

Taking a Public Health approach to the prevention and reduction of gambling related harm in Blackpool 2024-2027

Needs assessment and evidence review to inform the strategy

Blackpool Council



Gambling related harm strategy for Blackpool: Needs assessment and evidence review

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1. Acknowledgements

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The UK Health Security Agency Knowledge & Library Service provided support with systematic reviews of the published scientific evidence. In particular, Helen Medley supported the research question 'How can communities and services support/tackle/reduce people who have a gambling addiction or are at risk of gambling harms?' The full search strategy is available upon request.

2. Terminology

There is a great deal of stigma associated with gambling harms. In the production of this strategy, every effort has been made to use language that is inclusive and destigmatising wherever possible. This document reports a great deal of data from a range of sources including scientific research and survey data. In order to accurately report this data, it has sometimes been necessary to use the language and definitions used in the original study.

3. Executive Summary

4. Introduction

This document is the first part of a strategy to prevent and reduce gambling-related harm (GRH) in Blackpool.

Blackpool has not previously had a strategy in this area, and for that reason this strategy has been divided into two parts. This document covers a range of evidence relating to the scale and nature of gambling related harms and how they can be minimised, from a Public Health perspective.

The second part of the strategy builds on this base to identify our local strategic priorities and actions to be taken in partnership with stakeholders from across the system.

This document has been informed by local, national and international data and scientific evidence, as well as input from strategic partners including VCFSE sector organisations, NHS bodies and other parts of the council, as well as those with lived experience.

Chapter 5 will outline the nature and scale of the problems associated with gambling, provide an understanding of gambling related harms, and describe the role of the gambling industry in perpetuating these harms. Chapter 6 will go on to lay out some of the evidence for the different types of harm that can result from gambling activity.

Chapter 7 will briefly review some of the evidence for what works to reduce and prevent gambling related harms. While evidence in this area is limited, this should not prevent action, especially when accompanied by robust evaluation.

Chapter 8 is an overview of local evidence and data for Blackpool, including the scale of gambling related harm and the provision of local services.

5. Background

5.1 The nature of the problem

Public Health professionals have only relatively recently taken a serious interest in gambling as a public health issue. In this absence, our understanding of gambling harms has been dominated by the concept of ‘responsible gambling’ assiduously promoted by the gambling industry. Under this understanding, gambling is promoted as a safe and enjoyable leisure activity for the great majority of responsible gamblers. In contrast, a small population of ‘problem gamblers’ is identified, who are incapable of gambling ‘responsibly’, and may be identified clinically as having a gambling addiction.

This ‘responsible gambling’ approach has some significant limitations. By identifying the problem as within a particular group of gamblers, it ignores the evidence that different gambling products have different addictive potentials, and that marketing and design of these products work to maximise this effect (Livingstone *et al.*, 2008; Livingstone *et al.*, 2019; Abbott, 2020a).

Gambling can also deepen pre-existing inequalities, as more money is lost by those who can least afford to spare it, and gambling venues and machines cluster in more deprived areas (Beynon *et al.*, 2021b; Macdonald *et al.*, 2018; Wardle *et al.*, 2014).

The concept of ‘problem gamblers’ also limits our understanding of gambling harms only to those experiencing the most harm, overlooking the possibility that a greater proportion of those who gamble, as well as their friends, families and communities, are experiencing at least mild or moderate harms, adding up to a significant burden of harm across the population.

It is often argued that the playing of games of chance, like the consumption of alcohol, has formed part of human society for millennia. However, we can recognise this and still acknowledge that the size and the power of these modern industries is a much more recent development (Cassidy, 2020). The harms caused in both cases are related to the design and promotion of specific products. For this reason, attempts to reduce that harm cannot be limited merely to the provision of treatment to those who have already experienced the most severe harms associated with dependence. A comprehensive strategy must also include prevention work, including education, but also, crucially, measures to control the supply of and demand for those products associated with the most harm.

In the UK, gambling has been increasingly normalised (Cassidy, 2020). This widespread acceptance means that harmful behaviour can be perpetuated to the next generation (Beynon *et al.*, 2021b). In particular,

gambling has become more and more intertwined with professional sport, through advertisements and sponsorship. In 2022, fear of ‘missing out’ on betting on the Qatar World Cup disincentivised many gamblers from quitting, and triggered others who had attempted to quit to restart (Gosschalk *et al.*, 2023).

