Alcohol and other drug specialist treatment services and their managers: findings from a national survey

Abstract

Objective: To examine the characteristics of alcohol and other drug (AOD) specialist treatment agencies, their workforce and workforce development issues.

Methods: A national survey of AOD specialist treatment agency managers was conducted using the Clients of Treatment Service Agencies (COTSA) database as the sampling framework. Agency managers across Australia were surveyed by phone or electronically between April and October 2002. Qualitative and quantitative data were collected. Two hundred and thirty-four managers participated, representing 318 agencies, and a response rate of 65%. More than 50% of managers from each State and Territory participated in the study.

Results: The study found a high prevalence of alcohol-related problems. Managers estimated 45% of clients nominated alcohol as their primary problematic drug and that 53% of poly-drug clients identified alcohol-related problems. Managers reported increasingly complex client needs such as co-occurring substance and mental health issues. A harm minimisation treatment approach was supported by more than three-quarters of AOD agencies.
The majority of the AOD workforce were trained professionals and consisted of nurses (26%), general AOD workers (19%) and psychologists (9%). Approximately half the sample had been in their current managerial role for less than five years. Key workforce development issues identified were education and training, funding, and staff recruitment and retention.

Conclusion: More information is required on the key characteristics of the AOD workforce and their workforce development needs. Such information can contribute to policies and strategies that develop the capacity of the AOD sector to manage and treat the increasingly complex needs of clients.

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Ann Roche, Margaret O'Neill and Katrina Wolinski

National Centre for Education and Training on Addiction, Flinders University, South Australia

Alcohol and other drug use are major public health issues. The estimated social cost of alcohol abuse in 1998/99 is $7.6 billion, and for illicit drugs $6.1 billion.[1] These figures represent tangible social costs such as health care, workforce/household labour, road accidents and crime as well as intangible costs such as loss of life, pain and suffering.

Traditionally, problematic alcohol and other drug (AOD) use has been dealt with by specialist treatment agencies. Inquiry into the nature of these agencies has been minimal with only three studies to date: the Clients of Treatment Service Agencies (COTSA) census,[2-5] the National Minimum Data Set 2000-2001,[6] and a small study of 43 agencies.[7] The first two studies focus on client characteristics, the third on workforce issues. These studies are unable to provide current data on workforce development issues affecting the capacity of agencies to effectively engage with AOD clients.

The changing patterns of alcohol use[8,9] and client characteristics[3] raise questions about the capacity of Australian AOD specialist treatment agencies to meet clients' diverse needs. Very little is known about the nature of the AOD field, its workforce and its workforce development challenges.

Given this lack of information, the National Centre for Education and Training on Addiction (NCETA) initiated a national survey of managers of AOD specialist treatment agencies. The purpose of the study was to obtain information on the capacity of agencies to identify and manage problematic alcohol and polydrug use. The study aimed to identify the characteristics of specialist treatment agencies, determine the nature and size of the specialist AOD workforce and describe workforce development issues.

Method

Sampling frame

The COTSA database was used as the sampling frame. It is a listing of 549 AOD Federal, State and Territory government, non-government and private treatment agencies. COTSA defines an AOD treatment service as one which:

> *". . . provide(s) one or more face to face specialist treatment services to people with an alcohol and/or other drug problem, including among others a variety of outpatient treatment services, inpatient rehabilitation programs, detoxification, therapeutic communities, methadone maintenance plus an additional service, and smoking cessation programs".*[3]

Survey instrument

A structured survey instrument was developed for telephone and electronic interviews with managers of specialist AOD treatment agencies. The interview schedule contained 59 quantitative and qualitative items[10] and collected data on the agency, workforce, workforce development issues and manager's demographics.

Data collection

The survey was administered between April and October 2002. Recruitment letters and telephone calls were made to all agencies listed on the COTSA database.

