

**Submission  
No 8**

## **INQUIRY INTO IMPACT OF GAMBLING**

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**Date received:** 7/03/2014

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The Director  
Select Committee on Gambling  
Parliament House  
Macquarie St  
Sydney, NSW, 2000

## SUBMISSION TO THE NEW SOUTH WALES LEGISLATIVE COUNCIL INQUIRY INTO GAMBLING

**Submitted by:**

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**Disclosure:** The author of this submission is currently employed at the University of Sydney Gambling Treatment Clinic. The University of Sydney Gambling Treatment Clinic is funded under the NSW Government Responsible Gambling Fund (RGF). The views expressed here reflect the views of the author alone and not of the RGF, the University of Sydney, nor of the director or any other staff members of the GTC.

**Submission:**

*Introductory Comments*

I have been employed in the gambling treatment sector for a period since 2007, and have worked closely during this time with many clinicians and researchers in the field. As someone who has been trained in the scientist-practitioner model, I have consistently advocated for applying systematic review and accepted research methods to a given problem in order to generate sensible discussion and arrive at evidence-based conclusions.

Unfortunately, much of the debate on problem gambling has placed great emphasis on untested theories and approaches to understanding problem gambling. Given the large amount of money that is associated with the gambling industry, and the potentially massive impact that problem gambling can have on the lives of gamblers and their friends and family, it is understandable that the issue is a highly emotive one for many. However, it is often the case the claims and counter-claims made by both pro- and anti-gambling advocates, including those that have wide-spread support within either the gambling industry or the wider community, are often made on very weak or absent evidence, and rational evaluations of such claims often reveal them to be baseless.

I believe that listening to the individual stories of problem gamblers, both past and present, can help illuminate the high human cost that gambling can have. However, given that individuals perform quite poorly at deducing the reasons for their own behaviour<sup>1</sup>, and individual gamblers may not be consciously aware of what factors determine their

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<sup>1</sup> Nisbett, R. and T. Wilson (1977). Telling more than we can know: Verbal reports on mental processes. *Psychological Review*, 84, 231-259.

gambling behaviour<sup>2</sup>, any thorough review of treatment must move beyond stories of what problems individual gamblers have faced and what helped them reduce their gambling, and towards a systematic evaluation the currently available academic and clinical evidence on the best ways of preventing gambling problems and in assisting problem gamblers.

Given the extremely comprehensive terms of reference of the inquiry, this submission will focus on the issues that pertain most directly to areas where I have had previous experience: specifically the treatment of problem gambling and support of those affected, promotion of gambling treatment services and other public messages about gambling, and some specific regulatory issues. As much of this submission will outline, there are currently major holes in the available research evidence, and considerably more funding and attention should be directed to addressing these gaps. My submission however, has attempted to address the issues raised by the Committee on the basis of the currently available research evidence and a systematic review of what has been observed in my clinical work.

#### *Treatment and Support of Those Affected by Problem Gambling*

It was noted that one of the key terms of reference for the current inquiry was “The adequacy and effectiveness of problem gambling help services and programs, including service standards, qualifications and funding of chaplaincy, counselling and treatment services”. I believe that this is an important issue that needs a detailed examination.

At present, the majority of services for problem gamblers in NSW (including our service) are funded by the Responsible Gambling Fund (RGF). The RGF has long attempted to ensure that all residents of NSW have access to funded gambling treatment services, and has attempted to ensure that the services that are available are being utilised effectively by those in need. These aims are to be lauded. However, a potential unintended consequence of these aims has been that in funding services, the RGF has focused on client numbers and regional coverage in evaluating services, and less focus has been given to client follow-up data. There also appears to be a belief in the general community that all forms of support and treatment are equally effective. This approach is problematic for several reasons as shall be detailed below.

