

**Scottish Public Health Network (ScotPHN)**

**Gambling Update**

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## Background

Licensing authorities in Scotland must publish their renewed *Statement of Gambling Policy* by January 2019. This should involve consultation with partners including public health, to set out expectations of gambling operators and provide an effective local area profile to increase awareness of local risks for gambling related harm that gambling operators will need to address in their risk assessments. (1) (2)

To coincide with this, this short document seeks to raise awareness that might allow those working within public health in Scotland to better influence the development of local gambling policy, to advocate both for a preventive approach and to make best use of the existing opportunities that might reduce harms, even if imperfect. It summarises and incorporates new evidence and although there are many research gaps, this should not act as a brake on considering how we may prevent and address risky and problem gambling. ScotPHN has already generated key documents that set the scope for public health action in relation to gambling:

- [Gillies, M. \(2016\) \*Toward a public health approach for gambling related harm: a scoping document\*](#)
- [Thorpe, A & Miller, C. \(2014\) \*Gambling related harm: A review of the scope for population health intervention\*](#)

This update builds on this work, with particular reference to Gillies' recommendation that gambling be adopted as a public health issue requiring a shift away from a focus on the problem gambler and responsible gambling behaviours, to prevention of gambling harms and a broader understanding of the complex interactions between the individual, the gambling product and environment, and the wider social, cultural and economic contexts that determine health and wellbeing. For a wider assessment of the need for a public health approach to gambling in Scotland please refer back to Gillies' report.

## Gambling Participation

Gambling activity is translating into significant increases in Total Gross Gambling Yield (GGY) (gross turnover minus customer winnings), to £13.7bn in Great Britain (2016/2017) from £8.4bn in 2008/2009. (3) The remote sector (online gambling) generated the biggest share, 34% of GGY, an increase of 11% on the year before. The gambling industry employs 106,236 (March 2017), but numbers are falling in physical premises, which is also reflected in the number of physical outlets.<sup>1</sup> The number of gaming machines including Fixed Odds Betting Machines (FOBTs) however across all physical premises increased from 157,023 in 2009 to 182,916 in March 2017. The GGY generated by these machines has increased, and particularly for machines based within betting premises and casinos. (4-6)

Significant attention has been generated recently around FOBTs located in high street bookmakers. Government proposals indicate that the maximum gambling limit will be reduced from £100 to £2 (7) but it would be erroneous to conclude that problem gambling is *en route* to being eliminated, given that FOBTs form just one segment of a much wider industry that is increasingly played online.

Estimates of gambling behaviour tend to rely on the use of very small samples. Gambling Commission generated estimates for Great Britain indicate that in 2017, 45% of adults gambled in the previous 4 weeks, down from 55% in 2013. This is thought to reflect declining National Lottery participation. (8)

Health Surveys for England and Scotland and a Gambling Commission survey for Wales however indicate higher participation rates (for 2016) when respondents are asked about gambling in the previous 12 months, and particularly for Scotland. The rates for Scotland, England and Wales were 66%, 56% and 55% respectively. (9-11)

When National Lottery participants were excluded, the Scottish participation rate was 49%. The lottery is less popular among those aged 16-34, online betting and scratch-cards are more popular, while horse racing, for example, tends to be evenly spread across those aged 16-64. Men, and those aged 34-64 are more likely to gamble, when National Lottery players are excluded, participation is higher among those aged 25-44.

Information about trends in online gambling in Scotland is relatively absent, although in 2016, 11.8% of those aged 16+ gambled online during the previous 12 months, excluding National Lottery online gambling, broadly comparable with the year before. The latest UK (2017) evidence however indicates that 'in person' participation is declining, excluding horse racing and spread betting. Online participation is increasing and 18% of all adults had gambled online in the previous 4 weeks, 51% using a mobile phone or tablet, with phone use experiencing the largest increase in use. Those aged 25-34, and older groups, aged 55-64, experienced the largest increases in online gambling participation. Online gamblers have an average of 4 online accounts, higher for younger gamblers; 26% have played 'in-play', gambling while the event (e.g. sport)

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<sup>1</sup> Between 2009-2017, betting shop premises fell from 8,872 to 8,502, bingo venues from 641 to 583, casinos from 143 to 146 and licensed arcades from 2,396 (2011) to 1,750 (2017).

is taking place and 6% had bet on 'eSports' during the past 12 months, particularly 25-34 year olds, a form of competitive playing of video games, an increasingly popular form of entertainment and betting. (8) (9)

