17 Help for people affected by problem gambling

Box 17.1 **Key messages**

- All jurisdictions have problem gambling strategies in place, including the funding of problem gambling counselling and support agencies, although some strategies are more comprehensive than others.
- There are differences among jurisdictions in how the problem gambling strategies are funded. Main areas of difference are:
  - while most jurisdictions impose compulsory levies to fund problem gambling services, in Western Australia and South Australia funding is derived from voluntary contributions; and
  - in most jurisdictions, funding is derived from only one or a couple of gambling codes rather than the gambling industry as a whole.
- Funding sources of problem gambling services should be broadened to include all gambling activities that contribute to the need for counselling/treatment services.
- There would be advantages in having rolling triennial funding arrangements for problem gambling agencies in jurisdictions where annual funding rounds currently apply, especially where processes are in place to evaluate the effectiveness of counselling/treatment services.
- It is difficult to put a precise figure on the number of problem gamblers (and those affected by problem gambling) who are currently attending problem gambling counselling agencies — the number is likely to be well above 12 000. But such a figure does not capture all clients seeking help for gambling-related problems because:
  - it excludes those who seek help from group support organisations such as Gamblers Anonymous; and
  - it excludes problem gamblers who seek help from generic service agencies.
- Results from the Commission's *National Gambling Survey* indicate that the likelihood a problem gambler will seek help varies with the degree of severity of gambling problems.
- Areas requiring attention in terms of effective service delivery by problem gambling counselling agencies relate to:
  - approaches used to assess the severity of gambling problems of clients;
  - assessment of client outcomes after counselling/treatment;
  - the effectiveness of counselling techniques used; and
  - whether the needs of particular client groups are being met.

17.1 Introduction

Most state and territory governments have responded to problem gambling in a variety of ways, such as funding community education programs, telephone gambling helplines, professional counselling and treatment services to help those experiencing problems, and research into the social and economic impacts of gambling.

To provide an up-to-date snapshot of available problem gambling services, the Commission conducted a *Survey of Counselling Services* during the course of the inquiry. The survey focused on the main government funded organisations that provide services for problem gamblers and 'significant others' affected by problem gambling. Details of the survey methodology are presented in appendix L.

In section 17.2, a brief overview is presented of the range of information and help services that are available for problem gamblers and those affected by problem gambling. The problem gambling strategies currently in place in the various states and territories are outlined in section 17.3, and the funding arrangements are examined in section 17.4. The more important problem gambling help services are then described, in particular the 24-hour problem gambling telephone services such as G-line (section 17.5) and agencies providing problem gambling counselling and treatment (section 17.6). In considering the operation of these agencies, information is given on how many people affected by problem gambling are attending, and the types of counselling and treatment provided.

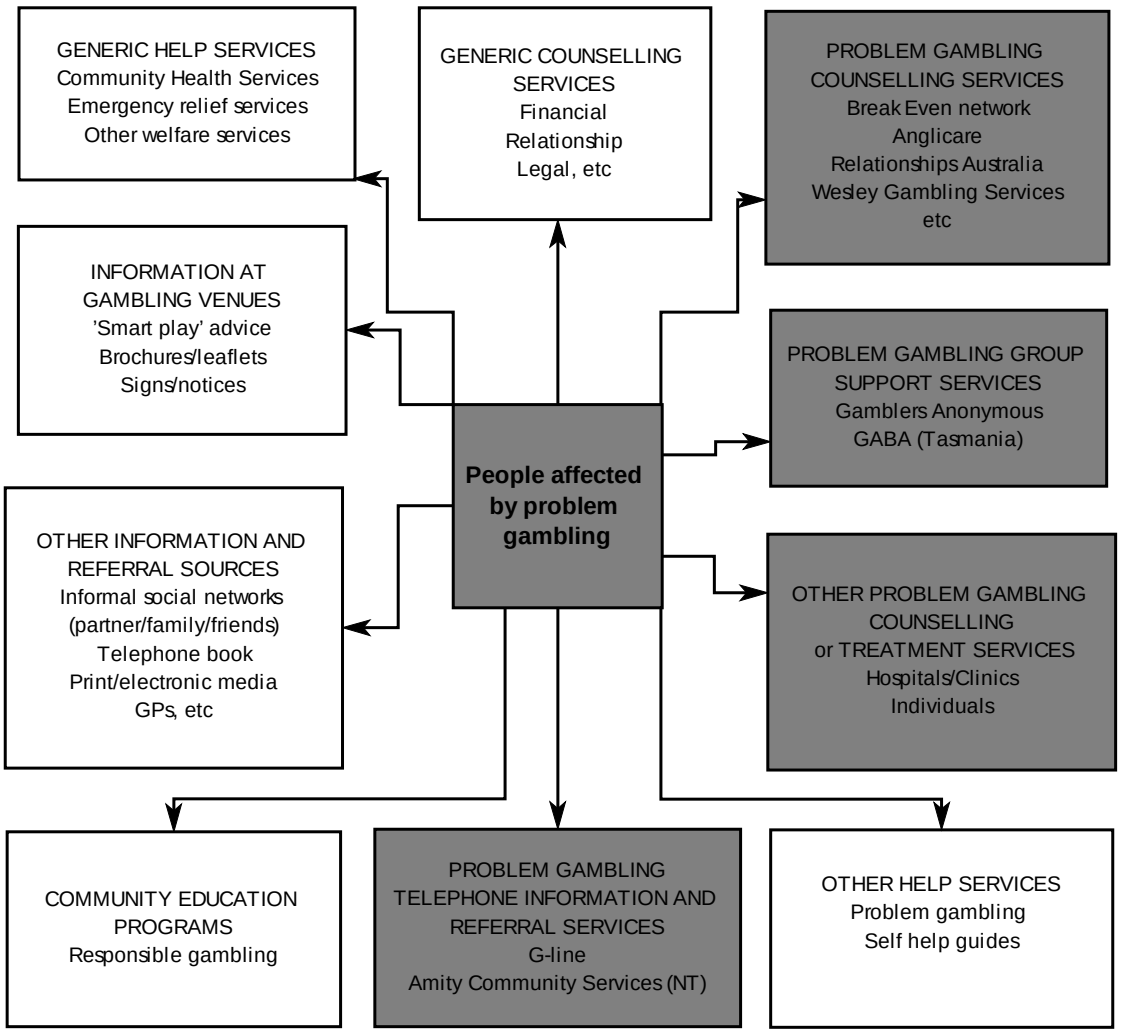
The chapter concludes with an examination of how successful the help services have been in meeting the needs of problem gamblers, and reports the views of the Commission and participants on the effectiveness of current strategies.

17.2 An overview of problem gambling help services

An indication of the main avenues by which those affected by problem gambling can obtain help is given in figure 17.1. The primary responsibility for the provision of help services for problem gamblers rests with state and territory governments. The decision to fund problem gambling services reflects a recognition by governments that the liberalisation of access to gambling has resulted in more people needing help for gambling related problems. As a response to this need, two common elements in most jurisdictions are the funding of direct help via:

- a network of problem gambling counselling and support services — in all states except New South Wales, a geographically-based network has been established under the banner of 'Break Even' to provide free counselling to gamblers, their families and friends; and
- a 24-hour telephone helpline to provide immediate counselling and support.

Figure 17.1 **Avenues for problem gamblers to access help services**



The ways in which a problem gambler (or those affected by problem gambling) might seek help will be influenced by the information and referral sources available. For many problem gamblers, their own informal social networks (including partners and family/friends) are the most important source of information about help services. Another important first point of contact might be a 24-hour problem gambling telephone helpline such as G-line.

General practitioners (GPs) can also play a role in assessing problem gamblers and their family members and referring them to appropriate counselling services. Patients may go to their GP to treat the adverse physical and psychological symptoms associated with gambling-related anxiety and depression. Indirect health effects may arise from inadequate nutrition, poor hygiene, and poor living conditions associated with gambling-related financial difficulties (AMA, sub. D204, p. 1).

But there are other sources of referral to gambling help services — for example, information might be obtained from a brochure or notice at a gambling venue, or problem gamblers themselves may self refer to a counselling agency.

The provision of problem gambling help services is carried out by a large number of quite varied and distinct organisations, including welfare, religious and other community groups, private individuals, and public and private hospitals and clinics. These service providers can be grouped into four broad categories (box 17.2). While some of these groups are restricted in the sorts of services they provide, others have a much wider focus.

Box 17.2 **Main providers of problem gambling help services**

Counselling agencies — largely comprise a wide variety of community organisations, such as welfare and church groups who provide a range of counselling services to problem gamblers.

Group support agencies — include organisations like Gamblers Anonymous. Gamblers Anonymous has grown out of alcoholics anonymous which believes that the only solution to alcoholic addiction is complete abstinence. Gamblers Anonymous has adopted a similar view to problem gambling.

Individuals — include people who either have a strong interest in the issue of problem gambling, know someone (friend or family) who has been affected by gambling, or they themselves were problem gamblers.

Clinics and hospitals — can range from professional individuals working in hospitals providing a service to problem gamblers to larger private clinics employing a number of professional staff.

But people adversely affected by problem gambling also access a broader range of community and counselling help services that are not gambling specific, such as:

- generic counselling services (financial, relationship, legal, etc);
- community health services (due to the incidence of physiological problems associated with problem gambling); and

- emergency relief and other welfare services (to provide food, clothing and other support for those deprived through problem gambling).

However, the problem gambling specific help agencies depicted by the shaded boxes in figure 17.1 are the focus of this chapter.

17.3 Government responses to problem gambling

In this section, features of the problem gambling strategies pursued by the state and territory governments are outlined. The funding arrangements for these strategies are described in section 17.4.

Origins of key elements of problem gambling strategies

The key elements of the state and territory problem gambling strategies are summarised in box 17.3. There are similarities in the structure of services developed across jurisdictions in Australia because those that have developed their strategies more recently have borrowed from the experiences and approaches developed earlier by other states as well as overseas countries. Some of the characteristics of services also reflect other similar services that already exist in areas like drugs, alcohol, relationships, etc.

The Break Even network concept of problem gambling counselling agencies originated in the 'resource centre' model developed in 1992 by the Queensland Department of Family and Community Services. The approach involved a range of strategies to help people affected by problem gambling, including (see Boreham et al. 1995):

- *direct services* for problem gamblers and their families — such as the provision of information and advice, and financial, addiction and family counselling;
- *prevention, education and community awareness* — involving networking with a wide range of other agencies and professionals in the community, and informing the community on gambling issues and prevention/harm reduction strategies; and
- *proactive strategies* — involving the active support and participation of key stakeholders in the gaming and wagering industry.

A 24-hour toll free problem gambling telephone helpline was first introduced in Victoria in 1994, and other states have gradually followed since that time. As Boreham et al. (1995) have noted:

> an appropriately advertised toll-free one number for enquiries/crises concerning problem gambling is an essential component in the provision of services for problem gamblers and their families (p. 28).

Box 17.3 **Key elements of problem gambling strategies**

New South Wales

- currently 39 problem gambling counselling, treatment and rehabilitation services for problem gamblers and their families receive funding from the Casino Community Benefit Fund.
- a 24-hour telephone counselling and referral service (G-line).
- promoting industry and community awareness of problem gambling and associated activities through education campaigns.
- funding research into the social and economic impact of gambling on individuals, families and the general community.

Victoria

- a problem gambling counselling services network, Break Even, in operation since 1995 — with 18 agencies throughout the state currently receiving funding from the Community Support Fund.
- a 24-hour telephone counselling and referral service (G-line).
- a community education and media campaign.
- establishment of a Problem Gambling Reference Group — comprising membership from a range of key organisations including the gaming industry, counselling services, key community groups and government representatives, to provide advice to the Department of Human Services.
- a problem gambling research program.

Queensland

- a problem gambling services network, Break Even, in operation since 1993, at six locations.
- a 24-hour telephone counselling and referral service — since September 1998 on a pilot basis (the Gambling Help-Line project).
- an advisory Committee (the Responsible Gambling Advisory Committee) comprising all major stakeholders — to provide advice on strategies to monitor, prevent and respond effectively to problem gambling.
- community education and problem gambling research.

Western Australia

- a problem gambling support service, Break Even, in operation since 1995.
- a telephone counselling and referral service (G-line).
- publicising the availability of problem gambling services.

Source: DGR 1999e; sub. 76; VCGA (sub. 60); Department of Human Services (Victoria) 1998.

Box 17.3 **Key elements of problem gambling strategies (cont'd)**

South Australia

- a problem gambling services network, Break Even, in operation since 1995 — with 12 agencies currently receiving funding from the Gamblers Rehabilitation Fund.
- a 24-hour telephone counselling and referral service (G-line) — introduced in early 1999.
- an information framework to enable monitoring of the results achieved by clients of the services.
- a statewide community education campaign.
- commissioning of relevant research.
- training and development of Break Even staff.

Tasmania

- a problem gambling service, Break Even, in operation since August 1997 — with 3 organisations currently operating 8 services in 5 locations.
- a 24-hour telephone counselling and referral service (G-line).
- a long-term community education strategy focusing on promoting responsible gambling through preventative programs.
- ongoing research and evaluation to ensure effective service delivery and accountability.

Australian Capital Territory

- little if any strategy other than two part-time counsellors operating at Lifeline Canberra (Gambling and Financial Counselling Service).

Northern Territory

- a problem gambling service provided by Amity Community Services, including counselling and operating a toll-free crisis telephone number.
- research into the impact of gambling on individuals and families.
- a community education program.

Source: Elliot Stanford & Associates 1998; Eckhardt 1998; sub. 128; McMillen and Togni 1997; Alder 1998.

Other elements in the problem gambling strategies of most jurisdictions include:

- a community education strategy; and
- a problem gambling research program.

Problem gambling strategies by jurisdiction

Queensland

A key element in the strategy to address problem gambling in Queensland is the network of six regional counselling services operated by Relationships Australia, Centacare and Lifeline under the Break Even banner. Five of the services have been operating since 1993 (Brisbane, the Gold Coast, Townsville, Toowoomba and Rockhampton) while a sixth service was established in Cairns in 1996, following the opening of the Cairns Casino.