Firstly, “gambling disorder” (previously referred to as “pathological gambling”) has long been recognised as a psychiatric condition, and is currently listed in the American Psychiatric Associations Diagnostic and Statistical Manual (DSM)<sup>3</sup>. As such, problem gambling should be treated as a serious condition, with a focus on treatment rather than support services. Just as with other psychiatric conditions, such as depression, anxiety and schizophrenia, whilst support services for affected individuals and their families is an important adjunct, government-funded treatment services should primarily be staffed with psychologists, psychiatrists and social workers. Similarly, problem gamblers often meet

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<sup>2</sup> Walker, M., Schellink, T., & Anjoul, F. (2008). Explaining why people gamble. In: Zangeneh, M., Blaszczyński, A., & Turner, N. E. [Eds.] *In the pursuit of winning: Problem gambling theory, research and treatment*. New York, NY, US: Springer Science + Business Media.

<sup>3</sup> American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

diagnostic criteria for other disorders that require treatment, with one study finding 73% of problem gamblers also meet diagnostic criteria for alcohol-use disorders, 49% meeting criteria for a mood disorder, 41% meeting criteria for an anxiety disorder, and 60% meeting criteria for a personality disorder<sup>4</sup>. Given this high rate of co-morbidity with other psychiatric conditions, it is necessary for any individuals working with problem gamblers to be able to also recognise and provide treatment options for such a broad range of disorders. Furthermore, other research has also found a high rate of suicidal ideation in problem gamblers<sup>5</sup>, and as such individuals working in the field need to possess high level of suicide assessment and management skills. While the RGF did institute a “minimum qualification” framework several years ago, which does include work on suicidality, the treatment focus of the qualifications obtained under this framework are, understandably, centred on primarily on the treatment of gambling, and provide little training on the assessment and treatment of other associated mental health conditions. As such, the RGF’s current focus on the “minimum qualification” framework should be expanded to include training related to the recognition of such conditions, and services that are funded should be staffed by, or have access to, high trained mental health professionals such as psychologists, psychiatrists and social workers who are qualified to work with such disorders.

Secondly, it has been raised in the terms of reference for the current inquiry that chaplaincy, self-help groups and other non-treatment-focused support services should also been granted increased funding. These forms of support are frequently discussed in the context of gambling, and anecdotally there are individuals who report satisfaction and improvements with these forms of support. However, given the paucity of the available scholarly evidence, I would argue against such approaches becoming a main-stay of gambling treatment. Only one of these forms programmes, the faith-based Gamblers Anonymous (GA), has been seriously evaluated for its effectiveness in treating problem gambling. Whilst undoubtedly there are those who do find such services helpful (and the committee is likely to hear from some of these individuals), the research evidence is generally mixed. While a review of studies have shown that improved outcomes in some individuals who have attended GA<sup>6</sup>, other studies have been less supportive, with one study showed that only 7% of attendees remain abstinent from gambling two years after attending meetings<sup>7</sup>. What does appear to be clear is that those who attend GA alone have poorer outcomes than those who attend professional treatment<sup>8</sup>. This would suggest that,

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<sup>4</sup> Petry, N. M., Stinson, F. S., & Grant, B. F. (2005). Comorbidity of DSM-IV Pathological Gambling and Other Psychiatric Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 66, 564-574.

<sup>5</sup> Maccallum F, & Blaszczynski A. (2003). Pathological gambling and suicidality: an analysis of severity and lethality. *Suicide and Life Threatening Behaviors*;33, 88-98.

<sup>6</sup> Ferentzy, P., & Skinner, W. (2003). Gamblers Anonymous: A critical review of the literature. *Journal of Gambling Issues*, 9.

<sup>7</sup> Stewart, R.M., & Brown, R.I. (1988). An outcome study of Gamblers Anonymous. *British Journal of Psychiatry*, 152, 284-288.

<sup>8</sup> Grant, J.E., Donahue, C.B., Odlaug, B.L., Kim, S.W., Miller, M.J. & Petry, N.M. (2009) Imaginal desensitisation plus motivational interviewing for pathological gambling: randomised controlled trial. *British Journal of Psychiatry*, 195, 266-267.

Petry, N.M., Ammerman, Y., Bohl, J., Doersch, A., Gay, H., Kadden, R., Molina, C., Steinberg, K. (2006). Cognitive-behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology*, 74, 555-567.

whilst this approach may work for a few supporters, the currently available evidence does not support its use as a treatment for the majority of problem gamblers.

