
7 Counselling and treatment support services

Key points

- Only a small proportion of people experiencing problems with their gambling seek professional help. The available data suggests that around 17 500 people attended gambling help services in 2007-08.
- Most clients of help services have either 'hit rock bottom' or are coming close.
- Social stigma associated with having a problem, denial of a problem or believing they can handle it themselves, are the main reasons why gamblers do not seek professional help.
- Interventions need to cover the full continuum of gambling problems and not just focus on 'treatment'.
 - Governments should place greater emphasis on community awareness, to dispel common myths about gambling, tell people how to gamble safely and encourage earlier help-seeking and interventions by family and friends.
 - Pathways for referral would be improved by better informing general practitioners and other front-line professionals.
- People experiencing problems with gambling can recover without professional help, and the evidence suggests that many do. Relatively low cost interventions have the capacity to increase self-recovery.
- Outcome studies show that the majority of clients who seek professional help benefit from treatment (irrespective of its form). And, while cognitive behavioural therapy has the most empirical support, no one style of intervention is necessarily best practice.
- There would be benefits in having an agreed minimum standard of specific training for problem gambling counsellors.
- Funding sources for gambling help services currently are too narrow in their coverage of gambling forms.
- Nationally consistent data is much needed. Common evaluation processes and coordination of the collection of data would be highly desirable.

A main element of the policy response by governments to problem gambling is to provide counselling and treatment support to people experiencing problems with gambling, as well as to family or friends who may be affected. All state and territory governments in Australia provide free treatment services, including:

- 24 hour gambling helplines (a national 1800 number) offering counselling, information and referral services
- websites providing information, online counselling, self-help material and tools
- face to face counselling, including intensive clinical therapy, financial and relationship counselling, and group support.

The states and territories also fund community education and research activities (appendix J).

The key question for this chapter is whether these services achieve their objectives and the extent to which there is scope to improve them. Help services are important to achieving good outcomes, but are also costly for governments (and therefore taxpayers). In 2007-08, around \$48 million was spent on specialist gambling counselling and support services, community education and research.

This chapter assesses:

- the capacity of the services to reach problem gamblers and what governments can do to enhance this (section 7.1)
- the effectiveness of the ‘treatments’ used to assist problem gamblers, and whether there are preferred approaches (section 7.2)
- whether there are benefits in increasing the qualifications or training of counsellors (section 7.3)
- the adequacy of funding arrangements (section 7.4).

The need for better evidence as a basis for decision-making about help services is a key theme (section 7.5).

7.1 Reaching the target population

A first step in improving the reach of services is an understanding of:

- how many people seek help (or do not)
- their motivations for doing so (or not)
- the nature and extent of their problems.

Relatively few people with problems seek help

Only a small share of people experiencing problems with gambling seek formal help from counselling and treatment services. While it is difficult to know the 'exact' number, client data collected by the states and territories suggest that around 17 500 people attended gambling counselling and treatment services in 2007-08 (appendix J). The data, however, are not strictly comparable (some jurisdictions collect data on 'all' clients, others on 'new' clients, some include clients attending gambling financial counselling). This estimate also excludes people seeking help from privately provided or voluntary gambling help services (such as Gamblers Anonymous and private psychiatrists) and those seeking help from generic community services as well as financial and relationship counselling agencies.

Based on there being around 80 000 and 160 000 Australian adults suffering significant problems from their gambling, and excluding clients seeking help for someone else's gambling problem (around 4000 people), this suggests a help seeking rate of between 8 and 17 per cent.

Low rates of help-seeking by people experiencing problems with gambling are not unique to Australia. Internationally, around 6-15 per cent of people experiencing problems with gambling are reported to seek help from problem gambling services (Slutske 2006, Suurvali et al. 2008).

Who does seek help?

Data collected by the states and territories suggests that:

- Most of those seeking formal help are primarily experiencing problems with electronic gaming machines (EGMs), or they identify EGMs as the principal preferred form of gambling activity.
- Most people seeking help have been experiencing problems for some time. Data collected in both New South Wales and Tasmania, show the most commonly reported length of time experiencing problems with gambling is 2 to 5 years (25 per cent in New South Wales and 32 per cent in Tasmania). Seventeen per cent of males and 12 per cent of females in New South Wales report having experienced problems for more than 15 years.
- Most clients do not receive prolonged periods of treatment. New South Wales, for example, reported a session-to-client ratio of 4 in 2007-08, with 30 per cent of problem gambling clients and 49 per cent of financial counselling clients receiving only one counselling session during the reporting period.

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- Many people seeking help for gambling problems also have co-morbidities. In New South Wales, for example, of those clients presenting for counselling, 43 per cent reported having at some stage been diagnosed with anxiety, 55 per cent with depression, 29 per cent with alcohol problems and 19 per cent reported problems with other drugs.

Additional client profile information is provided in appendix J.

What triggers help-seeking?

People experiencing problems with their gambling often do not seek professional help until a ‘crisis’ occurs — financial ruin, relationship break down, court charges or attempted suicide — or when they hit ‘rock bottom’. As one gambler said:

Recognition that I had a gambling problem came the day I went to buy some groceries and found there was no money in my account. The trigger ... was serious threats by my family to quit dealing with me. (quoted in McMillian et al. 2004, p. 155)

The evidence from counselling services is consistent with this:

... those clients who do seek help often do so some considerable time after they first recognise the problem, by which time gambling and its associated problems have reached crisis point and much damage has been done. (DoJ 2008, p. 8)

By the time people experiencing harm as a result of their own or someone else’s gambling find their way to counselling they are usually in a very distressed state. Of 249 Gambling Care clients whose files were active in the 07/08 financial year, 87 (34 per cent) had indicated they had seriously considered suicide and 17 (7 per cent) that they had attempted suicide as a result of their problems with gambling. A small but steady number found themselves before courts for the first time as a result of offences related to their problem gambling and we usually have at least one client serving a custodial sentence. (Gambling Care, Lifeline Canberra, sub. 123, p. 1)

Studies looking at reasons for seeking help for gambling consistently find ‘hitting rock bottom’, financial and relationship difficulties, negative emotions, work and legal difficulties and physical health, as the main reasons for seeking formal help (Suurvali et al. 2010, table 7.1). For example, Evans and Delfabbro’s study of 77 problem gamblers (61 had sought professional help), found help seeking to be largely crisis-driven rather than being motivated by a gradual recognition of problematic behaviour. They observed:

The majority of gamblers interviewed only sought help when they were on the verge of physical or psychological breakdown, and/or when they were facing financial ruin. This was evident not only in the nature of motivational items endorsed, but also in the range of items endorsed, indicating that the negative effects of gambling had already affected multiple areas of the person’s life. (2005, p. 149)

Table 7.1 Studies looking at help-seeking behaviour of people experiencing problems with gambling

<i>Study</i>	<i>Method</i>	<i>Results</i>
Evans and Delfabbro (2005), Australia	77 gamblers — 61 had sought professional help, 16 relied on self-help strategies. A questionnaire (with both open and closed-ended questions) was used to find out what factors motivated professional help seeking and self-help methods. Gamblers were also asked to rank key barriers to help seeking.	Help seeking found to be largely crisis-driven rather than being motivated by a gradual recognition of problematic behaviour. The main obstacles to seeking help were found to be psychological. Problem gamblers consistently endorsed two issues — (i) they were in denial, or were embarrassed if friends or family found out, and (ii) believed they would eventually regain control on their own, or would be able to gamble their way out of difficulties. Factors such as a lack of awareness of services and dissatisfaction with services were endorsed by relatively few.
McMillian, et al. (2004), ACT, Australia	Semi-structured interviews with representatives from a variety of cultural communities and a small sample of problem gamblers and their families.	A variety of factors prompted help seeking. For the majority, a problem was recognised as serious when it impacted on finances and relationships. Found 'shame and stigma' and 'failure of others to understand the problem' as obstacles to seeking help. Inadequacy of services on offer was also reported as an obstacle.
New Focus Research (2004), Victoria, Australia	Longitudinal study of problem gamblers, loved ones and providers of problem gambling services.	Main reasons for seeking help — 'hitting rock bottom' financially (36 per cent) and emotionally (15 per cent), pressure by family member/loved one (17 per cent).
Rockloff and Schofield (2004), Australia	1203 central Queenslanders (598 women, 605 men) aged 18+ completed a telephone survey.	Identified 5 potential barriers to treatment — availability, stigma, cost, uncertainty and avoidance. People with greater gambling difficulties were more concerned with the availability, effectiveness and cost of treatment.
Hodgins and el-Guebaly (2000) Calgary, Canada	Comparison of resolved (n=43) and active pathological gamblers (n=63).	Obstacles — embarrassment/pride (50 per cent), no problem/no help needed (50 per cent), unable to share problem (49 per cent) and stigma (53 per cent). 82 per cent of gamblers said that wanting to handle the problem on their own was moderately important. Ignorance of available treatment/lack of treatment options were also identified as obstacles.
Pulford, et al. (2009a,b) New Zealand	Structured multi-modal survey — users of a national gambling helpline + gamblers from general population.	Financial concerns most frequently reported reason for seeking help, also psychological distress, problem prevention, rational thought, physical health, relationship issues. Barriers included pride (78 per cent of help seeking (HS) and 84 per cent of non help-seeking (NHS) participants), shame (73 per cent HS, 84 per cent NHS), and denial (87 per cent NHS).

A study of problem gamblers who employed largely self-help methods to overcome their difficulties, also found that the only significant predictor of professional help seeking was the degree of severity of gambling problem. The help seekers' DSM-IV score was significantly higher than for those receiving minimum or no professional treatment (Hodgins and el-Guebaly 2000). These findings are consistent with the Commission's previous national gambling survey (PC 1999) — 1 in 5 gamblers with SOGS scores of 10+ had sought help, compared with 1 in 14 gamblers with scores in the 5-9 range.

In terms of the evidence as to why people experiencing gambling problems *do not* seek formal help, the main reasons appear to be:

- feelings of guilt, shame and embarrassment
- denial and
- believing that they can resolve their gambling problems without professional help (table 7.1).

Issues and dilemmas about help seeking

Given what we know about *when* people experiencing problems with their gambling seek professional help and the reasons *why* they do not seek formal help, key policy questions are:

- Is it possible to identify and help people experiencing problems with their gambling earlier? Can we do better than having an 'ambulance at the bottom of the cliff'?
- Can policy measures lessen the stigma attached to having a gambling problem?
- Are there ways by which government action can help people help themselves?

Can we do better than the 'ambulance'?

A number of participants argued that a 'treatment' focus is inadequate and that devoting more resources to addressing prevention and early intervention will improve the harm minimisation effort. For example:

Over the past decade, most focus on reducing gambling harm has been through the provision of tertiary level services focussed on individuals with gambling problems. These services are very important. However, improved use of primary and secondary responses, including public education and other risk reducing strategies will increase the reach, timeliness and effectiveness of the overall harm minimisation effort. (UnitingCare Australia, sub. 238, p. 7)

A treatment focused intervention regime is inadequate. ... The Council encourages the Commission to consider the scope to intervene at the community resilience and capacity building end of the spectrum as well as enhancements to early intervention approaches. (Council of Gambler's Help Services, sub. DR326, p. 1)

Clubs Australia, however, questioned the value of alternatives to treatment.

While some simplistically refer to treatment as the 'too late' option, in the absence of certainty about how to identify someone likely to become a problem gambler, the alternative to treatment (prevention) poses potentially enormous costs and uncertain outcomes. (sub. DR359, p. 27)

As discussed in chapter 4, gambling policy-relevant problems are much broader than 'problem gambling'. A central tenet of the public health model is not just assisting those currently experiencing harm, but to prevent or minimise the risk of future harm (in contrast to the medical approach which focuses on the *treatment* of the relatively small group of people suffering severe harm from gambling). It includes an inclusive notion of prevention.

