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Submission to the Department for Digital, Culture, Media and Sport Consultation on Proposals for Changes to Gaming Machines and Social Responsibility Measures

ResPublica Response

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Prepared by Dr. James Noyes

Contents

Summary

This paper sets out a series of proposed measures to strengthen the research, education and treatment (RET) of problem gambling. It is a response to Q14 and Q16 of the Consultation,[1] focusing on practical ways with which Government can encourage greater social responsibility within the gambling industry, and positioning this social responsibility at the heart of the debate over public health.

At present, the gambling industry contributes to the research, education and treatment of problem gambling through voluntary donations to GambleAware – a charity with the stated aim, as a commissioning and grant-making body, to "broaden public understanding of gambling-related harm as a public health issue and to help those that do develop problems get the support and help that they need quickly and effectively."[2] GambleAware is guided by the Responsible Gambling Strategy Board (RGSB), which publishes the National Responsible Gambling Strategy (NRGS). This Board both advises and is funded by the Gambling Commission.

In this paper, we argue that there are three main problems with the current arrangement.

First, the process of commissioning and fundraising problem gambling RET has not always reflected the "tripartite structure" advocated by the Gambling Commission in its strategic annual report of 2009[3] – a situation complicated by the subsequent merger of the Responsible Gambling Fund (RGF) and the industry-supported Gambling Research Education and Treatment (GREaT). Since then, voluntary industry contributions made to problem gambling RET have sustained a conflict of interest in that they have also been connected to the commissioning process. We argue that this has limited the opportunity for strategic independence of problem gambling RET, and that there is a case for reviewing the tripartite structure envisaged by the Gambling Commission in 2009.

Second, it is clear that a system of voluntary contributions from the gambling industry does not provide sufficient resources for the "improved funding arrangements for RET" proposed by the Gambling Commission. In

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[1] Q14 asks: "*Do you agree that the Government should consider alternative options, including a mandatory levy, if industry does not provide adequate funding for RET?*" In response to this question, we look at how a mandatory levy can be introduced in order to fund RET according to local need and harm to public health.

Q16 asks: "*Are there any other relevant issues, supported by evidence, that you would like to raise as part of this consultation but that has not been covered by questions 1-15?*" In response to this question, we look at how problem gambling can be understood in terms of the debate over social responsibility and public health, and how Government can reflect this debate in its systems of organisation and responsibility.

[2] See GambleAware (2017), "About Us" (online). Available at: https://about.gambleaware.org

[3] Gambling Commission (2009), *Annual Report 2008/*2009 (online). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248064/1062.pdf

2017, GambleAware announced that they raised over £8m from the industry in 12 months, and that while this was an increase on the previous year, it still fell 20% short of the £10m target set by the RGSB. GambleAware have called on the industry to donate a minimum of 0.1% of their Gross Gambling Yield to meet RGSB's funding guidelines.

We argue that even if the RGSB guidelines were met, there remains a significant gap between the resources available to problem gambling RET and the resources available to other types of addiction. We calculate that, taking into account both the industry contribution to GambleAware and the State's treatment of problem gambling through NHS mental health services, the total annual spend on problem gambling RET in England amounts to only £133 per capita, compared to £377 per capita spent on drug addiction and £385 per capita spent on alcohol misuse.

In other words, a problem gambler in England receives around three times less funding than problem users of alcohol or illicit drugs.

It means that the industry contribution to GambleAware represents only 13% of total spend on problem gambling RET, with the Government picking up the rest of the cost through expenditure on mental health services in primary and secondary care. This is at a time when problem gambling is on the rise. A breakdown of our calculations can be found on pages 8-11 and 13-15.

We argue that in order to achieve parity for problem gambling compared to other types of addiction RET, the industry should contribute 1% of its Gross Gambling Yield, not 0.1%, amounting to a total contribution of £135m for the UK.

Third, in addition to a funding shortfall, there is also a disparity between the type of treatment available to problem gamblers and other types of addiction. The treatment of problem gambling depends on three main options, each of which are funded by GambleAware: the National Gambling Helpline provided by Gam Care; the CNWL National Problem Gambling Clinic in London – the only clinic of its type in the country – and organisations like the Gordon Moody Association. An equivalent to Alcoholics Anonymous also exists (Gamblers Anonymous), that provides support through a "fellowship" forum.

Each of these organisations do vital and valuable work. But they remain either under-resourced or dependent on charitable donations. By contrast, the treatment of addiction to illicit drugs, alcohol, smoking and sugar in England is supported by the Public Health Grant, administered by local authorities and benefiting from the strategic clinical advice of Clinical Commissioning Groups (CCGs) or Sustainability and Transformation Plans (STPs). The treatment of problem gambling is not included as a specific service within the Public Health Grant. When problem gamblers do refer themselves to GPs, they are directed towards Improving Access to Psychological Therapies (IAPT) programmes, where their addiction is seen as part of a wider mental health problem and tends to be treated by Cognitive Behavioural Therapy (CBT).

Furthermore, there is a lack of clinical guidelines in the treatment of problem gambling – although the National Institute for Health and Care Excellence (NICE) is currently in the process of considering their introduction. The Royal College of Psychiatrists notes that clinicians in the UK usually make use of the Australian "Monash Guidelines", adding that "it is a widely held

view amongst treatment providers and regulators in the problem gambling sphere that if NICE were to produce clinical guidelines on the diagnosis and management of gambling disorders, this would be beneficial for patients across the UK. It would also help to clarify the responsibility of the NHS for treatment provision."[4]

We therefore propose the following recommendations:

1. The current industry voluntary contribution is insufficient and unreliable. We welcome the view of the Department for Digital, Culture, Media and Sport (DCMS) that gambling operators should step up funding for research, education and treatment. To achieve this, we propose that the industry contribution should become a mandatory levy, that it should be increased and that it should be "smart" – that is, it should be allocated proportionately according to a risk-based assessment of the different types of harm that problem gambling causes to public health. The details of this proposal are outlined on pages 6-13.

2. The funds raised from this mandatory, increased levy should be used to enable parity between the treatment of problem gambling and the treatment of other types of addiction, so that the funding gap per capita is reduced. We argue that by contributing 1% of Gross Gambling Yield instead of 0.1%, an industry contribution of around £135m would not only far exceed RGSB guidelines but would bridge the shortfall in spend per capita between problem gambling RET and other addiction services. We outline the details of this proposal on pages 13-15.

3. Efforts should also be made to reduce the disparity between types of treatment available to problem gamblers and other addictions. The evidence shows the need to harmonise the global treatment of addiction, allowing problem gambling to be understood in relation to other types of addictive behaviour (for example, alcohol misuse), as well as its socio-economic determinants and its connection to public health. This requires positioning problem gambling at the heart of thinking over public health, including the Public Health Grant, so that it can benefit from the strategic vision of commissioning structures like CCGs and STPs. The details of this proposal are outlined on pages 15-18.

4. Because problem gambling is a public health issue, there is a strong case to be made for its governmental oversight to be recalibrated, so that the relationship between DCMS and the Gambling Commission can be expanded to incorporate the Department of Health. This would have three key benefits: it would help implement the "tripartite structure" advocated by Government over the past decade; it would enable greater harmony with the NHS' strategy to tackle addictive behaviour; and it would reflect international best practice. We outline the details of this proposal on pages 18-21.

