

Chapter 9

Barriers to treatment

Introduction

9.1 This chapter will consider the low rate of help-seeking among problem gamblers and examine the barriers to treatment, including stigma and shame about having a gambling problem and a lack of awareness of available services. It will briefly introduce the issue of comorbidity which is discussed further in chapter 10. This chapter will also cover additional challenges in accessing treatment faced by people from Indigenous and culturally and linguistically diverse backgrounds.

Rate of help-seeking

9.2 The Productivity Commission's (PC) 2010 report on gambling found that relatively few people with gambling problems actually seek help.¹ Based on available client data, the PC concluded that the help-seeking rate was between 8 and 17 per cent (excluding clients seeking help for someone else's gambling problem). Internationally, the rates for help-seeking are believed to be similar (6 to 15 per cent).²

9.3 To improve the low rate of help-seeking, the PC recommended:

- stronger formal linkages between gambling counselling services and other community and health services, including referral pathways and screening tests, underpinned by dedicated funding;
- the promotion of self-help and brief treatment options as cost-effective ways of achieving self-recovery; and
- greater emphasis on campaigns that make the community aware of problem gambling behaviours to encourage earlier help-seeking by individuals or interventions by family and friends.³

9.4 During this inquiry, the committee heard these points re-emphasised by those working in the gambling treatment sector. Both this chapter and the next explore potential improvements to treatment services to address issues around individual access and awareness as well as systemic challenges.

When do people seek help?

9.5 Of those who do seek help for problem gambling behaviour, most only voluntarily seek help when they have reached a significant crisis point in their lives.

1 See also Australasian Gaming Council, *Submission 33*, p. 27; Centre for Gambling Education and Research, 'Gamblers at risk and their help-seeking behaviour', September 2011, report prepared for Gambling Research Australia.

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.3.

3 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.27.

These may be severe financial difficulties, emotional crises, employment problems or relationship and family breakdowns.⁴

9.6 Dr Sally Gainsbury told the committee about a three-year study on help-seeking behaviour, indicating that people who have a gambling addiction may be well aware of the existence of help and treatment services but will only seek help once personal circumstances become dire:

What we found looking at non-problem gamblers, moderate risk and problem gamblers recruited from help lines, from venues and from the general population was a common factor where people typically do not seek help for gambling problems until they reach a significant crisis point. They may recognise they have problems and they may try to implement various self-help strategies including barring themselves from venues or by things like leaving their credit cards at home or trying to put limits on themselves. But generally it comes to some sort of emotional, financial or relationship crisis, potentially even somebody putting to them the ultimatum of seek help or I will leave you. Unfortunately, that is generally the prompt people wait for until they do seek help. It does seem there really is a crisis point. It is not necessarily that they are unaware of the help seeking strategies.⁵

9.7 Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point Alcohol and Drug Centre, confirmed that sometimes a 'catastrophic event' might also trigger someone to seek help, such as the discovery of gambling by a partner or resorting to embezzling from the workplace.⁶

9.8 For others who do access treatment, the pathway to gambling help is sought only after receiving help from other services, such as health or financial counselling services. For example, Miss Shonica Guy told the committee:

It was not until some lady said to me, 'I think you might have a gambling problem,' that I thought: 'Do I? I don't know if it's a problem.' She offered to come with me to UnitingCare Wesley to get some financial counselling. I wanted to do that. She said there were gambling counselling services there. I was not really too keen on that. I do not think I was at the stage where I wanted to stop, but I went along for a few sessions just to keep her quiet. She told me about Pokies Anonymous as well, and three years later I made that phone call. Three years later after that, I made the phone call. I was ready and I made up my mind. I made that phone call and I went to the first

4 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 11. See also Evans, L. & Delfabbro, P., 'Motivators for Change and Barriers to Help-Seeking in Australian Problem Gamblers', *Journal of Gambling Studies*, Vol. 21, No. 2, Summer 2005, pp 133–55, which found that help-seeking is predominantly crisis-driven. See also Suurvali, H., Hodgins, D., Cunningham, J., 'Motivators for Resolving or Seeking Help for Gambling Problems: A Review of the Empirical Literature', *Journal of Gambling Studies*, (2010) 26: 1–33; and Carroll, A., Davidson, T., Marsh, D. and Rodgers, B., 'Help-seeking and Uptake of Services Amongst People with Gambling Problems in the ACT', Australian National University, report prepared for the ACT Gambling and Racing Commission, 31 October 2011.

