

The Responsible Gambling Strategy Board’s advice on the National Strategy to Reduce Gambling Harms 2019–2022

Part I: Introduction and executive summary

1. Gambling, and the extent of the harms associated with it, is a significant public health issue for Great Britain. There has been some progress in tackling it in recent years, but not enough. We need a new, more robust approach.
2. We therefore welcome the Gambling Commission’s assumption of responsibility for the new National Strategy to Reduce Gambling Harms.
3. We believe that the chances of successful outcomes for the new strategy are greater than for its predecessors, for three main reasons:
 - i. The Gambling Commission has resources, influence and enforcement powers to help facilitate action.
 - ii. Public opinion appears to be hardening towards gambling;¹ and
 - iii. While many have struggled fully to embed safer gambling into their corporate cultures,² recent fines, other regulatory settlements and threatened action on personal licences³ have led to increased recognition among operators that doing nothing is no longer an option.
4. The new strategy should be built on twin pillars of prevention and treatment, supported by an effective research programme. The traditional terminology of research, education and treatment (RET) risks too narrow a focus. Prevention is much broader than education alone.

Figure 1: A new approach



¹ The proportion of people who believe gambling is ‘conducted fairly and can be trusted’ has reduced from 48.8 per cent in 2008 to 33 per cent in 2017. Among people who have gambled in the past twelve months, the proportion reduced from 60.7 per cent to 37.5 per cent. Although in 2017, the majority (64 per cent) of people still supported the statement ‘people should have the right to gamble whenever they want’, 80 per cent thought ‘there are too many opportunities to gamble nowadays’, 71 per cent believed it is ‘dangerous for family life’, and 57 per cent thought ‘gambling should be discouraged’. Only 15 per cent supported the statement ‘on balance, gambling is good for society’ [Gambling participation in 2017: behaviour, attitudes and awareness](#), Gambling Commission, February 2018.

² [Raising Standards for Consumers - Enforcement Report 2017–18](#)

³ [Gambling Commission takes widespread regulatory action against online casino operators and senior management](#), Gambling Commission, November 2018

5. If it is to be successful, the new strategy will also need to:
- i. Have greater focus, with fewer priorities.
 - ii. Adopt as its main objective the reduction of gambling-related harms, including those experienced by family, friends and others adversely affected by a gambler's behaviour.
 - iii. Use a different mindset and terminology. Terms such as 'problem gambling' and 'responsible gambling' serve to diminish the severity of the issue. They also imply that fault rests solely or mainly with the individual. We know that to be far from the case.
 - iv. Take a more systematic and directive approach to implementation; and
 - v. Ensure that ownership of treatment and prevention is firmly taken by those best placed to exercise it.
6. Ten main recommendations about the new strategy are summarised below. Many build on advice we have given previously. Others reflect activities already under consideration. We believe all work with the grain of the Gambling Commission's three-year corporate strategy.⁴
- i. Gambling is increasingly recognised as a public health issue. Recognition needs to be followed through with effective action. Gambling should be addressed in the same way as other significant public health issues – with a coherent strategy using a continuum of interventions, including some at population level, and more explicit recognition of the influences of product and environment as well as individual circumstances.
 - ii. We should stop making clear distinctions between 'problem' gamblers, those 'at risk' and other gamblers. There is a continuum of harm; and different people can move in and out of harm at different times.
 - iii. The new strategy needs clear ownership and accountability. The Gambling Commission has both an appetite to address gambling-related harms and ability to address them. But if a continuum of prevention and treatment actions are to be brought to bear in a coherent way across Great Britain, a range of government departments and agencies need to take overall responsibility for their part of the strategy, with co-ordination from the centre.
 - iv. Responsibility for the provision and quality assurance of treatment should rest with GB health departments, not, as at present, with a charity funded by voluntary donations. This will require a compulsory levy with a strong and transparent structure for the distribution of funds raised. The greater emphasis in the new NHS England Long Term Plan⁵ on mental health (including the need to address gambling-related harms) provides an important opportunity. The implications of a change in responsibility are complex and need to be thought through carefully. An Expert Review Group should be appointed to review how best to achieve the change and make recommendations, including how to channel funding.
 - v. The strategy requires a coherent framework of prevention initiatives. In the short-term, the Gambling Commission is well placed to oversee action from the gambling industry. But ideally ownership should be taken by GB governments, who have the greatest ability to co-ordinate action from the wide range of stakeholders necessary to implement an effective approach. Particular focus should be on those population groups at higher risk of harm, with awareness that the different characteristics of each group may require different approaches. The strategy also needs to recognise the

⁴ [Gambling Commission Strategy 2018–2021](#)

⁵ [NHS Long Term Plan](#), NHS, January 2019

potential importance of families and peers, supporting them in protective behaviour and helping them avoid adverse impacts from their own behaviour.

- vi. Too much emphasis on voluntary action by operators is unlikely to achieve the desired impact, or pace. The Gambling Commission needs to continue to be more active in giving guidance and leadership on, for example, interventions to be piloted or implemented more widely.
- vii. We need a further major push to embed a culture of evaluation in both prevention and treatment, focusing on impact and not just process. The Gambling Commission should review the steps already taken and identify what further could be done to explain good evaluation practice to operators, create more opportunities for independent evaluation of safer gambling initiatives and develop opportunities to share findings between operators and others. The Gambling Commission and Government should lead by example in evaluating the impact of policy and regulatory changes affecting gambling.
- viii. There are significant concerns about the potential impact of gambling advertising and marketing on vulnerable groups, particularly children and young adults. There should be further consideration of appropriate controls, applying the precautionary principle and drawing on evidence from the marketing of products like alcohol and tobacco.
- ix. The Gambling Commission should take responsibility for the commissioning of the research necessary to underpin the strategy, and resource itself accordingly. The commissioning of other research relevant to gambling should be undertaken by an arms-length body.
- x. A compulsory levy on the industry should be introduced to replace the present voluntary arrangements and fund prevention, treatment and underpinning research on a greater scale, with a strong and transparent structure for the distribution of the funds raised.

Structure of this advice

7. This advice is structured as follows:

- Part II: The extent of the problem and lessons learnt.
- Part III: Prevention – our advice about where action should be taken to prevent harms from being caused by gambling.
- Part IV: Treatment and support – our advice on actions to be taken to improve treatment for gambling-related harms when they occur.
- Part V: Infrastructure – our advice on changes in the arrangements for commissioning research and funding.
- Part VI: Conclusion.

