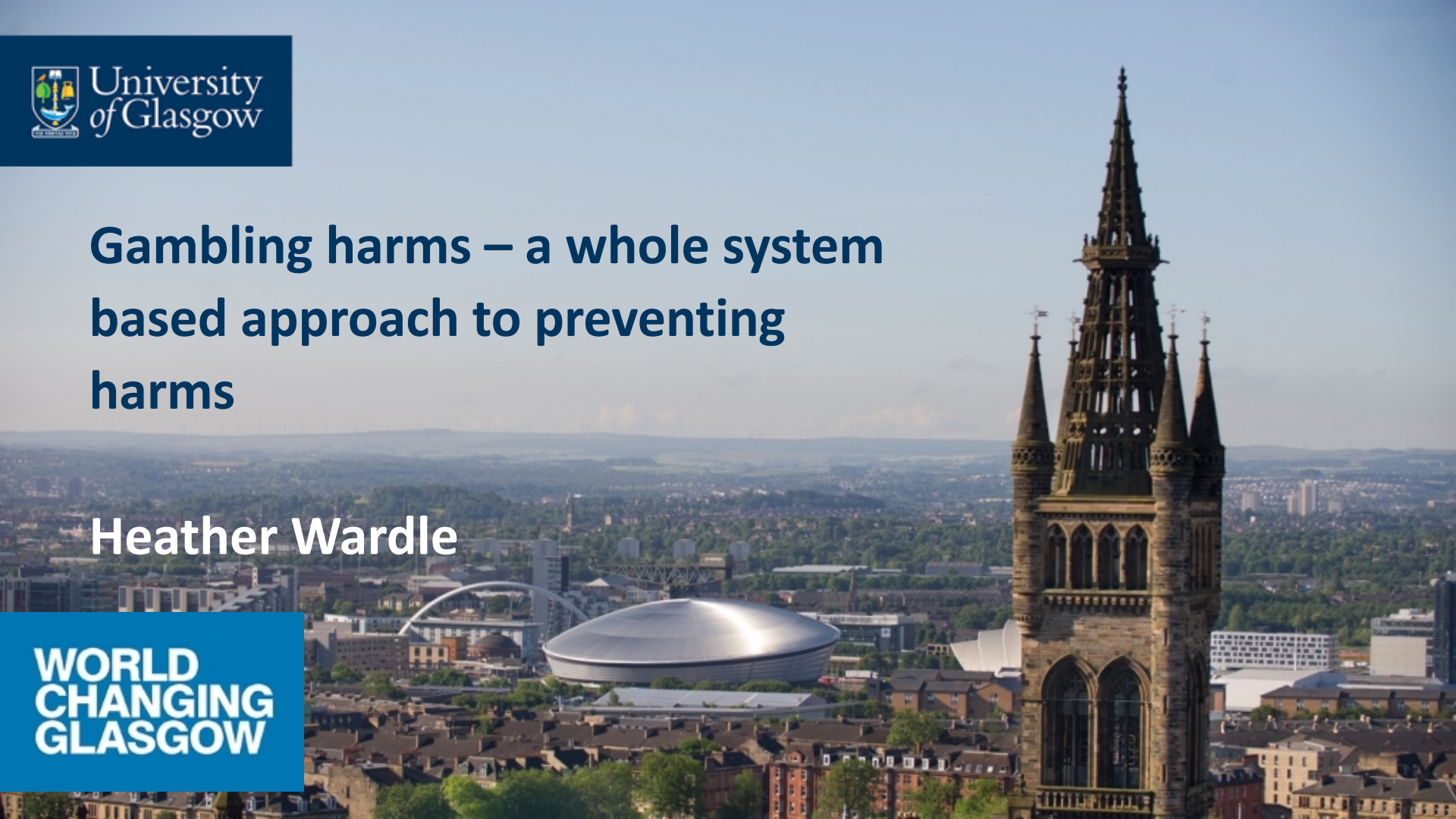

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Gambling harms – a whole system based approach to preventing harms

