

Chapter 10

Improving treatment services and systems

Introduction

10.1 This chapter will discuss ways to improve treatment services for problem gambling. First, it will look at a range of possible improvements to the current system from the perspective of those working in the sector, in particular the concept of integrated treatment services to deal with the complications of treating people with comorbid conditions. The chapter will then look at the need to integrate awareness of gambling addiction across the wider health profession to ensure better referral pathways. Finally, the chapter will cover qualifications and training, particularly in the context of clinical versus non-clinical services.

How can we improve treatment systems?

10.2 The committee heard about ways to improve the current treatment system including:

- lifting the rate of help-seeking;
- having a good mix of services to address all stages of gambling addiction, including online services;
- establishing better linkages between gambling treatment and other help services; and
- offering an integrated service designed to treat 'the whole person', particularly those who suffer from comorbid conditions.

10.3 These features are all discussed in further detail below.

10.4 Professor Dan Lubman, Director, Turning Point Alcohol and Drug Centre, succinctly described to the committee the challenges facing the sector:

...how we engage a very stigmatised population into treatment, how we think in a much more sophisticated way around systems and pathways of care, and how we assertively reach out to people and to professionals in terms of increasing the reach of service provision for gambling across the country.¹

Lifting the rate of help-seeking

10.5 The previous chapter explored the challenges of increasing the rate of help-seeking from the current low rate of 8 to 17 per cent. While acknowledging that a 100 per cent response rate would be unattainable, the Turning Point Alcohol and Drug Centre suggested that a rate of about 35 per cent would initially be a reasonable target:

1 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 44.

Senator XENOPHON: You are never going to have a perfect system but 10 per cent of problem gamblers getting help is quite imperfect. In terms of a strategy of advertising, social media—the sorts of things you are talking about—what do you think a benchmark or a target should be for the next two or three years if there were a concerted effort? What would be a good percentage of people in terms of other public health work that you have done to actually get through the door to get that help?

Prof. Lubman: If we benchmark ourselves against other mental disorders, for example, what we see in the area of anxiety and depression is a figure of around 35 per cent. So 35 per cent of people with a diagnosed anxiety depression seek health support.

Senator XENOPHON: So we should be aiming for that?

Prof. Lubman: I think we should be aiming for that. As I spoke about before, I think that is about a cultural change. That is not just about presenting services; it is about a cultural change about the role of gambling in society. It is a broader discussion and a community engagement about the harms it causes. It is a recognition that it is a real disorder that needs treatment and it is about hearing visible voices of people who have gambled who have recovered and who have good stories to tell about success stories about how recovery is possible.²

A good service mix

10.6 The Statewide Gambling Therapy Service (SGTS) advocated for a 'service mix' that catered for people at all stages of gambling addiction, from moderate to severe. Professor Malcolm Battersby, Director, SGTS, described the core elements of this 'step care'³ model:

You can have a range from brief intervention right through to the severe end, which is an inpatient program which I know you are aware we run at Flinders. The service mix should include people with that range of skills, but even brief interventions, which should now be around cognitive behaviour therapy, need to have properly trained staff. The brief interventions can include the internet. I think one of the big missing resources that we are not using in Australia is peers—people who have recovered from gambling problems. We can use them as part of the treatment mix as well.⁴

Online services an important part of the mix

10.7 As covered in chapter eight, online interventions and counselling have been shown to be relatively effective forms of help. According to the Turning Point Alcohol and Drug Centre, the surprising success of this mode of treatment provides an

2 Senator Nick Xenophon and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 49.

3 A 'step care' model was also explained by Professor Battersby in *Submission 8a*, p. 5 as a program 'from low intensity to high intensity with adjunct social prescribing for social isolation and signposting to community services e.g. unemployment, marital, financial counselling.'

4 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 1–2.