Part II: The extent of the problem and lessons learnt

8. Gambling-related harms impact on people's resources, relationships and health.⁶ Negative effects can include loss of employment, debt, crime, breakdown of relationships and deterioration of physical and mental health. At its worst, gambling can contribute to loss of life through suicide. Harms can be experienced not just by gamblers themselves. They can also affect their children, partners, wider families and social networks, employers, communities and society as a whole.

Figure 2: Gambling-related harms



9. The traditional practice of assessing the extent of gambling-related harms by reference to problem gambling prevalence rates can be misleading and hence lead to inadequate action.⁷ Prevalence rates fail to capture a number of important dimensions of harm, including those experienced by others than gamblers themselves. It could be even more misleading to assess the success or otherwise of a strategy by reference to changes in problem gambling prevalence rates. It is possible for substantial changes to happen in the nature or extent of gambling-related harms, in either direction, without any change in problem gambling rates. As new forms of online gambling are developing rapidly, keeping pace with the scale of change and possible harms becomes ever more of a challenge. It also makes comparisons over time, across jurisdictions and across different forms of gambling more difficult.
10. We suggest therefore that the new strategy moves away from a focus on problem gambling prevalence rates. It should instead have the objective of reducing gambling-related harms significantly.⁸
11. A programme to begin assessing these harms in a coherent way now exists.⁹ It is likely to be some time before it produces significant results. It would not be surprising, however, if it revealed considerably more harm associated with gambling than is currently recognised.

⁶ [Measuring gambling-related harms, a framework for action](#), Gambling Commission, RGSB, GambleAware, November 2018. Public Health England will shortly start some work on this topic.

⁷ [What's the wellbeing problem with problem gamblers](#), What Works Centre for Wellbeing.

⁸ Despite its limitations, the existing practice of measuring problem gambling prevalence rates should continue as it still provides useful, if narrower, information on the scale of the problem.

⁹ Building on the '[measuring gambling-related harms](#)' paper published in November 2018. It includes work funded by the Gambling Commission to understand the available methods to collect and analyse relevant data on harms.

12. Despite their limitations, the problem gambling prevalence figures make disturbing reading:
- i. There are currently thought to be around 340,000 adult problem gamblers in Great Britain.¹⁰
 - ii. Approximately 55,000 children aged 11–16 are also thought to be problem gamblers.¹¹
 - iii. A further 550,000 people are estimated to be suffering moderate harm.¹² Others may suffer lower levels of harm from time to time.
 - iv. The proportion of regular customers of the gambling industry likely to be suffering harm is significantly higher than those who only gamble occasionally. 8.4 per cent of people who gamble twice or more a week are classed as suffering moderate harm, and 4.5 per cent are problem gamblers.¹³ Problem gamblers often exhibit very low levels of well-being.¹⁴ Yet they are amongst the industry's most regular customers.
13. These statistics make it difficult to avoid the conclusion that there is a serious and pervasive issue to address, even without taking into account the harms that problem gambling prevalence rates do not capture and despite the much-quoted stability in such rates. The figures relating to children are, or ought to be, particularly disturbing. Changes in approach are needed if progress is to be achieved.

Lessons from the current strategy 2016–19

14. We have published reports at the end of each year of the current strategy giving our view on progress. Our April 2018 report¹⁵ concluded that progress had been made in relation to a number of the priority objectives set at the beginning.
- i. Work on more systematic identification of the nature of gambling-related harms and ways of measuring them has begun.
 - ii. Much more data is available. We know more about, for example, the amounts people stake and lose on certain products. (But see later about ease of access to these data.)
 - iii. Many operators now have access to algorithms which are likely to be useful in identifying problematic play. (But the inherent lack of transparency in proprietary systems makes it hard to assess the sensitivity and specificity of the screens; and they are only of value if followed by effective interventions.)

¹⁰ [Gambling behaviour in Great Britain in 2016](#), Health Survey England (HSE), Scottish Health Survey (SHeS) and the Wales Omnibus, 2016.

¹¹ [Young People and Gambling 2018](#), Gambling Commission, November 2018

¹² [Gambling Behaviour in Great Britain in 2016](#). The confidence interval for the estimated number of moderate risk gamblers in the population is 0.9 per cent to 1.5 per cent, meaning we can be 95 per cent confident that the true estimate of moderate risk gamblers in the population is somewhere between 420,000 and 710,000. The term 'moderate risk' does not refer to people who might become problem gamblers, but to those who are already suffering a moderate level of harm. [The impact of internet gambling on gambling problems: A comparison of moderate-risk and problem Internet and non-Internet gamblers](#). Gainsbury, S. M., Russell, A., Hing, N., Wood, R., & Blaszczynski, A. (2013). Psychology of Addictive Behaviors, 2013 and [Measuring the Burden of Gambling Harm in New Zealand](#), Browne et al Ministry of Health, 2017

¹³ [Gambling behaviour in Great Britain in 2016](#), Health Survey England (HSE), Scottish Health Survey (SHeS) and the Wales Omnibus, 2016

¹⁴ [An economic and social review of gambling in Great Britain](#), David Forrest, *The Journal of Gambling Business and Economics*, 2013

¹⁵ [Two years on: progress delivering the National Responsible Gambling Strategy](#), RGSB, May 2018

- iv. Some operators have started testing new ways of intervening with customers likely to be suffering harm. (But these pilots are not always effectively evaluated for evidence of what works.)
 - v. A number of operators have begun to try to develop a greater understanding of how games are played and of the characteristics which might lead to more harmful play.
15. Progress has, however, been partial and/or disappointingly slow in many areas. In particular, there has been a big gap in much of the industry between rhetoric and performance. Regulatory actions have brought to light too many examples of patterns of play which ought clearly to have caused concern failing to trigger appropriate action.¹⁶
16. There are a number of lessons for the new strategy from the experience of the current strategy, taking these and other factors into account:
- i. There were too many priority actions in the existing strategy. It would be better for the new strategy to identify fewer priorities, and to ensure they are effectively actioned.
 - ii. More emphasis is needed on the nature of harms and how we achieve harm reduction, and less of a focus on problem gambling rates.
 - iii. There needs to be an effective overarching strategy for nationwide delivery of treatment services, and clear ownership of the issue by the GB health departments and public health agencies.
 - iv. In retrospect, the approach to prevention was under-specified and too piecemeal. Prevention needs a coherent, overarching strategy of its own, within which it is possible to set realistic and appropriate priorities.
 - v. Placing too much emphasis on voluntary action does not achieve the desired impact or pace. The Gambling Commission needs to provide direction and/or guidance to push things forward, with activities co-ordinated and prioritised.
 - vi. Despite the (limited) evidence of some operators piloting new initiatives to reduce harm, there has not been enough meaningful evaluation of what works.
 - vii. The arrangements for commissioning research have been significantly improved over the period of the current strategy. But there remain a number of problematic issues – the less than automatic availability of data, the length of time it takes some projects to be commissioned, and funding arrangements which have discouraged some researchers from seeking funding opportunities because of what they see as ethical difficulties and potential or perceived conflicts of interest.¹⁷
 - viii. We do not understand enough about specific population groups, for example young adults and minority ethnic groups, nor about how best to support some of those who might be most vulnerable to harm.¹⁸
 - ix. Very little research has focused on women and gambling. The number of women who are problem gamblers is lower than that for men. Sample sizes in surveys are therefore often too small for meaningful analysis of gender (or other) differences. It

