

South Australian Gambling Survey 2025

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Gambling Harm Support SA commissioned CQUniversity to conduct the analysis and reporting in line with recent reports in other jurisdictions.

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Executive summary

Background

The South Australian Gambling Survey 2025 is the fourth in a series of prevalence surveys, commissioned by Gambling Harm Support SA, following studies in 2005, 2012 and 2018. The survey monitors trends in gambling participation, problems and harm, and extends previous approaches by incorporating updated harm measurement frameworks, including harm to affected others.

Considerable changes to the South Australian regulatory and legislative environments have occurred since 2018, providing important context for the findings. The Independent Gambling Authority was abolished, with its functions consolidated under the Liquor and Gambling Commissioner. The Gambling Administration Act 1995 was replaced by a new Act in 2019, introducing updated advertising and industry codes, and 2020 amendments to the Gaming Machines Act 1992 expanded the Gamblers Rehabilitation Fund to cover prevention, public education, treatment and research. Electronic Gaming Machine (EGM) changes include banknote acceptors, facial recognition requirements for larger venues, a \$250 per card per 24-hour ATM withdrawal limit, and restrictions on accepted banknote denominations. Changes in the online gambling space include the introduction of a Point of Consumption tax, and the staged rollout of the National Consumer Protection Framework for Online Wagering, which included updated messaging, the BetStop national self-exclusion register and strengthened customer verification. In addition, the Australian Communications and Media Authority began actively blocking illegal offshore gambling sites in late 2019. In 2025, EGM entitlements became traceable through the online Gaming Machine Entitlement Exchange (GMEX).

The most notable event outside of gambling reform was the COVID pandemic, with impacts from early 2020 including periods of venue closure and lockdown. While this had a notable effect on gambling at the time, research shows that these effects have largely dissipated and are therefore unlikely to have much of an impact on the present results (Hing, Russell, et al., 2024).

Methods

The survey used a mobile-phone only sampling frame drawn from the Integrated Public Number Database (IPND), interviewing 3,000 South Australian adults by telephone. The sample is smaller than comparable surveys in other jurisdictions (~10,000 in both NSW and the ACT), which limits statistical power for some subgroup comparisons.

The survey was conducted as part of a broader study, with limited space available for questions. There are some compromises due to space that limit findings, such as a comprehensive picture of online gambling in South Australia, detailed behaviour on different gambling forms, and no question capturing legacy harm.

Weighting was applied to maximise representativeness of the South Australian adult population. Confidence intervals are not reported in the main text but are included in the technical report, along with full technical details of the study. The survey followed independently certified ethical and quality standards.

Gambling participation

54.2% of South Australian adults reported gambling in the last 12 months (51.4% if major lottery tickets, i.e., raffle-like products, are excluded). This continues a long-term downward trend from 70% in 2005, 69% in 2012 and 65% in 2018. No significant gender differences were found in terms of overall participation (56.3% for men, 52.8% for women), although this may be due to the smaller sample.

Gambling participation was highest amongst older adults (~59%), those living outside of Adelaide, those who mainly speak English at home, those born in Australia, and those with higher personal and household income. Similarly, those without a tertiary education were significantly more likely to gamble than those who had completed tertiary education (56.6% vs 46.2%).

Gambling forms and online gambling

Lotteries and scratch tickets remained the most common form of gambling (41.1%), followed by EGMs/pokies (16.9%), major lotteries (16.2%) and race betting (8.1%). Sports betting participation was 6.0%, a slight decrease compared to previous surveys, and in contrast with increases seen in NSW and the ACT.

Most other forms showed relatively small participation rates. Newer forms such as esports betting (0.4%) and fantasy sports betting (0.3%) were rare, but disproportionately associated with gambling problems.

Young men were the most likely to engage in the riskiest forms of gambling: EGMs, casino games, sports betting. Compared to the rest of the population, young men (aged 18-34) were two to three times more likely to take part in using EGMs (27.8% vs 16.9% for the population), sports betting (18.7% vs 6.0% for the population) and casino table games (16.5% vs 5.7% for the population).

A formal online gambling participation rate could not be estimated due to survey limitations, notably space constraints. However, the available evidence strongly

suggests online gambling has increased since 2018, consistent with trends in other jurisdictions.

Gambling problems (PGSI)

This report refers to gambling problems, which are a construct measured by the Problem Gambling Severity Index (Ferris & Wynne, 2001). The PGSI classifies people into groups based on their answers to nine questions. The terminology used for these groups in this report is “minimal-risk gambling” (previously non-problem gambling), “low-risk gambling”, “moderate-risk gambling” and “problem gambling”. Importantly, the labels refer to the gambling behaviour, not the person. Labels like “problem gambler” should not be used as they are seen as highly stigmatising. This concern around stigma has also sometimes been applied to the term “problem gambling”, and other terms such as “high-risk gambling” have sometimes been used, including in the recent NSW prevalence report. However, the term “high-risk” also has issues because it implies that a person is only at-risk of problems and may not actually be experiencing a problem. This also applies to other PGSI groups, as they all include the term “risk”. This issue has been debated amongst researchers, government and people with lived experience, with no resolution. For this reason, in this report we use the terms “minimal-risk gambling”, “low-risk gambling”, “moderate-risk gambling” and “problem gambling”. We reiterate that it is important to refer to problem gambling, not problem gamblers.

9.8% of South Australian adults reported some degree of problems due to gambling in 2025 (6.4% low-risk, 2.7% moderate-risk, 0.8% problem gambling), as categorised by the PGSI.

Amongst people who gambled in the last 12 months, 18.1% experienced some degree of problems. This is the highest figure recorded to date in South Australian surveys.

This reflects an **intensification** of gambling problems. While a lower proportion of South Australians is gambling, the proportion of those who experience problems amongst those who do gamble is increasing. This pattern is consistent with findings in NSW and the ACT, as well as international evidence.

Young men are the most at risk, with 8.1% of men aged 18-34 experiencing moderate-risk or problem gambling, compared with 2.0% of women in the same age group. Higher risk was also associated with not having a current partner, not completing tertiary education, and lower household income.

Forms most associated with moderate-risk or problem gambling include EGMs, casino table games, sports betting, keno, and race betting. Lotteries and scratch tickets, despite high prevalence, were associated with low rates of problems.

Gambling harm

6.5% of South Australian adults (11.9% of gamblers) reported at least one harm from their own gambling in the last 12 months, equivalent to approximately 99,083 South Australian adults. The burden of harm to gamblers from their own gambling was estimated at 20,048 Years Lived with a Disability (YLD). That is, 20,048 years of healthy life were lost in 2025 due to gambling harm (1,315 YLD per 100,000 adults). Younger men (under 54) accounted for more than half of this burden.

In 2018, the same scale was used, and found that 6.6% of South Australian adults reported 1 or more harms from their own gambling (90,309 adults), for a total of 14,668 YLD (1,056 YLD per 100,000 adults). While the absolute number of people experiencing harm increased by approximately 10% between 2018 and 2025, in line with population growth, the total burden of harm at the population level increased by almost 25%, further reflecting an intensification of harm.

7.0% of South Australian adults reported harm from another person's gambling (i.e., affected others). This represents approximately 106,705 South Australian adults, associated with an estimated 17,801 YLD (1,167 YLD per 100,000 adults). In other words, an additional 17,801 healthy years of life were lost due to gambling harm experienced by affected others.

In total, approximately 12.0% of South Australian adults (around 182,923) reported at least one harm (i.e., from their own gambling or someone else's). This equates to a total of 37,849 years of healthy life lost amongst South Australian adults due to gambling harm., or 2,482 YLD per 100,000 adults.

Gambling harm is underestimated compared to other jurisdictions because the survey did not capture legacy harm, i.e., harm that is currently experienced due to past gambling, including by people who gamble, as well as by affected others. The prevalence study only captured data from adults, so this estimate does not include harm experienced by people under the age of 18.

Key gambling forms, demographic segments and wellbeing

EGMs accounted for approximately 40% of gambling problems and harm among South Australian gamblers, making them the single largest contributor to harm. Casino table games (in venues and online) accounted for approximately 30% of problems and harm, and wagering (betting on sports, races, novelty events, esports and fantasy sports) accounted for 12-15% of problems and harm experienced by South Australian adults who gamble. Despite being the most prevalent gambling form, lotteries and scratch tickets were associated with very little of the total burden of problems and harm.

Age and gender combined were the most important demographic predictors of harm, accounting for approximately 52% of variance in gambling problems and harm experienced by South Australian adults who gamble. Young men aged 18-39 were disproportionately affected, accounting for 40.6% of total gambling harm despite comprising 18.6% of the adult population. Household income, education and marital status were also significant predictors, each accounting for approximately 9-12% of variance.

Harm to affected others was more evenly distributed across gender and age groups compared to harm to people who gamble, though age and gender still accounted for approximately 33% of variance. This reflects slightly higher harm on average amongst younger people. Personal income was the next most important predictor, with lower income generally being associated with disproportionate levels of harm.

People who reported gambling in the last 12 months but who did not experience problems or harm showed similar subjective wellbeing to people who did not gamble. Those in higher-risk PGSI categories and those endorsing more harms showed significantly lower wellbeing, validating these measures of problems and harm.

Help-seeking awareness, uptake, and preferred support

About half of all South Australian adults (50.2%) were aware of at least one gambling help service. The most recognised was the gambling helpline/hotline (28.4%).

Awareness of help services was substantially lower among people who mainly speak a language other than English at home (27.7%), and those not born in Australia (33.4%), suggesting important gaps.

Help-seeking was very low, with only 2.0% of South Australian adults using a gambling help service (0.9% for their own gambling, 1.2% for someone else's gambling). Among those who sought help, the most common service was barring/self-exclusion (48.1%).

In terms of preferred mode of support, amongst all participants, face-to-face counselling was the most popular (50.4%), followed by telephone (22.6%) and online counselling (9.8%). This preference was broadly consistent across those experiencing problems or harm.

Detailed gambling behaviour

Lotteries and scratch tickets were the forms of gambling on which people were most likely to report they spent the most money (49.4%), followed by EGMs (16.4%) and major lotteries (15.1%), broadly reflecting participation rates. The subsequent

questions are based on the form on which they spent the most money, i.e., mostly lotteries. Interpretation of results is somewhat difficult due to different structural characters of gambling forms. For example, it is difficult to have a two-hour session buying lottery tickets, but it is feasible to have a two-hour session on an EGM.

Many people gamble relatively infrequently, with more than half reporting gambling five or fewer times a year. However, 20.5% reported gambling weekly or more often, indicating a substantial number of engaged users.

Almost two-thirds reported a typical session duration of 10 minutes or less, while 4.7% reported sessions of longer than two hours. Around half spent \$20 or less per typical session, while 7.8% spent more than \$100. 12.7% reported drinking alcohol often or always while gambling. 15.2% were members of gambling loyalty programs.

Those in higher PGSI risk groups showed significantly greater engagement, including frequency, duration, expenditure, alcohol use and loyalty membership.

Implications and conclusions

Despite a long-term decline in overall gambling participation, the proportion of people who gamble who experience problems (according to the PGSI) has reached its highest recorded level in South Australia, reflecting an intensification of gambling problems among an active, but shrinking, gambling population.

EGMs remain a primary concern as the primary contributor to gambling harm, consistent with findings in other jurisdictions. Policy approaches targeting EGM accessibility and harm-minimisation features are well supported by these data.

Young men, especially those aged 18-34, carry a disproportionate share of harm from their own gambling. This is due to being the most prevalent users of the most harmful forms of gambling: EGMs, casino games and sports betting.

Help-seeking remains very low relative to harm, and awareness is unequal across the population. Culturally and linguistically diverse groups are a notable gap.

These findings generally align with those seen in other jurisdictions. The similar analysis and reporting approach in this report facilitates direct comparisons with the recent NSW and ACT reports where possible.

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Chapter 1: Introduction

1.1 Background

The Experimental Gambling Research Laboratory at CQUniversity was commissioned by Gambling Harm Support SA to conduct the statistical analysis and reporting of the 2025 South Australian Gambling Survey. The survey was conducted within a broader survey, the Population Health Survey Module System (PHSMS), with fieldwork conducted by Ipsos Australia. Ipsos also assisted with data preparation and weighting calculations.

This is the fourth South Australian prevalence study, following previous studies in 2005 (South Australian Department of Health, 2005), 2012 (Office for Problem Gambling, 2013) and 2018 (Woods et al., 2018). Sample sizes were 17,745 (2005), 9,508 (2012) and 20,017 (2018). This 2025 study has a smaller sample size, N = 3,000, due to its inclusion as part of another survey, the 2025 PHSMS, commissioned by the Department of Human Services South Australia. These prevalence surveys are used to assess and monitor changing trends in participation in established and emerging gambling forms, and to assess the extent of gambling harm in the population, including assessing demographic and geographic profiles of people who gamble and of people who experience harm.

The 2025 survey builds on previous surveys, incorporating the latest measures of gambling-related harm (the Gambling Harms Scale – 10 items; GHS-10), as well as a measure of harm for people affected by somebody else's gambling (Gambling Harms Scale for Affected Others – 10 items; GHS-10-AO). These measures are asked amongst those who have gambled in the last 12 months (GHS-10) or family members, friends, or others in close relationships with a person who gambles (GHS-10-AO). The survey also uses the Problem Gambling Severity Index (PGSI), in line with previous South Australian surveys.

The previous surveys have each been conducted using the best practices of the time. The 2005 study recruited participants via random selection from the White Pages (a telephone directory). Telephone numbers were randomly selected from the Adelaide metropolitan and country regions EWP telephone listings. Within each household, the person who had their birthday most recently, and was 16 years or older, was selected for interview. There was no replacement for noncontactable persons. The 2012 study used a dual-frame methodology, with three-quarters of the interviews from randomly generated (RDD) landline numbers, and one-quarter of the interviews from participants selected from a list-based mobile phone sample. The 2018 study used a multi frame design, where participants could be recruited via landline, mobile phone or both (for people who owned both). Of the final sample, 77.8% were recruited via landline and 22.2% via mobile phone. The 2025 data were

captured exclusively via mobile phone numbers, using the Integrated Public Number Database (see Chapter 2 for more information about the IPND), with N = 3,000 participants. Interviews were conducted in other languages to ensure broader coverage of people who speak a language other than English (LOTE).

In 2025, only mobile phone numbers were included because landline ownership has continued to decline to the point that including landlines would lead to a decrease in data quality. While landlines can be targeted based on area codes, mobile phone numbers are not local to specific areas of Australia. To enable targeted calls to mobile phone numbers, Ipsos applied for and gained access to the Integrated Public Number Database (IPND). The IPND is a list of most Australian phone numbers, including landlines, payphones, mobile phone numbers and unlisted numbers, and also includes owner details, such as place of residence. The IPND can be used for research when this research is related to public health, and approval to use the IPND was gained on these grounds. This shift in sampling was necessary due to changes in consumer telephone use, and is in line with studies in other jurisdictions. The current survey also included the option for interviews in another language.

While the 2025 sample is expected to be representative of the population, the necessary change in methodology in 2025 means that comparisons with previous surveys should be treated with caution. For this reason, no statistical comparisons are shown with previous years, and instead trends over time are shown in figures. As discussed below, the smaller sample has meant some compromises in analysis, particularly subgroup analysis. This is most notable with reporting by a smaller number of age groups (2 or 3 depending on the analysis), compared to six age groups in other jurisdictions.

1.2 How have the gambling environment and products changed in South Australia since the last survey?

South Australia's gambling landscape has undergone significant transformation since the last prevalence study in 2018, following the Hon Tim Anderson KC's review of the administrative arrangements for the regulation of commercial gambling in the state. A key structural change was the consolidation of regulatory oversight under the Liquor and Gambling Commissioner, who became the single regulator of commercial gambling following the abolition of the Independent Gambling Authority and the transfer of its functions.

Substantial legislative reform has also occurred since 2018. Amendments to the Gaming Machines Act 1992, proclaimed on 30 July 2020, expanded both the State Government's contribution to the Gambler's Rehabilitation Fund (GRF) (increasing it by one million dollars per annum) and the scope of eligible expenditure. The scope now encompasses prevention activities, public education and information programmes, treatment and counselling for those harmed by gambling, relevant

information and advice, and gambling research and evaluation, whereas historically, at least 85% had to be directed towards treatment and counselling programmes.

The Gambling Administration Act 1995 was repealed and replaced by a new Gambling Administration Act 2019, introducing a revised administrative and regulatory framework. This brought with it amendments across regulations under each of the gambling acts, updated advertising and responsible gambling codes of practice, and new community impact guidelines. Among the practical changes introduced were revised rules governing the times and manner in which gambling may be advertised on radio or television; a new welfare barring arrangement; the introduction of banknote acceptors to electronic gaming machines (EGMs); a requirement for venues with more than 30 EGMs to implement facial recognition technology to help identify barred persons where at least one machine accepts note insertions; a \$250 per card per 24-hour limit on cash withdrawals in gaming venues; introduction of maximum credit balance limits; and new community impact assessment guidelines¹².

In 2020, Gambling Harm Support SA (GHS SA), operating within the Department of Human Services, explored options to operationalise the expanded legislative scope, which culminated in the *Minimising Gambling Harm in South Australia – Investment Plan 2021 to 2026*³. More recently, in 2025, a further development reshaped the South Australian gaming machine market, with gaming machine entitlements now able to be traded online through the Gaming Machine Entitlement Exchange (GMEX)⁴⁵.

The COVID-19 pandemic had significant short-term impacts on venue-based gambling, although South Australia had fewer lockdowns than other jurisdictions like NSW and Victoria. An initial lockdown occurred in November 2020, initially planned for six days, but restrictions were eased after approximately three days. An additional lockdown occurred during July 2021 for seven days following a cluster of COVID cases in Modbury Hospital. During these lockdowns, hospitality venues were shut for approximately three months from March 2020⁶, resulting in no access to venue-based gambling, particularly EGMs. Research from other jurisdictions has shown that, while COVID lockdowns resulted in reductions in venue-based gambling, figures have largely returned to pre-COVID trajectories (see Figures 1 and 2) (Hing, Russell, et al., 2024). The fieldwork for the present study occurred in 2025, after the

¹ https://www.cbs.sa.gov.au/documents/misc-documents/fn_gambling_reform_update_aug_2021b86c.pdf

² <https://www.cbs.sa.gov.au/sections/LGL/banknote-acceptors-and-ticket-in-ticket-out-systems#:~:text=The%20devices%20accept%20all%20Australian,machines%20must%20meet%20these%20requirements>

³ <https://gamblingharmssupport.sa.gov.au/about/investment-plan-2021-to-2026>

⁴ <https://www.sa.gov.au/topics/business-and-trade/gambling/running-a-gaming-venue/trading-gaming-entitlements>

⁵ <https://www.cbs.sa.gov.au/campaigns/gmex>

⁶ <https://www.abc.net.au/news/2020-06-30/reopening-pokies-a-missed-opportunity-for-gambling-addiction/12405272>

effects of COVID on gambling had dissipated, so COVID is unlikely to have had an effect on the results.

The regulatory environment for *online* gambling has also changed considerably since the 2018 survey, including through the staged implementation of measures under the National Consumer Protection Framework for Online Wagering (NCPF). These measures include updated messaging to replace the longstanding "gamble responsibly" tagline, the establishment of the National Self-Exclusion Register (BetStop), and strengthened customer verification requirements.

A Point of Consumption tax on online wagering (the Betting Operations Tax⁷) was introduced on 1st July 2017, with South Australia being one of the first to apply this tax. This was initially set at 15%, based on Net Wagering Revenue (i.e., bets minus payouts), with the first \$150,000 being tax-free. This rate has stayed unchanged since its introduction. This resulted in tax being collected by the jurisdiction where the bet was placed or, if unknown, the bettor's registered address, rather than the jurisdiction where the online bookmaker is licensed. While this tax was introduced prior to the previous survey, it has since become common across other states and territories in Australia, changing online betting taxation nationally.

In November 2019, the Australian Communications and Media Authority began blocking illegal offshore gambling sites, including online casinos, online EGMs, and online poker platforms, making it more difficult for Australian residents to access these services and potentially reducing participation in those forms of online gambling.

While venue-based gambling has largely recovered to pre-COVID trends across other jurisdictions, the broader uptake of digital technologies has continued apace, potentially accelerated by the pandemic period. Prevalence surveys conducted in other jurisdictions point to an increase in online gambling participation during this time (Browne et al., 2024; Rockloff et al., 2025), a context worth bearing in mind when interpreting the present findings.

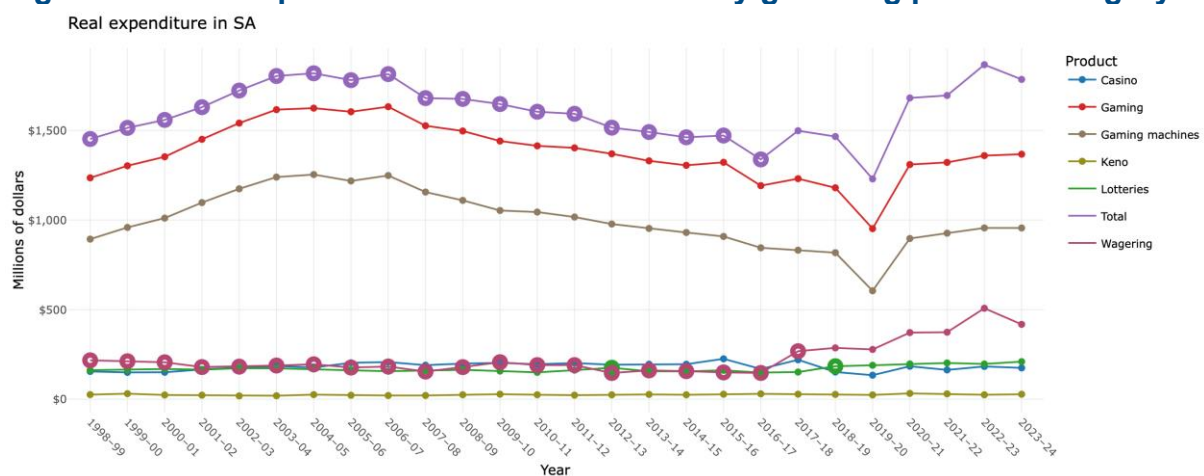
1.3 Australian Gambling Statistics

The figures below show the real (i.e., adjusted for inflation) expenditure in South Australia by gambling product category in total (Figure 1), and on a per capita basis (Figure 2). These figures are sourced from the Australian Gambling Statistics published by the Queensland Government Statisticians Office, and reproduced under a creative commons 4.0 license (Queensland Government Statistician's Office, 2024). The general downwards trend in EGMs (brown line) is also reflected in the total (purple) and gaming total (i.e., EGMs and casinos, red line), although a slight

⁷ <https://www.revenuesa.sa.gov.au/betting-operations-tax>

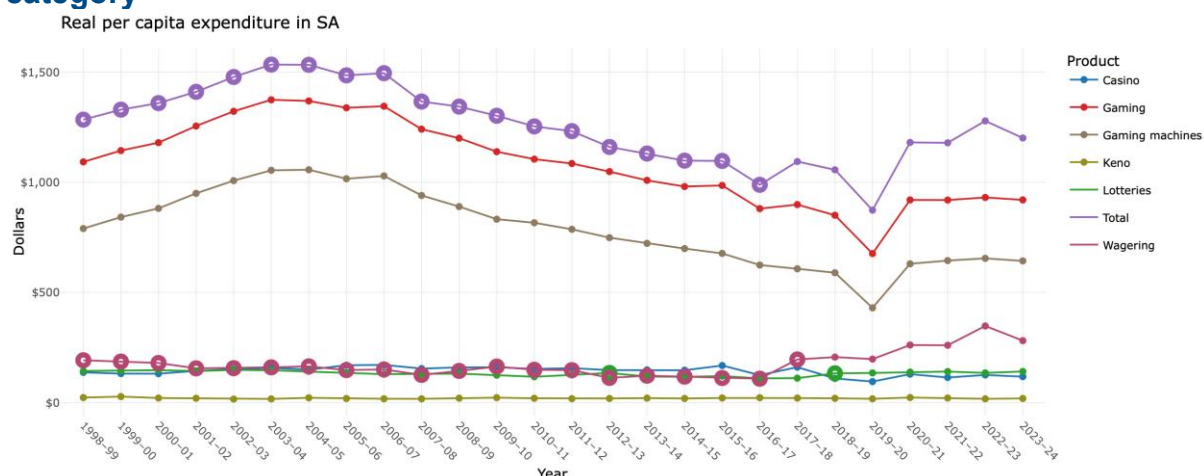
upwards trend is evident in recent years after a temporary drop in 2019-20 due to COVID restrictions. EGM revenue for 2025 topped \$1 billion, from 11,735 EGMs, for the first time (Consumer and Business Services, 2023). Wagering expenditure has increased, in part due to the change to a Point of Consumption tax (the Betting Operations Tax described above) from 1st July 2017, whereby revenue is paid to the jurisdiction in which the betting took place or, if unknown, the jurisdiction of the registered address of the bettor, rather than the jurisdiction where the betting operator is licensed. While this accounts for the initial rise around 2017, the trend for wagering has continued upwards.

Figure 1 – Real expenditure in South Australia by gambling product category



Queensland Government Statistician's Office, Queensland Treasury, Australian Gambling Statistics, 40th Edition. Note: Wagering, and therefore total, data incomplete until 2017-18. Lotteries reporting changed in 2012-13 to be turnover minus prizes won by participants, and in 2018-19, pools was withdrawn from the Australian Lottery market.

Figure 2 – Real per capita expenditure in South Australia by gambling product category



Queensland Government Statistician's Office, Queensland Treasury, Australian Gambling Statistics, 40th Edition. Note: Wagering, and therefore total, data incomplete until 2017-18. Lotteries reporting changed in 2012-13 to be turnover minus prizes won by participants, and in 2018-19, pools was withdrawn from the Australian Lottery market.

1.4 Research objectives

The survey captured data on gambling participation and gambling-related harm in South Australia. Where possible, data were aligned with previous surveys for comparison over time, and with current practices in other jurisdictions, notably the gambling harm measures. Specific objectives were to:

- Investigate gambling participation by activity,
- Measure gambling harm experienced by people due to their own gambling,
- Measure gambling harm experienced by people due to someone else's gambling,
- Enable comparisons with contemporary prevalence studies in other jurisdictions,
- Determine changes over time, noting changes in sampling frames,
- Identify at-risk population sub-groups,
- Investigate co-occurrence of health and wellbeing issues and gambling harm.

1.5 Structure of the report

This report is organised into the following chapters:

- **Chapter 2: Methodology** describes the survey design, sample characteristics, sampling methods, weighting and subsampling, analytical approaches and reporting conventions used in the report.
- **Chapter 3: Participation in gambling** presents findings on overall gambling participation, trends over time, and associations with demographics.
- **Chapter 4: Participation and frequency of gambling on each form, online gambling** provides prevalence and demographic comparisons for engagement in different gambling forms, plus online gambling analysis.
- **Chapter 5: Gambling problems** examines the prevalence of gambling problems using the Problem Gambling Severity Index (PGSI) and analyses risk factors.
- **Chapter 6: Gambling harm** explores the extent and nature of gambling-related harm, including impacts on people who gamble and affected others.
- **Chapter 7: Detailed gambling harm** includes more advanced analyses related to problems and harm, including proportion of problems and harm attributable to different products and demographic characteristics, and relationships with wellbeing.
- **Chapter 8: Help services** explores awareness and uptake of help services, and preferences for different help services.
- **Chapter 9: Detailed gambling behaviour** includes information on which gambling activity people spend the most money on, frequency duration and expenditure in typical sessions, time of day when people gamble, alcohol use while gambling and loyalty program membership.
- **Chapter 10: Discussion** synthesises key findings, discusses implications, and offers conclusions based on the survey results.

Appendices include additional information on weighting and sampling, as well as the survey instrument, margins of error and sample demographics. A separate technical report includes further details on sampling, weighting and other technical details.

Chapter 2: Methodology

This chapter summarises the methodology used for the South Australian Gambling Survey 2025 to assist in interpreting and understanding the results. It includes a high-level description of the methodology. More information is provided in the appendices and a separate technical report.

The project was carried out in compliance with ISO 20252, the Australian Data and Insights Association (ADIA) and The Research Society (TRS) standards. The 2025 Population Health Survey Module System was approved by the Department for Health and Wellbeing Human Research Ethics Committee (approval number 2020/HRE00418). CQUniversity obtained approval to conduct the data analysis from the CQUniversity Human Research Ethics Committee (approval number 25968).

2.1 Methodology overview

A total of 3,000 people aged 18 years or older from South Australia were surveyed via computer-assisted telephone interviews (CATI). The fieldwork period started in July and finished in September 2025. The response rate (completions amongst those eligible) was 9.6%, and the cooperation rate (completions amongst those who were eligible and with whom contact was made) was 91.9%. The survey took 14.9 minutes to complete on average (standard deviation = 4.1 minutes, median = 14.4 minutes). Twenty-two interviews were conducted in a language other than English (eight in Vietnamese, seven in simplified Chinese, four in Spanish, 2 in Arabic and one in Russian).

The survey was designed by the Gambling Harm Support SA (GHS SA), with some discussion with the Experimental Gambling Research Laboratory at CQUniversity in relation to harms measures. The survey was designed to be similar to previous years, while also incorporating elements (e.g., harm to affected others) that allow for cross-jurisdictional comparisons. Fieldwork, weighting and the technical report were conducted by Ipsos. The weighting was confirmed by CQUniversity, and all analyses were conducted by CQUniversity.

2.2 Sample characteristics

The sample is described in Table 1 below. Due to the use of probability sampling, the sample characteristics are very similar to those of the South Australian population. Weighting was applied to align the sample with the population on key demographics, but given the *unweighted* sample values and population values were similar, the effects of these weights were mild. Please see section 2.3.2 for further detail. Of particular note is the good representation of young people, who are often difficult to recruit to surveys.

Table 1 – Unweighted and weighted sample data and population data for gender and age

Gender and age						
Demographic	No weight	Weight	Pop'n	No weight	Weight	Pop'n
	Including don't know, refused, non-binary/gender diverse			Excluding don't know, refused, non-binary/gender diverse		
Gender						
Male or man	53.7%	48.6%	49.0%	54.2%	49.0%	49.0%
Female or woman	45.5%	50.5%	51.0%	45.8%	51.0%	51.0%
Non-binary/gender diverse	0.5%	0.6%	-	-	-	-
Prefer not to say	0.3%	0.3%	-	-	-	-
Age						
18-34	29.1%	27.8%	27.8%			
35-54	28.8%	30.2%	30.2%			
55+	42.1%	42.0%	42.0%			

Note: N = 3,000. No weight refers to unweighted sample data, weight to weighted sample data, and population to population data. Data sources: ABS Estimated Residential Population, 2024 release for age and sex. Prior to the forthcoming 2026 Census, the ABS collected sex, rather than gender, with no non-binary/gender diverse option available. A set of figures from the sample excluding non-binary/gender diverse responses is shown above to facilitate an accurate comparison between the sample and population.

2.3 Methods overview

This section includes a broad overview of the methodology. For further details, including detailed information about the weighting and subsampling, please refer to the appendices and technical report.

2.3.1 Mobile phone only sampling frame

The 2018 prevalence survey was an overlapping design, where participants could be selected by landlines, mobile phones, or both (for those who owned both). The final sample consisted of 77.8% recruited via landlines, and 22.2% via mobile phone. However, since 2018, the use of landline phones has declined. In 2022, about 1.6% of Australians had a landline, but not a mobile phone, and this is strongly biased towards older Australians⁸. Further, in 2022, 63% of Australians had a mobile but not a landline, and 34% had both a mobile and landline. Given this continual decline in landline ownership, and the almost ubiquitous nature of mobile phone ownership, contacting potential participants via landlines in 2025 would have decreased sample quality.

Therefore, the 2025 survey used only mobile phone numbers, in line with current practices across other jurisdictions and study topics. Phone numbers were provided from the Integrated Public Number Database (IPND). The IPND is a record of most

⁸ <https://www.acma.gov.au/publications/2022-10/report/how-australians-make-voice-calls-home>

Australian phone numbers, including listed and unlisted numbers. Permission was received from the Australian Communications and Media Authority to use the IPND database for this survey on 6th June 2025. While previous surveys have used random digit dialling (RDD) to randomly select participants from the population, the use of a list of telephone numbers still allows for random selection from the population, which is crucial for representative samples. A specific rule of using the IPND is that participants cannot be contacted for other purposes, such as follow-up surveys, so no contact details were retained.

Other details about the methodology are provided in the separate Technical Report.

2.3.2 Weighting

While the random selection from the population should result in a sample with approximately similar age and gender characteristics to the population, weighting is used to correct deviations to further maximise representativeness of calculated statistics. The sample was weighted for age and gender based on data from the Australian Bureau of Statistics for South Australia, specifically the 2023 Estimated Resident Population figures, which were the latest available at the time. People who have regular access to multiple mobile telephone numbers were also more likely to be selected. Additional weights were applied to account for this. In addition to age, gender and mobile telephone ownership, data were also weighted for marital status, education, dwelling status, employment status, metro/regional, household size and country of birth.

Table 1 above shows unweighted and weighted demographics, as well as population figures. The weighted and unweighted figures are very similar, indicating minimal effect of weighting, which is ideal. In the final weighted sample, age and gender are identical to the population as the sample was weighted on these variables.

All estimates (e.g. means and percentages), in this report are calculated using population weights unless explicitly specified otherwise.

Due to rounding and exclusion of don't know/refused responses, percentages may not sum to 100%.

2.3.3 Subsampling

There was no subsampling relevant to the gambling questions in this survey, so no subsample weights were required.

2.3.4 Survey instrument

The full survey instrument is provided in Appendix A.3.

There was a fieldwork error where the survey was in field for approximately one week, while missing one of the GHS-10 items, specifically “Felt ashamed of your gambling”. A total of 521 completed the survey without this item. Harm may therefore be underestimated for these people, and therefore for the total sample.

2.4 Reporting conventions

2.4.1 Terminology for PGSI groups

The Problem Gambling Severity Index categorises participants into four categories. The labels for these categories are “non-problem gambling”, “low-risk gambling”, “moderate-risk gambling” and “problem gambling”. PGSI category names have come under scrutiny, partly because people in the “problem gambling” category have sometimes been called “problem gamblers”, a term that is generally recognised as stigmatising. Some surveys have used alternative terms, such as “high-risk gambling” (Australian Gambling Research Centre, 2023; Browne et al., 2024), however these may also be problematic because this terminology can imply that people in this category are only at risk of experiencing problems, but may not actually be experiencing them. The issue of PGSI terminology is yet to be resolved and current work is being conducted to attempt to resolve this issue. Therefore, we have retained the “problem gambling” category name until a better term is determined.

However, we have modified the “non-problem gambling” category to “minimal-risk gambling”. This is because people in this category may not have endorsed an item on the PGSI scale, but it does not necessarily mean that they are entirely free from problems. No scale is perfectly accurate.

Therefore, for this report, the terms for the PGSI categories are:

- **“minimal-risk gambling”**,
- **“low-risk gambling”**,
- **“moderate-risk gambling”** and
- **“problem gambling”**.

It is important that the term “problem gambler” is avoided. Where it is necessary to refer to people in these categories, phrases such as “people experiencing problem gambling” are used. Binary analyses combine moderate-risk and problem gambling groups, and the combined category for the higher risk groups is referred to as “moderate-risk or problem gambling”. To help readers, we have included reminders

about how the new label for minimal-risk gambling aligns with the previous label (non-problem gambling) at regular intervals in the report.

