Gambling in Rural and Remote South Australia

Elly Grace Gannon

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DECLARATION

This report contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this report contains no materials previously published except where due reference is made.

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Elly Grace Gannon

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LITERATURE REVIEW

Gambling in Rural and Remote Australia: a Literature Review

Elly Gannon

School of Psychology

University of Adelaide

Supervisors:

Professor Paul Delfabbro

Dr Carly Sutherland

University of Adelaide

Abstract

There is a paucity of research that has examined what motivates rural and regional community members to engage in gambling, as well as what factors may impede their access to treatment for gambling. There are likely differences between rural locations and metropolitan regions. Accordingly, the aim of this review was to examine what is known from existing literature concerning people's motivations to gamble, risk factors for gambling, and factors associated with treatment seeking and service delivery and how this might differ between rural and non-rural settings. Future research remains necessary to discover what motivates the rural population to gamble, and what prevents them from seeking gambling treatment. A better understanding of how gambling in rural and remote communities is distinct from metropolitan areas may inform appropriate and effective service delivery.

Keywords: Rural Gambling, Motivations to Gamble, Barriers to Treatment Seeking, Rural and Remote

Gambling in Rural and Remote Australia: A Literature Review

Gambling has long been a part of Australian life and history, with some reports suggesting that these activities predate British settlement in Australia and were also part of Indigenous culture (Delfabbro & King, 2012). Gambling has taken many forms and includes wagering on the outcomes of races (e.g., horses or dogs) or sporting events as well as various forms of gaming which can be engaged in physical contexts (e.g., table games), offered electronically (e.g., electronic gaming machines) or delivered via the internet (Delfabbro & King, 2012; Gainsbury, et al., 2015). Electronic Gaming Machines (EGMs) were introduced in New South Wales in 1956, with other states, including South Australia, legalising these machines in the 1990s (Delfabbro & King, 2012). Following the introduction of EGMs in Australia, the gambling industry experienced a surge in revenue, seeing a $10 billion increase in a 20-year period; 60 per cent of which was EGM revenue (Delfabbro & King, 2012).

Based on national telephone surveys, prevalence studies have suggested that around 70 per cent of the national adult population gamble at least once per annum (Delfabbro, 2012; Gainsbury, et al., 2015). Lotteries are reported to be the most popular form of gambling in Australia in terms of regular participation and this is followed by EGMs and racing (Delfabbro, 2012). More recently, people have increasingly used the Internet as a means to access various forms of gambling with online wagering and online poker being found to be the most popular (Gainsbury, et al., 2015). Around 10 to 12 per cent of the Australian adult population are now thought to be accessing gambling online.

Although most people gamble safely, a small proportion of people experience problems with gambling. Problem gambling is characterised by the inability to control the

time and money spent on gambling, which results in negative ramifications or harms for the gambler and those who surround them (Hing, Russel, Nuske, & Gainsbury, 2015; Neal, Delfabbro, & O'Neil, 2005; Oakes, Gardiner, McLaughlin, & Battersby, 2012; Young, Stevens, & Morris, 2008). Pathological gambling was originally classified in the DSM-IV as an impulse control disorder; in the most recent edition (DSM-V), Gambling Addiction is now classified as an addictive disorder (American Psychiatric Association, 2013; Hing, et al., 2015).

Global estimates of gambling disorders have varied widely, but most Australian estimates tend to be in the range of 0.5 to 2 per cent of the adult population (Delfabbro & King, 2012; Oakes, et al., 2012). In South Australia, over half (65 per cent) of the population had participated in a gambling related activity in the 12 months prior to completing a gambling prevalence telephone survey (Department for Human Services [DHS], 2018). The most recent South Australian estimates place the prevalence of problem gambling at 0.7 per cent of adults (DHS, 2018). A further 2.2 per cent of South Australian adults have been classified as moderate risk gamblers, and a further 4.6 per cent have been reported to engage in low-risk gambling (DHS, 2018).

Consequences of problem gambling can include personal and interpersonal issues as well as financial burden (Oakes, et al., 2012; Young, et al., 2008). Gambling disorders are known to severely impact mental health and are reported to be highly comorbid with psychiatric disorders such as alcohol and substance misuse, anxiety disorders, mood disorders, and suicidality (Hodgins, Stea, & Grant, 2011; Oakes, et al., 2012). Lorains, Colishaw and Thomas (2011), based in Australia, sought clarification of gambling comorbidities; a systematic review was conducted and data was extracted from 11

studies. Results proposed that 60 per cent of gamblers experienced nicotine dependence, approximately 58 per cent had a comorbid substance abuse disorder, 38 per cent experienced a mood disorder, and 37 per cent experienced some form of anxiety. Consistent with this, Australian studies have reported 75 per cent of problem gamblers experienced some form of depressive symptoms (Delfabbro, 2012). In a large national survey of mental health in the United States, problem gambling preceded the mental health disorder a quarter of the time, and followed an existing mental health disorder three quarters of the time (Hodgins, et al., 2011). However, it is widely understood that the relationship between mental health disorders and gambling addiction is complex and potentially bidirectional (Chou & Afifi, 2011; Hodgins, et al., 2011; Lubman, et al., 2017).

Despite the complexities of gambling disorders and the high rates of comorbid mental health disorders, research has suggested that gamblers are underrepresented in treatment facilities. In a community-based sample in Australia, it was reported that less than 10 per cent of people with gambling problems presented for treatment (Slutske, Blaszczynski, & Martin, 2009). Further, it is predicted that half of those who enter treatment for gambling will drop out (Smith, et al., 2010). There are different forms of treatment that people with gambling problems can access. Motivational Interviewing is a brief form of treatment for problem gambling, which encourages clients to explore their motivations and barriers for change (Hodgins, et al., 2011). Cognitive Behaviour Therapy (CBT) is an effective treatment for gambling addiction and is considered the "gold-standard" of such treatments (Oakes, et al., 2012; Smith, et al., 2010). A CBT treatment approach for problem gambling is typically comprised of cognitive restructuring,

behavioural experiments, problem solving as well as exposure to gambling related stimuli and desensitisation (Delfabbro & King, 2012; Hodgins, et al., 2011). Self-help groups such as Gamblers Anonymous (12-step program modified from the Alcoholics Anonymous groups) are also available in Australia, albeit to a lesser extent than Alcoholics Anonymous Groups (Delfabbro & King, 2012; Hodgins, et al., 2011). Additional treatment options include financial counselling and relationship counselling (Delfabbro & King, 2012; Hodgins, et al., 2011).

The principal area of interest in this review is the extent to which broader findings and principles relating to gambling and problem gambling can be generalised to all parts of the community and, in particular, whether there may be important regional or geographic variations. This is important in places such as South Australia, which has a very geographically dispersed population where the experiences of people living in rural and remote locations might not necessarily reflect those of the larger Adelaide metropolitan region. Some insights into possible differences are found in the Gambling Prevalence South Australia (GPSA) survey, which examined whether gambling participation varied according to a variety of demographic factors, including geographic region. For the selected gambling activities in the survey, participation rates in rural areas were all higher than the rest of South Australia, with Eyre Western, Far North, Limestone Coast and the Murray Mallee regions all being significantly higher than that of the total population (Department of Communities and Social Inclusion [DCSI], 2012). In those regions, higher rates of participation were observed for land-based gambling activities such as lotteries and racing; Internet-based gambling was higher in the Eyre Western, Far North and Limestone Coast regions in comparison to metropolitan areas (DCSI, 2012).

More broadly, studies suggest that gambling is a popular activity in rural communities and that problem gambling can be as much of a concern in these areas as in the metropolitan areas (Riley, Smith, & Oakes, 2011). Many rural and remote communities are isolated and often provide a limited range of leisure options for community members. In such places, local hotels and clubs are often considered the “primary source of entertainment” and act as an “informal setting for airing local concerns” as well as facilitate social interaction (Brumby, Kennedy, & Chandrasekara, 2013; National Expert Advisory Committee on Alcohol [NEACA], 2001). As a consequence, it is not surprising that there is evidence of higher expenditure on gambling related activities including EGMs in some rural areas because of the availability of gambling in many rural hotels (O’Neil, Kosturjak, & Whetton, 2004; Oakes, et al., 2012; Tolchard, 2015). Little research has, however, been conducted to examine the role that gambling might play in rural communities and, in particular, whether there might be distinctive factors that encourage or motivate people in these regions to gamble and how this might relate to the development of problem gambling and help-seeking for these problems.

Inflated rates of gambling in particular rural areas may relate to higher risk of additional physical and mental health problems. The Australian Institute of Health and Welfare (AIHW) reported that Australians who live in rural and remote areas experience increased levels of health complications, decreased life expectancy and inferior access to health services in comparison to their metropolitan counterparts (Baxter, Hayes, & Gray, 2011) and these are problems known to co-occur with problem gambling. For example, studies have suggested that the rate of alcohol use increases with distance from major

cities (Brumby, et al., 2013) and substance use has been reported to be higher in rural and remote regions than metropolitan areas (Australian Institute of Health and Welfare [AIHW], 2017). Considering that problem gambling is known to be associated with an inflated risk of comorbidities for substance use disorders, mood disorders and anxiety disorders, this may make problem gamblers in rural communities particularly vulnerable. Furthermore, the rates of suicide in remote and very remote areas are almost double than major cities (AIHW, 2017) and being a gambler in a rural community further increases risk for suicide (Tolchard, 2015). Such findings potentially highlight the importance of the increased interest in research for rural mental health and the provision of services in these areas.

To the best of our knowledge, there has been little research to examine the experiences of people with gambling problems in rural and remote areas: why they gamble, why they develop problems and how they seek help. There are likely differences between rural locations and metropolitan regions. Accordingly, the aim of this review is to examine what is known from existing literature concerning people's motivations to gamble, risk factors for gambling, and factors associated with treatment seeking and service delivery and how this might differ between rural and non-rural settings.