The Queensland Government stressed in its submission the advantages of having a regional network of problem gambling services. First, because of the *regional* spread, agencies can respond to local needs in their area. And second, because each agency is also part of a statewide *network*, this enables consistent levels of service to be provided across the state, as well as information to be shared more easily among agencies, and statewide programs to be better coordinated (sub. 128, pp. 30-1).

Victoria

In February 1994, the then Department of Health and Community Services proposed that regionally-based problem gambling counselling services be established in Victoria, as part of a Problem Gambling Services Strategy. The proposal was a response to the rapid increase in access to legalised gambling in that state. After the proposal was approved later that year, Victoria followed Queensland in adopting the name of Break Even for the problem gambling services network.

A range of other problem gambling services have been funded in addition to the Break Even counselling services, including (Department of Human Services 1998):

- community education and gaming liaison officers — who operate in each region and the Central Business District ;
- innovative services for people from non English speaking background communities;
- financial counselling services — to support the work of existing problem gambling counselling services;
- training and skills development — for problem gambling and financial counsellors and Community Education and Gaming Liaison officers; and
- parenting services — to meet the needs of people who seek Help for people affected by problem gambling who also require help with related difficulties which impact on their families.

Victoria pioneered the establishment of a 24-hour problem gambling helpline (G-line) which was in operation for a year before the establishment of the Break Even network. Another feature of the Victorian strategy is an extensive program of problem gambling research — the Victorian Casino and Gaming Authority funding research into the social impacts of gambling, and the Department of Human Services funding research into service delivery for problem gamblers (see VCGA, sub. 60).

New South Wales

In New South Wales, there are currently 39 problem gambling counselling and treatment services funded by the Casino Community Benefit Fund (CCBF). The Fund was established under the *Casino Control Act 1992*, and has funded counselling and treatment services, public education and awareness, and research into problem gambling since its inception in September 1995.

New South Wales differs from the other states in that the service agencies are not integrated into an overarching network along the lines of the Break Even model adopted elsewhere. As Prosser, Hing et al. (1997) stated:

> In NSW many of the [problem gambling] services are available as discrete units but are not integrated under the Break Even name or organisational structure. Thus the NSW population have no publicly recognisable symbol or common element to associate with problem gambling services (p. 24).

Yet it has also been suggested that there may be some advantages in the New South Wales approach of not adopting a unifying label. As Michael Walker commented:

> Since it is not known which assumptions about the causes of problem gambling are correct and which treatment methods are the more effective, a heterogeneous collection of agencies is appropriate. Also, the NSW system avoids the poor treatment record of a single agency contaminating perceptions of the whole range of agencies (sub. D287, p. 1).

South Australia

Responses to problem gambling in South Australia date from around August 1994, when funding was announced by the then Premier "to initiate programs to deal with gambling addiction and to help their families". Such funding had been foreshadowed by the legislation introducing gaming machines in that state (the SA *Gaming Machines Act 1992*).

A range of problem gambling intervention and prevention services are funded by the SA Gamblers Rehabilitation Fund (GRF). In August 1995, the counselling agencies

funded by the GRF formed a network under the Break Even banner. The role of the network is to (see Elliot Stanford & Associates 1998, p. 16):

- contribute to adequacy and quality of services to gamblers and their significant others;
- provide information to stakeholders and advocate on gambling related issues and services;
- build co-operation and co-ordination between service providers; and
- raise community awareness of gambling related issues and their implications for individuals and the community.

Tasmania

A problem gambling strategy in Tasmania took effect in April 1997, when the government approved funding for three organisations to provide services for problem gamblers under the Break Even banner:

- Anglicare Tasmania (with counselling services in Hobart, Burnie and Devonport);
- Relationships Australia (with counselling services in Hobart and Launceston); and
- Gambling and Betting Addiction Inc. (GABA) (with group support meetings in Hobart, Launceston and Ulverstone).

The approach of the strategy was to provide problem gamblers with choice in two areas (Eckhardt 1998):

- *nature of help services* — a multiple service approach, which recognises the value of professional counselling as well as group support for helping problem gamblers and their families; and
- *number of organisations* — having more than a single provider of problem gambling help services.

However, Tascoss noted that one component of the problem gambling strategy — the community education program — operates only in Northern Tasmania, and has had limited broad impact within the community (sub. 114, p. 3).

Western Australia

The provision of problem gambling services in Western Australia dates from 1994, with the formation of the Problem Gambling Support Services Committee,

consisting of industry and government representatives. A major initiative of the Committee was that funding should be provided for a service to assist problem gamblers and their families. The successful applicant in the tender process was Centrecare Family and Marriage Service, which established a counselling service for problem gamblers under the name of Break Even in November 1995 (sub. 76).

Since its inception, the Problem Gambling Support Services Committee has continued to develop its role. As well as funding the 24-hour telephone help service (G-line) since August 1997, its recent initiatives include (sub. 76):

- negotiating an additional grant with Centrecare to provide more widespread publicity about the provision of gambling services; and
- undertaking research into problem gambling in ethnic communities.

Australian Capital Territory

In the ACT, the only response in place for dealing with problem gambling is a Gambling and Financial Counselling Service (GAFCS) operating in Lifeline Canberra (sub. 96). But current funding only allows for the employment of one part-time gambling counsellor and one part-time financial counsellor (sub. 103). As Lifeline Canberra stated:

> There is a need for an overall government strategy which incorporates research, education, prevention and counselling services. Both Victoria and Tasmania appear to have models which could be incorporated in the ACT (sub. 103, p. 3).

Lifeline Canberra identified a number of gaps in problem gambling service delivery in the ACT, such as (sub. 103, p. 3):

- current funding allows for the employment of only 1.4 counsellors (to service a total population of over 300 000);
- because of these resource constraints, any advertising to increase awareness of the service could not meet any resultant increase in demand;
- no regional counselling services are provided (in the surrounding regions of the ACT, particularly Queanbeyan);
- no funds are specifically allocated to community education, prevention or media campaigns; and
- no resources are available to adequately evaluate service effectiveness.

Clearly the ACT lacks most of the key elements of the problem gambling strategies of other jurisdictions.

Northern Territory

In 1994, the decision was made to extend the availability of poker machines in the Northern Territory to clubs and hotels. Because it was recognised that community gaming machines may contribute to problem gambling, in early 1995 a Select Committee made recommendations in relation to (Alder 1998):

- *rehabilitation funding* — establishing a Community Benefit Levy for problem gambling related services and community organisations;
- *community education* — relating to gambling and sensible family budgeting; and
- *research* — initiating a base line research study of the impact of gambling on individuals and families, as the basis for designing a rehabilitation services network.

The Northern Territory relies on general community service agencies to provide problem gambling support services. The main agency is Amity Community Services, which has received some funding for gambling counselling, operation of a toll-free telephone helpline, and a community gambling awareness program — which included pamphlets at all gaming venues, a self-help manual for gamblers with problems, and posters advertising their services (McMillen and Togni 1997).

17.4 Funding of services for problem gamblers

In this section, the funding sources for problem gambling support services in the states and territories are described, and the levels of funding reported. The earmarking of gambling taxes in a broader context is discussed in chapter 20.

In addition to the government funded and approved services, there are also other providers of help to problem gamblers who do not receive government funding. Notable among these is Gamblers Anonymous, whose charter does not allow fund seeking.

Funding sources

The funding sources for the problem gambling strategies followed in the various jurisdictions are reported in table 17.1. It is clear that there are differences in a number of respects, including:

- the parts of the gambling industry that provide funding specifically for problem gambling services; and

- whether funds are derived from statutory levies or contributed on a voluntary basis.

In most jurisdictions, levies are imposed on sections of the gambling industry which contribute to one or more community support programs. However, in many cases only a small proportion of the funds raised from the gambling industry are typically used to support help services for problem gamblers, and the parts of the gambling industry that make contributions to funding these services can be quite narrowly based.

Table 17.1 **Funding sources of problem gambling services, by jurisdiction**

State/Territory	*Fund*	*Funding source*
NSW	Casino Community Benefit Fund	Part of the tax paid by the Sydney Casino operator (equivalent to 2 per cent of the gross annual gaming revenue)
Victoria	Community Support Fund	Derived from 8.33 per cent of the net cash balance from gaming machines in hotels
Queensland	Charities & Rehabilitation Benefit Fund	Derived from a percentage of gaming machine and keno revenue collected by the Queensland Office of Gaming Regulation
WA	Fund managed by Lotteries Commission on behalf of Problem Gambling Support Committee	Voluntary contributions from Burswood Resort Casino, WA Totalisator Agency Board and Lotteries Commission of WA
SA	Gamblers Rehabilitation Fund	Voluntary contributions by the Australian Hotels Association and Licensed Clubs Association
Tasmania	Community Support Levy	Derived from a levy on gross profits on gaming machines in hotels (a rate of 4 per cent) and clubs (a rate of 2 per cent)
ACT	Community Services Grants Program	Derived from a percentage of gambling revenue
NT	Community Benefit Fund	Derived from a levy of 25 per cent of gross profit on gaming machines in hotels

Sources: DGR 1999e; VCGA (sub. 60); Queensland Government (sub. 128, p. 48); sub. 76; Elliot Stanford & Associates 1998; Eckhardt 1998; sub. 96; Alder 1998.

In Queensland, legislation provides for a proportion of the revenue from casinos, gaming machines in licensed clubs and hotels, keno and other forms of gambling to be allocated to a number of special funds (sub. 128, pp. 45-48): Casino Community Benefits Funds (CCBFs), the Gaming Machine Community Benefit Fund, the Sport & Recreation Benefit Fund, and the Charities & Rehabilitation Benefit Fund — in relation to the last of these, contributions are made from gaming machine and keno revenue, and funds are used for charitable, rehabilitative or social benefit purposes.

In aggregate, these special funds benefited by $92 million in 1997-98, with the Charities & Rehabilitation Benefit Fund (CRBF) alone amounting to $26.4 million (sub. 128, p. 45). However, only a very small portion of the CRBF is allocated to assist problem gambling services. For example, in 1998-99 around $1.56 million was allocated to recurrently funded problem gambling services (sub. D275, p. 24).

In Victoria, a percentage of the net cash balance from gaming machines in hotels contributes to the Community Support Fund (VCGA, sub. 60). The *Gaming Machine Control Act* 1991 requires that funds from the Community Support Fund must be used for (sub. 60, p. 1):

- research by the Victorian Casino and Gaming Authority into the social and economic impacts of gambling; and
- payment for or towards the provision of projects of benefit to the community, such as projects assisting problem gamblers, drug rehabilitation centres and projects of lasting significance which demonstrate substantial community benefit (such as those relating to youth, sport, recreation, tourism and the arts).

In New South Wales, the principal source of funding for counselling and treatment services for problem gamblers and their families, promoting public education and awareness, and supporting research into problem gambling is the Casino Community Benefit Fund. The Sydney casino operator pays a specified amount of tax (based on casino gross gaming revenue) to the New South Wales Government's consolidated revenue, and an amount calculated at 2 per cent of the casino's gross gaming revenue is separately hypothecated to the CCBF. But as IPART (1998) noted, other sources of funding for services and research include individual gaming operators, the Department of Community Services, NSW Health, universities and welfare groups (1998, p. 61).

In Tasmania, the Community Support Levy (CSL) is derived as a percentage of gross profits on gaming machines in hotels and clubs — but no contributions to the CSL are made from the profits on gaming machines located within the casino complexes. Funding in the Northern Territory is also very narrowly based — the Community Benefit Fund (CBF) is derived from a levy on gross profits on gaming machines in hotels only.

In Western Australia, problem gambling services are funded on an entirely voluntary basis by Burswood Resort Casino, the TAB and the Lotteries Commission. Each member of the industry provides their contribution to the Lotteries Commission, which then administers the grants program to G-line and Centrecare, and payment of the costs of research projects. As the Western Australia government commented:

> The voluntary agreement by the gaming industry in Western Australia to contribute to problem gambling support services appears to be unique in Australia (sub. 76, p. 33).

But South Australia also has a voluntary funding approach. The Gamblers Rehabilitation Fund (GRF) was established by the South Australian Government in August 1994, shortly after gaming machines were introduced to clubs and hotels. An amount of $1.5 million per annum is contributed voluntarily to the GRF by the Australian Hotels Association and the Licensed Clubs Association through the Independent Gaming Corporation (Elliot Stanford & Associates 1998, p. 7).

However, Anglicare (SA) expressed some concern that the voluntary funding arrangements in SA might not ensure that funding was adequate, and suggested that:

> in line with other Australian States, the formula for contributing to the [GRF] be based on turnover, and be set at between 2 and 5 per cent (sub. 104, p. 17).

Further views of participants and the Commission on funding arrangements are presented in the concluding section of this chapter.

Funding levels

Information on funding levels for problem gambling strategies by jurisdiction are reported in table 17.2.

In New South Wales, funding of problem gambling services in 1997-98 amounted to around $4.8 million, of which $3.7 million was allocated to problem gambling counselling services (sub. 163). In total, $13 million has been expended or committed since the inception of the CCBF in September 1995 on counselling and treatment services, public education/awareness and research in relation to problem gambling (CCBF 1999).

In Victoria, over the period since 1993 up to end-June 1999 a total of $39.4 million has been committed from the Community Support Fund for the development of a comprehensive problem gambling strategy. Of this amount, $30.4 million has been allocated to problem gambling and related services, $1.5 million to the research program, and $7.5 million to the community education campaign (Department of Human Services Victoria 1998). A further $21 million has been allocated for the three-year period to end-June 2002.

In Queensland, an amount of $1.556 was allocated in 1998-99 to recurrently funded problem gambling services, including funding of the Break Even network, piloting of the Gambling Help Line, and funding for the Secretariat for the Responsible

Gambling Advisory Committee, which is comprised of industry, problem gambler service provider and government representatives (sub. D275, p. 24).