Some analyses in Chapter 7 determine the relative importance of demographics and gambling forms in relation to gambling problems. These analyses use a continuous variable to measure gambling problems, reported as a log transformation of the raw PGSI score (+1). Rather than reporting the level of risk for each group, the analyses in Chapter 7 refer to PGSI scores.

2.4.2 Terminology for gender groups

Many analyses feature comparisons by age and gender. These figures or tables show data for each age category, including overall for the total sample, and then separately for men and women. A total of 15 participants responded to the question about gender with an answer other than man or woman and 10 people preferred not to respond. While separate lines are plotted by age group for men and women, it was not possible to plot an age line for people who identified as another (or no) gender by age group, due to small numbers in each age bracket. However, an overall statistic for people identifying as another (or no) gender is reported in these plots. Verbatim responses indicated a wide range of gender responses amongst these 15 people, such as “non-binary”, “gender queer”, or other terms. Points could not be plotted separately for each identity, due to low numbers of responses, so these 15 participants are plotted together under a single category, referred to as **“non-binary/gender diverse”**. This terminology is also used in recent prevalence surveys (Browne et al., 2024; Rockloff et al., 2025), and the terminology in that report was based on guidance from ACON as well as discussions with inclusivity teams in both the governments and CQUniversity. We recognise that these terms may not encompass every identity, and that terminology may change over time.

2.4.3 Statistical reporting and conventions

The 2025 survey includes a smaller sample size than is typical of prevalence surveys, with 3,000 participants compared to 5,000–20,000 (mode = 10,000) in previous studies in South Australia and other jurisdictions. This smaller sample size has implications for the level of detail that can be reliably reported, for the stability of estimates, and for the statistical power of analyses. In particular, it necessitates the use of broader reporting categories, as reporting by multiple demographic variables (e.g., age and gender) can result in small cell sizes and unstable estimates. This is especially relevant for lower-prevalence behaviours, such as engagement in most gambling activities, and experience of problems and harm, where participation rates in some forms are quite low (e.g., below 10%). This means that subgroup analyses may be based on very small numbers of respondents. This can result in estimates with large uncertainty, reducing the ability to generalise findings to the South Australian population. To address these constraints, reporting decisions have been

made to prioritise robustness over granularity, including the use of two or three age categories rather than the six age categories reported in other jurisdictions (see below for further explanation).

Statistical comparisons are made between categories but not interactions. No statistical comparisons are made with previous surveys, due to concerns about comparability given the change in sampling frame, and the small sample size for the current study. However, results are shown from previous surveys to put current results into context, and trends over time are interpreted holistically. For readability, the text sometimes refers to the present survey date as '2025'. Although all fieldwork was conducted in 2025, many key measures are based on a 12-month time frame (unless specified otherwise) and therefore technically provide a snapshot of part of the 2024-2025 period. A similar approach is applied when referring to prior surveys, with the year denoting the time at which survey fieldwork was completed. The authors recognise that it is a long document, and some users may refer only to specific sections. For this reason, certain acronyms (e.g., LOTE) are spelled out in full (e.g., language other than English) in some places in the report. Table 2 summarises the technical terms used in the report.

Where statistical comparisons are conducted, most are reported with respect to binary categories, for example comparing moderate-risk or problem gambling prevalence rates among people who have completed tertiary education compared to those who have not. Significant effects are noted with asterisks. If present, they indicate a statistically significant difference: $*p<.05$, $**p<.01$, $***p<.001$. In tables, when significant differences are present, the asterisks are shown next to the larger statistic, which is also shown in **bold**. However, some comparisons are made with respect to multiple categories, notably income. Reporting multi-category comparisons creates a small reporting dilemma in terms of which category is compared to which. Reporting all possible category comparisons presents readability issues, and avoiding multi-level statistical comparisons completely is undesirable. In this report, multiple-category groups are typically *ordered* groups, such as PGSI risk categories (minimal-risk to problem gambling) or income. Thus, we opted to select the split at which we judged the mean difference to be most informative, and where significant, highlight the grouping for which the statistic is higher, as described above. Where no discernible ordered effect exists, no test was conducted. This approach provides for a more informative and readable summary. However, they are necessarily post-hoc comparisons with researcher discretion involved, and the usual caveats should be applied to such comparisons.

Figures and tables indicate who was asked each question, and the source of the data (i.e. the question wording, or calculations to create the relevant variable). There are some instances where reporting is based on the whole sample, even though some relevant data were only captured from some participants. For example, to determine the proportion of adults who experienced harm due to their gambling in the last 12 months, those who did not gamble in the last 12 months were not asked

about harms experienced, and it was inferred that they had not experienced harm from their own gambling in the last 12 months, because they had not gambled.

Where participants refused or did not know the answer to a question, they are not counted towards the percentage, i.e., percentages are amongst those who answered the question. The exception was for calculating scores on scales (e.g., PGSI, GHS-10, GHS-10-AO), as missingness would result in no scale score. In these cases, missing data were treated as a “no” response, so as not to inflate estimates of problems or harm. Missingness due to refusals or not knowing varied by question, but there were typically <10 missing cases per question, i.e., less than 1% of the data, indicating very little effect on results. The exception was income, where people who refused or replied “don’t know” are reported as a separate group.

Due to the weighting procedure used, all analyses can be considered representative of South Australian adults. However the small sample size leads to wide confidence intervals around estimates, particularly for smaller groups. Confidence intervals are not shown in this report, to aid readability, but appendix A.4 includes reference tables and explanatory text to help interested readers determine confidence intervals and/or margins of error.

Analyses were organised to ensure that cell sizes were sufficient to detect meaningful differences. The most notable case of this is combining those in the moderate-risk and problem gambling groups for certain comparisons, when the number of those in the problem gambling group in the sample was insufficient for further breakdowns. Since the risk factors for moderate-risk and problem gambling are very similar, this results in little loss of information. In cases where cell sizes are low enough to preclude firm interpretation (<30 cases) this is noted in the text. In most cases, small cells are combined with others for analyses, but in some cases are excluded, particularly in relation to income and Aboriginal and Torres Strait Islander status in certain analyses. These instances are noted in the text. Some analyses, especially related to help-seeking, have a small total n.

For most age by gender analyses, age is divided into three age brackets. For some analyses, particularly around harm, age is treated as two categories (18-39 vs 40+). This is to facilitate interpretation of results in situations where too many age brackets may make the message difficult to follow. For example, the mosaic plots in relation to intersections of gambling harm to self and affected others use two age brackets as three age brackets would make the plots very difficult to follow.

Supporting text around tables and figures is designed to draw out particularly salient differences or effects. In general, these are differences that are both statistically significant and of meaningfully large magnitude. The supporting text is not intended to exhaustively repeat all information in figures and tables. Some figures are reported in **bold blue text**, to help them stand out in the text. These are generally headline figures.

Table 2 – Acronyms and terms used in this report

Acronym	Definition	Notes
PGSI	Problem Gambling Severity Index	Population screen for gambling problems (Ferris & Wynne, 2001).
Minimal-risk gambling	People whose gambling shows no identifiable signs of problems	PGSI category associated with a score of 0, previously referred to as “non-problem gambling”.
Low-risk gambling	People who, based on their scores on the PGSI, show low-level gambling problems	PGSI category associated with a score of 1 or 2. It is the same as the original PGSI category of low-risk gambling.
Moderate-risk gambling	People who, based on their scores on the PGSI, show moderate-level gambling problems	PGSI category associated with a score of 3 to 7. It is the same as the original PGSI category of moderate-risk gambling.
Problem gambling	People who, based on their scores on the PGSI, show high-level gambling problems	PGSI category associated with a score of 8 or higher, sometimes referred to as “high-risk” in other surveys.
Moderate-risk to problem gambling	People who, based on their scores on the PGSI, show moderate- to high-level gambling problems.	PGSI category associated with a score of 3 or higher. It is the same as the original PGSI categories of moderate-risk gambling and problem gambling combined.
GHS-10	The 10-item Gambling Harms Scale	Population screen for harm arising from one’s own gambling (Browne, Newall, et al., 2023).
GHS-10-AO	The 10-item Gambling Harms Scale for Affected Others	Population screen for harm arising from another person’s gambling (Browne, Newall, et al., 2023)
HRQoL	Health Related Quality of Life	A public health concept whereby one (1) reflects a 12-month period of ideal health and wellbeing and zero (0) reflects a life not worth living. Morbidity from health conditions, including harmful gambling, is understood as a decrement (e.g. -0.17) to this index. See Ashing-Giwa (2005) for an overview.
YLD	Years Lived with a Disability	For a condition such as harmful gambling, HRQoL decrements may be summed over individuals to capture the aggregate impact to health and quality of life (morbidity) incurred by population segments. This measure excludes any increased risk of mortality. The version calculated here includes only the last 12 months, not integrated over the lifespan.
LOTE	Language other than English	Participants were asked whether English was the main language they spoke at home (yes/no). This is a separate question to whether they would like to complete a survey in another language.
EGMs	Electronic gaming machines	Also known as pokies.
Sports betting	Betting on sporting events	Some surveys capture “novelty betting” (i.e., betting on events such as reality TV shows, elections or other events) within the sports betting category. In the current survey, sports betting was captured separately from novelty betting..

Chapter 3: Participation in gambling

Gambling participation in 2025 and over time

- Gambling participation (i.e., gambling on any form) in the last 12 months in South Australia has decreased over time, down to 54.2% in 2025, compared to figures between 65-70% from 2005 to 2018. If major lottery tickets are excluded, the figure is 51.4%.

Gambling participation by demographics

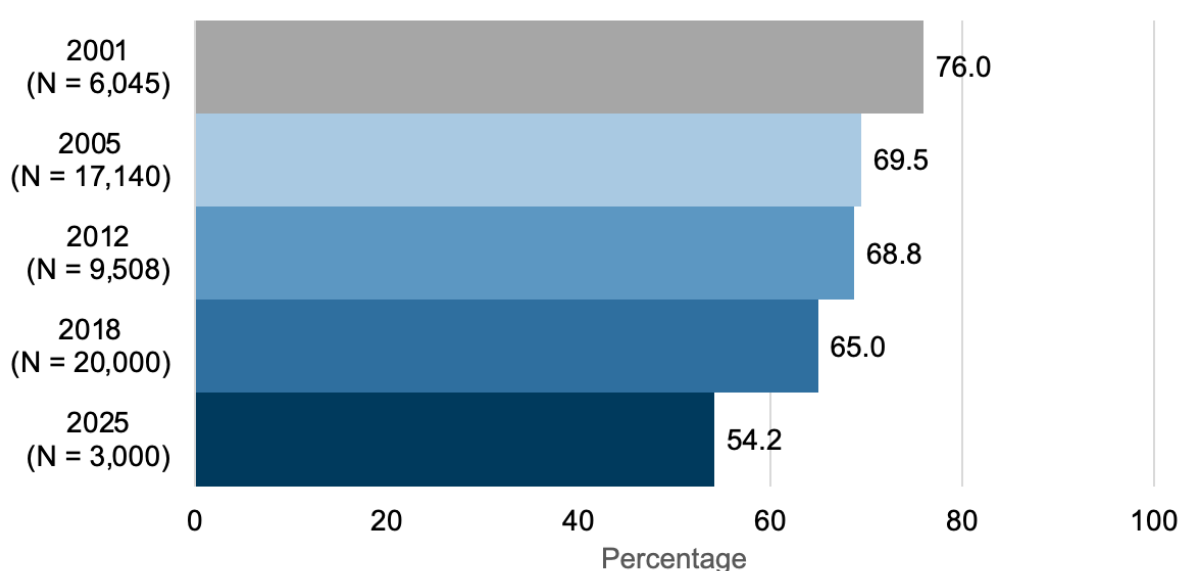
- No significant differences were observed between men and women in terms of the proportion taking part in any form of gambling in the last 12 months. Older people (35-54 and 55+; 58-59%) were significantly more likely to gamble in the last 12 months compared to younger people (18-34; 43.1%).
- Gambling participation was highest amongst those who lived outside of Adelaide (60.3% vs 52.5%), mainly spoke English at home (59.1% vs 36.2%), those born in Australia (60.4% vs 41.3%), those married or living with a partner (56.2% vs 52.1%) those in paid employment (56.4% vs 51.4%), and those who had not completed tertiary education (56.6% vs 46.2%). Participation rates were also higher for those with higher personal and household income.

3.1 Gambling participation (last 12 months) overall, and over time

In the 2025 survey, **54.2%** reported gambling on one or more gambling forms in the last 12 months. This includes all surveyed gambling forms, including lotteries and scratch tickets, EGMs, race betting, sports betting, casino table games, keno, bingo, novelty betting and informal betting. It also includes newer forms: betting on esports and fantasy sports, and online EGMs and casino games. This does not include simulated gambling (e.g., social casino games, loot boxes). If major lottery tickets are excluded, 51.4% of adults reported gambling in the last 12 months.

Figure 3 below shows how the proportion of South Australian adults taking part in any gambling form in the last 12 months has decreased over time. It is important to note that methodological differences and changes in surveyed gambling forms have occurred between the surveys, which may impact on results.

Figure 3 – Gambling participation (last 12 months) over time, 2001-2025



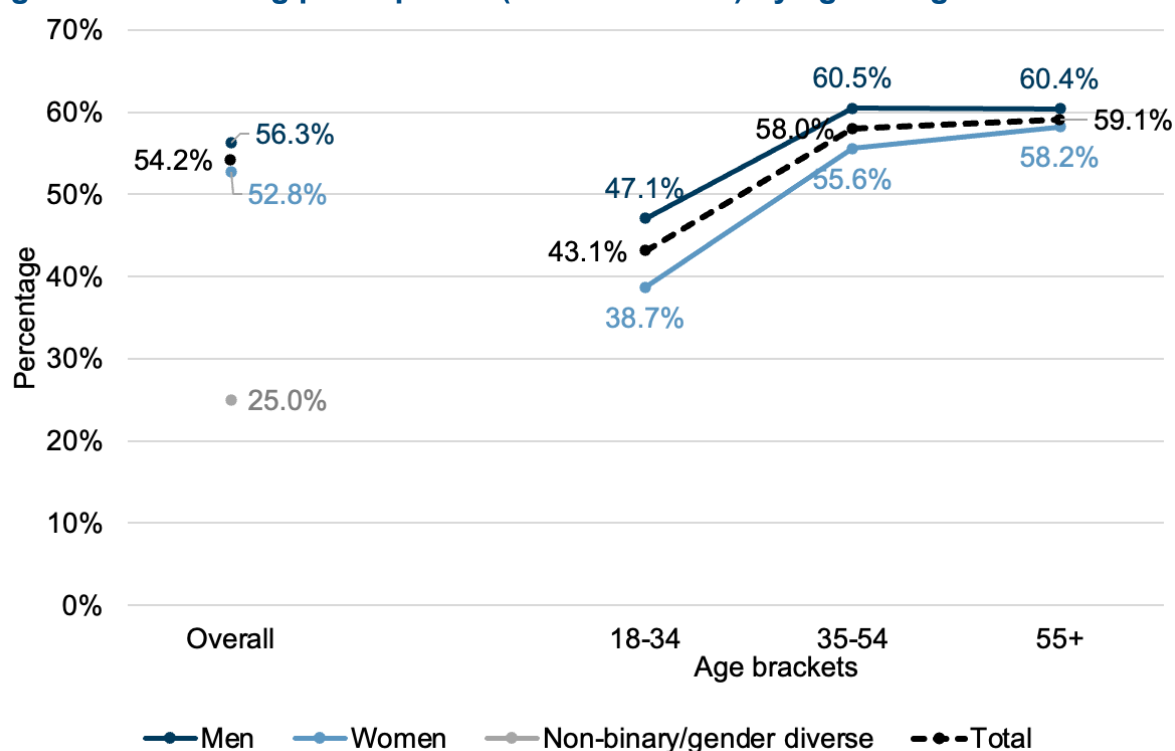
"In the last 12 months have you done the following....?" Base: All participants (N = 3,000). The gambling forms have changed each year, as have the sampling methods; caution should be applied when comparing between surveys. Data are weighted where appropriate and total N for each year is shown in the figure.

3.2 Gambling participation (last 12 months) by age and gender

Figure 4 below is the first age x gender figure in this report, and this section describes how to interpret them. The dots on the left, for “overall” show the total percentage for the sample (black dot), here 54.2%, for men (the darkest blue dot, 56.3%), for women (lightest blue dot, 52.8%), and for people who identify as non-binary or gender diverse (please see reporting conventions in Chapter 2; light grey dot, 25.0%). Gender comparisons can only be done on the basis of men vs women, due to a small number of participants identifying as another or no gender. Results from these comparisons are shown by asterisks next to the overall figure for the highest proportion, if a significant difference is observed. No gender difference was found in the comparison below, so no asterisks are shown. The line segments indicate age trends. The black dashed line shows the age trend for all participants, while the coloured lines show age trends separately for men (darkest blue) and women (lightest blue). No line is possible for non-binary and gender diverse people, due to low counts.

No gender difference was found in terms of gambling on any form in the last 12 months. In terms of age, gambling was highest amongst those aged 35 or older. The association between gambling participation and age was approximately similar for men and women. (Figure 5).

Figure 4 – Gambling participation (last 12 months) by age and gender



*“In the last 12 months have you done the following....” Base: All participants (N = 3,000). Asterisks (if present) indicates a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$. No age line is shown for non-binary/gender diverse participants due to low counts in all cells.*

3.3 Gambling participation (last 12 months) by other demographics

Gambling participation was significantly higher amongst people who lived outside of Adelaide, mainly speak English at home, were born in Australia, were currently living with a partner, were in paid employment, had not completed tertiary education, and who had higher personal and household income (Table 3).

Table 3 – Gambling participation by demographics

Demographic	Gambling participation
SA adults	54.2%
Location	
Adelaide	52.5%
Elsewhere in South Australia	60.3%***
Main language at home	
English	59.1%***
LOTE	36.2%
Country of birth	
Australia	60.4%***
Another country	41.3%
Identify as Aboriginal and/or Torres Strait Islander	
Yes	58.8%
No	54.1%
Married or living with a partner	
No (including divorced, separated, widowed, single)	52.1%
Yes	56.2%*
In paid employment	
No (including student, retired, etc)	51.4%
Yes (full time, part time, casual)	56.4%**
Tertiary education	
No	56.6%***
Yes	46.2%

Table 3 – Gambling participation by demographics (cont)

Demographic	Gambling participation
Personal income, per year	
Refused or don't know	41.5%
\$1 to \$25,999	42.0%
\$26,000 to \$51,999	54.1%***
\$52,000 to \$90,999	62.0%***
\$91,000 to \$155,999	64.7%***
\$156,000 or more	60.6%***
Household income, per year	
Refused or don't know	41.6%
\$1 to \$25,999	45.6%
\$26,000 to \$51,999	54.1%***
\$52,000 to \$90,999	56.1%***
\$91,000 to \$155,999	56.2%***
\$156,000 or more	64.3%***

*"In the last 12 months have you done the following....?" Base: All participants (N = 3,000). Asterisks (if present) indicates a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$.*

Chapter 4: Participation by gambling form, including online

Levels of participation by gambling form

- The most common form of gambling in the last 12 months remained buying lottery tickets or scratch tickets (41.1% of South Australian adults).
- This was followed by EGMs/pokies (16.9%), major lotteries (16.2%) and race betting (8.1%).
- Sports betting (6.0%), casino table games (5.7%), Keno (5.7%) and bingo (4.3%) were the next most popular forms. Most other forms showed relatively small participation rates, including newer forms such as esports betting (0.4%) and fantasy sports betting (0.3%).
- Participation rates have generally declined over time for all forms, with the exception of bingo. While sports betting has increased in other jurisdictions, the current South Australian data shows a slight decrease.

Demographic comparisons

- Demographic analysis for each form is limited due to the sample size. The analyses focus on forms with higher participation (e.g., lottery and scratch tickets), and those of specific interest (EGMs, casino table games, sports and race betting)
- Young men were the most likely to engage in EGMs, casino table games, race betting and sports betting in the last 12 months. In contrast, younger people were the least likely to buy lottery or scratch tickets (24.0% vs ~47% for older age groups), although uptake was still relatively high compared to other forms.
- Other demographic comparisons are not statistically significant for all forms, but where differences were found, those more likely to take part in these forms were most likely to live outside of Adelaide, speak English as their main language at home, be born in Australia, be in paid employment, and to not have completed tertiary education.

Online gambling

- Due to limited space in the survey, a formal online gambling participation rate could not be estimated. However, figures from previous South Australian studies, prevalence studies in other jurisdictions, and the

Australian Gambling Statistics data indicate that it is highly likely that online gambling participation rates have increased since 2018.

- The survey included participation in online EGMs and casinos, which cannot legally be provided to Australian residents. The results show that approximately 1.9% of South Australian adults took part in this form in the last 12 months.
- In addition, participants who had gambled in the last 12 months were asked where they had gambled most often, including online, in venues, at a TAB outlet, via a phone call or at a racetrack. Online (34.5%) was the most common response. It is important to note that this does not necessarily indicate online gambling on wagering products (e.g., race or sports betting), and the majority of this likely reflects buying lottery tickets online, based on data from other jurisdictions.
- Because this question includes online gambling on lottery tickets as well as wagering products, and these two types of products show different demographic uptake, no demographic analysis on online gambling was conducted.

4.1 Gambling participation for each form (last 12 months) overall, and over time

Figure 5 indicates the proportion of adults reporting engagement with each form, over time. Methodological changes between surveys, and the small sample size for the current study, mean that statistical comparisons over time have not been conducted. Instead, the results below describe general trends in the data, which are largely in line with the decline in proportion of adults taking part in gambling, as reported in Chapter 3.

Some traditional gambling forms have shown a decrease in participation rates:

- Lotteries and scratch tickets (combined) (48.0% in 2018 to **41.1%** in 2025)
- EGMs (26.5% in 2012 to 19.0% in 2018 to **16.9%** in 2025)
- Race betting (20.5% in 2012 to 12.0% in 2018 to **8.1%** in 2025)
- Keno (8.0% in 2018 to **5.7%** in 2025).

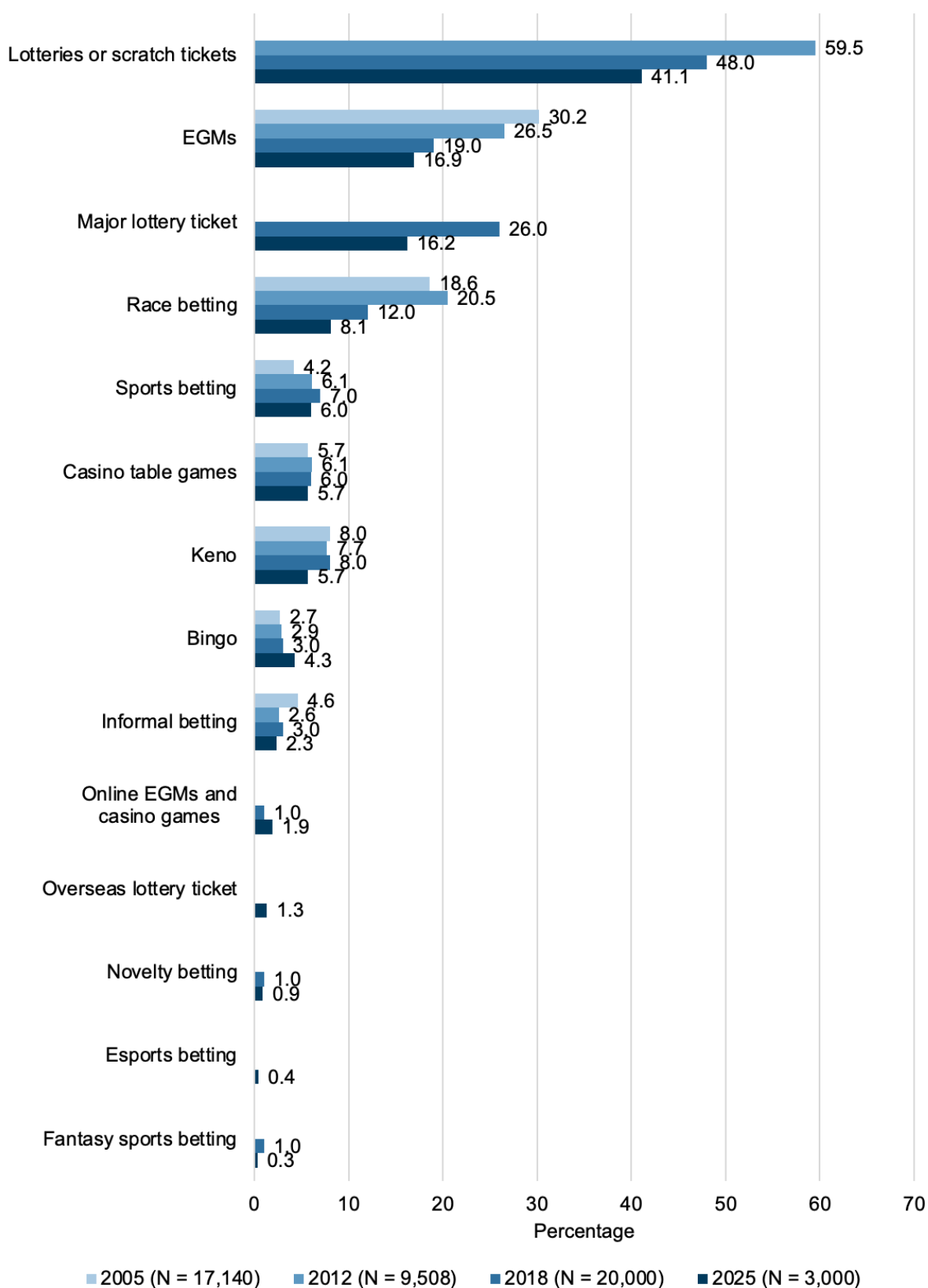
Sports betting has generally shown an increase over time, up from 4.2% in 2005, although a small decline in 2025 (**6.0%**, down from 7.0% in 2018). Bingo showed a small increase, from 3.0% in 2018 to **4.3%** in 2025.

Some forms were included for the first time, including esports betting (0.4%), overseas lottery tickets (1.3%) and online EGMs and casino games (1.9%). Fantasy sports betting was included for the second time, showing a decline from 1.0% in 2018 to 0.3% in 2025.

For most other forms, participation rates were largely similar to that seen in 2018, including casino table games, informal betting and novelty betting.

The *relative* participation rates of forms are similar over time – that is, while most forms have shown a decrease over time or have remained relatively stable, the *order* of forms in terms of participation rates has been consistent over time. Lotteries and scratch tickets remain the most popular form, followed by EGMs and race betting. Sports betting, casino table games and Keno all have similar participation rates to each other.

Figure 5 – Gambling participation by form of gambling activity over time, 2005-2025



"In the last 12 months have you done the following....?" Base: All participants over time, with Ns indicated in the legend. 2005 data for lottery or scratch tickets not available. Other missing data (e.g., esports betting prior to 2025) reflects that that form was not included in the survey for that year.

4.2 Gambling participation on each form by age, gender and other demographics

Figure 6 shows the percentage of all South Australian adults who gambled on select forms in the last 12 months by age and gender. The Y axis (%) differs between forms due to different participation rates. Due to statistical power considerations, these analyses focus on select forms that have higher participation rates and are of specific interest (EGMs, casino table games, race and sports betting), as well as lotteries, the form with the highest participation rate.

Men were significantly more likely to take part in EGMs, casino table games, sports betting and race betting, but not lotteries, compared to women. For EGMs, casino table games and sports betting, this was particularly apparent for younger men (18-34). In contrast, older people (35-54 and 55+) were more likely to buy lottery or scratch tickets compared to younger people (18-34).

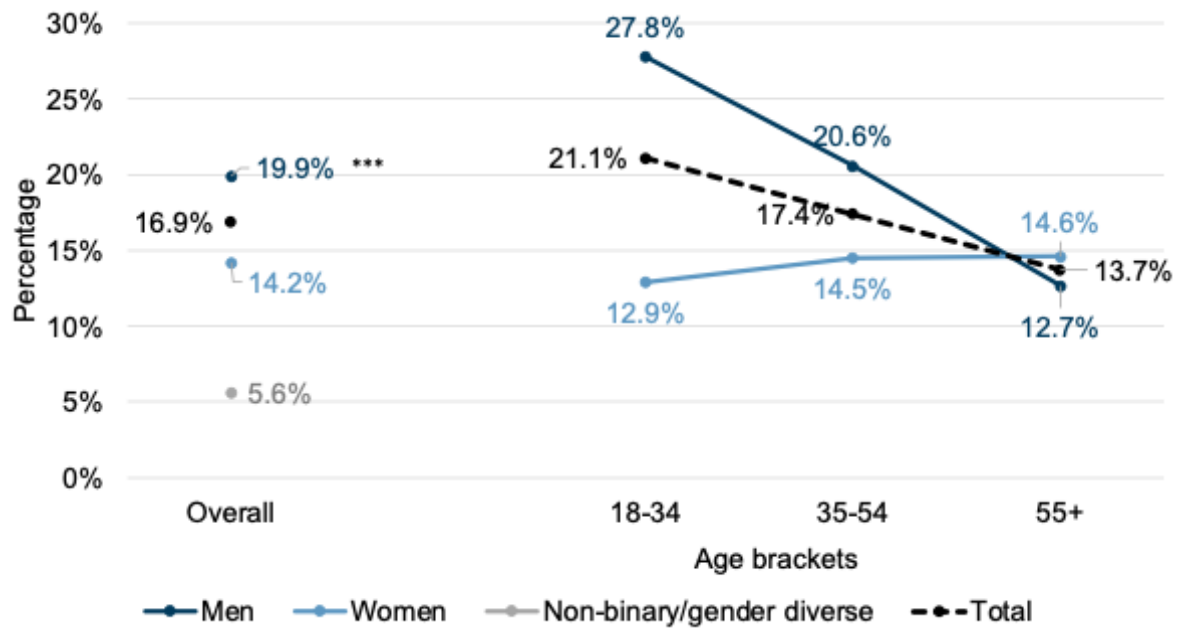
Further demographic comparisons were conducted across these five forms. Due to statistical power, analyses could not be conducted to compare results based on Aboriginal and Torres Strait Islander status, or personal or household income.

Results differ slightly by form (see Table 4). However, generally, where significant differences were observed, the same pattern was observed across forms. For example, differences by location (Greater Adelaide vs elsewhere in South Australia) were observed for EGMs, race betting and lottery and scratch tickets, but not casino table games or sports betting. Where differences were observed, people who lived elsewhere in South Australia were significantly more likely to engage in that form.

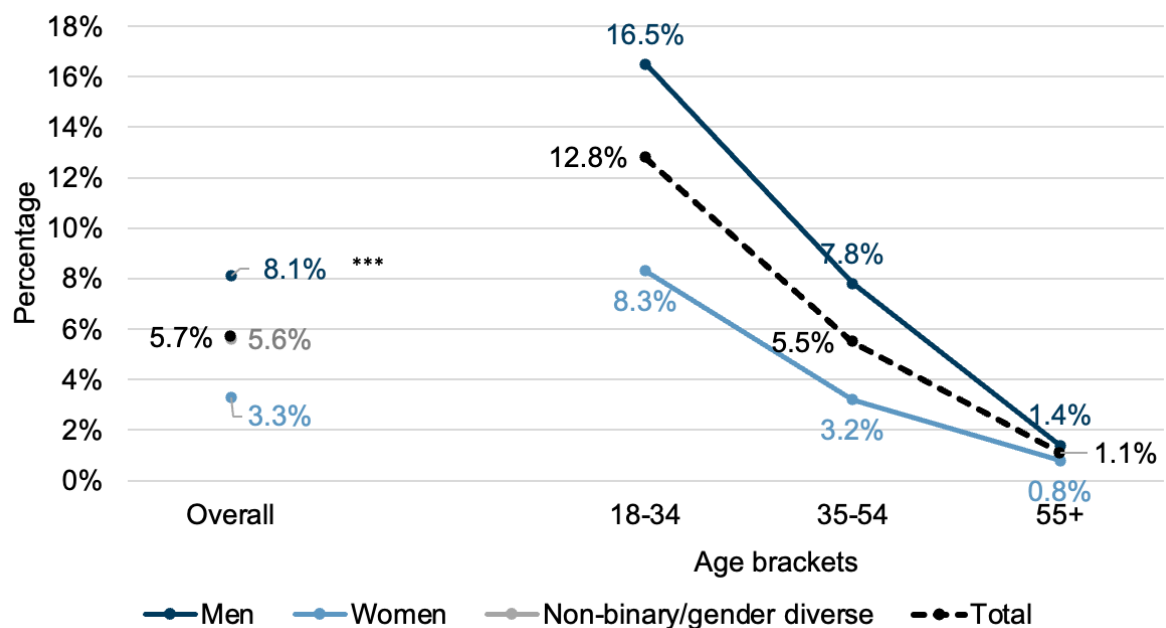
People who mainly spoke English at home and who were born in Australia were significantly more likely to take part almost all forms compared to people who speak another language, or who were born in another country. Those in paid employment were significantly more likely to take part in all forms except lottery and scratch tickets. Those who had not completed tertiary education were significantly more likely to take part in all five forms.

