cutting exercises such as the closure of intensive treatment services in favour of less intensive services in the name of the latter's superior cost-effectiveness. It is this fear that underlies the deep suspicion of brief and minimal interventions shared by many specialist drug and alcohol practitioners in Australia.

We cannot escape economic scrutiny by refusing to cooperate with it, as Christine Godfrey observes. If we fail to engage in collaborative efforts to appraise the costs and benefits of our interventions then cruder, less well-informed and unsympathetic allocation decisions will be made for us by individuals from outside the field.

Neither the misuse of economic analyses nor the difficult allocation decisions can be avoided by a refusal to countenance economic analyses of addiction services. Economic values are not the only values that matter; if they were we would have compulsory euthanasia rather than palliative care for the terminally ill. But economic values such as efficiency must contribute to our decisions because resources are not infinite and the inefficient use of resources is wasteful, and hence morally wrong. Certain forms of resource allocation may also be inequitable, such as when very expensive inpatient services are provided for the well-to-do few with less severe problems at the expense of providing any form of care for the more needy majority.

We should not assume that economic analyses will necessarily disadvantage specialist addiction services. The preliminary evidence on the costs and benefits of treatment for alcohol (e.g. that from Holder and his colleagues) and illicit drug dependence (Gerstein & Harwood, 1990) suggests that even expensive forms of treatment, such as lengthy inpatient hospitalization for alcohol, and residential therapeutic communities for illicit drug dependence, pay for themselves within a relatively short time. The evidence is reasonably clear that all forms of treatment provide much better value to the community in the medium- to long-term than not offering any form of treatment at all.

Rather than eschewing economic analyses, our response should be an intelligent engagement with the thought patterns of economists, not simply in the interests of self defence but with the expectation that our practice may benefit. At least some "addictionologists" should acquire sufficient economic knowledge to make useful contributions to the collaborative research that is essential for informed and informative economic analyses of our intervention activities. As well-trained economists are aware, economic analyses are not value-free or content-neutral. Value judgements will be made in deciding which costs and which benefits to count, and addiction practitioners should be contributing to their resolution. Economists also depend upon the specialist knowledge of those in the addiction field to ground their economic analyses. Only by collaborative studies of our interventions which involve practitioners, researchers and economists can we improve our efforts to change addictive behaviours for the better.

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The specter of accountability

Frederick B. Glaser

There is an odd but unmistakable strain of belief running through the helping professions that they are not appropriately held accountable for their work. With reference to social case-work and psychotherapy, one may read that "The certainty of value is not rooted in empirically verified results; it is rather the assurance derived from an unanalysable moral imperative" (Halmos, 1966, p. 150[1]). A fundamental aversion to accountability (as well as to the repudiation of dogma) may also be seen in the excessive negative reaction to pseudo-patient studies, both in the area of mental health[2] and alcohol problems.[3] One can also hear it argued that the work of helping professionals is not amenable to economic influence, though there is ample evidence to the contrary (cf. Rodwin, 1989[4]). Recently a colleague defined the term "professional" as someone who is paid for what they do, irrespective of the results produced. Another colleague

indicated on public radio that, no matter how costly, any intervention that produced even a small increment in health should be utilized regularly.

This belief may be derivative of an even more fundamental notion that health is the highest of all values. In the fifth century BC Hippocrates, the urphysician, wrote that "A wise man should consider that health is the greatest of human blessings". Somewhat later (*c.* 180 BC) the Apocrypha asserted that "healing comes from the Most High" and that those involved in it "will receive a gift from the king" (Sirach, 38:2). More modern sources have not failed to perceive that at least some healers were becoming comfortable with these regal and even divine attributes; George Bernard Shaw claimed that "the dogmas of omniscience, omnipotence, and infallibility, and something very like the theory of the apostolic succession and kingship by annointment, have recovered in medicine the grip that they have lost in theology and politics" (Boxill, 1969, p. 7[5]).

