



Progress Report on the National Strategy to Reduce Gambling Harms

Executive summary

- The Gambling Commission published the National Strategy during a year of rapidly growing interest in gambling related harms. The range of organisations now taking an active role represents a significant step forward, and there has been some progress in both priority areas of prevention and treatment.
- Much more, however, still needs to happen to achieve the objectives of the National Strategy. Failure to make progress on the issue of gambling related suicide must be urgently addressed.
- Our priority recommendations for year two include establishing a safer gambling league table and key baseline metrics from which to set targets and measure progress. Government, regulators, industry, the NHS and third sector organisations should agree areas of responsibility for ensuring these metrics are in place.
- There needs to be an acceleration of efforts to involve people with lived experience in the delivery of the National Strategy.
- To make faster progress on treatment, the NHS should lead the creation of a national treatment strategy working in partnership with the third sector. Agreed care pathways between the NHS and other providers are essential to the development of equitable services and there needs to be rapid implementation of quality assurance processes to monitor existing provision.
- Greater progress is also required to secure more effective arrangements for commissioning research – particularly on the measurement of gambling harms. We recommend that initial engagement with research councils is built upon to increase their involvement on this area.
- We continue to urge progress on a statutory levy to underpin all of this work with sustainable, independent funding. Without the levy, progress will be limited.
- The COVID-19 pandemic has created unprecedented challenges to almost every aspect of life in Britain. Gambling activity is no exception and the exhortation to “Build Back Better” is as relevant to the goal of safer gambling as it is elsewhere in society.

Section 1: Introduction

1. The Advisory Board for Safer Gambling (ABSG) is responsible for reporting annually on the progress of the National Strategy to Reduce Gambling Harms.
2. This is the first Progress Report,¹ setting out our views on the achievements and the gaps to date, concluding with our recommendations for the second year of the Strategy.²
3. The findings are relevant to a wide range of audiences – particularly those partners involved already in the implementation of the National Strategy.
4. This report contributes to the objectives of the National Strategy by highlighting:
 - Successes, so that this activity can be built upon
 - Gaps and areas where progress has been slow, so that action can be taken to address this
 - Areas where we recommend attention is focused in year two (and three) of the strategy to achieve the greatest impact on the reduction of harms.

Key governance documents

5. A more definitive list of activity related to the National Strategy is set out in the Gambling Commission's quarterly Implementation Updates.³ These documents set out more detailed project-by-project progress updates. These explain the range of activity being delivered by multiple partners in support of the National Strategy.⁴
6. As such, this report is best read in conjunction with these updates. This report is not intended to be a definitive record of all activity delivered in relation to the National Strategy. Under the previous National Strategy, progress reports from this Board included a detailed list of projects in progress. With the change in responsibilities for publishing the National Strategy now resting with the Commission, these detailed governance documents are now also produced by the Commission. The role of the progress report is to highlight high-level successes, gaps and recommendations.

Background

7. In April 2019, the Gambling Commission launched the National Strategy to Reduce Gambling Harms in London. Launch events in Cardiff and Edinburgh followed in June. The Strategy was welcomed as a significant milestone in

¹ The impact of COVID-19 lockdown led to the delay of the publication of this report. This was done so that information on progress could be obtained from bodies delivering the strategy – many of which were directly involved in the public health response to the pandemic.

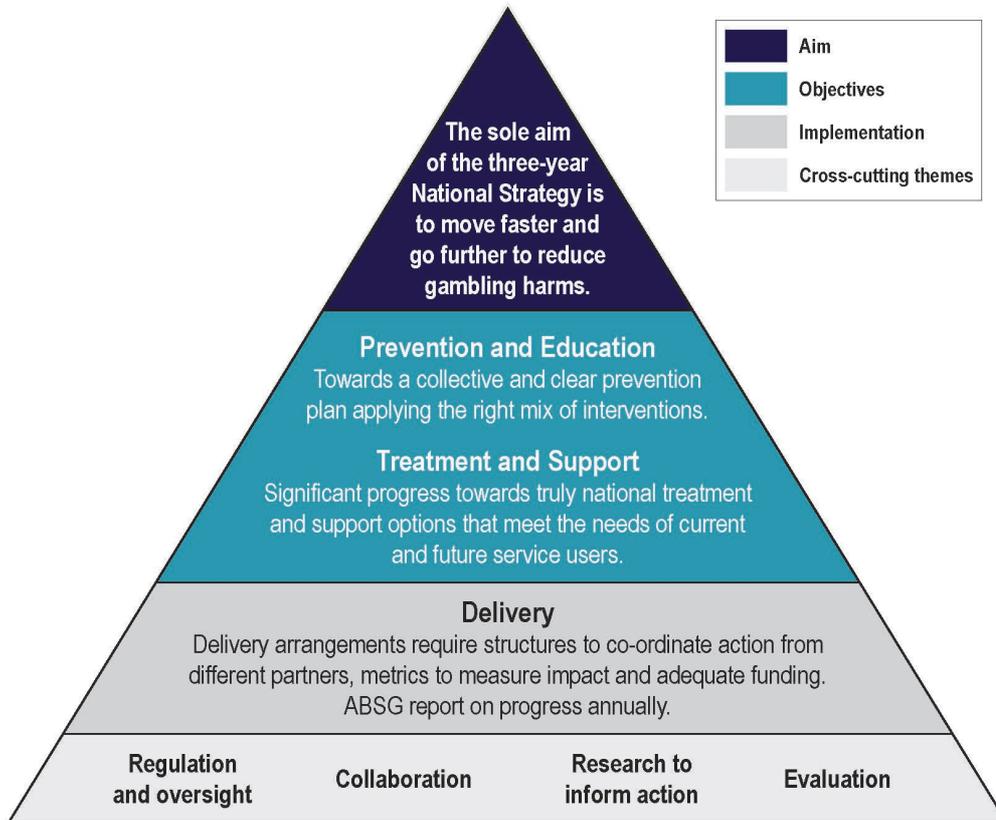
² ABSG has drawn on a range of sources of expertise in reaching its conclusions. These include published research evidence and Annual Reports, interim project reports, Commission document reviews and Assurance Statements, and feedback from a wide range of stakeholders.

³ [National Strategy – Progress Update](#), National Strategy to Reduce Gambling Harms, January 2020

⁴ The implementation update for Year 1 (and up to June 2010) is forthcoming and will be published on the [National Strategy](#) microsite – this follows a delay caused by COVID-19 which meant more time was needed to collect progress updates from partners.

efforts to address harms from gambling. It placed public health approaches firmly at its centre, providing new opportunities for better and faster progress.⁵

Overview of the National Strategy to Reduce Gambling Harms – aims, objectives and cross-cutting themes



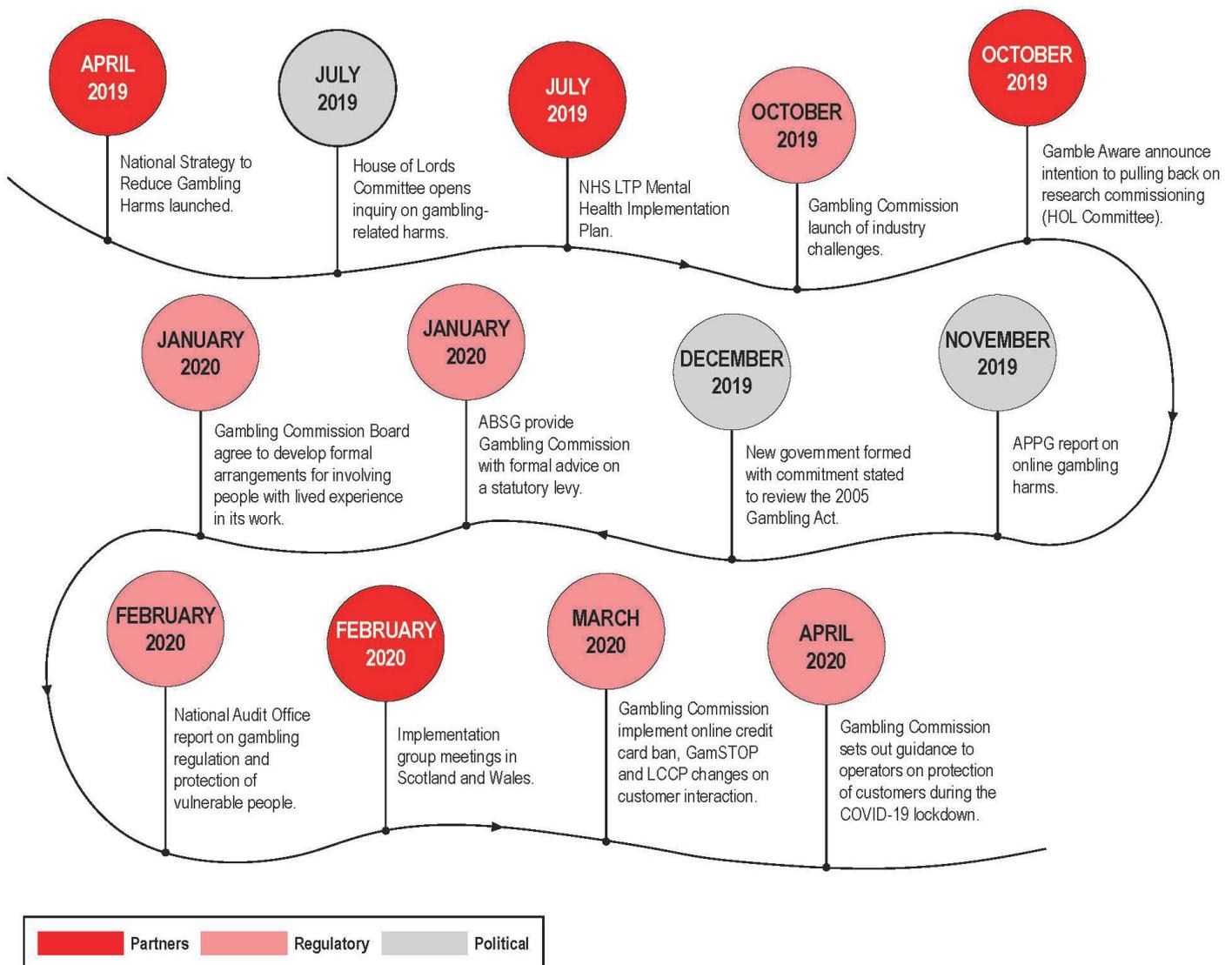
8. The National Strategy was launched during a year when many other new developments in addressing gambling harms were underway:
- Campaigning organisations brought challenging perspectives to public and political debate, stressing urgency and calling for tighter regulation measures and greater parity for treatment with other types of addiction.
 - The media’s interest in gambling and gambling harm grew throughout the year in ways not previously seen. Talking about gambling harm and recognising the need for action gathered momentum and brought the voice of those with lived experience to the forefront of public consciousness for many months during 2019/20.
 - The NHS in England began to take a more proactive stance through its Long Term Plan and made a commitment to opening 14 new treatment clinics.⁶
 - Implementation Groups have met in Wales and Scotland to start co-ordinating activity to deliver the National Strategy.

