

chapter thirty two

Researching, Limiting and Treating Problem Gambling

32.1 Our terms of reference require us to:

- Consider the availability and effectiveness of treatment programmes for problem gamblers and make recommendations for their future provision, potential costings, and funding.

32.2 It is estimated that there are between 275,000 and 370,000 problem gamblers in the UK. The recommendations in this report will increase access to gambling, at least for adults. We accept that this is likely to lead to an increase in problem gambling, even though many of our recommendations are framed with the intention of keeping such an increase to the minimum.

32.3 Accordingly we need to face the questions, first, of whether current facilities are adequate to deal with the current level of problem gambling, and second, whether facilities are available, or could be made available, to deal with any possible increase.

32.4 We note that the Rothschild Commission's first recommendation was that the "Government should establish a Gambling Research Unit to monitor the incidence, sociology and psychology of gambling". As this recommendation was not acted upon, our task in this respect has been made that much more difficult. In chapter 17 we point out how little research has been conducted in the UK on the nature of problem gambling. We have also had to rely on our own researches to establish what measures exist in the UK to limit and treat problem gambling, and we cannot be confident that we have uncovered the entire picture. Nevertheless, as detailed below, we strongly believe that current provision is woefully inadequate.

32.5 The task of limiting and treating problem gambling falls into a number of categories:

- recognition by regulators and by the gambling industry of the dangers of gambling and its social impact
- incorporation of socially responsible practices into regulation and the gambling industry
- education aimed at preventing problem gambling in the first place, including increased awareness of the dangers of excessive gambling
- reasonable availability of properly evaluated treatment programmes.

Regulation and Social Responsibility

32.6 We have been encouraged that many members of the gambling industry already accept that they have a social responsibility towards the vulnerable. Members of trade associations, BACTA for example, sign up to an industry code of practice which requires them among other things to display posters advertising help for problem gamblers. However, as things stand, this is an informal and voluntary practice, and operators who are not members of trade associations have no incentive to comply with any such codes.

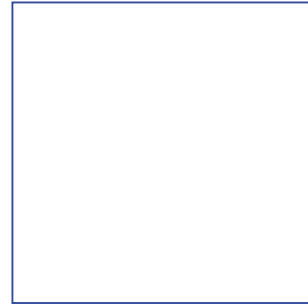
Education

32.7 To our knowledge it is not part of the standard school curriculum to advise children of the dangers of gambling, unlike the situation with regard to tobacco, drugs, alcohol and irresponsible sex. This is significant both because evidence suggests that adolescents have a higher incidence of problem gamblers than adults, and that, in general, the younger a person starts gambling the more likely he is to become a problem gambler. Gambling does not come with a health warning, and the incidence and nature of problem gambling, and the existence of facilities for problem gamblers, are not widely known.

Treatment

32.8 At the present time it seems that very little help exists for problem gamblers in the UK. Of course those who suffer financial difficulties and family breakdown have access to social services, bankruptcy laws, and other measures, in the same way as anyone with similar problems, but there is very little specifically directed to helping people overcome gambling addiction. The main organisations are GamCare, Gamblers Anonymous, and Gordon House. GamCare seems to have high status and regard within the industry, but operates on a small scale. It has a telephone helpline (handling 3,152 calls in the course of 2000) and a small counselling service in London. It has also financed the development of counselling services within existing substance misuse projects in Cumbria, Tyneside, Wales and Northern Ireland under the title "Breakeven project". The London and Breakeven counselling services counselled a total of 183 new clients in 2000, making them the largest providers of counselling services to problem gamblers nationally.

32.9 GamCare does not advertise and does not have a very high public profile. It sees a need to develop training

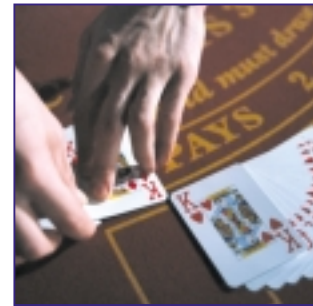
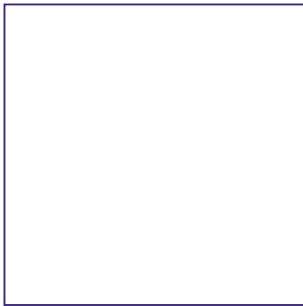


and courses for counsellors; to be better known through use of the broadcast media; to expand its care provision; to expand its helpline; to develop family counselling and to develop a regional structure in England, Wales, Scotland and Northern Ireland.

