

The Prevention and Treatment of Problem Gambling in South Australia through the Gamblers Rehabilitation Fund:

A STRATEGIC REVIEW

2005



Government of South Australia
Department for Families
and Communities



THE PREVENTION AND TREATMENT OF PROBLEM GAMBLING IN SOUTH AUSTRALIA THROUGH THE GAMBLERS REHABILITATION FUND:

A STRATEGIC REVIEW



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A Strategic Review

A report undertaken for the Gamblers Rehabilitation Fund by the:

Research, Analysis and Evaluation Branch

Strategic Planning and Policy Division

Department for Families and Communities

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1 INTRODUCTION

In March 2004, the Minister for Family and Communities endorsed a proposal put to him by the Gamblers Rehabilitation Fund (GRF) Advisory Committee, that contracts to Break Even services be extended for one year (2004/2005). During this time, a review would be conducted to inform the procurement of services for commencement of the new funding period, from 1 July 2005. This review would consider matters such as:

- the nature of problem gambling in South Australia
- the type of services currently funded by the GRF
- current best practice to address problem gambling
- gaps in current service delivery especially with regards to specific population groups, and strategies to deliver services to these groups
- the mix of services.

This report, containing the results of the Review, provides the Minister, the GRF Advisory Committee and the department with information and advice in the above areas to support decision-making with regard to the future planning of services.

This report is a broad and strategic review of the GRF program response to the issue of problem gambling in South Australia. It is not an evaluation of the existing system or of individual services and approaches.

Many sources of information have been utilised to prepare this report. Interviews were conducted with every Break Even service and services were given the opportunity to provide written comment. A joint forum was also held with Break Even service providers in August 2004. The Break Even Data Collection was extensively analysed as was other relevant data. Consultations were held with the GRF Advisory Committee and other key parties (including industry representatives) were given the opportunity to submit views. A consultation with some interstate Gambler Rehabilitation Funds was undertaken by telephone and relevant literature was reviewed regarding best practice approaches in this field.

2.1 Background

The Gamblers Rehabilitation Fund commenced in 1994 shortly after the introduction of gaming machines in South Australia. Its objective was to generate initiatives that specifically respond to or prevent problem gambling. The establishment and continuation of this fund is recognition that gambling can and does create a variety of problems for some individuals, and that these problems can extend into and impact on the community.

A Funding Policy for the GRF was developed in 1995 which guided the allocation of funds across a range of functions and service types. This Policy still provides the fundamental structure of the system, though allocation to specific areas has grown over time.

The current service system was established following a competitive tendering process in 1995. Since that time, contracts have been rolled over and there have been few changes to the original providers or Break Even network.

The last evaluation of the GRF took place in 1998. Elliot Stanford and Associates were contracted to assess the appropriateness of the GRF allocation and operational model, and to assess the effectiveness and efficiency of the Break Even service system. The consultants were also asked to comment on the appropriateness and effectiveness of GRF administration.

The evaluation concluded that there was a clear need for the services funded by the GRF and that these services were effective but not necessarily as efficient as they could be. The consultants identified a number of issues around GRF advisory and decision-making mechanisms that needed to be addressed.

Among the recommendations were that:

- Break Even support services be continued
- the GRF place a stronger focus on prevention
- future gambling policy be based on a harm minimisation approach
- the GRF support more research, especially into best practice approaches
- the mandate of the GRF Committee be clearly specified as an advisory role on broad matters relating to problem gambling, with the mandate for decision making on policy and specific funding allocations clearly resting as the responsibility of the Minister in conjunction with the Department in accordance with a relevant strategic plan. (Elliot Stanford & Associates, 1998, p 1-6).

This report builds on the findings and recommendations of the previous evaluation. Its focus is on the funding allocation under the GRF and strategic directions for the future.

The report canvases a range of issues. At the end of each chapter, a summary of key points and findings is provided. The final section draws these together and proposes priorities, key outcomes and major strategies for the next funding period.

3. THE NATURE AND CONTEXT OF PROBLEM GAMBLING IN SOUTH AUSTRALIA

3.1 The size of the Gambling industry

The relatively recent growth and diversification of the gambling industry in South Australia is well documented and still debated in many forums. It is estimated South Australia had 1,518 gambling businesses operating within its geographic boundaries in 2001/02. (Australian Gaming Council, 2003).

People who live in South Australia have many choices about the type of gambling activity they can engage in, with lotto, lottery games, instant scratch tickets and electronic gaming machines amongst the most popular. In 1999 the Productivity Commission reported on participation rates in different forms of gambling activity for the year 1997-98 (Table 1). This data confirms that gambling is now a popular and common activity, with 77% of South Australian adults participating in one or more forms (and even higher participation rates in other states). The 2001 South Australian prevalence survey found similar patterns, with 75% of respondents participating in at least one form of gambling in 2001 (Centre for Population Studies in Epidemiology, 2001).

Australians are amongst the heaviest gamblers in the world. The Productivity Commission (1999) reported that Australians spend on average at least twice as much on legalised gambling as people in North America or Europe. Gambling expenditure has steadily increased in Australia over the last two decades. Most of this increase occurred during the first half of the 1990s following the rapid expansion of gaming machines and the opening of casinos in a number of states. There are early, and some would say debatable, signs that this steady increase may be levelling off, but extraordinarily large amounts of money are still outlaid on gambling. Total expenditure across all forms of gambling in Australia rose from around \$10 billion in 1996-97 to \$15.01 billion in 2001-02. South Australia was recorded as having an aggregate gambling expenditure of \$909.6 million in 2001-02. As Banks (2003) points out, this expenditure is not spread evenly across all gamblers: problem gamblers spend much more time and money pursuing the activity than recreational gamblers. The Productivity Commission concluded that problem gamblers accounted for around one third of all total expenditure on gambling.

Table 1: Estimated per cent of adults in Australia that participated in gambling activities in the last 12 months by state/territory (1997-98)

Form of gambling	AUST	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
	% that played								
Played poker or gaming machines	39	39	45	41	41	16	36	37	33
At a club	30	35	34	36	19	5	18	37	12
At a hotel/pub	18	14	23	17	37	3	25	3	10
At a casino	17	12	22	20	18	15	27	5	27
Bet on horse or greyhound race	24	26	25	20	19	27	31	28	28
On-course	13	14	15	11	8	17	12	13	9
Off-course	19	21	19	17	16	18	26	21	22
By phone	3	3	4	3	3	2	3	2	1
Via the internet	-	-	-	-	-	-	-	-	-
Played lotto or other lottery game	60	54	62	64	55	74	52	53	63
Weekly	57	47	60	64	54	74	50	52	60
Daily	12	29	4	-	8	4	9	14	1
Brought instant scratch tickets	46	47	33	66	32	53	40	43	39
Played keno at club/hotel/casino/ other	16	16	11	25	14	9	34	13	21
Played table games at a casino	10	10	14	7	7	9	9	8	12
Played bingo at a club or hall	5	5	5	4	3	3	5	5	4
Bet on a sporting event	6	8	5	3	8	9	6	6	4
Played an internet casino game	-	-	1	-	-	-	-	-	-
Played games privately for money	5	5	6	4	10	5	6	4	3
Played any other gambling activity	1	1	-	1	-	1	-	-	4
Participated in any gambling activity	82	80	81	86	77	84	77	80	80

Source: Australian Gaming Council, 2003, p.61

In 2001/02, approximately 66.7% of total gambling expenditure in SA was on gaming machines (over six times more than the next highest form of expenditure: Table 2).

Table 2 : Aggregate gambling expenditure in Australia by state/territory (2001-02)

	Wagering	Lotteries	Gaming machines	Casino	Other	All
	\$ million					
NSW	746.1	456.0	4,307.0	534.0	4.1	6,047.2
VIC	549.8	333.2	2,562.9	911.2	7.6	4,364.6
QLD	256.3	312.0	1,129.4	541.1	66.9	2,305.7
SA	99.2	90.9	606.8	91.8	20.9	909.6
WA	171.9	187.6	0.0	291.7	22.3	673.4
TAS	27.9	21.2	98.8	87.8	20.7	256.4
ACT	22.2	16.9	174.4	16.2	1.6	231.3
NT	82.0	13.3	36.9	69.6	15.1	216.9
AUST	1,955.4	1,430.9	8,916.2	2,543.3	159.3	15,005.1

Source: Australian Gaming Council, 2003, p.16. Original source was the Tasmanian Gaming Commission 2003, *Australian Gambling Statistics 1976-77 to 2001-02 (including amendments)*.

Note : Australian Gaming Council footnotes report the figures for Gaming machines in many states are likely to be an under estimate as gaming machines expenditure from casino appears under the casino heading.

When adjustments are made for population size, South Australians are reported to spend less than many of their interstate counterparts on gambling. Australian Gaming Council Fact Sheets highlight that South Australian adults ranked equal fifth behind other states and territories in terms of the average proportion of Household Disposable Income (HDI) spent on gambling during 2001-02. The Australian average proportion of HDI spent on gambling was 3.41%. Adults in the Northern Territory spent the highest (4.45%), followed by NSW (3.83%), Victoria (3.81%), Queensland (3.19%), South Australia and Tasmania (2.95%), ACT (2.45%) and West Australia (1.64%).

Legalised gambling is an important source of taxation revenue for the states. South Australian government budget estimates for 2004/2005 anticipate collecting \$405.1 million from gambling taxes with increases expected in future years. Gambling taxes now form around 14% of total state-generated taxation revenue.

3.2 What is Problem Gambling?

People engage in gambling activity for different reasons, at different levels of intensity, with different expectations of what the outcome of their pursuit might be. Thus, many people gamble infrequently with friends on social occasions for fun and with an understanding they will probably lose their money. In such situations, if money that was not required for another purpose is lost, there is minimal inconvenience or harm to the individual and others.

In other cases however, people gamble more frequently, on their own and with the expectation that they might profit financially from the activity. These people may lose money which might have been required to purchase essential goods or services. This loss is more harmful and especially if it is repeated, might put the individual or their dependents at risk. This pattern of gambling activity could easily become problematic, and the impact of continual losses is likely to extend out from the individual to those around them (partner, family, work-place, community). The Productivity Commission has estimated that at least five to ten people are adversely affected by each problem gambler.

The propensity to gambling, and gambling uptake, appear to be influenced by a variety of factors, including personality (eg impulsiveness/impulse control and risk-taking); and other psychological issues (eg psychiatric problems, depression, cognitive competence). Social factors (such as family environment and exposure to gambling activity, social isolation and loneliness) have also been identified as playing a part, as have a range of other factors which make gambling and gambling venues attractive options (boredom, homelessness). (Melbourne Enterprise International 2003; DFC work in progress 2004) It is often the case that problem gambling is associated with other co-morbidities and problems. Cultural factors have also been identified as influential, and it appears that different cultural groups have different propensities to gamble and different motivations for doing so.

Availability and supply is another key factor influencing uptake. It is widely acknowledged that the increased availability of gambling products and new forms of gambling have increased the level of gambling in South Australia over the last decade, and it would also therefore appear the number of people experiencing problems due to their gambling.

The Productivity Commission National Gambling Survey attempted to quantify the health, financial and relationship problems that can arise from problem gambling and found that :

- one-tenth of those with significant gambling problems – and 60% of those in gambling counselling – admitted seriously contemplating suicide as a result of their gambling,
- nearly half of gamblers in counselling reported losing time from work or study due to gambling,
- gambling losses averaged around 20% of household income for problem gamblers compared with a little over 1% for recreational gamblers, and
- one in five gamblers admitted borrowing money without paying it back, with one or two going into debt to finance their gambling.

Other studies have reported the impact of problem gambling on key areas such as relationships, family, housing, employment and health.

A number of definitions of problem gambling have been postulated over the past thirty years. Many have been derived from a medical model and attribute the meaning primarily to the relationship between aspects of an individual's behaviour, the harmful consequences of that behaviour and that individual's psychiatric or psychological state. Hence, problem gambling is defined as loss of control over gambling activity, even when the negative consequences (eg. financial) mount up.

Since the mid 1990s, broader perspectives on the phenomenon of gambling have been utilised that focus not only on how problem gambling affects the individual but also on the costs and benefits to individuals, families and communities. Service planners, with responsibilities to develop a systematic response to problem gambling, have found these broader definitions useful in understanding community impact and managing the harmful effects of gambling. A current widely-accepted definition of problem gambling is as follows:

“Problem gambling refers to the situation in which a person's gambling activity gives rise to harm to the individual player, and/or to his family and may extend into the community”. (Productivity Commission 1999, p18).

This is the definition currently accepted by the Gamblers Rehabilitation Fund.

Attempting to understand problem gambling has led some to explore broader aspects of causation. It is now well accepted that problem gambling can be symptomatic of other unresolved issues. Consequently, problem gambling has been explored as resulting from social problems arising from disadvantage and

- Those in crisis/difficulties in other areas of their lives
- People with other co-morbidities or complex situations (eg other addictions, homelessness).

It also appears that some cultural groups are more likely to be involved in problem gambling than others. Although this is an area where extensive research has not yet taken place, it would appear that this is likely to be for a range of reasons including:

- The prevalence of the above issues (eg co-morbidities, isolation, depression, alcohol and drug use) amongst the group in question
- Attitudes and beliefs about gambling amongst the group.

3.3 Prevalence of Problem gambling

Point-of-time vs. cumulative counts

All prevalence surveys are based on 'point of time' counts (ie how many people in the community are gambling, and patterns of gambling behaviour, at the point of time when the survey was conducted). By contrast, a cumulative count is the total number of people experiencing the problem over a particular period of time – eg a year. The cumulative count will always be greater than the point-of-time count (over time, some people will recover or change behaviours and patterns, and new people will begin).

Problem gambling client data (new registrations of clients etc) is always a cumulative count (the number of people seen by services over a year).

The number of people in South Australia over a year who are affected by problem gambling is unknown. It is also difficult to compare the number of people who are receiving services related to problem gambling (a cumulative count) with the number identified in prevalence estimates as problem gamblers (a point-of-time count).