⁵ [Launch of the National Strategy to Reduce Gambling Harms](#), Gambling Commission, April 2019

⁶ [NHS to launch young people’s gambling addiction service](#), NHS England, 2019

- Public Health England and the National Institute for Health Research began their respective evidence reviews of gambling harms, and NICE signalled its commitment to producing guidelines once the reviews were published.
- Parliamentary Committees in the House of Commons and the House of Lords invited a wide range of experts to give evidence.
- The Gambling Commission Board invited ABSG to provide formal advice on a statutory levy.
- The Government made a manifesto commitment to a review of the Gambling Act during this Parliament.
- The Gambling Commission introduced a series of changes to its licencing requirements on credit card use, age verification checks, customer interaction requirements and self-exclusion measures, and issued the industry with new challenges to find ways to address harms.

Timeline - external environment



Impact of COVID-19 and lockdown measures

9. In March 2020, the UK Governments introduced lockdown measures in response to the COVID-19 pandemic. This had an almost immediate impact on many of the projects that were underway and moved the public and political focus away from gambling harm. As a result, the publication of this report, along with the Commission's own update on the progress of the Strategy, was postponed until June 2020.
10. The COVID-19 crisis has had a direct impact on gambling, with widespread cancellation of sporting events and closure of all premises based gambling outlets. We have yet to obtain data to give a full picture of the nature and extent of online gambling activity in this period.⁷
11. The consequences of these unprecedented changes have yet to be evaluated, but there are likely to be long-term health, social and economic impacts and exacerbated inequalities. Online gambling activity has increased in importance, which will mean more data on gambling patterns is now available to operators than ever before. However, challenges of availability of data means that reliable baseline estimates from which to measure recent changes are limited. This highlights the need for a fresh look at metrics that can help to identify those most at risk and do more to keep customers safe. The impacts of COVID-19 and "build back better" for the gambling industry will be reported on in ABSG's 2021 Progress Report.⁸

'Progress' versus 'impact' reporting

12. Harvard Professor Malcolm Sparrow,⁹ whose work on harm reduction in other sectors is well documented, suggests identifying key harms and agreeing on ways to measure them provides an effective catalyst for change. This approach helps to create common goals and improve coordination across multiple stakeholders. It is not enough simply to report on activities and timelines. Projects need to report on outcomes, and what has been achieved in reducing harm.
13. A key recommendation in this report is that specific metrics for measuring harm reduction need to be in place for the National Strategy as a whole, as well as for individual projects so evaluations can help measure the contributions being made. Where gaps exist, for example in establishing baseline data, efforts need to be made to address these, and responsibilities for collecting data assigned to specific organisations. DCMS has recently reinforced its commitment to doing whatever it can to 'free up data sources across government' that will contribute to this goal.¹⁰ We provide proposals for what these metrics should look like in Annexes 1 and 2.

⁷ [COVID-19 and its impact on gambling – what we know so far](#), Gambling Commission, May 2020.

Further data and updates will be provided by the Gambling Commission

⁸ [Build back better](#) – website & [We owe it to future generations to build back better](#), Business Green, 28 May 2020

⁹ [The Character of Harms](#), Sparrow, M, Cambridge University Press, 2009

¹⁰ [Public Accounts Committee](#), 27 April 2020

Structure of this report

14. This paper is structured as follows:

- Section 2 – Governance and delivery
- Section 3 – Prevention and education
- Section 4 – Treatment and support
- Section 5 – Indicators and metrics
- Section 6 – Recommendations and priorities for Year 2
- Section 7 – Conclusions.
- Annexes 1 and 2 - Set out proposals for goals and targets

Section 2: Governance and delivery

15. For every strategy, effective governance and oversight are essential to success. The National Strategy for Reducing Gambling Harms has required new structures to be formed. Some of these are not yet fully in place and some have been delayed by the impact of the COVID-19 crisis.
16. This section describes the progress and challenges in creating the necessary infrastructure to deliver the National Strategy, including implementation structures, involvement of people with lived experience, funding and research.

Governance and delivery – summary of progress	
Strengths	Weaknesses
<ul style="list-style-type: none"> • Strategy Implementation groups in Scotland and Wales now forming. • Work with people with lived experience commenced to co-create structures to put people with lived experience at the heart of implementation in Scotland. • The Gambling Commission announced plans to form an ‘experts by experience’ group to inform its own regulatory work. • The Gambling Commission is publishing quarterly implementation updates to highlight new activity being delivered to reduce gambling harms. 	<ul style="list-style-type: none"> • Limited cross government ownership of gambling harms. • Strategy Implementation group for England not yet in place. • No formal structures for involving people with lived experience in implementation decisions in England or Wales. • A risk register for the strategy has not been published. • Metrics for measuring progress not yet agreed. • Funding too reliant on voluntary donations from the Gambling Industry.

Summary of progress

Implementation structures

17. The National Strategy was published by the Gambling Commission. Its implementation, however, relies on the involvement of a wide range of organisations, including central and local government departments, public health bodies and the third sector. Specific approaches to implementation are required in England, Scotland and Wales to reflect the jurisdiction of different bodies at national level. Key developments include:

- In England, DCMS created the Research, Education and Treatment (RET) Group, which brought together some of the public bodies in England following the Gambling Review in 2018 and helped co-ordinate the regulatory changes which emerged. There is an opportunity for the group to widen its membership and become more proactive in coordinating activity to reduce gambling harms across England.
 - In Scotland, a group of stakeholders has formed the Implementation Group for Scotland. This includes the Scottish Government, the Scottish Public Health Network (ScotPHN), the Convention of Scottish Local Authorities (COSLA), Police Scotland, the Health and Social Care Alliance Scotland, and the Gambling Commission. A permanent chair needs to be identified, although in the short-term ScotPHN will provide this. The group in Scotland has a strong focus on engagement with the third sector and on working with people with lived experience, both of which will be co-ordinated through the Health and Social Care Alliance.
 - In Wales, a group of stakeholders have formed the Implementation Group for Wales. This initial group includes representatives from; the Welsh Government (Public Health Wales), the Local Authority Licensing panel, the Police, Police Substance Misuse Diversion service, PHSE Wales for schools Curriculum and Assessment, ARA (Recovery for All) and the Gambling Commission. A permanent chair needs to be identified, although this will be provided by Public Health (Education) Wales in the short-term. The group in Wales plan to integrate initiatives around gambling into their broader Wales-wide initiatives such as the Well-being of Future Generations Act, Police ACE programme and the new PHSE curriculum for 2022.
18. The establishment and operation of the strategy implementation groups in Scotland and Wales represents significant progress towards three country impact.
 19. Different ways of working across countries provides opportunities to test or accelerate alternative approaches. If well evaluated, this will provide evidence on what works, and what might be scaled-up.
 20. Shared across all three nations, however, is the need for greater ownership by government departments – including those responsible for health and public health. This is vital if the range of required actions to reduce harm are to be delivered.

Governance and oversight

21. The Gambling Commission is publishing quarterly implementation updates on the National Strategy.¹¹ These provide information on new activities and their status.
22. There are, however, notable gaps in governance and oversight reporting for the National Strategy:
 - i. The lack of a public risk register: This means there is less visibility of risks to the delivery of the National Strategy and clarity on who is responsible for managing them. The Gambling Commission maintains a risk register for its own Business Plan – including activity to make gambling safer and reduce gambling harms. It does not, however, maintain a risk register for the National Strategy as a whole.
 - ii. The absence of agreed metrics: Impact measurements provide strong accountability to ensure progress is being made. The difficulties of measuring gambling-related harms are well documented,¹² and, to date, the National Strategy does not include clear progress and impact measures to explain how these will be demonstrated.
23. Implementation groups in England, Wales and Scotland are ideally placed to take responsibility for these actions. These groups are, however, still in formation, and are still some way from considering and agreeing impact metrics and forming risk registers. As these groups take further shape over the next twelve months, we recommend that addressing these gaps is prioritised. The recommendations in this report will contribute to this.
24. We also note the National Audit Office recently highlighted a lack of clear impact measures in its report on gambling regulation¹³. The Gambling Commission has accepted the recommendations in the NAO Report and is working to develop a new measurement framework. We recommend the Commission's work is used to catalyse wider action on metrics for the National Strategy.

Involvement of People with Lived Experience

25. The National Strategy made a clear commitment that people with lived experience would be at the heart of delivery. More work is needed to embed this approach and create formal involvement by people with lived experience.
26. Key steps taken so far include:
 - In Scotland the goal is to ensure that people with lived experience be active partners in its Strategy Implementation Group. The Health and Social Care Alliance has been funded, via a regulatory settlement, to develop structures in Scotland to put people with lived experience at the

¹¹ [National Strategy to Reduce Gambling Harms, implementation update](#), Gambling Commission, January 2020

¹² [Measuring gambling-related harms: a framework for action](#), Wardle et al, July 2018

¹³ [Gambling Regulation: Problem Gambling and Protecting Vulnerable People](#), National Audit Office, February 2020

heart of delivering the National Strategy. There is a clear commitment to ensure people with lived experience will co-produce the structures that are required to bring about progress.