## Children

Gambling Commission estimates (using a sample of 2,881) for Great Britain, indicate that 12% of 11-16 years olds in 2017 had spent money on gambling in the past week, down from 16% in 2016 and 23% in 2011, a downward trend experienced for both males and females although gambling rates for boys are higher. 3% had spent money on online gambling, 7% using a parent's account. Most had gambled commercially rather than privately, particularly via fruit machines and National Lottery scratch-cards and most has been exposed to gambling advertising. 0.9% were classified as 'problem' gamblers, (c.31,000 children) and 1.3% 'at risk' with similar estimates for each year since 2014, when problem gambling was first measured. (12) Purchase of National Lottery products fell but fruit machine use increased from 23% to 40% between 2011-2017. Half of past week gamblers, under 16, in 2017 had gambled where they should not have been able to gain access. (13)

The Responsible Gambling Strategy Board (RGSB) therefore recommends a review of National Lottery restrictions on online instant win and scratch card products, currently legally accessible to 16-17 year olds, particularly as they may be associated with riskier gambling, and the positioning of National Lottery products in shops, often next to confectionery. They do not recommend a similar restriction on 'Category D' games machines, including fruit machines, pushers and cranes, (14) where there is no age restriction. However they do recommend that operators implement staff training and supervision, with potential licence loss where this is not met.

Further recommendations include use of a 'Challenge 25' approach, particularly as operator test purchasing data indicates a need for improvement in gambling venue age-verification procedures, and higher levels of local authority engagement in testing, which can be funded via operator premises licence fees, as well as inclusion of smaller gambling operators in testing. Online operators currently have 72 hours to confirm that a customer registering on their site for the first time is 18. RGSB recommends the removal of the opportunity to gamble in this period. Further recommendations extend to age verification prior to pushing in-app marketing, recognition of changing viewing habits (e.g. catch-up) that expose children to adverts before 9pm, as well as to sports sponsorship and bingo ads. (15)

## Problem and risky gambling

The Scottish Health Survey, indicates that in 2016, 3.6% of respondents (sampling c.4323 participants) were low or moderate risk gamblers, or 4.9% of all gamblers, compared with 4.3% for 2014. 1% could be classed as problem gamblers, equating to 1.3% of all gamblers. Rates of problem gambling were highest amongst men aged 25-34 (3.4%) and, among women, were higher for those aged 25-34 (0.5%) and 35-44 (0.5%). This translates into 45,000 problem gamblers and 162,000 at risk gamblers. (9) (16) This is comparable with 3.6% of respondents to the Health Survey for England (sampling c.8,000 individuals) identified as low or moderate risk gamblers and the 0.7% classified as problem gamblers. (10)

Estimated problem gambling prevalence among adults living in private households in England and Scotland in 2012 was around 0.4/0.5%. (17) The trend is not clear but the number of problem gamblers might be increasing, with problematic gambling estimated to be more acute among those using machines in bookmakers, online gamblers, those betting on dog racing, spread betting, playing poker in clubs/pubs and the football 'pools'. (10) (18)

## Who is at risk?

The following section includes new UK material and systematic reviews published between 2016-2018 that highlight potentially higher risks of problem gambling for particular groups, wider gambling related harms, gender differences in gambling behaviour and how the life-course, e.g. risks at crucial periods, or the accumulation of experiences, might increase risk.

### Vulnerable groups

Thorpe and Miller (ScotPHN, 2014) have shown that individual, contextual, environmental and familial factors are associated with problem gambling. These include behavioural and lifestyle factors (alcohol, tobacco, substance use), experience of imprisonment, occupational factors, particularly working in the gambling industry and familial context, e.g. having a close relative who gambles or has alcohol problems may increase risk of problem gambling, and becoming a victim of another's problem gambling within the context of the family might be a further feature of this. (19)

Research carried out by Wardle et al indicates that gambling harms, financial, personal, or social, might impact on a range of individuals, irrespective of whether they may be defined as a problem gambler. They allude to mixed evidence, and an absence of UK based research in some areas, but based on a consideration of the available UK and international evidence, risks might be higher according to:

- Socioeconomic factors: unemployment, living in a deprived area, homelessness
- Ethnicity: immigrants and British populations of Asian, Chinese or Afro-Caribbean origin
- Lifestyle: substance misuse, alcohol problems

- Age: younger age
- Health and disability: poorer mental health, learning disability, cognitive impairment
- Education and intelligence factors: low IQ, poorer educational attainment
- Experience of the criminal justice system, e.g. offender, on parole. (20)

