



Parliamentary Joint Select Committee on Gambling Reform

Third report

The prevention and treatment of problem gambling

October 2012

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Committee Membership

Members

Mr Andrew Wilkie MP (Chair)	Tasmania, IND
Mr Nick Champion MP (Deputy Chair to 14 March 2012)	South Australia, ALP
Ms Gai Brodtmann (from 14 March 2012, Deputy Chair from 20 March 2012)	Australian Capital Territory, ALP
Senator Chris Back (to 10 May 2012)	Western Australia, LP
Senator Catryna Bilyk (to 27 February 2012)	Tasmania, ALP
Mr Steven Ciobo MP	Queensland, LP
Senator Trish Crossin (to 21 June 2012)	Northern Territory, ALP
Mr Josh Frydenberg MP	Victoria, LP
Mr Stephen Jones MP	New South Wales, ALP
Mr Shayne Neumann MP	Queensland, ALP
Senator Louise Pratt (from 21 June 2012)	Western Australia, ALP
Senator Nick Sherry (from 27 February to 1 June 2012)	Tasmania, ALP
Senator Matt Thistlethwaite (from 27 June 2012)	New South Wales, ALP
Senator Nick Xenophon	South Australia, IND

Participating members

Senator Richard Di Natale (from 27 February 2012)	Victoria, AG
Senator John Madigan (from 27 February 2012)	Victoria, DLP

Secretariat

Ms Lyn Beverley, Committee Secretary

Ms Meg Banfield, Principal Research Officer

Ms Diana Harris, Administrative Officer (from 16 January to 5 April 2012)

Ms Lauren Carnevale, Administrative Officer (from 2 April 2012)

PO Box 6100

Parliament House

Canberra ACT 2600

Ph: 02 6277 3433

Fax: 02 6277 5952

Email: gamblingreform@aph.gov.au

Internet:

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=gamblingreform_ctte/index.htm

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Executive Summary

As acknowledged in the committee's first report there is no one solution to address problem gambling.¹ It requires a range of measures along the gambling continuum (low to high risk) including health promotion, harm reduction and treatment.

Although this inquiry focused on prevention and treatment, which are areas the committee has not covered before, it heard again of issues raised in previous reports such as the importance of a public health approach to gambling, the concentration of Electronic Gaming Machines (EGMs) in low socio-economic areas, the need to focus more on machine design and features to make them safer and the need for a new approach to research and data collection. The need for a public health approach, including through reforms to research funding and highlighting governance arrangements, is covered in chapter two, as is the concentration of EGMs in disadvantaged areas and the rising level of community concern about this, particularly in Victoria. Research and data is highlighted again in chapter 11 along with aspects specific to prevention and treatment.

The fact that these issues keep being raised with the committee means that little or no progress has been seen by those involved in these areas. This is profoundly disappointing, particularly as these areas have already been highlighted by the Productivity Commission in its two reports on gambling (1999 and 2010) which were completed well before this committee's work.

Prevention

Chapter three introduces approaches to prevention. The prevention of problem gambling should be inclusive: to prevent people from developing gambling problems; to limit harm and treat any problems early with early intervention; and to treat and reverse the effects should a problem develop. Increasing the focus on the prevention side of the spectrum is required to balance the current emphasis on 'downstream' activities such as providing counselling services. The numbers of people who seek treatment are small, around 8-17 per cent.² To increase these numbers the committee heard that the public perception of gambling, problem gambling and problem gamblers needs to be addressed by looking at the messages being sent into the community.

The committee heard about the mixed messages around gambling. It is promoted by the industry as a harmless form of entertainment but this is not balanced by clear messages about the possible risks. The amount of positive advertising overwhelms harm minimisation messages. Recognising problem gambling as an important public health issue will assist to facilitate a change in public attitude which would see a shift to more people seeking help as it would be seen as acceptable to do so.

1 Joint Select Committee on Gambling Reform, First Report, The design and implementation of a mandatory pre-commitment system for electronic gaming machines, May 2011, p. 97.

2 Productivity Commission, *Gambling*, vol 1, Commonwealth of Australia, Canberra, 2010, p. 7.3.

To facilitate this change in public attitude the right messages are important. One of the key messages to the committee was that the shame and stigma associated with a gambling problem is one of the main barriers to an individual seeking help. The focus on personal responsibility, conveyed in the variations of 'responsible gambling' messages used in public information campaigns, contributed to feelings of shame and stigma for individuals who developed a problem with gambling. The committee heard that this message reinforces the view that it is up to the individual to gamble responsibly. If they don't there must be something wrong with them, the problem is their fault, and they are personally to blame. This approach of placing an overwhelming responsibility on the individual for gambling problems can shame them into silence and create a barrier to help seeking. Consequently, the personal responsibility approach and the stigmatising effect of this approach may be one reason why very few people seek help. Rather, they may seek help only as a last resort, and feel discouraged from seeking help early.

The committee heard that there is greater stigma around seeking help for problem gambling than for illicit drug use. As seen with other public health issues such as obesity, alcohol and tobacco, the framing of problem gambling as an issue of personal responsibility advantages the gambling industry and governments as it takes the responsibility from them and places it solely with the individual. The committee heard of the limits to the personal responsibility approach for people with vulnerabilities.

Witnesses provided a number of suggestions to improve the messages used in social marketing initiatives (including campaigns, education initiatives and professional training) to address stigma and stereotypes and these are discussed in chapter four.

Chapter five covers other suggestions for more effective social marketing campaigns which include the need to understand why people gamble, to promote alternatives and the need for a range of messages to better target 'at-risk' groups such as those at moderate risk (e.g. young men who engage in sports betting) who may quickly develop risky gambling behaviour. There is also a need to include messages targeting growing gambling opportunities such as online gambling, and the need to raise awareness in adults of the effects of gambling on children and young people as well as to provide information to young people.

Industry measures

Industry measures are covered in chapter six. It was disappointing that industry groups (Clubs Australia, the Australian Hotels Association and the Australasian Casino Association) declined to appear at a public hearing to discuss measures beyond information provided in their submissions, respond to evidence received by the committee and discuss what improvements might be possible. To provide industry with the opportunity to respond to evidence the committee asked them to answer questions on notice. Responses have been made public on the committee website.³

3 See Clubs Australia, answers to questions on notice, received 27 July 2012; Australasian Casino Association, answers to questions on notice, received 5 September 2012; and Australian Hotels Association, answers to questions on notice, received 17 September 2012.

However, the committee notes with concern the refusal and/or reluctance of these organisations to engage in a meaningful way with the inquiry by discussion at public hearings.

The committee heard about the need for the industry to take greater responsibility for the dangers of gambling products. For example, the Productivity Commission made clear that EGMs are the riskiest form of gambling with the likelihood of harm rising steeply and continuously with the frequency of EGM gambling and expenditure levels. The committee was concerned to hear that despite showing obvious signs of problematic gambling in venues, none of the former problem gamblers who spoke to the committee had been approached by staff. Improving training for staff has been mentioned by government and the industry. This appears to be an admission that the current training focused on staff intervention is not working as well as it could, as evidenced by the personal stories told to the committee. While the intention to address training may equip staff with better skills to address problematic gambling behaviour, it does not address the other limitations such as conflict of interest, the practical difficulties of staff approaching people who may be showing signs of distress and the makeup of the venue workforce. The committee suggests some measures to improve the ability of staff to assist problem gamblers.

Strengthening self-exclusion programs has also been mentioned by government and industry. Self-exclusion can be helpful for some gamblers but it also has a number of limitations and should not be used as a stand-alone intervention. The committee heard that some programs are complex, require photos to be taken and there may be a need to reapply after a period of time. People can't self-exclude from all venues at one time. They may only have to travel a short distance to be able to gamble at another venue. The committee sees merit in investigating state-wide self-exclusion programs to make it simpler for those wishing to self-exclude. The committee also supports legislation for the forfeiture of prizes by those who are self-excluded as recommended by the Productivity Commission to act as a deterrent to breaching self-exclusion agreements.

Treatment

The reasons why some people develop a gambling problem and what can trigger a gambling problem are covered in chapter seven. This provides the context for the following chapters which cover various models of treatment and issues raised with the committee in relation to treatment. Chapter eight provides an overview of current treatment methods and refers to some existing treatment services across Australia which provided evidence to the committee. It also examines referrals to treatment, the factors for success in treatment and some measures to complement treatment services, such as what can be done by financial institutions to assist people with gambling problems.

Chapter nine considers the low rate of help-seeking among problem gamblers and examines barriers to treatment. Improving treatment services and systems is covered in chapter 10. It looks at a range of possible improvements to the current system from the perspective of those working in the sector, in particular the concept of integrated treatment services to deal with the complications of treating people with comorbid

conditions. This chapter also covers the need to integrate awareness of gambling addiction across the wider health profession to ensure better referral pathways and looks at ways to improve qualifications and training.

As well as addressing gambling research and data collection, chapter 11 also covers issues about the independence of research and transparency of funding sources. The chapter also details the evidence base for treatment and the evaluation of treatment services.

Additional comments have been provided by the Chair, Senators Xenophon, Di Natale and Madigan and these follow the committee report.

Recommendations

Recommendation 1

2.18 The committee emphasises the importance of jurisdictions ensuring appropriate performance targets are developed, and that ongoing monitoring and appropriate evaluation of individual initiatives is undertaken to build the evidence base for effective measures to address problem gambling. The committee recommends jurisdictions report to COAG each year on progress against the National Framework for Problem Gambling and that the reporting include key performance targets and evaluation information.

Recommendation 2

2.26 The committee recommends that the Commonwealth Government:

- designate gambling as a National Health Priority Area to be funded for research under the auspices of the National Health and Medical Research Council; and
- recognise gambling as an 'associated priority goal' under the Commonwealth Government's National Research Priority of 'promoting and maintaining good health', enabling funding support for gambling research to be provided by the Australian Research Council.

Recommendation 3

4.39 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs Problem Gambling Taskforce commission research on the complex causes and consequences of stigma and the most effective way to address and reduce the stigma associated with problem gambling. States could then draw on this work to develop strategies to address stigma and include appropriate messages in their own social marketing campaigns.

Recommendation 4

4.40 The committee recommends that gambling social marketing strategies, particularly those claiming to address stigma, are thoroughly market researched prior to launch and evaluated to determine effectiveness and any unintended consequences.

Recommendation 5

6.95 The committee recommends that as part of strengthening self-exclusion arrangements, governments, through the COAG Select Council on Gambling Reform, work with industry towards jurisdiction-wide venue exclusion as well as legislative changes which mean that prizes won by people in breach of self-exclusion orders should be forfeited to government revenue as recommended by the Productivity Commission.

Recommendation 6

8.96 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs, in consultation with the financial sector, commission further research on ways to progress practical measures that could be put in place by the financial sector to assist people with gambling problems and their families.

Recommendation 7

10.34 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs undertake further research on the impact of comorbidities on problem gambling and how integrated treatment services can be developed and implemented to effectively address comorbid conditions.

Recommendation 8

10.51 The committee recommends that the Commonwealth Government fund the establishment of a national helpline, similar to the Drug and Alcohol Clinical Advisory Service, as a practical resource for primary health care professionals to assist them to identify and refer patients who present with gambling problems.

Recommendation 9

11.54 The committee reiterates its call for a national independent research institute on gambling, as originally proposed by the Productivity Commission and recommended in the committee's previous two reports.

Recommendation 10

11.71 The committee recommends that any gambling research funded by the Commonwealth Government and made public should include: disclosure of any conflicts of interest; details about the nature and extent of any industry involvement; and list any additional sources of funding. The committee encourages jurisdictions to follow this approach.

Recommendation 11

11.86 The committee recommends that the COAG Select Council on Gambling Reform work to establish a national minimum dataset on gambling, in line with the Productivity Commission's recommendation. The dataset should be made publicly available.

Recommendation 12

11.95 The committee recommends that the COAG Select Council on Gambling Reform establish agreed parameters around the collection by governments of a basic level of nationally consistent industry data on gambling.

Recommendation 13

11.122 The committee recommends that the COAG Select Council on Gambling Reform work collaboratively with gambling treatment providers and relevant health professional bodies to build appropriate evaluation measures and benchmarking practices into gambling treatment services.

Chapter 1

Introduction and conduct of the inquiry

Terms of reference

1.1 On 9 February 2012, the Senate referred the following matter to the Joint Select Committee on Gambling Reform for inquiry and report:

- (a) measures to prevent problem gambling, including:
 - (i) use and display of responsible gambling messages,
 - (ii) use, access and effectiveness of other information on risky or problem gambling, including campaigns,
 - (iii) ease of access to assistance for problem gambling;
- (b) measures which can encourage risky gambling behaviour, including:
 - (i) marketing strategies,
 - (ii) use of inducements/incentives to gamble;
- (c) early intervention strategies and training of staff;
- (d) methods currently used to treat problem gamblers and the level of knowledge and use of them, including:
 - (i) counselling, including issues for counsellors,
 - (ii) education,
 - (iii) self-exclusion;
- (e) data collection and evaluation issues;
- (f) gambling policy research and evaluation; and
- (g) other related matters.¹

Conduct of the inquiry

1.2 Information about the inquiry was advertised in *The Australian* newspaper and on the committee's website. The committee wrote to relevant individuals and organisations to notify them of the inquiry and invite submissions by 30 March 2012. The committee received 60 submissions. A list of the individuals and organisations that made public submissions to the inquiry together with other information authorised for publication by the committee is at Appendix 1.

1.3 The committee held public hearings in Sydney on 2 May, Melbourne on 3 May and Canberra on 28 February, 20 March, 14 May, 18 and 26 June 2012. Details

1 Journals of the Senate, No. 75—9 February 2012, p. 2072.

of public hearings are referred to in Appendix 2. Hansards from the hearings are available at:

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=gamblingreform_ctte/prevention_treatment/hearings/index.htm.

Acknowledgements

1.4 The committee would like to thank individuals and organisations who contributed to the inquiry by preparing submissions and appearing at public hearings.

Scope of report

1.5 The terms of reference do not confine the committee to a particular type of gambling. The areas of prevention and treatment are relevant for all forms. However, as the Productivity Commission did, the committee recognises that the risks associated with poker machines are higher than other forms of gambling and they still account for the vast majority of problem gamblers.² In addition, as much of the evidence received by the committee was in relation to poker machines, the committee has focussed on this area.

1.6 The committee notes that interactive and online gambling, including wagering, gambling advertising and inducements, were addressed comprehensively in the committee's second report. It will comment on these areas briefly where relevant but refer to the committee's second report for more detail.³

1.7 During the previous inquiry, Professor Alex Blaszczynski and Dr Sally Gainsbury informed the committee about their preliminary research findings from collecting detailed information on the characteristics of internet gamblers in Australia.⁴ On 28 February 2012, the committee received an update from them on the outcomes of their research, which aims to further the understanding and effects of internet gambling in Australia to inform key stakeholders and guide policy responses.⁵

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 13.

3 Parliamentary Joint Select Committee on Gambling Reform, *Second Report: Interactive and online gambling and gambling advertising, Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, December 2011.

4 Dr Sally Gainsbury and Professor Alex Blaszczynski, *Submission 7*, Inquiry into interactive and online gambling and gambling advertising.

5 See:
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=gamblingreform_ctte/prevention_treatment/hearings/index.htm.

Structure of report

1.8 The terms of reference are covered in the following chapters. Prevention measures are dealt with in chapters two to five. Measures used by venues to assist problem gamblers are covered in chapter six. The development of gambling problems is covered in chapter seven. Treatment is addressed in chapters eight to 10; and research and data issues are covered in chapter 11.

Chapter 2

Getting the framework right

2.1 This chapter covers some key introductory issues, including the importance of a public health approach to gambling and how this may be achieved through reforms to research programs and governance arrangements, before discussion of the effectiveness of particular prevention measures in the next chapter. To illustrate the benefits of a public health approach, it covers evidence of growing signs that communities and local councils are demanding more engagement and control over issues such as the number of poker machines in their local areas, in recognition of the harm that can result.

Importance of a public health approach to gambling

2.2 As with the committee's first inquiry, the importance of a public or population health approach to gambling was emphasised to the committee. Such an approach considers the whole population rather than only the individuals experiencing problems or at high risk. This is particularly important as people can move very quickly in and out of risk categories (low, medium and high) on the gambling continuum.¹

2.3 Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, noted the lack of a coherent, public health based policy on gambling at both the national and state level despite it being recognised by many as a public health issue. This is in contrast to issues such as tobacco, drugs or alcohol.² Ms Roberts noted that the key strengths of a public health approach to gambling are the opportunities to work across many sectors of the community to effect change. In this model gambling is owned by the community and solutions need to be considered and owned by the community. Ms Roberts highlighted that the public health framework:

...enhances a comprehensive and integrated approach to the problem and thereby engages many sectors of the community in working towards solutions. It is not seen as the sole domain of governments, counsellors or an industry but creates the opportunity for all sectors to work towards defined and measurable goals.³

2.4 Ms Roberts spoke on addressing gambling harm using this approach:

...basically we should be looking at the social, political and cultural environment, de-normalising gambling in the community, reducing product

1 Parliamentary Joint Select Committee on Gambling Reform, *First report: the design and implementation of a mandatory pre-commitment system for electronic gaming machines*, May 2011, pp 49–57.

2 Gambling Impact Society NSW, *Submission 30*, p. 1.

3 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 36.

marketing and the dependency of industry and governments on revenue from it, looking at supply and accessibility, building community awareness around gambling risks and developing culturally appropriate programs. We should be looking at the personal aspects: the personal, individual, and also family and community vulnerabilities, health, poverty and social and cultural issues. We believe strongly in building the capacity of communities to build resilience to gambling problems; addressing the underlying socioeconomic disadvantages and strengthening that resilience and those skills through dealing with health issues and educating individuals and communities about risks; screening for the incidence of problem gambling and treating those affected; and basically providing a holistic approach through working with families and communities.⁴

2.5 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, spoke about the benefits of a public health approach which the Taskforce supports:

The public health model provides a holistic and meaningful way of thinking about gambling problems and gaming machines. Outsiders can sit outside pathologising individuals and placing the whole problem within the skin of one person. We recommend that the Australian Government adopts a public health approach. The public health approach takes an ecological approach to understanding and addressing health issues. Health or ill health does not just exist within one individual; it occurs within whole systems and communities. Consistent with this, the lines of causality are within whole systems too. The lines of causality for gambling problems come from the design and supply of the machines, venue practices, regulatory frameworks that enable or constrain, industries that have incentives to make profits even while causing harm at the same time and the full range of social and individual malaises that form the customer market niche for gambling industries. As we know it is marginalised and disadvantaged people, people on low incomes or people who have some sort of trauma, who form the market niche that poker machine industries can exploit.⁵

2.6 Dr Borrell used the following metaphor to illustrate such an approach:

A good metaphor is thinking of a community at the bottom of a mountain whose water has been contaminated upstream by a toxic industry. If children were dying, you would not just provide grief counselling. You would not even just provide public information such as, 'Your water is contaminated.' You would want to stop the water being contaminated at its source. That is where a public health approach is really useful for teasing out those lines of causality and where the most effective points of intervention are.⁶

4 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 36.

5 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 20.

6 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 20.

2.7 Rev. Tim Costello, Chair, Australian Churches Gambling Taskforce, said that as part of this approach there is a need to look wider than blaming individual problem gamblers by looking towards the dangers of the product:

Letting a dangerous product off the hook is not a responsible public health approach to this issue on pokies...⁷

2.8 Mr Mark Henley, Member, Australian Churches Gambling Taskforce, highlighted the importance of a public health approach in stopping people sliding towards the harmful end of the gambling continuum. He highlighted 'the absence of effective and ongoing prevention strategies currently being applied to gambling in Australia...'.⁸

2.9 Mr Henley pointed out one of the Taskforce's key recommendations:

The Australian Government formally adopt a public health framework for dealing with gambling harm, recognising the importance of primary and secondary prevention and early intervention measures as well as treatment for addiction.⁹

2.10 Ms Amanda Jones, Member, Public Interest Advisory Group, Australian Psychological Society, stressed the need for a public health or consumer protection focus. Product safety would be key to reducing the incidence of problem gambling and gambling related harm.¹⁰

2.11 As noted in the committee's first report, the Productivity Commission argued for the need to move beyond a model focused on problem gamblers and 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 in these hearings. Our framework has been a public health and broader consumer policy framework which included the medical perspective as well.¹¹

7 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, p. 20.

8 Mr Mark Henley, *Committee Hansard*, 3 May 2012, pp 9–10.

9 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 10.

10 Ms Amanda Jones, *Committee Hansard*, 14 May 2012, p. 28.

11 Mr Gary Banks, Productivity Commission, *Committee Hansard*, 15 February 2011, p. 42; Parliamentary Joint Select Committee on Gambling Reform, *First report: the design and implementation of a mandatory pre-commitment system for electronic gaming machines*, May 2011, pp 49–57.

2.12 The Productivity Commission noted a number of successful applications of the public health approach in areas outside gambling: social marketing to limit smoking; immunisation; the positioning of sleeping infants to reduce cot death rates; black spot programs to reduce traffic accidents; design changes to motor vehicles; and the removal of carbon dioxide from the domestic gas supply to reduce suicides.¹²

Committee view

2.13 In the committee's first report it accepted that a strategy adopting a public health and consumer protection framework would be appropriate. It recommended that in line with the Productivity Commission's recommendations, a public health approach to problem gambling be adopted across jurisdictions with a view to reducing the levels of problem gambling. The committee is encouraged by the government response to the committee's first report (recommendation 4) in which it notes: 'The Commonwealth Government supports a public health approach'.¹³ The committee notes that the public health model has been used successfully to address a number of health and social problems such as reducing smoking.¹⁴

2.14 The committee notes that in November 2000 the Council of Australian Governments (COAG) agreed that the Ministerial Council on Gambling (MCG) would develop a national strategic framework on problem gambling. Consequently the National Framework on Problem Gambling was endorsed by the MCG in 2004 to address four key focus areas: public awareness, education and training; responsible gambling environments; intervention, counselling and support services; and national research and data collection. It emphasises a harm minimisation approach to problem gambling. While not a comprehensive evaluation, a progress report on the Framework found that overall, most jurisdictions had implemented a range of initiatives around the key focus areas and it listed specific initiatives.¹⁵

2.15 However, while all jurisdictions have agreed to pursue a harm minimisation approach, there have been criticisms that too much emphasis is placed on so-called 'downstream' activities such as providing counselling services rather than 'upstream'

12 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 3.17.

13 Government response to the Parliamentary Joint Select Committee's First Report, available from:
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=gambling_reform_ctte/precommitment_scheme/index.htm

14 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 3.17.

15 *Ministerial Council on Gambling Progress Report to Council of Australian Governments on Implementation of the National Framework on Problem Gambling 2004-2008 (NFPG)* 01 January 2006 – 31 December 2008 (accessed 27 June 2012).

activities that deal with what is causing the harm in the first place such as electronic gaming machines (EGMs).¹⁶

2.16 The committee recognises the Productivity Commission looked at the extent to which states pursue a public health approach. It cited the Queensland *Responsible Gambling Strategy* which is based on a public health approach and Victoria's *Taking action on problem gambling 2006-2011*. The committee notes an Auditor General's report into Victoria's *Taking action on problem gambling* found that while the adoption of a public health approach to problem gambling was 'appropriate' and 'it was plausible that the 37 individual initiatives included in the strategy might reduce problem gambling and gambling-related harm', there was little or no evidence that the individual measures in the strategy would be effective. The Auditor's assessment suggested that even where a public health approach is adopted, effort needs to be dedicated to setting targets and benchmarks, measuring progress against these over time, and building a solid research base which can inform the development of policy.¹⁷ Queensland's evaluation of its strategy found it to be an effective mechanism for the development of a coordinated set of harm minimisation initiatives. However, it also found shortcomings in monitoring and evaluation, with an absence of adequate timelines and performance measures.¹⁸

2.17 As the Victorian and Queensland examples show, without clear and ongoing monitoring and evaluation of individual measures, as well as clear performance measures and timelines, the effectiveness of a public health approach can be diminished. The committee recognises that simply agreeing to adopt a public health approach is no guarantee that individual measures will be effective. Individual measures must be regularly and comprehensively evaluated against performance targets and lessons learnt should be used to enhance effectiveness.

Recommendation 1

2.18 The committee emphasises the importance of jurisdictions ensuring appropriate performance targets are developed, and that ongoing monitoring and appropriate evaluation of individual initiatives is undertaken to build the evidence base for effective measures to address problem gambling. The committee recommends jurisdictions report to COAG each year on progress against the National Framework for Problem Gambling and that the reporting include key performance targets and evaluation information.

2.19 The committee notes that recently all jurisdictions signed up to the National Partnership Agreement on Preventative Health which commits them to embedding

16 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 3.18. The criticism was levelled by Livingstone, Woolley & Keleher in a submission.

17 Victorian Auditor General, *Taking action on problem gambling*, Victorian Auditor General, Melbourne, July 2010, p. ix (accessed 27 June 2012).

18 Queensland Government, *Evaluation of the Queensland Responsible Gambling Strategy*, Queensland Government Office of Regulatory Policy, 2010, p. 84 (accessed 27 June 2012).

healthy behaviours in their communities in order to reduce the risk of chronic disease and requires them to meet certain performance targets in order to receive reward payments.¹⁹ While this agreement currently focuses on smoking, obesity and alcohol consumption, the committee notes that with the development of appropriate performance targets, it could be a model for the development of a future partnership agreement on problem gambling.

Making gambling a national research priority would support a public health approach

2.20 The committee looks closely at the broader gambling research landscape in chapter 11, including the need for a strategic national research program. However, at this point, the committee wishes to emphasise that one practical way to drive a public health approach to gambling would be to prioritise gambling research under the banner of health research.

2.21 Evidence from Australian gambling researchers suggested to the committee that a national research program on gambling could be further strengthened by designating gambling as a National Health Priority Area under the National Health and Medical Research Council (NHMRC) and as an 'associated priority goal' under the Australian Research Council (ARC).

2.22 Dr Sally Gainsbury was a strong advocate of this viewpoint, arguing that gambling researchers are currently at a significant disadvantage because funds from Gambling Research Australia (GRA)²⁰ and other government-based research organisations are not currently recognised as 'nationally competitive research grants'. Universities do not reward researchers that receive these grants, unless they come from bodies like the ARC or the NHMRC:

Unfortunately, the ARC and NHMRC do not appear to recognise gambling or problem gambling as being a research priority and it is extremely difficult to obtain funding from these schemes for gambling research. Where research grants are successful under these schemes, they generally have to be pitched at a related area to be considered important...*Gambling and problem gambling must be specifically listed as a national research priority and these granting bodies should be encouraged to fund gambling research.* This would ensure that academic researchers actively pursue and complete gambling-related projects, are free to publish in academic journals and are fully supported by Universities.²¹

2.23 Dr Gainsbury elaborated on the current system, where gaining funding for gambling research requires alignment with existing health research priorities. She

19 COAG, *National Partnership Agreement on Preventative Health, 2009-2015*.

20 Gambling Research Australia is a national research body set up in 2001 by the Council of Australian Governments.

21 Dr Sally Gainsbury, *Submission 37*, p. 12.

noted that researchers often try to emphasise the public health aspects of their work and even play down the focus on gambling itself in order to secure funding:

Essentially to get anything funded in relation to gambling you almost have to mask it to a certain extent and pretend you are looking at, for example, public health, and just using gambling as an example. So you really have to tie it in to one of their research priorities, which means almost playing down the fact that you are looking at gambling and really not emphasising that and pretending you are looking at psychology or public health, or, for example, tobacco or something else, to be able to get funds. Certainly there are some examples of gambling research being funded, but if you look at the success of gambling related projects to other fields it is very, very low. So you have to be quite clever. They are very competitive grants, but essentially it would be extremely helpful if gambling were up there on one of those priority lists where it would be clearly recognised. And that would also draw—and it is really key in the gambling field because it is so multidisciplinary—a lot of really capable researchers who are already in Australia who are not looking at gambling who would become interested in gambling if it were on the national priorities lists. So you would automatically just dramatically increase the capability and the number of people who could do this type of research.²²

2.24 The Australian Psychological Society was also supportive of the idea of listing problem gambling as a research priority, noting that only a small field of people currently researched gambling given the difficulties in securing funding:

It is difficult to put together research projects that will get over the bar for ARC and NHMRC funding because they are required to be very rigorous research designs with a great deal of control. If you are working in a very applied field like gambling, it is difficult to build the types of research designs that can get through all the methodological hoops that are required for the funding for ARC and NHMRC. If there are targeted calls for research then that encourages people to focus on that as an area of research and potentially fund a broader range of research projects because they are not having to compete with so many research priorities.²³

Committee view

2.25 The committee agrees that to strengthen the gambling research effort in Australia and to further drive a public health approach, gambling should be designated as a National Health Priority Area, enabling funding for research to be provided through the National Health and Medical Research Council. Research on gambling should also be recognised as an 'associated priority goal' under the Commonwealth Government's National Research Priority of 'promoting and maintaining good health', enabling funding support to be provided by the Australian Research Council. These steps would be consistent with the public health framework approach to gambling

22 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 14.

23 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 31.

affirmed by the committee. It would also encourage greater academic effort and more reliable funding streams in the field of problem gambling research, which is currently characterised by isolated studies and uncertain funding arrangements.

Recommendation 2

2.26 The committee recommends that the Commonwealth Government:

- **designate gambling as a National Health Priority Area to be funded for research under the auspices of the National Health and Medical Research Council; and**
- **recognise gambling as an 'associated priority goal' under the Commonwealth Government's National Research Priority of 'promoting and maintaining good health', enabling funding support for gambling research to be provided by the Australian Research Council.**

Governance arrangements

2.27 Governance arrangements for gambling were highlighted to the committee as another area that could benefit from incorporating a public health framework.

2.28 Some witnesses suggested to the committee that the development of effective public policy on gambling has been systemically constrained by portfolio arrangements governing gambling. In some jurisdictions, the way governance arrangements are set up pose inherent conflicts of interest, given the revenue received by the states from gambling as well as the regulatory role that governments must play. For example, the committee notes that in Tasmania, the Tasmanian Gaming Commission is supported by staff of the Liquor and Gaming Branch and the Branch is located within the Revenue, Gaming and Licensing Division of the Department of Treasury and Finance.²⁴

2.29 One change government could make to assist with improving outcomes would be to ensure gambling treatment falls under the health portfolios which are responsible for minimising harm.²⁵ This was supported by Professor Malcolm Battersby, Head of Department, Human Behaviour and Health Research Unit, Flinders University; and Director, Statewide Gambling Therapy Service (SGTS), who told the committee:

So one of the issues I was trying to raise in my submission is that I have noticed in travelling to other countries, including New Zealand, that the gambling treatment is often put under a whole range of departments which are unusual from a clinician's point of view: justice, treasury, addictions, health and community services. This reflects the confusion in Australian

24 See Tasmanian Government, Tasmanian Gaming Commission 2010-11 Annual Report, p. 6.

25 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, pp 36–37.

society about how severe problem gambling is and what the treatments are.²⁶

2.30 Professor Battersby was even more specific in suggesting that gambling treatment come under 'mental health if not addictions in the health sector'. He also argued that in addition, skills training and quality assurance should fit under the same paradigm. He noted that the SGTS service in South Australia is the only gambling treatment service sitting directly under the auspices of a health service.²⁷

2.31 Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, also raised the issue of governance, with specific reference to NSW where the Office of Liquor, Gaming and Racing is responsible for all gambling-related policy:

...we have allowed the whole sector to develop under [the] regulatory body for the industry and it is not embodied in the health and welfare sector ... It operates in isolation and it does not draw from those professions. Equally it does not integrate with those. It stands alone and has very much a treatment focus, and I guess my concern about that is because structurally it is not core business of the Office of Liquor, Gaming and Racing to be delivering treatment, health promotion and community education. They look after regulation and supply of alcohol and responsible service of alcohol but the treatment, research, community education and health promotion strategies, early intervention, go on by the Department of Health. To me it has always been a bit of a no-brainer to separate those duties and responsibilities and put them into the right structures, from which other things such as the training of staff, skills development and the ongoing professional development needs to happen.²⁸

Committee view

2.32 The committee acknowledges the broader systemic issues raised about governance arrangements covering gambling policy and services and the potential for conflicts of interest. Ultimately, portfolio governance arrangements are a matter for individual jurisdictions. The committee notes that gambling policy necessarily cuts across a range of portfolios, including licensing, community services, health, justice and treasury. Despite the cross-portfolio nature of gambling policy, the committee wishes to emphasise the importance of addressing gambling and gambling harm through a public health framework, as discussed throughout this chapter. The committee therefore encourages all jurisdictions to incorporate problem gambling as a policy priority under their respective public health strategic plans and programs. This would help to ensure that proper attention over the long-term is given to formulating policy responses to gambling through the lens of prevention and harm minimisation strategies, which are consistent with a public health approach.

26 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 1.

27 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 1.

28 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, pp 39–40.

Governments need better processes to engage with local communities

2.33 The committee agrees on the need for more community engagement as part of a public health approach. The Gambling Impact Society NSW reported that there have been minimal opportunities for the general community to be consulted on their view on gambling supply, regulation, measures to address problem gambling or public policy development. It recommended active engagement by policy makers with communities and consumers, recognising their role as major stakeholders.²⁹

2.34 The committee therefore notes with concern that communities which are trying to engage with government about gambling in their community appear to have little effect despite expending a great deal of time and resources on these efforts. Current processes in Victoria, for example, appear to place a significant financial burden on local governments to fight the introduction of more poker machines. Enough Pokies in Castlemaine (EPIC) told the committee their story:

We make our submission so that the inquiry understands the deeply felt disappointment of small local communities like ours, who want to stop the spread of problem gambling and related social problems, but are ignored by a flawed regulatory system. This disappointment is coupled with the enormous financial burden on local governments to fight against the introduction of more pokies, and the social costs that accompany poker machines. This creates in turn a significant challenge for already under resourced local councils. Pokies have been proven to cause damage to individuals, families, communities and our society as a whole. Our key recommendation to the Inquiry is if governments are serious about minimising the impacts of problem gambling, the regulation of the poker machine industry must also be considered. More pokies mean more problem gamblers and no amount of prevention strategies will change that.³⁰

2.35 EPIC outlined the efforts of the Castlemaine community to oppose the introduction of 65 additional poker machines. Despite the broad community support for the EPIC position, the Victorian Commission for Gambling and Liquor Regulation (VCGLR) approved the application to introduce new machines finding that:

- the social impact of the proposal will be negative, or at best neutral;
- the proposal will result in positive economic benefit to the town (from gambling income and job creation); and
- that on balance, the net economic and social impacts of approval on the well-being of the Castlemaine community will be neutral.³¹

29 Gambling Impact Society NSW, *Submission 30*, p. 2.

30 Enough Pokies in Castlemaine, *Submission 45*, p. 2.

31 Victorian Commission for Gambling Regulation, Decision and Reasons for Decision, 3 February 2012, available from: http://enoughpokies.org/wp-content/uploads/2012/02/mhs_decision.pdf (accessed 28 May 2012).

2.36 The Mount Alexander Shire Council had 28 days to appeal the matter to the Victorian Civil and Administrative Tribunal (VCAT) and voted to file an appeal at VCAT against the VCGLR's decision to grant the licence. The predicted costs of the VCAT appeal could be significant for the local council. EPIC intends to apply to be joined as a party to the VCAT appeal so that their legal team (Maurice Blackburn on a pro bono basis) can provide the community with the best representation:

This would ensure the unprecedented level of community opposition to more pokies is clearly demonstrated to VCAT and allow EPIC and the wider public to relieve the council of many costs associated with the case.³²

2.37 Maurice Blackburn Lawyers stated:

Maurice Blackburn and EPIC hope to break new legal ground in fighting to see EPIC become the first community organisation ever to join a council in taking such strong action against pokies developments.³³

2.38 On 26 June 2012 it was reported that EPIC can participate in the VCAT hearings, 'the first genuine community organisation to be able to participate in these kind of proceedings and the first non-council body to lead evidence in an appeal from the Commission at VCAT'.³⁴

2.39 Rev. Tim Costello, Chair, Australian Churches Gambling Taskforce, commented on the Castlemaine community case:

I think it is completely unacceptable where a community is overwhelmingly against a new venue on pokies, such as the community of Castlemaine, where the council is united on that. Where there is a clear, unequivocal, overwhelming community expression of sentiment that we do not want pokies that is overruled, they are put to the expense of going off to VCAT where, because of the way evidence works and costs work, they can only argue it on very limited planning grounds, land use grounds, evidence of the community is not of itself sufficient to see them succeed at VCAT. I think it is completely unacceptable and I feel this is why it is so stacked in favour of what I regard as a predatory industry...the state governments of whatever political persuasion are so hooked on the revenue and are unable to think imaginatively about how they would plug that revenue hole, it makes it virtually impossible for communities to express their view and win when they do not want pokies.³⁵

2.40 A brief search of media found other examples of similar situations, particularly in Victoria:

32 Information available from EPIC website: <http://enoughpokies.org/> (accessed 28 May 2012).

33 Maurice Blackburn Lawyers, 'EPIC battle against pokies to break new ground', *Media release*, 8 June 2012.

34 Information available from EPIC website: <http://enoughpokies.org/> (accessed 27 June 2012).

35 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, p. 26.

- The Whittlesea Council spent around \$225,000 to oppose a plan by a Tattersalls-led consortium for 40 poker machines for the proposed Laurimar Tavern. The community wanted the Tavern but not the poker machines. Despite the opposition of the council, the VCGLR approved the plan. The matter went to VCAT and the council won. The Tattersalls-led consortium announced it would appeal in the Supreme Court but subsequently dropped this action.³⁶ More recently the VCGLR granted Whittlesea Bowls Club gaming licences for an additional 10 poker machines which would increase the venue's number of poker machines to 50 despite opposition from the council.³⁷ In July 2012 residents were campaigning against 30 machines for the Royal Mail Hotel.³⁸
- Warrnambool Council has been engaged in a process to oppose 19 additional poker machines for Rafferty's Tavern but the investors lodged an appeal with VCAT,³⁹ which refused the permit.⁴⁰ It is also opposing a planning permit application by the Flying Horse Bar and Brewery for eight machines.⁴¹
- In 2010 Bendigo Council opposed an application for 30 poker machines at the Foundry Hotel in Bendigo. In 2011 both parties went to VCAT which incurred substantial costs and the council decision was overturned. The only option was to appeal the VCAT decision in the Supreme Court. However, the council decided this avenue was too costly.⁴²
- On 22 December 2011, VCAT ruled that the Club Italia Sporting Club could increase the number of poker machines at its premises from 38 to 60. The application had been rejected by the council and the VCGLR on the grounds that increasing the number of machines at the club would be detrimental to the Brimbank community because of increased expenditure.⁴³

36 Fran Cusworth, 'Whittlesea spend \$225,000 on pokies battle', *The Northern Weekly*, 10 April 2012; City of Whittlesea Council, 'Laurimar tavern update', 23 August 2011; City of Whittlesea Council 'Laurimar Tavern Court decision', 1 July 2011.

37 Anna Whitelaw, 'Whittlesea Council to block club pokies push', *Northern Weekly*, 5 March 2012.

38 Suzanne Robson, 'Protest against pokies in Whittlesea', *Whittlesea Leader*, 2 July 2012.

39 Peter Collins, 'Warrnambool mayor backs legality of pokies vote', *The Warrnambool Standard*, 13 January 2012.

40 Alex Sinnott, 'City council hails tribunal's decision as pub's pokies refused', *The Warrnambool Standard*, 28 April 2012.

41 Peter Collins, 'Warrnambool City Council ups stakes in anti-pokies fight', *The Warrnambool Standard*, 27 March 2012.

42 Karen Sweeney, 'Foundry hits jackpot with pokies application', *The Bendigo Advertiser*, 20 April 2011.

43 Anthony Loncaric, 'VCAT overruled Brimbank on pokies', *Brimbank Weekly*, 10 January 2012; Laura Wakely, 'More pokies upheld', *Star News Group*, 15 March 2012.

Additional efforts by local councils in Victoria to have community views heard

- In February 2012, the Ballarat City Council was still waiting after five months for a meeting with the gaming minister to discuss a machine cap drop for Ballarat. In January 2012, the council voted unanimously to amend its poker machine policy to reduce the state cap of 663 by 30 per cent. The council's responsible gaming committee member Cr Des Hudson said that without a lowered cap 'the council's ability to control gaming machines was limited'. In the past 18 months the council had visited VCAT three times in relation to gaming licences which had cost Ballarat taxpayers around \$30,000 in time and expert advice.⁴⁴
- In March 2012, it was also reported that Monash City Council had also requested a meeting with the gaming minister to discuss changing laws to protect vulnerable communities. The Monash mayor, Ms Stefanie Perri, stated that the VCGLR currently considers the larger area of Monash, where the numbers of poker machines per 1,000 people is 6.97, and not suburbs like Clayton where it is 10.5. Monash Council is deciding whether to go to VCAT over seven new poker machines approved for Clayton's L'Unico Hotel which would take the total to 35.⁴⁵ On 30 May 2012, it was reported that the council voted to appeal the decision taken by the VCGLR. The mayor stated that: 'In Clayton we have a pokies plague'.⁴⁶
- Port Phillip Council is also lobbying the Victorian gaming minister to reduce the numbers of poker machines. The mayor, Ms Rachel Powning, stated concern that the VCGLR 'was encouraging, not controlling, gambling'.⁴⁷

2.41 Ms Leah Galvin, Manager of Social Policy and Advocacy, St Luke's Anglicare, spoke about the rising frustration of local communities trying to keep additional poker machines out of their community:

There is [an] enormous amount of frustration in Victorian communities about the pokie venues almost being rubber stamped through the process. Lots of local government funding—and we mentioned this in our submission; hundreds of thousands of dollars—is being spent trying to defend the position of people who live in those communities. They have a strong policy setting and they might have gaming policy documents, so they

44 Neelima Choahan, 'Ballarat pokie talks snub', *The Courier*, 13 February 2012.

45 Emma Schmidt, 'Monash Council ponders pokies appeal', *Waverley Leader*, 29 May 2012. See also <http://www.abc.net.au/news/2012-05-18/more-pokies-for-melbournes-poorest-suburbs/4020650>.

46 Stephanie Anderson, 'Council goes to VCAT to fight 'pokies plague'', *ABC News Online*, 30 May 2012.

47 Sally Spalding, 'Port Phillip pushes on to fight pokies', *Caulfield Glen Eira Leader*, 26 May 2012.

have said. And that is on behalf of their communities—but that is not sufficient to stop large increases in the number of machines.⁴⁸

2.42 Ms Galvin described the distress and hardship this can cause in communities:

There are some really serious arguments going on about it and it is dividing communities. We have seen that in several communities in recent times. Despite every single survey that local governments conduct show[ing] that basically 70 per cent plus of the people in the community say that they do not want more machines, we see increasing numbers of machines every year and increasing numbers of problem gamblers. I think the data from Ballarat shows that, for every machine, 0.8 people will become problem gamblers. But that is just the tip of the iceberg. It affects their families, their communities and the places they work. So people do feel very strongly about trying to stop that push, but they feel powerless. That does not mean that they stop trying. There is an enormous amount of energy for it, but it has not been successful to date here in Victoria.⁴⁹

2.43 The committee notes a media article reporting that from 38 applications to the VCGLR for poker machines only one was refused. The article outlines the difficulties faced by communities in opposing additional poker machines and asserts that the commission process is 'seriously flawed, and the governing legislative regime, deficient'. The process 'undermines the responsibility of local councils to promote the wellbeing of their community by giving them no power to act on this issue. It disempowers communities by removing from them the right to have a say, and be truly heard, on an issue that can impact on them well into the future'.⁵⁰ It appears that the community where the application was refused did not have any poker machines at all.⁵¹ The committee heard that arguing against an increase in numbers, rather than arguing against the introduction of poker machines, appears to be a much harder argument to win.⁵²

2.44 St Luke's Anglicare stated that the burden falls to the community to prove the harm of introducing more poker machines. It stressed the financial cost for local councils to oppose the introduction of more poker machines into communities:

48 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 51.

49 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 51.

50 Anna Howard and Jessica Howard, 'Poker machine regulator barely more than a rubber stamp', *Sydney Morning Herald*, 9 February 2012.

51 See Romsey in 2009: <http://www.romsey.org.au/news.php?id=33> (accessed 4 June 2012) and also Jan Juc in 2010 both of which had no poker machines: http://www.geelongadvertiser.com.au/article/2010/11/05/223461_news.html (accessed 4 June 2012). See also: [http://www.vcgr.vic.gov.au/CA25766E0010A233/78824A2AAA2FF7B8CA25785B00182917/\\$file/DecisionBeachHotelJanJuc041010.pdf](http://www.vcgr.vic.gov.au/CA25766E0010A233/78824A2AAA2FF7B8CA25785B00182917/$file/DecisionBeachHotelJanJuc041010.pdf) (accessed 4 June 2012).

52 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, pp 54–55.

It is undoubted that local communities in Victoria who do not want more EGMs in their towns and suburbs are currently burdened by a system which requires them to prove the harm of introducing more pokies. The burden falls to opponents rather than resource rich venue operators. This creates a huge burden for resource strapped local governments, with cases to object frequently exceeding \$200,000 in costs. A decision taken in Bendigo in 2011 by the local council was to not object to a pro-pokies decision because of the predicted excessive financial cost to the council, despite a supportive local policy environment and strong community objection. In the last year Whittlesea Council spent in excess of \$600,000 to fight the introduction of EGMs in a new property development. We regard this as a waste of valuable community resources. Consequently we recommend that the real cost to communities of opposing additional pokies be researched and quantified to inform a system which currently creates an unfair burden.⁵³

2.45 Ms Galvin discussed these issues with the committee. She noted that many local councils have local gaming policies acknowledging the harm of poker machines. However, she advised that it seems almost impossible for local governments to make a case that the social impacts of additional poker machines outweigh the economic impact:

We have seen judgments, for example, where they have said things like that the council are biased because they have a policy that is anti pokies—which is, of course, ironic given that venue operators have a very strong financial bias in their applications. So communities are very frustrated by that. It does not matter how hard they work at it or how many people say they do not like it; it can still get pushed through and rubber-stamped. Then, of course, the next process is that they go off to the VCAT, which is a tribunal which has a slightly different way of taking decisions. But that is also a very expensive and lengthy process and also does not have terrific results for communities. So, despite these surveys saying that 70-plus per cent of people do not want more, it is rubber-stamped and machines are rolling out all over the place. That is how it feels in lots of communities in Victoria at the moment.⁵⁴

2.46 Ms Galvin spoke about the level of harm to communities, including economic harm as the money does not go into local businesses:

...the reality is that we know that the more machines that get put in the more harm that is done. We are also concerned about the economic harm to communities as well. I have not really mentioned that today, but money that goes into pokie venues does not go into local businesses. This means there are reduced opportunities for employment. In regional and rural cities this is a really big problem. Really, for us, it is a simple one. We have enough machines and, in fact, that is what we campaign on in the Loddon Mallee with a bunch of other faith based organisations. We have been running a

53 St Luke's Anglicare, *Submission 13*, p. 7.

54 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 54.

campaign saying 'enough is enough'. Others have tweaked onto that as well. But we do think that there are more than enough machines, because there is certainly more than enough harm.⁵⁵

2.47 St Luke's Anglicare noted that research is needed which shows the real costs to business, communities, families and problem gamblers:

Perhaps if research was able to quantify the real costs to our communities, this would not seem like such an attractive funding stream for governments.⁵⁶

2.48 It also suggested involvement by the Commonwealth Government to cap numbers of poker machines:

...the Federal Government should pursue a policy of capping the number of EGMs, so that not a single additional machine is installed in local communities around Australia. The data and research now very strongly shows that EGMs are a dangerous and damaging product. Prohibiting the installation of more machines would show respect for communities who consistently say they do not want any more and will also acknowledge the great potential harm to individuals, families and our society from pokies.⁵⁷

Other states

2.49 Examples in the local media of community concern over numbers of poker machines such as those above for Victoria are more difficult to find for other states. Of particular note, NSW, with the largest number of poker machines, seems to have had only one such story in the media over recent years. In 2009, in NSW The Mounties Group told Fairfield Council it was prepared to spend about \$3 million over 10 years to fund a youth and community centre. In 2011 it said it could not fund the centre unless it could transfer 60 poker machines from the satellite clubs on the northern beaches to the Mount Pritchard base. Concern was raised that the poker machines were being moved into the most disadvantaged local government area in Sydney. According to the Office of Liquor, Gaming and Racing the average machine in the Fairfield local government area makes more than \$85,000 compared to the \$31,000 average machine profit in Manly. The Fairfield Council and Cabramatta police recommended that the authority reject the Mounties proposal.⁵⁸

2.50 In Tasmania, Alderman Helen Burnett from Hobart City Council was interviewed in June 2012; she advocated local government having more power over

55 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

56 St Luke's Anglicare, *Submission 13*, p. 7.

57 St Luke's Anglicare, *Submission 13*, p. 8. See also Ms Joyce Sanders, *Submission 11*.

58 Jacob Saulwick and Matthew Moore, 'Club shifts pokies to poorer punters', *Sydney Morning Herald*, 15 October 2011; Sally Lee, 'Plans on hold as club pulls pin on funding', *Fairfield Champion*, 9 May 2012; Leesha McKenny, 'Club cancels funding over pokies row', *Sydney Morning Herald*, 9 May 2012.

the placement and numbers of poker machines, particularly in disadvantaged areas to minimise harm. She highlighted the link between accessibility and gambling harm. Alderman Burnett noted that local government has more control over bottle outlets but when she asked the gaming commission about a possible increase of poker machines in a local venue she was denied information. To engage with the community, a forum was held at the Town Hall in June 2012 on the social and economic impacts of poker machines on the community.⁵⁹

2.51 The Tasmanian Greens will table legislative amendments intended to provide local councils with a say on the location and number of poker machines in local communities as they currently do with liquor outlets.⁶⁰

Concern over the impact on vulnerable communities

2.52 The clear concern from the media reporting above is the number of poker machines in vulnerable or disadvantaged communities. Research has shown that poker machines are being concentrated in disadvantaged areas. For example, research undertaken for UnitingCare Australia by researchers at Monash University found that:

...consistent with other studies...poker machine losses tend to be higher in communities with lower incomes. At the CED [Commonwealth Electoral Division] level, those communities with lower incomes also tend to have higher numbers of poker machines, a factor that is also associated with higher average losses. These associations are statistically significant.⁶¹

2.53 Professor Alex Blaszczyński told the committee: 'There is a linear relationship between the dispersment and the number of gaming machines and socioeconomic status within those particular regions'. He explained:

What we could predict basically is that there would be an increase in the number of problem gamblers and gambling within those particular regions, primarily because the people who are lower in the socioeconomic scale tend to have more disposable income. They do not have assets but they have disposable income, which they then allocate to entertainment and to gambling, with the hope of winning large amounts of money.⁶²

2.54 Professor Dan Lubman, Director, Turning Point Alcohol and Drug Centre, also referred to upcoming research 'looking at density of poker machines and

59 Joel Rheinberger, 'Poisonous shellfish and poker machines', *936 ABC Hobart*, 5 June 2012. View the forum at <http://www.youtube.com/watch?v=jNU78e3UCKw&feature=relmfu> and <http://www.youtube.com/watch?v=kc2L7NFtOGQ&feature=relmfu>.

60 Matt Smith, 'Council say on pokies sought', *The Mercury*, 18 June 2012.

61 UnitingCare Australia, *Assessment of poker machine expenditure and community benefit claims in selected Commonwealth Electoral Divisions*, April 2012, p. 4.

62 Professor Alex Blaszczyński, *Committee Hansard*, 2 May 2012, p. 14.

demonstrating the confluence within socially disadvantaged areas and the relationship between that and gambling related harms'.⁶³

2.55 Ms Emma Sampson, Research and Policy Officer, Australian Psychological Society (APS), noted the correlation between lower socioeconomic areas and increasing numbers of poker machines and detailed the concerns of the APS:

That raises a number of concerns, from our point of view, in terms of opportunities for people to participate in their community through volunteering and other things, but we also are concerned in that there are people already who are suffering from mental health issues as well as lack of opportunities. This increase in electronic gaming machines does seem to fit in to a gap, which is highly concerning in the area I worked in. In the outer suburbs of Melbourne, there were not a lot of other opportunities for people to find employment or other ways of getting involved socially in the community. We were aware that venues were expanding at a rapid pace, and that was a huge concern. We were seeing a lot of people—not necessarily people with gambling problems but their family members—coming in, needing financial assistance on a regular basis.⁶⁴

2.56 Ms Leah Galvin, St Luke's Anglicare, pointed to the publicly available data showing that the average spend in disadvantaged areas is much higher. She added:

We do know that in the area that we work in, Loddon-Mallee, there is considerable problem gambling. There is a lot of spending in pokie machines, and that is why St Luke's chooses to speak out about it. We do hear the stories and the impacts from individuals and family members, and communities too. We are hearing a lot of feedback from various communities that are trying to push back against the rolling in of more pokies into those communities and they are very unhappy about it because they also see and understand the harm. I should also say that we actively support those community groups that are trying to speak out against more pokies being introduced, and likewise we offer support to local governments who are trying to push back against that rollout as well.⁶⁵

2.57 A story on *7.30 Victoria* on 18 May 2012 drew attention to the effects of poker machines in disadvantaged areas. Local councils believe they are left to pick up the pieces for problem gamblers while the state government receives the profits. The City of Monash wants the community benefit test strengthened; this was supported by other councils at the Municipal Association of Victoria's state council which urged the

63 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 48. See Barratt, M., Livingston, M., Matthews, S. & Clemens, S. (in press). Gaming machine density is correlated with rates of help seeking for problem gambling: A local area analysis in Victoria, Australia. *Journal of Gambling Issues*.

64 Ms Emma Sampson, *Committee Hansard*, 14 May 2012, pp 31–32.

65 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 50.

VCGLR to make gambling operators contribute more to the community and examine the impact of electronic gaming machines in vulnerable communities.⁶⁶

2.58 In its Strategic Work Plan 2012-13, the Municipal Association of Victoria noted:

The increasing number and concentration of electronic gaming machines in vulnerable communities is of grave concern to councils, with the current regulatory framework for gambling providing little protection to Victoria's most socio-economically disadvantaged. While councils can raise their concerns about the negative social and economic impacts of a proposed venue or increase in gaming machine numbers in their municipal district, councils' experience to date has been that these submissions, which are costly and time-consuming to prepare, are given little weight by decision-makers.⁶⁷

2.59 In an effort to discourage additional poker machines, the cities of Manningham, Moreland and Darebin are planning to impose special rates on poker machine venues. Manningham councillor David Ellis stated that poker machines left councils with 'all of the problems and none of the benefits'. The council's general manager said the move was designed to equitably impose a differential rate on gaming venues and raise revenue to improve the residents' quality of life 'having regard to the social and economic impacts of problem gambling'.⁶⁸ The state government has indicated that it may move against the practice of differential rate charges.⁶⁹ Affected venues are indicating it may result in a reduction of subsidised community activities to cover the increase.⁷⁰

66 See: <http://www.abc.net.au/news/2012-05-18/more-pokies-for-melbournes-poorest-suburbs/4020650>. See also: Sally Spalding, 'Port Phillip pushes on to fight pokies', *Caulfield Glen Eira Leader*, 26 May 2012; Municipal Association of Victoria, State Council, 17 May 2012, Resolutions from membership. Note: In 2010-11 in Maribyrnong, which according to the ABS covers Melbourne's second most disadvantaged suburb of Braybrook, \$985 was spent by each adult compared with the state average of \$613, see <http://www.vcgr.vic.gov.au/CA256F800017E8D4/gamblinginfo/A9CDBCD1535E0085CA25790500031F7E?OpenDocument> (accessed 20 June 2012). See also Alesha Capone, 'Gambling grief rises', *Star News Group*, 19 June 2012.

67 Municipal Association of Victoria, *Strategic Work Plan 2012-13*, May 2012, p. 13.

68 Anthony Loncaric, 'Rates respite for three gaming venues', *Brimbank Weekly*, 29 May 2012.

69 See Victorian Greens, 'Greens take on big parties in fight for Local Council's right to tackle problem gambling', *Media Release*, 16 August 2012 which indicates that both Liberal and Labor parties will be supporting the Local Government Legislation Amendment Bill 2012 which would prevent local councils from charging differential rates.

70 Kristian Silva, 'Council defends Manningham pokies sting', *Melbourne Weekly Eastern*, 29 May 2012; Laura Wakely, 'Rates hike anger', *Star News Group*, 29 May 2012. See also John Masanauskas, 'Council rates battle', *Herald Sun*, 21 May 2012, p. 12; Miki Perkins, 'City push for extra rates on pokie sites', *The Age*, 21 June 2012.

The VCGR process

2.60 The Victorian Commission for Gambling Regulation (VCGR) process is set out below:

Applications to increase the number of gaming machines in a municipal district are assessed by the VCGR, and local councils are also provided with an opportunity to present their views on an application affecting their community.

The VCGR assesses all applications at a public hearing where applicants must provide evidence to the VCGR in respect of their application to increase gaming machines in a municipal district. Local councils are able to attend these hearings and provide evidence to contest an application.

In summary, for approval to be granted, the VCGR must be satisfied that an application to increase the number of gaming machines will not result in net social and economic detriment to the local community.⁷¹

Caps

2.61 Caps on poker machines in Victoria were introduced in 2001 when the state government set what it believed to be appropriate regional caps on the numbers of poker machines in certain areas based on their vulnerability to the harm caused by large numbers of EGMs.⁷²

2.62 The committee notes in 2009 it was announced that the VCGR would review the caps (set by the Minister for Gaming in 2006) on the number of poker machines in areas of Melbourne and the state before the end of that year. By law these reviews must be held every five years 'but this inquiry has been brought forward because of new figures on the growth of the population and the radical change to the gambling industry after 2012'.⁷³ On 20 October 2009 the Minister for Gaming announced there would be twenty capped regions, with each region capped at a specific density of gaming machines per thousand adults. The VCGR determined the maximum permissible number of gaming machines in each capped region using the criteria set by the minister. Only one region, the City of Hume, required a reduction in gaming machines to meet the cap set by the VCGR. No reductions were required in the

71 Information available from:
<http://www.vcgr.vic.gov.au/CA256F800017E8D4/LicInfo/A4562839C30D540CCA25777C000428F9?OpenDocument> (accessed 14 June 2012).

72 Poker machine caps are a legal limit on how many poker machines can be operated within specific geographic areas of Victoria. Caps are set by the Minister for Gaming but the minister may refer his powers to the VCGLR. See
<http://www.vcgr.vic.gov.au/CA256F800017E8D4/LicInfo/07758F2C146D2A1DCA25777D0081CC21?OpenDocument> (accessed 28 May 2012). See also Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 54.

73 Victorian Commission for Gambling Regulation, 'Poker machine numbers to be reviewed in parts of Victoria', *Media Release*, 4 May 2009.

remaining 19 regions, but no more machines can be added to those regions.⁷⁴ Municipal caps were introduced in 2009 at a ratio of 10 poker machines per 1,000 adults. If the population rises, the limit may increase. Municipal limits are overridden if a regional cap also applies.⁷⁵

Victorian Government response to community concern

2.63 The committee is aware that many local councils have local gaming policies acknowledging the harm of poker machines.⁷⁶ The response from the Victorian gaming minister to date is that a cap has been put on the number of poker machines in vulnerable areas but essentially nothing can be done for 10 years as legally binding 10 year entitlements were issued by the previous government. The gaming minister pointed out the legal avenue for councils noting that the quality of council submissions was 'patchy at best' and councils need to 'do their homework so that they can present the best possible argument to the regulators'.⁷⁷

Committee view

2.64 As this issue was not central to the committee's terms of reference it did not receive a great deal of information directly. However, the committee notes with interest the significant amount of local media reporting in Victoria describing the levels of concern about increasing poker machine numbers, particularly in disadvantaged communities, and local councils engaged in attempts to oppose these additional poker machines. Given the concern does not appear to be so high in other states, the fact that in Victoria poker machines were introduced relatively recently, in the early 1990s, means that more Victorians may remember a time when there were no poker machines. In addition, the machines that were introduced were placed in community venues, often in disadvantaged areas, and were capable of high levels of harm which became evident quite quickly. This contrasts with the situation in New South Wales where poker machines were introduced in the 1950s and the evolution from the less to more harmful machines has been more gradual.

2.65 The committee notes the call from St Luke's Anglicare for the Commonwealth Government to put a cap on the numbers of poker machines. It also notes this is part of a process for gambling reform put forward by the independent Member for Lyne,

74 Information available from:
<http://www.vcgr.vic.gov.au/CA256F800017E8D4/gamblinginfo/DF7FE2471BC986ABCA25799F00173390?OpenDocument> (accessed 20 June 2012).

75 Responsible Gambling Advocacy Centre, Information Sheet, *Pokies Caps in Victoria*, March 2012.

76 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 54.

77 See: <http://www.abc.net.au/news/2012-05-18/more-pokies-for-melbournes-poorest-suburbs/4020650>.

Mr Rob Oakeshott MP.⁷⁸ In its first inquiry the committee noted that decisions around the distribution and caps of EGMs should remain a matter for state and territory governments and this remains its preference, provided local communities can effectively engage with their state government and its gambling regulators.

2.66 The current system in Victoria appears to leave local governments almost powerless to act on the wishes of a community opposing additional poker machines if an area is not fully saturated with them. The only option open to local councils, the appeal system involving VCAT and the Supreme Court, is an option too expensive for many to pursue. This particular system appears weighted against the community and in the face of increasing levels of community concern, the committee believes a more balanced process for meaningful engagement with the community should be found. However, the committee acknowledges the real challenges for state governments which benefit from poker machine revenue to take meaningful action to change a model that profits them.

2.67 The current response from the Victorian Government to the level of concern in some communities appears inadequate. The committee makes the point that a public health approach includes and engages the community to address problems. The committee notes with concern the extraordinary effort and potential expense facing some communities and local councils, particularly in disadvantaged areas, just to stop additional poker machines being introduced despite the already overwhelming evidence of the harm they can cause.