Gambling in Rural Australia

It is important to first understand the role of gambling in rural communities in order to comprehend why and how rural gambling may differ from gambling in metropolitan areas. Australian prevalence surveys for gambling in rural areas vary; as discussed, in South Australia selected gambling activities were significantly higher in at least three of the rural areas compared to the national population (DCSI, 2012). In rural

townships there is reported to be a "cultural heritage of pubs as the meeting place and watering hole" which suggests that local hotels are a social facilitator for rural towns (Brumby, et al., 2013). Studies in other states vary from South Australian studies; in Queensland rural and metropolitan gambling is comparable in most forms of gambling (Tolchard, 2015). In New South Wales there was a higher risk of problem gambling associated with only one rural region (Sproston, Hing, & Palankay, 2012) and problem gambling was more likely to be associated with metropolitan gambling in the Northern Territory, despite rural areas having an increased participation rate (Young, et al., 2008). In Tasmania, metropolitan gamblers participate in gambling related activities more frequently, but participation in EGM gambling was higher outside of metropolitan areas (South Australian Centre for Economic Studies, 2008; Tolchard, 2015).

There is a paucity of research that has examined what motivates rural and remote community members to engage in gambling, as well as what factors may impede their access to treatment for gambling. Bjedle, Chromy and Pankow (2008), studying older adults in a rural community in the United States, reported that barriers to seeking treatment for gambling addiction included lack of available services and distance to travel to receive services. They did not, however, report whether there may have been motivational factors which make people in rural and remote areas more dependent on gambling as a leisure activity, which might have implications for the effectiveness of treatment or reducing gambling problems. This issue is examined in the following section.

Why do people gamble?

There are several factors that motivate individuals to gamble and these are often conceptualized as corresponding to two distinct pathways. That is, a positive reinforcement (excitement, arousal, chance of winning) or negative reinforcement (escape from negative emotions, or a relaxation method to reduce stress) (Rickwood, Blaszczynski, Delfabbro, Dowling, & Heading, 2010). For example, Nower and Blaszczynski's (2010) Pathways Model, suggests that people who develop problems with gambling are typically motivated by a desire to win money (positive reinforcement) as well as to escape problems (negative reinforcement). As an alternative conceptualization of gambling motivation, research has proposed three 'types' of motivation, involving both internal and external stimuli (Clarke, 2004). Intrinsic motivation is internal motivation; for example gambling to learn new skills, for accomplishment and for stimulation. Extrinsic motivation is external motivation, such as gambling for rewards, to decrease tension and gambling for acceptance from others. The third motivational pathway is amotivation, which is being motivated by neither intrinsic nor extrinsic factors. Amotivation is associated with an inability to identify a link between actions and outcomes of gambling; thus, gambling with little meaning (Clarke, 2004).

Much like the three-type model, Rockloff and Dyer (2006) presented a multidimensional model to explain gambling motivation. Motivating factors include excitement, escape (avoiding unpleasant affect and social situations), esteem (avoidance of negative self-appraisal) and excess (difficulty controlling impulses). This model was termed the 4E model, and focused on emotive motivators. Flack and Morris (2014) investigated gambling motivations by comparing the emotion focussed motivation model

with the positive reinforcement motivation model (winning and monetary gain as primary motivator). In contrast to The Pathways Model, Flack and Morris (2014) reported that the chance to win money was not the primary motivation in predicting gambling severity. Rather, being motivated by emotions was a better predictor of problem gambling. Despite other competing theories, Clarke and Clarkson (2007) reported that problem gamblers were more inclined to be motivated to gamble to win money, as well as due to social and emotional factors.

Electronic Gaming Machines are postulated to be one of the "most damaging [forms] of gambling", associated with the highest rates of problem gambling (Gainsbury, et al., 2014; Nower & Blaszczynski, 2010; Thomas, Allen, & Phillips, 2009). It has been proposed that EGMs offer a physical retreat and appealing environment for gamblers, in addition to being highly accessible in many regions in parts of Australia (Thomas, et al., 2009). Therefore, understanding why people choose to gamble on EGMs is vital. Thomas and colleagues (2009) developed a measure of EGM gambling motivations based on qualitative research. The study extracted three primary motivating factors: escape, accessibility and social environment (Thomas, et al., 2009). Pertinent to this model, is the EGM-specific negative reinforcement model of motivation (Thomas, Allen, Phillips & Karantzas, 2011). This model posits that by gambling on EGMs, an individual has an opportunity to temporarily divert their attention away from negative or stressful stimuli as a coping mechanism. The authors suggest that a combination of individual, social and environmental factors motivates EGM gambling addiction (Thomas, et al., 2011).

Motivational factors have also been examined in relation to new forms of gambling such as those made available via the Internet. These include: a greater

opportunity to gamble, convenience, value for money, a greater variety of games to access and anonymity (McCormack & Griffiths, 2012). Binde (2013) described a five-factor model to explain motivation for internet gambling; this model suggested that that "the chance of winning" is an essential motivating factor to gamble online, with four additional motives dependent on personal disposition and preferences. The remaining four factors are the dream of hitting the jackpot, intellectual challenge, social rewards and mood change (Binde, 2013). Comparably, in a British Gambling Prevalence Survey, gambling for an intellectual challenge was also cited as a motivating factor to gamble (Francis, Dowling, Jackson, Christensen, & Wardle, 2014).

Gambling in Indigenous Australian Culture

It has been documented that in the 1700s, Indigenous Australians engaged in wagering with fishing fleets arriving from Indonesia (McMillian & Donnelly, 2008). However, more commonly cited forms of gambling include community card playing, which is believed to have been an important part of Indigenous culture, as it became a means for trading land based resources within communities (McMillen & Donnelly, 2008; Young, Barnes, Stevens, Paterson, & Morris, 2007). Gambling in the form of community card games has also been reported to benefit Indigenous cultures as they often involve the whole community (McMillen & Donnelly, 2008). By doing so, it is believed that gambling can facilitate positive social interactions and can protect individuals and the wider community from the harmful effects of more contemporary forms of gambling (McMillen & Donnelly, 2008).

Research conducted at Nunkuwarrin Yunti, an Aboriginal community controlled health organisation, inferred that historically, in Indigenous communities, gambling was

not only a social leisure activity, but an essential form of resistance towards authority, due to missionaries prohibiting gambling in some Indigenous communities (McMillian & Donnelly, 2008; Nunkuwarrin Yunti, 2005; Randall & McCabe, 1999). Other studies have suggested that money that is won from gambling is to be shared around the family rather than as an individual achievement (Hing, Breen, Gordon, & Russell, 2014b). This indicates that gambling can be and has been beneficial to Indigenous communities. However, since the introduction of more contemporary forms of gambling (such as TAB and EGMs) research has suggested that card games are no longer the primary form of gambling in Indigenous culture and consequently, Indigenous Australians are at risk for gambling problems (McMillen & Donnelly, 2008).

Indigenous Australians are reported to experience inflated rates of disease burden and mental health concerns, including higher psychological distress, hospitalisations due to self-harm and higher suicide rates (AIHW, 2015; Australian Health Ministers' Advisory Council, 2017; Simpson, Rochford, Livingstone, English, & Austin, 2014). Disease burden is reportedly higher in remote and very remote locations (AIHW, 2015) and a large percentage of Indigenous Australians live in rural and remote Australia, with only one per cent of the Indigenous population residing in major cities (Baxter, et al., 2011). Understanding why Indigenous Australians gamble will not only allow service models to be adapted to be culturally competent, but also may provide insight into why people living in rural and remote communities gamble.

Research has begun to explore the potentially unique factors that motivate different cultural groups to engage in gambling (Breen, Hing, Gordon, 2011; Breen, Hing, Gordon, & Buultjens, 2012; Hing, Breen, Gordon & Russel, 2014, 2014a, 2014b;

Oei & Raylu, 2010; Tse, et al., 2012). For example, in a sample of Indigenous Australians, gambling for pleasure was the most commonly endorsed motivation, followed by the potential to win money, for relaxation and to socialise with family and friends (Hing, et al., 2013). In a sample comprised of Indigenous males living in remote locations, motivating factors included gambling to relax, social influence and self-reported addiction to gambling (Hing, et al., 2013a) which are factors also observed for other non-rural populations. Similarly, in a sample of Indigenous Australian women, the primary motivating factor to engage in gambling was to socialise with family and friends (Hing, et al., 2013).

The primary motives for gambling amongst Indigenous Australians reflect the historical context of gambling and function to bring the community together. These factors are also cited in broader literature, such as the three-type model, which explains social factors as a primary motive to gamble (Clarke, 2004).

Barriers to Seeking Treatment for Gambling Addiction

Whilst it is important to understand the factors that influence the decision to gamble, it is equally as important to understand the factors that influence treatment seeking. Previous research has suggested that a number of factors influence treatment seeking in problem gamblers. These include interpersonal, personal and sociocultural factors that influence the decision to not seek treatment for gambling. For example, Rockloff and Schofield (2004) investigated attitudes towards seeking treatment for problem gambling via a factor analysis. Five key themes emerged of what inhibited or influenced the decision to seek treatment for problem gambling. These themes included limited availability of services, stigma, cost, uncertainty and avoidance (Rockloff &

Schofield, 2004). Other barriers to treatment seeking that have been reported include the desire or belief that they can handle the gambling problem without professional assistance (Hodgins & El-Guebaly, 2000) as well as comorbid mood disorders and mental health concerns (Gomes & Pascual-Leone, 2014).