Clarifying what forms of treatment and support for problem gamblers is the most effective is a question that is best answered through an examination of follow-up data of clients who have previously progressed through treatment. The RGF does encourage services to conduct follow-ups of their clients after they have completed treatment, which is to be praised. However, many of the questions are overly focused on clients' personal satisfaction with the service, rather than changes in their gambling behaviour, that can be examined through use of validated psychometric measures. Having the RGF collect and examine data from post-treatment follow-ups, which as mentioned before is already a requirement for services, and to change the questions asked to those based on validated psychometric measures of gambling would be a relatively simple change that would aid in the assessment of services.

The “any support is better than none” approach is also flawed as it assumes that there is no “gold-standard” approach to the treatment of problem gambling. Whilst there is considerable clinical and academic debate about the best approach to treatment, it is wildly incorrect to say that there are not proven, effective treatments available for problem gambling. One of the main objectives of during my time at the Gambling Treatment Clinic has been to work with my colleagues to determine the most effective treatment or treatments for problem gambling. To this end, several different treatment modalities have been examined, including Cognitive Therapy, Cognitive Behavioural Therapy, Solution Focused Brief Therapy, Imaginal Desensitisation, Multimodal Therapy and supportive counselling.

Cognitive Behavioural Therapy (CBT)<sup>9</sup> is currently the treatment for problem gamblers with the most available evidence supporting its efficacy in Australia and elsewhere, with a review of all treatment options from problem gambling recommending its use<sup>10</sup>. This treatment focuses on identifying and working with triggers to gambling, addressing some irrational beliefs about gambling, and looking for alternative behaviours to engage in instead of gambling. It remains one of the treatments that I have utilised during my practice.

However, unpublished data and therapist reports that I have observed during my practice reveal a slightly different story. In fact, I have good reason to speculate that pure Cognitive Therapy (CT) presents the best treatment option for problem gamblers. The CT approach, developed by the University of Sydney Gambling Treatment Clinic's Education and Training Officer, 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 literature from Canada supporting the effectiveness

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<sup>9</sup> Petry, N.M., Ammerman, Y., Bohl, J., Doersch, A., Gay, H., Kadden, R., Molina, C., & Steinberg, K. (2006). Cognitive-Behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology, 74*, 555–567.

<sup>10</sup> Toneatto, T., & Ladoceur, R. (2003). Treatment of Pathological Gambling: A Critical Review of the Literature. *Psychology of Addictive Behaviors, 17*, 284-292.

of related cognitive approaches to treating problem gambling<sup>11</sup>, and a recent review revealed an advantage of CT-based treatments over CBT<sup>12</sup>. Current data, gathered at the my workplace, 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<sup>13</sup>. In fact, preliminary data on CT that was reported in the Productivity Commission's 2010 report on gambling (pp. 7.34)<sup>14</sup> 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. The GTC is currently planning to commence a randomised control trial of both of these treatments shortly and will therefore be better able to inform the broader public about best practice in the treatment of problem gambling.

It should be noted that other treatments that I have come into contact with have failed to reach minimal standards for efficacy. One such treatment, Solution Focused Brief Therapy (SFBT)<sup>15</sup> is still popular and widely used in the sector but has no evidence to support its effectiveness a treatment for problem gambling. SFBT focuses on client strengths and avoids explicit discussion of the gambling behaviour itself. 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 2008, the use of SFBT was discontinued by staff at my workplace, the GTC, due to anecdotal reports of extremely poor client outcomes and high relapse rates in even the short-term.

