Dr Heather Wardle, Professor Gerda Reith, Professor Robert D Rogers and Erika Langham – Written evidence (GAM0043)

All views are the authors own.

Introduction

1. We are delighted to have the opportunity to contribute evidence to the House of Lords Select Committee Inquiry on the Social and Economic Impact of the Gambling Industry. We focus on three key elements:
    a. The need to prevent harms from occurring in the first place
    b. Presenting evidence that supports the need for action
    c. The need for a mandatory levy to be introduced to support effective prevention, treatment and research activities.

"Prevention is better than cure"

2. The harms from gambling are profound, impacting people's resources, relationships and health. Gambling harms can also be enduring, persisting long beyond when gambling has ceased and undermining people's well-being (Wardle et al 2018; Browne et al, 2016). Whilst problem gambling rates in Britain have tended to be stable, evidence suggests that a good proportion of affected individuals move in and out of problem gambling (see Appendix). This high level of 'churn', particularly movement into problem gambling, highlights the need for resources be dedicated to preventing harms from occurring in the first place.

3. Review of other public health issues suggests that effective prevention should include a range of measures including those targeted at individuals engaging in a particular activity (c.f health warning messages on cigarette packets as a parallel), interventions which aim to support people to reduce their gambling (c.f. smoking cessation programmes as a parallel) and, critically, broader measures that place greater restrictions on the access and availability of gambling and/or place restrictions on certain products (c.f. SmokeFree legislation or under the counter sales of cigarettes as a parallel).

4. A full range of different activities needs to be strategically planned, implemented and monitored with the overarching aim of preventing gambling harms from occurring in the first place. Whilst the Gambling Commission's National Strategy for Reducing Gambling Harms recognises prevention as important, the Gambling Commission, as the industry regulator, does not have sufficient resources or expertise to be able to realise these objectives. This is one reason we support the introduction of a mandatory levy and also advocate that policy responsibility for gambling be moved from the Department for Digital, Culture, Media and Sport to the Department of Health and Social Care (Wardle et al, 2019).

Harms are occurring now – and we have evidence to take action

5. As noted in the Appendix to this document, the number of people harmed from gambling is very likely to be far higher than the number of people who are categorised as problem gamblers. As outlined in the Appendix, we know

that problem gamblers experience a range of adverse consequences: they have significantly poorer levels of wellbeing, poorer mental and physical health and far higher rates of suicidality than others. Reports from treatment providers shows people citing relationship breakdown and severe financial difficulties as a result of gambling as further evidence of harms (GamCare, 2018).

6. In other jurisdictions, where the prevalence of gambling problems is similar despite different provision of gambling opportunities, gambling harms are estimated to be of greater magnitude than osteo and rheumatoid arthritis, diabetes mellitus, or chronic obstructive pulmonary disease (COPD). Annual population level harm from gambling are around two thirds of that of alcohol or major depressive disorder (Browne et al, 2016). These findings, generated in Australia, have been replicated in New Zealand giving greater confidence in their veracity (Browne et al, 2017).

7. Whilst there is more to learn about the extent and nature of harms in a British context, there is already much that we do know (see Appendix) and it is unlikely that the same harms found elsewhere do not occur widely here in the United Kingdom. Therefore, we do not believe that action to prevent harms should be put on hold until we learn more. Action should be taken now. In keeping with other public health issues, we strongly advocate implementing a precautionary approach to address gambling harms. Any actions taken should be supported with sound evaluation and piloting to better learn what works in the context of gambling-harm prevention.

We need different structures to effectively reduce harms

8. To effectively reduce harms requires a step change in how we approach, understand and fund gambling harms. The existing system by which voluntary contributions are raised from the industry and spent (mainly) through GambleAware does not raise enough money to implement the type of prevention strategy we advocate nor does it give many stakeholders confidence that the money is spent free from industry influence (van Schalkwyk et al, 2019).

9. We believe that only a mandatory levy on industry is capable of a) generating the level of sustainable resources needed to deliver a fully implemented prevention and treatment strategy and b) provide sufficient levels of independence and transparency needed for all parties to have confidence in the system.

10. We note that some operators have recently announced increasing their voluntary contributions to £60 million a year over the course of five years. We have significant concerns about relying on this funding for gambling-harms prevention and treatment.

