Chapter 4

Taking a broader approach to address problem gambling

4.1 This chapter outlines the rationale for adopting a population health approach.[1] It outlines the harms of high intensity EGMs and shows that these extend to the broader community. It also outlines the evidence pointing to shortcomings with current harm minimisation measures such as self-exclusion and venue-based interventions.

Why a population approach?

4.2 Some witnesses and submittors questioned why a mandatory pre-commitment scheme impacting on all gamblers should be imposed, when the vast majority of gamblers do not experience harms. Merimbula RSL, for example argued:

> Somewhere along the line, people have to take responsibility for their own actions and by all means put measures in place to help the individuals NOT shackle the 99.6% of people that have not got a gambling problem.[2]

4.3 Similarly, the Community Clubs Association of Victoria argued:

> In light of the tremendous improvements in reducing the incidence of problem gambling in the community, advocating full pre-commitment is the policy equivalent of using a sledgehammer to crack a nut. It is inefficient and likely to result in undesirable unintended consequences.[3]

4.4 In contrast, the Productivity Commission argued for the need to move beyond a model focused on problem gamblers but instead take a broader approach:

> As indicated earlier, the commission's proposals are not just focused on problem gamblers but also on those who are at risk and, indeed, the wider consumers who are often misled by gaming machine technology and do not really understand the nature of the machines or how much they are paying to use them. We therefore adopted a much broader framework than a medical perspective—and I know you have had some medical perspectives

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1 There are varying definitions but broadly a population health approach considers the health of the entire population, rather than those already ill or at risk of illness. It emphasises an orientation towards whole groups rather than individuals and complements approaches that seek to treat individuals. It tends to be multi-sectoral and takes into consideration socio-economic as well as clinical factors. Queensland Health, *Understanding population health*, Background Paper, http://www.health.qld.gov.au/phcareers/resources.asp (accessed 15 March 2011).

2 Merimbula RSL Club, *Submission 7*, p. 1.

3 Community Clubs Association of Victoria, *Submission 79*, p. 5.

> in these hearings. Our framework has been a public health and broader consumer policy framework which included the medical perspective as well.[4]

Who is at risk?

4.5 While some 600,000 Australians are estimated to play high intensity EGMs at least weekly, not all of them will develop a gambling problem. The Productivity Commission estimates that around 95,000 of this group are classified as 'problem gamblers' with a further 95,000 described as being at moderate risk of developing a problem.[5] However, the committee notes evidence that described problem gambling associated with EGMs as being a 'continuum of risk'.[6] Some EGM gamblers can move quickly from little or no risk to at risk and on to full addiction.

4.6 Mr Robert Fitzgerald, Commissioner, Productivity Commission, explained that pre-commitment is a measure that will help those at risk as well as those with a gambling problem:

> It is very important that in public policy terms in consumer protection—and the commission has done a number of inquiries in relation to consumer product safety and consumer policy—that one is concerned about not only those that are actually harmed but also those who are at risk of harm. Consumer protection and consumer policy look to the range of harms that may be evident from a particular product or service. We can apply exactly the same logic in relation to this product. Those at the very pointy end of problem gambling where it is a medical condition and requires substantial intervention will be affected in different ways from those that have commenced gambling but are at risk. Our policies look to cover both. The way in which it impacts on different groups and different individuals will naturally vary but the policy suite is geared to those that are at risk, those that are at high risk and those that are problem gambling.[7]

4.7 Dr Ralph Lattimore, Assistant Commissioner, Productivity Commission added:

> The fact is that everybody, problem gamblers and recreational gamblers, tends to underestimate their expenditure. For example, if you go to a New

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4 Mr Gary Banks, Productivity Commission, *Proof Committee Hansard*, 15 February 2011, p. 42.

5 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 5.1. The Commission also estimated the number of Australians classified as problem gamblers was 115,000; with a further 280,000 at moderate risk. See, Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 2.

6 Mr Mark Henley, UnitingCare Wesley Adelaide, *Committee Hansard*, 1 February 2011, p. 44, 48; Associate Professor Linda Hancock, *Submission 64*, p. 10; Dr Jennifer Borrell, *Submission 109*, Attachment 1, p. 3; Productivity Commission, *Australia's Gambling Industries*, vol. 1, Commonwealth of Australia, Canberra, 1999, p. 19, p. 6.18; Associate Professor Linda Hancock, *Proof Committee Hansard*, 2 February 2011, p. 10.

