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About the authors

Dr. Steve Sharman

Dr Steve Sharman is a Research Fellow at the University of East London (UEL). He was recently awarded a three-year Academic Research Fellowship from the Society for the Study of Addiction (SSA) to work at UEL. In this role, Steve will be using immersive virtual reality to investigate gambling behaviour, and the influence on specific within-game constructs such as speed of play and stake size (detailed in a separate submission). Prior to this, Steve was a Research Fellow at the University of Lincoln, working primarily with data from the Gordon Moody Association, alongside a range of other gambling-related research projects. Steve completed his PhD at the University of Cambridge, where his thesis investigated decision making and cognitions in gambling and problem gambling behaviour. Previously, Steve completed an MSc in Cognitive Neuroscience at UCL, and a BSc (Hons) in Psychology at UEL.

Prof. John Turner

Prof. John Turner is the Director of Research for the College of Applied Health and Communities at the University of East London. John is a co-founder and continuing member of the Drugs and Addictions Research group in the School of Psychology at UEL, working on projects relating to gambling treatment and education, nicotine addiction, alcoholism and recreational drug use. He has over 20 years research experience in the fields of drug use and addiction, and has produced and contributed to over 70 publications, mainly peer-reviewed journal papers and predominantly in the fields of drug and addictions research. John completed a PhD in the departments of Psychology and Neuroscience at the Institute of Psychiatry/Kings College London, after his first degree in Neuroscience (City of London Polytechnic).

Dr. Amanda Roberts

Dr. Amanda Roberts is a Reader in the School of Psychology, College of Social Science, University of Lincoln. She completed her first degree at University College London (BSc Hons Psychology), before moving to Cardiff University to conduct her PhD in Behavioural Neuroscience. Amanda took up her first permanent full-time post at Kings College London, before moving to Queen Mary University, University of East London and then to Lincoln. Amanda's main research covers specific areas in mental health and related areas, including forensic psychology and criminology. Amanda's current research interests include risk factors for antisocial behaviour, addiction, violence, pathological gambling, smoking and extensive pornography use. Other research includes the evaluation of addiction treatment programmes both in the community (pathological gambling) and in prisons. Additional interests extend across topics that relate to gambling comorbidity, gambling in vulnerable populations and gambling and interpersonal violence.

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Contents

1. Brief Introduction

Towards the end of 2017, the Department for Culture, Media and Sport (DCMS) announced a further 12-week review into proposals for changes to Gaming Machines and Social Responsibility Measures. Although addressing a range of components of gambling legislation, one of the more contentious issues to be addressed is the maximum stake size of B2 category games on Fixed Odds Betting Terminals (FOBTs) that are found in Licensed Betting Offices (LBOs). The current limit is £100 per spin, with proposals being considered to reduce the maximum stake per spin to anything between £50 and £2.

Much has been written, said and tweeted about FOBTs in recent months and years. The term 'crack cocaine of gambling' is a phrase often coined in the UK media and associated commentary to describe FOBTs, however to date little evidence exists to suggest that this specific form of gambling is any more addictive, and thus creates more gambling related harm, than any other specific form of gambling. Whilst plenty of harrowing and extreme anecdotal evidence of FOBT related harm having devastating effects on individuals and families exists, there is little larger scale statistical evidence to support the anecdotal evidence. Furthermore, the term 'gambling related harm' is frustratingly vague and actual harm is notoriously difficult to measure. As such, it is difficult to measure the impact of gambling in general, and of specific forms of gambling, at an individual level on a large scale.

To provide a more detailed insight in to gambler behaviour, our research team from the Universities of East London and Lincoln have been working closely with the Gordon Moody Association (GMA). Situated across two sites in Dudley and Beckenham, GMA is the UK's only gambling specific residential treatment centre. Although holding a wealth of historical and current data on treatment seeking pathological gamblers, GMA had not previously embarked on an academic collaboration to analyse this data.