5 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

6 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 47.

meeting and I was never going to play again: I never played again, I never put a dollar in.⁷

9.9 The time gap—sometimes of many years—between the development of a gambling problem and the decision to seek help is an area that needs further attention. The St Vincent's Hospital Gambling Treatment Program emphasised this point:

Almost 60% of our clients have had a problem with gambling for over 5 years prior to seeking treatment from our service and 32% have had a problem for over 10 years. Some of these clients have had treatment in the past but this certainly indicates that there is a proportion of individuals who do not experience natural recovery and that earlier engagement with treatment could be therapeutically beneficial.

Reducing this gap between problem development and treatment access is another key focus in improving the effectiveness of treatment and reducing the ongoing harm from gambling. By the time individuals engage with our service, they are often faced with enduring consequences from their gambling even if they do successfully stop gambling. Young men often have a sense of hopelessness when they realise that they are facing 10 years of debt repayments and this can significantly impact their motivation to stop.⁸

9.10 Once people are in treatment, they often wish they had sought help earlier. At a public hearing, St Vincent's Hospital was asked by the committee whether those who sought treatment were ever put off by their initial experience being too overwhelming. However, Ms Siobhan McLean, Clinical Psychologist, St Vincent's Hospital, confirmed that the opposite was usually the case:

...when they come in and then they say, 'Gee, if I knew it was like this I would have turned up five years ago.' So there is definitely not just a gap between when they have the problem and when they seek treatment but also a lack of awareness of what treatment entails. Often they get concerned that we are going to delve into their past and make them lie back on a couch and various things like that, and they are often quite surprised to find out that while it is analysis it is more about their current situation, when they are going, the triggers, the urges and those kinds of things.⁹

9.11 As discussed in the following section, one of the main reasons for delaying treatment is the intense feeling of stigma and shame surrounding problem gambling and perceived societal attitudes.

Stigma and shame

9.12 As discussed earlier in the report, witnesses and submitters to the inquiry overwhelmingly confirmed that the primary barrier to seeking help and treatment for

7 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 18.

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

9 Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 20.

problem gambling was the social stigma associated with admitting to this addiction. In chapter four, the committee noted that current 'responsible gambling' messages, with emphasis on personal responsibility, may contribute to feelings of stigma and shame for those unable to control their gambling. This then influences the low numbers of people seeking help. Negative stereotypes about problem gamblers also entrench societal attitudes which make admitting to a problem even more difficult. Social marketing campaigns which have a clear anti-stigma focus (i.e. positive messages which provide information from people who themselves have experienced gambling addiction, sought help and recovered) are required to address these ingrained attitudes.

9.13 Mr David Pigott, National Manager, Government Relations, Mission Australia, commented that those who seek help are often 'typical family people':

...but when they get into a spiral of gambling addiction they often are trying to hide it from their families, their spouse or their workplace. There is obviously a stigma attached because, once you get to the point where you have a major financial problem, that is when the issue starts spiralling. So I think there is a general stigma about the extent. You are on this spiral. If you are a smoker, you can probably only smoke a certain number of packets of cigarettes per week. So I think it is just the extent of the problem. Once you get to the situation where you are in dire financial straits where it is impacting on your job, potentially your family and even your accommodation, it is almost too late then. Obviously we come in and work at that level, but it is the stigma.¹⁰

9.14 The St Vincent's Hospital Gambling Treatment Program also told the committee that many people who should be seeking treatment are not doing so: 'treatment is a last resort in these people's minds...They are acutely embarrassed'.¹¹ Dr Katy O'Neill explained that people with gambling problems feel 'stupid' and that this is reinforced by society's view that 'gambling is a tax on the stupid'.¹²