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WORLD CHANGING GLASGOW

Disclosures

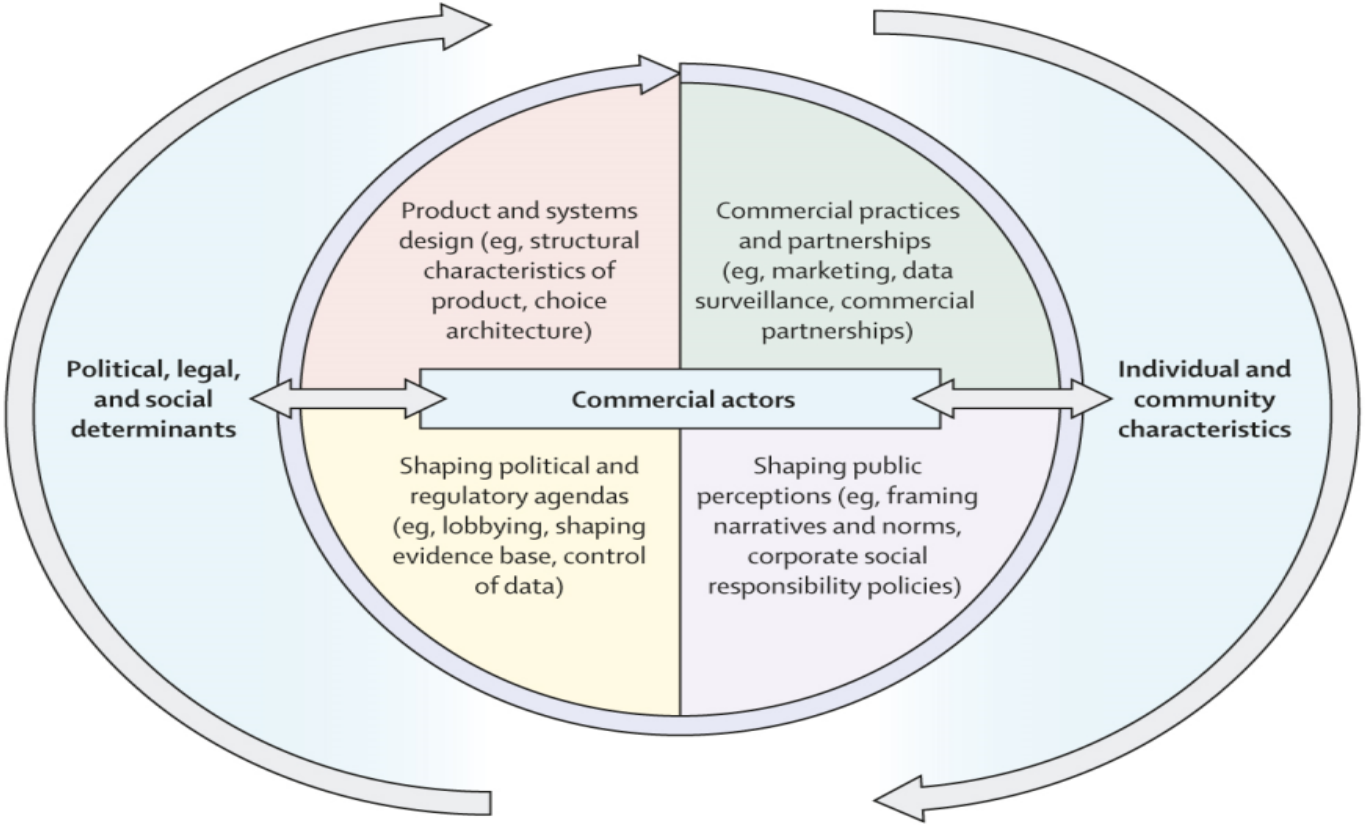
- **Disclosures:** HW served as independent advisors to UK government on gambling policy (2015-20). HW is co-chair of the Lancet Public Health Commission on gambling. Funded via National Institute of Health Research, UKRI, local and central government, including The Gambling Commission (incl regulatory settlement funding)
- Does not collaborate with industry or those who collaborate with industry.

