, W. Schapiro, M. L. Zagursky, K. Novotny, S. A double-blind placebo-controlled pilot study of olanzapine in childhood/adolescent pervasive developmental disorder. *J Child Adolesc Psychopharmacol*. 2006 Oct;16(5):541-8.
108. Hollis JMBBSG, David Ph D. Forrester, Loelle Brodaty, Henry D. Sc Touyz, Stephen Ph D. Cumming, Robert Ph D. Antipsychotic Medication Dispensing and Risk of Death in Veterans and War Widows 65 Years and Older. *American Journal of Geriatric Psychiatry*. 2007;15(11):932-41.
109. Howland RH. Paliperidone extended-release tablets: a new atypical antipsychotic. *Journal of Psychosocial Nursing & Mental Health Services*. 2007;45(5):15-8.
110. Hutchison KER, M. C. Niaura, R. Swift, R. M. Pickworth, W. B. Sobik, L. Olanzapine attenuates cue-elicited craving for tobacco. *Psychopharmacology (Berl)*. 2004 Oct;175(4):407-13.
111. Jarema M. Atypical antipsychotics in the treatment of mood disorders. *Current Opinion in Psychiatry*. 2007 Jan, 2007;20(1):23-9.
112. Jesner OSA-A, M. Coren, E. Risperidone for autism spectrum disorder. *Cochrane Database Syst Rev*. 2007(1):CD005040.
113. Jeste DVJ, H. Golshan, S. Mudaliar, S. Glorioso, D. Fellows, I. Kraemer, H. Arndt, S. Discontinuation of quetiapine from an NIMH-funded trial due to serious adverse events. *Am J Psychiatry*. 2009 Aug;166(8):937-8.

114. Jha AF, H. Risperidone treatment of amphetamine psychosis. *Br J Psychiatry*. 1999 Apr;174:366.
115. Johnsen EJHA, Svingen G.F. Practice regarding antipsychotic therapy: A cross-sectional survey in two Norwegian hospitals. *Nordic Journal of Psychiatry*. 2004;58(4):313-7.
116. Kang SGL, H. J. Kim, L. Restless legs syndrome and periodic limb movements during sleep probably associated with olanzapine. *J Psychopharmacol*. 2009 Jul;23(5):597-601.
117. Kaptan AD, Tzvi Lerner, Vladimir. Ziprasidone-associated depressive state in schizophrenic patients. *Clinical Neuropharmacology*. 2007 Nov-Dec, 2007;30(6):357-61.
118. Keltner NLV, D. E. Biological perspectives incarcerated care and quetiapine abuse. *Perspect Psychiatr Care*. 2008 Jul;44(3):202-6.
119. Kemner CW-S, S. H. de Jonge, M. Tuynman-Qua, H. van Engeland, H. Open-label study of olanzapine in children with pervasive developmental disorder. *J Clin Psychopharmacol*. 2002 Oct;22(5):455-60.
120. Kennedy AT, A. Kelly, W. S. Kilzieh, N. Wood, A. E. Abstinence, anticipation, reduction, and treatment (AART): a stepwise approach to the management of atypical antipsychotic side effects. *Essent Psychopharmacol*. 2006;7(1):1-14.
121. King BHB, J. Q. An update on pharmacologic treatments for autism spectrum disorders. *Child Adolesc Psychiatr Clin N Am*. 2006 Jan;15(1):161-75.
122. Kinon BJL, Ilya Edwards, S. Beth Adams, David H. Ascher-Svanum, Haya Siris, Samuel G. A 24-week randomized study of olanzapine versus ziprasidone in the treatment of schizophrenia or schizoaffective disorder in patients with prominent depressive symptoms. *Journal of Clinical Psychopharmacology*. 2006 Apr, 2006;26(2):157-62.
123. Kleijer BvM, RJ Egberts, ACG Jansen, PAF Knol, W. Heerdink, ER. Risk of cerebrovascular events in elderly users of antipsychotics. *J Psychopharmacol*. 2009 November 1, 2009;23(8):909-14.
124. Knapp ML, J. Jarbrink, K. Impact of psychotic relapse definitions in assessing drug efficacy and costs: comparison of quetiapine XR, olanzapine and paliperidone ER. *Curr Med Res Opin*. 2009 Jul;25(7):1593-603.
125. Knol WvM, Rob J. Jansen, Paul A. F. Souverein, Patrick C. Schobben, Alfred F. A. M. Egberts, Antoine C. G. Antipsychotic Drug Use and Risk of Pneumonia in Elderly People. *Journal of the American Geriatrics Society*. 2008;56(4):661-6.
126. Kogut SJY, F. Dufresne, R. Prescribing of antipsychotic medication in a medicaid population: use of polytherapy and off-label dosages. *J Manag Care Pharm*. 2005 Jan-Feb;11(1):17-24.
127. Kohen IS, A. Central sleep apnea in a geriatric patient treated with aripiprazole. *Am J Ther*. 2009 Mar-Apr;16(2):197-8.
128. Konstantinidis AH, W. Nirnberger, G. Windhager, E. Lehofer, M. Aschauer, H. Kasper, S. Quetiapine in combination with citalopram in patients with unipolar psychotic depression. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*. 2007;31(1):242-7.
129. Kornreich CD, Bernard Verbanck, Paul Pelc, Isy. Treating Charles Bonnet syndrome: Understanding inconsistency. *Journal of Clinical Psychopharmacology*. 2000 Jun, 2000;20(3):396.

130. Kranzler HRC, Jonathan Pierucci-Lagha, Amira Chan, Grace Douglas, Kara Arias, Albert J. Oncken, Cheryl. Effects of aripiprazole on subjective and physiological responses to alcohol. *Alcoholism: Clinical and Experimental Research*. 2008 Apr; 2008;32(4):573-9.
131. Kreyenbuhl JAV, M. McCarthy, J. F. Ganoczy, D. Blow, F. C. Long-term antipsychotic polypharmacy in the VA health system: patient characteristics and treatment patterns. *Psychiatr Serv*. 2007 Apr;58(4):489-95.
132. Lautenschlager MH, A. Paliperidone-ER: first atypical antipsychotic with oral extended release formulation. *Expert Rev Neurother*. 2008 Feb;8(2):193-200.
133. LeBlanc JCB, C. E. Armenteros, J. L. Aman, M. G. Wang, J. S. Hew, H. Kusumakar, V. Risperidone reduces aggression in boys with a disruptive behaviour disorder and below average intelligence quotient: analysis of two placebo-controlled randomized trials. *Int Clin Psychopharmacol*. 2005 Sep;20(5):275-83.
134. Lee KUJ, Y. W. Lee, H. K. Jun, T. Y. Efficacy and safety of quetiapine for depressive symptoms in patients with schizophrenia. *Hum Psychopharmacol*. 2009 Aug;24(6):447-52.
135. Lee KUW, W. Y. Lee, H. K. Kweon, Y. S. Lee, C. T. Pae, C. U. Bahk, W. M. Amisulpride versus quetiapine for the treatment of delirium: a randomized, open prospective study. *Int Clin Psychopharmacol*. 2005 Nov;20(6):311-4.
136. Lerner AGS, Emi Kodesh, Arad Rudinski, Dmitri Kretzmer, Gavin Sigal, Mircea. Risperidone-associated, benign transient visual disturbances in schizophrenic patients with a past history of LSD abuse. *Israel Journal of Psychiatry and Related Sciences*. 2002 2002;39(1):57-60.
137. Leslie DLR, R. A. From conventional to atypical antipsychotics and back: dynamic processes in the diffusion of new medications. *Am J Psychiatry*. 2002 Sep;159(9):1534-40.
138. Libby AMO, H. D. Valuck, R. J. Persisting decline in depression treatment after FDA warnings. *Arch Gen Psychiatry*. 2009 Jun;66(6):633-9.
139. Liebowitz MRS, E. Mech, A. Dunner, D. Johnson, A. E. Akhtar, J. Pratap, R. Ziprasidone monotherapy in bipolar II depression: an open trial. *J Affect Disord*. 2009 Nov;118(1-3):205-8.
140. Lile JAS, W. W. Vansickel, A. R. Glaser, P. E. Hays, L. R. Rush, C. R. Aripiprazole attenuates the discriminative-stimulus and subject-rated effects of D-amphetamine in humans. *Neuropsychopharmacology*. 2005 Nov;30(11):2103-14.
141. Lim MP, D. Y. Kwon, J. S. Joo, Y. H. Hong, K. S. Prevalence and clinical characteristics of obsessive-compulsive symptoms associated with atypical antipsychotics. *J Clin Psychopharmacol*. 2007 Dec;27(6):712-3.
142. Lindberg NV, M. Tani, P. Appelberg, B. Virkkala, J. Rimon, R. Porkka-Heiskanen, T. Effect of a single-dose of olanzapine on sleep in healthy females and males. *Int Clin Psychopharmacol*. 2002 Jul;17(4):177-84.
143. Lindsay RLEA, L. Aman, M. G. Vitiello, B. Posey, D. J. McDougale, C. J. Scahill, L. Pachler, M. McCracken, J. T. Tierney, E. Bozzolo, D. Dietary status and impact of risperidone on nutritional balance in children with autism: a pilot study. *J Intellect Dev Disabil*. 2006 Dec;31(4):204-9.

144. Liu YS, H. Q. Bao, Y. P. Li, S. X. Beveridge, T. J. Di, X. L. Yang, F. D. Lu, L. Subjective, cognitive/psychomotor, and physiological effects of aripiprazole in Chinese light and heavy smokers. *Drug Alcohol Depend.* 2009 Apr 1;101(1-2):42-52.
145. Lofthouse NF, M. A. Splaingard, M. Kelleher, K. Hayes, J. Resko, S. Web-survey of pharmacological and non-pharmacological sleep interventions for children with early-onset bipolar spectrum disorders. *J Affect Disord.* 2009 Sep 7.
146. Lu BB, R. Parthasarathy, S. Sedating medications and undiagnosed obstructive sleep apnea: physician determinants and patient consequences. *J Clin Sleep Med.* 2005 Oct 15;1(4):367-71.
147. Luby JM, C. Stalets, M. M. Belden, A. Heffelfinger, A. Williams, M. Spitznagel, E. Risperidone in preschool children with autistic spectrum disorders: an investigation of safety and efficacy. *J Child Adolesc Psychopharmacol.* 2006 Oct;16(5):575-87.
148. Luthringer RS, L. Noel, N. Muzet, M. Gassmann-Mayer, C. Talluri, K. Cleton, A. Eerdeken, M. Battisti, W. P. Palumbo, J. M. A double-blind, placebo-controlled, randomized study evaluating the effect of paliperidone extended-release tablets on sleep architecture in patients with schizophrenia. *Int Clin Psychopharmacol.* 2007 Sep;22(5):299-308.
149. Macfadden WC, J.R. McCoy, R. et al. . Antianxiety effects analysis of quetiapine in bipolar depression [abstract]. The 157th Annual Meeting of the American Psychiatric Association. New York, NY, USA; May 1-6, 2004
150. Madhusoodanan SS, P. Management of psychosis in patients with Alzheimer's disease: focus on aripiprazole. *Clin Interv Aging.* 2008;3(3):491-501.
151. Malhi GSA, Danielle Berk, Michael. Medicating mood with maintenance in mind: Bipolar depression pharmacotherapy. *Bipolar Disorders.* 2009 Jun, 2009;11(2):55-76.
152. Malhi SBNSGWGHMCG. Observations from postal research involving families of young people taking antipsychotic medication. *Acta Neuropsychiatrica.* 2010;22(2):102-.
153. Malone RP. Discontinuing risperidone results in relapse in children with autism spectrum disorders. *Evid Based Ment Health.* 2006 May;9(2):56.
154. Malone RPD, M. A. Hyman, S. B. Cater, J. R. Ziprasidone in adolescents with autism: an open-label pilot study. *J Child Adolesc Psychopharmacol.* 2007 Dec;17(6):779-90.
155. Malone RPG, S. S. Delaney, M. A. Hyman, S. B. Advances in drug treatments for children and adolescents with autism and other pervasive developmental disorders. *CNS Drugs.* 2005;19(11):923-34.
156. Malone RPM, G. Choudhury, M. S. Gifford, C. Delaney, M. A. Risperidone treatment in children and adolescents with autism: short- and long-term safety and effectiveness. *J Am Acad Child Adolesc Psychiatry.* 2002 Feb;41(2):140-7.
157. Malone RPW, A. The role of antipsychotics in the management of behavioural symptoms in children and adolescents with autism. *Drugs.* 2009;69(5):535-48.
158. Mancini FT, Cristina Martignoni, Emilia Moglia, Arrigo Nappi, Giuseppe Cristina, Silvano Pacchetti, Claudio. Long-Term Evaluation of the Effect of Quetiapine on Hallucinations, Delusions and Motor Function in Advanced Parkinson Disease. [Article].

159. Mandalos GES, B. L. New-onset panic attacks in a patient treated with olanzapine. *J Clin Psychopharmacol.* 1999 Apr;19(2):191.
160. Marcus RNO, R. Kamen, L. Manos, G. McQuade, R. D. Carson, W. H. Aman, M. G. A Double-Blind, Randomized, Placebo-Controlled Study of Fixed-Dose Aripiprazole in Children and Adolescents With Autistic Disorder. *J Am Acad Child Adolesc Psychiatry.* 2009 Sep 30.
161. Marder SRK, M. Ford, L. Eerdeken, E. Lim, P. Eerdeken, M. Lowy, A. Efficacy and safety of paliperidone extended-release tablets: results of a 6-week, randomized, placebo-controlled study. *Biol Psychiatry.* 2007 Dec 15;62(12):1363-70.
162. Martin AS, L. Anderson, G. M. Aman, M. Arnold, L. E. McCracken, J. McDougle, C. J. Tierney, E. Chuang, S. Vitiello, B. Weight and leptin changes among risperidone-treated youths with autism: 6-month prospective data. *Am J Psychiatry.* 2004 Jun;161(6):1125-7.
163. Martin SDL, S. E. Pratt, D. J. Brewin, J. S. Huq, Z. U. Saleh, B. T. Clinical experience with the long-acting injectable formulation of the atypical antipsychotic, risperidone. *Curr Med Res Opin.* 2003;19(4):298-305.
164. Masi GC, A. Millepiedi, S. Muratori, F. Pari, C. Salvadori, F. Aripiprazole monotherapy in children and young adolescents with pervasive developmental disorders: a retrospective study. *CNS Drugs.* 2009;23(6):511-21.
165. Masi GC, A. Mucci, M. Brovedani, P. A 3-year naturalistic study of 53 preschool children with pervasive developmental disorders treated with risperidone. *J Clin Psychiatry.* 2003 Sep;64(9):1039-47.
166. Masi GM, S. Perugi, G. Pfanner, C. Berloff, S. Pari, C. Mucci, M. Pharmacotherapy in paediatric obsessive-compulsive disorder: a naturalistic, retrospective study. *CNS Drugs.* 2009;23(3):241-52.
167. Matthews JDS, C. Dording, C. Denninger, J. W. Park, L. van Nieuwenhuizen, A. O. Sklarsky, K. Hilliker, S. Homberger, C. Rooney, K. Fava, M. An open study of aripiprazole and escitalopram for psychotic major depressive disorder. *J Clin Psychopharmacol.* 2009 Feb;29(1):73-6.
168. McAllister TW. Risperidone for autistic disorder. *Curr Psychiatry Rep.* 2005 Oct;7(5):369-70.
169. McConville BC, L. Sweitzer, D. Potter, L. Chaney, R. Foster, K. Sorter, M. Friedman, L. Browne, K. Long-term safety, tolerability, and clinical efficacy of quetiapine in adolescents: an open-label extension trial. *J Child Adolesc Psychopharmacol.* 2003 Spring;13(1):75-82.
170. McDougle CJS, K. A. Erickson, C. A. Posey, D. J. Atypical antipsychotics in children and adolescents with autistic and other pervasive developmental disorders. *J Clin Psychiatry.* 2008;69 Suppl 4:15-20.
171. McDougle CJS, L. Aman, M. G. McCracken, J. T. Tierney, E. Davies, M. Arnold, L. E. Posey, D. J. Martin, A. Ghuman, J. K. Shah, B. Chuang, S. Z. Swiezy, N. B. Gonzalez, N. M. Hollway, J. Koenig, K. McGough, J. J. Ritz, L. Vitiello, B. Risperidone for the core symptom domains of autism: results from the study by the autism network of the research units on pediatric psychopharmacology. *Am J Psychiatry.* 2005 Jun;162(6):1142-8.
172. McGlashan THZ, Robert B. Perkins, Diana Addington, Jean Miller, Tandy Woods, Scott W. A. Hawkins, Keith E. Hoffman, Ralph Preda, Adrian Epstein, Irvin

