

# **PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE**

## **Inquiry into the Victorian Auditor-General's Reports no. 99: Follow up of Regulating Gambling and Liquor (2019) and no. 213: Reducing the Harm Caused by Gambling (2021)**

Melbourne – Tuesday 25 July 2023

### **MEMBERS**

Sarah Connolly – Chair

Nicholas McGowan – Deputy Chair

Michael Galea

Paul Hamer

Mathew Hilakari

Lauren Kathage

Bev McArthur

Danny O'Brien

Ellen Sandell



**WITNESSES**

Professor Dan Lubman, Executive Clinical Director, and

Mr Rick Loos, Manager, Telephone and Online Services, Turning Point; and

Mr Damian Ferrie, Chief Executive Officer, Better Health Network.

**The CHAIR:** I declare open this hearing of the Public Accounts and Estimates Committee. I ask that mobile telephones please be turned to silent.

I begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting. We pay our respects to them and their elders past, present and emerging as well as elders from other communities who may be joining us today.

On behalf of the Parliament, the committee is conducting this follow-up inquiry into the Victorian Auditor-General's reports on regulation of gambling and liquor, and reduction of gambling harm in Victoria.

I advise that all evidence taken by the committee is protected by parliamentary privilege. However, comments repeated outside of this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of the transcript to check. Verified transcripts, presentations and handouts will be placed on the committee's website.

I welcome Professor Dan Lubman AM, Executive Clinical Director from Turning Point; Rick Loos, Manager of Telephone and Online Services, Turning Point; and Damian Ferrie, CEO of Better Health Network. You are very much welcome here this morning. I invite Turning Point to make an opening statement or presentation, if you have got one, followed by Better Health Network, and the committee will then ask you some questions. Over to you.

**Dan LUBMAN:** Thank you very much, Chair, and thanks to the committee for inviting us to speak today. I would like to start by acknowledging the traditional custodians of the land on which we are meeting and pay my respects to elders past, present and emerging, and I extend that respect to any Aboriginal or Torres Strait Islander peoples with us today.

I would also like to acknowledge the lived experience and resilience of people living with alcohol- and gambling-related harms or addiction.

The harms of alcohol and gambling reach far and wide, affecting millions of Victorians every year. Almost one in four Australians experience an alcohol use disorder in their lifetime, which is 2.5 times higher than the world average of 9 per cent, so it is no surprise alcohol is the most common drug of concern among Australians seeking treatment. Alcohol use is also responsible for 40 per cent of all liver cancer deaths and around one-third of all mouth and throat cancer deaths in Australia.

When it comes to gambling, Australians lose more money per person than any other country in the world. Victorians alone lost \$4.6 billion in 2019–20, making up more than a fifth of the country's total losses. Beyond gambling losses, the estimated social cost of gambling in Victoria was \$7 billion in 2017. Behind these numbers are real people experiencing serious harm. Those experiencing gambling harm are up to seven times more likely to attempt or consider suicide, and a recent report found that 184 Victorians died due to gambling-related suicide between 2009 and 2016. That is an average of 23 lives lost every year, and that is likely to be an underestimate.

The harms of alcohol use and gambling are devastating, but there is so much we can do to prevent and reduce them. In the alcohol space, liquor licence applications and renewals can be improved through additional risk-based fees determined by location-specific data on alcohol-related harms. This data is already available through aodstats.org.au – a world-first, Victorian-funded platform with 11 different alcohol and other drug interactive datasets, including alcohol-related ambulance attendances, hospital admissions, family violence data, road injuries, deaths, assault, helpline calls and episodes of care. There is a huge opportunity to leverage this platform to support data-driven, risk-based licensing fees. This could be done by developing, piloting and

evaluating a statistical model that underpins an alcohol harm index or rating system to also inform an efficient and risk-based approach to compliance.

When it comes to responding to gambling harms and addiction, just like other health conditions, we need to encourage people to seek help as early as possible. To do that we need to actively promote timely treatment and support that meets people where they are at. This should include the expansion of helpline support, similar to quit lines for smoking that proactively support Victorians experiencing harms. My colleague Rick Loos manages Turning Point's helplines and is happy to answer any questions you have about the current Gambler's Helpline and Gambling Help Online offerings and opportunities for improvement.

