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Thank you for the invitation to make a submission to this inquiry. As the chairperson of the Gambling Impact Society (NSW) I bring to this submission over 12 years of working in a partnership with those affected by problem gambling in raising awareness, developing community education programs, self-help resources and advocacy. But in writing this submission I will also be drawing upon my 30 year experience as a professional Social Worker in the health and welfare field, a background in working with mental health issues and also as a partner of someone who has struggled with a gambling problem and now recovered. In addition I am an AASW accredited Mental Health Social Worker working in private practice, have had many years as an RGF funded Problem Gambling Counsellor, and am an RGF accredited Problem Gambling Counsellor Supervisor. I am also undertaking PhD research at Monash University at present in the field of Public Health and Gambling.

As the Select Committee has access to many of the previous GIS submissions I have completed along with tribunal hearings I will endeavour to keep this submission focused on my main points and in direct reference to the inquiry's areas of exploration. I do however submit the following introduction as a background to our recommendations:

Introduction

It is increasingly evident that there is a lack of coherent, public health based policy on gambling at both a National and State level. This is in direct contrast to similar health issues such as tobacco, drug or alcohol. Yet it is beyond doubt that gambling has been recognised as a public health issue in Australia (Productivity Commission, 2010, Victoria Dept. Justice, 2006, Qld. Government Treasury, 2002) and internationally, Gambling and Public Health Alliance International, 2008, Health Sponsorship Council of New Zealand, 2006, Korn & Reynolds, 2009, Shaffer & Korn, 2002, Korn, Gibbons, & Azmeier, 2003; Messerlain et al, 2004)

As in other areas of public health concern, there are also powerful and significant vested interests with both political and financial investments in the maintenance of continued commercial promotion of gambling products. In NSW in particular there is a historically strong, almost symbiotic relationship between the major gambling operators, Clubs, and State government. NSW clubs operate the overwhelming majority of the poker machines which proliferate in suburban and regional NSW, and which generate far and away the greatest gambling expenditure and the most significant social and individual harm. State tax concessions to NSW clubs and the dependence of State government on gambling tax revenue are significant barriers to the development of healthy public policy on this issue, as the Productivity Commission has observed (Productivity Commission 1999 and 2010).

Gambling in NSW has been institutionalised, and organised gambling interests have wielded considerable power in resisting a public health approach in this State. This is most clearly demonstrated by the recent vigorous, well funded and sophisticated "License to Punt" & "Won't Work, Will Hurt" Club industry led campaign against the National gambling reforms. A campaign focussed upon personal responsibility, personal freedoms and the proposition that nothing other than counselling and self-exclusion will work for "problem gamblers". It is a campaign led by Clubs Australia with its heartland in NSW.

By contrast there have been minimal opportunities for the general community to be consulted as to their view on gambling supply, gambling regulation, measures to address problem gambling or public policy development. Whilst the opportunity to contribute to public inquiries such as these is important, their reach is often limited to only those who already have a professional or financial vested interest in the issue. Submissions by the general community and individual consumers are rare. Unlike Clubs Australia, the community and problem gambling consumers in particular have limited access to funds, campaign resources or political connections to raise their voice.

In Victoria and other jurisdictions (such as New Zealand) there have been concerted efforts by governments to harness community views through community attitude surveys and referendums. NSW with the greatest number of poker machines, and an evidently well resourced and vocal gambling industry, appears to have no government policy to actively engage with their community on this issue. Yet governments continue to make concessions and agreements with industry with no reference to community views or standards. This is was recently demonstrated by the NSW Liberal government's memorandum of understanding signed with Clubs NSW prior to their election and increased tax concessions to the NSW Club industry shortly afterwards. Such inequities in the democratic process and gaps in community attitude research need to be addressed.

The GIS promotes a public health approach to problem gambling which, under the WHO Ottawa Charter (1986) and its later Jakarta (1997) and Bangkok revisions (2005), amongst other strategies, recommends active engagement by policy makers with communities and consumers in recognition of their role as major stakeholders.

The Need for a Public Heath approach to problem gambling

A public health approach to problem gambling promotes a social science based understanding of the interaction of human behaviour and social determinants, positing that individual behaviours and outcomes will derive from a range of social, cultural, political, institutional and environmental factors

Unlike some other jurisdictions (Victoria, Qld and NZ) where more holistic and preventive approaches have been taken to problem gambling, NSW has adopted a more traditional medical model. This focuses predominantly on treatment programs

for those who have exhibited problems and by comparison, minimal health promotion or early intervention strategies.