5.2 The scale of the problem

The scale of harm associated with gambling globally has been estimated at two thirds to three quarters the magnitude of that associated with alcohol misuse or major depressive disorder and three times that of drug dependence (Abbott, 2020a).

In 2022, 60% of adults in Great Britain participated in some form of gambling activity (Gosschalk *et al.*, 2023). The government estimates that there are around 300,000 people in Great Britain experiencing problem gambling, and an additional 1.8 million gambling at an elevated level (DCMS, 2023).

A YouGov survey on behalf of GambleAware in 2022 found that 13.4% of adults in Great Britain (approximately 6.9 million individuals) scored above 0 on the PGSI scale (see box), indicating at least some level of risk in their gambling behaviour, and 2.9% (or 1.5 million adults) scoring 8+, falling into the highest risk category (Gosschalk *et al.*, 2023).

The Health Survey for England found that within England alone, a total of 1.76 million people are participating in harmful gambling, within which 168,000 were participating in problem gambling, a higher classification of harm (NHS Digital, 2019b).

However, as we will see, these estimates may significantly underestimate the levels of gambling related harm experienced by individuals, communities and society at large by taking a relatively narrow definition of harm and setting a high level of individual clinical significance. There is also evidence that surveys may underestimate levels of financial harm, as self-reported gambling expenditure can be unreliable (Wood and Williams, 2007; Muggleton *et al.*, 2021).

7% of the British public identified themselves as ‘affected others’ who have been significantly negatively affected by someone else’s gambling, most commonly immediate family of a gambler (Gosschalk *et al.*, 2023). It has been estimated that for every person with a gambling problem, between six and ten others are directly affected. A survey by Citizens Advice found that one in ten reported more than ten additional people negatively impacted by their gambling (Nash, MacAndrews and Edwards, 2018).

The total number of people in Britain affected either by their own or someone else's gambling has been estimated as between 4.8 and 10 million adults (Gosschalk *et al.*, 2023).

The Office for Health Improvement and Disparities (OHID) have attempted to estimate the societal costs associated with gambling related harm. By combining a limited set of measurable harms, including health impacts such as deaths from suicide and increased alcohol dependence, as well as some non-health outcomes, such as homelessness, unemployment and imprisonment, they estimated the total cost as high as £1.77 billion annually for England. They estimated health costs to government alone at £119.5 million (OHID, 2023). These estimates are likely to understate the true costs of gambling related harm, as they only looked at a very limited range of costs.

5.3 Defining gambling harms

Gambling related harm has recently, in the past decade or so, begun to attract more sustained attention from public health professionals, recognising that *'[h]armful gambling is a health inequality and social justice issue'* (LGA, 2018).

The Gambling Commission provides one explanation of the difference between problem gambling and gambling related harm. They define problem gambling as 'gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits', measure using the Problem Gambling Severity Index (PGSI) (Gambling Commission, 2020). They note limitations of 'problem gambling', including that it does not take account of affected others and that 'at-risk' gamblers may in fact be experiencing harms already. Gambling related harms, on the other hand, take into account all the adverse effects caused by gambling. They note that 'current practice of assessing the extent of gambling-related harms by problem gambling prevalence rates can be misleading', potentially underestimating the scale of harms, and that 'we need to move towards a fuller understanding of how people are affected by gambling' (Gambling Commission, 2020).

An attempt has begun to provide a robust definition and taxonomy of what exactly is meant by 'gambling related harm'. In other words, a clear understanding of what these harms are and who they affect, which would allow them to be measured and quantified more easily, as well as the effectiveness of efforts to minimise them.

Gambling related harms are often conflated with problematic gambling behaviour, but following Langham *et al.* (2016), 'harms' is used here to refer to the negative *outcomes* of the behaviour, not to the behaviour itself. Gambling related harms then include the full range of negative effects associated with gambling, and not just those behaviours that are used for diagnosis of addictive disorders. This widens the focus from individuals with a potentially diagnosable condition to also take in affected others, including their family and friends, their communities, and wider society, including even those who work in the gambling industry or those who provide treatment and support to those with gambling problems.

Langham *et al.* (2016) define gambling related harm as:

“Any initial or exacerbated adverse consequence due to an engagement with gambling that leads to a decrement to the health or wellbeing of an individual, family unit, community or population.”