[4] Royal College of Psychiatrists (2016), "Rapid Evidence Review of Evidence-Based Treatment for Gambling Disorder in Britain" (online). Available at: https://www.rcpsych.ac.uk/pdf/RAPID_EVIDENCE_REVIEW_PG_RCPSYCH_DEC2016.pdf

Policy Recommendations

1 The Case for a Mandatory Levy

The Government has stated that it wants "to see industry support for relevant research to build the evidence base, action to raise awareness of the risks and where to find help and support, and support services to those at risk of or experiencing harm. If this voluntary system fails to deliver on these issues, the Government will consider … the introduction of a mandatory levy." This reflects a policy position that has been maintained since the proposals of the Budd Report of 2001 and Gambling Act of 2005.

A mandatory levy has been advocated by both the Opposition and by GambleAware. At its party conference in 2017, the Deputy Leader of the Labour Party announced that, if in power, Labour would require the industry to pay a levy to fund problem gambling RET and end the "destructive cycle of addiction."[5] And the Chief Executive of GambleAware has argued that, because the industry has not demonstrated that it is "sufficiently willing to meet the current target, much less … to voluntarily meet the increased finding that will be necessary to improve research, education and treatment services,"[6] a statutory levy should be introduced.

The industry itself is increasingly open to the idea of a mandatory levy. The Association of British Bookmakers has backed an "evidence-based approach to helping problem gambling in the UK", adding that "we also would not oppose an appropriate, compulsory levy on the gambling industry to fund problem gambling treatment."[7] The Senet Group, an independent body founded by four of Britain's leading gambling companies, agrees that "if a statutory levy on gambling businesses is the only way to generate the money needed for work across the RET agenda, then this change has our support."[8] And the Remote Gambling Association has argued that "this

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[5] BBC News (2017), "Labour Plan Gambling Levy to Fund Addiction Treatment" (online). Available at: http://www.bbc.com/news/uk-politics-41394267

[6] *The Guardian* (2017), "Gambling charity warns betting firms are failing to fund addiction treatment" (online). Available at: https://www.theguardian.com/sport/2017/oct/30/force-gambling-firms-pay-levy-addiction-treatment-charity-gambleaware-betting-companies-donate

[7] BBC News (2017), "Labour Plan Gambling Levy to Fund Addiction Treatment" (online). Available at: http://www.bbc.com/news/uk-politics-41394267

[8] Senet Group (2018), "Has the time come for a statutory levy to fund gambling research, education and treatment?" (online). Available at: http://senetgroup.org.uk/time-come-statutory-levy-fund-gambling-research-education-treatment/

should be seen as an opportunity, not a threat", while emphasising that a mandatory levy could encourage a more "open" process of commissioning and funding RET, as resources would be "allocated in a way that is transparent, independent and achieve measurable benefits."[9]

There are international examples of how a mandatory industry levy can contribute to the research, education and treatment of addiction, including problem gambling. In New Zealand, the 2003 Gambling Act introduced "measures to promote public health by preventing and minimising the harm from gambling" through "independent scientific research associated with gambling, including longitudinal research on the social and economic impacts of gambling, particularly the impacts on different cultural groups."

This research is supported by an industry levy that is raised from the profits of New Zealand's four main forms of gambling: gaming machines in pubs and clubs ("pokies"); casinos; the New Zealand Racing Board and the New Zealand Lotteries Commission. The Ministry of Health is responsible for the prevention and treatment of problem gambling, including the funding and co-ordination of problem gambling services.

In Figure 1 of our Appendix, recent intervention client data shows that the number of people who have received problem gambling treatment services (or who have identified to the service provider a "primary problem gambling mode" causing them harm) has increased since the introduction of the mandatory levy.[10]

It should also be noted while that overall gambling expenditure continued to rise in New Zealand during this time period, the increase has been from spending in casinos, on the lottery or on racing, while spending on gaming machines or "pokies" has decreased since the 2003 Gambling Act (see Figure 2).[11]

In other words, there is evidence that since the introduction of a mandatory industry levy in New Zealand, the amount of money spent on gaming machines has decreased and the amount of people who have received treatment for problem gambling has increased. Advocates in other countries have noted the example of New Zealand, including recent policy proposals by organisations based in the Republic of Ireland.[12]

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[9] The Remote Gambling Association (2017), "RGA calls for Government to introduce a statutory levy" (online). Available at: https://www.rga.eu.com/rga-calls-for-government-to-introduce-a-statutory-levy/

[10] New Zealand Ministry of Health (2017), *Intervention client data* (online). Available at: https://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/service-user-data/intervention-client-data

[11] See Problem Gambling Foundation of New Zealand (2017), "Gambling in New Zealand" (online). Available at: https://www.pgf.nz/uploads/7/1/9/2/71924231/fs01-gambling_in_new_zealand.pdf

[12] See Barry Grant, Maebh Leahy and Cian Power (2013), *Gambling Control Bill – Detailed Joint Submission* (online). Available at: http://www.problemgambling.ie/uploads/9/0/0/2/9002949/gambling_control_bill_-_detailed_joint_submission_.pdf

Recommendation 1 (response to Q14): *There is clear support for a mandatory industry levy to support problem gambling RET from within Government, the Opposition, third-sector organisations and the industry itself. An appropriate levy would not only respond to calls from both Government and charities like GambleAware, it would also encourage greater transparency of RET funding and would reflect international best practice. We therefore recommend that an appropriate mandatory industry levy is introduced following this Consultation.*

2 The Case for an Increased Levy

According to a 2017 National Centre for Social Research (NatCen) report prepared for the Gambling Commission, there were over 430,000 problem gamblers in the UK in 2015, an increase from 280,000 in 2012,[13] with another 2 million at risk. According to GambleAware, only 2% of those who need help receive the support they need.

Last year, GambleAware raised over £8m from the industry in 12 months, equating to a 20% shortfall of the £10m target set by the RGSB. These funds have been allocated as follows:

Research: £1,500,000
Education / Harm Minimisation: £900,000
Treatment / Intervention: £6,350,000
TOTAL: £8,750,000[14]

In addition to the amount raised by GambleAware, treatment for problem gambling is also made available through the NHS. This is processed through referral from GPs to local mental health services, particularly IAPT, and is usually treated with CBT by therapists who are not specialists in gambling addiction. The treatment is part of a wider mental health therapy for disorders such as depression or anxiety.

This treatment has a cost. But because problem gambling is not treated as a separate disorder in itself, it is not possible to ascertain the exact amount spent by the NHS through IAPT on problem gambling RET. Data is rarely collected on the incidence of gambling disorders presenting as co-morbidities alongside other conditions eligible for IAPT.

However, the overall cost to Government of problem gambling has been calculated by the Institute for Public Policy Research (IPPR), in a report which includes the rate of gamblers being treated for mental health disorders.

