Analysis of South Australian Gambling Data

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# Background

The Office for Problem Gambling within the Department of Human Services asked the University of Adelaide to explore whether the characteristics of people gambling at risky levels in the community reflect the characteristics of people accessing gambling help services. This work will help identify at-risk populations and possible gaps in service delivery.

# Gambling in South Australia

The South Australian Gambling Prevalence Survey 2018 (the Prevalence Survey) asked 20,017 adult residents about their gambling habits, gambling-related harm, and help-seeking behaviour. It revealed that just under two thirds of South Australian adults (65%) had participated in at least one form of gambling in the previous 12 months. Around 3% of South Australian adults, or just under 40,000 people, gambled at risky levels.[[1]](#footnote-1) Risky gambling behaviours include spending more than you can afford, losing track of time when gambling, feeling guilty about your gambling, and gambling to win back money (i.e., chasing losses). Engaging in risky gambling behaviour increases an individual’s likelihood of experiencing gambling harm (Li et al., 2017).

***Gambling-related harm includes the adverse impacts from gambling on the health and wellbeing of individuals, families, and the community*** (Wardle, Reith, Best, McDaid & Platt, 2018).

The experience of gambling harm is different for everyone. Gambling can cause financial harm, damage to relationships, declines in psychological and emotional well-being and physical health, limit work and study opportunities, result in the neglect of cultural responsibilities, and, in some cases, lead to criminal activity (Langham et al., 2016). Some harms are short-lived while others can continue after an individual stops gambling.

In 2018 the number of South Australians affected by problem gambling would fill the Adelaide Oval.2

Gambling harm is not limited to the individual gambler. Researchers estimate that for every individual engaged in problem gambling behaviour at least six others are affected, moderate risk gambling affects three others, and low risk gambling affects at least one other person (Goodwin et al., 2017).[[2]](#footnote-2)

Gambling harm also impacts the wider community. This is principally through demand for system resources. Costs associated with gambling harm include financial costs, productivity and employment costs, legal costs, personal and family costs, and treatment costs (Browne et al., 2017). Browne and colleagues (2017) estimated that the cost to the community of risky gambling in Victoria in 2014-15 was $4.3 billion.

# South Australian Gambling Help Service System

The Gamblers Rehabilitation Fund established in 1994 under the *Gaming Machines Act* 1992 invests in programs and initiatives intended to minimise the harm caused by gambling. This includes community education campaigns, gambling help services (including the Gambling Helpline and Gambling Help Online), and programs targeted towards those groups known to be at increased risk of gambling harm.

Gambling Help Services provide free and confidential therapy, counselling, assistance, and support to those affected by gambling, including family and friends.[[3]](#footnote-3) Gambling Help Services are available across South Australia and in the form of face-to-face, telephone and online support.

# Service need, utilisation, and gaps

The Office for Problem Gambling within the Department of Human Services invited the University of Adelaide to compare the characteristics of people identified in the community as engaging in risky gambling behaviour with the characteristics of people accessing Gambling Help Services. To undertake this analysis, the University of Adelaide compared three separate data sources:

1. de-identified, first assessment data from gamblers who sought formal help from a funded face to face gambling help service in 2018-19;
2. the 2018 South Australian gambling prevalence survey – a telephone survey of a large (n = 20,017), representative sample of South Australian residents; and
3. de-identified demographic data compiled by Consumer Business Services within the Attorney-General’s Department for gamblers who had sought voluntary barring orders in 2018-19.

## Who is most likely to gamble at risky levels in the community?

The University of Adelaide explored the characteristics of Prevalence Survey respondents who reported gambling at risky levels.[[4]](#footnote-4) Analysis showed this group was typically male (69%), non-Indigenous (96%)[[5]](#footnote-5) and employed full time (43%). They were slightly more likely to be under 45 years of age (53%) than 45 years or over (47%), and slightly more likely to report being currently married or with a partner (44%) than having never married (42%).

