Enhancing gambling harm screening and referrals to gambling support services in general practice and community service settings in Fairfield LGA: a pilot study

September 2020

Fairfield City Health Alliance

Primary Authors:

Thi Huyen Linh Nguyen, South Western Sydney Primary Health Network

Nick McGhie, South Western Sydney Primary Health Network

Lead Contributors:

Dr Amy Bestman, The George Institute for Global Health

Jenny Ly, South Western Sydney Local Health District

Michelle Roberts, South Western Sydney Primary Health Network

Susan Gibbeson, Fairfield City Council

Dr Kate da Costa, Alliance for Gambling Reform

Dr Siggi Zapart, Centre for Health Equity Training Research and Evaluation

Pam Batkin, Woodville Alliance

Maria-Lujza (Marylou) Ghyczy, Multicultural Problem Gambling Service (MPGS)

Proudly funded by

ACKNOWLEDGEMENTS 4
FOREWORD 5
1. SUMMARY OF FINDINGS 6
2. PROJECT BACKGROUND 7
2.1 OVERVIEW 7
2.2 GAMBLING HARM IN THE FAIRFIELD LGA 8
3. LITERATURE REVIEW 10
3.1 GAMBLING HARM PREVALENCE IN NSW 10
3.2 CALD POPULATIONS AND GAMBLING 11
3.3 GAMBLING HARM AND THE IMPORTANCE OF COMMUNITY-BASED SCREENING 11
3.4 PRIMARY CARE 11
3.5 COMMUNITY SERVICE ORGANISATIONS 12
3.6 VALIDATED GAMBLING HARM SCREENING TOOLS 12
3.7 CULTURAL SENSITIVITY 14
4. RESEARCH DESIGN 15
4.1 STUDY AIMS AND RESEARCH QUESTIONS 15
4.2 RESEARCH TIMELINE 16
4.3 ETHICAL CONSIDERATIONS 16
5. RESEARCH METHODS – MODEL & TRAINING DEVELOPMENT 18
5.1 PHASE 1 (PART A): MODEL DEVELOPMENT 18
5.2 PHASE 1 (PART B): TRAINING DEVELOPMENT 18
6. RESULTS OF CO-DESIGN 20
6.1 BARRIERS TO SCREENING FOR GAMBLING HARM 20
6.2 SCREENING AND REFERRAL MODEL RECOMMENDATIONS 22
6.3 GP MODEL 26
6.4 COMMUNITY SERVICES MODEL 27
6.5 CULTURAL SENSITIVITIES 28
6.6 SUPPORTS/REFERRALS 29
6.7 TRAINING 31
7. RESEARCH METHODS – IMPLEMENTATION PHASE 32
7.1 SCREENING TOOL QUESTIONS 32
7.2 SCREENING PROCESSES AND IMPLEMENTATION OF SCREENING TOOLS 32
7.3 REFERRAL AND SUPPORT OPTIONS 32
7.4 CULTURAL SENSITIVITIES 33
7.5 RECRUITMENT 33
7.6 INFORMATION SESSION 34
7.7 SCREENING PROTOCOL 34
7.8 EMBEDDED RESOURCES 35
7.9 IMPLEMENTATION IN PRACTISE 36
7.10 INTERVIEWS AND FOCUS GROUPS 36
8. IMPLEMENTATION RESULTS 37
8.1 INTERVENTION UPTAKE AND RETENTION RATE 37
8.2 IDENTIFICATION OF GAMBLING HARM 37
8.3 SUPPORT/REFERRAL OF GAMBLING HARM 39
8.4 ACCEPTABILITY AND FEASIBILITY 40

9. RECOMMENDATIONS 49

Recommendation 1 49
Recommendation 2 50
Recommendation 3 50
Recommendation 4 51
Recommendation 5 51

REFERENCES 52

ACCOMPANYING RESOURCE – TRAINING & RESOURCE KIT 55

ACKNOWLEDGEMENTS

The project team wishes to acknowledge several key individuals and organisational partners who, throughout the project, offered their time, knowledge and expertise to the benefit of this important project. We acknowledge and thank;

- Key partners Fairfield City Health Alliance – South Western Sydney Primary Health Network (SWSPHN), South Western Sydney Local Health District (SWSLHD) and Fairfield City Council;
- SWSPHN Mental Health, Integrated Health and Communications Teams for assisting with co-design activities, developing referral pathways for GPs and community service workers and developing consumer resources;
- Fairfield Council interagencies, particularly the Fairfield Multicultural Interagency;
- Fairfield City Health Alliance Gambling Working Group members with representatives from the Alliance for Gambling Reform, Multicultural Problem Gambling Service, Woodville Alliance, Core Community Services, Centre for Health Equity Training, Research and Evaluation (CHETRE), The George Institute for Global Health, and Western Sydney University;
- Community services workers, health workers, GPs and consumers who participated in co-design activities. Your feedback was crucial in the development of our integrated screening and referral model, training program and cultural adaptations of consumer resources;
- People with lived experience and community members who shared their stories about the impact of gambling harm and their experiences seeking help;
- Undergraduate medical students from WSU who completed a desktop analysis of gambling services in NSW and conducted phone calls with gambling help services to develop referral pathways;
- Gambling counsellors across NSW;
- Gambling Expert Working Group for their assistance in the development of the training program and review of referral pathways to gambling services:
    - Angela Hall (Project Coordinator White Ribbon Accreditation, SWSLHD)
    - Eric Ho (Psychologist and Bilingual Counsellor, Multicultural Problem Gambling Service)
    - Monica Cochrane (Gambling Counsellor, Mission Australia)
    - Dr Kate Fennessy (Senior Clinical Psychologist and Clinical Lead, Gambling Treatment Program, St Vincent's Health Network);
- Janine Bleakley (Psychologist and Supervisor, Gambling Treatment and Research Clinic, The University of Sydney) for her time, knowledge and expertise in the development and delivery of the training program;
- Community service workers and GPs who gave their time to participate in the training program and research. Their support of patients who disclosed gambling harm has been invaluable to individuals and families;
- The project team and investigators also acknowledge and thank the New South Wales Government for funding provided under the 2018 Responsible Gambling Grants Program.

FOREWORD

Gambling is highly engaged in by residents in Fairfield Local Government Area (LGA). In addition to high gambling participation and expenditure, the area has high levels of disadvantage, poor health outcomes and high levels of cultural diversity, increasing the effects of gambling harm. The Fairfield Health Alliance, established in 2019, brings together South Western Sydney Primary Health Network (SWSPHN), the South Western Sydney Local Health District (SWSLHD) and Fairfield City Council (FCC). Governed by a formal Memorandum of Understanding (MOU) this Health Alliance identified gambling as one of three priority areas. As the project's lead agency, South Western Sydney Primary Health Network (SWSPHN) has brought together community groups, general practitioners, academics, gambling specialists and local individuals to develop a screening tool that is practical, effective and responsive to the cultural diversity of the area.

SWSPHN is dedicated to supporting general practitioners, practice nurses and other primary health providers to deliver the best possible care for their patients. Through planning and consultation, SWSPHN have a strong understanding of the health care needs and service gaps in the Fairfield LGA and are focused on improving access to primary care services, particularly for patients at risk of poor health outcomes.

The aim of the Fairfield Health Alliance is to deliver community health outcomes through partnerships and collaboration across health and social care sectors. Members of our Gambling Working Group include representatives from key partners who reflect the benefit of collaboration and partnership. Members include the Centre for Health Equity Training, Research and Evaluation (CHETRE); CORE Community Services; Woodville Alliance, Multicultural Gambling Service, as well as the SWSLHD, SWSPHN and FCC. The working group contains a diversity of skills and perspectives, making a valued contribution to the outcome.

The screening tool that has been developed seeks to local individuals who experience gambling harm either as gamblers or 'affected others' and is intended to be used in early intervention community organisations, community service settings, community-based health services as well as by general practitioners. This is in response to the community engagement process.

The ability to identify social and health impacts that result from gambling is essential to promote the health of all members of the community and to support children who are impacted as significant others.

We are proud to develop the first screening tool that has resulted from ethics approved research and has been validated. The ability to identify people who are experiencing gambling harm is the first step in treatment. It is expected that this tool will make a very important contribution to understanding the scope and depth of harm from gambling while informing the development of a broader range of services to address this issue.

1. SUMMARY OF FINDINGS

The Productivity Commission in 2010 recommended better linking of health professionals and community services to gambling support services and other referral pathways whilst advocating for a screening test as part of other mental health diagnostics particularly for those presenting with anxiety, depression, high drug and alcohol use[1].

This project sought to develop, implement, and evaluate a gambling harm screening and referral model for general practice and community services within the Fairfield LGA. The project was funded by the NSW Government's Office of Responsible Gambling.

Through co-design, a screening model was developed and selected for implementation. The screening model selected combines aspects of the Problem Gambling Severity Index Short Form (PGSI Short-Form) to identify individuals experiencing direct harm and the Concerned Others Gambling Screen (COGS) to identify individuals experiencing harm as a result of another person's gambling behaviour.

The gambling harm screening model was implemented over a 13-week period from May to July 2020. Due to COVID-19 restrictions which saw many GPs and community service providers move to telehealth delivery methods, the screening tool developed was moved to an online format. The design of the tool and the enablement of online data entry were perceived by participants as excellent - participants spoke very highly of the process.

The level of harm detected – with 60% of those screened indicating some level of gambling related harm - is vastly higher than would be expected from existing prevalence studies. The data is from non-random samples, but these indicative levels of harm suggest a need for an urgent roll-out of the screening model (across both the Fairfield area and more broadly across NSW) to better understand the level of gambling harm in the community. The high levels of gambling harm identified in this community sample highlight the need for further investigation and implementation of interventions that aim to prevent and reduce gambling harm. This work may require subsequent policy change to protect and prevent at-risk individuals and communities from the impacts of gambling harm.

The following recommendations have been developed regarding the model implementation and rollout across NSW.

Recommendation 1: The screening model developed and piloted, was an effective model to screen for gambling harm in the Fairfield area. This model has the potential for scalability for GPs, community workers, and Regional Service Providers, under the proposed new ORG delivery structure, across NSW.

Recommendation 2: Community services are uniquely placed to implement the screening model.

Recommendation 3: To improve GP uptake and ongoing usage, integration of the gambling screening model as part of, or complementary to, existing lifestyle screening[2] or alcohol and other drugs screening[3] (and thus embedded in practice software) is essential.

Recommendation 4: An indicative screening outcome based on patient responses would help guide interventions.

Recommendation 5: A centralised data store of screening results across regions would better inform state policy and local health needs assessments.

[1] Productivity Commission 2010, Gambling, Report no. 50, Canberra.
[2] The Royal Australian College of General Practitioners, 2019. *Views and attitudes towards physical activity and nutrition counselling in general practice: National survey report 2019.* East Melbourne, Vic: RACGP, 2019.
[3] South Western Sydney Primary Health Network. Alcohol and Other Drugs. Accessed 10/08/20. URL: https://www.swsphn.com.au/alcoholandotherdrugs, SWSPHN, 2020.

2. PROJECT BACKGROUND

2.1 Overview

The Fairfield City Health Alliance obtained funding from the 2018 Responsible Gambling Grants Program administered by the NSW Office of Responsible Gambling for a gambling harm screening tool project. The funded project aimed to develop, implement, and evaluate a gambling harm screening and referral model for general practice and community services within the Fairfield LGA.

The Fairfield City Health Alliance (FCHA) is a formal alliance established between South Western Sydney Primary Health Network (SWSPHN), South Western Sydney Local Health District (SWSLHD) and Fairfield City Council (FCC) to identify and address local health needs in the Fairfield Local Government Area (LGA). The FCHA aims to deliver community health outcomes through partnerships and collaboration with members across health and social sectors.

SWSPHN is one of 31 Primary Health Networks (PHNs) established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.

SWSPHN's catchment covers seven local government areas (LGAs) - Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

SWSLHD is one of the largest health districts in NSW. The District covers both rural and suburban communities and manages six acute public hospitals:

- Bankstown-Lidcombe Hospital
- Bowral and District Hospital
- Campbelltown and Camden Hospitals
- Fairfield Hospital
- Liverpool Hospital.

The District also operates 14 major community health centres providing prevention, early intervention and community-based treatment, palliative care and rehabilitation services.

As of 2016, the Fairfield Local Government Area (LGA) had a residential population of 198,817[4]. Fairfield City is one of the most culturally diverse communities in Australia and the most disadvantaged area in the Sydney metropolitan area. Immigration and refugee settlement are the largest contributors to population growth in the LGA.

Following a local health needs assessment and community consultation in 2017, gambling harm was identified as one of three shared priority health issues for the FCHA. A Gambling Working Group was established to plan, design, implement and evaluate strategies to address gambling harm. The Gambling Working Group are focused on two strategies:

(i) Research on the impact of gambling harm on health outcomes in the local area,

(ii) Equip and support General Practitioners (GPs) and community workers (CWs) to discuss gambling harm with patients[5].

Key project activities included:

[4] Australian Bureau of Statistics, 2016. *2016 Census QuickStats: Fairfield (C).* ABS, Canberra.
[5] The term "patient" is used throughout this report to denote someone who is accessing a GP or community worker. People accessing these services may also be referred to in practise as a client or a consumer depending on the service.

- Assessment of validated brief screening tools and degree to which any have been used within GP or CW providers in Australia;
- Implementation of identified screening tools suitable for use by GPs and CWs in Fairfield LGA;
- Development of localised screening protocols and referral pathways to gambling help services;
- Identification of culturally sensitive and effective ways primary care professionals and community workers can enquire about, and discuss, gambling harm with patients;
- Delivery of a culturally appropriate training program to primary care professionals and community workers on identifying gambling harm, appropriately supporting patients experiencing gambling harm, local referral pathways/gambling help services and motivational interviewing techniques to increase patient help-seeking behaviour.

Taking a public health approach, three target groups were identified for screening:

- An individual who is experiencing gambling harm.
- An individual who is at risk of developing gambling-related harm.
- Family members or significant others, who are affected by gambling-related harm or concerned for an individual.

The project was divided into two phases:

- Phase 1: Co-design: the development of an integrated model for gambling harm screening and referral, development of a training package within the local context and translation of screening tools and resources.
- Phase 2: Implementation: the implementation and evaluation of the integrated model for gambling harm screening and referral.

Both phases received ethics clearance from the SWSLHD Human Research Ethics Committee (2019/PID14411 & 2020/PID00262).

2.2 Gambling harm in the Fairfield LGA

The Fairfield LGA community are at increased risk of gambling harm due to:

- High density of poker machines. Fairfield LGA has the 5th highest number of gaming machines in NSW with 3,861 electronic gaming machines[6]. Fairfield LGA is classified as a Band 3 area and in 2018, new legislation imposed a cap on the number of new gaming machines permitted in Fairfield LGA[7].
- Significant level of electronic gaming machine expenditure. According to latest data released by the Office of Liquor & Gaming, there was a loss of $1.455 million per day on poker machines in Fairfield LGA (net profit on electronic gaming machines), which is the highest losses in clubs, and the fourth highest losses in pubs in NSW.[8]
- Low socioeconomic status. Fairfield LGA is most disadvantaged area in the Greater Sydney Area with a median household income of $1,222 per week (compared to the NSW average of $1,486)[9]. Evidence has shown that low socioeconomic status is a risk factor for gambling harm[10].

[6] Liquor & Gaming NSW, 2020. Gaming Machine Data. https://www.liquorandgaming.nsw.gov.au/resources/gaming-machine-data.
[7] Gaming Machines Amendment (Leasing and Assessment) Bill 2018 (Nsw)
[8] Liquor & Gaming NSW, 2020. Gaming Machine Data. https://www.liquorandgaming.nsw.gov.au/resources/gaming-machine-data.
[9] Australian Bureau of Statistics, 2016. *2016 Census QuickStats: Fairfield (C).* ABS, Canberra.
[10] Miller, H., 2015. Background Paper: Risk Factors for Problem Gambling: Environmental, Geographic, Social, Cultural, Demographic, Socio-Economic, Family and Household. Victorian Responsible Gambling Foundation.

- High proportion of culturally and linguistically diverse (CALD) communities. Nearly 60% of people in Fairfield LGA were born overseas and 76% of people speak a language other than English at home. Evidence indicates that people from a CALD background who gamble are at significantly greater risk of developing gambling problems than the general population[11]. Problem gambling rates among people from CALD communities were estimated to be much higher (two to eight times) than the general population although they gambled less[12]. This may point to some culturally specific factors such as beliefs about luck and chance, migrant stressors, particularly acute fear of shaming families[13].

[11] Dickins, M. and Thomas, A.C., 2016. *Gambling in culturally and linguistically diverse communities in Australia*. Australian Gambling Research Centre, Australian Institute of Family Studies.
[12] Blaszczynski, A., Huynh, S., Dumlao, V.J. and Farrell, E., 1998. Problem gambling within a Chinese speaking community. *Journal of Gambling Studies*, 14(4), pp.359-380; Victorian Casino and Gaming Authority, 2000. *The impact of gaming on specific cultural groups report.* Melbourne: Cultural Partners Australia Consortium.
[13] Dickins, M. and Thomas, A.C., 2016.

3. LITERATURE REVIEW

Gambling has been identified as a significant public health problem[14]. In a public health approach, gambling harm is assessed across the entire spectrum of gambling behaviour and severity. It is well-recognised in literature that harms can occur amongst non-problem gamblers[15] and can be distributed over time with the potential to occur long after problematic gambling behaviour has ceased[16]. Gambling harm can affect multiple domains within life of a person who gambles, their family and friends, and the broader community[17]. These domains include financial harm; relationship disruption, conflict or breakdown; emotional or psychological distress; decrements to health; cultural harm; reduced performance at work or study; and criminal activity. The causes of gambling harm are multifactorial, reflecting an interplay of individual, social and environmental processes[18]. However, unlike other public health issues, existing measures to quantify the impact of gambling harm on population health have been criticised for failing to capture the full breadth and complexity of gambling harm[19]. Most economic costing studies examine only problem or pathological gambling and its impacts on society which can underestimate the true cost of gambling harm[20]. Negative impacts of gambling harm also disproportionately affect vulnerable groups which imposes substantial health and social costs and a large economic burden on society[21].

3.1 Gambling harm prevalence in NSW

According to a 2019 prevalence study, 53% of NSW adult residents reported engaging in gambling within a 12-month period, with 1% categorised at the severe end of the Problem Gambling Severity Index (PGSI)[22], and 9.4% at moderate (2.8%) or low (6.6%) risk of experiencing gambling harm[23]. It is important to note that these figures do not account for 'affected others' and likely under-represent individuals from culturally and linguistically diverse (CALD) backgrounds. Additionally, these figures may not capture the true extent of harm in NSW as people experiencing gambling harm often feel shame and may not reveal their gambling behaviour and associated harms during a survey. Many questionnaires feature 'trigger' questions which allow only those who respond positively to proceed to the remaining questions[24]. This means that individuals who may benefit from completing the questionnaire in full may not be screened as they respond negatively to the trigger question. It is possible then that current prevalence statistics are under representative of current levels of gambling harm experienced by both individuals and affected others in NSW. For every individual experiencing gambling harm, 5-10 others are impacted[25]. As the Fairfield LGA community has multiple factors that increase the risk of gambling harm the prevalence of gambling harm in Fairfield may be higher than that reported in other LGAs across NSW. To date, however, there remains a gap in publicly available data relating to gambling harm prevalence in the Fairfield LGA.

---

[14] Thomas, S.L. and Thomas, S.D., 2015. The big gamble: the need for a comprehensive research approach to understanding the causes and consequences of gambling harm in Australia. *Australasian Epidemiologist*, 22(1), p.39; Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J. and Rockloff, M., 2016. Understanding gambling related harm: A proposed definition, conceptual framework, and taxonomy of harms. *BMC public health*, 16(1), p.80.
[15] Latvala, T., Lintonen, T. and Konu, A., 2019. Public health effects of gambling–debate on a conceptual model. *BMC public health*, 19(1), p.1077.
[16] Browne, M., Langham, E., Rawat, V., Greer, N., Li, E., Rose, J., Rockloff, M., Donaldson, P., Thorne, H., Goodwin, B. and Bryden, G., 2016. *Assessing gambling-related harm in Victoria: A public health perspective*. Victorian Responsible Gambling Foundation.
[17] Langham et al 2016.
[18] Wardle, H., Reith, G., Langham, E. and Rogers, R.D., 2019. Gambling and public health: we need policy action to prevent harm. Bmj, 365.
[19] Langham et al 2016.
[20] Latvala, Lintonen & Konu, 2019. p.1077.
[21] Wardle et al 2019.
[22] In other publications, these people are labelled as "problem gamblers".
[23] Browne, M., Rockloff, M., Hing, N., Russell, A., Boyle, C. M. and Rawat, V., 2019. *NSW Gambling Survey*. NSW Responsible Gambling Fund (revised 2020).
[24] Harrison, G.W., Lau, M.I. and Ross, D., 2019. The risk of gambling problems in the general population: A reconsideration. *Journal of Gambling Studies*, pp.1-27.
[25] Productivity Commission (2010), Gambling, Report no. 50, Canberra.

3.2 CALD Populations and Gambling

Prevalence studies specific to CALD gambling participation are limited. The few studies that have been conducted found that gambling is a common activity[26]. Research suggests that Chinese and Vietnamese communities may view gambling as a way of 'trying their luck' or view gambling as a highly popular social activity among friends. A study conducted in 2012 by the Multicultural Health Communication Service (MHCS) reported that more than 90% of respondents from the Vietnamese community and 81.9% from Arabic communities in NSW believed that gambling was a problem[27]. Speaking a language other than English, being of a non-Caucasian ethnicity and/or being an immigrant to Australia have been found to be risk factors for gambling harm due to differing beliefs on chance and luck, migration factors and issues such as stigma and shame[28]. Issues such as stigma and shame present a significant barrier to help seeking in these communities with individuals experiencing gambling harm often attempting to solve issues themselves or within their family or community, in turn leading to reluctance to discuss gambling with a professional[29].

3.3 Gambling Harm and the Importance of Community-based Screening

A 2016 Victorian study[30] identified seven types of harm experienced by people who gamble and those close to them: relationship disruption, conflict or breakdown, health, emotional or psychological distress, financial problems, issues with work or study, cultural problems, and criminal activity. These harms can be experienced on a spectrum that extends from no harm through to very severe harm, by both individuals and affected family, friends, and carers. Only 8-10 per cent of individuals with gambling problems seek formal help[31]. When an individual does present to a service it is often for other issues spanning across the seven above-mentioned areas of gambling harm. Primary care professionals, health workers, and other community workers are then ideally positioned to screen for and respond to gambling harm. The Productivity Commission highlighted a need to provide information and strategies to assist primary care professionals and frontline community workers in identifying gambling harm and appropriately referring patients[32].

3.4 Primary Care

Primary care, which includes general practice, is often an individual's first point of contact with the healthcare system. Unlike other addictive behaviours such as smoking or drug and alcohol misuse however, there is a gap in gambling harm screening and interventions within primary care which leads to a missed opportunity for health intervention[33]. Although there is limited prevalence data of gambling harm in primary care settings in Australia[34], international research suggests that primary care provides an important setting for gambling screening and referral. Some prevalence studies indicate that approximately 6 per cent of patients in primary care may experience gambling harm as a result of their

---

[26] Scull, S. and Woolcock, G., 2005. Problem gambling in non-English speaking background communities in Queensland, Australia: A qualitative exploration. *International Gambling Studies*, 5(1), pp.29-44.

[27] Harrison, F., 2012. *Gambling Awareness Survey 2012*. NSW Multicultural Health Communication Service. URL: https://www.mhcs.health.nsw.gov.au/mhcs/services/campaign/pdf/problem-gambling2011-2012surveyreport.pdf.

[28] Gainsbury, S., Hing, N. and Suhonen, N., 2014. Professional help-seeking for gambling problems: Awareness, barriers and motivators for treatment. *Journal of Gambling Studies*, 30(2), pp.503-519; Rossen, F., 2015. *Gambling and problem gambling: results of the 2011/12 New Zealand Health Survey*. UniServices; Wardle, H., Moody, A., Griffiths, M., Orford, J. and Volberg, R., 2011. Defining the online gambler and patterns of behaviour integration: Evidence from the British Gambling Prevalence Survey 2010. *International Gambling Studies*, 11(3), pp.339-356; Welte, J.W., Barnes, G.M., Tidwell, M.C.O. and Hoffman, J.H., 2011. Gambling and problem gambling across the lifespan. *Journal of Gambling Studies*, 27(1), pp.49-61; Dickins, M. and Thomas, A.C., 2016. *Gambling in culturally and linguistically diverse communities in Australia*. Australian Gambling Research Centre, Australian Institute of Family Studies.

[29] Dickins & Thomas 2016.

[30] Browne, M., Rockloff, M., Hing, N., Russell, A., Boyle, C. M. and Rawat, V., 2019. *NSW Gambling Survey*. NSW Responsible Gambling Fund (revised 2020).

[31] Victorian Responsible Gambling Foundation, 2018. Cross-sector collaboration; Sproston, K., Hing, N. and Palankay, C., 2012. *Prevalence of gambling and problem gambling in New South Wales*. Sydney: NSW Office of Liquor, Gaming and Racing.

[32] Productivity Commission (2010), *Gambling*, Report no. 50, Canberra.

[33] Manning, V., Dowling, N.A., Lee, S., Rodda, S., Garfield, J.B.B., Volberg, R., Kulkarni, J. and Lubman, D.I., 2017. Problem gambling and substance use in patients attending community mental health services. *Journal of Behavioral Addictions*, 6(4), pp.678-688.

[34] Productivity Commission 2010, *Gambling*, Report no. 50, Canberra.

own gambling, and 7 per cent as a result of somebody else's gambling[35]. There is then a demand for GPs to address gambling harm in primary care via screening and assessment.

Currently, screening for gambling harm is not part of routine practice in Australian primary care and may indicate a lack of professional awareness and education around the harmful effects of gambling. In a recent Victorian study of over 300 clinicians working in mental health services, only 10.6 per cent of clinicians were aware of screening and assessment tools for gambling harm[36]. In addition, only 1.9 per cent of clinicians reported using a standardised gambling screening tool. The Australian Medical Association (AMA) has recommended that information kits, which include evidence-based screening and assessment questionnaires, be shared with general practitioners (GPs) to help identify, manage and refer patients affected by gambling harm[37]. Primary care provides a setting that can identify both those experiencing harm and affected others.

3.5 Community Service Organisations

Community service organisations, particularly welfare services, are another first point of contact for individuals and family members experiencing gambling related harm. The Fairfield LGA has a history of a strong community services sector. To date, research relating to gambling harm in the community service setting is limited.

In Fairfield, local welfare services have noticed an increase in patient applications for financial support for basic living costs. Anecdotally, financial hardship has been attributed, in some instances, to gambling. Screening for gambling harm is not a part of routine practice and when harm has been identified, workers are unsure of how to support their patients and what steps to take. The provision of appropriate support and assistance is an ongoing challenge for frontline community workers.

Findings of a gambling harm workshop and survey facilitated by Fairfield City Council on behalf of the Fairfield City Health Alliance in April 2019 supports the concern from the community services sector in the area. The workshop aimed to obtain feedback from community organisations on current screening practices, and screening tool preferences. There were 35 respondents, representing 15 organisations. Key findings from this unpublished study were that many workers had no previous training in gambling harm (69%); 67% were not aware of screening tools; and 59% indicated they either sometimes, rarely, or never enquire about gambling harm. Respondents also indicated the most appropriate time for screening would be whenever a patient, carer, or family member discloses gambling harm or as part of a routine intake assessment. Of the respondents, 17% were gambling counsellors, therefore the results may be over-representative of level of awareness of screening tools and screening and referral behaviour.

3.6 Validated gambling harm screening tools

Screening is the process of identifying individuals who are likely to receive a positive diagnosis, although they may appear to be asymptomatic. It is often undertaken as an initial assessment using screening tools. Screening is different from diagnosis which refers to the formal process of detecting a suspected disease or condition. For gambling problems, some harms may occur well before the diagnostic process is recommended[38]. Therefore, standard instruments for measuring prevalence of gambling problems are designed to screen for potential gambling harms. An effective gambling harm screening tool should be able to capture multiple dimensions of gambling harms as well as harms to people affected by others' gambling behaviour[39].

Most gambling harm measurement tools have an emphasis on screening for problem gambling, rather than the measurement of the range of harms that can occur as a result of gambling. Measures of

[35] Cowlishaw, S., Gale, L., Gregory, A., McCambridge, J. and Kessler, D., 2017. Gambling problems among patients in primary care: a cross-sectional study of general practices. *British Journal of General Practice*, 67(657), pp. e274-e279.; Pasternak IV, A.V. and Fleming, M.F., 1999. Prevalence of gambling disorders in a primary care setting. *Archives of Family Medicine*, 8(6), p.515.
[36] Manning et al 2017.
[37] Australian Medical Association, 2013. *The Health Effects of Problem Gambling.* AMA Position Statement.
[38] Browne, M., Rockloff, M., Hing, N., Russell, A., Boyle, C. M. and Rawat, V., 2019. *NSW Gambling Survey*. NSW Responsible Gambling Fund (revised 2020).
[39] Browne, M., Rockloff, M., Hing, N., Russell, A., Boyle, C. M. and Rawat, V., 2019. *NSW Gambling Survey*. NSW Responsible Gambling Fund (revised 2020).

problem gambling often combine harms and clinical symptoms which are indicators of addiction. Whilst it appears that both types of items tend to be good at discriminating problem gambling, it neglects the possibility that harm can occur irrespective of whether addiction is present. It is argued that the measurement of gambling harm should be centred around incidence and extent of the harm which gambling creates rather than whether there is an addiction or clinical psychopathology[40].

In a study of the transition from consumption behaviours to addictive consumptive behaviours, it was noted that harm will tend to increase with the severity of the problematic behaviour of the addiction[41]. One can experience a high level of harm irrespective of the level of gambling, including at the recreational level. For example, while binge gambling may not be considered as severe as chronic problem gambling it can still result in significant harms to the individual and affected people around them[42]. Being at the highest severity scale of problem gambling does not always imply that the highest level of harm is occurring. A screening tool should then consider gambling harms an individual is experiencing in terms of intensity of harm rather than severity of gambling behaviour.

There are several instruments of measurement which were developed to report psychometric properties and underpin determination of the severity of an individual's gambling behaviour such as the South Oaks Gambling Screen (SOGS)[43] DSM V criteria[44] , Canadian Problem Gambling Index (CPGI)[45], and Victorian Gambling Screen (VGS)[46]. Some comparative studies have been conducted to assess the validity, sensitivity and reliability of those screening tools, however these studies do not conclude which screening tool is best to be used[47]. Screening tools typically consisting of 10 to 20 items pose many challenges to gambling harm screening in both clinical and community settings, ranging from time restriction and competing health priorities in clinical settings to low response rates and high costs in population research[48]. Brief screening tools with a smaller subset of items have been developed to address these challenges such as NODS-CLiP[49], Brief Problem Gambling Screen 3-item (BPGS-3)[50], Brief Biosocial Gambling Screen (BBGS)[51], Problem Gambling Severity Index (PGSI) Short-Form[52], Lie/Bet Questionnaire[53], Brief Problem Gambling Screen 2-item (BPGS-2)[54] and One-Item Screen[55]. A

[40] Svetieva, E. and Walker, M., 2008. Inconsistency between concept and measurement: the Canadian Problem Gambling Index (CPGI). *Journal of Gambling Issues*, (22), pp.157-173.
[41] Grover, A., Kamins, M.A., Martin, I., Davis, S., Haws, K., Mirabito, A.M., Mukherjee, S., Pirouz, D.M. and Rapp, J., 2013. From use to abuse: When everyday consumption behaviours morph into addictive consumptive behaviours. Available at SSRN 2207025.
[42] Griffiths, M.D., 2006. A case study of binge problem gambling. *International Journal of Mental Health and Addiction*, 4(4), pp.369-376
[43] Lesieur, H.R. and Blume, S.B., 1987. The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American journal of Psychiatry*, 144(9).
[44] American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders: DSM-5.* Arlington, VA, American Psychiatric Association.
[45] Ferris, J.A. and Wynne, H.J., 2001. *The Canadian problem gambling index* (pp. 1-59). Ottawa, ON: Canadian Centre on Substance Abuse.
[46] Wenzel, M., McMillen, J., Marshall, D. and Ahmed, E., 2007. *Validation of the Victorian gambling screen*. Gambling Research Panel, Melbourne.
[47] Arthur, D., Tong, W.L., Chen, C.P., Hing, A.Y., Sagara-Rosemeyer, M., Kua, E.H. and Ignacio, J., 2008. The validity and reliability of four measures of gambling behaviour in a sample of Singapore university students. *Journal of Gambling Studies*, 24(4), pp.451-462; Boldero, J.M. and Bell, R.C., 2012. An evaluation of the factor structure of the Problem Gambling Severity Index. *International Gambling Studies*, 12(1), pp.89-110; McMillen, Marshall, Ahmed, & Wenzel, 2004; Neal, P., Delfabbro, P., & O'Neil, M., 2005. *Problem gambling and harm: Towards a national definition. Literature review.* Commissioned for the Ministerial Council on Gambling. Prepared by the SA Centre for Economic Studies with the Department of Psychology, University of Adelaide. November 2005; Wenzel, M., McMillen, J., Marshall, D. and Ahmed, E., 2007. *Validation of the Victorian gambling screen*. Gambling Research Panel, Melbourne.
[48] Volberg, R.A. and Williams, R.J., 2011. *Developing a brief problem gambling screen using clinically validated samples of at-risk, problem and pathological gamblers*. Health Sciences.
[49] Toce-Gerstein, M., Gerstein, D.R. and Volberg, R.A., 2009. The NODS–CLiP: A rapid screen for adult pathological and problem gambling. *Journal of Gambling Studies*, 25(4), p.541.
[50] Volberg & Williams, 2011.
[51] Gebauer, L., LaBrie, R. and Shaffer, H.J., 2010. Optimizing DSM-IV-TR classification accuracy: A brief biosocial screen for detecting current gambling disorders among gamblers in the general household population. *The Canadian Journal of Psychiatry*, 55(2), pp.82-90.
[52] Volberg & Williams, 2011.
[53] Johnson, E.E., Hamer, R., Nora, R.M., Tan, B., Eisenstein, N. and Engelhart, C., 1997. *The Lie/Bet Questionnaire for screening pathological gamblers*. Psychological reports, 80(1), pp.83-88.
[54] Volberg & Williams, 2011.
[55] Johnson et al 1997.

systematic review and meta-analysis of brief screening instruments found evidence that some tools displayed satisfactory diagnostic accuracy in detecting both problem and at-risk gambling[56].

3.7 Cultural sensitivity

Consistent with the gaps in understanding gambling harm and gambling behaviours in CALD communities, there is a gap in research around the ability of screening tools to accurately collect information of the gambling harms experienced by CALD community members. Current screening tools for gambling are based predominantly on Western samples. Some studies have pointed out however that there are fundamental differences between Western and non-Western individuals in various issues related to gambling.

In Vietnamese culture, mental disorders are often labelled "điên" (literally translated as "madness") with only those with severe and persistent psychological concerns seeking support through counselling[57]. Broader education is necessary to assist patients of Vietnamese background with their understanding of the counselling process and how it may indeed help for a range of mental health issues.

For Arabic and Assyrian culture, research suggests there is also stigma and taboo associated with mental health and gambling, especially those from Islamic backgrounds. This inhibits people of Arabic culture from discussing their gambling issues with their family members and healthcare providers, therefore discouraging help seeking. In contrast, Australian culture dictates that gambling is an acceptable leisure activity. For migrants, exposure to gambling as a leisure activity and culturally and socially permissible may contribute to increased cases of gambling disorders. Arabic people found that self-disclosure of issues related to gambling is extremely challenging as they may risk being rejected by family, friends and community[58].

Due to the differences across gamblers from different cultural groups, cultural adaptation needs to be taken into consideration when screening and providing support and treatment to these populations. The current project sought to engage different cultures with the issue and ensure the tool used was relevant.

[56] Dowling, N.A., Merkouris, S.S., Dias, S., Rodda, S.N., Manning, V., Youssef, G.J., Lubman, D.I. and Volberg, R.A., 2019. The diagnostic accuracy of brief screening instruments for problem gambling: A systematic review and meta-analysis. *Clinical psychology review*, 74, p.101784.

[57] Do, M., McCleary, J., Nguyen, D., & Winfrey, K., 2018. 2047 Mental illness public stigma, culture, and acculturation among Vietnamese Americans. *Journal of Clinical and Translational Science*, 2(S1), 17-19. doi:10.1017/cts.2018.93

[58] Hamid, A. and Furnham, A., 2013. Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture*, 16(7), pp.741-758.

