National Suicide Prevention Strategy – Gambling – Response Template

On 24 January, the Secretary of State for Health and Social Care announced that we will publish a new National Suicide Prevention Strategy this year. This new Strategy will replace the existing National Suicide Prevention Strategy, which was published in 2012.

We have already been engaging widely across the sector to understand what our priorities should be for the new Suicide Prevention Strategy. As we consider the scope and content of the new strategy, we are now keen to undertake more targeted engagement.

This template includes some specific questions that we would be particularly welcome your views on in relation to harmful gambling and suicidality. You do not need to answer every question – any feedback, however small, is welcome.

Please submit your feedback and responses to the questions to the DHSC Suicide Prevention Plan mailbox using this template by **noon Monday 20th March**: SuicidePreventionPlan@dhsc.gov.uk

General Information

Name and organisation(s):	Charles Ritchie Co-founder, Gambling with Lives
Email address:	charles@gamblingwithlives.org
Any additional information:	Gambling with Lives (GwL) is a community of families bereaved by gambling-related suicide that provides support, raises awareness of the devastating effects of gambling disorder and campaigns for change.

1. **What do you think are the main factors influencing the link between harmful gambling and suicidality? By suicidality, we mean suicide, suicide attempts, suicidal thoughts, and suicidal ideation.**

A toxic combination of dangerous gambling products, predatory industry practices, and misinformation portraying gambling as safe are all critical factors that significantly shape the link between suicide and gambling disorder.

The most dangerous gambling products, some with addiction and at-risk rates as high as 45% [1] – higher than heroin – combined with the cross-selling from a small bet on the football team to “free” spins on online slot games, are designed to create

a condensed pool of customers who are psychologically compelled to continue to gamble despite their continued experience of psychological and financial harm.

This is supported by the suicide notes left by the loved ones lost by GwL families, many of whom expressed that they felt they'd never break free of gambling's grip. The experiences of the GwL families are also testament to the fact that gambling can be both the root cause – long-term degradation of mental and physical health – and the short-term trigger of a suicide – most took their own lives within a very short time of crashing out of a gambling session.

Addiction is the core of the gambling industry's business model: 86% of online gambling profits come from just 5% of customers[2]. Removing the National Lottery from the equation, that percentage rises to 90% of profits from 5% of customers, according to the CEO of the Gambling Commission, Andrew Rhodes [3].

Such addiction doesn't happen by accident: products are designed to be addictive[4] and incentives to gamble are targeted at people suffering gambling harm – people suffering with gambling disorder are 9 times more likely to be sent daily incentives to gamble than those not suffering gambling harm [5].

Advertising framing gambling as a harmless leisure pursuit increases the suicide risk by reinforcing the industry narrative of "responsible gambling" – the idea that people addicted to gambling can just "stop" when they wish to. As a result, people suffering with gambling disorder believe that they are somehow faulty and to blame when they find themselves unable to stop gambling.

Academic researchers and people with lived experience of gambling harm agree that the "responsible gambling" narrative contributes to discrimination, stigma, and further harm to mental health. This narrative suggests personal weakness is at the heart of gambling disorder, when the evidence shows that anyone can become addicted to addictive products [6].

Furthermore, people in recovery from gambling disorder report that stigma caused by a focus on individual responsibility increases feelings of low self-esteem, self-blaming, and suicidal thoughts. This is strongly supported by the content of suicide notes left to the GwL families. Academic researchers that have investigated "responsible gambling" narrative from the perspectives of those with a lived experience of gambling harm, found that participants perceived that the narrative:

- Contributed to both felt and enacted stigma.
- Created norms related to personal control, which led to personal blame and shame.
- Contributed to broader negative stereotypes that people who had developed problems with gambling were irresponsible and lacked self-control [7].

Proper public health information must focus on prevention of harm across the whole population, including messages about the correlation between gambling disorder and

suicide, and the levels of harm associated with certain products. This requires recognition that the public health problem arises not from “faulty” individuals but a complex interplay between products, industry practices, policy, environments, and individual life circumstances and exposure – all of which is completely at odds with the current misinformation.

All of these factors contribute to a high suicide risk: research tells us that people suffering with gambling disorder are two to three times more likely to attempt to kill themselves or have major depressive episodes than other types of addicts, with 12–18% of those seeking treatment having already attempted suicide[8] [9] [10] [11]. One landmark study found that people suffering with gambling disorder are 15 times more likely to take their own lives than members of the general population[12], whilst a 2023 Office for Health Improvement and Disparities estimated there are up to 496 gambling-related suicides in England alone every year[13].

