



# **Independent Gambling Authority**

**Inquiry into effectiveness of gambling  
rehabilitation programs**

# **Report**

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**CONTENTS**

<b>1.</b>	<b>INTRODUCTION.....</b>	<b>1</b>
1.1	Terms of reference .....	1
1.2	Background to the inquiry.....	1
1.3	Process for the inquiry .....	2
1.4	Declaration of interest.....	2
<b>2.</b>	<b>MATERIAL BEFORE THE INQUIRY .....</b>	<b>2</b>
2.1	Overview .....	2
2.2	Government.....	3
2.2.1	Minister for Families and Communities .....	3
2.2.2	Department for Families and Communities .....	3
2.3	Industry.....	7
2.3.1	Australian Hotels Association (SA Branch).....	7
2.3.2	Licensed Clubs Association of South Australia Inc .....	8
2.4	Concern Sector (other than direct service providers).....	9
2.4.1	Heads of Christian Churches’ Gambling Taskforce .....	9
2.4.2	Hon. Nick Xenophon MLC .....	12
2.4.3	Break Even Network .....	15
2.4.4	SA Financial Counsellors Association .....	16
2.5	Direct service providers.....	17
2.5.1	Anglicare SA .....	17
2.5.2	Centre for Anxiety and Related Disorders, Flinders Medical Centre .....	20
2.5.3	Gambling Addiction Treatment Services .....	22
2.5.4	Lifeline South East .....	23
2.5.5	Nunkuwarn Yunti .....	24
2.5.6	Relationships Australia .....	26
2.5.7	Salvation Army .....	28
2.5.8	12 Steps Self Help Anonymous Group.....	29
2.5.9	UnitingCare Wesley Partners.....	30
2.7	Individuals.....	33
2.7.1	Anonymous problem gambler— written submission.....	33
2.7.2	“Peter”, attending the hearing .....	33
<b>3.</b>	<b>CONCLUSIONS.....</b>	<b>34</b>
3.1	Effectiveness generally.....	34

Inquiry into effectiveness of gambling rehabilitation programs

Contents (continued)

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3.2	Issues with effective service delivery and rehabilitation.....	34
3.2.1	Agency resources.....	34
3.2.2	Coverage .....	35
3.2.3	Outcome measurement.....	36
3.2.4	Capacity and competencies .....	37
3.3	Funding .....	37
3.4	Management by the Department .....	39
3.5	Recommendations .....	39
<b>APPENDIX A</b>	.....	<b>40</b>
	Call for submissions.....	40
<b>APPENDIX B</b>	.....	<b>41</b>
	List of people and organisations .....	41

## 1. INTRODUCTION

### 1.1 Terms of reference

This inquiry is established by terms of reference given by the Minister for Gambling, Hon. Michael Wright MP, under section 13(1)(b) of the *Independent Gambling Authority Act 1995*.

The terms of reference for this inquiry are—

#### 1. General Scope

1.1 The Authority must report on the effectiveness of each gambling rehabilitation program conducted or funded (wholly or partly) by the Government of South Australia.

1.2 In designing its process and its reporting for this inquiry, the Authority must take into account that a purpose in commissioning this inquiry is to enable the Minister to comply with section 91 of the *Gaming Machines Act 1992*.

It has been indicated that the report should be made available to the Minister for Gambling by 9 June 2005.

### 1.2 Background to the inquiry

The *Gaming Machines (Miscellaneous) Amendment Act 2004* (Amendment Act) was assented to on 9 December 2004.

The Amendment Act was the end product of a very extensive debate in Parliament on a Bill to implement the recommendations of the Independent Gambling Authority in its *Report of Inquiry into the management of gaming machine numbers*, the most notable one being the recommendation to reduce gaming machine numbers by 3 000.

Certain provisions inserted into the Gaming Machines Act by the Amendment Act require the Minister to obtain a number of reports from the Authority. Of particular relevance is the new section 91:

#### **91— Minister to obtain report on gambling rehabilitation programs**

- (1) Within 6 months after the Governor assents to the Gaming Machines (Miscellaneous) Amendment Act 2004, the Minister must obtain a report from the Authority on the effectiveness of each gambling rehabilitation program conducted or funded (wholly or partly) by the State Government.
- (2) The Minister must, within 6 sitting days after receiving the report, have copies of the report laid before both Houses of Parliament.

### **1.3 Process for the inquiry**

The process for this inquiry was designed with a view to the Authority gathering and having before it all the relevant material in time to report to the Minister in June 2005.

The start of the process was to publish terms of reference and call for submissions; this was done by way of advertisements placed in the *Advertiser* on 25 and 29 January and the *Australian* on 25 January 2005. The text of the advertisement is set out in **Appendix A**.

To coincide with this call, a *Guide for making submissions* was issued on 25 January 2005. The guide set out the timetable for public consultation and gave some direction as to making formal submissions to the inquiry. The *Guide* also identified some of the issues it was thought might be usefully addressed by the stakeholders.

Written submissions were received from a number of stakeholders in late March 2005. The submissions are available on the Authority's website.

A public hearing was held on Tuesday, 12 April 2005. On that day the Authority heard from a number of those who had made submissions, from the Minister for Families and Communities and from a problem gambler who had attended the hearing.

Lists of those who made submissions and presented are set out in **Appendix B**.

The Authority subsequently asked, and received answers to, a set of questions directed to the Department for Families and Communities.

The inquiry process was completed by the delivery of this report to the Minister for Gambling.

### **1.4 Declaration of interest**

At the time the terms of reference for this inquiry were provided to the Authority, Mr Dale West (a member of the Authority since 1 October 2001) declared to the Authority that he was the director of an agency of the Catholic Diocese of Port Pirie, Centacare, which provided services falling within the terms of reference. He took no part in the inquiry process.

## **2. MATERIAL BEFORE THE INQUIRY**

### **2.1 Overview**

The material before the Authority, in this Inquiry, was comprised the contents of written submissions (provided to the Authority in March 2005) and what was offered to the Authority in a public hearing held in April 2005.

Submissions were received from five distinct areas:

- ◆ Government—both the Minister and the Department responsible for the provision of gambling rehabilitation services provided material;

- ◆ Industry—there were submissions from the peak bodies representing the holders of hotel and club gaming machine licences;
- ◆ the Concern Sector generally—organisations or individuals with a general or peak-body interest in gambling and problem gambling issues;
- ◆ direct service providers—agencies providing rehabilitation services to problem gamblers, including agencies funded from the Gamblers Rehabilitation Fund;
- ◆ two individual problem gamblers.

## 2.2 Government

### 2.2.1 *Minister for Families and Communities*

The Minister for Families and Communities advised the Authority that the South Australian Government had made a decision to reform its arrangements in relation to problem gambling services. The Minister prefaced the detail of the changes to arrangements with observations about the harm continuing to be caused by problem gambling, about problem gambling behaviour in relation to other vulnerabilities suffered in the community, and about the strain placed on the families of problem gamblers.

The Minister told the Authority of the Government's augmentation of the committed to gambling rehabilitation, and emphasised the need for those funds to be expended with rigour and vigour.

The Minister detailed the changes to arrangements as follows—

- ◆ the first is to incorporate the functions previously performed by the Gamblers Rehabilitation Fund Advisory Committee into the functions of the Department for Families and Communities;
- ◆ the second is to promulgate a statement of joint responsibilities between the Minister for Gambling and the Minister for Families and Communities, for the purposes of clarifying shared responsibilities existing in relation to problem gambling services.

The Minister anticipated that these changes would allow for greater co-ordination and integration of services to families. He also stated that, as an intended effect of the changes, the Minister for Families and Communities would now accept a greater level of responsibility for planning and evaluation of problem gambling services.

### 2.2.2 *Department for Families and Communities*

The Department for Families and Communities (DFC) supports the Minister for Families and Communities to fulfil responsibilities for the development and delivery of services aimed at addressing the negative social impacts of gambling, and supporting those affected by problem gambling by—

- ◆ administering the Gamblers Rehabilitation Fund (GRF);

- ◆ convening the Gamblers Rehabilitation Advisory Committee (membership is detailed in the 2004 Strategic Review report appended to the submission);
- ◆ undertaking work that informs service design and delivery, and community education processes (ie, best practice service models, research, evaluation, strategic information);
- ◆ implementing information strategies for promoting awareness of problem gambling and services.

The GRF was established in 1994 and has been managed by DFC over that time (or equivalents of the Department following a number of restructures). It is located within the Community Services Branch and is strategically linked to a range of antipoverty and community based funding programs managed by the branch. The role of the DFC central management is to prepare and monitor expenditure, service the GRF Advisory Committee, and report annually on financial and service outputs and outcomes.

A number of reviews have been undertaken with regard to the GRF since 1995, primarily about particular aspects of the program (eg, funding policy, information strategy and framework, Gambling Helpline, media campaign, Culturally And Linguistically Diverse services). Two reviews have been specifically about the GRF—*Evaluation of the GRF Program* (1998) and a major review (as opposed to an evaluation) completed in late 2004 resulting in the recently released report “*The Prevention and Treatment of Problem Gambling in South Australia Through the Gamblers Rehabilitation Fund: A Strategic Review*, a draft copy of which is appended to the submission.

As a state funded program, the GRF has to comply with public sector accountability and the performance criteria that are associated with public sector administered funds.

Details of the funding sources and amounts (in 2003/4 the Government contributed \$1.8 million, and hotels and clubs \$1.5 million) and the allocation of those funds, are provided in the Strategic Review report. In-kind support provided by DFC is also identified, while details of some specific funding allocations are provided in the primary submission (eg, in 2003/04 \$250 000 was allocated to GRF funded services for one off projects that addressed specific target groups and priority areas, examples of which are appended to the submission; funding is provided to support the Break Even Network, the mechanism by which service providers discuss service co-ordination and issues arising, exchange information with other bodies, and communicate with the Department on matters of common interest to service planning and delivery).

The submission identifies that considerable increase in the program’s scope since its inception has placed the funding base under pressure. The Strategic Review report identifies that the Government has recently increased its funding by \$350 000 per annum for the specific purpose of counselling support for venues. However, it also identifies that there is uncertainty about the continuation of the industry contribution.

The current scope of the GRF program, which offers a free therapeutic and financial counselling service (the *Break Even* service) to people concerned about their own or a significant other's problem gambling issues, includes—

- ◆ regionally based (metropolitan and rural) and state-wide community services, that also provide community education programs—services are generic and population specific (eg, Aboriginal, and Culturally and Linguistically Diverse populations); multimodal in interventions (the Strategic Review report details the range of therapies and approaches utilised by Break Even counsellors, and identifies that intervention approaches are inclusive of associated issues such as financial, legal, housing crisis, and relationship issues);
- ◆ 24 hour state-wide telephone Helpline—provides crisis counselling, information, and service referral);
- ◆ Centre for Anxiety and Related Disorders at Flinders Medical Centre—hospital based intensive treatment program; state-wide referrals; focused on treatment of problem gamblers using Cognitive Behaviour Therapy (CBT); small inpatient capacity; also funded to offer support and training re CBT to other GRF funded services.