A subsequent scoping review focused on gambling risk in those with acquired brain injury, intellectual disability, learning disabilities and the homeless, raises questions about a potential lack of, or unwillingness to apply any policies that would seek to protect vulnerable customers, by staff working in gambling venues, whilst acknowledging that gambling operators can't discriminate against at risk adults, and exclude them from participating in gambling as a group. Gambling may be experienced directly, or because a vulnerable person is living with or being cared for by someone who gambles which could then place them at greater risk of abuse or neglect or enticement to gamble or exploitation. The review concludes, based on a lack of evidence suggesting otherwise, that adult social care and safeguarding practitioners and other service providers, including local authorities, with responsibilities to protect vulnerable people, may not be equipped with the knowledge, resources or processes to identify and safeguard those at risk or to use safeguarding data to inform local regulation of gambling. (21)

## Environment

Some of the recent focus on risk, vulnerability and problem gambling has been centred on the clustering of gambling venues, particularly in deprived neighbourhoods. The findings of Glasgow focused research identifies several clusters in deprived neighbourhoods. (22) Earlier research elsewhere in the UK indicates a significant correlation between gaming machine density and socio-economic deprivation (23) although the relationship between deprivation and the presence of gambling opportunities may not be straightforward, and urban areas of the UK that are not deprived also offer concentrations of opportunities to gamble, attracting at risk groups to those locations. (24)

How local communities and local authorities may navigate a path towards better regulation of gambling to prevent harm has not been clear, given their relative powerlessness to act. Local authorities perceive a lack of ability to challenge clustering within their current powers. Changes in the planning class of betting shop premises from financial and professional services to a specific licenced betting premises class requiring planning permission has been deemed ineffective. (25) Support by local authorities for the use of 'cumulative impact assessments' has been growing,<sup>2</sup> although the UK Department for Culture Media and Sport would prefer that local authorities work within their existing powers. (26) The use of such assessments would not provide a means of dealing with existing premises and clustering. (27)

Even without clustering however, opportunities to gamble via a myriad of outlets (corner shops, supermarkets, petrol stations, newsagents, pubs) as well as a growing

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<sup>2</sup> The London Borough of Newham are using cumulative impact assessments to curb development of new bookmakers: <http://fobt-appg.com/wp-content/uploads/2017/01/Fixed-Odds-Betting-Terminals-Inquiry-Report-January-2017.pdf>

online presence means that if we focus solely on clustering we miss the broader picture of widespread availability, as well as opportunities to gamble in locations not characterised by deprivation.

## **Mental Health**

The evidence linking gambling and mental ill-health continues to develop. To better understand the temporal relationship between consistent reports of an association between gambling disorders and comorbid psychiatric and substance abuse conditions, a recent systematic review, based on 35 longitudinal studies from high income countries found that psychiatric disorders (depression, anxiety, and substance and alcohol use disorders) represent both a precursor to and a consequence of problem gambling. How comorbid conditions contribute causally to gambling problems hasn't been established and gambling problems might also increase the general risk of developing comorbid psychiatric conditions, but other individual and environmental factors are likely to be involved. (28)

At UK level, Churchill and Farrell use data from the combined dataset of the Health Surveys for England and for Scotland (2012), using a sample of c.9,000, the most recent UK data to examine the relationship between gambling and depression, to identify relationships between depression, suicidal ideation and problem gambling. To measure depression, the study used responses to the survey question: 'Have you recently been feeling unhappy and depressed?' and applied use of the *Diagnostic and Statistical Manual of Mental Disorders* and *Problem Gambling Severity Index* scales of gambling addiction to measure addiction. The findings indicate a positive association between gambling behaviour and depression, and in terms of gambling venue it is suggested that online gambling poses a significant mental health risk compared to gambling via other venues or outlets. (29)

Several UK studies focus on suicidality in treatment seeking problem gamblers at the National Problem Gambling Clinic, using a small (n=122) (30) and larger sample (n=903). (31) In the former sample 29% had suicidal thoughts, and, in the latter, 46%, higher than for most other international studies. In the smaller sample, poorer mental health rather than gambling severity was a more prominent feature of suicidality. In the latter, those with suicidal thoughts were more likely to report greater problem gambling severity. In the larger sample, females were more likely to report suicidal ideation than males (9% of the sample were female). The authors of both studies suggest that routine assessment of suicide risk appears justified for those seeking treatment for gambling problems, and the findings of the study using the smaller sample further suggest that mental health rather than gambling severity should be addressed initially within treatment.

