GAMBLING ACT REVIEW: CALL FOR EVIDENCE

Gordon Moody Response 2021

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Supported by

Introduction

The Gordon Moody Association is a registered charity with 50 years' experience in treating those most severely affected by gambling disorder. Our key purpose is to provide high quality, innovative therapeutic support to people with gambling disorder[1] and to raise awareness of the issues of gambling related harm. Our residential treatment centres, located in London and in the Midlands, provide the only residential care in the UK which is specifically designed for people with gambling disorder.

We support those most affected by their gambling disorder, those who have nowhere else to turn, those who have failed or been failed by other services available. Seventy percent of those we see have at some point contemplated suicide, many also have deep mental health issues, along with alcohol and drug related issues. We see those who really are on the brink of having nothing else to live for in their lives.

We support the Government's aim that "all those who choose to gamble in Great Britain to be able to do so in a safe way" and objectives to protect vulnerable people and to prevent gambling related crime.

However, as we argue in this document, these objectives cannot be met through regulation alone. In order to prevent the most serious gambling related harms, the government must put in place a strategy of targeted treatment and research, aimed at reducing harm to those most profoundly affected by gambling disorder and their loved ones.

Services

Gordon Moody's specialism lies in providing an intensive residential treatment programme for people with the most severe forms of gambling addiction. We also provide relapse prevention housing, to ensure our service users have the support they need to rebuild their lives following treatment.

Where full residential treatment is not appropriate, or it is impractical, we offer a retreat and counselling programme. This combines a short-stay residential course with at-home counselling support and is available separately to both male and female gamblers.

In addition to these core services, all of our service users have access to outreach support, post treatment, so that they can maintain their recovery.

We also provide an online support service, *Gambling Therapy*, which has an international brief - providing advice and signposting, through 1:1 and group sessions, and a unique support App provided in a range of languages.

This year, Gordon Moody will open the first residential treatment centre for women with gambling disorder in the UK. The centre will provide treatment for over 100 women per year severely affected by pathological gambling, both directly through their own gambling and as

[1] **ICD-11** DEFINITION
continuation or escalation of **gambling** despite the occurrence of negative consequences. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

an affected other as the partners of people with pathological gambling. This is provision that is much needed and currently unavailable.

Expertise

Gordon Moody specialises in providing treatment for those most profoundly affected by problem gambling. Up to 80% of the applications that we receive are from people who have already tried other treatment options – having gambled for, on average, 15 years.
Typically, our service users enter treatment at a point where addiction has come to dominate their lives. Many will have faced family breakdown, and damage to personal relationships due to their gambling. Issues of financial hardship and problem debt are also common, and many of our service users have reported difficulty in meeting their basic financial needs due to their gambling.

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The below table, comparing data for the cross-sectional prevalence of mental health and social comorbidity in callers to the National Gambling Helpline with Gordon Moody service users, gives an indication of the severity of the relative severity of the cases that we treat.

	NGH	Gordon Moody
Mental Health diagnosis	24%	59%
Suicidality	11%	70%
Alcohol use disorder	5%	14%
Drug use disorder	3%	15%
Involvement in criminal justice system	3%	25%

In order to meet the complexity of our service users' needs, we follow a mixed model of care.

