Scientific paper/ Izvorni znanstveni rad
Received: December, 2010
Accepted: January, 2011
UDC174.6(497.49)

POLICY CHALLENGES OF PROBLEM GAMBLING IN SLOVENIA

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SUMMARY

Debates on gambling and related policy-making are rarely based on conclusive and reliable data about this sector's social effects. The said is also true for Slovenia. In this paper, we are calculating social costs of gambling in Slovenia and in the Goriška region in view of plans of possible investments into new resort casinos. In the first section, we review the gambling history and the current gambling market. After that we estimate the extent of the current problem and pathological gambling on the basis of the limited available data and develop scenarios of possible future trends. After that we examine strategies used in Slovenia to help and care for pathological and problem gamblers, and evaluate existing mechanisms. At the end of the paper we present two conclusions. Firstly, preventing gambling addiction is a difficult task, although expansion of the gambling sector does not necessarily imply a steep increase in social costs of

Ključne reči:
gambling sector, social costs, problem and pathological gambling, prevention and treatment, evaluation.

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gambling. Comprehensive system of responsible gambling including preventive measures and treatment of gambling addiction is the key issue. Secondly, available data on trends and developments regarding problem gambling in Slovenia is insufficient. Therefore, it is vital that we establish an observatory for longitudinal research on these issues and it should become part of a comprehensive system of socially responsible gambling.

BACKGROUND

Slovenia is a country of about two million inhabitants, and belongs to the group of the new European Union members gaining membership in 2004. It has a developing market economy and a developing democracy (following the pre-1990s experience of communism). It gained the state independence in 1991. These changes – from Yugoslavia to an independent statehood; from dictatorship to a parliamentary democracy; from a 'self-managerial socialist' to a market economy – have been relatively smooth in the Slovenian case. In the political field, Slovenia is a comparatively stable democracy. The government is currently ruled by a coalition described as centre-left and led by the Social Democrats which took power after the 2008 parliamentary elections following the rule by the centre-right coalition led by the Slovenian Democratic Party.

From the economic point of view, Slovenia is relatively successful compared to the rest of the new market economies. In 2009., per capita gross domestic product (GDP) was €17,092. Nevertheless, the consequences of the recent global economic crisis were higher than in most other EU Member States. Following the years of relatively high annual growth rates, the GDP growth in 2009 was negative at -7.8%,. The official unemployment rate in November 2011 was 11.2 %, after years of relatively low unemployment rates. In January 2007., Slovenia became the first country among the EU newcomers to adopt the Euro over its former national currency.

GAMBLING HISTORY AND CURRENT GAMBLING MARKET

Though Slovenia is a young state and market economy, legalised gambling has a somewhat longer history. According to Luin (2004.), the first casino in what is now Slovenia was opened in the south-western resort town of Portorož on the Slovenian coast in 1913. It did not last long, however, as it was closed at the beginning of World War I. The Monarchy of Yugoslavia prohibited casino gambling and it became punishable under the Penal Code. Lottery games were allowed but each of them required explicit permission by the authorities.

The communist Yugoslavia was similarly restrictive in this regard. In 1946, the Ministry of Finance of the Federal People's Republic of Yugoslavia only allowed lottery gambling for humanitarian and cultural-educational purposes – but only with explicit approval by the authorities. The first basic legislation on gambling in communist Yugoslavia was adopted in 1962. The law dealt with the games of 'random outcome' such as lottery gambling and sports betting, and they were allowed under a specific state-awarded licence for welfare-humanitarian, cultural-educational, and sport-educational purposes, as well as for certain kinds of advertising. In 1965., the federal legislation allowed the Yugoslav republics to regulate gambling independently to a limited extent. The first Slovenian 'republic' (i.e., a 'socialist republic' within the Yugoslav federation) legislation followed swiftly – with the legislation adopted in 1965. This law introduced the concept of 'special games' that also included casino gambling. It allowed casino gambling for foreign tourists only and the games were played exclusively in foreign currency. Gambling in casinos by Yugoslav citizens was defined as an offence, punishable by up to 30 days of imprisonment and the requisition of the property gains. Following this legislation, the first two casinos were opened in 'socialist' Slovenia, both in the tourist places of Portorož (1964.) and Bled (1965.) (Luin, 2004.).

Though casino gambling was far from compatible with the communist ideology, it was clearly allowed because of pragmatic reasons – especially as an answer to the state's lack of the 'hard' western currency. However, the 'communist' beginning of legalised casino gambling organised for the western tourists was quite significant for the future development of this economic activity, since it began to establish it as an 'export-oriented' industry strongly connected to tourism. Until the 1980s, casino gambling was understood to be a supplement to the already existing tourist capacities. It was offered to the 'elite' foreign clients (Luin, 2004.). During the 1980s, this changed to some extent and casino gambling was not only a supplement for elite tourists, but became –while shifting more towards an 'American' concept of casino gambling – a central tourist attraction in some places, such as in the case of Nova Gorica, a westernmost Slovenian town at the border with Italy.

After 1990., the field became more liberalised, and the prohibition for Slovenian citizens to play in casinos was abolished. A new system of concession contracts between the state and the providers of gambling services was established (Luin, 2004.). Smaller casinos equipped with slot machines only (so called 'gambling halls') came into existence and started to become more and more common and significantly more accessible to the local Slovenian population. The systemic legislation (still valid today) was adopted in 1995., and later amended in 2001. and 2003. In 2007., new legislative proposals were introduced to allow further

liberalisation of the field while still maintaining 'efficient control' (Law Proposal Documentation EVA 2007-1611-0009). The Office for Gambling Supervision within the Ministry of Finance functions as the regulatory state agency.