A shift in paradigm from this treatment model toward a more public health orientated model for problem gambling underlies some of the recommendations of the 1999 Productivity Inquiry but particularly 2010 Productivity Commission's Inquiry into gambling. However, the implementation of this paradigm requires a change in approach from an individual treatment/behavioural focus to a more determinants based inter–sectoral community response to problem gambling at an individual, social, political, environmental and cultural level. There also needs to be a shift away from a desire to find uni-lateral causal relationships. Instead problem gambling could be viewed as existing in a more fluid context of multiple relationships and influencing social mores.

It has been suggested that constraints developing effective public policy on gambling in NSW are also a result of conflict of interest given the portfolio and responsibility for policy making has historically been kept with the Minister for Gaming and the NSW Office of Liquor Gaming and Racing (OLGR) – the regulatory body for the industry (IPART 2004, GIS submissions to PC 2010). This is in contrast to similar issues – drug, alcohol, tobacco and mental health where the responsibility for primary and tertiary services, research, health education and health promotion lies with the NSW Ministry of Health.

In response to these concerns a specific recommendation of IPART (2004) was to transfer gambling treatment services to the NSW Health Dept. and/or develop better working relations. The OLGR opted for the latter with a commitment to develop a joint advisory council with NSW Health. However this body has never met.

This ongoing conflict of interest results in a lack of organisational commitment or culture to seriously address the issue from a public health perspective. Leaving those "at risk" or affected, marginalised from the kind of support and services they could expect if dealing with another health issue:

> "The people I rang weren't helpful at all. It was frustrating and used a lot of energy. I wish he had a drug problem - then I would have found help." (McMillen et al 2004)

The 2010 Productivity Commission Inquiry reflected a significant move towards a more structured consumer protection and public health approach to gambling, with specific emphasis upon the technologies of gambling. The effective development of this new paradigm for problem gambling in NSW will require these conflicts of interest and structural governance issues to be addressed.

It has been suggested that real reform is only possible with Federal leadership (Marshall, 2004), because of the need to involve all tiers of government, industry and community groups in a coordinated approach. Marshall (2004) suggested that the

Federal government is clearly in the best position to coordinate such a strategy, which would incorporate a public health approach and have the authority to implement. In addition, he maintained that a further important reason for gambling to be tackled by the Commonwealth was to minimise the potential for conflict of interest. He considered that State governments have a dual role in gambling and clear incentives to maintain or indeed grow levels of gambling revenue. Simultaneously they are responsible for minimising the harm for excessive use. Marshall (2004) argued that:

> The Commonwealth is in a better position than the states from which to assess the national public health costs of gambling most objectively, and to introduce measures to tackle them. (Marshall, 2004:61).

The Productivity Commission's Inquiry 2010 clearly recommends a National approach to addressing problem gambling and the GIS endorses this approach. Recent political realities in the breakdown in the Willkie-Gillard agreement on pre-commitment suggest that the development of good public health policy has fallen in favour of protecting big business. Even in the wake of this controversy, public polling indicates 62% of the population was still in favour of mandatory pre-commitment (Essential Polls 23/1/12). There are strong echoes here from the experiences of those in the public health field of Tobacco control (Prof. Simon Chapman, RGAW seminar 2009) and clearly lessons to be learnt.

The 1999 Productivity Commission highlighted the need for “good governance” arguing that:

> “Good policy-making and regulatory processes require that decision-makers have the appropriate degree of independence and control; that their objectives are clear and their decisions well-informed, and that the basis for their decisions is transparent and publicly accessible. Such features are especially important in a policy area such as gambling, which is characterised by conflicting pressures and incentives for government — and the potential for major winners and losers, within business and the community, from different regulatory outcomes” (Productivity Commission, 1999:58).

The Gambling Impact Society encourages our National Government to strengthen its direction on meaningful gambling reform in the term of this government and beyond.

Our recommendations in relation to the specific areas of this inquiry are as follows:

Measures to prevent problem gambling, including:

(i) use and display of responsible gambling messages,
(ii) use, access and effectiveness of other information on risky or problem gambling, including campaigns,
(iii) ease of access to assistance for problem gambling;

A Public Health approach takes a multi-pronged approach to addressing problem gambling including the use of social marking, targeted marketing to vulnerable groups, community education programs and skills development for individuals and groups.