- *Primary prevention* activities are aimed at preventing individuals in the general population from developing gambling problems (such as public awareness-raising campaigns promoting responsible gambling).
- *Secondary prevention* activities seek to limit harm in the early stages of problem development (such as through intervening early), with a focus on at-risk groups.
- *Tertiary prevention* activities are about treating or reversing the effects of problem gambling (figure 7.1).

The Ottawa Charter for Health Promotion defines health promotion as 'the process of enabling people to get control over, and to improve, their health' (WHO 1986, p. 1). The five key areas of the health promotion framework which have become the focus of public health approaches include — building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting health services.

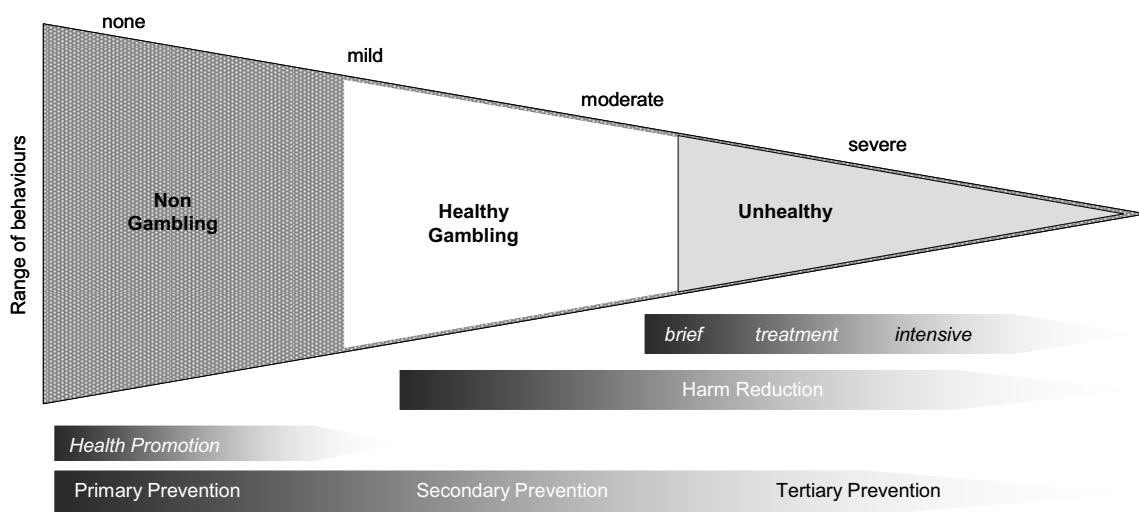
New Zealand has adopted a public health approach to gambling. The *Gambling Act 2003* requires that a public health focus be taken in addressing gambling harm, in recognition of the importance of prevention and addressing the determinants of health. A number of jurisdictions in Australia have also adopted a public health approach to gambling. For example:

- The Victorian Government said it 'believes there is compelling evidence to support programs for effective prevention, early intervention and treatment' (sub. 205, p. 11). Victoria's *Taking action on problem gambling* incorporates public health and social regulation into problem gambling policy responses (sub.

205, attachment 2). It provides an integrated approach to consumer protection and the prevention, early intervention and treatment of gambling related harm.

- Queensland’s *Responsible Gambling Strategy* covers early identification and prevention, consumer protection and rehabilitation initiatives (sub. 234).
- Tasmania’s Gambling Support Program develops programs within a public health model.

Figure 7.1 **Gambling problems lie on a continuum**



Source: Korn and Shaffer (1999).

Raising community awareness about gambling and help services

All states and territories have in place strategies for raising community awareness about gambling and help services (including media campaigns, gambling websites, problem gambling material, school education material, see appendix J).

But, as illustrated in chapters 4 and 8, faulty cognitions are widespread (such as thinking that on games of chance outcomes can be influenced by a certain system or strategy), and many people have problems controlling their gambling. The Victorian Government also argued that community learning about gambling is still at an early phase.

Unlike many areas of health where there is high community awareness (eg. smoking and lung cancer, seatbelts and accidents), problem gambling is a relatively new health issue for many members of the general public and health and community services. The community is only just starting to understand how gambling can become a health and well-being issue and concepts such as ‘responsible gambling’ are still being learned

(eg. setting limits, leaving ATM cards at home, working out the affordability of expenditure, avoiding chasing losses, minimising consumption of alcohol while gambling). ... community recognition of problem gambling as a public health issue is a key priority at this early phase of community learning. (DoJ 2009, p. 16)

Community awareness campaigns have the advantage of reaching a large proportion of the population. They can play an important role in addressing knowledge gaps in the community about gambling (debunking common myths) and the consequences of gambling consumption decisions. Campaigns can also inform people about how to avoid getting into trouble with gambling, how to recognise ‘at-risk’ behaviours and where to access help (they can also reduce shame and stigma associated with having a problem with gambling).

But, the impact of such campaigns may not be evident for several years, and as campaigns are often aimed at changing awareness and attitudes, it can be difficult to assess effectiveness. What is evident from interventions targeting general populations in other areas (such as tobacco), is that sustained campaigning over an extended period of time is generally required before population-wide changes in behaviour become evident. In the case of tobacco, behavioural changes took over 40 years to occur.

While improving awareness about responsible gambling can be an important part of building community resilience to problem gambling, in order to reduce harm associated with gambling, awareness campaigns need to induce behavioural change. This is very difficult to do. The relationship between being better informed about gambling and subsequent behaviour is not straightforward. Knowledge about gambling, for example, can be overridden by irrational beliefs (such as luck). Gambling awareness campaigns also have little impact if people are not obliged to attend to the information or have no intrinsic interest in it (Williams et al. 2008). This suggests targeting campaigns at ‘at-risk’ groups so they are better able to adopt control strategies and know where to access help.

The Victorian Government’s *Problem Gambling Community Awareness and Education Strategy* identifies target community segments at risk of developing a gambling problem to include: people with health issues (eg. mental health and co-morbid conditions), people in socio-economically vulnerable communities, people who are socially isolated, people with intellectual disability/cognitive impairments, people of Indigenous backgrounds, seniors, people on community services or corrective orders, people of CALD background and young people (sub. 205, p. 79).

However, community awareness campaigns should not be relied upon as a ‘panacea’ (a point made by the Council of Gambler’s Help Services, sub. DR326, p. 11), as they have only limited content. Information provided to the community

via other forms (such as websites, in-venue warning, posters, community educators, information provided in different languages) can play an important role in reinforcing community campaign messages about gambling and tailoring messages to at-risk groups. In-venue warnings and school-based gambling programs are discussed in chapters 8 and 9, respectively.

Messages to encourage gamblers experiencing problems to seek help earlier

Because financial loss is one of the main reasons gamblers seek help, Pulford et al. (2009b) suggest that campaigns that demonstrate increasing levels of financial loss and hardship over time could be particularly valuable as viewers/readers/listeners could conceptualise a continuum of financial loss. A recent review of help-seeking studies also found ‘fear of future consequences’ and a desire to prevent gambling problems from becoming more serious, to be key reasons for gamblers quitting or reducing their gambling (Suurvali et al. 2010). This suggests that gamblers are able to see where their gambling is leading them and to take action before they reach ‘desperation point’. Suurvali et al. suggested that:

Awareness and educational messages could feature, in addition to information meant to support and assist gamblers in crisis, positive statements about the benefits of reduced gambling involvement targeting heavier gamblers who have not yet experienced or acknowledged serious harms from their gambling. Inclusion of a preventative message is also a good idea, alerting gamblers to signs that their gambling might be becoming excessive or problematic and providing several clear, simple alternative suggestions (including sources of help) as to what they can do to nip the problem in the bud. (p. 30)

In another recent study where recovered problem gamblers were asked what would help active problem gamblers to cease or reduce gambling, one third suggested awareness-raising strategies, such as pointing out the negative consequences of problem gambling and the difference between what the individual wants to achieve and what continued gambling would lead to (Toneatto et al. 2008). Relationships Australia SA also said:

Focussing on financial losses will be an effective message to people at risk. We also believe that campaigns should emphasise the direct, harmful effects on the children and families of problem gamblers — highlighting not simply the risk of losing your family but the likelihood of harming your family. (sub. DR419, p. 1)

The evidence on the effectiveness of in-venue warnings is that to invoke a change in behaviour, warnings need to have an emotional impact (chapter 8). Personal stories (where gambling led people to, the effects of gambling on other family members and the effectiveness of their treatment) can be effective in this regard.

A number of participants (sub. 150, DR388, DR369) noted the importance of awareness campaigns and education being conducted in consultation with relevant community groups (particularly culturally and linguistically diverse groups) to ensure effectiveness. For example, Gordon (an Indigenous man and trained gambling counsellor with extensive experience in Indigenous community education and program development and delivery) said:

To begin addressing Indigenous Australians and gambling, we must understand Aboriginal people, their culture and communities. (sub. 76, p. 5)

The evidence suggests that cultural differences can affect how gambling and gambling help are perceived which points to the importance of culturally appropriate messages and forms of providing information (box 7.1).

Awareness of problematic behaviours

As a number of participants pointed out, it is not always obvious when people are experiencing problems with gambling. One participant observed:

... when you're an alcoholic, you can't hide it, everyone notices you're staggering around. When you're a drug addict, you can't hide it. But when you're a gambler, you can hide it well, and that's the sad thing. (Exodus Men's Group, trans., p. 208)

The parent of one individual experiencing problems with gambling also said:

... what distinguishes a recreational from a problem pokie player? Guidelines have been established for problem drinking. Data on what is considered normative or non-problem gambling, would help delineate this issue. (sub. DR313, p. 1)

Because of the 'invisibility' of the symptoms of problem gambling, campaigns that make the community aware of the sorts of behaviours that are indicative could promote earlier help seeking. People in contact with those experiencing problems with gambling may not know what they can do to help and what services are available. Again, this suggests targeting, this time at those likely to encounter people showing early signs of distress (partners, friends, colleagues, general practitioners and financial counsellors).

There is evidence that family and friends can play an important role in:

- identifying problematic behaviours (they are often aware of gambling problems, but not always the extent of the problems)
- helping those concerned with strategies to control their gambling
- referring those concerned to help services (box 7.2).

Box 7.1 **A culturally appropriate approach for Indigenous communities**

While there is little published data about gambling in Indigenous communities, available evidence and consultations with Indigenous community members suggests that gambling is a common activity in these communities. Card playing in communities is a traditional social activity, 'with benefits associated with extended families playing together and sharing their winnings' (Charles Darwin University 2009, sub. DR408, p. 2). With Indigenous people now also participating in regulated forms of gambling, money lost leaves the communities.

While problems can arise from both community-based and regulated gambling, these are 'accentuated with regulated gambling because there are no community mechanisms to mitigate the harm'. Commonly cited problems include financial hardship, the needs of children being overlooked, family arguments, tensions when gamblers ask for money for food, tobacco and rent and contact with the criminal justice system (sub. DR408, p. 7, AH&MRC 2007).

Having a problem with gambling is often seen as a weakness and seeking help as shameful – 'Aboriginal people keep it in their own backyard, don't like people to know about problems' (DOJ 2005b, p. 5). This results in people being reluctant to discuss and seek help for gambling problems (particularly people who work in professional roles or who are respected elders in the community), and points to the importance of encouraging discussion and acknowledgement of gambling problems within Indigenous communities. Some suggestions from key individuals in *Yolnu Matha* included:

... governments could set up more programs like Alcoholics Anonymous in our communities, not in the main centres but on our communities.

We're not just being, or just looking at the problem, one-sided. We have to look at it holistically, and then work our way around to help people in an appropriate manner.