'opportunity to think about how we reconfigure services to be much more aligned to people's needs':

We see huge traffic coming through and the challenge for us is how to cope with this. The way that we have been funded traditionally is to be in the old mindset of taking a call and referring on to face-to-face because face-to-face is better. What we now know from other areas of the health system is that telephone and online can be just as effective. Rather than just being a triage point, we need to start thinking about how we can deliver interventions and do assertive outreach using telephone and online means to engage a much broader proportion of the population in treatment.⁵

10.8 'Assertive outreach' is another potential improvement to online and telephone services, with Professor Lubman suggesting that greater 'two-way traffic' could be incorporated into Turning Point's service mix. Noting that currently, a person may send a couple of chat messages through an online forum when they are distressed, he stated:

Most of the time, most of our services are one-way traffic—they just come to us—whereas I think services should be set up to be two-way. If somebody rings us up we should have the facility to ring them or send them a text a couple of weeks later just to check up, saying: 'You rang our service and we wondered how you're doing. We wondered if you need any more help. We wondered if you're feeling on top of your gambling.' Being able to think in that much more assertive way, to reach out to the community rather than waiting for the community to come to us, would be a really helpful way of engaging more people in treatment.⁶

10.9 He described studies from other fields of mental health when people who had been treated in emergency departments for self-harm were followed up with weekly postcards:

The people who received the postcard, even though it was automated and just had support messages, showed significantly better outcomes over the follow-up period. Even though they knew that the postcards were automated they actually felt that there was somebody out there looking after them and thinking about them. We certainly know for this population they often feel very alone and isolated. So I think there is a lot of work we could do in terms of assertive outreach, either directly over the phone or online with either both automated and follow-up calls. I think assertive outreach is the way to go in terms of reaching out and keeping hold of people and encouraging them to seek treatment and support.⁷

10.10 Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point, discussed future improvements to the existing online services, including having 'moderated forums' to engage more visitors to the website in conversation. With over

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

6 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 47.

7 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 48–49.

100,000 visits to the website, but only 2,000 to 3,000 people taking up the interactive counselling option, moderated forums could engage more people earlier, before they reach a crisis point.⁸

Better linkages between services

10.11 The need for better linkages between gambling treatment services and other health services was raised in evidence to the committee.

10.12 For example, Associate Professor Peter Harvey, Manager, Statewide Gambling Therapy Service (SGTS), stated that services in South Australia tend to be set up in 'independent organisations that do not have a very effective nexus'.⁹ Better coordination of services, such as gambling treatment, family counselling, financial counselling and social support is required. Mission Australia told the committee that it aimed for a holistic service for its gambling help clients:

...we drill down to see what the underlying issues are for the client and where we can help. So, if a housing issue comes up, an alcohol issue comes up or even an unemployment issue comes up, because of our service suites, we can link them into either our services or other services that are in the area. We do not just focus on the one issue with our clients. We always look at the bigger picture.¹⁰

Example of service collaboration

10.13 A example of improvements to service collaboration involving gambling treatment services was provided to the committee by Associate Professor Peter Harvey, Manager, SGTS. He described a pilot program underway between Anglicare and Flinders University which aims to map out 'a process of cross-referral and self-management support for people in relapse prevention'. He noted that collaboration, not competition, between services was the key:

...the way the different services were set up tends to have them more in competition with each other for clients and activity rather than organised in a way that they can cross-refer, exchange data and work together to support the same client. So there are a number of pilot programs underway and we are hoping to build on that, basically using...our self-management initiative, which is based on a chronic disease self-management program, led by peer educators who have been through the treatment process themselves. We are offering that as a self-management forum so that a range of agencies can send clients at various stages of treatment along to those groups. Those sorts of mechanisms seem to be working; certainly there is more activity between us and other agencies than there was four or five years ago.¹¹

8 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, pp 45–46.

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

10 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 5.

11 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 4.

10.14 Having funding bodies support a collaborative approach between services has been the key to change at a systemic level:

I think what changed significantly in South Australia a few years ago was the way agencies were funded and the central agency that was providing the funding through the Office for Problem Gambling, which made a statement to the providers. It said, 'We are now happy for a client to exist in two or three programs and be counted in that way,' whereas prior to that clients virtually belonged to a service and there was competition across the agencies for that space. So, at more of a systematic level, having the funding bodies support that kind of collaboration is positive as well.¹²

10.15 Professor Malcolm Battersby, Director, SGTS, made some practical suggestions around how collaboration between services could be encouraged; for example, with financial rewards for cooperation and referrals. He also proposed an electronic referral system which would also assist with outcome measurement and data collection:

Another strategy would be to have a common outcome measurement system across the agencies such as if everyone were collecting the same data—or at least a minimum data set—and that was facilitated electronically. In other words, it could be an electronic referral system. There are examples of that in community and health sectors in South Australia investing a huge amount of money in a new electronic system. That is potentially another advantage of being in the health system rather than another system. Everyone in the health system is trying to move towards electronic data collection and sharing of communications, so that would definitely assist people in being able to transfer and, at a click, find out the people you should be referring to.¹³

Dealing with comorbidity

10.16 The term comorbidity refers to the co-occurrence of two or more disorders.¹⁴ In the field of pathological gambling, comorbidity may refer to someone with a gambling addiction also having a substance abuse or alcohol disorder and/or a mental illness such as depression or anxiety.

