

ATODA

Alcohol Tobacco & Other Drug
Association ACT



Alcohol, other drugs and gambling in the ACT

A cross-sectoral approach to harm minimisation

Report and analysis of focus group findings

ATODA

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Cover artwork: Detail from *Unspoken History, Map of Pain*, Sharon, 2020

About the artist

Sharon is a Stolen Generation Aboriginal artist who spent many years tracing her origins. After a long journey she reunited with her family of the Noongar tribe (/ 'noŋɑ:/), a constellation of peoples of Indigenous Australian descent who live in the south-west corner of Western Australia, from Perth on the west coast to Esperance on the south coast. At the age of 16 she married into the Ngunnawal tribe in Canberra where she has been living for the last 30 years. Her kids and grandchildren identify as Ngunnawal and many of them inherited her talent and are artists too.

About the artwork

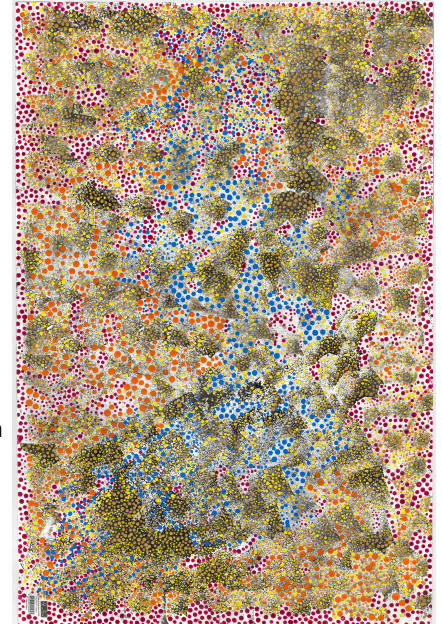
While I was painting this, I was thinking about all layers of unspoken history that I will never get to know. Unspoken history of my family, my tribe and my Aboriginal peoples.

My mother belongs to the Stolen Generation, she was taken from her mother very early and sent to Gnowangerup Christian Mission for Aboriginal kids stolen from their parents located in the town of Gnowangerup in the Great Southern region of Western Australia. When she was 13 years old, she was placed in a white family to clean their house. I never found out what happened to her in that family, how she was treated or how deep the trauma of having been taken away from her mother was, because she never talked to me about that. However, based on the fact that she had serious alcohol dependence which was the reason her children were taken away from her tells me – she never really recovered from it.

So, I was taken away from her as a baby and placed in a white family. She didn't want to give me away. It was only then when I was able to, reflecting on my pain, start thinking what she must have gone through. Stories of abuse you cannot talk about because you feel too ashamed, too vulnerable and too unprotected... Stories that stay unspoken because their sentences and words hurt as much as the deeds done to you. Stories you cannot tell because you feel by telling them you will fall apart, break into a million pieces and no one and nothing will be able to pick them up and put them together again...

So... this painting is about everything I don't know but I feel – the pain, the sorrow, sadness and grief but also hope and rare moments of happiness that the hope brings.

Sharon





Summary

As part of the *Alcohol, other drugs and gambling in the ACT: a cross-sectoral approach to harm minimisation* project, ATODA conducted a series of focus groups with service providers in the ACT. Focus groups were undertaken with workers and executives at eight services and involved both alcohol and other drug (AOD) workers and financial counsellors. Participants in the focus groups were asked to comment on the scope and nature of co-occurring harms in the treatment setting, if (and how) they are currently identifying co-occurring harms; what screening and assessment tools they are familiar with and/or utilising in their practice; their understanding of treatment options for co-occurring gambling and substance use harms; their familiarity with and utilisation of referral pathways; the barriers they face in addressing co-occurring gambling and substance use harms; and support needs for the sector/s.