Functions provided by DFC to support the services provided by the GRF, are—

- ◆ state-wide community education strategy;
- ◆ training (recently outsourced), service co-ordination, establishment of communication networks across service providers and related services;
- ◆ research and evaluation to build an evidence base for funding allocation, planning and service development;
- ◆ data management and reporting;
- ◆ administration and contract management.

The submission and the Strategic Review report provide an overview of what each of these areas entails and its role with regard to the conduct of the GRF program. For some of these areas, issues that have arisen, recent developments for improvement (eg, training and data management and reporting), and specific performance indicators, are also identified.

The overarching performance indicator framework for the GRF program and its services has existed since 1996, with effectiveness and efficiency being the two key performance indicators. Indicators of effectiveness involve measuring—

- ◆ accessibility and equity—the extent to which the target group (ie, people with gambling problems and their families and friends) have access to the service (eg, location, affordability, waiting times, cultural appropriateness, access by specific 'at risk' groups);
- ◆ quality—client outcomes (eg, client satisfaction; quality of processes; quality of service delivery, such as: staff competency; agency practices regarding consumer rights; compliance with performance indicators, benchmarks, best practice);

- ◆ appropriateness—relevance of intervention to the particular client’s needs.

Service Agreements with agencies specify the range and type of services being purchased and the outputs and outcomes expected.

DFC monitors agency performance through—

- ◆ data collection (submission includes examples of data analysis reports)—
  - client based (for example: demographics; family, living and employment status; gambling type; gambling behaviour patterns; source of clients access to service; application of assessment tools on entry, during treatment and on exit from service);
  - service based (for example: presentations to community groups; local promotion; awareness campaigns; number of calls and response times for the Helpline);
- ◆ agency visits;
- ◆ quarterly financial statements;
- ◆ annual reports of service activities, evidence of service plans and descriptions of treatment interventions;
- ◆ monitoring of waiting lists;
- ◆ periodical collection of information on staff qualifications;
- ◆ periodical conduct of training audits to inform a training agenda;
- ◆ monitoring of the operation of the services as a system (eg, participation of Break Even agency staff on reference groups, at the service network meetings, attendance in training programs, delivery of training programs, participation in consultation and planning forums for the GRF Program).

The submission identifies a range of issues that make it difficult to measure the effectiveness of problem gambling treatment programs (eg, no clear definition of a successful outcome for a client; difficulty in clearly attributing observed outcomes; difficulty in comparing different treatment models). The submission further identifies that an improved Break Even data collection system would provide limited evidence with regard to these areas.

The submission refers to a number of research reports and the Strategic Review report, with regard to broad indicators of “best practice”. These broad indicators encompass, but are not limited to—processes (assessment, clear goal setting, client participation); services provided (range of community based services; use of a range of intervention therapies and approaches, preferably evidence based and accepted techniques, with cognitive-behavioural therapy having very good credentials; inclusive of support for issues associated with problem gambling such as financial, relationship, etc; capacity building in other service systems); and standards of counselling (highly skilled, focussed, theory driven, client-counsellor relationship).

Whilst the submission states that the Strategic Review did not find glaring inadequacies in the existing system, and that rather, it identified substantial strengths and achievements, some relevant key findings of the Strategic Review with regard to the Inquiry are (noting that the report identifies 31 key findings)—

- ◆ review of the regional funding allocation model and development of a new formula that considers—population size and profile; socio-economic indicators; number of gaming machines in the region; total gambling expenditure in the region; existing service demand (Key finding 5);
- ◆ investigation of strategies to increase service reach (Key finding 6), with development of services to Aboriginal people a priority (Key finding 12) and consideration of other (identified) target groups (Key finding 13);
- ◆ accreditation and appropriate remuneration levels of staff, along with the urgent need for a training plan (Key finding 14);
- ◆ maintain allocation for research and evaluation, with the purpose of such being to—support service planning; provide strategic information and analysis regarding problem gambling in SA; improve services and methodologies;
- ◆ review of the current DFC program arrangements, with regard to options for improved management, leadership and co-ordination of the GRF, problem gambling services, and the government’s policy agenda (Key finding 17);
- ◆ when purchasing services in the next funding period, consideration be given to the capacity of therapeutic counselling services to articulate and demonstrate clear model(s) of practice, using evidence based and accepted techniques, which are then supported by expert supervision within the agency (Key findings 8 and 29);
- ◆ that existing client data does not suggest a particularly efficient service system, and so, a key direction for future funding should be to increase the amount of clients accessing GRF services—the review report identifies that approximately 10% of problem gamblers access Break Even each year, inclusive of new and on-going clients, as well as an estimated 750 non-gamblers (Key finding 23).

The submission concludes by saying that DFC will work to ensure that best practice elements are incorporated into the implementation of services funded by GRF, and that the findings of the Strategic Review will be considered and incorporated within the planning process currently underway to develop a 3 year GRF plan.

## 2.3 Industry

### 2.3.1 *Australian Hotels Association (SA Branch)*

The AHA is the peak industry body for hotels; its membership covers 85% of the gaming machines in South Australia.

The AHA presented a summary of industry statistics, stating that the hotel industry in South Australia employs approximately 24 000 people, with over 4 000 jobs created as a result of the gaming industry. The AHA also documented the contribution of

hotels and commitment of continued monetary support for the provision of services provided from the GRF.

The AHA referred the Authority to the report of the New South Wales Independent Pricing and Regulatory Tribunal—*Gambling: Promoting a Culture of Responsibility*, June, 2004—for further information with respect to the comments and recommendations documented in its submission.

The AHA supports the view that counselling services should be accessible, be culturally appropriate, involve client participation in goal setting and have positive client outcomes. Counselling services should also incorporate client-centred approaches and provide evidence of strong therapeutic alliances.

With respect to appropriate modes of treatment, the AHA further acknowledges that in the IART report not one particular model is advocated, and instead a multi-modal approach is endorsed as it enables the treatment to be designed to meet the needs of the individual client.

The AHA notes the similarity between what is recommended and what is provided in South Australia via the Break Even Service. However, reference is also made to comments made in a recent review by the Department for Families and Communities that describe a preference for evidence-based techniques that can be well articulated, and supported with expert supervision.

The AHA submission sets out the aims of its early intervention initiative and outlines the role of the responsible gambling/venue liaison officers. It states that the early intervention initiative has been well received by the Concern Sector and that the AHA's establishment of this initiative demonstrates ongoing commitment to tackling problem gambling.

The AHA recommends that judgements regarding the effectiveness of gambling rehabilitation services should be embedded within best practice models and principles and identifies recommendations contained in the IPART review with respect to developing accreditation practices, establishing minimum competency standards and ensuring reliable data collection and analysis.

The AHA submission also outlines problems associated with the Break Even data base that it says are precluding reliable outcome analyses to be performed regarding the effectiveness of its programs. The resolution of this issue is identified as critical by the AHA.

The AHA submission also describes a number of concerns identified in a review conducted by the Department for Families and Communities. These concerns refer to issues of co-morbidity, lack of trained financial counsellors, and ensuring that adequate services are provided in high risk groups and throughout rural communities.

### **2.3.2 Licensed Clubs Association of South Australia Inc**

In this submission, the Licensed Clubs Association (Clubs SA) identifies a number of factors likely to assist problem gamblers. Clubs SA describe these factors as

characteristics of an effective program for rehabilitation, where rehabilitation is described as a process of restoration.

As outlined by Clubs SA in their submission, the main characteristics of an effective program would include: a coordinated intervention system that is independent of the venue; an effective and transparent referral process, an emphasis on psychological aspects of the problem; a holistic approach with an emphasis on accountability.

Measures to quantify the extent of restoration would attempt to compare the degree that a problem gambler's individual problems, financial losses, and social dislocation have returned to a level comparable with a non-problem gambler (i.e., a baseline indicative of normal functioning).

Clubs SA advocates a position with respect to the funding of rehabilitation services by suggesting that all monies for rehabilitation should focus on the critical, or acute nature of the individual problem gambler and expenditure required for education and research should be provided by additional, and independent revenue.

## **2.4 Concern Sector (other than direct service providers)**

### ***2.4.1 Heads of Christian Churches' Gambling Taskforce***

In 1998, the Anglican Synod in South Australian passed a resolution requesting the SA Heads of Christian Churches to act on behalf of Christian Churches about the growing concern associated with problem gambling. The SA Heads of Christian Churches Interchurch Gambling Taskforce (GTF) was established in 1999. The GTF currently has representatives from Catholic, Anglican, Lutheran, Baptist and Uniting churches and the Salvation Army. The GTF is represented on the GRF committee.

The GTF has had a role in the implementing a number of public education and policy initiatives relevant to problem gambling. These are listed in the submission.

The submission states that an effective program is one in which primary, secondary and tertiary interventions are provided and supported by interagency or wider resources. It defines 'program' as "a suite of services provided through an identified funding allocation program with the intended outcomes being the reduction of problem gambling", with the three tiers of interventions encompassing the four programs funded through the GRF—

- ◆ primary (ie, public education programs);
- ◆ secondary (ie, Gambling Helpline, community education);
- ◆ tertiary (ie, Break Even services).

The GTF argues that the majority of resources are directed to primary and tertiary programs, but as most people with a gambling problem resolve their gambling primarily through the support of family, secondary programs should be at least equally funded. The submission supports this argument by identifying that 3 000 of an estimated 25 000 people in SA who are significantly affected by problem gambling

each year, access Break Even services, with most being repeat visitors. Thus, the majority of the target group are not accessing Break Even.

The submission argues that service effectiveness needs to occur at two levels—the funding program and the individual service. It identifies an effective rehabilitation program as one where the harm related to problem gambling is minimised. It lists a number of factors that the GTF argues would be indicative of harm minimisation, as well as criteria for an effective program.

GTF identifies that its observation is that Break Even services are currently not measured for effectiveness, but also says that some of the satisfaction measures and client follow-up by individual services suggests a reasonable degree of effectiveness in responding to clients seen.