Table 17.2 **Funding levels of problem gambling services, by jurisdiction**

State/Territory	*Period*	*$'000*	*Comments*
NSW	1997-98	4 781	Expenditure on problem gambling counselling, research and programs
Victoria	1993-94–1995-96	4 134	Triennial funding for the Problem Gambling Services Strategy
	1996-97–1998-99	35 300	Second round of triennial funding
	1999-2000–2001-02	21 000	Allocation for third round of triennial funding
Queensland	1998-99	1 556	Allocation to recurrently funded problem gambling services
WA	1998-99	113	
SA	1997-98	1 337	Total expenditure of $5.722 million since the
	1998-99	1 747	inception of the GRF in August 1994.
Tasmania	1997-98	303	$1.125 million allocated to problem gambling
	July 1998–April 1999	304	programs during period July 1997–April 1999.
ACT	1998-99	107	Funding to Lifeline ACT for the Gambling and
	1999-2000	127	Financial Counselling Service
NT		See text	

Sources: CCBF Trustees 1999; Commonwealth Department of Health and Aged Care (sub. 163, table 3); Jackson et al. 1997; Department of Families, Youth and Community Care (Queensland) 1999; Queensland Government (sub. D275, p. 24); Eckhardt 1999; ORGL 1999b; Department of Human Services (SA)1999; Department of Education and Community Services (ACT)1999; sub. D275.

In Western Australia, the Problem Gambling Support Services Committee has approved a budget of $113 000 for the provision of counselling services by Centrecare in 1999-2000, an amount similar to that approved in 1998-99 (ORGL 1999b).

In South Australia, the expenditure from the Gamblers Rehabilitation Fund in 1998-99 includes an allocation of $1.164 million for Break Even service agencies and specialist services, and $0.463 million for training, media and other services (Department of Human Services SA 1999).

In the Northern Territory, payments from the Community Benefit Fund were suspended in July 1997, pending the Gaming Machine Industry Review, which was completed in December 1998 (Alder 1998). However, that Review reports that the levy on hotels is still producing over $125,000 per month, and the balance of the fund is over $2 million.

On the situation in the ACT, Lifeline Canberra commented that the funding they receive:

> ... is considerably less than that which is received by gambling counselling services in other States. The number of citizens of the ACT attending the Gambling and Financial Counselling Service ... is consistent with that of other gambling counselling services although funding in the ACT is lower and availability of the service is less (sub. 96, p. 3).

Up-to-date or annual information on problem gambling funding is lacking for some jurisdictions. With that proviso, the total annual funding of problem gambling programs (including problem gambling counselling services, research into problem gambling, and other services such as G-line) is currently perhaps around $20 million. However, this understates somewhat the overall level of problem gambling support because people with gambling related problems access a wider range of help services than those which are gambling specific. As the Queensland Department of Families, Youth and Community Care (1999) pointed out:

> a wide range of funded and unfunded community based services and a number of government departments provide support, including counselling/health services, to people adversely affected by gambling in Queensland. These may be generic services which are not gambling specific, for example, a community health service or an emergency relief service.

Differences in levels of funding of problem gambling services across jurisdictions largely reflect differences in the number of clients attending problem gambling services (refer section 17.6). Comments on whether levels of funding are adequate and appropriate are reported in section 17.7.

17.5 Problem gambling telephone helpline services

Telephone help services for problem gamblers and people affected by problem gambling operate in all states and the Northern Territory. The current arrangements in the various jurisdictions are as follows:

Victoria, Tasmania, Western Australia and South Australia — a 24-hour telephone crisis counselling and referral service called G-line is operated by the Addiction Research Institute (ARI), an independent not-for-profit organisation supported by funding from both government and non-government sectors.

New South Wales — a G-line service was established in New South Wales in August 1997, operated by the ARI. From 1 August 1999 the New South Wales Government engaged a New South Wales-based company (High Performance Healthcare) to operate the 24-hour helpline, following a tender process. The new

operator conducts the service under the name 'G-line (NSW)' and uses the same telephone number as before — 1800 633 635.

Queensland — the Queensland Government has developed its own telephone help service model, the Gambling Help-Line pilot project, to meet the particular needs of the Queensland context. An independent evaluation of the pilot project has recently been completed, and the service will continue to operate in the pilot areas while a statewide model of operation is developed. The Gambling Help-Line is expected to be implemented across Queensland in early 2000 (sub. D275, p. 10).

Northern Territory — a telephone help service similar to G-line is operated by Amity Community Services.

The G-line service model

The G-line service was established first in Victoria, and became operational from October 1994. Since that time, a G-line service has been introduced in all states except Queensland (table 17.3).

Table 17.3 **G-line: commencement dates and funding support, by state**

State	*Date commenced*	*Funding body/source*
Victoria	October 1994	Department of Human Services (Community Support Fund)
Tasmania	October 1996	Tasmanian Gaming Commission (Community Support Levy)
New South Wales	August 1997	Department of Gaming and Racing (Casino Community Benefit Fund)
Western Australia	August 1997	Burswood Resort (Management) Ltd, Totalisator Agency Board and Lotteries Commission of WA
South Australia	End 1998/early 1999	Department of Family and Community Services

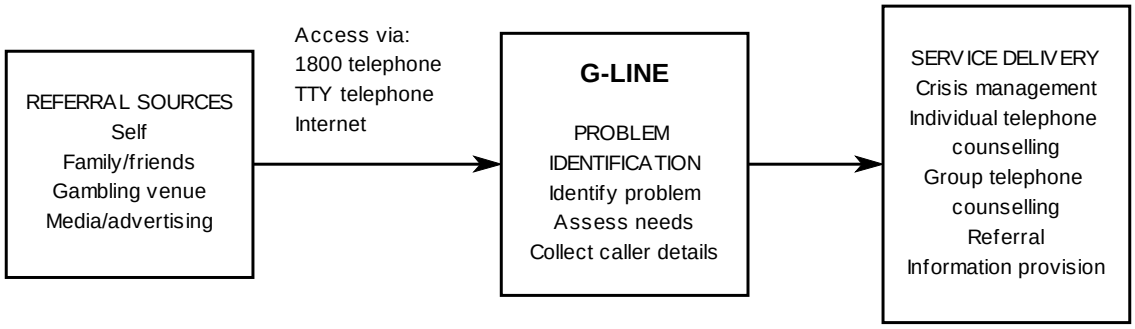
Source: Addiction Research Institute (sub. 37, attachment 2); http://www.g-line.org.au.

The key elements of the G-line service model — problem identification, provision of direct services, and referral — are depicted in figure 17.2. Other details on G-line are set out in box 17.4. G-line acts as a first point of contact for people affected by problem gambling to access a range of services, such as (sub. 37):

- *direct* services — including crisis counselling support, individual telephone counselling and group telephone counselling; and

- *indirect* services — including referral to services that provide problem gambling, relationship, financial and legal counselling; and provision of information.

Figure 17.2 **The G-line service model**



Source: Addiction Research Institute (sub. 37).

Box 17.4 **G-line at a glance**

Management	Addiction Research Institute (ARI).
Client group	People affected by problem gambling
Service provided	Individual and group telephone counselling, information and referral. The service is confidential and free of charge to callers.
Access	Clients can access the G-line call centre 24 hours a day, 7 days per week via a toll free 1800 telephone number. A TTY 1800 number is also available for the hearing impaired. An internet website (www.g-line.org.au) is accessible in 13 languages.
Coverage	Services delivered on a statewide basis in Victoria, Tasmania, South Australia and Western Australia.
Counselling staff	Professionally qualified telephone counsellors with specialist skills in problem gambling counselling and crisis management.
Funding	Funding for G-line services is received from state governments under contracts to provide those services for each state.

Source: Addiction Research Institute (sub. 37).

Group telephone counselling for problem gamblers is a program operated by the ARI which involves three to five clients participating in six, semi-structured, one-hour tele-counselling sessions per week. A G-line psychologist acts as the group's facilitator, and clients are required to make a commitment to participate in all sessions.

How do clients hear about G-line?

The main ways in which callers obtain the telephone number for G-line are reported in table 17.4. The information relates to Victoria, which has operated the G-line service for the longest period of time. The relative importance of the different referral sources has varied over time, with the most important *current* sources being the telephone book or directory assistance, notices at gambling venues, and brochures or pamphlets.

Table 17.4 **Main referral sources to G-line: Victoria**
per cent

Referral source	*Dec-98*	*Sep-98*	*Jun-98*	*Mar-98*	*Dec-97*	*Sep-97*	*Jun-97*
Family/friends, etc	6	10	8	6	6	6	11
Phone book, directory	30	32	29	20	18	13	38
Brochure/pamphlet/poster	20	24	25	8	6	7	17
Media (Paper/TV/radio)	7	7	12	45	56	63	14
Venue notice	28	19	15	11	9	8	12
Other	9	8	11	11	6	4	8
All	100	100	100	100	100	100	100

Source: Information supplied by Addiction Research Institute.

But the media was overwhelmingly the main referral source from the September quarter 1997 to the March quarter 1998. A publicity campaign for G-line during that period resulted in between one-half and two-thirds of callers listing the newspaper, television or radio (and especially television advertising) as the primary source of referral. It is clear then that media publicity can play a vital role in raising people's awareness of the availability of the G-line telephone help service.

How many clients are contacting G-line?

In some states, G-line has been operating for only a relatively short period of time (South Australia) or only on a pilot basis (Queensland). In relation to New South Wales, the Trustees of the CCBF declined to release G-line data to the Commission other than as an unidentifiable component of national G-line data. In respect of Western Australia, some concerns about the reliability of the G-line data were expressed to the Commission by the WA Lotteries Commission.

For these reasons, only limited information on the number of callers is available for reporting here — for Victoria and Tasmania (table 17.5). The trends in the number of calls to G-line in Victoria illustrate the importance of the ongoing need to keep

potential clients fully informed of the availability of the service by publicity and awareness campaigns.

Table 17.5 **Number of calls to G-line, by period and state**[a]

Half-year ending	*Victoria*	*Tasmania*
December 1996	4 077	n.a.
June 1997	4 274	27
December 1997	7 169	82
June 1998	6 354	67
December 1998	5 028	66 [b]

a The information relates to 'genuine' calls only. Because of the anonymity afforded callers, it is not possible to distinguish between those who contacted G-line once and those who made contact more than once, unless this was disclosed during the counselling process. Hence, the information refers to calls rather than callers.

b Relates to September quarter 1998 only

Source: Addiction Research Institute; Eckhardt 1998.

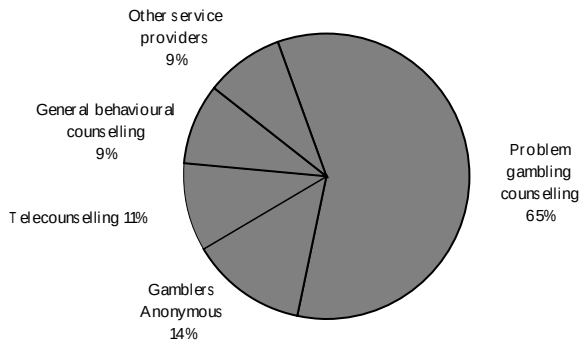
In Victoria, the number of calls to G-line increased steadily from the inception of the service in October 1994. In each of the first three quarters of 1995, total calls almost doubled, to reach around 700 in the September quarter 1995. A publicity campaign to increase awareness of the service later that year saw the number of calls increase from an average of 6-8 calls per day to 40-60 per day (Boreham et al. 1995, p. 28).

More recently, in the twelve month period to June 1997, 8351 calls were made. However, in the following twelve month period to June 1998, the number of calls jumped to 13 523. This period coincided with a major television and radio publicity campaign from July 1997 to February 1988. Since the June 1998 quarter, calls have declined somewhat with the number in the six-month period to December 1998 reaching 5028.

Where does G-line refer clients?

The current referral pattern for clients who contacted G-line in Victoria in the December quarter 1998 is depicted in figure 17.3. Around two-thirds of callers were referred to a problem gambling counselling agency, while around 15 per cent were advised to contact Gamblers Anonymous.

Figure 17.3 **Referrals by G-line to help services, Victorian clients**



Source: Information supplied by Addiction Research Institute.

17.6 Problem gambling counselling services

In this section, several aspects of problem gambling help services are examined, such as:

- how do people affected by problem gambling find out about counselling services?;
- how many people are attending problem gambling counselling services?;
- what types of gambling related problems do clients experience?;
- what types of counselling/treatment do clients receive?; and
- what are the outcomes of the counselling/treatment?

Some of the findings reported are drawn from the Commission's *Survey of Counselling Services.* Details on key characteristics of clients of these agencies, drawn from the Commission's *Survey of Clients of Counselling Agencies*, are reported in chapter 7.

How do clients find out about problem gambling counselling agencies?

The main referral and information sources for clients attending problem gambling counselling agencies are reported in table 17.6 for a selection of jurisdictions. In Victoria, the most important referral source is the telephone counselling service G-line, which accounted for 37 per cent of all referrals among new clients in 1997-98. In New South Wales and Tasmania, where G-line had been operating for a shorter period, the proportion of referrals from that source was only around 20 per cent.

Table 17.6 **Referral and information sources for clients of problem gambling counselling agencies**

Referral/information source	*Vic* [a]	*NSW* [b]	*Tas* [c]	*WA* [d]	*SA* [e]	*PC survey* [f]
Self-initiated	29	10	8	35	-	30
Family/friends	13	19	11	10	41	22
G-line	37	21	22	5	n.a.	21
Another agency/service	7	20	35	9	16	18
Brochure/advertising/media	8	11	9	10	10	-
Other therapist/counsellor medical /health service	6	6	-	4	4	-
Ministry of Justice/legal/parole	5	4	-	11	-	-
Telephone book	-	- [g]	6	17	12	-
Other/not known	4	9	9	-	17	9

[a] Based on problem gambler client registration data for 18 Break Even agencies, 1997-98. These percentages sum to more than 100 because some clients reported more than one referral source. [b] Based on a survey of 45 problem gambling counselling agencies, August 1998. [c] Based on registration data for 102 clients of Break Even agencies, July 1997 to September 1998. [d] Based on registration data for 123 clients. [e] Based on client registration data for Break Even agencies, November 1996 to March/May 1998. [f] Results from *Survey of Counselling Services*, referral sources reported by 79 agencies, weighted by the number of problem gamblers attending each agency. [g] Included in the advertising category.

Sources: Jackson et al. 1999b; Walker 1998a; Eckhardt 1998; ORGL 1999b; Elliot Stanford & Associates 1998; PC *Survey of Counselling Services*.

In seeking to explain why the share of referrals from G-line in New South Wales might not have been higher, Walker (1998a) concluded that:

> ... the most likely explanation is that the G-line service has not been advertised sufficiently widely. Although signage and brochures present the 1800 number for G-line, it may well be the case that large numbers of problem gamblers simply do not realise that help is a telephone call away and that there is likely to be a counsellor nearby who is easily accessible (p. 16).