[13] See NatCen (2014), *Gambling behaviour in England and Scotland: Findings from the Health Survey for England 2012 and Scottish Health Survey 2012* (online). Available at: http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-England-and-Scotland-Findings-from-the-Health-Survey-for-England-2012-and-Scottish-Health-Survey-2012.pdf; and NatCen (2017), *Gambling behaviour in Great Britain in 2015* (online). Available at: http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2015.pdf

[14] See GambleAware (2017), "About Us" (online). Available at: https://about.gambleaware.org/media/1480/gambleaware-commissioning-plan-2017-19.pdf

IPPR estimates an excess annual fiscal cost incurred on primary care mental health services by problem gamblers in England of between £10 and £20 million, and an excess annual fiscal cost incurred on secondary mental health services by problem gamblers in England of between £20 million and £50 million.[15]

The IPPR report acknowledges the variability between the upper and lower bounds of these figures – a variability that is in part due to the lack of available data. We have therefore taken a mean from these figures in order to ascertain an average total spend on problem gambling in both primary and secondary mental health services:

Cost of problem gambling to primary care mental health services: £15m
Cost of problem gambling to secondary care mental health services: £35m
T**OTAL:** £50m[16]

These figures apply to England, while the funds allocated by GambleAware apply to the whole of the UK. GambleAware states that the proportion of its resources available to England correlates with population levels. The population of England is 84.2% of the UK,[17] meaning that the amount spent by GambleAware on problem gambling RET in England can be estimated at £7.4m.

Adding the amount spent by the Government on problem gambling through mental health services to the funds allocated by GambleAware, we calculate the total spend on problem gambling RET in England as follows:

GambleAware: £7.4m
Primary care mental health services: £15m
Secondary care mental health services: £35m
TOTAL: £57.4m

When divided between 430,000 problem gamblers, this amounts to an annual spend

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[15] For details of this calculation, see IPPR (2016), *Cards on the table: The cost to government associated with people who are problem gamblers in Britain* (online). Available at: https://www.ippr.org/files/publications/pdf/Cards-on-the-table_Dec16.pdf

[16] A new report by the Centre for Economics and Business Research (CEBR) for the British Amusement Catering Trade Association estimates the cost of problem gambling to the economy, specifically the potential impact of maximum stake reduction on B2 gaming machines. Like us, CEBR draws on evidence from IPPR, and uses this evidence "to establish the share of the excess fiscal costs identified by IPPR that might reasonably be associated with problem gambling specifically linked to B2 gaming machines."

The scope of the CEBR report differs from our own in that it focuses on B2 gaming machines rather than total problem gambling RET. However, it is important to note CEBR's estimated costs of B2 gaming to mental health services. Using NatCen's latest figures, CEBR estimates that there are approximately 121,000 people in the UK who are B2 machine players and problem gamblers. The report calculates that the total excess fiscal cost associated with B2 problem gambling in 2016/17 is £208m, with the fiscal costs to mental health services estimated at £32m. Of these costs, £7.2m apply to primary care mental health services and £24.7m to secondary care – indicating that around half of our total estimated cost to primary care mental health services and two-thirds of our total estimated cost to secondary care mental health services is spent on B2 gaming machine addicts. See Centre for Economics and Business Research (2018), *Assessing the Potential Impacts of Maximum Stake Reduction on B2 Gaming Machines*.

[17] See Office for National Statistics, *Population estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016* (online). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest#population-of-england-reaches-55-million

per capita on problem gambling RET of £133.50.[18]

This spend is not enough. As we show on pages 13-15, a problem gambler receives around three times less funding for RET than problem drug users and alcohol-dependent people. Moreover, these figures show that the current industry contribution to GambleAware represents only 13% of total spend on problem gambling RET, with the Government picking up the rest of the cost through expenditure on the mental health services.

We argue that the current industry contribution is both insufficient and disproportionately less than the amount being contributed by taxpayers, and that a mandatory levy should be increased in order to raise the funds available for problem gambling RET. Some experts have advocated a mandatory levy with an increase that exceeds the RGSB target of £10m. Professor Jim Orford has in the past called for a £25m levy in order to meet the funding shortfall.[19] In this paper we go further, making the case that problem gambling RET will only achieve parity when it receives funding equal to drug and alcohol misuse services: a total UK industry levy of £135m.

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[18] For reasons of comparison outlined in Recommendation 4, these figures are for England. As stated, the GambleAware figure is based on the proportion of the total spend relating to the population of England (84.2% of the UK). The figures for both primary and secondary care mental health services are based on the mean between the bounds provided in the IPPR report. These figures are from 2016, the latest available. Unlike IPPR, we have not included hospital referrals in our calculations. This is because in our comparison of problem gambling with other addiction services such as drug and alcohol misuse, hospital referrals are not funded by the Public Health Grant.

It will be noted that we have not included other industry-led schemes in our calculations. These include Senet Group schemes as education through advertising, trade associations or similar operator initiatives. This is because of the level of controversy over the degree to which industry-funded advertising counts as independent research or education. We acknowledge the work done by the Young Gamblers Education Trust (YGAM), but as their total annual RET spend does not exceed £225,000, it cannot be considered as significant to our total calculations of problem gambling SPC in England. For details of YGAM's expenditure, see their *Annual Review and Accounts 2016/2017* (online). Available at: http://www.ygam.org/downloads/annual-report-2016-2017.pdf

It will also be noted that the figure of 430,000 is taken from the 2017 NatCen Report and applies to the whole of the UK. This report calculates that the number of adult problem gamblers in Great Britain was approximately 370,000 according to the DSM-IV, 300,000 according to the PGSI and approximately 430,000 according to either screen. It adds that "these estimates should be considered alongside the confidence intervals … The confidence interval for the DSM-IV estimate was 0.5% to 1.0%, for the PGSI estimate 0.4% to 0.9% and for either screen 0.6% to 1.1%. This equates to somewhere between 250,000 and 480,000 adults according to the DSM-IV, between 180,000 and 420,000 adults according to the PGSI, and between 300,000 and 560,000 adults according to either screen." In other words, there is a degree of variation in problem gambling prevalence according to different methods of screening. Furthermore, the report states that "problem gambling prevalence rates did not vary significantly by other socio-demographic characteristics: educational qualifications, socioeconomic classification (NS-SEC) of the household or region."

Taking into account the confidence intervals involved in these figures, the fact that the population of England represents 85% of the UK, and the fact that these figures are projected to have risen since 2016, we use 430,000 as our estimated number for problem gambling prevalence in England.

[19] See Jim Orford (2013), "The gambling industry levy: £25 million would be a more appropriate target" (online). Available at: http://www.gamblingwatchuk.org/about-gambling-watch-uk/mission-aims/78-uk-news/99-the-gambling-industry-levy-25-million-would-be-a-more-appropriate-target

Recommendation 2 (response to Q14): *The voluntary industry contribution is insufficient and falls short of the RGSB target of £10m. Furthermore, it represents just 13% of the total spend on problem gambling RET, with the State picking up the rest of the tab. This is at a time when problem gambling is on the rise. We therefore recommend that the mandatory levy should be increased to enable parity for problem gambling RET based on spend per capita, exceeding the RGSB guideline.*

3 The Case for a "Smart" Levy

In order to justify an increased mandatory levy, it needs to be both representative and targeted. The Government Consultation has stated the aim "to see more work done to understand the longer-term funding requirements for RET, particularly around treatment. For example, if treatment were to reach a materially greater proportion of problem gamblers, and if prevention efforts were increased to pre-empt gambling-related harm more generally, then the funding requirement could be much greater."

To achieve this, we argue that the levy should be "smart": that is, instead of the current arrangement, where RET funding risks being either unpredictable in its allocation to GambleAware or unaccountable within wider mental health spending, we argue that the amount raised by the levy should reflect the profits earned by different parts of the industry, and should be allocated to different RET services according to the harm done to areas of public health.