Slovenian legislation distinguishes between 'classical' gambling and casino gambling. Classical gambling includes lotteries, lotteries with instant prizes, quiz lotteries, bingo, lotto, sports betting, sports pools, raffles and other similar games. The administration of classical games in only allowed by two operators. These are *LoterijaSlovenije* (The Lottery of Slovenia), that runs eight different series of games and *Športnaloterija* (The Sports Lottery), that runs six games. Lotteries, bingo, and raffles may also be organised occasionally, i.e., no more than once a year, by humanitarian and non-profit associations in association with sports competitions. The licence for these activities is issued by the Minister of Finance. In 2006., for instance, four such 'occasional' licences were granted – including a local tourist association, a local firemen association, a skiing club and a sports-humanitarian association.

Moreover, the Slovenian legislation distinguishes between two types of places where special gambling can be organised. These are casinos and gambling halls. While the former may include an entire variety of casino games and an unlimited number of slot machines, the latter may only have between 100 and 200 slot machines and no other games. The legislation allows the government to award concessions for up to 15 casinos and up to 45 gambling halls. To date, 13 and 36, respectively, have been awarded (Law Proposal Documentation EVA 2007-16611-0009). The casino concessions have been awarded to *HIT* (the major corporation of the Slovenian gambling industry, with its headquarters and the main gambling facilities stationed in Nova Gorica), Casino Portorož, Casino Bled, Casino Ljubljana and Casino Maribor.

Slovenian legislation also imposes certain age restrictions in relation to gambling. Namely, the Article 83 of the Gambling Act, specifically mentions that those younger than 18 years are not allowed to engage in casino-style gambling. In fact, they are prohibited from entering the casino. However, there are no age restrictions for other types of gambling. The number of visitors to the casinos and gambling halls has been increasing significantly following both the liberalised legislation and the introduction of new market initiatives. The numbers of visitors to casinos increased more than 12 times from 1985. to 2005. (see Table 1).

Table 1. Numbers of visitors to Slovenian casinos between 1985. and 2005. (gambling halls not included) (Luin, 2006.).

Year	Casino Portorož	Casino Bled	HIT Nova Gorica	Casino Maribor	Casino Ljublja-na	Casino Kobarid	Total
1985	159,942	16,094	24,225				200,261
1990	426,549	23,319	518,498	23,441			991,807
1991	320,328	15,072	560,896	31,311			927,607
1992	470,969	19,409	829,253	39,341	28,351		1,387,323
1995	569,134	57,854	1,739,854	23,000	66,216		2,456,658
1996	583,400	60,250	1,834,500	19,000	55,000		2,552,150
1999	546,000	67,000	1,557,000	21,677	34,072		2,225,749
2000	526,124	69,200	1,528,000	27,697	45,173		2,196,194
2001	526,801	65,980	1,526,000	27,400	50,560		2,195,712
2002	537,429	71,000	1,478,300	38,000	50,600		2,166,200
2003	519,904	66,000	1,469,000	35,151	53,081		2,133,022
2004	507,608	65,054	1,489,000	37,931	53,637	31,900 (from July)	2,185,130
2005	584,918	64,500	1,566,000	41,173	78,927	86,223	2,421,741

In 2006., there were 4.2 million visitors in Slovenian casinos and gambling halls. The typical guest is a foreign tourist, as 86% of casino visitors and 54% of gambling hall visitors are foreigners. This tourist orientation of gambling and the relevance of gambling for tourism still remains to this day. Considering gambling income as a proportion of the entire income from its tourism, Slovenia resembles countries such as Monaco in Europe, or Nevada in the U.S. (Luin, 2006.). For example, in 2002, gambling contributed 22.4% to the total GDP created by tourism.

In 2006., the income from gambling before taxation totalled €489 million, which is a significant increase compared to 2001., when it totalled €264 million. Almost half of this income came from the casinos (49%), 22.5% from the gambling halls, 18% from the *Lottery of Slovenia*, and 10.5% from the *Sports Lottery*. Between 2001 and 2006, all game types recorded rises in absolute numbers. However, in relative terms, compared to the rest of the games, the market share of the casinos and the *Lottery of Slovenia* has decreased while the share of the gambling halls (slot machine casinos) and the *Sports Lottery* increased. By far the greatest annual growth

during the last five years was recorded by the gambling halls (47% increase). Most of this can be attributed to the establishment of the new gambling halls enabled by the legislative changes, especially the liberalisation concerning the gambling halls in 2001. and 2003. (Zagoršek, Jaklič and Zorič, 2007.). Significant parts of the income are transferred to the society via taxes and concession contributions. The concession contribution for casino gambling amounts to 20% and the tax rate is 18%. In 2006., the tax and concession contributions from all gambling (including the classical games) totalled €142 million. More than half of it, 54%, came from the casinos, 28% from the gambling halls, and 18% from the classical games (e.g., lottery). This represented 1.22% of all income of the budget of the Republic of Slovenia, and 1.68% of the incomes of the municipal budgets (EVA 2007-16611-0009).

Zagoršek et al. (2007.) have recently calculated that in 2006 the average annual expenditure for all types of legal gambling by a Slovenian inhabitant was €104 per capita. This is a sharp increase from €48 per inhabitant in 2001. The average annual growth rate is around 17%. However, the calculation does not include the Internet gambling as almost no relevant data on this phenomenon are available for Slovenia. While a typical casino visitor is a foreigner, a typical lottery player in Slovenia is a Slovenian. In 2006., €69 per inhabitant annually was spent for the classical gambling organised by the *Lottery of Slovenia* and the *Sports Lottery*. A total of €35 per inhabitant was spent on casino-style gambling (Zagoršeket al., 2007.).

We should add that since 2006. the trends have not been very positive as a result of several factors. The most important was perhaps the economic crisis, which contributed significantly to economic performances of gambling halls and casinos. The market itself became saturated as a result of the aforementioned partial liberalisation and an increase in number of gambling halls. Last but not least, Italy – the main market of Slovenian gambling industry - increased its number of slot machines in the last several years and is preparing further liberalisation.

CURRENT EMPIRICAL EVIDENCE

PRELIMINARY RESULTS

Most of the research attention in Slovenia has been paid to the casino gambling which has been the subject of a few studies. However, apart from some minor surveys, their research results not being fully available, the most significant research has been concentrated in western Slovenia, especially the Goriška region.

