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# Youth gambling education and prevention: Does it work?

Last year, the Responsibility in Gambling Trust (RiGT) commissioned Tacade and the International Gaming Research Unit to produce education materials on youth gambling to be used in schools and other youth education settings.

This initiative was featured in a previous issue of *Education and Health* (see Buczkiewicz & Griffiths, 2006) and the project led to the publication of two sets of comprehensive resources (*You Bet!* and *Just Another Game?*). Given the investment by RiGT in these educational materials, the obvious questions to ask are whether these - and other similar materials - actually work? Are they cost-effective? How long do any effects last? If there is little evidence of behaviour change, is awareness raising enough?

The new materials that Tacade and the International Gaming Research Unit produced have yet to be formally evaluated although initial feedback has been very good to excellent. For instance:

"Very good ... very positive feedback from teachers and students" (Lavington School, Wiltshire)

"Clear and concise, well thought and laid out. Students really enjoyed it" (Christ the King Catholic Maths and Computing College)

"Fab and young people friendly. Easy to use" (Caerphilly County Borough Council)

Given that this latest initiative has not yet undergone any formal evaluation, this article briefly reviews what we know about the prevention of gambling problems in young people.

## Primary, secondary and tertiary prevention

Prevention has historically been divided into three stages (Force, 1996). The term primary prevention has been used to describe measures employed to "prevent the onset of a targeted condition" (Force, 1996). Secondary prevention has been used to describe measures that "identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease but in whom the condition is not clinically apparent" (Force, 1996). Tertiary prevention has been used to describe efforts targeting individuals with identified disease in which the goals involve restoration of function, including minimizing or preventing disease-related adverse consequences (Force, 1996).

These divisions of prevention thus focus on different targets, with primary efforts tending to target the general population, secondary efforts at-risk or vulnerable groups, and tertiary efforts individuals with an identified disorder. However, there are other ways to categorize prevention initiatives such as those outlined by Williams, Simpson and West (2007). These are briefly overviewed and are divided into educational initiatives, restriction initiatives, and gambling addiction treatment and services.

## Health promotion and prevention work outside the gambling field

Prevention efforts targeting mental health and addictive disorders are widely

used internationally. However, less work has been done in the prevention realm for problem and/or pathological gambling. Furthermore, limited data are available on their effectiveness in terms of international best practice and are limited in comparison to other areas in the field of mental health and addictive disorders. Their effectiveness at reducing or eliminating problem and pathological gambling among youth and adult populations has not been adequately investigated to date.

## **Educational initiatives to prevent problem gambling**

### **Upstream intervention**

Williams et al (2007) describe these types of intervention as essentially family-based programmes to strengthen families and create effective parenting. There is no empirical evidence in relation to the prevention of youth problem gambling although some evidence for other addictive behaviours.

### **Information/awareness campaigns**

These are usually directed at the general public (although sometimes directed at very specific groups such as youth) and usually consist of information about one or more of the following:

- Encouragement to gamble responsibly/'know your limits'
- Warnings about potentially addictive nature of gambling
- Identification of the symptoms of problem gambling
- Information about where people can get help for a gambling problem
- Information about the odds of winning
- Information dispelling gambling fallacies and/or erroneous cognitions
- Guidelines and suggestions for problem-free gambling

This information can be disseminated in a wide variety of ways (e.g., websites, posters, pamphlets, media advertisements, etc.). However, there is very little evaluative research about such initiatives in the gambling literature. Evidence suggests that such initiatives increase awareness and knowledge but that there is no conclusive evidence that it effects behaviour change. Awareness campaigns appear to have limited impact if people are not explicitly asked to attend to the information. The exceptions are situations where behavioural change is comparatively easy to achieve and/or the consequences of not changing behaviour are significant (Williams et al, 2007).

### **Directed educational initiatives**

These initiatives are typically specific prevention programmes carried out in youth settings but there are very few evaluation studies in the literature and the few that have been carried out contain mixed results (Griffiths, 2003). Literature from other related fields unfortunately shows that even with comprehensive educational approaches, the effects on behaviour change are often small or non-existent (Williams et al., 2007).

### **Prevention through restriction initiatives on those who can gamble**

Prohibition of youth gambling - It is a common practice all over the world to restrict gambling opportunities to adults although the UK is one of the few countries that allows children to play legally on slot machines (Griffiths, 2002). There seems little good reason to allow minors to gamble particularly given the relatively high rate of 3.5% of problem gambling among this group (Wood, Griffiths, et al, 2006) although some people argue that exposure at an early age leads to lower levels of problem gambling in adulthood (as is the case in the UK where adult prevalence rates of problem

gambling are comparatively low at 0.6% of the adult population (Wardle et al, 2007). However, there are alternative explanations such as the low stake and low prize limit not appealing to adults (Williams et al, 2007).

### **Casino self-exclusion contracts**

These initiatives are now very common and although these contracts have some value in containing the harms to established problem gamblers, they could certainly be a lot more effective. There is little research demonstrating whether they stop gambling in either the short- or long-term as exclusion from one or more venues still leaves opportunities to gamble elsewhere (Williams et al, 2007). A small proportion of problem gamblers appreciate the opportunity to self-exclude and is a valuable service for them. However, youth gamblers are unlikely to use this option as they are not usually old enough to gamble legally in the first place.