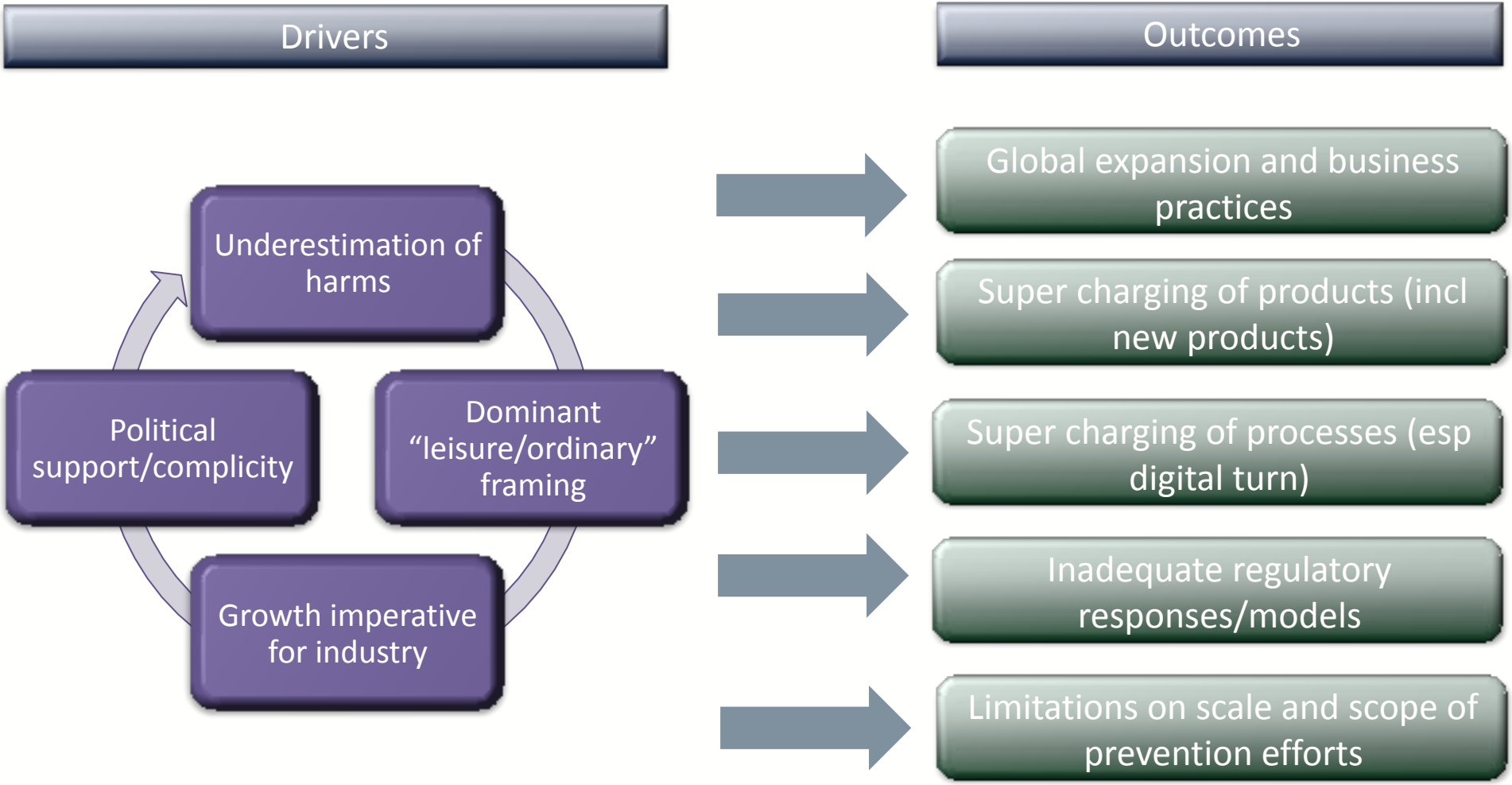
The Lancet Public Health Commission on gambling

*To make recommendations about actions to ensure that gambling is **provided** and **regulated** in the public interest – protecting the public from harm*

- Gambling is not an ordinary commodity: it is health harming for some
- Harms more wide ranging than previously acknowledged (global rates of PG c. 1.4%; but up to 1 in 6 for certain products).
- Gambling has potential to exacerbate inequalities
- Determinants of behaviour shaped by powerful corporate and political powers

Determinants of gambling and gambling harms




Drivers
Outcomes
Underestimation of harms
Dominant "leisure/ordinary" framing
Growth imperative for industry
Political support/complicity
Global expansion and business practices
Super charging of products (incl new products)
Super charging of processes (esp digital turn)
Inadequate regulatory responses/models
Limitations on scale and scope of prevention efforts

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Implications for prevention

"How you define something governs what you do about it"

(Korn &Shaffer, 1999)