Prevalence estimates

The Productivity Commission (1999) found a prevalence rate of problem gambling in Australia of 2.1% in 1997/98. The Commission estimated that this comprised 1% who had severe problems with their gambling and another 1.1% with moderate problems. This figure is considered to be a conservative and probably an underestimate (population-based prevalence surveys rely on voluntary disclosure by participants, and have poor capture of vulnerable populations such as the homeless, prisoners, people with complex needs and the mentally ill).

Table Three reproduces the Commission's estimates of the number of problem gamblers in Australia by state/territory.

Table 3: Productivity Commission estimates of the number of problem gamblers in Australia by state/territory (1997-98)

	% of all adults	No. of people
New South Wales	2.55	122,300
Victoria	2.14	75,925
Queensland	1.88	48,609
Western Australia	0.70	9,548
South Australia	2.45	27,809
Tasmania	0.44	1,526
Australian Capital Territory	2.06	4,588
Northern Territory	1.89	2,431
Australia	2.07	292,737

Source: Australian Gaming Council (2003) p.148

Although the data for South Australia reveals a higher than average prevalence rate, it is believed that this is the result of a sampling error.

The prevalence of problem gambling in South Australia was re-examined in 2001 by the Department of Human Services (Centre for Population Studies in Epidemiology). From a sample of over 6000 adults, 2% were identified as problem gamblers (as indicated by a score of 5 or more on the SOGS scale). This equated at the time to approximately 22,000 South Australian adults with a serious gambling problem.

The most common form of gambling amongst problem gamblers was reported to be gaming machines. This confirms previously published information by the Productivity Commission (1999) (Table 4).

Table 4 : Estimated number of problem and recreational gamblers by game in Australia (1997-98)

Please note the following abbreviations:

MPGs	Moderate problem gamblers
SPGs	Severe problem gamblers
NPGs	Non-problem (recreational) gamblers
PGs	Problem gamblers

	NPGs	MPGs '000	SPGs	Total PGs
Wagering	3,279.7	84.5	68.5	152.9
Lotteries	8,235.8	133.3	99.2	232.6
Scratchies	6,342.2	105.3	79.3	184.6
Gaming machines	5,196.6	141.5	112.9	254.4
Casino games	1,366.6	53.1	36.1	89.2
Other	3,134.8	105.6	80.5	186.1
All gambling	11,185.6	163.4	129.3	292.7

Source: Productivity Commission 1999, *Australia's Gambling Industries*, Report No. 10, AusInfo, Canberra (C.15)

Although it is difficult to compare the number of problem gamblers in South Australia with the numbers receiving treatment, it is clear that there is a major disparity, and that at any given time, the vast majority of people affected will be outside the Break Even service system.

3.4 Help seeking behaviour

It is generally agreed that a significant proportion of problem gamblers are unlikely or reluctant to seek help.

There is a small body of research which has investigated this phenomena. Whilst identified reasons include the design of services and the way they are delivered, most relate to the psychology of the problem gambler and the stigma attached to the problem. Hodgins and El-Guebaly (2000) found that the most common reason for not seeking treatment was people's desire to handle the problem on their own. Other factors included embarrassment/pride, stigma, and the inability to share problems.

The reluctant help-seeking of problem gamblers is a factor that must be taken into consideration in the planning and delivery of services. There are indications that problem gamblers can be motivated to seek assistance. For example, the South Australian state-wide community education campaigns in 2003 resulted in a 100% increase in calls to the Gambling Helpline and increased referrals to Break Even services. Breaking down barriers to service take-up will include ensuring good coverage of community education and information, and providing help to people in a variety of accessible, non-stigmatising forms and modalities to assist them resolve their problems.

3.5 Is Problem Gambling on the increase?

Evidence from prevalence surveys to date have generally supported the correlation between the expansion of the gambling industry and the increasing incidence of problem gambling. Gambling Expansion and Exposure theory (Korn,2003), postulates that increased gambling venues and opportunities will result in increased expenditure and numbers of gamblers, which will result in turn in an increased number of problem gamblers.

This is not to suggest that problem gambling has increased in all forms of gambling activity at the same rate. It could quite reasonably be suggested that as some forms of gambling diminish in popularity, problem gambling within that form might also diminish. It is obvious too that some forms of gambling are more universal and/or perhaps more addictive than others (for example, gaming machines), and as a result, may lead to higher rates of problem gambling within that form.

There is considerable evidence to support the view that the prevalence of problem gambling has increased in most Australian states over the last decade. Trying to predict or 'crystal ball' future trends is, however, more difficult. The factors which influence problem gambling are too multiple and complex to predict, and knowledge in this area is too embryonic. Government policy, industry practice, social conditions and trends and future development in modes of gambling, will all play a part. What is clear is that the problematic aspect of gambling is unlikely to quickly disappear, and that a sustained and ongoing service response is required. There is also no evidence at this stage that

different emerging forms of gambling (eg internet) will require different forms of intervention, although this must be closely monitored.

3.6 Key points and findings

Gambling in South Australia

1. Gambling is now a popular and common activity amongst South Australians. Approximately 75% of South Australians participate in one or more forms of gambling.
2. The introduction of gaming machines and casinos has substantially increased gambling participation. Most gambling expenditure in SA is now on gaming machines.
3. It is anticipated that the South Australian government will collect \$405.1 million (14% of total state-generated revenue) in gambling taxes in 2004-5.
4. It is conservatively estimated that 2% of South Australian adults have a serious gambling problem, equating to 22,000 people in 2001. It is also estimated that 5 to 10 people are adversely affected by the behaviour of each problem gambler, and that problem gamblers account for about one third of gambling expenditure. Problem gambling is a serious social issue affecting many South Australians.
5. Serious gambling problems have adverse impacts on the social, financial and health situations of problem gamblers and those around them. This impact varies in degree and includes high rates of suicide contemplation, relationship breakdown, housing difficulties, financial problems and reduced productivity in work and study.
6. Certain people and populations have a heightened risk of problematic gambling, including people with mental health problems (including depression), people who are socially isolated, people with cognition problems, people in crisis/difficulties in other areas of their lives, and people with other co-morbidities or complex situations (eg other addictions, homeless). There also appears to be higher risk for some cultural groups.
7. Many problem gamblers are reluctant to seek help.
8. There is considerable evidence to support the view that problem gambling has risen over the last decade. It is difficult, however, to predict future trends. There is no evidence at this stage that different emerging forms of gambling (eg internet) will require different forms of intervention, however this must be closely monitored.

Key finding 1: Given the impact and costs of gambling, there is a clear need for a ongoing service response to assist people adversely affected by problem gambling and prevent harm to those at risk.

Key finding 2: Early intervention, community education, prevention and intervention services should be available on a population-wide basis, but also targeted to vulnerable populations.

Key finding 3: Increasing service-take up and ensuring assistance is available to people through a range of modalities and forms, should be key goals.

4. THE GAMBLERS REHABILITATION FUND

Governmental responsibilities with regards to gambling are currently spread across a number of portfolios. Under the Minister for Gambling, the gambling portfolio is comprised of the Independent Gambling Authority (IGA), the Liquor and Gambling Commissioner (LGC) and the Gambling Policy Section in the Department of Treasury and Finance. The IGA and the LGC are established under statute. The IGA has a legislative mandate for research into gambling and the development of initiatives to reduce the harm caused by problem gambling. The Minister for Gambling is the South Australian representative on the Ministerial Council on Gambling (MCG).

The Minister for Families and Communities is responsible for the administration of the GRF and the funding and delivery of problem gambling services. The Minister for Families and Communities represents the Community Services Ministers on the Ministerial Council on Gambling.

The Treasurer is responsible for gambling tax policy and the Minister for Education and Children's Services holds responsibility for the development of gambling education programs in schools.

4.1 An Overview of the Gamblers Rehabilitation Fund

4.1.1 Operation and Structure of the Fund

Following the introduction of gaming machines into South Australia in 1994, the Government announced the creation of the Gamblers Rehabilitation Fund as a result of an agreement between the government and representatives of the hotel and club industry. The fund has since been promoted as a joint initiative between the South Australian Government, the Australian Hotels Association (AHA) and the Licensed Clubs Association (LCA).

The Fund comprises contributions from the government of South Australia, the Australian Hotels Industry and the Licensed Clubs Association. More recently Sky City Casino has become a contributor. The industry groups (barring the Casino) contribute their portion of the funds via the Independent Gaming Corporation to the Department of Treasury and Finance where it is paid into the consolidated revenue of the South Australian government.

Essentially, the recurrent GRF income for 2003/2004 was \$3.3m (Table 5). Funds available to the GRF vary from year to year depending on factors such as interest accruals, one-off allocations, minor unspent funds and so on.

Table 5: GRF Income – 2003/04

Industry Contribution	\$
Hotels and Clubs via the IGA	1.5 M
Government Contribution	1.8M
Total	3.3M

Recently there has been some uncertainty about the continuation of the voluntary contribution provided by industry, which has affected capacity for strategic planning. The capacity of the Fund has also been under pressure. Since inception there has been little real growth in the Fund and this growth has been mostly absorbed by the requirement for indexation and major new directions of the government (such as the media campaign). Indexation was only recently acquired (2004/05), and then only for the government portion of the funding. Currently, some key functions (notably the state-wide community education campaign) are funded with minimal recurrent funds and are dependent on one-offs or allocations of unspent monies to provide viable service levels. In the 2004-05 State Budget the Government committed to increase GRF funding by a further \$350,000 per annum to support counsellors in major venues.

Quality longer term strategic planning has been difficult to achieve in the GRF program. This has had negative flow-on effects. Strategically, there is a need for clear directions for the Fund and more effective cross-system planning. At the program planning level, the longer term goals and targets of the GRF program are unclear while at the service delivery level, Break Even agencies report difficulties managing an above-average turnover of agency staff.

The Terms of Reference for the GRF Committee state that its role is:

‘to provide the Minister for Families and Communities with broad funding recommendations in relation to the Gamblers Rehabilitation Fund, and expert and strategic advice on harm minimisation strategies. In particular, the Committee advises on rehabilitation and support services for those in the community affected by problem gambling, and on prevention measures aimed at the whole community’. (GRF Terms of Reference).

The Committee includes representatives from up to twelve parties including major funding stakeholders (the Australian Hotels Association (SA), Clubs SA and Sky City); a representative from the Australian Medical Association and the Law Society of South Australia; and representatives of the Heads of Churches Task Force on Gambling, the South Australian Council of Social Services, the Minister for Gambling, Families and Communities and the Department of Education. One place on the Committee exists for an individual with expertise in addictions and problem gambling.

The Committee is strong in its representation from industry and specific interest groups. Consideration could be given, however, to the capacity of the GRF with regards to expert advice on problem gambling, service development and delivery, community education and prevention, especially with regards to the

needs of specific population groups (eg Aboriginal, culturally and linguistically diverse) and areas of focus (eg mental health).

4.1.2 Allocation of Funding

GRF recurrent budget for 2003/04 totalled around \$3.3 million. In addition, one-off amounts were allocated to enable a state-wide community education campaign and a grants program. Of the recurrent \$3.3 million, approximately 72% was spent on the Break Even service system, 12.4% on other consumer services and 15.6% on program development, training and support services (Table 6). It should be noted that some expenditure crosses over these categories. For example, approximately \$15,000 to \$20,000 was allocated from the program co-ordination and administration budget line to cover costs associated with Break Even staff travel and other Break Even network support costs.

Table 6: Allocation of GRF funds to Break Even Services and Other – 2003/04

	Recurrent \$	% of recurrent	One-off \$
Break Even Services			
Metropolitan services	971,600	29.4%	
Rural services	532,900	16.1%	
State-wide Specialist services	873,500	26.4%	
Total	2,378,000	71.9%	
Other Consumer Services			
One –off Grants			150,000
S A Health Promotion – Community Education	410,000	12.4%	
One off media expenses			500,000
Total	410,000	12.4%	
Program Development & Support Services			
GRF Committee	10,000	.3%	
Workforce Training & Network Coordination	155,500	4.7%	
Data Management	30,000	.9%	
Program Administration	107,000	3.2%	
Research, development & evaluation	220,000	6.6%	
Total	517,500	15.6%	
Grand Total	3,305,500	100%	650,000

The Department for Families and Communities provides a range of supports for which it does not recoup costs from the GRF. This includes infrastructure and personnel costs (for example, office accommodation and equipment, staff on-costs, and staff allocations of time including at administrative, management and executive level.) This contribution has not been costed, but would be considerable.

Allocation of GRF funding can also be examined from the perspective of the functions within the program (Table 7). Estimates, however, are only approximate given that functions are spread across a number of agencies and service units (for example, Break Even agencies undertake some community education, in addition to that performed by Health Promotion SA).

Table 7: Estimated allocation of recurrent GRF \$ by program function – 2003/04

Functions	\$	% of total funding
Counselling & Treatment services*	1,355,110	41.0 %
Community Education services**	1,272,890	38.5 %
Gambling Helpline	160,000	4.84%
Program Development and Support services	507,500	15.35%
Miscellaneous	10,000	0.30%
Total	3,305,500	99.99%

* Calculated using relevant proportions of allocated Break Even service activity time for rehabilitative counselling and treatment services as stipulated in Break Even service contracts

** Calculated using relevant proportions of allocated Break Even service activity time for Community Education as stipulated in Break Even service contracts and recurrent budget for State-wide Community education

The allocation and distribution of GRF resources was originally guided by a Funding and Allocation Policy developed in 1995. This determined criteria, functions, target groups and the operational model for the program and is still the basis of the current system. The original model proposed that:

- 13% of funds be allocated to program development and support functions
- 17% to prevention services
- 17% to family support and
- 53% to direct intervention.

The Funding Policy was formulated around regional and state-wide specialist services. Whilst the allocation to program development and support functions have changed only marginally since the original Policy, proportions spent on consumer services have changed significantly, notably with increased allocation to community education services (38.5% in 03/04). It must be emphasised, however, that the original Funding Policy was developed very quickly, was based on a 'guesstimate', and there was little actual costing of likely components (notably community education) or a strong sense of what was required.

