Isle of Man Government

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# Joint Strategic Needs Assessment (JSNA) Gambling

DEPARTMENT OF HEALTH AND SOCIAL CARE

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# Revision History

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# Contents

# Executive Summary

## Aim of the report

**The aim of this report is to:**

- Improve understanding of gambling prevalence in the Isle of Man (IoM) and, where possible, identify trends and benchmark against the United Kingdom (UK).
- Understand links between gambling and other lifestyle behaviours.
- Understand the population need for and the evidence base to support: prevention/early intervention, treatment/ recovery, legislation/enforcement and governance/assurance.
- Understand perceptions of professionals working with problem gamblers.
- Identify gaps in current provision.
- Provide evidence based recommendations to inform and drive strategy to reduce the harms associated with gambling.

## Key findings

**Prevalence, attitudes and association with other lifestyle factors (Isle of Man Gambling Survey, 2017):**

- **75.9%** of adults had participated in gambling in the past 12 months.
- **56.9%** of adults had participated in National Lottery Draws.
- **18.5%** had gambled on line.
- **8.5%** were classed as at-risk gamblers (significantly higher than in the UK and higher than a previous IoM survey in 2012).
- **0.7%** were classed as problem gamblers (similar to the UK and the previous IoM survey).
- **77.9%** had a negative attitude to gambling.
- **3%** reported having been affected by someone in their family gambling in the past 12 months.

Gamblers are more likely than non-gamblers to have other health and wellbeing risk factors (poor general health, overweight/obesity, poor mental wellbeing, poor diet, smoking, high risk drinking and binge drinking).

We currently do not have any data on gambling or gaming behaviours in children and young people.

**Opportunities for gambling on-island**

- There are 23 licensed gambling venues including betting offices (also licensed for fixed odds betting terminals), a bingo hall, casino and adult gaming arcades.
- There are also 96 pubs, bars and clubs with fruit or slot machines and around 66 outlets selling lottery tickets.

**Risk factors for problem gambling**

- At individual level, men, younger people, people on low income/lower socio-economic status and gambling venue employees are at increased risk.
- At locality level, greater accessibility to gambling outlets and socio-economic disadvantage are associated with increased risk.

**Impact of problem gambling**

- Individual: poor mental health (including suicidal thoughts, self-harm and completed suicide), job loss, financial difficulty, relationship issues, loss of social connections.
- Family and friends: family neglect, domestic violence, relationship breakdown, poverty, homelessness, stigma and social isolation.
- Work: absenteeism, job loss, poor performance.
- Community: reduced social capital and resilience, increased reliance on government services/benefits, community disempowerment, poverty.

**Prevention of problem gambling**

- Current evidence is inadequate to support any particular approaches to prevention including awareness raising, education, restrictions on availability of gambling, restrictions on who can gamble or restrictions on how/where gambling is provided.

## Interventions for at-risk and problem/pathological gamblers

- There is evidence to support the use of 'identification and brief advice' and brief motivational conversations (Making Every Contact Count [MECC] Plus) to support behaviour change in problem gambling.
- There is evidence to support the use of cognitive behavioural therapy and motivational therapy for those with more severely disordered gambling behaviours.
- There is currently insufficient evidence to support the use of other interventions including mindfulness and Acceptance and Commitment therapy. These should be reviewed as further evidence becomes available.

## Current service and pathway provision

- Brief interventions and MECC Plus are not currently offered on island.
- GamCare Isle of Man (part of Motiv8) offers motivational interviewing and cognitive behavioural therapy (CBT) to support disordered gamblers and those affected by the gambling of family members.
- There is a gap in provision for disordered gamblers with complex needs, including co-morbid mental health conditions, learning disability,

complex physical needs or for those who pose risk to themselves or others.

## Fixed odds betting terminals (FOBTs)

- In the UK there is an association between high prevalence of FOBTs and areas of socio-economic deprivation. This has led to restriction of the maximum stake to £2. This geographical link is not present on island. The prevalence of FOBTs in the UK is 56 per 100,000 population compared to 42 per 100,000 in the Isle of Man. Restriction of maximum stake may be appropriate but would not be driven by the context seen in the UK.

## Qualitative feedback from services supporting gamblers and those with mental health issues and debt counselling services

GamCare staff considered that levels of harmful gambling on island are similar to the UK. Staff from other services tended to think that levels here are lower; suggesting that people with problem gambling may not be presenting to or being identified by current services (other than GamCare).

## Harms from internet gaming

- The 11th Revision of the International Classification of Disease (ICD-11) published in 2018, includes gaming disorder as a pattern of gaming (particularly internet video gaming) that results in significant impairment in personal, family, social, education, occupational or other important areas of functioning. Concerns have been raised that these criteria have not been validated and may result in stigmatising or medicalisation of people (including children and young people) who enjoy and are not suffering significant harms from their behaviour.
- The US classification of mental disorders, DSM-V (2013) includes a definition of 'internet gaming disorder' but lists it as a 'condition for further study'.
- There is currently a lack of evidence to support approaches to prevention or treatment for problem gaming behaviours.

## Governance, data and performance

- There is currently no cross-government organisational lead and reporting structure to oversee a co-ordinated response to gambling, including ongoing monitoring of gambling related harms and responsibility for development or delivery of strategic objectives to address them, including through legislation, enforcement and planning regulation if appropriate.

- There is currently no agreed dataset to enable oversight of gambling opportunities, activity, harmful gambling behaviour, or performance and outcomes of treatment services.

## Recommendations

**Prevention**

In view of the current inadequate evidence of the impact of interventions intended to reduce harmful gambling through focussing on either the environment or individual behaviour, any local initiatives should be based on current best evidence and include robust arrangements for monitoring, evaluation and review.

**Early intervention**

Training front line workers across government and the third sector in brief motivational interventions such as MECC Plus, would increase identification of those at risk from gambling and enable signposting to other services where appropriate. Training may be particularly relevant in areas such as housing, social security, employment and third sector organisations working with clients experiencing financial hardship, etc.

**Interventions for more severely disordered gambling**

Services for at risk and problem gamblers, currently provided through GamCare Isle of Man, should continue. The gap in provision for problem gamblers with complex needs should be addressed through the development of an appropriate service  building on the skills and experience of GamCare and the current DAT team. Organisational redesign (across GamCare and DAT) to ensure delivery of an integrated service should be considered.

A formal service specification for an integrated service for at risk and problem gamblers, and those affected by gambling should be agreed.  The specification should be supported by clear pathways building on those already developed by GamCare IoM.

**Fixed Odds Betting Terminals (FOBTs)**

Limiting the maximum stake to £2 in line with the UK should be considered to reduce the potential burden from FOBT use on those on low incomes. However, currently available data does not indicate an association of FOBT use with socio-economic deprivation on island.

**Harmful internet gaming**

The current evidence base does not allow recommendations for prevention or intervention to be made. The evidence, including any emerging local trends, should be kept under review.

## Governance, data and performance

- Consideration should be given to establishing a cross-government lead for gambling with supporting processes to oversee a co-ordinated response to gambling, including ongoing monitoring of gambling related harms and take responsibility for development or delivery of strategic objectives to address them, including through legislation, enforcement and planning regulation if appropriate. Widening the remit of the existing Substance Misuse Steering Group to include this, could be considered.
- A core dataset for monitoring gambling patterns, harms, services, performance and outcomes should be developed.
- The gambling prevalence survey (adults) should be repeated at regular intervals to monitor trends and identify emerging issues.
- Appropriate questions on gambling and gaming behaviour should be developed for inclusion in the Youth Survey (Isle of Man, Youth Trust).

# Introduction

The general definition of gambling is the activity of betting or risking money or other possessions on an event (e.g. a game, lottery or horse race) with an uncertain outcome. In legal terms, the Isle of Man Gambling Duty Act 2012 defines gambling as:

- Gaming, which is defined in the Gaming, Betting and Lotteries Act 1988 as playing a game of chance for winnings in money or money's worth, whether or not any person playing the game is at risk of losing any money or money's worth.
- Betting.
- Participation in a lottery.
- Taking a ticket or chance in a lottery that is not unlawful under the Lotteries and Amusement Act 1976.
- Online gambling.

There are a range of opportunities for gambling on the island, in addition to opportunities for on-line gambling. For many people, gambling is a leisure activity that does not result in any harm to them, their family or the wider community. Gambling can offer positive economic and employment benefits for communities. However, for some people gambling can lead to psychological, social and economic problems for the gamblers themselves, those close to them and, potentially, the social and economic fabric of their communities.

Gambling, and its potential beneficial and harmful effects at individual and community level, can be understood within a Public (or Population) Health framework. This includes facilitating the positive aspects, and preventing the negative effects, through approaches designed to manage the 'gambling environment' to reduce harms. Legislation can be used to prevent crime and disorder associated with gambling, protect the young and vulnerable adults and to ensure that gambling is conducted in a fair and open way. Safe and responsible gambling behaviour can be supported through education and awareness programmes. Problem gambling behaviours can be identified and addressed through motivational/behaviour change techniques.  Problem gamblers with complex needs may require treatment in a more specialist service.

