

CONSULTATION ON PROPOSALS FOR CHANGES TO GAMING MACHINES AND SOCIAL RESPONSIBILITY MEASURES

- RESPONSE FROM SHEFFIELD CITY COUNCIL

The evidence is clear that Fixed Odds Betting Terminals (FOBTs) have a detrimental impact on the health and wellbeing of populations across the UK. At present, the operation of FOBTs under existing legislation is counter to the Government's objectives of "*creating an industry and a wider economy that works for all*".

As set out in our response to the Review of gaming machines and social responsibility, an estimated **£13m was lost by people using FOBT machines in Sheffield**¹ in 2015. The proliferation of FOBTs has significant implications for the economic and financial wellbeing of people and particularly more vulnerable communities. Indeed, there are more than twice as many betting shops in the poorest 55 local authority areas compared with the most affluent 115².

In Sheffield:

- 44% of betting shops are in areas that are amongst the 20% most deprived in England
- 35% of betting shops are in areas that are amongst the 20% most *income* deprived in England

Given the above, Sheffield City Council was dismayed by recent reports at the end of 2017 that the Chancellor was considering scrapping the review into FOBTs due to fears that cutting the maximum stake to £2 would cost the Treasury in lost tax revenue. This position suggests a complete misunderstanding of the social, economic and wellbeing impact that FOBTs have on communities in Sheffield and across the UK. It is a false economy; while the Treasury pulls in the tax receipts from FOBTs, it is local public services that are left to pick up the complex, long-term and financially significant human costs of problem gambling in communities across our towns and cities.

To quote Carolyn Harris MP, "*It is morally bankrupt to allow this situation to go on because of a misunderstanding of the economics of FOBTs. Britain will be financially better off if we take action on these machines.*"

Sheffield City Council hopes that the Chancellor has revised his position and works with the new Secretary of State for Digital, Culture, Media and Sport to reduce the maximum FOBT stake to £2.

Sheffield City Council wholeheartedly supports the campaign to reduce the maximum stake of FOBT to £2³ but believe that the Government must go further by empowering councils with the necessary planning powers to restrict betting shop clustering in neighbourhoods.

We believe that there are **three steps** that the Government must take:

1. **Reduce the maximum stake on FOBT machines to £2**

The maximum stake on FOBTs is disproportionately high at £100 and should be reduced to £2. This will ensure that stakes are set at a level that continues to support an effective gambling industry in the UK whilst reducing the exposure of more vulnerable communities to problem gambling, financial exclusion and the associated impacts on mental wellbeing.

¹ Campaign for Fairer Gambling, 2016

² <https://www.newham.gov.uk/Documents/Campaigns/SCASubmission.doc>

³ Sheffield City Council (2017) *Tackling the Damage of Fixed-Odds Betting Terminals*, motion given By Councillor Julie Dore and seconded by Councillor Mazher Iqbal, 6th September 2017, <http://democracy.sheffield.gov.uk/mgAi.aspx?ID=15525>

2. **Empower councils to reduce clustering**

Government should address the fact that bookmakers have opened multiple premises in clusters to enable them to establish more machines in small geographical areas. Government should give local authorities the powers that they need to respond to concerns from their local communities and stop the proliferation of FOBTs and betting shops.

3. **Empower councils to shape economically vibrant and diverse urban centres**

Councils should have additional powers (e.g. a reintroduction of the demand test or a cumulative impact test), that would allow local authorities to reject applications for new shops in areas already saturated with betting shops. Such powers would enable Sheffield to create more economically inclusive urban centres and environments to support business growth, and enhance population productivity and wellbeing.

Consultation on proposals for changes to Gaming Machines and Social Responsibility Measures

Q1. Do you agree that the maximum stake of £100 on B2 machines (FOBTs) should be reduced?

Yes

If yes, what alternative maximum stake for B2 machines (FOBTs) do you support?

Option 4 - Maximum stake reduced to £2 on both B2 non-slots and £2 on B2 slots.

Q2. Do you agree with the government's proposals to maintain the status quo on category B1?

Yes

Q3. Do you agree with the government's proposals to maintain the status quo on category B3?

Yes

Q4. Do you agree with the government's proposals to maintain the status quo on category B3A?

Yes

Q5. Do you agree with the government's proposals to maintain the status quo on category B4?

Yes

Q6. Do you agree with the government's proposals to maintain the status quo on category C?

Yes

Q7. Do you agree with the government's proposals to maintain the status quo on category D?

Yes

Q8. Do you agree with the government's proposals to increase the stake and prize for prize gaming, in line with industry proposals?

Yes

Q9. Do you agree with the government's proposals to maintain the status quo on allocations for casinos, arcades and pubs?

Yes

Q10. Do you agree with the government's proposals to bar contactless payments as a direct form of payment to gaming machines?

Yes

Q.11 Do you support this package of measures to improve player protection measures on gaming machines?

Yes

Q.12 Do you support this package of measures to improve player protection measures for the online sector?

Yes

Q.13 Do you support this package of measures to address concerns about gambling advertising?

Yes

Q.14 Do you agree the Government should consider alternative options including a mandatory levy if industry does not provide adequate funding for RET?

Yes

Q.15 Do you agree with our assessment of the current powers available to local authorities

We agree that Local Authorities are now in a better position to deal with clustering of betting shops following the implementation of specific planning use for 'new' betting shops which was introduced in April 2015. This however does not control clustering or a negative impact where there is an existing planning use for Licensing Authorities.

Further powers should therefore be given to Local Authorities to control this and all types of gambling at a local level and the introduction of Cumulative Impact Assessments may be a way to do this.

Sheffield City Council also agrees with the introduction of additional licensing objectives and should be in line with the Licensing Act 2003; the prevention of crime and disorder, public safety, prevention of public nuisance, and the current Gambling Act objective; 'Protection of children and vulnerable adults'.

Q16. 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?

Please see attached material from Sheffield City Council's Public Health team which summarise the evidence of the wellbeing impact of problem gambling that was developed as part of a review into financial inclusion and debt in the city.

“Gambling related harm is a result of a complex interplay between an individual and their vulnerabilities, a gambling product, the gambling environment and wider physical, social, cultural, political and economic determinants of health and wellbeing that is not fully understood” (Michelle Gillies, Scottish Public Health Network, 2016, p11)

Introduction

As part of Sheffield City Council's (SCC) work on financial inclusion and debt, Sheffield City Council Public Health were asked for their view on problem gambling.

This paper briefly examines some of the publicly available literature available on the topic of problem gambling, health and wellbeing, and financial inclusion impacts and aims to summarise these pragmatically and succinctly to aid local decision making.

