Convenience Advertising
Submission to
Joint Select Committee on Gambling Reform

February 2011

Convenience Advertising

Established in **1984**

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Convenience Advertising

Contents

Forward

Convenience Advertising would like to thank the Committee for the opportunity to make a Submission and present to it. In particular, our submission invites the Committee's close attention to Chapter 8 ("In-venue information & gambling advertising") of the Productivity Committee Report Gambling (no. 50, 26 February 2010).

Introduction

In its findings the Productivity Commission stresses that in addressing the issue of problem gaming "warnings and notices within venues are important referral sources for gambling help lines"[1] which are themselves a vital element in minimising the harm associated with problem gaming.

"Harm minimisation" is the crucial element which links all programmes which are designed to modify risky personal behaviour, whether that be in relation to gaming, drug or alcohol use or sexual activity. The only health-based social marketing campaign in which harm minimisation is not a relevant consideration relates to tobacco use.

Senator Xenophon noted the significance of this approach in para 3.21 of his Minority Report attached to the Report of the Senate Community Affairs Committee on the Poker Machine Harm Reduction Tax (Administration) Bill 2008.[2] The approach was subsequently endorsed by the Productivity Commission.[3]

In its Report, the Productivity Commission drew attention to several aspects of advertising associated with this harm minimisation approach. Specifically it

- noted that interventions could be low cost but effective and
- recommended that "material should be placed in areas of relative privacy such as bathrooms".[4]

In order to achieve maximum results, the Commission recommended, inter alia:

- that steps be taken to "improve (advertising messages) performance by using visual images and improving the messages";
- that "dynamic" warnings be employed;
- that "more effective language" be used and that
- that a strategy of "changing messages" be used "as their effectiveness wains."[5]

Finally the Commission noted that a key measure of any successful outcome of such advertising strategy should be "an increase in people seeking assistance from gambling help services."[6] It recognised "gambling counselling contact cards and are a valuable source of information and that there was advantage in having such cards "available in the bathrooms (where they) could quickly and discretely be accessed by gamblers."[7]

In other words, the Commission recommended that the most effective way to address one issue of problem gambling was through the use of what is called "narrowcast" advertising and with some emphasis on placing this material and making it accessible in more private venues such as bathrooms. It also commented that such interventions were effective and that costs were "relatively low compared to other policy interventions."[8]

Narrowcasting

Narrowcast communications is a form of communication which

- specifically targets and interacts with those people or groups most in need of the information
- distinguishes its targets from the population in general
- addresses the targets in language specific and relevant to them and
- is delivered in the locus of risk or activity in question.

Appendix 1 provides a more detailed analysis of narrowcasting.

Members of the Committee will be familiar with the outstandingly successful use of narrowcast communication to deliver health messages related to a successive series of national campaigns related to HIV/AIDS and Hepatitis C. These campaigns have sought to target not the whole population but rather that segment of the population engaged in "risky behaviour." It has used language appropriate to the target group (often exceptionally specific and confronting) and it has delivered these messages in loci of risk such as bathrooms, nightclubs, sex on premises venues, brothels, and gay social venues. Narrowcasting has proved much more effective in affecting behavioural change or modification (harm minimisation) than more widely broadcast advertising such as the "Grim Reaper" campaign.

As already noted, narrowcasting messages can be highly specific. This allows avoidance of their either appearing to be from "a set of wowsers" or risking "warning fatigue" both of which were identified by Professor Peter Shergold (Chair of Ministerial Expert Advisory Panel) in recent comments.[9]

Additionally, because printing and maintenance costs are generally inexpensive it becomes possible to change or update messages more frequently. Current narrowcast bathroom technology which delivers messages on the screens of bathroom hand dryers makes possible both rapid changes of message at regular intervals but equally a variation of messages during the course of any one day to respond to the changing demographic of venue use.

Narrowcast Anti-Gambling Campaigns

Convenience Advertising (see Appendix 2) has conducted a significant number of narrowcast campaigns designed to address issues of problem gaming. Each has been rigorously evaluated and found to be successful.

1. Victoria

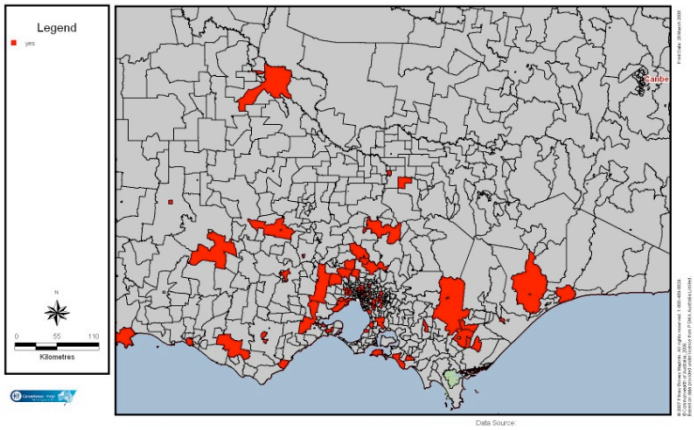
The Victorian Government, through the Department of Justice (and previously the Department of Human Services), have run the responsible gambling narrowcast program since 1999.

The program, involving three independent evaluations over this period has provided a safety-net to all gaming venue patrons throughout the state of Victoria.

The Victorian campaign involves the fortnightly maintenance of more than 2,300 A4 signs and 2,500 card holders that supply the take away information in all gaming venues. Specially trained Convenience Advertising maintenance officers visit each gaming venue to maintain all signs and replenish stock including the take away cards each fortnight.

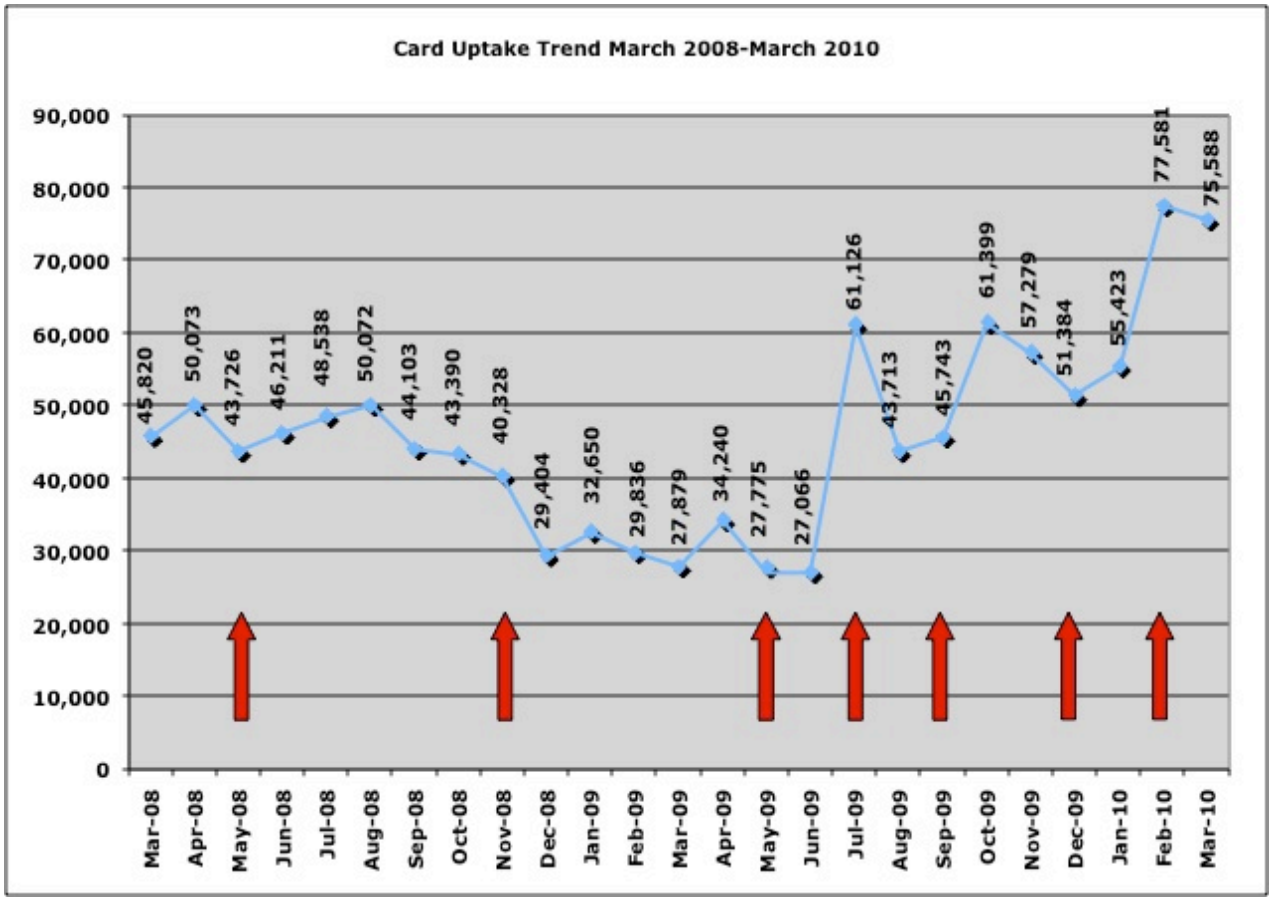
There are approximately 30 maintenance officers in Victoria servicing the program in the following DHS Health Regions:

- Barwon
- Gippsland
- Grampians
- Hume
- Loddon/Mallee
- North Western Metro
- Eastern Metro
- Southern Metro



Each maintenance officer, visits each gaming venue and replenishes all campaign material including the top-up of cards. Typically, over the course of a 2-year period approximately 1

million cards are collected by gaming venue patrons as the graph below displays. The red arrows indicate the number of creative rotations conducted for the program, which has increased over the past 3-years.



Card uptake activity over a two-year period. An estimated 1 million cards are collected during this length of time.

Three evaluations conducted on the program have supported the Productivity Commission findings that the messages are most relevant and noticed in the bathrooms of gaming venues.

The **1999 evaluation** found:

- 63% unprompted recall of the message;
- Two thirds of the respondents were frequent visitors of the gaming venues (several times a month); one third of respondents were very frequent visitors of the gaming venues (several times a week);
- The greatest impact was measured amongst the male respondents;
- 90% of respondents thought the bathrooms were an appropriate way to reach problem gamblers.

The **2003 evaluation** found:

- 55% unprompted recall of the message;
- Use of the BDB scale measured the extent of problem gambling activity through a gambling index. Unprompted recall amongst those who scored highly on the problem gambling index reached 80% meaning the messages were most relevant to problem gamblers;
- There was a clear fit between problem gambling scores and several aspects of the messages. Overall, the higher the problem gambling score:
  - the more likely a person was to recall seeing the message
  - the more likely s/he was to recall the key themes of the message
  - the more likely a person was to say the message was relevant.

The **2005 evaluation** found:

- 88% unprompted recall of the message;
- Only 8% of respondents had not seen the poster;
- 45% of the sample recalled seeing the take away cards and of those, 73% identified the key issue on the card as being "who to call for help";
- 66% said they would pass on information to a friend or family member they believed to be a problem gambler, an 8% increase from 2003;
- 79% of respondents used the poker machines over 16% who used the TAB.

