Gambling with Lives – Supplementary written evidence (GAM0131)

The NUMBER OF GAMBLING RELATED SUICIDES EACH YEAR IN THE UK.

3 studies carried out in the UK, Hong Kong and Sweden indicate that there are 250 to 650 gambling related suicides each year in the UK – 4% to 11% of total suicides.

There is a long history and substantial research literature showing a robust and consistent link between gambling and high rates of suicidal ideation, suicide attempts and completed suicides. These studies support the rates estimated from the 3 key studies.

Studies of Completed Suicides

1. UK study[1] (2017) showing 4% of suicides of 20-24 year olds in the UK are gambling related
   => **250 gambling related suicides per year in the UK**

2. Hong Kong study[2] (2010) showing 11% of suicides in Hong Kong are gambling related
   => **650 gambling related suicides per year in the UK**

3. Swedish study[3] (2018) showing suicide rate of people with gambling disorder is 15 times that of the general population => **550 gambling related suicides per year in the UK**

4. The same Swedish study found that suicide was the most common form of death of people diagnosed with gambling disorder, accounting for 31% of deaths.

5. Canada Safety Council[4] (2005) estimated 200 gambling related suicides per year ~ 5% of all suicides => **300 gambling related suicides per year in the UK**

A note on population estimates – a common pushback on estimating population figures from these studies is that studies relate to people diagnosed with gambling disorder and maybe receiving treatment. The implication is that these are a "more severe" group. We are not aware of any evidence to support this assumption. In the UK only 2% of gamblers receive treatment: we know virtually nothing about the other 98%. Only a few of the young men lost by Gambling with Lives families received any treatment; none had a diagnosis of gambling disorder; all took their own lives. This experience suggests that the treatment population is not "the tip of the iceberg" but just "the bit of the elephant that we can see".

Studies of Suicidal Ideation and Attempts

Table 1 - Suicidal ideation rates and suicide attempts (usually gamblers seeking treatment, several countries)

	No. of studies	Min	Max	Average
Suicidal ideation rate	13	10%	81%	42%
Attempted suicide	17	4%	40%	20%

1. A review of 13 UK and international studies[5-16] (1990 – 2019) which considered suicidal ideation showed that an average of 42% of gamblers seeking treatment had had suicidal thoughts … **around 3 times the average[18] of the general population.**

2. A review of 17 UK and international studies[10-16,19-27] (1990 – 2019) which considered attempted suicides showed that an average of 20% of gamblers seeking treatment had attempted suicide … **over 3 times the average[18] of the general population**.

3. The most recent UK study[20] (2018) showed that 30% of gamblers entering treatment in the UK in 2015 had attempted suicide … **over 5 times the average of the general population**.

   Applying this 30% to the approx. 10,000 gamblers receiving treatment[28] and using the estimated 10-25 attempts for each completed suicide[29]
   => **120 to 300 gambling related suicides per year in the UK.**

   Arguably we should apply the 30% to a much higher figure of gamblers to reflect the numbers who <u>should</u> be receiving treatment. Gambleaware/GamCare aim to treble the number in treatment
   => **360 to 900 gambling related suicides per year in the UK.**

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GAMBLING – SUICIDAL IDEATION, ATTEMPTS and COMPLETED SUICIDES

This summary presents robust evidence on the long established and clear relationship between gambling and suicidal ideation and behaviour.

It estimates that 4-11% of suicides in the UK are gambling related – indicating a figure of 250 to 650 completed gambling related suicides each year.

It also argues that in many cases gambling is the root cause of suicide.

1. Long established link between gambling and suicide

Academic papers have reported the link between gambling disorder and suicide from as long ago as 1935[1]. Since then numerous studies across the world have investigated the link between gambling and suicidal ideation[2-14], attempted suicides[7-23] and completed suicides[24-28].

1.1 Suicidal ideation and attempted suicides

The table below demonstrates the very high rates of suicidal thoughts and attempted suicides among problem gamblers seeking treatment.

Table 1. - Suicidal ideation rates and suicide attempts (usually gamblers seeking treatment, several countries)

	No. of studies	Min	Max	Average
Suicidal ideation rate	13	10%	81%	42%
Attempted suicide	17	4%	40%	20%

(The comparative figures in the general population show that around 16.7% of people have had suicidal thoughts and 5.6% of people have attempted suicide[29].)

Evidence that gambling is closely associated with high rates of suicidal ideation and attempts is robust and consistent across the studies, although the reported rates of suicidal behaviour may vary due to different demographic samples and measurement scales.

The most recent UK study[16] found that around 30% of gamblers entering treatment in 2015 had attempted suicide, a figure which had increased over the previous 3 years. This indicates that problem gamblers are **over 5 times more likely to attempt suicide** than other people.

Currently only around 9,000 people a year receive treatment for gambling disorder[30] in the UK, but this disguises the scale of the problem with around 340,000 people classified as "problem gamblers" and a further 1.7 million "at risk"[31]. It is estimated that for every completed suicide there are 10-25 attempts[56], so that applying the 30% attempted suicide rate to any of these figures gives a staggeringly high number of attempted suicides

1.2 Completed suicides

In most countries the underlying reason(s) why someone took their life is rarely recorded: coroners are required to record only the "when, where and how" of any suicide verdict. Coroners may refer to medical diagnoses where available but very few people are diagnosed with gambling disorder in the UK due to lack of GP training and because treatment is commissioned and provided outside the NHS. This contrasts with the common diagnosis and recording of alcohol and drugs dependencies in medical notes, which can then be referenced by coroners as factors associated with suicide.

We have identified three academic studies that have attempted to quantify the number of completed suicides linked to gambling that provide robust evidence of the scale of gambling related suicide.

1.2.1 Gambling disorder, increased mortality, suicidality and associated comorbidity: A longitudinal nationwide register study. (Sweden, 2018)

A recent study from Sweden[24] which tracked over 2000 people with a diagnosis of gambling disorder found that this group had a **suicide rate 15 times higher** than the general population. It also found that suicide was the leading cause of death for 20-74 year olds in the study, accounting for 31% of deaths.

Applying this 15 fold rate to the most recent estimate of problem gamblers (above) gives an estimated **550 suicides related to gambling each year in the UK – over 9% of all UK suicides**.

1.2.2 Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (UK, 2017)

This UK study[25], which examined the deaths by suicide of just over 100 young people aged 20-24 years in the UK, found that **4% of suicides were related to gambling**. The study was based on detailed examination of coroners' oral reporting and therefore will inevitably be a lowest estimate (see above).

Applying the 4% figure to the approximate 6,000 suicides each year in the UK gives a figure of **250 suicides related to gambling each year in the UK**.

1.2.3 A psychological autopsy study of pathological gamblers who died by suicide. (Hong Kong, 2010)

A study based on psychological autopsies of 150 deaths by suicide and 150 deaths by natural causes in Hong Kong[26] found that **over 11% of suicides were related to gambling**.

Applying the 11% figure to the approximate 6,000 suicides each year in the UK gives a figure of over **650 suicides related to gambling each year in the UK**.

1.2.4 Other international studies (Canada, 2005 and Australia, 2013)

> Some provinces in Canada require that coroners comment whether gambling is present when considering suicide cases. In 2005, the Canada Safety Council[27] estimated that around 200 suicides each year are related to gambling, equivalent to over 5% of all suicides. An Australian report[28] in 2013 based on coroners' records identified around 2% of suicides related to gambling, though the study acknowledged the weaknesses of using these records (see above) meaning that again this must be a lowest estimate.

Clearly there are issues about extending the results of the studies noted above to try to estimate the number of gambling related suicides in the UK figure each year, but applying them directly gives an estimated 250 to 650 gambling related suicides each year in the UK.

A common pushback on estimating population figures from these studies is that they relate to people diagnosed with gambling disorder and maybe receiving treatment. The implication is that these are a "more severe" group. Gambling with Lives is not aware of any evidence to support this assumption. In the UK only 2% of "problem gamblers" receive treatment each year: we know virtually nothing about the other 98%. Only a few of the young men lost by Gambling with Lives families received any treatment; none had a diagnosis of gambling disorder; all took their own lives. This experience suggests that the treatment population is not "the tip of the iceberg" but just "the bit of the elephant that we can currently see".

Some further brief notes about using these studies are appended and a fuller justification for using them can be found on the Gambling with Lives website www.gamblingwithlives.org.

In conclusion, we estimate that 4-11% of suicides in the UK are related to gambling. This compares to an estimated 8-17% of suicides where a diagnosis of "alcohol dependence" was recorded and 3-9% for "drug dependence"[32].

2. Gambling as the prime cause of suicide

It is widely acknowledged that the causes of any individual suicide can be complex, both in terms of the long-term history of the individual and any specific events which might trigger their death. However, there is a substantial research base which indicates that gambling itself can be a prime cause of suicidal behaviour. In particular several studies identify the level of gambling severity as being highly associated with suicidal behaviour[11,12,21,35,36,41], as is the early onset of gambling disorder[42-45]. Some studies even identify particular forms of gambling such as games of pure chance and gambling on electronic gambling machines as being more dangerous in terms of suicidal behaviour[46-48].

Clearly non-gambling issues may also trigger susceptibility to the development of gambling disorder and suicidal behaviour and there is a reasonable research base exploring co-morbidity across a range of psychological factors[11,17,33-36], other substance-related problems[37-39], and demographic factors[12,35]. However, in none of these studies do the other co-morbid factors and demographics 'explain' all of the likelihood of gambling disorder or suicidal behaviour. Rather they are themselves contributory factors. Several studies[49-52] explicitly identify gambling

as a factor associated with suicidal behaviour even after all other factors have been taken into account.

Furthermore, some studies indicate that gambling disorder actually precedes, and therefore possibly causes, the onset of psychological, economic or social problems[39-40]. Indeed it would be very surprising if a long term gambling disorder did not have a wide range of other impacts on an individual's well-being.

Further important evidence that gambling can be both the root and trigger for suicidal behaviours is the lived experience of the Gambling with Lives families. Without exception the young men lost by the families were normal, bright, happy and popular with great futures ahead of them. Their one problem in life was their addiction to gambling. All had started gambling when they were underage, some as young as age 12. While some did die with substantial debts, this was certainly not the case for all.