Table 8 summarises recurrent funding in 2003-04 against service types as indicated in the Funding Policy.

Table 8: Estimated Expenditure by Break Even agency – 2003/04

AGENCY	GEOGRAPHIC AREA	FUNDING (2003-2004)
<i>Metropolitan Services</i>		
UnitingCare Wesley - Adelaide	Southern Metro	\$250,300
Anglicare SA	Northern Metro	\$250,300
Salvation Army	Western Metro	\$113,200
Uniting Care Wesley - Bowden	Western Metro	\$107,500
Relationships Australia	Central & Eastern Metro	\$250,300
<i>Rural services</i>		
CentaCare - Whyalla	Whyalla-Eyre Peninsula incl. .Pt. Augusta, Pt. Lincoln, Ceduna, Cooper Pedy & remote areas	\$212,300
Lifeline - Mt Gambier	South East Country region	\$110,200
Uniting Care Wesley – Port Pirie	Port Pirie, mid-north and Yorke Peninsula	\$110,200
Relationships Australia – Riverland & Murraylands	Riverland & Murraylands incl. Murray Bridge	\$100,200
<i>State-wide Specialist Services</i>		
Flinders Medical Centre	State-wide	\$209,800
Nunkuwarn Yunti	State-wide	\$169,200
Overseas Chinese Association	State-wide with emphasis on Metro	\$59,900
Vietnamese Community in Australia	State-wide with emphasis on Metro	\$59,900
Cambodian Australia Association	State-wide with emphasis on Metro	\$59,900
Culturally and Linguistically Diverse Communities Service - PEACE (Relationships Australia)	State-wide	\$154,800
Gambling Helpline	State-wide	\$160,000

The Funding Policy recommended an equitable division of funding between regions, and this model still applies. There is a strong case, however, for the regional allocation model to be reviewed with regards to its robustness and validity, and consideration given to developing a new formula which takes into account factors such as:

- Population size and profile
- Socio-economic indicators
- Number of gaming machines in the region
- Total gambling expenditure in the region
- Existing service demand.

(Available data indicates considerable difference in regional service output, including between agencies that receive similar amounts of funding.)

It should be noted that recent work by the University of Adelaide (2003) continues to suggest that indicators of social and economic disadvantage are moderately associated with gambling-related losses, suggesting that people

from less advantaged areas are more likely to spend more on electronic gaming machines.

4.2 GRF Services and functions

Services and functions funded by the GRF can be categorised into the Break Even service system; other consumer services; and program support services. Each are discussed in turn below.

4.2.1 The Break Even Service System

Fourteen agencies make up the Break Even gambling service system in South Australia. The primary business of this service system is to deliver a variety of counselling, treatment and community education services across the state. Break Even agencies work from 23 worksites. In general, clients attend one of these worksites for services, although some agencies offer outreach to a small number of other sites such as community centres. Occasionally, staff meet clients elsewhere, especially in country areas where significant distances may need to be covered by client and counsellor.

The metropolitan and rural services are often referred to as mainstream services in reference to the fact that they are funded to provide services broadly to any member of the community affected by problem gambling. There are five metropolitan and four rural services, each sector working from eight worksites.

The state-wide specialist agencies are those funded to deliver services to sub-groups within the general population, such as culturally and linguistically diverse groups and the indigenous population. There are seven specialist agencies working from seven worksites. Departmental service agreements with specialist agencies recognise that some of these agencies will not be able to provide a true geographical state-wide service and anecdotal information highlights the city-centric nature of many of these services.

There are currently three specialist services targeting Asian populations, one multi-cultural service and one targeting the indigenous population. These groups are given special attention because of their recognised poor access to mainstream services and also often increased risk of problem gambling.

The Intensive Therapy Service for Problem Gamblers (Flinders Medical Centre) is a state-wide specialist service providing specialist cognitive behavioural treatment to people with chronic gambling problems. Also in the state-wide specialist category is the Gambling Helpline, offering a 24-hour telephone counselling, information and referral service.

All but two of the Break Even agencies are non-government organisations, with the exceptions being the Flinders Medical Centre program and the Gambling Helpline (DASC). The NGOs all have a history of delivering a range of welfare services and Break Even services are located in worksites which also deliver a

variety of other human services. Seven of the NGOs have links to church organisations.

The Break Even service system offers free services to any problem gambler who seeks help. Free services are an important element, with recent research indicating cost as one of the factors of significant concern (and a potential barrier) to people with gambling problems seeking treatment (Rockloff and Schofield, 2004).

Major services delivered by regional services

Service agreements stipulate that at least 80% of metropolitan and 60% of rural services funding is allocated for counselling and treatment services. During interview, agencies estimated they spent more time delivering counselling and treatment services than their contracts propose:

- Four of the five metropolitan agencies estimated that between 85% and 95% of their service activity time is spent on counselling and treatment services.
- Three of the five rural services estimated that they spent between 70% and 85% of their time delivering counselling and treatment services.

Counselling and treatment services are delivered to both problem gamblers and people affected by the gambling of others. Services are delivered to individuals and families, with some agencies also running groups. Just what is offered as a service varies between agencies and worksites and is often linked with other services the agency provides (eg financial counselling).

Many agencies reported increasing difficulty in delivering or accessing financial counselling services due to the lack of accredited training in this area. This is of considerable concern, given that people who present to agencies for assistance invariably do so with problems and needs related to both their problem gambling behaviour and the consequences that uncontrolled behaviour has had on their finances, relationships, accommodation etc.

Service models

Break Even Counsellors utilise a variety of therapeutic and/or treatment interventions. A number of factors should influence a counsellor's determination of the most suitable intervention approach to take with a client. These include the assessment of the aetiology of the client's problem; consideration about the strengths and weaknesses of any given approach; assessment of the intervention the client might be able to tolerate and practical considerations (eg how far the client can travel to attend counselling and/or treatment.) The intervention therapies and approaches Break Even counsellors indicated they utilise include:

- Family therapy
- Cognitive behavioural therapy
- Narrative therapy
- Motivational counselling
- Relationship counselling

- Grief counselling
- Rational-emotive theory
- Behavioural therapies (stress management and relaxation training, image desensitisation, money control strategies)
- Energy field therapy
- Feminist theory
- Decisional counselling
- Couples therapy
- Art therapy
- Micro-skills theory
- Social skills training

The above is not an exhaustive list of all interventions identified by Break Even counsellors, nor are all these types utilised at all worksites. It was not possible in this review to assess what the agencies meant by the identified approaches, how they utilise them or, of course, their efficacy. It must be said, however, that some of the identified modalities are more evidence-based, robust and relevant than others, some are not models but rather forms of practice or approaches, and some raise concerns about quality and standards.

In the majority of cases these interventions form part of a broader problem-solving framework (varying somewhat between agencies) but usually including assessment, goal setting with the client, and follow up as to how the intervention is working.

Specialist cultural services

Although small, the Break Even service system is quite impressive in its ability to engage different ethnic and cultural groups. It is hard to imagine that awareness about problem gambling could have been effectively spread amongst these communities without the involvement of the existing specialist organisations. This is not to suggest that all ethnic and cultural groups receive an equal amount of service, but this is inevitable given the range and diversity of ethnic communities and the limited funding available. The performance of the GRF program in this regard is a significant achievement. As gaps come to the fore, it may be possible to fine-tune the existing response to provide additional or other services.

Most services in this sector are funded primarily to work with targeted communities through community education and development. Agencies contracted to deliver services to Asian groups estimated they spend 40 to 55% of their time delivering counselling, whilst both Nunkawarrin Yunti and the Multicultural Service (PEACE) indicated the majority of their work was community education/community development. Agencies could not always clearly specify what they meant by these terms, however.

Although at different stages of development, some specialist programs appear to be more productive than others in their delivery of services. There is a clear need for ongoing support and development within this sector, and continuing development of interventions and strategies. In this regard, information-sharing and mutual support between these agencies would be beneficial, for example

opportunities for staff to meet and exchange information about how they work and what they do.

In practise, linking of culturally diverse clients into mainstream counselling services is often difficult to achieve (although some agencies cited a few examples of where this had occurred.) Thus, specialist agencies are providing more counselling than originally envisaged. It is important that counsellors in these services are appropriately trained and supported (not always the case at present).

The agency contracted to work with the indigenous population (Nunkawarrin Yunti) has a particularly challenging task: with limited resources, reaching a scattered and culturally diverse population amongst whom there is a high incidence of other social and health problems. The viability of this model (ie one state-wide service) is questionable, and this should be a priority area for development in the next funding period. Within a strategic planning context, consideration could be given to other models and options for delivering problem gambling services to Aboriginal communities, and also to increasing the allocation to Aboriginal services.

Other specialist services

Gambling help-lines are now established in every state of Australia. In South Australia, the service operates as a 24 hour, 7 day per week information and referral service. Its phone number enjoys a high recognition rate (it is the main number promoted through the media campaign). In mid 2004, the Helpline was receiving between 500 and 600 calls per month with around 30-40% of these prank calls.

In some jurisdictions and countries (eg. New Zealand), gambling help-lines are being further developed to provide a more comprehensive range of call centre services, including telephone counselling, direct link up with service providers, follow up calls and so on. Enhanced Call Centre options should be considered for South Australia.

The Flinders Medical Centre's Intensive Therapy Service for Problem Gamblers is funded primarily to provide in-patient and out-patient treatment in the form of cognitive-behavioural therapy. This is a method widely recognised for its effectiveness. This agency estimated that 80% of its service activity time is spent delivering treatment services with the remaining time spent on community education and training of other service providers in CBT techniques and related areas (such as mental health issues).

Access and availability

It has already been noted that many problem gamblers are reluctant help-seekers. Service take-up, however, can be improved or inhibited, and will be influenced by a range of factors which include:

- knowledge
- motivation
- geographical proximity

- service availability
- cultural appropriateness and
- service appeal and image.

The service system should have the necessary capacity and also diversity to maximise consumer choice and options. This, however, is a significant challenge for a system as small as Break Even.

Geographically, the service system strains to cover the state. Twenty three worksites in most of the major centres is good coverage for a relatively small workforce, but there are inevitably locations that are 'missing out' or poorly serviced. Coober Pedy is an example in point, where community leaders have recently commented in the media on the increasing negative impact of gaming machines. It does not appear, however, that Break Even services are provided in this town.

Consideration should be given to strategies to improve state-wide reach. Options include increased funding; the use of technology (eg telephone and tele-conferencing, internet-based self-help resources) and targeted strategies to build the capacity of other professionals to identify and respond to problem gambling in rural and remote locations.

Although metropolitan regions are geographically smaller than country regions, they still cover large areas with few staff. The Southern metropolitan region, for example, stretches out to Victor Harbor and the northern region well past Gawler.

Service system diversity is another important element in access. Although metropolitan services are regionally based, it is important clients are able to choose and access whichever agency they wish. Welfare or church-based NGOs, for example, will not be the agency of first choice for some people, but will be for others. Service planning and funding should therefore seek to achieve a variety in types of providers and models in the metropolitan area. In this, it is important to retain a specialist treatment capacity in a mainstream health agency that can offer inpatient facilities.

Access is also influenced by service availability: ideally, a service should be provided promptly to clients at a time and location that suits. Without measures that can monitor unmet demand or feedback from consumers who did not keep appointments, it is not possible to fairly comment on how well the current service system performs in this regard. It is clear that agencies are very sensitive of the need to provide a responsive and prompt service. A number of agencies indicated they experienced some difficulties, however, in being able to provide services out of normal business hours as often as might be desired. Generally, agencies reported that they did not have waiting lists.

Appropriate systems should be explored to maximise service availability. Options include an expanded role for the existing Gambling Helpline Call Centre. Call Centres can and are being used in other industries to assess aspects of client need and to set up initial appointments. They can provide

crisis counselling and maintain engagement of a client with the service system until face-to-face contact can be made, and they can be used to follow up client progress after treatment.

Vulnerable populations

The impact of problem gambling on vulnerable populations is a major issue of concern. From a range of sources, particular concerns have been identified about certain population groups, including:

- people with mental health problems
- people with intellectual disability
- the socially isolated
- prisoners
- the homeless
- youth
- Aboriginal people

Engaging such populations is a considerable challenge. Although many service providers were able to give some examples of relevant initiatives, many examples were also provided of the difficulties such exercises involved. Overall, consultation suggests that this is not currently a major feature of work. To some extent, the Grants program has enabled a number of focused service responses to vulnerable groups. However, responses must be sustained and built into normal service delivery across the areas of community education, early intervention and treatment, rather than conducted as one-off initiatives.

It is proposed that these target groups be considered as priority population groups for the next funding period. A consultative planning exercise with problem gambling and other sectors would add value in determining viable strategies in engaging and servicing these populations. Again, targeted strategies to build capacity in agencies working directly with these populations should be considered. Problem gambling counselling is not so unique that it cannot be provided by other relevant human service professionals, given appropriate training.

Workforce

The size and nature of a workforce is an important factor to consider in the design and performance of a state-wide gambling rehabilitation service system. To be able to do their jobs competently, staff need to have appropriate skills, knowledge and motivation. Performance on the job can be significantly impacted by factors such as whether staff feel their work is valued and the level and type of support workers receive in their job. Appropriate remuneration is also an important consideration.

When surveyed during May 2004, Break Even agencies reported an overall workforce totalling 34.2 FTEs. This was comprised of 15.8 FTEs in the metropolitan sector, 6 FTEs in the Country sector and 12.4 FTEs in the state-wide sector. This figure includes vacancies that agencies held at that time.

A number of key work-force issues emerged in the conduct of the review.