A key element of the Victorian campaign was to provide counselling cards through bathroom displays. During the period of the campaign some 1 million cards were distributed. Each provided a link to a number specific to the Area Health Service in which the venue was located.

Data is available showing the significant uptake of these cards reflected in calls to the help reflected in calls to each Health area in question.

Critically, the 2005 evaluation drew attention to the use and further potential of narrowcast communication through use of mobile phones and the internet.[10] It is beyond the scope of this submission to deal with internet gaming issues, suffice to say that narrowcasting is an effective medium of communication in this space.[11]

2. Queensland

In August 1998, Convenience Advertising was engaged to display the Gambling Help Line messages and distribute cards and holders to gaming venues in three pilot areas of Queensland, namely Mt. Isa, Cairns, and Rockhampton. The pilot program, coordinated by the Responsible Gambling Advisory Committee, sought to reach problem gamblers and their significant others with information about the telephone counselling service *Gambling*

Helpline.

The program was again extended in August 1999 and ran until April 2002. New cards were designed and installed into the Rockhampton and Cairns venues in July 2001. The communication material was collaboratively designed, and focus tested to ensure relevance and appropriateness. The messages were placed into registered clubs and hotels, in toilets nearest the gaming rooms.

Reports were provided detailing monthly card uptake data and quarterly reports detailing maintenance and resource activity, including message replacement and card uptake data together with reports of graffiti and other negative incidents. The communication material developed for this program, on behalf of the Department of Treasury, provides a locus of risk in-venue resource for people affected by problem gambling which signposts the Gambling Helpline, and provides a 1-800 telephone number for the Gambling Helpline. This call to action is reinforced by the take away information resource which can be discretely taken from the fixed A4 signage.

Program messages were also installed at 65 racetracks. To achieve this, a productive collaboration was realised between the following primary stakeholders: Department of Treasury, Clubs Queensland, Hotels Queensland, Queensland TAB and the Racing Industry. The support, input, and collaboration of each organisation has made possible a highly targeted, State-wide communications program which aims to make the Gambling Help-Line and Code of Practice messages accessible to all Queenslanders affected by problem gambling. A total of 1,413 venues participated in this intervention.

There was a change in creative "WANNA BET" in 2006 and changeover of existing messages, venues were also provided with signs that were placed at strategic locations within the gaming areas and also an updated manual. All hotels and clubs were also left with a minimum of 6 laminates to replace and rotate messages, and a number of boxes of cards, which was dependant on the size of the venue. Similar displays were installed in 170 TAB outlets.

A total of 1,392 venues are participating in this intervention. This represents all venues on the QOGR issued list. A total of 7,098 DPS were installed. Anecdotal feedback obtained from the in-site installation indicated the club gaming managers seemed to be better informed regarding the Responsible Gambling intervention than hoteliers. *This intervention won the AMI National 2006 Award for Social Marketing*.

Queensland narrowcast program in gaming venue common areas and bathrooms.

3. Tasmania

Convenience Advertising has recently established a pilot program for the Department of Health and Human Services in the local government areas of Glenorchy and George Town.

Focus tested messages employing an animation theme and adaptation of the Victorian Government messaging are featured in the venues for the pilot program. The campaign was installed into gaming and community venues to reach problem gamblers, at-risk gamblers and the significant others of problem gamblers for a 6-month period.

The pilot program employs the Victorian narrowcast model to convey the harm-minimisation messages to venue patrons. With 100 A4 messages and 48 card holders installed, the program is intended to roll-out state-wide into all gaming venues in Tasmania.

Tasmanian Government campaign material and in-venue display.

The Tasmanian programme has just recently been evaluated by the Centre for Health Initiatives at the University of Wollongong. They concluded:

> "Overall, this campaign was very well received by the public, who had excellent levels of recall, in excess of what would be expected from a campaign such as this, based on previous campaign evaluations. In addition, almost all adults surveyed were able to recall more than one main message from within the poster(s)."

Several questions based on the HBM were included in this survey in order to predict the likelihood of an individual (or the target group – problem gamblers) changing health-related behaviours based on the interaction between perceived benefits of and barriers to

seeking help for problem gambling, as well as talking to friends and family about getting help. In line with this, having seen the posters, a sizeable proportion of respondents reportedly that they themselves would talk to their friend(s) or family member(s) about gambling. Those surveyed were generally very aware of problem gambling support services in Tasmania, indicating that they have the information and resources required to follow through with this.

Interviewees were very likely to have remembered and described the posters in a positive fashion, with less than 10% of the sample having a negative opinion of them, although men were found to be significantly more likely to have ambivalent feelings about the posters (although they very rarely actively disliked them). Given that young males were least receptive to the posters, an alternate method and/or venue could be investigated to target this group, although it is very positive that young males were equally likely to have seen, understood, and remembered both the posters themselves, and the information within them.

Crucial, however, was the finding that nearly half of those surveyed found these posters relevant to them or someone that they know, which is particularly interesting given the significantly smaller estimated proportion of Tasmanian residents directly or indirectly affected by problem gambling. These findings could, therefore, reinforce our understanding that, among this sample, problem gambling is a more prominent issue than it is among the remainder of the Tasmanian population or, considerably more likely, that a significant proportion of people who saw the poster(s) believed that they were relevant to them *despite* not being a moderate risk or problem gambler, as well as not knowing anybody who fits into either of these categories. In addition, over one-third of the respondents believed that this campaign was targeted at the community in general, rather than only at gamblers or even problem gamblers. Together, these results strongly indicate community support for a campaign such as this – even from people who are not, themselves, problem gamblers."[12]

A copy of the Report is provided as Appendix 3.

Narrowcasting – Sensitive issues of personal behaviour

Narrowcasting came first to prominence in health promotion campaigns with the development of HIV/AIDS preventative strategies in the late 1980s. Convenience Advertising was a pioneer in this area achieving significant results for the Commonwealth backed by several program evaluations.[13]

Similarly campaigns related to such issues as cannabis use[14]; Chlamydia testing[15]; binge drinking[16]; drink spiking[17] and sexual health[18], based on narrowcast principles have received positive evaluations both in Australia and overseas.

More than 30 such evaluation reports directly relative to health promotion/behaviour modification are available.

Conclusion

In the absence of legislation which provides for the direct banning or outlawing of specific forms of gambling, a key element of public policy must be to promote harm minimisation as a strategy to deal, in part, with the negative consequences of problem gambling.

All too often health promotion campaigns have failed or at the very least failed to achieve maximum value for the public expenditure incurred because they have failed to resonate with key targets groups.

Experience with the early days of the HIV/AIDS epidemic are both useful and relevant. Initial campaigns ("Grim Reaper"/"Beds and Feet") were not sufficiently successful because they implied that all sexual activity was "risky" and that the entire Australian population was "at risk." In truth only certain behaviours were risky and only a limited number of people practiced such behaviours.

Similarly with gaming. Most Australians either do not gamble of when they do, they do so responsibly. It is only a small proportion of gamblers who have "problems" – although those problems are very real and have potentially disastrous consequences.

HIV/AIDS public health campaigns started to achieve maximum effect when they:

- targeted behaviours not people
- used words and images directly relevant to the target group
- provided flexibility in message delivery
- delivered messages in relevant places – loci of risk
- were linked with other sources of advice/help/counselling which were potentially beneficial for the individuals concerned.

The Productivity Commission in its Gambling Report has already recognised this and endorsed a preferred strategy for implementation. Volume 2 of the Report makes further recommendations regarding that advertising which actually promotes gaming.[19]

Any marketing strategy aimed to assist problem gamblers must combine elements of

- acceptance by the target group
- support of the broader public (especially families of problem gamblers)
- support of gaming authorities or organisations
- acceptance by venues and each locus of risk
- good design and product development
- a proven communications strategy and
- linkages with counselling or referral services

This Submission urges that in its Report the Committee endorse specifically the thrust of the findings and recommendations in the chapter 8 of the Productivity Commission Report. There will be pressures to engage in and commit large sums of public money to mass

media based campaigns in traditional media such as newspapers, radio and television. We respectfully suggest that such a strategy would be both disastrous in terms of outcome and a significant waste of public money. It will risk the alienation of the vast majority of the population who gamble responsibly while failing to connect with those who need to hear the messages involved.

It is in our submission, only by endorsing a focussed, tested and proven narrowcast strategy that success is likely to be optimised. Creative thinking about messages – developed in association with people who are problem gamblers (as was done with gay men in HIV/AIDS campaigns) - supported by venue owners and placed strategically – will yield results.

Problem gamblers leave their comfort zones primarily to obtain more money, obtain food and drink, or visit the bathroom.

It is primarily in the privacy of the last of these situations that an opportunity exists to maximise the chances that problem gambling advertising will be seen, noted and successful.

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[1] Productivity Commission Report: Gaming (no 50) 26 February 2010 Vol 1 at 8.1
[2] Senate Community Affairs Committee Report: Poker Machine Harm Reduction Tax (Administration) Bill 2008 (November 2008) Minority Report at 3.21
[3] Productivity Commission: op cit Vol 1 at 8.1
[4] ibid at 8.3
[5] ibid at 8.1; 8.3; 8.15
[6] ibid at 8.2
[7] ibid at 8.4
[8] ibid at 8.5
[9] Sean Nicholls, "Many levers to be pulled before pokie pledge is kept", Sydney Morning Herald 8.11.10 p5
[10] Qualitative and Quantitative Social Research: In-venue Problem Gambling Communication Analysis (A Review of the Convenience Advertising Gambler's Help Programme on behalf of the Department of Human Services, Victoria) May 2005 p23
[11] Richard Guillatt, "All Bets are On", Weekend Australian Magazine Aug 29-30, 2009 p12-15
[12] Centre for Health Initiatives (University of Wollongong): Problem Gambling Awareness Campaign Data Evaluation (2011)

[13] See Senate Hansard 3 June 1992 p3401-09; AGB McNair Evaluation 1993 "HIV/STDs Prevention Amongst Travellers"
[14] Tribos Instituut, Netherlands Institute of Mental Health and Addiction: Mass Media Campaign on Hash and Grass 1997 (Utrecht 1998); Rapportage Drugs Informatielijn (nr. 3, mei 1998)
[15] Chen, M.Y. et al" "Evidence for the effectiveness of a chlamydia awareness campaign: increased population ratio of chlamydia testing and detection" International Journal of STD and AIDS Vol 18 (4) Apr 2007; 239:43
[16] Millward Brown (Ulster): Convenience Advertising – Binge Drinking - Poster Evaluation (Oct 2007)
[17] Australian Drug Foundation: Drink Spiking Campaign Evaluation for Crime Prevention Victoria (Dec 2002)
[18] Maureen Gardner: "Convenience Advertising" Health Promotion Agency (Northern Ireland) December 2000; STI Campaign Evaluation Welsh Assembly Government (Nov 2002)
[19] Productivity Commission: op cit Volume 2, Appendix K

Chapter 7

Narrowcast communications

David Stanley, with Max McLean

Introduction

Most people are familiar with the term broadcasting, which describes commonly used forms of mass communication such as television and radio. Although mainstream broadcasting can be a highly effective vehicle for reaching large numbers of people, it is also generally very expensive. This expense is often not cost effective in the area of health promotion because many health issues only affect particular sections of the community. Such groups within the larger community may be a particular age-group or gender (e.g. older women are more susceptible to osteoporosis), or a group whose lifestyle (e.g. drug use) or occupation (e.g. long-distance truck drivers at risk of falling asleep while driving) put them in a particular category of risk.