Best practice responses to co-occurring gambling and substance use harms in the treatment setting are inhibited by a number of factors. Key issues include a lack of knowledge around co-occurring harms; a lack of confidence in responding to co-occurring harms when and where they present; and a lack of clear protocols for identification, screening, treatment and referral for co-occurring gambling and substance use harms.

Recommendations

1. *Building worker capability by identifying and/or developing training and professional development opportunities for the ATOD and gambling support sectors for enhanced*
 - a) *Identification of co-occurring harms;*
 - b) *understanding of the intersection between co-occurring harms; and*
 - c) *knowledge of appropriate responses to co-occurring harms through treatment and / or referral.*

2. *Building service and sector level capacity by*
 - a) *improving data collection for co-occurring harms;*
 - b) *developing enhanced identification and assessment tools for systematic screening at multiple points, in line with service capacity;*
 - c) *facilitating cross-sectoral communication for knowledge exchange and enhanced referral frameworks; and*
 - d) *developing and circulating formal screening and referral protocols.*



Background

The co-occurrence of substance use harms and gambling harms is recognised as a complicating factor in treatment for either condition and can result in poorer treatment outcomes across the board.^{1,2} Individuals experiencing both substance use and gambling harms can suffer more serious impacts to their physical and mental health, to their relationships, to their financial stability, and to their overall wellbeing. Individuals experiencing co-occurring harms are more likely to cease treatment prematurely³ and may require more treatment attempts or longer treatment timeframes.⁴ Additionally, some studies have indicated that successful treatment for one form of harm may precipitate other potentially harmful behaviors.⁵ The presence of co-occurring harms is known to affect different modalities of treatment, such as cognitive-behavioural therapies,⁶ behavioural therapies,⁷ in-patient treatment,⁸ and pharmacotherapies.⁹

Offering holistic screening and therapeutic interventions that address harms from both substance use and gambling can be an efficient and cost-effective way to reach a high-risk population and to reduce net harms.¹⁰ A recent literature review undertaken by the authors of this study¹¹ showed little evidence that a holistic approach is currently being used to address such co-occurring harms.¹²⁻¹⁴

In order to understand the treatment context for co-occurring harms in the ACT, ATODA undertook a series of focus group discussions with service providers from alcohol, tobacco and other drug (ATOD) treatment and harm reduction services and from a financial counselling service. This report collates the findings of these focus group discussions and should be read alongside other outputs from Stage 1 of the project *Alcohol, other drugs and gambling in the ACT: a cross-sectoral approach to harm minimisation*.

Output 1	Literature review	31 March 2023
Output 2	Report of focus group findings	30 June 2023
Output 3	Environment scan – training & resources	31 July 2023

The project *Alcohol, other drugs and gambling in the ACT* is funded, in part, through the Gambling Harm Prevention and Mitigation Fund, administered by the ACT Government's Gambling and Racing Commission. The project aims to provide workers with the skills, resources and confidence to respond to severe co-occurring substance use and gambling harms by addressing systemic barriers in the provision of holistic treatment and harm



minimisation services to ACT ATOD and gambling support service users. The objectives at Stage 1 of the project are to:

- 1) Expand knowledge of the intersections between gambling and substance harms and best-practice approaches to treatment and harm reduction.
- 2) Improve understanding of co-occurring gambling and AOD harms experienced by those accessing AOD or gambling support services in the ACT
- 3) Identify training gaps for both gambling support and AOD workers regarding co-occurring gambling and AOD harms and harm reduction, and how these gaps could be addressed

The project contributes to providing and/or ascertaining information about gambling harm in the ACT. It lays the foundation for increasing gambling harm prevention skills or capacity in the ATOD sector, while increasing substance use harm reduction skills and capacity in the gambling support sector.

About ATODA

As the peak body for the ATOD sector in the ACT, ATODA's vision is a healthy, well and safe ACT community with the lowest possible levels of alcohol, tobacco and other drug related harms. Underpinning ATODA's work is a commitment to health equity, the social and cultural determinants of health, and the values of collaboration, participation, diversity, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA's purpose is to lead and influence positive outcomes in policy, practice and research, as the peak body for the alcohol, tobacco and other drug sector in the ACT. These outcomes flow from initiatives in prevention, early intervention, harm reduction, treatment, peer services, and continuing care.

