Office of the Public Advocate

Submission to the IGA Inquiry into Barring Provisions

Presentation prepared for Inquiry into Barring Arrangements conducted by the Independent Gambling Authority of South Australia.

February 2009.

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Summary Statement Submitted Prior to the Hearing

Problem gambling can occur either in isolation or in association with mental illness such as mood disorders, anxiety disorders and substance use disorders. Pathological gambling is a severe form of gambling that impairs decision-making and is considered a mental illness. It is likely to be related to substance dependence, impulse control disorders, and obsessive-compulsive disorder in its underlying cause. Pathological gambling affects between 1-3.4% of the population, although some population studies have described higher rates.

Barring is just one strategy in a spectrum of interventions. Prevention and early intervention is needed as well as effective treatment when problem gambling develops. As with other mental health strategies a stepped approach can offer different levels of education and intervention depending on need.

Along with barring, a range of complementary public health measures can reduce harm from gambling. There is evidence to support the use of "supply reduction" strategies such as slowing the reel speed on poker machines so that money can be fed in less quickly, and reducing hours of service. A simple demand reduction strategy is readjusting machines to display money as "cash" rather than "credits."

At the present time the enforcement of barring relies on the facial recognition of the barred gambler through circulated photographs. This has significant limitations. Shame is a common experience of gamblers - some may wish to be barred, but not want their photographs displayed in licensed venues, particularly if they personally know staff. Other gamblers travel extensively so barring at a small number of venues (which is a necessity because of the limitation of photograph use) may be of limited value.

For these reasons, the adoption of technology, based on that already in use in loyalty programs, could permit people to be barred without requiring photographs and personal details to be sent to venues ahead of time, and provide a system for barring to operate across the state. This could be combined with pre-commitment so that a gambler declares how much they wish to gamble when they arrive and cannot gamble more.

The association between gambling and mental illness should be considered in developing policy. Causality can be bi-directional. Problem gambling can lead to depression and suicidal behaviour. On the other hand people with preexisting illnesses are more likely to gamble. A number of people who also have a mental incapacity as well as problem gambling are placed on financial administration orders through the Guardianship and Administration Act (1993) to limit expenditure on gambling and ensure that food is purchased and that rent and other expenses are paid.

The down side of Administration Orders is that they can still be circumvented - for example through the sale by the gambler of essential home appliances for gambling money that then need to be replaced. Effective barring provisions can deal with this shortcoming as it stops access to gambling rather than access to money. This can also help maintain an individual's rights and autonomy, because if gambling can be stopped through barring, then other controls over finances can be relaxed or even removed.

Barring can also act as a trigger for treatment. Now people are given information about where to get help when an Independent Gambling Authority order is put in place. This would be an ideal

time to offer a "first" appointment with a provider so an assessment can occur, and the barred person be offered treatment.

In conclusion, the Public Advocate will recommend an electronic statewide barring system. A clinical appointment should be provided to people when they are barred. Prevention and early intervention measures including community education, and other public health measures to reduce harm from gambling can complement barring as a strategy.

Introduction

The Office of the Public Advocate has a role reviewing programs that are provided for people who have a mental incapacity. This can result from underlying conditions such as mental illness, brain injury, intellectual disability and dementia.

Barring is relevant to this office and there are two key reasons.

First, it is likely that people who are barred will meet the criteria for pathological gambling, which itself is a mental illness. There are common population approaches for preventing and treating mental illness that can be applied to pathological gambling, such as providing community education as a prevention measure, intervening early where possible, and delivering evidence based therapies.

Second, pathological gambling, and problem gambling behaviours in general, frequently co-exist with other mental illness such as depression, anxiety and substance use. People who receive treatment within our broader mental health system, or who are 'protected' through guardianship and administration may need treatment for problem gambling and be assisted through access to barring provisions.

This presentation considers gambling as a psychiatric disorder, the need for barring to be seen within a spectrum of health interventions, and the implications of co-morbidity with other psychiatric disorder.

