Problem gambling

Dave Roberts

Mark Griffiths *gives his practical recommendations based on psychological theory and research.*

ALTHOUGH gambling is clearly of psychological interest and is a topic that *The Psychologist* has examined (see Orford, 2002), traditionally it has not been viewed as a public health matter (see Griffiths, 1996, and Korn, 2000, for exceptions). Research into the health, social and economic impacts of gambling are still at an early stage.

There are many specific reasons why gambling should be viewed as a public health issue – particularly given the massive expansion of gambling opportunities across the world. The costs of problem gambling are large, on both an individual and societal level. For adults, personal costs can include irritability, extreme moodiness, problems with personal relationships (including divorce), absenteeism from work, family neglect, and bankruptcy. There can also be adverse health consequences for both the gambler and their partner including depression, insomnia, intestinal disorders, migraines, and other stress-related disorders (Lorenz & Yaffee, 1986, 1988). Many similar effects have been found in adolescents, although education rather than work is compromised. Furthermore, problem gambling is twice as prevalent in adolescents than it is in adults (Griffiths, 2002).

WEBLINKS

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Health-related problems can also result from gambling withdrawal effects. Rosenthal and Lesieur (1992) found that at least 65 per cent of pathological gamblers reported at least one physical side-effect during withdrawal, including insomnia, headaches, upset stomach, loss of appetite, physical weakness, heart racing, muscle aches, breathing difficulty and chills. Their results were also compared with the withdrawal effects from a substance-dependent control group. They concluded that pathological gamblers experienced more physical withdrawal effects when attempting to stop than the substance-dependent group. Preliminary analysis of the calls to the UK's gambling helpline also indicate that a significant minority of the callers report health-related consequences as a result of their problem gambling. These include depression, anxiety, stomach problems, other stress-related disorders and suicidal ideation (Griffiths *et al*., 1999).

Although gambling in its most excessive forms can be viewed as an addiction, the fact that gambling does not involve the ingestion of a psychoactive substance makes it a very different kind of addiction from (say) drug addictions, particularly as there are no observable signs or symptoms. This may lead to people not taking it seriously if they cannot see the problem for themselves.

A previous 'Action plan' proposed by Gossop and Mitcheson (2003) to combat illegal drug use is only partially relevant to behaviours like gambling (e.g. treatment should be properly resourced, more input from psychologists would improve interventions). The minimisation of gambling problems needs a specific action plan of its own, particularly as some gambling-related behavioural consequences are unique to gambling (e.g. 'chasing' losses – one of the known risk factors for problem gambling).

My first recommendation is simple:

1. Limit the opportunities to gamble.

There is little doubt that opportunities to gamble will increase because of recently announced deregulation measures. Underpinning this recommendation is psychological research into the 'availabilty hypothesis' (Orford, 2002). What has been clearly demonstrated from research evidence by psychologists in other countries is that where accessibility of gambling is increased, there is an increase not only in the number of regular gamblers but also an increase in the number of problem gamblers (Griffiths, 1999). Therefore, number of outlets and opportunities must be capped. Particular psychological concern must be given to gambling in new media (e.g. internet,

interactive television, and mobile phone gambling), which may affect individuals in different ways.

A public-health approach to gambling-related harm adopts a broader conception of the causes of gambling-related problems. Traditional approaches tend to focus on the characteristics that predispose some gamblers to develop problems, whereas a public health approach focuses on the characteristics of the environment that encourages excessive gambling (e.g. advertising, time restrictions, etc.). The single most important measure would be to:

2. *Raise the minimum age of all forms of commercial gambling to 18 years*.

This could significantly reduce the number of children who gamble. It would also help gaming operators and shopkeepers prevent under-age gambling. Research by psychologists has consistently shown that the younger a person starts to gamble, the more likely they are to develop problems (Griffiths, 2002). Furthermore, gambling, like addictions involving alcohol and illicit drug use, are 'disorders of youthful onset' (Teeson *et al*., 2002). At present, many young adolescents as young as 11 and 12 years of age can pass for 16. An age rise to 18 would stop a lot of the very young adolescents gambling in the first place.