11. First, there are, as yet, few details about how this will be administered or the governance arrangements that will be put in place. Concerns about industry influence have not abated and industry statements about how this money will be spent have not been reassuring – with statements that the money will be directed to treatment, advertising, data sharing, transparency (Gallagher, 2019) Notably, prevention is missing from this list. This does little to dispel

the sense that industry will exert influence either overtly or covertly on how this money is spent.

12. Second, this offer is made on a voluntary basis, meaning there is no mandatory requirement for this level of funding to actually be provided or provided consistently over a number of years. This is a major concern given that industry have consistently failed to meet GambleAware's targets over a number of years. Sustainable levels of funding known and guaranteed over a period of years are needed if this funding is to be used to set up new treatment infrastructure or to contribute sustainably to the reduction of harms. Only a mandatory levy can provide this level of certainty.

13. Third, whilst £60 million per annum is an increase, it is insufficient to address existing need and is inequitable in the context of the profits made by industry. The industry generates over £14 billion per year in Gross Gambling Yield (GGY) (Gambling Commission, 2019). Gross Gambling Yield is the income retained by industry after bets have been paid out. Problem and moderate risk gamblers make up 3% of gamblers, meaning that at least £420 million of annual Gross Gambling Yield will be generated from problem or moderate risk gamblers. This is likely to be a conservative estimate, as evidence shows that problem gamblers spend more than non-problem gamblers (Orford et al 2011). A return of just £60 million per year (0.4% of Gross Gambling Yield) to deal with gambling harms is highly inequitable. This inequity means that gambling companies are disproportionately profiting from moderate risk and problem gamblers.

14. For these reasons, we advocate implementing a mandatory levy on industry to support the reduction of gambling harms. A levy would require new systems to be established to spend this money well (Reith et al, 2019). With respect to research, we support the idea that some funding be distributed through the pre-existing UK Research and Innovation infrastructure. This could include open calls for research but should also include investment in a research infrastructure that allows flexible, agile and responsive work to be undertaken quickly to respond to emerging policy issues or new concerns (especially relating to technology). We would strongly recommend that models such as the Public Health Research Consortium or the NIHR-funded Policy Research Units be considered as part of this.

Conclusion

15. We believe the harms from gambling have been under-estimated. There is a critical need to invest in the systematic prevention of gambling-harms and in a high quality and accessible infrastructure for treatment. We have sufficient evidence to do this now. This needs to be led by a central government department with the will, experience and expertise to drive forward this agenda, the Department of Health and Social Care, and funded by a mandatory and independent levy on industry.

About the authors

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Gambling, which provides advice on gambling policy to the Gambling Commission. She previously worked at NatCen Social Research (2002-2015), where she led their programme of gambling research. She runs a research consultancy for public and third sector bodies and leads the Gambling & Place Research Hub at Geofutures. She does not provide research or consultancy services for the gambling industry. She has worked on a variety of projects for GambleAware and has been funded by the ESRC, Wellcome, MRC and NIHR.

Gerda Reith is a Professor of Social Sciences at the University of Glasgow. Her work focuses on the sociology of consumption, with a specialism in gambling. She is a Commissioner of the Howard League for Penal Reform's Commission on Problem Gambling and Crime. Her research has been funded by NIHR, the MRC, the ARC and the ESRC. She was a member of the Responsible Gambling Strategy Board from 2008 to 2012. In 2018, she worked on a project at the University of Stirling that was funded by GambleAware.

Robert D. Rogers is a Professor of Psychology at Bangor University, North Wales. His has published widely on the psychological and neurobiological aspects of gambling, gambling problems and broader health impacts. He is an Associate Editor for the journal, International Gambling Studies. His work has been funded by the BBSRC, ESRC and MRC. Previously, he has received funding for two projects from GambleAware. Rogers also served on the Research Panel that previously advised the Responsible Gambling Strategy Board (now the Advisory Board on Safer Gambling). He was elected a Fellow of the Learned Society of Wales in 2016.

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Appendix: Evidence overview

This evidence overview updates one provided to the House of Lords Select Committee on August 28th, which was requested by the Committee during Dr Wardle's oral evidence presentation on July 23rd. The original letter provided to the Committee only considered evidence generated in Britain. This appendix supplements this with evidence generated internationally, where appropriate.