The high suicide risk associated with gambling disorder stems in part when the “excitement” of a gambling session, which is caused by the release of massive amounts of dopamine into the brain[14], ends and results in a crash in mood when this is removed[15] [16]. During a gambling session, decision-making is affected so that decisions are not based on rational thinking and experience but on magical thinking and a genuine belief in luck[17], leading to increased impulsivity[18] [19] and loss-chasing[20] [21].

It is therefore catastrophic when an individual crashes out of a gambling session to a reality of despair, low self-esteem and self-loathing, and financial problems – but retaining the faulty decision-making pathways in the brain, high arousal, and impulsivity. Unlike with people suffering alcohol or drug addictions, they remain fully capable physically, so they are highly capable of executing a suicide plan.

Despite this, there is nowhere near enough awareness of the suicide risk of gambling disorder in the healthcare community, which further exacerbates the risk. Gambling disorder is often misdiagnosed by healthcare professionals, or not at all diagnosed, with many HCPs unsure of how to spot the condition or where to refer if they do – all further increasing the suicide risk.

There is little public health information available to the general population either, meaning they are unaware of the high suicide risk and ill-equipped to intervene appropriately and effectively.

2. **What do you feel are the most impactful actions Government (national and local), NHS or others across the sector could take to reduce/prevent the risk of suicidality associated with harmful gambling? By suicidality, we mean suicide, suicide attempts, suicidal thoughts and suicidal ideation.**

There are multiple impactful government actions, specifically at national level, that would help reduce the risk of suicidality associated with gambling disorder:

A ban on all gambling advertising

A ban on all gambling advertising would stop the harmful misinformation that gambling is a harmless leisure pursuit and that those addicted can simply stop when they wish. This would empower people suffering to seek help, alleviating some of the suicide risk. Such a ban would also allow the appropriate public health warnings about the health and suicide risk of gambling disorder to be effective.

A statutory levy

A statutory levy of around 1% on the gambling industry's profits would raise over £100 million a year, which could be used to fund independent treatment, education, research, and health messaging. We note that the current voluntary levy is totally inadequate. In 2018/19, the industry made over £14 billion in profit and voluntarily donated just £10m (less than 0.1% of GGY) toward the cost of treatment, education, and research[22]. Undoubtedly, this lack of funding contributes to the current situation regarding treatment, with between 0.5% and 2% of people who need treatment for gambling disorder receiving any [23].

The current arrangement gives no security or certainty about the level of funding or how long it might last, which means that organisations cannot plan services or invest for the future. It also gives the industry influence over the delivery and content of research, education, and treatment, which helps perpetuate stigma and worsen gambling harms. The industry has regularly exercised their current right to cancel or redirect funding to organisations which they believe will not challenge or question their activities[24].

Every gambling-related suicide must be learned from

Several inquests into gambling-related deaths are currently underway: lessons must be learned from each of these deaths to prevent future suicides and Prevention of Future Deaths reports issued. At the inquest into the death of the GwL co-founders' son Jack Ritchie in 2022, the coroner concluded that Jack's death had been caused by failures in regulation, inadequate public information about the risks and dangers of gambling, and severe lack of availability of treatment[25]. The coroner issued a Prevention of Future Deaths Report to the three government departments covering gambling, health, and education.

Full training for healthcare professionals and greater equality of treatment

We firmly support the need for much more training for health professionals about how to effectively diagnose gambling disorder and refer to the correct service. Jack Ritchie's inquest highlighted the complete lack of training about gambling for GPs. Several of the loved ones lost by the GwL families went to see their GP, presenting with symptoms like insomnia and anxiety, but were not correctly diagnosed and did not receive the help that could have saved them.

This demonstrates a clear and basic lack of awareness and understanding of gambling disorder at triage level in the NHS. We strongly recommend that screening questions about gambling activity are built into the relevant GP assessment processes, in the same way that questions about drug, alcohol, and tobacco use are asked.

Greater equality of state treatment provision could also help mitigate the suicide risk: there are multiple NHS clinics dedicated treating people with gambling disorder in England, but none in Scotland or Wales.

Dangerous products must be made safer

The most dangerous products – some of which have addiction/at-risk rates of 45% – must be made safer. This should include slowing down the spin speed for online casino-style games and applying maximum stake limits to match their land-based equivalents. There is no evidence to show that the current maximum spin speed of 2.5 seconds is safe: indeed, it is clearly too fast since it underpins the current levels of addiction and harms.