Wardle *et al.* (2018) provide a different, but similarly wide-ranging, definition:

“Gambling-related harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society.

These harms are diverse, affecting resources, relationships and health, and may reflect an interplay between individual, family and community processes. The harmful effects from gambling may be short-lived but can persist, having longer-term and enduring consequences that can exacerbate existing inequalities.”

Harms can be categorised by whom they affect: the person engaging in gambling, an affected other, or the wider community and society as a whole.

Langham *et al.* (2016) also identify 72 different types of harm, categorised into seven broad categories including financial harms; relationship disruption, conflict or breakdown; emotional/psychological distress; decrements to health; cultural harm; reduced performance at work or study; and criminal activity (later work incorporates this into a broader category of social deviance). Browne and Rockloff (2018) found evidence that financial harms were the most common, followed by emotional/psychological harms and then harms to health.

Not all harms are *ipso facto* a cause for public health concern. Most of those who gamble will lose money, and this constitutes a financial harm. A bet within the bounds of what one can afford to lose can also be considered the cost of a leisure activity. However, financial losses that lead to debt and financial insecurity can have significant effects on health.

Not everyone who gambles experiences harm, and some degree of harm may be acceptable, not necessitating a public health response. However, a full accounting of the harms associated with gambling, and the costs they impose on, amongst others, the health and care system and local services, requires taking a comprehensive view of harms.

5.4 Quantifying gambling problems

The most commonly used measure of potentially harmful gambling behaviour is the Problem Gambling Severity Index (PGSI). This is assessed with a nine item checklist, scored by the answers never (0); sometimes (1); most of the time (2); almost always (3). The questions are:

Over the last 12 months,

1. Have you bet more than you could really afford to lose?
2. Have you needed to gamble with larger amounts of money to get the same feeling of excitement?
3. When you gambled, did you go back another day to try to win back the money you lost?
4. Have you borrowed money or sold anything to get money to gamble?
5. Have you felt that you might have a problem with gambling?
6. Has gambling caused you any health problems, including stress or anxiety?
7. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
8. Has your gambling caused any financial problems for you or your household?
9. Have you felt guilty about the way you gamble or what happens when you gamble?

The PGSI score is then translated into four categories. A score of 0 is a non-problem gambler; 1 is low risk; 2-3 is moderate risk; and 4+ is a 'problem gambler'.

There is also a shorter screening version of the PGSI used in some surveys, which uses only three questions (1, 7 and 9), and is scored to produce the four categories. A score of 0 is a non-problem gambler; 1-2 is low risk, or few negative consequences; 3-7 is moderate risk, or some negative consequences; and 8+ is high risk, a 'problem gambler', or one experiencing negative consequences and a possible loss of control.

The PGSI is very widely used and standardised, allowing for comparisons across place and time. However, it has its limitations. Low or moderate 'risk' is arguably a misleading descriptor for groups who may already be experiencing harm, not just be at risk of progression to higher harm categories. It is also not designed to

capture the full range of gambling related harms, which also affect other people apart from just the gambler themselves.

Other forms of screening and classification are used. Some studies use a diagnosis of gambling disorder made by a medical professional.

Another screening test is the Lie/Bet screen, derived from the DSM-IV diagnostic criteria for pathological gambling, and consisting of only two questions:

1. Have you ever felt the need to bet more and more money?
2. Have you ever had to lie to people important to you about how much you gambled?

‘Yes’ to either question is considered a positive result, and suggests a need for an onward referral for further assessment. While this is not sufficient for a diagnosis, and certainly does not include all who might experience gambling related harm, it is a very quick and simple test to identify those who might benefit from support and treatment.

Lancaster University is currently trialling a modified version of the Lie/Bet screening tool in the North West. This expanded version consists of three questions:

1. Have you ever had to lie to people important to you about how much you gambled?
2. Have you ever felt the need to bet more and more money?
3. Has your gambling activity led you to get into debt?

5.5 The role of the gambling industry

Gambling is extremely lucrative, for the industry that provides opportunities to gamble, if not for many of the punters who take advantage of those opportunities. In 2021, the market size of the casino and online gambling industry globally was estimated at a total of \$262 billion (Statista, 2023). Within the UK alone, gambling is a £14 billion industry (Gambling Commission, 2022).