- 32.10** Gamblers Anonymous (GA) has a higher public profile; it has a telephone helpline and with over 200 groups is the most accessible help available. At GA meetings, members talk (anonymously) about their problems and how they are dealing with them. The GA term for problem gambling is "compulsive gambling", and GA believes that total abstinence must be the goal. Their approach is encapsulated in a twelve-step recovery plan, which has a strong spiritual accent. Gordon House has two residential centres which, together, deal with around 20 individuals a year. None of these organisations receives public money for the treatment of problem gambling. Private clinics offering addiction treatment deal mainly with alcohol and drug abuse. The National Health Service (NHS) provides very limited direct input to problem gambling nationally, with clinical psychologists and behavioural psychotherapists providing assistance on an ad hoc basis. We have been able to identify only two NHS clinics where specialist treatment for problem gambling is available, one in London and the other in Sheffield.¹ Individual therapists and the help available from some addiction centres (most of which do not treat problem gamblers) do not significantly change the picture of very little help in total.²

Current treatment regimes

- 32.11** A range of approaches has been tried or is in use. But it seems that very little has been done to study the variety of types of addictive gambling, its causes and the effectiveness of possible treatments. The methods of treatment for problem gambling are varied, "ranging over the psychoanalytical, psychodynamic, behavioural, cognitive, pharmacological, addiction based, multi-modal and self-help".³ The pharmacological approach is relatively new. Results suggest medication may be of some benefit, but more systematic, randomised trials are needed.⁴ Counselling is used by Gamcare and counselling manuals exist (e.g. Bellringer 1999). The National Council on Problem Gambling in the US has been certifying gambling counsellors since 1989. However, little has been published on the explicit use of counselling for problem gambling.⁵
- 32.12** Gamblers Anonymous offers self-help, using techniques such as autobiography and aftercare planning. It is unclear how effective that help is, given that it has a huge drop-out rate (around 90% on the evidence of one study in which only 8% of the sample were abstaining one year after their first attendance).⁶ GA do not collect or publish data for themselves. However, GA has been a major source of help for
- problem gamblers for over 30 years, since its introduction in the UK in 1964. There is a trend for higher abstinence rates for gamblers whose spouses were present at meetings. Spouses and children of problem gamblers often suffer from depression and have problems of their own that are in need of therapy. GamAnon is the self-help organisation for the families of problem gamblers.
- 32.13** In 2000 there was a review of all randomised controlled trials of psychological and pharmacological treatments for problem gambling from both published and unpublished scientific reports (a Cochrane Review, by Oakley-Brown, Adams and Moberly). This concluded that cognitive behavioural therapy (CBT) approaches to treatment were the most promising in terms of outcome, and recommended further randomised trials.⁷
- 32.14** As far as we have been able to ascertain, the only NHS-funded research project relating to the treatment of problem gambling is a pilot project which has provided an assessment and treatment service for problem gamblers in the Sheffield area. It has received funding of around £28,000 per year over a three-year period. During the past three years, the project has included assessing the effectiveness of CBT; providing training and advice to health, social services, probation and voluntary sector staff; and research into the extent of gambling problems among the probation population in South Yorkshire. The report on this project has yet to be published.
- 32.15** Dr Ricketts, who has been running this project, has said in his evidence that clinical psychologists and others using a CBT approach are likely to be able to offer services, but there are barriers to treatment, in the form of waiting lists and referral processes which may reduce take-up by problem gamblers. He suggests that a stepped care approach to gambling difficulties may enable immediate access to support, whilst ensuring that more specialist input was available to those who did not improve with help from the voluntary sector. He proposes that the first level would be immediately accessible telephone advice (such as that provided by GamCare and GA). The second level would be voluntary sector counselling, which he believes would serve the needs of the majority of problem gamblers and is relatively inexpensive. The voluntary sector could receive support, training and supervision from NHS Clinical Psychology and Psychotherapy services in providing this service. The third level would be NHS treatment for individuals with more complex difficulties which do not respond to less specialist input. This model would provide for the use of limited NHS resources and collaboration with the voluntary sector in the form of referral, training and supervision.