This is far from coincidental since the concentration and the income from the casino business are the highest in this part of the country. Although research on gambling is a relatively recent phenomenon in Slovenia, one can already observe some interesting trends requiring comment and attention. The first gambling studies at the macro level typically focused on purely economic issues. Perhaps the most typical among them was 'The Slot Machines Gambling Market' from 2004. by Bole and Jere (2004.) for the Ministry of Finance. The authors admitted that they ignored the social impacts of gambling and only considered the profitability of the slot machines gambling halls. One of their conclusions was that the optimal distance between the slot machines providers was 11 to 22 minutes of driving by car. The study highlighted the relatively dense distribution of the slot machines casinos.

During the subsequent research, the economic aspects retained a key role and the economists remained leading authors (Jakličet al., 2006.; 2007.; Prašnikar et al., 2005.; Zagoršek et al., 2007.). However, they also began to include some analysis of the social impacts of gambling in their studies. Prašnikar et al. (2005.) briefly studied, amongst other things, the impact of gambling on deviance and family breakdown, and included some evidence from social surveys and qualitative research. Jaklič et al. (2006.), on the other hand, were the first to apply the methodology of the National Opinion Research Centre (NORC) from 1999. to evaluate the social costs of gambling.

Completely separate and isolated from these economic surveys, there were a few attempts to deal with the issue of gambling from the psychological and/or medical (and especially psychiatric) perspective. The research tried to identify and understand the major personal impacts of 'pathological hazard' (as they called it) through a survey among Slovenian psychiatrists (Dernovšek and Čebašek-Travnik, 2004.; Jeriček and Čebašek-Travnik, 2005.). The primarily medical 'micro' research trying to reach for pathological gamblers and the primarily economic 'macro' research of gambling co-existed, but they failed to communicate with each other. While the 'micro' perspective of Čebašek-Travnik and colleagues was characterised by a clear 'anti-gambling' orientation, the 'macro' perspective of the economists tended to be significantly more optimistic, claiming that there caould not be more than one per cent of problem and pathological gamblers within the Slovenian population (Zagoršek et al., 2007.).

PROBLEM AND PATHOLOGICAL GAMBLING: TENTATIVE ESTIMATES

Most recently, the research has also included other (especially) social aspects. There has been a systematic overview of public opinion concerning gambling issues (Makarovič and Zorec 2007.). Moreover, the macro level research of the social impacts of gambling began to focus more significantly on problem and pathological gambling. A study by Rončević et al. (2007.) attempted to provide the first estimate of problem and pathological gambling in the Goriška region and in Slovenia as a whole. The authors applied three different methodologies to estimate the social cost of gambling. These were those by NORC from the U.S. (National Gambling Impact Study Commission, 1999.), by the Australian Productivity Commission (APC; Productivity Commission, 1999.), and by Walker and Barnett (1999.). There are several theoretical and operational definitions of problem and pathological gambling and there may be a problem with their consistent use in the Slovenian research. Because of the lack of available data, the studies that have tried to estimate the proportion of problem and pathological gamblers in the population have used certain approximations of the operational definitions. Up to now, there has been no research based on the representative sample for the population using established measuring instruments such as SOGS or DSM-IV.

The first attempt to provide an estimate of the proportion of problem and pathological gambling within the population of Nova Gorica and in Slovenia as a whole, was based on the frequency of visits to the casinos. This research by Jaklič et al. (2006.) considered those who visited a casino at least once a week to be problem gamblers and those who visited it twice a week pathological gamblers. Clearly, there are significant limits to this approach. Though every problem and every pathological gambler tends to play frequently, this does not imply that everybody who visits a casino or another place where electronic gambling machines (slot machines) are available is a problem or a pathological gambler. The reasons for visiting a casino may vary. Moreover, even if the gambler decides to play and spend significant amounts of money on the games, it is not particularly relevant how much the gambler spends on gambling in absolute terms – as long as the gambler can afford it. Reith (2006.) argues that problem gambling »can be defined in more straightforward economic terms as playing that they can no longer afford« (Ibid., p. 21). Thus, there may be a general problem with even the most 'objective' measures such as those used by Williams et al. (2006.) that mention the average amount of money spent and the length of a visit in the casino as the major indicators. However, even these data are not available for Slovenia.

There are also practical problems with the visit frequency data. Perhaps the most objective data on the frequency of the visits in Slovenia may be obtained from

the casinos, where the visits are recorded on the regular basis. However, not all of the gaming operators are consistent in this practice and there may be problems with the availability and the validity of these types of data. Moreover, the data available from the casinos' own statistics only include a person's frequency of visits in a single casino, and not in the others. The casinos' statistics do not record visits of a single person within the different casinos operated by different companies because there is no central database on casino visits (and no central database on (self-)exclusion, which means that even this measure can only apply to a single casino not to the system as a whole). Consequently, the study by Jaklič et al. (2006.) attempting to measure the social costs of problem and pathological gambling was limited in its scope as to the social costs of the two casinos owned by the region's most significant provider of gambling *HIT*, namely Park and Perla.

Following the criteria that a problem gambler visits a casino at least once a week and a pathological gambler visits a casino at least twice a week, they concluded that there were 172 problem gamblers and 74 pathological gamblers in Nova Gorica and additional 77 problem and 17 pathological gamblers in the rest of Slovenia. This equates to 0.18% of problem gamblers and 0.08% of pathological gamblers in the Goriška population. For the rest of Slovenia, the percentages are even lower: there are 0.005% of problem gamblers and 0.001% of pathological gamblers in the rest of the Slovenian population. Though the data were the most reliable measure of the frequency of the visits by an individual in these two casinos, the validity of any general conclusions based on these data solely is highly questionable as the authors themselves noted.