In other studies, shame was the most commonly endorsed barrier to treatment engagement, with a smaller proportion of the sample indicating that they had difficulty acknowledging their problem, as well as perceived difficulties in accessing the treatment service (cost and convenience) (Suurvali, Hodgins, Toneatto, & Cunningham, 2012). Similarly, Gainsbury and colleagues (2013) reported that significant barriers to treatment seeking in a population of Australian gamblers included denial of the problem and concerns about the suitability of the treatment for different cultures. In South Australia, Evans and Delfabbro (2005) showed that treatment seeking is generally crisis-driven, and that shame, denial of the problem and social factors were significant factors that inhibited treatment seeking.

Stigma can be dichotomized into public stigma, perceived stigma and self-stigma (Hing, et al., 2015). Public stigma is the negative reaction of society towards a stigmatised population. Perceived stigma is the belief that an individual holds that others have passed negative judgements about their condition. Self-stigma is when an individual holds negative beliefs and judgements about themselves, which often results in decreased self-esteem and self-worth (Hing, et al., 2015). Self-stigma has been reported to be a product of public stigma applied internally, resulting in feelings of guilt, disappointment, shame and embarrassment (Hing, et al., 2015). It is therefore understandable that stigma can prevent problem gamblers from seeking treatment, as they view themselves as a

failure (Hing, Nuske, Gainsbury, Russell, & Breen, 2016; Horch & Hodgins, 2013). Similar observations were made by Dunn, Delfabbro and Harvey (2012) who found that high levels of guilt and shame and a lack of readiness for change can impede treatment seeking in problem gamblers. Additionally, they reported factors that can influence adherence to treatment including when individuals are gambling for pleasure or social interaction and when the motivation to gamble is to avoid or escape a negative mood (Dunn, Delfabbro & Harvey, 2012).

Specific Barriers to Treatment Seeking (Non-Gambling) in Rural Areas

Health disparities between rural and metropolitan areas are widely documented (AIHW, 2017; Sutherland & Chur-Hansen, 2014). Rural and remote communities experience distinct challenges in comparison to their metropolitan counterparts, including unpredictable climate impacts such as droughts, floods and bushfires, as well as increased levels of financial distress, poverty and unemployment (Simpson, et al., 2014; Sutherland & Chur-Hansen, 2014). Small, Curran and Booth (2010) reported that women from rural communities were less educated, earned less, were more likely to have experienced financial distress, and were more likely to find it difficult to afford basic necessities. It has been reported that the delay to seek treatment for anxiety and depressive disorders is greater in rural communities compared to metropolitan cities (Green, Hunt, & Stain, 2011). One study indicated that in a sample of Australians in rural and regional areas, higher psychological distress was associated with an avoidance of seeking help (Wilson, 2010). This raises the question of why people in rural communities delay seeking help for health concerns despite experiencing health challenges at a higher rate than metropolitan areas.

Previous studies have investigated the barriers for help seeking for mental health concerns in rural Australia (Dolja-Gore, Loxton, D'Este, Byles, 2014; Giallo, Dunning, & Gent, 2017; Green, et al., 2012; Rughani, Deane, & Wilson, 2011). Factors that have been reported to impede on accessing mental health services include public and self-stigma, self-reliance and lack of services (Brenes, Danhauer, Lyles, Hogan, & Miller, 2015; Collins, Winefield, Ward, & Turnbull, 2009; Stewart, Jameson, & Curtin, 2015). For example, in a study that examined the factors that prevented help seeking in a sample of rural Australian fathers, Giallo, et al. (2017) found that the barriers to treatment seeking for mental health concerns (such as anxiety, depression and stress), included self-reliance to improve their own symptoms, an increased likelihood of downplaying their symptoms, and a belief that treatment would not be successful.

Respondents from other studies based in rural and remote areas have also endorsed concerns about the lack of services available, transportation issues, confidentiality in a small town and concern regarding the competence of the health provider as barriers to seeking treatment (Rughani, et al., 2011; Wathen & Harris, 2007). Another study by Collins and colleagues (2009) underscored the importance of factors such as: people's awareness of mental illness and mental health services, the role of general practitioners and the need for change. Additional factors that are present in other studies include lack of psychological openness, doubt in the efficacy of the service in treating their concerns and a general mistrust in the capabilities of the health provider (Brenes, et al., 2015). In a similar vein, Collins and colleagues (2009) reported that lack of psychological mindedness in a general rural and remote population was related to a disinclination to seek help for mental health concerns.

Availability and Accessibility to Services. As cited in the literature, a common barrier to treatment seeking in rural and remote towns is the availability and accessibility of health and mental health care providers (AIHW, 2018; Simpson, et al., 2014; Sutherland & Chur-Hansen, 2014). Rural and remote communities have access to less mental health services in comparison to major cities (AIHW, 2018). More specifically, populations that live in rural and remote areas are disadvantaged if they need to access specialised mental health services for treatment of presentations such as eating disorders, personality disorders and addictive disorders (Simpson, et al., 2014). As remoteness increases, there is a decline in the full-time equivalent (FTE) rate of most health and mental health services per 100,000 people, including psychologists, psychiatrists and mental health nurses (AIHW, 2018). The FTE rate of psychologists in rural communities is less than one half of that in major cities; in remote and very remote communities, it is less than one third. Similarly, the rate of specialist medical practitioners FTE to the population in rural areas is half of that of major cities, and in remote and very remote areas it is less than one quarter.

In contrast to this, General Practitioners (GPs) have a higher number of FTE servicing remote and very remote areas, and similar rate of FTE GPs for outer regional, inner regional and major cities (AIHW, 2018). Interestingly, major cities have the lowest number of FTE GPs per 100,000 people servicing the area (AIHW, 2018). According to the AIHW 2016 to 2017 data, the rates for accessing a GP for primary health care reasons was similar across major cities, inner regional and outer regional, remote and very remote communities. The number of hospital emergency room presentations was higher in outer regional, remote and very remote communities in comparison to inner regional and major

cities (AIHW, 2018). A possible explanation for this could be due to the reduced number of specialised medical and mental health practitioners. Rural and remote GPs have a more prominent role in health care, as they service and manage more specialised and complex presentations (Collins, et al., 2009).

In response to the need for more specialised services in rural and remote communities; Fly-in-Fly-Out (FIFO) or Drive-In-Drive-Out (DIDO) services have been introduced as an alternative, but not a replacement, to residential face-to-face health care (Hanley, 2012; Sutherland, Chur-Hansen, Winefield, 2016). In addition to FIFO and DIDO psychological and specialised services, tele-psychology has become a model of psychological service delivery to reach rural and remote populations (McCord, Saenz, Armstrong, & Elliot, 2015; Simpson, et al., 2014). Tele-psychology has been described as not only an adequate service model but a potentially preferred model, as it increases access and reduces disparities in mental health services in rural and remote locations (McCord, et al., 2015). Research has supported the efficacy of tele-psychology with some studies suggesting that it is equivalent to face-to-face delivery (O'Reilly, et al., 2007; Simpson, et al., 2014). Tele-psychology is thought to be particularly suitable for presentations involving a high degree of shame, such as problem gambling, and can increase more open communication between the therapist and client (Berger, Wagner, & Baker, 2005; Godine & Barnett, 2013; McCord, et al., 2015). This indicates that tele-psychology is an alternative model of psychological or specialised service delivery to assist with rural health service disparities.

Addiction in Rural Areas

Insights into the challenges associated with treatment seeking for gambling addiction can be derived from studies in the broader substance use field. For example, research has shown that barriers for seeking treatment for methamphetamine dependence include issues with confidentiality, a lack of motivation and a lack of perceived need for treatment for their addiction (Wallace, Galloway, McKetin, Kelly, & Leary, 2009). Other factors included not being aware of the services as well as financial and transport barriers (Wallace, et al., 2009). A sample from rural New South Wales was less likely to seek treatment for methamphetamine dependence compared to those in metropolitan Sydney; of those who did seek treatment, motivations for seeking treatment included relationship, financial and mental health problems including paranoia and aggression (Wallace, et al., 2009).

Small and colleagues (2010) reported similar perceived barriers to treatment seeking in a sample of rural women seeking assistance for alcohol dependence. Interestingly, rural women consumed a higher number of alcoholic beverages per day than their metropolitan counterparts (Small, et al., 2010). Both internationally and in Australia, alcohol consumption is reported to be elevated in rural and remote communities (Brumby, et al., 2013). One proposed explanation for addictions in rural communities is that addictions are often “exacerbated” by the lack of services, social stigma and by limited social opportunities in these regions (Draus & Carlson, 2009; Small, et al., 2010). Further, there are reportedly a higher number of alcohol outlets per capita in rural areas (Matthews & Barratt, 2011; Small, et al., 2010). In addition to this, rural hotels are part of the community ethos, offering hospitality, entertainment and an

informal meeting place (Brumby, et al., 2013; NEACA, 2001). Rural communities also have a strong local sporting influence with sponsorship of sporting clubs being associated with hotels which is problematic for not only higher use of alcohol, but also gaming rooms in these venues, as well as local sports betting (Brumby, et al., 2013).

Conclusion

Understanding why people gamble is pertinent to understanding how treatment can be designed to address problem gambling. Gambling is believed to be more publically stigmatised than other social, physical and mental health presentations including alcohol abuse, obesity, schizophrenia, depression, and bankruptcy (Hing, et al., 2015). As a result of this, problem gamblers may fear that they will be discriminated against, or degraded if they were to access services. This potentially prevents problem gamblers from disclosing that they have a problem with gambling, and consequently can lead to reluctance in accessing help services (Hing, et al., 2015). Given the potential differences in the prevalence of gambling problems, and the documented challenges in accessing help in rural areas, it is particularly important to understand motivations for gambling in rural areas. Based on the current review, common barriers to treatment seeking in rural communities for non-gambling problems include stigma, the belief they do not need assistance for mental health concerns, as well as availability of services.