¹⁶ Disappointingly, many of these failings have affected some of the largest, and most well-resourced operators, who might have been expected to be best placed to make significant progress.

¹⁷ Encouragingly, however, GambleAware's latest call for innovative research proposal elicited 23 bids, including some from institutions and individuals who have not bid before.

¹⁸ Though there might be some useful insights about these groups to be gained from areas other than gambling studies.

could be wrong to assume that women experience harm in the same way as men, or that they are most effectively supported in the same way.¹⁹

- x. The current strategy called for greater public engagement to inform the development of interventions to prevent harm and treat those suffering it. Very little action has been taken to bring this about. In particular, there has been very limited use of ‘experts by experience’ – those individuals, their families and friends who have personal experience and whose voice is critical to finding solutions and co-producing new ways of reducing harms.

Part III: Prevention

- 17. Any strategy aimed at reducing gambling-related harms needs a strong and effective prevention plan. Prevention means undertaking a range of planned activities aimed at reducing risks or threats to health and preventing gambling-related harms from occurring in the first place.
- 18. Our understanding of best practice is that as well as enforcement action by the regulator, it should involve preventive measures aimed at reducing harms and risks of harm through mandatory standards, guidance and awareness raising.²⁰
- 19. Key principles are:
 - i. Prevention is broader than regulation. Regulation of products and industry practice are important levers in prevention. But regulation alone is not enough to reduce harms. It needs to sit alongside a range of other levers, involving multiple agencies.
 - ii. Effective prevention should include a broad range of activities, including some targeted at individuals, some at high risk groups and some at the whole population. This is because there are multiple factors influencing the generation of gambling-related harms – industry practices, the way gambling is promoted and regulated, the way gambling norms and practices are shaped within communities and peer groups, and vulnerabilities among individuals which interact with these influences.
 - iii. The GB governments should take ownership of a coherent prevention strategy to give focus to gambling-related harms and create impetus for action. Collectively, governments have the power and authority to engage with a range of others needed to implement the strategy - healthcare and social work professionals, banks and other financial institutions, schools and educators as well as the voluntary sector and the gambling industry. We welcome recognition of the need to work collaboratively to tackle gambling-related harms at source in the NHS (England) Long Term Plan.²¹

¹⁹ Some treatment organisations, such as [Gordon Moody](#), have recognised the need to develop services specifically designed to meet the needs of women.

²⁰ [A working model for anticipatory regulation](#), NESTA, November 2017

²¹ [NHS Long Term Plan](#), NHS, January 2019

Recommended prevention activities

20. We recommend that the new strategy focuses prevention activities around the framework shown in figure 3 below, drawing on the suggestions made for each level of prevention in the following paragraphs.
21. Limited evidence should not be used a reason for inaction. It should not be necessary for the Gambling Commission to have to prove beyond doubt that a certain practice is harmful or exploitative²² before action is taken. The precautionary principle should be applied where there is good reason to believe that significant harm may be being caused. In other areas of health the decision to act is frequently informed by the precautionary principle and the need to take preventive action despite inevitable uncertainties.²³

Figure 3: Levels of prevention activity



Indicated prevention activities

22. Indicated prevention measures are actions which are focused on intervening with individuals at high risk of developing gambling-related harms. Prevention activities for this group are likely to include (but are not limited to):
 - i. Continued development, testing and evaluation of industry interventions to identify and intervene with at-risk gamblers. Some operators can monitor gambling in real time and potentially identify behaviours that indicate harm. The potential use of warnings signs, making spend more transparent, opt-out mechanisms and so on is still under-exploited.
 - ii. Increased awareness, assessment and management of gambling-related harms among frontline staff – those who are most likely to come into contact with high risk individuals. This includes those working in healthcare, social work and other service providers (like Citizen Advice Bureaux or money management services) as well as gambling operators' own customer-facing staff.
 - iii. Working with financial institutions and banks to encourage more proactive design of banking applications. Some of the newer 'challenger' digital banks such as Monzo and Starling Bank are already developing new technologies to assist those at risk of harm.
 - iv. Effective self-exclusion schemes.

²² Despite being enshrined in the 2005 Act, the concept of 'exploitation' is applied far less often in regulatory decision-making than that of 'preventing harm'. It does, however, provide a useful yardstick against which to assess some industry practices.

²³ Identifying the environmental causes of disease: how should we decide what to believe and when to take action? Academy of Medical Science, 2007

Selective prevention activities

23. Selective prevention measures are those which are focused on groups or communities likely to be at higher risk of gambling-related harms. Such groups could be identified on the basis of their socio-demographic features (e.g. children or young men), economic circumstances, other health and wellbeing behaviours, interests (e.g. gaming, sports fandom, or e-sports), where people live (areas with high levels of deprivation and unemployment), ethnicity, religion or the types of products people play. Prevention activities for these different groups could include (but are not limited to):
- i. Programmes targeting people who work in specific professions where risk of harms is heightened – e.g. the armed forces, those in financial services or professional sports.²⁴ The gambling industry has a duty of care in respect of its own employees, who are exposed daily to gambling opportunities.²⁵ Programmes could range from education to brief interventions to more intensive interventions using a range of psychological approaches to encourage behaviour change, give insight into gambling risks, and provide tools to help mitigate harms.
 - ii. Preventive education among children. Learning from other areas suggests that work in schools is more likely to be successful if it focuses on developing resilience, decision-making under pressure, dealing with peer pressure and other skills and avoids advocating abstinence or making use of scare tactics.²⁶
 - iii. Proportionate (and ethical) additional product or regulatory restrictions for certain groups. For example, maximum loss limits, safe default settings for time limits on lengths of games for young people aged 18–21 – a group with greater incidence of problem gambling.²⁷

