
**Submission to the
Independent Gambling Authority**

**Inquiry into the effectiveness of gambling
rehabilitation programs in South Australia.**



Nunkuwarnin Yunti of SA Inc

March 2005

Introduction

Nunukuwarrin Yunti welcomes the opportunity to provide a submission to the Independent Gambling Authority into the effectiveness of gambling rehabilitation programs in South Australia.

The structure of the submission has followed the advice of the 'Guide for making Submissions' developed by the IGA, 2005:6

Submissions might address the following.

- (1) what you or your organisation think makes an 'effective' program;
- (2) how program effectiveness might best be measured;
- (3) whether programs are currently measured for effectiveness, and if so, how;
- (4) whether current measures of program effectiveness are adequate and explaining why;
- (5) thinking about the programs available in South Australia as a whole, and within the context of partly or wholly government funded, whether the breadth of the funded programs is effective within the context of (and please explain your answer).
 - . the funding provided;
 - . the needs of the target group;
 - . clinical approaches/treatment modalities available;
 - . all (including non-government funded) gambling rehabilitation programs available in South Australia;
- (6) with regard to the preceding point (5), if you say that the program provision is ineffective in any way, identify what gaps there are and what is needed to provide an effective program.

Extensive after hours work has gone into the writing of the submission, principally by Mr Michael McCabe who manages the safe gambling program at Nunukuwarrin Yunti, along with a range of other health promotion programs. Program staff – Ms Mandy Brown and Ms Lisa White have contributed ideas and feedback into the submission, gained from their working knowledge of the program and contact with Aboriginal people and communities affected by problem gambling.

It is hoped this submission contributes to the work the Independent Gambling Authority is involved with.

What you or your organisation think makes an “effective” program?

An effective gambling rehabilitation program is one that seeks to achieve sustainable change in factors that predispose, maintain or exacerbate problem gambling. Strategies employed should be based on a credible theoretical base consistent with the defined target group. From the perspective of Nunkuwarrin Yunti this is the Aboriginal community of South Australia. It is asserted in this submission because problem gambling has social as well as individual origins; rehabilitation is best understood as both a social and individual agenda. Strategies need then to be targeted across a variety of levels including Individual, Organisational, Community and Institutional (See Table 1).

Table 1- Levels of Intervention

Individual

- *Counselling (financial / therapeutic)*
- *Information Provision / Education*
- *Social Marketing*
- *Smart Card technology*
- *Self Exclusion / Self-Barring*

Organisational (Settings based approaches)

- *Gambling Codes of Practice*
- *Reduction in machines per venue/ times of operation*
- *Accessibility of gambling intervention services (time and place)*
- *Smart Card technology*
- *Workplace policies to support employees with problem gambling*
- *Industry based programs – Responsible Gambling Officers*

Community Action

- *Intra and Interagency Networks / partnerships*
- *Re-distributive activities affecting poverty and related social determinants of health*
- *Collective actions to address localised community concerns e.g. creating alternative social activities, reconciliation activities to promote greater racial understanding and harmony.*

Institutional

- *Legislative activities governing gambling licensing,*
 - *Product (formats of gambling)*
 - *Place (accessibility – time and place)*
 - *Promotion (Advertising)*
 - *Price (Fines for breaches of Codes of Practice/ Laws)*
- *Budgetary process to ensure resources allocated on a needs basis for range of activities i.e. counsellors and community educators / development workers being available, social capital development, regulatory bodies can adequately support compliance of codes of practice.*

It is implied in this submission that each of these levels of activity should be included in any analysis of state-wide ‘gambling rehabilitation program effectiveness’ as each contributes towards the rehabilitation of individuals experiencing gambling problems and address broader social impacts of problem gambling.

Some additional qualifiers

- Problem gambling operates along a continuum i.e. low, moderate, and severe.
- Different interventions are not exclusive and have different implications for the implementation timeframe, cost and prospect for sustainable effects.

	Level of Intervention			
	Individual	Organisational	Community	Institutional
Implementation Timeframe	Short	Medium	Medium to Long	Medium to Long
Implications for Resource Requirements	High and ongoing	High - Declines once change implemented	Significant at first then declines once change implemented	Significant over extended period then withdrawn once change implemented
Prospects for Sustainable Impacts	Low in absence of other level strategies.	Moderate – setting may only have limited impact on individual	Moderate – High Significant resistance a rule of thumb. Evidence for sustainability mixed	High Impact Significant resistance a rule of thumb

Swerissen & Crisp, 2004¹.

- Problem gambling is a complex problem that has multiple pathways (risk factors), reflecting differing circumstances of individuals and communities.
- Risk factors while multiple and complex can be aggregated to assist planned preventative practice (primary, secondary and tertiary).
- There exists enormous scope for preventative intervention alongside treatment options. Integration of these functions is consistent with a comprehensive primary health care approach to problem gambling.
- Specification of a target group is critical for program design and evaluation.
- Evaluation of effectiveness needs to be based on standards of research associated with the mode of intervention and other considerations such as cultural needs of specific population groups (not a one size fits all approach).