ATODA provides collaborative leadership for intersectoral action on the social determinants of harmful drug use, and on societal responses to drug use and to people who use drugs. ATODA works to provide alcohol, tobacco and other drug related expertise in the areas of policy; sector workforce development and capacity building; research, data and evaluation; health services planning; coordination and partnerships; training and education; communication; information and resources.



About the sector

The ATOD sector

The specialist ACT ATOD sector includes eleven government and non-government services that provide a diverse range of programs to prevent and reduce harms associated with ATOD use in the ACT community.

The eleven organisations are:

- Alcohol and Drug Services, ACT Health (ADS)
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra & Goulburn
- Directions Health Services
- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc
- The Salvation Army
- Ted Noffs Foundation ACT
- Toora Women Inc
- Winnunga Nimmityjah Aboriginal Health and Community Services

All eleven services were invited to participate. Seven ATOD service contributed to the project. Given operational constraints, four services declined to participate.

Frontline specialist AOD services offer a range of programs including: assessment; information and education; harm reduction services; counselling; case management; withdrawal support; pharmacotherapy support; outreach support; rehabilitation; and relapse prevention.

The gambling support sector

The gambling support sector is somewhat underdeveloped in the ACT. Counselling support and harm reduction education for gambling is provided primarily through Relationships Australia and by Care Financial Counselling as part of their broader financial counselling service. Much of the harm minimisation work around gambling continues to be offered by the clubs that are venues for electronic gaming machines. ATODA did not seek to include the perspectives of hoteliers or gaming machine venue staff in this project.

Focus groups

Five focus groups, involving 16 staff from 8 services, were conducted over a two-week period in May – June 2023.



Date	Group	# of participants	# of services
22/05/23	ATOD Service Executives (AOD 1)	5	5
24/05/23	ATOD Service Workers (AOD 2)	5	3
24/05/23	ATOD Service Workers (AOD 3)	3	3
30/05/23	ATOD Service Workers (AOD 4)	1	1
02/06/23	Gambling Support Service (GSS)	2	1

Following a literature review and in consultation with the ACT ATOD Executives Group and the ACT ATOD Workers Group, five broad domains were identified:

1. Scope and nature of co-occurring harms in the treatment setting
2. Identifying co-occurring harms
3. Screening and assessment tools
4. Treatment and referral pathways
5. Barriers and support needs for the sector/s

Through a collaborative process with the ATOD sector, a series of questions was developed for each domain as outlined in the table on page 6.

All but one focus group discussion took place online and focus groups were recorded and subsequently transcribed. Qualitative (thematic) analysis of findings was undertaken by the lead researcher on the project.