They seemed to share a set of common characteristics. They were all big cheerful characters; people who would 'light up a room'; they were outgoing; they tended to be people who you could 'tell your troubles to'. They shared a set of characteristics which would be seen as positive and advantageous in many walks of life – great indicators of success. This chimes with one academic study which found "cheerfulness" as a factor associated with gambling disorder[52] – no doubt a proxy for many other positive characteristics not regularly captured in data sets. It seems that the very characteristics which made them successful in the rest of their lives were also the factors that contributed most to their susceptibility to gambling addiction and suicide.

Friends and families of these young men attribute the entirety of their deaths to gambling. All were happy and untroubled until gambling entered their lives. It gradually destroyed their self-esteem and undermined their belief in themselves, a position confirmed by research[38,39,53]. They all seemed to acknowledge their addiction and felt that they would never be able to be free to lead a normal life. Many of them died after many months of being free of gambling and not betting, only to relapse – maybe targeted by an offer of a "free bet". Their relapses were catastrophic for them, not necessarily financially but mentally and emotionally. Gambling took their lives from them from an early age and then ended their lives tragically early.

Appendix – Using the studies to give an estimate of the number of gambling-related suicides in the UK

There are always issues about applying the results of any research study to derive an estimate of the number of gambling-related suicides each year in the UK. This is particularly the case when using international studies because of definitional, methodological and cultural differences between different countries. Ideally, the studies we have identified should be subject to expert epidemiological analysis to derive a robust estimate range.

In the absence of that we have proposed a simple and transparent approach while acknowledging some of the main issues below for each of the 3 main studies.

Swedish Study[24]

Criticism: The study is based on a population of people who have been diagnosed with gambling disorder and have received some treatment, so that they are "more severe" than the wider population with undiagnosed gambling problems.

Answer: The study refers to people with a diagnosis of gambling disorder, however, it is not clear whether they have received or are receiving significant treatment. The study indicates a total of just over 6,000 hospital admissions or outpatient appointments across the 2,000 individuals. It also notes that for inpatients, only 29% had received a main diagnosis of gambling disorder "at some point" and for outpatients the figures was 66%. Therefore, it is not clear that this is a severe treatment group.

Furthermore, there is the implication that a treatment group are more "at risk" of suicide that the wider population defined as suffering from "problem gambling". Gambling with Lives is not aware of any evidence to support this assumption. In the UK only 2% of gamblers receive treatment each year: we know virtually nothing about the other 98%. Only a few of the young men lost by Gambling with Lives families received any treatment; none had a diagnosis of gambling disorder; all took their own lives. This experience suggests that the treatment population is not necessarily "the tip of the iceberg" but just "the bit of the elephant that we can currently see".

Therefore, we have proxied the relevant population for the UK as the estimated number of problem gamblers identified in surveys. It could be argued that "gambling disorder" is a higher diagnostic threshold than "problem gambler". The British Gambling Prevalence Survey[55] (2010) found that around two thirds of people scoring as "problem gambler" would have fitted the classification of "gambling disorder/pathological gambler".

Criticism: The study reflects the situation in Sweden

Answer: It seems that Sweden is more advanced than the UK in recognising and diagnosing gambling disorder. For example, the UK does not have a nationwide register of individuals with a diagnosis of gambling disorder. Sweden also appears to be ahead of the UK in its approach to gambling research: it has had 3 longitudinal studies dating back to 1997/98 whereas the UK has not yet even started a first study. However, the study recognises that only a small

proportion of people diagnosed with gambling disorder actually receive treatment, similar to the UK.

The state has a much greater role in the delivery of gambling, through the state owned *Svenska Spel*, but the levels and profile of gambling appears to be similar. Problem gambling rates appear to be slightly higher in Sweden than the UK. However, we do not identify major differences between gambling in the two countries that indicate that the Swedish study should not be used to provide an estimate for the UK.

UK Study[25]

Criticism: The UK study is only of 20-24 year olds, so cannot reflect the whole population.

Answer: An Australian study[56] found that the mean age of problem gamblers who have taken their lives is around 40, so that the 20-24 year olds figure may be an underestimate.

Criticism: It is a small sample size – 100 suicides

Answer: True and on its own the result could be treated with some caution. However, the result is in line with UK studies on suicidal ideation and attempts and gives an estimate at the lower end of the range that they would suggest.

NOTE: The study is **likely to be an underestimate** because:

- It is based on coronial evidence which we know has inadequate recording of causes of suicide, in particular gambling
- The study records gambling as a subset of financial issues. The GwL experience shows that deaths by suicide are not necessarily linked to financial problems.
- The team were not looking for 'gambling' as an issue connected with the suicides so, similar to coroners themselves, may have missed signs of gambling.

Hong Kong Study[26]

There is a powerful internal consistency in the study which indicates that pathological gamblers in HK have a suicide rate 17 times that of the general population. This is similar to the 15 times higher rate found in the Swedish study.

Criticism: Hong Kong is too different to the UK to be able to use the results.

Answer: What are the most important ways that HK and the UK are different that would affect gambling suicide estimates?

- Casinos are much more widely used in HK (in particular Macau) – however, UK figures don't indicate that casino gambling is more dangerous than playing EGMs in bookmakers or online; and 85% of HK gamblers report that Macau casinos have no influence on their gambling.

- Problem gambling rates are much higher in HK than UK – it is questionable just how different the rates are. The most recent PG rate in HK is 1.4% - comparable with the UK and less than the PG rate for younger age groups in the UK. We also suggest that PG rates are much higher in the UK than official figures show: gamblers spend their lives disguising and hiding their addiction, we question whether they are likely to be honest when answering questions in a survey. Further, the internal consistency of the study showing the suicide rate of pathological gamblers as 15 times that of the general population is completely independent the level of PG.
- Gambling may be seen as being culturally different in HK – but in what way is this likely to affect suicide rates – up or down?

Studies of Suicides Attempts

1. The review of 17 UK and international studies (1990 – 2019, see Table 1) which considered attempted suicides showed that an average of 20% of gamblers seeking treatment had attempted suicide … over 3 times the average of the general population.

2. The most recent UK study[16] (2018) showed that 30% of gamblers entering treatment in the UK in 2015 had attempted suicide … over 5 times the average of the general population.

   Applying this 30% to the approx. 10,000 gamblers receiving treatment and then using the estimated 10-25[57] attempts for each completed suicide => **120 to 300 gambling related suicides per year in the UK.**

   Arguably we should apply the 30% to a much higher figure of gamblers to reflect the numbers who should be receiving treatment. Gambleaware/GamCare aim to treble the number in treatment => **360 to 900 gambling related suicides per year in the UK.**

3. A Canadian study[23] (2015) reported that problem gamblers were nearly 18 times more likely to report a suicide attempt than non-problem gamblers.

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Addictive Gambling Products

Supporters of the gambling industry like to focus on apparently low population "problem gambling" rates, enabling them to portray the problem as being about a "few flawed individuals". This ignores the fact that gambling is not a homogeneous enterprise, but comprises a wide range of products which includes some which are highly addictive and dangerous which should not be available in their current form.

Although the gambling industry would avoid the term 'addictive' preferring words like "compelling", "engaging" or "absorbing", a number of product design elements are generally accepted to contribute to the level of addictiveness. These include:

- speed of play/event frequency/continuity of play
- stake sizes and prize structures
- probability and frequency of winning
- a range of design features – free 'spins', 'losses disguised as wins', lights and sounds

These features can be combined to produce highly addictive high speed electronic products known as:

- **Electronic Gaming Machines (EGMs)**
  - **Fixed Odds Betting Terminals** – with "problem gambling/at risk rates" over 50%
  - **Online slots and casino games** – with "problem gambling/at risk rates" over 45%

There is also increasing concern about new sports betting products being developed to replicate the high speed continuous betting experience of EGMs, known as:

- **In Game Sports Betting/Microbetting** – a recent Australian study found "problem gambling" rates of 78% for people engaged in microbetting.

In 2016, FOBTs were associated with over half of all "problem gambling" in the UK, despite being played by only 3% of the population.

FOBTs were the first product that the government acknowledged were too dangerous to be available on the high street. In 2019 the maximum stake was reduced from £100 to £2 which should reduce the amount of money which will

be lost. However, nothing was done to slow down speed of play and nothing was done about the equivalent products which are available on line.

While more research may be needed to establish the relative importance of different game features, we need to recognise that "we don't know nothing". Given the levels of harm arising from gambling disorder, including 250-650 gambling related suicides every year in the UK, we need to establish a "precautionary approach" whereby gambling products – like all other legally available products – should be proven to be safe before they can be marketed.

1. Background

"Determinants of the decision not to gamble not only include the gambler's biological and physiological constitution but also the structural characteristics of the gambling activity itself. Such characteristics may be responsible for reinforcement, may satisfy gambler's needs, and facilitate excessive gambling. Showing the existence of such relationships has great practical importance. Not only could potentially 'dangerous' forms of gambling be identified but effective and selective legislation could be formulated. … It is shown that structural characteristics of fruit machines ***have the potential to induce excessive gambling regardless of individuals' biological and psychological constitution*** [our emphasis] *and that such insights may help in decreasing fruit machine gambling's "addictiveness" potential and help in formulating effective gambling policy."* [1]

The above is taken from the abstract of a paper written in 1993, long before the term Fixed Odds Betting Terminal (FOBT) had entered public vocabulary. Instead the paper refers to "fruit machines" which perhaps conjures the image of an apparently harmless seaside attraction. Yet even back then the "addictiveness" of gambling products had been identified and the argument made that these products could addict anyone.

It is astonishing that some 25 years later, the Association of British Bookmakers, GambleAware and the Responsible Gambling Strategy Board were still arguing that there was no conclusive evidence that a reduction in the maximum stake size on FOBTs would reduce the harm that they caused! [2]

Why significant research had not been conducted in the intervening decades is not the subject of this note, but we would link it to the massive influence that the gambling industry had in setting the research agenda that the gambling industry and which it continues to exercise [3]. Instead the industry has successfully sold a model of "individual responsibility" with a small number of "vulnerable individuals" who just need identifying and treating … once they have developed their addiction. This has meant that there has been a plethora of

studies which examine individuals, their characteristics and behaviours, identifying "vulnerable" groups or evaluating individual level interventions to identify and help "problem gamblers". Meanwhile study of gambling products and the practices of the industry has remained woefully sparse.

We acknowledge that this type of research is difficult both practically and ethically. But more crucially it requires the active cooperation and engagement of gambling operators to share the vast amount of data that they hold on individual players across a whole range of products.