This paper briefly summarises some of the evidence on:

- Prevalence estimates of problem gambling
- Risk factors and co-morbidity '(profile of a problem gambler)'
- Identifying problem gambling ('screening')
- Efficacy of clinical interventions for problem gambling
- Environmental interventions using Local Authority powers
- Gambling related debt

Caveat: *this is not a systematic review of the literature and does not include sources which are not publicly available, such as academic access websites or sources for which payment is required for full text. Information about search terms is given in the methodology.*

Methodology

A brief literature search was conducted using “Google Scholar” and NICE evidence search (<https://www.evidence.nhs.uk/>) using the search term “gambling”.

A further “google” search was conducted using the search terms:

- public health + gambling
- gambling + financial inclusion
- gambling + pharmacology

Definitions of gambling related harm

“There is no agreed level of participation at which gambling is considered harmful; the level at which one person might experience gambling as a fun leisure activity may for another person result in significant harm. There are no evidence-based guidelines on responsible gambling” (Gillies, 2016, p21)

In the literature on gambling, a range of terms are used to differentiate social and recreational gambling from “disordered/compulsive/pathological/problem” gambling.

In the literature gambling related harm is described as a continuum from “non-problem” to “at risk” and then “problem gambling” (The Cochrane Collaboration 2012, p6).

In this report the terms “non-problem”, “at risk”, and “problem” gambling are used, for which the following definitions may be helpful:

- Non-problem includes “non-problem” gamblers and non-gamblers (Shaffer et al, September 1999)
- At risk represents gamblers with sub-clinical levels of gambling problems (Shaffer et al, September 1999)
- Problem gambling is gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits (Lesieur and Rosenthal cited in Natcen, 2014).

There are clinical criteria for problem gambling as an impulse control disorder in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) <https://allpsych.com/disorders/dsm/> : “the essential feature of pathological gambling is persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuits” (cited in Shaffer et al, September 1999, p1369). In DSM-V pathological gambling is re-designated as a clinical psychiatric diagnosis of “Disordered Gambling” (LGA, August 2013).

In the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) <http://apps.who.int/classifications/icd10/browse/2010/en> pathological gambling is classified under mental and behavioural disorders as a disorder of adult personality and behaviour (F63.0):

“The disorder consists of frequent, repeated episodes of gambling that dominate the patient's life to the detriment of social, occupational, material, and family values and commitments”.

The idea of detriment to or disruption of life, work, family is common to both definitions and distinguishes problem gambling from a social or recreational pursuit.

The US National Gambling Impact Study Commission Final Report (1999) proposes three distinct sub-groups of gamblers manifesting impaired control over their behaviour (i) behaviourally conditioned problem gamblers (ii) emotionally vulnerable problem gamblers (iii) antisocial, impulsivist problem gamblers. These sub-definitions are advanced to support more effective clinical management of these conditions.

The authors of the report on Gambling Behaviour in England and Scotland point out that “there is no gold standard or commonly accepted way to measure problem gambling in population based surveys” (Seabury, Wardle, p7) so all estimates are exactly that, *estimates*.

Prevalence Estimates

The Health Survey for England 2012 and Scottish Health Survey 2012 findings report on Gambling Behaviour in England and Scotland (Seabury, Wardle 2014) used both the DSM-IV criteria and the Problem Gambling Severity Index to estimate prevalence of problem gambling. The results were marginally higher using the DSM-IV criteria but using either criteria “problem gambling prevalence among adults in England and Scotland was 0.6%, with men being more likely than women to be classified as a problem gambler (1.0% and 0.2% respectively)” (p7). Younger men aged 16-24 had higher problem gambling prevalence 2.4% (p8).

At risk gambling prevalence was calculated using the same methodology (DSM-IV, PGSI or either) with the estimates again showing higher prevalence of at risk gambling amongst men

than women (4.8% low risk = men, 1.6 low risk = women; 1.7% moderate risk = men, 0.4% moderate risk = women) (Seabury, Wardle, 2014 p7). Younger people aged 16-24 had higher rates of low risk and moderate risk gambling (7.3% and 2.3% respectively).

Problem gambling rates in Britain were considered to be relatively stable, however there were caveats placed around this as the survey techniques had changed during the period under study so there was not a continuous time series to make comparisons (Seabury, Wardle, 2014 p10).

A study in routine General Practice in England (Bristol) suggested that around 1 in 20 patients report gambling problems, mostly of low to moderate severity (Cowlshaw et al, 2017). Males and young adults reported higher rates of any gambling problems, and the authors more tentatively note higher rates for those within a student healthcare setting (Cowlshaw et al, 2017). The reported rates for problem gambling were lower than other mental health conditions and addictive behaviours (e.g. depression, alcohol misuse) which the authors suggest may be due to a “stronger tradition of recognition in primary care” (Cowlshaw et al, 2017, e277).

Within a North American context (US and Canada) Shaffer et al found that prevalence estimates amongst adolescents (3.9% problem, 9.45 at risk) were significantly higher than estimates among samples of adults (1.6% problem, 3.85 at risk) for both “problem” and “at risk” gambling. Shaffer et al found that prevalence estimates of disordered gambling have increased significantly over the past 20 years.

Risk Factors & Co-morbidity



Based on Shaffer et al (September 1999) associations with disordered gambling

The Cochrane Library review describes various risk factors implicated in the development and maintenance of pathological or problem gambling disorder including: young age, male sex, personality dispositions (impulsivity), cognitive biases (e.g. inaccurate beliefs about randomness), mental health comorbidity (e.g. major depression), neuro-cognition (e.g. deficits in working memory, inhibition) and alteration in neuro-biology (e.g. dopaminergic and opioidergic neurotransmitter systems) (The Cochrane Collaboration, 2012, p6).

In a study on Medication Management of Pathological Gambling (Grant et al 2006) there is discussion of pathological gambling as an impulse-control disorder with many similarities to substance misuse including “symptoms of tolerance and withdrawal; repeated unsuccessful

attempts to cut back or stop; and impairment in major areas of life functioning” (p2). The report notes that pathological gambling has also been categorised as an obsessive-compulsive spectrum disorder - because people who are compulsive gamblers tend to have repetitive thoughts and behaviours - as well as an affective spectrum disorder because the “pleasurable yet problematic behaviour” alleviates negative emotional states (Grant et al 2006 p2).

Shaffer et al found that age and sex (male) is significantly associated with problem gambling (p1372). Adolescent samples consistently showed significantly higher prevalence than general adult population samples (p1372). College students also had consistently higher estimates of problem gambling than general adult population samples (p1372).

Shaffer et al found that among all population groups studied, treatment/prison populations showed the highest prevalence of disordered gambling (p1372).

