Gambling with Lives – Submission to the Consultation on the statutory levy on gambling operators

Submitted 14th December 2023

Consultation question 1

1a. Do you agree with the proposal for how the levy should be charged? (Yes/No/I don't know)

1b. Please explain your answer. (Free text box)

We agree that funds should be levied relative to the level of harm caused by the products and practices of each part of the industry. Gambling is not just one activity or product – some forms of gambling are far more harmful and addictive than others.

A higher rate of levy should be charged on the most dangerous products, in particular both online and land-based slots and casino games which appear to have the highest "problem gambling and at-risk rates" (1). Consideration should also be given to applying these to newer products such as in-play betting, where official statistics don't yet exist but where research indicates some extremely high-risk figures (2). We note that there continues to be considerable growth in the revenues from online slots (3), so that harms will be increasing at a similar rate demanding prompt action.

The rates proposed in the consultation document don't appear to be appropriately applied. What is the rationale that the big four operators should be charged 1%, and all other online operators charged half of that percentage? We are not aware of any evidence that online operators outside the big four are half as harmful or have double the fixed costs.

The proposed figures also appear to be overly generous to elements of the land-based sector. This is particularly true in the context that 50.1% of land based revenues came from machine gambling according to the Gambling Commission's November 2023 industry statistics (4). Machine gambling typically offers the same products that are available online, which are some of the most addictive and harmful forms of gambling (1). It therefore makes no sense that a land-based operator that makes half its money from the most harmful forms of gambling should only pay 0.1% of its revenue, compared to 1% for the big four operators.

This is also true for casino operators, who will be able to operate more machines in their premises following the implementation of the Government's White Paper. Having successfully lobbied to expand the more harmful forms of gambling in their premises, it is not right that some casinos should only pay 0.2% of revenues to the levy, when other providers of the same products are paying 1%.

Given the proliferation of machine gambling we don't believe that land-based operators can claim to be delivering less harmful forms of gambling. Any

consideration of a relatively lower rate for land-based operators shouldn't therefore be based on an assumption of causing less harm. Should research be published that evidences lower levels of harm from different parts of the industry, which takes into account the growth in machine gambling at land based operators, then we would support the levy being applied at different rates on that basis.

References

1. https://www.greo.ca/Modules/EvidenceCentre/Details/gambling-behaviour-in-great-britain-in-2016
2. https://www.frontiersin.org/articles/10.3389/fpsyt.2020.574884/full
3. https://www.gamblingcommission.gov.uk/statistics-and-research/publication/industry-statistics-november-2023
4. https://www.gamblingcommission.gov.uk/statistics-and-research/publication/industry-statistics-november-2023#:~:text=The%20number%20of%20active%20accounts,last%20pre%2Dlockdown%20period%20end.

1c. Do you agree with the proposed total that the government estimates the levy needs to raise? (Yes/No/ I don't know)

1d. Please explain your answer (Free text box)

The total of £90 – £100m is not enough to deliver the outcomes the Government should be aiming to achieve from research, prevention, and treatment. However, this may be a reasonable target for the first years' of operation of the levy, and the introduction of the levy must not be delayed pending an assessment of the scale of funding required.

It would be possible to produce a realistic estimate of what is required by considering: the number of people who should be able to access treatment; the number of young people and adults who should receive awareness training and information (through schools, workplace and other settings); the cost of impactful public health campaigns; the backlog of research (including substantial longitudinal studies); and other initiatives.

There are almost 1.6 million adults in the UK who would benefit from some sort of treatment (1). There are also millions of young people that require education and many public health campaigns needed.

Just in the area of treatment, currently less than 0.5% of adults who need treatment receive any, which compares highly unfavourably to the 18 – 47% treatment rates for alcohol and opiate and crack cocaine users quoted in the levy consultation document (2). Based on aiming to achieve parity with alcohol and drugs treatment rates there should be an aim that at least 18% of people requiring treatment related to gambling should be able to readily access it. Expenditure on treatment for drug and alcohol harms are many orders of magnitude greater than what is being suggested for gambling in this consultation.

Furthermore, if a public health campaign funded by the prevention portion of the levy is going to stand up to £1.5bn of advertising from the gambling industry, then it will

need significantly greater funds than what might be available from the levy under the current plans for prevention funding in this consultation.

In the area of research, which has been dominated (and therefore skewed) by industry funding, the Gambling Commission has only recently announced key gaps in the research knowledge which is required to inform and evaluate regulation (3). Leading clinicians and academics have also highlighted the need for substantial (and expensive) longitudinal studies to understand the development, progress and treatment of gambling disorder (4). The whole areas of establishing and measuring gambling harms remains largely unaddressed. Therefore, there is the need for immediate and substantial research to be commissioned which would likely exceed the amount proposed.

Although £90 – £100 million might be reasonable figure to raise for RPT in the first year of the levy, whilst the sectors develop, it is vital that a proper assessment of the scale of funding required is carried out and that levy rates are increased as soon as possible to achieve that requirement.

The Government should not be afraid of increasing the amount of funds levied from the gambling industry, as the projects that will be funded are likely to be a cost effective way of reducing societal costs from gambling. A 2023 Public Health England study (5) estimated the economic costs associated with gambling harm as up to £1.77 billion each year, although this estimate doesn't even attempt to cost the majority of identified harms, meaning the actual cost and scale of harms is likely to be several times higher. There have been many UK and international studies which have attempted to quantify the cost of gambling harms, all of which put the cost hugely in excess of the proposed scale of levy.

