ATODA
Alcohol Tobacco & Other Drug Association ACT

What's the harm?

A guide to understanding and responding to co-occurring gambling and substance use harms in service settings

Artist Recognition

As part of its corporate identity in published content, ATODA is proud to feature artwork titled Unspoken History, Map of Pain (2020) by local artist Sharon. This work, unless explicitly stated otherwise, may not be reprinted, reproduced or published in any form without the permission of ATODA to ensure copyright ownership and agreement with the artist is upheld.

To learn more about the story behind the artwork, scan the QR code:

© Alcohol, Tobacco and Other Drug Association ACT, 2025

This work is copyrighted. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without the written permission of the publisher.

Published by the Alcohol, Tobacco and Other Drug Association ACT (ATODA)

PO Box 7009, Kaleen, ACT 2617
159 Maribyrnong Ave, Kaleen, ACT 2617
(02) 6249 6358
info@atoda.org.au
www.atoda.org.au

Suggested citation: Alcohol, Tobacco and Other Drug Association ACT. What's the harm? A guide to understanding and responding to co-occurring gambling and substance use harms in service settings. Canberra: ATODA, 2025.

Full report available on ATODA's website www.atoda.org.au

Acknowledgement of Traditional Custodians

ATODA proudly acknowledges the Ngunnawal people as Traditional Custodians of the land we work on and recognises all other peoples or families with connections to the ACT and region.

ATODA acknowledges, respects and celebrates the continuing culture and contributions of Aboriginal and Torres Strait Islander peoples to the life of the ACT and region. We respect and value the contributions of Aboriginal and Torres Strait Islander peoples to the alcohol, tobacco and other drug sector.

Acknowledgement of lived and living experience

ATODA recognises the contributions of people with lived and living experience of gambling and substance use harms in progressing the objectives of both the ATOD and gambling support sectors.

We are grateful for the insights and expertise of those with lived and living experience on the project's Expert Committee.

About ATODA

The Alcohol, Tobacco and Other Drug Association ACT (ATODA) is the peak body for the alcohol, tobacco and other drug sector in the ACT.

We lead, strengthen and advocate for the ACT's high-quality treatment and harm-reduction sector, working to provide a broad range of alcohol, tobacco and other drug treatment options to the community.

We represent organisations and people throughout the ACT committed to reducing alcohol, tobacco and drug related harms.

Our work is informed and guided by our highly valued members who work in true partnership with their peak to enhance our sector and support the ACT community.

Acknowledgement of contributors

ATODA: Elisabeth Yar (Project Lead), Leanne Bourke (Project Support), Jeanette Bruce (Design), with additional support from Anke van der Sterren (Deputy CEO), Anita Mills (CEO), Annie Bleeker, Ava Gajdatsy, Brigit Perry and Tess Rogel.

ATODA is grateful for contributions from an expert committee comprised of researchers, practitioners and experts by lived experience. We acknowledge the participation, in earlier stages of this project, of services and workers across the sector, including those who contributed to focus groups.

Expert Committee: Markus Fischer (ACT Gambling Support Service, Relationships Australia Canberra & Region), Kate Seselja (The Hope Project), Tristan O'Connor (Karralika Programs), Hannah Pitt (Deakin University),), Leanne Tomamichel (Directions) and Emilija Robeska (Directions).

This project was funded by the ACT Gambling and Racing Commission through the Gambling Harm Prevention and Mitigation Fund.

Using this practice guide

This practice guide has been developed to build the capacity of the workforce across two sectors in the Australian Capital Territory (ACT): the alcohol, tobacco and other drugs (ATOD) sector and the gambling support sector. It has the specific purpose of equipping workers in these sectors to support clients who are experiencing co-occurring gambling and substance use harms.

What's the Harm? A guide to understanding and responding to co-occurring gambling and substance use harms in service settings, emerged out of a project led by the Alcohol, Tobacco and Other Drug Association ACT (ATODA) and funded through the Gambling Harm Prevention and Mitigation Fund (GHPMF). This project identified an absence of clear guidelines for workers in responding to co-occurring gambling and substance use harms.

The practice guide provides guidance across ten themes, with suggestions that can be integrated into current practice and are intended to give workers the confidence to address the complexity of co-occurring gambling and substance use harms in the service setting. The practice guide was developed in collaboration with researchers, lived-experience experts, and frontline workers across a range of different service types.

While you are encouraged to read and familiarise yourself with this document in its entirety, it can also be used as an easy reference for day-to-day practice. A quick guide summary is organised by theme and provides concrete points of knowledge (knowledge points) and points of practice (practice points) that apply across a diverse range of client-facing roles in both ATOD and gambling support services. Additional resources have been collated and are available on the ATODA website to allow workers to explore a particular theme in greater depth or to engage further supports.

Key terms

While the term **AOD (alcohol and other drugs)** is commonly used to refer to the alcohol, tobacco and other drugs sector, ATODA's preference is to use the term ATOD (alcohol, tobacco and other drugs) when referring to the sector or to services. This acknowledges the role that specialist service providers in this sector play in providing tobacco cessation support. However, co-occurring harms, in this practice guide, refers to alcohol and other drugs harm and gambling harm and does not include co-occurring gambling and tobacco / nicotine use harms.

For the purposes of this document **gambling** refers to any form of placing a wager or bet in the form of money (or something else of value) on the outcome of an uncertain event that may involve the elements of skill and / or chance. In the ACT, 53.2% of adults have engaged in some form of gambling in the past 12 months and 9.1% (17.6% of gamblers) reported at least one harm from their own gambling in the same timeframe. This rises to 15.8% if we include harm from another person's gambling or 'legacy harm' from gambling prior to the last 12 months.[1]

In the context of this practice guide, **substance use** refers to alcohol use and non-prescribed use of drugs but is exclusive of tobacco. In the ACT the substance for which people most often seek treatment is alcohol (45.8% of closed treatment episodes), followed by amphetamines (19.0%), cannabis (12%), and heroin (11.7%). It is estimated that only 48%–58% of treatment need is currently being met in the ACT.[2]

In this document we use the term **harm** to capture a range of experiences that, on various measures, are defined as pathological (as per the SOGS assessment tool), problematic (PGSI), high risk (ASSIST) or disordered (AUDIT/DUDIT). Given the considerable stigma that impacts people experiencing gambling and / or substance use harms and the barrier this can create to accessing appropriate treatment and support, we have made every effort to avoid language that could exacerbate stigma. By focusing on harms, we recognise that both gambling and substance use are activities that are experienced by many people as pleasurable but that negative impacts of gambling and substance use can be experienced by anyone, can be widespread, and usually extend beyond the individual. In the case of legal products, such as alcohol and gambling, more harmful use may be more profitable to industry. As such, we talk about the **harm by design** that underpins these products and their marketing and distribution.

Contents

Using this practice guide	**iv**
Key terms	**v**
Quick guide	**1**
Theme 1: The experience of harms	**3**
Theme 2: The co-occurrence of gambling and substance use harms	**8**
Theme 3: Overcoming stigma and discrimination	**11**
Theme 4: Talking about co-occurring harms	**16**
Theme 5: Creating a safe environment through trauma-informed care	**20**
Theme 6: Screening and assessment for co-occurring harms	**23**
Theme 7: Responding to co-occurring harms	**26**
Theme 8: Making referrals	**35**
Theme 9: Developing cross-sectoral collaborations	**40**
Theme 10: Addressing the needs of specific populations	**43**
References	**48**

Quick guide

THE EXPERIENCE OF HARMS

1

Knowledge point: Harms from gambling and / or substance use are complex and overlapping, impacting not just the individual but a wider circle including family, community and society at large.

Practice point: Explore with service users their understanding and experience of the impacts of their gambling and substance use and what they have observed about the impact on those around them.

THE CO-OCCURRENCE OF GAMBLING AND SUBSTANCE USE HARMS

2

Knowledge point: Experiencing harms from substance use can increase the risk of experiencing gambling harms and vice versa.

Practice point: Be curious and ask questions that may open broader conversations about co-occurring gambling and substance use.

OVERCOMING STIGMA AND DISCRIMINATION

3

Knowledge point: People who are experiencing co-occurring gambling and substance use harms can face barriers to accessing or remaining engaged with treatment as a result of stigma (including self-stigmatisation) and discrimination, in relation to one or both of these issues.

Practice point: Be prepared to challenge your own biases and assumptions, so you can support service users in ways that are non-judgemental and empathetic. Consider interventions to reduce stigma at an individual and / or organisational or broader structural level.

TALKING ABOUT CO-OCCURRING HARMS

4

Knowledge point: The language used in a service setting can counter stigma and discrimination, signal a welcoming and non-judgemental environment, and create a safe place for mutually addressing co-occurring harms.

Practice point: Be familiar with best practice language but don't let fear of saying the wrong thing (or saying the right thing in the wrong way) stop you from having important conversations about a service user's gambling and substance use.

CREATING A SAFE ENVIRONMENT THROUGH TRAUMA-INFORMED CARE

5

Knowledge point: Trauma is a common factor in both gambling and substance use and is highly prevalent in people seeking support or treatment for co-occurring gambling and substance use.

Practice point: Integrate the principles of trauma informed care into your practice and adopt the 'universal precautions' approach. Be aware of the risk of vicarious trauma and take steps to ensure you have appropriate support and self-care practices in place.

SCREENING AND ASSESSMENT FOR CO-OCCURRING HARMS

6

Knowledge point: Screening tools can be useful in some contexts but don't necessarily capture everything about a service user's experience of harms from gambling and substance use.

Practice point: Use screening tools when appropriate but be aware of their limitations and be prepared for ongoing conversations about co-occurring harms.

RESPONDING TO CO-OCCURRING HARMS

7

Knowledge point: There are a range of different interventions for gambling and substance use, and no 'one-size-fits-all'.

Practice point: Brief Interventions are an important starting point. Utilise the FRAMES method – feedback, respect, advice, menu, empathy, and self-efficacy and follow up with the most appropriate support for the service user.

MAKING REFERRALS

8

Knowledge point: Referring to the right service or services will often be a critical factor in good treatment and harm reduction outcomes for a person experiencing co-occurring gambling and substance use harms.

Practice point: Take time to familiarise yourself with local services; get to know intake officers or other key personnel who can facilitate smooth referrals.

DEVELOPING CROSS-SECTORAL COLLABORATIONS

9

Knowledge point: Where there is greater collaboration between services, a service user will experience better treatment outcomes.

Practice point: Collaboration should be established at multiple levels and encompass both formal and informal partnerships between services and between individual workers.

ADDRESSING THE NEEDS OF SPECIFIC POPULATIONS

10

Knowledge point: The diverse backgrounds and experiences that service users come with may present an additional barrier to treatment access and engagement.

Practice point: Familiarise yourself with resources and services that can support service users of diverse backgrounds and experiences.

Theme 1: The experience of harms

At a population level the harms of gambling and substance use are substantial. The use of alcohol and other drugs collectively accounts for 7 percent of the total burden of disease in Australia.[1] Societal cost of substance use is estimated at $104.7 billion.[2] Nationally, per capita gambling losses reach a total of $31.5 billion per year,[3] while the associated societal cost of gambling is estimated at over $4.7 billion.[4]

Both gambling and substance use have a range of consequences that, at least for a subset of the population, are experienced as harms.[5]

An assumption of harm underpins policy approaches by the ACT Government through the *Strategy for Gambling Harm Prevention in the ACT (2019–2024)*—a document which positioned gambling as a matter of public health[6]—and the *ACT Drug Strategy Action Plan 2022–2026*—which is framed in terms of harm minimisation and has an overarching aim of improving the health and wellbeing of the Canberra community, and reducing the stigma experienced by people impacted by alcohol, tobacco and other drugs.[7]

HARM REFERS TO ANY NEGATIVE CONSEQUENCE CAUSED OR MADE WORSE BY A PERSON'S GAMBLING OR SUBSTANCE USE, OR BY SYSTEMIC FACTORS THAT EXERT FORCE ON THE LIVES OF THOSE WHO GAMBLE OR USE ALCOHOL OR OTHER DRUGS.

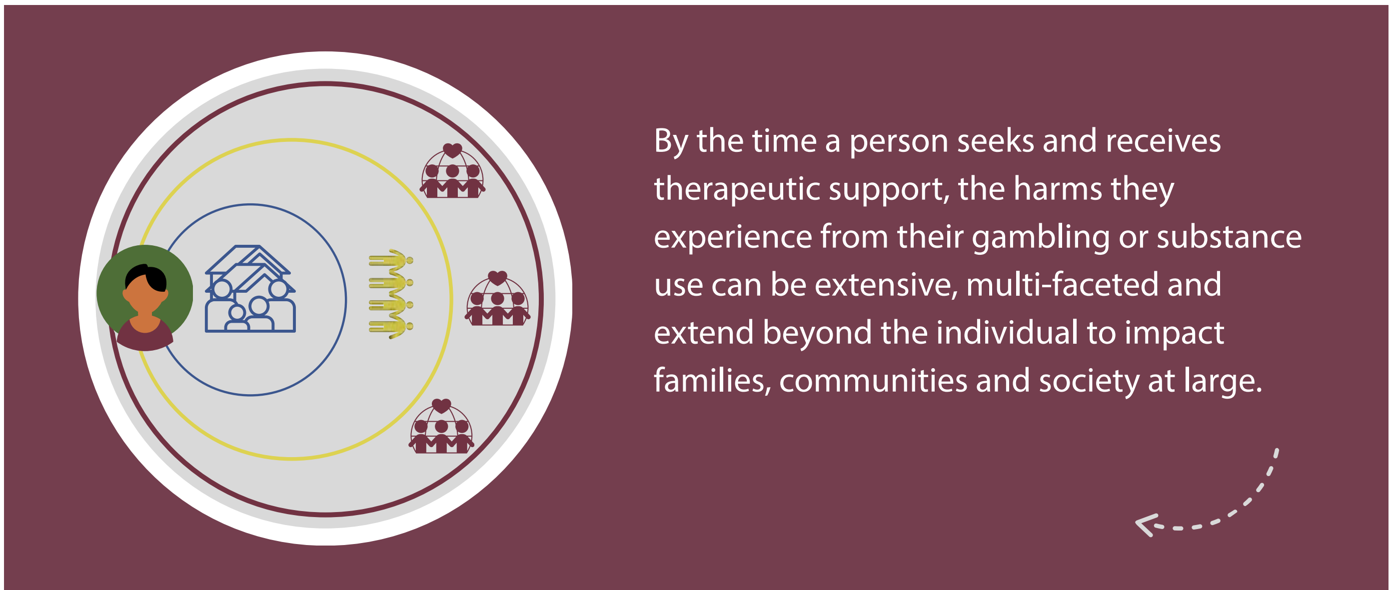
Figure 1.1 The Ottawa Charter

Adapted from https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

WHAT IS A PUBLIC HEALTH APPROACH?

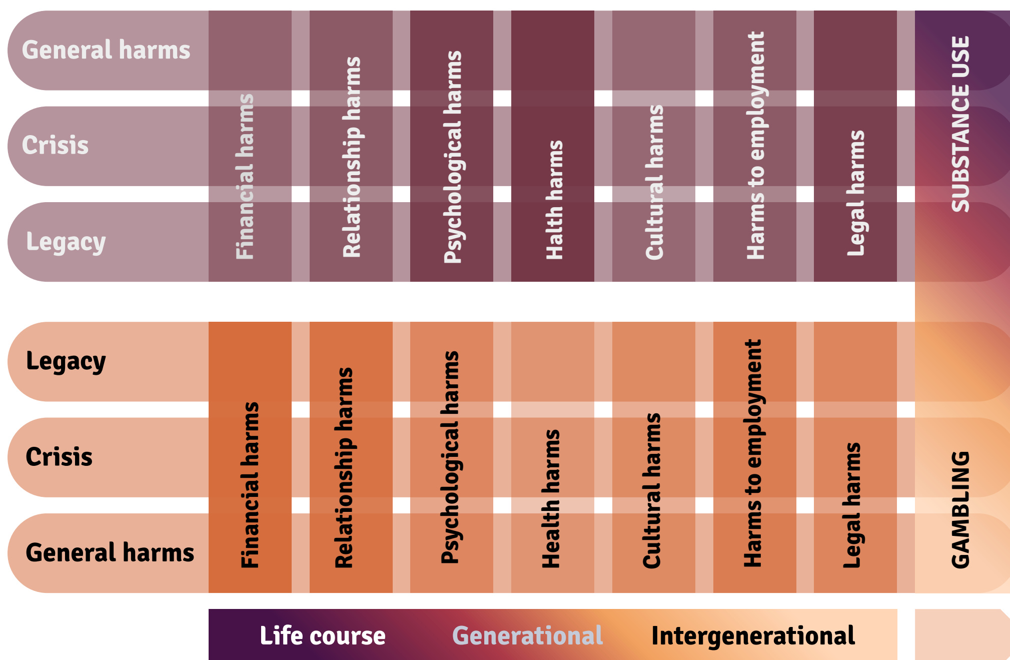
Public health approaches have been increasingly utilised in policy formation around substance use and, more recently, gambling. While the specificities of public health approaches vary by product,[8] there are some important commonalities that emerge out of shared origins in the World Health Organisation's 1986 Ottawa Charter for Health Promotion. These commonalities include a focus on preventing or minimising harm at individual, community and societal levels, a concern for regulation and an emphasis on rejecting punitive custodial approaches.