- *A thinly spread workforce:* The size of the work groups at the 23 worksites across SA ranged from 0.2 to 4.5 FTEs, with 9 worksites of up to 1 FTE. Most of the smaller worksites are in country locations or in the specialist cultural services. Thus, many workers are relatively isolated, and may be the only one in their agency 'doing gambling business'. This is far from ideal and has significant implications for staff support, program development and training.
- *Gender imbalance:* The significant majority of the Break Even workforce is female. However, prevalence data indicates that problem gambling tends to be slightly more prevalent amongst males than females. It is not clear what significance this gender imbalance would play in attracting and retaining male problem gamblers in counselling and treatment but there is increasing recognition in human services that gender-specific responses make sense, especially around issues where clients are difficult to engage.
- *Qualifications:* Nearly all workers were reported to have qualifications at degree level or higher in relevant human service areas.
- *Remuneration* for Break Even staff is significantly lower than what a private therapist (eg psychologist) would expect, which may limit capacity to attract and retain staff.
- *Certainty:* A number of agencies reported that the funding structure of the GRF has resulted in an increased number of short-term staff contracts which negatively impacts on staff retention and certainty of service.

In consultation, agencies expressed considerable dissatisfaction with current workforce training and support arrangements. A contract is currently being let to develop a Workforce Training Plan for the sector. This is urgently needed and must be clearly focused to address the considerable challenges for this workforce. The effectiveness of this Plan should be closely monitored.

4.2.2 Other Consumer Services

Community Education: Health Promotion SA

Community education (aiming at maximising community awareness in relation to problem gambling and promoting a harm minimisation approach) has been recognised as a vital component of the service response since the commencement of the GRF. Initially the then Department for Families and Communities contracted out tasks to various consultants. Since 1999, however, the GRF has contracted Health Promotion SA (now in the Department for Health) to undertake the state-wide community education program

During 2003, Health Promotion SA ran a TV, radio and press campaign in the mass media over a 12 month period. The mass media campaigns are largely

designed to reach the broad section of the population who watch TV, read the commercial papers or listen to radio. The phone number for the Gambling Helpline is always advertised. Health Monitor reports (February 2004) indicate that of 2012 South Australians surveyed in late 2003, 92% were aware of the Gambling Help Line. Printed materials such as A4 size posters and wallet-size cards with the contact details of Break Even services were also developed and sent out to all hotels, clubs and General Practitioners. A multi-cultural campaign commenced in November 2003 with contact details of Break Even agencies advertised on relevant ethnic radio programs in 11 languages and in print in 5 ethnic newspapers. Health Promotion SA develop and distribute a variety of other resource materials including a self help booklet, comics with gambling stories, fridge magnets and help line cards designed to be displayed near poker machines. This material has been voluntarily used by Hotels and Clubs and since 2004 the new gambling codes have made the display of material such as these a regulatory requirement.

Evidence from both South Australia and interstate indicates that state-wide community education campaigns increase help-seeking from problem gamblers. In the period following the TV campaign in mid-2003, calls to the Gambling Helpline doubled and Break Even agencies reported increased demand and attendance, with many agencies having to establish waiting lists. It is important to note, however, that there is not an adequate budget to pursue further mass media campaigns.

Consideration should therefore be given to an increased recurrent allocation to community education to support on-going mass-media campaigns. Targeted community education strategies are also needed for priority population groups who are unlikely to be reached by mainstream campaigns; and to support ongoing targeting of gamblers in venues. At the national level, a proposal is currently being developed for jurisdictions to share community education resources. This would be a considerable advantage to small states such as SA (SA has already benefited from Victoria granting this state the use of its mass-media campaign, without cost).

Community education is a specialist function and far more than just the development of advertisements and campaigns. The location of the funding in Health Promotion SA has brought a significant 'adding of value', in terms of expertise, planning, philosophy, a concerted approach, and additional (unfunded) management and administrative support, and is preferable to the contracting out model which operated previously. Consideration needs to be given to whether this function remains in Health Promotion following the split of the Departments

Grants

A regular submission based grants program is also administered, allowing for the funding of special projects conducted by Break Even and other interested agencies. During 2003-04, \$150,000 was allocated to one-off grants. This program has a number of benefits and supports innovation and service development. Funded projects are, however, at risk of not being sustained in the longer term.

4.2.3 GRF Program Support Services

GRF funds are dispersed on a range of program support and development functions, summarised below.

Administration, executive support and contract management

There are currently three gambling project officers (one with team leader functions), located within the Community Services and Development Team in the Community Services Branch of DFC, reporting to a Manager who has a range of other responsibilities and functions. (Until recently, the gambling program was located in the Drug Strategies unit of the Department of Human Services/Department of Health).

As identified in Table 6, 3.2% of the GRF is currently allocated to administration, executive support and contract management functions within the DFC. This is supplemented by uncosted contributions from the DFC in terms of salaries, on-costs, infrastructure and support. Two FTEs are assigned to these functions (the third FTE equivalent is assigned to network support and development, discussed below), with responsibilities including:

- Ministerial and Departmental support, advice, correspondence and coordination with regards to problem gambling
- Cross-government liaison
- Program funding, accountability, monitoring, contracting and budgets
- Executive support to the GRF
- Development and planning
- Negotiations with industry and other key stake-holders
- Liaison with other sectors, services and groups (eg self-help)

It must be said that 3.2% is quite a low allocation for administration, particularly given the range of functions that are required. There is no evidence or indication that this is an excessive amount, or that it has grown over the life of the Fund.

It was clear in the conduct of this Review that there are a number of issues in the current arrangements. Notable amongst these is the extent to which the current arrangements, with their associated demands, place pressure on the program leader, to an almost unsustainable degree. It was also clear that this program leader has been required to undertake responsibilities and roles which are beyond their current classification level. Further, the current arrangements do not necessary support strategic leadership of the GRF and the government's

policy agenda, departmental and cross-government coordination, or ensure optimal advice and program administration. It is therefore timely to reconsider this current configuration with regard to its capacity to deliver the outcomes desired by the Government and GRF.

Training, coordination and network support

In the initial Funding Policy, state-wide coordination was conceived as a means of developing communication networks, staff training and needs assessment. A tender was awarded to the then Field Services Division of the former Department for Family and Community Services to undertake this role, with major functions being:

- Establishment of communication networks across service delivery and other relevant organisations
- Liaison with other relevant bodies involved in the field
- Provision of advice regarding key rehabilitation directions and strategies for gambling and
- Coordination of training for field workers.

In 1999 a decision was made by the GRF Advisory Committee that this position was no longer required. Following representation from the sector, the function was re-instated in 2001.

Currently, \$155,500 (4.7% of the fund) is allocated to this function. Of this, \$57,000 is salary costs; the remainder is allocated to training, travel, the gambling library (located at DASC) and meeting costs etc for Break Even members. This allocation is supplemented by DFC, who pay staff on-costs as well as infrastructure and administrative components.

There is strong support in the sector for these functions to continue, and it is clear a focus on sector development and communication is required (especially given the small, scattered nature of this workforce). The sector, however, has recently advocated for the function to be placed outside of government, where they can have greater 'ownership'. Whether this would improve the efficacy of the position is debatable. Additional costs would also be incurred (the position is not fully funded).

As a first step, in consultation with stake-holders, the roles and activities which are required with regards to this function should be specified and prioritised. These may range from administrative roles (arrangements for travel and meetings); to capacity building (supporting expertise and innovation across agencies); to coordinating advice to government on behalf of the network and building capacity in other sectors. Options for discharging these functions could then be considered and should include greater flexibility and dispersal of functions as appropriate (not necessarily devolving all functions onto one officer.) Some elements of the role clearly sit within government as administrator of the Fund and budget; however some more 'peak body' functions (providing coordinated advice from the Network to government, for example) may best be undertaken by funding this capacity outside of government on a needs basis.

Research and Evaluation

Since the inception of the GRF and its national equivalents, there has been strong consensus that a quantum of funds should be quarantined for research, evaluation and development. This has been a very important allocation given that:

- the service system is still developmental
- problem gambling is a relatively new social problem
- treatment methodologies are still relatively experimental.

Currently \$220,000 per annum (6.6% of the Fund) is allocated to these functions.

Over recent years this allocation has been directed towards a salary component (.8 FTE since July 2004, in the Research, Analysis and Evaluation Unit of DFC), plus funds for research and evaluation studies. Over the recent years, major activities have included the 2001 prevalence study and assistance in the development of a new data set.

In 2002 a new Gambling Research Agenda was developed with priorities and briefs for research identified. However, this Agenda was not approved due to uncertainty about the role of the GRF in research, particularly given the mandate of the newly-established Independent Gaming Authority. Consequently, proposals did not proceed and allocated money was not expended.

Over the last 12 months, however, activity in this area has increased, supported by the move to the new portfolio of Families and Communities. In the new arrangements the staffing allocation has been used to directly undertake research, analysis and evaluation activities (as opposed to support or oversee) and it is believed this will improve 'value for money'. Thus:

- An Australian-first research study into the link between gambling and homelessness has been undertaken
- This review was undertaken, including an examination of community education activities in Break Even services
- In partnership with Flinders University, an Australian Research Council Grant was obtained for a three year study on gambling and homelessness
- A cognitive-behavioural therapy technique manual was produced
- A new round of graduate gambling scholarships were prepared and advertised
- The Health Monitor survey was funded to include gambling-related questions

- An annual data report is being prepared (by the Gambling Research Officer) for publication
- A consultant has been appointed to analyse a range of gambling-related data.

There is a clear need, however, to clarify the purpose and focus of this allocation, and to develop and implement a plan and process for the allocation of funds and the conduct of studies.

Data Management

Since 2001, \$30,000 from the Fund (.9%) has been allocated to Data Management (enhanced at times with one-offs for system enhancements). The Information Management Services in the Department of Health currently has the contract for this service, which must be undertaken within government. Data system management and reporting is an essential component of a program, and the allocation for this function is certainly modest.

4.3 Key points and findings

Operation and structure of the fund

1. The GRF, established in 1994 and directed at the prevention and treatment of problem gambling, has a recurrent income of \$3.3 million, the bulk of which (\$1.8 million) is a government contribution and the remainder (\$1.5 million) a voluntary contribution from industry.
2. Since inception there has been little real growth in the Fund and this has been mostly absorbed by the requirement for indexation and major new directions of the government (such as the media campaign). Indexation has only recently been applied to the Fund, and then only to the government contributions.
3. There is a level of insecurity in the Fund, with some key functions (eg state-wide community education campaigns) without an adequate funding base, and also some uncertainty with regards to industry contributions. This affects capacity for forward planning.
4. Quality long-term strategic planning has been difficult to achieve in the GRF and there is currently no long term strategic plan to guide development. This affects the capacity of the Fund.

Key Finding 4: A comprehensive 3 year plan should be developed and completed by July 2005 to inform the next funding period for the GRF. This Plan should consider and address the themes, issues and priorities identified in this report.

5. In 2003-04, approximately 84% of GRF funds were spent on client or consumer services and the remaining 16% on a variety of program development and support functions.

6. The bulk of funds (72%) was allocated to the state-wide Break Even service system for counselling, treatment, community education and Helpline services.
7. Funding allocation, and the structure of the service system, is still based on the original Funding Policy developed in 1994, which recommended an equitable division of funding between regions.

Key Finding 5: The current regional allocation model should be reviewed. Any revised formula should take into account factors including population size and profile; socio-economic indicators; numbers of gaming machines, gambling expenditure and existing service demand within regions.

GRF Services

8. The Break Even service system is a small and dispersed system of 14 mostly community based, non government agencies working from 23 worksites around the state.
9. The existing model of specialist and mainstream agencies is fundamentally sound and has enabled the GRF to provide a high level of coverage across the state, as well as penetration into specific populations. This is a substantial achievement for a very small service system. The service system, however, is under considerable pressure in attempting to provide state-wide and population-specific coverage.
10. In order to encourage access to services by problem gamblers, the service system needs to have the necessary capacity and also a diversity which maximises consumer choice and options.
11. The nature of services offered and the models used varies significantly between Break Even agencies and work-sites. Some models currently in use across the sector are more evidence-based and appropriate than others.

Key Finding 6: Consideration should be given to strategies to improve the state-wide reach, the availability of, and access to problem gambling services. Options include increased funding, but also the use of technology (eg telephone and tele-conferencing; internet-based self-help resources) and targeted strategies to build the capacity of other professionals to identify and respond to problem gambling especially in rural and remote locations.

Key Finding 7: The planning and purchasing of services should seek to achieve a variety in types of providers and models, especially in the metropolitan area. Improved access to intensive service treatments across the State should also be considered. The service mix should include at least one intensive treatment service in a mainstream health agency that can offer in-patient facilities.

Key finding 8: Whilst the purchasing of services for the next funding period should support diversity in the sector, it should also purchase for clear, articulated evidence-based treatment methodologies. This could include a mix of innovative and evidence-based treatments.

Key Finding 9: Especially in the metropolitan areas, clients should be able to choose between available providers.

Key Finding 10: Continued development of the cultural-specific sector is required.

Key Finding 11: Culturally-specific services should have the capacity to deliver skilled counselling. Strategies should be considered to ensure appropriate training and skills amongst workers in these agencies.

12. There is a lack of accredited training for Financial Counsellors which is affecting capacity to access this much-needed service.

13. The state-wide Aboriginal service (Nunkawarrin Yunti) has a particularly challenging task and the effectiveness, viability and capacity of the current model is questionable.

Key Finding 12: The development of services to Aboriginal people should be a priority area in the next funding period. Consultation and assessment should occur regarding other models and options for delivering problem gambling services to Aboriginal communities, and consideration should also be given to increasing the funding allocation.

Key Finding 13: Consideration should be given to a priority focus for the next funding period on people with mental health problems and intellectual disability; the homeless; prisoners; youth and Aboriginal people. A consultative planning exercise could identify viable strategies to reach and engage these populations across the spectrum of community education, early intervention and treatment. Such strategies should be built into service delivery in sustainable ways and also evaluated.

14. The current Break Even workforce is 34.2 FTEs, with 15.8 in metropolitan services; 6 in rural services, and 12.4 in state-wide services. Nine work-sites have 1 or less FTE. The work-force is thus very thinly-spread, which has implications for staff support, development and training. The workforce is predominantly female (in contrast, the majority of problem gamblers are men). Nearly all workers have appropriate qualifications. Remuneration is reported as a key issue in attracting and retaining staff.