Similar to the field of tobacco control, we believe there are opportunities to address the marketing of gambling, the location of gambling products and the normalising of gambling activities. Along with individual support and treatment for those who wish to change their own gambling behaviour.

Responsible Gambling messages to date have often been targeted towards the problem gambler either displaying odds of winning or information on help services. Most often these are situated in the gambling venue with relatively little information available generally in the community. It is suggest that messaging may be more useful if more generally available to the community and families in particular. It is also suggested and that messages should attend to identifying the risks of gambling, how to identify when you have a problem, along with information on where to get help.

There is a significant gap in factual information on the likely outcome of regular gambling i.e. the longer you gamble the more likely you will lose. This is in contrast to much of the industry marketing which portrays “everyone’s a winner”. It has been suggested that this directly influences cognitive distortions in an individual’s thinking – an underlying cause of problem gambling behaviour. Responsible Gambling messages could include more factual information to increase consumer information and assist people to make informed decisions.

The notion of RESPONSIBLE GAMBLING – in messaging seems to imply conversely that some individuals are “irresponsible”. Yet evidence in relation to EGMs (the largest contributor to gambling harms at present) suggests that if used in the manner in which pokies are designed to be used, a normal experience is loss of control, with almost 50% of regular players of EGM experiencing this phenomenon (Dickerson, 2003). The concept of the “irresponsible” gambler does little to support those who may need assistance to reduce their gambling behaviour and may lead to increased stigmatising. Stigma and shame have been identified as major contributor to people not accessing support services.

Commercial gambling has become a perceptually normalised activity in the community (although 70% of the community does not gamble on EGMs regularly). Similar to tobacco control, we need to de-normalise this behaviour and not demonise, victimise or stigmatise those who have developed problems with a commercial product which has known harms.

Whilst not prohibiting gambling, people need to have better information about its “normal” risks and informed choices about how to protect themselves from these risks. These strategies should include information on likely player outcomes but also include self-help information and skills development in reducing opportunities for harm.

However the emphasis should not be focused on individual behaviour alone but should be accompanied by changes in product safety standards to address the risks

of EGM play – “machine volatility” (speed of play, game volatility, maximum bets, jackpots, losses disguised as wins, note takes and maximum load ups). The GIS supports lowering jackpots to $500, maximum bets of $1 and mandatory pre-commitment.

It has been suggested by some that mandatory pre-commitment would have minimal effect on those with severe gambling problems, particularly if they could set high limits. It is acknowledged that this system will not be full proof in all situations. However, the GIS regrds the benefit of mandatory pre-commitment lies in the preventive aspects. The ability to provide all gamblers with a tool to set limits on their own behaviour (or future selves) is most likely to reduce the negative impact of interaction with the product.

My own clinical experience has suggested that many gamblers with problem gambling behaviour attempt to set limits when away from the venue. These have included: hiding ATM cards, placing ATM cards in blocks of ice so as to inhibit their actions when experiencing the impulse to gamble, posting ATM cards to themself on a Friday night to receive them on Monday knowing, this will prevent access over their vulnerable period - the weekend. As a clinician it is my belief that had these clients had access to pre-commitment technology they would have used it. It would be important that such limits could not be overridden, as is the case with current voluntary pre-commitment systems. Pre-commitment strategies could also be expanded to other forms of gambling such as internet gambling

The strength of a mandatory pre-commitment system for EGMs also lies in the player tracking mechanism. This would provide consumers with concrete data to assist them to track their gambling expenditure and modify their behaviour accordingly. Part of the cognitive distortions in problem gambling is the ability to elude oneself as to losses and wins. Player tracking data could assist those who may be at risk of problem gambling to identify this and assist those who have already developed a problem assess their ability to control expenditure. In addition the strength of player tracking data if made available with customer consent, to a third party would have the potential to increase opportunities for early intervention. In NZ Casino operators use this data to develop early intervention strategies with their customers. However, such data would need to be held with both consumer consent and strong privacy practices.

It has been suggested by the gambling industry that player tracking data and mandatory pre-commitment would be an invasion of privacy and an infringement upon civil liberties. However I would like to note that I am aware that existing Clubs loyalty scheme incurs significant data tracking information often used for product marketing as opposed to early interventions. Protections currently in place for customers are also inadequate.

