

A guide to using a health promotion approach to problem gambling

For Gambler's Help services and others working
to reduce gambling-related harm in Victoria

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A guide to using a health promotion approach to problem gambling has been completed in consultation with the Community Education Reference Group, and other Gambler's Help services and Primary Care Partnership representatives, who assisted in the:

- shaping of the guide's structure,
- sourcing of appropriate case studies,
- refinement of the guide's content.

Case studies have been provided by a range of organisations and their contributions are appreciated.

Introduction

The main purpose of this guide is to provide support for Gambler's Help services and Primary Care Partnerships to use an integrated health promotion approach to problem gambling.

This resource outlines the context shaping integrated health promotion and problem gambling in Victoria and explains a common framework for planning, implementation and evaluation of problem gambling integrated health promotion initiatives. This resource also provides examples of emerging practice applying an integrated health promotion approach to problem gambling.

This guide is designed to be:

- a practical resource that guides the application of an integrated health promotion approach to problem gambling community education;
- used in conjunction with the **Integrated health promotion resource kit**¹ and other relevant health promotion resources, as outlined in the Useful Resources section.

Why use an integrated health promotion approach to problem gambling?

Community education is critical in raising broader community awareness of the risks and signs associated with problem gambling, so that people can recognise when their gambling is causing them or others in their life harm. It is also important in promoting services so that people understand where they can go to seek the help they need, and plays a role in preventing the development of gambling-related harm by addressing the underlying causes, or social determinants, of problem gambling.

The local community education model for problem gambling in Victoria recognises that building community and individual resilience through addressing the social determinants of health can help prevent problem gambling or facilitate early intervention before gambling becomes a problem. For agencies delivering problem gambling community education, this involves a whole-of-community, public health approach to problem gambling, adopting the principles of the integrated health promotion framework to address the social determinants of health as they relate to problem gambling and problem gambling co-morbidities.

There is growing evidence worldwide of the effectiveness and financial benefits of investing in health promotion programs in an integrated way. It has been shown that single interventions, such as providing health information alone, have limited impacts. Therefore, using a mix of interventions to achieve a health promotion goal is consistent with the evidence that working at both the individual and population-wide levels provides the best outcomes.

In the past, problem gambling health promotion activities have provided an opportunity to provide information that targets the community at all points on the problem gambling continuum, from prevention and early intervention, through to reactive and responsive intervention activities. These activities align closely with integrated health promotion delivered within Primary Care Partnership catchments.² The integrated health promotion framework complements and enhances problem gambling health promotion, helping to create more coordinated, efficient and effective problem gambling health promotion programs.

¹ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services. Available at www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm

² For further information on Primary Care Partnerships, see www.health.vic.gov.au/pcps/about/index.htm

Gambler's Help services and Primary Care Partnerships are key to the delivery of the local community education model.³

The Gambler's Help Community Education Program is delivered by Gambler's Help services at both local and catchment levels. It involves delivery of a range of initiatives to prevent problem gambling as well as raise awareness at a community level about the risks associated with problem gambling and promoting Gambler's Help services.

Primary Care Partnerships help extend the reach of the Gambler's Help Community Education Program by broadening the partnership opportunities available to Gambler's Help services. They play a key role in raising awareness of problem gambling as a public health issue amongst members and integrating problem gambling into the agenda of agencies outside the Gambler's Help service system. They also play a key role in working with Gambler's Help services within their catchments to address the social determinants, or underlying causes, of problem gambling.

³ For more detail on the local community education model, refer to the Problem Gambling Operational Guidelines: Department of Justice (2011). Problem Gambling Operational Guidelines, Victorian Government Department of Justice, pages 53-64. Available on the Problem Gambling Professionals website at <http://professionals.problemgambling.vic.gov.au/>

Definition of problem gambling

Problem gambling is an important public health issue, impacting on the health and well-being of individuals, families and communities.

The Victorian government adopts the agreed national definition of problem gambling⁴: “Difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community”.

Gambling can be considered any activity that involves spending money in return for a chance of winning money or a prize. This may include activities such as:

- Informal private betting for money (for example, playing cards at home)
- Playing poker machines or Electronic Gaming Machines (EGM)
- Betting on table games like blackjack, roulette and poker
- Betting on horse or harness racing or greyhounds, excluding sweeps
- Betting on sports and event results – such as football or TV show results
- Lotto/Powerball/Pool
- Keno
- Scratch tickets
- Bingo
- Competitions/raffles/sweeps
- Competitions that cost money to enter, by phone or by sending an SMS message
- Speculative stock investments such as day trading (without a long term strategy)
- Online betting
- Telephone betting.

Different age groups, males and females are more likely to participate in certain gambling activities than others.⁵ The highest-participation gambling activities played by Victorian adults are lotto/Powerball or pools, followed by raffles/sweeps/competitions, poker machines or EGMs, horse/ harness/ greyhound racing (excluding sweeps) and scratch tickets.⁶

A study of gambling in Victoria showed that 43.29% of people with a gambling problem and 48.51% of moderate risk gamblers reported playing four or more gambling activities in the past year, compared with 14.34% of non-problem gamblers.⁷ The top gambling activities that people with a gambling problem reported participating in were poker machines or EGMs (91.04%) and lotto/Powerball or pools (75.77%), followed by buying tickets in raffles/ sweeps/ competitions (43.03%), scratch tickets (36.03%) and betting on horse or harness racing or greyhounds – excluding sweeps (33.58%).⁸

Poker machines or EGMs are reported as the highest spend gambling activity by almost two-thirds (64.14%) of people with a gambling problem, followed by table games such as blackjack, roulette and poker (11.21%), lotto products (9.73%) and betting on horse or harness racing or greyhounds – excluding sweeps (9.47%).⁹

4 Gambling Research Australia (2005), Problem Gambling and Harm: Towards a National Definition. Prepared by the South Australian Centre for Economic Studies/Department of Psychology, University of Adelaide. Victorian Government Department of Justice.

5 Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 5: Participation in Gambling Activities, available at www.gamblingstudy.com.au/pdf/FactSheet_5_v2.PDF

6 Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 8: Electronic Gaming Machines, available at, www.gamblingstudy.com.au/pdf/FactSheet_8_v2.PDF

7 Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 93

8 Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 89

9 Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 128

Problem gambling in Victoria is measured¹⁰ using the nine-item Canadian Problem Gambling Severity Index (PGSI). The PGSI measures an individual's risk for problem gambling and segments gamblers into four key risk categories:

- Non-problem gamblers
- Low risk gamblers
- Moderate risk gamblers
- Problem gamblers.

Who is affected by problem gambling?

Problem gambling is a public health issue that affects whole communities. The effect of problem gambling on communities is much broader than just financial impacts on individuals. In 2010, the Productivity Commission stated that “there is strong evidence that gambling can have adverse health, emotional and financial impacts on many more people than those categorised as ‘problem gamblers’.”¹¹

In Victoria, the prevalence of problem gambling is 0.7% of the adult population; and 2.36% of the adult population is considered to be moderate-risk gamblers.¹² Specifically:

- Males are typically more ‘at-risk’ of problem gambling than females
- People with a gambling problem are often males 25-34 years and 50-64 years (also males 35-49 years) and females 25-64 years
- Moderate risk gamblers are often males 18-24 years and 25-34 years and females 18-24 years and 50-64 years
- Low risk gamblers are often males 25-34 years and 18-24 years and females 50-64 years and 65 years and over.¹³

Population groups at risk of problem gambling

Problem gambling health promotion programs should be informed by identifying the population groups who have a gambling problem, those who are at a moderate risk of problem gambling and the determinants and risk factors associated with problem gambling. In Victoria, those population groups include:

- Young people, and in particular young males
- People experiencing substance use issues
- People with mental health issues
- People of culturally and linguistically diverse (CALD) backgrounds
- People of Indigenous backgrounds
- Families and friends of people with a gambling problem.

Evidence to support working with these, and other, population groups is provided in Appendix one. A demographic profile of people with a gambling problem and moderate risk gamblers is provided below.

¹⁰ By Gambler's Help Services and in the major study of gambling in Victoria: Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. Available at www.gamblingstudy.com.au/baseline-study.html

¹¹ Productivity Commission 2010, Gambling, Report no. 50, Canberra. Page 47.

¹² Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. Available at <http://www.gamblingstudy.com.au/baseline-study.html>

¹³ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 4: Prevalence, Age and Gender, available at www.gamblingstudy.com.au/pdf/FactSheet_4_v2.PDF

3.0 What is Problem Gambling?

A demographic profile of people with a gambling problem, relative to the Victorian adult population, shows that there is a significantly:

- higher proportion of males and lower proportion of females
- lower proportion of people 65 years and older
- higher proportion of people of Indigenous backgrounds
- lower proportion of professionals, technicians/tradesworkers and clerical/administrative staff and a significantly higher proportion of sales workers, machinery operators/drivers and labourers
- lower proportion of people with a personal income of under \$31,199 and a significantly higher proportion with an income of \$31,200-\$51,999
- lower proportion of households with an income of under \$33,799 and a significantly higher proportion of households with an income of \$62,400-\$103,999
- lower proportion in Eastern Metro and Grampians
- lower proportion of people who have migrated to Australia in the past 5 years.
- lower proportion of 'other households'^{14, 15}

In addition, relative to the Victorian population, a profile of moderate risk gamblers shows that there is a significantly:

- higher proportion of males
- higher proportion of adults 18-24 years and a lower proportion of adults 65 years or older
- lower proportion of people with university qualifications and a higher proportion of people with year 10 or lower as the highest qualification
- lower proportion of managers, professionals, technicians/trades workers and clerical/administrative workers
- higher proportion of community/personal services workers, sales workers, machine operators and labourers
- higher proportion of people personally earning between \$52,000 and \$83,199 per year
- lower proportion of households earning under \$33,799 per year and a higher proportion of households earning between \$62,400 and \$103,000 per year
- lower proportion of households comprised of couples without children and a higher proportion of group households.¹⁶

¹⁴ In this study 'other households' refers to any household that does not fit into the following categories: Couple with children, One parent family, Other family, Couple without children, Group household, and Lone person.

¹⁵ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 87

¹⁶ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 16: Moderate Risk Gamblers, available at, www.gamblingstudy.com.au/pdf/FactSheet_16_v1.PDF

Reasons for gambling

In Victoria the main reasons people gamble are to win money, for general entertainment and for social reasons. However, people with a gambling problem have reported being more likely than those without a gambling problem to gamble to take their mind off things, to relieve stress, for reasons of boredom and to gamble out of habit.¹⁷ Research also shows that people who develop a gambling problem more frequently gamble due to loneliness/social isolation, to reduce stress/anxiety/trauma and to raise extra money.¹⁸

The top three most preferred features of EGM venues for people with a gambling problem are that venues:

- are close to home
- have nice venue staff/manager
- are easy to get to.¹⁹

Common myths about gambling

At a whole of population level, a proportion of adults in Victoria – including non-problem gamblers – hold false beliefs about gambling. This may include views that games of chance can be ‘influenced’ and that ‘strategies’ can be used to shape the outcomes of gambling. Some segments of the community also see gambling as a way to ‘make money’ or address financial difficulties.

For instance, across Victoria, findings of a study exploring community attitudes and behaviours to gambling²⁰ showed that:

- 45% of the Victorian community believed that if someone has just won on a poker machine (EGM), this decreases the likelihood it will pay out on the next game **(a myth)**
- 43% of the Victorian community believed that poker machines pay out better at certain times of the day to keep patrons gambling **(a myth)**
- 37% of the Victorian community believed that there are some strategies that can be used to influence your chance of winning on poker machines **(a myth)**
- 17% of the Victorian community believed that increasing bet size on the pokies can help increase the chance of winning **(a myth)**
- 17% of the Victorian community believed that if you lose on a poker machine game, the next game should have a slightly higher chance of winning **(a myth)**
- 12% of the Victorian community believed that it’s worth reserving a winning poker machine if you need to take a break, as this will increase your chance of winning **(a myth)**.

¹⁷ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 15.

¹⁸ Department of Justice (2008) A market segmentation study of Victorian adults exploring community attitudes and behaviours to gambling, Victorian Government Department of Justice

¹⁹ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 13: Problem Gamblers, available at www.gamblingstudy.com.au/pdf/FactSheet_13_v2.PDF

²⁰ Department of Justice (2008) A market segmentation study of Victorian adults exploring community attitudes and behaviours to gambling, Victorian Government Department of Justice.

Problem gambling and public health issues

Problem gambling is closely related to interpersonal issues, relationship issues, mental health issues, drug, alcohol and substance abuse issues and even legal issues and incarceration. In addition, financial stress can be associated with food insecurity and poor physical and mental health and well-being. For these reasons, problem gambling is strongly associated with health inequality.

A study of gambling in Victoria showed that there was a strong tendency for health to decline with increasing risk status for problem gambling. For instance, when compared to people who do not have a gambling problem, people with a gambling problem reported:

- a slightly higher rate of diabetes (although the trend was only tending towards statistical significance)
- a significantly higher rate of lung conditions including asthma
- a significantly higher rate of depression
- a significantly higher rate of anxiety disorders
- a significantly higher rate of obesity
- a significantly higher rate of other miscellaneous physical or mental health conditions.²¹

The same study showed that the proportion of people with a gambling problem who reported their health as poor was nearly 17%, compared to 3.43% of non-problem gamblers.²²

When compared to non-problem gamblers, people with a gambling problem were also significantly more likely to have experienced at least one of the following life events in the past 12 months:

- the death of someone close to them
- a divorce
- legal difficulties
- a major injury or illness to either themselves or someone they are close to
- trouble with their work, boss or superiors
- a major change to their financial situation
- an increase in arguments with someone they are close to.²³

²¹ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 13: Problem Gamblers, available at www.gamblingstudy.com.au/pdf/FactSheet_13_v2.PDF

²² Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice. See also Fact Sheet 11: Health and Well-Being, available at www.gamblingstudy.com.au/pdf/FactSheet_11_v2.PDF

²³ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 185.

What is Integrated Health Promotion?

The Ottawa Charter (1986) defines health promotion as:

”The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.”²⁴

In Victoria, the term ‘integrated health promotion’ refers to agencies and organisations from a wide range of sectors and communities in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.²⁵

Integrated health promotion is a key program area within Primary Care Partnerships.²⁶ Primary Care Partnerships are voluntary alliances made up of a range of member agencies, including Gambler’s Help services, working in local catchments. Primary Care Partnerships play a key role in extending the reach of Gambler’s Help services by broadening the partnership opportunities available, raising awareness of problem gambling as a public health issue amongst members and integrating problem gambling into the agenda of agencies outside the Gambler’s Help service system.

For Gambler’s Help services, this means that there is an opportunity to work with others at local and regional levels to raise awareness of problem gambling as a public health issue and to promote the range of services offered by Gambler’s Help. In addition, Gambler’s Help services have an opportunity to contribute to the prevention of problem gambling through the promotion of responsible gambling and involvement in health promotion interventions that address the social determinants, or underlying causes, of problem gambling.

²⁴ World Health Organisation (1986), The Ottawa Charter for Health Promotion, Geneva

²⁵ Department of Health website, www.health.vic.gov.au/healthpromotion/what_is/integrated.htm, accessed July 2011

²⁶ For a comprehensive overview of the Primary Care Partnerships Strategy refer to the Department of Health website, www.health.vic.gov.au/pccps/about/index.htm

The social determinants of health – and how they relate to problem gambling

A public health approach embraces the social model of health²⁷, understanding that improvements in health and wellbeing are achieved by addressing the social and environmental determinants of health, in tandem with biological and medical factors.