Equally significantly, it is not always desirable to send particular health promotion messages to the community at large: many health issues are culturally sensitive (for example, issues around HIV, safe sex, and injecting drug use) and messages about them would have to be drastically watered down to make them acceptable to the general population. This can seriously undermine their efficacy in reaching and affecting the people who need them most.

Furthermore, because broadcasting, by definition, reaches a broad spectrum of people, those who most need to receive and relate to the information may not recognise that the information is particularly relevant to them. Nor will they necessarily receive that information at a time or a place or in a way that encourages them to connect the information with their own behavioural risk status. For example, an advertisement alerting women to the prevalence of drink spiking in nightclubs may be more effective if located on a cubicle door in a nightclub toilet than if seen on television at night during the middle of the week.

As a generalised source of information, broadcasting may also lack the authority, charisma, or influence to convince the people the health message is intended for to listen to and embrace it. For example, information alerting young people to the dangers of severe dehydration caused by a combination of amphetamine use and long periods of dancing in extremely hot, crowded dance

venues may have more influence if it is printed on a dance party ticket by the party organisers—who are perceived, approvingly, as peers—than the same information presented in a government health warning on television, which may, in comparison, be rejected as scare tactics by authoritarian outsiders. When messages are delivered to a group within a familiar place or setting that is part of their lifestyle and value system, there is greater potential that the viewer will embrace the message with an attitude of trust.

A final shortcoming of broadcasting is that, again by its nature, it is generally only able to talk *at* rather than *with* people. It may be more difficult to gauge how successful its communications have been, or adjust its messages quickly in response to feedback it could be getting from its target audience.

What are narrowcast communications?

In contrast to broadcasting, the term narrowcasting refers to forms of communication which specifically target *and interact with* those people or groups most in need of the information, often in the places in which they congregate. One of narrowcasting's chief benefits is that, because its messages are distributed directly to its target audience—and often through and by members of that target group themselves rather than coming from outside—there is a greater ability for the target group to become more involved and responsible for the management of its health as a group, and for the dissemination of its health messages to continue long after any initial information and education program is officially over.

Commonly used mediums for narrowcasting are:

- niche publications, cable TV, community radio (i.e. forms of broadcasting that are already tailored to reach particular groups within the broader community);
- database marketing: mail, phone, text-messaging, or email directed at databases of relevant recipients;
- special audience publications (e.g. university student newspapers, community group newsletters);
- out-of-home media (e.g. billboards and signs; advertisements in trams, trains, buses, aeroplanes, and places where transport is caught, such as bus stops, train stations, and airports);
- peer developed and distributed interventions (e.g. leaflets, booklets, safe-sex packs, compact discs);
- in-venue materials (e.g. toilet door advertising, in-house videos, printed messages on beer mats/drink coasters, messages on venue tickets and programmes); and
- promotional product marketing: these are items, of use or of novelty value to the target audience, that have messages on them and are provided free. Examples include: t-shirts; pens and pencils; computer mouse pads; key rings; calendars; caps; bookmarks; etc.

Setting your target

Long before any messages are printed on toilet doors, t-shirts, or novelty key rings, however, there are a number of processes involved in developing effective

public health campaigns aimed at particular target groups. The first step is to ascertain exactly who your target group is.

Once a health issue of concern has been identified, statistical, sociological, and/or epidemiological research needs to be undertaken to determine exactly why, when, and where the health problem is occurring.

Road accidents involving people over sixty years of age: why, when, and where?

A higher incidence of serious car accidents involving people over sixty years of age over a sustained period of time in the state of Victoria recently prompted the Transport Accident Commission (TAC) to investigate. It discovered that combinations of prescription medicines commonly used by older populations can adversely affect drivers' concentration and reflexes. It was decided to develop a campaign aimed at educating elderly drivers about these dangers and encouraging them to learn more about the medication they are prescribed and its potential interaction with moderate consumption of alcohol.

The problem then became a matter of determining the most efficient way to reach older people who drive, and to communicate the information to them effectively. Victoria's popular lawn bowling clubs, whose members are predominantly over sixty years of age, were chosen as an ideal locus for a range of on-location messages and information packs relating to road safety and the use of prescription drugs. Radio advertisements spoken by a radio personality popular with that age sector complemented these bowling club interventions.

This TAC case is an example of narrowcasting where the target group is easily identified (i.e. older drivers taking medication). Many public health issues are more difficult to target however and require a multi-faceted approach.

A multi-faceted approach to HIV/AIDS

Internationally, the fight against HIV/AIDS requires the pinpointing of a variety of target groups whose geographical, economic, social, and behavioural circumstances have put them at risk of infection. Australia has a high success rate in preventing HIV infection through a concerted and ongoing information/education/prevention strategy (federal, state and local government level) that relies largely on partnerships between government and community sectors that use various narrowcasting techniques.

However, within the major target group of people most at risk of contracting HIV in Australia—men who have sex with other men—there are a number of subgroups who, over the years, have had to be separately identified and targeted. For instance, men who have sex with other men but are perhaps married and do not identify with the larger gay culture are less likely to see safe-sex material that is distributed in gay bars or gay newspapers. Even if they do see it, they are less likely to regard it as something relevant to them. Research must therefore be done to find out where and how best to reach this segment of the target audience. To HIV/AIDS educators sexual identities, and identifications with different cultural groups, has always presented a challenge. Narrowcast communications make it possible to reach different cultural, religious, and social groups, with relevance and sensitivity, within the framework of a sustainable strategy. This minimises the exposure of the message to a non-intended audience.

In such instances, health agencies can benefit enormously from the partnerships and two-way information exchanges made possible by the on-the-ground nature of narrowcasting. This rapid flow of information back and forth means that setbacks such as message burnout can be investigated and counteracted rapidly and effectively.

The importance of partnerships

The concept of partnerships is essential for effective narrowcasting. As soon as a health issue has been identified, health promotion practitioners should seek to forge relationships with the following significant groups:

- stakeholders;
- gatekeepers; and
- target group representatives.

Stakeholders are the organisations and groups that work with and may provide services (directly or indirectly) to the intended audience. For example, stakeholders in a drink-driving program that seeks to reach young males aged between eighteen and twenty-four would typically include police, insurance companies, road authority, justice department, and hotel industry groups. Gathering together various interested groups such as these often has significant cost sharing advantages and maximises the range of resources available to the program.

Research should be undertaken by health promotion practitioners with the aim of developing an inventory of the priority target groups. This includes such information as numbers (i.e. how many people there are in the group), age, gender, ethnicity, and lifestyle factors. Practitioners should then make explicit the aims and communication objectives of the intervention, for themselves and for involved stakeholders. A list of relevant service organisations should also be developed, containing contact details, details of the clients they service, and the types of services they offer. It is important to collect details on the time and availability of these service providers.

Another significant group are the gatekeepers, so called because they can provide access to target groups and the places in which they congregate. In the example given above of a youth drink-driving campaign, gatekeepers would include the proprietors, managers, and staff of bars and hotels. Practitioners need good relations with gatekeepers in order to gain access to these venues where risk-related behaviour is occurring (i.e. drinking and then driving) and, accordingly, access to the target groups themselves. Ideally, narrowcasting communications will engage gatekeepers, stakeholders, and the target group itself in the intervention.

Finally, representatives of the target group also play an important role in any narrowcasting campaign. At the very least, members of the target group will be needed to participate in the initial research that determines the cause and nature of the health risk, and the subsequent research undertaken to determine how best to tailor the campaign's messages to communicate effectively with the group. In many cases however members of a health campaign's target group play a considerably more significant role. For example, it is widely acknowledged

that, in many countries, the gay community was instrumental in the formation, development, and maintenance of the fight against HIV/AIDS, and consequently had involvement, not only as target group representatives, gatekeepers, and stakeholders, but as public health practitioners as well (i.e. as the very instigators of the campaign).

Focus testing: before and after

In the preparation of narrowcasting campaigns, research is a two-step procedure. The first step, discussed above, involves determining exactly who the target group is. The second step involves discovering how best to reach this group and effectively communicate your message to them. Gatekeepers can prove invaluable here, providing access not only to members of the target group but also to their milieu. Here, creative teams (designers and writers working in social marketing and advertising agencies) working on the campaign can often benefit by seeing how other groups are successfully marketing to the same target group (e.g. in this instance, advertising by alcohol companies would be a prime example). Creative teams are then in a position to utilise visual language that is familiar and appealing to the target audience. For example, depending on the target group, this might borrow from cyber, digital, comic, graffiti, erotic, graphic, and poster art.

Once the nature of the message to be communicated has been determined, the campaign's creative teams commonly develop two or three possible visual solutions (e.g. three variations on the 'don't drink and drive' ad) and prepare these for focus testing. Focus testing is a process whereby the effectiveness of campaign material is evaluated by showing it to members of the target groups and asking for their reactions to it. It is important to ensure that, as far as is possible, the focus group environment seeks to replicate the environment and circumstances in which the proposed intervention will occur.

Focus testing of a campaign will typically involve showing groups comprised of a cross-section of the target audience the two or three developed visual solutions for the campaign (e.g. in poster form) one at a time. Questionnaires provided ask participants for their responses to the campaign's constituent parts so they can be separately evaluated. These constituent parts commonly include such things as the campaign's main slogan, the various images used to illustrate the message, the readability of the text, even such things as the colours used in the material. Asking participants to write down their reactions to material in private prevents the opinions of dominant members of the group from unduly influencing the reactions of others. However, subsequent group discussions are generally invaluable in expanding upon these initial responses.

Assessing the outcome

Focus testing is also an important component in the development of messages, specifically themes and all content including branding. Action research occurs

with the program maintenance and follow-up procedure by campaign managers once a narrowcasting campaign has been commenced, in order to test its efficacy. It is also common for government-funded health campaigns to be evaluated by an independent body in order to satisfy the funding body and other interested parties in government that money has been well spent and that the campaign is achieving the desired outcome. Qualitative and quantitative evaluations should measure the level of understanding, relevance and usefulness of the message or intervention for members of its target group. Sixty-percent-plus effectiveness across each of these indicators can be expected from community and collaboratively developed narrowcast strategies. Evaluations such as these are crucial for health practitioners because they provide essential information for the planning and guidance of subsequent campaigns. They are also helpful to the stakeholders as a means of quantifying the benefits of their involvement in the campaign.

Finally, it should be remembered that, as discussed earlier in the example of 'message burnout' in long-running safe sex campaigns in Australia, despite the initial success of a campaign, its continued effectiveness cannot be taken for granted. Depending on the nature of the health issue, practitioners may well discover in time that its target group has become resistant to the initial campaign and that it needs to be reasserted using new strategies. Where, as in the case of HIV/AIDS, the extended duration of the health crisis and consequently the extended duration of the campaign led to message burnout, one solution is a system of message rotation, in which a series of different strategies are rotated to maximise their affective power over time.

