

Chapter 8

Treatment of problem gambling

Introduction

8.1 This chapter will provide an overview of current treatment methods for problem gambling, with reference to some existing treatment services across Australia which presented evidence to the committee. It will also briefly examine referrals to treatment, the factors for success in treatment and some measures to complement treatment services.

Context

8.2 In earlier chapters, the preventative or public health approach to problem gambling was described. The treatments discussed in this chapter sit on the tertiary part of the spectrum of the public health approach to problem gambling. In examining treatment approaches, the committee notes the comments made by the Australian Churches Gambling Taskforce on the need for a holistic approach to the problem of gambling addiction:

With regard to treatment services, we continue to highlight the value of these services and the importance of a range of counselling and therapeutic approaches being readily available across the country. We also highlight that different people respond to different types of intervention, so we would actively discourage the committee from any suggestions of identifying a preferred or goldplated treatment model. There is no best model. There are a range of approaches which work. We have observed that approaches whereby any service places people of goodwill and a willingness to listen with a person with a gambling problem have quite high success rates. In fact, there is not much difference where there is a genuine relationship between a person trying to help and a person seeking assistance.

The Taskforce is deeply concerned about the preference for treatment and counselling as a preferred option—indeed, the only option suggested by many industry bodies. In the task force's opinion this is a self-serving position. People seeking treatment and counselling are more likely to have already lost large amounts of money, particularly in the poker machine industry. Once they are in crisis, their behaviour in venues, such as expressing distress, anger, crying, kicking machines et cetera is likely to be disturbing to other patrons. Thus, it is in the interest of venues to see these people directed to counselling services where they will not put off other patrons in the venue. A much more holistic approach is needed.¹

1 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 10. See also Mr Tim Falkiner, *Submission 4*.

Committee view

8.3 The committee affirms that the treatments described in the following chapters should not be considered in isolation from other measures to address problem gambling, including population-wide and targeted primary prevention initiatives and improving industry intervention, as recommended earlier in this report.

Models of treatment

8.4 As noted in the Productivity Commission's 2010 report into gambling, it is important to realise that there is no single conceptual theoretical model of gambling that can account for the multiple biological, psychological and ecological influences that contribute to the development of pathological gambling.

8.5 Three treatment models emerge from theoretical models to understand problem gambling:

- The ***medical model*** which sees problem gambling as an addiction or as an impulse-control disorder which needs to be treated as an illness;
- The ***behavioural model*** which interprets gambling as a learned behaviour, motivated and/or reinforced by the personal experience and social context of the gambler. The treatment focus is on 'unlearning' bad habits and learning how to minimise the harm arising from gambling through controlled gambling;
- The ***cognitive model*** which posits that problem gambling behaviours can be explained by irrational beliefs and attitudes about gambling. The gamblers think erroneously that they will win money and recoup losses despite personal experience. Problem gamblers have heightened expectations of winning and illusions of control over the outcome of a game.²

8.6 The main therapeutic approaches used for problem gambling include behavioural therapy,³ cognitive behavioural therapy (CBT), cognitive therapy and exposure therapy. Other approaches include pharmacotherapy⁴ and motivational enhancement therapy (or brief interventions).

8.7 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists (RANZCP), noted that treatment which combines various approaches often results in the best outcomes:

We in psychiatry know very well that usually the best outcomes are obtained by combining or integrating psychological treatments, behavioural

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.28.

3 Behavioural therapy, or behavioural modification, is a psychological technique based on the premise that specific, observable, maladaptive, badly adjusted, or self-destructing behaviours can be modified by learning new, more appropriate behaviours to replace them.

4 Treatment of disease through the administration of drugs.

treatments, with more biological treatments such as medications and pharmacotherapies—so there is huge scope still to come in that area.⁵

8.8 Treatment providers for problem gambling range from counselling services and self-help services like Gamblers Anonymous, to clinical services provided by psychiatrists and psychologists, offering cognitive therapy and other interventions such as pharmacotherapy. Below is a brief overview of the main approaches.

Cognitive behavioural therapy

8.9 Cognitive behavioural therapy (CBT) is a relatively short term, focused approach to the treatment of many types of emotional, behavioural and psychiatric problems. The application of CBT varies according to the problem being addressed, but is essentially a collaborative and individualised program that helps individuals to identify unhelpful thoughts and behaviours and learn or relearn healthier skills and habits. CBT has been practised widely for more than 30 years.⁶

8.10 CBT focuses on identifying triggers to problem gambling, recognising situations where gambling is likely and finding alternative ways and behaviours to deal with those triggers.⁷

8.11 This form of therapy is also the treatment for problem gamblers with the most available evidence to support its efficacy, in Australia and internationally.⁸ While acknowledging the weight of evidence supporting CBT, the University of Sydney Gambling Treatment Clinic told the committee that unpublished data from their Clinic suggests that pure cognitive therapy, described below, may provide the best treatment for problem gamblers.⁹

Cognitive therapy

8.12 Cognitive therapy is a type of psychotherapy. It is one of the therapeutic approaches within the larger group of cognitive behavioural therapies (CBT) and seeks to help the patient overcome difficulties by identifying and changing

5 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 39.

6 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 229–255.

7 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

8 According to the *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, the evidence supports individual or group cognitive behaviour therapy to reduce gambling behaviour, gambling severity and psychological distress in people with gambling problems. See Thomas, S., Merkouris, S., Radermacher, H., Dowling, N., Misso, M., Anderson, C. and Jackson, A., 'Australian guideline for treatment of problem gambling: an abridged outline', *Medical Journal of Australia*, 2011, 195: 1–4.

9 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 5. Mr Tim Falkiner, *Submission 4*, p. 7, also stated his view that CBT 'is good therapy but of itself is not enough to counter addiction'. His view was that 'CBT should be used as a precursor to hypnotic induction...'

dysfunctional thinking, behaviour, and emotional responses. Cognitive therapy concentrates on 'removing erroneous cognitions'.¹⁰

8.13 Mr Christopher Hunt, Psychologist, University of Sydney Gambling Treatment Clinic, explained the principles of cognitive therapy to the committee:

The cognitive therapy that was developed by Fadi Anjoul when he was first working at the gambling clinic several years ago is very much focused on people's beliefs about gambling. It is very much focused on people's understanding of how a poker machine works, how sports betting works or however their particular form of gambling works, understanding what it is about gambling that is exciting them. Usually that comes back to the thought of winning money. Essentially it provides corrective information, working with people to get a more realistic understanding of how their preferred form of gambling works. It is not as simple as just telling people, 'You're not going to make money,' because on some level people know that; it is about being able to work with them about why they are not going to be able to do it. It is a long and involved process and there is a lot of need to develop trust with the client. Essentially, the main thrust of things is identifying their beliefs and looking to see where corrective information might be able to be provided.¹¹

Exposure therapy

8.14 Exposure therapy is based on the theory that problem gambling arises from a psycho-physiological 'urge' to gamble, similar to cravings in substance addiction. Key elements of exposure therapy involve the reduction of the urge to gamble through graded exposure to gambling cues:

Early outcomes suggest that if the urge to gamble can be extinguished through the graded exposure treatment programme, relapse to problematic gambling is less likely... The process of cure is similar to that used with phobias where the client exposes themselves in a graded way with mild anxiety from pictures of the feared object to eventually approaching the real feared object. Staying in the situation for 20-40 minutes results in a reduction of the urge or anxiety. Repeating the same task daily results in eventual extinguishing of the urge to gamble. Many clients report eventually becoming bored by the venue, the machines and the idea of gambling. This approach is considered counterintuitive by some counsellors who concentrate on teaching clients ways of avoiding or thinking about gambling triggers. In these types of therapies, clients use will power which may work for weeks or months but the client reports being continually pre-occupied with the thought of gambling and vulnerable to relapse.¹²

10 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 225–6.