A study in routine General Practice in the UK (Bristol) found that rates of gambling problems were elevated where patients had drug use, alcohol risk and depression (Cowlshaw et al, 2017, e277-8).

The Responsible Gambling Strategy Board (December 2016) report that around 300,000 people in England, Scotland and Wales have problems with gambling and that for these groups gambling can be associated with higher levels of physical and mental illness, debt problems, relationship breakdown, criminality in some cases, drug and alcohol misuse; younger males, and people from certain social and ethnic groups appear to be more vulnerable to problem gambling (p2).

“Pathological gambling has been associated with a range of negative consequences including poor health, higher rates of divorce, unemployment, bankruptcy, domestic violence and with early and problematic gambling behaviour in children” (Griffiths, 2004; Griffiths 2006 cited in Anderson, 2011).

“Pathological gambling is highly co-morbid with substance misuse, mood, anxiety and personality disorders, suggesting that treatment for one condition should involve assessment and possible concomitant treatment for comorbid conditions” (Petry et al, 2005)

The Gambling Commission annual survey on the incidence and frequency of young people gambling (cited in House of Lords, 8 September 2017) stated that the prevalence of problem gambling amongst 11-15 year olds in the last week was considerably higher than that of smoking, drinking alcohol and using drugs although rates were considered to have remained relatively stable.

Children and adolescents are more likely to experience problem gambling if:

- gambling is initiated at an early age and the child has experienced an early “big win”;
- They are male, socioeconomically disadvantaged, substance misusers, and engaged in other anti-social behaviours;
- Their parents participate in gambling or have positive attitudes to gambling

(Gillies, August 2016, p10).



A US National Co-morbidity Survey Replication (NCS-R) provided information about age of onset (AOO), which is the age at which the first symptom of a given disorder was reported (Reilly 2009, p6). This enabled the researchers to determine that in about 75% of cases mental disorders pre-ceded gambling problems, in 23% of cases mental disorders followed the onset of gambling disorders, and in 2% of cases gambling and mental disorders emerged at the same time (Kessler cited in Reilly 2009, p6). This important finding may suggest that mental illness is a risk factor that makes individuals more vulnerable to problem gambling, although more research is needed to authoritatively establish social determinants (Shaffer, cited in Reilly 2009).

Environmental Factors and Interventions

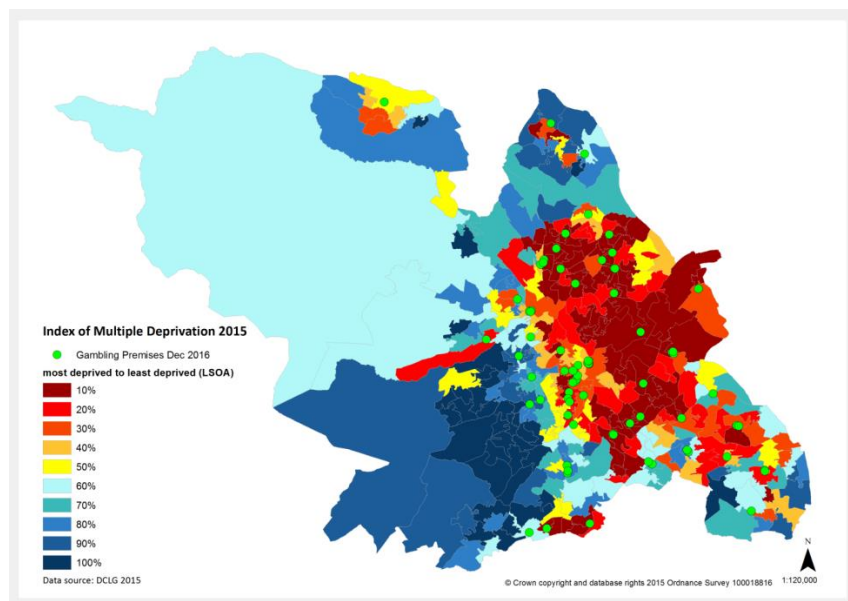
The gambling and gaming environment in Sheffield is much smaller than its near neighbour Core City Leeds, which has approximately 4 times as many licensed premises (Finch, 2017). However, these are relatively more weighted towards more deprived areas of the city and clustered in urban centres (Brennan and Cooper 2016).

Gambling and gaming venues in Sheffield (September 2017)	
Type of premises	Number of premises
Betting office	82
Track betting	4
Bingo hall	3
Adult gaming centre	13
Casino	5
Total	107

(Data from Finch, S., 2017)

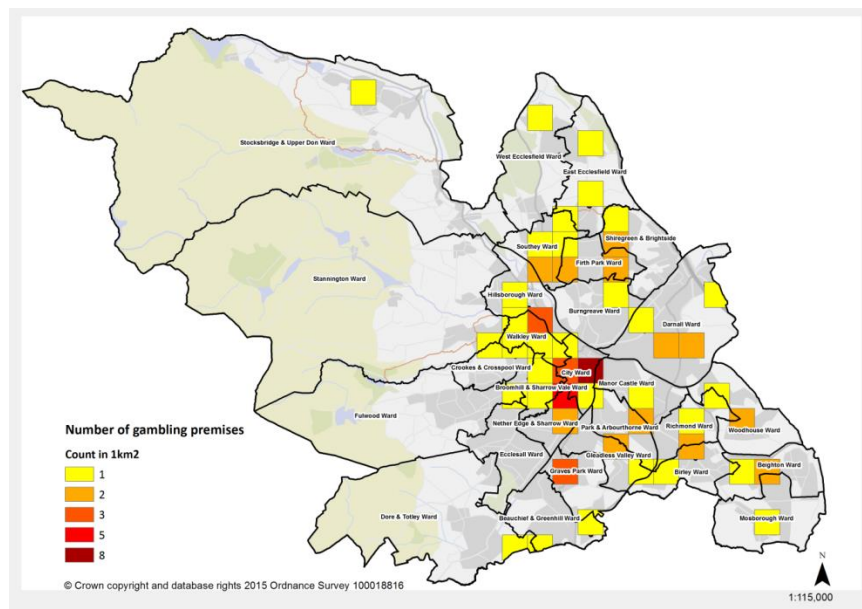
The east of Sheffield is relatively more deprived than areas in the west of the city and as map below shows (April 2015), gambling premises in Sheffield are relatively more weighted towards the population centres in the east of the city.

Gambling premises in Sheffield and IMD2015, April 2015



In particular, there are strong clusters of gambling premises around a small number of urban cores, particularly in Fitzalan Square (city centre), Darnall and Hillsborough. The map below shows that there are concentrations of licensed gambling premises within small areas, providing increased opportunity to access FOBT machines. Companies have opened multiple outlets in close proximity, increasing the number of FOBTs they can make available to customers in a community.

