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## Response to Letters

TO THE EDITOR: We thank Dr. Smith and Dr. Gould et al. for their interest in our study. The importance of conducting a power calculation based on suicide attempts instead of suicidal ideation with plans is a point well taken. Because the power calculator originally used for the article appears to have been removed from the Johns Hopkins web site, we identified a different power calculator and double-checked it with our in-house power calculation script. With N=94 and 50% dropout, and an attempt rate of 13% for lithium, the minimum hazard ratio for valproate detectable with 80% power is around 3.2. Based on these same assumptions for suicide events, the hazard ratio would be 2.2. In other words, based on these new calculations, it appears that the study was better powered than originally stated in the article. Note that

these calculations 1) are based on the proportional hazards regression analysis and 2) assume exponential times to event or attempt, neither of which applies to this data set. We are currently working on a power calculator for the log-rank test based on resampling.

We concur with Dr. Smith that even a 20% effect size would be of great clinical utility. This would be especially true in the context of a randomized controlled trial, in which one can obviate problems such as confounding by indication (doctors shying away from giving lithium to those patients at risk for overdose), sample bias (many lithium clinic data come from samples with a mean age over 40, possibly excluding the high-risk patients who may have already died from suicide), and key clinical variables (routine monitoring of blood levels maximizes both patient adherence to treatment and the likelihood of therapeutic levels of medication). It is our opinion that subdividing the hazard curves into smaller intervals would be a stretch of the data, especially given that the curves cross each other more than once, casting doubt that observed variations in the position of the curves with regard to each other are caused by the pharmacologic properties of the drugs.

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## Corrections

Table 4 in the article "Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience With the Mental Health Parity and Addiction Equity Act?" by K. John McConnell, Ph.D., et al. (published online September 2, 2011) contained an error in the last row, "Pooled plans A, B, C, D (N=100,328)." With respect to the 95% confidence interval in the difference-in-difference probability of using mental health and substance abuse services, the 95% CI should have read -0.79 to -0.11.

This error was corrected for the article's print appearance in the January 2012 issue and for its online posting as part of that issue.

At the time the article "Risk of Death From Accidental Overdose Associated With Psychiatric and Substance Use Disorders," by Amy S.B. Bohnert et al., was published online on September 28, 2011, Tables 1 and 2 contained several errors in hazard ratios and confidence intervals, some of which were repeated in the abstract and in the Results section. The errors in Table 1 were in the percentage of all patients in the 60–69 age group (the correct number is 19.8) and in the confidence interval for the 70–79 age group (the correct range is 0.16–0.28). The errors in Table 2 are highlighted below.

These errors were corrected for the article's print appearance in the January 2012 issue and for its online posting as part of that issue. None of the errors affected the study findings.

**TABLE 2. Adjusted Models of the Association of Psychiatric Diagnoses With Any Accidental Overdose Death, Medication-Related Accidental Overdose Death, and Alcohol/Illegal Drug-Related Accidental Overdose Death Among Veterans Health Administration Patients<sup>a</sup>**

Diagnosis	Any Accidental Overdose Death		Medication-Related Accidental Overdose Death		Alcohol/Illegal Drug-Related Accidental Overdose Death	
	Hazard Ratio	95% CI	Hazard Ratio	95% CI	Hazard Ratio	95% CI
Any substance use disorder	4.84**	4.41–5.30	4.19**	3.81–4.61	5.92**	5.03–6.97
Alcohol use disorders	3.73**	3.42–4.07	3.34**	3.01–3.71	4.05**	3.46–4.74
Drug use disorders	5.57**	5.04–6.15	4.67**	4.21–5.19	7.36**	6.08–8.91
Cannabis use disorders	2.86**	2.55–3.19	2.39**	2.08–2.74	3.63**	2.85–4.65
Stimulant use disorders	3.95**	3.57–4.37	2.72**	2.37–3.13	7.03**	5.79–8.55
Opioid use disorders	8.78**	7.73–9.96	7.37**	6.24–8.70	9.29**	7.34–11.76
Other drug use disorders	5.16**	4.69–5.67	4.56**	4.14–5.03	5.84**	4.93–6.91