References

1. https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates
2. https://www.gov.uk/government/consultations/consultation-on-the-statutory-levy-on-gambling-operators/consultation-on-the-structure-distribution-and-governance-of-the-statutory-levy-on-gambling-operators
3. https://www.gamblingcommission.gov.uk/about-us/print/evidence-gaps-and-priorities-2023-to-2026
4. https://assets.ctfassets.net/j16ev64qyf6l/5rJKX7DCyVsQZW1UuQe8B6/ce236c1db8486258cf462d9f856a6fb9/Longitudinal-Gambling-Scoping-Report_.pdf
5. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128002/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf

1e. Do you agree with the proposed de minimis threshold for the levy? (Yes/No/I don't know)

1f. Please explain your answer (Free text box)

We do not agree with the proposed £500,000 de minimis threshold for gambling operators. The “polluter pays” principle underlies the introduction of the levy, therefore any operator that is profiting from gambling should pay the levy. We are concerned that any such ‘loophole’ would be exploited by the industry to avoid payment by restructuring or other forms of accounting presentation.

1g. Please provide any additional views or evidence in this area the government should consider here. (Free text box)

First, we do not agree that the National Lottery should be exempt from paying the levy. The clear and widely accepted principle of the levy is that the ‘polluter pays’. While the weekly draw of the Lottery may be a relatively harmless gambling product, the National Lottery provider also runs a suite of online instant win products which are known to have high “problem gambling and at risk rates” so will be generating substantial harms. It should not become an accepted principle that gambling operators can cause harm as long as they give money to a range of charities or good causes.

We are also aware that the new lottery operator is considering how to voluntarily give money for RPT. It is important that in future there is a single coherent gambling harms prevention and treatment system, so that all monies should be collected through the levy system. However, where there are complexities to raising RPT levy funding from the national lottery provider, particularly given the current transition to a new provider, we would not want those complexities to delay the enactment of the remainder of the levy apparatus. The National Lottery could be brought into the levy arrangements at the first review point.

Second, we do not see any justification why the target year for the full scale of funding outlined in the consultation is 2027. It is clear that the treatment sector is expanding; there are developing and expanding offers around education and information; the research community has expanded but has continued to rely on funding from outside gambling. In this context 2025 should be a realistic target year to establish the levy funded sector. It can then adapt based on more detailed work to estimate requirements and through practical experience.

Finally, we do not believe that the levy should be a static figure. It is vital that the levy is administered and distributed in a way that ensures that all activity leads to a decrease in gambling harm so that treatment, in particular, should require a decreasing amount in due course. The levy must not be used to establish a sector which is self-perpetuating and does not tackle the core aim to reduce gambling harm.

Consultation question 2

2a. Should the government pursue option 1 or 2 in setting the timing of payment of the levy? (Option 1/Option 2/I don’t know)

2b. Please explain your answer. (Free text box)

A further priority for the Government should be that the levy funds start to be collected and utilised as soon as possible. The Gambling White Paper recognised that the current system is not fit for purpose, and there are organisations that rightly won't accept voluntary donations from the gambling industry that are struggling to survive whilst they wait for the levy. If the two options for collection of funds are finely balanced then the option which starts to deliver funding the soonest should be chosen.

2c. Do you agree that the levy with the proposal that licensees should make levy payments in advance i.e. based on projected GGY? (Yes/No/I don't Know)

2d. Please explain your answer. (Free text box)

The levy must be in place as soon as possible to begin to address the public health crisis caused by the gambling industry. Requiring licensees to pay in advance based on predicted GGY appears to be the most effective way of achieving this.

We are aware paying in advance may be challenging for operators with a significantly smaller turnover, and that it would be impossible for new operators.

Therefore, we propose a solution whereby operators whose GGY falls under the proposed de minimis threshold of £500,000 are permitted to pay their levy contribution in arrears.

2e. Please provide any additional views or evidence in this area the government should consider here. (Free text box)

Consultation question 3

3a. Do you agree with the proposal that levy funding should be allocated across the categories of research, prevention and treatment? (Yes/No/I don't know)

3b. Please explain your answer. (Free text box)

We agree with the broad categories for allocation, however it is crucial that within the category of prevention, adequate funding is made available to support lived experience advocates who will continue to offer invaluable insight and learning to inform prevention programmes. This must include funding for mental health support for those who want to engage in the arena, as well as investigatory support for those harmed by the industry – most notably bereaved families – and peer support to enable the development of community and collective voices.

Lived experience groups and leadership, such as that provided by families involved with Gambling with Lives, have been fundamental to achieving the reforms outlined in the White Paper, and will continue to be fundamental to development of further prevention policies and initiatives in the gambling harm space. Lived experience groups must therefore be funded to continue to offer the unique insights that only lived experience can bring.

We believe that early in the levy's existence a proper assessment should be made of the spending required across each of the elements of RPT. It is important that any allocations should be dynamic and structured in a way that the aims to reduce gambling harm. The levy should not build an RPT sector which continues to expand because of inadequate resourcing of prevention activities.

However, we recognise that at present there is an enormous population of up to 1.6 million adults, only 0.5% of whom are receiving formal support, who require treatment to help them get into recovery from addiction and harm. The immediate focus must therefore be on supporting this population, whilst better regulating the gambling industry to stop further people from being added to it.

Given the rapidly evolving nature of the gambling harm space we recommend that the overall amount of the levy and the allocations are reassessed in 3 years' time rather than 5.

Q3.c. This consultation addresses potential spending on projects and services in England, Scotland and Wales. A fair allocation of levy funding will need to be made across all three nations.

Is there any evidence the government should consider as to how a fair allocation of levy funding might be implemented across all three nations of Great Britain, whether by reference to the Barnett formula or some other mechanism?