The gambling industry has grown over the past few decades, in the UK and in tandem with a wave of deregulation and economic liberalisation in other wealthy nations (Markham and Young, 2015). In Britain, this can be traced to developments such as the establishment of the National Lottery in 1994 and the

Gambling Act 2005. The reforms of this era were wide-ranging. Gambling products were no longer to be directly taxed at source, as other harmful products like cigarettes and alcoholic drinks were, and restrictions on advertising were also lifted. Coinciding with the advent of smartphones and 24-hour sports coverage, as well as the Fixed Odds Betting Terminal (FOBT), introduced in 1999, these reforms ushered in a new era of gambling, and a huge increase in industry profits (Davies, 2023; Bullough, 2022; Cassidy, 2020).

The gambling landscape in Britain, and in Blackpool, today can be traced to these reforms. As noted by one commentator, these reforms were not prompted by widespread public pressure, but instead largely by the threat of gambling companies moving their profits offshore to Gibraltar (as some since have anyway): the reform 'essentially meant that the British government – concerned by the potential loss of revenue and perhaps seeking to make its concern look more principled – stopped looking at gambling as a public health issue and instead treated it like a leisure activity' (Bullough, 2022).

The 2005 Act is currently under review, resulting in the publication of the Government white paper High Stakes: Gambling Reform for the Digital Age in 2023 (DCMS, 2023). This paper recommends the replacement of the voluntary levy with a mandatory one, alongside stronger affordability checks and stake limits for online casino games, but stops short of some of the restrictions called for by campaigners, especially around advertising and promotion. There is evidence that advertising and marketing influences gambling behaviour, although less high-quality evidence that it contributes to harmful gambling (Beynon *et al.*, 2021a)

A recent analysis of industry responses to government consultations found similarities between the ways the gambling and alcohol industries frame the harms of gambling and alcohol, including arguing that harms are only experienced by a small minority of people and emphasising individual responsibility (the 'responsible gambling' formulation) (Bhuptani *et al.*, 2022).

The United Kingdom takes smoking very seriously as a public health issue. The UK is a signatory to the World Health Organization's Framework Convention on Tobacco Control, the first international treaty formed under the auspices of the WHO (WHO, 2023). The FCTC places requirements on the UK and its other signatories around interaction with the tobacco industry and its representatives, and the UK government has produced guidance on this topic that applies to national government, local authorities, arms-length bodies and anyone acting on behalf of any of these bodies (DHSC, 2023). In effect, all parts of the UK government face stringent restrictions on when and how they can interact with the tobacco

industry. Culturally and politically, it is no longer publicly acceptable for a politician to be seen to be accepting favours or gifts from the representatives of Big Tobacco.

This is not the case with all industries that promote products potentially harmful to health. It is certainly not the case with the gambling industry. In 2021, *The Guardian* newspaper reported that the gambling industry had provided 28 Members of Parliament with £224,281 worth of wages and hospitality in a little over a year (Davies, 2021). In 2023, the BBC reported that the value of hospitality provided to MPs by the gambling industry over the previous year had been at least £51,000 (BBC News, 2023).

The draft guidelines drawn up by the National Institute for Health and Care Excellence (NICE) on the identification, assessment and management of harmful gambling state unequivocally that '[g]ambling treatment services should be commissioned and provided without influence or involvement from the gambling industry' (NICE, 2023). The same must apply to local government strategies for the avoidance of gambling related harm. This is the approach that has been taken in the creation of this strategy.

6. The evidence for harms

Recent years have seen an increased attention paid to gambling related harms, and so a number of evidence reviews have been recently published, including one by Public Health England (PHE) in 2021, and several by the NHS in 2023 to inform provision of services. The evidence below is a very brief summary, drawing on those reviews and others.

The PHE evidence review took a systematic and rigorous approach to the evidence for gambling related harm in multiple domains. In this review, as with much other research in this area, causality is very hard to establish. With financial harms, for example, it can be possible that an association between gambling and debt may be in part due to individuals gambling as an attempt to pay off debt, as well as debt caused by gambling. Similarly, an association between gambling and depression could reflect, gambling affecting mood, depression prompting gambling behaviour, or both resulting from a third factor, such as financial problems.