In practice, working within a social model of health means investigating what determines health and wellbeing, or the social determinants of health. A determinant of health is a factor or characteristic that brings about a change in health, either for the better or the worse.²⁸

For agencies delivering problem gambling community education, such as Gambler's Help services, working within a social model of health is about investigating the social determinants of health as they relate to problem gambling. These are also referred to as the social determinants, or underlying causes, of problem gambling.

Problem gambling shares its social determinants with other public health issues. For example, social inclusion and access to economic resources are amongst the key determinants of mental health²⁹ as well as being linked to problem gambling. Agencies working on different issues, such as preventing problem gambling and improving mental health, can work together at a determinants level to address a broader range of health issues.

Below is a summary of the social determinants of health:^{30,31}

- **The social gradient:** People's social and economic circumstances affect health throughout life. A continuum exists from the disadvantaged to well-off rather than a binary effect at the extremes.
- **Stress:** The individual response to stress can cause physiological changes, which affect health. It is recognised that people's social and psychological circumstances can affect health through stress.
- **Early life:** The effects of early physiological and psychological development, both negative and positive, last a lifetime. The infant is dependent on their circumstances and significant others for both physical and emotional experiences.
- **Social exclusion:** Groups that are socially excluded include the unemployed, ethnic minorities, homeless, pensioners or people with disabilities. These groups experience worse health outcomes than the general population.
- **Work:** Stress in the workplace increases the risk of disease. An imbalance in two aspects of workflow control when work demands are high and an imbalance in effort in relation to reward (income, self esteem or status) – have been identified with negative health consequences.

Upstream interventions deal with population-wide influences on health, such as policies surrounding income distribution, education, public safety, housing, work environment, employment, social networks, food supply, transport and pollution. These interventions are extensive and large scale, but they can also be addressed effectively at a more local level via work with communities or groups who share interests and concerns (for example, a local government area).

In contrast, **downstream** interventions are usually discrete, targeted programs with an explicit health purpose. They address a narrower range of benefits and tend to focus more on individuals than whole communities.

²⁷ Garrard, J, Lewis, B, Keleher, H, Tunny, N, Burke L, Harper, S & Round R (2004) Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles, Victorian Government Department of Human Services,

²⁷ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 21

²⁸ Reidpath, D, Keleher, H. & Murphy, B. (2004) Understanding health: a determinants approach, Oxford University Press, page 9

²⁹ VicHealth (2006) Evidence-based mental health promotion resource, pages 20-22.

Available at: www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf

³⁰ Wilkinson, R. & Marmot, M. (Eds) (2003) Social determinants of health: the solid facts. 2nd edition, World Health Organization

³¹ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, pages 23-24

- **Unemployment:** Unemployment and job insecurity have a negative effect on health. Psychological and social resources are likely to increase in employment and decline in unemployment.
- **Social supports:** Friendships, good social support at home, at work and in the community improve both physical and mental health.
- **Addiction:** Individuals' use of alcohol, drugs and tobacco is influenced by a wider social setting. Addictive behaviours are generally detrimental to health.
- **Food:** Strong links have been established between nutrition (both under and over nutrition) and a range of diseases.
- **Transport:** Healthy transport means reducing driving and encouraging more cycling and walking, backed up by better public transport.

So how do the social determinants of health relate to problem gambling?

There is still a lot to learn about the social determinants of problem gambling, as it is a relatively new field of both research inquiry and health promotion. This contrasts with other public health issues where determinants are better understood. At this point, evidence implies a connection between problem gambling and some of the social determinants of health in particular. For instance:

Social exclusion and problem gambling

People with a gambling problem have significantly lower social capital than non-problem gamblers, which is indicated by being more likely to not have access to help from friends when they need it, lower rates of participation in organised groups, and being more likely to report not liking living in their community.³²

Addiction to smoking, alcohol and other drugs (AOD) and problem gambling

Problem gambling is linked to an increased risk of high alcohol and tobacco use.³³ In addition, people with a gambling problem and moderate-risk gamblers were more likely to report high levels of alcohol abuse than non-problem gamblers.³⁴

Stress and problem gambling

Problem gambling is associated with stress and anxiety and compared to non-problem gamblers, people with a gambling problem were significantly more likely to have a severe or moderate mental disorder.³⁵

Social supports and problem gambling

Family and friends of people with a gambling problem are affected both physically and emotionally.³⁶ Children of people with a gambling problem are two to four times more likely to develop gambling problems than their peers.³⁷

³² Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 220

³³ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 17

³⁴ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 17

³⁵ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 18

³⁶ Productivity Commission (2010), Gambling, Report no. 50, Canberra

³⁷ Dowling, N.A., Jackson A.C, Thomas S.A. & Frydenberg E. (2010) Children at risk of developing problem gambling, Final Report, page 36

Other possible links at the local level

At the local level, the links between the social determinants of health and problem gambling will be specific to each local community. Possible links include:

- Financial hardship associated with problem gambling could cause food insecurity to be a related problem
- Poor access to suitable public transport may increase social exclusion or prevent access to alternative recreation activities
- High unemployment may lead to financial stress, lack of access to nutritious food and reduced social supports.

The social determinants of problem gambling in the community are interlinked and interdependent. The agents for change to influence these determinants do not lie within the health field, but across a wide spectrum of government departments (federal, state and local governments), communities and organisations. Therefore, for change to be made at a population or community level, partnerships are used to target those determinants deemed to be most important to a community or amenable to change.

An integrated approach is required to address the underlying social determinants of problem gambling and to create a healthy community that is resilient to problem gambling.

Gambler's Help services use a planning framework³⁸ which is common across Primary Care Partnerships and other organisations involved in integrated health promotion. This common framework provides a cycle³⁹ for program management which incorporates:

- Planning – vision setting, priority setting and problem definition, solution generation, capacity building and planning for evaluation and dissemination
- Implementation
- Evaluation and dissemination.

At all stages of planning it is important to recognise and address the diverse cultural, linguistic and settlement needs of population groups. Cultural inclusiveness should be integrated into service planning, implementation and evaluation to ensure that programs are effective in addressing the needs of diverse communities.

6.1 Planning

Primary Care Partnerships develop a three year strategic plan and an integrated health promotion catchment plan, which are reviewed and updated annually.⁴⁰

Gambler's Help services develop a Community Education Program Annual Plan to guide work commitments throughout the year. It can be used to check progress at different stages and can assist community educators and partner organisations to maintain a focus on agreed priorities when competing demands arise. Appendix two provides a checklist to assist Gambler's Help services to develop and self-assess the quality of their annual plan.

Vision setting

The vision statement should clearly articulate where the organisation or partnership wants to be, in response to their health promotion response⁴¹ to problem gambling.

Priority setting and problem definition - conducting a needs assessment

A key component of planning a problem gambling health promotion program is assessing local community needs. A needs assessment is used to identify the priorities relating to the local community. Primary Care Partnerships and Gambler's Help services are encouraged⁴² to work collaboratively in assessing community needs and planning services.

A needs assessment involves:

- examining characteristics of a community (client, service and other regional data, including assessment of established or newly emerging CALD communities)
- conducting consultations and research to identify a range of health issues and needs (including consultation with Primary Care Partnerships)
- gathering information about issues and needs in the community
- analysing obtained information and identifying key priorities.

³⁸ See Department of Justice (2011) Problem Gambling Operational Guidelines, Victorian Government Department of Justice and Department of Justice (2011) Gambler's Help Performance Management Manual, Victorian Government Department of Justice. Available on the Problem Gambling Professionals website at <http://professionals.problemgambling.vic.gov.au/>

³⁹ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 31

⁴⁰ Planning and reporting requirements for Primary Care Partnerships are determined by the Department of Health. See www.health.vic.gov.au/pcps/about/prr.htm

⁴¹ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 33

⁴² Requirements are set out in Department of Justice (2011) Problem Gambling Operational Guidelines, Victorian Government Department of Justice and Department of Justice (2011) Gambler's Help Performance Management Manual, Victorian Government Department of Justice. Available on the Problem Gambling Professionals website at <http://professionals.problemgambling.vic.gov.au/>

Sources of information to be gathered for the needs assessment should include:

- client and service data – who, when and how clients present for services, identify service usage trends and consider service access barriers
- local and regional data , including EGM numbers, expenditure and socio-economic data
- consultation with the community, community groups, and community leaders
- consultation with other local organisations
- consultation with ethno-specific and/or multicultural organisations, clubs and associations
- research and evidence (including published/grey literature⁴³ and evaluations)
- stakeholder mapping and consultation – stakeholders who have a role to play in achieving targeted objectives.

Through the priority setting and problem definition process, a series of program goals and corresponding objectives should be developed.⁴⁴

Solution generation and capacity building

Solution generation requires analysis of the collected information and planning of health promotion interventions.⁴⁵ It involves decisions about the mix of interventions most likely to achieve the objectives and consideration of the partnership's capacity to deliver. Priority population groups and key stakeholders should be involved in the process of solution generation.

Capacity building involves an assessment of the resources needed to deliver the planned interventions and planning for how those resources will be obtained. This stage is concerned with creating the optimal conditions for a successful program.⁴⁶ Building the capacity of a Gambler's Help service is important in order to successfully deliver their Community Education Program Annual Plan.

Planning for evaluation and dissemination

It is important to plan for evaluation and dissemination during the planning stage of the problem gambling health promotion program. This will help to clarify the type of evaluation needed, the information that is needed, and how, when and by whom it will be collected.

⁴³ Information which has not been published or which, although published, is not readily accessible.

⁴⁴ For more detailed information about this process refer to Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, pages 34-35

⁴⁵ See section 7.1 of this Guide for more information about intervention types

⁴⁶ For more information about solution generation and capacity building refer to the Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, pages 36-39

⁴⁷ For more information about evaluation refer to Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, pages 40-41; Department of Human Services (2005) Planning for effective health promotion evaluation, Victorian Department of Human Services; Department of Human Services (2003) Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion, Victorian Government Department of Human Services.

6.2 Implementation

Managing the implementation of interventions can involve monitoring and recording information about what is happening in the program. One of the key components of implementing the program for Gambler's Help services will involve working in partnership with other organisations, including other Primary Care Partnership members, around the social determinants of health.⁴⁸

Working in partnerships

'Partnerships' is a broad term to describe working with other organisations.⁴⁹ The benefits of Gambler's Help services working in partnership with Primary Care Partnerships and others include, but are not limited to:

- increased access to resources, both financial and human
- shared responsibility for targeting the social determinants of problem gambling (determinants that are common to other health issues)
- access to and contribution to a diverse range of skills and knowledge
- reduced duplication and fragmented activity across organisations
- shared funding applications
- greater impact on health outcomes in the long-term, and less people experiencing problem gambling
- increased sustainability of health interventions and associated benefits.

Partnerships at the local level vary from one community to the next. Clear understanding of the reasons for participating in a partnership is needed. The social determinants of health impact on a wide range of health and societal issues, providing an opportunity for organisations with seemingly different interests to work together at a determinant level. Table 1 shows a range of reasons why different organisations may work together on a program to increase social connectedness.

⁴⁸ Planning templates for Gambler's Help services are provided in Department of Justice (2011) Gambler's Help Performance Management Manual, Victorian Government Department of Justice, Appendix B. Available on the Problem Gambling Professionals website at <http://professionals.problemgambling.vic.gov.au/>

⁴⁹ VicHealth Partnerships Fact Sheet, http://www.vichealth.vic.gov.au/en/~/_media/ResourceCentre/PublicationsandResources/General/Fact%20Sheet_Partnerships.ashx, accessed July 2011

6.2

Table 1: Example of partnership participation in a fictitious local community
 Program goal: to increase social connectedness

Organisation	Organisation's reason for participating in partnership program – intended change as a result of program
Local Government	To decrease perceptions of unsafe shopping precincts and increase usage of local parklands
Community Health service	To improve physical activity levels of young mums
Gambler's Help service	To increase the number of people seeking help for gambling-related problems and to build resilience to problem gambling
Victoria Police – local branch	To decrease rates of crime in the local area
Migrant Information Centre	To provide a range of culturally appropriate recreation opportunities for clients
Leisure Centre	To increase the uptake and participation rates of leisure centre facilities and sports offered through the centre
Retail outlet representatives	To increase patronage of shopping precinct during night-time shopping hours
Division of General Practice	To decrease incidence of cardiovascular disease
Neighbourhood House	To empower clients with leadership skills in order to increase their chances of employment
Local secondary college	To improve the transition stage between school and further studies and/or employment for students

Whilst the drivers of these organisations may be very different, they may share a common planning approach. Working together, they could develop, implement and evaluate a mix of interventions aimed at increasing social connectedness in the local community.

Making partnerships work well

Partnerships vary considerably. This is to be expected considering the variability of communities, organisations, work history, personalities, politics and a host of other factors impacting on them. Partnerships can operate for very different reasons and at differing levels of commitment.

The VicHealth Partnerships Analysis Tool⁵⁰ provides a continuum for partnerships from networking through to collaboration. In short:

- Networking involves the exchange of information for mutual benefit.
- Coordinating involves exchanging information and altering activities for a common purpose.
- Cooperating involves exchanging information, altering activities and sharing resources.
- Collaborating, in addition to the above activities, includes enhancing the capacity of the other partner for mutual benefit and a common purpose.

When working in a partnership it can be useful to clarify roles, responsibilities and resources formally with a Memorandum of Understanding or Terms of Reference.

⁵⁰ VicHealth (2008) Partnerships Analysis Tool, Victorian Health Promotion Foundation.
 Available at: <http://www.vichealth.vic.gov.au/en/Publications/Mental-health-promotion/Partnerships-Analysis-Tool.aspx>

Tips for working with different groups

Table 2 provides tips for practitioners working with different population groups. These tips are not research-based, but have been included as a practical prompt to help stimulate ideas for planning and implementing health promotion interventions specific to problem gambling.