Through this collaboration, we have been able to track patterns in gambler behaviour between 2000-2015, a timeframe encompassing both the announcement and implementation of the Gambling Act of 2005, and the introduction of FOBTs in to LBOs. Our analysis of this data is comprehensive and wide ranging. However, for succinctness and clarity, this submission will only refer to data relating to changes the forms of gambling identified as being problematic by treatment seeking pathological gamblers, and mental health variables.

Whilst we acknowledge that the research presented does not refer directly to the impact of stake size, or how any stake size reduction will influence gambling behaviour and gambling related harm, the authors believe that is of benefit to the DCMS to receive a submission that provides some wider context and details some changes in both pathological gambler's preferred form of gambling, and the mental health of treatment seeking gamblers.

2. Preferred Form

Data was collected from 768 treatment seeking gamblers who completed an initial assessment with Gordon Moody between January 2000 and November 2015. The age of applicants ranged from 17 to 70 at point of entry (*n* = 762, M = 34.82, *s.d.* 9.98). Individuals entering residential treatment with GMA complete a comprehensive assessment battery to ascertain suitability for the rehabilitation programme, which includes demographic information, a gambling audit to document current and past gambling behaviour, a need audit to understand health needs, a safety audit to understand current dynamic risk factors, and a life audit to understand the individual's life history.

Individual's gambling behaviour was recorded at multiple points in the assessment process; consequently, preferred form coding for each individual followed a strict protocol. Having identified the forms of gambling that individuals disclosed as being problematic for them at point of entry to GMA, a chi square analysis was used to track proportional distribution of the endorsement of each form of gambling across years.

Overall, forms of gambling identified as problematic at treatment start varied significantly by intake year (χ^2 (90) = 582.99, p<.001), indicating that the type of gambling identified as problematic has *not* remained the same over time.

The significant change in proportional distribution is driven by increases (Fig.1) and decreases (Fig.2) in some specific forms of gambling. There have been significant increases in those identifying FOBTs, other sports gambling, and poker as problem forms of gambling at point of entry into GMA.

Since 2003, there has been a consistent and statistically significant year on year increase in the proportion of treatment seeking gamblers identifying FOBTs as a problem form (χ^2 (13) = 108.58, p<.001). Since 2013, over 60% of gamblers entering GMA for treatment each year identify FOBTs as a problem form. From 2004 to 2015, FOBTs have consistently been the form of gambling identified most commonly by individuals as being a problem for them. No other single form of gambling is increasing so rapidly.

