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Embracing public health approaches to gambling?

A review of global legislative and regulatory trends

Daria Ukhova*, Heather Wardle*, Virve Marionneau**, Janne Nikkinen**, 23.11.2022

* University of Glasgow; **University of Helsinki

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Structure of the presentation

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- Research objectives
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Background: Emergence of public health approach to gambling

- Korn and Shaffer (1999): A ***whole system approach*** needed for the effective prevention of gambling harms

- 2000-2010s: Research and policy persistently focused on ***individual-level*** determinants of gambling harms

- Recently increasing calls for a ***broader public health-oriented approach*** to gambling harms (e.g. The Lancet, 2017; Wardle et al., 2019, 2021; van Schalkwyk et al., 2021)

Editorial

Problem gambling is a public health concern

Archaeological finds from China, Egypt, and Persia show that gambling has been a pastime for 5 millennia. Most readers will have gambled at some time, and 63% of people older than 16 years of age in Great Britain did so in the past year. But at what financial, social, and health cost is poorly understood. *Gambling Behaviour in Great Britain in 2015*, a report by NatCen for the Gambling Commission, published on Aug 24, provides a glimpse of who gambles, where, and how in England, Scotland, and Wales

Gambling and its health and social consequences concern all countries. A 2016 systematic review found the prevalence of problem gambling (as defined by the South Oaks Gambling Screen) was 0·1–5·8% worldwide, though estimates varied and data for many countries—such as China, where gambling is illegal—were unavailable. Particularly high rates of problem gambling were found in places as diverse as Estonia, Hong Kong, South Africa, and the USA.

In Great Britain, men gambled more than women and the highest rate of 68% was in Scotland. The national lottery was the most common pursuit, with 46% participation. Findings came from 15 563 responses within health surveys in Scotland and England, and a separate questionnaire in Wales. Estimates were based on the *Problem Gambling Severity Index* (PGSI), a screening tool validated in Canada, and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), a diagnostic guide. At-risk gamblers are those who show problematic traits, but are below the screening threshold for problem gambling (defined as "gambling to a degree that compromises, disrupts or damages family, personal, or recreational pursuits").

The report classified 2·8% of all British adults as low-risk and 1·1% as moderate-risk gamblers by the PGSI. On the basis of either PGSI or DSM-IV, 1·5% of men and 0·2% of women were problem gamblers, or between 180 000 and 560 000 people, depending on which metric was used and the 95% CI. Problem gamblers, and those at risk of being so, were most often male, aged 16–54 years, and economically inactive. Moreover, the type and range of gambling differed from those not at risk: particularly spread betting, club poker, online gambling, and machines at bookmakers, including fixed-odds betting terminals (fobtees). Fobtees are a particular concern because they allow bets of up to £100 every 20 seconds and 70–80% of those who use them will be net losers. In the past year, £1000 or more was lost on 233 071 occasions. Fobtees are a major source of revenue for bookmakers and contributed £1·8 billion of the £13·8 billion that gamblers lost across the UK in 2015–16. Less publicised is the growth of online gambling, with a potentially greater danger to health than other forms of gambling, particularly for those younger than 16 years of age.

Factors that contribute to problem gambling and solutions for people at risk will be multifactorial and likely require a holistic approach that goes beyond any one type of wager or stake limit. Regrettably, there is little firm evidence to guide either health policy or patient management. The Responsible Gambling Trust and others are working to fill the gap, but more research is needed. Problem gambling only entered DSM in version III, was listed as an impulse-control disorder in DSM-IV, and then recategorised in 2015 as a non-substance-related addictive disorder in DSM-5. The condition is heterogeneous, associated with substantial comorbidity (notably disorders of mood, anxiety, and substance use), and is often episodic. It can respond to cognitive behavioural therapy. Genetic tendencies are noted, but little is known about the underlying neurobiology or resulting harms. One study of suicide in Hong Kong found that 20% of deaths were in people who gambled, half of whom had debts.