- Addington, Donald Lindborg, Stacy Trzaskoma, Quynh Tohen, Mauricio Breier, Alan. Randomized, Double-Blind Trial of Olanzapine Versus Placebo in Patients Prodromally Symptomatic for Psychosis. *Am J Psychiatry*. 2006 May 1, 2006;163(5):790-9.
173. Meyers BSF, A. J. Rothschild, A. J. Mulsant, B. H. Whyte, E. M. Peasley-Miklus, C. Papademetriou, E. Leon, A. C. Heo, M. A double-blind randomized controlled trial of olanzapine plus sertraline vs olanzapine plus placebo for psychotic depression: the study of pharmacotherapy of psychotic depression (STOP-PD). *Arch Gen Psychiatry*. 2009 Aug;66(8):838-47.
174. Miller DD. Atypical antipsychotics: sleep, sedation, and efficacy. *Prim Care Companion J Clin Psychiatry*. 2004;6(Suppl 2):3-7.
175. Miral SG, O. Inal-Emiroglu, F. N. Baykara, B. Baykara, A. Dirik, E. Risperidone versus haloperidol in children and adolescents with AD : a randomized, controlled, double-blind trial. *Eur Child Adolesc Psychiatry*. 2008 Feb;17(1):1-8.
176. Mirandola MA, Margherita Corbari, Letizia Sorio, Adriano Nosè, Michela Barbui, Corrado. Prevalence, incidence and persistence of antipsychotic drug prescribing in the Italian general population: retrospective database analysis, 1999-2002. *Pharmacoepidemiology and Drug Safety*. 2006;15(6):412-20.
177. Misra LK, L. Risperidone treatment of methamphetamine psychosis. *Am J Psychiatry*. 1997 Aug;154(8):1170.
178. Misra LKK, L. Oesterheld, J. R. Richards, G. A. Olanzapine treatment of methamphetamine psychosis. *J Clin Psychopharmacol*. 2000 Jun;20(3):393-4.
179. Moeller OE, S. Deckert, J. Baune, B. T. Dannlowski, U. Nguyen, D. H. Arolt, V. Hetzel, G. The impact of ziprasidone in combination with sertraline on visually-evoked event-related potentials in depressed patients with psychotic features. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*. 2007 Oct, 2007;31(7):1440-3.
180. Mond JM, Rodney Owen, Cathy. Use of antipsychotic medications in Australian States and Territories between July 1995 and December 2001. *Australasian Psychiatry: Publication of The Royal Australian and New Zealand College of Psychiatrists*. 2003;11(3):267 - 72.
181. Morgan ST, E. Antipsychotic drugs in children with autism. *BMJ*. 2007 May 26;334(7603):1069-70.
182. Mouaffak FG, T. Bayle, F. J. Olie, J. P. Baup, N. Worsening of obsessive-compulsive symptoms after treatment with aripiprazole. *J Clin Psychopharmacol*. 2007 Apr;27(2):237-8.
183. Myers SM. The status of pharmacotherapy for autism spectrum disorders. *Expert Opin Pharmacother*. 2007 Aug;8(11):1579-603.
184. Nagaraj RS, P. Malhi, P. Risperidone in children with autism: randomized, placebo-controlled, double-blind study. *J Child Neurol*. 2006 Jun;21(6):450-5.
185. Nakaaki SM, Y. Furukawa, T. A. Efficacy of olanzapine augmentation of paroxetine therapy in patients with severe body dysmorphic disorder. *Psychiatry Clin Neurosci*. 2008 Jun;62(3):370.
186. Nasrallah HAB, Donald W. Goldberg, Joseph F. Muzina, David J. Pariser, Stephen F. Issues associated with the use of atypical antipsychotic medications. *Annals of Clinical Psychiatry*. 2008 Dec, 2008;20(4):S24-S9.
187. Navari RMB, M. C. Treatment of cancer-related anorexia with olanzapine and megestrol acetate: a randomized trial. *Support Care Cancer*. 2009 Sep 11.

188. Nunes JVB, P. A. Novel research translates to clinical cases of schizophrenic and cocaine psychosis. *Neuropsychiatr Dis Treat*. 2007 Aug;3(4):475-85.
189. Olgun HS, O. Karacan, M. Ceviz, N. An unreported side effect of risperidone in children: sinus arrest with long pauses causing syncope. *Pediatr Emerg Care*. 2009 Jul;25(7):465-6.
190. Önder ÜTE. Clinical and pharmacologic risk factors for neuroleptic malignant syndrome and their association with death. *Psychiatry and Clinical Neurosciences*. 2010;64(1):79-87.
191. Osuntokun OOM, B. Xu, W. I. Kryzhanovskaya, L. A. Robertson-Plouch, C. Carlson, J. L. Acharya, N. Corya, S. A. Metabolic parameters in patients treated with olanzapine or other atypical antipsychotics. *J Psychopharmacol*. 2010 May 24.
192. Owen RT. Extended-release paliperidone: efficacy, safety and tolerability profile of a new atypical antipsychotic. *Drugs Today (Barc)*. 2007 Apr;43(4):249-58.
193. Pae CU. A review of the safety and tolerability of aripiprazole. *Expert Opin Drug Saf*. 2009 May;8(3):373-86.
194. Pandina GJB, C. A. Youssef, E. Zhu, Y. Dunbar, F. Risperidone improves behavioral symptoms in children with autism in a randomized, double-blind, placebo-controlled trial. *J Autism Dev Disord*. 2007 Feb;37(2):367-73.
195. Pani LM, G. Expected clinical benefits of paliperidone extended-release formulation when compared with risperidone immediate-release. *Expert Opin Drug Deliv*. 2009 Mar;6(3):319-31.
196. Pappadopulos EW, S. Chait, A. Perkins, M. Connor, D. F. Jensen, P. S. Pharmacotherapy of aggression in children and adolescents: efficacy and effect size. *J Can Acad Child Adolesc Psychiatry*. 2006 Feb;15(1):27-39.
197. Parikh MSK, A. Hollander, E. Psychopharmacology of aggression in children and adolescents with autism: a critical review of efficacy and tolerability. *J Child Adolesc Psychopharmacol*. 2008 Apr;18(2):157-78.
198. Patel NCC, M. Lynn Hoagwood, Kimberly Johnsrud, Michael T. Rascati, Karen L. Wilson, James P. Jensen, Peter S. Trends in the Use of Typical and Atypical Antipsychotics in Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2005;44(6):548-56.
199. Patel NCC, M. Lynn Hoagwood, Kimberly Johnsrud, Michael T. Rascati, Karen L. Wilson, James P. Physician Specialty Associated With Antipsychotic Prescribing for Youths in the Texas Medicaid Program. *Medical Care*. 2006;44(1):87-90.
200. Patel NCS, Robert J. Johnsrud, Michael T. Crismon, M. Lynn. Trends in Antipsychotic Use in a Texas Medicaid Population of Children and Adolescents: 1996 to 2000. *Journal of Child and Adolescent Psychopharmacology*. 2002;12(3):221-9.
201. Posey DJE, C. A. McDougle, C. J. Developing drugs for core social and communication impairment in autism. *Child Adolesc Psychiatr Clin N Am*. 2008 Oct;17(4):787-801, viii-ix.
202. Posey DJE, K. A. Erickson, C. A. McDougle, C. J. Antipsychotics in the treatment of autism. *J Clin Invest*. 2008 Jan;118(1):6-14.
203. Potkin SGT, P. T. Alva, G. Bera, R. Yeh, C. Arvanitis, L. A. The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone, or thioridazine. *J Clin Psychopharmacol*. 2002 Apr;22(2):121-30.

204. Potvin SK, E. Lipp, O. Bouchard, R. H. Roy, M. A. Demers, M. F. Gendron, A. Astarita, G. Piomelli, D. Stip, E. Endogenous cannabinoids in patients with schizophrenia and substance use disorder during quetiapine therapy. *J Psychopharmacol.* 2008 May;22(3):262-9.
205. Preval HK, S. G. Southard, R. Francis, A. Rapid-acting IM ziprasidone in a psychiatric emergency service: a naturalistic study. *Gen Hosp Psychiatry.* 2005 Mar-Apr;27(2):140-4.
206. Procyshyn RMT, B. Patterns of Antipsychotic Utilization in a Tertiary Care Psychiatric Institution. *Pharmacopsychiatry.* 2004;38(01):12-7.
207. Radley DC, Finkelstein SN, Stafford RS. Off-label prescribing among office-based physicians. *Arch Intern Med.* 2006 May 8;166(9):1021-6.
208. Rao VS, Jennifer R. Handel, Sharon Onyike, Chiadi U. Clinical correlates of personality changes associated with traumatic brain injury. *The Journal of Neuropsychiatry and Clinical Neurosciences.* 2008 Win, 2008;20(1):118-9.
209. Rapoport MM, M. Shulman, K. I. Herrmann, N. Rochon, P. A. . Antipsychotic use in the elderly: shifting trends and increasing costs. *International Journal of Geriatric Psychiatry.* 2005;20(8):749-53.
210. Rausch JLS, E. L. Londino, D. L. Johnson, M. E. Carr, B. M. Bhatia, R. Miller, S. Open-label risperidone for Asperger's disorder: negative symptom spectrum response. *J Clin Psychiatry.* 2005 Dec;66(12):1592-7.
211. Reeves RK, Herbert Lieberman, Jordan Vyas, Rajiv. Creation of a Metabolic Monitoring Program for Second-Generation (Atypical) Antipsychotics. *Journal of Correctional Health Care.* 2009 October 1, 2009;15(4):292-301.
212. Reeves RRB, J. C. Additional evidence of the abuse potential of quetiapine. *South Med J.* 2007 Aug;100(8):834-6.
213. Reyes MB, Jan Toren, Paz Augustyns, Ilse Eerdeken, Marielle. A Randomized, Double-Blind, Placebo-Controlled Study of Risperidone Maintenance Treatment in Children and Adolescents With Disruptive Behavior Disorders. *Am J Psychiatry.* 2006 March 1, 2006;163(3):402-10.
214. Riedel MS, M. J. Strassnig, M. Spellmann, I. Muller-Arends, A. Weber, K. Zach, J. Muller, N. Moller, H. J. Risperidone plasma levels, clinical response and side-effects. *Eur Arch Psychiatry Clin Neurosci.* 2005 Aug;255(4):261-8.
215. Rishi MAS, M. Wolff, A. Amoateng-Adjepong, Y. Manthous, C. A. Atypical antipsychotic medications are independently associated with severe obstructive sleep apnea. *Clin Neuropharmacol.* 2010 May;33(3):109-13.
216. Rizos VPESCLCGDV. Atypical antipsychotics in the treatment of delirium. *Psychiatry and Clinical Neurosciences.* 2009;63(5):623-31.
217. Roerig JLM, James E. M. D. de Zwaan, Martina Crosby, Ross D. Gosnell, Blake A. Steffen, Kristine J. Wonderlich, Stephen A. PhD. A Comparison of the Effects of Olanzapine and Risperidone Versus Placebo on Eating Behaviors. *Journal of Clinical Psychopharmacology.* 2005;25(5):413-8.
218. Rohsenow DJT, J. W. Miranda, R. McGeary, J. E. Swift, R. M. Hutchison, K. E. Sirota, A. D. Monti, P. M. Olanzapine reduces urge to smoke and nicotine withdrawal symptoms in community smokers. *Exp Clin Psychopharmacol.* 2008 Jun;16(3):215-22.
219. Sacher JM, Nilufar Spindelegger, Christoph Klein, Nikolas Geiss-Granadia, Thomas Sauermann, Robert Lackner, Edith Joukhadar, Christian Muller, Markus Kasper,

- Siegfried. Effects of Olanzapine and Ziprasidone on Glucose Tolerance in Healthy Volunteers. *Neuropsychopharmacology*. 2007;33(7):1633-41.
220. Sandler L. Risperidone in children with autism and serious behavioral problems. *N Engl J Med*. 2002 Dec 5;347(23):1890-1; author reply -1.
221. Sanfelix-Gimeno GC-C, P. Peiro, S. Lopez-Valcarcel, B. G. Blazquez, A. Barbera, T. Effectiveness of safety warnings in atypical antipsychotic drugs: an interrupted time-series analysis in Spain. *Drug Saf*. 2009;32(11):1075-87.
222. Scahill L. How do I decide whether or not to use medication for my child with autism? should I try behavior therapy first? *Journal of Autism and Developmental Disorders*. 2008 Jul, 2008;38(6):1197-8.
223. Scahill LK, K. Carroll, D. H. Pachler, M. Risperidone approved for the treatment of serious behavioral problems in children with autism. *J Child Adolesc Psychiatr Nurs*. 2007 Aug;20(3):188-90.
224. Schneider RAL, M. H. Apparent seizure and atrial fibrillation associated with paliperidone. *Am J Health Syst Pharm*. 2008 Nov 15;65(22):2122-5.
225. Schwam JSK, E. Alonso, C. Perry, R. Risperidone and refusal to eat. *J Am Acad Child Adolesc Psychiatry*. 1998 Jun;37(6):572-3.
226. Scott LJD, S. Risperidone: a review of its use in the treatment of irritability associated with autistic disorder in children and adolescents. *Paediatr Drugs*. 2007;9(5):343-54.
227. Scott LJD, S. Spotlight on risperidone in irritability associated with autistic disorder in children and adolescents. *CNS Drugs*. 2008;22(3):259-62.
228. Setoguchi SW, P. S. Alan Brookhart, M. Canning, C. F. Kaci, L. Schneeweiss, S. Potential causes of higher mortality in elderly users of conventional and atypical antipsychotic medications. *J Am Geriatr Soc*. 2008 Sep;56(9):1644-50.
229. Sharp BP, C. Abnormal motor movements associated with combining psychostimulants and atypical antipsychotics in children. *CNS Spectr*. 2007 Sep;12(9):659-62.
230. Shepherd JG, V. M. De Leon, O. A. Waxing-and-waning catatonia after intermittent exposure to aripiprazole in a case of autism and bipolar disorder. *J Clin Psychopharmacol*. 2009 Oct;29(5):503-4.
231. Shoptaw SJK, U. Ling, W. Treatment for amphetamine psychosis. *Cochrane Database Syst Rev*. 2009(1):CD003026.
232. Silver HA, N. Schwartz, M. Attention deficit-hyperactivity disorder may be a risk factor for treatment-emergent tardive dyskinesia induced by risperidone. *J Clin Psychopharmacol*. 2000 Feb;20(1):112-4.
233. Smith ER, Anthony J. Heo, Moonseong Peasley-Miklus, Catherine Caswell, Melynda Papademetriou, Eros Flint, Alastair J. Mulsant, Benoit H. Meyers, Barnett S. Weight gain during olanzapine treatment for psychotic depression: Effects of dose and age. *International Clinical Psychopharmacology*. 2008 May, 2008;23(3):130-7.
234. Snoeck EVP, A. Sack, M. Horton, M. Mannens, G. Woestenborghs, R. Meibach, R. Heykants, J. Influence of age, renal and liver impairment on the pharmacokinetics of risperidone in man. *Psychopharmacology (Berl)*. 1995 Dec;122(3):223-9.
235. Snyder RT, A. Aman, M. Binder, C. Fisman, S. Carroll, A. Effects of risperidone on conduct and disruptive behavior disorders in children with subaverage IQs. *J Am Acad Child Adolesc Psychiatry*. 2002 Sep;41(9):1026-36.