The submission argues that the effectiveness of Break Even programs is best measured by determining the extent to which people with gambling related problems who have accessed the program, leave the program with those problems eliminated, substantially diminished, or appropriately addressed. GTF states that such measurement should involve—

- ◆ research using appropriate instruments and methodology before, during and after the intervention ;
- ◆ a longitudinal evaluation involving follow up of clients one and three years after they have concluded a rehabilitation program, using an independent evaluator appointed to monitor and audit evaluation processes in services, with the following caveat;
- ◆ in circumstances where evaluation is not intended for continuous improvement (eg, for compliance or political agendas), money would better be allocated to service provision and less costly proxies such as outputs and process measures used to measure service effectiveness (the submission details outputs and process measures).

The submission identifies a number of issues regarding evaluation of Break Even services and proposes that—

- ◆ data resulting from evaluation of inputs, processes and outcomes be published annually to indicate achievements and inform service improvement;
- ◆ a process be developed with service providers to accredit all funded problem gambling services and practitioners, inclusive of the development and monitoring of industry standards, and competency based training;
- ◆ an independent evaluation of program outcomes be undertaken promptly and repeated in five years, inclusive of the longitudinal client survey identified above.

GTF believes that program effectiveness has been measured by focussing on administration and process compliance of individual services, with no good program-wide review of effectiveness, particularly with regard to the management and administration of the program.

Issues that will need to be addressed to enable provision of an effective program, as well as recommendations, are discussed in the submission. In summary they are—

- ◆ a need to provide funding at a level that—
  - recognises projected increases in problem gambler numbers, and therefore sustains coverage;
  - enables appropriately qualified staff to be employed and is competitive with other service areas, including a consolidated training provision for service staff (the recent finalisation of a training provider is acknowledged);
  - provides commitment beyond a one year funding cycle (to assist staff procurement and retention, and service planning);
  - enables the development or trial of additional strategies to broaden the use of rehabilitation services (noting that about 10% of problem gamblers access Break Even services);
  - enables accessibility by potential clients (current services and certain types are not physically accessible for some people);
- ◆ co-ordination of government departments that have responsibilities associated with gambling, including linking rehabilitation service experience with gambling public policy and regulation development—
  - GTF suggests a stakeholder forum be established either as a ministerial advisory body or reference group to the Independent Gambling Authority (IGA);
  - during the public hearing GTF elaborated that its view is that the Minister for Gambling be the central minister for gambling policy, programs and practice; the IGA the central body for government for setting and integrating policy and direction; with a small advisory panel to the IGA to actually help set the parameters for funding for rehabilitation services;
- ◆ adequate support for the Break Even Network, and service providers encouraged to identify service gaps and responses, including involvement in strategic planning, with the GTF specifically recommending that—
  - an independent development officer be funded and based in SACOSS
  - funding be provided to the agency associated with the elected Chair of the Break Even Network, to address any service impact;
- ◆ adequate service provision, and capacity to identify areas of under servicing or over servicing, taking into consideration—where people will go due to ease of accessibility (eg, city, due to public transport); service provision outside normal hours; concentrations of gambling losses; areas of population growth; needs of specific population groups (ie, indigenous, cultural groups, prisoners, mental health, homeless);
- ◆ improved data collection and reporting to, in part, inform service improvement;
- ◆ provision of financial counselling services;

- ◆ targeted community education programs (eg, families, friends, community, professional groups that may have contact with problem gamblers) using the public health approach and developed independently from the gambling industry to ensure a proactive rather than reactive approach;
- ◆ awareness of potentially new gambling forms.

#### 2.4.2 *Hon. Nick Xenophon MLC*

Mr Xenophon premises his submission with a statement of his primary position regarding the introduction of poker machines into South Australia, and in particular, with regard to this inquiry, “that the removal of all poker machines from South Australia is the preferred option, but short of that, competent and effective treatments are vital to deal with the many thousands of South Australians whose lives have been affected adversely by the introduction of poker machines in this state”.

Mr Xenophon’s submission identifies the origins of the GRF and that it is funded by Government and gambling industry, commencing with \$1.5million in 1994 (\$800 000 contributed by Government) and set at \$3.3 million in 2004 with an additional amount of \$2 million committed by Government in December 2004 (yet to be provided).

The submission notes that GRF funding has not increased in line with increases in Net Gambling Revenue and Government revenue, with the amount dedicated for gambling treatment programs being “a fraction of the huge revenue going to the industry and the Government”.

Mr Xenophon argues that—

- ◆ statistics re problem gambler numbers (23 000 for South Australia with another 7 adversely affected for every problem gambler) indicate that widely available and effective treatment programs is critical;
- ◆ non-provision to date of the additional \$2 million committed by Government has created a great deal of uncertainty within the Breakeven Network and further strained an already strained service, highlighting the need for greater certainty for rehabilitation services and a more transparent system;
- ◆ a strong industry presence on the GRF Committee is inappropriate, and cites reasons why;
- ◆ there are conflict of interest and independence issues for counsellors employed by the Australian Hotels Association under its recently launched intervention scheme, including their ability to contact authorities when presented with evidence of breaches of legislation or codes of practice;
- ◆ attendant to the preceding and in relation to the \$350 000 assigned by Government to assist in funding an early intervention program, questions raised in Parliament relating to concerns about the level of training for the counsellors, and criteria and triggers for intervention, have yet to be adequately addressed;
- ◆ the “*Think of what you’re really gambling with*” advertising campaign was not accompanied by enough resources for both treatment programs and the Gambling

Helpline to deal with the consequential increase in demand, and similarly, this inability to respond to increased demand affects the ability of services to self promote;

- ◆ the intensive treatment program conducted through the Centre for Anxiety and Related Disorders at Flinders Medical Centre has been praised widely for its effectiveness but it is the only one of its type in the state, with waiting lists as well as significant difficulties for people in regional locations accessing the service;
- ◆ there is great need for gambling support in regional areas such as Coober Pedy, Port Pirie, and Port Augusta, particularly with regard to the indigenous community, with a real need for better funding and resources for these areas, and improved access to face-to-face counselling.

Mr Xenophon suggests that South Australia could gain much by examining the New Zealand system for the provision of problem gambling services, with specific reference to the Gambling Help Line and the Problem Gambling Purchasing Agency.

With regard to the Help Line, Mr Xenophon cites both the program funding structure and actual programs—

- ◆ prior to the passing of the New Zealand *Gambling Act 2003*, industry used to contribute to funding, but it is now solely through the New Zealand Department of Health—Mr Xenophon submits that South Australia should consider a similar funding approach for the GRF to both ensure independence from industry influence of strategies to combat problem gambling and avoid any conflict of interest;
- ◆ some elements of the program structure (emphasising an integrated care system) and services offered are described, with Mr Xenophon identifying that the main focus seems to be on a follow up system, which should be considered in SA programs.

With regard to the Problem Gambling Purchasing Agency (following the public hearing, Mr Xenophon provided the Authority with more details of the Agency and, in particular, that the service provided has now been taken over by Government) Mr Xenophon identifies a number of initiatives and attitudes to the way treatment programs are run, including: a focus on long-term outcomes for the client, with a sense that maintaining gains and recovery is more important than actual gains made during treatment; co-ordination across the system, partly to enable treatment choice for clients; follow-ups at six month intervals; and so on. Mr Xenophon suggests that current programs in South Australia would benefit from this more coordinated and long term outcome focussed approach, with the follow up procedures for clients being vital.

Mr Xenophon also submits that—

- ◆ client follow-up and program evaluation should occur at least annually, under a co-ordinated effort (noting that Mr Xenophon applauds the quality of current services operating under limited resources);

- ◆ a wide variety of co-ordinated treatment programs and methods need to be made available, all of which need publicising, resourcing, regular monitoring, and annual reporting regarding effectiveness, treatment types involved, and measures of progress;
- ◆ all should be conducted independently of industry control or direction.

With regard to intervention programs, particularly in-venue, Mr Xenophon argues that such programs have a key role in preventing exacerbation or triggering of gambling problems, and that the Authority has a powerful role to play in ensuring both clear guidelines for intervention and that venues act appropriately. An approach to ensuring compliance with the regulatory requirements of the codes of practice is discussed, with compliance identified as a means to enhance the effectiveness of rehabilitation programs.

The submission discusses the need to provide culturally appropriate services to address the needs of problem gamblers from a non-English speaking background, as well the indigenous population. Recent research is cited. In particular, the recommendations of the 2003 report—*Problem Gambling within non-English Speaking Background (NESB) Communities in Queensland: A Pilot Study*—some of which are highlighted in the submission, are identified as needing to be used as a national benchmark when working with people of non-English speaking background.

Mr Xenophon identifies all barring schemes, no matter how accessed, as needing to be considered within the context of the inquiry, and needing to be integral to rehabilitation programs. The submission refers to a report prepared for the Victorian Gambling Research Panel, which found that the utilisation rate of self-exclusion programs in South Australia is approximately three per cent of problem gamblers, with breaches of such programs being commonplace and largely undetected. Mr Xenophon identifies a need to improve the effectiveness of barring programs, particularly with reference to technology.<sup>1</sup>

The submission identifies that effective community and school education programs are integral to gambling rehabilitation program, but the latter should be funded from the Education Department's budget, so as not to impact on the limited GRF resources. Benchmarks for the effectiveness of school-based programs is briefly discussed.

The submission concludes with a reiteration of the New Zealand program model, stating that there is a need for—

- ◆ regular monitoring of program effectiveness against standard and transparent benchmarks;
- ◆ auditing of all treatment and rehabilitation programs for short, medium and long term effectiveness;
- ◆ careful monitoring and evaluation of the reasons for a problem gamblers' relapse after treatment.

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<sup>1</sup> *Note:* The Authority does not regard the operation and effectiveness of self-exclusion schemes as coming within the terms of reference for this inquiry.

During the public hearing, Mr Xenophon made additional comments on matters not discussed in detail in the submission, and largely in response to questions asked by the Authority, summarised as follows—

- ◆ regarding service reach, a concern that an estimated 10% of the target group access Break Even services, with it being particularly telling that during the media campaign there was about a 100% increase in people seeking help;
- ◆ funding for rehabilitation is inadequate when compared to gambling revenue which is approaching \$1 billion;
- ◆ the GRF data collection system has long been problematic and only in the last few weeks has the system become functional, however, there is the attendant issue of adequate resources at service level to collect data adequately, and an overall issue about insufficient (claimed by agencies as non-existent) departmental support to agencies ;
- ◆ staff remuneration and levels are inadequate (an estimated 32 and half full time equivalents work state-wide), the latter evidenced by the inability of services to temporarily replace staff who take any form of leave;
- ◆ a need for a notification system for advising of industry breaches of regulations, acts, codes of practice;
- ◆ very little support in the prison system for those whose offending is consequent to gambling;
- ◆ a need for one ministerial portfolio that deals with gambling issues;
- ◆ a need for an independent body to manage rehabilitation funding.