Table 2: Tips for practitioners working with different groups

<p>Young people</p>	<ul style="list-style-type: none"> • Partner with organisations who have a wide reach to young people (e.g. music festivals, large schools) • Young people may gamble via phone-in/SMS competitions, online and private (amongst themselves) betting (if young people are underage) • Parents can be a useful point of influence • Work with schools/TAFEs/universities • Integrate community education with alcohol/drug and mental health education
<p>People with substance use issues</p>	<ul style="list-style-type: none"> • Partner with health and community service providers, who already work with this group • Incorporate problem gambling education into existing health education interventions targeting this group • Educate the community about responsible use of alcohol during gambling - excessive drinking may lead to impaired control
<p>People with mental health issues</p>	<ul style="list-style-type: none"> • Work with Divisions of General Practise to educate General Practitioners about the links between problem gambling and mental health • Promote the use of problem gambling screening and referral practices • Work in partnership with others to increase social connectedness • Raise awareness about the link between problem gambling and mental health • Develop interventions to de-stigmatise problem gambling in the community and increase awareness of the social determinants and co-morbidities of problem gambling (including mental health issues) • Refer to the Evidence based mental health promotion resource (in the Useful Resources section of this kit)

6.2

People of CALD backgrounds

- Develop partnerships with services who already have established links with CALD communities and community leaders, i.e. ethno-specific agencies, Migrant Information Services, MGHP, other local services
- Consult with a range of community members and gatekeepers to ensure that information collected reflects the diversity that exists within each CALD community
- Allow sufficient time to build relationships and trust - this is fundamental for an effective and strong partnership
- Be clear about what you can offer, do not raise expectations that cannot be met
- Use appropriate settings – meet where the community meets
- Allow for mutual sharing of information
- Ensure effective communication through the use of interpreters, translators and bilingual workers when appropriate
- Be aware of your own cultural assumptions and respect cultural differences that can arise in expression of opinions and decision-making processes
- Allocate a budget for incentives for agencies to participate, sitting fees for community members attending meetings, catering, interpreters and translations because financial and human resources can affect an organisation's ability to engage and sustain partnerships
- Consider the decision-making and power structures that exist within a partnership, as the ECCV (2010) identified the perception of inequality between partner organisations and the disadvantage experienced by smaller organisations.
- Consult the Multicultural Gambler's Help Program⁵¹ for assistance and advice in relation to working with CALD communities

⁵¹ The Multicultural Gambler's Help Program is delivered by the Centre for Culture, Ethnicity and Health. The program works with the problem gambling and multicultural community sectors to build knowledge of problem gambling, improve access to problem gambling services among migrant and refugee communities, assist communities to develop prevention strategies, and support culturally appropriate and responsive service provision. For more information visit www.ceh.org.au/mghp

6.2

<p>People of Indigenous backgrounds</p>	<ul style="list-style-type: none"> • Regional Indigenous Councils and Local Indigenous Networks may provide access to working with Indigenous communities • Work with community networks such as Indigenous co-operatives and Indigenous community health and welfare services • Make contact/develop contacts with the local community i.e. organisations, networks with health, legal, justice, substance abuse workers, housing etc • Develop interventions to build community capacity to respond to gambling issues in Indigenous communities • Build community capacity to increase resilience to problem gambling in the community • Ensure services provided and education materials are culturally sensitive and appropriate • Working with community elders can assist with building the trust of a community • Contact local organisations and commission them to help with staff in-services and professional development activities • Understand that what works in one community won't necessarily work in another • Offer work experience to Koori students in local TAFE/universities • Invite local Elders to provide welcome to country ceremonies for important events • Understand relationships and partnerships take time and respect differing agendas • Try to join in with other opportunities for health promotion in local communities • Keep in contact, respectfully
<p>Family and friends of people with a gambling problem</p>	<ul style="list-style-type: none"> • Provide education about the prevention of, and services available for, problem gambling • Develop interventions to de-stigmatise problem gambling and to facilitate the process of help seeking
<p>Senior Victorians</p>	<ul style="list-style-type: none"> • General Practitioners may be potential partners for programs targeting older people • Provide responsible gambling education for senior Victorians • Target low socio-economic areas, where people may be more inclined to gamble to raise money • Work with large employer associations or organisations planning redundancies to develop strategies to help staff manage redundancy or retirement payments to mitigate risks association with problem gambling • Sporting events may also be a useful setting to reach this group

Hard-to-reach or disengaged groups

Community participation is an essential component of health promotion; however it can also be a challenge. Reaching people who are most in need of health promotion interventions can sometimes mean trying to engage people who are considered to be ‘hard-to-reach’ or who may be disengaged or cut off from the avenues practitioners would usually use to reach their target groups.

Below is a list of strategies that may assist practitioners to access and work with hard-to-reach or disengaged groups:

- **Establish who the community leaders are** - gaining access to a community can be achieved by first establishing who the community leaders are and consulting with them to gain trust and acceptance by the community members.⁵²
- **Build community capacity** - community capacity building is about working in partnership and supporting community decision making.⁵³ Community members must be involved in planning, implementing and evaluating programs. One method to do this is to invite community representatives to be members of a project advisory group that guides the project’s planning, implementation and evaluation.
- **Consumer engagement** is a population health approach that seeks to increase the uptake of and access to services by vulnerable population groups, including those experiencing disadvantage and/or social exclusion.⁵⁴ Processes include enhancing services so they are more likely to be used by the target group.
- **Strategic partnerships** offer one way of reaching hard to reach groups because other local organisations may already work with isolated groups.
- **Allow sufficient time to build relationships** with the community or target group. Ensure staff have the capacity to undertake community capacity building – training and mentoring support may be required if these are new skills that are required.

A community development approach is especially effective when working with disadvantaged and disempowered communities and hard-to-reach populations.⁵⁵ Community development principles treat communities as partners and experts of their own health needs. Engaging with the community at all stages:

- provides insight into community needs and issues
- enables the assessment of community readiness for action on problem gambling
- ensures culturally appropriate interventions
- provides credibility to the effort within the community
- provides access to the community, ethnic media, social groups and other key stakeholders
- increases community ownership of the project.

For example, a community development approach may be particularly useful when working with CALD communities due to stresses associated with migration and settlement, which can often result in people feeling disempowered and disconnected from the wider community.

⁵² Moodie, Rob and Hulme, Alana (Eds) (2004), Hands-on health promotion, IP Communications, page 137

⁵³ Ibid page 144

⁵⁴ Keleher, H. & Murphy, B. (2004) Understanding Health, A Determinants Approach, Oxford University Press, page 109.

⁵⁵ Egger, Spark & Lawson (1990) Health Promotion Strategies and Methods, Sydney McGraw-Hill Book Company.

6.3 Evaluation and dissemination

In integrated health promotion programs, planning steps are linked to different types of evaluation:

- The program goal is measured by outcome evaluation
- The program objective is measured by impact evaluation
- Health promotion interventions and capacity building strategies are measured by process evaluation.

It is important to think about evaluation during the planning stage of health promotion programs. Resources required (for example, financial and human resources) to collect, collate and report evaluation information need to be allocated at this time. Decisions need to be made about the type of information that needs to be collected and when, where and how it will be collected.⁵⁶

Dissemination is the active, purposeful process of knowledge transfer. Disseminating results from evaluations of initiatives in Community Education Program Annual Plans and Primary Care Partnership integrated health promotion catchment plans is essential to inform the next planning cycle for an organisation and partnership, but it is also critical for building the capacity of others. Sharing findings with others, whether they are positive or negative, adds to the evidence base for integrated health promotion and problem gambling.

Dissemination needs to be planned and resources allocated accordingly. A range of dissemination methods can be used including training, presentations at conferences, printed reports or articles, shared databases, organisational and Primary Care Partnership websites and committee or network meeting opportunities.

⁵⁶ For more information about Community Education Plan requirements refer to Department of Justice (2011) Gambler's Help Performance Management Manual, Victorian Government Department of Justice. Available on the Problem Gambling Professionals website at <http://professionals.problemgambling.vic.gov.au/>. For more information about what evaluation is and the types of evaluation refer to Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, pages 40-41; Department of Human Services (2005) Planning for effective health promotion evaluation, Victorian Department of Human Services; Department of Human Services (2003) Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion, Victorian Government Department of Human Services

Integrated health promotion specific to problem gambling is still a relatively new field, compared with other public health issues. This can be considered advantageous in that the health promotion field in general has evolved over time to better understand what is needed to be effective. Reflecting on what has worked for other health issues (such as tobacco control, healthy eating, skin protection) can be beneficial, as can building on these efforts and the existing structures developed. It may be useful to use the same setting that others have used, (for example, workplaces, schools, neighbourhood houses) or perhaps the same intervention types (for example, no-smoking policies in the workplace, education programs in schools). Many of these health promotion efforts are now well-documented.

It is worthwhile considering why and how health promotion efforts and progress with the community has evolved over time. Success (or population health improvements) in these areas can be attributed to:

- a long-term commitment and dedication of resources
- a coordinated and accumulative effort involving different organisations
- a mix of interventions used to change the culture of society to be conducive to good health.

These have included policy change, social marketing, health education and skill development, and changes to environments.

For health promotion to be effective at the local level, it should be locally driven and designed to suit the community's needs. Simply copying a model or program from another community (or health issue) may be ineffective because local needs, settings and priorities differ between communities. It is useful to understand why some programs have worked and others have not, and importantly, to consider the context in which programs have been, or are being, delivered, for example, funding levels or the scope or requirements of certain programs.

This section highlights:

- 7.1 - examples of health promotion intervention types relevant to the work undertaken by Gambler's Help services, Primary Care Partnerships and other organisations working to address social determinants of problem gambling
- 7.2 - emerging practice through case studies. Some of the case studies target problem gambling specifically, highlighting one main intervention type only. Other case studies target a determinant of problem gambling and showcase a mix of interventions. Some of the strengths and challenges of the case studies are also discussed.

Why use a mix of interventions?

Using a mix of intervention types makes the healthy choice an easy choice for individuals by providing healthy environments in which to live. It also increases the likelihood of sustained behaviour change in a population because complementary activities are all working towards the same end result.

For example, if community education was the only intervention used then knowledge about responsible gambling could be increased. This increased knowledge may not lead to behaviour change in the community though, unless other activities also worked to support that change. For example, improved knowledge could be supported by:

- social clubs providing alternative recreation activities to enable positive social connections
- a statewide social marketing strategy, complemented by local activities, to trigger change in community attitudes and behaviours relating to problem gambling
- local sporting clubs implementing a ‘welcoming policy’ to increase participation in sport
- community groups being empowered to advocate for increased access to public transport in isolated areas.

One organisation alone cannot deliver all these interventions, hence the need to work in partnership.

7.1 Intervention types

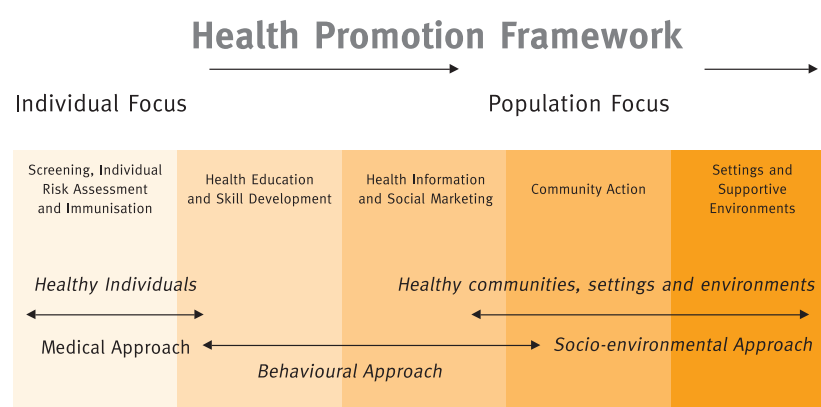
The Health Promotion Framework shown in Figure 1 outlines how interventions can be used to improve the health of individuals, or settings and environments in order to create healthy communities (populations). Along the continuum, three different approaches are shown to overlap: a medical approach, a behavioural approach and a socio-environmental approach.

Interventions using a behavioural through to a socio-environmental approach intend to affect the health of communities and populations, whereas those using a medical approach are more likely to target individuals.

Traditionally, community education delivered by Gambler’s Help services has predominantly used a behavioural approach to address problem gambling. However, Gambler’s Help services increasingly contribute to more preventative, population-based interventions, targeting the social determinants of problem gambling. This shift is facilitated by linking Gambler’s Help services with Primary Care Partnerships.

For health promotion to be effective, a mix of interventions, targeting individuals and populations, should be implemented. Not all interventions need to be delivered by the same organisation, but they should be supported by capacity building strategies.

Figure 1: Health promotion interventions and capacity building strategies⁵⁷



A mix of health promotion interventions should be used to address problem gambling. However, given the many services, programs and projects funded to address problem gambling in Victoria, coordination and collaboration is critical. Care must be taken to ensure new interventions address gaps and priorities, rather than duplicate existing services, resources or programs.

⁵⁷ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 44

Figure 2 illustrates some of the programs currently funded to address problem gambling in Victoria, and the key approaches or intervention types they might involve.

Figure 2: Examples of problem gambling programs in Victoria

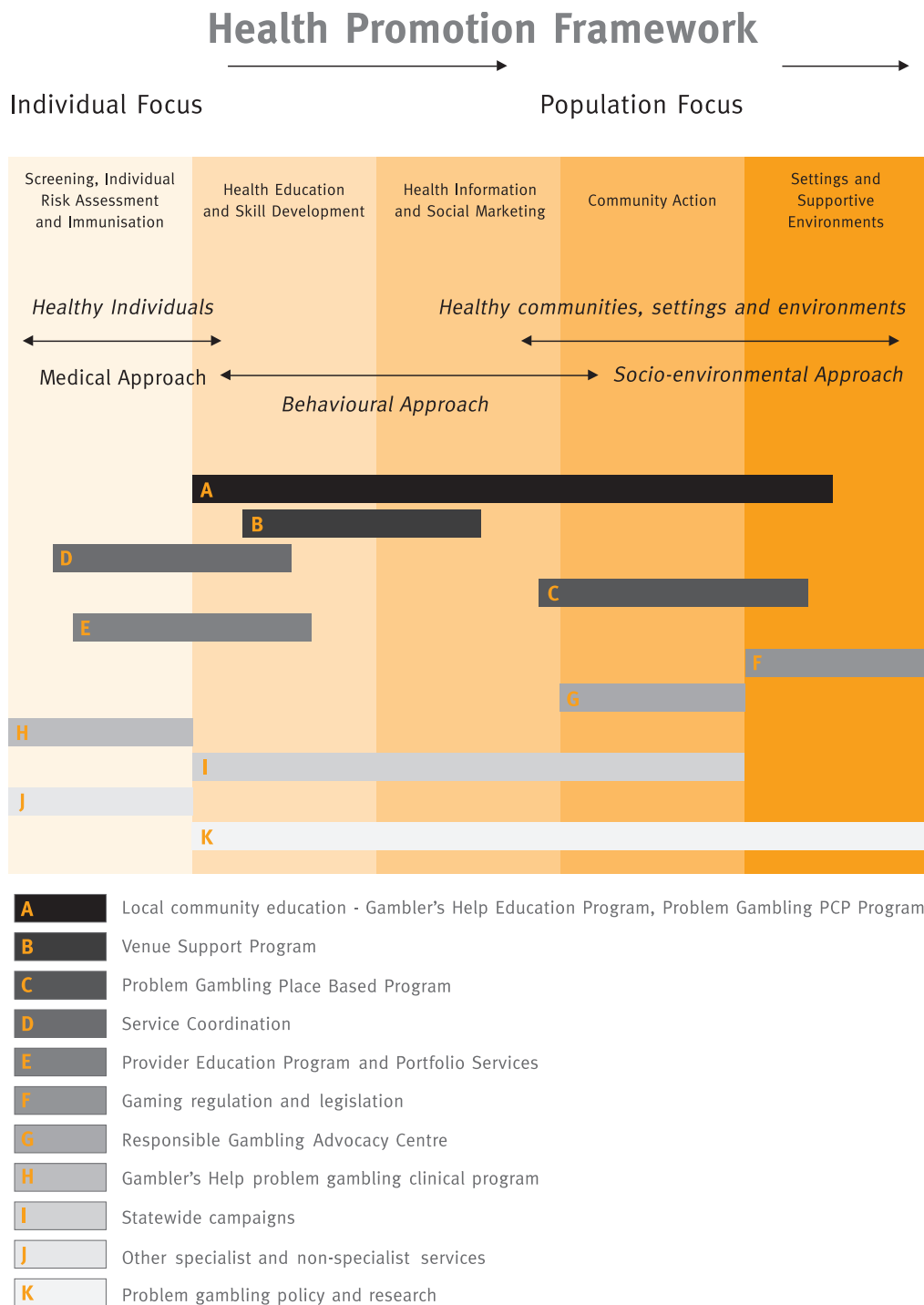


Table 3 provides examples of intervention types and capacity building strategies relevant to problem gambling. Gambler's Help services may use (but should not be limited to) these examples to assist with community education planning. Some of the examples listed may already be delivered by other programs within Gambler's Help services (for example, Provider Education), the Department of Justice or other organisations. Integrated health promotion planning allows for a coordinated approach to planning whereby activities of one organisation complement and add value to those provided by others.

