

## CATEGORY III – COMMUNICATION, TREATMENT & PREVENTION INTERVENTIONS – GAMBLING

### Introduction

Gambling is a common, socially acceptable and legal leisure activity in most cultures across the world. It involves wagering something of value (usually money) on a game or event whose outcome is unpredictable and determined by chance (Ladouceur et al, 2002). The various types of gambling activities commonly available in the UK are the national lottery, scratch cards, internet gambling, casino games, sports betting, bingo, slot machines and private betting.

Most people in Great Britain gamble: 63% of British adults gambled in the past 12 months (Conolly et al 2017), and most of them did so recreationally, without any negative consequence to themselves or others. Akin to substance use, gambling behaviours too exist on a scale of escalating severity and adverse consequences, ranging from no gambling, normal/recreational gambling, through problematic/sub-syndromal gambling to gambling addiction or gambling disorder.

### Summary

Gambling disorder, or gambling addiction, as it used to be called, has received scant attention in the medical literature, especially in the UK (Bowden-Jones, 2017). It has a prevalence rate of about 1% in most Western countries. Gambling disorder can adversely affect the individual, family and society, and also carries high rates of psychiatric comorbidity. Early identification and appropriate treatment can limit long-term adverse consequences and improve outcome. This factsheet will look at the epidemiology of gambling in the UK, will review assessment techniques and tools, and discuss treatment strategies for gambling disorder.

As gambling disorder is an important public health issue, associated with high rates of psychiatric comorbidity and wide-ranging personal, family and societal problems, it is crucial that medical students become familiar with this disorder, its assessment and treatment.



### Epidemiology: the British context

Data combined from the Health Survey for England (HSE) 2015, the Scottish Health Survey (SHeS) 2015 and the Wales Omnibus in 2015 found the following:

- 63% of adults (aged 16 and above) had gambled in the past year; men (66%) were more likely than women (59%) to do so.
- The National Lottery draws (46%), scratchcards (23%) and other lotteries (15%) were the most popular forms of gambling.
- Excluding those who only played the National Lottery, just under half of adults (45%) participated in other types of gambling activity; 49% of men and 42% of women.
- Across genders, overall participation was highest

among the middle age groups and lowest among the youngest and oldest age groups.

- Past year gambling participation rates varied from 52% in London to 68% in Scotland.

Adolescents are more vulnerable than adults to gambling and gambling-related problems. Although gambling is illegal for people under 18 years old, surveys have found that nearly three-quarters of adolescents had gambled in the previous year and that rates of problem and pathological gambling in adolescents were nearly twice those in adults. Gambling in this group is strongly associated with alcohol and drug misuse and with depression, and there is some evidence linking early onset of gambling to more severe later gambling and more negative consequences. Other at-risk populations include minority ethnic groups, those from lower socio-economic groups, and those with mental health or substance misuse problems.

### At risk gamblers in Britain

- At-risk gambling, as measured using the Problem Gambling Severity Index (PGSI), identifies people who are at risk of problems related to their gambling behaviour but who are not classified as problem gamblers.
- 2.8% of adults were classified as low risk gamblers and a further 1.1% as moderate risk gamblers. So, in all, 3.9% of adults were classified as at-risk gamblers.
- Rates of low risk and moderate risk gambling were higher among men than women and were higher among younger age groups.

Gambling cuts across age, gender, class and culture; young people and ethnic minorities are likely to be particularly vulnerable (Wardle, et al 2010). International research strongly suggests that increasing the availability of gambling opportunities will result in increased rates of problem gambling and gambling-related problems (National Research Council 1999). Britain's policy makers, gambling regulators, service commissioners and service providers should note this, as Britain has very liberal gambling laws (in the form of the Gambling Act 2005), a

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rapidly expanding online gambling industry and is awaiting the opening of casinos across the country.

### Problem gamblers in Britain

Problem gambling is defined as gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits (Lesieur & Rosenthal, 1991). When it becomes more severe, and meets diagnostic criteria, it is termed as gambling disorder (as in DSMV), or as gambling addiction / pathological gambling (previous terms for gambling disorder).

In 2015, problem gambling prevalence rates were 0.7% according to the DSM-IV and 0.6% according to the Problem Gambling Severity Index (PGSI). At a population level, this equates to between 360,000 and 420,000 adult problem gamblers in Britain.