In the one state reported in the table which had no G-line service at the time of the data collection (South Australia), family and friends were the most important referral source. That source is also relatively important in the other states.

In Tasmania, the large proportion of referrals from other agencies is largely accounted for by referrals from the group support organisation GABA, which was responsible for referring 19 per cent of the clients attending the two problem gambling counselling agencies (Relationships Australia and Anglicare).

Self referrals are relatively high in Victoria and Western Australia, whereas in the other states they take a much a lower ranking. Jackson et al. (1999b) have commented on the Victorian self referrals as follows:

> This concept of self-referral is a difficult one. While clients may be urged by others to seek help for their gambling associated problems, unless an actual referral is made, the client is regarded as self-referred. … Conversely, if a client self-refers to an agency, and that agency subsequently advises that Break Even is a more suitable agency to deal with the client's problem, then a referral from another health or welfare service is recorded, even though the client initiated the original contact (p. 39).

Self-referral might also be something of a catch-all category where a counsellor is not sure of the source of referral. With these provisos, results from the Commission's *Survey of Counselling Services* suggest that referrals initiated by problem gamblers themselves are the most common source of referral. Family/friends and G-line were also important referral sources, with Other agencies of slightly lesser importance overall. The relative importance of telephone help services as a referral source differed across jurisdictions. For example, the proportion of referrals in Victoria, Tasmania and New South Wales from G-line were 54 per cent, 23 per cent and 15 per cent respectively, whereas in the other states in which it has been introduced more recently, G-line accounted for less than 10 per cent of referrals.

How many clients are attending problem gambling counselling agencies?

The available information on the number of clients attending problem gambling counselling agencies is presented in table 17.7. Because the introduction of Break Even services is only relatively recent in some states, time series information is very limited. Similarly, the available information on clients is not always comparable — sometimes referring only to new clients rather than all clients, and combining problem gamblers with those *affected* by problem gambling.

The information for New South Wales on the number of problem gamblers receiving counselling or treatment is available from surveys commissioned by the CCBF and conducted by Walker (1997, 1998a). The surveys sought to obtain a complete coverage of clients attending all agencies providing services for problem gamblers, and included not only counselling and treatment services funded by Government sources, but other services as well. Among the findings were that:

- 310 problem gamblers were counselled during a one week period in September 1998, compared with 154 during a comparable week in 1997; and
- approximately 2377 problem gamblers received counselling during the twelve-month period to September 1998, compared with 1972 for the same period in 1997.

The annual figures suggest an increase of 20 per cent in the number of problem gamblers being counselled and treated by agencies in New South Wales between 1997 and 1998.

Table 17.7 **Number of clients attending problem gambling agencies**

State/Territory	*Period*	*Source*	*Number of clients*
NSW	1997	Survey of service agencies	1 972 problem gamblers
	1998	Survey of service agencies	2 377 problem gamblers
	Sept 1997 (1 week)	Survey of service agencies	154 problem gamblers
	Sept 1998 (1 week)	Survey of service agencies	310 problem gamblers
Victoria	1995-96	18 Break Even agencies	1 324 new clients
	1996-97	18 Break Even agencies	1 817 new clients [a]
	1997-98	18 Break Even agencies	3 149 new clients [b] 4 024 clients in total
Queensland	Sept 1998 to April 1999	3 Break Even services	384 new clients [c]
SA	1997-98	Break Even agencies	749 clients [d]
WA	1997-98	Centrecare services	160 clients [e]
Tasmania	1997-98	Break Even agencies	143 new clients [f]
	July 1998 to April 1999	Break Even agencies	241 new clients [f]
ACT	1997-98	Lifeline ACT (Gambling and Financial Counselling Service)	314 gambling counselling sessions; 109 financial counselling sessions

[a] Around 84 per cent were people who had problems with their own gambling behaviour. [b] Around 80 per cent were people who had problems with their own gambling behaviour. [c] Clients attending Break Even services in Brisbane, Gold Coast and Townsville for the 8-month period. These three agencies account for around 60 per cent of Break Even services funding in Queensland. Assuming service delivery is proportional to funding, and scaling up client attendances to a 12-month period gives an annual estimate of around 960 new clients. [d] 70 per cent were gamblers. There is some uncertainty attached to the SA figures. Elliot Stanford & Associates (1998) report a total of 4807 Break Even clients during the period November 1996 to March/May 1998. However, such a figure seems extremely high, relative to numbers attending in Victoria and NSW. The quoted figure of 749 clients is sourced from Department of Human Services 1999. The number of clients seen by the Break Even network in 1996-97 was 1645, of which 68 per cent were gamblers. Again, these figures appear to go against trends because in other States the number of clients has been increasing in recent years. [e] 83 per cent were gamblers. [f] Includes problem gamblers and those affected by problem gambling.

Source: Jackson et al. 1997, 1999b; Walker 1998a; Eckhardt 1999; ORGL 1999b; Department of Families, Youth and Community Care (Queensland) 1999; Department of Human Services (SA) 1999; Department of Education and Community Services (ACT) 1999.

The number of new clients presenting to the 18 Break Even problem gambling counselling services in Victoria increased from 1324 in 1995-96 to 1817 in 1996-97 (an increase of 37 per cent) and to 3149 in 1997-98 (a further increase of 73 per cent) (Jackson et al. 1997, 1999b). The overall number of clients attending counselling sessions in 1997-98 was 4024, which included new clients receiving counselling for the first time and clients who first presented prior to 1 July 1997 but who also obtained counselling in 1997-98. Around 80 per cent of the new clients

were problem gamblers themselves, with the remaining 20 per cent being partners and others affected by someone else's problem gambling behaviour.

Other jurisdictions have also recorded substantial increases in the number of clients attending problem gambling agencies. For example, if the available information for Tasmania for the period from July 1998 to April 1999 is scaled up to an annual basis, the increase over attendances in 1997-98 represents a doubling.

Information on client numbers attending Break Even services in Queensland is limited for a number of reasons. Although Break Even agencies collected some data prior to September 1998, use of the data base was inconsistent and as a result the statistics do not accurately reflect service delivery during the past few years (Department of Families, Youth and Community Care 1999). However, since September 1998 some limited but consistent statistical recording of clients has occurred and for that reason, only information for the period September 1998 to April 1999 is reported in table 17.7.

In South Australia, clients of Break Even services are allocated an encrypted identifier where possible, so that those who return at a later date or who attend more than one service can be identified. But of the 1645 clients in 1996-97, 30 per cent had an encrypted identifier while of the 749 clients in 1997-98, 55 per cent had an encrypted identifier. From these it is possible to identify repeat clients, but a limitation is, of course, that not all clients have an identifier.

The data in table 17.7 are consistent with a significant increase in the number of clients attending problem gambling counselling services in recent years. However, it is difficult to estimate the *total* number of clients that are *currently* attending problem gambling counselling agencies because of:

- differences in time periods and types of clients in the available data; and
- the information on clients of counselling agencies for all states except New South Wales includes only those attending services funded by Government sources. Hence in jurisdictions where there are also services providing help for problem gamblers that do not receive government funding, the reported figures will understate the *overall* number of problem gamblers receiving treatment.

In an effort to assemble the most up-to-date information, the Commission conducted its own *Survey of Counselling Services*. Findings are reported in table 17.8 on the number of clients (problem gamblers and those affected by problem gambling) receiving counselling or other help in the 12 month period prior to the survey. The agencies are classified into those which specialise in providing services for people experiencing gambling problems, and non-specialist agencies which provide help; and by jurisdiction.

The 53 specialist problem gambling counselling agencies which responded reported helping around 7 886 gamblers in the 12 months prior to the survey and a further 1 563 clients affected by someone else's gambling were also helped. Combined with around 2 157 helped by the non-specialist agencies surveyed, overall the respondent agencies reported counselling or helping around 11 600 problem gambler clients and other clients affected by someone else's problem gambling.

Table 17.8 **People seeking problem gambling counselling or help**

Number in 12 months period prior to survey

Agency/jurisdiction	*Agencies*	*Gamblers*	*Others*	*Total*
Specialist problem gambling	53	7 886	1 563	9 449
Non-specialist	26	1 720	437	2 157
NSW	21	3 448	484	3 932
Victoria	23	2 441	441	2 882
Queensland	8	969	306	1 275
Western Australia	5	180	32	212
South Australia	15	1 952	581	2 533
Tasmania, ACT, NT	7	616	156	772
Total	79	9 606	2 000	11 606

Source: PC *Survey of Counselling Services*.

Looking at the number of problem gambling clients by jurisdiction, differences arise between the survey findings (table 17.8) and the information in table 17.7 because of factors such as:

- *survey nonresponse* — not all agencies that were approached to participate in the Commission's survey agreed to do so, and not all who agreed to participate actually responded. For example, of 126 agencies included in the sample frame, 106 agreed to participate while completed returns were received from 82 (refer appendix L).
- *differences in coverage* — identifying all the agencies which provide counselling and help services for people with gambling problems in all of the various jurisdictions is a difficult task, and while the Commission's survey aimed to be as comprehensive as possible, inevitably coverage was less than complete. But the coverage of agencies in table 17.7 (apart from New South Wales) is also incomplete in that the reported data focus on agencies that receive government funding. Examples of differences in coverage include the following:
  - While 23 Victorian organisations providing problem gambling services responded to the Commission's survey, only 9 of these were common to the group of 18 Break Even services analysed in table 17.7. Hence, the Commission's survey includes data on 14 organisations which provide

problem gambling services but which are not covered in the Break Even statistics in table 17.7.

  - Similarly, the Commission's survey included 16 of the 45 agencies included in the Walker (1998a) survey for New South Wales, but also 6 agencies that were not in the Walker survey.

- *differences in time periods*. The Commission's survey data relates to the 12 month period prior to when most agencies completed the survey (around mid 1999). This is more recent than most of the data in table 17.7.

The information in *both* tables 17.7 and 17.8 understates the likely number of people affected by problem gambling because:

- *some group support organisations are excluded* — for example:
  - Walker (1998a) reports that attendances at Gamblers Anonymous meetings in New South Wales are around 550 in any given week; and
  - GABA in Tasmania reported overall attendances of 1740 at their weekly meetings from April 1997 to end-August 1998 (Eckhardt 1998).
- *many non-specialist help services are excluded* — not all problem gamblers seek help from agencies which specialise in the provision of problem gambling services. Some may seek help from generic community service, financial or relationship counselling agencies (other than those included in the Commission's survey).

On the last point, Professor Jan McMillen commented that:

> The work we've [the Australian Institute for Gambling Research] done suggests that we're really just seeing the tip of the iceberg in the designated gambling agencies. A lot of people are going to other support agencies for help, agencies that aren't getting funded to provide gambling assistance and don't have the time or resources to collect data and I think it's putting great pressure on those agencies (transcript, p. 1495).

Women's Health West (sub. 176) reviewed a range of information on clients of generic support services in Victoria, and while it is not possible to quantify the proportion of financial counselling caseloads which have gambling-related financial problems — because such information is typically not collected by these agencies — the following assessment seems apt:

> ... the caseload of the local Break Even service [is] a considerable underestimate of the workload imposed on community agencies by clients with gambling-related issues (sub. 176, p. 15).

The *Survey of Counselling Services* also provides an indication of the extent to which the number of clients presenting for counselling has *changed* in the last 12

months. Agencies were requested to provide information on their caseload of clients with gambling problems at the time of the survey and 12 months earlier. For the 64 agencies which reported information at both points in time (or who had commenced providing problem gambling services only in the previous 12 months), their overall caseload at the time of the survey was 2059 clients, compared with 1542 clients at the same time 12 months ago. Hence, the caseload of problem gamblers reported by respondents increased by around one-third in the space of a year.

In summary, it is difficult to know precisely how many clients are seeking help for problems related to gambling behaviour, because neither the information presented in table 17.7 nor that from the Commission's survey in table 17.8 is complete in its coverage. Because the findings from the Commission's survey are the most up-to-date, the number of problem gamblers (new and ongoing clients) and those affected by someone else's problem gambling behaviour who attended problem gambling counselling agencies in the past year is likely to be *well in excess* of 12 000.

There is a need for a National Minimum Data set to be collected on clients of problem gambling counselling agencies, using an identical set of definitions across all jurisdictions and an approach that would allow repeat clients to be identified as well as clients who attend more than one counselling service. The suggested approach would be not unlike that currently in place in relation to hospital admissions.

Problem gamblers who *do* and *don't* seek help

There has been some comment in the literature about apparent inconsistencies between the number of people estimated to be experiencing problems from gambling as suggested by the prevalence estimates (chapter 6) and the number of people who seek help for gambling related problems. The discrepancies are often used to suggest that the prevalence estimates overstate the extent of problem gambling. But as Thomas et al. (1998) have commented:

> There is ... the possibility that the 'low' numbers of clients presenting to problem gambling services may be due to low service uptake. In other words, there may well be large numbers of people with problems who do not present to services for a variety of reasons (p. 13).

Some of the reasons why people experiencing gambling problems might not seek help include:

- a limited knowledge of the availability of services;
- poor location of services;
- hours of operation might not be convenient;

- problems might not be considered serious enough;
- preference for other more informal assistance;
- cultural and/or gender factors; and
- the stigma associated with gambling problems.

Anglicare (SA) mentioned that some problem gamblers are deterred from seeking help because of feelings of shame and embarrassment:

> Many people, because of the shame and stigma associated with gambling problems, carry the burden in isolation, lacking the confidence or strength to disclose the problem to established social networks. ... Attending [a counselling] service for some people is embarrassing and avoided at all costs (sub. 104, p. 21).

Break Even-Eastern Problem Gambling Service commented that:

> Because there is so much stigma attached to problem gambling, many people are reluctant to seek help. Some ethnic groups do not seek assistance because culturally it is inappropriate to do so. To some cultures the concept of counselling is unknown (sub. 40, p. 8).

Jesuit Social Services referred to the under-use of gambling support services among the Vietnamese community as follows:

> The reluctance of gamblers and their families to seek outside help has been attributed to reasons such as the lack of community knowledge about services, the unfamiliarity with the concept and benefits of counselling, denial, shame, and lack of time or priority for focus on personal and psychological issues. Other communities such as the Arabic community share similar reasons for not attending formal support services (sub. D201, p. 1).