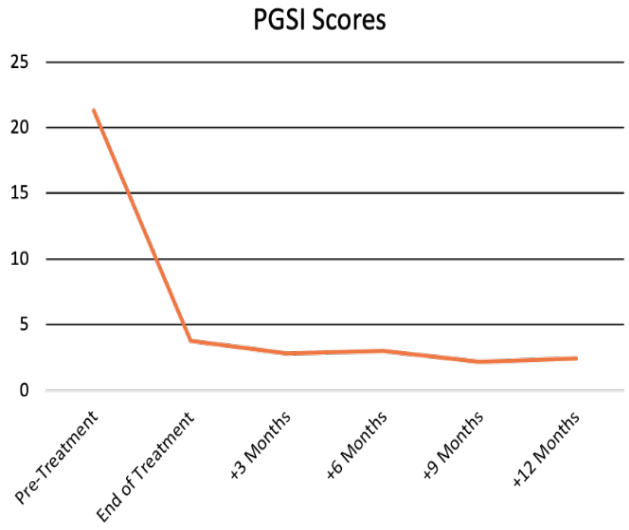
Our programme managers and front-line staff come from a wide range of professional backgrounds. These include therapeutic specialisms in clinical psychology, psychotherapy, counselling and addiction. Our peer support design enables those with lived experience to support those who are in the early stages of their treatment, especially in helping them transition into their new lives following addictions counselling and recovery support.

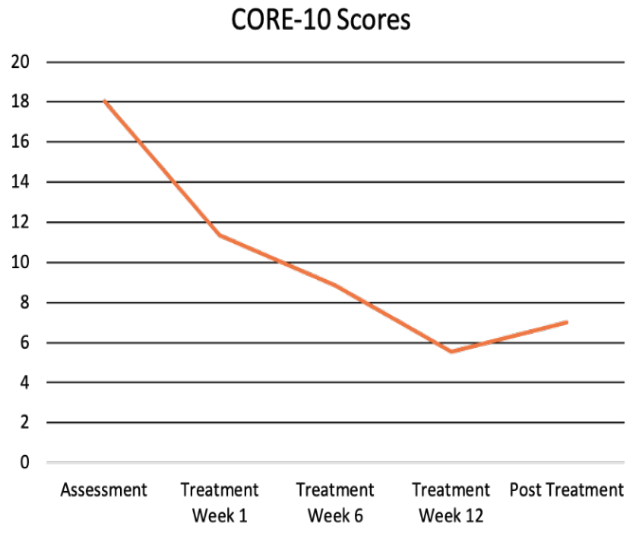
Impact

Gordon Moody has a track record in providing effective therapy, which helps our service users to transform their lives. 74% of our service users complete their treatment and 60% of our clients achieve freedom from gambling disorder for at least twenty-four months after completing their residential treatment course or retreat and counselling programme.
We work with our service users to build a sustained recovery – taking a holistic approach which addresses the client's mental health and wellbeing, relationships with others and broader set of life skills.

In line with the methodology used across the National Gambling Service, we measure the severity of disordered gambling using PGSI and Core-10 indicators. Whilst our service users typically enter treatment with higher scores, on both indicators, than is average for the NGTS, the also make the biggest improvements. The average improvement of PGSI score between the beginning and end of treatment in 2019/20 was 20 points and the average improvement of CORE-10 score was 13. This compares to NGTS scores of 12 for PGSI and 8 for CORE-10.

Graphical representation of those with gambling disorders treated by Gordon Moody, showing drop in PGSI and CORE-10 over time in treatment and recovery





The Gambling Review & Call for Evidence

Gordon Moody welcomes the Government's Review of Gambling Act 2005. Much has changed in the time since the last review, and the protections and supports for disordered gamblers stand in need of urgent update.

In what follows, Gordon Moody has provided responses only where we hold relevant data and/or have appropriate clinical expertise.

Unless otherwise stated, our evidence is primarily based on the needs of those most profoundly affected by disordered gambling – our service users, and the broader group of disordered gamblers who would benefit from our services.

This group represents a sub-category of disordered gambler that is at greatest risk of gambling related harm, and in turn poses the greatest risk to affected others. As we argue below, whilst progress has been made in terms of online and land-based gambling protections – this group stands in need of a more targeted support strategy.

Scope of the Review

We appreciate that the scope of the review is limited to the Gambling Act and is focused on matters within the remit of the Department for Digital, Culture, Media, & Sport. However, within this remit, we would argue that there is room for a broader discussion on the prevention of gambling related harm than is implied by the questions contained within the call for evidence.