New gambling products must be rigorously tested before they are released to the market, as any new car or pharmaceutical drug would be. A recent British Medical Journal paper[26] concluded “Why are we devising regulations that enable consumers to use dangerous products, rather than preventing their release onto the market?”.

3. **What actions could be taken to better identify those experiencing gambling-related harm who might be at risk of suicidality, with a view to supporting early intervention? By suicidality, we mean suicide, suicide attempts, suicidal thoughts, and suicidal ideation.**

Gambling disorder carries a high suicide risk, and the journey to addiction and ultimately suicidal ideation can be incredibly short – weeks and months, not years[27]. This is supported by the experience of the GwL families. Gambling harm and addiction is the result of dangerous gambling products and predatory industry practices, not of any individual flaw or failing – anyone can suffer gambling harm – which makes it very difficult to identify any individual at increased risk of addiction let alone suicidality.

Regulation must be preventative and underpinned by a thorough understanding of the psychiatric classification of gambling disorder under DSM V. Lived experience reports a chronic condition, highly correlated with suicidal ideation, in which abstinence is maintained with great difficulty. Acute episodes of even short recurrence are highly correlated with suicide attempts and completion. Therefore, we require solutions which acknowledge the speed of onset, the complexity of the

condition and the catastrophic consequences that can result from even a short engagement.

The emphasis must always be on preventative measures, as outlined in our previous answer, rather than waiting for the damage to happen and then trying to identify individuals at heightened risk. However, there are effective measures that can be implemented, such as affordability checks. But affordability checks must be triggered at sufficiently low levels of losses to allow an effective intervention before an individual has been given a serious life-threatening illness.

The deaths of the loved ones of GwL families are a clear demonstration of the failures of gambling operators to identify and intervene when people are suffering major harms from their gambling and at acute risk of suicidality. In many cases the amounts of money which people had lost were substantial and, in most cases, even if the amounts lost were not excessive, they were “unaffordable”.

Currently gambling operators currently don’t even intervene meaningfully when people are losing excessive amounts of money or when their gambling patterns/ patterns of play clearly indicate of harm. Preventative controls and checks must move to real interventions at harmful patterns of play, and not just financial losses.

Indeed, gamblers can feel suicidal even if they are not losing – many of the loved ones lost by GwL families were suicidal whilst believing they had suffered enormous losses when in fact they had experienced a low level of loss and were even in profit over a longer timeframe. Addiction robs the individual of their cognitive capacity, increases risk taking and impulsivity so that capacity for rational decision making while engaged in gambling is severely reduced [28].

With effective controls in place, we have no doubt the young people lost by GwL families would have been identified as spending more than they could afford or suffering harm due to their patterns of play and subjected to a “hard stop” intervention. In conjunction with an appropriate, health-focused intervention, they would likely be alive today.

Currently, the number of accounts subjected to telephone interventions is incredibly low. Research found that during a 1-year period just 0.13% of all gambling accounts were contacted by telephone, despite 10% of people gambling online suffering harm[29]. Very little is known about gambling operators’ algorithms – if they work, how they work, how they are used, what interventions they trigger – we need to know this information, and the algorithms must be made public and independently validated.

As emphasised in previous answers, healthcare professionals, crisis and frontline workers must all be fully trained to spot the signs of gambling disorder and that gambling can be a trigger for episodes of suicidality. This would enable them to identify patients presenting at increased risk, ask the appropriate question and refer

to the right treatment. Anyone identified as being harmed by gambling must be treated as a high suicide risk.

4. **What support/interventions are most appropriate for those who reach a more acute level of suicidality or crisis as a result of harmful gambling? By suicidality, we mean suicide, suicide attempts, suicidal thoughts and suicidal ideation.**

As stated in our answer to the previous question, the focus should always be on prevention and ensuring that people suffering with gambling disorder don't reach acute levels of suicidality in the first place. We have outlined our suggestions regarding this in our answers to questions 2 and 3.

However, there are still important interventions that could be applied at this advanced stage, which must all be grounded by a vastly improved understanding of gambling disorder and just how dangerous it really is, across frontline services and the general population.

Vitally, people at acute levels of suicidality must be asked directly about gambling, and in a non-stigmatising way. Frontline workers to be thoroughly trained must include crisis teams, A&E workers, paramedics, police, emergency call handlers, in addition to the general public. The person identifying a gambler at acute risk of suicidality and asking them about it must understand the increased levels of suicide in this moment and must know where to signpost or refer to.