Table 3: Examples of intervention types and capacity building strategies specific to problem gambling

Screening, individual risk assessment and immunisation

- focusing on individuals, this intervention can be used to systematically investigate a person's risk of a condition that is amenable to prevention or treatment. These interventions may be useful within an integrated health promotion program as an initial contact point to the broader health and community service system.⁵⁸

Examples:

- Work with CALD and Indigenous communities to identify problem gambling behaviour and refer to appropriate support services
- Work with employers in the construction and trades industry to identify signs of at-risk gambling in workers

Health education and skill development

- mainly targeting individuals or groups, this intervention aims to improve knowledge, skills, attitudes, self-efficacy and individual capacity to change. These activities need to be delivered as part of a mix of interventions that consider the broader determinants of health.⁵⁹

Examples:

- Provide leadership training to CALD community leaders
- Conduct life skills programs for groups at risk of problem gambling
- Deliver community education sessions to increase knowledge about responsible gambling practices and debunk myths about gambling
- Deliver men's and women's health and well-being programs
- Co-facilitate money management sessions with the community health service
- Provide training to increase knowledge and change attitudes to reduce stigma associated with problem gambling

⁵⁸ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 45

⁵⁹ Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, page 50

Social marketing and health information

- social marketing interventions seek to influence the voluntary behaviour of target groups and usually use persuasive processes in order to benefit the group or society.
- health information is about providing information to improve people's understanding about health and/or services available.

Examples of statewide interventions:

- The Department of Justice design and implement a diverse range of social marketing strategies and campaigns to support the response to problem gambling in Victoria. Social marketing campaigns are based on in-depth quantitative and qualitative research (e.g. market segmentation research) and include a diverse mix of communications. This includes development of television commercials, radio and print education materials for the Victorian community, along with specific strategies for at-risk population groups. The purpose of a social marketing strategy is to trigger change in community attitudes and behaviours relating to problem gambling, to develop awareness and demand for Gambler's Help services (for people in need of help) and to reduce at-risk behaviours that may be associated with problem gambling.
- Responsible Gambling Awareness Week (RGAW) is held annually across Victoria to raise awareness of the need for responsible gambling practices in the broader community. Gambler's Help services, the community and a range of other partners and stakeholders across Victoria participate in RGAW using a range of innovative strategies.

Examples of local social marketing interventions:

- Prepare and disseminate media release to promote new brochure/program
- Negotiate interview and announcement opportunities on local radio
- Attend local festivals or other community events to increase awareness of Gambler's Help services and problem gambling as a health issue and promote responsible gambling
- Distribute Gambler's Help collateral to local services
- Conduct promotional activities in Responsible Gambling Awareness Week
- Publish Gambler's Help newsletter/ articles for PCP newsletter
- With PCP members, distribute a range of mental health resources
- Produce 'pictorial story boards' resource to promote positive mental health and wellbeing messages
- Develop a survival guide for youth or a self-help kit, including Gambler's Help information
- Respond to requests for information sessions and Gambler's Help information/ brochures
- Provide opportunities for spokespeople to share their experience of problem gambling in variety of formats (i.e. media, radio interviews, newspapers articles, community forums and education sessions)
- Attend community or professional network meeting to share information with others about Gambler's Help services

Community action

- focusing on populations, community action intends to build the capacity of communities in order for them to make sustainable improvements in their social and physical environments.

Examples:

- Assist community members develop and run an organised social group to prevent social isolation in their community
- Build the capacity of and support international student welfare providers to reduce the vulnerability of students to problem gambling
- Work with and empower local indigenous communities to investigate and respond to social isolation
- Provide leadership training for community members from various demographics to speak publicly about their personal experiences with problem gambling
- Work with and support a family wellbeing group or local men's group to help build social connectedness and resilience
- Provide opportunities for community members to participate in the development and implementation of health promotion interventions
- Strengthen the peer support group for people who access Gambler's Help in order to build personal development skills and enhance overall health and wellbeing
- Assist CALD and Indigenous services to develop interventions to decrease the risk of problem gambling in their own communities

Settings and supportive environments

- focusing on population change, these interventions intend to make sustained health improvements to places where people live, work and play. They include health policies and legislation, economic and regulatory activities and advocacy.

Examples:

- Develop and implement an organisational policy to increase community participation in health promotion programs aimed at preventing problem gambling
- Work with local community groups and clubs to ensure organisational policies are non-discriminatory and inclusive
- Work with local sporting clubs to adopt policy to promote responsible gambling
- Work with sporting and recreation clubs to implement 'welcoming policy' to increase membership of newly arrived young people living in the community
- Implement an organisational policy around social inclusion and mental health
- Implement a youth friendly Gambler's Help services plan developed in consultation with a Youth Advisory Committee to address issues of boredom
- Participate in a Healthy Schools Committee which aims to create supportive environments for positive mental and physical health
- Work with local service providers to address settlement needs of migrants
- Work with social clubs to develop a policy to provide affordable and culturally appropriate alternative recreational opportunities

Capacity building strategies

- capacity building involves the development of sustainable skills, organisational structures, resources and a commitment to health improvement and is necessary in order to create optimal conditions for success.⁶⁰ These capacity building strategies intend to build the Gambler's Help services' capacity for integrated health promotion specific to problem gambling and its social determinants.

Examples:

- Ensure cultural competency training requirements are met for all staff
- Plan for management and staff to attend the mental health promotion short course
- Develop and implement an organisational policy regarding community participation and consultation in problem gambling health promotion programs
- Strengthen employees' understanding of the social determinants of problem gambling through regular internal workshops
- Establish a mentoring program with partner organisations
- Facilitate on-the-job learning opportunities between partner organisations
- Join and actively participate in professional networks
- Monthly presentations at staff meetings to share program information
- Provide work experience opportunities for students from a range of disciplines
- Share human resources with a partner organisation (e.g. administration resources provided to assist with partnership meetings)
- Present at and participate in relevant conferences
- Identify opportunities for staff training in leadership or working with disadvantaged groups

7.2 Case Studies

Reviewing case studies provides an opportunity to understand what others have done, what has worked or not worked in other communities, and the reasons why. Elements of these programs can then be transferred and adapted to suit local conditions, as appropriate.

Integrated health promotion specific to problem gambling is a relatively new and evolving field. Evaluation is essential and dissemination of the findings through case studies and other means is important in building the evidence base for this area.

Some of the case studies presented in this guide provide insight into programs with a specific problem gambling focus. Others showcase health promotion efforts that have targeted some of the social determinants of problem gambling.

Case study: Building Blocks of Life, Goulburn Valley Community Health Service

Since 2006 the Gambler’s Help team at Goulburn Valley Community Health Service (based in Shepparton) has offered a health promotion program called Building Blocks of Life (BBoL).

In 2006 it was observed that participation in group programs targeting problem gambling was low. In addition, clients expressed that they felt uncomfortable, conspicuous and too ashamed to attend a group focused on problem gambling. The staff also felt that issues around life skills often contributed to the development of gambling problems.

Gambler’s Help service clients were consulted around important topics and the BBoL content was developed. The program was piloted and program design was refined. The six week program provides two-hour sessions for small groups and aims to:

- promote personal and social development through the provision of education and enhancement of life skills
- enhance participant’s skills to cope with everyday life situations as a prevention/early intervention to developing gambling issues
- provide a life skills group program appropriate for clients with gambling issues.

The interactive sessions focus on life skills including self esteem and assertiveness, healthy relationships and good communication, conflict resolution, problem solving and positive thinking, budgeting, financial management and goal setting, nutrition and maintaining balance in life and relaxation and stress management. Screening for group appropriateness is conducted prior to participant involvement. This helps to ensure that group members are ready to participate.

Partnerships have been important in adapting the program to suit various groups, with over 40 programs (involving 300 participants) being delivered since 2006, across Greater Shepparton, Moira and Strathbogie.



STRENGTHS:

The program has evolved and been adapted over time to reflect feedback from participants and changing needs

The program was designed to meet a need in the local community

Flexible delivery, tailored to suit each group’s needs

Evaluation now measures impact three months after program

Catering to a range of literacy levels and ensuring that those with a low literacy level can participate in the program is a challenge. To help overcome this, the program is delivered using a variety of health education techniques (including activities and discussions) thereby enabling all participants to develop skills and confidence regardless of literacy skills.

Three Participant Questionnaires are used to evaluate BBoL – a pre-program questionnaire, an immediate post program questionnaire and a three-month follow up questionnaire. The participants are asked to rate their confidence in the life areas covered by BBoL before, at the conclusion of and three months after the program delivery. This data is used to determine the program's impact on confidence levels. Process data collected includes questions regarding the session content and facilitator delivery and engagement with the group. Participants are also asked about what they enjoyed about the program and what could be improved. The facilitators also record their observations and reflect on the program delivery.

Feedback from program participants has led to changes to the program's content over time. With no other local group program offering development of life skills, the demand exceeds the organisation's capacity to deliver programs.



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Case study: Girl's Magazine – promoting the positive

The Wimmera Primary Care Partnership (PCP), Wimmera Health Care Group, and Women's Health Grampians were partners in the 'Girl's Magazine – promoting the positive' project which intended to increase wellbeing through improved choices and access for social connection of youth.

The project partners determined a need to build self worth and to increase opportunities and skills for young women to make positive social connections. Social connection is a protective factor against problem gambling. It was recognised, being a determinant of health, as a priority for the Wimmera PCP.



STRENGTHS:

Focus on social connectedness

Participants developed new skills

Variety of industries involved

The project involved the development and publishing of a magazine for teenage girls. A 52-page full colour magazine was printed and distributed through the Wimmera Mail-Times. The process included girls from Horsham and St Brigid's Colleges taking part in Getting Gorgeous and Active Girl's Breakfast programs which delivered and explored health and wellbeing messages later included in the magazine. A working group of Year 9 students from the two schools was then formed to develop a magazine which discussed a range of social, physical and emotional health issues relevant to teenage girls.

The girls had the opportunity to meet a range of professionals and community members to develop skills such as research, writing, conducting interviews and surveying peers. Evaluation and feedback from the workshops and working group showed positive outcomes for participants. A growth in personal skills and

knowledge as well as relationships was reported. Initial community responses to the magazine have also been overwhelmingly positive.

The support of both schools, particularly from Horsham College and the Year 9 class who completed Getting Gorgeous, was an important factor on the success of the project. The commitment of the nine girls in the working group was also a key success factor.

A key challenge of the project was the staff changes during the course of the project. Also, the ability to include girls outside of the two participating schools was a limitation, as the working group met during school lunch times, and it was not feasible for schools outside of Horsham to attend. While initial attempts were made to engage with more marginalised groups of young women, this was not successful.

The girl's magazine was a pilot project. Commitment for further publications should consider:

- the amount of external funding required
- project partners' and staff time and commitment
- participation of girls outside of the Horsham area
- how to include girls not engaged in mainstream schooling
- the capacity of the secondary schools and their students.

Evaluation results about the process of the project have been shared through the Wimmera PCP Health Promotion Network at their regular monthly meetings. Once evaluation has been finalised the project will be written up for both poster and presentation format for relevant conferences and an article is being written for Health Victoria, a Department of Health publication.



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Case study: Multicultural Women's and Men's Health and Wellbeing Workshops

The Kingston Bayside Primary Care Partnership developed a pilot program to strengthen community connectedness and social inclusion with multicultural men in the City of Kingston. This program built on the experience of Gambler's Help Southern who, since 2003 have run a Women's Health and Wellbeing Program targeting Vietnamese and Cambodian women in the City of Greater Dandenong.

The aims of the men's pilot program were to:

- improve the community's knowledge of both responsible gambling and problem gambling
- raise awareness about Gambler's Help Southern services
- address underlying health needs of men through an information workshop mode
- provide men with an opportunity to establish social connections.

Consultation with community leaders helped to build trust about the program and assisted with access to the community groups. Existing Multicultural Senior's Groups were used as a means of engagement and consultation regarding needs. The leaders of these groups assisted in promoting and encouraging workshop attendance.

7.2

Close partnerships established between the six member agencies and particularly with a local Division of General Practice enabled the selection of appropriate guest speakers for five two-hour sessions held over five weeks.

Gender sensitivity in accessing multicultural groups for consultation and support and in the delivery of the men's health program was a challenge. Managing interpreting services in a multicultural setting was also challenging.

Increased knowledge was measured using pre and post evaluations and verbal evaluation was used at each session.

Three factors were identified as key to the success of the men's pilot program:

- a strong partnership with a history of working together and well established connections and relationships with the community
- access to existing multicultural senior's groups
- a partnership with a Division of General Practice to engage a General Practitioner who was supportive of the program and with whom the target community responded positively to during the sessions.



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Case study: Casino Bus Trips Project, Gambler's Help Northern, Banyule Community Health Service



STRENGTHS:

Focus on social connectedness

Participants increased awareness of various health issues

Program built on local experience

Existing partnerships strengthened



STRENGTHS:

Involvement of community groups in various parts of program

Participants increased knowledge and changed behaviours

Various key partner organisations

Building in sustainability through partnership with local government to distribute resources beyond the project completion

The Casino Bus Trips Project is run by Gambler's Help Northern (GHN), in partnership with North East Primary Care Partnership, and the Centre for Ethnicity and Health (Multicultural Gamblers Help Service). The project commenced in 2009, when GHN identified that organised group bus trips to the casino exposed group members to increased risk of experiencing gambling related harm.


The casino offers a group program which includes various marketing measures and other incentives to encourage community groups to attend the casino on day outings. The trips to the casino are a popular form of social outing due to the low upfront cost, the location of facilities, and the promotional offers made by the casino.

Research has identified that one of the significant at-risk populations for problem gambling is people from culturally and linguistically diverse (CALD) backgrounds.

Pilot research was undertaken in March 2009 with the intention of increasing the capacity of one community group to make informed decisions about the safety, appropriateness and value of the casino bus trips for participants. The research activity revealed higher spending patterns than anticipated and suggested that the casino bus trip led some members to engage in risky behaviours. The community group subsequently ceased its participation in casino bus trips.

The Casino Bus Trips Project has extended its reach to various CALD groups through targeted use of the ethnic media, including articles in four different ethnic media publications, SBS radio programs and community language television shows. This program also comprises a very grassroots component. It has sought to empower individuals and groups to voice their concerns about problem gambling within their groups and communities. The findings from the research component are very much 'owned' by groups who are then encouraged to make informed decisions. Groups also receive education material and participate in discussions to raise their awareness of how to ensure that gambling remains a safe activity for them. Some communities have also been involved directly in the development of a culturally appropriate harm minimisation brochure.

The project has recognised that groups do find it difficult to access affordable alternative outings. A Social Outings guide has been developed listing a range of culturally appropriate social options. Local government will continue to distribute the guide beyond the life of this project. In addition, some advocacy work with the casino has sought to change some of the components of the casino package that are most likely to cause harm to CALD communities.