This kind of risk-based assessment depends on robust data. Because problem gamblers tend to participate in multiple forms of gambling,[20] and because the treatment of problem gambling tends to involve multiple co-morbidities, there remains a need to understand more about the relationship between individual gamblers, types of problem gambling, and types of harm to public health.

A smart levy could provide the targeted funds to achieve this. It would have the following benefits:

- It would enable data to be provided on the connections and discrepancies between types of gambling, types of addiction and types of harm to public health;
- It would provide the sort of transparent funding structure called for by the industry, including the RGA;
- And it would enable this data to assist NICE in establishing clinical guidelines.

This approach is already established in New Zealand, which sets its levy every 3 years with a formula calculated "using rates of player expenditure (losses) on each gambling subsector and rates of client presentations to

[20] See Gambling Commission (2016), "Types of gambling and gambling involvement" (online). Available at: http://www.gamblingcommission.gov.uk/news-action-and-statistics/Statistics-and-research/Statistics/Types-of-gambling-and-gambling-involvement.aspx; and Per Binde et al (2017), "Forms of Gambling, gambling involvement and problem gambling: evidence from a Swedish population survey", *International Gambling Studies* 17:3.

problem gambling services attributable to each gambling subsector."[21]

The following formula used by the New Zealand Inland Revenue provides a mechanism for allocating among gambling operators, and collecting from them, the approximate cost of an integrated problem gambling strategy:

Levy rate = ({[(A × W1) + (B × W2)] × C} ± R) ÷ D[22]

We argue that a comparable formula for problem gambling in the UK would enable a mandatory levy to be calculated in the most proportionate way possible.This formula should establish not just the profit made from a particular gambling industry subsector but also its cost to public health, and should then calculate the proportion that the subsector contributes to the levy accordingly.

For example, research has shown that the growth in the number of Fixed Odds Betting Terminals (FOBTs) has been disproportionately located in deprived areas, and has been linked to the decline of high streets in some of Britain's poorest communities. This has an effect on local economies because the clustering of FOBTs in high street betting shops correlates with higher levels of unemployment and deprivation.[23]

This kind of impact – in addition to the impact of other forms of problem gambling, including different types of gaming machine, racing and sports events betting, and online betting – should be reflected in the mandatory levy, calculated according to its profits, impact on the economy and harm to public health.

Recommendation 3 (response to Q14): *A smart levy could help identify the profits made by a particular subsector of the gambling industry, use enhanced data to measure the harm done by that subsector to the public health of a particular demographic or locality, and would allocate RET funds accordingly. We recommend that the mandatory levy should be allocated according to a risk assessment of problem gambling and its harm to public health, and that the increased funds from the levy should be used to enhance the available data.*

[21] See the New Zealand Inland Revenue (online). Available at: http://www.ird.govt.nz/duties-levies/gaming-machines/problem-gambling/pgl-index.html

[22] In this formula, A is the estimated current player expenditure in a sector divided by the total estimated current player expenditure in all sectors subject to the levy; B is the customer presentations to problem gambling services that can be attributed to gambling in a sector divided by total customer presentations to problem gambling services in which a sector that is subject to the levy can be identified; C is the funding requirement for the period for which the levy is payable; D is the forecast player expenditure in a sector for the period during which the levy is payable; R is the estimated under-recovery or over-recovery of levy from a sector in previous levy periods; W1 and W2 are weights, the sum of which is 1.

[23] See the ResPublica 2017 report on the economic benefits of FOBT regulation: Edward Douglas, James Noyes and Phillip Blond (2017), *Wheel of Misfortune: The case for lowering the stakes on Fixed Odds Betting Terminals* (online). Available at: http://www.respublica.org.uk/wp-content/uploads/2017/10/Wheel-of-Misfortune-Embargoed-until-Monday-16th-October-00.01.pdf

4 Bridging the Funding Gap

A mandatory, increased industry levy should enable parity between the treatment of problem gambling and the treatment of other types of addiction, so that the funding gap per capita between the two is reduced.

According to latest figures, we have calculated that total funding for problem gambling RET in England amounts to £57.4m, if we combine the funds raised from the industry by GambleAware and the average amount spent by the State on problem gamblers as part of wider mental health services in the NHS. When divided by the number of problem gamblers, this equates to an annual spend per capita of £133.50.

We have argued that this is insufficient, because the spend per capita on problem gambling RET is around three times less than the spend on other types of addiction, namely illicit drug misuse and alcohol misuse, at a time when problem gambling is on the rise.

In order to ascertain the funding gap between the resources available to problem gambling RET and the resources available to other types of addiction, it is necessary to examine spending from the Public Health Grant, which has supported the treatment of drug addiction, alcohol misuse, obesity (through preventative schemes targeting diet and lifestyle) and substance abuse in England since 2013/2014. This is a resource provided by the Government (through the Department of Health) to local authorities, who then allocate it according to local need.[24]

In 2016 (the latest published figures available), the amount allocated by the Public Health Grant to the following addiction services was as follows:

Drug misuse (adults): £489,986m
Alcohol misuse (adults): £229,509m[25]

Calculating a spend per capita for these addiction services requires knowing how many people are either users or target users of them. For alcohol misuse, research carried out by the University of Sheffield and prepared for Public Health England found that in 2014-15 the number of people in England with alcohol dependence either in or potentially in need of

[24] As stated, these figures apply to England for purposes of comparison with the Public Health Grant, and because England represents around 85% of the UK population. Problem gambling RET in England, Scotland and Wales correlates with relative population levels, meaning that these figures can be scaled up to give a total for the whole of the UK.

[25] For these figures, see The Advisory Council on the Misuse of Drugs (2017), *Commissioning impact on drug treatment* (online). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf. These figures were published in September 2017. Figures for Public Health Grant spending for 2017-2018 are yet to be publicly available, although David Buck at the King's Fund has assessed cuts to the funds available to each local authority addiction service.

specialist assessment and treatment was 595,131, representing 1.4% of the adult population. The charity Alcohol Concern also uses this figure.[26]

Dividing the amount made available to alcohol misuse RET from the Public Health Grant by the number of people potentially in need of it gives us an SPC for problem alcohol misuse RET in England of £385.

For illicit drug misuse, the figure is less clear. Drugwise note that "those with drug-related problems tend to be difficult to find, and addiction is difficult to measure. Experts consistently fail to agree on what constitutes an addict, problematic use or problematic user. Estimates as to how many people are experiencing drug problems have to be drawn from different sources, using different ways of measuring."[27] There are 2.7 million illicit drug users in England and Wales a year, but clearly not all these people are problem users or in treatment.[28] At the other end of the scale, the National Drug Treatment Monitoring Service estimates that 288,843 individuals were in contact with drug and alcohol services in 2015-16. But this only applies to treatment, and does not include other forms of research and preventative education.[29]

Nevertheless, it is possible to estimate the number of people who can be categorised as "problem drug users" who are either in some form of structured treatment or who are in the target bracket. Data from NHS Digital shows us that 4.3% of men and 1.9% of women aged 16-64 have a "drug dependency", equating to 3.1%of the adult population which, in England, is around 1.6 million. Similarly, Home Office estimates from the 2015/16 Crime Survey for England and Wales show that 3.3% of all adults aged 16 to 59 were defined as frequent drug users (having taken a drug more than once a month on average in the last year), equating to just over 1.1 million people.[30] And an average figure taken from the 2.7 million people who have taken a drug over the past year and the 288,843 people in structured treatment equates to 1.5 million people in the UK, or 1.25 million people in England.