Victorians should also immediately strengthen consumer protections by establishing a statutory duty of care for gambling operators, prohibiting the offering and advertising of inducements to gamble, prohibiting turnover requirements for deposits and piloting the use of pop-up messages that prompt people to reflect on their gambling behaviour. Our submission also recommended introducing a mandatory shutdown period at gaming venues and expanding mandatory carded play and precommitment beyond the poker machines at Melbourne casino to include the other 90 per cent – or about 27,000 – of poker machines across Victorian pubs, clubs and hotels. We welcome the Victorian government's recently announced commitment to these measures and look forward to them being implemented.

Finally, we must acknowledge the harmful and pervasive stigma surrounding gambling harms and addiction, change the way people experiencing gambling harms are spoken about in Victorian laws and regulations and invest in an anti-stigma campaign to promote help seeking and connect people and families with support. Alcohol and gambling harms are widespread. We have the tools to prevent, reduce and treat them – we just need to use them. Thank you.

**Damian FERRIE:** If I could just say something about Better Health Network, it is responsible for the delivery of Gambler's Help Southern, which is funded by the Victorian Responsible Gambling Foundation. Better Health Network, or BHN, is a newly created, large, registered community health provider, with over 850 employees, operating in the south-east region of Melbourne. It was created in 2022 as the result of an amalgamation of three existing community health services: Star Health, Central Bayside Community Health and Connect Health and Community. The BHN is driven very much by a social justice imperative: reducing inequality in our communities and providing care for those who are left behind and suffer with stigma and exclusion. It provides a wide range of mental health and community programs and a comprehensive range of mental health, AOD and Gambler's Help intervention.

On a daily basis we see the harm caused by problem gambling, from the tradie living in Berwick who loses their home and that of their partner and children to the 80-year-old pensioner who is at risk of homelessness, who contacted our services following grief and trauma associated with the death of her husband and addiction to electronic gaming machines. As I said at the beginning, BHN remains concerned about some of the recent announcements associated with the machinery-of-government changes regarding the Victorian gambling foundation, and we are concerned that it will reduce our capacity to effectively respond to the harm that is caused by something of the \$300 million of investment in advertising per year. We remain concerned that there is no allocation of funding for Gambler's Help in the forward estimates. While reassured that the Premier has stated there will be no reduction in the government's commitment to Gambler's Help, we would be more assured if that commitment was reflected in budget papers, in the forward estimates.

We are concerned that harm reduction, prevention and therapeutic services currently sitting with the foundation are positioned appropriately in a part of government where knowledge, research and sector support and development can be protected and promoted. To give you some context, Gambler's Help Southern, in the south-east region, has four different components: teams that conduct therapeutic counselling, financial counselling, community engagement and, finally, venue support. To give you a sense of the size of this, the service covers the whole of the south-east Melbourne catchment, everywhere from Port Melbourne to Rosebud, and includes Dandenong, Casey and Cardinia. The therapeutic and financial counselling teams work from multiple locations across the catchment and see clients in person as well as via telehealth and in 2022–23 provided 16,000 hours of counselling. The venue support workers support 105 venues in the catchment.

**The CHAIR:** Thank you, Mr Ferrie. I am going to go to Mr O'Brien.

**Danny O'BRIEN:** Thank you very much, Chair. Good morning, all. Mr Ferrie, I might start with you, on the comments you were just making about the VRGF. What do you know about the change? We have sort of tried to find out a bit more information, but there is literally one line in the press release. VRGF told us yesterday there is a process. Have you been involved in a process for how gambling assistance and gambling help is going to be delivered in the future?

**Damian FERRIE:** No, not at this stage. We have had initial contact. The foundation has been in contact with providers and informed them of the changes that basically included the press release and data, but where we sit – and I think this is important in terms of the opportunities – what we are acutely aware of is that as a health service we deal with clients with a range of comorbidities. And the research is clear: the link between mental health, AOD and gambling addiction. They are related, and there has been a lot of research into that space that obviously Professor Lubman can speak to. We are very keen to ensure that both that analysis and the sort of comprehensive care that you would expect in a community health service is comprehensive and is able to provide appropriate responses to all those conditions.

**Danny O'BRIEN:** Do you have any concerns about merging the provider of the gambling help service – well, you are the provider, but ultimately VRGF has the money – with the regulator? Does that have any benefits, do you think?

**Damian FERRIE:** We naturally would think that while there may be some conversation in relation to where venue support works, in terms of therapeutic counselling we would want to see that in a part of government where there is expertise in that space, sitting firmly within a harm reduction and prevention framework.