2.68 The committee notes the planning process for venues is separate to the gaming licence process. Planning objections could include concerns about traffic, car parking, noise and disturbance, hours of operation, heritage issues, amenity and character impacts, and effects on CBD businesses and traders. The current situation appears to suggest that legal obligations override principles of good planning and community well-being. Although the committee can understand the reasons for the 10 year entitlements it believes this is an unreasonable length of time during which no changes can be made, as the character and needs of a community can change quite quickly. The committee strongly suggests that in future much shorter contracts be considered. There should also be review processes included where communities can provide input on the negative effects of gambling harm.

2.69 The committee would encourage the Victorian Government to enter into good faith negotiations to ascertain whether arrangements/conditions can be reviewed in some circumstances, particularly for communities in disadvantaged areas where considerable community opposition to additional poker machines is demonstrated. During this process the government should consider providing additional resources (advisory, financial) to disadvantaged communities which are opposing additional poker machines. In addition, where a community is unsuccessful, the government

78 See Mr Rob Oakeshott MP, Federal Member for Lyne, 'Oakeshott puts gambling reform to the parliament', *Media release*, 15 February 2012.

should indicate what resources will be provided to local communities to deal with increased problem gambling. The committee would also suggest that existing capping arrangements be reviewed after 12 months' operation of the new system with a view to taking into greater consideration the higher risk faced in disadvantaged communities of increased problem gambling.

2.70 The committee is, however, pleased to note that on 14 June 2012, the Victorian Treasurer directed the Victorian Competition and Efficiency Commission to undertake an inquiry into the social and economic costs of problem gambling in Victoria. It is to provide a final report by 14 December 2012.⁷⁹ The committee further notes that the terms of reference include 'the differential costs of problem gambling across geographical areas of Victoria'.⁸⁰

79 See <http://vcec.vic.gov.au/CA256EAF001C7B21/pages/vcec-inquiries-current-inquiry-into-social-and-economic-costs-of-problem-gambling> (accessed 23 July 2012).

80 See [http://www.vcec.vic.gov.au/CA256EAF001C7B21/WebObj/TermsofReference-ProblemGamblingInquiry/\\$File/Terms%20of%20Reference%20-%20Problem%20Gambling%20Inquiry.pdf](http://www.vcec.vic.gov.au/CA256EAF001C7B21/WebObj/TermsofReference-ProblemGamblingInquiry/$File/Terms%20of%20Reference%20-%20Problem%20Gambling%20Inquiry.pdf) (accessed 23 July 2012).

Chapter 3

Approaches to prevention

3.1 This chapter looks at prevention and the challenges of developing effective measures to assist people wherever they may be on the 'gambling continuum' from low to high risk. The committee's first report noted the 'gambling continuum' or that the severity of gambling problems is a dynamic process.¹ Gamblers and problem gamblers are not a static group as they move in and out of levels of risky gambling behaviour and can do so quite quickly.

3.2 This chapter and the next three will focus on primary and secondary prevention measures and related issues. Primary prevention aims to avoid the occurrence of a problem. The chapters will look at primary initiatives such as public information campaigns, communication strategies and education programs aimed at influencing individuals away from risky gambling behaviour. In this area the committee heard that there is no 'one size fits all' message that would be meaningful for all places on the gambling continuum. Serious concerns with the current key message of 'gamble responsibly' were also highlighted to the committee.

3.3 The following chapters will also cover secondary prevention measures which seek to diagnose and treat a problem early before it worsens and causes significant additional problems. With secondary prevention there is a degree of overlap across the chapters that address treatment issues, particularly in relation to getting people to seek help earlier. The treatment chapters will cover tertiary prevention measures, such as counselling, which seek to reduce the impact of a problem when already embedded, to restore functioning and reduce harm. This continuum of prevention measures is described below.

A public health approach to prevention

3.4 The public health approach assists not just those experiencing harms but also aims to prevent or minimise the risk of future harm, and uses an inclusive notion of prevention:

Primary prevention activities are aimed at preventing individuals in the general population from developing gambling problems (such as public awareness raising campaigns promoting responsible gambling).

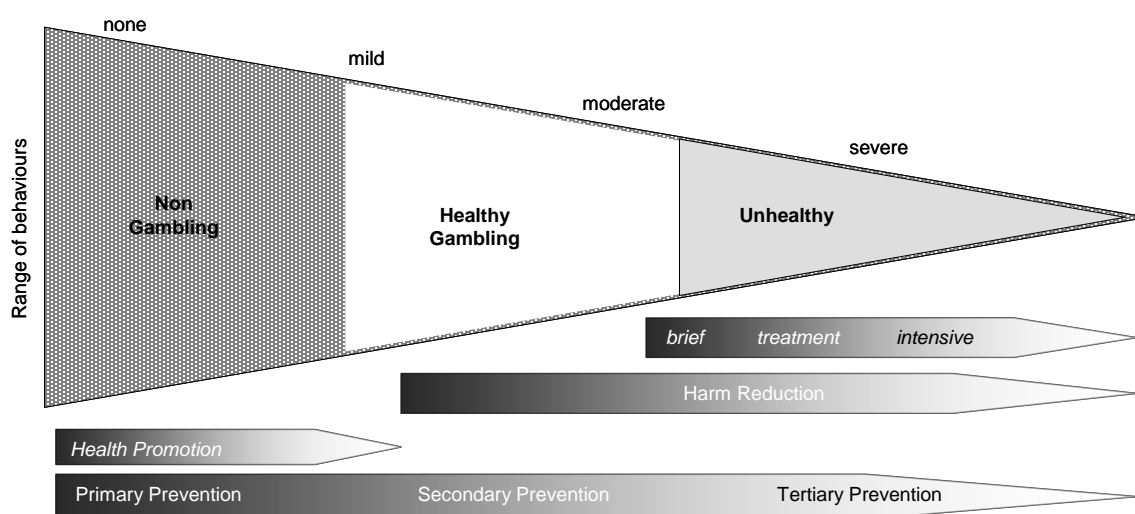
1 Parliamentary Joint Select Committee on Gambling Reform, *First report: The design and implementation of a mandatory pre-commitment system for electronic gaming machines*, May 2011, pp 49–57. Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity, and Treatment*, American Psychological Association, 2005, p. 13; The Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 5.

Secondary prevention activities seek to limit harm in the early stages of problem development (such as through intervening early), with a focus on at-risk groups.

Tertiary prevention activities are about treating or reversing the effects of problem gambling.²

3.5 These stages correspond to the following diagram:³

Figure 7.1 **Gambling problems lie on a continuum**



Source: Korn and Shaffer (1999).

Advantages of public information campaigns

3.6 The Productivity Commission (PC) emphasised that 'interventions need to cover the full continuum of gambling problems and not just focus on 'treatment':

Governments should place greater emphasis on community awareness, to dispel common myths about gambling, tell people how to gamble safely and encourage earlier help-seeking and interventions by family and friends.⁴

3.7 Public information campaigns can have a number of advantages which include: raising community awareness; increasing knowledge; encouraging people to

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.7.

3 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.8.

4 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.1.

recognise risky behaviour for themselves and others; and providing information on where and how to access help.⁵

Difficulties with measuring behavioural change

3.8 However, the PC pointed out that in order to reduce the harms associated with gambling, campaigns need to result in behavioural change which is difficult to achieve and to measure.⁶ Ms Penny Wilson, Chief Executive Officer, Responsible Gambling Advocacy Centre,⁷ pointed out that there is usually a spike in contact with treatment services after a public campaign but it is difficult to know whether this help-seeking continues and leads to ongoing behavioural change.⁸

3.9 The difficulty of assessing the effectiveness of such campaigns was confirmed by Dr Samantha Thomas, a public health sociologist from Monash University, who emphasised that while prevention is an important component of the problem gambling equation, it is difficult to measure:

How do you show that x number of people did not engage in behaviour? It is much easier to show that x number of people sought help, and gambled a lot less as the result of interventions.⁹

3.10 Despite the difficulty, Dr Thomas stated that as with many other health and social issues such as road safety, tobacco, obesity and alcohol use, 'prevention is a vital component of the health and wellbeing of individuals, communities and populations'.¹⁰

3.11 It is also difficult to assess the effectiveness of these campaigns as any effect on awareness and attitude may only be evident over the long term.¹¹ In order to change behaviour in other areas such as smoking, 'sustained campaigning over an extended period of time is generally required before population-wide changes in

5 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

6 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

7 The Responsible Gambling Advocacy Centre (RGAC) ceased operations on 30 June 2012. Many of the functions of the RGAC, including providing information to the public about responsible gambling and its regulation in Victoria, will continue to be provided by the Gambling Information Resource Office, which is part of the newly established Victorian Responsible Gambling Foundation.

8 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 28.

9 Dr Samantha Thomas, *Submission 52*, p. 2.

10 Dr Samantha Thomas, *Submission 52*, p. 2.

11 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

behaviour become evident. In the case of tobacco, behavioural changes took over 40 years to occur'.¹²

Campaigns can assist with connecting people and treatment services

3.12 An objective of campaigns which is much easier to measure is connecting people with treatment services. Dr Ralph Lattimore, Assistant Commissioner, Productivity Commission, explained to the committee that new awareness campaigns appear to have at least a temporary effect of attracting new clients to treatment services and this was shown by evaluations of campaigns in NSW, Tasmania and Victoria.¹³

3.13 Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, Gambling Treatment Program, St Vincent's Hospital, recalled a television advertising campaign from 2002 for the gambling helpline which seemed to raise awareness as the Program experienced an increase in referrals to treatment. While there have been other mediums such as radio used since then she could not recall a similar campaign using television.¹⁴

3.14 Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, emphasised that:

We know those programs have an effect because one of the groups which they say do not seek treatment is young men. Eighty per cent of the people we see are men and most of them are young. In their common parlance among themselves they say, 'I had a gambling hangover,' which is the remorse which drives them to treatment and that is a phrase which came from a media campaign.¹⁵

3.15 However, the University of Sydney Gambling Treatment Clinic (GTC) indicated that a basic analysis of their referral calls and information requests did not show a change in numbers following initiatives from the NSW Responsible Gambling Fund such as the 'Gambling Hangover' campaign, rebranding of services under the 'Gambling Help' banner, the 'Counsellor Sam' Facebook page and Responsible Gambling Awareness Week. In contrast, numbers of clients seeking treatment increased following GTC media releases to local and metropolitan print media which focused on new and evidence-based treatments on offer. The GTC explained:

These new callers typically reported high levels of dissatisfaction with their previous treatments and various services and had intentionally avoided treatment for many years. Our impression is therefore, that public awareness can be raised by providing newsworthy releases to media outlets

12 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

13 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

14 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 19.

15 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 19.

on the latest research on gambling, innovations in industry and research on gambling treatments, rather than simply highlighting the harms associated with excessive gambling.¹⁶

Issues concerning 'responsible gambling' messages

3.16 Witnesses raised concerns about the effectiveness of the key message in most campaigns which is a version of 'responsible gambling'. The concern centred on the almost exclusive focus on personal responsibility.

Focus on personal responsibility

3.17 Witnesses stressed to the committee that responsible gambling messages which leave all responsibility with the individual are largely ineffective, particularly for those already at increased risk or with a problem. This message focuses on individuals taking personal responsibility and seeking help if they experience problems. The key criticism was that the message heard by gamblers is that if someone can't gamble responsibly then something is wrong with them. The effects of this message can be seen in the level of stigma attached to admitting a gambling problem, which is in turn reflected in the low rates of people seeking assistance. The committee heard that this approach can shame people into silence through casting blame on the individual. Witnesses also felt that this message advantages the industry as it takes the responsibility from the industry and the product and places it solely with the individual.

3.18 Ms Julia Karpathakis, Manager, Pokies Anonymous, explained how this message can make people who have a gambling problem feel:

Firstly "Gamble Responsibly" makes absolutely no sense to a person who has become addicted to the pokies, it's too late! Also it is confusing to the person as it may make them think they are the only one with a problem that other people can gamble responsibly and that they can't. This phrase may cause them to never reach out for help with feelings of shame for being out of control.¹⁷

3.19 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists and Director, Turning Point Alcohol and Drug Centre, explained how this message feeds into the low numbers of people seeking help:

So we have a huge issue here with normalisation and certainly the messages that are promoted around alcohol and gambling are of individual responsibility, that is up to you and that basically if you have problems with alcohol or gambling then essentially there is something flawed in you as a person. I think that creates huge stigma. It means that, unlike other health disorders where we say to people that there are a whole range of reasons

16 University of Sydney, Gambling Treatment Clinic, *Submission 10*, pp 2–3.

17 Pokies Anonymous, *Submission 31*, p. 2.

people are vulnerable to developing problems and come to a health practitioner to get help, we are essentially saying that people with addictions have some sort of moral failure within them in controlling their behaviour. People then fear that in presenting to health professionals they are going to be similarly discriminated against and ostracised. I think there is a failure in the lack of understanding that there are effective treatments available for people in the community.¹⁸

3.20 Dr Samantha Thomas explained that this approach puts responsibility on the individual for:

...voluntarily listening to the message, and changing their behaviour to interact with the product 'responsibly'. It also is used repeatedly by industry (including alcohol, junk food, soda and gambling) as a reason not to change their practice—if people engaged 'responsibly' with our products there wouldn't be a problem.¹⁹

3.21 While noting that at a basic level there is nothing wrong with asking people to take responsibility for their interaction with a product, Dr Thomas emphasised that 'some individuals may be more able to take 'responsibility' than others'. She also pointed out that it is important for industry to take equal responsibility for the potential harms their product may cause. Dr Thomas also cautioned that as has been shown for other health and social issues, people will continue to enter 'at risk' groups unless 'upstream' prevention initiatives²⁰ effectively address why there is a problem in the first place.²¹ Work undertaken by Dr Thomas on how gambling is valued by different groups is covered briefly in chapter five.²²

3.22 The Productivity Commission recognised the limits of the personal responsibility approach and listed the groups who would be ignored by this model:

- the general vulnerabilities of consumers, which may be accentuated by particular aspects of the gaming environment and its technologies. Consumers who are misled by a supplier cannot be called 'irresponsible'
- the vulnerabilities of groups suffering from mental health problems. For example, people with depression and bipolar disorder have a much higher likelihood of developing gambling problems. Overall, around 35 per cent of problem gamblers have a severe mental disorder compared with around 2 per cent of non-problem gamblers (Jackson 2008). These people suffer a

18 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 38.

19 Dr Samantha Thomas, *Submission 52*, p. 3.

20 Changing the environment through policies and regulation.

21 Dr Samantha Thomas, *Submission 52*, p. 3.

22 See Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisation of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, 22 May 2012, report prepared for the Office of Gaming and Racing, Department of Justice, Victoria.
[http://www.justice.vic.gov.au/home/liquor+gaming+and+racing/research+and+statistics/report+-+conceptualisations+of+gambling+risks+and+benefits+\(pdf\)](http://www.justice.vic.gov.au/home/liquor+gaming+and+racing/research+and+statistics/report+-+conceptualisations+of+gambling+risks+and+benefits+(pdf)).

particular disadvantage that makes them susceptible to some of the risky features of some gambling technologies, such as the capacity to gamble in a trance for long periods of time or to ramp up spending from very small to very large amounts

- the large number of people who may be regarded as ‘irresponsible’ and their economic importance...problem gamblers are a significant proportion of the relevant group of gamblers and they account for a large share of spending
- the fact that apparently ‘irresponsible’ behaviour may have damaging consequences for many people beyond the actual gambler and even for society as a whole (for example, through fraud, domestic violence and work-related costs associated with problem gambling)
- groups where the strong incentives posed by the adverse personal consequences of their actions (gambling, but also binge drinking and dangerous driving) appear to have few effects on their subsequent behaviour. These groups — particularly poorly educated and disadvantaged young men — have systematically higher risks of persistent harmful behaviours. Merely asserting the value of self-responsibility does not necessarily address the costs to themselves (or others). In the case of motor vehicle safety, many of the gains in reduced accidents have in fact been based on modifications to the environment (roads, vehicle safety), not the behaviour of the driver...
- circumstances where people do not know what behaviours would equate with self-responsibility until it is too late. For example, people who believe that gambling losses today can readily be made up by wins tomorrow, next week or next month (a common faulty cognition), may not see current excesses in their gambling behaviour as irresponsible
- the potential for regulation to reinforce, rather than undermine, self-responsibility. In particular, pre-commitment and self-exclusion measures provide all gamblers with the option to exercise self-responsibility, not to undermine it
- the capacity for regulation to be targeted at those with problems, or at risk of experiencing substantial harm, without much effect on recreational gamblers. The need to uphold the principle of self-responsibility is reduced if ‘responsible’ people can still freely undertake an activity without burdensome constraints. For instance, it is hard to see what degree of freedom is lost by a capacity to insert no more than \$20 of cash into a gaming machine while the credit balance is above \$20, as recommended by the Commission. Nothing stops a gambler inserting more money when the balance falls below \$20, and given their usual intensity of play, this will occur only rarely for ‘responsible’ gamblers. Indeed, it even increases the demand on them to behave responsibly by actively requiring them to think about the personal consequences of investing more. Where such a measure would act most would be on impulsive people spending continuously at very rapid rates.²³

23 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, pp 3.13—3.14.

3.23 The committee notes that this focus on personal responsibility creates shame and stigma for those who develop gambling problems as it suggests there is something wrong with them if they cannot control their gambling. These feelings of shame and stigma contribute to the low rates of people who seek help. Suggestions to address this issue are covered in the next chapter.

Mixed messages

3.24 Apart from the focus on personal responsibility, witnesses discussed the lack of balance in gambling messages in a number of areas. The committee heard that gambling messages are overwhelmingly positive, they lack information on risk, possible negative effects and the amount of positive advertising completely overwhelms any other messages. Witnesses also put forward the view that a change in public attitude towards gambling is necessary to result in any significant improvement in help-seeking behaviour.

Is the message 'responsible gambling' really an ad to gamble?

3.25 It was pointed out that the focus of the 'gamble responsibly' message was still a message to gamble and the only choice was to do so responsibly or irresponsibly, rather than the message being about a choice to gamble or not. Mr Tom Cummings, former poker machine addict and gambling reform advocate, described this situation:

So I think we need to look at what is being offered and how it is being offered—the messages that are being put forward. Even something as simple as 'gamble responsibly'; whether it is responsible or irresponsible, the message that is being put forward is 'gamble'. Rather than it being a choice either to gamble or not to gamble, it is a choice to gamble either responsibly or irresponsibly. There is a third choice. Some people do not want to gamble. So why not change the message? I am not sure what to change it to. I am sure we could debate that for a long time.²⁴

Lack of balance in content of messages

3.26 Witnesses indicated the overwhelming message that people receive about gambling is positive. Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, spoke about the need for more balanced messages:

The marketing of the win and the marketing of the dream is not balanced. What that means is when we come to talk to people who are dealing with a gambling problem, part of their distortion is built on what they are fed, which is that this product can give you a wonderful life. But there is little balance. Actually the reality is that it is very unlikely you are going to have any sort of outcome other than losing. The longer you play, the more you are going to lose.²⁵

24 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

25 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

3.27 The committee discussed with Dr Enrico Cementon, Fellow, Royal Australian and New Zealand College of Psychiatrists, how gambling is promoted as glamorous and the effects of this. He stressed that one of the first things to address in the treatment of addiction is to reduce the positive aspects associated with the behaviour and increase the negative to achieve a balance 'which is one of the core drivers of the person's decision-making and the behaviours they engage in'. He added:

When the negative effect associated with gambling outweighs the positive effect, the person seeks to do something about it—to change their behaviour in some way. They either seek treatment or do something else.²⁶

3.28 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, also spoke about this imbalance:

I would go further to say that there is a current imbalance in the way that gambling is portrayed in the community. There is very strong marketing of and emphasis on the positive aspects of gambling and really a very small amount of information about the harms and the costs associated with gambling.²⁷

Lack of balance in amount of advertising

3.29 Witnesses also emphasised the lack of balance in the amount of gambling advertising which overwhelms responsible gambling messages. This is particularly evident for sports betting which has a notable amount of 'in-your-face' advertising and live odds commentary. The amount of this advertising is not in any way balanced by a comparable number of responsible or effective gambling messages to minimise risk. This view was supported by Professor Alex Blaszczynski who told the committee that the sports betting advertising should not just be constrained but that it should be abolished.²⁸ The committee addressed this issue in its second report covering interactive and online gambling and gambling advertising.²⁹

Lack of information on risk

3.30 Another element of the 'responsible gambling' message criticised was the lack of information on the element of danger or risk with the gambling product, instead leaving the responsibility for potential harm with the individual. Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, explained that the responsible gambling message emphasises that gambling is a benign activity, when there is solid research to indicate that regular use of poker machines in particular can be harmful for some:

26 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 41.

27 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 42.

28 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 17.

29 Joint Select Committee on Gambling Reform, *Second Report: Interactive and Online Gambling and Gambling Advertising and the Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, December 2011.

Many current public information messages about problem gambling actually provide misinformation. I think that public information or education is irresponsible in itself. I think it is dangerous. They speak of 'responsible gambling', which puts the onus of being responsible on the gambler. While people play with that phrase grammatically, that is what it means. It tells people to keep gambling and it is up to the gambler to be responsible. This contrasts with alcohol, where we use the term 'responsible serving of alcohol', so maybe we should talk about responsible serving of gambling. Most seriously, the message implies that gambling on EGMs is a benign activity as long as you act responsibly. I think that is quite serious misinformation, because it flies in the face of a solid body of research, including that by the Productivity Commission, that regular gambling on pokie machines is the main risk factor—that is, a large proportion of regular gamblers on the machines become hooked.³⁰

3.31 Dr Borrell further explained that the danger associated with regular use of poker machines is not part of any public education campaign:

This is the advice I give to people close to me. If I hear that they are idly putting a few coins in a machine while they are meeting family or friends at a pub, I tell them: 'You shouldn't do that, because that's dangerous. You don't know. You may get hooked; you may not. You don't know. But that's not a safe practice, to regularly put money in those machines.' If I say that to my family and friends, that is what I would want in a public education campaign: 'These machines are a dangerous product and should not be played on a regular basis.' I do not know why that should be so controversial, because the research for that is very, very solid and we all know it.³¹

3.32 Ms Kate Roberts, Gambling Impact Society NSW, added:

What we generally know is that people do not tend to see the messages that are out there at the moment. The information that is out there about the odds on winning et cetera do not mean anything. The information we have discussed before is about making the fact [known] that these products, electronic gaming machines, are highly addictive and we know that. Fifty per cent of people who play them as they are meant to be played will lose control.³²

Negative effects of gambling are not shown

3.33 Witnesses contrasted responsible gambling information campaigns with campaigns for other products such as smoking where possible negative effects are shown. Professor Malcolm Battersby, Head of Department, Human Behaviour and Health Research Unit, Flinders University, stated:

30 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 21.

31 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 21.

32 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

An example is the big smoking campaign. I was walking past the university the other day and almost the whole side of a bus showed a guy coughing blood into his handkerchief. 'That is not all you're coughing up, mate.' I thought, 'You could say exactly the same for the pokies but rather than blood you would have something else.' You do not see any ads like that.³³

3.34 Ms Julia Karpathakis also supported stronger advertising:

Instead of this namby-pamby 'responsible gambling' soft stuff, we need some really gutsy activity. On my fence at home, I have a billboard—a friend donated a billboard type thing to me—that says: 'Are the pokies ruining your life? Need help?' and then our phone number. We have made stickers for cars just to get the message out there: they are ruining lives. That is real. It is not 'responsible gambling' making you feel, 'Is there something wrong with me?' No, there is nothing wrong with you. If the pokies were not here, these people would not have problems. And the mental problems come after they have been playing.³⁴

Change in public attitude is required

3.35 Dr Sally Gainsbury commented on the mixed messages sent to the public being 'bombarded on television with all the odds of winning, and it is in venues, clubs, community halls, bars and restaurants'. Then there are occasional public information campaigns telling people to 'gamble responsibly'. She argued that problem gambling being recognised as an important public health issue is necessary to see a shift towards more people seeking help as it would be seen as acceptable to do so:

...generally what needs to happen before any kind of intervention can actually work is a systematic program to attempt to modify the public attitudes towards the behaviour and get it to the point where people can recognise gambling problems and are aware of what to look for.³⁵

3.36 Professor Alex Blaszczynski also commented on the mixed messages received by the public regarding gambling and agreed with the need to focus on changing public attitudes:

I think from a public health approach the key issue is not necessarily one of providing information but one of attitude change, and I think this is the difficulty. If you look at drink-driving, if you look at alcohol, if you look at bicycle helmets, all of those have been mandated by legislation and then there has been a shift in public attitude towards it, to the point where, for instance, smoking was acceptable in the past then legislation was introduced to prevent smoking indoors and now you are a pariah if you smoke, so public attitudes have significantly changed. With gambling we have the mixed messages, essentially, of James Bond type portrayals of

33 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 6.

34 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

35 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 13.

gambling; we have the media; we have the large—\$650 million—American lottery promotions et cetera and you have got the promotions within Australia, in particular through the media and sports betting.³⁶

3.37 Professor Dan Lubman also spoke about the need for a cultural change around the role of gambling in society:

As I spoke about before, I think that is about a cultural change. That is not just about presenting services; it is about a cultural change about the role of gambling in society. It is a broader discussion and a community engagement about the harms it causes. It is a recognition that it is a real disorder that needs treatment and it is about hearing visible voices of people who have gambled who have recovered and who have good stories to tell about success stories about how recovery is possible. It is a concerted effort and it speaks to my comments before around the role of an organisation like beyondblue.³⁷

What about the product?

3.38 Mr Tom Cummings highlighted that responsibility has to involve more than just the individual and must include the industry:

Things can be done to tighten up the industry and place a greater onus of responsibility on the industry that offers these products, whether it is poker machines, sports gambling or online gambling. Responsibility has to work in every direction. People do need to be responsible, and that is the message that is coming through very responsibly from the industry, but the industry needs to be responsible as well. They are offering this product and providing it for people to use, so they need to have a responsibility to do so ethically and with a minimum of harm. I think there is also a legislative responsibility. Industry will do what they can within the rules that apply. So it is almost a three way street, though I hate to say it that way. It is certainly something that needs to be looked at by all corners.³⁸

3.39 Dr Samantha Thomas agreed that along with the individual it is important for industry to take equal responsibility for the potential harms that a product may cause, particularly with vulnerable individuals or communities.³⁹ The adequacy of venue and product measures is covered in chapter six.

Contending with messages on machines

3.40 The committee notes that advertising for poker machines is banned. However, Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, pointed out

36 Professor Alex Blaszczyński, *Committee Hansard*, 2 May 2012, p. 14.

37 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 49.

38 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

39 Dr Samantha Thomas, *Submission 52*, p. 3.

other messages on the poker machines themselves which occur as part of the play that any public information messages and campaigns have to contend with:

So you need to look at the information and inducements to buy more products within the play itself, and often when people have lost control over their own reasoning processes. Examples of the information are: 'You just missed by a whisker,' 'You nearly won,' 'You just missed,' 'Keep playing and you will win soon,' 'If you keep playing, you will eventually win the jackpot,' or, worse, 'Congratulations, you are winning,' even though they are losing overall. So there is lots of information happening as part of the play. Any public information is weighed against that, as well as intermittent reinforcement, which is the devastating aspect of the machine—that you are being reinforced all the time. You are actually being given little bits of marketing and information to keep you there all the time. I think that is why there is a limit to how much public information messages can do, like telling people the odds, weighed against the hundreds or thousands of messages they are getting to the contrary.⁴⁰

3.41 Dynamic messages on poker machines are discussed further in chapter six.

Some campaigns to date

3.42 All states and territories have in place strategies for raising community awareness about gambling and help services. The committee wrote to all states and territories to ask about gambling campaigns over the last 10 years and their effectiveness. It received responses from South Australia, Western Australia, Queensland and the Australian Capital Territory. Below are the main campaigns including evaluations.

South Australia

3.43 In South Australia the Gamblers Rehabilitation Fund (GRF) is administered by the Office for Problem Gambling, Department for Families and Communities. It funds agencies to provide services to problem gamblers. Over the past 10 years there have been four campaigns: 'Think of What You're Really Gambling With' ran periodically from 2003 to 2006; 'Win back your life' ran periodically during April-June in 2011; Responsible Gambling Awareness Week 2009 and Responsible Gambling Awareness Week 2012. An evaluation of the 2003–2006 campaign showed a high recall rate from the TV advertising, an increased awareness of and use of gambling help services and increased awareness of gambling awareness week. An evaluation of the 2009 Responsible Gambling Awareness Week campaign showed the number of calls to the Gambling Helpline during that week increased but there was no increase in hits to the website.⁴¹

40 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 21.

41 Correspondence from the South Australian Department for Communities and Social Inclusion, received 21 May 2012.

Western Australia

3.44 In Western Australia the gambling awareness campaigns are funded by the Problem Gambling Support Services Committee. Over the past 10 years there have been three campaigns: a metropolitan problem gambling awareness for six weeks in 2005; a regional problem gambling awareness campaign for five months in 2007; and a 12 month problem gambling awareness campaign over 2011–12. In-house evaluations of the campaigns have indicated increases to problem gambling helpline calls during the advertising periods.⁴²

Queensland

3.45 In Queensland there have been four phases of a responsible gambling community awareness campaign over 2005 to 2007 using an early intervention approach, with the target group being low to moderate risk gamblers. Evaluation looked at recall, understanding and behavioural shift. With recall of the message dropping off, the campaign was refreshed and run in two month blocks over October 2009 and January 2010. Recall and behaviour change increased. 42 per cent of the low and moderate risk gamblers indicated that they had taken action as a result of the campaign; for example, thinking about their gambling and reducing gambling activities. In 2006 the 'Wanna Bet' campaign targeting problem gamblers and promoting help services was rolled out. Phase one included an 'out-of-venue' component of press advertisements. Phase two involved continued display of posters in gambling venues combined with press advertisements during 2008. An evaluation of phase one found recall and understanding was high. Phase two aimed to achieve greater community awareness and awareness of services and the helpline. Results indicated that awareness increased with the level of problem gambling risk. It concluded that message fatigue was occurring and the campaign materials should be refreshed. The 'Odds of Winning' was launched in 2009. Again recall increased with gambling risk. The committee notes advice that specific campaigns targeted to each 'at-risk' group are more effective than broad-based community awareness campaigns.⁴³

Australian Capital Territory

3.46 The ACT Gambling Counselling and Support Service is funded by the Problem Gambling Assistance Fund largely made up from a levy on gaming machine revenue. The fund is administered by the ACT Gambling and Racing Commission. Mission Australia has responsibility and funding to promote its services and raise awareness of problem gambling in the ACT. Over the past 10 years the Commission has conducted four responsible gambling awareness campaigns which usually

42 Correspondence from the Department of Racing, Gaming and Liquor (WA), received 24 May 2012.

43 Correspondence from the Office of Regulatory Policy, Liquor, Gaming and Fair Trading, Department of Justice and Attorney-General (QLD), received 4 June 2012.

coincide with Responsible Gambling Awareness Week.⁴⁴ In 2001 the Commission conducted a two month TV campaign to raise awareness of the mandatory code of practice which provides key harm minimisation measures for gambling. From 2009 to 2011 the Commission conducted campaigns featuring TV and print advertisements that coincided with the awareness weeks. To evaluate the campaigns, the Commission monitors traffic on its problem gambling websites as well as referrals to help services. Referrals to gambling help services generally increase during campaigns and the website receives more traffic. The ACT advised that while the campaigns to date have been successful in raising awareness, the Commission is currently undertaking research to help better target messages to key risk groups.⁴⁵

Committee view

3.47 The committee notes the view advanced by the industry that gambling is a harmless form of entertainment for most individuals.⁴⁶ Advertising reinforces this view by promoting gambling as glamorous and harmless fun. The committee heard that this message is not balanced by clear messages about possible risks and the amount of positive advertising overwhelms harm minimisation messages. The committee agrees that recognising problem gambling as an important public health issue will assist to facilitate a change in public attitude. This change in attitude would see a shift to more people seeking help as it would be seen as acceptable to do so.

3.48 To facilitate this change in attitude it is important to have the right messages. A major concern from witnesses was about the key message in many campaigns of 'responsible gambling'. The committee heard that this message reinforces the view that it is up to the individual to gamble responsibly. If they don't, there must be something wrong with them. This creates feelings of stigma and shame and contributes to the small numbers of people seeking help. People are so reluctant to seek help that they are usually involved in some crisis, for example, financial or relationships, before they do so. Suggestions on how to address this stigma and negative stereotypes of problem gamblers are covered in the next chapter.

3.49 Governments run occasional responsible gambling campaigns usually during the National Responsible Gambling Awareness Week. Many of these campaigns appear to be targeted at connecting people with gambling help services. While this is important and relatively easy to measure, it is focussed mainly on people who already

44 A national campaign run by each state and territory held in May each year since 2006.

45 Correspondence from the ACT Gambling and Racing Commission, received 8 June 2012.

46 Australasian Gaming Council, *A database on Australia's gambling industry 2009-10*, 2010, Chapter 4, p. 20; Australian Government, *The Facts, Gambling in Australia*, <http://www.problemgambling.gov.au/facts/> (accessed 5 June 2012); Thomas, A, Moore, S, Kyrios, M, Bates, G, Meredyth, D, Jessop, G, *Problem Gambling vulnerability: The interaction between access, individual cognitions and group beliefs/preferences*, Final Report prepared for the Victorian Government, Office and Gaming and Racing, Department of Justice, August 2012, p xiv.

have a problem. It is difficult to measure whether the increase in help-seeking that usually follows a campaign translates into ongoing behavioural change. There appears to be less focus on prevention campaigns although the committee did hear of examples in some states which are attempting to focus on this aspect. Improving the prevention aspect of information campaigns to better target messages and increase their effectiveness is the focus of chapter five.

Chapter 4

Improving prevention measures: addressing stigma and negative stereotypes

4.1 As outlined in the previous chapter, one of the key messages to the committee was that the shame and stigma associated with a gambling problem is one of the main barriers to an individual seeking help. The committee heard how the focus on personal responsibility, conveyed in the variations of 'responsible gambling' messages used in public information campaigns, contributed to feelings of shame and stigma for individuals who had developed a problem with gambling. The key criticism was that the message heard by gamblers is that if they can't gamble responsibly then something is wrong with them, that the problem is their fault, and they are personally to blame. The committee heard that this approach of placing an overwhelming responsibility on the individual for gambling problems can shame them into silence, and create a barrier to help seeking. Consequently the personal responsibility approach and the stigmatising effect of this approach may be one reason why very few people seek help. Rather, they may seek help only as a last resort, and feel discouraged from seeking help early. Disturbingly, the committee heard that there is greater stigma around seeking help for problem gambling than with illicit drug use. As seen with other public health issues such as obesity, alcohol and tobacco, the framing of problem gambling as an issue of personal responsibility advantages the gambling industry and government as it takes the responsibility from them and places it solely with the individual.

4.2 The committee would encourage readers to take the time to read the personal stories provided to the committee from those who have been and are going through an addiction to poker machines. These personal stories clearly convey the shame and stigma.¹

4.3 Addressing the stigma associated with problem gambling will go a long way to facilitating a necessary shift in public attitudes towards gambling and problem gamblers mentioned in the previous chapter. Witnesses provided a number of suggestions to improve the messages used in social marketing initiatives (including campaigns, education initiatives and professional training) to address stigma and stereotypes.

1 See for example, James, *Submission 19*; Mr Tom Cummings, *Submission 22*; Pokies Anonymous, *Submission 31*; Name Withheld, *Submission 38*; Name Withheld, *Submission 56*; Name withheld, *Submission 57*. See also personal submissions from previous inquiries.

The need to address and reduce stigma and stereotypes

4.4 As described by Mr Tom Cummings, former poker machine addict and gambling reform advocate:

It is a brutal addiction, one that bears the weight of a darker stigma than almost any other addiction or affliction in Australian society; there was a time when I would rather have died than admit that I had a problem.²

Stigma is a barrier to seeking help and seeking it earlier

4.5 Problem gambling is a stigmatised behaviour.³ Witnesses pointed out that the stigma and shame associated with a gambling problem is the main barrier to people seeking help and early intervention.⁴ Ms Christine Sanchez, Team Leader, Mission Australia, told the committee stigma is a huge barrier to seeking help:

It concerns me that gambling has more of a stigma attached to it than illicit drug use. People say, 'I use illicit drugs' or 'I'm a recovering alcoholic', and everyone gets congratulated and patted on the back and 'It's great that you're so strong'. Yet, when people say, 'I have a gambling problem', there is still all this stigma and guilt attached to it. When you think about it, illicit drug use, for example, comes along with a whole heap of breaking of society's rules and legalities and it is still seen as a better option than admitting to a gambling problem.⁵

4.6 UnitingCare Community emphasised that the stigma and embarrassment means that people keep their problems secret rather than seek help:

Avoid stigmatising or shaming problem gamblers. The shame and guilt drives the secrecy to gamble and this then drives the gambling behaviour to continue.⁶

4.7 Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, explained how the stigma attached to gambling problems makes them feel:

To put it really bluntly, I think gamblers feel stupid and a lot of the public rhetoric is about the problem being located purely inside the gambler. Once someone is in treatment...one of the things we spend a lot of time doing is saying that the reason they have a problem with gambling is the interaction between the human mind and typically for most of our clients the poker

2 Mr Tom Cummings, *Submission 22*, p. 1.

3 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 5.14.

4 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 24.

5 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 39. See also Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 2.

6 UnitingCare Community, *Submission 59*, p. 3.

machine, but that is not generally appreciated out in the public. You hear people saying gambling is a tax on the stupid, which we definitely do not agree with. We see a lot of very intelligent people, we see professionals, we have seen doctors, lawyers and engineers, and they all come in saying, 'I don't know what's wrong with me; I'm not a stupid person.' That relates to the stigma. A drug addict knows and can understand why they are doing it even if they think they should not be.⁷

Stigma contributes to low numbers of people seeking help

4.8 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, explained how the stigma feeds into the low numbers of people seeking help:

It means that, unlike other health disorders where we say to people that there are a whole range of reasons people are vulnerable to developing problems and come to a health practitioner to get help, we are essentially saying that people with addictions have some sort of moral failure within them in controlling their behaviour. People then fear that in presenting to health professionals they are going to be similarly discriminated against and ostracised. I think there is a failure in the lack of understanding that there are effective treatments available for people in the community.⁸

The 'responsible gambling' message contributes to stigma for problem gamblers

4.9 All those who spoke to the committee from personal experience or from dealing with people with gambling problems expressed the view that the current key message of 'responsible gambling' contributed to the amount of stigma around gambling problems and was ineffective, particularly for those who have already developed a problem. Dr Samantha Thomas, a public health sociologist from Monash University, indicated that one of the unintended consequences of the focus on personal responsibility is the stigmatisation of individuals. This discourages people with problems and those developing risky gambling behaviour from seeking help earlier.⁹

4.10 The limits of the 'personal responsibility' approach were emphasised by the Productivity Commission (PC):

...while there are reasonable social expectations that people take responsibility for their own behaviour, that does not limit the need for significant regulation of gambling. Moreover, to the extent that people face gambling problems because of co-morbid conditions or unsafe features of gambling technologies and venue environments, labelling them as

7 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 18.

8 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 38. See also Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p.xxiii.

9 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 24.

‘irresponsible’, as some industry groups have done, risks stigmatising people who need help, while deflecting attention away from product safety issues. A problem gambler wishing to self-exclude or to otherwise approach a venue or some outside body for help, may be less likely to do so if their behaviour is labelled as ‘irresponsible’.¹⁰

The need for de-stigmatisation

4.11 Witnesses emphasised that in order to encourage people to seek help and particularly to seek it earlier, the stigma associated with problem gambling needs to be addressed.¹¹ Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, agreed that addressing stigma would be the key to more people seeking help and seeking it earlier. He compared willingness to seek help for gambling with other mental health issues:

One of the issues we have with gambling is that it is very difficult for people to acknowledge, because of the stigma, that the gambling is an issue. They are much happier to come forward and acknowledge, for example, the mental health issues, on which, over the last 10 years there has been an immense amount of work in terms of destigmatisation. Ten years ago people probably would not have come for a mental health issue; they would have come for a physical disorder and then we might have broached mental health.

So this just emphasises that people do seek help but they seek help in ways that they are comfortable with. And they seek the help in ways that they feel are less stigmatised, be that for a physical or a mental health issue. We need to seize those opportunities then to address the underlying substance use or gambling issue.¹²

4.12 Dr Samantha Thomas also spoke about the need to address stigma in order to encourage more people to seek help. Dr Thomas explained that most current social marketing campaigns are based on people seeking help if they have a problem and that this focus on the individual creates stigma and negative stereotypes. Instead of targeting the individual, preventative messages and preventative campaigns would target the risks associated with the product or the industry:

I think the main barrier is stigma. So, if we seriously want to encourage help-seeking behaviour, not just from problem gamblers but from the huge number of individuals who may have moderate-risk gambling behaviours, who may bounce in and out of that category, we have to tackle stigma. That

10 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 3.14.

11 See Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p.xxiii.

12 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

needs to happen at a whole bunch of different levels. We need to learn a lot from mental health and from other highly stigmatised conditions. We may need to think about running antistigma campaigns in gambling. We also need to encourage a clearer community discussion around the issue of stigma which takes the emphasis off individual irresponsibility and puts it onto the problems with the industry and the products.¹³

4.13 Dr Thomas spoke about negative stereotypes created around problem gambling:

We have created a whole range of stereotypes around what a problem gambler looks like—that they are someone who has lost their house, they are in jail, their relationship has broken up and they have not taken responsibility for making correct choices with the product. In many ways we have created this unintended consequence which is stigmatising people and discouraging them from seeking help early.¹⁴

4.14 Ms Kate Roberts, Gambling Impact Society NSW, also spoke on the need to address stereotypes:

...there is also the need for families and the community generally to understand and reduce the kinds of stereotypes we have about problem gamblers or people who are dealing with problem gambling in their lives so that it is seen as a health issue. At the moment, both the industry and to some extent government messages stigmatise and add in. Even the concept of responsible gambling, by the alternative, suggests that someone is irresponsible.¹⁵

4.15 Ms Penny Wilson, Chief Executive Officer, Responsible Gambling Advocacy Centre, agreed and also spoke about the changes needed:

We know that messages that are negative and identify people as problem gamblers do not drive people to seek help. The advertisements often do not work effectively for the target audience they are seeking to engage with because people in a problem-gambling phase do not identify themselves as problem gamblers. The committee knows from previous inquiries that there is a lot of fluidity between problem gamblers, high risk gamblers and moderate gamblers—there is a lot of movement. Campaigns which encourage seeking help, but in a much more positive way, and campaigns that locate the issue not just with the individual but also in a wider context to make people feel more comfortable about seeking help would probably be the No. 1 change. The No. 2 change would be about better preventative education so that people are aware of issues and are not so frightened to seek help by the time they get to a situation in which they need to do it.¹⁶

13 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 24.

14 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 23.

15 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

16 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, pp 29–30.

4.16 The PC acknowledged that community awareness campaigns can reduce the shame and stigma associated with a gambling problem.¹⁷ Witnesses suggested a focus on reducing stigma using other successful campaigns in areas such as mental health as a guide.

Example of beyondblue and depression

4.17 The *beyondblue* work with mental health was highlighted as an example of a public health campaign which attempts to de-stigmatise seeking help for a mental illness. Mr Mark Henley, Member, Australian Churches Gambling Taskforce, explained how this would work for gambling to de-stigmatise help-seeking:

...the work that *beyondblue*, for example, has done with mental health is an example of public health advertising which tries to de-stigmatise. So, as applied to gambling, it is: 'If you're having a bit of a problem with your gambling, there's no shame in looking for help. Talk to friends, talk to family go to a help service.' I think that that is the sort of fairly simple mass media message that can be really effective.¹⁸

4.18 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, also spoke about lessons that can be taken from *beyondblue* and the area of depression:

I think there is a lot of lessons to be learnt here from our experience with, for example, *beyondblue*. Ten years ago the whole area of depression was seen as being highly stigmatised. There was not a visible face of depression, so it was a very silent disorder where people suffered in silence and the general view was that people who had depression got it because they were weak in some way and just could not cope with the everyday stresses of life. What *beyondblue* has successfully done over the last 10 years through a range of activities is educated the community around the normalisation of depression—the successes of depression and how people can be helped—and what it has made is a visible community of people who have recovered and are successful.

The key learnings there for the gambling area are that for the moment the people who suffer with gambling suffer in silence and are not visible and the people who successfully overcome the gambling do not talk about it—it is a shameful part of their pasts and they put it behind them—so the only message that goes to the community is that there are winners and only a small number of losers and that in some ways they deserve it because of their moral make-up.

So I think there is a lot of work we can do in terms of community awareness, and I would certainly be urging the committee to look at the positive outcomes from initiatives such as *beyondblue* and to think about

17 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

18 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 14.

how that sort of approach could increase community awareness and community engagement and understanding of a condition that is very poorly understood and treated.¹⁹

4.19 Professor Malcolm Battersby, Head of Department, Human Behaviour and Health Research Unit, Flinders University, agreed that efforts by *beyondblue* and governments in the area of depression have been successful and that the targeted marketing using all forms of media with a systematic funding cycle has also played a part in the success.²⁰

4.20 The committee discussed using the benchmarks of help-seeking for other mental disorders such as anxiety and depression as a target. Currently in the area of anxiety and depression around 35 per cent of people seek support. This compares with around 8 to 17 per cent for problem gamblers.²¹

Other campaigns to draw from

4.21 The Queensland Government is running the 'Change our Minds' campaign addressing mental illness. It includes personal stories and 'change champions' which in this case are sporting clubs joining the campaign to help reduce the stigma of mental illness.²² It has been running since October 2011. The Queensland Government committed \$8 million over four years to the campaign to get the message to the community. The government will provide a further \$600,000 over three years to the Queensland Alliance for Mental Health to change attitudes and behaviours at a grassroots level.²³

4.22 Following the release of the Queensland campaign in 2011, the former South Australian Greens spokesperson for Mental Health, Ms Tammy Franks MLC, called on the state government to fund a similar campaign and highlighted the benefits:

Anti-stigma mental health campaigns are proven to reduce the costs to society of mental illness. Research from the London School of Economics based on the Scottish See Me initiative identified that for every £1 spent on that anti-stigma social campaign there was an economy-wide saving of more than £8. Research on the Like Minds, Like Mine campaign in New Zealand identified a similar return on investment. Reducing discriminatory attitudes towards mental illness would mean people would be much more likely to talk about their mental health needs and seek support and treatment earlier. We know that when that treatment is sought early there are

19 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 42.

20 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

21 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.3.

22 See <http://www.changeourminds.qld.gov.au/> (accessed 4 July 2012).

23 Information from: <https://d2dl.groupsie.com/post/change-our-minds-new-qld-anti-stigma-campaign-announced> (accessed 5 July 2012).

significant benefits in reduced demand on crisis point services and productivity loss. That is why New Zealand, Scotland, England, Canada, the USA and Ireland have all seen the value in ending the stigma and discrimination of mental ill-health with anti-stigma campaigns.²⁴

4.23 The Stigma Project is a grassroots organisation in the USA that aims to lower the HIV infection rate and neutralise stigma associated with HIV/AIDS through education and awareness via social media and advertising.²⁵

4.24 Ms Penny Wilson, Chief Executive Officer, Responsible Gambling Advocacy Centre, spoke about a gambling example in Canada. The problem gambling treatment agencies in Ontario co-fund the Public Health Gambling Project.²⁶ It is a long established partnership between the University of Toronto, the Ontario Centre and the YMCA to deliver preventative gambling education to students, parents, schools and communities and de-stigmatise the issue.²⁷

Developing a social marketing campaign to address the stigma associated with problem gambling

4.25 Drawing largely from the area of mental health, the committee supports the development of social marketing campaigns that include addressing the stigma associated with a gambling problem. The messages would be embedded in areas such as public information campaigns, communication strategies, education programs and staff training and could include the following areas.

Anti-stigma campaigns

4.26 It is important to have anti-stigma campaigns targeting individuals. Instead of emphasising personal responsibility the messages for individuals experiencing problem gambling would encourage them to overcome the stigma and shame and seek help. This could be achieved by using social marketing strategies and messages which emphasise that this problem happens, it can happen to anyone and they should not be ashamed to seek help. The committee heard how it would be effective to use personal stories from people who have sought help as well as stories from high profile people who have experienced problem gambling, sought help and recovered.

Positive messages from individuals are needed

4.27 Witnesses advocated having more personal stories from people who have been through the experience of problem gambling as part of advertisements and

24 Information from: <http://www.tammyfranks.org.au/2011/10/12/time-to-change-our-minds-sa-needs-anti-stigma-mental-health-campaign/> (accessed 4 July 2012).

25 See <http://www.thestigmaproject.org/#!home/mainPage> (accessed 4 July 2012).

26 See <http://www.phgp.org/> (accessed 6 July 2012).

27 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 30.

information on gambling. Associate Professor Peter Harvey, Manager, Statewide Gambling Therapy Service, noted:

We were recently on a radio program, not as good as a television program in terms of coverage, with one of our volunteer recovered gamblers. She spoke very honestly about how that process affected her and how shameful it was and all that sort of thing. I think having more people who have been through that experience and getting the message out into the community and connecting with other people saying, 'Well, there is a person who has got the same sort of background or problem I have got. They have been able to challenge it and cope with it. They have gone to get help.' It is having them talking like that in public, more information out there about what the risks are and what sort of damage it does to families and the community. That is all about promotion, about communication. We are not doing that very effectively.²⁸

4.28 Ms Penny Wilson, Responsible Gambling Advocacy Centre, agreed that it is important for individuals to hear from people who have been through a gambling addiction:

I think the committee started out by hearing from people like Mr Tom Cummings this morning. I have heard Tom's story in many different ways many different times and it never fails to affect me and it is similar when I talk to other people who are self-identified problem gamblers about what they have gone through and what they experience. Learning from people who have faced the problem is certainly an important thing. Then you have to apply that to measures, policy settings, availability and access to Gamblers Help services.²⁹

4.29 In addition to individuals, anti-stigma campaigns targeted towards the public would address negative stereotypes of problem gamblers with messages that indicate anyone can be affected by problem gambling. Again the committee heard that using role models and people of influence for this message could be effective.

4.30 These campaigns should be supported by education and professional training programs which ensure stigma is a key component.

The use of de-stigmatising language

4.31 Using negative language to describe problem gamblers such as calling them irresponsible³⁰ contributes to the feelings of shame and embarrassment they already feel. Drawing from the area of mental health, the committee notes that sane Australia runs sane Stigma Watch which is a service where stigmatising language in the media

28 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 7.

29 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 28.

30 Clubs Australia, 'Clubs Express Concern at Gambling Report', *Media Release*, 21 October 2009.

or elsewhere concerning mental health can be reported.³¹ As part of an overall strategy it would be effective to challenge the use of stigmatising language around problem gambling in the media and elsewhere problem gamblers are given negative labels such as irresponsible.

Addressing any unintended consequences of campaigns

4.32 It is also important to ensure any campaigns don't have any unintended consequences by causing stigma—for example, putting blame on the individual which, as explained above, makes people feel more ashamed and less inclined to seek help. The committee heard repeatedly that the 'responsible gambling' message has created this unintended consequence by stigmatising people and discouraging them from seeking help, particularly discouraging earlier help-seeking.

Including new information formats

4.33 The committee heard how it would be useful to incorporate new information formats such as social media into campaigns.³²

Recent attempts at anti-stigma campaigns

4.34 In June 2012, the Queensland Government launched a campaign which asks people to consider whether they or someone they know are 'Gambling too much'. The messages will be available in venues and target problem gamblers. The Queensland Government claims that it is one of the first campaigns to seek to remove the stigma associated with problem gambling and counter negative stereotypes. It also aims to drive behaviour change through encouraging people to seek counselling assistance, explore self-help options or undertake self-exclusion measures.³³

4.35 During the inquiry a new advertising campaign was launched in the ACT coinciding with Responsible Gambling Awareness Week, with the tagline 'Gambling. If you have to lie, we need to talk'.³⁴ It was also accompanied by an image of lips sewn together. Ms Christina Sanchez, Team Leader, Mission Australia explained that the campaign is about getting people to talk so that gambling is no longer a secret.

It is about having those discussions that people are too scared or have felt too much shame and guilt to discuss and to talk about. When we discussed

31 See <http://www.sane.org/stigmawatch/how-stigmawatch-works> (accessed 5 July 2012).

32 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 7.

33 Attorney-General and Minister for Justice, The Hon. Jarrod Bleijie, 'Government campaign launched to help problem gamblers', *Media release*, 26 June 2012; Queensland Government, Office of Liquor and Gaming Regulation, <http://www.olgr.qld.gov.au/responsibleGambling/awareness/InvenuePGcampaign/index.shtml> (accessed 2 July 2012).

34 See <http://www.missionaustralia.com.au/daily-news/2587-gambling-if-you-have-to-lie-we-need-to-talk> (accessed 9 July 2012).

the ad, we had a limited amount of funds and we have such a wide demographic of people that are in trouble with gambling that we thought: how can we target everyone, and what is the common theme that goes over gambling? And it was lying: lying to yourself as well as to loved ones. The lies are: 'I can just walk away at any time' or 'I'll just put another \$20 and then I will never gamble again in my life.' It was about once you feel that you have to lie about a situation, then perhaps it is time you talked about it. Because people do not lie because something good is happening; they lie because they are ashamed or guilty about something, or there is someone they are trying to protect. It was about: let's talk, we need to talk; it is time that we talk about this issue.³⁵

4.36 Ms Sanchez said that Mission Australia did some market research with gamblers. While they found the image confronting they said it was how they felt: they were scared to talk, they didn't know who to talk to or whether they would be judged as bad people.³⁶

Committee view

4.37 The committee notes the contradiction that despite the growing normalisation of gambling in some areas such as sports wagering, stigma remains a considerable barrier to individuals seeking help for a gambling problem and particularly to seeking help before they reach a crisis point. The committee heard that to a person experiencing gambling problems, the current imbalance in social marketing campaigns which focus responsibility on the individual may be unintentionally increasing stigma. The committee believes that more research is needed on this issue to develop appropriate and effective messages for social marketing campaigns.

4.38 The committee heard that campaigns and broader social marketing initiatives need to address stigma head on with strong messages to encourage community awareness and discussion. While recent attempts to address stigma are well intentioned and it is encouraging to see this issue being thought about, the committee notes it will be important to evaluate the campaigns to see how effective they are and determine any unintended effects.

Recommendation 3

4.39 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs Problem Gambling Taskforce commission research on the complex causes and consequences of stigma and the most effective way to address and reduce the stigma associated with problem gambling. States could then draw on this work to develop strategies to address stigma and include appropriate messages in their own social marketing campaigns.

35 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, pp 38–39.

36 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 39.

Recommendation 4

4.40 The committee recommends that gambling social marketing strategies, particularly those claiming to address stigma, are thoroughly market researched prior to launch and evaluated to determine effectiveness and any unintended consequences.

4.41 The next chapter discusses other suggestions on how to address the current imbalance in social marketing campaigns.

Chapter 5

Improving prevention measures: better targeting messages and other suggestions

5.1 The previous chapter covered the need to address stigma and stereotypes associated with problem gambling to encourage more people to seek help and to seek it earlier and also to raise awareness in the community and change public perceptions. This chapter covers the remaining suggestions for more effective social marketing campaigns. Key messages in the chapter include the need to understand why people gamble and to find alternatives as well as the need for a range of messages to better target 'at-risk' groups and other key information to be included in social marketing campaigns.

Need to understand why people gamble

5.2 Dr Samantha Thomas, a public health sociologist from Monash University, indicated that in order to develop effective preventative programs there is a need to understand why individuals engage in gambling as a leisure activity. She stressed that until this occurs:

At the moment for gambling we are constantly trying to patch the road. We do that for a whole range of different issues. That approach puts the ambulance at the bottom of the cliff, rather than the fence at the top. We also constantly try to catch up with all of those individuals who have tumbled into the risk category.¹

5.3 Work undertaken by Dr Thomas for the Office of Gaming and Racing, Victorian Department of Justice,² showed that there are three clear groups of gamblers: low-risk, moderate-risk and problem gamblers, who interact with gambling in different ways. Low-risk gamblers fear losing money so they do not engage in gambling to a significant degree, while moderate-risk gamblers are more regular gamblers; they want the win and see gambling as social activity. This is seen in young men engaging in sports betting. Many moderate-risk gamblers can move in and out of the problem gambling category if they binge. This group is very focused on personal responsibility: that they should be able to control themselves. For problem gamblers, instead of wanting to win, they need to win to recover losses.³

5.4 When speaking about why people gamble, Dr Thomas highlighted the importance of promoting alternatives to gambling and using messages to shift behaviours to other leisure activities:

1 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 20.

2 Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisation of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, 22 May 2012, report prepared for the Office of Gaming and Racing, Department of Justice, Victoria.

3 Dr Samantha Thomas, *Committee Hansard*, 18 June 2012, pp 1–2.

One of the things we clearly know from social marketing is that you have to offer an alternative to people. You cannot just say, 'Do not gamble.' You cannot have that as your major message. You have to give an alternative. We know that when we have risk behaviours we have to offer something that is of benefit for the individual to then move to. At the moment we do not have that alternative.⁴

Offering and finding alternatives to gambling

5.5 The Victorian Local Governance Association (VLGA), while agreeing that seriously addressing primary prevention methods is important, highlighted the need to address the causes of excessive gambling and people's motivations to gamble as well as better understanding the product. It noted that people gamble for entertainment and excitement, to win money, for social reasons, such as boredom, isolation and loneliness, and to escape from their problems. There may be few other entertainment options in their area. The VLGA stressed that measures to prevent problem gambling need to focus on the motivations for gambling, particularly social connectedness, community strengthening and providing alternatives.⁵

5.6 Anglicare Tasmania said that they work with community groups to build their capacity to develop healthy alternatives to gambling in their communities:

For example, we recently commenced work in collaboration with Neighbourhood Houses to provide a range of interventions such as a 'chance to talk' and parenting courses. These programs aim to build the resilience and self-esteem of individuals so they are less likely to go for a game on the poker machines, help the Neighbourhood Houses develop activities that are meaningful and interesting and help them with referral pathways.⁶

5.7 Dr Samantha Thomas emphasised the importance of creating alternatives to gambling in order to create a new range of norms for a community:

There is no point in a town having a pokie venue as the only place of entertainment, the only place where people can go. We have got to create alternatives for communities. Then, with that layering on the top of exposing practices and so on, people shift naturally into different forms of activity and forms of entertainment. We have got to offer the community alternatives as well, otherwise we leave people with nowhere to go and that behaviour is very difficult to shift.⁷

5.8 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, emphasised that blaming individuals shames them into silence and a public health approach would look at not only better regulation of the product but also the reasons why people gamble:

4 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 22.

5 Victorian Local Governance Association, *Submission 25*, p. 2.

6 Anglicare Tasmania, *Submission 12*, p. 9.

7 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 25.

Another point about the public health approach is that it aims to empower people and communities to address their own health. This is taking it a bit broader. In contrast, the supply of pokies takes away people's control and shames them into silence through casting blame on individuals. An empowering approach would not only see the better regulation of a hazardous product, but it would address the social malaises that entice people into the psychological oblivion of the machines where they are trying to escape. Measures to promote meaningful social engagement and connection with other people should be supported.⁸

Committee view

5.9 The committee agrees that understanding why people gamble is important in addressing the social and environmental aspects of problem gambling. Communities and governments ensuring there are appropriate alternatives to gambling is also an important preventative measure. The committee notes that the need to find alternatives to gambling is highlighted in many of the problem gambling help websites.⁹ It also notes that the need to find recreational alternatives to gaming venues is starting to be recognised with programs such as 'the 3rd Place' concept which aims to connect individuals, decrease social isolation and to re-build strong, healthy, vibrant and interactive communities.¹⁰

5.10 A successful example is 'Don't gamble with your group'. This has been produced by the Victorian North East Primary Care Partnership in partnership with Gamblers Help Northern Services, Multicultural Gamblers Help Program, Spectrum Migrant Resource Centre and Northern Federation of Ethnic Senior Citizens Clubs. This resource has been developed for social, senior and ethnic groups in Melbourne's inner and northern suburbs. The aim of the resource is to provide groups that go on outings with appropriate non-gambling related options that can be undertaken at low to moderate cost.¹¹

5.11 Organisations could draw from these models to develop a resource for their communities. Resources created by and for the community can help bring about a fundamental shift in the public perception of recreational activities.

A range of messages are needed for different groups

5.12 The committee heard about the need for a range of public information messages as people can be at different places on the gambling continuum, from low to high risk, and can be in different stages of behavioural change, particularly for those with comorbid disorders.¹² Consequently, there is no one size fits all message.

8 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 22.

9 See http://www.problemgambling.sa.gov.au/asp/helpful_tips_and_support.aspx (accessed 6 July 2012).

10 See <http://www.ld.swin.edu.au/crd/thirdplace.htm> (accessed 6 July 2012).

11 See <http://www.nepcp.org.au/resources/social-outings-guide-don%E2%80%99t-gamble-your-group> (accessed 16 July 2012).

12 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

Messages need to be targeted to the different groups as people will only attend to what is relevant to them. Dr Samantha Thomas emphasised the need to target campaigns to reach different groups.

We cannot take a one-size-fits-all approach to gambling. Within gambling as an umbrella term there are a huge number of different types of products, and different types of individuals engage with those products in different ways.¹³

5.13 Dr Thomas provided a few possible examples of social marketing campaigns but cautioned that in order to develop appropriate messages it will be important to understand what a particular group values about gambling:

Social marketing campaigns should be targeted. They should be segmented. We should work out what that message needs to say. It may not be a message about taking personal responsibility with gambling. It may be something that is more around the benefits of engaging in different types of activities. The best social marketing campaigns will take something that has already been reformed. For example, it may be that we offer tax incentives for pubs to offer live music if they do not have pokie machines within the pubs. And then the social marketing campaign comes on top of that to encourage people to change their behaviour and to move away from the venue which has the pokie machines and move into the venue that has the live music and still offers all the same benefits that the pokie venue may have. It may also be something around value—so what you get for \$100 in a pokie machine venue and what you might get for \$100 somewhere else. But in order to really appropriately craft those campaigns, we need to work out what it is the community values about these activities in the first place.¹⁴

5.14 She emphasised that a better understanding of socio-cultural factors would facilitate appropriately tailored messages, social marketing campaigns and policies that respond to risky behaviour in different groups:¹⁵

At the moment we are seeing a concentration of effort in a certain area of gambling. What we need to do is to broaden that out to start to think about how we engage with and target different groups of individuals who may value engaging with different types of products in different ways. It is not until we really start to understand that that we will be able to really craft our prevention initiatives.¹⁶

Highlight the risk for various groups, particularly moderate risk

5.15 The committee heard about the need for messages to be targeted to the different risk groups, particularly those at moderate risk who could quickly develop riskier gambling behaviour. Greater awareness of risky behaviours could assist this

13 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 20.