10.17 Throughout the inquiry, the committee heard that people who are treated for gambling problems often present with a comorbid condition. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that people with mental illness were particularly vulnerable to the harms occurring from gambling.¹⁵ Professor Dan Lubman, RANZCP Fellow, told the committee about a recent meta-analysis

12 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 4.

13 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 4–5.

14 See Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 85. For more see: <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono71-toc~mono71-11~mono71-11-2>.

15 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 34.

which showed that around one-third of problem gamblers have an anxiety or depressive disorder, about half have a substance use disorder and about 60 per cent are nicotine-dependent.¹⁶

10.18 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital Gambling Treatment Program, described how people with anxiety may be drawn towards gambling, thereby developing a comorbid condition:

If you did not work with gamblers you would logically think that, if you were anxious, gambling would be the last thing you should do; it is only going to make things worse. But it does perform that sort of mental escape.¹⁷

10.19 She also explained how easy it was in the current service system for people with comorbid conditions to fall through the cracks:

I used to work in drug and alcohol, and there used to be this thing called bump-and-turf: a new psychotic person would turn up and there would be a bit of argy-bargy between, 'Is he one of yours?' as in, 'Is it the first episode of schizophrenia?' or, 'Is he one of yours?' as in, 'Has he taken too many amphetamines?' It is a people-fall-in-between-the-cracks problem when they first present. Another problem is that some people think the way to deal with co-morbidity is to say, 'Yes, about your depression—go and see that person.' But a person is just one person in their life, and it has to be treated in context because they are gambling due to the fact that they are depressed or they obviously get more depressed after they have lost. But we have seen people who have said themselves that the depression caused the gambling, and a GP has made the assumption that if we keep treating the depression then the gambling will logically fade away. We have seen people on doses of antidepressants that would cheer up anyone if it was in the water supply or something, and, while that may have been true at the start of gambling, now there are separate maintaining factors. That is a crucial part that clinical psychologists can tease apart.¹⁸

10.20 For a service like the University of Sydney Gambling Treatment Clinic which offers cognitive therapy, it was acknowledged that people with some comorbid conditions may find this form of treatment less effective:

...there are always going to be people, whether it is with depression or anxiety or whatever you are working with, for whom psychological treatments are not going to be effective—in particular, people with a traumatic brain injury or people with a comorbid mental illness such as

16 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 36. See also de Castella, A., Bolding, P., Lee, A., Cosic, S. and Kulkarni, J., 'Problem Gambling in People Presenting to a Public Mental Health Service', Office of Gaming and Racing, Department of Justice, Melbourne, Victoria, October 2011, which noted the prevalence of problem gambling in the study cohort (893 people) was more than four times that reported in the general community.

17 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 20.

18 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, pp 20–21.

schizophrenia or severe bi-polar disorder. For people in these sorts of categories, treatment is going to be less effective.¹⁹

10.21 The submission from Turning Point Alcohol and Drug Centre pointed out that very little is known about the best method to treat comorbid conditions (e.g. before, during or after gambling treatment). Also unknown is:

...how comorbidity impacts on outcomes or how clients would prefer to receive treatment for comorbid conditions.

The rates of comorbid conditions within helpline/online populations are unknown. Implementing screens within the helpline/online services would provide information for both clients and counsellors and contribute towards our knowledge of gambling and comorbidity.²⁰

10.22 Professor Dan Lubman, RANZCP Fellow, noted the recent push over the last decade to integrate services to try to deal effectively with comorbidity for both substance use and mental illness:

There is recognition that there is huge comorbidity between the two and service systems for both need to know how to work to address those issues. Gambling has been really silent in that space. While there has been increasing recognition of managing alcohol, drug and mental health issues there has really been no dialogue around gambling. It is seen as some sort of completely separate issue that does not overlap in any way whereas... there are huge underlying vulnerability markers of increased risk for all those disorders.²¹

Integrated treatment services

10.23 A key feature of a best practice service model for gambling help services is the concept of integrated treatment, particularly to address comorbid conditions as discussed above. This differs from a case management approach which may require people to seek a range of treatments from a number of different agencies, or to recover from one disorder before treatment can commence for another.²² An integrated treatment service, according to St Vincent's Hospital Gambling Treatment Program, offers 'individually tailored integrated treatment of the whole person'.²³

10.24 Dr Enrico Cementon, RANZCP Fellow, stated that each service offering integrated treatment packages needs to be 'welcoming to a person who presents with multiple problems':

They have to have an empathic and hopeful approach for that person and say, 'Yes, you have multiple problems, but let's have a look at all of them. We'll assess them and then develop an integrated treatment plan which

19 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59.