This Joint Strategic Needs Assessment (JSNA) presents the results of a population survey to identify the patterns and prevalence of gambling behaviours on island and attitudes towards gambling. It includes a review of the effectiveness of interventions for both the prevention and management of problem gambling based on published studies. It describes current services and pathways for problem gambling and includes qualitative information from those working with problem gamblers and potentially vulnerable groups.

**Two specific local issues form part of the context for this needs assessment.**

These are:

- Changes to the UK gambling legislation in 2014 resulting in the need to review arrangements for the funding of approaches to problem gambling on island. One of the drivers for this JSNA was the agreement between the Isle of Man Gambling Supervision Commission and the Department of Health and Social Care to undertake a strategic review and needs assessment to enable better alignment of funding and the social responsibility requirement with the needs of the island[1].
- Increasing concern about possible links between availability and distribution of fixed odds betting terminals (FOBTs) and harmful gambling behaviour. In the UK, this has led to a decision to reduce the maximum bet from £100 to £2, which will take effect in April 2019. It is important to understand the patterns of distribution and use of FOBTs on island to determine whether similar legislation should be considered here.

1 *S Brennan, Isle of Man Gambling Supervision Commission, Annual Report 2016/2017 - GD 2017/0048. (Isle of Man, Government, 2017) pp.17-18.*

# 1. Patterns of gambling behaviour and attitudes to gambling on island

In 2017, the Health and Lifestyle Survey[2] conducted by the IoM Public Health Directorate contained questions relating to gambling behaviours and attitudes towards gambling. The questions included in the survey also enabled analysis of the relationship between gambling behaviour and other lifestyle risk factors.

## Isle of Man Gambling Survey 2017

### GAMBLING PARTICIPATION

**75.9%** of adults have participated in gambling in the past 12 months

National Lottery draws
**56.9%**

Gambled online
**18.5%**


### PROBLEM AND AT-RISK GAMBLING

**8.5%** of adults were classed as at-risk gamblers (PGSI score 1-7)

The highest levels of at-risk gambling was amongst males aged 18-24 years

**0.8%** of adults were classed as problem gamblers (DSM-IV or the PGSI)

The highest levels of problem gambling was amongst males aged 35-44 years

### ATTITUDES TOWARDS GAMBLING AND SIGNIFICANT OTHERS' GAMBLING

**77.9%** of adults had a negative attitude towards gambling

**48.7%** agreed gambling should be discouraged

**53.9%** disagreed that gambling livens up life

**25.4%** disagreed that most people who gamble do so sensibly

**14.2%** agreed that it would be better if gambling was banned altogether

**70.6%** agreed there are too many opportunities for gambling nowadays

**53.9%** disagree that on balance gambling is good for society

**56.9%** agreed gambling is dangerous for family life

**36.1%** agreed people should have the right to gamble whenever they want

**3.0%** of adults reported having been affected by someone in their family gambling in the past 12 months

**7.6%** of adults had advised any family member, friends or acquaintances to gamble less in the past 12 months

*All figures presented on this page are based on sample data weighted by age and gender to align with the Isle of Man population.*

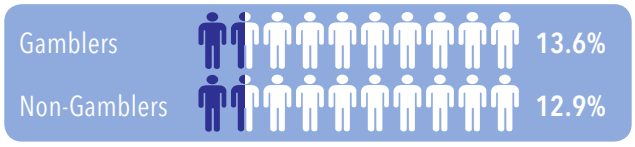
2 *N Butler, Z Quigg, R Bates et. al, Isle of Man Gambling Survey 2017: Prevalence, methods, attitudes (Isle of Man, Public Health Directorate) pp. i-ii.*

# Isle of Man Gambling Survey 2017

## HEALTH INDICATORS / HEALTH HARMING BEHAVIOURS

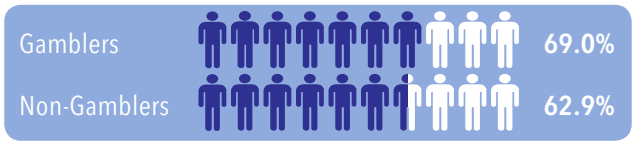
*After controlling for socio-demographics, compared to non-gamblers, gamblers were:*

### Poor general health



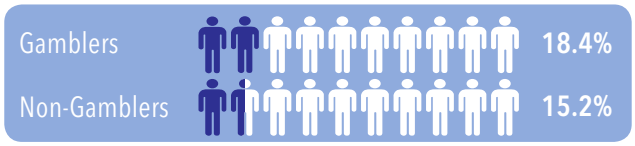

**1.5 times** more likely to report poor general health

### Overweight or obese *



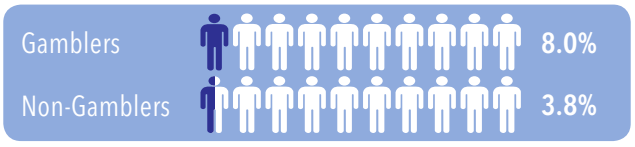

**1.3 times** more likely to be overweight or obese

### Life unworthwhile



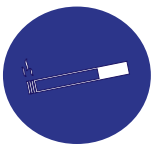

**1.5 times** more likely to report feeling that their life is unworthwhile

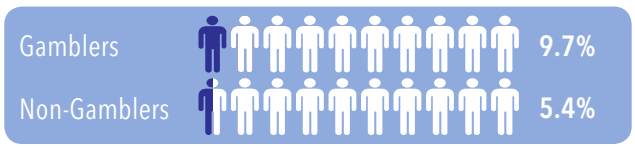
### Poor diet **




**1.8 times** more likely to report having a poor diet

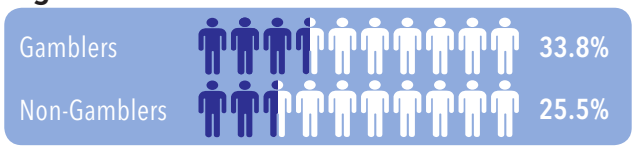
### Tobacco smoking **





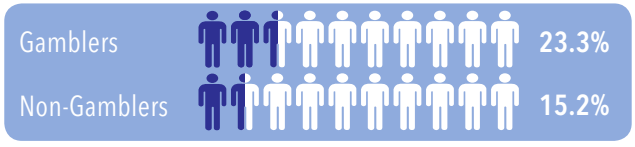

**1.7 times** more likely to report currently smoking tobacco

### High risk drinking **




**1.6 times** more likely to report high risk drinking

### Binge drinking **




**1.6 times** more likely to report binge drinking

*All figures presented on this page are based on sample data. Significance difference between groups: *p<0.05 **p<0.01*

*A report presenting the full methodology and results is available at www.ljmu.ac.uk/phi. Butler, N., Quigg, Z., Bates, R., Sayle, M., Ewart, H. (2018). Isle of Man Gambling Survey 2017: prevalence, methods, attitudes. Liverpool. Public Health Institute, Liverpool John Moores University.*

## Gambling participation

- Over three quarters (75.9%) of adults have participated in gambling in the past 12 months.
- Participation in National Lottery draws had the highest prevalence of all individual gambling activities, with over half (56.9%) of adults taking part in the past 12 months.
- Significantly fewer adults participated in any gambling activity in the past 12 months in the IoM 2017 survey compared to the IoM 2012 survey (76% v. 78%; $p<0.05$).
- Significantly more adults participated in any gambling activity in the past 12 months in the IoM 2017 survey compared to the Gambling Behaviour in Great Britain (GBGB) 2015 survey (76% v. 63%; $p<0.001$).

## Gambling methods, location and frequency

- A higher proportion of individuals gambled in person than online on: National Lottery draws; other lotteries; bingo; casino table games; poker; dog races; virtual dog or horse races; and other forms of gambling.
- Gambling online was more prevalent than gambling in person amongst individuals who gambled on: football pools; horse races; football; tennis; other sports; other events; and spread-betting.
- Over half of those who participated online in the National Lottery draws (54.3%) or football pools (58.5%) did so at least once a week.
- All forms of online gambling were undertaken at home by the majority of adults.

## Gambling prevalence and socio-demographics

- In general a higher proportion of males than females participated in each gambling activity grouping. In sample (unweighted) analysis there was a significant association between gender and participation in any gambling (excluding National Lottery draws only).
- The prevalence of participation in any form of gambling (excluding National Lottery draws only) decreased as age group increased, from 81.6% amongst

18-24 year olds to 46.6% amongst those aged 65+ years. In sample (unweighted) analysis age was significantly associated with participation in any form of gambling.

- Overall, a higher proportion of white adults than individuals of other ethnicities participated in at least one form of gambling in the past 12 months (75.9% v. 64.7%). However, in sample (unweighted) analysis there was no significant association between ethnicity and any gambling activity.
- A higher proportion of adults in a relationship participated in at least one gambling activity in the past 12 months compared to single adults (76.6% v. 74.4%). However, this relationship was not significant in sample (unweighted) analysis.
- Across income levels, adults reporting income of £20,000-£79,000 (mid-income) had the highest level of any gambling participation in the past 12 months (78.1% v. low 70.1%, high 76.1%). In sample (unweighted) analysis there was a significant positive association between income level and participation in any form of gambling.