In other words, around 1.3 million people in England can be categorised as problem drug users.

Dividing the £490m available for adult drug misuse RET from the Public Health Grant by the 1.3m people potentially in need of it gives us an SPC for problem drug misuse RET in England of £377.

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[26] See Robert Pryce et al (2017), *Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence* (online). Available at: https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

[27] See Drugwise (no date), "How many people are addicted?" (online). Available at: http://www.drugwise.org.uk/how-many-people-are-addicted/

[28] For this figure, see NHS Digital (2017), *Statistics on drugs misuse: England, 2017* (online). Available at: http://digital.nhs.uk/catalogue/PUB23442

[29] National Drug Treatment Monitoring System (2016), *Adult substance misuse statistics from the National Drug Treatment Monitoring Service* (online). Available at: https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse/adult-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016.pdf

[30] Home Office (2016), Drug Misuse: Findings from the 2015/2016 Crime Survey for England and Wales (online). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf

This means that the spend per capita on problem gambling RET is around three times less than the spend on problem drug and alcohol users, even though the number of problem gamblers is on the increase:

Spend per capita on problem gambling: £133.50
Spend per capita on problem drug use: £377
Spend per capita on problem alcohol use: £385

In order to meet this funding shortfall, we argue that the same spend per capita should be made for problem gamblers as it is for both problem drug and alcohol use. This can be achieved as follows: if the same is spent on problem gambling as on other addiction services, by multiplying a spend per capita of £380 by 430,000 problem gamblers, we arrive at a target RET funding figure of £163.4m. When we subtract the £50m already spent by the Government on problem gambling RET through NHS mental health services, we arrive at a shortfall figure of £113.4m in England and, if we scale it up to include the populations of Scotland and Wales (£21.28m) , we reach a target figure of £135m for the UK.

The mandatory levy should make up this shortfall, not the NHS. By contributing £135m instead of the proposed £10m set by the RGSB guidelines, the industry would bridge the funding shortfall that currently impedes problem gambling RET in the UK, and would contribute 1% of their Gross Gambling Yield instead of 0.1%.[31]

Recommendation 4 (response to Q14): *There is a significant shortfall in the amount of funding available to problem gambling RET compared to other types of addiction. Problem gamblers receive three times less funding than problem drug and alcohol users. We therefore recommend that the mandatory industry levy is increased to achieve parity for problem gambling RET, bringing it into line with other addiction services. This should amount to an increase of the industry contribution from RGSB's proposed £10m to £135m – equating to a contribution of their Gross Gambling Yield of 1% rather than 0.1%.*

5 Bridging the Treatment Gap

In addition to bridging the funding gap between problem gambling RET and other addictions, we argue that efforts should also be made to reduce the disparity between different types of treatment available.

The evidence shows the need to treat addiction in an integrated way, allowing problem gambling to be understood in relation to other types of addictive behaviour, as well

[31] Latest figures from the Gambling Commission suggest that the industry Gross Gambling Yield is £13.8bn, meaning that a 1% contribution would equate to £138m. However, this figure includes the National Lottery, which does not at present contribute to GambleAware. Our proposed levy of £135m would therefore not only meet the current RET shortfall for problem gambling in the UK, but would also reflect this higher estimate of 1% of the industry's Gross Gambling Yield.

as its socio-economic determinants and its connection to public health.[32]

In 2016, the King's Fund published ten priorities for integrating physical and mental health that acknowledged the extent to which "poor mental health is associated with higher rates of smoking, alcohol and drug abuse, lower educational outcomes, poorer employment prospects, lower resilience, decreased social participation and weaker social relationships – all of which leave people at increased risk of developing a range of physical health problems". Because of this, they argue that "a more integrated approach to population health would tackle the determinants of poor physical and mental health in a co-ordinated way, using 'place-based' approaches to combine resources from different sectors."[33]

Similarly, the public health priorities outlined by Strang et al in the 2013 Annual Report of the Chief Medical Officer state that "critical-to-treat patients and populations crucially need effective treatment of their addiction for proper management of their other health conditions." This means that "commissioners and clinicians must deliver preventive measures and active treatments of proven efficacy. With prevention and treatment, it is not a case of either/or: balanced provision is required." The authors propose a pyramid approach to achieving this, whereby public policy initiatives are directed towards accessing "hard-to-reach" patients through the provision of timely treatment (see Figure 3).

The Government has also acknowledged the importance of integration, saying that it welcomes the work that GambleAware has done in training frontline staff in GP surgeries, Citizen Advice Bureaus, housing offices and community nurses to help them "identify gambling issues, provide interventions and signpost to further support", and the fact that the Local Government Association will be working with GambleAware to help identify interested LAs in ensuring "maximum reach" for this programme of work.

However, experts in problem gambling RET have argued that a "treatment gap" exists between the prevalence of gambling problems and the provision of treatment for gambling disorders.[34] The fact that options for treatment remain insufficient due to the disparity in available funding – for example, only one specialised problem gambling clinic exists in the UK – means that only 2% of problem gamblers receive the help and treatment they need. George and Bowden-Jones (2014) argue that "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

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[32] See, for example, Thomas Kelly and Dennis Daley (2013), "Integrated Treatment of Substance Use and Psychiatric Disorders" in *Social Work in Public Health* 28:3; and John Strang et al (2013), "Addictions, dependence and substance abuse" in *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence* (online). Available at: https://www.kcl.ac.uk/ioppn/depts/addictions/news/CMO-report-Addictions-Strangetal-chapter16-2014.pdf

[33] King's Fund (2016), *10 priorities for integrating physical and mental health* (online). Available at: https://www.kingsfund.org.uk/publications/physical-and-mental-health/priorities-for-integrating

[34] See Sanju George and Henrietta Bowden-Jones (2014), *Gambling: the hidden addiction*. Royal College of Psychiatrists Faculty of Addictions Psychiatry, Faculty Report

than 300,000 adults experiencing drug and alcohol addiction."

For such an approach to succeed, the issue of problem gambling needs to be positioned at the heart of thinking over integrated public health. As we have argued in this paper, the RET of other types of addiction is resourced from the Public Health Grant and administered by local authorities.[35] This means that services are directed according to local need and are guided by the strategic leadership of clinical commissioning groups. By contrast, the treatment of problem gambling depends on an unpredictable process of commissioning from an insufficient industry contribution, or is subsumed within wider IAPT services.

Furthermore, there are no guidelines for problem gambling treatment, although NICE is currently in the process of considering their introduction. The Royal College of Psychiatrists notes that clinicians in the UK usually make use of the Australian "Monash Guidelines", adding that "it is a widely held view amongst treatment providers and regulators in the problem gambling sphere that if NICE were to produce clinical guidelines on the diagnosis and management of gambling disorders, this would be beneficial for patients across the UK."[36]

In order to overcome these barriers to integration, George and Bowden-Jones advocate a "hub and spoke" model whereby "each community-based drug and alcohol service (the spokes) would integrate screening, assessment and evidence-based treatment for gambling disorder into their provision framework … Such services should already have the medical expertise and clinical leadership to deliver this treatment." We argue that this approach would necessitate integrating problem gambling RET within the wider structures of public health spending on addiction RET, while maintaining the treatment of problem gambling as a distinct addiction and service in itself. It would have three main advantages:

- It would enable the research, education and treatment of problem gambling to benefit formally from the clinical expertise and strategy of clinical commissioning groups such as CCGs and STPs;
- It would enable the research, education and treatment of problem gambling to benefit from the expertise and strategies of local authorities, linking the question of gambling to other services affecting socio-economic deprivation, and ensuring that funding is allocated according to local need;
- It would provide the industry with the degree of transparency it seeks as part of a mandatory levy.