20 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 13.

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

22 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

23 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

looks at those problems and addresses them, perhaps in the order of priority of which is the riskiest at the moment, which is causing the most harm. Then we'll move through that in that sort of way. We may need to get in specialists to help us, in which case we will work with the same treatment plan. Rather than having separate treatment plans we will have an agreed management plan with similar, mutually acceptable goals and objectives.²⁴

10.25 He noted that having different clinical services—for gambling, for drug and alcohol addiction and for mental health services—ran the risk of frustration and poor outcomes for the individual seeking treatment if these services were not properly integrated:

...each of those different service sectors has to have a capacity within it to be able to manage these patients with multiple disorders rather than say, 'You've got a gambling problem so you've got to go over to the gambling service next door or in the next suburb.' Often that sort of ping-ponging that occurs leads to the person becoming frustrated, getting different messages from different service providers and then eventually dropping out of treatment. There can be even worse outcomes as a result of that.²⁵

10.26 Professor Dan Lubman, RANZCP Fellow, also observed that 'people seek help in the ways they are comfortable with' and people may present for treatment for mental health issues and not mention gambling problems. Integrated treatment services must be able to cater for people who are at different 'stages of change' in relation to different disorders and problems:

We offer integrated treatment for, say, substance use and mental health issues but we find the majority of people will present to us with the mental health issue because that is the issue they want addressed. When they initially come to treatment they will say that they do not see their substance use as an issue. One of the ways we engage and work with them is to work on the mental health issue but at the same time, through a series of therapeutic approaches, have them over time come to acknowledge that their substance use is contributing to their mental health problems. Then that allows us to also work on the substance use issues.

One of the issues we have with gambling is that it is very difficult for people to acknowledge, because of the stigma, that the gambling is an issue. They are much happier to come forward and acknowledge, for example, the mental health issues, on which, over the last 10 years there has been an immense amount of work in terms of destigmatisation. Ten years ago people probably would not have come for a mental health issue; they would have come for a physical disorder and then we might have broached mental health.²⁶

10.27 The ideal service system would therefore be one where there is 'no wrong door' through which to seek help when someone has variety of problems. The

24 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, pp 36–37.

25 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 36.

26 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

Australian Psychological Society said that given comorbidity is often associated with gambling problems, it is important that people are encouraged to get help by 'screen[ing] for gambling in those types of areas where people do seek help, although they are still not seeking help as much as they should. That is where people are already engaging in the system'.²⁷

10.28 The submission from St Vincent's Hospital Gambling Treatment Program also argued that while brief interventions could be valuable, the best treatment for problem gamblers must include the option of integrated treatment programs:

Brief interventions definitely have their place, as do public health information campaigns and the promotion of responsible gaming. However, despite the best efforts at prevention, some problem gamblers will need extensive treatment.²⁸

10.29 St Vincent's Hospital confirmed that its service tackles gambling early on, even if the client may have other comorbidities:

I think it is important to emphasise that we do actually target the gambling from day one; we do not start looking at other things, like whether they are depressed or not. The first focus is primarily on the gambling, because that is a crisis, and we try to bring some resolution and reduction of harm around the gambling.²⁹

10.30 Professor Dan Lubman, RANZCP Fellow, suggested that building incentives into the health system to encourage the implementation of certain treatments, including integrated treatment models of care, was needed:

I think what we can learn from other parts of the health system is that, if we want to increase the implementation of certain treatments in key disorder types, we have to incentivise the system. For example, in the area of immunisation, if we really want to see 100 per cent coverage or 90 per cent coverage of the population for childhood immunisation, we add MBS [Medicare Benefits Schedule] payments to general practitioners to encourage the uptake of that practice. From the wealth of resources that have been put into the primary care sector for alcohol abuse, if we were to follow a similar path for gambling, there would need to be a dual strategy both to develop those resources and to organise the top-down processes to make it an incentive for primary care to implement that assessment and treatment package.³⁰

Committee view

10.31 The committee notes that significant further research is needed to understand the true effects of comorbid conditions on problem gambling, including effects on help-seeking behaviour and the difficulties comorbidity may present for delivering

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

28 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

29 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 20.

