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The role of public health advocacy in preventing and reducing gambling related harm: challenges, facilitators, and opportunities for change

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Methods: Semi-structured qualitative interviews were conducted with a sample of 50 stakeholders with backgrounds in gambling policy, research, health promotion, and advocacy. Participants were asked about how advocacy could be used to address gambling harm, and the range of barriers and facilitators for effective advocacy responses. A constant comparative method of analysis was used on the data.

Results: While participants perceived that there was a role for advocacy in preventing and reducing gambling related harm, they discussed a range of challenges. These included restrictions associated with funding of research and services, the power of the gambling industry, and the role of stigma in preventing people with lived experience of gambling from speaking about their experiences. Participants also described a range of facilitators of public health advocacy approaches, including independent funding sources, reframing the 'responsibility' debate, developing opportunities and capacity for people with lived experience of harm, and developing broadly based coalitions to enable cohesive and consistent advocacy responses to gambling harm.

Conclusion: There is a clear role for public health advocacy approaches aimed at preventing and reducing gambling harm. Future research could identify how advocacy strategies may be implemented as a part of a comprehensive public health approach to gambling reform.

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Keywords: Advocacy, Gambling, Public health

Introduction

The role of advocacy is a rapidly growing area of interest in gambling reform (Thomas et al. 2015). Although there have been numerous calls for the reform of the gambling industry and its products, popular approaches have predominantly used an addiction-oriented approach, focusing on personal responsibility strategies to minimise harm (Miller et al. 2014; Hancock and Smith 2017). However, there is a long tradition in public health of using a variety of advocacy strategies as part of a comprehensive approach to protect and promote positive health outcomes in communities (Moore et al. 2013). Successful public health interventions have been achieved as the result of strong scientific evidence, community support, and advocacy as the drivers of policy change (Chapman 2004a; Daube 2017). Such strategies are strongly linked to action, engaging communities, and creating robust arguments for change (Bassett 2003). Advocacy includes 'spreading the word' to the community and decision-makers about strategies and policies that need to be enacted to protect and promote the health of communities (Avery and Bashir 2003 p.1207), and persuading:

> *"…decision makers of the need for change through identifying desired public health outcomes and effective and feasible methods of achieving that change"* (Moore et al. 2013 p.5)

Although there is no single formula for effective advocacy, a range of individual and collective strategies may facilitate successful campaigns (Jenkins 2006). Strategies can be grouped into five key approaches that are not necessarily mutually exclusive.

First are strategies that seek to *influence policy change through the use of sound scientific evidence* to highlight harms, challenge existing policy, and push for policy reform (Cullerton et al. 2016; Elliott-Green et al. 2016; Cohen and Marshall 2017). Second, is the development of *strong coalitions and partnerships* across agencies (such as health and other professional organisations) united by a common goal, which enable the fostering and use of explicit skill sets and greater access to a broader range of policy and decision-makers (Frieden 2014; Cullerton et al. 2016; Cohen and Marshall 2017). Third, are strategies that seek to *raise awareness and frame the public debate* about key issues, particularly through the development of key messaging strategies and the use of the media (Chapman 2004b Freudenberg 2005; Gen and Wright 2013). Fourth, are strategies that aim to *empower communities,* by providing a strong voice for individuals who are marginalised or unable to speak for themselves (Dorfman and Krasnow 2014), educating communities about product harms (Freudenberg 2005; Chaloupka et al. 2011; Brinsden and Lang 2015), and encouraging community participation in reform initiatives (Cohen and Marshall 2017). Finally, are strategies that *monitor and counter vested influences* that seek to resist and create barriers when industry reform efforts may be implemented (Chapman 2007; Jahiel and Babor 2007; Thomas et al. 2015).

Along with documenting facilitators for advocacy, researchers have identified a number of issues that may create barriers to successful public health advocacy campaigns (Farrer et al. 2015; Cohen and Marshall 2017; Smith and Stewart 2017).