#### **2.4.3 Break Even Network**

This submission comprises the views of members of the Break Even Services SA who attended a meeting on 9 March, 2004, and consensually agreed on the contents of this submission. However, it is noted that the views expressed in this submission may not be representative of all Members; and further, that some of the Member Organisations intend to submit separate submissions.

In this submission, the members propose that a general lack of resources results in inadequate resources for the provision of “sustainable and efficient service systems”.

Members propose that the Break Even Services SA be funded over a 5 year period and that funding from the Gambling Rehabilitation Fund (GRF) be distributed according to formula used interstate (i.e., “hypothecated model of funding”).

Members suggest that the annual rollover funding to Break Even Services SA impacts on the effectiveness of long term planning, evaluation and service delivery; results in short-term contracts; and, prevents retention of experienced staff whom have years of “practice wisdom” in the field of problem gambling.

Members propose that additional funding would enable the following initiatives to be implemented:

- ◆ Deployment of approaches and interventions in response to diverse community need in the areas of primary health care, community development and education, and specialist medical models of intervention;
- ◆ Development of community education materials, specifically for dissemination by the Break Even Services;
- ◆ Re-appointment of Break Even Services SA coordinator to facilitate information dissemination, consultation, research, and training and development opportunities for staff; and
- ◆ Training and development of financial counsellors in rural areas.

In terms of research, development and evaluation, members recommended the need to:

- ◆ Identify a research framework (incorporating qualitative and quantitative paradigms) that can be used within the Break Even services and permit external and/or independent evaluation;
- ◆ Assess the efficacy of the “integrated model of service delivery”, particularly for those experiencing multiple problems;
- ◆ Pilot and assess the applicability, and efficacy of intervention models for Indigenous and Culturally Linguistically Diverse cultures;
- ◆ Incorporate a community development approach to target disadvantaged and marginalized groups;
- ◆ Consider major changes/improvements to data-base system to improve utility of data; and
- ◆ Identify service systems that maximize resources and optimize current infrastructure.

Other recommendations included in Break Even SA’s submission focus on the need for effective consultation among stakeholders to ensure that problem gambling is acknowledged by the broader community. Members of the Break Even Service endorse the need to identify effective interventions and service systems in the problem gambling area, and acknowledge that on a local, and international level there is no one definitive model of intervention that results in the desired outcomes.

#### ***2.4.4 SA Financial Counsellors Association***

The South Australian Financial Counsellors’ Association Incorporated (SAFCA) is a volunteer organisation that represents a membership of approximately 50 financial counsellors working in Government and Non-Government organisations throughout South Australia. The Department of Families and Communities, via the GRF, has provided SAFCA with the funding of conferences and community education aimed at

assisting Financial Counsellors working with problem gamblers to promoting awareness of the services available in South Australia.

In their submission, SAFCA suggest that the role of Financial Counselling in problem gambling is clearly defined and provide a definition. Further, SAFCA note that clients with gambling problems present in a variety of ways and outline a number of impediments to financial counselling in the gambling area. SAFCA suggest that there is a lack of research conducted with a financial focus and that evaluations of effectiveness should include outcomes relevant to the financial status of the client.

At the public hearing, Mrs Geraldine Phillips represented SAFCA and proposed that financial counsellors are inadequately represented within the Break Even Services network and cited the benefits of establishing “a one stop shop” where individuals can access the services of financial counsellors and therapeutic counsellors. Mrs Phillips also noted the benefits associated with the introduction of the Dial A Debt Counselling service (a one-off GRF funded project), and noted the issues associated with discontinuation of this service.

## **2.5 Direct service providers**

### **2.5.1 *Anglicare SA***

Anglicare SA’s Break Even Gambling Counselling Service, Northern Metropolitan Adelaide & Barossa Region

Currently the Department for Families and Communities provides funding (via the Gambling Rehabilitation Fund) for Anglicare SA’s Break Even Gambling Counselling Service. Anglicare SA, is a not for profit organization that provides services across a variety of community interest areas, including aged care, family and community services, and social advocacy. Under current funding arrangements, Anglicare SA’s Break Even Gambling service delivers individual/family counselling, financial counselling, and community education.

Anglicare SA’s describes its position with respect to participation in gambling as one which acknowledges that gambling related activities can provide legitimate social and recreational activity for some adults. However, others (described as more vulnerable) are adversely affected by their participation in gambling activities. In their submission, Anglicare SA voice what they describe as a more general community concern that has evolved since the introduction of gaming machines, and suggest that the number of inquiries conducted at the local, and national level, evidence the breadth and dimensions of community concern in this area.

In this submission, Anglicare SA’s Northern Metropolitan Adelaide and Barossa Region provide information concerning their personnel, geographic locations and designated target service areas.

Anglicare SA employs a case manager (employed 2 days per week), 3 full-time and 2 half-time counsellors, and a half-time financial counsellor. These personnel are located across three sites in Salisbury, Elizabeth and Gawler (2-3 days per week only)

and service needs of those individuals that generally either live, or work in the local government areas of Salisbury, Playford, Gawler and the Barossa regions.

In their submission, Anglicare SA describes the Break Even model of service delivery. It is based on the integrated Anglicare Family Centre model of delivery that applies to other programs offered across Anglicare SA's 5 sites in the Northern region (known as Family Centre North).

With respect to program gambling, Anglicare SA's Break Even Gambling Counselling Service delivers services aimed at primary (community prevention), secondary (early intervention) and tertiary (rehabilitation) levels of intervention.

Anglicare SA describe Break-Even Gambling services as comprising counselling (individual, family and financial); information dissemination (re: Self Exclusion, Family Protection Act, gambling and non gambling problems); referral, advocacy and outreach services; and, community education.

Anglicare SA, propose a number of advantages of their current "integrated" model of service—

- ◆ Co-location of services minimizes stigma associated with seeking treatment;
- ◆ Provides a more consistent and streamlined service meeting people's major concerns (e.g., financial and personal/interpersonal)
- ◆ Provides access to a range of specialist support services (e.g., housing, personal and family counselling, youth and community work, financial assistance, and drug and rehabilitation)
- ◆ Enables assessment/resolution of underlying issues contributing to and/or associated with problem gambling activities

In their submission, Anglicare SA document their views and propose strategies with respect to a range of areas including funding, treatment perspectives, best practice, community education, and evaluation. Their views and recommendations are summarized as follows:

To enable the planning of service delivery, inclusive of trialling new initiatives, ensuring appropriate evaluation, and to retain qualified counsellors, the preferred funding arrangement would be a minimum of 3 years (preferably 5 years). Propose that while "one off injection of funds grants" offer the opportunity to pilot new initiatives they may raise community expectations that may not be able to be continued under current arrangements.

Anglicare acknowledges that there are a variety of therapies, emerging from a number of differing theoretical paradigms and acknowledges the successes of each, as well as the limitations they may have for some individuals and families. Treatment programs should be transparent and promote: empowerment, respect and privacy, attention to harm minimisation, client feedback, and social justice.

With respect to determining appropriate treatment for problem gamblers, Anglicare SA advocate for an approach that acknowledges the rights of individuals to make

choices, and decisions with respect to treatment options and considers the unique needs and issues of individuals presenting for treatment.

Anglicare SA suggest that Best Practice in treatment programs and delivery would demonstrate the presence of quality assurance systems and contain client involvement in planning, service design and evaluation; client complaint and grievance systems; appropriate data systems for collecting and reporting information on activities and outcomes; rigorous systems for selection/supervision of staff; ongoing training and professional development; sound agency planning and evaluation systems; documented operational policies and procedures

Anglicare endorses Community Education focused on primary prevention and early intervention as important harm minimisation strategies. Examples of efforts would include appropriate public awareness programs that contain consistent messages, incorporating significant others; a focus on health professional training in detection and treatment of problem gambling; and, a focus on improving information access to minority groups.

Anglicare SA advocate that an important component of assessing the efficacy of treatment programs is whether clients achieve the outcomes they seek and whether these are maintained over time. Presently, Anglicare SA provide for such evaluations by including satisfaction surveys at various points during treatment.

Changes to requirements with respect to obtaining “Informed Consent” has resulted in a compliance rate of approximately 98%. Recent changes that facilitate individual agency reports will be beneficial, however, Anglicare SA note that continuous technical problems has undermined the reliability and utility of the data already acquired.

Anglicare SA acknowledge that the current Inquiry into “The Effectiveness of Government Funded Rehabilitation Services” is a step forward in terms of attempting to assist in identifying strategies to assist those adversely affected by participation in gambling; and propose that systematic and rigorous research, based on a What and Why approach is required. What types of intervention work and why do some work better than others.

Anglicare SA comment on the applicability of models of therapeutic treatment available in the problem gambling area, and suggest that treatments adopted or adapted from addiction interventions may not be appropriate. Based on a review cited in their submission, they suggest that longitudinal research is required to support the current momentum supporting behaviourist based interventions in the problem gambling area.

Anglicare propose that a literature review on interventions in the problem gambling area be systematically conducted, replicated/piloted by government funded agencies, and independently assessed for efficacy.

Another area of concern noted by Anglicare SA in their submission included an increased propensity of problem gamblers who have co-morbid and psychotic conditions such as borderline personality disorder and schizophrenia whom they

describe as particularly vulnerable to gaming machines. In addition, Anglicare SA acknowledge that while the “expressed need” for gambling rehabilitation from rural areas has been low, it is an area that requires monitoring, particularly due to the stigma associated with seeking assistance for a gambling problem, and other issues such as the isolation and the vulnerability of certain groups living in rural areas (retirees, youth, individuals experience mental health issues).

#### **2.5.2 Centre for Anxiety and Related Disorders, Flinders Medical Centre**

The Intensive Therapy Service for Problem Gambling is located in the Centre for Anxiety and Related Disorders at Flinders Medical Centre, and will herein be referred to as “the Unit” in line with the submission wording. The Department of Human Services (now Department of Health) receives funding from the GRF and Government to provide the service. The Unit is a member of the executive committee for the Break Even Network.

The Unit provides a state-wide intensive service for problem gamblers, encompassing assessment, evidence based treatment, ongoing support and follow up. It also provides training in cognitive and behavioural therapy for a range of service providers across the state (including Break Even staff) and Flinders University mental health students. Research into treatment efficacy is identified as an important aspect of ongoing service delivery.

The Unit also provides an inpatient program for clients presenting with a particular set of issues (identified in submission) and assessed as being suitable for the program. The submission details the program, and identifies that current resources enable admission of no more than 15-20 patients a year.

Client contact is predominantly face-to-face, but also includes, where needed, phone contact or telemedicine. The treatment program is based on both cognitive and behavioural psychotherapy (explained in the submission). Eligibility for the program is briefly described in the submission, which also identifies that preliminary data from a 6-year follow up of clients that completed treatment, indicates positive treatment outcomes (substantiating data is provided in the submission).