Clustering of licensed gambling premises in Sheffield



The authors of Gambling Behaviour in England and Scotland found that problem gambling prevalence was highest amongst certain types of gambling activity, these are in order:

- Spreadbet (21%)
- Playing poker in pubs or clubs (13%)
- Bet on other events or sports (13%)
- Bet with a betting exchange (11%)
- Played machines in a bookmakers (7%)

- “National Lottery play (0.9%) and scratchcards (1.7%) had the lowest problem gambling prevalence of all activities”

(all bullets: Seabury, Wardle, 2014 p9).

Disordered gambling is more common in individuals who engage in a variety of different gambling activities “mixed mode gamblers” (British Gambling Prevalence Survey 2010, cited in LGA 2013 p4).

The Gambling Commission annual survey on the incidence and frequency of young people gambling (cited in House of Lords, 8 September 2017) includes the following findings:

- 16% of 11-15 year olds had participated in gambling, spending their own money, with boys almost twice as likely as girls to have gambled;
- Fruit machines were the most popular form of gambling (5%) with informal betting amongst friends (5%) and National Lottery scratchcards (4%);

Ben Cave Associates Ltd (2014) report that where there is easy access to electronic gaming machines these are more closely associated with problem gambling than other types of gambling activity (p2).

The Local Government Association (2017) highlight local area vulnerability to gambling related harm, in that there are higher problem gambling rates in more northern areas (or London), major urban areas, urban areas which are more densely populated, English Metropolitan boroughs, London boroughs, and wards classified as industrial, traditional manufacturing, prosperous and multi-cultural (para 10). Ben Caves Associates (2014) cite a common finding that regions with relatively high gambling supply tend to have higher levels of gambling activity (p2). In Sheffield, a local review of gaming machines and social responsibility found that:

- 44% of betting shops in Sheffield are in areas that are amongst the 20% most deprived in England;
- 35% of betting shops in Sheffield are in areas that are amongst the 20% most income deprived in England;

(Brennan and Cooper, 2016)

Academic reviews suggest that actions to control the density of gambling premises should be advanced as part of a comprehensive harm minimisation strategy rather than in isolation (Ben Cave Associates, 2014). The literature suggests that:

- “access to gambling venues increases gambling activity and problem gambling;
- “problem gambling is linked to poor health, low level and severe mental ill health and a co-dependence on alcohol;
- “whilst occasional responsible sports betting may be mildly positive, the use of multiple forms of betting, particularly fixed odds betting terminals (FOBT) by younger adults, can be associated with significant harm to health and wellbeing;
- “problem gamblers experience the worse health outcomes and tend to live in deprived areas;
- “areas of Britain with high densities of gambling machines have greater levels of income deprivation, more economically inactive people and a younger age profile”

(all bullets: Ben Cave Associates Ltd 2014, p2)

Local Authorities have specific responsibilities under the Gambling Act 2005 in relation to granting licenses for gambling premises but there is an assumption that license will be granted unless to do so would impact negatively on three licensing objectives:

- Preventing gambling from being a source of crime or disorder, being associated with crime and disorder or being used to support crime
- Ensuring that gambling is conducted in a fair and open way
- Protecting children and other vulnerable persons from being harmed or exploited by gambling

A licensing condition can be made to ensure an objective is met where there are concerns raised by responsible authorities or interested parties.

The LGA note that unlike the granting of alcohol licenses, health bodies do not have the right to make representations on applications for gambling licenses (August 2013 p11).

Local Authority the London Borough of Southwark is using planning powers - Article 4 Directions under the Town and Country Planning (General Permitted Development) Order 1995 - to restrict proliferation and clustering of gambling establishments in neighbourhoods where there are fears about saturation or cumulative impact (Ben Cave Associates Ltd, 2014, 1.1.2). This is in line with Government indications that Article 4 Directions should be used to control the number of payday loan and betting shops in local areas. The Local Authority has used its Local Plan to form a notion of “*protected shopfronts*” to preserve the character of local neighbourhoods’ retail and service offer (Ben Cave Associates Ltd, 2014,.3.1.2).

However, this policy is limited as “change of use” within classes does not require planning permission which has the impact that, in certain instances, betting shops can open without reference to the local planning authority. A further negative consequence is that banks and building societies are considered in the same class (A2) as betting shops and therefore undue restrictions on development may impact on desirable services and restrict Local Authority attempts to balance the local high street offer (Ben Cave Associates Ltd, 2014,.3.1.3). It appears that Article 4 Directions are the government’s preferred route for local planning authorities to regenerate and shape local neighbourhoods despite campaigns to place betting shops and payday loan companies within their own planning class (Ben Cave Associates Ltd, 2014,. 3.1.12 -3.1.13).

There have been calls on the government to take action on Fixed Odds Betting Terminals (FOBT) as these high stake machines enable gamblers to lose money quickly and frequently. Existing legislation to limit the number of FOBT machines per premise have resulted in the trade opening a number of premises in the same neighbourhood to circumvent the legislation for this high profit gambling activity. Sheffield City Council has a position on Fixed Odds Betting Terminals (FOBT) and clustering (motion to SCC 7th December 2016) and submitted a response to the government’s review of gaming machines and social responsibility (Brennan and Cooper, 2016). Campaigners on this issue, which include Local Authorities and the Local Government Association, have called for Local Authorities to be given powers to reduce clustering and saturation in order to regenerate neighbourhood centres with a more diverse offer (Brennan and Cooper 2016).

The focus on FOBT and on high street premises recognises that this is where Local Authority planning and licensing powers can influence the local environment. However, online gamblers are more likely to be problem gamblers than those gambling within terrestrial premises (Gillies, August 2016, p11) but there are no Local Authority powers in the virtual domain.

Therefore local environmental interventions will need to be balanced with interventions at an individual and a family level to comprehensively address gambling related harm.

There is no established causal link between exposure to gambling opportunities and problem gambling: the relationship is more complex (Gillies 2016, p12). There is debate about whether increased *exposure* to gambling activity increases prevalence of “at risk” and “problem gambling” or, whether after an initial exposure-related rise in presentations, *adaptation* occurs and communities surrounded by gambling premises gradually build up “immunity” to their surroundings (LaPlante, 2007 in NCRG 2009 p 20). This is an uncertain area of science. The LGA (August 2013) cite International evidence that the increasing availability of gambling, particularly density of electronic gambling machines is associated with an increase in problem gambling (p2). Research does consistently suggest that where there is close proximity to gambling opportunities, then problem gambling is more evident, but this link is not necessarily causal (LaPlante 2007, in NCRG 2009, p21).