## **Life-course**

Adolescents and Young People: The evidence around risks and problem gambling among children and adolescents, has indicated that problem gambling behaviour may be part of a constellation of other antisocial, risk-taking, and delinquent behaviours, particularly among males. (19)



The evidence base continues to build on this theme, with a recent scoping review finding a moderate to strong association between adolescent problem gambling and other delinquent non-violent and violent behaviours. This might include financially motivated delinquency to fund gambling but also a range of non-violent and violent behaviours not associated with financial gain. Problem gambling and delinquency therefore may have shared risk and protective factors that reflect a 'syndrome of risky behaviour'. (32)

Early risk and protective factors associated with the subsequent development of gambling problems are further identified by a systematic review of longitudinal studies from high income countries, following up participants from childhood or adolescence to early adulthood. Meta-analyses to quantify the effect size of 13 risk factors indicates that the gambling behaviour of children and adolescents and problem gambling severity was the strongest of risk factors identified by the review, with a significant medium to large effect size. A small to medium effect size was identified for a greater number of gambling activities in which youth participated.

Effects were strong for male gender, although gender might not be a direct predictor of gambling but rather a proxy for other risk factors including violence and illicit drug use. Small to medium effects were identified for alcohol use frequency, cannabis use, illicit drug use and tobacco use.

Antisocial behaviours (delinquency, theft, violence, peer antisocial behaviours) were significant risk factors, displaying small effect sizes, poor academic performance displayed a medium effect size. Personality characteristics (impulsivity and under-controlled temperament) displayed small to medium effect sizes. Less convincing evidence linked depression and problem gambling although the association was significant but small. The study did not find significant effects related to age, aggression, anxiety symptoms, big early loss or win, attention problems, early gambling onset, psychological distress, sexual risk taking, suicidal ideation or religious attendance. Protective factors identified included parental supervision and higher socio-economic status, effects were small but significant although findings were mixed. Paradoxically, social problems were a significant protective factor, suggesting that youth who get along with peers are more at risk of problem gambling. (33)

Workplace: UK based research generated by Dighton et al (2018) indicates that among those who have served in the armed forces, in line with international evidence, problem gambling rates may be higher. The study, although small (257 veterans compared against 514 sex and age matched controls, drawn from the 2007 *Adult Psychiatric Morbidity Survey*) finds that problem gambling was significantly more prevalent in veterans (1.4%) than non-veterans (0.2%), potentially reflecting greater experience of major traumatic events since the age of 16. (34)

Older Age: Gambling participation appears to decrease with age in Scotland. (9) However older adults may not be sufficiently included in research to the extent that estimates of gambling or problem gambling among this group can be deemed reliable. (35) Wardle et al found little or no evidence that older people (or women) should be considered especially vulnerable to problem gambling although they recognise that

these groups may be affected by other problems, such as social isolation, that gambling can then ameliorate. (20)

Some of the causes of problem gambling among older adults may not differ from those of other age groups (to win, excitement) but an accumulation of stressful life-events, isolation and lower social support networks, as well as significant comorbidities, (e.g. ill health, mental health problems, addictions) might contribute to problem gambling or be a consequence of it. (36)

Research undertaken with a small sample in the UK, aged 60s to 80s, primarily women, support this to some extent and age-related vulnerabilities that might drive a desire to gamble, even if not to problematic levels, include loneliness, loss and bereavement, caring responsibilities, retirement, loss of social networks, a sense of loss of meaning in later life and poorer physical health. Gambling can counteract this by providing accessible escapism, stress reduction, social opportunities and cognitive stimulation and gambling venues may be the only (older) female friendly social space in some neighbourhoods. Study respondents were not unaware of ploys by the gambling industry to encourage gambling (ATMs in premises, venue design) but were aware of a loss of control in spending, a frequent occurrence among respondents, associated with poor mental states and anxiety. However the study also points out that older people may rationalise gambling given their age, relative lack of responsibilities and a determination to spend money as they wish. (35) (37)

Ethnicity and Older Age: The intersection of ethnicity, older age and gambling appears to be under-researched in the UK. However a systematic review, based on studies drawn from high income countries, not including the UK, and focused on Asians, African Americans and indigenous groups makes useful points about immigrants and gambling, particularly the high cultural acceptability of gambling among some immigrant groups, gambling as a means of connecting with those from similar ethnic backgrounds as well as problem gambling as a possible by-product of a lifetime of stressors associated with being an immigrant and lack of help-seeking. (38)

## **Gender and Gambling**

Gambling preferences appear to be gendered but the paucity of evidence has meant that it has been difficult to trace how women's gambling patterns and behaviours differ from men's. (19) Even if women are not at greater risk of problem gambling, understanding how and why women gamble might be crucial in developing a preventative approach.