**Danny O'BRIEN:** I think we heard yesterday that it used to be provided through VicHealth or certainly through the Department of Health. Is that a more appropriate location for it?

**Damian FERRIE:** I do not really have an opinion on where it sits, but I do think it is important that the broad population health approach – primary health and population health interventions – are supported wherever it sits.

**Danny O'BRIEN:** Okay. And perhaps to the whole panel – the VRGF more broadly, how has its management of Gambler's Help, but also its research, assisted? Or has it assisted in terms of actually minimising harm and helping those who are most affected? As I said, I would welcome all of you to answer that if you like.

**Dan LUBMAN:** I think one of the really important royal commissions in recent times was the royal commission into mental health and the mental health system, which has acknowledged the impact of a siloed system on the individual care of Victorians. Victorians present with a whole range of issues, as Damian said, in terms of mental health, alcohol and drugs and gambling, but often our service system is very siloed in its approaches. There is a whole series of recommendations around integrated care and the delivery of integrated care and the acknowledgement that gambling services should form part of the locals – the local mental health and wellbeing system that is being developed. We welcome that opportunity to deliver a holistic package of care to Victorians at locations that are easy to access and that provide that comprehensive suite.

I think that has been the challenge for the gambling system at the moment, being siloed from other parts of health. And certainly a conversation we are having around the alcohol and drug space, the gambling space, the mental health space and that holistic physical health space as well is how we make sure that we better design services that meet the needs of Victorians. We really welcome the opportunity to think about how these current innovations around the mental health royal commission can consider how we integrate gambling into that space so that Victorians get a much better service response.

**Danny O'BRIEN:** Just back to the question on VRGF specifically, has its research been useful in both preventing and treating gambling harm?

**Dan LUBMAN:** I suppose I cannot comment on all its research. I know that a significant amount of research has gone into identifying harms and where harms occur. I think a number of people have identified that there are gaps in terms of our evidence base around how to improve our system responses and our actual treatment responses. I think that is an area that does need a greater level of investment. If we look at any other

health condition across the health system, there is significant investment in ensuring better outcomes for people with a range of physical and mental health conditions. That is an area that I think has been underdeveloped so far, and I really welcome the opportunities to think about how we can invest in actually improving those outcomes moving forward.

**Danny O'BRIEN:** You mentioned, Mr Ferrie, the link between AOD, mental health and gambling. Is it people suffering from problem gambling, or is it just people with an addiction? They are one and the same, I guess. What sort of percentage of people with a gambling problem have one of the other issues as well? Comorbidity I think you described it as.

**Damian FERRIE:** There is some data on this, and I was discussing this before the meeting with Dan, so maybe I will just refer to you because you have got that research at your fingertips.

**Dan LUBMAN:** Yes, so we did a large study for the VRGF around rates of the relationship between mental health and gambling. About 75 per cent of people presenting to a gambling service have a mental health issue.

**Danny O'BRIEN:** 75 per cent?

**Dan LUBMAN:** 75 per cent. I suppose just speaking to that integrated issue. For people with serious mental illness, they are less likely to gamble than the general population, so only about 41 per cent gamble. But the really interesting figure that we found is of those people who do gamble, they have got a one in two chance of developing a gambling problem, so less prevalent but if they do gamble, at high risk. And I think that just really just speaks to the importance of ensuring that when people present either to our gambling system or to our mental health system our workforce is adequately trained and supported to understand how to ask the question, how to support somebody and how to make sure that that issue does not exacerbate their underlying mental health and quality of life.

**The CHAIR:** Can I just quickly ask a question on the back of that. Is that number increasing, to suggest that maybe when they do present to mental health services that we are not asking the right questions or they are not getting the right support and then end up falling into the gambling trap?

**Dan LUBMAN:** I think that is a really excellent point. I think part of what we did in that study, and we are happy to share that with the committee, was we looked at doing a whole range of interviews and questionnaires with the mental health workforce. They recognised that they have not had adequate training around understanding gambling. They do not know how to screen, and they are not confident in knowing where to refer people. I think that just speaks again to this siloing of these different parts of the system: that we are not looking at somebody holistically and we are tending to sort of push people into how we design systems rather than to think about what their holistic needs are. So certainly the report we did a few years ago now was really about 'How do we upskill the mental health workforce?' But I think that is the challenge when different parts of government are trying to influence other parts of government; there is a challenge in how we actually make that normal business.

