

Department of Culture, Media and Sport

Review of Gaming Machines and Social Responsibility

Response from **Quaker Action on Alcohol and Drugs (QAAD)**, sent by **Helena Chambers**

QAAD welcomes the opportunity to respond to this call for evidence from the DCMS. QAAD is a recognised body of the Religious Society of Friends (Quakers in Britain). While we do not represent the Society generally, our contribution is based on our Quaker principles and in our concern and experience with problem use and dependency across alcohol, other drugs, and gambling.

1.1. Executive Summary

1.1.1. We are aware that this is a lengthy response that incorporates a large amount of evidence, so we begin with this summary of our main points. Our submission argues, and presents evidence for: (a) no increase in any stakes, prizes or numbers/venues for any class of machine; (b) a reduction in stake for B2s to £2; (c) preparation for, and a monitoring of, outcomes of this change. All of these measures would support the Government's objective of protecting consumers and communities. They would also help to meet what we regard as a prime objective of policy, namely the prevention and minimisation of gambling-related harm. We also make some additional suggestions for future progress.

1.1.2. We cite national and international evidence that EGM gambling is one of the forms of gambling most associated with harm; that higher stake and prize sizes are an acknowledged factor in this; that high accessibility is another risk factor; and that the various harms disproportionately affect those suffering from other forms of disadvantage. Problem gamblers and their close others are particularly affected - but as is the case in the parallel field of alcohol, gambling-related harm extends much more widely. A paradigm of a small group of problematic individuals who may be helped but cannot be allowed to inconvenience the majority does not fit the case, therefore. We argue that there should be no increase in stakes, prizes or distribution/numbers for any class of machine, and that this is in the interest of communities as a whole.

1.1.3 The current £100 maximum stake for B2 machines is irresponsibly high. Internationally, stakes on machines in highly available locations tend to be much lower, and often closer to £2. In Australia and New Zealand - countries with similarities to ours that also liberalised their gambling laws – research was undertaken and stake size was recognised as a risk factor. Reductions in stakes to low levels in accessible locations have been introduced in both countries. We argue that the maximum stake sizes available on FOBTs in this country should be brought in line with these evidence-based standards. We note that on occasion a timed amount of notice has been given to the industry as regards intended changes, so that they have time to adapt their business model.

1.1.4. We provide evidence that challenges the assumption that non-problem gamblers would be unduly and adversely affected by this reduction. We address suggestions about possible perverse outcomes from a £2 stake, including displacement to the internet or B3s. We review the evidence and conclude that potential problems are lesser than the positive effects of the reduction. Given the high-risk nature of B2s, a £2 stake size is most likely to reduce the incidence of future problems, which we believe should be the prime consideration. We propose that the stake reduction be carefully researched to measure impacts and that information/advice is offered to customers alongside the change.

1.1.5. While we believe displacement for existing gamblers is outweighed by the benefits, public health gains could be undermined if B3s are further expanded in an attempt to make up for lost B2 revenue. We do not think this is an argument for failing to reduce the stake to £2, but for evolving a holistic public health approach to all EGMs. This would mean no expansion in stakes, prizes, or entitlements to numbers of B3s in any permitted premises. It would also mean research/evaluation of the mix of risk factors at work in B3s, in recognition of the fact that stake size interacts with other structural features. We point to relevant research that gives a basis for such evaluations. Trialling and adopting promising harm reduction measures (for example limiting how much money can be lost in a given time period, and methods of reducing the likelihood of winnings being incorporated in a pattern of intensive gambling) would also be part of this general approach. We hope this can be taken forward by the RGSB.

1.1.6. There is a strong evidence-base that proximity/accessibility/density are related to gambling harm. Recent evidence in the UK also attests that B2 harm is related to proximity. We do not know of another country that specifically prevents Local Authorities from refusing licences on the grounds that they judge they already have too many gambling premises. This flies in the face of the evidence-base on harm prevention, and it actively works against achieving health equality because EGMs and EGM-related

problems are concentrated most in disadvantaged communities. Local Authorities need significantly more powers; ultimately, a change to primary legislation is needed, but a useful first step would be a cumulative impact provision. The fact that numbers of EGMs are already high in certain (often disadvantaged) areas means that it is even more important not to increase the numbers of any machines allowed in permitted premises, or their stakes or prizes.

1.1.7. The two aims of this call for evidence – the protection of individuals and communities and industry growth – are ultimately incompatible. We do not find the growth of an inherently high risk commodity like EGMs a desirable or appropriate goal for public policy. Such an aim works against public health and health equality, including as regards ethnic minorities, who were more heavily represented among ‘loyalty card’ problem gamblers in recent research on B2s. Harms are experienced most sharply by the most vulnerable people/communities who have the least resources to mitigate them.

1.1.8. In general there has been an imbalance between the two policy aims, with the economic factor taking precedence over public health arguments in policy discussions and evidence evaluation. Most of the harms of EGMs generally and B2s specifically were predictable from existing evidence-base about high-risk machines in casually accessible locations, but these risks were not acted upon. In the current scenario, apart from the risks of B3s, that same imbalance may also be perpetuated by an optimism about social responsibility measures and behaviour analytics that is well in excess of what the evidence indicates they can achieve.

1.1.9. Behavioural analytics models have a relatively low predictive power in terms of identifying problem gamblers, and of course only pick up on harm that is already present. We very much welcome the new emphasis on social responsibility from all quarters, but do not think that it can in any way substitute for effective regulation of well-evidenced structural risk factors like numbers, accessibility and machine features, including stake size. Rather, regulation (which concerns harm prevention) - and secondary measures (which generally involve harm reduction), both need to be strong, and to work together in a common framework.

1.1.10. We suggest the development of a clear public health framework for gambling. We point to the fact that research has produced some tools that measure the harms of different forms of gambling, and what configuration of problems they present in a country. We propose that research of this nature – which is mainstream elsewhere but marginalised in the UK – be undertaken. The results could then inform policy about EGMs and other forms of high risk gambling, along with other considerations.

1.1.11. Higher risk forms of gambling like EGMs should be regulated with a greater reference to the precautionary principle in view of their greater potential for harm. Adopting this as a central principle for policy would avoid the development and entrenchment of problems like the damaging ones we have seen with B2s, give the industry clarity, and enable the development of a full and effective public health strategy. We hope that policy makers will be moved to consider the human costs if insufficient measures are taken to address these issues.

Q1. What, if any, changes in maximum stakes and/or prizes across the different categories of gaming machines support the Government's objective set out in this document? Please provide evidence to support this position.

