Gambling: the hidden addiction

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Future trends in addictions – discussion paper 1

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Declaration of interest

S.G. was awarded a grant by the Responsible Gambling Fund (now the Responsible Gambling Trust) to study the gaps in identification of gambling problems by mental health professionals, and is also a member of the Responsible Gambling Strategy Board. H.B.-J. is the founder and director of the National Problem Gambling Clinic which is run by the Central North West London NHS Foundation Trust. She is also a member of the Responsible Gambling Strategy Board.

Summary

Taking responsibility

- The government needs to take more responsibility for services that treat adult problem gamblers.
- Funded almost exclusively by the gambling industry, current services are underdeveloped, geographically 'patchy', or simply nonexistent.
- A treatment response is needed to match the expansion of gambling in Britain. Research indicates that the overall number of adults gambling in Britain is increasing, and the number of adult problem gamblers is also rising with around 450 000 in Britain today.
- Significant concerns also exist about the heightened exposure of adults in Britain to gambling – betting shops are now reportedly visibly clustering together on the high street, fixed-odds betting terminals have been linked with problem gambling, and online and smartphone gambling is now regularly advertised on television.

The treatment gap

- Taken together, a gap potentially exists between the prevalence of gambling problems and the provision of treatment for gambling disorders.
- Presently, there is one specialist National Health Service (NHS) clinic in Britain providing treatment for adults with gambling disorders. Consequently, with at least 450 000 adult problem gamblers in Britain today, most will not be getting the help and treatment they need.
- Left untreated, adults with a gambling disorder can experience negative consequences (including higher rates of physical illness, mental health conditions, financial difficulties and involvement in criminal activity).
- Furthermore, an estimated 8 to 10 other people in the gambler's social network will be seriously affected, while there will also be wider societal costs.

Closing the treatment gap

- The government can, however, change this situation. By recognising gambling disorder as a public health responsibility, treatment could potentially begin to be provided from England's existing and experienced network of community drug and alcohol services.
- Commissioned by local authorities, these services already treat more than 300 000 adults experiencing drug and alcohol addiction. Expert and experienced in the medical treatment of addictions, these services could play an important role in tackling adult gambling disorder.
- If the government takes this action, it will help address an acute and increasingly visible public health challenge. Without government action, however, the increasing availability and public visibility of gambling provides the perfect conditions for a new generation of problem gamblers – a future trend in addictions that we are ill equipped to treat.

Gambling: the current picture

Most people in Britain have gambled. Be it the National Lottery, scratch cards, bingo or a bet made online, over the telephone or in one of Britain's 8822 bookmakers, around 73% of adults will have gambled in the past 12 months (Wardle *et al*, 2010). This is equivalent to around 35.5 million adults or around 27 million people (56% of adults) if participation in the National Lottery is excluded (Wardle *et al*, 2010).

Today, gambling occupies a highly visible place in public and political discourse in Britain. As a result of a relatively recent move towards a more liberal position on gambling (Box 1), several new trends have emerged.

- **The overall number of adults gambling is increasing.** Based on figures from the 2010 British Gambling Prevalence Survey (BGPS; a large-scale research study previously funded by the Government), the number of adults participating in a form of gambling in the previous year (excluding the National Lottery) was 56% in 2010, compared with 46% in 1999 and 48% in 2007 (Wardle *et al*, 2010).
- **The number of problem gamblers is increasing.** BGPS data also indicate that the prevalence of problem gambling appears to have increased from about 0.6% in 2007 to 0.9% in 2010 (Wardle *et al*, 2010). This is equivalent to around 450 000 adults experiencing a situation where gambling 'disrupts or damages personal, family or recreational pursuits' (Lesieur & Rosenthal, 1991), and where gambling can become a disorder similar to drug or alcohol misuse (Petry, 2011).
- **Problem gamblers may be contributing more than 20% of all money spent in Britain on certain forms of gambling.** Analysis based on BGPS data indicates that problem gamblers contribute as much as 27% of the overal betting spend in Britain on dog races, and 23% of money spent on fixed-odds betting terminals (Orford *et al*, 2013).
- **On the high street, betting shops are visibly clustering together.** The overall number of betting shops in Britain has marginally increased (in 1961 there were 8802, while in 2013 there were 8822; House of Commons Culture, Media and Sport Committee, 2012). However, concern has repeatedly been voiced by organisations – including the Local Government Association (which represents 370 councils in England and Wales) about betting shops 'clustering' together in large numbers in town centres (House of Commons Culture, Media and Sports Committee, 2012).
- **Fixed-odds betting terminals are a concern.** Touchscreen electronic gaming machines, fixed-odds betting terminals may pose a greater risk of causing problem gambling than other forms of gambling. This has been reported as being partly due to the ability to stake up to £100 on a game that can be played rapidly and repeatedly, and the introduction of more than 33 000 fixed-odds betting terminals into betting shops across Britain (Gambling Commission, 2013). According to the Gambling Commission, 51% of the net takings in betting shops came from fixed-odds betting terminals in 2012–2013 (Gambling Commission, 2013).
- **Participation in 'remote gambling' continues to grow rapidly.** Representing one of the most significant areas of growth in the gambling industry over the past decade, remote gambling covers online (via desktop