Research shows that between 80% and 95% of individuals engaged in problem gambling do not seek help.6

Among those individuals identified in the Prevalence Survey as engaging in highest levels of risky gambling (i.e., problem gambling), around two thirds (64%) reported that they had never sought formal help for their gambling or someone else’s gambling issues.[[6]](#footnote-6)

## Who is accessing the gambling help service system?

The University of Adelaide examined data from 530 gamblers who commenced treatment with a South Australian gambling help service in 2018-19. Analysis showed this group was typically male (67%), non-Indigenous (88%), born in Australia (79%), under 45 years of age (60%), and socially and economically vulnerable. For example, around one quarter of clients were in full time employment (27%), relatively few owned their own homes (16%), and only 30% reported being currently married or with a partner.

Most help-seekers reported gambling at risky levels (11% were moderate risk gamblers and 80% were problem gamblers). Most (72%) identified electronic gaming machines (EGMs) as the main gambling product causing them problems. Around 30% of help seekers described being preoccupied with gambling most (22%) or all (6%) of the time and had spent more than $500 on gambling products in the last 14 days. For comparison, the mean *annual* expenditure by gamblers in South Australia on gambling products in 2017-18 was $825.[[7]](#footnote-7)

Gamblers were typically at crisis point when seeking treatment.[[8]](#footnote-8)Just under two thirds reported experiencing marked to very severe financial problems (65%) and over two thirds (68%) had high or very high levels of psychological distress.[[9]](#footnote-9) When asked about the key reason/s for seeking help, individuals described struggling with their gambling (96%), financial issues (51%), mental health issues (37%), family problems (33%), and issues with substance use (27%). Most help seekers (80%) described experiencing more than one issue.

On average, it takes someone 5 years to seek help for problem gambling.7

Among help-seekers, gambling behaviours and the experience of harm differed depending on an individual’s age and gender. On average male help-seekers (38 years) were significantly younger than female help seekers (49 years). Young men (40 years or younger) were more likely than other age-gender categories to report a range of gambling activities as the source of their problems, while young women were most likely to report struggling with EGMs. A higher proportion of young men (14%) than any other age-gender category reported sports gambling as the source of their problems.

Older clients (41 years or older) were more likely than younger clients (40 years or younger) to report being affected by health problems, and both older clients and young women were more likely than young men to report experiencing social isolation (see Figure 1). Young women were also more likely than other age-gender categories to report domestic issues, while young men were more likely to report issues with offending.

Figure Gender and age differences in problems reported by help-seeking gamblers

### Self-exclusion

South Australia allows gamblers to voluntarily bar themselves from gambling. A barring order can apply to one or more venues as well as online betting products. Individuals can choose to be barred from gambling for a minimum of three months or longer. Someone who is concerned about another person’s gambling behaviour can also initiate a barring order.

To be effective, self-exclusion options require an individual to recognise they have a problem with gambling, take steps to address that problem, and comply with the barring order. Evaluations of the effectiveness of self-exclusion as a mechanism for reducing gambling harm are relatively rare and typically of low to moderate quality (Livingstone et al., 2019). Those which do exist suggest self-exclusion programs have a very modest effect and are most likely to be successful for people who are taking other steps to address their gambling (e.g., treatment, self-help) (Livingstone et al., 2019).

The University of Adelaide examined the characteristics of 339 people who sought voluntary barring orders in 2018-19. People who sought barring were typically older (91% aged 25 years or older), male (53%), and from metropolitan areas (70%). Most people barred themselves from gambling on EGMs (80%).

When compared to gamblers who commenced treatment with a gambling help service, gamblers who sought barring orders were more likely to be female and 25 years or older. That is, help-seeking men and young people are under-represented among those seeking barring orders. When compared to people in the community engaged in risky gambling (i.e., Prevalence Survey data), a similar story emerges. That is men and young people are under-represented among those seeking barring orders. People in regional locations are over-represented (and people in metropolitan regions under-represented) among those seeking barring orders. Unfortunately, it was not possible to determine whether those who sought voluntary barring orders were also participating in treatment.