A reasonable alternative or additional lens to a population-based formula for allocating funding across the nations could be to take into account relative prevalence of gambling related harm. Although we have significant doubts about the reliability of official statistics on prevalence, we believe that there are sources (1) which probably provide an adequate estimate of the relative prevalence between areas which should not be ignored. Therefore a calculation based on population adjusted to account for relative prevalence rates could be used. However, if this presents a level of complexity that would delay the enactment of the levy in 2024, we think that a consideration of prevalence could be factored in after the first review point for the levy.

A further consideration is that some activities might be conducted on a GB wide basis, such as national public health information campaigns. We believe that should such projects be deemed desirable by the state public health departments of each nation, then each nation could re-pool their funds to commission them.

There should be no favour given to arguments that a non-statutory body should be used to commission cross border programmes of work, as any such arrangement would lack transparency and accountability and would disengage the respective governments from the issue of gambling related harm.

References
1. https://ocsi.uk/2023/07/05/gambleaware-gambling-harms-data-profiles/

Q3.d. Please provide any additional views or evidence in this area the government should consider here.

Northern Ireland (NI)has not been considered as part of the levy proposals because gambling is a devolved issue. Despite gambling being a devolved issue, there are certain aspects of gambling regulation which remain reserved and there is a strong argument that the levy should be applied to NI both in terms of collection of funds, at least as they apply to remote gambling, and to the distribution of funds for RPT.

The 1985 Order in NI, which governs gambling there, does not reference remote or online gambling, and no licences have been issued to remote online gambling operators to permit them to operate (1). The Gambling (Licensing and Advertising) Act 2014 partially addressed this gap, by making it an offense to advertise in NI without a GB licence (2).

As a result, remote gambling operators have to be licenced by the UK Gambling Commission to advertise in NI. It is valid to argue that if the Commission is licensing remote gambling activities in Northern Ireland, then it should include revenues generated from remote gambling in NI as part of its GGY calculations for the collection of the levy, and NI should be included in the levy's distribution.

In the absence of a mechanism for the collection of a statutory levy solely for NI, we think that this is the route that should be pursued. It is particularly important given that NI has the highest levels of gambling harms of the home nations (3), and currently does not have an executive that is able to address the harms because Stormont isn't sitting.

However, as with other technical elements of the statutory levy that we argue for in this submission, such as the future development of the levy on a more rigorous polluter pays principle, we would not want to see a consideration to include NI delay the start of the levy for GB. We say this because there is nervousness that a General Election, lobbying from the gambling industry, or both, could derail the levy if it is not enacted early in 2024.

References:
1. The Betting, Gaming, Lotteries and Amusements (Northern Ireland) Order 1985
2. Gambling (Licensing and Advertising) Act 2014, Section 5.

3. https://niopa.qub.ac.uk/bitstream/NIOPA/6356/1/2016-ni-gambling-prevalence-survey-main-report.pdf

Consultation question 4

4a. Do you agree with the proposed objectives? (Yes/No/I don't know)

4b. Please explain your answer. (Free text box)

The key strategic objective of the levy must be to reduce gambling harm and this should underpin all supplementary objectives. The way that the objectives are currently drafted seems as if there is a long-term plan for the levy to fund the response to continued harm caused by the gambling industry. It is a mistake to see the levy in this way as it would be used as an excuse by the industry to carry on its current business models, supported by a 'gambling harm' industry funded through the levy. In part this would perpetuate the problems with the current system with no adequate or measurable focus on reducing gambling harm.

Short and medium term objectives for the operation of the levy should include:

- The rapid assessment of what is required to reduce harm. The absence of this assessment on day one should not however be allowed to delay the implementation of the levy. An assessment must be developed alongside the commissioning of services and research that are known already to be required and that are currently being delivered from industry perspectives.
- The development of targets and a robust monitoring and evaluation framework that the levy board's effectiveness can be measured against.
- The rapid expansion of research, prevention and treatment programmes in line with population based public health policies.

There should be an explicit target that the levy should not be necessary in the long-run, and that the RPT activities it funds should inform central government policy to regulate gambling in order to minimise harm.

Finally, while we agree that the levy could be used to support the Gambling Commission's capacity to directly commission research to understand emerging issues, we believe that funding for development of capacity as described in the consultation should be through the Commission's existing fee income calculation. It is a core, and potentially financially substantial, activity of the Commission which should not be 'top-sliced' from the levy arrangement. The levy should not be used to 'cross subsidise' activities which should be rightly paid from fees paid by industry to regulate the industry.

We believe that there should be a reassessment of the Commission's objectives to enshrine that "gambling harm reduction" (as opposed to "permitting") is primary. Therefore, the Commission should be able to receive adequate funding to undertake work to amend and implement policy aimed at reducing gambling harms.

4c. Please provide any additional views or evidence in this area the government should consider here. (Free text box)

Consultation question 5

5a. Do you agree with the proposal that 10-20% of funding raised by the levy should be allocated for sustained, high-quality, independent research? (Yes/No/I don't know)

5b. Please explain your answer. (Free text box)

We agree with this aspect of the levy proposal – a quality, independent research base is key to future harm prevention.

It is only earlier this year that the Gambling Commission finally published its view of evidence gaps and research requirements (1). In itself this is woeful, but at last it highlighted the following fundamental gaps in the knowledge base which are essential to inform regulation to minimise hambling harms:

- early gambling experiences and gateway products
- the range and variability of gambling experiences
- gambling-related harms and vulnerability
- the impact of operator practices
- product characteristics and risk

The existence of these gaps is a direct result of industry funding for research, which has given us a plethora of research on 'individual vulnerability' and almost nothing on products or industry practices. This has had a direct impact on the government and regulator's ability and desire to enact gambling harm prevention legislation.

Further, it is clear that there is an urgent need for longitudinal studies to understand the development, progress and treatment of gambling disorder (2). These are lengthy and expensive undertakings, but are vital to our future understanding.

