

## COMMENTARY

### Addiction Treatment: Who Needs It?

**T**HE POLICY MAKER WANTS TO KNOW who needs addiction treatment and what proportion of this population should, and do, receive it. The basic principles of needs assessment for addiction treatment are simple enough. One can calculate the ratio of the number of people who access treatment divided by the number of people in the population who need treatment in a given jurisdiction (Drummond et al., 2005). However, as several articles in this issue point out, producing a meaningful and practically useful estimate of the treatment access ratio is far from simple. Having a diagnosis of substance use disorder in a general population survey does not necessarily equal “need” (Ritter et al., 2019). Walking through the entrance of an addiction service does not equal receiving or benefitting from appropriate care (Ritter et al., 2019; Rush et al., 2019). Measuring and monitoring these events in real time can be costly, time consuming, and reliant on the quality of the information available and will be more challenging in resource-poor settings. Further, extrapolating from typical treatment-seeking populations to smaller subgroups such as youth or indigenous populations may not be appropriate and will require additional effort as well as different methodologies (Tremblay et al., 2019).

Nevertheless, it is pleasing to see from these collected articles that the field of needs-based service planning has developed into a sophisticated science since the original seminal work by Brian Rush (1990). Segmenting the in-need population into different severity subgroups—and treatment into different levels of intensity of care—is a welcome development and provides a better understanding of which needs are being (or are likely to be) met by which services. A simplistic model of the ratio of access to prevalence could, in the worst case, mask an inadequate treatment system that simply provides a lot of people with suboptimal or ineffective interventions. But congratulations all around on what a great job we are doing on improving treatment access.

The treatment system is a key part of a country’s overall public health response to substance misuse. The more people that access effective substance misuse treatment, the more that will recover, thereby reducing demand for substances and the burden of disease on the wider health system and society. In addition, there will be overall improved health

and quality of life for the individuals receiving effective care. Indeed, it is possible to model the impact of increasing treatment access on overall public health (Shield et al., 2014).

In an era of global austerity and rising burden of substance misuse, combined with the development of value-based health care, it is important to focus limited resources on achieving the greatest impact. Is there greater value in targeting the large number of hazardous and harmful drinkers with relatively low-cost interventions with the aim of reducing more costly harms in the future? Or are the returns on investment likely to be greater by providing more intensive and expensive treatment to people with alcohol dependence who are complex “high-need, high-cost” consumers of wider health care? In an ideal world the answer would be to do all of the above. But limiting factors will be resources and the feasibility of implementation. Rolling out universal alcohol screening and brief interventions in primary care is challenging. Equally, providing intensive specialist interventions for people with complex needs requires sufficient specialist expertise and a well-developed treatment system. The articles in this issue remind us that there remain wide differences in treatment access ratios across the globe. And even in high-resource countries, there can be large differences in access between regions, localities, and demographic groups.

An interesting development, and one that needs-assessment research will need to assimilate, is in viewing specialist addiction treatment less as a separate system of care and more as part of the wider health and social care (and criminal justice) system. In this paradigm, a treatment journey does not begin at the door of the addiction treatment center but is part of a more comprehensive integrated care pathway, beginning with identification in primary, acute, or mental health care. The development of addiction care teams in acute hospitals (Royal College of Physicians, 2001) and assertive outreach for hard-to-reach populations with complex needs (Drummond et al., 2017) are two examples of taking addiction care to the patient, rather than waiting for them to access conventional addiction services or develop serious illness and die without accessing addiction treatment at all. A similar model is being applied to the goal of eradication

of hepatitis C (Williams et al., 2018). But this will require a paradigm shift in both addiction services and the wider health care system. Our challenge is to measure, evaluate, model, and advocate for such a transformation, which could bring greater benefits to society as a whole.

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COLIN DRUMMOND, M.D., FRCP, FRCPSYCH., FFPH<sup>a</sup>

<sup>a</sup>*Professor of Addiction Psychiatry,  
National Addiction Centre,  
Institute of Psychiatry, Psychology and Neuroscience,  
King's College London  
4 Windsor Walk,  
London SE5 8BB,  
United Kingdom*

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