Universal prevention activities

24. Universal prevention measures are those which are focused on whole populations i.e. they seek to impact all gamblers – and potential gamblers – regardless of whether they are at risk. Such measures are a key component of most major public health strategies. Examples are mandatory use of seat belts, prohibition of smoking in public places, and restrictions on licensing hours for the sale of alcohol. Such measures have been proven to deliver significant public health benefits. Securing a meaningful reduction in gambling-related harms through the new strategy is also likely to require consideration of further population level measures.
25. Universal measures relating to gambling could include (but are not limited to):
- i. Public health awareness campaigns aimed at raising awareness of gambling as a potentially harmful health issue, delivered as part of a broader strategy to reduce shame and stigma attached to gambling (so as to reduce barriers to seeking treatment) and to highlight its risks.

²⁴ [GambleAware, Education, funded projects and funding requests](#)

²⁵ [How working in a gambling venue can lead to problem gambling: the experiences of six gambling venue staff](#), Nerliee Hing & Helen Breen, Southern Cross University, 2008. [Gambling by Ontario casino workers: gambling behaviours, problem gambling and impacts of the employment](#), Daniel Guttentag et al, University of Waterloo, 2012

²⁶ [Evaluation of GambleAware's harm minimisation programme: Demos and Fast Forward projects](#). Richard Ives, September 2018

²⁷ [Gambling and problem gambling among young adults: insights from a longitudinal study of parents and children](#), David Forrest & Ian McHale, September 2018

- ii. Product safety tests on gambling products before their introduction to the market. A testing regime already exists for the technical standards of products.²⁸ Additional tests for safety features could be explored. These tests could include assessment of the structural features of the games/product and the setting in which it was offered to understand the level of likely risk attached and thus inform any restrictions imposed by the regulator on how it is used (speed of play etc.).
- iii. Preventing the use of credit cards for gambling and/or implementing ongoing credit checks (where possible) to limit levels of gambling credit to what the individual gambler can afford.
- iv. Restricting advertising and marketing of gambling products (see paragraphs 31 to 35 where this is considered in more detail).
- v. Restricting certain features or products. Banning products with features which encourage players to stake more or take greater risks – e.g. by offering better odds for higher stakes²⁹ – or restricting time-limited calls to action such as ‘bet now’ which encourage people to make pressurised decisions with limited opportunity for reflection.
- vi. Reconsidering as part of the forthcoming competition for the Fourth National Lottery Licence the ability of the National Lottery to sell its products – particularly instant win products – to 16 and 17-year-olds, and reviewing the practice of displaying Lottery scratch cards next to products that appeal to children.

Facilitators and barriers to success

- 26. The current evidence base on what works in gambling-related harms prevention is thin.³⁰ The development, testing, and delivery of a prevention strategy will therefore require the joint efforts of a range of stakeholders – voluntary sector organisations working with high risk groups, local authorities with responsibility for public health, operators with their real time access to gamblers, financial institutions who can help set limits on gambling losses, the regulator and central government.
- 27. The success of some prevention measures will depend heavily on the industry. Progress in this area has not yet gone far enough, nor been sufficiently embedded in common practice across all parts of the industry. The Gambling Commission could encourage faster progress by:
 - i. Further development of robust Assurance Statements as a means of encouraging operators, at board as well as executive level, to reflect on their approach to preventing harmful gambling and to set out the actions they are taking in a formal document against which they can be held to account.
 - ii. Providing greater clarity about those harm-prevention activities which it wants to be piloted and tested, focusing attention on those with the greatest chance of success.
 - iii. Emphasising that it expects these activities to be evaluated. Operators should not be able to say they have taken steps to prevent harm without showing evidence about its impact. The Gambling Commission could usefully review the steps already taken to

²⁸ [Technical Standards](#), Gambling Commission

²⁹ ‘Up-selling’ to customers in gambling is not the same as in retailing.

³⁰ Though there may be more to learn from the experience of other jurisdictions, like Victoria, Australia, which has a more well-developed prevention strategy. The National Institute for Health Research is shortly to commence an evidence review which will provide an opportunity to explore these approaches in greater depth.

explain good evaluation practice to operators and identify what else could be done to improve matters. Central Government and the Gambling Commission should lead by example by ensuring that evaluation is embedded in all their own activities relating to gambling, including the new strategy.

- iv. Mandating through the licence conditions and codes of practice (LCCP) any proportionate harm-prevention activities which have been shown to work.
- v. Continuing to apply the precautionary principle. If the industry cannot demonstrate it is taking effective action, the presumption should be to restrict practices where there are reasonable concerns they might lead to harm.
- vi. Continuing to shift the focus of safer gambling from problem gamblers to one which is relevant to all gamblers. It is possible some people who could benefit from gambling management tools are deterred from using them as they are perceived as only for people with an identified 'problem'.
- vii. Ensuring sufficient funding is available, especially to fund activities such as public health campaigns and activities which need to be taken on by agencies new to gambling-harms prevention, such as voluntary sector organisations.

Families and others affected by someone else's gambling

28. The partners of people who gamble harmfully, their children, their wider family and friends and other social contacts, can also be harmed. There can be multiple knock-on effects, including reduced household budgets, less visible negative effects on personal relationships and, at the extreme, families dealing with the consequences of suicide. Some work has been done to address these harms in the recent past.³¹ The objective for the new strategy should be to consolidate and systematise the work, build awareness and broaden the resources and interventions available in family settings and beyond.
29. Causation is not always linear in nature, and direct impacts are rarely clear-cut. Gambling behaviours modelled in families and peer groups affect the gambling behaviour of others. In particular, parents have more influence than they might realise on affecting their children's behaviour.³² Their actions can either increase the risk of harmful gambling by their children or play a protective role.³³
30. An effective harm-prevention strategy needs to recognise these complex relationships and help families and peer groups play a more protective role and avoid transmitting risk to younger generations. Support and awareness raising could help them play a protective role more effectively. We suggested in a previous advice paper on children, young people and gambling³⁴ that this should include helping parents to know what their children are doing online – especially if this involves gambling with 'skins' or 'gambling-like activities' which may have the effect of normalising gambling for children.³⁵ Recent moves by the Gambling

³¹ [GambleAware funds support for family and friends of problem gamblers](#), GambleAware, October 2018