Current funding

32.16 In the United States, Canada, Australia, and Sweden, there is public funding to support the treatment of problem gambling.

- In the United States, where the prevalence rate of problem gambling is 1.1%, at least 17 States provide funding of between US \$100,000 (£70,000) and US\$1,500,000 (£1m) per state.⁸
- In Canada, where problem gambling prevalence varies from province to province, funding per year per province ranges from C\$150,000 (£75,000) to C\$10 million (£5m).⁹ The overall annual amount allocated to funding the social impact of gambling is in the region of C\$40 million (£20m)¹⁰. Canada has an estimated problem gambling rate of 1.6% representing approximately 500,000 problem gamblers¹¹.
- In Australia, funding is provided from taxation, levies on gross profit and from voluntary industry contributions. The annual funding is approximately Aus\$17,044,000 (£11.3m)¹². The estimated prevalence rate of problem gambling is 2.3%, representing approximately 430,000 problem gamblers.
- In Sweden, where the problem gambling rate is 0.6%, representing approximately 54,000 problem gamblers, the Swedish Government has allocated a budget of £125,000 a year to finance research into the treatment of problem gambling.¹³

32.17 There are voluntary funding arrangements in New Zealand and in South Africa.

- In New Zealand, where the problem gambling rate is estimated to be 1.3%¹⁴, (about 36,000 people) funding of just over NZ\$5.6million (£1.6m) per year¹⁵ is provided by the gaming industry.
- In South Africa, where the gambling industry is in its infancy, a voluntary funding programme for problem gambling was launched in 2000. It aims to raise a total of £2.5 million, with a contribution from each company of around 0.1% of gross gambling revenue.¹⁶

32.18 In Great Britain, the one project (in Sheffield) supported by public funding receives approximately £28,000 per year (see paragraph 32.14). This seems an extraordinary state of affairs, given the extent and impact of problem gambling. GamCare depends upon voluntary contributions, and, as we noted in chapter 17, its entire annual income is equivalent to £1 per

problem gambler. Gordon House is also funded by charitable donations. It lost its government grant several years ago and is now struggling.

32.19 Gamblers Anonymous is funded by its members, and does not accept funding from elsewhere.

Recommendations

32.20 We are concerned that:

- so little is known about the nature of problem gambling
- there are so few initiatives addressed to limiting and treating problem gambling in Great Britain
- so little is known about the relative effectiveness of possible treatments
- there is so little current funding for problem gambling in Great Britain.

We address each of these in our recommendations.

Monitoring the effects of implementing our recommendations

32.21 Although we anticipate a modest rise in problem gambling as a result of the implementation of our recommendations, we cannot be sure. Consequently **we recommend that research is carried out to monitor the effect on problem gambling of changes in regulation.** (The nature of the body that would commission and fund such research is set out below.)

32.22 It is possible that the research on monitoring the effect of changes would have a surprising result. We could find an explosion of problem gambling, or, conversely, no significant increase, or, indeed, a decline.

We recommend that the Gambling Commission should have a duty to respond to findings concerning changes in problem gambling. In the light of those findings, it should make appropriate adjustments to the regulations it governs, and should advise the Government on other changes that are necessary but are outside its control.

Research into gambling and problem gambling

32.23 Understanding problem gambling calls for a variety of research projects. In particular the development of problem gambling, and its risk factors, needs to be understood. This will go hand in hand with the need for



research into normal, responsible gambling, for it will be important to understand where the controls exercised by the vast majority of responsible gamblers fail in the case of problem gamblers. **We recommend that research is carried out to understand the nature of normal, responsible, gambling behaviour; and research is carried out to understand the development of, and risk factors for, problem gambling.**