¹ Note: Swerissen & Crisp (2004) discuss the broad topic of sustainability and health promotion practice. The article is not specific to problem gambling intervention.

While many of these qualifiers have broad application across a range of population groups, this submission will concentrate specifically on gambling program effectiveness for Aboriginal people. Before discussing gambling specific program effectiveness, it is important to discuss the Aboriginal definition of health

'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.' (National Aboriginal Health Strategy Working Party, 1989).

All programs operating within Nunkuwarrin Yunti work within this definition and approach to health. Working within this model requires an understanding that restoration of health is not solely for the benefit of the individual as the primary goal, but also to enable the individual to contribute to their community and re-engage in social roles if this is possible. It is also implied in this definition that any insult to the health status of an individual directly affects their capacity to fulfil their required social contribution to the community. This in turn generates the need to support broader community functioning now not being attended by this individual. Following from this is the need for community focused interventions that seek to restore some balance to the health of community by building additional community capacity and resilience required to mitigate negative social processes.

Based on the National Aboriginal Health Strategy definition it is also argued that responding appropriately to gambling health problems requires strong attention to the social and cultural determinants of health, not just individual psychological factors. This is because the latter is very much influenced by the former. Concentrating solely on the individual without consideration of the social context will reduce the effectiveness of individual rehabilitation practice, and can be potentially more harmful to the person i.e. blaming people for being in poverty.

It is also particularly important when working within an Aboriginal context of gambling rehabilitation that there is a strong appreciation of historical and contemporary social and cultural factors that influence individual and community health status related to gambling behaviour. Strategies that enable greater involvement of communities in shaping programs is critical within this context of service delivery due to the diversity of the community and the strong need for local ownership and authority. Nunkuwarrin Yunti in delivering community-based problem gambling services ensures there is an

- Appreciation that Aboriginal communities collectively have experienced similar negative impacts of colonization that can not be ignored in program design such as
 - Dispossession – forced relocation from lands without compensation
 - Dehumanisation – reflected in government policy and practice pre 1967
 - Stolen Generations and associated traumas
 - Ongoing exposure to racism and social exclusion
 - Inverse Accountability – Answerability is always weighted towards Aboriginal people rather than agents of mistreatment.

Consideration of these factors in turn require an understanding of the legacy of these processes in the contemporary context, which includes and is not limited to

- Intergenerational loss & grief
- High incidence of abuse (primary and secondary)
- Impacts of institutionalisation and over representation in ‘corrective’ systems (social and criminal).
- Welfare dependency as the predominant staple economic system
- Enormous disparities in co-morbidity and mortality rates across a spectrum of disease classifications; physical, psychological and social.

These past and present factors influence both the predisposition to developing gambling problems and influence actions taken at the individual, familial and community level to address problem gambling. An effective program thus needs to ensure that status of gambling and it’s associated problems within the community are not separated from the social and historical context, and recognises that addressing the problem from multiple approaches holds the highest prospect for sustainable improvements.

While recognising cultural and historical commonalties, it is also critical that work undertaken attends to diversity within the Aboriginal community and adheres to local protocols when advancing community projects and emphasises support for locally determined and controlled programs.

The program operating from within Nunkuwarrin Yunti is funded to provide state-wide coverage to address problem gambling for Aboriginal people. The program being positioned in an Aboriginal Community Controlled Health Service (ACCHA) enables the project to interact with a range of other programs delivering primary care (clinical) services, counselling and social health programs, and SA Link Up (Stolen Generations) services.

The gambling program is part of the Healthy Options Promotion & Education (HOPE) team which hosts a range of programs that focus on preventative health care, the Nu-hit (Blood Borne Viruses), the Drug Substitution Options and Support (SOS) program which supports Aboriginal seeking pharmacological treatment principally for opiate addiction, and Tune into Your Heath – a health promotion model that works in partnership with Aboriginal youth through song writing and recording to develop and transmit messages relevant to this target group. All program methodology is based on a comprehensive primary health care model, with a strong emphasis on the organisational and community levels of practice. The gambling service specifies a loading of 30% dedicated to individual focused interventions and 70% dedicated to community and organisational practice. The program employs two full time staff, one worker concentrating on the on the metropolitan area of Adelaide, and the other worker on regional and remote communities. Collaborative work is also undertaken.

The metropolitan worker undertakes a clinical load, which includes the provision of financial counselling services. The high level of informality requested by people wanting to access the service creates challenges for data collection in terms of gaining the type of data required to account for outcomes within the model currently adopted by the GRF, which emphasises psychometrics measures.

The extensive range of data also can be problematic to collect as it creates discomfort for people, many of whom have literacy issues and distrust of information systems as these have previously been used in a negative manner towards Aboriginal people by government bodies that have not acted in the best interest of the community.