#### *Promotion of Gambling Treatment Services and Public Health Messages*

It was noted that one of the terms of reference for the current inquiry was "The effectiveness of public health measures to reduce risk of gambling harm, including prevention and early intervention strategies". I welcome the committee examining this important issue. In my current position, I do not have access to the data and resources to conduct a formal evaluation of the effects of various campaigns and social media experiments targeting gambling launched by the NSW Responsible Gambling Fund, such as the rebranding of services under the "Gambling Help" banner, the "Counsellor Sam" Facebook page, and Responsible Gambling Awareness Week. I would note that client numbers have increased over the period that Counsellor Sam and the Gambling Help

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<sup>11</sup> Ladouceur, R., Sylvain, C., Boutin, C., Lachance, S., Doucet, C., Leblond, J., & Jacques, C. (2001). Cognitive treatment of pathological gambling. *Journal of Nervous and Mental Disease*, 189, 774-780.

<sup>12</sup> Gooding, P., & Tarrier, N. (2009). A systematic review and meta-analysis of cognitive-behavioural interventions to reduce problem gambling: Hedging our bets? *Behaviour Research and Therapy*, 47, 592-607.

<sup>13</sup> Hunt, C.J., & Prinz, K. (In preparation). The role of gambling belief and knowledge in the treatment of electronic gaming machine problem gamblers. University of Sydney.

<sup>14</sup> Australian Government Productivity Commission (2010). *Gambling*. Canberra: Authors.

<sup>15</sup> Berg, I.K., & Briggs, J.R. (2002). Treating the Person with a Gambling Problem. *Journal of Gambling Issues*, 6, doi: 10.4309/jgi.2002.6.1

branding have been active. While few clients specifically mention these campaigns when seeking treatment, it is possible that it still may be having an impact.

I also feel the need to bring attention to the “Gambling Hangover” campaign. This campaign, which was designed to appeal to young men who may experience gambling problems, may be misguided. The “Gambling Hangover” campaign highlights shame and guilt associated with gambling. My own research on this issue, which was recently presented at the National Association for Gambling Studies conference<sup>16</sup>, indicated that linking gambling to shame and guilt may in fact increase the stigmatisation of problem gamblers, which would make problem gamblers more reluctant to seek treatment. I am currently planning a follow-up study with various colleagues at the university to address this issue.

What has been noted, however, is that the numbers of clients seeking treatment at the GTC has increased following our own media releases to local and metropolitan print media. These releases, written by myself and contributed to by other staff at my service, 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 the service, our referral rates increased dramatically. These new callers often report that they had previously avoided seeking assistance for their gambling as they were not aware that effective treatment is available. My impression is therefore, 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.

### *Regulatory Issues*

Whilst the primary focus of my work is on the treatment of problem gambling, rather than on regulatory issues, I wish to make the following comments on some of the regulatory issues raised in the committee’s terms of reference, and other issues of current community concern.

#### *a) Pre-commitment and self-exclusion*

There has been considerable interest in the utility of pre-commitment, both mandatory and voluntary, in assisting problem gamblers with their gambling behaviour. Indeed, it was one of the terms of reference of the current inquiry. However, we would advise the committee to be extremely wary of any claims made about pre-commitment given the lack of currently available research evidence on the topic. A recent review of the limited research available suggested that whilst problem gamblers report a positive disposition towards such schemes, few utilise such limit setting technology when it is available<sup>17</sup>. There are also differing opinions amongst those clinicians working in the field as to whether

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<sup>16</sup> Hunt, C.J., Blaszczyński, A., Zadro, L., & Gonsalkorale, K. (November 2013). *The stigmatization of problem gamblers in Australia: A pilot study*. Presented at the National Association of Gambling Studies (Australia) Annual Conference, Sydney, Australia

<sup>17</sup> Ladouceur, R., Blaszczyński, A., & Lalande, D. R. (2012). Pre-commitment in gambling: a review of the empirical evidence. *International Gambling Studies*, 12, 215-230.

such an approach would be helpful or not, with even opinions within my current workplace varying wildly. This is understandable given the paucity of currently available research on the topic. Given the potential massive cost of implementing such a system, more research should be conducted before it is seriously considered being implemented, rather than the current reliance on asking problem gamblers whether they think it would be helpful