There is not a direct correlation between exposure and gambling problems and adaptation theory (long exposure providing “immunity”) is proposed as a plausible explanation for this non-linear relationship (LaPlante 2007, in NCRG 2009, p21). This is important as it suggests that exposure does not automatically lead to consequences of problem gambling and other factors such as individual vulnerability have a role to play (LaPlante 2007, in NCRG 2009, p22). A further important facet of the adaptation effect is that recent residents who are newly exposed to widespread availability of legal gambling may not have built up this immunity and therefore may be more vulnerable to developing problems (LaPlante 2007, in NCRG 2009, p22).

The debate about exposure and adaptation is important in the context of environmental remedies to problem gambling as this suggests that in a “do nothing” scenario, communities will gradually become naturally immune to gambling premises, and equally that concerted and aggressive efforts in local neighbourhoods to reduce exposure and access to gambling premises will not necessarily yield a commensurate reduction in problem gambling. This should not be taken as an argument for inaction but as a caution about the scale of anticipated effects. There is a lack of evidence on the comparative effectiveness of regulatory regimes for gambling to inform policy decisions and in the absence of evidence opinion based on moral standpoints has emerged into the debate (Planzer et al, cited in Gillies, 2016, p13).

The Scottish Public Health Network strongly urge a focus on gambling products, the gambling environment and wider determinants of gambling related harm rather than there being a continued focus on problem gamblers as individuals (Gillies, 2016, p14>

Identifying Problem Gamblers (Screening Tools)

A range of screening tools are discussed in the literature but there do not appear to be recommended prescriptive tools for screening. Tools referenced include:

- The South Oaks Gambling Screen , commonly used in the US
- Problem Gambling Severity Index
- GA-20 gamblers anonymous 20 questions
- Lie/Bet questionnaire
- DSM-IV or V criteria
- ICD-10 criteria

South Oaks is a self-administered tool but uses US terminology which would require some translation to a UK context e.g. 'craps' = dice games.

The Gamblers Anonymous GA-20 twenty question tool is a self-administered tool and has a UK and US version with terminology appropriate to each culture. The tool is available online and when submitted gives a view on whether gambling is problematic/compulsive.

The Lie/Bet tool is a simple two question tool and is recommended by the Royal College of General Practice for use by GPs – answering yes to either or both of the screening questions indicates that further assessment is needed.

The Problem Gambling Severity Index is a 9 question tool which gives a numerical score for questions, of which a score of 8+ indicates problem gambling. The questions in this tool are suitable for a UK setting and are written in such a way as to be self-administered or used in lay-settings.

DSM-IV, V and ICD-10 are both clinical tools which would only be appropriate to be used by appropriately trained staff in a clinical setting.

Cowlshaw et al (2017) note that primary care may be an important setting for identification of problematic gambling as it is an established context for address health related behaviours, including other addictions.

Therapeutic Interventions - Psychosocial

The Cochrane Library conducted a review on Psychological therapies for pathological and problem gambling (Cowlshaw et al, 2012) which concluded in supporting the efficacy of Cognitive Behavioural Therapy (CBT) in reducing gambling behaviour and other symptoms of pathological and problem gambling immediately following therapy, however the durability of the therapeutic gain was not known.

The review concluded that there was preliminary evidence for some benefits from motivational interviewing (MI) in terms of reduced gambling behaviour, but not necessarily other symptoms of pathological and problem gambling however more research was needed.

There was some evidence of some possible benefit from a 12-step programme but the evidence was insufficient to evaluate these therapies.

The authors gave caveats about risk of bias in studies and limitations of studies which may overestimate treatment efficacy.

The control used for the studies was “no treatment”, referral to Gamblers Anonymous and non-specific treatment component controls.

Psychological therapies under review ranged in intensity from:

- limited duration (5-30 minutes) intended for low level problems
- brief (1-4 sessions)
- moderate (5-7 sessions)
- intensive (8 or more sessions)

The review describes the main psychological therapies for pathological and problem gambling as based on cognitive and behavioural models: cognitive models focus on correcting erroneous beliefs about gambling, as well as biased information processing; behavioural models aim to address maladaptive learner behaviour and can include aversive therapy, systematic desensitisation, and behavioural counselling, activity planning, problem-solving training, and social skills and communication training. CBT combines various aspects of both cognitive and behavioural techniques (Cochrane Collaboration 2012, pp6-7). Motivational Interviewing aims to address ambivalence as regards behaviour through a focus on costs and benefits of changing versus sustaining behaviour (Cochrane Collaboration 2012, p6).

Leeds City Council (Leeds Beckett University March 2017, cited in LGA June 2017) published some findings of a research project into problem gambling. The research concluded that the specialist service for gambling (commissioned by GambleAware) was operating in almost complete isolation, despite significant co-morbidity of at risk and problem gambling with alcohol, tobacco and drug addiction. Service users were using other addiction services but care was not co-ordinated between services and there was a lack of screening or assessment in other services to identify gambling issues and provide joined-up care. Services working with problem gamblers tended to focus on the “presenting problem” of debt, family or health issues rather than the gambling itself. The overall view was that gambling addiction lagged behind the comprehensive and integrated approach taken in the city to address other addiction issues, poverty and homelessness (Leeds Beckett University March 2017, cited in LGA June 2017 para 12-13).

The gambling and debt pathfinder study (Downs and Woolrych, 2009) found that where GPs referred problem gamblers to mental health services, including drug and alcohol addiction services and NHS CBT, many of these services did not have a remit to assist problem gamblers (p9). The study reported that youth justice and young people’s drug and alcohol services were reluctant to engage with gambling problems (p10).

The National Problem Gambling Clinic offers CBT based interventions to patients aged 16 and over in England and Wales at its London base <http://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic/about-us/>

Therapeutic Interventions – Pharmacological

The Cochrane Library (Anderson et al, 2011) published a protocol for a systematic review of pharmacological interventions for the treatment of pathological and problem gambling. This review will examine the efficacy of any form of pharmacological treatment for pathological or problem gambling with another form of treatment, placebo, or other ‘non-intervention’ (e.g. wait-list control) (p4). The types of pharmacological intervention considered, designed to reduce symptoms or severity of pathological or problem gambling, include: antidepressants; mood stabilisers and anti-convulsants; opioid antagonists; and other pharmacological treatments (p5).