Key Finding 14: A strong work-force training and development strategy, and an effective network support mechanism, are important elements in a community based problem gambling service system. The Training Plan, to be developed in 2005, is urgently needed and must be clearly focused to address the considerable challenges for this workforce. Consideration should be given to appropriate levels of remuneration to encourage the employment of a skilled workforce. Consideration should also be given to accreditation for problem gambling counselling and the relevancy of the Diploma currently being developed in New South Wales.

15. Community Education is a vital and effective component of the GRF service system.
16. There are currently insufficient funds to conduct further and on-going mass-media campaigns.
17. The location of community education within Health Promotion SA has significantly added value to the community education 'investment' for the GRF. Further value will be added by a national proposal for the sharing of community education resources across jurisdictions.

Key Finding 15: If additional funding becomes available, consideration should be give to the allocation of additional funding for community education. This should be directed towards mass-media campaigns, as well as targeted responses to identified priority populations and gamblers in venues.

18. 3.2% of the fund is currently allocated to administration, executive support and contract management. This is supplemented by an in-kind DFC contribution.

Key Finding 16: The current allocation for administration, executive support and contract management is relatively modest and has not grown over the life of the Fund.

Key Finding 17: The current internal program arrangements within DFC with regards to gambling should be reviewed, with consideration given to options which support improved management, leadership and coordination, both of the GRF and problem gambling services and the government's policy agenda.

19. \$155,500 (4.7% of the Fund) is currently allocated to training, coordination and network support. \$57,000 of this is allocated to salary costs for an officer with DFC, with costs supplemented by DFC. The preference of the sector is that this position be located outside DFC.

Key Finding 18: In consultation with stake-holders, roles and activities with regards to program coordination and support should be specified and prioritised. Options for discharging these functions could then be considered with a view to introducing greater flexibility and dispersal of functions as appropriate.

20. The current allocation for research, evaluation and development is \$220,000 pa. Such an allocation is still necessary given the developmental nature of the service system; the relatively recent identification of problem gambling as a social problem, and the relatively experimental nature of treatment methodologies. This expenditure has been under-spent in recent years due to uncertainty and some conflict about the role and purpose of the allocation. An active program has, however, been pursued in the last 12 months.

Key Finding 19: An allocation for research and evaluation should be maintained.

Key Finding 20: It is proposed that the focus of the research and evaluation allocation be *problem gambling prevention, early intervention, prevalence and treatment*. It is further proposed that the purpose of this allocation should be *to support planning for problem gambling services; the provision of strategic information and analysis with regards to problem gambling in the SA community and the improvement of services and methodologies*. The major components of the expenditure should therefore be data analysis and development; review and evaluation with regard to problem gambling services and focused research and development projects. A program for this funding should be established with reference to government policy agenda, the findings of this report and the 3 year plan.

21. \$30,000 pa is currently allocated to data system management and reporting.

Key Finding 21: Data system management and reporting is an essential function in a modern service system which should be retained. The function should be within government. The current allocation is modest and its adequacy will need to be monitored over time.

5 FURTHER ANALYSIS OF SERVICES

5.1 Client data

Unfortunately, the Break Even data collection system has significant limitations in its ability to provide information about the extent and/or supply of services, as well as outcomes. Problems include:

- High levels of incomplete, missing or inaccurate data
- Little outcome data
- Inconsistencies as represented by enormous variations in data about service output from year to year and agency to agency.

Improvements were made to the Break Even data collection system during 2003 and it is hoped that data emerging in 2004 will be of better quality.

It is not possible to extract from the Break Even data collection system exact information about the number of people who are recipients of services. Clients who present for counselling services are generally “registered” by Break Even agencies when assisted. Registrations relate to a period of support which may involve one or more contacts with a worker. A registration ceases when a case is closed by a worker. However, the recording of outcome/end data in the system is so poor that it is impossible to identify when a client exits the system. In addition, not all people are registered because brief contacts can be recorded by workers as a casual contact only. A further complexity is that the total number of registrations is not equal to the number of individual clients seen by a Break Even service, as clients may be registered on more than one occasion during the course of a year. (From the limited data that can be reported on, this does not seem to occur very often, although it seems more clients will seek repeat services over the course of a number of years.)

In addition, agencies will ‘carry-over’ some clients from the previous year, which again is not visible in the data. Thus, the total number of clients seen in a given year will include clients continuing from the previous 12 months, plus new clients, but this figure cannot be calculated. Consultation with services, however, indicates that the period of support is usually relatively brief and the majority of clients are seen and discharged within the same year.

The Break Even data reports 2324 new registrations during 2003, comprising 1717 problem gamblers and 607 non gamblers. A rough estimate can be made of how many individuals these registrations might represent as the data allows for an encrypted code to be attached to all clients who provide consent. A total of 1002 registrations had this code attached in 2003. Of these, only 12 were registered twice in that year and one was registered three times. This suggests a small number of repeat clients; however precise figures cannot be provided.

Table 9 (below) outlines the number of registrations recorded over the last four years. As can be seen, the total number of registrations per year are relatively consistent: around 2,000 annually, with about 25% of these being non-gamblers.

Whilst any comment about the number of clients engaged by Break Even services in counselling can at best only be a guess-estimate, data suggests an absolute maximum of 3,000 clients per annum (based on new registrations plus a generous estimate of 50% of clients from the previous year carrying over into the next year) with 20-25% of these being non gamblers. Despite this generous estimate, it is still clear from this that the Break Even service system only treats a small percentage of potential clients (suggested by prevalence estimates to be approximately 22,000 problem gamblers in South Australia, with an estimate of 5–10 people affected by the behaviour of each).

Whilst the supply of counselling and treatment services meets only a small amount of potential demand for such services, there is not a lot of evidence to suggest actual ongoing unmet demand which the service system is struggling to satisfy. There are inconsistent agency reports about waiting lists for example, and when interviewed in April/May 2004 most agencies reported it was not their regular practice to have a waiting list. (This is not to suggest waiting lists are the sole measure of unmet demand.)

Whilst Table 9 suggests some consistency in the overall total of reported registrations from year to year, such consistency is not as evident between agencies within sectors, and it is important to consider what this variation in the supply of counselling and treatment services may mean. Reported registrations are, after all, an important measure of service output and if agencies receive the same level of funding but report significant differences in output, further investigation may be warranted.

Table 9:GRF Registrations 2000 - 2003, Services by year and client type

Region	Agency	2000		2001		2002		2003	
		Gambler	Non-gambler	Gambler	Non-gambler	Gambler	Non-gambler	Gambler	Non-gambler
		N	N	N	N	N	N	N	N
Metropolitan Services	A	531	191	609	163	359	102	377	67
	B	232	71	235	56	169	29	146	21
	C	338	157	383	220	248	156	350	172
	D	63	72	58	77	77	77	118	97
	E	68	6	97	30	105	30	92	22
	<i>Total</i>	1,232	497	1,382	546	958	394	1,083	379
Country Services	F	6	1	20	1	80	6	56	8
	G	58	25	62	38	85	52	91	52
	H	38	9	22	1	33	6	29	6
	I	24	7	31	9	27	9	22	6
	J	27	6	20	7	25	4	34	4
	K	18	9	9	12	6	3	1	1
	<i>Total</i>	171	57	164	68	256	80	233	77
Statewide Specialist	L	114	.	96	1	82	.	84	1
	M	.	.	.	1	.	.	.	.
	N	8	2	5	.	11	2	216	18
	O	22	50	27	37	37	26	34	42
	P	14	4	10	9	31	35	25	68
	Q	41	31	30	24	.	.	35	9
	R	.	.	.	.	.	.	7	13
	<i>Total</i>	199	87	168	72	161	63	401	151
Total	1,602	641	1,714	686	1,375	537	1,717	607	

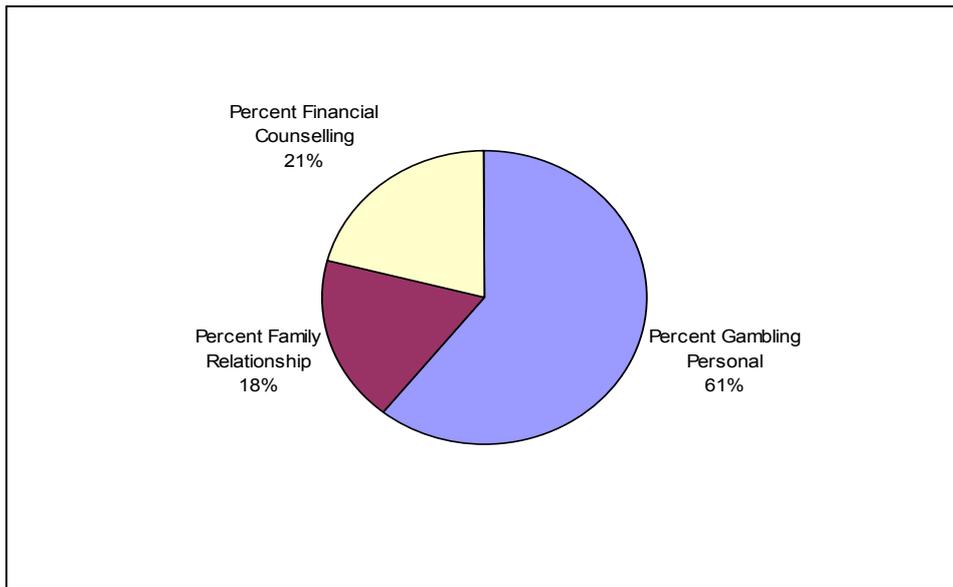
Source: BESA Data Collection

In 2003, 63% of all gambler registrations were in the metropolitan sector, 14% were in the country sector and 23% in the specialist sector.

Consultation with Break Even agencies indicates that the number of face-to-face contacts a client typically might have with a worker whilst in counselling or treatment is relatively small (ie less than ten), with the period of engagement usually under 6 months. Unfortunately, the Break Even data collection cannot provide more information about this issue.

Agencies are asked to report on the main focus of their contact with clients. On the basis of the very limited contact information the data system can provide, Figure 1 indicates that, whilst 60% of contacts were focused on counselling about personal problem gambling issues, financial and relationship counselling are important elements of the system that should be retained.

Figure 1:GRF Contacts, Percent of time on focus of intervention (%) 2003



Source: BESA Data Collection. (This figure is based on data from 2,412 contacts)

It is difficult to comment about matters such as the rate of client repeat use of counselling services. As indicated previously, many registrations are not recorded with the encrypted code necessary to track clients over time in the data system. Of the approximate 18,500 registrations that have been recorded over the life of the Break Even data collection (approximately 8 years), around 62% of registrations do not have a code. Of the remaining 37%, 86% have had one contact with the Break Even service system.

It is also not possible to make any comment about the effectiveness or efficiency of Break Even services from the data. Although the system allows for information to be collected about client outcomes and satisfaction, the information collected at client exit is so minimal that it cannot be considered valid.

In terms of efficiency, if the existing data about number of clients in the service system is accurate, the service system could not be described as particularly efficient. Given what is known about the reliability of the data, however, an assessment of efficiency is best deferred until a robust methodology is developed.

5.2 Community Education Services in Break Even agencies

One of the briefs of this review was to particularly examine community education services provided by Break Even Agencies. A full report is presented in a supplementary report.

In summary, all Break Even agencies reported undertaking community education which encompassed a wide range of activities, ranging from raising awareness of the impact of gambling and promoting Break Even services, to teaching strategies to control gambling behaviours and community development.

It is not possible to estimate how many South Australians were recipients of these services, but the data reports that agencies spent 24,348 hours (equivalent to 3246 days) on community education work in 2003. Unfortunately, the data does not accurately reflect the actual community education work done. When interviewed in May 2004, for example, most agencies said the output indicated by the data system for their agencies was an under-count of their actual work. The data system also reports very different output for agencies from one year to the next, indicating problems with the reliability and consistency of data over time.

Break Even agencies reported undertaking the following types of community education.

Break Even agencies: Community Education activities reported

Activity	Metro Services	Rural services	Specialist Services
Presentations	√	√	√
Forums	√	X	√
Training programs	√	√	√
Mailed information	√	√	X
Visits	X	√	X
Product development	X	√	√
Hand delivered information	√	√	√
Newsletters	√	√	√
Media work	√	√	√
Static displays	√	√	√
Public meetings	√	X	X
Festivals/Expos	X	X	√
Advocacy	√	X	X
Group work	X	√	√

Both metropolitan and rural sectors identified a diverse range of community groups as recipients of community education. The focus of this community education was diffuse, and it was difficult for agencies to specify significant numbers of particular target groups. This was particularly evident when it came to potential “at risk” populations such as people with mental health problems or intellectual disabilities.

As would be expected, the state-wide agencies tended to have a more narrow scope and clearer focus on their target populations.

Across the sector there was a good common understanding on the purpose of community education, although agencies in the state-wide sector displayed a broader interpretation of strategies and tools.

The most common concepts agencies used to describe the purpose of community education were:

- Raising awareness amongst the general population of the impact of problem gambling; of how gaming machines are configured and what people can expect to lose; and how to gamble safely and responsibly
- Promotion of Break Even services
- Minimising harm caused by gambling by teaching strategies for the protection of individuals and families; and teaching people how to recognise problem gambling and assess the size of their gambling activity
- Providing support to other service providers regarding identification of and response to a gambling problem.

Some of the less common community education activities agencies identified included:

- Advocating for consumers (trying to make the consumer voice heard)
- Engaging relevant communities and assisting them to think about problem gambling in their communities; working with them to devise strategies and actions to reduce the incidence of problem gambling in these communities
- Explaining the concept of counselling, what it involves and how it can assist people
- Educating people about how the gambling industry is organised
- Explaining why some people may develop unhealthy gambling habits

- Promoting and providing non-gambling forms of entertainment (to particular cultural groups)
- Providing training and support to other service providers regarding specific forms of intervention or cultural awareness.