However, health, though doubtless important, is hardly the highest value. Our heroes, indeed, include those who repudiate it by risking or suffering death in the service of other values that take precedence, such as justice or freedom. That physicians and other helping professionals should under some circumstances actively assist in the dying of a good death is an increasingly accepted idea and runs counter to the primacy of health as a value. Cherished beliefs to the contrary notwithstanding, there can be no legitimate exemption of helping professionals from the requirement of accountability on the grounds of the extreme importance of health—or, indeed, on any grounds whatever.

Becoming accountable is a perplexing and even frightening prospect. To provide the variety of accountability called for in Godfrey's editorial, value for money, two kinds of information are needed: outcome information and cost information. Neither kind is at present regularly available from programs that provide alcohol and drug treatment. Placing the burden of responsibility for furnishing such information upon the treatment provider will probably prove futile and, in the instance of outcome determination, objectivity requires a judgement that is independent of the provider. Research is often then invoked, but a specific research project for every program is a manifest impossibility. How, then, is the necessary cost benefit information to be developed?

One possible answer is to imbed individual treatment programs within true treatment systems, and to assign the responsibility for cost benefit determinations to the system as a whole, rather than to individual programs. A model for this kind of system has been proposed in considerable detail[6,7] and is now being further developed and tested through the Target Cities grant program in 19 major cities in the United States. Under the terms of the grant, each city must develop a central intake function, independent of treatment programs, for all individuals entering treatment. This provides a baseline pre-treatment assessment. Reassessment after treatment can be used to establish outcome. Each system must also have a computerized management information system, which can readily include cost data. Membership in such a system could produce thereby the requisite cost benefit information without imposing an additional burden on program personnel, who can accordingly spend their time treating people with problems.

As if this were not sufficient inducement, such a system is likely to improve the cost benefit results for its member programs. Based on the conclusion that no single program can treat all persons with alcohol or drug problems effectively, the system attempts to match clients to those programs that are more likely to produce positive results. In other words, good results also become the responsibility of the system as a whole.

Predictably, there is considerable reluctance to participate in systems of this kind—or of any kind.[8] But they at least offer an efficient means of meeting accountability demands. These are certain to increase over time; consider the probable impact of health care reform in the United States. At the signing of the Declaration of Independence, Benjamin Franklin remarked of the system of inter-related state governments that evolved into our nation: "We must all hang together, or assuredly we shall all hang separately". It is an observation that is becoming no less true of treatment programs than of states.

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Intelligent engagement between economists and addiction specialists—a way forward?

Christine Godfrey

There are many useful pointers in the commentaries as to the way forward in investigating the cost-effectiveness of a range of alcohol and drug interventions. In particular, Frederick Glaser discusses the feasibility of undertaking routine monitoring of services. Evaluations and information gathering are themselves costly. Data on both costs and benefits will only become more readily available if their use can be shown to improve services and their outcomes. Evaluations or monitoring systems must be in themselves cost-effective.

Measuring resource use could provide a useful auditing tool for treatment services. There are many general costing systems being developed that can provide data without overwhelming practitioners. These data can help in devising case review criteria and in realistic planning of the resource needs for the future development of services. As Harold Holder suggests, however, it may be more difficult to devise realistic unit costs for some types of prevention programmes. It is important to evaluate all types of alternative policies as not all prevention initiatives may prove as cost-effective as some "cures". For addiction services, as Wayne Hall suggests, a wide range of services, including intensive therapies for some groups, could well prove to be cost beneficial for society as a whole.

While there is some agreement on the need for economic evaluation, as Wayne Hall points out, no one should fear that this is the only criterion which should be applied when policy decisions are made, nor can the economic evaluations be left entirely to economists. The techniques can result in powerful results but the process does require numerous assumptions and value judgements. Well-conducted studies should aid the debates about what should be included in the evaluation process and how different items should be valued and compared. These debates should be informed by those with specialist knowledge. To conclude, as Wayne Hall suggests, intelligent engagement between economists, other researchers and practitioners is required if the use of economic evaluation techniques is to fully benefit those in need of effective interventions.

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