- The Gambling Commission hosted an 'Experts by Experience' Forum in November 2019, followed by another workshop in March 2020. This was well attended by people with lived experience from across GB. Participants made a number of recommendations to the Commission on ways to improve involvement. An Interim Experts by Experience Group for England and Wales has now been created. This will help co-design permanent arrangements for engagement with the Gambling Commission and national Strategy.¹⁴
 - Lived experience conferences, hosted by GambleAware, BetKnowMore and Gambling Harms North West Alliance, were held in Manchester and London. These provided opportunities for lived experience to be shared with a range of stakeholders in the National Strategy.
 - New organisations, such as the Gamvisory Group, have emerged to further represent the voice of lived experience and raise awareness of gambling harms.¹⁵
 - There have been a range of key achievements driven by those with lived experience, including campaigning work, work within treatment services and prevention and education work and these continue to gather momentum.
27. Despite these actions, greater pace is required to achieve the vision for involvement set out in the National Strategy. One year in, there is little evidence of specific decisions where people with lived experience have been involved in co-producing decisions or exerting influence on the actions that have been taken. Since March 2020, there have been a number of initiatives that signal greater involvement has begun.¹⁶ Creating an approach that represents a wide range of experiences is also a challenge. There continues to be gaps, for example among women, young people, and those from black and minority ethnic groups.

Case study 1: Health and Social Care Alliance Scotland – Scotland Reducing Gambling Harms Programme¹⁷

The purpose of this programme is to put people with lived experience at the heart of implementation of the National Strategy in Scotland.

The work to date includes a mixture of engagement activity and preparations to co-produce arrangements for a Lived Experience Forum in Scotland. The

¹⁴ [Experts by experience expert group created](#), gambling Commission, June 2020

¹⁵ [Gamvisory Group - website](#)

¹⁶ [Gambling Commission Business Plan 2020/21](#)

¹⁷ [New ALLIANCE programmes on reducing gambling harms](#), Health and Social Care Alliance Scotland, February 2020

challenges created by the Covid-19 pandemic have meant that engagement has had to be reframed and delivered virtually, including:

- virtual events across Scotland,
- an online survey,
- interviews with people with lived experience,
- membership engagement sessions.

The project has worked in close partnership with the Glasgow City Whole Systems project addressing gambling harms,¹⁸ Third Sector Interface (TSI) networks, Self-Management Network Scotland. It has become embedded into the initial discussions of the Implementation Group for the National Strategy in Scotland (SIG) and hosted an International Futures Forum (IFF) three horizons session with SIG members, including Scottish Government to frame the implementation plans within a person centred, public health approach. Through 'active implementation' this will help ensure these voices are part of the decision-making processes for the strategy.

In addition, the programme is scoping with academics in the field of gambling harm the establishment of a PhD on engaging people with lived experience, planning an outcomes focused, co-created evaluation of the programme, and gathering a collection of 'Digital Voices' stories in print and a range of digital media.

The project aims to have established a lived experience forum within Scotland by Winter 2020/21. This will ensure people with lived experience are fully involved in action to reduce gambling harm and inform the delivery of the National Strategy.

Funding

28. ABSG,¹⁹ the Gambling Commission,²⁰ and many other stakeholders, including parts of industry,²¹ have advocated the need for a statutory levy to replace the existing voluntary arrangements. This would provide sustainable funding for independent research, and long-term delivery of prevention and treatment services through statutory bodies working in partnership with accredited third sector organisations.
29. Although the voluntary system remains in place, the National Strategy is being delivered in an environment where funding arrangements are in a state of transition. With 2019/20 seeing significant developments in funding arrangements:
 - In December 2019, Lord Chadlington announced that a new charity would be established to administer an estimated £60 million fund pledged to

¹⁸ [Gambling related harm](#), Public Health Scotland

¹⁹ [Advice on the National Strategy to Reduce Gambling Harms](#), RGSB, February 2019

²⁰ [Launch of the National Strategy to Reduce gambling Harms](#), Speeches, Gambling Commission, April 2019

²¹ [RGA urge funding levy to combat problem gambling](#), iGamingTimes

address harms by the ‘big five’ gambling operators. In June 2020, the Betting and Gaming Council announced that its five largest members would deliver a £100 million fund through GambleAware over five years.²² These announcements have the potential to significantly change the funding landscape, but there is ongoing uncertainty about timeframes, exacerbated by the impact of the COVID-19 pandemic on the gambling industry. As yet, no new money has been forthcoming. It has been disappointing to see no explicit link in either announcement to the National Strategy itself, nor any mention of the critical need for investment in prevention.

- In January 2020, the Commission made changes to its guidance, which clarified the range of organisations that can receive voluntary donations from operators. Revised criteria, and a list of bodies that could demonstrate that they met these criteria, was published. The impact of this change on the distribution of funding is yet to be observed.
 - In October 2019, GambleAware indicated at an evidence session at the House of Lords Select Committee,²³ that its long-term objective was to reduce its commissioning of research and restrict future research funding to evaluation of its own treatment and other services, creating greater independence from industry donations.
30. Uncertainty remains about the future of the funding system for research, prevention and treatment. A continuing reliance on a voluntary system, wherever that may be situated is, in our view, not sustainable.²⁴ Concerns continue about independence, predictability and the quantum of funding, and in the absence of a levy, there are significant limitations on the scale of action that can be taken.²⁵ Activity to reduce gambling harms must still compete with other priorities in statutory health and public health budgets, and the financial impact of the COVID-19 pandemic on businesses and public services is likely to be significant.

Lack of agreed ‘baseline’ data set for measuring gambling harms

31. The National Strategy to Reduce Gambling Harms recognises that the concept ‘problem gambling/gamblers’ does not lend itself to expressing the broader social and economic causes, manifestations and impacts of harms from gambling to individuals, as well as their friends, families, communities, employers and financial institutions.
32. As stated earlier, measuring harms is difficult, but progress has been made in recent years. There are a number of detailed frameworks that define gambling

²² [Latest news](#), Betting and gaming Council, June 2020

²³ “– [Select Committee on the Social and Economic Impact of the Gambling Industry](#), House of Lords, 29 October 2019, p12 and p13

²⁴ Advice on a statutory levy, ABSG – publication pending

²⁵ House of Lords - Written Answers - Department for Digital, Culture, Media & Sport, Monday 4 May 2020

harms.^{26,27,28 29} However, now that gambling is recognised as a public health issue, participation and harm should be reported as key public health indicators at a level useful to local authorities. In order to achieve this in England and Wales,^{30,31} we recommend that their respective Public Health Outcomes Frameworks include gambling related metrics and that Scotland use their own well-established public health outcomes to obtain comparable data.³²

33. Focused research can further contribute to much needed new intelligence. Longitudinal cohorts can provide information on a range of broader social, cultural and economic influences and impacts. A scoping study for a longitudinal study has been completed to explore this³³ and there are also opportunities to utilise existing UK longitudinal cohorts.³⁴ Adequate funding and appropriate research governance are now required so these next steps can be taken.
34. There is also a need for epidemiological research to ensure that local level data is collected on gambling participation, attitudes and impacts as part of local authorities' wider public health responsibilities. Local data is most likely to lead to local action to address harms. Reducing inequality is a core function of public health and local information on age, sex, ethnic, geographic and income differences in participation and risk of harm is urgently needed to underpin effective prevention strategies and support the development of targeted and effective interventions.
35. Establishing baseline data is key to measuring progress and requires endorsement and support from government departments, regulators and third sector organisations.

Research infrastructure

36. The Strategy makes a clear commitment to developing an evidence-based approach to harms reduction. There are outstanding challenges with both infrastructure and delivery still to be addressed.
 - Independence from voluntary funding – as noted above, voluntary funding from industry is not optimal for research to inform the reduction of gambling harms.
 - Quality of research – ABSG's advice on the National Strategy highlighted the opportunities to make more use of the existing research council infrastructure to fund and quality assure gambling research and ensure adequate peer review and quality assurance. Greater strategic

²⁶ [Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms](#), Langham et al, BMC Public Health, 2016

²⁷ [Measuring gambling-related harms: a framework for action](#), Wardle et al, July 2018

²⁸ [Gambling-related harm evidence review](#), Public Health England, 2020

²⁹ [Measuring gambling-related harms: Methodologies and Data Scoping Study](#), McDaid and Patel, October 2019

³⁰ [Public health Outcomes Framework](#), Public health England

³¹ [Our Strategic Plan 2018-21](#), Public Health Wales

³² [The Scottish Public Health Observatory](#), Public Health Information for Scotland

³³ [Longitudinal study of gambling](#), Natcen, April 2019

³⁴ [Longitudinal study of gambling](#), Natcen, April 2019

involvement by funding bodies such as the National Institute for Health Research (NIHR), Medical Research Council (MRC), Wellcome, Economic and Social Research Council (ESRC) and UK Research and Innovation (UKRI) is essential. These funders are well-recognised globally as leaders in health and public health research, have robust governance and processes in place, and extensive expert and reviewer networks to support the development and delivery of high-quality research. Early conversations with the NIHR/DHSC, MRC and Wellcome have identified a strong interest in gambling research and a commitment to developing a robust evidence base around both participation and risk of harm, and inequalities associated with these. Continuing to develop these collaborations will make an important contribution to research infrastructure.

- Greater collaboration with the academic community – There is a need for more collaboration to help translate research into policy. In November 2019, the Commission and ABSG held a forum for academics from across GB to discuss this. There was consensus that progress on this would be useful. The Gambling Commission is responsible for the next steps to achieve this. Collaboration through existing ‘research into practice’ initiatives such as the regional NIHR Applied Research Collaborations (ARC)³⁵ and the regional Academic Health Science Networks³⁶ would also serve to engage with a wider group of public health academics working to address other addictions and health impacts.

Case Study 2: Gambling Research Exchange Ontario (GREO)³⁷

Based in Ontario, Canada, GREO has established a strong reputation for knowledge exchange and dissemination of findings from academic literature. In June 2019, GREO obtained funding from a regulatory settlement to provide support to the National Strategy.

