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Self-exclusion: A Proposed Gateway to Treatment Model

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ABSTRACT *Self exclusion is a programme utilized by the gaming industry to limit access to gaming opportunities for problem gamblers. It is based on the following principles: (1) The gaming industry recognizes that a proportion of community members gamble excessively and have difficulty controlling gambling behaviours; (2) The gaming industry has a responsibility to provide a safe gaming environment and to assist in minimizing the negative impact on individuals displaying problem gambling behaviours; (3) Individuals must accept personal responsibility for limiting gambling behaviours to affordable levels; and (4) Self exclusion is not a treatment designed to address psychological processes. The objective of the present paper is to propose a unifying structure for self exclusion programmes as a gateway to treatment based on a system operated by independent 'educators' whose roles and responsibilities include informing individuals of the purpose of self exclusion, establishing links and a gateway for access to supplementary services and monitoring and reporting the effectiveness of the overall programme.*

Introduction

Prevalence studies conducted in most jurisdictions reveal that between 0.2% and 2.1% of the population meet criteria for pathological gambling (Shaffer and Hall, 2001; Shaffer *et al.*, 2004). Despite significant psychosocial consequences, few pathological gamblers seek professional help. According to the National Gambling Impact Study Commission (1999) and the Productivity Commission (1999) reports, only 3 10% of pathological gamblers in the USA and Australia, respectively, are in formalized counselling services at any given time. Some pursue participation in self-help and peer counselling groups such as Gamblers Anonymous (GA), which gives participants the opportunity to discuss difficulties and discover ways to remain abstinent, while others simply recover without formal intervention (Nathan, 2003). Consistent with rates reported among substance abusers, it is estimated that about 39% of problem gamblers achieve 'natural recovery' (Hodgins *et al.*, 1999).

Whether or not gamblers utilize counselling or other services, participation in self-exclusion programmes can provide an effective barrier to accessing gambling venues, which, in turn, aids in the elimination or reduction of harm experienced by problem gamblers.

The purpose of this paper is to propose a systematic model to guide the initiation and evaluation of self-exclusion programmes. The proposed model is consistent with the Reno model, a strategic framework outlining the adoption

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and implementation of responsible gambling and harm-minimization initiatives (Blaszczynski *et al.*, 2004).

What is Self-exclusion and for Whom is it Designed?

Self-exclusion is the procedure most frequently utilized by the gaming industry to assist gamblers in minimizing the impact of harmful patterns of gambling behaviours. It is an industry-based programme that allows individuals who acknowledge that they have a problem with their gambling to enter into a voluntarily agreement to ban themselves from entering from one or multiple specified gaming venues and risk removal for knowing breaches. The ban may be permanent or issued for a limited duration. It is usually initiated by the gambler, although, in certain cases other individuals or family members may also initiate the procedure.

In the majority of cases, this programme is utilized by gamblers who exhibit symptoms corresponding to diagnostic criteria for pathological gambling. However, it may be that a small proportion of non-pathological recreational, at-risk or problem gamblers may also elect to take advantage of the programme by applying for voluntary self-exclusion for a variety of reasons, for example, recognizing early signs suggesting the development of a possible future problem.

Internationally, the requirements, procedures, processes and penalties that underlie self-exclusion programmes are inconsistent across jurisdictions. It is not the purpose of this paper to describe in detail the specific variations in self-exclusion programmes. (For further examination of self-exclusion programmes, see Nowatzki and Williams, 2002.) Rather, this paper focuses on developing principles for an effective model that can be adopted universally.

It should be emphasized that self-exclusion does not constitute a formal treatment intervention but rather represents an opportunity for immediate assistance in limiting further financial losses by imposing a barrier to direct access to gambling venues. A voluntary request for self-exclusion demonstrates that individuals accept to some degree that their gambling is excessive and causing harm, recognize a need to take personal responsibility to address the issue and demonstrate motivation to become active participants in the process. Most importantly, self-exclusion can be utilized to provide a gateway and referral pathway for adjunctive treatments.