Figure 1.2 Expanding circles of harm



A person may be motivated to seek (and to remain engaged with) treatment or other forms of support as a direct result of the harms they are experiencing—whether in the context of general harms or at a time of crisis.[9] Conversely, they may not make the connection between harms experienced and gambling or substance use, or may identify greater complexity in their circumstances than simply taking 'action' or 'responsibility' to address harms. Indeed, many of the harms that are understood to emerge out of gambling or substance use have also been identified as contributing or exacerbating factors.[10]

Figure 1.3 Harms from gambling; harms from substance use



Adapted from *Conceptual Framework of Gambling Related Harm*, 2016
https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2747-0

While there are possible common psychological, genetic and neural pathways that can make some individuals more susceptible to harmful gambling and substance use,[11] both behaviours share underlying risk factors beyond the individual. Harms are not evenly distributed or experienced across the population and people are exposed to different risk factors that may make them more or less likely to experience harms.

PEOPLE EXPERIENCING GAMBLING HARM WHO ARE LIVING ON THE LOWEST INCOMES SPEND A MUCH HIGHER PROPORTION OF THEIR HOUSEHOLD DISPOSABLE INCOME ON GAMBLING (26.5 PERCENT), THAN THOSE IN THE HIGHEST INCOME BRACKET (3.4 PERCENT), LEADING TO A HIGHER RISK OF FINANCIAL HARM.[12]

Both gambling-related harms as well as alcohol harms, have the potential to manifest more rapidly and intensely in lower socioeconomic status (SES) populations.[13] While higher income groups gamble more frequently and consume greater volumes of alcohol, people with lower SES report greater harms from gambling, along with more hazardous drinking patterns and higher self-reported alcohol-related harms.[14-16]

Geographic proximity to venues providing access to alcohol and / or gambling products has been shown to be a significant factor in the increased risk of harm. A concentration of such venues in lower SES areas is an example of 'harm by design' that places local populations at greater risk of developing hazardous gambling and / or alcohol consumption behaviours and experiencing gambling or substance use harms.[16-18]

THE WAY THAT HARM IS EXPERIENCED IS SHAPED BY A COMPLEX INTERPLAY OF CULTURAL, SOCIAL, COMMERCIAL, AND INDIVIDUAL FACTORS, MEANING THAT NO TWO PEOPLE IN TREATMENT WILL HAVE THE EXACT SAME EXPERIENCE OF HARM.

Exposure to trauma is strongly correlated to both gambling and substance use harms, with a significant gendered component. Women have been found to initiate gambling later in life but progress faster from 'recreational' to 'problematic' gambling, compared to men.[19] What has been described as a gendered 'telescoping effect' has also been documented in some substance use disorders, such as those related to alcohol or to opioid use.[20]

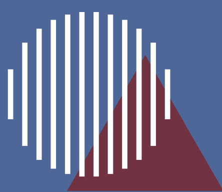
GENDER-AWARE TREATMENT FRAMEWORKS CAN HELP TO CHALLENGE BIASES THAT HAVE SIDELINED FEMALE EXPERIENCES OF GAMBLING AND SUBSTANCE USE HARMS.

Gambling and substance use can create harms that not only impact the individual. A person who is experiencing gambling harms typically affects six others.[21] This impact is magnified in some communities. For example, researchers in Victoria found that 23.5 percent of First Nations people have been harmed by someone else's gambling, compared to 5.9 percent of the state's non-indigenous population—reflecting, in part, different modes of kinship and other interpersonal relationships. Gambling practices may be experienced by First Nations people as both beneficial—bolstering culturally acceptable forms of sociality—and harmful.

IN CULTURES BASED ON COLLECTIVITY AND THE SHARING OF RESOURCES, GAMBLING LOSSES HAVE A WIDE IMPACT, EXTENDING FAR BEYOND THE INDIVIDUAL.

In recent years considerable effort has gone towards quantifying the harms to others from alcohol and, to a lesser extent, from other drugs, in part to exert pressure for policy reform.

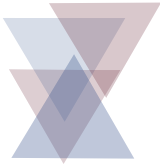
Understanding the impacts of gambling and substance use as extending beyond the individual can allow for appropriate supports to be identified and put in place for a broader segment of the population who are experiencing harms from their own or someone else's gambling or substance use.



Some forms of gambling are known to carry greater risks of harm. In the ACT, electronic gambling machines (EGMs) account for approximately one-third of harms (equivalent to a total of 2,277 Years of Health Life Lost due to a Disability [YLD]), followed by casino table games (1,118 YLD) and wagering products (1,115 YLD). Although lotteries (including keno and bingo) is the most prevalent form of gambling (39.0% of ACT adults bought a lottery ticket in the last 12 months), it accounts for relatively low burden of harm (376 YLD).[22]

Research has shown that the most harmful substances to people using drugs are fentanyl, heroin and crystal methamphetamine. The most harmful substances to affected others is alcohol, crystal methamphetamine and cigarettes / tobacco. Overall, alcohol is the most harmful drug when harm to users and harm to others is combined. Taking into consideration the prevalence of each substance in Australia, alcohol is again ranked the most harmful substance overall, followed by cigarettes, crystal methamphetamine, cannabis, heroin and pharmaceutical opioids.[23]

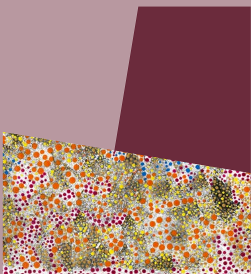
1



ACT Spotlight: In 2024, 5.7% of ACT adults reported experiencing harm due to another person's gambling; this represents approximately 21,000 ACT adults.[22]

A focus on harms can lead to a deficit approach within the clinical setting. Individuals seeking treatment or other forms of support for their gambling or substance use are, in many instances, exhibiting strength and resilience through their treatment-seeking behaviour. Identifying and building on protective factors such as knowledge of harm minimisation, social connectedness, or personal goals and ambitions can be key to effective therapeutic relationships and positive treatment experiences.

In relation to **gambling**, you may hear reference to **harm prevention**. Harm prevention can refer to efforts that are intended to:	In relation to **substance use** you may hear reference to **harm minimisation** and **harm reduction**. Harm minimisation is an approach that involves:
• Prevent gambling harm before it occurs	• Preventing uptake and delaying first use, reducing harmful use and supporting people to recover (demand reduction)
• Reduce the impact, duration, progression and complexity of gambling harm in individuals	• Controlling licit drug and precursor availability and reducing illicit drug availability and accessibility (supply reduction)
• Reduce the impacts of gambling in the broader community	• Reducing risk behaviours and providing safer settings (harm reduction)



Knowledge point: Harms from gambling and / or substance use are complex and overlapping, impacting not just the individual but a wider circle including family, community and society at large.

Practice point: Explore with service users their understanding and experience of the impacts of their gambling and substance use and what they have observed about the impact on those around them.

Theme 2: The co-occurrence of gambling and substance use harms

The co-occurrence of gambling and substance use has been well-established in the general population[1] and is further elevated in treatment-seeking individuals.[2] Experiencing harms from substance use can increase the risk of experiencing gambling harms and vice versa.[3] Co-occurrence can complicate clinical responses, raise the risk of premature cessation of treatment,[4] and increase the likelihood of a person presenting with additional co-occurring harms or complexities, including mental health conditions and suicidality.[5] Higher use and frequency of substances is predictive of more significant harms where gambling is co-occurring, and vice-versa.[6] In other words, harms may be amplified where there is co-occurrence of gambling and substance use.[7] Significantly, where there is co-occurrence, it is not unusual for further complex issues to accrue, some of which may require treatment or other forms of support or intervention.

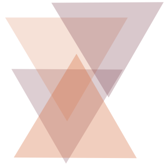
ALCOHOL AND GAMBLING

While much of the research on co-occurring gambling and substance use points to individual deficits (for example, poor impulse control or underlying psychiatric disorders), it is worth noting the way in which alcohol and gambling have been linked culturally, socially and spatially, often with the financial weight of industry upholding and reinforcing the association between products.

A study by the Foundation for Alcohol Research and Education (FARE) found that people at risk of harms and trying to reduce their use of alcohol and / or gambling were routinely having their data uploaded by alcohol and gambling companies and were targeted on social media with advertising for both products.[8]

Figure 2.1 Co-occurring health, mental health and wellbeing concerns

The evidence indicates that when alcohol is involved, individuals may be more likely to start gambling and / or less likely to stop gambling once they have started.[9] Those who frequently drink when gambling experience more gambling harms than those who don't drink. The ability to evaluate the costs and benefits of gambling and to recognise and respond to the impact of losses can be significantly reduced in the context of alcohol use. Conversely, the experience of gambling losses or wins can lead to greater quantities of alcohol consumed in shorter periods of time.[10]



ACT Spotlight: Those experiencing the most harms from gambling are the most likely to report frequent hazardous drinking (five or more standard drinks at one occasion on a weekly or more frequent basis).[11]

GAMBLING AND OTHER DRUG USE

The association between gambling and substance use (other than alcohol) is less clearcut and varies considerably by substance.

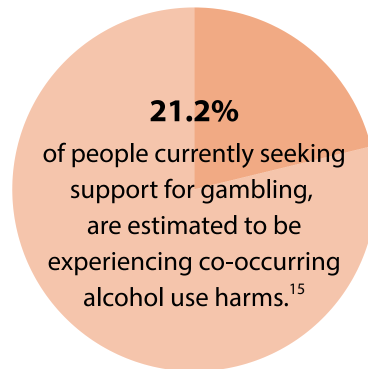
Cannabis use is correlated with lifetime gambling problems and, conversely, lifetime gambling problems are a predictor of cannabis use.[12] The link between the two is particularly evident in the context of online gambling.

Like alcohol, cannabis intoxication can impair decision-making and increase risk-taking. The higher the THC content, the more likely a person is to persist with high-risk activities, even when cued to desist (for example, by experiencing losses).[12]

More online gamblers reported past year cannabis use (32.9%) than offline gamblers (11.3%).[13]

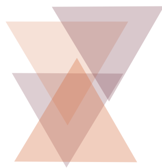
While the co-occurrence of *nicotine dependence* falls outside the scope of this practice guide it is worth noting the high prevalence of smoking in the treatment-seeking cohort. The *2023 ACT Service Users' Survey of Outcomes, Satisfaction and Experience (SUSOSE)* found that 81.8% of people accessing drug and alcohol treatment and harm reduction services in the ACT were daily smokers on entering the service (in the general population of the ACT the daily smoking rate is 4.8%).[14]

At 56.4%, nicotine dependence is the most common of all co-occurring conditions in individuals seeking treatment for gambling harms. Daily smokers demonstrate higher frequency and greater financial investment in gambling activity, lower perceived control over their gambling behaviour, and more severe gambling harms than non-daily smokers.[15]



The evidence on opioids (including opioid maintenance treatment) is mixed. One study found that as many as 52.7% of people accessing opioid maintenance treatment had a score of 5 or higher on the South Oaks Gambling Screen (SOGS), indicating probable pathological gambling.[16] However, an Australian study found that, despite higher rates of substance use disorders than the general population, none of the identified 'pathological gamblers' in the study (n=75) met the criteria for opiate use disorder.[17] This latter finding aligns with focus group data gathered during Stage 1 of the *Alcohol, other drugs and gambling in the ACT: a cross-sectoral approach to harm minimisation project*, where workers in the alcohol, tobacco and other drugs sector in the ACT identified alcohol or stimulants such as methamphetamine and (to a lesser extent) cocaine as the drugs of concern most often associated with co-occurring gambling harms, but did not anecdotally link opioid use and gambling.

"[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"
Project focus group participant



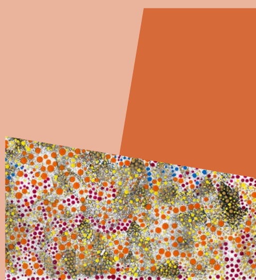
ACT Spotlight: Of ACT AOD service users who indicated that they had gambled in the past year, 22% felt that their gambling was causing them harm and 12.8% wanted to access support to stop gambling.[14]

There are some broad guiding principles that underpin working with people experiencing co-occurring harms, including co-occurring gambling and substance use harms.

GUIDING PRINCIPLES

1. Do no harm.
2. Work within your capacity.
3. Engage in ongoing professional development.
4. Adopt a 'no wrong door' policy.
5. Recognise that co-occurring conditions are common and that all clients should be routinely screened for co-occurring conditions.
6. Conduct ongoing monitoring and assessment of client outcome.
7. Focus on engaging the client in treatment.
8. Adopt a holistic approach based on treating the person, not the illness.
9. Adopt a client-centred approach.
10. Adopt a trauma-informed care approach.
11. Emphasise the collaborative nature of treatment.
12. Have realistic expectations.
13. Express confidence in the effectiveness of the treatment program.
14. Adopt a non-judgemental attitude.
15. Adopt a non-confrontational approach to treatment.
16. Involve families and carers in treatment.
17. Involve peers / lived experience practitioners in treatment.
18. Consult and collaborate with other health care providers.
19. Ensure continuity of care.

Adapted from: https://comorbidityguidelines.org.au/part-a-about-cooccurring-conditions/a3-guiding-principles



Knowledge point: Experiencing harms from substance use can increase the risk of experiencing gambling harms and vice versa.

Practice point: Be curious and ask questions that may open broader conversations about co-occurring gambling and substance use.

Theme 3: Overcoming stigma and discrimination

The stigma that is associated with gambling and substance use—and the discrimination that individuals are exposed to—can be a significant contributor to the experience of harm. Gambling and substance use carry overlapping burdens of stigma and discrimination that can be magnified where there is co-occurrence. As practitioners, it is important that we understand the mechanisms of stigma and discrimination as they can profoundly impact whether, when and how an individual discloses co-occurring harms. Recognising and challenging our own biases and assumptions can help to create a safer and more welcoming environment for service users to talk about the range of complexities that may be impacting their life and affecting treatment or harm reduction outcomes.

STIGMA

Stigma occurs in the context of uneven relations of power, where there is identification and labelling of difference, construction of (negative) stereotypes, separation of the labelled person/s into distinct categories, and assertion of disapproval, rejection and exclusion, leading to discrimination (see Figure 3.1).[1] Stigma is felt and enacted at both the individual level, and through institutions and structures.

