

# Gambling Harms and the Prevention Paradox in Massachusetts



September 7, 2021

**EXECUTIVE SUMMARY**

**SEIGMA**  **SOCIAL AND ECONOMIC IMPACTS  
OF GAMBLING IN MASSACHUSETTS**

UNIVERSITY OF MASSACHUSETTS SCHOOL OF PUBLIC HEALTH AND HEALTH SCIENCES

# Authorship and Acknowledgements

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## Authorship

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# Executive Summary

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Until quite recently, gambling harms have largely been identified with the clinical entity of problem gambling. In the past decade, however, a broader view of the impacts of gambling has emerged with a shift in focus from problem gambling to ‘gambling-related harm.’ This approach recognizes that there are many more people harmed by gambling than reflected in the rates of problem gambling alone. Similar to public health and health promotion approaches to alcohol consumption, this perspective on gambling consumption recognizes that gambling has some positive impacts on society, including generation of revenues to governments, industry employment, and new leisure options for communities, and that the majority of people gamble without experiencing any evident harm.

Use of the term ‘Prevention Paradox’ in relation to gambling focuses on the recognition that a far greater number of individuals experiencing gambling-related harm are low-risk gamblers because there are far more low-risk gamblers than high-risk gamblers in the population. The ‘paradox’ is that more aggregate harm is suffered by the low-risk gambling population even though, individually, people in the high-risk population (e.g., heavy gamblers and those experiencing gambling problems) suffer the greatest amount of harm per individual.

A public health approach to understanding and minimizing gambling harm requires: (a) a clear and consistent definition of the concept, (b) identification of the potential types of harm, and (c) the use of assessment instruments that adequately measure and capture this harm. While gambling harm can be challenging to define and measure, significant research has been done to classify the impacts associated with regular or heavy gambling involvement and to develop measures for use in population surveys.

The purpose of the present report is to examine whether the ‘Prevention Paradox’ in relation to gambling harm holds up in the Massachusetts context. In addition to extending our understanding of gambling harm in different cultural and regulatory contexts, this analysis builds on prior work by using Massachusetts population survey data and by employing an instrument that comprehensively and unambiguously assesses harm to self and others. The goal is to examine the distribution of different gambling harms in the Massachusetts context and to assess the extent to which different types of harm are concentrated in higher risk groups.

The analyses presented here draw from two population surveys that were carried out in Massachusetts in 2013 and 2014, prior to the opening of any casinos in the Commonwealth. These surveys were the Baseline General Population Survey (BGPS) and the Baseline Online Panel Survey (BOPS). While recognizing that the BOPS respondents were much more likely to engage in heavy gambling and to experience gambling problems compared with the BGPS respondents, the decision to combine the samples was a practical one taken to create a sample sufficient to analyze the **relative** prevalence of gambling harms among groups with different levels of gambling severity. We further chose to focus on regular gamblers because only these individuals were routed through the section of the survey questionnaire that assessed gambling harms. For the present analysis, endorsements of gambling harms based on responses to these survey questions were collapsed into six categories: financial, health, emotional/psychological, family/relationships, work/school, and illegal acts. The analysis is based on 5,852 individuals who gambled at least once a month on one or more of nine types of gambling.

In addition to differences in gambling participation and problem gambling rates, BOPS regular gamblers were significantly more likely than BGPS regular gamblers to be male and under the age of 65, and to have annual household incomes between \$50,000 and \$100,000. BOPS regular gamblers were significantly less likely than BGPS regular gamblers to be aged 65 and older, to have attended college or graduate school or attained a graduate degree, and to have annual household incomes over \$150,000.

The approach to assessing gambling severity was modeled on a recent study in Finland that utilized the same measure to assess problem gambling as was used in Massachusetts. For the present report, only items measuring impaired control and behavioral dependence were used to define the gambling severity groups in order to avoid overlap with the outcome of harmful impacts. Scores on items for impaired control and behavioral dependence were added and categorized into four Gambling Severity groups: None, 1-2, 3-4, and 5 or more. There was a strong relationship between scores on the subset of impaired control and behavioral dependence and scores on the full measure.