The gamblers who *do* seek help are usually motivated by some crisis involving one or more of the following triggers (Eckhardt 1998, p. 16):

- generally reaching 'rock bottom' or a crisis point and having nowhere else to turn;
- in a situation of major financial difficulty, family breakdown, job loss and/or criminal charges;
- a high level of sheer desperation and panic;
- contemplating suicide.

As Banyule Community Health Service noted:

> In our observation, many clients do not present until the problem is at crisis point and this has often occurred after a long period of gambling activity. In financial terms this crisis may be reached when savings are exhausted, credit is refused, bankruptcy filed, or criminal charges are pending (sub. 146, p. 2).

There is very limited information available on the proportion of problem gamblers who seek help. A study by Volberg (1997) estimated that only about 3 per cent of current pathological gamblers obtain professional treatment in a given year (not including participation in self help groups like Gamblers Anonymous). Volberg found that public clinics in the US state of Oregon had around 600 patients and/or affected family members per year, compared with an estimated prevalence of around 20 000 pathological gamblers.

To shed light on what the proportion of people with gambling problems who seek help might be, the Commission's *National Gambling Survey* sought information on whether (regular) gamblers in the last 12 months had:

- wanted help for problems related to their gambling;
- tried to get help for these problems; and
- received problem gambling counselling/support.

Around 0.8 per cent of adults reported they had wanted help, slightly less than half of these indicated they had tried to get help (0.32 per cent) and two-thirds of those who tried to get help reported they had received counselling for problems related to their gambling (table 17.9).

Table 17.9 **Help seeking by Australian gamblers**

Nature of help seeking behaviour	*Share of adult population (%)*	*Number of adults ('000)*
Wanted help for problems related to gambling	0.78	111
Tried to get help for problems related to gambling	0.32	45
Received counselling/support for gambling problems	0.20	28

Source: PC *National Gambling Survey.*

The scores obtained on the SOGS for the help-wanting and help-seeking groups of respondents is of interest.

- 97 per cent of those wanting help had a SOGS score of 5+, of which:
  - 26 per cent had a SOGS score of 10+ (severe problems); and
  - 71 per cent had a SOGS score of 5-9 (less severe problems).
- *all* of those who had sought help had a SOGS score of 5+, of which:
  - 34 per cent had a SOGS score of 10+; and
  - 66 per cent had a SOGS score of 5-9.

Furthermore, looking at the two categories of problem gamblers (figure 17.4):

- of those with a SOGS score of 10+, 63 per cent said they wanted help, 32 per cent had tried to get help and 23 per cent had received counselling/support; and
- of those with a SOGS score of 5-9, 32 per cent said they wanted help, 12 per cent had tried to get help and 7 per cent had received counselling.

Hence, the survey results suggest that perhaps 1 in 5 gamblers with severe problems obtain counselling whereas around 1 in 14 with less severe problems receive help.

Figure 17.4 **Help seeking behaviour by severity of gambling problems**

	WANTED HELP	TRIED TO GET HELP	RECEIVED COUNSELLING
SOGS 10+ (46,790)	63% (29,350)	32 % (15,040)	23% (10,590)
SOGS 5-9 (245,940)	32% (78,630)	12 % (29,750)	7 % (17,880)

Source: PC *National Gambling Survey*.

Respondents who indicated that they had tried to get help in the last 12 months for problems related to their gambling were asked:

- how they found out about services available to help people with gambling problems;
- who they first turned to for help for their gambling problems; and
- whether they had received counselling for problems related to their gambling.

Because the prevalence rate for problem gambling help seeking is small (0.32 per cent of the adult population) the number of help seekers identified in the survey was only 19. With the proviso that qualifications may attach to the representativeness of these respondents, some results are reported in table 17.10.

The most common ways in which respondents found out about help services for problem gambling were from signs and pamphlets (32 per cent) and the telephone directory (37 per cent). Also, respondents were most likely to turn firstly to their spouse/partner or family/friends for help in relation to their gambling (in 37 per cent of cases) while someone outside their immediate personal network (such as a GP or social worker or religious worker) was consulted in 26 per cent of cases. In respect of the organisations from which respondents obtained help:

- seven respondents reported attending Gamblers Anonymous (GA) — two of whom only attended GA, while five also received counselling from Lifeline or a Break Even agency; and
- eleven respondents reported having received counselling from an agency such as Lifeline, Break Even, a welfare or church organisation (for example, Salvation Army, Wesley, Anglicare) or a community health centre.

Table 17.10 **Aspects of problem gambling help seeking behaviour**[a]

Respondents who tried to get help in the last 12 months

How did you find out about help services?	*%*	*Who did you first turn to for help?*	*%*	*Where have you received counselling?*	*%*
Signs at a gambling venue	11	Spouse or partner	16	Gamblers Anonymous only	11
Pamphlets at gambling venue	16	Family or friends	21	GA and counselling agency	26
Signs or pamphlets elsewhere	5	GP (general practitioner)	5	Break Even or other agency	32
Telephone directory	37	Church or religious worker	11	Can't say	32
Radio and TV advertising	16	G-line or other referral service	11		
Newspaper	11	Social worker	11		
Health professional	16	Gamblers Anonymous	16		
Financial adviser	11	Someone else	21		
Word of mouth	11	Can't say/refused	11		
Asked someone for help	11				
Didn't/couldn't find out	11				
Other	11				
Can't say	5				

a Percentages may sum to more than 100 because some respondents found out about help services from more than one source, and turned to more than one person/group for help.

Source: PC *National Gambling Survey*.

But six respondents were unable to say where they had received counselling — of these, four had turned to someone for help while the remaining two either refused or were unable to say who they first turned to for help. So it is likely that while this group of respondents sought help in a broad sense, they may well not have obtained counselling or treatment.

On this assumption, the prevalence rate for people receiving counselling/support for problems related to their gambling is 0.20 per cent (table 17.9) — which scaled up to the population gives an estimate of around 28 000. The 95 per cent confidence interval around this estimate ranges from around 10 500 to 46 500. How do these results from the *National Gambling Survey* compare with the likely *actual* number of people seeking counselling for problem gambling — comprising problem gamblers and those affected by problem gambling?

The conclusion is that the *National Gambling Survey* findings are broadly consistent with the available data. It was noted above that the help organisations in the

Commission's *Survey of Counselling Agencies* reported seeing around 12 000 clients in the last 12 months, but that this number is likely to be a substantial underestimate of the total number of people seeking help for problem gambling because coverage of the survey was not complete, and it did not include people who attended Gamblers Anonymous meetings or who received help from generic counselling and help agencies. While the actual number is therefore difficult to estimate, it is likely to lie somewhere in the vicinity (on the lower side) of the *National Gambling Survey* mean estimate.

Star City casino was critical of findings such as these, suggesting the need for a "reality check" and pointing to:

> The massive discrepancies between the [number of] persons attending counselling agencies (as problem gamblers or persons affected) and the Commission's … estimate of gamblers with severe problems …(sub. D217, p. 23).

But the fact that many problem gamblers do not access help services is consistent with help seeking behaviour in other health and social problem areas. For example, the ABS *National Survey of Mental Health and Wellbeing of Adults* (ABS 1998d) found that only around 12 per cent of people with substance use disorders used available health services.

What problems are experienced by clients of counselling agencies?

To illustrate the variety of problems experienced by problem gamblers who seek help from counselling agencies, some information from clients of Victorian problem gambling agencies is reported in table 17.11.

Table 17.11 **Presenting problems of clients — Victorian problem gambling counselling services**

Per cent

Nature of problem	*1996-97* [a]	*1997-98* [b]
Gambling behaviour	87	89
Financial issues	77	57
Employment/work	51	24
Interpersonal/relationship	67	49
Legal issues	29	10
Family issues	66	39
Leisure use issues	74	44
Intrapersonal	80	56
Physical symptoms	44	13

[a] Relates to 1452 clients of 18 Break Even problem gambling counselling services. [b] Relates to 2456 new clients of 18 Break Even problem gambling counselling services.

Source: Jackson et al. 1997, 1999b.

The most common problems experienced by clients relate to their gambling behaviour, financial issues and intrapersonal problems (such as anxiety, mood swings, etc). Jackson et al. (1999b) note that while most problem gamblers who attend counselling present with more than one problem, the proportion reporting multiple problems has declined over the years — for example, 81 per cent of clients in 1995-96 reported 4 or more problems compared with 56 per cent in 1997-98. This suggests that problem gamblers are now seeking help earlier in their gambling careers.

Because of the wide range of problems that problem gamblers experience, counselling agencies need to have a range of skills to meet the needs of clients or, where those services are not available in-house, can refer a client to a suitable agency. Accordingly, the Commission's *Survey of Counselling Services* sought information on the types of services provided by agencies (table 17.12).

Table 17.12 **Services for people experiencing problems with their gambling**
per cent of agencies

Service provided	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Other* [a]	*Total*
Counselling for gambling dependence	95	100	100	67	93	86	94
Counselling for other co-morbidities	59	57	13	50	13	57	44
Legal advice	23	17	0	0	7	14	14
Financial counselling	50	65	75	17	87	43	60
Family counselling	82	91	63	67	73	71	79
Relationship counselling	77	87	100	67	87	71	83
Referral to other agencies/professionals	86	100	88	67	87	71	88
Emergency help	18	35	0	17	47	0	25
Other services	9	30	50	33	20	14	23

[a] Tasmania, ACT and NT.

Source: PC *Survey of Counselling Services*.

While, understandably, counselling for gambling dependence is the most common service provided, relationship and family counselling are also relatively important. Acting as a referral source to other agencies was the second most frequent service provided — presumably to other types of counselling, such as legal advice, which is much less generally available.

What types of gambling are the main source of problems?

There is a consistent pattern in Australia in relation to the forms of gambling that lead to or are associated with problem gambling (table 17.13). While gaming machines are overwhelmingly the form of gambling favoured by clients who seek

help for gambling problems, betting on horse racing and casino gaming are also sources of problems for some participants. A very small proportion of clients of counselling agencies report playing lottery games as the source of their problems.

Table 17.13 **Gambling activities favoured by clients of help services** [a]
per cent

Gambling activity	*Vic* [b]	*Vic* [c]	*NSW* [d]	*SA* [e]	*Tas* [f]	*PC survey* [g]
Gaming machines	81	72	79	68	72	71
Racing/TAB	20	16	12	16	15	12
Casino games	6	5	6	6	3	7
Lotteries	3	4	2	3	1	2
Other/combination	-	8	1	-	8	8

a Some percentages may sum to more than 100 because the question asked of clients did not in all cases require a unique response. **b** Relates to Break Even clients, 1996-97 — gambling activity on the most recent day of gambling. The entry for casinos refers to 'card games' and 'numbers'. **c** Relates to Break Even clients, 1997-98. **d** Relates to 310 clients seeking help in a one week period in September 1998 from a survey of 45 agencies providing counselling and treatment services for problem gamblers. Refers to the main form of gambling leading to problems for the client. **e** Relates to 986 clients of the Break Even agencies during the period November 1996 to March/May 1998. Refers to the type of gambling causing problems for clients. **f** Relates to 93 clients attending Relationships Australia and Anglicare in the period July 1997 to September 1998, whose preferred form of gambling was recorded. **g** Main source of gambling problems for clients of counselling agencies, weighted by number of clients.

Sources: Jackson et al. 1997; Walker 1998a; Eckhardt 1998; Elliot Stanford & Associates 1998; PC *Survey of Counselling Services*.

The Commission's *Survey of Counselling Services* revealed some appreciable differences in sources of gambling problems by jurisdiction. For example:

- gaming machines are overwhelmingly the main source of problems in all jurisdictions except Western Australia, where access to video card and keno machines is restricted to the casino;
- race betting and casino games are relatively important sources of problems in Western Australia (each causing problems for around 30 per cent of problem gamblers) and in Queensland (each accounting for problems in around 15 per cent of cases); and
- while lottery games attract the highest participation rates among gamblers Australia-wide, they are typically not associated with problematic behaviour. However, in Western Australia they account for gambling problems in around 9 per cent of cases, and in Queensland 4 per cent.

How are problem gambling clients assessed in terms of treatment needs?

The Society of St Vincent de Paul pointed out that formal assessments of problem gambling clients can serve a variety of purposes, such as (sub. D218, pp. 1-2):

- assisting in treatment planning and delivery;
- providing a baseline measure which can be used to assess progress and measure the effectiveness of counselling; and
- providing an input to research — by translating psychological states into data.

It is important to consider the ways in which counselling agencies assess the severity of gambling problems as a preliminary to providing clients with the most appropriate treatment.

An advantage of having a statewide network of problem gambling counselling agencies (such as Break Even) is that consistent approaches to assessing clients can be used by agencies. In Victoria, for example, at the first contact with a Break Even counselling agency, a client assessment form is completed which records details of the type and frequency of gambling behaviours, and the adverse effects of these behaviours including an assessment based on the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition).

But as Banyule Community Health Services in Victoria noted:

> Break Even is required to assess clients in accordance with the DSM-IV. Some counsellors consider this inappropriate to the range of behaviours presenting and prefer the South Oaks Gambling Screen. ... The recent development of a 'G-map' by the Break Even team at Maroondah Community Health Centre may be deemed a more relevant tool for assessment (sub. 146, p. 2).

The Break Even agencies in South Australia collect an even wider range of data on clients, including the South Oaks Gambling Screen, the Marks Parkin General Health questionnaire, the Index of Family Relations and the Work and Social Adjustment Scale. However, the information is collected only from clients who consent to provide the information — and only around one-third of problem gamblers who attend give their consent (Elliot Stanford & Associates 1998, p. 20). This is a serious weakness, and limits the extent to which the effectiveness of any problem gambling intervention can be gauged.

To gain an indication in a more general context of how problem gambling clients are assessed when they present for counselling, the Commission's *Survey of Counselling Services* sought information on the diagnostic tools used by counsellors to assess problem gambling severity and other client characteristics (table 17.14).