The government must work with the people, talk to the elders of the community and everybody, come to an 'agreed issue point' a new base that will help for individuals, the families and the community. (sub. DR408, pp. 15-16)

Indigenous community members consulted as part of an Aboriginal Health and Medical Research Council of New South Wales project also suggested incorporating 'gambling issues in general Aboriginal community events and activities and health promotion activities such as family camps' (AH&MRC 2007, p. 47) as well as providing a wider range of recreational activities for Aboriginal people (particularly for young people). Other strategies identified (and found to be used by service providers successfully working with Aboriginal clients and organisations) included:

- working in partnership with Aboriginal community organisations
- employing or working with Aboriginal workers
- visiting community settings to engage Aboriginal clients
- developing and providing specific Aboriginal resources and programs, and
- educating staff in working cross culturally with Aboriginal people.

Box 7.2 Family and friends can play an important role

- In a Victorian longitudinal study of problem gamblers, families, friends and service providers, the majority of problem gamblers stated that their families were aware of their gambling problems, although they were not aware of the extent of the problems (New Focus Research, 2004).
- Client data on referral to counselling services also shows that family, friends and neighbours are an important referral source to gambling help services. For example, 16 per cent of clients in New South Wales services reported family/friend/neighbour/partner as the most recent referral source. In Victoria and Queensland, around 8 and 6 per cent respectively, were referred to counselling services by family and friends in 2007-08 (appendix J).
- A study of problem, recovering and recreational gamblers across Glasgow found that close friends and family often played a key practical role in identifying services, applying pressure of various kinds and accompanying gamblers to counselling sessions (Anderson et al. 2009). Friends and family were also found to take an active role in helping participants stop or control their gambling including accompanying them when they went out, taking control of the gambler's finances (holding credit cards, managing and allowance), reminding gamblers what there was to lose by gambling (holidays, treats for children).

Evidence that community awareness campaigns increase demand for help

There is some evidence that campaigns to raise awareness of problem gambling issues and help services lead to increases in the number of calls to gambling help lines and in the number of clients accessing counselling services. For example, an evaluation of the Gambling Hangover Campaign in New South Wales (targeted at young males and friends/family of young males with gambling problems), showed that:

- there was high awareness and approval for the campaign among the target group. Half of the young men surveyed recalled the advertisement as 'attention getting', 'modern' and 'thought provoking'
- calls to G-line were up by an average of around 5 per cent and an estimated 85 new clients sought RGF-funded face-to-face services, citing the campaign as the reason for seeking help then (RGF, sub. 38, p. 5).

An evaluation of public awareness initiatives undertaken during *Responsible Gambling Awareness Week* in Victoria found that over 27 per cent of gamblers had heard about the week and all of them could recall the key messages. There was also a 50 per cent increase in visits to the problem gambling web site the following week and a 6 per cent increase in the number of calls to the Gambler's Help Line during

the week (Victorian Government, sub. 205, attachment 3). Similarly, an evaluation of a Gambling Awareness campaign undertaken in Tasmania in 2003 found that there was an increase of 52 per cent in first time callers to Gambling Helpline Tasmania and a significant increase in awareness of gambling support services.

Commenting on awareness campaigns internationally, Abbott et al. also concluded that they can be effective in raising awareness and increasing the number of gamblers seeking help (evidence also supported by awareness campaigns for tobacco and alcohol):

Evidence suggests that effective problem gambling awareness campaigns targeting adults can lead to measureable increases in awareness of community services, in the number of calls to help lines and in the number of first-time clients seeking help. Systematic reviews of mass media campaigns for tobacco and alcohol support the effectiveness of such approaches, particularly in combination with other strategies at the national and local levels. (2004, p. 23)

Overall, community campaigns can build community resilience to problem gambling by dispelling myths about gambling and making people aware of strategies to control their gambling. Awareness of how to gamble without getting into trouble is critical to people making rational choices, minimising harm and encouraging earlier help seeking. The evidence suggests that campaigns that focus on the threat of future consequences (financial loss, relationship breakdowns) could promote earlier and increased rates of formal help seeking. There is also evidence of a relationship between social marketing aimed at raising awareness about common signs of problems and help available, and increased help-seeking behaviour and interventions by family and friends.

Early intervention requires improved pathways for referral

An important component of a public health approach is the adoption of an integrated (whole-of-community) approach to prevention and early identification of gambling problems. Improving referral pathways between gambling counselling services and other professionals and services who are likely to encounter people experiencing problems with gambling — such as general practitioners, financial counsellors and community groups — is a way of encouraging earlier help seeking and intervention. As Morgan, Multicultural Problem Gambling Services, said:

We also need to work with the health services and their intake systems. Clients ring up presenting with problems like depression or psychosomatic symptoms, they don't ring to say they have a gambling problem. (New South Wales Problem Gambling Roundtable, 2008, p. 9)

Abbott et al. also said:

The majority of health and related professionals who have contact with problem gamblers are probably unaware that they do so. This is because practitioners who have most frequent contact with members of the community, including problem gamblers, are medical doctors, nurses and other professionals working in primary health and community settings. (2004, p. 51)

The evidence suggests that a high proportion of people presenting for help with gambling are also dealing with other health or behavioural issues. A Victorian survey found that the majority of problem gambling clients experienced between four and seven other issues in addition to their gambling (KPMG 2008). A study by the Problem Gambling Research and Treatment Centre in Victoria into the risk and protective factors associated with problem gambling, also found that in the problem gambling group:

- 36 per cent had a ‘severe mental disorder’
- the rate of ‘likely hazardous alcohol use’ was 50 per cent
- the risk of depression was 71 per cent
- the rate of daily smoking was 57 per cent (Thomas and Jackson 2008, p. ix).

People experiencing problems with gambling also often require services in addition to therapeutic counselling to address the impacts of gambling on their finances and relationships. A study of service users of the Western Australian Gambling Helpline found that people with gambling problems seek help from a wide range of specialist and generic services (including financial counsellors, Gamblers Anonymous, general practitioners, drug and alcohol use, criminal justice, legal agencies, ethnic community organisations, Matrix Consulting 2002).

This points to the importance of educating other health and welfare professionals about problem gambling and the help services that are available. As Westphal and Johnson (2007) said:

An awareness of co-occurring behaviours inspires an obvious targeting strategy for gambling disorder prevention, early intervention and screening efforts. The provision of these types of services at correction facilities, substance use and mental health treatment programmes should be a priority in jurisdictions with a public health perspective. (p. 91)

Health professionals and community services who could routinely be encountering people experiencing problems with gambling should be able to recognise and refer the person to gambling counselling services. But, the evidence suggests that few health professionals screen for problem gambling (Tolchard et al. 2007). Equipping

professionals with information, a screening tool and appropriate referral options (including where to access self-help material and online counselling) could increase opportunities for earlier intervention among people who are not actively seeking formal help for gambling.

Some states already have in place strategies to assist health and welfare workers in identifying gambling problems and appropriately referring clients (box 7.3).

Box 7.3 Information for health and welfare workers — some examples

- The *Early Intervention Prevention Community Engagement Strategy for Problem Gamblers in NSW, A Communication Framework 2009-2011*, includes strategies such as presentations at key seminars and conferences of partner members by problem gambling experts, the distribution of kits to partner members that contain information about problem gambling and gambling help, and articles in partnership newsletters.
- The Office of Problem Gambling has undertaken a project to engage with the South Australian Division of General Practice and their member GPs to identify, design and test resources to assist GPs in identifying high and medium risk gamblers and engage with them in confidence and offer therapeutic responses (SA Government, sub. 225, p. 50).
- The Victorian Government has developed a *Health Promotion Resource Kit* as a guide to assist health and welfare workers who encounter problem gambling issues. The kit is designed to assist in identification of gambling problems, support health and welfare workers in making effective referrals and other interventions on behalf of their clients.

Internationally, medical associations have devised policy statements and toolkits to guide medical practitioners in the treatment of problem gamblers and their families. In 2007, the British Medical Association released protocols for the treatment of gambling addiction within the United Kingdom National Health Service. Some jurisdictions in the United States have also provided clinical protocols to help health professional screen for and treat problem gamblers.

Thomas et al. (2008) argued that the standard diagnostic tools for problem gambling are too time-consuming for routine use in primary care practice (a New Zealand study where a practice review activity was trialled found ‘time’ to be an issue, Sullivan et al. 2006). Thomas et al. suggested a one-item screening test — ‘Have you ever had an issue with your gambling?’ — for use in primary care practice. They found that answers to this question closely predicted answers to the full Canadian Problem Gambling Index, and recommended screening patients

presenting with anxiety and depressive symptoms or high drug or alcohol use (because of the high co-morbidity of these conditions).

At the Ministerial Council of Gambling meeting in July 2009, the Ministers agreed to develop a national screening tool to help gamblers and service providers identify risky gambling behaviour before it becomes too entrenched. The screening tool is to contain questions to help individuals self assess and enable doctors, financial counsellors and other support services to be able to identify if a person is at risk of becoming a problem gambler (MCG 2009b). The Ministers also agreed to work together to provide better linkages between front-line Commonwealth and state-based gambling support services, to better support problem gamblers (MCG, 2009b). The Commonwealth funds a range of services which problem gamblers access, including Emergency Relief, Supported Accommodation Assistance Program and Commonwealth Financial Counselling and income support payments.

Overall the evidence suggests that equipping health professionals, counsellors and other community services with information and a brief problem gambling screening test (for inclusion in general mental health and financial risk assessments), would be a relatively low cost strategy that could result in earlier intervention. Screening could be targeted towards at-risk groups (such as those presenting with anxiety, depression, high drug or alcohol use).

Improved knowledge and awareness around screening, however, needs to be supported by clear referral pathways. As Relationships Australia SA said:

A screening test for health and community services workers to use is a very positive strategy to identify problem gamblers as they present for other issues. ... Screening is however, no use without action. Training on how to utilise and then follow through with referrals or support will be required. (sub. DR419, p. 1)

Clear referral pathways point to the importance of collaborative practices between providers of gambling services and other health and community service providers.

Integrating and coordinating care

Greater collaboration between problem gambling services and other health and community services was also considered important by a number of participants because of the need to provide a 'holistic' approach for clients presenting with multiple and complex needs.

... our clients present with mental health, housing, relationship, financial, parenting, drug and alcohol and grief issues that are significantly entwined with their gambling habits, and require attention as part of an holistic (successful) intervention. (Relationships Australia, SA, sub. 203, p. 18)

Services to assist people affected by problem gambling (individual gamblers, their families and communities) need to go beyond psychological or financial counselling to address the multitude of contributing factors which precipitate different experiences of problem gambling. It is encouraging that gambling support services in Victoria, for example, will be located in community centres with a range of health and social professionals. (McMillen sub. 223, p. 7)

In Tasmania, the Gambling Support Program is located within the Department of Health and Human Services. In Victoria, gambling services sit outside the health department, but are co-located with other health and community services. Victoria has also sought to better integrate gambling help services with the broader health and care sector, via Primary Care Partnerships (PCPs) and Integrated Health Promotion (IHP).

Working within PCPs enables Gambler's Help to liaise with relevant agencies in a cohesive and coordinated way so that problem gamblers receive a seamless and integrated service. Service coordination elements include initial contact, initial needs identification, assessment and care planning.

... IHP provides a framework for achieving collaborative partnerships across sectors that can facilitate the delivery of individual and population wide health promotion interventions for problem gamblers. (Victorian Government, sub. 205, p. 79)

Central to this collaborative approach is alignment of practices, process, protocols and systems, including the collection of a consistent set of information and the use of secure electronic systems to share consumer health and care information between agencies (box 7.4).

But, as noted by the Victorian Government, clients with complex needs are unlikely to seek specialist problem gambling services due to the level of disability experienced and referral to help services tends to result in non-attendance and/or early drop out. To address this, Victoria has also set up a specialist portfolio service program with dedicated specialist positions that work in collaboration with mental health services, alcohol and drug services and family services. The portfolio workers seek to develop strong links across services to enable greater coordination of care and the integration of specialist service responses for problem gambling clients (sub. 205, p. 81).

The Council of Gambler's Help Services, while supporting the Victorian approach, also indicated that it can be 'time consuming, complex and at times challenging', particularly where other service systems require convincing of the merits of closer collaboration (sub. DR326, p. 13). Measures aimed at facilitating more integrated care need to be evaluated in terms of improved outcomes for clients and earlier presentation to help services.