Since then, they have provided dedicated support focused on the Research to Inform Action and Evaluation enablers. This has led to a number of outputs, including:

- Developing a micro-site providing plain language summaries of the latest research on reducing gambling harms³⁸
- Creation of a webpage: ‘*Resources for Safer Gambling during COVID-19*’ assembling evidence related to gambling behaviour, mental health, and wellbeing in nine key topic areas.³⁹
- Developing resources to embed a culture of evaluation that supports capacity across all partners to understand what works.
- Completing a rapid evidence review: ‘*Effective Treatment and Support for Problem Gambling*’ to inform national treatment provision.

³⁵ [Applied research collaborations \(ARC\)](#), NIHR

³⁶ [Academic Health Science Networks](#), website – [add citation for Wales and Scotland equivalent]

³⁷ [GREO](#)

³⁸ [National Strategy Microsite - GREO](#)

³⁹ [Resources for Safer Gambling during COVID-19](#), GREO

GEO has also delivered 'evidence exchanges' on the following topics to support policy development and to help inform stakeholders in the National Strategy:⁴⁰

- Responsible gambling on regulated and unregulated online gambling sites (Aug 2019)
- Scratch card near-miss outcomes (Oct 2019)
- Proportion of revenue from problem gambling (Nov 2019)
- Stigma and gambling (Dec 2019)
- Jurisdictional scan on systems of funding for gambling research (Jan 2019)
- Warning labels and messaging for youth gamblers (Mar-2020).

Industry culture

37. The success of the National Strategy requires action from multiple stakeholders and the whole spectrum of operators from across gambling industry has a critical role to play in reducing harm by the way it implements measures to protect its customers.
38. Past performance has been mixed.⁴¹ There have been good examples of progress, such as improving the prominence of gambling management tools and some short term increased prominence of safer gambling tools within marketing.⁴² However, enforcement cases by the Gambling Commission over past years have frequently identified similar failings - operators have systematically either missed obvious warning signs of harm, or have failed to take appropriate action when these signs have been displayed.⁴³
39. We doubt whether the gambling industry has yet achieved the capacity and culture to give us confidence they are ready to fully engage in the delivery of the National Strategy. Making further demonstrable progress on changes to industry culture would be a key indicator of change.

⁴⁰ [Evidence centre - GREO](#)

⁴¹ [ABSG Publications](#) - RGSB progress reports on past strategy

⁴² [BGC members to remove TV and radio gaming advertising during COVID-19 lockdown](#), BGC

⁴³ [Enforcement report 2018/19](#), Gambling Commission

Section 3: Prevention and education

40. The National Strategy seeks a clear collective prevention plan, applying the right mix of interventions and targeting prevention activity where it will have the most impact.

Prevention and Education – Summary of progress	
Strengths	Weaknesses
<ul style="list-style-type: none"> Strengthened LCCP requirements – banning the use of credit cards for online gambling, stronger customer interaction requirements and mandating membership of GAMSTOP. Action by banks and financial sector to offer transaction blocking – and partnership work with Money and Mental Health Institute. City-wide public health prevention programmes with involvement of people with lived experience launched in Glasgow and Greater Manchester. Activity piloted to raise awareness of risks of gambling in children and young people – e.g. ParentZone, FastForward, Programme-A, YGAM and PSHE Association. Public Health England are conducting an evidence review – which is a key step to determining the role to be played by statutory bodies in England. 	<ul style="list-style-type: none"> Lack of prevention, early stage detection of harms and evaluation of outcomes. Limited action required to address suicide prevention. Lack of whole systems public health approach. More action required to reduce risks to children and young people – e.g. greater focus on gambling-like features within video games. Inconsistent local authority level data on which to base targeted interventions. Much activity is still at pilot stage and, if evaluation proves they are effective, challenges to spread and scalability. Delays to the publication of evidence reviews and subsequent actions

Summary of progress

Strengthening the LCCP

41. A ban on gambling with credit cards was introduced in April 2020. In addition, a number of changes have been made to the Gambling Commission’s licensing conditions and codes for gambling firms in 2019/20. These include:

- Minimum requirements for identity and age verification.
 - Requiring all online gambling to participate in GAMSTOP - the multi-operator self-exclusion scheme.
 - Strengthening requirements on how operators identify and interact with customers who may be at risk of or experiencing gambling harms.
42. It is encouraging that the Gambling Commission is now taking steps to evaluate the impact of the credit card ban. We look forward to the results of this evaluation later in the strategy period – and hope this can be used as an opportunity to lead by example in the evaluation of what works in reducing gambling harms. The evaluation should also provide valuable information on any unintended consequences from this policy change – for example increased borrowing from payday lenders.
43. The strengthening of ‘customer interaction requirements’ is positive – but evaluating the impact of this change on consumers will be essential. A key next step will be to accelerate work on ‘affordability checks’ and making further improvements to identify whether consumers are vulnerable to harm based on analysis of their data. This is central to avoiding gambling harm, and action will be needed to set clear standards and demand consistent approaches across the industry. The existing approach has seen too many instances where several operators’ practices have fallen significantly short of required standards.⁴⁴

The ‘industry challenges’

44. In October 2019, the Commission issued the following new ‘challenges’ to the gambling industry:
- Game design – to create an industry code for safe game design
 - Improved use of advertising technology – to reduce exposure for children and those who are vulnerable to harm
 - ‘High value’ customers⁴⁵ - to improve standards in an area of industry practice which has led to significant consumer detriment and multiple operator failings
 - ‘Single Customer View’ – to facilitate data pooling to create a more complete picture of potentially harmful online gambling behaviour. This would create a stronger foundation for a co-ordinated approach to ‘affordability’ as outlined above.
45. We welcome the focus of these activities on priority issues, which, if meaningful action is taken, have the potential to reduce gambling harms.⁴⁶

⁴⁴ [Enforcement report 2018/19](#), gambling Commission

⁴⁵ Sometimes referred to as ‘VIP’s by operators

⁴⁶ A [consultation has now been launched on high-value customers](#) to mandate some of the industries proposals and to identify further measures that are needed. Further consultations are forthcoming on the other challenges.

46. There are clear risks associated with an approach that rests on voluntary engagement and co-production with the industry. However, testing this co-production approach is worthy of exploration, and provides the industry with opportunities to demonstrate improvements.
47. The Commission must ensure that the industry is held to agreed timetables and outcomes before proposals are tested with a wider stakeholder group, in particular with those who have experienced gambling-related harms previously. There must be transparent accountability for progress in these four areas. If the progress is not adequate then the Commission will be right to act on its commitment to introduce alternative and robust regulatory requirements to protect consumers from harm.

Involvement of financial services sector

48. Engaging the financial services sector has been a significant positive development. Banks, including HSBC, Starling, Monzo, Halifax and Barclays are now offering customers the option of blocking gambling transactions.⁴⁷ NatWest has formed a partnership with GamCare to offer counselling services within its premises.⁴⁸ Other activities are being funded to further develop the preventative role that could be played by the financial services sector.

Case study 3: Money and Mental Health Policy Institute and the Personal Finance Research Centre⁴⁹

The Money and Mental Health Policy Institute, funded by a regulatory settlement, is using its expertise to help facilitate actions in the financial sector to reduce gambling harms.⁵⁰ The project will draw together and disseminate best practice – this will be done through events and workshops, with best practice shared through a virtual hub.

In addition, GambleAware has provided funding to the Personal Finance Research Centre at the University of Bristol to establish the Money and Gambling: Practice, Insight, Evidence (MAGPIE). This will carry out research on the effectiveness of approaches used by the financial services sector to reduce gambling harms, and help develop the role to be played by this sector.⁵¹

Both projects have agreed a research partnership to ensure learning and activities are co-ordinated. The projects will explore how to build on existing responsibilities of financial services firms to help protect vulnerable customers and ensure organisations that are well placed to help people manage their money and avoid financial harm have the support and tools to do so.

⁴⁷ [Gambling restrictions](#), HSBC - Website

⁴⁸ [NatWest to offer help to gambling addicts in high-street branches](#), The Guardian, October 2019

⁴⁹ [Money and Mental Health to launch new project to help financial firms tackle problem gambling](#), Money and Mental Health Policy Institute, October 2019

⁵⁰ [Get involved in our new project to tackle problem gambling](#), Money and Mental Health Policy Institute, January 2020

⁵¹ [Money and Gambling: Practice, Insight, Evidence](#) (MAGPIE), University of Bristol, September 2019

49. There are a number of wider initiatives, such as the Vulnerability Registration Service,⁵² which offer consumers the opportunity to opt out of contact from a wide range of services. This may have application in reducing gambling harms. There may also be further opportunities to explore lessons that can be learnt from data analysis in the financial services sector to identify where and how consumers become vulnerable to harms.⁵³

Suicide prevention

50. Gambling with Lives has drawn significant attention to the links between gambling and suicide and suicide ideation. Its work has helped focus attention on the seriousness of this issue and the need for urgent action.⁵⁴
51. The Commission published a package of research and analysis on this topic in May 2019. This work was undertaken with input from those with lived experience and included analysis of data from the Adult Psychiatric Morbidity Survey from 2007, the most recent and complete data available at the time.⁵⁵
52. The report made a number of recommendations. However, there has been no progress towards achieving any of these. There has been no commissioning of the psychological autopsy study, no confirmation on inclusion of gambling related suicide measures in the forthcoming Adult Psychiatric Morbidity Survey for 2021, no inclusion of gambling disorder in coronial codes, and no progress on steps to ensure awareness raising and training on gambling related suicides amongst coroners is mandated. This failure to make progress on an issue that takes young lives is unacceptable and needs to be urgently addressed.
53. The National Suicide Prevention Strategies and Action Plans in England, Scotland and Wales⁵⁶ give no prominence to the risk of suicide from gambling activities and nor do they explicitly utilise people with lived experience in campaigns to reduce gambling related suicides.
54. Annual Office of National Statistics data on suicide registrations are published each year, and the 2019 Cross Government Suicide Prevention Workplan sets out an ambition to reduce the overall number of suicides by 10% by 2021.⁵⁷
55. This is an area where rapid progress on establishing baseline metrics on gambling related suicide is needed and where government departments such as the Home Office, the Department of Justice, the Department of Health and Social Care, local authorities and third sector organisations and their equivalents in Scotland and Wales could make a significant contribution to obtaining data. For example, directing a qualitative review of existing coroner records to identify gambling related suicides, inclusion of gambling disorder in coronial codes, and the re-introduction of gambling in the 2021 Adult Psychiatric Morbidity Index.