14 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, pp 22–23.

15 Dr Samantha Thomas, *Submission 52*, p. 2.

16 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 20.

group to develop control strategies and seek help early. Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, stressed that:

There are no warning messages or health messages out there about people who are particularly at risk and what they can do to reduce their harms. Certainly there are a whole range of health promotion efforts that the government is pushing in a whole range of different disorders, and they increase people's knowledge around what their personal risk is and what they can do to minimise harms.¹⁷

5.16 Ms Kate Roberts, Gambling Impact Society NSW, also emphasised:

There needs to be some kind of information about giving consumers the real story around the potential risk that is more than about odds.¹⁸

5.17 Dr Samantha Thomas stated that apart from those at risk with poker machines the increase of sports and online betting has seen the emergence of new groups of individuals at risk:

...with the rise of things like sports and online betting, we are starting to see a number of different types of individuals who are coming into these moderate risk categories. In particular, we are focusing on young men.¹⁹

5.18 The Productivity Commission (PC) cautioned that with gambling, increasing knowledge can be overridden by irrational beliefs and campaigns can have little effect if people are not obliged to attend to the information or have no fundamental interest in it. The PC concluded that targeting campaigns at at-risk groups, to assist them to develop control strategies and know where to access help, may be effective.²⁰

5.19 The committee notes the range of gambling help campaigns undertaken by the Queensland Government which expressed the view that specific campaigns targeted to each 'at-risk' group are more effective than broad-based community awareness campaigns.²¹ The ACT also advised that it is currently undertaking research to help better target messages to key risk groups.²²

Need to target CALD/ATSI communities

5.20 The committee asked about information and resources available for people from a culturally and linguistically diverse background (CALD) and for Aboriginal and Torres Strait Islander (ATSI) communities. The PC noted that while there is little published data about gambling in Indigenous communities, the available evidence

17 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 42.

18 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

19 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 20.

20 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

21 Office of Regulatory Policy, Liquor, Gaming and Fair Trading, Department of Justice and Attorney-General, Queensland, correspondence received 4 June 2012.

22 Correspondence from the ACT Gambling and Racing Commission, received 8 June 2012.

suggests that gambling is a common activity in these communities. Having a problem with gambling is often seen as a weakness and seeking help as shameful.²³ Mr David Pigott, National Manager, Government Relations, Mission Australia, noted gambling is a concern in Indigenous communities:

The anecdotal evidence I have is that it is a huge issue for the Northern Territory, with backyard bingo or any number of kinds of gambling going on in communities, kids involved in the sense of running errands for parents and getting cash and things. It is a major hidden issue. Alcohol and drug abuse get the focus in Indigenous communities but, underlying that, there are a whole lot of forms of gambling going on which I presume are all illegal in some form or another but they are just happening within communities and groups.²⁴

5.21 Associate Professor Peter Harvey, Director, Flinders Centre for Gambling Research, advised that their project officer working in Indigenous communities in Ceduna reported anecdotally on the impact of problem gambling on Aboriginal families:

They seem to be a much more vulnerable group, and the gambling is actually affecting the families to a larger extent than it would in mainstream communities.²⁵

5.22 In their submission Associate Professor Peter Harvey and Professor Malcolm Battersby advised that:

Engagement with the wider ATSI communities, including enlistment of social networks and community leaders reduces the considerable denial, stigma and shame experienced by problem gamblers within ATSI communities that are barriers to treatment uptake and retention (see Clarke, Abbott, DeSouza & Bellringer, 2007).²⁶

5.23 The Australian Psychological Society (APS) noted an increased prevalence of gambling among Indigenous people and emphasised the importance of targeted interventions. It recommended that:

...further attention is given to gambling in Indigenous communities. In particular, interventions should be culturally appropriate and include broader community capacity building components.²⁷

5.24 The APS also highlighted the risk in CALD communities:

Emerging evidence suggests that there are indicators of risk in recently arrived and Culturally and Linguistically Diverse (CALD) communities.

23 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.12.

24 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 6.

25 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 6.

26 Flinders University, *Submission 8*, Attachment 1, p. 38.

27 Australian Psychological Society, *Submission 49*, p. 3, 14.

Multiple risk factors for these communities include dislocation, social isolation, lack of support systems in Australia, language barriers, cultural beliefs about gambling, luck and fate and lower income levels.²⁸

5.25 The committee notes there has been reporting in the media of people from the Vietnamese community resorting to crime to pay gambling debts.²⁹ The Victorian Local Governance Association noted concern for CALD communities:

A number of studies have showed that rates of problem gambling may be higher for CALD communities compared with the mainstream population. Although CALD communities had lower rates of overall participation in gambling than the general community, local governments in Victoria have recorded higher incidences of problem gambling...in CALD communities.³⁰

5.26 Research undertaken for Gambling Research Australia confirmed low rates of help-seeking behaviour among problem and moderate risk gamblers and particularly those from CALD and Indigenous populations. It found that the CALD survey and interviews:

...revealed strong reticence by CALD people to confide in others about gambling problems and, when they do, strong family ties and a desire to keep the problem hidden can prompt family and friends to extend funds to the gamblers, often exacerbating the gambling problem.³¹

5.27 However, in contrast, it found that Indigenous gamblers:

...may more readily seek help from family and friends, although a problem can be that these family and friends are also keen gamblers. Yet, many family members reported that they encouraged their significant others to seek help, although this advice was not often heeded.³²

5.28 The research found that shame and stigma were also significant barriers to seeking help in these populations:

Amongst the CALD interview and survey respondents, strong cultural values of success, self-reliance and pride reportedly deter help-seeking, as do shame and fears over confidentiality. Thus, severe crises generally develop before professional help is sought. Further, once financial problems

28 Australian Psychological Society, *Submission 49*, p. 14.

29 Ian Munro, 'Gambling turns Vietnamese women to crime', *The Age*, 22 June 2010; Mr Thang Ngo, 'Pokies and the victims who have no voice', *The Drum*, 2 November 2011.

30 Victorian Local Governance Association, *Submission 25*, p. 6.

31 Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p. xx.

32 Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p. xx.

are resolved, some CALD gamblers seem reluctant to address the underlying cause, which is the gambling problem.³³

5.29 The Productivity Commission emphasised the importance of awareness campaigns and education being conducted in consultation with relevant community groups, particularly culturally and linguistically diverse groups to ensure they are effective:

The evidence suggests that cultural differences can affect how gambling and gambling help are perceived which points to the importance of culturally appropriate messages and forms of providing information.³⁴

5.30 Anglicare Tasmania reported that they work on education with these communities:

Our educational work is particularly focussed on at-risk groups and communities such as those with mental health issues, those utilising DHHS family and disability services, CALD groups, young people, Indigenous people, seniors, people with intellectual disability or cognitive impairments, and people on community services or corrective orders.³⁵

Resources

5.31 The research by Hing et al contains guidelines for CALD and Indigenous specific initiatives which aim to increase help-seeking behaviour in at-risk gamblers.³⁶ The Aboriginal Health and Medical Research Council of NSW has identified gambling in Indigenous communities as a significant public health issue needing attention. Resources are available via the website.³⁷ The Aboriginal Safe Gambling Program is a program aiming to raise community awareness, provide information and help local gambling services with access, intervention and cultural awareness.³⁸ The committee notes that media company Isee-ilearn has uploaded cartoons to YouTube

33 Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p. xxiii.

34 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.11.

35 Anglicare Tasmania, *Submission 12*, p. 9.

36 Australasian Gaming Council, *Submission 33*, pp 10–11; Professor Nerilee Hing, Dr Elaine Nuske, Dr Sally Gainsbury, *Gamblers at risk and their help seeking behaviour*, Centre for Gambling Education and Research, Southern Cross University, final report for Gambling Research Australia, September 2011, Executive summary, p. xxvi.

37 See <http://www.aboriginalgamblinghelp.org.au/> (accessed 5 July 2012).

38 See http://www.koorimail.com/index.php?&row=6675&field=05_HotlinksAdvertising_pdf_upload (accessed 5 July 2012); See also 'Tackling Indigenous gambling Problems', *Manning River Times*, 7 December 2011.

which aim to educate people about gambling addiction. They are in nine territory languages and English.³⁹

5.32 The PC reported that the Victorian Government's Problem Gambling Community Awareness and Education Strategy identifies target community segments at risk of developing a gambling problem and this includes people of Indigenous and CALD backgrounds as well as people with health issues (e.g. mental health and comorbid conditions), people in socio-economically vulnerable communities, people who are socially isolated and people with intellectual disability/cognitive impairments.⁴⁰

5.33 The committee notes that the Multicultural Gambler's Help Program works to ensure that the needs of CALD communities are included in statewide (Victorian) responses to problem gambling. The Program is run by the Centre for Culture, Ethnicity and Health. The website provides short films on problem gambling, multilingual resources, the latest research on working with CALD communities and how to work with interpreters.⁴¹

5.34 The committee also notes that the NSW Government committed \$15 million in the 2012–13 Budget to the Responsible Gambling Fund⁴² to address problem gambling through counselling services, research and education and awareness activities. Most will go towards counselling and support services. However, there will be \$1.5 million over three years to establish a cadetship program for Aboriginal workers in Gambling Help counselling services. And there will be \$237,600 for a CALD problem gambling awareness campaign for multicultural communities.⁴³

5.35 Further discussion of gambling treatment services available for CALD and ATSI communities is in chapter nine.

Target growing gambling opportunities

Online

5.36 Witnesses highlighted the growth of gambling opportunities online and the need to incorporate this into preventative measures. Dr Sally Gainsbury told the committee:

39 'Cartoon hints', *Northern Territory News*, 7 June 2012, p. 2. See: <http://www.isee-ilearn.com/> (accessed 5 July 2012).

40 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.9.

41 See <http://ceh.org.au/mghp.aspx> (accessed 3 July 2012). See also Gambling Help online: <http://www.gamblinghelponline.org.au/accessing-support/non-english-speakers.aspx> (accessed 3 July 2012); Gambling Help NSW <http://www.gamblinghelp.nsw.gov.au/> (accessed 3 July 2012).

42 Funded by a two per cent levy on gambling revenue from Star City Casino.

43 NSW Budget 2012-23, Budget paper 2, Chapter 5, p. 5-9, 5-10.; See also Justine Ferrari, 'Punters tipped to add \$70m windfall to state coffers', *The Australian*, 13 June 2012.

There are differences between the different types of gambling. Sports gamblers are different from gaming machine players, and now internet gambling is introducing a whole new variable that we are currently looking at to understand how it impacts. It seems that existing problem gamblers gravitate to that form, and this unique mode also creates problems for gamblers who would not otherwise have had problems. The games develop and change. A gaming machine today is not the same as a gaming machine 20 years ago. That is why, as an ongoing research project, we really need to look at the differences in the games. With sport betting, you now have in-play betting, where it is possible to make bets every 30 seconds or every other minute instead of one bet once a week. It is important that different activities appeal to different types of people and cause their own unique problems as well.⁴⁴

5.37 Mr David Pigott, National Manager, Government Relations, Mission Australia, also highlighted the need to start looking at preventative measures for newer but growing gambling opportunities online:

I am not sure, looking at the future, how that mix is going to change other than that online gambling is going to be an increasing part of the mix. I am not sure whether, if you put tough regulations on poker machines, people are going to migrate to online gambling. I think you are dealing with a different client base which is, again, equally important and equally as devastating in terms of the impact on their lives and their families. It is probably a wake-up call for all of us to start thinking about how we grapple with those potential clients as well.⁴⁵

5.38 The committee notes that in recognition of the rapid increase of sports betting advertising and the accessibility of online gambling, in September 2011 the Victorian Government launched a campaign to raise awareness of the risks and consequences of excessive online gambling. The campaign generated a 1,213 per cent increase in online visits to *Gambling Help Online* which resulted in a 27 per cent increase in the number of live online counselling sessions provided. The campaign ran for eight weeks and during this time there was also a 23 per cent increase in calls to the Gambler's Help line. The advertisements were targeted at young males aged between 20 and 39. In March 2012 the Victorian Government announced that the Tasmanian Government would be adopting the online gambling campaign.⁴⁶

Youth

5.39 Ms Kate Roberts, Gambling Impact Society NSW, also spoke about the exposure of young people to gambling products:

44 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

45 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 5.

46 The Hon Michael O'Brien MP, Minister for Gaming, 'Victoria taking the lead with online gambling campaign', *Media release*, 5 March 2012.

What we also talked about is the need for young people who are really struggling out there. We know they are getting highly exposed to gambling products in all sorts of areas, not just to electronic gaming machines.⁴⁷

5.40 UnitingCare Community recommended raising awareness in adults of the effects of gambling on children and young people:

With increasing online issues it is noticeable that young people are becoming more involved. Within the Wide Bay Burnett the team have worked with a teenage girl who, using her father's credit card, lost a significant amount of money in one week. Children are being groomed by witnessing the actions of their parents who normalise gambling behaviour.⁴⁸

5.41 UnitingCare Community also reported that they work with children in schools to raise awareness:

The Gambling Educator for the Wide Bay Burnett has been presenting in school for over five years and has seen gambling move up into one of the top three issues that schools are dealing with, in particular the school students using internet gambling.⁴⁹

5.42 Ms Penny Wilson, Chief Executive Officer, Responsible Gambling Advocacy Centre, told the committee about the Public Health Gambling Project in Ontario. She said one of their most successful campaigns has been an animation developed by young people for young people which is available on YouTube offering two contrasting pathways through life and gambling.⁵⁰ She added:

That model is impressive because they have faced all the kinds of issues and questions that we are facing here now: is it appropriate; will it encourage people to gamble; to what age group do you start using words like 'gambling' and listing 'choice'? They have looked at that for some years and I would encourage the committee to look at that very closely.⁵¹

Committee comment

5.43 Witnesses stressed the need to better target messages to at-risk groups such as those at moderate risk who may quickly develop risky gambling behaviour. Greater awareness of risky behaviours could assist this group to develop control strategies and seek help early. The committee was pleased to note the resources available and being developed for Indigenous and CALD communities. As noted by the Productivity Commission, the committee stresses the importance of developing campaign and educational material in consultation with relevant community groups to ensure their effectiveness. The committee agrees there is a need to include messages targeting

47 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

48 UnitingCare Community, *Submission 59*, p. 3.

49 UnitingCare Community, *Submission 59*, p. 3.

50 Available from: <http://www.youtube.com/watch?v=rOwl0lwGrXA> (accessed 6 July 2012).

51 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 30.

growing gambling opportunities, such as online gambling, and a need to raise awareness in adults of the effects of gambling on children and young people as well as providing information to young people. This issue is addressed in more detail below.

Other information to be included in social marketing campaigns

5.44 Most social marketing campaigns include the following areas which were highlighted to the committee.

Raise general awareness

5.45 Part of de-stigmatising help-seeking and encouraging people to seek help earlier is raising the level of general awareness in the community. Mr Mark Henley, Member, Australian Churches Gambling Taskforce, discussed the different types of messages that are needed. He pointed out that simple messages can be effective for awareness—for example, that help is available:

I think the first thing to note is that there are very different experiences in different states. Victoria has had much more public health type advertising than have most other states. What this sort of advertising campaign can do is provide really simple messages. I think the first simple message that needs to go out on a semi-regular basis into the public space is, 'If you or someone you know is likely to be experiencing gambling harm, then ring the helpline number.' That straight awareness stuff about the helpline number is still very helpful advertising. I note from South Australian campaigns in the past that, as soon as public advertising started occurring, calls to gambling help services generally increased by 100 per cent or 200 per cent. So that sort of semi-regular, straight message of, 'Go to the helpline if needs be,' is helpful.⁵²

5.46 Ms Christina Sanchez, Team Leader, Mission Australia, pointed out the effect such advertising to raise community awareness can have:

We have just finished discussing this at the launch of our new ad campaign. I think the big issue is that gambling seems to be like the ignored topic. It has not been discussed in the same way that drugs and alcohol have been discussed. I do not think people have encouraged families to discuss gambling like they have drug and alcohol issues. You see the ads around speed use, and they encourage families to sit around the TV and talk or to sit around the dinner table and talk. I do not think that has been encouraged with gambling. I do not think gambling has, until recently, been a topic that people have wanted to talk about. It is still like the hidden taboo. I think once that gets happening, once people start talking more and having these conversations about gambling, more people will see that there is an issue. The thing that I like to point out as the big one that did a really quick turnaround is binge drinking. Ten or 15 years ago, who thought of binge drinking as an issue? Yet, once it was identified and there were some parameters put in place as to what binge drinking is and people started

52 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 14.

talking about it, then it became a recognised issue. I think that is something that has been lacking for gambling until now.⁵³

Increasing knowledge

5.47 Mr Christopher Hunt, Psychologist, Gambling Treatment Clinic, School of Psychology, University of Sydney, stressed the need for information campaigns to address the core pathology of problem gambling which is the belief that you can win money in the long term.⁵⁴

5.48 The committee notes that many but not all gambling help websites include information on knowing the odds of winning and addressing common gambling myths.⁵⁵

Messages for others affected

5.49 Mr Mark Henley pointed out that for every person with a gambling problem between seven and ten others are affected. Therefore the importance of the family in dealing with gambling harm needs to be highlighted:

So one of the public health measures that we will be supporting is recognising the role families can play in either helping people to deal with gambling risk or encouraging them to seek more formal help through gambling help services. Certainly as part of a prevention approach we need to better empower families and friends to identify the signs of problem gambling and encourage people to either accept help from family or seek help from agencies.⁵⁶

5.50 Ms Kate Roberts, Gambling Impact Society NSW, stressed that a lot of the current messages are in venues which won't assist family members.⁵⁷

If I can add to that, the focus has to be away from the venue as well as at the venue. We need to have this as early intervention in the community, not just be looking at venues. Obviously a venue is a place where you have a captive audience in the people there, but you have a lot of people who are also struggling to be away from the venue. And, most importantly, you have family members, who may or may not be attending the venues, and they need resources and information to actually help them, because often they are the person to whom the person with a gambling problem turns, or they are the ones who are aware of it a lot earlier and are dealing with the impacts of it.⁵⁸

53 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

54 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 58.

55 See for example *Gambling Help Online*: <http://www.gamblinghelponline.org.au/regaining-control/thinking-straight.aspx> (accessed 3 July 2012); the Victorian gamble aware website: <http://www.gambleaware.vic.gov.au/> (accessed 3 July 2012); South Australian Gambling Help http://www.problemgambling.sa.gov.au/aspx/the_odds.aspx (accessed 3 July 2012).

56 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 11.

57 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

58 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 42.

5.51 Ms Roberts mentioned a self-help guide developed by the Gambling Impact Society NSW based on a Canadian resource.⁵⁹ She emphasised the positive role family members can play in early intervention if they can find sufficient information and resources.⁶⁰

5.52 The committee notes that many gambling help websites include a section for families and friends of problem gamblers.⁶¹ Further discussion of the role family members can play in treatment is in chapter eight.

Format issues

Change messages frequently to prevent message fatigue

5.53 The committee notes the range of gambling help campaigns and evaluations undertaken by the Queensland Government. The evaluations highlighted the importance of refreshing information regularly to prevent message fatigue.⁶²

New formats needed

5.54 Witnesses emphasised that it is not just different messages that are needed but different formats as well. Professor Malcolm Battersby, Director, Statewide Gambling Therapy Service, Southern Adelaide Health Service and Professor, Flinders University, suggested the use of social media—for example, using the internet and YouTube to engage people and link with an anonymous initial treatment option via the internet.⁶³

Need for sustained campaigns utilising all forms of media

5.55 The committee heard that advertising campaigns tend to be occasional rather than systematic or sustained. Associate Professor Peter Harvey, Director, Flinders Centre for Gambling Research, noted that when the state government launches a gambling related initiative, increased activity is seen and if these initiatives were more sustained then more people would take notice and seek help:

At a lower level from *beyondblue*, when the state government does have an initiative here, we do see increased activity. If that were prolonged then you would probably get more people taking notice and eventually seeking help. But in the last few years here we have had no media coverage. The only media coverage we get for our service is when we are on the radio, Malcolm [Battersby] is on the television or something is happening that is

59 See <http://www.gisnsw.org.au/Gambling%20Impact%20Book/LOW%20RES%20VERSION/GIS%20LOW%20RES%20PRINT%20VERSION.pdf> (accessed 11 July 2012).

60 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 42.

61 See for example Gambling Help NSW: <http://www.gamblinghelp.nsw.gov.au/content/help-for-friends-and-family.aspx> (accessed 3 July 2012); Gambling Help Online: <http://www.gamblinghelponline.org.au/helping-others.aspx> (accessed 3 July 2012).

62 Office of Regulatory Policy, Liquor, Gaming and Fair Trading, Department of Justice and Attorney-General, Queensland, correspondence received 4 June 2012.

63 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 7.

organised in the media but not through a campaign. I think the current promotional campaign around Gambling Awareness Week is radio driven and has a bit of promotion on billboards and so on. The help line that we work with quite closely here have repeatedly said that, when in the past we have had those major media promotions, that is when the numbers increase and people do actually decide it is time to seek help rather than waiting till a crisis and for their life to be in such disarray that they are virtually forced to it as their last choice. So I think a systematic approach through the media would be significant.⁶⁴

5.56 As an example of the possible results, Professor Battersby mentioned a television appearance in Adelaide to discuss and promote a research study. This resulted in 18 calls the next day:

Just one little thing made that [number of calls happen]. That is quite significant. It was life changing for those people.⁶⁵

5.57 Ms Sanchez spoke about the ACT campaign for Responsible Gambling Awareness Week which uses posters on buses and in gambling venues as well as print media. However, it did not include radio or television. In discussion with the committee about how to target and get the attention of a younger demographic it was suggested that FM radio advertising might be worthwhile if television was too expensive. Ms Sanchez confirmed that television advertising was very expensive.⁶⁶

Is there a role for gambling education?

5.58 Earlier in this chapter the committee noted the exposure of children and young people to gambling advertising and products. Some witnesses saw value in including gambling in messages to young people about other public health issues. Mr David Pigott, National Manager, Government Relations, Mission Australia, spoke to the committee about this:

Why I mentioned early intervention at the outset is it is the most effective strategy. Again, we will be gathering evidence and data as time goes on for our clients in these services. The sooner you start the better. We are involved in early intervention and in getting messages out through schools and high schools as campaigns do with drugs and alcohol. The most effective way to start is with families at that stage...⁶⁷

5.59 The APS noted:

Gambling among young people is associated with risk taking behaviours characteristic of adolescence and higher mental health issues such as anxiety, depression and suicidal ideation and attempts (Dickson et al, 2008).⁶⁸

64 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 3.

65 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

66 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 40.

67 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 3.

68 Australian Psychological Society, *Submission 49*, p. 14.

5.60 Dr Samantha Thomas told the committee:

In many cases we also need to think very clearly about the education of young people. We have seen that clearly in other public health issues such as alcohol, sexual behaviour and so on. We need to start pre gambling to create better prevention messages for young people.⁶⁹

5.61 UnitingCare Community recommended raising awareness on how to control gambling as early intervention educates people about gambling being addictive.⁷⁰

5.62 Ms Penny Wilson, Chief Executive Officer, Responsible Gambling Advocacy Centre (RGAC), said that RGAC is frequently asked how to talk to young people about gambling by parents, teachers, principals, schools and sporting clubs. Ms Wilson stated that gambling is part of the community experience and has been normalised. Even those who choose not to gamble cannot escape gambling advertising and venue signage. Ms Wilson added:

Young people we now talk to between the ages of 18 and 21 I refer to as the 'pokies generation'. They have grown up in Victoria with pokies venues. They cannot actually remember when there were not pokies in the pubs and clubs that are around them.

We talk about gambling education from a public health perspective. You have heard from some experts this morning. We see this in a very practical way. It is about increasing the capacity of people to respond to the challenges of the environment around them to their wellbeing and to their health. We believe that education for children on gambling is now necessary so they can make appropriate choices on gambling and fully understand the issues around gambling, problem gambling and responsible gambling. But this education needs to be seated in resilience. Children need to grow up with an understanding of the concepts of advertising—of how people are trying to manipulate them into buying products—and have critical thinking skills about issues.

This is not education about how to gamble. It is not just maths and stats; it is about the whole person and navigating through pressures that come about from our sociocultural settings and by simply living in our community. We come to this view based on evidence of public health approaches to other difficult issues, such as sexual health, drugs and alcohol.

We completely respect the choice of parents and schools who may choose not to talk about gambling and who may teach abstinence from gambling as the appropriate behavioural choice. But we consider this to be an ethical and moral stance not a public health approach.⁷¹

5.63 Ms Wilson noted there is already a curriculum in Victoria developed by Consumer Affairs and the Office of Gaming and Racing in the Department of Justice, Victoria. The program is called 'Responsible gambling: building resilience for young

69 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, pp 22–23.

70 UnitingCare Community, *Submission 59*, p. 3.

71 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 27.

learners' for students in years 9 to 12. It is taught in around 50 schools and has been running since 2009. Ms Wilson pointed out that:

...it is not unusual for children to gamble, particularly using apps on smart phones. It is not unusual for children to do this and not understand that they are not meant to be doing this. It is not unusual for people under 18 to think that they are not taking a risk gambling, which is of great concern to the people around them, and that is something about understanding risk at appropriate age.⁷²

5.64 Ms Wilson pointed out that the Responsible Gambling Awareness Week would focus on youth and gambling: 'We now think it is necessary. The community, the government and even industry think that we need to talk to young people about gambling'.⁷³

5.65 The committee asked Ms Wilson to outline what is covered in the school campaigns:

Overall in Victoria there is a concept called 'life skills'. It is about resilience and it is taught from prep to year 12. It is situated in that broad resilience framework. The education about gambling itself comes in at around year-9 age, which is something like 13 to 15 years old in Victoria. They have already addressed concepts of bullying, manipulation by that age in different ways. And it is not just in one subject. It is addressed through a number of different subjects. They look at critical thinking skills. They look at the impact of advertising and what advertising is trying to get you to do. Then they look at more specific contextual questions.

Very recently I was contacted by a school in Melbourne that was looking at this as a current affairs issue, running a series of debates for year 8 and 9 students—who are roughly around 13 to 15 years of age—and wanting some good information. We were able to assist them by pointing out information, such as Dr Thomas's work, that was suitable for children of that age group to look at when preparing for their debates.

That is what the curriculum does. It brings in broad concepts at the appropriate age levels. Of course, heading towards year 12, where students are 17 and 18 years old, they are heading towards actual campaigns, actual gambling concepts and the risk they are taking. They are looking at it in the context of being a risk-taking behaviour: 'You are taking a risk when you are gambling. It is a legitimate entertainment choice if you are of age; however, you need to understand what you are doing when you do it and that all the advertising around gambling is trying to sell you a service.'⁷⁴

72 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 27.

73 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 27.

74 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 29. See also: *The Victorian Problem Gambling Community Awareness and Education Strategy*, March 2009 and *Taking Action on Problem Gambling, A Strategy for Combating Problem Gambling In Victoria*, October 2006.

5.66 During the previous inquiry Dr Jeffrey Derevensky, who has focused on youth gambling and problem gambling over two decades, told the committee that the International Centre for Youth Gambling Problems has prevention programs designed as school based programs. He explained that adolescents do see the risks associated with gambling but do not attribute those risks to themselves and they view them as occurring later in life. He stressed that most parents are concerned with issues other than gambling in relation to their children. This is why the Centre has included public service announcements in an effort to educate parents and raise awareness that some adolescents will become problem gamblers.⁷⁵

5.67 The committee notes that on this issue the Productivity Commission (PC) took a cautious approach:

...we were somewhat sceptical of some of the other ways of trying to engage people in areas of gambling—such as childhood early education—because we considered that there might be risks of perverse outcomes.⁷⁶

Committee view

5.68 To summarise, the committee notes the following suggestions to develop and target effective preventative programs:

- the need to better understand why different groups of people gamble;
- ensuring there are alternatives to gambling in the community;
- a range of messages are needed for different groups;
- those in the moderate risk group who can quickly develop risky gambling behaviour should receive particular attention;
- continue development of resources and culturally appropriate messages for CALD and ATSI communities;
- incorporate new and growing gambling opportunities into preventative measures such as online gambling and gambling targeting youth. This includes providing information to children and youth;
- continue messages around raising awareness, increasing knowledge, including for others affected such as families;
- change messages regularly to prevent message fatigue and utilise new formats such as social media; and
- the need for campaigns to be sustained.

5.69 The committee noted during its previous inquiry into interactive and online gambling its concern about potential new gambling opportunities which appear to be targeted at youth, such as Slotomania and online poker games such as Zynga poker

75 Parliamentary Joint Select Committee on Gambling Reform, Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011, p. 36.

76 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

which are accessible through Facebook applications. These games normalise the activity and can soften younger people to playing for money. Recent media reporting would appear to confirm this:

"...We believe there will be gambling potential on nearly all of Zynga's games," BTIG analyst Richard Greenfield said in a recent report...

...Zynga Poker starts players off with a sum of virtual money and gives them the ability to get free chips every eight hours and acquire more if they share the game with friends. It would presumably be logical to adopt a platform where players had the ability to use real money.⁷⁷

5.70 In another article:

Most of the games don't involve betting or real money, but they whet players' appetite for gambling and familiarize them with casino brands.

And they hope to promote those games, and ease people into real online gambling, via Facebook.

Over the past year, almost every major casino company has bought or partnered with an online game developer.⁷⁸

5.71 In yet another article, a new platform to allow real money bets on almost any online game has been developed. Although the company, which has a British gaming licence, has not announced any specific contracts it could be used by Facebook.⁷⁹ Zynga poker has confirmed it is exploring 'real money' online poker ventures.⁸⁰ On 7 August 2012 it was reported that Facebook launched the first real-money gambling app which allows users aged 18 and over to play games for cash prizes.⁸¹

5.72 Witnesses for the interactive and online inquiry told the committee that young people are encouraged to play free online games which then prepare them to play with real money. Cases such as the 12 year old boy in the UK with a £7,000 gambling bill on his father's credit card from online poker are becoming more frequent.⁸²

5.73 In recommendation 5 of the second report the committee supported the recommendation of the Productivity Commission that the COAG Select Council on Gambling Reform review new gambling opportunities, particularly those which

77 See <http://www.foxbusiness.com/technology/2012/07/02/bullish-zynga-analysts-all-in-on-game-maker-prospects/> (accessed 5 July 2012); Dr Jeffrey Derevensky; *Submission 7*, Attachments 1 and 2; see also Karen Seidman, 'Video game gambling puts kids at risk', *The Montreal Gazette*, 3 July 2012.

78 Ron Sylvester, 'Casinos going online, using Facebook to recruit new players', *Vegas inc*, 22 June 2012.

79 'Startup brings real bets to online games', *Herald Sun*, 10 July 2012.

80 See <http://www.gambling911.com/poker/zynga-gets-bids-offer-%E2%80%98real-cash%E2%80%99-online-poker-072312.html> (accessed 24 July 2012).

81 BBC News, 'Facebook's first real-cash gambling app launched', 7 August 2012.

82 James Tozer, 'Boy, 12, racks up £7k gambling bill', *IOL News*, 8 June 2012.

appear to target youth, with a view to developing a national regulatory approach. The government responded to this recommendation as follows:

Matter for jurisdictional consultation. New opportunities such as use of social networking sites are being considered in the review of *the Interactive Gambling Act 2001*. The Consultative Working Group on Cybersafety is also considering the issue of gambling services being made available through social networking sites. The Government will discuss this issue further with state and territory governments through the COAG Select Council on Gambling Reform.⁸³

5.74 The committee covered the issue of gambling advertising and inducements in its second report. However, the issue of advertising and marketing of gambling continues to be a concern that is repeatedly expressed to the committee. The main issue is the amount of gambling advertising, particularly for sports wagering.⁸⁴ As with the last inquiry, people were concerned that this level of advertising was normalising gambling for children.

5.75 During its previous inquiry the committee heard about the vulnerability of children to the high level of in-venue advertising at sporting matches. Sporting matches are promoted as family friendly, yet the environment exposes children to a very high level of marketing for an adult product. In addition the constant promotion of live odds updates at matches and within game play may have a normalising effect on children where they may consider the live odds, for example, to be part of the game.⁸⁵

5.76 The committee recommended (recommendation 12) that the COAG Select Council on Gambling Reform commission further research on the longer-term effects of gambling advertising on children, particularly in relation to the 'normalisation' of gambling during sport. The government responded:

Matter for jurisdictional consultation. The impact of advertising on gambling behaviours is a priority issue for the COAG Select Council. Specific research into the impact of advertising on children will be

83 Government Response to the Parliamentary Joint Select Committee on Gambling Reform, *Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, p. 4.

84 See for example: Dr Clive Allcock, *Submission 6*, p. 3; University of Sydney, Gambling Treatment Clinic, *Submission 10*, p. 3; Anglicare Tasmania, *Submission 12*, p. 3; Australian Psychological Society, *Submission 49*, p. 8; Mission Australia, *Submission 17*, p. 5; Social Issues Executive, Anglican Church, Diocese of Sydney, *Submission 26*, p. 2.

85 Joint Select Committee on Gambling Reform, *Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, pp 155–157; p.164; pp 253–255.

discussed with state and territory governments through the COAG Select Council on Gambling Reform.⁸⁶

5.77 The committee also recommended (recommendation 14) that the government legislate a total ban of the promotion of live odds both at venues and during the broadcast of a sporting event. The government responded:

Government announced on 21 January that it is working with the sporting and betting industries to reduce and control the promotion of live odds during sports coverage through amendments to their existing industry codes. If satisfactory amendments have not been put in place by broadcasters by the end of June 2012, the Australian Government will introduce legislation to ban the promotion of live odds in sporting broadcasts.

The promotion of live odds at venues is a matter for the states and territories and the Government will continue to work with states and territories through the COAG Select Council on Gambling to address this issue.⁸⁷

5.78 The committee notes that in relation to live odds, on 29 June 2012 the government announced that:

Broadcasters have agreed to amend their existing codes of practice to restrict live odds promotion including by banning sporting commentators from mentioning live odds and banning all live odds promotion during play. The principles that will underpin these restrictions are expected to be finalised in the coming weeks.⁸⁸

5.79 The committee also recommended (recommendation 19) that the *Broadcasting Services Act 1992* be amended to prohibit gambling advertising during times when children are likely to be watching. The government responded:

Noted. As indicated in the response to Recommendation 14, the government priority is to address the promotion of live odds during sports broadcasts.⁸⁹

86 Government Response to the Parliamentary Joint Select Committee on Gambling Reform – Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011, p. 5.

87 Government Response to the Parliamentary Joint Select Committee on Gambling Reform – Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011, p. 6.

88 Senator the Hon Stephen Conroy, Minister for Broadband, Communications and the Digital Economy, 'Government achieves agreement to reduce the promotion of live odds in sports broadcasts', *Media release*, 29 June 2012.

89 Government Response to the Parliamentary Joint Select Committee on Gambling Reform – Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011, p. 8.

5.80 The committee notes that one of the risk factors for problem gambling is early onset: the earlier one starts gambling, the more likely one is to continue gambling and along with that the probability of developing a gambling problem increases.⁹⁰ Given the proliferation of gambling advertising and gambling opportunities, the committee believes that providing educational information to children and youth about the possible risks and how to identify risky gambling behaviour may assist with enhancing prevention, awareness and anti-stigma messages.

5.81 The next chapter will move to industry measures and the call to shift the focus of responsibility, which currently lies with the individual, to make it more balanced by including the industry and product.

90 Parliamentary Joint Select Committee on Gambling Reform, *Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, p. 35.

Chapter 6

How effective are industry measures?

6.1 A public health approach encourages the involvement of industry as it is seen as having a responsibility to protect its patrons from the harmful consequences of problem gambling.¹

6.2 As indicated in earlier chapters, the committee heard of the need for more balance regarding the causes of problem gambling. This would involve the current emphasis on the need for the individual to act responsibly, but also include the role and influence of the industry and gambling products on those who are more vulnerable. The committee acknowledges that clubs, hotels and casinos do undertake a number of measures to assist problem gamblers. These include staff training to identify problem gamblers and self-exclusion. However, the committee heard of the real limitations of these measures² and their focus on gamblers who have already developed a problem.

Lack of industry engagement in the inquiry

6.3 The committee received submissions from Clubs Australia, the Australian Hotels Association (AHA) and the Australasian Casino Association (ACA). With the current emphasis from Clubs Australia on being 'part of the solution'³ to address problem gambling, the committee was surprised and disappointed that they refused to attend a public hearing despite measures such as self-exclusion and staff training clearly falling within the committee's terms of reference. The committee was keen to discuss these measures with industry, beyond information provided in their submissions, so they could respond to the evidence from witnesses and to discuss what improvements might be possible. Unfortunately Clubs Australia and the AHA declined two requests to appear before the committee while the ACA suggested a site visit to Crown Casino to their Customer Support Centre to speak to their General

1 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile, Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, pp 8–9.

2 Research has highlighted the significant limitations of responsible gambling codes, 'including: a lack of compliance by some venues, non-membership in peak bodies that co-ordinate the codes, and the absence of mandatory penalties for noncompliance'. See Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile, Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, p. 9.

3 On 15 June 2012, Clubs Australia announced a national campaign, Part of the Solution, to highlight the measures clubs have put in place to help problem gamblers. See Clubs Australia, 'Clubs launch TV and radio campaign: getting on with the job of gambling reform', *Media release*, 15 June 2012.

Manager, Responsible Gaming and their Responsible Gaming Psychologist. The committee notes that unlike a public hearing any such informal discussions would not have been on the public record and available to others.

Committee comment

6.4 The committee expressed its disappointment to each of these organisations for their refusal and/or reluctance to engage in a meaningful way with the inquiry, by discussion at public hearings. It would have provided industry with the opportunity to respond to the evidence received by the committee from witnesses, particularly in relation to staff training and self-exclusion. Therefore the committee can only outline the evidence received and is unable to include complete responses from industry obtained through discussion at a hearing. Given the emphasis, particularly by Clubs Australia, on helping problem gamblers the committee finds industry reluctance to further participate and discuss these areas in detail with the committee puzzling and worrying.

6.5 In order to provide the industry with an opportunity to respond to some of the evidence, the committee asked whether they would be willing to answer written questions on notice. They agreed to do so and a number of questions on notice outlining the evidence received were forwarded. A response was received from Clubs Australia in the timeframe requested. The Australian Hotels Association and the Australasian Casino Association requested additional time. The answers have been made available on the committee website.⁴

Greater attention on the dangers of the product

6.6 Witnesses argued that along with individuals taking responsibility, there needs to be greater responsibility taken by industry for the dangers of gambling products. The Productivity Commission (PC) recognised that some forms of gambling are riskier than others. It was very clear in recognising that electronic gaming machines (EGMs) are the riskiest form of gambling with the likelihood of harm rising steeply and continuously with the frequency of EGM gambling and expenditure levels.⁵ The committee's first report covered this aspect in detail.⁶ During that inquiry, Mr Alan Moss, Independent Gambling Authority (IGA) SA, told the committee that the IGA recognised the danger of EGMs for some people:

4 See Clubs Australia, answers to questions on notice, received 27 July 2012; Australasian Casino Association, answers to questions on notice, received 5 September 2012; and Australian Hotels Association, answers to questions on notice, received 17 September 2012.

5 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra 2010, p. 4.24.

6 Parliamentary Joint Select Committee on Gambling Reform, First Report: The design and implementation of a mandatory pre-commitment system for electronic gaming machines, May 2011, chapter 3, pp 23–48.

We believe that electronic gaming machines are potentially dangerous products. In the hands of a large section of the population they do not cause any trouble, but there certainly is a cohort of EGM users who cannot handle the machines in a way which does not cause them harm. As with any potentially dangerous product, the authority believes it makes ethical and governmental sense to introduce some measures of regulation. We do it for cars, we do it for guns, we do it for food—anywhere there is potential for some harm, government generally sees it as being appropriate to regulate.⁷

6.7 During this inquiry the risk associated with regular use of EGMs was also highlighted. St Luke's Anglicare pointed out that in relation to poker machines:

Research about pokie design has uncovered how unsafe EGMs are, particularly for problem gamblers. Overseas initiatives in Scandinavia have seen EGMs redesigned to improve their safety. This includes eliminating "false" reward signals such as sounds and flashing lights that imply success, when in fact the gambler is losing. Free spins also induce gamblers to keep gambling. The recent cigarette packaging laws have set a precedent which demonstrates that government do have the ability and authority to make products safer for users. Other redesign suggestions include returning to coin only machines to reduce the ease of feeding large amounts of cash into EGMs.⁸

6.8 Dr Samantha Thomas, a public health sociologist from Monash University, emphasised the need for industry to take equal responsibility for the potential harms of their product:

At the most basic level there is nothing wrong with asking people to take responsibility for engaging with a product. However, some individuals may be more able to take 'responsibility' than others. Furthermore, it is important that industry takes equal responsibility for the potential 'harms' that their product may cause – particularly with vulnerable groups of individuals or communities.⁹

6.9 This was supported by Mr Tom Cummings, former poker machine addict and gambling reform advocate, who stated that 'responsibility has to work in every direction' including the individual. A greater onus of responsibility should be placed on the industry that offers these gambling products:

They [industry] are offering this product and providing it for people to use, so they need to have a responsibility to do so ethically and with a minimum of harm. I think there is also a legislative responsibility. Industry will do what they can within the rules that apply. So it is almost a three way street,

7 Inquiry into pre-commitment, *Committee Hansard*, 1 February 2011, p. 23.

8 St Luke's Anglicare, *Submission 13*, p. 5.

9 Dr Samantha Thomas, *Submission 52*, p. 3.

though I hate to say it that way. It is certainly something that needs to be looked at by all corners.¹⁰

Dynamic messages

6.10 During the inquiry the work on dynamic messaging on poker machines was raised by the industry as a harm minimisation measure. Mr Ross Ferrar, Chief Executive Officer, Gaming Technologies Association Ltd (GTA), explained how these messages could provide effective information to players and put forward GTA's view on how best to deliver them:

In our view, a strict set of requirements must be present for messages to provide any meaningful information to poker machine players. Such messages must be delivered in the right place at the right time and must contain information that is relevant to the player. The right place is on the 'game play' screen and not on some display device located away from the player's direct line of sight. The right time is between reel spins, not on an ad hoc basis determined by factors outside the player's frame of reference. The right information is about the player's current activity; it is not about patronising phrases. Without these preconditions efforts to provide effective responsible gambling messages will, in our opinion, fail.¹¹

6.11 The committee asked whether there was any evidence to back up the GTA view about when a player would be most receptive to such messages and Mr Ferrar replied:

To us that is self-evident. While the reel spin is occurring the player is preoccupied, the player is waiting for the outcome of the reel spins. Then the player is looking at if they have won and what they have won. Then there is a pause while they make their decision to play again. So to us the optimum time to deliver a message is in that pause. The reverse side of that coin is to us we do not see much point in delivering messages while the player is preoccupied with the reel spin, hence our statement.¹²

6.12 Mr Cummings was asked if he thought messages on the screen about current play, amount lost or suggesting a break would have an effect. Mr Cummings responded that it may make a small difference for some but when he was playing, if a message suggesting a break would have come up, he would have just continued playing.¹³

6.13 Ms Julia Karpathakis, Manager, Pokies Anonymous, was of the view that messages on the machines need to be of sufficient intensity to provide a reality check

10 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

11 Mr Ross Ferrar, *Committee Hansard*, 2 May 2012, p. 45. See also Gaming Technologies Association, *Submission 23*, p. 4.

12 Mr Ross Ferrar, *Committee Hansard*, 2 May 2012, p. 46.

13 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 4.

for people playing. She suggested alternative pop-up messages and pictures to have on the screen including 'Do you have food?' or 'Do you have enough petrol?' or 'Did you pay the mortgage?' or 'Are your bills due?' or 'Reach out for help' or 'Is the rent due?' or 'Have you picked up your children?' She explained to the committee that such messages would have helped 'snap her out of it' and provided a reality check:

That would be a much quicker wake-up call than anything, I believe. It would not be shunned. I would not have felt so awful, so guilty and ashamed about what I was doing. I may have gone for help more quickly if it was seen as a normal problem, say, like going to the doctor if you have an earache.¹⁴

6.14 The committee notes that electronic warning messages and cost of play displays are part of the government package of gambling reforms.¹⁵

Player activity statements

6.15 Player activity statements show the customer's spending and are linked to loyalty programs.¹⁶ Players can request to see them but only a small proportion of people do so.¹⁷ The Australian Hotels Association (AHA) advised that loyalty programs in Victoria must provide annual player activity statements and in NSW they must be provided on request.¹⁸ The Australasian Gaming Council advised that the Tasmanian Responsible Gambling Mandatory Code of Practice includes a requirement for the provision of Player Activity Statements to loyalty program members at least once a year.¹⁹

6.16 The Australasian Casino Association advised that at Crown Casino:

Play Safe for gaming machines is only available to Crown Signature Club members who have agreed to receive and have viewed their Player Activity Statements within a 12 month period, who have a PIN and who are not excluded from the Casino for any reason.²⁰

At least once a year, Player Activity Statements are made available to EGM Crown Signature Club members. Members who play FATGs [Fully

14 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 14. See also Pokies Anonymous, *Submission 31*, p. 3, pp 5–13.

15 The Hon Jenny Macklin MP, the Hon Julia Gillard MP, the Hon Bill Shorten MP, Senator the Hon Stephen Conroy, 'Tackling problem gambling in Australia', *Joint media release*, 21 January 2012; Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 20*, p. 2.

16 Clubs Australia, *Submission 29*, p. 11; Australasian Casino Association, *Submission 46*, p. 7.

17 BetSafe, *Submission 32*, p. 5.

18 Australian Hotels Association, *Submission 43*, pp 7–8. See also NSW Gaming Machine Regulation 2010, Regs 48 and 101.

19 Australasian Gaming Council, *Submission 33*, p. 17.

20 Australasian Casino Association, *Submission 46*, Attachment 1, p. 4.

Automated Table Games] are able to collect a Player Activity Statement on request, at any Crown Signature Club desk. Player Activity Statements provide information on each member's EGM or FATG play, including all wins and losses for the period of the statement. Crown's responsible gambling message 'Stay in Control', as well as information regarding the availability of the Code, is incorporated in and forms part of Player Activity Statements.²¹

6.17 Mr Daniel Symond, Operations Manager, Betsafe, thought providing player activity statements on a regular basis could be useful 'because one thing that problem gamblers are good at is forgetting about the losses and remembering the winnings'.²²

6.18 Ms Rhian Jones, Member, Gambling Impact Society NSW, said she was not aware of these records until they were released to her ex-husband but they clearly showed her escalating gambling:

...you asked before what can be done by the venues. I was not aware that there were player tracking records until they were released as a breach of privacy to my ex-husband during our divorce case. It was blatantly obvious from the records that there was a lead-up to a massive addiction. When you are an addict—addiction is extremely secretive—you tend to hide the addiction not just from your family members but from yourself as well. It was obvious to me that the only people who had records were the actual venue. They were the only people who were aware of what was going on.²³

6.19 The committee notes that the Productivity Commission (PC) also found that gamblers have difficulty remembering losses and that the data from the Australian Household Expenditure Survey shows that people significantly underestimate their gambling spending. The PC pointed out that this is relevant for policies such as the provision of player activity statements and player information displays.²⁴

Committee view

6.20 The committee agrees that industry has a part to play in taking responsibility for the potential harms of its product, in this case poker machines, but this applies equally to online gambling.

6.21 The committee notes that features of poker machines are regulated by each state. For example when more immersive poker machines with earphones, which already exist in NSW, were planned for Victoria, the Victorian Minister for Gaming introduced an interim ban order prohibiting the use of the earphones for 12 months while the Victorian Commission for Gambling Regulation investigated whether it

21 Australasian Casino Association, *Submission 46*, Attachment 2, p. 13.

22 Mr Daniel Symond, *Committee Hansard*, 2 May 2012, p. 30.

23 Ms Rhian Jones, *Committee Hansard*, 2 May 2012, p. 39.

24 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra 2010, p. 4.6.

should be banned for up to 10 years.²⁵ The committee points to continuing research by the states into harm minimisation measures such as dynamic messaging on poker machines to achieve the best balance of evidence-based harm minimisation measures for vulnerable people, which do not adversely affect the playing experience for the majority of recreational players. The committee notes some research has been undertaken into dynamic messaging.²⁶ However, it agrees that messages on a poker machine need to be sufficiently strong to penetrate the trance-like state that some people experience while playing.

6.22 The committee notes that player activity statements could be a useful reminder to people of how much they have spent but would need to be provided on a much more regular basis than annually. The committee notes that the availability of player activity statements could be part of a range of harm minimisation measures for online gamblers as well.²⁷

6.23 The Chair, Senator Xenophon and participating Senators Di Natale and Madigan have provided additional comments in relation to dangers of gambling products and the role of the industry, which follow the committee report.

Staff training and intervention

Staff intervention in theory

6.24 Staff in venues are required to undergo 'responsible gambling training'. As noted by Clubs Australia:

A feature of the majority of current training courses is to provide venue staff with a range of commonly agreed indicators of problem gambling, to help them identify potentially problematic player behaviours.²⁸

6.25 Clubs Australia added that:

Staff interventions typically involve approaching patrons displaying the signs of problematic gambling and starting a respectful conversation to enquire about the patron's welfare and where necessary, offering them assistance such as self-exclusions or referral to appropriate help services.

25 Richard Willingham, 'Immersive pokie machines lashed', *The Age*, 26 October 2011. Minister for Gaming, the Hon Michael O'Brien MP, 'Victorian Coalition Government bans isolation audio technology from gaming machines', *Media release*, 22 December 2011.

26 Sally Monaghan and Alex Blaszczyński (2007), 'Recall of electronic gaming machine signs: A static versus a dynamic mode of presentation', *Journal of Gambling Issues: Issue 20*, pp. 253–267; Sally Monaghan and Alex Blaszczyński (2010), 'Impact of Mode of Display and Message Content of Responsible Gambling Signs for Electronic Gaming Machines on Regular Gamblers', *Journal of Gambling Studies* 26:1, 67–88; Sally Monaghan and Alex Blaszczyński (2009), 'Electronic Gaming Machine Warning Messages: Information versus Self-Evaluation', *The Journal of Psychology* 144:1, 83–96.

27 Betfair, *Submission 21*, p. 10.

28 Clubs Australia, *Submission 29*, p. 7.

Staff interventions create an additional level of safety that is unique to land-based gaming operators and is lacking in the online environment.²⁹

6.26 Delfabbro et al noted that a current national competency standard exists to provide guidance concerning the appropriate content of staff training courses. However, the content is very much governed by the regulatory environment prevailing in each state or territory.³⁰

Organisations assisting industry

6.27 Clubs are assisted in staff intervention by organisations such as BetSafe. BetSafe's members are predominantly larger NSW registered clubs:

BetSafe Pty Ltd provides an independent, comprehensive and integrated responsible gambling program for a group of leading NSW and ACT gaming machine venues as well as consultancy services and seeks to provide the highest standards in staff training, problem gambling counselling, self-exclusion and all other aspects of its program. BetSafe programs cover approximately one-tenth of the gaming machines in these jurisdictions.³¹

6.28 Clubs Australia has its own program called ClubSAFE³² although this was not mentioned in the Clubs Australia submission. The committee understands that ClubSAFE is run by ClubsNSW while BetSafe is a private operation. They offer similar services to help venues comply with legislative responsible gaming requirements but at different prices and each has different options for venues of different size. ClubSAFE only operates in clubs but BetSafe offers its services in clubs and hotels. In answers to questions on notice, Clubs Australia reported that ClubSAFE has provided a comprehensive service to more than 1,100 NSW clubs since 1999. In addition it has introduced more recently ClubSAFE Premium services which offer larger club groups a greater level of service, training and compliance support.³³

29 Clubs Australia, *Submission 29*, p. 8.

30 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile, Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, pp 10–11.

31 BetSafe, *Submission 32*, p. 2.

32 See http://www.clubsnsw.com.au/About_Us1/ClubsNSW_Services1/ClubSAFE_Program.aspx (accessed 10 July 2012).

33 Clubs Australia, answers to questions on notice, received 27 July 2012, p. 7.

6.29 The committee understands that in Victoria there is a program called the Venue Support Program which provides training and support in responsible gambling practices and environments for gaming venue staff and management.³⁴

6.30 The Australasian Casino Association reported that The Star Casino in Sydney uses the services of BetCare which has been appointed to 'provide gambling counselling and assistance for customers who identify with problem gambling behaviours'.³⁵

Identifying problem gamblers is possible

6.31 The committee is aware of research which lists clear indicators of problem gambling. Staff and counsellors interviewed agreed with the vast majority of indicators identified by the researchers.³⁶ The most salient indicators of problem gambling in venues included: strong emotional responses to losing such as people who became angry, depressed or violent towards the machines, rudeness to staff, complaints about losing, sweating a lot while gambling, trying to keep gambling at closing time and gambling for long periods. In addition, changes in expenditure patterns, mood states, and personal appearance such as trying to disguise their presence were also considered to be important indicators of gambling problems.³⁷

6.32 However, the research also found that the most significant barrier to identifying problem gamblers was lack of staff training addressing direct interventions with gamblers:

The most significant barrier to identifying problem gamblers was not staff turnover, the length of shifts, or even the size of venues, but the lack of staff training relating to direct interventions with gamblers on the gaming floor. Most staff did not feel confident about how patrons would respond if they were approached. For this reason, there was strong support for the introduction of further training to assist this process.³⁸

34 See <http://professionals.problemgambling.vic.gov.au/venue-support> (accessed 11 July 2012). See also Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 46; the Hon Michael O'Brien MP, Minister for Gaming, 'Venue support program proving a success', *Media release*, 17 May 2012.

35 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 2.

36 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile and Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, p. 14.

37 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile and Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, pp 14–15. See chapter 3.

38 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile and Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007.

6.33 The report made the following suggestions to enhance the ability of staff to identify and assist patrons experiencing gambling problems:

Staff should be given more extensive training into the nature of gambling and the range of visible behaviour that might be observed. The findings in this study could be usefully included in this training.

Staff require greater specific training relating to interactions with staff, e.g., how to approach gamblers, anger management, conflict resolution and counselling.

Expenditure and machine usage data might be more effectively tracked within venues so as to obtain objective information concerning player expenditure and time on machines.³⁹

6.34 This research was highlighted by Mr Mark Henley, Member, Australian Churches Gambling Taskforce:

Can I just make one more point on this issue to highlight some research done by Professor Paul Delfabbro in Adelaide. He looked at the question of whether there are observable signs in a venue on any particular day that would suggest that a person may have a gambling problem. If we go back five years the industry was saying, 'There are some pretty good physical indicators that a person has had too much to drink but with gambling it is impossible to tell.' But Paul Delfabbro has identified combinations of observable behaviours: sweating, abusiveness, going to ATMs frequently, kicking machines. There is a whole range of observable behaviours on a gambling floor at any time which give clear indications of a high likelihood of gambling harm. That research has shown very clearly that there are observable signs that gambling staff can be looking out for. So that argument, 'We can't tell who's got a gambling problem,' really does not stack up any more because of that very sound research that has been undertaken by Paul Delfabbro.⁴⁰

6.35 In answers to questions on notice the Australasian Casino Association (ACA) referred to the research undertaken by Professor Paul Delfabbro on the identification of problem gamblers. The ACA said its members were aware of the research 'and in many cases it has been used to develop many of the processes, resources and staff training programs related to identification of problem gambling behaviours'.⁴¹ In answers to questions on notice, the Australian Hotels Association also reported that this research forms part of training packages.⁴²

39 Dr Paul Delfabbro, Dr Alexandra Osborn, Dr Maurice Nevile and Dr Louise Skelt and Professor Jan McMillen, *Identifying problem gamblers in gambling venues*, Gambling Research Australia, 19 November 2007, p. 20.

40 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 13.

41 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 2.

42 Australian Hotels Association, answers to questions on notice, received 17 September 2012, p. 2.

The reality as told to the committee

6.36 The committee heard from a number of witnesses who have experienced gambling problems during this and previous inquiries. They told the committee that although they gambled for considerable periods of time at the same venues, sometimes over a number of years, no staff member ever approached them to discuss whether they had a problem and needed to seek help. Ms Julia Karpathakis, Manager, Pokies Anonymous, told the committee that she played poker machines for 10 years and during this time she was not approached by any staff:

I never got tapped on the shoulder. In fact, I was encouraged: my machine had not gone off and it could go off. I was basically encouraged to play on the machine that had not gone off...⁴³

6.37 Ms Karpathakis said she used to go back and forth to the ATM and changed the money into coins with a person behind the counter until she had nothing. She recalled that once she spoke to a staff member to express that she was worried and they gave her a card with a gambling helpline number which she never used.⁴⁴

6.38 Miss Shonica Guy, Volunteer Coordinator, Pokies Anonymous, spoke about her more recent experience. Miss Guy said that she could spend up to 10 hours in a session and was known as a regular at a few hotels: the New York Bar and Grill, the Flagstaff Hotel and the Tonsley Hotel. She told the committee that no staff member ever approached her as indicated in the following exchange:

Senator XENOPHON: Did anyone ever come up to you when you were playing?

Miss Guy: No.

Senator XENOPHON: Did you ever say anything to anyone as you were changing money?

Miss Guy: No.

Senator XENOPHON: So you never indicated anything to anyone that you were having problems?

Miss Guy: No.

Senator XENOPHON: But you were there for a prolonged period?

Miss Guy: Yes.

Senator XENOPHON: Did you notice other regulars there while you were there?

Miss Guy: Yes, usually the same people were there. I used to play, although I do not actually know what it is called now, this particular machine and there would be about another four people that would want to play that. There were only three machines, so it was who could get to them

43 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 11.

44 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, pp 12–13.

first sort of thing. There were at least four regulars that I knew just for the machine that I liked. But the same people were there every time and they would say, 'How are you going?' or 'I just got here' or 'How long have you been here for?' There was no conversation but we knew that we were always there.

Senator XENOPHON: Can I ask for any obvious tell-tale signs. Did you ever get upset when you were playing? Did you ever say anything to anybody while you were losing a lot of money?

Miss Guy: I remember once really early on, probably over 10 or more years ago or 12 years ago, getting free games and this older lady next to me said, 'Oh, free games,' and I said, 'Yeah, I'm not getting too excited yet because it probably won't give me anything.' Then I said, 'I shouldn't even be here anyway because I have got a bit of a problem,' and she goes, 'Oh no, dear!' She was horrified.

Senator XENOPHON: Was it one of the staff?

Miss Guy: No, this was just a lady sitting next to me. She said, 'Oh no, dear, because I wouldn't want that to happen to you. I am an old lady and I've already had my life and I'm established. I wouldn't want that to happen to you.' After the free games finished I felt so bad that I just cashed the money and left. I did not want to sit there anymore.⁴⁵

6.39 In answers to questions on notice, the Australian Hotels Association responded:

Without knowing the time frame of when these events occurred it is difficult to respond specifically. However SA Code of Practice requirements have changed significantly. Obligations to develop internal reporting processes, management reviews. The Introduction of Gaming Care whose role is to assist venues with compliance, and establishing relationships with local Gambling Help Services. Venue visits with Gambling Help Services together with enhanced training of senior staff have all been implemented to enhance early intervention with problematic gambling behaviour.⁴⁶

6.40 Miss Guy described the environment at the venues:

There is usually only one staff member. There used to be more when there was smoking. They are serving and trying to do their thing. They are not watching what is going on. One person cannot do all that.⁴⁷

6.41 She and Ms Karpathakis then said that they believe the staff know who has a problem:

45 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 13.

46 Australian Hotels Association, answers to questions on notice, received 17 September 2012, p. 3.

47 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 13.

Miss Guy: I think they know but—

Ms Karpathakis: Of course they know.

Miss Guy: But it is like here. Looking out here we know exactly who is here. Everyone in there is hooked, as far as I am concerned. You can see it. They are like zombies. The 40 per cent or whatever of people who have got problems with pokies, I think, is an underestimate, because any time I have been in venues everyone in there is hooked, basically. There are no people coming in there just for two seconds or for \$5 and leaving that I have ever seen. Usually, everyone is there and they are there for a long time, along with me.⁴⁸

6.42 Mr Tom Cummings spoke about this issue to the committee:

I think I mentioned in my submission the staff in gambling venues. I still pop into gambling venues regularly as part of what I write about to have a look around. I have yet to see one staff member approach a player and say, 'I think there's an issue,' or 'I think you might be gambling a bit too much; maybe you ought to take a break.' I have yet to see it happen.⁴⁹

6.43 In response to the committee, Mr Cummings emphasised that he is not aware of anyone who has ever been approached by a staff member about their gambling:

Senator DI NATALE: You mentioned in your submission that you had never been approached by a staff member. In your experience in this area, do you know of any other people who have been approached by staff members because their gambling is getting out of control? If so, has that intervention had any impact on their gambling?

Mr Cummings: I cannot answer the second question, because the answer to the first question is no. I do not know anyone, and I have spoken to a number of poker machine addicts in the last couple of years through my blog. I do not know of anyone who has ever been approached by a staff member.⁵⁰

6.44 Mr Ralph Bristow, Gambling Impact Society NSW, told the committee about his experience:

I have attended most clubs in New South Wales because I used to work out in the country. I lived in Sydney—I was born here. I have lived in Wollongong and Lane Cove and there were clubs I frequented quite regularly when I was home. Not once in 30 or so years would anyone have approached me as to my gambling problem. It would have been obvious from the number of times I went up to get change in those days but not once did I see an employee [approach] anyone as to their gambling problem.⁵¹

48 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

49 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 2.

50 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 6.