Box 7.4 The Victorian Primary Care Partnership Strategy

The Victorian Primary Care Partnership Strategy is focused on building relationships between agencies, better co-ordination and an integrated approach to health promotion. Membership of PCPs include hospitals, community health, local government, divisions of GPs, mental health, drug treatment and disability services. Central to achieving better coordination of services is the use of secure electronic systems including:

- Service Coordination Practices — the manual gives service providers agreed sharing practices for coordination of services and sharing of consumer health and care information.
- Service Coordination Tool Templates are used to document consumer information, identify consumer needs, coordinate care planning and make referrals.
- Agencies are able to access information about other services using electronic service directories.
- Electronic referral means that, with consent, consumer health and care information can be shared quickly and securely.

Source: www.health.vic.gov.au/pcps/about/index.htm#strategy

Given that a significant proportion of clients with gambling problems present with multiple needs, and those with the most complex needs typically present to other services, establishing strong relationships between specialist problem gambling services and other health and community services is critical. Aligning practices, processes and protocols between specialist gambling services and other health and community services is also likely to strengthen partnerships and the co-ordination of clients care. As such, dedicated funding should be provided to gambling help services to facilitate ‘formal’ partnerships with mental health services, alcohol and drug services and family services and enable individually tailored integrated treatment for clients (irrespective of where clients present for help).

Partnerships between counselling services and venues

Partnerships between counselling services and venues could also be strengthened. Given that people experiencing problems with their gambling are most likely to be found in venues, this is an obvious place to be providing gamblers with information about counselling. Garvin from Star City Casino suggested that observing people’s behaviour is more effective than brochures and signs:

Brochures, signs on the wall, et cetera, aren’t necessarily the best way to cut through. The best way is to observe behaviour and make direct contact, and then offer the

assistance that people need. (New South Wales Problem Gambling Roundtable, 2008, p. 16)

The industry has sought to better equip venue staff to identify problem gamblers and provide them with appropriate information about help services (chapter 12). The national principles for the conduct of responsible gaming machine activity in clubs and hotels state that information and support should be provided to patrons seeking help and those that have been identified by staff as potentially having a problem with gambling. Also that:

- venues should act promptly to assist persons to self-exclude if requested
- venues should display problem gambling help information in the gambling area and venue more broadly
- venues have a responsibility to train their staff in problem gambling issues
- specifically trained contact officers should be available in venues to provide referral information or assist with undertaking exclusion
- venues should monitor suspected problem gamblers and take reasonable steps to offer them assistance
- venues should not knowingly allow problem gamblers to gamble in their venues (MCG 2009b).

While venues are required to ‘monitor suspected problem gamblers and take reasonable steps to offer them assistance’, there are no penalties or consequences for ‘knowingly’ allowing problem gamblers to continue to gamble in venues. The Hunter Council on Problem Gambling said:

Occasions of contact with the local gambling industry (eg Clubs and hotel managers, venue staff) have suggested that there is an attitude amongst some in the industry that gambling treatment services are a threat to their business and revenue. This leads us to wonder if the responsibility, awareness and commitment for responsible gambling practices is truly being communicated, supported and displayed by all staff within gambling venues. (sub. 111, p. 4)

Nevertheless, inaction by venue staff may often reflect the difficulties with intervention in cases of suspected problem gambling. This was supported by first hand experiences of the Commission. Visits were made to several venues to understand gaming machines better and to observe venue environments and player behaviour. People were observed displaying behaviours typical of problematic play (as identified by Delfabbro). However, given certain aspects of those behaviours in some cases, there would have been a risk to venue staff and other patrons from immediate intervention. That said, such gamblers may be more approachable at particular times/places, such as when at the cashier or claiming a cheque.

In addition, Delfabbro, while acknowledging the difficulties associated with identifying and approaching gamblers in venues, noted that:

There is nothing to prevent staff members from providing information, advice, or support to patrons in an informal way, e.g., information packs could be provided to all gamblers in the venue whether they were showing warning signs or not, or staff members could post promotional information on notice boards that draws attention to the warning signs. ... Such information packs could include short gambling checklists such as the 8 Screen or SOGS, and counselling referral information, including the availability of counselling services on-site. (2008b, pp. 172-173)

The issue of incentives and challenges for venue staff to intervene is discussed further in chapter 12.

There is evidence that some clients learn about counselling services in the venues. Client data for G-line (New South Wales) shows that the most common means of learning about the help line is gambling venue notices/stickers. G-line was also the most commonly reported 'recent referral source' for government-funded counselling services in that state accounting for around 22 per cent of referrals in 2007-08. In Queensland around 8 per cent of callers to Gambling Help Line in 2007-08 nominated poster/venue notices as the source of referral and around 3 per cent said gaming venue/casino staff. Around 8 per cent of clients of counselling services in Queensland nominated venue staff as a source of referral of help services (appendix J).

Counsellors and community educators taking a more proactive approach in venues could be better than relying solely on venue staff to make information available. Counsellors do not face the same disincentives to intervene as venue staff. As one client of a counselling agencies said:

I would like counsellors to be more available when I felt I needed help (at the club). I would have sought help sooner. (PC survey of clients of counselling services)

There would appear to be value in involving problem gambling counsellors in interviews with individuals seeking self exclusion. This may improve formal help seeking and, where the gambler does not want formal help, there may be opportunity to provide brief intervention and self-help material (as discussed later there is some evidence that these work). Blaszczynski et al. (2007, pp. 60), while acknowledging that self exclusion does not constitute a formal treatment intervention, noted that it 'can be used to provide a gateway and referral pathway for adjunctive treatment'. They also pointed out the importance of an appropriate assessment being undertaken at the time a self-exclusion order is sought:

Gaming operators invested with the authority to complete a self-exclusion order in consultation with the gamblers generally do not have formal qualifications in behavioural health sciences or the requisite skills to undertake a competent clinical

assessment of the psychological status, specific needs of the gamblers, or the capacity to identify and respond to suicidal risk. Thus there is an imperative need for competent and comprehensive clinical assessment complementing the formal administrative/legal requirements to be conducted at the point of initiating self-exclusion. (p.65)

Under a pilot program in Victoria, gambling help staff attended self-exclusion interviews and assisted in the management, monitoring and ongoing support of people choosing to exclude from gaming venues. Around 60 per cent of those participating in the pilot elected to use the treatment pathway services. Self-help materials were provided to those not wanting to engage in formal help services. Betsafe also said that they had found referrals by gaming venues at the time of self exclusion to be an effective means of promoting counselling services to problem gamblers (sub. DR345, p. 2).

Funding for counselling and treatment services should allow for counsellors/community educators to take a proactive role in venues in conjunction with venue management, including being involved in interviews with gamblers seeking self exclusion, as this could facilitate earlier help seeking. Counsellors could also provide brief interventions and self-help material to people who do not want to engage in formal help services.

Lessening the stigma attached to having a gambling problem

On-line self-help services and internet therapy are strategies for getting around the reluctance of problem gamblers to seek face-to-face help for their problems with gambling. Further advantages of internet therapy are that clients can access counselling at any time or place convenient to them and such interventions are likely to be more attractive to young people. As noted by Monaghan, minimal therapist input is required and the limited evidence suggests that it is an effective form of treatment for people who would not otherwise have sought formal help:

Internet therapy has emerged as a new and innovative treatment option that enables clients to access a cognitive-behavioural therapy program, with minimal therapist input, at any time and place convenient to them. Although evidence in the field of Internet therapy is scarce, a review of the literature is being completed by myself and Professor Alex Blaszczynski, which suggests that this may be a very effective treatment intervention that is appropriate for those who would not otherwise seek treatment. (sub. 58, p. 6).

There is some evidence that problem gamblers will use interventions that do not require direct contact with a counselling agency (including computerised expenditure summaries and self-help books). In a study of 50 people using an online support group (known as 'GAweb'), 70 per cent said they had previously avoided

attending face-to-face programs because of concerns related to stigma. And, those in the group who were not attending a treatment program or Gamblers Anonymous appeared to have higher levels of concern about stigma than those receiving formal help (Cooper 2004).

In late 2008, the Ministers from each Australian jurisdiction signed a Memorandum of Understanding to undertake a three year trial of a national on-line gambling counselling service. The national on-line 24 hour gambling counselling service recently began operating (end of August 2009, www.gamblinghelponline.org.au). The new online program offers both live counselling and email support. The use of national on-line counselling services should be monitored and the program evaluated. On-line counselling is discussed further in chapter 15.

Some participants noted that the ‘label’ given to help services can influence whether people experiencing problems with gambling seek help.

... if you advertise yourself as a gambling counsellor, you will not see people. ... If you advertise yourself as a men’s group, you will get the people. (Exodus Men’s Group, trans., p. 208)

... people could come through the door of a community health centre and they could be there for anything. (The Gambling Impact Society of NSW, trans., p.129)

Given the stigma associated with experiencing problems with gambling, the labelling of help services could indeed make a difference to whether or not people experiencing problems use help services. Victoria has a ‘no wrong door’ approach to help services (expanding service reach with alternative access strategies). They offer problem gambling counselling and financial counselling, group work, on-line self help and self exclusion programs (Victorian Government, sub. 205).

Placement of help material also matters

Where gambling help service material is placed within venues also matters. Visits to venues by Commission staff found that it was not unusual for help service material to be only placed in prominent locations within venues (such as the front counter), although in some venues pamphlets and contact cards about help services were more discretely located (such as in bathrooms). A recent evaluation of gambling warning signs in Queensland found that a high proportion of survey participants recalled seeing help posters in bathrooms at gambling venues (see chapter 8). Locating information on gambling help services discretely would be more effective, would not impact on the recreational gambler and involve no additional cost.

Encouraging recovery without formal treatment

While not a lot is known about the ‘natural recovery’ of problem gamblers, what is known is that:

- more people experiencing problems *do not* seek formal help than those who do
- greater problem severity and co-existing problems increase the likelihood of using treatment. Natural or untreated recovery is the pathway chosen by gamblers with less severe problems (Hodgins and el-Guebaly 2000, Toneatto et al. 2008 and Suurvali et al. 2008)
- people experiencing problems with gambling can recover without professional treatment. Slutske (2006), for example, using data from two large US surveys, found that around one-third of gamblers recovered without formal treatment (box 7.5). As Suurvali et al. (2010) said ‘formal treatment ... is not a prerequisite for resolution, even among gamblers with severe problems’.

Given the importance of natural recovery, it is essential that those gamblers who choose to resolve their own problems have access to self-help material and support. The evidence suggests that self-help material and brief treatments can indeed be effective in reducing the severity of gambling (box 7.6).

Self-help and brief interventions are less expensive than extended periods of counselling and likely to appeal to a much wider group of problem gamblers. Such interventions also have the advantage of avoiding the perception of stigma associated with dealing with others. As Hodgins, et al. said:

For individuals not willing to seek formal treatment, brief interventions may be an attractive and nonthreatening effective alternative. Moreover, they are easily adopted for use by telephone gambling helpline service to provide immediate help for callers and are relatively inexpensive and time efficient. Materials can be readily provided to problem gamblers in remote areas without gambling treatment resources. (Hodgins et al. 2009, p. 950)

Relationships Australia SA also indicated that self-help approaches can bring people to formal treatment or counselling:

Self-help approaches (such as ‘bibliotherapy’, self help kits, or literacy tools) not only resolve problems in many cases but for some people act as engagement strategies to bring them into direct treatment or counselling. We would like to see more materials specifically for partners and friends of problem gamblers to assist them to encourage their loved one beyond the pre-contemplation state to actually accessing help. (sub. DR416, p. 2)

Box 7.5 Recovery without formal treatment

The few studies that have looked at 'natural recovery' have found that many people experiencing problems with gambling recover without formal treatment from counsellors.