Similarly (and again depending on the nature of the health issue in question), epidemiological and social data may reveal that new at-risk target groups (or segments of groups) have arisen since the initial campaign and that new campaigns need to be developed accordingly.

Five key points

1 Narrowcasting is effective in directly targeting and interacting with particular at-risk groups.
2 At-risk groups often contain subgroups that need to be individually targeted.
3 Good relations and co-operation are essential with interested parties including stakeholders, gatekeepers, and members of the target group.
4 Focus testing is vital to ensure that a campaign will reach its target audience in a useful, relevant, and measurable way.
5 Research should continue after the program has commenced to assess its efficacy, monitor changing conditions, and facilitate any fine tuning.

In the public health context, narrowcast communication strategies can provide more efficient, appropriate, and relevant solutions than broadcasting media. They offer the opportunity to directly address an identified population or

Case study 1: the Netherlands: responsible cannabis server program

Background

Cannabis use has been decriminalised in the Netherlands since the 1970s. Recent research indicated that, while cannabis use was often taken for granted by young people, there was a lack of knowledge and available information about the effects of its usage. The Ministry of Health, Welfare and Sport commissioned and funded the Trimbos Institute and the Netherlands Institute for Mental Health and Addiction, with Convenience Advertising, to co-ordinate a mass media information campaign about cannabis use aimed at young people.

The campaign

Narrowcasting techniques were used to efficiently and effectively target young people in the 'coffee shops' in which cannabis was legally purchased and used. Five hundred and seventy-five coffee shops in thirty-five cities or towns were selected, from an initial 800, as sites offering maximum exposure of material to the target group as well as co-operative owners/managers (i.e. gatekeepers).

The campaign consisted of educational materials in three formats:

1. 'faux' phone cards placed in bar stands and cardholders: these promoted a Drugs Info Line providing information on cannabis use;
2. leaflets offering ten tips for safer cannabis use: these were printed in Dutch and English and also located on coffee shop counters; and
3. A4 posters in two formats (rotated to avoid message burnout) were placed in shop toilets: they offered health-conscious messages and directed viewers to the phone cards and ten-tip leaflets.

Figure 7.1 Cannabis messages

Message in bathroom

Tips card

Take away card

Outcomes

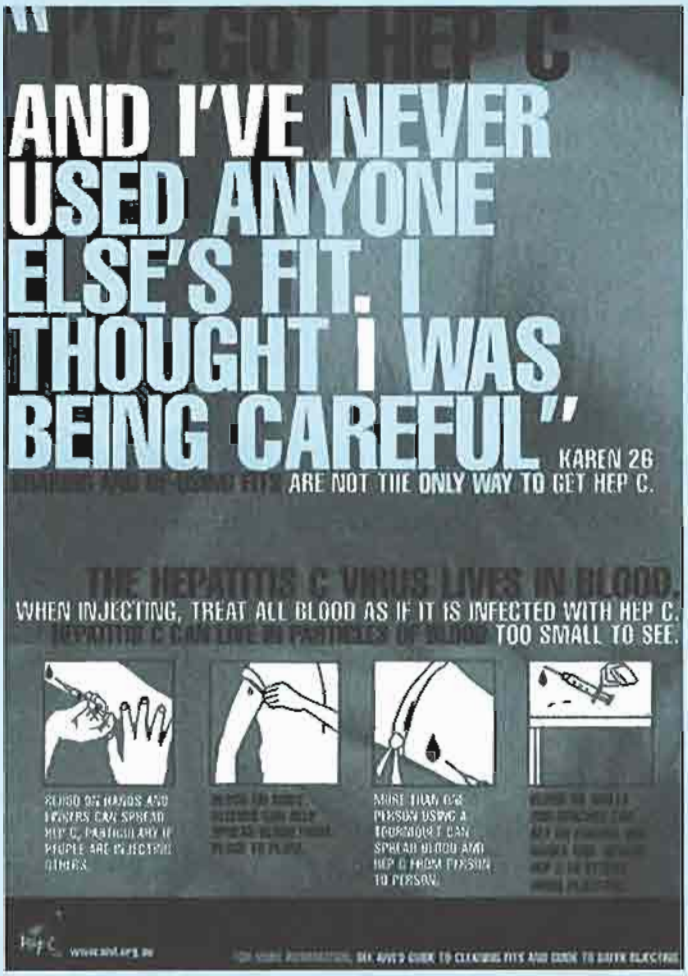
Independent evaluation four months after the campaign found that 180 000 flyers and 115 000 cards were distributed through the coffee shops. Seventy-five percent of coffee shop visitors surveyed had read the flyer and rated the information as useful, and over half the young people surveyed reported speaking to others about the issues raised in the campaign. In the first month of the campaign the number of calls to the Drugs Info Line rose from its monthly average of 2000 to 10 177.

Case study 2: Australia: national hepatitis C education and prevention campaign

Background

Research in Australia in 1997 indicated that some 200 000 people carried hepatitis C with a further 11 000 being infected annually. The epidemic is mainly confined to injecting drug users, whose total population in Australia—and therefore the potential for transmission—was estimated in 1997 at 100 000 regular users and 250 000 occasional users. In 1999, Convenience Advertising was selected to develop and implement a national education and prevention campaign in collaboration with the (NGO) AIVL and the Australian Commonwealth Department of Health and Aged Care.

Figure 7.2 Hep C messages



1: Hep C A4 message

Hep C
temporary tattoo

Liver First
booklet

Hep C
stress ball

The campaign

Following rigorous focus testing, eight key A4-sized messages were developed to inform/target IV users in the following eight key areas:

1 awareness of prevalence of hep C;
2 safer injecting methods;
3 cleaning fits (syringes);
4 nutrition information for hep C positive users;
5 dangers of re-infection with the same or different hep C strains;
6 tattooing and piercing as modes of hep C transmission;
7 problems faced when injecting in cars; and
8 problems faced when injecting in public toilets.

Nationwide, these were placed at 382 display points (e.g. near hand dryers in toilets) in 157 venues such as youth refuges, syringe exchange programs, tattoo parlours, and public toilets, all locations which stakeholders and direct in-field feedback indicated as target-appropriate. Messages were supplemented by 'message triggers', such as specially designed temporary tattoos, stress balls, and matchbooks aimed at providing a positive identification of and with the campaign. Discreet take-away cards providing more detailed information and advice contacts were also distributed to venues.

Outcomes

Through questionnaires provided to target group members, subsequent independent evaluation of the campaign determined an overall poster recall rate well above 80%, and a 50%-plus actual message content recall rate. Research also indicated that a large majority of respondents found the information in the posters and cards to be useful.

audience, in a way that is situationally relevant, specific, and culturally and linguistically sensitive. A further advantage of using narrowcast strategies is to directly inform qualitative and quantitative evaluation objectives.

Further reading

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World Health Organization, GPA, CNP & EVA 1992, *Workshop for Developing Interventions for Preventing Sexual Transmission: Group 1: Identification of Priority Target Groups*, WHO, Geneva.

Useful website

Convenience Advertising: <http://www.conads.com/>.

Profile of Convenience Advertising

Convenience Advertising is an Advertising Federation of Australia (AFA) accredited public health communications agency that has pioneered and perfected the use of narrowcast media over 26 years. The Convenience Advertising narrowcast method involves the dissemination of strategically planned public health communications programs through the placement of printed messages in public conveniences.

Since 1984, Convenience Advertising has worked with various Australian Governments, including the federal government, state and local governments for the display of public health campaigns including road safety, sexual health and drug and alcohol initiatives that aim to raise awareness and reduce harm.

More than 100 independent evaluations have been conducted on the Convenience Advertising narrowcast method and campaigns. The evaluations have shown that strategically implemented and culturally relevant campaigns have the greatest cut-through with unprompted recall rates exceeding 70 per cent.

One particular evaluation, conducted on behalf of the Commonwealth Department of Health and Human Services for a Chlamydia awareness program recorded an unprompted recall rate of 85 per cent. Moreover, the program, which directed young people to the DHS website and urged young people to get tested for Chlamydia was associated with an average increase of 42 per cent for all Medicare claims for Chlamydia testing amongst the 18-39 year old age group.

The strategy of placing materials in public conveniences allows for messages to reach the intended target audience in these private confines where dwell times are high and messages are more likely to be comprehended by the audience. This strategy is usually adopted in response to the high unprompted recall rates recorded by the Convenience Advertising medium.

The **narrowcast** method allows for communication programs to be implemented in locus of engagement and risk venues (including shopping centres, accommodation venues, sports centres, airports, licensed venues etc) by way of gender skew, demographic information area and lifestyle.

Problem Gambling Awareness Campaign Poster Evaluation

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Contents

Executive Summary

The problem gambling awareness campaign, developed by the Department of Health and Human Services in Tasmania through the Gambling Support Program was very well received by the public and there appears to be a broad level of community concern, suggesting not just those who meet the problem gambling criteria (or their families) are concerned about the effects of gambling. The results of the evaluation found:

- There was high campaign visibility, with 88.7% of respondents stating that they remembered seeing the posters. This compares significantly to other media such as TV advertising where recall is typically 59% (Carroll Media, 2010).
- There was also a high level of specific recall, with all of these respondents able to recall the main message of the poster(s) without being prompted. Most participants could identify at least two main messages.
- Having seen the posters, a sizeable proportion of respondents reported that they themselves would talk to their friend(s) or family member(s) about gambling, and high knowledge indicated that they have the information and resources required to follow through with this (those surveyed were generally very aware of problem gambling support services in Tasmania).
- Interviewees were very likely to have remembered and described the posters in a positive fashion, although men were found to be significantly more likely than women to have ambivalent feelings about the posters (although they very rarely actively disliked them). Despite this, young males were equally likely to have seen, understood, and remembered both the posters themselves, and the information within them.
- Nearly half of those surveyed found these posters relevant to them or someone that they know, which is particularly interesting given the significantly smaller estimated proportion of Tasmanian residents directly or indirectly affected by problem gambling. It is therefore likely that a significant proportion of people who saw the poster(s) believed that they were relevant to them *despite* not being

a moderate risk or problem gambler, as well as not knowing anybody who fits into either of these categories.

- These results strongly indicate community support for a campaign such as this – even from people who are not, themselves, problem gamblers.

Introduction

The 2007 prevalence survey that comprises part of the Social and Economic Impact Study into Gambling in Tasmania 2008 (SEIS) determined the prevalence of people experiencing gambling-related problems or who might be at risk of experiencing such problems. The SEIS survey found that 0.86% of the adult population in Tasmania are in the moderate risk group, and a small proportion of the population (0.54%) are experiencing problems due to gambling and fall into the problem gambling group. This equates to 3,113 and 1,955 Tasmanian adults respectively. The total number of moderate risk plus problems gamblers is 1.4% of the adult Tasmanian population, equating to 5,068 Tasmanians. It is important to note that the Productivity Commission (1999) estimates that for every problem gambler, between five to 10 other people are adversely impacted.