9.15 Mr Tom Cummings, a former poker machine addict, told the committee that there was a perceived stigma associated with help-seeking for gambling problems:

...so people try to do these things quietly or anonymously. If they want to seek help, they want to make sure nobody knows about it, because, at the end of the day, they do not want to be known to have had a gambling problem. It is a social disgrace.¹³

9.16 The University of Sydney Gambling Treatment Clinic confirmed that many of their clients feel stigma and do not want to admit to a gambling problem even when seeking treatment:

They do not want to admit that they have lost a lot of money and they do not want to admit that their financial problems or the other problems are the

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

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

12 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, pp 18–19.

13 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 6.

result of gambling. We get a lot of people coming in who, on the face of it, will say that they are coming for treatment for depression or for relationship issues when, after a session or two, it is quite clear that gambling is the central issue, but they like [to] couch what they are coming in for in terms other than problem gambling.¹⁴

9.17 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) compared the cultural stigma surrounding seeking help for alcohol addiction with the shame around seeking gambling treatments. Professor Dan Lubman, RANZCP Fellow, described the 'cultural normalisation of intoxication across Australia' and the idea that having an alcohol problem was seen as a personal failing:

Many of the young people that we see in treatment say to us, 'We know we struggle with our alcohol problems but we cannot go out on a Saturday night without getting intoxicated because otherwise we are ostracised from our social group.' So we have a huge issue here with normalisation and certainly the messages that are promoted around alcohol and gambling are of individual responsibility, that is up to you and that basically if you have problems with alcohol or gambling then essentially there is something flawed in you as a person. I think that creates huge stigma.¹⁵

9.18 The committee made recommendations in relation to strategies to address stigma in the context of improved prevention measures at the end of chapter four.

Lack of awareness

9.19 Another barrier to treatment is a lack of awareness about what services are available. St Luke's Anglicare told the committee that when people in Victoria call the central helpline number, often they are unaware that local help is available:

That might be because they were not ready to seek help, but the workers say to me that they think it is because there is a low level of awareness about the availability of the service beyond the helpline and that is potentially problematic.¹⁶

9.20 St Luke's Anglicare also advocated for greater promotion of local services.¹⁷

9.21 Although lack of awareness may be a factor in delays in help-seeking, it may be the case that people with gambling problems do have an awareness of what is available but feel uninformed about what to expect at these services, which leads to caution and procrastination.¹⁸ Dr Sally Gainsbury explained:

14 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 60.

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

16 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

17 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

18 See for example Rockloff, M. & Schofield, G., 'Factor Analysis of Barriers to Treatment for Problem Gambling', *Journal of Gambling Studies*, Vol. 20, No. 2, Summer 2004, pp 121–6. This study of general population attitudes in Central Queensland towards problem gambling treatment found that 'persons with greater gambling difficulties were more concerned with the availability, effectiveness and cost of treatment'.

Although there are generally low levels of awareness, problem gamblers seem to be more aware of services than other groups of gamblers so there is some level of awareness although that does need to be increased. Particularly there is a lack of understanding of what it means to seek help. Some people really think that it is being put in a room and not given very many options. There is a lack of understanding and that needs to be worked on but it is a crisis point that people wait for before they reach for external help.¹⁹

Comorbidity

9.22 A complicating factor for people with gambling problems that can affect help-seeking is the high rate of comorbidity²⁰ including depression, anxiety, substance use disorders and nicotine dependence. Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, told the committee:

The people who come for treatment for gambling problems often have other problems as well. I thought a snapshot of our current clients might be helpful. 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.²¹

9.23 Comorbidity is discussed in greater detail in the following chapter in the context of ways to better design treatment services to cater for people with comorbid conditions.

Ways to increase help-seeking

9.24 As discussed in chapter four, the committee heard several ideas about how preventative messages around problem gambling can be pitched to break down stigma through positive messages, including about the success of treatment, particularly using the voices of those who have sought help themselves.