- One Canadian study found that four out of six people reporting gambling problems recovered without treatment (Hodgins et al. 1999).
- A more recent US study looking at the rates of recovery, treatment seeking and natural recovery, found that 36-39 per cent of individuals with DSM-IV pathological gambling disorders in two large and representative surveys (the Gambling Impact and Behaviour Study and the National Epidemiological Survey on Alcohol and Related Conditions), had not experienced any gambling-related problems in the past year, even though only 7-12 per cent had ever sought either formal treatment or attended Gamblers Anonymous. The author concluded that:

The finding that roughly one-third of individuals with a history of pathological gambling recover from the problems suggests that pathological gambling does not always follow a chronic or persisting course. (Slutske 2006, p. 301)

- The most common pattern found in the National Epidemiological Survey, characterised by just over 60 per cent of pathological gamblers was one episode of problem gambling lasting one year or less, although some gamblers reported several episodes of problem gambling across their lifetime.
- Another recent study found that untreated recovery defined the pathway chosen by the moderate or mild problem gamblers and this group more closely resembled the behaviourally conditioned problem gambler. Recovering gamblers were found to employ strategies that were generally practical, problem-focused and cognitive-behavioural in nature, including avoiding gambling venues, adopting gambling-incompatible lifestyles, reducing access to money and recall of gambling-related negative consequences. The authors concluded that:

The development of easily accessible resources (e.g. books, tele-counseling, manuals, work-books, online, CDs/DVDs, chat rooms) for gamblers interested in self-recovery may be necessary to assist the vast majority of problem gamblers, who will never seek formal or professional assistance. (Toneatto et al. 2008, p. 119).
- A review of five prospective studies of gambling behaviour among non-treatment samples found *no* evidence to support the assumptions that:
 - individuals cannot recover from disordered gambling
 - more severe gambling problems are less likely to improve than individuals who have less severe gambling problems
 - individuals who have some gambling problems are more likely to worsen than individuals who do not have gambling problems.
- The authors concluded that 'individuals with some gambling problems experience considerable movement in and out of more severe and less severe levels of gambling disorder, and, often, considerable movement out of more severe levels without a return to those levels' (LaPlante et al. 2008, p. 59).

Box 7.6 Some evidence that self-help and ‘brief treatments’ work

Self-help methods have been proven to be effective in reducing the severity of gambling.

- A study comparing gamblers provided with a self-help manual with a group provided with the manual plus a telephone interview found that the manual only group reduced their weekly gambling sessions and weekly dollars wagered for six months after receiving the manual while the manual-plus interview group showed the reduction for only three months (Dickerson et al. 1990).
- Hodgins et al. (2001), comparing outcomes of a group that received a self-help book with a group that received a self-help book and a motivational interview, found that at the 12 months follow-up there were no significant group differences. In both groups, 25 per cent of gamblers reported abstinence and an additional 58 per cent reported a significant reduction in their gambling.
- A 24 month follow-up of the same groups found both groups doing well — 77 per cent were improved and 37 per cent reported 6 months of abstinence. The motivational intervention group, however, were found to have gambled fewer days, lost less money and had lower South Oaks Gambling Screen scores compared with the group just receiving the workbook (Hodgins et al. 2004).

There is also some evidence that the length or intensiveness of treatment may not be important in terms of outcomes. A recent randomised trial of brief interventions (Petry et al.), where problem gamblers were assigned either to assessment only, 10 minutes of brief advice, one session of motivational enhancement therapy (MET) or one session of MET plus three sessions of cognitive behavioural therapy — found that relative to assessment only, brief advice was the only intervention that significantly decreased gambling behaviour between baseline and week six. Brief advice was also associated with clinically significant reductions in gambling at nine months. The authors concluded:

These results suggest the efficacy of a very brief intervention for reduction of gambling among problem and pathological gamblers who are not actively seeking gambling treatment. (2008, p. 318)

While such interventions are currently available — for example, the new national online gambling help service provides self-help material and email support — there would appear to be scope to further develop and promote these options. The Council of Gambler’s Help, while seeing merit in self-help options, also argued that the ‘comprehensiveness and level of sophistication of many current approaches merits close attention’ in order to maximise positive outcomes (sub. DR326, p. 11).

Health professionals, counsellors and venue staff could refer gamblers not only to face-to-face counselling, but also make them aware of other help options. Awareness campaigns promoting help services could also promote the full range of help options available.

Where does that leave us?

Given that only a small share of people experiencing problems with gambling seek professional help, and most clients have either ‘hit rock bottom’ (or are coming close) when they seek help, there is a compelling case for interventions to cover prevention and early intervention activities and not just focus on ‘treatment’.

The available evidence suggests value in governments placing greater emphasis on community awareness about gambling to educate the community and encourage earlier help-seeking and interventions by family and friends. Improving knowledge around screening and developing stronger pathways for referral and relationships between problem gambling services and other health and community services is also likely to facilitate earlier intervention. The evidence also suggests that people experiencing problems with gambling can recover without professional help. Relatively low cost interventions have the capacity to increase self recovery.

RECOMMENDATION 7.1

Building on existing initiatives, governments should:

- *work to establish stronger formal linkages between gambling counselling services and other health and community services, including by:*
 - *ensuring that health professionals and community services have information about problem gambling and referral pathways*
 - *providing a one-item screening test, as part of other mental health diagnostics, for optional use by health professionals and counsellors. Screening should be targeted at high-risk groups, particularly those presenting with anxiety, depression, high drug and alcohol use*
 - *providing dedicated funding to gambling help services to facilitate formal partnerships with mental health, alcohol and drugs, financial and family services*
- *promote self-help and brief treatment options, as such interventions can be cost-effective ways of achieving self-recovery of people experiencing problems with gambling*
- *place greater emphasis on campaigns that (i) dispel common myths about gambling and tell people how to gamble safely (ii) highlight potential future consequences (financial losses, relationship breakdowns) associated with problem gambling and (iii) make the community aware of behaviours indicative of problem gambling, to encourage earlier help-seeking or interventions by family and friends.*

7.2 Effectiveness of treatment and support

What treatments for problem gambling?

A number of different factors are thought to come into play in how and why people develop gambling problems. The main theoretical models for understanding problem gambling include the mental disorder or medical addiction model, cognitive, behavioural and escape theories of gambling, and problem gambling as a social problem. Three treatment modes emerge from these theoretical models:

- The *medical model*, which sees problem gambling as an addiction, or as an impulse-control disorder which needs to be treated as an illness.
- The *behavioural model*, which interprets gambling as a learned behaviour, motivated and/or reinforced by the personal experiences and social context of the gambler. The treatment focus is on ‘unlearning’ bad habits and learning how to minimise the harm arising from gambling through controlled gambling.
- The *cognitive model*, which posits that problem gambling behaviours can be explained by irrational beliefs and attitudes about gambling. The gamblers think erroneously that they will win money and recoup losses despite personal experience. Problem gamblers have heightened expectations of winning and illusions of control over the outcome of a game (Jackson et al. 2003, IPART 2004).

There has been a move away from focusing on one aspect of gambling behaviour towards diverse approaches to explaining how and why gambling problems develop. Blaszczynski and Nower said:

At the moment, there is no single conceptual theoretical model of gambling that adequately accounts for the multiple biological, psychological and ecological variables contributing to the development of pathological gambling. (2002, p. 487)

Blaszczynski and Nower’s (2002) pathways model of problem and pathological gambling seeks to integrate the complex array of biological, personality, developmental, cognitive, learning theory and ecological determinants of problem and pathological gambling. It contends that there are three distinct subgroups of gamblers manifesting impaired control — behaviourally conditioned problem gamblers, emotionally vulnerable problem gamblers and antisocial, impulsivist problem gamblers. The model further assumes that the different subtypes require different types of interventions:

From a clinical perspectives, each pathway contains different implications for choice of management strategies and treatment interventions. (Blaszczynski and Nower 2002, p. 496)

The main therapeutic approaches used for problem gambling include behavioural therapy, cognitive therapy and cognitive-behavioural therapy (CBT). Other approaches include pharmacotherapy and brief interventions. Multimodal approaches to treatment are commonly used. Shaffer and Korn said:

Although it has unique elements, pathological gambling has many signs and symptoms shared with other disorders (e.g. anxiety, depression, impulsivity), consequently, disordered gambling is best thought of as a syndrome. From this perspective, the most effective treatments for gambling problems will reflect a multimodal ‘cocktail’ approach combined with patient-treatment matching. These multidimensional treatments will include combinations of psychopharmacology, psychotherapy, and financial, educational and self-help interventions, such treatment elements are both additive and interactive to deal with the multidimensional nature of gambling disorders. (2004, p. 198)

Overall, the evidence suggests that there are subtypes of gamblers with varying treatment needs. This is reflected in a variety of treatment techniques employed by counsellors (box 7.7). A survey of Victorian counsellors (Jackson et al. 2000) found that 83 per cent adopted an eclectic approach. The Commission’s 1999 survey of counselling services found that a high proportion of agencies used cognitive and CBT techniques.

What works?

As counselling and treatment support are the main interventions for people experiencing problems with gambling, a key policy issue is whether the interventions work. Do they have a positive effect on gambling behaviour? Are some interventions more effective than others? This section looks at what is known about the efficacy of the various support and treatments for problem gambling from the literature.

The evidence base on what makes for effective treatment of problem gambling is not strong. Toneatto and Ladouceur, reviewing the literature of treatment for pathological gambling, said:

Although the history of gambling treatment extends for several decades, there is a surprising lack of reliable knowledge of what constitutes effective treatment for problem gambling. (2003, p. 284)

In part, this is because many of the studies of gambling treatment outcomes suffer from methodological flaws, including:

- small sample sizes

-
- poorly-defined criteria and procedures for the inclusion of gamblers into treatment programs
 - varying levels of motivation among treatment populations, making generalisation of results problematic
 - a lack of standardised measures for gambling diagnostic criteria and outcomes measures
 - variable training of counsellors
 - treatments involving multi-disciplinary approaches (particularly where there are issues of co-morbidity). It can be difficult to distinguish between impacts of primary interventions when other interventions are being used simultaneously
 - lack of clear outcome measures (abstinence, reduced gambling)
 - variations in follow-up intervals (many studies cover relatively short periods, three-six months after treatment) and a lack of long-term outcome data (Walker 2005, Blaszczynski 2005, Battersby et al. 2008).

Box 7.7 Counsellors employ a variety of treatments

South Australian Government

The Statewide Gambling Therapy Services provides treatment using a CBT approach and a graded exposure program to treat people with gambling problems. This approach enables clients to overcome their urge to gamble and return to a normal life without gambling. ... Cognitive therapy is usually offered in combination with behavioural strategies including problem solving, social skills training, self-monitoring and stimulus control. (sub. 225, p. 48)

Tasmanian Government

Counselling is based around cognitive behavioural therapies although counsellors can utilise other therapies they deem appropriate. (sub. 224, p. 34)

Jackson et al.

The review of Gambler's Help program counselling practice and theories in use revealed that a broad range of theoretical perspectives underpin the delivery of the Victorian problem gambling program. Counsellors incorporate a variety of therapeutic strategies and theoretical perspectives to inform their counselling practice with problem gamblers, with the majority of counsellors adopting an eclectic approach to counselling. (2003, p. 7)

Psychological treatment

Most gambling treatment outcomes studies, irrespective of the type of treatment provided (behavioural, cognitive, or a combination of treatment) report that the majority of people receiving treatment respond to and benefit from treatment (with abstinence or controlled gambling). Pallesen's meta-analysis review of

psychotherapeutic treatments of pathological gambling (covering 22 studies involving 1434 subjects) concluded that:

The results from the present meta-analysis indicate that psychological interventions for pathological gambling are associated with favourable outcomes, both on a short-and long-term basis, and that the results seem robust. (Pallesen et al. 2005, p. 1421)

Treatment is also often reported to be accompanied by more general improvement in psychosocial functioning (Jackson et al. 2003). What is less clear is for how long clients benefit from treatment. That said, the studies generally show that the probability of relapse increases with time. It is also unclear how treated clients compare with comparable problem gamblers who do not receive professional treatment.