11 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

12 Professor Malcolm Battersby, *Submission 8a*, pp 3–4.

Pharmacotherapy

8.15 Pharmacotherapeutic approaches to problem gambling are relatively new. In some people with pathological gambling problems, changes in the body's biochemistry have been observed. These include changes in the serotonin, norepinephrine, dopamine and opioid systems. Hence, studies have been conducted on pharmacotherapies (drug treatments) which target these physiological systems.¹³ Although some positive effects have been noted from three types of medications (serotonin reuptake inhibitors; mood stabilisers; and opioid antagonists), the results have not been conclusive and further double-blind studies are required.¹⁴ Furthermore, most of the pharmacotherapy research has been conducted without concurrent psychosocial treatment in order to isolate any beneficial effects; however in a real life clinical situation, it is likely that both pharmacotherapy and psychosocial therapy would be provided.¹⁵

Naltrexone

8.16 In November 2011, researchers at Monash University reported that evidence from international studies showed some 'promising indications' for Naltrexone in treating problem gamblers. According to Dr Shane Thomas from the Problem Gambling Research and Treatment Centre:

You have in the body overproduction of endogenous opioids, so in the brain, and what happens is that this leads to reductions in impulse control. Now what Naltrexone does effectively is to block that and to improve the extent of impulse control.

...I think the current evidence is in favour of psychological therapies, you know, we have more and stronger evidence for that. You know, people are often very interested in the use of pharmacological agents for treatment of conditions because they hope it'll be, sort of the golden bullet, you know, that we can take a pill and cure or attend to these problems.¹⁶

8.17 The committee heard from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) that mental health disorders required the availability of a range of treatment methods, both pharmacological and psychological. Professor Dan Lubman stated that there was growing evidence for the role of Naltrexone in the

13 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 137.

14 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 148.

15 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 150.

16 Meredith Griffiths, 'Heroin addiction drug proposed for problem gamblers', *AM*, ABC Radio, 22 November 2011, <http://www.abc.net.au/am/content/2011/s3372620.htm> (accessed 23 July 2012).

treatment of problem gambling; however, more robust trials were needed.¹⁷ He explained:

Naltrexone has been shown to be highly efficacious for the treatment of alcoholism, yet we know in clinical practice that not everyone we give naltrexone to actually responds to it. There are different pathways into alcoholism, different biological circuitry. Certainly, naltrexone, on the evidence provided, has increasing support for its use but there needs to be more work in this area. It should be considered for some people. But...there needs to be more investment on other alternative strategies to manage the condition.¹⁸

8.18 Dr Enrico Cementon, RANZCP Fellow, also noted that other pharmacotherapeutic options apart from Naltrexone should be examined:

Naltrexone unfortunately runs the risk of being a drug which is then applied to a whole lot of addictive disorders, but is perhaps best only for one form of addiction rather than a whole range of them. We need to be looking at other pharmacotherapy options to be used in conjunction with the traditional psychosocial, behavioural or psychological interventions, which have been shown to be effective for gambling. There is huge scope for further knowledge expansion and application to clinical practice.¹⁹

8.19 He envisaged a future in addiction therapy where 'pharmacogenomics' could help to determine the best treatment approaches:

...we believe an important area of the search is that area of medicine which we call pharmacogenomics: the interaction between the drug that you are introducing into the person, with their genetic constitution, and the way that person, with their physiology and neurobiology response, reacts with that drug. Effectively, I see that in 15 or 20 years down the track we will be able to do some sort of genetic analysis on a person and say, 'This person with problem gambling is more likely to respond to naltrexone, or is more likely to respond to treatment with heroin, or more likely to respond to treatment with alcohol.' Who knows? Hopefully, that will be the state of the science for the treatment of addictive disorders, that in the future we will be able to tailor the treatment in a very scientific way.²⁰

Motivational enhancement therapy (brief interventions)

8.20 Motivational enhancement therapy takes the form of brief interventions, usually targeted at people with less severe forms of a disorder. For example, this therapy could take the form of short advice sessions of a few minutes and/or

17 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 36.

18 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 40–41.

19 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 39.

20 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 41.

motivational interviews in conjunction with a workbook.²¹ This form of treatment may be delivered by counsellors in non-clinical settings.

Examples of treatment

8.21 Several treatment providers from across Australia provided submissions to this inquiry and the committee heard valuable evidence at public hearings from a number of these providers. An overview of their services is outlined below.

8.22 The modes of delivery for different forms of treatment include face to face counselling and therapy, telephone interventions and online services (which are becoming increasingly popular—e.g. through the website *Gambling Help Online*). Self-help through grassroots volunteer organisations such as Pokies Anonymous is also undertaken.

St Vincent's Hospital Gambling Treatment Program

8.23 The St Vincent's Hospital Gambling Treatment Program opened in 1999 in Darlinghurst, NSW. The Program is currently staffed by about four full-time equivalent clinical psychologists and has treated almost 2,000 clients. It is funded by the Responsible Gambling Fund, which is administered by the NSW Office of Liquor, Gaming and Racing. As well as problem gamblers, the Program's clients are also family members—partners, parents and adult children of those with gambling problems.²²

8.24 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, described a 'snapshot' of the Program's current client base:

In the last three months, we have seen people with bipolar mood disorder, schizophrenia, personality disorders, severe anxiety disorders, chronic depression, histories of trauma, complicated grief, intellectual disabilities and alcohol use, in addition to their gambling problems. Our treatment is largely cognitive behaviour therapy... Sometimes clients do not need a huge amount of treatment and other times we are seeing them for quite long periods. There is an intense treatment phase and then there is a long follow-up period, because it is a bit of a relapsing disorder.²³

21 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 257–8. According to the *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, evidence supports motivational interviewing and motivational enhancement therapy to reduce gambling behaviour and gambling severity in people with gambling problems. Motivational interviewing is defined as a 'client-centred, directive counselling style for helping people explore and resolve ambivalence about behaviour change'. See Thomas, S., Merkouris, S., Radermacher, H., Dowling, N., Misso, M., Anderson, C. and Jackson, A., 'Australian guideline for treatment of problem gambling: an abridged outline', *Medical Journal of Australia*, 2011, 195: 1–4.