1.1. The general evidence base on machines and machine stakes

1.1.1. There is a strong, consistent and widely accepted body of international evidence that Electronic Gaming Machines (EGMs) are the form of gambling most widely and closely associated with problem gambling and gambling harm.^{1,2,3,4} The risks of EGM play at higher stake sizes were highlighted in the body of academic opinion consulted at the time of the 2009 Gambling Commission review of machine gambling.⁵ The report stated: *'there was general agreement that the impact of higher stakes on increasing the financial costs per hour of playing a gaming machine was an important determinant of harm...'* Similarly, *'there was broad support among the panel that high-stake machines would be more appealing to problem gamblers, or that higher stake machines would be more likely to be associated with harm...'*

1.1.2. Several international studies show that those seeking help for problem gambling most commonly cite EGMs as problematic. In the UK, FOBTs were cited by 26% of callers to GamCare in 2014-15, while slot machines were cited by 20%.⁶ These figures strongly suggest that the general pattern of greater problems with EGMs also pertains in the UK. They provide a clear indicator of harm.

1.1.3. Recent evidence on B1 machines underline these concerns. The maximum stake size of B1 machines has been increased from £2 to £5. A research report on the impacts of this change states:⁷ *"a disproportionate amount of the increase in B1 revenue may have derived from the young, from those living in deprived areas, from heavy players and from those playing late at night. All this suggests that the relative share of industry revenue derived from groups where harm is most concentrated has increased following the uplift in maximum stakes and prizes."* Given that problem gambling is often concentrated in poorer/disadvantaged groups, any rise in any stake size is likely to have its greatest impact on those already subject to disadvantage. This is particularly undesirable in a climate of austerity.

1.1.4. There is somewhat less evidence available on the effect of prize size on problem gambling, but it is thought to play a role: for example, a recent naturalistic study found⁸ *'EGM jackpots were associated with great spend overall, and PGSI score was associated with a greater spend per play.'* Another research study among gamblers generally that looked at higher and roll-over jackpots found *'certain high-value jackpot configurations may have intensifying effects on player behavior.'*⁹ A raise in prizes would be likely

¹ Binde, P. (2011). What are the most harmful forms of problem gambling? Analyzing problem gambling prevalence surveys. CEFOS working paper 12.

² White, M.A., Mun, P., Kauffman, N., et al. (2006). Electronic Gaming Machines and problem gambling. Report prepared for the Saskatchewan Liquor and Gaming Authority by the Responsible Gambling Council.

³ Griffiths, M. (2008). Impact of high-stake, high-prize gaming machines on problem gambling. Overview of research findings. Desk exercise by the Gambling Commission.

⁴ Livingstone, C. & Woolley, R. (2008). The relevance and role of gaming machine games and game features on the play of problem gamblers. Report prepared for Independent Gambling Authority South Australia.

⁵ Parke, J. (2009). A medium to long-term programme of research for investigating gaming machines in Great Britain: Recommendations from international and British expert panels. Report prepared for the Gambling Commission.

⁶ GamCare Annual Statistics, 2014-15. (NB the 2016 statistics are broken down by sector, so it was not possible to obtain global figures by activity.)

⁷ Forrest, D., McHale, I. M., & Wardle, H. (2015). Evaluating the impact of the uplift in stakes and prizes on B1 gaming machines in casinos. Responsible Gambling Trust Machines Research Programme.

⁸ Browne, M., Langham, E., Rockloff, M.J. et al. EGM Jackpots and Player Behaviour: An In-venue Shadowing Study J Gambl Stud (2015) 31: 1695.

⁹ Li, E., Rockloff, M.J., Browne, M. et al. Jackpot Structural Features: Rollover Effect and Goal-Gradient Effect in EGM Gambling J Gambl Stud (2016) 32: 707

to increase engagement, and to increase high-intensity playing particularly. For this reason, we do not think it should occur.

1.1.5. The majority of this submission concentrates on B2s/FOBTs, but their particular risks should not overshadow those of other classes of machine, nor the fact that the general evidence-base we cite also relates to other slot machines. All EGMs are a high risk form of gambling. We think that no increase in any form of stake or prize should take place.

1.2. Evidence that supports a reduction in stake size for B2s

1.2.1. There is an international evidence base that higher levels of problems are associated with casually available EGM gambling. A recognition of this evidence underlay the machine classification set out in the Gambling Act of 2005, in which higher risk/stake/prize machines were limited to less available locations. B2s/FOBTs with their massively elevated stake have always been a glaring anomaly in this system. We argued for many years that in the absence of immediate action, research on problem gambling rates among B2 players and differential impacts on poorer communities should be conducted because it was obvious from theoretical and practical studies that this would be occurring. Now that some of this research has been undertaken, the evidence for stake reduction is really overwhelming. It includes:

1.2.2. Evidence of high levels of problem gambling among B2 players

1.2.2.1. Predictably, problems arose quickly after the introduction of B2s. The statistics on help-seekers to Gamcare who have problems with B2s has to be considered in relation to B2's low general use: Gambling Commission 2015 figures indicate 1% population-wide participation in the last four weeks (as distinct from 32% participation in the National Lottery, for example). This large disproportion between use and problem rates is a clear indicator of the harm that is associated specifically with FOBTs. Similarly, in two study samples from the National Problem Gambling Clinic, FOBTs featured among the most frequently cited forms of gambling amongst patients.^{10,11}

1.2.2.2. It has been argued that machine gamblers are often multiple gamblers, and that that frequent engagement/high involvement in gambling is the significant risk factor, rather than a particular type/form of gambling. However, this explanation is not supported in relation to specific evidence on B2s/FOBTs. When looking at this exact question, an analysis of the 2010 Prevalence Study found: *"For almost all games, the addition of the involvement variable rendered the significant positive association between gambling type and gambling-related problems non-significant. The exception was virtual gaming machines, which maintained a significant positive relationship to disordered gambling status after adjusting for involvement"*.¹²

1.2.2.3. Similarly, the research from the National Problem Gambling Clinic's sample found that problem gambling scores of FOBT gamblers were higher on the PGSI, indicating a greater severity of problems (Ronzitti et al, 2016). The study also looked at frequency of engagement in gambling, and found some associations similar to those in the Prevalence Study. The authors state *"although the involvement has shown to be an important predictor factor of gambling disorder, there are some forms of gambling that are more associated with a higher severity of gambling-related problems, namely, FOBT and gaming machines."*

¹⁰ Ronzitti, S., Soldini, E., Lutri, V., et al. (2016). Types of gambling and levels of harm: A UK study to assess severity of presentation in a treatment-seeking population. *Journal of Behavioral Addictions* 5(3):439–447.

¹¹ Michalczuk, R., Bowden-Jones, H., Verdejo-Garcia, A., & Clark, L. (2011). Impulsivity and cognitive distortions in pathological gamblers attending the UK National Problem Gambling Clinic: a preliminary report. *Psychological Medicine*; 41(12):2625-2635.