4. RESEARCH DESIGN

4.1 Study aims and research questions

Phase 1: Co-design

Co-design in the context of this project aligns with the co-design process used in the Primary Health Network commissioning context. Co-design "brings together various stakeholders as a mechanism for better informing and supporting commissioning by harnessing a range of views, ideas and experience"[59]. Whilst the co-design process focuses on gathering input and contributions from stakeholders who have direct contact with the issue at hand, the approach goes beyond consultation[60]. Effective co-design requires active contribution from a diverse mix of stakeholders (including providers) and ensures that patient experience and needs are central to the design process.

The first phase of this research project aimed to:

1. Develop an integrated model for gambling harm screening and referral;
2. Develop a training package to be implemented within general practices and ancillary services[61] within the Fairfield LGA to support screening implementation at Phase 2.

This phase was guided by the following research questions:

1. What is the screening behaviour of GPs and community service workers (pre-intervention)?
2. What are the barriers to gambling harm screening and referral for English as Native Language (ENL), Vietnamese, Arabic, and Assyrian communities?
3. What does an ideal gambling harm screening process look like in general practice and in community services?
4. Once gambling harm is identified, what should a GP or community worker do to support the patient?

Phase 2: Implementation

Following the development of gambling harm screening and referral models, and the training package in Phase 1, the second phase involved piloting and implementing the model in Fairfield LGA primary care settings.

Phase 2 was guided by the following research questions:

1. How was the screening tool implemented by GPs and community workers?
2. To what extent did the tool identify gambling harm?
3. What are the lessons learnt for future implementation?

[59] Australian Government Department of Health, 2018. Co-design in the PHN commissioning context. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources
[60] Australian Government Department of Health, 2018. Co-design in the PHN commissioning context. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources
[61] Ancillary services in Australia refer to non-medical health services not covered by Medicare. These include Alcohol, Drug & Mental Health Support services.

4.2 Research timeline

Phase	Key activities
Phase 1 (Part A) Model Development	• Co-design surveys • Semi-structured interviews • 2 co-design Workshops
Phase 1 (Part B) Training Development	• Development of a Gambling Expert Working Group to develop and deliver training • Translation of tools and materials
Phase 2 Implementation	• Finalisation of service mappings; resources and information kit; training schedule & participation • Information session and distribution of required collateral • Screening of patients

4.3 Ethical considerations

The following ethical considerations underpinned our project design.

Discomfort and Psychological Harm

Participants of interviews and workshops may have experienced discomfort due to potential induced anxiety. Additionally, some questions asked may have been stressful for the participant and caused distress. Whilst all care was taken to maintain privacy and confidentiality, participants of workshops may have experienced embarrassment if one of the group members were to repeat what was said in a confidential group meeting.

A statement was made at the beginning of each interview and workshop stating that participation may bring up feelings of anxiety or feelings of distress due to the nature of the questions being asked. Participants were advised that participation is voluntary, they may skip a question and/or may withdraw at any time, and to alert a member of the research team if they experience any distress. Additionally, the importance of confidentiality was reiterated. Project team members, who are trained in Mental Health First Aid and some of whom are trained mental health professionals, were also available to provide support. Referrals and arrangement to further supports would be made for the participant if required.

Inconvenience

Participants in various research activities involved in this study may have experienced minor inconvenience due to time required to complete surveys, and time spent at interviews or workshops. All participants were informed that their participation was voluntary, and they could withdraw at any time.

Confidentiality and Privacy

The co-design survey was advertised broadly, and participants completed it online and anonymously. Data was de-identified unless the participant included their details indicating they would like to participate in other parts of this research study – in such cases, the information was removed from survey results and held separately for the purposes of recruitment.

Those who provided their contact details at the end of other co-design activities, such as one-on-one interviews and workshops, were only kept on file for recruitment purposes and again separated from the data. Only members of the research team had access to this information, and all information remained confidential.

Participants were invited to speak about personal matters during their interviews and during the workshops. The interviews were recorded with prior knowledge and consent of the participants. The recordings were transcribed, with pseudonyms used and thus de-identified.

All information obtained in connection with this study that can identify an individual or organisation, and general practice remained confidential. Throughout the entirety of the study, data was de-identified prior to analysis, and findings reported in a way that individual participants are not identifiable.

5. RESEARCH METHODS – MODEL & TRAINING DEVELOPMENT

5.1 Phase 1 (Part A): Model Development

Phase 1 aimed to develop an integrated model of gambling harm screening and referral for both general practice and community organisations. This model aimed to be culturally appropriate for ENL, Vietnamese, Arabic, and Assyrian communities in the Fairfield LGA. This process aimed to:

- Identify barriers to screening;
- Identify culturally sensitive and effective ways primary care professionals and community workers can enquire and discuss gambling harm with both individuals and affected others;
- Develop localised screening protocols that link into existing referral pathways.

A co-designed survey and semi-structured interviews with both consumers and service providers were conducted, alongside a co-design workshop. This data was analysed using a thematic analysis approach.

- Co-design survey questions asked about basic demographics, current screening, referral and treatment behaviour (where appropriate), preferences, barriers to screening, and recommendations for the model. This survey was in English, thus those from CALD backgrounds who do not have English-proficiency were unfortunately excluded. Questions regarding screening behaviour and self-efficacy were designed on a 5-point Likert scale ranging from 'Never' to 'Almost always' and 'Very uncomfortable' to 'Very comfortable'.
- Semi-structured interviews with service providers and GPs focused on participants' experience in identifying gambling harm, barriers to identification and referral, and their recommendations for the model and the training. Semi-structured interviews focused on consumers' experience with gambling harm, barriers, and their recommendations for the model. Consumers, individuals and affected others, were from ENL, Vietnamese, Arabic and Assyrian backgrounds. Accredited interpreters were available for consumers as needed for this part of the study.

The co-design workshop was held in November 2019. The workshop was facilitated by an experienced healthcare facilitator with over 10 years' experience in mental health training and service management.

5.2 Phase 1 (Part B): Training Development

Information collected in Phase 1 (Part A), and evidence gathered through a comprehensive review of the literature informed the capacity building intervention content. A Gambling Expert Working Group comprised of Gambling Help Counsellors and Psychologists was also formed to guide the project.

The training developed included information for GPs and community organisation staff relating to:

- Gambling harm and risk factors for those affected by their own gambling and those affected by the gambling of somebody else;
- Cultural considerations for affected communities;
- Methods for screening in different gambling harm scenarios (e.g. during an intake assessment, or opportunistically during a regular appointment);
- Stages of change and utilising motivational interviewing to move an individual through the stages; and
- How and when to refer to appropriate gambling help services.

A service which provides accredited translators, Australian Multi-Lingual Services, was engaged for translation of relevant consumer resources in Vietnamese, Arabic, and Assyrian. The translated

material was checked and back translated by bilingual Vietnamese, Arabic, and Assyrian staff from SWSPHN to ensure accuracy and cultural appropriateness.

The co-design process involved a wide range of activities with the participation of multiple stakeholders. It included: a workshop on 14 November 2019 with 39 participants; an online survey, open for 4 weeks (22 October 2019 to 19 November 2019), with 73 respondents; individual interviews with 29 participants; and two focus groups involving 8 professionals.

Individual interviews were conducted with 5 GPs, 14 health workers, 10 consumers. There were 11 males and 18 females. There was 1 person from Arabic background, 2 people from Assyrian background, 2 people from Vietnamese background and the remaining 24 people from other backgrounds. 2 people experienced harm as a result of their own gambling. 9 people experienced harm as a result of somebody else's gambling. The remaining 18 people (62%) have not experienced gambling harm.

Figure 1. Co-design participants.

Co-design workshop: 39 participants
Co-design survey: 73 responses
Focus group: 2 (8 participants in total)
Individual interviews: 29

Category		**Gender**	
GP	5	Male	11
Community worker	14	Female	18
Consumer	10		
Background		**Harm**	
Arabic	1	Individual	2
Assyrian	2	Affected other	9
Vietnamese	2	No harm	18
Other	24		

6. RESULTS OF CO-DESIGN

6.1 Barriers to screening for gambling harm

Co-design survey results showed that 66% of participants 'never' or 'rarely' asked a consumer about gambling issues. 22% of respondents reported feeling 'somewhat uncomfortable' raising the topic of gambling and its impacts. The co-design interviews also identified barriers impacting screening and referral of gambling harm.

Lack of Screening

Community barriers

GPs noted a gap in medical education regarding gambling related harm.

> *"GPs and medical providers are not fully literate about the harm involved with gambling. They are also not fully trained how to conduct these assessments." (Participant #21 – Community worker, retired GP)*

Due to the lack of knowledge of gambling harm, health professionals do not see it as a health issue. The focus of a presentation for what may indeed be gambling harm related often gravitates towards financial hardship rather than the impact of gambling on a person's health or other factors.

Low awareness of gambling related harms is also the result of existing cultural and societal norms.

> *"People only talk about [gambling] when they win and they tell everyone when they win… The harm is never highlighted – always portrayed as positive to make friends… It's like a social thing and socialising is a good thing." (Participant #3 – Consumer)*

A health worker stated that some patients perceived gambling as a part of normal social life. This belief prevents patients from seeking assistance when they have issues with gambling.

> *"A lot of patients do not see gambling as a problem but as a fun or social thing. Others might think of it as a personal issue. So they would not talk to their doctor about gambling and are more reluctant to admit gambling than smoking or alcohol." (Participant #28 – GP)*

Structural barriers

Gambling is seemingly given lower priority in comparison to other issues a patient is presenting with such as smoking or alcohol use:

> *"It can commonly occur with drug use, alcohol use or chronic health conditions that might be more urgent to address so you as the GP may never really have time to get to the gambling assessment, let alone management." (Participant #28 – GP)*

The failure to ask about gambling was confirmed by most of the consumers participating in the co-design process.

> *"They ask questions about everything else, but no one asks about gambling. Even when you see a psychologist and they ask about your sources of stress, or even if you go there specifically for money related issues, no one asks about gambling… no one asked about social expenditure/social life. Maybe it's because providers feel like it's none of their business, but I think it should be because it would uncover unhealthy habits. If someone was a smoker, they would be spending a lot on cigarette's, but no one would know if they don't ask the question." (Participant #3 – Consumer)*

Health professionals agreed that while gambling is the fundamental source, it precipitates or is co-morbid with issues like psychological harm and financial issues. Therefore, considering gambling as a psychosocial aspect when conducting a psychological assessment is necessary and would allow health professionals to have a greater spectrum of understanding of the issues that the patient is having.

"As a GP, I see all sorts of presentations and I find that with gambling, it is never the first thing that patients themselves present with. There are lots of different presentations and it might only be after multiple consultations that patients or their family members might bring it up as an issue." (Participant #28 – GP)

Health professionals noted that co-morbidities and the absence of immediate presentations or identifying factors make gambling issues hard to detect, although it could be the source underlying all other issues.

Time pressure was reported, particularly by GPs, as an active barrier to screening for gambling harm:

"Existing medical models of healthcare is a challenge. With 2-3 minutes, it's unlikely the GP would have time to reflect on questions being asked. So the system isn't welcoming to gambling disclosure, two-way communication and uncovering secondary issues." (Focus group #17)

"A GP would be more pressed for time than in a community setting. GP appointments are usually 10 to 15 minutes compared to community setting, which is 30 to 60 minutes. Gambling harm assessment may require motivational interviewing and thus can be quite time consuming. Because gambling is a behaviour and an issue with addiction, a proper assessment may take multiple consultations before the scale of impact of the gambling is realised. Patients also need to come back for effective management." (Participant #1 – Community worker)

In addition, one of the two focus group discussions suggested that although doctors need to spend extra time in screening for gambling harm, they may not be eligible to bill Medicare for this time. This is contrary to the fact that Medicare billing items do indeed exist for mental health presentations and indicates an underlying perception that GP participants in the co-design may not identify gambling harm as a mental health issue.

A short screening tool was identified as important for GPs:

"Time management is an issue but I think if it's a small question that can be done, I will be consciously trying to have the conversation if there is a 'yes' answer. If you never ask the question, you'll never know." (Participant #22 – GP)

Referral

Once a person is identified as experiencing gambling harm, there is a lack of knowledge of available referral options.

"As a GP, just having that knowledge of what are the sorts of treatment, how to get treatment and who to refer to locally could be the barriers." (Participant #27 – GP)

"For problem gambling, it's a really big and complicated issue and affects so many things. It's hard to work out what services could be meaningfully referred to that individual." (Participant #19 – GP)

An interviewed GP stated that the immediate support is difficult to provide because it really depends on what the risks are and what the person is experiencing. Advertisement of referral pathways for gambling is of great importance to ensure health professionals can refer to and provide the most appropriate and timely support for individuals impacted by gambling harm.

For CALD communities, language and location are also important factors to consider.

"… they [local services] are usually kept in one side and usually only in English. So in a community like Fairfield, these things need to be in more than one place and available in community languages for people to access." (Participant #24 – Community worker)

A health worker criticised the complexity of the process to be able to get to a gambling counsellor.

> *"The person might have to speak to 3 people before they get to the counsellor and has been proven to fail. We need to make the process to the expert much smoother." (Participant #10 – Community worker)*

Another barrier identified is the lack of awareness and acceptance in the community, and indeed within an individual, that gambling is an issue impacting their life.

> *"The gambler needs to have the initiative to seek change and resolve the issue. You can't force someone to use a service." (Focus group #17)*

When patients do not identify gambling as an issue, engagement in discussion and any subsequent referral options is lacking. Furthermore, some community workers were concerned that this may lead a patient to disengage with the service they have built a rapport with.

> *"From the CALD perspective, the concept of counselling, especially for gambling, is unfamiliar. They think it [gambling] is a behavioural issue and the person is in charge of addressing the problem. If you don't approach it as a health problem, such as addiction or mental health, then they aren't going to seek help from professionals." (Focus group #17)*

Community education about gambling harms is important. Interviewees advised that education would help increase the readiness of a person to engage and seek support for gambling related harm they may be experiencing.

6.2 Screening and Referral Model Recommendations

How should the topic be broached?

Feedback indicated a pre-amble explaining the nature of screening tools and the prevalence of gambling harm in the community prior to screening should be implemented to ensure the patient does not feel directly targeted or singled out.

It was also recommended that posters, digital displays and health messaging about gambling harm screening as a new initiative should be shown in the waiting room, with the aim to inform patients that questions about gambling harm may be asked and gambling harm is one of the issues which they can discuss.

What tool is used/what questions are asked?

Directly affected

Co-design results indicated a short and simple screening tool should be used with a maximum of 4 questions.

Consumers specifically noted that questions need to be asked in a non-judgmental way. They recommended asking both directly and indirectly. Recommended direct questions were "Do you gamble? What is your relationship with gambling?". Recommended indirect methods included:

- Asking about general lifestyle factors such as smoking, alcohol use, or financial situation;
- Asking about what the consumer does with their spare time (e.g. What do you do with your time out of your routine/work? or what do you do socially?);
- what do you do to cope during times of stress?

Whilst soft entry approaches were also recommended by professionals to segue into the topic of gambling, most recommended a direct approach suggesting the following types of questions:

- Has gambling ever affected your life?
- Do you gamble or do you know someone who gambles?

- Have you been impacted by gambling?
- Have you ever spent money/time gambling?
- Do you ever think about gambling or have urges to gamble?
- What's your gambling behaviour like?
- What are the impacts of gambling on you? or What kind of support do you need?

Based on the recommendations of a short and simple screening tool, we created a list consisting of 8 brief screening tools with less than 4 items. These include:

1. NODS-CLiP[62]
2. Brief Problem Gambling Screen 3-item (BPGS-3)[63]
3. Brief Biosocial Gambling Screen (BBGS)[64]
4. Problem Gambling Severity Index (PGSI) Short Form[65]
5. Lie/Bet Questionnaire[66]
6. Brief Problem Gambling Screen 2-item (BPGS-2)[67]
7. One-Item Screen[68]
8. PGSI Short-Form[69]

These tools were introduced to workshop participants and they had a chance to vote on a favourable one for use in GP settings and community settings after group discussion. The workshop results indicated that the BPGS-3 was preferred for a GP setting and the BPGS-2 for a community setting. However, a meta-analysis completed in December 2019 indicated the BPGS-3 does not meet the criteria for satisfactory diagnostic accuracy in detecting both problem and at-risk gambling[70]. The second most preferred tool for GPs was the one-item screen which was also not recommended[71].

The third most preferred tool was tied between the PGSI short-form and BPGS-2. The BPGS-2 firstly asks whether somebody has been preoccupied with gambling or whether they have often gambled longer, with more money or more frequently than they intended to. Whilst it appears that both types of items tend to be good at discriminating problem gambling, it neglects the possibility that harm can occur irrespective of whether addiction is present. It is argued that the measurement of gambling harm should be centred around incidence and extent of the harm which gambling creates rather than whether it is an addiction or clinical psychopathology[72].

The PGSI Short-Form was the next preferred in a GP setting and also the second preferred for a community setting. The PGSI-Short Form both considers harm and indicators of problem gambling.

---

[62] Toce-Gerstein, M., Gerstein, D.R. and Volberg, R.A., 2009. The NODS–CLiP: A rapid screen for adult pathological and problem gambling. *Journal of Gambling Studies*, 25(4), p.541.
[63] Volberg, R.A. and Williams, R.J., 2011. *Developing a brief problem gambling screen using clinically validated samples of at-risk, problem and pathological gamblers*. Health Sciences.
[64] Gebauer, L., LaBrie, R. and Shaffer, H.J., 2010. *Optimizing DSM-IV-TR classification accuracy: A brief biosocial screen for detecting current gambling disorders among gamblers in the general household population*. The Canadian Journal of Psychiatry, 55(2), pp.82-90.
[65] Volberg & Williams, 2011.
[66] Johnson, E.E., Hamer, R., Nora, R.M., Tan, B., Eisenstein, N. and Engelhart, C., 1997. The Lie/Bet Questionnaire for screening pathological gamblers. *Psychological reports*, 80(1), pp.83-88.
[67] Volberg & Williams, 2011.
[68] Johnson et al 1997.
[69] Volberg & Williams, 2012.
[70] Dowling, N.A., Merkouris, S.S., Dias, S., Rodda, S.N., Manning, V., Youssef, G.J., Lubman, D.I. and Volberg, R.A., 2019. The diagnostic accuracy of brief screening instruments for problem gambling: A systematic review and meta-analysis. *Clinical psychology review*, 74, p.101784.
[71] Dowling et al, 2019.
[72] Svetieva, E. and Walker, M., 2008. Inconsistency between concept and measurement: the Canadian Problem Gambling Index (CPGI). *Journal of Gambling Issues*, (22), pp.157-173.

Additionally, it is argued that harm stems from a financial loss, even if it occurs in one gambling session and thus those who do not present with the other indicators of problem gambling may be picked up through the first question in the PGSI-Short Form.

Among selected brief problem gambling screening tools, PSGI Short Form is not limited to binary response options (Yes/No) and is the only tool that also attempts to screen for at-risk gambling in addition to problem gambling[73]. A test of classification accuracy of brief screening instruments using PGSI score of 8+ as reference standard conducted by the Victorian Responsible Gambling Foundation indicated that the PGSI Short-Form displayed the highest overall diagnostic accuracy (0.976)[74]. Its sensitivity and specificity scores are higher than those of the BPGS-2.

Therefore, the Gambling Project Team decided to select the PGSI Short-Form to be implemented in Phase 2. The PGSI Short-Form is open source.

PGSI Short-Form[75]

Thinking about the last 12 months,

1. Have you bet more than you could really afford to lose?

Never (0); Sometimes (1); Most of the time (2); Almost always (3)

2. Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

Never (0); Sometimes (1); Most of the time (2); Almost always (3)

3. Have you felt guilty about the way you gamble or what happens when you gamble?

Never (0); Sometimes (1); Most of the time (2); Almost always (3)

Total scores: 3+ = problem gambling; 1−2 = at-risk gambling; 0 = non-problem gambling

Affected others[76]

Overall, participants noted that a GP or community worker would be able to be more direct when asking affected others about their gambling harm. However, consumers specifically recommended being non-judgmental, and suggested both informal/indirect ways of broaching the subject, and direct ways. Suggested questions were:

- Is gambling affecting your, or another person's, life/family?
- Has anyone in your life been affected by gambling?
- How does your friend or family member's gambling behaviour affect you?
- Have you ever been impacted by a friend or family member's gambling behaviour? How has it impacted you?

During the workshop, The Concerned Others Gambling Screen (COGS) was recommended as a tool for affected others. The tool is a three-item screening tool developed by Dr Sean Sullivan (2003) to assess the gambling harm on family or relatives of people significantly impacted by gambling[77]. This is an awareness-raising instrument that allows a person affected by another's gambling to indicate what assistance they desire. It does not have a scoring system but works based on positive response to the various questions.

[73] Dowling et al, 2019.
[74] Lubman et al., 2017.
[75] Volberg & Williams, 2012.
[76] The term 'affected other' is used throughout this report to refer to those who have gambling harm as a result of somebody else' gambling behaviours.
[77] Sullivan S, McCormick R, Lamont R and Penfold A. 2007. Problem gambling: patients affected by their own or another's gambling may approve of help from GPs. *New Zealand Medical Journal,* 120:1257.

The COGS has yet to be formally validated however it is considered appropriate to use in primary care settings and accepted by the New Zealand National Addiction Workforce Centre[78]. In addition, over the last decade, the COGS (under a name of Brief Family Affected Screen) has been a required screen for the Ministry of Health of New Zealand with government-funded gambling harm practitioners and several thousand affected others have been screened and responded positively to the screen[79].

COGS was identified by workshop participants as a good tool to be used but acknowledged that as a self-report instrument the questions need to be reworded to be used in conversation. Additionally, it was recommended that staff who perform screening need to be trained. After screening, further discussions can be followed up to explore relationship or financial issues and to build up rapport with patients.

As a result of the co-design, the decision was made to include the COGS to screen individuals affected by someone else's gambling in Phase Two. The COGS, as with the PGSI Short-Form, is open source.

The Concerned Others Gambling Screen (COGS)[80]

1. Do you think you have ever been affected by someone else's gambling?

- ☐ No, never (you need not continue further)
- ☐ I don't know for sure if their gambling affected me
- ☐ Yes, in the past
- ☐ Yes, that's happening to me now

2. How would you describe the effect of that person's gambling on you now? (tick one or more if they apply to you)

- ☐ I worry about it sometimes
- ☐ It is affecting my health
- ☐ It is hard to talk with anyone about it
- ☐ I am concerned about my or my family's safety
- ☐ I'm still paying for it financially
- ☐ It doesn't affect me anymore

3. What would you like to happen? (tick one or more)

- ☐ I would like some information
- ☐ I would like to talk about it in confidence with someone
- ☐ I would like some support or help
- ☐ Nothing at this stage

[78] Matua Raki National Addiction Workforce Development, 2011. Problem Gambling Screens: Concerned Others Gambling Screen (COGS). *Screening, Assessment and Evaluation: alcohol and other drug, smoking and gambling*, pp.40-41.
[79] Ministry of Health. 2019. *Preventing and Minimising Gambling Harm: Practitioner's Guide*. Wellington: Ministry of Health.
[80] Sullivan et al., 2007.

Who will be doing the screening?

It was recommended by gambling help specialists that GPs and community workers were suitable to identify gambling harm, rather than assess problem gambling. They further recommended that once gambling harm was identified, the consumer could be referred on for further assessment to determine their level of harm and need. Psychologists, counsellors and addiction practitioners were considered most appropriate for conducting gambling harm screening in terms of assessing the differing levels of problem-gambling risk, which this pilot study does not aim to address.

When being asked about assigning certain professions such as pharmacists and religious leaders to perform the screening, participants expressed doubts about its relevance.

> *"I also don't think [a pharmacist's] skillset is aligned to dealing with gambling harm screening and referral. Doctors are meant to do diagnosis, but pharmacists are not meant to. Pharmacists are not a source of referral."*

> *"[Bishop screening] might help but it's not necessarily better or necessary. It depends on who the person has developed a trusting relationship with… Our bishop was not judgmental and showed so much love toward him and he still wouldn't open-up about it."*

6.3 GP Model

Is screening appropriate in a GP setting?

Of GPs that completed the co-design survey, most (88%) indicated screening for gambling harm could be implemented within their practices and that they would be somewhat (59%) or very comfortable (24%) asking their patients about gambling. However, questions were raised as to whether it is appropriate setting to do so due to the following reported barriers:

- Lack of time and resources,
- Screening for gambling is of low priority,
- The perception that asking the question is of low yield,
- Navigating various cultures in our diverse area,
- Concern about the appropriateness of breaking the flow of a consultation to ask the question,
- Limited knowledge and inexperience of GPs,
- It's difficult to start the conversation,
- Patients reluctance to discuss gambling or deny that he/she has a problem due to shame and embarrassment, and
- Patient perception that healthcare and gambling not being relevant.

There are certain perspectives from people about what they expect when they see a doctor and often that doesn't necessarily include being asked about a raft of behaviours.

> *"I have so many other things to screen for that appear more immediately relevant to the patients"*

> *"A patient-centred approach requires respect for the patient's agendas and preferences to the flow of the consultation. It is important to remember that there are any number of other issues that should probably be routinely screened for that may be of higher priority (e.g., substance use, risky drinking, mental health, violence, etc.)"*

Some participants also expressed concerns about the sustainability of GP screening.

"The reality though is that there isn't really a system in which that could be done or demonstrated to be sustainable over the long term. For example, if you want to focus on screening for gambling over a certain month, what about in 2 months' time, next year or 5 years' from now? Is that activity going to be sustainable as a routine part of the operation?"

"It depends very much by what is meant by "screening". Generally, screening instruments in routine primary care practice that are decontextualised from the reason from presenting will not be sustainably implemented."

Who should be screened?

According to the co-design survey, 29% of GP respondents thought everyone should be screened, compared with 48% of other professionals. The GPs who didn't think everyone should be screened selected various specific presentations which they believed should trigger gambling harm screening.

When should screening take place?

GPs indicated that it would be most appropriate to use screening tools as part of an initial consultation (35%) or during follow up appointments (29%). However, whilst most service providers and GPs suggested that everyone be screened, challenges were also acknowledged, and interviewed GPs did not support the notion of personally screening every patient. A popular alternative approach to the doctor asking their patients the questions is to perform screening in the waiting room. Another suggestion was that the screening questions could be written into their practice software against a patient record.

"We can use some screening tools like an iPad device in the waiting room, which is well accepted by both the doctors and the patients. It's easier for the information to be directly linked to their health medical record."

Further suggestions were made to integrate a gambling harm screening into the patient information and medical history forms of which GPs could follow up and check in with the patient. Additionally, service providers during the co-design workshop mentioned the role of practice nurses and that they could potentially undertake screening. However, not all practices have practice nurses and not every patient typically sees one.

If GPs were to undertake screening themselves, the recommended time for screening would be when they are already doing a health assessment, a care plan for other health issues, or screening for mental health. Other than that, opportunistic screening when the question comes up in their mind during follow-up appointments, usually when other known comorbidities like drug or alcohol use are present or identified, is also considered acceptable by the GPs.

"Throughout appointments and assessments, if we identify some conditions such as mental health issues, financial difficulties, smoking, alcoholism, that could be associated with gambling further assessment should be performed to identify the root of the issue."

Both GPs and service providers suggested posters, digital displays and health messaging about gambling harm screening as a new initiative can be shown in the waiting room and on medical channels to let patients know that questions about gambling harm may be asked by the GPs and that gambling harm is one of the issues which they can discuss with their GPs.

6.4 Community Services Model

Who will be screened?

In comparison to the GP setting, community setting was regarded as more relevant to gambling harm screening because there is more time for communication and a presence of highly related issues such as mental health, alcohol and other drugs. Health workers thus can add extra questions when screening/doing intake assessments and the screening process can be normalised more easily.

The majority of community workers participating in the co-design process agreed that everyone could and should be screened for gambling harm. It was thought that this will normalise gambling harm screening and pick up on people that may not present with identifiable characteristics associated with gambling.

> *"I think something like a questionnaire that can be done and be available to all people would be very beneficial. This would make it easier to normalise as opposed to targeting those who may express that they have an issue or have encountered harm through their own or somebody else's gambling."*

When should screening take place?

The primary method suggested during the co-design workshop and interviews was at an intake assessment or initial consultation however, it was noted that follow up is important. Results of individual interviews are in line with the co-design survey results, with 53% of professionals working in community settings selected routine intake assessment or initial consultation as the most appropriate time for screening. 11% of respondents of the same group voted for follow-up appointments.

Some participants also suggested screening during one-on-one assessment in information sessions or community education events. This would involve setting up a screening booth at community events.

It was also recommended that screening take place only when the person is alone due to potential cultural sensitivities. This was echoed by advice from clinicians, that screening needs to be completed privately and where the consumer feels comfortable.

> *"Bringing it back to domestic violence as an example. When you have a baby and you're in hospital, you're asked about exposure to violence and I know I've been asked in a community nurse setting about it. So, if you're alone then it might be a good opportunity to ask about those issues. Whereas if you have the person doing the harm with you then you're not going to open-up."*

6.5 Cultural sensitivities

Some participants noted that support for affected others needs to be culturally adapted and take into consideration factors such as religion and language.

> *"I am a religious person and for me spirituality has to be involved. Psychology without religion can't touch the whole person, can't understand the whole person."*

The common suggestion from participants was that support options be available in a patient's language:

> *"As people from CALD may have poor English language skills, support options need to be available in their language."*

Arabic

One interviewee advised that to encourage a person from an Arabic background to disclose gambling harm, supports and treatment for gambling should be talked about as positive and hopeful instead of pointing to individual failure and blame.

> *"Because gambling is prohibited by Islam and is associated with shame, patients might not want to disclose their gambling behaviours. They fear that they will lose respect from other community members, which is considered a big thing in Arabic culture. Particularly, the Arabic community that lives in Fairfield LGA is of low socioeconomic background with a high rate of unemployment and has the association with the Centrelink. For these reasons, they are highly concerned about confidentiality and what was going to be passed on to the government or anybody else."*

In Arabic culture, patriarchal hierarchy plays an important role. It is also important to reassure patients about confidentiality. A respondent even suggested that it could make it easier for people in Arabic culture to talk about gambling if the doctor is from a different background in order to enhance confidentiality.

An issue identified is the perceived lack of availability of male counsellors, deemed important for patients of Arabic background:

> *"Besides, Arabic men tend to want to see a male counsellor and there are few available in the industry."*

Assyrian

Participants from the Assyrian community pointed out that the perception of what constitutes gambling is an important consideration for gambling harm screening:

> *"Assyrian people see card games or other types of betting as a hanging out activity rather than gambling. This makes it difficult for the patients themselves to respond to screening questions accurately."*

Similarities to the Arabic interviewees existed regarding confidentiality:

> *"Assyrian community has quite a few cultural sensitivities in common with Arabic community. Community leaders and church leaders have strong influence and they do not want to see professionals who are of the same cultural background for fear of losing anonymity."*

Vietnamese

One participant believed that because many Vietnamese people have escaped war and conflicts, they may not see gambling as an issue if it's not 'life or death'. Participants also posited that they see gambling as a chance to earn money to help family members back home.

> *"Vietnamese culture is quite family oriented and tend to deal with gambling as a family. They tend to keep the problems to themselves rather than going to see a doctor to get help, which makes it too real and shameful for them. On the other hand, because they prioritise family, it could be helpful to draw out how one's gambling might be affecting their family, particularly children in order to motivate them to receive supports and treatment."*

It was reported that Vietnamese people often do not want to go to a professional from the same group, although they need someone who speaks their language and is aware of cultural sensitivities.

General observations

> *"People perceive Australia as a place of wealth but it's in fact difficult for newly arrived refugees. They misinterpret that they can make money from gambling and then they lose money and become trapped in a vicious circle."*

Interviewees claimed that screening alone is not going to solve the problems associated with gambling harm that exist in our society and that there needs to be interventions at a government level in order to address access to gambling, harm minimisation measures and broader education of gambling as a public health issue.

6.6 Supports/referrals

Directly affected

There were several referral pathways suggested by participants for individuals experiencing gambling harm. The suggested referral pathways were fact-checked and informed the development of formal

pathways and resources for patients and practitioners in this project, more detail of which is discussed in Chapter 7.

We include participant's commentary of perceived supports/referrals available to represent what participants already knew patients/practitioners have access to in NSW.

Education

First and foremost, it was acknowledged by participants that health service providers can provide information of the risks and associated harm of gambling and inform patients of available services. The suggestion was that this information flow can be aided via the development and distribution of an accessible resource kit including handout materials, online resources, self-help apps and contacts of gambling help services. Education aims to ensure patients are aware of the risks associated with gambling and practical interventions available.

It was also recommended for those who do not use the internet frequently or have ready access that posters, leaflets and pamphlets in general practices would be of great help. Digital displays in practices and community services could also be utilised to provide gambling education and increase awareness of available support options.

Counselling

Participants referenced the availability of free telephone counselling such as NSW Gambling Help or the Multicultural Problem Gambling Service (MPGS), which are also advertised in gambling venues, on gambling websites such as sports betting websites and referenced during gambling advertisements. An interviewee advised a 24/7 Gambling Helpline or Lifeline is necessary because gamblers and family of people engaging in gambling behaviour can be faced with alcoholism, domestic violence and they may need support immediately.

Face-to-face counselling options with gambling specialists at MPGS, Wesley Mission, Vietnamese Community in Australia, Arab Council of Australia, Mission Australia and Catholic Care was regarded as the best referral option. It is important that people experiencing gambling harm have access to a gambling help counsellor, which includes financial counselling and psychological counselling options. Ideally, a specialist who speaks the same language as the patient is preferred. The perception was that general psychologists, general counsellors and services such as SWSLHD Mental Health services and Alcohol and Other Drug (AOD) services can be referred to in cases where a gambling specialist is not available.

Local networks

Social help including people who have experience with gambling harm is also an important resource.

Participants acknowledged the benefits of hearing other people's stories, in environments such as Gamblers Anonymous, so an individual can see a path out of gambling behaviours and recognise commonalities in experiences in the recovery process. Again, localised access and networks offering support in a patient's native language are preferred.

Other supports

There were suggestions that Gambling Help could link with financial institutions in order to flag abnormal withdrawals at clubs. Some also suggested that for those who receive allowances from Centrelink could be helped by restricting the payment in form of coupons and food vouchers, with the vouchers in their name and not transferrable so that they will not be able to sell them for cash.

We acknowledge that some of these suggestions seriously breach privacy provisions and/or may have unintended consequences.

Multi-venue self-exclusion should be enforced so that they don't enable the gambling. In severe cases, certain type of intervention which stops gamblers from attending the venue was recommended.

Affected others

Participants acknowledged that affected others should be referred to all the above-mentioned options.

Support groups were highly recommended for affected others – e.g. carers support networks or a place providing temporary accommodation, meals and social support such as the Salvation Army.

6.7 Training

Co-design respondents indicated that training provided to GPs and community workers should include:

- Basic information about gambling, the problem, how it affects people and what can be done to help;
- Screening questions and how to normalise the question and/or tools;
- Cultural views of gambling in various communities, awareness of CALD barriers and issues;
- Accessible and affordable support options for patients and carers;
- How to detect gambling harm via the use of a screening tool (i.e. interpreting screening results correctly);
- Real life case-studies; and
- An emphasis on the importance of early intervention, acknowledging that gambling is often a coping mechanism for underlying mental health issues.

7. RESEARCH METHODS – IMPLEMENTATION PHASE

Phase 1 of the research project informed the design and implementation of Phase 2. Several recommendations in relation to screening tool questions, screening processes and implementation, referral options, and cultural sensitivities have been incorporated in the proposed screening and referral model that was implemented in this study.

Findings from Phase 2 inform key recommendations to support gambling harm screening and referral in GP and other community settings.

7.1 Screening tool questions

Based on the co-design phase and literature review, two screening tools were chosen for this study:

1. The validated *Problem Gambling Severity Index (PGSI) Short-Form*[81] to identify individuals experiencing gambling harm.
2. The *Concerned Others Gambling Screen (COGS)* to identify family/friends (affected others) experiencing gambling harm as a result of someone else's gambling[82].

7.2 Screening processes and implementation of screening tools

For the purposes of the study, participants must have been provided services within the Fairfield LGA and the tool only administered to those over 18 years of age.

Universal screening, i.e. every patient is screened if they were over 18, was recommended to reduce stigma associated with gambling behaviour or harm. Within the framework of this project, the screening model was implemented for up to 13 weeks – depending on the capacity of GP and community worker participants. The duration of screening model implementation was agreed with each service prior to commencement.