Until that happens, we need to recognise that "we don't know nothing". There is an increasingly common agreement amongst independent researchers about the range of structural characteristics of gambling products which are most important in determining addictiveness. While we may not have perfect information on the relative importance of different factors, we do know enough to be able to highlight particular products which need to be substantially altered or even withdrawn. We need to take a "precautionary approach" where the requirement should be that a product is "proven safe" before it is allowed to be marketed … to bring gambling into line with drugs, medical treatments and indeed any product which is sold to the public.

2. Addictive by Design

Gambling has taken place for hundreds, if not thousands of years, whether it has involved games of skill and chance, or betting on the outcome of sporting and other events. It has always been recognised that gambling can lead to serious problems for some people, though the tended to be conceived as being mainly financial which could have a range of other social or health consequences.

However, over the past 30 years gambling has changed beyond recognition with the development of high speed electronic games and the explosion of online gambling. So that today it is possible to bet at any time on any event around the world or play in one of thousands of online casinos – and all via the mobile phone in your pocket.

It has also been recognised that gambling can have serious impacts of people's mental health. Gambling disorder was classified as an addictive disorder in 2013 alongside drugs and alcohol addiction. Treatment for gambling disorder is now included in the NHS long term plan with 14 dedicated clinics due to open over the next few years.

The development of the modern gambling industry has changed the nature of the relationship between gamblers and gambling operators (who might once have been referred to as "bookmakers") and has also introduced a range of

highly toxic products and practices which have been deliberately designed to draw people into gambling and keep them there as long as possible. "Addiction by Design" is the title of Prof. Natasha Dow Schull's ground breaking book [4]; "Vicious Games" is the title of Prof. Rebecca Cassidy's recent book [5]. Both titles are chosen for good reasons.

3. Structural Characteristics

Although industry sources and developers tend avoid the term 'addictive' preferring words like "compelling", "engaging" or "absorbing", a number of product design elements are generally accepted to contribute to the level of addictiveness [6-11]. These include:

- speed of play/event frequency/continuity of play – time gap between each gamble and the time between placing the bet and the result (win/lose)
- stake sizes
- prize structures – number and value of prizes
- probability and frequency of winning
- free or bonus 'spins'
- 'losses disguised as wins' – signalling a win which is less than the amount staked
- skill or pseudo-skill elements – which may or may not be real
- near misses – results which are perceived as "nearly winning" but which are a loss
- physical design features – lights, colours, sounds, ergonomic features

As noted above, it is shocking that there has been so little research, particularly in the UK, to explore the relative importance of each of these features. However, there is substantial agreement that "speed of play/event frequency/continuity of play" are key features in the addictiveness of any gambling product. Certainly considerable effort is devoted by "game" developers to 'tweak' the design of their product to keep the customer playing and to extract as much money as possible.

There are a set of other important elements of the gambling experience and engagements with the gambling industry which are also deemed important when considering the development of continuation of addiction. These include:

- availability and accessibility – how easy is it to access gambling products and opportunities
- type of environment/establishment – online, high street shop, arcade, casino
- marketing and advertising – increasingly marketing is targeted at individuals based on the huge wealth of information that gambling operators hold on individuals

- free spins and bonuses – used to attract new customers or ‘reward’ existing customers to encourage them the bet more
- VIP schemes – where high spending (losing) customers are assigned a ‘manager’ to develop a faux friendly relationship involving invitations to events, gifts and ‘rewards’ to keep the “VIP” betting

All of these can make gambling more dangerous and prolong gambling.

4. Dangerous Products

As noted above “speed of play/event frequency/continuity of play” are highlighted as key features in determining the addictiveness of a gambling product. Therefore, purchasing a National Lottery ticket is generally not regarded as addictive since the customer may have to wait a number of days before getting the result of their gamble. Lottery scratchcards are seen as being more addictive since they are “instant wins” or losses.

a) Electronic Gaming Machines/Fixed Odds Betting Terminals (EGMs/FOBTs)

However, the weight of research generally acknowledges that Electronic Gaming Machines (EGMs), both online and land based, are amongst the most problematic gambling products in terms of addiction and financial harms [7,9,10]. Not only are these products recognised as being addictive, studies have also shown that addiction can set in very quickly [12] and the products themselves are associated with a higher suicide risk [13,14].

In the UK, the most commonly known EGM is the Fixed Odds Betting Terminal (FOBT). The equivalent product in Australia is called a ‘pokie’. Examination of the history of gambling in Australia shows that the growth and widespread availability of ‘pokies’[1] drove the huge increase in gambling and the inevitable problem gambling in that country [15].

In April 2019, the addictiveness and harm caused by FOBTs was eventually acknowledged by the government and as a result the maximum stake was reduced from £100 to £2. That change was symbolically important since it was the first time that a gambling product was recognised as being too dangerous to be readily available on the high street in its current form. However, no change was made to the speed of play and no changes at all were made to identical online products. We will have to wait on future evaluation to assess the impact that this limited change will have on the rates of gambling disorder.

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[1] ‘Pokies’ are the Australian equivalent of Fixed Odds Betting Terminals and are widely available throughout Australia.

b) In-game Sports Betting (Microbetting)

At one time sports betting was based around predicting the outcome of a horse race, football match or similar. Technological advances in placing and processing bets allowed gambling operators to identify the opportunity to let a customer bet on any aspect of an event in real time – called in-play or in-game betting or microbetting. Therefore, the customer could bet on the next goal, corner or yellow card in a football match or literally on every point in tennis. This allowed them the replicate the addictive features, such as speed and continuity of play, with bets possible every minute, turning a football match into a 90 minute non-stop gambling experience.

There is already some evidence of how addictive and dangerous this form of gambling can be, with "problem gambling" rates amongst Australian micro-better approaching a staggering 80% [16]. Football has been the huge growth area for in-game betting in the UK. This type of gambling likely to appeal to more people who may have no interest in the casino style games (which make up the majority of games on FOBTs) but love the game of football and also believe that their knowledge of the game makes this more of a 'game of skill' rather than the random chance of a casino game. Research shows that this is an incorrect belief. [17].

We believe that in-game sport betting will eventually be shown to be as addictive and dangerous as sports betting and that its impact on addiction rates could be even greater because of the wider appeal that it will be possible to generate. However, national statistics on these new products are not available, so the next section of this note focuses on established addictive products – FOBTs and their online equivalents.

5. The Addictiveness of FOBTs and their Online Equivalents

Table 1 shows the "problem gambling" and "at risk" rates of a number of different gambling products to demonstrate the degree to which particular products are associated with problem gambling. Supporters of the industry may attempt to argue that "problem gamblers" are attracted to particular products rather than the products themselves causing "problem gambling". However, when we consider the range of features which are associated with addictiveness and the different products, that looks a very thin argument.

It is also the overwhelming experience of Gambling with Lives families that EGMs were the cause of their children's addictions. Similarly there is widespread agreement amongst experts by experience of gambling addiction that these machines are both highly addictive and dangerous.

Table 1 – “Problem gambling” and “at risk” rates of several gambling products [18]

	“Problem gambling” %	“at risk” %	Total Rate %
Any gambling (excl National Lottery draws only)	1.6	8.5	11.1
Horse racing (not online)	3.3	14.1	17.4
Bingo (not online)	3.9	10.4	14.3
Machines in bookmakers (FOBTs)	13.7	39.2	52.9
Online gambling on slots, casino or bingo games	9.2	35.6	44.8

Addiction rates on FOBTs are well over 10%, and over 50% if the “at risk” population is included. The rates for the equivalent games online (but including bingo) are only slightly lower. The basic analysis in Box 1 below indicates that these products are associated with over half of all problem gambling in the UK. Fortunately, historically only a small proportion of the population have accessed these products, e.g. in 2016 only 3% of the population played on FOBTs and similar figures online [18].

Box 1. Calculation of proportion of all "problem gambling" associated with FOBTs

It is possible to do a couple of simple calculations based on the most recent (2016) gambling behaviour statistics [18]

Proportion of population who play FOBTs – 3%

Proportion of people playing FOBTs classified as "problem gamblers" (PG) – 13.7%

⇨ Proportion of <u>total</u> population who play FOBTs and are PG = 3% x 13.7% = 0.4%

Estimated population PG rate is 0.7%, this means <u>that over half of all PG in the UK is accounted for by people who play FOBTs.</u>

Similarly for online slots, casino and bingo

Proportion of population who play online slots, casino and bingo – 3%

Proportion of people playing online slots, casino and bingo classified as "problem gamblers" (PG) – 9.2%

⇨ Proportion of <u>total</u> population who play online slots, casino and bingo and are PG = 3% x 9.2% = 0.3%

Clearly there will be an overlap between those who play these products on FOBTs or online, so we cannot just add the figures together. However, it is clear that **FOBTs and their online equivalents account for substantially over half pf all problem gambling in the UK, despite being played by less than 5% of the population.**

This indicates that as the accessibility of these products increases with the growth and availability of online gambling, there will be a corresponding increase in the rate of gambling addiction. It is estimated that a 10ppt increase in numbers accessing the very addictive products could lead to a further 1% increase in problem gambling, more than doubling the whole population measure.

Unless action is taken to curb their availability and accessibility or to radically alter their design, the impact on problem gambling rates could be catastrophic.

Similar regulation needs to be applied to newer highly addictive products such as sports ‘microbetting’.

Learning Lessons from (In)action on FOBTs

A full account of the story of FOBTs from their introduced into betting shops in 1999 to the implementation of the £2 maximum stake in 2019 is given in a House of Commons Briefing Paper [2]. Almost from the outset concerns were expressed about the association of the machines with “problem gambling”, with GamCare noting in 2003 that there had been an increasing trend in their clients seeking help related to FOBTs. It was even at this early stage that the term “the crack cocaine of gambling” first appeared.

The 20 years before the change was introduced was characterised by a vigorous defence of FOBTs by the Association of British Bookmakers (ABB) calling on a range of (subsequently discredited) ‘research’ reports. Given that the reports were commissioned and paid for by the ABB, it is not surprising that they found no evidence ‘proving’ that FOBTs were in any way a cause of problem gambling. This ‘evidence’ was deployed within the overall ‘Reno’ model [19], proposed by researchers who undertook substantial research and consultancy work for the industry, which located the issue of “problem gambling” within a small number of individuals who were in some way flawed, but whose “problematic play” could be identified and appropriate interventions or treatments made.