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Correspondence to:
Professor Ann Roche, National Centre for Education and Training on Addiction, Level 3B, Mark Oliphant Building, Science Park, Bedford Park, South Australia 5042. Fax: (08) 8201 7550; e-mail: ann.roche@flinders.edu.au

Table 1: Respondents (234) and participating agencies (318) by State/Territory.

State	Treatment agencies on 2001 COTSA database n (%)	Min 50% target	Completed surveys plus additional agencies represented[a]	Total agencies represented n	State %	Sample %
SA	40 (7%)	20	19 (+12)	31	78	6
TAS	17 (3%)	9	9 (+2)	11	65	2
VIC	82 (15%)	41	35 (+13)	48	59	10
ACT	11 (2%)	6	7 (+2)	9	82	2
NSW	247 (46%)	124	88 (+52)	140	57	29
QLD	89 (16%)	45	44 (+1)	45	51	9
NT	23 (4%)	12	12 (+0)	12	52	2
WA	40 (7%)	20	20 (+2)	22	55	5
Total	**549 (100%)**	**277**	**234 (+84)**	**318**	**–**	**65[b]**

Notes:
(a) 27 managers were responsible for more than one agency and responded on behalf of several agencies.
(b) The response rate has been adjusted for 63 agencies that were closed, non-contactable or inappropriate. The denominator for this calculation is 486.

Response rate

Two hundred and thirty-four managers of AOD specialist treatment agencies completed the survey. Twenty-seven managers responded on behalf of multiple agencies, accounting for 84 additional agencies (total=318).

Of the 234 respondents, 42 completed electronic surveys and 192 telephone interviews.

Forty-two per cent (n=231) of the original COTSA sample did not participate. Sixty-three agencies had closed, were uncontactable or not relevant to the study. These were removed from the sample, leaving an adjusted denominator of 486 (549-63=486) agencies. The remaining 168 non-participating agencies were classified as valid non-respondents and represented a 35% non-response rate (168/486=35%) and a final response rate of 65% (n=318) agencies.

A minimum response target of 50% of agencies from each State was achieved. Table 1 shows the State distribution of agencies.

Data analysis

Qualitative data were manually coded into themes. Quantitative data were analysed using the Statistical Package for Social Sciences (SPSS). Except where specified, the number of managers interviewed is used as the denominator, not number of agencies represented.

Results

Results are reported in four sections: presentation of AOD problems, characteristics of AOD agencies, the AOD workforce and workforce development issues.

Presentation of AOD problems

Prevalence of alcohol and other drug-related problems

Managers estimated that 45% of clients report alcohol to be their primary problematic drug and that 53% of polydrug using clients also report alcohol-related problems. Figure 1 provides a breakdown by State and Territory of managers' estimates.

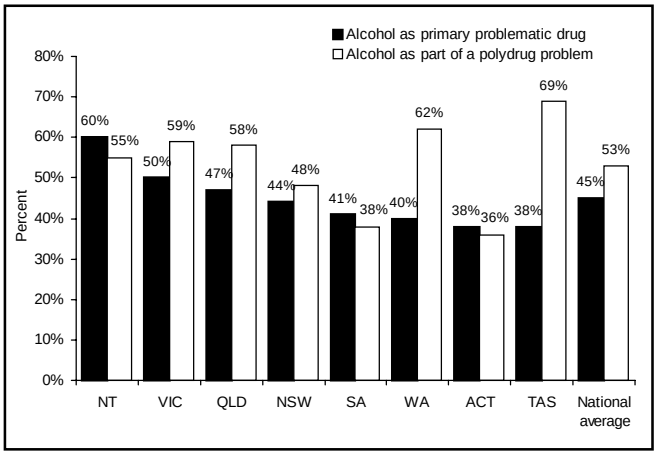
Trends in alcohol-related presentations

Increases in alcohol-related presentations over the next three to five years were anticipated by 40% (n=93) of managers. One-third believed they would remain stable (30%, n=70) and a few (6%, n=14) expected decreases. Approximately a quarter of managers (24%, n=57) were unsure about future trends. Increased alcohol use, as an adjunct to increasing amphetamine and polydrug use, was also identified.