### **Gambling addiction treatment and services for youth**

For adolescents with a gambling problem, the final option is most likely to be treatment. Internationally, the intervention options for the treatment of problem gambling include, but are not limited to, counselling, psychotherapy, cognitive-behavioural therapy (CBT), advisory services, residential care, pharmacotherapy and combinations of these (i.e., multi-modal treatment) (Griffiths, 2007). However, there is very little evidence that adolescents access these services and there have been a number of papers written on why adolescents do not access treatment services (see Griffiths & Chevalier, 2004)

There is also a very recent move towards using the Internet as a medium for guidance, counselling and treatment (see Griffiths & Cooper, 2003; Wood & Griffiths, 2007). Treatment and support is provided from a range of different people including specialist addiction nurses, counsellors,

medics, psychologists, and psychiatrists. There are also websites and help lines to access information (e.g., GamCare) or discuss gambling problems anonymously (e.g., GamAid), and local support groups where problem gamblers can meet other people with similar experiences (e.g., Gamblers Anonymous). This type of treatment may be more attractive to youth than traditional face-to-face interventions, although there is (as yet) no empirical evidence to substantiate such a claim.

Many private and charitable organisations throughout the world provide support and advice for people with gambling problems. Some focus exclusively on the help, counselling and treatment of gambling addiction (e.g., Gamblers Anonymous, GamCare), while others also work to address common addictive behaviours such as alcohol and drug abuse (e.g., Addiction Recovery Foundation, Priory). Unfortunately, anecdotal evidence suggests that adolescents do not participate in these types of treatment and that when they do they tend to feel alienated by other older people in treatment (Griffiths, 1995; 2002)

Many gambling service providers also encourage patients (and sometimes friends and families) to join support groups (e.g., Gamblers Anonymous and Gam-Anon), while others offer confidential one-to-one counselling and advice (e.g., Connexions). Most are non-profit making charities to which patients can self-refer and receive free treatment. Independent providers that offer residential treatment to gambling addicts are more likely to charge for their services. Some provide both in-patient treatment and day-patient services (e.g., PROMIS), and a decision as to the suitability of a particular intervention is made upon admission. Unfortunately, there is again little evidence that adolescents seek these types of service.

## **Conclusions**

It would appear from this brief review

that there is very little evidence to date that prevention strategies aimed at youth are effective although this is more due to the lack of evaluation studies rather than evaluation studies showing the methods to be ineffective. There is also little evidence that adolescents access treatment facilities although this is common across other addiction and health-related services.

On a more general level of preventing problem gambling, Williams et al.'s recent review (2007) makes several important points that need to be taken on board in relation to problem gambling prevention. These observations are also important when considering youth initiatives and best practice more generally.

- There exists a very large array of prevention initiatives.
- Much is still unknown about the effectiveness of many individual initiatives.
- The most commonly implemented measures tend to be among the less effective measures (casino self-exclusion, awareness/information campaigns).
- There is almost nothing that is not helpful to some extent and that there is almost nothing that, by itself, has high potential to prevent harm.
- Primary prevention initiatives are almost always more effective than tertiary prevention measures.
- External controls (i.e., policy) tend to be just as useful as internal knowledge (e.g., education).
- Effective prevention in most fields actually requires co-ordinated, extensive, and enduring efforts between effective educational initiatives and effective policy initiatives.
- Prevention efforts have to be sustained and enduring, because behavioural change takes a long time.

## RESOURCES

You Bet! Gambling Educational Materials For Young People Aged 11-16 Years. Tacade: Manchester (ISBN: 1-902-469-194)

Just Another Game? Gambling Educational Materials For Young People Aged 13-19 Years. Tacade: Manchester. (ISBN 1-902469-208).

These resources are free and can be obtained by placing an order on the Tacade website (<http://www.tacade.com/>)

## REFERENCES

Buczkievicz, M. & Griffiths, M. (2006). Educational work on problem gambling. *Education and Health*, 24(2), 21.

Chevalier, S. & Griffiths, M.D. (2004). Why don't adolescents turn up for gambling treatment (revisited)? *Journal of Gambling Issues*, 11. Located at: [http://www.camh.net/egambling/issue11/jgi\\_11\\_chevalier\\_griffiths.html](http://www.camh.net/egambling/issue11/jgi_11_chevalier_griffiths.html).

Force, U. S. P. T. (1996). *Guide to clinical preventative services* (2nd edition). Baltimore, MD: Williams & Wilkens.

Griffiths, M.D. (1995). *Adolescent gambling*. London: Routledge.

Griffiths, M.D. (2002). *Gambling and Gaming Addictions in Adolescence*. Leicester: British Psychological Society/Blackwells.

Griffiths, M.D. (2003). Adolescent gambling: Risk factors and implications for prevention, intervention, and treatment. In D. Romer (Ed.), *Reducing Adolescent Risk: Toward An Integrated Approach*. pp. 223-238. London: Sage.

Griffiths, M.D. (2007). *Gambling Addiction and its Treatment Within the NHS*. London: British Medical Association.

Griffiths, M.D. & Cooper, G. (2003). Online therapy: Implications for problem gamblers and clinicians, *British Journal of Guidance and Counselling*, 13, 113-135.

Wardle, H., Sproston, K., Orford, J., Erens, B., Griffiths, M.D., Constantine, R. & Pigott, S. (2007). *The British Gambling Prevalence Survey 2007*. London: The Stationery Office

Williams, R.J., Simpson, R.I. and West, B.L. (2007). Prevention of problem gambling. In G. Smith, D. Hodgins & R. Williams (Eds.), *Research and Measurement Issues in Gambling Studies*. pp.399-435. New York: Elsevier.

Wood, R.T.A. & Griffiths, M.D. (2007). Online guidance, advice, and support for problem gamblers and concerned relatives and friends: An evaluation of the Gam-Aid pilot service. *British Journal of Guidance and Counselling*, 35, 373-389.

Wood, R.T.A., Griffiths, M.D, et al (2006). *Under 16s and the National Lottery*. London: National Lottery Commission.