236. Soorya LK, J. Hollander, E. Psychopharmacologic interventions for repetitive behaviors in autism spectrum disorders. *Child Adolesc Psychiatr Clin N Am.* 2008 Oct;17(4):753-71, viii.
237. Soyka MW, U. Moeller, H. J. Risperidone in treatment-refractory chronic alcohol hallucinosis. *Pharmacopsychiatry.* 1997 Jul;30(4):135-6.
238. Stachnik JMN-T, C. Use of atypical antipsychotics in the treatment of autistic disorder. *Ann Pharmacother.* 2007 Apr;41(4):626-34.
239. Stahl SMG, M. M. A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem.* 2004 Feb;11(3):313-27.
240. Stigler KAD, J. T. Kohn, A. E. Li, L. Erickson, C. A. Posey, D. J. McDougle, C. J. Aripiprazole in pervasive developmental disorder not otherwise specified and Asperger's disorder: a 14-week, prospective, open-label study. *J Child Adolesc Psychopharmacol.* 2009 Jun;19(3):265-74.
241. Stigler KAM, C. J. Pharmacotherapy of irritability in pervasive developmental disorders. *Child Adolesc Psychiatr Clin N Am.* 2008 Oct;17(4):739-52, vii-viii.
242. Stoops WW. Aripiprazole as a potential pharmacotherapy for stimulant dependence: human laboratory studies with d-amphetamine. *Exp Clin Psychopharmacol.* 2006 Nov;14(4):413-21.
243. Stoops WWL, J. A. Glaser, P. E. Rush, C. R. A low dose of aripiprazole attenuates the subject-rated effects of d-amphetamine. *Drug Alcohol Depend.* 2006 Sep 15;84(2):206-9.
244. Tamayo JMS, V. K. Mattei, M. A. Diaz, B. Jamal, H. H. Vieta, E. Zarate, C. A., Jr. Fumero, I. Tohen, M. Effectiveness and safety of the combination of fluoxetine and olanzapine in outpatients with bipolar depression: an open-label, randomized, flexible-dose study in Puerto Rico. *J Clin Psychopharmacol.* 2009 Aug;29(4):358-61.
245. Tamayo JMS, Virginia K. Mattei, Manuel A. Diaz, Barbara Jamal, Hassan H. Vieta, Eduard Zarate, Carlos A., Jr. Fumero, Ileana Tohen, Mauricio. Effectiveness and safety of the combination of fluoxetine and olanzapine in outpatients with bipolar depression: An open-label, randomized, flexible-dose study in Puerto Rico. *Journal of Clinical Psychopharmacology.* 2009 Aug, 2009;29(4):358-61.
246. Tarsy DB, R. J. Tarazi, F. I. Effects of newer antipsychotics on extrapyramidal function. *CNS Drugs.* 2002;16(1):23-45.
247. Taylor DMF, Catrin Sparshatt, Anna Thomas, Arwel Bishara, Delia Cornelius, Victoria. Risperidone long-acting injection: A prospective 3-year analysis of its use in clinical practice. *Journal of Clinical Psychiatry.* 2009 Feb, 2009;70(2):196-200.
248. Tcheremissine OV. Is quetiapine a drug of abuse? Reexamining the issue of addiction. *Expert Opin Drug Saf.* 2008 Nov;7(6):739-48.
249. Thase ME. Quetiapine monotherapy for bipolar depression. *Neuropsychiatric Disease and Treatment.* 2008 2008;4(1):21-31.
250. Thase ME. Reply to comments by Dr Rifkin and Dr Dawdy. *Journal of Clinical Psychopharmacology.* 2008 Jun, 2008;28(3):368.
251. Thase MEJ, A. Khan, A. Bowden, C. L. Wu, X. McQuade, R. D. Carson, W. H. Marcus, R. N. Owen, R. Aripiprazole monotherapy in nonpsychotic bipolar I depression: results of 2 randomized, placebo-controlled studies. *J Clin Psychopharmacol.* 2008 Feb;28(1):13-20.

252. Thase MEM, W. Weisler, R. H. Chang, W. Paulsson, B. Khan, A. Calabrese, J. R. Efficacy of quetiapine monotherapy in bipolar I and II depression: a double-blind, placebo-controlled study (the BOLDER II study). *J Clin Psychopharmacol*. 2006 Dec;26(6):600-9.
253. Theisen FML, A. Konig, I. R. Martin, M. Remschmidt, H. Hebebrand, J. Spectrum of binge eating symptomatology in patients treated with clozapine and olanzapine. *J Neural Transm*. 2003 Jan;110(1):111-21.
254. Thomsen PH. Risperidone augmentation in the treatment of severe adolescent OCD in SSRI-refractory cases: a case-series. *Ann Clin Psychiatry*. 2004 Oct-Dec;16(4):201-7.
255. Tierney EA, M. Stout, D. Pappas, K. Arnold, L. E. Vitiello, B. Scahill, L. McDougale, C. McCracken, J. Wheeler, C. Martin, A. Posey, D. Shah, B. Parent satisfaction in a multi-site acute trial of risperidone in children with autism: a social validity study. *Psychopharmacology (Berl)*. 2007 Mar;191(1):149-57.
256. Torgovnick JS, Nitin K. Arsura, Edward. Aripiprazole-induced orthostatic hypotension and cardiac arrhythmia. *Psychiatry and Clinical Neurosciences*. 2008 Aug, 2008;62(4):485.
257. Towbin KE. Gaining: pediatric patients and use of atypical antipsychotics. *Am J Psychiatry*. 2006 Dec;163(12):2034-6.
258. Turgay A. Psychopharmacological treatment of oppositional defiant disorder. *CNS Drugs*. 2009;23(1):1-17.
259. Uchida HK, S. Mulsant, B. H. Graff-Guerrero, A. Pollock, B. G. Mamo, D. C. Sensitivity of older patients to antipsychotic motor side effects: a PET study examining potential mechanisms. *Am J Geriatr Psychiatry*. 2009 Mar;17(3):255-63.
260. Ukaegbu CB, J. Burton Carter, Nakia J. What drugs are best for bipolar depression? *The Journal of Family Practice*. 2008 Sep, 2008;57(9):606-8.
261. Unwin GLD, Shoumitro. Use of medication for the management of behavior problems among adults with intellectual disabilities: A clinicians' consensus survey. *American Journal on Mental Retardation*. 2008 2008;113(1):19-31.
262. Ushijima MY, Shin Sugiyama, Eiko Amano, Naoji. Contribution of perospirone and risperidone to reduce delirium in senile patients. *Psychogeriatrics*. 2008 Mar, 2008;8(1):4-7.
263. Valdovinos MGN, D. A. Zarcone, J. R. Hellings, J. A. Williams, D. C. Schroeder, S. R. Multimodal evaluation of risperidone for destructive behavior: functional analysis, direct observations, rating scales, and psychiatric impressions. *Exp Clin Psychopharmacol*. 2002 Aug;10(3):268-75.
264. Valiquette G. Risperidone in children with autism and serious behavioral problems. *N Engl J Med*. 2002 Dec 5;347(23):1890-1; author reply -1.
265. Volavka JC, L. Huertas, D. Update on the biological treatment of aggression. *Actas Españolas de Psiquiatría*. 2006 Mar-Apr, 2006;34(2):123-35.
266. Wachtel SRO, Amanda De Wit, Harriet. The effects of acute haloperidol or risperidone on subjective responses to methamphetamine in healthy volunteers. *Drug and Alcohol Dependence*. 2002 Sep, 2002;68(1):23-33.
267. Wagner KD. Medication and diagnostic issues. *Journal of Clinical Psychiatry*. 2009 Feb, 2009;70(2):238-9.

268. Wang JSZ, H. J. Markowitz, J. S. Donovan, J. L. Yuan, H. J. Devane, C. L. Antipsychotic drugs inhibit the function of breast cancer resistance protein. *Basic Clin Pharmacol Toxicol*. 2008 Oct;103(4):336-41.
269. Wang PSS, Sebastian Setoguchi, Soko Patrick, Amanda Avorn, Jerry Mogun, Helen Choudhry, Niteesh K. Brookhart, M. Alan. Ventricular arrhythmias and cerebrovascular events in the elderly using conventional and atypical antipsychotic medications. *Journal of Clinical Psychopharmacology*. 2007 Dec, 2007;27(6):707-10.
270. Waters BMJ, K. G. Intravenous quetiapine-cocaine use ("Q-ball"). *Am J Psychiatry*. 2007 Jan;164(1):173-4.
271. West LW, J. Risperidone use in the treatment of behavioral symptoms in children with autism. *Pediatr Nurs*. 2006 Nov-Dec;32(6):545-9.
272. West LW, J. Brunssen, S. Pharmacologic treatment for the core deficits and associated symptoms of autism in children. *J Pediatr Health Care*. 2009 Mar-Apr;23(2):75-89.
273. Wijkstra JB, H. van den Broek, W. W. Birkenhager, T. K. Janzing, J. G. Boks, M. P. Bruijn, J. A. van der Loos, M. L. Breteler, L. M. Ramaekers, G. M. Verkes, R. J. Nolen, W. A. Treatment of unipolar psychotic depression: a randomized, double-blind study comparing imipramine, venlafaxine, and venlafaxine plus quetiapine. *Acta Psychiatr Scand*. 2009 Aug 19.
274. Wilhelm SS, Alexander Wagner, Thomas. Use of antipsychotics and benzodiazepines in patients with psychiatric emergencies: Results of an observational trial. *BMC Psychiatry*. 2008 Jul, 2008;8:ArtID 61.
275. Williams SKS, L. Vitiello, B. Aman, M. G. Arnold, L. E. McDougle, C. J. McCracken, J. T. Tierney, E. Ritz, L. Posey, D. J. Swiezy, N. B. Hollway, J. Cronin, P. Ghuman, J. Wheeler, C. Cicchetti, D. Sparrow, S. Risperidone and adaptive behavior in children with autism. *J Am Acad Child Adolesc Psychiatry*. 2006 Apr;45(4):431-9.
276. Wilner KDA, R. J. Johnson, A. C. Miceli, J. J. Fricke, J. R. Titus, C. K. The anxiolytic effect of the novel antipsychotic ziprasidone compared with diazepam in subjects anxious before dental surgery. *J Clin Psychopharmacol*. 2002 Apr;22(2):206-10.
277. Wines JD, Jr. Weiss, R. D. Opioid withdrawal during risperidone treatment. *J Clin Psychopharmacol*. 1999 Jun;19(3):265-7.
278. Winterfeld ULH, M. F. Acquaviva, E. Mouren, M. C. Brion, F. Bourdon, O. [Off-label use of psychotropic medications in paediatric wards: a prospective study]. *Arch Pediatr*. 2009 Sep;16(9):1252-60.
279. Wright POF, Luke. Antipsychotic drugs: Atypical advantages and typical disadvantages. *Irish Journal of Psychological Medicine*. 2003 Mar, 2003;20(1):24-7.
280. Yang LPHP, Greg L. Paliperidone Extended Release. *CNS Drugs*. 2007;21(5):417-25.
281. Yoshimura AM, Masahiro Imai, Makoto Yamada, Naoto Okawa, Masako. Low-dose oral risperidone lengthened sleep duration in healthy participants. *Sleep and Biological Rhythms*. 2007 Oct, 2007;5(4):277-83.
282. Zito JMS, Daniel J. dosReis, Susan Gardner, James F. Magder, Laurence Soeken, Karen Boles, Myde Lynch, Frances Riddle, Mark A. Psychotropic Practice Patterns for Youth: A 10-Year Perspective. *Arch Pediatr Adolesc Med*. 2003 January 1, 2003;157(1):17-25.

283. Zito JMS, Daniel J. Valluri, Satish Gardner, James F. Korelitz, James J. Mattison, Donald R. Psychotherapeutic Medication Prevalence in Medicaid-Insured Preschoolers. *Journal of Child and Adolescent Psychopharmacology*. 2007;17(2):195-204.

Rejected, Population not human:

1. Bergman J. Medications for stimulant abuse: agonist-based strategies and preclinical evaluation of the mixed-action D-sub-2 partial agonist aripiprazole (Abilify). *Exp Clin Psychopharmacol*. 2008 Dec;16(6):475-83.

Appendix G. Adverse events analyses:

Appendix G. Adverse events analyses:

ADHD and Tourettes – Placebo Controlled Trials

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Appetite or Weight/Decrease	Aripiprazole	1	15	25	13	18	1.71	(0.40, 8.15)	NC	NC
Appetite or Weight/Decrease	Risperidone	1	1	18	1	16	1.13	(0.01, 94.13)	NC	NC
Appetite or Weight/Increase	Aripiprazole	1	22	25	14	18	0.49	(0.06, 3.35)	NC	NC
Appetite or Weight/Increase	Risperidone	2	0	31	8	28	+Inf	(2.52, Inf+)	4.00	(2.00, 8.00)
Cardiovascular	Aripiprazole	1	10	25	9	18	1.49	(0.37, 6.03)	NC	NC
Constitutional/Fever or Infection	Aripiprazole	1	5	25	5	18	1.52	(0.29, 8.12)	NC	NC
Dermatologic	Aripiprazole	1	14	25	11	18	1.23	(0.31, 5.11)	NC	NC
Endocrine	Ziprasidone	1	0	12	1	16	+Inf	(0.02, Inf+)	NC	NC
Endocrine/Prolactin	Ziprasidone	1	0	12	5	16	+Inf	(0.78, Inf+)	NC	NC
Gastrointestinal	Aripiprazole	1	25	25	18	18	NC	NC	NC	NC
Gastrointestinal	Risperidone	2	5	31	6	28	1.45	(0.28, 7.82)	NC	NC
HEENT	Aripiprazole	1	25	25	18	18	NC	NC	NC	NC
HEENT/Eye	Aripiprazole	1	14	25	12	18	1.56	(0.38, 6.81)	NC	NC
HEENT/Eye	Risperidone	1	0	18	2	16	+Inf	(0.21, Inf+)	NC	NC
Musculoskeletal	Aripiprazole	1	6	25	3	18	0.64	(0.09, 3.62)	NC	NC
Neuro	Aripiprazole	1	25	25	18	18	NC	NC	NC	NC
Neuro	Risperidone	1	3	18	0	16	0.00	(0.00, 2.64)	NC	NC
Neuro/Fatigue	Aripiprazole	1	14	25	15	18	3.81	(0.78, 25.71)	NC	NC
Neuro/Fatigue	Risperidone	1	1	18	6	16	9.54	(0.95, 496.02)	NC	NC
Neuro/Movement Disorder/Akathisia	Aripiprazole	1	3	25	2	18	0.92	(0.07, 9.02)	NC	NC
Neuro/Movement Disorder/Akathisia	Ziprasidone	1	0	12	1	16	+Inf	(0.02, Inf+)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro/Movement Disorder/EPS	Aripiprazole	1	8	25	15	18	9.96	(2.03, 69.36)	2.00	(1.00, 4.00)
Neuro/Sedation	Aripiprazole	1	25	25	18	18	NC	NC	NC	NC
Neuro/Sedation	Risperidone	2	3	31	4	28	1.53	(0.24, 11.33)	NC	NC
Neuro/Sedation	Ziprasidone	1	5	12	12	16	3.97	(0.66, 28.56)	NC	NC
Neuro/Sensory	Aripiprazole	1	13	25	8	18	0.74	(0.18, 2.93)	NC	NC
Psychiatric	Risperidone	1	0	18	2	16	+Inf	(0.21, Inf+)	NC	NC
Psychiatric/Aggression	Aripiprazole	1	9	25	10	18	2.18	(0.55, 9.15)	NC	NC
Psychiatric/Agitation	Risperidone	1	0	13	1	12	+Inf	(0.03, Inf+)	NC	NC
Psychiatric/Anxiety	Aripiprazole	1	25	25	18	18	NC	NC	NC	NC
Psychiatric/Cognitive	Aripiprazole	1	10	25	6	18	0.76	(0.17, 3.13)	NC	NC
Psychiatric/Cognitive	Risperidone	1	0	18	2	16	+Inf	(0.21, Inf+)	NC	NC
Psychiatric/Depression	Aripiprazole	1	14	25	8	18	0.64	(0.16, 2.50)	NC	NC
Psychiatric/Mania	Aripiprazole	1	8	25	5	18	0.82	(0.17, 3.68)	NC	NC
Psychiatric/Sexual/Decreased Function	Risperidone	1	0	18	2	16	+Inf	(0.21, Inf+)	NC	NC
Psychiatric/Sleep	Risperidone	1	1	18	1	16	1.13	(0.01, 94.13)	NC	NC
Psychiatric/Suicidal Ideation	Aripiprazole	1	5	25	5	18	1.52	(0.29, 8.12)	NC	NC
Pulmonary	Aripiprazole	1	9	25	7	18	1.13	(0.27, 4.68)	NC	NC
Sweating	Aripiprazole	1	11	25	10	18	1.57	(0.40, 6.41)	NC	NC
Urinary	Aripiprazole	1	2	25	1	18	0.68	(0.01, 14.13)	NC	NC