Screening tools were administered in either one of the two workflow scenarios below. The specific workflow scenario was agreed with each individual service before implementation commenced.

1. Pre-appointment (at reception or intake): patient to complete screening tools while waiting for their private appointment with a GP/community worker.
2. During appointment: a patient to complete the screening tools during their private appointment with a GP/community worker.

A flowchart was developed based on both scenarios (see *Gambling Harm Screening Flowchart, Training & Resource Kit, page 4*). The project team discussed both implementation timeframes and workflow scenarios with each service and confirmed which scenario they would implement prior to commencement.

7.3 Referral and support options

For both individuals experiencing gambling harm and affected others, education and information on gambling harm and available support services should be provided first and foremost. Suggestions included consumer brochures, online resources, self-help apps and contacts to gambling help services.

Referrals to gambling counselling, as previously identified, are considered pivotal. When gambling harm is identified by a GP or community worker, referrals to a gambling service can be made in two ways:

- Cold referral: a professional provides information about services/programs, including contact details, and the patient follows up with services/programs themselves.

---

[81] Volberg & Williams 2011.

[82] Sullivan S, McCormick R, Lamont R and Penfold A. 2007. Problem gambling: patients affected by their own or another's gambling may approve of help from GPs. *New Zealand Medical Journal*, 120:1257.

- Warm referral: a professional gains patient consent to directly organise an appointment with a gambling service or provide the patient's contact phone number to a gambling service for follow-up.

A list of local gambling services and programs, including culturally specific services, was provided to GPs/community workers who participated in the implementation phase (see *REFERRAL – Directory of local gambling services and programs, Training & Resource Kit, page 13)*.

7.4 Cultural sensitivities

This study focused on the three most prevalent cultural groups residing in the Fairfield LGA: Arabic, Assyrian and Vietnamese.

Specific information about cultural sensitivities such as stigma, religion, awareness of gambling and psychological interventions was included in the training session prior to commencement of the implementation period. Material was also translated, by an accredited translator, into Arabic, Assyrian and Vietnamese.

7.5 Recruitment

For the implementation phase, we initially aimed to recruit 30+ participants.

Due to the impact of COVID-19 – the impacts of which are discussed in the Results section of this paper – this aim was reduced to 10+ participants who implemented the model and participated in individual interviews[83]. The study was a quasi-experimental pre/post intervention study. A qualitative analysis method is used to evaluate the implementation of the model.

Participants were recruited via email correspondence with Fairfield City Health Alliance's existing network of community service providers. South Western Sydney Primary Health Network led the recruitment of GPs via email correspondence. All participants were provided with a Participant Information Sheet and signed a consent form prior to their involvement in the study. The project team also recruited, via email correspondence, GPs and community workers who had engaged in the co-design phase of the study.

Figure 2. Summary of Monitoring and Evaluation Plan

Research Question	**Outcome**	**Proposed Instrument / Measures**	**Time of measurement**
Identification of gambling harm	# of people screened and % identified as having gambling harm by cultural background within screening period	Screening and Referral Data	After screening each patient during implementation period
Support / referral of gambling harm	# of people received support/referral after gambling harm identification by type of services within screening period	Screening and Referral Data	After screening each patient during implementation period
Acceptability / Feasibility	Satisfaction with the intervention, perceived ease of use of the screening tool and referral pathways and	Interviews	Post-intervention

[83] Sandelowski, M., 1995. Triangles and crystals: On the geometry of qualitative research. *Research in Nursing & Health*, 18(6), pp.569-574.

	sustainability of the intervention		
	Intervention uptake	Attendance sheets	During information session
	Retention rate (% of GPs/community workers retained throughout implementation)	Participation data	2 weeks post-intervention

7.6 Information Session

Prior to the implementation, GPs and community workers were required to attend an information session, delivered by a gambling counsellor, to support the utilisation of the co-designed screening and referral model. The aim of the information session was to familiarise participants with this study, resources, consent processes and data management processes (see *Information session - slides, Training & Resource Kit, page 28).*

7.7 Screening protocol

Patients provided implied consent by completing the Gambling Harm Screen form with their GP or community worker with complete patient anonymity implicit in the design of the screening model.

A preamble to the screening was provided as follows:

> Gambling harm is a huge issue in Fairfield. Over $1.4 million is lost per day to pokies in the Fairfield LGA alone. We need your help to research and implement a model that is for the community, by the community.
>
> The Fairfield City Health Alliance has been funded by the NSW Office of Responsible Gambling to develop and implement a screening and referral model. The screening tool will identify people affected by gambling harm and connect them to support.

The initial aim was for patients to respond to the screening questions in one of two ways:

(i) If visiting the practices/services in person, they received a hard copy of the screening form to fill in. Participants (GP/community worker) inputted screening data and referral results after each patient visit via an online form. Alternatively, hard copies of the Gambling Harm Screen forms were sent back to SWSPHN every 3 weeks via registered mail.

(ii) If the appointment with their GP/community worker was online (e.g. via telehealth), the Gambling Harm Screen was sent to patients within an appointment confirmation email by the receptionist/administrative staff. The patient completed the survey in-appointment, administered by the GP/community worker. GPs/community workers inputted the screening data and referral results into an online form.

Due to the impact of COVID-19, the project team, with amended ethics approval, delivered an online version of the screening tool for GP and community workers to use. After screening patients, GPs and community workers entered the results online. The questionnaire also prompted the GP or community worker to record an outcome of the screening - whether gambling harm is identified in the person as (1) an individual who gambles, (2) an affected other of somebody else who gambles, or (3) both.

Data was regularly monitored with ongoing support provided by the Gambling Project Team to participants.

7.8 Embedded resources

With the screening tool provided as an online survey, convenient embedded links were provided for GPs and community workers to online service directory listings for gambling support services and referral advice – via SWSPHN's Recovery Point and HealthPathways/Health Resource Directory.

Figure 3. Screenshot of embedded resources in online screening model.

Resources

For healthcare practitioners:

- Gambling harm (via HealthPathways)

Your login details to access HealthPathways:
Username: fairfield
Password: network

For the public:

- Service listings (Recovery Point)
- Information for patients/clients

HealthPathways & Health Resource Directory

HealthPathways is an online clinical and referral information portal used by clinicians at the point of care. HealthPathways provides GPs access to management and treatment options on a range of clinical presentations and information about local clinical services and their referral processes.

The site uses a scalable format allowing users to customise the level of detail displayed, providing a quick access during consultations or more detailed information to be viewed later.

Links to reputable patient information (including translated patient information where available) and clinical resources are also provided in most clinical pathways.

Health Resource Directory.org.au is an initiative of South Western Sydney PHN, designed as a health information portal to support patients in learning more about their health issues. The site provides links to information recommended by local health professionals, including factsheets. Culturally appropriate resources, which have been specifically designed for Aboriginal and Torres Strait Islander people as well as people from culturally and linguistically diverse communities, are also provided.

A HealthPathway and Health Resource Directory page specific to gambling harm information and referral options was created for this project, with factsheets translated to Simplified Chinese, Arabic, Assyrian and Vietnamese[84].

Recovery Point

Recovery Point provides mental health information specific to South Western Sydney (Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wollondilly and Wingecarribee).

Recovery Point is designed for people who are experiencing mental health concerns, as well as their friends, family and carers. A key feature of Recovery Point is a comprehensive directory of local programs and services with built in interactive map functionality, displaying services closest to the user.

Recovery Point also provides quick and easy to access information about common mental illnesses, the different types of mental health professionals, emergency or crisis support, local mental health

[84] The HealthPathway for SWSPHN was rewritten and updated by Courtney Whittaker (the initial Project Manager) to reflect a more nuanced understanding of gambling harm – the revised version was approved by SWSPHN.

services, helplines, telephone and online counselling and support, online self-help tools, local consumer networks and additional information specific to young people.

All gambling support services were added to Recovery Point after an independent audit by the project team. These listings include websites, physical service addresses, operating hours, phone numbers, a service profile and instructions on how to refer to the service.

7.9 Implementation in practise

The co-designed screening model was implemented by GPs and community workers for a 13-week period spanning May, June and July 2020.

It is important to note that implementation of the screening tool was during COVID-19 restrictions in NSW. The disruptions to GPs and community workers during this period are explored in more depth in the discussion section of this paper. COVID-19 restrictions required the project team to pivot delivery methods of the information session and indeed the implementation of the screening tool itself.

In preparation for the implementation of the model, a 2-hour webinar was delivered on 28th April 2020 with the attendance of 1 GP and 7 CWs. Each participant was provided with an electronic resource kit containing the screening and referral model, promotional packages in English, Arabic, Assyrian and Vietnamese and reference materials, including service listings for gambling support services (see *Training & Resource Kit).*

During the 13-week screening period from 4th May to 31st July, 141 screening tools were completed by patients of the 2 participating GPs and 10 participating community workers.

7.10 Interviews and focus groups

All participants were invited to partake in semi-structured, one-on-one interviews or focus groups with the Gambling Project Team after the implementation period. Questions pertained to their experience implementing the model, including any barriers, effects, and perceived utility.

Interviews ran for approximately one hour via phone or video conferencing software due to COVID-19 physical distancing requirements at the time of the study.

Demographic data of the implementation participants, including profession and organisation, and patients including gender, ethnicity and the results of screening and referral were analysed using descriptive statistics.

Content analysis of qualitative data from individual and focus group interviews with professionals was conducted to identify themes. Acceptability of the intervention was measured by deductive coding in themes with supporting quotes based on seven component constructs in the Theoretical Framework of Acceptability (TFA)[85]: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy[86]. Feasibility of the intervention was also assessed through a combination of descriptive statistics of participant uptake and retention rate and qualitative analysis of various aspects such as demand, implementation and practicality[87].

Over four weeks from 6 July to 31 July, the project team conducted 7 individual interviews and 1 focus group with 9 participants including 1 general practice (GP) and 8 community workers (CW) from 1 practice and 4 organisations.

[85] Bowen, G.A., 2009. Document analysis as a qualitative research method. *Qualitative research journal*, 9(2), p.27; Sekhon, M., Cartwright, M. and Francis, J.J., 2017. Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC health services research*, 17(1), pp.1-13.
[86] Sekhon, Cartwright, and Francis, 2017.
[87] Bowen, G.A., 2009. Document analysis as a qualitative research method. *Qualitative research journal*, 9(2), p.27.

8. IMPLEMENTATION RESULTS

8.1 Intervention uptake and retention rate

The project recruited 12 participants including 2 GPs and 10 CWs to implement the gambling harm and referral model over 4-10 weeks. The participants represented 2 GP practices and 5 organisations based in the Fairfield LGA. By the end of the implementation period, 2 participants had dropped out – one for having no capacity to do the screening and another due to personal factors.

8.2 Identification of gambling harm

There were 141 responses in total, with an average completion time of just 1 minute and 25 seconds. The completion rate was 92% - 130 out of 142 cases completed the screening process in its entirety; 12 were partial completions where 10 did not proceed to the demographic and results section and 2 respondents only answered 'Yes' or 'No' to the introductory question but did not proceed to the screening questions.

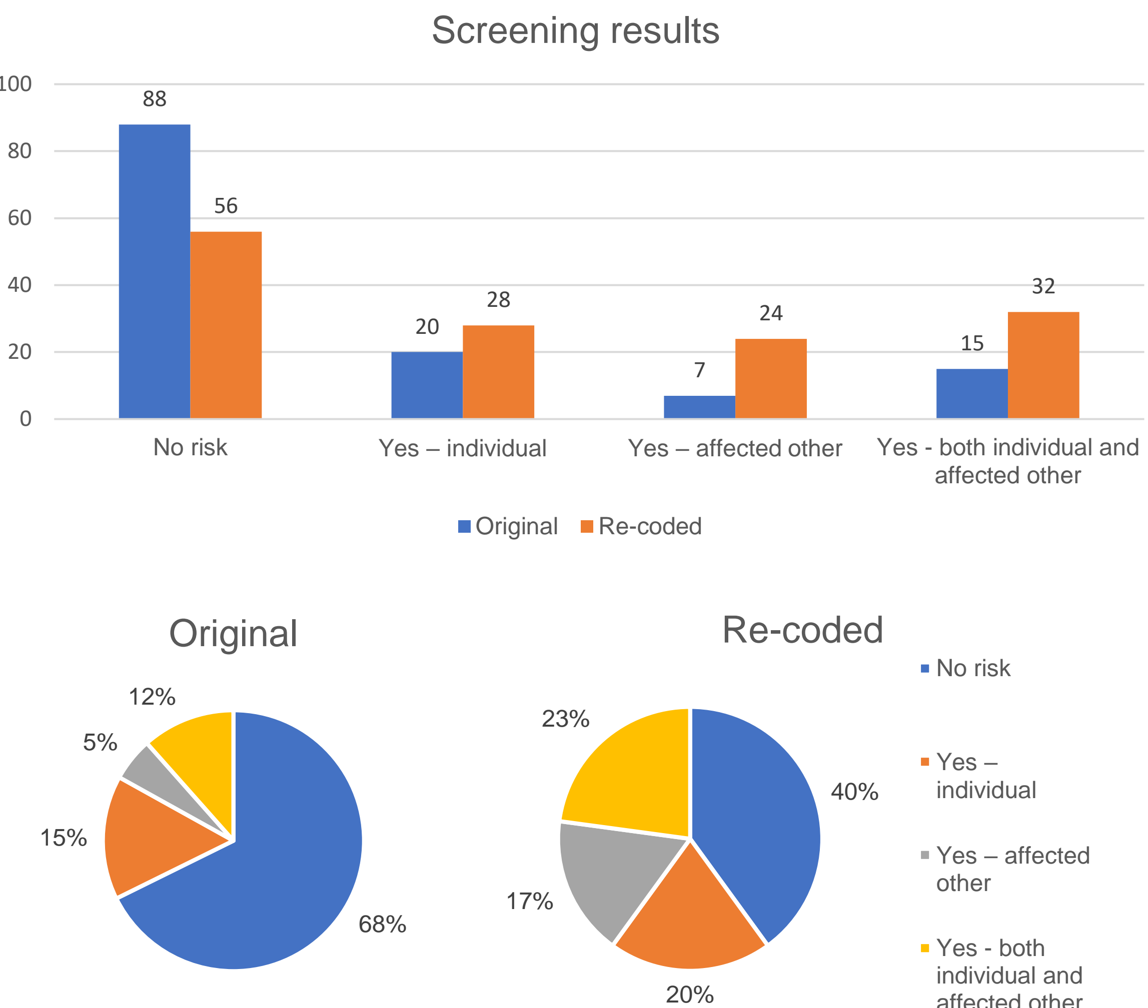
For the purposes of the implementation analysis, we have chosen to exclude these 12 partial completions.

Participants confirmed that they either entered the data when conducting telehealth consultations (phone or video call) with their patients or let patients fill in the screening form by themselves in face-to-face consultations.

Figure 4. Raw results of screening.

Raw data from screening tool results shows that 68% (88 patients out of 130) were regarded as having no risk of gambling harm. The percentage of patients who were perceived to be at risk of gambling harm because of their own gambling behaviour and somebody else's gambling behaviour is 15% and 5% respectively. There are 12% of patients who were believed to be at risk of gambling harm from both sources.

Figure 5. Patients identified as being at risk of gambling harm – original vs re-coded.



Screening results were not consistent among participants. If we assume that a consumer who responds positive to any of the screening question should be marked as being at risk of gambling harm, then there are cases where the screening results produce 'false positive' and 'false negative'.

- False negative: a patient responded positive to one or more screening questions but were marked as 'No risk'. This may stem from gaps in perception about gambling harm and the implication of the model. The participants may believe that the risk was too low to be captured. Another reason may be that the harm is in the past and the patients indicated that they are no longer affected by gambling harm. Thus, they are marked as having no risk of gambling harm.

- False positive: a patient was marked as "gambling harm identified" although the patient responded 'Never' to all the screening questions. This suggests that screening questions only play a supportive role in the judgement of a health professional regarding the harm level. Although a patient may respond negatively to the screening questions, a conversation with the GPs or community worker may reveal harm. For example, there was one case where the participant commented that the person was a gambler 10 years ago. In three cases, the patients were referred to gambling services. This implies that the participant considered the patient's situation before concluding on the screening result.

- No information: the participants only screened patients and skipped inputting the results of their screening and referral. Because the demographic/result section is optional, participants may skip

this part if their patient does not consent to giving out their information. This resulted in the total number of 130 in the results section while there were 141 patients who were screened.

We then re-coded the screening results based on the hypothesis of the gambling harm screening and referral model, which is to mark ‘No risk’ only when patients respond negative to all of the screening questions.

The re-coded results are represented in *Figure 5* together with the original screening results. The graph shows that there was a significant decrease in the number of ‘No risk’ cases by 36%. There was a dramatic increase in all 3 categories: ‘individual’, ‘affected other’ and ‘both’.

In addition, the number of cases where gambling harm is identified as an affected other rose sharply to account for 17% of the total screened patients. This is almost equal to 20% of patients who were identified to be at risk of gambling harm as a result of their own gambling. Over half of cases where patients were identified as an affected other (33 out of a total of 56, 59%) had been impacted by gambling harm in the past. 30 of them believed that it no longer affects them. Only 9 people (16%) thought that they are being affected by someone else’s gambling presently.

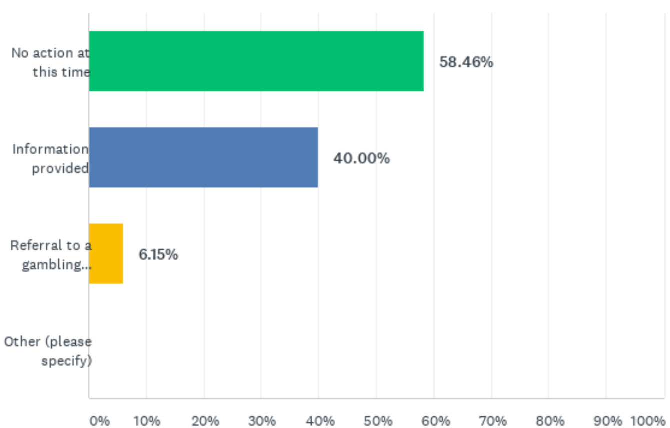
Figure 6. Re-coded results of screening.

Overall, these mismatches point to a need for further enhancing awareness of gambling harm among health providers and the improvement of the gambling harm screening and referral model so that it can be utilised smoothly and consistently.

8.3 Support/referral of gambling harm

Just over half (58%) of respondents were reported to not require any action. Just under half of patients (40%) were provided with information and only a small number (6%) of patients were referred to a gambling service. Among 8 referrals, 2 were specifically referred to Mental Health Therapy and Recovery Service and Anglicare Gambling Help. The remaining six cases were given information about gambling support services and helpline numbers to contact themselves.

Figure 7. Actions taken after screening.



Compared with the levels of harm identified, support and referral options were certainly much lower than the screening results indicated and arguably warranted. A main constraint of the screening tool and looking at outcomes in this way is that it does not consider conversations a GP or community worker may have had with the patient during the appointment. Perhaps, in some instances, after exploring issues in more depth, a referral was deemed as not appropriate by the practitioner at this time. Without allowing for this data collection during the screening however we cannot say.

8.4 Acceptability and Feasibility

Participant sentiment

All participants expressed positive attitudes towards the gambling harm screening and referral model. First, they regard it as being easy to use with only a few screening items, echoing a recommendation from co-design. The screening tool is also clear and to the point.

> *"The thing I do like is people are asked the correct questions this time." (Participant #3 – Community worker)*

> *"Look, it's actually a good model. What's good about it is that it's easy to use. There are not too many questions attached to it. The questions are not complicated either." (Participant #6 – Community worker)*

They therefore had a good experience with implementing the model. Some participants were familiar with using screening tools before participating in the project and as such for them it did not pose many challenges to their implementation of the gambling screening model.

> *"No more difficult than implementing other models. It actually gives us a little bit more insight as to how we can best help the patients." (Participant #3 – Community worker)*

More importantly, the participation in the project was reported to generate a change in participants' perception and interest about gambling harm. They claimed that they have become more concerned about gambling issues and thus more proactive in performing gambling harm screening.

> *"Prior to taking part I didn't think gambling was a big issue. In fact, I've never asked a question about gambling issues really. After a few interviews, after a few days, I certainly think a lot about gambling." (Participant #7 – GP)*

> *"…prior to the workshop itself, myself, I wasn't much attuned to the fact that gambling itself is a big concern in Fairfield, nor my staff members were particularly attuned to that… up until when we had participated in the actual workshop and then I shared that*

information with my colleagues during our staff meeting, everyone then did understand how significant this is an issue in Fairfield, so that's when we made that commitment to increase our participation in terms of screening." (Participant #5 – Community worker)

Perceived effectiveness

The model was considered effective in achieving its purpose of starting the conversation about gambling harm. As gambling is stigmatised in some cultures, it does not quite often come up in conversations. When the model is implemented, gambling can be discussed while stigma is avoided.

"…in our service, they don't actually mention gambling until they've getting comfortable with it. But when you ask them straight out, they're like, oh, yeah, I do gamble." (Participant #1 – Community worker)

Screening questions were reported to be "simple and easy questions, not embarrassing", "very straightforward and (they 're) easy (for them) to understand". Participants reported that patients who were asked were 'more than happy to engage'.

"I think it's a really good way to engage, especially young people, because it doesn't come from a judgemental – it's just like, we're just gathering information to make you aware of what could become a problem." (Participant #4 – Community worker)

The strongest point of the model, according to the interviewees, is its educational purpose. The definition of gambling is not clear for some people as they might think of it as recreational activities. Many participants reported that their patients, especially young people, did not realise they were gambling until it was pointed out that they suffered financial loss or abuse due to their gambling behaviours. Through the discussion with patients, participants had a chance to provide information and raise awareness about gambling. Screening for gambling harm, therefore, can act to prevent potential gambling harm.

"…just to teach them about budgeting, having more money aside for socialising, for going out and doing stuff, but just making sure that it's not going to become something that can then take over and become a problem." Participant #4 – Community worker)

Usefulness of Information and Support Provided

Before the participants started screening, a 2-hour webinar was delivered together with a resource kit in order to support the utilisation of the proposed model. The resources cover a wide range of knowledge including prevalence of gambling harm in New South Wales and particularly the Fairfield LGA, available screening tools to be utilised, screening and referral model and promotional packages available in English and three other languages (Arabic, Assyrian and Vietnamese). Information provided by the project was evaluated as being straightforward, useful and motivating. Especially, participants agreed that information about gambling harm may be available in many different resources but it makes more senses when combined into one single resource.

"The gambling information one. I actually did enjoy that one. It was very informative. I think it was very descriptive as well, which is what we needed." (Participant #6 – Community worker)

"The webinar was pretty useful and I also did the online training as well… I think it really gelled a lot of things together because sometimes you have your own perceptions or assumptions about people with gambling problems and they just do not know how to handle their money. But there are a lot of other issues or things that happen that impact on that and why they use that as an outlet. So that gave a really good insight to cement the whole thing together." (Focus group #8)

"Look the information we received was, first of all, it was mind blowing to learn about Fairfield itself. I knew previously that Fairfield has a gambling issue, but that was not compared against any other part of New South Wales or any other council. But learning or

understanding how much money being lost on a daily basis in Fairfield through the workshop itself, that was an additional motivation for me and my staff members say, hey, we're going to have to do something." (Participant #5 – Community worker)

The webinar was also appreciated for facilitating the exchange of information between the facilitator and the participants. The direct interactions allow the participants to clarify their questions about gambling issues and the screening tools, which enhances the efficiency of the utilisation of the model.

"…watching the webinar you could see the opportunities for discussion and to ask questions and that sort of thing. So yeah, I mean a lot of the things I would have asked or what not were all addressed in that webinar." (Participant #9 – GP)

In addition, the participants highly appreciated the availability of information in other languages. This pilot project places a focus on three main CALD communities in the Fairfield LGA including the Arabic, Assyrian and Vietnamese communities. Therefore, multilingual resources are helpful in targeting different cultural groups.

"The resource is quite resourceful in itself. Having it broken down in different languages that are quite mainly used in our community, it was great. It was really straightforward. It's something that you can easily hand out to a patient and say here, please read this. At least that way they can say well, I've been catered for, for me, depending on their cultural background. So yeah, very, very useful." (Participant #8 – Community worker)

When we first built the model, the screening was supposed to be paper based. However, it was later adjusted to be able to utilise online. The online screening form also includes referral information for GPs/community workers to refer to. Interestingly, the online tool is preferred for its simplicity, convenience and straightforwardness. The participants admitted that an online screening form allows them to easily and quickly navigate through questions. The information is also readily available to provide to patients.

"That was useful, because all you had to do is just put it straight into the computer in the SurveyMonkey and that would just tell you where to go from there. So I was able to refer off the list that's on there and I was able to give out information off there as well."(Participant #1 – Community worker)

It didn't take too much time, especially the survey on the internet. It was very cruisy, very, very cruisy." (Participant #7 – GP)

"I loved the SurveyMonkey. Very straightforward, easy to move on, next. Bang, bang, bang. Much better than paper form." (Participant #8 – Community worker)

Besides the knowledge related to gambling harm, screening tools and referral pathways, the project team also regularly updated participants on the current screening results. This aimed to recruit additional participants who are interested in being involved in the project, present the initial observations on the screening data and motivate participants to continue with their implementation. Upon being asked about communications with the project team, participants stated that frequent follow-up is supportive and inspiring.

"It's very important to updating as I feel like it [screening results] develops, especially your follow up of that is perfect". (Participant #2 – Community worker)

"Yeah, definitely and I think that getting the updates via email about how it's going, the numbers, the statistics, it's been really good to feel part of that, of being updated constantly." (Focus group #8)

One interviewee acknowledged the effectiveness and appropriateness of communication via email. Email communication is at the convenience of the receiver and easy to commit than other forms of communication.

> *"I think most communication has been done through email. It's probably more practical that way, only because it's – for instance, if it was any other type of communicative method, it is a lot more difficult, I guess, to commit to that way, because we are all already very busy in our current roles… So yeah, I think it's appropriate, the communication level, the way it is right now."(Participant #6 – Community worker)*

Ethicality

It was commonly agreed by the participants that the project has good fit with their value system. As gambling harm is included in the comorbidity with other mental health and alcohol and other drugs issues, the screening was seen to be a good fit especially for those who work in these areas already.

> *"Everything we do is about addiction. With the drugs and the alcohol and the gambling it all goes part and parcel of it, so it just complements what we're doing." (Participant #3 – Community worker)*

> *"It probably fits in there [individual's value system] 101 per cent… So the model, which looks at a very holistic point of view, again cannot sit anywhere else other than within 100 per cent with our organisational values and mission and purpose." (Participant #5 – Community worker)*

For that reason, all of the participants reported being comfortable asking the questions while maintaining good rapport with their patients. The interviewees believed that gambling issues need to be taken seriously. They mentioned that information about the prevalence of gambling harm that they have gained through participating in this project motivates them to be committed and continue to talk with community members about gambling.

> *"I might also mention that the organisation had decided over the past year, since last year, that we were not going to be applying for club grants anymore because of this affiliation with the gambling. So that is an appreciation of as taking gambling and gambling-related harm very seriously in Fairfield." (Participant #5 – Community worker)*

> *"I believe that obviously you always need to educate the community of ongoing statistics and say well, this is where you live, this is actually what's really happening."(Participant #8 – Community worker)*

Effort required and burdens

Most of the participants did not find any major burden or challenge to their work when they were involved in the implementation phase of this project. For some community workers, the screening process fits well into their consultation with patients. The screening process was regarded as being quick and straightforward. The screening was expected to go smoothly with the cooperation of the patients.

> *"It [the screening] was pretty short and straight to the point to get what you needed to get." (Participant #1 – Community worker)*

> *"It doesn't take too much time. I think it takes, like, maybe five minutes or so, depending on, I guess, how willing the patient is to cooperate as well." (Participant #6 – Community worker)*

According to our co-design results, one of the main barriers reported is the time restriction, especially in clinical settings. This barrier was reflected in the responses of some participants, including one GP and one community worker. This burden did not interfere much with the community worker's consultation. However, for the GPs, the issue of time restriction is accompanied by the barrier of priority of other health issues, which pose some challenges to the screening of patients. The GP also reported

that it would be difficult to do the screening when the environment of the clinic does not facilitate the conduct of research or survey. These challenges might affect the sustainability of the screening once the implementation period finishes.

> *"It was nothing, no massive concerns about it, it was just, like I said, just a little bit more time consuming." (Participant #3 – Community worker)*

> *"I've got a walk-in clinic… we don't have a research or survey kind of environment in our clinic… So that was certainly a kind of small challenge… when I see a patient I get into or get carried away with those problems. I have to remind myself that I'm doing a study… it will be a burden to actually go and do a survey." (Participant #7 – GP)*

Another participant who is a community worker agreed that the priority of the main issue of the consultation was a burden to conduct the screening. They indicated the need to concentrate on the current issue, which may disrupt the flow of the screening process.

> *"The only thing I would say is sometimes you forget, because I'm focussed on the current issue at hand. So, it could be whatever it is – the patient is sharing with me at the time, or their current crisis situation at the time… It may disrupt the flow a little bit, only if gambling isn't an issue, I guess, in their current situation." (Participant #6 – Community worker)*

Especially, in the context of the COVID-19 pandemic, many health services were forced to change their approach from face-to-face to online consultations. Some participants preferred face-to-face interactions, which allow them to form a closer relation with their patients and thus increase the comfortability to have a conversation. A participant pointed out that non-verbal languages help them understand the patients' reactions and make better judgement of their responses. Because of these reasons, some participants felt that more efforts were required to implement the screening and referral in the new context.

> *"We prefer face to face, it is more effective than the phone… When I say face to say, it is more flexible, it is more open with the patient." (Participant #2 – Community worker)*

> *"If you ask a question and they look away or they cross their arms, just those little things. You know that eye contact or you just watch their body, their shoulders will drop or they get a bit more tense, and you just can gauge that so much better than over the phone." (Participant #4 – Community worker)*

> *"I guess the effort that it takes on the phone to implement that case management and that level of support does take double the time than what it would if it was face-to-face… Face-to-face is a hundred per cent easier." (Participant #6 – Community worker)*

On the other hand, some services advised that they were able to quickly adapt to the new situation without any issue. As mentioned in the previous part, the online screening and referral model has its strong points of being more accessible, easy to navigate and having referral pathways integrated into the screening form. This suggests that the online screening model can be utilised effectively though it may take time for some services to transition to a new method of consultations.

> *"We have transitioned very successfully across to the new model, new platform of service delivery. We're probably running on par with an amount of service contacts face-to-face as to what we were doing online. So yeah… it's more about training staff and getting them into a different mindset which we've been able to do successfully." (Participant #3 – Community worker)*

> *"…having this other line of tools [online screening tools] already does make it much easier, I guess easier regardless of whether you're working from the office or home, so the accessibility of it is very much the same… But I don't think it would make any difference*

whether this was being done in person or online. I think I actually would prefer to have it as an online tool." (Participant #5 – Community worker)

Confidence implementing the model

Before participating in the implementation, the participants were asked to complete a survey to assess their knowledge, self-efficacy and behaviour related to gambling harm screening and referral. On a scale of 1 to 5 where 1 was 'I am not confident at all' and 5 was 'High level of confidence', the weighted average point of 11 participants who answered the survey is on an average of 2.64 for identifying gambling harm and 2.73 for providing information or support. After implementing the model, all of the interviewees reported an improvement in their confidence level. The participants self-rated their confidence level after participating ranging from 4 to 5, which was a significant boost. The participants advised that the more the model is utilised, the more confident they get. The participants also acknowledged the resources provided by the project team, which helped them to gain more knowledge and become more confident.

> *"I just made it part of the process so it was easy. Everyone – all staff that were asking the questions, it just became part of the everyday practice." (Participant #3 – Community worker)*

> *"For me at the beginning it was a bit iffy… But now I've gotten used to it and it's like second nature now… I think the more you practice, the better and more confident you get at it." (Focus group #8)*

> *"I was pretty confident. I think especially after that information session that we had. Like I said, it did clarify a lot of things. It did help us understand it better, so, yeah, I was pretty comfortable." (Participant #6 – Community worker)*

Opportunity costs

A majority of the participants did not find any opportunity costs which they had to give up in order to implement the screening and referral model. Some services advised that the screening is incorporated as part of their assessment process, which makes it easy and convenient. Similar to the burden of participation, time is the only concern of the GPs and community workers. However, they noted that the opportunity cost of time is worth in exchange for other benefits of participating.

> *"Like I said, it was – in regards to staff wise – it was just time consuming, just took a bit more time. So it was adding time to our assessment process, but we received the data we wanted so it was a good investment of time." (Participant #3 – Community worker)*

> *"The only thing I would mention is, when the information session took place, it was after hours. Obviously, I would, prefer to have anything that's work-related happening within our work hours. I tend to treasure those after hour moments, but that's the only thing I could think about." (Participant #6 – Community worker)*

> *"We did not expect any financial cost from our participation in there… We saw significant adding or added value of this participation onto what we already deliver." (Participant #5 – Community worker)*

Demand

The participants agreed upon a demand for the proposed model to be utilised in primary care and ancillary services and the importance of actions taken post-screening – be that a referral and/or providing information regarding support services available.

> *"Well it comes down to how far they're going to take. It's where the next step's going to come from. So if they're going to implement something with this information it's very helpful. If they're not going to implement anything with all this information, well it can be a waste of time." (Participant #3 – Community worker)*

The two screening tools that form our model were both considered appropriate to use in general settings to capture harm rather than clinical settings which are more inclined towards diagnosing problem gambling. This is echoed by one of our interviewees who proposed that the utilisation of the model should be flexible instead of adhering to rigid criteria to assess gambling harm in different individuals. That is to say, there is a high demand for the model but it needs to be used in a meaningful way.

> *"If the health care system operates on a holistic understanding of the person and understanding of individuals or community members that we are supporting as having very different levels of literacy and understanding, I would be saying that this is very likely to be adopted by the health system. But if the health system, on the other hand, operate on a very rigid approach, using the heavy medical terminologies, then it's not going to fit the purpose at all." (Participant #5 – Community worker)*

Implementation

Overall, the screening and referral model was evaluated as being useful in assisting the GPs and community workers to start the conversation on gambling issues and assess gambling harm. As discussed in the previous part, there were some mismatches between the screening results and the judgement of participants about identification of gambling harm. This was explained by one of the participants that the screening tools was able to generate accurate results. However, in some cases where there are gaps in understanding of the patients about gambling issues, conversations proved to be effective in detecting harm.

> *"I think it was pretty accurate. I think that the times that it didn't detect it were the times where people had no self-awareness of the fact that they had a gambling problem and it was a matter of having a further chat and exploring it a bit more to get them sort of a bit more self-aware." (Participant #1 – Community worker)*

Practicality

Acknowledging the usefulness of the model, all of the participants expressed their desire to continue to utilise it in their services in the future. It is particularly necessary when gambling harm screening is integrated with other issues within its comorbidity.

> *"The tool does offer services that can help them deal with that, I think it's always a good resource to have." (Participant #6 – Community worker)*

> *"There's no point in working on one if you're not working on the other as well." (Participant #1 – Community worker)*

The sustainability of the model, however, depends on some external factors other than the willingness of the health service providers. The first factor for this model to be implemented in the future would be the integration into the current system of each organisation. The model was well received in the assessment of the services. However, it was less likely to be utilised during consultations with patients. Participants found it hard to remember asking the questions during their consultations. Some professionals pointed out that they tend to forget asking the questions if they had to concentrate on the current issues of the patients. The two GPs in our project suggested that best practice would be to incorporate the screening tools and the referral pathways into a software that they are using.

> *"The only limitation is, I'm sure I'll forget unless I get it incorporated into my software by some means." (Participant #7 – GP)*

The second factor is the next steps after screening, especially for services who have some programs for gambling support/treatment. One participant reported that the program they run may depend on the funding that they receive. Therefore, they may not be able to integrate the screening for gambling harm in their service if the organisation does not receive funding for a gambling related program to help patients after screening. In other words, as stated in the demand for the model, the participants believed that the screening will not be meaningful if they cannot proceed with supporting or treating their patients.

This points out the importance of the maintenance of referral pathways for supporting and treating gambling issues.

> *"We will continue to identify, but at the moment, we're not funded to run any programs in regards to a gambling screen… We've done something which was able to get us numbers and identify there is a problem and identify people that actually need some form of intervention. But that intervention comes at a cost. To be able to cover that cost funding needs to come into it." (Participant #3 – Community worker)*

The participants also stressed the importance of support from their management. They referenced of course their willingness to participate in the project but commented that further utilisation of the model would require discussion with management in order to ensure that the screening aligns with other programs that the organisation is running.