Similarly, there has been much focus in Australia on the use of self-exclusion of gamblers from gaming venues as a method of tackling problem gambling, with gaming venues often using the existence of such schemes to promote themselves as responsible providers of gambling. However, this is again an area where there is little directly relevant scholarly research. The currently available published evidence does provide some limited support for self-exclusion-based programmes<sup>18</sup>. However, this research was primarily conducted in overseas jurisdictions with a significantly lower concentration of gaming venues (typically in areas with a single casino) than is seen in NSW, where gaming machines are ubiquitous. This may suggest that self-exclusion programmes, if carefully designed, have the potential to be helpful in areas where there are limited gaming venues (e.g. in remote areas, or in Western Australia where only the one casino exists). My experience working with clients in the Sydney Metropolitan area however, is that self-exclusion is a futile endeavour. This is primarily due to the sheer number of gaming venues that exist, that allows gamblers easy access to alternative venues after they have been excluded from others. Indeed, whilst Clubs NSW is trialling a new system that allows gamblers to self-exclude from a number of venues simultaneously, given that the number of venues they can exclude from is capped, and the system only incorporates registered clubs and not hotels or the casino, I am unsure how it can succeed when gamblers can also still easily access other gambling opportunities. Anecdotally, my clients also report that self-exclusion orders are often poorly enforced by venue staff. This claim has also been reported by researchers working in other jurisdictions<sup>19</sup>, and reinforces my concerns about the effectiveness of self-exclusion as even a harm reduction measure in problem gambling.

*b) Advertising of Gambling*

I also thank the committee for raising the issue of the advertisement of gambling, which I have long held as an issue for concern. Currently, gambling is almost exclusively advertised by linking it with glamour, money, skill, and excitement. This is problematic, as learnt associations between gambling and winning money,

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<sup>18</sup> Hayer, T., & Meyer, G. (2011). Self-exclusion as a harm minimization strategy: Evidence for the casino sector from selected European countries. *Journal of Gambling Studies*. 27, 685-700.

Tremblay, N., Boutin, C., & Ladouceur, R. (2008). Improved self-exclusion program: Preliminary results. *Journal of Gambling Studies*. 24, 505-518.

Townshend, P. (2007). Self-exclusion in a public health environment: An effective treatment option in New Zealand. *International Journal of Mental Health and Addiction*. 5, 390-395.

<sup>19</sup> Nelson, S. E., Kleschinsky, J. H., LaBrie, R.A., Kaplan, S., & Shaffer, H. J. (2010). One decade of self-exclusion: Missouri casino self-excluders four to ten years after enrollment. *Journal of Gambling Studies*. 26, 129-144



explicitly encouraged in most if not all forms of gambling advertising, have long been known to be a core feature of the psychology of excessive gambling<sup>20</sup>. Any marketing that encourages gamblers to overestimate their chances of winning, overestimate their own skills, or the role of knowledge or skill in gambling in order to win money and acquire wealth are therefore directly aimed at creating and increasing the core pathology of problem gambling. The pervasiveness of such language and imagery in advertising serves to validate such associations, presenting them as factual statements in the public's mind. The persistent presentation of such language is then used to normalise these associations, marketing 'truths' and 'well known facts' to the public that is frequently cited but rarely questioned in public discourse.

Furthermore, an individual's conviction in their ability to win in the long run is the core pathology in problem gambling. Indeed, the GTC's position is that this is the only necessary and sufficient causal factor in the development of problem gambling. It seems that this belief in winning, which emerges after the individual experiences meaningful early wins at gambling, drives the gambler's curiosity and subsequent theorising on how to go about replicating such wins in order to make money over time. My belief is that any advertising that reinforces theorising about winning, obscures the likelihood of losing or fails to help gambler's understand the difficulties they need to overcome in order to win in the longer term encourages the development of problem gambling.

