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## Social Inequalities and Antidepressant Use in Canada and France

**To the Editor:** In their interesting analysis of French universal health coverage in the May issue, which highlighted the role of social inequalities, Bocquier and colleagues (1) did not examine the impact that cost sharing may have on treatment adherence of individuals with low incomes. In the francophone province of Quebec, Canada, a public drug plan was set up in 1996 that included direct billing by pharmacists to the public plan in addition to a cost-sharing scheme. In 2001, a report based on analyses of health administrative databases showed that for elderly persons and welfare recipients, introduction of the universal drug plan was followed by reduction in use of essential drugs and a high rate of serious adverse events (hospitalization, nursing home admission, and mortality) (2). This led to a policy reversal and cost-sharing exemptions for low-income welfare recipients. Our own study of patients with depression in Quebec in 2006, which used the same administrative databases, showed that antidepressant use did not differ between individuals from low-socioeconomic neighborhoods and those from high-socioeconomic neighborhoods (3).

Bocquier and colleagues (1) showed how personal and provider characteristics might explain the low adherence to antidepressant therapy in their study. According to the authors, cost sharing or other economic disincentives are not used in France. Low-income individuals whose expenditures for drugs were reimbursed entirely by Couverture Maladie Universelle Complémentaire (Complementary Universal Health Insurance) (CMUC) had lower adherence. However, can the authors guarantee that everywhere in France individuals who are covered by CMUC never have to deal with refusals by some pharmacists to fill prescriptions as a result of reimbursement delays by CMUC (4)?

On the other hand, the absolute rate of antidepressant discontinuation reported by Bocquier and colleagues seems very high (71.6%), and the authors recognized that the criteria they used may have influenced the rate. For example, if two individuals had received three prescriptions of 28 days in the course of six months and the first individual took one dose out of two for six months and the second took all of it in three months, both would be considered early discontinuers. But should only the second one be considered to have discontinued early? Using criteria for continuation set by a Canadian research group, Sewitch and colleagues (3) found that the proportion of individuals among Quebec's elderly patients who were considered to discontinue early was similar to that found by Bocquier and colleagues. But practices may have improved since then.

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**In Reply:** We thank Dr. Lesage and his colleagues for their interesting and pertinent discussion. We think it useful to provide further details on the French National Health Insurance Fund (NHIF). The NHIF reimburses roughly 65% of overall individual prescription medications costs; the remaining 35% is patient copayments. Although many people have supplementary insurance to cover most of the copayment costs, this obviously creates an income-based obstacle to care (1). For this reason, the government introduced the CMUC in 2000, which exempts very low-income people from any copayments for a standard market basket of medical services.

Even with the introduction of the CMUC, we found that CMUC beneficiaries were at increased risk of antidepressant discontinuation. Lesage and colleagues state that in one of their studies in Quebec, they found, to the contrary, that cost-sharing exemptions for low-income individuals were not associated with social inequalities in antidepressant use (2). It was not entirely clear to us, however, whether the dependent variable in that study was

antidepressant treatment initiation or discontinuation or both. We note that we previously found that CMUC status was not associated with the overall probability of new antidepressant treatment but was associated with a lower probability of newly initiated long-term treatment (3). Moreover, Lesage and colleagues' measurement of socioeconomic status at an aggregated geographical level makes it difficult to draw conclusions at the individual level and thus to compare their results with ours.

To explain why the discontinuation rate was higher for CMUC beneficiaries than for others, Lesage and colleagues suggest that some pharmacists may have refused to dispense medication to these patients because of delays in reimbursement of pharmacists by the NHIF. Although this explanation cannot be excluded, pharmacist refusal was probably very rare because in 2008–2009 nearly 100% of pharmacists in France were paid directly by the NHIF regardless of the patient's CMUC status.

Lesage and colleagues thoughtfully note a French report mentioning that some physicians refuse to see CMUC patients (4). It is true that in France most patients pay physicians for the consultation directly and are reimbursed afterwards by the NHIF (and their supplementary insurance, if any), whereas physicians must await direct payment by the NHIF for their CMUC patients (5). This would not explain our results, however, because we adjusted our analyses for the number of visits each beneficiary had with private general practitioners and psychiatrists.

Finally, we acknowledge that the absence from the French NHIF databases of information on the actual duration of treatment and on the prescribed dose prevents an accurate calculation of discontinuation. As noted by Lesage and colleagues, misclassification may have occurred. However, we conducted sensitivity analyses using both less and more stringent definitions of discontinuation and found similar associations between CMUC status and the risk of discontinuation. Moreover, the percentage of individuals with only one reimbursement for an antidepressant (that is, one month or less of

treatment because prescriptions are dispensed in France for a maximum of 28 days) was also rather high (44.7%) and is in line with previous French studies.

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## Time to Invest in Engagement

**To the Editor:** There are wide-ranging ideas about how to address situations in which someone is clearly unwell but chooses not to seek support (1–3). Let's consider two of the loudest calls to action. Some argue that the problem is insufficient access to high-quality mental health services, calling for greater investment in voluntary, community-based, recovery-oriented services that defy financial, geographical, and cultural barriers. Others argue that the problem is that a small group of people with severe mental illnesses is often unwilling to seek treatment. They call for looser involuntary treatment criteria and greater investment in assisted outpatient treatment as critical strategies

to prevent terrible consequences of not treating this population (incarceration, homelessness, and large-scale tragedies).

I believe that the first group has not sufficiently acknowledged cases in which individuals have access to excellent services but still refuse care. For example, I recently talked with a mother who had learned about all available services in her community, including assertive community treatment, peer support, supported employment, and supportive housing, so that she could help her adult son understand and access these wide-ranging options. Despite her efforts and the availability of this service array, he would not consider seeking support. At this point, the second group might identify this woman's son—who lives with schizophrenia, experiences psychosis, and refuses care—as one of the “most seriously ill” who would benefit from involuntary treatment. However, this conclusion leaves a crucial stone unturned: engagement.

In this context, “engagement” refers to techniques used to help someone become amenable to seeking services. We have already developed many effective engagement tools, including motivational interviewing, psychoeducation, and peer outreach. But those who need these tools most—family members and providers—cannot consistently access them. The mother I spoke with may have unlocked the door to services, but she didn't know how to help her son walk through it.

What if all providers—not just psychotherapy practitioners but also primary care physicians, case managers, and others—had highly developed motivational interviewing skills? What if families could also develop a basic command of motivational interviewing? What if all people experiencing mental illness could easily access peer support? What if we extensively researched how best to reach people who are unwilling to seek support? With a better understanding of what truly works, we could develop new engagement strategies and improve existing tools.

To move in this direction, we must stop viewing people with mental illness as discrete categories: the “worried