In addition to the general methodological problems mentioned above, there were other methodological weaknesses: (a) despite the significance of *HIT*, its two casinos in Nova Gorica represent only a very small part of the gambling supply used by the local population; (b) the typical guests of the *HIT* casinos in Nova Gorica are foreigners (mostly Italians); (c) more locals (from Nova Gorica and from the rest of Slovenia) prefer to visit gambling halls (that have slot machines only) than the two *HIT* casinos in Nova Gorica (as is clear from Table 2) – in 2004, the local population visited the gambling halls 1.42-times more often than the casinos (Prašnikar et al., 2005.); and (d) there are many other casinos and gambling halls in other parts of Slovenia that are far more available to the population not living within the vicinity of Nova Gorica. Clearly, using the data from two casinos only, which are not even the most typical destinations for Slovenian guests, does not allow any direct generalisations on the prevalence in the entire Slovenian population. The limitation to these two casinos may seriously underestimate the prevalence of problem and pathological gambling. On the other, hand, the concepts of problem and pathological gambling based only on the frequency of visits may overestimate

the prevalence since frequent visits do not necessary imply gambling problems or even gambling addiction.

Table 2. Number of foreign and Slovenian visitors to casinos and gambling halls in Nova Gorica (Prašnikar et al., 2005.).

Visitors						
Year	Casinos Park and Perla			Gambling halls (slot machines only)		
	Foreign	Domestic	Total	Foreign	Domestic	Total
1999	n.a.	n.a.	1,340,357	n.a.	n.a.	
2000	n.a.	n.a.	1,217,883	n.a.	n.a.	
2001	1,170,811	50,361	1,221,172	n.a.	n.a.	211,749
2002	1,106,042	58,031	1,164,073	127,240	70,741	197,981
2003	1,089,405	57,962	1,147,367	149,809	70,170	219,979
2004	1,092,109	59,455	1,151,564	195,143	83,677	278,820

An alternative option is to use surveys. As mentioned, no survey using SOGS (or a similar questionnaire) has been used with the sample representative of the entire population. There are, however, some other survey data available that indicate frequencies of visits, socio-demographic characteristics of gamblers, their motives for the visits, and so on. Unfortunately, this evidence is only available for Nova Gorica, not for Slovenia more generally. However, since Goriška is the region where gambling is highly available, it may provide some idea of how the Slovenian population behaves in relation to these games. These survey data were presented by Prašnikar et al. (2005.) who concluded that there might be between 3% and 4% of people within the Nova Gorica local population who had gambling problems. They considered this a probable estimate, since it was close to some other societal environments characterised by a comparable availability of gambling.

The most recent study by Rončević et al. (2007.) was based on the assumption that problem gambling prevalence cannot be precisely estimated until a national gambling survey using some of the standardised measuring tools was done. Before this was done, the authors decided to set the highest and the lowest possible estimate of the amount of the problem and pathological gambling in the population. They referred to a combination of the already available survey data and some comparisons with the evidence from other countries with a roughly comparable gambling supply. In the survey used by Prašnikar et al. (2005.), 3% of the locals claimed that they visited a casino at least once a week and another 1% claimed that they visited a slot machine casino. It is worth noting that none of

those who visited gambling halls visited casinos. The most frequent visitors of the casinos were different people than the most frequent visitors of the slot machine gambling halls. While casino players tended to be older than the average, a typical slot machine player was a young male (Prašnikar et al., 2005.).

Moreover, Rončević et al. (2007.) claimed that the extent of problem and pathological gambling in Goriška would be overestimated if all of these 4% were considered to be problem or pathological gamblers. Therefore, they analysed the motives of the casino players in the same survey. Among those who visited a casino at least once a week, 40% claimed that the major motive for their regular visits was the additional entertainment offered (e.g., concerts, dancing, artistic programmes, other forms of entertainment). It is highly unlikely that any of those who said this was their major motive would be pathological or problem gamblers. The other reasons among those who visited a casino once a week included the fun of playing table games; the fun of playing slot machines (both together accounted for more than 40%) and 'other reasons' (less than 20%). On the other hand, among the people who reported visiting a slot machine casino at least once a week, none claimed to be motivated by any additional entertainment. Almost two-thirds of them reported that they were attracted by the fun of playing slot machines while the remainder reported 'other reasons'. This does not mean that the most frequent visitors of the gambling halls were problem gamblers but does give a rough estimate of the maximum number of problem and pathological gamblers. From these results and some further comparisons from the study by Rončević et al. (2007.), it can be concluded that there were up to 3% of problem and pathological gamblers in Goriška. This was considered to be the maximum value. The equivalent maximum estimate for the entire Slovenia was 2.5%.

Since casino gambling in Slovenia is mostly associated with the Goriška region and especially the company *HIT*, the maximum estimate for the entire Slovenia seems to be relatively high since it is not much lower than for Goriška. However, casino gambling, especially when considered as a service for the local Slovenian population, is dispersed across the country. A study from the U.S. found that problem gambling rates doubled if people lived within 50 miles of a casino (Gerstein et al., 1999.). Even if a 40 km distance is used as a 'range' of a casino, Slovenia is almost completely covered with these services.

The study by Rončević et al. (2007.) also calculated the financial estimate of the social costs of gambling. This was mostly motivated by heated public debates in Slovenia in spring 2007. relating to the expansion of gambling in a large gambling resort in Goriška (by *HIT* and *Harrah's Entertainment* from the U.S.). As a consequence, the non-governmental organisations, the local community, and other major stakeholders demanded concrete data on the social costs of gambling.

Applying (and adapting) the American methodology used by National Gambling Impact Study Commission (1999.), the average social annual cost was estimated to be €633 per problem gambler and €1,185 per pathological gambler. The Slovenian study has applied logistic regression coefficients from the American study and calculated the costs for particular items in relation to the Slovenian situation. The calculations for Slovenia (following the NORC methodology) are listed in Table 3.

Table 3. The average annual social costs per problem and per pathological gambler in Slovenia using the NORC methodology (in Euro).