51 Mr Ralph Bristow, *Committee Hansard*, 2 May 2012, p. 41.

6.45 Major Brad Halse, Member, Australian Churches Gambling Taskforce, also spoke on this point:

That is a comment that our social workers and our counsellors hear so often. It is often brought up in these types of venues. For all the commentary from the industry about trying to assist a potential problem gambler we never hear of people who were approached for whatever reason—the amount of time they are spending or when there are obvious signs of distress and concern—so even at the most basic level this duty of care seems to be overlooked or disregarded. It is a very serious issue.⁵²

6.46 Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, Gambling Treatment Program, St Vincent's Hospital, told the committee that she may have had one client who indicated that they had been approached by the staff in a venue. Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, was not sure that she had anyone referred that way.⁵³

6.47 The committee notes that recently the media reported an Adelaide woman was jailed for six years for stealing more than \$800,000 from two employers to feed her poker machine addiction. While accepting responsibility for her actions the woman questions 'why the venues where she gambled away the cash over seven years had never once approached her to ask if she had a problem'.⁵⁴

What could staff intervention achieve?

6.48 Former problem gamblers highlighted that an approach from staff would have made them stop and think. In the following exchange, Ms Rhian Jones, Member, Gambling Impact Society NSW, told the committee that if someone had approached her she believed it would have been sufficient to take action:

Ms Jones: ...If somebody had come up to me and said, 'I think you have a problem', that would have been enough for me.

Ms BRODTMANN: That would have been from the staff in the venue.

Ms Jones: Yes.

Ms BRODTMANN: Would there be anyone from the floor, the person selling drinks?

Ms Jones: It is quite funny because everybody knew. Everybody had access to the records so yes, but I would have preferred somebody who had some experience. I would have liked somebody who had some training and would have been able to come up to me and say, 'Excuse me but I think you might have a problem,' not somebody who serves drinks.

Ms BRODTMANN: What would your response have been at that stage?

52 Major Brad Halse, *Committee Hansard*, 3 May 2012, p. 13.

53 Ms Abigail Kazal, Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 23.

54 'Theft to pay for pokies', *Northern Territory News*, 14 July 2012, p. 12.

Ms Jones: As I said, it is an extremely secretive problem. If somebody had told me that they knew then it would have been enough to stop me.⁵⁵

6.49 Ms Jones added:

Ms Jones: ...Staff training and recognition of that problem would have been fantastic, and early intervention would have been brilliant. If somebody could have mentioned to me that I was an addict or that I was becoming an addict or that other people were aware of it, it would have helped me enormously, and I am sure it would help others as well. So early intervention and—

Senator XENOPHON: Mr Symond from BetSafe gave evidence earlier today and the tenor of his evidence was that that would not work. That can actually delay a recovery by years. You do not agree with that?

Ms Jones: Absolutely not. It would have taken one person to mention it to me.

Senator XENOPHON: It could have jolted you into action?

Ms Jones: Absolutely.⁵⁶

The difficulties with staff training

6.50 The committee was told at this and previous inquiries about a number of shortcomings with staff intervention which included: conflict of interest, casual workforce and the reluctance of younger staff to approach patrons displaying aggressive behaviours. Mr David Pigott, National Manager, Government Relations, Mission Australia, spoke about the conflict of interest for staff:

...There is inherently a potential conflict of interest with staff within venues having that role, but our early experience in the ACT is that those roles have been quite effective. As far as training goes, yes, I think there can always be more training, and I think it is a very useful expenditure of funds to do that. I am not an expert in the sort of training required, but I am not convinced national accreditation and those sorts of things are the way to go. Part of our concern relates to even our own staff having adequate backup and counselling support behind them to deal with these difficult issues.⁵⁷

6.51 This conflict was recognised by Professor Alex Blaszczyński:

The difficulty basically is that in my view they are not as proactive as they could be in identifying and responding to problem gamblers, because they are in a conflict position where their profits are derived from gambling. A proportion of their revenue is derived from problem gambling, and therefore they are in a conflict situation...⁵⁸

55 Ms Rhian Jones, *Committee Hansard*, 2 May 2012, p. 41.

56 Ms Rhian Jones, *Committee Hansard*, 2 May 2012, p. 39.

57 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 2.

58 Professor Alex Blaszczyński, *Committee Hansard*, 2 May 2012, p. 13.

6.52 Ms Amanda Jones, Member, Public Interest Advisory Group, Australian Psychological Society, spoke about the difficult position staff are put in:

I suppose that on principle, consistent with our opening statements, I would take the position that an on-the-floor venue responsible gambling approach in and of itself is woefully insufficient and problematic in many ways, not least the fact that a venue has a vested interest and it puts its staff in a pretty invidious position to be performing that kind of role.⁵⁹

6.53 The committee also heard that the makeup of the venue workforce also has an effect:

Mr FRYDENBERG: But you also say that a lot of the staff are university students and, therefore, it might be too much to expect them to have the self-confidence to approach someone.

Mr Cummings: Absolutely.

Mr FRYDENBERG: So how do we get over that?

Mr Cummings: I wish I knew. I have spoken to a number of Gambler's Help counsellors in the last couple of years, and very clearly the message coming to me from them was, through my writing, 'Please do not give people advice on how to stop gambling or what to do.' And I fully agree with that. I am not qualified. I do not have the years of experience or the training to counsel someone. I fail to see how a university student with an RSG could provide the same sort of service, even as an intervention measure, to someone that they suspect may have an issue with their gambling. It might be that having some sort of counselling service available in-venue might be an option, but we have a lot of venues and that is an awful lot of people.⁶⁰

6.54 Professor Linda Hancock spoke with staff from Crown Casino where they reported it being easy to identify problem gamblers, but floor staff are instructed not to intervene themselves and to refer such cases to a supervisor/manager. Despite the instruction, staff reported being too scared to intervene anyway because of uncertainty about how patrons would respond, lacking the skills to intervene or being scared of losing their job if they were seen to intervene. Almost 18 per cent of staff reported that they felt under pressure by management to keep people gambling.⁶¹

6.55 In answers to question on notice the Australasian Casino Association reported that 'Casinos train their staff to report observable signs that may indicate problem gambling behaviours'. It also advised that 'many casinos operate an independent (third party operated) "whistle-blower" service to take and handle any staff or supplier complaint or concern (which may be made anonymously) in relation to matters

59 Ms Amanda Jones, *Committee Hansard*, 14 May 2012, p. 30.

60 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 2.

61 Linda Hancock, *Regulatory Failure? The case of Crown Casino*, Deakin University, Australian Scholarly Publishing, 2011, pp 66–81.

including but not limited to, any issues of integrity, including harm minimisation matters. Casino operators regularly conduct awareness programs about the service'.⁶²

6.56 Showing the fraught nature of such staff/patron interaction, Mr Paul Symond, General Manager, BetSafe expressed the view that in his experience tapping people on the shoulder if they think they are displaying problematic behaviour forces people into therapy, which is then not very helpful:

Mr Symond: I will give you a 'for instance': in South Australia and the ACT they have to go up and tap someone on the shoulder if they think they are displaying behaviour that looks like they may have a problem. I have got some issue with that, because my experience has been that when you force someone into therapy I think it could probably knock them back five to 10 years therapeutically.

Senator XENOPHON: How do you say that, though?

Mr Symond: It is just my gut feeling on that, because most people who are forced into therapy resist it like you would not believe. We have seen them up here, where they are not forced to come in but the pressure on them by the family is very heavy. They come in, and I do not think the counselling session is all that helpful, because they are there under duress.⁶³

6.57 Contrast this view with that of an experienced clinical psychologist:

In terms of people who come really motivated to quit, there are those whose partner has said, 'You have to go.' As an overall thing, people who come off their own bat may be more motivated. But certainly with the other ones, you have them in your office so there is a chance to do something. Quite a lot of them will have come in saying, 'I don't have a problem but my wife thinks I do.' You question them and after a while, they think, 'Yes, I'll stick around for a bit.'⁶⁴

Committee view

6.58 The committee was very concerned to hear that despite showing obvious signs of problematic gambling, none of the former problem gamblers who spoke to the committee had been approached by staff. In addition, the counselling and other professional health services could not recall any clients mentioning they had been approached by staff. Unfortunately the committee was unable to discuss the experiences of the witnesses described above with the peak bodies such as Clubs Australia, the Australian Hotels Association and the Australasian Casino Association as they declined to appear at a public hearing.

62 Australasian Casino Association, answers to questions on notice, received 5 September 2012, pp 2–3.

63 Mr Paul Symond, *Committee Hansard*, 2 May 2012, p. 29.

64 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 24.

6.59 The committee majority notes the government announcement on 21 January 2012 of a number of actions to assist problem gamblers and their families which included improving training for staff in poker machine venues.⁶⁵ No further detail on how and when this will occur or what aspects will be improved has been made available. The committee is not aware of any response to the campaign launched by Clubs Australia which makes mention of improving staff training by providing training that encourages staff to directly intervene when they suspect problem gambling.⁶⁶ This appears to be an admission that the current training focused on staff intervention is not working as well as it could, as evidenced by the personal experiences described above. While this initiative may equip staff with better skills to directly address problematic behaviour it does not address the other limitations mentioned.

6.60 Without having had the benefit of speaking with industry the committee will attempt to make some concrete suggestions to address these limitations. To further address the issues of conflict of interest and the difficulty in approaching people displaying problematic gambling behaviour, the committee is reminded of a suggestion by Ms Julia Karpathakis from Pokies Anonymous during the committee's first inquiry. Her idea was to have people visit venues wearing an 'ask me' t-shirt so players can ask them if they need help. They could also work with venue staff. Ms Karpathakis pointed out from her personal experience that it is very difficult to confront someone with a gambling problem and it may be more realistic for someone to reach out.⁶⁷ As it was not the focus of the first inquiry, details were not discussed. Building on this and similar suggestions,⁶⁸ there could be merit in venues exploring partnership arrangements with non-government organisations and counselling providers who would talk to staff on a regular basis to see if there is a player they are worried about and they would then approach the individual. This would not replace the current arrangements and venue responsibilities but supplement them. The committee notes the recent announcement by ClubsNSW of a 12 month trial at Mingara Club on the NSW Central Coast to have a Salvation Army Chaplain available at the club.⁶⁹ Unfortunately, as industry did not attend public hearings, the committee was unable to discuss this trial in detail.

65 The Hon Jenny Macklin MP, the Hon Julia Gillard MP, the Hon Bill Shorten MP, Senator the Hon Stephen Conroy, 'Tackling problem gambling in Australia', *Joint media release*, 21 January 2012; Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 20*, p. 4.

66 Clubs Australia, 'Clubs launch TV and radio campaign: getting on with the job of gambling reform', *Media release*, 15 June 2012.

67 Pokies Anonymous, *Submission 34*, p. 5 (First inquiry into a pre-commitment scheme).

68 See Ian, *Submission 53* and *Submission 53A*.

69 ClubsNSW, 'Clubs and Salvation Army join together to fight problem gambling', *Media release*, 5 August 2012.

6.61 In addition, the committee notes the model used by casinos where staff are trained to report observable signs that may indicate problem gambling behaviours. It appears that the staff who directly approach and assist customers who may be experiencing gambling problems have further training and in some cases there are dedicated staff to do this.⁷⁰ This seems a useful model to address the natural reticence that younger and inexperienced staff may have in approaching people themselves who are showing signs of problematic gambling behaviour.

6.62 The committee also notes the model used by many casinos of an independent, third party operated 'whistle-blower' service where staff may anonymously report issues of concern including harm minimisation matters. Casinos with the service conduct regular awareness sessions about it.⁷¹ This could also be a useful model to address concerns expressed to the committee during its inquiries about staff feeling pressured to keep people gambling.⁷² The independence of such a system would be essential. The committee notes the Productivity Commission recognised the limitations of existing complaint systems through peak bodies and recommended there be a more visible mechanism for consumers and staff to make complaints to the regulators in each state and territory.⁷³

6.63 The committee was not able to discuss these models with the industry but would encourage all casinos as well as clubs and hotels to investigate putting in place such programs to further improve the ability of their staff to assist problem gamblers.

Self-exclusion in theory

6.64 Self-exclusion operates by self-identified problem gamblers 'voluntarily surrendering the right to enter the gaming areas of their local venues.' Clubs Australia advised the committee that:

There are a number of ways in which existing self-exclusion schemes can be improved upon. ClubsNSW is currently rolling out a state-wide multi-

70 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 1.

71 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 3.

72 Parliamentary Joint Select Committee on Gambling Reform, First report: the design and implementation of a mandatory pre-commitment system for electronic gaming machines, May 2011, pp. 59–62.

73 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 31. Note: The purpose of the COAG Select Council on Gambling Reform is to develop a national response to the findings and recommendations of the 2010 Productivity Commission report and its final report was due at the end of 2011. The committee is therefore unaware of any progress on reviewing existing complaint systems. See: <http://www.fahcsia.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/problem-gambling/coag-select-council-on-gambling-reform> (accessed 19 September 2012).

venue self-exclusion scheme, which allows patrons to exclude themselves from multiple clubs in their local area through a single application.⁷⁴

6.65 In February 2012, ClubsNSW launched online technology where through a secure website at their local club problem gamblers can complete a legally binding self-exclusion document in the presence of a gambling counsellor or a trained facilitator. They can choose to ban themselves from multiple clubs whereas previously patrons had to visit each club individually. In a six month trial of 51 clubs in Broken Hill and the Central Coast, 136 problem gamblers chose to ban themselves from a combined 569 clubs. They advised that self-exclusion was introduced by clubs and hotels in 2000 with an estimated 3,000 people banning themselves from a club or hotel each year.⁷⁵

6.66 In answers to questions on notice the Australasian Casino Association (ACA) advised that:

...casinos' experience in Self-Exclusion Programs is robust and extensive. While there are slight variations in casino Self-Exclusion Programs due largely to individual state jurisdictional differences, all operate on the principle that Self-Exclusion is a tool made available for those persons who wish to use it in assisting to manage and/or address their problem gambling behaviours. This tool importantly allows the individual to take a pro-active step towards making a positive change in their behaviours.⁷⁶

6.67 The ACA added that as part of the process people applying for self-exclusion are required to agree to legal and casino requirements. These include the request for the person to seek counselling and treatment and the release of liability against the casino.⁷⁷

6.68 Regarding self-exclusion programs, the Australian Hotels Association (AHA) noted that:

Self-exclusion is proven to help problem gamblers. It is one of a suite of measures, such as counselling and education that can help the small percentage of the population with gambling problems.

6.69 The AHA added:

Different self-exclusion schemes operate in all Australian States & Territories. A feature of self-exclusion is that venues keep on hand

74 Clubs Australia, *Submission 29*, p. 10.

75 ClubsNSW, 'Clubs launch online support for problem gamblers', *Media release*, 8 February 2012.

76 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 3.

77 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 4.

information, such as a photograph, of the self-excluded patron. This allows venues to identify self-excluded patrons and prevent them from relapsing.⁷⁸

The reality as described to the committee

6.70 Experiences of self-exclusion appear variable. Research undertaken by Dr Samantha Thomas asked gamblers about their experience of self-exclusion. One gambler:

...described how even though she was currently “excluded” from the three gaming machine venues in her local area, two of the three venues were not enforcing the conditions of the program, and would always “turn a blind eye” when she went there to gamble.⁷⁹

6.71 Others spoke of the difficulties they faced when trying to self-exclude:

“For a person like me who has taken advantage of everything I can, the one that I couldn't really do easily was get excluded from TABs. It's much more of a difficult process. You had to write away and...you couldn't just have it as a blanket sort of thing, it was almost going to be a TAB by TAB thing. It was going to be quite difficult whereas the Hotel's Association one is relatively easy. You go in for an interview, you know, they pull up on a computer all the different venues, they write to them all for you. It's all done within an interview, you know, and it's quite well-maintained. [Do we need look at maybe some easier ways with the TAB?] I think so and then the online gambling. I don't know how people self-exclude from all the online stuff that's happening.” (Male, 49 years old)⁸⁰

6.72 This was contrasted with another gambler's positive experience of self-exclusion at Crown Casino:

“...the way I was treated I thought that was exceptional, the way they took care. So I mean based on what I know and based on what I've done, I was very happy.” (Male, 22 years old)⁸¹

6.73 One player who participated in the study by Dr Thomas said she felt the need to reapply had led to her relapses:

78 Australian Hotels Association, answers to questions on notice, received 17 September 2012, pp 4–5.

79 Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisations of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, report prepared for the Office of Gaming and Racing, Victorian Department of Justice, May 2012, p. 70.

80 Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisations of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, report prepared for the Office of Gaming and Racing, Victorian Department of Justice, May 2012, p. 69.

81 Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisations of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, report prepared for the Office of Gaming and Racing, Victorian Department of Justice, May 2012, p. 69.

One female participant, who at the time of the interview was gambling daily on gaming machines, and scored 13 on the PGSI, criticized the AHA self-exclusion program because it required her to reapply every two years as opposed to Crown Casino where self-exclusion is for an indefinite period, and individuals need to reapply to be included back into Crown. She described how she believed this had directly led to relapses with her addiction with gaming machines. She questioned the two-year maximum imposed by the AHA self-exclusion program, and asked whether this put the welfare of “lifetime” problem gamblers like her at risk.⁸²

6.74 Ms Karpathakis described the system in South Australia:

CHAIR: How does the system of self-exclusion work in South Australia? Is it little photos on sheets of paper?

Ms Karpathakis: That is right. If you physically go into the IGA, they take your photo but you can self-exclude at a pub.

Miss Guy: They do not have photos at the pubs.

Ms Karpathakis: Not in the venue; not if you self-exclude. I can [go] into a venue and say: 'Bar me from here. I don't want to come here anymore.' If I go to the IGA, there is a photo and the records go to different places.

CHAIR: That is distributed to all venues?

Ms Karpathakis: The venues that you have requested.

CHAIR: How effective is that system?

Ms Karpathakis: We have had people who have gone into the venues they are barred from and they have never been noticed. I have one member who has been noticed and he ran away and never went back there, but he went to some other place because he was so freaked out. So there has been one record of one person, to my knowledge from my group, who has been picked up.⁸³

6.75 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital Gambling Treatment Program, described how they tend to refer back to the clubs for programs like self-exclusion and commented on the variability of it:

We tend to refer back to the clubs. In terms of, say, self-exclusion, I have said to clients, 'You should go and self-exclude.' A lot of clients are reluctant to and ironically enough those who are most reluctant to are probably the ones for whom it is going to be most effective because if you do not care about being embarrassed it is an easy thing to do. One of [the] things that happens is that some clubs really do not do it properly and we have had to ring up the RGF and say, 'That club is not doing it the way it is supposed to be done.' Other clubs just do it perfectly: the person is treated

82 Dr Samantha Thomas, Ms Sophie Lewis, *Conceptualisations of gambling risks and benefits: A socio-cultural study of 100 Victorian gamblers*, report prepared for the Office of Gaming and Racing, Victorian Department of Justice, May 2012, p. 69.

83 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, pp 16–17.

with respect and they can do it instantly. As to how the person is treated really varies when they go for self-exclusion.⁸⁴

6.76 Ms Leah Galvin, Manager of Social Policy and Advocacy, St Luke's Anglicare, spoke of the difficulties with self-exclusion systems:

...I understand that it is a manual system. I think this is one of the weaknesses. People can self-exclude, and there is a process that you go through to do that. I think you can do it either through the venue or through, again, a regulatory body. But sometimes those systems are really quite ad hoc; they might have pictures of you in a security area or something like that, and so if the security people are not alert it would be quite easy for you to pass through.⁸⁵

6.77 The committee notes recent media reporting that gamblers who self-excluded from The Star Casino returned 'numerous times'. Dr Keith Garner from Wesley Mission stated: 'It is common knowledge that self-exclusion schemes do not work as stand-alone interventions. Self-exclusion and gambling counselling must go hand in hand'. He called for a universal approach. The Star responded that 'it is explained to, and acknowledged by, patrons that when they self-exclude that ultimately this is their responsibility'.⁸⁶

Involuntary and third party exclusions

6.78 Mr Paul Symond, General Manager, BetSafe, reported on the availability of involuntary and third party exclusions:

Currently we have got a large number of self-exclusions. We also go into involuntary exclusions and this helps us out when we have got family and other people associated with the gambler. Also we have got third-party exclusions. We have got a fairly stringent readmission procedure. So when the six months or two months or three months of self exclusion is up, people cannot just walk back into the club, they have got to come to us and go through questions and an interview...⁸⁷

6.79 Mr Daniel Symond, Operations Manager, said BetSafe was in favour of full venue exclusions, not just the gaming area, and provided more detail on involuntary exclusions:

The other thing that Paul [Symond] mentioned earlier on—and this is something that is not legislated in New South Wales—is what we call involuntary exclusion. That is where a venue becomes aware that someone has a gambling problem and the venue excludes that person. In New South Wales at least, there is no legislative requirement to do that. It is very

84 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 24.

85 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

86 Zoe Nauman, 'Casinos bet on dodging gambler ban', *Sunday Telegraph*, 15 July 2012, p. 23.

87 Mr Paul Symond, *Committee Hansard*, 2 May 2012, p. 28.

common that a patron will approach a staff member, tell them they have got a gambling problem but refuse to self-exclude. Under the current legislation, there is no obligation on the club to do anything. Under our program and in our venues, we provide independent advice in those situations, and in general our venues will exclude someone, particularly if there is clear evidence of a gambling problem.⁸⁸

6.80 The committee notes the Clubs Australia campaign which proposes legislation empowering family members to approach gambling venues when they suspect a relative has a gambling problem.⁸⁹

6.81 In answers to questions on notice the Australasian Casino Association reported that third party exclusion is available in some jurisdictions (Tasmania, Western Australia and Queensland).⁹⁰

Making self-exclusion more effective

Jurisdiction-wide self-exclusion

6.82 In the absence of industry attending any public hearings, the committee discussed how to improve self-exclusion arrangements with others including Mr David Pigott, National Manager, Government Relations, Mission Australia. Mr Pigott pointed out some of the difficulties with self-exclusion including that it is currently not jurisdiction or venue-wide. While people may self-exclude from one club they could go to a nearby venue that does not participate. He suggested that self-exclusion should be across a whole jurisdiction for it to work effectively and added:

The fact that they have self-excluded is a positive step—as you say, they have recognised that they have got an issue. I guess then it is up to us to assist them in making that commitment.⁹¹

6.83 Clubs Australia responded to the suggestion of a jurisdiction-wide self-exclusion program via questions on notice:

All clubs do offer self-exclusion, a requirement in every jurisdiction. A mandatory jurisdiction-wide self exclusion zone would undermine the effectiveness of self exclusion programs. By limiting self exclusion to the local geographic residence and/or workplace of the individual gambler, the system does not become overburdened with venues required to identify and enforce the procedure for problem gamblers who are unlikely to enter the

88 Mr Daniel Symond, *Committee Hansard*, 2 May 2012, pp 32–33.

89 Clubs Australia, 'Clubs launch TV and radio campaign: getting on with the job of gambling reform', *Media release*, 15 June 2012.

90 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 4.

91 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 6.

premises. By limiting programs to those venues the individual is likely to enter assists venues with focusing their attention more effectively.⁹²

6.84 Mr Pigott also said that anecdotal advice from staff in NSW is that asking staff to identify people from photographs for self-exclusion is patchy in terms of effectiveness. He added:

It sounds like it [self-exclusion] has to be universal and, again, I am not familiar with the Tasmanian situation, but ideally, if you self-exclude from a venue here then it ought to be able to be recorded elsewhere. That is, again, presumably a reasonably complicated process. If alerts go out or whatever, I am not sure that that is ideal either. As I said, the whole idea of self-exclusion is that the onus is on the gambler to take some responsibility for his or her actions. Our role is to help and support them in meeting that commitment. How big a stick you use, I am just not sure. And what sort of technology you use to enforce that is also challenging.⁹³

6.85 Further illustrating the limitations of self-exclusion, the committee notes the problem gambler who banned himself from four Hobart venues. While he was turned away from three of the venues he was able to gamble undetected in one hotel for extensive periods and lost more than \$3,000.⁹⁴

Having effective systems in place

6.86 In order to increase effectiveness, Ms Leah Galvin, Manager of Social Policy and Advocacy, St Luke's Anglicare, spoke about swipe-in systems which can easily identify self-excluded gamblers:

This is one of the things where we think that greater protection could be offered for problem gamblers who have made that decision that they want to reduce or stop their gambling. I have heard of a system where there is almost like a swipe-in, so there is some sort of identification that is needed before people can proceed into venues. I understand it operates in some of the clubs in New South Wales; if people have self-excluded, the moment they try to swipe themselves into the venue—I am sure it is not all bells and whistles—they are discreetly removed from the venue.

It would be really great to strengthen that part of our system, because it is not strong. We do hear stories about people who have self-excluded because of their difficulties with gambling still being in venues and losing vast sums of money.

CHAIR: And in fairness to the staff in some of these venues, even the very best staff struggle to cross-reference hundreds of photos with thousands of people walking through the door.

92 Clubs Australia, answers to questions on notice, received 27 July 2012.

93 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 6.

94 Hannah Martin, 'Penalties for Pokies', *Hobart Mercury*, 30 August 2012.

Ms Galvin: Yes. I totally agree with that. It is certainly not any commentary about their capacity or their willingness; it is just that the system is not very strong. It makes it very hard for them actually to do the right thing by people who have tried to self-exclude as well.⁹⁵

6.87 The committee notes that ACT clubs are increasingly using scanning systems in order to facilitate access to venues. This system could be used to improve self-exclusion schemes; however, currently its use is optional.⁹⁶

Linking to prizes

6.88 The Productivity Commission recommended that prizes won by people shown to be in breach of self-exclusion orders should be forfeited to government revenue.⁹⁷ Clubs Australia also supported this action and stated that it would serve as a means of reducing the incentive for patrons to breach their self-exclusion agreement. Clubs Australia recommended that the forfeited prizes are remitted to a government fund dedicated to addressing problem gambling.⁹⁸

6.89 The committee understands that the forfeiture of prizes is not currently supported by legislation. This means that although it can be included in a self-exclusion agreement, it cannot be enforced and no patrons have handed back any prizes. Mr Daniel Symond and Mr Paul Symond, BetSafe, supported such legislation to act as a deterrent for people to breach self-exclusion agreements.⁹⁹

6.90 In answers to questions on notice, the Australasian Casino Association advised that sanctions for breaches by self-excluded persons vary from state to state:

For example, Victorian Legislation provides for the prosecution of persons who breach their exclusion in the casino. In addition, Self-Excluded persons must forfeit their winnings (including prizes) for the State for payment into the Community Support Fund (Casino Control Act 1991 (Vic) s 77A and s 78B respectively).¹⁰⁰

Committee view

6.91 The committee accepts that self-exclusion can be helpful for some gamblers but it also has limitations and should not be used as a stand-alone intervention. This is recognised by industry which advocates self-exclusion and counselling. The system

95 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

96 Christopher Knaus, 'ACT clubs scanning your licence', *The Canberra Times*, 23 July 2012.

97 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 53.

98 Clubs Australia, *Submission 29*, p. 10.

99 Mr Daniel Symond, Mr Paul Symond, *Committee Hansard*, 2 May 2012, p. 28, 33.

100 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 4.

for some self-exclusion programs appears complex and given the shame involved, asking people to identify themselves as a problem gambler and possibly have their photo taken as well as reapply after a period of time may be difficult for them. The fact that people can't self-exclude from all venues at one time is problematic. They may only have to travel a short distance to be able to gamble at another venue. The committee sees merit in investigating state-wide self-exclusion programs to make it simpler for those wishing to self-exclude.

6.92 The committee notes the recent program launched by Clubs Australia which is attempting to assist problem gamblers by allowing them to self-exclude from multiple venues by doing so from their local club. The committee is pleased to see a person can also avoid gaming venues and complete the process in the office of a certified gambling counsellor.¹⁰¹ While the committee acknowledges this is a step forward, the program is not currently jurisdiction wide, although it notes the intention to expand the system across NSW over the next 12 months. The system should then be expanded to cover other states. However, it is unclear how venues will effectively identify people who have self-excluded. Venues should have effective systems in place to do so in order to assist their patrons. The committee notes the response of Clubs Australia which seems to indicate a preference to limit self-exclusion to the local geographic area of an individual gambler.¹⁰² As Clubs Australia refused to attend a public hearing the committee is unable to reconcile this response with their program outlined above.

6.93 The committee supports legislation for the forfeiture of prizes by those who are self-excluded as recommended by the Productivity Commission to act as a deterrent to breach self-exclusion agreements.

6.94 The committee notes the government announcement on 21 January 2012 of a number of actions to assist problem gamblers and their families which include strengthening self-exclusion arrangements.¹⁰³ However, no further detail on how and when this will occur or what aspects will be strengthened has been made available.

Recommendation 5

6.95 The committee recommends that as part of strengthening self-exclusion arrangements, governments, through the COAG Select Council on Gambling Reform, work with industry towards jurisdiction-wide venue exclusion as well as legislative changes which mean that prizes won by people in breach of self-exclusion orders should be forfeited to government revenue as recommended by the Productivity Commission.

101 ClubsNSW, 'Clubs launch online support for problem gamblers', *Media release*, 8 February 2012.

102 Clubs Australia, answers to questions on notice, received 27 July 2012.

103 The Hon Jenny Macklin MP, the Hon Julia Gillard MP, the Hon Bill Shorten MP, Senator the Hon Stephen Conroy, 'Tackling problem gambling in Australia', *Joint media release*, 21 January 2012; Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 20*, p. 4.

Incentives to gamble from venues

Gifts and drinks

6.96 The committee heard that venues offer incentives to people to keep gambling. Ms Dorothy Webb, Secretary, Gambling Impact Society NSW, told the committee about her son:

We did not know our son was addicted for nearly 15 years; it went on for 20 years. Early intervention certainly would have helped him. We know absolutely, particularly after going recently to our local club for a sandwich, that these EGM players are nourished very, very well with drinks from the bar. We were there for half an hour, and four times in that half hour it came over the microphone to the poker machine area: 'If you would like a drink from the bar'—that first phrase gets them used to listening to a voice—'If you would like a drink from the bar, please'—then the emphasis—'press the blue button at the right-hand side of your machine and it will be brought to you.' This is what happened to our son and of course he developed a severe drinking problem as well; the two seem to go together.¹⁰⁴

6.97 Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, said that player tracking through loyalty schemes can be used to target customers:

...player tracking is used specifically to target customers who are seen as good customers, which I am sure you are aware of. I have already quoted a number of scenarios in the submission where people have been selected out as good gamblers, people having brochures sent to them from for instance the casino with their personal name on it when they have just lost seven grand or whatever. So it is not only that the consumer protections and the early interventions are not there; it is the adverse side of that, which is that it is actually being used to market to people who we know are vulnerable. Last year at our seminar we heard from a woman who is now serving four years in jail for embezzlement. It took four years for the case to be heard. She talked about how, during that time, the club would send her flowers, they would send her taxis, they would ring her up and tell her that she had not been there for a while. They basically very clearly targeted her to come back, knowing that this was a woman who was spending thousands and was clearly not in a position to do that.¹⁰⁵

6.98 Jurisdictions differ in their regulation of inducements. The committee notes the following table outlining regulations covering inducements provided by the Australasian Gaming Council:¹⁰⁶

104 Mrs Dorothy Webb, *Committee Hansard*, 2 May 2012, p. 42. See also Mission Australia, *Submission 17*, p. 5; Relationships Australia, *Submission 18*, p. 8; Mr Tom Cummings, *Submission 22*, p. 3; Gambling Impact Society NSW, *Submission 30*, p. 8; Pokies Anonymous, *Submission 31*, p. 17.

105 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, pp 41–42.

106 Australasian Gaming Council, *Submission 33*, p. 17.

ACT	No specific ban however the mandatory Code of Practice places restrictions on inducements including a prohibition on offering free or discounted alcohol.
NSW	Legislation bans gambling-related inducements offered by clubs, hotels and casino. Inducements cannot include free or discounted liquor or offer free credits to players.
NT	A ban on all gambling related inducements
QLD	No legislated bans on gambling inducements however the voluntary QLD Responsible Gambling Code of Practice provides that gambling providers are to develop and implement strategies to ensure advertising and promotions do not involve any irresponsible trading practices by the gambling provider.
SA	The mandatory Code of Practice outlines a strict ban on all inducements. ¹⁰⁷
TAS	Inducements are restricted by the mandatory Code of Practice.
VIC	No specific ban on inducements however provisions under the mandatory Responsible Gambling Codes of Conduct govern the activities of the gaming provider
WA	Gaming and Wagering Commission Regulations 1988 govern the activities of the casino.

Venue opening hours

6.99 Mr Tom Cummings also suggested looking at venue opening hours:

...little things like venue opening hours—there is no standard across the country for when things can be open. Sometimes I start work early at 7 o'clock, and the venue that I walk past on the way to work is open and there are people playing at 7 o'clock in the morning. I used to when I was playing. Some of the other venues are still open at 4 o'clock in the morning or 6 o'clock in the morning.¹⁰⁸

Is there a need for a legislated duty of care?

6.100 Witnesses emphasised to the committee that currently there is no onus on venues for early intervention by staff. Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, elaborated:

107 Other than participation in an acceptable loyalty program. See Clause 6A, *Gaming Machines Responsible Gambling Code of Practice (South Australia)*.

108 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

Among some of the things that we have raised in our submission is that the evidence—we know from studies both in Australia and in Switzerland et cetera—strongly suggests that people are demonstrating problems with their gambling; yet, at the moment, certainly in New South Wales, there is no onus of any kind on host responsibility for early intervention. We know, for instance, that the casinos in New Zealand have player tracking data and have used it to do exactly that, whereas in New South Wales that is not the case.¹⁰⁹

6.101 The Australian Churches Gambling Taskforce pointed to the need for a legislated duty of care for poker machine venues:

While there is value in training of venue staff to be able to identify clear signs that a patron is engaging in problematic gambling and that they are skilled to deal with such patrons, such skills will count for little if venue owners and managers do not authorise such assistance being given. Research with venue staff has shown that in some venues staff [are] unwilling to intervene with a patron displaying problem gambling behaviour out of fear of disciplinary action by the venue owner for causing a loss in revenue for the venue. The Taskforce therefore believes there should be a legislated “duty of care” for EGM venues to take reasonable steps to prevent problem gambling, including intervention when a person is displaying clear signs of a gambling problem. This is already the case in Switzerland.¹¹⁰

6.102 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, also called for duty of care regulation:

At a venue level, cash needs to be less accessible, and venues should be made responsible for not causing and profiting from harm, through duty-of-care regulation. In the past, people from the industry used to say, 'You can't tell if someone has a gambling problem,' but it has been in solid research for quite some time now that you actually can detect it. Some years ago in Canada, Schellinck and Schrans did very good, solid research on that, and I believe Delfabbro in South Australia has also done research. So there is no truth in saying that we cannot tell if people have gambling problems.

From my own research at a community level, talking to people who work in venues, actually often they do know, but they need their jobs, so they keep it to themselves. But they actually do know. They do see the people who are distressed coming in, day in, day out, spending all night, so they can detect gambling problems. They need to be responsible if they are taking their money.¹¹¹

6.103 Industry responses via questions on notice did not support duty of care legislation. Clubs Australia responded:

109 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 38.

110 Australian Churches Gambling Taskforce, *Submission 50*, p. 10.

111 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 21.

Existing legislation is already comprehensive, and club compliance with the legislation has resulted in falls in the prevalence of problem gambling in every Australian state and territory. Given research into this issue is continuing..., it would be difficult to legislate further at this time.¹¹²

6.104 Regarding a legislated duty of care provision, the Australasian Casino Association advised:

The Australian Churches Gambling Taskforce's suggestion that there should be a legislated duty of care provision is based on the false assumption that there is something so insidious or systematically improper about the gambling industry that it requires the introduction of a new statutory cause of action, which is not faced by businesses in other industries. This suggestion is based on the mistaken assumption that resolving conflicts through the courts is a desirable or optimal state of affairs. This assumption is fundamentally flawed. The underlying assumption appears to be that because very few gamblers have successfully brought proceedings against gambling venue operators that this means the law needs to be changed.

The ACA submits that it is more likely that this is indicative that gambling venue operators have not breached their duties and responsibilities to gamblers and this is in fact why few successful cases have been brought. The ACA would further submit that in order for a problem gambler to deal with his or her problem they must recognise that they have a problem and commit to deal with the problem. This is an accepted point by many researchers in this area. Accordingly, the threshold tests for a breach of common law duty of care or breach of existing consumer protection legislation should remain relatively high, as they are now. The Productivity Commission also accepted that it would be preferable for governments to pursue the enhancement of compliance and complaints handling mechanisms and that this "would improve incentives for venues to effectively implement and apply harm minimisation requirements".¹¹³

6.105 The Australian Hotels Association responded:

Venue staff are now trained in the responsible conduct of gambling. In addition harm minimisation signage is currently on display in all gaming rooms. All gamblers are also alerted to free telephone help lines.¹¹⁴

Committee majority view

6.106 The committee majority notes that the Productivity Commission looked very closely at the provision of a statutory duty of care but did not recommend it:

112 Clubs Australia, answers to questions on notice, received 27 July 2012, p. 6.

113 Australasian Casino Association, answers to questions on notice, received 5 September 2012, p. 5.

114 Australian Hotels Association, answers to questions on notice, received 17 September 2012, p. 4.

In the draft report, the Commission floated a statutory duty of care as a possible way of providing better redress for gamblers. While conceptually attractive, there are several obstacles to its practical implementation:

- actions would be likely to be slow and costly
- there would be difficulties in defining ‘egregious behaviours’ and distinguishing them from unconscionable conduct (which is subject to legal action under the Trade Practices Act and the common law).

Given such difficulties, the Commission has recommended enhanced compliance and complaints-handling arrangements — in particular, strengthening penalties and disciplines for serious breaches — to strongly discourage any inappropriate venue conduct. If governments did not implement these measures or they failed to deter egregious venue behaviour, a statutory cause of action could be given further consideration in the future.¹¹⁵

6.107 The Chair, Senator Xenophon and participating Senators Di Natale and Madigan have provided additional comments in relation to this issue which follow this report.

115 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, pp 31–32.

Chapter 7

Pathology of problem gambling

7.1 This chapter will detail some of the research that attempts to understand why some people develop gambling problems and what can trigger a gambling problem. It will provide context for the following chapters which cover how various models of treatment address the psychology and pathology behind problem gambling.

No 'one type' of problem gambler

7.2 It was acknowledged in evidence to the committee's first inquiry that there is no 'typical' or 'average' problem gambler. Research cannot accurately predict who will develop a gambling problem. However, there are a number of risk factors or experiences that can contribute to developing a gambling problem. For example, the committee heard from Mr Christopher Hunt, Psychologist, Gambling Treatment Clinic, University of Sydney, that an early positive experience with gambling is common for people who develop a gambling problem.¹ He also emphasised that there is no clear reason why some people go on to develop gambling problems and others do not. Apart from an early positive experience, Mr Hunt mentioned other factors such as being in a desperate financial situation and beliefs about money and winning also contributing to developing a problem. He stressed the need for campaigns to address the core pathology of problem gambling, which is a belief that one can win money in the long term.²

7.3 Professor Debra Rickwood, Professor of Psychology, University of Canberra; and Fellow, Australian Psychological Society (APS), noted there are many models of understanding gambling and different reasons why people develop problem gambling. Therefore a one-size-fits all approach to understanding problem gambling is not appropriate.

7.4 For example, the Blaszczynski-Nower integrated model emphasises that there are 'behaviourally conditioned' people who are exposed to gambling early; they tend to have early wins and end up chasing losses. In this model, conditioning and cognitive processes appear to be the most relevant in terms of the cause of problem gambling and how to address it. Professor Rickwood emphasised that most psychologists would take an integrated approach to understanding what determines problem gambling. She noted that:

There are also people who become problem gamblers because they are emotionally vulnerable. They have problems. They have problems with depression, anxiety, poor coping skills and social isolation, and the

1 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 58.

2 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 58.

dissociative state that gambling produces helps with the negative emotional states that such people experience. There are also biologically based, impulsive types of gamblers, who tend to be risk-takers. They have a high need for stimulation and arousal. So these different reasons for problem gambling are things we need to take into account in terms of our approach.³

7.5 Professor Alex Blaszczynski, Director, Gambling Treatment Clinic, University of Sydney, also emphasised that gamblers are not a homogenous group. He explained the complexity of dealing with addiction:

You see the complex interaction between environmental factors, personality and family upbringing—a whole range of factors that contribute to create problem pathological gambling or addictive type behaviours. In respect to gambling, I think we are making a mistake of conceptualising gamblers as a homogenous group of individuals.⁴

7.6 Professor Blaszczynski went on to describe three groups of gamblers—first, a group influenced by advertising, particularly sports advertising and the integration of gambling commentary into sporting events which normalises gambling. Young people often become involved in this activity. People in this group do not suffer psychiatric comorbidities but develop a belief they can win at gambling. They lose too much and start to chase their losses. This group is generally fairly responsive to brief interventions. The second group who gamble engage in addictive behaviours as a means of dissociating or escaping their problems.⁵ Gambling is part of their coping mechanism. The third group have a biological predisposition to a broad range of impulsive and risky behaviours. They may have some degree of ADHD/attention deficit disorder or be from dysfunctional family backgrounds. They may also be engaged in criminal behaviours, drug use and promiscuous behaviour. Professor Blaszczynski emphasised that the important element across all three groups is that the impact of excessive gambling is similar in terms of depression and alcohol abuse.⁶

Triggers for problem gambling are not fully understood

7.7 The committee heard that evidence for what triggers a gambling addiction is still relatively unknown. Anecdotally, life-stressing events can be a factor but there are a variety of reasons for the development of a gambling problem.

7.8 Professor Blaszczynski stated that among a range of triggers for losing control, some people can start to believe that gambling is a way of earning income:

They experience some clusters of good luck in the early stages of gambling, increase their gambling behaviour, start to accumulate debts and

3 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, pp 27–28.

4 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 11.

5 See also Anglicare Tasmania, *Submission 12*, p. 5.

6 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 11.

subsequently try to chase those debts...So there are a variety of reasons why people lose control.⁷

7.9 He added that research has found impulsivity is one of the key factors that contributes to the risk of developing problem gambling. He explained:

Males tend to be at risk for gambling behaviour simply because they tend to be more risk takers. Women tend to gravitate towards the games that are less prone to problems—apart from the gaming machines—bingo, lotteries and so forth. But slot machines, I think, had a peculiarity from the onset when Charles Fey developed the first one in the 1890s. He tapped into an excellent marketing tool of people simply pressing buttons for a reward—equivalent to pigeons taking a reward—which modifies people's behaviours.⁸

7.10 Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, Gambling Treatment Program, St Vincent's Hospital, also confirmed that from her clinical experience of 10 years:

...there is no single factor or group of factors about which you can say, 'Yes, this is causal', or, 'This will lead or predispose a person to gambling'. It is such a mix, such a variety—it can affect anyone.⁹

7.11 Regarding triggers for problem gambling, Ms Kazal also added:

Sometimes we say it is like being at the wrong place at the wrong time. These things may have happened to the person, but they happen to a lot of people who do not then develop gambling problems.¹⁰

Significant life events

7.12 Moderate gamblers can become problem gamblers by increasing the frequency or intensity of gambling or by a change in their situation. The reasons and predictors for escalating or reducing gambling are not well understood.¹¹ Professor Blaszczynski noted that certain life events can also trigger problem gambling behaviours in some individuals:

In my own experience dealing with some particular cases, I have had actual data regarding gambling behaviour—two years of their internet sports betting accounts. I had the good fortune to interview this particular person. Within six months of an emotional life-stressing event that occurred, one could see a rapid escalation of gambling behaviour. Surprisingly, in some

7 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 11.

8 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 12.

9 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 22.

10 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 22.

11 Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 13–14.

individuals the birth of a child triggers excessive gambling behaviour. Again, that is anecdotal. But I guess what I am alluding to is the notion that there are certain life events that do occur that subsequently trigger gambling behaviours. There are anecdotal cases of housewives who suddenly find their husbands are having an affair. They become depressed and turn to gambling as an anger mechanism. We had a case of a person who had Parkinson's disease who became quite depressed and believed her partner would abandon her. She consequently turned to gambling behaviour in an attempt to secure herself financially, but she achieved the opposite result.¹²

7.13 Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, also confirmed that there is no single cause, but that the transition from casual to problem gambling can be due to a life event such as redundancy, divorce and bereavement.¹³ Natural disasters can also lead to rates of problem gambling increasing, as she explained:

To someone unfamiliar with gambling that may seem really odd, but in a way you can sort of see the logic in it. As for people who are under financial duress, if there is no hope of getting the money that they need they might as well risk an amount on the chance that they might get a win.¹⁴

7.14 Dr Mark Zirnsak, Member, Australian Churches Gambling Taskforce, also emphasised that there are various life events that can make people more vulnerable to developing a gambling problem:

That is why we think there is a role for the community, through its governments, to provide protection for those vulnerable people against an industry that might otherwise prey on and profit from those vulnerabilities.¹⁵

7.15 The committee heard that some people gamble to escape their problems. Ms Rhian Jones, Member, Gambling Impact Society NSW, told the committee the story of what triggered her problematic gambling:

Ms Jones: [I started playing socially] In 1998. And within weeks I was heavily addicted. By 1999, I was losing hundreds of thousands of dollars.

Senator XENOPHON: On poker machines?

Ms Jones: Yes.

Senator XENOPHON: What triggered it? Was it an early win? What was it? Can you remember?

12 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 11.

13 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, pp 21–22.

14 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 21.

15 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 11.

Ms Jones: I really do not know. I was socially playing and the next minute I was addicted. It was a place for me to go, to get away from pressures in the home.¹⁶

7.16 Demographic risk factors for problem gambling include: age, (the earlier one starts gambling, the greater the likelihood of developing problems); higher rates of disordered gambling among members of ethnic minorities; lower socioeconomic status; marital status, with risky and problem gamblers more likely to be divorced or separated; and being male.¹⁷

7.17 Dr Katy O'Neill emphasised that the easy access and availability of gaming machines is also a factor as to why people play them.¹⁸ Anglicare Tasmania also pointed out the factors that cause people to lose control at the gaming venue:

Anglicare's research into gambling problems for people on low incomes in Tasmania has found there are a number of factors that cause people to lose control in a gaming venue, including the design of the poker machine, patrons' misunderstanding of how poker machines work, their desperation to get money and the consumption of alcohol.¹⁹

Some forms of gambling are riskier than others

7.18 The Productivity Commission's 2010 report into gambling stated clearly that poker machine gambling is the riskiest form of gambling activity.²⁰

7.19 Mr Tom Cummings told the committee about his personal experience with poker machines and described why he found them so addictive:

In my personal experience, once I had developed my problems—once I was in the throes of gambling on the pokies and not stopping—it was a case where I would lose myself in the game. Once I started playing, everything else would go away. I could stop worrying about the money that I owed, the hours I was losing from work or the fights that I was having with my partner. When I was playing, that was all there was. It was just the screen, the reels and waiting for the wins. If the win came up, it was great. I would take that and just keep playing. If I lost, I would just hit it again. It becomes your world when you are playing a poker machine because it is so constant, so quick and so repetitive. I hesitate to use phrases like 'the zone' or 'a trance', because they have been overused a lot, but I found that I would fall into the game. I would lose myself in it and I could play for hours without

16 Ms Rhian Jones, *Committee Hansard*, 2 May 2012, p. 38.

17 Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 57–72.

18 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 22.

19 Anglicare Tasmania, *Submission 12*, p. 5.

20 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 4.24.

realising it. I reached a point where I would have to set an alarm on my watch to go off after two hours to remind me that I had to get back to work because I had already used twice my lunch break. That was almost a voluntary term for me, but I would often just turn the alarm off and keep playing for another hour or so, then sneak back to work.

Even without the immersive measures that other companies are trying to develop, it is extremely easy to lose yourself in it because it is so constant. You can bet over and over again. I found with the horses, as a parallel, that it is something you have to take part in. You have to make a decision. You go off and choose which horses. If you are really interested, you have a look at the form and work out which horses are running well or not running well. I do not follow the horses. I have been a few times, and it has been a novelty. But I have gone with a budget. I think: 'I'll take \$50. I'm prepared to lose this.' I have lost it and had fun, and I have had no inclination to keep going. It was with the pokies from the very first time. Once I lost my money, I thought, 'No, I'll have to go and win this back,' because there was always the idea that I could. You do not have to do anything; you just push a button. So it is easy. That is the way it feels.²¹

7.20 From his own experience, Mr Cummings stressed to the committee that poker machine players differ from those attracted to other forms of gambling:

I fully believe that poker-machine addiction and problem gambling are two very different things. A problem gambler is someone who is addicted to gambling in general—this is my opinion—whereas a poker-machine addict is addicted to a particular form of gambling, being poker machines. That is why I call myself a former, maybe even current, poker-machine addict. I do not have a problem and have never had a problem with gambling; it was only ever poker machines. I think the majority of calls to health services are to do with poker machines. As far as I know, there is not a lot of transference between poker-machine playing and other forms of gambling. Certainly in my experience they are worlds apart.²²

7.21 Although services are starting to see and treat people with gambling problems from using the internet, the majority of clients still have a problem with poker machines. Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, St Vincent's Hospital, explained:

...we have not necessarily seen such a significant increase in internet gambling considering the much more significant availability of it so we are still seeing that the majority of our clients are actually having problems with poker machine play, rather than with the internet, so there has not been a mass increase in internet gambling.²³

21 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 6.

22 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 7.

23 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 21.

7.22 Dr Sally Gainsbury also reminded the committee of the differences between types of gambling:

Sports gamblers are different from gaming machine players, and now internet gambling is introducing a whole new variable that we are currently looking at to understand how it impacts. It seems that existing problem gamblers gravitate to that form, and this unique mode also creates problems for gamblers who would not otherwise have had problems. The games develop and change. A gaming machine today is not the same as a gaming machine 20 years ago. That is why, as an ongoing research project, we really need to look at the differences in the games. With sport betting, you now have in-play betting, where it is possible to make bets every 30 seconds or every other minute instead of one bet once a week. It is important that different activities appeal to different types of people and cause their own unique problems as well.²⁴

What is pathological gambling?

7.23 Clinicians gave evidence to the committee about the concept of gambling addiction and the pathology underlying it. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) told the committee that gambling is recognised as 'part of the suite of disorders that come under the rubric of addictions'.²⁵ Its submission defined problem gambling as follows:

...a pattern of behaviour that compromises, disrupts or causes damage to health, family, personal or vocational activities; the extreme end of this behaviour can be described as 'pathological gambling'.²⁶

7.24 Professor Alex Blaszczynski described addiction as repeated engagement in a particular behaviour which provides a person with some degree of benefit:

Those benefits may not be clearly observable or understandable from an external point of view. Certainly they are provided with some benefit.²⁷

7.25 Dr Enrico Cementon, Royal Australian and New Zealand College of Psychiatrists Fellow, told the committee that problem gambling should be seen as a mental health issue:

This may be different to other health organisations and even other parts of the medical profession which may not identify problem gambling as a health issue, but it is something that is important for the College of Psychiatrists. Our expertise lies in a couple of areas. One which is particularly important in terms of prevention of problem gambling is that we know a lot about how certain health problems develop, particularly

24 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

25 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 34.

26 Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 2.

27 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 11.

behavioural disturbances. We see gambling as an example of a behavioural problem. Problem gambling often starts during adolescent years. Although the gambling may not be a problem early on, it is something that then continues for a while and given the right circumstances—be it access to gambling or other stresses which may influence the person into increasing their gambling—harms, and problems develop as a result of that. Developmental problems are an area of expertise that we have.²⁸

Reducing the perceived benefits of gambling through treatment

7.26 Treatment of gambling addiction, according to Dr Cementon, should aim to reduce the perceived benefits people receive from gambling:

There is a lot of satisfaction and a lot of self-esteem bolstering...There are all these positive effects which occur as a result of engaging in the behaviour.

One of the first things you address in the treatment of addiction is trying to reduce the positive effect associated with the behaviour and to increase the negative effect, because it is that balance which is one of the core drivers of the person's decision-making and the behaviours they engage in. When the negative effect associated with gambling outweighs the positive effect, the person seeks to do something about it—to change their behaviour in some way. They either seek treatment or do something else. I agree that there is an anomaly: there is so much positive reinforcement which goes along with gambling in our culture that that therapeutic strategy of trying to redress the balance by increasing the negative effect and decreasing the positive effect is very difficult.²⁹

Pathological gambling in the DSM-IV and DSM-V

7.27 The *Diagnostic and Statistical Manual of Mental Disorders*³⁰ (DSM-IV) categorised pathological gambling as a clinical disorder in 1980. In the fifth version of the DSM to be introduced in 2013, it is likely that pathological gambling will be classified as an addiction because of its similarities to substance use disorders and the associated characteristics of tolerance, withdrawal and difficulty controlling urges.³¹

7.28 The current diagnostic criteria in DSM-IV for pathological gambling are as follows:

- is preoccupied with gambling;

28 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 34.

29 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, pp 41–2.

30 The DSM is published by the American Psychiatric Association and covers all mental health disorders for both children and adults.

31 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 27; Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 40.

- needs to gamble with increasing amounts of money in order to achieve the desired excitement;
- has repeated unsuccessful efforts to control, cut back or stop gambling;
- is restless or irritable when attempting cut down or stop gambling;
- gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression);
- after losing money gambling, often returns another day to get even ('chasing' one's losses);
- lies to family members, therapist or others to conceal the extent of involvement with gambling;
- has committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling;
- has jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling;
- relies on others to provide money to relieve a desperate financial situation caused by gambling.³²

7.29 Currently, to be diagnosed with pathological gambling, a person needs to have five or more out of the 10 possible symptoms. The DSM is in the process of being updated with revisions in diagnostic codes typically driven by evolving research that transforms the understanding of a disorder. Under proposed revisions by the DSM-V working group, the diagnosis may be reclassified from an impulse control disorder to a behavioural addiction within a new classification of 'Addiction and Related Disorders'. This category would replace the current 'Substance-Related Disorders' classification. The working group has also proposed to rename 'Pathological Gambling' to 'Disordered Gambling'.³³ The rationale for these changes are explained as follows:

...the growing body of scientific literature, especially research on the brain's reward center, has revealed many commonalities between pathological gambling and substance-use disorders, including cravings and highs in response to the gambling, alcohol or drug; the hereditary nature of all of these disorders; and evidence that the same forms of treatment (e.g., 12-step programs, cognitive behavioral therapy) seem to be effective for both gambling and substance-use disorders.

For example, the DSM-V Work Group cited studies showing a high rate of co-occurring substance use disorders with pathological gambling. One of the most definitive is the analysis of the gambling data in the National Comorbidity Survey Replication (NSC-R), a nationally representative sample of 9,282 English-speaking adults. The authors found that almost all

32 *DSM-IV*, American Psychiatric Association, 2000, p. 674.

33 Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 2.

participants who had pathological gambling during the course of their lifetime also had another lifetime psychiatric disorder (96.3 percent), and 64.3 percent suffered from three or more disorders. Substance-use disorders were significantly elevated among participants with pathological gambling (Kessler, Hwang, LaBrie, Petukhova, et al., 2008).³⁴

7.30 Other changes proposed include eliminating the 'illegal acts' criterion as it does not appear to be a decisive symptom for most people with gambling problems:

Individuals who commit illegal acts as a result of their gambling already reach the threshold of five or more symptoms and, therefore, this symptom does not improve the precision of the diagnostic code for identifying most individuals with pathological gambling.³⁵

7.31 Although the DSM-V working group has not proposed to alter the description of pathological gambling as a 'persistent and recurrent disorder' this has been challenged by several studies which found that:

...while healthy gambling and non-gambling behavior appears to be relatively stable over time, individuals with gambling problems experience considerable movement in and out of more severe and less severe levels of gambling disorders (LaPlante, Nelson, LaBrie, & Shaffer, 2008). Moreover, the authors observed that rates of recovery from pathological gambling, the most severe level of the disorder, appeared higher than anticipated. Consequently, the authors found no evidence to support the assumptions (1) that individuals cannot recover from disordered gambling, (2) that individuals who have more severe gambling problems are less likely to improve than individuals who have less severe gambling problems, and (3) that individuals who have some gambling problems are more likely to get progressively worse than individuals who do not have gambling problems.³⁶

7.32 Professor Debra Rickwood, Professor of Psychology, University of Canberra; and Fellow, Australian Psychological Society, noted the proposal to classify problem gambling as an addiction due to its similarities with substance use disorders. She emphasised that:

...most psychologists would take a broader approach. We see problem gambling in a biopsychosocial context so that problem gambling should be defined on a continuum of varying severity so that it is not viewing it just within a pathologised context, [which] is not a holistic view; there are

34 Information available from: <http://blog.ncrg.org/issues-insights/redefining-pathological-gambling-new-research-highlights> (accessed 17 May 2012).

35 Information available from: <http://blog.ncrg.org/issues-insights/redefining-pathological-gambling-new-research-highlights> (accessed 17 May 2012).

36 Information available from: <http://blog.ncrg.org/issues-insights/redefining-pathological-gambling-new-research-highlights> (accessed 17 May 2012).

biological, psychological and social aspects to problem gambling, and we need to take a holistic perspective.³⁷

7.33 Professor Malcolm Battersby, Head of Department, Human Behaviour and Health Research Unit, Flinders University also spoke on this issue:

There is now irrefutable evidence that problem gambling is a mental illness or mental disorder. It is in the DSM-4, and there are now proposals to have it moved into the addiction section in DSM-5. But that is a secondary issue in the sense that it has all the characteristics of every other mental disorder: distress, dysfunction and disability. You have a recognisable set of symptoms that people can be trained to assess and diagnose. There are a range of disabilities and severities, which means that a whole range of skills need to be put into place to really address this.³⁸

7.34 Professor Battersby's submission argued that *severity* of gambling addiction and not *risk* of gambling addiction should be measured when dealing with pathological gambling:

Because problem gambling has been defined as a mental disorder in the American Psychiatric Association Diagnostic Manual DSM IV-R as pathological gambling, it is treated by gambling therapy clinicians with mental health training in Australia, similarly to anxiety disorders or depression, i.e. there are clinical diagnostic criteria and validated screening tools for anxiety disorders and depression with cut off scores either giving specificity and sensitivity for correctly allocating the diagnosis, or cut offs for severity levels, mild, moderate or severe e.g. the Beck Depression scale. Gambling should be treated similarly with scales which measure severity not risk. Risk implies a much more theoretical and less real situation than severity and underestimates the implications of the problem in terms of its seriousness and consequences for the individual, their family and the community.³⁹

Committee view

7.35 The committee recognises that not everyone who gambles develops a gambling problem. This is the case for poker machines, even though the risks associated with poker machines are higher than for other forms of gambling and they still account for the vast majority of problem gamblers.⁴⁰ Unfortunately there does not seem to be one simple answer as to why some people develop gambling problems and others do not.⁴¹ The triggers for problem gambling are not well understood and no

37 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 27.

38 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 1.

39 Professor Malcolm Battersby, *Submission 8a*, p. 2.

40 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 13.

41 Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 3.

single risk factor or group of risk factors can be pinpointed. Triggers may range from significant life events such as childbirth, bereavement or divorce, experience of natural disasters, to early experiences of 'winning' at gambling. The committee heard that people who develop gambling problems are not a homogenous group. The fact that discussions about the nature of pathological gambling as an addiction are still being conducted in clinical and academic settings indicates to the committee that there is still much to learn about problem gambling and how to treat it.

7.36 As discussed in earlier chapters, there is no 'one size fits all' approach to prevention messages; different messages need to be tailored appropriately to reach different audiences. Similarly, the committee recognises that there can be no 'one size fits all' approach to treatment of problem gambling. In the following three chapters, the committee will examine how pathological or problem gambling is treated, including the range of treatment services available and how these services may be improved. The report will then conclude with a chapter looking at gambling research and data collection, including the evidence base for treatments and methods of evaluation.

Chapter 8

Treatment of problem gambling

Introduction

8.1 This chapter will provide an overview of current treatment methods for problem gambling, with reference to some existing treatment services across Australia which presented evidence to the committee. It will also briefly examine referrals to treatment, the factors for success in treatment and some measures to complement treatment services.

Context

8.2 In earlier chapters, the preventative or public health approach to problem gambling was described. The treatments discussed in this chapter sit on the tertiary part of the spectrum of the public health approach to problem gambling. In examining treatment approaches, the committee notes the comments made by the Australian Churches Gambling Taskforce on the need for a holistic approach to the problem of gambling addiction:

With regard to treatment services, we continue to highlight the value of these services and the importance of a range of counselling and therapeutic approaches being readily available across the country. We also highlight that different people respond to different types of intervention, so we would actively discourage the committee from any suggestions of identifying a preferred or goldplated treatment model. There is no best model. There are a range of approaches which work. We have observed that approaches whereby any service places people of goodwill and a willingness to listen with a person with a gambling problem have quite high success rates. In fact, there is not much difference where there is a genuine relationship between a person trying to help and a person seeking assistance.

The Taskforce is deeply concerned about the preference for treatment and counselling as a preferred option—indeed, the only option suggested by many industry bodies. In the task force's opinion this is a self-serving position. People seeking treatment and counselling are more likely to have already lost large amounts of money, particularly in the poker machine industry. Once they are in crisis, their behaviour in venues, such as expressing distress, anger, crying, kicking machines et cetera is likely to be disturbing to other patrons. Thus, it is in the interest of venues to see these people directed to counselling services where they will not put off other patrons in the venue. A much more holistic approach is needed.¹

1 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 10. See also Mr Tim Falkiner, *Submission 4*.

Committee view

8.3 The committee affirms that the treatments described in the following chapters should not be considered in isolation from other measures to address problem gambling, including population-wide and targeted primary prevention initiatives and improving industry intervention, as recommended earlier in this report.

Models of treatment

8.4 As noted in the Productivity Commission's 2010 report into gambling, it is important to realise that there is no single conceptual theoretical model of gambling that can account for the multiple biological, psychological and ecological influences that contribute to the development of pathological gambling.

8.5 Three treatment models emerge from theoretical models to understand problem gambling:

- The ***medical model*** which sees problem gambling as an addiction or as an impulse-control disorder which needs to be treated as an illness;
- The ***behavioural model*** which interprets gambling as a learned behaviour, motivated and/or reinforced by the personal experience and social context of the gambler. The treatment focus is on 'unlearning' bad habits and learning how to minimise the harm arising from gambling through controlled gambling;
- The ***cognitive model*** which posits that problem gambling behaviours can be explained by irrational beliefs and attitudes about gambling. The gamblers think erroneously that they will win money and recoup losses despite personal experience. Problem gamblers have heightened expectations of winning and illusions of control over the outcome of a game.²

8.6 The main therapeutic approaches used for problem gambling include behavioural therapy,³ cognitive behavioural therapy (CBT), cognitive therapy and exposure therapy. Other approaches include pharmacotherapy⁴ and motivational enhancement therapy (or brief interventions).