7 Mr Robert Fitzgerald, *Proof Committee Hansard*, 15 February 2011, p. 47.

> South Wales survey from 2006, which is one where you get a closer approximation of total spending, you see that recreational gamblers spend around $700 per year. A low-risk gambler spends about $3,500 a year. A moderate risk gambler spends about $6,600 a year. In this survey, problem gamblers spend $20,600 a year. I do not know whether the numbers would be exact. They would probably all have to be inflated somewhat because everybody underestimates their spending. It would nevertheless give you an idea of the relative magnitudes of spending that you see amongst the different classes of people.[8]

4.8 Professor Malcolm Battersby pointed out that some vulnerable groups in the community are at greatest risk, because high intensity EGMs tend to be located in lower socio-economic areas where they are more likely to reside:

> Another of the points I wanted to highlight which I did not put into my report is this whole issue in relation to at-risk groups of people, like our Indigenous population and our mental health population. We know that for people with current severe mental illnesses and then the Aboriginal population as a whole the problem gambling prevalence rates are much higher than for the general population. They are vulnerable because they are often living in the areas where the pokies are—lower socioeconomic areas—but they also might have problems with concentration, literacy and a general understanding of how the whole machine design works. [9]

The gambling continuum

4.9 As noted in chapter two, the committee heard that research cannot accurately predict who will develop a gambling problem. Dr Mark Zirnsak, Chair, Victorian Interchurch Gambling Taskforce said that as we don't know who might develop a gambling problem, systems need to be developed that assist and protect all gamblers:

> There are some common factors you can talk about in discussing why people develop gambling problems. There are issues of co-morbidity. Mental health issues are often high on that list. One of the issues is that you can never tell who might develop a gambling problem. Ideally, you have systems that assist all gamblers because you cannot know when a person might go on.[10]

4.10 Dr Zirnsak went on to speak about possible triggers for people to develop a gambling problem and how pre-commitment would provide protection for vulnerable people:

> Again, in Victoria the Sarah Hare report, which we would highly commend to you, found that some of the key factors for why people might go on to

8 Dr Ralph Lattimore, *Proof Committee Hansard*, 15 February 2011, p. 51.

9 Professor Malcolm Battersby, *Committee Hansard,* 14 February 2011, p. 56.

10 Dr Mark Zirnsak, Uniting Church in Tasmania and Victoria, *Proof Committee Hansard,* 2 February 2011, p. 22.

> develop gambling problems were things like a relationship break-up, whether it be divorce or some other significant relationship break-up; a death of someone close to them; the loss of a job; getting a payout from an injury at work. All these types of life incidents increase the probability of a person developing a gambling problem. Precommitment, in our view, will provide some tools that hopefully they have used before those life events occurred, and that might help provide some protective factors. Those are the kinds of things that can happen to anybody. Developing depressing [sic] could happen to anyone. You cannot pre-empt. It is not as if someone is stamped: you are going to be a problem gambler for life.[11]

4.11 Associate Professor Linda Hancock also spoke of the triggers that cause people to develop problems with their gambling and how this group is not always static:

> I think the crucial point is that this group is not a static group. People go in and out of the group. Where do you get your regular gamblers from? You get your regular gamblers from your recreational gamblers, so it is not like someone is a problem gambler or at risk and stays there. The point is that this is a system in flux. It has to do with triggers that motivate people to play for risky amounts of time and lose risky amounts of money. Those triggers are often emotional breakdown, loneliness, divorce et cetera. You have raised a really crucial point to understanding the usefulness of precommitment as one plank in a reform strategy because it will help people to not become risky regular gamblers.[12]

4.12 Reverend Brent Lyons-Lee, Victorian Baptist Church Representative, Victorian InterChurch Gambling Taskforce, reinforced the point that in their experience there is no 'typical' problem gambler:

> But the thing that constantly astounds us, and I think you have heard a little bit today, is the people it does affect randomly. Gambling is a stand-alone issue, and that is the thing that continually surprises me. It is not just the homeless people or people we see in dire need. It is actually the everyday mum and dad that you cannot stereotype that are continually the surprise factor.[13]

4.13 Mr Mathew Rowell, Relationships Australia, Tasmania, emphasised to the committee that 'you need to remember that there are recreational gamblers who are also at risk of becoming problem gamblers'.[14]

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11 Dr Mark Zirnsak, *Proof Committee Hansard*, 2 February 2011, p. 22.

12 Associate Professor Linda Hancock, Deakin University, *Proof Committee Hansard*, 2 February 2011, pp 10–11. See also Dr Kerry Chambers, *Proof Committee Hansard*, 25 March 2011, p. 5.

13 Reverend Brent Lyons-Lee, *Proof Committee Hansard*, 2 February 2011, p. 28. See also Dr Kerry Chambers, *Proof Committee Hansard*, 25 March 2011, p. 5, 6.