30 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 35.

effective treatment services. More information about comorbidity would enable treatment services to be better integrated and focused to meet the needs of people with co-occurring mental health or drug and alcohol issues.

10.32 The committee notes that integrated treatment plans are already being utilised to deal with co-occurring substance abuse and mental health conditions. The committee recognises that integrated treatment services should be able to provide assistance to people at any 'stage of change' at which they find themselves. For example, in the case of those who seek help firstly about a mental health issue, but who have a co-occurring gambling problem which they may or may not have acknowledged, treatment providers would ideally be able to offer a 'no wrong door' approach to service provision so that people may be engaged in integrated therapies. However, the committee recognises that more information is needed to help treatment providers deal effectively with comorbidities.

10.33 Recognising that further research on comorbidity and problem gambling is required, the committee considers that the Department of Families, Housing, Community Services and Indigenous Affairs should facilitate this further work.

Recommendation 7

10.34 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs undertake further research on the impact of comorbidities on problem gambling and how integrated treatment services can be developed and implemented to effectively address comorbid conditions.

Strengthening referral pathways

10.35 The Productivity Commission's (PC) 2010 report recommended that stronger formal linkages be forged between gambling help services and other health and community services.³¹

10.36 This was supported by Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, who also said:

We agree with people like Dr Clive Allcock and the Royal Australian and New Zealand College of Psychiatrists that clients of all health professionals should be assessed for gambling, even one or two questions, and then be referred to us.³²

10.37 Professor Dan Lubman, RANZCP Fellow, explained there was a real need to strengthen the role of the primary care sector in relation to referrals and screening:

...it is a key role of primary care to deal with these issues. However, when speaking to my health colleagues in those fields, often they do not know what to do, how to identify it or, if they do identify it, where they should refer to or how they should manage those problems. It is a huge gap in our

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

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

treatment sector and a huge issue to do with both workforce capacity building and development and also the development of appropriate screening and treatment paradigms.³³

10.38 He noted that a possible way to ensure a strengthening of referral practices was to tie assessment and screening requirements to incentive payments to primary health care professionals through the Medicare Benefits Schedule (as is done, for example, for childhood immunisation).³⁴

10.39 The Australasian Gaming Council's submission noted research³⁵ which had found that many Australian general practitioners (GPs) are not screening for gambling problems because screening tests may be considered to be 'too time consuming' for routine use. A one-item screening tool may be a reasonable compromise for use by GPs and other health care professionals.³⁶

10.40 In 2010, the PC specifically recommended providing a 'one-item screening test' for optional use by health professionals and counsellors to help identify gambling problems and that this should be targeted at high-risk groups, especially those presenting to services with anxiety, depression and heavy drug and alcohol use.³⁷

Committee view

10.41 The committee affirms the need for better linkages and collaboration across the health care system to strengthen assessment, screening and referral practices for problem gambling. Developing stronger pathways for referral will facilitate earlier intervention and help-seeking and enable individuals to address problematic gambling behaviour much earlier.

10.42 The committee agrees, in line with the Productivity Commission, that clients of primary care health professionals and counsellors who are considered 'high-risk' (particularly those who present with anxiety, depression, high drug and alcohol use) should be assessed for gambling problems using an optional one-item standardised screening test.³⁸

33 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 34.

34 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 35.

35 Problem Gambling Research and Treatment Centre (PGRTC) (2011) *Guideline for screening, assessment and treatment in problem gambling*, Clayton: Monash University, p. 44 and Thomas, S; Jackson, A; Browning, C and Piterman, L. (2009) *A one item screening tool for problem gambling for use in primary care settings*, Melbourne, PGRTC.

36 Australasian Gaming Council, *Submission 33*, p. 25.

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

38 A one-item standardised screening test would involve, for example, a general practitioner asking a patient a question such as 'Have you ever had a problem with your gambling?' See 'Why Screen?', *General Practice Problem Gambling Resource Kit*, Government of South Australia, 2009, http://www.problemgambling.sa.gov.au/asp/gps_nurses_and_clinicians.aspx (accessed 3 September 2012).