**Damian FERRIE:** It is one of the key principles of the way in which community health operates that if somebody walks through the front door, perhaps to visit a GP, and they present with a range of conditions that can be identified by the GP, those referrals, and warm referrals, are really encouraged within our services. You know, that has been a very effective tool in dealing with issues such as family violence, alcohol and drug abuse, mental illness and gambling. But it is one which I think has been highlighted really in the royal commissions into family violence and mental health. Where traditionally we have funding streams and, through no ill intent, traditionally we have set up a funding stream that has its own data collection that does not easily talk to other parts of the business, we can find ourselves in the situation where we have people presenting in some parts of the business receiving services and other parts of the business do not know, because the systems we have do not talk to one another. They are complex. We are clinicians and sit in the system and we find it complex; it is no wonder, as was pointed out in the royal commission, that people bounce around the system. The front door of the local, whether it be the Orange Door initiative and also of course the locals, is designed to create the one entry door. We are very anxious that that system does work well, and we are working on that as we speak along with a whole lot of other people in the sector.

**Dan LUBMAN:** Just on the follow-up, I think it is really important to emphasise – we said it, and I will throw to Rick in a second just to talk about the experience from the helpline – that we are talking about a very

highly stigmatised area of health. People do not normally disclose. If you do not ask the question, people do not normally raise it as an issue, and we have a workforce that does not really understand what it is. They often think it is a moral issue and often think it is about poor judgement, and so there is often a reluctance within the health system to ask the question. So because of that, it is not surprising that there is a huge delay in help seeking. So it can be a decade or more before people put their hand up for help, and in that time people can get into real strife. I think unlike other health conditions – so if somebody has got a mental health issue, if somebody has got an alcohol or drug issue, there are often visible signs that other people can pick up. But in this space, if it is just about financial health, you can go gambling and losing lots of money without your spouse or other members of the family knowing until often it is too late, and that is a real shame. Rick, do you want to just talk about that stigma and the helpline response?

**Rick LOOS:** Yes. Look, I do see this in the alcohol and drug sector, and I do see this in the mental health sector as well. Treatment retention is a real problem in this space, particularly around alcohol and drugs and gambling harm, because for a lot of people it is the coping mechanism they use to deal with other issues in their lives. So it might be those mental health conditions, such as anxiety, depression, trauma, grief and other mental health conditions; it is the coping mechanism. So it is difficult for someone to approach a service to disclose what is seen by the general public as a weakness or a level of irresponsibility. With the messages around responsible gambling, what you are really telling people is that they are being irresponsible. For that person to summon the courage to actually pick up a phone and ring and speak to somebody and then do it again and again and again and to re-expose themselves and lay bare what is perceived as their weakness or their irresponsibility is a difficult thing. I think what we do not do well enough is that work on retention and that integration between systems to allow people to safely navigate and to be supported through that navigation. I think while you isolate these sectors it becomes very, very difficult for a person who is dealing with lots of issues, not at their best, to navigate systems when they are also experiencing anxiety, trauma, stress and grief – and they have got a coping mechanism which is easy to fall back on to because it is constantly in their face – and then continuing to encounter those feelings of poor self-efficacy. To then expect them to re-energise and remotivate and pick up the phone and call again after they continue to hit lows in terms of their self-efficacy becomes harder and harder. So unless you do that, unless you have got really well-integrated systems and you are supporting people to get through that and to work with those systems, people will fall through the cracks, and that is what we see in helplines all the time – people repeat calling us because they are struggling to navigate themselves through systems.

**The CHAIR:** Thank you.

**Danny O'BRIEN:** Can I just get those figures again that you gave, Professor? Seventy-five per cent who present to a support service –

**Dan LUBMAN:** To a gambling service.

**Danny O'BRIEN:** come with a mental health issue. There was 40 per cent of something.

**Dan LUBMAN:** Forty per cent of people with a serious mental illness gamble – that is less than the general population – but those that do have got a one in two chance of developing some level of gambling problems.

**Danny O'BRIEN:** Mr Loos, I think you have probably answered what was my next question. One of the issues that we hear of in alcohol and drugs and mental health is that when the person is ready to get help, they make a call and they say, 'Yep, we can lock you into a new bed in six weeks time.' Is that the same for gambling help? It is a different treatment, obviously.