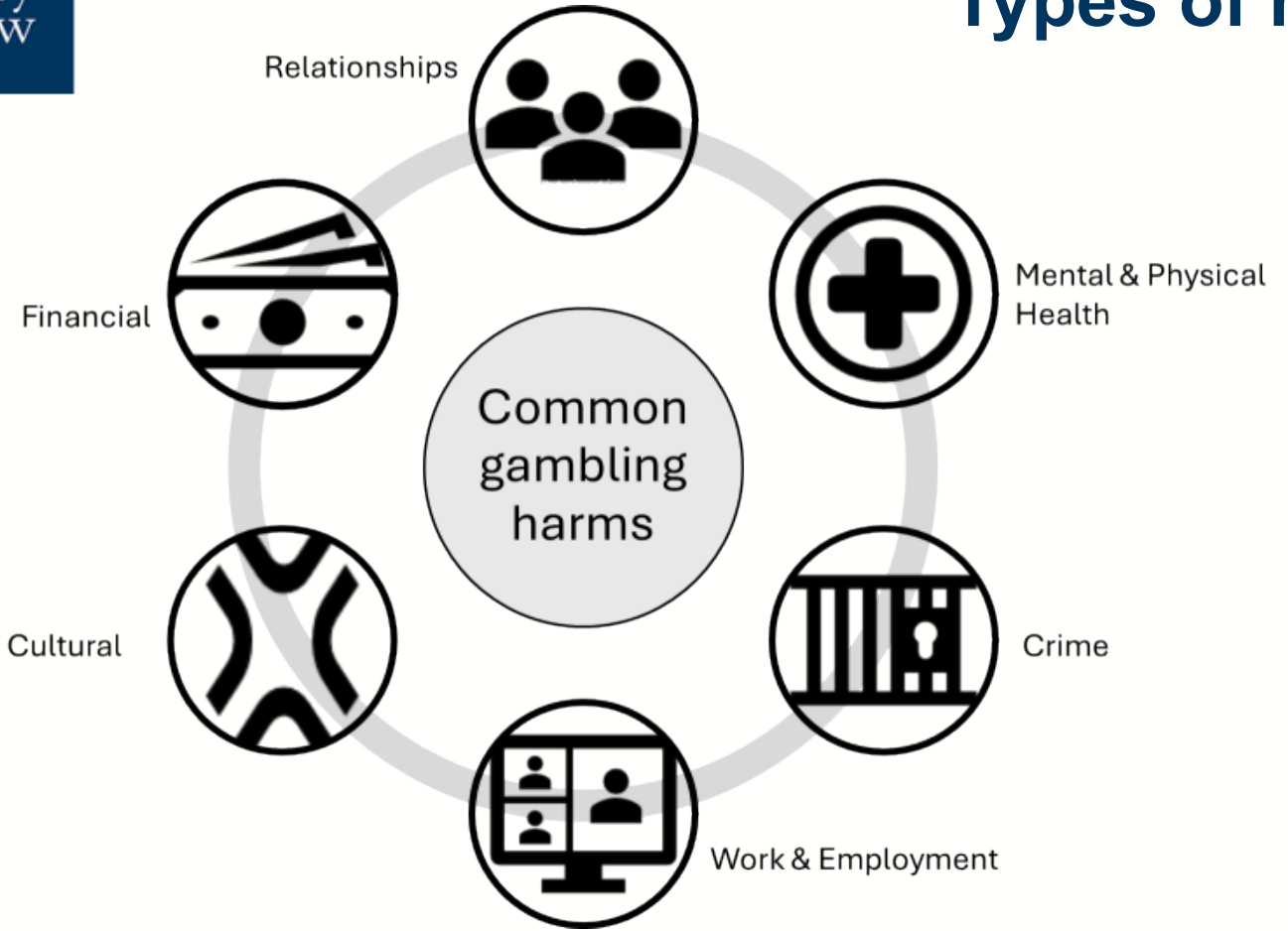
Needs a whole-systems approach to reduce harm

Need different regulatory approaches

Need global co-operation

Why a whole-systems approach?

Types of harms



Higher risk groups

Demographics	Socio-economic	Poor judgement/ impairment	Other
Youth	Unemployed	Low educational attainment	Poor mental health
Older people	Low income	Low IQ	Substance abuse/misuse
Women	Deprived areas	Under influence alcohol/drugs	
Ethnic groups	Financial difficulties/debt	Learning disabilities	
	Homeless	Personality traits	
	Migrants		
	Prisoners/ probation		

Source: Wardle, H (2015) *Exploring area based vulnerability to harms: who is vulnerable?*