Domain	ATOD Services	Gambling Support Service/s
Scope and nature of co-occurring harms in the treatment setting	<ul style="list-style-type: none"> a. How significant an issue is gambling to users of your service? b. How do gambling harms present (own gambling; others' gambling)? c. Is there a 'typical' service user who experiences gambling harms? Describe d. Are you aware of any particular demographic trends in gambling harms amongst service users? 	<ul style="list-style-type: none"> a. How significant an issue is co-occurring gambling and ATOD harms? b. How do such co-occurring harms present? c. Are there factors that increase the likelihood of an individual experiencing co-occurring harms?
Identifying co-occurring harms	<ul style="list-style-type: none"> a. How do you know that a service user is experiencing co-occurring gambling harms? b. If an individual is identified as experiencing co-occurring gambling harms what happens with this information? 	<ul style="list-style-type: none"> a. How do you know that a service user is experiencing co-occurring harms? b. If an individual is identified as experiencing co-occurring harms what happens with this information?
Screening and assessment tools	<ul style="list-style-type: none"> a. Does your service routinely screen for gambling harms? b. Yes: what is meant by routine screening? c. Yes: what screening tool/s are used? (refer to screening tools list) d. Yes: when does screening occur? e. Yes: are there additional assessment tools used? f. No: do you ever screen for gambling (formal or informal assessment tools)? g. No: what is the main factor that stops you from screening? h. No: would screening for gambling be a helpful exercise? Why or why not? 	<ul style="list-style-type: none"> a. Does your service routinely screen for gambling / ATOD harms? b. Yes: what screening tool/s are used? c. No: what is the main factor that stops you from screening for one or both harms? d. No: would screening for co-occurring harms be a helpful exercise? Why or why not?
Treatment and referral pathways	<ul style="list-style-type: none"> a. Are addressing gambling harms ever part of a treatment plan at your service? b. Yes: what does this look like? c. No: what stops this from happening? d. Are you aware of the therapeutic interventions available for gambling? e. Do you refer people for gambling support? f. Yes: where? What are the protocols (including follow up)? g. No: what stops this from happening? 	<ul style="list-style-type: none"> a. Do you refer people for ATOD support? b. What are the referral pathways and protocols? c. What might stop you from referring to an ATOD service?
Barriers and support needs for the sector/s	<ul style="list-style-type: none"> a. What are the main issues for your service in terms of supporting service users who are experiencing gambling harms? b. What does the sector need to better respond to co-occurring gambling harms? c. What training and resources are you aware of? 	<ul style="list-style-type: none"> a. What are the main issues for your service in terms of supporting service users who are experiencing co-occurring harms? b. What does the sector need to better respond to co-occurring harms? c. What training and resources are you aware of?



Findings

Scope and nature of co-occurring harms in the treatment setting

Service providers are aware that co-occurring gambling and substance use harms are experienced by people accessing their services but generally didn't have detailed data about the scope and nature of such co-occurring harms in the treatment setting.

Across the focus groups there were diverse opinions about whether the co-occurrence of gambling and substance use harms was, in fact, a significant issue in the treatment context. Participants from the same services provided inconsistent answers about the number of service users presenting with co-occurring harms and, in some cases, the same focus group participant claimed that co-occurring harms were and were not a significant issue for users of their service.

"I would say that we don't have a significant number of clients with these kinds of presentations." AOD 1d

"I can't say that there's think too many clients that we specifically worked on regarding their co-occurring gambling problems." AOD 3b

"Most of our ... people aren't involved, I'd say probably 3 or 4%." AOD 1a

"So, it certainly, for some of our people who come through, it's an issue." AOD 1b

"I would say that more than 50% of the individuals who are assessed for one of our programs identify some gambling in some way being an issue." AOD 2a

"It's really quite devastating...gambling seems to be the hidden addiction." AOD 2b

"It's pretty significant." AOD 3a

"We know that it's a big problem in this community." AOD 4a

"I think there would be quite a high proportion." GSS 1a

It appeared that focus group participants were more often than not guessing about the scope of harms. The absence of firm data around co-occurring harms was confirmed by focus group participants. In almost all cases, it seemed that reticence around identifying the scope



and nature of co-occurring harms was related more to internal processes, whereby services are not systematically identifying individuals who are experiencing co-occurring gambling and substance use harms, rather than any conviction that co-occurring harms are not an issue for service users.

When asked about the specifics of co-occurrence, AOD service providers consistently noted an association of gambling with alcohol and methamphetamine use.^{17, 18}

“It’s usually occurring with alcohol use, and sometimes methamphetamine use. No, of course it stretches across the whole breadth of drug use.” AOD 1b

“[Co-occurrence with] alcohol. People that suffer from an alcohol dependency and probably methamphetamine, too ... Those are probably the two most common ones that are discussed that we see.” AOD 3a

“Alcohol and methamphetamine. Oh, and cocaine. So, it’s quite linked to those drugs.” AOD 3c

Five focus group participants across three groups, noted that harm may be generated in the treatment-seeking individual by another person’s gambling and/or drug and alcohol use and that co-occurring harms may arise in the context of other potentially complicating factors such as domestic and family violence or involvement in the criminal justice system.