14 Mr Mathew Rowell, *Proof Committee Hansard*, 18 February 2011, p. 18.

Others harmed

4.14 The Productivity Commission report noted the 'ripple effects' of problem gambling, resulting in harms affecting family members, friends and workplaces.[15] As noted in the previous chapter, the numbers of those afflicted with gambling problems is likely to be under-reported, so estimating the numbers harmed overall is difficult. Mr Denis Fitzgerald, Executive Director, Catholic Social Services Victoria, gave this estimate:

> From memory, seven was the outlier factor, so for every problem gambler there are seven people affected. Gabby very bravely talks about her family and others. Whenever you get in a group of people, everybody knows someone well— someone at work who got into trouble; a cousin. Even if it is not immediate family, it impacts, it ripples through the community.[16]

4.15 All of the problem gamblers the committee spoke to highlighted the harms problem gambling inflicts on others, particularly on family members. Mr Stephen Menadue observed:

> But the people who are suffering the most are—I hate saying it over and over—–the families who do not have dinner and the kid who did not get a Christmas present.[17]

4.16 Ms Julia Kaparthakis, Pokies Anonymous, described some of the impacts on families:

> We have had horrific stories of whole families falling apart. There is one particular person who described their situation as like coming out of jail. They played since they were 17. They played for 14 years. They are only 30 but they are still struggling to relearn how to live life. They described it as living life as if they were in a jail...Some parents have been threatened with having their children taken away because they do not know what to do, how to handle them.[18]

4.17 St Vincent de Paul Society National Council pointed out that according to a 2008 study, gambling was the most common motivation for fraud.[19] A more recent study found that EGMs were the preferred mode for gambling stolen funds and

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15 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 16.

16 Mr Denis Fizgerald, *Proof Committee Hansard*, 2 February 2011, p. 17. In 1999, the Productivity Commission reported that on average around seven other people were adversely affected to varying degrees by a severe problem gambler's behaviour. Productivity Commission *Australia's gambling industries*, vol. 1, Commonwealth of Australia, Canberra, 1999, p. 7.1.

17 Mr Stephen Menadue, *Proof Committee Hansard*, 18 February 2011, pp 53–54.

18 Ms Julia Kaparthakis, *Committee Hansard*, 1 February 2011, p. 3.

19 St Vincent de Paul Society National Council, *Submission 50*, Attachment A, p. 1.

$13 million in stolen money was lost on EGMs between 2008–2010. The average loss to fraud where the person was solely addicted to EGMs was $233,975.[20]

4.18 Other witnesses highlighted the poor level of support and services for families of problem gamblers. Ms Kate Roberts, Gambling Impact Society (NSW), described the current situation regarding carers of problem gamblers:

> ...and my other hat is as the carer program coordinator for the—Shoalhaven health service. Doing all this work with carers with mental health issues, chronic health issues and drug and alcohol issues is acknowledged under the national action plan for carers, which then goes into a state action plan. Problem gambling does not get a guernsey. If you are in my program, you get a look-in, and we have actually been funded to develop a self-help resource for family members. Getting the recognition that this is a health issue is a huge part of looking at appropriate strategies and not these bits and pieces in isolation, which I think is what we have been looking at over 10 years. [21]

4.19 Some suggested that the burden of problem gambling which currently rests on individuals, is not being shared by industry. Dr Mark Zirnsak, Chair of the Victorian Interchurch Gambling Taskforce, observed:

> A big problem is that currently there is no consequence for the electronic gaming machine venues that allow customers to lose more than they can afford. For a bank, overspending on a credit card gives them the problem of a bad debt, but, for an EGM venue, overspending by gamblers gives them more profit and all the harm is pushed on to others. Currently, this results in market failure because the EGM industry does not suffer any of the costs involved in the harm it causes unless taxes are levied on them, but even these are not in proportion to the cost involved. Therefore, they have no real incentive to deal with problem gambling in a serious way except to the extent that the threat of regulation forces them to do so. This has been confirmed by the courts which, by and large, have argued that venues have no duty of care towards people with gambling problems, even when the venue knows that the person has a gambling problem. Precommitment, therefore, is a significant step to address the imbalance in law between the EGM industry and its customers.[22]

Denial

4.20 The committee also heard evidence that many problem gamblers remain in denial about the source of their problems, often for years. Mr Tom Cummings observed his denial lasted a decade:

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20 Brett Warfield, 'Gambling motivated fraud in Australia 2008–10', Warfield and Associates, 2011, http://www.warfield.com.au/Warfield_Gambling_Fraud_08_10.pdf (accessed 16 March 2011).