There is a lack of evidence from randomised clinical trials with good follow-up assessments. As Delfabbro, commenting on the quality of evaluations of gambling treatments puts it:

Very few meet the gold standard criteria set out by the American Psychological Association; namely, the use of a randomised design with a control group. (2008b p. 186)

Reviews of the controlled treatment literature (Pallesen et. al 2005, Oakley-Browne et al. 2000, Toneatto and Ladouceur 2003, Toneatto and Millar 2004, Korn and Shaffer 2004), while noting methodological flaws in many of the studies, find behavioural interventions (imaginal desensitization strategies) and cognitive-behavioural interventions to be effective treatments for problem gambling in the short term (table 7.2). The best evidence and support, however, is for cognitive-behavioural treatment approaches (even when it is delivered via manuals and involving only minimal therapist contact, Toneatto and Ladouceur 2003). The results on CBT for gambling are consistent with the evidence for the efficacy of CBT for other clinical conditions.

That said, most of the studies using controlled interventions have been for cognitive and behavioural therapies. As Korn and Shaffer said:

... the existing randomized clinical trials have limited their focus to cognitive and behavioural therapies. ... the absence of a randomized trial does not mean that other treatment approaches have little or no utility. Rather, this evidence simply is the best available research supporting these methods. (2004, p. 17)

Table 7.2 Reviews of psychotherapeutic and pharmacological treatments of pathological gambling

<i>Study</i>	<i>Method</i>	<i>Findings</i>
Pallesen, et al. (2005)	A quantitative meta-analytical review of psychotherapeutic treatments of pathological gambling. 22 studies including involving 1434 subjects.	At post-treatment, psychological treatments were found to be more effective than no treatment, an overall effect size of 2.01. At followed-up (averaging 17 months), the corresponding effect size was 1.59. Effect sizes were found to be higher in randomised controlled trials.
Oakley-Browne, Adams and Mobberley (2000)	4 randomised controlled trials of psychological treatments were identified (Echeburúa, Baez, & Fernandez-Montalvo 1996, McConaghy, Blaszczyński & Frnakova, 1983, McConaghy et al 1988, Sylvain, Ladouceur & Boisvert, 1997). The data were entered into the Cochrane Review Manager software. Relative risk analyses were conducted for the dichotomous outcome of controlled vs. uncontrolled gambling.	The experimental interventions, behavioural or cognitive behavioural therapy were found to be more efficacious than the control interventions in the short term (relative risk 0.44, 95 per cent confidence interval 0.24-0.81). Also long-term treatment with BT/CBT to be more efficacious than the control treatments, but statistical significance sensitive to statistical model used for meta-analysis.
Petry, et al. (2006)	Randomly assigned gamblers to 3 groups (1) referral to Gamblers Anonymous (GA), (2) GA plus a CB workbook, (3) GA + 8 sessions of individual. Assessments at baseline, 1, 2 (post treatment), 6 and 12 months later. Large sample (n=231), reasonable follow-ups.	Gambling reduced in all 3 groups, but benefits of CBT emerged both during the treatment with some effects maintained through follow-up. Individual CBT improved some outcomes compared with CB workbook.
Toneatto and Ladouceur (2003)	Criteria was randomisation to an experimental group and at least 1 control group, included 11 studies.	Cognitive-behavioural studies received the best empirical support.
Toneatto and Millar (2004)	Review of controlled clinical trials where subjects were randomised to either psychological or pharmacologic treatment.	Cognitive-behavioural and pharmacological treatments possibly efficacious, but specific treatment modality still limited. Cognitive-behavioural treatments found most effective. Found no compelling evidence for the efficacy of any drug except naltrexone.
Pallesen et al. (2007)	Qualitative review on studies of pharmacological interventions from 1966-2006. 16 studies met criteria, total of 597 subjects.	Pharmacological interventions found more effective than no treatment, overall effect size of 0.78% (95% CI 0.64-0.92). Effect lower in studies using placebo/control conditions. No differences in outcome between antidepressants, opiate antagonists, mood stabilizers.

Some recent studies, however, have found conflicting results with CBT failing to produce superior outcomes compared with other less costly methods such as gamblers anonymous and brief interventions (Toneatto and Dragonetti 2008).

Treatment with medication

The pharmacological approach to treating gambling problems is relatively new and includes three main classes of drugs: opiate antagonists (naltrexone and nalmefene); antidepressants and mood stabilizers. A recent meta-analysis involving 16 pharmacological treatment studies found that pharmacological treatments were more effective than no treatment/placebo (Pallesen et al. 2007). The magnitude of effect sizes at post-treatment, however, was found to be lower in studies using a placebo-control compared with those without controls. No differences in outcomes between the three classes of drugs were found.

While the authors concluded that pharmacological interventions for pathological gambling ‘may be an adequate treatment alternative in pathological gambling’, they also noted that psychological interventions appear to yield greater improvements than pharmacological ones (overall effect size of 0.78 for pharmacological treatments compared with 2.01 for psychological interventions, Pallesen et al. 2005, p. 357). But, because of differences in the use of control conditions and the outcome measures between non-pharmacological and pharmacological treatment studies, the authors concluded that it was unclear whether non-pharmacological treatments were really more effective than pharmacological treatments for pathological gambling (Pallesen et al. 2007).

FINDING 7.1

Gambling treatment outcome studies report that, irrespective of the type of treatment provided, most clients benefit. Although cognitive behavioural therapy is the approach with most empirical support, no one style of intervention can yet be recommended as best practice.

Outcomes from government-funded gambling counselling services

While limited, client outcome data collected from gambling counselling services show that the majority of people who seek formal help are able to better manage their gambling problems following counselling and treatment. For example, telephone follow-up surveys conducted by G Line (New South Wales) of clients of counselling services found the proportion of respondents saying they ‘can now manage their gambling’ in the affirmative to be 84 per cent at one month,

93 per cent at three months and 90 per cent at six months. Results from a number of counselling agencies in New South Wales also show significant decreases in clients' involvement in gambling, and in gambling-related problems, following treatment. The following are two examples:

- The University of Sydney Gambling Treatment Clinic (therapy is an intensive form of cognitive therapy involving 10 one hour sessions on average) reported the following outcomes, based on a sample of 190 problem gamblers treated by counsellors:
 - 54 per cent of clients were abstinent from gambling
 - 94 per cent of clients had decreased gambling significantly
 - 100 per cent of clients no longer met DSM-IV criteria for pathological gambling.

These results were maintained for two years after treatment and were based on data for the 60 per cent of clients that could be followed up (RGF 2008).

- Follow-up data collected by the Hornsby Drug, Alcohol and Gambling Services, in relation to gambling clients seen between October 2005 and November 2006 — at an average of nine months after initial presentation — found that:
 - SOGS scores had reduced from 9.61 to 3.75
 - average weekly gambling expenditure had fallen from \$1677 to \$262
 - there was an improvement in measures for depression (5.6 to 3.5), anxiety (5.6 to 4) and stress (6.8 to 4.4) (New South Wales Government, sub. 247).

Results from an earlier longitudinal evaluation of the Gambler's Help program in Victoria, also found high resolution levels among clients — the number of 'pathological gamblers' falling from 76 to 37 per cent (box 7.8).

FINDING 7.2

Outcome and client follow-up data for support services, while limited, show significant decreases in clients' involvement in gambling and their gambling-related problems following treatment.

Box 7.8 Some evidence from counselling and treatment services

A Longitudinal Evaluation of the Gambler's Help program in Victoria found:

- 43 per cent of clients had full or satisfactory resolution levels (clients received the highest level of full problem resolution in relationship and physical health problems)
- 46 per cent of clients experienced partial problem resolution
- 71 per cent of clients felt attending counselling impacted on their gambling in a positive way, 45 per cent indicated the impact as 'a great deal'
- the mean number of counselling sessions attended was low — 2.32 for non-resolved primary problem, 3.47 for partially resolved, and 4.15 for fully resolved
- 69 per cent rated their emotional wellbeing as being 'very poor' when commencing counselling; 78 per cent rated themselves as 'very good' at the end of counselling
- counselling had a positive effect on maladaptive behaviours — on the DSM-IV criteria for pathological gambling between 21-29 per cent improvement on clients in 8 of the 10 behaviours. The number of 'pathological gamblers' reduced from 76 to 37 per cent according to pre and post counselling measures
- the therapeutic relationship was the process variable that most consistently predicted positive outcomes (Jackson et al. 2000).

A more recent Victorian study (New Focus Research 2004) found that of the problem gamblers who sought help:

- 90 per cent were satisfied with the service. Between 88-95 per cent were satisfied with the ease of contacting the service, the frequency of contact provided, the waiting time and length of sessions and treatment
- the factors that made the service effective were thought to include the availability of group and individual counselling, ease with which counsellors could be contacted in an emergency, and the quality of the relationship with the counsellor.

7.3 Counsellors' qualifications and service standards

The effectiveness of counselling and treatment services obviously also depends on the training and experience of counsellors. Some participants raised concerns about the qualifications of problem gambling counsellors and variability among counsellors in their knowledge about the nature of gambling activities and technologies. For example:

Many counsellors are holding minimal qualifications. The counselling field of problem gambling has attracted those from a range of welfare sectors and whilst not belittling their interest or expertise in the welfare sector this area of work requires considerable skills in working with mental health, and other co morbid issues. It is not an area of

work for those with minimal qualifications or skills and the failure to recognise this places both staff and clients at risk. (Roberts, sub. 89, p. 2)

Counsellors providing gambling treatment services have a range of qualifications — from diploma to postgraduate qualifications in social work, mental health, drugs and alcohol, psychology and psychiatry. Some counsellors also have specific training in problem gambling.

Because of high co-morbidities among people experiencing problems with gambling, counsellors need skills in clinical diagnosis. The Gambling Treatment Program, St Vincent's Hospital said, 'complex presentations require specific interventions delivered by appropriately qualified health professionals' and training should be at the level of a clinical psychologist so that individually tailored integrated treatment programs can be offered to clients (sub. DR331, p. 1). The University of Sydney Gambling Treatment Clinic, in a submission to the IPART report, also argued that 'best practice' involves employing clinical psychologists in the treatment of problem gambling (box 7.9).

Base level training for counsellors, however, need not include specific training in gambling. Given the key role that counsellors play in correcting misconceptions that problem gamblers may have, it would seem essential that counsellors understand how gambling works. As Abbott et al. said:

Whilst most of the cognitive-behavioural techniques used in the treatment of problem gambling are shared with other addiction treatment approaches, treatment of problem gambling does include some unique elements. (2004, pp. 21-22)

This suggests that counsellors providing gambling help services (regardless of their base level qualifications) should also have a minimum level of training specific to problem gambling. A Massachusetts think tank (Massachusetts Council on Compulsive Gambling 2001) concluded that entry level staff should have problem gambling specific training regardless of other credentials. A further suggestion was a requirement of at least 24 hours of relevant gambling-specific continuing education every two years.

Some states and territories already have in place a minimum level of training specific to problem gambling. New South Wales, for example, has recently developed a minimum qualification — the Diploma of Problem Gambling Counselling — for problem gambling counsellors working in Responsible Gambling Fund (RGF) funded services. The Diploma consists of 13 units that are nationally accredited general community service competencies and 3 specially developed problem gambling competencies. In September 2008, the Diploma of Problem Gambling Counselling was accredited for five years by New South Wales Vocational Education and Training Accreditation Board.