A 2016 systematic review, drawing on evidence from high income countries indicates that there may be similarities between men and women, e.g. preference among both sexes for electronic gaming machines, but the mixed and conflicting findings of the included studies can only hint at some potential differences between women and men. Women problem gamblers may be more likely to suffer greater psychological distress, be unemployed or have experienced childhood abuse. Male problem gamblers may be more likely to have greater impulsivity, prefer more strategic activities, such as sports betting and casino games, and be more likely to report higher rates of substance and alcohol use. (39)

This correlates with the findings of a study of 1,178 treatment-seeking problem gamblers at the NHS National Problem Gambling Clinic to identify gender differences within this group, albeit that women formed just 7.5% of this sample. Men were more likely to be younger, white, and employed than women, possibly highlighting greater female economic vulnerability, although most male and female subjects were employed in this sample. Men had a preference for specific forms of gambling, principally FOBTs and sports betting versus a female preference for bingo. Men reported an earlier age onset of gambling behaviour, a higher gambling involvement and heavier use of alcohol and illicit drugs. Women in this sample were older than men, began gambling later, were more anxious and depressed, had higher gambling severity scores, possibly reflecting a reluctance to seek treatment, thus requiring gender specific treatment offers. (40)

## Trauma and Violence

Gambling harms extend beyond the gambler, and there is a growing body of research focused on connections between gambling and trauma and violence, in adult and childhood, as well as domestic abuse and intimate partner violence (IPV) perpetrated by problem gamblers and experienced by partners and within families. For example, the findings of research using data from the *Men's Health and Modern Lifestyles Survey*, a nationally representative sample of 3,025 UK men aged 18–64, collected in 2009 by the University of London, indicates the presence of links between trauma, life stressors in both childhood and adulthood and problem gambling. 80% of the sample had gambled, 64% of those were non-problem gamblers, 22% borderline problem gamblers, 6% problem gamblers and 8% probable pathological gamblers.

Male probable pathological gamblers and problem gamblers reported higher rates of experiencing trauma in both childhood and adulthood including witnessing violence in the home, physical abuse, sexual abuse or intimate partner violence in adulthood, and workplace violence. Both groups reported injuries, marital difficulties, homelessness, money problems and criminality more often than non-gamblers or non-problem gamblers. Probable alcohol and drug dependence was reported by around a third of pathological gamblers. The associations involving gambling problems and trauma were generally attenuated when adjustments were made for alcohol or drug dependence. However witnessing violence in the home as a child, domestic violence in the home as an adult, workplace violence and being convicted of a criminal offence, marital problems and money problems remained significant in some or all groups after adjustments. (41)

A recent international systematic review indicates that the evidence around IPV and gambling is not straightforward or equivocal but it does point to a significant relationship between problem gambling and being a victim or perpetrator of IPV. Various factors might be linked to problem gambling and IPV including under-employment, anger, alcohol or substance use. The temporal relationship may differ for some gamblers and IPV precede problem gambling. Risks for problem gambling for victims of IPV might also be higher, as they seek to gain a form of escape from abuse and violence. (42)

## Summary

The gambling industry is undergoing change, the propensity to incorporate technology to generate new sources of revenue means that opportunities to gamble are diversifying with online gambling generating a growing proportion of GGY, physical gambling outlets are declining, but GGY generated by FOBTs in physical venues is growing. As many as 200,000 people in Scotland may be problem or risky gamblers. Many more are likely to be exposed, including friends and family, to the problems that appear to result from this, including impacts on mental health and engaging in violence. Gambling participation might be declining in Scotland, reflecting falling National Lottery participation as in the rest of the UK, but participation rates also seem to be higher than elsewhere in the UK.

Various factors contribute to this but the link between the individual and problem gambling is not likely to be straightforward. The nature of the gambling product, broader environmental factors that expose individuals to gambling opportunities, and not solely in deprived areas, and the interplay of individual characteristics (gender, ethnicity, age) and experiences related to lifestyle, workplace, education, socio-economic factors, health and wellbeing, are likely to either protect or predispose individuals to gambling risks.