The problem gambling awareness campaign, launched in August 2010 by the Gambling Support Program in Tasmania, aimed to raise awareness of the Break Even services and to encourage problem gamblers and their significant others to contact the Break Even and other sign-posted services for counselling, referral and information. It achieved this by working with Convenience Advertising to place a variety of advertisements in easy-to-see locations in gaming (pokie) and community venues. The advertisements included 28 A4 posters with 12 accompanying card holders and take away information pamphlets that were installed in the bathroom facilities of targeted venues in the target area. This pilot program was conducted in George Town in Tasmania, and this evaluation is being conducted to assess the impact of the posters on the venue patrons, as well as their behaviours after seeing the posters.

A draft questionnaire was developed by the Department, Convenience Advertising and refined by the Centre for Health Initiatives at the University of Wollongong (UOW) (see Appendix A). The survey contained a short demographic section; questions to determine recall and recognition of the advertisements placed by Convenience Advertising; and questions about the main messages, their relevance and

appropriateness. The survey also asked about behaviours such as seeking help (for problem gamblers), talking to friends and family about problem gambling habits, visiting the gambling helpline website and calling the 24/7 gambling hotline in Tasmania. Finally, elements of the Health Belief Model (HBM) were explored through questions about whether or not the messages were relevant to them or someone they knew, and whether participants would seek further information for themselves or a friend. The HBM is most commonly used to explain behaviour change and as a framework for behaviour change programs (Janz *et al.*, 2002) and can be used to predict the likelihood of an individual (or a targeted group) changing health-related behaviours based on the interaction between the following four factors:

- *Perceived susceptibility*: a person's perception of their own risk of contracting a health problem;
- *Perceived severity*: a person's perception of the seriousness of the health problem, including the negative consequences that may occur as a result of the health problem;
- *Perceived benefits*: a person's perception of how effectively a new behaviour will reduce the susceptibility and severity; and
- *Perceived barriers*: a person's perception of the difficulties and costs involved in adopting the new behaviour.

Results

Interview Details

Surveys were collected from the following gaming venues and restaurants in George Town, Tasmania:

- The Pier Hotel (gaming venue)
- The George Town Heritage Hotel (gaming venue)
- The Motor Inn (gaming venue)
- Signal Station Tavern (gaming venue)
- George Town RSLA (gaming venue)
- Cove Bar and Restaurant (community venue)

Respondents

A total of 151 respondents were surveyed; they were asked if they had seen any posters on the walls of toilets (or anywhere else) and 134 stated they had seen the posters recently. Of the remaining 17 respondents, two did not answer the question and 15 stated that they had not seen the posters. These 15 respondents were then asked if they had seen any other types of advertisements or media regarding problem gambling, and all 15 respondents had viewed information on television, 14 had heard information on radio and 8 had seen messages on posters. These advertisements were most frequently seen within the previous month.

The 134 participants who had seen the current campaign material continued with the next section of the survey. When asked what the main message of the campaign was, 39 respondents could confidently recall the messages from the campaign but did not complete the remainder of the survey (see *main message of the posters* for all 134 responses). Thus a total of 95 people clearly identified the posters and completed the survey.

Demographics

Of the 95 adults who completed the entire survey, gender was evenly balanced (48 males and 46 females) and there was a relatively even spread throughout the five age groups with the highest proportion of respondents aged 25-34 (28.4%) and the lowest proportion aged 35-44 and 55 and older (16.8% each).

Table 1: Demographics

Sex	**Freq**	**%**
Male	48	50.5
Female	46	48.4
No response	1	1.1
Age (years)	**Freq**	**%**
18-24	19	20.0
25-34	27	28.4
35-44	16	16.8
45-54	17	17.9
55+	16	16.8

Main message of the posters

Of the 151 people approached by the interviewers, 134 could recall (without prompts) seeing the problem gambling campaign in George Town which equates to 88.7% of participants. This is an extremely high recall rate compared to other social marketing campaigns such as a Chlamydia awareness campaign in 2004 where the unprompted recall was only 56% (Chen et al, 2007) and the equivalent Victorian problem gambling campaign which scored a 61% unprompted recall rate in 2005 (Mugford, 2005) .

When asked what they thought was the main message of the campaign was, 82.1% of people identified 'Gambling', 78.4% stated '0 Credits' (one of the main campaign taglines; see Figure 1) and 74.6% said that the main message was about 'losing money'

(respondents were able to nominate more than one main message). In addition, almost half of the sample mentioned the takeaway cards (49.2%). A smaller, but still notable, proportion of the sample mentioned the 1800 phone number (18.7%), helping friends or family who have problems with gambling (18.7%), and access to the website (www.gamblinghelponline.org.au) (13.4%). Table 2 outlines all responses to this question.

Figure 1: Posters from the problem gambling campaign

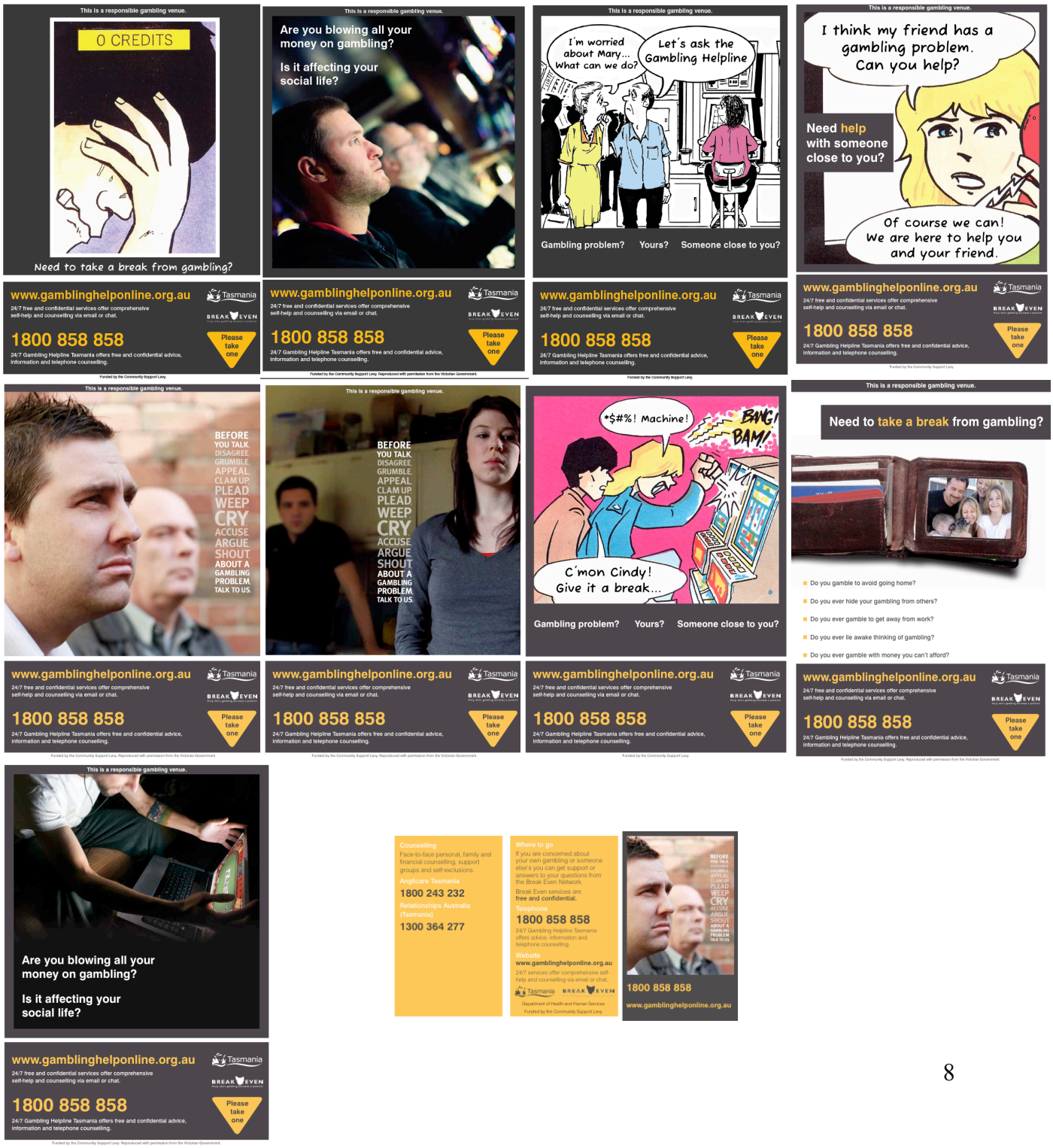


Table 2: Main message of the posters

Message	Freq	%
0 Credits	110	82.1
Gambling	105	78.4
Losing money	100	74.6
Online gambling	79	59.0
Please Take One/Cards	66	49.2
Emotional responses	58	43.3
Government messages	47	35.1
1800 number	25	18.7
Helping your friends and family who have problems with gambling	25	18.7
www.gamblinghelponline.org.au	18	13.4

Interpretation of perceived main messages of the campaign was very accurate, with the three most common responses including 0 credits, gambling and losing money. Importantly, all 134 people were able to identify at least one of these three main messages, which shows that the messages in the campaign were being clearly presented to the general public and that they were able to understand each message. Even more encouraging was that all but two of the respondents were able to give more than one response. Furthermore nearly half of people reported an 'emotional response' to the ads, highlighting that all respondents were able to recall the key messages.

Reactions to the poster

Interviewees were asked to describe their thoughts and feelings about the posters through an open ended question. Responses were coded thematically into positive (64.2%), neutral (26.3%), and negative groupings (9.5%; Table 3), and over 90% of respondents either had a positive or neutral reaction, indicating that the posters were well received and that people were paying considerable attention to them. Positive responses included 'excellent', 'fabulous advertising' and 'good idea I reckon', while

examples of negative answers were 'I didn't really like them' and 'I didn't like them'. Neutral or no reaction responses were often 'I didn't really have a reaction'. A more complete list of responses can be seen in Table 4.