³² [Beginning gambling: the role of social networks and environment](#). Gerda Reith and Fiona Dobby, University of Glasgow, January 2011

³³ [Gambling in families: a study on the role and influence of family and parental attitudes and behaviours on gambling-related harm in young people](#), Ecorys, September 2018 & [Perceptions, people and place: Findings from a rapid review of qualitative research on youth gambling](#), Dr Heather Wardle, London School of Hygiene and Tropical Medicine, October 2018

³⁴ [Children, young people and gambling: A case for Action](#), RGSB, June 2018

³⁵ [Virtual currencies, eSports and social casino gaming – position paper](#), Gambling Commission, March 2017

Commission and regulators in other countries to address these new challenges have been a positive development.³⁶

Gambling marketing and advertising

31. Any comprehensive prevention strategy needs to look carefully at the potential for harm associated with gambling marketing and advertising. A very large increase in the volume of such marketing and advertising is one of the more obvious developments since the 2005 Act. The greatest increase in recent years has been online – £747million was spent marketing online in 2017.³⁷ Operators now spend five times more on online marketing than they do on television advertising.
32. There is no clear published evidence that greater exposure to gambling advertising has led to measurable increases in gambling-related harms.³⁸ But the absence of proof is not, of course, proof of absence.³⁹ We share the concerns that have been expressed about the potential impact of this exposure to gambling marketing and advertising. We have also yet to fully understand how marketing and advertising are linked to the rise in so called ‘gamblification’ of football and other sports.⁴⁰ The innovative and fast-moving nature of the gambling industry means that considerable harm could have been caused before robust evidence of its causes is available.
33. Our concerns focus on three main groups:
 - i. Children and young people: Although the number of television advertisements children see has decreased,⁴¹ overall exposure is still high. A Gambling Commission survey shows 66 per cent of 11 to 16-year-olds⁴² recall having seen gambling advertising on television, 59 per cent on social media websites and 53 per cent on other websites.⁴³ 12 per cent of 11 to 16-year-olds follow gambling companies on social media. 7 per cent of children who had seen gambling advertisements or sponsorship report that they had been prompted to spend money on gambling when they were not otherwise planning to do so.⁴⁴ This equates to 5 per cent of all 11 to 16-year-olds, or around 200,000 in total.⁴⁵ There is also evidence in international literature of young people saying that advertising creates a context that makes them believe that they cannot enjoy sport without betting.⁴⁶

³⁶ [International concern over blurred lines between gambling and video games](#), Gambling Commission, September 2018

³⁷ This figure excludes affiliate marketing and on social media. [Gambling Advertising and Marketing Spend 2014-17](#), Regulus Partners, 2018

³⁸ [Gambling Advertising: A critical review](#). Per Binde, 2014. Further research on this topic will shortly be published by the [University of Sterling and Ipsos MORI](#)

³⁹ [Absence of evidence is not evidence of absence](#), US National Library of Medicine, National Institute of Health, Altman and Bland, 1995

⁴⁰ [Beyond the betting shop: Youth, masculinity and the growth of online sports gambling](#), University of Bath, Darragh McGhee, June 2018

⁴¹ [Children’s exposure to age-restricted TV ads](#), ASA, February 2019

⁴² [Young people and gambling](#) – a research study among 11–16-year-olds in England, Scotland and Wales, Gambling Commission, November 2018

⁴³ Exposure within television broadcasts is also prominent. Research showed that gambling logos or branding appeared on between 71 per cent and 89 per cent of the running time of *Match of the Day* (the BBC’s Premier League highlights show). [Frequency, duration and medium of advertisements for gambling and other risky products in commercial and public service broadcasts of English Premier League football](#), Rebecca Cassidy and Niko Ovenden, Goldsmiths, University of London, August 2017.

⁴⁴ [Young people and gambling](#) - a research study among 11-16-year-olds in England, Scotland and Wales, November 2018

⁴⁵ Based on Office for National Statistics 2017 mid-year estimates – subject to some caveats e.g. how representative the survey results are of 11-16 year-olds in forms of education which do not take part in the omnibus survey.

⁴⁶ [Young people’s awareness of the timing and placement of gambling advertisement on traditional and social platform: a study of 11–16 year-olds in Australia](#), Samantha Thomas et al, *Harm Reduction Journal*, 2018

- ii. 18 to 21-year-olds. There is a high incidence of new onset problem gambling between the ages of 18 and 20.⁴⁷ It is likely that a complex range of factors are responsible. Exposure to high volumes of advertising and marketing in childhood and adolescence could be one of them. In the absence of evidence, we do not know.
 - iii. People suffering gambling-related harm or in recovery. Exposure to marketing and advertising is a particular difficulty by people experiencing or recovering from problematic gambling at a stage when they are highly vulnerable to harm and struggling to control their gambling behaviour.⁴⁸
34. The precautionary principle might suggest targeted action to reduce exposure to gambling marketing and advertising for all these groups – particularly children, who in an ideal world should not be exposed to it at all. But the widespread nature of online marketing, sponsorship and advertising, particularly at sports events, and the range of media where this content currently appears, makes such action challenging in practice.
35. This does not, however, mean that a blanket ban on gambling marketing and advertising is the only available policy response. There are other, more targeted steps which could be worth considering as part of a new approach to prevention. For example:
- i. Gambling late at night is known to be associated with gambling-related harm.⁴⁹ Restricting the amount of volume of marketing and advertising at night could be a proportionate, targeted application of a precautionary approach.
 - ii. More generally, one of the most significant steps in reducing tobacco-related harm was legislation which prohibited smoking in public places. This legislation does not prevent people from smoking. But it does restrict the places where smoking takes place, so that other people's freedom not to smoke is protected. Equivalent 'gambling-free' legislation could play a role by creating spaces, including online, where children and families are not exposed to marketing and advertising related to gambling. The recently announced voluntary 'whistle-to-whistle' ban by Remote Gambling Association members on gambling advertisements during broadcast sports events is one example of this approach. We note, however, that advertising hoardings and shirt and programme sponsorship will remain highly visible on television during sports events, reducing any effect from the ban.
 - iv. Some advertising industry practices could, with advantage, be looked at more closely. For example, selling advertising space in bundles means that, to secure a desirable advertising slot, operators sometimes need also to purchase other less desirable slots, thus increasing the proliferation of such marketing.
 - v. Countervailing safer gambling messaging is at present very limited in nature. Just telling people to 'gamble responsibly' is unlikely to be very effective; and some existing messages have had a tendency to foreground the 'fun' elements of gambling rather than the potential risks, losses and harms. It would be important to pilot different forms of messaging as part of a coherent strategy, drawing on expertise from behavioural insights, advertisers, researchers, individuals who gamble and their families.