Model improvement

Screening tool

The current model for gambling harm screening and referral was considered by the participants to be good to use. The screening tools were good at picking up harm and gambling issues. One participant suggested that once the harm was detected, more questions could be asked to examine the issue further.

> *"There could be a separate set of follow-up questions later on that need to probably go into a bit more depth." (Participant #3 – Community worker)*

Another participant agreed with the idea that the online screening form is more manageable. The reason is that for an online form, the professional conducts the screening and inputs the patient's data into form. However, if it is paper based, participants would have to input the data again online, which doubles their work. Therefore, they prefer the data collection method through online form.

> *"I like the online one because I think it's easier and quicker." (Focus group #8)*

Another improvement suggested by participants is the adaption of screening questions depending on the cultural background of the patient:

> *"The model now is good, but maybe in the future we need to develop it a little bit... We maybe between time to time when you need updating, depends on the circumstances, depends on the kind of culture maybe we need to be fixed." (Participant #2 – Community worker)*

Regarding the utilisation of the screening model in clinical settings, a GP suggested that the barriers of time or priority can be overcome by integrating the screening tool into practice software. He also recommended that from his experience with MedicalDirector and Helix, there can be a column where GPs can make notes of gambling harm, which leads to an enhanced patient understanding and more personalised clinical outcomes.

> *"On the paper, probably people will forget. I think it has got a high chance of being used if it's incorporated into the medical software…there should be another column or row there which should be customisable for patients for their individual, say, area that they work in… For instance, I would like to have [an associated tab] on gambling and when I click, basically I get all these choices. So, if I live in a place where there are a lot of concerns or prevalence of harm, then there is something that comes up." (Participant #7 – GP)*

Referral

In addition to the utilisation of an online screening form, one participant suggested that an instant referral which they can make online rather than a list of referrals would be helpful.

"…if there was an actual referral where I could actually refer someone straight online straightaway, that would probably be good." (Participant #1 – Community worker)

Subject

The screening tool that we use in this pilot project (PGSI Short-Form) has only been validated for adult populations. Therefore, in the implementation phase we limited the utilisation of the model for population over 18 years old who can provide consent to be asked questions. However, the fact is that despite the legal age of gambling being 18, The Growing Up In Australia Longitudinal Study of Australian Children (2018)[88] found that one in six 16-17 years old reported having gambled in the past year. Therefore, this group of population needs to be taken into consideration when screening for gambling harm. One participant reported that they notified a tendency for gambling among children, which is hidden in online games. They thus recommended that children should be included in the screening model in the future when the it has a chance to be scaled up.

"I want to mention something that is another kind of gambling, children gambling… Children sitting on the computer and playing games and some of these games offer to buy some weapons… or something like that. This is the tools of the game, it is starting to, for example, they sold it for $5 or $2 or $6 and sometimes they 've gone crazy for $100, or $200… In my opinion, it's the beginning of gambling and needs to take care all that for the future if you want to update the model or update the session. (Participant #2 – Community worker)

[88] Warren, D. and Yu, M., 7 Gambling activity among teenagers and their parents. *Growing Up In Australia*, p.69.

9. RECOMMENDATIONS

The current study presents key findings that should guide the design and implementation of the gambling harm screening model and future scaling of this model across NSW.

Recommendation 1

The screening model developed and piloted, was an effective model to screen for gambling harm in the Fairfield area. This model has the potential for scalability for GPs, community workers, and Regional Service Providers across NSW.

New screening programs should be carefully piloted and tailored to the local community prior to wide-scale implementation. We also recommend any future screening programs should be implemented in a staged approach, ensuring they are relevant for the local context. The findings of this study highlight the effectiveness of the screening model implementation.

Prior to this research, there was a gap in knowledge around the prevalence rates of gambling in the local area. While this pilot aimed to develop and test the screening tool in the Fairfield area, the high levels of gambling harm detected (60% after recoding) is vastly higher than would be expected from current prevalence studies. While the data collected in this study is from a non-random sample, these levels suggest a level of urgency for increased gambling harm screening in GP and social service settings across the state. These findings also raise important questions around whether current prevalence studies accurately capture the level of gambling harm experienced in NSW. This study highlights the need for local evidence that identifies the magnitude of harm, in order to support the allocation of resources to reduce and prevent gambling harm. Further research should identify gambling behaviours in the local context to better develop interventions that address gambling harm.

From 2021, the NSW Government is redesigning the way gambling support and treatment services are delivered in NSW to better meet the needs of the community which includes the establishment of Regional Service Providers (RSPs) who will coordinate localised delivery of a state-wide branded suite of support and education services[89]. The current pilot project may be supported through this approach and suggests that such programs can be linked in part to the regular communication led by a single organisation and project team (such as the PHN) to be scaled across the state. This approach aligns with the strategic direction the ORG has for the future of gambling support in NSW.

Key areas for scaling of the pilot study are considered as per the **process approach to scalability**:

1.1. Assess effectiveness (within the local context)

The model was effective, within the local context, in *identifying harm*; *educating local health professionals* and community service providers; and aiding *improved knowledge of gambling support referra*l options. It was also proven to be relatively quick to complete the screening – with an average time of 1 minute and 25 seconds. We do recognise that actual time attributable during an appointment to gambling harm screening may indeed be higher depending on the issues raised by the screening tool.

1.2. Assess potential reach and adoption (within the local context)

The pilot project showed the potential to *reach consumers*, via community workers and general practitioners, in the local context of Fairfield LGA. The tool was well adopted by community workers and GPs following consultation around tool development and training. Participant drop-out from the project was minimal. We believe reach and adoption was achieved in the pilot due to the *unique engagement and marketing capabilities* each partner organisation provided, i.e. SWSPHN and SWSLHD's ability to reach health professionals and Fairfield City Council 's ability to reach community workers. Additionally, the current project sought to engage with specific cultural groups in the Fairfield community, identified as at increased risk of harm. This engagement was done through consultations with community members and local workers and dissemination of resources in language. Future work should seek to

[89]NSW Government. 2020. Delivering The NSW Gambling Support And Treatment System. [online] Available at: <https://www.responsiblegambling.nsw.gov.au/__data/assets/pdf_file/0009/294642/ORG_Roadshow_Handout_v3_Hi-res_200313.PDF> [Accessed 22 September 2020].

evaluate the effectiveness of these strategies and validate the extent to which the screening model implemented can identify harm within different cultural communities.

1.3. Assess alignment with the strategic context

The Responsible Gambling Fund (RGF) Trustees play a key role in advising the NSW Government, through the Office of Responsible Gambling, on the allocation of funds for initiatives and programs that support responsible gambling and help reduce gambling-related harms. The screening model identifies harm, educates local health and community service providers and supports gambling support service referrals which all contribute to the reduction of gambling-related harms. As such, the screening model aligns with the strategic context.

Additionally, based on the findings from this pilot we recommend that Gambling Help services develop a warm referral pathway, and to publicise this pathway to local community service organisations and GPs. SWSPHN hosts a mental health intake services for its commissioned mental health services. Such a service provides GPs with immediate access to a referral pathway and clear instructions on required documentation for referral. A warm referral pathway would ensure support is as accessible as it can be.

1.4. Assess acceptability and feasibility

Discussed at length in 7.4, the screening model was acceptable and feasible based on qualitative data collected.

Recommendation 2

Community services are uniquely placed to implement the screening model.

This pilot identified that this model was easily implemented within community services. Community organisations in-take procedures offer a unique opportunity for gambling harm screening. Additionally, community services have existing relationships with community members, including understanding around cultural nuances and impacts of gambling harm.

A key consideration for future work is to ensure buy-in of the community service organisation's management. One participant (a community service worker) suggested that additional funding should be provided for gambling screening in community settings. However, we feel that the model developed can be very easily embedded in existing intake forms and procedures and, as such, should not warrant additional funding. Additional funding should be considered to provide resources and training to community workers to implement such screening into practice. Additionally, consideration of an amalgamated data pool reporting requirement should be undertaken (and funded) to support state-wide reporting on screening outcome measures (see *Recommendation 5*).

It is also important to note that the design of the tool and the online data entry were easily adopted by clinicians and community workers. Participants spoke highly of the process, stating that the tool supported workers to become more informed and aware of the gambling harms experienced by individuals in the local community, and subsequently raise these with their clients/ patients. In order to further support the implementation of this screening tool, we also recommend that PHN directories are modified to include referral pathways for gambling help. For example, in this study, the SWSPHN updated HealthPathway for problem gambling, accessed by GPs (every PHN has HealthPathways) to reflect referral options (including the Multicultural Problem Gambling Service for NSW). Additionally, if a PHN maintains a mental health service directory – (SWSPHN refers to it as Recovery Point, some PHN maintain a directory but some do not), "Gambling Support Services" should be a category with services, their contact details and referral options listed.

Recommendation 3

To improve GP uptake and ongoing usage, integration of the gambling screening model as part of or complementary to existing lifestyle screening or alcohol and other drugs screening (and thus embedded in practice software) is essential.

The engagement of GPs in the project was lower than expected. A factor may have been COVID-19 associated disruptions, but both our GP participants indicated that without regular reminders they would forget to consistently screen.

We recommend existing assessment tools used by health professionals could be used to benchmark screening for gambling harm in primary care. These assessment tools include:

- Smoking, Nutrition, Alcohol and Physical Activity (SNAP) assessment[90]
- Alcohol Use Disorders Identification Test – Consumption (AUDIT-C)[91]
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[92]
- Kessler 10 plus (K10+) measure of psychological distress[93]

These screening and assessment tools are already embedded within Practice Management Software (PMS) widely used by GPs such as Medical Director and Best Practice.

The fact that these tools are embedded makes it easier for GPs to access and complete them, recording results against clinical records. PHNs also have access to amalgamated reporting of mental health measures when recorded in this way which could support increased data collection regarding gambling harm in a secure, centralised data store (see Recommendation 5).

Recommendation 4

An indicative screening outcome based on patient responses would help guide interventions.

Based on the findings from this study, there is a need to provide automated gambling harm indicators to clinicians and health workers in real-time. We envisage that following the screening of a patient, an indicative screening result would be displayed to the community worker/health professional at the conclusion of screening. For example, if a client/patient answered anything other than No/Never to individual gambling screening questions an indicator would appear for staff that indicates harm was identified. This eliminates potential user errors or misclassification of patients. The option to override the indicative outcome would allow community workers/health professionals the opportunity to personalise the interaction and provide direct feedback.

To achieve this, a program/survey/collection tool with this functionality would need to be selected that provides this functionality.

Recommendation 5

A centralised data store of screening results across regions would better inform policy and local health needs assessments.

Our pilot identified higher than expected levels of harm however we do acknowledge the small sample size inherently associated with pilots. Indicative high levels of harm identified in this study signal the need to screen more and collect screening outcome data to inform local health needs assessments and thus inform policy decisions regarding harm minimisation, support service provision and education programs.

For primary health, our recommendation is that screening conducted by GPs be collected by PHNs as the mechanisms to amalgamate regionally already exist.

For community services, there may be scope to expand existing data collection procedures, normally reserved for ORG funded gambling support services, to capture screening outcomes.

---

[90] The Royal Australian College of General Practitioners, 2019. *Views and attitudes towards physical activity and nutrition counselling in general practice: National survey report 2019*. East Melbourne, Vic: RACGP, 2019.

[91] South Western Sydney Primary Health Network. Alcohol and Other Drugs. Accessed 10/08/20. URL: https://www.swsphn.com.au/alcoholandotherdrugs, SWSPHN, 2020.

[92] South Western Sydney Primary Health Network. Alcohol and Other Drugs. Accessed 10/08/20. URL: https://www.swsphn.com.au/alcoholandotherdrugs, SWSPHN, 2020.

[93] South Western Sydney Primary Health Network. Mental Health Programs. Accessed 22/09/20. URL: https://www.swsphn.com.au/client_images/1937808.pdf. SWSPHN, 2020.

REFERENCES

American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders: DSM-5*. Arlington, VA, American Psychiatric Association.

Arthur, D., Tong, W.L., Chen, C.P., Hing, A.Y., Sagara-Rosemeyer, M., Kua, E.H. and Ignacio, J., 2008. The validity and reliability of four measures of gambling behaviour in a sample of Singapore university students. *Journal of Gambling Studies*, 24(4), pp.451-462.

Australian Bureau of Statistics, 2016. *2016 Census QuickStats*: Fairfield (C). ABS, Canberra.

Australian Government Department of Health, 2018. Co-design in the PHN commissioning context. URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources

Australian Medical Association, 2013. *The Health Effects of Problem Gambling*. AMA Position Statement. URL: https://ama.com.au/position-statement/health-effects-problem-gambling-2013#:~:text=Patients%20with%20problem%20gambling%20often,physical%20and%20psychological%20ill%20health.&text=The%20adverse%20consequences%20of%20problem,distributed%20evenly%20across%20the%20population.

Blaszczynski, A., Huynh, S., Dumlao, V.J. and Farrell, E., 1998. Problem gambling within a Chinese speaking community. *Journal of Gambling Studies*, 14(4), pp.359-380.

Boldero, J.M. and Bell, R.C., 2012. An evaluation of the factor structure of the Problem Gambling Severity Index. *International Gambling Studies*, 12(1), pp.89-110.

Bowen, G.A., 2009. Document analysis as a qualitative research method. *Qualitative research journal*, 9(2), p.27.

Browne, M., Rockloff, M., Hing, N., Russell, A., Boyle, C. M. and Rawat, V., 2019. *NSW Gambling Survey*. NSW Responsible Gambling Fund (revised 2020).

Central Queensland University and Auckland University of Technology. 2017. Measuring the Burden of Gambling Harm in New Zealand. Wellington: Ministry of Health.

Browne, M., Langham, E., Rawat, V., Greer, N., Li, E., Rose, J., Rockloff, M., Donaldson, P., Thorne, H., Goodwin, B. and Bryden, G., 2016. *Assessing gambling-related harm in Victoria: A public health perspective*. Victorian Responsible Gambling Foundation.

Cowlishaw, S., Gale, L., Gregory, A., McCambridge, J. and Kessler, D., 2017. Gambling problems among patients in primary care: a cross-sectional study of general practices. *British Journal of General Practice*, 67(657), pp. e274-e279.

Dickins, M. and Thomas, A.C., 2016. Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre, Australian Institute of Family Studies.

Do, M., McCleary, J., Nguyen, D., & Winfrey, K., 2018. 2047 Mental illness public stigma, culture, and acculturation among Vietnamese Americans. *Journal of Clinical and Translational Science*, 2(S1), 17-19. doi:10.1017/cts.2018.93

Dowling, N.A., Merkouris, S.S., Dias, S., Rodda, S.N., Manning, V., Youssef, G.J., Lubman, D.I. and Volberg, R.A., 2019. The diagnostic accuracy of brief screening instruments for problem gambling: A systematic review and meta-analysis. *Clinical psychology review*, 74, p.101784.

Ferris, J.A. and Wynne, H.J., 2001. The Canadian problem gambling index (pp. 1-59). Ottawa, ON: Canadian Centre on Substance Abuse.

Gainsbury, S., Hing, N. and Suhonen, N., 2014. Professional help-seeking for gambling problems: Awareness, barriers and motivators for treatment. *Journal of Gambling Studies*, 30(2), pp.503-519.

Gaming Machines Amendment (Leasing and Assessment) Bill 2018 (Nsw)

Gebauer, L., LaBrie, R. and Shaffer, H.J., 2010. Optimizing DSM-IV-TR classification accuracy: A brief biosocial screen for detecting current gambling disorders among gamblers in the general household population. *The Canadian Journal of Psychiatry*, 55(2), pp.82-90.

Griffiths, M.D., 2006. A case study of binge problem gambling. *International Journal of Mental Health and Addiction*, 4(4), pp.369-376.

Grover, A., Kamins, M.A., Martin, I., Davis, S., Haws, K., Mirabito, A.M., Mukherjee, S., Pirouz, D.M. and Rapp, J., 2013. From use to abuse: When everyday consumption behaviours morph into addictive consumptive behaviours. Available at SSRN 2207025.

Hamid, A. and Furnham, A., 2013. Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture*, 16(7), pp.741-758.

Harrison, F., 2012. Gambling Awareness Survey 2012. NSW Multicultural Health Communication Service. URL: https://www.mhcs.health.nsw.gov.au/mhcs/services/campaign/pdf/problem-gambling2011-2012surveyreport.pdf

Harrison, G.W., Lau, M.I. and Ross, D., 2019. The risk of gambling problems in the general population: A reconsideration. *Journal of Gambling Studies*, pp.1-27.

Johnson, E.E., Hamer, R., Nora, R.M., Tan, B., Eisenstein, N. and Engelhart, C., 1997. The Lie/Bet Questionnaire for screening pathological gamblers. *Psychological reports*, 80(1), pp.83-88.

Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J. and Rockloff, M., 2016. Understanding gambling related harm: A proposed definition, conceptual framework, and taxonomy of harms. *BMC public health*, 16(1), p.80.

Latvala, T., Lintonen, T. and Konu, A., 2019. Public health effects of gambling–debate on a conceptual model. *BMC public health*, 19(1), p.1077.

Lesieur, H.R. and Blume, S.B., 1987. The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American journal of Psychiatry*, 144(9).

Liquor & Gaming NSW, 2020. *Gaming Machine Data*. https://www.liquorandgaming.nsw.gov.au/resources/gaming-machine-data.

Loo, J.M., Raylu, N. and Oei, T.P.S., 2008. Gambling among the Chinese: A comprehensive review. *Clinical Psychology Review*, 28(7), pp.1152-1166.

Manning, V., Dowling, N.A., Lee, S., Rodda, S., Garfield, J.B.B., Volberg, R., Kulkarni, J. and Lubman, D.I., 2017. Problem gambling and substance use in patients attending community mental health services. *Journal of Behavioral Addictions*, 6(4), pp.678-688.

Matua Raki National Addiction Workforce Development, 2011. Problem Gambling Screens: Concerned Others Gambling Screen (COGS). *Screening, Assessment and Evaluation: alcohol and other drug, smoking and gambling*, pp.40-41

Miller, H., 2015. *Background Paper: Risk Factors for Problem Gambling: Environmental, Geographic, Social, Cultural, Demographic, Socio-Economic, Family and Household*. Victorian Responsible Gambling Foundation.

Ministry of Health. 2019. *Preventing and Minimising Gambling Harm: Practitioner's Guide*. Wellington: Ministry of Health.

Neal, P., Delfabbro, P., & O'Neil, M., 2005. *Problem gambling and harm: Towards a national definition. Literature review.* Commissioned for the Ministerial Council on Gambling. Prepared by the SA Centre for Economic Studies with the Department of Psychology, University of Adelaide. November 2005.

NSW Government, 2020. Delivering The NSW Gambling Support And Treatment System. (online) Available at: <https://www.responsiblegambling.nsw.gov.au/__data/assets/pdf_file/0009/294642/ORG_Roadshow_Handout_v3_Hi-res_200313.PDF>. Accessed 22/09/20

Oei, T.P. and Raylu, N., 2007. *Gambling and problem gambling among the Chinese*. Brisbane: School of Psychology, University of Queensland.

Pasternak IV, A.V. and Fleming, M.F., 1999. Prevalence of gambling disorders in a primary care setting. *Archives of Family Medicine*, 8(6), p.515.

Productivity Commission, 2010, *Gambling*, Report no. 50, Canberra.

Rossen, F., 2015. *Gambling and problem gambling: results of the 2011/12 New Zealand Health Survey*. UniServices.

Sandelowski, M., 1995. Triangles and crystals: On the geometry of qualitative research. *Research in Nursing & Health*, 18(6), pp.569-574.

Scull, S. and Woolcock, G., 2005. Problem gambling in non-English speaking background communities in Queensland, Australia: A qualitative exploration. *International Gambling Studies*, 5(1), pp.29-44.

Sekhon, M., Cartwright, M. and Francis, J.J., 2017. Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC health services research*, 17(1), pp.1-13.

South Western Sydney Primary Health Network. Alcohol and Other Drugs. Accessed 10/08/20. URL: https://www.swsphn.com.au/alcoholandotherdrugs, SWSPHN, 2020.

South Western Sydney Primary Health Network. Mental Health Programs. Accessed 22/09/20. URL: https://www.swsphn.com.au/client_images/1937808.pdf. SWSPHN, 2020.

Sproston, K., Hing, N. and Palankay, C., 2012. *Prevalence of gambling and problem gambling in New South Wales*. Sydney: NSW Office of Liquor, Gaming and Racing.

Sullivan S, McCormick R, Lamont R and Penfold A. 2007. Problem gambling: patients affected by their own or another's gambling may approve of help from GPs. *New Zealand Medical Journal*, 120:1257

Svetieva, E. and Walker, M., 2008. Inconsistency between concept and measurement: the Canadian Problem Gambling Index (CPGI). *Journal of Gambling Issues*, (22), pp.157-173.

The Royal Australian College of General Practitioners, 2019. *Views and attitudes towards physical activity and nutrition counselling in general practice: National survey report 2019*. East Melbourne, Vic: RACGP, 2019.

Thomas, S.L. and Thomas, S.D., 2015. The big gamble: the need for a comprehensive research approach to understanding the causes and consequences of gambling harm in Australia. *Australasian Epidemiologist*, 22(1), p.39.

Toce-Gerstein, M., Gerstein, D.R. and Volberg, R.A., 2009. The NODS–CLiP: A rapid screen for adult pathological and problem gambling. *Journal of Gambling Studies*, 25(4), p.541.

Victorian Casino and Gaming Authority, 2000. *The impact of gaming on specific cultural groups report*. Melbourne: Cultural Partners Australia Consortium.

Victorian Responsible Gambling Foundation, 2019. *Cross-sector collaboration*. URL: https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/cross-sector-collaboration/

Volberg, R.A. and Williams, R.J., 2011. *Developing a brief problem gambling screen using clinically validated samples of at-risk, problem and pathological gamblers*. Health Sciences.

Wardle, H., Moody, A., Griffiths, M., Orford, J. and Volberg, R., 2011. Defining the online gambler and patterns of behaviour integration: Evidence from the British Gambling Prevalence Survey 2010. *International Gambling Studies*, 11(3), pp.339-356.

Wardle, H., Reith, G., Langham, E. and Rogers, R.D., 2019. Gambling and public health: we need policy action to prevent harm. *Bmj*, 365.

Warren, D. and Yu, M., 7 Gambling activity among teenagers and their parents. *Growing Up In Australia*, p.69.

Welte, J.W., Barnes, G.M., Tidwell, M.C.O. and Hoffman, J.H., 2011. Gambling and problem gambling across the lifespan. *Journal of Gambling Studies*, 27(1), pp.49-61.

Wenzel, M., McMillen, J., Marshall, D. and Ahmed, E., 2007. *Validation of the Victorian gambling screen*. Gambling Research Panel, Melbourne.

Williams, R.J. and Volberg, R.A., 2012. *Developing a short form of the PGSI: report to the Gambling Commission.* Gambling Commission.

Training & Resource Kit

Gambling Harm Screening and Referral for GPs and Community Workers

TABLE OF CONTENTS

Introduction 3

Screening and Referral Model 4

SCREENING – Gambling Harm Screen Form

English 5
Arabic 7
Assyrian 9
Vietnamese 11

REFERRAL – Directory of local gambling services and programs 13

Information session – slides 28

Receptionist script 41

Posters

GP setting

English 43
Arabic 44
Assyrian 45
Vietnamese 46

Community setting

English 48
Arabic 49
Assyrian 50
Vietnamese 51

Consumer flyer

English 53
Arabic 54
Assyrian 55
Vietnamese 56

Consumer factsheet

English 58
Arabic 60
Assyrian 62
Vietnamese 64
Simplified Chinese 66

GP-SPECIFIC RESOURCES

SWSPHN Mental Health Programs 69

INTRODUCTION

DEVELOP AN INTEGRATED MODEL FOR GAMBLING HELP SCREENING AND REFERRAL IN THE FAIRFIELD LGA THAT IS SCALABLE ACROSS NSW

The Fairfield City Health Alliance has been funded by the NSW Government to develop and implement a screening and referral model. This will identify people affected by gambling harm and connect them to support.

In our preliminary study, we conducted a co-design process which involved a wide range of activities with the participation of approximately 150 multi-stakeholders. Several recommendations in relation to screening tool questions, screening processes, referral options, and cultural sensitivities for Arabic, Assyrian and Vietnamese communities have been incorporated in the proposed screening and referral model.

The purpose of the **Gambling Harm Screening & Referral Resource Kit** is to facilitate the implementation of the model within general practice and community services. Contents of the resource kit include:

- **Screening and Referral Model (flowchart)** with specific steps of implementation
- **Gambling Harm Screen Form** in English and translated versions into Arabic, Assyrian and Vietnamese because they are main community languages in Fairfield which was the pilot location
- **Referral directory** of available gambling harm support/treatment services
- **Information session (slides)**: to inform the implementation process
- **Receptionist script**: to support the involvement of receptionists at practices/services
- **Posters**: to be displayed at waiting rooms and create a friendly environment for gambling harm discussion
- **Consumer flyers & factsheet**: to be handed out to consumers after screening

This project is funded under the 2018 Responsible Gambling Grants Program.

GAMBLING HARM SCREENING FLOW CHART

If screening tool will be utilised pre-appointment
Q1 - Did you complete the Gambling Harm Screen?

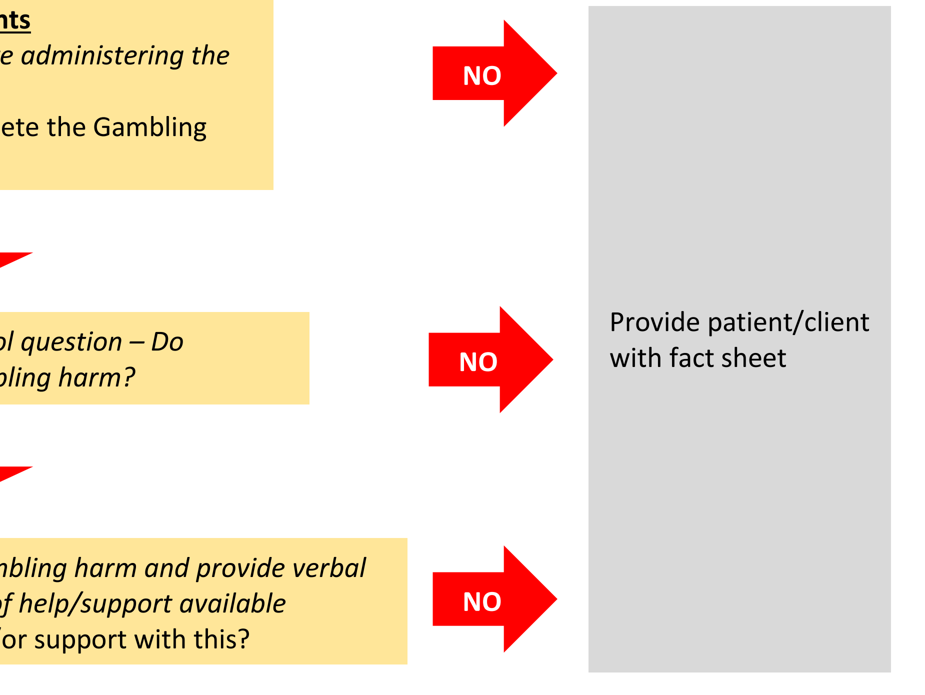
If screening tool will be utilised during appointments
Provide a brief preamble before administering the Gambling Harm Screen form
Q1b - Would you like to complete the Gambling Harm Screen now?

Review responses to screening tool question – Do responses indicate potential gambling harm?

Explain responses indicate potential gambling harm and provide verbal information, including the types of help/support available
Q2 – Would you like help and/or support with this?

Provide support/assist with referral and provide patient fact sheet.

If patient/client consents, link them to a gambling service for direct follow-up.



Gambling Harm Screen

We are asking everyone in the community about gambling harm. This is because gambling harm is an issue in the local area and affects people's health and wellbeing and can be serious. Gambling problems are often hidden for many years but there is a lot of help for people who may be experiencing gambling harm or who may be affected by someone else's gambling.

Answers to these questions or what you say is kept confidential and used for health purposes only. Information about your gender, cultural background and screening result will be collected in a de-identified way for research purposes and will not be shared with any third party.

You don't have to answer the questions if you don't want to. If you answer these questions, your GP or a community worker will discuss these questions with you during your appointment.

1. Have you ever gambled?
   ❑ Yes – *Go to question 2*
   ❑ No – *Go to question 5*

To help us identify if this is affecting your own well-being could you answer the questions below to the best of your ability.

Thinking about the last 12 months,

2. Have you bet more than you could really afford to lose?
   ❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost Always

3. Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
   ❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost Always

4. Have you felt guilty about the way you gamble or what happens when you gamble?
   ❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost Always

Sometimes someone else's gambling can affect the health and well-being of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting. To help us identify if this is affecting your own well-being could you answer the questions below to the best of your ability.

5. Do you think you have ever been affected by someone else's gambling?
   - ❑ No, never *(you need not continue further)*
   - ❑ I don't know for sure if their gambling affected me
   - ❑ Yes, in the past
   - ❑ Yes, that's happening to me now

6. How would you describe the effect of that person's gambling on you now? *(tick one or more if they apply to you)*
   - ❑ I worry about it sometimes
   - ❑ It is affecting my health
   - ❑ It is hard to talk with anyone about it
   - ❑ I am concerned about my or my family's safety
   - ❑ I'm still paying for it financially
   - ❑ It doesn't affect me anymore

7. What would you like to happen? *(tick one or more)*
   - ❑ I would like some information
   - ❑ I would like to talk about it in confidence with someone
   - ❑ I would like some support or help
   - ❑ Nothing at this stage

Thank you for completing these questions. We are providing everyone with an information pack which includes information about gambling support services and programs.

PATIENT/CLIENT INFORMATION

Please tick the appropriate box:

1. Your gender? ❑ Male ❑ Female ❑ Other
2. Your cultural background? ❑ Aboriginal and Torres Strait Islander
   ❑ Arabic ❑ Assyrian ❑ Vietnamese
   ❑ Other (please specify): ___________________________

OFFICE USE ONLY

Result:

3. Completed questionnaire? ❑ Yes ❑ No, specify reason:______________________________
4. Gambling harm identified? ❑ Yes – individual ❑ Yes – affected other ❑ No risk
5. Actions? ❑ No action ❑ Information provided
   ❑ Referral to gambling service (please specify):_________________
   ❑ Other (please specify):____________________________________

Comments (optional):

شاشة أضرار المقامرة

نقوم بطرح الأسئلة على كل الأهالي عن أضرار المقامرة. وذلك لأن الضرر الناجم عن المقامرة يعتبر مشكلة في منطقتنا ويؤثر على صحة الناس ورفاههم ومن شأنه أن يكون بالغًا. بالرغم من أن مشكلات المقامرة قد تستمر مخفية لسنوات عديدة في أحيان كثيرة إلا أن هناك الكثير من المساعدة المتاحة للمتضررين من ممارستهم أو ممارسة غيرهم للقمار.

يتم الاحتفاظ بسرية الإجابات على هذه الأسئلة وأقوالك واستخدامها لأغراض الرعاية الصحية فقط. سيتم جمع المعلومات حول نوعك الاجتماعي وخلفيتك الثقافية ونتائج الفحص لأغراض الدراسة وبطريقة لا تحدد هويتك ولن يتم التشارك بها مع أي جهة أخرى.

لست مضطرًا للإجابة على الأسئلة إذا لم ترغب في ذلك. فإذا أجبت عليها سيناقشها معك طبيبك أو أحد الأخصائيين الاجتماعيين أثناء مقابلتك.

1. هل سبق لك ولعبت القمار؟
   - ❑ نعم - انتقل إلى السؤال 2
   - ❑ لا - انتقل إلى السؤال 5

لمساعدتنا في تحديد ما إذا كان هذا يؤثر على رفاهك نرجو منك الإجابة على الأسئلة أدناه على قدر استطاعتك.

خلال الأشهر الاثنا عشر الأخيرة:

2. هل راهنت بأكثر مما يمكن أن تتحمل خسارته؟
   ❑ أبدا ☐ أحيانا ☐ معظم الوقت ☐ في أغلب الأوقات

3. هل انتقد الآخرون مراهنتك أو أخبروك أنك مدمن للقمار، بغض النظر عما إذا كنت تعتقد أنهم محقون في ذلك أم لا؟
   ❑ أبدا ☐ أحيانا ☐ معظم الوقت ☐ في أغلب الأوقات

4. هل شعرت بالذنب بسبب طريقة لعبك القمار أو بسبب ما يحدث عندما تقامر؟
   ❑ أبدا ☐ أحيانا ☐ معظم الوقت ☐ في أغلب الأوقات

في بعض الأحيان قد تؤثر المقامرة التي يمارسها شخص ما على صحة ورفاهية آخرين قد يكونون قلقين بشأنه. غالبًا ما يكون سلوك المقامر مخفيًا وغير متوقع، في حين تكون آثاره مربكة ومرهقة وطويلة الأمد. لمساعدتنا في تحديد إن كان هذا يؤثر على رفاهك نرجو منك الإجابة على الأسئلة أدناه على قدر استطاعتك.

5. هل تعتقد أنه سبق لك وتأثرت بممارسة شخص آخر للمقامرة؟
   - ❑ لا ، أبدًا (لا تحتاج إلى الاستمرار في الإجابة)
   - ❑ لست متأكدًا إن كانت مقامرته قد أثرت علي
   - ❑ نعم، في الماضي
   - ❑ نعم، حاليا

6. كيف تصف تأثير مقامرة ذلك الشخص عليك الآن؟ (ضع علامة واحدة أو أكثر على الإجابات التي تنطبق عليك)
   - ❑ أقلق بشأن الأمر أحيانًا
   - ❑ يؤثر الأمر على صحتي
   - ❑ من الصعب التحدث مع أي شخص حول هذا الموضوع
   - ❑ أنا قلق بشأن سلامتي أو سلامة عائلتي
   - ❑ ما زلت أدفع ثمنها ماليا
   - ❑ لم يعد الأمر يؤثر علي

7. ماذا تود أن يحدث؟ (ضع علامة على إجابة أو أكثر)
   - ❑ أود الحصول على بعض المعلومات
   - ❑ أود التحدث عن الأمر بسرية مع أحدهم
   - ❑ أود الحصول على بعض الدعم أو المساعدة
   - ❑ لا شيء في هذه المرحلة

نشكرك على إكمال الاستبيان. نحن نقدم لكل شخص رزمة معلومات حول خدمات وبرامج دعم المقامرين.

معلومات هامة للمرضى/العملاء

الرجاء وضع علامة على الخانة المناسبة:

1. ما هو نوعك الاجتماعي؟ ❑ ذكر ☐ أنثى ☐ أخر
2. خلفياتك الثقافية؟ ❑من السكان الأصليين وسكان جزر مضيق توريز
   ❑ عربي ☐ آشوري ☐ فيتنامي
   ❑ لا يوجد ☐ أخرى (يرجى التحديد): _ ______________________________

OFFICE USE ONLY

Result:

3. Completed questionnaire? ❑ Yes ❑ No, specify reason:________________________________
4. Gambling harm identified? ❑ Yes – individual ❑ Yes – affected other ❑ No risk
5. Actions? ❑ No action ❑ Information provided
   ❑ Referral to gambling service (please specify):__________________
   ❑ Other (please specify):____
   ❑

Comments (optional):

ܦܪ̈ܫܝ ܡܬܠܐ ܕܣܘܪܕܟܐ
ܕܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ

ܐܲܣܢܝ ܟܡܘܙܐ ܡܘܕ ܓܡ ܚܠ ܢܕ ܦܢܝ ܗܩܐ ܠܗ ܠܡܘܥܬܠܐ ܠܘܬ ܣܘܪܕܟܐ ܕܬܟܼܠܬܐ ܩܘܡܪ̈ܐ. ܟܡܟܝܡ ܡܘܕ ܐܗܐ ܟܝܕܝ ܠܗܝ ܕܣܘܪܕܟܐ ܕܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ ܢܕ ܝܠܬܐ ܝܠܗ ܠܗ ܐܢܬܐ ܕܘܟܠܬܐ ܦܢܝܠܬܐ ܕܟܝܘܪܐ ܝܠܗ ܩܐ ܣܘܠܚܢܐ ܘܬܟܘܬܐ ܕܢܝܫܐ ܕܐܢܫܐ ܘܚܝ̈ ܢܐ ܕܩܘܐ ܢܕ ܝܠܬܐ ܦܥܢܐ. ܐܢܐ ܠܟܫܐ ܝܠܬܐ ܕܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ ܟܐ ܗܘܝ ܠܥܢܝܐ ܩܐ ܐܢܐ ܥܝܢܐ، ܐܝܬܐ ܬܠܐ ܐܝܬ ܐܢܐ ܦܢܘܬܐ ܩܐ ܐܢܝ ܐܢܫܐ ܕܟܠܟܐ ܗܘܝ ܡܢܗܘܝܐ ܣܘܪܕܟܐ ܕܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ ܡܢ ܐܢܝ ܕܦܝܫܐ ܡܢܐ ܠܘ ܠܟܝܐ ܠܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ ܕܢܕ ܦܢܝ ܗܩܐ ܐܝܢܐ.

