

available for our analysis. The article by Stroup and colleagues was published the month our paper was accepted and thus was not available for inclusion our analysis (1). The analysis presented by Gupta and Rosenheck is based on unpublished data, and therefore they were unavailable for inclusion in our model. We would certainly amend the model to include these data in future publications should they become available.

Second, Mr. Gupta and Dr. Rosenheck report somewhat contradictory results in describing their unpublished data. The authors initially state that only 3% of patients with schizophrenia were hospitalized for more than 30 days, then later state the annual psychiatric inpatient days was 31 days. These numbers seem incompatible or suggest a highly skewed distribution, which would affect the results of a cost-benefit analysis. Regardless, as one of our sensitivity analyses, we examined the impact of assuming that hospitalizations were seven days; this model also resulted in significant cost savings (2). This result suggests that our findings are robust to a range of assumptions about the average length of stay.

Third, several of the studies mentioned may not be valid comparisons to the ones on which we based our study. The primary outcome for the Stroup study was a decrease in the number of hospital admissions rather than number of annual inpatient days, making direct application of their results to our study problematic (2). The randomized controlled trial that Mr. Gupta and Dr. Rosenheck mention did not explicitly report utilization, but rather reported expenditures. However, for the patients discharged, Essock and colleagues reported a significant decrease in rehospitalizations (3). The Sernyak and colleagues study did not use the standard definition for treatment resistance (failed trials of at least two antipsychotic agents) to match controls and therefore may not reflect a true difference for treatment-resistant patients (4). This is an important difference, in that a previous study we conducted reported that almost 25% of Veterans Affairs (VA) patients receive non-evidence-based treatments prior to clozapine initiation. Thus, studies of patients who received clozapine in the VA most likely do not reflect the patient population who would derive the most benefit from clozapine (5). In addition, both the Stroup and Sernyak studies were based on administrative data, which lack some clinical information, such as response rate, upon which our model is predicated (1,4).

We agree that the model is not based entirely on randomized controlled data, and there may be some regression to the mean in pre-post studies. However, this does not completely negate the utility of the data, especially in the absence of randomized studies.

In short, our model is consistent with the vast majority of literature and represents a starting point for discussing the potential benefits of clozapine in a large health care system. Certainly, the model can be further updated to reflect new information as it becomes available.

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An Update on “Insurance Coverage and Treatment Use Under the Affordable Care Act Among Adults With Mental and Substance Use Disorders”

TO THE EDITOR: In our article posted online January 17, we analyzed changes in insurance coverage and treatment utilization for individuals with mental illness and substance use disorders, comparing 2011–2013 versus 2014 data from the National Survey of Drug Use and Health (NSDUH) (1). Key coverage provisions of the Affordable Care Act (ACA), especially Medicaid expansion and health insurance marketplaces, were implemented in 2014. However, the 2014 interviews may not fully capture changes occurring under the ACA, especially for measures with a 12-month recall period. Including more recent data, we have now compared the 2014–2015 period with 2011–2013, providing a longer time frame in which to evaluate evolving trends.

Previously, we found substantial decreases in the uninsured rate and increases in Medicaid enrollment in 2014 in the subgroups with mental illness and substance use disorders. Changes were largest among low-income individuals ($\leq 200\%$ of the federal poverty level). In our updated analysis, we find the uninsured rate further decreased and Medicaid enrollment increased for both groups. [These results are shown in the first table of the online supplement.] For example, including 2015, the uninsured rate decreased by 6.8 percentage points ($p < .01$) among individuals with mental illness, and Medicaid enrollment increased by 4.8 percentage points ($p < .01$)—larger than the previously reported changes of 5.4 percentage points and 3.6 percentage points, respectively.

We previously reported that mental health treatment utilization increased by 2.1 percentage points. Surprisingly, when including 2015 data, this difference is eliminated

(.9 percentage points, $p=.21$), indicating that gains in treatment utilization were not sustained in 2015. [See second table of the online supplement.] We previously reported no change in use of treatment for substance use disorders in 2014, and this remained the case in 2015, indicating no improvement in treatment utilization.

Our findings related to setting and payment for treatment remained largely unchanged when including 2015 data, with a few exceptions. Including 2015, we find that among low-income individuals receiving treatment for substance use disorders, use of residential rehabilitation decreased (9.6 percentage points, $p=.02$) and payment by Medicaid increased (8.4 percentage points, $p=.03$). For low-income individuals with mental illness who received treatment, we find reduced self-payment (4.1 percentage points, $p=.02$) and increased payment by private insurance (3.5 percentage points, $p=.04$).

We note three limitations. First, in 2015 the NSDUH changed its screening for use of inhalants, methamphetamine, prescription pain relievers, tranquilizers, stimulants, and sedatives but not for use of alcohol and marijuana (the two most commonly reported substances) (2). Although the estimated prevalence of substance use disorders was very similar in 2015 and 2014, changes in sample composition could reduce comparability of substance use disorder estimates. Second, the NSDUH does not measure medication-assisted treatment for substance use disorders. Third, the public-use NSDUH does not include state identifiers, so we could not isolate the effect of states that opted for Medicaid expansion.

Overall, we find continued progress in reducing the uninsured rate among individuals with mental illness and substance use disorders in 2015 and some signs of reduced financial burden among those who received treatment in the year. However, coverage gains have not translated into increased service utilization overall. Investigating barriers to care, such as limited supply of providers and coverage restrictions in insurance plans, is an important priority for research.

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Taking Issue With Crime, Vulnerability, and AOT

TO THE EDITOR: In the February Taking Issue column, Munetz and Aultman (1) disagree that a special category is needed for potential research participants who are committed to assisted outpatient treatment (AOT). They argue that ethically responsible researchers should know how to deal with this population. Researcher responsibility is a necessary condition, but it is not sufficient given the lack of policy clarity surrounding this population.

Ideally, all researchers would be ethically responsible and realize that individuals on AOT are in a unique position, and in conducting their research they would be mindful of these individuals' unique vulnerabilities. As we described in our Open Forum, even highly responsible researchers sought out guidance in how best to work with this population (2). Ethical intuition, individual virtue, and responsible conduct can take us only so far. Categorical distinctions are sometimes warranted to help frame guidelines and policies in the interests of particular populations.

Moreover, it is likely that not all researchers or institutional review boards are knowledgeable enough about AOT to understand the vulnerabilities that civil commitment may create. We agree that individuals who are on AOT should not be conflated with criminality or confused with the incarcerated population. We make this distinction in our article. And yet, in the research world, this conflation persists.

The 21st Century Cures Act includes new funding for expanding AOT. The number of individuals on AOT is likely to increase. It is therefore important to better understand the unique vulnerabilities of these individuals in the context of biomedical or social science research. Continuing to consolidate individuals on AOT with detainees in research settings is incorrect, and continuing to ignore their particularly vulnerable status by treating them as community members in research settings is also inappropriate.

A goal in writing the Open Forum was to begin a conversation about research ethics issues related to AOT. We are gratified that we are now having that conversation.

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