My recent professional involvement in a Privacy Commissioner hearing illustrated the weakness of existing privacy constraints employed by some clubs. In this case, a Sydney based club provided significant amounts of player tracking data to a hostile third party (the client’s ex-husband) this had a major detrimental effect on my client. The Club was found in breach of the customer’s privacy rights, ordered to pay restitution, provide a written apology and increase their privacy training for staff. It

took the client over 4 years and significant amounts of stressful personal advocacy to have her case heard by the Privacy Commission.

It would appear that existing player tracking privacy arrangements provide minimal protections for customers and unsatisfactory processes for grievances to be addressed. Any new arrangement would need to ensure better practice. The Productivity Commission 2010 recommendations for an independent gambling body to oversee gambling regulation and a process for consumer redress would seem warranted.

Access to support for problem gambling issues needs to be better publicised in the community. Existing help services need to have greater resources to expand and increase both community education strategies and health promotion. Currently in NSW the focus is upon individual treatment and mainly attracts the problem gambler. Families have difficulties in knowing about services and are limited in accessing them although all PG services are able to provide a service to families and friends.

The model in Victoria where Gambling Help services employ a range of skills including those with community development, health promotion and community education in addition to counselling and financial counselling would seem of benefit. The closer link with health services and in particular drug alcohol and mental health services would assist in mainstreaming this issue.

As previously stated, the GIS recommend that the responsibility for Problem Gambling policy development and service development in NSW should be incorporated into the NSW Ministry of Health so as to integrate problem gambling services with Health services. This would provide the benefit of drawing on other expertise in addressing this population health issue. Whilst there are concerns that existing gambling treatment services may lose funding and independence, there are many successful precedents (for example Women's Health) where NGO services are integrated with and funded by Health. They collaborate under a policy direction, framework and objectives developed with NSW Health.

As in NZ we believe the issue of problem gambling should be split between NSW OLGR with it regulation responsibilities, and the Ministry of Health for research, community education, health promotion, prevention, early intervention and treatment. There are close associations with drug, alcohol and mental health issues in gambling and the marginalisation of problem gambling into a government department whose core business is not population health and welfare clearly disadvantages those affected. There is a clear need for political will to make this happen, effective policy development and organisational change to implement it.

Access to problem gambling assistance could then be mainstreamed through health services, and associated NGO's. This could operate under a Public Health Framework using core business models and the skills and access points of local Health services. Leading to an increase in access to a range of strategies for problem gambling delivered across health locals by a range of providers. Thus benefiting from philosophy, skills and processes of an organisation with a background, knowledge and skills base focussed on the health of the population, as opposed to the regulation and compliance of the gambling industry.

Addressing these “core business” structural and organisational issues would lead to a greater range and diversity of programs for the community on problem gambling. This would mean increased access by consumers to a range of supports, de-stigmatising by treating it as a mainstream health issue and access to a broader range of providers than at present. This would enable a greater sharing of resources and breadth of knowledge across the health and welfare sectors, increased training for health and welfare staff and recognition of problem gambling as a health issue by key gatekeepers such as GP’s. Ultimately increasing resilience and capacity to address the issue in the community.

In Australia, national health objectives were first published in 1988 and 1993 and were further refined in 1994 in *Better Health Outcomes for Australians* which focused on four specific areas: cardiovascular health, cancer control, injury prevention and control, and mental health. Diabetes, musculoskeletal conditions, arthritis, asthma were added later and obesity in 2007. These priority areas are reviewed regularly and added to when necessary. Biannual progress reports are published for each priority area. In addition, most states in Australia have their own health goals and targets.

It is proposed that problem gambling with its close association with mental health and addiction issues should be included in the national health objectives. This would increase focus on this issue, bring it in line with other issues of public health concern and increase the mandate for health services to address the issue.

Measures which can encourage risky gambling behaviour, including:

(i) marketing strategies,
(ii) use of inducements/incentives to gamble;

Current industry marketing of gambling products including online, sports betting and poker machines, emphasise the benefits of winning and distort the facts of the potential of losing. This contributes to an illusion for those who may gamble and distorts reality contributing to distorted thinking in the individual gambler and therefore contributing to gambling problems.