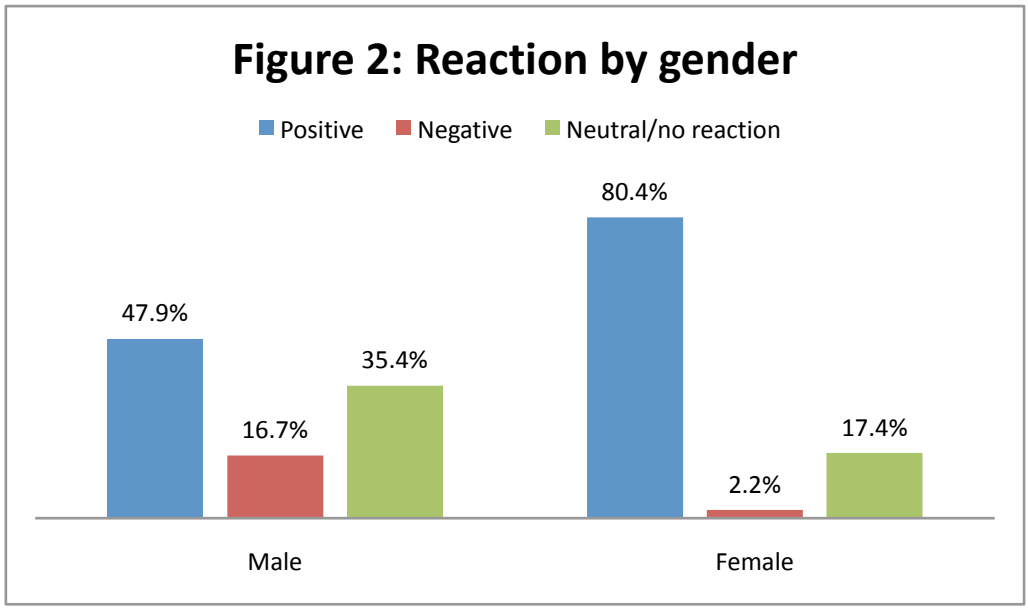
Table 3: Respondents reactions towards the posters

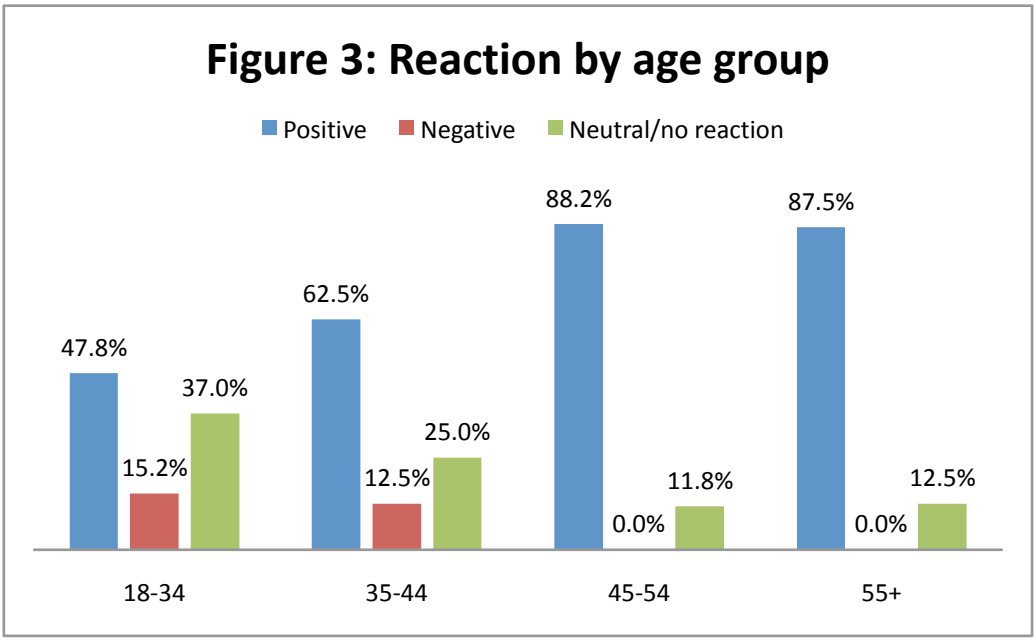
Reactions	**Freq**	**%**
Positive	61	64.2
Neutral	25	26.3
Negative	9	9.5
Total	**95**	**100.0**

Women were more likely than men to react positively to the posters (χ^2 (3, n=78) = 13.243, p = .002) and conversely, more men than women were unsure, indicating that more women than men formed a definite opinion of the posters. Furthermore, significant differences were found between age groups (χ^2 (9, n=79) = 20.284, p = .015) with individuals 35 years and over more frequently reporting positive reactions to the advertisements (n = 31; 66.0%; Figure 3).

Table 4: Typical responses from participants about the posters

Positive	Neutral	Negative
Should do more advertising like this	No reaction	Didn't really understand them
Fabulous advertising	I didn't really know what to think	I didn't really like them
I thought there must be something more we can do	I didn't really have a reaction	Didn't go for them much
Maybe people can be helped because of this	Didn't have a reaction but they were ok	Didn't really go much on them
Very good advertising	I honestly don't know	They didn't appeal to me
Good idea I reckon	Unsure what to think	Well, I didn't really like them
Thought it was a great idea	Didn't have a reaction.	I didn't like them
An excellent idea	Didn't think anything	Thought they were a bit strange
I thought it was a wonderful idea		





Relevance of posters

Almost half (46.3%) of the respondents indicated that the posters were personally relevant, or relevant to someone they know (Table 4); this differed significantly between males and females (χ^2 (3, n=94) = 9.832, p = .009), with men (68.7%) more likely to find the posters relevant than women (39.0%). This is a surprising result considering that less than 1.0% of people in Tasmania are classified as problem

gamblers. Further to this if the Productivity Commission (1999) estimates that for every problem gambler, between five to 10 other people are adversely impacted, then in our sample of 95, we would expect to find about 8.6% or 8 participants to find the poster relevant to them or someone that they knew. Our findings show that 46.3% of people find the material relevant and highlights that the campaign materials are very effective in making people more aware of the personal significance of gambling. This is perhaps the most important finding of the evaluation, even allowing that George Town is known to have extremely high gambling expenditure.

Table 5: Relevance of posters

Relevant	**Freq**	**%**
Yes	44	46.3
No	45	47.4
Prefer not to say	6	6.3
Total	**95**	**100.0**

Respondents who did not think the messages were relevant to them primarily gave the reason that they did not gamble or know any one that had a problem with gambling. The fact that they were still able to recall the campaign messages, however, means that it is likely to be top-of-mind if they later experience or see this behaviour.

Intended target Audience

Respondents were asked to identify who they thought the posters were aimed at and correctly identified gamblers or problem gamblers (48.4%) as the main target, followed by the general public (31.6%). This shows that the messages in the posters were clear and easy for respondents to understand which importantly allowed them to make the link to the target group. It also highlights that there is a broader level of concern with gambling than just those meeting the defined definition of problem gambling and that the community may be ready for an intervention.

Table 6: Perceived target group of the campaign

Target Group	**Freq**	**%**
Gamblers/Problem Gamblers	46	48.4
General Public	36	37.9
Not sure	13	13.7
Total	**95**	**100.0**

Both males and females could correctly identify gamblers as the target group however females were more likely to state that the campaign was aimed at the public (52.2% vs 25.0%; (χ^2 (3, n=95) = 13.471, p = .004).

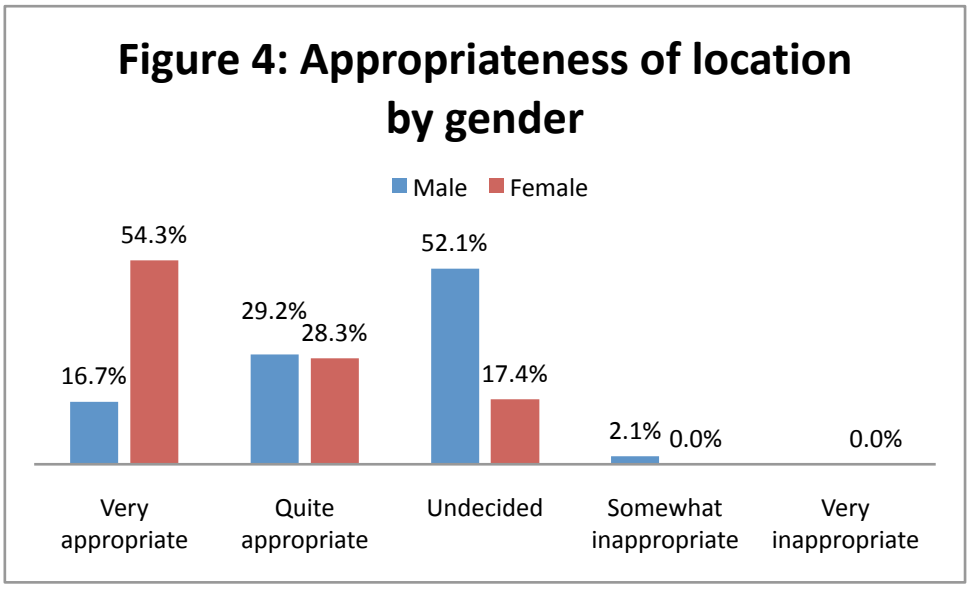
Perceived appropriateness of dissemination location

Nearly two thirds of respondents (n = 95, 64.2%) thought that it was very appropriate or quite appropriate to display this kind of information in the bathroom environment (Table 7). Approximately one third (34.7%) were undecided, while only one respondent said that it was an inappropriate location.

Table 7: Appropriateness of venue

Appropriateness	**Freq**	**%**
Very Appropriate	34	35.8
Quite Appropriate	27	28.4
Undecided	33	34.7
Somewhat Inappropriate	1	1.1
Very Inappropriate	0	0.0
Total	**95**	**100.0**

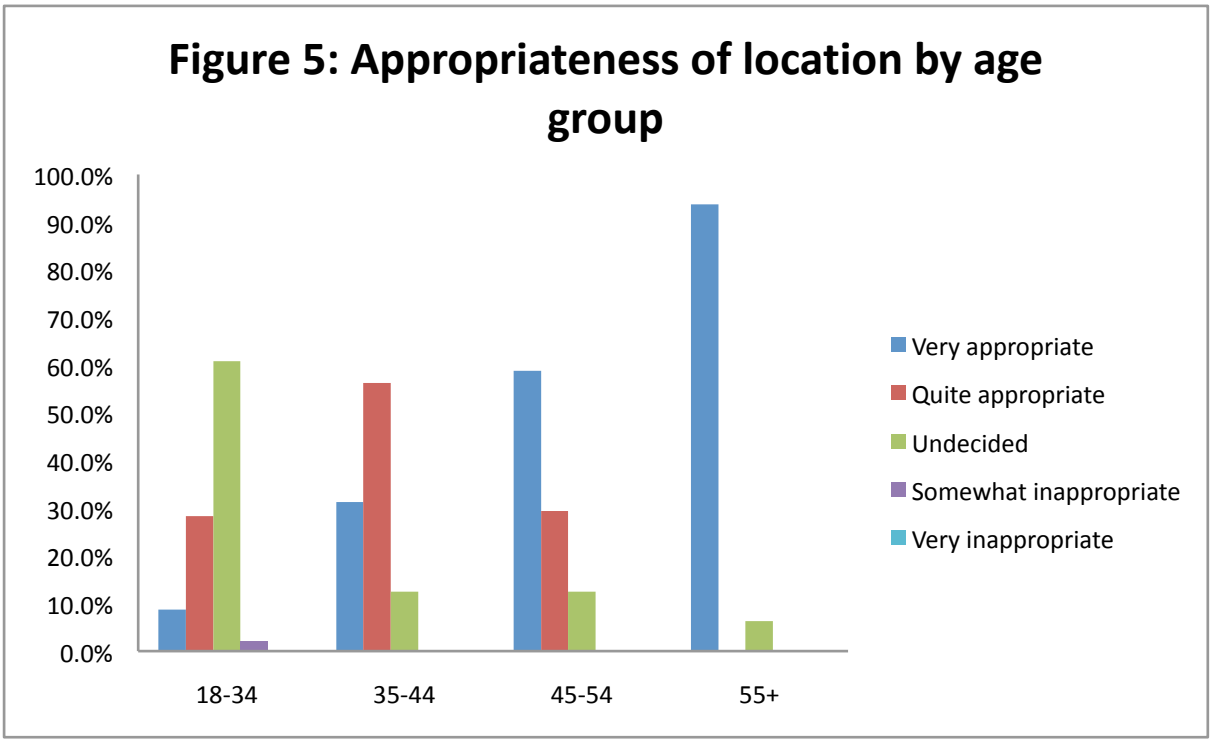
The degree of appropriateness of the bathroom as a venue for this information to be displayed differed significantly between males and females (χ^2 (2, n=94) = 13.988, p = .001; see Figure 4). A higher proportion of women than men thought that the location was appropriate; males were more likely to be undecided on the appropriateness of the location (52.1%).