Growth of Self-exclusion Programmes

In gambling, the concept of self-exclusion is an outgrowth of informal banning procedures historically used by casinos operators to evict unruly or unscrupulous patrons. The application of self-exclusion for purposes of assisting problem gamblers is a recent initiative (Nowatzki and Williams, 2002).

A literature review failed to identify any voluntary self-exclusion programme offered by other industries, for example, alcohol or tobacco. Self-disclosure and self-exclusion procedures have been used with blood donors to minimize health risks associated with transfusion of contaminated blood products. Potential blood donors are required to disclose certain high-risk sexual or drug-related activities and, if present, to refrain from donating blood or face severe legal penalties for knowingly misleading authorized agents.

Since the introduction of the concept in the late 1980s and early 1990s, sectors of the gaming industry throughout North America, Europe and Australia have gradually, albeit reluctantly, in some quarters, implemented the basic principles of the programme. The first formally constituted self-exclusion programme was initiated in Manitoba, Canada in 1989 concurrent with the opening of Canada's first permanent casino. Similar programmes were introduced between 1993 and 2000 in all provinces with casinos: British Columbia, Alberta, Saskatchewan, Manitoba, Quebec and Nova Scotia (Nowatzki and Williams, 2002).

In 1996, the Missouri Gaming Commission implemented the first such programme in the USA, followed by Illinois, Louisiana, Michigan, Mississippi, Missouri and New Jersey. Currently, such programmes operate in many casinos and gaming jurisdictions worldwide including South Africa, Poland, France, Switzerland, the Netherlands and Australia.

Effectiveness of Self-exclusion Programmes

To date, four studies have evaluated the effectiveness of self-exclusion programmes. Ladouceur *et al.* (2000) conducted an empirical study of 220 individuals who excluded themselves from the Province of Quebec's casinos. Of this group, 62% were males, with an average age of 41. Most participants (95%) were identified as pathological gamblers. The self-exclusion period varied, with 66% barring themselves for 12 months or less and 25% for 60 months. Almost all participants (97%) reported confidence that they would succeed in staying away from casinos during the self-exclusion period. However, 36% revealed that they had breached the self-exclusion agreement by entering the casino an average of six times during their self-exclusion period. In addition, 50% reported having gambled on other games, such as video-lottery games, during their self-exclusion period. Potentially, the most significant finding of this study was that 30% of the participants complied with their initial agreement and remained abstinent during their self-exclusion period. However, the remaining two-thirds complied with the agreement by not entering the nominated venue but continued to gamble elsewhere.

The effectiveness of a self-exclusion programme is subject to the criteria used to define outcomes. If the aim of self-exclusion through its very nature and structure is to foster abstinence, then the study suggests a failure rate in the vicinity of 70%. However, it cannot be dismissed that self-exclusion, although breached, may result in continued but lower levels of gambling activity and thus lead to a reduction in harm and potential improvement in control over behaviours in a larger proportion of gamblers. More research is necessary to investigate the nature and rates of decreased gambling behaviour post self-exclusion.

The second study to evaluate the impact of self-exclusion programmes was conducted in Australia, where it was estimated that 0.4 1.5% currently utilize the programme (O'Neil *et al.*, 2003). Between 1997 and 2002, the researchers conducted 4,083 interviews with gamblers. About half (56%) chose to self-exclude from an average number of 16.4 specified venues for an average period of 1.7 years. Of 933 individuals in the self-exclusion programme between 1996 and 2002, 137 (15%) of the self-excluded gamblers were detected breaching self-exclusion orders. These individuals reported an average of 3.2 breaches per person.

This study suffers from many methodological flaws. First, the authors provide insufficient information on the data collection procedures, the sample recruited

and the overall response rate. It is therefore impossible to determine whether their data are representative and generalizable to the broader population of self-excluders. In addition, there were no specific outcome measures on the efficacy of self-exclusion as a method to reduce gambling-related problems. Outcomes were determined according to self-reported compliance or detected breaches. Self-report accounts are unreliable and the absence of an effective identification and monitoring/reporting system suggest that not all breaches were reported, recorded or detected. As acknowledged by O'Neill *et al.* (2003): 'Administrative data and central record keeping is principally "input focused" and generally not used or useful for monitoring or evaluating outcomes or effectiveness of the programs' (p. 52). These issues reduce the validity and reliability of obtained data.