Whilst it goes without saying that most people exposed to gambling advertising will not go on to develop a gambling problem, advertising promoting this association is likely to have an influence on many individuals, especially on those who are particularly vulnerable to the effects of advertising, such as children or those with an intellectual disability. I would thus argue that advertising of gambling is likely to play a causal role in the development of gambling problems, and should be carefully regulated.

c) *Identification of problem gamblers by venue staff*

Whilst there has been a focus within the gambling industry and from other groups on training staff to identify problem gamblers within a gaming venue, there has been little published research investigating the most effective methods for doing this. Many training programmes focus on having venue staff identify potential problem gamblers based on losses of large sums of money or signs of distress during a single gaming session. Indeed, studies have shown that venue staff often feel confident in their ability to identify problem gamblers within a venue based

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<sup>20</sup> Joukhador, J., MacCallum, F., & Blaszczynski, A. (2003). Differences in cognitive distortions between problem and social gamblers. *Psychological Reports*, 92, 1203–1214.

Miller, N. V., & Currie, S. R. (2008). A Canadian population level analysis of the roles of irrational gambling cognitions and risky gambling practices as correlates of gambling intensity and pathological gambling. *Journal of Gambling Studies*, 24, 257–274.

Toneatto, T. (1999). Cognitive psychopathology of problem gambling. *Substance Use and Misuse*, 34, 1593–1604.

Toneatto, T., Blitz Miller, T., Calderwood, K., Dragonetti, R., & Tsanos, A. (1997). Cognitive distortions in heavy gambling. *Journal of Gambling Studies*, 13, 253–266

on certain discrete observable behaviours<sup>21</sup>. As problem gambling is defined by unaffordable losses over a long period of time, it would be difficult to identify problem gamblers with certainty based on their losses or behaviours during a single session. Research in this area has shown that despite their confidence, venue staff display poor accuracy and effectiveness in identifying and responding to potential problem gamblers.<sup>22</sup> Research into the behaviours displayed by problem gamblers over time in order to analyse whether any early displays of specific behaviours are predictive of later confirmed problem gambling is clearly needed. Training should be better designed to reflect any displayed behaviour identified by such research, as it appears that the current venue staff training regime results in false confidence in venue staff's ability to identify problem gamblers. As such, this line of research and training development should be a funding priority.

d) *Proposed new casino and the spread of casino table games*

Despite the wide ranging terms of reference of the current inquiry, it is notable that specific mention has not been made of the proposed new "high-roller" casino that is proposed for Barangaroo. Neither has reference been made to the recent loosening of laws concerning electronic versions of casino table games. As I have mentioned in public comments previously, and in keeping with the stated aim of the current submission of drawing attention to claims made without a factual basis, it would be remiss not to draw attention to both of these issues. At present in my clinical work I have seen an upswing of gamblers who gamble primarily on casino table games (either at the Star Casino or on electronic versions of these games located in registered clubs), with baccarat in particular proving to be increasingly popular at present. At such, the loosening of regulation around electronic casino games and the development of a new casino presents great risks of encouraging increasing number of individuals to develop gambling problems.

With the granting of the licence to the proposed new casino to be developed at Barangaroo, measures have been suggested to supposedly to discourage problem gamblers from accessing the approved new casino. Currently it has been proposed that the minimum bet sizes would be \$30 for baccarat, \$20 for blackjack and \$25 for roulette. In public statements, the Premier Barry O'Farrell has stated that such minimum bet sizes would deter the majority of local

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<sup>21</sup> Delfabbro, P., Osborn, A., Nevile, M., Skelt, & McMillen, J. (2007). Identifying Problem Gamblers in Gaming Venues: Final Report. Melbourne, AU: Gambling Research Australia.

Hing, N. & Nuske, E. (2011). Assisting problem gamblers in the gaming venue: an assessment of practices and procedures followed by frontline hospitality staff, *International Journal of Hospitality Management*, 30, 459-467

<sup>22</sup> Delfabbro, P., Borgas, M., & King, D. (2012). Venue staff knowledge of their patrons' gambling and problem gambling. *Journal of Gambling Studies*, 28, 158-169.

Delfabbro, P., Osborn, A., Nevile, M., Skelt, & McMillen, J. (2007). Identifying Problem Gamblers in Gaming Venues: Final Report. Melbourne, AU: Gambling Research Australia.