These findings suggest there may be some value in exploring the reasons why help-seeking men and young people appear less willing to take up self-exclusion options, and whether pairing treatment and voluntary barring is an effective intervention for these cohorts. There is also likely to be value in exploring why gamblers in regional locations are over-represented among those choosing self-exclusion options. This information would help ensure voluntary barring is used to maximum effect within the gambling help service system.

### Alternative sources of help and support

Participants in the Prevalence Survey who reported having ever sought formal help for their gambling were asked which support services they had used. Over a third had accessed the Gambling Helpline (36%), and a fifth had used Gamblers or Pokies Anonymous (21%).

Further analysis by the University of Adelaide revealed that those who phoned the Gambling Helpline were more likely to be working and in a relationship, whereas those who participated in Gamblers Anonymous tended to be older, single, or divorced, and less likely to be in paid employment.

## What opportunities are there to increase service uptake?

The University of Adelaide concluded that the characteristics of people gambling at risky levels in the community are broadly similar to those who access gambling help services.

There are, however, some cohorts who appear to experience barriers to help-seeking and who may benefit from targeted strategies to increase service uptake. Younger (18-24) and older (65+) age-groups, people who are employed or retired, and people who are in a relationship are under-represented among those seeking support from face-to-face gambling help services. Note that responses to the Prevalence Survey suggest that people who are employed or in a relationship may be more likely to seek help from the Gambling Helpline.

Loy et al (2018) report that the reasons for not seeking help are complex and involve both internal and external aspects. Compared to help-seekers, non-help seekers are more likely to report experiencing external barriers to treatment, such as cost, access, waiting time and distrust in treatment quality, as well as internal barriers such as stigma, shame, and problem denial (Loy et al., 2018). Males, in particular, are more concerned with shame, pride, and stigma, while women are more likely to delay help seeking because of shame (Loy et al., 2018).

Brown and Russell (2019) report that gamblers often delay help-seeking due to expectations of negative judgement from the community. Surveys have revealed limited understanding in the community of addicted gambling and the experience of gambling harm. People gambling at risky levels are often perceived to be in control of their behaviour and selfish, greedy, impulsive, and irresponsible (Brown & Russell, 2019; Loy et al., 2018). This community response is different from that shown to people with visible addictions (e.g., alcohol or drug problems) and contributes to the stigma, shame and secrecy displayed by gamblers (Loy et al., 2018).

Informal help, such as talking to family, a spouse or friends, reading books or pamphlets, using video or audio tapes, or participating in informal self-help or support groups, is typically considered to present fewer barriers than formal help (Loy et al., 2018). More gamblers report having sought informal help than report seeking formal help. Informal help is typically not considered a substitute for formal help but can be a useful mechanism for enhancing motivation to seek treatment. Informal help from significant others in a gambler’s life is likely to be particularly important (Loy et al., 2018).

Loy and colleagues (2018) identify five key activities needed to encourage help-seeking among people experiencing gambling harm:

* enhance capability among health professionals to recognise gambling problems;
* raise awareness and accessibility (e.g., time, day, location of treatment) of help available to lower structural barriers to help seeking;
* work to address stigma and negative stereotypes held by the community towards gamblers;
* increase informal and easily accessible interventions that support natural recovery; and
* conduct further research exploring particularly the barriers to help-seeking among gamblers compared to people with other addictive behaviours.

Figure Demographic characteristics of help-seekers and general population gambling at risky levels

# Limitations

There are some limitations to this analysis which mean there are important gaps in our knowledge regarding barriers to and facilitators of service uptake among South Australian cohorts experiencing gambling harm.

The available data did not allow for comparisons across some demographic characteristics known to increase an individual’s risk of experiencing gambling harm. For example, Aboriginal people were over-represented in the service data but under-represented in the Prevalence Survey making it difficult to conclude whether service uptake reflects community need. Similarly, the available data did not accurately capture the experience of people from culturally and linguistically diverse backgrounds who research suggests are at higher risk of experiencing gambling harm compared to the general population.