- Overall, there was a higher prevalence of all gambling activity groupings amongst adults who did not own their own home compared to those who did. In sample (unweighted) analysis there was a significant inverse relationship between home ownership and any gambling participation.
- Overall there was a higher prevalence of all gambling activity groupings amongst adults who had qualifications compared to those who did not, and were employed compared to those who were not. In sample (unweighted) analysis there was a significant association between qualification level and participation in any form of gambling (excluding National Lottery draws only). In sample analysis there was also a significant association between employment status and participation in any form of gambling in the past 12 months.

For some indicators, the 2017 findings can be compared with those of the previous survey carried out in 2012 and also with the 2015 and 2017 Great Britain gambling participation surveys.

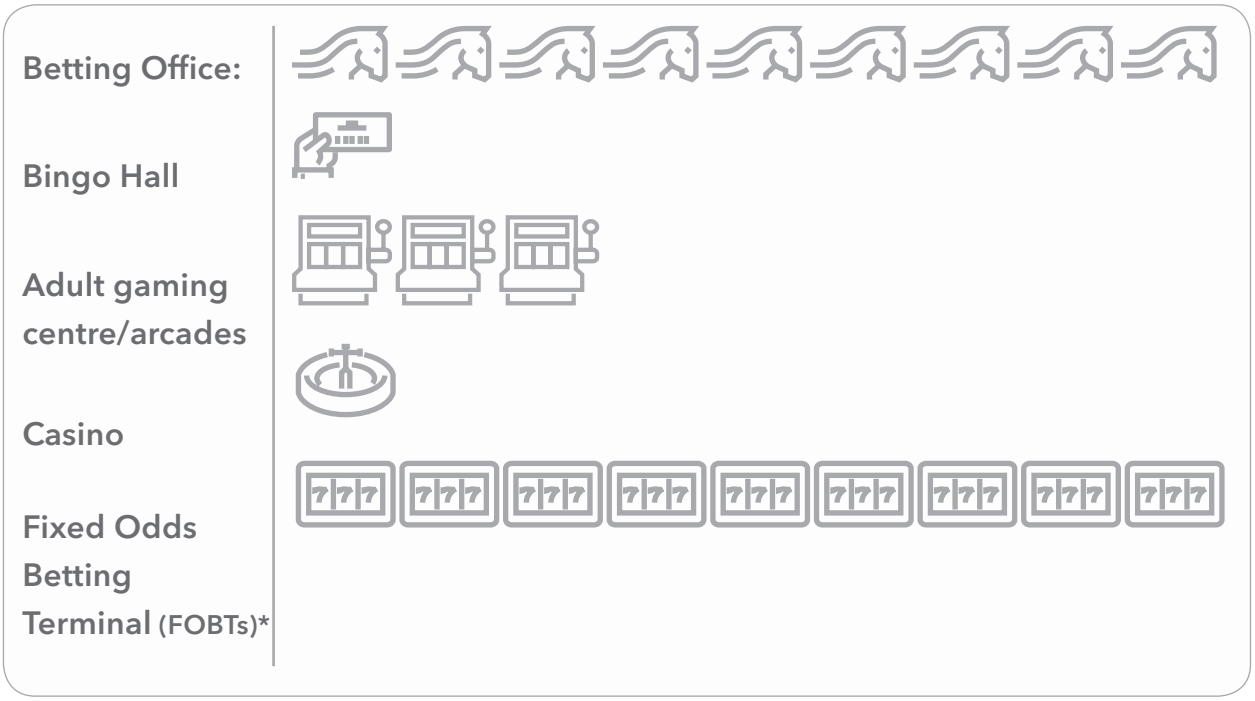
Table 1: Prevalence of problem gambling: comparisons with Gambling Behaviour in Great Britain (GBGB) 2017, 2015 and IoM 2012 surveys[3]:

| | UK 2017 | IoM 2017 | IoM 2012 | | GBGB 2015 | |
|---|---|---|---|---|---|---|
| | % | % | % | Sig. | % | Sig. |
| **DSM-IV** | | | | | | |
| Non-problem gambler | 99.2 | 99.4 | 99.8 | - | 99.3 | - |
| Problem gambler | 0.8 | 0.6 | 0.2 | <0.0001 | 0.7 | NS |
| **PGSI** | | | | | | |
| Non-problem gambler | 95.3 | 90.8 | Not available | | 95.5 | - |
| At-risk gambler | 3.9 | 8.5 | | | 3.9 | - |
| Problem gambler | 0.8 | 0.7 | | | 0.6 | <0.001 |

3 *Gambling Commission (Feb, 2018), Gambling participation in 2017: behaviour, awareness and attitudes - Annual Report.*

# 2. Licensed gambling venues - Isle of Man

Gambling and gaming venues in the Isle of Man (2018)[4]




** Note: the licences for FOBTs are held by the betting offices.*

In addition, there are 96 pubs, bars and clubs around the island that have "amusement with prize machines" (fruit or slot machines).

There are also around 66 outlets selling National Lottery tickets.

4 *Data: Isle of Man, Public Health Directorate - Intelligence Team 2019.*

# 3. Risk factors for problem / pathological gambling

There is evidence from good quality research, including systematic reviews, to indicate that the following features are associated with increased risk of problem gambling[5].

## Summary of factors associated with higher risk of problem gambling

### Environmental and geographic risk factors

- Accessibility of gambling is a significant risk factor for problem gambling.
- Greater expenditure at gaming machine venues is associated with an increased risk of problem gambling in the local area.
- There is some evidence that area level socio-economic disadvantage is linked to problem gambling.
- There is evidence from the UK that in large urban areas gaming machines (specifically Fixed Odds Betting Terminals [FOBTs]) are disproportionately prevalent in socio-economically disadvantaged areas and expenditure on gambling is higher in these areas[6].
- A lack of alternative leisure options and other services in the local area may be a risk factor for problem gambling.

### Social risk factors

- Low levels of social capital (for example, social networks marked by reciprocity, trust and cooperation) may be linked to problem gambling.
- There is some evidence that loneliness may be a risk factor in problem gambling.
- Being in the criminal justice system is a risk factor for problem gambling.

5 *H Wardle, G Astbury, M Thurstain-Goodwin et. al, Map data, local insights Gambling related harm: How local space shapes our understanding of risk Geofutures, (Bath, Geofutures, Feb 2016).*

6 *C E Lewis, L Roper and A Scott-Samuel, Fixed odds betting terminal use and problem gambling across the Liverpool City region (Liverpool, Liverpool Public Health Observatory, 15 Sep 2015).*

### Cultural risk factors

- There are inconsistent results about whether being from a culturally and linguistically diverse community is a risk factor although there is some evidence that individuals from some groups, such as Asian/Asian British, Black/Black British and Chinese/other ethnicity may be more vulnerable to problem gambling.
- There is some international evidence that religious adherence may be a protective factor.

### Demographic and socio-economic

- Male gender is consistently associated with increased risk for problem gambling.
- Rates of problem gambling decline with age.
- Children, adolescents and young adults (including students) may be more vulnerable.
- Lower socio-economic status is a risk factor for problem gambling.
- There is some evidence for an association between unemployment and problem gambling, this may be because problem gambling is a known cause of employment problems.
- People employed in gambling venues may be at an increased risk of problem gambling.
- People with mental health issues, including those experiencing substance misuse issues may be at increased risk of problem gambling which is often 'co-morbid' with substance addictions.

### Family and household factors

- There is inconsistent evidence about the relationship between family structure and problem gambling.
- There is some evidence that homelessness is linked to problem gambling, although it is not clear whether homelessness is a risk factor for or a result of financial difficulties related to problem gambling.

**Summary**

- There is strong evidence that some groups of people are at higher risk of problem gambling. Men, younger people and those of lower socio-economic status are all at risk, as are gambling venue workers. In addition, increased accessibility of gambling, socio-economic disadvantage and increased expenditure on gambling are risk factors for communities.

# 4. Impact of problem gambling

Problem gambling has an adverse impact on the individuals affected, their families, colleagues and local communities. Harms from problem gambling are summarised in **Table 2.**

Table 2: Levels of Harm from Problem Gambling diagram from LGA, Tackling gambling related harm, a whole council approach[7]:

| INDIVIDUALS | FAMILY AND FRIENDS | WORKPLACES, CLUBS, GROUPS | COMMUNITY | SOCIETY |
|---|---|---|---|---|
| • stress, depression, anxiety, MH issues<br>• job loss<br>• financial hardship<br>• family and relationship issues<br>• loss of social supports and community connections | • family neglect, domestic violence, relationship breakdown<br>• poverty<br>• homelessness<br>• stigma and social isolation | • absenteeism<br>• job loss<br>• poor performance<br>• theft<br>• lower participation rates | • reduced resources available<br>• increased reliance on welfare supports<br>• community dis-empowerment<br>• poverty | • less employment created by spending in gambling industry compared to other areas<br>• increased crime and associated costs<br>• poor performance<br>• loss of confidence in government due to perceived conflict of interest<br>• regressive tax |

*Source: Health promotion resource guide for problem gambling prevention in Melbourne North*[8]

7 *Public Health England. Tackling gambling related harm - A whole council approach Guidance. (England, Local Government Association, November 2018) p.8.*

8 *BNPCA, Health Promotion Resource Guide for Problem Gambling Prevention in Melbourne's North (Melbourne, Northern PCP Problem Gambling Initiative Steering Group, June 2009) Fig.1, p. 3.*

Problem gambling is associated with suicidal thoughts and self-harm[9]. Problem gambling is also associated with completed suicide. However, current recording methods for cause of death do not currently consistently identify cases in which gambling was a factor. A recent review identified two general trends: extreme gambling behaviour can lead to such a burden of economic loss and debt that suicidal acts appear to be the only solution; and suicidal acts in gamblers may be precipitated by interpersonal or work difficulties against a background of impulsivity traits and psychiatric morbidity[10].