Descriptive analyses were conducted to summarize the prevalence of harms reported by different severity groups. Results clearly demonstrated the inverse relationship between gambling severity and gambling harms and how these combine to contribute to the aggregate impact of each group. Due to the much larger size of the three lower severity groups, even the much smaller average number of harms endorsed by members of these groups account for nearly three-quarters (72.9%) of the aggregate number of harms across all of the groups. The analysis also illustrated that while almost all of the individuals in the highest severity group reported one or more harms, any particular individual reporting one or more harms was far more likely to be in a lower severity group. An important limitation of this result is that it ignores differing degrees of harm.

A more nuanced view of the distribution of gambling harm across severity groups examined the prevalence of regular gamblers reporting different numbers of harms, separated by gambling severity. This analysis demonstrated that the most severe group makes up less than a third of gamblers reporting one, two or three harms but more than 70% of those reporting six or seven harms and 90% or more of those reporting nine or more harms. Since a limitation of examining the aggregate count of harms is that it ignores differences in type and severity of harms, the final analysis examined the relative proportion of harms reported, separated by both harm domain and severity group. This analysis showed that financial, health, and emotional/psychological harms were the most common types of harm and the most broadly distributed across the gambling severity groups. However, even in the case of less common harms such as work/school, relationship, and illegal harms, the harms were broadly distributed across the different severity groups. Our conclusion is that the Prevention Paradox was supported across all of the harm domains in Massachusetts—a finding that contrasts with the Finnish study which found that the highest gambling severity group accounted for over 50% of the harms in the less common domains.

The classic formulation of the Prevention Paradox suggests that, if the aggregate number of harms is higher among individuals with less severe problems, then **primary** prevention efforts aimed at altering unhealthy or unsafe behaviors across the entire population should be emphasized, rather than or in addition to **secondary** prevention efforts aimed at halting or slowing the progress of the disorder among individuals at risk and **tertiary** prevention efforts aimed at helping those already experiencing gambling problems. The evidence suggests that the Prevention Paradox is indeed occurring in relation to gambling in Massachusetts and supports the notion that more resources should go toward primary prevention (including universal, selective, and indicated strategies) to forestall the development of gambling harms and somewhat fewer resources should go to the provision of formal treatment and recovery maintenance services.

This is counter to results from the Massachusetts Gambling Impact Cohort study, where we found that the majority of problem gamblers in Massachusetts were relapsed, rather than first-time, problem gamblers. It is possible that gambling harms among individuals with more severe problems have intensified since the casinos in Massachusetts opened. We plan to analyze data from two follow-up surveys (general population and online panel) that will be fielded in September 2021 to determine whether the paradox effect has changed since the opening of the casinos. It is also worth noting that our analysis of gambling harms is based on cross-sectional data and does not take into account the recurring nature of harms among those experiencing gambling problems. Massachusetts may be a jurisdiction where successful treatment of existing problem gamblers is just as important as prevention of problem gambling onset.

High rates of financial harms and health harms among regular gamblers in Massachusetts suggest the importance of raising awareness about gambling-related harm and educating community-based organizations about the extent of gambling harm among regular gamblers. Beyond community organizations, health professionals, financial counselors and even financial institutions such as banks and credit unions would benefit from a better understanding of the scope of gambling harm among their clientele as well as some knowledge of how to sensitively ask their clients about their gambling and the gambling of their family members and friends.

Both the BGPS and the BOPS have some limitations that must be acknowledged. With regard to the BGPS, one potential limitation is the 36.6% response rate attained in the survey. Another limitation of the BGPS is that the survey was restricted to adults living in households and did not include adults living in group quarters, incarcerated individuals, or homeless individuals. A third limitation is that the questionnaire was translated into Spanish but not into other languages. Like other prevalence surveys, the BGPS is a cross-sectional ‘snapshot’ of gambling and problem gambling at a single point in time which limits our ability to draw any causal conclusions from reported associations in the data. With regard to the BOPS, the main limitation is the non-representative nature of online panels and the fact that a non-random minority of people do not use the Internet, and thus are not eligible to be part of an online panel. A limitation of the decision to combine the samples for the present analysis is that the results cannot confidently be generalized to Massachusetts as a whole. A final limitation relates to the nature of self-report in surveys more generally which raises the possibility that respondents in the BGPS and BOPS under-reported their gambling behavior and harms due to social stigma.