Incomplete understanding is not an excuse for inaction on problem gambling. As with other addictions, responsible governments need to balance tax revenue with a duty of care to vulnerable members of society. This is yet to happen in the UK. A parliamentary study of fobtees (taxed at 25%) was undertaken in 2016, but has not been released. By identifying young men at risk and their gambling habits, *Gambling Behaviour in Great Britain in 2015* provides a start for broad-ranging, precautionary, public health strategies to reduce harm. Those harms are not confined to individual or family tragedies, but touch communities and society with direct consequences for mental health, crime, and the very composition of Britain's bookmaker-dense high streets. ■ *The Lancet*

For Gambling Commission report see http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2015.pdf

Background: I-frame vs. S-frame policies

- Chater and Loewstein (2022): *I-frame vs. S-frame* approaches to framing public policy issues
  - ***I-frame:*** Individual frailties and vulnerabilities deemed responsible for harms engendered and proposed interventions *'make often subtle adjustments that promise to help cognitively frail individuals play the game better.'*
  - ***S-frame:*** Problems are framed in systemic terms. Policies focus on systems, rules, and norms governing societal institutions.
- *I-frame* interventions have had modest results
- *I-frame* solutions have deflected attention and support away from s-frame policies

Chater, N., & Loewenstein, G. (2022). The i-frame and the s-frame: How focusing on individual-level solutions has led behavioral public policy astray. *Behavioral and Brain Sciences,* 1-60. doi:10.1017/S0140525X22002023

Background: I-frame vs. S-frame in gambling policy

- *I-frame*: RENO model approaches (Blaszczynski et al. 2004):
  - Dichotomous model of harm: ‘Problem’ vs. ‘responsible’ gambling
  - Focus on demand-side factors
  - E.g. tools to support the gambler in managing their own behaviours, education about harms, ‘responsible gambling’ public awareness advertising campaigns, behavioural algorithms using player data to identify those at risk of harm, etc.

- *S-frame*: Public health approaches (see Sulkunen et al., 2018; Livingstone et al., 2019):
  - Recognition of continuity of gambling harms
  - Focus on supply-side factors
  - E.g. regulation of gambling product design and gambling environment, advertisement and marketing, accessibility and availability of gambling, taxation