**Rick LOOS:** Yes, look, it is exactly the same. There might be weeks to wait for treatment, but in the meantime they are left with their problem, which can get worse. Like I said before, it is significant self-motivation to ring up, to pick up the phone and say you have got this sort of issue. But then on putting it down usually motivation drops immediately, and unless you are supported, it is quite unlikely that you are going to get to that next appointment.

**Danny O'BRIEN:** When you say 'motivation drops' – motivation to get help?

**Rick LOOS:** Motivation to get help – exactly. So you have motivated yourself to pick up the phone and disclose all these issues and lay bare your problems. But then once they have done that, most people go into

self-protection mode and find it hard again to then take that next step – to do that all over again – without support along the way. That is something we do not do well enough. We do not support people from that initial contact right to the point of that next step to make people feel –

**Ellen SANDELL:** Can I just follow up and ask on that: what is the process? Say you choose to make the call. Can you just step us through what then happens in an ideal situation and what happens currently in an ordinary, normal, average situation?

**Rick LOOS:** We are funded to take that initial call and then make a referral, and that is the limit of our funding.

**Ellen SANDELL:** And a referral to what service?

**Rick LOOS:** To a treatment service, so whether it be a gambling help treatment service – we might make that referral to a treatment service.

**Ellen SANDELL:** Would that be a residential service or just a –

**Rick LOOS:** No, it is usually a face-to-face counselling service. So it may be a –

**Ellen SANDELL:** With a psychologist?

**Rick LOOS:** It could be a financial counsellor. Damian will talk about the services they provide. If their significant presenting issue is the financial issue, we might recommend a financial counsellor or it might be a therapeutic counsellor, so a psychologist or whoever is employed at that treatment service. We provide a treatment. Then they might get a phone call in a couple of days time from a treatment service that might put them into an intake appointment. So depending on the availability –

**Ellen SANDELL:** The initial call to the helpline – does that provide any therapeutic support or is that simply just a referral?

**Rick LOOS:** We might deal with the distress that someone is experiencing at the time, and the majority of people who call us call us as a result of a loss. They have just had a loss in gambling, so they are dealing with distress. Most of the time they are not ready for treatment, and I think that is the thing that we notice as well. People contact us when they have experienced a loss, and they are not ready for treatment. What we try and do at that point is actually work with that distress – so dealing with the distress, making sure it is not at such a heightened level that there might be potential for some self-harm –

**Ellen SANDELL:** And if there was, would you then need to refer them to a separate service to deal with that, or is the helpline dealing with it?

**Rick LOOS:** Look, we'll deal with it unless we feel that there is imminent risk of self-harm, suicide or other issues of harm, whether it be family violence or child protection, for example. But we would deal with that. We would get emergency services involved when immediate help is required. We would encourage someone to keep contacting us back if the harm was at a lower risk, but the referral then goes on to the treatment service to then follow up with that particular person.

**Ellen SANDELL:** Sorry to take up time, but when you are referring someone to a treatment service, is that a private treatment service or a public treatment service, or does it just depend on the circumstances?

**Rick LOOS:** It is usually a public treatment service funded by the Victorian government – services such as Damian's Star Health service. We initially refer to a public treatment service, and then a follow-up call is made. But again it is the same sort of thing. We screen calls all the time when we get calls from numbers we do not know. Usually someone with a gambling problem is dealing with people chasing debt. So if you are trying to contact somebody, that is a problem, because they may not pick up the call. They might be screening the call, so the chances of someone actually following through on a referral are pretty low. But then yes, if they do follow up and they do make a call, there is then usually an appointment made for an intake. That could depend upon the waitlist at that particular service, so it could be weeks.

**Ellen SANDELL:** It sounds like it is not ideal, the treatment pathway, so what is the solution?



**Dan LUBMAN:** I think that the system is not fit for purpose. It is not designed to meet the gambler where they are at. The system is designed essentially, I think, for service provision, not for the person. We are talking about something that is incredibly stigmatising. People feel enormous shame. They feel responsible, they feel blamed and they are fearful of being judged, because everybody else is judging them. They put their hand up for help, and the best that we can offer at the moment is to say, 'Here's a number and connection to a service to go.' There are lots of doubts. We have no capacity to hold people to build that confidence and motivation. In other areas of health they have very strong stepped care models, where they can provide some brief interventions, provide support, build up their motivation, their self-efficacy –

**Ellen SANDELL:** Is there a model that you think that we should look to that does that well?

**Dan LUBMAN:** I mean, I think for us quit lines are a really great example of success. Quit lines do not just take a call from a smoker and refer to a bricks-and-mortar smoking-cessation clinic. They recognise that people need a range of different options. You are able to proactively follow up with people who call a quit line. We provide them with a whole range of resources that they can use to think about quitting. We tailor different interventions to support them, and if they still need a face-to-face, more intensive therapeutic encounter, we can refer them on to those settings. Stepped care models are mainstream in health; we just do not do it in the gambling system.