22 Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 18.

23 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 18.

8.25 The treatment services offered were described to the committee, beginning with a thorough assessment of the client's gambling. Forms of treatment include motivational interviews, psycho-education and teaching behavioural skills such as stimulus control, scheduling alternative/incompatible activities and skills to deal with emotions that perpetuate gambling:

Treatment is active: clients practise skills between sessions and monitor gambling, urges to gamble, triggers, thoughts, emotions, responses etc. Clients are taught to recognise the impact certain styles of thinking have on urges to gamble and how to modify such automatic and well-learned thoughts. This involves traditional cognitive therapy – the challenging of erroneous beliefs about gambling. However, in order for clients to understand their gambling and to adopt a meta-cognitive stance (essentially to think about their thinking) specific psycho-education about the way the mind works in the context of gambling is essential. This includes, for example, education about the strength of intermittent reinforcement, neurological pathways involved, how repetition trains automatic responses to cues and rewards, mental processes such as how we make judgments, various biases e.g. confirmation bias, and the effect arousal has on thinking. Current, relevant research findings from a range of sources are incorporated into this psycho-education e.g. affective neuroscience, behavioural economics, mindfulness.²⁴

8.26 St Vincent's Hospital reported that 70 to 80 per cent of the people they treat through the Gambling Treatment Program are men and most of the men are young:

In their common parlance among themselves they say, 'I had a gambling hangover,' which is the remorse which drives them to treatment and that is a phrase which came from a media campaign.²⁵

8.27 They also reported that the overwhelming majority of clients presented with problem gambling associated with poker machines. However, a rise in sports betting and online gambling problems was becoming apparent (though it was emphasised this was not a 'mass increase').²⁶

8.28 St Vincent's Hospital also told the committee that while 30 to 40 per cent of people drop out of the Gambling Treatment Program, they may make contact again several years later:

Ms McLean: A lot of those people might attend six sessions and then drop out. We hear from them seven years later and they say they have not gambled for the last six years but it has just started again now. Even with the ones that are dropping out, there is evidence that a lot of them are doing well and they have got what they needed out of the treatment. It is just that they go off—

24 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 1.

25 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 19.

26 Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 21.

Dr O'Neill: We keep follow ups. We look at how many days they gambled, how much they gambled and that type of thing.

Ms Kazal: Yes, we have standard ways of measuring outcomes. There are different ways of defining success. We try and address a number of different areas in their lives. The average figure is around 90 per cent.²⁷

8.29 St Vincent's Hospital also provided evidence of positive treatment outcomes to the committee, such as:

- number of days since last gambling episode increased following treatment (from an average of 11.22 days at intake to an average of 69.96 days post-treatment);
- frequency of gambling significantly decreased following treatment (from an average of 0.38 episodes per day pre-treatment to an average of 0.04 episodes per day post-treatment); and
- expenditure on gambling decreased following treatment (from an average per day of \$128.29 per day to an average of \$6.28 per day post-treatment).²⁸

Statewide Gambling Therapy Service

8.30 The Statewide Gambling Therapy Service (SGTS) is located at Flinders Medical Centre, Salisbury, Port Adelaide and across rural areas of South Australia. Clinical staff of the service include a psychiatrist, psychologists, social workers and mental health nurses with postgraduate qualifications in CBT. During 2009–10, 504 individual problem gamblers and 59 significant others used the service.²⁹

8.31 The SGTS was established in 2007, with treatment based on a program developed at Flinders University by Professor Malcolm Battersby (based on his work in the UK on exposure therapy for anxiety disorders). The main treatment model provided at the SGTS is graded exposure therapy in conjunction with cognitive therapy 'to challenge the thought processes of addicted gamblers'.³⁰

8.32 Upon arrival, clients undergo a complete mental health assessment and are provided with a range of treatment and support options including an inpatient program. Additional clinical support is provided to people with comorbid conditions and online support, family and peer support and self-help groups are also available. Collaboration and cross-referral between financial and family counselling services is also provided.³¹

27 Ms Siobhan McLean, Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 25.

28 Answers to Question on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, pp 1–2.

29 'Statewide Gambling Therapy Service', tabled by Professor Malcolm Battersby, 14 May 2012.

30 Professor Malcolm Battersby, *Submission 8a*, p. 3.

31 Professor Malcolm Battersby, *Submission 8a*, p. 4.

8.33 Professor Battersby, Director of the SGTS, described how the service is the only gambling help provider in South Australia that is offered as a 'health service':

The service that we have established in South Australia is unusual in the sense that nearly all the other gambling help services are non-government organisations with people who are called counsellors with a range of skills. We are the only service that is directly under the auspice of a health service. We were regarded initially as a bit of an anomaly, but the advantages of being part of that health service were that we were coming from a scientific evidence base and then translating that into training programs and skills and measuring outcomes. The reason we moved from being the Intensive Gambling Therapy Service from 1996-2007, when we were asked to become the Statewide Gambling Therapy Service, was that we were collecting our outcome measures. We were showing significant improvements in people not just over the short term but also the long term.³²

8.34 One of the strongest features of the SGTS is its commitment to evaluation and measurement of outcomes (see chapter 11 on research and data collection for further details). Professor Battersby explained the advantages of this approach:

The core elements of an outcomes based treatment service are that the service uses outcome measurements which are validated; there is an electronic system which helps to automatically collect that data and feed it back to the clinicians, government and services; and the staff are trained to use those outcome measures. In other words, they are not given as an administrative tool that someone happens to fill in; the staff are trained to actually understand how to use that.

...I think what we have done at Flinders should be a national model. We have asked every single patient or client who comes to our service to sign a consent form for longitudinal data collection. In other words, every patient who comes in has agreed to be followed up over the next three years to provide outcome data.³³

8.35 The SGTS also told the committee that its well trained staff accounted for its low drop-out rate, as clients come away from the first briefing session with a clear plan on what the program involves and what the expectations are. Volunteers who have been through the program and have recovered from problem gambling are used as peer educators and supporters:

We have a lot of letters from clients who have benefited from the service, and what was fascinating about some of them was that they talked about the reception staff and how welcoming, non-critical and non-judgmental they are. We have had two of the three staff for over five years and put a lot of effort into the training of reception staff as well as the clinical staff.

...There are a whole lot of steps that come out of training staff adequately that keep people engaged. We do things like text messaging between

32 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 1.