We have already suggested in another inquiry that the promotion of gambling during sports should be banned and restrictions on advertising on the outside of venues such as those in NSW should be applied across all jurisdictions. We consider the radio and television promotion of gambling products should be banned and that the use of logos of health organisations on any gambling promotion should be banned, even if such organisations have received funding support from that venue/industry.

We consider the promotion of gambling products, including Club Bingo, to children is inappropriate and should be banned. Currently there are no legislated age limits on Bingo promotions in NSW these are set by the venue and often as low as 6 years.

The use of inducements to gamble should be banned these include: loyalty incentives, free pizzas to winning customers, VIP customer programs providing free drinks and accommodation to regular gamblers.

The personalising of promotions should also be restricted e.g. a case reported to me (by another PG counsellor) of Star Casino personalising its invitation brochure (using

clients name) to take up a free accommodation offer to a regular “problem gambler” who had recently lost $7,000.

Another example of such incentives includes a client reporting a Sydney Hotel providing him with VIP status, keeping names of its customer who were designated as such (regular poker machine gamblers) and then given free drinks all night. In his words “I arrived (mid evening) bought one drink, played the pokies and never bought another drink” (leaving at about 3.00 am) “they kept me supplied all night”. This is a breach of both responsible conduct of gambling and responsible service of alcohol.

Early intervention strategies and training of staff;

As discussed, early interventions need to be included under the gambit of public health approaches similar to tobacco, drugs and alcohol. They include information to assist people to identify risky behaviour, self-help strategies and skills to reduce harm. Such information should also be widely available to family members who are often the people to whom a gambler may turn for support. Family members need increased information and education about problem gambling and their own self-help strategies.

An example of this is the recently published GIS resource Problem Gambling- A Self-Help Guide for Families (44 pages). This was developed last year, by GIS voluntary staff hours and a small amount of funding to support graphic design and an initial print run of 2,000 (from NSW Health and RGF). This resource has now been freely provided to the NSW OLGR for ongoing printing and distribution. In its initial year of publication demand has meant 17,000 copies have been printed and distributed across NSW. This could be modified for other States and Territories.

Greater self-help information needs to be developed and made available online and within public libraries, neighbourhood centres, health centres, GP practices as well as gambling venues.

Training of venue staff in signs of problem gambling and how to proactively intervene to support a customer is highly recommended. We also recommend the involvement of consumer voice programs (led by consumers, not the gambling industry) in the Responsible Conduct of Gambling training programs.

As with other health issues there needs to be a greater focus on prevention rather than cure. Although that is not to deny the need for effective treatment for those affected including family members and friends.

Methods currently used to treat problem gamblers and the level of knowledge and use of them, including:

(i) counselling, including issues for counsellors,
(ii) education,
(iii) self-exclusion;

As a problem gambling counsellor in NSW I am aware there are approximately 40 gambling counselling services across the state trying to do an important job with increasing demand and minimal resources. In NSW the funds available for gambling treatment is a 2% levy (approximately $12 million annually) on Star Casino. No other

gambling provider contributes to the NSW Responsible Gambling Fund (RGF). This is inequitable given the large contribution NSW Clubs and Hotels make to community and individual harm. The RGF is a limited pool of funding which could benefit from expansion.

In addition, mainstream health and welfare services do not readily treat problem gambling, nor are their staff trained to do so. This is despite many of those affected (mostly undisclosed) accessing their services and not accessing gambling specific treatment services.

It is incomprehensible to think that the limited funds available to the RGF would be the only funds in NSW to address this issue. Considering the extent of gambling tax revenue (9% of state tax revenue) mainstream funding should be made available.

Whilst there is now a minimal qualification for gambling counsellors in NSW it has been identified that the diverse range of baseline qualifications across the sector can lead to anomalies for consumers. For example some counsellors have limited backgrounds in various treatment modalities and therefore client choice is affected. Also, those services which employ clinical psychologists and access to Psychiatrists are often located only in the Sydney Metropolitan area.

Many counsellors are under pressure to do more community education and health promotion activities and yet this is not their core skills set. Services seem to increasingly being asked to do more with less and some skills sets are absent or at minimal level in the field e.g. health promotion, community education, community development. Yet these are skills specifically recruited for by other problem gambling services in other jurisdictions e.g. Victoria, NZ.