What evidence do we have that people are being harmed by gambling?

Data from the Health Surveys for England and Scotland 2016 show that around 0.7% of the British population are problem gamblers. This equates to around 340,000 people. Furthermore, 1.1% are moderate risk gamblers (550,000 people) which means that they are experiencing some difficulties with their gambling now (Connolly et al, 2018).

These are conservative estimates. First, prevalence rates of problem gambling are generated from a household survey which excludes people living in institutions, such as student halls of residence or prisons – both likely to have higher rates of gambling problems among their resident populations.

Second, they are measuring problem gambling in terms of clinical symptoms and behaviours rather than the harms (and distress) experienced among the wider population. Gambling harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society, affecting people's resources, family and social relationships, occupational and educational opportunities and physical and mental health (Wardle et al, 2018). Review of problem gambling screening instruments show they do not capture this broader range of harms simply because they do not ask about them all. National surveys of problem gambling use two instruments to measure gambling problems: the DSM-IV problem gambling screen and the Problem Gambling Severity Index (PGSI). The DSM-IV problem gambling screen includes just one question asking if participants have risked a relationship, job or work opportunity because of gambling, and one other question about committing crime because of gambling. It does not capture health problems as a result of gambling. The PGSI includes a single question on the health consequences of gambling and one on gambling causing financial problems. It does not capture any information about relationship problems. Neither screen capture data on the full range of financial or emotional difficulties to which gambling can contribute nor the impact of gambling upon other people – the partners, children and friends of gamblers.

Gerda Reith's work on gamblers in Glasgow, along with evidence from those seeking treatment, demonstrate the range and depth of harms associated with gambling which are simply not represented in standardised problem gambling screens (Reith et al, 2013; GamCare, 2018). Furthermore, the harms from gambling can be long-lasting (e.g. the lasting impact of severe financial difficulties, relationship breakdown or poor health), persisting beyond engagement in gambling itself. It is very likely that people continue to experience a range of adverse impacts long after they have stopped gambling. For these reasons, the number of problem gamblers in Britain should not be considered a robust measure of the total number of people harmed by gambling and could conceivably be viewed as only representing the minimum number of people affected.

Internationally, there is a wealth of evidence on the harms from gambling. Globally recognised burden of disease approaches have been applied to gambling harms allowing the calculation of population level measures of impact comparable to other health conditions (Browne et al 2016; Browne et al 2017). These studies have provided insights into the loss of health-related quality of life for individuals at different gambling severity levels, the loss of health utility for their family members, and the impact at the population level. These studies have identified the loss of health-related quality of life ranges from 13% loss for a low risk gambler to 44% loss for a problem gambler.

Because these analyses have used standardised methodologies these health-related quality of life losses can be compared with other major health outcomes at both the individual and population level, and robust economic costs of this loss can be calculated. This shows that gambling harms are estimated to be of greater magnitude than osteo and rheumatoid arthritis, diabetes mellitus, or chronic obstructive pulmonary disease (COPD). Annual population level harm from gambling are around two thirds of that of alcohol or major depressive disorder (Browne et al, 2016). When looking at harms across the whole population, the majority of lost health actually occurs among low risk gamblers due to the greater prevalence of low risk gambling. Essentially, lower-level harms for many people adds up to great amount harms in aggregate. This highlights the need for more strategies aimed at prevention and early intervention. Robust costing of these harms has also demonstrated that gambling operates at a net cost to the community, despite the industry generating some employment and other economic surpluses.

What do we know about the incidence of problem gambling?

The data collected by the Health Surveys for England and Scotland shows the prevalence of problem gambling. That is, how many people at a single point in time are problem gamblers. What it does not tell us is how many of these people are 'new' cases (incidence). It is possible to have static problem gambling prevalence rates but have very high incidence because of high levels of movement in and out of problematic behaviour.

It is important to know the incidence of problem gambling. If many people are becoming problem gamblers, then resources should be focused on prevention – that is preventing these people from becoming problematic gamblers in the first place. If the incidence rate is very low then resources may be best focused on treatment, ensuring those who are problem gamblers recover.

Longitudinal data is needed to measure incidence rates. Whilst, sadly, we do not yet have a national longitudinal study of gambling behaviour in Great Britain, there are three separate studies which suggest, as observed in jurisdictions like Australia, New Zealand and Canada, that the incidence rate for problem gambling in Britain is likely to be high.

