Contents page

Contents page 1

Introduction 5

Context 6

People Harmfully Affected 6

Children 8

Online Gambling 9

Service Provision Models 10

Lack of Research 10

RASA's experience in relation to specific population groups 12

Gender 12

Age 12

Young people 13

Retirees 14

Incarcerated People 14

Families 14

Culture 14

Culturally and Linguistically Diverse Communities 14

Aboriginal and Torres Strait Islander Australians 15

Rural and Regional Areas 16

Public Health Model 17

Who would be treated and for what? 19

Characteristics of Level 0 and 1 Gamblers 19

Characteristics of Level 2 and 3 Gamblers 20

Co-Morbidity and inter-related difficulties 20

Socio-economic status 21

Exposure 22

Characteristics of Level 4 Gamblers (Gambling Help clients) 23

Drugs and Alcohol 23

Characteristics of Level 4 Non-Gamblers (Gambling Help non-gambling clients) 24

Service Access Issues 24

Funding Model 26

Research Directions 28

Data Collection 29

Information Regarding Primary, Secondary and Tertiary Interventions 30

Primary Public Health Strategies: Prevention 30

Limiting Access 30

Education 30

General public 30

Gamblers 31

Banks and lenders 31

Community Development 31

Group work 33

Non-Monetary Gambling Options 33

Secondary Public Health Strategies: Harm Minimisation 33

Community Development 34

Controlled Gambling 34

Note Acceptors 34

Banks and lenders 35

Biometric ID 35

Limiting Sound Features on EGMs 35

Gambling Treatment Court 36

Tertiary Public Health Strategies 36

Community Development 36

Counselling and biopsychosocial methodologies 36

Commentary on a range of therapeutic methodologies 37

Brief Intervention 38

Cognitive therapies 38

Behavioural therapies 38

Cognitive behavioural therapies 39

Psychotherapeutic/motivational strategies 39

Relapse Prevention Training 39

Psychodynamic Psychotherapy 40

Bibliotherapy 40

Self-Exclusion 40

Natural recovery and self help 41

Summary 43

Reference List: 45

Introduction

Relationships Australia (SA) (RASA) has delivered a range of community services to the South Australian population for 60 years and provided counselling specifically in relation to problem gambling since November 1995. We have gradually expanded our gambling help programs to include community education, professional education and training, community development initiatives and a specialised multicultural service called the PEACE Multicultural Gambling Help Service.

Almost 14 years of diverse experience in the field of problem gambling leads us to present this submission to the Inquiry, strongly in support of a public health model for preventing and responding to gambling-related harm. We supply our rationale for this position, citing a range of research findings, as well as detailed comment on primary, secondary and tertiary gambling help interventions, many of which we have trialed or currently use.

We also enclose suggestions regarding future research directions based on information that we believe would build an understanding of problem gambling populations and support the quality and development of our practice as service providers.

Context

A 2005 study, with a sample size of 17 000 adults and 605 youth aged 16-17 years, found that 70% of adult South Australians had gambled at some time during 2005 (SADFC 2006). Excluding those who only play lotto or bingo, 14.5% of South Australian adults gambled at least fortnightly, classing them as frequent gamblers (SADFC 2006). The more frequently one gambles, the greater the risk of engaging in problematic gambling.

The rate of problem gambling, as measured by the Canadian Problem Gambling Index (moderate and high risk gambling), was 1.6% of the adult population in South Australia in 2005 (SADFC 2006). Prior to this, in 2001, the Department of Human Services found, from a sample of over 6000 South Australian adults, the prevalence of problem gamblers was 2% (as indicated by a score of 5 or more on the SOGS scale) (Olivieri & Rogers 2005a). It is our view that the drop in percentage is more likely due to a difference in measurement tool than a decrease in problem gambling and indeed, Olivieri and Rogers suggest 'there is considerable evidence to support the view that the prevalence of problem gambling has increased in most Australian states over the last decade' (Olivieri & Rogers 2005a). Delfabbro (2005) suggests the percentage of people identified as gambling within the problematic range (against the SOGS) actually increased by 50% from 2001 to 2004, making it 4% of the total adult population.

An issue engaging this proportion of the population is well-suited to a broad public health model in order to address issues across the spectrum from primary, secondary and tertiary interventions.

However, an inhibitor to effective strategies for prevention and early intervention may be the reliance on income generated through gambling. The South Australian government derives almost 13% of its' total tax revenue from gambling, the third-highest figure for 07/08 in the nation (McMillen 2009). This is a significant amount of revenue to source alternately, of which a considerable amount may be coming from problem gamblers.

People Harmfully Affected

The population considered to be gambling problematically will be experiencing some form of harm (see Graphs 1 and 2 below). In addition, it is estimated that a further 5 to 10 people are adversely affected by the behaviour of each problem gambler (Olivieri & Rogers 2005a). Based on Delfabbro's 4% of the 1.28 million adult population being "problem gamblers", there would be 51 200 problem gamblers in South Australia. Multiplying this by a conservative 5 people adversely affected, **it is possible that around 256 000 people are harmed by gambling in SA each year**.

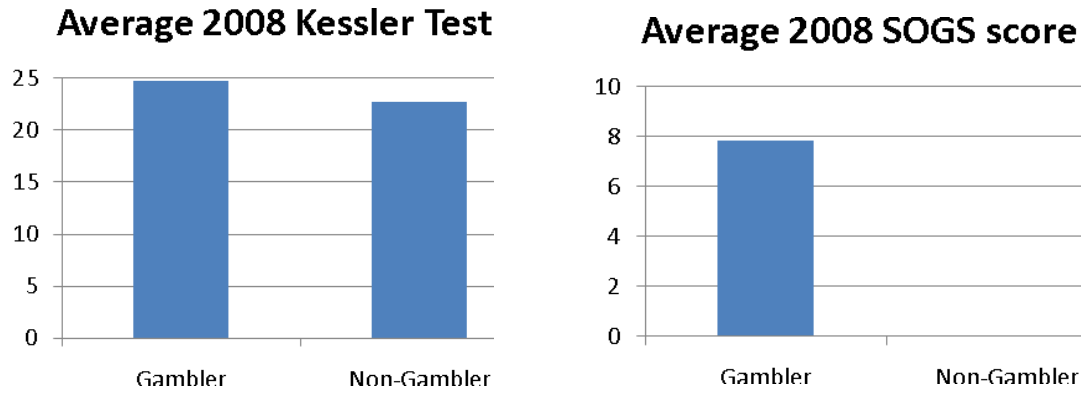
This figure, combined with RASA data indicating that 31% of our mainstream program clients and 44% of our multicultural program clients are not the problem gambler[1] but someone affected by *another's'* gambling, reveals the need for gambling help services to consider a gamblers'

[1] Based on 2007 and 2008 RASA multicultural and mainstream problem gambling program data

social and family context, and for costs associated with problem gambling to be accounted in terms of the social as well as individual harm incurred. The social costs or consequences of gambling such as poverty, financial stress, bankruptcies, gambling related crime, relationship breakdown, family violence, depression, anxiety, etc generally persist beyond the resolution of an individual gamblers' problematic gambling behaviour.

Our client data indicates that the levels of distress felt by those affected by another's problem gambling is equivalent to that of clients with a gambling problem, and can in some circumstances be greater. The average person using RASA problem gambling services – both gamblers and non-gamblers – will have a Kessler score being between 20 and 24 which represents a level of psychological distress high enough for treatment to be recommended by Crufad (the Clinical Research Unit for Anxiety and Depression[2]). Furthermore, one third of these people scoring between 20 and 24 are likely to meet current criteria for a mental disorder and to be mildly or moderately disabled by that disorder[3].

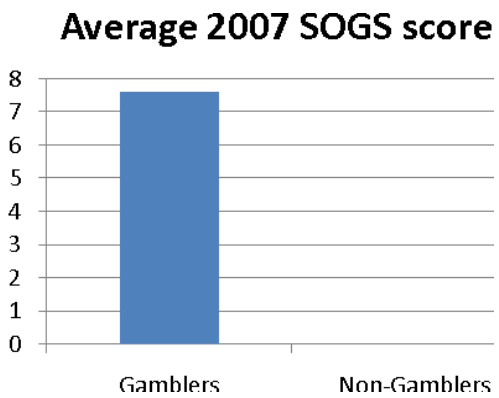
Graph 1: 2008 Kessler and SOGS scores for RASA mainstream problem gambling and non-gambling clients:



Graph 2: 2007 Kessler and SOGS scores for RASA mainstream problem gambling and non-gambling clients:

[2] Crufad are funded by the University of New South Wales, St Vincent's Hospital Sydney and the World Health Organization Collaborating Center. Crufad provides self-help information, comprehensive information for doctors and research.

[3] source: http://www.crufad.com/site2007/clinicianinfo/cliniciansupport.html, retrieved 30/3/2009 14:15



Children

Whilst most RASA problem gambling clients in 2008 (54%) did not live in a household with children, the 46% who did, have an average of 1.8 dependent children[4].