and handheld devices) and telephone betting. Popular because of its accessibility (24 hours a day), choice of games (allowing players to select the best odds) and often unlimited stakes and prizes, the UK online sector has a gross gaming yield of around £1.7 billion, which is a fifth of the size of the 'offline' UK gambling market (House of Commons Culture, Media and Sport Committee, 2012). In 2010, BGPS figures showed that 14% of adults used the internet to gamble in the previous year (including lottery tickets, betting, casino games, bingo, slot-machine-style games and football pools) (Wardle *et al*, 2010).

- **Exposure to gambling advertising has increased.** Gambling advertising on television was permitted following the Gambling Act 2005; prior to this, the only advertising that was permitted on television was for football pools, bingo premises and the National Lottery. Research for communications regulator Ofcom found that the total number of gambling advertisement spots shown on television increased from 152 000 in 2006 to 1.39 million in 2012. In 2006, there were 8 billion 'impacts' – the number of times an advert was seen by viewers. This grew to 30.9 billion impacts in 2012, when gambling adverts accounted for 3.2% of all advertising seen by adults (Ofcom, 2013).

Box 1 Gambling in the UK: a short history

- The era of prohibition. **Until comparatively recently, UK governments showed mainly prohibitionist attitudes to gambling. In the 19th century, all forms of lottery were made illegal (Lotteries Act 1823), 'betting houses' or offices were prohibited (Betting Act 1853), and anti-gambling sentiment found national expression through the formation in 1890 of the National Anti-Gambling League (NAGL). For the first half of the 20th century, little changed – betting was banned in all public places (Street Betting Act 1906), NAGL campaigns to ban betting on horse racing courses were very nearly successful, and two Royal Commissions recommended that betting offices remain illegal (1933) and all 'gaming machines' and technologies be prohibited (1951).**
- A more liberal position: 1960–1990s. **From the 1960s onwards, a more liberal position towards gambling emerged, gradually shaping the activity and industry we know in Britain today. The Betting and Gaming Act 1960 liberalised gambling law, legalising betting shops and creating an expansion of commercial gaming in locations such as restaurants, bingo halls and members' clubs. The Gaming Act 1968 created the Gaming Board for Great Britain to oversee and regulate the gambling industry, and made changes to restrict gambling to licensed premises (partly to tackle illegal gambling in private residences). Followed by a relaxation of restrictions on local lotteries in 1975 (Lotteries Act) and allowing televisions in betting shops in the mid-1980s to show live and recorded racing and other sports (Betting, Gaming, and Lotteries (Amendment) Act 1984), this shift culminated in the introduction of the National Lottery in 1994 (National Lottery etc. Act 1993).**
- Deregulation: the 1990s. **The success of the National Lottery resulted in subsequent demands from the rest of the gambling industry for a 'level playing field'. This led to increasing deregulation of the sector: Sunday racing (with on- and off-course betting in shop outlets), gaming machines being increasingly allowed in pubs and fast food outlets, casino opening hours being extended and membership restrictions being relaxed, and the removal of limits on prizes for 'national bingo' (played across the country).**
- The new law: the millennium. **The Gambling Review Board 2001 recommended abolishing the principle of 'unstimulated demand' for casinos and other gambling establishments (allowing their expansion), the legalisation of larger prizes, tighter controls on gaming machines, and the setting-up of a Gambling Commission. These recommendations led to the Gambling Act 2005 (which became fully operational in 2007). Depending on the viewpoint taken, this resulted in overdue modernisation or overwhelming liberalisation of gambling. Besides the National Lottery, Britain now has a large and innovative gambling sector covering betting outlets, gambling machines, casino, bingo, liberal internet gambling regulations, fixed-odds betting terminals, betting exchanges and spread betting. Gambling is now more freely advertised, and gambling contracts (and debts) are now legally enforceable.**
- 2014: new codes of practice: **Following public, media and political debate about problem gambling and fixed-odds betting terminals, and the clustering of betting shops on town centre high streets, the gambling sector has introduced new codes of practice, which may become mandatory later in 2014.**