Reducing stigma

9.25 As discussed in the previous chapter, the online counselling services offered by Turning Point Alcohol and Drug Centre afford anonymity and encourage help-seeking earlier:

19 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

20 The co-occurrence of two or more disorders. See Gambling Treatment Program, St Vincent's Hospital, Darlinghurst, *Submission 3* pp 1–2; University of Sydney, Gambling Treatment Clinic, *Submission 10*, p. 8; Clubs Australia, *Submission 29*, p. 9; Responsible Gambling Advocacy Centre, *Submission 35*, p. 3; Turning Point Alcohol and Drug Centre, *Submission 42*, p. 9; Dr Natalie Glinka, *Committee Hansard*, 14 May 2012, p. 8; Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2; Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 21, pp 85–115; The Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 5.

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

Ms Rodda: With the online counselling we notice that they are speaking to us earlier. They are speaking to us about concerns that the problems are getting worse, which is what you want people to be doing.

Prof. Lubman: One of the things that is really potent around the online counselling is the feedback that we get from consumers that, because there is no one there and they cannot even hear your voice, there is no one there to see you cry. It is a much more immediate way of getting help without feeling really overwhelmed and stigmatised.²²

How services are presented

9.26 St Luke's Anglicare noted that because of the social shame associated with seeking help for gambling addiction, services needed to be offered with discretion and sensitivity:

Our service, Gambler's Help, is collocated along with other services in the same building, and there is not a great big sign saying 'Gambler's Help here'. So anybody walking in off the street could be going into, for example, our financial counselling service as well or any of the other community services that we offer. I would agree that it is stigmatised, so you need to be careful.²³

9.27 Turning Point also commented that in offering its *Gambling Help Online* service, they were very careful not to use the words 'problem' and 'gambling' in the same sentence. This was a conscious decision to try to remove some of the stigma.²⁴

Positive messages about treatment success

9.28 The need for the development of more positive messages as part of information and social marketing campaigns about gambling has been raised in chapter four. The committee heard evidence that help-seeking rates could be improved by changing people's perceptions about whether treatment would be worthwhile. The Australian Psychological Society pointed out that a significant barrier to people accessing treatment was the belief that 'help does not help'.²⁵

9.29 Professor Malcolm Battersby, Director, Statewide Gambling Therapy Service, observed that the way messages about treatment are presented may be a factor in encouraging contact with help services. He gave the committee the following example of how marketing angles could be an important factor in targeting suitable messages about the availability of treatment:

We have recently been conducting a randomised controlled trial. We advertise in the media around that as being for a research project. I remember this guy said: 'I've been seeing your pamphlets and this gambling help number in the venues for a couple of years, and every time I see that I

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

23 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

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

25 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 29.

think, "Oh, I need to get help," but I just keep putting it off. But when I saw you had a research project, I thought: 'That's okay. I can do that.'" So it is like the message was a bit different and he felt like he could do it because it was part of research. He then was saying how he had enormously benefited from being part of the research and he wished he had come earlier.²⁶

9.30 Professor Battersby also emphasised the need to run effective social marketing campaigns showing the testimony of people who have successfully received help for gambling problems, using examples of people from all ages and backgrounds who would say:

'I've had this problem; you too can get help.' We have done that with smoking and with all sorts of other areas, and I do not think government has put enough money into social marketing and promotion of gambling help.

Another reason some people have said to us for why they did not seek help was that they did not think they could get better. There was not much they could do about it. They tried various things and just were not aware that there were actually successful treatments for it—and not just successful treatments but treatments that were not 'weird', meaning to be locked up in some sort of asylum or other myths about mental illness treatment in general.²⁷

9.31 The University of Sydney Gambling Treatment Clinic also confirmed that 'information based approaches' in the media have increased the number of people presenting for treatment:

Through the media office at the uni, we give stories to the media that are based on facts about the findings we are having—that treatment is likely to be successful or that we are running new treatment options. We find that that tends to result in a greater number of people coming through the door than do the scare based campaigns that are typically run to highlight the harms caused by problem gambling. Essentially, we find that giving people hope that treatment is likely to be effective if it is done properly is helpful in getting people through the door.²⁸

9.32 The committee notes that demystifying gambling by promoting positive media messages about the success of gambling treatment, as well as showing that problem gamblers come from a range of backgrounds and situations is crucial to breaking down stigma.