### The profile of problem gamblers

Data from the combined from the Health Survey for England (HSE) 2015, the Scottish Health Survey (SHeS) 2015 and the Wales Omnibus in 2015 provide some indication of lifestyle, socio-economic and demographic features that show correlations with problem gambling in the adult population. The points below provide a snapshot of the scale and distribution of problem gambling in the British population, according to the criteria applied by the DSM-IV.

- 0.7% of the British over-16 population can be classified as problem gamblers, corresponding to a figure of 420,000 adults.
- Men were more likely than women to be problem gamblers (1.3% and 0.2% respectively).
- Problem gambling prevalence was highest among men aged between 25 and 34 (2.0%), falling to 0.2% for men aged 75 and over.
- Problem gambling prevalence was significantly higher among Asian and black respondents compared to white respondents.
- The highest rates of problem gambling were among those who had participated in spread betting (20.1%), betting via a betting exchange (16.2%), playing poker in pubs or clubs (15.9%), betting offline on events other than sports or horse or dog racing (15.5%) and playing machines in bookmakers (11.5%).
- Problem gambling was more prevalent among people who had participated in a number of gambling activities in the past year (prevalence was 11.9% for those who participated in seven or more activities compared to 0.3% of those who had taken part in just one gambling activity in the last year).
- Problem gambling prevalence varied by economic activity. No full-time students within the sample were classified as problem gamblers, and problem gambling was low among retired people (0.2%).
- The highest prevalence of problem gambling was found among those who were economically non-productive such as the long-term sick, carers and those looking after home or family but not students, unemployed or retired (1.8%).

**Table 1: DSM – 5 Criteria for Gambling Disorder**

### DSM-5 DIAGNOSTIC CRITERIA: GAMBLING DISORDER

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:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of re-living past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

The gambling behaviour is not better accounted for by a manic episode.

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 2013* (section 312.31).

### Case Study

*John is a 42-year-old married father of two. He had recently lost his job as the manager of a betting shop. He consulted his GP with symptoms of insomnia, non-specific back pain and mild depression. His drinking had escalated since he lost his job and he was referred to the local alcohol service, where his gambling problem was coincidentally uncovered.*

*John started buying lottery tickets when he was in his teens. This gradually escalated to other forms of gambling such as betting on sport, casino – based games and online gambling. He had lost his job, his marriage was shaky and he was £20,000 in debt because of his gambling. He was referred to GamCare where he received 12 sessions of cognitive behavioural therapy (CBT). He also self-referred to Gamblers Anonymous but dropped out after two sessions. Six months later, he stopped gambling but continued to seek support from Gamblers Anonymous (GA).*

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### Gambling and its consequences

Problem gamblers suffer high rates of psychiatric comorbidity, including depression, anxiety, substance misuse and personality disorders (Petry et al, 2005). Severe gambling disorder is also associated with several stress-related and other medical disorders (e.g. cardiovascular, musculoskeletal, gastrointestinal), with resultant increased use of medical services (Morasco et al, 2006). Excessive gambling often results in financial losses, leading to debts and bankruptcy. Individuals may commit crime to fund their addiction. As the gambling addiction takes hold, employment and employability may suffer significantly. Moreover, it is estimated that for every pathological gambler, between 8 and 10 others are also directly affected, including family, friends and colleagues (Lobsinger et al, 1996). Spouses often bear the brunt, and instances of domestic abuse and violence are common (Mulleman et al, 2002). Children of gamblers have been found to have high rates of behavioural problems, emotional difficulties and substance misuse (Jacobs et al, 1989).

### Psychiatric comorbidity

Research has consistently noted the very high rates of psychiatric comorbidity in pathological gamblers. People with gambling disorder were many times more likely than the general population to report major psychiatric disorders: major depression, antisocial personality disorder, phobias and current or past history of alcohol misuse (Cunningham-Williams et al, 1998). Other disorders commonly comorbid with pathological

gambling are personality disorders, impulse-control disorders, anxiety disorders and attention-deficit hyperactivity disorder. Depression is probably the most common psychiatric disorder comorbid with pathological gambling. Prevalence figures quoted range from 50 to 75% (Becona et al, 1996).

Two theories have been put forward to explain the relationship between gambling and depression. One is that gambling-related losses and other adverse consequences result in depression. The second is that gambling is an activity engaged in to alleviate a depressed state – it is used as an ‘antidepressant’.

Suicidal ideation, suicide attempts and completed suicides are much more common in pathological gamblers than in the general population. The rate of suicidal ideation in pathological gamblers has been estimated to range from 20 to 80% and that of suicide attempts from 4 to 40%. Severe gambling, large debts, coexisting psychiatric disorders and substance use have all been associated with an increased suicide risk.