The organisation has a strong commitment to advancing health information systems in the interests of improved primary health care for Aboriginal people and actively participates in forums and processes to improve Aboriginal health data. The Office of Aboriginal and Torres Strait Islander Health in partnership with the National Community Controlled Health Organisation (NACCHO) has been involved in the national roll out of Patient Information Recall Systems (PIRS), which have enormous scope for early identification of a range of physical and social health conditions.

Nunkuwarnin Yunti is currently in the process of exploring the feasibility of integrating the Early Intervention Gambling Health Test developed by the Australian Medical Association (SA) and Flinders Medical Centre into the organisations Patient Information Recall System Communicare[®] to enable a more effective and sustainable method of screening for gambling problems as part of the routine enhanced primary health care clinical process. Trialling this module will improve the scope for more extensive application of such a screen within the state and national PIRS's within ACCHS if other organisations wanted to pursue this screening as part of comprehensive health care planning.

The Regional / Remote worker concentrates their activities towards community engagement in regional areas, usually in partnership with existing Aboriginal health infrastructure in regional areas. In this way the worker can offer gambling specific input within locally determined processes used to engage the community. The service also gets involved in community activities organised by other Aboriginal organisations such as attending sports carnivals organized by the South Australian Aboriginal Sport and Recreation Association, the Croc Fest in Port Augusta (an annual health and careers expo targeting Aboriginal school children from remote communities in South Australia), and health days/expos at various services. The worker also regularly attends an Aboriginal alcohol rehabilitation program Laklinjerri Tumbatin Waal run by the Aboriginal Sobriety Group, conducting gambling workshops and assisting people to engage with other social services beneficial to wellbeing. The workers also work together on certain projects such as providing regular workshops within Magill Training Centre (Adolescent Custodial Facility), and within the TAFE system targeting Aboriginal people undertaking formal studies in community services. The program is also available to provide cultural input into activities being advanced by mainstream services such as the Helpline, Health Promotions SA and BreakEven services.

While the current gambling program extends educative and promotional services at a state-wide level, the agency has for some period advocated to the GRF (*through the formal consultative processes undertaken in June 2003 and August 2004 coordinated by the then Department of Human Services*), that significant additional resources are urgently required to resource local capacity within the Aboriginal Community Controlled Primary Health Care Sector to employ staff to advance sustainable projects targeting problem gambling. It is clear that problem gambling is reaching more people in a more sustained and intensive manner than the current statewide program response.

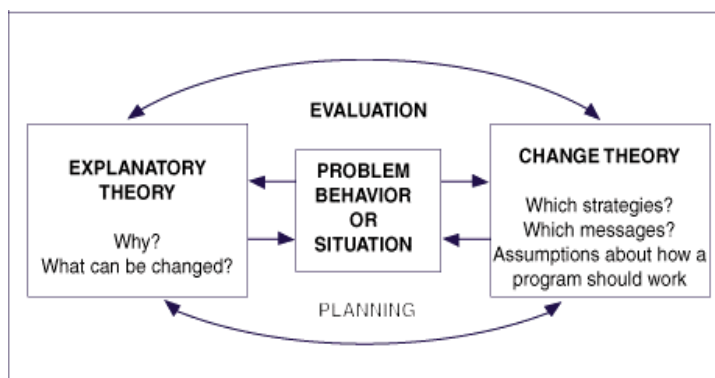
Having read the draft GRF Strategic Review document, it is pleasing to see that the Department of Families and Communities has recognised this need communicated by the agency, and Nunkuwarrin Yunti looks forward to the prospect of supporting more locally autonomous and sustainable Aboriginal gambling services in regional and remote areas of South Australia in the near future.

This is needed because while a mainstream model of health care is potentially beneficial to some Aboriginal people, it will for many not be sought or be very helpful because the model of service delivery is built on a different set of cultural assumptions. This in turn influences program design, which is optimally addressed within an Aboriginal organisational model of social service practice.

Figure 1 describes a basic conceptual model for applying theoretical frameworks to health promotion program development and evaluation. The model emphasises the importance of working from a comprehensive understanding of a problem, i.e. why the problem occurs in the first place, what can be changed and then settling on strategies that aim to reduce the occurrence or impacts of the problem informed from this analysis.

In addressing problem gambling from an Aboriginal perspective it is critical that all elements within the model are informed within an Aboriginal frame of reference. The outcome of operating from different set of assumptions will be that the problem will be ill defined; its causation misunderstood and prospects for sustainable change or benefit will be low.

Figure 1: Explanatory Theory and Change Theory in the Process of Program Planning and Evaluation
(Source: US National Institutes of Health: 2003)



Enabling a greater capacity for further development of Aboriginal specific practice models, mediated through local Aboriginal community structures on the ground, is regarded as the most effective way to make impacts across the various levels of intervention previously discussed.