Figure 6 – Participation in select forms of gambling by age and gender, 2025

EGMs



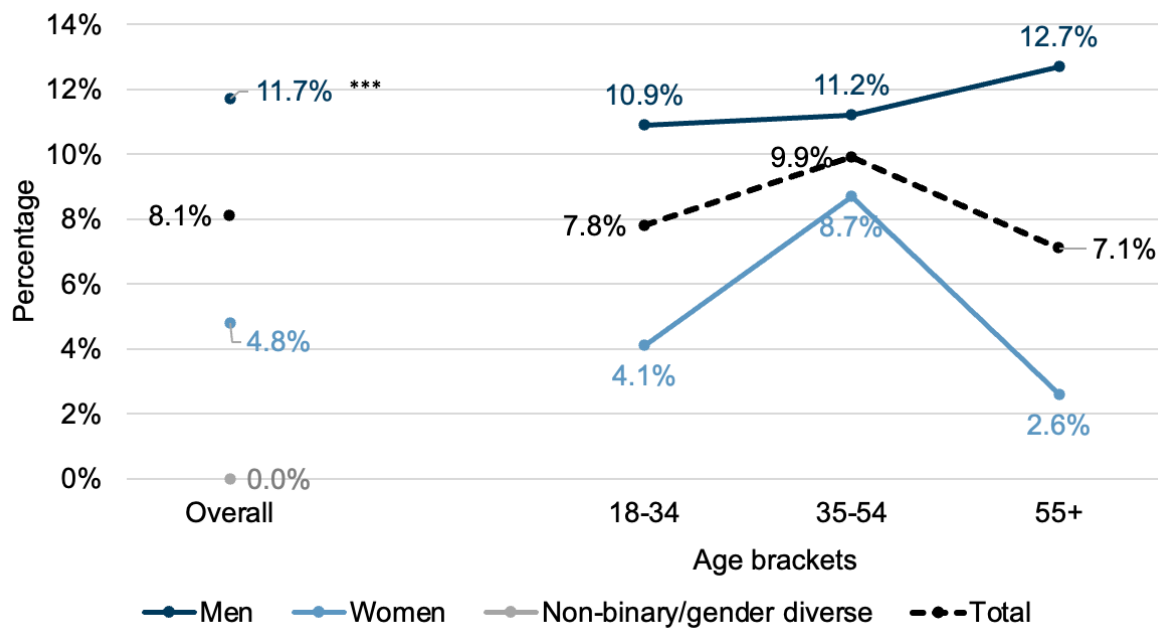
Casino table games



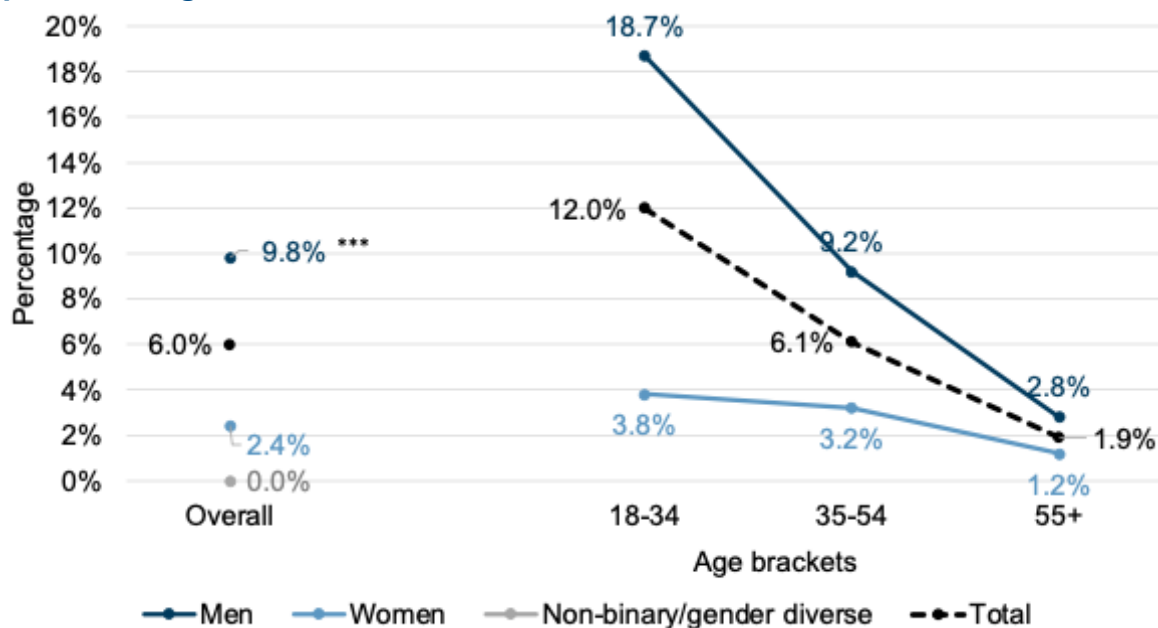
In the last 12 months have you done any of the following....?" Base: All participants (N = 3,000).

Figure 6 – Participation in select forms of gambling by age and gender, 2025 (continued)

Race betting



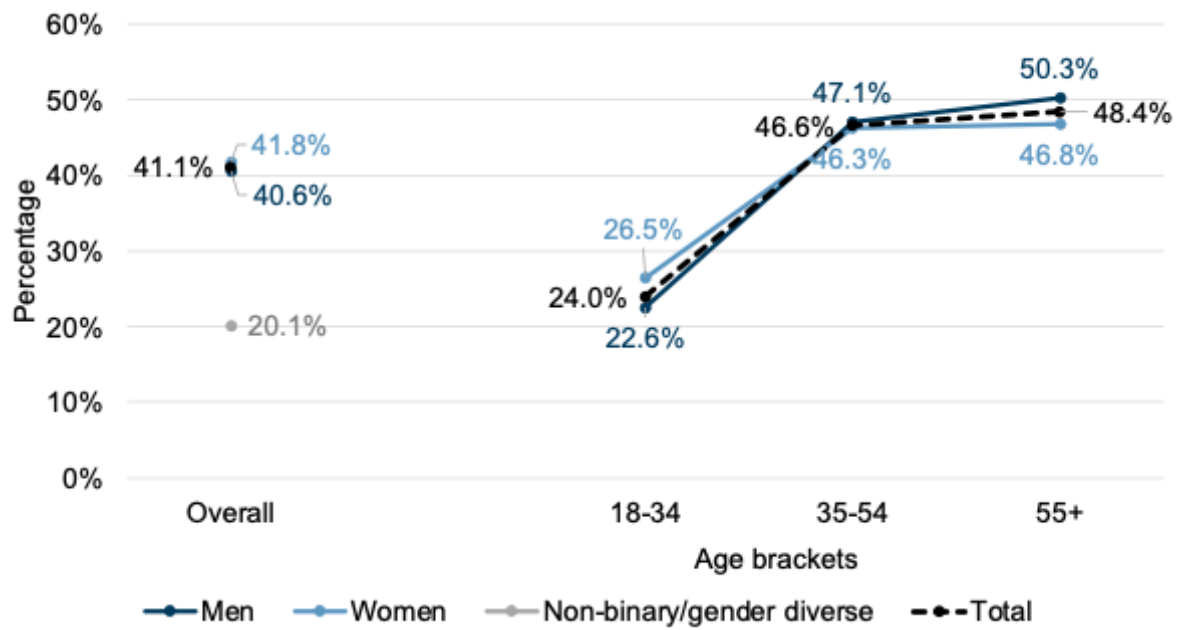
Sports betting



"In the last 12 months have you done the following.....?" Base: All participants (N = 3,000).

**Figure 6 – Participation in select forms of gambling by age and gender, 2025
(continued)**

Lotteries



“In the last 12 months have you done the following....?” Base: All participants (N = 3,000).

Table 4 – Participation in select forms of gambling in the last 12 months by other demographics

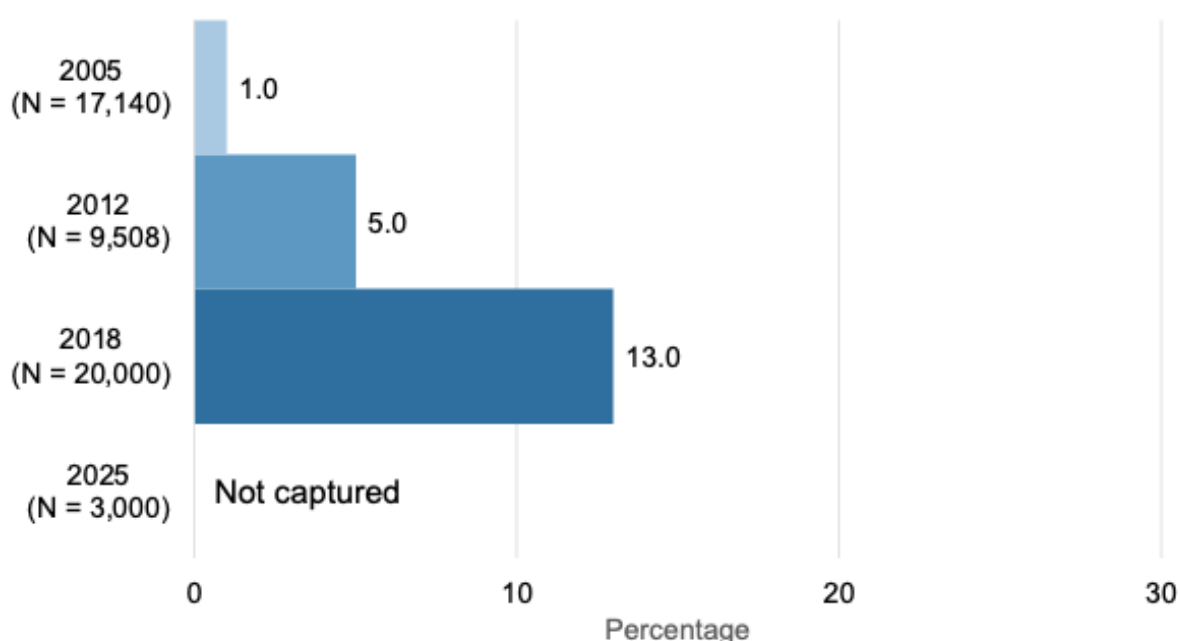
Demographic	EGMs	Casino table games	Race betting	Sports betting	Lottery and scratch tickets
SA adults	16.9%	5.7%	8.1%	6.0%	41.1%
Location					
Adelaide	16.0%	5.9%	7.4%	6.3%	39.4%
Elsewhere in South Australia	20.0%*	4.9%	10.7%**	4.9%	46.7%***
Main language at home					
English	19.2%***	6.0%	9.8%***	6.5%*	44.8%***
LOTE	8.4%	4.3%	2.5%	4.1%	27.2%
Country of birth					
Australia	20.3%***	6.4%*	10.5%***	7.2%***	45.5%***
Another country	9.6%	4.2%	3.0%	3.4%	31.7
Married or living with a partner					
No (including divorced, separated, widowed, single)	19.7%***	6.5%	7.9%	6.5%	37.3%
Yes	14.3%	5.0%	8.3%	5.5%	44.5%***
In paid employment					
No (including student, retired, etc)	14.6%	2.4%	6.5%	2.5%	40.1%
Yes (full time, part time, casual)	18.6%**	8.2%***	9.3%**	8.6%***	41.8%
Tertiary education					
No	19.6%***	6.1%*	9.1%***	6.5%*	42.6%***
Yes	7.6%	4.1%	4.7%	4.2%	35.6%

*"In the last 12-months have you done the following....?" Base: All participants (N = 3,000). Asterisks (if present) indicates a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$. Results could not be shown for income or Aboriginal or Torres Strait Islander status due to statistical power constraints.*

4.5 Online gambling participation (last 12 months) overall, and over time

In Australia, only certain forms of gambling can be legally provided online to Australian residents. These include buying lottery tickets (but not scratch tickets), and betting on sports, races, novelty events, esports and fantasy sports (i.e., wagering products), provided the bet is not placed during the match or race. In some jurisdictions, keno can also legally be provided online. Other gambling forms, such as EGMs and casino games, are available online in other countries, but are not supposed to be available to Australian residents. The legal forms (lottery tickets and wagering products) are also available in venues and via some other means (e.g., telephone call). To properly assess online gambling participation, it is necessary to ask each participant which forms they have engaged in online. Due to the limited space available in the survey instrument, this information was not captured this year, and trends in online gambling in South Australia cannot be determined. However, based on trends over previous surveys, trends in other jurisdictions, and Australian Gambling Statistics data, it is very likely that the current online gambling participation rate has increased since 2018. Caution should be applied to interpretation of this result, as it can easily be interpreted as an increase in online participation in wagering products only. However, data from other jurisdictions shows that increases are largely due to increases in purchasing lottery tickets online, given the high prevalence of lottery ticket purchasing.

Figure 7 – Online gambling participation (last 12 months) over time, 2005-2025



A combination of engagement in forms that are only available online (e.g., online casino games, online EGMs), and online engagement in forms that can be done online or in venues (e.g., lotteries, wagering products, Keno). Base: All participants (N shown for each year).

4.6 Online gambling participation (last 12 months) by form

Online gambling was captured in two ways in the survey: online gambling for specific forms (this section), and most commonly used mode of gambling (next section).

The survey captured participation in certain forms that are only available online. The uptake amongst South Australian adults in the last 12 months for these forms was:

- Online EGMs and casinos (1.9%),
- Overseas lottery tickets (1.3%), and
- Online Keno (0.9%).

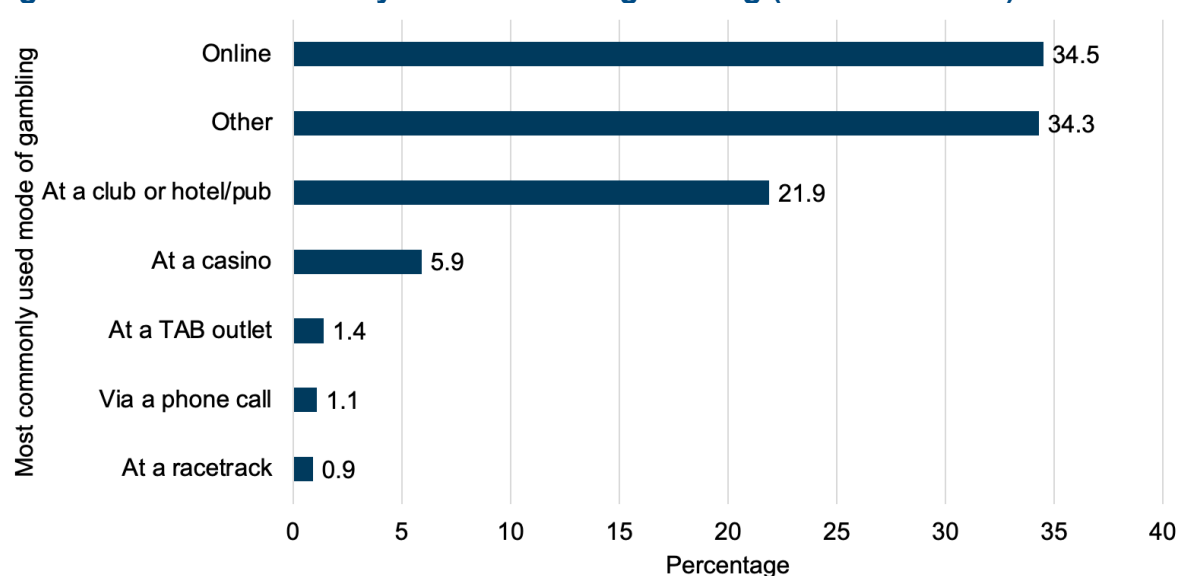
Due to space constraints, the survey did not capture online gambling on forms that are available both online and in venues (e.g., lotteries, sports and race betting).

4.7 Most commonly used mode of gambling

Participants who had gambled in the last 12 months were asked where they gambled most often. Response options included at a club or hotel/pub, at a casino, at a racetrack, at a TAB outlet, online using a website or mobile app, via a phone call, and other. Slightly more than one-third of participants reported “other”, with the vast majority of these describing venues such as newsagencies, chemists, pharmacies, services stations and supermarkets, likely reflecting lottery ticket or scratch ticket purchases.

The most common response was online (34.5%), followed by other (see note above, 34.3%), at a club or hotel/pub (21.9%), at a casino (5.9%), at a TAB outlet (1.4%), via a phone call (1.1%) and at a racetrack (0.9%).

Figure 8 – Most commonly used mode of gambling (last 12 months) 2025



“Which gambling activity have you spent the most money on overall, not including winnings?” Base: All participants who gambled in the last 12 months (N = 1,627).

Chapter 5: Gambling problems

Gambling problems in 2025, and over time

- The proportion of South Australian adults who took part in gambling in the last 12 months has decreased since previous surveys. This is also reflected with corresponding decreases in the proportion of people in the minimal-risk (previously non-problem) gambling category, but limited change in the low-risk, moderate-risk and problem gambling categories.
- In 2025, 9.8% of South Australian adults experienced some degree of gambling problems (6.4% low-risk gambling, 2.7% moderate-risk gambling, 0.8% problem gambling). Note that figures do not sum perfectly due to rounding.
- Due to the change in the proportion of people gambling, it is useful to consider these figures amongst people who gamble, allowing a comparative baseline. Amongst people who gambled in the last 12 months, 18.1% experienced some degree of problems due to their gambling (11.7% low-risk, 4.9% moderate-risk, 1.5% problem gambling).
- While the proportion of people who gambled in the last 12 months has declined since previous surveys, the proportion of people experiencing problems has increased, reflecting an **intensification** of gambling problems.

Gambling problems by demographics

- Subsequent comparisons in this chapter are based on the proportion of participants reporting either moderate-risk or problem gambling. Readers are referred to Chapter 7 for a more continuous approach to the PGSI, i.e., using PGSI scores rather than categories.
- Due to the relatively small sample size, some statistical comparisons are underpowered. For this reason, readers should be cautious in interpreting non-significant results as reflecting no difference in the population.
- Men, and particularly young men, were the most likely to experience moderate-risk or problem gambling. Amongst men aged 18-34, 8.1% experienced this level of problems, compared to 4.4% of men aged 35-54 and 1.8% of men aged 55+. For women, 2.0% of those aged 18-34, and those aged 55+, experienced this level of problems, compared to 3.5% of women aged 35-54.

- Those with lower income, no tertiary education and those not married or living without a partner were significantly more likely to experience moderate-risk or problem gambling.

Gambling problems by participation on different gambling forms

- These analyses report the overall prevalence of each form, and the proportion of those engaging in each form who experience moderate-risk of problem gambling. This does not necessarily reflect problems specifically due to that gambling form (see Chapter 7 for this analysis), but instead reflects the consumers of each form.
- Generally, the forms that are used by the highest proportion of people experiencing problems are lower-prevalence forms (e.g., esports betting, fantasy sports betting) or those that cannot be legally provided to Australian residents (e.g., online EGMs and casino games).
- Of the more prevalent forms, sports betting, casino table games, EGMs, keno and race betting are used by a higher proportion of people experiencing gambling problems.
- In contrast, lotteries and scratch tickets are the most prevalent form of gambling in South Australia, but are used by relatively low proportions of people with gambling problems.

5.1 Problem Gambling Severity Index, groups overall, and over time

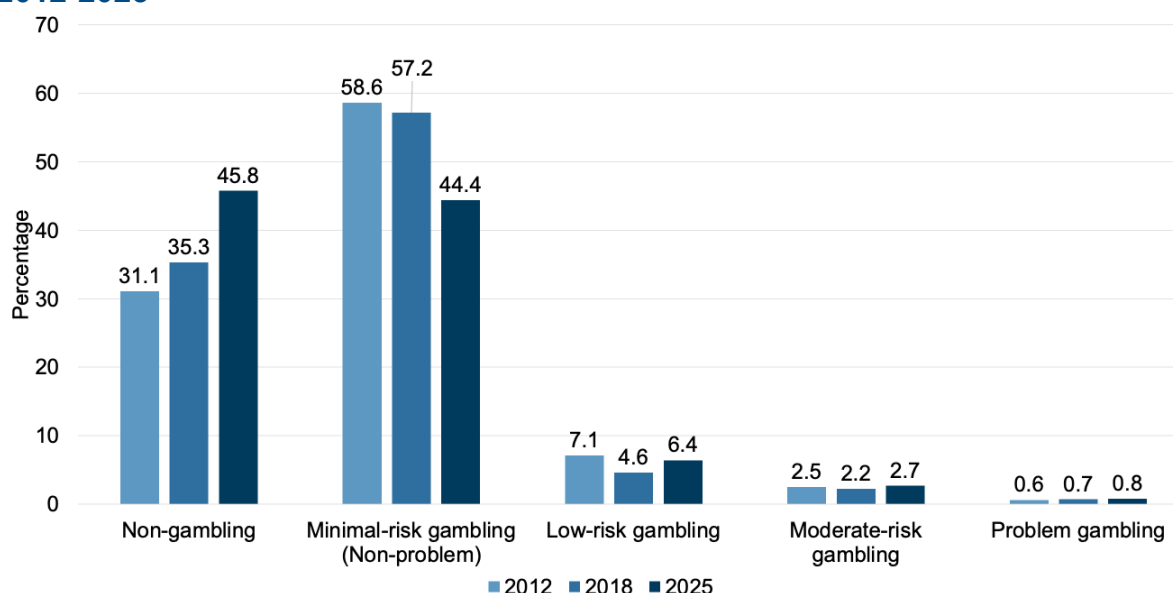
Figure 10 shows the proportion of South Australian adults in each PGSI risk category from 2012 to 2025, including people who did not gamble. This figure reflects ordered levels of risk, from minimal-risk (previously referred to as non-problem) gambling, through low-risk, moderate-risk and problem gambling. Please see Chapter 2 for a discussion around PGSI terminology.

In the 2005 survey, the PGSI was only asked of people who gambled frequently (at-least fortnightly), unless they only bought lottery tickets or took part in bingo. Since 2012, the PGSI was asked of all participants who had gambled in the last 12 months. The 2005 data, therefore, are not comparable and are not presented.

In line with falling participation rates, the proportion of people who had not gambled has increased since 2012. The proportion of people in the various risk groups (low-risk, moderate-risk and problem gambling) have remained relatively stable as a proportion of the adult population (Figure 9).

Overall, **9.8%** of adults in South Australia (approximately 149,400 people) experienced low-risk, moderate-risk or problem gambling in 2025.

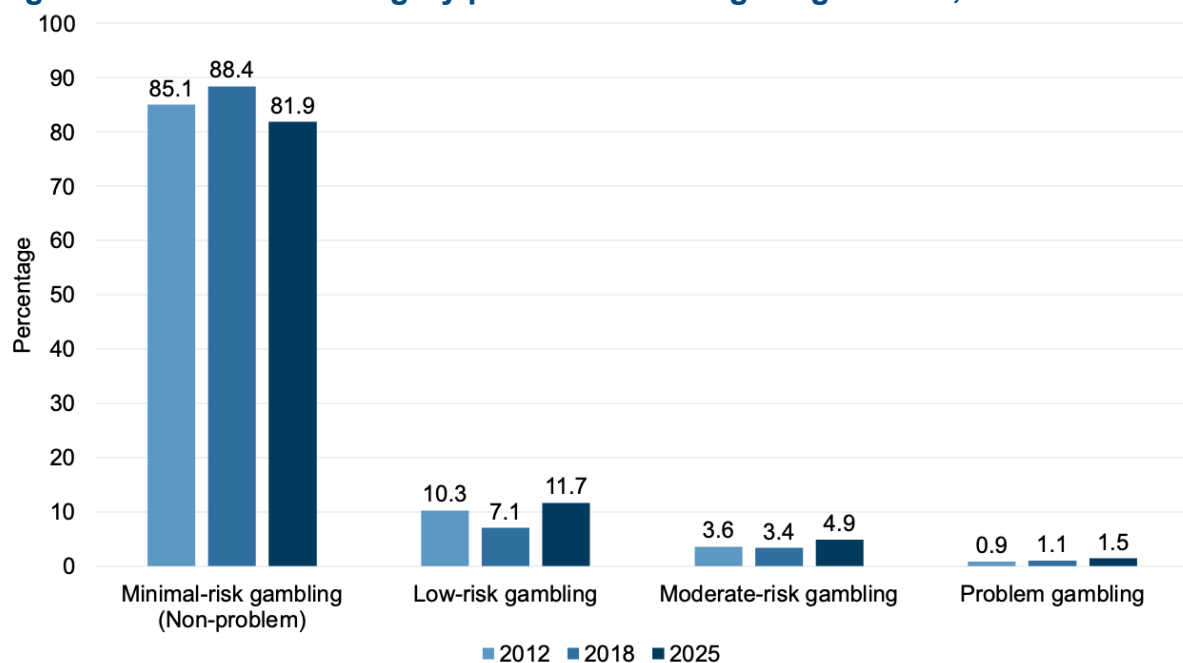
Figure 9 – PGSI risk category prevalence among South Australian residents, 2012-2025



Problem Gambling Severity Index (Ferris & Wynne, 2001). Base: All participants (N = 3,000).

The pattern of results in Figure 9 outlines changes in the population. The results are largely driven by changing proportions of people who do and do not gamble. When confined to people who gamble, a different pattern emerges. Generally, the proportion of people in the various risk groups has increased over time, with 11.7% experiencing low-risk gambling, 4.9% experiencing moderate-risk gambling and 1.5% experiencing problem gambling. In total, **18.1%** of adults who gambled in South Australia were experiencing some degree of problems due to their own gambling, which is the highest figure to date.

Figure 10 – PGSI risk category prevalence among SA gamblers, 2012-2025



Problem Gambling Severity Index (Ferris & Wynne, 2001). Base: All participants who had gambled in the last 12 months (N = 1,593).

5.2 Problem Gambling Severity Index moderate-risk or problem gambling categories by age, gender, location and other demographics

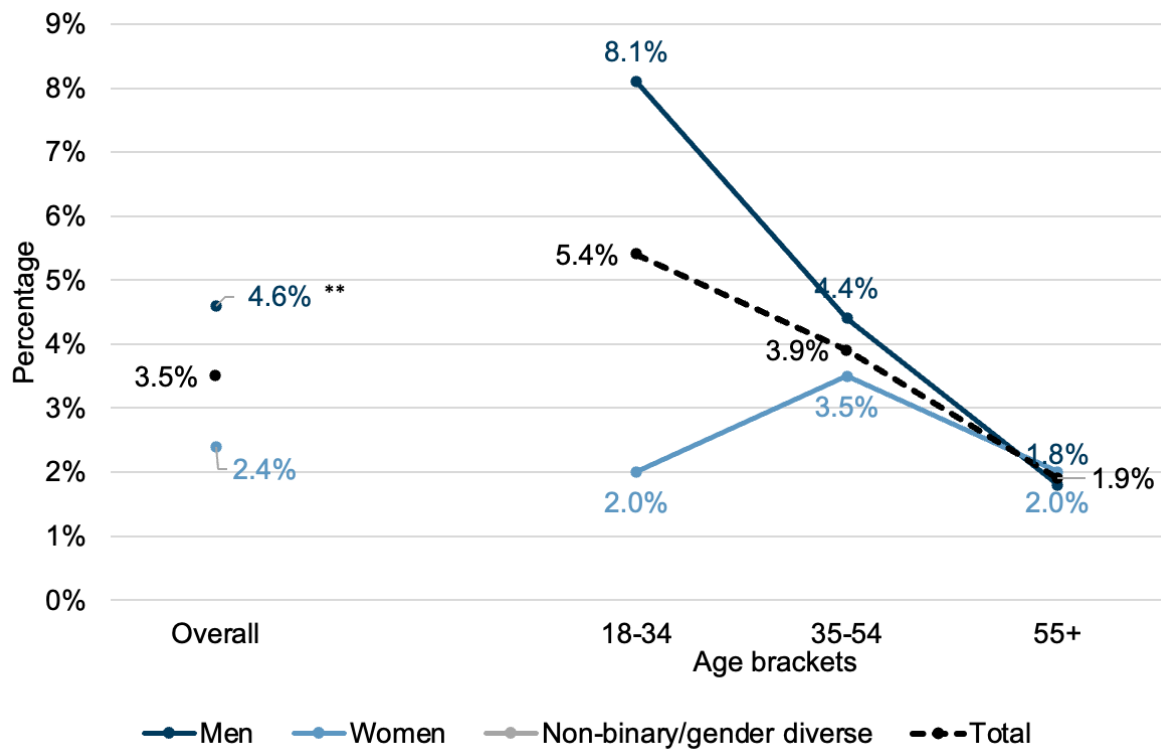
This section reports the proportion of people in the moderate-risk and problem gambling groups by different demographic splits. This is in line with the approach taken in previous studies, including prevalence reports in other jurisdictions, and provides a robust way of identifying those who experience gambling problems. Readers are also referred to Chapter 7, which includes additional analyses exploring gambling problems and harm.

Comparisons based on percentage of moderate-risk and problem gambling are somewhat underpowered due to the low sample size, so while statistical comparisons may not show statistically significant results, it is important to be cautious when generalising these findings to the population. For example, the estimate of moderate-risk and problem gambling is much higher for those who identify as Aboriginal or Torres Strait Islander compared to those who do not, but the comparison is not statistically significant. This is partly because of low prevalence of people in the Aboriginal and Torres Strait Islander group, as well as relatively small numbers of participants reporting moderate-risk or problem gambling. It does not mean that gambling problems amongst Aboriginal and Torres Strait Islander peoples are not higher than the rest of the community, but instead that the current data do not provide enough evidence to find a statistically significant result.

Figure 11 shows the percentage of people experiencing moderate-risk or problem gambling by age and gender. Men were significantly more likely to be classified in these categories compared to women, and this was most evident with young men (aged 18-34) being the most likely to be in these risk groups. For men, higher age was associated with lower levels of problems. For women, gambling problems were similar to men in older age groups, but much lower than men in the 18-34 age group. No participants who identified as other genders were classified in the moderate-risk or problem gambling categories, although this is a particularly small sample and should not be taken to infer that no people who identified as other genders experience problems due to gambling.

Statistically significant results were also found for marital status, tertiary education and household income (but not personal income) (Table 20). People who did not currently have a partner, who had not completed tertiary education, and had lower household income were significantly more likely to be experiencing moderate-risk or problem gambling.

Figure 11 – Prevalence of moderate-risk or problem gambling by age and gender



*Problem Gambling Severity Index (Ferris & Wynne, 2001). Base: All participants (N = 3,000). Asterisks (if present) indicates a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$. No estimate or age line is shown for non-binary/gender diverse participants due to low counts in all cells, but it is noted that 0 people who identify as a gender other than men or women reported gambling problems in this dataset.*

Table 5 – Prevalence of moderate-risk or problem gambling by demographics

Demographic	% Moderate-risk or problem gambling
SA adults	3.5%
Location	
Adelaide	3.8%
Elsewhere in South Australia	2.4%
Main language at home	
English	3.7%
LOTE	2.7%
Country of birth	
Australia	3.9%
Another country	2.6%
Identify as Aboriginal and/or Torres Strait Islander	
Yes	6.7%
No	3.4%
Married or living with a partner	
No (including divorced, separated, widowed, single)	4.3%*
Yes	2.7%
In paid employment	
No (including student, retired, etc)	2.8%
Yes (full time, part time, casual)	4.0%
Tertiary education	
No	3.9%**
Yes	1.8%
Personal income, per year	
Refused or don't know	2.8%
\$1 to \$25,999	3.7%
\$26,000 to \$51,999	2.9%
\$52,000 to \$90,999	4.3%
\$91,000 to \$155,999	4.0%
\$156,000 or more	3.1%
Household income, per year	
Refused or don't know	2.7%
\$1 to \$25,999	6.8%**
\$26,000 to \$51,999	2.0%
\$52,000 to \$90,999	3.7%
\$91,000 to \$155,999	3.7%
\$156,000 or more	4.4%

*Problem Gambling Severity Index (Ferris & Wynne, 2001). Base: All participants (N = 3,000). Asterisks (if present) indicates a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$.*

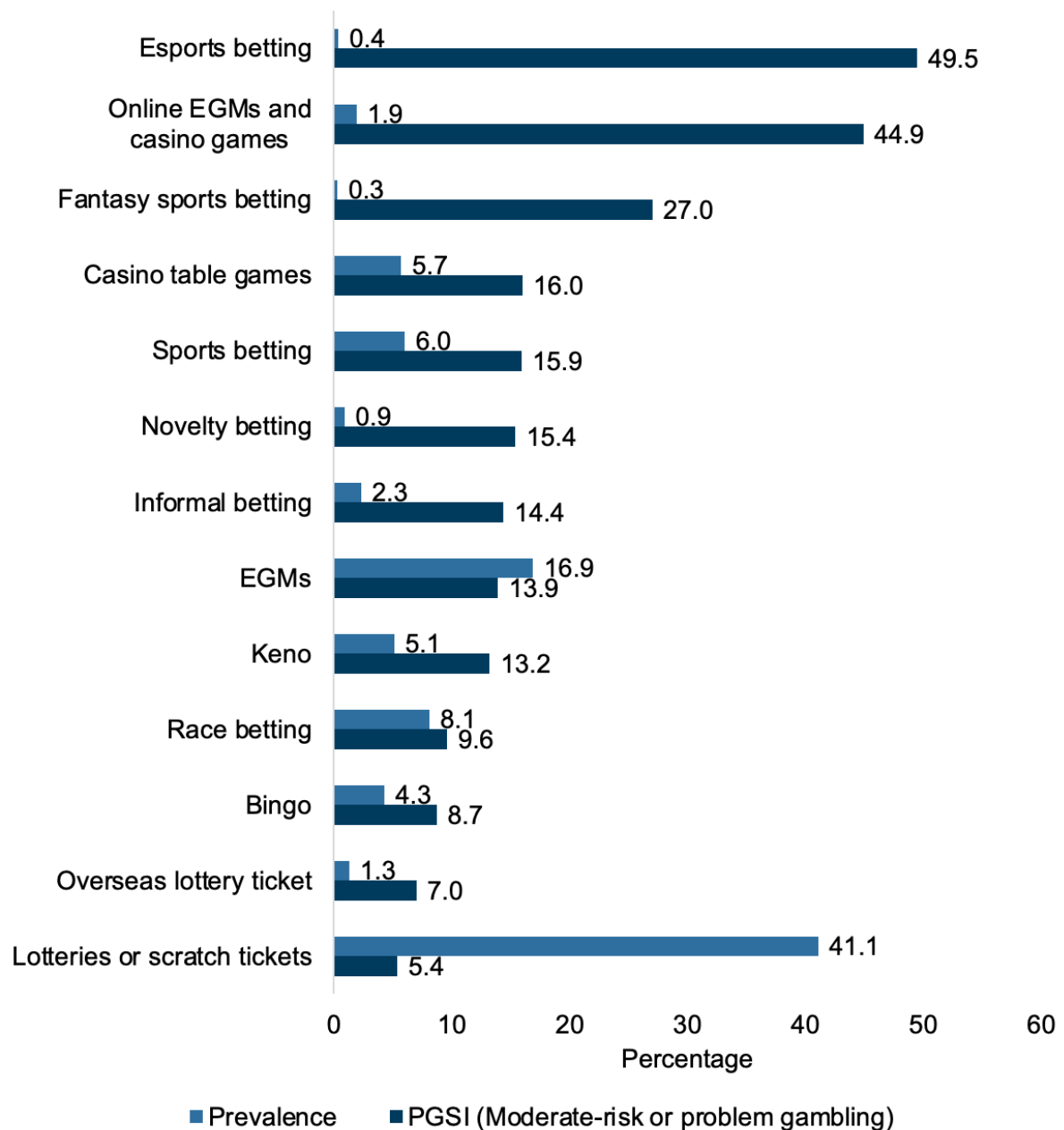
5.3 Problem Gambling Severity Index moderate-risk or problem gambling categories by engagement with each form

Figure 12 shows the relationship between participation rates for gambling forms and the proportion of people who took part in each form who experienced moderate-risk or problem gambling. The lighter bars show the participation rate for taking part in each form amongst the adult South Australian population, and the darker bars show prevalence of moderate-risk or problem gambling amongst those who took part in each form.

Importantly, this figure does not attribute these problems to this particular gambling form. Instead, this figure shows which forms are most likely to be used by those with higher levels of gambling problems, or which forms are disproportionately associated with problems. For example, 41.1% of the South Australian adult population take part in lotteries or scratch tickets, and of those 5.4% experience moderate-risk or problem gambling. Many participants take part in multiple forms of gambling, and therefore these observed problems amongst people who take part in lotteries and scratch tickets may be due to the other forms in which they take part. Please see Chapter 7 for analysis showing the proportion of problems and harm in South Australia that can be attributed to each gambling form.

Generally, the forms that were associated with a higher proportion of people experiencing moderate-risk or problem gambling were forms that had some of the lowest participation rates. For example, almost half of those who reported taking part in esports betting were classified as experiencing moderate-risk or problem gambling, but only 0.4% of South Australian adults reported taking part in esports betting. Typically, the forms that showed this pattern were newer forms, such as esports betting and fantasy sports betting, and forms that are not legally available to Australian residents, such as online casinos and online EGMs. Forms that have higher participation rates, such as lotteries and scratch tickets, tend to be less associated with moderate-risk or problem gambling. The rates of people experiencing moderate-risk or problem gambling are similar amongst the following forms: EGMs, casino table games, betting on sports or novelty events, informal betting, and keno. Importantly, this does not mean that these forms all result in similar levels of problems at the community level, because they have differing participation rates.

Figure 12 – Percentage of participants who engaged in each form in the last 12 months who experienced moderate-risk or problem gambling



Problem Gambling Severity Index (Ferris & Wynne, 2001). Base: All participants (N = 3,000).