21 Ms Kate Roberts, *Committee Hansard*, 4 February 2011, p. 78.

22 Dr Mark Zirnsak, *Proof Committee Hansard*, 2 February 2011, p. 15.

> For the decade following this time, I was in denial about what I had been through. I not only stayed away from poker machines; I pretended they didn't exist. I didn't want to know, and I certainly didn't want to acknowledge the fact that I was still tempted.[23]

4.21 Evidence was presented that very few problem gamblers actively seek professional treatment, and often when they do it is only after they have hit 'rock bottom'. Chapter two of this report provides examples of those who have experienced this. Associate Professor Paul Delfabbro noted:

> All of the evidence suggests that people tend to find it very difficult to seek help at the time when they probably most need it. Evidence overwhelmingly shows that people will tend to remain in a state of denial or try to gamble out of their problems over an extended period. They will only seek help, quite often when they have reached that rock bottom point where they have lost significant assets or they are about to go to jail or have other another significant life-changing event occur to them. Only then will they typically think about seeking help. For pathological gamblers, seeking help is very difficult. They find it very difficult to bring about behavioural change on their own.[24]

4.22 This was confirmed by organisations dealing with problem gamblers. Ms Margie Law from Anglicare Tasmania told the committee:

> I think the major problem with the treatment or care of people with a gambling problem is that they usually leave it to the very last minute. They are ashamed. They do not want to go for help because they do not want to admit they have got a problem. By the time they see a counsellor or by the time they have done self-exclusion, they are often heavily in debt, their relationships have fallen apart and they have lost their house. They are in very dire straits at the time they go for counselling. We think precommitment and a dollar bet limit would help slow that down and hopefully prevent a number of people actually getting to that point.[25]

Addictive features of EGMs

4.23 The particularly addictive features of high intensity EGMs were noted by a number of witnesses and are explored in chapter three. However, Dr Jamie Doughney from Victoria University summarised the view of many gambling researchers:

> It is not for no reason that researchers describe electronic gaming machines as the 'crack cocaine of gambling'. The reason is that they have very

23 Mr Tom Cummings, *Submission 113*, p. 1.

24 Associate Professor Paul Delfabbro, University of Adelaide, *Committee Hansard*, 1 February 2011, pp 70–71.

25 Ms Margie Law, *Proof Committee Hansard*, 18 February 2011, p. 7.

> similar neurobiological effects. The evidence on that is mounting considerably...[26]

Support for a public health approach

4.24 Broadly, a population or public health approach 'considers the entire population, rather than only ill or high risk individuals'. It emphasises an orientation towards whole groups rather than individuals and complements approaches that seek to treat individuals. It tends to involve a 'broad range of stakeholders' and takes into account socio-economic as well as clinical factors.[27] A number of witnesses supported a public health approach to problem gambling:

> Secondly, we talk about a public health approach and, again, the Productivity Commission talked about this approach. This recognises gambling, along with any other activity, as a continuum of risk from very low risk at one end to high risk at the other end. We recognise that gambling policy needs to address the whole continuum. A public health approach also recognises that the environment in which gambling operates is a really important part of how behaviours are determined and what sort of public policy is required.[28]

4.25 Associate Professor Paul Delfabbro described the basic principles behind a public health approach:

> As I mentioned in my submission and in the report from which it is derived, there are two general public health principles applied in this context. One is harm minimisation—that is, minimising harm before it occurs. This is probably more about helping those problem gamblers who are thinking about change and helping moderate risk gamblers from moving up to being problem gamblers. In that sense, reducing problem gambling will be about stopping it before it occurs. Harm reduction, the other commonly used term, probably refers more to trying to stop those who are already problem gamblers from engaging in harmful behaviour.[29]

4.26 Some suggested a public health approach should also adopt a broader population health strategy, involving the whole health sector and consumers:

> However, as we have also stated in our submission, we believe that these strategies need to operate within a new public health model for gambling. This would require a national framework to be developed to address the issue similar to those we have already developed for alcohol and tobacco. On that basis we support the proposed reforms. We hope that this will be the beginning of structural and organisational reforms to the approach taken

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26 Dr Jamie Doughney, *Proof Committee Hansard,* 2 February 2011, p. 45.

27 Queensland Health, *Understanding population health*, Background Paper, http://www.health.qld.gov.au/phcareers/resources.asp (accessed 15 March 2011).