## Preventing and Minimising Harm

Harm, as Langham et al have pointed out, has been too narrowly defined and measured, relying on use of diagnostic criteria to measure harm in problem gamblers, ignoring those with smaller, more prevalent problems. Harms accrue for gamblers and their communities, across financial loss, relationship conflict, emotional or psychological distress, health impacts, cultural harms, work or study performance, criminality and a range of determinants both proximate and distal to health. (43)

Recent intervention at UK government level that might mitigate harms has been limited to the *Gaming Machine (Circumstances of Use) (Amendment) Regulations 2015*, to stipulate a requirement for over the counter authorisation of FOBT stakes above £50 and encourage use of verified accounts to improve payer control by providing real time behavioural information. The regulations were not particularly effective. (44)

Within a Scottish legislative context, Section 52 of the *Scotland Act 2016* devolved legislative competence in relation to FOBTs within betting premises. Scottish Ministers can vary the number of machines allowed on betting premises, requiring an Order subject to the affirmative procedure but these powers apply only to applications for new premises licences. (45)

Preventing harm continues to rely therefore on the gambling industry to apply practices that might disrupt or prevent risky or problem gambling or on gamblers to recognise and address their gambling behaviours. Harm minimisation, or 'responsible gambling', criticism of which has focused on its emphasis on the consumer to gamble responsibly, not on responsible gambling provision, includes strands aimed at reducing gambling demand or supply including: customer or potential customer awareness raising; self-

exclusion from gambling; information about support or advice in gambling venues; restrictions on FOBTs to four in UK betting shops; gambling machine adaptations and staff interaction with gamblers to observe behaviour and intervene. (46)

However as Gillies (ScotPHN, 2016) has shown, several countries, e.g. New Zealand, Australia, Sweden, have developed policies that seek to move away from a focus on the problem gambler, to a much broader consideration of the determinants of gambling related harm that can then be located within a wider framework of public health actions to address health inequalities and reciprocal comorbidities. Specific groups vulnerable to gambling related harm are recognised within this approach, allowing for better targeting of resources and interventions.<sup>1</sup> (47)

The *New Zealand Strategy to Prevent and Minimise Gambling Harm* seeks to reduce the incidence of gambling harm, pointing out that while effective treatment reduces the impact of gambling and problem duration, it has limited impact on prevalence and incidence. Therefore prevention through a focus on social and other determinants is crucial.<sup>2</sup> (48)

Gillies incorporates the Korn and Shaffer model, proposed as a public health approach to gambling in Canada in the 1990's, and that seeks to prevent problems via public awareness, early identification and treatment, promoting informed attitudes toward gambling through knowledge, responsible choice and community participation and protecting vulnerable groups from harm through responsible gambling policies and community support programmes. In this approach, primary prevention, early intervention and treatment should take place at all stages of the gambling continuum, and target non-gamblers, healthy and problem gamblers. Primary prevention may be universal or targeted and include education campaigns or developing community understanding to then influence local gambling policy. Secondary prevention targets populations at risk of harm to e.g. self-exclude from gambling venues, gambling machine adaptations to encourage a reduction in use or spend, gambling venue staff training, and brief health and social care interventions. Tertiary prevention includes treatment and support services targeting those experiencing gambling related harm.<sup>3</sup> (47)

## Primary Prevention

Gambling provider educational interventions have included messages applied to advertising (*'When the fun stops, stop'*), pointers to forms of support, in gambling venues, and socially responsible gambling training for staff.

How many children and young people in the UK are exposed to gambling education is unclear. However promising interventions might include Fast Forward's *Youth Problem Gambling Initiative*, developed to prevent the onset of 'at-risk' gambling behaviour among young people, delivered to high schools in Edinburgh and the Lothians, as well as to youth workers, teachers and other practitioners working with young people across Scotland.<sup>4</sup> (49)

*Demos*<sup>3</sup> have piloted an intervention in a number of English schools and their findings indicate small but statistically significant falls in intervention participants playing cards for money or taking part in four or more types of gambling activity, and some positive changes in pupil ability to identifying problem gambling, describe how to help a problem gambler, seek help, and understand industry techniques to encourage gambling. (50)

RGSB have recommended that existing education pilots be scaled up, with support from local authorities, schools and the Department for Education, in tandem with training for those who work with young people, and support for families to have informed conversations about gambling risks with children and adolescents, with a role for public health agencies in considering how this may be achieved. (15)

Internationally, the evidence about what might work in schools appears patchy. The recommendations of a 2017 systematic review are almost wholly generic, but they do indicate that programs should be implemented universally, from aged 10, be orientated towards preventing problem gambling rather than preventing gambling, should teach mathematical principles to highlight long-term unprofitability and use multi-media platforms. (51)

It's worth noting that in spite of the likelihood of there being a higher risk of problem gambling for children of problem gamblers, the findings of a 2016 systematic review indicate that there remains a dearth of evidence around how interventions may support this group. (52)

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<sup>3</sup> In partnership with the PSHE (Personal, Social, Health & Economic) Association, Mentor (alcohol & drug misuse charity) and the Central and Northwest London NHS Foundation Trust and supported by GambleAware