This is not to suggest that non-Aboriginal stakeholders and services should not be part of the process, as these agencies have their own responsibilities to reduce the occurrence and impacts of problem gambling specific to Aboriginal people as well as the broader community. It can also be argued that the more effective non-Aboriginal stakeholders are at implementing effective strategies at the organisational, community and institutional levels, the greater the capacity for all stakeholders to benefit, which includes Aboriginal people. A case in point is the strategy recommended by the Independent Gambling Authority to decrease the numbers of electronic gaming machines in South Australia to reduce the incidence and prevalence of problem gambling. This stream of organisational and institutional level intervention is regarded as having a very strong potential as an effective measure to reduce gambling related harm in certain regions – thus is rehabilitative.

There are of course degrees of effectiveness. To ensure that this strategy will be more effective towards Aboriginal people and other at-risk populations it would be critical for this measure to be implemented strategically to ensure it has a positive impact in regions that are more socially and economically disadvantaged thus less able to tolerate a high threshold of gambling.

This example highlights on the important feature of an effective program strategy, i.e. being constructed in a manner that targets efforts towards a designated target group, preferably in partnership with the affected community to better understand the potential costs and benefits associated with the proposed strategy. It also demonstrates that social rehabilitation can be regarded as a worthwhile avenue for restorative health outcomes and measures of effectiveness are as critical as evaluation of psychotherapeutic interventions.

In respect to individual orientated service delivery there is certainly a strong argument that mainstream counselling and social service organisations should be actively involved in targeting their programs to reach Aboriginal people, coinciding with required modification of practice methodologies to maximise a goodness-of-fit in the service design to match the needs of Aboriginal clients. This requires attention to the

- *Setting in which the client consultation takes place – community based*
- *Timeframe for service contact- open / flexible*
- *Practitioner knowledge of the historical-socio-political context of Aboriginal experience that predispose, reinforce and enable problem gambling formation, maintenance and resolution.*
- *Consultation with local Aboriginal people on cultural matters to enhance service delivery at individual and organisational levels of practice.*
- *Involvement of family members in consultations (with consent of client)*
- *Prioritisation of concerns and intervention goals being generated by the client.*

While mainstream settings can and should modify service elements to support more effective outcomes for Aboriginal people, the situation will remain that these modifications are not a surrogate for service delivery within an Aboriginal community controlled health setting.

In concluding, it is important to consider the way the question of 'effectiveness' is asked, i.e. either the 'ideal world scenario' with no resource constraints, contrasted with what is achievable within the resource constraints. This is important as concluding the answer of what constitutes an effective gambling rehabilitation program is not estranged from resource considerations. Mapping an answer within an ideal world will take account of demand where as mapping an answer within the resource constraints requires consideration of supply and demand considerations. Regardless of the model Nunkuwarrin Yunti argues that resources should be allocated through analysis of population size, geographical coverage, gambling activity in local region, socio-economic composition and other key precursors of problem gambling. Consideration of existing service infrastructure, both human and capital is also required. Where deficiencies of either type are identified there needs to be a planned approach to bridging gaps to ensure expectations generated are realistic and feasible within resources available.

How program effectiveness might best be measured

The preceding section has stressed the need for increased emphasis on defining problem gambling rehabilitation within a multi-layered, multi-agency approach. This in turn creates a strong need for a coordinated approach to gambling rehabilitation to maximise effectiveness and efficiencies across the system. There is also a need to develop a broad set of measures that takes into account the full range of work being undertaken, with additional attention to system synergies or conflicts that detract from effectiveness, again from our perspective on outcomes being realised for Aboriginal people.

Specific measures need to be directly connected to the scope of focus i.e. individual, community, and organisational and / or institutional level change.

While convention may suggest that it is more important to restrict the focus of program effectiveness towards the rehabilitation of the individual, this does not allow for the value of other activities to be given due attention and scrutiny. As has been previously discussed, community, organisational and institutional level change is critical to supporting a healthier community, and in fact evidence suggest more sustainable achievements can be realised through advancing interventions at these other levels, particularly at the individual level of practice.

These principles are also featured strongly in generational health reform process underway in South Australia, which emphasises the important link between attending to social determinants of health to achieve better outcomes at the population / sub-population levels.

It is for this reason that this submission advocates that the attention the Independent Gambling Authority gives to assessing effective rehabilitation extends to the four levels of health promotion practice. From the perspective of Nunkuwarrin Yunti there is the added emphasis on considering the specific effectiveness of all activities in reducing gambling related harm for Aboriginal people and communities, particularly activities outlined in Table 1. These conclusions need to be informed from the broad views of Aboriginal communities within South Australia. Achieving this in a meaningful and effective manner requires active engagement from these stakeholders and following accepted data and evaluation protocols.

In considering the issue of how effectiveness may be measured, it is important that Aboriginal perspectives on health information and data is considered and factored into any analysis. The South Australian Aboriginal Health Partnership has in 2004 developed an Aboriginal Health Data and Information Framework that articulates many of the issues and strategies for making improvements to Aboriginal health data and information.