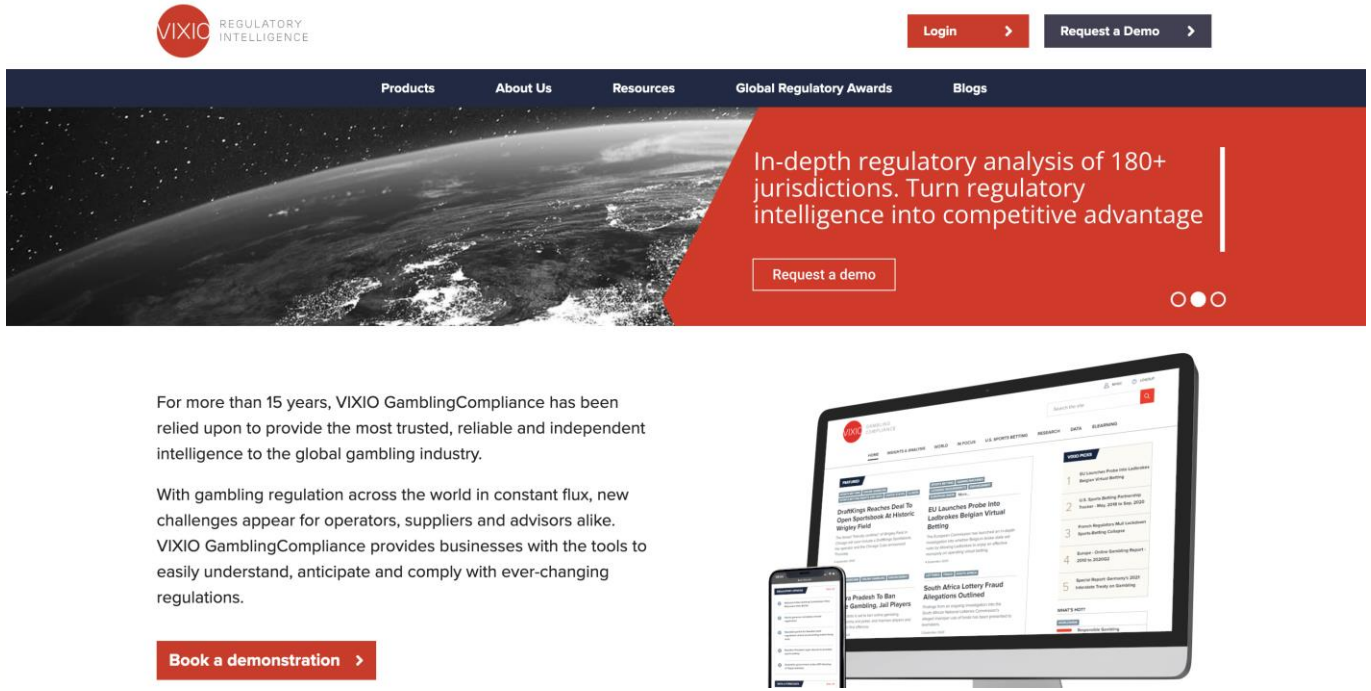
Research objectives

- To map where legislative and regulatory change is taking place

- To analyse what policy frames dominate in gambling legislation and regulation worldwide

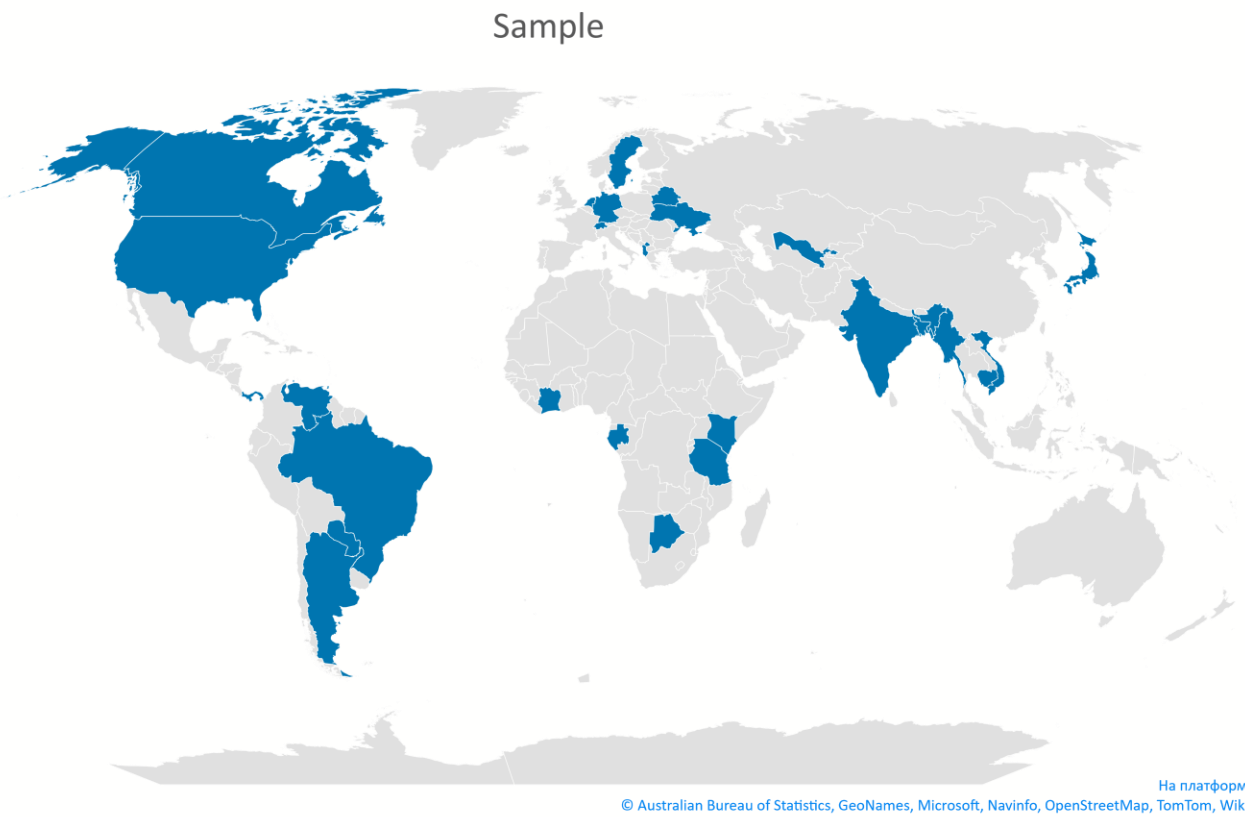
Methodology I: Global review and sample selection