8.7 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists (RANZCP), noted that treatment which combines various approaches often results in the best outcomes:

We in psychiatry know very well that usually the best outcomes are obtained by combining or integrating psychological treatments, behavioural

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.28.

3 Behavioural therapy, or behavioural modification, is a psychological technique based on the premise that specific, observable, maladaptive, badly adjusted, or self-destructing behaviours can be modified by learning new, more appropriate behaviours to replace them.

4 Treatment of disease through the administration of drugs.

treatments, with more biological treatments such as medications and pharmacotherapies—so there is huge scope still to come in that area.⁵

8.8 Treatment providers for problem gambling range from counselling services and self-help services like Gamblers Anonymous, to clinical services provided by psychiatrists and psychologists, offering cognitive therapy and other interventions such as pharmacotherapy. Below is a brief overview of the main approaches.

Cognitive behavioural therapy

8.9 Cognitive behavioural therapy (CBT) is a relatively short term, focused approach to the treatment of many types of emotional, behavioural and psychiatric problems. The application of CBT varies according to the problem being addressed, but is essentially a collaborative and individualised program that helps individuals to identify unhelpful thoughts and behaviours and learn or relearn healthier skills and habits. CBT has been practised widely for more than 30 years.⁶

8.10 CBT focuses on identifying triggers to problem gambling, recognising situations where gambling is likely and finding alternative ways and behaviours to deal with those triggers.⁷

8.11 This form of therapy is also the treatment for problem gamblers with the most available evidence to support its efficacy, in Australia and internationally.⁸ While acknowledging the weight of evidence supporting CBT, the University of Sydney Gambling Treatment Clinic told the committee that unpublished data from their Clinic suggests that pure cognitive therapy, described below, may provide the best treatment for problem gamblers.⁹

Cognitive therapy

8.12 Cognitive therapy is a type of psychotherapy. It is one of the therapeutic approaches within the larger group of cognitive behavioural therapies (CBT) and seeks to help the patient overcome difficulties by identifying and changing

5 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 39.

6 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 229–255.

7 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

8 According to the *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, the evidence supports individual or group cognitive behaviour therapy to reduce gambling behaviour, gambling severity and psychological distress in people with gambling problems. See Thomas, S., Merkouris, S., Radermacher, H., Dowling, N., Misso, M., Anderson, C. and Jackson, A., 'Australian guideline for treatment of problem gambling: an abridged outline', *Medical Journal of Australia*, 2011, 195: 1–4.

9 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 5. Mr Tim Falkiner, *Submission 4*, p. 7, also stated his view that CBT 'is good therapy but of itself is not enough to counter addiction'. His view was that 'CBT should be used as a precursor to hypnotic induction...'

dysfunctional thinking, behaviour, and emotional responses. Cognitive therapy concentrates on 'removing erroneous cognitions'.¹⁰

8.13 Mr Christopher Hunt, Psychologist, University of Sydney Gambling Treatment Clinic, explained the principles of cognitive therapy to the committee:

The cognitive therapy that was developed by Fadi Anjoul when he was first working at the gambling clinic several years ago is very much focused on people's beliefs about gambling. It is very much focused on people's understanding of how a poker machine works, how sports betting works or however their particular form of gambling works, understanding what it is about gambling that is exciting them. Usually that comes back to the thought of winning money. Essentially it provides corrective information, working with people to get a more realistic understanding of how their preferred form of gambling works. It is not as simple as just telling people, 'You're not going to make money,' because on some level people know that; it is about being able to work with them about why they are not going to be able to do it. It is a long and involved process and there is a lot of need to develop trust with the client. Essentially, the main thrust of things is identifying their beliefs and looking to see where corrective information might be able to be provided.¹¹

Exposure therapy

8.14 Exposure therapy is based on the theory that problem gambling arises from a psycho-physiological 'urge' to gamble, similar to cravings in substance addiction. Key elements of exposure therapy involve the reduction of the urge to gamble through graded exposure to gambling cues:

Early outcomes suggest that if the urge to gamble can be extinguished through the graded exposure treatment programme, relapse to problematic gambling is less likely... The process of cure is similar to that used with phobias where the client exposes themselves in a graded way with mild anxiety from pictures of the feared object to eventually approaching the real feared object. Staying in the situation for 20-40 minutes results in a reduction of the urge or anxiety. Repeating the same task daily results in eventual extinguishing of the urge to gamble. Many clients report eventually becoming bored by the venue, the machines and the idea of gambling. This approach is considered counterintuitive by some counsellors who concentrate on teaching clients ways of avoiding or thinking about gambling triggers. In these types of therapies, clients use will power which may work for weeks or months but the client reports being continually pre-occupied with the thought of gambling and vulnerable to relapse.¹²

10 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 225–6.

11 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

12 Professor Malcolm Battersby, *Submission 8a*, pp 3–4.

Pharmacotherapy

8.15 Pharmacotherapeutic approaches to problem gambling are relatively new. In some people with pathological gambling problems, changes in the body's biochemistry have been observed. These include changes in the serotonin, norepinephrine, dopamine and opioid systems. Hence, studies have been conducted on pharmacotherapies (drug treatments) which target these physiological systems.¹³ Although some positive effects have been noted from three types of medications (serotonin reuptake inhibitors; mood stabilisers; and opioid antagonists), the results have not been conclusive and further double-blind studies are required.¹⁴ Furthermore, most of the pharmacotherapy research has been conducted without concurrent psychosocial treatment in order to isolate any beneficial effects; however in a real life clinical situation, it is likely that both pharmacotherapy and psychosocial therapy would be provided.¹⁵

Naltrexone

8.16 In November 2011, researchers at Monash University reported that evidence from international studies showed some 'promising indications' for Naltrexone in treating problem gamblers. According to Dr Shane Thomas from the Problem Gambling Research and Treatment Centre:

You have in the body overproduction of endogenous opioids, so in the brain, and what happens is that this leads to reductions in impulse control. Now what Naltrexone does effectively is to block that and to improve the extent of impulse control.

...I think the current evidence is in favour of psychological therapies, you know, we have more and stronger evidence for that. You know, people are often very interested in the use of pharmacological agents for treatment of conditions because they hope it'll be, sort of the golden bullet, you know, that we can take a pill and cure or attend to these problems.¹⁶

8.17 The committee heard from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) that mental health disorders required the availability of a range of treatment methods, both pharmacological and psychological. Professor Dan Lubman stated that there was growing evidence for the role of Naltrexone in the

13 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 137.

14 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 148.

15 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 150.

16 Meredith Griffiths, 'Heroin addiction drug proposed for problem gamblers', *AM*, ABC Radio, 22 November 2011, <http://www.abc.net.au/am/content/2011/s3372620.htm> (accessed 23 July 2012).

treatment of problem gambling; however, more robust trials were needed.¹⁷ He explained:

Naltrexone has been shown to be highly efficacious for the treatment of alcoholism, yet we know in clinical practice that not everyone we give naltrexone to actually responds to it. There are different pathways into alcoholism, different biological circuitry. Certainly, naltrexone, on the evidence provided, has increasing support for its use but there needs to be more work in this area. It should be considered for some people. But...there needs to be more investment on other alternative strategies to manage the condition.¹⁸

8.18 Dr Enrico Cementon, RANZCP Fellow, also noted that other pharmacotherapeutic options apart from Naltrexone should be examined:

Naltrexone unfortunately runs the risk of being a drug which is then applied to a whole lot of addictive disorders, but is perhaps best only for one form of addiction rather than a whole range of them. We need to be looking at other pharmacotherapy options to be used in conjunction with the traditional psychosocial, behavioural or psychological interventions, which have been shown to be effective for gambling. There is huge scope for further knowledge expansion and application to clinical practice.¹⁹

8.19 He envisaged a future in addiction therapy where 'pharmacogenomics' could help to determine the best treatment approaches:

...we believe an important area of the search is that area of medicine which we call pharmacogenomics: the interaction between the drug that you are introducing into the person, with their genetic constitution, and the way that person, with their physiology and neurobiology response, reacts with that drug. Effectively, I see that in 15 or 20 years down the track we will be able to do some sort of genetic analysis on a person and say, 'This person with problem gambling is more likely to respond to naltrexone, or is more likely to respond to treatment with heroin, or more likely to respond to treatment with alcohol.' Who knows? Hopefully, that will be the state of the science for the treatment of addictive disorders, that in the future we will be able to tailor the treatment in a very scientific way.²⁰

Motivational enhancement therapy (brief interventions)

8.20 Motivational enhancement therapy takes the form of brief interventions, usually targeted at people with less severe forms of a disorder. For example, this therapy could take the form of short advice sessions of a few minutes and/or

17 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 36.

18 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 40–41.

19 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 39.

20 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 41.

motivational interviews in conjunction with a workbook.²¹ This form of treatment may be delivered by counsellors in non-clinical settings.

Examples of treatment

8.21 Several treatment providers from across Australia provided submissions to this inquiry and the committee heard valuable evidence at public hearings from a number of these providers. An overview of their services is outlined below.

8.22 The modes of delivery for different forms of treatment include face to face counselling and therapy, telephone interventions and online services (which are becoming increasingly popular—e.g. through the website *Gambling Help Online*). Self-help through grassroots volunteer organisations such as Pokies Anonymous is also undertaken.

St Vincent's Hospital Gambling Treatment Program

8.23 The St Vincent's Hospital Gambling Treatment Program opened in 1999 in Darlinghurst, NSW. The Program is currently staffed by about four full-time equivalent clinical psychologists and has treated almost 2,000 clients. It is funded by the Responsible Gambling Fund, which is administered by the NSW Office of Liquor, Gaming and Racing. As well as problem gamblers, the Program's clients are also family members—partners, parents and adult children of those with gambling problems.²²

8.24 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, described a 'snapshot' of the Program's current client base:

In the last three months, we have seen people with bipolar mood disorder, schizophrenia, personality disorders, severe anxiety disorders, chronic depression, histories of trauma, complicated grief, intellectual disabilities and alcohol use, in addition to their gambling problems. Our treatment is largely cognitive behaviour therapy... Sometimes clients do not need a huge amount of treatment and other times we are seeing them for quite long periods. There is an intense treatment phase and then there is a long follow-up period, because it is a bit of a relapsing disorder.²³

21 Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 257–8. According to the *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, evidence supports motivational interviewing and motivational enhancement therapy to reduce gambling behaviour and gambling severity in people with gambling problems. Motivational interviewing is defined as a 'client-centred, directive counselling style for helping people explore and resolve ambivalence about behaviour change'. See Thomas, S., Merkouris, S., Radermacher, H., Dowling, N., Misso, M., Anderson, C. and Jackson, A., 'Australian guideline for treatment of problem gambling: an abridged outline', *Medical Journal of Australia*, 2011, 195: 1–4.

22 Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 18.

23 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 18.

8.25 The treatment services offered were described to the committee, beginning with a thorough assessment of the client's gambling. Forms of treatment include motivational interviews, psycho-education and teaching behavioural skills such as stimulus control, scheduling alternative/incompatible activities and skills to deal with emotions that perpetuate gambling:

Treatment is active: clients practise skills between sessions and monitor gambling, urges to gamble, triggers, thoughts, emotions, responses etc. Clients are taught to recognise the impact certain styles of thinking have on urges to gamble and how to modify such automatic and well-learned thoughts. This involves traditional cognitive therapy – the challenging of erroneous beliefs about gambling. However, in order for clients to understand their gambling and to adopt a meta-cognitive stance (essentially to think about their thinking) specific psycho-education about the way the mind works in the context of gambling is essential. This includes, for example, education about the strength of intermittent reinforcement, neurological pathways involved, how repetition trains automatic responses to cues and rewards, mental processes such as how we make judgments, various biases e.g. confirmation bias, and the effect arousal has on thinking. Current, relevant research findings from a range of sources are incorporated into this psycho-education e.g. affective neuroscience, behavioural economics, mindfulness.²⁴

8.26 St Vincent's Hospital reported that 70 to 80 per cent of the people they treat through the Gambling Treatment Program are men and most of the men are young:

In their common parlance among themselves they say, 'I had a gambling hangover,' which is the remorse which drives them to treatment and that is a phrase which came from a media campaign.²⁵

8.27 They also reported that the overwhelming majority of clients presented with problem gambling associated with poker machines. However, a rise in sports betting and online gambling problems was becoming apparent (though it was emphasised this was not a 'mass increase').²⁶

8.28 St Vincent's Hospital also told the committee that while 30 to 40 per cent of people drop out of the Gambling Treatment Program, they may make contact again several years later:

Ms McLean: A lot of those people might attend six sessions and then drop out. We hear from them seven years later and they say they have not gambled for the last six years but it has just started again now. Even with the ones that are dropping out, there is evidence that a lot of them are doing well and they have got what they needed out of the treatment. It is just that they go off—

24 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 1.

25 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 19.

26 Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 21.

Dr O'Neill: We keep follow ups. We look at how many days they gambled, how much they gambled and that type of thing.

Ms Kazal: Yes, we have standard ways of measuring outcomes. There are different ways of defining success. We try and address a number of different areas in their lives. The average figure is around 90 per cent.²⁷

8.29 St Vincent's Hospital also provided evidence of positive treatment outcomes to the committee, such as:

- number of days since last gambling episode increased following treatment (from an average of 11.22 days at intake to an average of 69.96 days post-treatment);
- frequency of gambling significantly decreased following treatment (from an average of 0.38 episodes per day pre-treatment to an average of 0.04 episodes per day post-treatment); and
- expenditure on gambling decreased following treatment (from an average per day of \$128.29 per day to an average of \$6.28 per day post-treatment).²⁸

Statewide Gambling Therapy Service

8.30 The Statewide Gambling Therapy Service (SGTS) is located at Flinders Medical Centre, Salisbury, Port Adelaide and across rural areas of South Australia. Clinical staff of the service include a psychiatrist, psychologists, social workers and mental health nurses with postgraduate qualifications in CBT. During 2009–10, 504 individual problem gamblers and 59 significant others used the service.²⁹

8.31 The SGTS was established in 2007, with treatment based on a program developed at Flinders University by Professor Malcolm Battersby (based on his work in the UK on exposure therapy for anxiety disorders). The main treatment model provided at the SGTS is graded exposure therapy in conjunction with cognitive therapy 'to challenge the thought processes of addicted gamblers'.³⁰

8.32 Upon arrival, clients undergo a complete mental health assessment and are provided with a range of treatment and support options including an inpatient program. Additional clinical support is provided to people with comorbid conditions and online support, family and peer support and self-help groups are also available. Collaboration and cross-referral between financial and family counselling services is also provided.³¹

27 Ms Siobhan McLean, Dr Katy O'Neill and Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 25.

28 Answers to Question on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, pp 1–2.

29 'Statewide Gambling Therapy Service', tabled by Professor Malcolm Battersby, 14 May 2012.

30 Professor Malcolm Battersby, *Submission 8a*, p. 3.

31 Professor Malcolm Battersby, *Submission 8a*, p. 4.

8.33 Professor Battersby, Director of the SGTS, described how the service is the only gambling help provider in South Australia that is offered as a 'health service':

The service that we have established in South Australia is unusual in the sense that nearly all the other gambling help services are non-government organisations with people who are called counsellors with a range of skills. We are the only service that is directly under the auspice of a health service. We were regarded initially as a bit of an anomaly, but the advantages of being part of that health service were that we were coming from a scientific evidence base and then translating that into training programs and skills and measuring outcomes. The reason we moved from being the Intensive Gambling Therapy Service from 1996-2007, when we were asked to become the Statewide Gambling Therapy Service, was that we were collecting our outcome measures. We were showing significant improvements in people not just over the short term but also the long term.³²

8.34 One of the strongest features of the SGTS is its commitment to evaluation and measurement of outcomes (see chapter 11 on research and data collection for further details). Professor Battersby explained the advantages of this approach:

The core elements of an outcomes based treatment service are that the service uses outcome measurements which are validated; there is an electronic system which helps to automatically collect that data and feed it back to the clinicians, government and services; and the staff are trained to use those outcome measures. In other words, they are not given as an administrative tool that someone happens to fill in; the staff are trained to actually understand how to use that.

...I think what we have done at Flinders should be a national model. We have asked every single patient or client who comes to our service to sign a consent form for longitudinal data collection. In other words, every patient who comes in has agreed to be followed up over the next three years to provide outcome data.³³

8.35 The SGTS also told the committee that its well trained staff accounted for its low drop-out rate, as clients come away from the first briefing session with a clear plan on what the program involves and what the expectations are. Volunteers who have been through the program and have recovered from problem gambling are used as peer educators and supporters:

We have a lot of letters from clients who have benefited from the service, and what was fascinating about some of them was that they talked about the reception staff and how welcoming, non-critical and non-judgmental they are. We have had two of the three staff for over five years and put a lot of effort into the training of reception staff as well as the clinical staff.

...There are a whole lot of steps that come out of training staff adequately that keep people engaged. We do things like text messaging between

32 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 1.

33 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 2.

appointments, email follow-ups and really active follow-up. We do not wait for people to come back to us; if they drop out or miss an appointment, we very actively follow them up.³⁴

8.36 Associate Professor Peter Harvey, Manager of the SGTS, acknowledged that there were very low rates of presentation to treatment to the SGTS. He said that those who did access treatment were 'skewed toward the older age group':

Younger people, even though they are involved in online gambling and poker machine gambling, do not present at the same rate. This is a concern from the service practice side of things.³⁵

...There are a whole lot of younger people who are not reached through the processes that we use, so we have tried to develop mechanisms on our website and other ways of getting messages out to young people. Predominantly, the people who present are the middle-age group. They are coming through the normal help line connections and phone-in processes rather than being hooked in through the web more effectively.³⁶

University of Sydney Gambling Treatment Clinic

8.37 The University of Sydney Gambling Treatment Clinic was established in 1999 by Associate Professor Michael Walker. In 2010, Professor Alex Blaszczynski became Director of the Clinic. The Clinic offers a free, confidential, face to face counselling service for people with gambling problems as well as family and friends. Services are located across Sydney, including at Darlington, Campbelltown, Narellan, Tahmoor, Parramatta and Lidcombe. It receives funding from the NSW Responsible Gambling Fund.³⁷

8.38 The Clinic has researched a number of different therapies, including cognitive therapy, cognitive behavioural therapy (CBT), solution focused brief therapy, imaginal desensitisation, multimodal therapy and supportive counselling. While noting that CBT has the most evidence supporting its efficacy in Australia, the Clinic states that unpublished data suggest that pure cognitive therapy may be the best treatment option.³⁸

8.39 The submission from the Clinic notes that the cognitive therapy approach, developed by Dr Fadi Anjoul, differs from other approaches:

...by positing that persistence at gambling is motivated by the gambler's misguided understanding of the probabilities of winning. In other words, it assumes that problem gamblers make poorly informed decisions about gambling and are unaware of their own erroneous thinking. There exists some but limited literature from Canada supporting the effectiveness of

34 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 3–4.

35 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2.

36 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 3.

37 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 1.

38 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 5.

related cognitive approaches to treating problem gambling. Our data, gathered at the Gambling Treatment Clinic has clearly indicated that changes in an individual's beliefs and knowledge about gambling are one of the key predictors of reduced gambling behaviour. In fact, preliminary data on CT that was reported in the Productivity Commission's 2010 report on gambling (pp. 7.34) has indicated not simply excellent results at the completion of treatment, but minimal rates of relapse over the longer term. The current research imperative is therefore a more full investigation of the efficacy of pure CT as conducted at the GTC, and a comparison of this treatment to the currently well-supported CBT.³⁹

8.40 Treatment length at the Clinic is eight to 10 sessions, usually starting weekly, then fortnightly and monthly as time goes on. These sessions would normally go over a period of 12 to 14 weeks.⁴⁰

8.41 The committee thanks the University of Sydney Gambling Treatment Clinic for hosting a site visit on 2 May 2012.

Turning Point Alcohol and Drug Centre

8.42 The Turning Point Alcohol and Drug Centre is based in Fitzroy, Victoria and has provided gambling help and treatment services for the last 12 years to over 100,000 people. Its services include four statewide phone helplines (Victoria, Queensland, Tasmania and after-hours in the Northern Territory) as well as *Gambling Help Online*, a national online counselling and support program.⁴¹

8.43 The *Gambling Help Online* program was launched in 2009 by the then Ministerial Council on Gambling. Its primary aims are to:

...attract a new cohort of clients who may not otherwise access face-to-face services and...extend the availability of counselling and support by addressing issues around remoteness, anonymity and after-hours availability.⁴²

8.44 It features self-help information, local information as well as real-time 'synchronous' counselling and 'asynchronous' counselling provided via an email support program.⁴³

8.45 Another feature of Turning Point's service is the *Ready to Change* program which is a four to six week telephone-based intervention program based on CBT. It has been offered to callers of the Victorian Gambler's Helpline since 2008 and has been available more recently in Tasmania and Queensland.⁴⁴

39 University of Sydney Gambling Treatment Clinic, *Submission 10*, pp 5–6.

40 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

41 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 1.

42 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 2.

43 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 2.

44 Turning Point Alcohol and Drug Centre, *Submission 42*, pp 2–3.

8.46 Turning Point also appeared before the committee and elaborated on the clients who accessed its services:

We provide services to anyone affected by problem gambling, including family and friends, professionals, venue workers, students and, of course, the gambler. People contacting our services typically have a range of problems associated with gambling—from being asked to call us by a family member through to looking for strategies around managing their gambling. When someone contacts us they speak to a counsellor immediately. They are often provided with screening for gambling or other harms. [They] may be provided a brief intervention, referrals to other services, information around gambling products and self-exclusion, mail-outs and access to translation services. So we provide a whole range of things to a very diverse range of people who contact us through our helpline and online services.⁴⁵

8.47 Across both the helplines and *Ready to Change* service, Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point, estimated that around 20,000 calls per year were taken, with the helpline mainly attracting middle-aged people, split between males and females, and usually in relation to poker machine problem gambling. In contrast, the online service is popular with young men and about 70 per cent of contacts are made outside of business hours. For those who wish to access face to face counselling, Turning Point has also developed the capacity to chaperone people straight to a face to face agency.⁴⁶

Success of online service provision

8.48 Giving evidence to the committee, Turning Point highlighted the success rate of online services, noting that even clinicians were surprised at the findings that remotely delivered services can be as effective as face to face treatment:

Ms Rodda: We know that online counselling is effective across a range of disorders. There have been one or two studies on gambling—not in Australia but overseas—and there have certainly been studies in terms of treating depression, anxiety and other mental disorders online. One of the indicators of the success of that is that the person is attending for treatment in a way that they can access the treatment—they can get to the appointment or where the treatment is being offered. In terms of self-help there is quite a strong evidence base now for single-session interventions, and we know that they are effective.

Prof. Lubman: One of the most surprising things to clinicians is that delivering interventions over the telephone or even over the internet is just as effective as face-to-face treatment.⁴⁷

8.49 The convenience and ease of access to online services are crucial to its success, according to feedback from clients:

45 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44.

46 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44.

47 Ms Simone Rodda and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 44.

We have also found through our evaluation of the service that the people using it—typically, young men—said it is easy to access, easy to talk and convenient. We developed the four-to six-session semi-structured program specifically to improve access to services for people unable to get to a service. Some of our early clients for that were young mothers who had a couple of kids. I remember one client who had to catch three buses to get to a face-to-face appointment. Clearly that was not going to work very well. So she was able to get help over the telephone.⁴⁸

Success of brief interventions

8.50 Turning Point also emphasised that brief interventions can be very effective. Professor Dan Lubman, Director, Turning Point, explained this using the example of brief interventions in responding to drinking behaviour:

[It] is hard to believe, but there is a huge evidence base in the alcohol area that brief interventions by general practitioners have robust long-term impacts on drinking behaviour. The way to think about that is in a population sense. We are thinking about a population who are at risk or having problems. There is a whole group here who you can intervene with through very simple interventions. As we go across the population there is more of an entrenched group further down. It is just saying that we need a suite of options available for different people.⁴⁹

8.51 When asked about whether people usually want to be helped in the case of a brief intervention, Professor Lubman explained that this was not necessarily the case, but that the moment of intervention provided a brief opportunity for some good to be done:

There is very good evidence from the alcohol literature around brief opportunity interventions looking at people, for an example, who come into emergency departments with an alcohol related injury. If they have come in having had a fight while being intoxicated, there is very good evidence that brief opportunity interventions have good outcomes, because it is an opportunity to intervene. It is an opportunity to say, 'Hang on, you might not think you have a problem with alcohol, but how come you ended up in emergency?' It is using an opportunity to get people to think about where they are at the moment and how the gambling or alcohol might have contributed to their behaviour. Many people when they are confronted with that are prompted to change their behaviour.⁵⁰

8.52 Professor Lubman also observed that having a suite of service options available was crucial to meet the needs of clients:

48 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44. See also Ms Liza Carroll, Department of Families, Housing, Community Services and Indigenous Affairs, *Committee Hansard*, 14 May 2012, p. 55, who noted that some people prefer to access social policy services online.

49 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

50 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

Some people might just want to shop online and not try it on and not speak to anybody. Other people want to have a bit of a conversation. The important thing here is having a system of care where you can step up the level of expertise and input. You might start with just generic self-help online. That might step up to self-help with online counselling options which then might then lead on to telephone options with extended structured interventions over the telephone which then might lead on to face-to-face interaction with telephone support. It is having that way of stepping up, depending on what your need is. It is making sure that there is a suite of options available that tailors to the needs of the consumers.⁵¹

8.53 Turning Point noted that younger men came through online chat and older women used the email option:

That is already informing how we attract and target the groups that are coming to the website. At the moment we are redeveloping the website, so that the chat has a much younger feel and we are expanding the suite of services offered with that so that it is not just a counselling intervention, but it is moderated forum, self-help with tailored self-assessment. There will be a whole range of things to encourage that group to speak to us.⁵²

Committee view

8.54 The committee was pleased to hear that online treatment services can play a role in assisting people with gambling problems. While no silver bullet, the availability of such interventions, delivered flexibly and remotely, can also assist people who are not able or willing to access face to face services. These cost-effective outreach and brief intervention services are supported by the committee.

Non-clinical services

Mission Australia

8.55 Mission Australia provides gambling counselling and support services in the ACT and NSW. These services form part of a broader suite of family, youth and employment services across Australia. In 2011, Mission Australia's 10 gambling counselling services provided support to problem gamblers and their families through both individual and group counselling, including financial counselling.⁵³ In NSW, Mission Australia's gambling counselling services are funded through the Responsible Gambling Fund.⁵⁴

8.56 The committee heard from Ms Christina Sanchez, Team Leader, Mission Australia, about the gambling counselling services provided in the ACT. She told the committee that over the past eight months, Mission Australia has offered face to face, telephone and internet counselling through four gambling counsellors and one

51 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 46.

52 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 48.

53 Mission Australia, *Submission 17*, p. 2.

54 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 1.

financial counsellor. Each counsellor may see two or three clients per day.⁵⁵ She explained further the services on offer:

We have also started a support group for gamblers that runs every Monday night as well as a recently started support group for family and friends of people with gambling issues. So we do not just see the gambler; we see anyone that has been affected by gambling.

We are also in the process of launching a training package for GCOs [Gambling Contact Officers] and gaming managers of clubs here in the Australian Capital Territory to help them better address and approach people who they think may have an issue with gambling at their service, and to advise them on how to deal with and work with family members because they often get quite a few calls from distressed family members. We have also run a gambling officer forum for gambling officers in the Australian Capital Territory and are also developing a training package for the wider community sector around being able to identify and work with gamblers and to make appropriate referrals.⁵⁶

8.57 In the first three quarters of the 2011–12 financial year, the ACT's gambling Support Service through Mission Australia has provided counselling to 188 clients.⁵⁷ Mission Australia said that those who are being treated are usually in their 30s, but that age ranges from 25 to 65. The youngest client is 10 years old as he is experiencing family breakdown issues.⁵⁸

8.58 Ms Sanchez told the committee that Mission Australia's ACT service had been 'very successful':

Certainly the feedback we have been getting from our clients, although limited in the eight months, is that it is hard, it is not easy, but they are making small inroads. For example, we had a gentleman who spoke at our advertising launch today who has now not gambled for six months. His goal was to not gamble anymore, and he has been quite successful.⁵⁹

BetSafe

8.59 BetSafe is a responsible gambling program which provides services for a group of ACT and NSW gaming machine venues (43 registered clubs). It is solely funded by gaming industry members and offers a 24 hour problem gambling counselling service.⁶⁰

55 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

56 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 34.

57 Correspondence from the ACT Gambling and Racing Commission, received 12 June 2012, p. 1.

58 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 39.

59 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

60 BetSafe, *Submission 32*, p. 2.

8.60 Its submission described the flexible face to face counselling available to patrons of BetSafe member clubs:

BetSafe has no limit on the number of gambling counselling sessions, unlike a number of government funded services that only provided a fixed number of counselling sessions.

A rigid program of counselling that offers only a standardised program with a fixed number of counselling sessions lacks the flexibility to assist the wide range of people with gambling problems. The needs of individuals who seek counselling vary tremendously. In some cases a person may only attend a single counselling session to receive some benefit. In other cases, a series of intensive counselling may need to be followed by periodic maintenance counselling over a period of months. Some individuals value a long-term counselling relationship where they know they can call their counsellor at any time if they are suddenly struck with a strong urge to gamble. Some BetSafe counselling clients have maintained their abstinence from gambling by being able to call at such times, even over a period of years.⁶¹

8.61 At a public hearing, BetSafe again advocated a flexible approach to gambling counselling:

...we are certainly not of a one-size-fits-all model. While we do use cognitive behavioural therapy strategies in our counselling, our counsellors take a more overall approach in dealing with underlying issues, helping them to address those issues and therefore, as a result—and this generally happens—removing the need to gamble.⁶²

...We see them after hours, we see them Saturdays, we see them after work up until about nine or 10 o'clock. We talk to them on the phone at two and three in the morning. With gamblers, you have generally got one opportunity. That opportunity may only last 10 minutes to half an hour. If we do not grab them then, we have lost them, perhaps for four years. That is the vital thing: we have got to grab them straightaway. That is why it is important for us that we are potentially in contact with them genuinely 24 hours a day. I know a lot of people say they are, but a lot of it is voice messages and things like that. With us there is a contact 24 hours a day.⁶³

Self-help

8.62 Self-help groups are usually based on a 12-step program, similar to Alcoholics Anonymous, and involve people who have experienced gambling addiction coming together to talk with others who have had similar problems.

61 BetSafe, *Submission 32*, p. 9.

62 Mr Daniel Symond, *Committee Hansard*, 2 May 2012, p. 32.

63 Mr Paul Symond, *Committee Hansard*, 2 May 2012, p. 33.

Pokies Anonymous

8.63 Pokies Anonymous is a self-help group based in Adelaide. Ms Julia Karpathakis, Manager, gave evidence at a public hearing about her own struggle with poker machine addiction and also described how the organisation works:

None of us are counsellors. We all share our stories. We are all in the same boat. It is a 12-step program like Alcoholics Anonymous. I love it. I think it is amazing, and there are heaps of people coming. People come and go. People are struggling. At the moment I am really concerned about a couple of younger people who cannot seem to shift, but they are still attending meetings and still using the phone, so I have a great belief that they will stop playing the pokies. But it is about stopping. It is not about 'responsible' gambling, playing moderately or anything. It is about abstaining, not going into venues, and attending meetings and using the phone—those sorts of things.⁶⁴

8.64 Funding of \$20,000 per year comes from the South Australian Office of Problem Gambling.⁶⁵ Ms Karpathakis told the committee that around 40 people a week attended meetings and she outlined the help that she was able to offer them:

I refer people to the state-wide gambling therapy services. I refer them to get barred. I refer them to many places. I am always referring people; I offer it. With the barring and the Independent Gambling Authority, I used to physically go with the people to take them to the place and work with them because it is a bit scary. I was told that it would be best if I left the clients to ring up and make the appointments because sometimes it gets a bit messy. I have not had anyone wanting to go there, so it is really important that I instigate that and create that opportunity to get them there, and then it will happen. One person nearly has a year up and he got barred. If I was not there, they would have offered him four or five places to get barred from—and this guy has a major problem. So I suggested we bar in from the postcode from his work all the way to his home, and that has been a real point of success for him.⁶⁶

8.65 The committee heard that people involved in self-help groups like Pokies Anonymous provided each other with mutual support and created of a sense of community for people who may have been marginalised from society by gambling addiction:

...we create social events. There will be a midyear dinner soon and we have Christmas dinner. It is all about including people and creating community. A lot of people are lonely and a lot of people are hungry. Someone might come along and eat the biscuits and drink the coffee, but we have got someone who comes along as support and eats a lot of the food but they

64 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

65 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 15.

66 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 16.

have not got a problem. I do not mind. If he did not come, maybe that woman would not come along. So I do not mind.⁶⁷

8.66 The Australian Churches Gambling Taskforce also recognised the importance of mentoring from individuals who have experienced gambling problems themselves:

There are programs like Gabriela Byrne, where people who have a gambling problem, or have had one, are connected with alternative recreation and social events. But they are mentored in that. They are not just given a pamphlet saying 'Here are activities in your area.' They will have buddies and mentors to help them connect back.⁶⁸

8.67 However, the University of Sydney Gambling Treatment Clinic raised concerns about self-help groups, arguing that more rigorous clinical approaches offered more effective treatment for gambling problems:

Sometimes people become very passionate about the treatment option that they are offered. Recovering gamblers will say things like, 'This worked for me', but what we see from the research evidence is that these things that work for some people and not for others are not necessarily the most effective overall; whereas our initial findings are suggesting that the cognitive therapy that we offer is effective for most people who present with gambling problems. That is why we argue for this more removed approach to the evaluation of treatment. A lot of these treatment providers do not provide a formal evaluation of their treatment. They do not actually follow up with their clients after they finish treatment and they do not provide formal questionnaires about how much their clients are gambling at the end of treatment. That is why we argue against this eclectic 'do what you want'—do what the gambler wants—sort of approach to problem gambling which seems to be quite widespread, especially in New South Wales at the moment.⁶⁹

Committee view

8.68 The committee notes the range of clinical and non-clinical treatment and support services available for people with gambling problems. It is pleasing to hear about the variety of interventions available and the committee thanks treatment providers for sharing information about their services during this inquiry. In particular, the growing popularity of online intervention services is of interest to the committee.

67 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 17.

68 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 25.

69 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59. See also Media Release, 'New treatment guidelines for problem gamblers', *Medical Journal of Australia*, 22 November 2011, which stated that according to the new *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre, 'a large analysis of the research has revealed that interventions delivered by clinicians and psychologists were more effective than self-help interventions like workbooks and online therapies for reducing gambling severity and behaviour in people with gambling problems.'

8.69 The committee also commends the grassroots work of Pokies Anonymous in its efforts to assist people with gambling problems. It is heartened to hear evidence about assistance with referrals to professional help as well as the mutual support, care and encouragement which is generously provided by committed individuals. The committee notes that self-help groups can act as complementary and easily accessible support services.⁷⁰ The following chapters will explore barriers to accessing treatment services and ways to improve existing services.

Referrals to treatment

8.70 The committee heard about various ways in which people were referred to treatment services.

8.71 At St Vincent's Hospital over the last two years, 25 per cent of clients were referred through the gambling helpline; 20 per cent were referred through family; 11 per cent were referred through another counsellor or psychologist; 11 per cent came through St Vincent's own website and another 10 per cent came from various websites.⁷¹

8.72 St Luke's Anglicare described how people are referred to counselling services through the central helpline in Victoria:

Ms Galvin: That central line is like an intake process. They would do an assessment of what the person might need at that time. Perhaps they need that quick and fast intervention; that might be all they need. Maybe they are not far enough along to want to seek one-on-one. But they are offered all of the different options that are available. Then, if they choose to seek to have one-on-one counselling with our Gambler's Help workers, then that referral would be sent to us, and they would make an appointment and start on the process for treatment.

Senator DI NATALE: But how does that happen? The reason I am asking this question is I am aware that when somebody decides they have a problem there is often only a narrow window of time in which you can act. If you miss the boat—and it might just be a day later—they might not be inclined to follow up on what they did the day before. So is there a delay? The assessment is done initially through the initial phone call. How long does it take before contact is made with a local service provider?

Ms Galvin: I understand that varies. It depends when people call. If they call after-hours—we do not provide an after-hours service locally. I understand there sometimes is a delay and sometimes it is very fast.⁷²

70 For example, see Gomes, K. & Pascual-Leone, A., 'Primed for Change: Facilitating Factors in Problem Gambling Treatment', *Journal of Gambling Studies*, (2009) 25: 1–17, which notes that addiction literature generally shows some benefit to being involved in 12-step programs, especially when accompanied by professional treatment.

71 Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 19.

72 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 53.

8.73 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) described why someone might be referred by a general practitioner to a psychiatrist for treatment:

It is usually associated with an anxiety disorder, a depressive disorder or, less commonly, a psychotic disorder. If the patient presented just with a gambling problem and no other co-morbidity then I think the GP would think about a gambling help line or a gambling-specific service in terms of where to refer the patient.⁷³

8.74 Turning Point Alcohol and Drug Centre described how people are referred to services when they call a helpline. When a caller agrees to a treatment referral, the helpline will offer an immediate transfer to the relevant agency (during regular business hours). When a referral cannot be successfully transferred or made out of business hours, callers are given the option of a referral follow-up call:

Where there is capacity for follow-up at the agency level, basic contact/referral details are collected by the Helpline and forwarded by email to a designated contact person at the agency. Standard informed consent processes have been developed accordingly. The agency is then responsible for the follow-up process. Callers who decline to have their call transferred are also offered the referral follow-up option (i.e., email referral).⁷⁴

8.75 Turning Point also told the committee that it was exploring the possibility of self-referral services via smartphone technology, potentially in consultation with industry:

Ms Rodda: One of the things we are exploring in the future is self-help provided via iPhone, and we now have our site optimised for smart phones. I could see a place in the future where we could have a monitor of consumption that is linked into your betting account so that your help seeking and your betting are in the same device, and you are able to monitor and then click to call or click to speak to someone about what is happening. In the next few years you could imagine the benefits of doing gambling online could easily be joined in with your help seeking or your monitoring, or some other way of describing having a third party check up on what you are doing.

Senator DI NATALE: Is that something that industry could potentially do? There is no reason that they could not have that as part of one of the products that they offer—with referrals, of course. Am I missing something, any obvious obstacles that would prevent them from promoting sort of package? Apart from the obvious one; that it might cost some business.

73 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 37.

74 Answers to Questions on Notice, Turning Point Alcohol and Drug Centre, received 28 May 2012, p. 3.

Prof. Lubman: I think it sounds a very responsible way to promote your business and to look after the welfare of your patrons.⁷⁵

8.76 The following chapter will consider ways to improve the rate and effectiveness of referrals.

Success of treatment

8.77 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, commented on what factors contributed to the success of treatments:

In relation to counselling or formal support, the evidence from the research is that there is no one-size-fits-all and the best results and all the meta-analyses come to this conclusion: the best results come from professionals using a range of skills and theoretical orientations, and from drawing from their own experience to address the situations, needs and the people who are in front of them. So it is drawing from their own professional, theoretical toolkit and experience. The one constant thing for good outcomes that stands out is the relationship between the counsellor or the support professional and the person being supported—the relationship is very important and that comes out quite consistently too.⁷⁶

How can success be measured?

8.78 The committee heard it was sometimes difficult to pinpoint how to define effectiveness and success in terms of treatment. For example, Professor Dan Lubman asserted that there is a real difference between looking for help and getting treatment and this often depended on a person's readiness for change:

For example, to use an analogy, if I go shopping I might be interested in buying something nice and go to various shops where helpful salespeople offer me a range of things I might like to buy. I might not want to buy something, I am not ready to purchase that product, but I am interested to know what is available in the marketplace and to see whether it meets my needs. That is very different to when I have made a commitment that I know what I want and I seek that. Many people that we see are help seeking; this is the first time they want to explore what is on offer, what is available to deal with the issues they have and whether it is in line with what they are interested in receiving. That is very different to saying: 'I recognise I have a problem. I know I want to go to for treatment. I know what sort of treatment I want.' Often we and clinicians mix up the two. Often people come through our door looking to browse round the shop and we are immediately selling them the most expensive product in the shop and trying to convince them to come back on numerous occasions for more. I think there is a lot of confusion there and we need to understand that addiction—and problem gambling is in that vein—is a chronic relapsing condition. There is a whole series of phases of people working out what

75 Ms Simone Rodda and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 47–8.

76 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 22.

they want and where they want to be and where they are in that cycle in terms of accepting and being ready to receive help.⁷⁷

8.79 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, commented that some people are more self-motivated than others and this has an influence on how they fare in treatment:

In terms of people who come really motivated to quit, there are those whose partner has said, 'You have to go.' As an overall thing, people who come off their own bat may be more motivated. But certainly with the other ones, you have them in your office so there is a chance to do something. Quite a lot of them will have come in saying, 'I don't have a problem but my wife thinks I do.' You question them and after a while, they think, 'Yes, I'll stick around for a bit.'⁷⁸

8.80 The RANZCP also noted a 'myth' about treatment progressing in a straightforward and linear manner was something that needed to be addressed:

...we know for addictions in general that they are chronic relapsing conditions and people have multiple entries into treatment across the journey before they fully engage and have a full course of treatment. For example, there is recent data showing in the area of substance addiction that it is an average of one-quarter of a century from when people first start experimenting with alcohol and drugs to having full recovery. About 25 years is the average amount of time that people suffer with alcohol and drug dependence. In that time they are going to need a whole range of different responses that engage them in treatment and work with them. So this notion that we can get people in treatment and provide them with treatment and somehow they are going to be cured and will be able to play the pokies the following week and gamble responsibly is a myth that we really need to address.⁷⁹

8.81 Another treatment provider, Dr Natalie Glinka, told the committee of her pessimism about the ultimate success of counselling and treatment services to address some people's pathological gambling addictions:

People's desire to counsel pathological gamblers is noble; however, as a treatment, it is far from useful. I think it is a waste of money. The reason is that I have been in the doctoring business for 50-odd years and in psychiatry for 25 years. I have had three people who are inveterate gamblers in my care for longer than a decade, and I could see how their pathological gambling was related to denied painful feelings which they solved by a behaviour: going down to the casino. The excitement of getting a win was making them feel better, not so much the money. They would lose and they would chase the money. They would lie and borrow and lose their jobs and lose their relationships. So that is it in a nutshell. My counselling, whether it was insight oriented psychotherapy, supportive

77 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 45.

78 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 24.

79 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 38.

psychotherapy or cognitive behaviour therapy, was successful perhaps insofar as they realised that they had to stop gambling and maybe limit themselves. One went as far as to tell all the venues to chuck him out if he got to a certain level of loss. Well, that worked for a while and fell apart, naturally.⁸⁰

8.82 Chapter 11 which focuses on research and data collection will look more closely at the evidence base for treatment, how services are evaluated and how outcome measurements could be improved.

Role of family members in treatment

8.83 The role of family members in treatment is an important factor in treatment services. A 2008 study found that 'significant others' may act as social supports for gamblers who are in treatment and that 'involving loved ones in gambling treatment models may positively affect gambler treatment outcomes'.⁸¹

8.84 St Vincent's Hospital noted that 20 per cent of its Program's clients are referred through friends and family.⁸²

8.85 The Gambling Impact Society NSW tabled for the committee its self-help guide for families, noting that such resources are few and far between.⁸³ The support of family for people going through gambling treatment is crucial, yet support for families members themselves can be scarce:

As a family member myself, as a partner of someone who has had a gambling problem, it took me probably seven years to be able to find appropriate support and about another two years to find support that would actually work with us as a family as opposed to just focusing on the person with the gambling problem. Counsellors need training to work collectively with families, and with couples in particular; that is an important skill that is missing in the treatment sector. But bear in mind that we only reach about 10 per cent of people who are going to come in for treatment. You cannot have people, 90 per cent of them, struggling out there with nothing. And families are a key part of that and they need to be much better resourced and resourced through other community welfare points of contact, as indeed the community is generally.⁸⁴

8.86 The Statewide Gambling Therapy Service reported that having a 'significant other' involved in treatment was associated with better outcomes for problem gamblers:

80 Dr Natalie Glinka, *Committee Hansard*, 14 May 2012, p. 8.

81 Ingle, P.J. et al, 'Significant Others and Gambling Treatment Outcomes', *Journal of Gambling Studies* (24), 2008, pp 381–2.

82 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 6.

83 Gambling Impact Society NSW, tabled document, 2 May 2012.

84 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 42. See also Gambling Impact Society, NSW, *Submission 30*, p. 11.

...including increased retention in treatment and improved likelihood of successful treatment outcomes (for example, see Ingle, Marotta, McMillan & Wisdom, 2008). Nearly half of the non-gamblers to whom SGTS provided treatment during 2008-09 were the partner of a gambler being treated by [SGTS].⁸⁵

Measures to complement treatment

8.87 The committee also heard about measures to complement treatment for people with gambling problems. Financial counselling, as well as other measures to help limit access to money by financial institutions, are important adjuncts to treatment services.

Financial counselling

8.88 The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) told the committee about the Commonwealth Government's commitment to provide 50 new financial counsellors to work with problem gamblers and their families.⁸⁶ It is expected that this service will provide a gateway to more specific gambling help and therapies:

The financial counsellors will be focused on problem gambling; the majority of their work will be working with people who are affected by problem gambling. However, they will not go into the therapeutic type of gambling counselling that some of the other gambling counsellors do. It will really be with a financial counselling aspect. It will be looking at their household budgets, their credit and debt situations, whether they are in danger of bankruptcy—those kinds of issues—and dealing with their financial issues. There will really be a gateway to some of those other more intensive gambling counselling services and we will be referring off to those.⁸⁷

Assistance from financial institutions

8.89 Financial institutions can play a part in restricting access to money to assist people who are dealing with a gambling problem. St Vincent's Hospital Gambling Treatment Program discussed this with the committee at a public hearing:

Ms Kazal: We talk about access to money and access to venues as being the two most important factors in reducing the harm and reducing problem gambling. Banks could play a bigger role.

Senator CROSSIN: Are you talking about limiting the amount of money that you can take out of an ATM at a gambling venue?

Ms Kazal: Exactly. Things like daily withdrawal limits on ATM cards, linked accounts and just reducing the ease of access, and the ease of access to cash advances on credit cards.

85 Statewide Gambling Therapy Service, *Submission 8*, Attachment 1, p. 15.

86 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 20*, p. 3.

87 Ms Robyn Oswald, *Committee Hansard*, 14 May 2012, p. 56.

Dr O'Neill: I think it would be easy to pick who is a problem gambler because they go backwards and forwards to the ATM. That is quite common. They intend to spend only this amount and then they get enthralled by the machine and they go back. It would be quite easy for them to tell and maybe check that.

Ms McLean: The kinds of things that could be quite helpful if when a client approaches a bank and wants to reduce their withdrawal limit to a certain amount per day or set up an account that they cannot get access to until the following day with a transfer. There seems to be a lot of variation. Some banks will do it, some clients will speak to three different people at the same bank and two people will say, 'No' and one will say, 'Yes.' Having some regulations around that are needed.⁸⁸

8.90 The Australian Bankers' Association (ABA) provided a submission to the inquiry outlining existing measures and policies that its member institutions have in place to assist problem gamblers and their families. These include:

- financial literacy programs;
- financial hardship policies;
- referral to independent financial counsellors when appropriate;
- adjustment of maximum withdrawal limits on deposit accounts;
- cancellation of mortgage redraw facilities;
- restricting access to credit card cash withdrawals in gambling venues; and
- adjusting maximum credit limits on credit cards.⁸⁹

8.91 Regarding automatic teller machines (ATMs), the ABA's submission added:

As a result of banks removing ATMs from gambling venues over many years, currently there are very few bank owned ATMs installed in these venues. This market is primarily serviced by non-bank ATM deployers. Where some banks have maintained ATMs in gambling venues, the primary purpose is to provide a cash withdrawal facility in areas where there are few other convenient or safe options or are involved in long-term contracts.⁹⁰

8.92 A study commissioned by FaHCSIA titled 'Problem gamblers and the role of the financial sector' noted that problem gambling was linked to homelessness and severe financial difficulty. The report identified various options around how the financial sector could help to prevent problem gamblers from gambling with money withdrawn from home loans or joint bank accounts. It proposed a number of new measures to supplement the existing policies mentioned above, also noting that further

88 Ms Abigail Kazal, Dr Katy O'Neill and Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 24.

89 Australian Bankers' Association, *Submission 58*, p. 2.

90 Australian Bankers' Association, *Submission 58*, p. 1.

research would be required (for example, on privacy concerns and the practicalities of monitoring transactions) if such policies were to be implemented. These included:

- the introduction of more comprehensive credit reporting;
- financial institutions not offering line of credit and credit card products if the person applying seems to have trouble managing their finances (it would be preferable to offer loans on a principal plus interest basis);
- detailed case studies of problem gamblers and their experiences to be included on the Australian Securities and Investments Commission's website on financial tips and safety checks;
- improving financial literacy within the community;
- ensuring no one can access accounts in the name of their spouse or partner without the approval of the account holder;
- offering password protection to account holders;
- allowing customers to set daily cash withdrawal limits;
- setting limits on interest rates for other financial providers such as payday lenders; and
- removing automatic teller machines from gambling venues.⁹¹

Committee view

8.93 The committee welcomes the government's commitment to provide new financial counselling services for problem gamblers and their families. It also notes the government's commitment to introduce a \$250 daily withdrawal limit from automatic teller machines in gaming venues (although this excludes casinos) by 1 February 2013.⁹² Measures such as these, which supplement treatment services for problem gambling, will assist people addressing gambling problems to manage their individual financial situation in a supportive environment.

8.94 Banks can also assist with targeted measures as outlined above. The committee notes the work commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs in consultation with the financial sector on further measures that could be applied by the sector to address problem gambling. It welcomes further research to progress these measures, such as how to manage privacy concerns in relation to an individual's personal financial information and other practicalities around monitoring transactions.

91 South Australian Centre for Economic Studies, 'Problem gamblers and the role of the financial sector', Occasional Paper No. 33, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, 2010, pp v–viii.

92 The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, 'Tackling Problem Gambling in Australia', media release, 21 January 2012, <http://www.jennymacklin.fahcsia.gov.au/node/1701> (accessed 23 July 2012).

8.95 In the committee's view, any practical supplementary measures that can be put in place by the financial sector to assist individuals and their families affected by gambling addictions are to be encouraged.

Recommendation 6

8.96 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs, in consultation with the financial sector, commission further research on ways to progress practical measures that could be put in place by the financial sector to assist people with gambling problems and their families.

Chapter 9

Barriers to treatment

Introduction

9.1 This chapter will consider the low rate of help-seeking among problem gamblers and examine the barriers to treatment, including stigma and shame about having a gambling problem and a lack of awareness of available services. It will briefly introduce the issue of comorbidity which is discussed further in chapter 10. This chapter will also cover additional challenges in accessing treatment faced by people from Indigenous and culturally and linguistically diverse backgrounds.

Rate of help-seeking

9.2 The Productivity Commission's (PC) 2010 report on gambling found that relatively few people with gambling problems actually seek help.¹ Based on available client data, the PC concluded that the help-seeking rate was between 8 and 17 per cent (excluding clients seeking help for someone else's gambling problem). Internationally, the rates for help-seeking are believed to be similar (6 to 15 per cent).²

9.3 To improve the low rate of help-seeking, the PC recommended:

- stronger formal linkages between gambling counselling services and other community and health services, including referral pathways and screening tests, underpinned by dedicated funding;
- the promotion of self-help and brief treatment options as cost-effective ways of achieving self-recovery; and
- greater emphasis on campaigns that make the community aware of problem gambling behaviours to encourage earlier help-seeking by individuals or interventions by family and friends.³

9.4 During this inquiry, the committee heard these points re-emphasised by those working in the gambling treatment sector. Both this chapter and the next explore potential improvements to treatment services to address issues around individual access and awareness as well as systemic challenges.

When do people seek help?

9.5 Of those who do seek help for problem gambling behaviour, most only voluntarily seek help when they have reached a significant crisis point in their lives.

1 See also Australasian Gaming Council, *Submission 33*, p. 27; Centre for Gambling Education and Research, 'Gamblers at risk and their help-seeking behaviour', September 2011, report prepared for Gambling Research Australia.

2 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.3.

3 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.27.

These may be severe financial difficulties, emotional crises, employment problems or relationship and family breakdowns.⁴

9.6 Dr Sally Gainsbury told the committee about a three-year study on help-seeking behaviour, indicating that people who have a gambling addiction may be well aware of the existence of help and treatment services but will only seek help once personal circumstances become dire:

What we found looking at non-problem gamblers, moderate risk and problem gamblers recruited from help lines, from venues and from the general population was a common factor where people typically do not seek help for gambling problems until they reach a significant crisis point. They may recognise they have problems and they may try to implement various self-help strategies including barring themselves from venues or by things like leaving their credit cards at home or trying to put limits on themselves. But generally it comes to some sort of emotional, financial or relationship crisis, potentially even somebody putting to them the ultimatum of seek help or I will leave you. Unfortunately, that is generally the prompt people wait for until they do seek help. It does seem there really is a crisis point. It is not necessarily that they are unaware of the help seeking strategies.⁵

9.7 Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point Alcohol and Drug Centre, confirmed that sometimes a 'catastrophic event' might also trigger someone to seek help, such as the discovery of gambling by a partner or resorting to embezzling from the workplace.⁶

9.8 For others who do access treatment, the pathway to gambling help is sought only after receiving help from other services, such as health or financial counselling services. For example, Miss Shonica Guy told the committee:

It was not until some lady said to me, 'I think you might have a gambling problem,' that I thought: 'Do I? I don't know if it's a problem.' She offered to come with me to UnitingCare Wesley to get some financial counselling. I wanted to do that. She said there were gambling counselling services there. I was not really too keen on that. I do not think I was at the stage where I wanted to stop, but I went along for a few sessions just to keep her quiet. She told me about Pokies Anonymous as well, and three years later I made that phone call. Three years later after that, I made the phone call. I was ready and I made up my mind. I made that phone call and I went to the first

4 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 11. See also Evans, L. & Delfabbro, P., 'Motivators for Change and Barriers to Help-Seeking in Australian Problem Gamblers', *Journal of Gambling Studies*, Vol. 21, No. 2, Summer 2005, pp 133–55, which found that help-seeking is predominantly crisis-driven. See also Suurvali, H., Hodgins, D., Cunningham, J., 'Motivators for Resolving or Seeking Help for Gambling Problems: A Review of the Empirical Literature', *Journal of Gambling Studies*, (2010) 26: 1–33; and Carroll, A., Davidson, T., Marsh, D. and Rodgers, B., 'Help-seeking and Uptake of Services Amongst People with Gambling Problems in the ACT', Australian National University, report prepared for the ACT Gambling and Racing Commission, 31 October 2011.

5 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

6 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 47.

meeting and I was never going to play again: I never played again, I never put a dollar in.⁷

9.9 The time gap—sometimes of many years—between the development of a gambling problem and the decision to seek help is an area that needs further attention. The St Vincent's Hospital Gambling Treatment Program emphasised this point:

Almost 60% of our clients have had a problem with gambling for over 5 years prior to seeking treatment from our service and 32% have had a problem for over 10 years. Some of these clients have had treatment in the past but this certainly indicates that there is a proportion of individuals who do not experience natural recovery and that earlier engagement with treatment could be therapeutically beneficial.

Reducing this gap between problem development and treatment access is another key focus in improving the effectiveness of treatment and reducing the ongoing harm from gambling. By the time individuals engage with our service, they are often faced with enduring consequences from their gambling even if they do successfully stop gambling. Young men often have a sense of hopelessness when they realise that they are facing 10 years of debt repayments and this can significantly impact their motivation to stop.⁸

9.10 Once people are in treatment, they often wish they had sought help earlier. At a public hearing, St Vincent's Hospital was asked by the committee whether those who sought treatment were ever put off by their initial experience being too overwhelming. However, Ms Siobhan McLean, Clinical Psychologist, St Vincent's Hospital, confirmed that the opposite was usually the case:

...when they come in and then they say, 'Gee, if I knew it was like this I would have turned up five years ago.' So there is definitely not just a gap between when they have the problem and when they seek treatment but also a lack of awareness of what treatment entails. Often they get concerned that we are going to delve into their past and make them lie back on a couch and various things like that, and they are often quite surprised to find out that while it is analysis it is more about their current situation, when they are going, the triggers, the urges and those kinds of things.⁹

9.11 As discussed in the following section, one of the main reasons for delaying treatment is the intense feeling of stigma and shame surrounding problem gambling and perceived societal attitudes.

Stigma and shame

9.12 As discussed earlier in the report, witnesses and submitters to the inquiry overwhelmingly confirmed that the primary barrier to seeking help and treatment for

7 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 18.

8 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 6.

9 Ms Siobhan McLean, *Committee Hansard*, 2 May 2012, p. 20.

problem gambling was the social stigma associated with admitting to this addiction. In chapter four, the committee noted that current 'responsible gambling' messages, with emphasis on personal responsibility, may contribute to feelings of stigma and shame for those unable to control their gambling. This then influences the low numbers of people seeking help. Negative stereotypes about problem gamblers also entrench societal attitudes which make admitting to a problem even more difficult. Social marketing campaigns which have a clear anti-stigma focus (i.e. positive messages which provide information from people who themselves have experienced gambling addiction, sought help and recovered) are required to address these ingrained attitudes.

9.13 Mr David Pigott, National Manager, Government Relations, Mission Australia, commented that those who seek help are often 'typical family people':

...but when they get into a spiral of gambling addiction they often are trying to hide it from their families, their spouse or their workplace. There is obviously a stigma attached because, once you get to the point where you have a major financial problem, that is when the issue starts spiralling. So I think there is a general stigma about the extent. You are on this spiral. If you are a smoker, you can probably only smoke a certain number of packets of cigarettes per week. So I think it is just the extent of the problem. Once you get to the situation where you are in dire financial straits where it is impacting on your job, potentially your family and even your accommodation, it is almost too late then. Obviously we come in and work at that level, but it is the stigma.¹⁰

9.14 The St Vincent's Hospital Gambling Treatment Program also told the committee that many people who should be seeking treatment are not doing so: 'treatment is a last resort in these people's minds...They are acutely embarrassed'.¹¹ Dr Katy O'Neill explained that people with gambling problems feel 'stupid' and that this is reinforced by society's view that 'gambling is a tax on the stupid'.¹²

9.15 Mr Tom Cummings, a former poker machine addict, told the committee that there was a perceived stigma associated with help-seeking for gambling problems:

...so people try to do these things quietly or anonymously. If they want to seek help, they want to make sure nobody knows about it, because, at the end of the day, they do not want to be known to have had a gambling problem. It is a social disgrace.¹³

9.16 The University of Sydney Gambling Treatment Clinic confirmed that many of their clients feel stigma and do not want to admit to a gambling problem even when seeking treatment:

They do not want to admit that they have lost a lot of money and they do not want to admit that their financial problems or the other problems are the

10 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 2.

11 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 18.

12 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, pp 18–19.

13 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 6.

result of gambling. We get a lot of people coming in who, on the face of it, will say that they are coming for treatment for depression or for relationship issues when, after a session or two, it is quite clear that gambling is the central issue, but they like [to] couch what they are coming in for in terms other than problem gambling.¹⁴

9.17 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) compared the cultural stigma surrounding seeking help for alcohol addiction with the shame around seeking gambling treatments. Professor Dan Lubman, RANZCP Fellow, described the 'cultural normalisation of intoxication across Australia' and the idea that having an alcohol problem was seen as a personal failing:

Many of the young people that we see in treatment say to us, 'We know we struggle with our alcohol problems but we cannot go out on a Saturday night without getting intoxicated because otherwise we are ostracised from our social group.' So we have a huge issue here with normalisation and certainly the messages that are promoted around alcohol and gambling are of individual responsibility, that is up to you and that basically if you have problems with alcohol or gambling then essentially there is something flawed in you as a person. I think that creates huge stigma.¹⁵

9.18 The committee made recommendations in relation to strategies to address stigma in the context of improved prevention measures at the end of chapter four.

Lack of awareness

9.19 Another barrier to treatment is a lack of awareness about what services are available. St Luke's Anglicare told the committee that when people in Victoria call the central helpline number, often they are unaware that local help is available:

That might be because they were not ready to seek help, but the workers say to me that they think it is because there is a low level of awareness about the availability of the service beyond the helpline and that is potentially problematic.¹⁶

9.20 St Luke's Anglicare also advocated for greater promotion of local services.¹⁷

9.21 Although lack of awareness may be a factor in delays in help-seeking, it may be the case that people with gambling problems do have an awareness of what is available but feel uninformed about what to expect at these services, which leads to caution and procrastination.¹⁸ Dr Sally Gainsbury explained:

14 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 60.

15 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 38.

16 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

17 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

18 See for example Rockloff, M. & Schofield, G., 'Factor Analysis of Barriers to Treatment for Problem Gambling', *Journal of Gambling Studies*, Vol. 20, No. 2, Summer 2004, pp 121–6. This study of general population attitudes in Central Queensland towards problem gambling treatment found that 'persons with greater gambling difficulties were more concerned with the availability, effectiveness and cost of treatment'.

Although there are generally low levels of awareness, problem gamblers seem to be more aware of services than other groups of gamblers so there is some level of awareness although that does need to be increased. Particularly there is a lack of understanding of what it means to seek help. Some people really think that it is being put in a room and not given very many options. There is a lack of understanding and that needs to be worked on but it is a crisis point that people wait for before they reach for external help.¹⁹

Comorbidity

9.22 A complicating factor for people with gambling problems that can affect help-seeking is the high rate of comorbidity²⁰ including depression, anxiety, substance use disorders and nicotine dependence. Dr Katy O'Neill, Clinical Psychologist, Gambling Treatment Program, St Vincent's Hospital, told the committee:

The people who come for treatment for gambling problems often have other problems as well. I thought a snapshot of our current clients might be helpful. In the last three months, we have seen people with bipolar mood disorder, schizophrenia, personality disorders, severe anxiety disorders, chronic depression, histories of trauma, complicated grief, intellectual disabilities and alcohol use, in addition to their gambling problems.²¹

9.23 Comorbidity is discussed in greater detail in the following chapter in the context of ways to better design treatment services to cater for people with comorbid conditions.