28 Mr Mark Henley, UnitingCare Wesley, *Committee Hansard,* 1 February 2011, p. 44.

29 Associate Professor Paul Delfabbro, *Committee Hansard,* 1 February 2011, p. 73.

> with this issue from a population health perspective. We firmly believe that New South Wales Department of Health, local health networks, local government and consumers need to be included in the policy development, planning and procedural development of appropriate strategies to address gambling harm.[30]

Committee view

4.27 The committee broadly agrees with the Productivity Commission recommended approach which seeks to minimise harms of high intensity EGMs on the broader community. The committee believes that those individuals affected more broadly by problem gambling, including family members and in many cases children do not currently have a voice. Their needs should be a key consideration in our deliberations. For these reasons the committee accepts that a strategy which adopts a public health and consumer protection framework is the most appropriate.

Recommendation 4

4.28 The committee recommends that in line with the Productivity Commission recommendations a public health approach to problem gambling be adopted across jurisdictions with a view to reducing the levels of problem gambling.

Current harm minimisation approaches

Venue-based approaches

4.29 The committee heard evidence from many in the industry that gaming venues are required to ensure their management and gaming staff undertake regular training on identifying and helping problem gamblers.[31]

4.30 Most support Responsible Gambling codes of conduct and many are signed up to programs such as Club Safe.[32] The committee acknowledges the value of these industry efforts including Gaming Care in South Australia, which operates as an early intervention agency that supports venues and their staff to identify and assist problem gamblers.[33]

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30 Ms Kate Roberts, President Gambling Impact Society (NSW), *Committee Hansard*, 4 February 2011, p. 72.

31 For example, Responsible Service of Gambling training is mandatory in all venues in Queensland. RSL & Services Clubs Association Queensland, *Submission 108*, p. 17.

32 Club Safe is the club industry's Responsible Conduct of Gambling Program. It was initially developed by Clubs NSW with input from the Australian Institute for Gambling Research. Club Safe is a program designed to help registered clubs manage responsible gambling operations.

33 For more information see the Gaming Care website, http://www.gamingcare.org.au/ (accessed 15 March 2011).

4.31 However, a number of witnesses raised concerns over the current arrangements around the adequacy of staff training and support. Witnesses outlined what they perceived were the conflicts and limitations inherent in the current system which places a great deal of responsibility on venue staff. Ms Karpathakis explained her concerns:

> I just think that it is hard enough for people who are working, the staff, to do whatever they have to do and then try and approach somebody whom they may think has a problem. That, to me, is ridiculous and hard. If anyone approached me, I would never go back to that venue, so it is not a good idea. It might have worked for some people; I am sure it has. However, it is so difficult to be approached and to approach someone.[34]

4.32 To provide opportunities for individuals to approach people, Ms Karpathakis suggested the following:

> I imagine that a couple of people would just go from venue to venue with 'Ask Me' on their T-shirt perhaps—it is just an idea—so that, if someone is sitting there, they can say, 'What's your T-shirt about?' or, 'Can I talk to you?' That way, the person is approaching someone, instead of someone approaching the person. The person takes the initiative to talk to someone.[35]

4.33 Ms Gabriela Byrne described two occasions where she witnessed positive staff interventions:

> I remember the day that I won $300. At that stage I was one of the first generation gamblers where I had to take a piece of paper to the cashier. We did not have note acceptors. I said, 'Give me $200 and the rest in coins'. She said, 'Take that money and go.' I looked at her and in that moment I realised that she knew I had a problem. I took my money and I left. The woman I talked about who lost the $7,000 was tapped on the shoulder by one of the venue workers and he said to her, 'Do you realise that it does not matter how much money you put in here; you will not necessarily get it back on this machine?' At that moment she realised, first of all, that he knew and that he had watched her. She had that moment of interruption where she took the last $200 she had and left. People know.[36]

4.34 However, she outlined a subsequent conversation she had with a staff member that illustrates the difficulties for staff:

> At a later day I spoke to the woman who I developed a relationship with, who was the cashier in this particular venue. I questioned her about this incident and she said, 'You know, I could have got into trouble for what I did.' People are instructed, because they are not qualified, to stay away from these measures but those people who walk the floor are human beings and

34 Ms Julia Karpathakis, *Committee Hansard*, 1 February 2011, p. 18.

35 Ms Julia Karpathakis, *Committee Hansard*, 1 February 2011, p. 18.

36 Ms Gabriela Byrne, *Proof Committee Hansard*, 2 February 2011, p. 24.

> they see human misery. A lot of them have the ability and the desire to intervene but officially they are not allowed to.[37]

4.35 Another former problem gambler Ms Sue Pinkerton spoke to the committee about the research she had conducted on staff behaviour:

> In the research I did for Paul Delfabbro looking at in-venue behaviours of staff and problem gamblers, I found that the staff were in the gaming room observing patrons for maybe ten minutes out of an hour. Are they able to identify them? Do they have the training? Probably yes. Are they there to watch them? Is there a risk to their jobs if they actually do identify and approach those people? From what I have heard staff say, the answer to that is yes. So they just avoid seeing the problem. I know that in South Australia the turnover of gaming room staff is extremely high and I suspect—most people say—that the reason that they leave is because they cannot watch somebody put their rent money, their mortgage money through the machines again.[38]

4.36 Unfortunately during her gambling addiction not one staff member approached her:

> Nobody, apart from one girlfriend who approached me, has approached me. The staff are trained, as I understand it, to engage the gambler in a conversation about their gambling—they might say, 'I've noticed you here quite a bit recently'—without saying, 'I think you've got a problem.' They try and draw the person out as to whether they have a problem. I do not know that it works. Truly, I do not know. These people are bar staff. They are able to clean the gaming room. They are able to fix the machines. They manage the money. They count the till. They are not counsellors. The casino here has councillors on site that any staff member can call in to approach someone. But I truly do not know that that would work either. It would just stop me from going to the casino if I was approached by somebody there. I would be absolutely mortified that I had been approached, and so I would avoid going there.[39]

4.37 Ms Pinkerton also provided the committee with the following example:

> ...I had a 65-year-old lady, who turned up at my doorstep at nine o'clock in the morning. She had been at the venue from half past seven. She had a fan of ATM receipts in her hand. She was a blithering mess: 'I don't understand. How could they do this to me?' She had spent $1,800. We have a $200 ATM withdrawal limit on the machines here, and she had been back to that machine nine times in that time. There were three other people in the venue; two of them were staff. In an hour and a half she went back eight or

37 Ms Gabriela Byrne, *Proof Committee Hansard*, 2 February 2011, p. 24.

38 Ms Sue Pinkerton, *Committee Hansard*, 1 February 2011, p. 61.

39 Ms Sue Pinkerton, *Committee Hansard*, 1 February 2011, p. 61.

> nine times to that ATM. Didn't somebody twig that something was going on? They did not look.[40]

4.38 Mr Stephen Menadue pointed out that if a patron consumes too much alcohol then it is obvious and there is a requirement to act. However, a problem gambler in most cases is not disturbing anyone and this makes it more difficult for staff to approach.[41] He added that a pre-commitment system would 'take the responsibility for the staff and put it into a definable electronic form.'[42]

4.39 Ms Margie Law, Anglicare Tasmania described similar examples from the research undertaken by Anglicare:

> In the House of Cards report we did, the people we interviewed were all in counselling with Anglicare or Relationships Australia. A number of them said, 'The venue staff knew I had a problem.' When I'd come in they'd say, "Hey, the jackpot's going to go today." They knew I had a problem but they are there to make money for the venue, not to look after me.' People with a gambling problem do not cause a problem for the venue; whereas, people with an alcohol problem do cause a problem for the venue—it is in the venue's best interests to get them out of the venue. A person with a gambling problem is spending money and not causing problems through violence or abuse but just sitting quietly at their poker machine.[43]

4.40 During this inquiry, the Victorian Commission for Gambling Regulation released the results of a venue staff survey on the industry's efforts in implementing the Responsible Gambling Codes of Conduct (Codes) and self-exclusion programs (SEP). One of its key findings was that staff would like to learn more practical skills to identify and interact with potential problem gamblers or gamblers who were showing signs of distress. Other relevant findings include:

- 69 per cent of gaming industry employees have been provided staff training on their Code while 65 per cent have been provided staff training on their SEP;
- 42 per cent of employees said it is easy or very easy to identify self-excluded person, while 21 per cent found it difficult or very difficult;
- only 43 per cent of employees were satisfied with the level of training and help received for their Code overall, while only 44 per cent were satisfied with the level of training as assistance for their SEP;
- 36 per cent of employees were having some difficulty in identifying problem gamblers;

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40 Ms Sue Pinkerton, *Committee Hansard*, 1 February 2011, pp 60–61.