### Screening for gambling problems

It is seldom that patients will present to non-specialists with gambling problems and we do not recommend that you screen all your patients for gambling behaviours. However, it would be worthwhile screening high-risk patients such as those presenting with psychosomatic symptoms, stress-related symptoms and those with psychiatric morbidity. Patients suffering from depression, anxiety-spectrum disorders and substance misuse (especially alcohol and tobacco) all tend to have higher rates of co-existing problem gambling.

**Table 2: Screening Instruments for Gambling Disorder**

Detailed Screening Instruments			
Name	Description	Number of items/Time frame	Interpretation
<b>South Oaks Gambling Screen (SOGS)</b> (Lesieur and Blume, 1987)	Based on DSM-III criteria for Pathological Gambling	26 items out of which 20 are scored Lifetime, past year, and past 3 months	Score (5 or more) – Probable pathological gambler
<b>Problem gambling Severity Index (PGSI)</b> (Holtgraves, 2009)	Derived from Canadian Problem Gambling Index (31 items)	9 items Past year	Score (8 or more) – Problem gambling with negative consequences and possible loss of control
Brief screening instruments			
Name	Description	Number of items/Time frame	Interpretation
NODS - CLIP? (Toce-Gerstein et al, 2009)	Evaluates loss of control, lying and preoccupation	3 items, Yes or No Lifetime	If even 1 item is positive, warrants detailed evaluation
<b>NODS – PERC</b> (Volberg et al, 2011)	Looks for preoccupation, escape, risked relationships and chasing withdrawal, lying and borrowing money	4 items, Yes or No Lifetime	If even 1 item is positive, warrants detailed evaluation
<b>Lie/Bet scale (26)</b>	Lies to others about gambling behaviours, or bets more and more money	2 items, Yes or No Lifetime	“Yes” to one or both items indicates PG

Note that screening is only the initial step in the diagnostic process, and patients who screen positive should be referred on

for further assessment and specialist treatment.

### Assessment

A good assessment will help the clinician to formulate a comprehensive and effective treatment plan. The key areas to be explored are summarised in Box 1. Many gamblers feel ashamed and embarrassed to reveal the true extent of their problems. Hence, the clinician needs to be sensitive and tactful in exploring the individual's gambling behaviour. Sometimes, it might even be appropriate to obtain collateral information from the patient's partner, spouse or friends (with consent from the patient). It is good to ask the patient to describe in his or her own words the initiation, development and progression of the gambling behaviour in a chronological sequence. The key DSM V diagnostic criteria for pathological gambling include preoccupation with gambling, tolerance (the need to wager increasing amounts to achieve excitement), inability to control or stop gambling and 'chasing' one's losses, all of which adversely affect the individual's interpersonal, social and occupational functioning. Features of tolerance, craving, withdrawal symptoms and other diagnostic criteria, if present, will readily confirm the diagnosis, but this forms only part of the assessment.

#### BOX 1

##### Summary of key aspects of assessment of the pathological gambler

- Full psychiatric history, including history of presenting complaints, and psychiatric, family, treatment, past and personal histories
- Detailed assessment of gambling behaviour:
  - initiation
  - progression
  - current frequency (days per week or hours per day)
  - current severity (money spent on gambling proportionate to income)
  - types of games played
  - maintaining factors
  - features of dependence
- Consequences: financial, interpersonal, vocational, social and legal
- Reasons for consultation, motivation to change and expectations of treatment
- Assessment of suicide risk
- Assessment of Axis I and II comorbidity, including substance use disorders
- Comprehensive mental state examination

As maintaining factors can often inform specific interventions, it is important to ask 'What are the reasons why you gamble?' Most commonly reported maintaining factors include negative mood state, boredom and the need to overcome financial problems.

Previous attempts to cut back or quit gambling and treatments tried should inform the clinician in planning the current treatment type and setting. A sensitive exploration of the individual's financial situation (personal and family income and financial stability) and financial problems (gambling debts, bankruptcy) will guide the clinician in suggesting feasible and realistic solutions. The clinician must evaluate the impact of gambling on work (being late, absences, job losses, etc.) and interpersonal and marital life (strained relationships, neglect of family, domestic violence, etc.).

An understanding of a gambler's reasons for consultation will provide indicators of motivation to engage in treatment. A useful question to ask is 'Why are you seeking treatment now?' The person should also be specifically asked about his or her expectations of treatment, in terms of its type, duration and setting.