The cause of the ABB was helped immeasurably by an apparent belief in the Department for Culture, Media and Sport, the Gambling Commission and the Responsible Gambling Strategy Board that it would be possible to conduct experiments and provide proof that could quantify the addictiveness and damage done by FOBTs. This was accompanied by silence from the Responsible Gambling Trust (now GambleAware) and GamCare, who chose to take a “neutral stance” in relation to the addictiveness of particular products.

It is beyond the remit of this paper to explore why these different organisations took the attitudes that they did or why none of them commissioned any significant research which might have given a clear view on addictiveness (but see [20]). However, it is notable that the industry was closely involved with all the organisations and wielded huge influence through their direct funding of organisations and research. And of course the industry could point to the billions of pounds paid in tax.

However, also over that time campaigners and independent researchers challenged the power of the industry and questioned the very basis of the ‘Reno’ model [21]. Over time there came to be a wider acceptance of the scope and level of gambling harms, and increasingly gambling came to be seen as a public health issue. However, it is still noteworthy that the introduction of the £2

maximum limit took the resignation of a highly respected and competent Minister, Tracey Crouch. Unlike the regulators and bureaucrats, she was aware of the damage being done which was attributable to FOBTs because she met people with major gambling problems in her weekly surgeries who identified the link. She had representations from people who worked in bookmakers and who reported the impact that these products had on customers. She spoke directly to "problem gamblers" and others who had suffered major harms because of gambling, including families who had been bereaved by gambling related suicides.

Over the course of the 20 years that it took to get the change to FOBTs, based on international evidence compiled by Gambling with Lives, it is estimated that some 10,000 people will have died in gambling related suicides. For a high proportion of them FOBTs will have been the prime cause of their initial addiction and for their subsequent catastrophic engagement with gambling.

We cannot allow a further mass social experiment and debate to be conducted before we take action on other highly addictive products. We must exercise a "precautionary approach" whereby gambling products must be proven safe before they can be marketed to the public. This would bring gambling into line with other legal products where there is a recognised risk: we would not consider introducing a new drug or car onto the market without it satisfying the most rigorous safety testing.

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Gambling Disorder – The Inadequacy of Prevalence Measures

Summary

This note challenges the use of an all-population "problem gambling" figure, typically quoted as "stable" and "under 1%", as an adequate portrayal of the prevalence of gambling addiction. It suggests that its use supports a focus on identifying and treating individuals rather than adopting a public health approach which requires a wider focus to include regulation on practices of the gambling industry and action on particular highly addictive products.

In fact the rate amongst those who gamble[2] is actually 1.7%. A better indicator, which reflects the fact that people move into and out of "problem gambling" and are harmed by gambling, shows that **at least 10% of people who gamble are likely to suffer "problem gambling" or be harmed at some time**[3].

Even this figure disguises the fact that **certain products are associated with extraordinarily high levels of addiction and harm**, and that some groups within the population, in particular children, are at greatest risk of developing gambling addiction.

Reporting gambling addiction prevalence for the whole population disguises the very high addiction rates for young people, particularly children and young men. A staggering **40% of 11-16 year olds who gamble are either addicted or at risk**. The addiction rates for young men aged 25-34 are 4 times the overall population rate.

Certain gambling products – essentially **Electronic Gaming Machines (EGMs) which underpin Fixed Odds Betting Terminals (FOBTs) and their online casino and slot equivalents – are highly addictive** but this is masked by quoting population "problem gambling" rates because of the low proportion (3-6%) who use them. These products have addiction and at risk rates over 50% and **are associated with over half of all "problem gambling" in the UK**.

Combining these findings on young men and specific products, the most conservative estimate of the addiction rate for young men playing EGMs is likely to be between a third and a half.

[2] Only 42% of people gamble, excluding people who do not gamble or gamble on the National Lottery only – see ref [3]

[3] Includes people classified as "moderate risk" or "low risk"- see ref [3].

The note also argues that the published estimates derived from population surveys are likely to be a substantial underestimates for a variety of reasons. We suggest that the **actual rates of "problem gambling" are likely to 2 to 4 times higher than those quoted publicly**.

Finally, the note examines the claim that the "problem gambling" rate has been stable since the 2005 Gambling Act. We suggest that it is difficult to produce a definitive statement on the stability of "problem gambling" rates, but that it appears that the **problem gambling rate amongst those who gamble has actually steadily increased by 70% since 2007** with a levelling out only in 2016. This suggests that gambling products and practices of the industry have become more dangerous.

Overall, this means that an effective public health policy to tackle gambling addiction must include a focus on the design and availability of some products and address the marketing and promotional practices of the industry.

1. The Problem – the Person or the Product

Justifying the gambling regulation status quo often takes the form of quoting a "stable" rate of "problem gamblers". Currently this is estimated at 0.7% of the whole population [1] who are portrayed as being potentially genetically different and identifiable through "patterns of play". It is argued that to disrupt the leisure gambling enjoyed by the "responsible" general population by taking wider action is to infringe liberty. Instead, this "tiny minority" can be identified by "algorithms" and directed towards restrictions or treatment interventions which will allow them to "gamble responsibly". Therefore, it is argued that there is no need to restrict the availability and accessibility of particular products or to address the marketing and upselling practices of the gambling industry.

Examination of the history of gambling in Australia shows that the growth and widespread availability of 'pokies'[4] drove the huge increase in gambling and the inevitable problem gambling in that country [2]. Therefore, an alternative view of the data is that the use of overall population figures and the conflation of gambling products mask the fact that some gambling products are highly addictive and that they are associated with over 50% of problem gambling in the UK.

The only reason that the overall population "problem gambling" rate remains low is that these products are used by only a small proportion of the population. Their increasing availability through the growth of online gambling and the

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[4] 'Pokies' are the Australian equivalent of Fixed Odds Betting Terminals and are widely available throughout Australia.

development of new highly addictive products mean that unless action is taken on product design and availability, overall problem gambling rates will increase substantially.

2. Presenting “problem gambling” rates.

Table 1 highlights that using the “stable 0.7% problem gamblers” statistic disguises the underlying problems and issues which need to be identified and addressed if we are to tackle the gambling as a public health issue. Portraying the problem as applying to a small minority of people – though it should be noted that minority still comprises hundreds of thousands of people – disguises the astonishingly high addiction and at risk rates associated with some products and for some groups of people.

Table 1 - Percentage of People Harmed by Gambling [3 and 4]

	"Problem Gambler" %	"At Risk" %	TOTAL %
1. All population	0.7	3.5	4.2
2. Gamblers (42% of population)	1.7	8.3	10.0
3a. Children (11 – 16)			
• All	1.7	2.7	4.4
• Children who gamble (11%)	15.5	24.5	40.0
3b. Young Men (24 – 35)			
• All	2.4	10.5	12.9
• Young men who gamble (66%)	3.6	15.9	19.5
4. Products			
• FOBTs	13.7	39.2	52.9
• Online casino/slots/bingo	9.2	35.6	44.8

Some commentary of the different rows in the table are provided below.

1. The overall population vs people who gamble (rows 1 and 2)

Presenting problem gambling prevalence for the whole population is misleading since it includes both people who never gamble and those who use only the weekly National Lottery draw, which is generally accepted as non-addictive. The proportion of the population who gamble (excluding the Lottery) is nearer to 42% [1], so that the rate of problem gambling amongst people who gamble is around 1.7%, not the widely quoted 0.7% for the whole population.

Other tables in the report [3] indicate that rates for "regular gamblers" would be around 4 times higher than the population figures. Around 13% of people gamble 2 or more times a week. So it is clear that gambling is a highly dangerous and addictive activity for the substantial number of people who do it on a regular basis.

2. “Problem gamblers” vs at risk gamblers (columns 2,3 and 4)

Population surveys represent a snapshot of a moment in time and the assumption that they indicate a stable estimate of the number of people who suffer from problem gambling is misleading. It is widely recognised that the severity of gambling disorder is episodic and varies substantially over time. An individual who has experienced major gambling problems may not be classified as a problem gambler at the time of a survey but could ‘relapse’ the next day, week, month or year [5,6,7,8]. Some attempts to recognise this are made in population surveys by recording individuals as “moderate risk” or “low risk” gamblers.

Typically population surveys classify 5 times more individuals as at risk than addicted, so that it is arguable that a more appropriate estimate of the “problem gambling” prevalence rate is around 10% of those who gamble (6 x 1.7%).

Longitudinal studies are required to improve understanding of the development and life course of gambling disorder and enable a more thorough analysis of these numbers. However, a true assessment of the scale of gambling harms should be based on the proportion of people who as classified as “problem gamblers” or “at risk”.

3. Population Subgroups (row 3)

There have been a substantial number of research projects which attempt to identify people who are more likely to develop “problem gambling”. Most of these studies are based on data sets which are inadequate for identifying what are the real risk factors. Most contain only basic demographic and health information but nothing about an individual’s history of engagement with gambling (eg. products used, where, when, environment, win history, etc.) or their personality, family circumstances, community relationships, life events, etc. Some studies which have included a wider range of factors have identified “cheerfulness” as a risk factor for developing “problem gambling”! [9]

Most of these quantitative studies fail to provide information on how “good” they are at identifying individuals who are most “at risk”. This note is not the place to explore the intricacies of quantitative modelling analysis, but it is important to note although a factor might be identified as “statistically significant” it does not mean that it is <u>important</u> in terms of how much it explains. The few studies which do show how much is explained by the various factors identified still show that the vast majority of what appears to be linked to addiction only explains a tiny proportion. In other words the models are not very good at predicting who might be addicted – rather it could be anyone. Finally, quantitative analysis doesn’t even claim to identify “causality” (as opposed to “association”) or attempt to explain why a particular factor might be important.

However, there are some factors which even a basic statistical presentation show should be examined to understand the process of addiction and which also allow some targeted activities and interventions.

It is clear that young people (aged 11 to 16) and young men (aged 25-34) are both groups at high risk of developing gambling addiction.

a. For young people aged 11-16 (for whom gambling is actually illegal) the population PG rate is 1.7% [4]. Given that only 11% of young people aged 11-16 gamble, this means that a staggering 15.7% of young people who gamble are "problem gamblers". Given that a further 2.7% are classified as at risk, 40% of 11-16 year olds who gamble are either addicted or at risk.

b. All surveys identify that problem gambling rates are much higher in younger age groups than the overall population. The most recent estimates for Great Britain [3] show that while the overall population PG rate was 0.7%, the figure for young men aged 24-35 was 2.4% - nearly 4 times the population figure. Around two thirds of this group gamble, so that 3.6% of 24-35 year old men who gamble are "problem gamblers". This figure increases to nearly 20% if we include the "at risk" group.