¹² LaPlante D.A., Nelson S.E., LaBrie R.A. & Shaffer H.J. (2011). Disordered gambling, type of gambling and gambling involvement in the British Gambling Prevalence Survey 2007. *The European Journal of Public Health*; 21(4):532-537.

1.2.2.4. Further evidence emerged from the 2014 tranche of research into category B2 machine gambling in bookmakers. These studies, conducted by the Responsible Gambling Trust/Gamble Aware, showed shockingly high levels of problem gambling amongst frequent users. Within a sample of loyalty card holders, only 29% were classified as non-problem gamblers; 23% were problem gamblers, 24% moderate risk gamblers, and 24% low risk gamblers.¹³ Whilst it is true that loyalty card holders tend to be more highly engaged gamblers, roughly 10% of bookmaker clients hold these cards. It is clearly unacceptable for 70% of these customers to continue to experience such high levels of harm. We regret, in this connection, that further research on problem rates among non-loyalty card holders in bookmakers was not carried out. The report stated that the broad sample was generally congruent with the loyalty card sample in many respects, so it is possible that the incidence of problems among FOBT gamblers may be even more widespread than the available data indicate.¹⁴

1.2.3. High stake size is a significant variable in losses and harm.

1.2.3.1. This tranche of studies also points towards the significance of stake size with regard to losses and gambling related harm:

- The use of high stake size was related to losses. 52% of those who lost the most money on machines had ever placed a maximum bet of £100, whereas only 9% of those who lost the least money reported this.¹⁵
- Although the research indicates there is not a clear or linear relationship between problem gambling behaviour and stake size, problem gambling is associated with the use of high stake sizes. For every unit increase in problem gambling score (PGSI), the odds of placing the maximum stake increased by 5%. Problem gambling scores were significantly associated with placing a £100 bet more often (true even when frequency of gambling participation was taken into account).¹³
- Those using the maximum stake tend to be more highly engaged in machine gambling than those who did not, and to have a higher average number of machine sessions per week.¹³ Frequency of gambling is a risk factor for disordered gambling.

1.2.4. Those in vulnerable socio-economic groups and communities are affected significantly and disproportionately by FOBTs and their high stakes, both as regards problem gambling and gambling related harm.

1.2.4.1. FOBTs are more heavily concentrated in areas where there are several forms of disadvantage. Research commissioned by the Responsible Gambling Trust (now Gamble Aware) demonstrated, *“Areas close to betting shops tend towards higher levels of crime events, and resident deprivation, unemployment, and ethnic diversity.”*¹⁶

1.2.4.2. The same pattern of disadvantage is reflected in a concentration of problem rates in these groups and communities. In the 2014 loyalty card sample, problem gambling rates were higher among those living in areas of deprivation and low income groups:

¹³ Wardle, H., Excell, D., Ireland, E., et al. (2014). Report 2: Identifying problem gambling – findings from a survey of loyalty card customers. Research commissioned for the Responsible Gambling Trust.

¹⁴ Report 3 of the original tranche of research (appendix c) indicated that there was a broad congruence between the loyalty card sample and the general sample, though it was not possible from the statistical information given to deduce the exact differences between the samples as regards the two factors that had a lesser fit - session length and money cashed in.

¹⁵ Wardle, H. (2016). People who play machines in bookmakers: secondary analysis of loyalty card survey data. Research commissioned for the Responsible Gambling Trust.

¹⁶ Astbury, G., & Thurstain-Goodwin, M. (2015). Contextualising machine gambling characteristics by location. A spatial investigation of machines in bookmakers using industry data. Report prepared by Geofutures for The Responsible Gambling Trust.

- Problem gambling was higher among those who were unemployed (39% for men; 27% for women) and those who were economically inactive because of long term sickness or disability (33% for men; 25% for women).¹³
- Unemployed people were as likely as other groups to use the £100 stake, and were more likely to use the £100 stake more often.¹⁵
- Problem gamblers had lower income levels than non-problem gamblers (31% had an income of less than £10,400 per year compared with 24% for non-problem gamblers).¹³ Given the high rates of loss for problem gamblers and the losses within the wider sample as a whole, this clearly represents significant harm in relation to income.
- The odds of being a problem gambler were significantly higher among those from non-White ethnic groups (report 2). This is extremely concerning in terms of health inequality.
- Earlier research from the last UK Gambling Prevalence Study suggests that roughly 26% of revenue from FOBTs is likely to come from people with some level of problem gambling.¹⁷

1.2.4.3. There is now an increasing recognition, which we welcome, that gambling-related problems extend far beyond those defined as problem gamblers. A similar phenomenon is found in the parallel field of alcohol policy – namely, that a large amount of harm is experienced by those who have transient or episodic issues. The £100 stake – and indeed any stake that is a significant proportion of income – is a risk factor for consumers of lesser means whether they have a sustained problem or not, because of the large amount that can be lost on a single bet. The majority of FOBT gamblers *are* people of lesser means.

1.2.5. Machine gambling amongst prisoners

1.2.5.1. Research conducted within prisons provides additional evidence that machine gambling harms vulnerable groups in society. We have heard from a Quaker who volunteers within a prison and became aware of gambling problems amongst the group. She undertook an informal random research survey of 134 male prisoners within one prison to assess the levels of gambling-related harm. The results showed high levels: 20% of surveyed prisoners used to gamble 5 or more days a week outside prison, and 16% thought their gambling was connected to their being in prison. The most common vehicle for habitual gamblers was machine gambling. In general, prisoners who gambled on EGMs would gamble until all available money (including winnings) were exhausted. These findings are in accord with earlier work (for example, May-Chahal, 2012¹⁸), which demonstrated combined risk and problem gambling rates of 27.8% for male and 18.1% for female prisoners (though this study did not focus only on machine gambling). While it is fully acknowledged that problematic gambling is a complex phenomenon in this group, a high stake is an obvious risk for a group with high levels of impulsivity. Although classes of EGM were not identified in the Quaker enquiry, the pattern of playing until winnings are exhausted is very consistent with the chaotic pattern described by the secondary research on B2 gamblers (ref 25).

1.3. International evidence and practice as regards high stakes

1.3.1. Other countries with cultural similarities to ours, notably Australia and New Zealand, relaxed their gambling laws a decade or more earlier than the UK. They then rapidly became concerned about the harms of machine gambling (that is, problem gambling plus gambling-related harm). In both jurisdictions extensive research was conducted on harm reduction, including reduction in stake size (for example, Sharpe et al, 2005¹⁹). Although the exact role has not been precisely delineated – largely because there are a variety of dynamic risk factors – it was accepted that higher stakes are one of the structural risk elements of EGMs, and stake sizes were limited.