Despite the early start for many, overt signs of problems often do not occur until late in the pathological gambler's career. Problem gambling is very much the 'hidden' addiction. Unlike (say) alcoholism, there is no slurred speech and no stumbling into work. Yet problem gambling can be an addiction that destroys families and has medical consequences, so it is important that we:

3. *Raise awareness about gambling among health practitioners and the general public.*

There is an urgent need to enhance awareness about gambling-related problems within the general public and the medical and health professions (Griffiths & Wood, 2000; Korn, 2000). General practitioners routinely ask patients about smoking and drinking, but gambling is something that is not generally discussed (Setness, 1997). Problem gambling may be perceived as a somewhat 'grey' area in the field of health, and it is therefore is very easy to deny that health professionals should be playing a role. There are positive signs though: lack of popular and political support for policies that increase price or reduce availability has encouraged public education as an alternative approach. Psychologists have a clear role in educating both practitioners and the public about the psychosocial risks involved in excessive gambling.

However, despite moves towards raised awareness there has been little in the way of prevention and intervention initiatives in the UK. Psychologists can have a clear and direct role here and should:

4. *Set up both general and targeted gambling prevention initiatives.*

According to Korn (2002), the goals of gambling intervention are to (a) prevent gambling-related problems, (b) promote informed, balanced attitudes and choices, and (c) protect vulnerable groups. The guiding principles for action on gambling are therefore prevention, health promotion, harm reduction, and personal and social responsibility.

Throughout the world there are many actions and initiatives that are carried out as preventive measures in relation to gambling. The most common examples are shown in the box below: psychologists can be of direct help in all of these initiatives.

In addition to these preventive measures the government needs to:

5. *Introduce gambling support initiatives*.

Many (but not necessarily all) would require input by psychologists. These include problem-gambling helplines as a referral service, telephone counselling or web-based chatrooms for problem gamblers and those close to them, residential and outpatient treatment, and training and certification for problem gambling counsellors.

All these specific action points need to take place within a general move to:

6. *Embed problem gambling in public health policy*.

It is clear that the increasing amount of psychological research on problem gambling is being taken seriously by many countries across the world. This needs to be embedded into public health policy and practice (Shaffer & Korn, 2002). Such measures include the adoption of strategic goals, the endorsement of public health

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THE PLAN IN BRIEF

- Limit the opportunities to gamble
- Raise the minimum age of all forms of commercial gambling to 18 years
- Raise awareness about gambling among health practitioners and the general public
- Set up both general and targeted gambling prevention initiatives
- Introduce gambling support initiatives
- Develop intervention strategies for limiting problem gambling
- Embed problem gambling in public health policy

INTERVENTIONS – SCOPE FOR PSYCHOLOGICAL INPUT

- General awareness raising (e.g. public education campaigns through advertisements on television, radio, newspapers)
- Targeted prevention (e.g. education programmes and campaigns for particularly vulnerable populations such as senior citizens, adolescents, ethnic minorities)
- Awareness raising within gambling establishments (e.g. brochures and leaflets describing problem gambling, indicative warning signs, where help for problems can be sought)
- Training materials (e.g. training videos about problem gambling shown in schools, job centres)
- Training of gambling industry personnel (e.g. training managers of gambling establishments, and those who actually have interaction with gamblers, such as croupiers)
- Internet prevention (e.g. the development, maintenance and linking of problem gambling websites)

principles, and the adoption of harm reduction strategies.

At present the UK government is not doing enough to make problem gambling a focus for public health action and accountability. Therefore they need to adopt goals that prevent gambling-related problems among individuals and groups at risk for gambling addiction. They also have to pay more than lip service to the endorsement of public health principles. Prevention at all levels (primary, secondary and tertiary) is clearly a priority that needs adequate financial resourcing.

Throughout this action plan the implicit message is that problem gambling is not being taken seriously enough by legislators, health practitioners or the general public. In short, problem gambling needs to be added to the public health agenda along with drug abuse, problem drinking and smoking. We need to develop strategies that are directed at minimising the adverse health, social and economic consequences of problem-gambling behaviour. Such initiatives should include healthy-gambling guidelines for the general public (similar to low-risk drinking guidelines), vehicles for the early identification of gambling problems, and surveillance and reporting systems to monitor trends in gambling-related participation and the incidence and burden of gambling-related illnesses. Incorporating a mental health promotion approach to problem gambling will help foster personal and social responsibility for gambling policies and practices.

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