ܠܘܩܝܐ ܩܐ ܐܢܝܐ ܠܘܩܪ̈ܐ ܡܢ ܚܠ ܟܝܕܝ ܕܐܡܪܝܬܘܢ ܠܗ ܟܕ ܩܥܪ ܡܣܘܡܝܐ ܐܬܪ̈ܐܝܬ ܘܡܘܦܠܝܢܐ ܐܢܫܝ ܩܐ ܢܝܫܐ ܕܣܘܠܚܢܐ. ܟܡܕܟܢܘܬܐ ܠܘܬ ܠܫܩܘܡܟܘܢ ܘܠܘܬ ܟܬܪ̈ܘܬܘܟܘܢ ܟܬܕܘܬܢܬܐ ܘܠܘܬ ܦܠܚܐ ܕܦܪ̈ܫܝ ܡܬܠܐ ܟܕ ܩܥܫܐ ܡܘܦܥܬܐ ܠܣܕܐ ܐܘܪܢܐ ܕܝܠܗ ܡܟܠܢܐ ܠܗ ܡܢܝܘܬܘܟܘܢ (ܡܘܢܘܟܘܢ) ܘܟܕ ܩܥܫܐ ܠܘܦܠܝܚܬܐ ܩܐ ܢܝܫܐ ܕܠܘܪ̈ܝ ܐܢܐ ܘܝܠܗ ܟܕ ܩܥܫܐ ܡܘܟܢܬܐ ܩܐ ܐܢܦܢܕ ܠܝܟܐ ܐܝܢܐ.

ܠܝܬ ܢܝܠܐ ܟܠܘܟܘܢ ܕܠܘܡܝܬܘܢ ܠܗܘܢ ܠܘܩܪ̈ܐ ܟܝ ܠܐ ܡܬܘܢ ܟܡܢܐ ܗܕܟܐ ܠܟܬܪ̈ܐ. ܟܝ ܠܘܡܝܬܘܢ ܠܗܘܢ ܐܢܝܐ ܠܘܩܪ̈ܐ، ܐܗܡܘܟܘܢ ܠܟܘܢܐ ܡܢ ܢܕ ܩܠܢܐ ܕܡܘܥܬܐ ܟܕ ܕܪܥܝܠܗܘܢ ܐܢܝܐ ܠܘܩܪ̈ܐ ܟܬܘܟܘܢ ܠܟܠܢܐ ܕܟܕܢܐ ܕܦܬܘܟܘܢ.

1. ܗܝܢ ܠܡܐܠܐ ܡܬܘܢ ܩܘܡܪ̈ܐ؟ ❑ ܗܐ – ܙܕܥܘܢ ܠܚܘܩܪ̈ܐ ܕ 2 ❑ ܠܐ – ܙܕܥܘܢ ܠܚܘܩܪ̈ܐ ܕ 5

ܗܕܟܐ ܕܟܝ̈ ܕ ܕܪܥܝܢ ܟܝ ܐܢܬܐ ܟܡܟܬܐ ܬܠܗ ܐܢܐ ܟܠ ܬܟܘܬܐ ܕܢܝܫܐ ܕܟܬܘܟܘܢ، ܗܝ ܝܬܘܢ ܕܠܘܡܝܬܘܢ ܠܗܘܢ ܠܘܩܪ̈ܐ ܕܐܝܠܝܬ ܐܢܫ ܗܝ̈ ܬܘܟܘܢ.

ܟܕ ܦܣܘܡܝܐ ܠܘܬ 12 ܝܪ̈ܚܐ ܟܡܟܬܐ، 2. ܗܝܢ ܗܘܝܬܐ ܬܠܗ ܕܬܐܠܐ ܡܬܘܢ ܩܘܡܪ̈ܐ ܕܣܕܐ ܠܚܘܕܬܐ ܕܟܘܥ ܐܘܕܐ ܡܘܩܐ ܟܡ ܕܦܪܙܐܝܬ ܐܝܬ ܗܘܐ ܠܗ ܗܝ̈ ܬܘܟܘܢ ܠܝܣܩܪ̈ܐ؟ ❑ ܠܝܡ ܟܕܢܐ ❑ ܢܝܚܘܬܐ ܠܟܫܐ ❑ ܠܦܘܣܐ ܐܘܕܐ ܕܟܕܢܐ ❑ ܢܝܩܐ ܩܥܫܐ ܦܬܚܐ 3. ܗܝܢ ܗܘܝܬܐ ܬܠܗ ܕܐܢܫܐ ܠܘܝܢܘܗ ܡܢܐ (ܠܟܝܬܘܗ ܡܢܐ ܢܡܪ) ܠܬܟܼܠܬܘܟܘܢ ܕܩܘܡܪ̈ܐ ܡܢ ܐܡܢܘܟܘܢ ܡܢܐ ܕܐܝܬܠܘܟܘܢ ܢܕ ܝܠܬܐ ܕܬܟܼܠܬܐ ܕܩܘܡܪ̈ܐ، ܐܗܦܝ ܕܐܢܫܝܬܘܢ ܣܥܝܟܠܘܟܘܢ ܕܐܗܐ ܢܕ ܥܪ̈ܝܐ ܡܘܩܐ ܡܢ ܠܐ ܡܘܩܐ ܢܕ ܥܪ̈ܝܐ؟ ❑ ܠܝܡ ܟܕܢܐ ❑ ܢܝܚܘܬܐ ܠܟܫܐ ❑ ܠܦܘܣܐ ܐܘܕܐ ܕܟܕܢܐ ❑ ܢܝܩܐ ܩܥܫܐ ܦܬܚܐ 4. ܗܝܢ ܗܘܝܬܐ ܬܠܗ ܕܪ ܠܟܝܫܐ ܡܬܘܢ ܬܪܝܐ ܠܟܢܐ ܠܘܬ ܐܘܪܢܐ ܕܝܐ ܠܬܠܝܬܘܢ ܩܘܡܪ̈ܐ ܡܢ ܠܡܕܝ ܦܘܘܟܐ ܝܠܗ ܐܝܟܝ ܕܬܐܠܝܐ ܡܬܘܢ ܩܘܡܪ̈ܐ؟

ܢܵܫܹ̈ܐ ܟܲܕܘܼܝܵܐ ܡܫܟܠܬܐ ܕܩܘܡܪ ܕܚܕ ܦܪܨܘܦܐ ܟܡܐ ܕܟܒܝܪܐ ܒܐܪ ܥܠ ܚܘܠܡܢܐ ܘܡܫܟܠܬܐ ܕܒܝܬܐ ܕܐܚܪ̈ܢܐ ܐܚܪܢܐ ܕܐܝܬܠܗܘܢ ܝܘܕܥܐ ܥܡ ܡܫܟܠܬܐ ܕܩܘܡܪ. ܣܓܝܐ ܕܡܫܟܠܬܐ ܕܩܘܡܪ ܢܫܐ ܟܕܝܐ ܡܫܟܠܐ ܡܢܐ ܘܠܐ ܡܚܙܝܐ، ܒܪ ܐܢܫܘܬܐ، ܟܡܐ ܕܗܘܐ ܡܫܟܠܢܐ ܘܡܫܝܚܢܐ ܕܠܒܐ ܘܦܫܝܢܐ ܦܐ ܚܕ ܙܒܢܐ ܢܒܟܐ. ܠܗܘܢ ܠܐܚܢܐ ܡܢ ܐܚܪܐ ܡܚܒܪܐ ܝܠܗ ܐܝܟ ܥܠ ܡܫܟܠܬܐ ܕܒܝܬܐ ܕܐܚܘܢܗܘܢ، ܡܢ ܡܫܟܠܗܘܢ ܟܘܪܗܘܢ ܠܗܘܢ ܒܘܦܪܐ ܕܐܝܬܠܗ ܐܢܫ ܡܢܝ ܡܬܘܒܘܢ.

5. ܡܢܝ ܡܘܬܐ ܠܗ ܕܡܫܟܠܬܐ ܕܩܘܡܪ ܕܚܕ ܦܪܨܘܦܐ ܐܚܪܢܐ ܒܒܝܬܐ ܠܗ ܐܝܟ ܟܠܗܘܢ؟
- ❑ ܠܐ، ܒܒܝܬ ܝܪܚܐ (ܡܢ ܝܠܗܘܢ ܕܟܠܝܠܗܘܢ ܠܐܒܐ)
- ❑ ܠܐ ܗܘܢ ܢܫܝܬܐ (ܐܒܝܬܐ) ܡܢ ܡܫܟܠܬܗ ܕܩܘܡܪ ܒܒܝܬܐ ܠܗ ܐܝܟ ܟܠܝ
- ❑ ܐܝܢ، ܒܙܒܢܐ
- ❑ ܐܝܢ، ܐܚܪܐ ܝܘܡܝ ܦܘܪܣܐ ܝܠܗ ܟܠܝ ܗܕܝܐ

6. ܕܐܝܟ ܒܪ ܦܣܩܬܘܢ ܝܠܗ ܐܝܟ ܕܡܫܟܠܬܐ ܕܩܘܡܪ ܕܗܘ ܦܪܨܘܦܐ ܟܠܗܘܢ ܗܕܝܐ؟
(ܡܬܒܘܢ ܦܘܫܡܐ ܕܬܪܝܢ √ ܠܒܝܬ ܙܒܪܐ ܒܝ ܚܕ ܟܘܦܐ ܡܢ ܒܠܫܢܐ ܠܗ ܐܠܗܘܢ)
- ❑ ܒܐ ܡܫܚܝܢ ܒܗܘܬ ܕܚܕ ܢܫܘܬܐ ܟܕܘܝܐ
- ❑ ܒܒܝܬܐ ܠܗ ܐܝܟ ܥܠ ܚܘܠܡܢܝ
- ❑ ܡܫܟܐ ܠܗ ܠܡܬܘܒܐ ܥܡ ܐܚܪܢܐ ܒܗܘܬ ܐܚܪܐ ܝܘܡܝ
- ❑ ܒܕܪܒܐ ܗܘܢ ܒܗܘܬ ܦܣܩܬܐ ܕܟܠܝ ܡܢ ܕܡܬܒܘܬܝ
- ❑ ܠܗܠܐ ܦܪܒܐ ܗܘܢ ܐܠܗ ܒܡܫܟܢܝܬ
- ❑ ܐܚܪܢܐ ܠܐ ܠܗ ܒܒܝܬܐ ܐܝܟ ܟܠܝ

7. ܡܢܝ ܒܡܚܝܢܐ ܝܠܗܘܢ ܕܗܘܝܐ؟ (ܡܬܒܘܢ ܦܘܫܡܐ ܕܬܪܝܢ √ ܠܒܝܬ ܚܕ ܡܢ ܒܝܬ ܙܒܪܐ)
- ❑ ܒܡܚܝܢܐ ܗܘܢ ܕܦܟܠܝ ܢܫܘܬܐ ܡܥܠܘܡܘܬܐ
- ❑ ܒܡܚܝܢܐ ܗܘܢ ܕܡܚܝܒ ܐܚܪܢܝܬ ܒܗܘܬ ܐܚܪܐ ܝܘܡܝ ܥܡ ܚܕ ܦܪܨܘܦܐ
- ❑ ܒܡܚܝܢܐ ܗܘܢ ܕܦܟܠܝ ܡܕܪܬܐ ܡܢ ܡܕܪܬܐ
- ❑ ܠܐ ܗܘܢ ܡܣܝܩܐ ܠܚܕ ܝܘܡܝ ܦܐ ܗܕܝܐ

ܡܘܬܘܢ ܡܫܝܚܐ ܦܐ ܡܫܟܠܬܐ ܕܐܝܟ ܒܘܦܪܐ. ܐܝܢ ܡܫܘܚܐ ܗܘܕ ܣܪܐ ܡܥܠܘܡܬܐ ܕܡܥܠܘܡܘܬܐ ܦܐ ܟܠ ܚܕ ܦܪܨܘܦܐ. ܡܥܠܘܡܬܐ ܒܣܓܝܐ ܠܗ ܡܥܠܘܡܘܬܐ ܒܗܘܬ ܝܠܡܕܬܐ ܘܣܘܪܝܐ ܕܡܕܪܬܐ ܕܡܫܟܠܬܐ ܕܩܘܡܪ.

<u>ܡܥܠܘܡܘܬܐ ܕܡܦܪܢܐ\ܕܬܚܘܝܬܐ</u>

ܡܢ ܡܫܟܐ ܠܗܘܢ ܡܬܒܘܢ ܦܘܫܡܐ ܕܬܪܝܢ √ ܐܝܟܐ ܕܒܠܫܢܐ ܠܗ:

1. ܒܫܢܘܬܘܢ؟ ❑ ܐܘܪܐ ❑ ܝܡܢܐ ❑ ܐܚܪܢܐ
2. ܡܬܪܘܬܘܢ ܡܕܘܬܢܝܬܐ؟ ❑ ܥܪܒܢܐ ܐܝܟ ܠܐܐ ܘܥܪܒܢܐ ܕܐܪܡܝܬܐ ܕܐܘܪܚܝܬܐ ܕܬܘܪܝܐ
   ❑ ܡܪܒܢܐ ❑ ܐܬܘܪܝܐ ❑ ܒܝܬܢܚܪܝܐ
   ❑ ܐܦܠܐ ܚܕ ❑ ܐܚܪܢܐ (ܡܢ ܡܫܟܐ ܠܗܘܢ ܕܥܘܡܘܢ):____________________

<u>OFFICE USE ONLY</u>

Result:

3. Completed questionnaire? ❑ Yes ❑ No, specify reason:______________________________
4. Gambling harm identified? ❑ Yes – individual ❑ Yes – affected other ❑ No risk
5. Actions? ❑ No action ❑ Information provided
   ❑ Referral to gambling service (please specify):_________________
   ❑ Other (please specify):_____________________________________

Comments (optional):

Sàng Lọc Về Tác Hại Của Cờ Bạc

Chúng tôi đang hỏi tất cả mọi người trong cộng đồng về tác hại của cờ bạc. Lý do là vì tác hại của cờ bạc là một vấn đề tại khu vực địa phương và nó ảnh hưởng đến sức khỏe cùng sự an vui của người dân và có thể ở mức độ nghiêm trọng. Những vấn đề liên quan đến cờ bạc thường tiềm ẩn trong nhiều năm nhưng có rất nhiều sự giúp đỡ dành cho những người có thể gặp phải tác hại của cờ bạc hoặc những người có thể bị ảnh hưởng bởi người khác đánh bạc.

Câu trả lời cho những câu hỏi này hoặc những gì bạn nói sẽ được bảo mật và chỉ được sử dụng vì mục đích sức khỏe. Thông tin về giới tính, lai lịch văn hóa và kết quả sàng lọc của bạn sẽ được thu thập theo cách không được xác định cho mục đích nghiên cứu và sẽ không được chia sẻ với bất kỳ bên thứ ba nào.

Bạn không phải trả lời những câu hỏi nếu bạn không muốn. Nếu bạn trả lời những câu hỏi này, bác sĩ gia đình của bạn hoặc một nhân viên cộng đồng sẽ thảo luận với bạn về những câu hỏi này trong cuộc hẹn với bạn.

1. Bạn đã bao giờ chơi cờ bạc chưa?
   - ❑ Đã – *Chuyển sang câu hỏi số 2*
   - ❑ Chưa – *Chuyển sang câu hỏi số 5*

Để giúp chúng tôi xác định xem điều này có ảnh hưởng đến sự an vui của chính bạn không, bạn có thể trả lời những câu hỏi dưới đây với khả năng tốt nhất của bạn không.

Hãy suy nghĩ về 12 tháng qua,

2. Bạn đã đặt cược nhiều hơn bạn có thể thực sự đủ khả năng để thua?
   ❑ Không bao giờ ❑ Đôi lúc ❑ Hầu như mọi lúc ❑ Gần như luôn luôn

3. Mọi người đã chỉ trích việc cá cược của bạn hoặc nói với bạn rằng bạn có vấn đề về đánh bạc, bất kể bạn có nghĩ đó là sự thật hay không?
   ❑ Không bao giờ ❑ Đôi lúc ❑ Hầu như mọi lúc ❑ Gần như luôn luôn

4. Bạn có cảm thấy tội lỗi về cách bạn chơi cờ bạc hoặc về điều gì sẽ xảy ra khi bạn chơi cờ bạc?
   ❑ Không bao giờ ❑ Đôi lúc ❑ Hầu như mọi lúc ❑ Gần như luôn luôn

Đôi khi, việc một người khác chơi cờ bạc có thể ảnh hưởng đến sức khỏe và sự an vui của những người khác có thể có lo ngại. Hành vi chơi cờ bạc thường tiềm ẩn và không ngờ tới, trong khi những ảnh hưởng của nó có thể khó hiểu, căng thẳng và lâu dài. Để giúp chúng tôi xác định xem điều này có ảnh hưởng đến sự an vui của chính bạn không, bạn có thể trả lời những câu hỏi dưới đây với khả năng tốt nhất của bạn không.

5. Bạn có nghĩ rằng bạn đã từng bị ảnh hưởng bởi người khác cờ bạc không?
   - ❑ Không, không bao giờ *(bạn không cần tiếp tục nữa)*
   - ❑ Tôi không biết chắc rằng việc cờ bạc của họ có ảnh hưởng đến tôi không
   - ❑ Có, trong quá khứ
   - ❑ Vâng, điều đó xảy ra với tôi bây giờ

6. Bạn sẽ mô tả việc người đó cờ bạc có ảnh hưởng đến bạn bây giờ như thế nào? *(đánh dấu một hoặc nhiều ô nếu áp dụng với bạn)*
   - ❑ Đôi khi tôi lo lắng về điều đó
   - ❑ Điều đó đang ảnh hưởng đến sức khỏe của tôi
   - ❑ Thật khó để nói chuyện với bất kỳ ai về điều đó
   - ❑ Tôi lo lắng cho sự an toàn của tôi hoặc gia đình tôi
   - ❑ Tôi vẫn đang trả cho điều đó về mặt tài chính
   - ❑ Điều đó không ảnh hưởng đến tôi nữa

7. Bạn muốn điều gì xảy ra? *(đánh dấu một hoặc nhiều ô)*
   - ❑ Tôi muốn có một số thông tin
   - ❑ Tôi muốn nói chuyện về điều đó riêng với ai đó
   - ❑ Tôi muốn được hỗ trợ hoặc giúp đỡ
   - ❑ Không có gì ở giai đoạn này

Cảm ơn bạn đã trả lời những câu hỏi này. Chúng tôi sẽ cung cấp cho mọi người gói thông tin bao gồm thông tin về các chương trình và dịch vụ hỗ trợ về cờ bạc.

THÔNG TIN VỀ BỆNH NHÂN/KHÁCH HÀNG

Vui lòng đánh dấu vào ô thích hợp:

1. Giới tính của bạn? ❑ Nam ❑ Nữ ❑ Khác
2. Lai lịch văn hóa của bạn? ❑ Người Thổ Dân và Đảo Dân Eo Biển Torres ❑ Ả-rập ❑ Assyria ❑ Việt Nam ❑ Không ❑ Khác (vui lòng ghi rõ): ____________________________

OFFICE USE ONLY

Result:

3. Completed questionnaire? ❑ Yes ❑ No, specify reason:________________________________
4. Gambling harm identified? ❑ Yes – individual ❑ Yes – affected other ❑ No risk
5. Actions? ❑ No action ❑ Information provided
   ❑ Referral to gambling service (please specify):__________________
   ❑ Other (please specify):_____________________________________

Comments (optional):

Fairfield City Health Alliance
Gambling services and programs

All listings correct at date of publication. For up-to-date listings, please visit: Recovery Point https://recoverypoint.org.au/directory/ where service listings can be viewed under "Gambling Services"

Gambling services and programs – Mobile Apps

Name	Services	Cost	Platform
100 Day Challenge	• Self-assessment questionnaire • Daily tracker for individualised goals • Tips and advice on managing finances and building a support team • Activities to help resist the urge to gamble, categorised into six groups: Wellness, Solitary, Practical, Physical, Creative and Social • Community forum	None	Android, IOS
Gambling Therapy	• Self-assessment questionnaire • Text based live support • Mindfulness and self-help exercises • Crisis support information • Daily motivational quotes • Links to blocking software • Directory of organisations that can help • Community forum	None	Android, IOS
Stay on Track	• Gambling budget tracker	None	IOS
Monitor Your Gambling & Urges	• Gambling and gambling urge tracker that promotes self-awareness of gambling behaviours • Identify when and what triggers you to gamble • Record wins, losses and consequences when you chose to gamble • Record your feelings and alternative activities you do when you chose not to gamble	None	Android, IOS
Gamblock	• Blocks access to online gambling services	Variable price depending on type and number of device and the protection period – about $15 per device per month	Android, IOS, Windows, Mac

Gamban	• Blocks access to online gambling services	$54.99 per year with a 14-day free trial	Android, IOS, Windows
Betfilter	• Blocks access to online gambling services	Variable depending on plan – 1 year 1 device $5.83/month	Android, IOS, Windows, Mac
Bet Blocker	• Blocks access to online gambling websites on computers • Can be used by parents as a parental control program	None	Windows, Mac
Cost2Play	• A calculator that can be downloaded as an app or accessed via website that calculates one's gambling losses • Helps put into perspective the long term costs of gambling	None	Android, IOS, Website (Windows, Mac)
Quit Pokies	• Sends real time alerts when one enters a pokies venue • Sends timed reminders if one stays at the venue • Sends information on how much money is lost each day at specific venues one visits	None	IOS, Android

Gambling services and programs – Online Support Programs

Organisation	Service/program	Target group	Eligibility criteria	Referral process	Languages	Contact Details	Locations
Gambling Help Online	24-hour telephone helpline with counsellor 24-hour online chat Online self-help modules Peer support forums Referral to local face-to-face counselling	Anyone concerned about gambling (both their own and someone else's)	Nil	Self-referral through website	Telephone interpreter	Phone: 1800 858 858 https://www.gamblinghelponline.org.au/	Australia-wide

Gambling Less	Online self-help application	Any person experiencing issues with gambling	Nil	Self-referral	N/A – online service	Website: https://www.deakin.edu.au/apps/psychology/GAMBLINGLESS/	N/A - online

Gambling services and programs – All Support Groups

Name	Type of support	Target Group	Eligibility criteria	Referral process	Available languages/ interpreters	Contact Details	Locations
Gamblers Anonymous	Support groups	Problem gamblers	Nil	Self-referral or referral by healthcare professional via telephone	English	Phone: (02) 9726 6625 Email: ga_nsw@hotmail.com Website: https://gaaustralia.org.au/	Fairfield, Liverpool, Parramatta, Punchbowl Meetings held on/at: Tuesday, 7:30pm at Oakdene House Foundation Wednesday, 7:30pm at Fairfield Community Centre

							Friday, 12pm at Oakdene House Foundation
Gam-Anon (affiliated with Gamblers Anonymous)	Support group	Family and friends of problem gamblers	Nil	Self-referral	English	Phone: (02) 9726 6625 Email: gam-anon@live.com.au Website: www.gam-anon.org	Fairfield, Parramatta, Rockdale and Penrith
BetSafe	Self-exclusion from gaming venues in NSW, counselling, support groups	Problem gamblers	nil	Self-referral	Phone interpreters	Phone: (02) 9874 0744 Website: https://www.betsafe.com.au/	NSW wide
Smart Recovery Australia	Individually run Community Support Groups	Individuals with problematic behaviours, including gambling addiction	Over 18 years old	Self-referral	Dependant on individual groups	Phone:02 9373 5100 Email: smartrecovery@srau.og.au Website: https://smartrecoveryaustralia.com.au/	NSW-wide Meetings at 1/119 The Crescent, Fairfield every Monday 12:30pm-2:30pm
Arab Council Australia	Face to face counselling and casework Telephone counselling, counselling of family and friends Referrals to relevant organisations Weekly support group which provides a supportive environment for the clients Financial Counselling Service for persons with gambling problems which includes support,	Problem gamblers	Members of the Arab community	Self-referral, GP referral	Arabic staff	Email: info@arabcouncil.org.au Phone: +61 2 9709 4333 Fax: +61 2 9709 2928 Website: http://www.arabcouncil.org.au/ Address: 2/44-46 Mandarin St, Villawood NSW 2200; Shop 15-16/212 South Terrace, Bankstown Plaza, Bankstown NSW 2200	Bankstown, Villawood, Fairfield, Auburn Rockdale

	contacting creditors and advocacy.						

Gambling services and programs – All One on One Programs

Organisation	Service/program	Target group	Eligibility criteria	Referral process	Languages	Contact Details	Locations

Fairfield City Health Alliance
Gambling services and programs

Gambling Help Online	24-hour telephone helpline with counsellor 24-hour online chat Online self-help modules Peer support forums Referral to local face-to-face counselling	Anyone concerned about gambling (both their own and someone else's)	Nil	Self-referral through website	Telephone interpreter	Phone: 1800 858 858 https://www.gamblinghelponline.org.au/	Australia-wide
Multicultural Problem Gambling Service	Problem Gambling Counselling Service Financial Counselling Program Multicultural Problem Gambling Program for Chinese Communities Community education programs Service provider training on cross-cultural issues	Problem gamblers and their families from CALD backgrounds	Nil	Telephone referral, can be self-referral or healthcare provider referral	Bilingual staff Available in 30 languages	Website: http://www.dhi.health.nsw.gov.au/mpgs Phone: 1800 856 800 Email: WSLHD-MPGS@health.nsw.gov.au	NSW-wide (head office in North Parramatta)

SWSLHD Gambling Help Service	One-on-one treatment sessions for problem gamblers, their partners and families Treatment is based on behaviour therapy	Problem gamblers and those affected by problem gambling	Nil	Self-referral, family, health professionals via telephone	Interpreters	Intake line: 9616 4060 Address: SWSLHD Mental Health Service, Liverpool Hospital	Liverpool
Warruwi Gambling Help	Telephone information, counselling and referral service	All socio-demographic groups (e.g. males and females, adults and children, workers and non-workers, married and single	People who identify as Aboriginal or Torres Strait Islander	Self-referral via telephone		Phone: 1800 752 948 Website: http://www.gamblinghelp.nsw.gov.au/get-help/warruwi-gambling-help/	State-wide

University of Sydney Gambling Treatment Clinic	Hour-long sessions on a weekly basis, usually over a two-to-three-month period, depending on your needs.	Individual support as well as support for partners and family members.	Over 18	No referral is necessary, but you do need to make an appointment.		Phone: 1800 482 482 Email: psychology.gtc@sydney.edu.au Website: https://www.sydney.edu.au/brain-mind/patient-services/gambling-treatment-clinic.html	**Camperdown** Level 2, 94 Mallett Street Camperdown NSW 2050 **Parramatta** Suite 4, Level 4, 20-22 Macquarie Street Parramatta NSW 2150 **Lidcombe** 75 East Street Lidcombe **Campbelltown** Suite 12, 186 Queen Street Sky Gardens Plaza, Campbelltown 2060
Wesley Gambling Counselling	Personal counselling and support Financial counselling Legal services (via Wesley Community Legal Service)	Problem gamblers and/or family members and friends	Nil	Self-referral	Phone interpreters available	Address: 1 Dale St, Fairfield, NSW 2165 Phone: 1300 827 638 Email: gamblingcounselling@wesleymission.org.au Website: www.wesleymission.org.au	Fairfield, Newcastle, central coast, Sydney CBD, Sutherland, western Sydney, Wollongong and Ashfield

Wesley Community Legal Service	Legal advice	Problem gamblers and families experiencing legal issues	Nil	Self- referral	Phone Interpreters available	Address: Level 3, 220 Pitt Street, Sydney, NSW, 2000 Phone: (02) 9263 5577 or 1300 827 638 Email: gamblingcounselling@wesleymission.org.au	Sydney
Mental Health Therapy and Recovery Service (TARS)	Counselling, community access, leisure/recreation activities, mental health services and rehabilitation	18- 65 year-old diagnosed with a mental illness residing in Liverpool or Fairfield	18-65	Referrals made through the Liverpool/ Fairfield mental health intake service	Interpreters	Phone: 9794 1997 Address: 152-168B The Horsley Dr, Carramar NSW 2163	Carramar
Vietnamese Drug and Alcohol Professionals	Counselling	Vietnamese youth and parents	Members of the Vietnamese community	Self	Vietnamese	Phone: 02 9616 8586 or 02 9515 6311 Phone interpretation: 131 450 Email: info@vdap.org.au Website: https://mail.vdap.org.au/index.php/vdap/lien-lac	Southwest Sydney and Sydney centre

Fairfield City Health Alliance
Gambling services and programs

Arab Council Australia	Face to face counselling and casework Telephone counselling, counselling of family and friends Referrals to relevant organisations Weekly support group which provides a supportive environment for the clients Financial Counselling Service for persons with gambling problems which includes support, contacting creditors and advocacy.	Problem gamblers	Members of the Arab community	Self-referral, GP referral	Arabic staff	Email: info@arabcouncil.org.au Phone: +61 2 9709 4333 Fax: +61 2 9709 2928 Website: http://www.arabcouncil.org.au/ Address: 2/44-46 Mandarin St, Villawood NSW 2200; Shop 15-16/212 South Terrace, Bankstown Plaza, Bankstown NSW 2200	Bankstown, Villawood, Fairfield, Auburn Rockdale
Mission Australia	Financial and gambling counselling	Children, young people, families experiencing harm due to gambling	Children, young people, families	Self-referral, referral from other support services	Phone Interpreter	Website: https://www.missionaustralia.com.au/services?postcode=&keywords=Gambling+Counselling+Service Phone: 1300 883 067	**Campbelltown** Suite 7.03 and 7.04, Level 7, 171 Queen Street, Campbelltown 2560 NSW **Surry Hills** 19 Denham Street, Surry Hills 2010 NSW

Mission Australia continued							**Campsie** Shop 43, 14-28 Amy Street, Campsie 2194 NSW **Wagga Wagga** Unit 2, 36-40 Gurwood Street, Wagga Wagga 2650 NSW **Wollongong** 88 Swan Street, Wollongong 2500 NSW **Singleton** Singleton Neighbourhood Centre, 21 Mary Street, Singleton 2330 NSW **Kempsey** Shops 1 & 2, 40 Clyde Street, Kempsey 2440 NSW
Parramatta Mission/UCMH Counselling Services	Financial and gambling counselling	Those affected by heavy gambling, including partners and	Nil	Self- referral	Phone Interpreter	Phone: (02) 9891 6212 Address: Unit 204, 41-45 Rickard Rd, Bankstown NSW 2200; 25 Barbara St, Fairfield NSW 2165	Fairfield, Bankstown, Parramatta

		family members				Email: ucmh.cs@ucmh.org.au counselling@parramattamission.org.au	
BetSafe	Self-exclusion from gaming venues in NSW, counselling, support groups	Problem gamblers	nil	Self-referral	Phone interpreters	Phone: 02 9874 0744 Website: https://www.betsafe.com.au/	NSW wide
ClubsNSW	Self-exclusion from gaming venues in NSW	Problem gamblers	Nil	Self-referral	Interpreters	Phone: 02 9268 3000 Website: https://www.clubsnsw.com.au/	NSW wide
Gambling Less	Online self-help application	Any person experiencing issues with gambling	Nil	Self-referral	N/A – online service	Website: https://www.deakin.edu.au/apps/psychology/GAMBLINGLESS/	N/A - online
Vietnamese Community in Australia	Counselling	Vietnamese youth and parents	Members of the Vietnamese community	Self, GP or correctional facility referral	Phone interpretation, Vietnamese	Phone: 02 9727 5599 Address: 4/50 Park Road Cabramatta, NSW 2166; 23 Greenwood Ave, Bankstown NSW 2200 Email: office@vietnamese.org.au	Cabramatta and Bankstown
Centacare	Counselling	Problem gamblers	N/A	Self-referral	Interpreters	Phone: 02 8822 2222 Address: 51-59 Allawah St, Blacktown NSW 2148	Blacktown
CatholicCare	Financial and gambling counselling	Individuals and families who have been negatively impacted by gambling	Nil	Self-referral	Interpreters available for 1 on 1 sessions, not for group counselling	Phone: 02 8843 2530	Blacktown, North Parramatta, Emerton, Penrith, Springwood, Richmond

Fairfield City Health Alliance

Gambling services and programs

Co.As.It	Face to face, phone and skype counselling	Individuals, groups and families affected by problem gambling	Members of the Italian-Australian community	Self-referral	English and Italian	Phone: 9564 0744 Address: 67 Norton Street Leichhardt NSW 2040	Leichhardt
St Vincent De Paul Society	Counselling, referral and support to family members	Problem gamblers and their families	Nil	Self-referral	Interpreters	Phone: 02 4032 3543 Address: 15/25 Old Northern Road, Baulkham Hills NSW 2153	Baulkham Hills, Windsor
Sydney Women's Counselling Centre	Counselling	Problem gamblers	Women	Self-referral	Have bilingual staff for Mandarin, interpreters for other languages	Phone: 02 9718 1955 Email: help@womenscounselling.com.au Address: 4/2 Carrington Square, Campsie NSW 2194	Campsie
Anglicare	Counselling	Problem gamblers	Nil	Self-referral	Interpreters	Phone: 1300 111 278 Address: 40 Cumberland St, Cabramatta NSW 2166; Level 5, 31-39 Macquarie St, Parramatta NSW 2150	Multiple locations including Cabramatta and Parramatta

Gambling services and programs – Aboriginal and Torres Strait Islander Specific Services

Organisation	Service/program	Target group	Eligibility criteria	Referral process	Languages	Contact Details	Locations
Warruwi Gambling Help	Telephone information, counselling and referral service	All socio-demographic groups (e.g. males and females, adults and children, workers and non-workers, married and single	People who identify as Aboriginal or Torres Strait Islander	Self-referral via telephone		Phone: 1800 752 948 Website: http://www.gamblinghelp.nsw.gov.au/get-help/warruwi-gambling-help/	State-wide

Gambling services and programs – CALD Specific Services (Note: other services may also provide support via interpreters)

Fairfield City Health Alliance
Gambling services and programs

Organisation	Service/program	Target group	Eligibility criteria	Referral process	Languages	Contact Details	Locations
Multicultural Problem Gambling Service	Problem Gambling Counselling Service Financial Counselling Program Multicultural Problem Gambling Program for Chinese Communities Community education programs Service provider training on cross-cultural issues	Problem gamblers and their families from CALD backgrounds	Nil	Telephone referral, can be self-referral or healthcare provider referral	Bilingual staff Available in 30 languages	Website: http://www.dhi.health.nsw.gov.au/mpgs Phone: 1800 856 800 Email: WSLHD-MPGS@health.nsw.gov.au	NSW-wide (head office in North Parramatta)
Vietnamese Drug and Alcohol Professionals	Counselling	Vietnamese youth and parents	Members of the Vietnamese community	Self	Vietnamese	Phone: 02 9616 8586 or 02 9515 6311 Phone interpretation: 131 450 Email: info@vdap.org.au Website: https://mail.vdap.org.au/index.php/vdap/lien-lac	Southwest Sydney and Sydney centre

Fairfield City Health Alliance
Gambling services and programs

Arab Council Australia	Face to face counselling and casework Telephone counselling, counselling of family and friends Referrals to relevant organisations Weekly support group which provides a supportive environment for the clients Financial Counselling Service for persons with gambling problems which includes support, contacting creditors and advocacy.	Problem gamblers	Members of the Arab community	Self-referral, GP referral	Arabic staff	Email: info@arabcouncil.org.au Phone: +61 2 9709 4333 Fax: +61 2 9709 2928 Website: http://www.arabcouncil.org.au/ Address: 2/44-46 Mandarin St, Villawood NSW 2200; Shop 15-16/212 South Terrace, Bankstown Plaza, Bankstown NSW 2200	Bankstown, Villawood, Fairfield, Auburn Rockdale
Vietnamese Community in Australia	Counselling	Vietnamese youth and parents	Members of the Vietnamese community	Self, GP or correctional facility referral	Phone interpretation, Vietnamese	Phone: 02 9727 5599 Address: 4/50 Park Road Cabramatta, NSW 2166; 23 Greenwood Ave, Bankstown NSW 2200 Email: office@vietnamese.org.au	Cabramatta and Bankstown
Co.As.It	Face to face, phone and skype counselling	Individuals, groups and families affected by problem gambling	Members of the Italian-Australian community	Self-referral	English and Italian	Phone: 9564 0744 Address: 67 Norton Street Leichhardt NSW 2040	Leichhardt

1

ACKNOWLEDGEMENT OF COUNTRY

We acknowledge and pay our respects to the traditional custodians of the lands on which we are meeting on today.

