Registered Charity No: 1059310

A Company Limited by Guarantee Registration No 32655669

**Director: Alison Mather**

**PO Box 3344**

**Bristol BS6 9NT**

**0117 924 6981**

**E- mail:** **alison@qaad.org**

**Website:** [**www.qaad.org**](http://www.qaad.org)

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**QAAD RESPONSE TO THE GAMBLING COMMISSION’S CONSULTATION ON THE NATIONAL GAMBLING HARM REDUCTION STRATEGY (2019-22).**

**Q9 What are your views on our overall approach to the Strategy from defining the problem through to ensuring widespread adoption of good practice?**

We welcome the change in the new strategy’s focus, from addressing responsible gambling to reducing gambling harm. We agree that the former’s promotion of the ‘empowerment’ of individuals to make ‘healthy choices’ has de-emphasised the inherent harms associated with gambling product design and environments. The socio-economic model, described in the Measuring Gambling Related Harms framework[[1]](#footnote-2), incorporates individuals, families, communities and society, and highlights a range of risk (causal) factors which, we believe, will contribute to a richer and more comprehensive picture of how so many people are damaged through exposure to gambling.

In our view, the strategy’s proposed aim - ‘*to reduce gambling* *harms*’ - could be strengthened. For example, the new Drug and Alcohol Strategy for Scotland’s vision is that ‘*Scotland is a country where we live long, healthy and active lives... where individuals, families and communities have the right to health and life free from the harms of alcohol and drugs...’.* This vision will be achieved, it states,‘*by delivering Scotland’s Public Health Priority to reduce the use of and harm from alcohol and drugs, with a particular focus on reducing alcohol and drug deaths.’* [[2]](#footnote-3) We suggest that the Gambling Commission may wish to consider a similar statement which clarifies its vision regarding its long-term aspirations.

The structure of the strategy, with just five priority areas, offers a sharper focus than did the 2016-19 strategy. However, we suggest that it would benefit from further re-shaping, reducing the five draft priority areas to three:

* **Priority 1: Research.** In the draft strategy, this priority comprises three actions relating to the strengthening of the gambling research infrastructure, whilst the key research component, the implementation of the framework for measuring gambling related harms, is located under Priority 2 (Public Health, Prevention and Education). The framework report outlines a three-phase implementation process, including a substantial scoping exercise and selected research projects which could be undertaken immediately.

We suggest, therefore, that P1 should be re-titled ‘Research’ and include ‘*Strengthening the gambling research infrastructure’* as one of its actions. The proposed implementation plan could then specify how this would be done i.e. the three action points described in the draft strategy. The remaining P1 actions could, we suggest, include the scoping process and initial research projects proposed in the framework report. We believe that this would balance the strategic and pragmatic dimensions of the Strategy’s research objectives.

* **Priority 2: Prevention.** The current draft includes two action points which refer to ‘supporting’ the public health model and plans. We do not disagree with the principle of what is proposed here, but suggest that this strategy needs to specify action more explicitly. Furthermore, education in its broadest sense is a key *component* of prevention, rather than a concurrent activity, together with the adoption of evidenced-based good practice.

We would like to suggest that P2 is re-titled Prevention and includes actions directly related to the development of effective and targeted public health messages and campaigns, informed by existing and proposed research and evaluation into good practice. This could include the evidence-based toolkit included in the draft, and the relocation of the action ‘*To properly evaluate and compare the initiatives to prevent and tackle harm’*, currently under Priority 5, to P2.

* **Priority 3: Treatment.** We agree that this should be a priority area within the new strategy.One of the 2016-19 strategy’s objective was to ‘*build the quality and capacity’* of treatment for those diagnosed as problem gamblers.We are pleased, therefore, to learn that the delayed review of treatment models and gap analysis has now started, and that the NHS Northern Gambling Clinic will begin operating at the start of the new strategy’s term.

**Priority 4: Evaluation.** The draft strategy confirms that evaluation is ‘*genuinely cross-cutting across all other areas’*. In the light of this, we do not think that it should be included as a discrete priority, but act as an underlying objective for the whole strategy and included as a key output for actions in the implementation plan. See also our response to Question 18.