Comparably, stigma, accessibility to services, the belief that treatment is not necessary, and denial of the problem are also barriers to treatment seeking for problem gamblers in generalised settings. In addition to these factors, specific studies have suggested that mistrust of the capability of the health provider, and the efficacy of mental health treatments also can serve as a barrier to seeking treatment in rural and remote

communities. Whilst similarities can be drawn between substance use disorders and gambling addiction, future research remains necessary to discover what motivates the rural population to gamble, and what prevents them from seeking gambling treatment. By addressing this, the question can be answered of how gambling in rural and remote communities is distinct from metropolitan areas.

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RESEARCH REPORT

Gambling in Rural and Remote South Australia: Motivating factors, barriers and facilitators to help seeking.

Elly Grace Gannon

School of Psychology
University of Adelaide

Supervisors:

Professor Paul Delfabbro

Dr Carly Sutherland

University of Adelaide

Abstract

Although most people gamble safely, national prevalence rates indicate that approximately 0.2 to 1 per cent of the Australian population experience problems with gambling. An issue that has not been extensively researched in Australia is whether the nature of gambling and the associated harms is consistently observed across the nation. In particular, are there are differences between metropolitan and rural areas in people's experiences with gambling and the associated impacts? A qualitative study involving interviews with 10 help-seekers affected by problem gambling examined the nature of gambling in rural and remote areas and the potential barriers and challenges associated with help-seeking. Particular issues relevant to rural gamblers that set them apart from metropolitan gamblers were: limitations in leisure choices in rural areas; the problem of social familiarity in relation to anonymous help-seeking; and the dearth of specialised services. This study highlights the need to consider the role of rural-specific barriers, motivating and protective factors in developing service delivery models and specialised interventions for problem gambling in rural and remote communities.

Keywords: Problem Gambling, Rural Gambling, Rural Australia, Barriers to Help-Seeking

Gambling in Rural and Remote South Australia: Motivating factors, barriers and facilitators to help seeking.

Gambling is a topical and complex issue in Australian society. On the one hand, it is part of Australian culture and engages around 70 per cent of the adult population each year (Delfabbro, 2012). However, it has also been identified as a ‘significant public health issue’ due to the presence of problem gambling and gambling-related harm (Blaszczynski, Walker, Sagris, & Dickerson, 2007; Gainsbury, et al., 2014). Global estimates suggest that between 0.2 to 5.3 per cent of adults can be classified as having a gambling disorder (Hodgins, Stea, & Grant, 2011) and current problem gambling estimates in Australia have been reported to range between 0.2 to 1 per cent of the Australian population (Delfabbro & King, 2012; Oakes, Gardiner, McLaughlin, & Battersby, 2012). Problem gambling is characterised by the inability to control the time and money spent on gambling that results in detrimental effects on the gambler, their environment and those who surround them (Neal, Delfabbro, & O’Neil, 2005). Gambling disorders are known to be highly comorbid with other psychiatric disorders, including substance abuse disorders, mood disorders, anxiety disorders and suicidality (Hodgins, et al., 2011; Oakes, et al., 2012). This highlights the pervasive impact that gambling can have on the individual and their broader social environment.

An issue that has not been extensively researched in Australia is whether the nature of gambling and the associated harms and co-morbidities is consistently observed across the nation. In particular, are there differences between metropolitan and rural areas in people’s experiences with gambling and the associated impacts? Such considerations are important due to implications for public policy as well as the provision of treatment

services and other supports. Current national statistics indicate, for example, that many conditions known to covary with gambling disorders (e.g., substance use disorders, mood disorders, anxiety and suicidality) appear to be more prevalent in rural and remote regions in comparison to metropolitan areas (Australian Institute of Health and Welfare [AIHW], 2017). Similarly, problem gambling is known to be higher in some rural and remote regions throughout Australia (AIHW, 2017; Department of Communities and Social Inclusion [DCSI], 2012), although there are also figures from some States (e.g., Queensland, Northern Territory and Tasmania), which show that problem gambling rates are comparable between rural and metropolitan areas (South Australian Centre for Economic Studies, 2008; Tolchard, 2015; Young, Stevens & Morris, 2008). In New South Wales, a higher risk of problem gambling was associated with only one rural area, whereas South Australian research indicated that there are significantly higher rates of gambling in at least three rural areas compared to the national population (DCSI, 2012). Of these regions, two were associated with higher engagement in Electronic Gaming Machines (EGMs), which have been recognised as one of the most harmful forms of gambling, associated with the highest rates of problem gambling (Gainsbury, et al., 2014; Nower & Blaszczynski, 2010; DCSI, 2012; Thomas, Allen, & Phillips, 2009).

There is a wealth of literature that has explored why people from the general population (that is, largely samples from metropolitan areas) gamble; however, there is a paucity of research examining whether there are distinctive motivations for people who gamble in rural and remote communities. Literature that pertains to the general gambling population has reported that common motivating factors can be classified into two distinct pathways; that is, gambling as a form of positive or negative reinforcement

(Rickwood, Blaszczynski, Delfabbro, Dowling, & Heading, 2010). Gambling for excitement, arousal and for the chance of winning money are conceptualised as positive reinforcement where as gambling to escape negative emotions, or to reduce stress are often conceptualised as negative reinforcement (Nower & Blaszcynski, 2010; Rickwood, et al., 2010). Other factors that have been reported to influence the decision to gamble include gambling for intellectual stimulation, as well as for social engagement (Clarke & Clarkson, 2007; Francis, Dowling, Jackson, Christensen, & Wardle, 2014; Thomas, et al., 2009). Research has suggested that when gambling is socially motivated or motivated by the desire to avoid or escape negative emotions, then adherence to treatment for gambling is at risk (Dunn, Delfabbro, & Harvey, 2012). This highlights that understanding why people gamble is pertinent to providing effective services to address problems with gambling.

For gambling treatment services to be effective, any barriers to treatment seeking must be wholly understood. Research has proposed a combination of interpersonal, personal and sociocultural factors that impede seeking treatment for gambling. Stigma, shame, and embarrassment have all been reported as barriers to accessing treatment services (Dunn, et al., 2012; Hing, et al., 2015; Horch & Hodgins, 2013). These factors are associated with negative beliefs that society, others, or the gamblers holds of themselves, such as the belief that gambling means they are a failure (Hing, et al., 2015). Other factors that are known to prevent gamblers from accessing services include the lack of specialised services available, the cost of treatment, and the uncertainty of the efficacy of treatment (Rockloff & Schofield, 2004). Denial of the problem, concerns about the cultural suitability of treatment services and the belief that the problem can be resolved

without professional assistance can also impact treatment seeking (Evans & Delfabbro, 2005; Gainsbury, Hing, & Suhonen, 2014; Suurvali, Hodgins, Toneatto, & Cunningham, 2012). Further, Evans and Delfabbro (2005) reported that treatment seeking is generally crisis-driven, which could suggest that there is a small window of opportunity in which the problem gambler is willing to access help services. Therefore, screening for problem gambling needs to be brief and non-judgemental.

Limited research exists regarding help-seeking behaviours (including barriers) for problem gambling in rural and remote areas. Help seeking behaviours have, however, been explored in rural and remote communities to gain insight into the challenges community members face when accessing help services for other mental health concerns. Financial and geographical factors, lack of trust in mental health services, denial, and stigma are known to impede treatment seeking in rural and remote areas (Brenes, Danhauer, Lyles, Hogan, & Miller, 2015; Collins, Winefield, Ward, & Turnbull, 2009; Giallo, Dunning, & Gent, 2017; Stewart, Jameson, & Curtin, 2015; Wallace, Galloway, McKetin, Kelly, & Leary, 2009). Such factors can be further compounded by the fact that rural and remote communities have fewer specialised services. Such circumstances could potentially contribute to a lack of community awareness about the availability or effectiveness of services, the competence of the clinician, and concerns regarding confidentiality within the service (Brenes, et al., 2015; Collins, et al., 2009; Rughani, Deane, & Wilson, 2011; Stewart, et al., 2015; Wathen & Harris, 2007).

A challenge in providing services for both general mental health concerns and problem gambling in rural and remote communities is the relatively limited availability of mental health specialist services including mental health nurses, psychologists and

psychiatrists, compared to metropolitan areas (AIHW, 2018). Given that the number of specialist mental health services decreases as rurality increases, this may also indicate that there are inadequate services in rural and remote communities for problem gambling (AIHW, 2018). Alternative models have been proposed to address the shortage of resident mental health professionals in rural and remote areas, including Fly-In-Fly-Out (FIFO) and Drive-In-Drive-Out (DIDO) (Sutherland, Chur-Hansen & Winefield, 2016) and tele-psychology (McCord, Saenz, Armstrong, & Elliot, 2015; Shepherd, et al., 2006; Simpson, Rochford, Livingstone, English, & Austin, 2014).

These models have potential advantages for community members and service providers, including increasing equity and accessibility of services to rural and remote areas, as well as mitigating confidentiality concerns (Hussain, Maple, Hunter, Mapedzahama, & Reddy, 2015). However, there are associated disadvantages with these modalities, including increasing the risk of burnout amongst clinicians due to travel commitments and potential ethical and legal implications including limited ability to assist if a client is in crisis (Drum & Littleton, 2014; Hussain, et al., 2015; Sutherland & Chur-Hansen, 2016). Given the lack of specialist services, a significant proportion of mental health services in rural and remote areas are provided by General Practitioners (GPs) (AIHW, 2018). Rural and remote community members may therefore have different experiences of seeking help for problem gambling, associated with provision of services under different service delivery models.

The Present Study

The aim of the present study was to explore the experiences of people with gambling problems living in rural and remote locations. The study investigates the place

of gambling in the lives of people in these communities (e.g., their motivations to gamble), potential barriers to help seeking for problem gambling, and their perception of services. Given that this topic has not been extensively studied, an exploratory qualitative approach was adopted, with a focus on the following specific research questions:

1. Are problem gamblers in rural communities motivated by similar or different factors to those previously identified for the general population?
2. Do problem gamblers in rural areas experience the same barriers to treatment seeking as the general gambling population? For example, shame, stigma and denial of the problem.
3. Do problem gamblers in rural areas experience the same known barriers to treatment seeking for general mental health concerns in rural areas? For example, are there concerns about confidentiality, lack of services or knowledge of services?