First, public health advocates can *encounter significant opposition to reform agendas*, particularly when advocating for policy change that conflicts with the socio-cultural, political or economic interests of dominant social agencies, governments, or industries (Andrews and Edwards 2004). Chapman (2004a) has commented that public health advocates often encounter fraught and highly organised opposition to change from a range of agencies:

> *"Opposition can come from governments, industry, community and religious interest groups, and from within the public health field itself."* (Chapman 2004b p.361)

Second, are the *challenges that arise from the commercial interests of large corporations*, and the resourcing and influence that these bring. These include the ability of large organisations to influence governments through means such as using political donations, paid lobbyists, and political advertising and campaigning (Brownell and Warner 2009; Hawkins et al. 2012; Freudenberg 2014). In contrast, there are few resources for public health advocacy or translation initiatives, which arguably remain the 'poor cousin' within the public health field (Chapman 2001). Corporate Social Responsibility (CSR) initiatives are another example of strategies used by industries as a public relations tool, through the support of community programs, donations to charities, and the provision of resources for youth initiatives (Rosenberg and Siegel 2001; Lyness and McCambridge 2014; Richards et al. 2015). When industries create positive perceptions in the community, and a reliance on industry funding, it may be difficult for community organisations to move away from

relationships with these companies, to advocate for the promotion of health (Jane and Gibson 2017).

Third, are the *challenges resulting from funder influence over research* (Chapman 2001; Livingstone and Adams 2016). For example, a recent study of funder influence over published research outputs in a major addiction journal identified that around one third of authors (n=117, 36%) had experienced at least one incident of funder interference in their research including the censorship of research findings, the language used in reports, the writing of reports, and when and how findings were released (Miller et al. 2017). Researchers have also explored government suppression of health information in the Australian health sector, identifying that governments delayed or prohibited publications, using a range of methods of suppression that included blocking funding, delaying access to data, controlling report findings, and sanitising reports (Yazahmeidi and Holman 2007). Such suppression may impact on a researcher's ability to use scientific evidence to argue for policy reform, or regulatory change.

Finally, there are the *debates about whether and to what extent academics should be involved in advocacy*. Smith and Stewart (2017) identified a number of challenges for academics engaging in advocacy, including the perceived ethical implications of traditional researchers moving beyond their research findings to provide policy recommendations; a perception that involvement in advocacy initiatives was for ideological rather than empirically driven reasons; and concerns that continued involvement in advocacy might compromise perceptions of research independence and credibility (Smith and Stewart 2017). Further to this is the concern that

167 academics are often judged by conventional research outputs, but rarely by their
168 broader impact (Mirvis 2009; Vale and Karataglidis 2016). This may ultimately limit
169 the involvement of academics in policy development (Lauder 2014).
170
171 How then do those who wish to engage in advocacy in the area of gambling
172 negotiate their way through the range of challenges and facilitators to effective
173 advocacy initiatives? In particular, how does this occur when there is significant
174 opposition from vested interests? Although the shift to a public health approach to
175 gambling reform is gaining momentum, researchers have documented significant
176 barriers to this, including challenges in producing scientific research (Adams 2011;
177 Cassidy et al. 2013). Utilising qualitative interviews with an international sample of
178 health promotion workers, researchers, policy makers, and advocates working in
179 gambling harm reduction and prevention, we posed three research questions:
180
181 1. What are the challenges and facilitators to effective advocacy initiatives?
182 2. Which strategies are most effective in countering opposition, and building
183 feasible methods for change?
184 3. What role can advocacy play in reducing and preventing gambling related
185 harm?
186
187 **Methods**
188
189 *Approach*
190

The data presented in this paper was collected within a broader study of the range of issues contributing to the normalisation of gambling (Thomas et al. in press). The present study specifically explored questions regarding the role of advocacy in gambling harm prevention and reform. Constructivist Grounded Theory (CGT) methods were used in the creation of research questions, data collection and analysis (Charmaz 2006). CGT recognises the subjective nature of data collection and analysis, the interactions between study participants and researchers, and how the researcher is situated within the interpretation of study data (Charmaz and Belgrave 2012). The use of CGT methods resulted in an interpretive data analysis and descriptive presentation of study findings (Charmaz and Belgrave 2012).

Sample selection and recruitment

To guide the sample selection for this study, we used the stakeholder categories outlined in the Australian National Preventive Health Agency Stakeholder Engagement Strategy, which included those working in health promotion, academia or research, government and policy, and in non-governmental organisations, including peak bodies and advocacy organisations (Australian National Public Health Agency 2012). To recruit participants, the research team constructed a list of potential participants in each of the categories, based on their existing networks in, and, knowledge of the field. The team also scanned websites for additional researchers and health promotion and non-government organisations involved in gambling harm prevention activities. Participants were initially approached by email, with snowball-sampling techniques (Sadler et al. 2010) employed to identify additional participants, particularly from countries outside Australia. Ethical approval

was received from the University Human Research Ethics Committee (HEAG-H 01_2016).