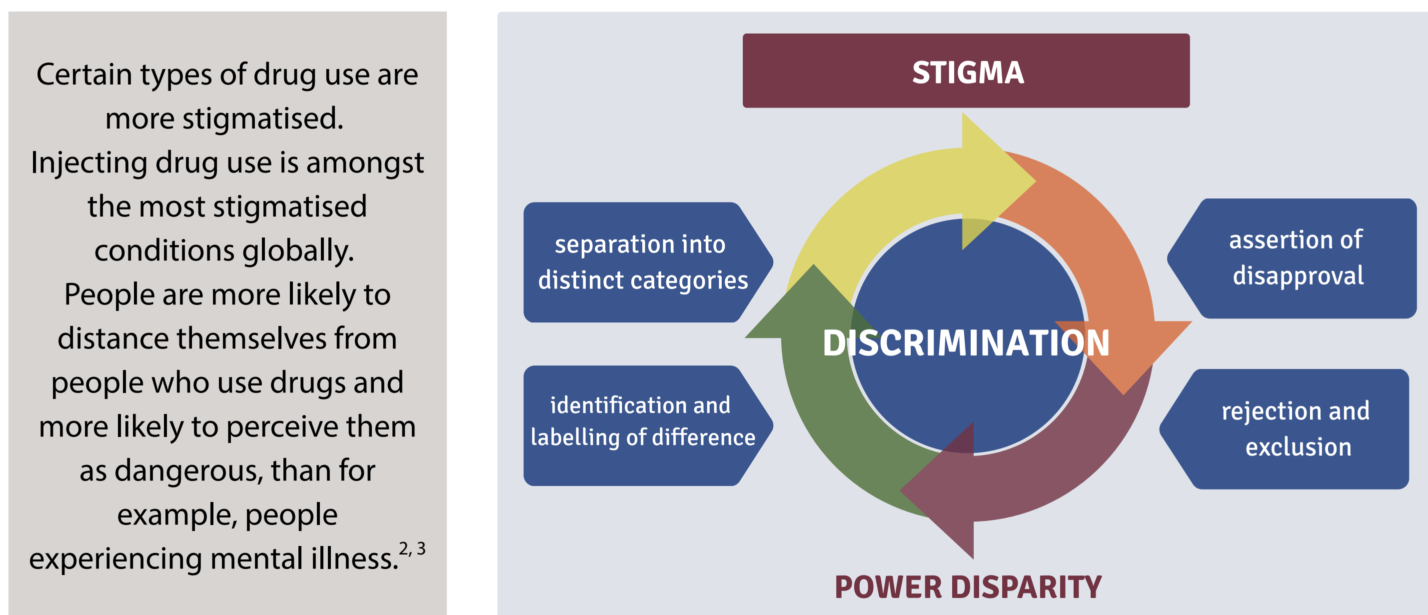
SELF-STIGMA

The concept of 'self-stigma' or 'internalised stigma' is important in the context of gambling and substance use harms. Self-stigma can powerfully shape an individual's subjectivity (how they see themselves and their place in the world). Self-stigma may be enacted through changed behaviour and changed ways of thinking and being.

SELF-STIGMA IS THE NEGATIVE THOUGHTS AND FEELINGS (E.G. SHAME, EMBARRASSMENT, FEAR) THAT EMERGE FROM IDENTIFICATION WITH A STIGMATISED GROUP

Figure 3.1 Stigma

Certain types of drug use are more stigmatised. Injecting drug use is amongst the most stigmatised conditions globally. People are more likely to distance themselves from people who use drugs and more likely to perceive them as dangerous, than for example, people experiencing mental illness.[2, 3]



STIGMA BY ASSOCIATION

Stigma can be felt by others who are associated with the individual experiencing direct harm from gambling and / or substance use.[4, 5] The association may be a genuine association—for example family members—or a perceived association—for example, having a shared cultural background.

STIGMA BY ASSOCIATION HAS BEEN REPORTED IN PEOPLE WHO WORK WITH STIGMATISED INDIVIDUALS AND COMMUNITIES, SUCH AS THOSE WORKING IN THE ALCOHOL AND OTHER DRUGS SECTOR OR IN GAMBLING SUPPORT.

ACT Spotlight: On a measure of stigma by association, workers in the alcohol, tobacco and other drugs sector in the ACT scored a moderate 2.27 out of 5.[6]

DISCRIMINATION

Discrimination follows from stigma. It is defined as actions from members of a dominant group that aim to harm individuals that are part of a less dominant group.[7]

The more narrow, legal definition of discrimination refers to unfavourable treatment or unfair effect because of a protected attribute such as race, gender identity or religious belief.[8] Experience of gambling and / or substance use harms or experience of accessing treatment or other services for gambling and / or substance use harms are not protected attributes under ACT or Commonwealth law. Nor do people within these categories comprise priority populations in any current ACT strategy or policy document.[9]

STIGMA AND THE PERSONAL RESPONSIBILITY NARRATIVE

Where products or behaviours are not only legal but have broad cultural acceptance—as is the case for alcohol and gambling—it is the harms rather than the products or behaviours per se that are stigmatised.[8] Both the gambling and alcohol industries have invested large sums of money in developing and perpetuating a narrative of personal responsibility. This narrative has subsequently been perpetuated through policy, research and service provision. It blames the extensive harms caused by the products and practices of industry on a few 'flawed' individuals who gamble or drink 'irresponsibly'. Research has shown that responsibility discourses play a significant role in the perpetuation of stigma and that this extends to stigma and discrimination in the healthcare context, where professionals may feel that people harmed by alcohol or gambling are not as deserving of help as their 'problems' are 'self-inflicted' and that they are, or should be, capable of taking rational actions to reduce their harms.[10] In other words, harms come to be seen not as indicative of harmful products (harm by design) but as evidence of weakness, lack of self-control, or even moral failure on the part of the individual.[11]

ACT Spotlight: Over 52% of adults in the ACT agree with the statement that 'people are completely responsible for the negative consequences of their gambling'.[12]

STIGMA AND CRIMINALISATION

The stigma and discrimination associated with drug use (and particularly with injecting drug use) is magnified by criminalisation.[13] The historic criminalisation of drug use has made socially acceptable and permissible the forms of stigma and discrimination that people who use drugs in the ACT report as routine. Recent changes to legislation that have resulted in the removal of criminal penalties for carrying small quantities of some drugs may not necessarily have brought about reductions in public stigma (already falling in the ACT) or in self-stigmatisation of people who use drugs.

ACT Spotlight: Approximately 40% of service user respondents in the *2023 Service Users' Survey of Outcomes, Satisfaction and Experience (SUSOSE)* said that they often or always experience stigma or discrimination in relation to their alcohol or other drug use.[14]

STIGMA, DISCRIMINATION AND CO-OCCURRING HARMS

Where there are co-occurring gambling and substance use harms, a person may experience stigma and discrimination in relation to one or both, and either independently or in ways that are overlapping or deeply intertwined. The experience of stigma and discrimination in the context of co-occurring harms can create additional barriers to accessing support and lead to further complex harms. Much of the research on stigma and discrimination in co-occurring conditions has focused on the intersection of mental health and substance use.[15-17] These studies show that stigmatising attitudes held by clinicians tend to be higher and worsen over time where there are co-occurring conditions.[18] Where a worker lacks experience or knowledge in relation to a co-occurring condition, they may hold certain biases (including unconscious biases) that impact the development of the therapeutic relationship.

STIGMA AND DISCRIMINATION AS A BARRIER TO TREATMENT

Stigma has been identified as a significant barrier to treatment for people experiencing gambling or substance use harms.[19, 20] Those who have experienced stigma or discrimination, or perceive that stigma exists, are less likely to access treatment services or seek help. Stigma experienced in a specialist health setting (such as an alcohol and other drugs treatment service) may influence an individual to cease treatment before its conclusion.[21] For those experiencing co-occurring harms, there are heightened risks of stigma and discrimination where treatment and/or expertise is siloed, such that the primary treating service or clinician is (or feels themselves to be) inadequately educated, informed or resourced about best practice responses to the co-occurring issue. The burden of self-stigmatisation can make an individual reluctant to disclose co-occurring harms, particularly in a setting where they feel these harms may not be understood or where disclosure may result in the experience of discrimination.

STIGMA, DISCRIMINATION, AND GENDER

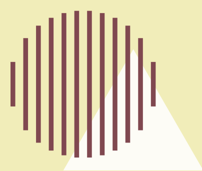
Women face multiple barriers to accessing treatment for substance use harms, and are less likely to seek treatment at a specialised service.[22] However, they are also less likely to cite shame or stigma as inhibiting factors in treatment-seeking.[23]

For women, where stigmatisation occurs in the context of gambling and substance use, it is closely linked to social norms around femininity and motherhood.[24] Intersecting dynamics of gender, race, class and other forms of inequality and the effects of living in societies that do not fully value women's participation, viewpoints, and healthcare concerns shape gendered experiences of stigma and discrimination.[23] Intersectional stigma exposes women to higher rates of harm, including increased risk of blood borne diseases and higher rates of violence from intimate partners, acquaintances and strangers.[25]

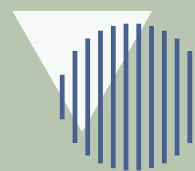
STIGMA AND DISCRIMINATION AS RISK FACTORS IN CO-OCCURRING HARMS

People come to treatment with a range of backgrounds and life experiences that may make them more or less likely to experience harms. Being part of a stigmatised group or experiencing discrimination in other areas of life, may increase an individual's risk of experiencing gambling and substance use harms. Stigmatised groups that experience higher rates of gambling and substance use harms include people who identify as Aboriginal and / or Torres Strait Islander,[26, 27] people who come from culturally and linguistically diverse backgrounds,[28, 29] and people who are part of the LGBTIQA+ community.[29]

PEER WORKERS AND LIVED EXPERIENCE WORKERS



In the ATOD sector in the ACT, the term **peer worker** refers to workers who are in roles in which they are identified as peers and in which they use general and peer-specific skills acquired through a combination of training and lived / living experience of alcohol and drug use to support service users, undertake individual and systemic advocacy, and offer training and education in harm reduction.



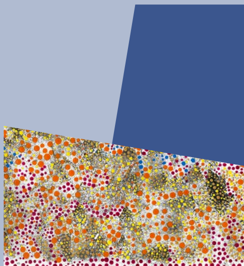
The term **lived experience worker** is heard more often than 'peer worker' in the gambling support sector and can refer to individuals who utilise their lived experience of gambling in counselling, education or advocacy roles.

3

Peer workers and lived experience workers play a critical role in addressing stigma and discrimination.[30] The availability of such roles in alcohol, tobacco and other drugs (ATOD) treatment services and in gambling support services, addresses barriers to employment that people with lived experience of gambling or substance use can face as a result of stigma and discrimination. Furthermore, peer and lived experience workers model hope and can lower the barrier to accessing treatment that self-stigmatisation imposes. Importantly, peer and lived experience workers can facilitate cross-sectoral links through education and by supporting warm referrals between ATOD and gambling support services.

There are a range of stigma-reducing interventions that can support the community sector to better address the issue of stigma and discrimination. These range from training that aims to shift attitudes and behaviours of individual healthcare professionals, through to effecting policy change and shifting cultural constructions of gambling and substance use.[7] Across all such interventions people with lived and living experience (including peer workers) should be empowered to drive the process.

ORGANISATIONAL OR STRUCTURAL INTERVENTIONS ARE IMPORTANT IN CREATING SERVICES AND PROGRAMS THAT REDUCE STIGMA AND AVOID THE PERPETUATION OF DISCRIMINATORY PRACTICES THAT PLACE BARRIERS TO SERVICE ACCESS FOR THOSE EXPERIENCING CO-OCCURRING HARMS.[31]



Knowledge point: People who are experiencing co-occurring gambling and substance use harms can face barriers to accessing or remaining engaged with treatment as a result of stigma (including self-stigmatisation) and discrimination, in relation to one or both of these issues.

Practice point: Be prepared to challenge your own biases and assumptions, so you can support service users in ways that are non-judgemental and empathetic. Consider interventions to reduce stigma at an individual and / or organisational or broader structural level.

Theme 4: Talking about co-occurring harms

The language we use as clinicians matters. Language can be a powerful way of under-cutting stigma and discrimination, signaling understanding and non-judgement, and creating a safe place for mutually addressing co-occurring harms.[1] As a broad approach, it is best practice to avoid stigmatising language and prioritise person-centred language (language that foregrounds the person, rather than the condition or behaviour).[2]

Language norms and what constitutes non-stigmatising language shifts over time and can vary between different treatment settings.[3] Service users may come with their own understanding of appropriate ways of talking about their experiences with gambling and substance use. Language guides can be useful resources to have on hand.

SIX SUGGESTIONS FOR USING A LANGUAGE GUIDE

1. Language changes—regularly update the language guides you use and be willing to learn and change your language practices as needed.

2. Language is adaptable—avoid being overly prescriptive in your use of language guides.

3. Take a person-centred approach to language—amongst other things, this may mean taking the lead on language-use from the service user.

4. Language should challenge stigma—if you are taking language cues from a service user, guide them away from language that may reinforce self-stigmatisation.

5. Language is local—know where and for what purpose your language guide was written: what's considered appropriate language can vary in different parts of the world and amongst clients from different cohorts (age groups, cultural backgrounds etc.).

6. Don't sweat your language—language 'mistakes' can happen and shouldn't be a reason to avoid raising the issue of co-occurring harms.

There are a range of language guides that can support respectful and responsible communication about gambling and substance use. Links ro language guides are available in the Resource booklet, as an appendix to this Guide

In collaboration with the project's Expert Committee, the following communication tips have been developed for workers in the ACT gambling support and ATOD sectors to support service users experiencing co-occurring gambling and substance use harms.

4

TIPS FOR TALKING ABOUT CO-OCCURRING GAMBLING AND SUBSTANCE USE

Use person-centred language and focus on the service user as an individual, rather than 'a problem', a diagnosis or a set of symptoms. Avoid language that removes agency from the person or that makes the harms they are experiencing appear impossible to solve.

- person who gambles
- person experiencing gambling harms
- person with lived experience of gambling harms

Consider the issue of harm by design and steer clear of language that suggests gambling is 'a bit of fun' or 'harmless'. Avoid slang terminology such as 'pokies' or references to 'gaming' and 'play'. Think about the language that is preferred by industry and consider how it minimises risk and passes responsibility for harm to the individual.

- electronic gambling machines

Consider the diverse range of experiences and treatment aims that an individual may come with - from abstinence to harm reduction. Avoid language that suggests linear progression, as this can exacerbate feelings of failure and shame when a person's journey is (as is more typically the case) complex and non-linear.

- person who uses drugs / alcohol
- person who experiences drug / alcohol harms
- person who has stopped / is not currently using drugs / alcohol
- person with lived experience of drugs / alcohol

Ask yourself whether the language you are using carries negative connotations and how this may add to the burden of stigma. Listen to the language of the service user and consider what this may tell you about their experiences of stigma and discrimination and about self-stigmatisation and shame.

- negative / not negative
- urine / drug test
- used syringe
- smoking implement

Medical language can be useful in educating and empowering service users to engage with a range of services. However, such language can also be confusing or alienating to a service user. It may contribute to feelings of helplessness and a lack of control over their own life and in their engagement with treatment or harm reduction services.

