Submission to the 2009 Productivity Commission Inquiry into Gambling

About the Author

As a clinician of 30 years in the field of social work and more recently as a specialist gambling counsellor (11 years), RGF accredited Gambling Counsellor Supervisor and Problem Gambling Educator. I am writing to provide ideas and comments on the current arrangements for the treatment of those negatively affected by problem gambling.

I would like to note that I am also a member of a family impacted by problem gambling and have already provided a submission in my capacity as Chairperson of the Gambling Impact Society (NSW) inc. I am also currently undertaking PhD studies into the gambling harm minimisations policies of Australia. However for this submission I wish to concentrate on the current arrangements for therapy for those affected by PG in NSW.

Since 1999 there has been a commitment to provide specialist treatment services to those affected by problem gambling in NSW. This is funded from $12 million provided by the Star City Casino revenue (2% of the Casino tax revenue raised from gambling). It is noted that unlike our neighbours in New Zealand, Star City is the only contributor to this fund and all other gambling activities are not required to make contributions. The result of this funding has seen the development of a range of treatment services across the State (52 currently) providing treatment counselling for those affected.

There are however considerable anomalies with this arrangement provided through the NSW Office of Liquor Gaming and Racing (OLGR) which I will illustrate as follows:

Transient Staffing

The current RGF tendering arrangement (now in four year cycles) provides minimal job security for those employed in the sector and as a result the sector suffers from considerable transience in counsellors. This impacts directly on the client group who often having long term counselling needs, are unable to maintain continuity with their counsellor relationship.

Such insecurity in employment has led to a lesser qualified staff than some other sectors of counselling. Many counsellors in the PG field are joining the sector shortly after qualifying and then move on. Those more experienced staff are unable to secure permanent employment and in the current economic climate are more likely to engage with an employer who is able to offer more security of tenure.

In addition, current pay conditions for many in the sector are poor (SACS Award) compared to other areas of counselling and once again experienced high calibre staff are choosing to seek employment elsewhere.

For example in my own region (Shoalhaven) once the area health service axed its 8 yr old problem gambling service,(it was considered non "core business") the displaced workers, Psychologists (some at senior levels within the public health sector) were

unable to move across to the other NGO funded body as the pay discrepancies were considerable. In some cases this would have resulted in a full time equivalent of salary loss amounting to some $30,000 pa - a loss most professionals would be unable to accommodate. Thus senior highly qualified and experienced staff were unable to transfer their skills into the NGO sector. This is a considerable quality loss to both the sector and clients who were no longer able to access that calibre of counselling.

Many counsellors are holding minimal qualifications. The counselling field of problem gambling has attracted those from a range of welfare sectors and whilst not belittling their interest or expertise in the welfare sector this area of work requires considerable skills in working with mental health, and other co morbid issues. It is not an area of work for those with minimal qualifications or skills and the failure to recognise this places both staff and clients at risk.

Training Needs & Qualifications

The current standard of a minimal qualification process introduced by the OLGR when fully implemented will still allow this practice to continue due to its vocational qualification focus. One risks being labelled elitist when imparting a view that registered Psychologists and Social Workers do bring to this field a breadth of clinical and intellectual knowledge not found in generic welfare diploma or generalist counselling training programs. This area of counselling needs the recognition that the client deserves the equivalent of no less. Why should those affected by problem gambling be receiving psychological services from those lesser qualified than any medical patient in a public hospital ward or community health centre.

NSW Health has developed a system of accreditation, registration and recognition for qualifications and skills in the psychological services why should people affected by problem gambling receive anything less than that standard?

In addition, those currently working as counsellors in the field are often expected to undertake activities beyond either their interest or abilities. So for instance counsellors who generally train to work individually with people or groups at an inter or intra psychic level are being asked increasingly by the RGF to take on the responsibility of marketing their service, educating the public and developing community capacity building activities. Whilst some are more than happy to develop new skills many feel torn between their roles and unable or unwilling to take on a new skills set. This practice also under values the definitive skills required of those activities more akin to health promotion or health education disciplines and reflects a piecemeal and ad hoc approach to prevention or early intervention without a guiding framework or appropriate skills base.