Data collection

The questions relating to advocacy within the interview schedule focused on three key themes of inquiry: the role of advocacy in gambling reform; perceived challenges or facilitators for advocacy; and previously successful advocacy efforts in gambling harm reduction. Five researchers, including the first and second authors conducted semi-structured interviews lasting on average 60 minutes. These interviews were conducted via telephone or Skype and audio-recorded with the permission of participants. Consistent with qualitative methods (Miles and Huberman 1994) as the data were collected and analysed, the interview schedule was modified to reflect new and emerging issues raised by participants.

Data analysis

After transcription of the interviews, all data were de-identified to ensure anonymity of participants, QSR NVivo 10 was used to manage the data. Using a thematic analysis approach (Miles and Huberman 1994) the first author led the data analysis process. Each transcript was read, re-read and coded to establish the themes and sub-themes emerging from the data relevant to the research questions. Using a process of open coding, emerging themes and sub themes were compared across the data to enable the identification of any patterns in participant responses. Authors read the transcripts and engaged in multiple detailed discussions about the

interpretation of emerging themes and sub-themes, and, the similarities and differences in responses. The authors regularly returned to study the research questions and advocacy theory to interpret responses. In instances where the authors differed in their interpretation, transcripts were again reviewed and analysed, with discussions between the authors occurring until consensus was reached and the final themes and subthemes were agreed. While qualitative research does not seek to provide numerical values to data, in reporting the results of the data we indicate ‘a few’ to represent less than 25% of participants, ‘some’ as up to 50%, ‘many’ as up to 75%, and ‘most’ as over 75% agreement.

Results

A total of 50 participants were interviewed. Although participants were from eight countries, over half were from Australia (n=32). Participants came from a range of professional backgrounds, which were grouped into four categories: 1) academics and researchers (n=19), 2) health promotion organisations (n=16), 3) advocacy, not for profit, and peak bodies (n=10), and 4) government organisations and policy makers (n=5).

Table One
Overview of background of study participants

Field / Country	Academia and/or research	Health promotion organisations	Advocacy, not for profit and peak bodies	Government organisations and policy makers	**Total**
Australia	9	13	6	4	32
New Zealand	2	2	1	1	6
United States of America	2	0	3	0	5
Canada	2	0	0	0	2
United Kingdom	2	0	0	0	2
Sweden	1	0	0	0	1
Finland	1	0	0	0	1
Ireland	0	1	0	0	1
Total	19	16	10	5	50

Participants described a range of challenges to the implementation of effective advocacy initiatives, and strategies to overcome these challenges.

Responding to the influence of the gambling industry

The first theme related to the influence and power of the gambling industry and the difficulties this created for advocating for comprehensive reduction and prevention strategies. While a range of industry influences were described, the potential influences over political decision making, research, and the framing of the public debate about gambling provided the three biggest challenges for advocates. Some participants described the powerful mechanisms used by industry to influence government policy. These included making political donations, lobbying politicians, and having a seat at the policy making table. Some participants perceived that these

mechanisms led to the development of government policy and legislation that were *'sympathetic'* to the industry, and that undermined the ability of public health advocates to convince governments to implement evidence-based reforms to reduce gambling harm. One participant described how the power of political donations and lobbying limited the ability of advocates to influence political decision-makers, and argue for evidence-based reform:

> *"...trying to convince government when there's significant money that flows to political parties and politicians from the industry makes it much tougher for people campaigning and seeking reasonable reforms."* - Participant 20, Policy

Participants also described the role of industry in influencing research funding agendas, and in directly (or indirectly) funding academic research. This included having input into the setting of priorities for research funding agendas. Participants particularly described the role of industry in raising money for research, sponsoring academic conferences, and indirectly funding treatment services. One participant stated that while the gambling industry did not necessarily seek to control or co-opt research, it ensured that research supported its agenda:

> *"So, it's not the co-opting of research. It's rather disproportionately funding research people and research areas that support their story."* – Participant 4, Academics/Researchers

This provided a challenge for public health researchers and advocates who reported that the involvement of industry in research, or research agenda setting, meant that

there was limited critique of industry practices and how to counter these. Some participants also noted that direct or indirect funding of research and treatment services by industry made it very difficult for researchers and services to speak out about the harms perpetuated by the gambling industry and its products. Describing the role of treatment providers, one participant commented:

> *"So, they're very torn; yes, they want to be rid of them* (pokies)*, no, they don't want to lose funding, and so they end up not doing anything."* – Participant 8, Health Promotion

Some described the important role of independent funding sources in enabling researchers and services providers to persuade decision makers of the need for regulatory reform of the industry and its products. Participants acknowledged that independent funding for academic research, treatment services, and community groups was important in ensuring that messages about reform were not misrepresented:

> *"I think the other thing is independence, so the ability to actually frame issues and raise issues from the local level without those issues being watered down, or filtered down, or disrupted."* - Participant 36, Academics/Researchers

Developing clear advocacy messages, and reframing the public debate

Participants discussed how the financial capacity of the gambling industry enabled it to run effective campaigns to frame the debate about problem gambling and to challenge reform initiatives. Some commented that the industry had been very effective in framing problem gambling as an issue relating to personal responsibility. Some participants described the *'very smart PR and marketing departments'* that were engaged by the gambling industry, and their ability to mount *'sophisticated campaigning'* strategies. One participant noted that the lack of resources available to advocates was a significant limitation in advocacy initiatives:

> *"If the gambling industry can advertise, and the government can advertise, and the advocacy groups don't have any money to do anything like that, that's a severe limitation… it all comes down to resources."* – Participant 41, Health Promotion

Many participants noted the importance of reframing discourse about problem gambling away from individual responsibility and towards the health and social costs of gambling harm. This included reframing gambling related harm as a public health issue, rather than a political or economic issue:

> *"They need to continue to talk about the harms. They need to continue to talk to the government about their role in this as a health issue, a public-health issue, and try to get the government to stop only looking at it from an economic point of view….and, oh, to stop framing the problem gambling as an individual's problem."* – Participant 28, Health Promotion

Some believed that the most effective way of overcoming these resource limitations was effective engagement with the media. Participants noted that media-based advocacy enabled a broad reach of messages to key target audiences. These had impact because governments and the gambling industry were often responsive to what was *'said in the media'*:

> *"It's only when the public gets really upset with the way in which gambling's being delivered and it threatens a politician's likelihood of being re-elected things are going to change…So media is very, very important."* – Participant 4, Academics/Researchers

Participants also noted that there was a critical need for independent (i.e. not aligned with the gambling industry or government) peak bodies on gambling harm, which would serve as '*umbrella organisations'* which could help to reframe the public debate about gambling, and to drive reform. For example, one participant identified the Alliance for Gambling Reform (an Australian based coalition of local councils, churches, and other community organisations concerned about the harms associated with gambling) as a key driver in reframing the debate about gambling related harm towards problematic gambling products. Others commented that in the absence of these peak bodies, researchers, local government, and community organisations should build and consolidate their networks to work together for change in local communities. In particular, participants described the need for open, transparent, consultation about gambling reform:

> *"We need a national response and strategy to gambling in Australia that is evidence-informed and treats it as a health and social issue in terms of public health. Whenever we have a discussion about gambling, we need to include research, academia, treatment and people who consume gambling products to ensure that we have an open consultative process about this harmful product.*" - Participant 43, Health Promotion

Overcoming ideological differences relating to the role of advocacy

The third theme related to ideological differences between individuals and groups about advocacy strategies, and the goals and aims of advocacy. While there was general agreement that advocacy was needed from participants from a range of professional backgrounds, participants particularly commented on the ideological differences relating to the involvement of academics in advocacy. A few participants questioned whether academics should have, or felt comfortable with, a role in advocacy. One participant commented that academics did not *'like to consider'* themselves advocates, that research needed to be purely empirically driven, and that agendas ran the risk of being motivated *'purely by ideology'* and *'not evidence'*. Others were concerned about the impact of the involvement in advocacy on the reputations of academics, with a few commenting that when researchers became involved in advocacy their work was often *'tarnished as unscientific'*, or that their objective could be described as *'propaganda'*.