Trends in polydrug-related presentations

Approximately two-thirds of respondents (63%, n=146) predicted increases in polydrug use over the next three to five years (see Figure 2). Few (15%, n=34) expected the level of polydrug use would remain static. The majority of managers identified the growing use of amphetamine-type stimulants as a major contributor to increases in polydrug-related presentations. Other factors included the accessibility and affordability of a range of drugs and the impact of the heroin drought (in 2000/01). Managers also

Figure 1: Managers' estimates of per cent of clients who report alcohol as their primary problematic drug and alcohol as part of their polydrug problem.



commented on increasing use of prescription opioids/ benzodiazepines and the complexity of polydrug use, including secondary problems (e.g. infections) and multiple disorders requiring specialist treatment (e.g. co-occurring substance and mental health issues).

Ability to effectively manage and respond to trends

Approximately half (51%, n=112) the sample indicated that they could effectively manage and respond to trends in alcohol presentations, and 46% (n=100) believed they could effectively manage and respond to polydrug trends. Some managers reported that their services were well resourced, offered a range of services and had a flexible service approach with agencies recognising and meeting community needs through strategic planning, networking and evaluation of their programs. Respondents maintained that having trained staff was a major factor in an agency's ability to manage and respond to these trends.

Twenty-four per cent of the sample reported they would not be able to manage and respond to alcohol (n=52) and polydrug trends (n=53), while 25% (n=55) of managers were unsure if their agency could manage alcohol trends and 30% (n=66) were unsure of their agency's capacity to manage and respond to future polydrug trends. Managers reported a range of reasons affecting their agencies' capacity to manage and respond to alcohol and polydrug trends, including: a lack of resources, closure of beds and programs, inability to retain staff, lack of qualified staff and unique challenges in rural areas. Managers who indicated they would have difficulty managing polydrug trends frequently cited co-occurring mental health issues as the reason.

Characteristics of AOD agencies

Type and location of organisations

Forty-two per cent (n=98) of managers were from government agencies, 50% (n=117) from non-government and 8% (n=19) from private agencies. Fifty-nine per cent (n=318) of agencies were located in metropolitan areas. Over 50% of government, non-government and private agencies were located in a metropolitan area. More than four out of five private agencies were located in metropolitan areas.

Services offered by AOD agencies

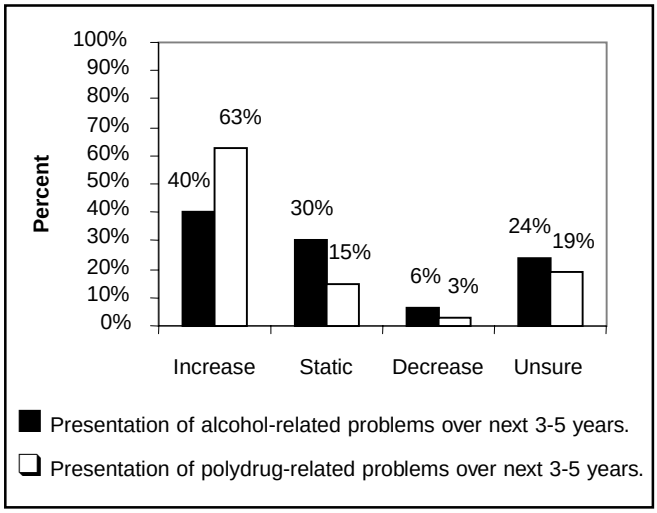
Services offered were broadly classified into inpatient, outpatient, rehabilitation withdrawal (including detoxification) and therapeutic communities (see Table 2). Half the sample, 51% (n=119), offered only one type of treatment service, 32% (n=75) offered two, 14% (n=33) offered three, 2% (n=5) offered four and 1% (n=2) offered five types of treatment services.