## Secondary Prevention

Self-exclusion: There are a plethora of secondary prevention approaches associated in particular with machine and venue adaptations, limit setting, but also self-exclusion. Their use is low, e.g. c.10% of gamblers set financial limits in 2017. Awareness of self-exclusion among the never excluded is 35%. 6% of gamblers have ever self-excluded, usually men and those gamblers aged 25-34. (8) Self-exclusions are increasing, particularly for online gambling, with 1.15 million new self-exclusions (2016-2017), up from 0.62m the year before<sup>4</sup> with 75,891 breeches of this. (4) (53)

Individuals should be able to make a single request to self-exclude from the same types of gambling venues in their area but online gamblers must self-exclude from each operator. (54) Physical venues (bingo, arcades, betting shop, casino) each offer self-exclusion schemes. (55) Individuals can self-exclude online, but trade body advice also includes attending or contacting the gambling venue directly (56) (57), which is potentially counterproductive, and embarrassing. (58) There are clearly drawbacks, including reliance on venue staff to identify the excluded, multiple schemes, breeches and low use, but self-exclusion may be more attractive to problem gamblers, might reduce expenditure, improve sense of control and mental health and reduce problem severity. (59) (60)

Machine and Venue Adaptations: Recent review level evidence is mixed but does suggest potential benefits, as well as problems:

- Removing large note acceptors on machines and ATM from venues: there is some evidence that removing ATMs within venues or limiting withdrawals and withdrawal of note acceptors might be a worthwhile intervention in terms of reducing expenditure, gambling frequency and time spent on gambling (46) (61)
- Pop-up and on-screen messages (machine / online): messages can provide information about session length, expenditure, odds of winning, irrational beliefs or be worded to encourage a focus on gambling behaviour. The evidence is mixed with individuals often reporting no perceived impact but messages might also increase knowledge, reduce irrational beliefs, time and money spent, although gamblers are likely to have to play for a certain time before they see a message. Self-appraisal messages, to reflect on gambling behaviour may be particularly helpful, as well as dynamic and interactive messages (i.e. that have to be removed by the patron) over static messages (46) (61) (62)
- Breaks in play: imposed short breaks in play, for gaming machines, might be effective but might also increase desire to gamble (46)
- Behavioural tracking tools: these provide the opportunity to track behavioural player data to provide gamblers with personalised feedback to generate behaviour change. While positive evidence exists for the use of such tools, the specific features of tools most likely to positively change behaviour remain unclear (46)
- Setting time and money limits before gambling: the available evidence is mixed suggesting positive benefits for some but increased gambling problems for others,

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<sup>4</sup> There were 38,542 new self-exclusions from betting shops in the same period, around 18,000 breeched those exclusions. Source: <http://live-gamblecom.cloud.contensis.com/Docs/Gambling-industry-statistics.xlsx>

as gamblers might swap machine used or gambling venue when limits have been reached.  
(46) (63)

## **Tertiary Prevention**

As Gillies points out, tertiary prevention in the form of treatment and support is almost wholly delivered by the third sector (e.g. Gamblers Anonymous, GamCare) primarily in receipt of funding from GambleAware, a charity set up by the gambling industry to fund treatment and prevention, with just one specialist centre, the National Problem Gambling Clinic, based in London and within the NHS. (47) (64) This is deemed patchy and not appropriately distributed to match need, with calls for gambling treatment to be included alongside existing drug and alcohol treatment services. (64) (65)

Models of care and treatment pathways are undefined. (47) NICE guidelines on the diagnosis and management of gambling disorders, if developed, could support treatment and as George and Bowden-Jones point out, would benefit patients across the UK and help to clarify NHS responsibility for treatment provision. (64)

Many problem gamblers will not identify themselves as such, and the level of unmet need for support and treatment services has been unquantified. (47) Where problem gamblers are engaging with primary care, evidence drawn from a small sample of GPs in Solihull (n=98), indicates that most had seen gambling addicts in their practice, none had received training in managing gambling addiction and most expressed a lack of confidence in doing so. Most were keen to receive training but highlighted resource and capacity issues as potential barriers to managing gambling addiction in primary care. Interestingly, around half thought that the gambling industry should fund gambling treatment services and not the NHS. (66)

GambleAware now captures data about who receives treatment via GambleAware funded providers (GamCare, National Problem Gambling Clinic, Gordon Moody Association). During April 2016-March 2017, 8,808 clients were treated, primarily self-referring and receiving treatment from GamCare. 82% were men, usually in their mid-30s, white British, employed, married or in a relationship, with no additional psychological diagnoses. Those affected by other's gambling, also primarily self-referring, tended to be females, in their mid-40s, white British and employed. There was on average a 7.5 year time lag between starting to gamble and presenting for treatment. At first assessment, most had a moderate to severe gambling problem and severe psychological distress. Around 12% had lost a job, 77% were in debt (15% in debt over £20,000) and 25% had lost a significant relationship due to gambling. Only around half of problem gambling clients completed treatment, 69% of affected others. (67)

If those who receive treatment, who form a small proportion of the estimated numbers of problem and risky gamblers in the UK, are representative of this wider group or are simply representative of those who are most able to identify sources of treatment and to self-refer, or are willing to be referred to treatment, is unclear.