Cost specification	Problem gambler	Pathological gambler
Losing employment	98.97	149.84
The Court for Labour issues	2.00	3.00
Unemployment benefits	354.08	536.08
Welfare benefits	67.84	102.70
Unpaid debts	28.56	58.54
Imprisonment	4.89	9.96
Arrest	7.01	7.32
Divorce	0.48	1.62
Health	33.40	229.78
Mental health	36.21	36.21
Therapy	0	50.25
Total annual social costs	633	1,185

Having no data available on the ratio between the problem and the pathological gamblers, the study compared the ratios between the problem and the pathological gamblers in most of the countries where national gambling surveys using the SOGS test had been carried out. It was found that the ratio between both of them was relatively stable regardless of the proportion of both taken together within the population. The proportion of pathological gamblers within the population of problem and pathological gamblers taken together was mostly between 30% and 40%. The average proportion was 35% of pathological gamblers and this ratio was also applied as an approximation by the Slovenian study in order to estimate the total social cost of gambling. The maximal annual social cost for Slovenia based on the presumption that 2.5% of the population were problem or pathological gamblers according to the calculations following

the NORC methodology was €33.3 million. Furthermore, the methodology of the APC was also applied and recalculated following the Slovenian data. The estimated maximum annual social cost of gambling according to the APC was €29.4 million. The final calculations for Slovenia have turned to be surprisingly close to the ones of the NORC methodology (see Table 4).

Table 4. Social costs of problem and pathological gamblers according to the APC methodology (in Euro).

Financial costs	Minimum estimate (1% of problem and pathological gamblers in the population)	Maximum estimate (2.5% of problem and pathological gamblers in the population)
Bad debts	628,650.20	1,571,625.50
Productivity and employment		
Decreased productivity	514,198.77	1,285,496.92
Changing the workplace – costs of the state	254,720.33	636,800.83
Changing the workplace – costs of the employer	65,088.45	162,721.13
Crime		
Police intervention	9,239.88	23,099.71
Courts	40,713.58	101,783.95
Prisons	178,896.00	447,240.00
Personal and family costs		
Emotional pain of the family members	9,146,504.04	22,866,260.10
Financial costs of divorce	22,340.97	55,852.41
Emotional costs of separation	49,196.43	122,991.07
Emotional costs of divorce	114,309.34	285,773.36
Emotional costs of violence	20,573.87	51,434.68
Depression	300,484.05	751,210.13
Thinking about suicide	42,926.29	107,315.73
Suicide attempts	31,497.17	78,742.92
The impact of suicide to the family members	51,970.33	129,925.82
Treatment costs		
Treatment costs for pathological gamblers	283,112.32	707,780.80
Total	11,754,422.03	29,386,055.07

It should also be noted that estimating the emotional and family costs according to this methodology was the most interesting and needed aspect of calculations, as it is often argued by opponents of gambling that studies systematically ignore them. Indeed, there was only one real financial cost in this category (i.e., the financial cost of divorce), which included easily calculable costs of the court and legal counsel. The rest of the costs are calculated by the estimated number of people suffering various emotional adverse consequences, as outlined in Table 4, and multiplied by the costs of legally guaranteed compensation for emotional suffering, which can be granted by the court. The calculation not only included gamblers, but also their family members. A causality factor was also applied.

The application of the Walker and Barnett methodology (1999.) produced significantly lower figures – up to 10 times lower than those obtained when the APC methodology was applied. Since the Walker and Barnett methodology has been criticised for allegedly underestimating the social costs of problem and pathological gambling, it has been used with great caution. Thus, any (over)generalisations based on this methodology should be avoided. Considering the major investment by *HIT* and *Harrah's Entertainment*, the study concluded that the increase of social costs does not depend so much on the gambling activity but more on the development (or underdevelopment) of socially responsible gambling policies implemented by all of the relevant stakeholders.

Taken together, the research on gambling in Slovenia to date clearly demonstrates the growing interest in the social impact of gambling, especially through the issue of problem gambling. It also demonstrates the need for a national gambling survey that would provide reliable data compared to the estimates that have been constructed on the basis of the available empirical data. Furthermore, this research should attempt to identify problems stemming from other types of gambling. Until now we have had no reliable data on other types of gambling addiction in Slovenia. However, they should be taken into account. Although addictiveness of casino gambling is much higher than addictiveness of other games, other gambling activities should nevertheless be taken into account having in mind high levels of turnover produced by them.

ACTION

This section examines strategies used in Slovenia to take care and help pathological and problem gamblers and whether this help is effective. In examining this issue, there are some other factors to take into account: (a) regardless of how significant the gambling problem is, it seems very difficult to find a person who is

able and willing to talk about his/her gambling-related problems; (b) the help for pathological and problem gamblers is usually not used by the target population – according to some estimates, only 3% of pathological gamblers seek professional help (Dickerson, 1997.; Volberg, 1997.). A Slovenian doctor involved with treatment of pathological gamblers was quoted as saying that the bigger the gambling problem is, the less likely it is for an individual to seek treatment.

A PRELIMINARY EVALUATION APPROACH

Evaluation research can be quantitative or qualitative, or both. The nature of the subject that is to be evaluated suggests that qualitative methods should be adopted, because large samples could not be analysed. It seemed unlikely to find many organisations that provided such treatment. Individuals with gambling problems were also very hard to find for this study.

The sampling method for this exploration was a snowball technique. We expected experts and practitioners to give us names of people to interview. Therefore, semi-structured interviews with representatives of organisations that provided help for problem and pathological gamblers were conducted (Easterby-Smith et al., 2005.). We were able to sample 10 competent informers form all relevant organisations. Overall, two distinct areas were evaluated: organisations or persons that aimed to cure problem and pathological gamblers; and mechanisms that aimed to prevent these problems as much as possible. For instance, one of the most common mechanisms are entry restrictions, and in some cases, entry prohibition. The aim was to visit organisations that provide help for problem and pathological gamblers, such as health institutions that treat patients who suffer from different types of addiction (gambling, illegal drugs, alcohol); psychiatric hospitals; other relevant experts/healers/health institutions; centres for social care; support groups; and youth centres (in case they provided such help). In order to find preventing mechanisms, the State Office for Gambling Supervision was contacted, which is responsible for gambling regulation and supervision. The Gambling Act in Slovenia enables casinos and gambling houses to restrict or forbid the entry to some visitors. We tried to gather information on implementation of this Article of the Gambling Act, using interviews as well.