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Case study: Central Goldfields Social Inclusion for Women 55+ Project, Central Victorian Health Alliance PCP

The Central Victorian Health Alliance (CVHA) Primary Care Partnership was funded to develop and implement an Integrated Health Promotion Gambling Prevention Project in the Central Goldfields Shire. Identified as a location of serious disadvantage, there are two venues with Electronic Gaming Machines (EGMs/pokies) in the Shire. Both are community owned sporting clubs and operate under the governance of a board of community members.

The Central Goldfields Social Inclusion for Women 55+ Project Reference Group was established to inform and develop the project plan. The project reference group included representatives from local community groups, service providers and agencies, and a local community champion. The group had extensive local knowledge and they contributed to the planning (including evaluation planning) and implementation of each project activity. Wherever appropriate, group members also assisted in delivering activities, in particular workshops.

The project reference group selected women aged 55-74 years as the target group for the project, based on evidence from the Loddon Mallee IHP Problem Gambling Catchment Plan, the Department of Justice and the experience of the local Gambler's Help service and local representatives. The project intended to reduce social isolation of people 'at risk' of problem gambling within the shire, particularly women 55 years and over. An early assumption was that the target group would be disadvantaged due to low socioeconomic status. However, interviews and anecdotal evidence indicated that the target group had some disposable income and appeared to be socially connected. Their reasons for gambling included such things as a need for 'me time' and a change of circumstances.



STRENGTHS:

The project's lead agency had established links with the target community

Participants increased knowledge and changed behaviours

Findings from the project to be incorporated into future work with the community

More robust data collection to be inform future planning

Interventions for the project included:

- random sampling of EGM players in two venues
- interviews with 32 women aged 55 – 74 years and other stakeholders
- promotional activities during Responsible Gambling Awareness Week and presentations to local community groups
- a gambling activity survey conducted by three local welfare/service agencies
- a workshop titled “Making The Most Of Me Time” for women 55+ who play the pokies
- a workshop for community groups titled “Great Groups Grow” to offer community groups ideas about being more socially inclusive
- development of a resource manual for community groups with strategies to be more socially inclusive.

One of the key challenges for the project was a lack of local information or research to inform the project development, other than mandatory statistics kept by the venues. Much of the information provided at the commencement of the project was based upon metropolitan information. It became evident that local information needed to be collected using surveys, observations and interviews.

A key factor of the success for the project was the use of a lead agency that already worked actively in the local community and employment of a local worker as the project officer. Following the project’s completion, the findings from the project will be incorporated into ongoing work with community groups and organisations as the project officer returns to a community development role within the shire. In addition, some local service providers and agencies will continue to include survey questions in their assessment and intake procedures. This will provide more robust data about their clients gambling activities and can be used for future planning.

Process, impact and outcome evaluation was undertaken and methods included collection of verbal and written feedback during and /or after the workshop, facilitator and project worker observation, and telephone interviews conducted three months after the “Making the Most of ‘Me Time’ Workshop”.

The VicHealth Partnership Evaluation tool was used twice to evaluate the development of the project partnership. A major shift was evident in the partnership members’ thinking about gambling and particularly about the impact of social isolation and how it can be addressed. It is envisaged that this new understanding will inform and influence their future work within the community.

CVHA is currently exploring a partnership opportunity with Campaspe Primary Care Partnership to conduct a scoping project to define the social determinants of health contributing to the issue within the rural Shire of Campaspe.



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Case study: An Upstream Approach: Social Connection as a protective factor for Problem Gambling, Central Hume Primary Care Partnership

The Central Hume Primary Care Partnership (PCP) has developed a project to address social isolation, as a key determinant of problem gambling. The project provides an opportunity for PCP member organisations to strengthen current work in the catchment addressing social connection for older people (55+). In this context, the relationship between health promotion and problem gambling is to encourage health promotion interventions that build communities that are more resilient to developing problem gambling issues. It does not aim to prevent Victorian communities from participating in or enjoying gambling.

The project aims is to increase levels of social connection for older adults aged 55 years and over, across the Wangaratta and Alpine Shires. The lead agency model used for this project has enabled the partnership to manage and oversee the project, with major decision making occurring through the PCP’s existing Integrated Health Promotion Advisory Group, which has representation from a broad range of agencies.

The project has been integrated into the PCP’s strategic plan in various areas and is linked under several key areas including the health promotion priority of Mental Health and Wellbeing and the priority group of older people. Project activities include:

- the establishment of a lead agency and appointment of a project officer
- a system to support decision making
- a clearly defined action plan developed by key stakeholders
- a funding process for community groups and organisations to provide the target group with more opportunities to be socially connected
- training planned to build the capacity of the community and agencies to engage vulnerable older adults.

The Social Connection Evaluation Tool, which was developed by the CHPCP IHP Advisory Group, will be used by funded projects to measure social connection.

Some of the factors for success of this project include agency buy in, the existing partnership environment, the use of multiple strategies, embedding the project within existing work of agencies working on social connection aimed at the target group, and agencies understanding the journey “or how the project got to this point”.

Some of the key challenges include obtaining agency buy-in and identifying common ways to strengthen current social connection work of agencies across the two local government areas. To overcome these challenges, most of the activities within this project have been informed and primarily led by member agencies already doing work in this area. This was a key consideration when deciding the direction of this project, as the only way to get agency buy-in and sustainability was to strengthen the activity already occurring around social connection. Many member agencies didn’t think they were doing integrated health promotion to address problem gambling. They now realise that work on social connection and mental health for particular target groups can have significant impact on problem gambling.



STRENGTHS:

Involvement of community leaders and elders ensured interventions were culturally appropriate and increased project ownership by community.

Capacity of taskforce members increased to respond to gambling issues in their community.

Partner agencies had strong community and stakeholder links.

The project has been limited by the current capacity of workers to take on additional work, and vacant positions in agencies.

Activities undertaken as part of this project will be built into the Mental Health Wellbeing Priority beyond the funded life of the project to ensure sustainability of the activities and research undertaken. A number of activities within the action plan have been included to help inform future planning and keep social connection on the agenda within the mental health and wellbeing priority. This includes data gap analysis and use of the social connection evaluation tool.



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Case study: Eastern Region Partnership Project – Chinese Spiritual Leaders

In 2008, the Victorian Multicultural Gambler's Help Program (MGHP) and Gambler's Help (GH) Eastern undertook a partnership project with the Chinese community in the eastern metropolitan region.

Due to the eastern region's high Chinese population, research findings, GH Eastern's links with the community and learning's from past initiatives, GH Eastern identified the need to undertake a project with the Chinese community. Due to the diversity of the Chinese community (i.e. various ethnic groups, age cohorts, settlement waves, etc) and the range of existing organisations and associations, GH Eastern proposed to engage Chinese spiritual leaders in identifying gambling related issues, needs and solutions. Spiritual leaders were considered to be key stakeholders as they play a significant community support role and have extensive community 'reach'.

The Chinese Gambling Concern (CGC) accepted an invitation to join the project as a key project partner due to the organisation's expertise and experience in addressing gambling issues in their community, existing relationship with GH Eastern and strong community and stakeholder links. The partnership was formed to develop and implement tailored, culturally appropriate and coordinated strategies for problem gambling prevention and early intervention in the Chinese community. First the project team engaged with Chinese spiritual leaders by organising a forum to explore gambling and help-seeking issues in the Chinese community and to seek interest in project participation.

A key strategy to engage with the target community was to form a taskforce with key stakeholders. The taskforce comprised of project partners (including two representatives from GH Eastern; a community educator and a Chinese speaking problem gambling counsellor, one representative from MGHP and three representatives from CGCI), four Chinese religious leaders and representatives from the Chinese Health Foundation and the Chinese media. The taskforce met regularly throughout the life of the project. The major aim of the taskforce was to develop and implement a tailored action plan for early intervention and prevention of problem gambling in the Chinese community.

The project aimed to reduce harm caused by gambling within the Chinese community in the eastern metropolitan region. Some of the achievements of the project included:

- engagement of Chinese religious leaders – this was demonstrated through their regular participation in taskforce meetings and their commitment to the project
- improved understanding of taskforce members regarding problem gambling and available services
- increased confidence and capacity of taskforce members to respond to the issue within their community

- increased awareness about problem gambling and GH services among the Chinese spiritual leaders
- implementation of a mix of interventions, including seminars, media work, poster development and resource dissemination
- successful and collaborative partnership established between GH Eastern, MGHP and CGCI
- a commitment from GH Eastern and CGCI to continue working with the Chinese community.

A key strength of the project was the involvement of religious leaders and other key stakeholders of the Chinese community through the taskforce. It ensured that planned interventions were culturally appropriate and also created a sense of community ownership of the project, resulting in commitment and proactive involvement in the implementation of action plan strategies.

Through the project activities relationships, links and trust were established between participating agencies, religious leaders and other key stakeholders from the Chinese community. This has created the foundation for ongoing work.

The MGHP project budget provided remuneration for the CGCI, enabled the payment of sitting fees for taskforce members' participation in meetings and allowed for the implementation of action plan activities.

The project highlighted the need to work with and support religious leaders as they might be the preferred help seeking option for the Chinese community. It also demonstrated that there is a need to promote GH services to family members of problem gamblers. The project also highlighted vulnerable groups within the Chinese community including international students, elderly and restaurant workers.


Another key factor for success of this project was the use of bilingual workers. A GH Eastern Chinese speaking counsellor involved in this project had previously established links with the community, had insights into cultural issues and was able to utilise her bilingual skills during meetings and seminars.


Limited life of the project restricted the number of strategies that could be implemented. Ongoing work with the community is needed to achieve the goal of reducing harm caused by gambling within the Chinese community.

Taskforce members and project partners stressed the need for more resources to work with the Chinese community as the needs are complex and require diverse approaches.

 **STRENGTHS:**

- Community members employed to facilitate the program
- Project was guided by community elders and leaders
- Community identified most important issues in their community and planned and implemented solutions - this led to increased confidence and capacity in community

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Case study: Coming Together: Two cultures, One life, Foundation House

In 2004, Foundation House undertook a community development project with the largest group of refugees arriving in Melbourne at the time, the Dinka Sudanese community in St Albans. The project aimed to build the capacity of the Sudanese community to be better able to identify and resolve important issues and problems that they were experiencing in the resettlement period as a result of their experience of trauma.

Two Sudanese community development workers were employed (a man and a woman) to provide insight and knowledge about the community and to facilitate the project.

Key stakeholders were identified, including service providers, community organisations and community leaders. Ten community elders and leaders were invited to guide the project and assist in recruiting and motivating community participants, and in guiding workshops and meeting discussions. This group was fundamental to the success of the project, its sustainability and effective community engagement.

The project also successfully engaged with the wider Dinka community by initially organising a community forum to seek direction for the project. The leaders and elders assisted in organising and promoting the forum and community members were asked to identify and prioritise key issues of concern.

Parenting was recognised as the key issue of concern for the community, which was contrary to research that indicated employment was the main issue for the community. The authors of the project report say: “This reminded us of the importance of the community deciding the direction of the project!”⁶¹ The community decided to focus on the following three main areas of parenting:

- parents’ role in education in Australia
- being a parent in Australia
- impact of trauma on the family.

Subsequently, three community subcommittees were formed to plan for three weekend workshops on each topic. The workshop participants identified issues and prioritised solutions for each topic. The planning for the implementation of those solutions was led by the three subcommittees and three action plans were developed.

Some of the project interventions include:

- establishment of a partnership between a local primary school and the South Sudanese parents, resulting in a four-week training program for Sudanese parents about the Australian education system
- implementation of a pilot project to train Sudanese parents to become community educators who can inform new Sudanese arrivals about the Australian education system and how to support their children
- appointment of a Sudanese community member to the school council
- engagement of the Sudanese community and trust built trust in Foundation House. A project report states: “The Sudanese community is committed to ongoing involvement in strengthening their own community and increasing their participation in the broader Australian community”.⁶²

⁶¹ Foundation for Survivors of Torture Inc (2006) Coming Together: Two Cultures One Life case study, page 26. Available at: www.foundationhouse.org.au/resources/publications_and_resources.htm. Accessed July 2011.

⁶² Foundation for Survivors of Torture Inc (2006) Coming Together: Two Cultures One Life case study, page 58

The community increased their confidence and abilities to identify and solve their own problems. “They identified areas where they felt disempowered (...) and initiated actions to help them become informed, less fearful and better able to negotiate control over their community’s future”.⁶³

For more details about this project, the project report is available from the Foundation House website: http://www.foundationhouse.org.au/resources/publications_and_resources.htm

Case study: Comparison of two interventions implemented by the Victorian Aboriginal Health Service

Established in 1973, the Victorian Aboriginal Health Service (VAHS) provides a culturally appropriate and accessible health service. This case study compares two interventions delivered by VAHS, which had very different outcomes for the participants.

‘Talking About Pokies’ was a ‘formal talk’ about pokies with a free lunch, held in March 2009 at the Aborigines Advancement League. The speaker was a non-Aboriginal, highly qualified lawyer, an expert in field of Electronic Gaming Machines. The speaker didn’t appear to have a previous relationship with the organisers, that is, they were not known in the Community.

Approximately 40 people attended the session, which focused on ‘the bad pokies’. There was a perception that people were being ‘preached to’ and made to feel guilty for enjoying and managing their gambling responsibly. A formal lecture format was used and contained a lot of jargon. It was felt that the presentation was ‘targeting Aboriginal people’ and there was no Community ownership/self-determination of the initiative. In particular no problem gamblers were involved in the planning and content of the event.

Many participants went away taking exception to the view that all gamblers were addicted, alienating responsible gamblers in the audience. As a VAHS supported initiative this event was counter-productive in many respects.

On the upside, most of the audience were recovered problem gamblers and some health professionals. The recovered problem gamblers reiterated the operation of an ‘anonymous counselling’ process (involving family and friends) in Aboriginal communities in relation to aspects of health including gambling addiction, as this was their own experience. This experience was a catalyst for further discussion in the Community.

On reflection, a more positive approach would have included a practical focus of a session, co-facilitated by a community member. This would have provided legitimacy, shown leadership, provided back-up, and helped with translation. More use of plain language, without ‘dumbing down’ or being patronising and some humour. The presentation should also have involved a more culturally diverse group, to take away the feeling of being stigmatised and of being targeted as an ‘Aboriginal’ problem. An initiative driven from bottom up would involve better community consultation in design and delivery of program.

‘Venues Code of Conduct’ was a three-month promotion between November 2009 and January 2010 that used the radio, internet & word of mouth to reach about 1000 Aboriginal people. The Junction Hotel, Croxton Park Hotel and Cramers Hotel in the northern suburbs of Melbourne were used to access the community.

⁶³ Foundation for Survivors of Torture Inc (2006) Coming Together: Two Cultures One Life case study, page 57

The project was controlled by Aboriginal people and was instigated by problem gamblers. The promotions featured gamblers’ testimonials and information exchanges about standards of behaviour in venues across Victoria. Supporting venue inspectors from the Victorian Commission for Gambling Regulation (VCGR), the impetus was through community consultations.

The project involved Aboriginal interpretation of practical application of the Code. As a result of the intervention, Aboriginal people frequenting targeted venues decreased the amount of time and money spent at machines in all venues. There was a reported increase in confidence and self-awareness, of self-control of time and money by Aboriginal people involved in the project. The results were reported by Aboriginal people who gamble and who attend targeted venues and the information was provided to VCGR regarding venues, inspectors and Codes of Conduct.