The framework document cautions that data that solely concentrates on individual pathology of non-health, limits the attention and scope for understanding, which in turn limits prospects for advancing health outcomes for Aboriginal people.

Specifically the framework states

The majority of major Australian Health Information systems tend to focus on diseases and their treatment. This domination of service related by-product data in the clinical health fields creates specific difficulties for Aboriginal people.

- *The Aboriginal population is younger than the rest of the South Australian community. If health service allocations are made on the basis of mortality rates and hospital separations, there will be little consideration of the needs of the majority of Aboriginal society. In addition, if services are not available, or their use is delayed, need is underestimated.*
- *The Aboriginal view of health is inclusive and wide ranging, covering all aspects of body, mind and spirit and all of the environmental, cultural and social factors that have an impact on well-being. Data on disease therefore meet only a small part of the need for information in Aboriginal cultures.*
- *While the narrow focus of clinically based systems is offset to some extent by health and housing surveys, the sample sizes of these surveys do not permit accurate estimates to be made of the health of Aboriginal people, especially at the local level at which health planning is required.*

(South Australian Aboriginal Health Partnership, 2004:5)

This highlights the need for a broad and inclusive approach to data collection and analysis to inform program planning, monitoring and outcomes.

Current measures for effectiveness with the SA Gamblers Rehabilitation System.

Nunukuwarrin Yunti recognises that there are different stakeholders with different data needs. The Department of Families and Communities, which administers the GRF fund and contracts the agency is provided with audited accounts of the use of resources received. This measures that the resources have been used in accordance with the objectives of the contract and provides accountability for the funds.

There is also the expectation that the agency provide quarterly reports through the GRF Data Module largely developed by the department. The service agreement between the Department of Families and Communities and Nunukuwarrin Yunti has a weighting of 70% concentrated on community education / community development functions and the residual 30% focused on individual orientated activities.

There has been a range of difficulties experienced in collecting the full range of individual client focused data within this module due to the fact that the information relies on the completion of a range of psychometric measures. While the agency operates in a manner to maximise the level of data collected, it is rare for the agency to collect the full range of individualised measures as required for the current data model. This trend has been observed over a range of years by a range of workers indicating that the issue is related to the data model and its cultural fit, not idiosyncrasies or skills sets of workers.

A further explanation is the fact that the agency uses the Narrative Therapy model of therapeutic practice, which is not as compatible with the administration of instruments as a primary assessment model.

The Narrative Therapy approach has a clear and robust assessment process whereby problem 'stories' are explored with people in a manner that assists them to make better sense of their origins and effects of problems to enable an approach to problem resolution that is inclusive of the client's perspective and meaning of factors preventing and supporting change. The model, in being more qualitative in its approach, experiences difficulties in advancing overly quantitative approaches to problem description through criteria that is less informed by the system-of-meaning the client operates within. The model is not incompatible with using therapeutic approaches such as cognitive reframing or behavioural modification; however there is a much stronger emphasis on partnering with clients in exploring the bio-psycho-social context of action.

This is not to suggest that other models of practice, which rely heavily on the collection, and recollections of quantitative data are without merit. However it is reasonable to conclude that a one size fits all approach to data collection within a delivery system that is trying to meet the needs of a range of discrete population groups will experience difficulties in meet the diverse needs of all these groups.

The Department of Families and Communities can be commended for their approach of listening and recognising the needs of this agency in trying to meet the data collection requirements of the department, based on the reality of extending the service to meet the needs of the Aboriginal community.

The agency has no problems in complying with recording data related to community education / community development functions. This data is concentrated on measuring activity, target groups, and time spent planning, delivering and evaluating these activities. In terms of the investment of time and effort to develop robust measures of effectiveness for this area of gambling rehabilitation practice, it would not be unkind to suggest that there is considerable work that needs to be undertaken to improve this area of data collection within the GRF funded functions. It can be concluded from an analysis of the GRF community education / community development activity data that at this point in time this important area of work is not given the same level of attention or worth as individual focused therapeutic practice.

Nunkuwarrin Yunti has developed its own methods of gaining feedback of effectiveness of various community based activities it undertakes. A strong ethic of soliciting feedback in the interests of improving the program is an entrenched work practice. Given the diversity of the community and the range of activities undertaken, program workers rely on a range of methodologies to gauge the effectiveness of the specific intervention being undertaken. In conducting workshops for example, the data sought includes shifts in understanding of the risks inherent with gambling and knowledge of the avenues for individual and family support. There is also strong focus on strategies that people can employ to prevent gambling problems and discussion of ways to reduce stigma and shame associated with gambling problems.

Data collection methods may include the distribution of feedback forms after delivering a workshop / education session or simply seeking feedback in a less formal manner through conversation within or after the session. Consulting Elders and community members about the value the workshops also provides a method of gaining immediate feedback on the value being realised through community-based activities.