It is clear therefore that there is an urgent requirement for a substantial programme of research. Whilst we agree with the percentage allocation for research under the levy proposals we are concerned that it will only deliver £10 - £20 million per year for gambling research, which we feel will be inadequate to help fill the research gaps in the field, particularly in the early years.

References

1. https://www.gamblingcommission.gov.uk/about-us/print/evidence-gaps-and-priorities-2023-to-2026
2. https://assets.ctfassets.net/j16ev64qyf6l/5rJKX7DCyVsQZW1UuQe8B6/ce236c1db8486258cf462d9f856a6fb9/Longitudinal-Gambling-Scoping-Report_.pdf

5c. Do you agree with the proposal for levy funding to establish a bespoke Research Programme on Gambling led by UKRI? (Yes/No/I don't know)

5d. Please explain your answer. (Free text box)

We support the creation of a bespoke gambling research programme, similar to the alcohol programme. We agree that the development of the programme should be overseen by a publicly accountable body whose expertise is acknowledged and respected by key stakeholders and throughout the research community. UKRI fulfils these criteria.

However, we note that much of the gambling research which has not been funded by the gambling industry has been funded through the NIHR, partly because of the links with public health and the current relationships within the gambling research community. Therefore, we believe that UKRI should work with NIHR to share expertise in order to be able to develop the programme, initially focusing on filling existing research gaps.

We also believe that people with lived experience of gambling harms must be formally and meaningfully involved from the outset – as with all other areas of spend proposed in this consultation. Lived experience had been at the forefront of the call for gambling reform and is a key resource in identifying the gaps in evidence and the need for particular research.

A good example of how research can engage with and benefit from the leadership of lived experience is the Gambling Suicide Research Study being led by the University of Lincoln, which partners with Gambling with Lives, GamLEARN and GamFam and will involve the wider lived experience community. In this study lived experience participants have been recruited to be co-investigators, and adequate funds have been made available to support the broad engagement of lived experience throughout the study.

In 2018 Gambling with Lives had identified the huge gap in knowledge about both the scale of gambling suicide and also the mechanisms that drive the relationship between gambling and suicide. It was substantially through our efforts that the Gambling Commission eventually identified funding to commission research in this area. The project has demonstrated that lived experience must be involved in the earliest stages of identifying and developing a powerful research programme, and the conduct of the research is providing a new model of how lived experience should be engaged throughout.

5e. Is there any additional evidence in this area the government should consider? (Free text box)

Consultation question 6

6a. Do you agree that 15-30% of funding raised by the levy should be allocated for the described prevention activity? (Yes/No/ I don't know)

6b. Please explain your answer. (Free text box)

We believe that 30% of the levy's funding should be allocated to prevention.

Bereaved families provide evidence that the current system of prevention is inadequate both in provision of information on the harms associated with gambling and in enabling lessons to be learnt that enable regulation to prevent harm.

Public information, training for key professionals and schools education has been provided by organisations dependent on industry voluntary funding and has been affected by the culture determined by this dependency. The information is incomplete in that there is no information on the dangers of products or predatory commercial practices. This is akin to teaching about tobacco without providing information on the physical consequences of smoking.

At the inquest of Jack Ritchie in 2022, the coroner identified that the information available to the public and professionals was "woefully inadequate". Previously he had identified that there was confusion about both the responsibility for provision and the content of information to be provided. In particular, he identified a lack of training for GPs and other frontline health staff. The responses to the Prevention of Future Deaths reports that he issued showed that while there had been developments in the treatment available, in particular through the NHS, the system and content of education and information (which largely remained the responsibility of the industry funded charities) remained inadequate.

The introduction of the levy gives the opportunity for the whole area of prevention to be expanded and conducted with no influence from the industry. Therefore, we support the allocation of 30% of funds to prevention at the outset of the levy. The long-term strategic objective of the levy must be harm prevention, and to that end we think the percentage allocation for prevention should be reassessed in 3 years' time, not 5, to see if there is sufficient room within the treatment budget to reallocate more funding to prevention.

6c.

How should the commissioning system for prevention be organised under the statutory levy? (Free text box)

We disagree with the Government that there is no clear and obvious choice for the commissioner of prevention under the levy. We believe that prevention should be commissioned by the Government's public health agencies - the Office for Health Improvement and Disparities (OHID) for England, Public Health Scotland for Scotland, and Public Health Wales for Wales for the following reasons:

i. OHID was created by Government precisely to fulfil this type of role in England and it already has the structures in place for scrutiny and oversight of public funds and activities. The same is true of Public Health Wales and Public Health Scotland.

ii. The White Paper says that the statutory levy is being implemented to put the independence of the system beyond doubt. This will only be achieved by ensuring that decisions on funding and commissioning are taken via statutory bodies such as OHID, PH Scotland, and PH Wales.

iii. The consultation proposal that commissioners of treatment and research under the statutory levy have been indicated to be statutory bodies (The NHS and UKRI) is welcome. This must now be extended to commissioning prevention work to provide rigour and accountability to how significant public funds are spent.

iv. OHID, PH Scotland and PH Wales are the national experts in their respective nations on health harm prevention, leading policy on issues such as tobacco, alcohol, and gambling. OHID have an expert gambling harms team in place whose roles could be part funded and added to with additional team members using the Levy's prevention funds; they already manage the distribution of funds to local authorities and the third sector in other areas of public health and prevention; they have expertise in how to work with the emerging Integrated Care Boards; and they govern national risk awareness campaigns around other harmful commodity industries. OHID therefore has the wherewithal, expertise, and track record to fulfil the functions of the prevention commissioner under the statutory levy for England.

v. Furthermore, choosing OHID in England to commission prevention programmes will ensure the best possible chance that they are integrated with treatment programmes, which will be commissioned by the NHS, through a Provider Collaborative Model or ICBs and with local authorities, with whom they already work closely. This is also true of PH Scotland and Wales, which are both integrated with the NHS in those nations.

vi. Choosing OHID for England alongside PH Scotland, and PH Wales, would provide access to well established partnership working relationships for any prevention activities carried out across GB. The three public health agencies have daily contact and co-working, most recently for example on the Government's roll out of its groundbreaking tobacco policy.