Hing, N. & Nuske, E. (2011). Assisting problem gamblers in the gaming venue: an assessment of practices and procedures followed by frontline hospitality staff, *International Journal of Hospitality Management*, 30, 459-467

gamblers. Such statements are seriously misguided. Typically, individuals who gamble on such games and who seek treatment at the clinic are making bets of a much larger size than this, with bet sizes of \$100 or more not uncommon. Indeed, these forms of gambling are characterised by the loss of large sums of money over very short periods of time. Furthermore, the individuals I have seen in my work who are losing large sums of money on these forms of games do not fit the stereotype of the “high roller”, and are frequently individuals such as students, new immigrants, or working class individuals. Also problematic is the idea that the casino will be “members only”, with proposed 24-hour “cooling-off” period for new members being presented as a responsible gambling measure. Given that problem gamblers often spend weeks between pay-cheques thinking of gambling, such a “cooling-off” period would only represent a one-off, very minor irritant rather than a serious deterrent of any kind. In addition, the designation of the casino as members only also heightens the perceived glamour of gambling, thus further strengthening the association between gambling and glamour and excitement, which was noted in above comments as being problematic. As such, the statement made by the Premier that these minimum bet sizes and 24-hour cooling off period for membership would function as measures that would deter everyday Sydney-siders from developing gambling problems is inaccurate.

It is also highly concerning that at the time of the recent passing of laws relaxing the regulation of electronic casino games, members of Parliament stated that they had received advice from the gambling lobby that such games were “safer” than traditional poker machines as they involved a slower rate of play and occurred in a more social setting where bets would be observed by others. Such advice is inaccurate. As noted above, such games are associated with large losses over short periods of time, with typical bet size made on such machines being several times larger than those made on traditional poker machines. Furthermore, it was asserted that people would gamble less on such machines as they occur in group settings, rather than in the individual setting typical of poker machines. This assertion is entirely false. There is unambiguous research that has found that on casino table games individuals will gamble more and make riskier bets when in the presence of others<sup>23</sup>. There is thus no reason at all to assume that such games would be “safer”. It is most likely that the reason why gambling problems related to poker machines are more common than those related to casino table games at present is primarily due to the greater availability of poker machines. As noted above, the current trend being witnessed in my workplace is for an increase in clients who are presenting with problems relating to casino games, who have typically loss far greater sums of money than those who have developed problems related to poker machines. We would hope that the Committee will address some of these concerns, as no attempt has been made to seriously consult clinical or academic experts on gambling on these issues up until this point, with the Government instead relying on advice from the gaming industry.

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<sup>23</sup> Cole, T., Barrett, D. J., & Griffiths, M. D. (2011). Social Facilitation in Online and Offline Gambling: A Pilot Study. *International Journal of Mental Health and Addiction*, 9(3), 240-247.

Rockloff, M. J., & Dyer, V. (2007). An experiment on the social facilitation of gambling behavior. *Journal of Gambling Studies*, 23(1), 1-12.

**Recommendations:**

Based on the above review of the current evidence, the following recommendations are put forward:

1. A refocus of the funding of gambling treatment services in NSW, with a shift towards a model that recognises that problem gambling is a serious condition for which effective treatments do exist, that are best delivered by trained mental health practitioners.
2. A more stringent approach to service evaluation that incorporates long-term follow-up of clients and focuses on changes in gambling behaviour rather than client satisfaction.
3. A move away from public health and promotional campaigns such as “Gambling Hangover” which focus on the shame and guilt associated with gambling, and towards campaigns that instead focus on the fact that effective help is available.
4. Restrictions on gambling advertising and marketing, particular those that equate gambling with any of winning, excitement, fun, glamour or intelligence.
5. More funding to be directed towards research in key areas, in particular the identification of problem gamblers by venue staff, whether pre-commitment will prove to be effective, and effective treatments for problem gamblers in Australian settings.
6. A serious review of laws regarding electronic versions of casino table games, which were passed under the demonstrably false assumption that they are “safer” than traditional poker machines.
7. A more thorough attempt to put in place measures to limit problem gambling at new and existing gambling venues in NSW, in particular casinos, that involves consultation with academic and clinical experts on gambling and not just industry representatives.

Sincerely,

Christopher John Hunt, PhD