The third study conducted by Ladouceur *et al.* (in press) was designed to assess changes in gambling behaviours and gambling problems for self-excluded patrons and to follow self-excluded gamblers for a 2-year period (during and after the self-exclusion period). Individuals who excluded themselves participated in telephone interviews after signing the self-exclusion agreement and were followed at 6, 12, 18 and 24 months. Results found that 73.1% of participants met diagnostic criteria for pathological gambling. The self-exclusion programme had many positive effects. Participants reported that, at follow-up, the urge to gamble was significantly reduced while the perception of control increased significantly for all participants. The intensity of negative consequences for gambling was significantly reduced for daily activities, social life, work and mood. In addition, DSM-IV scores were significantly reduced from baseline to 6-month follow-up.

Although patrons in these studies reported benefits from self-exclusion, such programmes are in need of improvements to increase utilization rates and improve outcomes over time. For example, O'Neill et al. (2003) and Nowatzki and Williams (2002) have criticized the industry for offering marginal support of the programme, thereby falling short of individual and community aspirations for effectiveness. In particular, the authors assert that the industry has invested more resources in defending the credibility of self-exclusion programmes than in developing an effective, integrated system of self-exclusion that complements other harm minimization measures or in introducing appropriate systems for outcome monitoring. Absent such measures, it is premature to draw conclusions regarding the overall effectiveness of self-exclusion programmes beyond the assertion that such programmes seem to benefit a small number of problem gamblers who elect to use them.

The most recent study, conducted by Nower and Blaszczynski (2006), explored gender-related differences in the demographic and gambling-related characteristics of 2,670 problem gamblers participating in a state-administered (Missouri) casino self-exclusion programme between 2001 and 2003. The authors evaluated existing data, maintained by the Missouri Gaming Commission, on female ($n = 1{,}298$, 48.4%) and male ($n = 1{,}372$, 51.1%) participants ranging in age from 21 to 84 years. The study noted gender-related differences among demographic variables, patterns of gambling behaviour, reasons for self-exclusion and involvement in self-help, counselling and bankruptcy services. Female self-excluders were more likely than males to be older at time of application, African American and either retired, unemployed or otherwise outside the traditional workforce. In addition, female self-excluders were more likely to report a later age of gambling onset, a shorter period between onset and self-exclusion, a preference for non-strategic forms of gambling and prior bankruptcy. The main predictors for

female participation in self-exclusion included a desire to gain control and prevent suicide and referral by a counsellor. The desire to save the marriage was a motivating factor for all participants. The study was limited by the nature of the questionnaires prepared by the government agency, which contained no measures of gambling problem severity or outcome evaluation of the effectiveness of the self-exclusion programme post application.

The limitations of the previous studies highlight the need to develop a systematic, widely applicable model that can be tailored to a wide variety of venues and evaluated for utilization rates and efficacy of outcomes. Such a model must be based on underlying principles and expectations designed to best ensure provision of the best possible assistance to problem gamblers.

Issues Associated with Self-exclusion

Expectations

In designing a self-exclusion model, it is first important to clarify expectations regarding the role and limits of responsibility of individual gamblers, industry, legal/government authorities and interested community members in the self-exclusion process to avoid unrealistic expectations and unfair criticisms.

First, problem gamblers must clearly understand that the self-exclusion agreement between the gambler and gaming operator does not constitute a formal contract enforceable by law (Napolitano, 2003). Rather, it represents an arrangement wherein a venue voluntarily offers, or is obliged by law to offer, a service where:

- Individuals identifying themselves as problem gamblers may approach a gaming operator or delegated staff with a request or application to exclude themselves from future entry into a gaming venue for a determined period of time (6 months to lifetime);
- The individual agrees to be removed from the specified gaming venue by the operator or delegated staff should they be identified as in breach of the self-exclusion order;
- The individual agrees to have their names removed from mailing, marketing and promotional lists and databases; and
- The individual understands that a penalty may be imposed for breaches of the self-exclusion agreement: this may include assent to confiscation of winnings (e.g. Illinois, USA), arrest for trespass (e.g. Missouri, USA) or fine (e.g. New South Wales, Australia).