Despite the high rates of psychiatric comorbidity in pathological gamblers, they often go unrecognised and untreated. A detailed psychiatric history-taking and mental state examination should establish whether there is comorbidity. Gamblers should also be asked about their use/misuse of psychoactive substances and, even more important, their use of alcohol and drugs during gambling sessions.

Assessment of suicide risk (past attempts at self-harm and ongoing suicidal thoughts and plans) forms a crucial part of the overall assessment.

### Treatment of gambling disorder

#### Pharmacological interventions for gambling disorder

No drug has been approved for use in the UK to treat gambling disorder and no clear guidelines are currently available. Trials have shown that selective serotonin reuptake inhibitors (SSRIs such as fluoxetine, citalopram, paroxetine, etc.), naltrexone and mood stabilisers (such as lithium, carbamazepine, valproate, etc.) are all effective, although none has demonstrated superiority over others. Naltrexone in relatively high doses (between 100mg and 200mg per day) have been found to be useful <http://infohub.gambleaware.org/document/guideline-for-screening-assessment-and-treatment-in-problem-gambling/>.

The existence of comorbidity might often help determine the choice of drug. For example, choose an SSRI if there is coexisting obsessive-compulsive-spectrum disorder or depression; choose a mood stabiliser in the presence of comorbid bipolar disorder; and prefer naltrexone if pathological gambling is associated with other impulse-control disorders. Doses of SSRIs and naltrexone required are often at the higher end of the therapeutic range and side-effects are therefore more common. As discontinuation studies are lacking, there is no clear evidence on how long to continue treatment: at least 4–6 months initially and then maybe maintenance treatment. Although empirical evidence is lacking, a combination of pharmacological and psychological therapies might be the best option. More robust studies looking at augmentation strategies, continuation and maintenance treatment and combined pharmacotherapy and psychotherapy are warranted.



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### Psychological interventions

#### Brief intervention for problem gambling

Brief interventions (BIs), are by definition, brief psychological interventions designed for use with people who use addictive substances or engage in behaviours (such as gambling) problematically but who have not yet developed a full-blown addiction. The rationale is that such brief interventions will prevent the progression of the addictive disorder. Brief interventions in the field of alcohol misuse are well evidenced (Bien, Miller & Tonigan, 1993): a simple 5 to 10 – minute intervention has been shown to be very effective. A brief psychological intervention model for problematic gambling developed by Petry et al, (2005) is as follows.

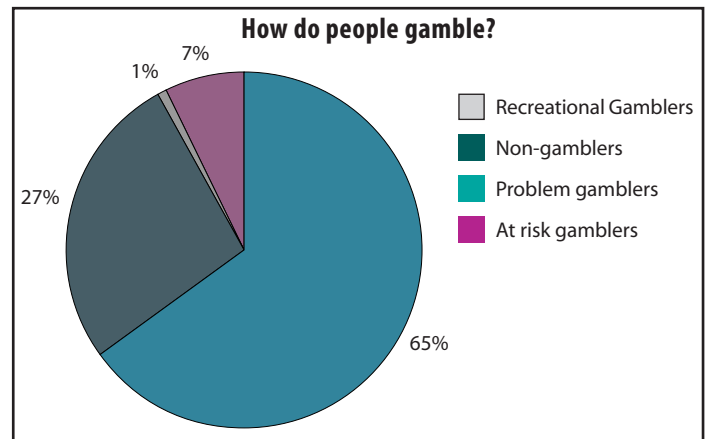
This intervention takes no more than 10 to 15 minutes, and consists of 3 steps. In **step 1** using the pie chart, the person is given a percentage breakdown of how people gamble – i.e. relative breakdown of non-gamblers, recreational gamblers, problematic gamblers and pathological gamblers in the general population. Note here that these are the past 12 – month prevalence figures for Britain, as no life – time prevalence studies have been done in Britain. Key characteristics of each category are also briefly mentioned.

**Non-gamblers:** 27% of the population did not gamble in the past 12 months.

**Recreational gamblers:** The large majority of adults (65%) are recreational or occasional gamblers. They usually gamble not more than a few times a month: a flutter on the National Lottery or a scratch card, or an odd bet on a football match/horse race. They never spend more than they intend to spend on gambling and usually gamble as a form of entertainment.