Managers also reported provision of a broad range of specific treatments and programs such as assessment, counselling, education, dual diagnosis and referral.

Treatment approach

More than three-quarters of the sample (77%, n=181) identified their agency's treatment approach as harm minimisation.

Figure 2: Managers' predictions of future presentations in alcohol and polydrug use (n=234 and 233 respectively).



Ninety per cent (n=88) of government, 71% (n=83) of non-government and 53% (n=10) of private agencies advocated harm minimisation as shown in Table 3.

Only 15% (n=35) of the sample reported an exclusively abstinence-based approach. These managers were predominantly located in non-government and private organisations.

Client groups served

Managers were asked whether their agency provided services for a specific client group. Over half the sample (52%, n=116) provided services for the general population. Table 4 lists the specific client groups reported.

The AOD workforce

Frontline workers

Managers, representing 318 agencies, reported that their services involved a total workforce of 6,668 as shown in Table 5. Seventy per cent of the workforce (n=4,690) were identified as therapeutic staff. Twenty-seven per cent (n=1,811) were non-therapeutic workers, e.g. ancillary and administration staff and managers without a caseload. Estimated staff numbers were

Table 2: Services provided by AOD specialist treatment agencies.

Type of service[a]	n (%)
Outpatient rehabilitation	149 (64)
Outpatient withdrawal	78 (33)
Inpatient withdrawal	65 (28)
Inpatient rehabilitation	64 (27)
Therapeutic community	35 (15)
Other	7 (3)

Note:
(a) Managers (n=234) could nominate more than one type of service.

extrapolated from the sample, holding constant the relative distribution of staff categories.

Managers were asked to describe their staff by occupational group. Table 5 indicates that the workforce comprises nurses (26%, n=1,206), general AOD workers (19%, n=873), psychologists (8%, n=400), counsellors (6%, n=272) and social workers (5%, n=265). Managers reported a range of other occupations including teachers, pharmacists, health promotion officers, Indigenous workers and youth workers.

Managers

The mean age of managers was 46 years (range: 23-69, n=231). Few managers were aged under 30 years. Nearly half of all managers were in the 41-50 year bracket, with a further 26% aged 51-60 years.

Fifty-seven per cent (n=134) of managers were female, with similar proportions of female managers in government and non-government organisations (57%, n=56 and 55%, n=64, respectively). A high proportion of female managers was identified in private organisations (74%, n=14).

Ninety per cent (n=210) of managers reported that they had some type of AOD qualification and/or training. Managers frequently reported more than one qualification. Non-accredited training courses were the most frequently cited type of training (55%, n=129), followed by accredited short courses (36%, n=83). Approximately half the sample held a university qualification in AOD work or a related field (47%, n=108).

The average time managers had worked in the AOD field was 12 years (range: 1-40, n=232). Almost half the sample (46%, n=104) had spent between 6-15 years in the field, and 30% (n=71) had spent 16-40 years. A quarter had been in the field less than five years, 16% (n=37) between three and five years and 8% (n=20) less than two years.

The average time in their current managerial position was 4.8 years (range: 1-25, n=232). Nearly half the sample (45%, n=104) had been in their current managerial position for less than two years, a quarter (26%, n=60) between three to five years and 12% (n=27) for more than 10 years.

Seventy-nine per cent of managers indicated they had managerial education, training or experience. Over a quarter of these managers (29%, n=65) reported tertiary management qualifications, while another 20% (n=43) had attended short courses, workshops or seminars.

Table 4: Managers' (n=234) identification of their agencies' principal client group.

Specific group	n (%)
No specific group	116 (52)
Adults (18 years and over)	30 (14)
Youth (12-25 years)	19 (9)
Males only	12 (5)
Aboriginal & Torres Strait Islanders	9 (4)
Females only	7 (3)
Justice system	7 (3)
Illicit drug users	5 (2)
Dual diagnosis	4 (2)
Private health insurance	4 (2)
Clients with dependents	3 (1)
Construction workers	2 (1)
Homeless	2 (1)
Alcohol only	1 (0.5)
Navy personnel	1 (0.5)
Total[a]	**222 (100)**

Note:
(a) Denotes 12 non-response missing cases.