A British Journal of Clinical Psychology Study (Grant et al, 2012, Abstract) found that antidepressants, atypical antipsychotics and mood stabilisers demonstrate mixed results in controlled clinical trials. The authors note that opioid antagonists and glutamergic agents have some demonstrated efficacy, particularly in controlling urges to gamble, but that information is limited (Grant et al, 2012, Abstract) . While offering cautious optimism for opioid antagonists as a first

line treatment for problem gambling the authors note several caveats with study design, including that these studies did not include those with co-occurring psychiatric disorders and were therefore non-representative clinical groups (Grant et al, 2012, Abstract).

A University of York and National Institute for Health Research review and meta-analysis of outcomes of pharmacological treatments of pathological gambling (Pallesen et al, 2009) cautiously concluded that pharmacological interventions may be an adequate treatment alternative for pathological gambling. The study authors highlighted the need for further large-scale controlled studies in people with pathological gambling and other co-morbid conditions with long term follow up periods, and the need to investigate newer drugs such as Dopamine D2 and D2 receptor antagonists, NMDA receptor modulator Acamprosate, calcium channel inhibitor Isradipine and 5-HT3receptor antagonists (Pallesen et al 2009)..

The National Problem Gambling Clinic offers pharmacological interventions to patients aged 16 and over in England and Wales at its London base <http://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic/about-us/>

Peer support for problem gamblers

Gamblers Anonymous UK <https://www.gamblersanonymous.org.uk/> offer peer support meetings in Sheffield from a “12 steps of recovery” perspective.

Smart Recovery UK also offer peer support meetings in Sheffield from “a secular and science based perspective”:
(<http://www.sheffielddirectory.org.uk/kb5/sheffield/directory/service.page?id=puae3M1HARw>)

No Treatment

Treatment is not essential for all problem gamblers; approximately one third of problem gamblers get better on their own without formal treatment (Slutske, 2006 cited in Reilly 2009, p7).

However, there are those who would benefit from treatment but actively avoid it as an active process; it is suggested that further research is conducted to understand this behaviour (Slutske, 2006 cited in Reilly 2009, p7).

Gambling related debt

The gambling and debt pathfinder study (Downs and Woolrych, 2009) critically examines the nature of the relationship between gambling and debt (p2) and uses the term “gambling related debt” to describe where “a significant proportion of debt is said by an individual to have occurred as a result of gambling behaviour” (p3).

The report found that significant debt was incurred through gambling “for all but the wealthiest individuals” (p4) with gambling debts averaging >£60,000 for gamblers with unmanageable debt, compared to estimates of £17,500 of average debts disclosed to Gamcare (Downs and Woolrych, 2009 p4). In Sheffield, a local review of gaming machines and social responsibility found that in 2015, an estimated £13,000,000 was lost by people using Fixed Odds Betting Terminals (FOBT) in Sheffield (Brennan, Cooper 2016).

Gambling related debt was evidenced through secured and unsecured debt repayments not being met, arrears with household bills and cutting back on items such as food and clothes (Downs and Woolrych, 2009 p4).

The report found that gambling related debt was more likely than other types of debt to lead to relationship difficulties and breakdowns due to “resentment and bitterness toward the individual who was seen as the source of the financial difficulties and issues of ‘blame’, ‘responsibility’, and ‘trust’” (Downs and Woolrych, 2009 p5).

The report found that gambling related debt had more severe consequences for health and wellbeing than either problem gambling or problem debt as single issues and found that attempts to manage these issues in isolation, rather than holistically as inter-linked problems, was detrimental to health and wellbeing for both the individual and their family (Downs and Woolrych, 2009, p5).

The gambling and debt pathfinder study (Downs and Woolrych, 2009, p6) offers interesting insights into how problem gamblers self-manage their problem through avoiding increases in income above subsistence level to limit their access to disposable income and credit (p6). The report gives qualitative evidence regarding those in paid employment with access to higher disposable income and credit, and responsibility for paying priority debts such as rent and council tax - rather than these being paid directly through the benefits system - having more difficulty managing their finances in the context of their problem gambling (p6).

The interventions to address gambling related debt examined in the report range from (Downs and Woolrych, 2009 pp7-8):

- family members assuming control of family finance;
- community finance workers assuming responsibility for finance in non-family settings;
- self-exclusion from gambling activities;
- agreement of a repayment plan with creditors;

Although the report notes that in most cases primarily gambling and debt focussed approaches (self-exclusion and repayment plan) resulted in a breakdown of arrangements and a resumption of problem gambling behaviour (Downs and Woolrych, 2009 p8).

The gambling trade has shown willingness to engage with socially responsible business practices and policies, and around 80% of UK operators subscribe to a voluntary Code for Responsible Gambling (the ABB Code) (Gillies, 2016, p14). The types of prevention interventions that gambling operators can offer include:

- supporting self-exclusion
- supporting pre-commitment on time or expenditure limits
- use of warning messages
- responsible gambling interventions by gambling operators

(Gillies, 2016, p19)

Operators are now required by the Gambling Commission to have self-exclusion policies in place and offer time and money limits on FORTs (Gillies, 2016,p27).

However, a review found little evidence of the effectiveness of self-exclusion in the UK setting with most agreements being breached and with difficulties in enabling self-exclusion across multiple operators (Gillies, 2016, p27). Further, uptake of self-exclusion is extremely low with a reluctance to identify as a problem gambler being a barrier to engagement (Gillies, 2016, p28).

A report for the London Borough of Southward (Ben Cave Associates Ltd, 2014) noted the proximity of gambling establishments and payday loan companies providing a ready source of credit. Therefore, action on high streets to address gambling related harm and debt may need to encompass the availability of credit as part of the wider context of problem gambling.

Recommendations within the literature

Various *recommendations* are made in the literature by a range of organisations from the Local Government Association (LGA), to Industry bodies such as the Responsible Gambling Strategy Board (RSGB), and social welfare organisations. This paper summarises those for local organisations (the Local Authority Sheffield City Council, the NHS Clinical Commissioning Group and other NHS, debt, youth organisations) as it is within local powers to respond to these recommendations.

Sheffield City Council (2016) – calls on the government to take action on maximum stakes on Fixed Odds Betting Terminals, empower councils to reduce clustering of FOBTs and betting shops, and enable councils to reduce saturation of betting shops by rejecting new applications for gambling licenses through cumulative impact or demand tests.

Local Government Association (26 June 2017, para 26-30) – draws on the work of Leeds City Council and is developing an add-on for problem gambling to its current mapping tool for Local Authorities (LG Inform data tool). The LGA will produce new guidance on gambling for councillors and regulatory/public health officers with a practical and best practice focus, and will lobby the industry to make a greater contribution to the cost of gambling related harm. The LGA recognises sensitivities around public health involvement as it has been argued that gambling, as a behavioural addiction, was not part of the transfer of public health responsibilities from the NHS to Local Government (para 7), but the LGA feels it is timely to produce guidance. The “ask” from the LGA to councillors, regulatory and public health officers is to “think about whether they understand the issue of problem gambling, how they interact with problem and at risk gamblers and whether appropriate signposting mechanisms are in place to ensure they get the right support” (para 29).