¹⁷ Jim Orford, Heather Wardle & Mark Griffiths (2013) What proportion of gambling is problem gambling? Estimates from the 2010 British Gambling Prevalence Survey, *International Gambling Studies*, 13:1, 4-18,

¹⁸ May-Chahal, C, Wilson, A, Humphreys, L & Anderson, J 2012, 'Promoting an Evidence-Informed Approach to Addressing Problem Gambling in UK Prison Populations' *The Howard Journal of Criminal Justice*, vol 51, no. 4, pp. 372–386.

¹⁹ Sharpe, L., Walker, M., Coughlan M.J., et al. (2005) Structural changes to electronic gaming machines as effective harm minimization strategies for non-problem and problem gamblers. *Gambling Studies*; 21(4):503-520.

1.3.2. Stakes for non-casino machine gambling in New Zealand are limited to \$2.50 (£1.44 at present values, but possibly closer to our £2 when it was set); whilst in all but two Australian territories the maximum bet is \$10, even in casinos, with \$5 as a common limit in more readily accessible locations. The Australian Productivity Commission has argued that there are grounds for further reducing the maximum stake to \$1.

1.3.3. In broader international terms, there are very few jurisdictions where anything approaching the level of a £100 stake is in use in highly accessible gambling venues, and often stakes of this level are not even available in casinos.²⁰ Stakes in highly available locations more commonly tend to be roughly commensurate with the £2 level that the existing UK regulations allow for non-casino EGMs. FOBTs should be brought in line with these evidence-based standards.

1.4. Evidence for a £2 stake

1.4.1. The current B2 maximum stake of £100 is significantly and irresponsibly misaligned with the evidence base on high risk gambling, and there is now clear evidence of harm. Poorer communities and at risk individuals are most adversely affected by these high-risk machines. It is apparent that a reduction in stake size is needed: the question then becomes what level of reduction there should be.

1.4.2. The harm-reduction measures that limit the circumstances in which a £100 bet can be placed have had some impact, in that there is an overall reduction of spend of roughly 10%. The impact on problematic gambling is not known, but it is probably reasonable to assume there may have been some limited benefit. However, the measure was offset by the fact that bets under £50 increased, which underlines the need for stronger action.

1.4.3. We are aware that there is likely to be discussion about the size of stake reduction. We believe the decision should be made on the basis of public health, rather than some kind of bargaining on the basis of industry business models. The predictable problems of B2s would not have occurred if the evidence-base on EGM risks/harms had led decision-making, and much stress for the least advantaged groups could have been avoided or diminished. To correct this mistake now and adopt a £2 stake would be in line with international best practice. It would bring B2 machines into the framework of risk set out by the Gambling Act, with high-stake high-prize machines being limited to less accessible locations. The deleterious effects of the rise in the B1 stake for the most vulnerable gamblers are already apparent. It is clearly inconsistent and harmful for B2 machines to have a higher stake, given their greater accessibility.

1.4.4. In the more general gambling population, harm can occur even at low to moderate stakes²¹ and a recent research study suggests that harm can accrue on EGMs as spend increases even from low level. The authors conclude:²² *‘For total losses and electronic gaming machines, there is no evidence of a threshold below which increasing losses does not increase the risk of harm...’* A reduction in maximum stake size to £2, therefore, would be the safest option to limit gambling-related harm.

1.4.5. A £2 stake is the safest solution to the structural risks of a highly variable stake size

²⁰ Ziolkowsky, S. (2016). World Count of Gaming Machines 2015. Published by the Gaming Technologies Association.

²¹ Blaszczynski, A., Walker, M., & Sharpe, L. (2001). The assessment of the impact of the reconfiguration on electronic gaming machines as harm minimisation strategies for problem gambling. Report prepared by the University of Sydney Gambling Research Unit for The Gaming Industry Operators Group;

²² Markham, F, Young, M and Doran, B. (2015) The relationship between player losses and gambling related harm: evidence from nationally representative cross-sectional surveys in four countries (Addiction, 2015 doi:10.1111/add.13178

1.4.5.1. Several pieces of research have identified *variable* stake size as a significant risk factor in EGM problem gambling. Indeed, assessment tools/instruments have been developed by academics to assess the riskiness of EGMs, and variable stake size is one of the key dimensions used.^{23,24} The B2 machine fits this pattern of risk in that it contains a B3 content: from the point of view of the gambler it can effectively act as a single machine, as switching is easy. The result is a hybrid that combines the risk factor of high speed (2.5 seconds for the B3) with the risks of a very high stake. Once again, problems were predictable.

1.4.5.2. The 2014 Machines Research Programme concerning FOBTs found that variable staking was highly significant. Staking inconsistently over a wide range was found most frequently among problem gamblers – a pattern the study authors describe as chaotic.²⁵ *‘Problem gamblers tend to be more chaotic, that is using a higher number of distinct stake levels as well as levels that span larger ranges of values...’* These researchers incorporated a ‘range of stake sizes used’ measure as one of the factors in the algorithm to predict problem gambling. It is therefore clear that the high stake size of FOBTs, which gives rise to a very wide staking range, is a structural risk factor that is being translated into harm for gamblers.

1.4.5.3. Using this data as part of a tool that flags up problematic gambling *after it has become established* (by relying on an algorithm to pick up problematic gambling) is very far from being the best public health approach. It would be far more effective to reduce the range of the stake size directly, by cutting the maximum stake to a single, low level. This would act preventatively, by reducing the risk of this chaotic pattern of problem gambling developing in the first place.

1.4.6. The possibility of displacement to other forms of gambling is not sufficient to outweigh the benefits of a £2 stake

a) Internet gambling

1.4.6.1. In the past, the Gambling Commission has argued that reducing stake size for B2s may be of limited benefit, given the availability of high-risk high-stake gambling on the internet. In general terms we do not find this an adequate response: the difficulties of regulating risk in one environment is no reason for not doing so in another. This is particularly true given that internet gambling, while rising quickly, is still not extensive, and only part of the existing B2 demographic is likely to use it.

1.4.6.2. The displacement argument also does not take sufficient account of the fact that a reduction in stake size will be likely to have positive preventative effects for future land-based gamblers. It is important to note in this context that many problematic online gamblers have a pre-existing land-based gambling problem, which they take with them onto the inherently high risk platform of the internet.²⁶ The study of Wood and Williams (2011), for example, found that 23.8% of participants thought that slot machine gambling contributed most to their gambling problem.²⁷ This finding makes effective land-based regulation even more important, since it could indirectly help to reduce the incidence of internet gambling problems. Adopting measures to reduce the numbers of future problematic B2 gamblers,

²³ Meyer, G., Fiebig, M., Häfeli, J. & Mörsen, C. (2011). Development of an assessment tool to evaluate the risk potential of different gambling types, *International Gambling Studies*; 11(2):221-236.