Table 3: Treatment approaches in AOD government, non-government and private sectors.

Agency	Govt n (%)	NGO n (%)	Private n (%)	Total n (%)
Harm minimisation[a]	88 (90)	83 (71)	10 (53)	181 (77)
Exclusively abstinence	6 (6)	23 (20)	6 (32)	35 (15)
Other approaches[b]	3 (3)	10 (8)	1 (5)	14 (6)
Missing (non response)	1 (1)	1 (1)	2 (10)	4 (2)
Total	98 (42)	117 (50)	19 (8)	234 (100)

Notes:
(a) Managers identified a continuum of harm minimisation that could include abstinence.
(b) Other approaches identified: a client directed approach and abstinence that can include harm minimisation.

Table 5: Reported staff in sample agencies (n=318) and estimated staff in COTSA 2001 agencies (n=486).[a]

Type of staff	n (%)	Total estimated staff (COTSA)
Therapeutic staff		
Nurses	1,206 (26)	1,843
AOD workers	873 (19)	1,334
Psychologists	400 (8)	611
Counsellors	272 (6)	416
Social workers	265 (5)	405
Other occupational groups[b]	1,674 (36)	2,558
Total therapeutic staff	4,690 (70)	7,167
Other staff[c]	1,811 (27)	2,768
Alcohol-specific staff	167 (3)	255
All staff	6,668 (100)	10,190

Notes:
(a) 63 agencies were closed, non-contactable or inappropriate, leaving 486 active agencies on the COTSA database.
(b) Managers reported a diverse range of other occupations including teachers, pharmacists, health promotion officers, Indigenous workers, youth and peer workers.
(c) Administrative and maintenance staff.

Workforce development issues

Managers were asked to identify and discuss relevant workforce development issues. Most managers (94%, n=220) nominated more than one issue as shown in Table 6. The three most frequently cited issues are outlined below.

Education and training

The majority of managers (84%, n=197) identified the need for more and/or better education and training as a specific workforce development issue for their agency. Managers highlighted issues such as education and training in new drug trends, the needs of specific population groups and issues around mental health and dual diagnosis.

Funding

The need for more funding was expressed by 77% (n=180) of managers as a specific workforce development issue. Many managers (72%, n=166) reported current funding to be inadequate for the effective operation of their agencies, especially in the areas of prevention and intervention, mental health and outpatient services. Concern was also expressed about high client/staff ratios, the cost of staff training and development, the ability to cover future salary increases, difficulty in recruiting and retaining staff, especially shift workers, and the provision and maintenance of infrastructure.

A higher proportion of managers from non-government organisations (84%) identified their funding as inadequate compared with government (63%) and private (39%) organisations. The majority of managers (61%, n=11) from private organisations indicated their funding was adequate because of private health insurance and the user-pays system.

Seventy eight per cent (n=75) of managers from non-metropolitan areas indicated their funding was inadequate compared with 67% (n=91) in metropolitan areas.

Staff vacancies

The third most frequently identified workforce development issue was difficulty filling staff vacancies. Two-thirds of managers (67%, n=157) reported the need for workers to fill short- and long-term vacancies. Managers also identified a range of recruitment/retention and career opportunity issues that affected their ability to fill vacancies such as: a lack of qualified and/or experienced workers; poor remuneration; the challenges of working in a rural location; the stigma attached to the AOD field; and the shortage of nurses.

Difficulty in filling staff vacancies was reported equally across different types of agencies and locations. The majority of government (68%, n=67), non-government (60%, n=68) and private agencies (63%, n=12) had difficulty filling vacancies. Sixty-two per cent (n=85) of managers in metropolitan areas and 66% (n=62) of managers in non-metropolitan areas indicated recruitment difficulties.