Sources: Orford (2011), Forrest (2013), House of Commons Culture, Media and Sport Committee (2012).

Gambling disorder: half a million adults

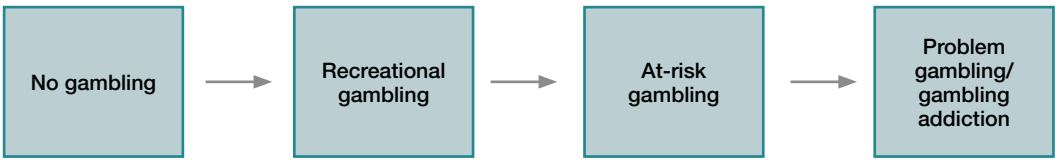
For almost half a million Britons today, gambling is no longer a recreational pleasure but has escalated to become a full gambling problem (Wardle *et al*, 2010). This is where gambling 'disrupts or damages personal, family or recreational pursuits' (Lesieur & Rosenthal, 1991) (Box 2), and where it can become a disorder with traits similar to drug or alcohol misuse (Petry, 2011). Left untreated, a gambling disorder can have devastating consequences for:

- **the gambler** – including higher rates of physical illness, the development of mental health conditions, severe financial difficulties, and criminal activity to fund gambling (Petry *et al*, 2005; Morasco *et al*, 2006)
- **their family** – for every problem gambler, 8 to 10 other people are directly affected (Lobsinger & Beckett, 1996), including spouses (who may experience domestic violence; Mulleman *et al*, 2002), family members, children (with higher rates of behavioural, emotional and substance use problems) (Jacobs *et al*, 1989), friends and colleagues
- **wider society** – due to the likely increases in criminal activity attributable to gambling disorder, absenteeism from work and lost economic productivity (Orford, 2011).

In addition to the half a million problem gamblers living in the UK today, it is also estimated that around 6.5% of the population have gambling behaviours that place them 'at risk' of becoming problem gamblers (Wardle *et al*, 2010). This risk has been observed as higher among adults from minority ethnic groups (Forrest & Wardle, 2011), younger people, and those with existing mental health or substance misuse problems (Petry, 2005).

Box 2 Gambling and gambling disorder: definitions

- Gambling **is betting something of value (usually money) on an event (usually a game) whose outcome is unpredictable or determined by chance (Ladouceur *et al*, 2002). For the large majority, gambling does not result in problems, is a socially sanctioned leisure activity, and is widely prevalent in most countries.**
- What is gambling disorder? **Consensus is now emerging that gambling can be a potentially addictive behaviour, similar to psychoactive substance use (Petry, 2011). Whereas the global discussion about 'gambling disorder' is conducted in the context of the DSM-5 (American Psychiatric Association, 2013), which is predominately used in the USA, clinicians in the UK will draw on the ICD-10 (World Health Organization, 1992). ICD-10 currently defines 'pathological gambling' as a disorder characterised by a preoccupation with gambling and the excitement that gambling with increasing risk provides. Pathological gamblers are unable to cut back on their gambling, despite the fact that it may lead them to lie, steal or lose a significant relationship, job or educational opportunity. Like substance use, gambling behaviours exist on a scale of escalating severity and adverse consequences, ranging from no gambling through to problem gambling/gambling addiction:**



Getting help – few places to turn

Treatment provision for problem gamblers across the UK is currently underdeveloped, geographically patchy or often simply nonexistent (Box 3). Currently, there is one specialist NHS service in Britain treating gambling disorder. Provided by Central and North West London NHS Foundation Trust, this operates as a national clinic and deals with around 700 referrals a year. Other care and support for problem gambling is provided by GamCare (a charity that offers treatment, support, information and advice to anyone suffering through a gambling problem) which has partner agencies in several parts of Britain, and Gamblers Anonymous (a network of self-help groups modelled on Alcoholics Anonymous, but operating on a much smaller scale across the UK). There are also some private sector organisations that offer treatments for gamblers.