- Using Vixio database, coded 200 jurisdictions by types of legislative and regulatory change **since 2018**
- + State-by-state coding in Australia, Canada, India, and US



Sample: Jurisdictions with *major* legislative changes

- 33 jurisdictions that have either legalized (*N=26*) or banned (*N=7*) one or more types of gambling and/or modes of their provision (land-based/online) since 2018



Methodology II: Critical frame analysis (CFA)

- CFA is a comparative policy analysis method for large-N studies (Verloo, 2005; Verloo & Lombardo, 2007).

> *'A policy frame is an organising principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly enclosed (…) policy frames are not descriptions of reality, but specific constructions that give meaning to reality, and shape the understanding of reality' (Verloo, 2005, p.20)*

- CFA starts by asking *sensitizing questions* linked to specific *dimensions* of a policy frame:

- Codes for *'marker fields'* that mark difference between frames (Dombos et. al, 2012)

Dimensions of policy frame	Diagnosis	Attribution of causality	Prognosis & Call for action
Sensitising questions	What is wrong?	Who/what is responsible for the problem?	What should be done? And who should do this?

Methodology III: Document selection, key terms search, coding

- **Data:** Primary legislation and secondary legislation/regulations *specifically focused* on addressing gambling-related harms *passed* since 2018 or most recently prior to that (if no new policies)

- **Stage 1 (33 jurisdictions): Key word search** of extracted documents – whether any focus on gambling-related harms or consumer protection?

- **Stage 2 (25 jurisdictions):** Coding and analysis using **CFA**

Methodology IV: Coding frame

Diagnosis (What is wrong?)	Attribution of causality (Who/what is responsible for the problem?)	Prognosis and call for action (What should be done? And who should do this?)
How is the **nature** of **gambling addiction** and/or **gambling-related harms** identified? • Is desire to gamble framed as 'natural'? • Are harms framed as a problem of a small (and stable) proportion of players? • Is gambling framed as safe for the majority of players? • Is there a recognition of the continuum of gambling-related harms? • Harms understood as only individual harms, or also consider social and societal harms / population level harms?	What/if any is identified as **key causes** of gambling addiction and/or gambling-related harms? • Individual psychological/neurobiological predisposition? • Belonging to vulnerable population groups? • Illegal/unregulated market? • Product design? • Product availability? • Marketing promotions, advertising? • Social networks?	Is **'responsible gambling' principle** explicitly invoked? Who/what is considered 'responsible' and in what way? Examples of codes for **policy measures** (49 codes in total): 'Informed choice' measures (Self-)exclusion Advertisement/Marketing Ban on parallel play Funding for prevention of addiction Funding for treatment of addiction Increasing the cost of gambling Information/Awareness Campaigns Limiting gambling venue hours Limiting illegal gambling Mandating data sharing for compliance monitoring purposes Mandating data sharing for research purposes Mandatory gambling statements to player Mandatory player identification [...]

Results I: (Public) health & other framings of policy rationale

- (Public) health framing (18/25)
- Ensuring transparency/integrity of games (14/25)
- Crime prevention/anti-money laundering (10/25)
- Economic growth/job creation/tourism development (10/25)
- Revenue generation incl. for social policies, charitable initiatives, and/or sport development (10/25).
- Consumer protection (9/25)
- Ensuring the integrity of sports competition (6/25)
- Tackling illegal gambling (6/25)
- Supporting further development of the competitive/innovative gaming industry (3/25).
- Ensuring equality among players, providers, etc. (2/25)
- Legalization as a way to maintain confidence in government (1/25).