Over 700 referrals have been received during the Unit’s 8 years of operation. Current waiting lists are about 2 weeks for screening and up to 8 weeks for treatment. The Unit states that severe constraints related to the programs funding must be addressed and that much needed additional resources are crucial to meeting the increasing demands placed on the service.

With regard to treatment, the submission provides an overview of—

- ◆ co-morbid mental health disorders, as a precursor to describing the management of such within the intensive therapy program;
- ◆ the Unit’s relapse prevention support group, which it identifies is advantageous to continue as part of a complete treatment package, but is currently without funding;
- ◆ the Unit’s experience of working with people from non-English speaking background and considerations when working with such.

The Unit regards as adequate, its current measures for providing an evidence base for treatment and follow-up outcomes. The submission details the measures implemented with clients prior to, and at intervals during and after treatment, with follow-up measures being completed by some clients up to five years after treatment.

The submission provides detailed discussion about the need for research, arguing that provision of an effective rehabilitation program requires research to—

- ◆ measure effectiveness and ongoing development of services provided;
- ◆ ensure that best practice models are provided for rehabilitation;
- ◆ inform ongoing review and development of programs (with a clear need for long term research into program development that addresses lapse, abstinence and why treatment is not effective).

Research areas, cited in a report emanating from the Victorian Gambling Research Panel as being relevant to ensuring best practice in the treatment of problem gambling, are detailed.

The submission also provides a description of research currently being conducted by the Unit, as well as a list of 11 research questions relevant to the South Australian setting. With regard to the latter, during the public hearing, representatives of the Unit said they could conduct such research over the next five years if funding were immediately available. It was stated that one of the research items has been funded and funding has been sought for another, but that approaches to the GRF to fund the remainder have not occurred as it is expected to not be successful.

The submission details various activities with regard to training (inclusive of a range of health professionals and students, and Break Even staff) and community education undertaken by the Unit, as well as its involvement in the development and evaluation of a treatment group for problem gamblers at another agency.

The Unit asserts that an effective rehabilitation program for problem gamblers needs to provide a range of interventions and entry points. An extensive (but not exhaustive) list of what would be included in an effective program is provided. Whilst noting that the submission provides more detail and brief explanations of intent for each point, some of those points are—

- ◆ evidence based treatment programs;
- ◆ comprehensive screening and assessment;
- ◆ option of an inpatient admission for particular clients;
- ◆ relapse prevention strategies for all clients and follow up after treatment, as well as a support group for people after completion of treatment;
- ◆ use of validated outcome measures, and common outcome measures across all agencies;
- ◆ evidence of continuous clinical improvements, including clinical trials of a variety of treatment interventions;

- ◆ training for rehabilitation workers to gain competencies, and training and support for mental health workers;
- ◆ early intervention and treatment model inclusive of harm minimisation;
- ◆ easily accessible financial advisors both for client and significant others, with counselling available for significant others;
- ◆ specific interventions to identify and treat particular groups;
- ◆ a variety of treatments (examples identified in submission), and a variety of approaches/service formats to increase accessibility, as well as education of other types of services providers to identify problem gamblers and respond effectively.

With reference to the preceding, the submission concludes by detailing a range of recommendations across the areas of education and training, service delivery, research, community education, financial counselling, and service provider representation at GRF meetings.

### *2.5.3 Gambling Addiction Treatment Services*

Gambling Addiction Treatment Services (GATS) is a privately owned counselling provider, specialising in treatment for individuals diagnosed with Pathological Gambling Disorder (DSMIV). Owned by Sue McPherson, the GATS program was developed by Robert Mittiga, described in the written submission as an accredited gambling counsellor and addiction specialist in the United States of America.

The GATS program has operated in South Australia for almost 3 years. GATS receive the majority of its referrals from private advertising sources. According to GATS, 68% of clients have already received rehabilitation services from other gambling rehabilitation service providers. GATS offer a program based on an abstinence philosophy. The program is client funded at a cost of \$3, 500 per client, which can be paid in monthly instalments over the duration of the 12 month program.

In their submission, GATS focused on issues such as identifying gaps in current problem gambling services in South Australia such as the lack of accredited training programs and the need to develop such programs; the lack of collaboration (i.e., lack of referral between public and private service providers); and, the need to develop a centralized research process that is accessible by private and public service providers. Included in their submission are descriptions of the GATS Treatment Program, written statements from users of the program, and results of evaluations of the effectiveness of their program.

Other main points were made by Mr Wells, Mr Mittiga and Ms McPherson as representatives of GATS at the public hearing, and included:

- ◆ Pathological problem gambling is a problem which has consequences in criminal law;
- ◆ GATS services to be considered for GRF funding; and

- ◆ GATS services to be seen as a one of a number of service options offered by the service network.

In conclusion, GATS would like to have representation on the GRF committee by personnel trained in addiction. Further, they requested acknowledgement that GATS do not reject the philosophy of harm minimisation, however, they do not adopt it as their treatment model.

#### *2.5.4 Lifeline South East*

Lifeline South East (Lifeline SE), based at Mt Gambier, provides a range of social support services to the south eastern region of South Australia, including a Break Even service since 1995 with funding from the GRF.

The Break Even service provides counselling and treatment services to problem gamblers and people affected by the gambling of others, and includes—provision of financial counselling; advocacy and negotiation; phone support; outreach at Naracoorte; self-help mail outs; provision of a service to the local prison; and referral to specialist programs. It also undertakes community education and awareness programs, which are described in the submission.

Lifeline SE presents its submission from the experience of a rural based Break Even service. It identifies that one of its strengths has been the development of a relationship with the local gambling industry (ie, hotels and clubs). It argues that effective partnerships, including with other local agencies, is critical to rural services.

The submission identifies gambling as one of a suite of issues presented by clients and provides a description of a range of approaches used by the service when working with clients.

Lifeline SE identifies that best practice treatment of problem gamblers, as used by its service, involves—

- ◆ an approach that is client-centred (ie, uses clear, theoretical models that give choice and diversity to clients and are respectful of client needs and circumstances);
- ◆ financial counselling as a crucial component;
- ◆ a range of service options additional to face to face counselling, such as telephone counselling and self-help mail outs;
- ◆ partnerships and linkages with other agencies and services, particularly with regard to capacity building.

Lifeline SE identifies that issues for rural services with regard to providing an effective service are: difficulties recruiting and retaining skilled counsellors (due to one year contracts not being sufficient inducement for potential staff), and lack of accredited training for financial counsellors.

### 2.5.5 *Nunkuwarrin Yunti*

Nunkuwarrin Yunti is funded by the GRF to provide a state-wide program to address problem gambling for Aboriginal people. The program is positioned in an Aboriginal Community Controlled Health Service, which enables it to interact with a range of other programs delivering clinical services, counselling and social health programs, and SA Link Up (Stolen Generations) services. The gambling service is part of a wider team that uses a methodology based on a comprehensive primary health care model, with a strong emphasis on organisational and community levels of practice.

The gambling service is provided by two full time staff, one focussed on metropolitan Adelaide (clinical service including financial counselling), the other on regional and remote communities (focussed on community engagement). The service agreement with DFC specifies a weighting of 30% focused on individual focused interventions and 70% concentrated on community education/development functions and.

Nunkuwarrin Yunti's submission concentrates specifically on gambling program effectiveness for Aboriginal populations and describes a contextual framework fundamental to its discussion—

- ◆ the Aboriginal definition of health (provided in submission) within which Nunkuwarrin Yunti operates—
  - restoration of health is not solely for the benefit of the individual but also to enable the individual to contribute to their community and re-engage in social roles if possible;
  - responding appropriately to gambling health problems requires strong attention to the social and cultural determinants of health, not just individual psychological factors;
- ◆ work in an Aboriginal context needing to strongly appreciate historical and contemporary social and cultural factors that influence individual and community health status related to gambling behaviour—these factors influence both predisposition to developing gambling problems and actions taken at the individual, familial and community level to address problem gambling;
- ◆ strategies that enable greater involvement of communities in shaping programs is critical to service delivery due to the diversity of the community and the strong need for local ownership and authority.

Various issues regarding current effective service provision to the Aboriginal community are discussed in the submission—

- ◆ challenges regarding data collection to account for outcomes within the current GRF model due to—
  - a high level of informality requested by people who access the service;
  - the extensive range of data to be collected, which creates discomfort for people, many of whom have literacy issues and distrust of information systems;

- ◆ an urgent need for significant additional resources to employ staff locally, particularly in regional and remote areas, to increase capacity for further development of locally mediated Aboriginal specific practice models;
- ◆ active involvement by mainstream counselling and social service organisations in modifying their programs to reach Aboriginal people (submission identifies key elements), but recognising that such service delivery is not a surrogate for service delivery within an Aboriginal community controlled health setting;
- ◆ construction of state-wide strategies in a manner that enables strategic implementation with regard to specific target groups (eg, in partnership with affected communities to understand potential costs and benefits);
- ◆ realistic and feasible expectation regarding service effectiveness, in the context of what is achievable with the resources provided, and noting that resources should be allocated through analysis of population size, geographical coverage, gambling activity in local region, socio-economic composition, other key precursors of problem gambling, and existing service infrastructure, both human and capital.

Nunquwarrin Yunti identifies an effective gambling rehabilitation program as one that seeks to achieve sustainable change in factors that predispose, maintain or exacerbate problem gambling and asserts that rehabilitation strategies need to be targeted across a variety of levels—individual, organisational, community and institutional (a description regarding each level is provided in the submission). Analysis of program effectiveness therefore needs to consider all of these strategic levels (but with a number of qualifications, which are detailed in the submission).