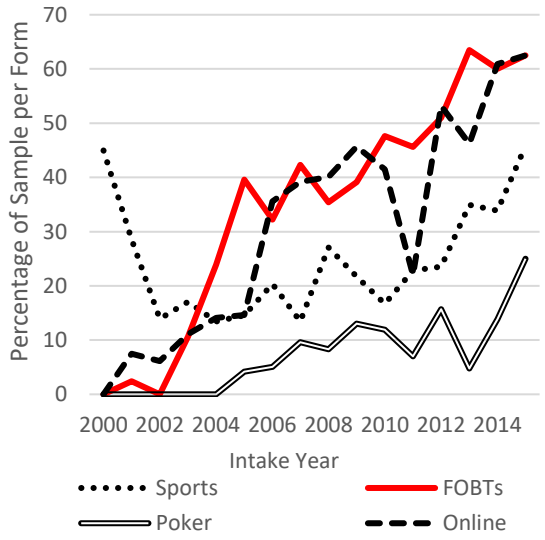

Figure 1: Increase in gambling form engagement

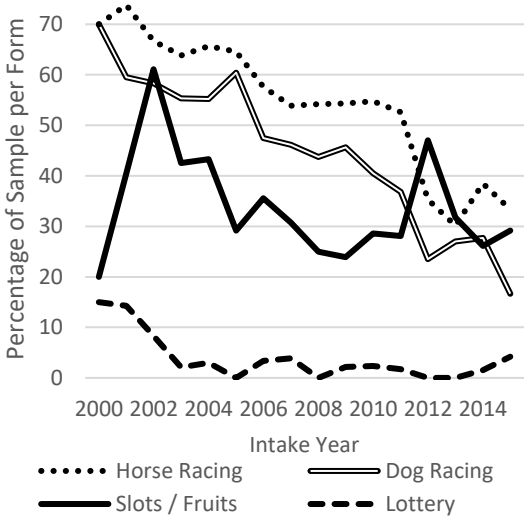

Figure 2: Decrease in gambling form engagement

Results also indicate a significant increase in those identifying Other Sports as a problem form (χ^2 (15) = 69.68, p<.001). Following a substantial drop in engagement between 2000 and 2002, the proportion of gamblers identifying sports gambling as a problem form has remained relatively consistent with minor fluctuation between 2002 and 2012. Since 2012, the proportion has generally steadily increased until 2015, where sports gambling reached its highest proportions. Identification of Poker as problem form is also increasing (χ^2 (10) = 35.28, p<.001), particularly since 2013.

Furthermore, results indicate significant decreases in the proportion of gamblers identifying what could be considered more traditional forms of gambling as a problem form, including Dog Racing, Horse Racing, Slot / Fruit Machines, and the National Lottery (all p<.001) (Fig.2).

It should also be noted that using the internet as means of accessing gambling is also increasing (Fig.1). Although the exact form of gambling being accessed is not specified, so is therefore not exactly comparable to the other lines showing specific forms, use of the internet as a means of accessing gambling increased significantly across intake year (apart from an unexplained drop in 2011). In 2015 over 60% of gamblers coming to GMA had used the internet to gamble.

Summary

Much of the recent political and media focus, and indeed a significant focus of this DCMS review has been on one specific form of gambling, FOBTs. This research shows that whilst the attention afforded to FOBTs is not without foundation, the focus should not be to the detriment of research in to the concurrent increase in sports betting, poker, and use of the internet to access many forms of gambling.

3. Health and Gambling

Using GMA data, we are also able to analyse patterns in reported health of treatment seeking gamblers over time. The proportion of individuals who reported any co-occurring mental health disorder increased significantly by intake year (χ^2 (15) = 31.99, p< .01; Fig. 3), rising sharply between 2011 (25%) and 2015 (50%). The most common mental health disorders identified were depression and anxiety. Furthermore, the proportion of individuals arriving for treatment already taking prescribed medication varied significantly by year, rising sharply since 2009 (χ2 (15) = 69.27, p < .001). In 2015 almost 70% of those arriving for treatment were on some type of medication – most commonly anti-depressants. The proportion who reported any physical health disorders did not vary significantly by intake year (χ^2 (15) = 17.26, p>.05; Fig. 3).