Ways to increase help-seeking

9.24 As discussed in chapter four, the committee heard several ideas about how preventative messages around problem gambling can be pitched to break down stigma through positive messages, including about the success of treatment, particularly using the voices of those who have sought help themselves.

Reducing stigma

9.25 As discussed in the previous chapter, the online counselling services offered by Turning Point Alcohol and Drug Centre afford anonymity and encourage help-seeking earlier:

19 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 12.

20 The co-occurrence of two or more disorders. See Gambling Treatment Program, St Vincent's Hospital, Darlinghurst, *Submission 3* pp 1–2; University of Sydney, Gambling Treatment Clinic, *Submission 10*, p. 8; Clubs Australia, *Submission 29*, p. 9; Responsible Gambling Advocacy Centre, *Submission 35*, p. 3; Turning Point Alcohol and Drug Centre, *Submission 42*, p. 9; Dr Natalie Glinka, *Committee Hansard*, 14 May 2012, p. 8; Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2; Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 21, pp 85–115; The Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 5.

21 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 18.

Ms Rodda: With the online counselling we notice that they are speaking to us earlier. They are speaking to us about concerns that the problems are getting worse, which is what you want people to be doing.

Prof. Lubman: One of the things that is really potent around the online counselling is the feedback that we get from consumers that, because there is no one there and they cannot even hear your voice, there is no one there to see you cry. It is a much more immediate way of getting help without feeling really overwhelmed and stigmatised.²²

How services are presented

9.26 St Luke's Anglicare noted that because of the social shame associated with seeking help for gambling addiction, services needed to be offered with discretion and sensitivity:

Our service, Gambler's Help, is collocated along with other services in the same building, and there is not a great big sign saying 'Gambler's Help here'. So anybody walking in off the street could be going into, for example, our financial counselling service as well or any of the other community services that we offer. I would agree that it is stigmatised, so you need to be careful.²³

9.27 Turning Point also commented that in offering its *Gambling Help Online* service, they were very careful not to use the words 'problem' and 'gambling' in the same sentence. This was a conscious decision to try to remove some of the stigma.²⁴

Positive messages about treatment success

9.28 The need for the development of more positive messages as part of information and social marketing campaigns about gambling has been raised in chapter four. The committee heard evidence that help-seeking rates could be improved by changing people's perceptions about whether treatment would be worthwhile. The Australian Psychological Society pointed out that a significant barrier to people accessing treatment was the belief that 'help does not help'.²⁵

9.29 Professor Malcolm Battersby, Director, Statewide Gambling Therapy Service, observed that the way messages about treatment are presented may be a factor in encouraging contact with help services. He gave the committee the following example of how marketing angles could be an important factor in targeting suitable messages about the availability of treatment:

We have recently been conducting a randomised controlled trial. We advertise in the media around that as being for a research project. I remember this guy said: 'I've been seeing your pamphlets and this gambling help number in the venues for a couple of years, and every time I see that I

22 Ms Simone Rodda and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 47.

23 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 52.

24 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, p. 44.

25 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 29.

think, "Oh, I need to get help," but I just keep putting it off. But when I saw you had a research project, I thought: 'That's okay. I can do that.'" So it is like the message was a bit different and he felt like he could do it because it was part of research. He then was saying how he had enormously benefited from being part of the research and he wished he had come earlier.²⁶

9.30 Professor Battersby also emphasised the need to run effective social marketing campaigns showing the testimony of people who have successfully received help for gambling problems, using examples of people from all ages and backgrounds who would say:

'I've had this problem; you too can get help.' We have done that with smoking and with all sorts of other areas, and I do not think government has put enough money into social marketing and promotion of gambling help.

Another reason some people have said to us for why they did not seek help was that they did not think they could get better. There was not much they could do about it. They tried various things and just were not aware that there were actually successful treatments for it—and not just successful treatments but treatments that were not 'weird', meaning to be locked up in some sort of asylum or other myths about mental illness treatment in general.²⁷

9.31 The University of Sydney Gambling Treatment Clinic also confirmed that 'information based approaches' in the media have increased the number of people presenting for treatment:

Through the media office at the uni, we give stories to the media that are based on facts about the findings we are having—that treatment is likely to be successful or that we are running new treatment options. We find that that tends to result in a greater number of people coming through the door than do the scare based campaigns that are typically run to highlight the harms caused by problem gambling. Essentially, we find that giving people hope that treatment is likely to be effective if it is done properly is helpful in getting people through the door.²⁸

9.32 The committee notes that demystifying gambling by promoting positive media messages about the success of gambling treatment, as well as showing that problem gamblers come from a range of backgrounds and situations is crucial to breaking down stigma.

Encouraging discussion of gambling

9.33 Ms Christina Sanchez, Team Leader, Mission Australia, commented that gambling addiction was still a 'taboo' subject and that the way to address this was to encourage open discussion in society, especially among families. She illustrated this

26 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

27 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 3.

28 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 60.

with reference to campaigns about binge drinking, which have raised community awareness about the problem.²⁹

Examples of advertising campaigns to increase help-seeking

9.34 Chapter five has already discussed how social marketing campaigns need to be better targeted to different groups, particularly those 'at-risk' to increase awareness of risky gambling behaviours as well as how to access help and treatment services.

9.35 The Productivity Commission acknowledged that awareness campaigns appeared to have 'at least temporary effects' in attracting people to counselling and treatment services. This has been shown by campaigns in NSW, Tasmania and Victoria.³⁰

9.36 St Vincent's Hospital noted there had been a 'big spike' in referrals to gambling treatment after a television advertising campaign on the G-line in 2002.³¹ There were second round advertisements during 2003–04 but these were not screened on television.³²

9.37 The Responsible Gambling Advocacy Centre (RGAC) noted that Victoria's Know the Odds campaign in 2011 was very successful in encouraging people towards help services. However, Ms Penny Wilson, CEO of RGAC, posed a question about whether such campaigns led to ongoing behaviour change or just initial help-seeking or information-gathering.³³

9.38 Turning Point Alcohol and Drug Centre's submission noted that calls to the Victorian Gambler's Helpline had risen to a high of 11,000 during 2010–11. This was attributed to large spikes in call volumes following television and online advertising campaigns.³⁴

9.39 The University of Sydney Gambling Treatment Clinic ascribed a dramatic rise in clients seeking treatment to the Clinic's own media releases to local and metropolitan print media:

These releases, written by our staff, have focused on a range of issues relating to gambling, from the escalation of sports betting to trials of new treatments at the clinic. When the press release referred to new and evidence-based treatments on offer at our service, our referral rates increased dramatically. These new callers typically reported high levels of dissatisfaction with their previous treatments and various services and had intentionally avoided treatment for many years. Our impression is therefore,

29 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 36.

30 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

31 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 19.

32 Answers to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 6.

33 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 28.

34 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 3.

that public awareness can be raised by providing newsworthy releases to media outlets on the latest research on gambling, innovations in industry and research on gambling treatments, rather than simply highlighting the harms associated with excessive gambling.³⁵

Committee view

9.40 The committee acknowledges the immense feelings of shame and stigma that people with a gambling addiction can feel. It is understandable that so few people seek help and treatment when the overwhelming message from the wider society is that admitting to a gambling problem denotes personal failure and a lack of individual responsibility. As noted earlier in this report, the current emphasis on messages to 'gamble responsibly' may unintentionally contribute to this. The committee agrees with treatment service providers who emphasised the need to disseminate positive messages about the success of treatment services, including using the testimony of people from all backgrounds who have successfully sought help for gambling problems.

9.41 Strategies to develop campaigns built on these positive messages have already been discussed in chapters four and five. The committee notes that these campaigns should be designed not only to raise community awareness about problem gambling and to break down negative stereotypes, but also to encourage people who are dealing with gambling problems to seek help and treatment services and to seek them out earlier.

Treatment services for Indigenous and culturally and linguistically diverse groups

9.42 As well as broader barriers discussed above (social stigma, lack of awareness and comorbidity), culturally and linguistically diverse (CALD) groups can also face more entrenched challenges in accessing treatment.

9.43 The Australian Churches Gambling Taskforce argued that greater focus needs to be placed on specific population groups, including remote Indigenous and some Asian communities.³⁶ The Taskforce called for more national funding to undertake developmental work to provide targeted support for these groups.³⁷ Preventative messages and other resources designed to assist at-risk groups such as CALD and Indigenous populations have been discussed in chapter five.

9.44 Several of the gambling treatment services which appeared before the committee also have in place specialist treatments and outreach methods for people who come from CALD backgrounds. For example, the Statewide Gambling Therapy Service (SGTS) described its services for CALD groups. Ten years ago, one or two Indigenous people per year would attend the SGTS but now it is 35 people per year:

35 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 3.

36 Australian Churches Gambling Taskforce, *Submission 50*, p. 7.

37 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 15.

We have also worked with the Vietnamese, Chinese and other CALD communities in South Australia to increase that collaboration. We have translated our program into Vietnamese and recently launched the Vietnamese New Year celebrations here in Adelaide with a new series of booklets and resources that we use to work with people in the Vietnamese community with gambling problems....[T]he master of mental health science program here [at Flinders] is training Vietnamese-speaking therapists to go back and work in the community under supervision from our more senior therapists. So the amount of CALD and Aboriginal community activity was low a few years ago, but we have certainly increased that and it looks to be growing even more now.³⁸

9.45 Tabled documents provided by the SGTS provide overviews of manuals and programs used for Vietnamese and Indigenous communities.³⁹ Professor Malcolm Battersby, Director, SGTS, noted that funding has been provided to appoint a project officer to work on cultural diversity:

Part of her role—and I can say it is Sue Bertossa—was to develop the relationships, do a whole lot of collaboration, develop manuals and also at the same time provide some therapy. She focused her Aboriginal work up in Ceduna and has been so successful she won a South Australian award for mental health in Indigenous communities. But she has also been working very closely with the Vietnamese community. What is really interesting about all of this is that there was a kind of statement around that non-English-speaking sophisticated communities will not be able to use cognitive behaviour therapy or this fancy university based sort of therapy. So the challenge was: can you transfer the same cognitive behaviour skills into non-English-speaking and other communities? Sue has shown that she can do that quite successfully in both those communities. Her skill is in community development as well as therapy, and there was such a successful process that they actually got the launch of the Vietnamese manuals and therapies as the second item on the Vietnamese New Year celebrations.

Going back to the question about recruitment of people into the service, and shame, I understand there was quite a lot of resistance initially to the Vietnamese leaders having a shameful thing being publicly displayed, but they actually did a lot of work behind the scenes and got that to be publicly presented to the community.⁴⁰

9.46 Mission Australia also described to the committee how its counselling services cater for CALD groups with the help of interpreters:

A person will make a phone call and say that they have an issue with gambling. If the counsellor identifies that the person might have a problem with English they will ask whether the person wants an interpreter present. If the person says yes they will be asked if they would like one to come in

38 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 5.

39 Tabled documents from Professor Malcolm Battersby, 14 May 2012.

40 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 5.

and be with them or whether they would like it to be done over the phone. Sometimes that will alter when the person comes in and finds that over the phone is not satisfactory—it has to be on speaker phone, so it is a bit more cumbersome. We generally prefer the interpreter to come in and definitely so for financial appointments: when you are looking at credit card and other statements it is very hard to describe things over the phone. We will book that in, the person will come in and have the interpreter sit in and interpret for the session. If the person wants another session we may book the interpreter again; it is up to the person. If the person says, 'No, I am quite happy to do this on my own,' that is quite fine too.⁴¹

9.47 The University of Sydney Gambling Treatment Clinic also provided information about CALD groups. In 2011, four per cent of all new clients at Darlington were from an Indigenous background. These clients presented with a range of particular needs:

They have a higher incidence of drug and alcohol dependence, poverty, homelessness, illiteracy, domestic violence and trauma. They also have a higher incidence of problem gambling than the rest of the population. For this reason, dealing with problem gambling in the community presents with some unique problems. Although they are aware that problem gambling is an issue, the community itself sees this problem as being one of many, and certainly not one which should be taking centre stage.

Ashley Gordon (probably the most experienced aboriginal problem gambling counsellor in Australia) said himself that he faces an uphill battle putting problem gambling on the agenda for aboriginal elders and workers in the community.⁴²

9.48 The Clinic also identified a number of cultural barriers to access to services, which include:

...mistrust of non-aboriginal service providers; the physically imposing nature of our facilities; the ethnicity of our counsellors; the expectation of timely attendance at appointments; the structured and Socratic nature of counselling conversations - to name a few. If we were going to provide effective counselling we would need to spend a great deal of time in the community, building friendships and relationships of trust that have nothing to do with the provision of counselling and would need to provide this assistance in an informal, unstructured manner in the community and not on campus. For us, this just isn't practical or possible.⁴³

9.49 The St Vincent's Hospital Gambling Treatment Program told the committee that since 2002, 0.7 per cent of clients have identified themselves as Indigenous Australians; 2.4 per cent Greek; 2 per cent Italian; 1.8 per cent Lebanese and 1.3 per

41 Ms Christina Sanchez, *Committee Hansard*, 14 May 2012, p. 38.

42 Answer to Questions on Notice, University of Sydney Gambling Treatment Clinic, received 23 May 2012.

43 Answer to Questions on Notice, University of Sydney Gambling Treatment Clinic, received 23 May 2012.

cent Chinese. The Program has access to a hospital interpreter service but will generally refer people to the Multicultural Problem Gambling Service if language is a difficulty.⁴⁴

9.50 The Turning Point Alcohol and Drug Service provided information showing that 17 per cent of callers to the Victorian Gambler's Helpline come from countries other than Australia, including Vietnam, China and India. For *Gambling Help Online* services, the CALD groups using the real time chat and email programs were mostly from Chinese, New Zealander and Indian backgrounds.⁴⁵

9.51 Interestingly, the Statewide Gambling Therapy Service noted particular success with the form of treatment known as motivational interviewing for Indigenous clients:

Fourteen Indigenous clients received modified treatment; changes to treatment were based on the advice of Indigenous workers, representatives and clients, collected via interviews, daily journal of community consultations and case-note review. It was found that the adoption of Motivational Interviewing (MI) was helpful in engaging Indigenous clients in treatment, with most clients recognising exposure based treatment as an important part of their therapy.⁴⁶

9.52 The Department of Families, Housing, Community Services and Indigenous Affairs has also commissioned work on the development of culturally appropriate problem gambling services for Indigenous Australians, noting that some key principles for service development are:

- viewing problem gambling as less of a 'social issue' and more of a public health issue, thus placing more emphasis on primary prevention;
- supporting existing problem gambling help services to build stronger links with the local Indigenous community;
- adopting a more community development-type approach when working with Indigenous communities;
- helping to develop the capacity to tackle the issue at a 'grassroots' level; and
- placing a greater focus on workforce development in the future.⁴⁷

44 Answer to Questions on Notice, St Vincent's Hospital Gambling Treatment Program, received 23 May 2012, p. 7.

45 Answer to Questions on Notice, Turning Point Alcohol and Drug Centre, received 28 May 2012, pp 1–2.

46 Flinders University, *Submission 8*, Attachment 1, p. 43.

47 Cultural & Indigenous Research Centre Australia, 'Development of culturally appropriate problem gambling services for Indigenous communities', Occasional Paper No. 40, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, 2011, p. vi.

Committee comment

9.53 The committee recognises that stigma and shame, lack of awareness of services and comorbid conditions all present barriers to help-seeking to the general population. People from culturally and linguistically diverse (CALD) backgrounds and Indigenous Australians, contend not only with those barriers but may face additional difficulties in accessing treatment such as language and cultural issues. The committee notes the work being done by treatment services to provide effective and tailored support for people from CALD communities. It recognises the range of services available such as counselling with the help of interpreters and engagement of cultural diversity officers to liaise with communities and community leaders to help disseminate positive messages about help and treatment. The committee acknowledges the specialist work and efforts of treatment providers to facilitate access to effective treatment services for CALD and Indigenous clients.

Chapter 10

Improving treatment services and systems

Introduction

10.1 This chapter will discuss ways to improve treatment services for problem gambling. First, it will look at a range of possible improvements to the current system from the perspective of those working in the sector, in particular the concept of integrated treatment services to deal with the complications of treating people with comorbid conditions. The chapter will then look at the need to integrate awareness of gambling addiction across the wider health profession to ensure better referral pathways. Finally, the chapter will cover qualifications and training, particularly in the context of clinical versus non-clinical services.

How can we improve treatment systems?

10.2 The committee heard about ways to improve the current treatment system including:

- lifting the rate of help-seeking;
- having a good mix of services to address all stages of gambling addiction, including online services;
- establishing better linkages between gambling treatment and other help services; and
- offering an integrated service designed to treat 'the whole person', particularly those who suffer from comorbid conditions.

10.3 These features are all discussed in further detail below.

10.4 Professor Dan Lubman, Director, Turning Point Alcohol and Drug Centre, succinctly described to the committee the challenges facing the sector:

...how we engage a very stigmatised population into treatment, how we think in a much more sophisticated way around systems and pathways of care, and how we assertively reach out to people and to professionals in terms of increasing the reach of service provision for gambling across the country.¹

Lifting the rate of help-seeking

10.5 The previous chapter explored the challenges of increasing the rate of help-seeking from the current low rate of 8 to 17 per cent. While acknowledging that a 100 per cent response rate would be unattainable, the Turning Point Alcohol and Drug Centre suggested that a rate of about 35 per cent would initially be a reasonable target:

1 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 44.

Senator XENOPHON: You are never going to have a perfect system but 10 per cent of problem gamblers getting help is quite imperfect. In terms of a strategy of advertising, social media—the sorts of things you are talking about—what do you think a benchmark or a target should be for the next two or three years if there were a concerted effort? What would be a good percentage of people in terms of other public health work that you have done to actually get through the door to get that help?

Prof. Lubman: If we benchmark ourselves against other mental disorders, for example, what we see in the area of anxiety and depression is a figure of around 35 per cent. So 35 per cent of people with a diagnosed anxiety depression seek health support.

Senator XENOPHON: So we should be aiming for that?

Prof. Lubman: I think we should be aiming for that. As I spoke about before, I think that is about a cultural change. That is not just about presenting services; it is about a cultural change about the role of gambling in society. It is a broader discussion and a community engagement about the harms it causes. It is a recognition that it is a real disorder that needs treatment and it is about hearing visible voices of people who have gambled who have recovered and who have good stories to tell about success stories about how recovery is possible.²

A good service mix

10.6 The Statewide Gambling Therapy Service (SGTS) advocated for a 'service mix' that catered for people at all stages of gambling addiction, from moderate to severe. Professor Malcolm Battersby, Director, SGTS, described the core elements of this 'step care'³ model:

You can have a range from brief intervention right through to the severe end, which is an inpatient program which I know you are aware we run at Flinders. The service mix should include people with that range of skills, but even brief interventions, which should now be around cognitive behaviour therapy, need to have properly trained staff. The brief interventions can include the internet. I think one of the big missing resources that we are not using in Australia is peers—people who have recovered from gambling problems. We can use them as part of the treatment mix as well.⁴

Online services an important part of the mix

10.7 As covered in chapter eight, online interventions and counselling have been shown to be relatively effective forms of help. According to the Turning Point Alcohol and Drug Centre, the surprising success of this mode of treatment provides an

2 Senator Nick Xenophon and Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 49.

3 A 'step care' model was also explained by Professor Battersby in *Submission 8a*, p. 5 as a program 'from low intensity to high intensity with adjunct social prescribing for social isolation and signposting to community services e.g. unemployment, marital, financial counselling.'

4 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 1–2.

'opportunity to think about how we reconfigure services to be much more aligned to people's needs':

We see huge traffic coming through and the challenge for us is how to cope with this. The way that we have been funded traditionally is to be in the old mindset of taking a call and referring on to face-to-face because face-to-face is better. What we now know from other areas of the health system is that telephone and online can be just as effective. Rather than just being a triage point, we need to start thinking about how we can deliver interventions and do assertive outreach using telephone and online means to engage a much broader proportion of the population in treatment.⁵

10.8 'Assertive outreach' is another potential improvement to online and telephone services, with Professor Lubman suggesting that greater 'two-way traffic' could be incorporated into Turning Point's service mix. Noting that currently, a person may send a couple of chat messages through an online forum when they are distressed, he stated:

Most of the time, most of our services are one-way traffic—they just come to us—whereas I think services should be set up to be two-way. If somebody rings us up we should have the facility to ring them or send them a text a couple of weeks later just to check up, saying: 'You rang our service and we wondered how you're doing. We wondered if you need any more help. We wondered if you're feeling on top of your gambling.' Being able to think in that much more assertive way, to reach out to the community rather than waiting for the community to come to us, would be a really helpful way of engaging more people in treatment.⁶

10.9 He described studies from other fields of mental health when people who had been treated in emergency departments for self-harm were followed up with weekly postcards:

The people who received the postcard, even though it was automated and just had support messages, showed significantly better outcomes over the follow-up period. Even though they knew that the postcards were automated they actually felt that there was somebody out there looking after them and thinking about them. We certainly know for this population they often feel very alone and isolated. So I think there is a lot of work we could do in terms of assertive outreach, either directly over the phone or online with either both automated and follow-up calls. I think assertive outreach is the way to go in terms of reaching out and keeping hold of people and encouraging them to seek treatment and support.⁷

10.10 Ms Simone Rodda, Coordinator, Gambling Treatment Programs, Turning Point, discussed future improvements to the existing online services, including having 'moderated forums' to engage more visitors to the website in conversation. With over

5 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 45.

6 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 47.

7 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, pp 48–49.

100,000 visits to the website, but only 2,000 to 3,000 people taking up the interactive counselling option, moderated forums could engage more people earlier, before they reach a crisis point.⁸

Better linkages between services

10.11 The need for better linkages between gambling treatment services and other health services was raised in evidence to the committee.

10.12 For example, Associate Professor Peter Harvey, Manager, Statewide Gambling Therapy Service (SGTS), stated that services in South Australia tend to be set up in 'independent organisations that do not have a very effective nexus'.⁹ Better coordination of services, such as gambling treatment, family counselling, financial counselling and social support is required. Mission Australia told the committee that it aimed for a holistic service for its gambling help clients:

...we drill down to see what the underlying issues are for the client and where we can help. So, if a housing issue comes up, an alcohol issue comes up or even an unemployment issue comes up, because of our service suites, we can link them into either our services or other services that are in the area. We do not just focus on the one issue with our clients. We always look at the bigger picture.¹⁰

Example of service collaboration

10.13 A example of improvements to service collaboration involving gambling treatment services was provided to the committee by Associate Professor Peter Harvey, Manager, SGTS. He described a pilot program underway between Anglicare and Flinders University which aims to map out 'a process of cross-referral and self-management support for people in relapse prevention'. He noted that collaboration, not competition, between services was the key:

...the way the different services were set up tends to have them more in competition with each other for clients and activity rather than organised in a way that they can cross-refer, exchange data and work together to support the same client. So there are a number of pilot programs underway and we are hoping to build on that, basically using...our self-management initiative, which is based on a chronic disease self-management program, led by peer educators who have been through the treatment process themselves. We are offering that as a self-management forum so that a range of agencies can send clients at various stages of treatment along to those groups. Those sorts of mechanisms seem to be working; certainly there is more activity between us and other agencies than there was four or five years ago.¹¹

8 Ms Simone Rodda, *Committee Hansard*, 3 May 2012, pp 45–46.

9 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2.

10 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 5.

11 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 4.

10.14 Having funding bodies support a collaborative approach between services has been the key to change at a systemic level:

I think what changed significantly in South Australia a few years ago was the way agencies were funded and the central agency that was providing the funding through the Office for Problem Gambling, which made a statement to the providers. It said, 'We are now happy for a client to exist in two or three programs and be counted in that way,' whereas prior to that clients virtually belonged to a service and there was competition across the agencies for that space. So, at more of a systematic level, having the funding bodies support that kind of collaboration is positive as well.¹²

10.15 Professor Malcolm Battersby, Director, SGTS, made some practical suggestions around how collaboration between services could be encouraged; for example, with financial rewards for cooperation and referrals. He also proposed an electronic referral system which would also assist with outcome measurement and data collection:

Another strategy would be to have a common outcome measurement system across the agencies such as if everyone were collecting the same data—or at least a minimum data set—and that was facilitated electronically. In other words, it could be an electronic referral system. There are examples of that in community and health sectors in South Australia investing a huge amount of money in a new electronic system. That is potentially another advantage of being in the health system rather than another system. Everyone in the health system is trying to move towards electronic data collection and sharing of communications, so that would definitely assist people in being able to transfer and, at a click, find out the people you should be referring to.¹³

Dealing with comorbidity

10.16 The term comorbidity refers to the co-occurrence of two or more disorders.¹⁴ In the field of pathological gambling, comorbidity may refer to someone with a gambling addiction also having a substance abuse or alcohol disorder and/or a mental illness such as depression or anxiety.

10.17 Throughout the inquiry, the committee heard that people who are treated for gambling problems often present with a comorbid condition. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that people with mental illness were particularly vulnerable to the harms occurring from gambling.¹⁵ Professor Dan Lubman, RANZCP Fellow, told the committee about a recent meta-analysis

12 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 4.

13 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, pp 4–5.

14 See Nancy M. Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, p. 85. For more see: <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono71-toc~mono71-11~mono71-11-2>.

15 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 34.

which showed that around one-third of problem gamblers have an anxiety or depressive disorder, about half have a substance use disorder and about 60 per cent are nicotine-dependent.¹⁶

10.18 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital Gambling Treatment Program, described how people with anxiety may be drawn towards gambling, thereby developing a comorbid condition:

If you did not work with gamblers you would logically think that, if you were anxious, gambling would be the last thing you should do; it is only going to make things worse. But it does perform that sort of mental escape.¹⁷

10.19 She also explained how easy it was in the current service system for people with comorbid conditions to fall through the cracks:

I used to work in drug and alcohol, and there used to be this thing called bump-and-turf: a new psychotic person would turn up and there would be a bit of argy-bargy between, 'Is he one of yours?' as in, 'Is it the first episode of schizophrenia?' or, 'Is he one of yours?' as in, 'Has he taken too many amphetamines?' It is a people-fall-in-between-the-cracks problem when they first present. Another problem is that some people think the way to deal with co-morbidity is to say, 'Yes, about your depression—go and see that person.' But a person is just one person in their life, and it has to be treated in context because they are gambling due to the fact that they are depressed or they obviously get more depressed after they have lost. But we have seen people who have said themselves that the depression caused the gambling, and a GP has made the assumption that if we keep treating the depression then the gambling will logically fade away. We have seen people on doses of antidepressants that would cheer up anyone if it was in the water supply or something, and, while that may have been true at the start of gambling, now there are separate maintaining factors. That is a crucial part that clinical psychologists can tease apart.¹⁸

10.20 For a service like the University of Sydney Gambling Treatment Clinic which offers cognitive therapy, it was acknowledged that people with some comorbid conditions may find this form of treatment less effective:

...there are always going to be people, whether it is with depression or anxiety or whatever you are working with, for whom psychological treatments are not going to be effective—in particular, people with a traumatic brain injury or people with a comorbid mental illness such as

16 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 36. See also de Castella, A., Bolding, P., Lee, A., Cosic, S. and Kulkarni, J., 'Problem Gambling in People Presenting to a Public Mental Health Service', Office of Gaming and Racing, Department of Justice, Melbourne, Victoria, October 2011, which noted the prevalence of problem gambling in the study cohort (893 people) was more than four times that reported in the general community.

17 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 20.

18 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, pp 20–21.

schizophrenia or severe bi-polar disorder. For people in these sorts of categories, treatment is going to be less effective.¹⁹

10.21 The submission from Turning Point Alcohol and Drug Centre pointed out that very little is known about the best method to treat comorbid conditions (e.g. before, during or after gambling treatment). Also unknown is:

...how comorbidity impacts on outcomes or how clients would prefer to receive treatment for comorbid conditions.

The rates of comorbid conditions within helpline/online populations are unknown. Implementing screens within the helpline/online services would provide information for both clients and counsellors and contribute towards our knowledge of gambling and comorbidity.²⁰

10.22 Professor Dan Lubman, RANZCP Fellow, noted the recent push over the last decade to integrate services to try to deal effectively with comorbidity for both substance use and mental illness:

There is recognition that there is huge comorbidity between the two and service systems for both need to know how to work to address those issues. Gambling has been really silent in that space. While there has been increasing recognition of managing alcohol, drug and mental health issues there has really been no dialogue around gambling. It is seen as some sort of completely separate issue that does not overlap in any way whereas... there are huge underlying vulnerability markers of increased risk for all those disorders.²¹

Integrated treatment services

10.23 A key feature of a best practice service model for gambling help services is the concept of integrated treatment, particularly to address comorbid conditions as discussed above. This differs from a case management approach which may require people to seek a range of treatments from a number of different agencies, or to recover from one disorder before treatment can commence for another.²² An integrated treatment service, according to St Vincent's Hospital Gambling Treatment Program, offers 'individually tailored integrated treatment of the whole person'.²³

10.24 Dr Enrico Cementon, RANZCP Fellow, stated that each service offering integrated treatment packages needs to be 'welcoming to a person who presents with multiple problems':

They have to have an empathic and hopeful approach for that person and say, 'Yes, you have multiple problems, but let's have a look at all of them. We'll assess them and then develop an integrated treatment plan which

19 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59.

20 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 13.

21 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 36.

22 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

23 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

looks at those problems and addresses them, perhaps in the order of priority of which is the riskiest at the moment, which is causing the most harm. Then we'll move through that in that sort of way. We may need to get in specialists to help us, in which case we will work with the same treatment plan. Rather than having separate treatment plans we will have an agreed management plan with similar, mutually acceptable goals and objectives.²⁴

10.25 He noted that having different clinical services—for gambling, for drug and alcohol addiction and for mental health services—ran the risk of frustration and poor outcomes for the individual seeking treatment if these services were not properly integrated:

...each of those different service sectors has to have a capacity within it to be able to manage these patients with multiple disorders rather than say, 'You've got a gambling problem so you've got to go over to the gambling service next door or in the next suburb.' Often that sort of ping-ponging that occurs leads to the person becoming frustrated, getting different messages from different service providers and then eventually dropping out of treatment. There can be even worse outcomes as a result of that.²⁵

10.26 Professor Dan Lubman, RANZCP Fellow, also observed that 'people seek help in the ways they are comfortable with' and people may present for treatment for mental health issues and not mention gambling problems. Integrated treatment services must be able to cater for people who are at different 'stages of change' in relation to different disorders and problems:

We offer integrated treatment for, say, substance use and mental health issues but we find the majority of people will present to us with the mental health issue because that is the issue they want addressed. When they initially come to treatment they will say that they do not see their substance use as an issue. One of the ways we engage and work with them is to work on the mental health issue but at the same time, through a series of therapeutic approaches, have them over time come to acknowledge that their substance use is contributing to their mental health problems. Then that allows us to also work on the substance use issues.

One of the issues we have with gambling is that it is very difficult for people to acknowledge, because of the stigma, that the gambling is an issue. They are much happier to come forward and acknowledge, for example, the mental health issues, on which, over the last 10 years there has been an immense amount of work in terms of destigmatisation. Ten years ago people probably would not have come for a mental health issue; they would have come for a physical disorder and then we might have broached mental health.²⁶

10.27 The ideal service system would therefore be one where there is 'no wrong door' through which to seek help when someone has variety of problems. The

24 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, pp 36–37.

25 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 36.

26 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

Australian Psychological Society said that given comorbidity is often associated with gambling problems, it is important that people are encouraged to get help by 'screen[ing] for gambling in those types of areas where people do seek help, although they are still not seeking help as much as they should. That is where people are already engaging in the system'.²⁷

10.28 The submission from St Vincent's Hospital Gambling Treatment Program also argued that while brief interventions could be valuable, the best treatment for problem gamblers must include the option of integrated treatment programs:

Brief interventions definitely have their place, as do public health information campaigns and the promotion of responsible gaming. However, despite the best efforts at prevention, some problem gamblers will need extensive treatment.²⁸

10.29 St Vincent's Hospital confirmed that its service tackles gambling early on, even if the client may have other comorbidities:

I think it is important to emphasise that we do actually target the gambling from day one; we do not start looking at other things, like whether they are depressed or not. The first focus is primarily on the gambling, because that is a crisis, and we try to bring some resolution and reduction of harm around the gambling.²⁹

10.30 Professor Dan Lubman, RANZCP Fellow, suggested that building incentives into the health system to encourage the implementation of certain treatments, including integrated treatment models of care, was needed:

I think what we can learn from other parts of the health system is that, if we want to increase the implementation of certain treatments in key disorder types, we have to incentivise the system. For example, in the area of immunisation, if we really want to see 100 per cent coverage or 90 per cent coverage of the population for childhood immunisation, we add MBS [Medicare Benefits Schedule] payments to general practitioners to encourage the uptake of that practice. From the wealth of resources that have been put into the primary care sector for alcohol abuse, if we were to follow a similar path for gambling, there would need to be a dual strategy both to develop those resources and to organise the top-down processes to make it an incentive for primary care to implement that assessment and treatment package.³⁰

Committee view

10.31 The committee notes that significant further research is needed to understand the true effects of comorbid conditions on problem gambling, including effects on help-seeking behaviour and the difficulties comorbidity may present for delivering

27 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 29.

28 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

29 Ms Abigail Kazal, *Committee Hansard*, 2 May 2012, p. 20.

30 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 35.

effective treatment services. More information about comorbidity would enable treatment services to be better integrated and focused to meet the needs of people with co-occurring mental health or drug and alcohol issues.

10.32 The committee notes that integrated treatment plans are already being utilised to deal with co-occurring substance abuse and mental health conditions. The committee recognises that integrated treatment services should be able to provide assistance to people at any 'stage of change' at which they find themselves. For example, in the case of those who seek help firstly about a mental health issue, but who have a co-occurring gambling problem which they may or may not have acknowledged, treatment providers would ideally be able to offer a 'no wrong door' approach to service provision so that people may be engaged in integrated therapies. However, the committee recognises that more information is needed to help treatment providers deal effectively with comorbidities.

10.33 Recognising that further research on comorbidity and problem gambling is required, the committee considers that the Department of Families, Housing, Community Services and Indigenous Affairs should facilitate this further work.

Recommendation 7

10.34 The committee recommends that the Department of Families, Housing, Community Services and Indigenous Affairs undertake further research on the impact of comorbidities on problem gambling and how integrated treatment services can be developed and implemented to effectively address comorbid conditions.

Strengthening referral pathways

10.35 The Productivity Commission's (PC) 2010 report recommended that stronger formal linkages be forged between gambling help services and other health and community services.³¹

10.36 This was supported by Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital, who also said:

We agree with people like Dr Clive Allcock and the Royal Australian and New Zealand College of Psychiatrists that clients of all health professionals should be assessed for gambling, even one or two questions, and then be referred to us.³²

10.37 Professor Dan Lubman, RANZCP Fellow, explained there was a real need to strengthen the role of the primary care sector in relation to referrals and screening:

...it is a key role of primary care to deal with these issues. However, when speaking to my health colleagues in those fields, often they do not know what to do, how to identify it or, if they do identify it, where they should refer to or how they should manage those problems. It is a huge gap in our

31 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.27.

32 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 19.

treatment sector and a huge issue to do with both workforce capacity building and development and also the development of appropriate screening and treatment paradigms.³³

10.38 He noted that a possible way to ensure a strengthening of referral practices was to tie assessment and screening requirements to incentive payments to primary health care professionals through the Medicare Benefits Schedule (as is done, for example, for childhood immunisation).³⁴

10.39 The Australasian Gaming Council's submission noted research³⁵ which had found that many Australian general practitioners (GPs) are not screening for gambling problems because screening tests may be considered to be 'too time consuming' for routine use. A one-item screening tool may be a reasonable compromise for use by GPs and other health care professionals.³⁶

10.40 In 2010, the PC specifically recommended providing a 'one-item screening test' for optional use by health professionals and counsellors to help identify gambling problems and that this should be targeted at high-risk groups, especially those presenting to services with anxiety, depression and heavy drug and alcohol use.³⁷

Committee view

10.41 The committee affirms the need for better linkages and collaboration across the health care system to strengthen assessment, screening and referral practices for problem gambling. Developing stronger pathways for referral will facilitate earlier intervention and help-seeking and enable individuals to address problematic gambling behaviour much earlier.

10.42 The committee agrees, in line with the Productivity Commission, that clients of primary care health professionals and counsellors who are considered 'high-risk' (particularly those who present with anxiety, depression, high drug and alcohol use) should be assessed for gambling problems using an optional one-item standardised screening test.³⁸

33 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 34.

34 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 35.

35 Problem Gambling Research and Treatment Centre (PGRTC) (2011) *Guideline for screening, assessment and treatment in problem gambling*, Clayton: Monash University, p. 44 and Thomas, S; Jackson, A; Browning, C and Piterman, L. (2009) *A one item screening tool for problem gambling for use in primary care settings*, Melbourne, PGRTC.

36 Australasian Gaming Council, *Submission 33*, p. 25.

37 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 7.27.

38 A one-item standardised screening test would involve, for example, a general practitioner asking a patient a question such as 'Have you ever had a problem with your gambling?' See 'Why Screen?', *General Practice Problem Gambling Resource Kit*, Government of South Australia, 2009, http://www.problemgambling.sa.gov.au/asp/gps_nurses_and_clinicians.aspx (accessed 3 September 2012).

Embedding awareness of gambling across the health system

10.43 The committee heard evidence on ways to further strengthen the health system to incorporate knowledge and awareness of problem gambling among health professionals. Professor Dan Lubman's view was that there was a 'failure across the medical profession to understand and treat gambling issues'.³⁹

Training of medical students

10.44 The RANZCP noted that there was a need for further capacity building in the gambling treatment sector and that this could be improved by changes to the training system:

Addictions are rarely taught in any great detail within most undergraduate and postgraduate courses, so there is a lack of training and capacity building in the recognition and management of addictions across a whole range of health professionals, including primary care providers. Similarly, in terms of opportunities for postgraduate expertise and training, again there are limited opportunities for placements or postgraduate training in the addictions field, so again there is a lack of capacity building in this sector when it comes to the recognition and management of gambling by primary care and other health providers.⁴⁰

10.45 Dr Enrico Cementon, RANZCP Fellow, also mentioned efforts made in Melbourne to have psychiatrists interested in problem gambling impart their knowledge to medical students, although this was not a systemic practice:

I know that there were a couple of sporadic efforts within Melbourne where certain psychiatrists are interested in problem gambling. They consciously make an effort to talk to the medical students that they are teaching about problem gambling but I do not think there is any cohesive strategy in relation to medical student teaching and problem gambling. Perhaps there needs to be some policy around that in the universities.⁴¹

Promotion of problem gambling across the health profession

10.46 In order to promote awareness of problem gambling throughout the health profession, the RANZCP undertakes activities directed towards up-skilling their professional counterparts. These activities were described by Professor Lubman and Dr Cementon, RANZCP Fellows:

Professor Lubman: The college is part of the mental health professionals network where it links with psychologists, general practitioners and nurses and it arranges professional development activities that include management of mental health, substance and gambling issues. There is a range of activities that it is involved in. We have position statements; we promote it heavily. We are both involved through the section with presentations at our congresses, with professional development and other

39 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 37.

40 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 34.

41 Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 37.

activities that we run. Certainly, we promote it very heavily in there but even within our own college there is a lot of work to be done in upskilling our college membership in the recognition and management of gambling issues. There is a lot of work to be done in this area. Unfortunately, we are a long way behind where we would like to be.

Dr Cementon: We had a small win about 10 years ago when the college training was revised with addiction training for all training psychiatrists. We introduced in the first three years of training the requirement to compile a logbook of 10 addiction cases. Nine of them were substance related and one of them was a gambling case where the gambling problem was identified, assessed and managed as a focus of the overall treatment of the patient. We consider that to be an important win. There was a bit of training that went out with that—for example, the DAG [drug, alcohol and gambling] assessment which was determined by Dr Allcock in Sydney. You might have come across Clive in your travels. The drug, alcohol and gambling assessment has been a very core part of the overall psychiatric assessment of a patient.⁴²

10.47 St Vincent's Hospital agreed that further education of health professionals would assist in helping to break down stigma across society about problem gambling:

We see a lot of people who have seen psychiatrists, general practitioners and other psychologists and they have not mentioned their gambling problem, which gives you an idea of the stigma.⁴³

A helpline for health professionals

10.48 The committee heard from the Turning Point Alcohol and Drug Centre about a practical idea to assist health professionals more broadly to understand, recognise and help people with gambling problems:

...in the drug and alcohol space we are funded through government to provide a service called the Drug and Alcohol Clinical Advisory Service...There is a number that is put across a number of jurisdictions where any health practitioner can ring up and get advice about how they manage a client. Most of [the] calls we get are from GPs. They know that they can speak to a psychiatrist or an addiction medicine specialist about somebody with alcohol and drug problems in their clinic at that moment. They ring us and we give them advice. A similar sort of service for problem gambling is needed, so that GPs knew that if they had somebody there that there is somebody they could ring immediately to speak to to work out who to refer to and what they should do next. That level of support would really enhance the amount of pickup amongst general practitioners and other professionals.⁴⁴

42 Professor Dan Lubman and Dr Enrico Cementon, *Committee Hansard*, 3 May 2012, p. 41.

43 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 22.

44 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 49.

10.49 According to its website, the Drug and Alcohol Clinical Advisory Service (DACAS) is a 24 hour, 7 day specialist telephone consultancy service available to all health professionals in Victoria, Tasmania and the Northern Territory. It is operated by the Turning Point Alcohol and Drug Centre and is funded by the Victorian Department of Health. The service provides clinical advice to health professionals who have concerns about the clinical management of patients and clients with alcohol and other drug problems. Initial inquiries to the service are handled by professional drug and alcohol counsellors. If the inquiry is medical in nature, it is referred to a DACAS consultant (addiction medicine specialists) for a secondary consultation. Consultants aim to respond to calls within one hour, or as soon as possible if the matter is urgent.⁴⁵

Committee view

10.50 The committee supports the efforts currently underway to embed awareness of problem gambling across the health profession, from medical students to practising health professionals. Initiatives such as a helpline for health professionals to assist them to identify and help patients with gambling problems are good practical measures which the committee hopes will lead to improvements in service provision for people with gambling problems across the health service system.

Recommendation 8

10.51 The committee recommends that the Commonwealth Government fund the establishment of a national helpline, similar to the Drug and Alcohol Clinical Advisory Service, as a practical resource for primary health care professionals to assist them to identify and refer patients who present with gambling problems.

Qualifications and training

10.52 The issues of qualifications and training for both clinical and non-clinical gambling treatment services were raised with the committee as an area for further attention and standardisation.

10.53 The committee discussed the variability of qualifications and training with the Productivity Commission (PC). Dr Ralph Lattimore noted that for non-professional staff who perform interventions and referrals in a gambling venue, for example, it is important that people not 'stray over the line...we do not want people being amateur psychologists'. He described the different levels of qualifications expected depending on the intervention or treatment:

So that goes to the heart of the question of qualification that may be needed for venue staff as compared with people who may be actively involved. It is also then a distinction between people who are undertaking, effectively, clinical roles. If you are applying or researching cognitive behavioural therapy at a professional level—people like professors Blaszczyński and

45 Drug and Alcohol Clinical Advisory Service, http://www.dacas.org.au/Find_Help.aspx (accessed 23 July 2012).

Delfabbro—then you need to be a highly trained professional. Similarly, pharmacological interventions require that level of training.⁴⁶

Calls for a clinical approach

10.54 Clinicians who gave evidence to the committee advocated strongly for the value of a clinical approach to treatment of problem gambling. For example, Dr Katy O'Neill commented on the rigorous approach offered by clinical psychologists at St Vincent's Hospital:

I think what psychologists bring to this is that we know how to read research. We do not take things as: you must see people for six sessions, you must cover this et cetera. We do not have that cookbook approach. We can see what the research is aimed at, what the theory is and then apply it.⁴⁷

10.55 Clinical psychologists undertake a minimum of six years full time university training, including at least two years post-graduate clinical studies with extensive supervised placements in mental health settings.⁴⁸ Dr O'Neill told the committee that 'treating gamblers is a specialist skill' and that only those properly trained in psychology and learning theories are best placed to help problem gamblers:

I do think that a fairly robust, self-motivated person could probably succeed no matter who they saw, but there is deep ambivalence when people come in; there is embarrassment. Some of the learning principles involved in why they keep getting hooked into it are quite complicated.

...We run a lot of our clients through a mini psychology course: this is why you are reacting like this; this is why you might be at home, slumped, and you think of gambling—you have not even gone yet—and suddenly you have got a little bit more energy. What causes that motivation? We explain to them things to do with the dopamine system. They do end up with quite a lot of specific knowledge about gambling, and that, to me, is possibly why our rates might be higher.⁴⁹

10.56 Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager, St Vincent's Hospital, added that clinical psychologists are well placed to provide integrated treatment as they are 'trained to assess the entangled functional relationships between presenting problems and can thus offer individually tailored integrated treatment of the whole person'.⁵⁰

10.57 Particularly for the treatment of comorbid conditions, St Vincent's Hospital emphasised that only appropriately qualified health professionals should deliver treatment and that poorly informed treatments 'no matter how well intentioned, can occasionally exacerbate mental health problems':

46 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 45.

47 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 23.

48 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

49 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 25.

50 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 1.

The addition of a few mental health units in the minimum qualifications for a problem gambling diploma is no substitute for the extensive training involved in post-graduate mental health qualifications.⁵¹

10.58 These views about qualifications were echoed by the University of Sydney Gambling Treatment Clinic, which noted that many people who work with problem gamblers do not necessarily come from a mental health or psychology background. Even those who are trained in psychology, social work and psychiatry may require more specialised training in problem gambling because most training programs for these professions do not specifically address problem gambling.⁵² To address this, the Clinic suggested that a review and adjustment of tertiary training programs for formal mental health qualifications should take place, as well as the development of centres of excellence, capable of retraining mental health professionals in best practice methods for treating problem gambling.⁵³

10.59 Mr Christopher Hunt, Psychologist, University of Sydney Gambling Treatment Clinic, raised serious concern about people without proper expertise working with problem gamblers:

I would argue that this is a problem, because the government—not just this government but also governments in the past—have noted the importance of getting properly trained people to work with sufferers of depression, anxiety, schizophrenia, bipolar disorder. But in the area of problem gambling we are seeing that there is still this preponderance of people with minimal qualifications working on treating this disorder, and we would say that is far from an ideal situation. Essentially, anyone that puts their hand up and says, 'Yes, I want to help problem gamblers,' is able to get funding. But it is not an ideal situation for the gamblers that there are these people with lower levels of qualification who are offering treatment.⁵⁴

10.60 The Clinic's submission cited a lack of training for counsellors, 'who are not typically trained to attend to the various mental health comorbidities that frequently occur in problem gamblers'.⁵⁵

Committee view

10.61 The committee acknowledges the views of the Productivity Commission and the health professionals who presented evidence regarding the need for a clinically rigorous approach to treatment of problem gambling, particularly when dealing with comorbid mental health conditions. It is important to have the highest standards of care and service available for those dealing with gambling problems. While this would be an ideal situation, the committee also notes that clinical services exemplifying best practice are not in reach of or suit everyone who has a gambling problem, particularly

51 St Vincent's Hospital Gambling Treatment Program, *Submission 3*, p. 2.

52 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 58.

53 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 8.

54 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 59.

55 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 8.

people in regional and remote communities. The committee therefore acknowledges the good work being undertaken at all levels, by both clinicians and non-clinical counsellors.

Minimum standards for counsellors

10.62 Ms Rosalie McLachlan, Inquiry/Research Manager, Productivity Commission (PC), explained why the PC's recommendation on minimum training standards for counsellors was made:

A number of participants to our inquiry actually expressed concerns about the level of qualifications of counsellors, and there was certainly evidence of variability of levels of qualifications. But, even in terms of just understanding the technologies, I remember going to a gambling counsellor conference and being amazed at some of the questions that were being asked about how the technologies work. Given that they are seeking to correct misperceptions about gambling, I suppose I was surprised at the lack of understanding of some counsellors of how gambling worked and how the technologies worked. So an absolute minimum requirement would be to actually understand the technologies and how problem gambling comes about in terms of misconceptions.⁵⁶

10.63 The Gambling Impact Society NSW acknowledged that many in the counselling sector were doing well with the few resources they have at hand. However, Ms Kate Roberts, Chairperson, noted there was still room for better 'theoretical grounding' in relation to counselling people with gambling problems, especially those with comorbidities:

We know that people need a gamut of different forms of treatment and I am certainly an advocate for people having choices, but there needs to be at least a baseline of people being able to have a range of skills. So the area in New South Wales has developed very much around a treatment area and consequently the recruiting to that has had people coming from a whole range of different kinds of counselling backgrounds. Whilst there is nothing wrong with that initially, what we are really saying is that as we know more about it there are huge co-morbidities and you really do need to have a baseline of very good theoretical grounding about dealing with those comorbidities.⁵⁷

10.64 To improve training, Professor Malcolm Battersby suggested a national training program for therapists or counsellors:

...which teaches in a rigorous way at least a graduate certificate level those with mental health qualifications mental health assessment with a gambling focus, anxiety and depression assessment and management similar to that provided by the Master of Mental Health Science course at Flinders

56 Ms Rosalie McLachlan, *Committee Hansard*, 14 May 2012, p. 45.

57 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, pp 39–40.

University, a course for non-psychologists in evidence based psychological therapies.⁵⁸

10.65 The PC examined the issue of qualifications and training in its 2010 report, concluding that a minimum standard of training for counsellors was desirable, given the complex nature of gambling problems. National accreditation was considered as an approach by the PC but was deemed too costly and difficult to be approved across all jurisdictions.⁵⁹

Committee view

10.66 The committee supports the Productivity Commission's recommendation to establish a minimum standard for counsellors to enhance the quality of service provision. The committee supports jurisdictions and professional bodies working together to develop national minimum standards of training for counsellors who deal with problem gambling, in line with the Productivity Commission.

10.67 The committee also sees merit in exploring other ways in which best practice in problem gambling treatment could be better shared between clinical and non-clinical services (that is, between professionals and non-professionals) without compromising clinically rigorous approaches—for example, through courses offered by clinicians for non-psychologists as recommended by Professor Malcolm Battersby.

58 Flinders University, Professor Malcolm Battersby, *Submission 8a*, p. 5.

59 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

Chapter 11

Gambling research and data collection

Introduction

11.1 This chapter will cover issues relating to gambling research and data collection. It will consider areas for improvement, including subjects for further gambling research and the need for a more strategic national research agenda. The chapter will then deal with the independence of research and transparency of funding sources as well as matters relating to standardised data collection. The evidence base for treatment will also be covered, as well as evaluation of treatment services and ways to incorporate benchmarking practices into clinical services.

11.2 Dr Katy O'Neill, Clinical Psychologist, St Vincent's Hospital Gambling Treatment Program, provided an interesting perspective on the gambling knowledge and research base which is still relatively unexplored, telling the committee:

So would more research on gambling help? Yes. But gambling is really quite a mystery. I worked in the drug and alcohol area for years and the amount of literature in drug and alcohol abuse is huge compared to the amount of literature on gambling. One thing I noted—and I sometimes show this to students—in 1957 someone wrote a book *The Psychology of Gambling* and basically said, 'I don't understand it.' Then in 1995 someone wrote another book *The Psychology of Gambling* and he also said, words to the effect, 'I don't understand it.' In 2003 someone wrote: 'There are Skinnerian principles, there is conditioning, there is reinforcement, but we do not quite understand it.'...

Sometimes I think to myself that if we understand gambling we will practically understand human nature.¹

The current state of gambling research and data collection

11.3 As covered in the committee's last two reports, Australia's knowledge base on gambling needs considerable development. During the committee's three inquiries into gambling reform, the need for better, more targeted research and data collection is a theme that has been emphasised repeatedly.

View of the Productivity Commission

11.4 The Productivity Commission's (PC) 2010 report on gambling identified significant shortcomings in data collection that constrained research capacity and meaningful policy development. Data shortages were also compounded by differences in the ways that jurisdictions specified, measured, recorded and reported gambling

1 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 23.

data. Better coordination of data collection would 'obtain more comprehensive coverage and greater consistency across jurisdictions'.²

11.5 The PC also proposed that improvements to gambling research and data could be pursued by increasing transparency of data (e.g. allowing greater public access to datasets, research methodologies and results) and 'refocusing research agendas' to ensure greater attention is placed on ways to reduce harm arising from gambling.³

11.6 During the current inquiry, the PC confirmed that little had changed with regard to advancements in systemic data collection since 1999 when the PC first looked closely at the issue, although Dr Ralph Lattimore acknowledged there had been some progress in assessing effectiveness of treatment methods such as cognitive behavioural therapy. Overall, however, the policy framework recommended by the PC to address research deficiencies had not been progressed.⁴

Areas for improvement

11.7 The committee heard confirmation of the PC's observations about the need for substantial improvement of gambling research and data collection. Submitters and witnesses raised a number of research methods and priorities for further investigation which are summarised below. These include:

- types of research (the value of longitudinal and prevalence studies);
- greater international cooperation;
- more research on 'responsible gambling'; and
- further research on gambling harm (including the impact of gambling on families and children).

11.8 Dr Sally Gainsbury summarised the vision for improvement in the gambling research landscape, telling the committee:

We do need empirical research on prevention and on intervention, at every stage of gambling, and also to look at things like evaluating policies which are put in place, so that when we have public health campaigns, educational campaigns or mass media campaigns put out to the general public not just the gamblers and not just problem gamblers, we can see how effective they are, whether this is money well spent or whether these resources should be directed elsewhere. The idea is to invest resources, time, money and research to ensure that the larger pool of funding is directed into appropriate

2 Productivity Commission, *Gambling*, vol.2, Commonwealth of Australia, Canberra, 2010, p. 18.4.

3 Productivity Commission, *Gambling*, vol.2, Commonwealth of Australia, Canberra, 2010, p. 18.1.

4 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 42.

interventions which are effective and modified where required, and that they are having the intended effect.⁵

Types of research

11.9 Several suggestions about types of research methodologies were put to the committee, relating to longitudinal studies as well as the value of prevalence and incidence studies.

Longitudinal research

11.10 The Australian Psychological Society (APS) emphasised the need for 'longitudinal studies of developmental trends in gambling participation' to identify risk and protective factors and to better understand the links between exposure and harm.⁶ Dr Jeffrey Derevensky, a Canadian youth gambling researcher, stated:

...longitudinal research to examine the natural history of pathological gambling from childhood to adolescence through later adulthood is required and will add substantially to our knowledge.⁷

Prevalence studies

11.11 A number of submitters were supportive of gambling prevalence studies. For example, Sportsbet called for a 'comprehensive and robust Annual National Problem Gambling Prevalence Survey'.⁸ The NSW Government's submission described a study currently underway on prevalence of problem gambling 'to inform gambling policy and program activity by assessing the extent of problem gambling, its geographic spread and the profile of problem gamblers'.⁹

11.12 Noting that different jurisdictions undertook their own prevalence studies, the Social Issues Executive, Anglican Diocese of Sydney, also suggested an evaluation of gambling prevalence in Australia be established on the Council of Australian Governments (COAG) agenda to ensure consistent information sharing between all jurisdictions:

To support the co-ordination and monitoring of these measures, we suggest a gambling policy research and evaluation function be established in the Department of Prime Minister and Cabinet, possibly connected to the Social Inclusion Unit.

5 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 10.

6 Australian Psychological Society, *Submission 49*, p. 12.

7 Dr Jeffrey Derevensky, *Submission 7*, Attachment 1, p. 13.

8 Sportsbet, *Submission 40*, p. 2.

9 NSW Government, *Submission 51*, p. 8.

Further we suggest that every second year COAG deliver a publicly available report on the progress of anti-gambling measures and the prevalence of gambling in Australia.¹⁰

11.13 However, Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, observed that studying gambling prevalence only 'captures one point of time' and must be interpreted in light of people's denial of existing gambling problems. She argued strongly for more incidence studies:

Incidence is looking at the fact that people come in and out of this phenomenon and we need to be capturing that. We need to be looking at what the precursors to that are, what the volatilities are and what the things that we need to be measuring are, and what we need to seek to change. Prevalence does not give us any of that.¹¹

11.14 The Gambling Impact Society's submission emphasised that 'prevalence studies do little to capture the lived experience of problem gambling' and called for the balance between prevalence and incidence studies to be redressed.¹²

11.15 BetSafe also criticised the tendency to fund prevalence studies and other generalised research:

Research should focus on the development and evaluation of detailed practical measures to combat problem gambling...Often research projects conclude with a comment that they provide preliminary results but more research is required to provide practical answers.¹³

11.16 Dr Sally Gainsbury similarly observed:

There is currently a lot of money going into things like public opinion polls which survey quite small, non-representative samples and do not give answers we need to inform policy, to inform interventions. I recognise that the long-term nature of research sometimes is not consistent with the need to put policies in place in a more timely basis, but really Australia has the opportunity to be at the forefront of gambling research internationally.¹⁴

11.17 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, mentioned the limitations of current research which focused on 'counting heads' and instead called for greater focus on harms from gambling:

We also need to stop counting heads of those identified as being problem gamblers as a measure of the problem. This can only ever indicate the pointy end of the problem. Identification of people who can be

10 Anglican Church, Diocese of Sydney, Social Issues Executive, *Submission 26*, pp 3–4.

11 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 40.

12 Gambling Impact Society NSW, *Submission 30*, p. 13.

13 BetSafe, *Submission 32*, p. 17.

14 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 9.

unequivocally diagnosed as having a gambling problem at a clinical level is only the pointy end of the problem. That is like if you were trying to look at the impact of alcohol on car accidents and you only counted people if they were clinically diagnosed as an alcoholic. You would be missing all the times that alcohol is actually affecting people's driving because you are not counting them unless they are an alcoholic, but also you are not looking at harm.¹⁵

Greater international cooperation

11.18 Collaboration with New Zealand and greater multilateral cooperation on gambling research and data collection were proposed during the inquiry. The PC's 2010 report already proposed the involvement of New Zealand in any national gambling research framework, noting the country's considerable research expertise and opportunities for shared learning between Australia and New Zealand given the different regulatory regimes in place.¹⁶

11.19 The Australian Churches Gambling Taskforce expressed strong support for this idea, noting that the Problem Gambling Foundation of New Zealand would be a good partner,¹⁷ and stating that:

We think there is real merit in working collaboratively with the New Zealanders. The New Zealand government and industry and help services are world leaders in a number of aspects of gambling policy and gambling treatment. We believe that a partnership between Australia and New Zealand on independent research and data collection would add value to both countries.¹⁸

11.20 The Taskforce also believed that such cross-Tasman cooperation could also lead to opportunities for more extensive multilateral efforts on problem gambling research:

We also note that there is potential for shared research with partners beyond Australia and New Zealand, an option that we believe is worth exploring - for example [a] UnitingCare employee was invited by the Korean Government to speak to an international gambling conference in that country in 2010 and UnitingCare is aware that there is considerable interest in gambling research in Korea and we are also aware of some growing interest [in] gambling research particularly around consumer protection measures in a growing number [of] South Pacific nations.

Linking Australian and New Zealand gambling researchers [is] strongly recommended. Then the option of further international collaborat[ion] is

15 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 22.

16 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.21.

17 Australian Churches Gambling Taskforce, *Submission 50*, p. 4.

18 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 10.

also worth exploring, particularly in relation to multilateral regulation/protocols regarding on-line and interactive gambling. Both the Commonwealth, through CHoGM and the G20, as well as the World Health Organisation provide potential for shared research, leading to policy and regulation opportunities multilaterally.¹⁹

More research on 'responsible gambling'

11.21 The committee also heard calls for more research on 'responsible gambling' measures, largely from industry participants. For example, Clubs Australia supported research to investigate 'the benefits of community awareness campaigns that have a direct emphasis on prevention through the promotion tips and strategies to assist consumers to gamble responsibly'.²⁰

11.22 BetSafe emphasised the need for more research into ways individuals could be helped to control their gambling activity:

What the Commonwealth should be doing is funding research into ways in which recreational gamblers can be better equipped to make decisions and keep control of their gambling. BetSafe and others have tried a number of strategies to provide information and responsible gambling strategies, but the cost of independent evaluation is high, so much of the available material is based on anecdotal information.²¹

Further research on gambling harm

11.23 In contrast to calls for more research on ways for individuals to 'gamble responsibly', a key theme that emerged in this inquiry was for research to be more focused on harm reduction measures. This view was held by a number of submitters to the inquiry, such as the Victorian Local Governance Association, which said:

More research is needed to look at examining the impact on individuals, families and the community generally and what preventative work can be done to limit harm.²²

11.24 Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists (RANZCP), also made an observation about the threshold for regulatory action in other areas such as drug addiction, despite gaps in the evidence base:

It is of interest to me that, as soon as a drug comes along that is identified as potentially addictive, the Commonwealth, before gaining any evidence of its potential harm, seeks to ban it because it recognises that that is in the public's interest. In the area of gambling we are allowed to actually produce

19 Australian Churches Gambling Taskforce, *Submission 50*, p. 14.

20 Clubs Australia, *Submission 29*, p. 4.

21 BetSafe, *Submission 32*, p. 10.

22 Victorian Local Governance Association, *Submission 25*, p. 6.

machinery that is known to be addictive and to cause significant harm to individuals, yet we do not have the equivalent of the TGA, an overriding body, looking at the addictive nature of certain equipment and how we might minimise harm in that regard.²³

11.25 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, put forward the argument for adjusting the research agenda to focus on harm, as well as practical ways to reduce harm:

We really need to shift the attention away from that pathological model and start doing really good research on harm and look at monitoring and the connection between poker machine design—or any gambling design and supply features—with the harm that has been caused. And monitor that—have a feedback loop; do not have a big research project that trots on for three years, then at the end of that three years we find out that in the last three years this was really harmful and 1,000 people killed themselves and 2,000 families broke down. We need to have research set up so we are looking at the information that is coming in on a regular basis and being able to respond to that.²⁴

11.26 Calls for a clear focus on research about gambling harm, which can then be translated into practical policy measures, were heard from a number of witnesses, including Anglicare²⁵ and the Australian Psychological Society (APS), which urged:

...prioritising further independent evaluation and research into the impact of policies designed to reduce gambling related harm and, in the absence of a sound evidence base, urges governments to exercise their social responsibility to protect the public from exposure to gambling products that cause harm.²⁶

11.27 Ms Heather Gridley, Manager, Public Interest, APS, questioned why research was not currently focused on product safety and risks of harm:

We do need to come back to that question of why aren't we researching product safety and what is the resistance to that—and it is fairly obvious where the resistance would come from. Often calls for more research can be ways of slowing down our response while more people are suffering in between. We just need to be a bit careful about our own industries that we build around a problem as well as the industry itself.²⁷

11.28 The APS submission posited that there was tension for governments in terms of balancing the goal of preventing and reducing harm against potential restrictions to gambling as entertainment for consumers, as well as revenues to government. Harm

23 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 40.