- person experiencing complex / co-occurring harms

SCREENING, ASSESSMENT AND LANGUAGE

A number of screening tools and diagnostic instruments make use of language that might be considered 'not best practice' in other contexts and when considered through the lens of potential stigmatisation.[4] The Diagnostic and Statistical Manual, 5th Edition (DSM 5) for example, uses the terms "Substance Use Disorder" and "Gambling Disorder"[5]; the *South Oaks Gambling Screen (SOGS)* uses the term "pathological gambler" and the *Problem Gambling Severity Index (PGSI)* categorises respondents in terms of "severity" from "none" to "problematic".[6] The language of these tools may be required when working in or communicating with clinical settings where they are used. However, outside the diagnostic realm, it is preferable to use terms that centre and give agency to the person ahead of any disorder, pathology or problem.[7]

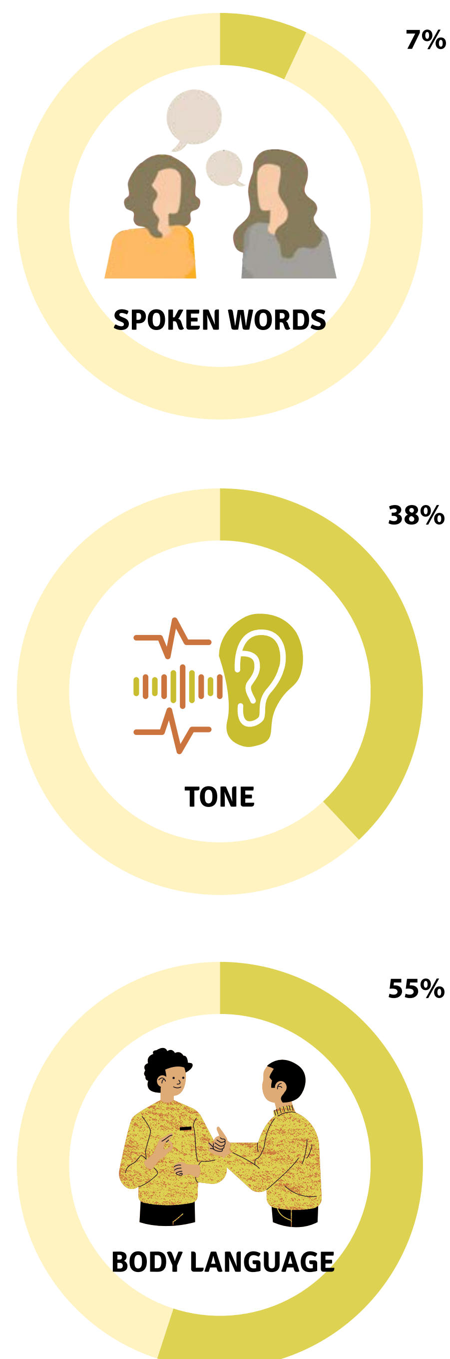
MEANINGFUL COMMUNICATION

Beyond issues of stigma and discrimination, it is important that the language we use meaningfully communicates to service users. This may mean balancing ordinary, everyday language with appropriate clinical discourse. Using clinical terminology can educate and arm service users as confident advocates of their own health and wellbeing needs into the future. Peer-led education can play a particularly important role in bolstering the health literacy of service users in ways that are relatable.[8]

GETTING BODY LANGUAGE RIGHT

Most of our communication happens in ways that are nonverbal. Being aware of body language can help us avoid communicating stigma around a service users' gambling and substance use.

Figure 4.1 Most of our communication is nonverbal

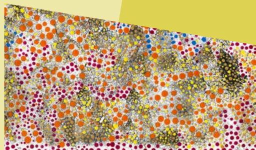


4

Put yourself in the practitioner role and consider how the different descriptions below might influence your perception of the individual and your subsequent interactions and treatment plan. What are the implications of the language you use for how individuals come to think about him / her / their self and their journey?

Brett is a difficult client who first came to the service when he was a homeless alcoholic. Although he has a long history of drug abuse, in the past Brett has managed to get clean. In counselling Brett confessed to being a gambling addict which had cost him his job, his home and his relationship. Brett wants to get sober and clean up his life.

When they first came to the service, Sam was experiencing a period of homelessness and was using alcohol. Sam has previously interacted with ATOD services and has ceased using drugs and alcohol on several prior occasions. During counselling, Sam disclosed details of gambling harms, including legacy harms that continue to impact them to the present day. Sam has indicated a wish to stop using alcohol and to get support to reduce gambling harms.



Knowledge point: The language used in a service setting can counter stigma and discrimination, signal a welcoming and non-judgemental environment, and create a safe place for mutually addressing co-occurring harms.

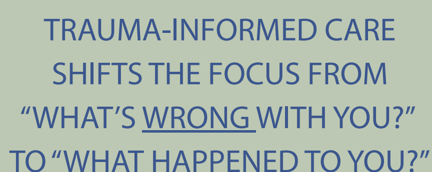
Practice point: Be familiar with best practice language but don't let fear of saying the wrong thing (or saying the right thing in the wrong way) stop you from having important conversations about a service user's gambling and substance use.

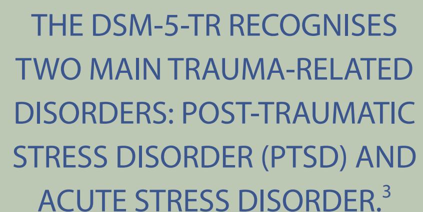
Theme 5: Creating a safe environment through trauma-informed care

Trauma—including but not limited to childhood trauma—is a common factor for people seeking support for gambling and / or substance use harms. In Australia, over 80% of people accessing alcohol, tobacco and other drug services report lifetime experience of trauma.[1] Similarly, childhood and lifetime traumatic events are significantly associated with pathological gambling (according to DSM-IV criteria) and an increase in the number of lifetime traumatic events is associated with an increased risk of experiencing gambling harms.[2]

A 2021 review, examining the link between gambling harms and post-traumatic stress disorder (PTSD) found that there was an association between stressful and traumatic life events and the likelihood of gambling harms occurring alongside substance use harms.[4] Experiences of trauma can be life-changing, and may significantly shape a person's views about themselves and the world around them.

Trauma-informed care is an approach whereby services integrate knowledge of the high rates of trauma exposure amongst their service users into policies, procedures, programs and practices to create a safe environment for all service users, including (but not limited to) those with a history of trauma.[5] Importantly, trauma-informed approaches can establish a safer environment for both service users and service providers.





At a service level, a trauma-informed approach crosscuts an organisation. It provides a framework that supports all staff—not just those involved in clinical care—to implement trauma-informed practices in every interaction and process.

WHAT IS TRAUMA?

Trauma is the response we have to an event, a sequence of events or a set of circumstances that are experienced as physically or emotionally harmful, overwhelming or life-threatening. Trauma can arise in response to a single incident or be complex: having its origins in sustained, cumulative or unresolved events.

5

THERE ARE SIX GUIDING PRINCIPLES FOR INCORPORATING TRAUMA INFORMED CARE INTO YOUR SERVICE

1. Safety: Ensuring clients and staff feel safe—physically and psychologically. This relates to both the physical setting and interpersonal relations and interactions.

2. Trustworthiness and transparency: Making decisions openly and without secrecy to build and maintain trust.

3. Peer support: Promoting mutual support amongst peers with shared experiences.

4. Collaboration and mutuality: Working together to counter power disparities and recognise the contribution that everyone plays.

5. Empowerment, voice, choice: Recognising and building on individuals' experiences and strengths (including their strength in surviving trauma and seeking help) and helping service users to establish a sense of control.

6. Cultural, historical, gender issues: Acknowledging and addressing the impact of historical trauma, stigma and discrimination, and implicit biases.

It is generally recommended that workers adopt a 'universal precautions' approach, operating on the assumption that all service users have experienced trauma. This does not, however, negate the need to assess service users individually. Trauma exposure should be routinely assessed by suitably trained practitioners. Before conducting trauma assessments, workers should seek training and supervision in dealing with trauma responses, and recognising and managing vicarious trauma or secondary traumatic stress.

Vicarious trauma is the cumulative effect of consistent exposure to hearing about other people's traumatic experiences.

Secondary traumatic stress (sometimes referred to as compassion fatigue) is a response that mimics post-traumatic stress disorder and is caused by hearing about another person's firsthand traumatic experiences.

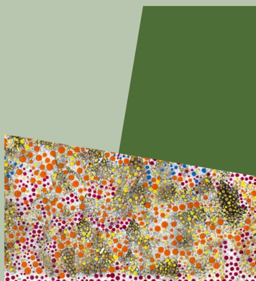
When a service user is experiencing harms from gambling and substance use, they may feel a lack of control over their circumstances. A similar sense of being out of control also characterises trauma disorders. Providing choice in the service setting and allowing service users control over their treatment can be important in building the sense of safety and trust that underpins the therapeutic relationship.

TRAUMA AND CO-OCCURRING HARMS

Individuals experiencing co-occurring gambling and substance use harms may have more severe trauma histories and a higher likelihood of trauma-related mental health conditions than those experiencing gambling harms only.[6]

Co-occurring gambling and substance use harms significantly increases the risk of suicidality.[7, 8]

Given its prevalence, a potential history of trauma (including childhood trauma) is important to acknowledge in the service setting. However, trauma can also have its origins in gambling or substance use. Many of the harms that are associated with gambling and substance use—family conflict, breakdown of relationships, financial losses, involvement with the custodial system, reduced physical or mental health, and suicidal ideation or suicide attempts —can, themselves, be experienced as traumatic. A trauma-informed approach can create a therapeutic space in which these experiences can be safely explored and the appropriate supports put in place, to minimise the impacts of trauma in the individual and their broader network.



Knowledge point: Trauma is a common factor in both gambling and substance use and is highly prevalent in people seeking support or treatment for co-occurring gambling and substance use.

Practice point: Integrate the principles of trauma informed care into your practice and adopt the 'universal precautions' approach. Be aware of the risk of vicarious trauma and take steps to ensure you have appropriate support and self-care practices in place.

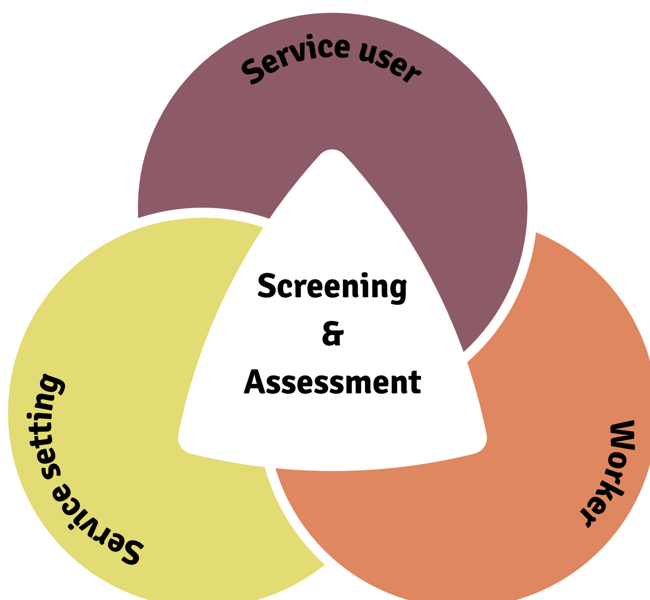
Theme 6: Screening and assessment for co-occurring harms

How screening and assessment is conducted can vary depending on the type of service, the expectations of service users, and the knowledge and capacity of workers.

While some services utilise highly formalised screening tools and processes, others may find that a less formal approach is suitable. The type of screening that you already use at your service may strongly influence what mechanisms are put in place to screen for co-occurring harms. What is important is not how screening happens, but rather that it is applied with some level of consistency.[1]

Routine screening can remove an element of subjectivity and helps prevent biases and assumptions from influencing whose needs are recognised and who gets help. Importantly, with practice, routine screening can undercut any sense in the client that they are being unfairly profiled.[2]

Figure 6.1 What factors contribute to deciding when and how screening occurs?



Barriers to screening for co-occurring gambling and substance use harms

1. Relevant questions are not part of existing processes
2. There is a lack of clear guidelines or knowledge about how to respond to information received through screening
3. There is fear of damaging the therapeutic relationship
4. Workers don't feel that co-occurring issues are important or relevant
5. Services want to prioritise core business and / or face funding restraints
6. There are other co-occurring issues that take precedence
7. There is insufficient time to undertake assessment
8. Service users are unwilling to disclose co-occurring issues
9. Service users underestimate the impact of co-occurring issues

GAMBLING SCREENING TOOLS			
Brief Biosocial Gambling Screen (BBGS)*	3 items	1–3 minutes	Gebauer, LaBrie, & Shaffer (2010)
Early Intervention Gambling Health Test (EIGHT)*	8 items	5–10 minutes	Sullivan (2007)
Lie/Bet*	2 questions	1 minute	Johnson, Hamer, Nora, Tan, Eistenstein, & Englehart (1988)
South Oaks Gambling Screen (SOGS)*	20 items	10 minutes	Lesieur & Blume, (1987)
NODS-PERC	4 questions	2 minutes	Volberg, Munck & Petry, 2011
Problem Gambling Severity Index (PGSI)*	9 items	2 minutes	Ferris & Wynne, (2001)

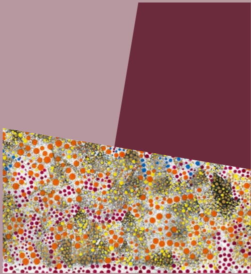
* validated for use in ATOD settings

SUBSTANCE USE SCREENING TOOLS			
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	8 items	5–10 minutes	World Health Organisation (1997)
Alcohol Use Disorders Identification Test (AUDIT)	10 items	5–10 minutes	World Health Organisation (1989)
Drug Use Disorders Identification Test (DUDIT)	10 items	5–10 minutes	Bergman, Bergman, & Palmstierna (2003)

6

A review of current practices around screening for co-occurring harms found eleven screening tools that were validated in substance use treatment settings, including in mental health treatment settings where substance use affects a significant proportion of service users.[3] However, the same review found that there are no tools validated that screen specifically for substance use in a gambling treatment setting.

ACT Spotlight: In a survey of ACT ATOD workers, a significant proportion (19%) disagreed or strongly disagreed with the statement: 'I know how to screen for gambling harms'. This contrasts with the self-assessment of capabilities in respect of co-occurring mental health issues or co-occurring domestic and family violence, where only 2% of respondents did not feel confident in their knowledge of mental health conditions or in identifying and responding to DFV, respectively.[4]



Knowledge point: Screening tools can be useful in some contexts but don't necessarily capture everything about a service user's experience of harms from gambling and substance use.

Practice point: Use screening tools when appropriate but be aware of their limitations and be prepared for ongoing conversations about co-occurring harms.

Theme 7: Responding to co-occurring harms

In responding to co-occurring gambling and substance use harms, there are a range of interventions that may be appropriate at different points in time and in different contexts.

Within the service setting the response is most likely to be treatment and / or harm reduction interventions to support those experiencing harm from their own gambling and substance use or, in specific contexts, from somebody else's gambling or substance use. There are a wide range of therapies and strategies that are suitable for those who are experiencing co-occurring gambling and substance use harms.[1]

GAMBLING	SUBSTANCE USE
Brief intervention	Brief intervention
Withdrawal (non-medical)	Withdrawal (medical or non-medical)
Counselling (e.g. CBT, MI)	Counselling (e.g. CBT, MI)
Support for affected family and friends	Support for affected family and friends
No residential rehabilitation currently available for gambling in the ACT	Residential rehabilitation
Pharmacotherapy (naltrexone – off label)	Pharmacotherapy (acamprosate, naltrexone and disulfiram – alcohol; methadone, buprenorphine and buprenorphine / naloxone – opioids)
Peer support / lived experience educators in non-peer service setting (there are no peer-led gambling support services currently available in the ACT)	Peer support / peer treatment support in non-peer or peer-led service-setting
Mutual-help / peer-led groups (e.g. Gamblers Anonymous, SMART Recovery)	Self-help / peer-led groups (e.g. Alcoholics Anonymous; SMART Recovery)
Harm prevention strategies	Harm reduction strategies
Relapse prevention	Relapse prevention

7

The intervention type will depend on the service setting and the needs, goals and expectations of the service user. Many of the interventions that are routinely used for those experiencing harms from only gambling or only substance use can be effectively applied or adapted to those experiencing co-occurring harms. Where the needs of a service user cannot be accommodated within the specific service setting, it may be appropriate to discuss options to another service or program. In all cases, interventions for co-occurring harms should be person-centred and oriented towards meeting the holistic health and wellbeing needs of the individual within the broader context of public health imperatives.

A PERSON-CENTRED APPROACH IS ONE THAT TREATS SERVICE USERS AS INDIVIDUALS AND AS EXPERTS IN THEIR OWN LIVES.

Figure 7.1 Person-centred approaches

PRINCIPLES OF PERSON-CENTRED APPROACHES

1. Respectful: Treating each person with respect and recognising their inherent worth.

2. Individualised: Tailoring care to the specific needs and preferences of each person.

3. Holistic: Considering the person's physical, emotional, social, and spiritual well-being.

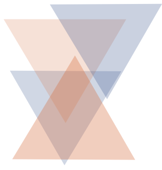
4. Transparent: Working with the person to make informed choices about their care.

5. Empowering: Supporting the person to take control over their lives and their health in ways that are sustainable into the future

6. Co-ordinated: Recognising that people may have multiple needs and working with other services to ensure they are able to access appropriate support.

7. Collaborative: Recognising the importance of involving family, friends, and carers in the person's care where appropriate and in consultation with the individual.