The challenge

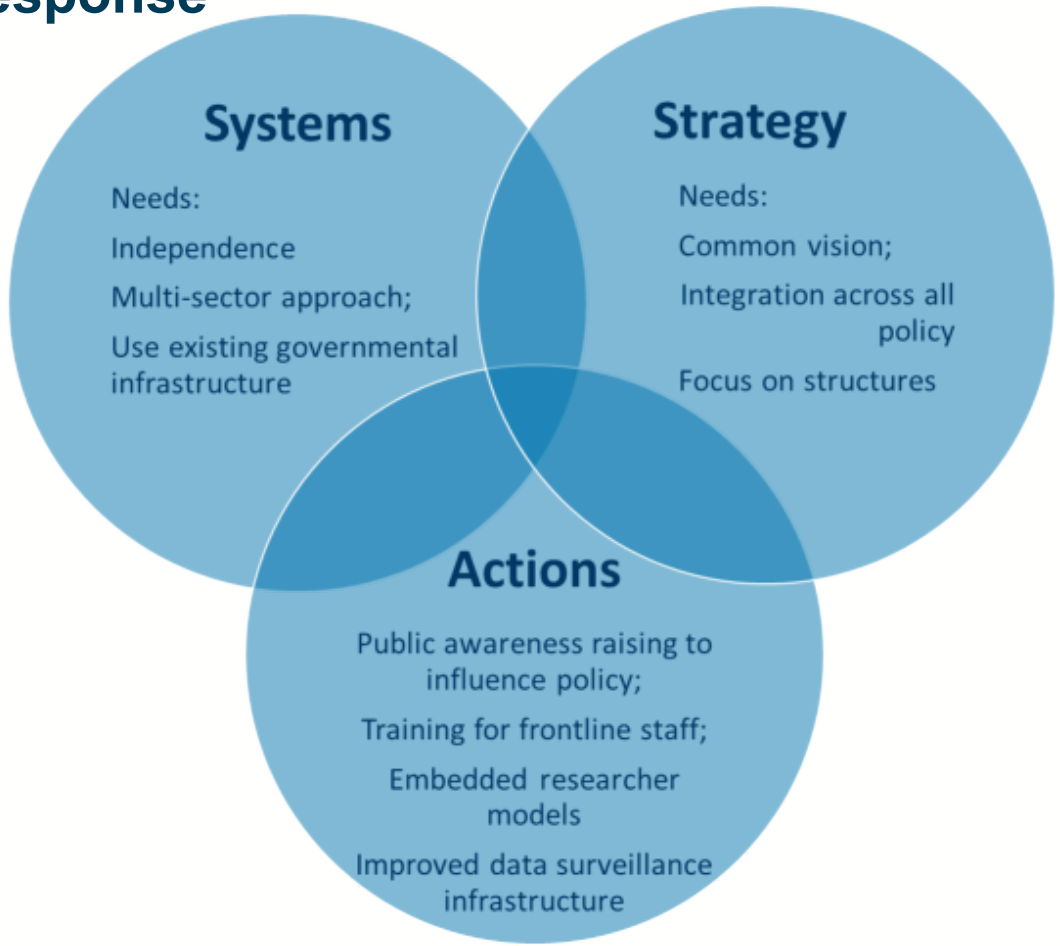
Effective prevention requires:	The White paper contains:
Strong range of upstream interventions focusing on commercial practices	Limited upstream interventions; greater focus on industry-led prevention
Restrictions on products and how products are promoted	Limited restrictions on products and their promotion
Clear focus on primary objective of protecting health	Dual focus on protecting the vulnerable and aiming to permit and grow the industry

An unresolved tension:

A prevention strategy to mitigate harms will lack efficacy if the underlying political basis and legislative framing does not support the implementation of measures most likely to be effective. This tension limits what the Levy can reasonably expect to achieve with respect to prevention.

The pragmatic response

There was widespread recognition that the current policy environment is not optimal for a fully realised public health prevention strategy. However, it was also recognised that there is an opportunity to start building towards this ambition, using the Levy to implement stronger, robust and independent systems and to start work in some priority actions areas whilst a more comprehensive and commonly-held Prevention Strategy was developed. The features of the systems proposed and the priority actions can be implemented now. In turn, they may generate impetus for political and policy change over the medium to longer term.



Primary recommendations: Systems

Systems

Ensure Independence

- Prevention strategy and its implementation needs to be designed and delivered by those with experience and competence in this area.
- Industry and those affiliated with industry should have no role in the development of the prevention strategy
- Prevention, policy and research needs to be insulated from industry influence.

Integrate multi-sectoral approach

- Health and social care professionals, third sector, researchers and all tiers of government need to be active in an effective prevention system
- At local levels, Local Authorities have experience and competence for multi-sector working both within local government and working with local community partners
- There are examples of effective regional multi-sectoral partnerships; though recognitions that all LA do not operate at the same pace.