4. Products (row 4)

People who are not involved with gambling may retain an image of it being based around people "having a flutter" on the horses or betting on who will win a football match in their local bookies, or doing the pools and of course the National Lottery. However, the past 25 years has seen the rapid development and rise of a whole range of new electronic gambling machines (EGMs), the most infamous of which are probably the Fixed Odds Betting Terminals (FOBTs). However, technological advances have also seen the arrival of instant "in play" bets meaning that a gambler can bet on virtually any aspect of any game in any country at any time: this means that a football match anywhere in the world becomes a 90 minute permanent gambling experience.

Although industry sources and developers would never use the term 'addictive', preferring words like "compelling", "engaging" or "absorbing", a number of product design elements are generally accepted to contribute to addictiveness. These include speed of play, continuity of play, stake/prize sizes, 'losses disguised as wins' and a range of physical design features. [10,11,12,13]

These features and the products involved are discussed in more depth in the Gambling with Lives companion paper *Addictive Gambling Products*. However, another consequence of quoting population "problem gambling" statistics is that it disguises the fact that gambling is not a single homogenous product and that hidden within the overall product range are some products which appear to be highly addictive. Certainly they are associated with incredibly high rates of addiction and risk.

a. FOBTs were the first gambling product that the government recognised as being too dangerous to be available on the high street in their current form. In recognition of this, in April 2019 the maximum stake was reduced from £100 to £2. This change happened only after many years of campaigning and strenuous attempts by high street bookies to hide the scale of the problem. Row 4 of the table shows the addiction and at risk rate of these products is over 50%. FOBTs have by far the highest simple "problem gambling" rate of any gambling product – more than 4 times the rate for betting on horse races.

b. However, the same products remain available online with no limit to stake sizes. The addiction and at risk rate of online casino games and slots is just under 50%.

Analysis presented in the *Addictive Gambling Products* paper shows that FOBTs are associated with over half of all problem gambling in Great Britain. Fortunately only 3% of people actually used FOBTs, otherwise we could be looking at substantially higher population addiction figures. But it is clear that FOBTs and their online equivalents must be the subject of detailed investigation. Meanwhile, we should take a precautionary approach and introduce further restrictions on their format and availability.

At present, published statistics do not show figures for addiction rates for people who use in game betting products, but there are indications that these are likely to be even higher than either land based or online EGMs. [14]

3. Rates are probably much higher than official published estimate.

There are other considerable methodological issues in estimating the rate of gambling disorder across a population, which inevitably lead to any figures being underestimates. [2]. In particular:

- gambling addiction is recognised as the "hidden addiction" where addicts hide their disorder from family, friends and themselves, so that the accuracy of tick box self definition is highly questionable

- clinical addiction severity tools requiring a detailed discourse between treatment specialist and patient are not suitable for self-completion or use by a medically unqualified researcher and will underestimate "problem gambling" [15]
- certain key populations with known high problem gambling rates (e.g. prisoners, armed forces, homeless, students) are generally excluded or under-represented

It is also instructive to learn from estimates which have been made in other fields of health and social research. Population estimates of other "hidden" or "socially unacceptable" conditions such as smoking, drugs and eating disorders indicate that actual addiction rates may be 2-4 times higher than population surveys suggest [2,16,17,18].

This 'multiplier' rate is useful when considering any of the figures presented in this note.

4. Are "problem gambling" really stable?

Supporters of the status quo on gambling regulation are always keen to say that, despite the "liberalisation" of gambling in the 2005 Gambling Act and the increase in the amount and types of gambling that followed, the rate of "problem gambling" has remained stable.

In fact it is difficult to assess the truth of this situation – partly because of changes in the approaches used to assess "problem gambling" rates and partly because of the sample sizes involved do not allow statistically significant changes to be confirmed. However, the increasing dangers associated with gambling have also been disguised by the use of the "all population" figures, rather than the rate amongst people who gamble.

Table 2 – Problem Gambling Rate for All Population and for Those who Gamble

Survey and Year	Pop. PG Rate %	Proportion Gambling %	Gamblers PG Rate %
BGPS			
• 1997	0.6	46	1.30
• 2007	0.5	48	1.04
• 2010	0.7	56	1.25

Country Health Surveys • 2012 • 2015 • 2016	0.6 0.8 0.7	43 45 42	1.39 1.78 1.67

Estimates of "problem gambling" rates for 1997, 2007 and 2010 were derived from the British Gambling Prevalence Survey (BGPS) [19]. This was a custom designed survey which provided data on participation in all forms of gambling in Great Britain, the prevalence of problem gambling and attitudes to gambling. The survey was abandoned after 2010 and estimates of gambling behaviour have been derived from a more limited set of questions in the annual country health surveys conducted in England, Scotland and Wales.

It is widely accepted that substantial changes to data gathering and survey methodology inevitably have consequences on comparability of results over time. Therefore, we have to accept that there is a "data discontinuity" between 2010 and 2012 and that in fact we have two very short time series of comparable data. These both show increases in "problem gambling" rates. Very few of the changes were statistically significant – though it needs to be recognised that testing significance of 'rare events' using relatively small samples is tricky methodologically.

However, it is also instructive to look at the "problem gambling" rate amongst people who gamble (other than those who gamble on just the National Lottery). It is arguable that this figure gives the clearest indication of how dangerous and addictive gambling products are becoming. The fourth column in table 2 shows that this has increased steadily from 1.04% in 2010 to 1.78% in 2015 - this is an increase of over 70% in an 8 year period. The table shows a drop to 1.67% in 2016, but this still represents an increase of 60% over a 9 year period.

Despite the changes in survey methodology, likely problems in accuracy of any estimates (explored in section 3) and issues of statistical significance this simple analysis certainly poses a very substantial question mark over whether "problem gambling" has remained stable since the 2005 Gambling Act.

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Expanded Answers to Committee Questions

House of Lords Select Committee on the Social and Economic Impact of the Gambling Industry (25th February 2020)

Liz and Charles Ritchie, and Jo Holloway gave evidence to the HoL Select Committee on Tues 25th February, 2020. The Committee asked for some additional evidence. This has been supplied in a number of notes.

This note briefly expands on 2 of the questions which members of the Select Committee asked during the formal evidence session held on 25th February 2020. We ask that the Committee considers this extra information alongside the answers recorded in the transcript. Unfortunately the evidence session was not able to run for the allotted time and on reflection we felt that our answers to these 2 questions were rather hurried and lacked clarity.

Q175 **The Lord Bishop of St Albans:** Where are the gaps in the research that we need to fill?

Additional Response:

I would like to summarise the key areas of research which need to be addressed. This does not represent a complete picture of research which is required, rather they are some of the key areas that we have identified as directly arising from our work and investigations.

1. **Suicide and Gambling** – it is clear that there is a long established link between gambling and suicide (and we have provided an additional note on this). However, to the immense frustration of GwL families, there is still no robust assessment of the number of gambling related suicides each year in the UK.

   We believe that one of the greatest contributions that GwL has made to the debate and campaign for better regulation of gambling is that we were the first people to highlight the undeniable link and provide an estimate of the scale of gambling related suicides in the UK (250-650 deaths per year). We also provided proof that these deaths involved "bright, happy, ordinary young people from happy families with great futures ahead of them". The young people dying did not have a range of mental health or social issues; the deaths did not all involve high levels of debt; all the young people had started gambling as children. The clear message is that gambling can kill anyone.

   In our earliest meetings with those responsible for gambling regulation, research and treatment providers the link between gambling and suicide seemed to be a revelation and certainly none had any appreciation of the number of deaths. One of our earliest demands of the Gambling Commission and GambleAware was that they should commission a significant quantitative study of gambling and suicide, probably along the lines of the "psychological autopsy" study which formed the basis of the Hong Kong study referenced in our paper.

Some 2 years later, the only study on gambling and suicide which has been commissioned was a small scale exercise involving analysis of the 2007 Adult Psychiatric Morbidity Study. While the study confirmed the higher suicidal ideation and attempts associated with "problem gambling" and identified gambling as a factor in suicidal ideation and attempts even after all other factors were accounted for, this is a totally inadequate response to our demands and the need for us all to know the scale of deaths.

The lack of progress on commissioning any significant research on quantifying gambling suicides highlights a major concern that many people involved in campaigning for the reform of gambling regulation and gambling researchers: the industry still exercises huge influence on those responsible for regulation, education and treatment. The message that gambling contributes substantially to suicides in the UK would provide a massive impetus for change.

In addition to a large scale quantitative study, we would also seek a wider research programme to understand more the motivation and development of suicidal thoughts and attempts which are related to gambling.

2. **Products and Practices** – we have provided a separate note on which products are most addictive and dangerous. That note explores some of the reasons why there has not been adequate research to understand the addictiveness of some products and what characteristics underlie this. Similarly, there is even less research on the impact of a range of practices of the industry including:

    - targeted marketing and advertising
    - inducements such as free bets/spins and bonuses
    - VIP schemes
    - affiliate marketing
    - lack of affordability checks
    - deposit limits
    - time limits
    - methods for identifying "problematic play" and interventions

    This research will require that gambling operators engage fully in the research by providing access to the massive sets of data which they hold on customers. See below requirement for an **Independent Data Repository.**

3. **Longitudinal Studies** – there is a desperate need to be able to understand the development and progress over time of gambling disorder. Currently UK studies have to rely on "cross sectional" data sets (ie. surveys taken at a particular point in time). This allows some exploration of links between different factors, but it is virtually impossible to be able to study "cause and effect" without a longitudinal study.

    Sweden has a long running longitudinal study which is partly enabled by the fact that gambling disorder is diagnosed within primary care in Sweden so that it is possible to identify a group of people to be able to follow over time. However, it is necessary to conduct longitudinal studies which include people not diagnosed with gambling disorder in order to eb able to understand the development of the disorder.

A major problem with longitudinal studies is the cost and length of time that it takes to get any meaningful results. However, we feel that it is essential to establish a substantial **population wide study** and number of **targeted longitudinal studies** in order to understand the effectiveness of:

- **treatment interventions** – there is a lack of rigorous monitoring and follow up of patients receiving treatment for gambling disorder to understand what treatments work and what further support may be required; we have concerns that some treatments may even be "contra-indicated". (See additional notes provided on treatment).
- **education interventions** – there is a shocking lack of rigorous studies to understand the impact of the very limited set of 'educational/awareness' activities which take place with children and adults; programmes are currently being offered with little theoretical basis and no proof of long term impacts and outcomes.