As we have set out below, there are limits to the extent to which gambling related harms can be regulated out of the gambling industry through measures such as product design and account controls. For those most profoundly affected by disordered gambling, harm reduction will ultimately require treatment.

To this end, we need to better understand, and remove, the barriers to treatment.
We would argue that it is a matter of urgency that the gambling industry, treatment providers and government and related agencies work together to develop a strategy to prevent harm to people with severe gambling disorder. In particular there needs to be urgent collaboration to devise a more coherent, adequately resourced and effective referral and commissioning process to ensure the most vulnerable do not slip through the treatment net.

It is those who slip through the 'treatment' net that are most often used as the cases to argue that gambling companies and intervention mechanisms are failing the person with gambling disorder.

Online protections - players and products

Q1: What evidence is there on the effectiveness of the existing online protections in preventing gambling harm?

As set out in the introduction, Gordon Moody specialises in treating those with severe gambling disorder, often with considerable comorbidity. By definition, therefore, the protections currently used by online operators have not been effective in preventing harm to this group.

However, whilst we recognise that online protections, such as “time outs” and “self-exclusion”, play an important role in reducing gambling harm amongst the general population, and that improvements in this area may reduce harm further still, these protections alone are unlikely to prevent harm to those most severely addicted to gambling.

For our service users, the compulsion to return to gambling (even at times when such has proven to cause harm to the individual) is per definition no longer a behaviour over which the individual exerts control. Existing measures in place by operators are frequently reported by our service users to not only fail them, but to undermine the ‘power’ of their addiction.

Gambling disorder is a severe mental health disorder, which has complex psychological roots. Whilst it may be triggered or accelerated by the environment of online gambling websites, for those most severely affected, treatment will usually be required.

The key to minimising and preventing harm to gamblers within this group, therefore, is to ensure that they receive treatment at the earliest possible stage. This not only provides a much stronger and more tailored protection against each individual’s specific gambling patterns but will also enable the gambler to identify and address any underlying mental health conditions, impairments to emotional coping and other issues that will otherwise continue to fuel further gambling, often irrespective of protective barriers offered by the operators. Seeking treatment presents its own challenges, which we discuss further below, insofar as many disordered gamblers may be ambivalent about entering treatment because of the powerful motivational pull of their addiction.

Nevertheless, it is important to recognise that treatment will always be one of the most important elements in any strategy to prevent gambling related harm.

Q3: What evidence is there for or against the imposition of greater controls on online gambling accounts, including but not limited to deposit, loss, and spend limits?

For lower risk gamblers, a break in play triggered by account controls, may prevent harm. However, higher risk gamblers may simply move on to another licenced site, or to a black-market site.

Many of our service users would testify that, prior to entering treatment, they held multiple accounts and would simply move on to another operator if challenged on their play. People

with gambling disorder, similar to those suffering from drug or alcohol addiction, are by definition highly preoccupied by gambling and will often go to extraordinary lengths to continue gambling.

Q7: What evidence is there from behavioural science or other fields that the protections which operators must already offer, such as player-set spend limits, could be made more effective in preventing harm?

This falls somewhat outside of Gordon Moody's area of expertise. Such protections are likely to be of benefit to the general population rather than the severely addicted population that we serve. However, we can see certain clear benefits to further research in this area.

As in any area of addiction, it is important for disordered gamblers to recognise that they have a problem and to seek help as early as possible within their addiction. Therefore, any improvement in the design of outreach messaging, which cause the disordered gambler to reflect on their behaviour may help to reduce gambling related harm.

For instance, it may be instructive to commission research on how treatment options should be advertised, on online gambling sites, in order to maximise the chances of people with gambling disorder reaching timely help. Motivation to change is likely to fluctuate as it does in other addictions, so limiting barriers to treatment when someone experiences an increase in motivation is important.

Q10: Is there any additional evidence in this area the government should consider?