The perceived appropriateness of the bathroom as an advert location also differed significantly between age groups (χ^2 (6, n=95) = 29.082, p = 0.000). Individuals under 35 years of age were more likely to be undecided than other age groups (n = 28; 61.0% of the age group) about the appropriateness of the venue, whilst individuals 45 years and over most commonly supported this location (n = 30; 91.0% of the age group; Table 8).

Table 8: Appropriateness and age group

	Age group (years)				Total
	18 - 34	35 - 44	45 - 54	55+	
Very Appropriate	4	5	10	15	**34**
Quite Appropriate	13	9	5	0	**27**
Undecided	28	2	2	1	**33**
Inappropriate	1	0	0	0	**1**
Total	**46**	**16**	**17**	**16**	**95**



Actions and intentions

Of the 95 respondents who could recall the specific campaign message, 44 (46.3%) reported the posters as being relevant to themselves or someone they know, while just over a quarter (26.3%) of all participants who had seen the posters reported that they

had since thought about their gambling habits or those of someone they know which, when considered alongside the number of people who found the posters relevant, is noteworthy. That is, based on these previous findings, one would not expect any more than 46.3% of this sample to have "thought about their gambling or thought about someone else's gambling", given that problem gambling is neither relevant to them, nor anyone that they know. Finally, the likelihood of thinking about gambling or about someone else's gambling was not significantly different between gender and age groups.

Considering taking action about gambling habits

Table 9: Actions considered since seeing the poster

	Yes		No	
Actions considered	**Freq**	**%**	**Freq**	**%**
Seeking help for problem gambling	0	0.0	44	100.0
Talking to your friend(s) and family about gambling	19	43.1	26	59.9
www.gamblinghelponline.org.au	0	0.0	44	100.0
Calling the 1800 number	0	0.0	44	100.0

In regards to respondents considering taking action after seeing these posters (n=44), 19 respondents stated that they would *talk to their friend(s) and family about gambling* (Table 9).

Taking action about gambling habits

Of the 25 respondents who had thought about taking action, 7 had *taken action* on their gambling or the gambling of someone close to them after seeing the posters (Table 8). Participants who explained what actions they had taken (*n* = 7), either spoke with family or friends (n=5) or had thought about their own gambling habits (n=2). This

finding is very positive considering that less than 1% of the population in Tasmania are classified as problem gamblers.

Table 10: Action taken since seeing poster

Taken action	**Freq**
No	18
Yes	7
Total	**44**

Other media relating to problem gambling

Participants were then asked if they had seen an advertisement or message about problem gambling in any other location (they were able to cite several other locations). Besides the poster in the venue toilets, the most commonly cited was "a poster in another venue" (n = 78; 82.1%), indicating that people who gamble tend to move around between gambling venues, and not just gamble at one exclusively. Television (n = 52; 54.7%) and radio (n = 12; 12.6%) were also commonly cited, while health newsletters received in the mail or internet were each stated by one participant. Significantly more males than females had heard information on the radio (t (92) = 5.61, p = .02), but no other gender differences were evident.

Table 11: Location of other media relating to problem gambling

Location (n = 93)	**Freq**	**% of cases**
Poster in another venue	78	82.1
Television	52	54.7
Radio	12	12.6
Newsletter or Internet	2	2.2

Hearing the information on radio differed significantly between age groups (F(3,94) = 3.691, MSE = .379, p < .05). Post-hoc Tukey's HSD tests showed that individuals over 55 years were significantly more likely to hear a message on the radio than individuals

aged between 18 and 34 years. All other comparisons for seeing posters and television commercials by age and gender were not significant.

Most exposure to other messages about problem gambling occurred during the previous week (67.3%); followed by within the previous month (20.0%; Table 12). One respondent did not recall having ever seen media relating to problem gambling, whilst nine participants stated they were unsure. Recollection of previous exposure did not differ significantly between gender or age group.

Table 12: When did you see other advertisements or messages about gambling?

When	Freq	%
Less than 2 days ago	29	30.5
Less than 1 week	35	36.8
1 – 2 weeks ago	8	8.4
2 – 4 weeks ago	6	6.3
More than 4 weeks	5	5.3
Unsure	12	12.6
Total	**95**	**100.0**

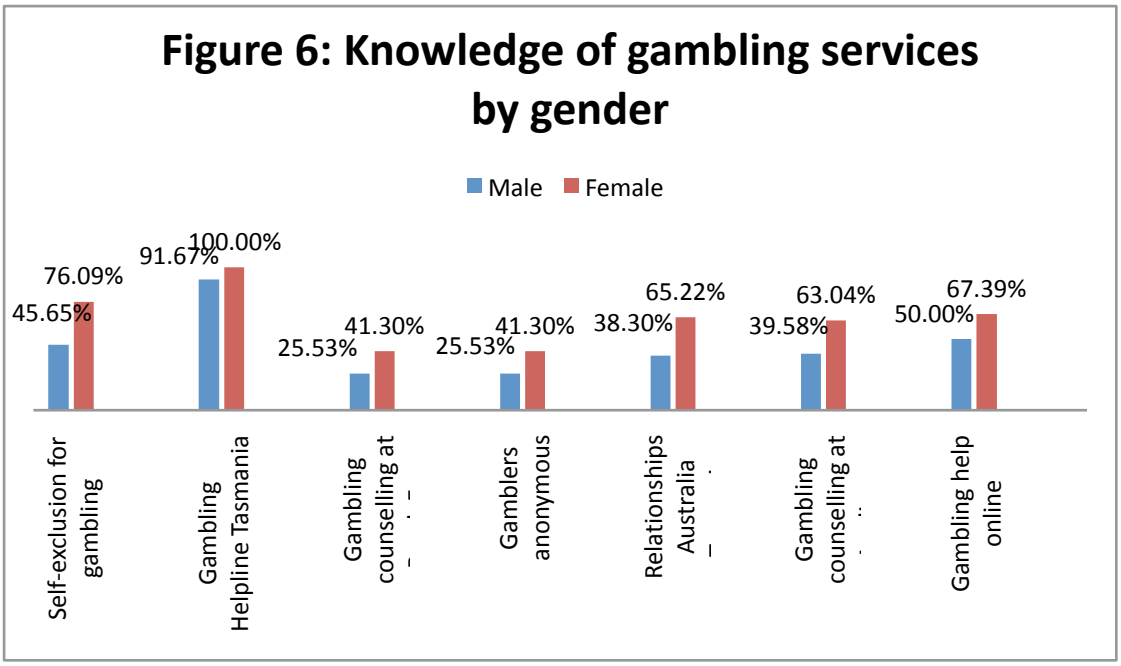
Knowledge of gambling support services

There were 360 responses from 92 participants regarding knowledge of various gambling support groups (participants were able to give more than one response; Table 13). Almost all of these participants knew of the Gambling Helpline Tasmania (95.8%). Over half of respondents had heard of self-exclusion (58.9%), gambling help online (57.9%), Relationships Australia Tasmania and services at Anglicare Tasmania (50.5% each).

Table 13: Knowledge of gambling support services

Service	**Freq**	**%** of cases
Gambling Helpline Tasmania	91	95.8
Self-exclusion	56	58.9
Gambling help online	55	57.9
Relationships Australia Tasmania	48	50.5
Counselling at Anglicare Tasmania	48	50.5
Counselling at Break Even	31	32.6
Gamblers Anonymous	31	32.6
Total	**360**	**-**

Across all gambling services, females were more likely than males to report knowledge of the service. Specifically, significant gender differences were apparent for knowledge of Gambling Helpline Tasmania ($t(92) = 2.023$, $p = .046$), knowledge of self-exclusion ($t(91) = 3.231$, $p = .002$), knowledge of Relationships Australia Tasmania ($t(91) = 2.668$, $p = .009$), and, finally, knowledge of gambling counselling at Anglicare Tasmania ($t(92) = 2.315$, $p = .023$).



The majority of individuals (93.6%) felt that they would use the above gambling support services if they thought they needed to. Although males were slightly less likely than females to report that they would use services (89.6% to 98.8%, respectively), this gender difference was not significant. Table 14 highlights what services respondents said they would use, with Gambling Helpline Tasmania gaining the biggest response (n=87, 91.6%).

Table 14: What services would participants use?

Service	**Freq**	**% of cases**
Gambling Helpline Tasmania	87	91.6
Self-exclusion	56	58.9
Gambling help online	56	58.9
Gamblers Anonymous	54	56.8
Relationships Australia Tasmania	46	48.4
Counselling at Anglicare Tasmania	48	50.5
Counselling at Break Even	29	30.5
Total	**376**	**-**

Recommending support services

The majority (96.8%) of participants would recommend these services to a friend or family member who they felt needed support (Table 15).

Table 15: Would you recommend these services to a friend or family member who you felt needed it?

Recommend?	**Freq**	**%**
Yes	92	96.8
No	3	3.2
Total	**95**	**100.0**

Gambling Helpline Tasmania was the most likely to be recommended (*n* = 90, 94.7%), followed by gambling helpline online (*n* = 57, 60.0%), self-exclusion for gambling (*n* = 57, 60.0%), and Gamblers Anonymous (*n* = 55, 57.9%). Up to half of the respondents would recommend the remaining services. Ninety four of the 95 participants correctly identified what 'self-exclusion' is.

Table 16: Which services would you recommend?

Service (N = 95)	**Yes (n)**	**%**
Gambling Helpline Tasmania	90	94.7
Gambling help online	57	60.0
Self-exclusion for gambling	57	60.0
Gamblers Anonymous	55	57.9
Anglicare Tasmania	49	51.6
Relationships Australia Tas	47	49.5
Break Even Services	30	31.6

Online gambling

The majority of participants (*n* = 61, 64.2%) had not gambled on the internet (for money or otherwise) in the previous three months, while just over one-third (*n* = 34, 35.8%) had done so. For those who *had* gambled online, online poker was the game most frequently played during the three months prior to the survey (*n* = 25), followed by virtual pokies and Keno (*n* = 19 for each), lotteries and blackjack (*n* = 18 for each). Fewer than 10 respondents played any other online gambling game in the three months prior to survey.

Table 17: What type of game/activity(ies) did you play online?