Method

This project was approved by the School of Psychology Ethics Subcommittee (19/06). Ten semi-structured interviews were conducted with ten participants; all interviews were conducted individually.

Participants

Participants were rural community members either with a previous history of problems with gambling, or at the time of the interview were accessing help services for gambling concerns. Residence was classified by the Modified Monash Model (MMM) Remoteness Structure. The MMM is the most up to date classification system (based on the 2016 Census data) and is the recommended rural classification system (Australian

Government Department for Health, 2019). The MMM classification has seven categories as opposed to five (in the previous Australian Standard Geographical Classification [ASCG] structure) and locations that are classified from four to seven range from Inner Regional to Very Remote under the previous ASGC system (AIHW, 2004). Eligibility criteria for the current study also included that participants must have been over the age of 18, and needed a score of 8 or more on the Problem Gambling Severity Index at the time of their gambling problem.

A purposive sampling approach was employed, and participants were recruited through the Whyalla Interagency Network meeting. This meeting is an opportunity for representatives from community and government agencies to exchange information regarding community concerns and service provision, including for problem gambling. Ten participants were referred through different branches of the same financial counselling service, and one was recruited from a psychologist working in the SA Intensive Gambling Help Service. Ten of the participants completed the interview process and one did not attend the interview and did not respond to follow-up contact. Seven of the interviews were conducted face to face in the participant’s town of residence and three interviews were conducted via telephone due to participants’ limited availability. Interviews took place between April and July 2019.

Participants were given verbal and written information about the nature and purpose of the study, as well as the possible risks and benefits of participating. Participants were given time to consider the information and to ask questions prior to their participation in the study. The participants also had the opportunity to discuss their participation with their financial counsellor or psychologist before consenting.

Participants were advised that their participation was voluntary, and that they could withdraw from the study at any time. A consent form was provided and participants were given the option of returning this in person or via mail, email, or providing verbal consent at the time of interview. It was not anticipated that the interview would cause any adverse reactions or trauma; however, if a participant was to become distressed throughout the duration of the interview, the interview would cease and they would be provided with the appropriate supports. No participants reported distress or a desire to cease the interview throughout the study.

Participants (n = 10) ranged in age from 31 to 68 (M = 58). Six participants were men and four were women; each participant lived in a South Australian country town with MMM classification of four or more. Participants were located in the following regions of South Australia: Yorke Peninsula, Eyre Peninsula and the Mid-North. Of the participants, seven were previous gamblers classified as in remission, and the remaining three were in treatment for gambling however had not completely ceased all forms of gambling. Electronic Gaming Machines were the primary form of gambling for all participants, with others noting that occasional gambling had occurred via TAB, Lotto and community poker nights. One participant gambled using online wagering accounts. Three of the participants started their gambling in a major city (Adelaide) and continued gambling in their rural location; six commenced gambling in a town classified on the MMM of five to six.

Procedure

All interviews were recorded using a digital voice recorder and transcribed verbatim by the interviewer. The first author conducted all interviews, which ranged from

31 to 78 minutes in length (*M* = 50). The interview was semi-structured and included questions about participants' experiences of gambling in a rural town. Questions included basic demographics about their town of residence, questions regarding their motivations to gamble, and what services were available in their town. Participants were also asked about their experiences of accessing help services, what services would be best suited to their town and how gambling in a rural town may differ from those gambling in a metropolitan area. A copy of the interview schedule is included as an appendix.

Transcripts were sent to participants via email and registered mail, allowing for a process of participant validation; participants made no objections to the transcripts. Interviews were conducted until data saturation was reached, and no new themes emerged. Data saturation was determined by the method of constant comparison; that is, where possible, each interview was subject to preliminary analysis before the next was conducted (Baker & Edwards, 2012).

Data Analysis

Data were analysed using thematic analysis as outlined by Braun and Clarke (2006, 2013); the first author conducted analysis. The first phase of analysis involved the transcriptions of the interviews being completed by the first author, and initial ideas and primary themes being noted simultaneously. The second phase entailed identifying initial semantic codes by working through the interviews systematically. Following this, the semantic codes were collated into themes and sub-themes and were then compared against coded extracts across the entire data set.

In order to enhance rigor in the qualitative process, an audit trail in the form of a journal was documented throughout the entirety of data collection and analysis to

increase the transparency of the analysis (Tracey, 2010). To further increase the rigor and trustworthiness of the analysis, one of the supervisors coded an interview transcript. Similarities were evident between the two analyses; discussion and a review of the initial codes was completed in order to reach consensus of final themes.

Results

Many of the themes that emerged in the current study are largely consistent with previously reported motivating factors to gamble and barriers to treatment seeking for gambling. The current study found that the majority of participants identified they gambled to win money, to escape (negative emotions) and for excitement. Other motivating factors included chasing losses and gambling for social reasons. These factors are known to be common motivating factors amongst gamblers in the general population, which suggests that there are similarities between rural and remote gamblers and metropolitan gamblers. The data from the current study identified two main themes that were specific to gambling in rural communities: ‘What else is there to do?’ and ‘Rural Culture’.

Similarly, the current study identified barriers to treatment seeking that are comparable to existing literature, including denial of the problem; shame and stigma; the belief they could cure their gambling addiction on their own and being unwilling to stop gambling. Two themes emerged from the current study that were specific to rural and remote areas: ‘Everybody Knows Everybody’ and ‘Limited Help Services.’

Facilitators to treatment seeking from the current study that are consistent with existing literature included hitting rock bottom, interpersonal reasons (such as support from family and relationships), acceptance and helplessness. Two protective factors that

emerged from the current study that were relevant to rural and remote areas were: ‘Everybody Knows Everybody’ and ‘Limited Help Services.’ The current study will focus on factors that are unique to the participants living in rural and remote communities. Themes and subthemes are summarised in Table 1.

Table 1. Themes and Subthemes

Motivating Factors to Gamble	**Barriers to Treatment Seeking**	**Protective Factors**
What else is there to do?	Limited Help Services	Limited Help Services
Limited Leisure Opportunities	*Unaware of Services*	
Gambling is Convenient	*Not GPs' Area of Expertise*	
Rural Culture	Everybody Knows Everybody	Everybody Knows Everybody
FIFO/DIDO Lifestyle	*Small Town Gossip*	
Pubs & Sport	*Knowing the Service Provider*	
	Concerns about Confidentiality	

Motivating Factors to Gamble

The theme ‘What else is there to do?’ encompassed the idea that there are ‘Limited Leisure Opportunities’ in rural and remote towns, and that ‘Gambling is Convenient.’ The Theme ‘Rural Culture’ captured the subtheme of ‘FIFO/DIDO Lifestyle’ as well as ‘Pubs and Sports.’

What Else Is There To Do?

Limited Leisure Opportunities

Inadequate alternative leisure opportunities in rural and remote towns was a commonly endorsed theme; in comparing rural townships to metropolitan lifestyle, some participants had the experience of living in both urban and rural areas.

> …I think in the city you've got a lot more to do, here you haven't got a great deal if you don't play sport. So what are you going to do? (Participant 3).

The idea that leisure opportunities exist, but are restricted was also cited as a contributing factor to be motivated to gamble.

> …That's the other thing you know, when we've been out and feel like going for a coffee [there is] not many coffee shops open so if you go, you go to the pokies to have a coffee. (Participant 6).

Gambling is Convenient

The convenience and ease of access to gambling venues in rural townships was a strong motivating factor for many of the participants. The idea that gambling venues are common and easily accessible was apparent.

> …I come back here and everywhere, everywhere is a gambling venue; every corner, every venue you see and every pub has pokies. (Participant 4).

Further, Electronic Gaming Machines were discussed in the context of being inescapable.

> …Every pub you go to has a poker machine room…you're exposed to it everywhere you know…the thing is with gambling is you can be exposed to it seven days a week. (Participant 8).

For some participants, the geographical layout of the rural townships enabled gambling.

> …It's close by, yeah everything is close by…I walk, and that would be why it would be easier for me in the country, ah in the city it was quite a way for me to get to a pub so that would be one reason why it was easier. (Participant 3).

Rural Culture

FIFO/DIDO Lifestyle

Fly-in-fly-out work and drive-in-drive-out work is common in rural and remote communities. A theme that emerged in the current study was the opportunity that FIFO/DIDO workers had to gamble. More time off work was a contributing factor to one participant.

> …Because I worked away I had two weeks home each month where I didn't have a lot to do so yeah it started out more of the ah horses, punting on the horses. (Participant 8).

Unstructured time at home was highlighted as a motivating and enabling factor for gambling. Escaping the hardships of FIFO/DIDO work was also cited as a motivating factor to gamble.

> …I was working really long hours and I was working in the [boating industry] and it was stressful, the job I was in, and people were hard to work with and I thought gambling might be the escape from it. (Participant 4).

Pubs and Sports

Local hotels (pubs) and sports clubs were cited as common meeting places in rural communities. In the context of limited leisure opportunities, it was evident that pubs and sporting clubs provide a social outlet, as well as an opportunity to discuss gambling related content and engage in gambling related activities.

> …For me it was probably, yeah more the exposure would have been through the sporting groups…but yeah I can see, I know a lot of people do go to the pub after work every day for a beer…[it is] common to talk about horses or different races or different sporting events like AFL and soccer. (Participant 10).

Several participants discussed the role of local hotels as providing both social and gambling opportunities. Hotels were discussed as being an appealing environment to gamble in, as well as in close proximity to participants.

> …The local hotel put on free nice coffee for people playing the pokies, so I thought *'oh well three or four dollars for a coffee or three or four dollars in the pokies, what's it matter?'* Of course, it mattered a lot in the end didn't it? (Participant 5).