4. **Independent Data Repository** – gambling operators hold a massive amount of data on all aspects of their customers. This data is a very powerful resource in terms of being able to understand an individual's engagement with gambling, including the development of serious problems. It also holds the clue to what products are the most dangerous and addictive.

   We recognise that this data is both individually and commercially highly sensitive. But we believe that independent researchers should have free access to an anonymised version of this data set in order to be able to undertake a wide and powerful set of studies. We also recognise that it is a substantial undertaking to establish and maintain such a data set.

   Therefore, we recommend that an **Independent Data Repository** should be established. We also recommend that gambling companies should be required to supply data to the repository in an agreed format as part of their licensing conditions. We are aware that there has been an initial feasibility study of such a repository, undertaken by at Leeds University. We commend this report to the Committee.

5. **Research Structures** – in addition to the suggestions for research to be carried out. We believe that changes do need to be made to the basic structures and processes for commissioning gambling research as follows:

   - **Independent funding of research through a statutory levy on the gambling industry** – we believe that the inadequacies of the research programme around gambling is largely due to the influence of the gambling industry in both determining the content and scale of the programme. This must change. The statutory levy should be used to pay for research, education and prevention, and treatment and needs to be administered completely independently of the industry.
   - **Gambling research centres** – the gambling research community in the UK is far too small. This is partly due to the funding and reputation of gambling. We believe that a small number of gambling research centres should be established – probably linked to universities. This would allow both the development of a healthy and diverse gambling research community and access to a pool of expert researchers who

could provide ‘immediate’ advice for policy makers, regulators and others.

- **Open call for research** – however gambling research money is allocated, we believe that one element should be an open call for research proposals. While it is sensible to construct a research programme to meet the identified needs of policy makers, we need to recognise that researchers, experts by experience of gambling harms and others are likely to be able to identify issues for research based on their own detailed knowledge of gambling and gambling harms. We believe that there should be an open call for research ideas against a substantial fund allocated from the statutory levy.

Q182 **The Chair:** Give us your best single recommendation.

In addition to Charles Ritchie’s call to say that the industry cannot be left to self-regulation and that it had “demonstrated its inability to implement change without pressure from outside”, he would like to have added:

“A key illustration of the industry’s inability to implement change is the example of GAMSTOP. Back in 2013 the development and implementation of GAMSTOP was handed over to “the industry” by DCMS and the Gambling Commission.

By a terrible coincidence, on the 23rd November 2017 – the day after our son Jack had taken his own life because of his gambling addiction – Lord Browne had secured a debate in the House of Lords on online gambling. During the debate he referred to the fact that during the debate in 2014 he had been persuaded to withdraw his amendment to require a ‘multi operator self-exclusion scheme’ for online gamblers with the guarantee that this was in hand and that substantial progress would be made in 6 months. In fact development took a further 5½ years.

Now in 2020, the Gambling Commission has only just introduced the requirement that online operators must sign up to the resulting product GAMSTOP. There are still concerns about its reliability. It is inconceivable that a multi-billion high tech industry could not develop a self-exclusion tool within months if it had been to their advantage. However, they prevaricated and dragged their feet delaying implementation for 5 years.

If they and the Gambling Commission and DCMS had developed GAMSTOP in anything approaching their promised timescale, our son Jack would have been here today.

This is not an industry that can be relied upon to “do the right thing” or to do it quickly enough. The days of light touch and inadequate regulation must be consigned to the past.

The transcript of the HoL debate on 23/11/17 can be found at:

https://hansard.parliament.uk/Lords/2017-11-23/debates/4939B7F6-844C-40C0-A420-38E931AE7DDB/OnlineGambling

The key extract is as follows:

“My first engagement with online gambling came in 2014, when I responded to the Gambling (Licensing and Advertising) Act, which was narrowly concerned with online gambling. During the debates on the Bill I argued that online problem gamblers are discriminated against because they cannot access one of the main protections for problem gamblers—self-exclusion—on anything resembling a level playing field with offline problem gamblers.

…

In response to this I proposed, through amendments, multi-operator self-exclusion, whereby the online problem gambler needs to self-exclude only once with the Gambling Commission or its nominated body, and all online sites with a Gambling Commission licence are required to respect the self-exclusion. On Report the Government announced that they were finally persuaded of the need for multi-operator self-exclusion, but explained that they did not want to implement it on a statutory basis. I was asked to withdraw my amendment on the basis that the Government had asked the Gambling Commission to introduce multi-operator self-exclusion and it would make substantial progress towards its realisation in the next six months. Mindful of the Government’s willingness to compromise, I decided to withdraw my amendment. In June this year it was finally announced that the Remote Gambling Association would run multi-operator self-exclusion—or MOSES, as it is now referred to—for the Gambling Commission, and that it would be called GAMSTOP and would be up and running by the end of the year.

As we address this subject nearly four years later, I make the following points. …

First, it is regrettable that nearly four years on from when the commitment was made we still do not have multi-operator self-exclusion up and running. We cannot afford to waste any more time.

Gambling with Lives Evidence to the House of Lords Select Committee on the Social and Economic Impact of the Gambling Industry

Gambling Disorder Treatment

This evidence describes expert by experience concerns regarding the treatment system for gambling disorder. The Gambling with Lives (GwL) families, bereaved by gambling related suicide, believe that lost family members who were suffering from gambling disorder would be alive today if they had been provided with appropriate referral and adequate treatment. GwL Trustees include people with Director level experience in NHS commissioning, Consultant NHS clinical (mental health) experience, and senior Civil Service research experience.

Following the deaths the GwL families have been through a process of attempting to learn about the current system and provision. Our standpoint has been to request information from the current commissioners and providers - Gamble Aware, GamCare and the NHS. We aim to collect evidence and to engage in constructive debate in order to improve services and save lives. To date our experience has been one of a systematic refusal to provide answers and documents from GambleAware and GamCare. In contrast the NHS have been collaborative, prompt and informative. However, it is also clear that the NHS and CQC have not had the remit or the political backing to take a systemic overview or to raise concerns about safety.

During the past two years we have raised concerns multiple times with Ministers, the APPGs on Gambling Related Harm and Suicide Prevention, NHS England, the CQC, the Gambling Commission, GambleAware and GamCare. We have become increasingly frustrated with the systematic refusal to listen to bereaved families and the organisational inertia that continues to fail to prevent deaths.

It has also become clear that Gamble Aware and GamCare continue to promote their organisations as "expert" commissioners and providers despite the safety concerns we and others have raised which we believe is inappropriate, undemocratic and clinically unethical.

This paper describes our broad conclusions and recommendations and follows the attempts to find answers. Although this paper details our concerns about the current system, of course as retired senior NHS professionals, we have ideas about solutions to contribute to the debate – but we leave those for a future paper.

Conclusion and recommendations

- At GwL we have come to the conclusion that the current system of treatment of gambling disorder in the UK has been and is still totally inadequate in commissioning, specification and provision and in our view this continues to result in avoidable deaths.
- GwLbelieves that only the NHS can provide the systematic pathway analysis, commissioning and clinical accountability for national treatment for such a prevalent and life-threatening condition. We believe that there

is an urgent need for NHS England to set up a pathway working group to provide clear instruction to primary and secondary care about referral pathways and the nature of provision for disorder severity tiers. GwL will be writing to NHS England and DHSC to request that this is done.

- GwL believes that it is inappropriate and unethical for small charities funded by the industry that creates the life-threatening illness that they attempt to treat, to promote themselves as more expert than the NHS in pathway design, service commissioning and provision. We believe that if the NHS had the remit to develop a comprehensive system integrated with the existing robust structures, the true level of harm and need for services would be revealed. It is difficult to avoid the conclusion that there may be vested interests at work in suppressing this information.

  GwL believes that the services currently provided by GamCare and its sub-contractors, commissioned by GambleAware, do not meet the needs of people experiencing gambling disorder, and may be contraindicated given that most, possibly all patients currently referring are more than double the threshold for psychiatric diagnosis and treatment. In summary this is because:

  - we have not been provided with evidence of assurance procedures, robust governance or adequate clinical quality control systems,
  - we have not been provided with evidence that the GamCare Helpline (currently the main referral pathway mechanism) has triage criteria or staff with the competencies and clinical support required to fulfil the specification to screen and triage to appropriate treatment,
  - specifications do not offer evidence of a model of gambling disorder that is compatible with the evidence based NHS model and that includes the nature of addiction to gambling, the role of the environment in the creation of the disorder, the need for abstinence or the risk of suicide
  - there is evidence that the development of a coherent pathway design could be disrupted by lack of collaboration and that GamCare (currently the most highly funded provider in the system) may be acting as a rival provider to the NHS.
  - the reliance on discretionary funding from the gambling industry appears to create an inappropriate dependence on the industry, constraining the charities for fear of losing funding, leading to the failure to be explicit about the full extent of harms, causes of harms and risk to life

1. The NHS

NHS commissioning and provision has been restricted to providing accommodation for one clinic in London until this year. Although specialist clinics are now being commissioned with funding from the NHS Long Term Plan (albeit minimally), this still does not include any systemic pathway plan that covers primary care including a complete failure to include systematic GP training. GP failure to diagnose gambling disorder has directly resulted in deaths

and will feature in the inquest for Jack Ritchie for which Article 2 of the Human Rights Act is engaged.

A comprehensive NHS plan from primary to specialist care was indicated by the BMA scientific committee in 2007 (Ref 1). As far as we can see there has been a complete failure to implement these recommendations and this failure has cost many lives – probably thousands – including lives of family members of the GwL families.

The DCMS Consultation on proposals for changes to Gaming Machines and Social Responsibility Measures (October 2017) (Ref 2) presented information about apparently comprehensive provision in primary care (including a GP diagnostic tool), specialised mental health services and local authority addiction services as well as the IAPT programme. As far as we can see this information is not based on evidence of commissioning or service specification by DHSC. This information also seems to be based on a lack of recognition of the specialist requirements of services required to deliver treatment to life-threatening serious psychiatric conditions.