**Priority 5: Operators.** As stakeholders, operators will be accountable for delivering actions in the implementation plan and contribute their knowledge and experience in relation to past and current practice as representatives on the Strategy Board. We do not agree, therefore, that this is a discrete priority area. See also our response to Question 20.

**Q10 Do you have any views on what should be prioritised under a new national strategy?**

We support the aims of this Strategy, and that of the Gambling Commission’s own Research Programme, to develop a greater understanding of risks and impact. However, there is a substantial body of evidence regarding gambling-related harms from UK and international studies over the past 20 years. We think that it is important to strengthen the focus on (and investment in) the piloting and evaluation of promising approaches which are supported by robust evidence. Rising public awareness of gambling-related harm, combined with falling levels of people who believe that gambling is fair and can be trusted[[3]](#footnote-4), suggests that there is a growing call for action.

The development of a detailed implementation plan to accompany the new strategy which identifies objectives, timescales, outputs and lines of accountability, needs to be undertaken as a matter of urgency following the strategy’s launch in April 2019.

**Q12 Do you have any other comments on P1? For example, what other actions should be considered? How could these actions be taken forward and which organisations should be involved?**

*To be read in conjunction with our comments in response to Question 9, above.*

It would be helpful if the Strategy could provide greater clarification on how its research component will be linked to, and informed by, the Gambling Commission’s Research Programme (2018-22), and work being undertaken by other bodies e.g. Public Health England’s evidence review and the newly- established Gambling Harm Alliance.

1. **The Prevention Paradox**

Research into the relevance of the ‘Prevention Paradox’ (Canale et al, 2016) to analysis of gambling related harm provided some compelling evidence to support the case for reviewing harms at a population level. It found that ‘*[gambling harms] were distributed across low to moderate-risk gamblers... and reported by the majority of gamblers who were non-high time and spend regular gamblers.’[[4]](#footnote-5)*  We suggest that future UK research into reducing gambling-related harm therefore includes population level studies to build on this research and target public health prevention activity where it is likely to have the greatest impact.

1. **Qualitative data**

The proposed data repository will help to build a valuable resource of industry data for independent researchers, policy makers and stakeholders. However, over-dependence on quantitative data and industry algorithms will provide only a partial insight into gambling-related harms. In addition, algorithms can, as the RGSB has acknowledged[[5]](#footnote-6), ‘*mask fundamental* *weaknesses*’ in identifying those at risk. We recommend that the scoping of the framework’s implementation considers the balancing of quantitative and qualitative methodologies, to include individual and group consultations targeting gambling addicts in recent and long-term recovery; family members (including young and adult children) and friends of problem gamblers; and people with complex and multiple needs. We appreciate that this is both cost-intensive and complex, but we believe that it is essential for people’s stories and experiences to be heard and understood if genuine change is to be achieved.

1. **Experts by Experience**

A further consideration could be the establishment of an ‘Experts by Experience’ Advisory sub-group to the Board, which could contribute fresh insights and perspectives for the strategy’s work. They could also, potentially, directly engage those who may be reluctant to participate in more formal research processes and/or design peer research processes to achieve this objective.

1. **Close others**

In its 2018 guidance for local councils[[6]](#footnote-7), the Local Government Association quotes research findings that found between six and 10 people i.e. *a potential 2.5m – 4.3m people* are directly affected by a single problem gambler[[7]](#footnote-8). Research by academics at Sheffield Hallam University (Banks et al, 2018)[[8]](#footnote-9) provided valuable insight into the serious and multiple harms experienced by close others and the not inconsiderable barriers for them to access support. The authors refer to a ‘*dearth of UK specific research’* in this area of gambling related harm, and we are pleased to note that it has been included in the framework. We believe that further research needs to be prioritised under the new Strategy. If policy, action and related funding continue to underestimate the scale and impact of gambling for close others, large numbers of families and communities will be left struggling to cope and dealing with long term damage.

