EVIDENCE ON THE PREVENTION PARADOX WITH RESPECT TO GAMBLING-RELATED HARM

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THE PREVENTION PARADOX

Which group accounts for more adverse consequences?

Large low-risk group

Small high-risk group
WHY DO WE CARE?

To minimise harm, we need to resource interventions appropriately

Product safety, regulation, broad-scale campaigns.

Identification, acute intervention and treatment

Small high-risk group
THE PP AND GAMBLING

• Raisamo et al (2015) noticed significant harms at low-mid spectrum
  o Suggested more attention be paid to these categories
• Canale et al (2016) observed harms occurring across LR, MR, PG groups
• Browne et al (2016, 2017) found:
  o Significantly higher per-person impact for PGs
  o Significantly higher pop-level impact for LR and MR gamblers
• Delfrabbo & King (2017) made a critical review of the PP wrt gambling
  o Different answers depending on which consequence considered
  o Importance of focusing on genuine, significant consequences
  o Using standard threshold for (PGSI) risk categories
CHALLENGE

• We need detailed information on harmful consequences, that is population representative
• A recent population study cost $894k, but yielded on 23/5000 PG cases
• Population samples
  o Too expensive to include long instruments
  o Not enough cases at the severe end of spectrum
• Stratified / convenience samples
  o Easy to get severe cases
  o Ability to collect detailed information
  o Not representative

• Our method resolves this problem, via one reasonable assumption
METHOD

Stratified sample of harms

Population prevalence of risk-groups

\[ \hat{p}(H) = p(H | C)p(C) \]
WHAT’S THE CATCH?

- Key assumption – $p(H|C)$ in sample is the same as $p(H|C)$ in the population
- E.g. A PG in the sample has the same probability of ‘increased credit card debt’ as a PG in the population
METHOD

• Sample estimates of harms p(H|C)
  o 1524 regular gamblers
  o Oversampling higher risk categories: 39.5% RG, 22.3% LR, 17.4% MR, and 20.6% PG
  o Demographics (age, gender, ethnic background, education) similar to general population
  o PGSI using standard scoring
  o 72 item harms checklist (Browne et al, 2016)

• Population estimates of risk category prevalence p(C)
  o PGSI using standard scoring
  o Hare’s (2015) recent prevalence survey
  o RG .5759, LR .0891, MR .0279 and PG .0081
INCIDENCE OF HARMS BY PGSI CATEGORY

(a) P(PGSI Category)  
(b) Average count of harms per person  
(c) Harms per 1000 people

PGSI Category: RG, LR, MR, PG
PROPORTION OF POPULATION REPORTING 1+ HARM

1+ Harms indicated  No  Yes
NUMBER OF HARMS PER PERSON

(a) (b)

Incidence per 1000 persons

Number of harms reported (/72)

PGSI Category: RG LR MR PG
INCIDENCE OF HARMS BY RISK AND DOMAIN

Harm Domain

Proportion of incidents

PGSI Category: RG LR MR PG
RELATIVE INCIDENCE OF SPECIFIC DEVIANCE HARMS
RELATIVE INCIDENCE OF SPECIFIC FINANCIAL HARM
RELATIVE INCIDENCE OF SPECIFIC RELATIONSHIP HARMs
RELATIVE INCIDENCE OF SPECIFIC EMOTIONAL / PSYCHOLOGICAL HARMS
RELATIVE INCIDENCE OF SPECIFIC HEALTH HARMS
DISCUSSION

• The PP is not supported in certain specific cases
  o Very rare, severe harms (e.g. bankruptcy, criminal activity)
  o These include many ‘social deviance’ consequences (crime, violence, neglect, etc)
  o However, these make up a small proportion of the total impact

• The PP is supported for the vast majority of harmful consequences
  o Including moderately severe harms (e.g. threat of separation, selling personal items)
  o Across all domains, except social deviance

• Aggregate impact is spread across all PGSI categories
  o Accords with findings from the public health method (Browne et al, 2016, 2017)
  o Accords with findings from the economic costing method (Browne et al, 2017)
RECOMMENDATIONS

• My view is that comparisons with alcohol harm are very apt
  o Individuals with alcohol use disorder account for only a portion of total harm
• Monitoring gambling impact from prevalence studies must change
• Psychological addiction is distinct from harmful consequences

• A political focus on the (low) prevalence of PGs is unhelpful and potentially misleading
• Efforts to reduce impact should include a strong focus on population-wide interventions
  o Product safety ($1 bets anybody?), limitation of availability, cultural norms, etc
• A public health model is more helpful than a medical / psychological addiction model
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