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[35] Drawing on analysis from David Buck at the King's Fund, we acknowledge that the Public Health Grant is diminishing in terms of the amounts available to spend on addiction treatment. We also recognise that CCGs are increasingly overloaded as a result. Because of this, we argue that the idea of a mandatory industry levy could become transformative not just for the RET of problem gambling but also for wider ways of approaching spending on public health. An industry levy could help supplement the funds allocated by the Public Health Grant, enabling the industry to work with both local authorities and central government in a mutually-beneficial way. If this were to happen, we believe that problem gambling RET could become a pioneer in terms of how public health is funded, and no longer an outsider.

[36] Royal College of Psychiatrists (2016), "Rapid Evidence Review of Evidence-Based Treatment for Gambling Disorder in Britain" (online). Available at: https://www.rcpsych.ac.uk/pdf/RAPID_EVIDENCE_REVIEW_PG_RCPSYCH_DEC2016.pdf

Recommendation 5 (response to Q14 and Q16): *There is a need to reduce the disparity between types of treatment available to problem gamblers compared to other types of addiction. This requires an integrated approach that takes account of the socio-economic determinants of problem gambling as well as its connection to public health. We therefore recommend that problem gambling RET is brought into line with other types of addiction under the remit of local authorities and the strategic leadership of clinical commissioning groups, according to NICE guidelines.*

6 Putting Problem Gambling at the Heart of Public Health

Since the Marmot Review of 2010, research has shown that people living in the poorest neighbourhoods of England die on average seven years earlier than people living in the richest neighbourhoods, and that health inequalities arise from an interaction of various social factors, including income, education, housing and isolation. In other words, social deprivation is linked to poor public health.

Research also shows that social deprivation is linked to problem gambling. Glasgow, Birmingham and Liverpool are local authority areas with the highest estimated number of betting shops, and in each the unemployment rate and proportion of workless households far exceeds both regional and national levels. Analysis for *The Guardian* found that bookmaker turnover was four times higher in unemployment blackspots than in wealthier areas.[37] There are now twice as many betting shops in the poorest 55 boroughs as there are in the wealthiest 115.[38] And the Local Government Association has used data commissioned by the Responsible Gambling Trust (now GambleAware) to show that "areas close to betting shops tend towards higher levels of crime events, resident deprivation, unemployment, and ethnic diversity … [and that] players overall tend to live in neighbourhoods with higher levels of resident unemployment, multiple deprivation and economic inactivity."[39]

In other words, a relationship can be established between social deprivation, problem gambling and poor public health. That is why problem gambling is a public health issue, and why we have argued that a mandatory industry levy should be calculated

[37] *The Guardian* (2013), "£5bn gambled on Britain's poorest high streets: see the data" (Online). Available at: https://www.theguardian.com/news/datablog/2013/jan/04/5bn-gambled-britian-poorest-high-street

[38] APPG on Fixed Odds Betting Terminals (2017), *Fixed Odds Betting Terminals - Assessing the Impact* (Online). Available at: http://www.fobt-appg.com/wp-content/uploads/2017/01/FINAL-FOBT-APPG-REPORT.pdf

[39] See the Local Government Association Response (2016) to the *Review of Gaming Machines and Social Responsibility Measures* (online). Available at: https://www.local.gov.uk/sites/default/files/documents/LGA%20gambling%20review%20submission%20FINAL%20%28Dec%202016%29.pdf

according to the impact of problem gambling on the economy and its harm to public health.

When problem gambling is understood as a public health issue, its narrative over responsibility is transformed. At present, problem gambling RET is often subsumed within wider mental health services like IAPT, placing the onus of responsibility on the mental health of the individual gambler and absolving the industry of its duty of public care. When understood it in terms of harm to public health, the onus is placed on those companies that have enabled, as part of their corporate strategy, problem gambling to cluster in our most deprived communities.

This change in narrative from individual onus to corporate responsibility needs to be reflected in the way that Government frames, regulates and supports problem gambling RET. We believe that there are three particular areas that could benefit from reform: first, in doing more to strengthen the tripartite structure in the funding and commissioning of problem gambling RET, as advocated by the Gambling Commission; second, in continuing to reduce the potential for industry influence in the commissioning of problem gambling RET; and third, in ensuring that problem gambling is put at the heart of public health, by harmonising the strategic vision of NHS services, the Department of Health and DCMS.

In 2009, the Gambling Commission's Annual Report recommended improved funding arrangements for RET, adding that all stakeholders should have access to expert and independent strategic advice – to be achieved through a tripartite structure "consisting of a strategy board to advise on research, education and treatment components of a national responsible gambling strategy and set priorities; a fundraising body; and a distributing body to ensure the money raised is spent on the priorities determined by the strategy board, taking into account our and DCMS' regulatory requirements."[40]

These respective roles were to be performed by RGSB, GREaT and RGF. Since 2009, however, the tripartite structure has become less clear, with the merger of GREaT and RGF into the Responsible Gambling Trust leading to the risk of overlap in the processes of fundraising and commissioning. There have also been past concerns over the level of industry influence in this process. In 2011, the Responsible Gambling Fund cancelled its funding partnership with Gambling Research Education and Treatment as it was "unable to operate with a degree of independence" from industry involvement, and that the charity would "not be complying with charity law" if the partnership were to continue. Noting that "the Gambling Commission's 2008 Review of RET spelled out the need for an independent distributor of funds, free from industry influence", the Chair of the RGF urged "the Commission to ensure that whatever arrangements succeed the current ones the distributor is empowered to make and

[40] Gambling Commission, *Annual Report 2008/*2009 (online). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248064/1062.pdf

implement funding decisions independently, so that choices of priority between research, education and treatment – and within each of these categories – are not dominated by the views of the industry or any of the providers."[41]

In the Consultation, the Government has recognised the need for independence in the tripartite arrangement between the Gambling Commission, RGSB and GambleAware, noting that "GambleAware now has an independent chair and a much greater proportion of non-industry members on its board. In addition, it has made other governance changes around how it commissions research, and how it manages contracts for treatment to address any concerns of industry influence." We welcome this, but argue that more could still be done to maintain independence not only within the commissioning and funding arrangements of the industry contribution, but also in the relationship between GambleAware, RGSB, the Gambling Commission and the Government.

We argue that the introduction of an industry levy represents an ideal opportunity for review, enabling the tripartite structure to be strengthened and the potential for industry influence reduced. Instead of the same organisations overlapping in their responsibility for commissioning, funding and advising, which we believe has limited past opportunities for independence in the strategy and scrutiny of problem gambling RET, a mandatory levy – we have recommended a target figure of £135m – would represent a "clean slate" with which these organisations can recalibrate their relationship.

