SUBMISSION TO THE JOINT SELECT COMMITTEE ON GAMBLING REFORM.

Written - March 2012.

Thank you for the invitation to provide a submission. My background in the field of gambling is that I am a psychiatrist who for thirty five years or more has worked with problem gamblers as part of my clinical load and still continue to do so. I have published as sole or joint author in peer reviewed journals as well as lay publications. I have also conducted workshops, given lectures and been involved with many committees in this field. Currently I am an Honorary Clinical Senior Lecturer with the University of Sydney.

My experience with gambling has also embraced the “other side”. I have raced horses, been a director and racing manager of a racing and breeding company, written articles on sensible approaches to gambling (I hope!) and remain a small but regular punter. I will provide my thoughts by working my way through your terms of reference.

The prevention and treatment of problem gambling, with particular reference to

(a) measures to prevent problem gambling:-

(A) Poker Machines.

I am of the view that if it is decided that the community wishes, through its political representatives , to bring measures into place to regulate this form of gambling that the “commitment” to pre-commitment should be abandoned.

My reasons for this are as follows:-

Over two years ago after attending a conference of the National Association for Gambling Studies at which some enthusiasm for pre- commitment had been expressed I too was of the view that it seemed a good idea. The Productivity Commission had recommended a trial but when I looked at the reasons why this was so it appeared to be solely based on opinions expressed from problem gamblers in one sample who felt this would help.

I started asking my patients what they thought. To my surprise once I explained what pre-commitment was, as most did not know, overwhelmingly they felt it would not help. Voluntary options would not be taken up and mandatory insistence would be met by resistance. They would go to other venues so any system would have to be able to “cross check” and require a central data base with personal information stored (for all players) and would be costly to install. My patients would also set high limits thus defeating the purpose or swap or buy cards off others.

It is in the nature of the problem to manipulate, hide and deny what amounts are gambled. Pre-commitment does not appear to be able to deal with this very basic issue for the seriously troubled who are the target of its intent.

Fortunately, I gave them other options. The first was to lower the maximum prize to, say, $500. Most felt this made machine playing much less attractive for large

amounts of play. Some strong "evidence" for this approach helping comes from England where the maximum prize is around fifty pounds ($A75 approximately). Problems with this form of gambling (called fruit machines there) do not feature in the top five forms of gambling that cause problems in recent surveys.

The other option I gave was the lowering of the amount to be "invested" per spin to $1. Again this reduced the attraction. Some research exists to support this. While a few said they may still have problems even with $1 maximum the combination of these two approaches would seem more likely to reduce problems with poker machines than would pre-commitment. I am concerned that in the current discussions the option of lowering the maximum prize is not being considered fully and it may well be the best of all three being canvased. Also while a few have said they may turn to other forms of gambling most felt interest in gambling would not have been created or maintained if these two measures were in place.

Some evidence against pre-commitment now exists. Voluntary pre-commitment has shown in trials to have poor uptake. Where forms of pre-commitment have been tried the measures suggested by my gamblers have been utilised to get around it. Even Norway, cited by supporters of this approach, has seen a rise in the prevalence not a fall in problem gambling after such an approach was adopted. There are complex factors at play here involving shifts in forms of gambling within populations but the main conclusion is that pre-commitment appears not to lower rates of problem gambling.

In short I suggest evidence is against the value of the pre-commitment approach and if there is a desire to regulate machines then the $1 per spin AND the lowered prizes are the better options.

B) HORSE RACINGAND SPORTS BETTING.

I have been involved in this form of gambling as noted before. A bookie I bet with for a number of years on his retirement noted that "I had been no early use to him whatsoever" which I regard as the highest testimonial a bookmaker can give! Nevertheless when horse racing was the predominate form of gambling problems I was concerned about how to help those with problems over this form of betting. What is often forgotten in the discussion these days is that thirty years ago it was this form of gambling that gave around 70% of the problems with the machines then around 20%. When the machines became available in the hotels the percentage shifted in around one year to the current 80% machines but the racing industry suffered a loss of income with this. In other words, as some in the industry said to me at the time; –"The mug money (read problem gamblers) moved from racing to machines" with no evidence that the prevalence of problem gambling in the community changed. To be fair few surveys were carried out then but it is cautionary in that it may be that with much effort the prevalence can be lowered to a certain point but as one door closes another opens. By that I mean there will always be a small percentage with a gambling problem and we should always work to keep it as low as possible but the gambler will always find a form of gambling that attracts them.