Pathological Gambling as a psychiatric disorder

Barring orders might potentially assist two groups of people:

(1) *Problem gamblers* - those people where gambling is negatively affecting a person or their family. Problem gambling is a broad term, that includes a larger group of people who may have some of the symptoms of pathological gambling (listed below), but the symptoms they have may be fewer in number or not sufficiently intense to warrant a diagnosis.

(2) *Pathological gambling* - those people with the more severe, persistent and recurrent disorder. This is defined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000 reproduced in Text Box 1 on the next page)

Pathological gambling affects between 1-3.4% of the population (Hollander et al, 2000; Raylu and Oei, 2001). In the current diagnostic manual it is currently classified as an impulse control disorder however it has much in common with addictions to alcohol and other drugs, and to obsessive compulsive disorder.

These definitions are important. Unlike in other countries there has been a history of Australian researchers avoiding these medical terms in the past (Productivity Commission, 1999).

This is now changing, but as noted by the Productivity Commission (1999), lesser terms that emphasise a departure from responsible gambling as opposed to the making of a clear diagnosis may weaken the perceived severity of the gambling and the motivation to intervene.

The diagnostic criteria, while intended to be used in a clinical setting, can can form the basis of a simple checklists that can be used in educational material for gamblers.

Currently gaming venue staff in general do not have a systematic approach to identifying problem gamblers. Some rely on a 'gut feel' that a person is in trouble. If they do have suspicions they could similarly use these criteria to illicit information in conversation, to confirm concerns, and then to recommend barring.

Venue staff generally want more training to help identify problem gamblers and then feel confident to intervene (Delfabbro et al, 2007)

Checklists can also be used in primary care by general practitioners, and in mental health settings, where practitioners may accurately make other diagnoses of depression, but may fail to detect pathological gambling, particularly if a patient is reticent and ashamed to raise the matter.

Text Box 1

Diagnostic Criteria for Pathological Gambling (DSM-IV)

A. Persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:

(1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)

(2) needs to gamble with increasing amounts of money in order to achieve the desired excitement

(3) has repeated unsuccessful efforts to control, cut back, or stop gambling

(4) is restless or irritable when attempting to cut down or stop gambling

(5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)

(6) after losing money gambling, often returns another day to get even ("chasing" one's losses)

(7) lies to family members, therapist, or others to conceal the extent of involvement with gambling

(8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling

(9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling

(10) relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behaviour is not better accounted for by a Manic Episode.

The South Oaks Gambling Screen (Lesieur and Blume, 1987) is a commonly used instrument that is self administered. The tools accuracy in Australia may be questionable because of the high base rate of gambling in Australia and the need for further

validation (Battersby and Tolchard, 2002). Yet the tool can be a useful screening instrument that can identify people who need clinical assessment (and perhaps barring) and be followed up by other inquiry. A copy of the tool is reproduced in the appendix of Lesieur and Blume (1987).

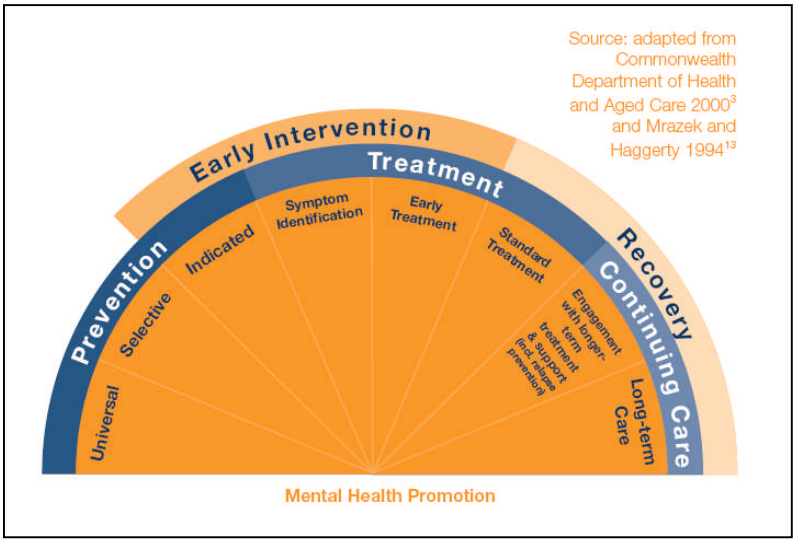
Gambling and impaired decision making

The term decision making disability is normally used to describe a person who may have cognitive disability or is unwell with a mental illness, who is then unable to make the usual decisions they might have normally made.