24 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 22.

25 Anglicare, *Submission 12*, p. 10.

26 Australian Psychological Society, *Submission 49*, p. 3.

27 Ms Heather Gridley, *Committee Hansard*, 14 May 2012, p. 31.

minimisation and public health approaches were also acknowledged by the APS as quite difficult to evaluate:

This is partly due to the fact that although a broad range of potential strategies have been identified and discussed world-wide, few initiatives have been implemented in any consistent or organised manner (Dickson-Gillespie, Rugle, Rosenthal, & Fong, 2008) and initiatives of this scale are unlikely to be measurable at the population level (Council of Gamblers Help Services, 2009).²⁸

11.29 Similarly, the Statewide Gambling Therapy Service advocated an extension of the research enterprise into 'the arena of public policy and the wider social determinants of health and wellbeing in relation to the impact of gambling upon individuals, families and communities'.²⁹

11.30 As already covered in chapter two, the social cost to communities of poker machine gambling can be significant, although there is little firm research to quantify these costs. St Luke's Anglicare described in its submission the burdens placed on local communities which object to the introduction of more poker machines, yet are asked to prove the harm the machines will have on their communities. Without well-targeted research on harms, such proof is difficult to present and this places local communities in an unfair position:

St Luke's Anglicare feels that EGMs have now become a highly politicised issue with governments reluctant to cut off a funding stream which contributes significantly to their finances. Consequently research which shows the real costs to business, communities, families and problem gamblers directly needs to be modelled. Communities when surveyed consistently say they do not want machines and yet they are approved. Perhaps if research was able to quantify the real costs to our communities, this would not seem like such an attractive funding stream for governments.³⁰

11.31 The RANZCP also favoured research which would 'inform the generation of risk benefit analysis of the costs to the community associated with problem gambling versus the revenue generated'.³¹

Effect of gambling on families and children

11.32 Another area for further research work was the effect of gambling on children and families. For example, the RANZCP highlighted that little research into the emotional effect of problem gambling on families and the community had been undertaken to date and that a national study on the effect of gambling on children and

28 Australian Psychological Society, *Submission 49*, pp 12–13.

29 Flinders University, *Submission 8*, p. 3.

30 St Luke's Anglicare, *Submission 13*, p. 7.

31 Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 4.

families should be done. This would also be able to inform future responsible gambling campaigns.³² The Gambling Impact Society NSW also supported further research in this area,³³ as did UnitingCare Community, which noted that specific focus on children and families in the mining sector would be very beneficial for gambling help services.³⁴

11.33 The Tasmanian Department of Health and Human Services also cited a 'blind spot' in understanding how problem gambling affects child development. This is a key area identified for further research:

Disability and Community Services within DHHS Tasmania is currently considering the best approach to understand the extent to which problem gambling is adversely affecting household budgets for essentials, the emotional impact of gambling related stress and distress, and the impact on children and parenting ranging from family violence, child protection concerns, the potential cumulative harm impact on child development.

These areas for further research should be of direct interest to governments and human services agencies faced with current and emerging pressures on family functioning and capacity.³⁵

11.34 Specific research to understand the influence of gambling marketing strategies in sporting matches, with specific reference to children and young people, was also suggested by the Australian Psychological Society.³⁶

Other research priorities

11.35 A range of other priorities for further research were put to the committee, including:

- rates of suicide attributable to gambling problems;³⁷
- the impact of poker machines on vulnerable groups such as culturally and linguistically diverse communities and among international students;³⁸ and
- technology-based solutions to address problem gambling.³⁹

32 Royal Australian and New Zealand College of Psychiatrists, *Submission 27*, p. 9.

33 Gambling Impact Society NSW, *Submission 30*, p. 13.

34 UnitingCare Community, *Submission 59*, p. 7.

35 Tasmanian Department of Health and Human Services, *Submission 47*, p. 16.

36 Australian Psychological Society, *Submission 49*, p. 2.

37 Mr Tim Falkiner, *Submission 4*, p. 10.

38 Victorian Local Governance Association, *Submission 25*, p. 6.

39 AMC Convergent IT, *Submission 34*, p. 10.

Committee view

11.36 The committee takes the view that further research into problem gambling should be undertaken in order to enrich the evidence base and provide a firm grounding for policy and regulatory decisions about gambling. The committee heard suggestions about a range of priority areas for further research, including longitudinal and prevalence studies. Greater trans-Tasman collaboration and multilateral opportunities for cooperation should also be pursued in an effort to share information more widely on gambling research and data collection. The committee also strongly supports a greater research focus on gambling-related harms on communities, including product safety and practical harm reduction measures.

11.37 The committee supports further research on the effects of gambling on families and children and reiterates its recommendation from its last report that the COAG Select Council on Gambling Reform commission further research on the longer-term effects of gambling advertising on children, particularly in relation to the 'normalisation' of gambling during sport. The committee notes that the government response to this recommendation was that it was a 'matter for jurisdictional consultation' with 'specific research into the impact of advertising on children [to] be discussed with state and territory governments' through the COAG Select Council on Gambling Reform.⁴⁰

11.38 While the committee supports further research being conducted on the areas outlined above, it also recognises that a more strategic, targeted and relevant research agenda must be developed. This is discussed in the following section.

A national research agenda is needed

11.39 The goal of a national research program to strategically drive an enhanced research agenda into gambling was supported by a broad cross-section of witnesses.⁴¹

11.40 Professor Alex Blaszczynski highlighted the 'dearth of effective long-term treatment outcome studies' which he attributed to the 'lack of an effective long-term research plan':

What we require is some degree of effective, systematic research and the longer term prospective studies that will address many of these particular issues. No doubt the committee will be informed of the lack of research and the extent to which people's opinions and ideology influence some of their interventions with treatment.⁴²

40 Government Response to the Parliamentary Joint Select Committee on Gambling Reform – Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011, p. 5.

41 For example see University of Sydney, Gambling Treatment Clinic, *Submission 10*, p. 9.

42 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 9.

11.41 A more strategic approach would start to address the current research landscape, which Professor Blaszczynski saw as generally 'reactive and designed with policies in mind in essence either to block policies or to implement policies, with no attempt to systematically evaluate it all'.⁴³ Dr Sally Gainsbury agreed, stating that:

Very short time frames are put in place for researchers and very large scope, so it is very difficult to conduct methodologically rigorous scientific research. What is really needed is a program that is independently run that looks at putting together a long-term research strategy that hires independent academic researchers who are interested in doing research to put in the public domain to publish in scientific peer reviewed journals that will hold it up to a very high standard of accountability. The current situation is such that the research projects are very reactive and are looking to fill gaps.⁴⁴

11.42 Dr Samantha Thomas, a public health sociologist from Monash University, saw possibilities for gambling researchers to work with existing bodies like the National Preventative Health Taskforce which include gambling under a broader remit in terms of prevention:

I think, as researchers, we need to lobby hard to have gambling included on the agenda. I do not know whether we need a whole separate task force or organisation for gambling because many of the issues that we have seen in gambling are very similar to other issues and are probably interrelated in many ways. I guess at the core of this are issues around social class and health inequalities.

...I have only been working in this area for two or three years, but I bring my skills and experiences from other health conditions into this. I think it is still heavily concentrated in psychiatry and psychology and addiction frameworks. But those of us in public health are starting to notice it and that is really a lot to do with the work of this committee, issues that have been raised around gambling...We are starting to see the capacity grow and that is a really important and positive thing.⁴⁵

11.43 Clubs Australia also described Australia's gambling research landscape as 'ad hoc', noting that 'conflicting findings' made it difficult to discern what evidence was credible for the purposes of designing policy:

Moreover, much of the research is aimed at gaining publication in academic journals and lacks relevance to contemporary gambling policy. Where research has been initiated by governments it has typically involved a protracted process, taking several years to commission and complete, further inhibiting the development of evidence-based policy.⁴⁶

43 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 10.

44 Dr Sally Gainsbury, *Committee Hansard*, 2 May 2012, p. 9.

45 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 25.

46 Clubs Australia, *Submission 29*, p. 11.

11.44 The Gaming Technologies Association Ltd (GTA) called for a national fund for research oversight, stating that current gambling research 'suffers from jurisdictional inconsistencies' and that research outcomes are 'piecemeal and of questionable motives'. The GTA and the Australasian Casino Association both suggested that national oversight could be provided by the National Health and Medical Research Council (NHMRC).⁴⁷

11.45 The Australasian Gaming Council (AGC) also raised a number of problems with the research environment, including: integrating research findings from different jurisdictions when variations exist in methodologies; currently funded gambling studies being small and stand-alone ventures; lack of a data-set of reliable statistics and information; and an absence of appropriate benchmarking and peer review against established guidelines. To address these shortcomings, the AGC put forward the following suggestions:

The AGC believes that there is potential benefit in combining gambling studies with other studies, (such as those in health and education), in order to be able to study larger and better samples and provide a comprehensive foundation to inform public health initiatives.

A solid empirical evidence base, one that is nationally co-ordinated, clearly structured, appropriately funded and that evidences the highest level of academic rigour while demonstrating clear policy relevance is an urgent requirement if gambling research in Australia is to keep a proper pulse on the outcomes of initiatives and policies already undertaken - while adequately informing policy makers of any likely best 'next steps'.⁴⁸

11.46 The AGC endorsed the idea of a national research institute which, at a minimum, would:

- Coordinate a research store/agenda of direct national policy relevance;
- Formulate clear guidelines, methodologies and processes to ensure all Australian gambling research is nationally consistent and of the highest academic standard;
- Maintain up to date national data and statistics regarding gambling and problem gambling that is easily accessible to the public;
- Collaborate with other public health research centres; and
- Integrate knowledge and resources via a stakeholder advisory panel.⁴⁹

47 Gaming Technologies Association Ltd, *Submission 23*, p. 5; Australasian Casino Association, *Submission 46*, p. 10.

48 Australasian Gaming Council, *Submission 33*, p. 28.

49 Australasian Gaming Council, *Submission 33*, p. 28.

11.47 The Clubs Australia submission argued for a 'national gambling research program' to ensure that 'all government funded research into gambling is consistent with best practice research standards'. Such a coordinated national approach would prevent duplication across states and territories and also facilitate national surveys.⁵⁰

11.48 Clubs Australia also suggested setting up a gambling research advisory board which would be responsible for developing and overseeing the national program. This board should:

- have representation from both the industry and the state and territory government agencies responsible for regulating gambling;
- be responsible for setting the research agenda and establishing funding priorities;
- establish guidelines, methodologies and processes for government funded research;
- where appropriate coordinate evaluations, surveys and reviews on a national basis;
- maintain a nationally consistent data set on gambling and problem gambling;
- review the quality and usefulness of research with respect to developing gambling policy; [and]
- disseminate concise summaries of research that is both valid and policy relevant to all stakeholders.⁵¹

Gambling Research Australia

11.49 Gambling Research Australia (GRA) is the current national research body, established in 2001 as an initiative of the Council of Australian Governments' (COAG) former Ministerial Council on Gambling. In its 1999 report, the Productivity Commission (PC) had proposed that 'a properly constituted national research facility' be set up 'to facilitate national cooperation and coordination in data collection and research'⁵² and the establishment of GRA was a response to this recommendation.

11.50 However, the committee notes the PC's criticism in 2010 of GRA on a number of grounds, particularly:

- its lack of independence;
- lack of research capacity and limited capacity to assess research it commissions;

50 Clubs Australia, *Submission 29*, p. 11.

51 Clubs Australia, *Submission 29*, p. 11.

52 Productivity Commission, *Australia's Gambling Industries*, vol. 2, Commonwealth of Australia, Canberra, 1999, p. 23.16.

- failure to incorporate stakeholder input; and
- lack of transparency and accountability.⁵³

11.51 During this inquiry, the Australasian Casino Association commented that a review of the current arrangements overseeing GRA was warranted because 'there has been overlap and duplication of research projects with little consideration given to coordination at the national level'.⁵⁴

11.52 Dr Sally Gainsbury also noted the less than ideal situation for research funding in Australia where the majority of funds came from 'government-related organisations for prescribed projects, often with unrealistic timeframes and expected outputs'. She was critical also of certain organisations, including GRA:

...which receive funds from the gambling industry, demand that they jointly own copyright, and in some cases are able to restrict publication of results, leaving very little incentive for universities to permit their researchers from accepting such grants. In the case of Gambling Research Australia, who encourages publication of results in scientific journals, this organisation also demands the right to place full copies of research reports online, which generally happens before researchers would be able to publish results in scientific journals, subsequently dramatically hindering the publication process.⁵⁵

Committee view

11.53 In recognition of significant gaps in research, data collection and coordination, the committee sees the need for a more strategic approach to the national research effort around gambling. A greater focus on the risks of gambling harm and a less 'ad hoc', more systematic and directed research agenda is required. The committee also notes shortcomings in relation to the capacity and independence of the current research body, Gambling Research Australia. Both of the committee's previous reports recommended the establishment of a national, accountable and fully independent research institute on gambling.⁵⁶ The committee notes that the government response to this recommendation has been that future research arrangements are a matter for

53 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.13.

54 Australasian Casino Association, *Submission 46*, p. 10.

55 Dr Sally Gainsbury, *Submission 37*, pp 11–12.

56 Parliamentary Joint Select Committee on Gambling Reform, *First Report: The design and implementation of a mandatory pre-commitment system for electronic gaming machines*, May 2011, p. 92; Parliamentary Joint Select Committee on Gambling Reform, *Second Report: Interactive and Online Gambling and Gambling Advertising and Interactive Gambling and Broadcasting Amendment (Online Transactions and Other Measures) Bill 2011*, December 2011, p. 42.

discussion through the COAG process.⁵⁷ The committee is not aware of any progress being made in responding to its recommendations around research. The committee remains very disappointed that little progress has been made towards instituting this or a similar body given the calls to improve research in this area over many years. Once again, the committee firmly reiterates the need for such a body to drive and coordinate gambling research in Australia.

Recommendation 9

11.54 The committee reiterates its call for a national independent research institute on gambling, as originally proposed by the Productivity Commission and recommended in the committee's previous two reports.

11.55 As already recommended in chapter two, the committee considers that a national research program could be further strengthened by designating gambling as a National Health Priority Area under the National Health and Medical Research Council (NHMRC) and as an 'associated priority goal' under the Australian Research Council (ARC). This would be consistent with the public health framework approach to gambling supported by the committee in chapter two.

Independence of research and funding sources

11.56 A contentious issue that came up during the inquiry was industry involvement and funding of research efforts into gambling. The Productivity Commission's (PC) 2010 report recognised that industry participation in or funding of research entailed both opportunities and risks. On one hand, industry involvement could improve access to data, provide assessments of compliance costs and technical and practical matters associated with policy implementation; on the other hand, there is the potential for conflicts of interest and a perception that findings based on industry data may not be reliable.⁵⁸

11.57 The PC also noted that there are 'no clear examples of other industries that generate harm being directly involved in publicly funded, policy focussed research to reduce harms associated with the use of their product'.⁵⁹

11.58 Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, observed that there has been a 'long history of public health researchers looking to independence in research and not accepting industry money, because of the obvious contamination

57 Government Response to the Parliamentary Joint Select Committee on Gambling Reform – First Report: The design and implementation of a mandatory pre-commitment system for electronic gaming machines, p. 8.

58 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.23.

59 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.25.

potential there'.⁶⁰ She advocated for research funding to be overseen by a central body to ensure that funding sources for researchers are distanced from potential conflicts of interest:

If we are going to accept industry money, and as you said it is a well-funded industry, then it needs to be well and truly at arm's length. What we have at the moment is some direct funding into research for prominent researchers who are basically rolled out for the case and get picked up by the media, and I think it really skews our knowledge about this issue. There are precedents in other areas such as tobacco and alcohol where we have had to look clearly at how research is funded and put industry money at arm's length from the researchers, but we certainly have not achieved that in this area at the moment.⁶¹

11.59 Mr Tom Cummings highlighted what he viewed as 'an inherent conflict of interest' arising from gambling research and studies that are funded by industry, arguing that 'a far greater level of truly independent research into problem gambling in Australia, and an organisational structure that supports this approach [is needed]'.⁶²

11.60 The Responsible Gambling Advocacy Centre (RGAC) raised concern about researchers who did not always declare their funding sources in publicly accessible ways. Its submission noted that in other sectors, such as medicine or business, plain language professional declarations of interest are used. RGAC argued:

To ensure that the community can appreciate the basis of evidence given, interpret research in an informed manner, and invest trust in findings and evaluations, RGAC argues that clear declarations of funding sources is necessary. These should provide answer[s] to questions such as:

- Who funds your current research?
- Who has funded your past research and work?
- What third party consultancies do you receive a retainer from, or have engaged you on a 'fee for service' basis?
- Do you receive a retainer from any organisations (other than your academic institution)?
- Do you own or directly hold shares in an organisation connected with the provision of gambling services?⁶³

60 Ms Roberts also referred to the recently formed Lonsdale Coalition of Independent Researchers, which will not accept funding from the gambling industry or associated groups, *Committee Hansard*, 2 May 2012, p. 40. See also 'Gambling reformers to learn from public health campaigns past', 17 February 2012, <http://www.monash.edu.au/news/show/gambling-reformers-to-learn-from-public-health-campaigns-past> (accessed 25 July 2012).

61 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 40.

62 Mr Tom Cummings, *Submission 22*, p. 5.

63 Responsible Gambling Advocacy Centre, *Submission 35*, p. 11.

11.61 Dr Samantha Thomas also affirmed the importance of independence in research to support the development of social marketing campaigns to address gambling:

It is encouraging to see the funding of independent research that is able to provide policy makers and other community stakeholders with detailed information about how individuals conceptualise the risks and benefits of gambling, and how different groups make meaning of gambling within their personal and social contexts. This information is essential in tailoring messages and interventions which are able to provide an effective alternative to the messages given by the gambling industry. Evidence from other health and social issues (such as tobacco) have also highlighted the importance of independence in social marketing initiatives – that is, that they are designed with communities, and are free from industry influences in the design and promotion of the initiatives.⁶⁴

11.62 Dr Thomas observed that the issue with independence was not so much the relationship of researchers with industry but the transparency of that relationship.⁶⁵ She commented that declaring interests systematically should be the natural, common practice for all researchers and told the committee that an international code of conduct for gambling researchers would be desirable:

Then people like you and the community and so on can weigh up the evidence that we have presented in the light of those interests. I think at the moment we have a lot of shades of grey and it is all a bit murky around who funds who and who does not and what that means and so on. So clearer transparency will help that.⁶⁶

11.63 Dr Thomas gave the example of the data made available by the tobacco industry which then informed and improved tobacco regulation and policy:

One of the things I think was most valuable in the tobacco industry was when tobacco industry corporate documents were made available for researchers so that we could clearly look at their marketing strategies and we could clearly see when they were targeting different groups. For example, we could clearly see when they were targeting young people. We can start to use regulation to create more clarity and transparency in the industry so that people like me can start to look at that in more detail, and then we will start to see a cultural shift. But they do not do it willingly, obviously.⁶⁷

11.64 Associate Professor Peter Adams, a New Zealand gambling academic, provided a submission which questioned the integrity of the current knowledge base due to 'widespread conflicts of interest associated with the profits from gambling'. He

64 Dr Samantha Thomas, *Submission 52*, p. 6.

65 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 24.

66 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, p. 24.

67 Dr Samantha Thomas, *Committee Hansard*, 3 May 2012, pp 24–25.

raised caution about distortions in current gambling literature, noting that it was still commonplace for gambling researchers to accept funding from industry, whereas this was not the accepted practice in other fields (e.g. tobacco and alcohol studies). Associate Professor Adams asserted that researchers who accept industry funds will have an interest in taking on projects or presenting results 'which conform (or at least avoid challenging) industry interests' and that:

...as a result, much of the funding for research has been over-invested in two safe and convenient but overall minimally useful areas, namely large population surveys and treatment evaluation research. Little has been invested in approaches that might make a difference in reducing gambling harm.⁶⁸

11.65 However, in contrast, Dr Sally Gainsbury argued that greater cooperation between researchers and stakeholders must take place to advance gambling research.⁶⁹ She noted the views of some in the research community who 'immediately derided' colleagues that collaborated with industry for research purposes and countered these views with the following statement:

Although this argument may be highly principled, it is somewhat irrational given that actual research on gamblers cannot be conducted in isolation from the industry. Furthermore, any researchers that refuse to engage in collaborative research or accept funding through direct or indirect industry sources (including any funds coming from government bodies or organisations that receive funds from the government such as NHMRC due to taxes obtained from gambling) are unlikely to achieve any career enhancement.⁷⁰

11.66 The Australasian Gaming Council supported the concept of strengthening stakeholder partnerships, describing such links as 'integral to fostering a solid research agenda that incorporates evidence and learning about all forms of gambling, gamblers and the gambling industry'. Its submission promoted the benefits of 'tripartite' arrangements between government, community and industry:

Good examples of industry, government and research collaborative effort (for example in the pre-commitment trials and evaluations that have been held in Queensland and South Australia) already exist.

68 Associate Professor Peter Adams, *Submission 39*, pp 1–2. See also Adams, P., 'Ways in which gambling researchers receive funding from gambling industry sources', *International Gambling Studies*, Vol. 11, No. 2, August 2011, pp 145–52; Adams, P., Buetow, S. and Rossen, F., 'Poisonous partnerships: health sector buy-in to arrangements with government and addictive consumption industries', *Addiction*, 2010, 105: 585–90; and Adams, P., 'Redefining the gambling problem: The production and consumption of gambling profits', *Gambling Research*, May 2009, Vol. 21, No. 1, pp 51–4.

69 This need for cooperation was also supported by Professor Alex Blaszczynski who gave the committee an example of a lack of cooperation by industry for an evaluation of a research project on 1c gaming machines, *Committee Hansard*, 2 May 2012, p. 10.

70 Dr Sally Gainsbury, *Submission 37*, p. 13.

Advisory groups that represent tripartite stakeholder views are also evident in various jurisdictions throughout Australia and a similar stakeholder construction has provided input to the federal government on pre-commitment via the Ministerial Expert Advisory Group (MEAG).

This collaborative partnership approach should be extended to offer industry a seat at the table when determining a national research agenda.⁷¹

11.67 The Australasian Casino Association also agreed that industry stakeholders should be included in determining future research programs.⁷²

Committee view

11.68 The committee notes that declaration of conflicts of interest would be required as a condition of funding gambling research projects if gambling was designated as a National Health Priority Area under the National Health and Medical Research Council or as an associated priority goal recognised by the Australian Research Council as recommended in chapter two. The committee considers that these declarations should also be made public.

11.69 While noting that collaboration with industry can be extremely useful for gambling researchers in terms of access to data, gambling venues and even funding sources, the committee also sees merit in ensuring transparency about the nature and extent of such relationships.

11.70 The committee believes that gambling research funded by the Commonwealth Government and made public should include disclosure of any conflicts of interest and the nature and extent of any relationship with industry and the committee encourages jurisdictions to follow this approach. The research should also disclose any additional sources of funding.

Recommendation 10

11.71 The committee recommends that any gambling research funded by the Commonwealth Government and made public should include: disclosure of any conflicts of interest; details about the nature and extent of any industry involvement; and list any additional sources of funding. The committee encourages jurisdictions to follow this approach.

71 Australasian Gaming Council, *Submission 33*, p. 29. Note: the Ministerial Expert Advisory Group (MEAG) was established in 2010 and it is understood that the MEAG last met in mid-2011. See: http://www.google.com.au/url?sa=t&rct=j&q=meag%20fahscia&source=web&cd=6&ved=0CD0QFjAF&url=http%3A%2F%2Farchive.treasury.gov.au%2Fdocuments%2F1958%2FPDF%2F10_Final_MEAG_papers.pdf&ei=TMN0ULiCHYGiiGFV_IHwCQ&usg=AFQjCNHkKsZaE6-hjtxPelAeqW_NxfeAQ (accessed 9 October 2012).

72 Australasian Casino Association, *Submission 46*, p. 10.

Data collection

11.72 Evidence on data collection issues was also extensively covered during the inquiry. The following section will raise a number of these issues, including the need for a national dataset and well as greater public access to data, especially to data collected by industry. As noted by AMC Convergent IT, data collection sheds light on gambling behaviour and can be used as a resource for further research into the prevention and treatment of problem gambling.⁷³

11.73 The Productivity Commission's (PC) view, as outlined in its 1999 and 2010 reports, was that systematic data collection across Australia should be taking place so that accurate analyses of different interventions can be done:

That means that you have to collect similar sorts of outcomes data, similar sorts of data about the population and similar sorts of data about what treatments were applied. In the absence of that we are not entirely flying blind, but we are not flying entirely informed either. The studies should be undertaken in an independent fashion and peer reviewed, in the typical way that you would undertake clinical trials.⁷⁴

11.74 Ms Rosalie McLachlan, Inquiry/Research Manager, PC, told the committee that there were limitations in the gambling data compilations in the PC's own reports because it was very difficult to compare existing data across jurisdictions.⁷⁵ Mission Australia also raised this point.⁷⁶

Examples of data collection

11.75 Some submitters, including states, provided examples in their submissions of their data collection activities.

11.76 For NSW, gambling information regularly collected by the Office of Liquor, Gaming and Racing includes data about: the 24 hour gambling helpline; usage of free face to face Gambling Help counselling and treatment services; usage of the national *Gambling Help Online* service; quality of services provided; effectiveness of problem gambling awareness activities such as changes to client contacts and traffic on relevant websites. This data is used by the Office to 'evaluate and improve current programs as well as informing the development of new programs to help prevent and treat problem gambling'.⁷⁷

73 AMC Convergent IT, *Submission 34*, p. 5.

74 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 42.

75 Ms Rosalie McLachlan, *Committee Hansard*, 14 May 2012, p. 43.

76 Mr David Pigott, *Committee Hansard*, 2 May 2012, p. 4.

77 NSW Government, *Submission 51*, p. 8.

11.77 The Tasmanian Department of Health and Human Services described its Client Information System which is a database for collecting client demographics, gambling behaviour and treatment information.⁷⁸

11.78 BetSafe's submission described the client data it kept in relation to its counselling and self-exclusion programs. This is provided to the NSW Office of Liquor, Gaming and Racing on a de-identified basis. Limitations in gaining an accurate picture of the success of BetSafe counselling services were also described in the submission:

One of the issues faced by BetSafe as well as other providers of counselling services is the difficulty in gaining an accurate picture of clients success in controlling their gambling after they have completed their counselling or been readmitted to gambling venues. It seems likely that the former counselling clients and former excluded patrons who have succeeded in overcoming their gambling problems are more willing to provide feedback on their successes than those who are still struggling or have relapsed.

We believe that there is a need for a large-scale national evaluation of counselling and self-exclusion initiatives to enable comparisons to be made between the different program elements. This would provide a basis for the development of a best practice benchmark.⁷⁹

Sample size and measurements

11.79 Dr Clive Allcock's submission noted that while it was pleasing that more research into gambling was being carried out, better 'information exchange' could occur by establishing linkages across jurisdictions in order to increase sample sizes:

...similar topics could be explored at the same time in different States and the work be joined to increase sample size and make more relevant findings. Most work that focuses on problem gamblers is hampered by small samples and it is not correct to take those scored in surveys as being at "moderate risk" and then add them to the problem gamblers to reach a conclusion. Some reports suggest these are two different groups or that the validity of the at risk groups is a dubious concept and so conclusions based on such groupings may be wrongly reached.⁸⁰

11.80 Associate Professor Peter Harvey, Manager, Statewide Gambling Therapy Service, also noted that over the last 10 to 15 years, prevalence measurements had changed, so getting accurate data was therefore more complicated.⁸¹

78 Tasmanian Department of Health and Human Services, *Submission 47*, p. 15.

79 BetSafe, *Submission 32*, p. 17.

80 Dr Clive Allcock, *Submission 6*, p. 8.

81 Associate Professor Peter Harvey, *Committee Hansard*, 14 May 2012, p. 2.

Need for a national dataset

11.81 The committee heard calls for a national gambling dataset. Mr Mark Henley, Member, Australian Churches Gambling Taskforce, noted that a national dataset 'which can be accepted as beyond reproach' was needed as a sound basis for developing good policy.⁸²

11.82 The Turning Point Alcohol and Drug Centre also pointed out that while it operated four of the eight statewide gambling helplines in Australia, each minimum dataset differed in terms of labels and values (e.g. type of gambling, ethnicity versus cultural identity):

In addition, research currently being undertaken on Gambling Help Online suggests jurisdictional differences in demographics and gambling involvement. A single national minimum dataset would lead to greater ease of comparisons between jurisdictions.⁸³

11.83 The Productivity Commission (PC) looked closely at the value of developing a national minimum dataset and concluded that there would be clear benefits to jurisdictions working collaboratively on data collection efforts 'to obtain more comprehensive coverage and greater consistency'.⁸⁴ Ideally, the PC envisaged jurisdictions conducting surveys on gambling prevalence at the same time and using the same sampling approaches. Concerns about governments collecting gambling data were also raised, with the PC acknowledging the confidentiality and privacy concerns inherent in data collection activities. However, the PC noted these concerns are managed by de-identifying and disaggregation of data.⁸⁵

11.84 Ultimately, the PC recommended that all jurisdictions should improve the usefulness and transparency of gambling survey evidence by:

- conducting prevalence surveys using a set of core questions that are common across jurisdictions;
- ensuring that surveys meet all relevant National Health and Medical Research Council standards and guidelines, so as not to limit their use by researchers; and

82 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 15.

83 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 12.

84 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.4.

85 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, pp 18.5–18.8.

- depositing all survey data into a public domain archive, subject to conditions necessary to manage confidentiality risks and other concerns about data misuse.⁸⁶

Committee view

11.85 The committee sees value in the establishment of a national minimum dataset on gambling. The committee recognises the significant gains that could be made in designing evidence-based policy if gambling data were more easily accessible and collected in a nationally consistent manner. In line with the Productivity Commission's recommendation,⁸⁷ the committee supports joint efforts by jurisdictions to improve the consistency and transparency of gambling survey data in order to create a publicly available national dataset.

Recommendation 11

11.86 The committee recommends that the COAG Select Council on Gambling Reform work to establish a national minimum dataset on gambling, in line with the Productivity Commission's recommendation. The dataset should be made publicly available.

Access to data

Access to industry data

11.87 Gaining access to industry data was also raised a key area for further development. The Australian Churches Gambling Taskforce noted that much useful data could be gained from loyalty programs run by the gambling industry:

There is a large amount of helpful data collected in Australia that is not available to inform public policy development, because it is controlled by the gambling industry through loyalty schemes and industry controlled monitoring systems. This data needs to be held by regulators and made available, in de-identified form, to policy makers and researchers.

Gambling providers know who spends how much, on which machines and when, data that is used to effectively target individual gamblers to extend their gambling. This sort of information, even in basic form is not available outside of the industry, an unsatisfactory situation.⁸⁸

11.88 Mr Ross Ferrar, Chief Executive Officer, Gaming Technologies Association Ltd, was asked about the potential for release of industry data in order to assist the gambling policy research effort:

86 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.8.

87 Recommendation 18.1 in Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.8.

88 Australian Churches Gambling Taskforce, *Submission 50*, p. 13.

Senator XENOPHON: Would you have a difficulty if there were a legislative requirement through an accredited research body or, for instance, under the auspices of the Australian Research Council and if it said, 'These researchers want access to your data, how the machines work, the par sheets and the probability counting reports'? Do you think your members would have a difficulty with that if it were mandated?

Mr Ferrar: Our members compete with each other fiercely for sales, as in any other industry, I guess. Provided that their commercial confidentiality is protected, absolutely not—they would have no problem with providing access to any part of their premises. In fact, as I mentioned here earlier, a company licensed by jurisdiction—in some cases our members are licensed in over 300 jurisdictions—must provide access to appropriate regulatory and investigatory authorities for each of those jurisdictions. They have no difficulty with providing access provided their commercial confidentiality is protected.⁸⁹

Public access to data

11.89 Concerns about the extent to which useful and comparable gambling data is made available to the public were also raised. Mr Tom Cummings gave his perspective on the problem of inconsistency in data collection and varying degrees of access to this information. He advocated a 'national reporting standard', citing the Victorian approach as the template for the rest of the country to follow:

...the requirements for the collection and reporting of gambling data, especially with regards to poker machines, vary wildly from state to state. We find ourselves in a ludicrous position where venue-specific and LGA [Local Government Area]-specific financial information is freely available to the public for all Victorian poker machine venues, yet across the border in New South Wales the same information is only available on request, in a limited fashion that excludes actual revenue figures, and only after paying hundreds of dollars for the reports which are for personal use only.

...Without access to this kind of information, it is practically impossible to judge what kind of financial impact gambling is having in any given area.⁹⁰

11.90 The PC also noted the stark jurisdictional imbalances in terms of access to gaming machine data. While Victoria, South Australia and Queensland provide 'regular and locally disaggregated data' about poker machine revenue, New South Wales does not. The PC noted this was 'a major obstacle to independent analysis and community debate'.⁹¹

89 Senator Nick Xenophon and Mr Ross Ferrar, *Committee Hansard*, 2 May 2012, pp 53–54.

90 Mr Tom Cummings, *Submission 22*, pp 4–5.

91 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.9.

11.91 For example, in Victoria, the Minister has determined that access to gaming expenditure data from clubs and hotels is in the public interest and full details about gaming machine revenues for individual community gaming businesses are available online.⁹²

11.92 The PC argued that the gambling data collection and research effort would be much improved if jurisdictions agreed to:

- collect a basic level of nationally consistent industry data;
- make these data freely accessible;
- disaggregate EGM data by location (local government area) and venue type (club, hotel and casino); and
- publish more comprehensive data for casino gaming and wagering.⁹³

Committee view

11.93 The committee agrees that industry data on gambling behaviour and revenue is valuable and can contribute to strengthening the evidence base on problem gambling. The committee notes the undertaking given by Mr Ross Ferrar of the Gaming Technologies Association that there would be 'no difficulty with providing access' to data for researchers, as long as commercial confidentiality is protected.

11.94 In addition, the committee takes the view that in order to achieve greater transparency and better data on gambling, governments should agree to collect a basic level of nationally consistent industry data, as recommended by the Productivity Commission. In terms of public access to data, the committee notes the glaring inconsistencies between different jurisdictions around the presentation of gambling data for use by researchers and the public. The committee considers that the COAG Select Council on Gambling Reform should consider applying the approach taken by the Victorian Government as a possible model for data accessibility and transparency across all jurisdictions.

Recommendation 12

11.95 The committee recommends that the COAG Select Council on Gambling Reform establish agreed parameters around the collection by governments of a basic level of nationally consistent industry data on gambling.

92 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.9.

93 Productivity Commission, *Gambling*, vol. 2, Commonwealth of Australia, Canberra, 2010, p. 18.10.

Evidence base for treatment

11.96 The committee heard that there was some reliable evidence to recommend particular forms of treatment for problem gambling, although overall the evidence base for the effectiveness of treatment was not as robust as it could be.⁹⁴

11.97 According to the PC, gambling treatment outcome studies, irrespective of the type of treatment provided (behavioural, cognitive or a combination), report that the majority of people receiving treatment respond to and benefit from treatment (with abstinence or controlled gambling). In addition:

- studies generally show that the probability of relapse increases with time;
- there is a lack of evidence on treatments from randomised clinical trials with good follow-up assessments;
- the best evidence and support is for cognitive-behavioural treatment approaches;
- while limited, client outcome data collected from gambling counselling services show the majority of people who seek formal help are able to better manage their gambling problems following counselling and treatment.⁹⁵

11.98 The PC also noted, however, that there is a significant lack of evidence as to what constitutes effective treatment:

It is not surprising—there are lots of complexities in this area in gauging what works. That said, you do not have to be entirely pessimistic about what options are available. While the evidence is not as strong as would be desirable, the cognitive behavioural therapy has looked to be the better of the variety of options that are available. However, there is a range of other approaches which have some merit. General counselling has clear merit. Pharmacological interventions are sometimes suggested. Our consultations in the Australian circumstance suggested significant apprehension about those approaches, but US researchers have certainly investigated them and some work suggests that they have roughly similar efficacy to psychological interventions. However, it is an area of some complexity—especially when there are comorbidities present.⁹⁶

11.99 The Australian Psychological Society (APS) argued that much more work needed to be done to strengthen the evidence base for treatments. Professor Debra Rickwood, Professor of Psychology, University of Canberra; and Fellow, APS, drew

94 One of the key difficulties in the evaluation of problem gambling treatment is that there are few studies comparing the effectiveness of different treatment modalities. See discussion in Gonzalez-Ibanez, A., Rosel, P. and Moreno, I., 'Evaluation and Treatment of Pathological Gambling', *Journal of Gambling Studies*, Vol. 21, No. 1, Spring 2005, pp 35–42.

95 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, pp 7.31–7.33.

96 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

the committee's attention to existing evidence-based work on treatment guidelines done by the Problem Gambling Research and Treatment Centre at Monash University:⁹⁷

...we do have some knowledge of effective treatments in this field, although there are no studies that currently meet the highest level of efficacy standards for treatment in problem gambling. But I draw your attention to some work that has been done by the Problem Gambling Research and Treatment Centre. They put out some guidelines, which were developed in line with appropriate NHMRC procedures, for screening, assessment and treatment which trawl through all the evidence in a very thorough way and show that there is level B evidence—so the second grade of evidence for some treatments. That means that we have a body of evidence that can be trusted to guide practice in most situations but certainly not in all situations. These guidelines recommend cognitive behavioural therapies and motivational enhancement types of treatment as effective, delivered both individually and in groups.⁹⁸

11.100 Describing the evidence base for different treatments trialled at the University of Sydney Gambling Treatment Clinic, the submission from the Clinic noted several treatments trialled have 'failed to reach our minimal standards for efficacy'. These included Solution Focused Brief Therapy, which is 'popular and widely used' and focuses on client strengths but not on explicit discussion of gambling behaviour:

As such, it was a relatively simple therapy to learn that required no research or technical knowledge from therapists. In the early sessions of this therapy, both therapists and clients reported a high level of enjoyment of the therapy as there was little to no discussion of the client's difficulties and little to no resulting distress during appointments. In 2007, we were forced to discontinue the use of this treatment research due to extremely poor client outcomes and high relapse rates in even the short-term.⁹⁹

11.101 The Clinic also looked at Imaginal Desensitisation:

...a treatment modality that focuses on pairing thoughts of gambling stimuli to relaxation. Whilst this treatment has received some support in the past in trials conducted in inpatient settings, here at the outpatient setting of the Gambling Treatment Clinic, we also discontinued a trial of this treatment due to extremely poor compliance with essential components of the treatment and extremely high relapse rates in the short, medium and longer term.¹⁰⁰

97 The *Guideline for screening, assessment and treatment in problem gambling* from the Problem Gambling Research and Treatment Centre is available from: <http://www.med.monash.edu.au/sphc/pgrtc/guideline/index.html> (accessed 16 July 2012).

98 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 28.

99 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 6.

100 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 6.

11.102 Professor Malcolm Battersby's submission highlighted to the committee some work that had been done in the UK (the National Health Service Improving Access to Psychological Therapy Services) in relation to clinical therapy for anxiety and depression, suggesting that such a rigorous, evidence-based program could be a model for application here in Australia for treatment of problem gambling:

The National Institute of Clinical Excellence (NICE) recommended the brief cognitive and behavioural therapy approaches for anxiety and depression in a stepped care model i.e. from low intensity to high intensity with adjunct social prescribing for social isolation and signposting to community services e.g. unemployment, marital, financial counselling. New (community members) and existing therapists were trained in a one year national curriculum to the low intensity counsellors and existing cognitive behavioural psychologists and other health professionals were trained to be high intensity therapists. i.e. when a person was too complicated for brief – 5-10 sessions they were 'escalated' to high intensity therapy. These services have been provided across the UK to over 110,000 people. A key element of the model is that all clients have outcome measures taken at each session using an electronic data management system called PC-MIS (York University). Data completion rates of over 95% have been achieved. Outcomes have been impressive with over 50% of those attending achieving recovery.¹⁰¹

Evaluation of treatment

11.103 Noting that the overall evidence base needs enhancement, gambling treatment providers also reinforced the importance of evaluation and consistent outcome measurement during the inquiry. Evidence to the committee suggested that there is a need for better benchmarking of outcomes and more consistent follow-up practices with clients who have accessed treatment services. Ways to incorporate better research and evaluation practices into clinical services were also put forward.

11.104 For example, Mission Australia noted there was a need for more research into the efficacy of different treatment methods, mentioning also its current work with the Australian National University's Centre for Gambling Research on an evaluation of Mission Australia's ACT gambling counselling services.¹⁰²

11.105 The Australian Psychological Society (APS) cited the Problem Gambling Research and Treatment Centre's (PGRTC) 2011 guideline as exemplifying best practice in Australian gambling treatment services. However, the APS also noted that insufficient evidence in these areas also led to weaknesses in making firm recommendations about treatment:

The recent PGRTC (2011) Guideline notes that 'given the current immaturity of the research literature in the problem gambling field, only a

101 Flinders University, Professor Malcolm Battersby, *Submission 8a*, pp 4–5.

102 Mission Australia, *Submission 17*, p. 7.

few evidence-based recommendations could be formulated in this guideline' (p.15). The insufficient evidence for effective screening and assessment tools and treatment approaches however does not suggest that these are ineffective or of poor quality, but that there is insufficient evidence to determine the current state of knowledge about their effectiveness.¹⁰³

11.106 The APS stated that limited pre and post evaluation of treatment had 'inhibited the evidence base' and what evidence was available was characterised by shortcomings:

While the treatment outcome literature provides some research evidence about the effectiveness of treatment with problem gamblers, this literature is characterized by a range of methodological limitations, including small sample sizes, high attrition rates, low numbers of women affected by problem gambling and heterogeneity in forms of gambling.¹⁰⁴

11.107 Improvements in research about interventions for different subtypes of problem gamblers could ideally lead to clinicians being able to 'offer more definitive and individually tailored intervention recommendations'.¹⁰⁵

Incorporating research into clinical services

11.108 One of the key ways to improve evaluation of treatment services would be to incorporate measurements of success (or benchmarking) into service delivery, which is already done to some extent by a number of treatment providers who gave evidence.

11.109 The University of Sydney Gambling Treatment Clinic suggested that a compulsory part of gambling service delivery should be a requirement for evaluation to be undertaken:

The existence of free services that are widely available across New South Wales is laudable, but it remains a contentious issue that services can continue to be funded without documenting the standards and effectiveness of their treatments.¹⁰⁶

11.110 The Clinic described its own evaluation and follow-up practices:

In following up with clients, we contact them six months, one year and two years after we have finished treatment to get a sense of how they are going. We do that by giving out formal questionnaires about the amount of money they are spending gambling at that time, the amount of time they are gambling and specific questions about any harm they are experiencing at that time which may be related to gambling. Two years after treatment is

103 Australian Psychological Society, *Submission 49*, p. 12.

104 Australian Psychological Society, *Submission 49*, p. 12.

105 Australian Psychological Society, *Submission 49*, p. 13.

106 University of Sydney Gambling Treatment Clinic, *Submission 10*, p. 8.

quite a long period but we find that, if people are going to relapse, it is at the six-month to one-year mark, so that is the time you need to have as a minimum. A lot of treatments do only the six-month follow-up option, and we find that most clients who go through treatment, regardless of the treatment, are still doing pretty well at six months, but it is that six-month to one-year mark where things may start to fall apart a bit, which is why we like to do that longer term follow-up.¹⁰⁷

11.111 Dr Clive Allcock also suggested a 'six monthly follow up at a minimum and preferably one year also' with a standardised short interview format to assist such evaluation. He added:

Many follow ups will need to be done out of normal working hours to catch those working themselves and to so maximize the number of follow-ups able to be achieved. It should be made clear to those seeking help that a reluctance to agree to follow up does not prevent their receiving help.¹⁰⁸

11.112 St Vincent's Hospital described for the committee how they conduct routine follow-up:

We do use questionnaires. We see how many criteria for problem gambling a person meets. We also do a quantity frequency analysis to see the change of our treatment. Part of this is because clinical psychologists are trained to work out, 'Did what we did work?' It is like a doctor would say, 'Is it less painful now?' I am surprised when I hear that other services are not doing follow-ups or that they are annoyed that they have to. It should just be routine, and actually it is pretty much routine practice for clinical psychologists to just measure pre and post and then at follow-ups. It helps the clients as well.¹⁰⁹

11.113 The Turning Point Alcohol and Drug Centre's submission emphasised the current work being done to embed evaluation measures into its treatment services. It described itself as uniquely placed to develop and evaluate evidence-based interventions and provided the following example of how evaluation work is undertaken:

In 2008, Turning Point undertook a quantitative and qualitative review of calls from family and friends to the Queensland and Victorian helplines. This included an internal analysis of data over three years including presenting issues and contact outcomes (such as counselling and referral interventions). In parallel, Turning Point undertook a series of interviews with helpline counsellors to identify knowledge and attitudinal factors in responding to this population.

Issues identified through this project were reviewed in the context of (limited) practice literature, resulting in a checklist to assist counsellors to

107 Mr Christopher Hunt, *Committee Hansard*, 14 May 2012, p. 61.

108 Dr Clive Allcock, *Submission 6*, pp 7–8.

109 Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 19.

respond to family members in Queensland. Counsellors were then engaged in a series of group exercises to promote learning outcomes and further development of the checklist. Learnings from this project were also presented to the Gambling Help network at the annual Queensland forum in 2008 and have been extended to all Gambling Helplines.

This initial investigation involving family and friends prompts further questions on how best to treat this group. Little is known on whether brief interventions are effective, the most efficient delivery of services (e.g., helpline, online, face-to-face) or key ingredients for evidence based interventions (e.g., increasing confidence, reducing distress) for concerned family or friends.¹¹⁰

11.114 Evidence from Turning Point also emphasised the importance of evaluating brief interventions, which are often excluded from research on problem gambling treatments. Its submission described the growing international evidence base for single session and brief interventions.¹¹¹

11.115 Turning Point advocated the development of evidence-based national guidelines for single session online interventions (which attract a large number of clients), as well as standardised screening and treatment guidelines for brief and short-term interventions over the phone and online.¹¹²

Example of a model—Statewide Gambling Therapy Service

11.116 Professor Malcolm Battersby promoted the work of the Statewide Gambling Therapy Service (SGTS) in South Australia as a 'national model' for such evaluation systems:

I think what we have done...should be a national model. We have asked every single patient or client who comes to our service to sign a consent form for longitudinal data collection. In other words, every patient who comes in has agreed to be followed up over the next three years to provide outcome data.¹¹³

11.117 Close collaboration between the SGTS and the Flinders Centre for Gambling Research (FCGR) is forming a more robust evidence base for the efficacy of cognitive behavioural therapy approaches to problem gambling 'as this body of work, including book chapters, treatment manuals, journal articles and presentations, chart patients' journeys through treatment and document short and longer-term treatment outcomes'.¹¹⁴ Current studies are outlined below:

110 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 13.

111 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 12.

112 Turning Point Alcohol and Drug Centre, *Submission 42*, p. 13.

113 Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 2. See also Flinders University, Professor Malcolm Battersby, *Submission 8a*, p. 2.

114 Flinders University, *Submission 8*, p. 2.

SGTS, in collaboration with the Flinders Centre for Gambling Research [FCGR] is also exploring relapse prevention strategies and the application of peer-led, self-management programmes to assist recovered gamblers to prevent relapse to problematic gambling following treatment...The service is also diversifying its treatment options to include clients from culturally and linguistically diverse (CALD) and Aboriginal communities...with programme adaptations, bi-lingual educational materials and a new treatment manual now in place for Vietnamese people with gambling problems.

Currently the FCGR is working on a number of studies exploring the efficacy of behavioural, cognitive and cognitive behavioural therapy in the treatment of disordered gambling. An initial randomised controlled trial conducted through the FCGR is looking at the benefits of pure exposure therapy compared with pure cognitive therapy...and a larger study is being developed in collaboration with Professor Ladouceur from Laval University in Canada and Professor Abbott in Auckland, NZ, to investigate the relative merits of a number of other treatment options for people experiencing gambling disorders.¹¹⁵

11.118 Ideally, the SGTS would like evaluation to move 'beyond self-reported outcome measures in problem gambling treatment including the use of physiological measures and more direct methods for collecting data on the rates of use and impact of gaming technologies...'.¹¹⁶

Committee view

11.119 The committee supports the objective of incorporating consistent outcome measurements into gambling treatment services in order to evaluate success and contribute to the broader evidence base.¹¹⁷ It commends the work already being done by a range of service providers to integrate their own benchmarking practices to achieve this goal. However, much greater national coordination is required before robust and uniform outcome measurements are fully embedded across the treatment system.

11.120 As a first step towards this goal, the committee supports the COAG Select Council on Gambling Reform, along with treatment providers and relevant health professional bodies, working collaboratively to ensure that consistent outcome measurement practices are built into gambling treatment services (as appropriate for individual services). The committee also notes that these proposed arrangements could

115 Flinders University, Professor Malcolm Battersby, *Submission 8a*, p. 4.

116 Flinders University, *Submission 8*, p. 3.

117 For example, the Department for Communities and Social Inclusion (SA) has implemented reporting strategies across the South Australian Gambling Help Services to enable the consistent measurement of the effectiveness of gambling treatment interventions. See correspondence from the Office for Problem Gambling, Department for Communities and Social Inclusion (SA), received 24 May 2012.

be strengthened, for example, by making funding dependent on treatment services having their own benchmarking practices in place.

11.121 Better benchmarking practices will contribute to the broader effort around evaluation of the effectiveness of treatment interventions for problem gambling. The committee notes that these initial steps would also be in line with the concept of 'translational research', which attempts to create better information flows or 'translation' between basic research and practical applications of research in clinical settings.¹¹⁸

Recommendation 13

11.122 The committee recommends that the COAG Select Council on Gambling Reform work collaboratively with gambling treatment providers and relevant health professional bodies to build appropriate evaluation measures and benchmarking practices into gambling treatment services.

Mr Andrew Wilkie MP

Chair

118 Translational research encompasses a two-way information flow between research and clinical settings – i.e. it can be characterised as 'bench to bedside' but also relies on clinical observations and findings informing further research. For further information see: 'Translational Research', <http://commonfund.nih.gov/clinicalresearch/overview-translational.aspx> (accessed 24 July 2012). The new Australian National Preventative Health Agency has also been provided funding of \$13.1 million to focus on translational research in the context of preventative health; see media release from the Hon Julia Gillard MP and the Hon Nicola Roxon MP, 'Biggest investment in Australia's history to fight preventable diseases', 26 October 2010, <http://www.pm.gov.au/press-office/investment-fight-preventable-diseases> (accessed 25 July 2012).

Chair's additional comments

1.1 Witnesses to this inquiry expressed disappointment that no progress has been made on poker machine reform by the Commonwealth. This disappointment involved not only the Prime Minister breaking her commitment to implement the gambling reforms agreed to after the 2010 federal election, but also the watered down package of reforms announced on 21 January this year. I share this disappointment.

1.2 After negotiating significant improvements in the Government's watered down package of reforms I reluctantly agreed to support the legislation. These changes were to ensure the independence of a trial of mandatory pre-commitment on poker machines, and to ensure that in the future all poker machines would be ready to convert to mandatory pre-commitment at the flick of a switch.

1.3 The Government's proposed poker machine reforms are far from perfect. But they're better than nothing and worth pursuing. In the circumstances I will not be the person who stands in the way of getting at least something done, not the least of which would be the precedent of Commonwealth intervention in poker machine regulation.

1.4 However the Government's reforms will not be realised unless the Liberal/National Opposition or the Greens agree to support them. And as far as the Greens at least are concerned, this will not happen unless the Government agrees to implement a \$1 maximum bet limit on poker machines.

1.5 I support \$1 maximum bets and tried to reach an agreement with the Government on this after the 2010 election. However the Government continues to have no interest in this important Productivity Commission recommendation and we run the very real risk of seeing no poker machine reform in this parliament. Frankly, for the Greens to continue to hold out for \$1 maximum bets is entirely unhelpful and likely to sound the death knell of poker machine reform for many years to come.

1.6 In the circumstances the Government and Greens need to try and reach an agreement that in future poker machines will be both \$1 maximum bet and mandatory pre-commitment capable. This would be a significant development and one that would give a future federal government the option of adopting either \$1 maximum bets or activating mandatory pre-commitment. Significantly, it would also give state and territory governments the option of going it alone.

1.7 The Committee heard that the millions of people affected in one way or another by problem gambling are fed up and frustrated by the delays with reform. The indifference, policy purity and political grandstanding behind these delays must stop.

Mr Andrew Wilkie MP

Chair

Coalition committee members' additional comments

1.1 Coalition committee members agree with the need to find effective prevention measures and treatment methods to further improve rates of problem gambling. We therefore broadly agree with the direction of the committee's report.

1.2 We stress that problem gambling needs to be addressed through approaches that can effectively prevent, mitigate and address problem gambling. Effective policies are those that target the small percentage of the population who suffer gambling problems and gaming addictions.

1.3 Policies must be demonstrably capable of delivering real, meaningful and measurable outcomes for problem gamblers across all forms of gambling.

1.4 Coalition committee members do not support comments in the report that "little or no progress has been seen" with respect to tackling problem gambling. The committee was provided evidence of industry and others initiatives that indicate work being undertaken to address problem gambling.

1.5 Some specific committee observations in the report such as those contained in paragraphs 2.15, 2.64 and the end of 6.21 appear to Coalition committee members to be gratuitous. For example, in the absence of a specific committee observation and/or recommendation regarding how a 'public health approach' should be applied to 'upstream' activities, Coalition committee members do not associate themselves with these general observations.

1.6 Although the report expresses disappointment that Clubs Australia, the Australian Hotels Association, and the Australasian Casino Association did not appear as witnesses before the committee, Coalition members recognise the industry groups have provided significant assistance and information to the committee on numerous occasions historically, as well as agreeing to answer questions on notice.

1.7 The committee view at paragraph 8.93 of the report is not a view necessarily shared by Coalition members. Arbitrary daily limits on ATMs located in venues, although well intentioned, have not been adequately justified by evidence.

1.8 In November 2011, the Coalition launched a policy discussion paper on gambling reform¹ and established a working group to consult with industry, state and territory governments, experts and the wider community to investigate policy options that effectively address problem gambling. The gambling landscape changed in January 2012 when the Prime Minister reneged on her deal with Mr Andrew Wilkie MP. There is now a stalemate with the government refusing to introduce its gambling legislation until its passage through the parliament is assured. The Greens and Senator Nick Xenophon have contributed to stalling gambling reform by refusing to support the legislation. Meanwhile, arrangements for the trial of mandatory pre-commitment

1 *The Coalition's Policy Discussion Paper on Gambling Reform*, November 2011.

in the ACT are on hold until the government legislation is passed. As the final Coalition policy will need to take account of any government legislation that may be passed as well as the status of the trial it will release its final position on any changes to gambling laws when appropriate.

1.9 In the meantime, in the absence of government action, Coalition committee members are pleased to note that clubs have been developing their own response. The policy paper, *Part of the Solution* highlights the range of prevention, intervention and treatment measures clubs across Australia have put in place to help problem gamblers. It also makes a number of evidence based recommendations.² This shows how the industry is willing to be part of the solution to introduce evidence-based measures to assist problem gamblers.

Mr Steven Ciobo MP

Mr Josh Frydenberg MP

2 Clubs Australia, *Part of the Solution, Clubs Promoting a Culture of Responsible Gambling*, 2012.

Additional comments by the Chair and Senators Xenophon, Di Natale and Madigan

1.1 While we support the committee's report we believe it does not go far enough in a couple of areas. These include: addressing machine design within the overall approach to reduce harm; and the need for a legislated duty of care for venues to address the lack of staff intervention.

Prevention measures

1.2 We agree that more needs to be done in the area of prevention. The committee heard that the almost exclusive focus on personal responsibility is imbalanced and may be unintentionally increasing the stigma associated with a gambling problem and contributing to low rates of help-seeking. The message of 'gamble responsibly' says to those who can't do so that they are irresponsible and the fault lies in them. This shame and stigma attached to having a gambling problem is one of the main reasons that so few people seek help. The committee heard how work done by organisations such as *beyondblue* in the area of mental health can provide a good basis to draw from in order to work on de-stigmatising problem gambling to get more people seeking help and seeking it earlier. We therefore agree with the recommendations made in the committee report in this area.

1.3 However, there is one area we have decided where further action is required. The committee heard calls for the federal government to put a cap on the number of poker machines (chapter two) and we see merit in a national cap.

Recommendation 1

1.4 That the government cap the number of poker machines nationally and that the Department of Families, Housing, Community Services and Indigenous Affairs investigate a means for nationally capping the number of poker machines.

Advertising and help-seeking

1.5 The committee has already noted that industry promotion of gambling as a harmless form of entertainment is not balanced by clear messages about possible risks. Pro-gambling promotions are also not balanced by information about available gambling treatment services.

1.6 Given the effectiveness of TV advertising in increasing the number of problem gamblers seeking help, we believe the government should facilitate access to TV advertising by gambling counselling and treatment services. For every advert that goes to air promoting gambling, appropriate advertising promoting the risks of gambling and the availability of treatment should be aired in a comparable time slot.

1.7 Such adverts would serve a dual purpose: firstly to draw attention to the fact that gambling is a risky activity and secondly to alert those already suffering from a gambling addiction that help is available.

Industry needs to take more responsibility for a dangerous product

1.8 Consistent with a public health approach, the responsibility for gambling harm needs to be broader than just the individual. Industry must play a larger part. This was explained by Mr Tom Cummings, former poker machine addict and gambling reform advocate:

Things can be done to tighten up the industry and place a greater onus of responsibility on the industry that offers these products, whether it is poker machines, sports gambling or online gambling. Responsibility has to work in every direction. People do need to be responsible, and that is the message that is coming through very responsibly from the industry, but the industry needs to be responsible as well. They are offering this product and providing it for people to use, so they need to have a responsibility to do so ethically and with a minimum of harm. I think there is also a legislative responsibility. Industry will do what they can within the rules that apply. So it is almost a three way street, though I hate to say it that way. It is certainly something that needs to be looked at by all corners.¹

1.9 We recognise that industry has taken some measures which can help some people, such as self-exclusion, but industry, like government, has a conflict of interest. The committee heard how industry doesn't wish to implement measures that will meaningfully affect their revenue stream. As noted by Mr Mark Henley, Member, Australian Churches Gambling Taskforce:

The primary objective of the industry, appropriately, is maximising profit. That is a construct that is quite contrary to our objective, which is about harm reduction. We would argue that an appropriate level of harm reduction is an area of market failure, if we were to give a purely economic analysis of this. No industry that I can think of, particularly one that is dealing with a moderately harmful product, has ever been effective at self-regulating because the primary objective is quite contrary to the public benefit objective.²

1.10 Dr Mark Zirnsak, Member, Australian Churches Gambling Taskforce, agreed that industry is unwilling to implement strong effective measures:

That is not to say the industry has not taken some measures that have had some positive effect, but it has always been at the soft end. They have demonstrated their unwillingness to take strong measures, even where they have commissioned their own research. They commissioned some research by Alex Blaszczyński in 2001 to look at a range of measures that the New South Wales government was considering at the time. That report certainly made a recommendation that a \$1 bet limit would be a good thing to do. The industry rejected that finding and, in fact, implemented none of the measures that were there. Our experience over a long period of time has been that the industry will not buy into any measure that seems likely to be more effective in this space. It feels more like they are willing to take

1 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

2 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 11.

measures that are at the soft end. The thing they seem most open to is the idea of informing gamblers—the argument about making an informed choice. The evidence seems to suggest that that benefit is not really strong if we look at problem gambling evidence on an ongoing basis. At the other end there is treatment. Once someone says they [have] a gambling problem and they need help, the industry is generally willing to help. But beyond those measures there is very little willingness to really move on effective measures.³

1.11 Therefore the committee heard the focus of the industry is providing treatment once people have already developed a gambling problem. We believe people should not have to hit rock bottom before seeking or accepting help. We can do better than this 'ambulance at the bottom of a cliff' approach. We are reminded of the words of Ms Kate Roberts, Chairperson, Gambling Impact Society NSW, during the first inquiry who said:

I think it is really important that we do not get fixed on this idea that hitting rock bottom is the only way out. With a well-informed community and families that are strengthened and people with an understanding of this issue, we are not going to need people to hit rock bottom before they start reaching out for a variety of kinds of supports to assist them. It is rather an old model that says you have to wait for someone to hit bottom before they will change. In fact there is plenty of evidence that you do not.⁴

1.12 There are a number of ways in which industry can take greater responsibility and one is in the area of machine design.

Machine design

1.13 Through this and previous inquiries the committee has heard about poker machines being the riskiest form of gambling. This was recognised by the Productivity Commission.⁵ The committee has spoken with many former problem gamblers and heard how they enter a trance-like state when playing poker machines. For people who are vulnerable this can lead to them becoming addicted and given the current design of machines, players can lose up to \$1,200 per hour.⁶ Although this figure has unsurprisingly been disputed by the industry⁷ there is no doubt that by using this so-called 'recreational product' in one hour you can lose much more than you would spend on other entertainment products.

3 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 11.

4 Ms Kate Roberts, *Committee Hansard*, 4 February 2011, p. 80.

5 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 4.1.