⁵² [Vulnerability Registration Service](#) - website

⁵³ [Consumer Vulnerability](#), Financial Conduct Authority, February 2015

⁵⁴ [Gambling with lives](#), website

⁵⁵ [Gambling and suicide research](#), GambleAware, 2019

⁵⁶ [National Suicide Prevention Strategy for England](#), [Scotland Suicide Prevention Action Plan](#), [Suicide Prevention Wales](#)

⁵⁷ [Suicide prevention: cross government plan](#), Department for Health and Social Care, January 2019

Taking a 'whole systems approach' to harms reduction

56. The National Strategy makes clear that reducing gambling harms is a public health issue. Positive examples of this being put into practice are found in the Greater Manchester and Glasgow city area public health pilot projects (see case study 4).

Case study 4: Greater Manchester Public Health Pathfinder

The Greater Manchester Combined Authority (GMCA) is delivering a programme of work to embed a public health approach to reducing gambling harms across Greater Manchester. This pathfinder project is funded by a regulatory settlement and will aim to show how local level approaches can help reduce harms caused by gambling.⁵⁸

The partnership includes ten local authorities who will work together to:

- increase support for those experiencing harm,
- improve prevention programmes across the region,
- collect evidence of the impact of interventions, and
- share best practice as part of a gambling harm reduction group.

Activities in development include early identification of gambling harms in university students – including student welfare, financial advisers, student unions and student GP practices. Also in development are plans to ensuring each local authority has delivered awareness raising sessions with front line staff. The partnerships work will be informed by people with lived experience of harm.

57. To build on this, action is needed to embed gambling in existing public health policy. A key step would be to include gambling metrics in the Public Health Outcomes Framework.⁵⁹ This is reported annually for all local authorities in England and Wales⁶⁰ and is key to local policy making and health and wellbeing strategies.⁶¹ An example of this can be found on the Public Health Wales Observatory webpages, which provides interactive profiles of particular public health concerns and their impacts at health board and local authority level.⁶² Formally including gambling metrics here would mean local authorities would better understand both participation and harm in their populations so they can develop prevention strategies and respond to those experiencing harm. Equivalent action would be required in Wales and Scotland, such as the Scottish Schools Adolescent Lifestyle and Substance Use Survey, could be

⁵⁸ [Gambling Commission welcomes new local public health approach to reduce gambling harm in North West](#), Gambling Commission, January 2020

⁵⁹ [Public Health Outcomes Framework](#), Public Health England. There are a number of options for adding new metrics to existing national surveys, for example the ONS annual population survey, the GP Patient survey and the Active Lives Survey. New metrics on loneliness introduced into the PHOF in 2018 would provide a useful example on how this could be achieved

⁶⁰ [Our Strategic Plan 2018-21](#), Public Health Wales

⁶¹ [Public Health Outcomes Framework](#), Public Health Wales Observatory

⁶² [Alcohol in Wales](#), Public Health Wales Observatory

utilised.⁶³ Achieving this would require a co-ordinated approach to ensuring local level data is collected across Great Britain.

Developing prevention for high risk groups

58. Initiatives have also been developed to target groups at higher-risk of gambling related harms.
- **Healthy Stadia:** Targeting spectators at sporting events, this is a pilot of a stadium-based education programme to reduce the incidence of unhealthy gambling behaviour.
 - **PRoGRAM-A:** A peer delivery prevention programme for secondary school pupils focusing on understanding the potential risks of gambling.
 - **YGAM National Education Programme for Children and Young People:** An awareness development programme targeting parents, families and wider networks.

Case study 5: The Howard League⁶⁴

The Commission on Crime and Problem Gambling was set up by the Howard League for Penal Reform following a regulatory settlement. The Commission on Crime and Problem Gambling is made up of academics, professionals and people with lived experience of addiction. Launched in June 2019, it will run for three years and aims to answer three questions:

- What are the links between problem gambling and crime?
- What impact do these links have on communities and society?
- What should be done?

The first stage of its work was a review of the evidence of links between crime and problem gambling across six areas (Australasia, USA, Canada, Germany, Scandinavia and the UK).⁶⁵ The literature review has revealed useful insights.

Prevalence of problem gambling among prisoners (a population excluded in the Health Surveys) is internationally recognised as being higher than that of the general population. Evidence suggests problem gambling rates are five to ten times higher in prisons than in the general population. Research also suggests there is little treatment and support for problem gamblers in prison, There is also some evidence of resistance to undertaking treatment whilst in prison as a result of the stigma attached to gambling addiction.

As the review continues it will collect further evidence from the UK and other jurisdictions and make recommendations on steps that can be taken to reduce gambling-related crimes and to support those who are affected.

⁶³ [ScotPHO profiles](#), Scottish Public Health Observatory

⁶⁴ [Commission on Crime and Problem Gambling](#), The Howard League for Penal Reform

⁶⁵ [Crime and problem gambling, a research landscape](#). Commission on Crime and Problem Gambling, 2020

Lack of ‘universal’ prevention’

59. Although the project set out above targeting higher-risk groups is positive, there is a gap in wider ‘universal’ prevention initiatives. Much prevention activity remains unproven. The ‘When the fun stops, stop,’ campaign has been challenged for lacking impact and focusing too strongly on promoting the message that gambling is fun.⁶⁶ There is some emerging evidence which supports this.⁶⁷
60. There needs to be further activity focusing on children and young people.⁶⁸ Young people consider gambling to be an increasingly normalised presence in their lives⁶⁹ with gambling harms associated with a significantly increased risk of health issues such as depression and anxiety. Types of gambling that are available to young people have been shown to be associated with disordered gambling amongst adults.⁷⁰ Young people are increasingly likely to experience gambling in the context of video games, eSports and skins betting.⁷¹
61. The value of activity focusing on children and young people is highlighted in the recommendations of the Royal Society for Public Health (RSPH) ‘Skins the game report’.⁷² The Department for Education has announced that gambling as a risky behaviour will be included in the schools PHSE curriculum in England from September 2020.⁷³ The government in Wales has set a similar approach⁷⁴ but there are no indications as yet on how the impact of these measures will be evaluated.
62. GambleAware has launched its ‘BetRegret’ Campaign – which focuses on promoting awareness of risky behaviours – such as gambling when drunk or bored. An evaluation of the campaign is currently underway and we look forward to the publication of its findings.⁷⁵ New awareness raising initiatives led by those with lived experience are at proof of concept stage and we will report on its progress in 2021.

⁶⁶ [Testing a gambling warning label’s effect on behaviour](#), Newall, Walasek, Singman, Ludvig, PsyArXiv Preprints, September 2019

⁶⁷ [Equivalent gambling warning labels are perceived differently](#), Newall, Walasek, Ludvig, 2020

⁶⁸ [Advice to the Gambling Commission on actions to reduce online harms](#), ABSG, February 2020

⁶⁹ [Skins in the game, a high stakes relationship between gambling and young people’s health and wellbeing?](#) Royal Society for Public Health, December 2019

⁷⁰ [Frequency of engagement with legal youth gambling products is associated with adult disordered gambling](#), Newhall, Russell, Sharman, Walasek, PsyArXiv Preprints, March 2020

⁷¹ [Reducing online harms](#), ABSG, July 2019

⁷² [Skins in the Game](#), Royal Society for Public Health, Dec 2019

⁷³ [Resources promoting resilience to gambling](#), PSHE Association

⁷⁴ [Framing a public health approach to gambling harms in Wales: Challenges and opportunities](#), Rogers, January 2019

⁷⁵ [BetRegret](#), GambleAware

Section 4: Treatment and support

63. The National Strategy aims to help all those affected by gambling harm to access effective high-quality treatment and support wherever they live, with positive outcomes.

Treatment and support – summary of progress

Strengths	Weaknesses
<ul style="list-style-type: none"> • Clear recognition of gambling harms in the NHS England Ten-Year Plan – leading to expanded treatment through NHS clinics • Pilot of a 24-hour operation of the National Problem Gambling Helpline. • Initial commitment to develop a quality assurance system for treatment by the Care Quality Commission (CQC). • Expanded range of pilot activity to treat gambling harms in a range of setting and through increased engagement with new statutory providers – such as GPs, Custody Suites and Recovery Colleges. 	<ul style="list-style-type: none"> • Little published evidence from evaluation of existing treatment and support to guide current decisions about the expansion of services. • A lack of agreed outcomes data. • Systemic weakness in research funding has contributed to this lack of evidence. This includes the pace at which research has been commissioned and delivered and quality of final research produced. • Delays to NICE guidelines, which would further embed treatment for gambling harms to mainstream health services • No national needs assessment – meaning there is limited assurance that activity is well-matched to need. • Over-reliance on regulatory settlements to fund new treatment activity.