²⁴ Griffiths, M.D., Wood, R.T.A. & Parke, J. (2008). GAM-GaRD: A new social responsibility tool. *National Council of Problem Gambling National News*; 11(3):7.

²⁵ Excell, D. & Grudzien, P. (2016). Featurespace Report: Secondary Analysis of Machines Data. Report prepared for the Responsible Gambling Trust.

²⁶ Gainsbury, S., Russell, A., Hing, N., et al. (2014). The prevalence and determinants of problem gambling in Australia: Assessing the impact of interactive gambling and new technologies. *Psychology of Addictive Behaviors*; 28(3):769-779.

²⁷ Wood, R.T. & Williams, R.J. (2011). A comparative profile of the Internet gambler: Demographic characteristics, game-play patterns, and problem gambling status. *New Media & Society*; 13(7):1123-1141

rather than adding to the current reservoir by failing to address land-based problems sufficiently, is surely the most responsible and evidence-based approach.

b) Other machine gambling, particularly B3s

1.4.6.3. It has also been suggested that a drastic reduction in stake size may result in a displacement to B3 gambling, with the increased riskiness of its faster machine speed. We note that B3s are the fastest growing machine sector and of course B3s are already in bookmakers. It cannot be denied that displacement might be a risk for some customers (perhaps the 'diverse aware' group of problem gamblers who are most likely to have problems with machines). However, we think this is not a case for keeping the stake above the safer £2 level, but rather a case for careful planning, research/monitoring of impacts during the transition period, and a holistic approach to the risks of displacement (see 1.4.6.4.) One of the chief reasons for our view is that the body of evidence cited above indicates a £2 stake would be most likely to reduce the numbers/level of problem gambling and of gambling-related harm occurring on B2s in the future. We think this is the salient consideration.

1.4.6.4. It is important, however, that a reduction in stake size for B2s should not act as a driver for developments in B3 machines that would increase their profitability, but also their risk. Some firms seem to be seeing B3s as a potential form of growth to offset a probable decrease in B2 revenue, and this pattern has already begun in terms of increases in Gross Gambling Yield. Research has identified several features as having a role in the risks of EGMs (for example, multi-stake lines, high event frequency, losses disguised as wins and autospins). Australian research has also suggested in relation to intensity of gambling that spend per hour may be a critical factor, and recommended that this be brought down to \$20. As indicated, there is already an evidence-base about the composite risks of machines and tools have been developed to gauge these risks (see refs 23/24). We hope that the structural risks of B3s could be referred urgently to the expert machine panel of the RGSB and the Gambling Commission so that a full assessment of B3s and their risks (current and potential) can take place, and action taken to limit the factors identified. Planning and full outcome monitoring of the reduction in B2 stake size in the research programme as a whole would obviously be essential, which would include an assessment of problems among B3 gamblers.

Impact on non-problem gamblers

1.4.6.5. It is sometimes argued (including in formal advice to government at the last review) that a reduction in stake would 'bear down hard' on non-problem gamblers. As far as we know, no evidence was cited in support of the assertion and we think it is somewhat over-stated. There is some evidence that non-problem gamblers may not be unduly affected by a reduction in stake. The 2005 study of Blaszczynski et al. found:²⁸ *"Overall, little effect on satisfaction or enjoyment was found for either social or problem gamblers in respect to concurrent modifications limiting maximum bet size and reducing high denomination bill acceptors."*

1.4.6.6. Recent research in Australia also indicates that non-problem gamblers find a low minimum bet size more attractive than a high maximum, while problem gamblers do not share this preference, or not to the same degree.²⁹ Another Australian study also showed non-problem gamblers were not negative about a range of harm-reduction measures.³⁰

1.4.6.7. As regards the specific picture in relation to FOBTs, a change in stake size would not be likely to bear down too hard on many gamblers. Of the 6.7 million bets studied in the original full research

²⁸ Blaszczynski, A., Sharpe, L., Walker, M. et al. (2005). Structural Characteristics of Electronic Gaming Machines and Satisfaction of Play Among Recreational and Problem Gamblers. *International Gambling Studies*, 5(2):187-198

²⁹ Rockloff, M., Thorne, H., Goodwin, B., et al. (2015). EGM environments that contribute to excess consumption and harm. Victorian Responsible Gambling Foundation, Melbourne.

³⁰ Jackson, A.C., Christensen, D.R., Francis, K.L., & Dowling, N.A. (2016). Consumer Perspectives on Gambling Harm Minimisation Measures in an Australian Jurisdiction. *Journal of Gambling Studies*; 32:801.

sample in the 2014 Machines Research Programme, half were placed on B3s or other categories of machine that do not involve a stake size of over £2. 70% of the total bets across all categories were staked at £2 or under, and it is only between the 80th and 90th centile that stake size exceeds £5. Median stake size was £1.³¹ The impact on many customers may not be as drastic as might appear from the size of the reduction.

1.4.6.8. In addition, the publicity about FOBTs has been quite considerable and social concern is high. In this context a drastic reduction in stake size would be likely to be understood, and may not be as unpopular with customers as feared. Importantly, it would also send out a public health message about the risks of high-spend gambling. We very much hope that this reduction will be made. We think it could be an excellent opportunity for harm reduction advice and information on help to be provided to customers generally, and particularly to customers who find the change difficult. Again, this should be monitored and evaluated by research.

Q2. To what extent have industry measures on gaming machines mitigated harm or improved player protections and mitigated harm to consumers and communities? Please provide evidence to support this position.

2.1. We welcome the initiatives that are being taken, though gather that the evidence so far is still fairly sparse. The evaluation of the Player Awareness System that is being trialled in certain bookmakers suggests that it is too early to be sure of any benefits from the system (*‘Very little data is available on the impact of different types of interactions and messages’*).³² The evaluation did not seem to give information about the exact nature of the messages being delivered, but it is to be hoped that they contain a mixture of self-appraisal and informative messages that reinforce autonomy, which seem to be the most promising style of interventions,³³ at least as regards dynamic messaging on-screen. It is apparent that a wide range of methodologies are in use and that there have been some difficulties in implementation. However, we do find the development of these initiatives a positive step.

2.2 We do think, however, that the limitations regarding what these methods can be expected to achieve must also be acknowledged. For example, in relation to pop-up messaging, one study found it helped, to some degree, roughly a quarter of gamblers surveyed.³⁴ However, another found less promising results as regards behaviour: only 1.39% of people ceased gambling, even when the optimal method (which contained normative information) was used.³⁵ This is not an isolated case in harm reduction generally: many interventions are more successful at assisting awareness than they are at altering behaviour.

2.3. Nevertheless, we certainly support them being tried, as the benefits may help some individuals considerably, and also individual harm-reduction measures need to be considered as part of a combination of measures that can be beneficial cumulatively. However, the variable impact on behaviour underlines the fact that harm minimisation methods are a complement to, not a substitute for, harm prevention at the primary level through effective regulation.