Most agencies did not have a community education plan, and those that did reported that they often had problems 'sticking' to it.

The examination of agency-based community education suggested that there are a number of options for improvement, including:

- Clarification of the nature, type and purpose of community education to be delivered by services and the contract expectations with regards to these.
- Reducing the notional allocation in contracts for community education, especially in metropolitan areas. (Most agencies are currently doing less than their allocations allow).
- An examination of the continuing relevance of community education as the dominant mode of service delivery to specific cultural groups, given that this has now been in place for ten years; and clarification of what 'community education' means in this context.
- A coordinated approach to the delivery of community education between agencies in metropolitan Adelaide.
- Identifying 'value for money' strategies which are likely to have the highest impact (eg through gambling venues or for key population groups) and which are promoted across the system.

A Community Education plan is currently being developed: these issues should be considered in that context and in the context of the proposed 3 year plan.

5.3 The recipients of services

The Break Even data system can report to various degrees on some characteristics of the clients of treatment services through registrations data. Table 10 reports on client registrations by gender. In 2003, 54.1% of registrations were for females and 45.9% were for males.

Table 10: GRF Client registrations, Gender by service sector and gambler / non-gambler, 2003

Region		Male N	Female N	Total N
Metropolitan Services	Gambler	564	519	1,083
	Non-gambler	108	271	379
	<i>Total</i>	<i>672</i>	<i>790</i>	<i>1,462</i>
Regional Services	Gambler	112	121	233
	Non-gambler	21	56	77
	<i>Total</i>	<i>133</i>	<i>177</i>	<i>310</i>
Statewide Specialist Services	Gambler	203	198	401
	Non-gambler	59	92	151
	<i>Total</i>	<i>262</i>	<i>290</i>	<i>552</i>
Total	Gambler	879	838	1,717
	Non-gambler	188	419	607
	Total	1,067	1,257	2,324

Source: BESA Data Collection.

Table 11 indicates that well over 70% of registrations were in the 25 to 55 age bracket, with the 35 to 45 age group being the highest group. (Note that while the sample size is for 1,023 registrations, a further 1,301 registrations did not report age. With 56% of the data missing, information about the age of recipients must be considered of low validity.)

Table 11: GRF Client registrations, Age by service sector, 2003 (%)

Age	Metropolitan Services	Country Services	Statewide Specialist Services	Total
5 to 18 years	0.3	0.0	0.0	0.2
18 - 25 yrs	6.3	3.9	4.3	5.6
25 - 35 yrs	22.5	25.7	12.4	21.1
35 - 45 yrs	30.4	27.0	30.1	29.8
45 - 55 yrs	24.2	22.4	29.6	24.9
Over 55 years	16.4	21.1	23.7	18.4
<i>Total (% valid responses)</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
<i>Total (number with valid responses)</i>	<i>685</i>	<i>152</i>	<i>186</i>	<i>1,023</i>
Number with missing data	777	158	366	1,301
% missing data	53.1	51.0	66.3	56.0
Total (number)	1,462	310	552	2,324

Similarly, 52.7% of all registrations did not report on the country of birth (Table 12).

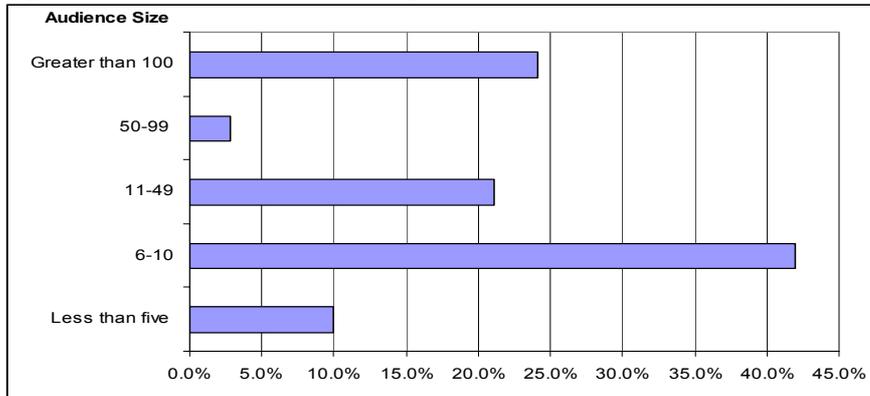
Table 12: GRF Client registrations, Country of birth by service sector, 2003

COB Client	Metropolitan Services		Country Services		Statewide Specialist Services		Total	
	N	%	N	%	N	%	N	%
Australia	529	77.0	144	86.2	64	26.1	737	67.1
The United Kingdom and Ireland	54	7.9	7	4.2	10	4.1	71	6.5
Asia	21	3.1	2	1.2	161	65.7	184	16.7
Other	70	10.2	12	7.2	10	4.1	92	8.4
Not stated	13	1.9	2	1.2	0	0.0	15	1.4
Total Valid data	687	100.0	167	100.0	245	100.0	1,099	100.0
Missing	775	53.0	143	46.1	307	55.6	1,225	52.7
Total	1,462		310		552		2,324	

The data system cannot provide any useful information about the indigenous status of clients: this item was not completed in 98% of client registration data in 2003.

The data also provides some information about the recipients of Break Even community education activities. For example, agencies are asked to report on the size of the audience they feel they will reach. It can be seen from Figure 2 that 27 % of all Break Even community education work hours in 2003 were reported to be with/for audiences of over 50 people. Smaller audiences are engaged more often.

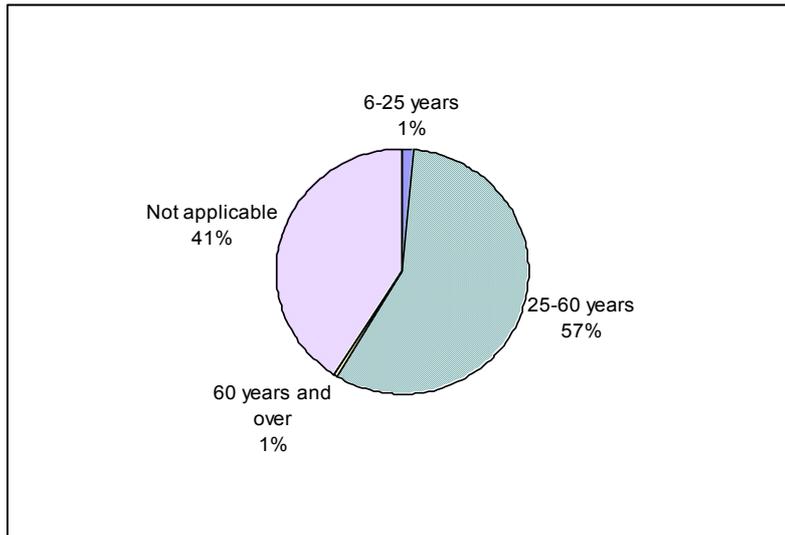
Figure 2: Break Even community education service output by audience size



Source: Break Even data collection system

Figure 3 reports on the age of recipients of agencies' community education during 2003. The relatively low level of activity directed at youth and the elderly is the notable feature of this analysis.

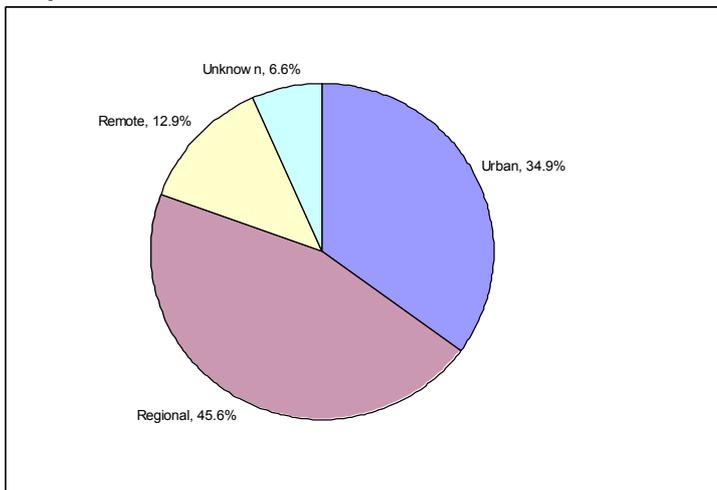
Figure 3: Break Even community education service output by age of recipients



Source: Break Even data collection system

Finally, Figure 4 reports where Break Even community education services were delivered, with the majority being in regional or country areas.

Figure 4: Break Even community education service output by geographical location of recipients



Source: Break Even data collection system

5.4 Key points and findings

1. There are significant limitations in existing Break Even data, severely limiting the possibility for analysis and monitoring.
2. Data indicates 2324 new clients were registered in 2003, of whom 26% (607 people) were non-gamblers. This is fairly consistent with previous years, where approximately 2000 clients were registered, including 25% non-gamblers.
3. A 'guess-estimate' of the number of individuals engaged in counselling/treatment by services in a given year suggests an absolute maximum of 3000 (this includes a generous estimate of people carrying over from the previous year). Compared with prevalence estimates, this suggests the system only treats a small proportion of potential clients.
4. Whilst there is clear potential unmet demand for services (with prevalence data indicating approximately 22,000 problem gamblers in South Australia), there is little evidence of ongoing actual unmet demand.
5. There are significant variations between agencies (including those with equal funding) as to the number of client registrations.
6. Interventions with problem gamblers are usually relatively brief (ie less than ten consultations, over less than 6 months).
7. Whilst personal gambling problems are the major focus of counselling, relationship and financial counselling are also significant issues.
8. From the existing data it is not possible to comment on the effectiveness or efficiency of services. The existing data does not suggest a particularly efficient service system.

Key finding 22: The GRF data set must be complete, robust and accurate, and achieving this should be a non-negotiable for the next funding period. The software system used for the collection, entering and extracting of data must be user friendly. Actions should include ensuring the quality and utility of the data items; addressing problems that arise; closely monitoring compliance; providing training where necessary; ensuring the data is fed back to agencies; and reporting and using the provided data in decision making.

Key finding 23: Existing client data does not suggest a particularly efficient service system. A key direction for the coming funding period should be to increase the amount of clients receiving services from the GRF system.

Key finding 24: Relationship and financial counselling are important elements of the service mix that must be maintained.

Key finding 25: A priority for expenditure under the Research and Evaluation allocation should be to explore options and then establish systems to monitor and assess the effectiveness and efficiency of the problem gambling service system.

9. All Break Even agencies undertake community education work to varying degrees, although most reported they do less than their service agreements allow for, citing demand for counselling services as the primary reason for this. BESA data system reports indicate that in 2003 Break Even agencies spent 23,348 hours or 3246 days on Community Education work. By sector, Metropolitan agencies undertook 4% of this work, rural agencies 27% and the state-wide specialist agencies 69%.

Key finding 26: Community education at the local level is an important activity for Break Even agencies. However, current practice could be improved by a more planned approach. Priority could also be given to targeting the populations identified as priorities for the next funding period.

6. CURRENT BEST PRACTICE THINKING

It is important that current best practice thinking about responding to and treating problem gambling, at both a systemic and individual level, is taken into consideration in the planning and development of a suitable service response. This section briefly reviews such thinking.

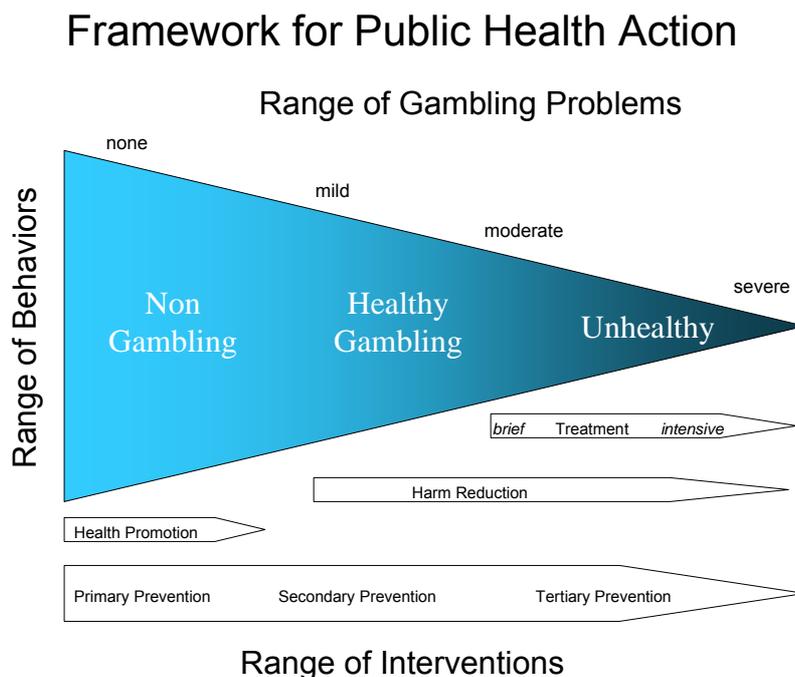
6.1 Problem gambling response frameworks

It is generally agreed that problem gambling interventions may be targeted at:

1. Restricting or modifying the supply of gambling products
2. Influencing the propensity to gamble
3. Ameliorating the negative outcomes and consequences of problem gambling. (Melbourne Enterprise International 2003)

Population-based or public health models are currently enjoying high status as best practice models for systemic responses to whole of community social and health problems. Korn & Shaffer(1999) have adapted a population health model to illustrate how the theory can be utilised to better understand and guide a systemic response to problem gambling.

Korn and Shaffer's model is reproduced below.