In principle, self-exclusion programmes are designed to eliminate gambling behaviour by preventing access to gambling venues. In this context, the ultimate criterion for successful outcome is abstinence as opposed to controlled gambling. Given that the explicit intent is simply to set barriers in place to prevent access rather than to address irrational cognitions or psychological factors contributing to impaired control, self-exclusion should not be misconstrued to represent a method of psychological treatment. In this regard, the gaming industry's reliance on self-exclusion as the primary option for the management of problem gambling has been criticized by counselling service providers (O'Neill *et al.*, 2003).

It is important for self-excluded gamblers to fully understand the respective responsibilities and roles of the industry in detecting and enforcing orders and

those of the individual in complying with conditions. Otherwise, a misunderstanding of the roles and responsibilities in self-exclusion can result in dissatisfaction, resentment and criticism of the programme. As noted by O'Neill et al. (2003), gamblers attributing responsibility for enforcement of the self-exclusion order to gaming venues differ significantly in their response from those who accept personal responsibility for compliance. A proportion of problem gamblers, the authors note, express the opinion that it is the gaming industry's role to enforce the provisions of self-exclusion. Such enforcement would be optimally possible if each gambling venue worldwide utilized an identification system that severely restricted the points of entry and egress. However, mandating such a system would be virtually impossible in a number of jurisdictions. In the USA, for example, some jurisdictions provide gaming machines in convenience stores and airports that are highly travelled by individuals of all ages with varying interests besides gambling. In addition, Indian tribal casinos are subject to federal rather than state law, making it additionally difficult to impose additional requirements. In Australia, a majority of gaming machines are in bars and clubs that intersperse machines with restaurants, lodging and athletic facilities that attract a wide variety of non-gambling patrons.

Absent a statutory requirement to produce valid identification to gain entry to a venue, it is unrealistic for gamblers to expect the gaming staff, armed with photos, to detect any gambler in breach of the self-exclusion agreement in a crowd, particularly in jurisdictions where self-excluders number in the thousands. This is particularly impractical given the number and frequency of patrons entering venues, the high turnover of casual staff and the changes in individual appearance over time.

Other problem gamblers, particularly those who ascribe to the tenets of 12-step programmes, acknowledge that the primary responsibility for complying with the conditions set out in self-exclusion agreements rests with the problem gambler. In these cases, the problem gambler acknowledges that the acceptance of personal responsibility for his or her actions is an essential step toward recovery and views the gaming operator as simply providing a service to assist the problem gambler.

Assessment and Referral

There are three critical elements related to the assessment of individuals seeking self-exclusion: Suitability for the programme, need for concurrent counselling interventions and determining risk for self-harm.

To initiate a self-exclusion order, individuals are required to contact a gaming floor staff member with a request to become a self-excluded person. The staff member provides preliminary information on self-exclusion and its formal procedures before directing the individual to a customer liaison or support officer. The liaison officer is concerned with the provision of detailed information regarding the administrative, procedural and legal conditions, requirements and implications of the self-exclusion agreement. This officer also provides information outlining a range of counselling services accessible to the individual but does not assess or advise which services are most appropriate for the individual's immediate or longer term psychological needs.

A significant proportion of individuals initiating self-exclusion often do so spontaneously in a state of emotional distress in response to heavy losses

sustained during a gambling session. Such decisions may be considered 'spur of the moment' reactions that are subsequently regretted in the 'cooling off' period. Attempts are then made to revoke the order and if unsuccessful, may lead the gambler to deliberately breach the order or attend other venues to continue gambling.

In other circumstances, gamblers may present to the liaison officer in an emotional state where there is a high risk for suicide or self-harm and a need for immediate mental health professional interventions to guarantee safety. High rates of depression, suicidal ideation and substance abuse are known to be prevalent co-morbid conditions associated with problem gambling (Petry, 2005). Referral to an appropriate crisis intervention centre may be required to address the relevant disorder.