Activity (n= 34)	**Yes (n)**
Poker	25
Virtual Pokies	19
Keno	19
Lotteries	18
Blackjack	18
Racing	9
Sports betting	8
Bingo	8
Baccarat/roulette/outcomes	8

Favourite activity or game

Seven of the 33 participants who answered said that their favourite online game or activity was nominated Poker. Virtual pokies (*n* = 5, 5.3%), Keno, Sports betting and Bingo (*n* = 4, 4.2%, each) were the next favourite activities.

Table 18: What is your favourite online gambling game or activity?

Activity	**Freq**
Poker	7
Virtual pokies	5
Keno	4
Sports betting	4
Bingo	4
Lotteries	3
Racing	2
Blackjack	2
All	2
Total	**33**

Frequency of online gambling

All respondents who reported gambling in the last three months also stated that they had done so within the last month, and more often than not within the last fortnight, indicating that those who do gamble online do so reasonably frequently, rather than irregularly.

Table 19: How often have you gambled online in the last three months?

Frequency (N = 34)	**Yes (n)**
At least once a week	18
At least once a fortnight	12
At least once a month	5

Duration of online gambling sessions

Respondents that gambled at least once a week (n=18) were asked how long their online gambling sessions usually last for. Half reported spending 1-2 hours per gambling session, with a further seven spending more than two hours gambling online per session.

Table 20: How long do most of your online gambling sessions last for?

Duration (n = 18)	**Yes (n)**
Less than one hour	2
1 to 2 hours	9
2 to 3 hours	6
More than 3 hours	1

Online gambling and money

When asked if participants returned to gambling in order to win back any money they had lost to previous online gambling, all respondents stated that they had done this in the past. Specifically, the majority reported 'sometimes' returning to win back money, four reported doing this most of the time and two reported always doing this.

Table 21: In the last three months how often have gambled another day to try to win back the money you lost?

Frequency	**Yes (n)**
Sometimes	12
Most of the time	4
Almost always	2
Total	**18**

Findings based on these final two questions (regarding frequency of online gambling and returning to win money back) are difficult to generalise, however, this figure must

be interpreted within the wider context of the total number of adults surveyed as part of this pilot study. In fact, it is fair to say, therefore, that if trends noted in this pilot study are found to be consistent across the entire state, the problem of online gambling is unfortunately much greater than currently estimated (for example, online gambling is currently estimated as being responsible for less than 10% of Tasmania's gambling revenue[1]), especially given that a substantial proportion of this sample (18.9% to be exact) participated in online gambling at least weekly (16 of these for at least one hour per session), and ***all*** reported returning to gambling at some stage to win back losses.

[1] Australian Government Productivity Commission - Gambling Enquiry Report (found at http://www.pc.gov.au/projects/inquiry/gambling-2009/report)

Conclusion

Overall, this campaign was very well received by the public, who had excellent levels of recall, in excess of what would be expected from a campaign such as this, based on previous campaign evaluations. In addition, almost all adults surveyed were able to recall more than one main message from within the poster(s).

Several questions based on the HBM were included in this survey in order to predict the likelihood of an individual (or the target group – problem gamblers) changing health-related behaviours based on the interaction between perceived benefits of and barriers to seeking help for problem gambling, as well as talking to friends and family about getting help. In line with this, having seen the posters, a sizeable proportion of respondents reportedly that they themselves would talk to their friend(s) or family member(s) about gambling. Those surveyed were generally very aware of problem gambling support services in Tasmania, indicating that they have the information and resources required to follow through with this.

Interviewees were very likely to have remembered and described the posters in a positive fashion, with less than 10% of the sample having a negative opinion of them, although men were found to be significantly more likely to have ambivalent feelings about the posters (although they very rarely actively disliked them). Given that young males were least receptive to the posters, an alternate method and/or venue could be investigated to target this group, although it is very positive that young males were equally likely to have seen, understood, and remembered both the posters themselves, and the information within them.

Crucial, however, was the finding that nearly half of those surveyed found these posters relevant to them or someone that they know, which is particularly interesting given the significantly smaller estimated proportion of Tasmanian residents directly or indirectly affected by problem gambling, as discussed previously. These findings could, therefore, reinforce our understanding that, among this sample, problem gambling is a more prominent issue than it is among the remainder of the Tasmanian population or,

considerably more likely, that a significant proportion of people who saw the poster(s) believed that they were relevant to them *despite* not being a moderate risk or problem gambler, as well as not knowing anybody who fits into either of these categories. In addition, over one-third of the respondents believed that this campaign was targeted at the community in general, rather than only at gamblers or even problem gamblers. Together, these results strongly indicate community support for a campaign such as this – even from people who are not, themselves, problem gamblers.

Appendix A: Survey

Department of Health and Human Services Tasmania
Evaluation Questionnaire

Preamble
Excuse me, I wonder if you could help with some research we are doing? It will only take a few minutes of your time.

My name is _____and I'm carrying out a project on behalf of the Department of Health and Human Services to assess some health messages placed in this venue.

The information you give me will help determine the success of the messages and will be given in complete confidence and will be recorded anonymously. Your answers will help develop better health messages in the future.

Age (Please Circle)

18-24 25-34 35-44 45-54 55+

Gender (Please Circle

Male Female

If you have used the toilet facilities here this week, did you see any posters on the walls or anywhere else?

Yes No

Go to Question 1 Terminate Interview

DO NOT INCLUDE IN SAMPLE – ASK QUESTIONS BELOW ONLY

When did you last see or hear an advertisement or message about problem gambling?

_____

Where did you see this advertisement or health message?

i) Television advertisement	Y 1	N 2
ii) Radio	Y 1	N 2
iii) Poster in another venue	Y 1	N 2
iv) Health Newsletter in the mail	Y 1	N 2
v) Comics	Y 1	N 2
vi) Other (please specify) _____	Y 1	N 2

Q.1 What was the main message(s) presented in the poster? Circle all responses made (note: wording need not be identical)

Gambling 1
Helping your friends and family who have problems with gambling 2
Please Take One/Cards 3
Government Message 4
Online Gambling 5

Emotional Responses 6
0 Credits 7
Losing Money 8
gamblinghelponline.org.au 9
1800 number 10
Other 11 Please Specify: _____
Don't Know 12 - Why? _____ go to question 1a

Q.1a The posters are about problem gambling, do you remember them now?

Yes

No (Terminate Interview-DO NOT INCLUDE IN SAMPLE

Q.2 What was your reaction to the poster/s?

_____

_____

Q.3 Do you think the messages are relevant to you or someone you know? Why or why not?

_____

_____

Q.4 Who do you think the messages are aimed at?

_____

_____

Q.5 How appropriate do you think it is to display this kind of health information in the toilet facilities?

Very appropriate 1
Quite appropriate 2
Undecided 3
Somewhat inappropriate 4
Very inappropriate 5

Q.6 Since you saw this poster, has it made you think about your gambling or think about someone else's gambling?

Yes 1 go to question 6a
No 2 go to question 7

Q.6a Since you saw this poster have you considered:

i) Seeking help for problem gambling	Y 1	N 2
ii) Talking to your friend(s) and family about gambling	Y 1	N 2
iii) Visiting the gamblinghelponline website	Y 1	N 2
iv) Calling the 1800 number	Y 1	N 2

Q.6b Since you saw this poster, have you taken any action on your gambling or the gambling of someone close to you?

Yes 1 go to question 6c
No 2 go to question 7

Q.6c What course of action did you take?

_____

_____

Q.7 Besides the posters in the toilets, approximately when did you last see or hear an advertisement or message about problem gambling?

_____

_____

Q.7a Where did you see this advertisement or health message?

i) Television advertisement	Y 1	N 2
ii) Radio	Y 1	N 2
iii) Poster in another venue	Y 1	N 2
iv) Health Newsletter in the mail	Y 1	N 2
v) Comics	Y 1	N 2
vi) Other (please specify) _____	Y 1	N 2

Q.8 Which of the following gambling support services have you heard of?

i) Self-exclusion for gambling	Y 1	N 2
ii) Gambling Helpline Tasmania	Y 1	N 2
iii) Gambling counselling at Break Even Services	Y 1	N 2
iv) Gamblers Anonymous	Y 1	N 2
v) Gambling counselling at Relationships Australia Tasmania	Y 1	N 2
vi) Gambling counselling at Anglicare Tasmania	Y 1	N 2
vii) Gambling help online	Y 1	N 2

Q.8a Would you use any of the above gambling support services if you felt you needed it?

Y 1 N 2

If yes, which services would you use?

i) Self-exclusion for gambling	Y 1	N 2
ii) Gambling Helpline Tasmania	Y 1	N 2
iii) Gambling counselling at Break Even Services	Y 1	N 2
iv) Gamblers Anonymous	Y 1	N 2
v) Gambling counselling at Relationships Australia Tasmania	Y 1	N 2
vi) Gambling counselling at Anglicare Tasmania	Y 1	N 2
vii) Gambling help online	Y 1	N 2

Q.8b Would you recommend any of the above services to a friend or family member who you felt needed it?

Y 1 N 2

If yes, which services would you recommend?

i) Self-exclusion for gambling	Y 1	N 2
ii) Gambling Helpline Tasmania	Y 1	N 2
iii) Gambling counselling at Break Even Services	Y 1	N 2
iv) Gamblers Anonymous	Y 1	N 2
v) Gambling counselling at Relationships Australia Tasmania	Y 1	N 2
vi) Gambling counselling at Anglicare Tasmania	Y 1	N 2
vii) Gambling help online	Y 1	N 2

Q.9 What is self-exclusion? (Circle relevant responses)

i) Self-banning/not being able to go into venues (or similar)

ii) Don't know

iii) Other/not gambling/deciding not to gamble (or similar irrelevant response)

Q.10 Have you gambled on the internet (either for money or no money) in the last three months?

Yes 1 go to question 11

No 2 **Thanks for giving us your time and your input into this research project**

Q.11 What type of game/activity(ies) did you play online?

i) Poker	Y 1	N 2
ii) Blackjack	Y 1	N 2
iii) Baccarat	Y 1	N 2
iv) Roulette	Y 1	N 2
v) Virtual pokies	Y 1	N 2
vi) Racing	Y 1	N 2
vii) Sports betting	Y 1	N 2
ix) Bingo	Y 1	N 2
x) Outcome of events	Y 1	N 2
xi) Lotteries	Y 1	N 2
xii) Keno	Y 1	N 2

Q.11a Which is your favourite online gambling game or activity?

_____

Q.11b How often have you gambled online in the last three months?

i) At least once a week	Y 1	N 2
ii) At least once a fortnight	Y 1	N 2
iii) At least once a month	Y 1	N 2
iv) At least once in the last three months	Y 1	N 2

If yes to question i) above go to question 12. For other responses, Thanks for giving us your time and your input into this research project.

Q12 How long do most of your online gambling sessions last for?

i) Less than 1 hour	Y 1	N 2
ii) Between 1 and 2 hours	Y 1	N 2
iii) Between 2 and 3 hours	Y 1	N 2

iv) More than 3 hours Y 1 N 2

Q13 In the last three months, if you gambled online for money, how often have you gambled another day to try to win back the money you lost?

Never 1
Sometimes 2
Most of the time 3
Almost always 4
Doesn't apply to me 5

Thanks for giving us your time and your input into this research project.