5. **What do you think are the main gaps in data or evidence that need to be addressed to enable implementation of effective policy and practice to address harmful gambling and to prevent/reduce gambling related suicidal events? By suicidal events, we mean suicide, suicide attempts, suicidal thoughts and suicidal ideation.**

There are multiple gaps in data and evidence that must be improved. However, there is more than enough data and evidence to act on, which should be as much of a priority as addressing the gaps in data.

When GwL was established in 2018, bereaved families were shocked that there were no official figures on the number of deaths related to gambling and how little public understanding there appeared to be about the link between gambling and suicide. Early work by families uncovered a research literature stretching back decades, which those involved in gambling, gambling regulation and treatment should have known about.

GwL were the first to collate international research literature and establish that there were an estimated 250 to 650 gambling-related suicides every year in the UK[30] [31] . Subsequent advocacy and campaigning by GwL families has put suicide at the heart of the need for reform of gambling and gambling regulation, and the scale of deaths has provided some urgency for the need for change: though in truth the speed of progress has been woeful.

Gambling reform featured in all the main party manifestos for the 2019 General Election. In December 2020, the government finally announced its Review of the 2005 Gambling Act. However. Fast forward over 2 years and the White Paper has still not been published but is "imminent"'. This failure to make progress on the issue of gambling suicide itself has been widely acknowledged[32].

Despite GwL's call from the outset for research to both quantify and understand the link between gambling, very little further work has been done in the UK. Although OHID have estimated there are up to 496 gambling-related suicides each year in England, we still don't know the exact number as coroners do not regularly record gambling as a cause or contributing factor in suicides. This must be addressed quickly.

Access to gambling industry and banking data could be incredibly important. It may be possible to make statistical inferences from bank data on gambling expenditure and all-cause mortality[33] . If bank and mortality data linking could be enabled, the association between suicide and patterns of expenditure could be explored further longitudinally, or in a case control study of those who died by gambling related-suicide and matched controls.

If established, an independent data repository of gambling operator data could similarly provide scope to explore patterns of gambling activity associated with suicide and enable better identification of those at risk of suicidal behaviours.

The link between gambling and suicide has been long been known to academics and researchers, but until relatively recently the public has been unaware, with the gambling industry and its lobbyists frequently attempting to discredit and obscure.

The need for more data has been widely recognised. The Gambling Research Exchange Ontario (GREO) opened a call for proposals on the link between gambling and suicide – we know that the link is strong, but we need more data on why it is so strong. In our proposal[34], we have identified the following qualitative and quantitative studies/ areas of interest:

Qualitative

- What are the gambling experiences, events, triggers, and circumstances that lead people who gamble to suicidal thinking and to taking their own lives?
- What patterns characterise the development of suicidal thoughts and behaviour for people experiencing gambling harms?

- What are the possible warning signs or risk markers?
- What specific risk and mitigating factors are involved?
- What role do gambling products, promotions and the gambling environment play?
- What are the public and professional attitudes and understanding of gambling suicide?
- What interventions exist, what are the critical points for interventions and postventions and how effective are they?

Quantitative

Retrospective studies

- Analysis of existing coronial records
- Psychological autopsy study

'Real time' approaches

- Routine recording – coronial process, real time surveillance
- Multicentre monitoring study of self-harm
- Data linking with routine recording gambling problems/diagnosis
- Banking data
- Operator data

Longitudinal studies

Triangulation with other data sets

Finally, a statutory levy to fund independent research and studies into gambling-related suicide is fundamental in to painting a full picture of the scale of gambling suicides in the UK. This data should then be used to inform effective preventative policies.

Is there anything else you would suggest is important for us to consider?

As stressed in several answers, prevention must be the foundation for reducing gambling-related suicides. We need to acknowledge the gambling industry as the primary source of gambling suicides, not individuals, and preventative policy must stem from this. This acknowledgement must be accompanied by an explicit rejection of the "responsible gambling" model across all policy areas – GwL families know that this model, and its messaging, substantially increase suicide risk.

Gambling is the dominant cause in a significant number of suicides – this vital realisation must be acknowledged by the state and widely known by the public.

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[2] https://www.begambleaware.org/sites/default/files/2021-03/PoP_Interim%20Report_Short_Final.pdf

[3] https://www.gamblingcommission.gov.uk/news/article/gambleaware-conference-2021

[4] https://www.natashadowschull.org/addiction-by-design/

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[22] https://publications.parliament.uk/pa/ld5801/ldselect/ldgamb/79/7903.htm

[23] https://www.begambleaware.org/media/2289/annual-stats-2019-20.pdf

[24] https://www.theguardian.com/society/2023/jan/07/betting-industry-will-keep-back-funds-from-gambling-harm-charity

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