## Conclusion and Recommendations

Gambling is a pursuit that many people enjoy and will do so without harm. It generates significant revenues for government and operators but it's also costly, not solely for the individual, but for government in the form of health, welfare, employment, housing and criminal justice costs. The Institute for Public Policy Research estimates that Scottish excess fiscal costs incurred by people who are problem gamblers are likely to fall within £20-£60 million each year (between £260 million to £1.16 billion per year for the UK as a whole), with health incurring the biggest costs. (68)

The widespread availability of gambling opportunities, as well as clustering, and not solely in deprived areas combined with the growing pool of evidence that links gambling to a range of other problems (co-morbidities, violence, trauma, social isolation) whether as cause or effect requires that local licencing authorities, in their renewal of the *Statement of Gambling Policy*, are aware of the factors that might give rise to risky and problem gambling and the potential for harms that might arise from this, for the gambler and the wider community.

It is recommended that the SDsPH seek to influence this process. As Gillies (47) has previously advocated, the SDsPH should recognise gambling related harm as a public health issue and seek to encourage debate within the public health community on the place of gambling within our society.

Within the context of the opportunity to contribute to the refresh of local *Statements of Gambling Policy*, we recommend that the SDsPH:

- Engage with local licencing authorities to ensure that statements are informed by an understanding of the factors that might increase gambling risks (individual, environmental, lifestyle, workplace, education, socio-economic and health and wellbeing related).

In the run up to and beyond the development of the *Statements of Gambling Policy* we further recommend that the SDsPH provide advocacy around the development and application of universal and targeted primary preventive approaches, the need for secondary preventive approaches that are applied effectively and which might reduce harm, and the place and funding of tertiary prevention activity, i.e. treatment and support, within the NHS.

We recommend that the SDsPH:

- Engage with local licencing authorities, local authorities and wider partners to consider how gambling risks may be mitigated among children and young people. This could involve engagement with frontline health and care staff and third sector organisations working with at risk children and young people as well as advocating for the use of universal interventions aimed at all children and young people, such as those developed by *Fast Forward* and *Demos*, described above
- Build interest among public health practitioners in response to Responsible Gambling Strategy Board recommendations that this group consider how they may

support families and carers to have informed conversations about gambling risks and harms with children and adolescents

- Engage with frontline health and care staff to consider the feasibility of developing awareness raising about risky and problem gambling to identify those at risk and who it may be most worthwhile to screen based on existing morbidities or for example, admission of financial problems. This should extend to adults subject to safeguarding, and include awareness raising around the impact of gambling on families and children of problem gamblers
- Engage with frontline health and care staff to ensure that there is an understanding and awareness of sources of treatment and support for risky or problem gambling and how patients and clients may be referred
- Seek to encourage an awareness among health and care staff of some of the measures, such as self-exclusion, that might provide benefits for some risky and problem gamblers.

Local regulation of gambling is complex, with evidence of conflicting views, and significant challenges around how its physical presence may be managed. However we recommend that SDsPH:

- Advocate that local licencing authorities and local authorities use as wide a range of powers within their remit to prevent and reduce gambling risks and harms. This includes the need for physical gambling venue staff to be trained to effectively apply any policies that might protect vulnerable or under-age customers and the application of effective self-exclusion opportunities. Opportunities must also be extended to local communities to engage with, and understand, how the parameters that determine the presence of gambling opportunities within local areas may be discussed and influenced.

### **Search**

- This update is based on a search of databases including Medline, Embase, ASSIA, International Bibliography of the Social Sciences, Web of Science, PsycArticles, PsycInfo, Proquest Public Health and Sociological Abstracts to identify journal articles and systematic reviews published between 2014 and 2018. The emphasis was on identifying material generated about the UK, or systematic reviews
- The search terms included: gambling, gaming, betting, fixed odds, FOBT, roulette, National Lottery, lottery ticket, bingo, scratchcard, bookmaker, casino, fruit machine and slot machine
- This was supplemented by a search for grey literature using Google Advanced.

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