33 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 2.

appointments, email follow-ups and really active follow-up. We do not wait for people to come back to us; if they drop out or miss an appointment, we very actively follow them up.³⁴

8.36 Associate Professor Peter Harvey, Manager of the SGTS, acknowledged that there were very low rates of presentation to treatment to the SGTS. He said that those who did access treatment were 'skewed toward the older age group':

Younger people, even though they are involved in online gambling and poker machine gambling, do not present at the same rate. This is a concern from the service practice side of things.³⁵

...There are a whole lot of younger people who are not reached through the processes that we use, so we have tried to develop mechanisms on our website and other ways of getting messages out to young people. Predominantly, the people who present are the middle-age group. They are coming through the normal help line connections and phone-in processes rather than being hooked in through the web more effectively.³⁶

University of Sydney Gambling Treatment Clinic

8.37 The University of Sydney Gambling Treatment Clinic was established in 1999 by Associate Professor Michael Walker. In 2010, Professor Alex Blaszczynski became Director of the Clinic. The Clinic offers a free, confidential, face to face counselling service for people with gambling problems as well as family and friends. Services are located across Sydney, including at Darlington, Campbelltown, Narellan, Tahmoor, Parramatta and Lidcombe. It receives funding from the NSW Responsible Gambling Fund.³⁷

8.38 The Clinic has researched a number of different therapies, including cognitive therapy, cognitive behavioural therapy (CBT), solution focused brief therapy, imaginal desensitisation, multimodal therapy and supportive counselling. While noting that CBT has the most evidence supporting its efficacy in Australia, the Clinic states that unpublished data suggest that pure cognitive therapy may be the best treatment option.³⁸

8.39 The submission from the Clinic notes that the cognitive therapy approach, developed by Dr Fadi Anjou, differs from other approaches:

...by positing that persistence at gambling is motivated by the gambler's misguided understanding of the probabilities of winning. In other words, it assumes that problem gamblers make poorly informed decisions about gambling and are unaware of their own erroneous thinking. There exists some but limited literature from Canada supporting the effectiveness of

34 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 3–4.

35 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2.

36 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 3.

37 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 1.

38 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 5.

related cognitive approaches to treating problem gambling. Our data, gathered at the Gambling Treatment Clinic has clearly indicated that changes in an individual's beliefs and knowledge about gambling are one of the key predictors of reduced gambling behaviour. In fact, preliminary data on CT that was reported in the Productivity Commission's 2010 report on gambling (pp. 7.34) has indicated not simply excellent results at the completion of treatment, but minimal rates of relapse over the longer term. The current research imperative is therefore a more full investigation of the efficacy of pure CT as conducted at the GTC, and a comparison of this treatment to the currently well-supported CBT.³⁹

8.40 Treatment length at the Clinic is eight to 10 sessions, usually starting weekly, then fortnightly and monthly as time goes on. These sessions would normally go over a period of 12 to 14 weeks.⁴⁰

8.41 The committee thanks the University of Sydney Gambling Treatment Clinic for hosting a site visit on 2 May 2012.

Turning Point Alcohol and Drug Centre

8.42 The Turning Point Alcohol and Drug Centre is based in Fitzroy, Victoria and has provided gambling help and treatment services for the last 12 years to over 100,000 people. Its services include four statewide phone helplines (Victoria, Queensland, Tasmania and after-hours in the Northern Territory) as well as *Gambling Help Online*, a national online counselling and support program.⁴¹

8.43 The *Gambling Help Online* program was launched in 2009 by the then Ministerial Council on Gambling. Its primary aims are to:

...attract a new cohort of clients who may not otherwise access face-to-face services and...extend the availability of counselling and support by addressing issues around remoteness, anonymity and after-hours availability.⁴²

8.44 It features self-help information, local information as well as real-time 'synchronous' counselling and 'asynchronous' counselling provided via an email support program.⁴³

8.45 Another feature of Turning Point's service is the *Ready to Change* program which is a four to six week telephone-based intervention program based on CBT. It has been offered to callers of the Victorian Gambler's Helpline since 2008 and has been available more recently in Tasmania and Queensland.⁴⁴

39 University of Sydney Gambling Treatment Clinic, *Submission 10*, pp 5–6.

40 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

41 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 1.

42 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 2.

43 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 2.

44 Turning Point Alcohol and Drug Centre, *Submission 42*, pp 2–3.

8.46 Turning Point also appeared before the committee and elaborated on the clients who accessed its services:

We provide services to anyone affected by problem gambling, including family and friends, professionals, venue workers, students and, of course, the gambler. People contacting our services typically have a range of problems associated with gambling—from being asked to call us by a family member through to looking for strategies around managing their gambling. When someone contacts us they speak to a counsellor immediately. They are often provided with screening for gambling or other harms. [They] may be provided a brief intervention, referrals to other services, information around gambling products and self-exclusion, mail-outs and access to translation services. So we provide a whole range of things to a very diverse range of people who contact us through our helpline and online services.⁴⁵

8.47 Across both the helplines and *Ready to Change* service, Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point, estimated that around 20,000 calls per year were taken, with the helpline mainly attracting middle-aged people, split between males and females, and usually in relation to poker machine problem gambling. In contrast, the online service is popular with young men and about 70 per cent of contacts are made outside of business hours. For those who wish to access face to face counselling, Turning Point has also developed the capacity to chaperone people straight to a face to face agency.⁴⁶

Success of online service provision

8.48 Giving evidence to the committee, Turning Point highlighted the success rate of online services, noting that even clinicians were surprised at the findings that remotely delivered services can be as effective as face to face treatment:

Ms Rodda: We know that online counselling is effective across a range of disorders. There have been one or two studies on gambling—not in Australia but overseas—and there have certainly been studies in terms of treating depression, anxiety and other mental disorders online. One of the indicators of the success of that is that the person is attending for treatment in a way that they can access the treatment—they can get to the appointment or where the treatment is being offered. In terms of self-help there is quite a strong evidence base now for single-session interventions, and we know that they are effective.

Prof. Lubman: One of the most surprising things to clinicians is that delivering interventions over the telephone or even over the internet is just as effective as face-to-face treatment.⁴⁷

8.49 The convenience and ease of access to online services are crucial to its success, according to feedback from clients:

45 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44.

46 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44.