Evidence in this area is a mix of quantitative and qualitative evidence. In many cases, but not all, there is limited robust quantitative data on harms, and more qualitative studies which are suggestive of harm, but cannot give information on how widespread or severe the harms they identify are. Most evidence relates to direct effects on gamblers themselves, some qualitative evidence relates to friends and family, and very little looks at the wider costs to society.

While more research is needed into gambling related harms, the current state of evidence is sufficient to indicate the presence of significant harm, and justify efforts to moderate these. Bhuptani *et al.* (2022) found that the gambling industry uses the apparent lack of conclusive evidence to argue against regulation and harm prevention measures.

PHE found evidence of harm in multiple domains: financial harms; relationship disruption, conflict or breakdown; mental and physical health; employment and education; criminal and anti-social behaviour; and cultural harms (Beynon *et al.*, 2021b). One study attempted to estimate overall harm from gambling and found that among gamblers aged 23 to 75, only 25% reported no harm, and 27.5% reported significant harm (Beynon *et al.*, 2021b).

6.1 Financial harms

PHE found evidence of financial harms affecting gamblers, their close associates and wider society, as well as legacy effects on the children of gamblers. There was also evidence that higher numbers of electronic gaming machines in an area led to more bankruptcies (Beynon *et al.*, 2021b). Half of affected others in Britain reported some negative financial impacts from another's gambling (Gosschalk *et al.*, 2023).

It should be noted that financial harms can lead on to other harms. Gambling related debt is an important driver of harm, including mental and physical health harms (Beynon *et al.*, 2021b). Gamblers may use credit cards to pay off other cards, seek payday loans at high interest rates, lack the money for basic expenses, and at the most extreme end, face bankruptcy, eviction and homelessness. These can then impact on physical and mental health for gamblers and their families.

A recent paper by Muggleton *et al.* (2021) used a large dataset of financial transactions, covering over 10% of the UK population, to look at gambling transactions and their relation to a range of financial and non-financial outcomes. As noted above, they found evidence of severe harms increasing sharply among the highest-spending gamblers, but also evidence of harm accruing to those gambling at lower levels. In terms of financial harm, they found that higher rates of gambling was associated with higher risks of using an overdraft; missing a credit card, loan or mortgage payment; taking a payday loan; or interacting with a bailiff.

6.2 Mental and physical health harms

There is evidence linking gambling with mental health disorders, alcohol, tobacco and drug use, although the direction of causality and the exact nature of the relationship is unclear (Beynon *et al.*, 2021b). Causation is particularly hard to prove in this domain of harm.

One large cohort study in Sweden found evidence of increased mortality associated with a diagnosis of gambling disorder. For men aged between 20 and 49, mortality was 4.6 times higher than in those without a diagnosis, and for women 10.5 times higher. For all in this age group, the risk of death by suicide was 19.3 times greater for those with a diagnosis of gambling disorder compared to those without (Karlsson and Håkansson, 2018).

Other evidence also supports elevated risk of suicide among gamblers (Beynon *et al.*, 2021b). In England, problem gambling has been shown to be associated with suicidality in adults and young people, even controlling for common mental health problems (Wardle *et al.*, 2020; Wardle and McManus, 2021). There

is evidence that financial difficulties are an important mediating factor in gambling related suicides (Andreeva, Audette-Chapdelaine and Brodeur, 2022)

Qualitative evidence suggested associations between gambling and a range of health harms for gamblers and their close associates, including stress; anxiety; depression; sleep problems; lack of self-care; and isolation. Cross-sectional studies reported a significant positive association between mental health harms and gambling severity in both adults and younger people (Beynon *et al.*, 2021b).

Muggleton *et al.* (2021) used financial data to provide evidence of health harms. Those who spent more money on gambling were found to spend less on self-care and fitness activities, social activities, hobbies and education. This may suggest at least one mechanism by which financial harms translate into other domains. In addition they found that gamblers were more likely to spend at night, linking to reported sleep problems. Higher gambling spend was also associated with a higher risk of future unemployment and future physical disability, as well as higher all-cause mortality at high rates of gambling.

Several studies suggest that at-risk or problem gambling in early adulthood was associated with a higher risk of developing alcohol dependence, suggesting that intervention to prevent gambling problems in younger people may reduce alcohol issues later in life (Beynon *et al.*, 2021b).