1. **Longitudinal research**

We note that the Gambling Commission’s Research Programme (2018-22) includes as one of its themes ‘Changes in gambling behaviour over time’ and agree that this is an important dimension to its objectives. The Public Health Agency of Sweden’s longitudinal gambling study (Swelogs)[[9]](#footnote-10) is an approach which produced valuable findings over its seven-year implementation and may be a model worthy of consideration in a UK context. It is also interesting to note that Swelogs sub-divided its adult cohort into two age groups (27-35 years and 36-85 years) to explore generational differences, and compared risk factors for new and experienced gamblers.[[10]](#footnote-11)

1. **Society Lotteries**

To date, society lotteries have not featured prominently in work to reduce gambling-related harm. As a well-established vehicle for charity fundraising, we recognise that they have raised significant sums for good causes. Viewed by some as a ‘soft’ form of gambling, evidence confirms that the National Lottery and Society Lotteries represent a low proportion of problem gambling[[11]](#footnote-12). However, problem and at-risk gamblers typically bet using a range of formats to sustain their addiction and to chase losses, and the low levels of problematic gambling directly attributed to Society Lotteries (and the National Lottery) therefore only apply to individuals who do not also use other higher risk gambling products.

Larger Society Lotteries have been developing increasingly sophisticated and ‘harder’ gambling products which pose a higher risk of gambling addiction and threaten to blur the boundaries between lotteries and mainstream gambling.  The fact that Society Lotteries tickets can be purchased by 16-year olds; the availability of Society Lotteries online, and via scratchcards and phone apps; and the offer of substantial prizes by the larger Society Lotteries are causes for serious concern. Online, Society Lotteries are available 24/7 and now offer instant wins and rapid re-play – all factors widely acknowledged as contributing to problem gambling, particularly when combined with other vulnerability factors such as substance misuse and mental ill-health. On this basis, we would like to recommend that research into society lotteries’ contribution to gambling-related harm is included within the research priority.

**Q14 Other comments re P2 (prevention, education)? For example, what other actions...?**

Public education on gambling needs to include clear, evidence-based information on the characteristics of high-risk forms of gambling, and which forms have higher problem rates. The public needs to know that swift, repetitive forms of gambling with few structural breaks carry more risks of problem gambling behaviours than do those with a lower ‘event frequency’. We hope that the development of UK public health information and campaigns will draw on examples of international work, for example in New Zealand where the public is provided with clear, unequivocal information derived from treatment data about the relative risks associated with specific forms of gambling*[[12]](#footnote-13)*.

Research focusing on Human Computer Interaction methods in relation to internet gambling and harm reduction information/messages (Auer and Griffiths, 2016) has found that personalised messages based on the individual’s gambling data seemed to be effective in influencing behaviour, and that (generally speaking) this was more effective than normative messages. The authors conclude that the study ‘*demonstrates one way in which operators could use the big data that they routinely collect to help inform and encourage responsible gambling among its clientele.’[[13]](#footnote-14)*

**Q16 Other comments re P3 (treatment)? For example, have we adequately mapped current treatment provision? What other actions should be considered? How could these actions be taken forward and by which organisation?**

Given that improved capacity will depend, to a significant extent, on increased funding, we hope that the gap analysis will include an assessment of the additional resources required to increase both treatment capacity and access.

As the consultation document points out, only a very small proportion (approximately 2.6%) of those classified as problem gamblers received treatment in 2017/18. The potential number in need of support – given that those seeking help will represent a small proportion of people experiencing harm – highlights the current, substantial, deficit in treatment provision. It is not clear, on reading the Northern Gambling Clinic’s proposal (October 2018)[[14]](#footnote-15) how many service users it aims to support each year and by which method i.e. in person, via help lines, community outreach etc. Such analysis will be helpful when considering the case for a mandatory levy for the industry. In addition, we suggest that the national Strategy needs to include an objective under this priority area which quantifies increased provision over its three-year period.

**Q18 Other comments re P4 (evaluation)? For example, what other actions...?**

We do not think that this should be a discrete priority area (see also our response to Question 9).