Source: Korn, D, An International perspective on Gambling and Public Health (2003)

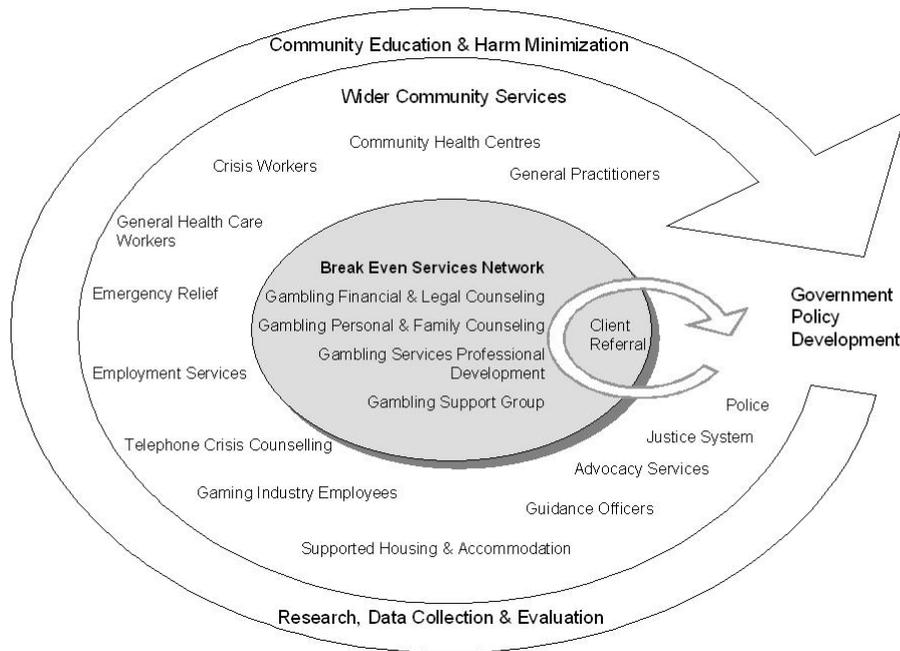
The model identifies a continuum of gambling behaviour (from non-gambling to severe), with a small minority of the population at any one time at the 'unhealthy' or 'severe' end. Further, the model indicates that responses to problem gambling need to be applied across the continuum, to the whole population, and indicates the range of responses (health promotion, harm reduction and treatment) which can be categorised as primary, secondary and tertiary prevention. The model identifies that an effective response to problem gambling is far more than simply 'treatment' for the minority who are addicted, and must incorporate preventive and educative strategies for the whole community and a range of responses.

Although approximate and simplistic, it may be useful to consider where and how the South Australian population fit in the above framework. Firstly, it is known that around 75% of South Australian gamble, therefore approximately 25% of the South Australian population fall into the non-gambling segment of this model. The model suggests that a general and low level of preventative intervention is appropriate for this population, such as mass media problem gambling campaigns designed to raise awareness of the risk of problem gambling. Of course, if non or low level gamblers are in a situation where they are being adversely affected by the problem gambling of others, other kinds of intervention and support may also be necessary.

It has been identified that around 2% of the population are problem gamblers (as defined by a SOGs score of 5 or more). These would obviously fall into the moderate and severe end of the continuum, where it is more likely that brief and/or intensive treatment and counselling paradigms would be appropriate.

This leaves around 70-73% of the population in the mild and lower moderate range of gambling behaviour. While some brief individual treatment may be appropriate for this population, the model suggests appropriate intervention would include targeted community education and other harm reduction strategies.

Another example of a framework is that developed by the Department of Health and Human Services in Tasmania (2001). This recognises the fact that an effective response to problem gambling cannot sit within a small problem gambling service system alone, and requires involvement and responsibility from many stake-holders. Linkages are required with a broad range of services, systems and other parties. The role of the wider services system will vary from being a source of problem identification and referral to the provision of services required by problem gamblers (eg legal, financial, health).



Source: Tasmanian Department of Health and Human Services (2001)

The current best-practice thinking about problem gambling responses thus indicates the need for:

- a population-based model in which strategies should be targeted at the whole of community (rather than simply problem gamblers)
- a variety of responses and strategies, far broader than simply treatment
- involvement, responsibility and commitment from a wide range of stakeholders.

6.2 Best practice treatment

Since the inception of the GRF, there has been a substantial growth in international knowledge and expertise with regards to problem gambling treatment and a parallel growth in the research literature. The Victorian Government has recently funded a number of reviews of literature, evidence and practice in problem gambling (Melbourne Enterprise International, 2003; Victorian Department of Human Services 2002; NCETA 2000). Key findings from this (and similar) research indicates:

- There are no internationally-established best practice models
- Identifying best practice is difficult for a number of reasons, including the many limitations of the evaluations and outcome studies that have taken place.

- Some intervention models lend themselves better to clinical trials or other quantitative analysis than others – thus are more likely to have outcome studies conducted (for example, cognitive behavioural therapy). Other community-based problem gambling interventions are not so easy to rigorously evaluate, though this does not necessarily mean lesser efficacy.
- Outcome studies report positive outcomes from a wide range of interventions and models, which suggests that problem gambling is a treatable condition which responds well to intervention.
- There appears to be support for a broad bio-psychosocial approach, using cognitive-behavioural oriented and multimodal approaches, delivered in community-based generalist agencies.
- Effective intervention includes a thorough assessment; clear goal-setting processes with client participation; and processes of review.
- A range of factors, aside from the model used, will influence outcome, including characteristics of the client, their context, and characteristics of the agency and counsellor.
- Given the above, services need to have clear theoretical models and therapeutic strategies.
- The quality of the therapeutic relationship has been found to be a major predictor of outcome.

The authors concluded that one of the strengths of the Victorian system was its ability to provide a range of interventions at individual, couple, family and community level.

A number of elements are clear from the literature and other evidence, namely:

- A best-practice system should have a range of models and intervention types.
- Problem gamblers need more than simply ‘treatment’ and necessary services include financial counselling, advocacy and negotiation (eg around housing), and relationship counselling.
- Problem gambling counselling and treatment needs to be highly skilled, clearly focused, and theory driven.
- Cognitive-behavioural therapy has very good credentials as a theoretical approach.

It is further clear that the 'right' model to use in any given situation will be determined by a range of factors including the client's circumstances, needs and attributes, their reasons for gambling, factors maintaining their gambling, and their preferences. Thus, for example, CBT is less likely to be the appropriate response for people with complex needs (for example, a homeless person with a wide range of other co-morbidities who is gambling regularly at the casino primarily because it is a warm and safe place to go.)

A best-practice system in South Australia would therefore:

- retain choice and diversity in the models and interventions used, as well as in the nature of providers,
- have excellent assessment processes, to ensure the right 'fit' between model, agency and client,
- have the capacity for clients to choose or move between models and providers (ie collaborative approaches between service providers to refer clients to the 'most suitable' service for them), and
- include provision for people with complex and multiple needs.

6.3 Community education

Community education is a vital element in any problem-gambling strategy and a legitimate and necessary area for funding. It is a major element in prevention and harm-minimisation strategies. Community education should include:

1. Community-wide campaigns, including through the mass media, directed at the mainstream population
2. Targeted approaches and specific strategies for particular population groups.

It is also clear that messages should cover at least three areas:

1. raising community awareness of problem gambling
2. harm minimisation, awareness of risk and 'early warning' messages
3. information, including about sources of help and services.

It has long been recognised that targeted community education strategies are needed for specific population groups who are less likely to be reached by mainstream media and messages. This will include Aboriginal and culturally and linguistically diverse communities; but also vulnerable groups such as the homeless; people with mental illness and people with intellectual disability. It is also logical that community education messages should be targeted specifically

at people with an existing medium to high level of gambling, who may be at risk of becoming problem gamblers.

6.4 Key points and findings

Key finding 27: Problem gambling responses should be informed by a population-based model in which strategies are targeted at the whole-of-community (rather than simply problem gamblers). A variety of response and strategies are required; as is the involvement, responsibility and commitment of a wide range of stakeholders.

1. There are no internationally-established best practice models of therapeutic intervention for problem gambling; however positive outcomes have been identified from a range of models.
2. Effective therapeutic intervention is best achieved through a strong theoretical framework and clear model which guides intervention.
3. Factors which influence outcome include characteristics of the client; their context; characteristics of the agency and the counsellor; the model used; and the quality of the therapeutic relationship.

Key finding 28: Problem gambling generally appears to be a treatable condition which responds well to intervention. Funding of treatment services along the continuum is thus a sound investment.

Key finding 29: Therapeutic/counselling services should be able to articulate and demonstrate a clear model(s) of practice, using evidence-based and accepted techniques, which are then supported by expert supervision within the agency. The capacity of agencies in this regard should be a key consideration in the purchasing of services in the next funding period.

Key finding 30: A best-practice problem gambling system will retain choice and diversity in the models and interventions used, as well as the nature of providers, and also contain provision for people with complex needs.

4. Community education should include community-wide strategies in conjunction with approaches that target particular population groups.

Key finding 31: Targeted community education responses to the priority population groups should be pursued over the next funding period.

7. IMPLICATIONS FOR THE FUTURE

7.1 Building on a solid base

This review has not found glaring inadequacies in the existing system; rather it has identified substantial strengths and achievements. These strengths and achievements include:

- For a small funding program, the GRF has achieved impressive reach and breadth, geographically, across functions, and to different population groups
- There is an innovative mix of state-wide coverage and targeted service delivery, and responses are provided across the continuum of primary, secondary and tertiary intervention
- A considerable body of expertise and experience has been built up across both the service system and amongst planners
- There is a diversity of providers, models, approaches and strategies
- Good links have been developed between service providers and communities, especially in rural areas and ethnic communities
- There are strong collaborative links between Break Even agencies
- People seeking help are responded to quickly.

However, the current service system and structure has now been in place for ten years, and it is timely to consider new directions, approaches and priorities, especially against the experience of the last decade and the substantially improved knowledge base in the area of problem gambling. It is the assessment of this Review that this will best be achieved through three major mechanisms:

- 1. Strong, focused leadership to the Program**
- 2. The development of a comprehensive Plan, which considers and addresses the issues identified in this Review, and provides a work program for the next three to five years.**
- 3. Strategic purchasing of services for the next Funding Period, to support achievement against the priorities identified in this Review.**

This final section, therefore, brings together all the findings and proposals made throughout the Report. It is presented as a guide to the planning and purchasing of services over the next three year funding period, and proposes key outcomes, strategies and priorities for that period.

7.2 Key objectives and outcomes of the GRF system

Objectives

On the basis of the information considered in this review, it is proposed that the two key objectives of the GRF service system are:

- 1. The harmful impacts of gambling are minimised amongst the South Australian community**
- 2. High quality and effective services are available to all South Australians adversely affected by problem gambling**

These objectives should drive planning and investment over the next funding period.

Priority outcomes

Identifying priority outcomes supports focused focusing planning and decision making. It also provides benchmarks against which achievement during the next funding period can be assessed. In light of the issues identified in the Review, the following key outcomes are proposed for the next funding period:

1. More people are treated and assisted by GRF services.
2. There is an increase in services, supports and information provided to people through mediums other than face-to-face contact.
3. There is a greater capacity to identify and respond to problem gambling in other service sectors.
4. Aboriginal people access and receive relevant problem gambling services and supports.
5. There is an improved reach into identified priority populations, with the development of successful strategies and approaches.
6. Service data is robust, relevant and utilised.
7. High quality services are in place, and the system can demonstrate and monitor its effectiveness and efficiency.

7.3 Priority populations

The GRF has a universal intention and nature, but it is also very limited in capacity. Resources, therefore, must be targeted to those most at risk and for whom special concerns exist. The identification of priority populations for the next funding cycle will assist in focusing planning and decision making.

It is therefore proposed that whilst the universal focus of the program remain, priority populations for the next funding period should include:

- Indigenous people
- People with mental health problems
- People with intellectual disability
- Prisoners
- Youth
- People from culturally and linguistically diverse backgrounds
- The homeless.

Improved service approaches and communication strategies are required to improve these population groups access to problem gambling services.

The purchasing of services for the next funding period should seek to engage agencies with demonstrated capacity and strategies to engage and provide services to these groups.

7.4 Growth priorities

In light of the information considered in this Review and the government's policy directions, priorities for any additional funding allocations or growth should include:

1. Services to identified priority populations but particularly Aboriginal people
2. Community education, to enable regular state-wide media campaigns and also targeted responses to the identified priority populations
3. Strategies which directly target problem or high risk gamblers (eg in venues)

4. Strategies which promote integrated service delivery to vulnerable populations
5. Strategies which increase the reach of the program and encourage access, including by providing alternatives to current arrangements.

7.5 Key directions

From the information considered in this Review and in light of the current structural arrangements around the GRF, it is our assessment that there are four over-arching directions which should be pursued over the next funding cycle. These are:

1. **Refining the existing service and funding framework**
2. **Improving the existing system through:**
 - A. **Building leadership, management and support**
 - B. **Ensuring quality services**
3. **Growing capacity**
4. **Supporting continuous learning, accountability and development through a refocused research and evaluation agenda.**

These are presented in greater depth below.

Direction 1: Refining the existing service and funding framework

- There is a clear need for a dedicated and ongoing response to assist people adversely affected by problem gambling and prevent harm to those at risk.
- Evidence indicates problem gambling is a treatable disorder; funding of treatment services is therefore a sound investment.
- The current service and funding framework is based on the original Funding Policy developed in 1995.
- This framework reflects many aspects of recognised best practice. It enables primary, secondary and tertiary interventions; combines universal service provision with targeted approaches to specific populations; and supports a range of functions which are essential to ongoing effectiveness and development.
- The framework is still conceptually sound, although there are opportunities for refinement.

Proposal:

1.1: It is therefore proposed that the Service and Funding Framework be refined with regards to:

1.1.1 The regional allocation formula. Any revised formula should take into account factors including population size and profile; socio-economic indicators; numbers of gaming machines, gambling expenditure and existing service demand.

1.1.2 The broad allocation between functions to reflect changed circumstances and intentions since the original funding policy was developed.

Direction 2: Improving the existing system

More people should access problem gambling services, and improvements can also be made which will enhance client outcomes. Strategies which will serve both these aims have been categorised into two major areas:

A. Building leadership, management and support

B. Ensuring quality services

These are discussed below.

