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Submission to Parliamentary Joint Select Committee on Gambling Reform

Please find attached my submission presented for consideration to the Parliamentary Joint Select Committee on Gambling Reform.

Yours sincerely,

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Director Statewide Gambling Therapy Service, South Australia

I have been Director of the Intensive Gambling Therapy Service, in South Australia from 1996, and from 2007, the Statewide Gambling Therapy Service i.e. a total 15 years. Our current annual client intake is over 550 problem gamblers and 80-90 significant others per year, with our service having seen over 4000 patients in the last 15 years. Initially established to provide the mental health component of a state government funded rehabilitation service our model of cognitive behaviour therapy had documented success rates of over 60% which led the government to fund us on a statewide basis. We have offices in 3 metropolitan sites and provide an outreach service to rural patients. We also offer an in-patient program to those who have complex and severe conditions, to those who have failed outpatient treatment, and those from the country who cannot access a treatment service.

Firstly I am going to describe the phenomenon of pathological or problem gambling that I and our therapists have seen in several thousand patients and then relate this to the pre-commitment technology proposal.

Background

It is indisputable that population EGM gambling use or expenditure is directly related to the number of machines and that problem gambling prevalence is directly related to gambling turnover or expenditure. Nowhere is this more apparent than the difference in problem gambling rates between Western Australia where machines are only in the Casino and the prevalence is 0.03% and EGM gambling states where EGMs are highly available throughout most communities and the prevalence ranges from 1.2 - 1.8%. i.e. 5 times more prevalent. Whilst these rates may sound relatively low they are the equivalent to schizophrenia and bipolar disorder combined. Continuing the comparison, the harm caused by problem gambling exceeds that of these two serious mental disorders because of the financial losses which have an impact on the family, employers and the community. The other similarity with serious mental disorders is that problem gambling can lead to

suicide attempts and completed suicide. A recent survey at the Alfred Hospital emergency department found 18% of all people presenting with self-harm had an underlying gambling problem.

Gambling and problem gambling has also been shown to be higher in lower socio economic communities where the machines are more highly concentrated. In this respect the availability of EGM gambling has a regressive and discriminating effect on the most vulnerable in our society. Given that EGM taxation provides 8% to 16% of the state's income, the poor are subsidizing the rest of the community, i.e. a reverse Robin Hood effect.

There is no evidence that gambling related harm minimization measures have reduced problem gambling, indeed in most jurisdictions, gambling related income has increased steadily over the last decade apart from short term reductions in gambling expenditure related to the introduction of no smoking regulations. Where some prevalence studies have indicated reduced or shown a plateau of problem gambling in some jurisdictions, it has been partly related to the use of different gambling screening instruments such as the Canadian Problem Gambling Index, which has been shown in Australian and overseas studies to underestimate problem gambling.

Problem or pathological gambling is an addiction

As a psychiatrist I have seen firsthand many patients who have the psychiatric diagnosis of pathological gambling as defined in the DSM-1V diagnostic manual. Almost all of the patients who have attended our service over the last 15 years would fulfill these diagnostic criteria. I think of pathological or problem gambling as a mental disorder just as I would diagnose and treat post-traumatic stress disorder, depression or alcohol dependence. The defining symptoms are what patients describe as 'an uncontrollable urge to gamble'. Patients describe the urge as a powerful mixture of physical feelings like anxiety i.e. racing pulse, shallow fast breathing, sweating, coming out in 'goose bumps' and thoughts like, 'I have to gamble', 'I've got to put money in the machine', 'I want to win', 'I'm going to win'. It usually comes on instantly after a trigger e.g. the sight of money or seeing a bill.

Over the 15 years I have rarely seen a patient who has not been able to describe this uncomfortable and distressing phenomenon of an urge. Of interest, the newly developed DSM-V has proposed that pathological gambling be re-classified as an Addiction, moving it from the 'impulse control disorders' category. I believe that pathological gambling indeed fulfills all of the criteria of an addiction. A consequence of this re-classification is the recognition of the seriousness of the condition or disorder with characteristics such as the serious impacts in terms of distress, disability and dysfunction including the risk of suicide. Another is the description of a craving, or urge for the substance, drug or behaviour. It is this 'urge' which sets apart a problem gambler from a recreational non problem gambler. A major implication of this reclassification is that psychiatrists, medical practitioners, and psychologists who use the manual and ultimately the judiciary and the public should regard pathological gambling as a mental disorder over which the person has little control.

The current paradigm 'blames the victim'. Those who do not understand the existence let alone the powerful nature of the urge regard problem gamblers as antisocial, weak individuals who are greedy and wanting an easy way out of debt. They are regarded as

people who have a range of addictions and that if they didn't have problem gambling it would be something else. The unspoken attitude is 'it's their own fault'.

Why do 'normal people' become problem gamblers?