Despite this, many participants both within and outside academia believed that academics had an important role in advocacy initiatives that aimed to influence

policy and decision makers. Participants noted, that it was important for independent evidence generated by academics to be effectively disseminated to local groups to be used in their advocacy campaigns, and that it was important for this evidence to be shared in *'an easily digestible format that is reliable and valid and easily accessible…'.*

Building coalitions and working towards a common goal

The fourth challenge for advocacy initiatives related to getting diverse groups of individuals to work together toward a common goal of addressing gambling harm. Some participants stated that one of the challenges associated with advocacy initiatives was that while many *individuals* had advocated for gambling reform, gambling reform would not be achieved when individuals worked alone or in small groups. One participant stated that a key difficulty with current advocacy initiatives was getting individuals to come together and advocate for reform without getting people *'offside'*:

> *"If you have lots of individuals coming together they all have their own story, their own idea. How do you then drive that to one common goal, and how do you then get access to the people that you need to get access to in a way that you're not going to get them offside?"* - Participant 45, Health Promotion

Participants commented that in order for meaningful reform to occur, academics, local councils, community groups, and sporting organisations needed to work together to convince decision makers to enact change. One participant noted that

advocacy initiatives needed to be targeted toward governments, with a wide range of groups coming together to argue for change. Participants commented that *'working together'* and *'trying to work collaboratively'* was key to successful advocacy. Some participants considered that shifting to a public health approach for the prevention of gambling harm would enable the development of coalitions. This was because effective approaches to gambling reform would depend on getting *'the philosophy right… a turnaround of the ideology… this is the only thing that will really make a difference'*. Overall, participants argued for a clear shift in advocacy initiatives towards a focus on harmful products:

> *"I think there's an acceptance now that we need to look at population level effects and that we need to look at the product and move away from the individual responsibility."* - Participant 27, Academics/Researchers

Engaging communities and those with a lived experience of harm

Finally, were the challenges associated with engaging those with a lived experience of gambling harm, and local communities, in advocacy initiatives. Participants observed how the stigma associated with 'problem gambling' meant that potential advocates feared that such stereotypes might *'jeopardise'* their jobs, relationships and result in negative judgments from others. This was a critical factor in *'whether or not people decided to be involved'* in advocacy. Stigma extended beyond the individual, with family and friends also concerned about the negative impacts of people speaking out. Yet, participants acknowledged that encouraging individuals to speak out played a crucial role in achieving gambling reform. Participants

commented on the need to empower individuals with a lived experience of gambling harm to be involved in advocacy, arguing that those who had a lived experience of gambling harm, and their friends and families, were the most *'authentic advocates for policy reform'.* Participants suggested a range of initiatives that would encourage people with a lived experience of gambling harm to make a contribution to the debate about gambling reform. This included strategies such as advocacy and media training to enable the communication of the most up to date evidence about gambling related harm. As one participant stated:

> *"There's nothing more powerful than hearing a personal story from somebody who is actually just like you…"* - Participant 18, Advocate

Finally, some participants discussed the importance of *'firsthand knowledge',* the need to build a *'groundswell'* of support to advocate for gambling reform, and the power of grassroots movements in providing a voice for those who struggled to be heard:

> *"…people who have less power and agency within society are always going to struggle to be heard. There's the classic people who need the most advocacy always struggle to advocate for themselves because they don't have the social capital to do that and the knowledge and the networks."* - Participant 19, Health Promotion

Discussion

Although public health advocacy has previously been critical in reform on significant public health issues such as tobacco control (Chapman 2004a; Daube 2017), there has been limited discussion about how public health advocacy can address gambling-related harms (Thomas et al. 2015). The results of this study highlight that while no one clear advocacy strategy has been implemented across stakeholder groups, participants are actively engaging in advocacy associated with gambling harm reduction and prevention. However, this advocacy is fragmented in its implementation. The creation of a clear pathway or 'road map' is necessary to unite public health and other advocates and implement effective public health advocacy initiatives. This study provides the starting point for constructing this road map.