Results II: Harmful gambling (*diagnosis*)

- On-going primacy of the *i-frame*:
  - Focus on individual's gambling addiction
  - Very limited recognition of other gambling-related harms, especially, of family and wider social and economic harms.
  - Extensive use of stigmatizing language ('problem gamblers', 'high-risk players') → gambling harms *a result of* individual's failures
  - Discursive juxtaposition of 'problem gamblers' vs. 'responsible gamblers'

- However, some countries adopting the *s-frame:*
  - E.g. Japan's Basic Action Plan on Gambling Addiction highlighted multiple harms, including debts, crime, poverty, child abuse, suicides, etc.

Results III: *'Causes'* of harmful gambling

- Some focus on the supply-side causes*:*
  - Illegal gambling/'Black market'
  - Availability of gambling
  - Harmful effects of gambling advertisement
  - Addictive product design
  - Operator's not fulfilling their duty of care: *'Players [may be] allowed to play excessively by operators'* (Ontario, Registrar's Standards 2022)

- Overall, extremely limited discussion → default individualizing understanding of causes

Results IV: *Prognosis:* Who is responsible for 'responsible gambling'?

- 'Responsible gambling' – most dominant framing of the proposed measures (*in vivo* codes in 18/25 cases)
- In few cases, focus shifting onto operators' *responsibility* towards players
  - Sweden and Netherlands wrote operators' 'duty of care' into new legislation
  - But very different conceptualization of responsibility:

Swedish Gambling Act*: '§1 A licensee shall ensure that social and health considerations are observed in the gambling activities in order to protect players against excessive gambling and help them to reduce their gambling where there is a reason to do so (duty of care).'*

Netherlands Remote Gambling Act (KOA): *'2.2.1. The license holder who organizes remote games of chance (as do operators of land-based casinos and gaming arcades) has an active duty of care to help the player as much as possible in taking their own responsibility.'*

Results V: *Prognosis:* What should be done?

***I-frame measures*:**

- Self-exclusion (18/25)
- 'Informed choice'-type of measures targeted at individual players (18/25)
- Signposting to treatment (16/25)
- Gambling venues staff training (13/25)
- Voluntary limit-setting (12/25)
- Pro-active interventions with 'at-risk' players (10/25)

NB: I-frame measures generally much more elaborated than the s-frame ones

S-frame measures:

- Universal ban on youth gambling
- Restricting advertisement and marketing (21/25)
- Restrictions on access to cash (ATMs) or provision of credit (13/25)
- Restricting the location, number, and/or operating hours of gambling venues (11/25)
- Funding treatment (9/25)
- Funding prevention (5/25)
- Restrictions of product design (6/25)
- Mandatory limit-setting (3/25)
- Limiting operator's power through greater public control:
  - Operators to report on the effectiveness of actions taken to prevent gambling-related harm (2/25)
  - Mandating data sharing for research purposes (4/25)

Results VI: Emerging public health-based prevention approaches

- Mandating ***operators' duty of care*** (e.g. Sweden, Netherlands)
- Restricting ***advertisement and marketing*** (e.g. ban on tv and internet advertisement from 6AM to 9PM in Germany)
- Reducing ***accessibility*** of gambling (e.g. Paraguay's ban on EGMs outside of casinos)
- Regulating ***game features and design*** **(**e.g. ban on features facilitating parallel play in Ontario)
- Mandatory ***deposit (or loss) limits*** enabled by a requirement for account-based gambling (e.g. 1000 EUR/month in Germany)
- Mandating the use of ***gambling revenue for prevention and treatment services*** (e.g. Trinidad and Tobago's Rehabilitation Fund to receive 5% of gambling revenue annually)
- Legally requiring gambling operators to ***share data for research purposes*** (e.g. Germany, Netherlands, Switzerland)

Conclusion

- On-going predominance of the *i-frame* in conceptualization of gambling harms, their causes and ways to address them
- Gambling harms framed as primarily individual and as something that affect the ‘irresponsible’ minority who can be easily separated from the ‘responsible’ majority
- Identifying and targeting so-called ‘problem gamblers’ and ‘at-risk gamblers’ remains a priority
- Some jurisdictions (e.g. Germany, Sweden) emerging as champions of the public health-based approaches to gambling harms
- But so far no comprehensive adoption of the *s-frame* in legislation and regulation around the world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