Chapter 6: Gambling harm

This chapter reports two sources of gambling harm: harm from one's own gambling (GHS-10) and harm from someone else's gambling (affected others; GHS-10-AO).

Harm from own gambling

- 6.5% of South Australian adults (11.9% of adults who gamble) reported at least one harm from their own gambling in the last 12 months. This equates to approximately 99,083 adults.
- The harm to South Australian adults from their own gambling was measured in terms of health utility; Years Lived with a Disability (YLD), totalling 20,048 YLD, or approximately 1,315 YLD per 100,000 adults.
- In 2018, 6.6% of South Australian adults reported one or more harms from their own gambling in the last 12 months. This represents approximately 90,309 adults.
- In 2018, the total YLD was 14,668, or approximately 1,056 YLD per 100,000 adults. While the absolute number of people experiencing harm has increased by approximately 10%, in line with population growth, the *severity* of harm at the population level has increased by about 25%.
- Younger men, under the age of 54, are 30.3% of the population, but account for more than half of the burden of harm (56.1%). Other segments that accounted for a disproportionate amount of harm were those living in Adelaide, born in Australia, not currently living with a partner, in paid employment, and who had not completed tertiary education.

Harm to affected others

- 7.0% of SA adults reported some degree of harm from another person's gambling in the last 12 months, equating to approximately 106,705 South Australian adults. The burden of harm for affected others was 17,801 YLD, or 1,167 YLD per 100,000 adults.
- No significant differences were observed in terms of burden of harm between men and women. Those most over-represented in terms of burden of harm as an affected other were: men aged 18-34, men and women aged 35-54, those outside of Adelaide, Aboriginal or Torres Strait Islander people, people who are not currently married or living with a partner, people in paid

employment, people who have not completed tertiary education, and those with lower personal income, but higher household income.

Total harm

- Altogether, about one in eight South Australian adults (12.0%) – approximately **182,923** adults – reported at least one type of harm, either from their own gambling or from another person's gambling in the last 12 months.
- Total YLD in the population was 37,849 years of health life lost.

Chapter 5 describes information related to gambling problems, using the Problem Gambling Severity Index (Ferris & Wynne, 2001). The PGSI includes questions related to behavioural dependence, such as chasing losses, as well as harm, such as financial harm. The PGSI is included as it has been used in historical surveys and so allows trends over time, and because it is widely used in prevalence surveys in other Australian and foreign jurisdictions, allowing direct comparisons.

Over time, there has been a shift to measures that exclusively measure harm. A number of different scales have been developed and used in different jurisdictions. This includes the Gambling Harms Scale (10 items; GHS-10), as well as a corresponding scale for measuring harm amongst affected others, the GHS-10-AO (Browne, Newall, et al., 2023). While the PGSI only measures problems experienced by the person who gambles, the combination of these harms scales allows for a more comprehensive picture of harm in the South Australian community.

Gambling harm refers to consequences due to engagement with gambling products that leads to a decrement to health or wellbeing of the person who gambles, people around them (e.g., family and friends), the community and the population as a whole.

The GHS-10 includes 10 questions that are indicators of gambling-related harm. For each question, participants select either no (0) or yes (1). Scores are summed for a total from 0 to 10. The 10 items were developed based on an extensive checklist of 72 potential gambling-related harms, and were chosen on the basis that people who endorsed these harms were also very likely to endorse other harms. In other words, the 10 items are *indicators* or *symptoms* of harm.

The GHS-10 measures harm to people based on their own gambling. However, gambling harm is not restricted to people who gamble, and gambling often harms people around the person who gambles. These people are referred to as “affected others”, and the current survey includes a scale that measures harm amongst these people; the Gambling Harms Scale for Affected Others (GHS-10-AO) (Browne, Newall, et al., 2023). The scale features similar questions to the GHS-10, but are

asked in relation to another person's gambling, rather than their own. A person may experience harm from their own gambling, another person's gambling, or both.

Both the GHS-10 and GHS-10-AO are asked in relation to gambling within the last 12 months. However, for many people who experience gambling-related harm, the gambling may stop but harm may persist. This is known as *legacy harm* (Rockloff et al., 2021, 2022). The current survey did not have space to capture legacy harm. Despite this, this study includes the most comprehensive picture of gambling harm in South Australia, although it does not account for harm experienced by minors.

Harm itself is conceptualised as an impact to an individual's global health-related quality of life (HRQoL), rather than the specific harms outlined in each item in the GHS-10 and GHS-10-AO. For this reason, the GHS-10 and GHS-10-AO have been benchmarked against health utility scores, measured in Years of Health Life Lost due to a Disability (YLD). HRQoL YLD scores can be interpreted as the proportion of a health life lost due to living with a disease in a given year⁹. One YLD is the equivalent of one full year of health life lost due to disability or ill-health. Summed over individuals in a population, YLD captures the total number of equivalent years lost (through disability) due to a condition. As suggested by the name, YLD is typically used in a variety of health-related fields, including public health issues such as gambling-related harm. YLD scores are drawn from benchmarking work by Browne et al. (2023). There is ongoing work on improving these benchmarked values and new values may become available over time.

These HRQoL YLD scores are used for reporting in most of the present analyses¹⁰. YLD values are based on GHS-10 and GHS-10-AO scores, based on benchmarking research (Browne, Newall, et al., 2023). YLD values are calculated separately for the GHS-10 and the GHS-10-AO. It is possible to have YLD values other than 0 both due to one's own gambling, and due to someone else's gambling. For one's own gambling, anyone who has not gambled in the last 12 months has a YLD score of 0. Anyone who has gambled in the last 12 months but has a GHS-10 score of 0 also has a YLD score of 0. That is, people who have not gambled, or who have gambled but have not reported any harms, do not receive any YLD values. A score of 1 on the GHS-10 translates to a YLD value of .10. If a population group of 50,000 people have a GHS-10 score of 1, the YLD values for these participants are summed (i.e., .10 times 50,000 = 5,000 YLD). A GHS-10 score of 2 translates to a YLD value of .19. Each GHS-10 score translates to a YLD value up to .45 for a GHS-10 score of 10 (the maximum). In other words, a person experiencing the most severe harm essentially loses nearly half a year (45%) of healthy life due to harm from their own gambling. Note that these values are not linear. While an increase from GHS = 1 to

⁹ <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/160>

¹⁰ For a full description of how these values are calculated, please see section 2.4 of Browne et al. (2023). *The Gambling Harms Scales: Instruments to assess impacts to gamblers and affected others that are benchmarked to health utility*. Victorian Responsible Gambling Foundation. Note that updated weights have been used based on Tulloch et al. (2026), in line with other jurisdictions.

GHS = 2 is an increase of .09 in YLD (from .10 to .19), this does not mean a .09 YLD increase for each GHS score increase. The YLD values rise more sharply for lower GHS-10 scores, and then plateau at around GHS = 4 and 5. See Tulloch et al. (2026) for a discussion.

The same is the case for affected others, using the GHS-10-AO. Anyone who does not report a close relationship with someone who gambled, or who did report a relationship but had a score of 0 on the GHS-10-AO (i.e., did not indicate any harm as an affected other), receive a YLD score of 0 for the GHS-10-AO. A score of 1 is associated with a YLD value of .07, while a score of 10 is associated with a YLD decrement of .40. Therefore an affected other who scores 1 on the GHS loses 7% of a year of healthy life due to another person's gambling, while an affected other who scores 10 on the GHS loses 40% of a year of healthy life due to another person's gambling.

Participants may experience harm only due to their own gambling (i.e., YLD values greater than 0 for GHS-10, but 0 for GHS-10-AO), only as an affected other (i.e., YLD values greater than 0 for GHS-10-AO, but 0 for GHS-10), neither (YLD values of 0 for both GHS-10 and GHS-10-AO) or both (i.e, YLD values greater than 0 for both GHS-10 and GHS-10-AO).

These values must then be scaled up to the population. Without this scaling, the summed values are based only on the sample size (i.e., N = 3,000 adults), not the entire population. This is accomplished by dividing YLD values by the sample size and multiplying them by the adult population of South Australia.

YLD scores can be used in a few different ways. First, they can be used to determine the amount of healthy life lost due to gambling harm, which can be tracked over time. While population prevalence of harm may remain stable, populations generally increase in size over time, and YLDs may therefore also increase. Second, they allow for comparisons across jurisdictions, such as by determining YLD per 100,000 adult population. Third, they can be used to determine comparisons between groups, to determine which groups experience disproportionately more harm compared to others (see below). Finally, they can be used for comparisons with other health conditions, where the YLDs for other health conditions have been determined in the same way. YLD benchmarking can differ for different conditions, such as using different benchmarking scales. For this reason, we have opted not to compare gambling harm in South Australia to other conditions.

Because YLD values are summed within each group, the YLD measure for a group is in part dependent on the number of people in that group. This is important for interpretation. If two groups have an equal total YLD, but one group contains much more people than the other, then the average amount of harm per person in the smaller group must be larger. For example, if two groups both have total YLD values of 1,000, but one group consists of 100,000 people, while the other consists of

10,000 people, the average YLD in the first group must be .01, compared to .1. That is, harm is 10 times stronger in the smaller group. For this reason, when reporting the percentage of YLD attributed to each group, we also report how much of the overall population is in that group, to determine which groups experience disproportionate amounts of harm. In Table 6 for example, 15.3% of the South Australian adult population are men aged 18-34. If harm is evenly distributed across age and gender groups, men in this category would also experience 15.3% of the harm experienced by the total population. However, the table shows that men aged 18-34 experience a much larger share of the harm, 31.3%. This indicates that they are overrepresented in terms of the harm they experience. While other figures in this report show the proportion of people in each demographic group who report the dependent variable (e.g., gambling on a form), the reporting for harm must be different due to the way that YLD values are determined.

In addition, the proportion of participants who scored 1 or more on the GHS-10 and GHS-10-AO are also reported, to provide an overall prevalence figure for gambling-related harm amongst South Australian adults. These prevalence measures are also more independent of the number of people in a group, because they represent the proportion of people reporting harm within a group, rather than the number (sum) of people reporting harm within a group. Therefore, YLD and proportion provide two complementary perspectives on harm. Readers are also referred to Chapter 7 for further gambling-related harm analyses.

6.1 Harm experienced by people who gamble, overall and changes over time

In 2025, **6.5%** of South Australian adults endorsed one or more items from the GHS-10. The ABS estimates South Australia's adult population to be 1,524,355 in 2025, which means that an estimated **99,083** South Australian adults reported some level of harm from their own gambling in the last 12 months. This represents a total YLD of **20,048, or approximately 1,315 YLD per 100,000 adults**. In other words, during the previous 12 months, **20,048** years of healthy life were lost to gambling harm amongst people who gamble. Please see below for additional health disutility for affected others.

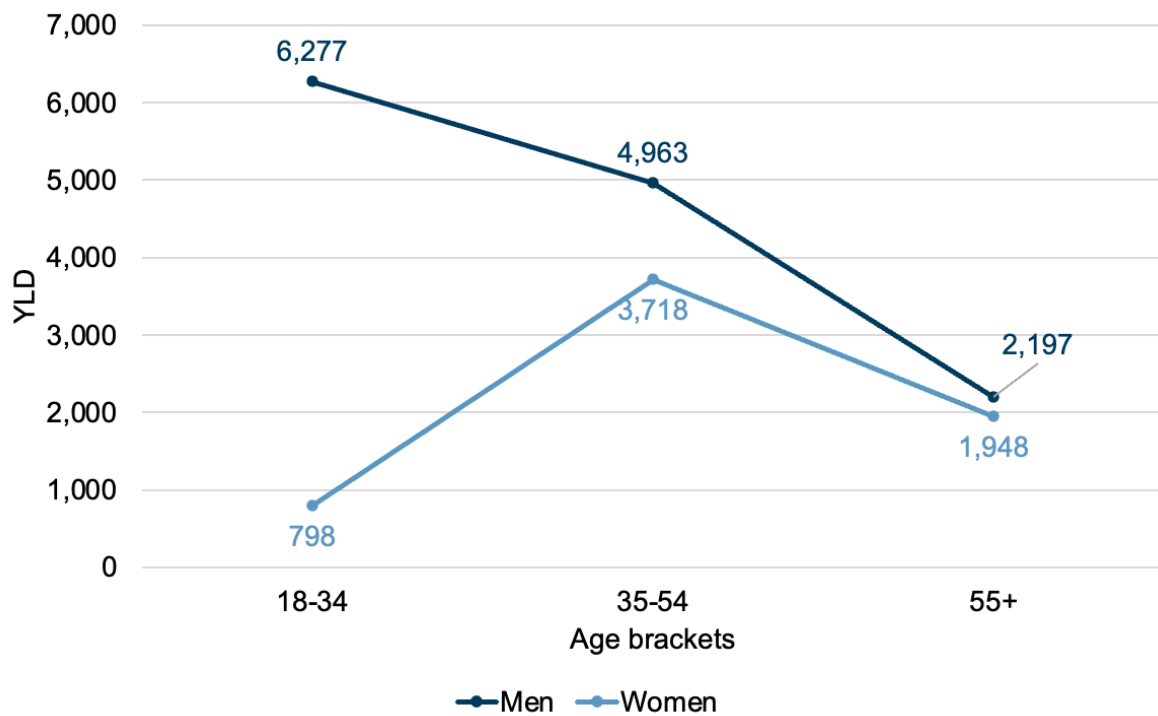
The previous 2018 survey used the GHS-10 (then known as the SGHS). In 2018, 6.6% of adults reported experiencing harm due to their own gambling (approximately 90,309 South Australian adults), indicating that the proportion of adults affected by gambling has remained stable over time, but the absolute number has increased due to population growth, despite the proportion of adults gambling declining over time. The YLD value for the population was not calculated in 2018, but our secondary analysis conducted as part of this report found that the total YLD in 2018 was **14,668, or approximately 1,056 YLD per 100,000 adults**. This indicates that while the proportion of adults experiencing harm is similar, and absolute number of adults experiencing harm has increased by approximately 10%, the *severity* of harm experienced has increased by approximately 25%.

6.2 Harm experienced by people who gamble by age, gender, location and other demographics

6.2.1 Burden of harm from own gambling by age and gender

Men reported experiencing more than twice as much harm compared to women (13,437 vs 6,465 YLD), with non-binary and gender-diverse people estimated to experience 146 YLD. Figure 13 below shows YLD by age bracket separately for men and women. Please note that this figure represents TOTAL YLD for each segment, and this is partly influenced by the number of people in the population in each segment – see the next table for more information. The burden of gambling harm was highest for young men, aged 18-34, and was lower for middle-aged men, followed by older men. For women, the burden of harm was highest amongst middle-aged women (35-54), lower for older women, and lowest for younger women. The burden of harm for women was much lower than men in the youngest age bracket, slightly lower in the middle-age bracket, and similar for the oldest age bracket.

Figure 13 – Burden of gambling harm from own gambling by age and gender



Non-binary and gender-diverse people not shown due to sparse cell counts. Gambling Harms Scale (10 items). Base: All participants who gambled in the last 12 months ($n = 1,627$). This figure does not include totals as they are summed values and would extend the Y-axis substantially. Non-binary and gender diverse people account for an additional 146 YLD.

6.2.3 Burden of harm from own gambling by other demographics

Because YLD is summed, rather than averaged within a group, it is important to consider how many people are in each population segment. Table 6 compares the proportion of the population who are in each group to the proportion of YLD experienced by that group. To interpret this table, readers should first look at the estimated % of the population figure. For example, men aged 18-34 account for 15.3% of the adult population of South Australia. The next column, HRQoL YLD %, indicates the proportion incurred by this group, at 31.3%. This figure has three asterisks, indicating that this is a statistically significant difference ($p < .001$). If harm was evenly spread across the population, then we would expect men aged 18-34 to experience 15.3% of the harm in the population, but they experience 31.3%. They are therefore disproportionately affected by harm from their own gambling.

Populations that experienced a disproportionately high burden of harm were: younger men (18-34 and 35-54), those living in Adelaide, those born in Australia, those not currently married or living with a partner, those in paid employment, and those who have not completed tertiary education. Findings for income are mixed, with those with a middling personal income more likely to be overrepresented in terms of harm from their own gambling, whereas for household income, those most overrepresented were those in the lowest and highest household income brackets.

Table 6 – Burden of gambling harm from own gambling by demographics

Demographic	HRQoL YLD	Estimated % of the pop'n	HRQoL YLD %
Age by gender			
Men 18-34	6,277	15.3	31.3***
Men 35-54	4,963	15.0	24.8***
Men 55+	2,197	18.5	11.0
Women 18-34	798	12.1	4.0***
Women 35-54	3,718	15.2	18.5
Women 55+	1,948	23.4	9.7***
Non-binary/gender diverse	146	0.5	0.7
Location			
Adelaide	16,351	78.0	81.6*
Elsewhere in South Australia	3,697	22.0	18.4*
Main language at home			
English	16,228	78.7	80.9
LOTE	3,820	21.3	19.1
Country of birth			
Australia	15,121	67.8	75.4***
Another country	4,928	32.2	24.6***

Table 6 – Burden of gambling harm from own gambling by demographics (continued)

Demographic	HRQoL YLD	Estimated % of the pop'n	HRQoL YLD %
Identify as Aboriginal and/or Torres Strait Islander			
Yes	476	2.7	2.4
No	19,572	97.3	97.6
Married or living with a partner			
No (including divorced, separated, widowed, single)	12,210	47.2	60.9***
Yes	7,838	52.8	39.1***
In paid employment			
No (including student, retired, etc)	6,336	43.0	31.6***
Yes (full time, part time, casual)	13,712	57.0	68.4***
Tertiary education			
No	17,562	77.2	87.6%***
Yes	2,486	22.8	12.4%
Personal income, per year			
Refused or don't know	1,333	12.3	6.6***
\$1 to \$25,999	2,749	13.5	13.7
\$26,000 to \$51,999	6,373	34.6	31.8
\$52,000 to \$90,999	6,756	23.6	33.7***
\$91,000 to \$155,999	2,163	10.5	10.8
\$156,000 or more	674	5.4	3.4**
Household income, per year			
Refused or don't know	2,835	19.1	14.1***
\$1 to \$25,999	1,740	5.3	8.7**
\$26,000 to \$51,999	3,265	21.7	16.3***
\$52,000 to \$90,999	4,443	18.5	22.2*
\$91,000 to \$155,999	1,859	12.5	9.3*
\$156,000 or more	5,906	23.0	29.5***

YLD are rounded to integer values. Asterisks (if present) indicate a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$, with values in bold showing groups that are overrepresented in terms of YLD % compared to population %. These represent a test of proportions comparing population prevalence and the proportional YLD burden attributable to that segment. Base: All participants ($n=3,000$).

6.3 Harms to affected others overall

The GHS-10-AO was used to measure gambling-related harm amongst affected others. This scale was not used in the 2018 survey because it was created and validated after that survey. Therefore, there are no earlier data for direct comparisons.

The GHS-10 is asked of all participants who have gambled in the last 12 months. In contrast, the GHS-10-AO (for affected others) has a lead-in question that is used to identify *potential* affected others. This question asks whether the participant has been in a close relationship in the last 12 months with someone who gambles. Out of all 3,000 participants, 20.5% responded yes to this question and were therefore asked to complete the GHS-10-AO. Participants were identified as an affected other if they endorsed one or more items on the GHS-10-AO.

In 2025, **7.0%** of South Australian adults reported experiencing harm due to another person's gambling, which represents **106,705** South Australian adults. The total for affected others in 2025 was **17,801** YLD, or **1,167 YLD per 100,000 adults**. That is, amongst affected others, 17,801 years of health life were lost due to harm experienced by someone else's gambling in 2025.

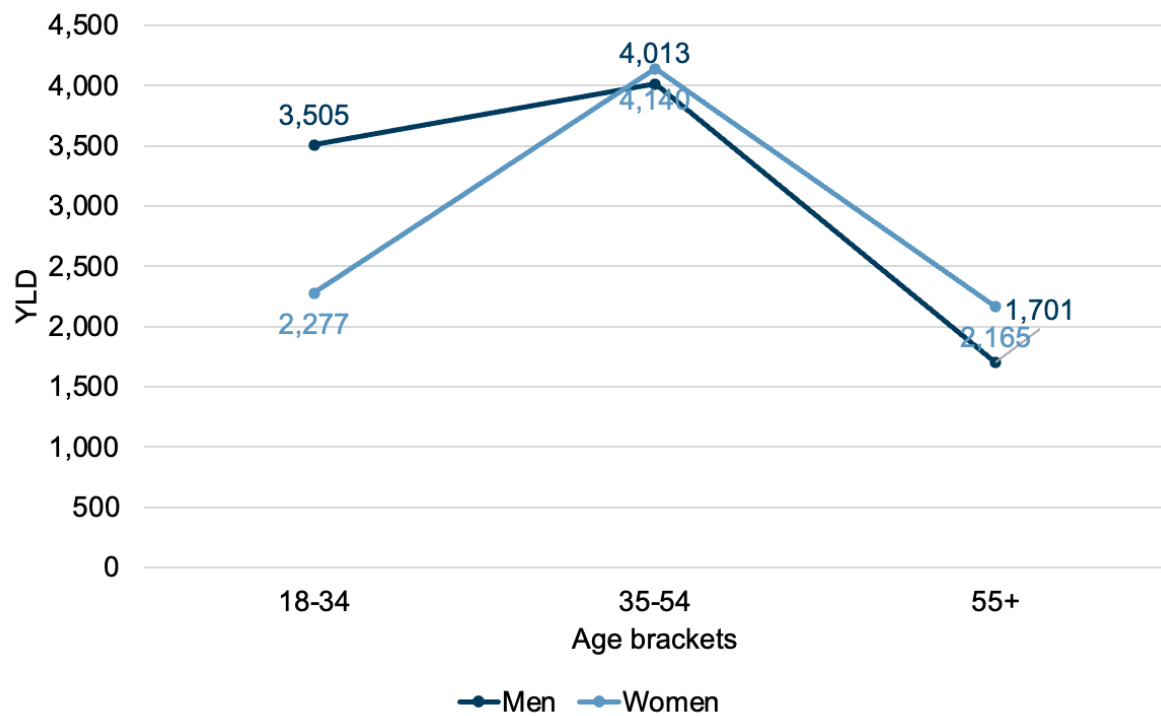
6.4 Harm to affected others by age, gender, location, other demographics, and relationship with the gambler

6.4.1 Burden of harm to affected others by age and gender

There was no significant difference between men (YLD = 9,219) and women (YLD = 8,582) in terms of amount of harm experienced as an affected other. No non-binary or gender diverse people reported experiencing harm as an affected other, although it is noted that this is based on a small number of participants and should not be taken to infer that no harm is experienced in this community.

Figure 14 indicates an overall pattern where men and women between 35 and 54 experienced the most harm as an affected other, followed by younger people, and then older people. Notably, young men were more likely to report harm as an affected other compared to younger women.

Figure 14 – Burden of gambling harm to affected others by age and gender



Non-binary and gender-diverse people not shown due to sparse cell counts. Gambling Harms Scale for Affected Others (10 items). Base: All participants (n = 3,000). This figure does not include totals as they are summed values and would extend the Y-axis substantially.

6.4.3 Burden of harm to affected others by other demographics

Table 7 shows which demographic groups are disproportionately affected by harm due to someone else's gambling. Please see section 6.2.3 for information on how to interpret these results. Table 7 shows that the groups with a heightened burden of harm as affected others were men aged 18-34, and both men and women aged 35-54, people living outside of Adelaide, people who speak English as their main language at home, people born in Australia, people identifying as Aboriginal or Torres Strait Islander, people who are not currently married or living with a partner, people in paid employment, people who have not completed tertiary education, and those with lower personal income, but higher household income. Importantly, while people identifying as non-binary or gender diverse did not report any harm as affected others, this is based on a very small sample and should not be taken to mean no harm in this part of the community.

Table 7 – Burden of gambling harm from someone else's gambling by demographics

Demographic	HRQoL YLD	Estimated % of the pop'n	HRQoL YLD %
Age by gender			
Men 18-34	3,505	15.3	19.7**
Men 35-54	4,013	15.0	22.5***
Men 55+	1,701	18.5	9.6***
Women 18-34	2,277	12.1	12.8
Women 35-54	4,140	15.2	23.3***
Women 55+	2,165	23.4	12.2%***
Non-binary/gender diverse	0	0.5	0
Location			
Adelaide	13,174	78.0	74.0*
Elsewhere in South Australia	4,627	22.0	26.0*
Main language at home			
English	14,994	78.7	84.2***
LOTE	2,807	21.3	15.8***
Country of birth			
Australia	13,996	67.8	78.6***
Another country	3,805	32.2	21.4***
Identify as Aboriginal and/or Torres Strait Islander			
Yes	1,989	2.7	11.2***
No	15,813	97.3	88.8***

Table 7 – Burden of gambling harm from someone else’s gambling by demographics (cont)

Demographic	HRQoL YLD	Estimated % of the pop’n	HRQoL YLD %
Married or living with a partner			
No (including divorced, separated, widowed, single)	10,479	47.2	58.9***
Yes	7,323	52.8	41.1***
In paid employment			
No (including student, retired, etc)	6,231	43.0	35.0***
Yes (full time, part time, casual)	11,571	57.0	65.0***
Tertiary education			
No	15,404	77.2	86.5***
Yes	2,398	22.8	13.5***
Personal income, per year			
Refused or don’t know	515	12.3	2.9***
\$1 to \$25,999	2,923	13.5	16.4**
\$26,000 to \$51,999	5,861	34.6	32.9
\$52,000 to \$90,999	5,744	23.6	32.3**
\$91,000 to \$155,999	1,436	10.5	8.1*
\$156,000 or more	1,323	5.4	7.4*
Household income, per year			
Refused or don’t know	2,203	19.1	12.4***
\$1 to \$25,999	901	5.3	5.1
\$26,000 to \$51,999	3,932	21.7	22.1
\$52,000 to \$90,999	3,528	18.5	19.8
\$91,000 to \$155,999	2,461	12.5	13.8
\$156,000 or more	4,778	23.0	26.8***

YLD are rounded to integer values. Asterisks (if present) indicate a statistically significant difference: * $p < .05$, ** $p < .01$, *** $p < .001$, with values in bold showing groups that are overrepresented in terms of YLD % compared to population %. These represent a test of proportions comparing population prevalence and the proportional YLD burden attributable to that segment. Base: All participants ($n=3,000$).

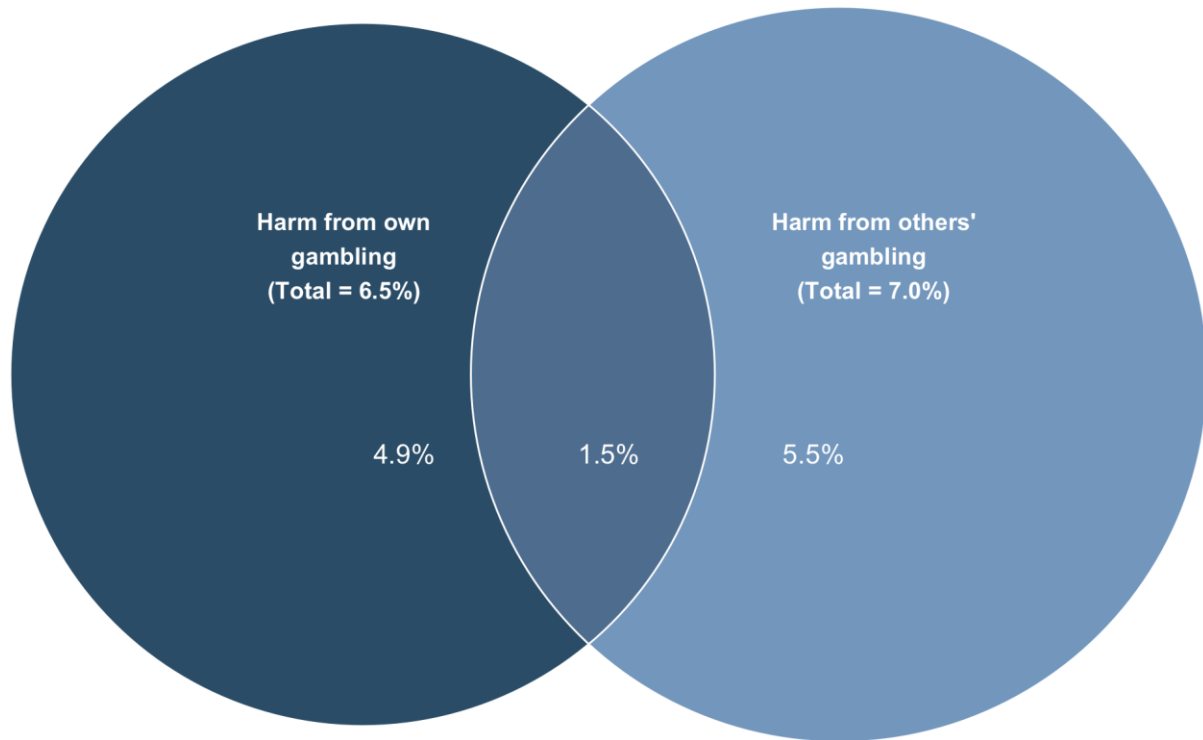
6.5 Harm from all sources

As described above, 6.5% reported one or more harms from their own gambling (GHS-10) and 7.0% reported harm due to another person's gambling (GHS-10-AO). Individuals could report harm from one or both of these sources. Figure 15 below shows the prevalence of each combination of these different sources of harm.

In total, **12.0%** of South Australian adults reported harm from one or more sources of gambling harm, which equates to approximately **182,923** South Australian adults. There is some overlap between those who experience harm from their own gambling and someone else's gambling, with about 1.5% of the adult population experiencing both sources of harm (Figure 15). This equates to a total Health Related Quality of Life decrement of **37,849 YLD**, or **2,482 years of healthy life lost due to gambling harm per 100,000 adults**. This figure does not capture legacy harm (i.e., harm due to gambling that occurred more than 12 months ago), or harm amongst people under the age of 18.

This figure contrasts with common narratives around gambling problems: that only a small proportion, typically 1%, experience problems due to their gambling. This figure of 12.0% is more informative compared to that for gambling problems, as it includes people who experience harm due to someone else's gambling, and also does not focus only on those who experience the most severe harm, in line with a public health approach to gambling harm. In addition, please see Chapter 7 for an analysis describing how wellbeing is reduced even for those in lower PGSI categories, or those reporting a smaller number of harm items.

Figure 15 – Prevalence of harm from all sources: own gambling and others' gambling



The GHS-10 and GHS-10-AO measure harm from ongoing gambling (last 12 months) as a result of one's own gambling (GHS-10) or someone else's gambling (GHS-10-AO). The percentages reported describe endorsement of any item on each scale. Percentages refer to prevalence in the population.

Chapter 7: Which forms and demographic segments account for problems and harm to gamblers and affected others

Different gambling forms vary in their contribution to total harm

- Approximately 40% of the problems and harm experienced by South Australian adults who gamble was attributable to EGMs, followed by casino table games (online or in venues; ~30%) and wagering (~12-15%).

Demographics associated with harm to gamblers

- Age and gender, were the most important demographic variables for problems and harm experienced by South Australian adults who gamble, accounting for approximately 52% of problems and harm.
- Young men, aged 18-39, experienced higher harm on average, and accounted for 38.9% of harm experienced due to one's own gambling, despite being 18.6% of the population.

Demographics associated with harm to affected others

- In contrast, harm to affected others was more evenly spread across demographic groups. Age and gender accounted for approximately 33% of harm. The next most important was personal income.
- While harm experienced by people due to their own gambling was disproportionately experienced by young men, harm for affected others was more evenly mixed between genders and age segments.

Associations between wellbeing, harm and gambling problems

- People who gambled but did not experience problems or harm showed similar overall wellbeing levels to people who did not gamble. People who were in higher PGSI categories, or endorsed more harms, had significantly lower scores in terms of subjective wellbeing.

7.1 Which gambling forms contribute the most to gambling problems and harm?

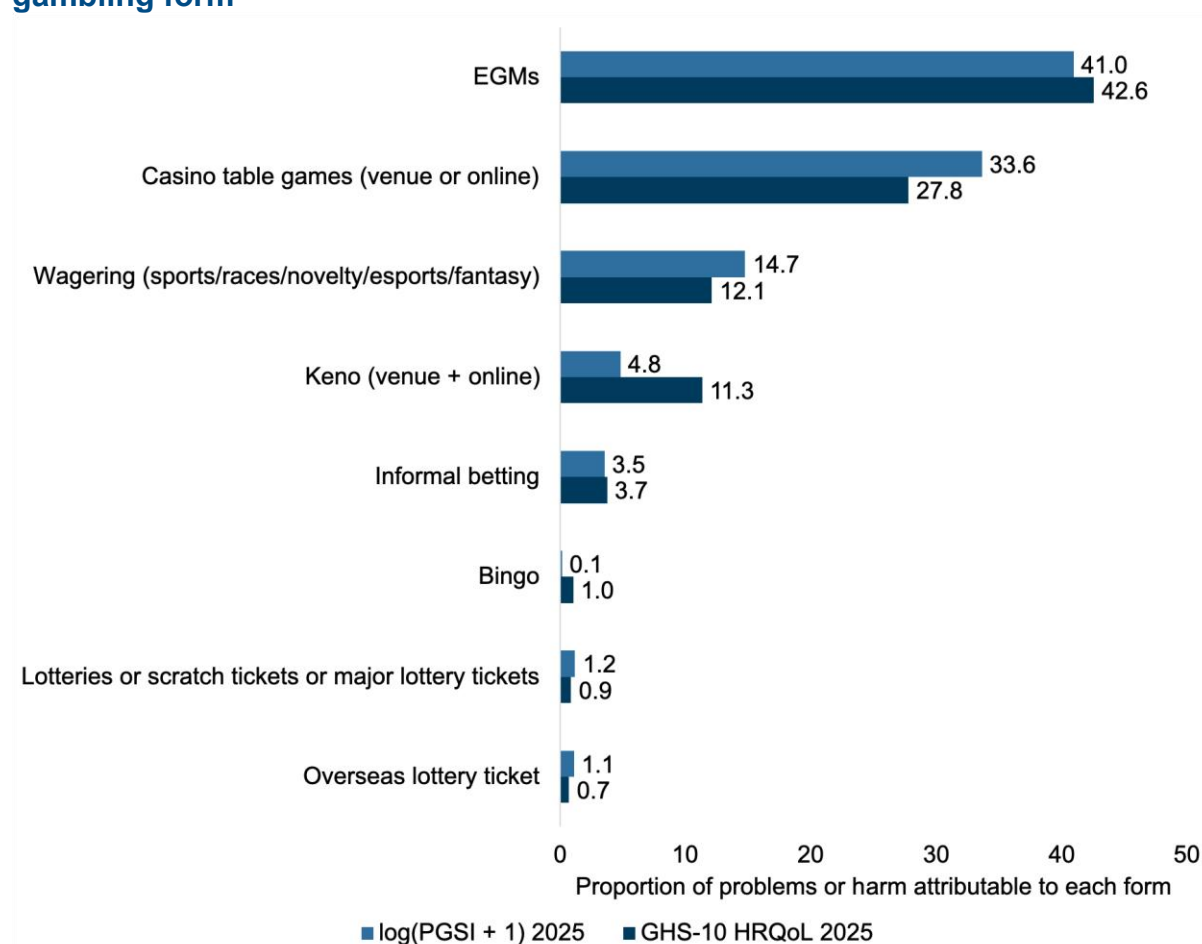
Gambling problems and harm from one's own gambling often occur due to gambling on more than one form of gambling. Section 5.3 explored how many people who take part in each form experience moderate-risk or problem gambling, which is useful for determining which forms are preferred by who experience more harm or problems. However, this does not attribute harm to particular forms. For example, 5.4% of those who buy lottery or scratch tickets experience moderate-risk or problem gambling, but this does not mean that they experience these problems due to lottery or scratch tickets. This chapter aims to address this gap, by determining which gambling forms have the strongest associations with problems and harm, by accounting for people taking part in multiple forms. In addition, similar analyses have been done to determine relationships between demographics for gambling problems, harm due to a person's own gambling and harm due to someone else's gambling.