1) Gerda Reith's (2013) longitudinal study of gambling behaviour among Glaswegians found that over a five-year period patterns of stable gambling behaviour were not the norm and that people moved in and out of problem gambling as their levels of gambling engagement increased and decreased. She concluded that gambling problems were episodic in nature.

2) Forrest and McHale (2018) studied a cohort of 17-year olds living in the South West of England and followed them up three years later when they were aged 20. The prevalence of moderate harm or problem gambling among this group tripled in this three-year period (rising from 1.4% to 4.6%) and the incidence was very high: 84% of those experiencing moderate harm or problem gambling at age 20 had not done so at age 17.
3) Wardle et al (2017) looked at changes in problem gambling between 2014 and 2016 among British gamblers holding loyalty cards for certain bookmakers. This showed that around 30% of those classified as problem gamblers in 2016 were new cases; that is they were not classified as problem gamblers when interviewed in 2014. In both 2014 and 2016, the prevalence of problem gambling was similar (20% in 2014; 19% in 2016). This demonstrates how static prevalence rates can mask a great deal of churn in behaviour and as such, are a poor basis for policy development.

These studies suggest that the occurrence of new cases of problem gambling (incidence) in Great Britain is likely to be high, despite having relatively stable problem gambling prevalence rates.

It should also be noted that those moving out of problem gambling will not just be because they have recovered but may also be because they have moved into institutions (such as prisons) or because of higher mortality among this group. As well as knowing how many people become problem gamblers, we also need to better understand why people stop being problem gamblers.

The British evidence above is consistent with that from other jurisdictions which have used longitudinal data to look at the incidence of problem gambling and have repeatedly found the incidence rate to be high. In a review of 14 longitudinal studies, Williams et al (2015) noted that less than half of problem gamblers remained so in the next reporting period. This means that the number of new cases identified over time by these studies is high. This includes Victoria, Australia where approximately 50% of problem gamblers identified at follow-up were new cases; Sweden, where over three quarters of moderate risk/problem gamblers were new cases; and a further Australian study of 17-24 year olds where over 60% of problem gamblers identified at follow-up were new cases (with authors stating that new incidence was the most prevalent behaviour) (Scholes-Balog et al, 2016). Given the strength of the international evidence, we have little reason to suppose this would be different in Great Britain.

What do we know about gambling behaviour among children?

Data about gambling among children in Britain comes from the Gambling Commission's annual survey of young people. This is a robust, nationally representative survey of those aged 11-16. The study uses a very similar methodology to studies which provide national statistics on smoking, drinking and drug use.

The most recent data from 2018 shows that 14% of children aged 11-16 had gambled in the past week and 39% had gambled in the past year. This includes gambling with family and friends but also gambling on commercial forms of gambling, with playing slot machines, buying lottery tickets and scratch cards being the most popular forms. Around 5% of 11-16 year olds had gambled online in the past year and 1% had gambled online in the past week (Gambling

Commission, 2018). This makes gambling more prevalent among children than smoking cigarettes, drinking alcohol or using drugs. Gambling is also more popular than activities like playing hockey, going ten pin bowling or swimming (Wardle, 2018).

Like most other risky behaviours, gambling has declined among those aged 11-16, falling from 23% to 14% in 2018. The majority of this decline can be explained by falling engagement in lotteries and private gambling.

However, half of all gambling among children is still on what should be age-restricted forms. Furthermore, in 2018 around 55,000 (1.7%) children were categorised as problem gamblers. The likelihood of being a problem gambler among children was higher among those who had gambled online (Wardle, 2019).

We also know that children also engage in gambling-like activities in the context of video/online gaming, such as paying to open Loot Boxes and gambling with skins.[1] Those who gambled skins and also engaged in other forms of gambling were more likely to be problem gamblers than those who either gambled skins alone or gambled on other forms of activities alone (Wardle, 2019). There is increasing interest in the intersection between gambling-like activities within video games and more traditional forms of gambling. Concern has been raised that practices like loot boxes exploit children or that they prime children to engage in risky, gambling-like activities.

Is there a relationship between gambling and suicide in Great Britain?

Yes. Three separate British studies have shown a strong association between suicidal ideation and suicide attempts and problem gambling.