**Ellen SANDELL:** Interesting. Thank you.

**Damian FERRIE:** I said that community health wants to work or does specifically work and focus on people who are often left behind and excluded. If you impose poverty, ill health, mental distress and gambling addiction – these are complex people to work with. They are complex communities, and the solutions are not simple. I think what we are pointing to is that, in terms of the research that needs to be done, research is one thing but service model design is another, and it is probably unlikely to be one system. It is going to be a range of options for different people as they respond.

If you think about the sort of investment that the gambling industry is putting into advertising and the sophistication of it, we have not responded to that at all. We have a service system. Whether it is electronic engagement with younger people – we know the rates of online gambling are increasing. You see it every day of the week. I think that what we are really calling for is the need for a sophisticated approach that actually is not defensive but says, 'There are a range of options here.' That service design that I think Dan is referring to is absolutely the sort of process that we need to go into, and we would like to use the opportunity of rethinking about the foundation as that sort of a conversation. How do we respond as a service system – as people that actually are on the ground working with people and responding to them? How do we provide that grade of services that means that when somebody does call the helpline we can respond in a variety of ways? Electronically – you know, there is very good evidence, for example, in counselling that text-related counselling can be very successful as well and has been used in regional Victoria very successfully.

**Ellen SANDELL:** Thank you.

**The CHAIR:** Thanks, Ms Sandell. I am going to go to Ms Kathage. I am waiting for the nod.

**Lauren KATHAGE:** Thank you. In response to the audit recommendations the Victorian Responsible Gambling Foundation undertook a review of its treatment services. How can the prevention and treatment of gambling harm and gambling addiction be improved? You have spoken a bit about siloing. You have spoken a bit about follow-through support. Can you speak a bit more to VRGF changes to treatment services since the audit and if there is more that needs to be done?

**Dan LUBMAN:** I am not aware at the moment – I know the planning has occurred. I am not aware of what the planned changes are. I am not privy to that. I do not think –

**Damian FERRIE:** Since the VAGO audit, the foundation has initiated a service review, and the sector has been involved in conversations with those consultants appointed, the results of which I think are still to be rolled out – but that work is underway. But the details of it I am not aware of.

**Dan LUBMAN:** I think one of the things that we have all been talking to is we clearly need an outcomes framework. We need to know what it is that we are actually trying to achieve with an investment in prevention

and treatment. What are the outcomes that we want to see? As Rick has already alluded to, we have no idea, you know, how many people who put their hands up for help actually get help. It would be great to have a KPI where we are working towards ensuring that the majority of people who put their hands up for help get help and get help that actually works. At the moment we do not have a framework that does that or specifies that, and I suppose that is what we are really keen to do – have clear parameters of what we are trying to achieve and design a service system and service approaches that maximise and ensure we meet and deliver on those targets.

**Lauren KATHAGE:** Have you reviewed the foundation's outcomes framework?

**Dan LUBMAN:** I have not seen the outcomes framework, no.

**Lauren KATHAGE:** Sorry, you were going to say something.

**Rick LOOS:** I was just saying I was involved in some of those early workshops around the sector redesign and move towards a stepped care model, which is something that the alcohol and drug sector did 10 years ago now I think. I know, from a lot of those discussions, a lot of the gambling service providers were talking about the need for the link with the mental health system and feeling like it was not linked and needed to be linked. So I think while we move to a stepped care model, that is an area that we need to really consider with all of these systems – how integrated they can be.

I also feel that still there is a need to really consider the idea of getting people to and through treatment. It is one thing to have a stepped care system that looks good to us, but to help someone navigate through those steps and to support them through that I think is something that really needs to be considered as part of any review of this system – that support to get people to treatment and through treatment. So yes, I think that still needs to occur. But I do know that we are working towards a stepped care process.