6.3 Relationship harms

Evidence shows that gambling causes relationship problems, affecting gamblers and their close associates, including children. Moderate risk and problem gambling were found to predict lower levels of family functioning and social support, and qualitative studies reported conflicts, abuse and relationship strain related to gambling, often with long-lasting and inter-generational impacts, and frequently connected to financial losses and debt (Beynon *et al.*, 2021b). One survey found that 78% of affected others felt that the gambling problem of someone else had affected a relationship (Gosschalk *et al.*, 2023). These harms had a 'ripple' effect on communities and society at large.

The evidence around gambling and domestic violence is inconclusive, suggestive of a relationship, the exact nature of which is unclear. Problem gambling may be part of a range of risk factors for both perpetration and victimisation, alongside others including mental health and substance misuse problems (Beynon *et al.*, 2021b).

6.4 Employment and education harms

There is very little robust evidence in this area. Some qualitative work is suggestive of the impact of gambling on work and educational performance (Beynon *et al.*, 2021b).

6.5 Criminal and anti-social behaviour

Quantitative studies reviewed by PHE showed no evidence that gambling predicted crime or anti-social behaviour. However, qualitative evidence is suggestive that much gambling related crime may be acquisitive and target family members, who may be reluctant to report it (Beynon *et al.*, 2021b). Gambling related crime is likely to be directly related to gambling related debt, which is a mediating factor in many gambling related harms. Research relying on self-reporting is likely to underestimate levels of criminality and anti-social behaviour.

Cassidy (2020) found evidence of widespread violence in betting shops, directed against staff and patrons, which managers unanimously agreed increased since the introduction of FOBTs. She also found evidence to suggest that staff were encouraged not to report incidents, to protect the reputation of the company or the industry as a whole.

A survey carried out in 2012 by the Community union found that 10% of betting shop staff had been physically assaulted in the preceding 12 months, and 50% had been threatened (Evans, 2014). In surveys carried out in 2022 by the Affinity union, 90% of staff had witnessed violence or threats of violence by customers and 75% reported that they or other staff had been threatened with assault after they left work (Affinity, 2023).

Adeniyi, Tura and Newton (2023) found evidence that the number of betting shops in an area correlates with higher crime, particularly theft and disorder offences, even controlling for deprivation and other predictors of crime.

6.6 Cultural harms

Cultural harms result from the disruptive effects of gambling on cultural beliefs, practices and community cohesion. It is likely that the particular approaches to and norms around gambling in certain cultures will affect its impacts and the propensity and ability of those affected to seek help (Beynon *et al.*, 2021b).

6.7 Inequalities

The social gradient in health refers to the fact that a large number of health outcomes, from life expectancy to the prevalence of specific diseases, get worse as at lower levels of socioeconomic status (Marmot, 2004; Marmot *et al.*, 2020).

There is evidence from the UK and internationally that supports the idea of a social gradient in gambling related harm (Orford *et al.*, 2010; Castrén *et al.*, 2018; Henkel and Zemlin, 2016; Tu, Gray and Walton, 2014; Rintoul *et al.*, 2013).

There is qualitative evidence suggesting that gambling may exacerbate pre-existing health inequalities (Beynon *et al.*, 2021b).

6.8 Risk factors

There is some evidence that particular groups are at greater risk of gambling related harm: men; young people; people with co-existing substance misuse problems; people with poorer mental health; those in deprived areas; those with lower incomes; those with lower educational attainment; the unemployed and members of some ethnic minority groups (Wardle, 2015; Abbott, 2020a).

A PHE review with more stringent standards failed to find conclusive evidence for many of these risk factors, or others, although there was some evidence of an association between deprivation and gambling. They did conclude with high confidence that risk factors for harmful gambling in children and young people included impulsivity; substance use including alcohol and tobacco; being male and having depression (Beynon *et al.*, 2021a).

One large survey found that British people from an ethnic minority background are twice as likely to be gambling at a high risk level (PGSI 8+) or be an affected other than White respondents (Gosschalk *et al.*, 2023).

Gosschalk *et al.* (2023) found less evidence of a link between area deprivation and total gambling participation, although there was evidence of greater participation in some of the more harmful activities in more deprived areas, including three times the rate of using FOBTs in bookmakers in the most deprived third compared with the least deprived (Gosschalk *et al.*, 2023). Scratch cards, fruit or slot machines, bingo, casino gambling and online casino games were all more common in more deprived areas.

