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## COMMENT & RESPONSE

### Cost Sharing Does Not Lead to an Overall Increase of Involuntary Commitments in the Netherlands

**To the Editor** In 2012, the Dutch government increased the out-of-pocket price for mental health care, aiming to achieve cost savings but possibly overlooking negative downstream consequences. Ravesteijn and colleagues<sup>1</sup> showed that immediately after the introduction of the new cost-sharing policy, regular service use decreased by 13.4%. In contrast, acute mental health care use increased by 25.1% and involuntary commitment increased by 96.8%. The authors concluded that the higher out-of-pocket price generated aggregate savings but increased costs for acute care and involuntary commitment.

However, these numbers do not match other information sources or everyday clinical practice, to our knowledge. Ravesteijn and colleagues<sup>1</sup> reported an absolute doubling of all court-ordered and emergency involuntary commitments,

from 1092 in 2011 to 2156 in 2012. However, according to data from the Council for the Judiciary, the increase from 2011 to 2012 was only 3%, whereas the total number of involuntary outpatient treatment and admissions counted more than 20 000.<sup>2</sup> What can Ravesteijn and colleagues<sup>1</sup> conclude about increased costs based on data that compose less than 10% of all involuntary commitments? Moreover, generally, court-ordered treatment and involuntary commitment in the Netherlands is not the start of a new care trajectory after a period without mental health care contacts. These commitments are an *ultimum remedium* issued mostly only after previous treatment efforts have failed.<sup>3</sup>

Ravesteijn and colleagues<sup>1</sup> highlighted that service use changed right after cost sharing had been increased. However, many patients with serious psychiatric illnesses in long-term treatment trajectories were not immediately affected by the reform. Out-of-pocket costs were not billed in 2012; in some cases, billing was delayed until 2014. On top of that, several city councils compensated out-of-pocket treatment costs through social benefits. More importantly, higher cost sharing did not involve assertive outreach teams, emergency psychiatry, or involuntary commitments. Because billing of out-of-pocket expenses was delayed and health care programs for the most vulnerable populations were spared, the abrupt increase of acute mental health care records and involuntary admissions seems counterintuitive.

The study by Ravesteijn and colleagues<sup>1</sup> is one of the first to evaluate health care reform in the Netherlands using the national database of treatment records and health care costs. The results beg to ask whether this kind of data reliably reflects changes in mental health care use. It would be interesting to investigate what happened after the national government already abolished the mental health copayments in 2013.

André I. Wierdsma, PhD  
Cornelis L. Mulder, MD, PhD

**Author Affiliations:** Department of Psychiatry, Erasmus Medical Centre, University Medical Centre Rotterdam, the Netherlands.

**Corresponding Author:** André I. Wierdsma, PhD, Department of Psychiatry, Erasmus Medical Centre, University Medical Centre Rotterdam, Dp-0452, 's-Gravendijkwal 230, 3015 CE Rotterdam, the Netherlands (a.wierdsma@erasmusmc.nl).

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**In Reply** We thank Wierdsma and Mulder for their comments on our article,<sup>1</sup> which investigated the effects of a 2012 increase in cost sharing for specialist mental health care in the Netherlands. Our article shows that after the increase in cost sharing, there was a sharp decline in treatment records opened

for regular care and a sharp increase in records opened for acute care and for involuntary commitment (rising from 1092 records in 2011 to 2156 in 2012).<sup>1</sup>

Wierdsma and Mulder point out that in the Netherlands, the total number of involuntary commitments is much higher (more than 20 000 annually) and that there was a 3% rise in these total numbers between 2011 and 2012. However, their figures refer to requested commitments rather than the number of commitment requests that were granted and executed.<sup>2</sup> Moreover, Wierdsma and Mulder include commitments in disability or nursing homes, those that occur during treatment records that have already been open for at least 1 month<sup>3</sup> and those that occur during inpatient mental health treatment beyond a year. In our data, we tested whether, after the cost sharing increase, some individuals avoided mental health care but eventually experienced involuntary commitments. That is why we exclusively investigated the number of specialist mental health care treatment records that were opened for involuntary commitment. We would not have been able to study this effect if involuntary commitment within ongoing treatment records had been included.