Person-centred approaches are inherently multi-disciplinary and draw on expertise from a diverse range of sources including medical specialists; psychologists, counsellors and other therapists; social workers; alcohol and other drug workers; financial counsellors; peer workers and others with lived experience of gambling and / or substance use harm.



ACT Spotlight: Just 1.5% of gamblers in the ACT reported ever wanting any sort of help for issues related to their own gambling.[2]

BRIEF INTERVENTIONS

Brief interventions are most suitable for people at risk of experiencing harms or who are experiencing mild to moderate harms. A brief intervention can be undertaken at any point in the treatment process but is often used when an individual has first been identified as at risk of experiencing harms, through routine screening. Repeating brief interventions whenever possible rather than focusing on a single session, will improve efficacy.[3]

It is not necessary to be an expert in gambling and / or substance use to provide a brief intervention. A basic understanding of risks and harms and a working knowledge of simple interventions to reduce harm, including referral options, are the essential requirements. For example, those providing brief interventions for harmful use of alcohol need to know basic facts and effects about alcohol, standard drink measures, low risk drinking advice for men and women, basic tips for cutting down and stopping (including risks associated with this) and knowledge of specialist agencies to which to refer people.

Regardless of the approach to brief intervention, there are key elements that apply in all contexts. These can be summarised by the acronym FRAMES:

F **Feedback**: Provide feedback about personal risk or level of current harm, as indicated by the screening process.

R **Respect**[1]: Always respect the person's autonomy. You can empower a person to make positive choices but the decision to do so is ultimately theirs.

A **Advice**: Increase the person's awareness of the costs and consequences of their behaviour and provide advice to support change.

M **Menu**: Outline the menu of options or strategies to support positive change; help with goals and action planning if appropriate to the person.

E **Empathy**: Listen and reflect; maintain rapport; use a communication style grounded in empathy.

S **Self-efficacy**: Convey optimism and strengthen the person's self-efficacy and capacity for change.

[1] In a traditional FRAMES approach the R stands for 'Responsibility'. Recognising the way in which the concept of responsibility has been framed by industry (e.g. through the 'gamble responsibly' narrative) and contributes to increased stigma, a decision was made by the Expert Committee to use the word 'Respect' in its place, while retaining the same ideas about service user autonomy.

WITHDRAWAL

Withdrawal (also known as detoxification or detox) is the process of stopping or cutting back, on gambling or on using alcohol or other drugs. Withdrawal can result in symptoms indicative of physical dependence and / or psychological dependence.[4]

The reward or pleasure effects of both gambling and substance use involves activation of the brain's dopamine and opioid signalling system. Dopamine is a neurotransmitter inside the brain that reinforces sensations of pleasure and connects those sensations to certain behaviours or actions.

Withdrawal from gambling

Most people who experience gambling harms report restlessness and irritability when attempting to cut down or limit their gambling. A significant 65% report at least one withdrawal-like symptom (e.g. insomnia, headaches, stomach upset / diarrhea, loss of appetite, etc.)[6] There are no specific withdrawal programs available for people in the ACT who are experiencing harms from gambling. However, educating service users about the likelihood of withdrawal-like symptoms is important in managing the process and identifying appropriate interventions.

Withdrawal from substance use

Experience of withdrawal from substance use varies significantly depending on the substance and factors such as length of use, general health of the individual and the support environment. In some cases, medical supervision is required for safe withdrawal.

MEDICATION CAN BE AN IMPORTANT COMPONENT OF WITHDRAWAL MANAGEMENT

PHYSICAL DEPENDENCE OCCURS WHEN A PERSON COMES TO RELY ON THE PHYSIOLOGICAL RESPONSES TO GAMBLING OR SUBSTANCE USE IN ORDER TO FEEL 'NORMAL'.[4, 5]

PSYCHOLOGICAL DEPENDENCE OCCURS WHEN A PERSON BELIEVES THEY NEED THE SUBSTANCE OR BEHAVIOUR TO FUNCTION, EITHER IN PARTICULAR SITUATIONS OR MORE GENERALLY.[4, 5]

HOME-BASED WITHDRAWAL	OUTPATIENT WITHDRAWAL	RESIDENTIAL WITHDRAWAL
Experience of withdrawal from substance use varies significantly depending on the substance and factors such as length of use, general health of the individual and the support environment. In some cases, medical supervision is required for safe withdrawal.	Outpatient withdrawal is similar to home-based withdrawal. However, rather than medical professionals attending the person's home, regular visits to a hospital or community-based withdrawal unit will be made by the person undergoing withdrawal.	Residential withdrawal provides a safe, secure and supportive environment for people to withdraw from drugs and / or alcohol.
All three types of withdrawal are available, for at least for some substances, in the ACT.		

COUNSELLING

There are a wide range of counselling approaches that may be utilised in a treatment setting for people experiencing gambling and / or substance use harms.[1] Two approaches that are backed by evidence of efficacy in regards to both gambling and substance use harm are cognitive behavioural therapy (CBT) and motivational interviewing (MI).[7,8]

Clinical guidelines recommend individual or group CBT and motivational interviewing delivered by trained practitioners. While evidence for other treatments is limited, clinical consensus suggests mindfulness-based therapies, solution-focused brief therapy, interpersonal psychotherapy, narrative therapy, acceptance and commitment therapy, dialectical behaviour therapy, and family interventions may also be effective.

Cognitive Behavioural Therapy

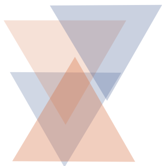
CBT is a goal-oriented form of psychotherapy in which a trained clinician supports a service user to identify negative patterns of thought or behaviour and to develop a range of skills to put in place more positive approaches. CBT can be offered in individual or group settings, using face-to-face or online delivery.

Motivational Interviewing

MI is a technique to help service users identify what may be causing ambivalence about change and to enhance their commitment to achieving identified goals.

SUPPORT FOR AFFECTED FAMILY AND FRIENDS

Appropriate psycho-social interventions for affected family and friends can be critical in ensuring that the service user has the support to enact long-term change and achieve their treatment and harm reduction goals.



ACT Spotlight: In the ACT affected family and friends can access information, speak to counsellors or attend support groups by contacting Family Drug Support or Relationships Australia / ACT Gambling Support Service (AGSS).

PHARMACOTHERAPY

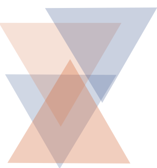
Pharmacological interventions may be recommended as part of a holistic treatment plan in consultation with a prescribing healthcare provider.

DRUG / BEHAVIOUR OF CONCERN	RECOMMENDED MEDICATION
Alcohol	Diazepam Acamprosate[9] Naltrexone[9] Disulfiram[9]
Cannabis	There are no specific pharmacotherapies listed by the TGA for managing cannabis withdrawal (medication may be recommended for symptomatic relief)
Opioids	Methadone Buprenorphine Buprenorphine/naloxone Buprenorphine long-acting injections (LAI)
Methamphetamine and cocaine	No specific pharmacotherapies for managing withdrawal. Short-term medication use may be recommended for symptomatic relief, including benzodiazepines and atypical antipsychotics*
Gamma Hydroxybutyrate (GHB)	Diazepam Diazepam and baclofen
Gambling	Naltrexone[10]

Unless otherwise indicated, this information has been adapted from https://www.health.nsw.gov.au/aod/professionals/Publications/clinical-guidance-withdrawal-alcohol-and-other-drugs.pdf *Some atypical anti-psychotics have been associated with an increased risk of developing a gambling disorder.

PEER SUPPORT

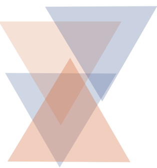
Peer workers and lived experience workers can play an important role within the service setting. Workers who have experienced co-occurring harms and are able to bring that experience to their work practice, provide a model of hope and can be critical in enlisting and retaining individuals in treatment. Peer workers and lived experience workers may liaise with services to ensure co-occurring gambling and substance use harms are appropriately addressed, referrals are suitable and meet the needs and expectations of the service user, and broader needs of the service user are met wherever possible. Importantly, peer workers and lived experience workers play a role in improving systems and in reducing the stigma (including self-stigmatisation) and discrimination that can present a barrier to accessing support.



ACT spotlight: ATOD peer workers can be found in many ATOD services in the ACT but are primarily located at the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), the ACT's peer-led drug and alcohol service. Gambling support peer workers are located at the ACT Gambling Support Service (AGSS).

MUTUAL-HELP / PEER-LED GROUPS

Participation in community-based programs such as mutual-help or peer-led groups can assist individuals through support, accountability and structure. Such group interventions—if offered alongside other forms of support—can be helpful for some service users.



ACT Spotlight: In the ACT there are a number of mutual help / peer led groups available for individuals experiencing gambling or substance use harms, as well as groups for affected family and friends.

HARM PREVENTION STRATEGIES / HARM REDUCTION STRATEGIES

There are a number of different harm reduction and harm prevention strategies that may be useful tools to support better health, social and economic outcomes for people experiencing co-occurring gambling and substance use harms. These strategies can sit at a social policy level (for example, strategies to manage online sales of alcohol, decriminalisation of small quantities of illicit drugs or a reduction in the number of EGMs) or at an individual level (for example needle and syringe programs [NSPs] or bet / loss limits).

For information about services, visit the ACT Alcohol, Tobacco and Other Drug (ATOD) Program Directory

https://directory.atoda.org.au/

HERE IS SOME ADVICE YOU MIGHT PROVIDE TO YOUR SERVICE USERS ON REDUCING OR PREVENTING HARMS	
GAMBLING	**SUBSTANCE USE**
• Set time limits • Set loss limits • Avoid gambling venues • Utilise self-exclusion where available – including online self-exclusion (BetStop) • Avoid drinking alcohol or using drugs when gambling • Participate in events that don't involve gambling • Request activity statements when using EGMs • Speak to a Gambling Contact Officer (GCO) on the floor at your gambling venue • Understand the relative harms of different forms of gambling and consider lower risk activities	• Limit alcohol and drug use to certain times of the day and avoid driving • Alternate alcoholic beverages with water • Swap drinks to low / no alcohol options • Take daily thiamine if you are drinking at higher-risk levels • Set a daily / event limit • Participate in activities not involving drugs or alcohol • Consider alternatives to injecting drug use and become familiar with vein health • Engage in safer injecting, such as using 'fit packs' and avoid sharing needles • Test your drugs (CanTEST) • Access at-home naloxone if you or a loved one is at risk of opioid overdose (or if you are not testing your illicit drugs) • Use safer smoking equipment such as steel implements (avoid plastic or aluminium)

THE MODEL YOU USE AND THE ORDER OF TREATMENT MAY DEPEND ON THE SPECIFIC TREATMENT NEEDS AND CIRCUMSTANCES OF THE SERVICE USER

Sequential treatment: The service user is treated for one condition first, which is followed by treatment for the other condition.

Integrated treatment: Gambling and substance use are treated simultaneously (usually by the same service provider) in a way that is mutually re-enforcing

Parallel treatment: Gambling and substance use are treated at the same time but independently of each other

Historically, there has been a preference for treating co-occurring harms sequentially. Within this model, substance use would typically be treated first and gambling addressed only after the service user has exited ATOD treatment. More recently, there has been an emphasis on integrated treatment, services, and systems within a broader push to acknowledge and respond to co-occurring issues around mental health and substance use. While the evidence on outcomes related to order of treatment remains inconclusive, there would appear to be some advantages to an integrated treatment model, particularly around avoiding disengagement and promoting consistent treatment objectives.[11, 12]

ADDRESSING BARRIERS TO TREATMENT

In the ACT, service users at ATOD services were asked about issues that had made it difficult to access ATOD services in the previous five years.[13] Notwithstanding the fact that those who answered had, in fact, overcome or partially overcome these barriers in order to access the service, a number of issues were identified.

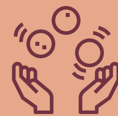
Figure 7.2 What makes it hard to access ATOD services

Fear of being stigmatised or judged

Lack of support from family or friends

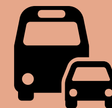
Someone I know might find out

The service or other people told me the waiting list was too long



Caring or other responsibilities

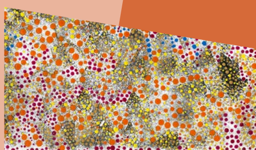
Couldn't smoke at the service



Couldn't get to the service

Financial situation

Note: For each question, non-responses have been excluded. Where relevant, 'prefer not to say' is not reported - for further details see main report



Knowledge point: There are a range of different interventions for gambling and substance use, and no 'one-size-fits-all'.

Practice point: Brief Interventions are an important starting point. Utilise the FRAMES method – feedback, respect, advice, menu, empathy, and self-efficacy and follow up with the most appropriate support for the service user.

Theme 8: Making referrals

It may be necessary to make a referral to another program or service to ensure that a service user receives appropriate support for co-occurring harms. As a clinician, recognising when somebody requires support beyond your own sphere or level of expertise is an important skill to be cultivated in the workplace.[1]

Referrals may involve transferring a service user out of a program or service either temporarily or permanently. Alternatively, it may involve instigating a shared care arrangement. Indeed, it is generally considered best practice to retain a service user experiencing co-occurring harms in the service or program they initially entered, even when they are simultaneously accessing other services.[2] In recognition of this, a number of services—including gambling support services—undertake in-reach to ATOD programs (especially, although not exclusively, to residential services).

Referrals are often the point in which service users—particularly those with more complex and/or co-occurring harms—may slip through the cracks.

It is important that the referral process occurs in such a way as to minimise the risk of service users exiting treatment altogether. Developing cross-sectoral collaborations can support service users with co-occurring gambling and substance use harms to remain engaged in the treatment process.[3]

WHEN REFERRING A SERVICE USER TO ANOTHER PROGRAM OR SERVICE, IT CAN BE HELPFUL TO GET THE SUPPORT OF A COLLEAGUE, MANAGER OR CLINICAL SUPERVISOR.

In-reach refers to bringing allied services to people who are already engaged within a healthcare service.

TYPES OF REFERRALS

COLD REFERRAL	WARM REFERRAL
Cold referral or passive referral occurs when a service user is provided the details of another service (for example, by being provided a pamphlet) in order to make their own appointment. This method is generally not suitable for service users with co-occurring conditions—although it may be used where there is a strong preference by the service user to manage the process independently.	**Warm referral** or facilitated referral is the preferred method for people experiencing co-occurring harms. A warm referral may involve a number of activities: from contacting a service for or with the service user; to going with a service user to a new service to assist in building rapport; and following up to make sure that the referral has been successful and that the service user is receiving the support they need.

Referrals should always be undertaken with the full knowledge and consent of the service user.

TO ASSIST THE CLIENT IN ATTENDING A REFERRAL APPOINTMENT, IT CAN BE USEFUL TO DISCUSS ISSUES SUCH AS:

- The purpose and value of the referral;
- Where the service they are being referred to is located and how the service can be contacted;
- How the service user will get to the new service and any transportation or other access needs that can be supported;
- What the service user can expect on arrival at the new service;
- Any concerns the service user has about the referral; and
- How contact can be maintained with the original service and/or worker.

Support should continue to be provided to the service user until an appointment with the new service has been arranged.

WHAT TO DO IF A SERVICE USER DECLINES A REFERRAL?

1. Respect the service user's decision. There are a number of possible reasons that a service user may be unwilling or unable to accept a referral at that particular time.
2. Consider whether, in the absence of a warm referral, the service user will accept written information (e.g. pamphlets) about the other service.
3. If appropriate ask the service user if they would like you to prepare a letter or other communication for them to take to services in their own time.
4. If appropriate, be prepared to return to the issue of referral at a later stage in the treatment process.

A KEY BENEFIT OF A WARM REFERRAL IS REDUCING THE NEED FOR THE SERVICE USER TO REPEAT THEIR STORY MULTIPLE TIMES.

A REFERRAL ROUNDABOUT CAN HAPPEN WHEN SOMEBODY SEEKS HELP AND GETS PASSED FROM SERVICE TO SERVICE UNTIL THEY END UP WHERE THEY STARTED.