How is it possible that a person can become addicted to a machine you might ask? I understand that a drug or alcohol has a substance that somehow does something to the brain that results in a craving for the drug and this feeling or need is so strong that the person will do literally do anything to obtain that drug. I understand that the drug addict has withdrawal or tolerance to the drug and over time needs more to satisfy the withdrawal effects.

The answer is simple. The machines nowadays are made up of a fancy attractive facia behind which sits a computer game. The screen looks like the old fashioned spinning reels but in fact there are no reels and only an image generated by a computer with graphics that can be manipulated by the computer game. The program generates rapid random numbers which determine which combination of queens comes up in line. Research has shown that the most powerful reward sequence to increase a behaviour is variable ratio intermittent reinforcement. What does this mean? In plain language it means that the reward is unpredictable in terms of when and the amount is unpredictable. Another reinforcing characteristic is that the play is made to look as if there is a 'near miss' i.e. 4 out of 5 Queens. The designs have at least 9 characteristics or ways in which they can be varied all of which have been shown by research to produce a level of excitement or urge. Others include the machine characteristics especially spin rates i.e. the quicker the reward the greater the reinforcer. This characteristic is I believe responsible for the significant increase in expenditure in Victoria compared to say SA where the number of machines has not changed.

The whole principle of an EGM is based on conditioning i.e. like Pavlov's dog, i.e. classical conditioning in which wins produce excitement (the beginnings of the urge) which your mind links with the sights and sounds of the machine. Just like the dog can become conditioned to the sound of a bell and salivate, so people can become conditioned just to the sight of the machine, the sounds of the machine and eventually, the venue (driving past), advertisements, money (a $5 note). We call these external triggers. Similarly there are internal triggers i.e. boredom, irritability after an argument, sadness, or loneliness. Initially the feeling is positive and one of excitement then as it increases in intensity it becomes uncomfortable. It is this discomfort that is relieved when the person puts the money or token in the machine. Short term relief gives way to an increasing of the urge and the cycle is repeated. I have been struck how people from all walks of life can become addicted. They know what they are doing is wrong and has terrible consequences yet they cannot stop themselves. By avoidance and distraction they can control it for weeks or months but eventually a trigger is too powerful to resist.

Although each person is unique in their personality, family, and culture, we have found that unless we help them extinguish this urge many of the attempts to help with the family, financial and work consequences are doomed whilst they are still captive to the automatic urge. Once the urge is extinguished, we help the person look at the reasons they might have started gambling, the consequences and the rehabilitation required. Our treatments are successful with over 68% of those who start treatment improving or totally eliminating their urge.

Additional evidence of the role of the urge comes from our recently completed study into 'the predictors of relapse in problem gambling'. This two year study was funded by Gambling Research Australia. An international consensus Delphi process helped define relapse in problem gambling. We conducted focus groups of gamblers and therapists and carers, and followed this with an 18 month observational study of people entering treatment. Both the focus groups and the observational study of 158 individuals showed that urge was the single greatest predictor of relapse in problem gambling. People who had entered treatment, recovered to some degree but had not extinguished their urge were prone to relapse. Some gamblers described an altered state of awareness they called 'the zone' when all rational thinking was overridden by the urge to gamble.

Pre-commitment

Why is this urge relevant to pre-commitment technology? I understand that the policy questions are whether the technology is aimed at just preventing recreational gamblers from becoming problem or pathological gamblers, or secondly that it will prevent existing problem gamblers control their gambling. From my experience, the second question is easier to answer. Because of the uncontrollable urge, once the gambler has the urge almost nothing will stop them seeking to gamble and once they do, they are unable to stop until all their money is depleted. If they run out they will go to the ATM until all their funds are withdrawn. If the venue closes or they are banned they will go to another venue. In other words unless the protocols are a) universal i.e. all patrons in all venues b) a maximum time and spending limit is set by the state c) precautions are put in place to ensure that the card cannot be transferred e.g. finger printing, then problem gamblers will find a way to gamble.

The simplest example of the inability of the addicted person to exercise control is the lack of evidence that barring reduces harm or gambling by the problem gambler. As therapists we learn that our clients have broken bans frequently even though at the time they agreed to the ban they were determined and desperate to take control.

When people are addicted they cannot exercise rational judgment. Once the urge is triggered, logic takes a back seat. Unless a pre-commitment regime takes this into account, with clear limits on maximum spends and playing time, 30-40% of regular gamblers who are problem gamblers will receive minimal benefit.

For the non-problem regular gambler, I believe that unless the system is mandatory with predetermined state set time and money limits, those at risk may not use the system. If they do, they may be lulled into a false sense of security believing they are protected from becoming addicted. With no limits on time or spend the fundamental machine principles of intermittent reinforcement will encourage or induce an urge which will result in loss of judgement and loss of control. If gamblers can opt out and they experience an early big win and for some this is a small as $100, at risk gamblers may become addicted. Coupled with the existing machine designs as described above there will still be a pathway to addiction. If the system was mandatory and the limits were combined with reduced spin rates there would be a strong likelihood of people being protected from becoming problem gamblers.