**Problematic/sub-syndromal gamblers:** About 7% of the population gambles frequently or heavily. They usually gamble up to several times a week and spend more than they intended on gambling. They do not have severe problems related to their gambling, but sometimes lose track of time while they are gambling, or hide the amount they gamble from family and/or friends. Other people may tease or criticise them about their gambling. Some of these gamblers will go on to develop pathological gambling.

**Pathological gamblers:** About 1% of the adult population suffers from pathological gambling. Pathological gamblers usually gamble very often (every day or even several times a day) and spend hundreds of pounds or more each month on gambling. Pathological gamblers develop severe financial problems and also frequently experience unemployment, legal and family problems related to their gambling. Gambling becomes the only purpose of their lives and takes precedence over everything else. Pathological gambling can lead to debts and bankruptcy, depression, and even suicide.



**Step 2** involves highlighting some of the risk factors for problematic gambling such as a positive family history of gambling behaviours, co-existing psychiatric disorders, comorbid substance misuse disorders and major life events.

### WHAT ARE THE RISK FACTORS FOR GAMBLING?

1. People with a history of substance misuse (alcohol or drugs) and those with some psychiatric conditions (obsessive-compulsive disorder, bipolar disorder, ADHD) are at greater risk of developing gambling problems.
2. Being male, young, smoker, belonging to an ethnic minority group and people whose parents regularly gambled and had experienced problems with their gambling behaviour.
3. People who gamble frequently or heavily may be at risk for developing gambling problems.
4. People who report strong superstitious behaviours, such as a preferred slot machine/s, lucky numbers, or a feeling of 'knowing' when they are 'due' a win may be at greater risk for developing gambling problems.
5. Major life changes (divorce, death in the family, retirement, children leaving home) may be associated with development of gambling problems.

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**Step 3** (see below) consists of discussing simple, practical measures to reduce the risk of developing gambling problems. These consist of the following: limiting the amount of money available to gamble, restricting the time and days spent gambling, not seeing gambling as a means to make money, and spending more time in alternative recreational pursuits.

### What can you do to reduce the risk of developing gambling

1. Limit the amount of money you spend gambling. If you go to the casino, take a set amount of cash. Leave your bank and credit cards at home. Never buy more than a limited number of scratch cards or lottery tickets. If you gamble online, set a small limit. When the money runs out, stop gambling.
2. Limit the amount of time and days you gamble. If you buy scratch cards or lottery tickets, don't buy them every day. If you bet on sports, watch some games without betting on them. If you go to the casino, make a commitment to your partner or a friend to meet them later that day so that you must leave at a reasonable time. When the time runs out, leave whether you are winning or losing.
3. Don't look to gambling as a way of making money. Remember that the house is always guaranteed to win in the long run. The more you gamble, the more likely you are to come out behind.
4. Spend time pursuing other recreational activities. Many problematic gamblers gamble as a way of relieving boredom, anxiety or depression, or for fun. Find other activities that you enjoy and that fill these needs for you. Join a sports club, take a further education class, or volunteer somewhere. Go to a movie, out to dinner, or take a walk. Plan these activities during times you are most likely to gamble.

Psychotherapy remains the mainstay of treating problem gamblers and Cognitive Behaviour Therapy (CBT) is the most commonly used. CBT includes cognitive and behavioural strategies. Gambling addicts have various cognitive distortions such as illusions of control, overestimates of one's chances of winning, biased memories, etc. The underlying premise here is that as gambling is essentially about judging the probability of outcomes and decision making, it follows that cognitive distortions will lead to impaired judgement and poor decision making. CBT aims to address these cognitive distortions and, through functional analysis of gambling triggers, helps manage them and cope with cravings. Cognitive-behavioural treatment approaches often involve identifying high-risk situations (through functional analysis) or internal and external triggers that lead to urges to gamble and then working on effective coping strategies. Treatments often incorporated in cognitive-behavioural packages include training in assertiveness, problem-solving, social skills, relapse prevention and relaxation.

### Gamblers Anonymous

Gamblers Anonymous is a self-help group modelled on Alcoholics Anonymous. It was founded in 1957 in California and

is currently one of the most popular and extensively accessed treatment models for pathological gambling. Gamblers Anonymous uses a medical model of pathological gambling and views total abstinence as the treatment goal. The '12-step recovery program' forms the cornerstone of this treatment and gamblers are assisted in working through steps 1 to 12 by regular attendance at and active participation in group meetings.

Generally, despite its high rate of attrition, those who regularly attend Gamblers Anonymous groups benefit from this intervention. From a clinical perspective it is more pragmatic to offer Gamblers Anonymous in conjunction with other treatments. Gamblers Anonymous also run support groups for families and friends affected by their loved one's gambling.