Box 7.9 Comments on the appropriate qualifications for counsellors

Gambling Treatment Program, St Vincent's Hospital

While some anxiety and depression may respond to therapy offered by generalist gambling counsellors, more complex presentations may require specific interventions delivered by appropriately qualified health professionals. Poorly informed treatments, no matter how well intentioned, can occasionally exacerbate mental health problems. It is vital that treatment for vulnerable individuals who have sought to escape their problems by gambling is provided by those who are suitably qualified such as Clinical Psychologists or Psychiatrists. The addition of a few mental health units in the minimum qualifications for problem gambling diploma is no substitute for the extensive training involved in post-graduate mental health qualifications. (sub. DR331, p. 1)

The University of Sydney Gambling Treatment Clinic

Since many individuals with gambling problems also have other clinical problems, it is essential to assess the nature of these problems and to determine whether the gambling is the primary problem or secondary. Accurate clinical diagnosis depends on supervised training of the kind provided in postgraduate clinical psychology programs. (Walker et al. 2003, pp. 9-10)

Clubs Australia

A key requirement for counsellors should be an understanding of co-morbid disorders (depression, drug and alcohol dependency, mental disorder) and how those conditions manifest as problem gambling. Counsellors must also be empowered to make interventions if required. This additional power should only be granted to individuals who are qualified and accredited to determine which interventions are appropriate. (sub. DR359, p. 29)

Council of Gambler's Help Services

The Council is concerned that a low entry requirement to this field as accepted in some jurisdictions may not be appropriate. A minimum undergraduate degree with relevant experience and preferably a post graduate qualification with relevant experience should be the target standard. The Council supports a stronger emphasis on service standards, and consideration of worker accreditation. (sub. DR326, p. 2)

Betsafe

Gambling counselling is challenging work that is best conducted by skilled professionals. There is a place for theoretical training, but the reality is that gambling counselling is most effective when conducted by experienced addictions counsellors who understand gambling issues. (sub. DR345, p. 3)

The RGF also funds a state-wide training service, the Centre for Community Welfare Training to provide training for workers in RGF-funded gambling counselling and support services:

The service provides gambling-specific training plus generalist courses dealing with mainstream topics relevant to the work undertaken in gambling counselling services such as 'measuring client outcomes in problem gambling services and 'cognitive therapy for excessive poker machine play'. It also provides generalist courses dealing with mainstream topics relevant to the work undertaken in gambling counselling

services such as ‘alcohol and other drugs’, ‘counselling and therapy’ and ‘management and governance’. (New South Wales Government, sub. 247, p. 66)

Victoria’s Centre for Problem Gambling Treatment and Research also provides training for new and existing staff working in gambling services (Victorian Government, sub. 205).

Many participants supported a national minimum level of training for counsellors, with a number supporting an undergraduate degree as the minimum (box 7.9). Internationally, problem gambling treatment is generally provided by counsellors who have received gambling-specific training and a graduate degree or advanced certificate in the behavioural health field.

The minimum level of training for counsellors should be based on the evidence on the efficacy of treatment based on staff qualifications. However, this is an area where the evidence base is thin. That said, given the need for clinical knowledge for the application of therapies — including the ‘unique elements’ involved in treating problem gambling — and for dealing with co-morbidities, there appears to be grounds for a level of competency training for problem gambling counsellors that is equivalent to that required in other human service areas. As pointed out by some participants, exceptions to minimum standards might be required in particular circumstances. Amity Community Services, for example, argued that:

- training should be adaptable to the needs of remotely based or culturally diverse counsellors.
- training should be made available to generalist counsellors who work with problem gamblers as well as gambling specific counsellors.
- content be tailored to meet the needs of the community the counselling is made available to. For example, remote communities may require a community development focus given that some communities may not be accustomed to utilising traditional counselling services. (sub. DR388, p. 2)

RECOMMENDATION 7.2

Governments should work together to establish a national minimum standard of training for problem gambling counsellors.

Service standards

Participants also raised questions about the service standards that are in place, suggesting that under current arrangements the result is inequitable services for clients and a lack of confidence in service competencies. The Australian Casino

Association, for example, recommended a national system of accreditation for problem gambling service providers (sub. 214).

Accreditation is an approach that is adopted in other health and community service policy areas and is aimed at achieving minimum standards of performance. As noted by IPART (2004), accreditation does not of itself guarantee quality, but it does provide a useful framework for encouraging the development of a quality culture. New South Wales is currently rolling out an accreditation system for RGF-funded counselling services (as recommended by IPART):

The purpose of the accreditation process is to ensure that a continuous quality improvement cycle is incorporated into the management and dealing of services, resulting in better outcomes for service users. ... Many funded services have achieved, or are nearing the point of achieving, accreditation with all on track to achieve accreditation by 2009. (New South Wales Government, sub. 247, p. 66)

While a number of jurisdictions have formal service standards in place, a national accreditation system would provide a consistent standard of service across Australia and a national framework for continuous improvement. A number of participants supported a national accreditation system (sub. DR355, sub. DR326), however, others saw value in allowing flexibility at the local level. UnitingCare Australia, for example, said:

... a strong relationship that allows funders and service providers to use a solution focused approach to developing improved quality of service outcomes provides the best environment to achieve high standard services.

A key concern regarding a national accreditation process is that accreditation programs need to be linked to a specific set of Standards. When considering the diversity of client groups and site locations for problem gambling support service delivery, there is the very real risk that a standards set would be based on a one size fits all approach and end up with a minimum set of service standards as opposed to encouraging and supporting services that provide an optimal response to people accessing services and local conditions and work towards a best practice approach. (sub. DR387 p. 3)

The Gambling Support Program, Department of Human Services, Tasmania also suggested that:

A national accreditation scheme would have to recognise state and territory differences in terms of legislation, industry and help services. (sub. DR370, p. 1)

A national accreditation system would also not come without costs to service providers (and ultimately tax-payers). UnitingCare Australia expressed concern that it would involve duplicate processes, something that should be avoided (sub. DR387). The Gambling Support Program, Department of Human Services, Tasmania also expressed concern about costs for generalist counsellors working with gambling clients in a small town (sub. DR370).

The Commission is of the view that the same objectives of a national accreditation system are likely to be achieved by way of funding arrangements, a national minimum level of training for counsellors, and requirements for initial assessments, evaluations and follow-ups linked to the collection of a minimum national data set (section 7.5).

7.4 Funding of gambling help services

Funding for problem gambling services generally occurs through mandatory levies and voluntary contributions. While funding arrangements for problem gambling vary, in a number of jurisdictions levies are imposed on only parts of the gambling industry (appendix J). For example:

- in New South Wales, the Responsible Gambling Fund derives its income from a levy (set at a rate of 2 per cent of the casino's gaming revenue) paid by the operator of the Sydney Casino.
- in Victoria, under the *Gambling Regulations Act 2003*, net gaming revenues from hotels with gaming machines are subject to an additional tax of 8.33 per cent. The additional tax payable by hotels does not apply to club venues provided clubs make a community benefit contribution of at least 8.33 per cent of their net gaming revenues (Victorian Government, sub. 205).

A number of submissions raised the issue of the 'narrowness' of funding sources and supported all gambling forms contributing to gambling help services:

... we suggest that all gambling venues (Clubs, pubs, TAB agencies) should be directed to contribute part of their gambling revenue to their local gambling treatment services as an acknowledgement of where this revenue comes from, and also to demonstrate recognition of problem gambling as a serious issue affecting our communities. (Hunter Council on Problem Gambling, sub. 111, p. 4)

Since 1999 there has been a commitment to provide specialist treatment services to those affected by problem gambling in NSW. This is funded from \$12 million provided by the Star City Casino revenue (2%). Unlike our neighbours in NZ, StarCity is the only contributor to this fund and all other gambling activities are not required to make contributions. (Roberts sub. 89, p.1)

In NSW, the gambling venues that most problem gamblers patronise do not contribute to the fund that finances problem-gambling treatment services. Harm minimisation measures and treatment services should be increased by spreading the cost across the industry. (The Public Interest Advocacy Centre, sub. DR389, p. 5)

Others, however, pointed to jurisdictional differences for variations in funding bases.

... different funding mechanisms have evolved in each state and territory that are appropriate for each jurisdiction. The current system works. (Australasian Casino Association, sub. DR365, p. 26)

... the EGM tax regime in Victoria that funds gambling support services cannot be equated to that in other states where clubs enjoy major advantages over hotels. The lower tax contribution in Victoria from clubs acknowledges their community services and benefits. (Community Clubs Association of Victoria, sub. DR366, p. 7)

Despite differences in the way funding arrangements have evolved in the various jurisdictions, as all gambling forms contribute to the need for problem gambling services, the whole industry should contribute to the funding of gambling counselling and treatment support services. That said, given that gaming machines are the main source of gambling problems, they should be a proportionately large source of funding, regardless of venue type.

New Zealand has a problem gambling levy, set under the *Gambling Act 2003*, to reimburse the government for the costs of delivering problem gambling services. The problem gambling levy is collected on the profits of the four main gambling operators and is calculated using rates of player expenditure (losses) on each gambling subsector and rates of client presentations to problem gambling services attributable to each gambling subsector (box 7.10).

Client presentations are considered a ‘reasonable indicator of the proportion of responsibility each gambling sector should carry for the individual harm of problem gambling’ (Ministry of Health 2009a, p. 63). The reason for also basing the levy on rates of gambling expenditure on each gambling subsector is to reflect the fact that the funding in New Zealand is not only for problem gambling treatment services, but for an integrated problem gambling strategy (based on a public health approach and including research).

... Gambling expenditure also needs to be considered. The Ministry believes that gamblers’ expenditure in each gambling sector also represents the degree of responsibility of the respective industry for the broader harm likely to be occurring in communities.

Presentations only represent a small subset of gambling harm, as they are a measure of the demand on problem gambling intervention services from each sector of the gambling industry, and tend to represent the more severe end of the problem gambling spectrum. (p. 63).

Box 7.10 Problem gambling levy — New Zealand

Problem gambling services in New Zealand are funded and co-ordinated by the Ministry of Health. The problem gambling levy is set under the *Gambling Act 2003*. The purpose of the levy is ‘to recover the cost of developing, managing, and delivering the integrated problem gambling strategy’. The problem gambling levy is collected on the profits of New Zealand’s four main gambling sectors — non-casino gaming machine operators, casinos, the New Zealand Racing Board and the New Zealand Lotteries Commission.

The levy is calculated using rates of player expenditure (losses) on each gambling sector and rates of client presentations to problem gambling services attributable to each gaming sector. The levy rates are set every three years. The Act specifies that the Ministry ‘must take into account the latest, more reliable, and most appropriate source of information’ to use in the formula for calculating the levy.

For the 2007–08 to 2009–10 levy period, a weighting of 10 per cent on expenditure and 90 per cent on presentations was applied to determine the relative shares for each gambling sector. For the 2010–11 to 2012–13 levy period the Ministry of Health proposes a weighting of 30 per cent on expenditure and 70 per cent on presentations. The Ministry of Health considers the levy rates should continue to apply a heavier weighting to presentations over expenditure because presentations are a reasonable indicator of the proportion of responsibility each gambling sector should carry for the individual harm of problem gambling occurring in New Zealand.

Levy rate = $((A*W1) + (B*W2))*C/D$, where:

- A = estimated current expenditure in a sector, divided by the total estimated current player expenditure in all sectors subject to the levy
- B = the number of customer presentations to problem gambling services that can be attributed to gambling in a sector, divided by the total number of customer presentations to problem gambling services in which a sector that is subject to the levy can be identified
- C = the funding requirement for the period
- D = forecast players
- W1 and W2 are weights, the sum of which is 1.

Source: Ministry of Health (2009a).

The forms of gambling causing greatest harm as reported by clients presenting to help services provides a reasonable basis for apportioning funding contributions by gambling forms. Most clients who call gambling helplines and access counselling and treatment support for gambling are experiencing problems with gaming machines or identify these as their main form of gambling (appendix J, tables J.3 and J.4). And, given the Commission’s support for a public health approach

(including prevention and early intervention strategies), contributions could also be based on gambling expenditure by gambling type.