In the light of the disappointing pace of progress regarding the development of an evaluation culture during the 2016-19 strategy, we would like to suggest that future evaluations should be undertaken primarily by external, expert evaluators with no professional links to the industry. In our view, this would go some way to help strengthen public and professional confidence in gambling policy and regulation. We would add to this the suggestion that such evaluations are formative, rather than summative or retrospective, which would allow for the cumulative refinement of innovations during the pilot phase.

Our further concern is the selection of innovations chosen by operators to pilot. Whilst we understand that it is not the intention of the regulator to prescribe the industry’s activities, and would not wish to see innovation stifled, we suggest that some of the same concerns regarding independence and objectivity are pertinent here. Any choice of pilot needs to demonstrate clearly that it is based on evidence of what works; to select otherwise leaves such decisions open to the criticism that they have been made, at least in part, on the basis of technical compliance and/or commercial considerations.

For these reasons, we have responded 'neither agree/disagree' to the first and fourth elements of Question 17.

**Q20 Other comments re P5 (operators)? For example, what other actions...?**

We do not think that this should be a discrete priority area (see also our response to Questions 9 and 18). We support the actions identified under Priority 5 of the draft consultation regarding targeted collaboration to focus industry efforts for safer gambling and the widespread adoption of evidence-based good practice. Our concern remains with the inconsistency of operators’ commitment to robust piloting and evaluation, demonstrated during the previous strategy period. For this reason we have responded 'neither agree/disagree' to the second element of Question 19.

**Alison Mather**

**Director, QAAD**

**February 2019**

1. ‘*Measuring gambling-related harms – a framework for action’*, Wardle et al, 2018 [↑](#footnote-ref-2)
2. Rights, Respect and Recovery- Scotland’s strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths, Scottish Government, 2018 [↑](#footnote-ref-3)
3. ‘*Gambling participation in 2017: behaviour, awareness and attitudes, Annual report’*, Gambling Commission, 2018. [↑](#footnote-ref-4)
4. *‘The Extent and Distribution of Gambling-Related Harms and the Prevention Paradox in a British Population Survey’,* Canale, N et al, 2016 [↑](#footnote-ref-5)
5. ‘*Two Years On: Progress delivering the National Responsible Gambling Strategy’*, RGSB, April 2018 [↑](#footnote-ref-6)
6. ‘*Tackling gambling related harm – a whole council approach’*, Local Government Association, November 2018 [↑](#footnote-ref-7)
7. [www.citizensadvice.org.uk/about-us/policy/policy-research-topics/consumer-policy-research/out-of-luck-an- exploration-of-the-causes-and-impacts-of-problem-gambling/](http://www.citizensadvice.org.uk/about-us/policy/policy-research-topics/consumer-policy-research/out-of-luck-an-%20exploration-of-the-causes-and-impacts-of-problem-gambling/) [↑](#footnote-ref-8)
8. *‘Families Living with Problem Gambling: Impacts, Coping Strategies and Help-Seeking’,* Banks, J et al, October 2018. [↑](#footnote-ref-9)
9. <https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/living-conditions-and-lifestyle/alcohol-narcotics-doping-tobacco-and-gambling/gambling/swelogs/> [↑](#footnote-ref-10)
10. ‘*What are the features that make gambling risky?’,* Swelogs Fact Sheet No 16, Public Health Agency of Sweden, April 2014. [↑](#footnote-ref-11)
11. #  Gambling Behaviour in Great Britain in 2015, NatCen, 2017

 [↑](#footnote-ref-12)
12. <https://www.pgf.nz/fact-sheet---gambling-in-new-zealand.html> [↑](#footnote-ref-13)
13. Personalized Behavioural Feedback for Online Gamblers: A Real World Empirical Study, Auer MM, Griffiths MD *, Frontiers in Psychology*. 2016;7:1875. oi:10.3389/fpsyg.2016.01875 [↑](#footnote-ref-14)
14. *‘The NHS Northern Gambling Clinic - a proposal by Leeds and York Partnership NHS Foundation Trust and GamCare’*, October 2018 [↑](#footnote-ref-15)