Self-exclusion is not a clinical or counselling intervention in its own right. While imposing a barrier to access gaming venues may be sufficient to decrease or eliminate problem gambling for an unknown proportion of self-excluded gamblers, self-exclusion should be considered a gateway or initial barrier to access that may best be supplemented by other interventions. Referral to specialist gambling counsellors, clinicians and mental health services may be necessary to deal with factors that may contribute to chronic gambling urges, co-morbid disorders, marital dysfunction and personal issues: appropriate mental health interventions reduce risk for relapse.

Gaming operators invested with the authority to complete a self-exclusion order in consultation with the gamblers generally do not have formal qualifications in behavioural health sciences or the requisite skills to undertake a competent clinical assessment of the psychological status, specific needs of the gambler, or the capacity to identify and respond to suicidal risk. Thus there is an imperative need for competent and comprehensive clinical assessment complementing the formal administrative/legal requirements to be conducted at the point of initiating self-exclusion.

Audit and transparency

Monitoring the effectiveness of self-exclusion programmes is generally limited by a number of factors including:

(i) The inability to monitor non-compliance due to the lack of an identification system, inadequate staffing to track patrons and insufficient staff training to enforce detection;
(ii) A lack of systematic protocols for outcome analysis;
(iii) The lack of a centralized management system and procedures for notification of breaches;
(iv) The absence of binding sanctions for violators;
(v) The inability to identify gamblers who merely continue their gambling activity at other venues;
(vi) Failure to release evaluation audits to the public domain;
(vii) A lack of independent auditing of self-exclusion programmes and procedures.

Tension exists among gaming industry operators between promoting a legitimate commercial product for profit and implementing responsible gaming initiatives

whose purpose is specifically designed to reduce gaming and, *ipso facto*, gaming revenue. While it is acknowledged that responsible gaming codes of conduct are required to ensure the longer-term sustainability of the industry, conflicts of interest arise. As O'Neill *et al.* (2003) state in their report: 'There is also a conflict of interest where enforcing self-exclusion may impact directly on operator income. Clearly discretionary systems are vulnerable to the action of self-interested parties' (p. 12). To address this issue, it is imperative to introduce an objective and transparent system of monitoring and auditing industry utilization and compliance with self-exclusion programmes.

Consequently, an optimal system would remove the responsibility for overseeing the self-exclusion programme from the gaming operator in favour of an independent third party with clearly defined and delineated lines of responsibility and reporting and release monitored outcomes and data within the public domain.

Principles for Self-exclusion

Before proposing a comprehensive strategy that maximizes the effectiveness of self-exclusion, it is important to clarify the fundamental premises and set of principles underlying such a programme. The following proposed principles underlie a successful self-exclusion programme.

Responsibilities of the industry:

- To provide the necessary procedures, policies and infrastructure to implement an effective self-exclusion programme;
- To train staff in the principles underlying self-exclusion and the operational procedures utilized in implementing such a programme;
- To ensure self-exclusion programmes are easily accessible and that information explaining the programme and its implications is easily understood;
- To simplify formal procedures to take out a self-exclusion;
- To institute policies and procedures to effectively detect breaches of self-exclusion orders.

Responsibilities of the individual self-excluder:

- To recognize and accept the existence of a gambling problem;
- To be willing and motivated to deal with the gambling problem;
- To make a considered decision to self-exclude rather than impulsively and emotionally responding to a crisis;
- To maintain motivation over time;
- To accept responsibility for complying with self-exclusion orders;
- To fully commit to a specified duration of self-exclusion and refrain from attempts to vary it later.

In addition, a system of self-exclusion should include independent third-party participation to maximize objectivity and effectiveness. That independent party should: (a) assume responsibility for open and transparent monitoring and auditing compliance with and the effectiveness of, self-exclusion programmes; (b) assess all self-excluders for counselling needs, risk for harm and referral

to appropriate services; (c) ensure that qualified and competent counsellors are vested with the responsibility of conducting assessments and referrals to treatment services; (d) assess requests for revocation and/or the extension of self-exclusion orders independent of the gaming venue operator.