Although there was uncertainty amongst service providers about the scope of co-occurring harms in their own treatment settings, the literature is clear on the association between gambling and substance use harms. A systematic review and meta-analysis of available population surveys found that 57.5% of individuals experiencing gambling harms experienced co-occurring substance use harms.¹⁵ Rates of co-occurring harms in treatment-seeking populations (both those seeking treatment for gambling harms and those seeking treatment for substance use harms) are known to be considerably higher than in the general population.^{12, 16, 17}



Identifying co-occurring harms

Identification of co-occurring harms is generally happening on an ad-hoc basis and largely depends on the confidence, knowledge and experience of individual workers at intake.

Across the focus groups, participants agreed that identification of co-occurring harms most frequently happens on an ad-hoc basis and is largely dependent on the skills and experience of individual workers. One worker noted, “We certainly don't have things in place at the moment to identify and work with [co-occurring harms]” (AOD 3b). While some AOD services include a single question to identify gambling at intake, often in the context of developing a broader picture of the experiences, concerns and risks for the treatment-seeking individual, a number of services have no systematic method by which they identify co-occurring gambling harms. Instead, the issue of gambling harms is being raised in the context of established therapeutic relationships.

*“Gambling needs to be really problematic for that person for it to come up in the mix”
AOD 1b*

“It definitely comes up later when there's the trusted relationship as a treatment issue or a treatment goal.” AOD 1c

“This would come about through self-disclosure rather a bit later on in the treatment episode.” AOD 1d

“They'll come back later, and they'll say: 'actually there is a gambling issue'.” AOD 2b

Some participants expressed concern that pressing people who had already initiated engagement with a treatment service to disclose additional issues of concern, could risk alienating service users or trigger a trauma response, where the service was not equipped to address the co-occurring harm and where a treatment-seeking individual may be waiting days or weeks to access a specific program.

Financial counsellors with whom the researchers spoke in the context of developing this report, indicated that both gambling and substance use are only rarely disclosed at initial intake. While individuals who contact financial counsellors are routinely asked about gambling and gambling harms, there is no systematic gathering of data around substance use and substance use harms. Whether a counsellor feels confident to broach the issue of substance use, is often dependent on them having completed particular (non-core / elective)



units of study (e.g. CHCMHS005 - Provide services to people with co-existing mental health and alcohol and other drugs issues or CHCCCS004 - Assess co-existing needs).

Screening and assessment tools

- 1. Knowledge of screening and assessment tools for co-occurring harms is low.**
- 2. There are barriers to undertaking additional screening in the treatment setting that need to be addressed.**

Knowledge of available screening tools for co-occurring harms was relatively low across the services. Only one ATOD service indicated that they used a gambling screening tool (the PGSI) as part of their formal assessment.

“So, when they make contact, a brief initial is completed and if they express that they do partake in gambling activities, even if it's not problematic. We'll then go and use ... I believe it's the PGSI.” AOD 3a

The PGSI is just one of 19 screening tools that were identified by the authors of this report in the earlier literature review and one of 11 gambling screening tools that have been validated for use in a substance-use treatment settings or, in other treatment settings where there was a significant clinical caseload of substance-use treatment needs.

There was a recognition that screening and assessment is already a protracted process, and that adding additional screening for co-occurring harms may be unfeasible and may detract from a service's core business. This was further discussed in the context of barriers and the support needs of the sector.