Wierdsma and Mulder also argue that the increase in involuntary commitment after the reform seems counterintuitive. However, our findings are consistent with 2 mechanisms through which we expected involuntary commitment to increase. First, a commitment procedure could be initiated immediately after it had become clear that an individual would either not voluntarily seek treatment or discontinue treatment beyond the maximum duration of a treatment record, while treatment was deemed critical for that individual's well-being. Second, once individuals forwent treatment after the reform, their mental health could deteriorate to the point that a commitment procedure was eventually initiated. In our article,<sup>1</sup> we showed a decrease in treatment of patients with psychosis (-10.6%) and bipolar disorder (-6.5%) and a 16.3% decrease among the lowest income decile. Therefore, it appears that the most vulnerable populations were certainly affected by the reform.

We agree that there are important limitations inherent in our methods, which we enumerate in the Discussion section of our article.<sup>1</sup> Still, we are convinced that the Dutch reform offers an excellent opportunity to study the effects of patient cost sharing for mental health care and that the registries we accessed for the study are among the best available. Moreover, additional analyses on the full treatment record data set that was recently made available to us confirm our published findings (unpublished data, 2017).

In conclusion, although we appreciate Wierdsma and Mulder's comments, the conclusions presented in our article are sound and suggest that reducing coverage for mental health care may have negative unintended consequences for patients with severe mental disorders, such as schizophrenia and bipolar disorder.

Bastian Ravesteijn, PhD  
Aartjan Beekman, PhD  
Richard Janssen, PhD

**Author Affiliations:** Laboratoire Interdisciplinaire de Recherche Appliquée en Economie de la Santé Department of Health Economics, Paris Descartes University, Paris, France (Ravesteijn); Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts (Ravesteijn); Department of Psychiatry, Vrije University, Amsterdam, the Netherlands (Beekman); Tranzo, Tilburg University, Tilburg, the Netherlands (Janssen).

**Corresponding Author:** Bastian Ravesteijn, PhD, Department of Health Care Policy, Harvard Medical School, 180 Longwood Ave, Boston, MA 02115 (ravesteijn@hcp.med.harvard.edu).

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## Tramadol Extended Release and Opioid Withdrawal Management—Legal Implications

**To the Editor** The study investigating the efficacy of tramadol extended release for opioid withdrawal by Dunn et al<sup>1</sup> offers a promising approach to the management of acute opioid withdrawal. Substance abuse treatment programs in the United States that provide management of acute opioid withdrawal in inpatient and residential settings currently use methadone (if registered as a narcotic treatment program), buprenorphine, or nonopioid medication (such as clonidine), and the results of the study by Dunn et al<sup>1</sup> suggest that tramadol extended release may be an additional tool in the addiction psychiatrist's armamentarium for treating patients in acute opioid withdrawal. However, based on my understanding of the US federal drug laws, the use of tramadol extended release may only be permissible if the treatment program is registered with the US Drug Enforcement Administration as a narcotic treatment program. For inpatient and residential substance abuse treatment programs not registered with the US Drug Enforcement Administration as a narcotic treatment program, federal law<sup>2</sup> stipulates that only Schedule III, IV, or V narcotic medications approved by the US Food and Drug Administration specifically for use in opioid maintenance or detoxification treatment can be dispensed or prescribed. Because tramadol extended release is a Schedule IV narcotic medication and is not currently approved by the US Food and Drug Administration for treatment of opioid dependence, its use in opioid withdrawal management appears to be forbidden by this law unless the treatment program is registered by the US Drug Enforcement Administration as a narcotic treatment program. At the present time, there is only 1 opioid medication available that meets the criteria for use in a program that is not registered as a narcotic treatment program: buprenorphine.<sup>2</sup> Many addiction treatment centers in the United States providing opioid withdrawal management (ie, "detoxification") services are not registered with the US Drug Enforcement Administration as a narcotic treatment program, and it is important that health care professionals are aware of the federal regulations governing the use of opioid medications in treating patients with substance use disorders.