⁴⁷ [Gambling and problem gambling among young adults: insights from a longitudinal study of parents and children](#) David Forrest and Ian McHale, September 2018

⁴⁸ [Gambling Advertising: A critical review](#). Per Binde. 2014

⁴⁹ [Using grounded theory to understand problem gambling and harm minimisation opportunities in remote gambling](#), Dr Jonathan Park & Dr Adrian Parke, Sophro & University of Lincoln, 2018

Figure 4: Existing protections for children and young people

Some restrictions already exist on the exposure of young children to gambling advertising and marketing. The main one is the so-called 25 per cent rule. Broadly speaking, gambling advertising must not appear in media where children or young people make up a disproportionately high proportion of the audience.⁵⁰ The figure is set at 25 per cent to reflect the approximate proportion of the population who are under 18. If a higher proportion is viewing particular media, advertising there is considered deliberate targeting and in principle is banned. The Advertising Standards Agency (ASA) also require marketers to use tools available to them on social media to ensure content is targeted at an age-appropriate audience.⁵¹

There are three main limitations with this approach:

- i. The 25 per cent figure is out of date. Latest figures from the Office for National Statistics⁵² suggest that the proportion of 0 to 17-year-olds in the total Great Britain population is now 21 per cent, not 25 per cent. Babies under one year old are unlikely to be viewing advertising in a conscious way. Arguably therefore the limit should be lower than 21 per cent.
- ii. More importantly, even if the threshold was adjusted to fit better with actual demographics it still overlooks the potential for extremely high levels of exposure when broadcast events are viewed by millions of people. If exposure is a concern, whether a programme or event has particular appeal to children is less relevant than the absolute numbers of children that are exposed to it.
- iii. The approach is not applicable to online marketing – the area where there is the largest growth in exposure for children and young people. Concerns include those relating to in-app marketing and the role of social influencers.

Part IV: Treatment and support

36. Treatment and support for those affected by gambling-related harms involves a continuum of services – information, online resources, self-help (e.g. Gamblers Anonymous), help with stimulus control, online cognitive behavioural therapy (CBT)⁵³ and other forms of counselling as well as pharmacological treatment delivered in clinical settings.

Figure 4: Continuum of treatment services – reflecting range of support needs



⁵⁰ A rule to achieve a similar effect, the 120 Index, applies to broadcast media – [Identifying TV programmes likely to appeal to children](#), Committee of Advertising Practice (CAP)

⁵¹ [Children: Targeting](#), Online advice, ASA, August 2018

⁵² [Mid-2017 report](#), Office for National Statistics, June 2018

⁵³ [The predictive capacity of DSM-5 symptom severity and impulsivity on response to cognitive-behavioral therapy for gambling disorder: A 2-year longitudinal study](#), Mestre-Bach et al, European Psychiatry, January 2019

37. There are a number of significant weaknesses in the present arrangements for delivery of treatment services to those who need them. The new strategy, and the announcement of expanded support for problem gamblers as part of the greater prominence being given to mental health and well-being in the new NHS 10-year plan,⁵⁴ present a significant opportunity to address those weaknesses.
38. In our view there needs to be an urgent national review of the arrangements for commissioning, funding and quality assuring treatment for gambling-related harms to make sure this opportunity is not lost, with a view to handing responsibility for oversight to the GB health departments.

Recent developments in treatment

39. GambleAware has made a number of important changes in relation to treatment during the current strategy period. Among other things:
- i. It has improved its contracting process and begun to define treatment pathways for clients with different levels of need.⁵⁵ It has also begun to collect and report data on the immediate effect of treatments using problem gambling screens,⁵⁶ though little is known about longer-term impact. The governance of GamCare and other subcontractors has been improved.
 - ii. It will be funding a second regional treatment clinic opening in Leeds in 2019 to add to the existing clinic in London. The new clinic will be hosted by the Leeds and York Partnership NHS Trust.⁵⁷ A GamCare Problem Gambling Support Team will also be based in Leeds, focusing on early identification, screening and support and intended to improve access for under-represented groups. Options are being explored to increase further the geographical coverage of services provided by GamCare and to boost its online offering through the addition of e-based Cognitive Behavioural Therapy.
 - iii. It has commissioned research on alternative treatment models and gaps in provision – including opportunities for innovation online.⁵⁸
 - iv. It has started a pilot project with the aim of improving the ability of GPs, social workers, employment advisors, probation officers, debt advisors and others to identify gambling-related harms, to give initial advice and to signpost appropriate support.⁵⁹
 - v. It has set up a local area pilot in Aberdeen to build awareness of the National Problem Gambling Helpline and promote its use;⁶⁰ and has begun work to improve aftercare and relapse prevention, e.g. through on-going peer support.
40. A number of important issues, however, still need to be addressed:
- i. There is a significant amount of unmet need. Numbers currently accessing treatment account for only two to three per cent of the total number of people in Great Britain

⁵⁴ [The NHS Long Term Plan: 10 key public health points](#), Public Health Matters, Public Health England, January 2019

⁵⁵ [Outline specification: GambleAware Problem Gambling Treatment Services](#), April 1st 2017 – March 31st 2020, GambleAware, May 2016

⁵⁶ [Annual Review 2017/18](#), GambleAware

⁵⁷ Leeds and York Partnership NHS Trust website – [news](#)

⁵⁸ [Treatment delivery gap analysis \(a needs assessment for treatment services\)](#), [Research Brief](#). Responsible Gambling Strategy Board, May 2018