Younger people are at greater risk of harmful gambling: in one survey 14% of 18-24 year olds were classified as problem gamblers (PGSI 8+) and/or an affected other, compared to only 5% of over 65s (Gosschalk *et al.*, 2023). Early exposure to gambling was associated with a higher risk of being a problem gambler. PHE, however, failed to find conclusive evidence that age of starting gambling was a risk factor for problem gambling in young people (Beynon *et al.*, 2021a).

While the average age to begin gambling in Britain is 19, 16% of gamblers began when they were between 12 and 17, and 6% under the age of 11. Early exposure to gambling is both common (59% of respondents to one survey were exposed to gambling before turning 18) and associated with increased risk of gambling harm later in life: 64% of problem gamblers (PGSI 8+) knew someone who gambled regularly before they turned 18, higher than those in lower risk groups (Gosschalk *et al.*, 2023).

The age of first exposure to gambling seems to be falling over time: 45% of under 25s were first exposed to gambling under the age of 12, compared with 34% of 35-54 year olds and 26% of over 55s, with an apparent matching trend of people beginning to gamble at younger ages (Gosschalk *et al.*, 2023).

The evidence indicates that more men gamble than women, and that more men subsequently have problems with gambling. However, there is some evidence that the gap in gambling participation is narrowing (IFF Research, 2023).

6.9 Types of gambling

There is evidence that some gambling products are more associated with harm and with problem gambling behaviour than others. The most common form of gambling participation in Britain is probably the National Lottery, in which about 44% of Britons take part, although this may not include minor activities than many would barely consider gambling, such as local raffles (Gosschalk *et al.*, 2023; Cassidy, 2020). These activities are not strongly associated with harm, although they may play a part in the social normalisation of gambling.

Electronic Gaming Machines (EGM, including FOBT) are designed to maximise return, optimising factors such as time between bets, bonus spins, apparent near misses and losses disguised as wins (when gamblers receive a payout less than the amount staked) (Cassidy, 2020; Livingstone *et al.*, 2019). These factors may increase the risk of harmful gambling behaviour.

One study in Wales found that engagement with FOBTs in Licensed Gambling Outlets and online sports betting were significant predictors of problem gambling behaviour (John *et al.*, 2020). There is evidence from Australia that increasing the density of EGMs correlates with increasing prevalence of problem gambling (Storer, Abbott and Stubbs, 2009).

The Health Survey for England 2018, the last to break down its analysis by type of gambling activity, found a range of rates of problem gambling, from 0.9% among players of the National Lottery, to over 10% for particular forms of betting including dog races and betting exchanges, all the way to 12.7% for machines in a bookmakers (i.e. FOBTs) (NHS Digital, 2019a). This could mean simply that these forms of betting are more popular with problem gamblers, but it could also indicate higher addictive potential for some products, as suggested by other evidence.

Philander and MacKay (2014) note that those who gamble online have consistently been found to report more disordered gambling behaviour, but their research suggests that this is not a causal relationship. In other words, people who gamble in ways that are harmful may be more likely to gamble online, but it is not online gambling that causes these behaviours. In fact, they suggest a protective effect from gambling online as opposed to offline. This underscores the complexity of ascribing causation around these risk factors.

6.10 Stigma

Stigma is an important part of gambling related harm. Those with gambling problems experience a high level of social stigma, which can have deleterious effects on their mental health, and act as a barrier to recognising and admitting those problems, and to seeking help and support. 48% of Britons gambling at an elevated level (PGSI 8+) reported feeling embarrassed or ashamed all or most of the time. Even among lower risk categories, 31% of any risk gamblers (PGSI 1+) reported feeling embarrassed or ashamed at some time, and 17% all or most of the time (Gosschalk *et al.*, 2023). When providing support for those with gambling problems, and raising awareness of gambling related harms, care must be taken to avoid reinforcing stigma. This necessitates care with language and framing.

Qualitative evidence suggest that extensive gambling advertising, and the associated normalisation of gambling, leads to a reduced perception of harmfulness by the public. This then reduces sympathy for those experiencing gambling problems, in comparison to the more medicalised perception of alcohol or drug addictions (Gosschalk *et al.*, 2023).