As a professional Social Worker in the Problem Gambling sector I am also aware there are few of my peers in the sector in NSW. This is possibly due to the lowly wages offered by some NGO's in some areas and the lack of inclusion of this field in social work training. Yet I would consider the discipline has much to offer with regards the systemic training background, community development, group work, casework and counselling. This is an area that could be developed by providing problem gambling training into Social Work University courses, active recruitment and improvement in the sectors professional salary levels.

Whilst some may argue the benefits of CBT over other treatment modalities it would appear that other modalities of treatment have not been targeted for outcome research in this field. It is therefore hard to make comparisons. It is often the case that PG client present with a complex array of issues requiring attention. Generally it would seem that PG counsellors need to have a good breadth of treatment and casework knowledge to enable them to respond to client differences.

The ability to identify and appropriately respond to co-morbid issues such as depression, anxiety and other mental health issues would be considered paramount in this field due to the high level of co-morbidities presenting in problem gambling clients. However, not all counselling training programs deliver this skill set, theoretical knowledge or supervised practice. It has been suggested that the minimal qualification for problem gambling in NSW may leave some counsellors with minimal skills, lack of underpinning knowledge or sufficient practice in these areas. This potentially places both themselves and their clients at risk. From both a professional

and consumer perspective this is troubling and an area for ongoing professional development in the sector.

In addition some family members have raised their concern with the GIS that they have found it hard to access services which will work with them collectively as a family. Indeed this is validated by other research into help seeking behaviour (McMillen, 2004). It seems to be highly dependent again on the training and qualifications of the counsellor and the location of the client in terms of being able to access services that work from a family or couples therapy model. There appear to be limited options for consumers and families in particular. This may reflect the limited training of some PG counsellors in working with families as groups (family therapy) or couples (couple counselling). This is an area for professional development.

Most consumers would have no way of knowing which service applies which model before accessing the service as a client. But by then this may be too late to make an informed selection. It would be helpful if consumers could have more information about what modalities are available for treatment (and their success rates) and which services offer what modality and are conducive to working with families as units or only individuals. Information on those that provide group work would also be helpful.

The movement toward increased quality systems and accreditation in NSW is laudable but in some cases has resulted in doubling up on accreditation systems for the few gambling counselling services already within other agencies with strong accreditation systems. This would apply to the four gambling counselling services within in NSW Health services (Liverpool Hospital, Hornsby Hospital, Mnt Druitt Community Health and St. Vincent's Hospital).

Services in NSW need to be better resourced to provide a more diverse range of treatment modalities and an increase in opportunities for consumers to access a broader range of specialists such as clinical psychologists, mental health social workers and psychiatrists where necessary.

As stated there is a need for a shift in paradigm to embrace a public health approach to this issue. An increase in health promotion and early intervention programs along with community development is needed to re-focus from a treatment only approach particularly in NSW.

It is somewhat unwieldy and professionally dubious to consider that the existing counselling treatment workforce could change over their treatment emphasis and embrace a new skill set in the short term. Therefore the existing gambling treatment services in NSW need to be supplemented with health promotion and early intervention programs developed by individuals/organisations with a background in this field and the ability to deliver alongside and in partnership with their treatment interventions. Such programs would need to be funded appropriately without undermining existing counselling service provision in NSW.

Resourcing such a initiative could be a mixture of re-orienting mainstream health services to include problem gambling in their service delivery, integrating existing counselling services with other health and welfare services, developing shared training and resources and increasing funding to this area by a levy on other gambling providers such Clubs and Hotels. At present NSW receives about half of

what the Victorian government allocates to this issue, such inequities in service provision need to be addressed. This is an example of where a National Problem Gambling Framework with objectives to create some policy harmonisation is required.

Self exclusion as a strategy has mixed effectiveness. As a counsellor, I sense that clients find the psychological deterrent greater than its practical application. In metropolitan areas I believe there are more breaches and in rural areas clients are more likely to be known to the venue personally which may strengthen the effectiveness.

However, as a strategy this could be further strengthened by pre-commitment technology which could enable a gambler to self exclude with ease, simply by using the technology to lock out of the system.

Third party exclusions (SA, ACT) along with access to other family initiated legal interventions (SA) are available in some states and not in others - again the need for harmonisation. As in NZ it would be beneficial to have greater accountability on both the venue and the gambler. Sanctions such as fines on venues have proven a powerful tool to increase effectiveness.

D**ata collection and evaluation issues**;

The GIS supports evaluation of treatment programs (both qualitative and quantitative) and other strategies to address problem gambling.