A number of challenges, facilitators and effective strategies for advocacy responses in gambling harm reduction and prevention were identified in this study. Some of these challenges centred on the power of the gambling industry, which was perceived by participants as affecting all aspects of the advocacy process. These include potential conflicts of interest between organisations who would like to be involved in advocacy and their funding sources, donations to political groups, the distortion of evidence and influence over research priority setting. Similar issues have been identified in relation to other unhealthy commodity industries such as tobacco, junk food and alcohol (Brownell and Warner 2009; Freudenberg 2014; Brinsden and Lang 2015). The World Health Organization (WHO) (2003) has sought to address tobacco industry interference through mechanisms such as the WHO Framework Convention on Tobacco Control (FCTC), which commits all 181 signatory governments to protect their tobacco control policies from the political influence of the tobacco industry (WHO 2003). Given the globalisation of gambling

products (Hellman et al. 2017), conventions such as the FCTC may also play a key role in reducing gambling harm. The FCTC focuses on the implementation of evidence-based strategies that can reduce the demand for tobacco products, the regulation of products, the supply of these products, education, and advertising restrictions. Research indicates that many of these strategies are used by the gambling industry to promote their products and to resist regulatory reform (Thomas et al. 2017). National and international conventions may support the development of clear strategies aimed at preventing and reducing gambling harm.

A number of other advocacy challenges identified focused on practical limitations. Inadequate distribution of resources often limits advocates' ability to implement effective strategies. Also apparent were the difficulties associated with different groups working together for a common goal. Coalitions are known to be important in bringing a variety of voices together and have been critical in the development of effective advocacy responses in other areas of public health (Douglas et al. 2015; Cullerton et al. 2016; Weishaar et al. 2016), such as the successful implementation of a range of tobacco free policies (Douglas et al. 2015; Weishaar et al. 2016). It was clear from participants' responses that the development of gambling advocacy coalitions is critical in creating successful initiatives. However, those working to address gambling harm were often seen as appearing to focus on targeted, specific advocacy responses, rather than 'big picture' approaches. For example, advocacy initiatives were seen as often being reactive to single issues such as the regulation of gambling advertising in live sport, or specific behaviours associated with industry. Further, there is limited measurement of or reflection on the success of advocacy initiatives. At present there are few initiatives that take a long term, proactive focus

on bigger issues that would significantly prevent or reduce gambling related harm. In a previous paper we have argued that such big picture approaches would include embedding advocacy strategies into broader planning for public health initiatives, and developing coalitions with advocates working to reform other harmful industries (Thomas et al. 2015). Further steps should include development of a 'road map' to guide advocacy strategies, identify any commonalities with other public health issues (e.g. the advertising of products in sporting matches), and potential coalitions. As argued by participants in this study, this road map could be constructed within broader national or international public health strategies or international conventions.

The engagement of those with a lived experience of gambling harm is important in highlighting issues by incorporating a human element with which people can identify (Jernigan and Wright 1996; Thomas et al. 2015). Given research that has highlighted the importance of the lived experience in successful advocacy initiatives (Holder and Treno 1997), the stigmatisation of individuals and their families who have experienced harm from gambling is an important issue to address. It is notable that engagement in advocacy for those with a lived experience of gambling harm will not necessarily involve talking to the media. Media advocacy is not for everyone, and people with a lived experience may wish to be involved in activities that do not involve recounting their experience. Organisations should therefore seek to provide a range of training and advocacy opportunities for those directly impacted by gambling harm, including individuals, their families, and communities. Some organisations have started to consider how to include people with a lived experience in advocacy. For example, the Champions for Change program in Australia (Alliance for Gambling Reform 2018) includes a range of participation options for people with a lived

experience of gambling harm, including engaging with the media, speaking to politicians and/or policy makers, engaging with the public and community groups, volunteering, and promoting venues that do not contain poker machines.

Although current strategies to address gambling harm have predominantly focused on individual responsibility approaches, it is clear that there is a need to challenge this framing and present gambling harm as a broader public health issue. The use of individual responsibility rhetoric is a tactic known to be used by other unhealthy industries such as tobacco. Research has demonstrated that this framing deflects perceptions of harm away from products or industry practices and creates concern amongst the public regarding freedom of choice (Moodie et al. 2013; Friedman et al. 2015). In addressing this, discussions about the causes of gambling harm need to continue to reiterate the society wide impact of gambling harm, while clearly linking this harm to a range of determinants, including gambling product and industries.

Participants also spoke of some ideological challenges to effective advocacy. Advocacy is perceived as a strategic approach to advance social or public policy objectives, usually by organisations, whereas, personal activism can take more direct and less planned forms. Notwithstanding the overlaps in these definitions, and some confusion about the differences, what is important is the recognition that advocacy is essential in the creation of harm reduction and prevention strategies in gambling. Ensuring that advocacy is evidence based and that independent funding is available for research and services, and providing opportunities for academics to publish articles in journals which support researchers discussing the implications of

their research for policy and practice, may help to dispel some of the myths associated with engagement in advocacy.