47 Ms Simone Rodda and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 44.

We have also found through our evaluation of the service that the people using it—typically, young men—said it is easy to access, easy to talk and convenient. We developed the four-to six-session semi-structured program specifically to improve access to services for people unable to get to a service. Some of our early clients for that were young mothers who had a couple of kids. I remember one client who had to catch three buses to get to a face-to-face appointment. Clearly that was not going to work very well. So she was able to get help over the telephone.⁴⁸

Success of brief interventions

8.50 Turning Point also emphasised that brief interventions can be very effective. Professor Dan Lubman, Director, Turning Point, explained this using the example of brief interventions in responding to drinking behaviour:

[It] is hard to believe, but there is a huge evidence base in the alcohol area that brief interventions by general practitioners have robust long-term impacts on drinking behaviour. The way to think about that is in a population sense. We are thinking about a population who are at risk or having problems. There is a whole group here who you can intervene with through very simple interventions. As we go across the population there is more of an entrenched group further down. It is just saying that we need a suite of options available for different people.⁴⁹

8.51 When asked about whether people usually want to be helped in the case of a brief intervention, Professor Lubman explained that this was not necessarily the case, but that the moment of intervention provided a brief opportunity for some good to be done:

There is very good evidence from the alcohol literature around brief opportunity interventions looking at people, for an example, who come into emergency departments with an alcohol related injury. If they have come in having had a fight while being intoxicated, there is very good evidence that brief opportunity interventions have good outcomes, because it is an opportunity to intervene. It is an opportunity to say, 'Hang on, you might not think you have a problem with alcohol, but how come you ended up in emergency?' It is using an opportunity to get people to think about where they are at the moment and how the gambling or alcohol might have contributed to their behaviour. Many people when they are confronted with that are prompted to change their behaviour.⁵⁰

8.52 Professor Lubman also observed that having a suite of service options available was crucial to meet the needs of clients:

48 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44. See also Ms Liza Carroll, Department of Families, Housing, Community Services and Indigenous Affairs, *Committee Hansard*, 14 May 2012, p. 55, who noted that some people prefer to access social policy services online.

49 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

50 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

Some people might just want to shop online and not try it on and not speak to anybody. Other people want to have a bit of a conversation. The important thing here is having a system of care where you can step up the level of expertise and input. You might start with just generic self-help online. That might step up to self-help with online counselling options which then might then lead on to telephone options with extended structured interventions over the telephone which then might lead on to face-to-face interaction with telephone support. It is having that way of stepping up, depending on what your need is. It is making sure that there is a suite of options available that tailors to the needs of the consumers.⁵¹

8.53 Turning Point noted that younger men came through online chat and older women used the email option:

That is already informing how we attract and target the groups that are coming to the website. At the moment we are redeveloping the website, so that the chat has a much younger feel and we are expanding the suite of services offered with that so that it is not just a counselling intervention, but it is moderated forum, self-help with tailored self-assessment. There will be a whole range of things to encourage that group to speak to us.⁵²

Committee view

8.54 The committee was pleased to hear that online treatment services can play a role in assisting people with gambling problems. While no silver bullet, the availability of such interventions, delivered flexibly and remotely, can also assist people who are not able or willing to access face to face services. These cost-effective outreach and brief intervention services are supported by the committee.

Non-clinical services

Mission Australia

8.55 Mission Australia provides gambling counselling and support services in the ACT and NSW. These services form part of a broader suite of family, youth and employment services across Australia. In 2011, Mission Australia's 10 gambling counselling services provided support to problem gamblers and their families through both individual and group counselling, including financial counselling.⁵³ In NSW, Mission Australia's gambling counselling services are funded through the Responsible Gambling Fund.⁵⁴

8.56 The committee heard from Ms Christina Sanchez, Team Leader, Mission Australia, about the gambling counselling services provided in the ACT. She told the committee that over the past eight months, Mission Australia has offered face to face, telephone and internet counselling through four gambling counsellors and one

51 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

52 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 48.

53 Mission Australia, *Submission 17*, p. 2.

54 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 1.

financial counsellor. Each counsellor may see two or three clients per day.⁵⁵ She explained further the services on offer:

We have also started a support group for gamblers that runs every Monday night as well as a recently started support group for family and friends of people with gambling issues. So we do not just see the gambler; we see anyone that has been affected by gambling.

We are also in the process of launching a training package for GCOs [Gambling Contact Officers] and gaming managers of clubs here in the Australian Capital Territory to help them better address and approach people who they think may have an issue with gambling at their service, and to advise them on how to deal with and work with family members because they often get quite a few calls from distressed family members. We have also run a gambling officer forum for gambling officers in the Australian Capital Territory and are also developing a training package for the wider community sector around being able to identify and work with gamblers and to make appropriate referrals.⁵⁶

8.57 In the first three quarters of the 2011–12 financial year, the ACT's gambling Support Service through Mission Australia has provided counselling to 188 clients.⁵⁷ Mission Australia said that those who are being treated are usually in their 30s, but that age ranges from 25 to 65. The youngest client is 10 years old as he is experiencing family breakdown issues.⁵⁸

8.58 Ms Sanchez told the committee that Mission Australia's ACT service had been 'very successful':

Certainly the feedback we have been getting from our clients, although limited in the eight months, is that it is hard, it is not easy, but they are making small inroads. For example, we had a gentleman who spoke at our advertising launch today who has now not gambled for six months. His goal was to not gamble anymore, and he has been quite successful.⁵⁹

BetSafe

8.59 BetSafe is a responsible gambling program which provides services for a group of ACT and NSW gaming machine venues (43 registered clubs). It is solely funded by gaming industry members and offers a 24 hour problem gambling counselling service.⁶⁰

55 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

56 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 34.

57 Correspondence from the ACT Gambling and Racing Commission, received 12 June 2012, p. 1.

58 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 39.

59 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

60 BetSafe, *Submission 32*, p. 2.

8.60 Its submission described the flexible face to face counselling available to patrons of BetSafe member clubs:

BetSafe has no limit on the number of gambling counselling sessions, unlike a number of government funded services that only provided a fixed number of counselling sessions.

A rigid program of counselling that offers only a standardised program with a fixed number of counselling sessions lacks the flexibility to assist the wide range of people with gambling problems. The needs of individuals who seek counselling vary tremendously. In some cases a person may only attend a single counselling session to receive some benefit. In other cases, a series of intensive counselling may need to be followed by periodic maintenance counselling over a period of months. Some individuals value a long-term counselling relationship where they know they can call their counsellor at any time if they are suddenly struck with a strong urge to gamble. Some BetSafe counselling clients have maintained their abstinence from gambling by being able to call at such times, even over a period of years.⁶¹

8.61 At a public hearing, BetSafe again advocated a flexible approach to gambling counselling:

...we are certainly not of a one-size-fits-all model. While we do use cognitive behavioural therapy strategies in our counselling, our counsellors take a more overall approach in dealing with underlying issues, helping them to address those issues and therefore, as a result—and this generally happens—removing the need to gamble.⁶²

...We see them after hours, we see them Saturdays, we see them after work up until about nine or 10 o'clock. We talk to them on the phone at two and three in the morning. With gamblers, you have generally got one opportunity. That opportunity may only last 10 minutes to half an hour. If we do not grab them then, we have lost them, perhaps for four years. That is the vital thing: we have got to grab them straightaway. That is why it is important for us that we are potentially in contact with them genuinely 24 hours a day. I know a lot of people say they are, but a lot of it is voice messages and things like that. With us there is a contact 24 hours a day.⁶³

Self-help

8.62 Self-help groups are usually based on a 12-step program, similar to Alcoholics Anonymous, and involve people who have experienced gambling addiction coming together to talk with others who have had similar problems.