Encouraging discussion of gambling

9.33 Ms Christina Sanchez, Team Leader, Mission Australia, commented that gambling addiction was still a 'taboo' subject and that the way to address this was to encourage open discussion in society, especially among families. She illustrated this

26 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

27 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

28 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 60.

with reference to campaigns about binge drinking, which have raised community awareness about the problem.²⁹

Examples of advertising campaigns to increase help-seeking

9.34 Chapter five has already discussed how social marketing campaigns need to be better targeted to different groups, particularly those 'at-risk' to increase awareness of risky gambling behaviours as well as how to access help and treatment services.

9.35 The Productivity Commission acknowledged that awareness campaigns appeared to have 'at least temporary effects' in attracting people to counselling and treatment services. This has been shown by campaigns in NSW, Tasmania and Victoria.³⁰

9.36 St Vincent's Hospital noted there had been a 'big spike' in referrals to gambling treatment after a television advertising campaign on the G-line in 2002.³¹ There were second round advertisements during 2003–04 but these were not screened on television.³²

9.37 The Responsible Gambling Advocacy Centre (RGAC) noted that Victoria's Know the Odds campaign in 2011 was very successful in encouraging people towards help services. However, Ms Penny Wilson, CEO of RGAC, posed a question about whether such campaigns led to ongoing behaviour change or just initial help-seeking or information-gathering.³³

9.38 Turning Point Alcohol and Drug Centre's submission noted that calls to the Victorian Gambler's Helpline had risen to a high of 11,000 during 2010–11. This was attributed to large spikes in call volumes following television and online advertising campaigns.³⁴

9.39 The University of Sydney Gambling Treatment Clinic ascribed a dramatic rise in clients seeking treatment to the Clinic's own media releases to local and metropolitan print media:

These releases, written by our staff, have focused on a range of issues relating to gambling, from the escalation of sports betting to trials of new treatments at the clinic. When the press release referred to new and evidence-based treatments on offer at our service, our referral rates increased dramatically. These new callers typically reported high levels of dissatisfaction with their previous treatments and various services and had intentionally avoided treatment for many years. Our impression is therefore,

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

30 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

31 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 19.

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

33 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 28.

34 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 3.

that public awareness can be raised by providing newsworthy releases to media outlets on the latest research on gambling, innovations in industry and research on gambling treatments, rather than simply highlighting the harms associated with excessive gambling.³⁵

Committee view

9.40 The committee acknowledges the immense feelings of shame and stigma that people with a gambling addiction can feel. It is understandable that so few people seek help and treatment when the overwhelming message from the wider society is that admitting to a gambling problem denotes personal failure and a lack of individual responsibility. As noted earlier in this report, the current emphasis on messages to 'gamble responsibly' may unintentionally contribute to this. The committee agrees with treatment service providers who emphasised the need to disseminate positive messages about the success of treatment services, including using the testimony of people from all backgrounds who have successfully sought help for gambling problems.

9.41 Strategies to develop campaigns built on these positive messages have already been discussed in chapters four and five. The committee notes that these campaigns should be designed not only to raise community awareness about problem gambling and to break down negative stereotypes, but also to encourage people who are dealing with gambling problems to seek help and treatment services and to seek them out earlier.

Treatment services for Indigenous and culturally and linguistically diverse groups

9.42 As well as broader barriers discussed above (social stigma, lack of awareness and comorbidity), culturally and linguistically diverse (CALD) groups can also face more entrenched challenges in accessing treatment.