Barriers to Treatment Seeking

The two themes that were identified as barriers to treatment seeking in rural communities included 'Everybody Knows Everybody' and 'Limited Help Services.' The theme 'Everybody Knows Everybody' encompassed the ideas that small town gossip, concerns about confidentiality and the potential of knowing the service provider contributes to disinclination to accessing treatment services in rural communities. The theme 'Limited Help Services' refers to the limited nature of help services, and included the subthemes of being unaware of the services available, as well as the idea that gambling is not typically an issue for GPs to address.

Everybody Knows Everybody

Small Town Gossip

The participants indicated that there is less anonymity in rural towns and as a result, they feel more vulnerable to having others pass judgements about them when

seeking treatment for problem gambling. One participant explained that simply by entering into the treatment facility they were concerned about who might see them and what they might perceive they are seeking help for. Others wondered whether entering a non-specialised treatment service would make then vulnerable to community hearsay or whether it could expose their gambling addiction.

> …I think a lot of people are like that in small country towns; it's the privacy. I know the privacy is [supposed] to be there, but they know that everybody knows everybody, so you know, if somebody sees somebody going into a place [to seek help] they might think *"oh I wonder what's going on in their [life]"*…it would be more so about how people would think of me. (Participant 6).

Other participants highlighted that accessing help from the wrong person can expose the reasons for seeking help:

> **…**If you tell one person, the wrong person, then the whole town knows you got a huge problem and it's not what you want people to know…if you got 800 people in town and you go to talk with the person to…get some advice and they tell everybody else, then everybody in town knows what your problem is. (Participant 4).

Knowing the Service Provider

Knowing the service provider was a concern that many participants shared; highlighting that not only are services limited in rural communities but service providers are also limited.

> …Nine out of 10 [times] you might know people in there and I know they're sort of governed not to say anything but it's still sort of people that you know, and that might stop people from going there and speaking to them. (Participant 10).

Participants alluded to the idea that despite not knowing the service provider personally, they may still be apprehensive of seeking help from them, due to concerns about who the service provider was affiliated with.

> …You got to be careful with what you say [because] you know who's related to who and who's tied up with who…you got to be careful of what you say and do. (Participant 4).

Concerns about Confidentiality

Knowing the service provider was not the only concern in relation to help services; the idea that despite being a confidential service, information may not remain confidential was a common subtheme.

> …A lot of people think, *'oh I'll come and help you'* but you actually hear that it's been spread right around and I just feel as though what's the sense in in talking about…that's why I found it very difficult to come and visit [financial counsellor]…if they knew that there was a social worker or counsellor that they could trust…that they wont break their confidence, they'll come into the service knowing it wont go any further. (Participant 9).

Interestingly, travelling to major cities was favourable for some participants, as they shared the concerns regarding confidentiality and the potential of knowing service providers in small rural communities.

> …If I went anywhere I'd go to town and see doctors in Adelaide…I would be reluctant to go here if they lived here [you] know. (Participant 4).

It was common to suggest that if confidentiality could be guaranteed, then they would be more inclined to seek help.

> …If they (gamblers) knew of somewhere they could go where they could talk impartially to somebody without being judgemental…it would be probably a help…there's nobody in town who you talk to [because] you don't know who you could trust virtually. (Participant 4).

Limited Help Services

Unaware of Services

The limited number of help services for problem gambling was discussed as a barrier to treatment seeking for many of the participants; other participants acknowledged that the services may be available, but they were unaware of what assistance they could offer, and how they could access them.

> …I originally thought it might have been for drug or drug related and alcohol stuff and sort of family issues…probably didn't think about it too much that they would do the gambling sort of stuff. (Participant 10).

In contrast, some participants were aware of the services that are available for problem gambling, however acknowledged that the staff who could provide treatment were limited.

> …There's not enough people here, not enough support groups here that should be in place [because] either they can't support [them] here or they just burnout in the end from all of the problems that country people do have. (Participant 9).

Not GPs' Area of Expertise

Specialised gambling treatment services are limited in rural areas; approaching GPs for assistance with problem gambling was explored in the interviews. It was

unanimous that participants did not consider approaching their GP for treatment for problem gambling.

…No, not really. I just didn't really even think about going to the GP to be honest. (Participant 10).

Several participants shared the same views that GPs are only for assistance with medical conditions and that discussing problem gambling was not part of their role.

…I don't think many people would see it as the GPs area of expertise. (Participant 5).

Protective Factors

Whilst 'Everybody Knows Everybody' was a barrier to treatment seeking, it was also cited as a facilitator to cease gambling. The theme encompassed the idea that community hearsay contributes to a disinclination to continue gambling in rural and remote towns. The theme 'Limited Help Services' was also cited as a barrier to treatment seeking; however, it was referred to as a facilitator to help seeking, as it meant that services could be located efficiently.

Everybody Knows Everybody

Several participants indicated that in small rural and remote towns, it is difficult to avoid hearsay; some perceived community hearsay as pertinent to them stopping gambling.

> …I did play when I first came here and lost a bit of money and quite a bit of money, and then everyone talks about you losing quite a bit of money…so you don't feel very comfortable. So I stopped playing…up here in the country, because everyone knows everything you do. It's very um, how can I put it. You're targeted all of the time. You've [sort of] [got to] watch everything you do. So if you go to play the pokies, they know how much you put in and they talk, they know how much you put through and how much you lost and what you won. So it's very… It's very intense. (Participant 4).

Others attributed the nature of rural communities and gambling venues as being central to becoming known for gambling problems.

> …Everyone knows everyone, so if someone sees you in there all the time betting…word would get back to your family or whoever if you were hiding it from someone. (Participant 10).

The idea of anonymity in metropolitan areas compared to rural areas was reiterated throughout other interviews.

> …The city is a bit more impersonal…it gets reasonably personal in a country town if you're frequenting the same places and spending the money frequently. (Participant 5).

While concerns about confidentiality and small town gossip were, at times, considered a barrier to help seeking, here they were also considered a protective factor in encouraging participants to stop gambling.

Limited Help Services

Limited service provision in rural communities was cited as a barrier to treatment seeking, as for some, lack of services translated to not having adequate help for gambling problems. However, for others, limited services enabled them to find the suitable treatment for their gambling problems with ease.

> …I [suppose] in a smaller town like this, it's a lot [easier] and I had the time…to seek that help, where maybe in Adelaide I might've been an hour drive to find someone…but yeah that time was sort of a hindrance to start with helped now. (Participant 10).

Discussion

The aim of this research was to examine the nature of gambling in rural and remote areas and the potential barriers and challenges associated with help-seeking for people affected by problem gambling. Based on the thematic analysis of 10 qualitative

interviews, both similarities and differences were found in relation to what has previously been reported for the general gambling population. For example, rural South Australians participating in this study generally had similar motivations to gamble as other people in non-rural areas, but were also influenced by limitations in other leisure choices and aspects of rural culture. Individuals who engaged in problem gambling in rural communities may encounter similar barriers to help seeking. However, they experience additional issues associated with the greater social familiarity and dearth of specialised services in rural and remote locations.

The current study indicated that gamblers in rural areas shared many of the psychological motivations to gamble as other people. They saw gambling as a way to win money (Binde, 2013; Clarke & Clarkson, 2007; Nower & Blaszcynski, 2010), as well as a way to escape negative emotions such as stress, depression, anxiety and trauma (Flack & Morris, 2015; Nower & Blaszcynski, 2010; Rickwood, et al., 2010; Rockloff & Dyer, 2006). Other motivations to gamble cited in the current study included gambling for social opportunity (Thomas, et al., 2009), for excitement and enjoyment (Rockloff & Dyer, 2006; Thomas, Allen, Phillips, & Karantzas, 2011), and due to being psychologically trapped by the EGMs (Oakes, Pols, Lawn, & Battersby, 2018). However, consistent with the emergent themes - 'What else is there to do?' and 'Rural Culture'- the current study also indicated clear differences in rural communities. For example, participants indicated rural communities offer problem gamblers less alternative distractions and a higher volume of EGMs with local hotels providing convenient gambling opportunities in a small geographic area. This is consistent with reports that

suggest that rural and remote communities in South Australia have a “disproportionately large” quantity of EGMs (Riley, Smith, & Oakes, 2011).

Further, participants described the culture in their communities as revolving around gambling, with local hotels and sporting clubs providing both social outlets and exposure to gambling related content/opportunities to gamble. This was largely consistent with reports that local hotels and clubs are the “primary source of entertainment” in rural communities (Brumby, Kennedy, & Chandrasekara, 2013). Local pubs are considered part of the “cultural heritage” of rural communities and offer social interaction amongst townships that have limited leisure alternatives (Brumby, et al., 2013). Many of the participants in the current study indicated that they work under FIFO/DIDO arrangements, suggesting that this allows for less structured time with less supervision. This is not surprising, as reports have suggested that FIFO/DIDO workers can become vulnerable to spending their salary on gambling activities when they return home off-shift (Misan & Rudnik, 2015).

Consistent with previous research based on the general gambling population, the current study found that people who gamble in rural communities may not seek treatment for gambling due to shame and stigma; the availability of services; the belief that it can be resolved without treatment and denial of the problem (Evans & Delfabbro, 2005; Gainsbury, et al., 2014; Hing, et al., 2015; Hodgins & El-Guebaly, 2000; Rockloff & Schofield, 2004; Suurvali, et al., 2012). The rural-specific barriers to treatment seeking in the current study depicted rural communities as having insufficient information regarding local services as well as limited number of services available. This is consistent with reports that people who require specialised services in rural communities are unable to

access the treatment they need (Simpson, et al., 2014). This is unsurprising, as previously stated, mental health specialists, including psychologists, are limited in rural and remote communities (AIHW, 2018).