61 BetSafe, *Submission 32*, p. 9.

62 Mr Daniel Symond, *Committee Hansard*, 2 May 2012, p. 32.

63 Mr Paul Symond, *Committee Hansard*, 2 May 2012, p. 33.

Pokies Anonymous

8.63 Pokies Anonymous is a self-help group based in Adelaide. Ms Julia Karpathakis, Manager, gave evidence at a public hearing about her own struggle with poker machine addiction and also described how the organisation works:

None of us are counsellors. We all share our stories. We are all in the same boat. It is a 12-step program like Alcoholics Anonymous. I love it. I think it is amazing, and there are heaps of people coming. People come and go. People are struggling. At the moment I am really concerned about a couple of younger people who cannot seem to shift, but they are still attending meetings and still using the phone, so I have a great belief that they will stop playing the pokies. But it is about stopping. It is not about 'responsible' gambling, playing moderately or anything. It is about abstaining, not going into venues, and attending meetings and using the phone—those sorts of things.⁶⁴

8.64 Funding of \$20,000 per year comes from the South Australian Office of Problem Gambling.⁶⁵ Ms Karpathakis told the committee that around 40 people a week attended meetings and she outlined the help that she was able to offer them:

I refer people to the state-wide gambling therapy services. I refer them to get barred. I refer them to many places. I am always referring people; I offer it. With the barring and the Independent Gambling Authority, I used to physically go with the people to take them to the place and work with them because it is a bit scary. I was told that it would be best if I left the clients to ring up and make the appointments because sometimes it gets a bit messy. I have not had anyone wanting to go there, so it is really important that I instigate that and create that opportunity to get them there, and then it will happen. One person nearly has a year up and he got barred. If I was not there, they would have offered him four or five places to get barred from—and this guy has a major problem. So I suggested we bar in from the postcode from his work all the way to his home, and that has been a real point of success for him.⁶⁶

8.65 The committee heard that people involved in self-help groups like Pokies Anonymous provided each other with mutual support and created of a sense of community for people who may have been marginalised from society by gambling addiction:

...we create social events. There will be a midyear dinner soon and we have Christmas dinner. It is all about including people and creating community. A lot of people are lonely and a lot of people are hungry. Someone might come along and eat the biscuits and drink the coffee, but we have got someone who comes along as support and eats a lot of the food but they

64 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

65 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

66 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 16.

have not got a problem. I do not mind. If he did not come, maybe that woman would not come along. So I do not mind.⁶⁷

8.66 The Australian Churches Gambling Taskforce also recognised the importance of mentoring from individuals who have experienced gambling problems themselves:

There are programs like Gabriela Byrne, where people who have a gambling problem, or have had one, are connected with alternative recreation and social events. But they are mentored in that. They are not just given a pamphlet saying 'Here are activities in your area.' They will have buddies and mentors to help them connect back.⁶⁸

8.67 However, the University of Sydney Gambling Treatment Clinic raised concerns about self-help groups, arguing that more rigorous clinical approaches offered more effective treatment for gambling problems:

Sometimes people become very passionate about the treatment option that they are offered. Recovering gamblers will say things like, 'This worked for me', but what we see from the research evidence is that these things that work for some people and not for others are not necessarily the most effective overall; whereas our initial findings are suggesting that the cognitive therapy that we offer is effective for most people who present with gambling problems. That is why we argue for this more removed approach to the evaluation of treatment. A lot of these treatment providers do not provide a formal evaluation of their treatment. They do not actually follow up with their clients after they finish treatment and they do not provide formal questionnaires about how much their clients are gambling at the end of treatment. That is why we argue against this eclectic 'do what you want'—do what the gambler wants—sort of approach to problem gambling which seems to be quite widespread, especially in New South Wales at the moment.⁶⁹

Committee view

8.68 The committee notes the range of clinical and non-clinical treatment and support services available for people with gambling problems. It is pleasing to hear about the variety of interventions available and the committee thanks treatment providers for sharing information about their services during this inquiry. In particular, the growing popularity of online intervention services is of interest to the committee.

67 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 17.

68 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 25.

69 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59. See also Media Release, 'New treatment guidelines for problem gamblers', *Medical Journal of Australia*, 22 November 2011, which stated that according to the new *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, 'a large analysis of the research has revealed that interventions delivered by clinicians and psychologists were more effective than self-help interventions like workbooks and online therapies for reducing gambling severity and behaviour in people with gambling problems.'

8.69 The committee also commends the grassroots work of Pokies Anonymous in its efforts to assist people with gambling problems. It is heartened to hear evidence about assistance with referrals to professional help as well as the mutual support, care and encouragement which is generously provided by committed individuals. The committee notes that self-help groups can act as complementary and easily accessible support services.⁷⁰ The following chapters will explore barriers to accessing treatment services and ways to improve existing services.

Referrals to treatment

8.70 The committee heard about various ways in which people were referred to treatment services.

8.71 At St Vincent's Hospital over the last two years, 25 per cent of clients were referred through the gambling helpline; 20 per cent were referred through family; 11 per cent were referred through another counsellor or psychologist; 11 per cent came through St Vincent's own website and another 10 per cent came from various websites.⁷¹

8.72 St Luke's Anglicare described how people are referred to counselling services through the central helpline in Victoria:

Ms Galvin: That central line is like an intake process. They would do an assessment of what the person might need at that time. Perhaps they need that quick and fast intervention; that might be all they need. Maybe they are not far enough along to want to seek one-on-one. But they are offered all of the different options that are available. Then, if they choose to seek to have one-on-one counselling with our Gambler's Help workers, then that referral would be sent to us, and they would make an appointment and start on the process for treatment.

Senator DI NATALE: But how does that happen? The reason I am asking this question is I am aware that when somebody decides they have a problem there is often only a narrow window of time in which you can act. If you miss the boat—and it might just be a day later—they might not be inclined to follow up on what they did the day before. So is there a delay? The assessment is done initially through the initial phone call. How long does it take before contact is made with a local service provider?

Ms Galvin: I understand that varies. It depends when people call. If they call after-hours—we do not provide an after-hours service locally. I understand there sometimes is a delay and sometimes it is very fast.⁷²

70 For example, see Gomes, K. & Pascual-Leone, A., 'Primed for Change: Facilitating Factors in Problem Gambling Treatment', *Journal of Gambling Studies*, (2009) 25: 1–17, which notes that addiction literature generally shows some benefit to being involved in 12-step programs, especially when accompanied by professional treatment.

71 Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 19.

72 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 53.