The analyses in this chapter use multiple regression and dominance analysis (see Appendix A.2) to attribute impact to specific gambling forms. These analyses allow us to account for participants who gamble on more than one form of gambling. The dominance analysis approach, combined with weighted data, captures population-level impact that takes into account both prevalence and severity of impact (Browne, Delfabbro, et al., 2023). Some forms were combined due to overlap between participants who take part in those forms, notably wagering products (sports, race, novelty, esports and fantasy sports betting).

Figure 16 illustrates the proportion of total population impact associated with each gambling form, taking into account participation on multiple forms of gambling. The GHS-10 is coded using HRQoL weights, which correspond to the proportion of total YLD attributable to that form, aligning results from this chapter with those seen in Chapter 6. Please see the start of Chapter 6 for an explanation of harm metrics, including YLD.

EGMs account for around 40% of the problems and harm experienced by South Australian adults who gamble, followed by casino table games (~30%) and wagering (~13%). Keno accounts for about 5% of problems, but 11% of harm. Lotteries and scratch tickets, despite being the most prevalent form of gambling, account for very little problems and harm.

Figure 16 – Proportion of gambling harm and PGSI scores attributable to each gambling form



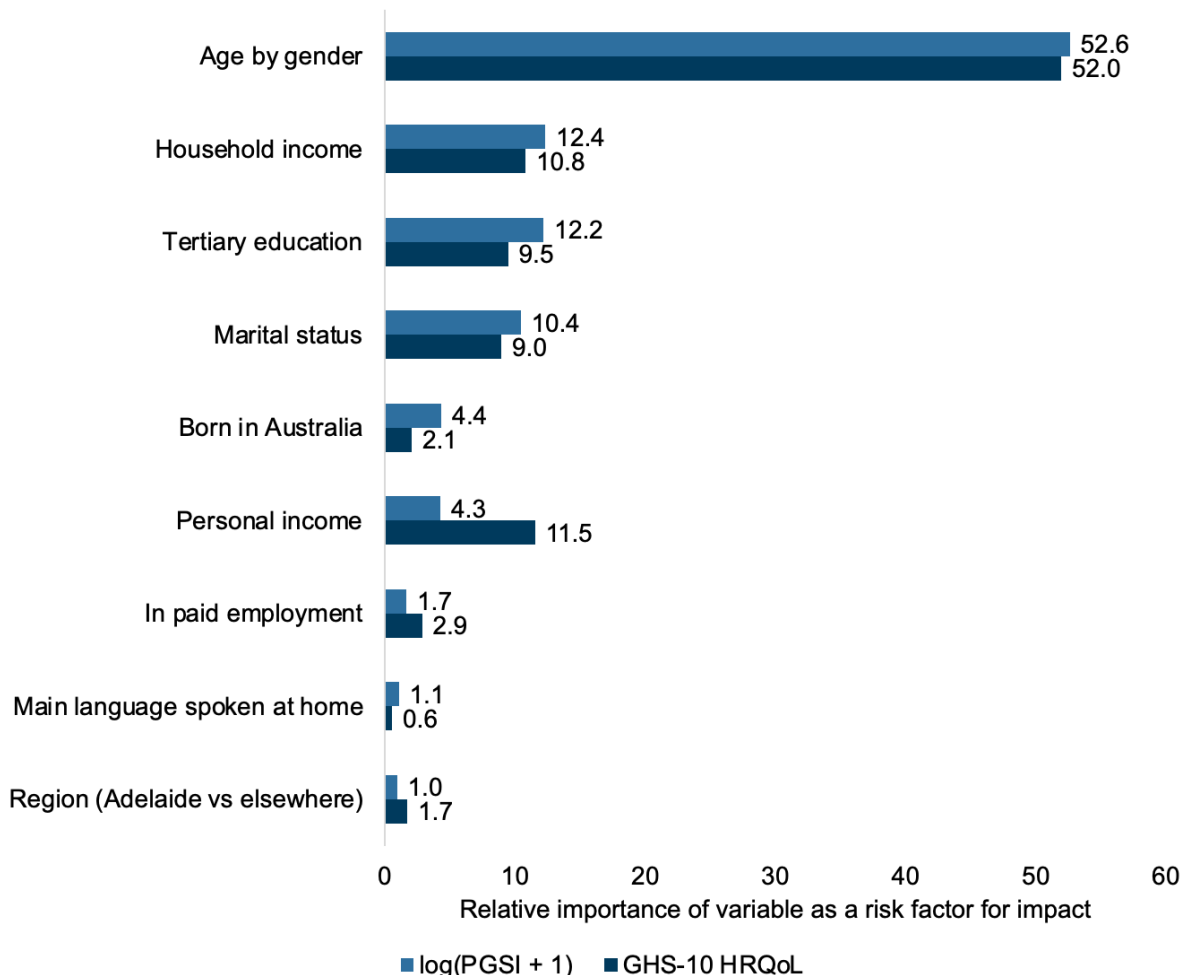
Base: All participants who had gambled in the last 12 months ($n = 1,627$). Scores of 0 inferred for non-gamblers.

7.2 Which demographic segments experience the most gambling problems and harm

Figure 17 shows a similar analysis to the relative importance of each gambling form, this time for demographic variables to determine which demographics explain most of the impact on the population. This extends the findings in Chapters 5 and 6, which showed which groups experience more problems and harm (e.g., young men), by showing which factors account for the most problems and harm.

The most important demographic predictor was age and gender (combined), accounting for about 52% of problems and harm. This was followed by household income, tertiary education and marital status, each accounting for about 9-12% of problems and harm.

Figure 17 – Proportion of gambling harm and PGSI scores attributable to each demographic variable



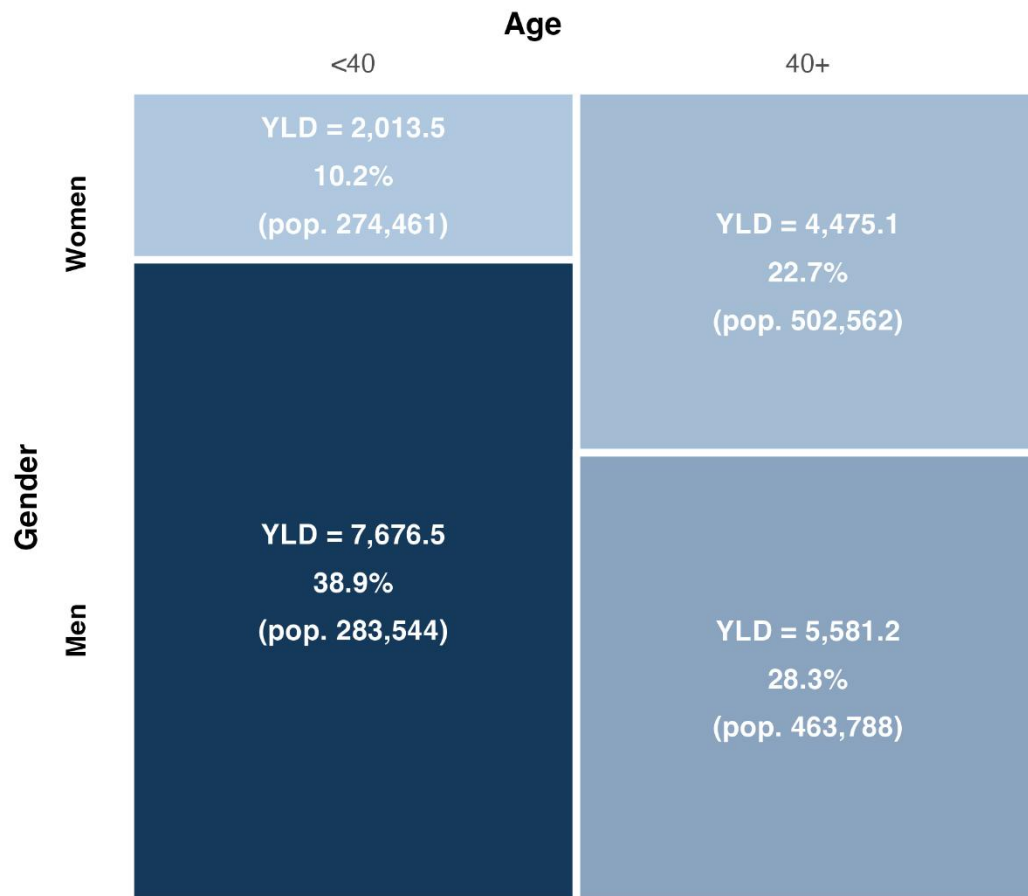
Base: All participants who had gambled in the last 12 months ($n = 1,627$). Scores of 0 inferred for non-gamblers.

Figure 18 shows a mosaic plot. Each rectangle is proportional to the YLD due to Health-Related Quality of Life (HRQoL) impacts from gambling to the gamblers themselves. These YLD values represent both prevalence (i.e., the number of people in each segment) and the severity of harm experienced by individuals in that segment on average. This figure represents an intersection between gender and age. Similar analyses in other jurisdictions have included education, but this was not possible due to the sample size.

The colours of the rectangles represent average YLD amongst people in that rectangle, and the size of the rectangles represents the total YLD for people in that group. We show both metrics because the number of participants in each cell is not equal. Darker colours therefore represent more individual impact, and larger rectangle areas represent more impact on the segment as a whole. For example, if we compare the rectangles for men aged 40+, the colour is lighter for men aged 40+, meaning on average each person in that cell is experiencing less HRQoL disutility than younger men. So even though there are more men aged 40+ in the population ($n = 463,788$) compared to those aged 40 or under ($n = 283,544$), the *total* YLD is higher amongst those younger men (YLD = 7,677) compared to older men (YLD = 5,581) because those who are older experience much less harm on average, even though there are more older men in the population.

The figure shows that young men, aged 18-39, experience 38.9% of the burden of harm due to their own gambling in the population. In contrast, young women experience only 10.2% of the harm. Amongst older people, men experience slightly more harm at the population level (28.3%) compared to women (22.7%).

Figure 18 – Impact incurred by key population segments due to harm from one's own gambling

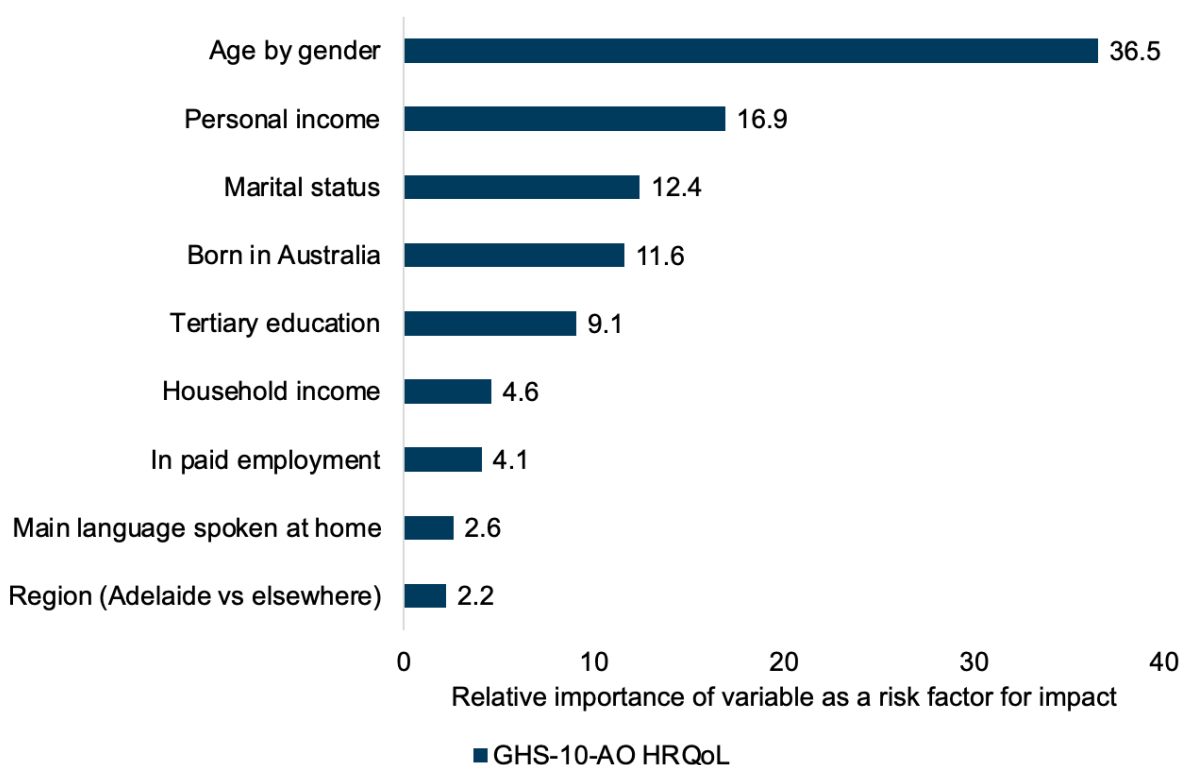


Base: All participants who had gambled in the last 12 months (n = 1,627). Scores of 0 inferred for non-gamblers. Note, YLD for non-binary and gender diverse people, and people who refused to disclose their gender, are not represented in the mosaic due to low numbers (YLD = 146, 0.9%).

7.3 Which demographics are most strongly associated with harm to affected others?

Figure 19 shows the same analyses as section 7.2, but for people harmed by someone else's gambling (affected others), using the GHS-10-AO (Browne, Newall, et al., 2023). Like for harm experienced due to one's own gambling, age and gender were the most important predictors for harm experienced by affected others (36.5%). This was followed by personal income, marital status, being born in Australia and having completed tertiary education.

Figure 19 – Proportion of gambling harm to affected others attributable to each demographic variable

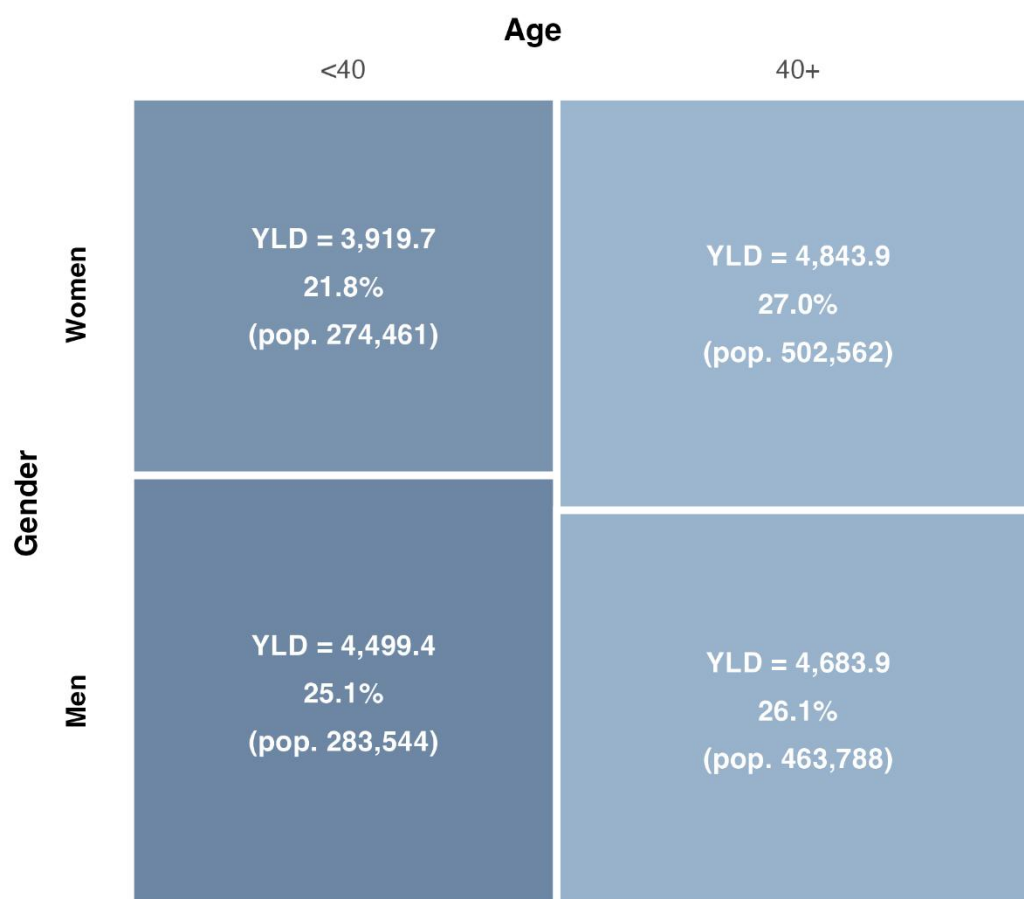


GHS-10-AO. Base: All participants (n = 3,000). Scores of 0 inferred for non-gamblers.

Figure 20 shows a mosaic plot for harm to affected others by intersections of gender and age. Please see section 7.2 for a description of how to interpret the mosaic plot.

While the highest level of gambling harm from one's own gambling was experienced by younger men, the findings for affected others indicate that harm is more evenly distributed across age and gender. The average harm experienced by people in different age and gender categories is similar, indicated by the similar shades of blue in the mosaic plot below. While younger people experiences slightly more harm on average compared to older people (hence slightly darker shades of blue), there are more people in the older age categories, so the total YLD for older people is slightly larger.

Figure 20 – Impact incurred by key population segments due to harm to affected others

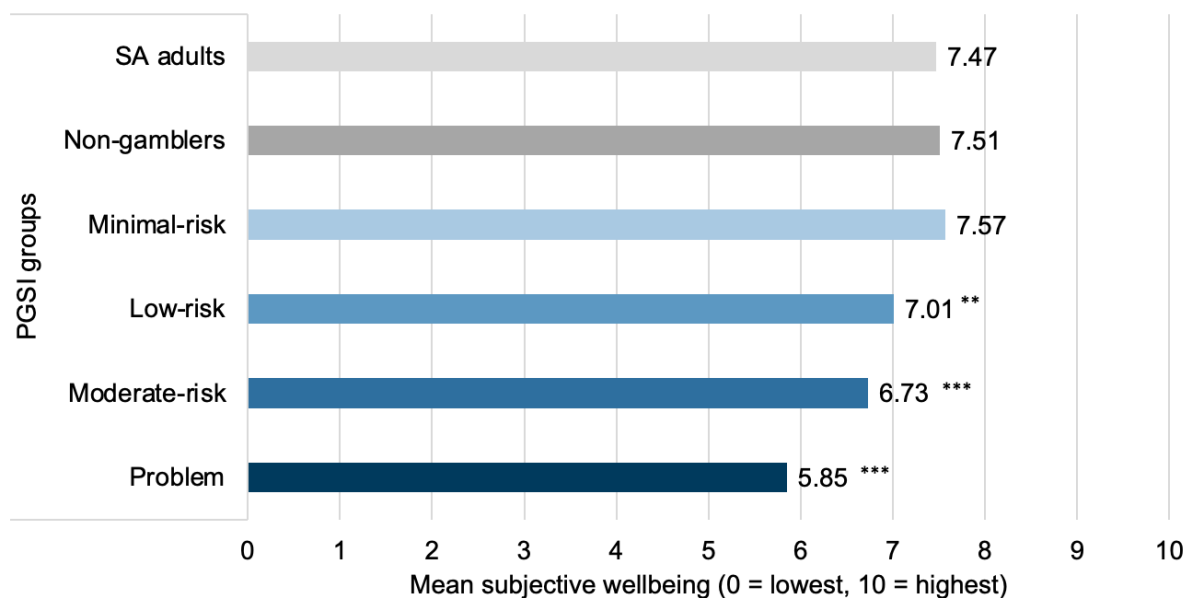


GHS-10-AO. Base: All participants (n = 3,000). Scores of 0 inferred for those not identifying as affected others. Note, YLD for non-binary and gender diverse people, and people who refused to disclose their gender, are not represented in the mosaic due to low numbers (YLD = 0).

7.4 Harm, gambling problems and wellbeing

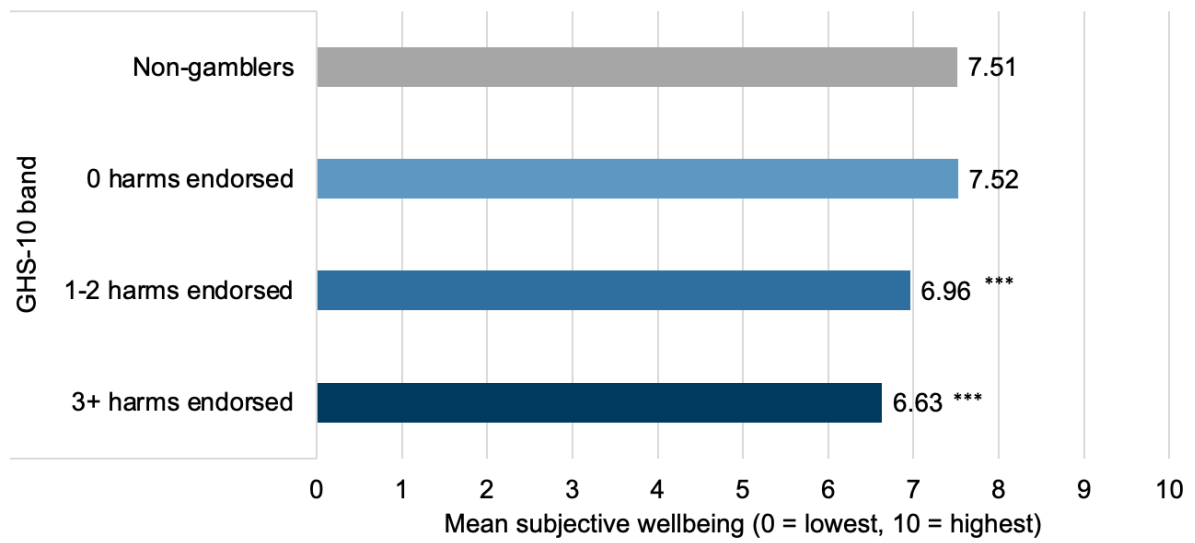
All participants completed questions related to wellbeing, including a global subjective wellbeing question “Overall, how satisfied are you with your life nowadays?”. Response options ranged from 0 (not at all) to 10 (completely), with higher scores indicating higher subjective wellbeing. For both the PGSI and the GHS-10, participants who showed no problems or harm reported slightly (but not significantly) higher wellbeing compared to people who did not gamble. This finding mirrors similar effects seen in other studies (Blackman et al., 2019). Higher risk categories (PGSI) and more harms endorsed (GHS-10) were associated with significantly lower wellbeing, indicating the validity of the measures of problems and harm (Figures 21 and 22).

Figure 21 – Association between PGSI category and wellbeing



“Overall, how satisfied are you with your life nowadays?” Base: All subsampled participants (n = 3,000).

Figure 22 – Association between GHS-10 bands and wellbeing



"Overall, how satisfied are you with your life nowadays?" Base: All subsampled participants (n = 3,000).

Chapter 8: Awareness and uptake of help services, and preferred help services

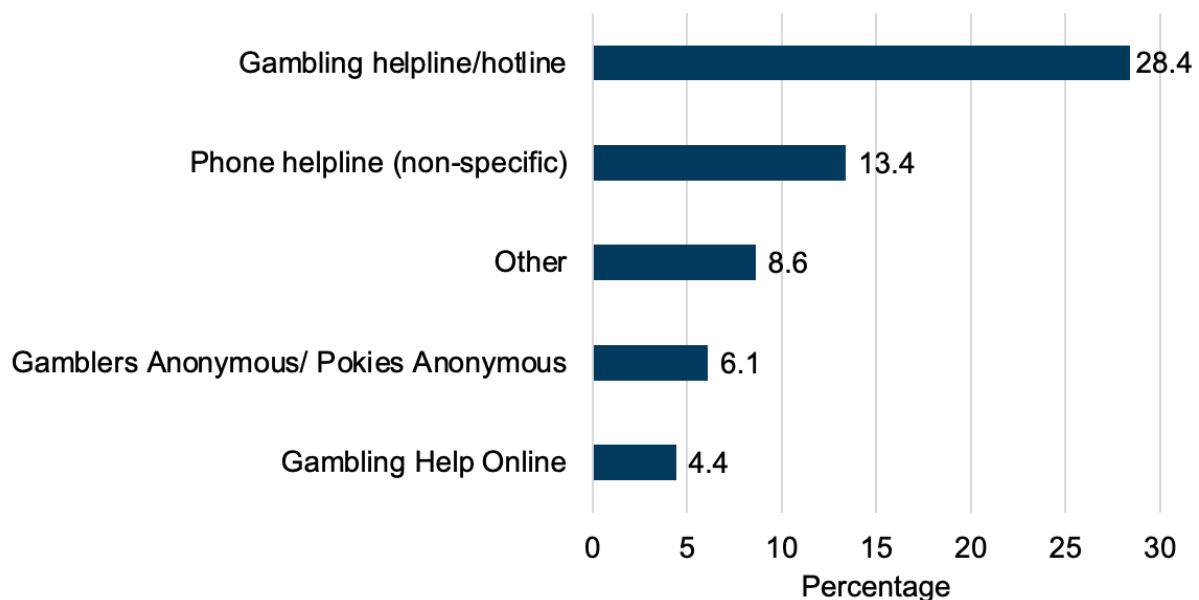
- About half of the South Australian adult population reported awareness of one or more help services (50.2%). The most commonly reported was the gambling helpline (28.4%), non-gambling specific helplines (13.4%) and Gamblers Anonymous/Pokies Anonymous (6.1%).
- Awareness of help services was notably lower for people who speak a language other than English at home (27.7%), and those not born in Australia (33.4%).
- Awareness of help services was slightly lower for younger people.
- Awareness of help services was also lower for those living in Adelaide, those in paid employment, people without a current partner, and people with lower income.
- Uptake of help services was very low. A total of 61 participants, out of 3,000 (2.0%), reported using a help service for either their own gambling issues (0.9%), or someone else's gambling issues (1.2%), noting that participants could indicate both responses.
- The 61 participants who had sought help were asked which help services they had used. The most common response was barring/self-exclusion (48.1%), followed by Gambling Help Online (25.1%) and Gamblers Anonymous/Pokies Anonymous (24.1%). Verbatim responses included Relationships Australia and Lifeline.
- All participants were asked their preferred method for seeking help. About half (50.4%) said face-to-face counselling, followed by telephone counselling (22.6%), online counselling (9.8%) and also online self-help (9.0%).
- This pattern was largely similar when the analysis was restricted to those experiencing problems or harm due to their own gambling, or harm due to someone else's gambling.
- Common "other" preferred sources of help included family and friends, medical help (e.g., GP), blended/hybrid (online and face-to-face). A small number mentioned AI chatbots.

8.1 Awareness of help services, including amongst people who experience problems or harm from their own gambling, or harm due to someone else's gambling

All participants were asked which gambling help services they were aware of. The most well-known service was the gambling helpline/hotline (28.4%), followed by non-gambling-specific phone helplines (13.4%) (Figure 23). Awareness of the gambling helpline/hotline was higher amongst people experiencing problems or harm due to their own gambling, and affected others, with around 45-50% aware of this help service (Figure 24). Awareness of other help services (non-gambling-specific phone helplines, Gamblers Anonymous/Pokies Anonymous and Gambling Help Online) was similar for those experiencing problems or harm compared to the general population.

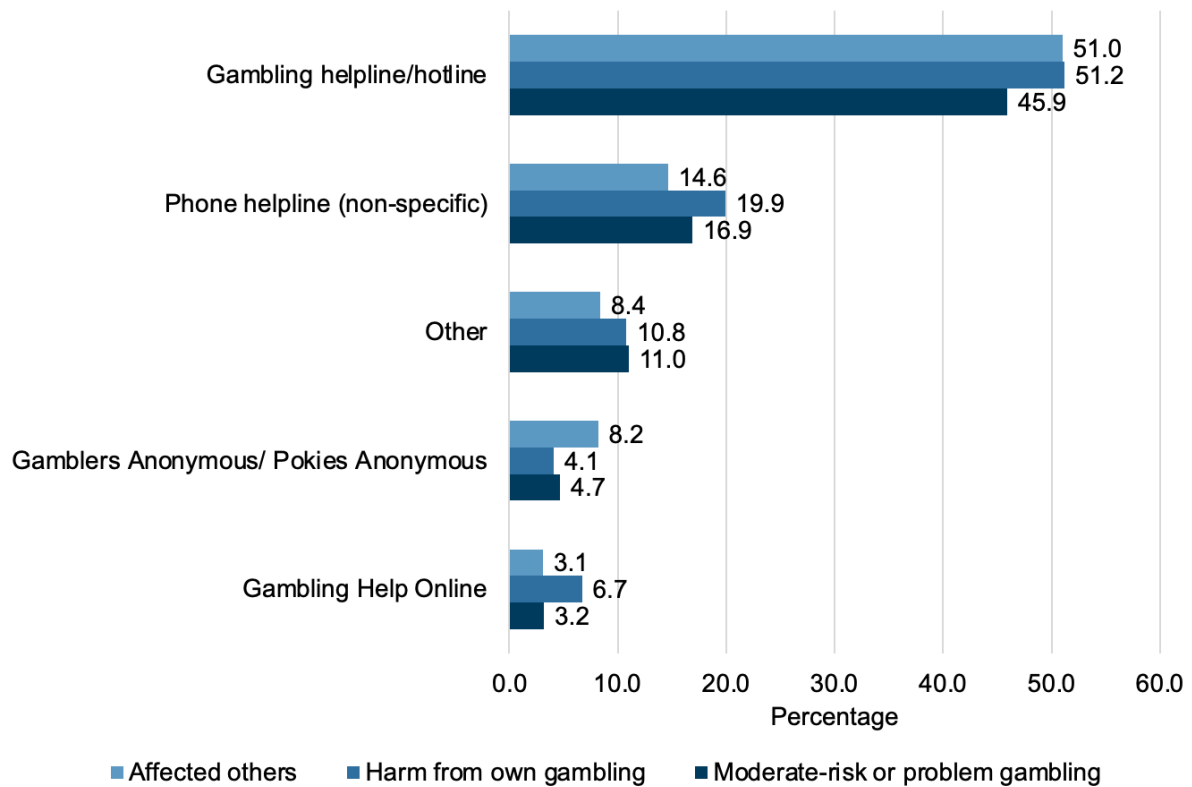
Participants who said “other” were asked what other help services they knew of. The most common response was advertising, referring to ads on TV, radio, streaming services, and “gamble responsibly” messages at the end of these advertisements, which have now been phased out. Other options include Lifeline, Beyond Blue, Relationships Australia, self-exclusion or self-barring, in-venue signage/materials, GP or mental health practitioners, Gambling SA and state-based services, Employee Assistance Programs, Salvation Army, Anglicare or Uniting Care and financial services, such as financial counsellors or budgeting support.

Figure 23 – Awareness of help services



“What telephone, online, and face to face services are you aware of to assist people harmed by gambling?”
Base: All participants (n = 3,000).

Figure 24 – Awareness of help services by PGSI, gambling harm and affected other status

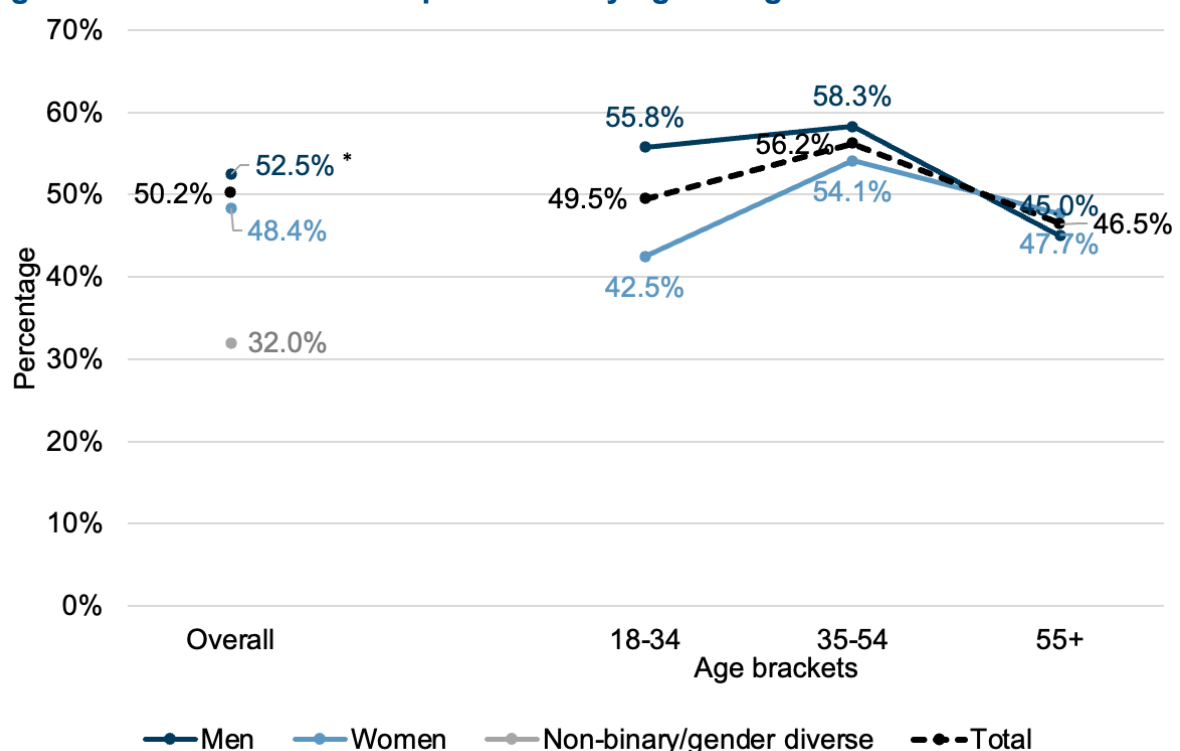


“What telephone, online, and face to face services are you aware of to assist people harmed by gambling?”
 Base: All participants (n = 3,000).

Figure 25 shows awareness of any help service by age and gender. Awareness of help services was slightly higher for men compared to women, and low for non-binary or gender diverse people, although this is based on a small sample. Awareness was highest amongst those aged 35-54, for both men and women.

Awareness of help services was very low for people who speak a language other than English at home, and those not born in Australia. Awareness of gambling help services was also lower for those living outside Adelaide, those not in paid employment, those who have completed tertiary education, and those with lower personal or household incomes (Table 8).

Figure 25 – Awareness of help services by age and gender



"What telephone, online, and face to face services are you aware of to assist people harmed by gambling?"
 Base: All participants (n = 3,000).