Very little is known about the impact of parental problem gambling on children in Australia. However it has been noted that 'the home environment of pathological gamblers may leave children socially isolated and physically and emotionally deprived (Lesieur and Rothschild 1989), and [children of problem gamblers] are 'two to three times more likely to be abused by both the gambler and by the spouse' (Lesieur and Rothschild 1989; Lorenz 1987 in RASA 1998). Further attention to the needs of these children is required.

RASA Client Case Study: Jenny

Jenny, a client (aged 37) has two children aged 12 and 5. Her husband works long hours and she has responsibility for managing the children, the house, the family budget, savings and investments. Four years ago she found staying at home by herself with a baby and attending to the housework stressful so her husband encouraged her to enjoy the relaxation of going to the casino in the evening when he was able to look after the children. Her sister had recently died in suspicious circumstances and her son is an insulin-dependent diabetic. Many nights she would arrive home at 4.00am, crawl into bed and wake to find her husband had gone to work, her son had made his own lunch, attended to the baby's immediate needs and taken himself to school, and her young daughter had the run of the house. This continued for a few years and while her daughter had started at kindergarten, Jenny was frequently too tired to take her there.

Having lost several hundred thousand dollars that her husband was unaware of, she accessed our service and stopped gambling. Soon after this Jenny's daughter turned 5 and started school. It was then that Jenny noticed that her daughter had very poor

[4] Based on 2008 RASA mainstream and multicultural programs

> language and social skills. She realised how pre-occupied she had been with her gambling and that for five years she rarely talked to her daughter, and had never read to her.

Under a solely Harm Minimisation approach, focusing predominantly on identification and treatment of problem gamblers themselves, the effects on children living in such households are overlooked. Further research is required on the impacts for children and their needs should be considered in the funding and structures of gambling help services.

Online Gambling

Another emerging concern is the increasing level of online gambling. A recent international study conducted by the University of Nevada apparently found that Australians were betting more online than any of the other 104 countries included in the survey[5]. Both online and mobile

phone technologies significantly increase the availability and ease of gambling and thus heighten the risk of problem gambling. These technologies are particularly accessible and attractive to young people. Such modes of gambling are less visible, even more isolating than in-venue options and will require innovative methodologies for intervention.

[5] Reported in the Sunday Telegraph. Accessed at www.news.com.au/heraldsun/story/0,21895,25219928-662,00.html March 22 2009

Service Provision Models

Lack of Research

In South Australia the 'growth in NGR [net gaming revenue] has increased every year since gaming commenced in 1994… despite the significant number of harm minimisation and responsible gambling measures introduced in recent years' (OLGC 2007). Whilst some may suggest there has been an 'explosion of scientific research focusing on gambling' (NCRG 2007), this focus has been directed primarily upon the gamblers' habits rather than on the effectiveness of problem gambling interventions. There is a dire lack of research regarding the effectiveness of different types of interventions with problem gamblers (NCRG 2007, Griffiths undated, Gray, Oakley Browne & Radha Prabhu 2007). This includes little or no research/evaluation of telephone counselling, the self-exclusion process, venue-level and machine-based interventions, cultural differences in gambling (DHHS 2005, Rodda and Cowie 2005, Raylu & Oei 2002) and the link between counselling outcomes and counselling processes (Rodda and Cowie 2005).

In saying this, we are aware of, and welcome the valuable work of the Responsible Gambling Working Party (RGWP) and the recent commissioning of two trials to be conducted in 10 hotel and club venues across SA to test the efficacy of "smart card" player tracking capability via loyalty card systems. In addition to this a cashier-assisted card system will also be tested and all trials will be evaluated in the coming months.

Yet despite this move, there is currently no standard for what constitutes a measure of "efficacy" within gambling help intervention.

> *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.*
>
> (Olivieri & Rogers 2005)

At the very best, there appears to be no acknowledged range of "best practice" approaches in relation to models of gambling help service provision (DHHS 2005, Victorian Gambling Research Panel 2003, Griffiths undated, Toneatto and Millar 2004), and where there is 'promise', there 'is not a single initiative where the evidence is conclusive' (Williams, West & Simpson 2007, p40).

Further to this, what research does exist is said to be lacking in quality, with 'very few meet[ing] the gold standard criteria set out by the American Psychological Association' (Delfabbro 2008, p186).

This lack of evidence supports the timeliness of a public health framework, as it would provide the opportunity to contextually trial and research diverse primary, secondary and tertiary responses to gambling-related harm.

RASA's experience in relation to specific population groups

> *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.*
>
> (Olivieri & Rogers 2005)

Accordingly, the South Australian governments' *Problem Gambling Services: Action Plan* (2007) recommends developing treatment and support services to respond to the needs of Aboriginal, CALD and young people and integrated treatment and support plans for clients who also have depression, anxiety and drug and alcohol problems, for example the development of referral networks to gambling help services for health and human services providers. This is welcome, and it needs to be understood in terms of the need to tailor methodologies at the local level to respond to the very specific group, individual or family receiving support.

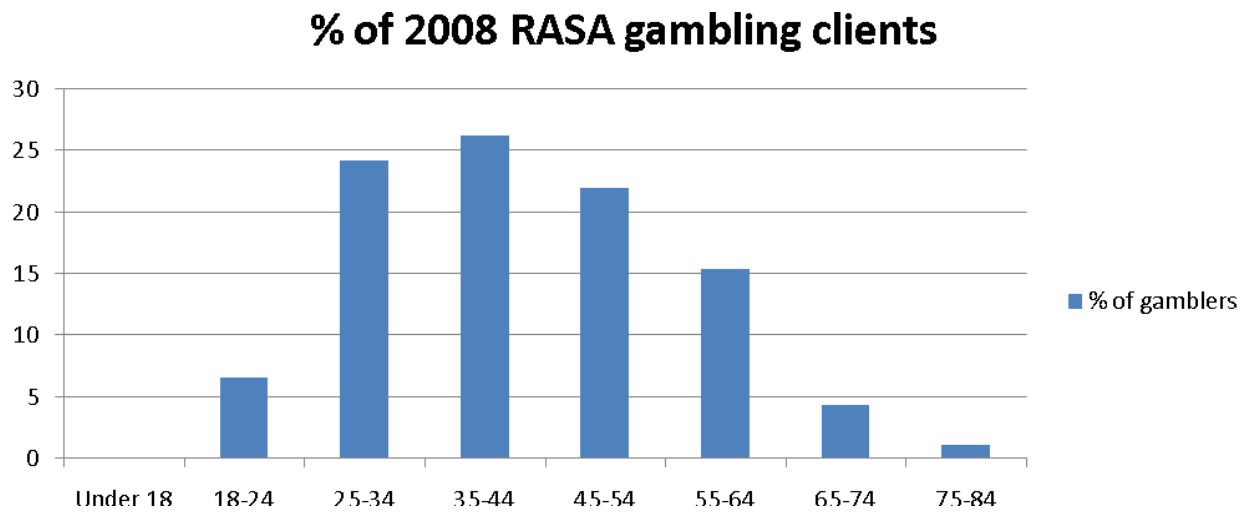
Gender

As stated previously in *Context*, men gamble problematically far more than women, and should therefore be targeted in health promotion messages and service responses.

Age

Studies demonstrate that gamblers in different age groups differ in their gambling behavior including treatment response (Gonzalez-Ibanez et al 2005 and Lynch, Maciejewski & Potenza 2004).

RASA clients fall across the age spectrum:



Young people

> The literature shows that gambling has a very early onset age - around the ages of 12 to 14 years (Felsher et al., 2004, Petry, 2005). Therefore, interventions need to be implemented prior to the onset of gambling behaviour in order to delay or prevent the behaviour from occurring. This age group generally does not have any prior gambling misconceptions which need to be corrected.
>
> (Gray, Oakley Browne & Radha Prabhu 2007)

Whilst participation in gambling is relatively even across the age ranges (Delfabbro 2005), 'prevalence estimates of *disordered* gambling among youth reveal rates that are two to four times that of the general adult population' (Korn and Shaffer 2004, p31, italics added). A 2005 South Australian survey reports 44% of young people aged 16 to 17 years had gambled in the past year, with 1% of these young people classified as problem gamblers. In the 18-24 year age group the figure for problem gambling rose to 12.29% (Delfabbro 2005).

As corroborated by our client data, younger men are the most likely population group to problematically gamble (Delfabbro 2005). In 2007, 4.7% of RASA gambling clients were aged 24 and under, with that figure rising to 6.6% in 2008. Of these young clients however, in 2007 85.7% were male, and in 2008 100% RASA clients aged 24 and under were male.

Australian research also indicates that whilst problem gambling is a major issue for young people, they do not often seek help (YACV & GHYAG 2004).

Adolescent problem gamblers have been found to have lower self-esteem, higher rates of depression than otherwise expected, poor general coping skills, higher anxiety and heightened risk for suicide ideation and attempts (Dickson, Derevensky and Gupta 2002).

Given this, and the fact that young people rarely seek help for gambling, it would seem appropriate to link with youth services who may already be responding to these issues.

Retirees

There appear to be insufficient social and community engagement opportunities for older adults, thus gaming venues are very popular for their welcoming environment and often cheap food. We are seeing retirees spending their own and their partners' retirement funds; a scenario that will not only be burdening families, but also impact on the numbers of government pensions sought.