“So, we don't screen [for gambling]. It's drug and alcohol treatment.” AOD 1c

“Our comprehensive assessment is already detailed, adding things about ‘and now tell us about your gambling and tell us about your...’ but it's a bit like, you know we really need to understand enough about the person coming into a drug and alcohol program to make sure that ours is the one that will meet their needs.” AOD 1c

“We already have quite a long comprehensive assessment form and so we're not actively screening for gambling in that initial intake assessment.” AOD 1d

The identification of co-occurring harms is closely related to the utilisation of formal screening and assessment tools. A 2020 Australian study that addressed the capacity of



mental health clinicians (including those working in ATOD services) to respond to gambling harms, found that most had ‘limited knowledge of screening tools to detect PG [problem gambling]’ and only 16% of clinicians were found to screen ‘often’ or ‘always’.¹⁹

Treatment and referral pathways

Referral pathways are developing and can be further developed through intersectoral collaboration and the implementation of more formalised processes.

A key question that was asked in the focus groups was around what happens where a co-occurring harm is identified. Responses were divided into treatment—which in the case of ATOD services took place in house and alongside ATOD treatment—and referral, including support with self-referral. The literature review previously undertaken by the authors of this report identified four responses: 1) psychosocial interventions (e.g. motivational interview, cognitive behavioural therapy); 2) pharmacological plus psychosocial intervention; 3) referral; and 4) non-invasive neurological interventions.

Given that the services that the researchers spoke with provide psychosocial interventions, it is unsurprising that responses to co-occurring gambling and substance use harms were limited to psychosocial interventions and referral.

“It’s normally something that we can you can sort of do some work with individually and it sort of pulls up.” AOD 1a

“We talk through our capacity to manage the gambling side of things in session. Usually, we would support them with gambling in session, alongside substance use stuff.” AOD 2b

“There’s the individual treatment plan. So, if they’ve said gambling at assessment, we kind of ask the client if that’s something they want to address with their counsellor and what are their goals around that. And we kind of treatment match as well with the counsellor.” AOD 3c

“And motivational interviewing stuff. It’s the motivational interviewing stuff where you might be talking to people about shifting the balance to requesting help [for substance use] and supporting them, you know supporting their decision.” GSS b

Amongst ATOD service providers, there was some uncertainty about appropriate treatment regimens for gambling. One participant asked, “Like if you’re doing, you know, CBT type stuff, can you, can they work together?” (AOD 3b).



Where the co-occurring issue was identified as more complex or entrenched, participants agreed that referral was likely to be the appropriate response. However, referral pathways were not necessarily clear or well-utilised.

“A lot of the referrals are to, or some referrals are to, you know, like a 1800 number or something like that.” AOD 1b

“I’m aware that RA [Relationships Australia] and Gambling Anonymous exist, but we very rarely refer clients.” AOD 3b

“We would usually ask the client like whether they wanted a referral, or you know whether they were interested in finding out more.” GSS b

Referrals worked better where there were established relationships between services. Gambling education in residential and outreach programs is playing an important role in forging these relationships. However, there are gaps in the knowledge of service providers around what is available and how to guide service users in accessing support for co-occurring harms.

Participants indicated that in some cases incompatibilities in service provision hindered closer co-ordination between ATOD services and gambling support services.

“Gambling counselling services are still really structured counselling, where it’s like you’ve got to be here at this time, at this point. Like it’s not as flexible as I guess our counselling model is.” AOD 1a

Follow-up after referral was not happening consistently or systematically, leaving further gaps in the knowledge of service providers in respect of whether current responses to co-occurring harms are appropriate and/or effective.

“Most people go for that initial appointment, but whether they stick around, probably not so much.” AOD 1a

“One of the things that we’ve been quite successful at, is doing warm referrals [in the context of co-occurring needs other than gambling]. So actually, taking people, transporting people, and potentially sitting with them as an advocate during those appointments if they want, which has really helped us track the outcomes of those referrals and which is why I bring it up.” AOD 1b



Barriers and support needs for the sector/s

Additional support for the sectors will address some of the barriers that services experience in the provision of best practice for co-occurring harms.