Under no circumstance should the prevention commissioner be a third sector organization for the reasons below. Specific reference is made to GambleAware since they are the body which has overseen the development and conduct of the current 'information system' which was called "woefully inadequate" by the coroner at Jack Ritchie's inquest, and commissioned and funded 'education' which independent academics have found to align with industry interests and to stigmatise children (1).

i. The funds that will be distributed under the prevention stream of the levy are statutory funds, and it must be for a statutory body to provide oversight, transparency and accountability for how they are spent. For the levy board to delegate its statutory commissioning function to a charity would be inappropriate and would make an exception for prevention when both the treatment and research strands will be governed by statutory organisations.

ii. Experience from alcohol and tobacco indicates that the long term funding of charities by the harm-causing industry has an inevitable consequence of developing an organizational culture that fails to question the narrative promoted by the funder in which competing arguments are not sufficiently reviewed (2, 3), Any charity which has received industry funding over years should not be considered as a possible commissioner.

iii. GambleAware has governed the system of prevention under the voluntary levy arrangements and that system has not had the necessary accountability to deliver successful outcomes. The Levy Consultation accepts this saying 'It is also crucial that there is sufficient trust, independence and integration across the system. The current voluntary system is no longer fit for purpose.'

iv. GambleAware do not have a track record of overseeing how public money is spent, scrutinized and accounted for.

v. GambleAware's work on prevention aligned with industry interests – there is little mention of the impact of industry products and practices on the begambleaware website; the charity's stigma campaign fails to mention industry products and practices; its education materials have been found on academic analysis to align with industry interests and to problematize children; and GambleAware's newly produced training resources for health professionals make little mention of industry products and practices. This one-sided approach is inappropriate in preventing gambling harm at population level under the new statutory levy.

vi. Gamble Aware is perceived by academics, clinicians, public health leaders, and lived experience advocacy groups, to operate with a lack of independence from industry in its commissioning activities. In this light, giving GambleAware any decision-making role on a statutory levy board would fail to achieve two of the objectives of the statutory levy, which are to 'guarantee independence', and ensure 'there is sufficient trust…across the system'.

vii. GambleAware have the stated ambition "to be seen as the 'go to' organisation on gambling issues, by increasing our profile in national, consumer and health media" and to produce "public health campaigns on a national scale and provide practical support to local services and partners". This would put them in the role of bidding for statutory levy funding rather than holding a commissioning role.

During the consultation phase we have heard arguments that OHID should not become the commissioner for prevention because its gambling team lacks the

capacity. This is an argument that appears to promote the continuation of the current system on grounds of existing capacity, despite this consultation having described the current system as “not fit for purpose” . OHID has the expertise and the democratically accountable remit, and the required increase in its capacity will inevitably follow from an increase in independent funding through the levy.

During the consultation phase we have also heard an additional false argument that the devolved nature of health could prevent a unified approach to prevention and treatment provision across GB. We understand that there are strong examples of joint working across OHID, PH Scotland, and PH Wales, not least through the newly announced ambitious policies on tobacco control.

References:

1. https://www.repository.cam.ac.uk/items/be55bccc-4be5-44a5-8da4-bb1897249c8b
2. https://bmjopen.bmj.com/content/10/9/e035569
3. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00012-0/fulltext

6d. What are the priority projects, services and outcomes the government should consider in the prevention of gambling-related harm? (Free text box)

Gambling harm is caused by the sale of harmful gambling products. This harm is greatly exacerbated by the failure to inform the public about the harm to health that arises from engagement with these products. To prevent harm we need to make products safer, and reduce the amount of time and money that are spent on them. In this simple equation the most important outcomes that prevention programmes should target are:

1. That the most dangerous gambling products are made safer.
2. That the most dangerous gambling products are restricted from sale, particularly to young people, but they should be harder to access for those over 25 too.
3. That people who are sold the most harmful products use them less and are properly informed of the risks.

The strongest prevention programmes are therefore those that deliver stronger regulation of dangerous gambling products. We acknowledge that some limited action is planned in this regard by the Government’s White Paper. Accepting that the levy board will not have control of regulation, the activities of the prevention commissioners should fall into three buckets that support limiting the use of the most dangerous products:

1. **Management of a fund for local authorities and third sector organisations to apply to for funding for effective population level public health prevention programmes.** One of the core activities that must be supported is for local authorities to enforce local operator licences to reduce underage gambling in adult gambling centres and bookmakers. Local authorities should also be supported to find ways to reject licences for new gambling premises that offer machine gambling. The fund must include financial assistance for lived experience support and advocacy organisations so that they can continue to inform prevention practice at the national level.

2. **Direct commissioning of national universal harm prevention measures including risk awareness campaigns and the development of point-of-sale risk messaging to replace Take Time To Think.** Currently there is no national campaign that informs people of the differential risk of gambling on different product types, and the point-of-sale messaging has been shown to be wholly ineffective (1,2). The levy commissioner must quickly rectify this through commissioning public health information campaigns in the model of those that have worked for tobacco, which are focused on the danger presented by the product, not pushing the narrative of individual responsibility.