Incarcerated People

Australian studies indicate prevalence rates of problem gambling amongst prisoners to be between 17.4% and 33% (Lahn 2005, Williams, Royston & Hagen 2005). In South Australia for example, Marshall, Balfour, and Kenner (1997) found that 33% of a sample of 107 prisoners could be classified as probable pathological gamblers, and a further 8% were problem gamblers (in Williams, Royston & Hagen 2005). In a number of studies, Australian prisoners were also found to be engaging in gambling within prison (though not necessarily 'problematically'), and were interested in gambling support (Williams, Royston & Hagen 2005). These are extremely high rates of problem gambling, and may also correlate with high levels of mental illness amongst the prison population, thus people in prisons should be targeted for support.

RASA has experienced high demand from Mobilong Prison and Cadell Training Centre in offering group gambling help programs as well as individual counselling.

Families

Parents and relations access our services with concerns about their child, partner or other relative. Their concerns relate primarily to theft and demanding behaviour, including aggression and violence. They are generally seeking advice on what to do or what to say to the gambler to arrest the loss of money and change anti-social behaviours.

Culture

Culturally and Linguistically Diverse Communities

> *There is scant available literature that quantifies levels of gambling across different CALD groups. The most comprehensive study of this nature is the report prepared by Cultural Partners Australia Consortium (2000) for the Victorian Casino and Gaming Authority… The study found there were clear cultural differences in preferences for gambling activities and in participation in those activities across the respondents. In most cases, participation rates in various forms of gambling activity were lower for CALD communities than for the general community… [however] among those who gamble, the risk of developing problem gambling*

> *behaviour… was five to seven times higher than that for the general community in all four cultural groups [Vietnamese, Greek, Chinese and Arabic].*
>
> (DOJ 2005a, p23)

Consideration of CALD communities is therefore paramount in a population health strategy.

As with the mainstream population, a Victorian survey found that poker machines were the most common form of gambling for both male and female CALD participants, with gambling at the casino being identified by around one in three participants (DOJ 2005a).

CALD groups vary considerably in their reasons for gambling, and reasons for abstaining from gambling (DOJ 2005a), and should be considered on an individual basis. That said, boredom, loneliness and social isolation (limited English proficiency) have been noted as reasonably prominent self-reported reasons for gambling amongst CALD people (DOJ 2005a). Whilst 'it has been argued that religious affiliation is an important determinant of gambling involvement… there is little evidence to suggest this is now the case' (DOJ 2005a, p27).

For CALD communities, the damage caused by problem gambling can be exacerbated because of isolation, disconnection from mainstream cultural mores regarding gambling, the trauma of migration and unrealistic expectations about making money in Australia.

With funding from the State Office for Problem Gambling we have conducted our own small qualitative study of CALD experiences of and responses to problem gambling and gambling help services.

Aboriginal and Torres Strait Islander Australians

Whilst there are few studies published about Aboriginal people and gambling issues, a number of studies with small sample sizes (between 100 and 650 participants), indicate that problem gambling occurs more frequently among Aboriginal populations; as much as 15 times that of the non-Aboriginal population (AH&MRC NSW 2007, DOJ 2005).

> *A survey of 128 members of the Aboriginal and Torres Strait Islander community in gambling venues in Queensland found the average weekly gambling expenditure was $60, of which half was spent on gaming machines (Australian Institute of Gambling Research & Queensland University Labour and Industry Research Unit 1995). This is far higher than that found among Queensland gamblers in general.*
>
> (DOJ 2005b, p21)

Aboriginal people are therefore an important population group for gambling help services.

As with the mainstream population, poker machines are reported as the preferred gambling mode of Aboriginal 'problem gamblers' (DOJ 2005b).

Aboriginal clients have been described as being concerned about shame and confidentiality (and that these concerns are a primary barrier to accessing services) and as experiencing discomfort and requesting informality in relation to data collection (AH&MRC NSW 2007, DOJ 2005). There does not appear to be a screening tool 'developed or validated for use with Aboriginal population groups' (AH&MRC NSW 2007, p49). These are significant shortcomings in the design of services for Aboriginal people. Of the 7 Aboriginal clients our mainstream program saw over the last 2 financial years, only 2 attended for more than one session (1 for 22 sessions, the other for 6).

Aboriginal service providers also recommended a mobile counselling system and telephone counselling for Aboriginal people (AH&MRC NSW 2007, DOJ 2005). The need for a holistic, integrated approach to an Aboriginal client's welfare was reiterated in this report, as was utilising community awareness to reduce stigma, possibly through existing health programs (AH&MRC NSW 2007).

We have some experience in delivering a range of non gambling –related counselling and community education programs to Aboriginal communities and would support the above recommendations including community development methodologies providing integrated services across a range of health and wellbeing issues.

Rural and Regional Areas

In the design of services, it is important to consider potentially unique characteristics of gambling in rural and regional areas. In many of these locations, entertainment options may be limited, sometimes severely. Many pubs that house Electronic Gaming Machines may also be community-owned, thus there is a perception that gambling is, in a sense, a form of donation or community service. Concerns regarding confidentiality, and simultaneously mistrust with community "outsiders" may be stronger and thus inhibit help seeking.

Public Health Model

Olivieri & Rogers' (2005a) review of South Australian problem gambling preventions and treatments suggested that learning should be gleaned from 'the strengths of the Victorian system [which] was its ability to provide a range of interventions at individual, couple, family and community level'. In particular, its claim that 'problem gamblers need more than simply 'treatment' and necessary services should include financial counselling, advocacy and negotiation (eg around housing), and relationship counselling'.

In 2007 the Office for Problem Gambling (OPG) developed Service Standards for the sector (currently still in draft form and to be finalized for implementation alongside contracts awarded to service providers in 2009) which details the range of treatment modalities used by gambling help services across the sector, as well as a range of community capacity building strategies inclusive of community education, identification of risk factors, early intervention, and promoting responsible gambling (Draft Service Standards p9).

"This approach is reflective of a broad range of frameworks …which aim to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient services to undertake prevention and early intervention strategies alongside the treatment." (Draft Service Standards p10)

This framework of prevention, community education, early intervention, and treatment in a context of healthy public policy and strengthening communities, articulates and promotes a public health model of managing gambling and problem gambling in South Australia, which we fully support. We caution against a contraction of this framework away from prevention and community education to concentrate service effort more on treatment. While this is understandable given the need to ensure that current funding is directed toward improving client access to help services, we feel additional attention should be directed toward prevention and community development methodologies.

The Responsible Gambling Working Party, appointed by the Minister for Gambling in 2006 to investigate harm reduction strategies for customers using EGM's, primarily through the use of player tracking technologies, has broadened its focus to investigate and support education programs on money management and understanding gambling products both in venues and, potentially, in schools.

We have learnt too that the Department of Education and Children's Services (DECS) has been awarded funding to deliver a Financial Literacy and Responsible Gambling program that will enable young people to develop money management skills and aims to protect them from developing gambling related problems.

Certainly education is a key component of both prevention and, consequently, harm reduction and this work is of significant value.

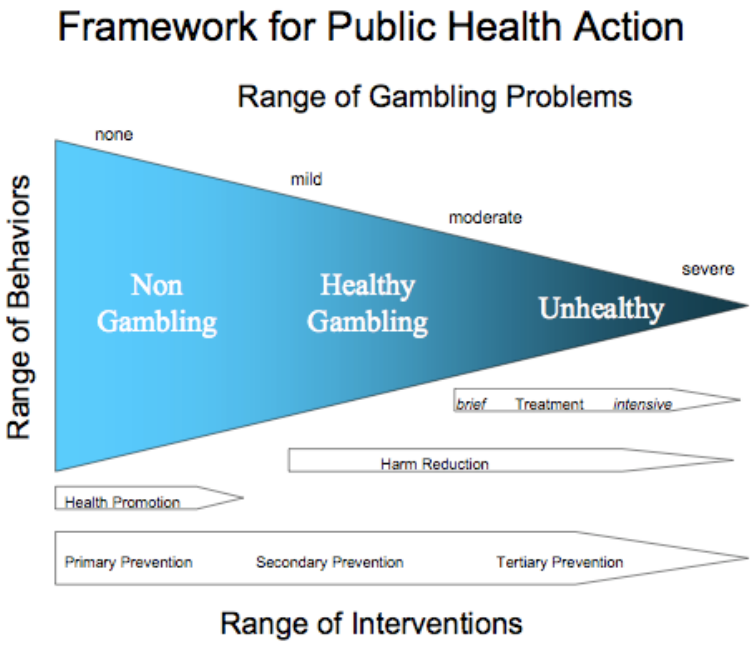
All of these developments along the Harm Minimisation continuum are highly commendable but we are concerned about the lack of attention directed towards prevention.