9.43 The Australian Churches Gambling Taskforce argued that greater focus needs to be placed on specific population groups, including remote Indigenous and some Asian communities.³⁶ The Taskforce called for more national funding to undertake developmental work to provide targeted support for these groups.³⁷ Preventative messages and other resources designed to assist at-risk groups such as CALD and Indigenous populations have been discussed in chapter five.

9.44 Several of the gambling treatment services which appeared before the committee also have in place specialist treatments and outreach methods for people who come from CALD backgrounds. For example, the Statewide Gambling Therapy Service (SGTS) described its services for CALD groups. Ten years ago, one or two Indigenous people per year would attend the SGTS but now it is 35 people per year:

35 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 3.

36 Australian Churches Gambling Taskforce, *Submission 50*, p. 7.

37 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 15.

We have also worked with the Vietnamese, Chinese and other CALD communities in South Australia to increase that collaboration. We have translated our program into Vietnamese and recently launched the Vietnamese New Year celebrations here in Adelaide with a new series of booklets and resources that we use to work with people in the Vietnamese community with gambling problems....[T]he master of mental health science program here [at Flinders] is training Vietnamese-speaking therapists to go back and work in the community under supervision from our more senior therapists. So the amount of CALD and Aboriginal community activity was low a few years ago, but we have certainly increased that and it looks to be growing even more now.³⁸

9.45 Tabled documents provided by the SGTS provide overviews of manuals and programs used for Vietnamese and Indigenous communities.³⁹ Professor Malcolm Battersby, Director, SGTS, noted that funding has been provided to appoint a project officer to work on cultural diversity:

Part of her role—and I can say it is Sue Bertossa—was to develop the relationships, do a whole lot of collaboration, develop manuals and also at the same time provide some therapy. She focused her Aboriginal work up in Ceduna and has been so successful she won a South Australian award for mental health in Indigenous communities. But she has also been working very closely with the Vietnamese community. What is really interesting about all of this is that there was a kind of statement around that non-English-speaking sophisticated communities will not be able to use cognitive behaviour therapy or this fancy university based sort of therapy. So the challenge was: can you transfer the same cognitive behaviour skills into non-English-speaking and other communities? Sue has shown that she can do that quite successfully in both those communities. Her skill is in community development as well as therapy, and there was such a successful process that they actually got the launch of the Vietnamese manuals and therapies as the second item on the Vietnamese New Year celebrations.

Going back to the question about recruitment of people into the service, and shame, I understand there was quite a lot of resistance initially to the Vietnamese leaders having a shameful thing being publicly displayed, but they actually did a lot of work behind the scenes and got that to be publicly presented to the community.⁴⁰

9.46 Mission Australia also described to the committee how its counselling services cater for CALD groups with the help of interpreters:

A person will make a phone call and say that they have an issue with gambling. If the counsellor identifies that the person might have a problem with English they will ask whether the person wants an interpreter present. If the person says yes they will be asked if they would like one to come in

38 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 5.

39 Tabled documents from Professor Malcolm Battersby, 14 May 2012.

40 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 5.

and be with them or whether they would like it to be done over the phone. Sometimes that will alter when the person comes in and finds that over the phone is not satisfactory—it has to be on speaker phone, so it is a bit more cumbersome. We generally prefer the interpreter to come in and definitely so for financial appointments: when you are looking at credit card and other statements it is very hard to describe things over the phone. We will book that in, the person will come in and have the interpreter sit in and interpret for the session. If the person wants another session we may book the interpreter again; it is up to the person. If the person says, 'No, I am quite happy to do this on my own,' that is quite fine too.⁴¹

9.47 The University of Sydney Gambling Treatment Clinic also provided information about CALD groups. In 2011, four per cent of all new clients at Darlington were from an Indigenous background. These clients presented with a range of particular needs:

They have a higher incidence of drug and alcohol dependence, poverty, homelessness, illiteracy, domestic violence and trauma. They also have a higher incidence of problem gambling than the rest of the population. For this reason, dealing with problem gambling in the community presents with some unique problems. Although they are aware that problem gambling is an issue, the community itself sees this problem as being one of many, and certainly not one which should be taking centre stage.