Table 8 – Awareness of any help service by demographics

Demographic	% Aware of any help service
SA adults	50.2%
Location	
Adelaide	48.5%
Elsewhere in South Australia	56.3%***
Main language at home	
English	56.4%***
LOTE	27.7%
Country of birth	
Australia	56.2%***
Another country	33.4%
Identify as Aboriginal and/or Torres Strait Islander	
Yes	53.7%
No	50.1%
Married or living with a partner	
No (including divorced, separated, widowed, single)	49.9%
Yes	50.5%
In paid employment	
No (including student, retired, etc)	45.2%
Yes (full time, part time, casual)	54.1%***
Tertiary education	
No	51.4%*
Yes	46.3%
Personal income, per year	
Refused or don't know	33.9%
\$1 to \$25,999	41.8%**
\$26,000 to \$51,999	51.2%***
\$52,000 to \$90,999	55.9%***
\$91,000 to \$155,999	60.6%***
\$156,000 or more	57.4%***
Household income, per year	
Refused or don't know	36.4%
\$1 to \$25,999	40.1%*
\$26,000 to \$51,999	51.2%***
\$52,000 to \$90,999	52.9%***
\$91,000 to \$155,999	51.4%***
\$156,000 or more	60.4%***

"What telephone, online, and face to face services are you aware of to assist people harmed by gambling?"

*Base: All participants (n = 3,000). Asterisks (if present) indicates a statistically significant difference: * p < .05, ** p < .01, *** p < .001.*

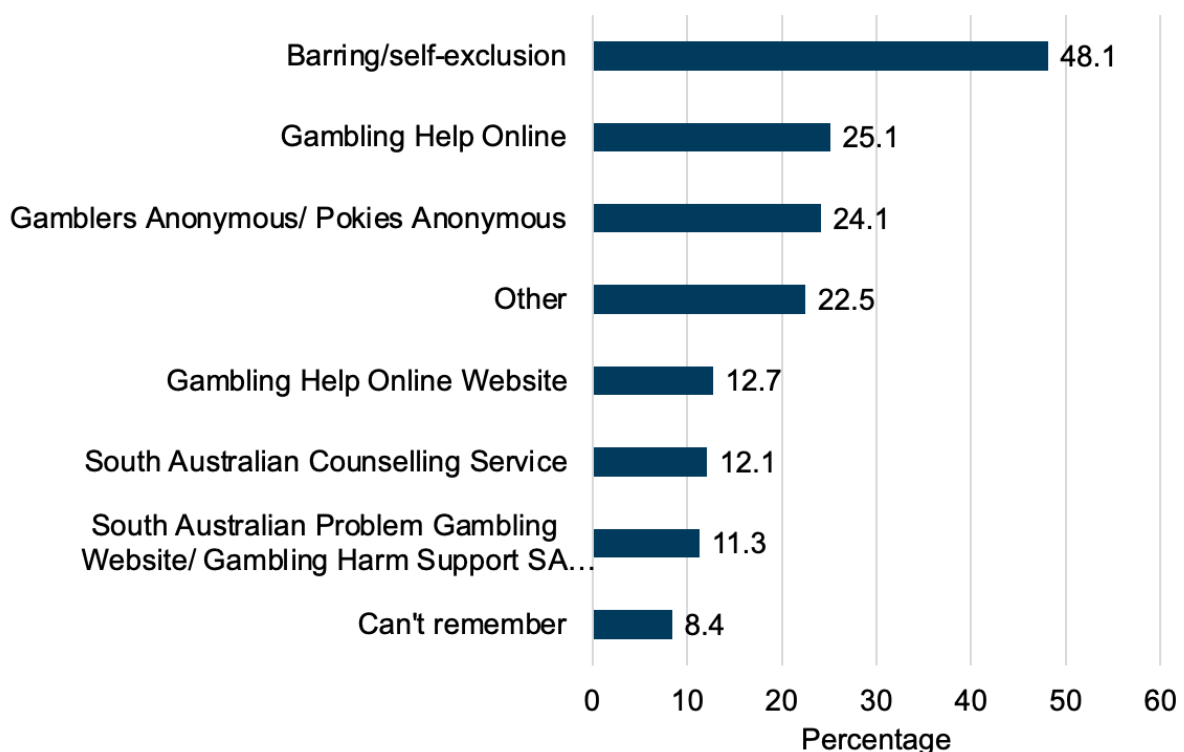
8.2 Uptake of help services

All participants were asked if they had ever used a gambling help service for their own or someone else's gambling issues. Out of the 3,000 participants, 27 (0.9%) reported that they had used a help service for their own gambling issues, and 35 (1.2%) reported that they had used a gambling help service for someone else's issues. Participants could endorse both responses.

Given the small number of participants, an analysis of uptake by demographic or other factors was not possible.

All participants who had sought help (n = 61) were asked which help services they had used. The most common response was barring/self-exclusion (48.1%), followed by Gambling Help Online (25.1%), Gamblers Anonymous/Pokies Anonymous (24.1%) and other (22.5%) (Figure 26). The most common "other" responses were Relationships Australia and Lifeline.

Figure 26 – Which help services were used by those who have sought help



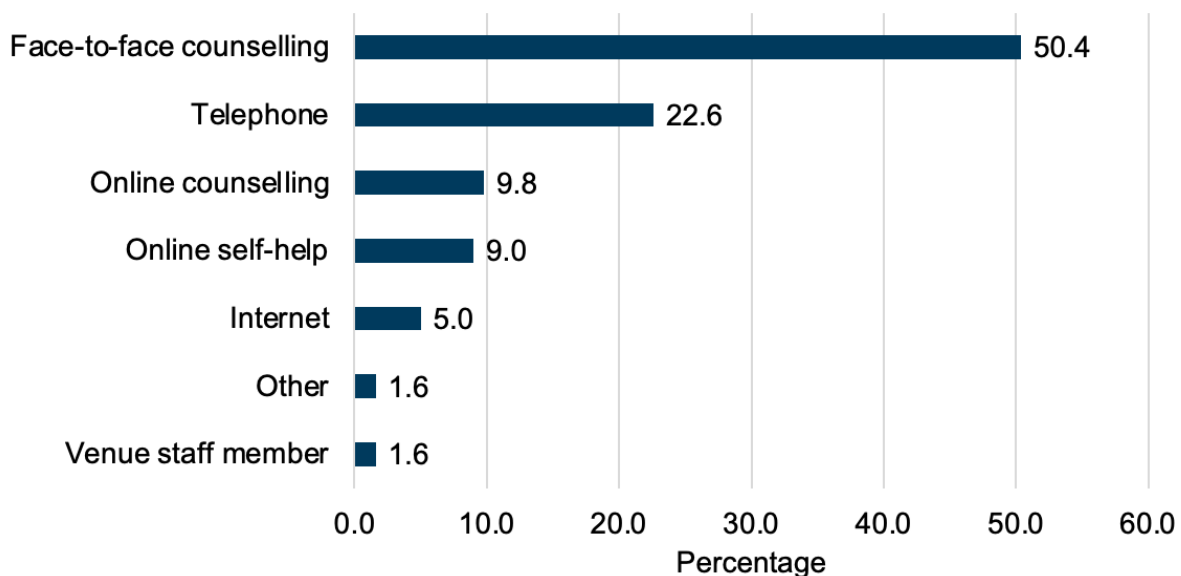
"Which service did you use?" Base: All participants who had ever sought help (n = 61).

8.3 Preferred method of receiving help

All participants were asked what method they would or do prefer for receiving help. The most common response, endorsed by just over half of the participants, was face-to-face counselling, followed by telephone (22.6%), online counselling (9.8%), and online self-help (9.0%) (Figure 27). Common “other” responses were family and friends, medical help (e.g., GP), blended/hybrid options (e.g., online and face-to-face counselling), formal help services and religious help services. Some participants preferred a prohibition response, such as banning all gambling or advertising. A small number indicated preference for AI-based help services.

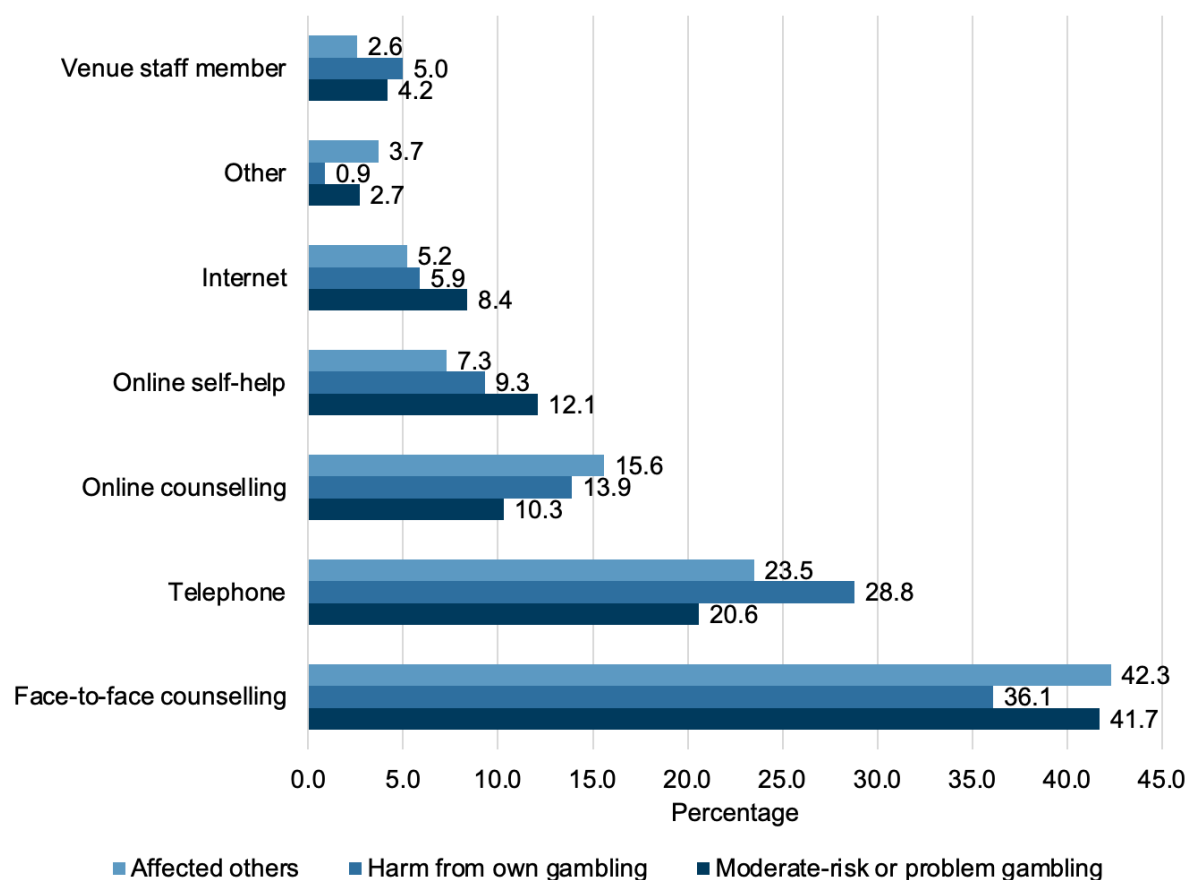
When restricting responses to those in the moderate-risk or problem gambling groups, those who experienced harm due to their own gambling, or those who experienced harm due to someone else’s gambling, the general pattern of responses is similar: a preference for face-to-face counselling, telephone counselling or online counselling (Figure 28).

Figure 27 – Preferred method for seeking help



“What would be or is your preferred method of receiving gambling-help regarding either your own gambling or someone else’s gambling?” Base: All participants (n = 3,000).

Figure 28 – Preferred method for seeking help amongst those experiencing problems or harm due to their own gambling, or harm due to someone else's gambling



“What would be or is your preferred method of receiving gambling-help regarding either your own gambling or someone else’s gambling?” Base: All participants (n = 3,000).

Chapter 9: Detailed gambling behaviour

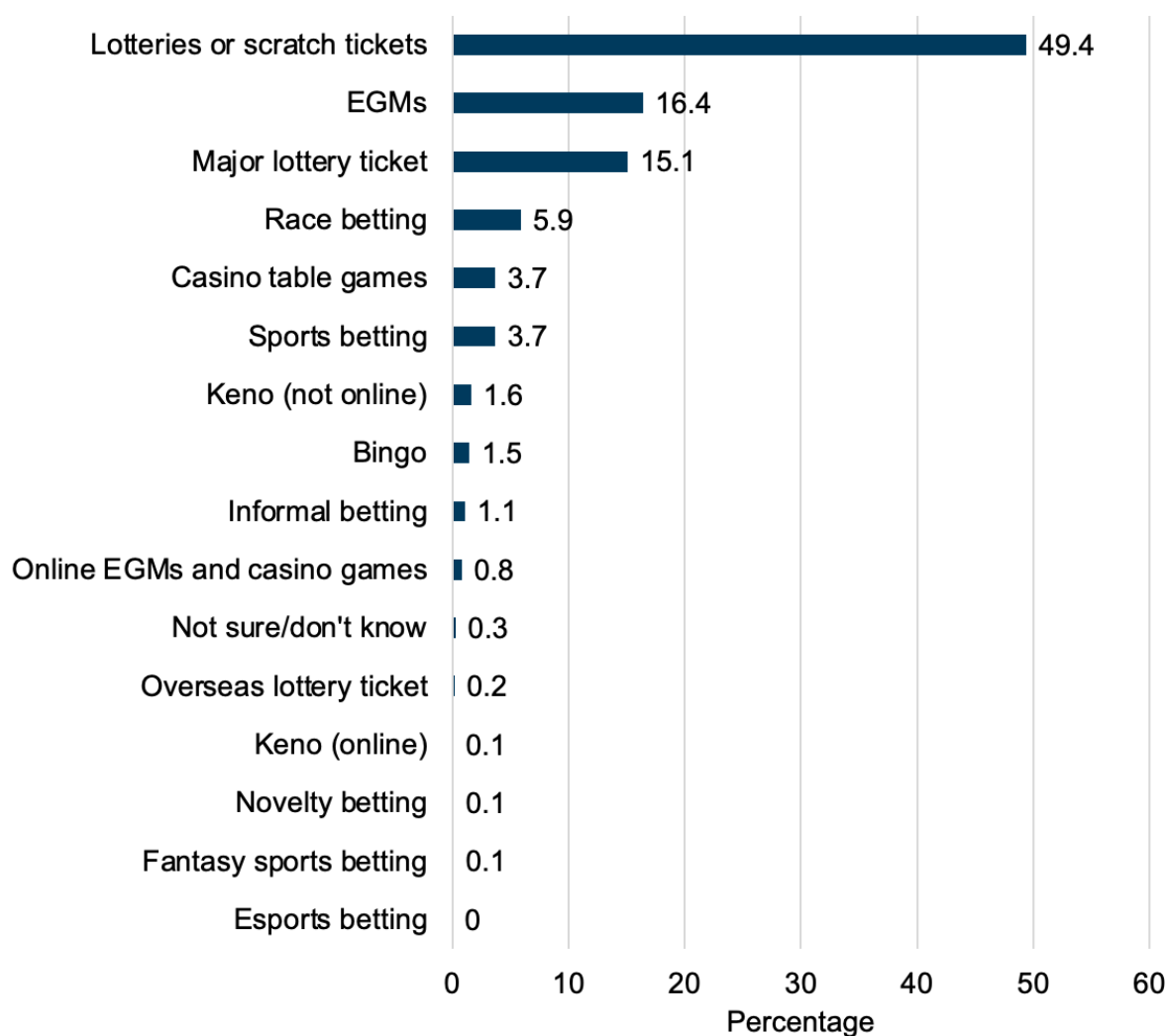
- The forms on which participants reported spending the most money largely aligned with the prevalence of each form. Lotteries and scratch tickets were the most commonly-reported (49.4%), followed by EGMs (16.4%) and major lottery tickets (15.1%). Race betting (5.0%), casino table games (3.7%) and sports betting (3.7%) were the only other forms above 2%.
- More than half of the participants reported typically gambling at a frequency of less than once a month.
- Typical sessions were 10 minutes or less for almost two-thirds of the participants, with 4.7% reporting sessions more than two hours in length.
- Around half reported spending \$20 or less in a typical session, while 7.8% reported spending more than \$100 on a typical session.
- The most common times of day for gambling were between 10am and 6pm, and 6pm and midnight.
- Almost two-thirds reported never drinking alcohol when gambling, while 12.7% reported drinking alcohol often or always while gambling.
- 15.2% reported being a member of a gambling loyalty program.
- For all measures (frequency, session duration, typical spend, alcohol use and loyalty program), people in higher-risk PGSI groups were significantly more likely to gamble more often, for longer, to spend more, to drink alcohol while gambling, and to be a member of a loyalty program, compared to those in lower-risk PGSI groups. People in higher-risk PGSI groups were also significantly more likely to gamble after midnight compared to those in lower-risk groups.

The analyses in this chapter report findings on detailed gambling behaviour, including which form participants typically gambled on, typical session frequency, duration and expenditure, and time of day. Participants reported their main gambling activity, and then further information based on that activity. Due to the limited survey space and sample size, the only activity with enough participants for disaggregated reporting was lottery and scratch tickets. Different gambling forms have different structural characteristics, which makes the aggregated data difficult to interpret, and any comparisons based on demographics likely reflect demographic differences between gambling forms. This chapter therefore reports the findings for the sample as a whole, because they cannot be split by gambling form due to sparse cell counts, and because demographic comparisons reflect differences in gambling forms that have been reported in earlier chapters. PGSI comparisons are reported where data allow.

9.1 Which gambling activity people spent most money on

Participants who had gambled within the last 12 months were asked on which gambling form they had spent the most money. The findings are presented in Figure 29, with figures generally reflecting relative prevalence of each form. The most commonly-reported forms were lotteries or scratch tickets, EGMs and major lottery tickets, followed by race betting, casino table games and sports betting. Most other forms were reported by <2% of participants.

Figure 29 – Gambling form on which participants spent the most money



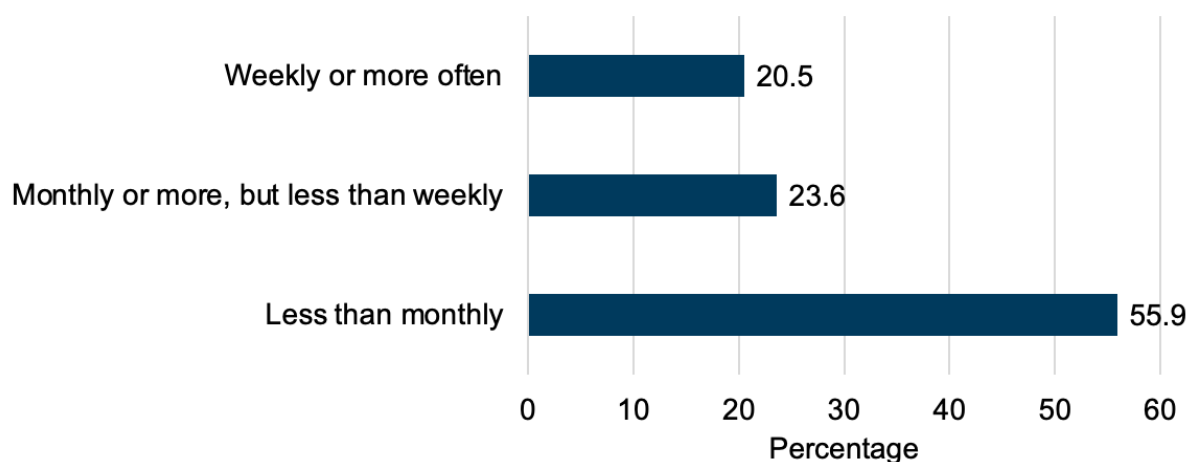
"Which gambling activity have you spent the most money on overall, not including winnings?" Base: All participants who gambled in the last 12 months (n = 1,627).

9.2 Frequency of a typical gambling session

Participants were asked how often they gambled on their main activity. About 56% of people who gambled in the last 12 months reported gambling 5 times a year or less, and 20.5% reported gambling weekly or more often (Figure 30).

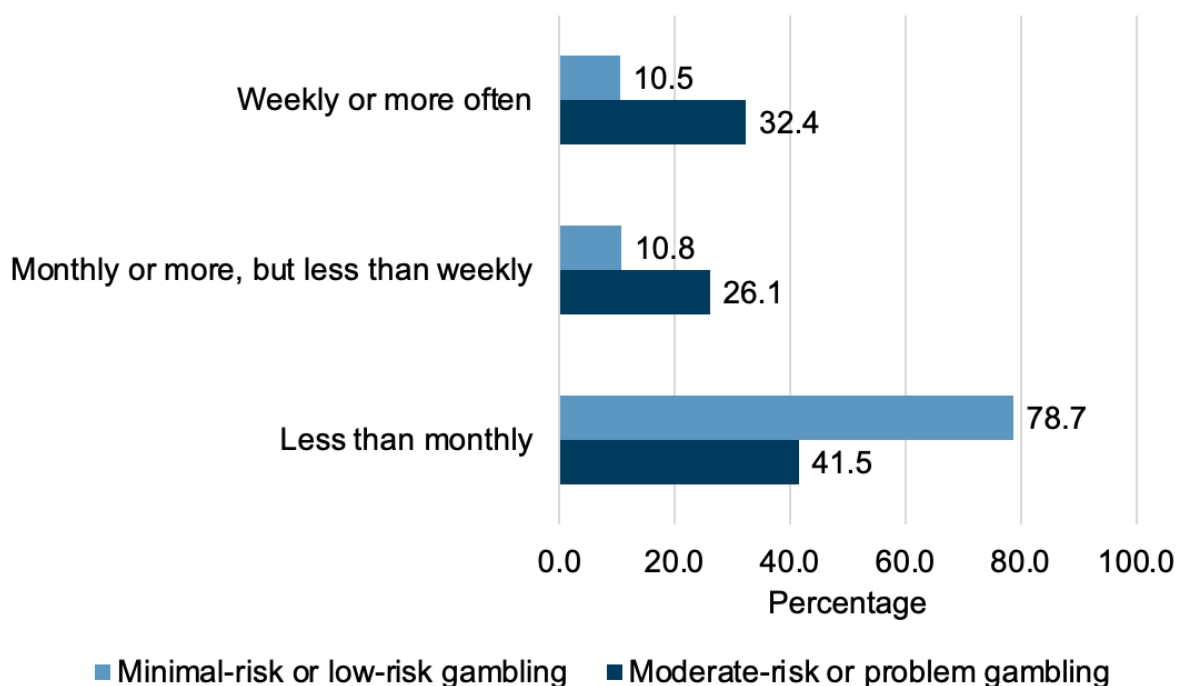
On average, those who experience moderate-risk or problem gambling according to the PGSI reported 58 sessions per year ($SD = 77$), compared to 22 sessions per year ($SD = 55$) for those who experience minimal-risk or low-risk gambling. This difference was statistically significant, $Welch\ t(66.2) = 3.66, p < .001$.

Figure 30 – Frequency of a typical gambling session



"How often did you gamble?" ($n = 1,627$).

Figure 31 – Frequency of a typical gambling session by PGSI

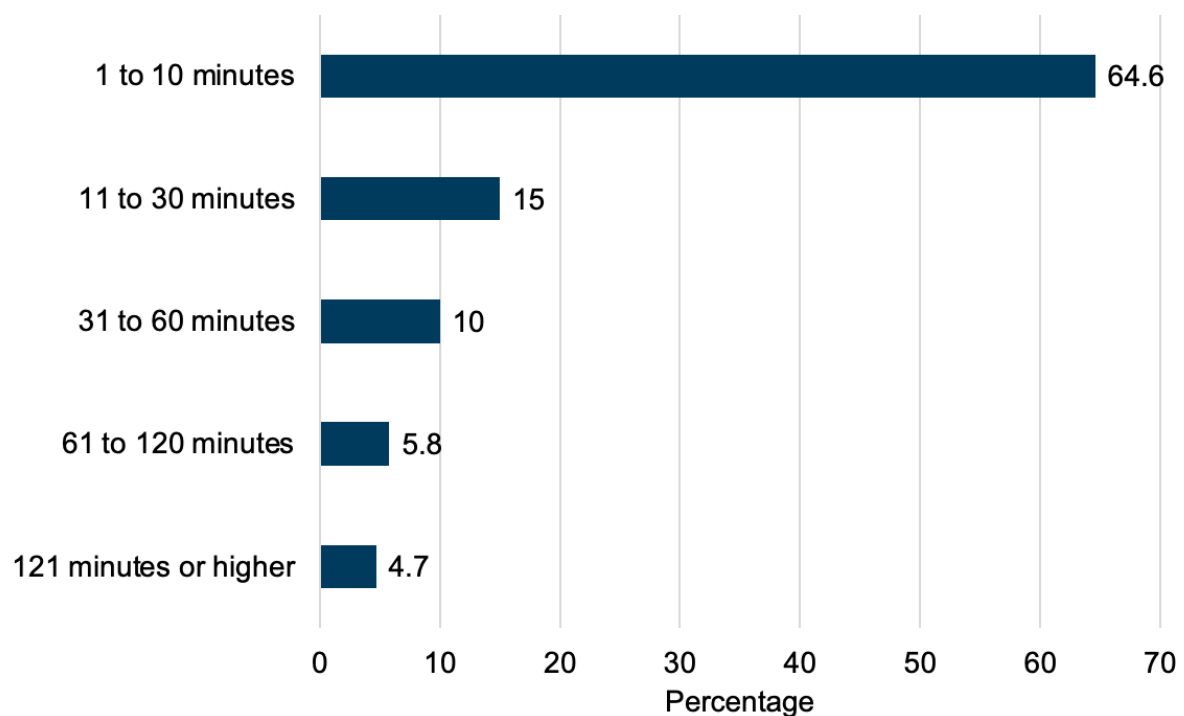


"How often did you gamble?" ($n = 1,627$).

9.3 Duration of a typical gambling session

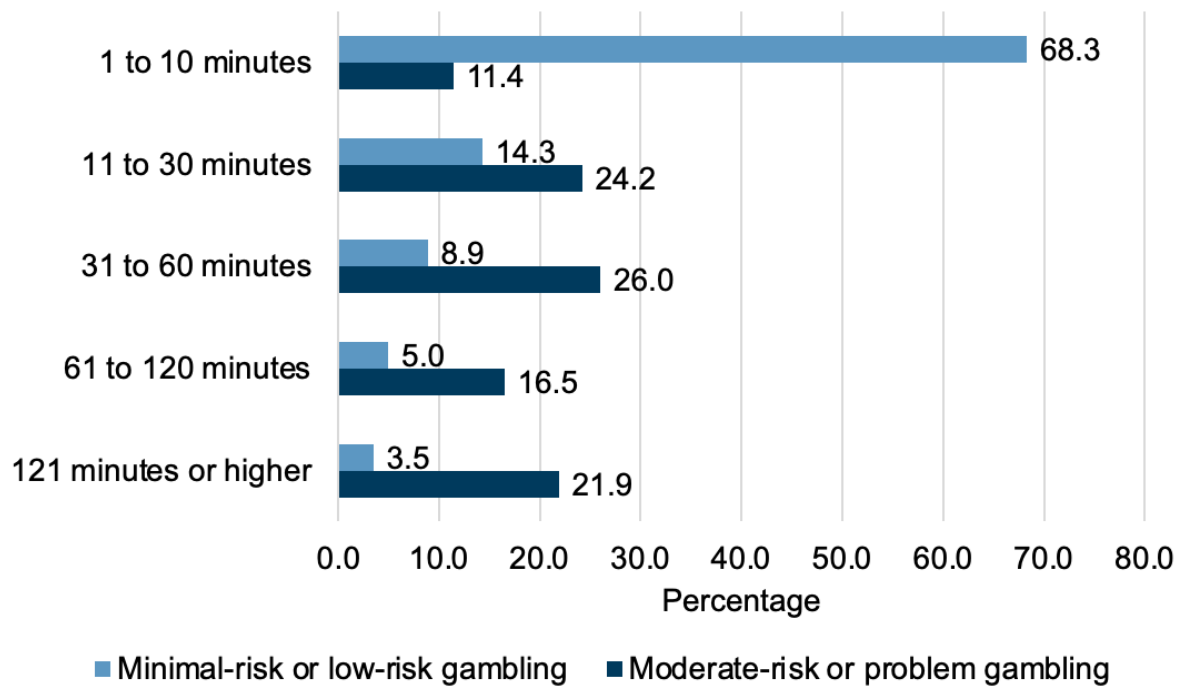
Participants were asked how much time they spent on a typical gambling session, with responses ranging up to 900 minutes (15 hours). Potential interpretations of these data are limited by the different nature of gambling forms. For example, certain forms such as lotteries or scratch tickets are characterised by discrete purchases, whereas gambling sessions are more appropriate for forms that are more continuous (EGMs, wagering products, bingo). This is reflected in Figure 32 below, where almost two-thirds of participants reported a typical session of 10 minutes or less. Approximately 4.7% of participants reported sessions of more than two hours in length. Those who experience moderate-risk or problem gambling were significantly more likely to report longer sessions, $\chi^2(4) = 174.03$, $p < .001$, $\phi = .33$ (Figure 33).

Figure 32 – Duration of a typical gambling session



"How much time did you spend gambling in a typical gambling session?" (n = 1,592)

Figure 33 – Duration of a typical gambling session by PGSI



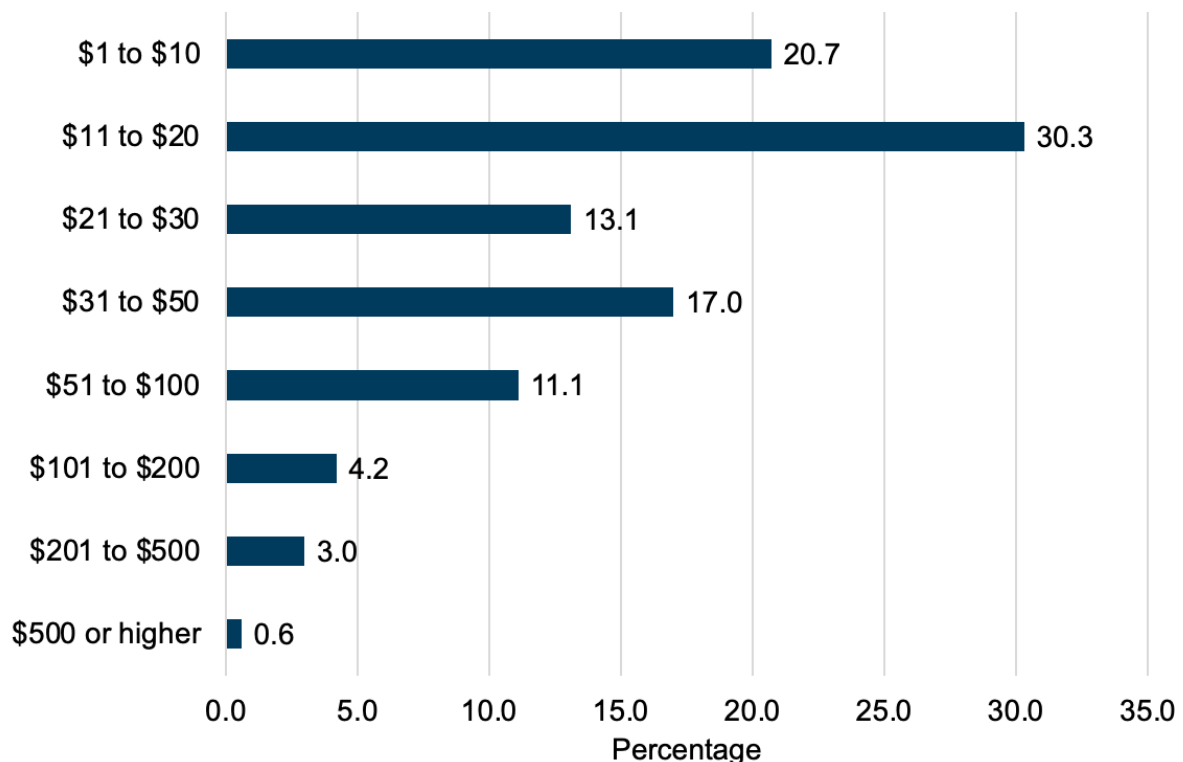
"How much time did you spend gambling in a typical gambling session?" (n = 1,592)

9.4 Expenditure during a typical gambling session

Participants were asked how much they spent in a typical gambling session. The highest value was \$10,000 (one participant), followed by \$2,000 (one participant), \$1,500 (one participant) and \$1,000 (five participants). More than half reported values of \$20 or less (Figure 34).

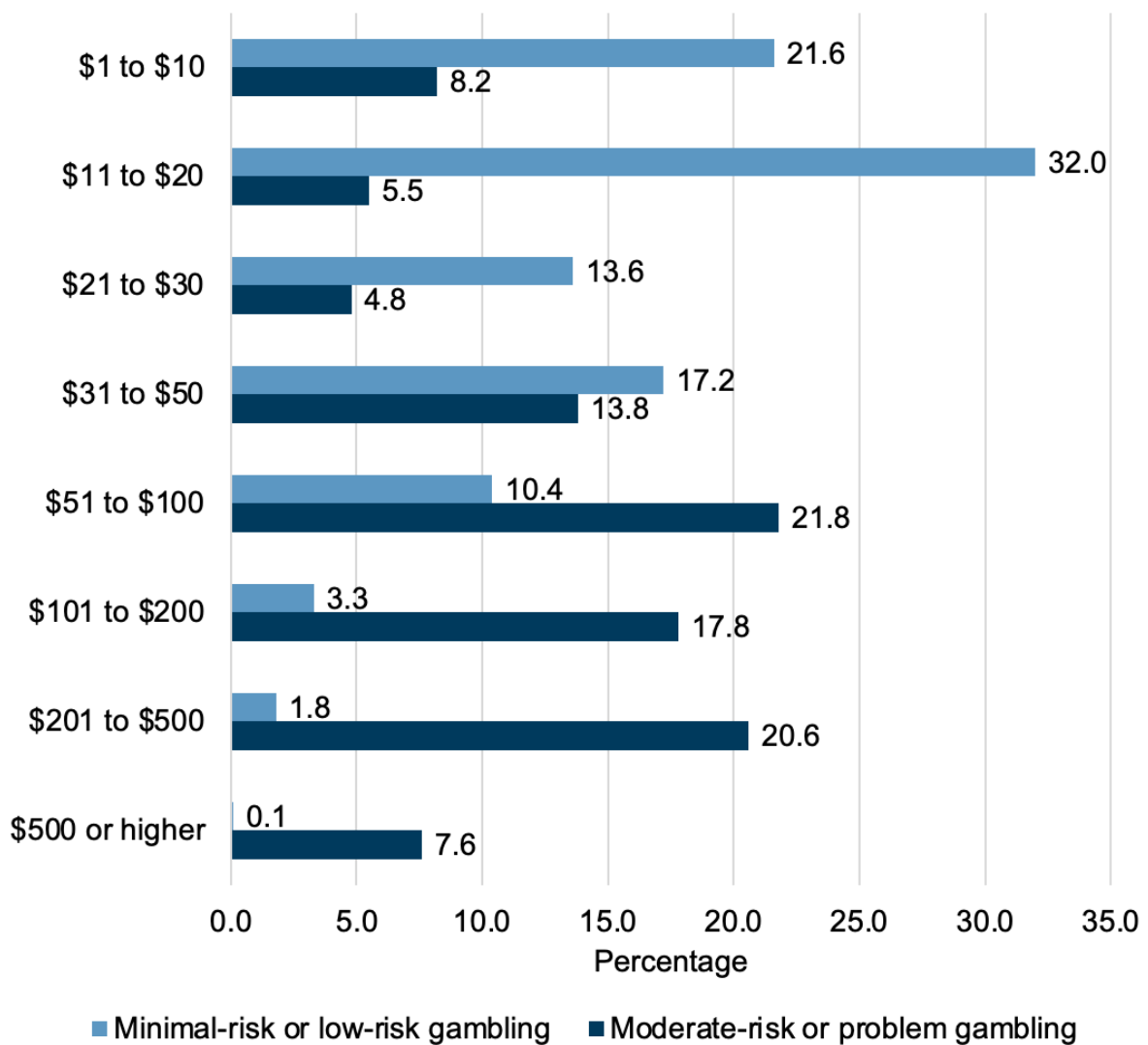
Approximately half reported spending \$20 or less in a typical session, while 7.8% reported spending \$100 or more. When considering problem gambling status, more than half of those in the minimal-risk and low-risk categories spent \$20 or less in a typical session, while more than two-thirds of those in the moderate-risk or problem gambling categories spent \$51 or more in a typical session, $\chi^2(7) = 297.97$, $p < .001$, $\phi = .43$ (Figure 35).