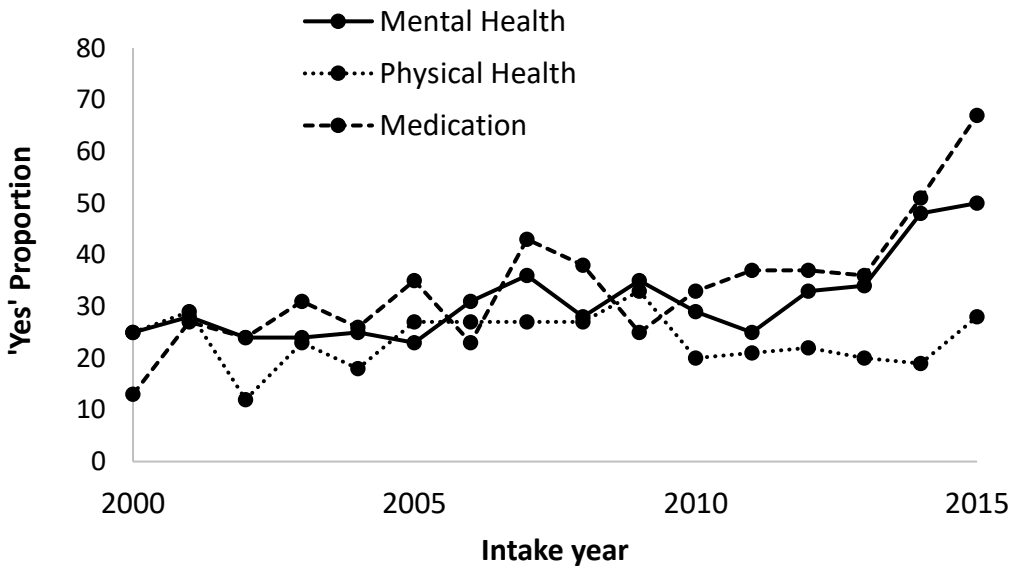

Figure 3: Frequency of co-occurring mental and physical health disorders and prescribed medication frequency in treatment seeking gamblers 2000-2015

The increasing proportions of individuals reporting a co-occurring mental health disorders could indicate that over time, the mental health of treatment seeking gamblers is getting worse. However, it could also be that an increased awareness and acknowledgment of mental health disorders within males makes such disorders more likely to be disclosed, rather than more likely to be experienced. Alternative explanations notwithstanding, the consistent increase in proportions of individuals reporting a mental health disorder and reporting for treatment already taking prescribed medication emphasise the negative influence of gambling problems on mental health.

Suicide

A further factor we were able to analyse was attempted suicide. The proportion of individuals who reported attempting suicide varied significantly by intake year, with a higher proportion of individuals entering treatment attempting suicide in more recent intake years (χ2 (14) = 38.44, p < .001). That is, the number of people who attempt suicide due to gambling prior to arriving at GMA is increasing. Instances of suicidal thoughts did not vary by intake year (χ2 (15) = 16.5, p>.05).

The proportion of individuals who disclosed a suicide attempt prior to arriving at GMA has remained at around 30% since 2013; almost a third of those finally seeking treatment for gambling issues have already tried to take their own life. The most common method of attempted suicide was taking an overdose. When considering the implications of this finding, it is important to view the data in the wider context of suicidal intention; individuals reporting that they had experienced suicidal thoughts did not vary by intake year (although it should be noted the mean proportion across intake years who had suicidal thoughts due to gambling was 81%). Therefore, it can be implied that across time, gamblers who experience suicidal thoughts have become more likely to act on those thoughts and are more likely to attempt to take their own life. The implications of this result exemplify how the consequences of gambling related harm extend beyond the gambler themselves and can have a significant negative impact on those close to the individual.

4. Summary and Conclusions

Working in partnership with one of the UK's leading gambling treatment providers has allowed us to quantify the variation in disordered gamblers behaviour patterns over an extended period. To the authors' knowledge, this is the first and only research of this kind in the UK.

The key findings from this work are that the forms of gambling identified as problematic by those entering treatment has changed over time, driven primarily by increases in those identifying FOBTs, other sports gambling, and / or poker as problem forms. The proportion of individuals using the internet to access undefined forms of gambling is also rapidly increasing.

The mental health of gamblers entering treatment also appears to be demonstrating some concerning patterns. In more recent years, gamblers arriving for treatment at GMA are more likely to have attempted suicide, are more likely to report a co-occurring mental health disorder (most commonly depression) and are more likely to already be taking prescribed medication.

As stated in the introduction to this submission, this data does not directly inform the consultation on the potential impact on gambler behaviour or gambling related harm that a significant stake reduction would have, however what we have done is provided empirical support for the notion that FOBTs are the most commonly identified problem form amongst a large cohort of treatment seeking gamblers. Furthermore, our data highlights that since they were introduced to the UK gambling environment, the proportion of treatment seeking gamblers identifying FOBTs as a problem form has increased more rapidly than any other form of gambling. However, the authors also note that sports gambling, and the use of the internet to access all forms of gambling are also increasing and should not be neglected in favour of focussing specifically on FOBTs.