## Recommendation:

Local work on suicide prevention should consider the potential links with problem gambling and the implications for services seeing clients with debt problems, substance misuse or mental health problems.

**Note: Public Health England is undertaking a review of the evidence for public health harms from gambling in England. This is due to be published in Spring 2020 and should be reviewed to inform policy and strategy on island.**


9 *A Penfold, Chapter 12: Suicide and Problem Gambling: Evaluating Intervention Needs. (New Zealand, HMA, McMaster Book, 2016). pp. 143-152.*

10 *G Martinotti, F Sarchioni, F Fiori, et al. Gambling disorder and suicide: an overview of the associated co-morbidity and clinical characteristics. (Electronic publication e28307, International Journal of High Risk Behaviours and Addiction, Sep 2016).*

# 5. Prevention of harmful gambling behaviour

Studies from the UK, Europe and Australasia have shown a social gradient in gambling and gambling related harms, with lower income individuals having higher gambling expenditure relative to income. This suggests that, in order to reduce both overall harms from gambling and reduce inequalities, both population and individual-level interventions are required[11].

Achieving behaviour change in individuals to reduce harmful behaviour requires interventions across a number of domains – affecting both the environment and the choices made by individuals. The model for behaviour change that is currently widely used to underpin work in this area is 'COM-B' which postulates that to make changes, individuals need 'capability - C', 'opportunity - O' and 'motivation-M' in order to achieve behaviour change - B[12]. The application of this model for reducing harms from gambling is shown in **Table 3**.

Table 3: Matrix of intervention strategies to prevent and reduce harm from gambling[13]:

| | Supply reduction | Demand reduction | Harm reduction |
|---|---|---|---|
| **CAPABILITY**<br>**Physical capability:** physical skill.<br>**Psychological capability:** the capacity to engage in the necessary thought processes - comprehension, reasoning. | n/a | Interventions that reduce gambling demand through changes in knowledge and understanding. | Interventions that reduce gambling harm through changes in cognitive processes e.g. gambling fallacies. |
| **OPPORTUNITY**<br>**Physical opportunity:** e.g. opportunity afforded by the environment.<br>**Social opportunity:** opportunity afforded by the cultural milieu that dictates the way that we think about things (e.g., the words and concepts that make up our language). | Interventions that reduce supply through changes in control and regulation of gambling opportunities. | Interventions that reduce gambling demand through changes in the physical and social context of gambling opportunities. | Interventions that reduce gambling harm through limiting continuous or excessive opportunity to gamble. |

11 *N McMahon, K Thomson, E Kaner et al. Effects of prevention and harm reduction interventions on gambling behaviours and gambling related harm: An umbrella review. (Science Direct, Addictive Behaviours, Volume 90. March 2019), pp. 380-388.*

12 *S Michie, M van Stralen and R West. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. (Implementation Science, April 2011), 6: 42.*

13 *McMahon, Effects of prevention, Table 1: Matrix of intervention strategies, p.381.*

| | Supply reduction | Demand reduction | Harm reduction |
|---|---|---|---|
| **MOTIVATION**<br>**Reflective motivation:** reflective processes, involving evaluations and plans.<br>**Automatic motivation:** automatic processes involving emotions and impulses that arise from associative learning and/ or innate dispositions – possibly depending on nature of pop-up messages. | n/a | Interventions that reduce gambling demand through changes in motivation to participate. | Interventions that reduce gambling harm through changes in motivation e.g. feedback on behaviour or performance. |

A range of educational and policy initiatives have been proposed to reduce the harms of gambling, summarised in **Table 4** below.

Table 4: Estimated effectiveness of problem gambling prevention initiatives[14]:

| | high | moderately high | moderate | moderately low | low |
|---|---|---|---|---|---|
| **Educational initiatives** | | | ✓ | | |
| Childhood interventions | | ✓ | | | |
| Information/awareness campaigns | | | | ✓ | |
| On-site information/counselling centres (RGIC) | | | | ✓ | |
| Statistical instruction | | | | ✓ | |
| School-based prevention programmes | | | ? | | |
| POLICY INITIATIVES | | | ✓ | | |
| **Restrictions on the general availability of gambling** | | ✓[1] | | | |
| Restricting the number of gambling venues (casinos/racinos*) | | ✓[1] | | | |
| Restricting more harmful types of gambling | | ✓[1] | | | |
| Limiting the number of gambling formats | | | ? | | |

*14 R J Williams, B L West, R I Simpson. 'Prevention of Problem Gambling: A Comprehensive Review of the Evidence and Identified Best Practices'. (Ontario, University of Lethbridge Research Repository, OPUS, Oct 2012). pp. 82-83.*

| | | | | | |
|---|---|---|---|---|---|
| Restricting gambling to dedicated gambling venues | | | ? | | |
| Restricting the location of gambling venues | | ✓ | | | |
| Limiting gambling venue hours of operation | | | | ? [2] | |
| **Restrictions on who can gamble** | | | ? | | |
| Prohibition of youth gambling (lower age limit) | | | ? [3] | | |
| Increasing the legal age for gambling | | | ✓ | | |
| Restricting venue entry to non-residents | | ? [4] | | | |
| Restricting venue entry to higher socio-economic classes | | | ? | | |
| Casino self-exclusion | | | | ✓ [5] | |
| **Restrictions on or alterations to how gambling is provided** | | | ✓ | | |
| Modifying electronic gambling machine (EGM) parameters | | | | ✓ [6] | |
| Player pre-commitment | | | ✓ [7] | | |
| Eliminating reward/loyalty cards or changing their parameters | | | ? | | |
| Operator imposed maximum loss limits | | ? | | | |
| Problem gambling training for employees at gambling venues | | | | ✓ [8] | |
| Automated/mandated intervention for at-risk gamblers | | | ✓ | | |
| Restricting access to money | | | ? | | |
| Restricting concurrent use of alcohol and tobacco | | ✓ | | | |
| Restricting advertising | | | | ✓ [9] | |
| Gambling venue design | | | | | ? |
| Increasing the cost of gambling | | | | ? [10] | |
| Government provision and supervision of gambling | | | ✓ | | |

** Racinos: a building complex or grounds having a racetrack and gambling facilities for playing slot machines, blackjack, roulette, etc.*

1 If the reductions are substantial.

2 Unless the time reduction is substantial.

3 A more effective strategy might be to model responsible gambling to youth prior to the legal gambling age.

4 Prevention benefits are limited to residents rather than non-residents.

5 Even with effective detection mechanisms, this initiative has limited preventive value because of its tertiary nature.

6 Decreasing maximum bet and win size, slower speed, reducing frequency of near misses, reducing number of betting lines, eliminating note acceptors, reducing their interactive nature, presenting pop-up messages, and absence of seating.

7 Only if mandatory. Also more effective if irrevocable, applicable to all EGMs or all gambling in a jurisdiction, with non-swappable ID.

8 The value of this measure may be increased if staff intervention is mandatory and compliance is enforced.

9 More important for preventing relapse in problem gamblers and preventing involvement in gambling among young people.

10 Greater harm minimization potential with raising minimum bet size and lowering maximum prize size.

**Note. Question mark (?) indicates uncertainty due to insufficient evidence.**

Many of these proposals are difficult to implement or sustain in practice. A recent 'umbrella review' (a review of systematic reviews) by McMahon et al identified ten systematic reviews of prevention and harm reduction interventions[15] which covered 55 relevant primary studies.

Interventions covered by the studies mainly related to pre-commitment and limit-setting, self-exclusion, youth prevention programmes and machine generated messages/feedback.

The quality of the all the studies was considered to be weak. The poor quality limits the strength of the conclusions that can be drawn from these studies.

In summary, the evidence indicated:

**Youth education/prevention interventions:** Six studies reported no effect. Five studies showed a reduction in gambling behaviours or gambling problems. Duration or extent of the improvements were not reported.

**Reduced opening hours of gambling machine venues:** One study reported a 3.3% reduction in gaming expenditure at venues reducing their hours.

**Caps on electronic gaming machines:** One study showed no change in gambling expenditure or on venue profits.

**Pre-commitment/limit-setting:** No change in gambling behaviour but may reduce duration of play and gambling activity. Problem gamblers were more likely to set but to then exceed time and monetary limits.

**Self-exclusion:** Positive effects were seen during exclusion period, including reduced anxiety/depression and reductions in family and work difficulties. Positive effects reversed once excluders returned to gambling.

**Machine generated messages/feedback:** Some positive effects seen on gambling behaviour. Self-appraisal messages were more effective than informational messages in reducing session length.

**Personalised feedback interventions (PFI)*:** PFI reduced gambling behaviour more than a cognitive intervention.

**Removal of large note acceptors:** Two studies showed no impact. Two studies found a reduction in gambling frequency and in money and time spent on gambling.

**Maximum bets:** Two studies showed no self-reported effect. One study showed reduced time spent gambling and reduced losses.