Use existing governmental infrastructure

- There are existing governmental infrastructure and processes for the delivery of prevention activity in public health. Gambling should be integrated **within** these systems. This includes; local and regional activity organized through the Public Health grant (funds could give a ring-fenced supplement to the PH grant in priority geographical areas (see Smoking Cessation funds); or have opportunities for regional consortium bids drawing on models such as the Health Action Zones) and/or national activity led by organisations with competence for prevention delivery (i.e., DHSC/OHID, Public Health Wales, Public Health Scotland; recognizing that systems differ across Scotland and Wales to England) and partnership working with NIHR and other research councils to integrate research, prevention development and evaluation.
- Concerns that significant proportion of levy could be swallowed by costs of setting up new bureaucracy.

Primary recommendations – Immediate Actions

Immediate actions

Training for frontline staff	• Mobilise large network of existing frontline health and social care and range of other professionals (i.e. criminal justice etc) who intersect with the public by training them to identify and intervene to prevent gambling harm. • Engage independent third sector, local government and researchers to develop and/or scale existing gambling harm prevention training packages. • Have national co-operation and oversight to ensure consistency of key messages
Awareness raising	• Increase knowledge and understanding of gambling harms and how they are generated among the public through wide-ranging and co-ordinated awareness raising initiatives. • This is a longterm route to more substantial change – build public support for legislative level prevention measures, increasing political will.
Embed research	• A reflexive and dynamic relationship between prevention activity and research is needed, with fast feedback loop where evidence generated as prevention is implemented. • Embed researchers 'at the coal face' to work with health and care professionals, treatment providers and service managers to rapidly develop evidence and practice that supports gambling harm prevention. Draw on existing models for doing this, such as the NIHR School of Public Health model
Improve data infratructure	• Better data and data infrastructure is needed to drive evidence-based prevention. This includes developing systems for monitoring and surveillance of gambling across a range of functions. Should look to examples for alcohol and drug reporting to emulate. Levy funding could start to develop this system. • Access to industry data, without compromising independence, needs to be prioritised. • Coroners should uniformly implement a mechanism for recording gambling involvement in suicides.

Primary recommendations – Strategy

Strategy

Vision	• Prevention strategies work best when there is unity of vision and purpose. • Vision needs to be clearly articulated and co-developed by a multi-sector, independent, community which is invested in gambling harm prevention. • There needs to be common goal so that everyone involved in the system knows they are working towards. • This strategy needs to be underpinned with clear understanding on how different activities contribute to strategy delivery with clear articulation of the short term, medium term and longer-term outcomes that mark progress towards success. • Fora for developing this community are important e.g. through cross-sector knowledge exchange conferences
Govn owned	• Government ownership of strategy by departments with competence for health, with co-ordinated working with devolved governments to achieve common ambitions
Integrated provision	• Gambling prevention should be integrated across all relevant policies at local and national levels. Gambling should not be siloed but built into working practices of a wide range of professional specialists. • A gambling harm prevention strategy needs to integrate horizontally – across sectors – and vertically – from national to local – with bi-directional flows of information and resource. • Potential model: regional tobacco control managers who monitor locally but also have systems of national level data reporting.
Wider determinants	• A gambling harms prevention strategy needs to be aligned with efforts to address wider determinants of health e.g. poverty, precarious employment, other forms of harmful consumption.

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Immaturity of existing system: what actions are needed now to build better systems and strategies going forward?

Immediate actions

- Training of professionals on gambling harms
- Awareness campaigns for gambling harms and how industry works
- Local area action (equivalent to Health Action Zones or Scottish/Welsh equivalents) to start to build practice and knowledge
- Embedded researchers models to improve the quality and quantum of evidence and insight
- Invest in building community of civil society engagement
- Prioritise getting better data e.g. mandatory coroner reporting; greater access to and scrutiny of industry datasets

leading to

part of strategy to:

Longer term ambitions

- Increase awareness among professionals which builds support and requirements for joined up data monitoring systems
- Increase public awareness generates impetus for policy action, where prevention is in parliament
- Evidence from local area action supports widespread roll out and embedding gambling prevention with resource dedicated to producing this
- Civil society organisations act as conduit for knowledge translation and focus for accountability (see models such as Action on Smoking and Health, Alcohol Health Alliance).
- Improved surveillance data builds case and evidence for greater action

Concluding remarks

- Instituting effective prevention may require wholesale reframing of the way gambling is considered
- Needs systems-based approach, and recognition of taking action across the whole system; a multi-sectoral approach
- Regional and local-level co-ordinated action is possible and possible to make in-roads in the immediate term