Early Intervention is the primary domain of the early intervention agencies Gaming Care (hotels), Clubsafe (clubs), now Approved Intervention Agencies or AIA's, and the Host Responsibility Coordinators (casino) who respond (as in the case of the HRC team at the casino) or support and train gaming staff to respond to a patron in a venue exhibiting signs of problem gambling. The new Codes of Practice mandated on 1st December 2008 with which gambling providers are required to comply, include expectations of relationships between the venue, the AIAs, and the local Gambling Help Services; as well as gaming staff intervention with patrons of concern. It is hoped that formalizing these interactions will result in earlier interventions, increased help-seeking behaviours and improved referrals and follow up.

In addition, we believe a public health model will more effectively respond to the context of problem gamblers (variables influencing gambling behaviour) and the effects of problem gambling. We see this as important because our clients present with mental health, housing, relationship, financial, parenting, drug and alcohol and grief issues that are significantly entwined with their gambling habits, and require attention as part of an holistic(/successful) intervention.

> *RASA Case Study: Rosa*
>
> Rosa has a gambling problem, but its significance is far outweighed by her on-going difficulties with her violent ex-husband. "I know I have a gambling problem, it's making me upset too, but sometimes if I have the husband problem, I don't care about the money. I don't care if I lose or win, I feel very sad and I just keep going there and I keep losing. It just comes from my ex, this problem, I can't handle it any more."
>
> Rosa sought help from various gambling help agencies, who appeared to feel mandated to focus on her gambling problem alone, without attending to the domestic violence. "Different places they see me, two times, three times, they don't want listen any more. I asked at that place to help, and they say, no they can't see you no more. Like your help is done. I was in lots of problem and I just want to share with someone. I feel like talk someone, even if they help or not, I just want someone to listen to me, just to help me." (RASA 2007, p16).

Korn and Shaffer's seminal model of a public health framework for gambling recommends primary, secondary and tertiary interventions across society – including for non- and low-frequency-gamblers – *that also accounts for particular population groups* (Shaffer 2003, p3).



Who would be treated and for what?

Shaffer notes that 'gambling researchers use levels ranging from 0 to 4 to describe the prevalence of gambling-related behavior . Level 0 represents people who do not gamble. Level 1 represents those people who gamble recreationally with no adverse consequences. When gambling behavior is associated with any of a wide-range of negative consequences, however, it is classified as level 2 gambling. Level 3 represents people with adverse consequences that are sufficiently serious and co-occurring as to meet the diagnostic criteria for disordered gambling. Finally, gamblers enter level 4 when they seek help for their problem regardless of the extent of their distress.' (2003, p8)

All "levels" of the community would be targeted for primary services; prevention and education work, including community development, with a particular focus on some level 0 and 1 gamblers, such as youth. This is consistent with other public health initiatives such as tobacco intervention. The public health model is particularly focused at this end, with the rationale that prevention and management is ultimately more cost effective than treating harm..

Level 2 and 3 gamblers would be targeted for harm minimisation and treatment interventions, to varying intensities according to their situations.

The methodologies/interventions offered need to match the characteristics and experiences of the public however, and a public health model pays attention to 'biological and behavioural dimensions… [as well as] social and economic determinants of gambling' (Shaffer 2003, p2). Attachment One details our thoughts on a range of primary, secondary and tertiary interventions.

Characteristics of Level 0 and 1 Gamblers

Some information is known about the characteristics of problem gamblers (which follows in *Characteristics of Level 2 and 3 Gamblers*) however more understanding is needed of the characteristics and contexts, and appropriate messages and channels for messages, for level 0 and 1 gamblers.

Characteristics of Level 2 and 3 Gamblers

In a 2005 South Australian survey of 17 000 adults, the most popular gambling activity among moderate and high risk gamblers in South Australia was poker (gaming) machines (SADFC 2006).

From the above survey, moderate and high risk South Australian gamblers were identified as more likely to be male, or have no children in the household, or to have secondary school education only (SADFC 2006). This is congruent with our client data.

Our experience as a service provider has shown us that gambling problems often appear after a period of extreme emotional vulnerability. This may arise from a significant loss or disappointment, such as the death of a loved one, the breakdown of a relationship or the loss of a job. The person either consciously or unconsciously discovers that playing poker machines gives them symptomatic relief. The more they use poker machines as a tool to avoid their pain, the more likely they are to develop other, gambling-related problems.

Co-Morbidity and inter-related difficulties

'A variety of mental disorders occur at disproportionately high levels among disordered gamblers… [including] substance use disorders, mood disorders, anxiety disorders, personality disorders and impulse disorders' (Korn and Shaffer 2004, p33). 62% of South Australian moderate and high risk gamblers used alcohol or drugs while they were gambling and 41% had experienced feelings of serious depression in the year preceding the survey (SADFC 2006).

'Community service recipients in general and the homeless in particular evidence elevated rates of gambling disorders' (Korn and Shaffer 2004, p32). 26% of clients of South Australian Break Even services in 2005 were identified as experiencing housing problems due to gambling; 16% were at risk of homelessness; 6.5% were currently homeless and 15% had experienced homelessness in the past due to their gambling (Rogers 2005). 34.3% of people in contact with correctional services in the ACT were defined as having a problem with gambling (using SOGS) (Lahn 2005).

Conversely, 'Serious gambling problems have adverse impacts [including]… high rates of suicide contemplation, relationship breakdown, housing difficulties, financial problems and reduced productivity in work and study' (Olivieri & Rogers 2005a).

There also appears to be a link between smoking and gambling, with people living in smoking households at higher risk of gambling, as well as gamblers accessing help services having higher rates of smoking (Rodda and Cowie 2005). The introduction of

smoking restrictions was 'consistently recognised or cited by EGM players when asked or prompted about… harm minimisation measures' (Rodda and Cowie 2005). In the year following the in-venue ban on smoking, RASA saw a decrease in client numbers.

Housing, health, welfare and correctional services may therefore be useful sites for promoting gambling help services. Models need to have clear cross-issue referral or collaborative practice approaches due to co-morbidity and variant presentation.

Socio-economic status

Several studies cited in a Department of Justice research paper identify low socio-economic status and unemployment as characteristics of gamblers (it is not clear however, if these characteristics are identified with 'problem gamblers") (2005). Of our mainstream problem gambling clients over the last 2 financial years, only 19% were unemployed or on the Disability Support Pension. Delfabbro et al (2005) however, associate problem gamblers with a lower socio-economic demographic, *regardless of where they live* or whether they are employed.

Those with moderate/high risk frequent gambling are cited as having a statistically significant and high correlation with being employed full time (Delfabbro et al 2005). Our client data indicates gamblers accessing our services are primarily employed (69% average across the 2 last financial years for our mainstream program), and earn an income across the full range of income levels, with some trends amongst particular groups. Graph 3 shows an inclination for our central metropolitan mainstream service clients to have a higher income than clients within our multicultural service.

Graph 3: Weekly income levels of RASA mainstream and multicultural program clients

These findings pose some concerns for funding being distributed according to socio-economic factors.

Carrig, Grogan and Henley observe that 'the number of EGMS in lower socio-economic communities continues to be very high and the machines for which approval has been given to relocate have, in aggregate, moved from communities with a higher SEIFA index than the location to which they have been moved... [and that] this issue has been of significant concern for over a decade' (undated, p6). We echo their call to stop 'further movement of machines to a location with a lower SEIFA index than that of the location from which they are proposed to move' (Carrig, Grogan and Henley ud, p6) and for there to be a general cap on EGM density in any given area.

Exposure

Correlations between exposure to gambling opportunities (eg. prevalence of gaming machines in proximity of your house) and pathological and problem gambling have been found to be moderately high (Nelson 2004) and 'marginally important in predicting risk of problem gambling' (Rush, Veldhuizen & Adlaf 2007, p193).

Characteristics of Level 4 Gamblers (Gambling Help clients)

People accessing our Gambling Help Service - men and woman across the age spectrum – report that EGM gambling alleviates feelings of loneliness, isolation, grief, sorrow, anger, disappointment, stress, inadequacy, depression and anxiety. It provides relief, relaxation, excitement, a heightened sense of possibility and hope, and a focused consciousness to the exclusion of all else.

> *RASA Client Case study: Joylene*
>
> Joylene rang recently in tears. While she was concerned about her debt, she disclosed that her son had died 11 months ago and her husband had died 5 weeks later. Both deaths were unexpected.
>
> The image of her son lying in his coffin flooded into her mind a few days before she rang and said she hadn't been able to stop crying since the image came. When asked if this meant that she had not been crying in the months since her son's death, Joylene adamantly confirmed that she had not shed a tear; she had been playing the pokies.
>
> The depth of numbness Joylene had achieved through her preoccupation with gambling was remarkable to her.

Drugs and Alcohol

Many clients describe gambling under the influence of alcohol or drugs. Interestingly, some clients have reported taking up gambling specifically after being prescribed and taking antidepressant medication, with their gambling escalating to a problematic level very quickly. We wonder if this warrants detailed investigation.

Stimulant drugs also do not mix well with gambling, sometimes leading to excessive losses:-

> *RASA Client Case study: Chad*
>
> Within 4 days of selling his house, under the influence of speed, Chad gambled $160,000 on the pokies.

Characteristics of Level 4 Non-Gamblers (Gambling Help non-gambling clients)

Information supplied previously in the *Context* section of this paper details characteristics of our non-gambling clients.