**Removal of ATMs (cash machines) from venue:** One study showed no effect. One study showed a 7% reduction in electronic gaming machine expenditure.

** Personal feedback interventions help individuals work through erroneous beliefs they may have about the behaviour of their peer group with the intention of reducing particular behaviours.*

*15 McMahon, Effects - Ten Systematic reviews pp. 382-386.*

There is currently insufficient evidence to draw firm conclusions about the effectiveness of interventions designed to achieve gambling behaviour change. It is, therefore, not possible to provide evidence-based support for any approach to prevention on the Isle of Man. In general, 'awareness campaigns' as a means of encouraging behaviour change are known to have very limited impact, particularly if people have no intrinsic interest in the information conveyed[16].

In the UK, GambleAware, an independent charity that funds research, education and treatment services to reduce harms from gambling, has partnered with other organisations to produce resources for youth education, including PSHE lesson materials. These initiatives are currently in progress and no evaluations of the impact are yet available. A note of caution can be drawn from evaluations of comprehensive educational approaches to other health and lifestyle issues (e.g. smoking, drug use, healthy eating, physical activity, etc.). These have shown that both short and long term effects on the desired behaviours are often modest or small[17].

Here, GamCare (a service supporting prevention and treatment of problem gambling managed by the Motiv8 addictions service) delivers education programmes in schools and University College Isle of Man.

### Conclusion:

There is insufficient evidence to recommend, as being of proven benefit, any specific interventions to prevent gambling related harms through behaviour change either focussed on the individual or the environment. This conclusion should be reviewed as evaluations of projects currently in progress become available.

### Recommendation:

Any local interventions intended to reduce harmful gambling behaviour should be delivered within a clear framework for monitoring and evaluation, and subject to regular review.

**Note: The National Institute for Health Research is undertaking a review of the effectiveness of policies and interventions to reduce gambling related harms. It will be published as part of the Public Health England report discussed on p26.**

16 *Williams, Prevention, pp.15-16.*

17 *Williams, Prevention, pp.22-24.*

# 6. Interventions for people with harmful gambling behaviour – evidence of effectiveness

**A note on clinical definitions:** conceptual frameworks for and definitions of gambling behaviours of different severities have been evolving at least since 1980, when 'pathological gambling' was first included in the American Diagnostic and Statistical Manual of Mental Disorders, edition lll (DSM-lll). Its inclusion in DSM-lll was largely based on the work of one consultant psychiatrist, Dr Robert Custer. The criteria included in DSM-lll were not independently validated, and drew on Dr Custer's experience and that of other professionals. The DSM-lll definition classified pathological gambling as an impulse control disorder that required seven diagnostic criteria to be met to substantiate a diagnosis.

The next edition, DSM-lV (1994), modified the definition to note the similarity to substance dependence and that excessive gambling could be an indicator of a manic episode, and thus lead to a primary diagnosis of bipolar disorder. Under DSM-lV, ten criteria for pathological gambling were listed, of which at least five needed to be met for a diagnosis. Individuals meeting four or fewer criteria were classified as problem gamblers[18].

DSM-V, published in 2013, has renamed 'pathological gambling' as 'gambling disorder' and changed the classification from 'impulse control disorder' to 'addiction'. The definition of gambling disorder includes nine criteria and the need to exclude a manic episode. The disorder is recognised as being a spectrum from mild (4-5 criteria met), through moderate (6-7 criteria met) to severe (8-9 criteria met).

The DSM-lV and DSM-V definitions are shown in **Appendix 1**. One result of the changes between DSM-lV and V, is that the terminology used to describe patients included in studies altered at the point of change from DSM-lV to V. This means that it is not possible to directly compare patient groups from studies or surveys carried out pre-2013 with those in subsequent studies.

18 *C Reilly and N Smith. White Paper: The Evolving Definition of Pathological Gambling in DSM-V. (Washington, National Centre for Responsible Gaming, May 2013).*

That is, the DSM-lV definitions of problem or pathological gambling do not map neatly across to the DSM-V definitions of mild, moderate or severe gambling disorder.

## Evidence of effectiveness

A systematic review, Cowlishaw et al, for the Cochrane Collaboration (2012)[19] summarised the current evidence for psychological therapies for the treatment of pathological and problem gambling. The review included randomised controlled trials, where outcomes from the intervention could be compared with 'no treatment' controls or referral to Gamblers Anonymous. The interventions evaluated were:

a) Cognitive behavioural therapy: a psychotherapy that combines cognitive therapy with behaviour therapy by identifying faulty or maladaptive patterns of thinking, emotional response, or behaviour and substituting them with desirable patterns of thinking, emotional response, or behaviour;

b) motivational interviewing therapy: this therapy focuses on exploring and resolving ambivalence and centres on motivational processes within the individual that facilitate change;

c) integrative therapy: a combined approach to psychotherapy that brings together different elements of specific therapies.

The authors identified 14 studies and combined data from these. Data from nine studies indicated benefits of cognitive behavioural therapy (CBT) in the period immediately following treatment. However, there were few studies across longer periods of time (e.g. 12 months) after treatment, and little is known about whether effects of CBT are lasting. Data from three studies of motivational interviewing therapy suggested some benefits in terms of reduced gambling behaviour, but not necessarily other symptoms of pathological and problem gambling. However, the authors conclude that the data from these studies is insufficient to reach firm conclusions about the effectiveness of motivational interviewing and further research is required.

The available evidence on integrative therapies (two studies) and other psychological therapies (one study), was insufficient to evaluate the efficacy of these therapies.

19 *S Cowlishaw, S Merkouris, N Dowling et.al. Psychological therapies for pathological and problem gambling. (Online, The Cochrane Library, John Wiley & Sons, Ltd, Nov 2012). p.15.*

Another, more recent systematic review (Petry N, Gimley M and Rash C, 2017)[20] confirmed the findings of the Cochrane review in respect of CBT and motivational therapies and, in addition, reviewed the effectiveness of brief identification, feedback and advice interventions. The authors concluded that brief interventions can be effective in those 'with less pronounced symptoms'. However, as in the Cochrane review, the lack of long term data to demonstrate the durability of outcomes was noted.

There is currently insufficient evidence to support so called 'third wave' therapeutic interventions for gambling [including mindfulness and Acceptance and Commitment Therapy (ACT)] as routine options within treatment services and care pathways[21]. In common with CBT and MI, there is interest in the potential of mindfulness and ACT in a wide range of conditions. Further research is needed to enable their place within therapeutic pathways to be fully understood.

There are a number of screening tools available from the UK to support identification of problem gambling behaviours as part of 'identification and brief advice' programmes. A pilot project by Cheshire police identified problem gambling behaviours at point of arrest by adding questions about gambling to a screening tool already in use to identify drug or alcohol issues. Thirteen percent of those arrested screened positive for problem gambling – significantly higher than the proportion in the general population. Of the 99 individuals identified, 29 accepted the offer of referral to a treatment service[22].

## Conclusion:

There is some evidence to support the use of brief interventions to encourage and support behaviour change in those with harmful gambling behaviours. There is evidence to support the effectiveness of CBT and in-depth motivational therapy in those with more severe gambling disorder. There is currently inadequate evidence of clinical and cost effectiveness to support the prioritisation of other therapeutic approaches in routine pathways.

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20 *N Petry, M Ginley, C Rash. A systematic review of treatments for problem gambling (Washington, Psychology of Addictive Behaviours, Dec 2017), 31(8), 951-961.*

21 *Based on a MedLine search [acceptance and commitment therapy OR mindfulness AND gambling] which did not identify any high level evidence (systematic reviews, randomised controlled trials) to support these interventions. [Medline search date 21 May 2019].*

22 *Local Government Association and Public Health England. Tackling gambling related harm: a whole council approach. (London, Local Government Association, November 2018) p.26.*

## Recommendations:

There is sufficient evidence to support brief interventions to support behaviour change in problem gambling. These could include 'identification and brief advice', a methodology already widely used for alcohol misuse; or Making Every Contact Count Plus (MECC Plus), an established 'very brief' motivational approach addressing a range of lifestyle behaviours.

These interventions are delivered by trained frontline staff and include signposting to treatment services where appropriate. In view of the lack of data on long term efficacy of these approaches, any local programmes should include arrangements for monitoring and evaluation.

There is sufficient evidence to support the use of CBT and motivational therapy for those with more severely disordered gambling behaviours. Again, lack of data on long term efficacy means that local programmes should include arrangements for monitoring and evaluation. There is currently insufficient evidence to support the routine use of other therapeutic interventions (including mindfulness and ACT). The evidence base for these should be kept under review.

The National Institute of Clinical and Care Excellence recommends that services for people with drug use disorders and/or alcohol misuse should routinely provide information about self-help groups and mutual aid groups to support recovery and integration. NICE specifically mentions twelve step programmes and SMART Recovery as examples[23]. By inference, these approaches may be expected to be appropriate for problem gamblers. A SMART Recovery group is available on island but currently there is no twelve step programme (Gamblers Anonymous).