RECOMMENDATION 7.3

Governments should ensure that existing funding mechanisms for gambling help services be based on greater contributions from those gambling forms found to involve the greatest social harms:

- ***with the gambling types causing greatest harm, as reported by clients presenting to help services, used as the basis for determining these contributions.***

Where funding is also used for prevention and early intervention strategies, contributions should be based on expenditure by gambling type.

The *adequacy* of funding was also a concern for some participants. For example:

... there is still very minimal funding going towards problem gambling services when compared to the taxation revenue collected by state governments. ... Counsellors have expressed concerns to me about the lack of funding available to them to service the needs of people in the community with a gambling problem. Given that so little is received by each individual service provider by way of grants, agencies often lack the resources to advertise their services in a way that adequately reaches the community. (Xenophon, sub. 99, p. 6)

And some participants considered the need to expand funds to cover prevention and early intervention measures. Relationships Australia (SA), for example, said:

... in the pool of funds currently directed to managing gambling here in SA needs to be larger to adequately meet the primary, secondary and tertiary public health needs. ... It may be that Gambling Rehabilitation Funds are directed to tertiary and some secondary responses, and that primary interventions are funded through different, Health or Welfare funding. (RASA sub. 203, p. 28)

If governments are to place greater emphasis on prevention/early intervention strategies, establishing stronger partnerships with other health and community services and developing better evaluation systems and data collections (section 7.5), additional funding for problem gambling services will be required (at least initially).

Some participants considered that there was a conflict of interest in funding arrangements.

The counsellors who treat gamblers and their families receive funding from the Responsible Gambling Fund or equivalent. Open criticism of the industry that funds their work is not likely. The counsellors prefer to work with the situation and do what they can. (David, sub. 56, p. 12)

The GRF also has a strong industry presence on its Committee — apparently to reflect the co-contribution funding arrangements. This is akin to the tobacco industry directly funding lung cancer research and having a role in the scope and direction of that research (Xenophon, sub. 99, p. 5)

Given the potential for competing incentives with industry involvement in funding arrangements, there is merit in an independent body having responsibility for the funding of counselling and treatment support services and for evaluating the effectiveness of the services (governance issues are discussed further in chapter 17).

7.5 Building a better evidence base

A better evidence base is needed to answer basic questions about the effectiveness of prevention and early intervention strategies and counselling and treatment services. Better monitoring and evaluation also ensures that government funded services are accountable, funds are appropriately allocated between prevention, early intervention and treatment activities, as well as providing a basis for future policy direction. A number of participants were also of this view (box 7.11).

The thin evidence base on the most cost-effective ways of preventing the onset and progression of problem gambling is partly because evaluating such strategies is not easy. It can take years for the benefits of social marketing campaigns to become evident and many of the benefits are manifested as a ‘non-event’ (for example, enhancing protective factors or reversing or reducing risk factors). As noted in an OECD paper on health promotion and prevention:

Medical or public health-driven preventive interventions struggle to fit into a broad health care resource allocation framework alongside curative, diagnostic and palliative interventions, because of the somewhat uncertain and distant nature of their outcomes. This places them in a league of their own and often makes governments (and, indeed, health insurance organisations) uncomfortable about diverting resources away from uses that have a more immediate and certain return, particularly in a tightly resource-constrained health care system in which it is not even possible to fund all potentially available curative interventions. (Sassi and Hurst 2008, p. 47)

Evaluations of social marketing campaigns are typically assessed by message recall and increases in the number of clients presenting for help at specialist gambling services. As noted in chapter 4, evaluations of the effectiveness of community awareness campaigns need to take into account the impact on the full spectrum of ‘harm’ and not just focus on the effects on prevalence rates of problem or moderate risk gamblers or presentations at gambling help services. While preventative measures may have a small effect at the individual level, at a population level the effect can be significant. Taking the full spectrum of harm into account in

evaluations is particularly important when comparing the cost effectiveness of prevention strategies with treatment.

Box 7.11 The need for a better evidence base — participants' views

Clubs Australia

ClubsAustralia supports community campaigns that provide information and general assistance to problem gamblers. However, it is not known to what degree such campaigns represent value for money compared with more targeted approaches. (sub. DR359, p. 28)

Counsellors should have to account for how their grant money is spent, through regular reporting with independent oversight. Such reports should detail how many people have been treated over the period, the proportion of people whose treatment is deemed successful, and other relevant information. This information could be used by government to help assess whether new problem gambling measures are effective over time, and would assist in identifying areas that are under-or-over serviced. (sub. DR359, p. 31)

The Australasian Casino Association called for

... the development of a comprehensive national data set to be used as a tool that is utilised by problem gambling service providers as well as being a means of providing feedback to counselling services, industry and the community on a regular basis. (sub. 214, p. 4)

Relationship Australia (SA) said

RASA is constantly looking to improve our data collection. We have found that we are interested in data that is not required to be collected for reporting purposes and are thus mid process updating our data collection categories and processes. A state or national integrated framework that agencies could input to and access from would be very useful, particularly in relation to client outcomes and methodologies used. (sub 203, p. 29)

UnitedCare Australia

... there is limited formal evaluation of gambling help services to quantitatively determine service effectiveness. The valuations need to be undertaken to determine effectiveness and to identify areas of improvement. (sub. 238, p. 8)

Senator Xenophon

The efficacy of gamblers' rehabilitation services needs to be assessed on a rigorous and systematic basis and this could best be carried out by a national research body that is independent of governments, industry and any other vested interests. In particular it needs to be established how many people with a gambling problem are currently receiving help, and of those, how many have been helped to break free of their problem. (sub. 99, p. 6)

Differences in evaluation processes across jurisdictions suggests that a consistent conceptual framework for evaluating preventative strategies would help build the evidence base. The Commission's proposed national centre for gambling policy research and evaluation (chapter 18) could establish a consistent set of methodologies and evaluation processes for preventative strategies. There would also be value in evaluations being made publicly available (to overcome a lack of transparency in evaluation findings), so that jurisdictions can learn from each other.

Gambling help client data

The Commission's attempts to gather data about clients seeking help across Australia also revealed the absence of a *nationally consistent* data set for gambling help services. The Commission's 1999 report, pointed to the need for a national minimum data set that collected data on clients of problem gambling counselling agencies using an identical set of definitions across the jurisdictions. While there has been agreement among jurisdictions on the need for more consistent data (a number of jurisdictions have sought to improve their data sets and the jurisdictions have agreed to a data dictionary), Australia is still a long way off having a national minimum data set.

Because data are not collected in a common format (if collected at all), aggregation of client numbers and characteristics is difficult, as is undertaking comparisons across jurisdictions. Greater compatibility in terms of what data are collected and recorded would build the evidence base on clients attending help services and allow a more robust comparison of clients across problem gambling services in Australia. There is also variation in the extent to which jurisdictions make data publicly available — and thus available to assist service providers, researchers and the community more generally.

A national data set would not preclude jurisdictions and service providers from collecting data specific to their needs, but it would ensure that minimum uniform data are available nationally. The Commission's proposed research and evaluation centre ideally should coordinate the collection of a national dataset on gambling help services (chapter 18).

Outcome data and follow-ups

Client data also provide only limited outcome and follow-up information needed to assess the effectiveness of interventions in reducing gambling problems. To allow for an accurate measure of client change following counselling, a standardised interview should be conducted both pre and post treatment. Follow-up assessments should be routinely carried out at regular intervals after counselling is completed (for up to two years). Data should also be collected on:

- the nature and severity of the problems with which gamblers present, including co-morbidities
- the type of interventions provided
- the number of treatments provided to individual clients
- the level of counsellor training.

In some jurisdictions, outcome measures are already collected. In South Australia, pre and post measure testing has been required by services since 2004. Victoria has recently put out a revised approach to Gambler's Help Performance Management that involves collecting baseline client data, performance outcome measures and client satisfaction surveys, and all RGF-funded counselling services in New South Wales are required (since July 2008) to conduct structured client follow-ups. However, a more structured approach to evaluating outcomes and conducting follow-ups from counselling and treatment support services within and across jurisdictions would help build the evidence base on the effectiveness of gambling counselling services. A set of outcome measures (agreed to following consultation between the jurisdictions) should form part of the national data set.

New Zealand's service-user statistics provide a guide in terms of outcome measures that might be used (Ministry of Health, 2008a). Three measures — SOGS-3M score, a measure of how much money is spent, and a test of the client's assessment of the degree of control they have over gambling — are collected at assessment and repeated at follow-up. The Gambling Treatment Clinic at the University of Sydney has also developed a Structured Clinical Interview for Problem Gambling that uses the DSM-IV criteria, and measures time and money spent on gambling and assesses the level of debt of the client.

The collection of assessment data and information on treatment variables, such as the type of interventions provided, the number of sessions and counsellors qualifications, should be routinely undertaken by counselling agencies. There may, however, be value in an independent body undertaking follow-ups. In New Zealand, the telephone counselling service conducts the follow-ups of clients and assesses progress against outcome criteria. This model has also been used in New South Wales. This model avoids any possible problems associated with counselling services following up their own clients and has the added advantage that it ensures funding is made available specifically for follow-up of clients.

RECOMMENDATION 7.4

Governments should cooperate to:

- ***create a nationally consistent and publicly available dataset on gambling help services, including measures of their effectiveness***
- ***develop national guidelines, outcome measures and datasets for prevention and early intervention measures.***

The collection of data and evaluations of help services and prevention measures should be coordinated through the Commission's proposed national centre for gambling policy research and evaluation (recommendation 18.3) or by another agency with expertise in public health analysis.

There is also currently very little tracking of clients. Jackson et al., looking at new clients and those presenting again concluded that:

... distinguishing between first treatment contact and subsequent entry to treatment is clinically relevant, and that the examination of problem gambling from a treatment career perspective is deserving of further attention. (2008, p. 618)

This suggests that there would be value in having individual identifiers to link records and to reactivate a closed case if a client re-presents for help. Such linkages would provide more information about relapses and could also mean better case management of clients. The use of individual identifiers, including issues around confidentiality, warrants further investigation.

Areas for further research

There are a number of areas where further research is required to address gaps in knowledge about interventions to assist problem gambling. There is a particular need to know more about the effectiveness of early interventions in:

- preventing or reducing the likelihood of groups at risk from developing gambling problems and ensuring they have the information to make informed choices
- educating the public about the visible signs of problem gambling.

Essential questions about the efficacy and effectiveness of treatment for gambling problems — including self-help and brief interventions and the types of treatments that are most effective for different sub-groups of gamblers experiencing problems (such as adolescents and culturally and linguistically diverse groups) — still need to be answered. The Problem Gambling Research and Treatment Centre (a joint initiative of the University of Melbourne, Monash and the Victorian Government) is currently developing evidence based clinical guidelines for the screening and assessment and treatment of problem gambling. The guidelines will identify, appraise and summarise the best available evidence. They will be based according to the Australian National Health and Medical Research Council (NHMRC) clinical

guidelines development process (the guidelines will be submitted for NHMRC endorsement upon their completion) and the Cochrane review protocol.¹

To further strengthen the evidence base, however, more standardised randomised controlled trials with extended follow-up periods are required. Future outcome evaluations should attempt to overcome the methodological issues that have weakened the evidence base and have sufficiently long follow-up periods. The critical period in judging whether the effectiveness of treatment for problem gamblers is considered to be two or more years after the completion of treatment. Walker recently said:

If we are serious about helping problem gamblers, it has to be help, not for six months or twelve months, but for life. We need research to determine approaches to helping people to quit gambling for life. The available evidence suggests that we help problem gamblers quit for six months; we need to do better than that. (NSW Problem Gambling Roundtable, 2008, p. 17).

Longitudinal research on clients and problem gamblers more generally could shed further light on the effectiveness of counselling, natural recovery and relapse. Long term effectiveness is also critical in terms of assessing cost effectiveness.

Further research is also needed to establish what clinical variables have an impact on treatment efficacy.

¹ Cochrane reviews are considered the most rigorous way of assessing research evidence. The reviewers require training and support from the sponsoring Cochrane centre which is chosen from an international network of centres.