¹ NNH=Number Needed to Harm

ADHD and Tourettes – Atypicals vs. Clonidine

Adverse Events	Drug	# of studies	Clonidine		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
HEENT/Decreased Salivation	Risperidone	1	1	12	0	9	0.00	(0.00, 52.00)
Neuro	Risperidone	1	2	12	1	9	0.64	(0.01, 14.44)
Neuro/Movement Disorder/EPS	Risperidone	1	1	12	2	9	2.97	(0.13, 201.94)
Neuro/Sedation	Risperidone	1	5	12	1	9	0.19	(0.00, 2.32)

ADHD and Tourettes – Atypicals vs. Conventionals

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Increase	Risperidone	1	20	24	22	26	1.10	(0.18, 6.75)
Neuro/Fatigue	Risperidone	1	9	24	10	26	1.04	(0.29, 3.81)
Neuro/Headache	Risperidone	1	2	24	5	26	2.57	(0.37, 29.80)
Neuro/Movement Disorder	Risperidone	1	5	24	2	26	0.32	(0.03, 2.25)
Neuro/Movement Disorder/EPS	Risperidone	1	8	24	4	26	0.37	(0.07, 1.68)
Neuro/Sedation	Risperidone	1	10	24	12	26	1.20	(0.34, 4.25)
Psychiatric/Depression	Risperidone	1	6	24	8	26	1.33	(0.33, 5.68)
Psychiatric/Sleep	Risperidone	1	7	24	1	26	0.10	(0.00, 0.90)
Trauma	Risperidone	1	6	24	1	26	0.12	(0.00, 1.16)

Dementia – Placebo Control Trials

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Anticholinergic Events	Olanzapine	1	12	90	60	178	3.29	(1.62, 7.17)	5.00	(3.00, 10.00)
Appetite or Weight/Decrease	Aripiprazole	3	48	367	105	619	0.94	(0.63, 1.44)	NC	NC
Appetite or Weight/Decrease	Olanzapine	2	15	141	32	363	0.75	(0.38, 1.56)	NC	NC
Appetite or Weight/Decrease	Quetiapine	1	8	92	18	241	0.85	(0.34, 2.34)	NC	NC
Appetite or Weight/Decrease	Risperidone	1	8	94	11	196	0.64	(0.23, 1.90)	NC	NC
Appetite or Weight/Increase	Aripiprazole	2	10	223	23	472	1.02	(0.44, 2.49)	NC	NC
Appetite or Weight/Increase	Olanzapine	3	6	326	34	482	4.69	(1.87, 14.14)	19.00	(13.00, 40.00)
Appetite or Weight/Increase	Quetiapine	1	4	142	5	94	1.93	(0.40, 10.01)	NC	NC
Appetite or Weight/Increase	Risperidone	2	5	236	14	281	3.40	(1.08, 12.75)	35.00	(17.00, -364.0)
Cardiovascular	Aripiprazole	2	22	242	74	488	2.20	(1.27, 3.96)	16.00	(9.00, 80.00)
Cardiovascular	Olanzapine	5	9	440	40	778	2.33	(1.08, 5.61)	32.00	(19.00, 95.00)
Cardiovascular	Quetiapine	3	15	254	29	355	1.08	(0.53, 2.30)	NC	NC
Cardiovascular	Risperidone	6	34	1010	119	1757	2.08	(1.38, 3.22)	29.00	(20.00, 56.00)
Cardiovascular/BP/Decrease	Aripiprazole	1	6	125	4	131	0.63	(0.13, 2.71)	NC	NC
Cardiovascular/BP/Increase	Aripiprazole	1	5	102	4	106	0.76	(0.15, 3.65)	NC	NC
Cardiovascular/BP/Increase	Olanzapine	1	1	67	2	137	0.98	(0.05, 58.55)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Cardiovascular/BP/Increase	Quetiapine	1	0	20	1	20	+Inf	(0.03, Inf+)	NC	NC
Cardiovascular/Rhythm	Aripiprazole	3	2	253	6	340	2.25	(0.38, 23.74)	NC	NC
Cardiovascular/Rhythm	Olanzapine	2	6	209	3	237	0.37	(0.06, 1.85)	NC	NC
Cardiovascular/Rhythm	Quetiapine	1	4	142	3	94	1.14	(0.16, 6.89)	NC	NC
Cardiovascular/Rhythm	Risperidone	2	10	161	8	105	0.85	(0.24, 2.83)	NC	NC
Constitutional/Fever or Infection	Aripiprazole	1	0	26	1	103	+Inf	(0.01, Inf+)	NC	NC
Constitutional/Fever or Infection	Olanzapine	3	5	231	38	541	3.23	(1.23, 10.71)	21.00	(13.00, 50.00)
Constitutional/Fever or Infection	Quetiapine	1	6	99	3	91	0.53	(0.08, 2.57)	NC	NC
Constitutional/Fever or Infection	Risperidone	3	19	427	59	825	1.41	(0.80, 2.57)	NC	NC
Death	Aripiprazole	5	10	499	11	471	1.67	(0.55, 5.58)	NC	NC
Death	Olanzapine	2	4	232	2	278	0.48	(0.04, 3.62)	NC	NC
Death	Quetiapine	2	7	241	5	185	0.91	(0.22, 3.41)	NC	NC
Death	Risperidone	5	17	916	39	1561	1.19	(0.63, 2.31)	NC	NC
Dermatologic	Aripiprazole	4	128	492	232	750	1.40	(1.06, 1.84)	20.00	(10.00, -558.0)
Dermatologic	Olanzapine	1	7	47	19	159	0.78	(0.29, 2.35)	NC	NC
Dermatologic	Quetiapine	1	13	99	12	91	1.00	(0.39, 2.55)	NC	NC
Dermatologic	Risperidone	2	82	333	133	629	1.24	(0.87, 1.79)	NC	NC
Endocrine/Diabetes	Risperidone	1	5	238	4	235	0.81	(0.16, 3.80)	NC	NC
Endocrine/Prolactin	Risperidone	1	0	238	0	235	NC	NC	NC	NC
Gastrointestinal	Aripiprazole	5	53	518	152	853	1.74	(1.22, 2.53)	13.00	(9.00, 25.00)
Gastrointestinal	Olanzapine	2	11	232	30	278	2.01	(0.93, 4.64)	NC	NC
Gastrointestinal	Quetiapine	4	21	353	56	446	1.67	(0.95, 3.05)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Gastrointestinal	Risperidone	2	66	312	40	252	0.54	(0.33, 0.87)	-19.00	(90.00, -9.00)
HEENT	Aripiprazole	1	6	121	17	366	0.93	(0.34, 2.96)	NC	NC
HEENT	Olanzapine	1	3	47	16	159	1.64	(0.44, 9.17)	NC	NC
HEENT	Quetiapine	1	10	99	5	91	0.52	(0.13, 1.75)	NC	NC
HEENT	Risperidone	2	27	333	80	629	1.27	(0.78, 2.12)	NC	NC
HEENT/Decreased Salivation	Quetiapine	1	0	20	1	20	+Inf	(0.03, Inf+)	NC	NC
HEENT/Eye	Aripiprazole	1	3	121	13	366	1.45	(0.39, 8.05)	NC	NC
HEENT/Eye	Olanzapine	1	1	142	0	100	0.00	(0.00, 55.38)	NC	NC
HEENT/Eye	Quetiapine	1	1	142	0	94	0.00	(0.00, 58.92)	NC	NC
HEENT/Eye	Risperidone	2	19	312	20	252	1.10	(0.53, 2.26)	NC	NC
HEENT/Increased Salivation	Aripiprazole	1	1	121	13	366	4.41	(0.65, 189.35)	NC	NC
Heme	Aripiprazole	1	8	125	14	131	2.01	(0.73, 6.11)	NC	NC
Heme	Olanzapine	1	1	142	1	100	1.42	(0.02, 112.58)	NC	NC
Heme	Quetiapine	1	1	142	2	94	3.05	(0.16, 182.09)	NC	NC
Heme	Risperidone	2	13	380	10	320	0.82	(0.32, 2.08)	NC	NC
Infections	Aripiprazole	1	16	121	66	366	1.44	(0.78, 2.79)	NC	NC
Infections	Olanzapine	1	5	90	10	178	1.01	(0.30, 3.90)	NC	NC
Infections	Quetiapine	2	9	191	25	332	2.08	(0.88, 5.32)	NC	NC
Infections	Risperidone	2	33	333	54	629	1.05	(0.64, 1.75)	NC	NC
Liver Function Test Abnormality	Aripiprazole	1	1	102	0	106	0.00	(0.00, 37.53)	NC	NC
Musculoskeletal	Olanzapine	1	3	90	0	178	0.00	(0.00, 1.21)	NC	NC
Neuro	Aripiprazole	1	9	121	52	366	2.06	(0.96, 4.91)	NC	NC
Neuro	Olanzapine	3	38	326	104	482	2.51	(1.62, 3.96)	10.00	(7.00, 21.00)

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro	Quetiapine	4	23	353	36	446	1.83	(0.99, 3.45)	NC	NC
Neuro	Risperidone	2	29	236	53	281	1.93	(1.12, 3.37)	15.00	(8.00, 270.00)
Neuro/CVA	Aripiprazole	3	2	253	2	340	0.70	(0.05, 10.48)	NC	NC
Neuro/CVA	Olanzapine	2	4	232	6	278	1.46	(0.33, 7.44)	NC	NC
Neuro/CVA	Quetiapine	2	6	241	3	185	0.65	(0.10, 3.08)	NC	NC
Neuro/CVA	Risperidone	4	8	753	24	1099	3.12	(1.32, 8.21)	89.00	(44.00, -8861)
Neuro/Fatigue	Aripiprazole	5	25	518	88	853	3.04	(1.85, 5.19)	18.00	(12.00, 37.00)
Neuro/Fatigue	Olanzapine	3	9	326	36	482	2.37	(1.08, 5.75)	21.00	(13.00, 57.00)
Neuro/Fatigue	Quetiapine	2	5	234	25	335	2.92	(1.03, 10.26)	19.00	(12.00, 51.00)
Neuro/Fatigue	Risperidone	2	4	236	20	281	3.56	(1.13, 14.96)	18.00	(11.00, 50.00)
Neuro/Headache	Olanzapine	1	0	67	4	137	+Inf	(0.32, Inf+)	NC	NC
Neuro/Headache	Risperidone	1	11	170	8	167	0.73	(0.25, 2.05)	NC	NC
Neuro/Movement Disorder	Olanzapine	1	2	142	10	100	7.72	(1.59, 74.05)	12.00	(7.00, 42.00)
Neuro/Movement Disorder	Quetiapine	1	2	142	5	94	3.91	(0.62, 41.89)	NC	NC
Neuro/Movement Disorder	Risperidone	1	2	142	7	85	6.23	(1.15, 62.91)	15.00	(8.00, 149.00)
Neuro/Movement Disorder/Akathisia	Olanzapine	1	0	142	1	100	+Inf	(0.04, Inf+)	NC	NC
Neuro/Movement Disorder/Akathisia	Quetiapine	2	1	162	1	114	1.23	(0.02, 98.52)	NC	NC
Neuro/Movement Disorder/Akathisia	Risperidone	1	0	142	0	85	NC	NC	NC	NC
Neuro/Movement Disorder/EPS	Aripiprazole	5	23	499	46	593	2.02	(1.17, 3.59)	32.00	(17.00, 317.00)

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro/Movement Disorder/EPS	Olanzapine	1	2	142	18	100	15.21	(3.50, 138.55)	6.00	(4.00, 11.00)
Neuro/Movement Disorder/EPS	Quetiapine	3	9	254	18	355	1.15	(0.46, 3.08)	NC	NC
Neuro/Movement Disorder/EPS	Risperidone	5	31	916	130	1561	3.00	(1.96, 4.70)	20.00	(15.00, 32.00)
Neuro/Movement Disorder/Gait	Aripiprazole	1	1	121	16	366	5.47	(0.83, 231.93)	NC	NC
Neuro/Movement Disorder/Gait	Olanzapine	4	15	373	79	641	2.75	(1.52, 5.29)	12.00	(9.00, 20.00)
Neuro/Movement Disorder/Gait	Quetiapine	3	6	333	18	426	2.36	(0.85, 7.59)	NC	NC
Neuro/Movement Disorder/Gait	Risperidone	3	8	406	32	448	3.04	(1.32, 7.84)	19.00	(13.00, 41.00)
Neuro/Movement Disorder/Tardive Dyskinesia	Olanzapine	1	4	142	3	100	1.07	(0.15, 6.46)	NC	NC
Neuro/Movement Disorder/Tardive Dyskinesia	Quetiapine	1	4	142	2	94	0.75	(0.07, 5.36)	NC	NC
Neuro/Movement Disorder/Tardive Dyskinesia	Risperidone	4	14	713	4	949	0.31	(0.07, 1.03)	NC	NC
Neuro/Pain	Aripiprazole	2	18	242	81	488	2.80	(1.58, 5.19)	11.00	(7.00, 22.00)
Neuro/Pain	Olanzapine	2	10	137	36	337	1.31	(0.60, 3.10)	NC	NC
Neuro/Pain	Quetiapine	1	11	99	12	91	1.21	(0.46, 3.23)	NC	NC
Neuro/Pain	Risperidone	1	13	163	33	462	0.89	(0.44, 1.89)	NC	NC
Neuro/Sedation	Aripiprazole	6	30	620	161	959	3.59	(2.34, 5.68)	8.00	(7.00, 11.00)
Neuro/Sedation	Olanzapine	5	25	440	158	778	4.58	(2.87, 7.55)	7.00	(5.00, 9.00)