Sharman et al (2018) showed that in 2015 one third of people in residential treatment for problem gambling had attempted suicide, rising from 15% in 2001 and that around 80-90% had thought about taking their lives. Ronzitti et al (2019) showed that 46% of people attending an NHS clinic for problem gambling had thought about taking their lives in the previous 12 months. The odds of current suicidal ideation increased as problem gambling severity increased and this relationship persisted once experience of depression and substance abuse was taken into account. Wardle et al (2019) showed similar patterns among problem gamblers living in the general population. Problem gamblers were more likely to report thinking about taking their lives (19.7%) and to have attempted suicide (4.7%) in the past year than those who were not problem or at-risk gamblers (4.1% and 0.6% respectively). This relationship persisted when co-occurring common mental disorder and substance abuse/misuse was taken into account.

The evidence observed in Great Britain is supported with evidence from a range of other jurisdictions. A strong relationship between gambling and suicidality among those seeking treatment has been noted in Spain, France, Sweden and the USA (Guillou-Landreat et al, 2016; Mallorqui-Bague et al, 2018; Karlsson & Hakasson, 2018; Ledgerwood & Petry, 2004). Studies from USA and Canada have also highlighted the same association among problem gamblers living in the community (Newman & Thompson, 2003;2007; Moghaddam et al, 2015). In

[1] Skins are decorative in-games items that can be bought or won within video games. They have no bearing on the outcome of the game.

Sweden, a study found that the risk of suicide mortality among those with a diagnosis of disordered gambling was 15 times higher than others (Karlsson & Hakasson, 2018). These studies have given various explanations for this relationship. Some have argued that this association is driven by other mental ill-health (Newman & Thompson, 2003; Hodgins et al, 2006) whilst others have shown that this relationship persists once mental health is taken into account (Newman & Thompson, 2007; Wardle et al 2019) and highlighted familial discord, social conflict and financial problems as other factors which confer risk for suicidality among problem gamblers (Carr et al, 2018).

Whilst more work is needed to understand theses associations, it is clear that problem gamblers in Britain, regardless of whether they are seeking treatment or not, should be viewed as a high-risk group for suicidality. British evidence conducted to date suggests that this relationship is not fully explained by the existence of other common mental health disorders among problem gamblers.

What is known about the impact of gambling on health and wellbeing?

Problem gamblers have very low levels of wellbeing, are more likely to be in poor physical health and to have probable mental ill-health. These associations have been demonstrated in analysis of both the British Gambling Prevalence Survey (BGPS) 2010 and also the Health Survey series, which have used slightly different measures but found the same results. The BGPS 2010 analysis found wellbeing (measured by the Office of National Statistics standardised question on happiness) decreased as problem gambling scores increased, with the authors concluding that gambling problems, including gambling at sub-clinical thresholds, is negatively associated with wellbeing (Farrell, 2018).

Forrest's analysis of the same data concluded that the magnitude of this association was such that problem gamblers experience similar levels of low wellbeing to those with very serious physical illnesses. Forrest also showed that those with close relatives who have gambling problems also have significantly lower rates of wellbeing than the general population (Forrest, 2014).

Looking at the Health Survey series, analysis showed the odds of being a problem gambler were 7 times higher among those with the lowest levels of wellbeing (measured by the Warwick-Edinburgh Mental Wellbeing Score). Likewise, those with probable mental ill-health problems (including psychological distress, depression, anxiety and somatic symptoms (as measured by the GHQ-12) are more likely to be problem gamblers than those with no mental-ill health (Wardle et al, 2014; Connolly et al, 2018). The Health Surveys data also showed the odds of problem gambling were higher among those with high blood pressure (even after age was taken into account), demonstrating a relationship with poor physical health as well as mental health (Wardle et al, 2014). Using data from the 2007 Adult Psychiatric Morbidity Survey 2007, Cowlishaw and Kessler demonstrated strong associations between problem and at-risk gambling and anxiety, neurotic symptoms (such as sleep problems, fatigue and irritability) and substance use/misuse (Cowlishaw & Kessler, 2015).