Research into problem gambling treatments

- 32.24 It would be wrong to say that there is no knowledge at all about the relative effectiveness of possible treatments. Studies have been undertaken abroad, and small studies are in process in the UK. Nevertheless, much work remains to be done. In the light of the limited state of current knowledge, **we recommend that research is undertaken to evaluate which forms of treatment for problem gambling are the most effective. Such research should include the development of treatment programmes and should build on existing knowledge.**

Limiting problem gambling

- 32.25 As remarked above, much of the industry has embraced the idea of offering gambling in a socially responsible way. **We recommend that the Gambling Commission should issue formal codes of social responsibility to which operators should adhere as a condition of the licence.**

Treatment

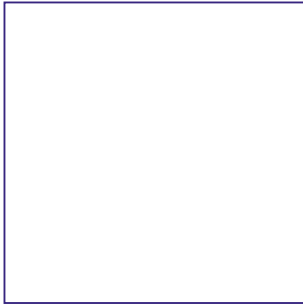
- 32.26 We have admitted that not enough is known about the effectiveness of forms of treatment for problem gamblers. Nevertheless current provision exists in a small, and, we believe, highly inadequate form. We have noted in chapter 17 that problem gambling is often associated with behavioural disorders and substance abuse, for which treatment is more accessible. One contributor to the review suggested that the number of problem gamblers was comparable to the size of the hard drug problem.¹⁷ £15 million per year is spend on research concerning drug misuse¹⁸ and £328 million per year is spent on the treatment of drug misuse.¹⁹ We see a need for a mixture of NHS and voluntary funding for the treatment of problem gambling. Proposals on how the interface between the two sources of funding might work were contained in Dr Ricketts' submission and are outlined in paragraph 32.15 above. **We recommend that increased funding should be made available by the NHS for the treatment of problem gambling; that**

problem gambling should be recognised as a health problem by the Department of Health; and that Health Authorities should develop strategies for dealing with problem gambling.

Funding and infrastructure

- 32.27 Many of those who gave evidence to us from the industry accepted that they had a responsibility to limit the extent of problem gambling even if they did not necessarily accept that their own activities contributed to it. As we describe in chapter 17, we believe that the evidence suggests that the incidence of problem gambling increases with gambling opportunities. That in turn leads us to conclude that the industry has a duty to finance measures to limit and treat problem gambling.
- 32.28 We have heard arguments from the industry that they already contribute significant amounts to the public purse in taxation (the six excise duties relating to gambling activities raised £1,513 million in 1999-2000). Their question why they should be required to contribute more. We think they can afford to do so. Our recommendations will provide the gambling industry with the opportunity to expand its operations, and consequently the potential to increase its turnover and profit. The gambling industry already has an estimated turnover of £42 billion.
- 32.29 Our remit asks us to consider implications for the current system of taxation. Our views on taxation are set out in chapter 36. We considered whether we should make any recommendations linking the levels of duty to the level of danger or addictive potential of the gambling activity. There are parallels: in the case of alcohol and tobacco, tax levels are used as a disincentive to consumption. We decided against that course and against recommending hypothecation of taxes as a means of funding the research and treatment of problem gambling. Instead, we decided to recommend that the industry should be given the opportunity to participate in a voluntary scheme. We take the view that if the industry is unable to formulate a framework that provides a level of funding of approaching £10 per problem gambler, (amounting to around £3 million) then the Government should impose a statutory levy. We think this sum looks modest in comparison to New Zealand, Canada and Australia, where the funding per problem gambler equates to about £44, £40 and £26 respectively.

In seeking models for a funding structure we have been influenced by recent developments in South Africa and New Zealand. Accordingly **we recommend that the**



industry should set up a voluntarily funded Gambling Trust. We recommend that the government should reserve powers to impose a statutory levy, possibly linked to gross profit, if such a Trust is not established or subsequently ceases to operate.

32.31 The Gambling Trust should:

- secure funding of not less than £3 million a year, for at least three years.
- provide for possible renewal of the scheme thereafter (amount to be adjustable in the light of experience)
- have a governing body which includes representation from the industry, problem gambling service providers, the medical/scientific funding councils and the Gambling Commission, with an independent Chairman
- allocate funding for the types of research and treatment outlined above (without limitation)
- report to the Gambling Commission, advising on adjustments to regulation in the light of considerations concerning problem gambling.