Embedding awareness of gambling across the health system

10.43 The committee heard evidence on ways to further strengthen the health system to incorporate knowledge and awareness of problem gambling among health professionals. Professor Dan Lubman's view was that there was a 'failure across the medical profession to understand and treat gambling issues'.³⁹

Training of medical students

10.44 The RANZCP noted that there was a need for further capacity building in the gambling treatment sector and that this could be improved by changes to the training system:

Addictions are rarely taught in any great detail within most undergraduate and postgraduate courses, so there is a lack of training and capacity building in the recognition and management of addictions across a whole range of health professionals, including primary care providers. Similarly, in terms of opportunities for postgraduate expertise and training, again there are limited opportunities for placements or postgraduate training in the addictions field, so again there is a lack of capacity building in this sector when it comes to the recognition and management of gambling by primary care and other health providers.⁴⁰

10.45 Dr Enrico Cementon, RANZCP Fellow, also mentioned efforts made in Melbourne to have psychiatrists interested in problem gambling impart their knowledge to medical students, although this was not a systemic practice:

I know that there were a couple of sporadic efforts within Melbourne where certain psychiatrists are interested in problem gambling. They consciously make an effort to talk to the medical students that they are teaching about problem gambling but I do not think there is any cohesive strategy in relation to medical student teaching and problem gambling. Perhaps there needs to be some policy around that in the universities.⁴¹

Promotion of problem gambling across the health profession

10.46 In order to promote awareness of problem gambling throughout the health profession, the RANZCP undertakes activities directed towards up-skilling their professional counterparts. These activities were described by Professor Lubman and Dr Cementon, RANZCP Fellows:

Professor Lubman: The college is part of the mental health professionals network where it links with psychologists, general practitioners and nurses and it arranges professional development activities that include management of mental health, substance and gambling issues. There is a range of activities that it is involved in. We have position statements; we promote it heavily. We are both involved through the section with presentations at our congresses, with professional development and other

39 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

40 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 34.

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

activities that we run. Certainly, we promote it very heavily in there but even within our own college there is a lot of work to be done in upskilling our college membership in the recognition and management of gambling issues. There is a lot of work to be done in this area. Unfortunately, we are a long way behind where we would like to be.

Dr Cementon: We had a small win about 10 years ago when the college training was revised with addiction training for all training psychiatrists. We introduced in the first three years of training the requirement to compile a logbook of 10 addiction cases. Nine of them were substance related and one of them was a gambling case where the gambling problem was identified, assessed and managed as a focus of the overall treatment of the patient. We consider that to be an important win. There was a bit of training that went out with that—for example, the DAG [drug, alcohol and gambling] assessment which was determined by Dr Allcock in Sydney. You might have come across Clive in your travels. The drug, alcohol and gambling assessment has been a very core part of the overall psychiatric assessment of a patient.⁴²

10.47 St Vincent's Hospital agreed that further education of health professionals would assist in helping to break down stigma across society about problem gambling:

We see a lot of people who have seen psychiatrists, general practitioners and other psychologists and they have not mentioned their gambling problem, which gives you an idea of the stigma.⁴³

A helpline for health professionals

10.48 The committee heard from the Turning Point Alcohol and Drug Centre about a practical idea to assist health professionals more broadly to understand, recognise and help people with gambling problems:

...in the drug and alcohol space we are funded through government to provide a service called the Drug and Alcohol Clinical Advisory Service...There is a number that is put across a number of jurisdictions where any health practitioner can ring up and get advice about how they manage a client. Most of [the] calls we get are from GPs. They know that they can speak to a psychiatrist or an addiction medicine specialist about somebody with alcohol and drug problems in their clinic at that moment. They ring us and we give them advice. A similar sort of service for problem gambling is needed, so that GPs knew that if they had somebody there that there is somebody they could ring immediately to speak to to work out who to refer to and what they should do next. That level of support would really enhance the amount of pickup amongst general practitioners and other professionals.⁴⁴

42 Professor Dan Lubman and Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 41.

43 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 22.

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

10.49 According to its website, the Drug and Alcohol Clinical Advisory Service (DACAS) is a 24 hour, 7 day specialist telephone consultancy service available to all health professionals in Victoria, Tasmania and the Northern Territory. It is operated by the Turning Point Alcohol and Drug Centre and is funded by the Victorian Department of Health. The service provides clinical advice to health professionals who have concerns about the clinical management of patients and clients with alcohol and other drug problems. Initial inquiries to the service are handled by professional drug and alcohol counsellors. If the inquiry is medical in nature, it is referred to a DACAS consultant (addiction medicine specialists) for a secondary consultation. Consultants aim to respond to calls within one hour, or as soon as possible if the matter is urgent.⁴⁵

Committee view

10.50 The committee supports the efforts currently underway to embed awareness of problem gambling across the health profession, from medical students to practising health professionals. Initiatives such as a helpline for health professionals to assist them to identify and help patients with gambling problems are good practical measures which the committee hopes will lead to improvements in service provision for people with gambling problems across the health service system.