On reflection, the reasons why this project was successful included that it was highly practical and used a harm minimisation approach. It was controlled by people in the Aboriginal community, and the impetus was from Kooris who gamble. The timing of the project was strategically integrated with Christmas and the holiday period along with other health information about diet, sexual health, drug and alcohol, and managing money. It was also integrated with news and information about Aboriginal-selected activities that are suitable alternatives to gambling. The project also was perceived to target settings and environments for gambling and not gamblers as such.

Some of the key features for this project’s success include:

- talks were discreet and informal
- interactive, unsolicited feedback was exchanged between gamblers, VAHS, 3KND, VACSAL & VCGR
- Stakeholders had matching service delivery objectives
- it enabled cultural diversity
- self-determination was strengthened
- it was respectful to gamblers
- genuine community consultations with immediate practical response
- Aboriginal gamblers wanted support to control gambling behaviours

A comparison of the two interventions highlight the following different characteristics:

Talking about Pokies	Venues Code of Conduct
Isolated activity	Integrated activities focusing on many health issues
Top down approach	Bottom up approach
Rigid presentation	Flexible design
Surveys	Community impetus and consultation
White lecturing / preaching	Equal Aboriginal partnership
Targeting Aborigines	Targeting environment
Irreverence	Respectful
Theoretical	Practical
Easy Reporting	Complexities in Reporting



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The list below presents resources and websites which may be useful to support integrated health promotion work in problem gambling (current as at July 2011).

Useful resources:

Integrated health promotion resource kit. Department of Human Services (2003)

This resource kit provides detailed information about the foundations of and planning frameworks for Integrated Health Promotion (IHP) in Victoria.

Accessible from: www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm

The partnerships analysis tool. VicHealth (2008)

This tool is designed to help organisations involved in health promotion to reflect on, monitor and strengthen partnerships.

Accessible from: www.vichealth.vic.gov.au/en/Publications/VicHealth-General-Publications/Partnerships-Analysis-Tool.aspx

Evidence-based mental health promotion resource. VicHealth (2006)

This resource provides practitioners and policy makers with a list of evidence-based interventions for mental health promotion, including interventions to increase social connectedness.

Accessible from: www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf

Planning for Effective Health Promotion Evaluation. Department of Human Services (2005, reprinted 2008).

This resource provides a planning framework for evaluating health promotion practice and aims to assist anyone working in health promotion to evaluate their programs effectively.

Accessible from: www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm

Measuring health promotion impacts: A guide to impact evaluation for health promotion.

Department of Human Services (2003)

This resource was developed to support agencies working within Primary Care Partnerships to assess and report on the impact of their health promotion activity. It promotes a rigorous approach to planning and evaluation.

Accessible from: www.health.vic.gov.au/healthpromotion/steps/evaluation.htm#measuring

Useful websites:

<http://professionals.problemgambling.vic.gov.au/>

The Problem Gambling Professionals website is supported by the Department of Justice and provides information, guidance and resources to help health and welfare professionals identify problem gambling clients and effectively respond to their needs.

www.problemgambling.vic.gov.au

Providing background information on the current help options for people with a gambling problem and highlights the social marketing campaign developed by the Department of Justice Victoria.

www.gamblingresearch.org.au

Gambling Research Australia (GRA) is an initiative of the Ministerial Council on Gambling. GRA funds nationally relevant gambling research. The Secretariat for GRA is managed by the Department of Justice Victoria. This website includes an extensive database of gambling related publications and research.

www.vcgr.vic.gov.au

The Victorian Commission for Gambling Regulation (VCGR) is the regulator of gambling in Victoria. A range of EGM expenditure statistics for regions can be accessed within the 'statistics' section of the site.

www.facs.gov.au/aboutfacs/programs/gambling/default.htm

The National Snapshot of Harm Minimisation Strategies summarises gambling harm-minimisation regulations nationally and has been prepared by the Department of Families, Housing, Community Services and Indigenous Affairs.

www.abs.gov.au/CDataOnline

The Australian Bureau of Statistics offers an online service called CData Online – sign up for access to an unlimited range of Census statistics.

www.aboriginalaffairs.vic.gov.au

This explains how Governments currently liaise with Indigenous communities and Regional Indigenous Councils across Victoria.

www.health.vic.gov.au/healthpromotion

The Victorian Government's website for health promotion.

www.vichealth.vic.gov.au

The website for VicHealth (the Victorian Health Promotion Foundation) provides information about health promotion priorities, evidence based resources, workforce development and funding opportunities.

www.dpcd.vic.gov.au/communitydevelopment

The Department of Planning and Community Development website provides information about community development / community strengthening initiatives and funding opportunities.

www.responsiblegambling.org.au

The Responsible Gambling Advocacy Centre is a not for profit consumer organisation set up to help people think about and make informed decisions about gambling.

www.multicultural.vic.gov.au

The Victorian Multicultural Commission provides policy input to the State government and has a range of useful resources including a multicultural directory of services and organisations, census data on CALD communities and cultural celebrations.

www.foundationhouse.org.au

Foundation House provides a range of services to people of refugee backgrounds who are the survivors of torture or war related trauma, including client and group work, resources and professional development for service providers.

www.ceh.org.au

The Centre for Culture Ethnicity and Health provides training, information (tip sheets and profiles) and support on a range of issues and topics including specialised gambling information and consultancy to assist services provide a high quality of care to refugee and migrant clients.

www.vacsal.org.au

The Victorian Aboriginal Community Services Association Ltd (VACSAL) is a state-wide agency that provides advice to Government on a range of community development issues as well as being a major provider of extensive services to the Aboriginal community in both the metropolitan and some regional areas.

Appendices

Appendix one: Evidence to support working with Victorian groups who may be at risk of problem gambling

Gambling Research Australia⁶⁴ provides access to an extensive database of gambling-related publications and research. This appendix provides an overview of some available research relating to gambling and population groups, rather than a comprehensive literature review.

Young people and young males

Young people and particularly younger males are frequently considered more likely to experience problem gambling and be at-risk for problem gambling. Research particularly shows that males 25-34 years have higher rates of problem gambling and younger males 18-24 years have higher rates of moderate risk gambling.⁶⁵

Research relating to gambling and young people, including young males, includes:

- A report on Young People and Problem Gambling (2004), developed by the Gambler's Help Youth Action Group and Youth Affairs Council (Victoria), highlights a number of reasons why young people may not seek help for a gambling problem. Barriers to seeking support in young people with a gambling problem were proposed to include:
 - a) lack of problem recognition
 - b) stigma and shame - young people feeling ashamed of their gambling problem
 - c) developmental stage - adolescence is a time of risk taking
 - d) access to services - young people often have limited knowledge of available services
 - e) lack of knowledge of service providers working with youth
 - f) privacy - young people fear having their privacy compromised
 - g) parental gambling - the key barrier to young people seeking help for their parents' gambling may be a sense of loyalty to their parents and shame about their family experiencing problems
- Delfabbro et. al (2006) explored the relationship between problem gambling and psychological and social adjustment in 926 Australian (ACT-based) adolescents, aged an average of 14.46 years. Adolescents classified as having a gambling problem were found to have poorer scores on all psychosocial measures, indicating a link between problem gambling and mental health conditions
- Desai et. al (2005) found that, in a sample of adolescents, problem gambling was more likely to be associated with dysphoria/depression in girls (only). In contrast, gambling was linked to elevated rates of alcohol use and abuse/dependence in both boys and girls. The author then pointed to the possibility that gambling may lead girls to experience higher rates of psychiatric symptoms compared to adolescent boys
- Splevins (2006), on behalf of Waverley Action for Youth Services (WAYS) NSW, found gambling was a common activity among Eastern Sydney adolescents. In total, 81% reported gambling and 6.7% met the criteria for probable problem gambling and showed a tendency towards being male with an average age of 15.2 years.
- A NSW problem gambling prevalence study (2006) showed that 'at-risk' gamblers were more likely to be young adult males (aged 18-24 years) compared with the total NSW adult population (34.3% compared with 4.5%)

⁶⁴ www.gamblingresearch.org.au

⁶⁵ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 17

- The South Australian Prevalence Study (2005) found a higher proportion of young males to be at-risk for problem gambling and particularly at-risk between ages 18-24 years
- A study in Victoria by Jackson et. al (2000) found that 41% of year 8 students had gambled in some form over the past 12 months and that gambling was more common in male students, compared to females (with the exception of lottery tickets). Around half the sample also considered gambling as a way to make money
- Moodie and Finnigan (2006) in a Scottish study surveyed 2043 children aged 11-16 years to investigate types, frequency and correlates of gambling and then measured problem gambling prevalence in a second study. Prevalence rates were 9%, with a further 15% classified to be at-risk. The study then concluded that there was the need for intervention strategies aimed at young people with a gambling problem, possibly as early as age twelve.

People with substance use issues

People experiencing drug, alcohol, nicotine and other substance use issues or addictions are reported to be both more likely to gamble and more likely to experience gambling problems. People with a gambling problem and moderate risk gamblers consume a significantly higher number of drinks per week than people who do not have a gambling problem.⁶⁶

Research relating to gambling and people with substance use issues includes:

- Cunningham-Williams et. al (2007) found that substance abusers with violent tendencies were about three times as likely as those without such tendencies to have a gambling problem, after controlling for socio-demographics
- Petry, Stinson and Grant (2005) surveyed over 43000 respondents in a major epidemiological study and found that the lifetime rate of alcohol abuse or dependence was 73.2% among lifetime pathological gamblers, compared to only 25% among non-gamblers. In addition, 38% of lifetime pathological gamblers also had a disorder with one or more other substances including sedatives, tranquilizers, opiates, stimulants, hallucinogens, cannabis, cocaine, inhalants/solvents, heroin and other drugs
- Grant and Potenza (2005) explored the link between problem gambling and tobacco use. Compared with the group of people who had never smoked, current and prior daily smokers were more likely to be older, female and have stronger urges to gamble. The study then flagged treatment for tobacco use and nicotine dependence as a potential treatment in the context of problem gambling, as smoking was found to be linked to more severe urges to gamble
- Gerstein et. al (1999) found that individuals with a lifetime diagnosis of pathological gambling had nine times the rate of substance use disorders (9.9%) compared to non-gamblers (1.1%)
- Welte et. al (2001) found the rate of current alcohol dependence in lifetime pathological gamblers to be 25%, compared to only 1.4% in non-gamblers
- Bland et. al (1993) surveyed 7214 adults in two Canadian provinces. Rates of lifetime alcohol abuse or dependence were found to be almost four times higher in individuals with lifetime pathological gambling (63.3%), compared to non-pathological gamblers (16.5%)
- Ibanez et. al (2001) evaluated gamblers in a treatment program and found that 35% had a history of alcohol abuse and 23% had current alcohol problems
- Feigelman et. al (1995) found that rates of problem gambling were high (7%) in patients receiving clinical treatment for drug abuse (patients were on a methadone program)

⁶⁶ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 195

- Desai, Maciejewski, Pantaloni and Potenza (2006) examined the interactive effects of alcohol use and gender on health and gambling attitudes and behaviors in recreational gamblers. In a study of 2417 adults, results of the study showed moderate-to-high frequency alcohol consumption correlated with heavier gambling in men more than in women
- Weinstock, Blanco and Petry (2006) conducted a study in methadone maintenance patients. Of the sample, 52.7% were classified as lifetime pathological gamblers and the majority of pathological gamblers were actively gambling within the past 2 months. Further analyses also showed that methadone maintenance patients with pathological gambling had significantly poorer mental and physical health than methadone maintenance patients without pathological gambling.

People with mental health issues

People with a gambling problem are significantly more likely to have a severe mental disorder, a moderate mental disorder or a mild mental disorder than non-problem gamblers.⁶⁷

Research relating to gambling and people with mental health issues includes:

- Petry, Stinson and Grant (2005) found that depression was approximately three times higher in pathological gamblers compared to non-gamblers. Dysthymia (a disorder characterised by chronically depressed mood for over two years) was significantly more likely to occur in pathological gamblers (20% versus 4.9%) and rates of manic episodes were eight times higher
- Specker et. al (1996) found that gamblers seeking outpatient treatment had about three times the rate of depression, compared with non-pathological gamblers
- Queensland Household Gambling Survey (2006-2007) found that 72% of people with a gambling problem reported feeling seriously depressed in the past 12mths, although only 39% reported being under a doctor's care. Around 19% had also seriously thought about or attempted suicide
- Sullivan (2000) examined GP attitudes towards problem gambling in New Zealand. Findings of the study showed that GPs held reasonably positive attitudes towards their role in counseling patients and in referring patients to non-medical professionals. However, many did not view problem gambling as an issue for medical intervention and some lacked confidence in talking about problem gambling. In addition, 55% believed that they didn't have the training to identify and help people with a gambling problem and 37% wouldn't know what to do if they came across a gambling issue
- Petry et. al (2005) found that pathological gamblers experienced a higher rate of generalised anxiety disorders, panic disorders with or without agoraphobia, specific phobias and social phobias at a greater rate than non-problem gamblers
- The Canadian Community Health Survey (2007) found the weighted prevalence of problem gambling was significantly higher (6.3%) amongst people with bipolar disorder, compared to the general population (2%) and those with major depressive disorder (2.5%)
- Petry and Steinberg (2005) found in a study of 149 pathological gamblers that women scored higher (compared to men) on a scale measuring childhood trauma (Childhood Trauma Questionnaire) and particularly on its subscales measuring childhood physical neglect, emotional abuse and sexual abuse. Severity of childhood maltreatment was significantly and independently associated with lower age of onset of gambling and increased severity of gambling problems
- Erikson et. al (2005) found that people 60 years or over experiencing problem/pathological gambling showed evidence of greater physical and mental health problems than non-problem gamblers

⁶⁷ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 215

- Ledgerwood and Petry (2006) examined post-traumatic stress disorder (PTSD) among pathological gamblers in a sample of 149 treatment-seeking people with a gambling problem. 34% of the people with a gambling problem reported a high frequency of PTSD symptoms
- Kausch et. al (2006) found that 64% of gamblers reported a history of emotional trauma, 40.5%, physical trauma and 24.3% sexual trauma. Most trauma was found to occur in childhood.

People of culturally and linguistically diverse (CALD) backgrounds

There are a number of reasons that may contribute to CALD communities being at risk of problem gambling. Migration and settlement experience can be very stressful and is often associated with social and financial stressors. Migrants struggle to find employment and are often under-employed as their overseas qualifications and experience are not fully recognised. Many refugees experienced trauma, torture and grief and loss that might put them at risk of gambling as a form of escape. Additionally, low English proficiency might result in poor access to information about gambling, problem gambling, and available services. Limited social networks and lack of alternative recreational opportunities are additional risk factors for CALD communities. There are also a number of service access barriers that might prevent CALD communities from using Gambler's Help services, including: shame and stigma, lack of understanding of the concept of counselling, concerns about confidentiality, the reluctance of seeking help outside the family, lack of awareness about the service offered and low English proficiency. All above factors should be considered in responses to problem gambling in CALD communities.