Nunquwarrin Yunti argues that there exists considerable room for improvement to the current system to measure and enhance program effectiveness, and identifies a range of issues and suggestions for improvement—

- ◆ difficulties in collecting the full range of individual client focussed data required, due to the data model and its cultural fit, and the agency's therapeutic approach (submission notes that difficulties will occur regardless, with a data management system that is trying to accommodate a range of service approaches and needs);
- ◆ a need further work to occur to improve data collection regarding community education/development activities (the submission details Nunquwarrin Yunti's internal processes for collecting such data);
- ◆ a need for data collection and reporting by other agencies involved in gambling rehabilitation activities, about the effectiveness of such programs with regard to processes and outcomes (eg, Aboriginal involvement in barring programs);
- ◆ a need to gather and share data from the range of social service agencies (noting that gambling affects people in a variety of ways, including financial, legal, familial, housing crises, family violence, prostitution and child neglect) so that services can be co-ordinated and concentrated in areas of need;
- ◆ better co-ordination, promotion and use in planning processes, by all stakeholders, of data that is already available, requiring a centrally co-ordinated data system;

- ◆ an urgent need for the development of an effective data and information system, that considers data beyond that collected by gambling rehabilitation services, to enable evidence based planning for the allocation of resources, with such system to consider the recommendations of the newly released South Australia Aboriginal Health Partnership framework for health data and information;
- ◆ a critical need to support Aboriginal people and communities to be more involved with processes of planning, monitoring and evaluation;
- ◆ provision of dedicated resources to local gambling rehabilitation services to enable more internal evaluation of the effects of chosen strategies, with resources allocation reflecting the specific evaluation models required;
- ◆ a need to develop more evidence on the specific consequences of gambling within Aboriginal communities and families;
- ◆ a need for greater funding—
  - Nunkuwarnin Yunti commends the GRF service model for recognising different population groups in South Australia and being a national leader for its strategic approach;
  - it argues that the amount of funding available is not sufficient to make significant inroads into prevention of gambling related harms in Aboriginal communities across South Australia;
  - it advocates that a levy be placed on gambling providers specifically to resource rehabilitation services, with the formula for the levy to be based in part on the contribution certain [gambling] formats make to the prevalence and incidence of problem gambling, and the needs of the South Australia community as defined from effective social service planning.

#### **2.5.6 Relationships Australia**

Relationships Australia (SA), herein referred to as RASA, is a secular, not-for-profit, non-government organisation that has been providing counselling services in South Australia since 1948. In 1995 it began to receive GRF funding to provide gambling rehabilitation services, which services now include—

- ◆ a Break Even service in three areas of the State—central, east and north eastern areas of metropolitan Adelaide; Murray Lands; and Riverland—encompassing counselling to individuals with gambling problems and their families and friends, in combination with community education activities;
- ◆ P.E.A.C.E. Multicultural Break Even Services, a state-wide service established in 2003, which provides training and community capacity building skills to Culturally and Linguistically Diverse (CALD) communities;
- ◆ through the Australian Institute of Social Relations, a division of Relationships Australia (SA), a recently awarded tender to provide training to the problem gambling rehabilitation sector.

In addition, RASA provides group work at two of its locations, and periodically conducts therapeutic groups at Cadell Prison and Northfield Women's Prison.

The submission provides a description of the practice model that operates for its Break Even programs—

- ◆ central and eastern metropolitan services, and the Riverland, consider the client to be the decision-maker, with a focus on achieving goals regarding gambling behaviour; managing associated problems such as financial, emotional, job, legal, relationship etc; and addressing underlying issues;
- ◆ P.E.A.C.E. Multicultural Break Even Services, which aims to increase gambling awareness information and services for people from CALD backgrounds, provides a range of holistic and flexible services based on the principles of community development and community education, with a strong focus on facilitating partnerships between CALD and mainstream agencies and CALD communities.

RASA's submission details various projects, action research and presentations consequent to its desire to bring the experience of counsellors with the voice of the consumer to the attention of the decision makers.

RASA's submission identifies a number of challenges—

- ◆ barriers to accessing services (during the public hearing RASA identified that 90% of people who are affected by problem gambling do not access Break Even services) —
  - the focus of funding agreements on counselling throughput, rather than primary prevention (ie, working with gambling venues as the first contact point, and other services and agencies where vulnerable populations are provided a service but may not identify or address problem gambling);
  - confidentiality, particularly in small communities such as regional areas;
  - isolation from mainstream services in CALD communities due to language barriers, fragmentation of relationships through migration, and cultural differences;
- ◆ accessing the consumer's voice—consumers are key stakeholders and their views and experiences of gambling services is extremely valuable, but current inquiry processes are too formal and intimidating (possible solutions are identified by RASA);
- ◆ data collection—RASA details data access and reporting issues, and argues that whilst the DFC Strategic Review report suggests that agency compliance with data requirements is the issue, this masks DFC's responsibilities to provide an adequate system;
- ◆ the relationship between the Break Even Network and DFC, combined with a lack of representation of the GRF committee, is a barrier to service development;
- ◆ salary awards and a one year funding cycle, which hampers the retention of qualified and experienced counsellors (and each agencies' future planning);

During its presentation at the public hearing, RASA also identified a need an independent evaluation of services and the methodologies, so that there could be more confidence in talking about what works and what doesn't work.

RASA's submission concludes with a raft of recommendations to address these barriers and other issues. It also affirms that Break Even provides a high quality service, the evidence for which has been hampered by a poor data collection system.

#### *2.5.7 Salvation Army*

The Salvation Army has operated its Break Even Gambling Service in the Western suburbs of Adelaide since 1995. Their service is principally based on a holistic approach to working with problem gamblers and their families.

Cognitive Behaviour Therapy is used as the main treatment approach and the therapy is provided within a harm minimization framework. They provide family and relationship counselling, grief counselling, and assistance to deal with anxiety and other issues that are associated with gambling problems. As far as possible, financial counselling is provided in an integrated and coordinated manner to fit with therapeutic interventions that specifically target gambling behaviour and related behaviours. When necessary, referral to other service providers external to the Salvation Army occurs (e.g., Assessment and Crisis Intervention Service) and when Emergency relief is required (food, shelter) referral occurs within the Salvation Army services.

In their submission, The Salvation Army acknowledges the diverse needs of the target group and advocate for the availability of multi-disciplinary services. The Salvation Army describe an effective gambling rehabilitation program as one that attracts referrals from the problem gambler and those affected by the program gambling; that is delivered in a timely and appropriate manner; and, is tailored to suit individual needs yet integrated with other services in the Salvation Army and the broader community. In their submission, they also list a number of characteristics of effective programs and suggest some measures that could be included in evaluations of program effectiveness.

With respect to current measures of program effectiveness, the Salvation Army's view is that the level of accountability in terms of reporting outcomes is high and that the outcomes utilized in the current Break Even data base appear to have a sound evidence base. They suggest that difficulties with utilizing the data for research purposes are the result of the difficulty in maintaining follow up with clients.

In terms of the breadth of funding for programs in South Australia, they suggest that the current funding amount is inadequate and suggest that with a small increase in demand the current services would be overwhelmed with dire consequences for staffing resources. Further, they describe why evaluations are required to determine if one-off projects should receive ongoing funding.

According to the Salvation Army, it is appropriate to allow a level of choice in terms of allowing some gambling support services to operate independently of those provided by government funding; however, the Salvation Army suggest that these

services may not operate under the same level of scrutiny (and peer review) required by those funded by the GRF.

With respect to identifying gaps in service, and proposing ideas for meeting these gaps, The Salvation Army note the lack of gambling services available in rural areas and offer remedies for this. Other areas of improvement noted include developing the scope of collaboration between current service providers and Indigenous and Culturally and Linguistically Diverse groups, and the consideration of a “safe-house” for problem gamblers.

Finally, with respect to resources applicable to problem gambling, The Salvation Army, refer the Authority to the publication, entitled “An Anthology of Gambling Tales”, edited by May Shotton.

#### **2.5.8 12 Steps Self Help Anonymous Group**

The Stable Christian Centre Incorporated is located in Morphett Vale and provides for rehabilitation of individuals referred for social problems such as gambling, alcoholism and illicit drug dependency. Don Smith (Maori Chaplain), along with other members of the “Christian” church run support groups, and offer their volunteer services by visiting homes, Correctional centres and The Family Courts to advocate for individuals and families in need of comfort and support. According to Don Smith, who submitted the submission on behalf of the Christian Church, many of the individuals presenting, or referred to them are experiencing financial difficulties occurring as a result of someone in the family having a gambling, alcohol, or drug problem. The programs offered by the Church are self funded, mostly funded by donations made to the church.

In this submission, it is proposed that the “12 Steps Stabilization and Holistic Replacement Program” used in Stable Courts Self Help Anonymous groups could be used as an alternative, and/or in conjunction with existing treatment services. The philosophy of the 12 step program is that: “Addicts who seek help from support groups have often hit ‘rock bottom’ and are in desperate need of a stabilizing influence. The stabilization is provided by continuous attendance at meetings, usually with a mentor or sponsor of the individual’s choice”.

The program offered by Stable Courts Self Help Group is offered in a holistic manner; that is, it incorporates an ongoing spiritual connection with the church of the clients’ choice, and encourages a commitment to living in an environment free from the needs of illicit drugs, alcohol, or compulsive gambling.

At the hearing, Mr Smith and Ms Hoet represented the Stables Christian Centre to discuss aspects of their submission. It was identified that approximately 60 to 70 individuals, with issues associated with gambling and/or alcohol, currently attend the support groups at the Stables Christian Centre. The representatives acknowledged that the Church are happy to remain self-sufficient in terms of funding, and note that it would be against their beliefs to accept money from the GRF. However, the Church would appreciate inclusion by the GRF service network as a support service available to be readily accessed by problem gamblers and their families.

### **2.5.9 *UnitingCare Wesley Partners***

UnitingCare Wesley (UCW) is a major provider of community services in South Australia. The submission was made jointly by three of its four areas, namely those that provide a Break Even service—Adelaide, Bowden, and Port Pirie. The fourth, Port Adelaide, does not provide direct gambling rehabilitation services but deals with gambling issues through other services, while a senior staff member represents SACOSS on the Gamblers Rehabilitation Fund. The submission provides both consolidated views with regard to the focus of the inquiry, as well as individual agency views.

UCW Adelaide provides services that respond to the harm caused by addictive behaviours, 45 different community services in total. As Adelaide Central Mission, it established the first specialised gambling rehabilitation service in the early 1990s, mainly dealing with people with gambling problems associated with wagering and casino gambling. It established its Break Even service in 1995, providing a service to problem gamblers and their families in Adelaide's southern suburbs and Fleurieu Peninsula (data of the numbers accessing the service since 1996/97 are provided). The submission also identifies that UCW Adelaide is active in industry training and policy development and advocacy for regulatory and legislative change.

UCW Bowden is located in the inner west suburbs of Adelaide, where its work is focussed, an area of high cultural diversity. It was previously known as the Bowden Brompton Mission and commenced its Break Even service in 1995.

UCW Port Pirie provides its Break Even service to a large geographic area from the Yorke Peninsula to the NSW and Northern Territory borders. Apart from its general service, it has received special project funding to target the Indigenous community.

The submission identifies that there are a number of program areas funded by the GRF but its submission focuses on the Break Even program.

UCW identifies effectiveness as a core element of evaluation and defines it to be about meeting a program (or project) outcome or objective. Evaluation is identified as encompassing the three criteria of efficiency, effectiveness and appropriateness. UCW suggests that evaluation and programme effectiveness need to be understood in the context of quality performance measures, which it argues are hard to develop for human service organisations due to the qualitative nature of intended outcomes.