23 *Drug misuse in over 16s: psychosocial interventions, NICE Clinical Guideline 51, 2007, recommendation 1.3.2, https://www.nice.org.uk/guidance/cg51/chapter/1-Guidance#brief-interventions-and-self-help [accessed 17 May 2019); Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, NICE Clinical Guideline 115, 2011, recommendation 1.3.1.7, https://www.nice.org.uk/guidance/cg115/chapter/1-Guidance [accessed 17 May 2019].*

# 7. Current service and pathway provision

GamCare Isle of Man, an affiliated partner of GamCare UK, offers information and practical help to those affected by gambling either face to face or via telephone. GamCare Isle of Man is part of the range of addiction services provided by Motiv8, a registered charity. GamCare Isle of Man offers both Motivational Interviewing (MI) and CBT methods to support disordered gamblers and those affected by the gambling behaviour of family members.

**Gamcare Referral Data, 2011-2018**

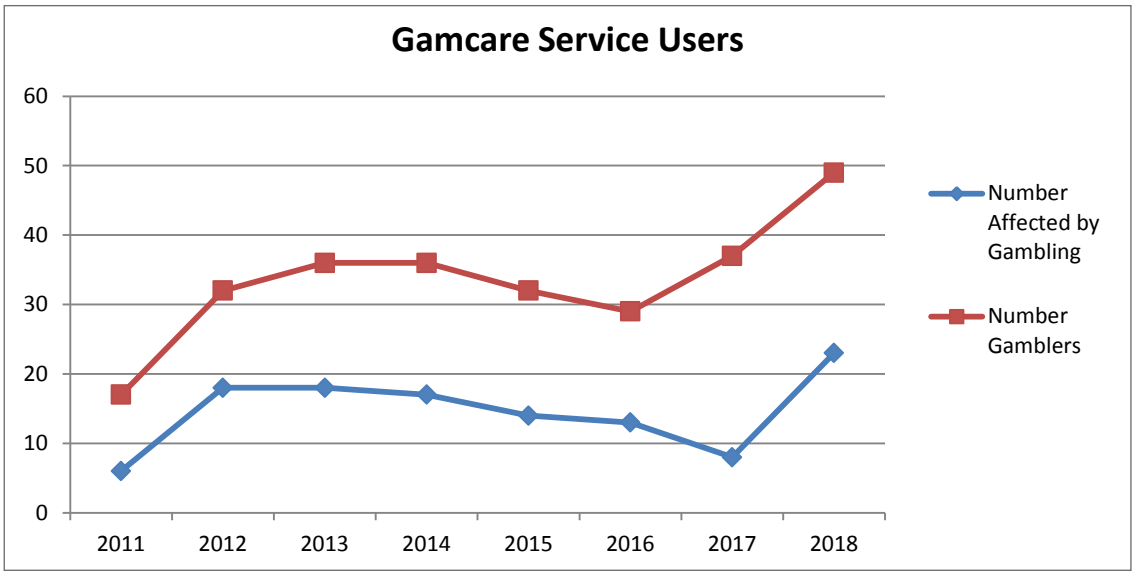


*Figure 1: GamCare*

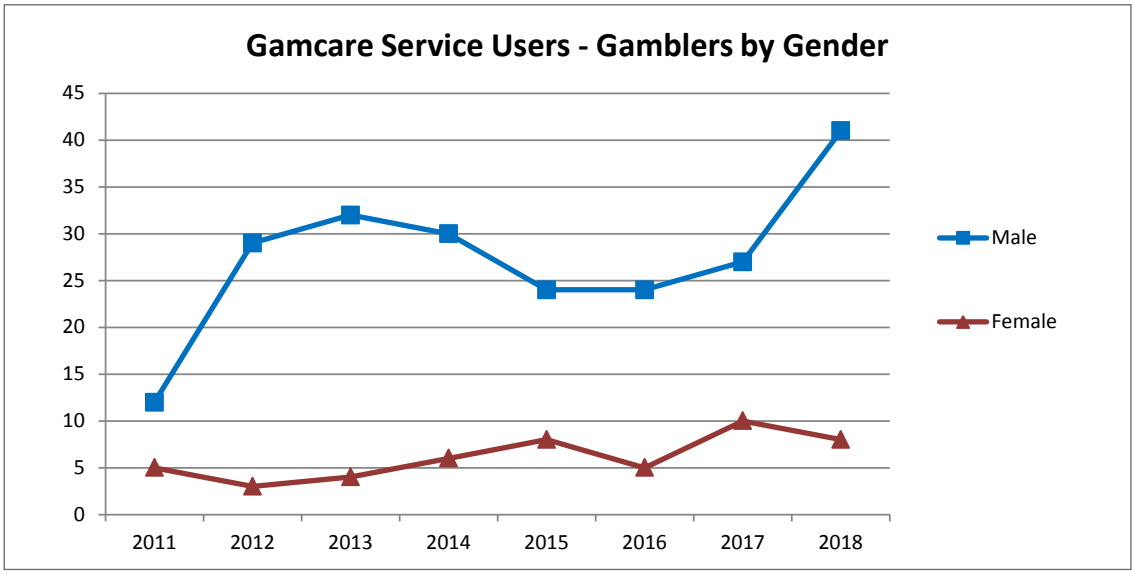


*Figure 2: GamCare*

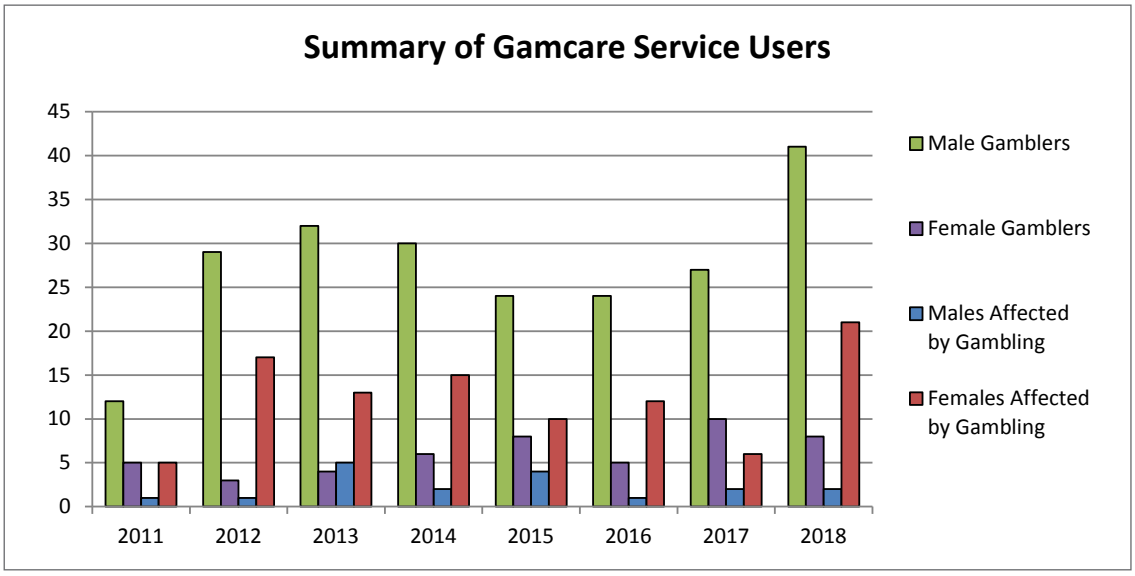


*Figure 3: GamCare*

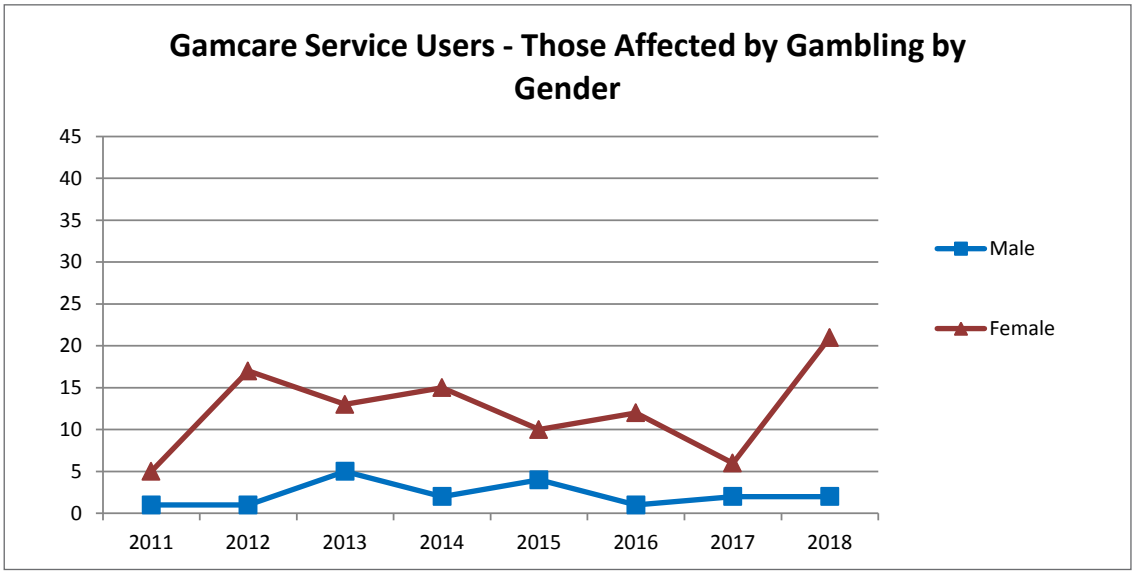


*Figure 4 : GamCare*

The Isle of Man Drug and Alcohol team has extensive experience of delivering structured interventions including MI and CBT approaches for treatment of substance misuse. The team does not currently accept referrals for gambling disorder.