Central to this clean slate is also the question of responsibility for public health. The Government has recognised the need for DCMS to work closely with other departments in tackling problem gambling. Think tanks like IPPR have advocated developing a clear national strategy to recognise problem gambling as a public health issue, as a precursor to effective local implementation. And in this paper, we have argued that a mandatory levy could ensure a fully transparent process of RET commissioning and funding, which in turn would benefit proposed NICE guidelines for problem gambling.

Each of these initiatives draw on a vision of public health that depends on the Department of Health and the NHS, as well as DCMS. If problem gambling is a matter of public health, in need of independent strategy, we argue that it does not make sense for it to remain under the sole responsibility of DCMS. Indeed, before the 2005 Gambling Act and the creation of the Gambling Commission, regulation came under the Gaming Board for Great Britain under the Home Office. It was only transferred to DCMS in 2001.

In this paper, we have pointed to the pioneering work done in New Zealand to combat problem gambling through a mandatory industry levy. In New Zealand, it is the Ministry of Health that oversees the funding and coordination of problem gambling services under the Gambling Act 2003, which requires the development of an integrated problem gambling strategy focused on public health.

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[41] Linda Hancock and Shannon Hanrahan (2015), *Review of the Responsible Gambling Trust Machines Research Programme* (online). Available at: http://www.stopthefobts.org/wp-content/uploads/2015/03/Hancock-and-Hanrahan-CfFG-Final-Report-4March15.pdf. For the purpose of disclosure, note that Hancock and Hanrahan's report was commissioned by the Campaign for Fairer Gambling, an organisation that has also commissioned this document.

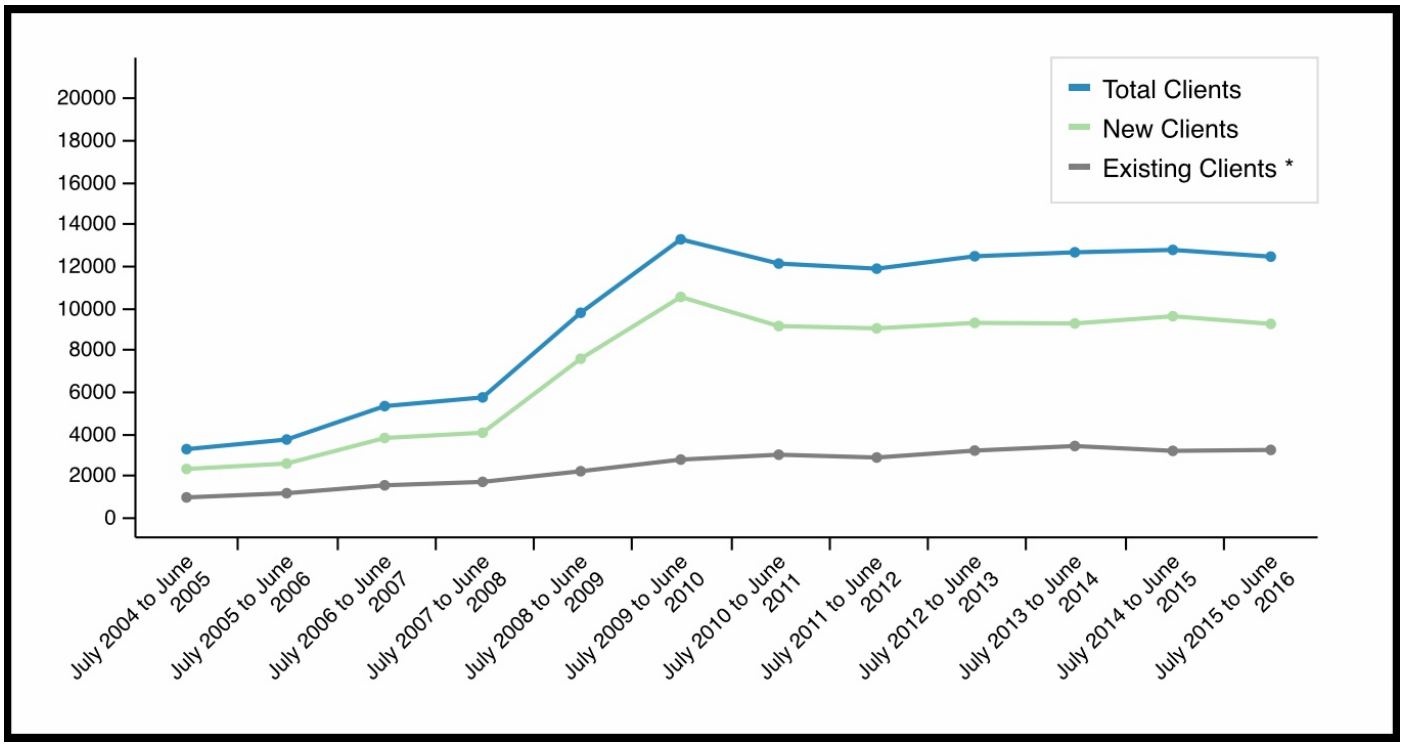
We argue that the Government's approach to problem gambling could benefit from a similar recalibration of departmental responsibility. Concerns over the tripartite structure and independence from industry influence could be resolved if clinical commissioning groups like CCGs or STPs had a greater role in harmonising the RET of problem gambling with other addiction services and their wider approach to public health. Similarly, we have argued that local authorities should have a greater role in administering problem gambling RET according to local need.

We do not believe that the need for tripartite independence requires the creation of another quango. The current arrangement of the Gambling Commission, RGSB and GambleAware could work – but it would benefit from being joined up with public health strategy alongside clinical commissioners and local authorities. And this requires a stronger sense of the shared responsibility between DCMS and the Department of Health.

Recommendation 6 (response to Q16): *Problem gambling is a public health issue and needs a joined-up strategy, both in terms of current funding and commissioning arrangements and also in terms of the relationship between the industry, regulators and the Government. But this kind of "tripartite structure" risks being undermined by a lack of clarity and accountability. We therefore recommend a clean slate in the commissioning process and a recalibration in departmental chains of responsibility, with an emphasis on independence in strategy and harmony in delivery. Crucially, this requires putting problem gambling at the heart of Government's strategy on public health, enabling gambling regulation to benefit from collaboration with both clinical commissioners and local authorities.*