Recommendation 8

10.51 The committee recommends that the Commonwealth Government fund the establishment of a national helpline, similar to the Drug and Alcohol Clinical Advisory Service, as a practical resource for primary health care professionals to assist them to identify and refer patients who present with gambling problems.

Qualifications and training

10.52 The issues of qualifications and training for both clinical and non-clinical gambling treatment services were raised with the committee as an area for further attention and standardisation.

10.53 The committee discussed the variability of qualifications and training with the Productivity Commission (PC). Dr Ralph Lattimore noted that for non-professional staff who perform interventions and referrals in a gambling venue, for example, it is important that people not 'stray over the line...we do not want people being amateur psychologists'. He described the different levels of qualifications expected depending on the intervention or treatment:

So that goes to the heart of the question of qualification that may be needed for venue staff as compared with people who may be actively involved. It is also then a distinction between people who are undertaking, effectively, clinical roles. If you are applying or researching cognitive behavioural therapy at a professional level—people like professors Blaszczyński and

45 Drug and Alcohol Clinical Advisory Service, http://www.dacas.org.au/Find_Help.aspx (accessed 23 July 2012).

Delfabbro—then you need to be a highly trained professional. Similarly, pharmacological interventions require that level of training.⁴⁶

Calls for a clinical approach

10.54 Clinicians who gave evidence to the committee advocated strongly for the value of a clinical approach to treatment of problem gambling. For example, Dr Katy O'Neill commented on the rigorous approach offered by clinical psychologists at St Vincent's Hospital:

I think what psychologists bring to this is that we know how to read research. We do not take things as: you must see people for six sessions, you must cover this et cetera. We do not have that cookbook approach. We can see what the research is aimed at, what the theory is and then apply it.⁴⁷

10.55 Clinical psychologists undertake a minimum of six years full time university training, including at least two years post-graduate clinical studies with extensive supervised placements in mental health settings.⁴⁸ Dr O'Neill told the committee that 'treating gamblers is a specialist skill' and that only those properly trained in psychology and learning theories are best placed to help problem gamblers:

I do think that a fairly robust, self-motivated person could probably succeed no matter who they saw, but there is deep ambivalence when people come in; there is embarrassment. Some of the learning principles involved in why they keep getting hooked into it are quite complicated.

...We run a lot of our clients through a mini psychology course: this is why you are reacting like this; this is why you might be at home, slumped, and you think of gambling—you have not even gone yet—and suddenly you have got a little bit more energy. What causes that motivation? We explain to them things to do with the dopamine system. They do end up with quite a lot of specific knowledge about gambling, and that, to me, is possibly why our rates might be higher.⁴⁹

10.56 Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, St Vincent's Hospital, added that clinical psychologists are well placed to provide integrated treatment as they are 'trained to assess the entangled functional relationships between presenting problems and can thus offer individually tailored integrated treatment of the whole person'.⁵⁰

10.57 Particularly for the treatment of comorbid conditions, St Vincent's Hospital emphasised that only appropriately qualified health professionals should deliver treatment and that poorly informed treatments 'no matter how well intentioned, can occasionally exacerbate mental health problems':

46 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 45.

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

48 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

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

50 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

The addition of a few mental health units in the minimum qualifications for a problem gambling diploma is no substitute for the extensive training involved in post-graduate mental health qualifications.⁵¹

10.58 These views about qualifications were echoed by the University of Sydney Gambling Treatment Clinic, which noted that many people who work with problem gamblers do not necessarily come from a mental health or psychology background. Even those who are trained in psychology, social work and psychiatry may require more specialised training in problem gambling because most training programs for these professions do not specifically address problem gambling.⁵² To address this, the Clinic suggested that a review and adjustment of tertiary training programs for formal mental health qualifications should take place, as well as the development of centres of excellence, capable of retraining mental health professionals in best practice methods for treating problem gambling.⁵³