Research relating to gambling and people of CALD backgrounds includes:

- Blaszczynski, Huynh, Dumlao, and Farrell (1998) examined the prevalence of problem gambling within a metropolitan Chinese community. This revealed a prevalence rate of 2.9% for problem gambling and males showed a higher rate (4.3%) compared to females (1.6%)
- Yamine and Thomas (2000) conducted a survey of 664 respondents and found that 7.2% of people of Arabic background, 10.7% of people of Chinese background, 9% of people of Greek background and 10.5% of people Vietnamese showed signs of problematic gambling. Study also suggests that aspects of the immigration experiences of individuals may be important predictors or determinants of their engagement with gambling.
- Thomas & Thomas (2006) results indicated that international students have greater risk of developing gambling related problems. 18% of surveyed international students were at risk of developing problem gambling, Chinese male students and Chinese students from Hong Kong were the most at risk. The research also revealed that significant proportion of students started gambling in Australia (60.3%).
- Blaszczynski, Huynh, Dumlao and Farrell (1998) identified the incidence of problem gambling in Australia's Chinese community at 2.9% (with males showing a higher rate of 4.3% compared to females at 1.6%), which is more than double the general Australian prevalence rate.
- Zysk (2003) identified sadness, loneliness, boredom, limited knowledge of and access to other entertainment and low English proficiency as reasons for EGM gambling among the Vietnamese community.
- The Gambling among members of ethnic communities in Sydney (GAMECS) Project (1999) examined gambling activities of 976 regular gamblers across nine ethnic groups in Sydney. Findings showed that casino gambling was popular with Vietnamese, Chinese, Korean, and Croatian participants. Cards were popular with Greek, Italian and Arabic participants (accounted for 15% of gambling money spent). Macedonian, Korean, and Spanish participants preferred club

- EGMs and horse racing was more prevalent among Croatians and Macedonians. The study also found interesting differences in motivations to gamble among different cultures. For instance:
- a) Korean and Arabic people reported using gambling for entertainment and to ‘escape’
 - b) Arabic participants were found to be ‘ashamed’ of their gambling
 - c) Chinese participants regarded gambling as a regular social activity rather than as an ‘escape’
 - d) Vietnamese participants often saw gambling as a means of ‘making money’
 - e) Italians reported using gambling as a leisure activity
 - f) Spanish people viewed gambling as a hobby and a social activity
- Scull and Woolcock (2005) explored gambling and problem gambling within the Chinese, Vietnamese and Greek communities in Queensland and identified a number of service access barriers. These included: denial of a gambling problem; the ‘loss of face’ for the gambler and their family; cultural tendencies to resolve problems within the family; and aspects of the migration experience that leave individuals and families without support networks of extended family.
 - The Centre for Gambling Research at the Australian National University (2004) conducted a study examining help seeking patterns of people with a gambling problem of different cultural backgrounds. The study found that:
 - a) Most people turn to families/friends, group support or other general community agencies for help for problem gambling (rather than specialised help services)
 - b) Isolation/personal stress were factors which led to gambling problems
 - c) Men and women differed in help seeking - with men less likely than women to seek help
 - d) Barriers of different cultural groups to help seeking included: suspicion of mainstream services, shame and ‘loss of face’, language barriers, concerns about trust/confidentiality, unfamiliarity with or resistance to the concept of counselling, lack of information/culturally appropriate services
 - Volberg (1994) American study found that the likelihood of developing problem gambling increases with the length of exposure to legalised gambling. For people migrating to Australia from countries where there are limited gambling opportunities, the likelihood of developing gambling problems may increase the longer they stay in Australia, as their exposure to gambling increases.
 - Multicultural Gambler’s Help Program (2008) research with four refugee communities identified that gambling was more of an issue for established groups (such as Iraqis and Somalis) rather than it was for newly arrived groups (eg Liberians and Sudanese).

People of Indigenous backgrounds

Indigenous people, including people of Aboriginal or Torres Strait Islander backgrounds, have been identified as being at-risk for problem gambling.⁶⁸ Gambling for Indigenous people may include both commercial forms of gambling (eg. pokies in pubs and clubs) and in some communities, more informal ‘unregulated’ forms of gambling (eg. cards, backyard bingo).

Research relating to gambling and people of Indigenous backgrounds includes:

- Paterson (2007) conducted a study of gambling in a major Indigenous community in the Northern Territory. While it has been purported that Aboriginal card games typically fall outside mainstream government regulation, there was proposed to be a type of ‘regulatory structure’ that applied to

⁶⁸ Hare, S. (2009) A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice, page 87

card game play in Indigenous communities. In particular, it was identified that Aboriginal gaming structures work in their own context to create an ‘internal regulatory system’, some aspects of which have a corresponding resonance to regulation in the mainstream gaming industry. For instance, there are rules and regulations that structure games, which are designed to protect individual players and the community against harmful effects

- The Aboriginal Health & Medical Research Council of NSW (2007) identified the importance of raising community awareness and encouraging the discussion of gambling in Indigenous communities in NSW. Indigenous community members and gambling treatment providers consistently reported that existing mainstream gambling treatment services were often not utilised by Indigenous people. Useful strategies to build capacity in mainstream gambling treatment to respond to the needs of Aboriginal people included:
 - a) The development and delivery of cross-cultural training to staff
 - b) Employing Aboriginal people as counsellors
 - c) Facilitating and supporting engagement with local Aboriginal communities and their organisations through the development of resources, documentation of case studies and models of good practice and providing networking and information-sharing opportunities
- McMillan and Donnelly (2008) reviewed indigenous studies of problem gambling throughout Australia and advocated the benefits of culturally-relevant problem gambling help services for Indigenous communities
- A study by the former Queensland Department of Families, Youth and Community Care Queensland (1996) conducted a survey of 128 Aboriginal and Torres Strait Islander people in an Indigenous Land Council. Findings indicated that 78% of Indigenous respondents preferred EGMs, 11% preferred lotto, 7% preferred TAB and 4% preferred other types of gambling such as cards and bingo. Respondents reported a range of gambling-related problems including family financial assistance to pay gambling debts (8%) and putting important relationships at-risk because of gambling (6%)
- Kinsella and Carrig (1997) examined therapeutic models of intervention for Aboriginal people with a gambling problem in South Australia. The authors identified that Aboriginal gambling was widespread in the form of card games (Hunter and Spargo, 1988) and the card ring was described as an acceptable form of recreation within most communities (Goodale, 1987)
- Altman (1985) and Goodale (1987) discussed two modes of card games in Indigenous communities:
 1. ‘Fun and family-based gambling’ - family and socially-oriented card games where small amounts of cash are at stake (slow games) and
 2. ‘Business and hard work gambling’ – this is where card games are played with remarkable intensity and substantial amounts of money circulate (fast games).It was also proposed that, when Indigenous people play slow games, there’s a significantly higher degree of talking and laughing. In contrast, fast games are more serious, typically coincide with ‘pay day’ and domestic requirements take second place.

Family and friends of people with a gambling problem

A market segmentation study of Victorian adults exploring community attitudes and behaviours to gambling (2008) documents some of the many impacts of problem gambling on ‘significant others’. Other studies highlighting some potential impacts/issues relating to families and friends of people with a gambling problem include:

- Productivity Commission (1999) found that 20% of people with a gambling problem had insufficient time for their families, 11% reported gambling contributing to a break-up of a relationship and 42% reported arguments over money
- Dickerson et. al (1995) reported that a third of clients attending counselling had experienced a breakdown in a relationship due to gambling
- Jackson et. al (1997) reported that 55% of clients attending gambling counselling in Victoria reported having jeopardised or lost important relationships due to problem gambling
- Darbyshire, Oster and Carrig (2001) reported that children of parents experiencing problem gambling described their parent as being agitated, irritable, selfish and had lost interest in the child. Impacts on the family budget were also reported by children.

Senior Victorians

Research relating to gambling and older adults includes:

- Pietrzak and Petry (2006) examined the link between problematic gambling severity and psychosocial functioning in older adults (over 60 years of age). Compared with people with a gambling problem, pathological gamblers reported increased severity of gambling and family social problems on the Addiction Severity Index (ASI), scored higher on the Geriatric Depression Scale (GDS), Brief Symptom Inventory (BSI) and UCLA-Loneliness Scale and scored lower on the Social Provisions Scale (SPS). The author then concluded that severity of gambling problems is associated with increased psychosocial distress in older adults and that a significant proportion of older adults with a gambling disorder may be aware of their gambling problem and interested in treatment
- Moufakkir (2006) explored the trip characteristics and gambling behaviour of the elderly, compared to other age groups. Visitors to two large casinos completed a follow-up telephone survey. Findings showed that elderly gamblers were the least likely to engage in other leisure activities apart from gambling. They were also found to prefer to visit casinos on weekdays and indicated an interest in buying weekday package trips that included stops at several casinos
- Southwell et. al (2008) investigated gambling in older people aged 60 years and over in South East Queensland. The study gathered data via a postal survey of 80 managers of licensed clubs, interviews with Gambling Help services and a survey of 414 people aged 60+ who regularly played EGMs. Results of the study suggested that there are many circumstantial factors which explain why older people gamble. These included factors such as being without a partner, having a disability that impacts on everyday activities, having a low annual income and no longer participating in the workforce. Around 27% of the sample also reported drawing on savings to fund EGM play and this was noted as higher in older people without a partner or those with a disability. It was then concluded that this explains why older people had high overall levels of motivation for playing EGMs and greater reliance on EGMs to meet social, recreational and mental health needs
- Philippe and Vallerand (2006) examined the prevalence rate of gambling problems in senior citizens (55 years and older). Based on a sample of 810 older adults living in the Province of Quebec, the study revealed that the 12-month prevalence rate was 1.2% for pathological gambling and 1.6% for at-risk gambling. While these rates were deemed comparable to those reported elsewhere in Canada/the US, the at-risk gambling rate of older people was significantly higher than for the general population. Based on completion of the Gambling Passion Scale (GPS), results also revealed that the trait of 'obsessive passion' was higher for pathological gamblers than for at-risk and non-problematic gamblers.

Appendix two: Checklist for writing an effective Gambler’s Help Community Education Plan

The following checklist will assist services to develop and self-assess the quality of their plans.

	Self-assessment
<p>Does the IHP vision state ‘the difference’ the GH service will make within the community, around priority issues? Does the vision relate to the PCP vision? <i>The agency vision statement should clearly articulate where you want to be with respect to your health promotion response. The vision is the ‘big picture’ you are contributing to.</i></p>	
<p>Has the rationale been provided for the selection of 1-3 health promotion priorities? <i>The rationale should explain why you have chosen your priorities and why they are important to your organisation. The priorities of an agency can be informed by a variety of sources including demographic data, health surveillance and service data collections, information from consultations, and research on the social determinants of health.</i></p>	
<p>Does the Community Education Plan link to other plans such as the Primary Care Partnership, the Municipal Public Health Plan, Community Health Service plan, Neighbourhood Renewal plan, etc? <i>The plan should outline who else you are working with around your priority issues and make links with other plans. Working with others who share a common interest in an issue or target group / community increases the likelihood that you will make an impact in the long term.</i></p>	
<p>Have previous needs assessment, plans, evaluations, and consultations been considered? <i>For health promotion to be effective there should be an accumulative effect of efforts for change. That is, one-off, stand alone activities are unlikely to make any change to health status, behaviours of communities or the environments that impact on people. Longer-term commitment is required, whereby interventions build on previous work and adjustments are made to changing situations as needed.</i></p>	
<p>Does at least one priority align with the PCP’s priority? (Is this clearly stated/ linked?) <i>It is important to align at least one of your priorities with a PCP priority because for health promotion to be effective a coordinated response with others is required.</i></p>	

<p>Has a rationale been provided for the choice of target group/s? <i>It is important to clarify why and how you chose the target groups for this program. With competing demands for resources, it is important to explain why you are investing in particular groups.</i></p>	
<p>Have the social determinants of health have been considered? <i>Focusing on the social determinants of health has been shown to provide long-term benefits to the health status of populations. For health promotion efforts to be effective, the social determinants of health need to be addressed.</i></p>	
<p>Has evidence been used to inform the selection of planned strategies? <i>Explain why you have chosen to use the strategies/ interventions you have outlined in your plan. Is your choice based on what you have done in the past, what has worked for others, or innovation? Was the selection of strategies guided by key stakeholders or community members.</i></p>	
<p>Is there evidence of partnerships / consultation with other local practitioners and or organisations? <i>Who are you working with in partnership around shared priorities?</i></p>	
<p>Does the goal state the long-term changes that are intended? <i>The goal will not be evaluated within the lifespan (one year) of your plan. It outlines the big picture change you are contributing to.</i></p>	
<p>Are the objectives stating what must happen in order to achieve the goal? <i>Objectives operationalise the goal. What are the achievements / changes you hope to be able to measure by the end of the program?</i></p>	
<p>Are your objectives SMART?⁶⁹ <i>In order for you to effectively evaluate your objectives, you need to ensure that the way you write your objectives is SMART:</i> <i>Specific?</i> <i>Measureable?</i> <i>Achievable?</i> <i>Relevant/Realistic?</i> <i>Time specific?</i></p>	

⁶⁹ For more information about SMART objectives refer to the Department of Human Services (2003) Integrated health promotion resource kit, Victorian Government Department of Human Services, available at: http://www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm

<p>Is there a mix of interventions? <i>The mix of interventions chosen should reflect the needs of your target group and your capacity to deliver them. A mix of intervention types is recommended for health promotion to be effective.</i></p>	
<p>Is there at least one ‘upstream’ intervention included? <i>The term ‘upstream’ refers to interventions which target the distal determinants⁷⁰ of problem gambling.</i></p>	
<p>Is it clear who will undertake each intervention? <i>The plan should clearly outline roles and responsibilities for delivery of interventions across partner organisations and within your own organisation.</i></p>	
<p>Will the selected interventions complement other local organisations’ activities? Is there duplication? <i>Planning in consultation with others will reduce duplication (and wasted resources) and increase the opportunities to deliver complementary activities with a greater impact in the long-term.</i></p>	
<p>Are there opportunities for community leadership and participation (ownership)? <i>Community members should have the opportunity to participate and have a say about what health issues need to be collectively addressed and how they can make a difference. Community consultation processes should be inclusive of all target groups and conducted in culturally appropriate and gender sensitive ways (for example, interpreters are provided, gender separate consultations are undertaken where appropriate).</i></p>	
<p>Are selected interventions supported by capacity building strategies? <i>Capacity building strategies ensure that staff have well developed skills in quality health promotion practice. A range of capacity building strategies can be used.</i></p>	
<p>Has enough resources/time been allocated for planned interventions? <i>Do you have the capacity and time to deliver what is planned?</i></p>	

⁷⁰ For more information about the social determinants of health refer to section 5 of this Guide.