While pathological gambling is not considered a decision making disability and I am not suggesting that it should be, there is much in common. Patient descriptions from those who have been addicted to poker machines are illustrative. Patients describe being in "the zone".
In “the zone”, a poker machine player becomes totally preoccupied with the machine and what will happen next on the machine. The person does not talk to other people. The person does not notice what is happening around them. People in the zone report losing track of how much money they have spent. Some cannot recall how many visits they have made to the automatic teller machine.

To have capacity to make a decision a person needs to understand the options available and the consequences of each of the options. This does not occur in “the zone”. The barring order is a preemptive way of making that decision in advance, away from the gambling environment where the capacity to make the decision to walk away or not get more cash is lost.

Barring as part of a population health based strategy



For any mental health condition, including pathological gambling, we need to consider population health strategies starting at health promotion, prevention, early intervention, treatment programs, and rehabilitation for people severely affected. The full spectrum needs to be addressed. Therefore it is argued that it is not possible to consider the place of barring arrangements without considering actions elsewhere in the spectrum of intervention.

In the National Mental Health Plans (Commonwealth Department of Health and Ageing, 2003) interventions are placed within a spectrum of health promotion (see diagram). This spectrum can be applied to gambling. This framework ensures that education for the entire population is considered, the identification of illness early in at risk groups as well as taking the more obvious actions to provide treatment for people who need standard treatment and rehabilitation. The

Stepping Up Report into South Australias Mental Health system (Social Inclusion Board, 2007) emphasises the need to have a balanced stepped system, with effective interventions at each step gradually increasing in intensity. This analysis demonstrated the impact of "missing steps" in general mental health. It is reasonable to apply the same concept to barring, which will be less effective and targeted if earlier interventions are not available.

Mental health promotion includes the education of people about gambling - during and after formal education. Given that 70-90% of the population gamble at some point in their lives (Raylu and Oei, 2002) quality education about gambling should be universal at school.

It has been suggested that primary prevention interventions can be best delivered to students aged 12-14 in years 7 and 8, possibly under a health or social science curriculum (Gray et al, 2007). Gambling studies might be delivered as part of a specific program but specific information can also be incorporated into a range of subjects. Examples of possible curriculum materials, are described in text box 2.

Text Box 2

Examples of Content for School Curriculums & Community Education

Mathematics & probability

The concept of fixed return rates of poker machines & other forms of gambling.

Behavioural psychology

The underlying psychological principles of reinforcement that underpin gambling behaviour. In particular the powerful effect of variable reinforcement as described in learning theory. The experimental example is that of a rat pressing a bar for food in a box. When the food arrives on a variable basis, after a random number of responses, but on a predetermined average the learning is strongest. The behaviour learned this way tends to remain constant and this behaviour is difficult to extinguish. This variable reinforcement schedule that is programmed into poker machines.