WHERE TO REFER

Referring a service user who is experiencing co-occurring **gambling harms**

In the ACT

- The ACT Gambling Support Service (AGSS) is a free and confidential support service for people experiencing harm, as a result of theirs, or someone else's gambling: https://actgamblingsupport.org.au/
- Gambling harm can have a significant impact on relationships. Relationships Australia Canberra & Region is the lead agency responsible for the management of AGSS: https://racr.org.au/
- Care provides financial counselling services to help those experiencing or witnessing gambling harm: https://www.carefcs.org/

Nationally

- Gambling Help Online provides free online support 24/7 across Australia for anyone affected by gambling: https://www.gamblinghelponline.org.au/
- The National Gambling Helpline can be contacted on 1800 858 858 and provides free, professional and confidential support 24 hours a day, 7 days a week.

Referring a service user who is experiencing co-occurring **substance use harms**

In the ACT

- An up-to-date directory of current programs available within the ACT alcohol, tobacco and other drug sector is available at https://directory.atoda.org.au/programs/. The ACT Alcohol, Tobacco and Other Drug (ATOD) Program Directory can be accessed by health professionals, as well as by people experiencing harms from alcohol, tobacco or other drug use and their families and friends.
- The ACT Health Central Health Intake (CHI) line for community and clinic services is (02) 5124 9977 (option 2 for drug and alcohol services)

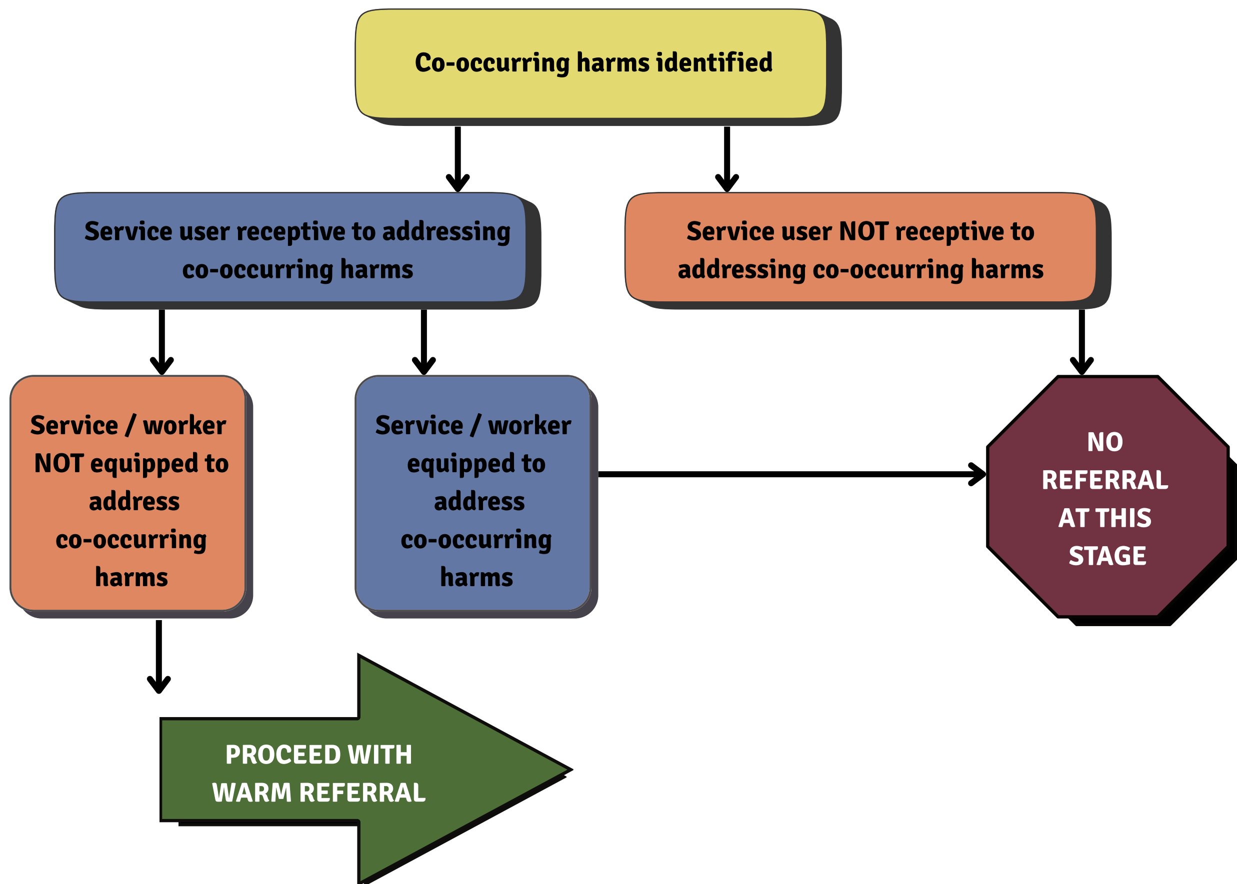
Nationally

- The Alcohol and Drug Foundation offers Path2Help to allow people to find tailored support recommendations for someone impacted by alcohol or other drugs https://adf.org.au/help-support/path2help/

- Counselling Online is a free and confidential service that provides 24/7 support to people across Australia affected by alcohol or drug use https://www.counsellingonline.org.au/

- The National Alcohol and Other Drug Hotline provides confidential support for alcohol and other drug harms 24 hours a day, 7 days a week on 1800 250 015

Figure 8.1 A guide to when to refer



PRINCIPALS OF COMMUNICATION AT REFERRAL

1. Gain the service user's consent before sharing any information—both at the outset and any time you are communicating new information to another service.

2. Maintain confidentiality—only share relevant and necessary information and ensure communication procedures are in place to limit the risk of breaching confidentiality.

3. Obtain written permission from the service user before sharing case notes or other documentation and mark all reports as 'strictly confidential'.

4. Avoid jargon—remember, the person you are communicating with may not be familiar with acronyms or commonly used term in your sector.

5. Be clear about where information comes from.

6. Avoid stigmatising language.

8

COMMUNICATING WITH OTHER SERVICES DURING THE REFERRAL PROCESS

Good communication between service providers involved in the care and support of people experiencing co-occurring harms is essential to ensuring a positive treatment experience and improving outcomes.

Services may develop their own referral protocols. However, existing models such as **ISBAR** (identification, situation, background, assessment, recommendation) can provide a standardised verbal or written tool for clear, cross-sectoral communication.

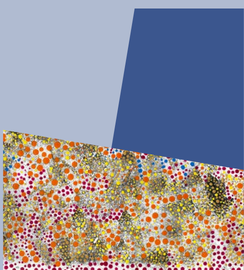
I — ***Identification*** > *Introduce yourself and the service user > I am [name]…I work at [service]… as a [role]; I am calling / writing to you about… [include relevant details of the service user's identity (e.g. name, gender, age]*

S — ***Situation*** > *Briefly state the situation > [Service user] initially came to this service for… they are experiencing co-occurring… [gambling / substance use harms]*

B — ***Background*** > *Using a trauma-informed approach, provide relevant contextual information such as the service user's medical history, intervention/s to date, and social or cultural background > The background/context is...*

A — ***Assessment*** > *Provide a summary of your interpretation of the situation > I think the issue might be…/I'm not sure what the issue is but I have noticed…*

R — ***Recommendations*** > *Outline actions that may be required after referral > I'd like to recommend that [service user] be referred into your service / that we enter into a shared care arrangement to support [service user's] needs*



Knowledge point: Referring to the right service or services will often be a critical factor in good treatment and harm reduction outcomes for a person experiencing co-occurring gambling and substance use harms.

Practice point: Take time to familiarise yourself with local services; get to know intake officers or other key personnel who can facilitate smooth referrals.

Theme 9: Developing cross-sectoral collaborations

Building collaborative partnerships between ATOD services and services offering support to people experiencing gambling harms, can be important in a) strengthening the knowledge and confidence of workers to recognise and respond to co-occurring harms; b) aiding referral; c) reducing the risk of disengagement by providing seamless continuity of care; and d) developing holistic, person-centred approaches that are responsive to the needs of service users who are experiencing co-occurring harms.

STRENGTHENING KNOWLEDGE AND CONFIDENCE

Identification of co-occurring gambling and substance use harms at services in the ACT generally happens on an ad-hoc basis and is largely dependent on the confidence, knowledge and experience of individual workers.[1] Key to increasing the capacity of workers is the embedding of cross-sectoral collaborations that enable and encourage knowledge sharing around gambling and substance use.

'Building networks and working collaboratively makes a lot of sense and can deliver many things that are not possible by working alone. But they don't always happen organically or by magic. Most are hard to create and even harder to sustain. They are also not business as usual and require new ways of thinking, behaving, managing, leading and evaluating.'[2]

EXISTING MECHANISMS FOR CROSS SECTORAL COLLABORATIONS FOR KNOWLEDGE SHARING IN THE ACT

In-service programs

An example of an in-service program is peer workers from the ACT Gambling Support Service (AGSS) visiting ATOD services to provide education to both service users and health professionals.

Allied sector training

An example of allied sector training is ATODA's Alcohol, Tobacco and Other Drug Information and Harm Reduction Training.

Communities of practice

An example of a community of practice is the Gambling Harm Prevention Community of Practice.

9

AIDING REFERRAL

Referring a service user to a clinician who is better placed to respond to a particular co-occurring harm is an ethical practice that ensures appropriate treatment needs are met. A finding of the first stage of the project was that referral pathways in the ACT are under-developed. These pathways can be further developed through intersectoral collaboration and the implementation of more formalised processes.

REDUCING THE RISK OF DISENGAGEMENT

Although entering a program may have come at considerable personal and / or financial cost and a service user may be genuinely committed to treatment, the risk of disengagement remains high. Disengagement can occur at any point in the treatment process, however, there are some pivotal moments where the risk of disengagement increases. One of these is when the service user moves between services. For this reason, integrated or parallel treatment of co-occurring harms is preferred over sequential treatment. Efforts to reduce the risk of disengagement include building cross-sectoral collaborations to ensure that service users remain 'in sight' and do not fall between the cracks and aligning processes so that the experience of moving between services (whether that occurs once or multiple times through the treatment process) is seamless.

DEVELOPING HOLISTIC, PERSON-CENTRED APPROACHES

Service users place high value on cross-sectoral cooperation, particularly in terms of case management and coordinated care. Where services work more collaboratively, service users report that their needs are better met.[3]

***Wrap-around care** means that services are brought to the client through co-location of services, facilitated referral pathways or some other system.*

***Facilitated referral** means that a service user does not have to individually negotiate all the different services that they require. Negotiation about service provision happens behind the scenes and is led by the service provider.*

***No wrong door** is the idea that a client can gain access into the entire human services system regardless of the service type at which they first present.*

***Self-directed care** is the idea that clients have a right to decide on the number and timing of needs to be addressed and the services that are to be involved in their care.*

Figure 9.1 Key benefits of developing cross-sectoral collaboration

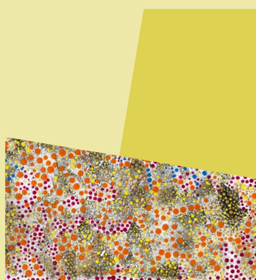
Better treatment outcomes have been associated with coordinated care approaches, where such approaches are inclusive of frequent in-person contact, close interaction between primary care providers and case managers, and where services are culturally aware and responsive.[4]

Collaboration can take a number of different forms and, ideally, should be established at multiple levels and encompass both formal and informal partnerships between services and between individual workers.

A common example of a formal partnership is a Memorandum of Understanding. Informal partnerships can be fostered through a number of mechanisms including communities of practice and other inter-sectoral forums and shared training and professional development opportunities.

BARRIERS TO COLLABORATION

Even where there is recognition of the need for collaboration to support service users experiencing co-occurring gambling and substance use harms, the practical implementation of this may be hampered by structural barriers, service silos, incompatible clinical practices, restrictive contractual arrangements, competition for funding and resources, and hard-to-navigate processes.



Knowledge point: Where there is greater collaboration between services, a service user will experience better treatment outcomes.

Practice point: Collaboration should be established at multiple levels and encompass both formal and informal partnerships between services and between individual workers.

Theme 10: Addressing the needs of specific populations

Often service users face intersectional issues that can present additional challenges and may create barriers to accessing your service or remaining engaged in a program of treatment or harm reduction. Where a clinician is aware of these issues and able to make appropriate adjustments to service provision, better outcomes can be achieved.

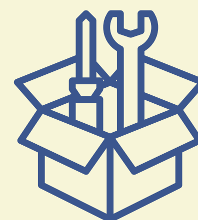
Socio-cultural, environmental, and commercial determinants can overlap with individual motivations, to increase the likelihood of some populations of people experiencing greater harms from gambling or substance use.

Environmental determinants *include those various external physical factors within a person's surroundings that can influence their gambling or substance use and the likelihood of experiencing associated harms. An example of an environmental determinant is the geographic concentration of liquor stores or gambling venues.*

Socio-cultural determinants *include those various external cultural or social factors in a person's life that may make them more or less susceptible to gambling or substance use harms. An example of a socio-cultural determinant is the gendered ideals of masculinity that may contribute to greater risk-taking in young men.*

Commercial determinants *include those factors that are driven by a commercial profit imperative and contribute to greater harms in people using usually legally available products such as alcohol, gambling or pharmaceuticals. An example of a commercial determinant is exposure to advertising.*

This practice guide provides you with a non-exhaustive list of service user cohorts that may require specific consideration. For services or additional resources to support the needs of specific populations go to www.atoda.org.au.



ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

There are a range of issues that service providers will want to consider when working with Aboriginal and Torres Strait Islander peoples, including the trauma inflicted by colonisation, the profound impact of the Stolen Generations and the ongoing effects of racism. These factors can amplify the harms of gambling and substance use and can make accessing services more difficult. The stigma and discrimination experienced by Aboriginal and Torres Strait Islander peoples can intersect with the stigma and discrimination around gambling and substance use in ways that can make co-occurrence of harms harder to disclose.

Many Aboriginal and Torres Strait Islander peoples will prefer to access Aboriginal Community Controlled Organisations (ACCOs), citing a lack of cultural safety in mainstream services.[1] However, all services should be striving to embed cultural safety and ensuring that, where treatment or harm reduction needs are best met in a mainstream service, there are no barriers to access and engagement by Aboriginal and Torres Strait Islander peoples.

CULTURALLY SAFE SERVICES WILL CONSULT WITH LOCAL ABORIGINAL LEADERS AND ORGANISATIONS TO LISTEN AND LEARN ABOUT HOW THEIR COMMUNITY MIGHT BEST BE SERVED.

PEOPLE WITH ADDITIONAL COMPLEX HEALTH NEEDS

PEOPLE WITH A DISABILITY ARE MORE LIKELY TO USE ALCOHOL AND OTHER DRUGS BUT LESS LIKELY TO ACCESS TREATMENT SERVICES THAN THE GENERAL POPULATION.

People who are experiencing co-occurring gambling and substance use harms are more likely to have additional complex health needs including: experiencing poorer mental health; living with a form of neurodiversity (ADHD, ASD, etc.); having a disability; or suffering a chronic illness.[2] These can create a barrier to accessing services and can impact treatment outcomes.

PEOPLE WHO IDENTIFY AS BEING GENDER OR SEXUALITY DIVERSE (LGBTQIA+)

Although the proportion of LGBTQIA+ people who drink alcohol is decreasing, in line with the general population, people who identify as being of diverse sexuality are 1.2 times as likely as heterosexual people to consume alcohol at what is considered 'risky levels' (1.3 times for trans and gender diverse people).[3] Use of other drugs is higher amongst people who identify as LGBTQIA+ for a host of reasons, ranging from modalities of pleasure to experiences of marginalisation.[4] The higher proportion of substance use and intersectional issues such as stigma and discrimination or weaker support networks, can place LGBTQIA+ people at risk of greater harm from substance use.

Where a person identifies as gender or sexuality diverse and experiences harm from gambling, they are more likely to also be experiencing substance use harms than their peers.[5] Studies have shown that people who identify as being gender or sexuality diverse may experience greater risk of harm from gambling, including a significantly higher underlying risk of suicidality.[6] Older sexual minority men have particularly elevated risk of gambling harm, as do gender diverse youth.[7]

Accessing appropriate services can be complicated by stigma and discrimination in relation to gender or sexual diversity or by the perception of services as not culturally safe, relevant or accessible.

