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Commentary on Chalmers et al (2016) Estimating met demand for alcohol and other drug treatment in Australia: a thoughtful integration of routine data sources and primary research findings

Abstract

~~Taking a broad health system perspective, Chalmers et al have developed a useful blueprint for combining data sources to estimate the number of individuals receiving alcohol and other drug treatment.~~ The work of Chalmers et al highlights the importance of key datasets to health service system planning and is a powerful argument for the continued funding of such resources. To maximise the usefulness of ~~their~~ the Chalmers method as a first step in~~results for~~ modelling unmet demand, future work could also consider socio-demographic and clinical subgroups.

Jo's suggestion

Routinely collected data sources are essential for health service system planning, enabling estimations of both met and unmet demand. Future modelling of unmet demand could consider socio-demographic and clinical subgroups as well as regional level data

Commentary

Chalmers et al (1) address the challenge of estimating the number of unique individuals receiving alcohol and other drug treatment (AOD) in Australia in a single year. As in many countries, the Australian AOD treatment system is comprised of multiple inter-related sub-systems with varying mechanisms for recording "treatment encounters, episodes of care, and consultations". Further, an individual may interact with multiple subsystems on multiple occasions. The complexity of relationships between specialist treatment and other services within a treatment "system" is recognised in the conceptual model of Babor and colleagues.(2) However, even where well-developed treatment utilization monitoring protocols are in place, such as in Belgium, they do not necessarily include the full range of AOD specialist and non-specialist services.(3)

The authors build upon their previously published treatment provider map (4) to identify potential data sources, as well as additional primary research evidence to inform both the conversion of episodes to unique people within datasets and to avoid double counting of individuals across datasets. A methodological strength of the Chalmers et al paper is the clarity with which the relevant datasets and conversion factors are described, as well as the step by step process of estimation. While available data sources will differ between countries, the consideration given here to what evidence can be used to underpin assumptions about multiple treatment contacts within the one sub-system or use of several sub-systems will be instructive for similar estimation efforts elsewhere. For example, the estimated proportion of entrants to treatment who had also utilized hospital or other outpatient services was available from a study of patient pathways in Australian alcohol and drug treatment.(5, 6) Similar data are potentially available in other countries, either through studies involving in treatment populations such as for the TREAT-project,(7) or through general population surveys such as the US National Epidemiologic Survey on Alcohol and Related Conditions.(8)

Understanding the extent of met demand is important not only for accurately estimating current service provision, but is also a crucial input for estimating the extent of *unmet* treatment demand.(9, 10) The authors rightly argue estimation of met demand is a "fundamental piece of the planning puzzle" because when considered in conjunction with estimates of the prevalence of dependence on alcohol and other drugs, it provides insight into the size of the potentially in-need population who are not currently accessing any form of treatment. The authors indicate such work requires sophisticated modelling techniques beyond the scope of the study. Should the authors extend their work in that direction, there are a number of additional factors which such modelling of treatment utilisation in relation to underlying prevalence of dependence could usefully take into account. These include the nature (e.g. alcohol, opioids) and severity of dependence, complex needs (e.g. polysubstance use, mental health problems), and the age and gender of individuals needing and using treatment, all of which may influence the both the likelihood of treatment being sought and type of treatment required.(11-14) Consideration of lower-level geographies would also be useful, as there are likely to be regional differences in both substance dependence and available services in many countries.(9, 15, 16) Sub-national estimates of the distribution of met demand are therefore required to ascertain the scale geographic disparity in treatment access rates.

This paper highlights the value of routinely collected data sources in health service system monitoring and planning. While the development of a method for estimating met need was clearly a substantial stand-alone project, updating these for ongoing monitoring of the quantum of treatment provision an annual basis should be a relatively straightforward undertaking as new yearly data become available. However, as the recent disinvestment in the BEACH study (17, 18) makes abundantly clear, ongoing funding for key datasets cannot be assumed. There is therefore an onus upon end users (including researchers) to continue to engage with relevant funders to argue for the preservation of key datasets, drawing attention to how they can be used singly or in combination to inform health service system planning.

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