³¹ Wardle, H., Ireland, E., Sharman, S. et al. (2014). Patterns of play: analysis of data from machines in bookmakers. Research commissioned by the Responsible Gambling Trust.

³² Evaluation of the Player Awareness System Implementation (2016). Responsible Gambling Trust.

³³ Trial of dynamic warning messages on EGMs (2014). Australian Government Department of Social Services.

³⁴ Palmer du Preez, K., (2014). Investigation into the effects of gambling game characteristics, PIDs and pop-up technology on gambling and problem gambling behaviour. Gambling and Addictions Research Centre, Auckland University of Technology. Report prepared for the New Zealand Ministry of Health.

³⁵ Auer, M.M. & Griffiths, M.D. (2015). Testing normative and self-appraisal feedback in an online slot-machine pop-up in a real-world setting. *Frontiers in Psychology*; 6:339

2.4. In this context we note previous advice by the Gambling Commission that a move towards targeted measures like behaviour analytics will be more appropriate than the ‘blunt’ instrument of general regulations for machine gamblers.³⁶ We do hope that this is not their current position. General regulations – such as on machine stakes or machine numbers – are essentially about harm *prevention*, while measures such as behaviour analytics are essentially about *harm reduction/minimisation* – so, for example, if a person is flagged up as showing some sign of problem gambling, an action would be triggered (such as a pop up message or staff interaction). To try to substitute harm reduction for harm prevention would be a fundamental error, and an extremely damaging one in public health terms.

2.5. This would be the case if harm reduction measures were better developed and more successful than they actually are, but in the present state of knowledge it would be even more misguided. Behavioural analytics models have a relatively low predictive power in terms of identifying problem gamblers: the improved model in the most recent Featurespace report (Secondary Analysis of Machines data) only achieves a true positive rate of 61.9% at a false positive rate of 30%. This is far too little to rely on, particularly in view of the fact that, as has already been discussed, subsequent triggered actions, while definitely worth pursuing, are essentially post-hoc and have variable rates of effectiveness. Similarly, social responsibility measures have yet to be fully validated in the UK in terms of effectiveness – though again, it is extremely positive that they are moving into practice.

2.6. We do acknowledge that machine modifications (such as a recent trial in which various features were tried, including ‘banking’ winnings)³⁷ could potentially be very helpful and work more in the way of primary prevention. However, once again, we do not think these are developed enough to obviate the need for strong regulation.

Q3. What other factors should Government be considering to ensure the correct balance in gaming machine regulation? Please provide evidence to support this position.

3.1. There are several linked points we would like to make here. We believe the government should (i) accept the evidence on the harms of EGM gambling and investigate the profile of high risk forms of gambling in the UK; (ii) regulate high-risk forms of gambling, including EGMs, with a much greater reference to the precautionary principle;³⁸ (iii) accept that the growth of high-risk gambling – which hits disadvantaged groups hardest and effectively acts as a mechanism that transfers money away from poorer communities and individuals – is in no way a fitting or desirable goal for public policy; (iv) enable Local Authorities and other local mechanisms to address needs and problems in their own communities.

3.2. EGMs, harm and public policy

3.2.1. Over the years we have seen a reluctance at all levels of policy to address the problems of machine gambling squarely and specifically. We welcome the fact that a review is occurring now, but/and note that the crux of the issue is contained in this call for evidence – namely the wish to minimize gambling-related problems, but also to see the industry grow. In our view, the expansion of high-risk forms of gambling is simply not a desirable objective for public policy. It is inconsistent with a public health approach, with reducing health inequality - including as regards ethnic groups - and ultimately with the third objective of the Gambling Act.

³⁶ Strengthening social responsibility: Amendments to the social responsibility provisions in the license conditions and codes of practice (LCCP) for all operators. Gambling Commission report, 2015.

³⁷ Błaszczyński, A., Gainsbury, S. & Karlov, L. J *Gambl Stud* (2014) 30: 697.

³⁸ NB Gaming machines are not the only high-risk form of gambling, but we concentrate on it here because this is the nature of the current review.

3.2.2. Discussion, and policy/regulatory options relating to EGMs have often been headed off by the argument that problem gamblers typically gamble in many forms, so to single out one form can only ever be a partial approach. However, this does not give sufficient weight to the large body of evidence that specifically links EGMs with higher levels/more widespread harm. This evidence-base includes qualitative studies that indicate EGM gambling can tip existing gamblers into higher risk or problem gambling – for example Breen (2004);³⁹ Smoliak (1997).⁴⁰ As Binde summarises:¹ *“The common experience of treatment providers and researchers doing qualitative studies of problem gamblers (including the present author) is that on average they indeed participate in more forms of gambling than non-problem gamblers, but that in the majority of cases problems are caused mainly by the excessive engagement in one single form of gambling.”*

3.2.3. In our view, economic considerations have undermined a public health approach and the way the evidence base is construed. For example, several years ago, we pointed to the evidence that multiple gambling is a risk factor for problem gambling, and for this reason argued against combining different forms of gambling in the same premises (introducing machines into betting shops and bingo halls, and increasing their numbers, for example). This argument was well-founded in evidence, but the economic case for expansion/growth was acted upon instead. From a public health perspective it is sad to note that the same body of evidence that was not accepted as sufficient to take regulatory action on risk was later used to justify not taking regulatory action on harm.

3.2.4. The problem gambler/multiple gambler pattern also exists in other jurisdictions. This has not prevented these countries from teasing out the different elements involved, identifying EGMs as one of their most problematic forms of gambling, and adopting methods to address it specifically. The New Zealand government, for example, makes statements that give a clear underlying principle for their regulatory framework:

“...since gaming machines are considered the most harmful form of gambling (i.e. they pose the most reasonably significant and/or widespread harm when measured against other forms of gambling), precautionary approaches are more likely to focus on matters related to gaming machines.”⁴¹

3.2.5. Similarly, recent research from Australia shows that problem gamblers are often multiple gamblers – but it also used various measures to identify that EGMs, table games, horse racing and sports betting are associated with more harms.⁴²

3.2.6. These countries have worked from an evidence-base and used methods that take the multiple gambling pattern into account when they frame their policies. This research includes that of Binde and others,⁴³ who produced methodologies/indices that combine to make comparative assessments of the harms of specific forms of gambling at country level. One ingredient in this methodology involves collecting data from people who present for treatment about what their ‘primary form’ of problem gambling is. This gives one component that enables an evaluation of what forms of gambling are presenting most problems in a society. There has been considerable resistance to/delay about this data being collected in the UK. It does happen now (as of 2016), but at present we are not confident that it

³⁹ Breen, R.B. (2004). Rapid onset of pathological gambling in machine gamblers: A replication. *Community: International Journal of Mental Health & Addiction*; 2(1):44-49.