3. **Direct commissioning of national training and education programmes for children and young people, adults, health care and other professionals to be offered free at point of use across GB.** The education and training on the market in the UK is woefully inadequate in that it is almost entirely devoid of information on the differentiated product risk of gambling. This has been a result of the gambling industry having effectively commissioned the education and training programmes through the use of voluntary donations. The prevention strand of the levy offers the opportunity to rectify this rapidly. The commissioner should commission new or choose existing education and training programmes that provide complete information including on the source of harm and the differentiated risk of products. The commissioner should subsidise the delivery of programmes that meet high standards of quality and independence in this area for delivery across GB. In the case of schools education, we believe that it is important the DfE are engaged in the oversight and development of new programmes as part of the PSHE subject area.

Across the activities listed above there must be complete adherence to independence from the gambling industry. It is our suggestion that no organisation that has taken gambling industry donations on a voluntary basis in the past twelve months should be able to be involved in prevention activities commissioned by the levy board. This would provide a safeguard against conflicts of interest harming the quality of programmes, and it would safeguard the reputation of the statutory levy. Ideally a longer period of absence of industry donation should be applied. 12 months must be a minimum and should be possible for existing providers in the system given that the Gambling Commission provided £32.8 million of regulatory settlement funding to ‘stabilise’ the system during the transition period.

Finally, on the basis that the strongest opportunity for prevention is through tighter restrictions on the most harmful gambling products, the levy board must become a forum that government use to inform themselves of what is working and what further regulations are required to prevent harm. The board should not simply be convened to distribute funds and evaluate their use, it must also be a forum for those with the power and authority to prevent harm at the population level to improve their understanding.

References:

1. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00279-6/fulltext
2. https://www.cambridge.org/core/journals/behavioural-public-policy/article/evaluation-of-the-take-time-to-think-safer-gambling-message-a-randomised-online-experimental-study/9CFD881028DB7C1CFC0E83AD6AEBD67A

6e. What evidence is there, including from other health areas, that prevention is effective at reducing gambling harms? (Free text box)

There is abundant academic and real-world evidence that indicates prevention measures, such as health messaging campaigns that provide the full information about the link between harmful products, practices, and health, can reduce harm.

For example, an analysis of multiple health messaging campaigns concerning smoking found that such campaigns were associated with a drop of up to 25% in smoking rates (1).

In 2022, the Greater Manchester Combined Authority launched a prevention campaign called Odds Are: They Win, which highlighted gambling products and industry practices as the source of harm and moved away from the model of individual responsibility.

After seeing the campaign, a member of a local gambling harm lived experience group said:

"The fundamental message that I needed to hear at 16, 17 years old was that the gambling industry makes 14 billion a year. It doesn't do that by making lots of winners. Ninety-nine percent of the customers lose. The other 1% get their accounts restricted or closed. This is the industry you're up against." (2)

There is also a body of evidence that education programmes that are delivered from a public health approach to other harmful commodities are a cost-effective way to influence the health of young people. Gambling harm education could be equally as effective if lessons from drug, tobacco, and alcohol education programmes are applied.

Key lessons include:

I. Education needs to be independent from the influence of harmful industries.
II. The focus of education should be on the denormalisation of the product. Tobacco youth education campaigns that focused on revealing industry tactics, and engaging youth in critical dialogues about these products have contributed to an overall suite of initiatives that have significantly reduced smoking rates among adolescents (3).
III. The focus of education should be building skills rather than correcting knowledge. The World Health Organization (4) developed a handbook which provided support for schools to implement interventions to address risk factors for non-communicable diseases such as smoking tobacco and alcohol consumption.
IV. Education should be ongoing and should incorporate supportive environments. The World Health Organization's approach (4) emphasises the importance of creating supportive environments for students in addition to education programs. It suggests implementing:

- School policies to prohibit the use of tobacco and alcohol.

- Restricting tobacco and alcohol advertising on school property and in school publications, and
- Developing supportive social environments to support healthy behaviours.

However, we want to reiterate that the greatest opportunity for preventing gambling harm is in stronger regulation which affects the design and availability of the most dangerous gambling products on the market.

References:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6050159/
2. https://www.sciencedirect.com/science/article/pii/S0033350623002937
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447482/
4. https://www.who.int/publications/i/item/9789240080553

6f. Please provide any additional views or evidence in this area the government should consider here. (Free text box)

Consultation question 7

7a. Do you agree with this proposal that 40-60% of funding raised by the levy should be allocated for treatment? (Yes/No/I don't know)

7b. Please explain your answer. (Free text box)

In the short-medium term, effective evidence-based treatment for people experiencing gambling harm must be prioritised as there are 1.6 million people who would benefit from treatment. Currently only 0.5% receive any support and for those that do the outcomes from the existing industry funded non evidence based provision are not satisfactory – 30% do not complete treatment and 30% leave treatment still meeting the diagnostic threshold for severe disorder. (1)

We support the work of NICE in producing a treatment guideline that works towards ensuring that the standards of treatment of gambling disorder are raised to match the severity of the patient population currently requiring life saving treatment. Obviously this has enormous resource implications in training and upskilling the NHS and third sector workforce.

We further support the work from NICE which is currently engaged in a resource impact assessment of implementation of the coming guideline and we will engage with this consultation. In terms of capacity, it is essential that evidence based NHS commissioned treatment capacity should match at a minimum the provision for other addictions, which is at least 18 - 47% of those directly harmed (2).

Furthermore, the OHID estimates that there are 1.6 million adults in England who would benefit from receiving treatment or support for gambling harm are likely to be an underestimate because they are based on an extrapolation from out-of-date prevalence data from the Health Survey England. If figures were used from the Gambling Commission's emerging methodology for measuring prevalence, showing figures up to 8 times higher (3), the estimate of the number of people who need treatment would be several orders of magnitude higher.

Even at the low estimate of 1.6 million people, only 0.5% of them currently receive any support. This is a function of funding, but also the complete failure of the current industry funded treatment system to reach people and to integrate with the NHS.