The available data could not provide insights into who remains in treatment beyond first assessment (i.e., dropouts). Reasons for leaving a service are likely to be varied and unique to each individual. However, understanding who does not continue with treatment and the reasons why is important for ensuring services remain fit for purpose and capable of addressing clients’ treatment needs.

Similarly, the data could not show what proportion of people currently accessing the help service system had previously sought help through the same or other help services (i.e., relapse). Abbott (2020) argues that the plateauing of problem gambling prevalence rates despite general declines in gambling within the community may be due in part to relapse. He cites recent research which shows that over a one-to-three-year period, at least half of ‘new’ problem gamblers are past cases relapsing. This points to the need for a help service system that is equipped to enhance recovery, prolong remission, and prevent relapse if we are to see reductions in gambling harm at a population level. The first step in building this system will be improving our understanding of the who, why, when, and how of relapse among South Australian gambling help service system clients.

# Conclusions

Those people accessing face to face gambling help services in South Australia are broadly similar to those thought to be engaging in risky gambling in the community. This suggests the current system is accessible to high-risk gamblers and therefore an important part of efforts to minimise gambling harm in the State.

That said, there are some cohorts who are less likely to access the current system and who may benefit from targeted strategies to increase service uptake. This includes younger (18-24) and older (65+) age-groups, people who are employed or retired, and people who are in a relationship.

Activities that address structural barriers (e.g., increasing awareness, improving service accessibility, and diversifying service offerings) could be quickly and easily implemented in the short term, and will likely go some way towards increasing service uptake among these cohorts. Informal support can be effective in increasing motivation to engage in help-seeking. Improving access to resources that facilitate informal support (e.g., information for families, engaging loved ones in care) as well as public education campaigns to raise awareness of how people can assist others struggling with their gambling may also increase service uptake among gamblers (Hing, Nuske & Gainsbury, 2011). Ultimately, initiatives that challenge community attitudes towards problem gambling and effectively tackle stigma are likely to have the greatest effect on service uptake but operate on a longer timescale.

More research is needed to understand who remains in treatment and the circumstances surrounding relapse in South Australia. This will help ensure the gambling help service system is not only accessible to those who need it, but also responsive to their treatment needs and able to support them throughout their journey of recovery.

# References

Abbott, M.W. (2020). The changing epidemiology of gambling disorder and gambling related harm: public health implications. *Public Health*, https://doi.org/10.1016/j.puhe.2020.04.003

Browne, M, Greer, N, Armstrong, T, Doran, C, Kinchin, I, Langham, E & Rockloff, M 2017, The social cost of gambling to Victoria, Victorian Responsible Gambling Foundation, Melbourne.

Browne, M., Rawat, V., Newall, P., Begg, S., Rockloff, M., & Hing, N. (2020). A framework for indirect elicitation of public health impact of gambling problems. *BMC Public Health*, 20, <https://doi.org/10.1186/s12889-020-09813-z>

Brown, K. & Russell, A.M.T. (2019). What can be done to reduce the public stigma of gambling disorder? Lessons from other stigmatised conditions. *Journal of Gambling Studies*, <https://doi.org/10.1007/s10899-019-09890-9>

Delfabbro, P. & Wallace, E. (2020). Analysis of South Australian Gambling Data. Report prepared for the Office of Problem Gambling, Department of Human Services. Adelaide: South Australia.

Goodwin, B.C., Browne, M., Rockloff, M. & Rose, J. (2017). A typical problem gambler affects six others. *International Gambling Studies*, 17 (2), 276-289.

Hing, N., Nuske, E. & Gainsbury, S. (2011). Gamblers at-risk and their help-seeking behaviour. Report prepared for Gambling Research Australia. Accessed January 2021 via: https://www.responsiblegambling.nsw.gov.au/\_\_data/assets/pdf\_file/0006/880377/Gamblers-at-risk-and-their-help-seeking-behaviour.pdf

Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J., Rockloff, M. (2016). Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC public health* 16: 80

Li, E., Browne, M., Rawat, V., Langham, E., & Rockloff, M. (2017). Breaking bad: Comparing gambling harms among gamblers and affected others. *Journal of Gambling Studies*, 33(1), 223-248.