The Scottish Public Health Network – advocates for gambling related harm to be considered a public health issue, approached from a public health lens and calls for public health engagement and public health guidance on the issue. The network recommends that Scottish Directors of Public Health:

- recognise gambling related harm as a public health issue;
- encourage an open, inclusive, informed and critical debate in Scotland toward reaching a consensus within the public health community on the place of gambling in our society;
- request that a public health needs assessment of gambling related harm in Scotland be undertaken as a useful step toward engaging key stakeholders in formulating a comprehensive, collective response to the prevention of gambling related harm in Scottish communities;

(all bullets: Michelle Gillies, August 2016)

The Responsible Gambling Strategy Board (December 2016, p2) - calls on statutory bodies and other agencies that could and should take actions at a population level to recognise their important role in tackling problem gambling. Specifically, the RSGB call on NHS Clinical

Commissioning Groups⁴ to assess the level of need for support and treatment of problem gamblers and commission services to meet that need. They call on Local Authorities⁵, and Health and Wellbeing Boards to conduct local needs assessments and consider gambling as a key issue when assessing risks to the wellbeing of their communities.

The British Journal of General Practice ((Cowlshaw et al, 2017, e278) - cross sectional study of gambling problems in routine general practice in the UK (Bristol) recommends that GPs and clinical staff should be vigilant for gambling problems, particularly among young males, and patients who are depressed or using alcohol or drugs. There should be, as a minimum, training and support for clinical staff in identification of gambling problems and pathways to care. Selective screening of high risk groups (young males, patients with depression) or in high risk contexts (university settings) is potentially appropriate. The authors warn that identification is only appropriate if adequate treatment is available, and raise concerns about gambling industry funded and commissioned treatment calling instead for such treatments to be included within the remits of mainstream health commissioning bodies.

Conclusion – identify, treat or refer

“At risk” and “problem gambling” is a relatively small and stable problem but one which can cause significant harm to individuals and their families.

“At risk” and “problem gamblers” could be helped through early identification, either by asking the question as part of routine assessment and care planning or where appropriate using the Problem Gambling Severity Index screening tool as a self-administered or practitioner-administered questionnaire. Once identified, providers may either treat or refer.

A number of conditions are associated or co-morbid with problem gambling and these service providers may already have the tools to identify and treat or refer. Most service providers working with other addictions will already have the therapeutic tools (psychosocial and pharmacological) to treat problem gambling if empowered to do so by commissioners.

Young people, particularly young men are more likely to become “at risk” or “problem gamblers” and therefore youth settings should have the tools to identify and treat or refer.

Debt organisations may see service users with gambling related debt and should have the tools to identify and treat or refer.

Trade organisations (gambling premises) may have awareness of customers developing difficulties with gambling. Where this concerns younger adults or those with impaired mental capacity this will have safeguarding consequences. In other cases, voluntary self-exclusion and other tools, including referral to self-help, debt advice and peer support may assist customers.

Peer support is available in Sheffield for problem gambling.

⁴ <http://www.sheffieldccg.nhs.uk/Your-Health/gambling-addiction.htm> The Sheffield NHS CCG does include advice on gambling addiction on its webpages.

⁵ A search for gambling on Sheffield.gov.uk links to gambling license applications

<http://www.sheffield.gov.uk/content/sheffield/utilities/search-result.html?q=gambling> A search for gambling addiction finds no results.

The Local Authority can explore the use of its available and emerging powers through Licensing and Planning to restrict access and availability of gambling activity.

Appendix 1 - References

- Anderson, C., Cowlshaw, S., Dowling, N., Jackson, A., Lorains, F., Merkouris, S., Misso, M. L., Radermacher, H., Thomas, S. (2011) Pharmacological interventions for the treatment of pathological and problem gambling. Cochrane Database of Systematic Reviews 2011, Issue 1, John Wiley and sons
- Brennan, L. and Cooper, B. (2016) Review of gaming machines and social responsibility: Sheffield City Council submission
- Cave, B., Pyper, R., (7th March 2014) Betting, borrowing and health: Health impacts of betting shops and payday loan shops in Southwark, Ben Cave Associates Ltd
- Cowlshaw, S., Merkouris, S., Dowling, N., Anderson, C., Jackson, A., Thomas, S. (2012) Psychological therapies for pathological and problem gambling, Cochrane Database of Systematic Reviews 2012, Issue 11, John Wiley and sons
- Cowlshaw, S., Gale, L., Gregory, A., McCambridge, J., Kessler, D (2017) Gambling problems among patients in primary care: a cross-sectional study of general practices, *British Journal of General Practice* 2017; 67 (657): e274-e279
- Downs, C.M. and Woolrych, R. (2009) Gambling and debt pathfinder study, University of Salford, Manchester
- Gillies, M (August 2016) Scottish Public Health Network (ScotPHN) Toward a public health approach for gambling related harm: a scoping document, ScotPHN report
- Grant, J.E. and Suck Won Kim (2006) Medication Management of Pathological Gambling, *Minnesota Medicine Journal* 2006 Sep; 89 (9): 44-48 (accessed from www.ncbi.nlm.nih.gov/pmc/articles on 12/09/2017)
- Grant, J.E., Odlaug, B.L., Schreiber, L.R. (2012) Pharmacological treatments in pathological gambling, *British Journal Clinical Pharmacology*, 2014 Feb; 77 (2): 375-81 (Abstract accessed through PubMed www.ncbi.nlm.nih.gov/pmc/articles on 12/09/2017))
- LaPlante, D.A. and Shaffer, H. (2007) Understanding the Influence of Gambling Opportunities: Expanding Exposure Models to Include Adaptation, *American Journal of Orthopsychiatry*, 2007 vol 77, number 4 pp616-623 published in National Center for Responsible Gaming (2009) Increasing the Odds A Series Dedicated to Understanding Gambling Disorders Volume 3: Gambling and Public Health, Part 1
- Local Government Association (26 June 2017) Strengthening local approaches to tackling problem gambling
- Local Government Association and Public Health England (August 2013) Problem Gambling Frequently asked questions: Briefing for councillors
- National Center for Responsible Gaming (2009) Increasing the Odds A Series Dedicated to Understanding Gambling Disorders Volume 3: Gambling and Public Health, Part 1
- National Gambling Impact Study Commission United States of America (June 1999) National Gambling Impact Study Commission Final Report
- Pallesen, S., Molde, H., Arnestad, H.M., Laberg, J.C., Skutle, A., Iversen, E., Stoylen, I.J., Kvale, G., Holsten, F (02/09/2009) Outcome of pharmacological treatments of pathological gambling: a review and meta-analysis, University of York Centre for Reviews and Dissemination and National Health Service National Institute for Health Research
- Petry, N. M., Stinson, F. S., and Grant, B. F. (2005) Comorbidity of DSM-IV Pathological Gambling and Other Psychiatric Disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Psychiatry*, 66 (5), 564-574
- Reilly, C (2009) The Prevalence of Gambling Disorders in the United States: Three Decades of Evidence published in National Center for Responsible Gaming (2009) Increasing the Odds A Series Dedicated to Understanding Gambling Disorders Volume 3: Gambling and Public Health, Part 1
- Responsible Gambling Strategy Board (December 2016) Gambling-related harm as a public health issue: Position paper
- Seabury, C. and Wardle, H. (15/04/2014) Gambling Behaviour in England and Scotland Headline findings from the Health Survey for England 2012 and the Scottish Health Survey 2012, Report prepared for The Gambling Commission by the NatCen Social Research
- Shaffer, H. J., Hall, M. N., Vander Bilt, J. (September 1999) Estimating the Prevalence of Disordered Gambling Behaviour in the United States and Canada: A Research Synthesis, *American Journal of Public Health*, September 1999, Vol. 89, No 9, pp1369-1376
- Taylor, R., (8 September 2017) House of Lords Library Briefing, Gambling Advertisements: Effect on Children Debate on 14 September 2017