Philosophically, the current system is hampered by a focus on external control that all but abrogates individual responsibility for controlling gambling behaviour. Individuals are active in initiating the programme but, once initiated, they become passive as responsibility shifts to the gambling venue operator to detect and police possible breaches. Such a perspective effectively limits opportunities for gamblers to develop improved stress-coping skills and increases the possibility that they will return to gambling or substitute alternative, maladaptive coping strategies in the future (see Blaszczynski *et al.*, 2004).

In contrast, the following proposed system is one that advocates the need to move away from a detection-based enforcement model to an active approach of personal responsibility with opportunities for additional support from external counselling programmes. Under this system, gamblers would not only utilize self-exclusion as one step but also choose to integrate their own level of treatment tailored to their individual needs. Potential services could include counselling, stress-coping and problem-solving training, assistance with financial management and referral to self-help groups including Gamblers Anonymous. Periodic evaluation will determine the efficacy of extending the term of exclusion.

The Proposed Model

The proposed philosophy represents a shift in perspective away from a punitive approach to an individual, client-centred or skills-based humanistic model where the focus is on enhancing internal controls of the individual to assist them in regaining control over gambling behaviour. Under the proposed model, self-exclusion would function as a gateway to accessing a system of complementary services and community resources that are individually tailored.

The Self-exclusion Educator

In contrast to current casino-operated procedures that rely on external barriers and industry policing efforts, the proposed model utilizes a qualified trained educator system that provides monitoring in a supportive environment and facilitates internalizing control for the gambler over time. Each self-exclusion educator is clinically trained to provide support to self-excluders during their period of self-exclusion and to provide options for accessing additional services.

Upon admission to the self-exclusion programme, the educator contacts the individual to assess their motivation and gambling problems. Based on this assessment, the educator offers options to access a variety of services such as regular telephone support, treatment programmes, Gamblers Anonymous and financial counselling as well as non-gambling related services such as substance abuse treatment and skills training. The educator also conducts an introductory class or series of classes to explain the principles and purposes of self-exclusion, review concepts involved in problem gambling and the recovery process and introduce a menu of available treatments and services.

Throughout the process, the educator provides the self-excluder with intensive case-management with frequent contact and serves as an on-going supportive linkage between workers at gaming venues, gamblers and available resources.

Responsibilities of the Venue

It is important to note that the proposed model, while placing primary responsibility on the gamblers, recognizes the on-going need for gaming venues to participate actively in self-exclusion programmes and provide vigilant, continuous support to participants. Though the authors acknowledge that monitoring systems are imperfect and breaches will occur, venues should be accountable to publicly report data and document the provision of adequate staff allocation, training and surveillance to provide a workable infrastructure for gamblers who desire to self-exclude. Accordingly, the current proposal would require venues to: (a) provide employee education and infrastructure support needed to initiate the self-exclusion process and facilitate contact with the educator; (b) educate clients on the availability and public value of self-exclusion based on empirically-derived information; (c) devise and institute protocols for identifying and managing individuals who breach self-exclusion agreements; and (d) display adequate signage regarding self-exclusion options. In addition, gambling venues should be required to cooperate with periodic, random spot-checks by independent auditors. They should also be subjected to some forms