**Dan LUBMAN:** And I think the other thing to say is we have unfortunately a very flat structure in the gambling treatment system at the moment. We have a response that is sort of a one-step response. In other areas of health if you have not responded to a particular level of care, there is an ability to be referred to a further level of support with more specialisation and more support. We do that for diabetes, we do that for heart disease, we do that for depression. We do not do that in gambling; we have a very flat structure and not the sophistication of that stepped care model.

**Lauren KATHAGE:** Do you mean the treatment people receive is the same and there is not an opportunity to escalate or change that treatment?

**Dan LUBMAN:** That is right. There is not a clear model of care in terms of what happens, as Damian says, when we have people who present with a range of complexities who are not responding to what we are currently offering. What is the ability to step up the level of care to be more intensive and more sophisticated, to actually provide a greater quality of service delivery for that group who do not respond? In other areas of health, when people do not respond to treatment, we do not blame the individual. If you have chemotherapy for cancer and it does not work, we do not say, 'Sorry, you're not motivated enough. Please come back again, and we'll try the chemotherapy again next time. Hopefully, if you're motivated enough, it will work.' We do not blame people; we look at other treatment options because we recognise that people are different and often require different treatment approaches. Unfortunately in the gambling space we do not have much more to offer.

**Lauren KATHAGE:** Presumably a more sophisticated outcomes framework would be able to identify what treatment is working for whom and therefore guide service delivery.

**Dan LUBMAN:** At the moment we have no idea who responds and does not respond, what the characteristics are of people who respond, what additional support they need and what greater level of treatment they need. It is completely absent at the moment – we are working in the dark. When we are working in other areas of health, that is the work that is being done behind the scenes.

**Lauren KATHAGE:** How has that gap in knowledge come about? Why is there that darkness?

**Dan LUBMAN:** I think there has not been investment, and this is broadly – not just in Victoria, but worldwide. The focus has largely been on prevalence and harms and looking at broad treatment responses, but

there has not been that focus on, I suppose, health services research, so understanding how people navigate through the system, how people respond and, for people who do not respond, what predicts that. It is a huge area of gap in terms of investment in research.

**Lauren KATHAGE:** Is it just investment, or is there more that government can do to improve the research output by VRGF?

**Dan LUBMAN:** I think one of the examples – and Rick might talk to this – is around the data collected. At the moment unfortunately we are not able to have access to the data around people coming through the gambling system. Turning Point works very closely with the Victorian government, particularly the Department of Health, around the alcohol and drug treatment system. There is a lot of work there around understanding pathways through care – who needs what, what the outcomes look like and how we can improve that. We are a bit in the dark in the gambling space around who is actually receiving care and what sort of care they receive. That is something that we would really welcome in terms of thinking about how we can improve our own services. I do not know, Rick, if you want to make a comment.

**Rick LOOS:** We administer the post-treatment client outcome surveys on behalf of the Victorian Responsible Gambling Foundation. That outcomes survey happens at three months and six months post treatment. There is a survey that occurs – that is meant to happen – immediately post treatment, but that survey of the client actually happens at intake because of the poor retention rate. People drop out of treatment all the time, so you do not get that post-treatment survey and then the follow-up surveys that then match that treatment. The initial survey is often done at intake, and then someone will drop out of treatment. When we do the three- and six-month review, we do not know what treatment they have had, if they have had any treatment at all. Then trying to extract data out of the existing system to try and work out how many treatment episodes they had – and from where and what their population type was – was virtually impossible.

Not only that, but we are not setting people up to provide that feedback right from the very beginning. When we do make calls to do those outcome surveys, the response rate is really poor. We only tend to get responses from people who are unemployed or retired who maybe have time to take the call, but a lot of other people either have not experienced treatment, are not expecting that contact, are not willing to provide feedback and have not been supported to provide that initially in treatment as well. We do not know what an episode of treatment is. I mean, what is it? Is it two sessions, is it three? And then how are we measuring the effectiveness of that treatment? What model of care have we followed, and how effective is that model of care? These are things that are just not in the design of the review.

**Damian FERRIE:** I think the thinking and the work around the redesign of the mental health system is instructive in this process. As you are aware, one of the key themes that emerged out of the royal commission was this system needs to be redesigned with the client at the centre and the peer workers – those affected, those who experience mental illness – should be in the driving seat of a lot of that.