Thirty-six per cent of managers did not experience recruitment difficulties, partly attributed to a stable workforce resulting in few vacancies. A number of managers also indicated that their agency had good networks in the field and strategies to recruit and train locally.

Discussion

The study reports findings from managers of approximately two-thirds of the AOD specialist treatment service agencies available in Australia. It extends the findings of the COTSA census[3] and the National Minimum Data Set[6] by focusing on agencies' services and workforce rather than clients.

Limitations

The COTSA database, used as the sampling frame for the survey, was last updated in 2001.[3] Since then, a number of agencies have closed, amalgamated or relocated and other agencies opened. These agencies could not be included in this study. Hence the sampling frame contains limitations.

Data presented here are in part based on agency data collections and in part on managers' estimates and should be interpreted in this light.

Alcohol and polydrug use

Alcohol was identified as the most problematic drug with which

Table 6: Managers' identification of workforce development issues.

Workforce development needs[a]	Government n=98		NGO n=117		Private n=19		Total n=234	
	n	(%)	n	(%)	n	(%)	n	(%)
1. Education and training	79	(81)	101	(86)	17	(90)	197	(84)
2. More funding	68	(69)	102	(87)	10	(53)	180	(77)
3. Staff to backfill positions	66	(67)	84	(72)	7	(37)	157	(67)
4. Need for professionalisation of AOD workers	52	(53)	76	(65)	12	(63)	140	(60)
5. More management support	52	(53)	75	(64)	9	(48)	136	(58)
6. Other e.g. rural issues, funding, staffing, comorbidity	61	(62)	62	(53)	11	(58)	134	(57)
7. Implementation of workforce development policies	46	(47)	63	(54)	9	(48)	118	(50)
8. Lack of suitable courses/training	47	(48)	51	(44)	8	(42)	106	(45)
9. Provide incentives to attend training	31	(32)	55	(47)	4	(21)	90	(39)

Note:
(a) Rank ordered by frequency of response, 220 managers selected more than one category.

clients present to specialist treatment agencies. Forty per cent of managers predicted future increases in alcohol-related presentations because of risky drinking in specific populations, such as binge drinking. About a quarter of the sample thought they would not be able to manage and respond to future alcohol trends.

This study's findings highlight the extent to which alcohol-related problems are often closely associated with polydrug use – a much-overlooked phenomenon, despite research suggesting that polydrug use is becoming the norm among many drug-using clients.[11] The study found that more than half of polydrug-using clients were also estimated to have problems with alcohol. This association is often not recognised by treatment providers. Approximately two-thirds of managers also predicted that the presentation of polydrug-related problems would increase and nearly a quarter believed they would not be able to effectively manage and respond to this trend.

The majority of managers supported an integrated approach to AOD treatment and the need for a multi-disciplinary workforce to treat and manage alcohol- and drug-related problems.

Type of services offered

The majority of agencies offered outpatient rehabilitation and withdrawal. Fewer agencies offered inpatient services. These findings are consistent with national and international trends away from inpatient and towards outpatient care for AOD clients.[12]

Treatment approach

Support for harm minimisation was very strong, with three-quarters of AOD agencies supporting a harm-minimisation approach. Strongest support for harm minimisation was found among managers of government agencies (90%). Three-quarters of non-government agency managers indicated support for a harm-minimisation treatment philosophy compared with just over half the managers of private organisations.

Overall, less than one in six agency managers reported an exclusively abstinence treatment approach. This finding reflects the broadening of treatment approaches and the shift away from abstinence-only treatment options and adoption of a broader public health approach to the management of AOD problems.[13]

Meeting client needs

The present study identified limited numbers of agencies that provided services for youth and males only, and few agencies that specifically addressed the needs of Indigenous Australians and females. It also identified growing concern related to clients with co-occurring AOD and mental health problems and few agencies catering for this group and their complex needs.