## Gaps in current service provision

Brief interventions ('identification and brief advice' or MECC Plus) are not currently offered on island.

GamCare Isle of Man has worked with key potential referrers including Isle of Man Prison, mental health services, social services teams, the local gambling industry and others (e.g. GPs and the Drug and Alcohol Team) to develop written pathways, referral forms, supporting literature, a website, social media presence and joint working through, for example, team meetings.

There is a gap in provision for clients who require services or support beyond that offered through GamCare Isle of Man[24]. This includes patients with severe gambling disorder, complex needs such as co-morbid mental health disorder or learning disability, complex physical health needs, clients who pose a risk to themselves or others, and clients where there may be a complex safeguarding issue. Similar gaps in provision exist across the UK, where the only specialist NHS gambling clinic is currently in London. GambleAware is now commissioning an NHS gambling clinic for the North of England which will start from a hub in Leeds in Spring 2019, with a view to extending across North East and North West England, North Wales, Yorkshire and Humber and the north Midlands within six months. The service will be provided by Leeds and York Partnership NHS Foundation Trust with GamCare – enabling a service across tiers 1-5 to be offered. The service specification for the NHS gambling clinic is available online and could form a basis for development of a local service building on existing expertise in GamCare IoM and the Drug and Alcohol Team[25]. However, it is difficult to predict the number of clients on island who would require this level of service. The services in England cover very much larger populations than we have on island and it may be that a specialist service on island may not be feasible or sustainable.

## Conclusion:

Evidence based interventions for lower levels of problem/pathological gambling are being delivered by GamCare within the Motiv8 service. Pathways are in place between key referrers and GamCare. Clear pathways into the service and onwards into more intensive therapeutic services for clients with more complex needs appear to be lacking. Both GamCare IoM and the Drug and Alcohol Team within DHSC Mental Health, have the expertise that could be developed to

24 *M Morris. Delivering Longer and Healthier Lives, Our vision: the best small-island health and care system - 'tiered' model of service provision (Isle of Man, Department of Health and Social Care, IoM Government, Aug 2018) p.27.*

25 *Leeds and York Partnership. The NHS Northern Gambling Clinic - A proposal by Leeds and York Partnership (Leeds & York, NHS Foundation Trust and GamCare, Oct 2018).*

provide such a service, subject to sufficient resource and capacity. However, the low number of clients likely to require a specialist service on island may make sustaining a quality service on island challenging.

### Recommendations:

The following should be considered:

- Existing pathways and approaches to joint working should be supported and, where appropriate, extended.
- Development of brief and very brief interventions (identification and brief advice, MECC Plus) to identify problem gamblers and support behaviour change. This should include training for frontline staff likely to encounter problem gamblers (general practice, emergency department, police, housing, social security, etc.) to deliver these interventions and signpost/refer onwards when appropriate.
- Development of a service for clients with complex needs which cannot be met within the current service. This could be developed from the existing expertise in GamCare IoM and the Drug and Alcohol Team as part of an overall addictions recovery service. However, the low number of clients with complex needs on island may make sustaining a quality specialist service difficult.

# 8. Fixed Odds Betting Terminals

Fixed odds betting terminals (FOBTs) are electronic slot machines which allow players to bet on the outcome of various games and events which have fixed odds. The most commonly played game is roulette. Other games offered include bingo and simulated horse or greyhound racing. In the UK, FOBTs have become part of the standard offer of high street betting shops and account for a significant proportion of the income of these establishments. Latest figures from the UK Gambling Commission indicate that there are 36,611 FOBTs in the UK, each generating a 'take' in excess of £53,000 per year. Stakes of between £1 and £100 pounds per bet have been permitted. Individual gamblers have lost more than £1,000 on FOBTs on more than 233,000 occasions in a recent 10 month period reported by the UK Gambling Commission. Fourteen percent of FOBT users in the UK meet criteria for problem gambling – a higher proportion than for other forms of gambling. A correlation between numbers of FOBTs and areas of socio-economic deprivation has been noted raising concerns that the high financial losses that can be incurred from their use land disproportionately on those least able to afford them[26].

In view of these concerns, the UK Government has introduced a restriction on the maximum stake to £2, to be implemented from April 2019. This is a new measure, without an established evidence base, and the impact of it on problem gambling/gambling disorder will need to be monitored.

On the Isle of Man, whilst there are undoubtedly socio-economic inequalities across the population, the nature and distribution of these are currently poorly understood. The mixed nature of communities on the island means that we do not see the geographical correlation of socio-economic deprivation with locality that is a clear feature in UK urban areas. There are currently nine premises (all licensed betting offices) licensed by the Gambling Commission for FOBTs. There is a limit of four machines per site.

*26 R Davies. 'Maximum Stakes for Fixed Odds Betting Terminals Cut to £2'. Data and information from the UK Gambling Commission and the UK Government (UK, The Guardian, 17 May 2018).*

The Gambling Commission do not track the number of machines available to the public at any given time and this fluctuates as machines are rotated for repairs. The maximum number of machines on-island at any given time is 36. Eight of the licensed betting offices are in central town locations (seven in Douglas, one in Peel and one in Ramsey). One is in a more residential location (Governor's Hill, Douglas)[27].

The prevalence of FOBTs in the UK is 56 per 100,000 population compared to the Isle of Man prevalence of 42 per 100,000*.

## Conclusion:

The association of high prevalence of FOBTs with areas of socio-economic deprivation that is characteristically seen in UK towns and cities, is not a feature on island and the overall prevalence of FOBTs is lower than that in the UK. The context that has driven the decision to limit the maximum stakes for FOBTs in the UK is, therefore, not currently present here.

## Recommendation:

Limiting maximum stakes for FOBTs may be appropriate but is not driven by the current number or distribution of FOBTs in the way that it has been in the UK.

* *UK prevalence based on 36,611 FOBTs licensed by the Gambling Commission in 2018 and a population of 65 million; IoM prevalence based on 36 machines licensed by the Gambling Supervision Commission in 2019 and a population of 85,000.*

*27 Data: Licensed Betting Office Locations (Isle of Man, Gambling Supervision Commission, Feb 2019).*

# 9. Harms from gaming

There is debate about whether certain patterns of gaming (most commonly video gaming via the internet) are associated with harms in such a way as to characterise them as a medical condition. Video-gaming behaviours in young males aged 12 to 20 years have raised particular concerns, and prevalence of excessive gaming in this group is thought to be higher in Asia than in Europe or North America. DSM-V (2013) has included a definition of 'internet gaming disorder' but lists this as a 'condition for further study' after which a decision on inclusion will be taken. The proposed diagnostic criteria are shown in Appendix 2[28].

The 11th Revision of the International Classification of Diseases (ICD-11) published by the World Health Organisation in 2018 includes a definition of gaming disorder as a pattern of gaming behaviour ("digital-gaming" or "video-gaming") characterized by impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and continuation or escalation of gaming despite the occurrence of negative consequences.

For gaming disorder to be diagnosed, the behaviour pattern must be of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning and would normally have been evident for at least 12 months.

However, some experts argue that this risks "pathologising" behaviours that are not associated with harm for most people[29]. In technical terms, there are concerns that the criteria have low specificity resulting in the thoughts or feelings of many gamers being flagged as pathological. This could stigmatise or medicalise many people for whom gaming is a significant source of enjoyment and not associated with any harms.

The evolving nature of concepts of gaming disorder and the continuing debate around what constitutes disordered/pathological gaming is reflected in the paucity of published studies on interventions for prevention, early intervention or treatment. It is not, therefore, possible to make any evidence based recommendations in respect of gaming behaviours beyond keeping the literature under review and revisiting once the evidence base becomes stronger.

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28 *S Sarkis. Internet Gaming Disorder in DSM-V: A disorder for further study. (USA, Sussex Publishers, Psychology Today, 18 July 2014).*

29 *A Van Rooif, C Ferguson, M Carrus, et al. A weak scientific basis for gaming disorder: Let us err on the side of caution (Journal of Behavioural Addiction, 7(1) · March 2018).*

# 10. Stakeholder perspectives

## Focus groups

Two focus groups were undertaken as part of this JSNA. The two groups took place in February 2018 and included professionals across relevant services on the Isle of Man. Representatives from the following services participated in the groups: Alcohol Advisory Service, Mental Health Services (both inpatient and community), Debt Counselling services, The Drug and Alcohol Team and GamCare Isle of Man[30].

The groups were asked the question, 'What are you seeing as professionals on the ground in relation to problem gambling?'

Themes emerging from the focus groups are summarised below:

- The general perception is that the prevalence of problem gambling on the Isle of Man is lower than in the UK. Staff from GamCare did not share this perception and their view that levels are similar to the UK is borne out by the survey data presented earlier in this report.
- There was a consensus from the group that problem gambling is under reported, with comments such as "Are they [people with problem gambling] coming forward?" suggesting the perception that people may not be.