In the true spirit of respect I would like to acknowledge their connection to their people, to their culture and to their land.

This respect is warmly extended to Aboriginal and Torres Strait Islander people and Elders who are with us today and to the emerging elders of tomorrow.

2

WHAT IS GAMBLING?

Traditionally gambling is an activity where someone risks money or belongings, there is an element of randomness or chance involved and the purpose is to win.

The traditional methods that usually come to mind are:

- Gaming Machines/Pokies
- Lottery
- Scratch cards
- Online Gambling
- Sports betting

References
Gambling Help Online. 2020. What Is Gambling?. [online] Available at: <https://www.gamblinghelponline.org.au/understanding-gambling/what-is-gambling> [Accessed 15 April 2020].

3

WHAT IS GAMBLING? (CONT'D)

As different ways to gamble have developed it has become difficult to identify some instances when someone has a gambling problem.

Emerging gambling activities include:

- Online investment trading
- Fantasy sports
- Games with In-App Purchases
- Online Auctions.

References
Gambling Help Online. 2020. What Is Gambling?. [online] Available at: <https://www.gamblinghelponline.org.au/understanding-gambling/what-is-gambling> [Accessed 15 April 2020].

4

THE PROBLEM – GAMBLING IN FAIRFIELD

- Significant financial losses: $1.4 million lost per day to pokies in Fairfield LGA (1).
- Low socioeconomic status: Fairfield LGA is the most disadvantaged area in the Greater Sydney Area. Median personal income in the LGA is $439 per week (2).
- Strong history of migration and refugee settlement: Approx. 4,700 refugees arrived in Fairfield LGA during 2016 (3).
- High proportion of CALD communities: Nearly 60% of residents were born overseas (2) and 76% of residents speak a language other than English at home (2).
- High density of poker machines: Fairfield LGA is classified as a Band 3 area with approx. 3,800 poker machines (4).

References
1. NSW Department of Industry (2018). Annual Report 2017-18. Accessed online at: https://www.opengov.nsw.gov.au/download/17634;jsessionid=F95D5F48DB193CC4DF1A1276F34B2270
2. Australian Bureau of Statistics (2017). 2016 Census QuickStats. Accessed online at: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/LGA12850
3. Settlement Services International (2017). The facts about Syrian refugees and Fairfield [webpage]. Accessed online at: https://www.ssi.org.au/news/ssi-news-blog/938-the-facts-about-syrian-refugees-and-fairfield
4. Liquor & Gaming NSW (2018). Gaming machine report by Local Government Area (LGA). Accessed online at: https://www.liquorandgaming.nsw.gov.au/resources/gaming-machine-data

5

PROJECT OUTLINE

Aim: To develop, implement and evaluate a model for gambling harm screening and referral in general practices and community organisations in the Fairfield LGA.

Primary objectives:

1. General practitioners and community workers have:
   - Improved knowledge of gambling harm
   - Increased confidence in screening for and responding to gambling harm, and
   - Increased screening and referral behaviour
2. Consumers are identified as being at risk of developing or experiencing gambling harm and referred appropriately to services, thereby improving their access to services and supports

6

GAMBLING HARM AS A PUBLIC HEALTH ISSUE – SEVEN TYPES OF HARM

DIMENSIONS OF HARM
(classification)

TEMPORAL CATEGORY: GENERAL HARMS; CRISIS; LEGACY

FINANCIAL HARM
RELATIONSHIP DISRUPTION, CONFLICT OR BREAKDOWN
EMOTIONAL OR PSYCHOLOGICAL DISTRESS
DECREMENTS TO HEALTH
CULTURAL HARM
REDUCED PERFORMANCE AT WORK OR STUDY
CRIMINAL ACTIVITY

LIFECOURSE, GENERATIONAL AND INTERGENERATIONAL HARM

Browne, M, Langham, E, Rawat, V, Greer, N, Li, E, Rose, J, Rockloff, M, Donaldson, P, Thorne, H, Goodwin, B, Bryden, G & Best, T (2016), *Assessing gambling-related harm in Victoria: a public health perspective*, Victorian Responsible Gambling Foundation, Melbourne.

7

IDENTIFYING GAMBLING HARM – THE ROLE OF GENERAL PRACTICE

- People suffer for approximately 10 years before seeking treatment
- Evidence shows that most gambling harm is unrecognised in primary care settings and therefore health needs go untreated (1)
- Patients may present with the following clinical features for gambling harm: (2)
  - Signs of stress, depression and/or anxiety
  - Disrupted sleep
  - Changed eating patterns
  - History of alcohol or nicotine dependence
  - Unexplained loss of time or money
  - Dissatisfaction with quality of life.
- What are other common signs or symptoms?

1. Lubman, D., Manning, V., Dowling, N., Rodda, S., Lee, S., Garde, E., Merkouris, S. and Volberg, R. (2017). Problem gambling in people seeking treatment for mental illness. Victorian Responsible Gambling Foundation.
2. Rodda, S., Luman D., and Latage, K. (2012). Problem gambling. Australian Family Physician. 41(9): 725-729.

8

IDENTIFYING GAMBLING HARM – THE ROLE OF COMMUNITY WORKERS

- People suffer for approximately 10 years before seeking treatment
- Community services are often the first point of contact during major life crises, such as significant debt or relationship breakdown. Anecdotally, gambling harm has been reported by community workers as the cause for these crises.

9

ASSESSMENT AND TREATMENT OF GAMBLING HARM – GAMBLING SERVICES

- Gambling counsellors use a variety of approaches with clients which may include:
  - Behavioural therapy
  - Cognitive behavioural therapy (CBT)
  - Exposure therapy
  - Motivational enhancement therapy (or brief interventions)
- Gambling counsellors support clients based on their priorities. They may want to address other concerns such as anxiety, finances or relationships before focusing on gambling behaviour
- Take any opportunity to link patients/clients directly to gambling help services, such as making a warm referral or appointment with a counsellor

10

CO-DESIGNED MODEL

11

WHO ARE WE SCREENING?

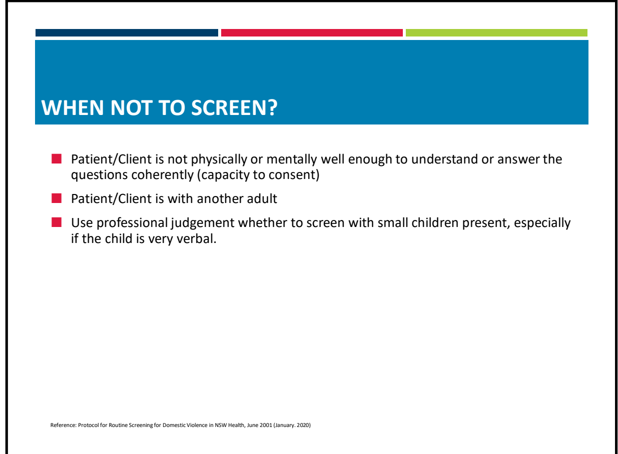
- Adults over 18 years old (due to ethics requirements)

To identify:

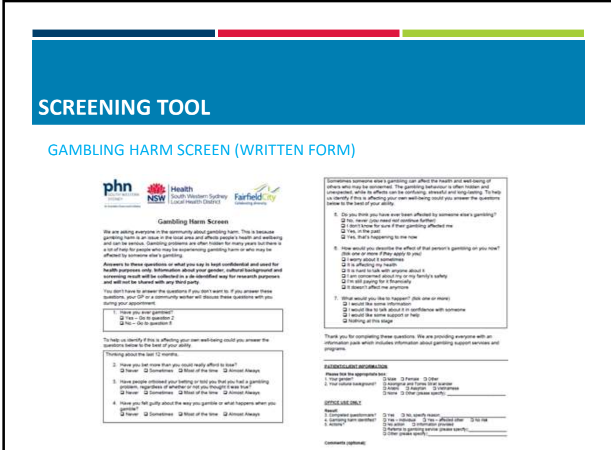
- Individuals experiencing gambling harm
- Affected others: For every person with a gambling problem, it is estimated that an additional 5 to 10 people are negatively affected by their gambling (1).

1. Australian Medical Association (2013), Health Effects of Problem Gambling. Available online: https://ama.com.au/position-statement/health-effects-problem-gambling-2013

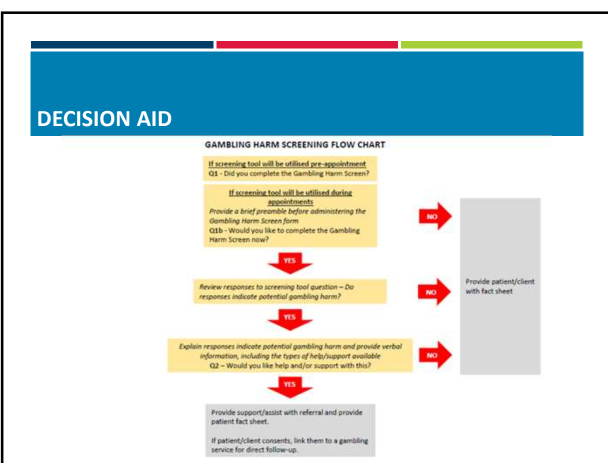
12



13



14



15

PREAMBLE

We are asking everyone in the community about gambling harm. This is because gambling harm is an issue in the local area and affects people's health and wellbeing and can be serious. Gambling problems are often hidden for many years but there is a lot of help for people who may be experiencing gambling harm or who may be affected by someone else's gambling.

Answers to these questions or what you say is kept confidential and used for health purposes only. Your personal information will not be shared with any third party.

You don't have to answer the questions if you don't want to. If you answer these questions, your GP or a community worker will discuss these questions with you during your appointment.

16

SINGLE-ITEM QUESTION

"Have you ever gambled"?

❑ Yes

❑ No

Responses will determine which screening tool a patient/client goes on to complete (individual or affected other)

17

SCREENING TOOLS

INDIVIDUAL – Problem Gambling Severity Index (PGSI) Short-Form

Thinking about the last 12 months,

1. Have you bet more than you could really afford to lose?

❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost always

2. Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost always

3. Have you felt guilty about the way you gamble or what happens when you gamble?

❑ Never ❑ Sometimes ❑ Most of the time ❑ Almost always

A 'Sometimes', 'Most of the time' or 'Almost always' response to any one of the questions above identified that the person may be experiencing harm as a result of their own gambling

18

SCREENING TOOLS

AFFECTED OTHERS – Concerned Others Gambling Screen (COGS)

1. Do you think you have ever been affected by someone else's gambling?

- ❑ No, never *(you need not continue further)*
- ❑ I don't know for sure if their gambling affected me
- ❑ Yes, in the past
- ❑ Yes, that's happening to me now

A 'yes' to any one of the last three responses in Q1 identifies that the person may be negatively affected by another's gambling

2. How would you describe the effect of that person's gambling on you now? *(tick one or more if they apply to you)*

- ❑ I worry about it sometimes
- ❑ It is affecting my health
- ❑ It is hard to talk with anyone about it
- ❑ I am concerned about my or my family's safety
- ❑ I'm still paying for it financially
- ❑ It doesn't affect me anymore

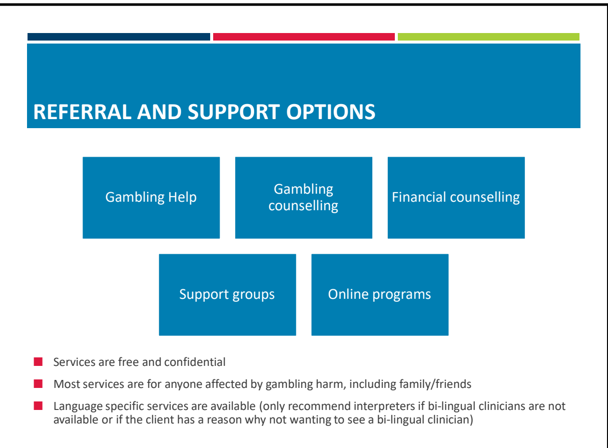
3. What would you like to happen? *(tick one or more)*

- ❑ I would like some information
- ❑ I would like to talk about it in confidence with someone
- ❑ I would like some support or help
- ❑ Nothing at this stage

Responses to Q3 gives an indication of the desired intervention

19

REFERRAL AND SUPPORT OPTIONS



- Services are free and confidential
- Most services are for anyone affected by gambling harm, including family/friends
- Language specific services are available (only recommend interpreters if bi-lingual clinicians are not available or if the client has a reason why not wanting to see a bi-lingual clinician)

20

REFERRAL AND SUPPORT OPTIONS – GAMBLING COUNSELLING

- Gambling counsellors use a variety of approaches with clients
- Gambling counsellors support clients based on their priorities. They may want to address other concerns such as anxiety, finances or relationships before focusing on gambling behaviour
- Take any opportunity to link patients/clients directly to gambling help services, such as making a warm referral or appointment with a gambling counsellor

21

CONSUMER EDUCATION AND INFORMATION

- DL Flyer
- Health Resource Directory Patient Factsheet (Problem Gambling), including Arabic, Assyrian and Vietnamese translated factsheets

22

GAMBLING HARM IS IDENTIFIED

- Assess whether there are immediate safety concerns, in line with your organisation's processes or policies
- Respond supportively and express empathy

"It can be hard or difficult to talk about this, thank you for your honesty"

"I'm here to listen to you"

"I'm here to give you support and options"

- Provide Factsheet and point out support/referral options

"Would you like to do something about how gambling is impacting you?"

"What would you like to see as next steps?"

"Have you considered talking to someone?" or "Have you tried speaking about this to anyone else?"

"What have you tried before?"

Reference: Protocol for Routine Screening for Domestic Violence in NSW Health, June 2001 (January. 2020)

23

NO GAMBLING HARM IS IDENTIFIED

- Thank patient/client for answering the questions
- Offer the Flyer and briefly talk through potential gambling problems

"Here is some information we are giving to everyone about gambling harm"

- Keep your door open to them should they need support or information in future

"I want to let you know that is a safe space, and you can speak freely about your or your family's gambling behaviour in future. You are most welcome to come back at anytime, I'm here to listen"

24

STARTING THE CONVERSATION

25

ENCOURAGING DISCLOSURE

- Engage and build on rapport and trusting relationship
- Create a safe place

"It's difficult to talk about issues that everyone has a different opinion about, but there is support available"

- Remind patient/client of confidentiality
- Reassure patients/clients that gambling harm is a health issue

1. Queensland Government & Lives Lived Well. Screening for Problem Gambling: Tools & Support Resources.

26

MOTIVATIONAL INTERVIEWING

- Clients may be relieved when you bring up gambling in a professional and non-judgemental manner

"What I've noticed is worrying about how much money you spent on gambling is affecting your sleep"

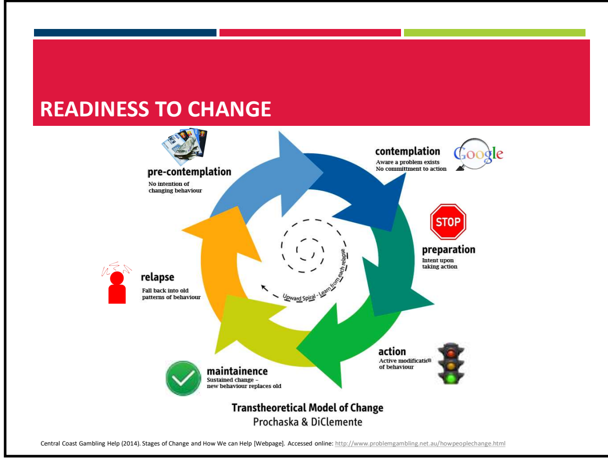
- Express empathy
- Focus on the problem, not the person

"How does this impact you day-to-day?"

Victorian Responsible Gambling Foundation (2018). Counselling techniques. Available online: https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/identifying-problem/counselling-techniques/

27

READINESS TO CHANGE



Central Coast Gambling Help (2014). Stages of Change and How We can Help [Webpage]. Accessed online: http://www.problemgambling.net.au/howpeoplechange.html

28

CULTURAL SENSITIVITIES

GENERAL

- CALD people who gamble may be more likely to develop problems than individuals from the general population due to different beliefs about luck and chance, factors relating to migration, and issues around shame and stigma (1)
- Stigma and shame can create significant barriers to help seeking (1)
- Concepts of counselling or other therapies are not well understood so may require further explanation and education, and reassurance about confidentiality
- It may be easier to talk about gambling with someone from a different cultural background for fear of being identified
- Importance of support and information in different languages (1)

1. Dickins, M. and Thomas, A. (2016), Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre.

29

CULTURAL SENSITIVITIES

ARABIC COMMUNITIES

- Gambling activities considered a source of entertainment and refuge but also of shame, a source of quick money (1)
- Consider religion – gambling is forbidden in Islam which makes it more difficult to disclose behaviour or admit harm
- For those dependent on government services or financial support, there is a significant concern about confidentiality and what information might be passed on to other government agencies – reassure confidentiality and anonymity
- Important role of patriarchal hierarchy

1. Dickins, M. and Thomas, A. (2016), Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre.

30

CULTURAL SENSITIVITIES

ASSYRIAN COMMUNITIES

- Gambling activities considered a game or social activity (1)
- Some cultural sensitivities in common with Arabic community
- Community leaders and church leaders have a strong influence

1. Dickins, M. and Thomas, A. (2016), Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre.

31

CULTURAL SENSITIVITIES

VIETNAMESE COMMUNITIES

- Gambling activities considered as enjoyable, a source of quick money, a game of luck and skill (1)
- Individuals or affected others may be reluctant to discuss gambling harm due to their concerns about 'losing face' in the community or reflect a problem with the family as a whole (2)

1. Dickins, M. and Thomas, A. (2016), Gambling in culturally and linguistically diverse communities in Australia. Australian Gambling Research Centre.
2. Flinders University. Vietnamese Problem Gambling Treatment Program – Therapist Manual. Available online: http://www.aph.gov.au/DocumentStore.ashx?id=1ad9e4b1-cd6a-427b-bc63-79f20623960a

32

CULTURAL SENSITIVITIES

CHINESE COMMUNITIES

- Some of Chinese population in Fairfield LGA arrived as refugees in the 70's.
- Gambling is ingrained in Chinese culture and is viewed as a social activity especially during festivities.
- Chinese communities hold an ambiguous attitude towards gambling, depending on the outcome. It is not viewed as a problem if you win. Winning is considered to be a blessing from the gods/ancestors.
- Belief in luck, destiny or supernatural forces has a play in gambling outcome.
- Chinese people tend to solve most problems within the family circle first. Going to professional counselling is the last option.
- As both gambling and counselling bear stigma and shame in Chinese culture, most Chinese who cannot speak English do not want an interpreter (i.e. another community member) involved in the process.
- Similar to Vietnamese, 'CBT' does not have relevant translation in Chinese. Many Chinese may not understand or have the ability to collaborate in the process.

33

IMPLEMENTATION

34

INCLUDING RECEPTIONISTS IN WORKFLOW

- Receptionists at practices and community services can assist participants by providing information to patient/clients about screening.
- However, they will not be able to use the screening tool with patients/clients or review responses.
- Receptionists can record how many surveys were handed out, to check against totals of completed or attempted surveys.
- Specific questions from patients/clients to be raised with a GP or community worker.

35

PARTICIPANT ACTIVITIES

- Attending an education session to learn how to implement the intervention.
- Using the screening tool in your routine practice during April to June.
- Completing an online feedback questionnaire before and after implementation.
- Keeping track of screening and referral data.
- Participating in a focus group or individual interview after implementation.

36

PROJECT TEAM CONTACTS

- Nick McGhie, Project Manager Gambling, South Western Sydney PHN
  E: Nick.McGhie@swsphn.com.au, M: 0402 644 451
- Linh Nguyen, Research & Evaluation Officer (Gambling), South Western Sydney PHN, E: Linh.Nguyen@swsphn.com.au

37

ACKNOWLEDGMENTS

- Janine Bleakley – Psychologist, Gambling Treatment & Research Clinic, University of Sydney
- Monica Cochrane – Gambling Counsellor, Mission Australia (Campbelltown)
- Dr Kate da Costa – NSW Campaigner, Alliance for Gambling Reform
- Eric Ho – Psychologist & Bilingual Counsellor, Multicultural Problem Gambling Service
- Dr Kate Fennessy – Senior Clinical Psychologist & Clinical Lead Gambling Treatment Program, St Vincent's Health Network
- Angela Hall – Project Coordinator White Ribbon Accreditation, South Western Sydney Local Health District
- Jenny Ly – Project Manager, South Western Sydney Local Health District
- Linh Nguyen – Research & Evaluation Officer, South Western Sydney Primary Health Network

38

SCREENING TOOL PROJECT

RECEPTIONIST ACTIONS

The survey should only be given to a patient/client who is an adult (18+). For privacy, it should not be given to adults who have arrived together. An adult with children can receive the survey. An adult with a professional interpreter can receive the survey.

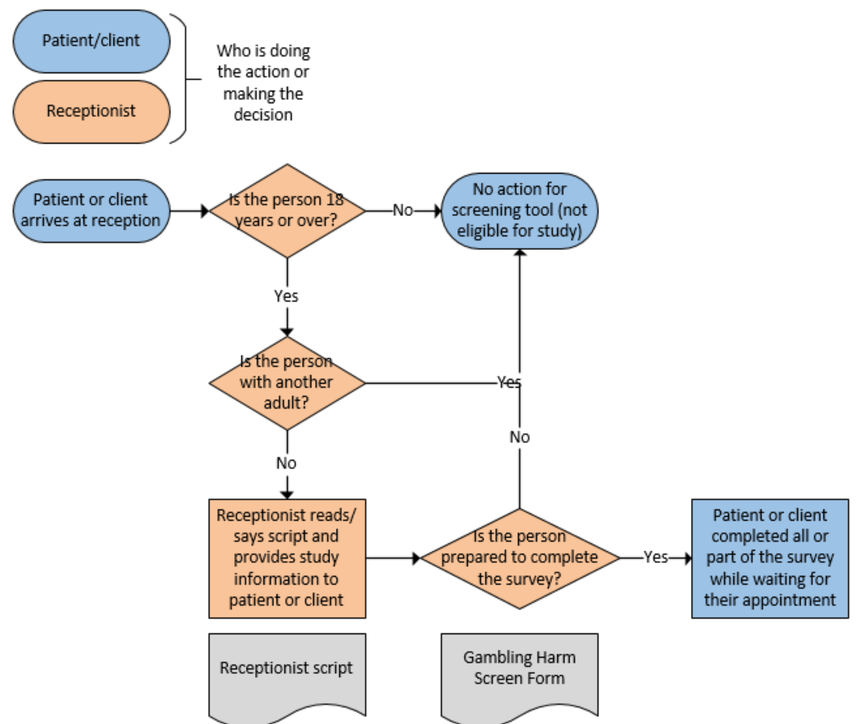
Receptionists will provide information to potential participants about the study. They will not determine capacity for consent to complete the survey. Receptionists will be told that if the patient/client accepts the survey form, they do not have to complete it. The GP/CW will determine consent and capacity to make an informed decision to complete the screening tool during the appointment.

Reception should record how many surveys are handed out, to check against totals of completed or attempted surveys.

SCRIPT

"*Hello. This practice/service is currently participating in a research project. This practice/service wants to work with other organisations to reduce harm from gambling in our community. We are asking every patient/client, 18 or over, to assist in the project by completing this survey while waiting for their appointment. We are not targeting any age group, or community group – it is a practice/service wide research project.*

The survey is about gambling. It is anonymous – your name is not recorded anywhere. Here is the form if you would like to be involved you can fill it in while you're waiting or take it into your appointment. If you don't understand the form or if you have any questions, you can discuss it with your GP/CW.



Gambling doesn't have a face. Anyone can be affected.

At this practice we are asking everyone the question:

Have you had problems in your life because of your or someone else's gambling?

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties

Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

We are asking everyone to complete a quick screening form about gambling which can be discussed with your GP.

If your or someone else's gambling is causing problems in your life, **talk to your GP.** There are many free resources and support. These are available in different languages.

Call Gambling Help for free, confidential support, available 24/7 1800 858 858

For support in other languages, call the Multicultural Problem Gambling Service 1800 856 800

ليس للمقامرة وجه ويمكن أن تؤثر على أي شخص.

في هذه العيادة نطرح السؤال التالي على الجميع:

هل واجهت مشاكل في حياتك بسبب لعبك أنت أو شخص آخر القمار؟

قد تسبب المقامرة مشاكلًا بطرق عدة وقد تكون تلك المشاكل خفية ومخفية لسنوات طوال

وقد تشمل:

مشاكل مالية

صعوبات في العلاقات الخاصة

مشاكل صحية منها صعوبة النوم

الضيق العاطفي أو النفسي

انخفاض الأداء في العمل أو الدراسة

نطلب من الجميع إكمال استمارة فحص قصيرة عن المقامرة يمكن مناقشتها مع طبيبك.

إذا سبب لعبك أنت أو شخص آخر القمار مشاكل في حياتك **تحدث مع طبيبك.** هناك العديد من الموارد والدعم المجاني متاح بلغات مختلفة.

اتصل بخط مساعدة المقامرين للحصول على دعم مجاني وسري متاح على مدار الساعة طوال أيام الأسبوع ١٨٠٠ ٨٥٨ ٨٥٨

للحصول على الدعم بلغات أخرى اتصل بخدمة مساعدة المقامرين المتعددة ثقافيا ١٨٠٠ ٨٥٦ ٨٠٠

ܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ ܠܲܝܬ ܠܵܗ̇ ܚܕܵܐ ܦܵܬܵܐ. ܗܝ ܡܲܨܝܵܐ ܕܡܲܥܒܸܕܵܐ ܥܲܠ ܟܠ ܚܲܕ ܡܸܢ ܕܘܼܢܝܵܐ.

ܠܵܐ ܐܵܢܵܐ ܝܲܕܥܹܐ ܐܲܝܟ ܐܸܣܬܲܪ ܐܲܢܝ̈ܢ ܕܩܘܼܡܵܪܵܐ ܡܲܣܘܲܩ ܡܸܢ ܟܠ ܚܲܕ ܦܲܪܨܘܿܦܵܐ ܠܲܚܘܿܕܵܐ

ܗܲܝܕܝܼ ܗܵܘܹܝܢܵܘܟ݂ܘܿܢ، ܐܲܝܢܵܐ ܡܲܫܟ݂ܠܵܐ ܠܵܗ̇ ܒܢܘܼܦܵܩܘܿܢ، ܒܕܲܪܓ݂ܵܐ ܕܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ ܕܒܝܼܬܘܿܢ، ܝܲܢ ܕܚܲܕ ܦܲܪܨܘܿܦܵܐ ܐܵܚܹܪܹܢܵܐ؟

ܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ ܡܲܨܝܵܐ ܕܡܲܥܒܸܕܵܐ ܡܲܫܟ݂ܠܵܐ ܒܐܘܼܪܚܵܐ ܦܪ̈ܝܼܫܵܐ. ܐܲܝܟ ܡܲܨܝܵܐ ܕܗܵܘܹܐ ܠܵܐ ܡܲܢܫܘܼܢܵܐ ܘܡܲܫܟ݂ܠܵܐ ܗܵܘ ܕܵܪܵܐ ܝܲܬܝܼܪܵܐ.

ܐܲܝܟ ܦܬܵܠܬܵܐ ܕܚܲܕܟ݂ܲܕ ܡܲܥܒܕܵܢܹܐ ܐܲܝܟ:

ܡܲܫܟ݂ܠܵܐ ܕܡܵܡܘܿܢܵܐ

ܦܘܼܫܵܟ݂ܵܐ ܕܐܲܚܵܢܘܼܬܵܐ (ܦܘܼܠܵܓ݂ܵܐ)

ܡܲܫܟ݂ܠܵܐ ܕܚܘܼܠܡܵܢܵܐ، ܐܲܝܟ ܦܘܼܫܵܟ݂ܵܐ ܒܕܸܡܟ݂ܬܵܐ

ܡܲܓܘܼܫܵܢܵܐ ܕܠܲܝܬܵܢܘܼܬܵܐ ܝܲܢ ܢܘܼܬܵܪܵܐ

ܥܒܵܕܘܼܬܵܐ ܒܡܲܕܪܲܫܬܵܐ ܠܵܐ ܦܘܼܠܚܵܢܵܐ ܝܲܢ ܡܲܕܪܵܢܵܐ

ܐܲܝܟ ܦܬܵܠܬܵܐ ܡܲܣܘܲܩ ܡܸܢ ܟܠ ܚܲܕ ܦܲܪܨܘܿܦܵܐ ܕܥܵܒܸܕܠܵܗ̇ ܚܲܕܵܐ ܦܵܬܵܐ ܕܢܵܫܘܿܬܵܐ ܡܲܠܘܼܠܬܵܐ ܒܗܵܘ ܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ
ܐܲܝܟ ܕܡܲܨܝܵܐ ܕܦܵܫܵܐ ܕܥܵܒܸܕܬܵܐ ܥܲܡ ܐܲܚܘܿܢܵܘܟ݂ܘܿܢ، ܠܲܐܢܵܫܵܐ.

ܐܸܢ ܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ ܕܒܝܼܬܘܿܢ، ܝܲܢ ܕܚܲܕ ܦܲܪܨܘܿܦܵܐ ܐܵܚܹܪܹܢܵܐ ܡܲܥܒܸܕܵܢܵܐ ܝܠܹܗ ܡܲܫܟ݂ܠܵܐ ܠܵܘܟ݂ܘܿܢ، ܘܩܘܼܡܘܼܢ، ܥܲܡ ܐܲܚܘܿܢܵܘܟ݂ܘܿܢ، ܠܲܐܢܵܫܵܐ. ܐܝܼܬ ܠܲܢ ܕܵܪܵܐ ܡܲܥܘܼܕܵܢܵܐ ܘܗܲܝܲܪܬܵܐ ܡܲܠܟ݂ܵܢܝܼܬܵܐ. ܐܝܼܢܵܐ ܡܲܨܝܵܐ ܕܦܵܫܚܝܼܬ ܡܸܢܝܵܐ ܒܥܸܕܵܢܹ̈ܐ ܦܪ̈ܝܼܫܹܐ.

ܡܲܚܘܼ، ܩܵܐ ܫܘܼܬܵܦܵܐ ܥܲܠ ܡܲܫܟ݂ܠܵܢܹ̈ܐ ܕܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ ܠܡܲܥܘܼܕܵܢܵܐ ܗܲܝܲܪܬܵܐ ܡܲܠܟ݂ܵܢܝܼܬܵܐ ܘܡܲܕܪܲܫܬܵܢܵܝܬܵܐ. ܫܘܼܬܵܦܵܐ ܦܘܼܫܵܩܵܐ ܡܲܠܹܐ 7\24

1800 858 858

ܠܡܲܠܟ݂ܵܢܹ̈ܐ ܗܲܝܲܪܬܵܐ ܒܠܸܫܵܢܹ̈ܐ ܐܵܚܹܪܹ̈ܢܹܐ ܡܲܚܘܼ، ܩܵܐ ܡܲܠܟ݂ܵܢܘܼܬܵܐ ܡܲܥܕܘܼܪܬܵܢܝܼܬܵܐ ܕܡܲܫܟ݂ܠܵܐ ܕܦܬܵܠܬܵܐ ܕܩܘܼܡܵܪ 1800 856 800

Cờ bạc không có hình dạng bề ngoài. Bất kỳ ai cũng có thể bị ảnh hưởng.

Tại phòng mạch này, chúng tôi đang hỏi mọi người câu hỏi:

Bạn có bị những vấn đề trong cuộc sống do việc chơi cờ bạc của mình hoặc người khác không?

Cờ bạc có thể gây ra các vấn đề theo nhiều cách. Chúng có thể vô hình và tiềm ẩn trong nhiều năm.

Đó có thể là những thứ như:

Những vấn đề về tài chính

Những khó khăn trong mối quan hệ

Những vấn đề về sức khỏe, chẳng hạn như khó ngủ

Đau khổ về cảm xúc hoặc tâm lý

Giảm hiệu suất trong công việc hoặc học tập

Chúng tôi đang yêu cầu mọi người hoàn thành một mẫu đơn sàng lọc nhanh về cờ bạc - bạn có thể thảo luận với bác sĩ gia đình của mình về việc này.

Nếu việc chơi cờ bạc của bạn hoặc ai khác đang gây rắc rối trong cuộc sống của bạn, **hãy nói chuyện đó với bác sĩ gia đình của bạn.**
Có nhiều tài nguyên và sự hỗ trợ miễn phí. Sẵn có bằng các ngôn ngữ khác nhau.

Hãy gọi Gambling Help (Trợ Giúp Về Cờ Bạc) để được hỗ trợ miễn phí, bảo mật, có sẵn 24/7 **1800 858 858**

Để được hỗ trợ trong các ngôn ngữ khác, hãy gọi Dịch Vụ Cờ Bạc Có Hại Đa Văn Hóa **1800 856 800**

Gambling doesn't have a face. Anyone can be affected.

At this organisation we are asking everyone the question:

Have you had problems in your life because of your or someone else's gambling?

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties

Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

We are asking everyone to complete a quick screening form about gambling which can be discussed with a community worker.

If your or someone else's gambling is causing problems in your life, **talk to a community worker.** There are many free resources and support. These are available in different languages.

Call Gambling Help for free, confidential support, available 24/7 1800 858 858

For support in other languages, call the Multicultural Problem Gambling Service

ليس للمقامرة وجه ويمكن أن تؤثر على أي شخص.

في هذه المنظمة نطرح السؤال التالي على الجميع:

هل واجهت مشاكل في حياتك بسبب لعبك أنت أو شخص آخر القمار؟

قد تسبب المقامرة مشاكلًا بطرق عدة وقد تكون تلك المشاكل خفية ومخفية لسنوات طوال

وقد تشمل:

مشاكل مالية

صعوبات في العلاقات الخاصة

مشاكل صحية منها صعوبة النوم

الضيق العاطفي أو النفسي

انخفاض الأداء في العمل أو الدراسة

نطلب من الجميع إكمال استمارة فحص قصيرة عن المقامرة يمكن مناقشتها مع أحد الأخصائيين الاجتماعيين.

إذا سبب لعبك أنت أو شخص آخر القمار مشاكل في حياتك **تحدث مع أخصائي اجتماعي.** هناك العديد من الموارد والدعم المجاني متاح بلغات مختلفة.

اتصل بخط مساعدة المقامرين للحصول على دعم مجاني وسري متاح على مدار الساعة طوال أيام الأسبوع **١٨٠٠ ٨٥٨ ٨٥٨**

للحصول على الدعم بلغات أخرى اتصل بخدمة مساعدة المقامرين المتعددة ثقافيا **١٨٠٠ ٨٥٦ ٨٠٠**

ܦܠܚܘܬܐ ܕܩܘܡܪ ܠܝܬܝܗ̇ ܠܐ ܚܕܐ ܩܛܬܐ. ܗ̇ܝ ܡܨܝܐ ܕܡܥܒܕܐ ܚܘܪܒܐ ܥܠ ܟܠ ܦܪܨܘܦ ܕܗ̇ܘܐ.

ܠܐ ܐܢܬ ܒܠܚܘܕܝܟ ܐܢܫܐ ܕܩܘܡܪܝ ܠܗ̇ ܡܢ ܟܠ ܚܕ ܦܪܨܘܦܐ ܐܚܪܢܐ ܒܩܘܡܪܐ:

ܗܝܢ ܩܘܡܪܝܟܘܢ ܐܝܟܐ ܡܨܝܐ ܠܐ ܫܘܝܟܘܢ ܒܥܠܡܐ ܕܦܠܚܘܬܐ ܕܩܘܡܪ ܕܩܘܡܪܟܘܢ ܝܢ ܕܚܕ ܦܪܨܘܦܐ ܐܚܪܢܐ؟

ܦܠܚܘܬܐ ܕܩܘܡܪ ܡܨܝܐ ܕܡܥܒܕܐ ܡܫܟܠܐ ܒܕܘܟܝܬܐ ܣܓܝܐܐ. ܐܝܟ ܡܨܝܐ ܕܗ̇ܘܝܐ ܠܐ ܡܬܚܫܚܢܐ ܘܡܫܟܠܢܐ ܗ̇ܘ ܕܟܠ ܝܘܡܐ.