Nunkuwarrin Yunti also produces six-monthly reports to the Department of Families and Communities that outline the work plan of the program and achievements against these goals. This is in addition to the minimal requirements of reporting, as the agency believes this is a more constructive way to communicate to the Department of Families and Communities on activities being undertaken as it provides a richer account of the strategies being advanced by the program and the rationale underpinning these strategies. This also supports internal process evaluation.

In terms of the broader question of the current success of data models to measure gambling rehabilitation program effectiveness, it is the perspective of this submission that there exists a range of stakeholders engaged in efforts to support gambling rehabilitation that also need to be contributing data on effectiveness of activities being deployed. Assessment of effectiveness includes general population benefits and specifically outcomes being realised for at-risk populations such as Aboriginal people.

If for example it is concluded that self barring / exclusion models is an acceptable and useful strategy for supporting the rehabilitation of people it is important that there are specific measures within the evaluation methodology employed to report the number of Aboriginal people seeking this strategy to gauge the success of this strategy. Process data that specifies the particular activities that have been undertaken to support this type of strategy to meet the needs of Aboriginal people is also critical to enable an analysis of the actual outcomes. If it were found that insufficient consultation has been undertaken resulting in Aboriginal people not accessing this strategy, this deficit in consultation could be identified as a causal factor reducing success and would support rectifying this situation before an adequate conclusion could be drawn on the effectiveness or otherwise of this strategy. This highlights the importance of measuring 'effectiveness' equally through process and outcome data.

It is recognised that gambling problems affect a range of people in a variety of ways including financial, legal, familial and a multiple array of social problems such as housing crises, family violence, prostitution and child neglect. GRF services are but a small part of the array of social service agencies that are routinely supporting people with these types of problems.

Concerted efforts to better gather and share this data of service need and response are urgently required. This would also enable bodies such as the Department of Families and Communities and IGA to better map social consequences in geographical areas for concentrated coordinated responses.

Divisions within the South Australian government again should be commended for some data work that is being undertaken in various pockets. Important work such as the *Inequalities in South Australia – Key determinants of wellbeing Vol 1* (Hetzl, Page, Glover & Tennant, 2004) coordinated through Health Promotions SA, which has reference to social inequalities and problem gambling, needs greater recognition.

It is also recognised that there exists a range of data that is available in the public domain that can be better coordinated, promoted and used in planning processes by all stakeholders.

The gambling program operating through Nunkuwarrin Yunti has constructed a table of all Local Government Areas within South Australia, which documents the population statistics of Aboriginal and non-Aboriginal people (numbers and proportional percentage), numbers of gaming venues, and net gambling losses across these geographical areas. This planning tool has been shared with Break Even services to assist these agencies to be more aware of Aboriginal populations and gambling activity in their respective service boundaries. The data also serves to assist the program to be more specific about the level of gambling in various communities when conducting community education events / workshops.

Whether current measures of program effectiveness are adequate and why

This submission would argue that there exists considerable room for improvement to the current system to measure program effectiveness. Much of the previous discussion has covered areas in which these improvements should be concentrated particularly the need for a more comprehensive and coordinated approach to planning, monitoring and evaluating efforts of gambling rehabilitation through activities advanced from multiple stakeholders across the various levels of activity. Supporting Aboriginal people and communities to be more involved with processes of planning, monitoring and evaluation is also critical.

The following commentary summarises the main points for consideration

Greater attention needs to be placed on gathering data from the full complement of actors engaged with supporting gambling rehabilitation outcomes in South Australia across the various levels of program activities (see table 1). This is to enhance coordination of efforts being undertaken and enable adequate analysis of where the system is working well or requires modification or attention. This centralised coordination information system would also enable cross-referencing of strategies to more clearly identify resource implications and opportunities for efficiencies across areas that intersect a range of stakeholder responsibilities.

Specific strategies need to be developed to enable Aboriginal communities to have greater input into the various strategies being employed by the full complement of actors engaged with supporting gambling rehabilitation outcomes in South Australia. Aboriginal people and communities also need to be elevated as active partners in the efforts to evaluate the effectiveness of all strategies being advanced. This would require consideration of current models of engagement and the development of systems to seek guidance from Aboriginal people to ensure cultural protocols are followed.

Enabling Aboriginal people to have greater representation on decision-making bodies that influence gambling rehabilitation strategy formation and resource allocations is also strongly advocated. Strategy formation is not without considerable reflection and analysis of data and implications for the selected process.

Unless Aboriginal people are part of this process it is clear that the needs of Aboriginal people will not be able to be considered. Inclusion would achieve systemic improvements through enabling greater attention to the perspectives of Aboriginal people, which in turn will enhance the end goal of an effective gambling rehabilitation system for all South Australians.