Service Access Issues

The following is relevant to the design and promotion of services:

In a study of almost 46,0000 American adults, Slutske found the "number of individuals seeking formal treatment was low" (in NCRG 2007). This is corroborated by a survey of South Australian Break Even services (Olivieri & Rogers 2005a) and in an Australian national survey by the Productivity Commission, of those identified as having a problem with gambling, only 10% had received support from a counselling service (Delfabbro 2008).

A survey of 70 'problem gamblers' in South Australia (Evans and Delfabbro 2002 in Delfabbro 2008) revealed 'that concerns about physical and mental health, financial pressure, and relationship difficulties were by far the most common reasons for seeking assistance… [with] over half the problem gamblers cit[ing] four or more reasons for seeking help' (Delfabbro 2008, p176).

Mainstream RASA clients were primarily made aware of the gambling help service (and thus accessed the service in the first half of 2008) by looking in the phone book (21.5%), from a friend or relative (18.5%), through community information (12.3%) or through a health professional/other agency (9.2%).

RASA supports the work of industry staff to approach clients they are concerned about in venues, and believe this will result in increased service access. We provide advice and training to assist in the appropriate level of response from such staff and would like to see greater confidence and encouragement for this from venue proprieters.

Whilst young people rarely seek help for gambling problems, we have also found that South Australian youth services rarely ask clients about gambling in assessment interviews (RASA 2004). We look forward to contributing to the upskilling of health and community services staff in relation to awareness of problem gambling and capacity to appropriately refer and respond.

It has been noted that for CALD communities 'The most common referral points [to gambling help services] are family, and to a lesser extent, friends' (DOJ 2005a, p3). The RASA PEACE multicultural gambling help program however contradicts this trend through having a strong community development focus; working with communities, as well as supporting individuals. The vast majority of PEACE problem gambling clients access the service via contact with one of

the service's multicultural Community Educators (63%[6]). Problem gambling is so stigmatized in many CALD communities that it is counter-productive to use the gambling problem as a first point of contact as it immediately stimulates denial and resistance (RASA 2007, p10). PEACE Community Educators listen to and aim to address wider community issues, rather than focusing solely on problem gambling, and in terms of access, this approach appears to be working as we have a small, steadily increasing client base for financial and gambling help counselling.

Counselling and the role of social services are new and often alienating concepts to the many CALD communities. Such services may be perceived as only for the mentally ill or 'insane', and

therefore highly stigmatized and stigmatizing. Building effective access means involving the community in developing relevant and appropriate services and being part of the delivery of those services. (RASA 2007, p3)

The three main barriers for CALD people in accessing gambling help services were identified in the Victorian survey as being:

- lack of confidence that a service can help
- concerns around confidentiality
- feelings of shame and stigma.

Limited English was also mentioned as a barrier.

(DOJ 2005a, p5)

Aboriginal people do not often seek assistance from mainstream gambling treatment services (AH&MRC NSW 2007) although when they do, they are most commonly referred by Indigenous organizations and friends and family (DOJ 2005b). Our experience with Aboriginal community education and development programs (not related to gambling) encourages us to recommend community capacity building and cultural development activities as significant strategies for creating responses to prevent and intervene in problem gambling. These strategies would be long term and would emerge from community themselves once a working partnership is established with a gambling help agency. Similarly to the CALD community response mentioned above, problem gambling as the point of first contact is not an effective approach as many other issues have a greater priority in the lives of Aboriginal community members.

[6] Based on RASA multicultural program data for the first half of 2008, however this is consistent with other timeframes also (varying between 52% and 71%)

Funding Model

South Australian gambling help funding was previously distributed on a per capita basis, and is now distributed based on an Index of Disadvantage. Whilst this is appropriate if a disproportionate influx of EGMs into low socio-economic regions is allowed, there otherwise does not appear to be a strong research base suggesting that (were there equal density of EGMs) problem gambling is particularly concentrated in lower socio-economic *areas*.

In South Australia in 2001 and 2004 surveys it was found that 'around 85% of those who scored in the problematic range on the rating scale reported playing poker machines, with 60% of all reports of problem gambling amongst others found to be related to this form of gambling. Thus, consistent with recent South Australian Break Even data reported by the Department, poker machines clearly remain the major cause of gambling related problems in South Australia' (Delfabbro 2005, p21). It is reasonable to suggest that *tertiary* gambling help interventions may be better funded in accordance with the location distribution of EGMs.

In line with a public health model, RASA advocates the adoption of a more complex funding model separated into Primary, Secondary and Tertiary interventions, and directed to high-need population groups within each of these intervention clusters – as they have different priority audiences. For example, in terms of Primary intervention, funding may be distributed according to youth density, either per youth population or number of schools in the region. Secondary interventions would have funding distributed according to the core target groups for harm minimisation, such as frequent gamblers, consumers of community services (co-morbidity), etc... Finally, tertiary measures would target problem gamblers, for example funding may be distributed according to EGM distribution.

Example of possible funding matrix for gambling help interventions:

	Primary interventions Prevention	Secondary interventions Harm minimisation and early intervention	Tertiary interventions Support services
High need/ target populations:	For example: • youth • children of people gambling problematically • recreational and frequent EGM gamblers • online gamblers • general public • CALD and Aboriginal specific populations	For example: • recreational and frequent EGM and online gamblers • people living with co-morbid conditions such as mental illness • young men • CALD populations • Aboriginal populations	• people identified as gambling problematically
Funding distributed according to characteristics of target populations or indicators of high risk:	• number of school students • children of gambling help service clients • number of EGMs in region per capita • access to CALD and Aboriginal populations	• men, particularly young men • number of EGMs in region per capita • online gambling patterns • access to CALD and Aboriginal populations	• number of EGMs in region per capita • access to CALD and Aboriginal populations

Regardless of the model used, the pool of funds currently directed to managing gambling harm in South Australia needs to be larger to adequately meet the primary, secondary and tertiary public health needs. We particularly believe a strong and ongoing awareness campaign needs to be funded communicating the risks of gambling, particularly frequent gambling. It may be that Gambling Rehabilitation Funds are directed to tertiary and some secondary responses, and that primary interventions are funded through different, Health or Welfare funding.

Research Directions

McMillen argues that 'Community groups are still fragmented and lack equivalent resources [in relation to gambling research or advocacy], but their collective submissions can be equally important if they maintain an essential distinction between mere opinion and evidence-based advocacy' (2009). The lack of research to date, the ad hoc nature of that which does exist, and the need for quality research to support evidence-based practice, means the future of gambling research is very important to us.

In alignment with McMillen, we suggest that 'research tends to be state-based and inconsistent, preventing comparative analysis' (2009) and the development of quality evidence. A coordinated response to research is required, both in terms of method and content. That said, we believe that having different harm minimisation responses in operation may be more helpful than disruptive as it will increase the range of measures that can be researched. Whilst this does not make for consistent research, it does allow for research of difference. Mares (2009) notes that, 'there are no ATMs in pokie pubs and clubs in Tasmania, which may partly explain why the losses of Tasmanian gamblers are significantly lower than those in other states and territories'. Research on differences such as these may contribute to existing tentative findings.

Importantly however, individual components of gambling (such as the presence or absence of ATMs in venues) need to be considered and evaluated in their full context. It is important to look at gambling as an ecosystem rather than looking at isolated factors – for example, whilst per capita spending may not have been affected post the introduction of note acceptors into a particular region, did these venues not have ATMs inside or were the venues limited in EGM density? A more sophisticated picture of the interactions of factors will contribute to a more practical knowledge base, and undermine narrow presentations of gambling research results that can be misleading.

We note that the introduction of initiatives in order to research their impact – such as the introduction of note acceptors – poses a potential risk to consumers given their relatively unknown impact and is thus an ethical dilemma.

Whatever research directions are taken, we believe that incumbent upon researchers (and funders of research) is an ethical mandate to clearly inform the public of their rationale so as to avoid previous problems in which policy has been 'driven mainly by fiscal problems, revenue dependency, and pressure from industry groups' (McMillen 2009).

In particular, we would welcome research into the issues mentioned in this paper:

- impacts of problem gambling on children
- prevalence of online gambling and appropriate awareness messages, harm prevention strategies, harm minimisation strategies and treatment responses
- electronic EGM player tracking
- number of patrons in EGM venues who are problem gamblers as opposed to the number overall within the general population
- characteristics and contexts, and appropriate messages and channels for messages, for level 0 and 1 gamblers (non-gambling and gambling unproblematically)

- factors aiding service access for different populations
- community development practices in relation to gambling support within Aboriginal, CALD and youth communities
- development of culturally-specific screening and assessment tools
- non-monetary gaming venues and non-monetary gaming events hosted within existing community venues
- the gambling preferences of deaf people, to add to the existing knowledge base re sound features of EGMs
- which populations respond best to which education, prevention and treatment methodologies
- correlations and relationships between different factors related to gambling

Data Collection

RASA is constantly looking to improve our data collection. We have found that we are interested in data that is not required to be collected for reporting purposes, and are thus mid-process updating our data collection categories and processes. A state or national integrated framework that agencies could input to and access from would be very useful, particularly in relation to client outcomes and methodologies used.