ܐܝܟ ܦܠܛ̈ܐ ܕܣܓܝܐ ܡܬܚܙܝܢ ܐܢܝ:

ܡܫܟ̈ܠܐ ܕܟܣܦ̈ܐ

ܫܚܘܩܝܐ ܕܐܚܘܢܘܬܐ (ܝܠܕ̈ܐ)

ܡܫܟ̈ܠܐ ܕܫܘܠܡ̈ܢܐ، ܐܝܟ ܫܚܘܩܝܐ ܒܕܡܟܬܐ

ܒܩܘܪ̈ܐ ܕܥܩܬ̈ܐ ܝܢ ܙܘܥ̈ܐ

ܥܒܘܕܘܬܐ ܒܝܫܬܐ ܠܐ ܦܘܠܚܢܐ ܝܢ ܝܘܠܦܢܐ

ܐܝܟ ܦܠܛ̈ܐ ܡܢ ܟܠ ܚܕ ܦܪܨܘܦܐ ܕܡܫܟܠܘ ܗ̇ܘܢ ܦܘܫܐ ܕܢܦܫܐ ܡܫܘܠܛܐ ܒܘܗ̇ ܦܠܚܘܬܐ ܕܩܘܡܪ ܐܝܟ ܕܡܨܝܐ ܕܦܫ̈ܐ ܕܢܦܫܬܐ ܥܡ ܚܕ ܦܠܚܐ ܕܒܝܬܐ.

ܝܢ ܦܠܚܘܬܐ ܕܩܘܡܪܟܘܢ ܝܢ ܕܚܕ ܦܪܨܘܦܐ ܐܚܪܢܐ ܡܥܒܕܝܐ ܡܫܟܠܐ ܠܐ ܫܘܝܟܘܢ، ܘܡܣܘܣܝܢ ܥܡ ܚܕ ܦܠܚܐ ܕܒܝܬܘܬܐ. ܐܝܬ ܠܝܬ ܚܕܐ ܡܬܘܝܐ ܘܗܕܝܐ ܡܠܝܬܐ. ܐܢܐ ܡܨܝܐ ܕܦܫܝܢ ܡܢܝܢ ܒܝܬ̈ܝܐ ܣܓܝܐܐ.

ܡܕܘ، ܗ̇ܐ ܚܘܫܒܐ ܦܠܝܓܘܬܐ ܕܦܠܚܘܬܐ ܕܩܘܡܪ ܠܡܥܕܪܐ ܗܕܝܐ ܡܠܝܬܐ ܘܐܕܘܪ̈ܬܐ. ܚܘܫܒܐ ܦܬܝܚܐ ܝܘܡܐ 7\24

1800 858 858

ܠܡܠܟ̈ܐ ܗܕܝܐ ܒܝܬ̈ܝܐ ܐܚܪ̈ܢܐ ܡܕܘ، ܗ̇ܐ ܡܠܘܫܐ ܦܠܓ ܡܕܒܪܢܘܬܐ ܕܡܫܟܠܐ ܕܦܠܚܘܬܐ ܕܩܘܡܪ 1800 856 800

Cờ bạc không có hình dạng bề ngoài. Bất kỳ ai cũng có thể bị ảnh hưởng.

Tại tổ chức này, chúng tôi đang hỏi mọi người câu hỏi:

Bạn có bị những vấn đề trong cuộc sống do việc chơi cờ bạc của mình hoặc người khác không?

Cờ bạc có thể gây ra các vấn đề theo nhiều cách. Chúng có thể vô hình và tiềm ẩn trong nhiều năm.

Đó có thể là những thứ như:

Những vấn đề về tài chính

Những khó khăn trong mối quan hệ

Những vấn đề về sức khỏe, chẳng hạn như khó ngủ

Đau khổ về cảm xúc hoặc tâm lý

Giảm hiệu suất trong công việc hoặc học tập

Chúng tôi đang yêu cầu mọi người hoàn thành một mẫu đơn sàng lọc nhanh về cờ bạc - bạn có thể thảo luận với một nhân viên cộng đồng về việc này.

Nếu việc chơi cờ bạc của bạn hoặc ai khác đang gây rắc rối trong cuộc sống của bạn, **hãy nói chuyện đó với một nhân viên cộng đồng.** Có nhiều tài nguyên và sự hỗ trợ miễn phí. Sẵn có bằng các ngôn ngữ khác nhau.

Hãy gọi Gambling Help (Trợ Giúp Về Cờ Bạc) để được hỗ trợ miễn phí, bảo mật, có sẵn 24/7 **1800 858 858**

Để được hỗ trợ trong các ngôn ngữ khác, hãy gọi Dịch Vụ Cờ Bạc Có Hại Đa Văn Hóa **1800 856 800**

Gambling doesn't have a face. Anyone can be affected.

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties

Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

Call Gambling Help for free, confidential support, available 24/7

1800 858 858

For support in other languages

Call the Multicultural Problem Gambling Service

1800 856 800

Gambling doesn't have a face. Anyone can be affected.

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties

Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

Call Gambling Help for free, confidential support, available 24/7

1800 858 858

For support in other languages

Call the Multicultural Problem Gambling Service

1800 856 800

ليس للمقامرة وجه
ويمكن أن تؤثر على أي شخص.

قد تسبب المقامرة مشاكلًا بطرق عدة وقد تكون تلك المشاكل خفية ومخفية لسنوات طوال

وقد تشمل:

مشاكل مالية

صعوبات في العلاقات الخاصة

مشاكل صحية منها صعوبة النوم

الضيق العاطفي أو النفسي

انخفاض الأداء في العمل أو الدراسة

اتصل بخط مساعدة المقامرين للحصول على دعم مجاني وسري متاح على مدار الساعة طوال أيام الأسبوع

١٨٠٠ ٨٥٨ ٨٥٨

للدعم بلغات أخرى

اتصل بخدمة مساعدة المقامرين المتعددة ثقافيا

١٨٠٠ ٨٥٦ ٨٠٠

Gambling doesn't have a face.

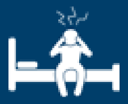
Anyone can be affected.

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties


Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

Call Gambling Help for free, confidential support, available 24/7

1800 858 858

For support in other languages

Call the Multicultural Problem Gambling Service

1800 856 800

ܓܪܵܠܬܵܐ ܕܩܘܼܡܵܪ ܠܝܼܗ ܟܠܵܐ ܚܕܵܐ ܦܵܬܵܐ.

ܗܿܝ ܩܵܝܢܵܐ ܕܡܲܟܒܸܕܵܐ ܟܠܵܐ ܐܢܫ ܒܟܠ ܩܵܢܝ ܕܗܘܹܐ.

ܓܪܵܠܬܵܐ ܕܩܘܼܡܵܪ ܩܵܝܢܵܐ ܕܡܲܟܒܕܵܢܵܐ ܝܡܠܵܐ ܠܟܘܼܠܚܕܵܐ ܦܪܝܫܵܐ. ܐܲܝܟ ܩܵܝܢܵܐ ܕܗܘܹܐ ܟܠܵܐ ܝܡܚܫܘܒܬܵܐ ܘܝܠܡܵܐ ܩܵܐ ܕܟܠܵܐ ܝܘܡܵܐ.

ܐܲܝܟ ܚܠܟܵܐ ܕܫܒܵܒܐ ܝܡܒܟܝܵܐ ܐܝܢ:

ܝܡܠܵܐ ܕܟܫܦܝܵܐ

ܓܥܘܼܫܝܵܐ ܕܐܲܚܢܘܬܵܐ (ܓܠܵܠܵܐ)

ܝܡܠܵܐ ܕܚܘܠܡܵܢܵܐ، ܐܝܟ ܓܥܘܼܫܬܵܐ ܒܕܡܟܬܵܐ

ܟܒܘܼܥܵܢܵܐ ܕܓܠܝܬܵܢܵܐ ܒ ܢܘܼܬܢܵܐ

ܟܒܫܘܬܵܐ ܒܝܕܬܵܐ ܠܗ ܦܘܠܚܵܢܵܐ ܒ ܝܕܢܵܐ

ܡܕܘܼ، ܩܵܐ ܚܘܼܟܵܐ ܓܠܒܘܦܵܢܵܐ ܕܓܪܵܠܬܵܐ ܕܩܘܼܡܵܪ ܠܒܥܘܬܵܐ ܗܢܒܬܵܐ ܡܟܪܬܵܐ ܘܐܕܘܪܬܵܐ. ܚܘܼܟܵܐ ܦܬܝܚܵܐ ܡܝܘܡ 7\24

1800 858 858

ܝܡܠܠܵܐ ܗܢܒܬܵܐ ܒܝܠܝܵܐ ܐܝܕܥܝܵܐ
ܡܕܘܼ، ܩܵܐ ܝܡܠܦܗ ܗܠܒ ܡܕܒܘܬܵܢܬܵܐ ܕܝܡܠܵܐ ܕܓܪܵܠܬܵܐ ܕܩܘܼܡܵܪ

1800 856 800

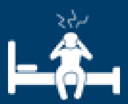
Gambling doesn’t have a face. Anyone can be affected.

Gambling can cause problems in lots of ways. They can be invisible and hidden for many years.

This may include things like:

Financial problems

Relationship difficulties



Health problems, such as difficulty sleeping

Emotional or psychological distress

Reduced performance at work or study

Call Gambling Help for free, confidential support, available 24/7

1800 858 858

For support in other languages

Call the Multicultural Problem Gambling Service

Cờ bạc không có hình dạng bề ngoài.

Bất kỳ ai cũng có thể bị ảnh hưởng.

Cờ bạc có thể gây ra các vấn đề theo nhiều cách. Chúng có thể vô hình và tiềm ẩn trong nhiều năm.

Đó có thể là những thứ như:

Những vấn đề về tài chính

Những khó khăn trong mối quan hệ

Những vấn đề về sức khỏe, chẳng hạn như khó ngủ

Đau khổ về cảm xúc hoặc tâm lý

Giảm hiệu suất trong công việc hoặc học tập

Hãy gọi Gambling Help (Trợ Giúp Về Cờ Bạc) để được hỗ trợ miễn phí, bảo mật, có sẵn 24/7

Để được hỗ trợ trong các ngôn ngữ khác

Hãy gọi Dịch Vụ Cờ Bạc Có Hại Đa Văn Hóa

Health Condition Factsheet
Released March 2020

Problem Gambling

What is it?

Some people can gamble responsibly, but others find it hard to stop. Gambling becomes a problem when it starts to disrupt a person's personal, family and work life. Problem gambling can also affect those around them.

If your quality of life is suffering due to your or someone else's gambling, there is help.

What will my GP do?

If you have a problem with gambling, your GP can give you tools, resources and support to help you cut back or quit. Your GP will want to talk to you about how often you gamble and how you feel about gambling. You'll be asked to talk about any symptoms or behaviours that might affect your gambling – for example, if you drink or take drugs.

Your GP will also:

- Talk to you about how you can keep track of your gambling
- Help you notice how your gambling affects you and your family
- Look for and treat any other health concerns related to your gambling, such as anxiety and depression
- Refer you to get further support. This referral could be to a to a gambling helpline or for counselling.
- Give you information to help you learn more about gambling

If you are being affected by someone else's gambling, your GP can also offer referrals and information on how you can get support. There are many support services available for those affected by gambling.

What can I do?

Gambling affects people from all walks of life and in different ways. It is ok to need some form of help to stop gambling. Remember, your GP is here to help you, and there is plenty of support available. Talk to your GP about a referral for a counsellor.

Changing a habit takes time and effort, and you may need to try a few times before you are able to stop completely. It may help to:

- Think about any triggers that cause you to rely on gambling, like alcohol or drugs. Talk to your GP about how to manage these triggers and ask for tools to help you cope with your urges to gamble
- Stay positive. Many people are able to overcome gambling problems and return to a good quality of life
- Try to stay active and healthy
- Follow up on any referrals your GP may make
- Use the resources available for people wanting to change their gambling behaviour

If you are being affected by someone else's gambling, it is important that you seek support for yourself. Talk to your GP about what supports are available.

The effects of gambling harm

Gambling harm can occur in the following ways:

Financial losses and pressure
•
An increase in physical and mental health concerns
•
Harm to relationships
•
Difficulty in social interactions
•
Impacts on education and employment

Gambling harm doesn't just affect the person who gambles, it can also affect those around them.

It is estimated that for every person who engages in harmful gambling, six people are affected.

Problem Gambling

What supports are available?

Gambling HELP
NSW Government funded service offering free and confidential support 24 hours a day. Phone **1800 858 858**.

South Western Sydney LHD Gambling Treatment Program
Free for people affected by problem gambling. District-wide service. Location: Mental Health Unit, Liverpool Hospital. Phone **9616 4354**.

Warruwi Gambling Help
Problem gambling support for Aboriginal and Torres Strait people and communities. Phone **1800 752 948**.

Mission Australia Problem Gambling Service
Free support for anyone living in the Macarthur region. Phone **4621 7400**.

The Bridge Program
Free support and programs for problem gambling. Phone **9743 4535** or **13 72 58**.

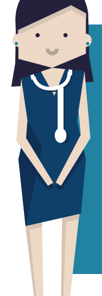
Moneycare Financial Counselling
Free services for those with problem gambling concerns. Visit salvos.org.au

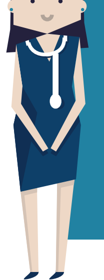
St John of God
Support for people affected by problem gambling. Fees apply. Phone **8746 4400** or visit sjog.org.au

Uniting Gambling Counselling Service
Free online, phone and in-person support. Phone **4629 7070** or visit uniting.org

USYD Gambling Treatment Clinic
Free support run by the University of Sydney School of Psychology. Phone **1800 482 482**.

Recovery Point
Find other supports and services in the Recovery Point directory. Visit recoverypoint.org.au





What questions could I ask my doctor?

- [ ] *How can I get help for my gambling problem?*
- [ ] *What treatment options are available?*
- [ ] *What should I do if my problem gets worse?*
- [ ] *Should I see a mental health professional?*

Where can I learn more?

- **Arab Council of Australia:** arabcouncil.org.au
- **Better Health Channel – gambling:** betterhealth.vic.gov.au
- **Gamblers Anonymous:** gansw.org.au
- **Gambling Help Online – how to help:** gamblinghelponline.org.au
- **Multicultural Problem Gambling Service of NSW:** dhi.health.nsw.gov.au/mpgs
- **NSW Government – gambling help:** gamblinghelp.nsw.gov.au

This information is to be viewed by someone who has received a diagnosis from their doctor. It is not designed to be used to diagnose a condition or as a substitute for ongoing medical care

Health Resource Directory is an initiative of South Western Sydney PHN

نشرة معلومات عن الحالة الصحية
صدرت في مارس/آذار ٢٠٢٠

إدمان القمار

ما هو إدمان القمار؟

يمكن لبعض الأشخاص المقامرة بشكل مسؤول، بينما يجد البعض الآخر صعوبة في التوقف عن ممارستها. تصبح المقامرة مشكلة عندما تبدأ في تعطيل حياة الشخص الشخصية والأسرية والعملية. كما يمكن أن يؤثر إدمان القمار أيضًا على من حولهم.
المساعدة متاحة إذا تدهورت نوعية حياتك بسبب لعبك أنت أو غيرك القمار فهناك مساعدة.

ماذا سيفعل طبيبي؟

إذا كنت مدمنًا للقمار فبوسع طبيبك أن يمنحك الأدوات والموارد والدعم لمساعدتك على التقليل منه أو الإقلاع عنه. سيحتاج طبيبك إلى التحدث معك عن وثيرة ممارستك للقمار وشعورك حيال الأمر. سيُطلب منك التحدث عن أي أعراض أو سلوكيات قد تؤثر على لعبك القمار - كتناول الكحول أو المخدرات مثلا.
وسوف يقوم طبيبك أيضا بالتالي:

- التحدث معك عن كيفية تعقب لعبك القمار
- مساعدتك على ملاحظة آثار المقامرة عليك وعلى أسرتك
- تقصي أي مشاكل صحية أخرى تتعلق بمقامرتك، مثل القلق والاكتئاب، وعلاجها.
- إحالتك للحصول على مزيد من الدعم. يمكن أن تكون هذه الإحالة إلى خط مساعدة المقامرين أو للحصول على إرشاد.
- مدّك بالمعلومات لمساعدتك على معرفة المزيد عن المقامرة

إذا كنت متأثرًا بمقامرة شخص آخر، يمكن لطبيبك العام أيضًا تقديم إحالات ومعلومات حول كيفية الحصول على الدعم. هناك العديد من خدمات الدعم المتاحة للمتضررين من القمار.

ماذا يمكنني أن أقوم به؟

تؤثر المقامرة على الأشخاص من جميع مناحي الحياة وبطرق مختلفة، ومن المقبول أن نحتاج إلى المساعدة بشكل أو أخر للتوقف عنها. تذكر أن طبيبك هنا لمساعدتك وأن هناك الكثير من الدعم المتاح. تحدث إلى طبيبك العام حول إحالتك إلى مرشد نفسي.
يستغرق تغيير أي عادة وقتًا وجهدًا وقد تحتاج إلى تكرار المحاولة عدة مرات قبل أن تتمكن من التوقف تمامًا. قد يساعدك التالي:

- التفكير في أي عوامل تجعلك تعتمد على المقامرة، كالكحول أو المخدرات. التحدث إلى طبيبك حول كيفية التحكم في هذه العوامل وطلب أدوات لمساعدتك على التأقلم مع رغباتك في المقامرة
- الحفاظ على الإيجابية. استطاع العديدون التغلب على المشاكل الناجمة عن القمار والعودة إلى حياة جيدة.
- محاولة الاستمرار في مزاولة الرياضة والحفاظ على صحتك
- متابعة أي إحالات قام بها طبيبك العام
- استخدام الموارد المتاحة للأشخاص الذين يريدون تغيير سلوكهم المتعلق بالمقامرة

آثار إدمان القمار

يمكن أن تحدث أضرار من جراء المقامرة بالطرق التالية :
الخسائر والضغوط المالية
•
ارتفاع المخاوف المتعلقة بالصحة البدنية والعقلية
•
الإضرار بالعلاقات الشخصية
•
صعوبات في التفاعلات الاجتماعية
•
آثار تترتب على التعليم والعمل

لا يؤثر إدمان القمار على المقامرين فحسب بل وأيضًا على من حولهم

ويقدر أنه كل شخص يمارس القمار بشكل ضار يؤثر على ستة أشخاص آخرين

آثار أضرار القمار

إذا أثرت مقامرة شخص آخر عليك فمن المهم أن تسعي لمن يدعمك. تحدث إلى طبيبك حول أنواع الدعم المتاحة لك.

إدمان القمار

ما هي أنواع الدعم المتاحة؟

مساعدة المقامرين (Gambling HELP)

خدمة ممولة من حكومة نيو ساوث ويلز تقدم دعمًا مجانيًا وسريًا على مدار الساعة. الهاتف: ١٨٠٠ ٨٥٨ ٨٥٨

برنامج معالجة المقامرة التابع لمنطقة الصحة المحلية لجنوب غرب سيدني

مجانًا للأشخاص المتأثرين بإدمان القمار. خدمة على مستوى المنطقة. العنوان: وحدة الصحة النفسية، مستشفى ليفربول. الهاتف: ٤٣٥٤ ٩٦١٦

واروي لمساعدة المقامرين

دعم لمدمني القمار من السكان الأصليين وسكان جزر مضيق توريز ومجتمعاتهم المحلية. الهاتف: ١٨٠٠ ٧٥٢ ٩٤٨

خدمة مساعدة مدمني المقامرة التابعة لميشون أستراليا

دعم مجاني لأي شخص مقيم في منطقة ماكارثر. الهاتف: ٤٦٢١ ٧٤٠٠

برنامج بريدج (Bridge Program)

دعم وبرامج مجانية عن إدمان المقامرة. الهاتف: ٩٧٤٣ ٤٥٣٥ أو ١٣ ٧٢ ٥٨.

مونيكير للمشورة المالية

خدمات مجانية لمن يعانون من مشاكل تتعلق بإدمان المقامرة. قم بالاطلاع على الموقع salvos.org.au

سانت جون أوف غود

دعم للأشخاص المتأثرين بإدمان القمار. تطبق رسوم على الخدمات. اتصل على الرقم ٨٧٤٦ ٤٤٠٠ أو اطلع على الموقع sjog.org.au

خدمة يونايتينغ لإرشاد المقامرين

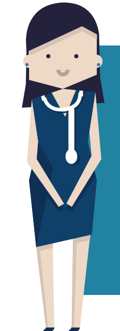
دعم مجاني عبر الإنترنت والهاتف ووجها لوجه. اتصل على الرقم ٤٦٢٩ ٧٠٧٠ أو اطلع على الموقع uniting.org

عيادة جامعة سيدني لعلاج إدمان القمار

دعم مجاني تديره كلية علم النفس بجامعة سيدني. الهاتف: ١٨٠٠ ٤٨٢ ٤٨٢

نقطة استرداد العافية (Recovery Point)

ابحث عن الدعم والخدمات الأخرى في دليل Recovery Point. قم بالاطلاع على الموقع recoverypoint.org.au



ما الأسئلة التي يمكن أن أطرحها على طبيبي؟

- ☐ كيف يمكنني الحصول على المساعدة بصدد إدماني للقمار؟
- ☐ ماذا أفعل إذا تفاقمت مشكلتي؟
- ☐ ما خيارات العلاج المتاحة؟
- ☐ هل يجب أن أقابل أخصائي صحة نفسية؟

أين يمكنني معرفة المزيد؟

- المجلس العربي الأسترالي: arabcouncil.org.au
- قناة الصحة الأفضل - المقامرة: betterhealth.vic.gov.au
- المقامرون المجهولون: gansw.org.au
- مساعدة المقامرين عبر الإنترنت - كيفية المساعدة: gamblinghelponline.org.au
- خدمة مساعدة المقامرين المتعددة ثقافيا في نيو ساوث ويلز: dhi.health.nsw.gov.au/mpgs
- حكومة نيو ساوث ويلز - مساعدة المقامرين: gamblinghelp.nsw.gov.au

دليل الموارد الصحية هو مبادرة من شبكة الرعاية الصحية الأولية في جنوب غرب سيدني

هذه المعلومات مخصصة لأشخاص حصلوا على تشخيص من طبيبهم. وهي غير مصممة للاستخدام لحالة مرضية أو كبديل للرعاية الطبية المستمرة.

An Australian Government Initiative

South Western Sydney PHN

ܡܫܘܼܬܦܘܼܬܼܵܐ ܕܒܘܼܚܵܪܵܢܵܐ ܕܚܘܼܠܡܵܢܵܐ

ܦܘܼܫܵܩܵܐ ܕܡܲܥܠܡܵܢܘܼܬܼܵܐ ܕܒܸܣܬܵܢܵܐ ܕܚܘܼܠܡܵܢܵܐ
ܦܲܪܨܘܿܦܵܐ ܚܕܼܵܬܼܵܐ ܕܫܢܼܵܬܼܵܐ 2020

ܡܘܼܫܟܸܠܵܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ

ܡܘܿܕܝܼ ܝܠܹܗ ܐܵܗܵܐ ܡܸܢܕܝܼ؟

ܩܘܼܡܵܪܵܐ ܐܲܢܝܼܬܵܐ ܗ̇ܘܹܐ ܕܦܲܬܠܬܵܐ ܩܘܼܡܵܪܵܐ ܒܲܥܘܼܡܵܪܵܐ، ܐܸܢܵܐ ܐܵܝܡܵܢܵܐ ܒܸܕ ܫܲܘܬܼܵܦܵܐ ܒܲܚܡܵܐ ܠܦܲܬܠܵܬܼܵܐ ܡܸܢ ܠܦܲܬܵܠܬܼܵܐ. ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܗܵܘܹܐ ܒܸܕ ܡܲܫܟܠܵܐ ܡܵܕ
ܕܗ̇ܘ ܒܲܚܢܵܐ ܡܲܫܘܼܚܠܵܦܘܼ ܒܝܼܫܵܐ ܦܲܪܨܘܿܦܵܐ ܘܡܲܥܠܘܼܡܵܬܼܵܐ ܘܚܘܼܠܡܵܢܵܐ ܕܒܸܫܵܐ ܦܲܪܨܘܿܦܵܐ. ܡܘܼܫܟܸܠܵܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܐܵܦ ܗ̇ܘܹܐ ܕܟܹܐ ܐܵܬܹܐ ܥܲܠ ܐܲܢܝܼܬܵܐ
ܕܠܸܒܵܐ ܕܦܲܬܠܬܵܐ ܠܝܼ.

ܝܼ، ܫܲܘܬܼܵܦܵܐ ܕܫܘܼܢܵܝܵܐ، ܒܲܚܘܼܫܵܒܼܵܐ ܝܠܹܗ ܒܦܲܬܠܬܵܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܕܒܸܫܵܐ، ܟܹܐ ܗܵܘܹܐ ܒܸܕ ܦܲܪܨܘܿܦܵܐ ܐܲܚܪܵܢܵܐ، ܐܵܗܵܐ ܐܝܼܬܼ ܗܘܵܝܬܼܵܐ.

ܡܘܿܕܝܼ ܒܸܕ ܥܵܒܹܕ ܐܲܝܟ ܡܲܢܵܢܵܐ؟

ܝܼ، ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܗ̇ܘ ܡܘܼܫܟܸܠܵܐ ܒܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ، ܐܲܝܢܵܐ ܕܡܲܢܵܢܵܐ ܗ̇ܘܹܐ ܕܢܲܦܫܵܝܬܼܵܐ، ܐܵܦܵܐ ܘܡܲܟܬܒܼܵܢܵܐ ܘܗܲܝܡܵܢܘܼܬܼܵܐ
ܠܚܘܼܠܡܵܢܵܐ، ܕܡܲܥܒܪܵܢܘܼܬܼܵܐ، ܠܵܐ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܡܲܥܒܪܵܢܘܼܬܼܵܐ، ܠܵܐ. ܐܲܝܢܵܐ، ܒܸܕ ܗܘܵܝܘܼ ܡܲܟܬܒܼܵܢܵܐ، ܗ̇ܘܸܐ
ܥܲܠ ܚܲܕܼܵܐ ܒܸܕ ܒܹܗ ܦܲܬܠܬܵܐ، ܩܘܼܡܵܪܵܐ ܘܕܵܒܹܩ ܒܹܗ ܒܵܬܹܐ، ܒܸܕ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ. ܒܸܕ ܦܲܬܠܬܵܐ، ܡܲܘܕܥܵܢܵܐ ܗ̇ܘܹܐ
ܒܲܚܢܵܐ ܒܸܕ ܕܲܒܼܚܵܐ ܕܦܲܬܠܬܵܐ ܥܵܒܸܕ ܩܵܐ ܥܲܠ ܦܲܬܠܬܵܐ، ܕܩܘܼܡܵܪܵܐ — ܩܵܐ ܦܘܼܠܚܵܢܵܐ، ܝܼ، ܒܸܕ ܡܲܥܠܵܐ، ܦܲܬܠܬܵܐ
ܒܸܕ ܡܲܢܵܢܵܐ، ܗܲܝܡܵܢܘܼܬܼܵܐ. ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܡܲܢܵܢܵܐ ܐܵܦ ܒܸܕ:

- ܒܸܕ ܦܲܬܠܬܵܐ، ܗ̇ܘܹܐ ܕܲܒܼܚܵܐ ܗ̇ܘܼ، ܒܸܕ ܡܲܢܵܢܵܐ ܥܲܠ ܡܸܢܕܝܼ ܗ̇ܘܹܐ ܦܲܬܠܬܵܐ، ܕܩܘܼܡܵܪܵܐ
- ܒܸܕ ܦܲܬܠܬܵܐ، ܕܡܲܥܒܪܵܢܘܼ، ܕܲܒܼܚܵܐ ܦܲܬܠܬܵܐ، ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܡܲܢܵܢܵܐ ܠܹܗ ܥܲܠ ܐܲܝܟܵܢܵܝܘܼ، ܘܥܲܠ ܗܲܝܡܵܢܘܼܬܼܵܐ،
- ܒܸܕ ܡܲܢܵܢܵܐ ܠܟܠ ܡܘܼܫܟܸܠܵܐ ܚܘܼܠܡܵܢܵܐ، ܐܲܝܟ ܡܲܥܠܘܼܡܵܬܼܵܐ ܘܚܘܼܫܵܒܼܵܐ ܕܠܸܒܵܐ
- ܒܸܕ ܦܲܬܠܬܵܐ، ܕܡܲܥܒܪܵܢܘܼ، ܗܲܝܡܵܢܘܼܬܼܵܐ ܘܲܚܕܼܵܐ. ܐܸܢܵܐ ܦܲܬܠܬܵܐ ܥܵܒܸܕ ܕܗ̇ܘܹܐ ܠܒܸܕ ܚܘܼܫܵܒܼܵܐ ܦܘܼܠܚܵܢܵܐ ܕܦܲܬܠܬܵܐ ܒܸܕ
ܠܦܲܬܠܬܵܐ ܡܲܠܟܵܐ.
- ܒܸܕ ܦܲܬܠܬܵܐ، ܡܲܥܒܪܵܢܘܼܬܼܵܐ ܠܚܘܼܠܡܵܢܵܐ، ܕܡܲܥܠܘܼܡܵܬܼܵܐ، ܒܸܕ ܘܲܚܕܼܵܐ ܗ̇ܘܹܐ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ

ܝܼ، ܐܝܼܬܼ ܠܹܗ، ܒܸܕ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܦܲܪܨܘܿܦܵܐ ܐܲܢܝܼܬܵܐ، ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܡܲܢܵܢܵܐ ܐܵܦ ܗ̇ܘܹܐ ܕܡܲܥܒܪܵܢܵܐ ܦܲܬܠܬܵܐ
ܘܡܲܥܒܪܵܢܘܼܬܼܵܐ ܗ̇ܘܹܐ ܕܲܒܼܚܵܐ ܗ̇ܘܼ، ܕܡܲܥܒܪܵܢܘܼ، ܗܲܝܡܵܢܘܼܬܼܵܐ. ܐܵܗܵܐ ܐܝܼܬܼ ܕܵܒܼܵܐ ܚܘܼܫܵܒܼܵܐ ܕܗܲܝܡܵܢܘܼܬܼܵܐ ܩܵܐ ܐܲܝܟ ܕܦܲܬܠܬܵܐ ܠܝܼ
ܒܸܕ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ.

ܡܘܿܕܝܼ ܗ̇ܘܹܐ ܕܥܵܒܹܕ ܐܲܢܵܐ؟

ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܥܵܒܸܕ ܥܲܠ ܥܲܠ ܟܠܗܘܿܢ ܦܲܬܠܬܵܐ ܕܐܲܢܝܼܬܵܐ ܘܚܘܼܠܡܵܢܵܐ ܦܲܪܨܘܿܦܵܐ. ܡܲܥܒܪܵܢܘܼܬܼܵܐ ܠܹܗ ܕܐܲܢܝܼܬܵܐ ܗ̇ܘܹܐ
ܠܒܸܕ ܦܲܬܠܬܵܐ ܕܚܘܼܫܵܒܼܵܐ ܠܡܲܥܠܡܵܢܘܼ ܡܸܢ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ. ܕܒܸܕ، ܕܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܡܲܢܵܢܵܐ ܐܵܗܵܐ ܠܹܗ ܠܚܘܼܠܡܵܢܵܐ،
ܘܐܵܗܵܐ ܐܝܼܬܼ ܗܲܝܡܵܢܘܼܬܼܵܐ ܒܚܘܼܫܵܒܼܵܐ. ܒܸܕ، ܐܲܝܟ ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܡܲܢܵܢܵܐ ܗ̇ܘܹܐ ܦܲܬܠܬܵܐ ܠܚܘܼܠܡܵܢܵܐ ܩܵܐ ܒܸܕ ܦܲܬܠܬܵܐ.
ܚܘܼܠܡܵܢܵܐ ܒܸܕ ܒܸܕ ܗܲܝܡܵܢܘܼܬܼܵܐ ܠܹܗ ܠܒܸܕ ܘܚܘܼܫܵܒܼܵܐ، ܘܡܲܥܠܡܵܢܘܼ ܕܗܲܝܡܵܢܘܼܬܼܵܐ، ܠܦܲܬܠܬܵܐ ܡܲܥܠܡܵܢܘܼ ܒܸܕ
ܡܸܢ ܒܸܕ ܕܗܘܵܝܘܼ، ܕܡܲܥܒܪܵܢܘܼ، ܡܸܢ ܠܦܲܬܠܬܵܐ ܩܘܼܡܵܪܵܐ ܒܲܥܠܵܢܵܐ. ܐܸܢܵܐ ܒܸܕ ܕܦܲܬܠܬܵܐ ܐܲܝܟܵܢܵܝܘܼ، ܒܸܕ:

- ܒܸܕ ܗܘܵܝܘܼ، ܗ̇ܘܹܐ ܐܲܝܟ ܡܲܥܠܡܵܢܘܼܬܼܵܐ ܕܒܸܕ ܦܲܬܠܬܵܐ ܕܡܲܢܵܢܵܐ، ܥܲܠ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ، ܐܲܝܟ ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ ܒܸܕ
ܡܲܥܠܡܵܢܘܼܬܼܵܐ. ܒܸܕ، ܥܲܠ ܐܲܝܟܵܢܵܝܘܼܬܼܵܐ، ܡܲܢܵܢܵܐ ܗ̇ܘܹܐ ܕܲܒܼܚܵܐ ܡܲܥܒܪܵܢܘܼ، ܠܗܘܿܢ، ܐܸܢܵܐ ܡܲܥܠܡܵܢܘܼܬܼܵܐ ܘܦܲܬܠܬܵܐ،
ܕܲܢܦܲܫܵܝܬܼܵܐ، ܐܵܦܵܐ ܕܒܸܕ ܡܲܥܒܪܵܢܘܼ، ܕܡܲܥܒܪܵܢܘܼ، ܠܗܘܿܢ، ܠܦܲܬܠܬܵܐ، ܠܦܲܬܠܬܵܐ ܩܘܼܡܵܪܵܐ
- ܒܸܕ، ܕܲܒܼܚܵܐ، ܡܲܥܠܡܵܢܘܼ. ܕܵܒܼܵܐ ܐܲܢܝܼܬܵܐ ܒܸܕ ܗ̇ܘ ܡܲܥܠܵܐ ܠܦܲܬܠܬܵܐ ܥܲܠ ܡܘܼܫܟܸܠܵܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܘܡܲܥܒܪܵܢܵܐ
ܠܚܘܼܫܵܒܼܵܐ ܥܵܒܼܕܵܐ
- ܒܸܕ، ܕܦܲܬܠܬܵܐ، ܥܵܒܸܕ ܘܚܘܼܠܡܵܢܵܐ ܥܵܒܼܕܵܐ
- ܒܸܕ، ܠܗܘܿܢ، ܒܸܕ ܡܲܥܒܪܵܢܘܼܬܼܵܐ ܕܐܲܝܟܵܢܵܝܘܼ، ܡܲܢܵܢܵܐ ܡܲܥܠܡܵܢܘܼ ܠܹܗ ܩܵܐ ܠܹܗ،
- ܒܸܕ، ܠܗܘܿܢ، ܒܸܕ ܡܲܥܠܡܵܢܵܐ ܕܒܹܗ ܩܵܐ ܐܲܝܟ ܐܲܢܝܼܬܵܐ ܕܒܸܕ ܕܚܘܼܠܡܵܢܘܼ، ܕܦܲܬܠܬܵܐ ܗ̇ܘܹܐ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ

ܝܼ، ܐܝܼܬܼ ܠܹܗ، ܒܸܕ ܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܦܲܪܨܘܿܦܵܐ ܐܲܢܝܼܬܵܐ، ܐܲܢܫܵܝܬܼܵܐ ܠܹܗ ܕܦܲܬܠܬܵܐ، ܗܲܝܡܵܢܘܼܬܼܵܐ ܩܵܐ ܐܲܝܟܵܢܵܝܘܼ،. ܒܸܕ، ܥܲܠ ܐܲܝܟܵܢܵܝܘܼ،
ܡܲܢܵܢܵܐ ܗ̇ܘܹܐ ܐܲܝܟ ܗܲܝܡܵܢܘܼܬܼܵܐ ܗ̇ܘܹܐ، ܕܡܲܥܒܪܵܢܘܼ، ܠܗܘܿܢ،.