It is also recommended that specific dedicated resources be provided to local services engaged in gambling rehabilitation strategy formation and implementation to enable more internal evaluation the effects of chosen strategies. These resource allocations should reflect the specific evaluation models that are required i.e. individual focused tertiary service impact can be measured within a short time interval from the intervention, sustained effect requires a longitudinal model that follows progress over time. Community and organisational focused interventions required a different methodology and associated resource considerations. This recommendation is to strengthen internal capacity to develop more rigorous evidence based practice that reflects a diverse stream of providers and practice models in operation within South Australia.

There is also an urgent need for the development of an effective data and information system to enable evidence based planning for the allocation of resources based on geographical and socio-psychographic characteristics of communities, correlated with gambling specific data (expenditure and accessibility) and existing social service infrastructure that can support addressing problem gambling through a multi-pronged approach. This strategy is recommended to enable the mapping of existing service coverage with need and to better identify gaps.

Mapping need should not be solely based on signals from the gambling rehabilitation data system in terms of service supply and demand modelling. This is particularly the case for many Aboriginal people due to the dual effect of low utilisation of conventional counselling services and the fact, as previously stated from the South Australian Aboriginal Health Partnership document, that the age profile of Aboriginal people is comparatively much younger than the non-Aboriginal population. The Productivity Commission (1997) concluded that younger people were significantly more at risk of developing gambling problems, however were least likely to seek assistance through counselling / psychotherapeutic methods. Also the needs of young children impacted by the consequences of problem gambling do not feature adequately in the BESSA service data, however it is assumed that this data may be available in DFC child abuse data systems to assist family wellbeing workers to respond appropriately to the needs of the children and families in these cases.

Much of what is recommended in this section is mirrored in the newly released South Australia Aboriginal Health Partnership framework for health data and information.

Key features of future information systems

A future Aboriginal and Torres Strait Islander peoples health information system must be underpinned by a broad definition of health and well being that is not dominated by clinical health service and disease models and actively promote preventive strategies. There is need for information to be gathered routinely from a wide range of sources and for this to be processed and packaged to meet the needs of stakeholders in an efficient and effective manner.

The database should cover:

- *The physical, mental and social and economic health status of the Aboriginal population*
- *The environment in which Aboriginal people live*
- *The distribution of services to Aboriginal people*

And be:

- **Accessible** - *It must be physically easy to access, conceptually simple and meaningful, and presented in a fashion that enables easy use by the full range of stakeholders*
- **Accurate** - *Indicators should not be subject to major doubts about validity or biases in coverage or measurement*
- **Affordable** - *Information from the database should be free of charge to users The core needs of stakeholders at state, regional, and local level can be met by: Routine presentation of aggregate data at state, regional and local level A facility to undertake more detailed analysis*

Easy access of users of information to the primary data owners

Data needs to be presented in a simple and straightforward manner using charts and tables. The technical analysis of the data needs to be done behind the scenes to ensure high integrity of the reports and to relieve the end-user of the responsibility of dealing with large and often unfamiliar data sets.

The data should be available via a “one-stop-shop” which also has access points to other relevant data, held by other organisations.

(South Australian Aboriginal Health Partnership, 2004:7)

It is recommended that IGA consider the recommendations of this framework which has been developed through wide ranging community consultation, and reinforce the importance of moving forward in a manner that is meaningful for the Aboriginal community.

There is also a need to develop more evidence on the specific consequences of gambling within Aboriginal communities and families. The literature describing Aboriginal perspectives of problem gambling is almost non-existent anywhere in Australia. The Aboriginal Drug And Alcohol Council (ADAC) and Relationships Australia undertook a study on therapeutic approaches with Aboriginal people (Kinsella & Carrig, 1998), however a range of methodological issues exists with this report.

Gambling, similar to consumption of alcohol, was forbidden to Aboriginal persons restricted to Missions in South Australia up until the late 1960's, and gambling in this context was sought as a method of resistance to authoritarian rule by Missionaries, as well as pursued as a social leisure activity. In contemporary Australian society, coexisting factors such as lower health status, high rates of alcohol and drug abuse by members of the Aboriginal community who consume alcohol and other drugs, and the remnants of historical suppression and oppression, would indicate a lower threshold of protective factors at both the community and individual level.

In respect to EGM's, the only study conducted on this subject of note was in Northern Queensland in 1995, exploring the impacts on an Aboriginal community three years after the introduction of EGM's in that state. This study concluded that "compared with non-indigenous respondents, Aboriginal and Torres Strait Islander players spend significantly more on gaming machines and all forms of gambling"(AIGR, 1997:8). An important finding in this survey was that of the people surveyed "29% of persons had not gambled at all prior to the introduction of gaming machines" (AIGR, 1995:6).

An analysis of client statistics of presentations to BreakEven services in South Australia revealed an over representation of Aboriginal persons accessing counselling services being just under 5% of all clients when comparative to population estimates should be of the order of 2% (Elliot Stafford & Associates, 1998:Appendix 3.3). These authors also noted that EGM's pose particular risks to Aboriginal populations because "EGM's requires small stakes, regular small amounts of winnings received are appealing, there exists a preference for continuous format and it provides respite from disadvantaged lifestyles" (Elliot Stafford & Associates, 1998:51).