Although such organisations provide invaluable support, they cannot meet either existing or future need. One reason for this is that help and treatment for problem gambling is funded almost exclusively (with the exception of Gamblers Anonymous) by the gambling industry through the Responsible Gambling Trust. This funding is welcome, but not enough to meet the growing need for help.

One consequence of this poor availability of specialist treatment is that people either do not seek help for their gambling disorder, or they see their general practitioner (GP) for the treatment of the symptoms of their gambling problem, including physical and mental health problems such as cardiovascular, musculoskeletal, depression, anxiety and substance misuse problems (Petry *et al*, 2005; Morasco *et al*, 2006). Critically, due to low awareness among health professionals about problem gambling, such symptoms are often treated on 'face value', resulting in the underlying addiction remaining hidden and ignored.

The government can change this situation – by making gambling disorder a public health responsibility, treatment for problem gamblers could be provided from an existing network of addictions services.

Box 3 Case study: overcoming gambling addiction

Owen is currently receiving treatment for his gambling disorder. After self-referral to the one existing specialist NHS service, he received an 8-week course of cognitive–behavioural therapy and still attends monthly post-treatment support groups. Owen reports that what he learnt about his condition during his treatment was instrumental in his recovery.

- **'Unlike my dependency [on] alcohol which was slow and progressive, I believe I was always destined to experience problems with my gambling. My first exposure and experience of gambling would certainly have been when I was very young and in pubs. My mum worked as a barmaid and cleaner and I recall being intrigued by the fruit machines. As soon as I was old enough to earn a wage and get away with being in a bookies or [an amusement] arcade without being asked to leave, that was it, gambling became a prominent part of my life. I never set out to become an addict. I don't believe any of us do. I set out to make money. I grew up very poor and I had this strong sense of lacking. I was not satisfied just earning a normal wage in a normal job. At 18 I moved in with my dad, found a well-paid job, drank with my dad, and gambled with him too. This was the period I discovered casinos. I was taken in straight away. Still 18, the Sunday before Christmas I went into a casino with £200. I walked out with over £5000 that night. For a young man who grew up poor, to win that kind of money was a very powerful experience. For once I had freedom, I had options. I had achieved a dream. But that win proved to be very damaging in the end as I eventually lost my winnings.**

  I decided to go travelling in Europe, but while crossing the North Sea, I spent my time and money in the onboard casino on roulette, and as we docked I was homeless and penniless. When I returned to England a few days later, it was the beginning of a 7-year journey of homelessness, Big Issue vending, homeless hostels, drug abuse, psychosis, depression, and of course gambling addiction. It was during this time that my gambling worsened due to the arrival of fixed-odds betting terminals. By this time, I was living in a homeless hostel, unable to work as I was in treatment for my alcoholism, and was receiving income support. It became a priority for me. Every single time I came into a bit of money I would become overwhelmed by craving to go gambling. This is the nature of the compulsive gambler, win or lose, we're going to lose.

  Today, I am pleased to say I have not gambled for over 8 months. For once I can breathe and the relief I am feeling is immense. From a point where I could see myself in prison or, worse, dead… I've continued being serious about my recovery.'

Gambling disorder: future steps

The first step: providing specialist medical care

If the government were to recognise gambling disorder as a public health responsibility, this would represent an important first step towards treatment being potentially provided from England's existing network of community drug and alcohol services. Commissioned by local authorities, these community-based services already help more than 300 000 people each year to tackle addictions such as drug and alcohol misuse (Public Health England, 2013a,b). Increasingly based on strong partnerships between the NHS and voluntary sector, such services have the experience and expertise to work towards helping people with a gambling disorder. Extending treatment to the 'third addiction' of gambling could deliver similar benefits, and would also help ensure that care is joined-up, efficient and seamless.

How would this work?

A 'hub and spoke' model would be implemented. Each community-based drug and alcohol service (the spokes) would integrate screening, assessment and evidence-based treatment for gambling disorder into their provision framework. This treatment would potentially include cognitive–behavioural therapy for gambling disorder, family therapy and money management. Such services should already have the medical expertise and clinical leadership to deliver this treatment. These community-based drug and alcohol services would then be able to seek, where required, clinical advice, staff training, supervision, treatment protocols, and research expertise from a series of central or regional 'hubs'. These hubs would not necessarily receive referrals or see patients, but would instead operate as a centre of clinical, training and research excellence.