The current study also highlighted that gamblers living in rural communities face additional challenges when seeking help due to the fear of knowing the service provider, of being the subject of hearsay, as well as concerns about confidentiality. These themes are not strongly depicted in the general gambling literature. However, rural mental health literature has identified these barriers to treatment seeking for rural Australians seeking assistance for mental health concerns (Brenes, et al., 2015; Collins, et al. 2009; Rughani, et al., 2011; Stewart, et al., 2015; Wathen & Harris, 2007). This suggests that problem gamblers in rural communities potentially encounter a dual challenge when accessing help services for gambling.

Protective factors were also explored in the current study. The two themes that emerged indicated that what served as a barrier to accessing treatment for some participants could also act as a facilitator. While the fear of being the subject of community hearsay may deter some from seeking help, it was also a deterrent to continue gambling for others. For example, participants expressed concern that local community members may notice the amount of time or money that they spent gambling, and pass judgement on them. The theme 'Limited Help Services' highlighted that whilst a reduced number of treatment facilities can make help seeking difficult; it can also make the process more direct because there are fewer services to consider.

Implications for Help Services

Problem gamblers are underrepresented in treatment facilities and have a high attrition rate (Slutske, Blaszczynski, & Martin, 2009; Smith, et al., 2010). This highlights the importance of gambling treatment options being available and accessible to this population. Statistics have indicated that people living in rural and remote communities are more likely to access mental health care through their GP or by presenting in the Emergency Department (AIHW, 2018). Therefore, it could be assumed that problem gamblers may be more likely to access assistance for problem gambling through their GP; however, the respondents in the present study did not support this.

Previous studies have emphasised the importance of the GP in rural communities as a service provider, with Collins, et al. (2009) reporting that GPs often play a critical role in health provision in rural areas; perhaps due their trusted role and availability per head of population (AIHW, 2018). In the current study, the participants indicated that whilst the GP may be available to address medical needs, they would not see problem gambling as part of their expertise. This difference in perception may be due to the misunderstanding as to what services the GPs can provide; namely, to make referrals to more specialised services or that they might play a preliminary role in screening for problem gambling. Other studies have highlighted the potential value of screening for problem gambling in primary care and mental health care settings because it is known that problem gamblers are underrepresented in treatment services (Dowling, et al., 2018; Lubman, et al., 2017; Rodda, Manning, Dowling, Lee, & Lubman, 2018). Given that GPs are more accessible in rural areas, they are well suited to offer a referral or initial

intervention for problem gamblers (Dowling, et al., 2018). This suggests that rural GPs should be better supported to address screening questions for problem gambling.

In a study conducted in New Zealand, a sample of GPs were surveyed regarding their involvement in treatment for problem gambling. The majority of participants indicated that it was within their role as a GP to facilitate intervention for problem gambling (Sullivan, Arroll, Coster, Abbott, & Adams, 2000). However, GPs experience challenges when screening for problem gambling in primary care settings, due to limited time, resources and funding available (McCambridge & Cunningham, 2007). Lack of confidence, training and knowledge regarding problem gambling also interfere with screening for problem gambling (Sullivan, et al., 2000; Sullivan, McCormick, Lamont, & Penfold, 2007; Tolchard, Thomas, & Battersby, 2007). As discussed, problem gambling is known to be highly comorbid with other mental health presentations; screening for problem gambling in primary care settings may reduce the burden of these disorders and improve client outcomes (Lubman, et al., 2017). Therefore, brief and effective screening tools must be employed to minimise the burden on GPs and other health professionals and maximise the benefits for rural gamblers.

Brief screening tools, such as the five-item Brief Problem Gambling Screen (BPGS) have been shown to display high sensitivity and specificity in detecting any level of problem gambling (Dowling, et al., 2018). The NODS-CLiP (a three-item screening tool that takes approximately one minute to administer) and a three-item version of the BPGS were also identified as efficient screening tools in identifying moderate to high risk problem gambling (Dowling, et al., 2018; Toce-Gerstein, Gerstein, & Volberg, 2009). Such screening tools may allay some concerns about the time required in GP

consultations, but there may be a need for greater GP training or information to administer these screening tools. It may also be beneficial for GPs in rural communities to be directly connected with specialised service providers, such as psychologists, to support their role in identifying problem gambling. Further, promotion throughout rural communities specifying that GPs can provide assistance for gambling may reduce the reluctance for community members to raise the issue of problem gambling with their GP.

If GPs are not the first service sought by people in regional areas for problems associated with gambling, then other service provision models may prove to be useful. Such models include tele-psychology, which has been introduced as a solution to increase service provision to rural and remote areas, reduce the financial and geographical difficulties that clients encounter, as well as mitigate the confidentiality concerns (Hussain, et al., 2015). Mental health services that utilise either the FIFO/DIDO or tele-psychology format allow for specialised services to be delivered to rural areas and potentially provide a solution to concerns about confidentiality, knowing the service provider, or small town gossip within the community that were endorsed in the current study. Future research is needed to address the efficacy of FIFO/DIDO and tele-psychology service models in delivering specialised treatments for problem gambling in rural areas, such as Cognitive Behavioural Therapy.

Given the findings from the current study regarding barriers to treatment seeking, gambling services in rural areas should take particular care to ensure clients are aware of requirements around confidentiality, to ensure rural community members seeking treatment for problem gambling understand that their information will not leave the service and become community hearsay. Further, rural pubs and sporting clubs were

identified as the primary social outlets in rural communities in both the current study and previous studies; these social outlets could be better supported to encourage non-gambling activities for community members. Treatments should also consider broader psychosocial factors in rural communities, such as paying particular attention to supporting clients to engage in alternative leisure activities and raise awareness of opportunities available in the region. Therefore, it is suggested that rural pubs, sporting clubs and other known social outlets could incorporate education throughout these facilities on problem gambling as well as provide information regarding local support services. More broadly, further research exploring health promotion strategies regarding problem gambling in rural areas should be conducted with attention to the rural-specific factors from the current study.

Limitations

Due to the qualitative nature of the current study, the data is not representative of all problem gamblers from rural communities. As gambling prevalence statistics suggest, problem gambling rates vary between states in Australia (South Australian Centre for Economic Studies, 2008; Sproston, Hing, & Palankay, 2012; Tolchard, 2015; Young, et al., 2008). Some states have equivalent rates of problem gambling between rural and metropolitan regions; others were higher in rural areas. South Australia in particular was one of the Australian states in which several rural and remote communities had inflated rates of gambling compared to the national population (DCSI, 2012). South Australia, in comparison to eastern states, is a small but widely dispersed state; this may suggest that rural and remote communities in South Australia experience unique challenges (Rural Doctors Workforce Agency, 2011). For example, a more widely dispersed population

may generate additional motivating factors to gamble (due to less social opportunity, or limited leisure options), but may also further complicate attempts to access services (limited service providers available and concerns about confidentiality).

More extensive research is warranted to explore motivations to gamble and barriers to seeking help for rural and remote Australians outside of South Australia who gamble. Further, the older adult age demographic (55 years and over) was overrepresented in this study and the primary form of gambling was EGMs. This may limit the findings of the current study, as they may not capture and reflect the experiences of younger adults who gamble, or gamblers who engage in land based or online wagering. Accordingly, the question remains whether problem gamblers who live in rural and remote Australia face more factors that can influence them to gamble and experience more barriers to seeking and engaging in help services than urban Australians. Future research is needed in this area with a more inclusive sample from states and territories outside of South Australia. Nevertheless, the current study has provided an insight into the complexities of gambling in rural communities.

Conclusion

While rural gamblers are motivated by similar factors to gamble as the general population, there are also unique factors that influence their decision to gamble. This has implications for rural communities, as it indicates that there are limited alternative leisure opportunities that can engage community members. Further, the leisure opportunities that are available, such as local hotels and sporting clubs, can be seen to facilitate gambling related discussions and engagement. Therefore, rural hotels and sporting clubs could better support community members who have problems with gambling. Given that the

current study is not representative of the wider rural Australian population, it is recognised that not all rural communities may have limited leisure opportunities. Despite this, local educational events promoting gambling help services may be beneficial across the wider rural population.

Barriers to seeking treatment for gambling were largely consistent with established literature; however, the current study suggests that rural gamblers encountered additional challenges when accessing help services. Whilst the themes from the current study may reflect novel barriers to treatment seeking in the field of gambling, they are somewhat reflective of the literature pertaining to barriers to treatment seeking for general mental health concerns in rural communities. This highlights the challenges that rural gamblers face when seeking help, and has implications for how services can design an effective service model to address problem gambling in rural areas.

Given the barriers to treatment seeking for rural and remote residents identified in this study, help services for gambling in rural communities need to be easily accessible, confidential and non-discriminatory. Specialised psychological services are limited in rural areas, therefore indicating that rural GPs may play a significant role in connecting rural gamblers with gambling help services. As discussed, tele-psychology and FIFO/DIDO service provision may be a solution to the concerns about confidentiality, the potential of knowing the service provider, as well as the limited services in rural areas. This study recognises the need to consider the role of rural-specific barriers, motivating and protective factors in developing service delivery models and specialised interventions for problem gambling in rural and remote communities.

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Appendices

Appendix A: Participant Information Sheet

Participant Information Sheet

You are invited to join a study being led by Professor Paul Delfabbro, Dr Carly Stagg and student researcher Ms Elly Gannon from the University of Adelaide, School of Psychology.

Study Title: Gambling and Problem Gambling in Rural and Regional Areas: Implications for services and help seeking.

What is the study about?
This project aims to investigate whether there are unique factors in rural and regional communities that influence gambling behaviour, as well as prevent seeking assistance for problem gambling. Exploring these factors will allow service providers to have a greater understand of rural gambling, and assist in designing effective treatment approaches in rural and remote areas.