Ashley Gordon (probably the most experienced aboriginal problem gambling counsellor in Australia) said himself that he faces an uphill battle putting problem gambling on the agenda for aboriginal elders and workers in the community.⁴²

9.48 The Clinic also identified a number of cultural barriers to access to services, which include:

...mistrust of non-aboriginal service providers; the physically imposing nature of our facilities; the ethnicity of our counsellors; the expectation of timely attendance at appointments; the structured and Socratic nature of counselling conversations - to name a few. If we were going to provide effective counselling we would need to spend a great deal of time in the community, building friendships and relationships of trust that have nothing to do with the provision of counselling and would need to provide this assistance in an informal, unstructured manner in the community and not on campus. For us, this just isn't practical or possible.⁴³

9.49 The St Vincent's Hospital Gambling Treatment Program told the committee that since 2002, 0.7 per cent of clients have identified themselves as Indigenous Australians; 2.4 per cent Greek; 2 per cent Italian; 1.8 per cent Lebanese and 1.3 per

41 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 38.

42 Answer to Questions on Notice, University of Sydney Gambling Treatment Clinic, received 23 May 2012.

43 Answer to Questions on Notice, University of Sydney Gambling Treatment Clinic, received 23 May 2012.

cent Chinese. The Program has access to a hospital interpreter service but will generally refer people to the Multicultural Problem Gambling Service if language is a difficulty.⁴⁴

9.50 The Turning Point Alcohol and Drug Service provided information showing that 17 per cent of callers to the Victorian Gambler's Helpline come from countries other than Australia, including Vietnam, China and India. For *Gambling Help Online* services, the CALD groups using the real time chat and email programs were mostly from Chinese, New Zealander and Indian backgrounds.⁴⁵

9.51 Interestingly, the Statewide Gambling Therapy Service noted particular success with the form of treatment known as motivational interviewing for Indigenous clients:

Fourteen Indigenous clients received modified treatment; changes to treatment were based on the advice of Indigenous workers, representatives and clients, collected via interviews, daily journal of community consultations and case-note review. It was found that the adoption of Motivational Interviewing (MI) was helpful in engaging Indigenous clients in treatment, with most clients recognising exposure based treatment as an important part of their therapy.⁴⁶

9.52 The Department of Families, Housing, Community Services and Indigenous Affairs has also commissioned work on the development of culturally appropriate problem gambling services for Indigenous Australians, noting that some key principles for service development are:

- viewing problem gambling as less of a 'social issue' and more of a public health issue, thus placing more emphasis on primary prevention;
- supporting existing problem gambling help services to build stronger links with the local Indigenous community;
- adopting a more community development-type approach when working with Indigenous communities;
- helping to develop the capacity to tackle the issue at a 'grassroots' level; and
- placing a greater focus on workforce development in the future.⁴⁷

44 Answer to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 7.

45 Answer to Questions on Notice, Turning Point Alcohol and Drug Centre, received 28 May 2012, pp 1–2.

46 Flinders University, *Submission 8*, Attachment 1, p. 43.

47 Cultural & Indigenous Research Centre Australia, 'Development of culturally appropriate problem gambling services for Indigenous communities', Occasional Paper No. 40, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, 2011, p. vi.

Committee comment

9.53 The committee recognises that stigma and shame, lack of awareness of services and comorbid conditions all present barriers to help-seeking to the general population. People from culturally and linguistically diverse (CALD) backgrounds and Indigenous Australians, contend not only with those barriers but may face additional difficulties in accessing treatment such as language and cultural issues. The committee notes the work being done by treatment services to provide effective and tailored support for people from CALD communities. It recognises the range of services available such as counselling with the help of interpreters and engagement of cultural diversity officers to liaise with communities and community leaders to help disseminate positive messages about help and treatment. The committee acknowledges the specialist work and efforts of treatment providers to facilitate access to effective treatment services for CALD and Indigenous clients.