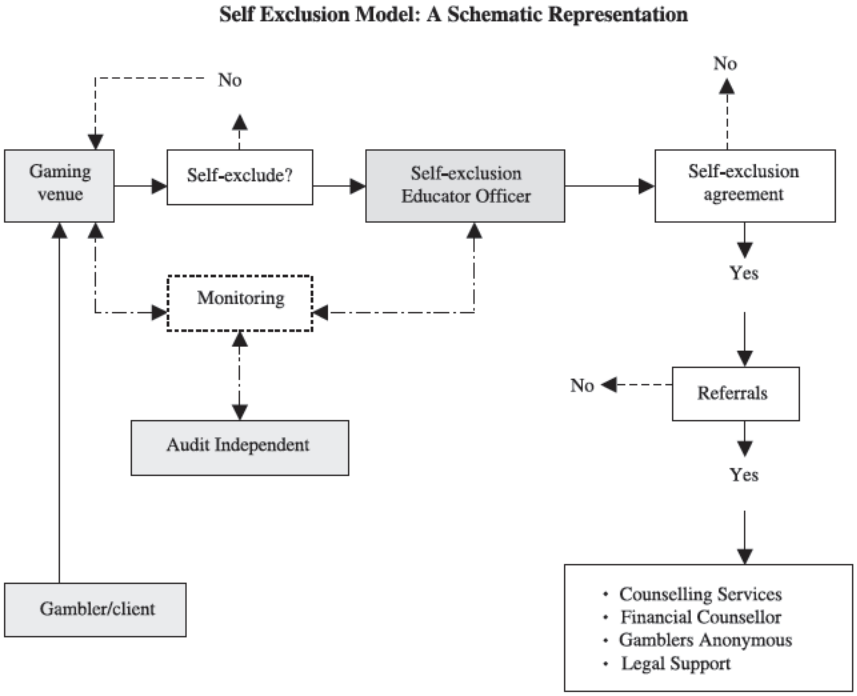

Figure 1. Proposed self-exclusion model

of penalties for non-compliance, the form yet needing to be determined. Research needs to be conducted on this important issue. Such requirements increase the transparency of the process and motivate the industry to maintain their responsibilities.

Responsibilities of the Independent Auditor

In addition to a self-exclusion educator, the model proposes the utilization of an independent auditor whose primary responsibility is to provide performance reports describing the operation and effectiveness of the self-exclusion programme including the performance of the industry and educators. The auditor would review and report compliance with (a) (d) above and consult with the educator and staff members regarding the implementation of the programme and recommendations for continued improvement.

Self-exclusion Procedure

The proposed self-exclusion programme functions as a system that provides continuous feedback between individuals, educators, gambling venue staff and outside resources.

Optimally, the procedure would be as follows:

1. *Gambler/client*: The referral process is initiated by the gambler wishing to self-exclude. The gambler will be informed by various pamphlets and documents that they first need to approach an employee in the gambling venue or contact the educator directly. The employees will be trained in procedures and approaches to inform the potential individual. Their role is not to deliver services other than being empathic and to provide all the pertinent information to the gambler.
2. *Gambling venue*: Venues will refer the individual directly to the self-exclusion educator who will deal with crisis cases immediately or assess others within 24 48 hours. This latter time frame will give the gambler an opportunity to calm down and to be in an emotional state sufficient to make an informed decision. Gamblers who request and insist on immediate self-exclusion will have the option of completing a temporary 24-hour self-exclusion form with the gaming employee pending assessment by the educator. Gamblers will still be asked for their consent for the venue staff to provide their name to the self-exclusion educator for further contact and continuity of care. If a gambler refuses to agree to have his or her name referred to the educator, the gaming venue staff member will document the refusal and provide the individual with additional information should s/he decide to reinitiate the process at a later date. No further contact will be made with the gambler.
3. *Self-exclusion educator officer*: The next step will involve the individual meeting with the self-exclusion educator who will conduct a standardized in-depth interview to assess the individual's motivation and goals for undertaking self-exclusion. The educator will provide educational information and will then outline appropriate treatment and service options at a meeting outside the gaming venue. The gambler will then decide on the types of additional services that may be available and the duration of the self-exclusion period (from 12 months to 5 years at the discretion of the gambler) and sign a standard

agreement form. The contents and details of the agreement should be uniform for all venues and programmes within a given jurisdiction. The gambler may choose from a range of formal treatment options, determine the frequency of weekly or monthly phone contacts and whether to attend GA or other services. During the self-exclusion period, the educator will continue to provide ongoing support, monitoring, mentoring and initiate follow-up contact by agreement. Should the gambler refuse on-going contact, the educator will document the refusal in the agreement and contact the gambler only once yearly to obtain progress and outcome information for governmental reporting.