It is difficult to quantify with any precision the number of high-risk gamblers. However, figures from the Gambling Commission on fines and settlements, and a proliferation of media coverage on the topic, would suggest that there is a significant number of individuals who are currently suffering severe gambling related harms.

As set out in answer to question 1, it is highly unlikely that harm to this group can be designed out of the gambling industry entirely. This is because the roots of severe gambling disorder are complex, and affected people often seek out alternative gambling opportunities when their gambling behaviour is challenged by any given operator – online or at a land-based gambling establishment. Nationwide bans from all bookmakers, life-long barring options as well as more rigorous enforcement of barred customers, particularly from bookmakers, are all frequently mentioned requests from our treatment seeking gamblers. Gamblers within this group are amongst those most likely to suffer the most profound gambling related harms, and in turn are associated with the greatest harms to affected others and to wider society. Harm prevention for this group, and their affected others, can therefore only be achieved through treatment.

Whilst progress has been made in developing tools and controls to prevent harm to the general gambling population, Gordon Moody would argue that a strategy targeted at high risk and severely disordered gamblers is necessary in order to yield significant reductions in gambling related harm.

Such a strategy would include the following elements:

1. **Research.**

   In general, disordered gambling is an under-researched phenomenon. Further research is needed to understand how many high risk or disordered gamblers exist within the general population and what the trajectory of high-risk gambling is i.e. what proportion evolves into gambling disorder and whether there are prognostic indicators.
   As mentioned under question 7, we also need to develop better outreach methods in order to facilitate prompt access to treatment when people feel motivated to change. We need to help people with gambling disorder to recognise their problem earlier and seek help sooner.

   Finally, further research is needed to evaluate treatment impacts to ensure that the best treatments are funded, with maximum harm reduction.

2. **Sectoral collaboration**

   To support the above research agenda, higher levels of collaboration between the gambling industry, the Gambling Commission, and treatment providers are needed.

3. **Treatment Integration**

   Further collaboration will be needed to ensure that product design and customer data analysis can help to deliver a seamless referral pathway. In particular the interface with crisis services for those service users with suicidality and the interface with drug and alcohol services for those with comorbid substance use disorders will be important.

Gambling Commission's powers and resources

Q16: What, if any, evidence is there to suggest that there is currently a significant black market for gambling in Great Britain, or that there is a risk of one emerging?
Q17: What evidence, if any, is there on the ease with which consumers can access black market gambling websites in Great Britain?
Q18: How easy is it for consumers to tell that they are using an unlicensed illegal operator?

Answer Q16, Q17 & Q18
Gordon Moody recognises that there is an ongoing debate about the relative size of the black market for gambling in Great Britain, and the implications that this has for gambling and gamblers.

Many of our service users would attest to the ease with which such sites can be accessed online with limited technical knowledge. Indeed, those most profoundly affected by disordered gambling may seek out such sites out deliberately, when challenged on their play by licenced operators.

It may prove impossible to prevent high risk gamblers from using black-market sites. This reinforces our view that the sector must work together to ensure that those at risk of becoming a problem gambler are targeted with help at the earliest possible stage.

Q19: Is there evidence on whether the Gambling Commission has sufficient investigation, enforcement and sanctioning powers to effect change in operator behaviour and raise standards?
Q20: If existing powers are considered to be sufficient, is there scope for them to be used differently or more effectively?
Answer Q19 & Q20

The Gambling Commission has a mandate to protect young and vulnerable gamblers. It does this by developing and enforcing a code of practice which sets standards for the gambling industry. Whilst much has been achieved in recent years to protect the general gambling population, we would argue that more must be done to minimise harm to those people with a gambling disorder.

Whilst further research will be needed to understand the true nature and scale of the most serious forms of gambling, there are indications that there is a significant group of disordered gamblers who would benefit from receiving treatment sooner. For instance, there have been 200,000 self-exclusions through GamStop since its introduction as a licencing condition. This is an indication that problematic play is widespread, however, only 9,000 individuals received treatment for disordered gambling in the last year.