Funding Arrangements.

South Australia can in fact be proud of the fact that the existing GRF model recognises the specific need for service modelling that takes account of different population groups in South Australia such as Aboriginal people and CALD populations. While there exists a small number of Aboriginal programs in other state and territory jurisdictions, the strategic approach by the South Australian governments can be regarded as a leader nationally. The agency would still argue however 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.

A model outlining the resource requirements to meet the needs of South Australians affected by problem gambling segmented into specific target groups are at this time do not seem adequate, or if adequate are unknown to this agency. This process would assist all stakeholders to better identify where the South Australian gambling rehabilitation system is adequately resourced and where there exists a strong case for injections meeting specific goals. This would also support the identification of where there are deficiencies, which then leads to a more realistic appraisal of what can be achieved given the resource contingencies. Resources are defined as both monetary (capital) based, and human resource skill capacity required across the system.

Nunkuwarn Yunti has shared our practice experience and resources with agencies from other jurisdictions upon request, and as an agency would like to see more concerted efforts across other jurisdictions in rolling out programs in partnership with Aboriginal communities.

As was previously noted, Nunkuwarn Yunti has communicated formally to the DFC of the need for considerable expansion in the resources for allocation to effectively meet the needs of Aboriginal people based on a range of feedback the agency receives in discussing gambling related problems within the community. Nunkuwarn Yunti is pleased that these communications have led to formal recognition in the draft report considering priorities for the expanded GRF allocation through the South Australian government. However, in order to effectively address gambling rehabilitation needs within the Aboriginal community it is clear that significant resources need to be found from within government or through a funding model that places greater responsibility on the gambling industry to meet some of the externalities borne by this industry.

Nunkuwarn Yunti advocates that a hypothecated levy be placed on gambling providers to remove existing problems of resource scarcity. The formula for the levy should be based in part on the contribution certain 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.

Conclusion

In conclusion it is hoped this submission has added some value to the IGA in determining the current state of effectiveness of gambling rehabilitation programs operating within South Australia.

The submission has deliberately taken a broad approach to defining the 'service sector of interest' as it is clear that many stakeholders are involved with progressing gambling rehabilitation across various levels of intervention, all of which hopefully aim to achieve the same goal. Restricting the focus to the individual level of intervention limits the scope of analysis of the way the system is working as a whole to meet rehabilitation goals. If charged with the responsibility of rehabilitating a forest, it would not make sense to solely focus on a tree, it would also be important at a minimum to understand the topography, waterways, economic activity that constrains the agenda of sustainability, and other factors that have put / or continue to put stress on the forest.

It is hoped the IGA can see the forest and the trees, and the good work undertaken supports critical attention required to support so many South Australians adversely affected by gambling.

References

- AIGR, 1997. ***The Social and Economic Impact of Gaming Machines on Aboriginal and Torres Strait Islander Communities in Queensland.*** Department of Youth and Community Care. Queensland Government. Brisbane.
- Elliot Stanford & Associates. 1998. **Evaluation of the Gamblers Rehabilitation Fund – Final Report.** Adelaide. Department of Human Services.
- Hetzel, D., Page, A., Glover, J., & Tennant, S. 2004. **Inequalities in South Australia – Key determinants of wellbeing Vol 1: The Evidence.** Adelaide. Department of Health.
- Kinsella, C., & Carrig, H. 1998. **Therapeutic Models of Intervention for Aboriginal Problem Gamblers.** Kent Town. South Australia. Aboriginal Drug and Alcohol Council (ADAC).
- Independent Gambling Authority. 2005. **Inquiry into the effectiveness of gambling rehabilitation programs - Guide for making submissions.** Adelaide. Independent Gambling Authority
- National Aboriginal Health Strategy Working Party. 1989. **A national Aboriginal health strategy.** Canberra: Commonwealth Department of Aboriginal Affairs
- Productivity Commission. 1999. **Australia's Gambling Industries. Inquiry Report. Volume 1: Report (Parts A-C) & Report Volume 2: (Part D).** Report No 10.. Commonwealth of Australia. Canberra, ACT. November
- South Australian Aboriginal Health Partnership. 2004. **Aboriginal Health – Everybody's Business. Health Data & Information.** A South Australian Strategy for Aboriginal and Torres Strait Islander People. 2005 -2010. South Australia. Department of Health.
- Swerissen, H. & Crisp, B,R. 2004. The sustainability of health promotion interventions for different levels of social organization. in **Health Promotion International.** Vol 19. (1). Oxford University Press.
- US National Institutes of Health. 2003. **Theory at a Glance: A Guide for Health Promotion Practice.** <http://cancer.gov/aboutnci/oc/theory-at-a-glance/page2>. Accessed February 2005.