Suicide Rates in the Army Up for All Ages, Sexes

BY DAMIAN MCNAMARA

ORLANDO — Psychiatrists and primary care physicians outside the military health care system have a pivotal role to play in helping to lower suicide rates, which have been on the rise across all components of the United States Army, according to a new study.

Within the U.S. Army, suicide rates are up among all age groups and in both genders, Dr. Ritchie explained at the annual meeting of the American Association of Suicidology. Stepped-up efforts are needed to identify soldiers, reservists, and veterans who are at elevated risk.

There were about 166 suicides in the army in 2009, a rate of approximately 21 suicides per 100,000 people, or more than twice the rate in 2001. “We have had difficulties with access to care, we have stigma, ... and our services are only partially integrated,” said Dr. Ritchie, medical director of the Army Medical Department’s Office of Strategic Communications.

A lack of providers who accept the military health plan, TRICARE, is a barrier to those seeking care, Dr. Ritchie said, “The best way you as a provider can help is to sign up for TRICARE.” Physicians who register for the program (www.tricare.mil) become a source for referrals and treatment outside of the military health care system.

Although most active and veteran military personnel receive health care services through institutions such as Walter Reed Army Medical Center and the Veterans Affairs system, there are exceptions. For example, some soldiers are students, have private insurance, or are members of the Reserves. “One of our struggles is how to provide support when they leave active duty and go back into the Reserves.”

Suicide Risk Doesn’t Vary Across Antidepressant Drugs

BY MARY ANN MOON

The risks of attempted suicide, completed suicide, and violent suicide showed “no clinically meaningful variation” by the type of antidepressant used in a large cohort study.

“Our finding of equal event rates across antidepressant agents supports the U.S. Food and Drug Administration’s decision to treat all antidepressants alike in their advisory labeling,” the investigators said.

They studied all adult residents of British Columbia who initiated the use of an antidepressant medication between 1997 and 2006. They excluded patients who used bupropion because it is sometimes used for smoking cessation rather than depressive symptoms, escitalopram because it was not marketed until near the end of the study period, and duloxetine because it was not marketed in Canada during the study period.

The medications were classified as selective serotonin reuptake inhibitors (SSRIs) (citalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline); serotonin norepinephrine reuptake inhibitors (venlafaxine); tricycles (amitrptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nortriptyline, protriptyline, and trimipramine); newer and atypical agents (mirtazapine, nefazodone, and trazodone); and monoamine oxidase inhibitors ( moclobemide, phenelzine, and tranylcypromine).

A total of 287,543 adults were assessed for 1 year. About 5% had been hospitalized previously for a psychiatric condition, and 0.6% had made a previous suicide attempt.

During the first year, 846 adults attempted suicide (751 adults) and/or completed suicide (104 adults), yielding an event rate of 6.06 attempted and completed suicides per 1,000 person-years, they wrote.

There were no significant differences in suicide rates among antidepressant classes or among individual antidepressants. This finding held true when the data were truncated to cases of suicide attempt only and suicide completion only, and violent suicide only.

Although some researchers have posited that some antidepressants might raise suicide risks only in the first few months after they are initiated, Dr. Schneeweiss and his associates found similar results—no differences among the various antidepressants—even when the data were truncated to only 6 months of follow-up.

In initial analyses, a higher rate of suicidal events in venlafaxine users was found compared with SSRIs users, but this effect was attenuated when further, more refined analyses were performed. This suggests that there was a confounding effect with venlafaxine, perhaps related to the tendency of clinicians to prescribe venlafaxine for more severe depression.

The findings reinforce that “treatment decisions should be based on efficacy, and clinicians should be vigilant in monitoring after initiating therapy with any antidepressant agent,” they said.

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