One major concern was related to possible evaluation criteria and the goal to find all of the possible mechanisms or institutions that either help prevent pathological gambling or cure pathological and problem gamblers. Such mechanisms should then be evaluated according to various criteria (Phillips et al., 1994) including:

- Effectiveness – Do these mechanisms prevent pathological gambling or cure this problem effectively?
- Efficiency – How much input is needed for recommended results?
- Accessibility – Is care available to all the people that need such care?
- Equity – Are all the patients equally treated?
- Appropriateness – Is available care relevant according to the needs?
- Acceptability – Is appropriate care acceptable for the patients (i.e., is it in accordance with tradition and/or religion etc.)?

It was first intended to establish whether there was care available for people with gambling problems. If there was, we tried to find out: (a) What do these programmes look like? What kind of pathology definition is in the root of the programme? (b) How are these programmes conducted? Is there a separate programme for pathological gamblers? Are individual patients treated together with patients with other addiction problems? (c) What is the scope of the gambling problem compared with the number of individuals treated for gambling problem? Are there any dropouts from the programme? (d) What is the effectiveness of care provided? Does it cure the problem or are the results short-lived? (e) What is the efficiency of the treatment? What is the average time needed for treatment? How much resources is needed to treat one patient? (f) Is treatment available to all the people in need of such treatment? (g) Is treatment relevant for the needs of such people? (h) Is care acceptable for the patients? Is it in accordance with tradition and/or religion? (i) Are all the patients with the same problem equally treated? Is this kind of help and care financed from health insurance?

In general, there are lots of questionnaires available that measure quality of services. For example, Parasuraman and colleagues developed universal dimensions of quality of services: tangibles, reliability, responsiveness, communication, credibility, security, competence, courtesy, understanding, access (cited in Bergman and Klefsjö, 1994.). However, the services were too infrequent to enable us to use standardised questionnaires, and the sample was not big enough to enable us to analyse all the proposed dimensions.

EVALUATION OF PREVENTIVE MECHANISMS

Before presenting some findings in detail, it should be acknowledged that problem gambling cannot be eliminated in a global society. Even if we decide to close all the casinos and gambling houses in Slovenia, there are many casinos at the border with Slovenia. It should also be kept in mind that addiction to gambling

occurs not only in the casinos. People can also be addicted to lotto and other type of games. Internet gambling is also widely spread and dangerous especially for youngsters. Furthermore, the possibility of preventing the entry to the casinos and gambling halls should be mentioned. In Slovenia, persons younger than 18 years are not allowed the entry. However, this does not prevent minors from using slot machines, which can be found in many public places and represent a big threat to the potential pathological gamblers.

In Slovenia, self-imposed restriction is also possible. If a person wishes to cope with their gambling problem, they can make such a request to a casino or a gambling hall to prevent them from entering the casino. We do not have the exact number of such exclusions but according to interviews it seems that they work quite well. However, we do see a problem when the request is made by a relative (e.g., a partner or a family member) because the Gambling Act does not address this issue. Casinos have different policies about those exclusions. If such claims are posted to the State Office for gambling supervision, they recommend to a casino or a gambling house to forbid entrance to a person mentioned in a claim for a limited period of time (usually 6 months). It seems plausible that there are a lot of such claims because relatives are usually the first who address gambling problem and they start looking for help.

The Article 84 of the Gambling Act gives casinos and gambling halls the opportunity to forbid the entrance to a person or a group of visitors without explanation. What is the scope of these incidents in Slovenia? The State Office for Gambling Supervision analysed the implementation of this article in Slovenian casinos and gambling halls. They found that some casinos and gambling houses in Slovenia have not used this article since 2005, whereas others have used this article regularly. In addition, entry is also forbidden in the case of recommendation by the court or by health institutions. However, we could not find such cases or data about their frequency. Through interviews we detected a serious problem with the Article 84. The criteria for restrictions are not defined and the decision rests upon the casinos themselves. However, responsible gambling requires a clearer definition of those criteria and should provide orientations based on the best practices.

Interviews showed another serious problem with the entry restrictions. In Slovenia, there is no central register of visitors and guests to whom entry has been forbidden. Single registers are kept by the casinos, which means that a person whose access to a certain casino is denied may visit another one. The national policy in this field is not possible without a central database regarding entry restrictions to the various casinos and halls.

There are of course also other restriction mechanisms such as limited access. However, such measures are usually not implemented in Slovenia. An exception refers to an instrument available in *HIT* casinos. Since their policy tends to be one of responsible gambling, they decided to restrict entry for the local population. Studies show that restrictions influence problem gambling (Reith, 2006.), therefore they allow visitors from their region to visit *HIT* casinos for a maximum of four times a month. In order to visit *HIT* casinos a fifth time per month, residents need to write an application.

Do the casinos and gambling houses enhance responsible gambling? We did not have the time and resources to make an in-depth study of this issue, but according to our interviews, responsible gambling is not yet a priority in Slovenia. For example, entry restrictions (allowed by the current law) have not been implemented by many casinos and gambling halls. In one casino we found tickets including a message about dangers of pathological gambling. The casino congratulated the guests on their choice of entertainment and wished them a nice time in the resort but the casino also warned them about gambling addiction. The same casino included a similar notice in a contract with the frequent guests of the casino.