Summary of progress

Embedding treatment in NHS provision

64. The recognition of gambling harms in the NHS England Long-Term Plan⁷⁶ and subsequent Long-Term Plan for Mental Health⁷⁷ provided a key driver for a greater focus on gambling harms in the NHS.
65. Over the past year, practical progress has been made through the opening of new clinics in Leeds, with new services open in Manchester and Sunderland, and a specialist clinic for children and young people in London.⁷⁸ NHS England has committed to opening up to 14 clinics across England.
66. The creation of these clinics has started to embed the process of treating gambling harms within the NHS. This is a positive start – but there are still weaknesses in commissioning, referral pathways and infrastructure. The focus for next year must be on:
 - i. Creating integrated care pathways and a screening item screening tool for use by primary care, third sector and local authorities so that treatment services are readily accessed by those who need them (See Case study 5).
 - ii. Clear commissioning agreements need to be developed in terms: of cut-offs for treatment pathways between treatment providers; staffing qualifications, training, skills and supervision arrangements for health professionals providing treatment in third sector providers; governance arrangements to ensure good quality treatment provision across all treatment providers.
 - iii. More evaluation - NHS clinics can lead by example on good practice for evaluating the impact of their services. Evaluation should include outcome evaluation strategies such as standardised assessment measures of mental health, gambling severity and risk. Establishing an outcome/pathway following treatment would be a relatively low-cost and efficient method to provide basic outcome data that is currently lacking. Inclusion of standardised assessment measures could be simple and straightforward and follow a similar model to the NHS Improving Access to Psychological Therapies (IAPT) services where assessments are completed at prescribed intervals and data collated nationally.
 - iv. The creation of equivalent services through the NHS in Scotland and Wales. Scotland and Wales favour an approach of embedding treatment in existing addiction and other support services, rather than setting up bespoke services for gambling. The Scottish and Welsh Government's approach to tackling gambling is aligned with the goals set out in the National Strategy, which highlight the need to provide treatment and support services alongside preventative and education interventions to remove or reduce the harms resulting from gambling. We welcome the

⁷⁶ [NHS Long-Term plan](#), NHS England, January 2019

⁷⁷ [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#), NHS, July 2019

⁷⁸ [NHS to launch young people's gambling addiction service](#), NHS England, 2019

Scottish and Welsh Government's work to reduce inequalities and the causes of inequalities as part of their national Public Health Priorities. This provides an opportunity to learn about the relative strengths and weaknesses of different intervention approaches.

- v. Creating targeted education and training programmes for NHS staff working in primary care, mental health and addictions services as part of building capacity in the wider health and care workforce. This would ensure early identification, signposting to specialist centres and some treatment and support can be delivered at this level.

Case Study 6: NHS Northern Gambling Service⁷⁹

The NHS Northern Gambling Service (also known as the Northern Gambling Clinic) is part of Leeds and York Partnership NHS Trust. It provides specialist addiction therapy and recovery to people affected by gambling addiction. This NHS service comprises a team made up of registered psychologists, therapists, psychiatrists, and mental health nurses and people with lived experience. The team works in collaboration with other services, including third sector specialist services, GP practises, local authority services, and debt advisory services, signposting to support and advice where this is needed.

The services are delivered in parallel with services provided by GamCare and funded by GambleAware.

Through clinics in Leeds, Salford and Sunderland, these services can be accessed by people across the North of England and Northern Midlands. It is used by people with gambling addictions who may also be experiencing depression, anxiety, trauma, and suicidal feelings. The support offered is also available to people affected by someone else's gambling – such as family, partners, and carers.

The core programme includes eight to ten sessions of cognitive behavioural therapy (CBT), sessions with family and friends, follow up after these sessions have ended, support with tackling all the impacts of gambling addiction, and connecting with others who have had similar experiences.

Quality assurance and care pathways

- 67. Unlike the NHS, third sector treatment provision for those with gambling disorders is subject to internal quality assurance. As yet there is no nationally agreed external quality assurance process in place, and a lack of comparable outcome data.
- 68. In March 2020, the Care Quality Commission (CQC) finalised the first stage of its inspection regime for treatment providers in England, which included people with lived experience on the core team. Using the same quality assurance regime in NHS and third sector provision will provide comparable indicators on

⁷⁹ [Northern Gambling Service](#), NHS Leeds and Yorkshire NHS Foundation Trust

standards of service. For NHS organisations, CQC inspections include questions relating to research activity within the organisation. We would hope to see this included in gambling treatment provider inspections to support the further development of evidence informed practice.

69. Despite reference to NICE guidelines work being implemented in 2020 there is no confirmed date for this work to be completed.⁸⁰

Increased activity to identify and treat harm in a range of settings

70. A number of pilot activities have commenced – these have engaged a wider range of organisations in the delivery of treatment and support than previously, and expanded the range of places and environments where harms can be detected and support offered.
71. These pilot projects will provide opportunities to learn about what works, and build capacity to treat and support those experiencing gambling harms. Examples of such activities include:
- i. Pilot of 24-hour operation of the National Problem Gambling Helpline.⁸¹
 - ii. A pilot project to explore the design and delivery of an NHS based integrated community service in London, launched in November 2019. This involves primary care, specialist and third sector organisations, and aims to form a bridge between NHS primary and specialist (secondary care) services and allow GPs to directly refer individuals for care.⁸²
 - iii. Two Recovery Colleges in NHS Trusts in England began a pilot project in January 2020 project involving people with lived experience on the design and delivery of a weekly support service.⁸³
 - iv. BetKnowMore and GamCare have started recruitment for a Peer Aid programme, providing mutual aid and integrating individuals with lived experience into the treatment network as peer supporters.⁸⁴
 - v. Beacon Council Trust are piloting screening and development of care pathways for custody suites in five police forces in England, with potential to extend to police forces in Wales and Scotland.
 - vi. Launch of computerised cognitive behavioural therapy modules from GamCare.⁸⁵

Reliance on settlements to fund activity

72. Much positive treatment activity is now being funded via regulatory settlements. This funding sources works well to fund relatively small scale, time-limited projects. There remain fundamental structural weaknesses in the system of

⁸⁰ [Gambling](#), NICE Guidance, NICE

⁸¹ [National Gambling HelpLine to Pilot 24-hour Service](#), GamCare, August 2019

⁸² [National Strategy Implementation Update 30 January](#), national Strategy to Reduce Gambling Harms micro-site, January 2020

⁸³ [National Strategy Implementation Update 30 January](#), national Strategy to Reduce Gambling Harms micro-site, January 2020

⁸⁴ [BetKnowMore](#) – website

⁸⁵ [GamCare](#) – Website

funding to allow successful pilots to be rolled out and embedded into mainstream health service provision.⁸⁶

Limited evidence from evaluations to guide decisions on treatment provision

73. Care pathways are still not well defined between different parts of the treatment system, for example between the NHS and GamCare and its partners, nor is there clear agreement on thresholds for onward referral, and which service offers what level of treatment and support and follow up. This is impeding progress on delivering the right treatment at the right time.
74. Leeds Beckett University was commissioned to evaluate the current GambleAware-funded treatment and support system. The first phase of this evaluation will focus on setting up and evaluation framework to assess the effectiveness of the treatment system and referral pathways. This will report in mid-April 2020, with the implementation of the systems evaluation against this framework then continuing until Summer 2021. A subsequent phase, looking at treatment outcomes at a provider level may not start until 2022.
75. The work being carried out by Leeds Beckett University is important and will provide useful evidence. The timeframes for this work, have been significantly delayed, which means the evidence the project hopes to produce will not be available until late in the current strategy period.
76. One implication of this is that decisions about the expansion of treatment will need to be made without this evidence from evaluation of existing services.

Delays in supporting research

77. GREO are currently undertaking a rapid review of international evidence on international best practice for treatment and support of gambling harms.⁸⁷ This follows the failure of a research project by University of Huddersfield, commissioned by GambleAware to answer the same questions.⁸⁸ When complete, the GREO work will help make greater use of international research.
78. The delays and failures of these research projects limit opportunities to take evidence-based decisions about future treatment provision. This suggests there are weaknesses in the current system of commissioning and quality assurance of research via a small charity funded by voluntary industry donations.

⁸⁶ See section above on Governance and Delivery - Levy

⁸⁷ [Treatment](#), GREO

⁸⁸ The failure of this project to meet publishable quality standards demonstrates concerns previously flagged about GambleAware's capacity to commission and quality assure research. Advice on the National Strategy to Reduce Gambling Harms, RGSB, February 2019

Section 5: Future indicators and metrics

'We must avoid making what is measurable important, and find ways to make the important measurable' - Robert MacNamara

79. One of the weaknesses of the first year of the Strategy has been the absence of a clear line of sight between the strategic priorities, the implementation plan, and measurable outcomes to show impact. Since February 2020, the Commission has been working on a wider set of impact measures, which may well be aligned with some of the recommendations outlined in this report
80. ABSG proposes two overarching recommendations to address the gap:
 - A. **Create a framework for measuring harm reduction.** This will allow measurement of the overall impact of the strategy towards achieving its primary aim of reducing gambling harms.
 - B. **Create a league table to measure progress by operators.** This is designed to create greater transparency on the progress operators are making to reduce harms and to incentivise further progress.
81. Both recommendations are explained below.

Framework for measuring harm reduction

82. Gambling harms have a negative impact on individuals' lives and on society as a whole. Action is needed to measure these and ensure the strategy is achieving an impact on the most significant areas of harm.
83. As the National Strategy moves into its second year – a clearer articulation of the priority harms to measure should be created. This new framework would be designed to improve how we measure impact of the National Strategy. It would also address some of the concerns raised in the National Audit Office (NAO) Report ⁸⁹ about an absence of measures to demonstrate the impact achieved by the Gambling Commission through its regulatory work.
84. With reference to published descriptions of harms, we have identified those that constitute the greatest priority because of their impact on individuals, families and communities:

⁸⁹ [Gambling Regulation: Problem Gambling and Protecting Vulnerable People](#), National Audit Office, February 2020

Table 1: Recommended priority gambling harms
Gambling related suicides
Gambling-related debt
Gambling-related homelessness
Gambling-related loss of employment
Gambling-related domestic violence
Gambling-related crimes
Gambling-related impact on mental health

85. Progress will require:

- i. **Agreeing priority areas, baseline metrics and targets for reducing harms.** Areas where there are currently no baseline metrics should have plans in place to make these measurable by the end of Year 2 and implemented by the end of Year 3.
- ii. **Partnership working with agencies that are well positioned to collect relevant data.** The Commission works with other regulators for example, financial and advertising regulators as well as health bodies, coroners, the criminal justice system, the NHS across Great Britain and third sector organisations. More could also be done with banks and financial institutions to secure baseline data on gambling expenditure and gambling related suicides.
- iii. **Avoiding allowing the complexity of causality and attribution getting in the way of work to gather and analyse data.** We understand the importance of considering cause and effect – but this will only be understood through more data, more research, and more engagement with those who have experienced these harms themselves.
- iv. **The issue of funding needs to be addressed.** For too long limited progress has been made, despite the existence of detailed frameworks,^{90,91} Longer-term, progress will need a funding system that can support more research on these topics and facilitate this through research councils which have so far not been adequately involved in funding research on gambling related harms

86. We should start by establishing baseline data, with a view to setting targets for harm reduction over time. The harms prioritised above will require actions by specific agencies (see Appendix for details).