Table 17.14 **Frequency of use of diagnostic tools for assessing problem gambling clients, Australia**

per cent of agencies

Assessment tools	*Never*	*Rarely*	*Some-times*	*Often*	*Always*	*Don't Know*	*Total*
South Oaks Gambling Screen (SOGS)	35	8	18	18	17	4	100
DSM-IV criteria	21	14	16	12	35	3	100
G-Map assessment guide	68	10	14	4	0	4	100
Addiction Severity Index	79	13	3	1	0	4	100
Gamblers Anonymous 20 questions	55	20	17	4	3	3	100
Taylor-Johnson temperament analysis	91	3	3	0	0	4	100
Relationship questionnaire	61	5	17	8	6	3	100
Other formal diagnostics	45	3	18	20	13	1	100

Source: PC *Survey of Counselling Services*.

Across the 78 problem gambling counselling agencies which provided information, the use of one or more of the available diagnostic tools was generally not commonplace. The SOGS was never or only rarely used in 44 per cent of agencies, and the DSM-IV never or only rarely used in 36 per cent of agencies. At the other end of the scale, the DSM-IV was always used in around 35 per cent of agencies, and the SOGS always used in around 17 per cent of agencies.

The frequency of use of diagnostic tools by agencies in the various jurisdictions are reported in table 17.15. On the basis of findings from the September 1998 survey of New South Wales agencies, Walker described practices by problem gambling service providers as generally being "far from satisfactory" and "not reaching the standards set in Victoria or New Zealand":

> The majority of counsellors and therapists have no formal assessment of the problems caused by gambling or the severity of the gambling problem itself. The DSM-IV assessment criteria are not widely used and a full assessment of co-morbidity is made by only three treatment professionals. With only one exception, structured interviews are not used in assessment. The G-map assessment guide is not used. The addiction severity index is not used. The South Oaks Gambling Screen is not widely used (1998, p. 17).

However, both the Commission's *Survey of Counselling Services* and Walker's more recent 1999 survey of New South Wales agencies suggest that the situation has changed. In the Commission's survey, 55 per cent of agencies in New South Wales reported using either the SOGS or DSM-IV 'often or always', with their use being even more common among agencies in Queensland, South Australia and Victoria. Walker's 1999 survey undertaken around six months later than the Commission's survey reveals even more widespread use of these tools among New South Wales agencies, with around 90 per cent using a recognised assessment. According to

Walker, this change in procedure has probably occurred because of training schemes initiated in New South Wales in the last two years, a demand by the CCBF that assessment be included, and also possibly the stark findings from the 1998 report (sub. D287).

Table 17.15 **Frequency of use of diagnostic tools, by jurisdiction**
per cent of agencies using often or always

Assessment tools	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Other* [a]	*Total*
South Oaks Gambling Screen (SOGS)	45	5	0	0	88	43	35
DSM-IV criteria	45	73	100	0	8	29	46
Either SOGS or DSM-IV or both	55	73	100	0	88	43	67

[a] Tasmania, ACT and NT.

Source: PC *Survey of Counselling Services*.

The Society of St Vincent de Paul pointed out that appropriate counselling and treatment depends on more than just using preliminary formal assessment tools like the DSM-IV or SOGS — rather, assessment should be an ongoing part of the counselling process:

> … it needs to be pointed out that counsellors are making assessments, judgements, and evaluations of the client continuously as part of the counselling program. … We should recognise formal assessment for what it is. It is simply a systematic and replicable way of observing or asking questions of the client, which often enables the client's responses to be compared to a normative group or groups. Whether such quantification and comparison assists the therapeutic process is open to debate (sub. D218, p. 1).

The Society of St Vincent de Paul also indicated that the need and scope for formal assessment will differ depending upon the particular needs of the client and that different situations call for a variety of assessment/counselling approaches (sub. D218, pp. 1-2). In particular, the Society stressed:

- the importance of relationship building in the therapeutic process — sometimes it may be best simply to accept the client's opinion as to the degree of his or her problem, rather than searching for an objective measure of the client's distress, especially in crisis situations or where time is limited; and
- the appropriateness of brief interventions and single-session therapy with some clients — for clients who only attend one session of counselling, a treatment such as motivational interviewing would be appropriate, whereas subjecting the client to a full assessment of co-morbidity would be counterproductive.

In summary, around two-thirds of the counselling agencies at the time of the Commission's survey were often or always using at least one of the two most widely

recognised problem gambling diagnostic tools. But because of the different types of clients who present for counselling, the use of less structured and formal assessments by some agencies can still be consistent with meeting the counselling and treatment needs of particular clients.

What types of counselling and treatment are used by problem gambling agencies?

There is a wide range of counselling and treatment services available to assist people affected by problem gambling. Such services can differ in relation to the form of help, the types of problems being addressed, and the nature of the counselling/treatment provided (box 17.5).

Free Yourself Program — an example of a self-help therapy

The 'Free Yourself Program' is a self-help approach developed by Gabriela Byrne, a former problem gambler (subs. 9, 74, D196). 'Free Yourself' aims to free people of their 'addiction' to gambling, based on improving their physical, mental and spiritual wellbeing. The program was developed as an alternative to approaches used by Gamblers Anonymous and conventional problem gambling counselling.

Group support/self-help approach — Gamblers Anonymous

Gamblers Anonymous (GA) views compulsive gambling as an illness, and the only way to recover from this illness is to stop gambling — the illness/abstinence model. The number of GA meeting groups in the various jurisdictions are: New South Wales (69), Victoria (31), Queensland (18), South Australia (4), Western Australia (2), Tasmania (2), Northern Territory (1), and ACT (3). Walker (1997) reported that in New South Wales, an estimated 550 gamblers attended GA meetings each week in 1997, compared with 154 attending all other problem gambling counselling agencies each week in that year.

Approaches used by problem gambling counselling agencies

A number of problem gambling counselling agencies reported on the counselling and treatment approaches to problem gambling that they typically used, and a selection is presented in box 17.6. As Break Even-Western commented:

> Problem gamblers are variously referred to as compulsive, pathological, addictive or excessive. The varying terminology reflects the differing views on the nature of the problem, and consequently different models and approaches that are used in treatment (sub. 64, p. 4).

Box 17.5 **Broad types of help/treatment for problem gambling**

Self help — is where an individual is largely responsible for dealing with the problems associated with their gambling, drawing upon information provided in self-help kits distributed by some counselling agencies and programs developed by former problem gamblers, such as:

- *Free Yourself Program* (Gabriela Byrne 1997); and

self-help guides developed by clinical practitioners, such as:

- *Overcoming Compulsive Gambling: A self-help guide using Cognitive Behavioural Techniques* (Alex Blaszczynski 1998b).

Group support — is another type of self-help approach but in a group context, such as that used by:

- Gamblers Anonymous, and
- GABA (in Tasmania).

Counselling — usually involves individual or group face-to-face counselling with problem gamblers, their partners, or others affected by problem gambling behaviour. The types of counselling can cover one or a combination of the following:

- gambling behaviour (addiction) counselling
- financial counselling
- relationship counselling
- family counselling and support
- legal advice
- counselling for co-morbidities (psychiatric/emotional disorders, alcohol, drugs).

Medical approaches — adopt more intensive therapies for treating problem gambling, in cases where clients present with signs or symptoms of disorders (such as a suicide risk or a co-morbid condition such as schizophrenia) which indicate such treatment is appropriate, and can involve:

- inpatient or residential care
- medication therapy (for example to control depression or reduce impulsivity).

The Commission's *Survey of Counselling Services* sought information on the approaches or techniques used by the agencies to treat problem gamblers (table 17.16). The information refers to the proportion of agencies which use a particular method, rather than the proportion of clients who are treated by a technique. With that proviso, the general impression is that as many agencies appear to be using modern types of treatment like cognitive-behavioural therapy (CBT) as are using more traditional supportive counselling approaches.

There is some debate as to what are preferred types of treatment for problem gambling. As Blaszczynski, Walker et al. (1997) have noted:

> There is a consensus that problem gambling is a treatable condition … However, there is no single intervention modality that is the 'gold standard' or 'best practice' in the

management of problem gambling. Strategies and goals should be developed in conjunction with the client, taking into account co-morbid conditions and other relevant environmental factors (p. 19).

Box 17.6 **Counselling and treatment approaches used**

- Society of St Vincent de Paul — use an approach called GAME (a proGram for gAmblers and their faMilies with problEms) which is a non-medical 'competency-based' program, involving a combination of financial counselling and goal oriented therapy. Such an approach places an emphasis on working with clients to achieve *their* goals, and means that it does not necessarily advocate abstinence from gambling (sub. 36).
- Break Even Southern (Victoria) — typically uses a two-stage counselling/treatment process. The first stage uses behavioural and cognitive behavioural interventions to address gambling itself. Treatment in middle and later stages typically incorporates a range of techniques to address relapse prevention and interventions for other life issues faced by clients (sub. 132).
- Break Even-Western — uses a family therapy/systemic approach involving three main constructs: the model of change (change is possible for gamblers and their families, but it is a slow process that needs to be worked out); assessment of gambling behaviour (clients are provided with rational, program-oriented therapy, learning rules for responsible gambling or how to give up completely); and exploration of underlying factors, mainly through systems theory (to determine what problems contribute to gambling as an escape) (sub. 64).
- Relationships Australia (SA) Inc. — uses an approach which focuses on crisis management (including immediately assisting clients with legal, financial and relationship issues); attention to gambling behaviour (including the development of individual strategies to modify or cease this behaviour); resolution of underlying issues (to ensure long-term effectiveness of intervention); and management and response to lapses (sub. 118).
- Wesley Gambling Counselling Service — stressed that problem gambling counselling requires flexibility and the use of a broad range of techniques. Utilisation of only one method is very limiting and in fact may not be helpful for clients requiring different strategic approaches. Therefore, as each individual has their own personality and style, so the counselling approach must be suited to the unique needs of the individual client (sub. 26).

Currently favoured interventions include behavioural modification techniques and cognitive techniques, either on their own or in combination (CBT). But in relation to past New South Wales experience, Walker (1998a) has commented that:

> With few exceptions, counsellors and therapists are not using these approaches. When asked about their approach, many counsellors responded that they talk to the client and from their experience know what to say. [But] client-centred counselling has been shown to be relatively ineffective across a wide range of problems (p. 18).

Results from the Commission's *Survey of Counselling Services* appear to suggest a generally more favourable picture: a high proportion of the agencies which responded reported the use of cognitive, and cognitive-behavioural techniques, even

in New South Wales. This finding is consistent with the 1999 New South Wales survey conducted by Walker, where it was found that CBT is the most commonly used approach (sub. D287).

Table 17.16 **Techniques used to treat people with gambling problems**
per cent of agencies

Methods/techniques	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Other* [a]	*Total*
Supportive counselling [b]	91	100	100	67	94	86	93
Cognitive/Cognitive-behavioural [c]	86	100	100	67	81	86	89
Systemic therapies [d]	59	70	75	33	69	71	65
Psychodynamic therapies [e]	27	52	50	0	38	29	37
Other methods or approaches	32	57	25	50	75	29	48

[a] Tasmania, ACT and NT. [b] Includes allowing clients to vent feelings and offer a general supportive environment. [c] Includes analysis of beliefs through pattern restructuring; behavioural advice. [d] Includes structural, strategic family therapy, psychodrama. [e] Includes use of transference.

Source: PC *Survey of Counselling Services*.

Another source of information on approaches to treatment in government funded Victorian problem gambling agencies is the analysis of the 18 Break Even services (Jackson et al. 1999b). That study found that the most common treatment technique used was supportive counselling (for 60 per cent of problem gambler clients), cognitive behavioural approaches (33 per cent of clients) and systemic therapies (19 per cent of clients). However, these results are not necessarily inconsistent with the Commission's findings — the *Survey of Counselling Services* obtained information on whether a particular technique was being used, but cannot distinguish clearly between whether most or only a few clients are receiving such types of treatment.

Any conclusion on the application of different treatment approaches remains uncertain, because as Walker has suggested, the issue of treatment is a complex one and possibly one that is not accurately described by any data:

> The problem is knowing what actually occurs in therapy. An agency may say that it uses CBT but we do not know how strictly the criteria for CBT are being met. … CBT is a "buzz" word in therapy currently and most counsellors will have heard the term and have some understanding of what is involved. But whether their understanding is sufficient to categorise their own therapy is another matter (sub. D287, p. 2).

Training and accreditation of counsellors

The Commission's *Survey of Counselling Services* sought information on whether agencies required counsellors to have accreditation. Across the 82 respondent agencies, it was found that:

- 71 per cent of agencies required counsellors to have accreditation; and
- 89 per cent required counsellors to have educational qualifications.

While these results might seem favourable, the details provided by agencies on the types of accreditation indicated very few requirements in problem gambling specific counselling areas. For example, while two of the New South Wales agencies reported training of staff at the Wesley Gambling Counselling Service course, other accreditations were typically in areas such as social worker, psychologist, addiction counselling qualification, etc.

Some respondents to the survey also expressed concerns about training and accreditation, with comments such as:

- "accreditation body for training is lacking" (New South Wales agency)
- "there should be a minimal accreditation requirement of all those who work in gambling counselling" (SA agency)
- "our counsellors would appreciate the availability of more training" (New South Wales agency)

Training was seen as an important issue by the Ethnic Affairs Commission NSW:

> Training is particularly important because it ensures that those working with problem gamblers do so professionally, using sound and proven methods, based on an understanding of the cultural basis for gambling problems (sub. D281, p. 142).

Walker has indicated that there is a move in New South Wales to set up accreditation standards for the training of problem gambling counsellors (sub. D287).

The Commission sees merit in a framework being established to achieve improved training and a consistent accreditation process for gambling counsellors Australia-wide.

What outcomes are achieved by counselling/treatment?

The effectiveness of problem gambling counselling services can be gauged in terms of the extent to which clients achieve the outcomes they seek. In relation to gambling behaviour, for example, client expectations prior to counselling can range from wanting to stop gambling completely, to 'getting in control' such that gambling is no longer the source of any significant problems.

At Break Even problem gambling agencies in Victoria prior to August 1997, a Case Close Summary Form was completed at the final contact with a client. The

outcomes recorded were whether the problems for which a client primarily sought help were either fully resolved, partly resolved or unresolved. The outcomes for clients whose problem gambling counselling was completed in 1996–97 are reported in table 17.17. It should be noted that some clients who dropped out before indicating to a counsellor that they were not planning a further contact would not be included — though it is difficult to speculate the extent to which dropouts cease further contact because their problems have been resolved.