Some managers reported that agencies were not always equipped to cope with clients presenting with drug-related problems and mental illness. Further investigation is needed on the current capacity of the AOD sector to meet the needs of clients with dual diagnoses as research shows increasing levels of comorbidity for AOD problems and mental illness. It is estimated that 25% of people with mental illness also engage in problematic alcohol and/or other drug use.[14]

The provision of appropriate services for priority groups is an area of growing concern. Client access to AOD services is a public health issue of major importance. There is a need for increased collaboration between AOD specialist treatment agencies, health and allied health professionals and the community.

Agency location

This study found that the majority of managers in rural areas felt constrained by funding levels, staffing issues and their ability to manage co-occurring mental health issues and alcohol-related problems. As these issues can have a marked impact on the quality of service provision, it is important that future research address the unique challenges faced by rural AOD agencies.

Agency capacity to effectively manage and respond to trends

The high proportion of managers who believed they would be unable to effectively manage and respond to present and future alcohol and polydrug trends was a concern. Conversely, some managers reported their agencies had the capacity to manage and respond to the range of current and predicted client needs. These managers reported that their agencies recognised and met community needs through strategic planning, consultation and evaluation.

Further research with agencies that reported the capacity to manage and respond to client needs may identify strategies that could be emulated to support workforce development across the AOD sector and other public health services.

The AOD workforce

The study identified a workforce predominantly comprising nurses, general AOD workers, psychologists, counsellors, social workers and other medical and allied health professionals. This finding is contrary to the common perception that the AOD specialist treatment services are dominated by non-professional staff, often with a personal background of problematic AOD use.

The top five occupational groups reported by managers included three groups from university-qualified professions: nursing, psychology and social work, representing approximately 40% of the AOD specialist treatment workforce. The remaining two groups of general AOD workers and counsellors constitute broad and loosely defined classifications. Managers reported a diverse range of workers under these categories including recent university graduates from various disciplines, TAFE graduates and people with relevant life experiences including former drug users. Almost 50% of staff who could be classified as 'therapeutic staff' came from university-trained professions. It is anticipated that the apparent trend towards greater professionalisation of the AOD workforce will continue in the future.

Managers

Although there was a broad range in the number of years managers had worked in the field (1-40), most managers were relatively new to their role. Approximately half the managers had

been in their current managerial role for less than two years. Such a high proportion of relatively inexperienced managers in Australian AOD specialist treatment agencies highlights the need for workforce development strategies that include training in management skills and support.

Approximately 60% of managers identified the need for "more management support" as a workforce development issue for their agency. The form that such support should take was not noted; however, it could involve both management training in areas such as finance and budgeting and/or the provision of extra resources such as more administrative staff.

Funding

Funding constraints were identified as a major factor in an agency's ability to manage and respond to alcohol and polydrug presentations. More managers from non-government and rural agencies identified their funding as inadequate. Many managers reported that long-term planning was difficult when there was no guarantee of continued funding. Funding constraints require managers to be highly strategic and it has important workforce development implications.

Recruiting and retaining staff

The majority of managers indicated that difficulty in filling vacancies was a priority workforce development issue. Australia and the United States have reported similar recruitment and retention difficulties, sharing common barriers such as the lack of career structure, few incentives to work part time, short-term contracts, shift work and high workloads.[15] An inability to recruit and retain staff in specialist treatment agencies compounds workplace pressures.[16]

Recruitment and retention are significant workforce development issues for the AOD field and the broader public health sector. Retention of staff for extended periods of time contributes to stability and consistency in an agency and may lead to better treatment outcomes.[17] There is a need to identify and develop systems that support the participation and retention of workers in the AOD sector.

Conclusion

Problematic alcohol and drug use is a major public health issue in Australia. Changes in patterns of use and increasingly complex client needs are major challenges for the AOD sector. Identification of the composition of the AOD workforce and priority workforce development issues will enhance planning and development of strategies to increase the capacity of the AOD sector to manage and treat a diverse range of clients.

Acknowledgements

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