Currently, and overseas as well as here the move is to internet and sports betting and so if there are regulations onto machine gambling some thought should be given to the newer forms that are taking hold in the younger community.

Excessive advertising, targeting those who may be chasing losses, by frequent advertising of odds, mobile phone use and very generous incentives to get started are all approaching the vulnerable and especially the young. Mostly these are males aged 18-24 who community surveys show are the biggest group with problems.

While most will grow out of their problems (natural recovery) the damage done to these people and those around them may have lasting effects.

There needs to be restrictions on the amount of advertising, inducements and especially credit limits that operators can provide most essentially without adequate proof the individual can pay for the limits requested. I would support the Productivity Commission's suggestion of legalisation of online gambling but with regulations in place to provide such checks and balances. Advertising should have limits per hour or event. No comment by the commentators on gambling odds should occur as this practice would seem to "normalise" the idea that gambling is part of sport watching while it should be very separate and an optional choice to watching a sporting activity. The same comment could apply to betting markets run on matters such as what colour tie a politician could be wearing to a meeting over a party spill – indeed should there be betting on the outcome of such events at all? Industry will say these are only fun markets but they help to create a "gambling on anything" atmosphere and if the community is concerned about gambling levels then some though is needed as to how many events of life are fair games for a gamble!

C) Casino Gambling.

Generally, excluding machines whose issues are described above casino games produce smaller numbers of problem gamblers at this time. Blackjack, roulette and poker have some who gamble to excess but as long as the awareness of problem gambling is maintained and irresponsible inducements are prohibited this setting lower on the list of concerns based on numbers presenting for assistance.

However, it is not immune from concerns. The targeting of "heavy gamblers", "whales" and "regular customers" should include tight surveillance of the ability to pay. A history of past problems should exclude further approaches by gambling agencies and when individuals with a history of problems wish to open or re-open accounts then caution by the casino rather than encouragement should be expected. The difficulty is how to fairly regulate for this, but while responsibility should rest with the individual some should also be shouldered by industry.

(1) use and display of responsible gambling messages.

This has been mentioned to some degree already – fewer adds, not placed at times vulnerable individuals are chasing losses, not having odds promoted by commentators.

But also advertisements for the relevant helpline number in each State or Territory need to be clearly displayed and held on screen for a good length of time. Likewise radio help messages should be clearly spoken and include the helpline number quite frequently if not with every add. There is a tendency on TV to have small print and a quick display.

In my time of working with problem gamblers we as a community have moved from a position of little or no concern or help offered to now having both clearly evident. This is tremendous progress. One factor leading to people seeking help (be they the affected individual or a family member) has been the noting of a number to call and so this useful means of getting the message across must be maintained and encouraged.

Even though we know many with problems do not seek help and most will still change their gambling behaviour for the better over time without seeking help ("natural recovery" or "self-change") display of messages warning of the possibility of problems developing and where help is available do continue to create and promote a community atmosphere that can encourage contemplation and change.

(ii) use, access and effectiveness of other information on risky or problem gambling including campaigns.

I am not sure what is meant by "other information". Clear communication that problems can occur and where to go for help should be freely required as noted.

Campaigns speed up the recognition process. One a week would be nonsensical overkill for example and the impact deadened but once a year as a special week, government and industry supported synchronised to a national flow in the same week ideally would produce a peak of awareness and calls to helpline numbers –as data already supports. Occasional "boosters" four or six monthly by way of newspaper ads or other public media would augment this week.

If "other information" is meant to include education in schools such as that in place for, say, alcohol and drugs, then while I share some of the Productivity Commission's concerns as to effectiveness or unforseen consequences I do feel on balance such education within the maths and life skills curriculum is worthwhile.

(iii) ease of access to assistance for problem gambling.