Participants in the focus groups indicated a range of barriers to instituting responses to co-occurring gambling and substance use harms. These barriers included:

- the service delivery context (particularly for outreach services) – some service delivery environments preclude examination of deeper issues of concern to the service user due to constraints of time or private consultation space;
- the challenge of establishing a safe space in which therapeutic relationships can flourish and the risk to that relationship posed by asking probing questions about issues for which an individual has not sought treatment;
- the length and complexity of existing assessment tools and reluctance to expand these; and
- a general lack of awareness around co-occurring harms amongst service providers.

When asked how their sector or specific service might be supported to better address the presentation of co-occurring harms, participants mentioned the importance of education and the role of gambling service in-reach to facilitate service-level relationships and support service user needs.

“We also get, I cannot remember who it is, but we get some people to come in to do some, run some groups for this around gambling and uh, some of those behaviours.”
AOD 1a

“So, we had a guy from Relationships Australia come out to talk to us about it. Uh, last week, as an in service, and that was really interesting and gave us some ideas about kind of and gambling harm reduction.” AOD 1b

“We’re lucky enough to have a Relationships Australia and GA facilitator come on site. He does that fortnightly and he expresses his own story and gives out his card to clients.” AOD 3a

An idea that was raised was the development of easily accessible resources to facilitate identification, screening, brief interventions, and referrals. The financial counsellors mentioned the utility of the ACT ATOD sector program directory, while ATOD executives expressed concern that gambling support services might not be familiar with the full range of ATOD treatment services and programs.



A number of participants mentioned the potential benefits of training and professional development to enhance skills in responding to co-occurring gambling and substance use harms.

“So, some training, some tools, some resources, a list of places to refer people.” AOD 1c

“Education about how to ask that. We have a lot of experience talking about AOD with our clients but not gambling specifically.” AOD 2a

“Maybe some training for gambling addiction for people who work specifically in the AOD sector.” AOD2c

“Some training would be really good and just some information around it.” AOD 3b

Reporting the findings

Initial findings from the focus groups were reported back to a) focus group participants b) the ACT ATOD Workers Group c) the ACT ATOD Executives Group. Focus group participants indicated that participation had been a positive experience and that focus groups had generated examination and discussion of service practices around co-occurring harms.

In light of the lack of data around the scope of co-occurring harms in the treatment setting, ATODA included a question about gambling amongst ATOD service users in the 2023 Service Users Satisfaction and Outcomes Survey (SUSOS), with findings to be reported to the sector in the coming months.



Discussion and recommendations

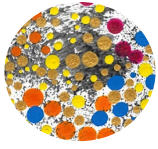
The gambling and substance use treatment settings are ideally placed to identify, screen for, treat, and/or refer individuals who are experiencing co-occurring gambling and substance use harms. However, at present, there are a number of factors that are limiting the achievement of better outcomes for treatment-seeking individuals who are experiencing such co-occurring harms.²⁰ These inhibitory factors exist across the treatment cycle, from initial intake and identification of needs, through screening, treatment, referral and follow-up. Service providers recognise many of the barriers that they face in providing support for service users experiencing co-occurring harms and distinguish systemic barriers (those that cannot be addressed at a service level), from more mundane barriers (those that can be addressed at a service, or individual worker, level). In addressing these latter, mundane, barriers, focus group participants identified a number of supports that could be put in place. ATODA has consolidated the findings of the focus groups into key recommendations:

1. *Building worker capability by identifying and/or developing training and professional development opportunities for the ATOD and gambling support sectors for enhanced*
 - a) *identification of co-occurring harms;*
 - b) *understanding of the intersection between co-occurring harms; and*
 - c) *knowledge of appropriate responses to co-occurring harms through treatment and / or referral.*

2. *Building service and sector level capacity by*
 - a) *improving data collection for co-occurring harms;*
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 - d) *developing and circulating formal screening and referral protocols.*



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