A: Building leadership, management and support

- A strong funding program needs the guidance of a plan. As a matter of priority, such a plan should be developed, and should encompass the range of matters discussed in this report, as well as other issues as required. The Plan should contain targets and clear goals; it should drive change, development and funding decisions; and provide clarity and a work-plan for program leaders, managers and services. The Plan should reflect best practice and cutting-edge developments in problem gambling service systems and interventions.
- It is also timely to consider a reconfiguration of existing arrangements for program administration and support, in order to ensure high quality leadership, management and administration of both the GRF and the government's policy directions with regards to gambling.
- Consideration should also be given to strengthening the capacity of the GRF to provide representative and expert advice with regards to problem gambling, service development and delivery, community education, and priority populations.

Proposals:

2.1: An overarching plan should be developed to inform the next three-year funding period. This plan should:

2.1.1 reflect the Key Findings and Directions identified in this Review

2.1.2 provide a framework for sub-plans in specific areas, notably workforce development and community education

2.1.3 be supported through the allocation of one-off resources for a thorough planning process which addresses the identified issues and includes stakeholders.

2.2. With regards to the management and support of the gambling program within the DFC:

2.2.1 The current internal program arrangements should be examined, with consideration given to options which support improved management, leadership and coordination, both of the GRF and problem gambling services and the government's policy agenda.

2.2.2 The functions required to support both the Program and the government's policy agenda should be identified, and optimal arrangements for the performance of these functions considered.

2.2.3 In this context, particular attention should be given to the issues surrounding network support. Different options for expenditure of the current allocation which simultaneously meet the needs of stakeholders and satisfy the requirements of services and government should be considered, with a view to introducing both greater flexibility and specificity in the dispersal of functions as appropriate.

B: Ensuring quality services

- Community Education is an essential strategy, and has become a major focus of expenditure in the GRF. A Community Education Plan which guides and supports the work of both Health Promotion SA and Break Even agencies is urgently needed. Such a plan will strengthen the capacity for collaborative approaches and shared messages, and provide clarity of goals, priorities, roles and expenditure.
- There is a considerable notional allocation to community education in Break Even agencies. This review has identified a number of options for improving on and maximising the benefit from this allocation.
- Quality services are dependent on a quality workforce. The vulnerabilities of the Break Even workforce were identified in this

review. The recruitment of properly qualified workers, and the ongoing development and support of the workforce, must be a priority. A Workforce Training Plan will be developed in 2005, and it has also been recommended that network support strategies be redefined. Other potential strategies include internet-based communication; professional development forums; orientation of new workers; and regular circulation of new literature and research. However, it must be clear that the primary responsibility for the training, supervision and support of the workforce rests with employing agencies, rather than the central Program, and agencies also have a responsibility to recruit qualified, skilled staff.

- There is currently no accreditation or quality framework for problem gambling services. This issue is being considered at the national level; it should also be pursued in South Australia.
- The current Funding Policy has successfully ensured dedicated responses to culturally and linguistically diverse communities and Aboriginal people. Priorities for the next funding period include the development of treatment options for these populations, and the building of capacity especially in Aboriginal services.
- The service system needs to have a capacity and also diversity which maximises consumer choice and options. It also appears that there is some discrepancy at present between the extent to which agencies use treatment models that are evidence-based and appropriate.

Proposals

2.4: With regards to Community Education and Prevention:

- 2.4.1 As a subsidiary to the proposed 3 year plan, a Community Education and Prevention plan should be developed, which includes and links the work of Health Promotion SA and Break Even agencies.**
- 2.4.2 The priority population groups identified in this report should be a focus for community education and prevention activities in the next funding period.**
- 2.4.3 Consideration should be given to strategies to improve the quality, coverage and impact of community education in agencies. As a first point, the nature, type and purpose of this community education (for both mainstream and culturally specific services) should be clarified and contract expectations developed which support this expectation. Generally, the notional allocation for community education in agencies should be reduced.**

2.5: With regards to workforce and quality:

2.5.1 A Quality Workforce Strategy, which incorporates a Workforce Training Plan, should be developed. This must be clearly focused to address the considerable challenges for this workforce.

2.5.2 In the purchasing and contracting of services, preference should be given to agencies which demonstrate a clear commitment and capacity in the areas of professional recruitment, development, supervision, standards and support.

2.5.3 Consideration should be given to the development of quality or accreditation standards for problem gambling services in South Australia.

2.6: A special focus on culturally and linguistically diverse populations and Aboriginal people should be retained in the service system.

2.6.1 In the next funding period, priorities should include the continued development of this sector, with a special focus on the needs of these workers in the Workforce Training plan; and the building of treatment models and options for CALD populations and Aboriginal people.

2.6.2 Building capacity with regards to services to Aboriginal people should be a particular priority. The effectiveness and efficiency of a small, two person, state-wide model in Aboriginal services has to be questioned, and other alternatives should be considered, including a regional approach.

2.7: With regards to the planning and purchasing of services for the next funding period:

2.7.1 The planning and purchasing of services should seek to achieve a variety in types of providers, services and models, especially in the metropolitan area.

2.7.2 Crisis intervention, particularly around financial, relationship and legal matters, are important elements in the service mix which should be maintained and strengthened.

2.7.3 In this service mix, a specialist treatment capacity in at least one mainstream health agency is an important element.

2.7.4 Whilst the purchasing of services for the next funding period should support diversity in the sector, it should also purchase for clear, articulated and evidence-based treatment methodologies, including new and innovative approaches.

2.7.5 Funding and contracting practices and arrangements should take into consideration the need for stability and certainty in the service system

Direction 3: Growing capacity

- The GRF is a very small fund, and tightly stretched across many functions and populations. There is limited capacity for further growth or innovation within existing resources. The lack of indexation across all income will continue to 'shrink' the actual value of the Fund and its purchasing capacity.
- It is clear that problem gamblers are most likely to be found in gambling venues, indicating the need for collaborative working arrangements between venues and services. This may be easier to achieve in rural areas (due to the small number and different nature of venues), but it is also generally recognised as a difficult and challenging area of practice. The development and trial of new and innovative models would add capacity in this area.
- A system as small as the existing Break Even does not have the capacity to provide comprehensive state-wide coverage, and will always be challenged by the spread and diversity of the South Australian population.
- Other treatment and intervention strategies are therefore required, including building capacity in other service systems to respond to problem gamblers, and developing alternative and innovative treatment options and responses.
- It is also recognised that many people in the identified priority populations will have complex and multiple needs and are likely to already be the clients of other services. This requires joined-up responses and different ways of working.

Proposals

3.1: Quantum of Funds:

- 3.1.1 The capacity of the Fund to achieve the outcomes desired by government and the GRF should be closely monitored, and consideration given to increasing the quantum of funds if necessary, including indexation across all components.**
- 3.1.2 There is an immediate need to consider the recurrent allocation to state-wide community education campaigns, in order to ensure their viability, and also to Aboriginal-specific services.**

3.2 Over the next funding period, strategies should be developed to improve the links between problem gambling services and gambling venues.

3.2.1 Any initiatives in this area should be evaluated in order to develop best-practice approaches and options.

3.3 Alternatives to traditional treatment modalities:

3.3.1 Consideration should be given to options which extend the availability of out-of-hours treatment.

3.3.2 Similarly, options for people to access help, information and treatment through alternative modalities could also be explored and developed (eg self-help resources, interactive web resources, telephone counselling).

3.4 Building capacity in other sectors:

3.4.1 Targeted strategies and plans should be developed to build the capacity of other professionals and service systems to identify and provide a level of response to problem gambling. Ideally, other professionals should be:

- **Aware and informed about the impact of problem gambling**
- **Able to identify where gambling is a problem**
- **Able to deliver some early counselling and crisis response**
- **Supporting engagement and effective referral of their clients to problem gambling services as appropriate**
- **Case-managing with problem gambling services as appropriate**
- **Delivering treatment and crisis services as appropriate**

3.4.2 This strategy is particularly relevant in rural and remote areas, and also with regards to the identified priority populations.

3.4.3 Many people in the priority populations are likely to have complex and multiple needs. Strategies to address gambling in this context, and in partnership with other services, should also be developed.

3.4.4 The DFC should pursue strategies to ensure the availability of high quality training and support for financial counsellors in South Australia.

Direction 4: Continuous learning, accountability and development through a refocused strategic information agenda

- There has been considerable uncertainty in recent years around the role of the GRF in relation to research, evaluation and analysis. This review has supported the ongoing allocation of funding to these functions, but highlighted the need for clarity in role and purpose and a clear strategic agenda.

- The Break Even data collection must improve its accuracy, completion and robustness. The low quality of data which has existed for so many years should not continue.
- The only true measure that can be undertaken of the impact or otherwise of the government's harm minimisation and treatment strategies as well as other gambling policy directions is through the conduct of prevalence studies. South Australia has had few such studies – consequently, there is limited evidence base on which to base assumptions and also monitor impact.
- The original Break Even data set contained a range of items which were intended to support the assessment of outcomes and efficiency. However, there was very poor compliance in the completion of the data, and the items have now been changed. A range of studies have since highlighted the complexities and difficulties in assessing outcomes for problem gambling. It is clear, however, that assessing the effectiveness of Break Even services, and of alternative models within the system, is an important challenge that must be addressed.
- Finally, major innovative or developmental strategies undertaken in the GRF system should be subject to evaluation as with regards to their effectiveness and in order to ensure continuous improvement and refinement. This is particularly the case with regards to initiatives targeting the priority populations, and also major areas of new expenditure (such as counsellors in venues).

Proposals:

4.1 It is therefore proposed that:

- 5.1.1 The allocation for research and evaluation of GRF services should be maintained.***
- 5.1.2 The focus of this allocation should be on problem gambling prevention, early intervention, prevalence and treatment.***
- 5.1.3 The purpose of this allocation should be to support planning for problem gambling services; the provision of strategic information and analysis with regards to problem gambling in the SA community; and the improvement of services and methodologies.***
- 5.1.4 The major components of expenditure should therefore be data analysis and development; review and evaluation with regards to problem gambling; and focused research and development projects in the area of problem gambling.***

- 5.1.5** *The expenditure of this allocation should be guided by the government's gambling agenda, priorities identified in this Review and the 3 year plan which is currently being developed.*
- 5.1.6** *Other state and national research around problem gambling should be taken into consideration when research priorities are being considered.*

4.2: With regards to data collection, it is proposed that:

- 4.2.1** *Discussions should continue to be held between problem gambling agencies and the DFC to address any problem in the new data system. In particular, it is important to ensure that all items being collected are necessary and have high utility.*
- 4.2.2** *Agency compliance with data collection requirements should be a clear expectation in service agreements, and monitored accordingly.*
- 4.2.3** *Ongoing training should support continued data compliance and quality.*
- 4.2.4** *Strategies should be put into place to ensure agencies have improved access to the data, and can utilise it for management purposes. Data should be analysed and published by the department on an annual basis.*
- 4.2.5** *De-identified and summarised data should be regularly used in planning, decision making, policy and contract monitoring, and also made public in an accessible form.*

4.3: Monitoring prevalence

- 4.3.1** *Regular prevalence surveys (approximately 3 yearly) should be considered, at least for the next decade, to monitor trends in the South Australian community with regards to prevalence.*
- 4.3.2** *It is also proposed that additional strategies be undertaken to measure prevalence in hard-to-reach groups (as has recently occurred with the homeless), particularly in the priority populations.*

4.4: Measuring effectiveness: An expert consultancy should be considered to identify options and develop a methodology for evaluation and the measurement of effectiveness in Break Even client services. On the basis of the recommendations of this project, systems should then be put in place to support ongoing evaluation, monitoring and improved accountability.

4.5: Evaluation should accompany major new initiatives and innovative practice developments.

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9. APPENDICES

9.1 Individuals, Organisations & Committees Consulted

Break Even Service Providers

Mr	Trevor	Bignell	Uniting Care Wesley Adelaide
Ms	Christine	Nancarrow	
Ms	Janet	Firth	Anglicare SA
Ms	Jane	Oakes	Intensive Therapy Service for
Mr	Angus	Forbes	Problem Gamblers Flinders Medical Centre
Ms	Sharna	Hardie	Centacare, Port Lincoln
Ms	Eve	Barratt	Lifeline South East, Mount Gambier
Ms	Deb	Nelson	Uniting Care Wesley Port Pirie
Ms	Belle	Cheney	Relationships Australia -Adelaide
Mr	Mark	Waters	
Ms	Margaret	Blake	Relationships Australia - Riverland
Ms	May	Shotton	Salvation Army
Ms	Anne	Woodhouse	Uniting Care Wesley Bowden
Ms	Andrea	Brebner	
Ms	Arja	Korhonen	
Mr	Michael	McCabe	Nunkuwarrin Yunti
Ms	Lisa	White	
Mr	Robin	Fan	Overseas Chinese Association
Ms	Lan	Nguyen	Vietnamese Community in Australia
Ms	Savry	Ouk	Cambodian Association of SA
Ms	Enaam	Oudih	Multicultural Break Even Service PEACE - Personal Education & Community Empowerment Relationships Australia
Ms	Lynn	Stevens	Gambling Helpline

A Break Even Forum attended by 24 Break Even staff was held on Thursday 26th August to discuss “Future directions for problem gambling services in South Australia”.

Other Organisations & Committees

Ms Yvonne Tiss	Team Leader, GRF Program, DFC
Mr. Martin Bailey	Senior Project Officer, GRF Program, DFC
Mr. Roger Peck	Senior Project Officer, GRF Program, DFC
Ms Elena Di Biz	Health Promotion SA, Department of Health
Mr. Michael Keenan	Executive Director, Clubs SA
Mr. John Lewis	General Manager, Australian Hotels Association (SA)
Ms Trudy McGowan	General Manager, Marketing and External Relations Sky City Adelaide

Gamblers Rehabilitation Fund Committee

The Prevention and Treatment of Problem Gambling in South Australia through the Gamblers Rehabilitation Fund:

A STRATEGIC REVIEW

2005



Government of South Australia
Department for Families
and Communities