Crucial. The moment of decision to seek help can be fleeting. Poor reception of calls and appointment time delays are often described to me by people saying "If only it had worked a year ago".

While acknowledging that about 30% who make a first appointment do not turn up the converse is that 70% do. Why 30% fail to make that first contact can vary but sometimes it is delay ("We can see you on Tuesday week at 11a.m."!) as well as fear or change of heart.

We need to ensure that waiting lists are kept as short as practical. That is a

combination of enough counsellors at appropriate times (early morning, late afternoon and weekends for workers as an example) and at appropriate easily reached rooms if face to face counselling is requested. Ensuring that potential help seekers are aware of other options such as 'phone counselling, internet helplines and Gambler's Anonymous are all relevant contact point that must be promoted by the advertisements, the campaigns and the industry settings

Some parts of the community have higher levels of problem gambling, those being suburbs more socio-economically disadvantaged, and services need to be matched to such reality.

Treatment styles also need consideration. While it is not something for gambling reform report to specifically target State and Territory agencies funding services must look to their budgets to ensure value. Best practice therapies are usually shorter rather than longer (although needs vary with each individual) and involve cognitive and cognitive –behavioural approaches using both those modalities as a broad description to incorporate different styles of help under those umbrellas!

b) measures which can encourage risky gambling behaviour.

i) marketing strategies.

To some extent I have covered this above but advertising should not provide false hope or make misleading claims such as "Everyone's a winner!"

ii) use of inducements /incentives to gamble.

The industry has a legitimate right to offer inducements to compete with other entertainment forms and between themselves.

However when people have closed accounts, industry should NOT be permitted to try after a time to encourage those people to return to them. Because of the nature of gambling those closing accounts may have problems and should be left to eal with these without being encouraged to go back again.

c) early intervention strategies and training of staff.

I have acknowledged in the past how difficult it is at times to recognise someone as having a problem whilst they are gambling.

However, over the years I have seen some "pointers" that seem to be the most reliable in suggesting likely problems.

They are the behaviour in front of a machine or in any gambling setting and the length of time spent gambling.

Recently, in a gambling arena at 7.15 a.m. (I swear I was just looking for an early breakfast venue to be open!!) I noted a man emitting a different sort of swearing at a poker machine. I took a seat a little away to watch proceedings as I also had seen a nearby security guard speaking into his lapel microphone. Impressively, within two minutes, another five guards materialized and hovered near their customer. He looked over his

shoulders, took the hint and left.

I remain uncertain how ”therapeutic” the experience was for the customer but an approach by the guards or counsellor with an expression of concern and suggestion of possible assistance may be deemed a better solution!

This shows to my mind the need for all staff to be trained in simple interview skills and to be knowledgeable about potential help.

Time is the other factor.

I have been amazed when patients tell me they have sometimes played for sessions as long as ten hours without once being approached by a staff member. One can only be suspicious that such lengthy spells are quietly supported by some management for obvious reasons.

Research suggests that playing machines, to pick one form of gambling with a high continuous element in it, for four hours straight and certainly six strongly suggests a problem.

Staff training must include some ability to recognize long staying customers and approaches to them to politely offer a break or discussion about their playing.

d) methods currently used to treat problem gamblers and the level of knowledge and use of them, including

i) counselling including issues for counsellors.

Current approaches highlight cognitive behavioural lines of therapy although more supportive or even psychodynamic styles may be better for some. Gambler’s Anonymous should been amongst the help choices offered as this is often downplayed in some settings yet in the real world has been extremely helpful for many – often after other more academically supported methods have failed. The reverse is also true in that Gambler’s Anonymous should not be promoted as the only approach or even as a compulsory part of other approaches without recognizing that it is not the best way for some. Those who did not find GA helpful will recount to me the actual group size (some do not like to speak in such settings), the perceived religious element and the constant repetition of stories. Still it should be included in the “mix” of options for those seeking help. No one approach stands out as the best at this stage of our knowledge.

One issue is more complicated. That is the ability to recognise co-morbid conditions and how to treat them.