Livingstone, C., Rintoul, A., de Lacy-Vawdon, C.., Borland, R., Dietze, P., Jenkinson, R., Livingston, M., Room, R., Smith, B., Stoove, M., Winter, R. & Hill, P. (2019). *Identifying effective policy interventions to prevent gambling-related harm*. Victorian Responsible Gambling Foundation, Melbourne.

Loy, J.K., Grune, B., Braun, B., Samuelsson, E., & Kraus, L. (2018). Help-seeking behaviour of problem gamblers: a narrative review. *Sucht*, 64 (5-6), 259-272.

McGowan, V., & Nixon, G. (2004). Blackfoot traditional knowledge in resolution of problem gambling. *Canadian Journal of Native Studies*, 24, 7-35.

Tavares, H., Zilberman, M., Beites, F.J., et al. (2001). Gender differences in gambling progression. *Journal of Gambling Studies*, 17, 151–159.

Wardle, H., Reith, G., Best, D., McDaid, D., & Platt, S. (2018). Measuring gambling-related harms. A framework for action. Gambling Commission, London.

Woods, A., Sproston, K., Brook, K., Delfabbro, P., & O’Neil, M. (2018). Gambling Prevalence in South Australia (2018) Final Report. Report prepared for the Department of Human Services, South Australia. Accessed January 2021 via: <https://problemgambling.sa.gov.au/__data/assets/pdf_file/0017/80126/2018-SA-Gambling-Prevalence-Survey-Final-Report-Updated-07.02.19.pdf>

1. The Prevalence Survey measured gambling severity using the Problem Gambling Severity Index (PGSI). The PGSI is a standardised screening tool that is used widely in both international and Australian gambling surveys. Risky gambling is defined as those scoring between 3 and 7 (moderate risk gambling) and 8 or higher (problem gambling) on the PGSI. [↑](#footnote-ref-1)
2. The Prevalence Survey estimated 0.7% of South Australian residents engage in problem gambling, or 9,588 individuals based on a population estimate of 1,369,753 in 2018. This means around 57,530 (9,588 x 6) South Australian residents are affected by problem gambling. [↑](#footnote-ref-2)
3. In addition to therapeutic support, Gambling Help Services are responsible for working in community to raise awareness of gambling harms, reduce stigma surrounding problem gambling, and encourage help seeking. Services are also expected to build strong working relationships with venues to improve their capability to assist people experiencing gambling harm and establish appropriate referral pathways. [↑](#footnote-ref-3)
4. This includes those individuals who were categorised as moderate-risk gamblers or problem gamblers by the PGSI. [↑](#footnote-ref-4)
5. It is important to note that Aboriginal and Torres Strait Islander people were under-represented in the Prevalence Survey. That said, they were significantly more likely to be classified as at-risk gamblers (5.6%) compared to non-Indigenous people (2.9%), and more likely to report being impacted by someone else’s gambling (10% of Aboriginal and Torres Strait Islander people compared to 6% of non-Indigenous people). [↑](#footnote-ref-5)
6. Loy, Grune, Braun, Samuelsson, & Kraus (2018). [↑](#footnote-ref-6)
7. Queensland Government Statistician’s Office, Australian Gambling Statistics 1992-93 to 2017-18 35th Edition, Brisbane, 2019. [↑](#footnote-ref-7)
8. Tavares and colleagues (2002) reported that on average 5 years elapsed between the experience of the first problem caused by gambling and the first attempt to have treatment. [↑](#footnote-ref-8)
9. As measured by the Kessler Psychological Distress Scale (K10) which assesses 10 anxiety and depressive symptoms experienced in the last four weeks. [↑](#footnote-ref-9)