YOUNG PEOPLE

Young people experience different risks than those over the age of 24, with a generally higher susceptibility to risky behaviour. The earlier a young person starts gambling or using substances, the more likely this becomes entrenched and the greater risks they experience. While support and treatment for young people is likely to look similar to that provided for older cohorts, there are some specific life course considerations including the role of the family in treatment and capacity to provide ongoing support; engagement with formal education or training; and shorter histories of gambling or substance use.[8]

ACT Spotlight: In the ACT, family members accounted for 55.1% of those who reported impacts from other people's gambling. Affected family and friends can access information and support by contacting Family Drug Support or Relationships Australia / ACT Gambling Support Service (AGSS).[9]

AGING POPULATIONS

Gambling and substance use can pose challenges in aging cohorts. The median age for people who use illicit drugs in Australia is increasing. Older age groups are more likely to have used illicit drugs in the past 12 months, and those who consume alcohol are more likely than other age groups to do so on a daily basis.[10] Long term substance use can cause significant harms to health which can further complicate the health-related impacts of aging. High levels of loneliness and social isolation in older Australians can increase risks of gambling and substance use harm.[11, 12]

PEOPLE EXPERIENCING DOMESTIC AND FAMILY VIOLENCE

There are complex intersections between gambling and substance use on the one hand and domestic and family violence (including other forms of intimate partner violence and sexual violence) on the other. While experiences of gambling and substance use harm do not directly or solely cause domestic and family violence, where drivers of violence in interpersonal relationships exist, the risk of violence is significantly exacerbated by gambling and substance use.[13]

Violence can be a consequence of the pharmacological effects of various substances; loss of inhibition and impulse control; increased threat perception and the emergence of withdrawal symptoms.[14]

GREATER ALCOHOL USE HAS BEEN SHOWN TO INCREASE THE LIKELIHOOD OF MEN USING PHYSICAL OR SEXUAL VIOLENCE IN THEIR INTIMATE RELATIONSHIPS.[15]

Where the person gambling is also managing the family's finances (or there are gendered expectations that they do so), the risk of economic abuse is high.[16, 17]

Both gambling and substance use can also be a form of escape from domestic and family violence and a response to the trauma of being in a relationship where there is violence or coercive control.

ACT Spotlight: In the ACT, 44.6% of female ATOD service users and 15.9% of male service users report having experienced domestic and family violence in the past 12 months.[18]

PEOPLE IN CONTACT WITH THE CUSTODIAL SYSTEM

People in contact with the custodial system tend to have high self-reported rates of alcohol and other drug use. Nationally, approximately 45% of detained adults say that their alcohol and other drug use contributed in some way to their current detention, while prevalence of substance use in prisons is persistently high. At the same time, it is estimated that close to a third of adults in the custodial system have experienced or are currently experiencing gambling harms. Rates of gambling harms in prisons are consistently and significantly higher than rates of gambling harms recorded among the general population.[19]

ACT Spotlight: ATOD and gambling support services work within the ACT custodial system to provide treatment and harm reduction / prevention services to detainees and others within the system.

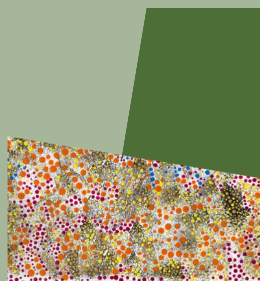
PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

A growing body of research suggests that while those from culturally and linguistically diverse backgrounds are less likely to take part in gambling activities overall, those who do gamble may be at greater risk of experiencing harms.[20]

ACT Spotlight: In the ACT, people who speak a language other than English as their main language at home, and people born outside of Australia gamble less but are over-represented in gambling losses across the most harmful products.[9]

Data from the National Drug Strategy Household Survey (NDSHS) indicates that people who speak a language other than English at home are less likely to use alcohol and other drugs.[21] However, the harms from alcohol and other drugs may be exacerbated for some people from culturally and linguistically diverse backgrounds due to higher exposure to stressors such as isolation, unemployment or under employment, language barriers, loss of cultural practices or connections, histories of trauma, lack of awareness of support availability and lack of familiarity with the principles and policies of ATOD services (such as non-disclosure).

ACT Spotlight: Just 8.4% of service users accessing ATOD services in the ACT were born overseas and 9.0% speak a language other than English at home.[18] There are complex reasons why people from CALD communities may be less likely to seek support for their alcohol or other drugs use.



Knowledge point: The diverse backgrounds and experiences that service users come with may present an additional barrier to treatment access and engagement.

Practice point: Familiarise yourself with resources and services that can support service users of diverse backgrounds and experiences.

References

1

1. Australian Government. Alcohol, Tobacco & Other Drugs in Australia. Canberra: Australian Institute of Health and Welfare (AIHW), 2025. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about.
2. NSW Government. Current Landscape of Substance Use and Associated Impacts. Sydney: NSW Ministry of Health, 2024. https://www.health.nsw.gov.au/aod/summit/Publications/substance-use.pdf.
3. Equity Economics. Gambling in Australia's Cost-of-Living Crisis. Sydney, 2025. https://www.equityeconomics.com.au/report-archive/gambling-in-australias-cost-of-living-crisis-the-black-hole-in-household-budgets.
4. Productivity Commission. Gambling: Inquiry Report. Canberra, 2010. https://www.pc.gov.au/inquiries/completed/gambling-2010/report.
5. Rodriguez-Monguio R, Errea M and Volberg R. Comorbid pathological gambling, mental health, and substance use disorders: Health-care services provision by clinician specialty. *Journal of Behavioral Addiction* 2017; 6: 406-415. 20170831. DOI: 10.1556/2006.6.2017.054.
6. ACT Government. Strategy for gambling harm prevention in the ACT: A public health approach 2019 – 2024. Canberra: Gambling & Racing Commission, 2019. https://www.gamblingandracing.act.gov.au/__data/assets/pdf_file/0009/1436580/Strategy-for-gambling-harm-prevention.pdf.
7. Langham E, Thorne H, Browne M, et al. Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health* 2016; 16: 80. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2747-0.
8. Crépault J-F, Russell C, Watson TM, et al. What is a public health approach to substance use? A qualitative systematic review and thematic synthesis. *International Journal of Drug Policy* 2023; 112: 103958. https://doi.org/10.1016/j.drugpo.2023.103958.
9. Wolfe S, Kay-Lambkin F, Bowman J, et al. To enforce or engage: The relationship between coercion, treatment motivation and therapeutic alliance within community-based drug and alcohol clients. *Addictive Behaviors* 2013; 38: 2187-2195. https://doi.org/10.1016/j.addbeh.2013.01.017.
10. Coelho SG, Tabri N, Kerman N, et al. The Perceived Causes of Problems with Substance Use, Gambling, and Other Behavioural Addictions from the Perspective of People with Lived Experience: a Mixed-Methods Investigation. *International Journal of Mental Health and Addiction* 2024; 22: 722-745. DOI: 10.1007/s11469-022-00900-3.
11. Manning V, Dowling NA, Lee S, et al. Problem gambling and substance use in patients attending community mental health services. *Journal of Behavioral Addictions* 2017; 6: 678-688. https://akjournals.com/view/journals/2006/6/4/article-p678.xml
12. Fong TW. The vulnerable faces of pathological gambling. *Psychiatry* (Edgmont) 2005; 2: 34-42.
13. Thomas SL, Crawford G, Daube M, et al. Time for policies on gambling to benefit health - not the gambling industry. *Health Promotion Journal of Australia* 2023; 34: 267-271. https://doi.org/10.1002/hpja.721.
14. Barnes GM, Welte JW, Tidwell MC, et al. Gambling and Substance Use: Co-occurrence among Adults in a Recent General Population Study in the United States. *International Gambling Studies* 2015; 15: 55-71. DOI: 10.1080/14459795.2014.990396.
15. Rossow I and Bye EK. The alcohol harm paradox: is it valid for self-reported alcohol harms and does hazardous drinking pattern matter? *BMC Public Health* 2024; 24: 3053. DOI: 10.1186/s12889-024-20530-9.
16. van der Maas M. Problem gambling, anxiety and poverty: an examination of the relationship between poor mental health and gambling problems across socio-economic status. *International Gambling Studies* 2016; 16: 281-295. DOI: 10.1080/14459795.2016.1172651.
17. Morrison C, Gruenewald PJ and Ponicki WR. Socioeconomic determinants of exposure to alcohol outlets. *Journal of Studies on Alcohol and Drugs* 2015; 76: 439-446. DOI: 10.15288/jsad.2015.76.439.
18. Welte JW, Wieczorek WF, Barnes GM, et al. The relationship of ecological and geographic factors to gambling behavior and pathology. *Journal of Gambling Studies* 2004; 20: 405-423. DOI: 10.1007/s10899-004-4582-y.
19. Hayden L, Newton G, Carah N, et al. How Alcohol and Gambling Companies Target People Most at Risk with Marketing for Addictive Products on Facebook. Canberra: Foundation for Alcohol Research and Education, 2024. https://fare.org.au/wp-content/uploads/FARE_AlcoholandGambling_Report.pdf.
20. Towers EB, Williams IL, Qillawala EI, et al. Sex/Gender Differences in the Time-Course for the Development of Substance Use Disorder: A Focus on the Telescoping Effect. *Pharmacological Reviews* 2023; 75: 217-249. https://doi.org/10.1124/pharmrev.121.000361.
21. Weinstock J, Blanco, C. & Petry, N. M. . Health Correlates of Pathological Gambling in a Methadone Maintenance Clinic. *Experimental and Clinical Psychopharmacology* 2006; 14: 87-93.

22. Rockloff M, Russell AMT, Browne M, et al. 2024 ACT Gambling Survey. Experimental Gambling Research Laboratory. Bundaberg: Central Queensland University, 2025. https://www.gamblingandracing.act.gov.au/__data/assets/pdf_file/0012/2861796/2024-ACT-Gambling-Survey.pdf.
23. Bonomo Y, Norman A, Biondo S, et al. The Australian drug harms ranking study. *Journal of Psychopharmacology* 2019; 33: 759-768. 20190513. DOI: 10.1177/0269881119841569.

2

1. Langham E, Thorne H, Browne M, et al. Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health* 2016; 16: 80. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2747-0.
2. Grant JE, Levine L, Kim D, et al. Impulse Control Disorders in Adult Psychiatric Inpatients. *American Journal of Psychiatry* 2005; 162: 2184-2188. DOI: 10.1176/appi.ajp.162.11.2184.
3. Grant JE and Chamberlain SR. Gambling and substance use: Comorbidity and treatment implications. *Progress in Neuropsychopharmacology & Biological Psychiatry* 2020; 99: 109852. DOI: 10.1016/j.pnpbp.2019.109852.
4. Wieczorek Ł and Dąbrowska K. Difficulties in treatment of people with comorbid gambling and substance use disorders. *Journal of Substance Use* 2020; 25: 350-356. DOI: 10.1080/14659891.2019.1704078.
5. Holdsworth L and Tiyce M. Untangling the Complex Needs of People Experiencing Gambling Problems and Homelessness. *International Journal of Mental Health and Addiction* 2013; 11: 186-198. DOI: 10.1007/s11469-012-9409-y.
6. Manning V, Dowling NA, Lee S, et al. Problem gambling and substance use in patients attending community mental health services. *Journal of Behavioral Addictions* 2017; 6: 678-688. https://akjournals.com/view/journals/2006/6/4/article-p678.xml.
7. Cowlishaw S, Merkouris S, Chapman A, et al. Pathological and problem gambling in substance use treatment: a systematic review and meta-analysis. *Journal of Substance Abuse Treatment* 2014; 46: 98-105. 20130924. DOI: 10.1016/j.jsat.2013.08.019.
8. Hayden L, Newton G, Carah N, et al. How Alcohol and Gambling Companies Target People Most at Risk with Marketing for Addictive Products on Facebook. Canberra: Foundation for Alcohol Research and Education, 2024. https://fare.org.au/wp-content/uploads/FARE_AlcoholandGambling_Report.pdf.
9. French MT, Maclean JC and Ettner SL. Drinkers and bettors: Investigating the complementarity of alcohol consumption and problem gambling. *Drug and Alcohol Dependence* 2008; 96: 155-164.
10. Cowlishaw S, Hakes JK and Dowling NA. Gambling problems in treatment for affective disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Journal of Affective Disorders 2016; 202: 110-114. 20160526. DOI: 10.1016/j.jad.2016.05.023.
11. Rockloff M, Russell AMT, Browne M, et al. 2024 ACT Gambling Survey. Experimental Gambling Research Laboratory. Bundaberg: Central Queensland University, 2025. https://www.gamblingandracing.act.gov.au/__data/assets/pdf_file/0012/2861796/2024-ACT-Gambling-Survey.pdf.
12. Novin MH, Razaghi E, Farzadfar F, et al. Measuring the Harms Caused by Illicit Drugs. A New Methodology for Estimating Drug Harm Index. *Substance Use and Misuse* 2024; 59: 1870-1878. 20240728. DOI: 10.1080/10826084.2024.2383973.
13. Kairouz S, Paradis C, Nadeau L. Are online gamblers more at risk than offline gamblers? *Cyberpsychology, Behavior, and Social Networking* 2012;15 (3):175-80. doi: 10.1089/cyber.2011.0260.
14. ATODA. Service Users' Survey of Outcomes, Satisfaction and Experience 2023: A survey of people accessing alcohol, tobacco and other drug services in the ACT. 2025. Canberra: Alcohol, Tobacco and Other Drug Association ACT. https://www.atoda.org.au/wp-content/uploads/2025/03/SUSOSE-Report-2023-compressed.pdf.
15. Dowling NA, Cowlishaw S, Jackson AC, et al. Prevalence of psychiatric co-morbidity in treatment-seeking problem gamblers: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry* 2015; 49: 519-539. DOI: 10.1177/0004867415575774.
16. Elman I, Borodovsky J, Howard M, et al. Co-occurring Disordered Gambling Among Treatment-Seekers at a Community Outpatient Addiction Clinic. *Journal of Addiction Medicine* 2016; 10: 339-343. DOI: 10.1097/adm.0000000000000242.
17. Weinstock J, Blanco, C. & Petry, N. M. . Health Correlates of Pathological Gambling in a Methadone Maintenance Clinic. *Experimental and Clinical Psychopharmacology* 2006; 14: 87-93.

References

3

1. Link BG and Phelan JC. Conceptualizing Stigma. *Annual Review of Sociolog*y 2001; 27: 363-385. https://www.annualreviews.org/content/journals/10.1146/annurev.soc.27.1.363.
2. Ezell JM, Walters S, Friedman SR, et al. Stigmatize the use, not the user? Attitudes on opioid use, drug injection, treatment, and overdose prevention in rural communities. *Social Science & Medicine* 2021; 268: 113470. https://doi.org/10.1016/j.socscimed.2020.113470.
3. Phillips LA and and Shaw A. Substance use more stigmatized than smoking and obesity. *Journal of Substance Use* 2013; 18: 247-253. DOI: 10.3109/14659891.2012.661516.
4. Brown KL and Russell AMT. What Can be Done to Reduce the Public Stigma of Gambling Disorder? Lessons from Other Stigmatised Conditions. *Journal of Gambling Studies* 2020; 36: 23-38. DOI: 10.1007/s10899-019-09890-9.
5. O'Shay-Wallace S. "We Weren't Raised that Way": Using Stigma Management Communication Theory to Understand How Families Manage the Stigma of Substance Abuse. *Health Communication* 2020; 35: 465-474. DOI: 10.1080/10410236.2019.1567443.
6. ATODA. ACT Alcohol, Tobacco and Other Drugs Sector Workforce Profile 2024-25. Forthcoming.
7. Lancaster K, Seear K and Ritter A. Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use. Brisbane: Queensland Mental Health Commission, 2017. https://www.drugsandalcohol.ie/29689/
8. ACT Human Rights Commission. Discrimination. Canberra, 2024. https://www.hrc.act.gov.au/discrimination
9. Bowles D, Yar E and van der Sterren A. Prioritising people who use drugs in health policy: An Australian Capital Territory case study. *Drug and Alcohol Review*; n/a. https://doi.org/10.1111/dar.14001.
10. Wyllie C, Killick E and Kallman A. A review of gambling harm training materials for healthcare professionals. Westcliff-On-Sea: Tackling Gambling Stigma, 2023. https://tacklinggamblingstigma.com/wp-content/uploads/2023/04/A-Review-of-Gambling-Healthcare-Training-Tackling-Gambling-Stigma.pdf
11. Corrigan PW. Defining the stereotypes of health conditions: Methodological and practical considerations. *Stigma and Health* 2018; 3: 131.