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro/Sedation	Quetiapine	4	18	353	84	446	5.16	(2.93, 9.51)	7.00	(6.00, 11.00)
Neuro/Sedation	Risperidone	6	102	922	265	1260	2.33	(1.79, 3.05)	10.00	(8.00, 14.00)
Psychiatric/Aggression	Olanzapine	1	1	94	14	204	6.82	(1.01, 292.81)	17.00	(10.00, 57.00)
Psychiatric/Aggression	Risperidone	2	19	264	22	363	0.91	(0.45, 1.85)	NC	NC
Psychiatric/Agitation	Aripiprazole	4	56	393	83	722	0.94	(0.63, 1.41)	NC	NC
Psychiatric/Agitation	Olanzapine	4	36	373	76	641	1.19	(0.76, 1.90)	NC	NC
Psychiatric/Agitation	Quetiapine	2	35	241	18	185	0.61	(0.31, 1.16)	NC	NC
Psychiatric/Agitation	Risperidone	5	102	807	120	1145	0.84	(0.62, 1.14)	NC	NC
Psychiatric/Anxiety	Olanzapine	4	19	373	40	641	1.04	(0.57, 1.95)	NC	NC
Psychiatric/Anxiety	Quetiapine	1	3	142	0	94	0.00	(0.00, 3.65)	NC	NC
Psychiatric/Anxiety	Risperidone	2	12	236	20	281	0.89	(0.39, 2.12)	NC	NC
Psychiatric/Cognitive	Aripiprazole	1	0	26	3	103	+Inf	(0.10, Inf+)	NC	NC
Psychiatric/Cognitive	Olanzapine	2	3	232	15	278	4.00	(1.08, 22.38)	24.00	(14.00, 93.00)
Psychiatric/Cognitive	Quetiapine	1	1	142	0	94	0.00	(0.00, 58.92)	NC	NC
Psychiatric/Cognitive	Risperidone	1	1	142	1	85	1.67	(0.02, 132.68)	NC	NC
Psychiatric/Depression	Olanzapine	2	4	232	16	278	3.05	(0.94, 13.04)	NC	NC
Psychiatric/Depression	Quetiapine	1	2	142	2	94	1.52	(0.11, 21.30)	NC	NC
Psychiatric/Depression	Risperidone	1	2	142	0	85	0.00	(0.00, 8.90)	NC	NC
Psychiatric/Psychotic	Olanzapine	3	14	326	62	482	2.81	(1.49, 5.64)	12.00	(8.00, 21.00)
Psychiatric/Psychotic	Quetiapine	1	3	142	0	94	0.00	(0.00, 3.65)	NC	NC
Psychiatric/Psychotic	Risperidone	2	13	236	32	281	1.35	(0.65, 2.96)	NC	NC
Psychiatric/Sleep	Olanzapine	3	13	326	30	482	1.50	(0.73, 3.26)	NC	NC
Psychiatric/Sleep	Quetiapine	1	5	142	5	94	1.54	(0.34, 6.88)	NC	NC
Psychiatric/Sleep	Risperidone	2	10	236	15	281	1.17	(0.46, 3.09)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Pulmonary	Aripiprazole	1	3	102	6	106	1.97	(0.41, 12.54)	NC	NC
Pulmonary	Olanzapine	1	3	94	0	204	0.00	(0.00, 1.10)	NC	NC
Pulmonary	Risperidone	1	3	94	6	196	0.96	(0.20, 6.05)	NC	NC
Trauma	Aripiprazole	6	130	620	249	959	1.62	(1.23, 2.13)	20.00	(11.00, 132.00)
Trauma	Olanzapine	5	50	440	114	778	1.31	(0.89, 1.96)	NC	NC
Trauma	Quetiapine	4	137	353	167	446	0.76	(0.53, 1.09)	NC	NC
Trauma	Risperidone	5	289	807	403	1145	0.79	(0.63, 0.99)	- 163.0	(27.00, - 20.00)
Urinary	Aripiprazole	5	77	594	221	856	2.72	(1.98, 3.79)	8.00	(6.00, 11.00)
Urinary	Olanzapine	1	1	94	19	204	9.51	(1.47, 401.07)	12.00	(8.00, 27.00)
Urinary	Quetiapine	2	12	191	44	332	2.37	(1.16, 5.15)	14.00	(8.00, 51.00)
Urinary	Risperidone	4	71	665	164	1060	1.55	(1.13, 2.13)	21.00	(13.00, 63.00)

Dementia – Atypicals vs. Acetylcholinesterase Inhibitors

Adverse Events	Drug	# of studies	Acetylcholinesterase Inhibitor		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Risperidone	1	0	14	0	13	NC	NC
Gastrointestinal	Risperidone	1	10	14	2	13	0.10	(0.01, 0.78)
Neuro/Fatigue	Risperidone	1	2	14	1	13	1.09	(0.01, 92.68)
Neuro/Movement Disorder/EPS	Risperidone	1	0	14	2	13	+Inf	(0.03, Inf+)
Neuro/Sedation	Risperidone	1	0	14	4	13	+Inf	(0.88, Inf+)
Psychiatric/Agitation	Risperidone	1	1	14	1	13	+Inf	(0.03, Inf+)

Dementia – Atypicals vs. Benzodiazepines

Adverse Events	Drug	# of studies	Benzodiazepine		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Cardiovascular	Olanzapine	1	0	68	2	137	+Inf	(0.09, Inf+)
Cardiovascular/BP/Increase	Olanzapine	1	2	68	2	137	0.49	(0.03, 6.91)
Cardiovascular/Rhythm	Olanzapine	1	0	68	3	137	+Inf	(0.20, Inf+)
Neuro/Headache	Olanzapine	1	1	68	4	137	2.01	(0.19, 100.69)
Neuro/Sedation	Olanzapine	1	7	68	5	137	0.33	(0.08, 1.27)
Trauma	Olanzapine	1	3	68	3	137	0.49	(0.06, 3.74)

Dementia - Atypicals vs. Conventionals

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Olanzapine	1	3	28	4	30	1.28	(0.19, 9.61)
Appetite or Weight/Increase	Olanzapine	3	19	221	28	223	1.53	(0.79, 3.03)
Appetite or Weight/Increase	Risperidone	1	0	20	0	20	NC	NC
Cardiovascular	Olanzapine	1	2	173	6	173	3.06	(0.54, 31.45)
Cardiovascular/BP/Decrease	Olanzapine	1	7	20	2	20	0.11	(0.00, 1.01)
Cardiovascular/BP/Decrease	Risperidone	1	7	20	4	20	0.47	(0.08, 2.36)
Cardiovascular/BP/Increase	Quetiapine	1	1	11	1	11	1.00	(0.01, 86.25)
Cardiovascular/Rhythm	Olanzapine	2	6	48	3	50	0.46	(0.07, 2.29)
Cardiovascular/Rhythm	Risperidone	1	5	20	2	20	0.17	(0.00, 1.80)
Constitutional/Fever or Infection	Olanzapine	1	3	173	0	173	0.00	(0.00, 2.41)
Death	Olanzapine	1	6	173	4	173	0.66	(0.13, 2.84)
Dermatologic	Olanzapine	1	12	28	7	30	0.41	(0.11, 1.43)
Endocrine/Diabetes	Olanzapine	2	2	193	3	193	1.50	(0.17, 18.14)
Endocrine/Diabetes	Risperidone	1	0	20	0	20	NC	NC
Gastrointestinal	Olanzapine	3	64	221	24	223	0.14	(0.06, 0.30)
Gastrointestinal	Quetiapine	1	0	11	1	11	+Inf	(0.03, Inf+)
Gastrointestinal	Risperidone	2	10	49	6	49	0.43	(0.10, 1.65)
HEENT/Decreased Salivation	Olanzapine	2	10	48	3	50	0.25	(0.04, 1.05)
HEENT/Decreased Salivation	Risperidone	1	6	20	0	20	0.00	(0.00, 0.72)
HEENT/Increased Salivation	Olanzapine	1	7	28	4	30	0.47	(0.09, 2.14)
Infections	Quetiapine	1	1	11	0	11	0.00	(0.00, 39.00)
Neuro	Olanzapine	2	20	48	15	50	0.55	(0.20, 1.47)
Neuro	Risperidone	1	3	20	0	20	0.00	(0.00, 2.34)
Neuro/Fatigue	Olanzapine	2	22	48	18	50	0.42	(0.11, 1.49)
Neuro/Fatigue	Risperidone	1	0	20	2	20	+Inf	(0.03, Inf+)
Neuro/Movement Disorder	Olanzapine	1	18	28	19	30	0.96	(0.29, 3.20)

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Neuro/Movement Disorder/Akathisia	Olanzapine	2	6	48	5	50	0.57	(0.10, 2.76)
Neuro/Movement Disorder/Akathisia	Risperidone	1	0	20	0	20	NC	NC
Neuro/Movement Disorder/EPS	Olanzapine	2	24	48	17	50	0.37	(0.12, 1.10)
Neuro/Movement Disorder/EPS	Quetiapine	1	2	11	0	11	0.00	(0.00, 5.24)
Neuro/Movement Disorder/EPS	Risperidone	1	4	20	2	20	0.23	(0.00, 2.65)
Neuro/Sedation	Olanzapine	3	67	221	64	223	0.90	(0.57, 1.42)
Neuro/Sedation	Risperidone	3	25	163	18	164	0.68	(0.33, 1.36)
Neuro/Sensory	Olanzapine	1	2	28	2	30	0.93	(0.06, 13.69)
Psychiatric/Apathy	Olanzapine	1	16	28	10	30	0.38	(0.11, 1.23)
Psychiatric/Cognitive	Olanzapine	1	49	28	53	30	NC	NC
Psychiatric/Depression	Olanzapine	1	20	28	17	30	0.53	(0.15, 1.77)
Psychiatric/Irritability	Olanzapine	1	23	28	24	30	0.87	(0.18, 3.97)
Psychiatric/Sexual	Olanzapine	1	0	20	0	20	NC	NC
Psychiatric/Sexual	Risperidone	1	0	20	1	20	NC	NC
Psychiatric/Sexual/Decreased Function	Olanzapine	1	3	28	4	30	1.28	(0.19, 9.61)
Psychiatric/Sleep	Olanzapine	2	23	48	34	50	NC	NC
Psychiatric/Sleep	Risperidone	1	0	20	1	20	NC	NC
Sweating	Olanzapine	1	4	28	5	30	1.20	(0.23, 6.79)
Trauma	Olanzapine	1	13	173	1	173	0.07	(0.00, 0.49)
Urinary	Olanzapine	2	12	201	12	203	0.90	(0.29, 2.80)
Urinary	Risperidone	1	0	29	1	29	+Inf	(0.03, Inf+)

Dementia – Atypicals vs. SSRIs

Adverse Events	Drug	# of studies	SSRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Cardiovascular/BP/Decrease	Risperidone	1	0	53	1	50	+Inf	(0.03, Inf+)
Constitutional/Fever or Infection	Risperidone	1	0	53	2	50	+Inf	(0.20, Inf+)
Endocrine	Risperidone	1	1	53	0	50	0.00	(0.00, 41.34)
Gastrointestinal	Risperidone	1	1	53	2	50	2.15	(0.11, 130.24)
Infections	Risperidone	1	2	53	0	50	0.00	(0.00, 5.63)
Liver Function Test Abnormality	Risperidone	1	0	53	1	50	+Inf	(0.03, Inf+)
Neuro	Risperidone	1	1	53	0	50	0.00	(0.00, 41.34)
Neuro/Movement Disorder/EPS	Risperidone	1	1	53	3	50	3.28	(0.25, 177.53)
Neuro/Movement Disorder/Gait	Risperidone	1	1	53	3	50	3.28	(0.25, 177.53)
Neuro/Sedation	Risperidone	1	1	53	0	50	0.00	(0.00, 41.34)
Psychiatric/Agitation	Risperidone	1	12	53	7	50	0.56	(0.17, 1.72)
Psychiatric/Depression	Risperidone	1	1	53	0	50	0.00	(0.00, 41.34)
Psychiatric/Psychotic	Risperidone	1	1	53	1	50	1.06	(0.01, 84.88)
Psychiatric/Serious	Risperidone	1	2	53	3	50	1.62	(0.18, 20.19)
Psychiatric/Suicide Attempt	Risperidone	1	0	53	1	50	+Inf	(0.03, Inf+)
Trauma	Risperidone	1	1	53	0	50	0.00	(0.00, 41.34)

Dementia – Head-to-Head Trials

Adverse Events	Risperidone	Olanzapine or Quetiapine	# of studies	Risperidone		Olanzapine or Quetiapine		Pooled OR	95% CI
				# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Risperidone	Olanzapine	1	11	196	13	204	1.14	(0.46, 2.90)
Appetite or Weight/Increase	Risperidone	Olanzapine	3	14	301	27	324	1.87	(0.92, 3.95)
Appetite or Weight/Increase	Risperidone	Quetiapine	1	8	85	5	94	0.54	(0.13, 1.97)
Cardiovascular	Risperidone	Olanzapine	2	16	281	13	304	0.75	(0.33, 1.70)
Cardiovascular	Risperidone	Quetiapine	2	4	119	6	132	1.38	(0.31, 6.89)
Cardiovascular/BP/Decrease	Risperidone	Olanzapine	1	4	20	2	20	0.23	(0.00, 2.65)
Cardiovascular/Rhythm	Risperidone	Olanzapine	3	3	124	2	140	0.92	(0.07, 12.95)
Cardiovascular/Rhythm	Risperidone	Quetiapine	1	1	85	3	94	2.75	(0.22, 147.08)
Constitutional/Fever or Infection	Risperidone	Olanzapine	1	0	196	2	204	+Inf	(0.18, Inf+)
Death	Risperidone	Olanzapine	1	1	85	1	100	0.85	(0.01, 67.39)
Death	Risperidone	Quetiapine	2	1	119	3	132	2.75	(0.22, 147.08)
Dermatologic	Risperidone	Olanzapine	1	0	19	1	20	+Inf	(0.02, Inf+)
Endocrine/Diabetes	Risperidone	Olanzapine	1	0	20	1	20	+Inf	(0.03, Inf+)
Gastrointestinal	Risperidone	Olanzapine	2	7	105	9	120	1.42	(0.42, 5.18)
Gastrointestinal	Risperidone	Quetiapine	2	8	119	3	132	0.31	(0.05, 1.37)
HEENT/Decreased Salivation	Risperidone	Olanzapine	1	0	20	0	20	NC	NC
HEENT/Eye	Risperidone	Olanzapine	1	0	85	0	100	NC	NC
HEENT/Eye	Risperidone	Quetiapine	2	2	119	0	132	0.00	(0.00, 4.73)
Heme	Risperidone	Olanzapine	1	2	85	1	100	0.42	(0.01, 8.22)
Heme	Risperidone	Quetiapine	1	2	85	2	94	0.90	(0.06, 12.71)
Musculoskeletal	Risperidone	Quetiapine	1	5	34	0	38	0.00	(0.00, 0.92)
Neuro	Risperidone	Olanzapine	3	53	301	81	324	1.54	(1.02, 2.34)
Neuro	Risperidone	Quetiapine	1	22	85	19	94	0.73	(0.34, 1.55)
Neuro/CVA	Risperidone	Olanzapine	2	2	104	4	120	1.75	(0.25, 19.64)

Adverse Events	Risperidone	Olanzapine or Quetiapine	# of studies	Risperidone		Olanzapine or Quetiapine		Pooled OR	95% CI
				# adverse events	sample size	# adverse events	sample size		
Neuro/CVA	Risperidone	Quetiapine	2	2	119	2	132	0.90	(0.06, 12.71)
Neuro/Fatigue	Risperidone	Olanzapine	3	22	301	18	324	0.80	(0.39, 1.61)
Neuro/Fatigue	Risperidone	Quetiapine	2	5	119	8	132	1.47	(0.41, 5.88)
Neuro/Movement Disorder	Risperidone	Olanzapine	1	7	85	10	100	1.24	(0.40, 4.02)
Neuro/Movement Disorder	Risperidone	Quetiapine	1	7	85	5	94	0.63	(0.15, 2.40)
Neuro/Movement Disorder/Akathisia	Risperidone	Olanzapine	2	0	105	2	120	+Inf	(0.02, Inf+)
Neuro/Movement Disorder/Akathisia	Risperidone	Quetiapine	1	0	85	1	94	+Inf	(0.02, Inf+)
Neuro/Movement Disorder/EPS	Risperidone	Olanzapine	3	19	124	18	140	0.84	(0.38, 1.82)
Neuro/Movement Disorder/EPS	Risperidone	Quetiapine	2	20	119	3	132	0.12	(0.02, 0.41)
Neuro/Movement Disorder/Gait	Risperidone	Olanzapine	3	22	300	26	324	1.13	(0.60, 2.16)
Neuro/Movement Disorder/Gait	Risperidone	Quetiapine	1	1	85	3	94	2.75	(0.22, 147.08)
Neuro/Movement Disorder/Tardive Dyskinesia	Risperidone	Olanzapine	1	3	85	3	100	0.85	(0.11, 6.49)
Neuro/Movement Disorder/Tardive Dyskinesia	Risperidone	Quetiapine	1	3	85	2	94	0.60	(0.05, 5.34)
Neuro/Sedation	Risperidone	Olanzapine	5	63	391	89	428	1.40	(0.96, 2.05)
Neuro/Sedation	Risperidone	Quetiapine	2	17	119	32	132	1.93	(0.97, 3.97)
Psychiatric/Aggression	Risperidone	Olanzapine	1	13	196	14	204	1.04	(0.44, 2.47)
Psychiatric/Agitation	Risperidone	Olanzapine	2	35	281	44	304	1.22	(0.73, 2.04)
Psychiatric/Agitation	Risperidone	Quetiapine	1	5	85	11	94	2.11	(0.64, 8.11)
Psychiatric/Anxiety	Risperidone	Olanzapine	2	20	281	19	304	0.90	(0.44, 1.83)
Psychiatric/Anxiety	Risperidone	Quetiapine	1	0	85	0	94	NC	NC
Psychiatric/Cognitive	Risperidone	Olanzapine	1	1	85	5	100	4.39	(0.48, 211.54)
Psychiatric/Cognitive	Risperidone	Quetiapine	1	1	85	0	94	0.00	(0.00, 35.27)
Psychiatric/Depression	Risperidone	Olanzapine	1	0	85	4	100	+Inf	(0.57, Inf+)