Table 17.17 **Client outcomes of problem gambling counselling, Victoria, 1996-97** [a]

Problem area	*Fully resolved (%)*	*Partly resolved (%)*	*Unresolved (%)*	*Clients with problem (No.)*
Financial issues	14.8	48.2	37.0	670
Gambling behaviour	27.1	42.3	30.6	840
Interpersonal	18.9	45.3	35.8	603
Family issues	17.7	45.9	36.3	586
Physical symptoms	41.1	32.4	26.5	392
Employment/work role	30.6	29.7	39.7	421
Leisure use issues	19.0	48.0	32.9	583
Intrapersonal	19.1	52.5	28.4	669
Legal issues	57.1	19.7	23.1	350

a Information relates to 1001 clients whose cases were closed in the period.

Source: Jackson et al. 1997.

There is considerable variation in the extent to which particular problems were resolved after counselling. While problems in all areas were either partly or fully resolved in the majority of cases, problems remained unresolved in 20 to 40 per cent of cases. The two areas with a relatively larger degree of problems being fully resolved were physical symptoms and legal issues associated with problem gambling. In other areas like financial issues, interpersonal and family issues, it is perhaps not surprising that problems may take longer to resolve than just the period of the counselling. Jackson et al. conclude that:

> ... while many clients experience full resolution of their problems, ... it is the case that many do not achieve resolution. ... This is consistent with the chronic nature of problems experienced by people with problem gambling behaviour (1997, p. 29).

Other information on outcomes of counselling services is available from a survey of clients of Break Even agencies in South Australia, conducted by Elliot Stanford & Associates (1998) as part of an evaluation of the GRF. A questionnaire was provided to all clients attending Break Even services during a two-week period, which sought perceptions on the severity of their problems before they started

counselling and at the time of the survey, and the extent to which counselling had made an impact on their problems (table 17.18).

Table 17.18 **Client perceptions of outcomes of problem gambling counselling, SA**

Severity of the gambling problem	*Clients No.*	*No problem (%)*	*Slight (%)*	*Definite (%)*	*Marked (%)*	*Very severe (%)*
Before counselling	130	1	5	18	19	57
Currently	129	10	34	32	11	13
Impact of counselling on gambling related problems:		*Made no difference (%)*	*Slight difference (%)*	*Definite difference (%)*	*Marked difference (%)*	*Very large difference (%)*
Gambling behaviour	118	-	21	31	31	18
Family & relationships	73	6	14	36	29	16

Source: Elliot Stanford & Associates (1998, Appendix 7).

The Elliot Stanford & Associates' survey revealed that before counselling, 76 per cent of clients perceived their gambling behaviour to be causing marked or very severe problems, whereas only 24 per cent still thought that way currently. Also, around half the clients thought that counselling had made at least a marked difference in their gambling behaviour, with only a slightly smaller proportion (45 per cent) reporting a similar impact on family and relationship problems. Again, these data have the proviso that the sample respondents were still in treatment, and so perceptions of dropouts were not captured.

The Society of St Vincent de Paul reported on outcomes from their GAME program, which involves a combination of financial counselling and goal oriented therapy as follows:

> We ... found that we have a high client self report (85 per cent approximately) success rate where clients received at least some improvement in their gambling behaviour. ... By focussing on the positive and their competencies, we offer them hope [and] this in turn motivates them to change (sub. 36, p. 3).

However, a limitation of much of this evidence on gambling treatment outcomes is that it is very short term in nature, with assessments generally made at the time of, or immediately after, counselling. What is more important in determining if treatment is effective is whether follow-up assessments of outcomes made at different points in time after counselling yield similar results.

To investigate this and other aspects of gambling treatment outcomes, the Commission's *Survey of Counselling Services* sought information on:

- whether an agency made an assessment of the outcome of the counselling for each client;
- how soon after completion of the counselling such an assessment was made; and
- what percentage of clients achieved a satisfactory outcome from the counselling provided.

Overall, 71 per cent of respondent agencies reported that they assessed how successful the counselling treatment had been for each client (table 17.19). In around two-thirds of the agencies, such assessments were carried out immediately after counselling was completed and in around one-third of agencies from one to three months after completion. But assessments after periods longer than three months were not common. Three of the agencies reported that they undertook multiple follow-ups — such as after 3, 6 and 12 months.

Table 17.19 **Assessment of client outcomes of gambling counselling**
per cent

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Other*[a]	*Total*
Assess outcomes of counselling (per cent of agencies)	77	48	100	100	75	57	71
How soon after counselling? (per cent of agencies) [b]							
Immediately after	64	70	38	50	81	71	66
1-3 months after	36	4	88	33	31	29	31
4-6 months after	9	52	0	17	6	0	20
More than 6 months after	9	0	0	0	0	0	2
Satisfactory outcome achieved (per cent of clients) [c]	63	54	41	42	52	49	57

[a] Tasmania, ACT and NT. [b] Percentages can sum to more than 100 because some agencies reported more than a single assessment period — some only assessed clients some months after completion of counselling rather than immediately, while others assessed clients immediately after counselling as well as some months later. [c] Calculated as the percentage of an agency's clients achieving a satisfactory outcome, weighted by the number of clients.

Source: PC *Survey of Counselling Services*.

Across the various jurisdictions, on average 57 per cent of the clients of respondent agencies were assessed by those agencies as having achieved a 'satisfactory' outcome from the counselling provided in the sense that gambling was no longer the source of any significant problems for the client. But because clients were generally assessed either immediately or a short time after counselling was completed, this is not necessarily an indication of the longer term effectiveness of the counselling and treatment provided. As Walker (1998b) has noted:

> From the perspective of counsellors, it may appear that most of their clients benefit from the counselling received; the majority of clients are satisfied with the counselling

> and the clients have not gambled during the counselling program. However, to believe that counselling is effective based on such perceptions is fundamentally misguided. … The recommended period at which to judge the effectiveness of counselling therapy is *two years* after the completion of treatment (p. 53).

Results from a longitudinal study of client outcomes from problem gambling treatment programs in Minnesota have been reported by Stinchfield and Winters (1996). In that study, clients were administered follow-up assessments of outcomes at periods of 6 and 12 months after treatment. One finding of interest is that while most clients were gambling on a daily or weekly basis before treatment, 79 per cent reported no gambling at the conclusion of treatment. However, this impressive outcome was not sustained — the proportions reporting no gambling after 6 and 12 months were 43 per cent and 42 per cent respectively.

Short-term assessments of outcomes can therefore give a misleading impression of treatment effectiveness. According to Walker (1998a), a review of the literature on treatment outcomes indicates that correctly measured success rates (such as after a follow-up period of two years) are typically only about 20 per cent with supportive counselling — for example, around 80 per cent of problem gamblers so treated return to excessive gambling within two years. However, the exceptions to this generally negative view of treatment are behavioural modification techniques and cognitive-behavioural techniques (Walker 1998b, p. 52).

17.7 Aspects of help services delivery

This section addresses a number of issues relating to the effectiveness of delivering problem gambling help services to clients.

Who should contribute to funding problem gambling services?

As noted in section 17.4, the parts of the gambling industry which contribute to the funding of problem gambling services differ among jurisdictions. For example:

- in New South Wales a portion of the tax paid by the Sydney Casino operator is hypothecated to the CCBF;
- in Victoria funding is derived from gaming machines in hotels only;
- in Queensland funding is derived from gaming machine and keno revenue;
- in South Australia contributions to funding are made by hotels and clubs;
- in Tasmania funding is derived from gaming machines in hotels and clubs; and

- in the Northern Territory funding is derived from gaming machines in hotels only.

There is a broader-based approach in Western Australia, where the three major stakeholders contribute (Burswood Casino, the TAB and Lotteries Commission).

A number of participants were critical of the narrowness of the funding sources. For example, in relation to the approach in New South Wales the Society of St Vincent de Paul stated that:

> ... whilst Star City is obliged by legislation to contribute 2 per cent of their revenue to combat the negative effect of their activity, there is no such legislation relevant to other gaming venues. Only 2 per cent (approximately) of our clientele are 'victims' of the activities of Star City whilst 80 per cent (approximately) are [those] of the pubs. This illustrates how the casino must subsidise the rectification of the socially negative aspects of gambling in pubs and to a lesser degree clubs (sub. 36, p. 5).

Gamblers Help Line Inc. suggested that the funding sources of the CCBF should be broadened to include not only *all* gambling/gaming operators but also a contribution from the government as well:

> ... all businesses which profit directly from gambling operations should contribute — not just the casino. ... As the industry moves to seriously addressing responsible gambling issues and problem gambling issues, it would seem glaringly obvious that the Government do the same through policy and financial support. [Gamblers Help Line] recommends that the government pay to the Community Benefit Fund $1 for every $2 the industry contributes (sub. 179).

In Tasmania, Tascoss was critical of the fact that no contributions to funding problem gambling services are made from the profits on gaming machines located within the casino complexes:

> Patrons using the gaming machines through casinos are [just] as likely to be experiencing gambling related problems as those within the wider community, particularly given the revenue increases in this area (sub. 114, p. 3).

For the Northern Territory, a recent review of the gaming machine industry (Alder 1998) made suggestions in relation to both the uses and sources of the Community Benefit Fund as follows:

> ... the CBF ... should only be used for gambler services, gambler education and gambling research ... [and] this revenue [should] be drawn from the gambling industry as a whole (0.25 per cent of all gambling gross profits) (Alder 1998, p. 15).

Anglicare (SA) was critical of the approach in South Australia, and suggested that all gambling codes should contribute to the GRF:

> It is important to acknowledge that problem gambling can be associated with other codes [as well as pokies]. In making $1.5 million p.a. available to fund the Break Even

> gambling services, the Australian Hotels Association and Licensed Clubs Association are accepting responsibility for helping pokie gamblers with a problem. Other gambling codes are at present not doing that, despite the fact that their patrons needing counselling attend Break Even programs (sub. 104, p. 17).

The Australian Hotels Association (SA) and Licensed Clubs Association (SA) shared this view:

> ... neither the racing industry via the TAB nor the Lotteries Commission make any provision, either voluntarily or otherwise to the provision of services to those adversely affected by broader gambling products despite the fact that it was widely recognised that there were significant problem gamblers before gaming machines were introduced (sub. 101, section 7a).

All gambling forms contribute to the need for problem gambling services and therefore should also contribute to funding. While in principle some differentiation by gambling code according to the risk of becoming a problem gambler might be appropriate — for example, lottery games rarely contribute to problem gambling — in practice this would be too difficult to administer over time. Gaming machine revenue should be the predominant source, and this should be regardless of venue.

The Commission is of the view, therefore, that the funding arrangements for problem gambling counselling and support services, as well as research and public education programs, should include compulsory contributions from all gambling codes. This should not negate government responsibilities in broader health areas.

Are funding levels for problem gambling strategies adequate?

A number of participants commented on the adequacy of the funding arrangements in their jurisdiction. Reporting on the experience in South Australia, the Adelaide Central Mission stated that:

> Existing services for problem gamblers are over stretched and subjected to unreasonable uncertainty regarding their future funding. The scope of services available is restricted and does not adequately meet the needs of particular groups of people, particularly families of problem gamblers and problem gamblers facing criminal charges. At Adelaide Central Mission the complexity and number of cases that are arising has meant that our limited staff have difficulty maintaining manageable caseloads (sub. 108, p.18).

In relation to Tasmania, Tascoss (sub. 114) considered current funding of problem gambling services to be inadequate in a number of respects. They suggested that the Community Support Levy should be broadened (to include a contribution from the profits obtained from gaming machines within the casino complexes) and increased (by 2 percentage points) to allow (sub. 114, pp. 3-4):

- an extension of the community education program;
- a broader range of programs to be funded under Break Even; and
- research into problem gambling to be carried out.

According to Tascoss:

> The Break Even program [in Tasmania] has now developed a 'closed shop' approach with a limited number of programs funded on an annual basis. This has been undertaken without community consultation and has excluded a notable service provider, Gamblers Anonymous (sub. 114, p. 4).

A review of gambling legislation in the ACT by the Allen Consulting Group (1998) recommended earmarking 0.5 per cent of all gambling-related tax revenue to fund baseline research into problem gambling, measures to prevent problem gambling, and counselling for problem gamblers. This would correspond to funding of around $230 000 per year, compared with the $85 000 per year allocated at the time of the review. But according to Lifeline, even that higher level of funding:

> would not be sufficient to adequately fund the necessary research on gambling, provision of education programs, a 24-hour telephone service (G-line), an adequately resourced counselling service and independent evaluation of those programs (sub. 96, p. 3).

But in a more general context, to what extent are available problem gambling counselling services adequate to meet the demand for those services? A recent study by Walker (1998a) examined two aspects of problem gambling services delivery in New South Wales:

- whether clients face long waiting periods to see a counsellor; and
- the usage of services in relation to capacity (capacity being gauged as the maximum number of clients who could be seen if counsellors were to maintain their current standards).

The survey conducted by Walker (1998a) of 78 counsellors at 45 problem gambling agencies found that:

- only 3 of the 78 counsellors surveyed indicated that they had a waiting list (defined as whether a new client had to wait longer than seven days to see a counsellor); and

- services in New South Wales were generally working at around one-third of capacity.

However, because the number of problem gamblers seeking help in New South Wales appears to be increasing rapidly, if the number doubles again in the coming twelve months then more than 50 per cent of the maximum capacity of current services will be used in providing counselling and treatment (Walker 1998a, p. 16).

A similar assessment has been carried out for counselling agencies in SA as part of an evaluation of the GRF (Elliot Stanford & Associates 1998). Across the seven Break Even agencies examined, they found a variation in the utilisation of service capacity ranging from 34 to 99 per cent, with only one agency operating above 70 per cent capacity (Adelaide Central Mission). They also found that country services tended to have a lower utilisation rate than metropolitan services (28 per cent compared with 70 per cent respectively).

But the notion of what waiting time should be considered acceptable (say up to seven days) is debatable. Because waiting lists are a deterrent to a gambler's commitment to seek help, Eckhardt (1998) reports that agencies in Tasmania consider there is a need to reduce client waiting times — such as ensuring that a client can obtain counselling within 24 hours of the initial telephone contact.