It must be a priority for the Government to rectify this injustice. We don't believe that approximately £50m will be anywhere near enough funding, so we reiterate that the total funding pot should be increased by increasing the levels of contribution from gambling operators. However, the percentage allocation seems appropriate, as it is also essential that some funds are made available for prevention and research.

In addition to the numbers directly suffering from harm to mental health from gambling, there are millions of people affected by another's gambling who require support and treatment. Currently there is even less support for this client population most of whom are either suffering without support or currently engaging with existing publicly funded mental health and social support services. It is essential that resources required to support this population are estimated so that in the future the levy can provide funding for this support and prevent this hidden harm from being a drain on other services.

References

1. https://www.begambleaware.org/sites/default/files/2023-12/ENGLISH%20GA_Annual%20STATS%202022-23%20Report_FINAL.pdf
2. https://www.gov.uk/government/consultations/consultation-on-the-statutory-levy-on-gambling-operators/consultation-on-the-structure-distribution-and-governance-of-the-statutory-levy-on-gambling-operators
3. https://www.gamblingcommission.gov.uk/statistics-and-research/publication/gambling-participation-and-the-prevalence-of-problem-gambling-survey-final

7c. Do you agree that the NHS should have a major role in commissioning the treatment pathway to improve and expand treatment provision? (Yes/No/I don't know)

7d. Please explain your answer. (Free text box)

We agree strongly that the NHS should commission treatment. It is essential that treatment is democratically accountable, transparent and meets well developed standards of evidence and clinical governance. This can only be achieved by NHS commissioning of an evidence based treatment pathway that provides a system

overview to commission NHS and third sector providers and integrates services with existing mental health and social care provision. This is the remit of NHS commissioning services which is supported by existing NHS structures ensuring excellence and innovation and it cannot be replicated by a third sector commissioner. Arguments that the NHS will not commission third sector providers are not supported by ample evidence of existing NHS commissioning of third sector providers in multiple other health areas.

Currently, treatment provision is bifurcated between the NHS and third sector providers. The pathway is not integrated and patients with diagnosed high severity of gambling disorder are being inappropriately treated with non evidence based support by untrained clinicians despite the high suicide risk correlated with gambling disorder. Reform of this system is urgent and will save lives.

Gambling with Lives has heard and seen how the current system is failing those who need help. People experiencing gambling harms have told us they faced low awareness of gambling disorder in mainstream services. They felt expected to identify their condition and navigate the treatment system themselves, without key information and advice provided early on. The lack of referral into NHS services despite multiple low level support episodes has resulted in completed suicides.

Equally concerning only 0.5% of people who need treatment receive any support at all. The most recent report from the National Gambling Support Network (which no longer includes the NHS) shows that the system provided Tier3/4 treatment for just 6,645 people of whom just over 5,500 were gamblers (1). This is fewer than the system provided 5 years ago, despite GambleAware's stated ambition 4 years ago to treble the numbers in treatment. The vast majority were 'self-referrals', drop out from treatment remained at just under 30% and 30% of people leaving treatment are still scoring 8+ on the PGSI. It is clear that the current system has stagnated and is not fit for purpose.

Considering public accountability, access, expertise and quality standards, the NHS is the only body capable of successfully executing a major role in commissioning treatment from third sector providers. There must be no role for the current commissioner, GambleAware, not even an advisory role. The system needs a reset and breaking from the past is essential in restoring trust.

References

1. https://www.begambleaware.org/sites/default/files/2023-12/ENGLISH%20GA_Annual%20STATS%20Report_FINAL%20DESIGN.pdf

7e. Is there any additional evidence on the provision of treatment for gambling-related harm in England, Scotland and Wales the government should consider? (Free text box)

7f. Is there any additional evidence to support the establishment of an integrated system of treatment for gambling-related harm across Great Britain, particularly from other areas of health, the government should consider? (Free text box)

We are aware of an argument that the devolved nature of health could prevent a unified approach to prevention and treatment provision across GB. We do not believe this argument has merit as the NHS in England, Scotland, and Wales work closely with each other and share best practice. As with the commissioning of prevention, which we recommend operates through OHID, PH Scotland and PH Wales, the devolved nature of health should not stand in the way of ensuring an effective system of preventing and treating gambling related harm across GB. It should be for the NHS to decide what's appropriate in this area.

The fact that health is devolved should not be used as an argument that gambling harm treatment should be organised differently to other health related matters, and therefore needs its own commissioner. This would be an example of gambling exceptionalism and would defeat the purpose of instituting the statutory levy.

Consultation question 8

8a. Do you agree with the proposed role and remit of the Levy Board? (Yes/No/I don't know)

8b. Please explain your answer. (Free text box)

We agree with the proposed role and remit of the levy board however it needs to be added to in the following ways:

- It is clear that the key opportunity to prevent gambling harm is stronger regulation which is properly enforced. Therefore, the levy board must take responsibility for ensuring that the outputs and outcomes of levy expenditure are used by the Government and the Gambling Commission to inform new regulations on the gambling industry. If the levy board doesn't fulfil this role there is a risk that the levy expenditure fails to deliver value for money or to prevent harm. It cannot be allowed to happen that the levy becomes an excuse for the continued operation of the gambling industry in its current form.
- The levy board must also become the overt guardians of the independence of the system from the gambling industry and take responsibility for it. In line with statements in the White Paper, that the independence of the system must be put beyond doubt, the levy board will need to adopt as a foundational principle that the industry, or any body that they've funded or otherwise influenced in the past 12 months minimum, shall have no influence over any element of the new system.

The Levy Board must be made up of statutory bodies only as this is the only way to guarantee independence and a clean break from the current influence of the industry.