Adverse Events	Risperidone	Olanzapine or Quetiapine	# of studies	Risperidone		Olanzapine or Quetiapine		Pooled OR	95% CI
				# adverse events	sample size	# adverse events	sample size		
Psychiatric/Depression	Risperidone	Quetiapine	1	0	85	2	94	+Inf	(0.17, Inf+)
Psychiatric/Psychotic	Risperidone	Olanzapine	2	32	281	52	304	1.70	(1.02, 2.85)
Psychiatric/Psychotic	Risperidone	Quetiapine	2	1	119	0	132	0.00	(0.00, 34.89)
Psychiatric/Sexual	Risperidone	Olanzapine	1	1	20	0	20	NC	NC
Psychiatric/Sleep	Risperidone	Olanzapine	3	16	301	19	324	1.19	(0.56, 2.57)
Psychiatric/Sleep	Risperidone	Quetiapine	1	4	85	5	94	1.14	(0.24, 5.93)
Pulmonary	Risperidone	Olanzapine	1	6	196	0	204	0.00	(0.00, 0.80)
Trauma	Risperidone	Olanzapine	3	30	300	50	324	1.64	(0.98, 2.76)
Trauma	Risperidone	Quetiapine	2	10	119	12	132	1.09	(0.41, 2.94)
Urinary	Risperidone	Olanzapine	1	25	196	19	204	0.70	(0.35, 1.38)
Urinary	Risperidone	Quetiapine	1	0	34	2	38	+Inf	(0.17, Inf+)

Patients aged 18-64 – Placebo Control Trials

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Accidental Overdose	Aripiprazole	1	1	146	0	149	0.00	(0.00, 38.21)	NC	NC
Alcohol Related	Olanzapine	1	0	159	1	155	+Inf	(0.03, Inf+)	NC	NC
Appetite or Weight/Decrease	Olanzapine	1	1	159	0	155	0.00	(0.00, 40.00)	NC	NC
Appetite or Weight/Decrease	Quetiapine	4	7	634	16	925	1.56	(0.59, 4.56)	NC	NC
Appetite or Weight/Decrease	Ziprasidone	1	1	21	1	41	0.51	(0.01, 41.19)	NC	NC
Appetite or Weight/Increase	Aripiprazole	4	8	686	35	701	4.18	(1.88, 10.56)	26.00	(18.00, 49.00)
Appetite or Weight/Increase	Olanzapine	11	103	819	382	818	11.30	(8.22, 15.74)	3.00	(3.00, 3.00)
Appetite or Weight/Increase	Quetiapine	12	86	1690	265	2733	2.66	(2.01, 3.54)	22.00	(16.00, 32.00)
Appetite or Weight/Increase	Risperidone	4	5	197	24	237	3.78	(1.35, 13.09)	13.00	(8.00, 32.00)
Appetite or Weight/Increase	Ziprasidone	2	2	113	5	251	1.24	(0.19, 13.59)	NC	NC
Cardiovascular	Olanzapine	2	8	125	11	124	1.63	(0.51, 5.57)	NC	NC
Cardiovascular	Quetiapine	2	4	192	1	186	0.26	(0.01, 2.60)	NC	NC
Cardiovascular	Risperidone	1	1	133	4	141	3.84	(0.37, 191.22)	NC	NC
Cardiovascular	Ziprasidone	1	0	48	2	91	+Inf	(0.10, Inf+)	NC	NC
Cardiovascular/BP/Decrease	Olanzapine	3	22	433	20	422	1.02	(0.44, 2.38)	NC	NC
Cardiovascular/BP/Decrease	Quetiapine	4	30	734	58	734	2.09	(1.29, 3.44)	26.00	(16.00, 72.00)
Cardiovascular/BP/Decrease	Ziprasidone	1	0	92	3	210	+Inf	(0.18, Inf+)	NC	NC
Cardiovascular/BP/Increase	Olanzapine	1	6	377	2	370	0.34	(0.03, 1.90)	NC	NC
Cardiovascular/BP/Increase	Quetiapine	3	81	568	122	568	1.71	(1.22, 2.39)	14.00	(9.00, 36.00)
Cardiovascular/BP/Increase	Risperidone	1	3	133	0	141	0.00	(0.00, 2.27)	NC	NC
Cardiovascular/Rhythm	Aripiprazole	1	1	146	0	149	0.00	(0.00, 38.21)	NC	NC
Cardiovascular/Rhythm	Olanzapine	1	1	377	1	370	1.02	(0.01, 80.20)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Cardiovascular/Rhythm	Quetiapine	4	45	727	60	885	1.32	(0.86, 2.03)	NC	NC
Cardiovascular/Rhythm	Risperidone	1	0	11	1	14	+Inf	(0.02, Inf+)	NC	NC
Cardiovascular/Rhythm	Ziprasidone	1	0	21	1	41	+Inf	(0.01, Inf+)	NC	NC
Constitutional/Fever or Infection	Aripiprazole	3	1	514	4	524	3.92	(0.39, 193.38)	NC	NC
Constitutional/Fever or Infection	Olanzapine	1	5	16	2	18	0.29	(0.02, 2.14)	NC	NC
Constitutional/Fever or Infection	Quetiapine	4	15	354	21	504	1.28	(0.61, 2.75)	NC	NC
Death	Quetiapine	2	1	542	1	695	0.71	(0.01, 58.88)	NC	NC
Dermatologic	Olanzapine	3	3	72	3	70	1.02	(0.13, 7.90)	NC	NC
Dermatologic	Quetiapine	2	1	189	8	186	+Inf	(1.51, Inf+)	27.00	(15.00, 147.00)
Dermatologic	Risperidone	1	0	9	1	11	+Inf	(0.02, Inf+)	NC	NC
Dermatologic	Ziprasidone	2	2	69	7	132	1.87	(0.34, 18.94)	NC	NC
Endocrine	Olanzapine	2	15	190	31	184	2.37	(1.18, 4.94)	11.00	(6.00, 43.00)
Endocrine	Quetiapine	1	1	148	5	298	2.50	(0.28, 119.45)	NC	NC
Endocrine	Risperidone	1	0	12	1	19	+Inf	(0.02, Inf+)	NC	NC
Endocrine	Ziprasidone	1	0	30	2	30	+Inf	(0.19, Inf+)	NC	NC
Endocrine/Diabetes	Olanzapine	1	1	377	5	370	5.14	(0.57, 244.28)	NC	NC
Endocrine/Diabetes	Quetiapine	5	11	857	31	1537	1.40	(0.68, 3.12)	NC	NC
Endocrine/Prolactin	Risperidone	1	0	10	1	15	+Inf	(0.02, Inf+)	NC	NC
Gastrointestinal	Aripiprazole	6	86	727	90	742	1.03	(0.74, 1.43)	NC	NC
Gastrointestinal	Olanzapine	11	126	863	99	859	0.72	(0.53, 0.98)	NC	NC
Gastrointestinal	Quetiapine	16	455	1919	762	3144	1.15	(0.99, 1.33)	NC	NC
Gastrointestinal	Risperidone	5	44	253	34	290	0.62	(0.36, 1.06)	NC	NC
Gastrointestinal	Ziprasidone	5	71	212	149	392	1.00	(0.68, 1.48)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
HEENT	Olanzapine	1	1	31	2	29	2.20	(0.11, 136.07)	NC	NC
HEENT	Quetiapine	7	81	1262	89	1801	0.85	(0.61, 1.18)	NC	NC
HEENT	Risperidone	1	8	133	5	141	0.58	(0.14, 2.06)	NC	NC
HEENT	Ziprasidone	1	1	48	4	91	2.15	(0.21, 108.65)	NC	NC
HEENT/Decreased Salivation	Aripiprazole	1	11	178	6	184	0.51	(0.15, 1.55)	NC	NC
HEENT/Decreased Salivation	Olanzapine	8	59	826	126	810	2.64	(1.86, 3.81)	12.00	(9.00, 19.00)
HEENT/Decreased Salivation	Quetiapine	16	131	1928	911	3171	5.31	(4.34, 6.52)	5.00	(4.00, 5.00)
HEENT/Decreased Salivation	Risperidone	5	9	241	30	281	2.99	(1.31, 7.54)	14.00	(9.00, 38.00)
HEENT/Decreased Salivation	Ziprasidone	3	6	134	34	271	3.34	(1.31, 10.20)	12.00	(7.00, 36.00)
HEENT/Eye	Aripiprazole	2	6	350	25	361	4.25	(1.68, 12.83)	19.00	(12.00, 44.00)
HEENT/Eye	Olanzapine	1	5	100	1	101	0.19	(0.00, 1.77)	NC	NC
HEENT/Eye	Quetiapine	4	9	467	29	769	2.09	(0.94, 5.11)	NC	NC
HEENT/Eye	Risperidone	1	0	20	3	20	+Inf	(0.43, Inf+)	NC	NC
HEENT/Eye	Ziprasidone	2	0	42	6	61	+Inf	(1.07, Inf+)	10.00	(6.00, 42.00)
Heme	Quetiapine	2	1	320	4	464	2.78	(0.26, 141.18)	NC	NC
Increased Cholesterol	Quetiapine	3	73	528	149	1067	1.02	(0.74, 1.40)	NC	NC
Infections	Aripiprazole	2	20	350	28	361	1.39	(0.74, 2.65)	NC	NC
Infections	Quetiapine	4	42	722	46	1022	0.85	(0.53, 1.38)	NC	NC
Infections	Risperidone	1	3	133	0	141	0.00	(0.00, 2.27)	NC	NC
Infections	Ziprasidone	1	0	21	1	20	+Inf	(0.03, Inf+)	NC	NC
Liver Function Test Abnormality	Aripiprazole	1	2	146	10	168	4.61	(0.93, 44.57)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Liver Function Test Abnormality	Olanzapine	1	0	69	12	70	+Inf	(3.16, Inf+)	6.00	(4.00, 12.00)
Liver Function Test Abnormality	Risperidone	1	0	11	1	14	+Inf	(0.02, Inf+)	NC	NC
Liver Function Test Abnormality	Ziprasidone	1	0	48	1	91	+Inf	(0.01, Inf+)	NC	NC
Metabolic Lab Abnormality	Quetiapine	3	32	537	108	903	2.20	(1.43, 3.47)	17.00	(11.00, 32.00)
Musculoskeletal	Aripiprazole	1	1	178	0	184	0.00	(0.00, 37.73)	NC	NC
Musculoskeletal	Olanzapine	3	14	59	14	59	1.01	(0.18, 5.62)	NC	NC
Musculoskeletal	Quetiapine	5	29	748	60	906	1.86	(1.16, 3.06)	36.00	(21.00, 162.00)
Musculoskeletal	Risperidone	2	8	190	6	195	0.62	(0.15, 2.21)	NC	NC
Neuro	Aripiprazole	6	127	795	111	805	0.83	(0.62, 1.12)	NC	NC
Neuro	Olanzapine	8	56	377	74	369	1.55	(1.00, 2.42)	NC	NC
Neuro	Quetiapine	17	459	1933	834	3181	1.28	(1.11, 1.48)	40.00	(20.00, 2734.0)
Neuro	Risperidone	6	63	261	54	301	0.72	(0.45, 1.15)	NC	NC
Neuro	Ziprasidone	5	18	212	57	392	1.95	(1.06, 3.72)	17.00	(9.00, 108.00)
Neuro/Fatigue	Aripiprazole	4	31	686	82	701	2.86	(1.83, 4.55)	14.00	(10.00, 23.00)
Neuro/Fatigue	Olanzapine	7	43	737	80	720	2.06	(1.37, 3.12)	19.00	(12.00, 41.00)
Neuro/Fatigue	Quetiapine	11	73	1638	279	2702	2.82	(2.10, 3.82)	17.00	(14.00, 23.00)
Neuro/Fatigue	Risperidone	4	9	233	9	274	0.83	(0.28, 2.41)	NC	NC
Neuro/Fatigue	Ziprasidone	2	0	69	8	111	+Inf	(1.59, Inf+)	14.00	(8.00, 42.00)
Neuro/Headache	Aripiprazole	1	0	146	1	149	+Inf	(0.03, Inf+)	NC	NC
Neuro/Headache	Olanzapine	3	94	506	68	495	0.69	(0.48, 0.98)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro/Headache	Ziprasidone	2	40	140	68	301	0.72	(0.44, 1.17)	NC	NC
Neuro/Movement Disorder	Olanzapine	2	8	56	8	52	1.33	(0.35, 5.13)	NC	NC
Neuro/Movement Disorder	Quetiapine	2	23	320	42	464	1.99	(1.10, 3.66)	54.00	(17.00, -50.00)
Neuro/Movement Disorder	Ziprasidone	1	0	30	0	30	NC	NC	NC	NC
Neuro/Movement Disorder/Akathisia	Aripiprazole	5	24	769	190	779	11.78	(7.40, 19.61)	5.00	(4.00, 6.00)
Neuro/Movement Disorder/Akathisia	Olanzapine	1	7	25	9	23	2.04	(0.50, 8.92)	NC	NC
Neuro/Movement Disorder/Akathisia	Quetiapine	4	5	488	10	632	1.31	(0.38, 5.07)	NC	NC
Neuro/Movement Disorder/Akathisia	Risperidone	1	0	18	1	19	+Inf	(0.02, Inf+)	NC	NC
Neuro/Movement Disorder/Akathisia	Ziprasidone	3	9	161	36	321	2.11	(0.96, 5.15)	NC	NC
Neuro/Movement Disorder/EPS	Aripiprazole	5	43	605	99	610	2.75	(1.83, 4.19)	11.00	(8.00, 18.00)
Neuro/Movement Disorder/EPS	Olanzapine	3	18	65	17	71	0.87	(0.25, 2.97)	NC	NC
Neuro/Movement Disorder/EPS	Quetiapine	5	32	731	104	1110	2.54	(1.63, 4.03)	20.00	(14.00, 37.00)
Neuro/Movement Disorder/EPS	Risperidone	1	1	10	0	15	0.00	(0.00, 26.00)	NC	NC
Neuro/Movement Disorder/EPS	Ziprasidone	3	6	161	28	321	3.12	(1.15, 10.62)	20.00	(11.00, 135.00)
Neuro/Pain	Olanzapine	2	5	85	13	88	2.74	(0.86, 10.40)	NC	NC
Neuro/Pain	Quetiapine	7	65	1107	128	1609	1.59	(1.13, 2.25)	48.00	(25.00, 593.00)
Neuro/Pain	Risperidone	1	3	133	0	141	0.00	(0.00, 2.27)	NC	NC
Neuro/Pain	Ziprasidone	2	12	140	26	301	1.02	(0.48, 2.29)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Neuro/Sedation	Aripiprazole	7	73	810	160	820	3.03	(2.15, 4.32)	10.00	(7.00, 14.00)
Neuro/Sedation	Olanzapine	14	127	904	279	901	2.95	(2.29, 3.82)	6.00	(5.00, 8.00)
Neuro/Sedation	Quetiapine	15	345	1899	1517	3135	4.73	(4.07, 5.51)	3.00	(3.00, 4.00)
Neuro/Sedation	Risperidone	8	25	290	54	336	2.43	(1.39, 4.34)	13.00	(8.00, 42.00)
Neuro/Sedation	Ziprasidone	5	21	212	95	392	3.90	(2.15, 7.44)	7.00	(5.00, 12.00)
Neuro/Sensory	Quetiapine	1	2	157	4	157	2.02	(0.29, 22.66)	NC	NC
Neuro/Speech Disorder	Quetiapine	1	0	21	1	21	+Inf	(0.03, Inf+)	NC	NC
Psychiatric	Aripiprazole	1	1	146	0	149	0.00	(0.00, 38.21)	NC	NC
Psychiatric	Olanzapine	4	27	313	16	303	0.58	(0.27, 1.22)	NC	NC
Psychiatric	Quetiapine	1	1	21	1	21	1.00	(0.01, 82.37)	NC	NC
Psychiatric	Ziprasidone	1	5	21	24	41	4.41	(1.24, 18.48)	3.00	(2.00, 9.00)
Psychiatric/Aggression	Olanzapine	3	16	288	8	280	0.49	(0.17, 1.25)	NC	NC
Psychiatric/Agitation	Aripiprazole	7	28	803	108	813	4.26	(2.75, 6.80)	10.00	(8.00, 14.00)
Psychiatric/Agitation	Olanzapine	3	31	288	19	280	0.57	(0.28, 1.11)	NC	NC
Psychiatric/Agitation	Quetiapine	2	3	305	9	455	2.07	(0.50, 12.19)	NC	NC
Psychiatric/Agitation	Ziprasidone	3	16	161	27	321	0.84	(0.42, 1.74)	NC	NC
Psychiatric/Anxiety	Aripiprazole	4	28	270	57	268	2.40	(1.42, 4.12)	9.00	(6.00, 21.00)
Psychiatric/Anxiety	Olanzapine	6	89	708	70	691	0.76	(0.53, 1.09)	NC	NC
Psychiatric/Anxiety	Quetiapine	5	19	936	32	1314	1.36	(0.73, 2.58)	NC	NC
Psychiatric/Apathy	Quetiapine	1	2	20	3	20	1.57	(0.16, 20.98)	NC	NC
Psychiatric/Cognitive	Aripiprazole	1	3	146	14	149	4.92	(1.33, 27.29)	14.00	(8.00, 47.00)