⁹⁰ [Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms](#), Langham et al, BMC Public Health, 2016

⁹¹ [Measuring gambling-related harms: a framework for action](#), Wardle et al, July 2018

87. The National Strategy is also clear that projects should be evaluated for impact. Through these evaluations, ideally, we would like to see evidence of impact in these high-level areas of harms. This will often be challenging, as impact of harms will often be significantly downstream of the intervention itself. But focusing on some priority areas would give these evaluations increased focus on priority areas of harm.

Create a league table measure progress by operators

88. We know from other regulated sectors that transparency is an important driver of change. The National Audit Office report stated that a wider range of tools are needed to drive change.⁹² For online gambling, the opportunities for using data are a particularly important area to focus on. We recommend, therefore, the Gambling Commission introduces a 'safer gambling league table' to be populated by new mandated metrics from the industry.

The principle of an operator league table

89. Our key recommendation is that operator data is published in a league table format with aim of increasing transparency and, through this, incentivising greater progress towards a safer online gambling market. Details of what this would include for online and land-based activities will differ, but the principle of increasing transparency applies to both.
90. Publishing data in this way is used routinely in other regulated industries to maintain and improve standards. Examples include:
- i. Care Quality Commission, who publish data on a range of metrics related to hospital performance, patient care and outcomes.⁹³
 - ii. The water regulator, Ofwat, who publish data on performance indicators with financial incentives attached to good performance.⁹⁴
 - iii. The Solicitors Regulation Authority, who publish data on diversity characteristics of law firms employees with the aim of promoting a more representative legal workforce.⁹⁵
91. In all of these examples, the transparency created by publishing data means regulated businesses are open to increased scrutiny, not only by the regulator, but from a wider range of stakeholders and the public as a whole. This scrutiny means that businesses are incentivised to maintain higher standards – this can help them attract customers, protect share value and demonstrate corporate values.

⁹² [Gambling Regulation: Problem Gambling and Protecting Vulnerable People](#), National Audit Office, February 2020.

⁹³ [Care Quality Commission](#), Publications

⁹⁴ [Ofwat](#) - website

⁹⁵ [Solicitors Regulation Authority](#) – Law firm diversity

Possible metrics

92. At this stage we do not have firm view on the specific metrics which should be included in the league table. In a data rich sector, such as online gambling, there is a wide range of possible options, and different gambling activities would require different metrics in order for comparisons to be meaningful. We recommend a working group is established to agree these. This group should be made up of a wide range of experts from across the sector, and must include people with lived experience. The Commission would also need to examine unintended consequences of these metrics and any potential perverse incentives they might create
93. We propose four categories of metrics to be considered as a starting point: affordability checks, Gross Gambling Yield metrics, time spent gambling online and warning labels. Each of these are discussed below – but these and other options should be considered in more detail by the working group tasked with identifying the most effective safer gambling metrics.

Affordability checks

94. At their evidence session in the House of Lords,⁹⁶ industry leaders asked the Commission to take the lead on affordability checks, suggesting there should be a standard across the industry. The GVC CEO, suggested that *“if we can tackle the [affordability] issue and get it right then the numbers of problem gamblers would come down significantly”*
95. Whilst there appears to be broad consensus on the need for affordability checks, there is less agreement on how best to develop such standards. Industry leaders view their own internal processes as commercially sensitive.
96. There is little agreement on what constitutes ‘affordability’ or level of spend, and there will of course be wide variation across different gambling activities. Another barrier to progress is finding ways to monitor a single customer spend *across* operators. However, the Commission could consider a number of options;
 - Require operators to publish the number of customers to lose £100 or more in a day, and the proportion of these who have received an affordability check. The figure of £100 could be reduced in future years once a reporting process has been established.
 - Require operators to publish the percentage of gamblers with cumulative losses of more than £500 per month.
 - If either or both of those options are implemented, then operators should also make the full distribution of daily and monthly losses and affordability checks available.
 - Require operators to publish the actions taken as a result of these affordability checks – e.g. the % where a hard loss limit is subsequently implemented or gambling by a customer is suspended.

⁹⁶ [Gambling industry committee, Parliamentlive.tv](#), (response at 16.50), February 2020

- Where customers are being sent incentives – such as bonus offers - require operators to publish the % of these customers who have received an affordability check.

Gross Gambling Yield

97. Gross Gambling Yield is the amount retained by operators after payment of winnings (before the deduction of operating costs). Any profitable gambling business is built upon the creation of GGY. Gambling expenditure (i.e., losses) has been shown to be a strong predictor of gambling-related harm.⁹⁷ Even small increases in gambling expenditure are linked to gambling-related harm, providing evidence that gambling-related harm is broad-based and is not limited to a small fraction of gamblers. An operator could reduce its per-customer GGY either by decreasing its house-edge, or by encouraging customers to play more slowly or for shorter amounts of time. These are all game design features operators may be incentivised to maximise without the use of such a league table metric.
98. The Commission routinely publishes overall GGY for all operators. We propose the Commission goes further and requires more detail on GGY. The risk of harm is greater where a large part of revenue derives from a small number of players
99. Proposals for consideration by the working group might include:
 - All operators could be asked to provide informative data on their GGY per customer or yield per head compared with totals. Total GGY per-customer is influenced by the house-edge, speed of play, and length of play. GGY as a fraction of the total amount bet is equivalent to the house-edge. Just publishing this statistic would still provide operators with an incentive to encourage customers to play faster or for longer periods of time.
 - All operators could be asked for the percentage of GGY extracted from the top 10% of account holders.
 - All operators could be asked to provide metrics that illustrate the degree of concentration of spending among its customers.

⁹⁷ [The relationship between player losses and gambling-related harm: evidence from nationally representative cross-sectional surveys in four countries](#). Markham, Young, Doran, 2016.

Time spent gambling

100. Gambling-related harms are not always financial – time spent gambling, at the expense of time with family, friends, or in employment are often highlighted as significant causes of harm.⁹⁸
101. To recognise this, we recommend an operator league table also includes metrics on time spent gambling. Total time spent gambling online per week, or average time spent gambling online for the top 10% longest playing customers, would provide a good insight into potentially harmful periods of play.

Warning labels

102. The effectiveness of warning labels and safer gambling signposting is not clear cut, and research on this is mixed.⁹⁹ However, in the interests of promoting greater transparency and accessibility, we advocate further exploration is undertaken of both warning labels and safer gambling messages. Unlike the three categories above, this category would not involve operators publishing their own data but would involve the Commission in making an assessment of operators' performance and publishing the results.
103. Operators would be ranked according to the number of products displaying clear and demonstrably effective warning labels on their products. In addition to clear displays of warning labels, operators could also be ranked on the prominence of their signposting to helplines, or use of pop-ups.
104. The categories above are a starting point – methodologies for calculations will need further exploration and consultation and consideration given to how to weight the different metrics in a composite score to determine league position. In the longer term, the Commission could consider using star ratings and/or financial incentives (a percentage of licence rebate if an operator achieves a certain rating on the safer gambling league table).

Other issues

Use of existing data

105. There are a number of metrics that have been collected through survey methodologies for many years. Although there continues to be debate on whether the term 'problem gambling/gambler' and its associated metrics are of value,¹⁰⁰ we recommend the Commission continues to use these widely used tools as one of a number of measures until other validated metrics emerge to replace them.
106. The Commission and its partners should continue to replicate these in order to record changes in behaviour, frequency, characteristics, recognising such methodologies depend on self-reported measures that have inherent weaknesses and may not necessarily provide us with the metrics we need to assess impact.

⁹⁸ [Measuring gambling-related harms – a framework for action](#), Wardle, Reith, 2018

⁹⁹ [Equivalent gambling warning labels are perceived differently](#), Newall, Walasek, Ludvig, 2020.

¹⁰⁰ [Advice on the National Strategy to Reduce Gambling Harms](#), RGSB, February 2019

107. We should, however, review the metrics collected to identify where new forms of data should be included. We should also review what data could be provided from other sources – e.g. data from financial services or social media companies, etc. This will tell us more about real time behaviour – as opposed to behaviour reported through surveys.
108. There is an imperative to ensure the voice of those with lived experience is included in new ways in any such approach. This is an area where the Experts by Experience Groups will provide an important steer.

The impact of COVID-19 on data and metrics

109. In any work on data, the impact of COVID-19 on gambling behaviour must be considered. This will have an impact on behaviour recorded in statistics collected this year. For example, participation rates will fall. Use and variety of online products will increase. Figures on average spend will be distorted compared with previous years. It will be important to review the metrics and decide which ones will best inform us on how and where harms have been reduced.
110. We welcome steps already being taken by the Gambling Commission to understand the impact this will have – for example the COVID-19 tracker to explore initial impact.¹⁰¹

¹⁰¹ [Covid-19 and its impact on gambling, what we know so far](#), Gambling Commission, Updated June 2020

Section 6: Recommendations and priorities for 2020

111. This section summarises the key recommendations in relation to:

- Delivery and governance
- Prevention and education
- Treatment and support.

Recommendations – Delivery and governance

112. ABSG’s key recommendations are:

- I. Develop structures and responsibilities for implementation in England, Scotland and Wales – which would establish clear roles, decision making and accountability. Multiple stakeholders need to work in collaboration to achieve this.
- II. Accelerate progress involving people with lived experience in the implementation of the National Strategy – particularly in England and Wales, where best practice in creating infrastructures could be transferred from developments that are starting to take place in Scotland.
- III. The Gambling Commission to deliver its commitment to form an Expert by Experience Advisory Group to directly inform its work, and to explore with DCMS how people with lived experience can contribute at Board level in the Commission.
- IV. Accelerate progress towards a mandatory levy – so independent funding can be secured to fund activity and engage the right delivery partners. In the meantime, progress must continue by finding ways to channel available funding to priority activities.
- V. Create appropriate infrastructures with the national Research Councils for funding and commissioning research. Prioritise a new prevalence survey to be completed by April 2021 and longitudinal study in place by April 2022

Measures of Longer-Term Success

<i>Aiming for...</i>	<i>Minimum...</i>	<i>Stop....</i>
Effective delivery arrangements in each of the three Nations. Government should play a leading role – recognising that reducing gambling harms requires co-ordinated action beyond just regulation of operators. People with lived experience to be engaged and able to influence decisions.	Regular meetings of key stakeholders from government, public health, regulation and health. Development of effective forums for people with lived experience in Scotland, England and Wales.	Relying on voluntary funding arrangements to provide the resources to deliver activity to reduce gambling related harms.

