

Critical revision of the manuscript for important intellectual content: Cheng, Breslau, Anthony.

Statistical analysis: All authors.

Obtained funding: Anthony, Breslau.

Administrative, technical, or material support: Anthony.

Supervision: Cheng, Breslau, Anthony.

Conflict of Interest Disclosures: None reported.

Funding/Support: This work was supported by the National Institute of Drug Abuse (grant T32DA021129 to Dr Cheng and grant KO5DA015799 to Dr Anthony), the National Institute on Minority Health and Health Disparities (grant RO1MD010274 for Dr Breslau), and Michigan State University (Drs Cheng and Anthony and Mr Kaakarli).

Role of the Funder/Sponsor: The funding organizations had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The content is the sole responsibility of the authors and does not necessarily represent the official views of Michigan State University, RAND Corporation, the US National Institute on Drug Abuse, or the US National Institutes of Health.

Additional Contributions: Public use files are made available by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and Center for Behavioral Health Statistics and Quality via this website: <https://www.icpsr.umich.edu/icpsrweb/ICPSR/series/64>. These institutions did not provide funding to this study, and no compensation was received from a funding sponsor for such contributions.

1. Grant BF, Chou SP, Saha TD, et al. Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV alcohol use disorder in the United States, 2001-2002 to 2012-2013: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry*. 2017;74(9):911-923. doi:10.1001/jamapsychiatry.2017.2161
2. United States Substance Abuse and Mental Health Services Administration. *Comparing and Evaluating Youth Substance Use Estimates From the National Survey On Drug Use And Health and Other Surveys, HHS Publication No. SMA 12-4727, Methodology Series M-9*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2012.
3. Lau J, Antman EM, Jimenez-Silva J, Kupelnick B, Mosteller F, Chalmers TC. Cumulative meta-analysis of therapeutic trials for myocardial infarction. *N Engl J Med*. 1992;327(4):248-254. doi:10.1056/NEJM199207233270406
4. Committee on Preventive Psychiatry. Problems of estimating changes in frequency of mental disorders. In: Committee on Preventive Psychiatry. *Group for the Advancement of Psychiatry: Reports and Symposiums*. New York, NY: Group for the Advancement of Psychiatry Publications Office; 1961: 469-521.
5. Han BH, Moore AA, Sherman S, Keyes KM, Palamar JJ. Demographic trends of binge alcohol use and alcohol use disorders among older adults in the United States, 2005-2014. *Drug Alcohol Depend*. 2017;170:198-207.

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 colleagues¹ 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 colleagues¹ 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 20 000.² What can Ravesteijn and colleagues¹ 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.³

Ravesteijn and colleagues¹ 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 colleagues¹ 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).

Published Online: December 13, 2017. doi:10.1001/jamapsychiatry.2017.3832

Conflict of Interest Disclosures: None reported.

1. Ravesteijn B, Schachar EB, Beekman ATF, Janssen RTJM, Jeurissen PPT. Association of cost sharing with mental health care use, involuntary commitment, and acute care. *JAMA Psychiatry*. 2017;74(9):1-9.
2. Broer J, Koetsier H, Mulder CL. The number of compulsory admissions continues to rise: implications for the new Dutch law on obligatory mental health care [in Dutch]. *Tijdschr Psychiatr*. 2015;57(4):240-247.
3. Wierdsma AI, Driessen GA, Smeets HM, Visser E. Regional differences in the care and treatment of compulsory admissions in the Netherlands [in Dutch]. *Tijdschr Psychiatr*. 2012;54(9):777-783.

In Reply We thank Wierdsma and Mulder for their comments on our article,¹ 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).¹

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.² 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 month³ 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,¹ 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.¹ 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).

Published Online: December 13, 2017. doi:10.1001/jamapsychiatry.2017.3274

Conflict of Interest Disclosures: None reported.

1. Ravesteijn B, Schachar EB, Beekman ATF, Janssen RTJM, Jeurissen PPT. Association of cost sharing with mental health care use, involuntary commitment, and acute care. *JAMA Psychiatry*. 2017;74(9):1-9.
2. Broer J, Koetsier H, Mulder CL. The number of compulsory admissions continues to rise: implications for the new Dutch law on obligatory mental health care [in Dutch]. *Tijdschr Psychiatr*. 2015;57(4):240-247.
3. DBC Onderhoud. Spelregels DBC-registratie ggz RG12, versie 20111201. https://www.nza.nl/1048076/1048155/Spelregels_GGZ_2012_v20111201.pdf. Published January 1, 2012. Accessed November 6, 2017.

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 al¹ 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 al¹ 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 law² 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.² 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.