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Psychiatric/Cognitive	Olanzapine	1	1	25	5	23	6.51	(0.64, 333.53)	NC	NC
Psychiatric/Cognitive	Quetiapine	4	9	226	18	378	1.56	(0.64, 4.11)	NC	NC
Psychiatric/Cognitive	Risperidone	1	0	133	3	141	+Inf	(0.39, Inf+)	NC	NC
Psychiatric/Cognitive	Ziprasidone	1	0	21	2	20	+Inf	(0.20, Inf+)	NC	NC
Psychiatric/Depression	Aripiprazole	2	15	98	9	93	0.57	(0.20, 1.54)	NC	NC
Psychiatric/Depression	Olanzapine	3	12	259	11	254	0.91	(0.35, 2.38)	NC	NC
Psychiatric/Depression	Quetiapine	2	8	180	16	327	1.78	(0.63, 5.52)	NC	NC
Psychiatric/Depression	Ziprasidone	1	0	21	4	41	+Inf	(0.34, Inf+)	NC	NC
Psychiatric/Irritability	Quetiapine	7	50	1081	70	1739	0.82	(0.55, 1.23)	NC	NC
Psychiatric/Irritability	Risperidone	1	0	57	1	54	+Inf	(0.03, Inf+)	NC	NC
Psychiatric/Mania	Aripiprazole	1	11	83	5	78	0.40	(0.09, 1.45)	NC	NC
Psychiatric/Mania	Quetiapine	1	7	181	9	361	0.63	(0.21, 2.04)	NC	NC
Psychiatric/Self-Injurious Behavior	Aripiprazole	2	8	172	2	175	0.20	(0.02, 1.16)	NC	NC
Psychiatric/Self-Injurious Behavior	Olanzapine	1	0	159	1	155	+Inf	(0.03, Inf+)	NC	NC
Psychiatric/Serious	Ziprasidone	1	3	30	4	30	1.38	(0.21, 10.33)	NC	NC
Psychiatric/Sexual/Decreased Function	Olanzapine	3	12	55	13	53	1.32	(0.48, 3.68)	NC	NC
Psychiatric/Sexual/Decreased Function	Quetiapine	4	21	423	26	797	0.96	(0.46, 2.07)	NC	NC
Psychiatric/Sexual/Decreased Function	Risperidone	3	4	28	1	37	0.19	(0.00, 2.07)	NC	NC
Psychiatric/Sexual/Decreased Function	Ziprasidone	1	0	92	2	210	+Inf	(0.08, Inf+)	NC	NC
Psychiatric/Sleep	Aripiprazole	2	24	98	25	93	1.21	(0.56, 2.66)	NC	NC
Psychiatric/Sleep	Olanzapine	2	77	477	39	471	0.46	(0.30, 0.71)	NC	NC
Psychiatric/Sleep	Quetiapine	5	16	391	27	690	1.17	(0.59, 2.39)	NC	NC
Psychiatric/Sleep	Ziprasidone	3	15	161	28	342	0.82	(0.40, 1.72)	NC	NC

Adverse Events	Drug	# of studies	Placebo		Atypicals		Pooled OR	95% CI	NNH ¹	95% CI NNH
			# adverse events	sample size	# adverse events	sample size				
Psychiatric/Suicidal Ideation	Aripiprazole	2	2	350	1	361	0.48	(0.01, 9.32)	NC	NC
Psychiatric/Suicidal Ideation	Olanzapine	1	4	159	10	155	2.66	(0.75, 11.90)	NC	NC
Psychiatric/Suicidal Ideation	Quetiapine	1	1	172	1	166	1.04	(0.01, 81.82)	NC	NC
Psychiatric/Suicidal Ideation	Risperidone	2	0	22	2	34	+Inf	(0.12, Inf+)	NC	NC
Pulmonary	Quetiapine	1	4	157	5	157	1.26	(0.27, 6.46)	NC	NC
Pulmonary	Ziprasidone	1	2	48	8	91	2.21	(0.42, 22.18)	NC	NC
Sweating	Quetiapine	6	31	524	28	828	0.75	(0.41, 1.37)	NC	NC
Thirst	Olanzapine	1	0	5	1	7	+Inf	(0.02, Inf+)	NC	NC
Thirst	Quetiapine	3	0	310	6	465	+Inf	(0.97, Inf+)	NC	NC
Trauma	Aripiprazole	1	1	178	0	184	0.00	(0.00, 37.73)	NC	NC
Trauma	Quetiapine	1	1	148	4	298	2.00	(0.20, 99.16)	NC	NC
Urinary	Quetiapine	3	7	571	20	724	2.31	(0.92, 6.59)	NC	NC
Urinary	Risperidone	1	0	8	1	8	+Inf	(0.03, Inf+)	NC	NC

¹ NNH=Number Needed to Harm

Patients aged 18-64 – Atypicals vs. Conventionals

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Olanzapine	1	115	636	149	1306	0.58	(0.44, 0.77)
Appetite or Weight/Increase	Aripiprazole	1	14	431	44	859	1.61	(0.85, 3.21)
Appetite or Weight/Increase	Olanzapine	3	112	794	398	1472	2.65	(2.07, 3.41)
Cardiovascular/BP/Decrease	Olanzapine	1	1	7	0	8	0.00	(0.00, 34.12)
Cardiovascular/Rhythm	Olanzapine	1	63	636	86	1306	0.64	(0.45, 0.92)
Constitutional	Olanzapine	1	36	636	45	1306	0.59	(0.37, 0.96)

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Constitutional/Fever or Infection	Olanzapine	1	48	636	56	1306	0.55	(0.36, 0.84)
Endocrine/Diabetes	Olanzapine	1	0	26	0	35	NC	NC
Gastrointestinal	Olanzapine	2	161	768	209	1437	0.60	(0.48, 0.77)
HEENT/Decreased Salivation	Olanzapine	1	103	636	290	1306	1.48	(1.15, 1.91)
HEENT/Eye	Olanzapine	1	96	636	139	1306	0.67	(0.50, 0.90)
HEENT/Increased Salivation	Olanzapine	1	124	636	113	1306	0.39	(0.29, 0.52)
Heme	Olanzapine	1	0	132	6	131	+Inf	(1.22, Inf+)
Musculoskeletal	Olanzapine	1	16	132	4	131	0.25	(0.06, 0.80)
Neuro	Aripiprazole	1	38	431	65	859	0.85	(0.55, 1.32)
Neuro/Fatigue	Olanzapine	1	104	636	150	1306	0.66	(0.50, 0.88)
Neuro/Movement Disorder	Olanzapine	1	115	636	102	1306	0.38	(0.29, 0.52)
Neuro/Movement Disorder/Akathisia	Aripiprazole	1	108	431	111	859	0.44	(0.33, 0.60)
Neuro/Movement Disorder/Akathisia	Olanzapine	2	266	768	203	1437	0.31	(0.25, 0.38)
Neuro/Movement Disorder/EPS	Aripiprazole	1	171	431	118	859	0.24	(0.18, 0.32)
Neuro/Movement Disorder/EPS	Olanzapine	3	400	794	369	1472	0.28	(0.23, 0.35)
Neuro/Movement Disorder/Gait	Olanzapine	1	20	636	22	1306	0.53	(0.27, 1.03)
Neuro/Sedation	Aripiprazole	1	32	431	43	859	0.66	(0.40, 1.09)
Neuro/Sedation	Olanzapine	3	220	669	340	1349	0.69	(0.56, 0.85)
Psychiatric	Olanzapine	1	15	636	13	1306	0.42	(0.18, 0.94)
Psychiatric/Agitation	Aripiprazole	1	30	431	53	859	0.88	(0.54, 1.45)
Psychiatric/Anxiety	Aripiprazole	1	50	431	108	859	1.10	(0.76, 1.60)
Psychiatric/Anxiety	Olanzapine	1	51	132	27	131	0.41	(0.22, 0.73)
Psychiatric/Lability	Olanzapine	1	7	132	10	131	1.55	(0.48, 5.45)

Adverse Events	Drug	# of studies	Conventional		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Psychiatric/Psychotic	Aripiprazole	1	70	431	156	859	1.14	(0.83, 1.58)
Psychiatric/Sleep	Aripiprazole	1	88	431	185	859	1.07	(0.80, 1.44)
Psychiatric/Sleep	Olanzapine	1	632	636	1122	1306	0.03	(0.01, 0.09)
Sweating	Olanzapine	1	84	636	89	1306	0.48	(0.35, 0.67)
Urinary	Olanzapine	1	39	636	47	1306	0.57	(0.36, 0.91)

Patients aged 18-64 – Atypicals vs. Mood Stabilizers

Adverse Events	Drug	# of studies	Mood Stabilizer		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Olanzapine	1	11	214	7	217	0.62	(0.20, 1.78)
Appetite or Weight/Increase	Olanzapine	2	23	340	44	342	2.10	(1.19, 3.77)
Appetite or Weight/Increase	Quetiapine	1	2	14	0	14	0.00	(0.00, 5.26)
Gastrointestinal	Olanzapine	2	108	340	68	342	0.28	(0.16, 0.48)
Gastrointestinal	Quetiapine	1	0	14	2	14	+Inf	(0.19, Inf+)
HEENT	Olanzapine	1	0	126	6	125	+Inf	(1.21, Inf+)
HEENT/Decreased Salivation	Olanzapine	1	8	126	42	125	7.41	(3.22, 19.23)
Heme/Low platelets	Olanzapine	1	10	126	0	125	0.00	(0.00, 0.42)
Liver Function Test Abnormality	Olanzapine	1	0	126	6	125	+Inf	(1.22, Inf+)
Neuro	Olanzapine	1	15	126	20	125	1.41	(0.65, 3.12)
Neuro/Fatigue	Olanzapine	1	17	126	20	125	1.22	(0.57, 2.63)
Neuro/Headache	Olanzapine	2	40	340	37	342	0.91	(0.54, 1.54)
Neuro/Movement Disorder/EPS	Olanzapine	1	6	126	21	125	4.02	(1.50, 12.64)

Adverse Events	Drug	# of studies	Mood Stabilizer		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Neuro/Movement Disorder/EPS	Quetiapine	1	7	10	0	10	0.00	(0.00, 0.39)
Neuro/Pain	Olanzapine	1	18	126	17	125	0.94	(0.43, 2.06)
Neuro/Sedation	Olanzapine	2	26	340	55	342	2.81	(1.59, 5.07)
Neuro/Sedation	Quetiapine	1	0	14	7	24	+Inf	(0.19, Inf+)
Neuro/Speech Disorder	Olanzapine	1	1	126	10	125	10.79	(1.49, 475.41)
Psychiatric	Quetiapine	1	1	10	0	10	0.00	(0.00, 39.00)
Psychiatric/Agitation	Olanzapine	1	14	126	14	125	1.01	(0.42, 2.40)
Psychiatric/Anxiety	Olanzapine	2	31	340	25	342	0.79	(0.43, 1.42)
Psychiatric/Depression	Olanzapine	1	25	214	45	217	1.97	(1.13, 3.51)
Psychiatric/Mania	Olanzapine	1	44	214	17	217	0.33	(0.17, 0.61)
Psychiatric/Sleep	Olanzapine	2	49	340	24	342	0.43	(0.25, 0.75)

Patients aged 18-64 – Active Control Trials – Atypicals vs. SSRIs

Adverse Events	Drug	# of studies	SSRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Quetiapine	1	5	157	4	157	0.80	(0.15, 3.77)
Appetite or Weight/Decrease	Risperidone	1	1	10	0	10	0.00	(0.00, 39.00)
Appetite or Weight/Increase	Olanzapine	3	38	408	170	293	11.27	(7.20, 18.00)
Appetite or Weight/Increase	Quetiapine	2	15	374	42	596	1.94	(1.02, 3.85)
Appetite or Weight/Increase	Risperidone	1	3	10	3	10	1.00	(0.10, 10.33)
Cardiovascular	Olanzapine	2	2	266	20	261	9.78	(2.31, 87.80)
Cardiovascular	Risperidone	1	0	10	1	10	+Inf	(0.03, Inf+)
Cardiovascular/BP/Decrease	Quetiapine	1	1	157	7	157	7.24	(0.91, 330.16)