Recommendations - Prevention and education

113. ABSG's key recommendations are:

- I. Progress industry challenges vigorously. Work is needed to build on the proposals developed by industry – going further where these have fallen short of expectations. People with lived experience should inform this work.
- II. Include gambling metrics in the Public Health Outcomes Framework for England and equivalent public health frameworks for Scotland and Wales. This will ensure gambling activity can be identified at a local level and interventions targeted to at risk groups.
- III. Evaluate whole systems approaches to reduce gambling related harms. Positive progress has been made by establishing pilots in Greater Manchester, London and Glasgow. In order to support similar activity in new areas, the learning from these pilots should be used to develop guidance for local authorities on how to incorporate a system wide approach to gambling.
- IV. Improve activity and evaluation to prevent harm in people who have not yet started to exhibit risky behaviour. A key audience for primary prevention activity is children. Although great care is needed to avoid elevating risks, we also need to recognise that gambling participation and harms are widespread in this population group. There is an opportunity to build on steps in education by including gambling harms in PSHE outcome measures. The need for evaluation of this type of activity is paramount.
- V. Make suicide prevention a priority area for action. Steps should be taken to embed the understanding of risk of suicide associated with gambling into national suicide prevention strategies in England, Scotland and Wales.

Measures of Longer-Term Success

<i>Aiming for...</i>	<i>Minimum...</i>	<i>Stop....</i>
Comprehensive prevention plan – including universal prevention activity and activity focusing on higher risk groups.	All prevention activities evaluated for impact.	Activity that is not being evaluated.

Recommendations – treatment and support

114. Our key recommendations are:

- I. Implement the co-creation of a National Gambling Treatment Strategy led by DHSC with PHE, CQC, NICE, LGA, those with lived experience and established third sector partners. There should be equivalent co-creation in Scotland and Wales. This should ensure treatment and support is consistent and coordinated with clearly defined treatment pathways.
- II. Develop a single screening tool and co-ordinate its use across a wide range of screening, triage and treatment settings in primary care and local authority settings.
- III. Agree and publish care pathways for those with gambling addictions in common with agreed criteria for those with other forms of addiction. If implemented quickly, this would mitigate against the current ad hoc delivery and gaps faced by potential service users. This work should be led by DHSC, in partnership with NHSE, PHE and the third sector
- IV. Expand treatment provision to a wider range of high-risk environments – e.g. custody, debt advice services, people who are homeless. A number of pilots provide opportunities to build on this.
- V. Agree a minimum data set to measure treatment outcomes, to ensure individuals receive the right care in the right place at the right time. This minimum data set needs to be available for further analysis to inform future service provision and understand which treatments work best and why. Reference to minimum data sets held for services for those with alcohol or drug addictions would help to ensure gambling harms are integrated and delivered in similar ways.
- VI. Accelerate routine quality assurance of treatment services by statutory inspectorates - CQC in England, Health Improvement Scotland and Healthcare Inspectorate Wales - so all treatment providers are subject to the same degree of scrutiny across the three countries.

Measures of Longer-Term Success

<i>Aiming for...</i>	<i>Minimum...</i>	<i>Stop....</i>
Clear treatment pathways – available to people presenting early signs of harm to targeted provision for high-risk groups. All treatment subject to robust quality assurance.	Operating with a more fragmented system – provided access is increased and all services subject to robust quality assurance.	Ad hoc delivery with gaps faced by many potential clients for treatment.

Section 7: Conclusions

115. The National Strategy was launched in April 2019 amidst a mood of shared optimism. Since then, much progress has been made, but there is much more still to be done before any substantial claims can be made on its success. Reducing harms requires a societal response.
116. The health and care system's response to the COVID-19 crisis has highlighted how much cross-agency working can be done differently and better if there is commitment to a shared goal.¹⁰² It has also exposed the gaps in systems and processes that need to be addressed for the longer term.
117. The response to gambling harms requires whole system changes. Government departments, regulators, and the third sector need to commit to establishing baseline measures on specific harms.
118. The Commission has taken a hugely important step in setting out the National Strategy. It now needs to take a lead on industry metrics and the creation of a new safer gambling league table to accelerate and standardise promises of progress and to implement specific targets. This may be challenging in a post pandemic environment where industry focus will be on increasing revenues, but nevertheless essential to progress on reducing harms.
119. However, other partners in the Strategy need to do more. Government led initiatives such as inclusion in the Public Health Outcomes Framework, the Adult Psychiatric Morbidity Index, NICE guidelines and care pathways will be essential to progress on early identification, treatment provision, outcomes measurement and quality assurance. The third sector's contribution is essential to campaigning, awareness raising and the provision of prevention and treatment provision in partnership with statutory bodies.
120. Researchers in the UK and further afield will be needed to continue to find answers to many of the outstanding research questions that remain and require urgent attention. All of these initiatives will be strengthened through the increased involvement of those with lived experience.
121. Finally, we would urge further progress on a statutory levy to underpin this work. Without it, there cannot be sustainable independent funding for research, prevention, education and treatment.

¹⁰² [Learning from staff experience of Covid-19, Let the light come streaming in](#), The Kings Fund, June 2019

Annex 1: Impact Measurement Framework

Goal	Data source	Measurement	2020 KPI	2021 KPI	Responsible for action	Actions to deliver result
Reduce number of problem and moderate gamblers	Health Survey (Published in 2021) NHS data/third sector	Baseline = PG:0.7% 340,000 Moderate risk Gamblers: 1.1% 550,000	Baseline data from clinics	50% reduction by year end	GC statistics Industry NHS/third sector	Replicate Health Survey Industry, NHS and third sector harm reduction strategies
Zero gambling related suicides Zero suicide ideation	Coroner records Banks (via exploring open banking) Adult Psychiatric Morbidity Index	Coroner recorded suicides Bank mortality data Inclusion in 2021 survey	Identify baseline numbers Include in 2021 survey	100% reduction PHE Harm reduction strategy published Survey results published	GC funded pilot Coroner Banks DHSC	Agencies provide access to data for analysis and to amend guidelines DHSC
Establish baseline data on gambling related homelessness, loss of	Local authorities Shelter Banks	PHOF	Baseline data	10% reduction	PHE. Local authority, third sector organisations	Data collated by local authorities in partnership with third sector

employment, bankruptcy	Local authorities	Bank data on loss of employment				
Establish baseline data on gambling related crime, prison sentences number in custody suites	Courts police, prisons	Number of gambling related crimes, sentences	Establish baseline	10% reduction	Courts, police, prisons	GC funded project Courts, police, prisons
Establish baseline numbers: domestic abuse and partner violence cases associated with gambling	Courts, police, third sector e.g. NSPCC, Refuge	Numbers	Establish baseline	10% reduction	Police, courts, NHS and third sector	GC funded project
Establish baseline data on gambling-related debt	Financial services sector Citizens Advice Trussell Trust (Food banks)	Numbers	Establish baseline	10% reduction	GC Banks CAB and third sector	GC funded project
Establish data on gambling-related mental health	NHS, mental health support services, mental health charities – e.g. MIND	Numbers	Establish baseline	10% reduction	NHS and third sector	GC funded project

Annex 2: Outcome Measurement Framework

Prevention						
Goal	Data source	Measurement	2020 KPI	2021 KPI	Responsible for action	Actions to deliver result
Prevent children being exposed to gambling marketing	Operators and affiliates	Marketing to children by industry and affiliates	50% Reduction	100% reduction	Industry and affiliates	Industry and affiliates change in strategy on children
Gambling recorded on the Public Health Outcomes Framework	PHE	Gambling indicator on PHOF	Goal agreed	Measure in place	PHE, Local authorities	Project initiated by PHE
Establish pilots in whole systems harm reduction approach	Glasgow Manchester London pilots	Est. Baseline local gambling harm profiles (e.g. QOF, local area risk profiles)	3 pilots underway	10 % change	Local authority and third sector	Guidance for local authorities on how to incorporate a system wide approach to gambling Establish baseline measures
All young people receive teaching on gambling harm	PHSE programmes in schools	PHSE outcome measures	50% of schools	100% of schools	Local authorities	Local authorities and third sector

Standards for limits on losses introduced	Affordability checks	Standard set for all operators E.g. loss limit set at £XX per month)	50% compliance by year end	100% compliance by year end	Operators GC Compliance Team	Submit data to GC
Treatment						
Goal	Data source	Measurement	2020 KPI	2021 KPI	Responsible for action	Actions to deliver result
Increase numbers in treatment	NHS and third sector providers	Number receiving treatment (baseline currently estimated at 2%)	7%	10%	NHS and third sector	Implement single item screening tool across system Agree care pathway Implement across system
Create quality assurance checks for treatment provision	CQC	CQC standards (including research activity)	50% of all providers inspected and approved	75% of all providers inspected approved	CQC in England HCI Scotland HI Wales	Inspections by CQC, HCI Scotland and HI Wales
Create a single item screening tool	NHS primary care, local authority and third sector providers	Single item screening question	50% uptake in primary care settings	100% update in primary care settings	Primary care networks, Local authorities and third sector organisations	Agree screening tool Test in pilot settings Publish and disseminate

Create agreed care pathways	NHS, PHE, third sector	Care pathway	In place in 50% of settings	100% of settings	NHS, PHE third sector	Agree criteria
Increase treatment for those in custody	Third sector providers	Numbers in treatment in custody	7%	10%	Third sector	Third sector interventions