Information Regarding Primary, Secondary and Tertiary Interventions

Primary Public Health Strategies: Prevention

Limiting Access

Gambling problems develop when opportunities to gamble are available. While there continues to be some contention (Shaffer, LaBrie and LaPlante 2004 in Abbott, In press), Relationships Australia (SA) concur with the abundance of research that suggests 'there are strong associations between particular forms of gambling, particularly EGMs, and problem gambling' (Abbott, In press, p8). We therefore support strategies that limit the concentration of EGMs in both venues, and geographical locations.

We also support strategies that limit access to funds, such as the removal of ATMs from gaming venues, paying out larger winnings by cheque rather than cash and the use of smart cards.

Education

General public

Research indicates it is more useful to 'target potential gamblers in education programs before they become involved in gambling and develop cognitive bias regarding the facts about gambling' (Rodda and Cowie 2005). This is why awareness campaigns are important for young people who are at high risk for problem gambling but are rarely exposed to "youth gambling" as a problem (RASA 2004). Inclusion of the storyline of youth problem gambling in television drama storylines, mainstream media, documentary production and "youth friendly" brochures, posters, literature, and websites are suggested modes to raise this awareness (RASA 2004). It is also suggested that schools integrate messages about gambling (such as the Dicey Dealings program) together with other general health initiatives (RASA 2004).

In line with the South Australian governments' *Problem Gambling Services: Action Plan* (2007), education aimed at people in high-risk groups (such as frequent recreational gamblers) and people in the lives of these population groups, may be usefully focused on breaking down stigmas that limit help-seeking, identifying problematic behaviours and providing information on supports available. In terms of encouraging and enabling gamblers to access support before their difficulties are chronic, broadening community capacity to identify problematic gambling and approach friends/family with information in relation to it, may be helpful.

Gamblers

Dickerson, Haw & Shepherd (2003 in Abbott, In press, p7, emphasis added) have concluded that 'impaired control and subsequent problem development are an understandable and 'natural' consequence of regular, high intensity EGM play rather than

something confined to a small minority of constitutionally predisposed or mentally disordered problem gamblers. **It appears from this research that most regular EGM participants need to use active and planned strategies to remain within their preferred time involvement and budget**. However, even when they do, it appears that about half still lose control at least occasionally.' 'Community education messages should [thus] be targeted specifically at people with an existing medium to high level of gambling, who may be at risk of becoming problem gamblers' (Olivieri R & Rogers N 2005a).

The challenge to these ideas is an explicit lack of support from EGM players for educational strategies such as advertising messages in gaming venues (Hing 2003, Rodda and Cowie 2005). The limited research on their impact that does exist suggests their ability to '*produce actual changes in behaviour is much less common*' than their influence on knowledge and attitudes, which diminishes over time anyway (Williams, West & Simpson 2007, p9).

It appears awareness campaigns are only useful if people have been '*explicitly asked to attend* to the information' or have an 'intrinsic interest' in it (Williams, West & Simpson 2007, p8). For example, an awareness campaign in Indiana USA utilizing radio announcements, billboards, brochures, newspaper advertisements, posters, pens, t-shirts, press conferences and public meetings resulted in only 8% of the general public having 'recalled seeing or hearing any of the advertising', however 'of that 8%, 72% reported… [it] had increased their knowledge of problem gambling' and 1% of the total sample 'took action based on seeing/hearing the ad' (Najavits, Grymala and George 2003 in Williams, West & Simpson 2007, p8). At the same time, two Victorian public awareness campaigns yielded significant increases to the gambling helpline (a 70% increase in the second campaign), however Williams, West & Simpson (2007) make the point that increasing the engagement of distressed gamblers into services – whilst a fantastic outcome – is not a particularly 'preventative' outcome.

'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' (Olivieri R & Rogers N 2005a).

Banks and lenders

Banks and other financial services are in a key position to notice and respond to financial stress that may be a result of problem gambling. We would advocate for these institutions to have an awareness of the prevalence and common indicators of problem gambling and be able to conduct risk assessment and referral. Comment on secondary interventions that could be made by these institutions is made in this document on page 31.

Community Development

Community development tailored to regional needs and expectations is an approach strongly advocated for responding to the needs of Aboriginal clients (DOJ 2005b) and CALD communities (DOJ 2005a).

RASA's Multicultural Gambling Help Services are based on the principles of community development and community education and have a strong focus on facilitating partnerships between CALD and mainstream agencies and CALD communities.

> *RASA Client Case Study: Mohammed*
>
> Mohammed was a dutiful son from the Kurdish community. He studied, he worked, he had his family's respect. His father was famous in the community, a freedom fighter, proud, with strong traditional values. He was close to his son.
>
> When Mohammed was seventeen he was taken to the pokies by a TAFE classmate. He watched her win, then put in a couple of dollars himself and won $50. He can still remember the sound of the three lines ringing into place. That sound has haunted him for years, drawing him back to the same machine. Before long he was gambling his week's wages. Then he started borrowing.
>
> There were some other Kurdish students at TAFE and they saw him in the pub. They told his dad. It wasn't so much dobbing as community solidarity, but it changed everything for Mohammed. His dad ignored him, isolated him. When a son does something wrong, the community points at the parents. They were overcome with shame.
>
> Fortunately there is a Kurdish Community Educator in the PEACE program. He heard about Mohammed through the community and approached his father. In fact he spends as much time with the father as the son, explaining how it is in Australia, the social pressures, the temptations that just weren't there in the old country, trying to build bridges between the cultures and within the family.
>
> It's been four years and the sound of that machine still rings in Mohammed's ears, dragging him back. But he's at Uni now and the pokies are farther away. Most importantly, he's still at home. The community educator still spends hours on the phone with the dad, and still takes Mohammed to the beach, the aquatic centre, anywhere they can talk and find a neutral space between conflicting cultures.
>
> (RASA 2007, p7)

Given that the majority of PEACE clients access the service via Community Educators (63%[7]), we see this as a very successful mode and would encourage the expansion of community development practices in relation to gambling support within Aboriginal and youth communities.

The active engagement of young people in the delivery of awareness campaigns through 'consumer voice' speaking engagements, peer-based programs including 'floor walking' and programs engaging the family and friends of 'youth problem gamblers' have been recommended (RASA 2004). Byrne et al (2005) 'felt that using youth spokespeople to focus on personal stories, including loved ones and family members who are affected by gambling addiction, can have a great deal of impact' (in Gray, Oakley Browne & Radha Prabhu 2007).

Group work

Gray, Oakley Browne & Radha Prabhu (2007) reviewed gambling help interventions. Within this review, the only systematic review of primary preventions found by Gray et al (2007), reported that interventions that involved human interactivity, such as those 'that used lectures and activities... were found to work'. Delfabbro (2008, p180) also found that 'Practical and active support involving interaction with other people, rather than a reliance on information alone [such as signs on venue walls], appears to be a key element in reducing problem gambling'.

Non-Monetary Gambling Options

Gaming venues are well-aware of the social aspect to gambling; they, for example, send their clients "we miss you" text messages when they haven't "seen them" for a while.

Non-monetary gaming houses that include the social and welcoming environment of standard gaming venues, may be an appropriate option for some community members.

Non-monetary gaming events hosted within existing community venues may also be attractive, such as the recent popularity of the National Poker League's Texas Hold'em Poker.

Secondary Public Health Strategies: Harm Minimisation

There is a distinct lack of research into the effectiveness of Responsible Gambling measures (RGMs) in Australia, Europe, Canada and the United States (Hing 2003), however a 2001 Australian audit of mandatory and voluntary responsible gambling programs across the various gambling sectors 'found no evidence to support the efficacy of responsible gambling measures' (Hing 2003). Harm minimisation measures implemented thus far have received the same bleak review, although the range of measures implemented is limited (Rodda and Cowie 2005).

[7] Based on RASA multicultural program data for the first half of 2008, however this is consistent with other timeframes also (varying between 52 and 71%)

In Hing's 2002-03 survey of NSW adults, those most positively affected by responsible gambling measures, were those who were already considered 'problem gamblers' (using the Harm to Self Scale of the Victorian Gambling Screen) (Victorian Casino and Gaming Authority, 2001).

Even with this client group, however, outcomes were modest, particularly in changing key aspects of gambling behaviour (frequency, session length and expenditure):

- 26.2% of problem gamblers compared to 8.6% of non- problem gamblers reported RGMs to have influenced them to gamble less often
- 23.1% of problem gamblers compared to 9.9% of non- problem gamblers reported RGMs to have influenced them to gamble for a shorter time
- 53.7% of problem gamblers compared to 33.7% of non-problem gamblers felt RGMs changed how they think about their gambling, and
- 23.2% of problem gamblers compared to 5.3% of non-problem gamblers felt RGMs changed how they felt about gambling by making it less enjoyable to some extent
- (Hing 2003).

Regardless of the model and strategies adopted, we have found that people are not accessing support until they are experiencing serious difficulty. For problem gamblers thus, harm minimisation measures such as voluntary banning or biometric ID use, will be "too late", but may contribute to easing future burdens. For regular recreational gamblers however, harm minimisation measures could prevent crossing over to more harmful, problematic gambling, and it is really to this group of people that harm minimisation measures need to be directed.