However with regards the development of new harm reduction strategies the onus of proof should not be so high as to reduce the opportunity to move forward on meaningful reform in Australia. Some in the gambling industry would seek to apply such standards that would delay and potentially dismantle moves to progress a population health approach to this issue. The vested interests of “big business” should not be allowed to jeopardize the need for consumer protection or the potential health benefits of a new approach which would include specifically addressing product technology.

The gambling industry has benefited from many years (in NSW some 50 years) of a gambling product which has reaped considerable financial reward to its providers without any assessment of its potential for community harm before its introduction. Indeed until a decade ago there was virtually unfettered expansion of commercial gambling which rewarded both an industry and supplied an easy indirect taxation system for State governments. It would appear that both State governments and the industry are reluctant to wean themselves from this ready source of funds. The targeting of Federal government backbenchers in marginal seats by the recent NSW Clubs campaign highlights the depth of the political power this industry seeks to wield in riding rough shod over the needs of the community.

Whilst it may be hard to turn that tide, it is not impossible, and consumers wait in anticipation for their Federal government to demonstrate real leadership on this issue and not be swayed by those who have mostly financial benefit to gain. Families are wearing the social and health costs in large proportion. The NSW health report of 2007 found over 10.4% of families were affected by problem gambling.

G**ambling policy research and evaluation**

There has been very little research with regards the incidence of problem gambling in Australia and a large focus on prevalence studies. This balance need to be re-dressed. Prevalence studies do little to capture the lived experience of problem gambling and gamblers as a community themselves require further investigation. There is minimal research into the impacts on families and particularly children and this too needs more focus.

There has been much discussion of the concept of “natural recovery’ in more recent research and yet what does this mean? What is natural recovery”? – does this really mean unaided? Or is it the use of informal supports, self help strategies and the support of families? We need to know more about this and how to enhance strategies and support those who choose this method.

Other related matters.

It is evident in the field of problem gambling that, unlike other health areas (Alzheimer’s, Cancers, and Mental Health etc), there are few policies that value the role of consumers (those affected by problem gambling) for their experience, skills or knowledge in this field. It appears there is sometimes trepidation by some government departments and negative comments by the industry at the suggestion that consumers may have a valid role in policy development, service delivery or program development. This is a policy and practice area which needs to change and barriers to consumer participation need to be addressed.

As an example the Gambling Impact Society (NSW) is, as far as we know, one of only two consumer led health promotion charities working on this issue in Australia. We have been active for over 12 years and have accessed various small grants and occasional larger grants to support our work in self-help, community education and professional training. Our role in community activity on in this issue has more recently led to a loss of funding opportunities through the CDSE (Clubs grant program). Despite the high ranking priority of our applications, local clubs, who presumably objected to our consumer representation in the gambling reform debate, chose not to fund us last year. There is no dedicated pool of funds in NSW for our type of work. Other than the funds we can gain through such small grant programs we rely on professionals and consumers who give their time voluntarily often many hours – such as writing this submission (12 hrs).

Similar NGO’s in other health related issues have been able to access health funding for their strategies. However there are no health funds in NSW allocated to problem gambling and the RGF funds are primarily directed to treatment services and are already over stretched.

Consumers have a valid role to play as stakeholders in policy development, service development and delivery. This has been more recently recognised in the latest Gambling Research Australia study into gambling risk and barriers to help seeking (Hing et al, 2011) where the further development of the Consumer Voice programs has been recommended.

The GIS is pleased to have recently been granted FaHCSIA funds to develop a Consumer Voices pilot program in NSW. This is after many unsuccessful requests to other funding bodies in NSW over the past four years (including the NSW Responsible Gambling Fund branch). We hope that this demonstration project may lead to future funding to enhance this service. However, this is one of many programs we would like to develop.

We strongly believe we have a valid role, expertise and knowledge to make a valuable contribution to this issue at a National, State and Regional level. Over the past 12 years we have developed a strong community base and are recognised as a consumer peak body on this issue. We therefore think, as with other health issue peak bodies, there should be a stream of funding at either State or National level, or both, open to our organisation. This would enable us to seek funds to staff our organisation appropriately without having to rely on volunteer hours for the major body of our professional work.

We thank you once again for this opportunity to contribute and look forward to maintaining our involvement in the inquiry.

Yours sincerely

Kate Roberts

Chairperson

30/3/12

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