<p>Is estimated reach included? <i>How many people, community groups, schools, workplaces, etc do you intend to reach during this program?</i></p>	
<p>Flexible component allocated is no more than 10% of budget. <i>Up to 10% of your budget is available to respond to needs that may arise during the year. This may include responding to requests for unplanned community education opportunities, researching emerging issues, etc.</i></p>	
<p>Has sustainability been considered? <i>For health promotion to be effective it is important that sustainability of interventions, benefits and partnerships is considered when planning. Many of the features of this checklist will increase sustainability including:</i></p> <ul style="list-style-type: none"> - <i>Community consultation and involvement at all stages of the program development, implementation and evaluation;</i> - <i>The social determinants of health are considered;</i> - <i>A mix of intervention types is used, including population based strategies;</i> - <i>There is evidence of meaningful partnerships.</i> 	
<p>Is there a plan for evaluation? <i>Who will evaluate, how will you evaluate? How will data be collected? Is there an allocation of approximately 10% of the program budget for evaluation?</i> <i>Has communication/dissemination of evaluation results been planned? Will the evaluation findings to be integrated back into planning for sustainability?</i></p>	

References

- Abbott, M.W., & McKenna, B.G.** (2005). Gambling and Problem Gambling Among Recently Sentenced Women in New Zealand Prisons. Affiliation: Auckland University of Technology, Auckland, New Zealand. University of Auckland. Auckland, New Zealand. *Journal of Gambling Studies*, 21 (4), 559-581.
- Abbott, M.W., McKenna, B.G., & Giles, L.C.** (2005). Gambling and Problem Gambling among Recently Sentenced Male Prisoners in Four New Zealand Prisons. *Journal of Gambling Studies*, 21 (4), 537-558.
- Altman, J.** (1985). Gambling as a mode of redistribution and accumulating cash among Aborigines: A case study from Arnhem Land. In Caldwell, G., Haig, B., Dickerson, M., & Sylvan, L. (Eds.), *Gambling in Australia*, Croom, Sydney.
- Hare, S.** (2009). A study of gambling in Victoria: Problem gambling from a public health perspective, Victorian Government Department of Justice.
- Bland, R.C., Newman, S.C., Orn, H., & Stebelsky, G.** (1993). Epidemiology of pathological gambling in Edmonton. *Canadian Journal of Psychiatry*, 38, 108-112.
- Blaszczynski, A., Huynh, S., Dumlao, V.J. and Farrell, E.** (1998). Problem gambling within a Chinese speaking community. *Journal of Gambling Studies*, 14, 359-380.
- Canadian Community Health Survey (CCHS)** (2007). Record No. 3226. Statistics Canada. Canadian Problem Gambling Severity Index: Final Report Feb 19, 2001. Submitted for the Canadian Centre for Substance Abuse (CCSA) by J. Ferris & H. Wynne. Consultants - R. Ladouceur, R. Stinchfield & N. Turner.
- Centre for Gambling Research (CGR)** (2004): Report authors: McMillen, J., Marshall, D., Murphy, L., Lorenzen, S. & Waugh, B., Centre for Gambling Research (CGR), RegNet Program, RSSS & Australian National University. Report title: Help-seeking by problem gamblers, friends and families: a focus on gender and cultural groups.
- Cunningham-Williams, R.M., Ben Abdallah, A., Callahan, C. & Cottler, C.** (2007). Problem Gambling and Violence Among Community-Recruited Female Substance Abusers. *Psychology of Addictive Behaviours*, 21 (2), 239-243.
- Darbyshire, P., Oster, C. & Carrig, H.** (2001). The Experience of Pervasive Loss: Children and Young People Living in a Family Where Parental Gambling is a Problem. *Journal of Gambling Studies*, 17 (1), 23-45.
- Delfabbro, P., Lahn, J., & Grabosky, P.** (2006). Psychosocial correlates of problem gambling in Australian students. *Australian and New Zealand Journal of Psychiatry*, 40 (6-7), 587-595.
- Desai, R.A., Maciejewski, P.K., Pantalon, M.V., & Potenza, M.N.** (2005). Gender Differences in Adolescent Gambling. *Annals of Clinical Psychiatry*, 17 (4), 249-258.
- Dickerson, M.G., Boreham, P., Harley, B., Maddern, R., & Baron, E.** (1995). Evaluation of the Break Even resource centres for problem gamblers and their families: A report of the second year of the study into the social and economic impact of the introduction of gaming machines to Queensland clubs and hotels.
- Dowling, Nicki A ., Jackson, Alun C ., Thomas, Shane A ., Frydenberg Erica,** Children at risk of developing problem gambling, Final Report, May 2010.
- Egger, G., Spark, R. and Lawson, J.** 1990 'Health Promotion Strategies and Methods' Sydney McGraw-Hill Book Company.
- Erickson, L., Molina, C.A., Ladd, G.T., Pietrzak, R.H., & Petry, N.M.** (2005). Problem and pathological gambling are associated with poorer mental and physical health in older adults. *International Journal of Geriatric Psychiatry*, 20 (8), 754-759.
- Feigelman, W., Kleinman, P.H., Lesieur, H.R., Millman, R.B., & Lesser, M.L.** (1995). Pathological gambling among methadone patients. *Drug and Alcohol Dependence*, 39, 75-81.

- Foundation for Survivors of Torture Inc** (2006). Coming Together: Two Cultures One Life case study, page 26. Available at: www.foundationhouse.org.au/resources/publications_and_resources.htm. Accessed July 2011
- Gambling Prevalence in South Australia** (2005). Department of Families and Communities, Government of South Australia.
- Gambling Research Australia Report** (2005). Problem Gambling and Harm: Towards a National Definition (South Australia Centre for Economic Studies, Department of Psychology, University of Adelaide, Australia).
- (GAMECS) Project** (1999). Gambling Amongst Members of Ethnic Communities in Sydney, Australia. NSW Office of Liquor, Gaming & Racing, NSW Government, Australia.
- Gerstein, D., Volberg, R., Toce, M., Harwood, H., Johnson, R., Buie, T., Christiansen, E., Chuchro, L., Cummings, W., Engelman, L., Hill, M., Hoffman, J., Larison, C., Murphy, S., Palmer, A., Sinclair, S., & Tucker, A.** (1999). Gambling Impact and Behaviour Study: Report to the National Gambling Impact Study Commission. Chicago: National Opinion Research Centre, University of Chicago, USA.
- Gambler's Help Operational Guidelines and Performance Management Manual**, on the professionals website <http://professionals.problemgambling.vic.gov.au/>
- Goodale, J.C.** (1987). Gambling is hard work: Card playing in Tiwi society. *Oceania*, 58 (1), 6-21.
- Garrard, J, Lewis, B, Keleher, H, Tunny, N, Burke L, Harper, S & Round R** (2004). Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles, Victorian Government Department of Human Services.
- Grant, J.E., & Potenza, M.N.** (2005). Tobacco Use and Pathological Gambling. *Annals of Clinical Psychiatry*, 17 (4), 237-241.
- Banyule Nillumbik Primary Care Partnership** (2009). Health Promotion Resource Guide for Problem Gambling prevention in Melbourne's North.
- Hunter, E. & Spargo, R.** (1988). 'What's the big deal? Gambling in the Kimberley region'. *Medical Journal of Australia* 14, 668-672.
- Ibanez, A., Blanco, C., Donahue, E., Lesieur, H.R., Perez de Castro, I., Fernandez-Piqueras, J., & Saiz-Ruiz, J.** (2001). Psychiatric Comorbidity in Pathological Gamblers Seeking Treatment. *American Journal of Psychiatry*, 158, 1733-1735.
- Department of Human Services** (2003). Integrated health promotion resource kit, Victorian Government Department of Human Services.
- Jackson, A.C., Thomason, N., Ryan, V., & Smith, S.** (1997). Analysis of clients presenting to problem gambling services July 1995 to June 1996. Client and services analysis Report No. 1. Victorian Department of Human Services.
- Jackson, A.C., Patton, G., Thomas, S.A., Wyn, J., Wright, J., Bond, L., Crisp, B., & Ho, W.** (2000). The Impacts of Gambling on Adolescents and Children. Victorian Department of Human Services.
- Jones, C., & Crawford, S.** (2007). The psychosocial needs of NSW court defendants. Cited in Contemporary Issues in Crime and Justice No 108, March 2007. Bureau of Crime and Statistics Research, NSW, Australia.
- Kausch, O., Rugle, L., & Rowland, D.** (2006). Lifetime Histories of Trauma among Pathological Gamblers. *The American Journal on Addictions*, 15 (1), 35-43.
- Keleher, H. and Murphy, B.** Understanding health: a determinants approach, Oxford University Press, 2004
- Kinsella, C., & Carrig, H.** (1997). Therapeutic Models of Intervention for Aboriginal Problem Gamblers. The 'Aboriginal Counselling Research and Development Project', funded by the Department for Family and Community Services, Family and Community Development Program (South Australia Gamblers Rehabilitation Program), Australia.
- Lahn, J.** (2005). Gambling among offenders: Results from an Australian survey *International Journal of Offender Therapy and Comparative Criminology*, 49 (3), 343-355.

- Ledgerwood, D.M., & Petry, N.M.** (2006). Post-traumatic Stress Disorder Symptoms in Treatment-Seeking Pathological Gamblers. *Journal of Traumatic Stress, 19* (3), 411-416.
- Linden, R.D., Pope, H.G., & Jonas, J.M.** (1986). Pathological gambling and major affective disorder: Preliminary findings. *Journal of Clinical Psychiatry, 47*, 201-223.
- McMillan, J. & Donnelly, K.** (2008). Gambling in Australian Indigenous communities: the state of play. *Australian Journal of Social Issues, Spring 2008*.
- Department of Human Services** (2003) Measuring health promotion impacts: A guide to impact evaluation in integrated health promotion, Victorian Government Department of Human Services.
- Moodie, C., & Finnigan, F.** (2006). Prevalence and correlates of youth gambling in Scotland. Affiliation: Department of Psychology, Glasgow Caledonian University, Glasgow, United Kingdom. *Addiction Research Theory, 14* (4), 365-385.
- Moodie, Rob and Hulme, Alana,** 2004, Hands-on health promotion, IP Communications, Melbourne, 2004
- Moufakkir, O.** (2006). An Analysis of Elderly Gamers' Trip Characteristics and Gambling Behaviour: Comparing the Elderly with Their Younger Counterparts. *UNLV Gaming Research & Review Journal, 10* (2), 63-75.
- Multicultural Gambler's Help Program** (2008). Problem Gambling in New and Emerging Refugee Communities. Multicultural Gambler's Help Program, Centre for Culture Ethnicity and Health.
- Nixon, G., Leigh, G., & Nowatzki, N.** (2006). Impacting attitudes towards gambling: A prison gambling awareness and prevention program. *Journal of Gambling Issues, 17*, Aug 2006, (n.p.).
- Ottawa Charter for Health Promotion:** First International Conference on Health Promotion, Ottawa, Canada, Nov. 21, 1986 - WHO/HPR/HEP/95.1. Co-sponsored by the Canadian Public Health Association, Health & Welfare Canada and the World Health Organisation.
- Paterson, M.** (2007). The regulation of "unregulated Aboriginal gambling". Paper presented at the National Association of Gambling Studies Conference Nov. 2007, Cairns, Queensland, Australia.
- Petry, N.M., & Steinberg, K.L.** (2005). Childhood Maltreatment in Male and Female Treatment-Seeking Pathological Gamblers. *Psychology of Addictive Behaviours, 19* (2), 226-229.
- Petry, N.M., Stinson, F.S., & Grant, B.F.** (2005). Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychology, 66*, 564-574.
- Philippe, F. & Vallerand, R.J.** (2006). Prevalence rates of gambling problems in Montreal, Canada: A look at old adults and the role of passion. *Journal of Gambling Studies*, (in press).
- Pietrzak, R.H., & Petry, N.M.** (2006). Severity of Gambling Problems and Psychosocial Functioning in Older Adults. *Journal of Geriatric Psychiatry and Neurology, 19* (2), 106-113.
- Department of Human Services** (2005) Planning for effective health promotion evaluation, Victorian Department of Human Services.
- NSW Office of Liquor, Gaming and Racing** (2007). Pressing problems, Gambling issues and responses for NSW Aboriginal communities. Project and report by the Aboriginal Health & Medical Research Council of NSW. Funded by the Responsible Gambling Fund, NSW Office of Liquor Gaming and Racing, Department of Arts, Sport and Recreation.
- NSW Office of Liquor, Gaming and Racing** (2006). Prevalence of Gambling and Problem Gambling in NSW – A Community Survey. NSW Office of Liquor, Gaming and Racing, Department of the Arts, Sport and Recreation.
- Department of Human Services** (2001). Primary Care Partnership Strategy (2001): Evaluation. Community Health Unit, Department of Human Services, Victorian Government, Melbourne, Australia.
- Productivity Commission** (1999). Australia's gambling industries (Report No. 10): Ausinfo. Canberra, Australia.
- Productivity Commission** (2010), Gambling, Report no. 50, Canberra.

- Scull, S.** & Woolcock, G. (2005). Problem gambling in non-English speaking background communities in Queensland, Australia: A qualitative exploration. *International Gambling Studies*, 5 (1), 29-44.
- Wilkinson, R.** & Marmot, M. (Eds) (2003). *Social determinants of health: the solid facts*. 2nd edition, World Health Organization
- Southwell, J.,** Boreham, P., & Laffan, W. (2008). Problem Gambling and the Circumstances Facing Older People: A Study of Gaming Machine Players Aged 60+ in Licensed Clubs. *Journal of Gambling Studies*, 24 (2), 151-174.
- Specker, S.M.,** Carlson, G.A., Edmonson, K.M., Johnson, P.E., & Marcotte, M. (1996). Psychopathology in pathological gamblers seeking treatment. *Journal of Gambling Studies*, 12, 67-81.
- Splevins, K.** (2006). Prevalence of problem gambling, associated harms, and help-seeking behaviours among private high school students in the Eastern suburbs of Sydney. Waverley Action for Youth Services (WAYS), Sydney, New South Wales, Australia.
- Sullivan, S.** (2000). Problem gamblers: Do GP's want to intervene? *The New Zealand Medical Journal*, 113 (1111), 204-207. *Journal of Gambling Studies*, Vol. 24, no. 4, pp. 535-553. Dec 2008.
- VicHealth** (2008). Partnerships Analysis Tool, Victorian Health Promotion Foundation
 Department of Justice (2008) A market segmentation study of Victorian adults exploring community attitudes and behaviours to gambling, Victorian Government Department of Justice
- Thomas, N.,** Thomas, T., 2006, Influence of cultural background and cognitive distortions on the gambling behavior of international students, In: Katsikiti (ed.), *Proceedings of the Joint conference of the Australian Psychological Society and the New Zealand Psychological Society*, p. 435-439), Auckland, Australian Psychological Society.
- VicHealth** Partnerships Fact Sheet, http://www.vichealth.vic.gov.au/en/~media/ResourceCentre/PublicationsandResources/General/Fact%20Sheet_Partnerships.ashx, accessed July 2011
- Volberg, R.** 1994, The Prevalence and Demographics of Pathological Gamblers: Implications for Public Health *American Journal of Public Health*, Vol. 84, No. 2, February 1994, pp. 237-241.
- Weinstock J.,** Blanco C. & Petry, N.M. (2006). Health correlates of pathological gambling in a methadone maintenance clinic. *Experimental and Clinical Psychopharmacology*, 14, 87-93.
- Welte, J.,** Barnes, G., Wieczorek, W., Tidwell, M.C., & Parker, J. (2001). Alcohol and gambling pathology among U.S. adults: Prevalence, demographic patterns and comorbidity. *Journal of Studies on Alcohol*, 62, 706-712.
- Williams, R.J.,** Royston, J., & Hagen, B. (2005). Gambling and problem gambling within forensic populations: A review of the literature. *Criminal Justice and Behaviour*, 32, 665-689.
- Yamine, R.** & Thomas, S. (2000). The impact of gaming on specific cultural groups. Project Report. February 2000. A report to the Victorian Casino and Gaming Authority.
- Young People and Problem Gambling.** (2004). Forum Report organised by Gambler's Help Youth Action Group and Youth Affairs Council of Victoria Inc.

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