4. *Self-exclusion agreement*: The educator will inform individuals refusing to sign the self-exclusion agreement that they may resume the procedure at any time by re-contacting the educator.
5. *Expiration of the self-exclusion period*: Toward the expiration of the contract period, the self-exclusion educator will contact the gambler by registered letter and arrange a meeting to determine whether s/he wants to renew or terminate the contract. Individuals who meet with the educator will receive further assessment and assistance in determining further options. However, if gamblers fail to respond to the letter, self-exclusion will terminate as scheduled at the end of the contract period. Such a renewal process will limit the burdensome and ineffective task of policing individuals who may have moved, died, or otherwise dropped out of the system without notification.

Management of Breaches

It is important to balance individual responsibility with foreseeable consequences of breaches. Therefore, the self-exclusion agreement will include a clause stating that it is the individual's responsibility to refrain from re-entering the venue during the period of self-exclusion. Current detection penalties will remain in place pending empirical evaluation of their effectiveness. Theoretically, the introduction of educators would optimally shift the focus over time from an industry-policing focus to individual monitoring of gambling self-efficacy. Since the self-exclusion programmes have not been systematically evaluated, there are some difficulties in selecting a preferred modality for penalties and the proper design for assessing the efficacy of the programme.

Conclusion

The current philosophy represents a shift from an industry-based to an individual-based response to self-exclusion. Ultimately, the gambling venue will provide a basic service in an effort to shift from a punitive detection model to active intervention in the form of a supportive clinical education/counselling model that promotes individual self-efficacy and is designed to facilitate long-term improvement in the individual's quality of life. In addition, the proposed model provides interaction among micro, mezzo and macro systems with information feedback that will foster improvements in the system's optimal functioning over time. Empirical data will determine the feasibility, the efficacy and the effectiveness of the present new self-exclusion model.

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References

Blaszczynski, A., Ladouceur, R. and Shaffer, H. 2004. 'A science based framework for responsible gambling: The Reno Model', *Journal of Gambling Studies*, 20, pp. 301 17.

Hodgins, D.C., Wynne, H. and Makarchuk, K. 1999. 'Pathways to recovery from gambling problems: follow up from a general population survey', *Journal of Gambling Studies*, 15, pp. 93 104.

Ladouceur, R., Jacques, C., Giroux, I., Ferland, F. and Leblond, J. 2000. 'Analysis of a casino's self exclusion program', *Journal of Gambling Studies*, 20, pp. 301 7.

Ladouceur, R., Sylvain, C. and Gosselin, P. in press. 'Self exclusion program: a longitudinal evaluation study', *Journal of Gambling Studies*.

Nathan, P.E. 2003. 'The role of natural recovery in alcoholism and pathological gambling', *Journal of Gambling Studies*, 19, pp. 279 86.

National Gambling Impact Study Commission. 1999. *Final Report*. Government Printing Office, Washington, DC.

Napolitano, F. 2003. 'The self exclusion program: legal and clinical considerations', *Journal of Gambling Studies*, 19, pp. 303 15.

Nowatzki, N.R. and Williams, R.J. 2002. 'Casino self exclusion programmes: a review of the issues', *International Gambling Studies*, 2, pp. 3 25.

Nower, L. and Blaszczynski, A. 2006. 'Characteristics and gender differences in casino self excluders: Missouri data', *Journal of Gambling Studies*, 22, pp. 82 99.

O'Neil, M., Whetton, S., Dolman, B., Herbert, M., Giannopolous, V., O'Neil, D. and Wordley, J. 2003. *Part A Evaluation of self exclusion programs in Victoria, and Part B Summary of self exclusion programs in Australian States and Territories*. Gambling Research Panel, Melbourne.

Petry, N.M. 2005. *Pathological gambling: etiology, comorbidity and treatment*. American Psychological Association, Washington, D.C.

Productivity Commission. 1999. 'Australia's gambling industries: Final report', Ausinfo, Canberra.

Shaffer, H.J. and Hall, M.N. 2001. 'Updating and refining prevalence estimates of disordered gambling behaviour in the United States and Canada', *Canadian Journal of Public Health*, 92, pp. 168 72.

Shaffer, H.J., LaBrie, R.A., LaPlante, D.A., Nelson, S.E. and Stanton, M.V. 2004. 'The road less travelled: moving from distribution to determinants in the study of gambling epidemiology', *Canadian Journal of Psychiatry*, 49, pp. 504 16.