Appendix 2 - Problem Gambling in Sheffield (A4 Summary)

Why?

Problem gambling (gambling behaviour that is frequent, repeated, dominates lives and disrupts personal, family, or vocational pursuits) is a relatively low prevalence and stable problem in the UK. However, problem gambling is associated with a range of harms including health, divorce, unemployment, bankruptcy, domestic violence and inter-generational impacts for children of problem gamblers. For this reason, problem gambling there are calls for problem gambling to be viewed as a public health issue alongside other addictions such as tobacco, alcohol and drugs.

Who?

Around 1 in 20 people aged 16+ in general practice report problem gambling at a low or moderate severity. Problem gambling is seen more often in those who are already vulnerable due to young age, mental illness, and other addictions. Young, economically inactive men are particularly vulnerable. New arrivals, un-used to the widespread availability of legal gambling in the UK, may be more vulnerable to developing problems. Where people have mental health and gambling problems, in most cases, the mental health problems precede the problem gambling, but in 25% of cases mental health problems are first reported after a person develops problem gambling.

What?

There are currently 107 premises in Sheffield licensed for gaming or gambling including Bingo, Casinos, Betting offices, track betting. This does not include online gambling which is more strongly associated with problem gambling.

Gambling premises are often clustered in deprived neighbourhoods, near sources of credit such as payday lenders. This particularly impacts those who may already be financially excluded. The area around Fitzalan Square in Sheffield is an example of this with three betting shops, an adult gaming centre, a bingo hall and a cheque cashing/pawnbrokers shop in close proximity. 44% of betting shops in Sheffield are in areas that are amongst the 20% most deprived in England. Where there is geographical proximity to gambling premises then problem gambling is more evident, but this link is not necessarily causal.

Gambling-related debt is more likely than other types of debt to lead to relationship difficulties and breakdown with self-reported average debts of problem gamblers ranging from £17,500-60,000.

How?

The strategies for dealing with problem gambling include:

- Addressing the gambling products
- Addressing the gambling environment
- Addressing wider determinants of gambling related harm (vulnerabilities)
- Addressing gambling related debt
- Addressing the addiction through treatment

Addressing the gambling products: For young people (aged 11-15) “fruit machines” are one of the most popular formal gambling activities. For adults problem gambling prevalence is highest for: spreadbetting (21%); poker games and betting on events or sports (both 13%); betting with a betting exchange (11%); with playing machines in a bookmakers such as Fixed Odds Betting Terminals (7%). Online gamblers are more likely to be problem gamblers than those placing bets in premises. FOBT have received national and local attention because high stakes and high frequency play mean large sums are lost very quickly. Legislation to limit the number of FOBTs in any one premise was circumvented by operators opening multiple clustered premises.

Address environmental factors: Local Authorities may use planning powers (Article 4 directions under the Town and Country Planning Order 1995) to restrict proliferation and clustering of gambling establishments and/or license conditions where granting a license would impact negatively on the three Gambling Act 2005 licensing objectives.

Addressing wider determinants: Addressing social determinants such as neighbourhood deprivation and youth unemployment through regeneration and community development.

Identify: Recognising individual risk factors, the “profile” of a likely problem gambler may enable identification through selective screening and early intervention. There are simple screening tools, which can help identify problem gamblers. These include self-administered tools. The Royal College of GPs recommends the 2 question Lie/Bet tool for GPs who are well placed to identify problem gamblers in routine practice.

Treat: Clinical treatments that are effective for problem gambling include psychosocial interventions (Cognitive Behavioural Therapy) and pharmacological interventions (using drugs which work with other addictions to limit pleasure and reward). One third of people will get better on their own with no treatment. There has been criticism of industry-funded and commissioned treatment.

As problem gambling is highly co-morbid with a range of mental health conditions and addictions it is likely that problem gamblers are already receiving treatment from those with relevant clinical skills so where possible clinicians could concurrently address problem gambling.

Refer: Peer support groups are available in Sheffield including Gamblers Anonymous and SMART recovery. There is one specialist NHS clinic for England and Wales, the National Problem Gambling Clinic.

Address debt holistically as part of wider issues: Addressing debt in isolation tends to be detrimental. Industry and user-led mitigation and self-help measures such as self-exclusion, time-limits or cash-limits have low take-up, are often breached, and there is little evidence of effectiveness.

So What?

Problem gambling is more than a financial inclusion issue or a public health issue, it becomes a health inequalities and social justice issue about why the most vulnerable in society are most exposed to products and environments which are likely to cause them harm.

Local Authorities can use their powers (through planning and licensing) to promote healthy neighbourhoods, not harmful neighbourhoods. The virtual sphere is out of Local Authority control, so there will always need to be services and interventions on the individual level, not just the environmental level to support problem gamblers as individuals.

Health commissioners can empower clinicians to treat problem gambling as a concurrent condition with other mental health problems and addictions. GPs are very well placed to identify problem gamblers and intervene early. Other providers working with young people, debt, domestic abuse, offending also have opportunities to identify problem gamblers. The industry itself can adhere to voluntary codes to enable self-exclusion, time and cash limits.