8.73 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) described why someone might be referred by a general practitioner to a psychiatrist for treatment:

It is usually associated with an anxiety disorder, a depressive disorder or, less commonly, a psychotic disorder. If the patient presented just with a gambling problem and no other co-morbidity then I think the GP would think about a gambling help line or a gambling-specific service in terms of where to refer the patient.⁷³

8.74 Turning Point Alcohol and Drug Centre described how people are referred to services when they call a helpline. When a caller agrees to a treatment referral, the helpline will offer an immediate transfer to the relevant agency (during regular business hours). When a referral cannot be successfully transferred or made out of business hours, callers are given the option of a referral follow-up call:

Where there is capacity for follow-up at the agency level, basic contact/referral details are collected by the Helpline and forwarded by email to a designated contact person at the agency. Standard informed consent processes have been developed accordingly. The agency is then responsible for the follow-up process. Callers who decline to have their call transferred are also offered the referral follow-up option (i.e., email referral).⁷⁴

8.75 Turning Point also told the committee that it was exploring the possibility of self-referral services via smartphone technology, potentially in consultation with industry:

Ms Rodda: One of the things we are exploring in the future is self-help provided via iPhone, and we now have our site optimised for smart phones. I could see a place in the future where we could have a monitor of consumption that is linked into your betting account so that your help seeking and your betting are in the same device, and you are able to monitor and then click to call or click to speak to someone about what is happening. In the next few years you could imagine the benefits of doing gambling online could easily be joined in with your help seeking or your monitoring, or some other way of describing having a third party check up on what you are doing.

Senator DI NATALE: Is that something that industry could potentially do? There is no reason that they could not have that as part of one of the products that they offer—with referrals, of course. Am I missing something, any obvious obstacles that would prevent them from promoting sort of package? Apart from the obvious one; that it might cost some business.

73 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 37.

74 Answers to Questions on Notice, Turning Point Alcohol and Drug Centre, received 28 May 2012, p. 3.

Prof. Lubman: I think it sounds a very responsible way to promote your business and to look after the welfare of your patrons.⁷⁵

8.76 The following chapter will consider ways to improve the rate and effectiveness of referrals.

Success of treatment

8.77 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, commented on what factors contributed to the success of treatments:

In relation to counselling or formal support, the evidence from the research is that there is no one-size-fits-all and the best results and all the meta-analyses come to this conclusion: the best results come from professionals using a range of skills and theoretical orientations, and from drawing from their own experience to address the situations, needs and the people who are in front of them. So it is drawing from their own professional, theoretical toolkit and experience. The one constant thing for good outcomes that stands out is the relationship between the counsellor or the support professional and the person being supported—the relationship is very important and that comes out quite consistently too.⁷⁶

How can success be measured?

8.78 The committee heard it was sometimes difficult to pinpoint how to define effectiveness and success in terms of treatment. For example, Professor Dan Lubman asserted that there is a real difference between looking for help and getting treatment and this often depended on a person's readiness for change:

For example, to use an analogy, if I go shopping I might be interested in buying something nice and go to various shops where helpful salespeople offer me a range of things I might like to buy. I might not want to buy something, I am not ready to purchase that product, but I am interested to know what is available in the marketplace and to see whether it meets my needs. That is very different to when I have made a commitment that I know what I want and I seek that. Many people that we see are help seeking; this is the first time they want to explore what is on offer, what is available to deal with the issues they have and whether it is in line with what they are interested in receiving. That is very different to saying: 'I recognise I have a problem. I know I want to go to for treatment. I know what sort of treatment I want.' Often we and clinicians mix up the two. Often people come through our door looking to browse round the shop and we are immediately selling them the most expensive product in the shop and trying to convince them to come back on numerous occasions for more. I think there is a lot of confusion there and we need to understand that addiction—and problem gambling is in that vein—is a chronic relapsing condition. There is a whole series of phases of people working out what

75 Ms Simone Rodda and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 47–8.

76 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 22.

they want and where they want to be and where they are in that cycle in terms of accepting and being ready to receive help.⁷⁷

8.79 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, commented that some people are more self-motivated than others and this has an influence on how they fare in treatment:

In terms of people who come really motivated to quit, there are those whose partner has said, 'You have to go.' As an overall thing, people who come off their own bat may be more motivated. But certainly with the other ones, you have them in your office so there is a chance to do something. Quite a lot of them will have come in saying, 'I don't have a problem but my wife thinks I do.' You question them and after a while, they think, 'Yes, I'll stick around for a bit.'⁷⁸

8.80 The RANZCP also noted a 'myth' about treatment progressing in a straightforward and linear manner was something that needed to be addressed:

...we know for addictions in general that they are chronic relapsing conditions and people have multiple entries into treatment across the journey before they fully engage and have a full course of treatment. For example, there is recent data showing in the area of substance addiction that it is an average of one-quarter of a century from when people first start experimenting with alcohol and drugs to having full recovery. About 25 years is the average amount of time that people suffer with alcohol and drug dependence. In that time they are going to need a whole range of different responses that engage them in treatment and work with them. So this notion that we can get people in treatment and provide them with treatment and somehow they are going to be cured and will be able to play the pokies the following week and gamble responsibly is a myth that we really need to address.⁷⁹

8.81 Another treatment provider, Dr Natalie Glinka, told the committee of her pessimism about the ultimate success of counselling and treatment services to address some people's pathological gambling addictions:

People's desire to counsel pathological gamblers is noble; however, as a treatment, it is far from useful. I think it is a waste of money. The reason is that I have been in the doctoring business for 50-odd years and in psychiatry for 25 years. I have had three people who are inveterate gamblers in my care for longer than a decade, and I could see how their pathological gambling was related to denied painful feelings which they solved by a behaviour: going down to the casino. The excitement of getting a win was making them feel better, not so much the money. They would lose and they would chase the money. They would lie and borrow and lose their jobs and lose their relationships. So that is it in a nutshell. My counselling, whether it was insight oriented psychotherapy, supportive

77 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 45.

78 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 24.

79 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 38.

psychotherapy or cognitive behaviour therapy, was successful perhaps insofar as they realised that they had to stop gambling and maybe limit themselves. One went as far as to tell all the venues to chuck him out if he got to a certain level of loss. Well, that worked for a while and fell apart, naturally.⁸⁰

8.82 Chapter 11 which focuses on research and data collection will look more closely at the evidence base for treatment, how services are evaluated and how outcome measurements could be improved.

Role of family members in treatment

8.83 The role of family members in treatment is an important factor in treatment services. A 2008 study found that 'significant others' may act as social supports for gamblers who are in treatment and that 'involving loved ones in gambling treatment models may positively affect gambler treatment outcomes'.⁸¹

8.84 St Vincent's Hospital noted that 20 per cent of its Program's clients are referred through friends and family.⁸²

8.85 The Gambling Impact Society NSW tabled for the committee its self-help guide for families, noting that such resources are few and far between.⁸³ The support of family for people going through gambling treatment is crucial, yet support for families members themselves can be scarce:

As a family member myself, as a partner of someone who has had a gambling problem, it took me probably seven years to be able to find appropriate support and about another two years to find support that would actually work with us as a family as opposed to just focusing on the person with the gambling problem. Counsellors need training to work collectively with families, and with couples in particular; that is an important skill that is missing in the treatment sector. But bear in mind that we only reach about 10 per cent of people who are going to come in for treatment. You cannot have people, 90 per cent of them, struggling out there with nothing. And families are a key part of that and they need to be much better resourced and resourced through other community welfare points of contact, as indeed the community is generally.⁸⁴

8.86 The Statewide Gambling Therapy Service reported that having a 'significant other' involved in treatment was associated with better outcomes for problem gamblers:

80 Dr Natalie Glinka, *Committee Hansard*, 14 May 2012, p. 8.

81 Ingle, P.J. et al, 'Significant Others and Gambling Treatment Outcomes', *Journal of Gambling Studies* (24), 2008, pp 381–2.