2. Gamble Aware and GamCare

Currently the main commissioning and provision is from the third sector – Gamble Aware and GamCare and in the view of GwL these organisations are not fit for purpose on multiple grounds. These include the following:

2.1 Lack of democratic accountability to the State.

The usual commissioning and governance systems that normally provide assurance on NHS treatment for life threatening conditions are not in place and there is no overview and scrutiny of the current gambling treatment system equivalent to the health service which is accountable to the Secretary of State for Health and Social Care. We have not received evidence that the following mechanisms of scrutiny are in place:

- Open Board meetings and published papers.
- Non-executive directors and governing bodies including lay members.
- Robust service user groups and voice.
- Public sector procurement processes and monitoring and scrutiny from commissioners.
- A Patient Advisory and Liaison Service to consult.
- Local Authority and elected members, through defined processes.
- Oversight by and accountability to the Care Quality Commission, NHS Improvement, NHSE, DHSC and ultimately Parliament.
- Ombudsman capable of overseeing treatment complaints
- An embedded culture of learning from mistakes in the interests of service improvement

So families who have lost family members have found that it is not clear who is accountable for treatment failures. GamCare is funded by GambleAware, which states it is a quasi-public sector body, following best practice in health and social care commissioning. GamCare states that it is the largest provider of support and treatment for those affected by gambling harms. However, it seems that GamCare is also a secondary commissioner. GambleAware passes money to GamCare, who then commission a variety of 'partners' to deliver treatment (it is

not demonstrated what value is added by having GambleAware commission GamCare to commission others, what administrative costs this creates, and how accountability works between these two commissioners). That GamCare is not transparent regarding these commissioner and provider relationships and does not publish disaggregated statistics for different providers in its network, gives further concern regarding accountability arrangements. The provider network is extremely opaque with no clarity as to variation between providers in outcomes, quality and access.

In line with the requirements for transparency of public sector bodies Gamble Aware and GamCare should provide documents and data when requested. Instead, engagement with GwL has been characterised by generalised statements of intent, failure to provide evidence and increasingly aggressive defence of the status quo. Despite repeated requests, both organisations have declined to provide any evidence of any of the above mechanisms. We have not seen evidence of quality assurance, continuous improvement processes or involvement of people with lived experience, and there is no external validation of the generalised statements of reassurance provided. It would be helpful if these charities could provide evidence of being learning organisations by providing information on frequency of situations which have resulted in a change to algorithms and processes.

In the experience of families bereaved by suicide, it would appear no one is accountable or considers themselves responsible. Small charities with unreliable funding cannot be expected to provide the appropriate clinical governance and legal assurance necessary for national commissioning and provision on this scale and severity. GwL believes that the continued promotion of these organisations as appropriate and adequate for this task is unethical. It is a fact that you cannot run a national treatment system safety and effectively on c£10 million per annum, and making claims of competence, equivalence, quality and outcomes is at best naïve and dangerous. This is misleading the public and putting lives at risk.

2.2 Gambling Industry influence

Currently all gambling treatment third sector providers are reliant on gambling operator money. GamCare receives industry money from GambleAware and also directly from operators. This kind of discretionary funding leaves the treatment system subject to a lack of stability and creates a dependence and accountability only to the gambling industry.

There seems to be a reluctance to be transparent about the number of GamCare Board members who have links to or who have come from the gambling industry. This is not to disparage the individuals, but simply to note the lack of transparency and acknowledgement of potential conflicts of interest and it is hard not to feel vested interests are being defended at the expense of the people these charities are meant to serve. Currently GamCare has two Board members with a background in addictions, and the other five come from commercial backgrounds. Of course, commercial experience on a Board can be useful to charities particularly those dependent on raising money from industry. However, backgrounds in big business, finance, pharmaceuticals, oil and gas, leisure, alcohol and gambling are likely to influence worldview and consequently decision-making. Importantly, those that defend GamCare's existence are not

suitably qualified to do so, from legal practices to individual consultants making profit themselves from gambling operators.

To be specific about GamCare Board links to the gambling industry:

- John Hagan has been GamCare Deputy Chairman, for 14 years, since 2006. He is a founding partner of the law firm Harris Hagan, whose is business is gambling law, compliance and regulation – for an industry notorious for lack of compliance. The firm's website provides quotes praising the firm for its 'understanding' of the Gambling Commission and what operators want. The website states: '*We view ourselves as a business within the gambling industry, which happens to be a law firm, rather than external advisors to the gambling industry. Our future success and sustainability is inextricably intertwined with that of the gambling industry*' (Ref 3)
- GamCare chairman Sir Ian Prosser was Chairman and CEO of Bass plc (Ref 4), brewery, hotel and pub business, which owned Coral the bookmakers.
- Dominic Harrison worked for Bass plc '*before joining Ladbrokes in 2002 as Commercial Director. He spent nearly a decade in the gambling sector becoming CEO of Gala Coral in 2008*'. (Ref 4) He worked with Neil Goulden, who was executive chair of Gala Coral, and chair of the Association of British Bookmakers while being chair of GambleAware – at the time the organisation attracted criticism for providing research it claimed did not support a reduction in FOBT stakes.

2.3 The Responsible Gambling Model

In the experience of GwL families GamCare and GambleAware have systematically refused to engage with expert by experience views on the reduction of stigma and the role of the "responsible gambling" model in increasing the risk of suicide. The model of gambling disorder promoted by both charities does not include the role of environment (including product characteristics and availability or industry practices) in initiating and progressing addiction and in triggering relapse. A cursory look at the GamCare website, including messages to those seeking help, information on treatment and training, self-help materials and Safer Gambling Standards for industry, are all within the framework of 'responsible gambling'.

Addiction is framed as an individual problem related only to personal psychology and relapse is seen as triggered by personal failures of impulse control. GwL families view this "individual responsibility" model as implicated in the deaths of their family members who in their suicide notes took sole responsibility for their addiction although they were addicted as children to products and in environments that they and their families were told were "safe".

GamCare continues to state publicly that for the organisation to comment on addictive products and predatory practices would be "campaigning". It is a strange position for a charity to take – to state that it has no comment on that which causes harm to its beneficiaries – no judgement about gambling industry practice and products which cause harm to those the organisation purports to treat and support. We believe that it is disingenuous to characterise this position (which in the past has included a formal Board position of neutrality on FOBTs) as "supportive" to addicts and as an attempt to minimise stigma and encourage people to seek treatment. Our view is that it is an attempt at sleight

of hand to place this within the received therapeutic "non-judgemental" standpoint and to refuse to listen to the loud voices of bereaved families and recovering addicts which say that the opposite is the case. We all have attempted to tell these charities that a shared allocation of responsibility with industry and state and understanding of the role of addictive products and predatory practices would go much further to remove stigma and decrease the self-blame that characterises addictive suicidal ideation. Self-evidently gambling companies are accountable only to shareholders and have an ultimate commercial imperative. It is difficult to avoid the conclusion that the inappropriate structure of funding limits the ethos and actions of both charities and makes them unable to speak publicly about the role of addictive products and predatory marketing practices in the creation of the next generation of addicts and the increase in severity of addiction in the already addicted.

We note that the large gambling corporation GVC has funded GamCare and YGam to provide youth education. This education is also in the responsible gambling framework, unchallenging to industry and its extensive investment in normalising gambling, capturing and grooming a younger generation.

2.4 Conflicts of Interest

- GamCare accredits gambling companies with its Safer Gambling Standard. Gambling companies use a GamCare kitemark as endorsement of their 'safe' practice, for the very people who go on to be harmed, and then come to GamCare for treatment. It is hard to see how this does not constitute a conflict of interest. It appears GamCare has signed off operators in the past who have received substantial regulatory settlements, while some on the list of those currently accredited are likely to be met with dismay by Experts by Experience. (Ref 5)
- Gamble Aware's outline specification of gambling treatment services (Ref 6) clearly attempts to outline a National Treatment model containing all levels of treatment that mirror the stepped care model for mental health treatment tiers 2 – 4 while there is no evidence that the organisations have made adequate links into existing NHS systems.
- GwL believes that there is evidence of a clear conflict of interest in allowing GamCare to be commissioned to provide the National Helpline which is the main referral point into the system which now includes the NHS specialist clinics in London, Leeds and Manchester and others proposed as part of the DHSC long term plan. In the absence of a systemic NHS owned pathway and by serving as the primary point of triage and access to gambling treatment services, GamCare determines the triage system, the number of referrals into the partners the organisation commissions and the number of people who are able to access NHS treatment. The service proposal for the Leeds NHS clinic specifies the severity score which indicates psychiatric diagnosis and requires NHS referral. The severity score of service users currently accessing GamCare commissioned services is more than double this threshold. However, the NHS have recently confirmed in a letter to GwL (March 2020) that there have been no referrals into the Leeds clinic from the helpline.

- The apparent failure of GamCare to implement the GambleAware service specification for helpline provision and triage seems to provide further evidence of a conflict of interest surrounding the helpline. Although the Gamble Aware specification references a triage and referral system it seems that the helpline advisors are not qualified or registered which would indicate competence to undertake the clinical steps necessary to screen including assess risk and refer on with appropriate clinical information. There seems to be confusion between the operation of a general helpline (which can be accredited by the Helplines Partnership) (Ref 7) and specialist mental health or clinical triage with crisis operating standards. The NHS runs a health helpline – NHS 111. This is not comparable with the GamCare helpline. NHS 111 has algorithms, follows NICE guidelines and has a pool of clinical advisors and senior clinical advisors. NHS111 is intertwined with the NHS pathway, so clinical decision making is prompt, efficient and responsive to risk, including risk of immediate harm. In conversations with GamCare there also seems to be a worrying confusion between management and clinical escalation and risk management – having a manager on call for helpline operators who are alone at home is not the same as NHS procedures which include at hand cover by senior clinicians.
- GwL have repeatedly asked for the triage criteria used by the helpline, for the suicide protocol used and for the number of referrals to which service. We have had no answers to these questions or evidence that people are getting the right care. GwL are concerned about current statements from GamCare that seem to reframe the triage criteria for referral into NHS service or GamCare commissioned partners as determined by case complexity rather than severity. As far as we are aware the PGSI severity scoring is an internationally researched and well recognised measure and that there is little justification in operating with a different triage process.
- GwL believe that the opaque nature of the helpline and refusal to provide triage criteria and evidence that staff are qualified to operate these is a risk to life.