Figure 34 – Expenditure in a typical gambling session



"How much money did you spend in a typical gambling session?" (n = 1,612)

Figure 35 – Expenditure in a typical gambling session by PGSI

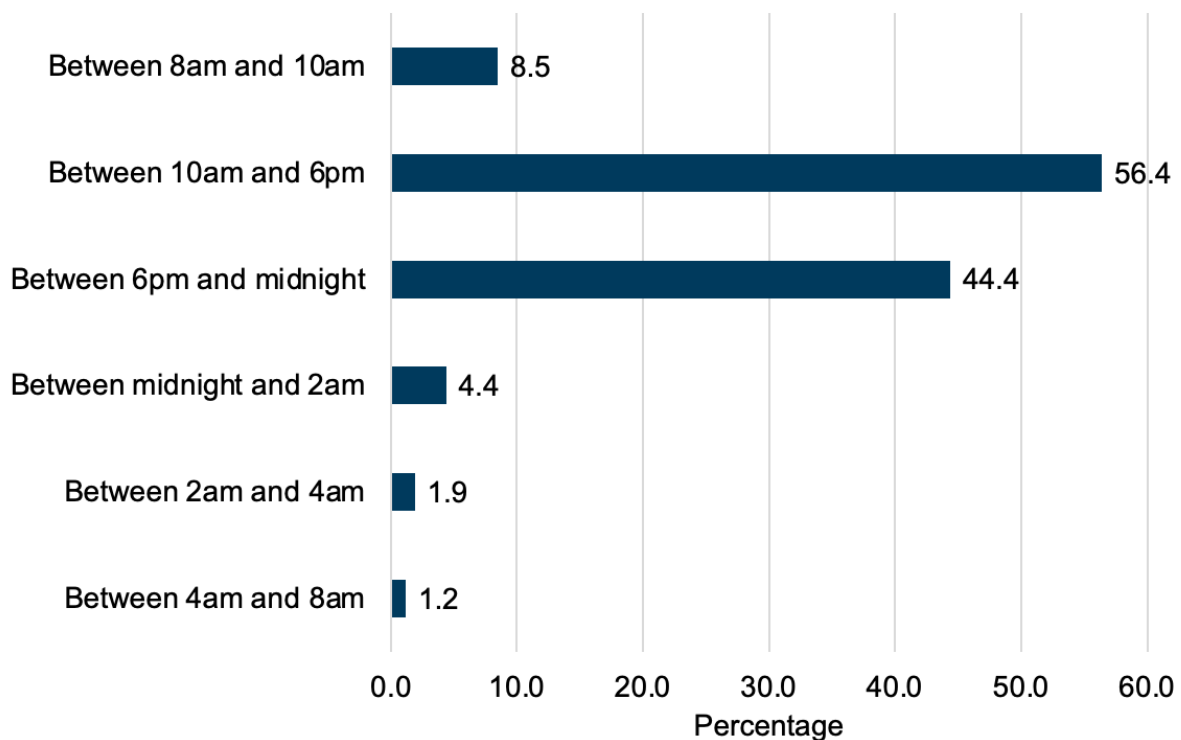


"How much money did you spend in a typical gambling session?" (n = 1,612)

9.5 Time of day at which people typically gambled

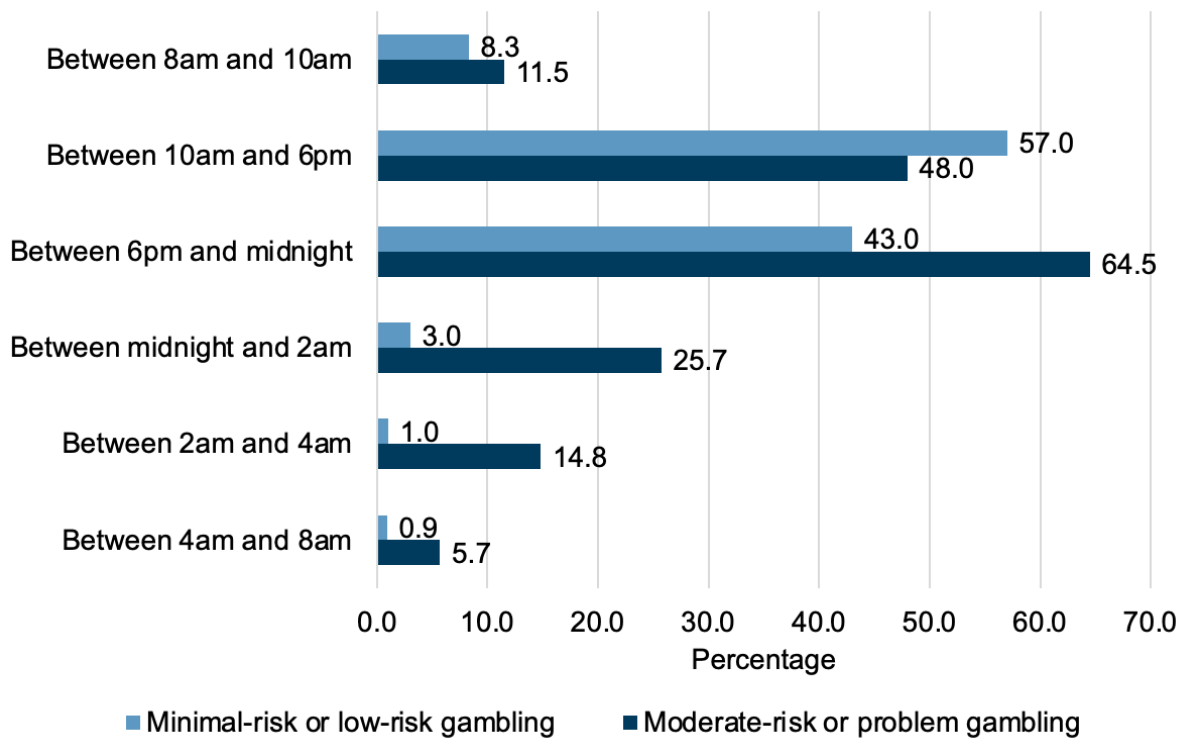
Participants were asked at which time of day they typically gambled, with the option to select multiple time periods. Most gambling occurred between 10am and 6pm, followed by between 6pm and midnight (Figure 36). People in higher-risk PGSI groups were significantly more likely to gamble between 6pm and midnight compared to those in lower-risk groups. This was particularly pronounced for gambling after midnight through until 8am (Figure 37).

Figure 36 – Time of day of a typical gambling session



"Thinking about the last 12 months, did you typically gamble between the following times?" Multiple responses possible, to values sum to more than 100%. (n = 1,612)

Figure 37 – Time of day of a typical gambling session by PGSI

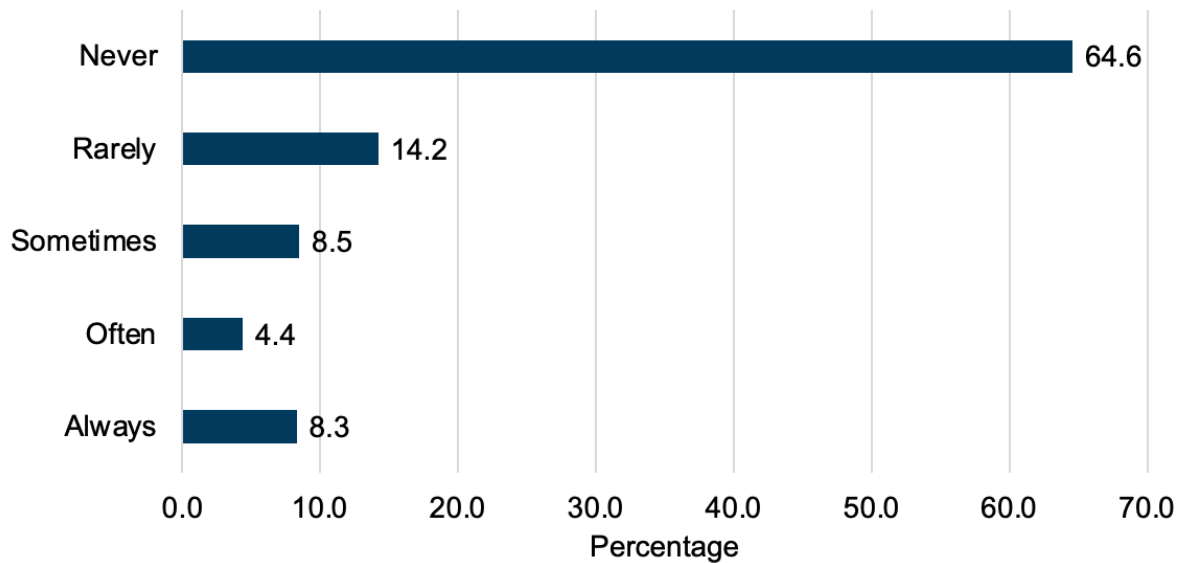


"Thinking about the last 12 months, did you typically gamble between the following times?" Multiple responses possible, to values sum to more than 100%. (n = 1,612)

9.6 Alcohol use while gambling

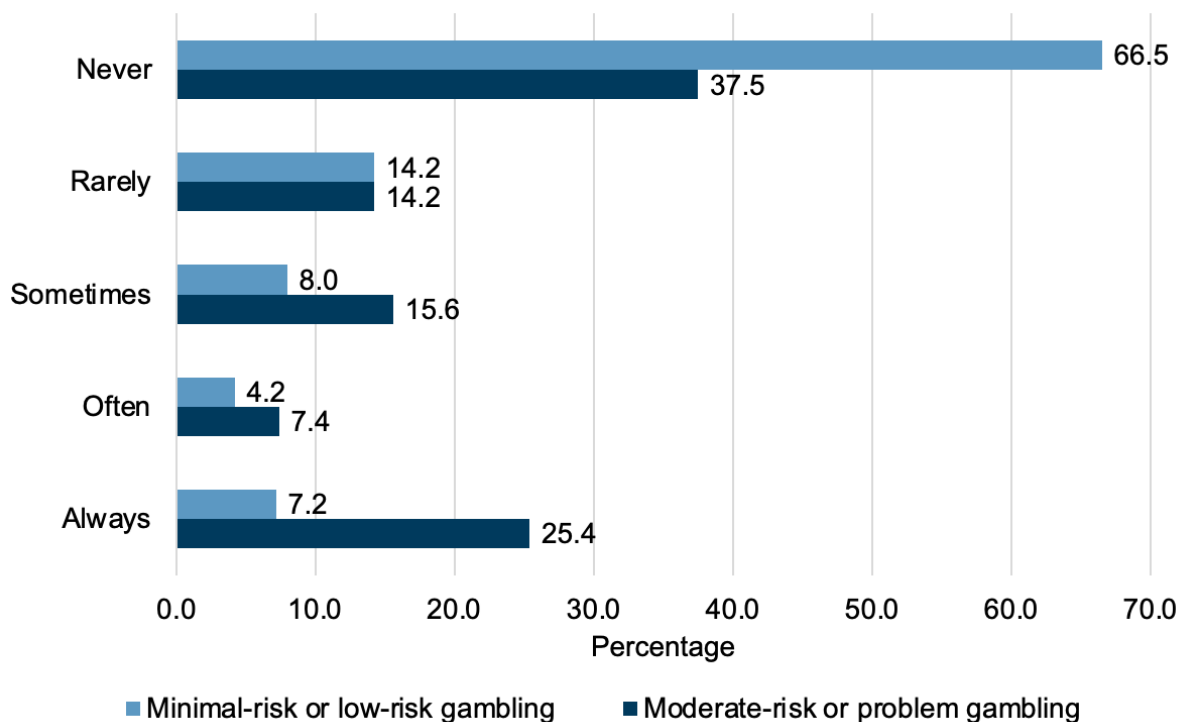
Participants reported how often they used alcohol while gambling in the past 12 months. Almost two-thirds of participants reported never drinking alcohol while gambling (Figure 38). People in the higher-risk PGSI groups were significantly more likely to report drinking alcohol while gambling sometimes, often or always compared to those in lower-risk groups, $\chi^2(4) = 60.04$, $p < .001$, $\phi = .19$ (Figure 39).

Figure 38 – Frequency of alcohol use when gambling



"How often during the past 12 months did you drink alcohol while gambling? (n = 1,622)"

Figure 39 – Frequency of alcohol use when gambling by PGSI



"How often during the past 12 months did you drink alcohol while gambling? (n = 1,622)"

9.7 Loyalty cards

Participants who reported gambling most often in venues (clubs, hotels, casinos, racetracks, TAB outlets) were asked if they were a member of a loyalty card program, such as Jackpot Club Loyalty or SkyCity Rewards. 15.2% reported that they were. This figure was significantly higher for those in the moderate-risk or problem gambling groups (30.4%), compared to those in the minimal-risk or low-risk groups (12.8%), $\chi^2(1) = 14.13$, $p < .001$, $\phi = .17$.

Chapter 10: Discussion

10.1 Context and Rationale for the 2025 Survey

This is the fourth South Australian gambling prevalence study, following studies in 2005, 2012 and 2018. It provides the most comprehensive assessment of gambling-related harm in South Australia to date, including validated and benchmarked measures of harm, both for harm experienced from a person's own gambling, and harm experienced by affected others. The current study also draws on analysis and reporting conventions introduced in the recent NSW and ACT 2024 studies (Browne et al., 2024; Rockloff et al., 2025), facilitating cross-jurisdiction comparisons.

There has been substantial regulatory and legislative change since the 2018 survey, including reforms for venue-based gambling, as well as federal reforms for online gambling. These are described in detail in section 1.2 of this report. These changes shape the context of the current results.

10.2 Methodological Overview and Sampling Innovations

The survey was conducted as part of a broader health study. The sample was limited to 3,000 participants, compared to 10,000-20,000 that is typical of gambling prevalence surveys. This survey size allowed for estimation of gambling behaviour, problems and harms, but limited some analyses, such as analyses of low-prevalence behaviour or groups, notably people identifying as Aboriginal or Torres Strait Islander. Age reporting was confined to three age brackets, compared to six age brackets in other jurisdictions with larger samples. This limits some conclusions that can be drawn. This smaller sample size also meant that, in some cases, differences that may have been statistically significant with a larger sample were not in the current sample. Therefore, in some cases, results might differ to other jurisdictions on the basis of sample size rather than actual meaningful differences in results.

The number of questions was also limited, due to available space within the survey. The limitations of this approach are most noticeable in questions about detailed gambling behaviour (e.g., frequency, typical session duration, typical session expenditure), which were asked in relation to the form that a person engages in the most. This limits information about most forms, particularly since many people engage in more than one gambling form. Another notable exception due to space constraints was the omission of legacy harm. Legacy harm has been included in recent studies to capture a comprehensive picture of current harm in other jurisdictions. This recognises that harm is generally captured in relation to the last 12 months, but gambling harm typically lasts much longer (Rockloff et al., 2022).

The survey was conducted via a mobile-only sampling frame, moving away from the overlapping design (i.e., both landlines and mobile phones) used in 2018. This change in sampling frame is in line with best practices within the telephone survey industry. In addition, the sample was sourced from the Integrated Public Number Database, a list of most public and private numbers within Australia. The IPND has the advantage that billing address is included with the phone number, enabling targeting of mobile phone numbers by location. The IPND has been used in most recent gambling prevalence studies and has been shown to capture a sample that is demographically similar to the population. This is particularly true in terms of capturing young men, who are typically difficult to sample, and who are often a group of high interest due to the higher levels of problems and harm that they experience. The benefit of this approach is that the weighting was relatively mild, minimising statistical power issues.

The survey adhered to independently certified ethical and quality standards. Additional details on the methods are provided in the appendices and in the accompanying technical report.

10.3 Gambling Participation and Demographic Patterns

Gambling participation continued to decline, following the trend seen over previous studies: 54.2% of adults engaged in at least one gambling activity in the last 12 months, down from 65-70% in previous South Australian studies. An additional figure of 51.2% was calculated, reflecting prevalence on any form apart from major lotteries (i.e., raffle-like promotions), as these are not included in most other Australian jurisdiction prevalence studies. The figure of 51.2% therefore reflects the best figure for comparisons with other jurisdictions.

Unlike studies in other jurisdictions, there was no significant difference between genders in terms of overall gambling participation, although this may be partly due to the smaller sample, as smaller samples reduce statistical power to find significant differences. Older adults were typically more likely to take part in gambling, reflecting their higher uptake of the most prevalent gambling forms: lotteries and scratch tickets (see next section). This age result, and other demographic results (e.g., gambling is higher amongst those who speak English at home, and those who had not completed tertiary education), were broadly consistent with those seen in NSW and the ACT.

10.4 Forms of Gambling, Frequency and Online Engagement

The long-term downward trend in overall participation foreshadowed a similar downward trend for most gambling forms. Lotteries and scratch tickets remain the

most popular form (41.1%), consistent with national trends. However, their contribution to harm is relatively low, despite their high prevalence.

While the prevalence of most forms has declined in most jurisdictions, sports betting has increased in NSW and the ACT. This trend was not found in South Australia, where the proportion of adults taking part in sports betting has slightly decreased. This may reflect the small sample size, where trends may be less apparent, or factors specific to South Australia, although this cannot be determined from the findings. However, almost one in five young men take part in sports betting, and this form is associated with gambling harm. Research should continue to monitor sports betting trajectories in South Australia. Newer forms, such as esports betting and fantasy sports betting, remain relatively low prevalence. However, they are disproportionately associated with gambling problems, with a high proportion of participants experiencing gambling problems.

A formal online gambling rate could not be estimated in the current study due to space constraints. While some forms can be attributed to online gambling (e.g., online EGMs and casino games), others (e.g., sports betting, race betting) can be conducted either online or in venues or by telephone call. Assessing online gambling on these forms required a follow-up question for each form, which could not be included due to space constraints. However, based on trends in other jurisdictions and the Australian Gambling Statistics data, it is highly likely that online gambling participation has increased since 2018. This is an important limitation in the current design, and consideration for future studies.

Young men (18-34) are the demographic that are most likely to engage in higher-risk forms of gambling (EGMs, casino games, sports betting). This pattern is consistent with findings in NSW and the ACT.

10.5 PGSI Risk Categories and Gambling Problems

Amongst all South Australian adults, 9.8% experienced some degree of gambling problems in 2025. While a lower proportion of South Australian adults reported taking part in gambling, approximately similar proportions of adults experienced some degree of problems. Further, amongst those who reported gambling, a higher proportion reported experiencing some degree of problems. This finding of an **intensification** of gambling problems mirrors findings in NSW and the ACT. That is, while the proportion of adults who are gambling has decreased, the reduction has mostly been amongst those in the non-problem gambling group, rather than those who experience some degree of problems. Further evidence of this intensification is increased losses on EGMs (see the Australian Gambling Statistics in Chapter 1), despite a decrease in the proportion of adults taking part, down to 16.9% in 2025 compared to 19.0% in 2018, and 30.2% in 2005.

Young men aged 18-34 were the highest-risk demographic group: 47.1% reported taking part in any form of gambling in the last 12 months. While the low sample size precludes detailed analysis of every demographic, some additional analyses were conducted specifically for young men aged 18-34 due to the high level of harm experienced by this group. These could not be conducted for all other demographic splits due to the sample size, so are reported here only for the young men group. Of the 47.1% taking part in gambling, 22.1% were classified in the low-risk gambling category, 13.6% in the moderate-risk category and 3.6% in the problem gambling category. That is, almost 2 in 5 young men experienced some degree of problems due to gambling. In addition, 27.4% reported experiencing some level of harm due to their own gambling. This finding strongly aligns with findings in NSW and the ACT. It is likely driven by young people being most likely to take part in forms of gambling that are traditionally associated with higher problems, such as EGMs, casino games and sports betting.

Those in higher risk categories were more likely to gamble more frequently, to have longer typical gambling sessions, and to spend more in typical gambling sessions.

10.6 Gambling-Related Harm from Own Gambling and Affected Others

Gambling-related harm from one's own gambling was reported by 6.5% of South Australian adults (11.9% of those who gambled in the last 12 months), representing approximately 99,083 adults and 20,048 YLD. YLDs refer to years lived with a disability, and represent a health decrement or disutility. A YLD of 1 indicates that entire year of health was lost due to a disability. The term "disability" may seem odd in relation to gambling harm, however it is the term that is used across health conditions. The gambling harms scales have been benchmarked against health utility to determine a person's YLD based on their score on the harms scales. Someone with a GHS-10 score of 0 does not receive any YLD decrement (i.e., YLD = 0) because they have not indicated any gambling-related harm. A GHS-10 score of 1 is associated with a YLD decrement of .10, while a GHS-10 score of 10 is associated with a YLD decrement of .45. That is, if someone endorses all 10 items on the GHS-10 scale, they are measured to have lost almost half a year of wellbeing due to their gambling-related harm. These scores are then summed and scaled up to the population to determine the population-level burden of harm due to gambling. The same is done for the GHS-10-AO scale for affected others. People can experience decrements or health disutility due to their own gambling, someone else's gambling, or both.

The 2018 data was reanalysed as part of the current reporting. That survey also used the GHS-10, then known as the SGHS, allowing direct comparison. The previous study found that 6.6% of adults reported 1 or more harms from their own gambling, for a total of 90,309 adults, reflecting a 10% increase in the total number

of people experiencing harm. This is approximately in line with population growth, but also represents a relative increase due to the declining proportion of adults taking part in gambling. However, the YLD total from 2018 indicates a concerning trend. The 2018 total YLD was 14,668, or approximately 1,056 YLD per 100,000 adults. This indicates that while the raw number of people experiencing harm from their own gambling increased by approximately 10%, the *severity* of harm experienced increased by approximately 25%.

In addition, 7.0% reported harm as an affected other, which represents approximately 106,705 South Australian adults, for 17,801 YLD. Notably, this is a higher proportion than harm to people who gamble, consistent with the NSW finding that affected other harm exceeds self-harm in aggregate. The previous South Australian study used a slightly different measure (SGHS-CSO), and found that 6% of South Australian adults reported harm as an affected other. Due to the different measure, direct comparisons over time cannot be made.

When considering both forms of harm, 12.0% of South Australian adults (about 182,923 people) reported either harm from their own gambling, harm from someone else's gambling, or both. The total Health Related Quality of Life decrement or disutility for South Australian adults was 37,849 years of health life lost due to gambling harm. This figure provides a population-level indicator of how far harm reaches into the South Australian community. The comparable figures for the other jurisdictions are 13.3% (ACT) and 18.3% (NSW).

The 12.0% figure is likely to be an underestimate of the current prevalence of gambling-related harm in the South Australian population because legacy harm was not measured. Legacy harm refers to harm from gambling that was experienced in the last 12 months, but occurred due to gambling that occurred more than 12 months ago. When legacy harm was included in the ACT and NSW studies, an additional 2.5% (ACT) to 2.7% (NSW) of the adult population indicated that they were experiencing legacy harm, but not harm on the GHS-10 or GHS-10-AO scales. Thus, it can be inferred that the proportion of South Australian adults who are currently experiencing harm from gambling is likely to be approximately 14.5% if legacy harm were also measured.

In addition, due to a fieldwork error, one item from the GHS-10 was excluded for a small number of participants, and thus harm may have been underestimated for these participants. Finally, harm was not captured amongst people under the age of 18, because they were not surveyed. Therefore, harm in the South Australian population is likely to be substantially higher.

Younger men account for a disproportionate share of harm from their own gambling. Men aged 18-34 account for 15.3% of the population, but account for 31.3% of the burden of harm experienced by people who gamble. Men aged 35-54 account for another 15.0% of the population, but 24.8% of the burden of harm. In contrast,

women aged 18-34 make up 12.1% of the population, but experience 4.0% of the harm. Young men are therefore overrepresented in terms of burden of harm at the population level. This finding is in line with the ACT and NSW.

For affected others, the pattern in the ACT and NSW is that women are overrepresented. This pattern was partially evident in South Australia, although the result is based on a relatively small number of participants who identified as affected others, and should be treated with caution. For affected others, younger men are also overrepresented, with men aged 18-54 accounting for 30.3% of the population but experiencing 42.2% of the harm, while women aged 18-54 account for 27.3% of the population and experience 36.1% of the harm for affected others.

10.7 Gambling Forms and Demographics Linked to Problems and Harm

EGMs account for approximately 40% of gambling problems and harm experienced by South Australian gamblers – the largest single contributor. This is broadly consistent with the dominant role of EGMs in NSW (~57% of gambling harm) and the ACT (approximately one-third of harm), although specific percentages differ across jurisdictions.

Casino table games account for approximately 30% of harm in South Australia. This share is larger than that seen in other jurisdictions. Wagering (betting on sports, races, novelty events, esports or fantasy sports) accounts for approximately 12-15% of harm. In other jurisdictions, the proportion of wagering occurring online has increased over time, and this is likely to be the case in South Australia. From the current data, it is not possible to determine the share of harm attributable specifically to *online* wagering, but trends in other jurisdictions indicate that it is likely to be increasing.

Age and gender combined were the most important demographic predictors of harm, accounting for approximately 52% of variance. This report uses two different age splits, to align as much as possible with reporting in other jurisdictions. In other jurisdictions, age is reported in six brackets (e.g., 18-24, 25-34, etc), while the smaller sample in this report meant that reporting could only occur across three age brackets (18-34, 35-54, 55+). This reporting meant that results could be compared with other jurisdictions. Reporting in other jurisdictions also used a simplified version of age (18-39 vs 40+) for more detailed analysis of gambling harm. Therefore, to further facilitate comparability with other jurisdictions, this report also used the same age brackets for the same analyses.

Young men aged 18-39 accounted for 38.9% of total burden of harm despite accounting for 18.6% of the population. This high level of harm amongst young men

is consistent with other jurisdictions, reflecting that young men are most likely to take part in the most harmful forms of gambling (EGMs, casino games, sports betting).

Harm to affected others was more evenly distributed across gender and age groups compared to harm to gamblers, with age and gender explaining about one-third of the variance in harm to affected others. Younger people experienced higher harm on average, but when comparing those aged 18-39 vs 40+, there are more people in the population who are aged 40+, so the total YLD for older people is higher than that for younger people. Personal income was the next most important predictor for affected others, with lower income generally associated with higher levels of harm.

People who gamble but do not experience problems or harm showed similar subjective wellbeing compared to people who do not gamble. However, those in higher-risk PGSI categories, or those endorsing more harm, showed significantly lower wellbeing. This finding is important because it validates the measures used, but also highlights the real-world impact of gambling harm on quality of life.

Taken together, these findings highlight the interaction between product-level risk (particularly for EGMs and casino games), and individual-level risk (especially young men). This supports an integrated public health approach that targets both product regulation and demographic outreach simultaneously. Additional factors that could be targeted, such as advertising, were not captured in the current survey but also have potential for intervention to reduce harm.

10.8 Help-Seeking

Around half (50.2%) of South Australian adults were aware of at least one help service, most commonly the gambling helpline (28.4%). These results were virtually identical with those from the 2018 study (50% of adults aware of any service, 29% of the gambling helpline). Awareness was substantially lower for people who mainly speak a language other than English at home (27.7%) and those not born in Australia (33.4%). These findings echo results in the ACT and NSW, and highlight a clear need to promote these services to these communities.

Actual uptake of help services was very low (2.0%), consistent with the 2018 report (2%) and also consistent with patterns in NSW and the ACT. These data suggest that awareness is not the only barrier to help-seeking. Future surveys should explore perceived need and access barriers in more depth. Likely topics include stigma and denial. Among those who sought help, the most common service was self-exclusion.

Amongst all participants, face-to-face counselling was the most preferred mode for seeking help, followed by online and telephone options. In addition, participants indicated a desire for a blended/hybrid online and face-to-face approach.

10.9 Limitations of the Survey

The South Australian 2025 Gambling Survey has several limitations. The most notable limitations are the sample size (3,000), which is smaller than other jurisdictions, and resulted in some compromises in terms of analysis and reporting. This is particularly relevant for lower-prevalence findings, including newer gambling forms and Aboriginal and Torres Strait Islander people. The mobile-only sampling frame, and low response rate (although in line with recent studies), introduce the potential for selection bias. However, the IPND provided good coverage of all demographics, somewhat negating this concern.

While the IPND provides good coverage of demographics, it cannot necessarily solve for issues with representation (i.e., non-response bias). Telephone survey response rates have declined over time, from ~30% in the 1990s to ~5% today. The IPND does typically receive a slightly higher response rate (8-10%), as seen in recent studies in NSW and the ACT, reducing but not eliminating this concern.

The survey was conducted in English, with very few completed in another language (n = 22). This limits the representativeness of findings for those who mainly speak another language than English, or those who were born in another country. These groups had some particularly interesting results, notably awareness of help services. Focused research, conducted in native languages, may be informative.

A formal online gambling participation rate could not be established due to survey space constraints. Some other information, especially around detailed gambling behaviour, was limited due to survey space constraints.

The 2018 survey included the most comprehensive measures of gambling harm to date, including the GHS-10 and GHS-10-AO. Due to space constraints, legacy harm was not captured and therefore could not be included in harm estimates. Due to a fieldwork error, one item from the GHS-10 was not included for 521 early participants. Due to the exclusion of legacy harm, and the accidental omission of one item for some participants, harm is likely to be underestimated.

Self-report data are subject to recall bias and social desirability bias, which may lead to underreporting of factors such as gambling behaviour, gambling problems and gambling-related harm. The Ipsos telephone team are well-versed in these studies, and have conducted multiple gambling telephone surveys recently. Their training and familiarity with the topic may help to reduce these biases.

10.10 Summary of Key Findings and Policy Implications

Despite a sustained decline in overall gambling participation, gambling problems have intensified amongst those who continue to gamble. This pattern has now been observed in NSW and the ACT. This strongly suggested that current preventative harm-minimisation approaches may not adequately prevent harm from beginning, and that stronger measures may be required. Public health frameworks of gambling harm have identified a range of potential causes for gambling harm, including gambling products and their features, environments, exposure (e.g., marketing), and resources, as well as biological, social, psychological and cultural elements (Hilbrecht et al., 2020). Over time, approaches to gambling harm have changed from models whereby the consumer is largely expected to protect themselves from harm, to models where it is assumed that consumers can make informed decisions about potentially addictive products, to public health approaches that recognise a role for governments, industry, consumers, help services, and community groups in preventing and minimising harm (Hing et al., 2020). While most jurisdictions, including South Australia, have taken active steps to develop and enforce stronger standards, research has consistently identified limitations with current approaches, including voluntary measures for consumers with low uptake (e.g., limit setting in online gambling), structural characteristics of gambling products, prolific marketing and increasingly advanced marketing practices, and a variety of other concerns (Hing, Browne, et al., 2022; Hing, Rockloff, et al., 2024; Hing, Smith, et al., 2022; Kraus et al., 2024; Livingstone, 2017). In comparison, other conditions take a more stringent public health approach, such as road safety, where measures are taken to minimise harmful conditions (e.g., improved road conditions), to promote and enforce safe levels of driving (e.g., mandatory speed limits, random breath testing), and to reduce harm should an incident occur (e.g., car safety standards). In contrast, current approaches to gambling harm policy still generally allow customers to gamble with very few restrictions, on products that are known to be associated with high levels of gambling harm.

EGMs remain the form most strongly associated with harm, similar to findings from other jurisdictions. Policy approaches that reduce EGM accessibility (e.g., reduction in venues that have EGM licenses, reduction in number of EGMs, spending limits, mandatory pre-commitment) are supported by the current evidence, as well as findings in other studies (Russell et al., 2023). Casinos, including online, account for a larger proportion of harm in South Australia compared to other jurisdictions, which also requires regulatory attention.

Young men are the highest-risk demographic group across all problem and harm indicators, experiencing 38.9% of total harm by people who gamble, despite accounting for only 18.6% of the population. Targeted interventions for this group should be a priority, including via online and social media channels where this group is most likely to be reached. An example of an intervention is reframing the attractiveness of these products from exciting, social, harmless activities to products

that are associated with a high degree of harm, particularly EGMs, casino games and sports betting.

Women, and affected others, are a significant but sometimes overlooked dimension of gambling harm. Notably in South Australia, affected others outweigh people harmed by their own gambling. Support services should explicitly address the needs of those harmed by someone else's gambling.

Gambling problems and harm are associated with significantly lower subjective wellbeing, reinforcing the case for interventions that address harm across the continuum, not just at the highest-risk groups. Approaches that can prevent or minimise harm amongst those in lower-risk categories can have large impacts on population-level gambling harm, given the higher prevalence of people experiencing lower levels of problems or harm.

Help-seeking is very low, partly due to somewhat limited awareness of help services, especially amongst those from culturally and linguistically diverse backgrounds. Evidence from other studies indicates that stigma is one of the largest issues in relation to help-seeking (Leslie & McGrath, 2024). This represents an opportunity to expand help service messaging. Participants also reported that they would prefer speaking to family and friends, but these people often have no training in helping people who are experiencing gambling harm, and may also be affected others. Therefore, family and friends may not be in the best position to help someone experiencing gambling harm. Raising awareness of, and reducing barriers to uptake of, help-seeking can help to reduce harm once it is occurring. However, people do not typically seek help until they are at crisis level, meaning a significant level of harm has already occurred. It is for this reason that proactive approaches to preventing harm from occurring in the first place will have the biggest impact on harm at a population level.

The survey provides the opportunity for comparison with NSW and the ACT, with a forthcoming study in Tasmania and a reanalysis of Victorian prevalence data to come. These studies, collectively, allow for the most direct cross-jurisdiction comparison to date. Future prevalence studies should explore larger sample sizes and ideally add more questions to the survey to facilitate deeper insights.

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A.1 Weighting

This section provides further detail around the weighting procedure used, allowing the methods section in Chapter 2 to remain approachable to most audiences, while providing further information for interested readers. Full details of the weighting are provided in the Technical Report.

While the sampling method (randomly calling telephone numbers from the IPND) was expected to provide a sample that had similar age, gender and location characteristics to the South Australian adult population, it is standard practice with population surveys to apply weighting to ensure that the sample more closely aligns to the population. Population data are required for weighting variables (age and gender and other variables) to conduct this weighting.

The population data were the June Quarter 2025 data from publication 3101.0 National, state and territory population, table 34, Estimated Resident Population by Single Year of Age, South Australia (ABS, 2025). These data include population projections for males and females for each age from 0 to 99, and then a bracket for 100+. These data were used to apply corrective weights for age as reported by the participants. There were no missing data for this question, as participants were required to answer it to confirm eligibility to continue with the survey.