Biology, neurosciences & health

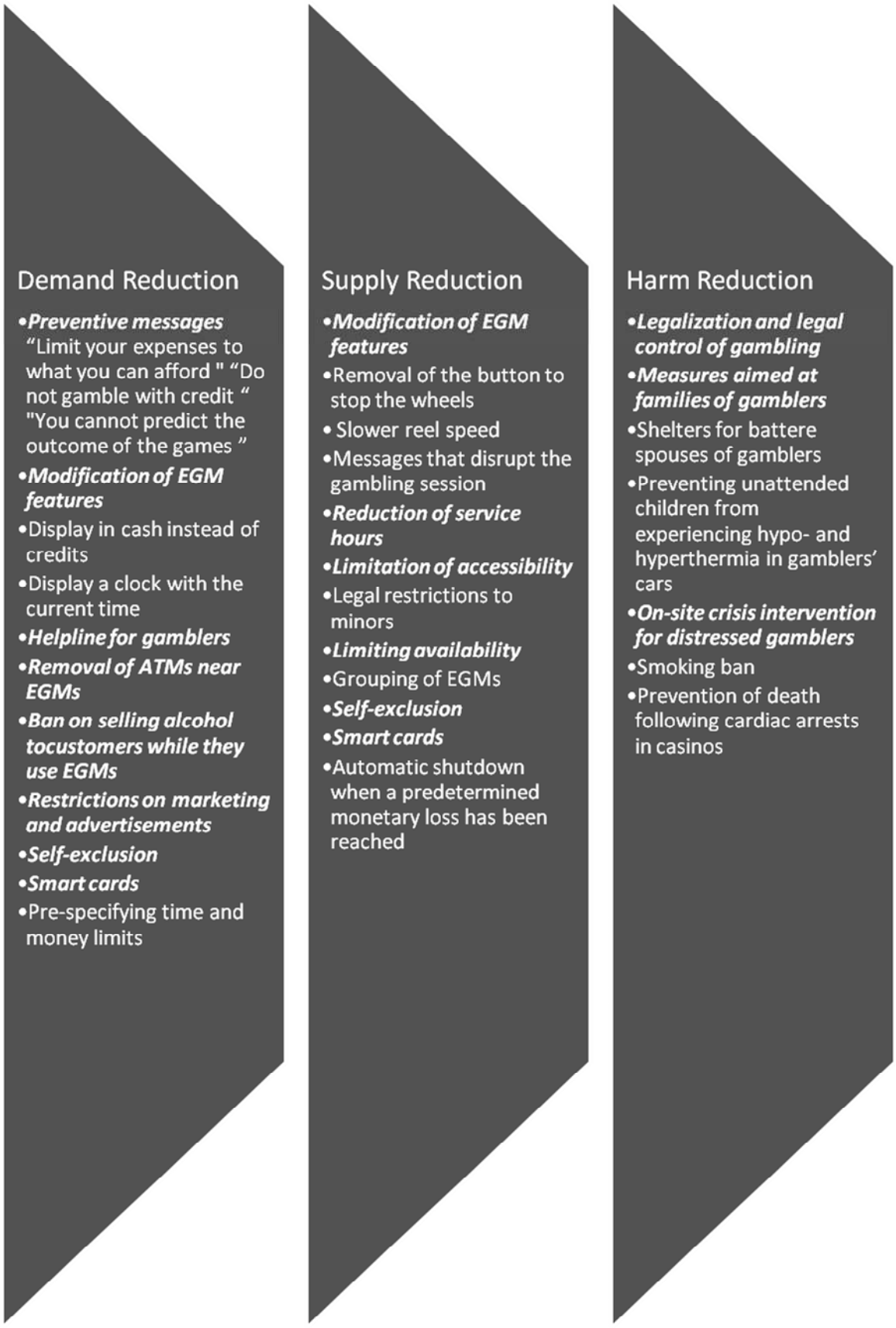
Changes in brain chemistry associated with pathological gambling. There is evidence of increased release of the neurotransmitter dopamine in reward systems in the brain, that is similar to changes seen in people who are dependent on opiates. There is also a reduction of serotonin levels, which is also seen in other impulse control disorders.

Early intervention requires access to treatment for people when they first become concerned - even if the problem is mild.

Practically this can involve the provision of education and resources to primary care providers - general practitioners and generic mental health providers who can give warnings, information about gambling and basic first line treatment.

Practitioners often have the skills to deliver a basic intervention using their generic counselling or therapeutic skills, but may need some structure, assessment tools, and information to give to patients. There are already some programs doing this, once again it is a matter of ensuring that there is state-wide reach so that practitioners receive screening tools, self help resources to give to patients, and basic guidance on initial interventions.