2.5 Inadequate model of Gambling Disorder, failures of commissioning and continuous improvement

There seems to be a systematic refusal to recognise the life-threatening severity of gambling disorder in the commissioning by GambleAware and secondary commissioning and provision by GamCare. This includes:

- A service specification that does not refer to treatment of "addiction" or detail requirements for suicide risk assessment, crisis referral and management. Despite repeated requests in person and by letter GamCare continues to provide generic reassurance regarding safeguarding and suicidality but no assurance evidence of protocols, process or opportunities for learning. There has been a systematic refusal to provide data, for example, on safeguarding incidents, serious incidents, suicidality, complaints, suicide risk assessment tool and training. We have asked and not been provided with information on the number of referrals to emergency services. Given the published research on suicidality (Ref 8) it should be possible to calculate how many of the 30,000 contacts with

the helpline should require referral into NHS crisis services which would enable an estimation of the effectiveness of helpline triage and pathway provision. It is difficult not to see the refusal to provide this information as evidence of a refusal to be subjected to service improving scrutiny.

- A treatment model specification that aims for "moderated gambling" that seeks to return addicts to "safe" gambling in contrast to the NHS evidence-based model which works with and aims for abstinence.
- Lack of systems for long term management and follow-up post discharge, which seem to be linked to characterisation of relapse as internally triggered rather than initiated by environmental influence such as advertising and predatory marketing of addictive products.
- Refusal to provide medium and long-term outcome data and failure to provide evidence of follow up procedures and long term case management.
- Failure to monitor deaths post treatment, initiate critical incident reviews and root cause learning from deaths.

It is difficult to avoid the conclusion that it might benefit the gambling industry to have treatment specified, commissioned and provided by charities that systematically fail to monitor the deaths that result from the condition and to recognise the life-threatening severity of the psychiatric condition induced by gambling on industrialised, repetitive, fast paced electronic products and that collude with industry favouring models of the illness.

2.6 Inadequate specification of levels of competence and training

As far as we can tell, there has been no external validation or accreditation of training and registration required for tiered specialist gambling disorder provision or validation of GamCare's internal induction and training. We understand that treatment practitioners in GamCare provider services have a professional qualification at NVQ 3 level. This is a level down from Improving Access to Psychological Therapies (IAPT), which has clear tiers and skills required for different tiers, and interventions against clinical need, as a national service with a genuinely stepped model. NVQ level 3 also does not indicate competence in the relevant modality. For example, being qualified as a mental health nurse does not mean one is qualified to provide Cognitive Behavioural Therapy (CBT) or other psychosocial interventions, any more than a medical doctor who has worked in paediatrics for ten years is fit to perform heart surgery.

GwL believe that it is essential to commission a specification of client need matched to clinical competence. This must include matching the qualifications and Continuous Professional Development (CPD) of each worker against the PGSI and CORE criteria of their client group.

GamCare have not provided information on training and competence of counsellors in in the providers they commission, or how as commissioner they assure themselves in this area. There is no evidence that a generic person centred counselling training plus minimal internal induction provides competencies to treat the psychiatric condition of gambling disorder with high levels of severity and suicidality.

3. Narrative of learning about the system and attempts to alert authorities

3.1 Initial Experts by Experience (EbE) experience

Our concerns were prompted by our families' reports about the treatment their sons had received, where they had sought help for their addiction to gambling. Broadly, there were two areas of concern – GP response and "specialist" services.

Our experience of the GP response was that GPs uniformly failed to diagnose gambling disorder although diagnostic tools for other addictions were sometimes administered (e.g. alcohol addiction). Occasional referral into IAPT also resulted in failure to diagnose gambling disorder with symptoms of anxiety, depression and suicidal ideation remaining unconnected to gambling activity and treated (unsuccessfully) as separate conditions.

Our families' experience of services marketed as specialist was generally that the service was poor, with a limited number of sessions offered, no follow up, and little availability. In particular, one lost son's experience was that the service told him he was cured and that he could return to limited gambling. He was not followed up post treatment. Although a critical incident review has been requested neither the local service nor Gamcare have been willing to undertake this process.

3.2 Attempts to find information and raise concerns

As a result of these concerns, we set about finding out more. We asked questions of GambleAware about how treatment was planned and funded, and asked Gamcare about the specific case referred to above. Although both GambleAware and Gamcare were willing to meet us, we had a limited response to our concerns, and both organisations either didn't respond or avoided many of our questions, and appeared uncomfortable with the challenges we posed.

The key issues we identified include:

- failure to recognise addiction as a problem, with no evidence that the service considered itself to be treating an addiction and no aim to help patients achieve abstinence
- failure to recognise the risk of suicide associated with gambling addiction, with no evidence of assessment of suicide risk
- staff not required to have experience or training in gambling addiction
- a weak service specification
- no evidence of quality assurance – such as audit – or accountability in the service

These concerns were – and are – based on the service specification used by GambleAware to commission the current service (Ref 6), and the guidance GamCare issued to its staff, and its subcontractor staff (no longer available online, GwL have a paper copy). The words "suicide" and "addiction" seem to be absent from these documents.

June 2018 GwL raised a concern and met with the CQC about lack of accountability and regulation of 3rd sector provision of gambling disorder treatment. Although Dr Paul Lelliott (CQC Deputy Inspector & Lead for Mental Health) expressed serious concern, it was clear that the CQC had no remit to raise the issue or the funding to undertake inspections. He wrote to GwL "I would not … want to raise your hope that there is a prospect of bringing such providers into the scope of regulation by CQC."

July 2018 GwL met with Gamble Aware's Director of Commissioning. We were not reassured by the response we received, which included a failure to provide information and a failure to implement agreed actions.

September / October 2018 a summary of our concerns (as summarised above) was sent to the Gambling Commission, and which we understand was used in a provider workshop in late 2018. GwL requested but was refused entry to the meeting.

December 2018 / January 2019 the Gambling Commission set up a meeting with GambleAware and Gamcare. Following that meeting we sent a letter summarising the meeting and again raising concerns about safety in detail. GwL received no response, including no provision of the information promised in the meeting (e,g. the suicide protocol and triage criteria)

January 2019 GwL raised a concern with NHS England's Director of Mental Health, Claire Murdoch by email about the safety of the treatment system and the failure to prevent deaths. GwL included reference to the meeting and communication with the CQC and its lack of remit and funding. We also referred to the lack of response and refusal to engage on the part of GambleAware and GamCare. Ms Murdoch responded with an honest response: "I don't have easy answers in the short term to some of the concerns you have raised" and directed us to the NHS Long Term Plan promise of specialist clinics. GwL appreciated this honesty but also raised the issue of siting the clinics within the current primary and secondary care NHS infrastructure which necessitates the development of a clear care NHS pathway and clinical training in the diagnosis and tier 2 & 3 treatment of gambling disorder. It was clear that there was no remit or political backing for the NHS to take a strategic view or to undertake due diligence investigations about the partnership with GambleAware and GamCare required by the NHS Long Term Plan. Since this letter we have raised this issue of the development of an NHS Care Pathway both with NHS England and DHSC and as far as we can see there remains no political remit for instructing this vital life saving piece of work.

June 2019 GwL wrote to the Chair of Gamble Aware, to escalate our concerns. In addition to repeating the issues raised in all the correspondence above we included the following concerns about GamCare treatment and services:

- Confused and limited understand of gambling disorder and lack of evidence base for counselling
- Severity of presentation, refusal to supply suicide protocol, triage criteria and care pathways into NHS evidence based treatment with the relevant risk management and governance

- Risk of discharge process and lack of follow-up of particular concern given the volatility of suicide risk and extreme risk of completed suicide on relapse
- Funding of GamCare in May 2019 of a further £3.9 million without a procurement exercise or standards review
- Risk that Gamble Aware and GamCare are seeking to compete with the NHS rather than collaborate.

July 2019 The response from the Chair of Gamble Aware was evidence that our concerns are not taken seriously and indeed indicated a thinly veiled hostility to any scrutiny. We received only generalised statements of an intention to collaborate with the NHS, commissioning objectives and a generalised assurance that gambling addiction is taken seriously. The letter did not include any attempt to provide evidence of these statements. The lack of publication of safeguarding procedures was admitted but dismissed as "detail". Particularly worrying was the apparent lack of understanding that treatment can be contraindicated if it is inappropriate or inadequate and can increase the risk of suicide. That this was followed by an invitation for GwL families to support promotion of GamCare services seemed to indicate a complacent indifference to the suicide risk and particularly the deaths of GwL family members that prompted these questions.

July 2019 We replied indicating our disappointment and restating all our concerns particularly noting again the safety concerns, the apparent rivalry and lack of collaboration with the NHS and the absolute failure to provide evidence of assurance and governance. We received no reply.

September 2019 In response to the evidence submitted to the APPG on Gambling Related Harm, GwL provided evidence of a list of discrepancies between that evidence and the experience of GwL members. We also submitted a list of questions and requests for evidence that the APPG could ask following the Gamble Aware and GamCare's failure to supply answers to GwL. We have written to the APPG secretariat to request that this evidence could be shared with the Lords enquiry.

January 2020 GwL wrote to the NHS Director of the Northern Gambling Service requesting assurance on safety and clinical models and requesting a response to the same scrutiny directed at Gamble Aware and GamCare.

March 2020 The NHS response was very reassuring about the quality and attention to risk of the NHS delivered services and demonstrates to us that many of the concerns we have raised about GamCare's services do not apply to the NHS clinics – including the application of NHS clinical quality standards to the service and recognition of the nature of the addiction and the risk of suicide.

However the response also indicates that our initial concerns about GamCare remain valid (through the lack of evidence to the contrary) and we are concerned that the NHS continues to face constraints in current ability to act to resolve the problems. The phrase used in response to each concern about GamCare governance and safety procedures is that the NHS "would expect" these to be in place. We do not think that "expectation" is the appropriate governance mechanism given that lives are at risk. It is difficult to avoid the conclusion that if the NHS had conducted a due diligence process, it would not

partner with GamCare due to lack of assurance about service quality and therefore patient safety.

In addition, a new specific concern is raised by the letter – the nature of the partnership with GamCare. It is evident from this letter, and from the specification for the GamCare Gambling Helpline (Ref 6), that there is no capability or expertise for assessment of needs of those who contact it – it is therefore unfit to act as the point where people can be triaged to either GamCare or NHS services. There is also no capability to assess for suicide risk.

The fact that there are no referrals from GamCare to the NHS service raises a further concern that GamCare appear to be acting as a rival provider. Although the presenting referrals are double the threshold for internationally recognised psychiatric diagnosis (with accompanying suicide risk), GamCare continue to refer only into partner 3rd sector providers who are commissioned to provide only generic counselling for mild to moderate severity, rather than co-operating to get people into the right treatment, despite the evident differences in competencies, qualifications and registration plus a remit from DHSC to collaborate.

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