In our interviews we traced some additional ideas on responsible gambling in Slovenia, such as entrance fee for the second and third visit within a month, higher fees for higher frequency of visits per month; and entrance restriction for local visitors (similar to *HIT*'s policy for local population). Furthermore, public awareness about this type of addiction is needed because pathological gambling is still a 'hidden' phenomenon (e.g., brochures, lectures about addiction problems are needed in secondary schools).

Unfortunately, we could not access information about the number of patients who were treated for pathological gambling in Slovenia. It is hard to describe the profile of a typical pathological gambler other than from foreign studies. These studies (see Reith, 2006.) and our interviews showed that there were at least two risk groups: (a) the under-aged, because their personality and value system are less stable compared to adults (and minors are especially vulnerable and are heavily exposed to Internet games); (b) the employees of casinos and gambling houses. This latter group of people is seriously under threat because they are exposed to gambling several hours per day (usually in evening hours). The statistics of pathological gamblers, treated in Nova Gorica, show high number of employees among patients. Casino employees have to pass serious tests to get their license. Usually only one third of candidates get this type of job. Nevertheless, the evidence demonstrates that addiction to gambling cannot often be prevented in advance. The lifestyle of casino employees – late working hours – prevents them

from a 'normal' social life with friends from other branches. Work behind gambling tables and their social life enhances addiction with gambling, as we found casino employees were often guests of other casinos. Although empirical data about the frequency of this phenomenon is missing, we strongly recommend changes regarding the licenses for casino employees and believe the license should include entry restriction to other casinos.

EVALUATION OF THE CARE SYSTEM

It can be assumed that gamblers with such a problem (or their relatives) will first come to the social care centres. Interviews showed that employees were aware of pathological gambling but did not have sufficient experience in dealing with the problem. In 2004, the State Office for Gambling Supervision conducted an analysis of the social care centres, asking them whether they came across any negative consequences of gambling. This analysis showed that the centres did not keep the record of such cases, and were more focused on other issues such as violence, drug abuse, and alcoholism. Gambling problems are most often detected together with other problems of an individual or family (e.g., financial, depressions, alcoholism etc.). It should also be noted that 53 social care centres replied to these questions (out of 62 centres in total). They recognized 45 cases of pathological or problem gamblers during the period of the last four years (see Table 5).

Table 5. Pathological gamblers (2000.-2004.) recognized by centres for social care (State Office for Gambling Supervision).

Problematic gambling form	Status	Gender	Visitors of Slovenian casinos and gambling houses	Visitors abroad
- 29 casino gambling - 16 gambling halls	- 28 employed -13 unemployed - 2 high school - 2 retired	- 39 male - 6 female	43 cases	2 cases

From the research reports on gambling and from some interviews, we learned that gambling was a particular threat for young people, who develop addictive be-

haviour quicker than adults. Therefore, members of some youth centres, which are part of centres for social help, were interviewed. Surprisingly, we did not find any cases of heavy gambling problems within the younger population or inside their families. Young people mostly have problems with self-identity, conflicts with their environment, alcoholism in their families, family physical and emotional violence, as well as drug abuse. There was one therapist in Youth Aid Centre Association in Ljubljana who detected three cases of the Internet gambling addiction.

We recognized the lack of evidence about such cases in all the support organisations mentioned above. Pathological gambling is not as widespread phenomenon as alcoholism and violence, but is becoming a greater part of everyday life. Thus, more data is needed on this type of addiction and more information on help provided. Furthermore, we analysed the health care institutions to find out the way the care for individuals with gambling problems is organised. Gamblers with an addiction problem can visit psychiatrists in a health centre. According to the diagnosis, the patient is then directed to a psychiatric hospital or a drug or an alcohol treatment centre. It was discovered that in Slovenia, a special centre for individuals with gambling problems or pathological gamblers did not exist. There is a health care centre in Nova Gorica that provides treatment to individuals with various addiction problems, including pathological gambling, though this treatment cannot be financed through basic health insurance.

In Slovenia, care for pathological gamblers is organised mostly inside psychiatric help centres. Psychiatry gives priority to traditional mental diseases and more frequent addictions. Pathological gamblers were also treated inside these psychiatric facilities. However, we could not get the exact number of such patients and treatment programmes but again it could be recognised that there were not many cases of pathological gamblers seeking treatment. Unfortunately, a psychiatrist who specialized in treating pathological gamblers passed away this year. The centre for treating alcoholics lost a few psychiatrists due to the concession delivered by the Ministry of Health in 2006. Their capacities are now smaller so they are not proactive in finding and treating pathological gamblers. Nevertheless, there are several psychiatrists in Slovenia who treated individuals with gambling problems. Analysis among 52 Slovenian psychiatrists showed that they treated 41 pathological gamblers. They also treated 45 patients with other diagnoses, but who also suffered from pathological gambling. There were 15 patients who developed this type of addiction while being treated for other disorders (Dernovšek and Čebašek-Travnik, 2004.).

CONCLUSION

Overall, we believe preventing gambling addiction is a difficult task. Even if all casinos in Slovenia were closed, pathological gamblers would use lotteries, Internet games, and/or illegal forms of gambling. Thus, there is the need to develop responsible gambling programmes and enhance public awareness of this problem through educational programmes in primary and secondary schools, stressing dangers of various addiction problems, especially for young people; public brochures in health care facilities, centres for social care, various youth centres, addiction centres etc.; and summer school programmes. There are several mechanisms that casinos and gambling houses can adopt, such as giving information to their guests about their rights and their options when problems occur (entry restrictions, counselling etc.); inform their guests about dangers of gambling addiction; monitor the situation in a casino and talk to potential problem gamblers about their problem and possible solutions; exchange views and ideas about responsible gambling and management practices among themselves; and exchange data about entry restrictions to various guests and consult on a common strategy for those individuals. At the national level, the State Office for Gambling Supervision could promote responsible gambling on various levels and encourage (also with resources) diverse actions and practices – like the ones already mentioned; promote prevention mechanisms; publish brochures about the different addiction forms; organise (together with various experts in this field) conferences on responsible gambling and discuss different strategies and actions; prohibit casino employees entry to casinos (and gambling halls) in their non-working time; define criteria for entry restrictions employed by casinos and gambling halls; and build a single information system for all the casinos and gambling halls that includes entry restrictions and other measures taken by different casinos and gambling halls.