The submission identifies that while much effort has occurred to develop quality performance systems for human services, different funding programs have different quality and performance measures, making data collection management and reporting on a program-by-program basis by a community service, sometimes expensive and counterproductive. Noting that caveat, the submission identifies that UCW Adelaide has made considerable effort to attend to data collection for Break Even, appending a data sample to the submission.

With regard to measuring effectiveness, UCW identifies that—

- ◆ formal, independent evaluations of the whole GRF program should be undertaken every three to five years, thus enabling best practice community service

approaches to be utilised and benchmarking against like services, both state based and nationally;

- ◆ rigorous, independent evaluation, including longitudinal outcome surveys, should be undertaken at the service level to ascertain a services' effectiveness in reducing gambling harm.

UCW identifies that it understands there are five programs funded through the GRF—Break Even; Gamblers Helpline; early intervention, which is concentrated on public awareness raising; community education; and research. UCW states that the programs are generally measured for outputs and compliance rather than effectiveness, and provides its view of what has been measured for each.

UCW is of the view that the GRF program, particularly Break Even, have not been as effective as it could have been. Identified concerns include:

- ◆ contracts that make staffing and planning difficult;
- ◆ long term data management issues;
- ◆ ad hoc planning and decision making;
- ◆ deficit funding;
- ◆ resources for rehabilitation services to respond to everyday demand and additional demand from promotion/education programs.

The submission details how each of the three UCW service areas measures the effectiveness of its Break Even service—

- ◆ Adelaide—in accordance with the organisations quarterly Management Indicator Report, which, for each of its services, attempts to measure service outputs, client satisfaction (100% since 2001/2), client outcomes where possible (88–100% 'situation improved or resolved' since 2001/02), and processes (eg, audits of client file management);
- ◆ Port Pirie—referrals from external agencies and internally; time lapse for various levels of service provided; level of support required; client feedback; observed change to client's situation (eg, improved financial situation, ability to undertake alternative activities to gambling); time client needs service; time client takes to move through cycle of support; and when client no longer needs support;
- ◆ Bowden—outcomes based, with outcome ascribed by counsellor and determined by assessing the progress made by the client during the counselling process (eg, 85 % of clients who undertook counselling since 1 January 2004 experienced some degree of benefit from participating in program and 13.2% did not achieve any of their goals), but would like to be able to compare pre and post-treatment outcome scores.

UCW's submission details a number of gaps in program effectiveness. It also suggests that effectiveness has been diminished by a highly politicised environment of gambling policy, services and industry power contributing to an often restrictive and controlling climate, citing examples such as—the lack of 3 year funding cycles over

the decade of GRF funding; the Government taking network coordination and training functions from direct Break Even network control; and the limited service input to the GRF.

UCW Port Pirie cites a number of inadequacies and gaps for the Break Even program generally as well as Port Pirie specifically, with some suggestions for addressing those issues. Some of these issues are—

- ◆ data inefficiencies;
- ◆ non-customisation of media campaigns to local community, including use of Messenger newspaper, which is irrelevant to rural communities;
- ◆ lack of a whole community approach (eg, responsibilities of gambling providers, banking industry);
- ◆ need for an early intervention and holistic approach, including first point of contact agencies identifying and referring to Break Even (eg, GPs, community health, CYFS financial advisors and hospitals);
- ◆ lack of uniform, adequate, state wide support services in regional South Australia (eg, Mental Health, relationship and family counselling, etc), as well as access to social and recreational alternatives;
- ◆ medical model of treatment has a limited impact within rural communities (eg, intense inpatient service available only at a city location, need for access to Cognitive Behavioural Therapy program);
- ◆ short term funding contracts of one year, which impact on planning;
- ◆ inequity in distribution of resources to and between communities, with funding unavailable for long term strategies and a need to recognise impact of distances in rural areas;
- ◆ lack of service access by Indigenous and Culturally and Linguistically Diverse communities.

UCW Adelaide cites a range of issues regarding the Break Even service—

- ◆ funding not meeting need—UCW Adelaide has supplemented funding for its Break Even service for many years with \$69 410 over the last three years and 9% supplementation this current year, an amount described by DFC as representative of “unmet need” (at the public hearing UCW Adelaide also identified one year funding contracts as a major issue);
- ◆ community education and awareness campaigns severely test service capacity—planning should include an attendant increase in service capacity, inclusive of sufficient time to recruit, attractive contract periods, and sustained for the period of the impact of the campaign;
- ◆ a need for some short term projects to enhance service delivery, with the submission detailing potential projects;

- ◆ a need to enhance service delivery, with a number of approaches described in the submission such as—a buddy service to assist clients to implement their post counselling action plan; reintroduction of the telephone counselling Debt-Line; visiting service to towns in southern vales area; establishment of an office at Marion.

The submission concludes by describing the range of treatment process and therapeutic models and approaches used by each UCW Break Even service, with financial counselling being a component of all three services. (UCW Adelaide, during its presentation at the public hearing, argued that financial counsellors are an important component of a gambling counselling team. They also argued that the “one stop shop” scenario, where an agency provides a service for a range of issues, enables an holistic approach to be taken to support a client when gambling is one of a series of impacting factors).

## 2.7 Individuals

### 2.7.1 *Anonymous problem gambler—written submission*

An anonymous author provides a submission based on their personal experience with support services offered in South Australia. In summary, the author opposes the view and/or approach that gamblers participate in gambling activities to avoid their pain, or to escape their problems.

According to statements provided in the submission, the counselling offered in South Australia tends to be client centred (e.g., where the client is encouraged to explore issues that may be contributing to, and or maintaining their gambling).

Although the author abstained from gambling following her experiences with the counselling service, the author describes a number of dissatisfactions with the services. The main dissatisfactions were (a) taking advice to relinquish access to money (b) focus on interpersonal/family issues (c) being referred to as a “special client”.

The author also notes a preference for the “stimulus exposure, response prevention” program offered at Flinders University.

### 2.7.2 *“Peter”, attending the hearing*

Peter told the Authority about his personal experiences as a problem gambler having undertaken a range of treatments, including that provided by a psychologist, an addiction counsellor and an interstate Break Even service, and also attendance at Gamblers Anonymous meetings. Peter also told the Authority that, professionally, he had worked as a senior bureaucrat in health agencies.

Peter argued that there was a need for Government to receive assistance, in the area of research, from independent people with experience in addiction, in psychology and in the welfare sector. In the area of service provision, he argued that rehabilitation

services should be provided through a mix of agencies rather than by a government department.

### **3. CONCLUSIONS**

#### **3.1 Effectiveness generally**

The Parliament has asked that the Authority inquire into and report upon the effectiveness of each rehabilitation agency whether fully or partly funded, bearing in mind the provisions of section 91 of the Gaming Machines Act.

The submissions which have been received in writing from the Break Even Network Agencies and the other agencies which seek to provide gambling rehabilitation support and assistance and the submissions made to us at the hearing reveal that much important work is done by these agencies in seeking to provide relief to those affected by problem gambling.

There is no doubt that numbers of problem gamblers are provided with assistance and it can reasonably be assumed that some do resolve their problems as a result of the assistance which is provided.

The submissions made to us evidence that each of the service providers satisfied us that they take their work seriously and that they are committed to achieving real and measurable success in their programs. It was also clear that in each agency there are skills, experience and understanding of a high order.

Understandably there are some strongly held views as to the most appropriate and effective way of providing these services and who will benefit from what. For example there is a small number of agencies taking the view that total abstinence and rigorous monitoring are ultimately the only really effective means of banishing addiction from the sufferer's life, while others suggest that education aimed at building insight and immunity together with mutual support will be better.

There is a range of views and emphases. Most seem to accept that different approaches will suit different dispositions and different types of problem.

At that level it may be concluded that each of the agencies is effective.

#### **3.2 Issues with effective service delivery and rehabilitation**

##### ***3.2.1 Agency resources***

However, almost all of the agencies accepted that insufficient funding and staff, difficulties in collecting or accessing data about outcomes, lack of a uniformly accepted training protocol and standards, limited availability of some specialist services, and the absence of enforceable early intervention processes had tended to hamper them in getting to more than a minority of the target population and being able to verify the effectiveness of their endeavours for individual cases.

So far as funding is concerned there has been an indication that further money will be available for rehabilitation work but that is contingent at this stage.

In the case of data collection, several agencies said that although they had collected data for quite some time they were not able to access it from the Department's "computer". This seems odd to the Authority and it needs to be addressed by the Department as a priority.

Training is very important and we have made it the subject of a specific recommendation.

Early intervention is more difficult because it is largely dependent upon the facility owners to allow for it and, at least in the case of the hotels, the clubs and SA TAB, that is not yet available in a form which the Authority is satisfied would be enforceable.

For example, we do not know how many hotels will comply with the AHA's proposed scheme and we do not know what capacity the intervention counsellors or staff will have to ensure that intervention is allowed to occur where it is required. As a result it is difficult for the Authority to express a concluded view about the precise level of effectiveness of each agency or service at a level of great detail.

There may be a small number of exceptions. For example, the Flinders Medical Centre was able to identify outcomes in a verifiable way and was also able to explain with a deal of specificity the types of person it is able to provide services to; this may be the result of being specialized in the provision of clinical therapies to acute cases but, whatever the reason, it was a very helpful aspect of the reporting we received.

### **3.2.2 Coverage**

The single most troubling information available to the Authority has been the fact that, while on the view taken by the Productivity Commission namely that 2.8 percent of the adult population or approximately 22 000 South Australians suffer as problem gamblers, only a few thousand seem to have found their way each year to one of the rehabilitation services.

What are we to make of this?

An effective program of rehabilitation for problem gamblers might be expected to have at least the following two features—a spread of services which matched the identified needs of the community; a system for determining whether the services being provided were achieving desired outcomes.

At most, as we have said, the current rehabilitation services are estimated to deal with 2000–3000 people per annum. Therefore at most they reach ten percent of the likely problem gambler population. The other ninety per cent are not reached.

This is not necessarily a reflection of the inadequacy of the services provided. People cannot be obliged to present themselves for rehabilitation. It is however an important statistic.

The Department for Families and Communities, which administers the gambling rehabilitation services, has told the Authority that it attempts to spread rehabilitation services across the State and to reach Aboriginal and Torres Strait Islander communities and communities which are culturally and linguistically diverse. Funds are allocated specifically for services to these communities.

There is no evidence, however, of any systematic attempt to assess whether the needs for rehabilitation services are greater in some geographical areas than in others or in some communities rather than in others. In the absence of any such assessments it would be fortuitous if the allocation of funds for rehabilitation services met the real needs.

It is relevant that submissions from some of the service providers stressed the need for funds to be better targeted both geographically and towards the needs of specific communities.