Wesley Gambling Counselling Service also commented on waiting times as an indication that funding is inadequate for them to meet the needs of clients:

> We are now operating on a 'waiting list' of two weeks which is *not on* when dealing with problem gambling. During that waiting period, clients often go and gamble and fail to return (sub. 26, p. 17).

A Queensland agency reported that:

> This particular gambling counselling service has been severely under-resourced. We have been running a waiting list since October 1995. As at end March 1999, 52 per cent of those waiting have dropped out without accessing any assistance whatsoever (Respondent to *Survey of Counselling Services*).

To investigate how common this situation might be, the Commission's *Survey of Counselling Services* sought information on the frequency and duration of waiting times. Results are reported in table 17.20 for a metropolitan/regional breakdown of agencies.

Overall, slightly more than one-third of the 82 agencies reported that clients seeking counselling faced a waiting list, and the average waiting time for those agencies was 11 days. However, the survey also indicated that:

- the majority of agencies with waiting lists were able to schedule an appointment for clients in the coming week; and
- the proportion of agencies with a waiting list was systematically lower in regional areas.

Among the 22 New South Wales agencies which responded, four (18 per cent) reported a waiting list of longer than seven days. This proportion is somewhat higher than that obtained by Walker in three annual surveys of New South Wales agencies providing services for problem gamblers (sub. D287). Walker found that the number of agencies not able to offer appointments within a week was typically very small — for example, 3 out of 78 counsellors (from 46 agencies) in the 1998 survey. Two factors might account for the apparent differences. First, there are differences in coverage between the two surveys — of the 22 respondents to the Commission's survey, 16 are common to 45 agencies surveyed by Walker while 6 are not included in Walker's survey. Second, the fact that the Commission's survey was conducted at a different time of the year may also be part of the explanation — the Commission's findings may be representative of that different point in time.

Table 17.20 **Waiting list for clients with gambling problems seeking help**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Other*[a]	*Total*
Proportion of agencies with a waiting list							
Metropolitan	64	44	33	50	38	17	43
Regional	36	0	40	0	50	0	28
Total	50	30	38	17	44	14	37
Proportion of agencies with a waiting list longer than 7 days							
Metropolitan	36	19	33	0	13	0	20
Regional	0	0	20	0	38	0	11
Total	18	13	25	0	25	0	16
Average waiting time in days for agencies with a waiting list							
Metropolitan	10	10	15	7	7	7	10
Regional	4	0	17	0	15[b]	0	10
Total	8	10	16	7	11	7	10

[a] Tasmania, ACT and NT. [b] Includes two regional services where counselling was only available on one day per month.

Source: PC *Survey of Counselling Services.*

Overall, there appear to be some agencies which because of waiting lists of longer than seven days may not be delivering fully effective services to problem gamblers. But generally speaking, the availability of problem gambling counselling and treatment services appears adequate to meet existing demand for those services. However, there is also the issue of latent demand — any advertising to increase

public awareness of the help services available would put increased pressure on some agencies to meet any resultant increase in demand.

Funding arrangements with problem gambling service providers

Nature of funding agreements

Some participants in jurisdictions where counselling agencies are required to seek funding on an annual basis were in favour of longer term agreements. For example, in relation to the New South Wales arrangements, the Society of St Vincent de Paul stated that:

> In our opinion the current rounds of annual funding are inadequate and counterproductive and we would prefer a three year funding period instead of the current annual one (sub. 36, p. 4).

Similarly, Wesley Gambling Counselling Service reported on the problems that arise for agencies from the annual funding mechanism:

> When the yearly round of funding ends, our agency is required to wait until the next round of funding submissions is called for. In our case, our first year of funding ended on May1 1998, [and] ... submissions [for the next round of funding] were not called for until August, [which left] agencies waiting until end-November to find out if they were successful. ... This process is so time consuming and exhausting and it takes away from the very service we offer to the community (sub. 26, p. 18).

In a review of the Gamblers Rehabilitation Fund (GRF) in South Australia, Elliot Stanford & Associates also favoured a longer funding agreement for problem gambling counselling service providers:

> GRF funded services are one of the few Departmentally funded services [in SA] not to receive funding on a minimum three year cycle. This is an anomaly and needs rectification. There are concerns that the temporary nature of the funding arrangements impacts adversely on the development and retention of staff competency and service continuity (1998, p. 66).

In its Report on charitable organisations in Australia, the Commission favoured funding agreements with community social welfare organisations for a period longer than a year. The conclusion expressed in that Report is also relevant for funding agreements with problem gambling counselling agencies:

> Longer term agreements would provide greater stability of funding and allow [service providers] to plan with greater certainty. This would give [them] greater flexibility and offer increased opportunities to innovate rather than waste resources on repetitious negotiations (1995, p. 382).

Who should receive funding?

Because of the many different reasons why people take up gambling, and the broad range of harms that many gamblers experience, there is unlikely to be a single counselling or treatment solution for all problem gamblers. Hence the Commission favours the funding of a diverse range of problem gambling services, so as to ensure that:

- *clients have choice in relation to counselling and treatment approaches* — ranging from self-help and group support, to individual and group outpatient services, to inpatient or residential care (in cases, for example, where there is a suicide risk or where a co-morbid condition is present); and
- *needs of particular client groups are being met* — such as people of culturally and linguistically diverse backgrounds, aboriginal people, and women.

But with the proviso that it is also important that:

- *funding should not be wasted on treatments that are ineffective*.

On the second point, Walker (1998a, p. 18) reports that there are few services in New South Wales that cater specifically for the problems faced by the immediate family of the problem gambler, and suggests that such services might be made more available. Currently, the main support for family members is provided by the GamAnon self help groups. In relation to Tasmania, Eckhardt (1998, p. 27) also reported that services for families and victims of gambling need to be considered.

GABA indicated that they would like to provide more help for particular groups in the community such as the aboriginal community and elderly citizens groups. These communities have been approached and information presented but the response has been low (Eckhardt 1998, p. 23).

Rolling triennial funding arrangements for agencies, such as applies in Victoria, have merit because of associated advantages for service delivery in terms of planning, training and retention of skilled people. But such arrangements should be contingent on processes being in place to evaluate the effectiveness of the counselling and treatment services provided by agencies.

The efficacy of different types of counselling/treatment

While problem gambling counselling agencies use a wide variety of techniques and approaches to treat problem gambling behaviour, the question arises as to whether the techniques that are actually being used are the most effective. As Blaszczynski, Walker et. al. have stated:

> There is limited knowledge as to the best counselling and clinical strategies that should be applied for the management of problem gambling. There is a need for psychologists to carry out controlled treatment outcome studies to develop 'best practice' approaches in the management of problem gambling (1997, p. 23).

The Society of St Vincent de Paul suggested the value of funding clinical trials to compare the efficacy of different treatment methods:

> ... we feel the need for more research of the Brief Solution Focused approach [we use] to make more substantive claims about our therapeutic efficacy. We would welcome the opportunity to participate in a comparative outcome study with other applications (sub. 36, p. 4).

After reviewing the various approaches used to treat problem gambling (such as psychodynamic, behavioural, cognitive, addiction-based and self-help) and the available international literature on their effectiveness, the US Committee on the Social and Economic Impact of Pathological Gambling concluded that:

> At this point, we do not know which treatments work best and why they work, and we do not know the extent to which gamblers can recover naturally (1999, p. 211).

In view of the uncertainties surrounding the effectiveness of the various treatment approaches, the Commission sees merit in providing funding to allow:

- **problem gambling agencies routinely to carry out follow-up assessments of clients, at (say) 6 and 12 month intervals after counselling; and**
- **on a more limited scale, longitudinal research on client outcomes at (say) two and five year intervals after treatment.**

Such evaluations are important for determining best practice treatments for problem gambling and thus achieving more cost effective funding.

Needs of people of culturally and linguistically diverse backgrounds

The particular help needs of people with culturally and linguistically diverse backgrounds were raised by several participants. For example, Break Even-Western (Victoria) pointed out that many such people with gambling problems are not using mainstream counselling services to any significant degree (sub. 64).

The Chinese Community Problem Gambling Action Group (Victoria) stated that one reason for this is that mainstream counselling approaches are not appropriate for the Chinese and other ethnic communities:

> The Action Group is not convinced that therapeutic counselling, the organisation of self help groups and financial counselling provide an adequate range of service responses to

> the needs of Chinese people with gambling problems. ... Service providers (and government departments charged with the disbursement of funds to alleviate problem gambling) need to be much more 'open' to new suggestions as to effective ways to both inform and help those adversely affected by gambling activities (sub. 139, p. 4).

The Ethnic Affairs Commission (NSW) listed a number of factors why people in ethnic communities have particular difficulties in accessing problem gambling help services (sub. D281):

- lack of proficiency in English;
- a stigma about problem gambling that prevents them seeking help;
- a cultural tradition against discussing emotional problems, particularly with people outside the family;
- cultural values different from those that underpin Western concepts of counselling; and
- a lack of knowledge of available services.

Some Break Even agencies in areas with relatively large ethnic communities reported initiating projects to improve service delivery to these groups. For example, the issue of the most effective form of intervention was raised by Broadmeadows Care and Kildonan Child and Family Services. These two agencies commenced a joint project in December 1997 to work with ethno-specific communities in their regions to provide information about problem gambling counselling services and financial counselling. However, in their view, their experience so far:

> ... raises questions about the effectiveness of therapeutic intervention and financial counselling models as they are currently practised with such communities. ... [S]ignificant research about these two questions needs to be undertaken to inform Government and the community sector about the most effective form of intervention (sub. 77, p. 4).

The Commission sees benefit in the funding of further research on approaches for determining how best to deliver problem gambling help services to particular groups in the community for whom mainstream approaches may not be suitable.

Other counselling needs

Links between problem gambling and criminal offences are discussed in chapter 7 (and appendix H). Many problem gamblers turn to crime to finance their gambling habits once legitimate sources of funds are exhausted. The Commission's *Survey of Clients of Counselling Agencies* revealed that around 40 per cent of clients seeking

help had committed a gambling related crime at some stage of their gambling careers. While the majority of offences committed by problem gamblers do not result in legal action, typically around 40 per cent of offenders are charged and convicted. In relation to such problem gamblers, Blaszczynski, Walker et al. (1997) suggest that:

> Psychological rehabilitation programs should be recommended for offenders in addition to any penalty imposed by the courts (p. 23).

In considering the referral sources for new clients of counselling agencies (table 17.6), the detailed information available for some jurisdictions provides evidence of court order/legal system referrals. For example, around 5 per cent of new clients who attended Victorian Break Even services in 1997-98 did so to fulfil legal requirements that they receive counselling for issues associated with their gambling.

In relation to problem gamblers who receive custodial sentences, Marshall, Balfour and Kenner stated that:

> There is a gap in [problem gambling counselling] services for problem gamblers in custody and there is an urgent need to provide them with rehabilitation services (sub. 116, p. 15).

But whether problem gambling counselling and treatment alone for this group is likely to be effective (in the sense of making such people less likely to re-offend) depends on the nature of the crimes committed (Blaszczynski et al. 1989, pp. 150–1):

- for those committing only gambling related offences, treatment programs for the problem gambling may well be associated with a reduced likelihood to re-offend;
- but problem gamblers who engage in both gambling and non-gambling related offences would be expected to have higher recidivist rates and be less responsive to treatment; and
- for problem gamblers who engage in non-gambling related offences only, treatment for problem gambling only would be expected to be effective in reducing some gambling-related problems but to have little impact on their re-offending.

For the last two groups, there is a need for counselling and treatment for psychological and psychiatric co-morbidity as well as for problem gambling.

Coordination of services

An important consideration is the extent to which the current organisational structure of help services result in problem gamblers having their problems assessed adequately and receiving the most appropriate treatment.

In discussing assessment procedures in counselling agencies in the previous section, it was concluded that standards across jurisdictions and agencies are somewhat mixed. Because the most appropriate form of treatment for a problem gambler is likely to depend on the severity of the gambling problem, poor assessment may limit the ability to adequately deal with the problem.

In addition to assessment there is also the issue of referral. Even if organisations accurately assess the severity of the gambling problem, they may be reluctant to refer the client to the most appropriate treatment, instead attempting to help the clients themselves. As one participant reported:

> There were several opportunities for professionals in generic services to refer me on to a more appropriate, knowledgeable service … [but] most of these professionals appeared to want to retain my appointments for themselves which is service-centred care not client/family-centred care (confidential submission by the spouse of a problem gambler).

This raises the issue of whether there is a need for problem gamblers and those affected by problem gambling to have access to an independent source to assess their problems and then a subsequent referral to the most appropriate counselling or treatment.

Most states have contracted the ARI to provide a telephone counselling and referral service (G-Line). While providing a much needed service, the independence of G-Line is questionable given that it has been contracted to supplement the existing organisational structure in most states. G-Line, however, are only able to refer people to those organisations that actually exist, which largely depends on whether or not they receive government funding. These organisations are predominantly counselling agencies, some of which may be using relatively ineffective techniques in dealing with problem gambling. In addition, referrals made by G-Line are to some extent also geographically based rather than determined by what treatment is best for the individual.

Who should control the funds for problem gambling services?

Several participants raised concerns about the potential scope for the gambling industry to influence funding decisions. For example, a counselling agency in Western Australia stated that:

> One of the major constraints in WA is the funding body — given that the gaming industry funds our agency and has the desire to be involved in most decision making processes about funding allocation (Respondent to *Survey of Counselling Services*).

Similarly, a counselling agency in South Australia commented that:

> Whilst funding is through the State government, the actual funds are a donation from the Australian Hotels Association (AHA). As a result, they sit on the funding committee and have a greater than necessary influence on how funds are allocated. Also, funding is meant to be targeted at EGM gamblers as the other gambling codes refuse to pay a similar levy [as that] paid by the AHA (Respondent to *Survey of Counselling Services*).

However, the Australian Hotels Association disagreed with the counselling agency's view:

> The AHA does not have the balance of power on the GRF so therefore any recommendations the AHA makes can be rejected by the GRF. … We believe that the AHA's involvement on the GRF has been essential, facilitating better understanding between welfare agencies and industry (sub. D231, p. 79).

Given the potential for competing incentives with industry-based involvement, in chapter 22 the Commission presents a model with the funding of problem gambling programs being placed under the control of an independent board, established under the auspices of an independent gaming control authority.