⁴⁰ Smoliak, A. R. (1997). Unplugged from the machine: VLT problem gambling treatment clients. Alberta Alcohol and Drug Abuse Commission.

⁴¹ New Zealand Department of Internal Affairs website: URL: https://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-Internal-Guidelines-for-Harm-Prevention-Harm-Minimisation-and-Responsible-Gambling?OpenDocument

⁴² Billi, R., Stone, C.A., Marden, P., & Yeung, K., (2014). The Victorian Gambling Study: A longitudinal study of gambling and health in Victoria, 2008–2012. The Victorian Responsible Gambling Foundation.

⁴³ see refs 1 and 22

will be used to inform policy in the way that happens in other jurisdictions - namely to evaluate harm and enhance policies that address higher risk forms of gambling.

3.2.6. We would like to see research conducted based on this kind of methodology to assess the harms of specific forms of gambling in the UK^{44, 45} - and for this to form part of policy discussions. We do understand that the relative weightings of gambling type and gambling engagement (plus a variety of other factors) make this a topic of debate in the literature, and we take Blaszczynski's point⁴⁶ about concentrating too exclusively on gambling type at the expense of gambling milieu/context/levels of engagement. However, the discussion about gambling type, and about EGMs in particular, has been far too marginalised in the UK. This type of evidence needs to be gathered and included in the policy discourse. We hope that this recalibration can take place.

3.2.7. The result of trying to reconcile public health with the wish to enable gambling growth has sometimes involved a lurch between competing pressures (for example an economic industry case versus the public campaign on FOBTs). A rational framework for assessing risk and harm, and the setting out of clear principles on which regulation is based is what is needed. Researched and identified forms of higher risk gambling could then be regulated in a clear framework. This would be a far safer and more rational approach, and one that would allow the industry some certainty as well as giving the public health agenda the primacy that it should have.

The need for increased local powers

3.2.9. This is all particularly important given the impacts of gambling related harm on less advantaged individuals and communities. Again, this pattern is a common phenomenon, and it is recognised in the literature that action needs to be taken if health inequalities are not to continue and be deepened. As the authors of a recent public health review point out: *"The underlying principle is to protect vulnerable and disadvantaged groups in society so that the detrimental aspects of gambling do not fall disproportionately on these sections of the population."*⁴⁷

3.2.10. A critical imbalance exists in current gambling regulation, in that Local Authorities are unable to deal effectively with the risks of gambling-related harm of their own communities. (We appreciate that Westminster has done the best possible job within existing terms, but 93 Local Authorities, including those in the poorest areas, have made it clear that their powers are insufficient). Local Authorities need to be empowered to deal with number and location of EGMs in general and FOBTs in particular, in the same way as they have been empowered to deal with numbers of alcohol licensed premises. At present, Local Authorities are specifically disempowered from refusing a licence on the grounds that they already have a high concentration of premises/machines. This is exactly one of the powers that is needed, given that recent research shows: *"Problem gambling and moderate risk prevalence rates were higher among those who lived in LBO (Licensed Booking Office) concentration areas."*⁴⁸

⁴⁴ We acknowledge within this point that it is possible that fuller investigation among UK gamblers may find other forms of gambling are more problematic than EGMs, as the study of Welte et al (2009)³⁹ did among young US gamblers between the ages of 14 and 20 (again, multiple gambling was controlled for). However, the important point is that the investigation takes place.

⁴⁵ Welte, J. W., Barnes, G. M., Tidwell, M.-C. O., & Hoffman, J. H. (2009). The Association of Form of Gambling with Problem Gambling Among American Youth. *Psychology of Addictive Behaviors : Journal of the Society of Psychologists in Addictive Behaviors*; 23(1):105–112.

⁴⁶ Blaszczynski, A. (2013). A critical examination of the link between gaming machines and gambling-related harm. *The Journal of Gambling Business and Economics*; 7(3):55-76

⁴⁷ Rodgers, B., Suomi, A., Davidson, T., Lucas, N., & Taylor-Rodgers, E. (2015). Preventive Interventions for problem gambling: a public health perspective. Report funded by the Australian Capital Territory Gambling and Racing Commission through the Problem Gambling Assistance Fund.

⁴⁸ Astbury, G., & Wardle, H. (2016). secondary Analysis of Machines Data: Examining the effect of proximity and concentration of B2 machines to gambling play. Report commissioned by the Responsible Gambling Trust.

3.2.11. The specific siting of premises is also an issue: at present, if a gambling business can show social responsibility measures, it is likely to be granted a licence – but it may be the location itself that is inappropriate in terms of accessibility. Research from other jurisdictions has found this to be important – for example a study related to EGM proximity in Australia, from which the authors concluded: *“Spatial accessibility of EGMs is an important determinant of gambling risk and should be explicitly considered by regulators.”*⁴⁹

3.2.12. Existing mechanisms in the UK do not enable this to happen in many cases. The populations of the poorest local authorities are often the most affected, and they are also the least able to risk costly legal challenges that the gambling industry can fund with very little difficulty. As regards solutions, we would prefer to see the ‘aim to permit’ term of the Gambling Act amended, because it severely limits the effective powers of Local Authorities. If this is not to occur, a cumulative impact provision would at least be a helpful beginning.

Q4. What, if any, changes in the number and location of current gaming machine allocations support the Government’s objective set out in this document? Please provide evidence to support this position.

4.1. The evidence so far cited is all relevant to our submission that as a higher-risk form of gambling, any upward expansion in any numbers or locations is undesirable, and would work against the prevention and reduction of harm. We note that one of the higher categories of problems in bingo halls relates to combined bingo and slot machine players. We regret that no single analysis of slot machine players was produced within this research, but the existing levels certainly suggest no increase should take place.

4.2. There is a strong case for the existing numbers/dispersal of B2 machines to be limited, given that proximity to these gambling venues is associated with heavier use. Another welcome approach would be to limit further the number of machines that are allowed in each premises.

Q5. What has been the impact of social responsibility measures since 2013, especially on vulnerable consumers and communities with high levels of deprivation?

5.1. Practice and research is in an early phase, and we accept this. Self-exclusion has a promising evidence-base, so we look forward to much more progress in this area.

5.2. We can see that account-based gambling has its benefits in terms of increasing the ability to flag up risky or problematic patterns. However, we also think there is a balance to be struck, in that account-based gambling would not be so desirable if it weren’t considered a necessary measure to address high-risk forms of gambling. It is interesting to note that relatively few B2 players signed up for account-based gambling as a way of making £100 bets, and many chose instead to gamble at limits below £50. This implies that account-based gambling is not necessarily popular: whether people would prefer more account-based gambling of a high risk nature, or whether they would prefer universal measures to reduce risk is an open question.