41 Mr Stephen Menadue, *Proof Committee Hansard*, 18 February 2011, p. 54.

42 Mr Stephen Menadue, *Proof Committee Hansard*, 18 February 2011, p. 54.

43 Ms Margie Law, *Proof Committee Hansard*, 18 February 2011, p. 10.

- 21 per cent felt less than comfortable in responding to a patron request for help with gambling compared to 66 per cent who were less than comfortable when required to initiate this contact with patrons;
- 48 per cent of managers were less than comfortable in approaching patrons displaying indicators of a gambling problem.[44]

4.41 Associate Professor Linda Hancock from Deakin University advised the committee about the study she conducted on employees of Crown Casino in Melbourne. Based on this research she concluded that the current codes are not working:

> At the moment the codes do not work. The paper that you have in my additional submission is a detailed study, based on interviews with 225 Crown Casino employees, about the implementation of the Crown code of conduct based on nine signs of problem gambling. It leads to a very benign, non-interventionist venue stance and basically a breakdown in operator and regulator enforcement, hence the need and the opportunity for non-vested interests, like the Commonwealth, to step in with a national code of conduct that will also look at the venue angle when you have people in venues playing cards, playing table games or playing machines who are manifesting the well-known signs of problem gambling. [45]

4.42 Associate Professor Hancock elaborated on the findings:

> The problem in the Crown study was that the upward-report-to-supervisor system does not work because it is not enforced. No-one checks it. There are no checklists of who has been referred on and what happened. Many of the workers were saying, 'What is the use of referring it on to the supervisor when nothing happens?' Also, you have a situation where very rational corporate interests are oriented to profit maximisation. This is in direct conflict with consumer and public protection.[46]

4.43 The committee was advised that Crown Casino rejected the findings of this report. Mr Chris Downy, Executive Director of the Australasian Casino Association explained:

> Crown has a track record in terms of its commitment to responsible gambling. Crown Melbourne was the first casino anywhere in the world to set up a customer support centre with its own psychologist and its own staff. Burswood is following the same process.[47]

4.44 He elaborated on their training commitment:

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44 Victorian Commission for Gambling Regulation News, Summer, 2011, p. 4, http://www.vcgr.vic.gov.au/CA256F800017E8D4/WebObj/0F75A07731BDED5FCA2578180020421C/$File/VCGRSummer2011.pdf. (accessed 24 February 2011).

45 Associate Professor Linda Hancock, *Proof Committee Hansard*, 2 February 2011, p. 5.

46 Associate Professor Linda Hancock, *Proof Committee Hansard*, 2 February 2011, p. 7.

47 Mr Chris Downy, *Proof Committee Hansard*, 18 February 2011, p. 40.

> Crown is a major employer of young people entering the workforce. It just opened a $10-million, purpose-built training facility to ensure that its staff are trained to standards that would be expected at a premium resort such as Crown. It has received awards from the Australian government and other organisations because of its training programs and the like.[48]

4.45 Ms Penny Wilson of the Responsible Gambling Advocacy Centre agreed there were times where staff were failing to meet the requirements under the code of conduct, but that this was not confined to the casino:

> It is a situation that I have heard about in other venues as well where particularly casual staff—either because they do not feel empowered to make representations in the correct manner or because they do not understand what is required or because their duty managers at the time do not understand what is required—fail to act in the manner that is required by the codes of conduct. It is a common theme that I hear across the industry. That shows the need for continual education and monitoring of those training systems and follow up with the staff on the floor. It is not unique to the casino.[49]

4.46 It was also pointed out that the training venue staff had received was not always the most suitable. Ms Kate Roberts, Gambling Impact Society (NSW), described an instance where staff were trained, but not in the correct strategy:

> My colleagues at the Nowra Community Health Centre and I conducted some training with some gaming staff when we were still in existence. Basically, the staff felt that they had gained more awareness from our kind of training—and they had all been through the compulsory responsible gambling training. A good example was that if someone had breached their self-exclusion, staff had been encouraged, in the culture they existed in, to shame that person into not being there again. Once the staff realised that the gambler was already dealing with a magnitude of shame—that is, in fact, partly why the person is gambling and the cycle of gambling contributes to that—the penny started to drop that maybe such shaming was not the best strategy for proactively supporting someone who was breaching their exclusion. So I think that kind of support and training could go into staff.[50]

4.47 The genuine efforts of venue staff were however, recognised by some witnesses:

> We place venue staff in a difficult position sometimes and they do a reasonable job under those circumstances. I think that is why those programs are really important, and it is really important that they are done in partnership with the gambling industry and our industry.[51]

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48 Mr Chris Downy, *Proof Committee Hansard,* 18 February 2011, p. 40.