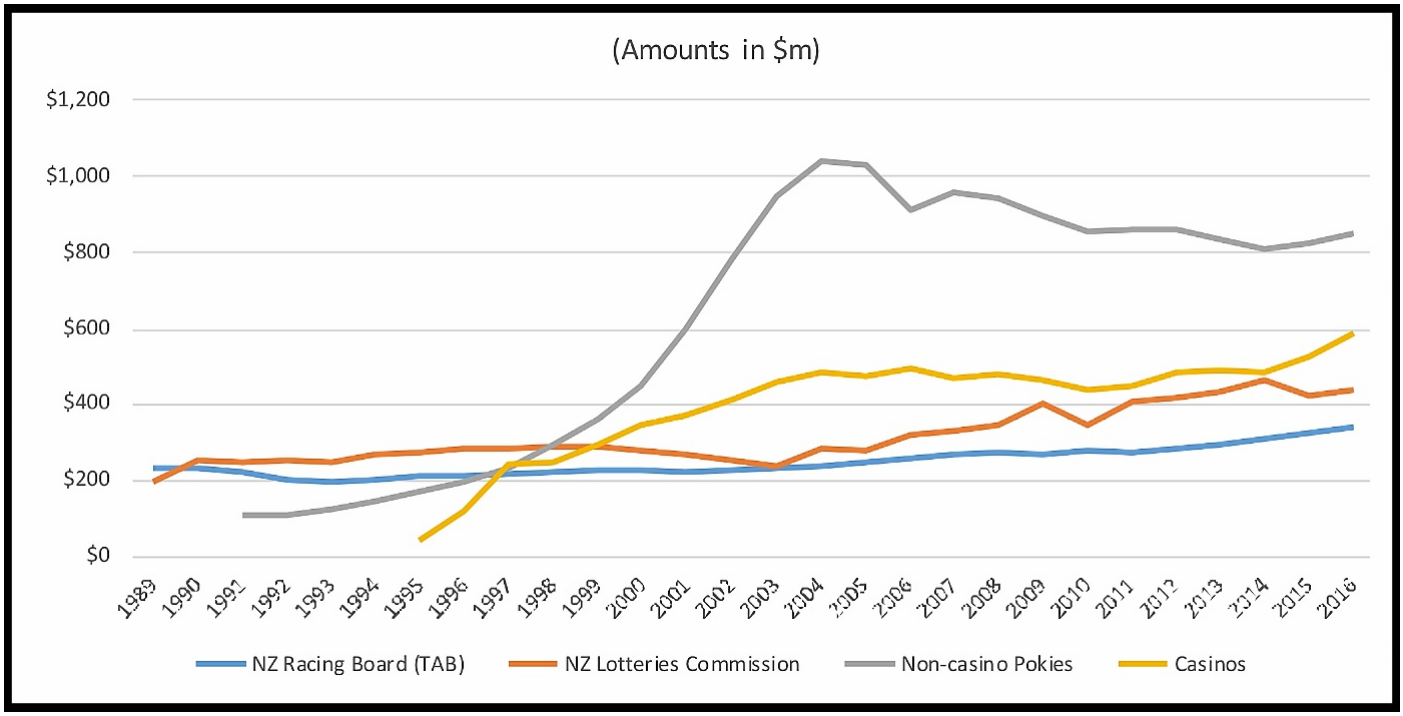
Appendix

Figure 1: Total Clients Recorded (All Interventions) who have received problem gambling treatment services in New Zealand since 2004/2005



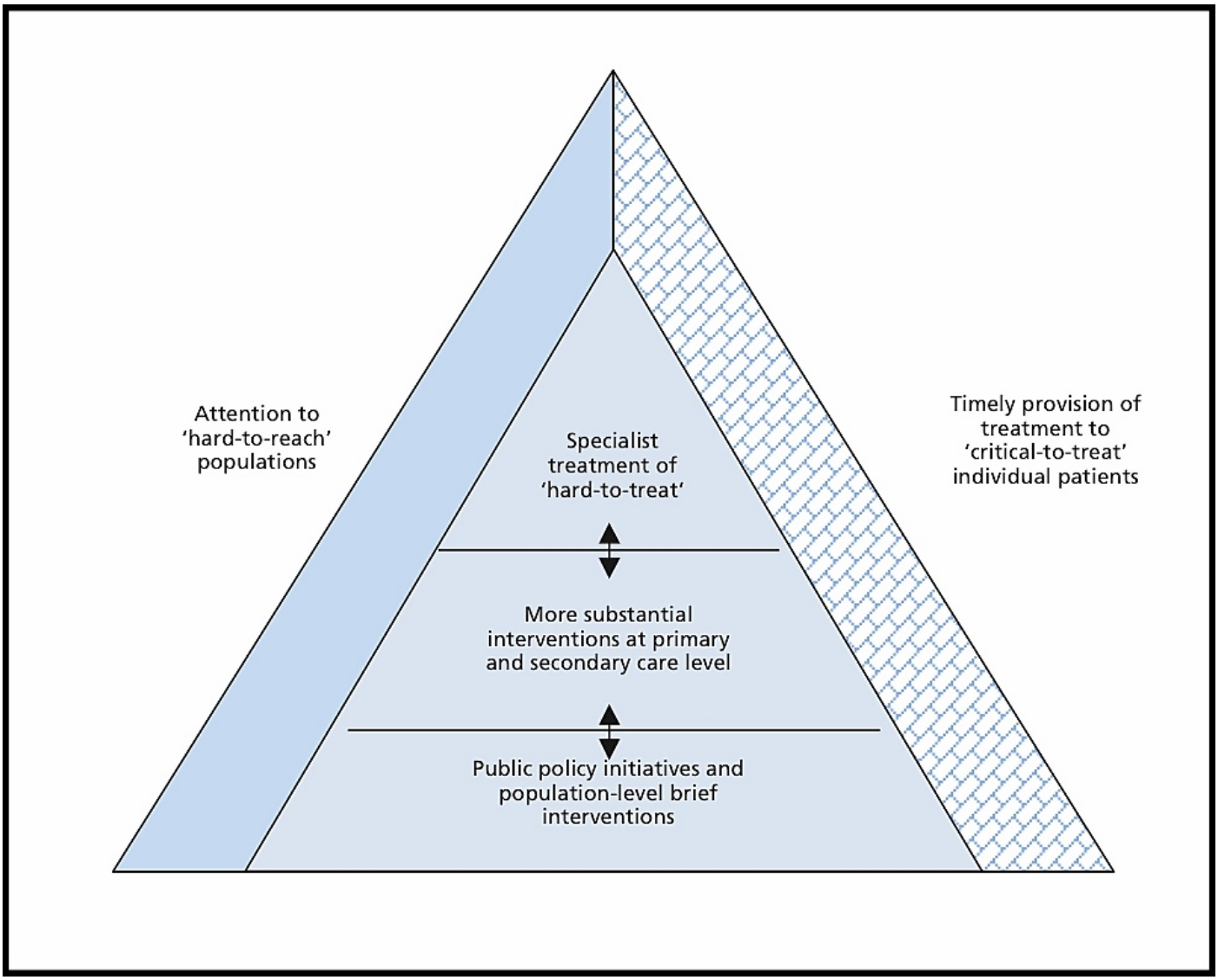
Source: New Zealand Ministry of Health (2017)

Figure 2: New Zealand Gambling Expenditure 1989-2016



Source: Problem Gambling Foundation of New Zealand (2017)

Figure 3: Addressing hard-to-reach, hard-to-treat and critical-to-treat substance abusers



Source: Annual Report of the Chief Medical Officer – Public Mental Health Priorities: Investing in the Evidence (2013)

About the Author

Dr. James Noyes is a Research Associate at ResPublica.

About ResPublica

The ResPublica Trust (ResPublica) is an independent non-partisan think tank. Through our research, policy innovation and programmes, we seek to establish a new economic, social and cultural settlement. In order to heal the long-term rifts in our country, we aim to combat the concentration of wealth and power by distributing ownership and agency to all, and by re-instilling culture and virtue across our economy and society.

About the Campaign for Fairer Gambling

The Campaign for Fairer Gambling is a not-for-profit organisation that aims to ensure delivery and enforcement of the licensing objectives of the 2005 Gambling Act, including preventing gambling from being a source of disorder or crime, ensuring that gambling is conducted in a fair and open way, and protecting children and other vulnerable persons from being harmed or exploited by gambling.