Other strategies to reduce the harm caused by gambling have been classified recently by Cantinotti and Ladouceur (2007). The strategies are listed below.


Demand Reduction
•Preventive messages "Limit your expenses to what you can afford " "Do not gamble with credit " "You cannot predict the outcome of the games "
•Modification of EGM features
•Display in cash instead of credits
•Display a clock with the current time
•Helpline for gamblers
•Removal of ATMs near EGMs
•Ban on selling alcohol tocustomers while they use EGMs
•Restrictions on marketing and advertisements
•Self-exclusion
•Smart cards
•Pre-specifying time and money limits
Supply Reduction
•Modification of EGM features
•Removal of the button to stop the wheels
• Slower reel speed
•Messages that disrupt the gambling session
•Reduction of service hours
•Limitation of accessibility
•Legal restrictions to minors
•Limiting availability
•Grouping of EGMs
•Self-exclusion
•Smart cards
•Automatic shutdown when a predetermined monetary loss has been reached
Harm Reduction
•Legalization and legal control of gambling
•Measures aimed at families of gamblers
•Shelters for battere spouses of gamblers
•Preventing unattended children from experiencing hypo- and hyperthermia in gamblers' cars
•On-site crisis intervention for distressed gamblers
•Smoking ban
•Prevention of death following cardiac arrests in casinos

Collectively these strategies can assist people using poker machines who are in "the zone". Real money value on the screen rather than “credits” can assist in recognising cumulative loss. Pre-commitment to a maximum amount that can be lost, can reduce the risk of acting on a desire to win losses back. This should at least be available as a voluntary option that a gambler can chose to take up.

Machines could also have their reel speed reduced. In Australia we have high intensity gaming machines characterised by high maximum spending per game and speed of play (Dowling, Smith and Thomas, 2004). Reducing reel speed and sound can reduce enjoyment, excitement and the level of tension reduction for pathological gamblers. Although there may also be some loss of enjoyment for other gamblers, the overall benefits to those vulnerable to problem gambling or pathological gambling would outweigh this cost.

Although not cited above, restrictions on the use of loyalty cards could be an additional strategy to reduce losses. As noted in the previous section, poker machines themselves are potent behavioural conditioners, so having a loyalty card on top of this can further reinforces this behaviour. Rather than paying for meals with loyalty credits, gamblers could be encouraged to pre-commit to a maximum loss that leaves them with enough money in the pocket to purchase their food and beverages outright. The loyalty card technology could be used instead to identify gamblers who are barred, and set pre-commitment limits.

Reducing availability is another form of supply reduction. I have been told of outer suburban gaming rooms open until 4am. The rest of the venues I am told are quiet with most business coming from the gaming room rather than bars. This suggests that extended opening hours, rather than catering for shift workers or other people who might attend the venue to socialise over meals and drinks, are probably catering for people with problem gambling.

Improved barring

An improved state-wide barring system is recommended, that would require the use of electronic technology. The reasons for this include providing effective barring across a greater number of venues, and preserving privacy.

The current system is limited to barring each individual from a small number of venues. This is because it relies on photographs and facial recognition of the barred gambler. For this system to work practically, there is a limit to the number of photographs that a venue can reasonably monitor and enforce so there would be little point in sending hundreds of names and photographs to venues across the state. Electronic identification could overcome this limitation to the benefit of gamblers who regularly travel across the state or to different parts of the city.

Privacy within the barring system is a further issue. With the current system a person is identified whether or not they attempt to break a barring order. With an electronic system there is no need to give venues names and identifying information about people who may never attempt to break the ban. With an electronic system a banned gambler is not identified at a venue, unless they actually attempt entry. This is a better way for managing privacy, because the ‘confidentiality’ of the information is only broken, at the point that it is necessary to do so. Given that pathological gambling in this context is an illness, a person’s identity and the nature

of the diagnosis should remain private, in the same way as it would for any other health condition, unless there is an immediate need for the confidentiality to be broken. In this case the immediate need would be attempted entry to a venue contrary to a barring order.