### Barriers

Problem gambling often goes unnoticed, not least because of the lack of physical manifestations that are often evident in the case of drug or alcohol misuse. This objective 'invisibility' is in turn compounded by low rates of self-presentation to health practitioners by problem gamblers. At the same time, the existence of co-morbidities can mask the existence of gambling problems. It is estimated that most people with gambling problems in Britain do not seek help and even when they do, they present to non-gambling support services with symptoms that may not be directly attributable to gambling. Most problem gamblers go unrecognised and their health needs arising from their problem go unaddressed. This may be for various reasons, such as a reluctance to disclose the role of gambling in contributing to negative health impacts. Healthcare professionals' low awareness of problem gambling is linked to their limited knowledge regarding how to identify and assist patients experiencing gambling-related harm. It is likely that even where health or social care practitioners do identify the existence of gambling-related harm, they regard this as a personal or 'social' problem, rather than a health issue, meaning that the needs of relevant individuals are largely unaddressed. So all in all, gambling disorder remains largely 'hidden' and ignored.

### Current treatment provision for gamblers in Britain

At present, almost all dedicated funding to address gambling-related harm is provided by voluntary contributions from the gambling industry and the level of service provision is far from adequate.

Treatment services for those with gambling problems, in Britain, are at best patchy and at worst non-existent. And where they do exist, it is limited to a few, predominantly non-NHS specialist services. Furthermore, these services only cater to the very few, severely addicted gamblers – the very tip of the 'iceberg'. So too, treatment interventions for gamblers, in the UK, have so far almost exclusively focussed on relatively medium to long-term psychological interventions.

For the nearly half a million problem gamblers and the 6.5% at risk, as well as those in their social networks who are affected, there is only one National Health Service (NHS) clinic the National Problem Gambling Clinic (NPGC), which is part of the Central and North West London NHS Foundation Trust). There

are some of third-sector agencies that provide treatment.

The charity GamCare ([www.gamcare.org.uk](http://www.gamcare.org.uk)) provides support and treatment for problem gamblers. An industry that generates billions of pounds in revenue every year, and growing year on year, voluntarily donates approximately 0.1% of that to fund gambling treatment, research and education in Britain. In Britain, the government takes no responsibility for the commissioning of gambling treatment services, as strikingly made evident by the Department for Culture, Media and Sport having responsibility for gambling rather than the Department of Health.

Those with gambling problems are best treated in specialist gambling treatment services if such services exist. If not, these patients are best referred to the more generic addiction (drugs and alcohol) services. Contact with the local addiction service should be the first port of call, and if this yields no success, patients could be signposted to GamCare and/or Gamblers Anonymous. Patients can self-refer to both.

### The policy context in Britain

Britain has liberal laws regulating gambling and this has resulted in some significant new trends in this field. First is the clustering of betting shops on the high streets. Second, the introduction of 33 000 fixed-odds betting terminals into betting shops across Britain. Third, a rapid expansion in remote gambling (i.e. internet and telephone betting), which is currently a fifth of the 'offline' gambling (where the gambler needs to be physically present) market. Fourth, a large increase in exposure to gambling advertising on television (the number of gambling advertising spots on television increased from 152 000 in 2006 to 1.39 million in 2012).

Gambling-related harm tends to sit fairly low on the list of priorities of healthcare providers, policy makers and treatment commissioners who will therefore prioritise allocation of time and other resources on more obvious public health issues such as drugs, alcohol, smoking, diet, and risky sexual behaviour.

### Resources

#### How to get help:

National Problem Gambling Clinic  
69 Warwick Road, London, SW5 9BH.  
United Kingdom

Telephone: **020 7381 7722**

Fax: **020 7381 7723**

Email: [gambling.cnwl@nhs.ne](mailto:gambling.cnwl@nhs.ne)

Website: <https://www.cnwl.nhs.uk/service/problem-gambling/>

Gamcare: Helpline: **0808 8020 133** (Freephone)

Gordon Moody Association: Tel: **01384 241292**

Gordon Moody in the South East: **020 8778 3331**

or email: [help@gordonmoody.org.uk](mailto:help@gordonmoody.org.uk)

GA (Gamblers Anonymous): Tel: **020 7384 3040**

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- Royal College of Psychiatrists' information leaflet <https://www.rcpsych.ac.uk/healthadvice/problemsanddisorders/problemgambling.aspx>
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