What does the study involve?
If you consent to partake in the study, it will involve you taking part in an individual interview regarding your gambling behaviours (past or present). The interviews will be audio recorded so that they can be transcribed verbatim to ensure your responses are not altered in any way. The audio recordings will be destroyed after the transcription has taken place.

Are there any risks for partaking in this study?
There are no anticipated risks for partaking in this study; however, if you feel distressed throughout the process of the interview please inform he interviewer and the appropriate action will be taken including ceasing the interview, or referring you to a free service to assist with these feelings of distress.

What happens to the information that is collected in this study?
Privacy and confidentiality will be protected by removing your personal identifiers and replacing them with pseudonyms. You will be offered feedback via a copy of the final report, and a transcript of your interview if you are interested.

What will happen with the study results?
The results of this study will be written up as a thesis for a Master of Clinical Psychology program; there is a possibility that these results will be published in an academic journal and presented at a conference.

What happens if I change my mind and do not want to partake in the study?
You can choose to withdraw at any stage of the research. To withdraw from the study please contact:

Has the study received ethics approval and who can I contact if I have a complaint?
The study has been approved by the University of Adelaide Human Research Ethics Community (HREC), You can contact Professor Paul Delfabbro at Paul.Delfabbro@adelaide.edu.au for further information.

THE UNIVERSITY
of ADELAIDE

Appendix B: Participant Consent

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	**Gambling in rural and regional areas: Implications for services and help-seeking.**
Ethics Approval Number:	

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.

3. Although I understand the purpose of the research project, it has also been explained that my involvement may not be of any benefit to me.

4. I agree to participate in the activities outlined in the participant information sheet.

5. I agree to be:
   Audio recorded □ Yes No

6. I understand that I am free to withdraw from the project at any time.

7. I have been informed that the information gained in the project may be published in a journal article / conference presentation.

8. I have been informed that in the published materials I will not be identified and my personal results will not be divulged. I have been informed that while I will not be named in the published materials, it may not be possible to guarantee my anonymity given the nature of the study and/or small number of participants involved.

9. I agree to my information being used for future research purposes as follows:
   - Research undertaken by these same researcher(s) Yes ☐ No ☐
   - Related research undertaken by any researcher(s) Yes ☐ No ☐
   - Any research undertaken by any researcher(s) Yes ☐ No ☐

10. I understand my information will only be disclosed according to the consent provided, except where disclosure is required by law.

11. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: ______________________ Signature: ________________________ Date: __________

Researcher/Witness to complete:

I have described the nature of the research to ____
(print name of participant)

and in my opinion she/he understood the explanation.

Signature: ___________________ Position: _________________________ Date: __________

Appendix C: Interview Schedule

Semi-Structured Interview for Rural Gambling/Help Seeking

Introduction

- *Explain Confidentiality, Discuss & Sign Consents, Ask questions regarding information sheet.*

The Setting / Rural Environment

- Can you describe the town in which you live (*Prompt: its size/population, distance from Adelaide or other major centre*)?
- Do you have family members or friends in [*Insert Town Name*]?
- What do people typically do to amuse themselves when they are not working?
- Are there many sporting clubs, hotels or other places people can go if they want to get away from work?

Gambling Related Questions

- To what extent is gambling a common leisure activity where you live or amongst your family or friends? (*Prompt: are you aware of any family or friends who gamble?*)
- What sorts of (gambling related) activities do people in your town participate in? (*Prompt: What about the Pokies, Sports Betting, TAB?*)
- Can you tell me what gambling has been like for you?
- *If not already answered:* When did you start gambling? (*Prompt: where, when, what, etc.)*
- Could you describe a typical day or session?
- Who do you gamble with? (*Prompt: Did you gamble alone or with friends?*)

- What sort of activities (gambling related)?
- When did you start to think that you might have a problem? (*Prompt: What was happening? Were you under stress at this time?*)
- In what ways did (your gambling) affect you and those around you?
- What factors influenced your decision to gamble? What made it hard to stop?
- Did you have any other problems or issues which occurred before you ran into problems with gambling?
- Did you use gambling to fulfil particular needs?
- Is there anything about living in the country that makes gambling different for someone living in the city?

Help-Seeking

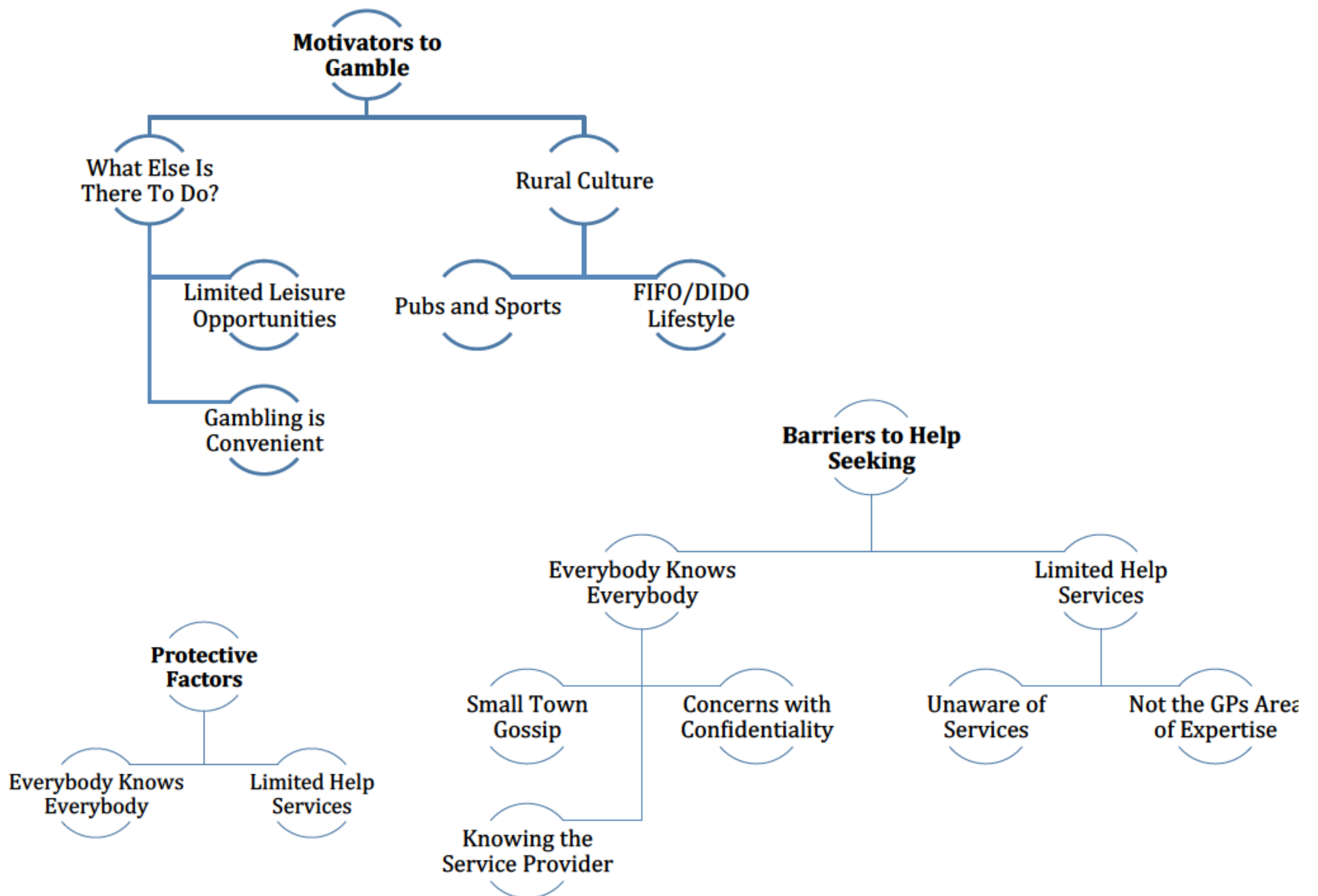
- What professional people or organisations would people approach if they had a problem with gambling in your town?
- Would they go elsewhere? (*Prompt: What other supports would they look to use?*)
- Had you been seeking help from anyone before or during the time your gambling problems arose?
- Where you did first look for help? *(Prompt: Where; GP, psychologist?)*
- What about family members or friends?

Barriers to Help Seeking

- What do you think motivated you to seek treatment?
- Is there anything that prevented you from seeking treatment earlier?
- How did you find the process of accessing gambling help services?
- Can you tell me your experience with seeking help?

  - *What made it difficult for you to seek help in [Town Name]?*
  - *What made it easy for you to seek help in [Town Name]?*
  - *Were you aware of who you could speak to?*
- Do you see any particular challenges for people in the community getting help for problems like gambling?
- Do you think gambling is any different from other problems when it comes to help-seeking? *If Yes: in what ways? If No: How do you think it is the same as other problems?*
- Do you think that there are other people in your town who need help with gambling?
- What is stopping some of them from seeking help?
- What sort of service model do you think would work best to help people with gambling problems in regional towns? *If unclear: What type of help service would best work in your town?*

Appendix D: Thematic Map



Appendix E: Journal of Gambling Studies Instructions for Authors

EDITORIAL PROCEDURE

Double-blind peer review
This journal follows a double-blind reviewing procedure. Authors are therefore requested to submit:

A blinded manuscript without any author names and affiliations in the text or on the title page. Self-identifying citations and references in the article text should be avoided.

A separate title page, containing title, all author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page.

MANUSCRIPT SUBMISSION

Manuscript Submission
Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

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Please ensure you provide all relevant editable source files. Failing to submit these source files might cause unnecessary delays in the review and production process.

TITLE PAGE

Title Page
The title page should include:

The name(s) of the author(s)
A concise and informative title

The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
A clear indication and an active e-mail address of the corresponding author
If available, the 16-digit ORCID of the author(s)

If address information is provided with the affiliation(s) it will also be published.

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Abstract
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