Shame is a common symptom for many gamblers. Some gamblers who see clinical staff for other mental health problems such as depression can be reluctant to admit that they have a gambling problem and reveal the extent of their losses even in a confidential treatment setting. For a person still working and active in the community it can be difficult to take action that leads to their name listed at the local pub where neighbours or relatives might work. For those shamed by their gambling behaviour, barring can become a last resort measure for a person who has hit rock bottom. A private electronic scheme on the other hand, may engage some people earlier on in their problem gambling, before their losses have escalated.

It is reasonable to speculate that if a state-wide scheme were implemented, the privacy issue would be greater because of the sheer number of hospitality workers who would see names and photographs on the list, if the current approach is used.

A further improvement in the system is the provision of a therapeutic assessment and treatment for people who are barred. Barring is an opportunity to break a gambling pattern, but needs to be supported with other interventions.

For example appointments could be routinely offered for all people who are barred under the provisions of the Independent Gambling Authority Act 1995. A one off assessment and advice could come from a provider with experience in assessing and treating problem gambling behaviours, and occur at the time of the barring interview.

Co-morbidity with other psychiatric illness

There are higher rates of pathological gambling in people who have other psychiatric illness. This has been examined two ways. Some studies have looked at rates of pathological gambling in people who have other mental illnesses. Conversely, other studies have looked at rates of other psychiatric disorders in people who have pathological gambling.

There is a strong association between a gambling disorder and substance abuse. In studies of substance abuse populations rates of pathological gambling varies from 9 to 33% (Hollander et al, 2000)

A 2006 study of 1,709 psychiatric outpatients demonstrated that 2.3% had a pathological gambling disorder with higher rates in patients with manic depression, social phobia, panic disorder with agoraphobia, alcohol use disorder and other impulse control disorders.

There is a strong association with mood disorders both depression and manic depression in people who have pathological gambling.

Up to a half may have a depressive disorder. The direction of causation may not always be clear. Some may engage in gambling to escape depression, while others become depressed because of financial losses (Kim, et al, 2006). Suicide is a well recognised risk with disturbingly high suicide rates reported in pathological gambling reviews undertaken overseas, and stories

of gambling losses featuring in retrospective reviews of suicide deaths.

Up to a quarter have a manic disorder, although definitions can be unclear because diagnostically if gambling is caused by mania it is not considered to be pathological gambling.

There is also an association with schizophrenia reported but this is less conclusive (Borras and Huguelet, 2007). The extent to which people with schizophrenia experience pathological gambling has not been fully investigated in the current literature.

These high rates demonstrate another benefit of providing an automatic mental health assessment to people when they are barred. As well as receiving an assessment for pathological gambling, a number of other mental illnesses may be detected and then treatment started.

Gambling problems also emerge for people who have a pre-existing mental incapacity which might be caused by mental illness, intellectual disability, or brain injury.

Mental incapacity as defined in the Guardianship and Administration Act (1993) means the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of
(a) any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or
(b) any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever

A persons with a mental incapacity may have a guardian appointed to make health, accommodation or lifestyle decisions on their behalf or an administrator to make substitute financial and legal decisions.

Gambling may be one of many problems or be specifically mentioned at application for Guardianship. This usually refers to gambling by the protected person themselves. It can however be gambling by a family member. For example if a child has been given an enduring power of attorney to manage the finances of an incapacitated parent, there is a risk to that function if they become a problem gambler and spend their parents money on their own gambling.

Some recent informally collected numbers are as follows. Over a 3 week period, there were 47 applications for administration orders to the Guardianship Board, and gambling was cited on 3 occasions. At the same time a team leader at the Public Trustee informally asked 30 of his trustee officers how many their protected people had a gambling problem. The estimate was between 20-30 people out of 3,500. There is an impression that gambling problems are increasing in recent times.