At the time of writing, the Australian Bureau of Statistics collects data for sex (i.e., a biological construct), while the survey captured gender (a social construct). The population data includes categories for male and female sexes, while the gender question includes male/man, female/woman, non-binary/third gender, other (with responses captured verbatim), as well as refused and don't know. Participants who reported a gender of male/man were weighted using the male population data, while participants identifying as female/woman were weighted using the female population data. We note that for some participants, there may be a disparity between their reported gender and their biological sex. No population data are available for people who identify as a gender other than men or women, or who refuse to report their gender or who do not know their gender. A total of 25 participants did not identify as either a man or woman, with 15 identifying as a gender other than man or woman and 10 refusing to answer or preferring not to say. As there are no normative data for people who identify as another gender, or refuse or don't know, it is impossible to weight them, which would mean that these participants could not be included in any weighted analyses, i.e., the entire report. Therefore, purely for weighting purposes, a "hot deck" approach was used, where these 25 people were assigned to the male or female categories purely for the purpose of weighting. This approach allowed weights to be calculated on their other demographic features, so that they could be included in analyses. Importantly, this assignment was only used for the purpose of weighting. For any gender analyses, participants who reported a gender other than man or woman were treated as a combined non-binary/gender diverse category. This

statistical procedure should not be construed as ignoring or downplaying important issues around gender diversity. However, we acknowledge the limitations of the approach in terms of assuming alignment between gender (survey) and sex (population), as well as the lack of population data for gender in general, including people who identify as genders other than men or women.

Weighting calculations

Weights were calculated by comparing the proportion of the sample in each cell to the proportion of the population in each cell (with proportions based on adult participants only, 18+), and calculating a calibration factor, which is different for each combination of conditions (i.e., 18-24 female from Adelaide has a different calibration to 18-24 female from the rest of South Australia), but the same for all people within a combination of conditions. Cells that are underrepresented in the sample compared to the population are weighted “up” (i.e., have a normalised weight greater than 1), while those in overrepresented cells are weighted “down” (i.e., have a normalised weight of less than 1).

In addition, participants were asked to report how many mobile phones they have access to, both personal and for business purposes. Participants who had access to more than one mobile phone had an increased chance of being selected in the sample and appropriate weighting was also included to account for this by down-weighting these responses. The full details, including calculations, are shown in the Technical Report.

The above weights were used for all questions that were asked of the main sample of 3,000 people.

Importantly, the weights ensure that the results apply to the population, although the population of interest differs depending on the question. For example, a statistic that determines the participation rate of sports betting in the adult population is representative of the adult population in South Australia. A statistic that determines the amount of harm among young men is representative of young men in South Australia. That is, while the sampling method and weighting ensure population representativeness, the population in question is not always the entire adult population of South Australia.

When weights are applied, each person does not necessarily count for an n of 1 in an analysis. This can lead to confusing finding where, for example, an unweighted n of 40 out of 100 participants answered a question a particular way, but the weighted n is not 40%. This is especially true for questions asked of the subsample. For this reason, we have opted not to report unweighted or weighted n s in the body of the report, and instead report weighted percentages. The unweighted and weighted n s for key variables are reported in an appendix.

A.2 Technical notes on analysis methods

To determine the relative importance of variables (e.g. forms, demographics) in explaining gambling problems and harm, multiple regression was first applied, followed by checks for multicollinearity. These models were then analysed using dominance analysis (Genizi, 1993).

Dominance analysis is an established approach used to determine the relative importance of predictors in a regression model (Groemping, 2007). It is particularly useful when dealing with correlated predictors, as it provides a more complete understanding of each variable's contribution than traditional methods like standardised regression coefficients.

The *relaimpo* package in R was used to implement dominance analysis for the linear and regression models employed. It calculates several metrics of relative importance, including general dominance weights. The default metric is the *lmg* metric, which has been previously applied to gambling data and was also used here (Browne, Delfabbro, et al., 2023). These weights represent the average additional contribution of each predictor across all possible subset models.

The *rlm* (Robust Linear Model) function, part of the MASS package in R, was employed to calculate robust means for expenditure data. This method is particularly useful when dealing with datasets that may contain outliers or exhibit non-normal distributions, which are common in expenditure data (Hampel et al., 2005; Venables & Ripley, 2002).

The *rlm* function fits a linear model using an iterative reweighted least squares algorithm. It offers several options for the weight function, with the default being Huber weights, which was used here. This approach gives less weight to outlying observations, resulting in estimates that are more resistant to extreme values compared to ordinary least squares regression. By using *rlm* rather than ordinary means, we obtain robust estimates of central tendency that are less influenced by outliers, providing a more stable and representative measure of average expenditure across the population segment of interest.

A.3 Survey instrument

CATI Introduction

Hi, my name is < >, I'm calling on behalf of SA Health from Ipsos (a Social Research Provider). We're conducting an important Government study with residents of South Australia aged 18 years and over. Would that be you?

The survey takes around 20 minutes depending on your responses.

This survey will ask you questions about your health and wellbeing. Question topics include general health and wellbeing, and gambling behaviours, and your cultural heritage among others.

This call is being recorded and may be monitored for quality assurance and training purposes. Please let me know if you do not wish for this to occur.

IF NECESSARY:

WEBSITE: I can give you a web address where you can read about the survey if you want. (ARRANGE CALL BACK)

GENDER: I can arrange for a male/female interviewer to call you back. (ARRANGE CALL BACK)

LANGUAGE: 'Which language do you prefer for future contact?'

1. Arabic
2. Cantonese
3. Croatian
4. Dari (Afghanistan)
5. Farsi (Persian/Iran)
6. French
7. German
8. Greek
9. Hindi
10. Indonesian
11. Italian
12. Japanese
13. Korean
14. Macedonian
15. Mandarin
16. Portuguese
17. Russian
18. Serbian
19. Spanish
20. Tagalog (Filipino)
21. Thai
22. Turkish
23. Vietnamese

- 24. Nepalese
- 25. Punjabi
- 26. Other (Specify)
- 27. Language not established

Interviewer note: [Terminate as LOTE callback outcome and write language to sample record – thank respondent] – Thank you for your time, we will call you back with an interviewer who can speak your preferred language.

Screenener questions

Ask all

S1. Can I please confirm in which state you live?

- 1. SA (Continue ELSE CLOSE)
- 2. NSW
- 3. Vic
- 4. Qld
- 5. WA
- 6. TAS
- 7. ACT
- 8. Other territory
- 9. Overseas
- 10. Prefer not to say location

S2. Can I just check your suburb, town and postcode, as we are working to ensure that we have a good spread of participants across South Australia.

Start typing your suburb/town or postcode in the box below and then select.

- 1. Can't find in list above
- 2. Prefer not to say (PC terminate Int)

Record preferred first name of respondent.

(All doing survey)

OK, let's get started.

This phone number has been randomly selected from the Integrated Public Number Database (IPND), which contains most Australian phone numbers. The Australian Communications and Media Authority (the ACMA) has authorised the random selection of some mobile phone numbers from that database for this study.

Taking part in the survey is voluntary and confidential and usually takes around 20 minutes but I will let you know if it's going to take any longer. Would you have some time to help out?

The information and opinions you provide will be deidentified prior to analysis and used only for research purposes. The survey is voluntary, and you can withdraw consent at any stage during the call.

Demographics (1)

As this is a survey about health, can you tell me your age please?

(Single response)

Enter age (range 18–110)

1. Not stated
2. Don't know

Sequence guide: If Q1 = 1 (age), go to Q3.

Which age group are you in? Would it be...

(Single response)

1. 18 to 24 years
2. 25 to 34 years
3. 35 to 44 years
4. 45 to 50 years
5. 51 to 54 years
6. 55 to 64 years
7. 65 to 74 years
8. 75 years or over
9. Prefer not to say (End interview)

What was your sex recorded at birth?

(Single response)

1. Male
2. Female
3. Another term (specify _____)
4. Prefer not to say

How do you describe your gender?

(Single response)

1. Man or male
2. Woman or female
3. Non-binary
4. I/they use a different term (specify)
5. Prefer not to say

How many people aged 18 or over live in this household including yourself?

(Single response, enter number of people 18 years or over)

1. (Enter number)
2. Not stated

How many children under 18 years live in your household?

(Single response, enter number of people under 18 years; enter 0 if none)

Enter number (range 0–20)

1. Not stated

Overall Health

In general, would you say that your health is:

(Single response)

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor
6. Don't know
7. Prefer not to say

Mental Health

In the last 12 months, have you ever been told by a doctor that you have any of the following conditions?

(Select as many as apply)

1. Anxiety
2. Depression
3. A stress related problem
4. Any other mental health problem
5. None of the above
6. Don't know
7. Prefer not to say

Wellbeing

The next few questions are about how you rate your general wellbeing. On a scale of 0 to 10, where 0 means 'not at all' and 10 means 'completely'...

Overall, how satisfied are you with your life nowadays?

(Single response)

1. Not at all – 0
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6
8. 7
9. 8
10. 9
11. Completely – 10
12. Don't know – 11
13. Prefer not to say – 12

Overall, to what extent do you feel the things you do in your life are worthwhile?

(Single response)

1. Not at all – 0
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6
8. 7
9. 8
10. 9
11. Completely – 10
12. Don't know – 11
13. Prefer not to say – 12

Overall, how happy did you feel yesterday?

(Single response)

1. Not at all – 0
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6
8. 7
9. 8
10. 9
11. Completely – 10
12. Don't know – 11
13. Prefer not to say – 12

Overall, how anxious did you feel yesterday?

(Single response)

1. Not at all – 0
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6
8. 7
9. 8
10. 9
11. Completely – 10
12. Don't know – 11
13. Prefer not to say – 12

Gambling Activities

The next series of questions are regarding gambling behaviour over the last 12 months.

In the last 12 months have you done the following...

Played gaming machines or 'pokies', not including similar games played online?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Bet on horse, harness or greyhound races, not including sweeps?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Bet on a sporting event such as football, cricket, boxing, or motorsports but not including fantasy sports and e-sports?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Interviewer note: Footy tipping competitions are not considered to be gambling (only tell respondent if asked).

Bet on fantasy sports games for money, such as Draftstars?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Interviewer note: Fantasy sports is a type of online game, where participants assemble virtual teams of real sports players. Betting on fantasy sports involves spending money and includes placing bets on Draftstars and Moneyball (only tell respondent if asked).

Bet on e-sports?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Interviewer note: E-sports, short for electronic sports, refers to organised, competitive video game play, often at a professional level.

Bet on elections, reality TV shows, or other novelty events?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Bought instant scratch tickets or other lottery products like Powerball, in person or online?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Bought a ticket for an overseas lottery?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Bought a major lottery ticket, which is a ticket in a draw for a house, car, boat, or other major prize?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played keno, not including online?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played online keno?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played bingo at a club, hall, or other place?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played table games at a casino such as blackjack or roulette?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played online pokie games or other casino games for money?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Played card games like poker, mah-jong, or dice games privately for money?

(Single response)

1. Yes
2. No
3. Not sure
4. Prefer not to say

Sequence guide: If Q13 to Q27 = 2–4 (No/not sure/prefer not to say) go to Gambling Harms Scale for Affected Others (GHS-10-AO) (Q46). If Q13 to Q27 = 1, continue.

Gambling Behaviour

The following questions relate to time and money investments in gambling activities. Thinking about the last 12 months...

How often did you gamble?

(Single response)

1. Enter number _____ (minimum 1) time(s) per week
2. Enter number _____ (minimum 1) time(s) per fortnight
3. Enter number _____ (minimum 1) time(s) per month
4. Enter number _____ (minimum 1) time(s) per year
5. Not sure/don't know
6. Prefer not to say

Interviewer note: respondent can answer with how many times per week, fortnight, month or year. Only one response is required (can prompt respondent if needed).

How much time did you spend gambling in a typical gambling session?

(Single response)

1. Enter number _____ hour(s)
2. Enter number _____ minute(s)
3. Not sure/don't know
4. Prefer not to say

How much money did you spend in a typical gambling session?

(Single response)

1. Enter amount _____ (minimum \$1)
2. Not sure/don't know
3. Prefer not to say

Interviewer note: respondent can answer with spend for week, fortnight, month or year. Only one response is required (can prompt respondent if needed).

Which gambling activity have you spent the most money on overall, not including winnings?

(Single response)

1. Playing gaming machines or 'pokies', not including similar games played online
2. Betting on horses, harness or greyhound races, not including sweeps
3. Betting on a sporting event such as football, cricket, boxing, or motorsports, but not including fantasy sports and e-sports
4. Betting on fantasy sports games for money, such as Draftstars
5. Betting on e-sports
6. Betting on elections, reality TV shows, or other novelty events
7. Buying instant scratch tickets or other lottery products like Powerball, in person or online
8. Buying tickets for overseas lotteries
9. Buying a major lottery ticket, which is a ticket in a draw for a house, car, boat, or other major prize
10. Playing keno, not including online
11. Playing online keno
12. Playing bingo at a club, hall, or other place
13. Playing table games at a casino such as blackjack or roulette
14. Playing online pokie games or other casino games for money
15. Playing card games like poker, mah-jong, or dice games privately for money
16. Not sure/don't know
17. Prefer not to say

Where did you gamble most often?

(Single response)

1. At a club or hotel/pub
2. At a casino
3. At a racetrack
4. At a TAB outlet
5. Online, using a website or mobile app
6. Via a phone call
7. Other (specify)
8. Not sure/don't know
9. Prefer not to say

Thinking about the last 12 months, did you gamble between the following times?

(Multiple response, select all that apply)

1. Between 8am and 10am
2. Between 10am and 6pm
3. Between 6pm and midnight
4. Between midnight and 2am
5. Between 2am and 4am
6. Between 4am and 8am
7. Not sure/don't know
8. Prefer not to say

How often during the past 12 months did you drink alcohol while gambling?

(Single response)

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always
6. Not sure/don't know
7. Prefer not to say

Loyalty Cards

Only ask loyalty cards question if Q32 = 1–4. Otherwise proceed to Canadian Problem Gambling Severity Index (Q36).

In the last 12 months, were you a member of any gambling loyalty program, such as Jackpot Club Loyalty or SkyCity Rewards?

(Single response)

1. Yes
2. No
3. Not sure/don't know
4. Prefer not to say

Canadian Problem Gambling Severity Index

I will now read out some questions about gambling experiences. You may find these questions uncomfortable, remember you do not need to answer them if you do not want to, if these questions bring up unwelcome feelings for you there is help available.

For the next set of questions tell me how often you have had these experiences, thinking about the last 12 months...

Have you bet more than you could really afford to lose?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Have you needed to gamble with larger amounts of money to get the same feeling of excitement?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

When you gambled, did you go back another day to try to win back the money you lost?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Have you borrowed money or sold anything to get money to gamble?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Have you felt that you might have a problem with gambling?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Has gambling caused you any health problems, including stress or anxiety?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Has your gambling caused any financial problems for you or your household?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Have you felt guilty about the way you gamble or what happens when you gamble?

(Single response)

1. Never
2. Sometimes
3. Most of the time
4. Almost always
5. Don't know/can't say
6. Prefer not to say

Gambling Harms Scale (GHS-10)

Randomise the order of reading out the responses

In the last 12 months, have you experienced any of the following issues as a result of your own gambling...

(Multiple response, select all that apply)

1. Reduction of your available spending money
2. Reduction of your savings
3. Less spending on recreational expenses such as eating out, going to movies or other entertainment
4. Had regrets that made you feel sorry about your gambling
5. Sold personal items
6. Increased credit card debt
7. Spent less time with people you care about
8. Felt distressed about your gambling
9. Felt like a failure
10. Felt ashamed of your gambling
11. Not sure/don't know
12. Prefer not to say

Gambling Harms Scale for Affected Others (GHS-10-AO)

These next questions are about how another person's gambling can affect you in a negative way.

Interviewer note: Affected in the question below refers to finances, relationships, emotional and mental health, physical health, work and/or study.

In the past 12 months, have you had a close relationship with someone who has gambled?

(Single response)

1. Yes
2. No
3. Not sure/don't know
4. Prefer not to say

Interviewer note: 'Close relationship' is often a family member, is one in which you know each other well, you care about each other, and you depend on each other.

Sequence guide: If Q46 = 1, go to Q47. Otherwise proceed to Help Seeking Awareness section (Q48).

During the last 12 months, did any of these issues occur to you as a result of their gambling? If there is more than one person, think about the person whose gambling negatively affected you the most.

(Multiple responses allowed, select all applicable)

PN: Randomise statements

1. Late payments on bills (utilities, rates)
2. Reduced performance at work or study (i.e., due to tiredness or distraction)
3. Loss of sleep due to stress or worry about their gambling or gambling-related problems
4. Stress related health problems (e.g., high blood pressure, headaches)
5. Increased experience of depression
6. Feelings of hopelessness about their gambling
7. Felt angry about not controlling their gambling
8. Got less enjoyment from time spent with people I care about
9. Threat of separation or ending a relationship/s
10. Took money or items from friends or family without asking first
11. Not sure/don't know
12. Prefer not to say

Help Seeking – Awareness

Now for some questions about available services to support people affected by gambling.

What telephone, online, and face to face services are you aware of to assist people harmed by gambling?

(Multiple responses allowed, select all applicable, do not prompt)

1. Gambling Helpline/Hotline
2. Phone Helpline non-specific
3. Gamblers Anonymous/Pokies Anonymous
4. Gambling Help Online
5. Other (specify)
6. None
7. Not sure/don't know
8. Prefer not to say

Help Seeking – Uptake

Have you ever used gambling-help services for your own or someone else's gambling issues?

(Single response, with the exception of responses 1 and 2 which can be selected together)

Interviewer note: If Q49 = yes, probe whether it was for themselves or someone else

1. Yes – for myself
2. Yes – for someone else
3. No
4. Not sure/don't know
5. Prefer not to say

Sequence guide: If Q49 = 1 or 2, go to Q50. Otherwise go to Q51.

Which services did you use?

(Multiple response, select all applicable)

1. Gambling Helpline
2. Gamblers Anonymous/Pokies Anonymous
3. National Gambling Help Online Website
4. South Australian Problem Gambling Website/Gambling Harm Support SA Website
5. South Australian counselling service
6. Barring/self-exclusion
7. Other (specify)
8. Can't remember
9. None
10. Not sure/don't know
11. Prefer not to say

What would be or is your preferred method of receiving gambling-help regarding either your own gambling or someone else's gambling?

(Single response)

1. By telephone
2. Face-to-face counselling
3. Internet
4. Online self-help
5. Online counselling
6. Venue staff member
7. Other (specify)
8. Not sure/don't know
9. Prefer not to say

The next set of questions ask about your culture, language and ancestry.

Are you of Aboriginal or Torres Strait Islander origin?

(Single response)

1. No
2. Aboriginal
3. Torres Strait Islander
4. Aboriginal and Torres Strait Islander
5. Prefer not to say

What is the main language you speak at home?

(Single response)

1. English
2. Italian
3. Greek
4. Mandarin
5. Vietnamese
6. Cantonese
7. Arabic
8. German
9. Polish
10. Spanish
11. Punjabi
12. Hindi
13. Other (specify)
14. Prefer not to say

Which language did you first speak as a child?

(Single response)

1. English
2. Italian
3. Greek
4. Mandarin
5. Vietnamese
6. Cantonese
7. Arabic
8. German
9. Polish
10. Spanish
11. Punjabi
12. Hindi
13. Other (specify)
14. Prefer not to say

Sequence guide: If Q53 > 1 or Q54 > 1, go to Q55. Otherwise, proceed to Q56.

How well do you consider you speak English?

(Single response)

1. Very well
2. Well
3. Not well
4. Not well at all
5. Prefer not to say

What is your ancestry?

(Up to two responses only)

1. English
2. Irish
3. Scottish
4. Chinese
5. Italian
6. German
7. Indian
8. Greek
9. Dutch
10. Australian
11. Other (specify)
12. Prefer not to say

In which country were you born?

(Single response)

1. Australia
2. Afghanistan
3. Austria
4. Bosnia-Herzegovina
5. Canada
6. China
7. Croatia
8. Egypt
9. Lebanon
10. France
11. Germany
12. Greece
13. Holland/Netherlands
14. Hungary
15. Iran
16. India
17. Italy
18. Malaysia
19. Malta
20. New Zealand
21. Philippines
22. Poland
23. Slovenia
24. South Africa
25. UK or Ireland
26. USA
27. Vietnam
28. Former Yugoslav
29. Other country (specify)
30. Not stated/prefer not to say

Sequence guide: If Q57 > 1, go to Q58. Otherwise, go to Q59.

In which year did you first arrive in Australia to live (for one year or more)?

(Single response)

1. Enter date
2. Not stated
3. Don't know

The next two questions are about the countries in which your parents or caregivers were born.

What was the country of birth for parent 1/caregiver 1?

(Single response)

1. Australia
2. England
3. New Zealand
4. India
5. Philippines
6. Vietnam
7. Italy
8. South Africa
9. Malaysia
10. Scotland
11. Other (specify)
12. Don't know
13. Prefer not to say

What was the country of birth for parent 2/caregiver 2?

(Single response)

1. Australia
2. England
3. New Zealand
4. India
5. Philippines
6. Vietnam
7. Italy
8. South Africa
9. Malaysia
10. Scotland
11. Other (specify)
12. Don't know
13. Prefer not to say

The next question asks about cultural and linguistic diversity. The term “culturally and linguistically diverse” is used to reflect a diverse range of people from different backgrounds, whose cultural heritage is different from the dominant Australian culture.

Are you part of a culture or do you have a cultural heritage different from the dominant Australian culture?

(Single response)

1. Yes
2. No
3. Don't know
4. Prefer not to say

Demographics (2)

Now to finish with some general questions.

Which of the following best describes your current marital status?

(Single response)

1. Married
2. Living with a partner
3. Separated
4. Divorced
5. Widowed
6. Never married
7. Prefer not to say

What is the highest level of education you have completed?

(Single response)

1. Never attended school
2. Some primary school
3. Completed primary school
4. Some high school
5. Completed high school
6. TAFE, trade or certificate
7. Diploma, advanced diploma
8. University or some other tertiary degree
9. Other (specify)
10. Prefer not to say

Which of these best describes your current employment status? Are you...

(Single response)

1. Full-time employed (permanent/contract) including self-employed
2. Part-time employed (permanent/contract) including self-employed
3. Casual
4. Unemployed
5. Engaged in home duties
6. Student
7. Retired
8. Unable to work
9. Carer
10. Other (specify)
11. Don't know
12. Prefer not to say

The next question is about housing. Is where you live...?

(Single response)

1. Owned or being purchased by the occupants
2. Rented from Housing SA
3. Rented privately
4. Retirement village
5. Other (specify)
6. Prefer not to say

What is your approximate annual gross income? This is, before tax is taken out. (Read out)

(Single response)

1. Up to \$12,000
2. \$12,001–\$20,000
3. \$20,001–\$40,000
4. \$40,001–\$60,000
5. \$60,001–\$80,000
6. \$80,001–\$100,000
7. \$100,001–\$150,000
8. \$150,001–\$200,000
9. More than \$200,000
10. Not stated/prefer not to say
11. Don't know

What is the approximate annual gross income of your household? This is, before tax is taken out. (Read out)

(Single response)

1. Up to \$12,000
2. \$12,001–\$20,000
3. \$20,001–\$40,000
4. \$40,001–\$60,000
5. \$60,001–\$80,000
6. \$80,001–\$100,000
7. \$100,001–\$150,000
8. \$150,001–\$200,000
9. More than \$200,000
10. Not stated/prefer not to say
11. Don't know

Do you receive any government pension or concession card benefits?

(Select as many as apply)

1. Aged pension
2. Disability support pension
3. Carer payment
4. Special needs pension
5. Parenting payment
6. Pensioner concession card
7. Senior's card
8. Commonwealth Seniors Health Card
9. Other (specify)
10. None
11. Don't know
12. Prefer not to say

If you feel distressed following this call or these questions have caused you concern, you may find it helpful to contact the following support services for support:

- Lifeline – 13 11 44
- Adult Mental Health Service – 13 14 65
- Gambling Helpline: 1800 858 858

We have nearly finished the survey. For statistical analysis purposes, can you tell me is there at least one working fixed line telephone inside your home that is used for making and receiving calls?

1. Yes
2. No
3. (Don't know)
4. (Refused)

**Ask all (for weighting purposes)*

X2. Including this one, how many active mobile numbers do you have?

SR/NUM [Allowable range 1–10]

1. Refused – do not read out
2. Don't know – do not read out

**If IPND sample and W10 > 1*

X3. How many of the other mobile phones are business mobile phones?

<Record number> [Allowable range = 1–W10]

<Record D for don't know, R for refused>

CLOSE.

This research has been conducted on behalf of the South Australian Government and in keeping with the Australian Privacy Principles, the industry Privacy Code and the market research industry's Code of Professional Behaviour. Our privacy policy is available on our website (<https://www.ipsos.com/en-au/privacy-aus>). This policy explains how you can access or correct your personal information, the process for making a privacy related complaint.

Your individual deidentified data (responses) will only be used by, or on behalf of, the South Australian Government for research and planning purposes.

(If required: If you would like to check any of these details further, I can direct you to the Australian Data and Insights Association's website or if you have any queries you can call Ipsos directly. Would you like any of these details?

If yes, say: The website is <https://dataandinsights.com.au/> or if you have any queries you can call Ipsos on (02) 9900 5100.

CLOSE2

(All)

That is the end of our questions. Thank you very much for your assistance. Sometimes my supervisor needs to ring back and check my work. May I just confirm your name and number? [Confirm details].

A.4 Margin of error calculations and reference tables

Survey estimates are based on a sample of the population and are therefore subject to sampling error. Sampling error reflects the fact that any single sample will differ somewhat from the true population value by chance alone. Two related statistics are used to quantify this uncertainty:

Standard Error (SE): a measure of the average distance between a sample estimate and the true population value.

Margin of Error (MOE): the half-width of a 95% confidence interval, calculated as $1.96 \times SE$. A 95% confidence interval is the survey estimate $\pm$ MOE.

Relative Margin of Error (RMOE): the MOE expressed as a percentage of the survey estimate ($MOE \div \text{estimate} \times 100\%$). This allows comparison of precision across estimates of very different magnitudes.

The following tables provide reference MOE and RMOE values for the South Australian Gambling Survey (n = 3,000 respondents; adult population N = 1,524,355). Two types of survey estimate are covered: estimates of population counts and estimates of proportions or percentages. All are based on questions asked of the total sample, or that can be inferred to the full population. For example, gambling problems and harm from one's own gambling were only asked of people who gambled in the last 12 months, but estimates can be inferred to the full population. Estimates based on only certain participants have wider margins of error.

Margins of error and/or confidence intervals are not shown in the report, to improve readability. The information in this section allows interested readers to determine these values.

Margin of Error for Estimates of Population Counts

When a survey result is expressed as an estimated number of people (a weighted count), the MOE is calculated using the following formula, which incorporates a finite population correction (FPC):

$$\text{MOE} = 1.96 \times \sqrt{(X \times (N - X) / n)}$$

where X is the weighted survey estimate, N is the adult population size (1,524,355), and n is the sample size (3,000).

The FPC accounts for the fact that when the sample represents a non-trivial fraction of the population, the effective uncertainty is smaller than it would be for an infinite population. With $n/N \approx 0.2\%$ for this survey, the FPC effect is modest at small estimates but becomes more pronounced as estimates approach N . As a consequence, the MOE is symmetric around $N/2$ — for example, the MOE for an estimate of 400,000 equals that for an estimate of 1,124,355 ($= N - 400,000$).

The RMOE is calculated as $\text{MOE} \div X \times 100\%$. Estimates with an RMOE above 25% should be interpreted with caution; estimates above 50% are generally considered unreliable for reporting purposes.

Table 9 – Margin of error and relative margin of error for weighted count estimates ($N = 1,524,355$, $n = 3,000$)

Weighted survey estimate	MOE	RMOE
15,000	±5,400	35.9%
25,000	±6,900	27.7%
50,000	±9,700	19.4%
75,000	±11,800	15.7%
100,000	±13,500	13.5%
150,000	±16,200	10.8%
200,000	±18,400	9.2%
250,000	±20,200	8.1%
300,000	±21,700	7.2%
400,000	±24,000	6.0%
500,000	±25,600	5.1%
750,000	±27,300	3.6%
1,000,000	±25,900	2.6%
1,250,000	±21,000	1.7%
1,500,000	±6,800	0.5%

To use this table: identify the row with the weighted estimate closest to your survey result, then read off the corresponding MOE and RMOE. The 95% confidence interval is estimate $\pm$ MOE.

Margin of Error for Percentage Estimates

The Wald interval

When a survey result is expressed as a percentage or proportion (e.g., 54.2% of adults gambled in the past 12 months), the standard MOE formula is:

$$\text{MOE} = 1.96 \times \sqrt{(p \times (1 - p) / n)}$$

where p is the sample proportion (e.g., 0.542) and n is the sample size (3,000). The finite population correction is not applied here because its effect is negligible when n/N is as small as 0.2%.

This formula produces a symmetric interval: estimate $\pm$ MOE. It is known as the Wald interval and is the conventional approach reported in government and population health surveys. The MOE is largest at $p = 50\%$ (approximately $\pm 1.8\%$ for $n = 3,000$) and decreases as estimates approach 0% or 100%, reflecting the natural constraints on a proportion.

Table 10 – Margin of error and relative margin of error for percentage estimates, Wald interval ($n = 3,000$)

Percentage estimate	MOE ($\pm$)	RMOE
1%	$\pm 0.4\%$	35.6%
5%	$\pm 0.8\%$	15.6%
10%	$\pm 1.1\%$	10.7%
15%	$\pm 1.3\%$	8.5%
20%	$\pm 1.4\%$	7.2%
25%	$\pm 1.5\%$	6.2%
30%	$\pm 1.6\%$	5.5%
35%	$\pm 1.7\%$	4.9%
40%	$\pm 1.8\%$	4.4%
45%	$\pm 1.8\%$	4.0%
50%	$\pm 1.8\%$	3.6%
55%	$\pm 1.8\%$	3.2%
60%	$\pm 1.8\%$	2.9%
65%	$\pm 1.7\%$	2.6%
70%	$\pm 1.6\%$	2.3%
75%	$\pm 1.5\%$	2.1%
80%	$\pm 1.4\%$	1.8%
85%	$\pm 1.3\%$	1.5%
90%	$\pm 1.1\%$	1.2%
95%	$\pm 0.8\%$	0.8%
99%	$\pm 0.4\%$	0.4%

Asymmetric confidence intervals: the Wilson score interval

The Wald interval assumes that the sampling distribution of a proportion is approximately normal. This assumption holds well in the mid-range (say, 20%–80%) but deteriorates near the extremes. Near 0% or 100%, the Wald interval can produce lower bounds below 0% or upper bounds above 100%, which are mathematically impossible for a proportion.

The Wilson score interval addresses this by using an asymmetric formula that keeps both bounds within [0%, 100%] regardless of the sample proportion. It is calculated as:

$$\text{centre} = (p + z^2/(2n)) / (1 + z^2/n)$$

$$\text{bounds} = \text{centre} \pm (z / (1 + z^2/n)) \times \sqrt{ p(1-p)/n + z^2/(4n^2) }$$

where $z = 1.96$ for 95% confidence, p is the sample proportion, and $n = 3,000$.

In practice, for this survey ($n = 3,000$), the Wald and Wilson intervals are very similar for estimates between 5% and 95%. Below 5% or above 95%, the Wilson interval is preferable as it avoids the possibility of bounds outside the valid [0%, 100%] range. The table below presents both for comparison.

Table 11 – Wald margin of error and Wilson score 95% confidence interval bounds for percentage estimates (n = 3,000)

Percentage estimate	Wald MOE ($\pm$)	Wilson lower	Wilson upper
1%	$\pm 0.4\%$	0.7%	1.4%
5%	$\pm 0.8\%$	4.3%	5.8%
10%	$\pm 1.1\%$	9.0%	11.1%
15%	$\pm 1.3\%$	13.8%	16.3%
20%	$\pm 1.4\%$	18.6%	21.5%
25%	$\pm 1.5\%$	23.5%	26.6%
30%	$\pm 1.6\%$	28.4%	31.7%
35%	$\pm 1.7\%$	33.3%	36.7%
40%	$\pm 1.8\%$	38.3%	41.8%
45%	$\pm 1.8\%$	43.2%	46.8%
50%	$\pm 1.8\%$	48.2%	51.8%
55%	$\pm 1.8\%$	53.2%	56.8%
60%	$\pm 1.8\%$	58.2%	61.7%
65%	$\pm 1.7\%$	63.3%	66.7%
70%	$\pm 1.6\%$	68.3%	71.6%
75%	$\pm 1.5\%$	73.4%	76.5%
80%	$\pm 1.4\%$	78.5%	81.4%
85%	$\pm 1.3\%$	83.7%	86.2%
90%	$\pm 1.1\%$	88.9%	91.0%
95%	$\pm 0.8\%$	94.2%	95.7%
99%	$\pm 0.4\%$	98.6%	99.3%

For the main body of the report, symmetric Wald $\pm$ MOE values (as in Table 2) are used, consistent with standard practice for Australian population surveys. For any individual estimate at or below 5%, the Wilson interval lower and upper bounds from Table 3 should be reported in preference.

Guidance on Reporting

For count estimates: use Table 9. Identify the row closest to your weighted estimate and report as “estimate $\pm$ MOE (95% CI: lower-upper)”.

For percentage estimates (5%-95%): use Table 10. Report as “estimate $\pm$ MOE%” or as a 95% CI.

For percentage estimates below 5% or above 95%: use Wilson bounds from Table 11 and report the asymmetric CI explicitly.

Estimates with RMOE > 25%: should be flagged as having high relative uncertainty and interpreted cautiously.

Estimates with RMOE > 50%: are generally considered unreliable and should not be reported as standalone figures.

A.5 Unweighted and weighted sample demographics

Table 12 – Demographic profile of the sample

Demographic	Unweighted % of sample	Weighted % of sample
Age and gender		
Men aged 18-34	17.4	15.3
Men aged 35-54	15.4	14.9
Men aged 55+	20.9	18.4
Women aged 18-34	11.2	12.0
Women aged 35-54	13.3	15.1
Women aged 55+	21.0	23.3
Non-binary/gender diverse, any age	0.8	0.9
Location		
Adelaide	77.3	78.0
Elsewhere in South Australia	22.7	22.0
Main language at home		
English	79.5	78.7
LOTE	20.5	21.3
Country of birth		
Australia	68.3	67.7
Another country	31.7	32.3
Identify as Aboriginal and/or Torres Strait Islander		
Yes	2.9	2.7
No	97.1	97.3
Married or living with a partner		
No (including divorced, separated, widowed, single)	45.0	47.6
Yes	55.0	52.4
In paid employment		
No (including student, retired, etc)	42.9	43.1
Yes (full time, part time, casual)	57.1	56.9
Tertiary education		
No	61.2	77.3
Yes	38.8	22.7

Table 12 – Demographic profile of the sample (cont)

Demographic	Unweighted % of sample	Weighted % of sample
Personal income, per year		
Refused or don't know	11.7	12.3
\$1 to \$25,999	12.2	13.5
\$26,000 to \$51,999	32.9	34.6
\$52,000 to \$90,999	24.2	23.6
\$91,000 to \$155,999	12.2	10.5
\$156,000 or more	6.9	5.4
Household income, per year		
Refused or don't know	19.2	19.1
\$1 to \$25,999	4.3	5.3
\$26,000 to \$51,999	20.3	21.7
\$52,000 to \$90,999	18.0	18.5
\$91,000 to \$155,999	11.9	12.5
\$156,000 or more	26.3	23.0