Adverse Events	Drug	# of studies	SSRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Cardiovascular/Rhythm	Quetiapine	1	8	157	6	157	0.74	(0.21, 2.50)
Constitutional/Fever or Infection	Olanzapine	1	0	206	0	199	NC	NC
Constitutional/Fever or Infection	Quetiapine	1	4	157	13	157	3.44	(1.03, 14.82)
Death	Olanzapine	2	0	266	0	261	NC	NC
Death	Quetiapine	1	0	157	0	157	NC	NC
Dermatologic	Quetiapine	1	1	157	5	157	5.11	(0.56, 244.23)
Dermatologic	Risperidone	1	1	10	1	10	1.00	(0.01, 87.11)
Endocrine/Diabetes	Olanzapine	2	8	241	10	231	1.31	(0.45, 3.90)
Endocrine/Diabetes	Quetiapine	1	3	217	3	439	0.49	(0.07, 3.70)
Gastrointestinal	Quetiapine	2	178	374	206	596	0.74	(0.54, 1.01)
Gastrointestinal	Risperidone	1	7	10	5	10	0.45	(0.05, 3.67)
Gastrointestinal	Ziprasidone	1	0	21	9	43	+Inf	(1.07, Inf+)
HEENT	Quetiapine	2	25	374	23	596	0.62	(0.33, 1.17)
HEENT	Ziprasidone	1	0	21	3	43	+Inf	(0.20, Inf+)
HEENT/Decreased Salivation	Olanzapine	2	22	266	73	261	4.54	(2.64, 8.10)
HEENT/Decreased Salivation	Quetiapine	2	43	374	151	596	3.00	(2.04, 4.50)
HEENT/Decreased Salivation	Risperidone	1	3	10	1	10	0.28	(0.00, 4.35)
HEENT/Decreased Salivation	Ziprasidone	1	0	21	6	43	+Inf	(0.60, Inf+)
HEENT/Eye	Quetiapine	1	4	157	6	157	1.52	(0.35, 7.46)
HEENT/Eye	Risperidone	1	0	10	0	10	NC	NC
HEENT/Eye	Ziprasidone	1	0	21	5	43	+Inf	(0.46, Inf+)
HEENT/Increased Salivation	Risperidone	1	0	10	0	10	NC	NC
Increased Cholesterol	Olanzapine	1	3	206	5	199	1.74	(0.33, 11.37)
Increased Cholesterol	Quetiapine	1	31	217	50	439	0.77	(0.47, 1.29)
Infections	Ziprasidone	1	0	21	5	43	+Inf	(0.46, Inf+)
Metabolic Lab Abnormality	Olanzapine	1	0	206	1	199	+Inf	(0.03, Inf+)
Metabolic Lab Abnormality	Quetiapine	1	8	217	25	439	1.58	(0.67, 4.12)
Musculoskeletal	Quetiapine	1	4	157	13	157	3.44	(1.03, 14.82)

Adverse Events	Drug	# of studies	SSRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Musculoskeletal	Risperidone	1	0	10	1	10	+Inf	(0.03, Inf+)
Neuro	Olanzapine	3	56	280	38	277	0.65	(0.40, 1.05)
Neuro	Quetiapine	2	144	374	217	596	1.10	(0.82, 1.47)
Neuro	Risperidone	1	1	10	0	10	0.00	(0.00, 39.00)
Neuro	Ziprasidone	1	1	21	15	43	10.42	(1.38, 473.14)
Neuro/Fatigue	Olanzapine	2	21	266	39	261	2.15	(1.18, 4.02)
Neuro/Fatigue	Quetiapine	2	34	374	88	596	1.68	(1.08, 2.65)
Neuro/Fatigue	Risperidone	1	2	10	2	10	1.00	(0.06, 17.08)
Neuro/Fatigue	Ziprasidone	1	0	21	9	43	+Inf	(1.07, Inf+)
Neuro/Headache	Risperidone	1	1	10	1	10	1.00	(0.01, 87.11)
Neuro/Movement Disorder	Olanzapine	1	0	14	0	16	NC	NC
Neuro/Movement Disorder	Risperidone	1	0	10	1	10	+Inf	(0.03, Inf+)
Neuro/Movement Disorder/Akathisia	Olanzapine	1	5	14	4	16	0.61	(0.09, 3.78)
Neuro/Movement Disorder/Akathisia	Quetiapine	1	5	157	2	157	0.39	(0.04, 2.45)
Neuro/Movement Disorder/EPS	Olanzapine	2	21	348	16	199	0.91	(0.41, 1.99)
Neuro/Movement Disorder/EPS	Quetiapine	2	33	374	39	596	0.78	(0.46, 1.32)
Neuro/Movement Disorder/EPS	Risperidone	1	1	10	1	10	1.00	(0.01, 87.11)
Neuro/Movement Disorder/EPS	Ziprasidone	1	1	21	7	43	3.82	(0.44, 183.88)
Neuro/Movement Disorder/Tardive Dyskinesia	Olanzapine	1	0	14	0	16	NC	NC
Neuro/Pain	Quetiapine	1	18	157	14	157	0.76	(0.33, 1.68)
Neuro/Pain	Ziprasidone	1	0	21	4	43	+Inf	(0.32, Inf+)
Neuro/Sedation	Olanzapine	3	22	280	69	277	4.32	(2.48, 7.83)
Neuro/Sedation	Quetiapine	2	104	374	275	596	2.55	(1.90, 3.45)
Neuro/Sedation	Risperidone	1	2	10	5	10	3.72	(0.40, 53.84)
Neuro/Sedation	Ziprasidone	1	2	21	8	43	2.15	(0.37, 22.77)
Neuro/Sensory	Quetiapine	1	4	157	4	157	1.00	(0.18, 5.47)
Neuro/Sensory	Risperidone	1	0	10	0	10	NC	NC

Adverse Events	Drug	# of studies	SSRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Psychiatric/Agitation	Quetiapine	1	3	157	4	157	1.34	(0.22, 9.31)
Psychiatric/Agitation	Risperidone	1	0	10	0	10	NC	NC
Psychiatric/Agitation	Ziprasidone	1	0	21	9	43	+Inf	(1.07, Inf+)
Psychiatric/Anxiety	Quetiapine	2	18	374	18	596	0.71	(0.34, 1.48)
Psychiatric/Anxiety	Risperidone	1	0	10	1	10	+Inf	(0.03, Inf+)
Psychiatric/Anxiety	Ziprasidone	1	2	21	0	43	0.00	(0.00, 2.55)
Psychiatric/Cognitive	Risperidone	1	1	10	0	10	0.00	(0.00, 39.00)
Psychiatric/Cognitive	Ziprasidone	1	0	21	4	43	+Inf	(0.32, Inf+)
Psychiatric/Depression	Risperidone	1	0	10	0	10	NC	NC
Psychiatric/Irritability	Quetiapine	1	8	157	9	157	1.13	(0.38, 3.47)
Psychiatric/Serious	Olanzapine	1	0	206	0	199	NC	NC
Psychiatric/Sexual/Decreased Function	Quetiapine	1	16	217	6	439	0.17	(0.06, 0.48)
Psychiatric/Sexual/Decreased Function	Risperidone	1	2	10	0	10	0.00	(0.00, 5.23)
Psychiatric/Sexual/Decreased Function	Ziprasidone	1	1	21	0	43	0.00	(0.00, 19.05)
Psychiatric/Sleep	Risperidone	1	2	10	1	10	0.46	(0.01, 10.51)
Psychiatric/Sleep	Ziprasidone	1	1	21	13	43	8.45	(1.10, 386.39)
Psychiatric/Suicide Attempt	Olanzapine	1	1	14	0	16	0.00	(0.00, 34.12)
Pulmonary	Quetiapine	1	1	157	5	157	5.11	(0.56, 244.23)
Sweating	Quetiapine	1	12	157	8	157	0.65	(0.22, 1.79)
Sweating	Risperidone	1	1	10	1	10	1.00	(0.01, 87.11)
Thirst	Quetiapine	1	1	157	4	157	4.06	(0.40, 202.11)
Urinary	Risperidone	1	1	10	0	10	0.00	(0.00, 39.00)

Patients Aged 18-64 - Active Control Trials – Atypicals vs. Tricyclic Antidepressants

Adverse Events	Drug	# of studies	Tricyclic		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Cardiovascular/BP/Decrease	Olanzapine	1	10	20	4	20	0.26	(0.05, 1.21)
Endocrine/Prolactin	Olanzapine	1	1	20	6	20	7.76	(0.80, 393.79)

Patients Aged 18-64 - Active Control Trials – Atypicals vs. SNRIs

Adverse Events	Drug	# of studies	SNRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Quetiapine	1	8	151	5	304	0.30	(0.08, 1.06)
Appetite or Weight/Increase	Olanzapine	1	6	59	26	62	7.74	(2.60, 28.30)
Appetite or Weight/Increase	Quetiapine	1	4	151	23	304	3.00	(1.00, 12.17)
Cardiovascular	Olanzapine	1	1	59	5	62	3.96	(0.38, 200.38)
Death	Olanzapine	1	0	59	0	62	NC	NC
Death	Quetiapine	1	0	151	1	304	+Inf	(0.01, Inf+)
Endocrine/Diabetes	Quetiapine	1	1	151	9	304	4.57	(0.62, 201.90)
Gastrointestinal	Quetiapine	1	95	151	71	304	0.18	(0.11, 0.28)
HEENT/Decreased Salivation	Olanzapine	1	3	59	10	62	4.79	(0.93, 47.59)
HEENT/Decreased Salivation	Quetiapine	1	28	151	109	304	2.45	(1.50, 4.09)
HEENT/Eye	Quetiapine	1	4	151	16	304	2.04	(0.64, 8.53)
Infections	Quetiapine	1	6	151	7	304	0.57	(0.16, 2.09)
Neuro	Olanzapine	1	13	59	12	62	0.94	(0.35, 2.54)
Neuro	Quetiapine	1	52	151	81	304	0.69	(0.44, 1.08)
Neuro/Fatigue	Olanzapine	1	5	59	11	62	2.94	(0.81, 13.51)
Neuro/Fatigue	Quetiapine	1	10	151	12	304	0.58	(0.22, 1.54)

Adverse Events	Drug	# of studies	SNRI		Atypicals		Pooled OR	95% CI
			# adverse events	sample size	# adverse events	sample size		
Neuro/Sedation	Olanzapine	1	5	59	11	62	2.94	(0.81, 13.51)
Neuro/Sedation	Quetiapine	1	65	151	197	304	2.43	(1.60, 3.70)
Psychiatric/Irritability	Quetiapine	1	0	151	11	304	+Inf	(1.27, Inf+)
Psychiatric/Sleep	Quetiapine	1	4	151	13	304	1.64	(0.50, 7.03)
Sweating	Quetiapine	1	11	151	0	304	0.00	(0.00, 0.19)
Urinary	Quetiapine	1	8	151	8	304	0.48	(0.15, 1.51)

Patients Aged 18-64 – Head-to-Head Trials

Adverse Events	Drug 1	Drug 2	# of studies	Drug 1		Drug 2		Pooled OR	95% CI
				# adverse events	sample size	# adverse events	sample size		
Appetite or Weight/Decrease	Risperidone	Quetiapine	2	3	221	7	601	1.55	(0.33, 10.01)
Appetite or Weight/Decrease	Ziprasidone	Olanzapine	1	10	192	2	202	0.18	(0.02, 0.87)
Appetite or Weight/Increase	Risperidone	Quetiapine	2	19	221	40	601	1.75	(0.85, 3.75)
Appetite or Weight/Increase	Ziprasidone	Olanzapine	1	19	192	62	202	4.02	(2.25, 7.48)
Appetite or Weight/Increase	Ziprasidone	Quetiapine	1	0	9	3	15	NC	NC
Cardiovascular	Ziprasidone	Olanzapine	2	7	328	16	335	2.39	(0.91, 7.01)
Cardiovascular/Rhythm	Risperidone	Quetiapine	1	0	46	0	48	NC	NC
Constitutional	Ziprasidone	Olanzapine	1	52	136	39	133	0.67	(0.39, 1.15)
Constitutional/Fever or Infection	Ziprasidone	Olanzapine	1	5	192	0	202	0.00	(0.00, 1.42)
Death	Risperidone	Quetiapine	1	0	175	4	553	+Inf	(0.21, Inf+)
Dermatologic	Risperidone	Quetiapine	1	0	46	0	48	NC	NC
Dermatologic	Ziprasidone	Olanzapine	1	14	136	10	133	0.71	(0.27, 1.79)
Endocrine	Ziprasidone	Olanzapine	1	6	136	14	133	2.54	(0.88, 8.34)
Gastrointestinal	Risperidone	Quetiapine	1	3	46	4	48	1.30	(0.21, 9.40)

Adverse Events	Drug 1	Drug 2	# of studies	Drug 1		Drug 2		Pooled OR	95% CI
				# adverse events	sample size	# adverse events	sample size		
Gastrointestinal	Ziprasidone	Olanzapine	2	76	328	57	335	0.66	(0.43, 1.00)
HEENT/Bruxism	Ziprasidone	Olanzapine	1	4	192	0	202	0.00	(0.00, 1.42)
HEENT/Decreased Salivation	Risperidone	Quetiapine	2	13	221	83	601	2.34	(1.25, 4.70)
HEENT/Decreased Salivation	Ziprasidone	Olanzapine	1	20	192	32	202	1.56	(0.82, 3.01)
HEENT/Eye	Risperidone	Quetiapine	1	3	46	1	48	0.31	(0.01, 4.01)
Heme	Ziprasidone	Olanzapine	1	3	136	5	133	1.73	(0.33, 11.36)
Musculoskeletal	Ziprasidone	Olanzapine	1	8	136	8	133	1.02	(0.32, 3.24)
Neuro	Risperidone	Quetiapine	2	16	221	75	601	1.81	(1.01, 3.44)
Neuro/Fatigue	Risperidone	Quetiapine	1	6	46	9	48	1.53	(0.44, 5.76)
Neuro/Headache	Risperidone	Quetiapine	1	11	175	52	553	1.55	(0.77, 3.37)
Neuro/Headache	Ziprasidone	Olanzapine	1	25	192	32	202	1.21	(0.66, 2.24)
Neuro/Movement Disorder	Risperidone	Olanzapine	1	1	14	0	14	0.00	(0.00, 39.00)
Neuro/Movement Disorder	Ziprasidone	Olanzapine	1	0	192	5	202	+Inf	(0.88, Inf+)
Neuro/Movement Disorder/EPS	Risperidone	Quetiapine	2	75	221	227	601	0.92	(0.64, 1.31)
Neuro/Sedation	Risperidone	Olanzapine	1	11	14	8	14	0.36	(0.04, 2.45)
Neuro/Sedation	Risperidone	Quetiapine	2	32	221	179	601	2.30	(1.50, 3.61)
Neuro/Sensory	Ziprasidone	Olanzapine	1	8	136	6	133	0.76	(0.21, 2.57)
Psychiatric	Risperidone	Olanzapine	1	1	14	0	14	0.00	(0.00, 39.00)
Psychiatric/Agitation	Risperidone	Quetiapine	1	3	175	34	553	3.75	(1.16, 19.33)
Psychiatric/Anxiety	Risperidone	Quetiapine	1	3	46	7	48	2.42	(0.51, 15.51)
Psychiatric/Anxiety	Ziprasidone	Olanzapine	1	82	136	64	133	0.61	(0.37, 1.02)
Psychiatric/Irritability	Ziprasidone	Olanzapine	1	7	192	2	202	0.26	(0.03, 1.42)
Psychiatric/Psychotic	Ziprasidone	Olanzapine	1	15	192	5	202	0.30	(0.08, 0.89)
Psychiatric/Serious	Risperidone	Olanzapine	1	0	14	1	14	+Inf	(0.03, Inf+)
Psychiatric/Sexual/Decreased Function	Risperidone	Quetiapine	1	3	46	3	48	0.96	(0.12, 7.53)
Psychiatric/Sleep	Risperidone	Quetiapine	1	17	175	65	553	1.24	(0.69, 2.32)
Psychiatric/Sleep	Ziprasidone	Olanzapine	1	35	192	25	202	0.66	(0.36, 1.19)
Pulmonary	Ziprasidone	Olanzapine	1	24	136	16	133	0.64	(0.30, 1.33)

				Drug 1		Drug 2			
Adverse Events	Drug 1	Drug 2	# of studies	# adverse events	sample size	# adverse events	sample size	Pooled OR	95% CI
Sweating	Risperidone	Quetiapine	1	1	46	1	48	0.96	(0.01, 76.81)
Urinary	Risperidone	Quetiapine	1	0	46	0	48	NC	NC
Urinary	Ziprasidone	Olanzapine	1	9	136	5	133	0.55	(0.14, 1.90)