ܫܲܪ̈ܒܹܐ ܕܚܘܼܪ̈ܵܒܹܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ

ܚܘܼܪ̈ܵܒܹܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܗ̇ܘܹܐ ܕܗ̇ܘܹܐ ܒܚܘܼܫܵܒܼܵܐ ܕܡܲܥܠܡܵܢܘܼ ܐܝܼܬܼ: ܚܘܼܫܵܒܼܵܐ ܘܚܘܼܠܡܵܢܵܐ ܕܡܲܥܠܡܵܢܘܼ

•

ܚܕܼܵܐ ܘܲܚܕܼܵܐ ܠܹܗ ܡܘܼܫܟܸܠܵܐ ܦܲܬܠܬܵܐ ܘܚܘܼܠܡܵܢܵܐ ܕܗ̇ܘܹܐ

•

ܚܘܼܪ̈ܵܒܹܐ ܠܐܲܢܝܼܬܵܐ (ܒܸܕ ܥܲܠ ܐܲܢܝܼܬܵܐ ܐܲܢܫܵܝܬܼܵܐ)

•

ܒܸܕ ܡܲܥܠܡܵܢܘܼ ܒܲܥܘܼܡܵܪܵܐ ܦܲܬܠܬܵܐ

•

ܫܲܪ̈ܒܹܐ ܥܲܠ ܡܘܼܠܵܦܵܐ ܘܦܘܼܠܚܵܢܵܐ ܚܘܼܪ̈ܵܒܹܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܒܸܕ ܐܲܢܝܼ ܥܵܒܹܕ ܫܲܪܒܵܐ ܥܲܠ ܦܲܪܨܘܿܦܵܐ ܕܦܲܬܠܬܵܐ ܠܹܗ ܩܘܼܡܵܪܵܐ، ܐܸܢܵܐ ܐܵܦ ܗ̇ܘܹܐ ܕܥܵܒܹܕ ܫܲܪܒܵܐ ܥܲܠ ܐܲܝܟ ܕܒܸܕ ܠܚܘܼܫܵܒܼܵܐ ܕܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ. ܦܲܬܠܬܵܐ ܠܹܗ ܚܘܼܫܵܒܼܵܐ ܕܩܵܐ ܒܸܕ ܦܲܪܨܘܿܦܵܐ ܕܒܸܕ ܠܹܗ ܒܦܲܬܠܬܵܐ ܕܩܘܼܡܵܪܵܐ ܚܘܼܠܡܵܢܵܐ، ܐܝܼܬܼ ܐܲܢܝܼܬܵܐ ܐܲܢܫܵܝܬܼܵܐ ܒܸܕ ܡܲܥܠܵܐ ܐܲܝܟܵܐ.

ܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܕܦܘܣܬܐ

ܐܝܡܟܐ ܗܬܒܥܬܐ ܡܨܝܐ ܕܫܩܠܝܢ ܗܘܦܠܝܢܐ؟

Gambling HELP

ܚܕܐ ܚܠܡܬܐ ܗܘܦܠܬܐ ܒܝܕ ܛܘܠܦܘܢܐ ܕ NSW ܡܢ ܡܫܡܫܢܐ ܗܬܒܥܬܐ ܡܠܝܫܢܬܐ ܘܐܘܪ̈ܚܢܬܐ 24 ܫܥ̈ܐ ܒܝܘܡܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1800 858 858.

South Western Sydney LHD Gambling Treatment Program

ܡܠܝܫܢܬܐ ܩܐ ܐܢܫ̈ܐ ܕܦܝܫܐ ܡܢܐ ܠܒܘܫܪܐ ܒܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܕܦܘܣܬܐ. ܚܕܐ ܚܠܡܬܐ ܗܘܦܠܬܐ ܘܡܛܝܒܐ ܠܗ ܒܠܬܐ ܦܝܫܬܐ. ܕܘܟܬܐ: Mental Health Unit, Liverpool Hospital. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 9616 4354.

Warruwi Gambling Help

ܗܬܒܥܬܐ ܕܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܕܦܘܣܬܐ ܩܐ ܐܢܫ̈ܐ ܘܒܢܘܗܝ̈ܢܐ ܕܝܡܬܬ̈ܐ ܐܚ̈ܪܢܐ ܘܕܐܘܪ̈ܚܢܬܐ ܕܡܘܕܠܬܐ ܕܗܘܦܠܗ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1800 752 948.

Mission Australia Problem Gambling Service

ܗܬܒܥܬܐ ܡܠܝܫܢܬܐ ܩܐ ܐܝܟ ܕܝܬܝܢ ܡܢܐ ܠܗ ܦܝܫܬܐ ܕ Macarthur. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 4621 7400.

The Bridge Program

ܗܬܒܥܬܐ ܘܣܘܕܪܐ ܡܠܝܫܢܐ ܩܐ ܐܝܟ ܕܐܒܗܠܗܘܢ ܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܕܦܘܣܬܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 9743 4535 ܝܢ 13 72 58.

Moneycare Financial Counselling

ܚܠܡܬܐ ܡܠܝܫܢܐ ܩܐ ܐܝܟ ܕܐܒܗܠܗܘܢ ܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܦܘܣܬܐ. ܣܥܘܪܘܢ ܠܐܬܪܐ salvos.org.au

St John of God

ܗܬܒܥܬܐ ܡܠܝܫܢܬܐ ܩܐ ܐܢܫ̈ܐ ܕܦܝܫܐ ܡܢܐ ܠܒܘܫܪܐ ܒܡܥܕܪ̈ܢܐ ܕܓܢܒܠܬܐ ܦܘܣܬܐ. ܡܦܠܫܝܢܐ ܝܕ ܩܕܡܝ ܩܐ ܚܠܡܬܐ ܗܘܦܠܬܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 8746 4400 ܝܢ ܣܥܘܪܘܢ ܠܐܬܪܐ sjog.org.au

Uniting Gambling Counselling Service

ܗܬܒܥܬܐ ܡܠܝܫܢܬܐ ܥܠ ܝܘܒܠܝܗ ܘܚܘܠܒܘܗ ܘܗܘܡܝܢܬܐ ܦܪܝܘܦܠܝܗ ܦܠܐ ܠܦܠܬܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 4629 7070 ܝܢ ܣܥܘܪܘܢ ܠܐܬܪܐ uniting.org

USYD Gambling Treatment Clinic

ܗܬܒܥܬܐ ܡܠܝܫܢܬܐ ܗܘܡܝܢܬܐ ܒܝܕ ܡܕܒܪܢܬܐ ܕܐܗܘܗ ܢܦܫ̈ܐ ܕܝܢܗ ܝܘܡ̈ܐ ܕܫܒܬܐ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1800 482 482.

Recovery Point

ܡܬܒܣܘܢ ܠܗܘܢ ܗܬܒܥܬܐ ܘܚܠܡܬܐ ܐܝܟܢܝܐ ܠܗ ܡܒܘܥܢܐ ܕ Recovery Point. ܣܥܘܪܘܢ ܠܐܬܪܐ recoverypoint.org.au

ܐܝܟ ܒܘܣܢܐ ܡܨܝܐ ܕܒܥܕܪ ܠܗܘܢ ܡܢ ܐܚܝܢ؟

- ܕܐܒܝܢ ܡܨܝܐ ܕܡܒܠܝܢ ܦܘܪܣܬܐ ܩܐ ܥܕܫܬܐ ܕܡܥܕܪܝܢ ܕܓܢܒܠܬܐ ܕܦܘܣܬܐ؟
- ܐܝܟܢ ܠܒܘܫܪܐ ܕܦܕܡܬܐ ܡܨܝܐ ܕܡܦܠܝܝܢ ܠܗܘܢ؟
- ܡܦܘܕܝܢ ܠܐܕܠ ܕܠܟܕܝܢ ܝܢ ܡܥܕܪܝܢ ܝܘܡܢܐ ܘܠܗ ܒܘܣ ܡܕܢܐ؟
- ܐܒܝܢܫܬܐ ܡܠܝܘ ܕܫܘܝܢ ܩܐ ܚܕ ܐܚܢܐ ܡܚܒܕܐ ܕܚܘܠܫܢܐ ܕܗܘܢܐ؟

ܐܚܪ̈ܢܐ ܡܨܝܐ ܕܡܠܝܩ ܒܘܣ ܝܕܥܐ؟

- Arab Council of Australia: arabcouncil.org.au
- Better Health Channel – gambling: betterhealth.vic.gov.au
- Gamblers Anonymous: gansw.org.au
- Gambling Help Online – how to help: gamblinghelponline.org.au
- Multicultural Problem Gambling Service of NSW: dhi.health.nsw.gov.au/mpgs
- NSW Government – gambling help: gamblinghelp.nsw.gov.au

ܡܒܘܥܢܐ ܕܡܛܘܒܬܐ ܕܚܘܠܡܢܐ ܒܝܘ ܚܕܐ ܡܕܡܒܬܐ ܕ South Western Sydney PHN

ܐܢܐ ܡܘܕܥܢܘܬܐ ܠܐܕܠ ܕܦܠܢܐ ܣܘܒܬܐ ܒܝܕ ܦܪܝܘܦܐ ܕܗܘܒܐܠܐ ܡܝܗ ܚܕܐ ܦܪܝܘܦܬܐ ܡܢ ܐܚܝܗ. ܐܢܐ ܡܘܕܥܢܘܬܐ ܠܐ ܡܠܐ ܦܝܫܬܐ ܗܘܕܪܬܐ ܕܦܠܢܐ ܗܘܦܠܝܫܬܐ ܩܐ ܦܪܝܘܦܬܐ ܕܝܕ ܡܕܠܐ ܝܢ ܕܬܡܠܐ ܠܗ ܬܘܦܐ ܕܡܫܡܫܬܐ ܕܬܠܐ ܐܗܘܬܢܝܬܐ ܐܡܝܢܝܬܐ

Tờ Thông Tin Về Sức Khỏe

Lưu hành vào Tháng Ba 2020

Cờ Bạc Có Hại

Cờ bạc có hại là gì?

Một số người có thể chơi cờ bạc có trách nhiệm, nhưng những người khác cảm thấy khó dừng lại. Cờ bạc trở nên có hại khi nó bắt đầu phá vỡ cuộc sống, gia đình và công việc của một cá nhân. Cờ bạc có hại cũng có thể ảnh hưởng đến những người xung quanh.

Nếu chất lượng cuộc sống của bạn đang bị ảnh hưởng bởi việc bạn hoặc người khác chơi cờ bạc, thì đã có sự giúp đỡ.

Bác sĩ gia đình của tôi sẽ làm gì?

Nếu bạn gặp vấn đề với cờ bạc, bác sĩ gia đình của bạn có thể cung cấp cho bạn những công cụ, tài nguyên và sự hỗ trợ, giúp bạn cắt giảm hoặc bỏ cờ bạc. Bác sĩ gia đình của bạn sẽ muốn nói chuyện với bạn về tần suất bạn chơi cờ bạc và cảm giác của bạn về cờ bạc. Bạn sẽ được yêu cầu nói về bất kỳ triệu chứng hoặc hành vi nào có thể ảnh hưởng đến việc chơi cờ bạc của bạn - ví dụ: nếu bạn uống bia rượu hoặc dùng ma túy.

Bác sĩ gia đình của bạn cũng sẽ:

- Nói chuyện với bạn về cách bạn có thể theo dõi việc cờ bạc của mình
- Giúp bạn nhận thấy việc cờ bạc của bạn ảnh hưởng đến bạn và gia đình bạn như thế nào
- Tìm kiếm và điều trị bất kỳ mối quan ngại về sức khỏe nào khác liên quan đến việc cờ bạc của bạn, chẳng hạn như chứng lo lắng và trầm cảm
- Giới thiệu bạn để nhận được sự hỗ trợ thêm. Việc giới thiệu này có thể là một đường dây trợ giúp về vấn đề cờ bạc hoặc để được tư vấn.
- Cung cấp cho bạn thông tin giúp bạn hiểu thêm về cờ bạc

Nếu bạn đang bị ảnh hưởng bởi việc người khác cờ bạc, bác sĩ gia đình của bạn cũng có thể cung cấp các giới thiệu và thông tin về cách bạn có thể nhận được sự hỗ trợ.

Có nhiều dịch vụ hỗ trợ dành cho những người bị ảnh hưởng bởi cờ bạc.

Tôi có thể làm gì?

Cờ bạc ảnh hưởng đến mọi người từ mọi tầng lớp và theo những cách khác nhau. Bạn có thể cần một số hình thức trợ giúp để dừng chơi cờ bạc. Hãy nhớ rằng, bác sĩ gia đình của bạn ở đây để giúp bạn, và luôn có sẵn rất nhiều sự hỗ trợ. Hãy nói chuyện với bác sĩ gia đình của bạn để được giới thiệu gặp một cố vấn.

Thay đổi một thói quen cần có thời gian và công sức, và bạn có thể cần phải thử một vài lần trước khi bạn có thể dừng lại hoàn toàn. Nó có thể giúp bạn:

- Suy nghĩ về bất kỳ tác nhân nào khiến bạn phải dựa vào cờ bạc, như rượu hoặc ma túy. Hãy nói chuyện với bác sĩ gia đình của bạn về cách kiềm chế những tác nhân kích hoạt này và yêu cầu những công cụ giúp bạn đối phó với sự thôi thúc chơi cờ bạc của mình
- Lạc quan. Nhiều người có thể khắc phục những vấn đề về cờ bạc và trở lại với một cuộc sống có chất lượng tốt
- Cố gắng duy trì hoạt động và khỏe mạnh
- Theo dõi bất kỳ lời giới thiệu nào mà bác sĩ của bạn có thể đã làm cho bạn
- Sử dụng những tài nguyên có sẵn cho những người muốn thay đổi hành vi cờ bạc của họ

Nếu bạn đang bị ảnh hưởng bởi việc người khác đánh bạc, điều quan trọng là bạn phải tìm kiếm sự hỗ trợ cho chính mình. Hãy nói chuyện với bác sĩ gia đình của bạn về những sự hỗ trợ sẵn có.

Những tác hại của cờ bạc

Cờ bạc có hại có thể xảy ra theo những cách sau:

Tổn thất tài chính và áp lực

•

Gia tăng những quan ngại về sức khỏe thể chất và tinh thần

•

Có hại cho các mối quan hệ

•

Khó khăn trong tương tác xã hội

•

Tác động đến giáo dục và việc làm

Cờ bạc có hại không chỉ ảnh hưởng đến người chơi cờ bạc, nó còn có thể ảnh hưởng đến những người xung quanh.

Ước tính, đối với mỗi người tham gia vào cờ bạc có hại, sẽ có sáu người bị ảnh hưởng.

Cờ Bạc Có Hại

Những sự hỗ trợ sẵn có?

Gambling HELP (TRỢ GIÚP Về Cờ Bạc)
Dịch vụ do Chính Phủ NSW tài trợ cung cấp sự hỗ trợ miễn phí và bảo mật 24 giờ mỗi ngày. Điện thoại **1800 858 858**.

Chương Trình Điều Trị Bỏ Cờ Bạc thuộc Y Tế Địa Phương Vùng Tây Nam Sydney
Miễn phí cho những người bị ảnh hưởng bởi cờ bạc có hại. Dịch vụ toàn vùng. Địa điểm: Khoa Sức Khỏe Tâm Thần, Bệnh Viện Liverpool. Điện thoại **9616 4354**.

Warruwi Gambling Help (Trợ Giúp Về Cờ Bạc Warruwi)
Hỗ trợ về cờ bạc có hại cho người dân và cộng đồng Thổ Dân và Đảo Dân Eo Biển Torres. Điện thoại **1800 752 948**.

Dịch Vụ Về Cờ Bạc Có Hại thuộc Mission Australia
Hỗ trợ miễn phí cho bất kỳ ai sống ở khu vực Macarthur. Điện thoại **4621 7400**.

The Bridge Program (Chương Trình Nhịp Cầu)
Hỗ trợ miễn phí và các chương trình dành cho cờ bạc có hại. Điện thoại **9743 4535** hoặc **13 72 58**.

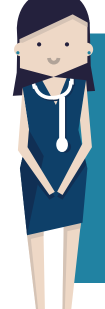
Tư Vấn Tài Chính Moneycare
Dịch vụ miễn phí cho những người có quan ngại về cờ bạc có hại. Truy cập salvos.org.au

St John of God
Hỗ trợ cho những người bị ảnh hưởng bởi cờ bạc có hại. Lệ phí áp dụng. Điện thoại **8746 4400** hoặc truy cập sjog.org.au

Dịch Vụ Tư Vấn Bỏ Cờ Bạc Uniting
Hỗ trợ trực tuyến, qua điện thoại và trực tiếp miễn phí. Điện thoại **4629 7070** hoặc truy cập uniting.org

Phòng Khám Điều Trị Bỏ Cờ Bạc USYD
Hỗ trợ miễn phí được điều hành bởi Trường Tâm Lý Học thuộc Đại Học Sydney. Điện thoại **1800 482 482**.

Recovery Point (Điểm Phục Hồi)
Tìm các hỗ trợ và dịch vụ khác trong thư mục Recovery Point. Truy cập recoverypoint.org.au



Những câu hỏi tôi có thể hỏi bác sĩ của mình?

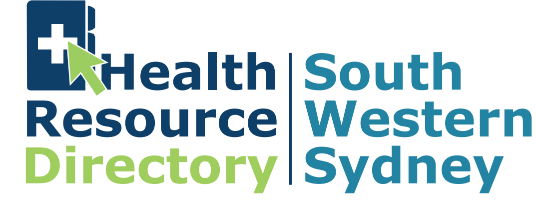
- ☐ *Làm cách nào tôi có thể nhận trợ giúp cho vấn đề cờ bạc của mình?*
- ☐ *Lựa chọn điều trị nào có sẵn?*
- ☐ *Tôi nên làm gì nếu vấn đề của tôi trở nên tồi tệ hơn?*
- ☐ *Tôi có nên gặp một chuyên gia sức khỏe tâm thần?*

Tôi có thể tìm hiểu thêm ở đâu?

- **Hội Đồng Ả-rập Úc Châu:** arabcouncil.org.au
- **Kênh Better Health Channel – cờ bạc:** betterhealth.vic.gov.au
- **Gamblers Anonymous (Những Người Chơi Cờ Bạc Ẩn Danh):** gansw.org.au
- **Trợ Giúp Trực Tuyến Về Cờ Bạc – cách thức giúp đỡ:** gamblinghelponline.org.au
- **Dịch Vụ Cờ Bạc Có Hại Đa Văn Hóa NSW:** dhi.health.nsw.gov.au/mpgs
- **Chính Phủ NSW – trợ giúp về cờ bạc:** gamblinghelp.nsw.gov.au

Thông tin này sẽ được đọc bởi một người đã nhận được chẩn đoán từ bác sĩ của họ. Nó không được thiết kế để được sử dụng cho chẩn đoán một bệnh về sức khỏe hoặc thay thế cho sự chăm sóc y tế đang diễn ra

Danh Mục Tài Nguyên Y Tế là một sáng kiến của PHN Tây Nam Sydney



健康状况信息单
2020年3月发布

问题赌博

这是什么？

有些人可以负责任地赌博，但其他人却很难停止赌博。当赌博开始扰乱一个人的个人、家庭和工作生活时，赌博就成为了一个问题。问题赌博也会影响他们周围的人。

如果你的生活品质因你或他人的赌博而受到影响，请寻求帮助。

我的家庭医生会做些什么？

如果你有赌博问题，你的家庭医生（GP）可以为你提供一些工具、资源和支持，以帮助你减少赌博或戒赌。家庭医生会想和你谈谈你赌博的频率，以及你对赌博的感受。医生会让你谈谈可能影响你赌博的任何症状或行为——例如你是否饮酒或吸毒。

家庭医生还将：

- 告诉你如何记录你的赌博情况
- 帮助你注意到你的赌博如何影响到你和家人
- 寻找并治疗与你的赌博相关的任何其他健康问题，如焦虑症和抑郁症
- 为你提供转介以获得进一步支持。这种转介可能是赌博帮助热线或心理辅导
- 为你提供信息，帮助你了解有关赌博的更多信息。

如果你受到他人赌博的影响，你的家庭医生也可以提供转介以及如何获得支持的信息。受赌博影响的人可以获得许多支持服务。

我能做些什么？

赌博以不同的方式影响各行各业的人。如果你需要某种形式的帮助来停止赌博，这是很正常的。请记住，你的家庭医生可以帮助你，而且还有很多支持服务可以帮到你。请与家庭医生讨论获得心理辅导师转介。

改掉一个习惯需要时间和精力，你可能需要尝试数次才能完全停止赌博。以下方面可能有些帮助：

- 想想任何导致你依赖赌博的诱因，比如酒精或毒品。与你的家庭医生讨论如何管控这些诱因，并请医生提供一些工具帮助你应对赌博的冲动
- 保持积极的态度。许多人都能够克服赌博问题，恢复良好的生活品质
- 尽量活动起来，保持健康
- 跟进医生提供给你的任何转介
- 为想要改变赌博行为的人提供可用的资源

如果你受到他人赌博的影响，你为自己获得支持也非常重要。请咨询家庭医生了解都有哪些支持服务。

赌博伤害的影响

赌博伤害可能通过以下方式发生：

财务损失和压力
•
身心健康问题增加
•
损害人际关系
•
社交互动困难
•
对教育和就业造成影响

赌博伤害不仅会影响赌博者本人，还会影响他们周围的人

据估计，对于每个从事有害赌博的人，有六个人会受到影响。

问题赌博

都有哪些支持？

赌博帮助（Gambling HELP）
一项由新南威尔士州政府拨款的免费服务，每天24小时提供保密的支持。请致电1800 858 858。

悉尼西南区本地医疗区域赌博治疗计划
为受问题赌博影响的人提供的一项全区域范围的免费服务。地点：利物浦医院精神健康科。请致电 9616 4354。

Warruwi赌博帮助
向土著和托雷斯海峡居民和社区提供的问题赌博支持。请致电 1800 752 948。

澳洲使命（Mission Australia）问题赌博服务
为居住在Macarthur地区的任何人提供的免费支持服务。请致电 4621 7400。

桥梁计划
为问题赌博提供的免费支持和计划。致电 9743 4535 或 13 72 58。

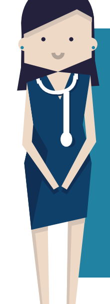
Moneycare财务规划咨询
为有问题赌博担忧的人提供的一项免费服务。请访问 salvos.org.au

St John of God
为受问题赌博影响的人提供的支持服务。需支付费用。请致电 8746 4400 或访问 sjog.org.au

联合赌博辅导服务
免费的在线、电话和面对面支持。请致电 4629 7070 或访问 uniting.org

USYD赌博治疗诊所
由悉尼大学心理学学院提供的免费支持。请致电 1800 482 482。

恢复点（Recovery Point）
在恢复点目录中查找其他支持和服务。请访问 recoverypoint.org.au



我可以问医生哪些问题？

- *如何获得帮助应对我的赌博问题？*
- *都有哪些可用的治疗选择？*
- *如果我的问题变得更加严重，应该做些什么？*
- *我是否应该去见精神健康专业人士？*

在哪里可以了解更多信息？

- 澳大利亚阿拉伯理事会：arabcouncil.org.au
- 更好的健康频道 – 赌博：betterhealth.vic.gov.au
- 赌博者匿名服务：gansw.org.au
- 赌博帮助热线 – 如何提供帮助：gamblinghelponline.org.au
- 新州多元文化问题赌博服务：dhi.health.nsw.gov.au/mpgs
- 新州政府 – 赌博帮助：gamblinghelp.nsw.gov.au

GP SPECIFIC RESOURCES

FREE Mental Health Commissioned Services – For GPs

South Western Sydney PHN commissions a range of FREE mental health services in line with a stepped care model. This means that services can be matched to the patients level of need.

For all mental health enquires please phone Mental Health Central Intake on **1300 797 746**

GP Mental Health Referrals and Mental Health Treatment Plans can be downlaoded from http://www.swsphn.com.au/formsandtemplates and are to be faxed to: **4623 1796**

*Please note: This is not a crisis service, for patients at high risk of suicide or harm to themselves or others, please phone **000** or the Community Mental Health Emergency Team (CoMHET) on **1300 797 799**.*

STAR4Kids (3-12 years):

Psychological therapies for children aged 3-12 years with, or are at risk of developing childhood emotional or behavioural concerns. Up to 12 Free sessions per calendar year delivered by a mental health professional (psychologist, mental health nurse, mental health accredited social worker, occupational therapist).

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan for Children, see: http://www.swsphn.com.au/formsandtemplates

---

headspace (12-25 years):

Support for young people aged 12 -25 for their mental health, physical health (sexual health), alcohol and other drugs and work and study.

Referral Process: No referral required – patient to phone or visit their local centre:

- Bankstown: **(02) 9393 9669** | 1/41-45 Rickard Rd, Bankstown
- Campbelltown: **(02) 4627 9089** | Level 8, 171-179 Queen St, Campbelltown
- Liverpool: **(02) 8785 3200** | 1/50 Macquarie St, Liverpool

ReFrame Youth Service (12-25 years):

Psychological therapies for young people aged 12-25 living in Wollondilly and Wingecarribee. Services are delivered by youth mental health workers and youth mental health professionals (psychologists, mental health nurses and social workers).

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan, see: http://www.swsphn.com.au/formsandtemplates

---

NewAccess:

6 mental health coaching sessions (+ 2 aftercare sessions) over phone, skype of face-to-face for anyone (18 years and over) needing support to deal with day-to-day stress/life pressures or emerging depression or anxiety.

Referral Process: No referral required – patient to phone: **1800 010 630**

You in Mind:

Psychological therapies for people with mild - moderate mental health concerns. Up to 12 sessions per calendar year delivered by a mental health professional (psychologist, mental health nurse, mental health accredited social worker, occupational therapist).

Eligible Groups (12 years +):

- People who identify as Aboriginal and/or Torres Strait Islander
- People who are from a Culturally and Linguistically Diverse Background
- Residents of Airds, Claymore and the 2168 postcode
- Residents of Wollondilly and Wingecarribee (with barriers to gaining support through Better Access)
- People experiencing financial hardship
- Women experiencing pre or postnatal depression
- People 65 years +
- People who identify as LGBTIQA+

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan, see: http://www.swsphn.com.au/formsandtemplates

Connect for Wellness:

Psychological therapies and peer support for adults with severe and persistent mental illness. Up to 20 sessions per calendar year delivered by psychologist's and peer workers.

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan, see: http://www.swsphn.com.au/formsandtemplates

---

Consultant Psychiatry Service:

Psychiatry support for people living with severe and persistent mental illness with barriers to accessing psychiatrists, as well as support for GPs in the treatment and management of these patients. Service delivered as telehealth across SWS (phone and web-based) and face-to-face at specific hubs (select General Practices in Bankstown, Liverpool, Fairfield, Campbelltown and Wollondilly)

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan, see: http://www.swsphn.com.au/formsandtemplates

---

Credentialed Mental Health Nurse Service:

Psychological therapies and coordination of clinical services for adults with a severe and complex mental illness. Unlimited sessions delivered by a credentialed mental health nurse.

Referral Process: SWSPHN GP Mental Health Referral and GP Mental Health Treatment Plan, see: http://www.swsphn.com.au/formsandtemplates

---

Clinical Suicide Prevention Service:

Priority access to services for people who have attempted suicide or have suicidal ideation of low to medium risk. Up to 10 sessions within 2 months delivered by a mental health professional (psychologist, mental health nurse, mental health accredited social worker, occupational therapist).

Referral Process: SWSPHN Clinical Suicide Prevention GP Referral, see: http://www.swsphn.com.au/formsandtemplates

---

Lifeline Crisis Support Suicide Aftercare Program:

Short term telephone crisis support to people (18 years +) who have attempted suicide. The service provides outgoing phone calls to monitor an individual's wellbeing and help keep the person connected. Phone calls are provided by an accredited and experienced Lifeline Crisis Supporter.

Referral Process: Referal form available to download, see: http://www.swsphn.com.au/lifeline-macarthur

Consultant Psychiatry Service

FOR GENERAL PRACTITIONERS (GPs)

South Western Sydney PHN has commissioned Dokotela to deliver the Consultant Pschiatry Service

About the Consultant Psychiatry Service:

The Consultant Psychiatry Service, delivered by Dokotela, provides FREE access to a psychiatrist for people with severe and persistent mental illness who have barriers to accessing a psychiatrist, as well as providing support to their GP in their patients treatment and care.

The service offers flexible delivery:

- Face to face at select practices in Bankstown, Fairfield, Liverpool, Campbelltown and Wollondilly. The patient will be allocated to their nearest face to face practice (Hub). Typically utilised for an initial assessment.
- Telehealth through telephone or Zoom conferencing, to any general practice in South Western Sydney.

Eligibility:

People with a severe and persistent mental illness requiring support from a psychiatrist however, due to barriers, are unable to access a psychiatrist. In addition, GPs requiring support in the treatment and management of this patient cohort. This is not an emergency/crisis service.

The service is available to young people and adults.

How to Refer:

GPs can refer to the Consultant Psychiatry Service by completing the SWSPHN Mental Health Referral form available to download from: http://www.swsphn.com.au/formsandtemplates

Referrals are to be faxed to SWSPHN Mental Health Central Intake **(02) 4623 1796**

Dokotela will then contact the patient and their GP to make an appointment. Future appointments may be booked online or by calling Dokotela on (02) 8003 7668.

Contact:

Dokotela Specialists

Phone (02) 8003 7668 or email admin@dokotela.com.au

MBS Items Claimable:

1. Items for organising a Case Conference

- MBS Item 735 Benefit: $86.55
- MBS Item 739 Benefit: $90.75
- MBS Item 743 Benefit: $151.25

2. Items for participating in a Case Conference

- MBS Item 747 Benefit: $38.95
- MBS Item 750 Benefit: $66.75
- MBS Item 758 Benefit: $111.15

Items 735-758 should generally be undertaken by the patient's usual general practitioner. This is a general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

3. Items for Patient Consultation

- MBS Item 23 Benefit: $37.60

Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant:

(a) taking a patient history;

(b) performing a clinical examination;

(c) arranging any necessary investigation;

(d) implementing a management plan

(e) providing appropriate preventive health care

Connector Hub supports people living with severe mental illness to achieve their goals and improve wellbeing.

Connector Hub is a psychosocial program giving those with severe mental illness support to live and participate in the community the way they want to.

Call Central Intake Line
1300 797 746
(1300 SWS PHN)

For more information visit
www.swsphn.com.au/mentalhealthcommunity

One Door Mental Health in partnership with Flourish Australia has been selected to deliver the Connector Hub in South Western Sydney for SWSPHN

This service is supported with funding from the Australian Government through the PHN Program

Connector Hub
South Western Sydney

A Psychosocial Support Program helping you live the life you want

What is Connector Hub?

Connector Hub is a psychosocial support program to help people with a mental illness live and participate in the community the way they want to.

Working with a Recovery Support Worker and Peer Worker, you can develop the goals you want to achieve and participate in a range of activities to help you live your best life.

This program offers:

- Social activities, outings and connecting people in your community
- Groups focusing on understanding your mental illness, improving physical health, & living the life you want
- Individual support & assistance
- Linking you with services, supports and health professionals that can help you
- Support to reach your education, employment & financial goals

Who can access Connector Hub?

Connector Hub is for people who:

- Live with severe mental illness which cause some difficulties in your everyday life
- Aged 18+ years
- Live in South Western Sydney local government areas of: Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly & Wingecarribee
- Are not receiving funding under the National Disability Insurance Scheme (NDIS)

Connector Hub is a **FREE** service in South West Sydney.

How do I access Connector Hub?

Anyone can refer an eligible person to the program (with their permission) including:

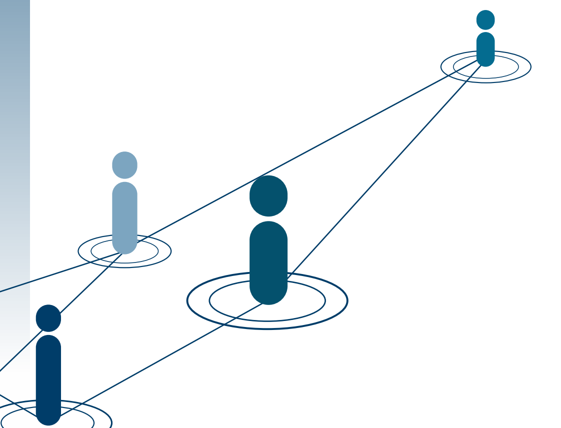
- Self-referral
- Carers, family or friends
- Health Professionals

Call SWSPHN Mental Health Central Intake Line

1300 797 746

(1300 SWS PHN)

For more information visit www.swsphn.com.au/mentalhealthcommunity



SWSPHN does not directly provide the healthcare services in this brochure. These services are provided by external health practitioners who are commissioned by SWSPHN.

PREVENTION & SELF-HELP

Recovery Point
Head to Health
5 Ways to Wellbeing

EMERGING OR LOW NEEDS

NewAccess

EXISTING OR MODERATE NEEDS

STAR4Kids (3-12)
headspace (12-25)
ReFrame Youth Service (12-25)
You in Mind (12+)

SEVERE OR HIGH NEEDS

Connect for Wellness
Tharawal Social and Emotional Wellbeing

COMPLEX & MULTISERVICE NEEDS

Credentialed Mental Health Nurse Service
Tharawal Social and Emotional Wellbeing
Partners in Recovery

SUICIDE PREVENTION

Clinical Suicide Prevention Service
Lifeline Macarthur Regional Suicide Prevention

Alcohol & Other Drugs
Primary Health Network Commissioned Services

South Western Sydney PHN funds key organisations to introduce new or expand existing local support and treatment services for people with alcohol or other drug concerns. These services work with clients, their families and with GPs to provide withdrawal management, rehabilitation, before and aftercare, and psychosocial counselling.

headfyrst (12-25 years)

headfyrst is an innovative, integrated alcohol and other drugs (AOD) and mental health co-morbidity service providing free, high-quality treatment, counselling and support services for young people aged 12 to 25.

The Salvation Army Youthlink, which provides early intervention, AOD recovery and intensive case management, is working with headspace youth mental health centres in South Western Sydney to provide the **headfyrst** service. The program also offers a SMART Recovery Group (Self Management

Referral Process

To make an appointment, call **headfyrst** or complete the referral form

- **Bankstown** - call 9393 9669
- **Campbelltown** - call 4627 9089
- **Liverpool** - call 8785 3200

Odyssey House NSW

Providing psychosocial counselling, care coordination, after care and case management services for adult clients with co-occurring AOD and mental services are available in Campbelltown with outreach in Tahmoor, Bowral and Bankstown.

Referral Process

Download Odyssey House referral form

St Vincent de Paul

Delivers a six-week non-residential rehabilitation day program in Campbelltown to support clients including before and after care, psychosocial counselling, case management, psychosocial education groups, and support groups for adults with AOD dependency and misuse.

Referral Process

Referral to Rendu House Drug Health Day Program or self-referral call 4621 5500

DAMEC - Drug and Alcohol Multicultural Education Centre

DAMEC works to reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse communities. DAMEC provides culturally appropriate support for individuals and families affected by drug and alcohol related issues through counselling, group programs, and education.

Referral Process

Complete the DAMEC referral form

Get the latest updates, healthcare information and alerts.

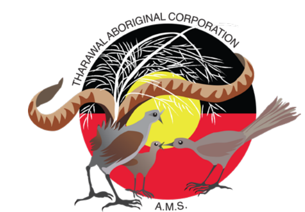
Follow us on

www.swsphn.com.au

Alcohol & Other Drugs
Primary Health Network Commissioned Services

Tharawal Drug and Alcohol Support

Tharawal Drug and Alcohol Support is a specialist weekly drug and alcohol service for Aboriginal and/or Torres Strait Islander people with substance use issues. The Alcohol and Other Drug (AOD) Senior Social Worker assists in providing cultural and clinical support to clients wanting assistance with a vast range of Mental Health and Drug and Alcohol issues, through use of specialist skills, and dedicated expertise ensuring wraparound psychosocial support to individuals, couples and families.



Referral Process
Complete the referral form or call 4624 9430

South Western Sydney PHN and South Western Sydney LHD jointly fund the General Practice Drug & Alcohol Advice & Support Service.

General Practice Drug & Alcohol Advice & Support Service

This service is aimed at supporting GPs providing care to patients with AOD and associated health issues.

- Available weekdays 9am to 5pm (excl. public holidays)
- Direct Access to local consultant drug health clinicians (including medical team)
- Advice on clinical issues related to substance misuse

What we provide:

Understanding the complex nature of patients and the demand on general practice, this service aims to provide **prompt advice when management issues arise during the course of a consultation.**

A drug health nurse consultant will provide this telephone service and can advise on clinical issues and referral pathways to relevant services.

We are happy to take calls regarding specific patient care at the time of the consultation, as well as calls about general issues in drug and alcohol medicine outside of consultations.

- **Advice on referral pathways**
- **All enquiries welcome from simple to complex cases**
- **Available to GPs in South Western Sydney**
- **Case conferencing available**

Access the GP Drug & Alcohol Advice & Support Service:
Call 0455 079 436