These rates about 1% are close to the population rate. However this informal review is likely to underestimate the number, as it predominantly involves people who have been identified because of the financial consequences of their gambling. There are likely to be more within this group who have problem gambling.

An administrator will control bank accounts, and might arrange for food bills to be paid directly so funds cannot be gambled.

An effective barring arrangement in these circumstances can still assist even though an administration order is in place. Barring stops access to gambling, where as a financial administration order stops access to money. If gambling can be controlled through barring and treatment, controls over finances can potentially be relaxed, enhancing a persons' individual rights and autonomy.

Even when financial administration is required for other reasons, a barring order may still be necessary. Financial trustees may not be able to easily stop home appliances being sold or pawned for gambling money. A barring order can remove the motivation for such behaviour.

Recommendation of this submission

(1) An state-wide barring system be introduced. This could be electronic, and only indentify barred individuals when they attempt to present themselves to a venue.

(2) Barring be accompanied by a system of pre-commitment that would give gamblers the option of voluntarily setting a limit to their losses on arrival.

(3) Other complementary demand reduction and supply reduction measures be considered such as reduction of poker machine spin rates, converting machines to display cash amounts rather than credits and reducing the hours of opening of venues.

(4) That barring be accompanied by a comprehensive population health strategy. Components of this strategy should include health promotion (through education in schools and community), early intervention (more resources for GPs and other practitioners in the community to help them better assist gamblers) and treatment (provision of appointments for assessment and treatment for all people who are barred).

References

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition - Text Revision, American Psychiatric Association.

Battersby M, Thomas L, Tolchard B and Esterman A (2002), The South Oaks Gambling Screen: A Review with Reference to Australian Use, *Journal of Gambling Studies,* 18:257-270

Borras L and Huguelet P (2007) Schizophrenia and Pathological Gambling, *The American Journal of Addiction*, 16:269-271.

Cantinotti M and Ladouceur R (2008) Harm reduction and electronic gambling machines: does this pair make a happy couple or is divorce foreseen, *Journal of Gambling Studies*, 24:39-54

Commonwealth Department of Health and Ageing (2003) National Mental Health Strategy – 2003 to 2008, Department of Health and Ageing.

Dowling N, Smith D and Thomas T (2005) Electronic gaming machines: are they the 'crack cocaine' of gambling? *Addiction*, 100:33-45.

Delfabbro P, Osborn A, Nevile M, Skelt L, McMillen J (2007) Identifying Problem Gamblers in Gambling Venues: Final Report, Gambling Research Australia. Available at www.gamblingresearch.org.au .

Gray K, Oakley Browne M and Prabhu V (2007) Systematic review and meta-analysis of studies on early intervention and prevention for problem gambling, Prepared for Gambling Research Australia. Available at www.gamblingresearch.org.au

Hollander E, Buchalter A, and DeCaria C (2000) Pathological Gambling, *Psychiatric Clinics of North America*, 23:629-642.

Kim S, Grant J, Eckert E, Faris P and Hartman B (2006) Pathological gambling and mood disorders: clinical associations and treatment implications, *Journal of Affective Disorders*, 92:109-116.

Lesieur, H. R., & Blume, S. B. (1987). The South Oaks Gambling Screen (SOGS): a new instrument for the identification of pathological gamblers. *The American Journal of Psychiatry, 144*(9),1184–8.

Productivity Commission (1999) Australia's Gambling Industries, Productivity Commission, Commonwealth of Australia.

Raylu N and Oei T (2001) Pathological Gambling A Comprehensive Review, *Clinical Psychology Review* 22: 1009-1061.

Social Inclusion Board (2007) Stepping up : a social inclusion action plan for mental health reform 2007 – 2012, Government of South Australia, http://www.publications.health.sa.gov.au/spp/16/

Zimmerman M, Chelminski I and Young D (2006) Prevalence and Diagnostic Correlates of DSM-IV Pathological Gambling in Psychiatric Oupatients, *Journal of Gambling Studies*, 22:255-262