In Victoria the need for public /community education has been recognised as a separate skills set from counselling and there each PG service is also supported by a health eduction role. This I understand this has worked well.

If NSW was to fully embrace a public health model for Problem Gambling (as in drug and alcohol services) these prevention and capacity building roles would need to expand to include more health promotion and community development type activities. This would require the necessary skill base to underpin them. It is too much to expect

treatment counsellors to diversify into these areas and generally leads to a diluting of appropriate community interventions due to the limitations of counsellors and their need to provide a counselling service as their priority.

Lack of Recognition of PG as a Health Disorder.

Interestingly despite academic recognition of problem gambling as a public health issue there has been minimal attendance to this at a policy or performance level. The fact that Problem gambling remains in the portfolio of the Office of Liquor, Gaming and Racing as opposed to NSW Health or another Community Service department is a clear lack of understanding of the nature of the disorder and its significant health impacts.

The marginalisation of service provision via predominantly faith based charitable organisations has led to considerable inequity for those impacted by problem gambling. Depending on where you live will decide the agency and whether or not this is a faith or secular based service. Charitable organisations whilst providing welfare programs are not the providers of mainstream health services and should not be expected to have the skills or approaches to truly embrace a public health approach to the issue. Whilst there may be many opportunities for NGO's to partner in providing a range of services within a public health framework for gambling the basic policy direction, treatment and rehabilitation programs one would anticipate better placed within mainstream health services. This would ensure equity of access and the required cross linking between problem gambling, mental health and other addiction based services.

The current arrangement means that services often work in isolation with no underpinning philosophy of a pubic health framework to guide their interventions and as a result their capacity to respond to the issues they obverse are much limited. In addition clients are unable to access a case management approach to their co-morbid issues and unlike a community health service where collaborative co-working relationships between therapeutic interventions are common, much of the counselling is conducted without integration with other services. Indeed as directed by RGF the expectation is that "we deal with the PG issues other services have to deal with the other aspects". Clients do not lead such compartmentalised lives and nor should they be expected to have to access a range of counsellors for every different experience.

The fact that PG remains outside the Health umbrella reinforces stigma for those affected. Unlike smoking, alcohol or drug use, few health services address gambling issues and as such those affected cannot draw on health services to support them. Communities are encouraged to see those other addictive behaviours within a health perspective but not so problem gambling. Those affected by PG are not able to walk into a health service knowing that they could be there for a range of health problems- no they have to seek out a specialist PG treatment service. Family members are expected to do likewise as they too cannot seek support from their local health service and unfortunately only 16% (OLGR CDS Annual Reports) of those seeking help from PG treatment services are family members.

The latest study by the OLGR into the Stae treatment services indicated that the RGF services are significantly lacking in family interventions (2008). The heavy reliance on some individual focussed counselling interventions both by practice and discipline also means that families are often unable to access systems/family therapy based services for this issue. Family members are often the person to whom the person with the PG turn first (NSW prevalence study 2006) and yet they often remain the least supported by the treatment services.

The fact that PG remains outside the gambit of services provided for drug, alcohol and mental health services in NSW Health means that the culture of service provision has not developed to the same extent as with these other disorders. For instance the current emphasis on consumer inclusiveness, carer inclusiveness and family partnership in decision-making, program development and delivery in Mental Health Services in NSW Health has totally by-passed problem gambling. As such families and consumers remains inequitably serviced because their issue is not regarded as a mainstream health issue served by such policy directions and service delivery models. Yet at its pathological level Problem Gambling is a recognised mental health disorder (DSM1V).

One has to ask why is this the case? when we have academic research and health models which could be made available to this issue yet by the structural development of the service delivery model of PG they remain treated in isolation. It may be that the political willingness to embrace these facts has been hijacked by other incentives and vested interests of other stakeholder groups which go beyond the interests of the health of a population. However we hope the democratic process will prevail in this inquiry and that these issues will be addressed.

Kate Roberts
30/3/09