6 Productivity Commission, *Gambling*, vol.1, Commonwealth of Australia, Canberra, 2010, p. 2.3.

7 Gaming Technologies Association, *Submission 23*, p. 2.

A dangerous product

1.14 The committee has been told repeatedly of the addictive features of poker machines which trigger a loss of control. With the emphasis placed on individual responsibility the committee heard how an individual's capacity to exercise informed choice in relation to poker machines can become severely impaired due to their essential design features. The product is therefore inherently dangerous. Ms Amanda Jones, Member, Public Interest Advisory Group, Australian Psychological Society, stated:

We are saying that it is [an] inherently dangerous product and therefore the current responsible gambling/informed choice strategies of government and industry really are not addressing that fundamental and will only, therefore, take us so far.⁸

1.15 Mr Tom Cummings emphasised the need to focus more on the product:

However, on a preventative side I ultimately believe that there is a problem with the offering of the product and, in some cases, with the product itself. Poker machines are unique in terms of gambling. They are constantly refined and technologically advanced. New technology is being introduced constantly, all with the aim of getting people playing these machines for longer and spending more money because it is a business. That is to be understood. I have been looking at an American company that has signed agreements with a company here, and they are looking at rolling out machines down the east coast. They have immersive gaming where they have high-backed seats with surround sound and massive screens, and they promote this as such. It is designed to absolutely surround the player and remove all distractions. I really cannot see how that can be a responsibly offered gambling product when the idea is to be not so much a leisure activity but to keep them playing and remove all distractions.⁹

1.16 Mr Cummings elaborated on the need to have more measures to address the safety of the product:

I fully believe that gambling is and should be a legitimate leisure pastime. People have been gambling around the world for centuries; it is nothing new. However, there are markets open at certain points in time. Here in Victoria it was in the early nineties with poker machines, and more recently around the country it has been sports gambling following the court decision that allowed advertising around the country. The opportunities present themselves and businesses move in to take advantage of those opportunities. I understand that these are businesses and will do what they can to maximise their revenue. They have every right to do that legally. The problem is when the product that is being offered such as gambling, poker machines or sports gambling has the potential to cause harm and the industry that is offering those services does not—in my opinion anyway—

8 Ms Amanda Jones, *Committee Hansard*, 14 May 2012, p. 29.

9 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

take sufficient measures to make sure that does not happen with the product that they themselves are offering.¹⁰

1.17 Ms Kate Roberts, Gambling Impact Society NSW, also stressed the need to look at the product itself which would include:

...looking at changing national standards for safer electronic gaming machines and using the technology to create a win-win for both the community and the providers; reducing the negative impacts by building in those seatbelts and airbags—and we regard smart card technology and \$1 maximum bets as a key component of that; limiting access to high-intensity machines, which I guess we believe should be in the casino and not on every street corner; really making this product truly recreational if it is to be marketed as such.¹¹

1.18 Mr Mark Henley, Member, Australian Churches Gambling Taskforce, also highlighted that gambling can be a dangerous product for some and the exclusive focus on the individual to be responsible with a dangerous product does not take into consideration those who are vulnerable:

We wish to reiterate the Taskforce's clear understanding that gambling is a dangerous product and, as such, needs to be understood from a clear consumer protection perspective. We have observed that, over the last decade, there has been a tendency in the provision of gambling help to move from an approach where prevention is a part of the approach to an approach perhaps more characterised by pathologising people with a gambling problem. This approach is unhelpful. It simply alienates a small group and fails to recognise the range of risks being experienced by another group.¹²

1.19 Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, also emphasised that the design features of poker machines need to be addressed:

We know the main source of pokie related gambling problems is the design as well as the supply and accessibility of the machines. This is what we need to target for meaningful reform. The Productivity Commission identified that one dollar bet limits and mandatory precommitment looked like effective measures to reduce harm generation from the machines. Of course we support those measures. We also recommend a ban on linked jackpots on gaming machines, as an unacceptable inducement to people, who end up chasing their losses.¹³

1.20 Ms Amanda Jones, Member, Public Interest Advisory Group, Australian Psychological Society, spoke about how the design features of machines contribute to loss of control and impaired decision-making:

10 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 2.

11 Ms Kate Roberts, *Committee Hansard*, 2 May 2012, p. 36.

12 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 9.

13 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, pp 20–21.

...there is a significant amount of literature that has been emerging on the nature of EGM gambling experience and the intrinsic design features as powerfully effective in building uncontrolled consumption and impaired decision making. I suppose we would want to be really making a very strong point about differentiating between an informed choice or responsible gambling perspective and product safety consumer protection perspective.

The unsafe product analysis really takes us much more critically into an understanding and acknowledgement that EGMs are designed in such a way to precisely promote the loss of control. That is the point of the product. So it is extremely difficult for people to gamble responsibly when the design of these machines and the setting in which they are consumed are about interfering with that intention, if indeed consumers have that intention, because certainly from our experience the pleasure of loss of control is precisely part of what they are seeking.

The product safety perspective is absent in our view or it is underdone in the responsible gambling frame of reference and public policy agenda. It really represents an industry operator and government failure to apply existing consumer protection law in a way to exercise a duty of care to protect the community.¹⁴

1.21 The committee discussed whether this aspect should be a factor taken into account before the machine is approved. The Australian Psychological Society (APS) thought that this would be helpful and Professor Debra Rickwood, Professor of Psychology, University of Canberra; and APS Fellow, suggested they could be rated along these lines:

Prof. Rickwood: I would think that, with our understanding of the learning principles and the way machines are developed, you could probably rate them in terms of the different elements of their level of impact.

Senator XENOPHON: If you were given a research project of rating these machines—a bit like a safety rating of a car—would you have a set of criterion to make that assessment in a reasonably robust way?

Prof. Rickwood: I would imagine we could. I am not aware of anybody who has done that, except they would probably all be rated very high. There may not be very much variation in them.¹⁵

1.22 Ms Heather Gridley, Manager, Public Interest, APS, supported looking at the design of the machines but noted:

One reason it has been difficult to undertake research in some of these areas is that there is some resistance to trialling things which might disadvantage industry in some way and, unfortunately, governments also become implicated in that when they have a large revenue base.¹⁶

14 Ms Amanda Jones, *Committee Hansard*, 14 May 2012, pp 28–29.

15 Professor Debra Rickwood, *Committee Hansard*, 14 May 2012, p. 32.

16 Ms Heather Gridley, *Committee Hansard*, 14 May 2012, p. 32.

1.23 Ms Leah Galvin, Manager of Social Policy and Advocacy, St Luke's Anglicare, also noted that some machines are more dangerous than others and there are no restrictions on replacing less harmful machines with more harmful machines:

That is an interesting point that you raise, as it relates to one of our other concerns. It is a strange way to describe it, but some machines are safer than others. With the new generation of machines you can lose much more money much faster. There does not seem to be any real restriction on venues, once they have a licence, replacing these lower-loss machines with higher-loss machines. You in fact increase the damage even though you do not have extra licences. So there is the potential for that as well. I do not know if others have spoken about that before the committee.¹⁷

1.24 Witnesses noted other legal products which are highly regulated as a consumer protection measure. They argued that gambling is no different to any other product with which there is a risk.¹⁸

Meaningful messages

1.25 We believe that warning messages on poker machines or online could play a role in alerting gamblers to risky play. The Productivity Commission noted:

Since EGMs are a major source of problem gambling and these are electronic games, the nature of the technology provides a unique capacity to assist in primary and secondary prevention—machine design, exclusion and personalised and generic warnings based on style of play—similar to a speed alert on a car or beeps emitted when people fail to fasten their safety belts. Online gambling shares many of these features.¹⁹

1.26 We note industry and government are looking at dynamic or electronic warning messages. For this to be effective the messages need to be strong enough to reach gamblers on poker machines who are 'in the zone' which is what they use to describe their trance-like state. Ms Julia Karpathakis, Manager, Pokies Anonymous, provided examples of strong messages which could come up during risky play.²⁰

I believe that messages to jolt people out of the trance will be of great use. These messages will trigger people to have to think about their outer surroundings and real life and to change the focus from the make-believe and isolated world of the pokies of to the real world out there.²¹

1.27 We support meaningful messages on poker machines that are able to reach gamblers in that trance-like state that has been described to the committee to provide them with a reality check.

17 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 51.

18 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 18.

19 Dr Ralph Lattimore, *Committee Hansard*, 14 May 2012, p. 41.

20 Pokies Anonymous, *Submission 31*, p. 3.

21 Pokies Anonymous, *Submission 31*, p. 2.

Altering parameters of machines would help reduce harm

1.28 It is clear that altering the parameters of the machines to reduce the amount of money that can be lost will lessen the amount of harm for those who lose control. And a key outcome from making the machines safer would be a reduced need for counsellors:

Senator XENOPHON: If you made the machines safer and reduced the demand, that would solve the problem, wouldn't it? If you did not have as many people falling off the cliff in the first place, you would not need to have as many counsellors.

Ms Wilson: I think if there were not as many problem gamblers you would not need as many counsellors.²²

1.29 Ms Amanda Jones, Member, Public Interest Advisory Group, Australian Psychological Society, noted the ability to change machine parameters to make them safer:

We could certainly immediately introduce some sort of regime that requires that they meet certain parameter values. We already know what those are—we are talking about maximum price, maximum bet, load-up limits and all those things, along with a genuine seatbelt type approach through mandatory precommitment.²³

1.30 The committee discussed with Professor Alex Blaszczynski the effects of altering the parameters of the machines:

There is some empirical evidence out there now about people and lotteries, for example. The larger the prize pool for a lottery the greater the number of people who will participate in it. So if you have a situation where, for example, electronic gaming machines are put forward as recreational devices, with large amounts of jackpots in linked machines, it would seem to be sensible to reduce the potential prize pool, which would then reduce the motivation for people to gamble. If I am \$10,000 in debt and I am trying to chase that then I will be prepared to gamble \$2,000 or \$3,000 if the jackpot is \$186,000. I would be less likely to do that if the major jackpot was \$500.²⁴

1.31 Mr Cummings confirmed that reducing the intensity of poker machines by measures such as reducing the maximum bet and jackpots would make a difference to problem gamblers.²⁵ He also spoke about the lure of jackpots and agreed that lowering jackpots to no more than \$500 would discourage people from chasing their losses:²⁶

22 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 29.

23 Ms Amanda Jones, *Committee Hansard*, 14 May 2012, p. 32.

24 Professor Alex Blaszczynski, *Committee Hansard*, 2 May 2012, p. 15.

25 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 3.

26 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 3.

I think jackpots are a big lure. I have been looking into that reasonably recently with linked jackpots and venue-wide jackpots. I think they encourage people to play the machine just in case the jackpot goes off.²⁷

1.32 He added:

...I know a lot of people who play just to win jackpots. They look for the machines that have the big signs at the top and that is what they play for. Having said that, when I did win my one big jackpot, the \$5,000, it was an incredible experience. I had about five seconds worth of elation, and then all I could think was that I could use this to start putting more money back in. My experience with that was that it was a lure and it was also an encouragement to keep gambling. If you win one jackpot, you are not going to be satisfied with one: you are going to try and win them all.²⁸

1.33 As in previous inquiries, witnesses again put forward their support for measures which address machine design. These include reducing the parameters of the machine which includes maximum \$1 bets as well as mandatory pre-commitment:

Senator XENOPHON: You talked about how you thought that mandatory precommitment would have been an effective way of doing things.

Ms Karpathakis: Yes, definitely.

Senator XENOPHON: Another proposal, which could be done at the same time as mandatory precommitment, is to have \$1 bets so that you cannot lose more than on average \$120 an hour or to try to limit the losses to much less than that \$120 an hour. Would slowing down the rate of loss have made a difference? I will ask both of you, you and Shonica, that. In other words, it is if a machine could not take so much money so quickly. I think, Shonica, you said that you lost \$250 in 22 minutes.

Miss Guy: It was probably worse than that but I can just remember that one.

Senator XENOPHON: Yes, but, firstly, if there were a lower rate of loss?

Ms Karpathakis: That would be heaps better. Anything would be better than it is now.²⁹

Maximum \$1 bets

1.34 Rev. Tim Costello, Chair, Australian Churches Gambling Taskforce, told the committee that the Taskforce supported \$1 maximum bets on all machines which would limit losses to \$120 per hour. In addition, they support reduced access to cash in gambling venues and restrictions on online gambling in recognition of the explosion in sports wagering.³⁰ In relation to poker machines, he added:

27 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 3.

28 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 7.

29 Ms Julia Karpathakis and Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 14.

30 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, p. 20.

I have never been a prohibitionist and therefore, by implication, I agree that there is an acceptable risk...[T]he risk at the moment is completely unacceptable because the very simple argument of machines that are often banned elsewhere in the world being normal here is not allowed to be given expression, because of the pathologising of the individual. I do believe that if there were \$1 machines, with loss limits of \$120, there would still be damage. There would still be people who could sit there for five hours straight and do some damage to themselves. But it is a far more acceptable risk and loss than what the current situation is, where you can lose thousands of dollars within an hour and go on to commit crime. As the Victorian Justice Department research showed, pokies' contribution to crime is second only to illicit drugs. By implication I think there probably is an acceptable risk. We are nowhere near that at the moment because of the way this debate has been framed. When we are closer to actually seeing what is a much less dangerous machine we will have greater community consensus around the acceptable risk than we do at the moment.³¹

1.35 Mr Tom Cummings also spoke about limiting maximum bets to \$1:

With regard to \$1 bets, I think they are a good measure. They would make a difference. I do not think they would be quite as effective as mandatory precommitment; however, it is not hard to implement without a trial in my opinion as an IT professional for 20 years. Making those kinds of changes can be done and can be rolled out progressively over a period of two or three years. We have done it in Victoria, dropping the bet limits to \$5. Dropping to \$1 is just a matter of degree. And it removes the capacity to think, 'Oh, my luck's in; I'll up my bet.' You can only go so far. I think both measures in combination would have been fantastic. What was originally offered and walked away from would have been a lot simpler than it was put forward to be and, I think, would have been very effective.³²

1.36 Ms Leah Galvin, Manager, Social Policy and Advocacy, St Luke's Anglicare, agreed this would be helpful:

We like any harm minimisation measure! I think the \$1 bet, so that you can reduce the amount of money that can be lost in an hour—given how people behave when they are in front of the machines—would be really great. I think that is a really simple solution, but we also support the other ideas that are being espoused as well; although we think that there are potential weaknesses in the choosing how much you gamble before you do system, and that it will not be that hard for people to manipulate it or to get around it. You would have to design such an airtight system that I think there might be vulnerabilities with that. So we would go for the \$1 bet.³³

1.37 Dr Mark Zirnsak, Member, Australian Churches Gambling Taskforce, stated:

31 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, pp 25–26.

32 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 4.

33 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

The Taskforce has a strong position of supporting \$1 bet limits. That was a recommendation of the first Productivity Commission report in 1999, and it is something that we have supported. The research by Alex Blaszczynski in 2001 found three times as many people with gambling problems bet over \$1 when compared to those who are recreational gamblers. The Productivity Commission covered this in quite a bit of detail. The number of people betting over \$1 in the Queensland research had increased quite substantially from that 2001 research. According to the Queensland research, 50 per cent of people with gambling problems were betting over \$1. So, from our perspective, you would not trial a \$1 bet limit; you would simply implement it as a measure. However, from our perspective, it does not remove the need for the ability of people to set themselves enforceable limits.³⁴

1.38 We note that in Victoria the maximum bet was lowered from \$10 to \$5 seemingly without much fuss from the industry. Ms Penny Wilson, CEO, Responsible Gambling Advocacy Centre, said that from historical analysis, the maximum bet limit change:

...went through rather smoothly. Looking back, our staff found there was lots of very robust discussion at the time, but it was achieved and the regulatory measures were put into place to achieve that.³⁵

1.39 The committee wrote to the Victorian Commission for Gambling and Liquor Regulation to discuss the implementation of this change but did not receive a response. We note the bill currently before the committee, the Poker Machine Harm Reduction (\$1 Bets and Other Measures) Bill 2012 sponsored by Senators Di Natale, Madigan and Xenophon. The intention was to inquire into this bill at the same time as the government legislation on poker machine reform. However the government legislation has not yet been introduced.³⁶

Pre-commitment

1.40 Witnesses also expressed support for mandatory pre-commitment. For example, Rev. Tim Costello, Chair, Australian Churches Gambling Taskforce, told the committee that the Taskforce strongly supported mandatory pre-commitment.³⁷

1.41 The Chair asked Mr Tom Cummings his view on voluntary measures for problem gamblers. Mr Cummings replied that they would be more suited to a person who is at risk of developing a gambling problem. He then went on to describe how he, as a former poker machine addict, found setting voluntary limits unsuccessful:

I know that for years I tried to voluntarily limit my own spending. I would put money into accounts I could not touch or I would leave my credit cards at home and I would always find a way. The two or three times I tried

34 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 17.

35 Ms Penny Wilson, *Committee Hansard*, 3 May 2012, p. 32.

36 Note: The committee has since decided to start its inquiry into this legislation.

37 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, pp 25–26.

leaving my wallet at home when I would go out gambling just strengthened my resolve to make sure I took it with me the next time. I was trying to get myself out of a situation that I had put myself into, and the only way I could see to do that was gambling. I did not feel that I could front up about it. I did not feel that I could walk away from the losses that I had incurred and the secrets that I had kept. The only way that I could see out of it—and it is an irrational concept and I realise that now—was to repair the damage, put the money back and then walk away from it, pretending it had never happened.

When you have that mindset, when you believe in that sort of irrational concept, a voluntary measure for harm minimisation is not going to have a lot of impact, in my opinion.³⁸

1.42 Mr Cummings provided his view on mandatory pre-commitment:

On mandatory precommitment: I know a little bit about smartcards through my work and I have thought for quite some time that mandatory precommitment would have been fantastic for me I certainly would have made use of it. I think it has the capacity not just to bar yourself from all poker machines. Even if I set a high limit and blew all the money so player's remorse kicks in, I would have thought: 'I don't want to do this anymore. I will restrict how much I can play. I'll drop my limit down to \$100 a day or \$50 a day.' I fully believe that would have helped me.³⁹

1.43 Mr Mark Henley, Member, Australian Churches Gambling Taskforce, stated:

We remain absolutely committed to supporting limit setting as a crucial protection measure that is there to make gambling, including poker machine gambling, safer for consumers.⁴⁰

Cost of \$1 bets or mandatory pre-commitment

1.44 Witnesses discussed the cost estimates of mandatory pre-commitment and emphasised that when you look at the amount of money made from gaming machines, particularly over the life of a machine, and even if you take the industry's more extreme cost estimate, you could argue that it is still reasonably affordable. Dr Mark Zirnsak highlighted:

The question is: how much does it actually reduce the revenue that comes through the machines? The Productivity Commission's work suggests 40 per cent of money from electronic gaming machines is coming out of the pockets of people with gambling problems. If it is effective at reducing that—that is probably a larger slice of the pie—but the question is: is it reasonable for an industry to keep living off the back of creating huge harm in the community? They say, 'We don't want one dollar from people with gambling problems.' If that is the case, they need to be willing to give up the money they are currently getting from people with gambling problems.

38 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 2.

39 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 4.

40 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 9.

It is a contradictory argument, 'We do not want to pay the cost, but we do not want money from people with gambling problems.' Which is it? I am not clear.⁴¹

1.45 Mr Mark Henley added:

Let's also be clear about the cost of implementing precommitment schemes. We already have precommitment schemes operating in this country. In South Australia there is a jackpot group, 60-odd hotels who have a precommitment scheme in place already, and that program has been evaluated...Queensland has some precommitment schemes in place. We have casinos with precommitment schemes in place. So we actually have precommitment already happening in some jurisdictions, at virtually no cost. So let's not get too excited about the outrageous figures that the industry keeps promulgating; because precommitment is in place, it is happening now. So the move to make precommitment mandatory is not a huge expenditure. That can be done in the natural course of replacing central monitoring systems.

The other thing that I think makes perfectly good sense is that the marginal cost of implementing precommitment and \$1 bet limit capability on a new machine is minimal. So simple regulation, as soon as possible—all new machines with precommitment and \$1 bet enabled—is a minimal cost to the industry. So we simply do not buy the inflated figures that the industry promulgates; they are just not based on fact.⁴²

Norway experience

1.46 To discuss the benefits of setting limits, the committee spoke with Norsk Tipping which is a wholly state-owned company under the jurisdiction of the Ministry of Culture in Norway. It is the dominant provider of gambling in Norway, offering lottery and bingo-type games, sports betting and, since 2009, new interactive video terminals which replaced the old slot machines. These new machines have an upper monthly and daily limit set by the government but the individual can also set a limit within the overall limit. The officials were very clear that the new system has worked to reduce problem gambling.⁴³

1.47 This was confirmed by information from the Norwegian Ministry of Culture which stated:

It was an undisputed fact that slot machines were the direct reason for an increase in problem gambling in Norway. Since the ban in 2007 we have witnessed a substantial decrease in problem gambling in Norway, especially in relation to children under 18 years of age.⁴⁴

41 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, pp 17–18.

42 Mr Mark Henley, *Committee Hansard*, 3 May 2012, p. 18.

43 Mr Bjorn Hoffmann, Mr Lars Ottesen, *Committee Hansard*, 26 June 2012, pp 1–2.

44 Norwegian Ministry of Culture, Correspondence received 13 July 2012.

1.48 It emphasised that the 'limits have worked well and been well accepted by people. Only around 21% of players reach their limits every month' and not many people have chosen to set their own limits as the limits set by the government were quite low from the outset.⁴⁵

1.49 Regarding whether people moved to online gambling, Norsk Tipping said there was not a huge movement to online gambling but they did see an increase in electronic bingo.⁴⁶ The Norwegian Ministry of Culture confirmed there was not a big shift to online gambling:

One of the big questions related to the Norwegian machine reform was where will the money go. After machines were banned there was a slight rise in turnover on other games on the Norwegian market as well as online, but nothing as equivalent to the turnover from slot machines.⁴⁷

1.50 While the environments and systems differ to those in Australia, it is clear that setting limits in Norway has reduced problem gambling and gambling harm. Limits in Norway have been set by the government, whereas with mandatory pre-commitment the intention is to provide that tool to the gambler to set their own limit.

Disappointment with the current government position

1.51 Witnesses expressed their frustration with the lack of progress on meaningful gambling reform and expressed disappointment at the withdrawal of support for mandatory pre-commitment by the government in January 2012. Rev. Tim Costello, Chair, Australian Churches Gambling Taskforce, told the committee:

I think all members of the Taskforce were very disappointed with what happened on 21 January. I would put on the record that the Stop the Loss Coalition, which involves Neil Lawrence, Sue Cato, the Australian Churches Gambling Task Force and has included the GetUp! campaign. That campaign was actually formed at the direct request of Minister Macklin last year to give the government some respite from the pokies lobby's particular attacks on New South Wales Labor-held electorates. The politics of that, you can imagine, for churches—and I should say this is a united view across all the mainstream churches, from Catholic to Salvation Army to Baptist to Uniting; I won't go through them all—is that there needs to be reform of these dangerous machines. The particular agreement between you [the Chair] and the government was the best chance—a historic opportunity, a once-in-a-lifetime opportunity—to get reform, given that we know that the industry boasted of a \$40 million fund. They applied extraordinary pressure. They certainly had support with some of the Murdoch press outlets, particularly the Daily Telegraph, to say pretty simply that community and junior sport is all at risk if there is reform of

45 Norwegian Ministry of Culture, Correspondence received 13 July 2012.

46 Mr Bjorn Hoffmann, *Committee Hansard*, 26 June 2012, p. 3.

47 Norwegian Ministry of Culture, Correspondence received 13 July 2012.

these dangerous machines. So it has been a highly politicised environment.⁴⁸

1.52 Rev. Costello added:

The Taskforce has voted on a position that says we support the Productivity Commission's recommendation on both \$1 maximum bets, which they recommended without trial; and mandatory pre-commitment, which was the original deal that you [the Chair] had with the Prime Minister; and, if it becomes clear that the government simply will not countenance those then, on the position that something is better than nothing, accept the watered-down bill—which has some good features in terms of ATM withdrawals. But very strongly the Taskforce has, for most of its existence, been advocating for the Productivity Commission's recommendations. It came into existence precisely to support the government and you to see that deal go through. That is still its strongest first position but, should that not have any chance of success, we say that something is better than nothing.⁴⁹

1.53 Ms Julia Karpathakis, Manager, Pokies Anonymous, stated:

If it is that easy to make it voluntary precommitment, it is that easy to make it mandatory precommitment. What is the big hoo-ha about how much money and how much it is going to cost to change the machines? That is ridiculous. It should be mandatory. We need action straightaway. People are actually killing themselves over stupid poker machines. I was at Kmart the other day and I was cursing because this lady asked me for Flybuys. If I knew Flybuys were from Coles or whatever, I would never have got them. I continued to tell her that Woolies and Coles own all the poker machines. She was just a person there at the till and she said that that on Monday a woman she knew killed herself and left behind three kids and a husband, and it was from the pokies. That is a random Flybuys conversation. It is a serious problem.

I know of people who have disappeared and I do not know what has happened to them—they have lost everything. I have helped them go to Cash Converters so that the interest does not have to go onto the car that they have hocked, and they could not even do that. They could not even pay off without the interest so they could get their car back. I do not know what happens to people out there. I think it is really sad that those reforms did not happen.⁵⁰

1.54 Witnesses spoke about the appearance or 'vener' of reform. Dr Jennifer Borrell, Adviser, Australian Churches Gambling Taskforce, expressed her view:

Nonchalance is an interesting word. I can speak for Victoria because that is where I am and where I have done a lot of my research. Reforms will be brought in to great fanfare and everyone thinks, 'They look really good.' But there is always a lot of lobbying from the industry and that lobbying often

48 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, p. 23.

49 Rev. Tim Costello, *Committee Hansard*, 14 May 2012, p. 23.

50 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 18.

takes the form of changing it in some operational sense. It is like having a fantastic car but while you were not looking someone sneaked in and disconnected a couple of wires so that it does not work. There has been a pattern. I wrote a thesis about this and I have written about it and studied it, and it has been published as a book. It is basically a pattern that has been going on for a long time. It looks really good that, for example, local communities can say whether they are having pokies in their area, but when it comes to putting it in place there are hearings with judges and QCs with rules of evidence about not using research that shows it is a dangerous product. Once all of that happens the communities do not really have a say, but it has cost millions of dollars. This is the pattern with all gambling reforms.⁵¹

1.55 Dr Borrell said that if reform was done in a meaningful way, revenue for the industry would go down and as the industry does not want to change its business model, any reforms tend to get watered down:

One thing I have been heartened by is the move to look at regulation at a national level, because as you know the states are very dependent on the revenue. The problem as we all know is that the revenue is tied to the generation of harm. Talking about preventing or reducing harm, if you did it meaningfully and industries do not change their business models, the revenue will go down. No-one ever wants to look at anything that will make the revenue go down. So, it is not necessarily people going out and saying, 'Let's sabotage these new reforms.' It is more a matter of, 'We want it to look like we are doing something meaningful, but we still want the revenue to come in.' What happens when you do that when the revenue comes in? A huge proportion of it comes from problem gambling. That is where it happens. People talk about accountability, but it is a complete waste of taxpayers' money.⁵²

Government responsibility

1.56 Governments have introduced a gambling product in poker machines⁵³ that has contributed to mental health and other problems in the community for those who are vulnerable.⁵⁴ Government therefore must share the responsibility to limit the harms. This is currently achieved through legislation, regulation and codes of conduct. However governments are also dependent on gambling revenue so a conflict of interest exists. The emphasis on individual responsibility suits not only the industry but also governments which rely on the revenue. This is captured in the following exchange:

51 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 25.

52 Dr Jennifer Borrell, *Committee Hansard*, 14 May 2012, p. 25.

53 Except Western Australia where they are confined to the casino.

54 See discussion between Senator Xenophon and Professor Malcolm Battersby, *Committee Hansard*, 14 May 2012, p. 6. See also Nancy M Petry, *Pathological Gambling: Etiology, Comorbidity and Treatment*, American Psychological Association, 2005, pp 30–33.

Senator MADIGAN: That is it. So, on the one hand, it seems that concern is expressed, but these people are considered to be collateral damage. Would you agree with that?

Dr Glinka: If you mean that we are called upon to treat them and at the same time they are free to undo the treatment as soon as they walk out the door, yes—if that is what you mean.

Senator MADIGAN: Yes.

Dr Glinka: That is eminently totally unreasonable.⁵⁵

1.57 Senator Xenophon and Professor Dan Lubman, Fellow, Royal Australian and New Zealand College of Psychiatrists, also discussed this issue:

Senator XENOPHON: Is the greater obligation on the state? Unlike addiction to, say, heroin, which is illegal, you are dealing with something that has been sanctioned by the state. I know that one psychiatrist in Adelaide, Professor Malcolm Battersby, I do not know if you know him, made a point a number of years ago that struck me. He said that he does not know of any other form of something that is sanctioned by the state that has actually increased the level of mental harm and mental illness in the community compared to poker machines. Do you take into the mix the fact that it is something that is a problem that would not exist but for that sanction?

Prof. Lubman: There are certainly similar parallels with alcohol and various states' struggles with alcohol and drug acts and how you legislate for people who continue to drink despite causing significant damage to their body and who continue to put themselves in life-threatening situations. It is something we struggle with all the time. I do not think there is an easy answer to that. But what it does highlight for the committee is the recognition that there is a significant disorder where people cannot control their behaviour and which leads to significant harms to themselves. There is a recognition that in some way there needs to be safeguards in place to minimise the risks.⁵⁶

1.58 This conflict and the possible effects were also noted by Ms Leah Galvin, Manager of Social Policy and Advocacy, St Luke's Anglicare:

I think it is hard when you rely on those revenues, particularly in financially challenging times. I wonder how conflicted you are then to make a decision that is really about what communities want versus what the state finances might need. Again, all political persuasions are involved in that. This is not political commentary.⁵⁷

1.59 There is a growing call for the federal government to do more in this space. It was recognised by the Productivity Commission which noted that 'generally there is a need for the Australian Government to take a greater leadership role in pushing for, or

55 Dr Natalie Glinka, *Committee Hansard*, 14 May 2012, p. 10.

56 Professor Dan Lubman, *Committee Hansard*, 3 May 2012, p. 40.

57 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

sustaining reforms'. It suggested there was a particular role for government to create a more policy-oriented and strategic approach to gambling research, for example. It also stated that it was important for the Australian Government 'to actively engage with state and territory government in the development of new machine design features, standards and protocols'.⁵⁸ The committee heard from witnesses in Victoria who wanted the federal government to step in to ensure no more poker machines were forced upon communities there.⁵⁹

Other suggestions to limit harm

Venue-specific measures

1.60 Miss Shonica Guy, Volunteer Coordinator, Pokies Anonymous, proposed other ideas to limit harm such as reducing venue opening hours, taking out ATMs and addressing other design features:

Miss Guy: I think there are a lot of things that they could be doing now that would not cost anything. They could reduce the gaming hours. They could take the ATMs out—they are a huge problem and I think that would make a great difference. Mandatory precommitment in the future would be a good idea....If all the symbols were evenly distributed on all the reels, that would probably be good too. They use starved reels, and that is a cheating device, in my opinion. When I found that out I felt more ripped off than I did before. I felt cheated. I remember when found that out, Julia said, 'Are you all right?'—apparently I was all white and I was shaking because I felt like I had been really taken advantage of.

CHAIR: When you went into play, were you consciously or subconsciously thinking that the machine had to return a certain amount to you, that the odds were not too bad?

Miss Guy: Yes, basically. I do not know what delusion I was under because I never won. I have heard of people winning but I never did. Over the time I played, 14 years, my biggest win was \$4,000 in one session, and that was it. I would get \$100 here and there but I was not a winner at all.⁶⁰

1.61 Mr Cummings summed up what he would like to see happen:

I would like to have seen mandatory precommitment legislated. I do not think that is going to happen. I would like to see advertising limitations legislated. I would like to see things like venue opening hours changed. I would like to see \$1 bets come into effect. There are a number of things I would like to see. I would like to see the state governments taking these things onboard as they should be, at least in terms of poker machine gambling. Failing that, I would like to see it happen at a federal level

58 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 39.

59 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55. See chapter two of the committee report.

60 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 19.

because, when the states do not act, there is only one alternative as far as I can see...⁶¹

1.62 Ms Leah Galvin, St Luke's Anglicare, said the biggest thing the federal government could do to help would be to ensure numbers of machines are not increased:

That is a simple one for us: no more machines—the pokies. We know that that would be a difficult thing to do, but the reality is that we know that the more machines that get put in the more harm that is done. We are also concerned about the economic harm to communities as well. I have not really mentioned that today, but money that goes into pokie venues does not go into local businesses. This means there are reduced opportunities for employment. In regional and rural cities this is a really big problem. Really, for us, it is a simple one. We have enough machines and, in fact, that is what we campaign on in the Loddon Mallee with a bunch of other faith based organisations. We have been running a campaign saying 'enough is enough'. Others have tweaked onto that as well. But we do think that there are more than enough machines, because there is certainly more than enough harm.⁶²

1.63 Ms Galvin added:

There is also putting coins into machines rather than dollars, because it takes a lot longer and you have to think about it. The other one we like, too—and it was mentioned earlier—was ensuring that people who work in the venues feel that they have the capacity to speak to somebody whom they are concerned about, who has been sitting at the machine for a long period of time. We do know that if they interrupt people when they are in the zone that can have people stop and reassess what they are doing. So having the workers feel empowered to do that and trained to do that would be really great as well.⁶³

1.64 We note the recent announcement by ClubsNSW of a 12 month trial to provide a Salvation Army Chaplain at the Mingara Club on the NSW Central Coast. While we support such initiatives to assist problem gamblers, again this is likely to focus on those who have already developed a gambling problem. Clubs continue to promote the stance that the issue is all about people with problems. This conveniently points at others and away from themselves and their products. However, we are pleased to note that the Salvation Army is funding the trial and therefore they will be independent of ClubsNSW influence.⁶⁴

61 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 5.

62 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

63 Ms Leah Galvin, *Committee Hansard*, 3 May 2012, p. 55.

64 ClubsNSW, 'Clubs and Salvation Army join together to fight problem gambling', *Media release*, 5 August 2012; The Salvation Army, 'Salvos trial new initiative to assist problem gamblers', *Media release*, 5 August 2012.

Loyalty programs

1.65 Membership in loyalty programs at venues and the perceived exclusivity that these programs offer may serve as an inducement to patrons to gamble more in order to achieve a higher membership status.

1.66 We note that the South Australian Mandatory Code of Practice does not apply to the Adelaide Casino. Instead, the Casino is required to abide by the Adelaide Casino Responsible Gambling Code of Practice, which does not have a clause prohibiting inducements.

1.67 Membership to Adelaide Casino's 'REWARDS' program entitles gamblers to a number of 'benefits'. Members of the Platinum Program are given access to a 'private gaming facility', as well as complimentary food and alcoholic beverages.⁶⁵ Clause 6 of the Adelaide Casino Responsible Gambling Code of Practice states that the Casino must ensure that alcohol is 'not supplied to reward, promote or encourage continued gambling'. It is difficult to see how the provision of free alcohol to members who have achieved 'Platinum' status is not a 'reward' for their gambling expenditure.

1.68 Furthermore, as alcohol is a well-known disinhibitor it is highly possible offering free alcohol in an environment exclusively dedicated to gambling will encourage customers to gamble more. The Productivity Commission recommended 'Governments should prohibit venues from offering inducements that are likely to lead to problem gambling, or are likely to exacerbate existing problems, including offering free alcohol to a patron who is gambling'.⁶⁶ We fully endorse the Productivity Commission recommendation.

1.69 We are encouraged by the current South Australian Independent Gambling Authority Codes of Practice Review and will watch with interest the Authority's findings.

Online gambling

1.70 It is also imperative the government takes a proactive approach to preventing the onset of, and increase in, widespread gambling addiction brought about by online gambling. As Rev. Tim Costello has said 'with online gambling it is possible to lose your home without ever leaving it'.⁶⁷ Priority must be given to reducing the risk of gambling addiction from online gambling by way of effective prevention strategies.

1.71 The recent case of 'Eric' and the online bookmaker Bet365 demonstrates how quickly gambling behaviours can escalate to reach problematic levels. Within days of

65 Adelaide Casino, 'Benefits', available at: <http://www.adelaidecasino.com.au/Action-Rewards/Benifits.html>, accessed 14 September 2012.

66 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 12.47.

67 Interview by Laurie Oakes with Reverend Tim Costello, National President Baptist Church, *Sunday*, 23 April 2000, available at: http://sgp1.paddington.ninemsn.com.au/sunday/political_transcripts/article_473.asp?s=1, accessed 18 September 2012.

signing up to Bet365, 'Eric' was placing over 200 bets per day. Within the space of 18 months he had lost over \$40,000.⁶⁸

1.72 Online casino-style games should be prohibited where money is used to participate in a game but where it is not possible to win 'money or anything else of value' as a result of bets placed.⁶⁹ Examples of such games include online roulette, blackjack and poker machines. These games still enable gamblers to lose vast sums of money in short spaces of time in unregulated environments.

1.73 We believe the government must take a more proactive approach to preventing the emergence of online gambling addictions through more rigorous regulation of the industry. This could be achieved—in part—by:

- amending the definition of an 'interactive gambling service' contained in the *Interactive Gambling Act 2001*; and
- prosecuting those websites that have been found to be in breach of the Act.

1.74 Currently Australians are able to use 'real' money to play online casino-style games. However, as long as they cannot win 'money or anything else of value', the website hosting the games is not considered to be a prohibited gambling service pursuant to the *Interactive Gambling Act 2001*.⁷⁰

1.75 Social networking sites such as Facebook are the platform for many of these games. We hold grave concerns that Australia will witness an extraordinary increase in the number of people developing gambling problems due to the sheer number of casino-style games available and the ease with which they will be accessed, particularly by young people.

1.76 Also of concern is that even where the Australian Communications and Media Authority (ACMA) has identified a website as being in contravention of the *Interactive Gambling Act 2001*, the Australian Federal Police (AFP) have not prosecuted nor issued fines to a single website as a result.⁷¹ If the government takes the threats posed by online gambling seriously, it must start by prosecuting those sites that are operating in Australia illegally.

The need for a legislated duty of care

No evidence that anyone has been approached by staff

1.77 As with earlier inquiries, the committee heard again from a number of problem gamblers who spent sometimes years frequenting the same venues, exhibiting signs of problematic gambling behaviour and yet none had been approached by staff.

68 Geesche Jacobson, 'Punter wants return of 'proceeds of crime'', *Sydney Morning Herald*, 25 May 2012, p. 2.

69 Section 4, *Interactive Gambling Act 2001* (Cth).

70 Section 4, *Interactive Gambling Act 2001* (Cth).

71 Senate Standing Committee on Environment and Communications, Additional Estimates Hearing February 2012, Broadband, Communications and the Digital Economy Portfolio, Question Number 60.

A former problem gambler listed all the behaviours they exhibited at the venue they attended regularly, adding that no staff intervened:

Clubs have a duty of care. Most of my gambling occurred at one club and I exhibited well known signs of problem gambling that should have led to intervention by staff but did not. These included:

- I gambled on my own
- I did not interact or talk with other gamblers
- I attended one club on a very frequent basis – 3-4 consecutive nights every week
- I visited this club at an odd time – from midnight to early in the morning, often up to 4.00am when the club closed. As I arrived late, the doors to the club were locked and a staff member was required to let me in
- I usually had large bets, often playing the maximum bet
- I carried on playing even after large wins
- I was secretive about finances
- I made numerous ATM withdrawals on the same night
- I had superstitions - only played certain machines, either sitting on one machine for a very long time or moving quickly between my favourites.
- I talked to the machines or touched/stroked them
- I always sat in the same position
- I gambled for relatively long periods of time without taking any breaks
- I played very fast, putting money in and pushing buttons quickly
- I would get angry and frustrated. I would groan, curse and sometimes hit a machine if I was losing
- I would feel depressed or get edgy or anxious or worried if I was losing but could be euphoric when I won

For staff in gaming venues, the signs of problem gambling are extremely important to know. The club I gambled in claims it adhered to all the legislation governing its activities and responsibilities. BUT they were negligent in my case and breached enacted codes of conduct and regulations governing gaming machines. They did not have a gambling contact officer on duty and if any staff were trained in recognising problem gamblers they did not act on their suspicions. I interacted with staff yet no-one intervened.⁷²

1.78 Ms Julia Karpathakis, Manager, Pokies Anonymous, played for 10 years and was not approached but instead was encouraged to play on as the machine had not

72 Name Withheld, *Submission 57*, pp 2–3.

gone off.⁷³ She exhibited behaviour patterns consistent with a gambling problem such as going back and forth to the ATM.⁷⁴

1.79 Miss Shonica Guy, Pokies Anonymous, told the committee about her more recent experience. Miss Guy said that she could spend up to 10 hours in a session and was known as a regular at a few hotels: the New York Bar and Grill, the Flagstaff Hotel and the Tonsley Hotel. She told the committee that no staff member ever approached her.⁷⁵

1.80 Miss Guy and Ms Karpathakis then said that they believe the venue staff know who has a problem:

Miss Guy: I think they know but—

Ms Karpathakis: Of course they know.

Miss Guy: But it is like here. Looking out here we know exactly who is here. Everyone in there is hooked, as far as I am concerned. You can see it. They are like zombies. The 40 per cent or whatever of people who have got problems with pokies, I think, is an underestimate, because any time I have been in venues everyone in there is hooked, basically. There are no people coming in there just for two seconds or for \$5 and leaving that I have ever seen. Usually, everyone is there and they are there for a long time, along with me.⁷⁶

1.81 Mr Tom Cummings told the committee that he was not aware of anyone who has ever been approached by a staff member about their gambling.⁷⁷ Mr Ralph Bristow, Member, Gambling Impact Society NSW, reported that he had not been approached about his gambling problem over 30 years. He added that his problem would have been obvious from the number of times he got change. He also never saw staff approach anyone else.⁷⁸

1.82 Major Brad Halse, Member, Australian Churches Gambling Taskforce, also mentioned that despite the commentary from industry about trying to assist problem gamblers he has never heard of anyone reporting they have been approached by staff and therefore:

...even at the most basic level this duty of care seems to be overlooked or disregarded. It is a very serious issue.⁷⁹

73 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, p. 11.

74 Ms Julia Karpathakis, *Committee Hansard*, 14 May 2012, pp 12–13.

75 Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 13.

76 Ms Julia Karpathakis and Miss Shonica Guy, *Committee Hansard*, 14 May 2012, p. 15.

77 Mr Tom Cummings, *Committee Hansard*, 3 May 2012, p. 2, 6.

78 Mr Ralph Bristow, *Committee Hansard*, 2 May 2012, p. 41.

79 Major Brad Halse, *Committee Hansard*, 3 May 2012, p. 13.

1.83 Staff from the Gambling Treatment Program at St Vincent's Hospital recalled there may have been one client who indicated they had been approached by the staff in a venue.⁸⁰

1.84 On 12 July 2012, the ABC's *730* program showed the story of a woman who was about to go to jail for stealing money from employers to feed a poker machine addiction. Her gambling started socially in the late 1990s and escalated after a relationship breakdown. Her losses were almost entirely from three hotels in Adelaide's south:

She says although she was losing more than \$1,000 an hour at times, the venues did not intervene.

"I believe the staff are trained to identify problem gamblers and if they are trained why aren't they doing it?" she said.

"I would see other people spending just as much or more than I was and I never saw them tapped on the shoulder either."⁸¹

1.85 This story, like so many others, illustrates a number of issues. It shows that staff do not intervene and it shows that if the maximum bet was reduced she would have lost much less. It also shows that the hotels which had the trained staff who took no action bear no responsibility even though this woman would have been exhibiting signs of problem gambling.

How to ensure action is taken

1.86 In 2006, the Ontario Problem Gambling Research Centre released a report 'Do Ontario and its Gaming Venues Owe a Duty of Care to Problem Gamblers?' which examined the role of the state to act in the public interest.⁸² Researchers on this issue have stated:

In the gambling literature little has been said about supply-side issues of product safety, host responsibility and player protections, as part of industry or provider corporate social responsibility (CSR); and governments have been slow to embrace these in terms of legislation or regulation; since their vested interests render them limited by conflict of interest.⁸³

80 Ms Abigail Kazal, Dr Katy O'Neill, *Committee Hansard*, 2 May 2012, p. 23.

81 See <http://www.abc.net.au/news/2012-07-12/leanne-scott-pokies-addiction/4127246> (accessed 13 July 2012).

82 William V. Sasso and Jasminka Kalajdzic, 'Do Ontario and its Gaming Venues owe a Duty of Care to Problem Gamblers?', Final report submitted to the Ontario Problem Gambling Research Centre, February 2006. Note: A detailed critique of this paper was prepared by Cameron (2007) a professor of Law at the request of a legal firm which has acted for the Ontario Lottery and Gaming Corporation. See further discussion in Hancock, L, Schellinck, T, and Schrans, T, 'Gambling and corporate social responsibility (CSR): Re-defining industry and state roles on duty of care, host responsibility and risk management', Science Direct, *Policy and Society*, 27 (2008) 55–68.

83 Hancock, L, Schellinck, T, and Schrans, T, 'Gambling and corporate social responsibility (CSR): Re-defining industry and state roles on duty of care, host responsibility and risk management', Science Direct, *Policy and Society*, 27 (2008), p. 66.

1.87 The researchers concluded that a legislated duty of care may place pressure on providers to be more proactive in protecting consumers:

We argue these debates on duty of care have reached a tipping point in relation to electronic gaming machines (EGMs). The spectre of legal liability may put new pressure on providers (and on governments as legitimators of gambling products). It may compel more coercive player-protection interventions, as gaming is bracketed with other social harms such as tobacco and alcohol, in terms of new expectations on both industry and governments to adopt more proactive consumer protection strategies; or face the threat of legal action.⁸⁴

1.88 Dr Mark Zirnsak, Member, Australian Churches Gambling Taskforce, argued that in order to change this situation in Australia, the Taskforce recommends a legislative duty of care to make clear there is a duty of care towards patrons which would encourage different behaviour by venues:

In our submission we make a recommendation about building in a legislative duty of care similar to what governments have done with occupational health and safety—employers have been made responsible for ensuring that there is a safe workplace. If it was made much more clear under law that there was a duty of care towards patrons, I think you would see very different behaviour from gaming venues. You would probably see, as we have seen in some Canadian casinos, a willingness to provide staff intervention when people are displaying clear signs of problem gambling.

But at the moment is very hard to get the courts to uphold a duty of care, even where they have identified that the person has a gambling problem. One of the most perverse cases was in the UK. Despite the fact that the person had a gambling problem and the venue knew they had a gambling problem, the judge made a ruling that the person would have lost their money somewhere else if they had not lost it at that venue, and therefore the venue was not responsible for the person's harm.⁸⁵

1.89 Dr Zirnsak added that currently:

Even in cases where a casino is individually targeting a person with a whole lot of inducements—free gifts, limousine rides and hotel stays—courts have generally not taken a view that there is a duty of care towards that person or that the venue had any obligation to figure out where that person's finances were coming from. And those were cases where people were defrauding their employers or stealing from their employers to provide the finance for their gambling. So, even when somebody has been individually targeted by a gambling provider the courts have not generally seen a duty of care being required.⁸⁶

84 Hancock, L, Schellinck, T, and Schrans, T, 'Gambling and corporate social responsibility (CSR): Re-defining industry and state roles on duty of care, host responsibility and risk management', Science Direct, *Policy and Society*, 27 (2008), p. 67.

85 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 12.

86 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 12.

1.90 Mr Mark Henley, Member, Australian Churches Gambling Taskforce, said that such legislation is already in place in jurisdictions like Switzerland.⁸⁷ Dr Zirnsak explained that under this proposal they would expect to see a change of behaviour within the industry and a change in culture to adopt a duty of care approach in order to avoid such cases. He pointed out that even now with self-exclusion contracts there is a clause indemnifying the venue against having to enforce the self-exclusion contract in Victoria, which is a deliberate attempt to avoid any judicial action by a gambler.⁸⁸ Dr Zirnsak provided the following example of a successful action:

The case I can think of where there was successful action against a venue in New South Wales, to my recollection, was a case where the venue knew the person had a gambling problem. The person was getting cash advances on their Amex card. From recollection, the venue was assisting them defrauding. The venue was eventually prosecuted by Amex for the misuse of the credit card, not because the venue had been preying on the person with the gambling problem.⁸⁹

1.91 The Productivity Commission identified international examples from New Zealand and Switzerland which have 'mandatory requirements for more 'proactive' identification and intervention in venues'.⁹⁰

1.92 We note a move towards a greater duty of care in some clubs for staff who are not allowed to gamble off-duty due to the results from research that found staff working at gaming venues have a greater risk of developing gambling problems than the general population.⁹¹ Surely a duty of care to staff should be extended to patrons.

Conclusion

1.93 We note the Productivity Commission investigated this issue of a legislative duty of care and initially recommended it in the draft report but it was removed from the final report.⁹² Research has shown that problem gamblers can be identified and there is a checklist of behaviours available. Given developments in this area we believe this issue requires further investigation drawing on international examples.

1.94 The lack of staff intervention was again reinforced to the committee during this inquiry as in previous inquiries. Despite all the claims from the industry about staff training and wanting to assist problem gamblers, the committee has heard from many problem gamblers who gambled at the same venues for extended periods,

87 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 12.

88 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 12.

89 Dr Mark Zirnsak, *Committee Hansard*, 3 May 2012, p. 13.

90 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 12.38.

91 Mairi Manley, 'Club staff banned from pokies', *My Daily News*, 18 April 2012.

92 Productivity Commission, *Gambling*, vol. 1, Commonwealth of Australia, Canberra, 2010, p. 22.

sometimes years, and were known to the staff. Not one has reported being approached by the staff at a venue.

1.95 We recognise the difficulty and conflict this measure places on staff. These venues are a business and if patrons are spending a lot of money then it is not in the interest of the business to have staff approach them. The committee has heard that some staff fear for their jobs should they do so. In addition, approaching someone exhibiting signs of distress and fearing their response would be a difficult task for a person despite receiving some form of training.

1.96 This proposal would make the industry more responsive to problematic gambling behaviour. Under a legislated duty of care, if a person frequents the same venue for a lengthy period, is known as a patron, exhibits behaviour consistent with a gambling problem on a regular basis, is not approached by staff and subsequently gets into difficulty with their gambling then they would be able to take action against the venue for breaching their duty of care under the law. So for example, people like Miss Shonica Guy who named the pubs she frequented, Ms Julia Karpathakis and others who frequented the same venues, for lengthy periods, were known to staff, were not approached by staff and developed gambling problems would be able to take such action. We believe this would result in a change of behaviour from venues.

Recommendation 2

1.97 That the Problem Gambling Taskforce within the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs commission work by an independent individual/organisation to further investigate a legislated duty of care for venues. This work would draw on international examples, discuss and weigh up the obstacles, benefits and costs and be reported to the COAG Select Council on Gambling Reform and made public.

Treatment, research and data collection

1.98 We support the recommendations made by the committee throughout the second half of the report on treatment, research and data collection. The committee heard from service providers about the range of different treatments for problem gambling, both clinical and non-clinical (i.e. counselling and self-help). We commend all treatment service providers who gave evidence to the inquiry for their dedication in assisting people with gambling addictions and their commitment to find ways to continually improve their services to achieve better and more rigorous treatment outcomes. We also support the work of voluntary self-help organisations such as Pokies Anonymous who provide grassroots community support for people and families affected by gambling problems. We were surprised to hear about the success of online interventions which provides people with anonymity and flexibility. Given the shame and stigma associated with problem gambling, which is a key barrier to accessing help, we are pleased that these flexible models of treatment are becoming increasingly available to assist people with gambling problems, particularly young men.

1.99 We also heard about suggested improvements to the treatment services system, including better integrated services to deal with people who have comorbidities, such as co-occurring gambling and substance abuse problems. We agree that referral pathways to assistance can be strengthened by increasing knowledge and awareness of gambling problems across the health system, particularly among primary care health professionals such as general practitioners.

1.100 In relation to data collection, we support the committee's recommendations on the need for a national research agenda, overseen by an independent research institute on gambling, as well as the designation of problem gambling as a National Health Priority Area under the National Health and Medical Research Council and an associated health priority eligible for funding under the Australian Research Council's National Research Priority on health. We also agree that joint efforts should be made across all jurisdictions towards establishing a national minimum dataset on gambling. Governments should also work together to collect a basic level of nationally consistent industry data.

1.101 Also in line with the committee, we affirm the need for researchers engaged in gambling studies to declare clearly all potential conflicts of interest and funding sources, particularly relationships with industry. Any government-funded research should require full transparency of such relationships. We also support the committee's recommendation to build good outcome measurements and benchmarking practices into treatment services to strengthen evaluation of the best ways to assist people with gambling addictions.

Other issues

Debt repayments and access to credit

1.102 The committee heard that for some problem gamblers, the prospect of having years of debt repayments ahead of them can reduce their motivation to stop gambling. We note that this clearly indicates that it needs to be harder for problem gamblers to access credit, as debt serves as a disincentive to seek help.

Possible triggers for problem gambling

1.103 We note the link between certain medications and the onset of problem gambling. A class action is currently underway against the drug companies that manufacture the Parkinson's drugs 'Permax' and 'Cabaser' where the plaintiffs claim their compulsive gambling was a side effect of the drug. The Adelaide woman who was jailed for six years for stealing over \$800,000 from two previous employers reported that shortly after she was prescribed the antidepressant 'Efexor-XR' she developed a poker machine addiction.⁹³

93 See Guy Stayner, 'Addicts link anti-depression drug to gambling habit', ABC News Online, 24 July 2012, <http://www.abc.net.au/news/2012-07-23/addicts-link-anti-depression-drug-to-gambling-habit/4148950> (accessed 14 September 2012); 'Parkinson's medication "causes sex, gambling addictions"', ABC News Online, 4 June 2010, <http://www.abc.net.au/news/2010-06-04/parkinsons-medication-causes-sex-gambling/854000> (accessed 14 September 2012).

1.104 There is emerging anecdotal evidence of the connection between problem gambling and 'Efexor-XR'.

Recommendation 3

1.105 That an appropriately resourced research facility initiate a study into the possible link between Efexor-XR and the onset of problem gambling.

Mr Andrew Wilkie MP

Chair

NICK XENOPHON

Independent Senator for South Australia

Senator Di Natale

Australian Greens

Senator for Victoria

Senator John Madigan
Democratic Labor Party
Senator for Victoria

Appendix 1

Submissions received for the inquiry into the prevention and treatment of problem gambling

Submission No.

1. Name Withheld
2. Scientific and Technology Innovations
3. Gambling Treatment Program, St Vincent's Hospital Darlinghurst
4. Mr Tim Falkiner
4A. Supplementary Submission
5. Mr Douglas Stewart
6. Dr Clive Allcock
7. Dr Jeffrey Derevensky
8. Flinders University
8A. Supplementary Submission
9. ACT Gambling and Racing Commission
10. University of Sydney Gambling Treatment Clinic
11. Ms Joyce Sanders
12. Anglicare Tasmania
13. St Luke's Anglicare
14. Confidential
15. Tasmanian Gaming Commission
16. Oakdene House Foundation
17. Mission Australia
18. Relationships Australia
19. James
20. Department of Families, Housing, Community Services and Indigenous Affairs, Problem Gambling Taskforce
21. Betfair
22. Mr Tom Cummings
22A. Supplementary Submission
23. Gaming Technologies Association Limited
24. Beverley Kliger and Associates

25. Victorian Local Governance Association
26. Anglican Church Diocese of Sydney
27. The Royal Australian and New Zealand College of Psychiatrists
28. Australian Christian Lobby
29. Clubs Australia
30. Gambling Impact Society (NSW)
31. Pokies Anonymous
32. BetSafe
33. Australasian Gaming Council
34. AMC Convergent IT
35. Responsible Gambling Advocacy Centre
36. FamilyVoice Australia
37. Dr Sally Gainsbury
38. Name Withheld
39. Associate Professor Peter Adams
40. Sportsbet
41. City of Moonee Valley
42. Turning Point Alcohol and Drug Centre
43. Australian Hotels Association
44. Regis Controls Pty Ltd
- 44A. Confidential Supplementary Submission
45. Enough Pokies in Castlemaine
46. Australasian Casino Association
47. Tasmanian Department of Health and Human Services
48. iBus Media Limited Isle of Man
49. Australian Psychological Society
50. Australian Churches Gambling Taskforce
51. NSW Government
52. Dr Samantha Thomas
53. Ian
- 53A. Supplementary Submission
54. Ms Beverley Kilsby
55. Independent Gambling Authority

56. Name Withheld
57. Name Withheld
58. Australian Bankers' Association
59. UnitingCare Community
60. Name Withheld

Additional Information Received

1. Tabled document from Gaming Technologies Association, at Sydney public hearing 2 May 2012
2. Tabled document from Gambling Impact Society NSW, at Sydney public hearing 2 May 2012
3. Tabled document from Australian Psychological Society, at Canberra public hearing 14 May 2012
4. Tabled document from Australian Psychological Society, at Canberra public hearing 14 May 2012
5. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
6. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
7. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
8. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
9. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
10. Tabled document from Professor Malcolm Battersby, at Canberra public hearing 14 May 2012
11. Correspondence from the Office for Problem Gambling, Department for Communities and Social Inclusion (SA), received 24 May 2012
12. Additional Information from Norsk Tipping, received 6 June 2012
13. Additional Information from Ms Ingeborg Lund, received 12 June 2012
14. Additional Information from The Norwegian Ministry of Culture, received 16 July 2012

Answers to Questions on Notice

1. Professor Alex Blaszczynski, received 7 May 2012
2. Betsafe, received 7 May 2012
3. University of Sydney Gambling Treatment Clinic, received 23 May 2012
4. St. Vincent's Hospital Gambling Treatment Program, received 23 May 2012
5. Gaming Technologies Association Ltd, received 25 May 2012
6. Gaming Technologies Association Ltd, received 25 May 2012
7. Gaming Technologies Association Ltd, received 25 May 2012
8. Turning Point Alcohol and Drug Centre (VIC), received 28 May 2012
9. Australian Psychological Society, received 6 June 2012
10. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
11. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
12. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
13. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
14. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
15. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
16. Department of Families, Housing, Community Services & Indigenous Affairs, received 19 June 2012
17. Gaming Technologies Association Ltd, received 20 June 2012
18. Gaming Technologies Association Ltd, received 20 June 2012
19. Gaming Technologies Association Ltd, received 20 June 2012
20. Clubs Australia, received 27 July 2012
21. Australasian Casino Association, received 5 September 2012
22. Australian Hotels Association, received 17 September 2012

Correspondence

1. Correspondence from the South Australian Department for Communities and Social Inclusion, received 21 May 2012
2. Correspondence from the Department of Racing, Gaming and Liquor (WA), received 24 May 2012
3. Correspondence from the Office of Regulatory Policy, Liquor, Gaming and Fair Trading, Department of Justice and Attorney-General (QLD), received 4 June 2012
4. Correspondence from the ACT Gambling and Racing Commission, received 8 June 2012
5. Correspondence from the ACT Gambling and Racing Commission, received 12 June 2012

Appendix 2

Public Hearings and Witnesses

Tuesday, 28 February 2012 – Canberra, ACT

Prof. Alex Blaszczyński

Dr Sally Gainsbury

Tuesday, 20 March 2012 – Canberra, ACT

Roy Morgan Research

Mr Victor Dobos, Business Development Manager

Ms Michele Levine, Chief Executive Officer

Mr Norman Woodcock, Director, Business Development

Wednesday, 2 May 2012 – Sydney, NSW

Mission Australia

Mr David Pigott, National Manager, Government Relations

Professor Alex Blaszczyński

Dr Sally Gainsbury

St Vincent's Hospital Gambling Treatment Program

Dr Katy O'Neill, Clinical Psychologist

Ms Abigail Kazal, Senior Clinical Psychologist and Program Manager

Ms Siobhan McLean, Clinical Psychologist

BetSafe

Mr Paul Symond, General Manager

Mr Daniel Symond, Operations Manager

Gambling Impact Society (NSW)

Ms Kate Roberts, Chairperson

Mrs Dorothy Webb, Secretary

Mr Ralph Bristow, Committee Member

Ms Rhian Jones, Committee Member

Gaming Technologies Association Ltd

Mr Ross Ferrar, Chief Executive Officer

Thursday, 3 May 2012 – Melbourne, VIC

Mr Tom Cummings

Australian Churches Gambling Taskforce

Major Brad Halse, Member

Mr Mark Henley, Member

Dr Mark Zirnsak, Member

Dr Samantha Thomas

Responsible Gambling Advocacy Centre

Ms Penny Wilson, Chief Executive Officer

Royal Australian and New Zealand College of Psychiatrists

Professor Dan Lubman, College Fellow

Dr Enrico Cementon, College Fellow

Turning Point Alcohol and Drug Centre

Professor Dan Lubman, Director and Professor of Addiction Studies and Services,
Monash University

Ms Simone Rodda, Coordinator, Gambling Treatment Programs

St Luke's Anglicare

Ms Leah Galvin, Manager of Social Policy and Advocacy

Monday, 14 May 2012 – Canberra, ACT

Professor Malcolm Battersby

Associate Professor Peter Harvey

Dr Natalie Glinka

Pokies Anonymous

Ms Julia Karpathakis, Manager

Miss Shonica Guy, Volunteer Coordinator

Australian Churches Gambling Taskforce

Reverend Tim Costello, Chair

Dr Jennifer Borrell, Adviser

Australian Psychological Society

Ms Heather Gridley, Manager, Public Interest

Ms Amanda Jones, Member, Public Interest Advisory Group

Ms Emma Sampson, Research and Policy Officer

Professor Debra Rickwood, Professor of Psychology

Mission Australia

Ms Christina Sanchez, Team Leader

Productivity Commission

Dr Ralph Lattimore, Assistant Commissioner

Ms Rosalie McLachlan, Inquiry/Research Manager

Department of Families, Housing, Community Services and Indigenous Affairs

Mr David Agnew, Branch Manager, Problem Gambling Taskforce

Ms Liza Carroll, Deputy Secretary

Ms Amanda Cattermole, Group Manager, Problem Gambling Taskforce

Ms Robyn Oswald, Branch Manager, Money Management Branch

University of Sydney Gambling Treatment Clinic

Mr Christopher Hunt, Psychologist

Monday, 18 June 2012 – Canberra, ACT

Dr Samantha Thomas

Tuesday, 26 June 2012 – Canberra, ACT**Norsk Tipping**

Mr Bjorn Helge Hoffmann, Senior Adviser

Mr Lars Martin Ottesen, Games Manager VLT

Mr Arve Sjølstad, Brand Manager VLT (Multix/Belago)