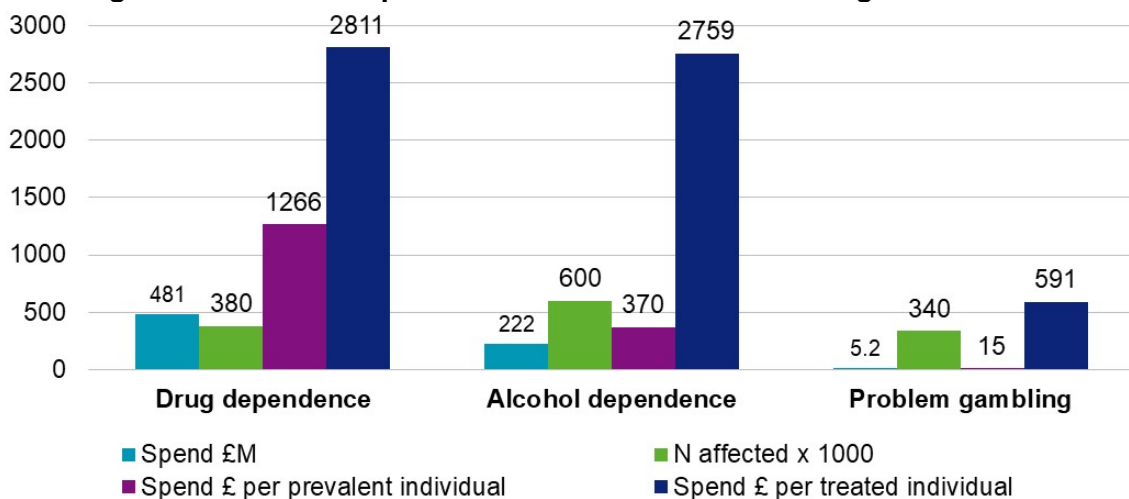
⁵⁹ [RSPH launches free access e-learning](#), GambleAware, November 2018 & [GambleAware invests £1.5million in partnership with Citizens Advice](#), September 2018

⁶⁰ [GambleAware announces initiative to promote services across Aberdeen](#), GambleAware, November 2018

estimated to be problem gamblers.⁶¹ We do not know how many people would benefit from which sort of treatment. But this statistic compares badly with equivalent figures for those being treated for alcohol or drug addiction.⁶² Average spend on those who receive treatment is also lower than in other areas of addiction treatment (see Figure 5).⁶³

- ii. The reasons for poor take-up are only partially understood. But they are likely to include stigma, shame, pessimism about treatment effectiveness, inadequate awareness of what is available, gaps in provision, and the fact that, unlike other addictions, gambling has no obvious physical symptoms – which has the effect of making it a more hidden problem.
- iii. GambleAware does not commission any services at all for those under 18, on the grounds that their needs are likely to be different to those of adults and best dealt with by NHS-provided Child and Adolescent Mental Health Services (CAMHS).⁶⁴
- iv. Very little is yet known about those who do not at present come forward for treatment, who may have different needs to those who do, about which forms of treatment are most effective in treating people at different points in the disorder spectrum, including how best to identifying and target people at risk of suicide, or about the effectiveness of self-help groups delivering mutual aid.
- v. Quality assurance of commissioned services is still at an early stage.

Figure 5: Treatment spend on different addictions in England 2016/17⁶⁵



⁶¹ In 2017/18 around 8,800 individuals received treatment for their gambling problems from GambleAware-funded providers ([GambleAware Annual Review 2017/18](#) – page 20). This represents approximately 2.6 per cent of the 340,000 who are classified as problem gamblers in Great Britain in the [latest data published](#) by the Gambling Commission in September 2018. Some others may, however, be accessing help in other ways, for example through self-help groups like Gamblers Anonymous.

⁶² Six per cent of people with alcohol dependence receive treatment, and 30 per cent of people with drug dependence. 2016-17. Prevalence statistics from: [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing 2014](#), NHS Digital, September 2016. Treatment statistics from: [Adult substance misuse statistics from the National Drug Treatment Monitoring System \(NDTMS\), 1 April 2016 to 31 March 2017](#) (Page 5), Public Health England, Department of Health, November 2017.

⁶³ Treatment expenditures statistics from: [2016-2017 Alcohol and Drugs Treatment Commissioning Tool – Guidance Document](#). Public Health England

⁶⁴ However, NHS research on this client group does not currently cover gambling-related harms and so there is a risk that their needs are not adequately being understood or addressed. [Mental Health of Children and Young People in England 2017](#), NHS Digital, November 2018

⁶⁵ All alcohol and drug dependence figures are based on England 2016/17 only (adults aged 18+). Problem gambling treatment spend is based on Great Britain 2016/17 (adults aged 18+) Problem gambling prevalence figure is based on Great Britain 2016 (adults aged 16+).

41. It is our view that, despite the progress that has been made, GambleAware as a small, independent charity does not have the scale of expertise necessary to commission specialised services, assure their quality and safety and deal with these other issues in the most effective way. Nor is it reasonable to expect it to do so, particularly when the relevant framework and expertise already exists elsewhere, on a much greater scale. It would make much more sense for the national, comprehensive and fully quality-assured service we believe to be necessary for the treatment of gambling-related harms to be part of the NHS and social care architecture, with overall responsibility resting with GB health departments and public health agencies.
42. In saying this we are not intending to diminish the role of local partners in the voluntary sector and elsewhere. Such partners can be catalysts for change, particularly where there is an appetite for more coherent local strategies for prevention and treatment combined. Our belief is that these networks would be more effective if they were commissioned, funded and monitored by the GB health departments, either directly or through local authorities, in the same way as other addiction services.
43. The details of how best to organise gambling-related harm treatment services in the NHS requires further thought. There are obvious issues of inter-relationships, legal framework, finance etc. which would have to be addressed through the review we have suggested.

Other aspects of a new treatment strategy

44. Other issues to be addressed in a new treatment strategy, include the following. Some could be introduced fairly quickly, in advance of subsequent more fundamental change:
 - i. Ensuring that treatment services being offered to people experiencing harms are accountable, assessed against recognised standards and subject to inspection. Discussions between the Gambling Commission and Care Quality Commission (CQC) in England, and separately with Health Improvement Scotland and Healthcare Inspectorate Wales, are in progress.
 - ii. Prioritising working with experts by experience in the co-design and delivery of services.
 - iii. Working with other agencies such as Health Education England, Health Education and Improvement Wales and NHS Education Scotland on developing a workforce strategy, to ensure the right skills and experience are available.
 - iv. Ensuring that family and friends and others adversely affected by other people's gambling are able to access support, including bereavement support for families and friends of people who have taken their own lives.
 - v. Making sure that gambling is one of the issues picked up in the national suicide prevention strategies. One helpful step would be to find effective ways of collecting more information from coroners about cases where gambling is suggested to have been a contributory factor.⁶⁶
 - vi. Encouraging planned work by NICE and other bodies to develop a comprehensive set of national clinical care guidelines.
 - vii. Making better use of available data on who comes forward for treatment. An annual 'state of treatment report' setting out geographical spread, demographic details and

⁶⁶ [Some research](#) is underway to analyse the limited available data and develop methodologies for collecting more evidence to understand this issue better.

services accessed could help give greater prominence to the issues, and identify hotspots and areas of unmet need.