### **3.2.3 Outcome measurement**

With few exceptions there is no evidence that the actual outcomes of interventions by service providers are measured against desired outcomes established at the commencement of the treatment program.

In most cases it seems that clients are asked what they would like to achieve from the program but very little follow up occurs to establish whether these outcomes are achieved to the satisfaction of the client or against other objective criteria.

One feature common to all problem gamblers is that they spend too much money on gambling. It was not evident from the material presented to the Authority that service providers set out to measure systematically whether spending on gambling is being reduced or that this important benchmark receives particular attention in measuring the progress being achieved by problem gamblers.

The Department was asked how it measured the effectiveness of the rehabilitation services for which funds were provided from the Gamblers Rehabilitation Fund. The answer was that attention was focused on ensuring that agencies implement best practice interventions. This is not a satisfactory response since it is analogous to measuring the effectiveness of a medical procedure by reference to the doctor's technique.

The Draft Report of analysis, apparently prepared by the Department, was said to deal with the performance of rehabilitation services and options for the future. For several important reasons this report was unsatisfactory and needs to be reviewed at a higher level or with a more objective intention. It is not appropriate that we deal with it in detail here; rather the Authority recommends that this be looked at by the Authority in the near future in the context of developing policy settings for service provision in this area. The questions involved in determining the appropriate way of measuring the effectiveness of the services, the suitability of training, and the allocation of research funds should all be dealt with at this level.

The Authority suggests that as a matter of high priority the Department should seek to establish, in consultation with the funded service providers and ideally with their clients, some consistent outcome measures by which the effectiveness of interventions can be measured. These should be provided to the Authority for comment and response, and if satisfactory they should form the basis of future evaluations.

The Authority does not suggest that the achievement of those outcomes will be easy. There seems to be no consensus amongst service providers on which therapies are most effective in rehabilitating people with severe gambling problems. Several service providers laid stress on the fact that they offered a range of therapies to their clients.

This is not necessarily reassuring since no insights were offered into how the needs of individual clients were assessed and matched with the particular expertise of individual service providers. Rather one was left with the impression that individual providers did the best they could with the skills they had available.

It would seem to the Authority a major step forward if a better process could be devised of establishing the therapeutic needs of individual clients and matching them with providers skilled in the application of those therapies. This might lead to some greater specialisation amongst service providers since the range of alternative therapies seems quite wide.

#### **3.2.4 Capacity and competencies**

In this context the Authority notes the concerns expressed about the shortage of appropriately skilled counsellors and the moves towards accreditation of counsellors. Such a process might be assisted by a greater specialisation.

The Authority notes also the views expressed by some providers in favour of early involvement of specialised financial counsellors to assist problem gamblers regain control over their finances.

Effective links between other counsellors and specialist financial counsellors would seem to be a desirable feature of future service provision particularly if the supply of skilled financial counsellors continues to fall short of demand.

### **3.3 Funding**

One of the major reasons that these things—outcomes, information about outcomes, agencies' capacities and resources and the coverage of the services—are important is that significant amounts of money need to be allocated to this work if it is to be done, and those involved in the allocation are naturally looking to see whether reasonable results are being achieved for the money which is spent.

Government wants to see that money which is allocated under a budgetary process which is subject to scrutiny by the Parliament, both through the office of the Auditor General and by Parliamentary Committees, is being properly spent and that the policy objectives for which the money is allocated have been achieved.

The former Department of Human Services and now the Department for Families and Communities has an added interest in the matter.

It appears from submissions which were made to us that the Department would prefer to see the problems associated with gambling addiction as simply one example of a number of behavioural disorders which seem to affect members of our community. Other forms of addiction which give rise to dysfunctional behaviour include drug addiction, alcoholism and addiction to sex and other obsessive behaviours.

In this context the Department seems to want to view those matters as part of overall questions of public health policy. In that sense, it seems the Department would argue that no special or particular policy for any one addiction problem should be formulated without regard to all of the other public health issues that might be considered.

This is certainly a credible view and one which warrants acknowledgement. However it all too readily reduces to a position where all funding directed to any health problem is to be consolidated into a general fund to be administered by the Department on a basis determined by it alone.

The Authority considers that there are some difficulties with this approach.

In the past (as seems apparent from the submissions made to us) significant sums from the Gamblers Rehabilitation Fund were simply attributed to general administrative expenses without much further explanation. In addition to this, money allocated to the gambling rehabilitation work seems to have found its way into research projects of a highly academic and esoteric nature concerned with questions relating to addiction generally.

No doubt this research work and its outcomes are significant both for academic and clinical practitioner purposes but also because they were directed across the generality of public health problems. Against this however, it must be acknowledged that money which is allocated to gambling rehabilitation bears that imprimatur and must be subject to that constraint.

Whether or not everyone in the community agrees with the method by which the money is collected there can be no doubt but that Parliament has determined that a portion of the money levied from poker machines takings is allocated to rehabilitation and gambling research.

Parliament has also established the Independent Gambling Authority with a special statutory charter which not only includes regulation of gambling activities generally but also a responsibility for developing strategies aimed at ameliorating the harm caused by problem gambling.

In this way it can be seen that it will simply not be conformable with Parliamentary intention to make the Gamblers Rehabilitation Fund money available only as part of an overall budget for health or for families and communities. Such an approach would not conform with the Parliamentary intention and is unlikely to meet with the expectations of those with special interests in the area.

The responsibility for allocating the Gamblers Rehabilitation Fund moneys should rest with the Authority which will determine the broad policy settings, and the research program through consultation with the relevant stakeholders. The process of procurement of services and the monitoring of service provision, subject to guidelines which will be established by the Authority will be handled by the Department.

### **3.4 Management by the Department**

There is one further matter that requires mention.

A significant number of the representatives who attended the hearing expressed dissatisfaction and frustration with the Department's handling of this area. There was a real sense of unease about the relationship between the service providers and the Department, particularly prior to its recent restructuring and under its former leadership. The Authority accepts that there is a basis for that dissatisfaction.

If the Department has not been able to engender confidence and support of those providing these very important services then that of itself would be a reason for the Authority to decline to recommend that the Department have substantial control of the former GRF Advisory Committee responsibilities.

What is of present importance is that the Department restore the confidence of the service providers and attend to maintaining good relationships in this area.

### **3.5 Recommendations**

The Authority therefore recommends as follows:

1. That responsibility for setting policy that would otherwise have been undertaken by the GRF Advisory Committee or the Department in that area be referred to the Independent Gambling Authority;
2. That the Authority determine the objectives and standards to apply to the provision of rehabilitation services and set the criteria upon which procurement of those services will be made;
3. That the Department for Families and Communities continue to be responsible for the procurement of gambling rehabilitation services and the daily management of the program;
4. That, subject to the setting of the new objectives and standards and the new procurement criteria, a fresh procurement process be undertaken with a view to new contracts being in place within 18 months after the publication of this report;
5. That the Authority be made responsible for the determination of the allocation of GRF research funds, in consultation with relevant stakeholders;
6. That the Authority review the manner in which training is provided and set a policy for its standardisation and improvement.

## APPENDIX A

### Call for submissions

#### Independent Gambling Authority

#### Gambling rehabilitation programs inquiry

#### Call for submissions

The Independent Gambling Authority is South Australia's senior regulator of commercial gambling activities. The Authority has been Australian Government has directed to report on the effectiveness of gambling rehabilitation programs conducted or funded (wholly or partly) by the Government of South Australia.

The report is required to be completed by 9 June 2005.

An inquiry under the *Independent Gambling Authority Act 1995*, with terms of reference, has been established for this purpose. The Authority now invites interested members of the public to make submissions to this inquiry.

A guide for making submissions, setting out the terms of reference and the key issues, has been prepared and is available from the Authority's office and on its website, [www.iga.sa.gov.au](http://www.iga.sa.gov.au).

#### **The closing date for written submissions is Monday, 21 March 2005.**

Stakeholders wishing to make oral presentations on submissions will have the opportunity, when submitting their written submissions, to register to present at a public hearing scheduled for **Tuesday, 12 April 2005**. Details of this hearing, including venue and commencement time, will be published on the website no later than 5 April 2005.

*For further information, please contact the office of the Authority—*

- by mail—Post Office Box 67, Rundle Mall SA 5000;
- by telephone—(08) 8226 7233—or facsimile—(08) 8226 7247;
- by email—[rehabinquiry@iga.sa.gov.au](mailto:rehabinquiry@iga.sa.gov.au).

## APPENDIX B

### List of people and organisations

#### *Organisations and individuals making formal written submissions*

Anglicare SA

One individual who asked to remain anonymous

Australian Hotels Association (SA Branch)

Break Even Network Services SA

Centre for Anxiety and Related Disorders (Flinders Medical Centre)

Clubs SA (Licensed Clubs Association of SA Inc)

Department for Families and Communities

Gambling Addiction Treatment Services

SA Heads of Christian Churches Gambling Taskforce

Lifeline–South East (SA) Inc

Nunkuwarrin Yunti of SA Inc

Relationships Australia (SA)

Salvation Army

SA Financial Counsellors' Association Inc

12-Steps Self Help Anonymous Group SA

Uniting Care Wesley Partners

Hon. Nick Xenophon MLC

#### *Hearing—12 April 2005*

*Who appeared*  
*(listed in order of appearance)*

*capacity in which appearing*

Hon. Nick Xenophon MLC

No Pokies Campaign Inc

Ms Helen Carrig and Mr  
Mark Henley

SA Heads of Christian Churches Gambling Task  
Force

Dr Malcolm Battersby and Ms  
Jane Oakes

Centre for Anxiety Related Disorders, Flinders  
Medical Centre

Appendix B: List of people and organisations—continued

<i>Who appeared (listed in order of appearance)</i>	<i>capacity in which appearing</i>
Mr Ian Law and Ms Belle Cheney	Relationships Australia (SA)
Mrs Geraldine Phillips	SA Financial Counsellors Association
Hon. J W Weatherill MP	Minister for Families and Communities
Ms Gwen Moore and Mr Trevor Bignell	UnitingCare Wesley Partners
Ms Leeanne Head and Ms Lynette Pugh	Department for Families and Communities
Ms Frances Nelson, QC, with Mr John Lewis and Ms Rhonda Turley	Australian Hotels Association (SA Branch)
Mr Jonathan Wells, QC, Ms Sue McPherson and Mr Robert Mittiga	Gambling Addiction Treatment Services
Mr Michael Keenan	Clubs SA (Licensed Clubs Association of SA Inc)
Mr Don Smith and Ms Lyn Hoet	12 Steps Self-Help Anonymous Group SA
“Peter”	Anonymous problem gambler



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