5.3. We take the points Forrester makes about tracking of B1 machine gambling in casinos, and the fact that account could help with pre-commitment⁵⁰, which does seem promising. However, we are also

⁴⁹ Young, M., Markham, F., & Doran, B. (2012). Too close to home? The relationships between residential distance to venue and gambling outcomes. *Journal of International Gambling Studies*; 12(2):257-273

aware that account-based gambling could also increase the opportunity for marketing and perhaps encouraging engagement in customers. We hope this dimension could be considered in planning/research.

5.3. We agree that the Gambling Commission's initiative that requires risk plans and assessments for gambling premises is a positive development, though we are not yet aware of outcomes.

Q6. Is there anything further that should be considered to improve social responsibility measures across the industry? Please provide evidence to support this position.

We welcome the progress that is being made in this area and the RGSB/Gambling Commission approach that is encouraging innovations in social responsibility. We agree that independent evaluations are very important in this regard.

We note that in other jurisdictions there has been more research that practically trials harm minimisation modifications to machines (including as regards stake size) and assesses how both problem gamblers and non-problem gamblers relate to them. The trials addressed important questions such as whether note acceptors and/or debit cards might increase gambling-related problems, or whether it would reduce gambling-related harm if winnings had to be taken within a limited space of time. We would like to see more of this kind of research on the structural elements of machines conducted here.

In Australia and New Zealand there are regular (we believe annual) reviews of the standards for EGMs, which are produced jointly between the two countries. We would suggest that the GC and the RGSB consider these (if they do not do so already) to see if there are any harm minimisation standards that could be useful here.

Q7. Is there any evidence on whether existing rules on gambling advertising are appropriate to protect children and vulnerable people from the possible harmful impact of gambling advertising?

7.1. Possible harmful effects of gambling advertising include effects on gambling prevalence or gambling harm amongst young people or vulnerable adults (problem gamblers or those in low-income groups). Whilst there is relatively little published work into the impact of gambling advertising on gambling prevalence, there is a great deal of evidence on the effect of alcohol and tobacco advertising on consumption, and it is likely that these effects are to some extent generalisable to other legal behaviours such as gambling. Almost all the published studies find an association between estimated advertising exposure and subsequent alcohol use – especially in relation to use from a younger age which increases the risk for developing problems. A systematic review of alcohol advertising and drinking behaviour in young people (Smith and Foxcroft 2009) demonstrated a relationship between exposure to advertising and the amount of alcohol consumed at follow-up.⁵¹

7.2. The potential harmful effects of gambling advertising upon young people is in part mitigated by the 9pm advertising watershed. There is evidence to support this - a recent paper examining the impact of gambling advertising on children and adolescents concluded that "gambling advertisements should not be permitted to be shown during television and radio timeslots primarily accessed by children or adolescents".⁵² Our concern is the exception to the 9pm watershed for bingo and sports betting around

⁵⁰ Forrest, D. McHale, I. (2016) Tracked play on B1 gaming machines in British casinos The Responsible Gambling Trust

⁵¹ Smith L.A. & Foxcroft D.R. (2009). The effect of alcohol advertising, marketing and portrayal of drinking behaviour in young people: a systematic review of prospective cohort studies. BMC Public Health; 9:51.

⁵² Monaghan S., Derevensky J., & Sklar A. (2008). Impact of gambling advertisements and marketing on children and adolescents: Policy recommendations to minimise harm. Journal of Gambling Issues; 22:252-274.

televised sports events. This significantly undermines the effect of the watershed, particularly since sports betting is advertised so heavily. It has the effect of 'normalising' gambling for children and makes a solid connection between sports and betting; this may pose a particular risk for boys, who are more likely to watch sports events and have a greater likelihood than girls of developing gambling problems. These major exceptions to the watershed work against the significant evidence base concerning the effects of alcohol advertising on young people. More generally, they give a message to children that many parents may feel uncomfortable with, even if they have no objection to adult gambling.

7.3. Televised gambling advertising around sports events can also have a significant effect upon problem gamblers. Problem gamblers are particularly susceptible to the impact of advertising – a review of gambling advertising, marketing and behaviour in New Zealand found that problem gamblers reported seeing advertising more frequently than non-problem gamblers – i.e. they are 'primed' to be aware of advertising of the particular form of gambling that they participate in. Problem gamblers were also found to be more vulnerable to the influence of this advertising. Concerningly, the review also found that being of a lower financial situation was also a consistent predictor of the effects of some forms of advertising. This suggests that advertising will have a greater impact upon vulnerable adults, and in this way work against the intentions of the Gambling Act.

7.4. An Australian study specifically concerning the impact of betting promotions during televised sports events found that more frequent exposure was a predictor of greater intended frequency of sports betting, and that problem gamblers are the audience most likely to be stimulated by these promotions.⁵³ Similarly, a recent study concluded that *“rather than inciting non-gamblers to begin gambling, advertisements appear to serve the function of maintaining established gambling habits and were particularly problematic to youth with gambling problems”*.⁵⁴

7.5. Sports betting, and betting 'in-play' has obvious structural risk factors in that it lends itself to impulsive gambling, multiple bets are possible, and there are few natural breaks. We do not know of any evidence on this, but it is concerning that children may normalise higher-risk gambling like this, either by seeing it directly or by seeing it advertised.

7.6. Taken together, all this evidence suggests that gambling advertising during televised sports events could potentially have a significant harmful impact upon young people, problem gamblers and other vulnerable adults. Given the vulnerability of children and the potential long-term consequences, we think there is a very strong argument for applying the precautionary principle. We think the exception to the 9pm watershed should not continue. We welcome the Gambling Commission's interest in the impact of gambling-like activities on the internet and its potential influence on children.

Q8. Any other relevant issues, supported by evidence that you would like to raise as part of this review but that has not been covered by questions 1-7?

We have presented our response in terms of the relevant evidence but write also from our human concern for those who suffer from dependency themselves, or who are affected by that of another. We also write from our concern as Quakers with equality; there is abundant evidence that problem gambling and gambling-related harms are experienced more in disadvantaged communities and ethnic groups. We believe that public policy should address, and try to change, this pattern of inequality. We welcome the fact that there seems to be increased interest from the Department of Health and hope that this will be built on significantly.

⁵³ Hing, N., Lamont, M., Vitartas, P., & Fink, E. (2015). Sports-embedded gambling promotions: A study of exposure, sports betting intention and problem gambling amongst adults. *International Journal of Mental Health and Addiction*; 13(1):115-135.

⁵⁴ Derevensky J., Sklar A., Gupta R., & Messerlian C. (2010). An empirical study examining the impact of gambling advertisements on adolescent gambling attitudes and behaviors. *International Journal of Mental Health and Addiction*; 8:21-34.