4

1. Werder K, Curtis A, Reynolds S, et al. Addressing Bias and Stigma in the Language We Use With Persons With Opioid Use Disorder: A Narrative Review. *Journal of the American Psychiatric Nurses Association* 2022; 28: 9-22. DOI: 10.1177/10783903211050121.
2. Zwick J, Appleseth H and Arndt S. Stigma: how it affects the substance use disorder patient. *Substance Abuse Treatment, Prevention, and Policy* 2020; 15: 50. DOI: 10.1186/s13011-020-00288-0.
3. Paton E, Jones EP, Peprah J, et al. Our words matter: finding consensus on evolving and personal language around suicide, mental health concerns and alcohol and other drug use. *Media International Australia* 2024; 193: 80-95. DOI: 10.1177/1329878x241278005.
4. Stone BM. Removing Stigmatizing Language in Self-Reports: Effects on Psychometric Properties and Respondent Beliefs. *International Journal of Mental Health and Addiction* 2024. DOI: 10.1007/s11469-024-01298-w.
5. Reichert RA, da Silva EA, De Micheli D, et al. Substance Use Disorders: History, Theoretical Models and Diagnostic Criteria (ICD-11 e DSM-5-TR). In Reichert RA, Andrade ALM and De Micheli D (eds). *Neuropsychology and Substance Use Disorders: Assessment and Treatment*, pp.3-49. Cham: Springer, 2025.
6. Orford J, Wardle H, Griffiths M, et al. PGSI and DSM-IV in the 2007 British Gambling Prevalence Survey: Reliability, item response, factor structure and inter-scale agreement. *International Gambling Studies* 2010; 10: 31-44.
7. Volkow ND, Gordon JA and Koob GF. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology* 2021; 46: 2230-2232.
8. Holt M and and Treloar C. Understanding comorbidity? Australian service-user and provider perspectives on drug treatment and mental-health literacy. *Drugs: Education, Prevention and Policy* 2008; 15: 518-531. DOI: 10.1080/09687630701690674.

5

1. Dore G, Mills K, Murray R, et al. Post-traumatic stress disorder, depression and suicidality in inpatients with substance use disorders. *Drug and Alcohol Review* 2012; 31: 294-302.
2. Scherrer JF, Xian H, Kapp JMK, et al. Association between exposure to childhood and lifetime traumatic events and lifetime pathological gambling in a twin cohort. *The Journal of Nervous and Mental Disease* 2007; 195: 72-78.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th, text revision ed. 2022.
4. Moore LH and Grubbs JB. Gambling Disorder and comorbid PTSD: A systematic review of empirical research. *Addictive Behaviors* 2021; 114: 106713. https://doi.org/10.1016/j.addbeh.2020.106713.
5. Killeen TK, Back SE and Brady KT. Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. *Drug and Alcohol Review* 2015; 34: 234-241.
6. Stefanovics EA, Potenza MN, Tsai J, et al. Gambling and Substance Use Disorders in U.S. Military Veterans: Prevalence, Clinical Characteristics, and Suicide Risk. *Journal of Gambling Studies* 2024; 40: 2119-2139. DOI: 10.1007/s10899-024-10359-7.
7. Manning V, Koh PK, Yang Y, et al. Suicidal ideation and lifetime attempts in substance and gambling disorders. *Psychiatry Research* 2015; 225: 706-709. https://www.sciencedirect.com/science/article/abs/pii/S0165178114008671?via%3Dihub
8. Håkansson A and Karlsson A. Suicide attempt in patients with gambling disorder—associations with comorbidity including substance use disorders. *Frontiers in Psychiatry* 2020; 11: 593533.

6

1. Prael G, Peacock A, Rawlings L, et al. Strategies to reduce harms among older adults. Sydney: National Drug and Alcohol Research Centre, UNSW, 2024. https://www.unsw.edu.au/research/ndarc/resources/strategies-to-reduce-aod-related-harms-among-older-adults
2. Campbell G, Pocuca N, Newland G, et al. Clinical profiles of people enrolling in alcohol and other drug treatment in Australia: Do youth differ from young adults and adults? *Drug and Alcohol Review* 2024; 43: 2010-2020.
3. Yarbakhsh E, van der Sterren A and Bowles D. Screening and Treatment for Co-occurring Gambling and Substance Use: A Scoping Review. *Journal of Gambling Studies* 2023 20230726. DOI: 10.1007/s10899-023-10240-z.
4. ATODA. Service Users' Survey of Outcomes, Satisfaction and Experience 2023: A survey of people accessing alcohol, tobacco and other drug services in the ACT. Canberra: Alcohol, Tobacco and Other Drug Association ACT, 2025. https://www.atoda.org.au/wp-content/uploads/2025/03/SUSOSE-Report-2023-compressed.pdf

7

1. Rowe C, White M, Long C, et al. Slots and Shots: A Gambling Resource for AOD Workers. Melbourne: Odyssey House, 2015. https://nceta.flinders.edu.au/application/files/6515/0646/7735/EN603.pdf.
2. Goodwin BC, Browne M, Rockloff M, et al. A typical problem gambler affects six others. *International Gambling Studies* 2017; 17: 276-289. DOI: 10.1080/14459795.2017.1331252.
3. Rodgers C. Brief interventions for alcohol and other drug use. *Australian Prescriber* 2018; 41: 117-121.
4. Alcohol and Drug Foundation. Withdrawal, 2025, accessed 6 June 2025. https://adf.org.au/reducing-risk/withdrawal/
5. Potenza MN. Review. The neurobiology of pathological gambling and drug addiction: an overview and new findings. *Philosophical Transactions of the Royal Society B: Biological Sciences* 2008; 363: 3181-3189. DOI: 10.1098/rstb.2008.0100.
6. Blaszczynski A, Walker M, Sharpe, et al. Withdrawal and Tolerance Phenomenon in Problem Gambling. *International Gambling Studies* 2008; 8 (2): 179–92. doi:10.1080/14459790802140007.
7. Moreira D, Dias P, Azeredo A, et al. A Systematic Review on Intervention Treatment in Pathological Gambling. *International Journal of Environmental Research and Public Health* 2024; 21: 346.

References

7

8. Ahluwalia T, Xu X, Nelson A, et al. A Narrative Review of Old and Emerging Treatment Modalities for Substance Use Disorders. *Cureus* 2024; 16.
9. Crowley P. Long-term drug treatment of patients with alcohol dependence. *Australian Prescriber* 2015;38:41-3. https://doi.org/10.18773/austprescr.2015.015
10. Australian Psychological Society. Psychological care for people experiencing gambling harm, 2025. https://psychology.org.au/getmedia/ee38cd20-60d4-47ba-bf11-1a58846cfaff/0425-psychological-care-for-people-experiencing-gambling-harm-final.pdf
11. Marel C SE, Fisher A, Gournay K, Deady M, Baker A, Kay-Lambkin F, Teesson M, Baillie A, Mills KL. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Sydney: Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney, 2022. https://comorbidityguidelines.org.au/
12. Foley C. Collaborating with clinicians and consumers to improve the uptake of integrated care in a residential mental health rehabilitation unit: A co-design approach. NDARC. Sydney: UNSW, 2018. https://www.unsw.edu.au/research/ndarc/news-events/blogs/2018/12/collaborating-with-clinicians-and-consumers-to-improve-the-uptak
13. ATODA. Service Users' Survey of Outcomes, Satisfaction and Experience 2023: A survey of people accessing alcohol, tobacco and other drug services in the ACT. Canberra: Alcohol, Tobacco and Other Drug Association ACT, 2025. https://www.atoda.org.au/wp-content/uploads/2025/03/SUSOSE-Report-2023-compressed.pdf.

8

1. Lubman D, Manning V, Best D, et al. A study of patient pathways in alcohol and other drug treatment. Fitzroy: Turning Point, 2014. https://www.health.gov.au/sites/default/files/study-of-patient-pathways-in-alcohol-and-other-drug-treatment.pdf
2. Marel C SE, Fisher A, Gournay K, Deady M, Baker A, Kay-Lambkin F, Teesson M, Baillie A, Mills KL. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Sydney: Matilda Centre for Research in Mental Health and Substance Use, The University of Sydney, 2022. https://comorbidityguidelines.org.au/
3. Fisher A, Rochesson SED, Mills K, et al. Guiding Principles for Managing Co-occurring Alcohol/Other Drug and Mental Health Conditions: a Scoping Review. *International Journal of Mental Health and Addiction* 2024; 22: 1251-1298. DOI: 10.1007/s11469-022-00926-7.

9

1. Yarbakhsh E, van der Sterren A and Bowles D. Screening and Treatment for Co-occurring Gambling and Substance Use: A Scoping Review. *Journal of Gambling Studies* 2023. 20230726. DOI: 10.1007/s10899-023-10240-z.
2. Wise M, Harris E, Finlay P, et al. Working Together: Collaboration for Health. Sydney: UNSW, NSW Health: Sydney Local Health District, 2022. https://www.unsw.edu.au/research/cphce/research/projects/working-together-collaboration-for-health-a-practical-guide
3. Flatau P, Conroy E, Thielking M, et al. How integrated are homelessness, mental health and drug and alcohol services in Australia? Melbourne: AHURI, 2013. https://www.ahuri.edu.au/research/final-reports/206
4. Guerrero EG, Andrews C, Harris L, et al. Improving Coordination of Addiction Health Services Organizations with Mental Health and Public Health Services. *Journal of Substance Abuse Treatment* 2016; 60: 45-53. 20150814. DOI: 10.1016/j.jsat.2015.08.002.

References

10

1. Australian Institute of Family Studies. Resources to support culturally safe service delivery to Aboriginal and Torres Strait Islander peoples. AIFS, 2024. https://aifs.gov.au/resources/resource-sheets/resources-support-culturally-safe-service-delivery-aboriginal-and-torres
2. Stefanovics EA, Potenza MN, Tsai J, et al. Gambling and Substance Use Disorders in U.S. Military Veterans: Prevalence, Clinical Characteristics, and Suicide Risk. *Journal of Gambling Studies* 2024; 40: 2119-2139. DOI: 10.1007/s10899-024-10359-7.
3. Australian Government. National Drug Strategy Household Survey 2022–2023: LGBT people's use of alcohol, tobacco, e-cigarettes and other drugs. Australian Institute of Health and Welfare, 2024. https://www.aihw.gov.au/reports/lgbtiq-communities/lgbt-people-alcohol-drugs
4. Pienaar K, Murphy DA, Race K, et al. Problematising LGBTIQ drug use, governing sexuality and gender: A critical analysis of LGBTIQ health policy in Australia. *International Journal of Drug Policy* 2018; 55: 187-194. DOI: https://doi.org/10.1016/j.drugpo.2018.01.008.
5. Stanmyre JF, Nower L and Malkin ML. Problem Gambling and Sexual Minority Individuals: Evaluating Influence of Age and Comorbid Mental Health and Substance Use Problems. *Journal of Gambling Studies* 2024; 40: 957-969. DOI: 10.1007/s10899-023-10264-5.
6. Grant JE and Chamberlain SR. Does gambling differ in people with a minority sexual orientation? *Annals of Clinical Psychiatry* 2023; 35: 23-30. DOI: 10.12788/acp.0102.
7. Bailey L, Zeeman L, Sawyer A, et al. LGBTQ+ people and gambling harms: a scoping review. Brighton: Public Health and Health Conditions Research Excellence Group, Centre for Transforming Sexuality and Gender, University of Brighton, 2024. https://research.brighton.ac.uk/en/publications/lgbtq-people-and-gambling-harms-a-scoping-review
8. Campbell G, Pocuca N, Newland G, et al. Clinical profiles of people enrolling in alcohol and other drug treatment in Australia: Do youth differ from young adults and adults? *Drug and Alcohol Review* 2024; 43: 2010-2020.
9. Rockloff M, Russell AMT, Browne M, et al. 2024 ACT Gambling Survey. Experimental Gambling Research Laboratory. Bundaberg: Central Queensland University, 2025. https://www.gamblingandracing.act.gov.au/__data/assets/pdf_file/0012/2861796/2024-ACT-Gambling-Survey.pdf..
10. ACT Government. ACT Drug Strategy Action Plan 2022–2026. 2022. Canberra: ACT Health Directorate. https://www.act.gov.au/__data/assets/pdf_file/0003/2197200/Drug-Strategy-Action-Plan-2022-26.pdf
11. Johnson RH, Pitt H, Randle M, et al. A scoping review of the individual, socio-cultural, environmental and commercial determinants of gambling for older adults: implications for public health research and harm prevention. *BMC Public Health* 2023; 23: 362. DOI: 10.1186/s12889-022-14930-y.
12. Morrison C, Gruenewald PJ and Ponicki WR. Socioeconomic determinants of exposure to alcohol outlets. *Journal of Studies on Alcohol and Drugs* 2015; 76: 439-446. DOI: 10.15288/jsad.2015.76.439.
13. Hing N, O'Mullan C, Nuske E, et al. The relationship between gambling and intimate partner violence against women. Sydney: ANROWS, 2020. https://www.anrows.org.au/publication/the-relationship-between-gambling-and-intimate-partner-violence-against-women/
14. ATODA. ACT Alcohol and Other Drug Safer Families Program 2017 – 2021: Design, Model, Implementation Plan and Evaluation Framework. Canberra: ATODA, 2017. https://www.atoda.org.au/wp-content/uploads/2023/07/ACT-AOD-Safer-Families-Program-2017-2021-FINAL-REPORT.pdf
15. Shorey RC, Stuart GL, McNulty JK, et al. Acute alcohol use temporally increases the odds of male perpetrated dating violence: a 90-day diary analysis. *Addictive Behaviors* 2014; 39: 365-368. 20131021. DOI: 10.1016/j.addbeh.2013.10.025.
16. Centre for Innovative Justice. Compulsion, convergence or crime? Criminal justice system contact as a form of gambling harm. Melbourne: RMIT University, 2017. https://apo.org.au/sites/default/files/resource-files/2017-10/apo-nid116126.pdf
17. Lind K, Kääriäinen J and Kuoppamäki S-M. From problem gambling to crime? Findings from the Finnish National Police Information System. *Journal of Gambling Issues* 2015; 30: 98-123.
18. ATODA. Service Users' Survey of Outcomes, Satisfaction and Experience 2023: A survey of people accessing alcohol, tobacco and other drug services in the ACT. Canberra: Alcohol, Tobacco and Other Drug Association ACT, 2025. https://www.atoda.org.au/wp-content/uploads/2025/03/SUSOSE-Report-2023-compressed.pdf.
19. Banks J, Waters J, Andersson C, et al. Prevalence of Gambling Disorder Among Prisoners: A Systematic Review. International *Journal of Offender Therapy and Comparative Criminology* 2020; 64: 1199-1216. DOI: 10.1177/0306624x19862430.

References

20. Dickins M and Thomas A. Gambling in Culturally and Linguistically Diverse Communities in Australia. Melbourne: Australian Gambling Research Centre, Australian Institute of Family Studies, 2016. https://aifs.gov.au/research/research-snapshots/gambling-culturally-and-linguistically-diverse-communities-australia
21. Australian Government. Alcohol, tobacco & other drugs in Australia. Australian Institute of Health and Welfare (AIHW), 2025. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about

KEY TERMS

1. Rockloff M, Russell AMT, Browne M, et al. 2024 ACT Gambling Survey. 2024. Experimental Gambling Research Laboratory, CQ University.
2. Australian Government. Alcohol, tobacco & other drugs in Australia. 2025. Australian Institute of Health and Welfare (AIHW). https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about

Full report, themes by topic and additional resources available at **www.atoda.org.au**

www.atoda.org.au
PO BOX 7009 KALEEN ACT 2617
info@atoda.org.au