The use of peer workers, particularly in mental health and in health more generally, has really helped health services, or therapeutic services, to actually refocus their intervention not so much on the needs of clinicians and the way we see the system and the way we think it works, but on the way in which the individual who experiences, in this case gambling addiction – how they experience it. And that is an area that requires investment. It is a sophisticated task. It is not a simple task. People need to be trained to do that – to engage with the systems. Our systems are hard. And so that is a focus that I know the committee was interested in reflecting on. And we would simply say that there are a couple of small programs where peer workers are used. Of course, if you think about AA and GA, they are good examples where people with experience can support other people. That is instructive, but I guess I am talking about a different level of involvement of service design and planning that involves those with lived experience being at the heart of that redesign process.

**Lauren KATHAGE:** Thank you. And I guess what it sounds like you are describing, Mr Loos, is around the uncertainty and the gaps around understanding of what treatment people have received and being able to assess whether it was successful, because you do not have a best practice model to judge it against or the outcomes listed to be taking against.

In your submission, Professor Lubman, you talk about where prevention and treatment of gambling harm should sit, and you do say that you support the transition of these services to the Department of Health. Are you able to speak to that?

**Dan LUBMAN:** Yes. I think one of the things that we have all highlighted is that there is a sophistication of thinking around how to deliver health services. Models of care, quality standards, clear outcome frameworks and system intelligence – that is what we are used to working in the health system. We are used to being clear about what we are trying to achieve. We have an infrastructure around that that provides feedback to services around how they are performing compared to other services and compared to what is expected. There are mechanisms for consumer feedback that are readily integrated, as Damian said, and that is really important for looking at the quality and experience of care. I think these are the tools that are core components of what health service delivery is. I think the challenge of having a gambling system that sits outside of that without the sort of intelligence that sits within the department and the usual models of delivery and service delivery and oversight in a very small sector is it creates this absence of this broader system thinking and intelligence.

**Lauren KATHAGE:** And I guess –

**The CHAIR:** I am just going to have to go, Ms Kathage. I just mindful of time. Ms Sandell just had another question.

**Ellen SANDELL:** I just had one further one, perhaps for you, Professor Lubman. You talked about welcoming the government's recent announcement around some of the harm prevention interventions. We heard yesterday that some of the researchers were saying the mandatory shutdown period for pokies venues could be perhaps longer or at a different point. I am just interested in your views on whether you think the interventions that have been announced go far enough, or if you would like to see any changes to those?

**Dan LUBMAN:** Well, I think it is really welcome that we are seeing some changes. I think we can all agree that there is significant harm to the community around gambling. It is really welcome to see that we are putting some brakes on that and relief for Victorian families. I think in terms of the hours of operation, I think the plan is between 4 and 10 am. Is that what you are referring to?

**Ellen SANDELL:** Correct.

**Dan LUBMAN:** I think there is evidence to suggest that significant harm happens between 2 and 4 am, so we would welcome some work in that space to sort of quantify that and to see whether the measures could extend beyond that. But I think in this space that we have been working in, there really has not been much focus on limiting harm, and it is really welcome to see that conversation commencing. I think a lot about road safety and responsible driving. If we were to just say to the car industry that people like driving cars and basically you regulate yourselves in terms of how many safety features you put on your cars and what safety features you put on the roads, but really what we do is just tell people to drive responsibly, and if they speed and they do not wear seatbelts and they do not have any other measures, then they are just being irresponsible and they need to be blamed. I think as a community we need to take a public health response. We have a big focus on reducing car and motor vehicle accidents and harms, and we educate and take a big responsibility in mandating safety measures because we know driving is an inherently risky activity. I think that is the lens we need to take to gambling. Australians gamble, but it is a risky activity, and we as a community need to make sure that we put measures in place to make sure that when people do that, they can do that safely.

**Ellen SANDELL:** Thank you.

**The CHAIR:** Thank you, Ms Sandell. Unfortunately we have come to the end of the time allocated for this session. I feel like we could talk to you for hours more; I mean, I have got burning questions. I think, if it is okay with you all, that the committee might actually write to you with additional questions perhaps. But thank you so much for being here today and sharing your knowledge, your wisdom, your on-the-ground work and what you are seeing. It is amazing work that you are doing.

I do not think there were any questions taken on notice, but if Hansard finds that there are, I just want to let you know you have five working days to respond to us. The committee will follow you up for that. The committee is going to take a short break before recommencing the hearing in the next 5 minutes, and I declare this hearing adjourned.

**Witnesses withdrew.**