49 Ms Penny Wilson, *Proof Committee Hansard,* 2 February 2011, p. 78.

50 Ms Kate Roberts, *Committee Hansard,* 4 February 2011, pp 77–78.

51 Mr Mathew Rowell, Anglicare Tasmania, *Proof Committee Hansard,* 18 February 2011, p. 19.

4.48 It was also suggested that staff would require training in any new pre-commitment scheme.[52]

Self exclusion

4.49 A number of witnesses cited problems with current self-exclusion arrangements:

> Another study that we commissioned that Michael O'Neil conducted was showing the absolutely fraught nature of photo ID systems that are currently in place to try to help people who have self-excluded. The Nova Scotian follow-up to that, which used actors posing as excluded people where there were photos in venues, found that even when the venues knew that this experiment was going on they did not pick them up. A national barring system would immeasurably help people because they would know that wherever they went they would be protected from their vulnerability.[53]

4.50 Ms Margie Law, Anglicare Tasmania, explained how problem gamblers try to circumvent self-exclusion:

> I know people who are desperate to go in to gamble will dress differently or they will go further away where they think people are not going to look at their photograph. As a venue operator it must be very difficult to keep on top of all the people that are self-excluded from your venue.[54]

4.51 Mr Mathew Rowell, Chief Executive Officer, Relationships Australia, Tasmania, noted the difficulties for venue staff:

> Since self-exclusion is hard to monitor and enforce, venue staff do a really good job under really difficult circumstances, I reckon. Certainly our clients would say self-exclusion is one of the motivating factors for them, but then it is really quite easy in lots of venues to slip in the back door or change your appearance, and where there has been staff turnover people are often unable to keep on top of those things…[55]

4.52 Mr Stephen Menadue told the committee of the barriers to getting himself excluded from venues:

> I have since been on the self-exclusion program in Tasmania, but that did not stop me. I was pulled up once at Bellerive Tote because they recognised my picture. I was picked up once at the Queens' Head tavern because they recognised my picture, But apart from that, at least at a dozen other poker machine venues I have never been picked up as being on that self-exclusion list. In fact, a few weeks ago I went down to my local tote to tell them that I did no want to be served anymore, because it is an easy avenue for me to go

52 Ms Sarah Hare, Schottler Consulting, *Proof Committee Hansard,* 3 February 2011, p. 24.

53 Associate Professor Linda Hancock, *Proof Committee Hansard,* 2 February 2011, pp 12–13.

54 Ms Margie Law, *Proof Committee Hansard*, 18 February 2011, p. 13.

55 Mr Mathew Rowell, *Proof Committee Hansard,* 18 February 2011, p. 19.

> down. With my gambling, I will not travel. I figured that, it I go and cut my local source off at the tote, I would be right. So I went down there and told that that I was on the self-exclusion list and asked them where they could refuse to service me. They had a look through their book and it appears I was not even in their book, even though I had started this program four years ago. To me that is showing up a fault in that system.[56]

Committee view

4.53 The committee appreciates that many venues hold genuine concerns over the welfare of problem gamblers and recognises that genuine efforts are made by venue staff to assist problem gamblers. The engagement of venues in certified training programs such as Club Safe, are a testament to that. However, the committee is also concerned that the commercial interests of venues do not always align with their responsibilities for gambler welfare. The committee accepts the evidence that staff training can be improved and that staff will need additional training in pre-commitment.

Recommendation 5

4.54 The committee recommends that an independent review of training programs be undertaken to assess whether these are effectively equipping staff with adequate training to apply problem gambling interventions.

Recommendation 6

4.55 The committee recommends that industry codes of conduct should include effective protection for venue staff who highlight shortcomings with training.

Recommendation 7

4.56 The committee recommends that venue staff receive appropriate training in assisting patrons with pre-commitment.

Conclusion

4.57 The committee accepts that the harms of high intensity EGMs affect a broader spectrum than just problem gamblers, and includes those who are at risk, the families of gamblers and the wider community. Vulnerable groups are at particular risk from harm. The committee acknowledges that many problem gamblers do not access treatment, even where it is available and that consequently the harms of their gambling can persist. It also accepts that the greatest burden of harm is often borne by the most vulnerable.

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56 Mr Stephen Menadue, *Proof Committee Hansard*, 18 February 2011, p. 46.

4.58 The committee accepts the evidence showing that, despite good intentions, there are flaws with current venue-based harm minimisation arrangements, particularly those that rely on self-exclusion or on individuals to attempt intervention.

4.59 As Mr Mathew Rowell, Chief Executive Officer, Relationships Australia, Tasmania, commented:

> In summary, we support the introduction of a mandatory precommitment scheme as one of the ways that harm can be minimised or mitigated for people who are problem gamblers, but it is also for the people around them—their kids, their families, their partners and their workplaces...[57]

57 Mr Mathew Rowell, *Proof Committee Hansard,* 18 February 2011, p. 16.