As the Code of Practice evolves across fresh iterations, it will need to incorporate an evidence-based approach to identifying problematic play and guiding disordered gamblers towards help sooner. We identify some gaps in the research, which urgently need to be addressed in order to improve the Code of Practice in this regard, under question 22.

Q22: What are the barriers to high quality research to inform regulation or policy making, and how can these be overcome? What evidence is there that a different model to the current system might improve outcomes?

It is widely accepted that gambling disorder is an under-researched phenomenon – particularly when compared to drug and alcohol addiction. Greater resources are needed to ensure that we can continue to develop and improve treatment.

However, Gordon Moody would also argue that a specific research programme needs to be funded, which would underpin a strategy to better target treatment at those most profoundly affected by gambling disorder.

For instance, we know that our treatment programme has been transformational for our service users over the last 50 years – however, we need to understand how to bring disordered gamblers to treatment sooner, so that they are protected from the most profound harms.

This will always be inherently challenging as people with gambling disorder, as in other addictions, may be ambivalent about committing to treatment. However, it is not well understood how interactions with gambling websites – or, indeed, land-based gambling

establishments – might affect the decisional balance. It is highly evident that there is a lack of awareness and understanding that treatment exists for those with a gambling disorder. It is understandable that research has focused on the general gambling population in terms of developing safer gambling tools – however many of the most serious harms associated with gambling are suffered by high-risk gamblers and their affected others. Earlier intervention for these gamblers could significantly reduce the social and economic costs associated with problem gambling.

We also need to understand how to reach all groups within society with treatment. Whilst there is no evidence to suggest that disordered gambling has a greater prevalence amongst any particular ethnic, racial or cultural group, 82% of our male service users are from White British or White Irish backgrounds. This would suggest that we need to build evidence-based, outreach programmes that ensure that treatment services are accessible to all.

Q23: Is there evidence from other jurisdictions or regulators on the most effective system for recouping the regulatory and societal costs of gambling from operators, for instance through taxes, licence fees or statutory levies?

Gordon Moody is not in a position to outline the best mechanism for recouping the regulatory and societal costs of gambling from operators. However, we would argue that further research is needed to establish the nature and extent of those costs.

Within our own area of expertise, we know that many disordered gamblers are continuing to gamble to the point of causing themselves, and their affected others, severe harm.

To reduce these harms, we need to shape and fund a harm reduction strategy targeted specifically at disordered gamblers within this group.

Consumer Redress

Q27: Individual redress is often equated with financial compensation for gambling losses. However, there may be risks associated with providing financial lump sums to problem and recovering gamblers, or risks of creating a sense that gambling can be 'risk free'. Are there other such considerations the government should weigh in considering possible changes to redress arrangements?

Gordon Moody is not in a position to comment on the ethics surrounding redress – nor the principles upon which a settlement should be made. However, our clinical staff have noted that the manner and timing of a settlement can have an impact on therapy. In cases where redress is appropriate, therefore, the Government may wish to consider measures to minimise any consequent disruption to the recovery process.

According to our clinical staff, service users are particularly vulnerable in the early stages of treatment and in the weeks after they have left treatment – and are adjusting to a new life free from gambling. In both instances, even a modest lump sum may be instrumental in triggering a relapse.

Nevertheless, a financial lump sum should not be seen as intrinsically negative. In the context of a strong therapeutic relationship, with adequate support, a "lump sum" may help patients to develop strategies to manage their own finances – a key step within the recovery process. A possible way of reconciling these concerns would be for payment to be made direct to outstanding debts or other financial obligations.

Financial redress therefore needs to be considered within the context of recovery, with measures in place to ensure that the priority is placed on "getting well first".
Any such measures would need broader ethical consideration.

Gordon Moody would be happy to advise on the design of an appropriate scheme from a clinical perspective.

[Ends]

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