- viii. Completing and following through the planned or already commissioned work on harms, the treatment gap and a systematic review of treatment services.⁶⁷
- ix. Research on those who do not currently come forward for treatment. We need to learn what prompts people to seek treatment, and how needs differ among those who do not currently present for treatment.
- x. Implementing a new longitudinal study to understand more about how people move in and out of harmful play and treatment.
- xi. Building a stronger culture of evaluation to inform future commissioning decisions.

Part V: Infrastructure

Research

- 45. Good policy is underpinned by sound evidence. That in turn requires good data, a sizeable, consistent and reliable flow of funding and a large enough pool of researchers able and willing to respond to invitations to tender for commissioned research, or prepared to identify useful research topics on their own initiative.
- 46. The present arrangements, though considerably improved over the last few years, fall short in all three respects.
 - i. Much more data is available, but often only in response to ad hoc requests which frequently encounter difficulties because of concerns about confidentiality, data protection or other issues. Sorting that out afresh on each occasion takes time and introduces an unnecessary inhibition on potentially useful research.
 - ii. The majority of funding for commissioned research is either supplied voluntarily by the industry or becomes available through regulatory settlements. The latter are, by their nature, unpredictable and irregular.
 - iii. There is resistance on the part of some potential researchers to accepting funds voluntarily provided by the industry and routed through GambleAware because of concerns that the source of funding may present conflicts of interest and compromise the integrity of the research. Steps have been taken to establish more transparent governance arrangements and to make clear that there is no industry involvement in the published research programme. There has, in consequence been some limited success in widening the pool of potential researchers. But there is still some way to go.
- 47. In addition, the current arrangements for delivering research directly underpinning the national strategy involve an unnecessary two-step process which requires GambleAware to commission and manage projects on behalf of the Gambling Commission (which writes the research briefs and sets the research questions with advice from the Responsible Gambling Strategy Board).
- 48. We believe these arrangements need to change. It is unusual for a statutory regulator to rely on a charity to carry out research commissioning on its behalf. Dividing responsibilities between three different bodies creates inefficiencies which can delay the pace of progress and an additional tier of decision making is created by GambleAware's Research Committee.

⁶⁷ [Research projects](#), GambleAware

49. In our view the new strategy should require:

- i. A change of responsibilities. The Gambling Commission should take responsibility for directly commissioning the research necessary to underpin the strategy, rather than doing so via a third party (GambleAware), and resource itself accordingly. The commissioning of other research relevant to gambling should be undertaken by arms-length bodies, such as the National Institute for Health Research (NIHR) and the Economic and Social Research Council (ESRC).
- ii. A repository of regularly updated anonymised data, accessible to UK and international researchers under agreed governance arrangements, covering, for example, information on staking patterns, frequency of play and levels of losses. Some work is already in hand on how best to achieve this.⁶⁸
- iii. Better arrangements for collating research, promulgating the findings and assessing the implications for policy and practice.

Funding

50. The new strategy will also require a regular and predictable flow of funding.

51. The volume of funding will inevitably have to be increased if:

- i. Accessibility for treatment is to be improved. It seems unlikely that full funding for this will be made available from NHS bodies or local authorities in their current financial situations.
- ii. An effective and co-ordinated prevention strategy, including potentially expensive public education campaigns among other measures, is to be adequately resourced.
- iii. Sufficient finance is to be made available for the research programme we believe to be necessary to underpin the strategy.

52. The current arrangements are unsustainable. Their voluntary nature of the arrangements means that the amount received is uncertain and therefore difficult to plan against and the overall quantum of funding raised is insufficient to meet the level of need set out in our advice. A number of organisations and individuals perceive ethical difficulties in receiving money directly from the industry; and it would not be easy to scale up voluntary contributions very quickly or proportionately to what is needed.

53. A compulsory levy would help to address all these issues. It would be more efficient to collect and distribute. Volumes would be predictable and levels could be linked to what is needed. It would also be fairer by eliminating free-riders.

54. The legislation for a compulsory levy already exists in the Gambling Act 2005. The relevant provision can be activated by secondary legislation; and most of the industry trade associations are now in favour. We believe there to be strong arguments for now bringing it into operation.

55. The mechanics of how to distribute funding provided by a compulsory levy require further thought, including as part of the review of treatment provision we suggested in paragraph 40.

Part VI: Conclusion

⁶⁸ Research is being carried out on [patterns of play](#) which will provide recommendations on the data which could be made available in such a repository.

56. We have argued that there is both a compelling need for a different approach in the new strategy to reduce gambling-related harms and a real opportunity to use it to make a significant difference to the volume of harm experienced by the population of Great Britain.
57. We have put forward the key features of such a strategy. In our view it requires:
- i. Changes in mindset – much greater focus on harms as a whole, less emphasis on problem gambling prevalence rates, effective follow through on the notion of gambling as a public health issue, to be addressed in the same way as other public health issues, and greater recognition of the influence of product and environment as well as individual behaviour.
 - ii. Changes in organisation – responsibility for the commissioning and oversight of treatment to be taken by the UK health departments, following an independent review, and responsibility for commissioning research underpinning the strategy to be taken directly by the Gambling Commission.
 - iii. Changes in the approach to prevention – a more coherent framework in which priorities can be established in relation to need and effectiveness and interventions made at a variety of different levels, consistent with a public health approach. In the short-term it is most practical for this to be overseen by the Gambling Commission, but ideally government departments are best placed to initiate action from a broad range of agencies, particularly those outside the gambling industry.
 - iv. Changes in implementation – an effective delivery plan, involving a wide range of organisations and experts by experience, guidance and direction from the Gambling Commission, and industry and others taking further steps to apply and evaluate what works.
 - v. Changes in funding – A compulsory levy to provide an increased volume of stable and predictable funding.
58. Some of these things could be done fairly quickly. Others will take more time to implement, particularly those involving institutional changes. The implementation plan will need to give careful thought to how the transition should be managed.
59. There will be changes in our own role. We will shortly no longer be the ‘owner’ of the National Strategy and the strategy itself is to be renamed. Our current title – the Responsible Gambling Strategy Board – will soon become inappropriate. We propose a new name is agreed to better reflect our role contributing to achieving a Great Britain free from the consequences of gambling-related harms.

Responsible Gambling Strategy Board
February 2019