Community Development

Community development is a framework that is appropriate to primary, secondary and tertiary modes of working. See the section above *Community Development* in *Primary Public Health Strategies: Prevention* for further comment.

Controlled Gambling

Gambling in a controlled manner, rather than abstaining from gambling completely, is generally advocated within the gambling sector. Whilst we support clients' right to work towards this, we notice that the vast majority of gambling clients entering our service want to stop gambling altogether because of the adverse consequences to them and those close to them. Many have already attempted to institute controls over their money, frequency of gambling and time spent, but found their urge to gamble quickly overwhelms their intent.

Note Acceptors

Research into the benefits or otherwise of the use of note acceptors is in its infancy, and thus varying findings have been reported.

Bill Healey of the Australian Hotels Association suggests 'recent data indicates that restrictions on note acceptors have no impact on per capita gaming machine expenditure' (2007).

SACOSS has identified research that has suggested 'there may be only marginal economic consequences to the industry for lower limits on note acceptors but significant benefits to gambling harm minimsation measures for people at risk' such as 'reductions in money spent at EGMs, duration spent playing and frequency of visits, levels of enjoyment and reductions in the money spent on other forms of entertainment at gaming venues (Brodie, Honeyfield and Whitehead 2003 in SACOSS 2007, p3).

In the same paper however, Nova Scotia research was referenced which reported that 'while players rated the use of note acceptors highly in the self management of expenditure while playing EGMs the findings actually demonstrated that the rate of expenditure was faster on the machines that included the acceptor' (Schellink and Schrans in SACOSS 2007, p5).

Until a more cohesive body of evidence is built, we would advocate acting cautiously in relation to the introduction of note acceptors as

- they appear to be more attractive to problem gamblers (a 'survey demonstrated that 65 per cent of problem gamblers use note acceptors 'often' or 'always' compared to just 22.7 per cent of non-problem gamblers' (in SACOSS 2007, p6) and it is not yet known why or whether this is helpful
- it is known that less interruption to EGM play increases risk of problematic gambling, and needing to access a change machine or the cashier enforces breaks in play.

Banks and lenders

Upon self-declared, notified or assessed status as a "problem gambler", it would be helpful for banks and lenders to proactively offer advice (such as voluntarily limiting their own access to their funds through caps on Automatic Teller Machine withdrawal amounts) or financial counseling (possibly funded through gambling funds).

It would be particularly beneficial for banks and lenders to institute policy related to problem gamblers that encouraged strategies such as *not* offering problem gamblers further credit or loans without the support of a gambling help agency.

Biometric ID

RASA supports the introduction/trialling of biometric ID technology as it 'enables players to pre commit as well as supporting player monitoring and tracking' (Carrig, Grogan and Henley ud, p8).

Limiting Sound Features on EGMs

We are interested that RASA clients with hearing impairment are not accessing Electronic Gaming Machines as their gambling mode of choice. It is well-documented that sound/noise features heavily in the design and attraction of EGMs, and we would advocate the option of limited sound features on EGMs. We have been unable to find any research conducted in relation to the gambling preferences of people with hearing impairment, but wonder what insight such research may add to the existing knowledge base regarding sound features of EGMs.

Gambling Treatment Court

Judge Mark Farrell established the Gambling Treatment Court in 2001 in the US. The Gambling Treatment Court steers offenders who have committed non-violent crimes consequent to their gambling, to a contracted treatment regime and if completed, incarceration is avoided. South Australia currently utilizes this model in their Drug Treatment Court.

We understand that the Problem Gambling Family Protection Orders Scheme (PGFPOS - currently administered by the IGA) could be utilised to provide an initial basis for a Gambling Treatment Court here, without significant cost and infrastructure.

A submission was made to the IGA Inquiry into Current Barring Arrangements which sought to have the powers available under the PGFPOS Act extended to magistrates, as an initial step in a hopeful journey towards the establishment of a Gambling Treatment Court. The Gambling and Crime Subcommittee (of the Australian Crime Prevention Council SA) is hopeful that in time, the Act itself may be broadened to provide improved protection to family members who currently do not meet the criteria under the act but are being harmed by problem gamblers on whom they are dependent. RASA is represented on this Subcommittee, and we support this submission and dealing with gambling related crime therapeutically in the court system so as to minimise further harm or trauma.

Tertiary Public Health Strategies

The more the public learn of the symptoms of problem gambling, as well as the opportunity to access support services, the more demand for tertiary services are likely to increase.

Community Development

Community development is a framework that is appropriate to primary, secondary and tertiary modes of working. See the section above *Community Development* in *Primary Public Health Strategies: Prevention* for further comment.

Counselling and biopsychosocial methodologies

In 2004, the Independent Pricing and Regulatory Tribunal of NSW found 'a consensus in the literature and among stakeholders that counselling services are an important component of any responsible gambling policy framework'. Further, because 'many programs do not take the view that any single intervention is likely to be successful on its own, …a combination of many forms of treatment [are] *combined with counselling'* (Delfabbro 2008, p180, italics added).

> *In relation to counselling techniques, while few studies on problem gambling counselling have produced conclusive results, most reported that counselling results in positive outcomes, primarily linked to eclectic therapeutic approaches, client assessment, counsellor characteristics and client participation in goal setting.*
>
> (Independent Pricing and Regulatory Tribunal of NSW (IPART) (2004) *Gambling: Promoting a Culture of Responsibility.* Final Report)

Though there 'is very little information concerning the effectiveness of counselling services' (Delfabbro 2008, p181), a 2005 study of "problem gamblers" in Victoria found that 'over 90% were satisfied with the service' they had received from counsellors (New Focus in Delfabbro 2008, p188). These people felt 'availability of group and individual counselling, the ease with which the counsellor could be contacted in an emergency, and the quality of the relationship with the counsellor' were what made the counselling service effective.

In an evaluation of Victoria's Break Even networks, Jackson et al (1997 in Delfabbro 2008) found 'counselling was generally effective in dealing with legal issues, physical symptoms arising from gambling, and also appeared useful in reducing excessive gambling' (Delfabbro 2008, p181). A 2002 evaluation of a Victorian gambling counselling service found that 43% of clients had full or satisfactory resolution of problems, a further 46 percent reported partial resolution of problems and two-thirds stated they gambled *'a lot less'* than before counselling (Jackson et al 2002 in Rodda and Cowie 2005).

One Victorian survey found counselling services to be 'significantly more effective' in responding to CALD clients when they employed bilingual staff (DOJ 2005a, p7) and another recommended the employment of Aboriginal or 'appropriate' (culturally aware and accountable) counsellors be employed (DOJ 2005b).

Whilst it is important to be multimodal in approach, the selection of those used is not arbitrary and requires further documentation as to the rationale for using a particular approach, and its success. For example, Blaszczynski and Nower (2002) have more specifically articulated which approaches are useful for three particular client groups (ie those whom are behaviourally conditioned, those described as emotionally vulnerable and those with the most complex issues who are described in their model as 'antisocial impulsivist' problem gamblers).

In summary, RASA agrees that counselling services need to be client-centred and respond to the needs of clients rather than being led by a particular mode of delivery (DFC 2007).

Commentary on a range of therapeutic methodologies

Brief Intervention

Hodgins (2005, p3), in a study of a brief intervention, found 'the participants who had the motivational style of interview showed much better outcomes in terms of their gambling,

compared to participants who had the more traditional clinical interview'. In a study comparing different methodologies, Petry et al (2008) found the brief intervention of a single session of 'brief advice' was more successful than motivational enhancement therapy and cognitive behavioural therapy, although all (including assessment only) made some difference for participants.

These treatments have differing financial implications, and differing impact depending on the population group. Their signs of success make them currently attractive, and RASA welcomes the positive results, as well as further and more detailed research into their effectiveness. Comment is made below on different methodologies within this group of interventions as we believe it is important not to generalise across these methodologies when considering which may be useful.

Cognitive therapies

In a US study of 35 people being treated using cognitive therapy, participants improved by at least 50% on all four variables being measured, compared with only 7% of control participants who did not undergo treatment (NCRG 2007).

Blaszczynski et al (2000 in Delfabbro 2008) conducted group CT sessions and found 'this treatment was no more, nor less, effective in reducing gambling urges than imaginal desensitization conducted using minimal therapist involvement' (Delfabbro 2008, p184).

Behavioural therapies

Systematic imaginal desensitsation (ID) 'has demonstrated significant and favourable differences between desensitization techniques and other behavioural procedures as evidenced by decreased anxiety and gambling behaviour… [in a now-dated] randomized clinical trial' (McConaghy et al 1991 in Korn and Shaffer 2004, p21). Blaszczynski, MacCallum and Joukhador (2000 in Delfabbro 2008) also found in a small sample size study that 'home-based ID was found to be as effective as the more labour-intensive sessions of CT [cognitive therapy] and the combination of ID and CT'.