Consequently, this raises the question of how to create and develop feasible public health advocacy responses to address gambling harm. These responses are pictorially illustrated in Figure One.

First, there is the need to *develop and enable advocates*, which could be done with a combination of different strategies. In the area of gambling, there is concern about the role of stigma in preventing individuals, particularly those with a lived experience of gambling harm, being involved in advocacy. It is therefore critical that those working in public health are mindful of the potential for stigma to occur when developing future advocacy campaigns and initiatives. Further, those mechanisms that enable community participation in advocacy by providing supportive environments (Flynn 2015) require consideration. For example, the creation of environments where healthy food choices were encouraged was critical in the effective implementation of sugar-sweetened beverage levies (soda taxes), where community driven advocacy was central to policy reform (Grumbach et al. 2017).

There is a need to *challenge the structural barriers* created by industry influence. In public health there is a growing body of literature that argues that researchers should not accept funding from the industries they are studying (Stuckler and Nestle 2012; Chew et al. 2014). This would help ensure that researchers' ability to advocate is uninhibited. Smith and Stewart (2017) suggest that by creating a collaborative environment, researchers could indirectly involve themselves in advocacy efforts

(Smith and Stewart 2017). Given the inherent conflict of interest created by industry being involved in research (Adams et al. 2010; Cowlishaw and Thomas 2018), it is clear that using alternative funding sources would be one way to address this conflict.

Finally, there is a need to consider how best to use limited resources *to create broadly based and consistent advocacy responses*. Other industries (e.g. tobacco) have successfully promoted their products and prevented reform using consistent advocacy strategies (Menashe and Siegal 1998; Saloojee and Dagli 2000). A key component to the success of coalitions in other areas of public health has been the development of social capital (Dean and Gilbert 2009; Ogden et al. 2013). By building social capital among advocates for gambling reform - developing relationships with community members, government, academics, and researchers - it could be possible to create strong connections, and subsequently coalitions that can develop strategies, advocate for and ultimately implement gambling reform initiatives. It is important that strong, respected and informed public health leaders take a leading role in the coordination of coalitions.

INSERT FIGURE ONE

This study has a number of limitations. First, the initial recruitment of participants included recruitment and referral from those among the researcher's networks, which contributed to the higher participation from individuals based in Australia. Second, although this study has a large sample size for a qualitative research study, it focuses on a specific group of individuals who were working predominantly in areas

of gambling reform. Thus, the study cannot be generalised to all individuals working in gambling research, policy, or practice. A larger sample of international participants, including those who work with or receive funding from industry, would provide a broader picture of attitudes across the gambling field. Given both the exploratory nature and specific focus of this study, more in-depth consultations with stakeholders should now be used to build a road map of specific public health advocacy strategies, which are relevant to different geographic or cultural contexts. Consensus among stakeholders could identify what feasible and realistic advocacy strategies for gambling harm should look like, including establishing (and implementing) evidence-based priority areas in relation to the reduction and prevention of gambling harm.

Conclusion

There is a role for advocacy in future gambling harm reduction and prevention strategies. However, a number of key challenges need to be overcome for this to occur. Those working in public health could explore ways of addressing these challenges, learning from experience in advocacy on other public health issues, and consider how to create comprehensive and feasible strategies to facilitate public health advocacy in gambling with a continuing focus on clear and consistent messages, coalitions and community engagement.

Abbreviations

CGT: Constructivist Grounded Theory

CSR: Corporate Social Responsibility

FCTC: Framework Convention on Tobacco Control

WHO: World Health Organization

Declarations

Ethical approval

Ethical approval was obtained from Deakin University Human Research Ethics Committee. Participants provided written and/or oral consent prior to participating in the study.

Consent for publication

All participants consented to the data being used for publications.

Availability of data and material

This data will not be made available to ensure the privacy and anonymity of the study participants.

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Authors' contribution

JD was the lead researcher; she contributed to data collection and led data analysis and prepared the first draft and critical revisions of the paper. ST was the Chief Investigator and conceptualised the study, contributed to initial data collection, analysis and interpretation and, prepared the first draft and critical revision of the paper. MR and MD were study investigators and contributed to data interpretation, writing and critical revision of the paper. SB contributed to critical revision of the paper.

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Figure One

Developing public health advocacy responses to reduce and prevent gambling harm