A wealth of international evidence supports that problem gambling is associated with a range of health consequences, it is beyond the scope of this submission to review this full extant literature here. Recent analysis from two studies in Australia supports British evidence in showing that personal wellbeing declined

with increasing gambling problems (Blackman et al, 2018). This analysis, like that of Forrest (2014), also noted that those who gamble without any problems have elevated rates of wellbeing compared with those who do not gamble. However, the authors stated that the negative contribution to wellbeing of gambling problems is larger than the positive contribution of gambling engagement (Blackman et al, 2018).

What is the relationship between gambling advertising and marketing and gambling behaviour?

The Gambling Commission's Youth Gambling Study has repeatedly demonstrated a relationship between exposure to gambling advertising and intentions to gamble. In 2018, 7% of children aged 11 to 16 who had seen gambling advertisements or sponsorships said that it prompted them to gamble when they would not have done so otherwise. This represent about 5% of children aged 11-16 overall. This means that approximately 200,000 children aged 11-16 gambled as a result of advertising, marketing or sponsorship exposure.

Measuring the impact of advertising upon gambling behaviours is difficult. A recent review noted that there was very little evidence available in a British context (Newall et al, 2019). Whilst highlighting this evidence gap, the authors noted evidence from two recent Australian studies showing that gambling advertising prompts greater frequency of gambling and higher risk bets to be placed (Newall et al, 2019). Another recent review of youth gambling behaviour noted how several studies demonstrated that advertising and marketing influenced the normative environment for gambling, making it seem like gambling was something that everyone does and should do, and encourages some youth to want to gamble (Wardle, 2018).

What is the relationship between online gambling and gambling harms?

Health survey data indicate that those who gamble on online slots, casino or bingo games consistently have higher rates of problem gamblers among their player base than most other activities.

Strikingly, other survey data from a broadly UK-based sample show that individuals who play online slots and casino games (as well as betting on sports online) reported elevated rates of depressive symptoms, anxiety, alcohol and substance misuse and past year use of major illicit and psychotropic drugs, as well as self-harm as a result of their gambling (Lloyd et al, 2010) These same individuals were more likely to have sought help for addiction and report higher rates of mood-disturbance including sleeplessness (an obvious risk factor for hazardous online gambling) than other types of online gambler. (Lloyd et al, 2010).

The levels of moderate risk and problem gambling among online slot/casino/bingo players seen in the Health Surveys are like those who played Fixed-Odd Betting Terminals (see Table 1). This is of concern as online gambling is the largest growth sector for the industry in terms of Gross Gambling Yield (Gambling Commission, 2019). Rates of moderate risk and problem gambling among those who bet on sports tend to be lower than those who gambling online on slot/casino and bingo games and are like those who gamble on fruit/slot machines.

The Health Surveys do not ask about how people place their sports bets and so there is limited evidence about the relationship between in-play sports betting and problem gambling. However, the Health Surveys do show that people who gamble more frequently are more likely to be problem gamblers, with problem gambling prevalence rising to 5% among those who gamble at least twice a week from around 1% for those who gamble less often than this (Connolly et al, 2018). As in-play betting encourages fast-pace, repeated betting this may be likely to be associated with more problematic play (Russell et al, 2019).

Table 1: problem gambling and moderate risk gambling rates among people who took part in different types of activities:

	Health Surveys 2016		**Health Surveys 2015**		**Health Surveys 2012**	
	Moderate risk gambling	Problem gambling	Moderate risk gambling	Problem gambling	Moderate risk gambling	Problem gambling
Online gambling casino, slots or bingo	13.7%	9.2%	13.4%	10.4%	11.2%	6.3%
Fixed Odd Betting Terminals	13.5%	13.7%	8.2%	11.5%	14.7%	7.2%
Online betting on sports etc	8.4%	2.5%	6.5%	5.4%	6.3%	3.8%
Slot machines	7.2%	6.4%	6.2%	5.7%	6.5%	2.6%

Similarly, a survey of online gamblers showed that 6% were problem gamblers and a further 23% were experiencing moderate harms (PWC, 2017). This study also showed that problem gamblers were more likely to use their mobile phones as their main device to gamble online than non-problem gamblers and spent more time per week gambling than non-problem gamblers (PWC, 2017). This is notable as ease of access and availability of gambling products have been key concerns with online gambling.

The odds of being an at-risk or problem gambler among children aged 11-16 were 8.4 times higher among those who had gambled online on a monthly basis than those who had not (Wardle, 2019).

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