"Cue exposure" is being trialled at the South Australian Flinders Medical Centre, and whilst participants who complete treatment perceive themselves as having experienced a significant reduction in the urge to gamble – which is a welcome outcome – 'unsuitable candidates are probably excluded during the initial referral and assessment process', with 23% dropping out at this point (Delfabbro 2008, p184). Further clarity is thus required on the populations to which these treatments are best suited.

Cognitive behavioural therapies

Cognitive Behavioural Therapy (CBT) is 'supported by randomized controlled clinical trials demonstrating efficacy and improved clinical outcomes… [however] this research often has limited subjects that complete the course of treatment' (Korn and Shaffer 2004, p19). Results for female pathological gamblers in Melbourne were reported by Dowling, Smith and Thomas (2006 in Delfabbro 2008, p184) to show that '89% of the treatment sample had achieved abstinence or controlled gambling by the end of treatment (24 sessions) and that 72% were still either abstinent or controlled 6 months post-treatment'. In further analysis of initial treatment dropout rates however, Delfabbro suggests the success rate with these women may in fact be 44% at the end of initial treatment (2008). 'Cognitive behavioural interventions in a non-randomized study involving a small number of adolescents have demonstrated clinically significant

improvements for perception of control and severity of problem' (Korn and Shaffer 2004, p31).

'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.)' (Olivieri & Rogers 2005a).

Solution-focused brief therapy is linked to cognitive behavioural principles though 'research on this treatment is in its early stages, the effectiveness of this approach has not been fully demonstrated' but is described by Korn and Shaffer as 'promising' (2004, p23).

Psychotherapeutic/motivational strategies

Motivational enhancement strategies and strategies linking motivational strategies to stages of change are under-researched but described by Korn and Shaffer as "promising" and "important steps to formulating treatment strategy" (2004, p25). Allcock and O'Connor (1996 and 1999 in Delfabbro 2008, p 185) found that "motivational factors play a critical role in achieving change… [and thus] motivational counselling has become a key component of many treatment programs". Hodgins (2005) found that brief interventions would be more effective if they focused on motivational strategies.

Relapse Prevention Training

There is 'a paucity of research addressing the effectiveness of relapse prevention in the gambling field' (Korn and Shaffer 2004, p21). Hodgins (2005, p4) however, found these would be more effective if they 'have a clear focus on motivational properties'.

Psychodynamic Psychotherapy

There is 'a paucity of psychodynamic research in the gambling field and sparse evidence in the outcome literature to support its effectiveness' (Korn and Shaffer 2004, p22).

Bibliotherapy

Bibliotherapy is not thoroughly researched but has been found to be of use to some clients. Data from Hodgins et al indicating 'that the single and repeated mailing groups showed significant improvement in overall gambling as indicated by SOGS and NODS scores and fewer gambling days and dollars lost. Self-efficacy also increased significantly for both groups and overall, the sample exhibited fewer depressive symptoms.' However, for these same clients 'Although general improvement was evident, it is also clear that a majority of participants continued to experience problems as indicated by the NODS (54%) and SOGS (70%).' (Hodgins et al 2007, p52)

Self-Exclusion

Of 954 NSW adults surveyed in 2002-03 (53% of whom gambled weekly or more often), one-third did not know what 'self-exclusion' was and two-thirds had not 'seen related signs' (Hing 2003). That said, 'the respondents generally agreed that responsible gambling is more likely to happen when a club provides a self-exclusion program' (Hing 2003).

Self-exclusion 'provides an excellent opportunity for [gambling help services in] engaging with the person, providing information about support services and encouraging acceptance of counselling or group support.' (DHHS 2005)

The long-term effectiveness of self-exclusion is unknown and requires further research (Korn and Shaffer 2004) although a recent Canadian study with a sample of 161 found after 'six months… major improvements were recorded on the urge to gamble, perceived control over gambling, and the intensity of the negative consequences of gambling on daily activities, social life, work and mood. SOGS scores as well as DSM-IV scores were reduced' (Ladouceur, Sylvain & Gosselin 2007, p92) as per the table below:

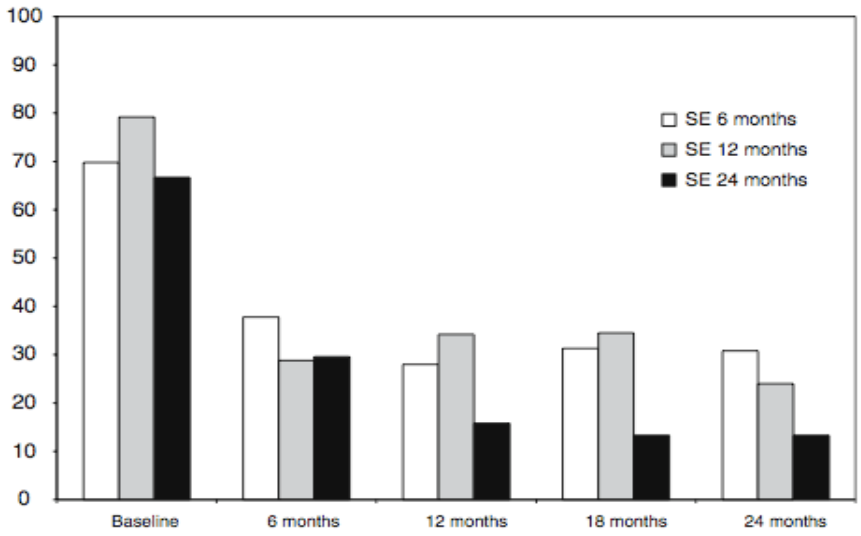


Fig. 3 Proportion of pathological gamblers (DSM-IV) according to the 6, 12 and 24 months of self-exclusion groups

This graph would seem to indicate strong encouragement for 12 months of Self-Exclusion.

Natural recovery and self help

The phenomenon of people with problematic gambling recovering without professional support is known as 'natural recovery'. Research into natural recovery is limited, but in a study of almost 46,0000 American adults, Slutske (in NCRG 2007) found that approximately one-third of people with a gambling problem seemed to recover on their own, without formal treatment. It was not known however, whether these people had used gambling help-lines, nor what resources from their own lives they drew upon to manage their problem gambling. 'Emerging research on 'natural recovery' suggests some may be helped through brief interventions' (Griffiths undated).

RASA finds that many clients access our service after they have stopped gambling (either in their own timing or due to a significant event such as being caught for theft or their partner discovering the extent of losses and delivering an ultimatum regarding the future of the relationship). Some clients access the service for someone to whom they are accountable as they endeavour to adhere to an abstinence regime and with whom they can celebrate their achievements.

It has also been suggested, but not known, that 'those experiencing a greater number of symptoms of pathological gambling disorder, those whose problems have persisted for a long time, or those also dealing with other disorders — such as alcoholism, drug abuse, or depression — may have a much harder time achieving recovery on their own and are likely candidates for formal treatment.' (NCRG 2007).

Some suggest that self-help workbooks (including online methods) may be an effective intervention for improving gambling behaviour (Gray, Oakley Browne & Radha Prabhu 2007, NCRG 2007) however, to our knowledge there remains 'a paucity of research' directed to evaluating the effectiveness of any self-help strategies (Korn and Shaffer 2004, p22). It is known that dropout rates for 'Gamblers Anonymous' can be as high as 70% (Stewart & Brown

1988 in Korn and Shaffer 2004) with abstinence rates after one year as low as 8% (Brown 1985 in Korn and Shaffer 2004).

Self help materials did not receive strong support from Aboriginal respondents to a Victorian survey (DOJ 2005b).

Summary

Responses to problem gambling need to occur along, and relative to, the continuum of how problem gambling develops and exists in our communities. Though research into problem gambling support and treatment methodologies is somewhat fragmented, what does exist suggests that prevention and harm minimization strategies may currently be of little effect unless targeted at people before they commence gambling.[8] The number of problem gamblers continues to rise in spite of such harm minimisation measures and harm minimisation strategies focusing on gamblers in venues are important but may need to be further researched. In the meantime, the provision of 'downstream' support services needs to continue to address the factors that increase the risk of commencing gambling and then becoming a problem gambler.

Olivieri R & Rogers N (2005a) note that the *tertiary-end* of a best-practice system in South Australia should:

- 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.

We understand the South Australian Government through the OPG is striving for this within its funding model, however potential pressure from industry bodies to focus funding solely on treatment of identified problem gamblers, with measures of success related only to the cessation of problem gambling may affect what is possible to achieve. We would continue to advocate for a greater focus on prevention and broad early intervention initiatives. This includes increasing community development and capacity building approaches in high risk populations rather than only identifying individual problem gamblers and delivering treatment programs to them.

We believe that a Public Health approach will expand the existing harm minimisation model and;

- best enable those who currently do not have a problem, to remain problem free, thereby contributing to community health;
- facilitate increased access to services;
- continue to develop the effectiveness of harm minimisation measures; and
- continue to develop the effectiveness of treatment responses.

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[8] Hing, N (2003) *The efficacy of responsible gambling measures in NSW clubs: the gamblers' perspective*. National Association for Gambling Studies (Australia) 2003 Conference Proceedings
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We would be happy to discuss any of the information that has been presented in this submission.

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