At the moment, it seems almost impossible to evaluate the effectiveness of Slovenian treatment facilities. Efficiency of treatment cannot be assessed either. For example, we could not compare different treatment practices. Experts could not give us information about preferred length of treatment and preferred method of treatment because treatment specifics were individually-based. The psychiatrist first talks to the patient and suggests the length and the type of treatment. Some patients prefer individual counselling; some patients find it stimulating to work within a group of patients. Homogeneous groups are sometimes helpful (e.g., a group of pathological gamblers, a group of alcoholics) but sometimes heterogeneous groups (people with different addiction problems) are preferable.

From the literature and from our interviews we realised that the type of treatment can also depend on the definition of a problem. Medicine defines patholo-

gical gambling as a behaviour disorder – as compulsive behaviour, whereas other sources define pathological gambling as an addiction problem. Medicine does not define pathological gambling as an addiction because it defines addiction only in connection to psychoactive substances, such as illegal drugs and alcohol. Some therapists, on the other hand, tend to define addiction as an excessive behaviour pattern that harms a person but a person cannot control it. According to such a definition, addiction – including pathological gambling – is a disease and should be treated as such. As a consequence, we believe round table discussions among experts are needed to exchange information on the best practices. Another important question concerns accessibility of treatment. A responsible society should make it possible for all individuals with this kind of problem to access treatment, bearing in mind that pathological gamblers are individuals with big personal (financial) losses and they usually cannot afford to pay their own treatment.

Accessibility of treatment leads to two types of problems: (a) should treatment be financed from basic health insurance or other types of health insurance?; and (b) do all the individuals who decide to get treated, receive such a treatment? We learned that different addictions, including pathological gambling, can be treated inside the public health system. However, basic insurance does not cover treatment of gambling addiction. Interviews with practitioners revealed that individuals who came to public health care facilities were accepted and treated in any case, but this was sometimes concealed from insurance companies by presenting it as some other type of addictive behaviour. In a very few cases, institutions or individual practitioners financed through contributions from the local community did specialise in treatment of pathological gambling. Notwithstanding, they did mention the shortage of staff and the lack of experience in the field of pathological gambling. In Slovenia, psychiatrists have a lot of experience in treating alcoholics and drug addicts, much more than in treating pathological gamblers. How does this fact influence equity of treatment for the same diagnosis? We believe the exchange of experience in treatment is needed as well as strengthening capacities for treating pathological gamblers.

In the field of health and social care, the following actions should be put into practice:

- we need more information on people who looked for this kind of help within social care centres and health care institutions;
- we find it necessary to organise round table discussions among experts about treating pathological gamblers aimed at exchanging best practices;
- we need more experts in the field of pathological gambling to enable equity in treatment and accessibility of such treatment. We should

encourage some psychiatrists, who deal with various addiction problems, to specialise in pathological gambling;
- we will probably need a national centre for treating pathological gamblers as well as network of psychiatrists who will regularly exchange ideas and best practices;
- the Ministry of Health should follow responsible gambling strategy while delivering concessions to psychiatrists and encourage development of a network of experts in the field;
- treatment of pathological gamblers should be free of charge as a part of the basic health care package;
- we need telephone help-lines because of the low percentage of pathological gamblers who decide to get treated. Depending on resources available, the telephone helpline could be established for pathological gamblers only, or for all addiction problems individuals might have.

The evaluation approach presented in this chapter gave us a lot of answers and many more questions that need to be answered. We believe significant further research is needed in Slovenia, particularly (a) an extensive national gambling prevalence survey to indicate the extent of current gambling problems within the population, and the categories within the population that may be particularly vulnerable to gambling problems; (b) a longitudinal research regarding the matter; (c) a national research on pathological gambling in the context of various addiction problems and their treatment; (d) a system of indicators designed to monitor the social, cultural, and economic effects of gambling at the societal level; and (e) a research on the individual characteristics of pathological gamblers. Despite some research already carried out, it is clear that Slovenia is still at an early stage of research on gambling problems and other gambling-related issues.

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Ljetopis socijalnog rada 2011., 18 (1) 127-152 str.

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IZAZOVI PROBLEMA KOCKANJA U SLOVENIJI

SAŽETAK

Rasprave o kockanju i politici prema kockanju u Sloveniji ne temelje se na mjerodavnim i pouzdanim podacima o socijalnim učincima ove pojave.

U ovom tekstu procjenjujemo socijalne troškove kockanja u Sloveniji i Goriškoj, imajući u vidu planove za moguće ulaganje u kasina. U prvom dijelu prikazali smo povijest kockanja i trenutno stanje na kockarskom tržištu. Nakon toga procijenili smo rasprostranjenost ovog problema i patološkog kockanja na temelju ograničenih dostupnih podataka te razvili scenarij mogućih trendova u budućnosti. Nakon toga ispitali smo kako Slovenija skrbi i pomaže patološkim i problematičnim kockarima i evaluirali postojeće mehanizme. Na kraju smo došli do dva zaključka. Prvo, prevencija ovisnosti o kockanju je težak zadatak, iako ekspanzija u kockarskom sektoru nužno ne dovodi do povećanja socijalnih troškova kockanja. Cjelovit sustav odgovornog kockanja, koji uključuje preventivne mjere i tretman kockarske ovisnosti je ključni cilj. Drugo, imamo malo podataka na raspolaganju o trendovima i razvoju problematičnog kockanja u Sloveniji. Od vitalne je važnosti da smo ustanovili polazište za longitudinalno istraživanje o ovoj temi koje treba postati dijelom cjelovitog sustava socijalno odgovornog kockanja.

Ključne riječi: *kockarski sektor, socijalni troškovi, problematično i patološko kockanje, prevencija i tretman, evaluacija.*