8c. Do you agree with the proposed role and remit of the Advisory Group? (Yes/No/I don't know)

8d. Please explain your answer. (Free text box)

We agree with the proposed role and remit of the advisory group. It is fundamental to the success of the levy that it is truly independent from the industry and is perceived as such. To that end it is essential that no industry influence is allowed onto the Advisory Group either directly or through organisations or individuals who are funded by or owe allegiance to industry interests.

Instead, the advisory group should be populated with representatives from the following groups:

- People with lived experience of gambling harm
- Academics who specialise on gambling and gambling harm
- Clinicians who lead treatment of gambling harm
- Public health leaders who specialise in commercial determinants of health

We propose that any organisations or individuals who have received direct funding from the gambling industry or its proxies in the past 5 years are not permitted to join the advisory group.

8e. Please provide any additional views or evidence in this area the government should consider here. (Free text box)

It is widely recognised that lived experience has been at the forefront of the call for reform and has provided real and significant input in both identifying key areas for reform and the range of solutions required.

The value of lived experience has been acknowledged by a wide range of statutory bodies including the Gambling Commission and the NHS, and many third sector organisations, all of whom have set up panels or directly employed people with lived experience. Further there are a number of charities which have been set up and are led by people with lived experience.

Indeed the decision to institute a statutory levy was called for by the Gambling Commission's Lived Experience Advisory Panel, which is a positive example of how lived experience can inform the operations of a statutory body.

In the operationalisation of the levy there must be real involvement for lived experience at key stages, including on the Advisory Board and in each of the commissioning bodies for Research, Prevention and Treatment.

The importance of this input must be recognised by all elements of the system established for determining and distributing the levy.

This involvement will need to be supported by resources to allow people with lived experience to come together, share their understanding and experiences, hear wider views and research, develop their knowledge and skills, and develop their ideas for change while maintaining their complete independence from any industry bodies or industry stakeholders.

This will require the grassroots development of structures which meet the needs of the wide range of people with lived experience. The development and establishment of such structures should be funded by the levy but must be allowed to remain independent of any individual organisation.

Consultation question 9

9a. Do you agree with our proposal for DCMS and HMT approval of levy spending to be supported by a Levy Board to provide broader government oversight of the allocation of levy funds? (Yes/No/I don't know)

9b. Please explain your answer. (Free text box)

We agree with the proposal to create a levy board that brings in broader statutory expertise to augment that of HMT and DCMS. It is important that the levy board in its entirety takes decisions regarding the levy, and that HMT and DCMS do not use their positions under the Act to overrule the levy board.

On the basis that the harms that the levy is designed to research, prevent and treat are health harms, it is important that the Department of Health and Social Care is given the leading role on the levy board. We suggest that DHSC should chair the board, and should be granted a casting vote.

We agree with the proposal that DSIT should also join the levy board, and the Gambling Commission's role should be limited to one of administrative collection and distribution of funds.

It is important that the Gambling Commission don't sit on the levy board themselves, not least due to the existence of an industry advisory panel that advises the leadership of the Commission, which could bring the independence of the levy structures into question. However, it is essential that the Gambling Commission is enabled to share in the learning that the levy board will develop during its operation.

9c. Is anything further the government needs to consider in putting in place robust accountability mechanisms into the levy system? (Free text box)

To deliver against the aim of putting the independence of the levy beyond doubt, the board and other committees of the levy should operate with high degrees of transparency. The minutes of meetings of the Levy Board and the basis for decisions must be made public and be available for scrutiny in a timely manner. Any approaches to any of the levy board participants about the operation of the levy by the industry should be declared.

Consultation question 10

10a. Do you agree with the proposal for a review of the levy every five years? (Yes/No/I don't know)

10b. Please explain your answer. (Free text box)

As noted, we believe that the £90-£100m target is substantially inadequate to meet the needs of the RPT system in the early years. While it might be considered the target for the very first year, a proper assessment of the scale of need should be undertaken quickly to establish a robust target for the future. Considering the scale and complexity of the levy, the first review must be in three years' time instead of five.

Following the completion of a thorough assessment of the scale and sources of harm plans for the levy to be allocated across the industry in a 'smart' way on a polluter pays principle should be developed and adopted.

The gambling industry is adept at reacting to new circumstances to create new revenue streams and we believe the industry's reaction to the measures in the white paper will result in new threats to public health which will need to be considered.

Furthermore, reviewing the levy after 3 years means that a review period will likely not come at the end of a parliamentary term, ensuring that it will receive the proper political attention it deserves.

Finally, it is essential in the early years of the levy that the levy board is not required to spend funds in the year in which they are collected. The system will take time to develop and expenditure is likely to be lumpy as it grows. The levy board should be enabled to make decisions on expenditure based on what will best deliver the long term objective of reducing gambling harm, and should be able to accrue funds if it needs them for strategic investments, or if time is required for the harm prevention system to develop.

Consultation question 11

11a. Please indicate if you believe any of the proposals in this consultation are likely to have a negative impact on persons who share such protected characteristics and, if so, please explain which group(s) of persons, what the impact on any such group might be and if you have any views. [Free text box]

11b. Please indicate if you believe any of the proposals in this consultation are likely to have positive effects on persons who share such protected characteristics and, if so, please explain which group(s) of persons, what the effect(s) on any such group might be and if you have any views. [Free text box]

There is a body of evidence that gambling exacerbates disadvantages that are felt by communities with protected characteristics, most notably those aged between 18 and 25. The levy should be seen as an opportunity to have a positive impact of people who share protected characteristics through reducing gambling harm.

Consultation question 12

12. Are there any other factors or points you wish to highlight that have not been considered above? [Free text box]

Consultation question 13

13. Please upload any further supporting evidence that you wish to share. [Upload attachments]

END