82 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 6.

83 Gambling Impact Society NSW, tabled document, 2 May 2012.

84 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 42. See also Gambling Impact Society, NSW, *Submission 30*, p. 11.

...including increased retention in treatment and improved likelihood of successful treatment outcomes (for example, see Ingle, Marotta, McMillan & Wisdom, 2008). Nearly half of the non-gamblers to whom SGTS provided treatment during 2008-09 were the partner of a gambler being treated by [SGTS].⁸⁵

Measures to complement treatment

8.87 The committee also heard about measures to complement treatment for people with gambling problems. Financial counselling, as well as other measures to help limit access to money by financial institutions, are important adjuncts to treatment services.

Financial counselling

8.88 The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) told the committee about the Commonwealth Government's commitment to provide 50 new financial counsellors to work with problem gamblers and their families.⁸⁶ It is expected that this service will provide a gateway to more specific gambling help and therapies:

The financial counsellors will be focused on problem gambling; the majority of their work will be working with people who are affected by problem gambling. However, they will not go into the therapeutic type of gambling counselling that some of the other gambling counsellors do. It will really be with a financial counselling aspect. It will be looking at their household budgets, their credit and debt situations, whether they are in danger of bankruptcy—those kinds of issues—and dealing with their financial issues. There will really be a gateway to some of those other more intensive gambling counselling services and we will be referring off to those.⁸⁷

Assistance from financial institutions

8.89 Financial institutions can play a part in restricting access to money to assist people who are dealing with a gambling problem. St Vincent's Hospital Gambling Treatment Program discussed this with the committee at a public hearing:

Ms Kazal: We talk about access to money and access to venues as being the two most important factors in reducing the harm and reducing problem gambling. Banks could play a bigger role.

Senator CROSSIN: Are you talking about limiting the amount of money that you can take out of an ATM at a gambling venue?

Ms Kazal: Exactly. Things like daily withdrawal limits on ATM cards, linked accounts and just reducing the ease of access, and the ease of access to cash advances on credit cards.

85 Statewide Gambling Therapy Service, *Submission 8*, Attachment 1, p. 15.

86 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 20*, p. 3.

87 Ms Robyn Oswald, *Committee Hansard*, 14 May 2012, p. 56.

Dr O'Neill: I think it would be easy to pick who is a problem gambler because they go backwards and forwards to the ATM. That is quite common. They intend to spend only this amount and then they get enthralled by the machine and they go back. It would be quite easy for them to tell and maybe check that.

Ms McLean: The kinds of things that could be quite helpful if when a client approaches a bank and wants to reduce their withdrawal limit to a certain amount per day or set up an account that they cannot get access to until the following day with a transfer. There seems to be a lot of variation. Some banks will do it, some clients will speak to three different people at the same bank and two people will say, 'No' and one will say, 'Yes.' Having some regulations around that are needed.⁸⁸

8.90 The Australian Bankers' Association (ABA) provided a submission to the inquiry outlining existing measures and policies that its member institutions have in place to assist problem gamblers and their families. These include:

- financial literacy programs;
- financial hardship policies;
- referral to independent financial counsellors when appropriate;
- adjustment of maximum withdrawal limits on deposit accounts;
- cancellation of mortgage redraw facilities;
- restricting access to credit card cash withdrawals in gambling venues; and
- adjusting maximum credit limits on credit cards.⁸⁹

8.91 Regarding automatic teller machines (ATMs), the ABA's submission added:

As a result of banks removing ATMs from gambling venues over many years, currently there are very few bank owned ATMs installed in these venues. This market is primarily serviced by non-bank ATM deployers. Where some banks have maintained ATMs in gambling venues, the primary purpose is to provide a cash withdrawal facility in areas where there are few other convenient or safe options or are involved in long-term contracts.⁹⁰

8.92 A study commissioned by FaHCSIA titled 'Problem gamblers and the role of the financial sector' noted that problem gambling was linked to homelessness and severe financial difficulty. The report identified various options around how the financial sector could help to prevent problem gamblers from gambling with money withdrawn from home loans or joint bank accounts. It proposed a number of new measures to supplement the existing policies mentioned above, also noting that further

88 Ms Abigail Kazal, Dr Katy O'Neill and Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 24.

89 Australian Bankers' Association, *Submission 58*, p. 2.

90 Australian Bankers' Association, *Submission 58*, p. 1.

research would be required (for example, on privacy concerns and the practicalities of monitoring transactions) if such policies were to be implemented. These included:

- the introduction of more comprehensive credit reporting;
- financial institutions not offering line of credit and credit card products if the person applying seems to have trouble managing their finances (it would be preferable to offer loans on a principal plus interest basis);
- detailed case studies of problem gamblers and their experiences to be included on the Australian Securities and Investments Commission's website on financial tips and safety checks;
- improving financial literacy within the community;
- ensuring no one can access accounts in the name of their spouse or partner without the approval of the account holder;
- offering password protection to account holders;
- allowing customers to set daily cash withdrawal limits;
- setting limits on interest rates for other financial providers such as payday lenders; and
- removing automatic teller machines from gambling venues.⁹¹

Committee view

8.93 The committee welcomes the government's commitment to provide new financial counselling services for problem gamblers and their families. It also notes the government's commitment to introduce a \$250 daily withdrawal limit from automatic teller machines in gaming venues (although this excludes casinos) by 1 February 2013.⁹² Measures such as these, which supplement treatment services for problem gambling, will assist people addressing gambling problems to manage their individual financial situation in a supportive environment.

8.94 Banks can also assist with targeted measures as outlined above. The committee notes the work commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs in consultation with the financial sector on further measures that could be applied by the sector to address problem gambling. It welcomes further research to progress these measures, such as how to manage privacy concerns in relation to an individual's personal financial information and other practicalities around monitoring transactions.

91 South Australian Centre for Economic Studies, 'Problem gamblers and the role of the financial sector', Occasional Paper No. 33, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, 2010, pp v–viii.

92 The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, 'Tackling Problem Gambling in Australia', media release, 21 January 2012, <http://www.jennymacklin.fahcsia.gov.au/node/1701> (accessed 23 July 2012).

8.95 In the committee's view, any practical supplementary measures that can be put in place by the financial sector to assist individuals and their families affected by gambling addictions are to be encouraged.

Recommendation 6

8.96 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs, in consultation with the financial sector, commission further research on ways to progress practical measures that could be put in place by the financial sector to assist people with gambling problems and their families.