10.59 Mr Christopher Hunt, Psychologist, University of Sydney Gambling Treatment Clinic, raised serious concern about people without proper expertise working with problem gamblers:

I would argue that this is a problem, because the government—not just this government but also governments in the past—have noted the importance of getting properly trained people to work with sufferers of depression, anxiety, schizophrenia, bipolar disorder. But in the area of problem gambling we are seeing that there is still this preponderance of people with minimal qualifications working on treating this disorder, and we would say that is far from an ideal situation. Essentially, anyone that puts their hand up and says, 'Yes, I want to help problem gamblers,' is able to get funding. But it is not an ideal situation for the gamblers that there are these people with lower levels of qualification who are offering treatment.⁵⁴

10.60 The Clinic's submission cited a lack of training for counsellors, 'who are not typically trained to attend to the various mental health comorbidities that frequently occur in problem gamblers'.⁵⁵

Committee view

10.61 The committee acknowledges the views of the Productivity Commission and the health professionals who presented evidence regarding the need for a clinically rigorous approach to treatment of problem gambling, particularly when dealing with comorbid mental health conditions. It is important to have the highest standards of care and service available for those dealing with gambling problems. While this would be an ideal situation, the committee also notes that clinical services exemplifying best practice are not in reach of or suit everyone who has a gambling problem, particularly

51 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 2.

52 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 58.

53 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 8.

54 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59.

55 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 8.

people in regional and remote communities. The committee therefore acknowledges the good work being undertaken at all levels, by both clinicians and non-clinical counsellors.

Minimum standards for counsellors

10.62 Ms Rosalie McLachlan, Inquiry/Research Manager, Productivity Commission (PC), explained why the PC's recommendation on minimum training standards for counsellors was made:

A number of participants to our inquiry actually expressed concerns about the level of qualifications of counsellors, and there was certainly evidence of variability of levels of qualifications. But, even in terms of just understanding the technologies, I remember going to a gambling counsellor conference and being amazed at some of the questions that were being asked about how the technologies work. Given that they are seeking to correct misperceptions about gambling, I suppose I was surprised at the lack of understanding of some counsellors of how gambling worked and how the technologies worked. So an absolute minimum requirement would be to actually understand the technologies and how problem gambling comes about in terms of misconceptions.⁵⁶

10.63 The Gambling Impact Society NSW acknowledged that many in the counselling sector were doing well with the few resources they have at hand. However, Ms Kate Roberts, Chairperson, noted there was still room for better 'theoretical grounding' in relation to counselling people with gambling problems, especially those with comorbidities:

We know that people need a gamut of different forms of treatment and I am certainly an advocate for people having choices, but there needs to be at least a baseline of people being able to have a range of skills. So the area in New South Wales has developed very much around a treatment area and consequently the recruiting to that has had people coming from a whole range of different kinds of counselling backgrounds. Whilst there is nothing wrong with that initially, what we are really saying is that as we know more about it there are huge co-morbidities and you really do need to have a baseline of very good theoretical grounding about dealing with those comorbidities.⁵⁷

10.64 To improve training, Professor Malcolm Battersby suggested a national training program for therapists or counsellors:

...which teaches in a rigorous way at least a graduate certificate level those with mental health qualifications mental health assessment with a gambling focus, anxiety and depression assessment and management similar to that provided by the Master of Mental Health Science course at Flinders

56 Ms Rosalie McLachlan, *Committee Hansard*, 14 May 2012, p. 45.

57 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, pp 39–40.

University, a course for non-psychologists in evidence based psychological therapies.⁵⁸

10.65 The PC examined the issue of qualifications and training in its 2010 report, concluding that a minimum standard of training for counsellors was desirable, given the complex nature of gambling problems. National accreditation was considered as an approach by the PC but was deemed too costly and difficult to be approved across all jurisdictions.⁵⁹

Committee view

10.66 The committee supports the Productivity Commission's recommendation to establish a minimum standard for counsellors to enhance the quality of service provision. The committee supports jurisdictions and professional bodies working together to develop national minimum standards of training for counsellors who deal with problem gambling, in line with the Productivity Commission.

10.67 The committee also sees merit in exploring other ways in which best practice in problem gambling treatment could be better shared between clinical and non-clinical services (that is, between professionals and non-professionals) without compromising clinically rigorous approaches—for example, through courses offered by clinicians for non-psychologists as recommended by Professor Malcolm Battersby.

58 Flinders University, Professor Malcolm Battersby, *Submission 8a*, p. 5.

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