Taking such an approach would help the nearly half a million adults with problem gambling to engage with evidence-based treatment, with improved access through the existing English network of community drug and alcohol services.

Staffing and resources

Given that the basic infrastructure of service settings and staff already exists, incorporating gambling disorder within this structure provides a method to meet a critical and growing need, and one which not only needs to be seriously considered by the government, but also acted on. Research with staff already working in drug and alcohol services indicates that if training and adequate support were provided, they would be content to treat adults with gambling disorder (Orford *et al*, 2003).

Furthermore, the joint provision of treatment services to alcohol and drug users demonstrates that positive benefits can be accrued in terms of cost-effectiveness, patient-centredness and sustainability.

However, introducing gambling disorder into this structure will not be entirely cost neutral. Additional resources will need to be identified and ring-fenced, with the most significant cost being the training of existing staff in community drug and alcohol services to deliver this programme of interventions, and the potential employment of new staff to meet demand.

The second step: improving non-specialist care

We noted earlier that health professionals working in primary care (and other non-specialist services including mental health services, criminal justice services, debt advice agencies, primary care services, etc.) also need to do more to help problem gamblers who present to them. This includes:

- **screening for problem gambling** – non-specialists, including GPs and other professionals, should screen their high-risk patients for problem gambling (there are numerous screening tools, for an overview see Problem Gambling Research and Treatment Centre, 2011). If a patient screens 'positive' for gambling problems, they should be offered a brief intervention or referral to specialist care;
- **provision of brief interventions** – these low-cost interventions are designed to prevent people moving from being 'at-risk' of developing a gambling disorder, to developing a full disorder. They are also helpful when working with patients who are currently unwilling to seek formal or more intensive treatment for their disorder. Such brief interventions take 10–15 minutes to deliver, are applicable to a range of settings, and are frequently used in the USA and Canada (George *et al*, 2013). Of these, the interventions described by Petry and colleagues (Box 4) have good evidence of efficacy.

Box 4 A brief intervention for problem gambling

- **Petry *et al* (2009) developed a very brief gambling intervention that has evidence of efficacy. This intervention takes no more than 10 to 15 minutes to deliver, and consists of three simple steps. In step 1, the concept of the gambling continuum and the meaning of these terms are explained. Then, a pie chart demonstrates how people gamble; this includes the relative breakdown of non-gamblers, recreational gamblers, at-risk gamblers and problem gamblers in the general population. Step 2 involves discussing the harms associated with problem gambling: these include financial harms, family harms, health harms and negative impact on work. Step 3 consists of discussing simple and practical measures to reduce gambling such as limiting the amount of money one spends gambling, reducing the amount of time and days spent gambling, not viewing gambling as a way of making money, and spending time on non-gambling.**

Conclusion: if we do nothing

Gambling, as is now widely accepted, can become a disorder comparable to that of drug or alcohol addiction. Representing a significant public health problem, it should rightly sit within addiction treatment services, both in commissioning and treatment delivery terms.

The UK has liberal gambling legislation, ever-expanding remote gambling opportunities (including smartphones, TV and the internet), and gambling is physically visibly present through advertising, high-street betting shops and higher-end 'super-casinos'.

As international evidence reminds us, an increase in the availability and accessibility of gambling opportunities is likely to result in an increase in gambling-related adverse consequences. This is a fertile environment in which there is a high likelihood of generating more British problem gamblers, and more individuals, families and communities affected by addiction. Significantly, it is estimated that a large number of gamblers could be at risk of developing future gambling disorders. Furthermore, as with other health problems, it is often the more vulnerable (young people, women, ethnic minorities and people otherwise disadvantaged) on whom the impact is disproportionately severe.

If we do nothing now, we not only turn away from the needs of nearly half a million Britons living with gambling disorder (and many more carers and family members), but will also ignore a preventable future trend in addiction that we are ill equipped to treat.

Useful resources

Royal College of Psychiatrists' information leaflet on problem gambling (http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/problemgambling.aspx)

National Problem Gambling Clinic (http://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic/)

Gamblers Anonymous UK (www.gamblersanonymous.org.uk)

GamCare (www.gamcare.org.uk)

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