Perceived 'main problems' in relation to gambling:

- A perceived problem the professionals involved discussed was that problem gamblers often lack the motivation to seek support until they are in a crisis. It was suggested that there are 'windows of opportunity' to help problem gamblers, which usually occur after a crisis such as following theft, fraud or other criminal activity. It was suggested by the first focus group that problem gamblers tend to present with co-morbidity, specifically occurring alongside other addictive behaviours for example drugs and participating in other risk taking behaviours. All agreed that the treatment had to depend on the severity and impact of the gambling on the individual.

*30 Data: Two local focus groups, qualitative data collected in February 2018.*

- This suggests support for methods based on identification and brief advice or MECC Plus as a means of initial identification of people who could benefit from and are ready to engage with signposting or referral.

### Professionals' perceptions of prevalence of different gambling methods:

Online gambling was perceived by the group to be the most common and most problematic method of gambling, compared to methods such as scratch cards, fruit machines and fixed odds betting terminals. It was perceived that mobile phones offer ready and easy access to online gambling, with members noting that this allows individuals to gamble secretively. This fits into the concept noted by the group that problem gambling is often a 'secret addiction.'

# 11. Governance, data and performance

There is currently no agreed dataset to enable ongoing oversight of prevalence of gambling opportunities and activity, harmful gambling behaviour, patterns of gambling, or activity and outcomes from treatment services. There is no organisational lead or reporting structure to take responsibility for the development or delivery of strategic objectives in relation to gambling.

## Recommendations:

**Governance:**

A governance structure to oversee and monitor gambling and its related harms on island should be considered. This could include expanding the role of the cross-government Substance Misuse Steering Group to take on a wider remit for 'Addictions' which would enable it to include gambling. If this model were adopted, the line of accountability would then be to Social Policy and Children's Committee. The role and reporting line of the Gambling Services Commission should be considered within this.

Public Health has a role in supporting government through the agreed governance structure to understand gambling as a public health issue, including its impact (positive and negative) on individuals and communities and evidence-based interventions to manage these. Reporting lines to Safeguarding Board in respect of any identified risks to children or vulnerable adults should be developed.

**Data and performance:**

The gambling behaviour and attitudes survey should be repeated at regular intervals (five yearly is suggested) and should be aligned where possible with the UK survey to enable comparisons.

As formal identification and treatment pathways and service specifications are developed, these should include performance metrics and outcome measures. These, along with key data items from the prevalence survey should be used to develop an agreed dataset of 'gambling performance and outcomes metrics' which can be reported regularly through the governance framework.

**Note:**

**The Gambling Commission has recently launched a 'National Strategy to Reduce Gambling Harms' (see: http://www.reducinggamblingharms.org/).**

**It is beyond the scope or capacity of this JSNA to review the Gambling Commission Strategy in detail. However, the framework for it and the evidence supporting it may be relevant here and could be used to inform local strategy and policy as appropriate.**

# Appendix 1

## Evolving Definitions of Pathological Gambling and Gambling Disorder

**DSM-IV (1994)**

Pathological Gambling (classified within Impulse Control Disorders not elsewhere classified)

1. A preoccupation with gambling (e.g., preoccupation with reliving past gambling experiences, handicapping or thinking of ways to get money with which to gamble)
2. A need to gamble with increasing amounts of money in order to achieve the desired level of excitement
3. Repeated, unsuccessful efforts to control, cut back or stop gambling
4. Feels restless or irritable when attempting to cut down or stop gambling (withdrawal symptoms)
5. Uses gambling as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of hopelessness, guilt, anxiety and depression)
6. After losing money gambling, often returns another day to get even ("chasing" one's losses)
7. Lies to family members, therapist or others to conceal the extent of one's involvement with gambling
8. Has committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling
9. Has jeopardized or lost a significant relationship, job or educational or career opportunity because of gambling
10. Relies on others to provide money to relieve a desperate financial situation caused by gambling.

**Pathological Gambling:** **5 or more criteria met**

**Problem Gambling:** **1-4 criteria met**

**DSM-V (2013)**

Gambling Disorder (classified within Addictions and Related Behaviours)

1. Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12 month period:

    a) Needs to gamble with increasing amounts of money in order to achieve the desired excitement

    b) Is restless or irritable when attempting to cut down or stop gambling

    c) Has made repeated unsuccessful efforts to control, cut back, or stop gambling

    d) Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)

    e) Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed)

    f) After losing money gambling, often returns another day to get even ("chasing" one's losses)

    g) Lies to conceal the extent of involvement with gambling

    h) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling

    i) Relies on others to provide money to relieve desperate financial situations caused by gambling.

2. The gambling behaviour is not better explained by a manic episode.

    **Specify if:**

    - Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months
    - Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

**Specify if:**

- In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.
- In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

**Specify current severity:**

- Mild: 4–5 criteria met
- Moderate: 6–7 criteria met
- Severe: 8–9 criteria met

From the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (Section 312.31)

# Appendix 2

## DSM-V definition of internet gaming disorder

**In summary, the diagnostic criteria for Internet Gaming Disorder includes:**

Repetitive use of Internet-based games, often with other players, that leads to significant issues with functioning. Five of the following criteria must be met within one year:

3. Preoccupation or obsession with Internet games.
4. Withdrawal symptoms when not playing Internet games.
5. A build-up of tolerance–more time needs to be spent playing the games.
6. The person has tried to stop or curb playing Internet games, but has failed to do so.
7. The person has had a loss of interest in other life activities, such as hobbies.
8. The person has had continued overuse of Internet games even with the knowledge of how much they impact a person's life.
9. The person lied to others about his or her Internet game usage.
10. The person uses Internet games to relieve anxiety or guilt –it's a way to escape.
11. The person has lost or put at risk an opportunity or relationship because of Internet games.

There are severity modifiers for Internet Gaming Disorder: mild, moderate, or severe. These modifiers are based on how much time is spent playing the games, and how much they impact a person's overall functioning.

Internet Gaming Disorder is not an "official" disorder in the DSM-V, the APA is encouraging further research on the disorder for possible inclusion in future editions of the DSM.

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Director of Public Health, Public Health Directorate

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# Acronyms and Abbreviations

| | |
|---|---|
| ACT | Acceptance and Commitment Therapy |
| APA | American Psychiatric Association |
| ATMs | Automated Teller Machine (cash machine) |
| AWP | Amusement with prize machine |
| CBT | Cognitive Behavioural Therapy |
| DAT | Drug and Alcohol Team |
| DHSC | Department of Health and Social Care |
| DSM | Diagnostic and Statistical Manual of Mental Disorders (Editions) |
| EGM | Electronic gambling machines |
| FOBTs | Fixed Odds Betting Terminals |
| GBGB | Gambling Behaviour, Great Britain |
| ICD | International Classification of Diseases |
| IoM | Isle of Man |
| JSNA | Joint Strategic Needs Assessment |
| MECC | Making Every Contact Count |
| MH | Mental Health |
| MI | Motivational Interviewing |
| PFI | Personalised feedback interventions |
| PSHE | Personal, Social and Health Education |
| PGSI | Problem Gambling Severity Index |
| RGIC | Responsible Gambling Information Centre |
| UK | United Kingdom |

Isle of Man Government

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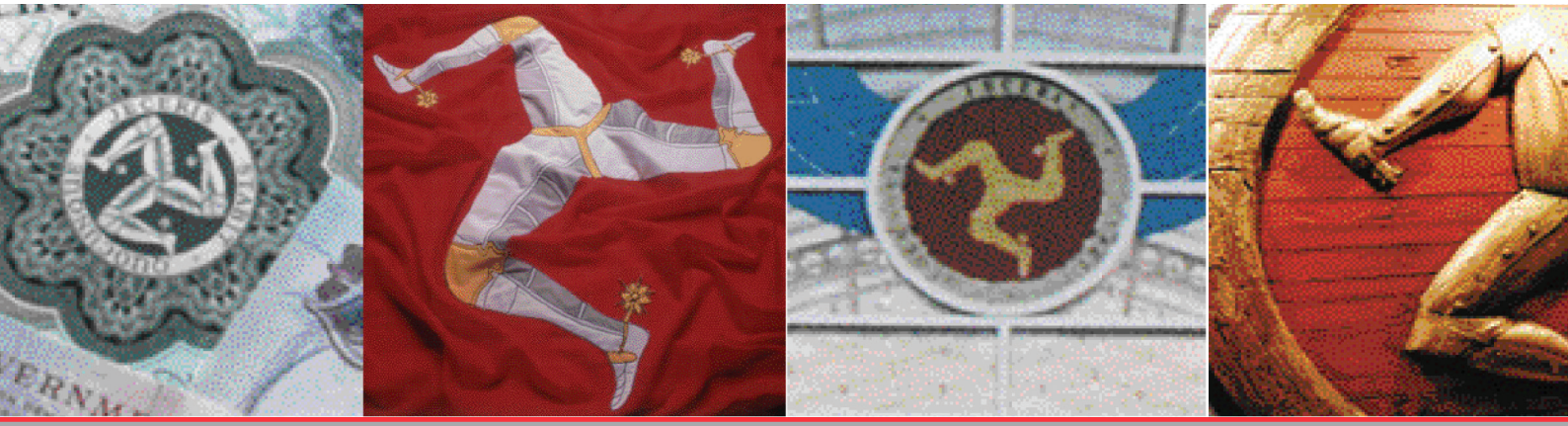

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