While depression co-exists frequently this is most often secondary to the gambling problems and improves over time after the gambling comes under control. However sometimes the depression is more extreme and entrenched requiring medication to assist. Counsellors and psychologists in this field cannot prescribe and so must work with psychiatrists or general practioners to ensure co-ordinated treatment and to this end the need for a medically qualified person linked to services should be considered. Given the initial need is to diagnose first perhaps that person should be a psychiatrist where possible but I may be exposing a bias there!

The same concerns apply to the growing possibility that some anti-craving medications in use for drug and alcohol clients, with Naltrexone being the one most to the fore, may help certain individuals as well. Currently this medication is not available for gambling problems alone in Australia and if evidence grows that this is useful then the availability of this drug should be extended. Anecdotal reports from those who have a drinking and a gambling problem and are on Naltrexone are that gambling urges and behaviours decrease or go but of course as these are often linked to the drinking it is hard to be clear as to what affects what behaviour. Nonetheless, the future may see more use for such medications and again emphasise the need for links to medical personnel.

So two needs exist – the need to diagnose beyond just the gambling where labels such as personality disorder, PTSD and many others contributing to the gambling require recognition and links to treatment prevision when the main clinician cannot cover all are important aspects of a full treatment service. Education for all counsellors can help with the former and links to doctors the second.

(ii) education,

In NSW a thorough training programme exists which sets a sound standard. I cannot speak for other States but clearly some minimum standards for understanding gambling issues need to be provided for those entering this field. The depth may vary with more detailed courses required when counsellors are solely working with gambling clients but smaller training modules should be drafted into other training settings – especially drug and alcohol – to increase awareness and encourage/train counsellors into asking about gambling. This still remains an ignored area of enquiry and as it often is not obvious (e.g not drunk or under drugs) a heavy gambling history can be hidden with a focus on other matters.

(iii) self exclusion,

A useful though not completely effective tool that seems to work well for a small percentage. To be effective for those people it needs to be easily accessible. The ideal is to have a “one stop shop” for an individual to go to, see one person and be able to be excluded from as many sites and forms of gambling as they would wish. The same setting obviously with agreement across the different arms of the industry would permit exclusion from clubs, pub, TAB and casino settings.

And to be truly effective it must be understood that breeching the order has legal consequences of fines and also that any winnings will be forfeited. This latter point is essential to help diminish any ideas of returning for possible financial gain.

e) data collection and evaluation issues

All services should be funded to provide six monthly follow up at a minimum and preferably one year also. Standardised short interview format can be developed to assist this. Many follow ups will need to be done out of normal working hours to catch those

working themselves and to so maximize the number of follow-ups able to be achieved.

It should be made clear to those seeking help that a reluctance to agree to follow up does not prevent their receiving help.

f/g) gambling policy research and evaluation and other related matters.

Much research is being carried out and many areas of gambling behaviour explored – a pleasing contrast to the situation three decades ago.

The ideal however is that within the bounds of academic competition there is free information exchange flowing as to what research is being done , where possible similar topics could be explored at the same time in different States and the work be joined to increase sample size and make more relevant findings. Most work that focuses on problem gamblers is hampered by small samples and it is not correct to take those scored in surveys as being at "moderate ' risk" and then add them to the problem gamblers to reach a conclusion. Some reports suggest these are two different groups or that the validity of the at risk groups is a dubious concept and so conclusions based on such groupings may be wrongly reached.

On other matters 1) All States and Territories (including WA!) should be federally funded to conduct standardised community prevalence studies at least every three years and at the same time. This is the only way we will know what is working or get to see any changing patterns of gambling behaviour emerge

2) A situation of occasional concern is when a family member is gambling and losing heavily, perhaps affecting the immediate family, perhaps creating concerns that they are jeopardizing their own financial future. While being very conversant of the civil liberties and legal issues here it still seems relevant to have a mechanism in every state to allow others to apply to have the gambler's financial situation reviewed and if deemed necessary controlled by a financial manager. A review and possible extension of the South Australia system could be useful. Further investigation of how this can be most wisely implemented is warranted.

I have provided some brief thoughts on the range of issues you presented and would be happy to develop any points further if I can and if needed.

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