6.11 Children and young people

The impact of gambling harms on young people is also an area of growing public health concern. The protection of children from gambling related harm has been identified as a priority by the government (DCMS, 2023). In 2019 the Royal Society of Public Health published a report into the relationship between gambling and the health and wellbeing of young people. They found that young people felt that gambling was increasingly a normalised part of their lives, and had become highly linked with both sports and gaming, with damaging effects. In particular, gaming has introduced new forms of gambling activity, like loot boxes and skin betting (RSPH, 2019).

In 2023, 26% of 11 to 17 year olds spent their own money on gambling, most commonly on legal unrestricted forms of gambling like arcade games (19%), bets between friends and family (11%) and playing cards with friends and family (5%). An estimated 0.7% of 11 to 17 year olds are already problem gamblers according to a specialised youth gambling screen, with 1.5% classed as at risk and 23% as non-problem gamblers (Gambling Commission, 2023). This is in addition to the harms experienced by children and young people as affected others when parents or family members gamble.

Young people are exposed to high levels of gambling advertising. In one study, only 4% of 11-24 year olds reported having no exposure to gambling marketing in the preceding month (Ipsos Mori, 2020). Current regulation is intended to ensure that advertising does not appeal to children or young people, for example by including celebrities or sportspeople with a particular appeal to children, or references to youth culture (Woodhouse, 2024). Sporting figures, however, remain a frequent presence in gambling advertising and marketing materials.

6.12 The prevention paradox

The prevention paradox, also known as the Rose paradox, is a well-recognised phenomenon in Public Health, which has been applied to a wide range of risks to health. Essentially, this states that, even though

a small number of people in the population may be at high risk of harm from a particular health risk, the greater total harm across the entire population is actually found amongst those judged to be at low or medium risk. This is because those at low or medium risk make up a much greater proportion of the total population. This means that efforts to prevent harm can be much more effective when applied to the whole population rather than being highly targeted.

One example could be some forms of cancer screening. If we were to look for cancers in the small high-risk population, we would find a higher likelihood of cancer than in the general population. However, by screening the entire population, we would find more cancers in total among the larger low and medium risk groups, and therefore prevent more harm.

Whether the prevention paradox applies to gambling related harm is a matter of some controversy and debate. The question is whether the majority of harm across society is felt by a relatively small group of problem gamblers, or whether the greater burden is in the larger category of those engaging in gambling but not categorised in the highest-risk category. The term 'risk' is somewhat misleading here, as low- and medium-risk gamblers may not just be at 'risk' of harm, but actually experiencing harms, albeit likely at a lower severity than high-risk or problem gamblers.

There are reasons to doubt the applicability of the prevention paradox to gambling. There is evidence that, in some areas at least, the gambling industry relies on a small group of heavy gamblers rather than lower levels of gambling across the population. One study suggested that 86% of the gross gambling yield (the total wagered minus the winnings paid back) in the online gambling market in Great Britain came from just 5% of accounts (Forrest and McHale, 2021). Muggleton *et al.* (2021) looked at financial transactions for a large cohort (over 10% of the UK population) and found a highly skewed distribution, with the top 10% of gamblers spending close to 8% of their total spending on gambling.

Orford, Wardle and Griffiths (2013) estimated the proportion of revenue coming from problem gamblers for different types of gambling in the UK. While the National Lottery came in at only 1.5% and Bingo 4.2%, other forms of gambling derived a much greater proportion of their revenue from problem gamblers: 22.9% for FOBTs and 27.2% for dog racing.

Delfabbro and King (2017) examined some earlier claims that the prevention paradox did apply to gambling, and suggested that these findings were the result of inconsistent classification of gambling behaviours and too broad a definition of harms. Browne and Rockloff (2018) looked again at this issue, using the standardised PGSI ranking, and found mixed results. To some extent, whether the prevention

paradox applies is dependent on which harms are considered significant. Nevertheless, they did find evidence of the prevention paradox for some non-trivial harms, particularly within the category of financial harms, such as increased credit card debt, late bill payments and selling personal items to fund gambling (Browne and Rockloff, 2018). However, it does not apply to some of the least frequent, but most severe, harms such as bankruptcy, self-harm and attempted suicide.

Muggleton *et al.* (2021) found evidence that the risk of some severe harms, like unemployment and mortality, increased sharply for highest-spending gamblers, but also that increasing gambling was associated with increasing harms even at lower levels of gambling, and that individuals could rapidly transition between levels.

Recognising this issue, Public Health England's systematic review of the evidence (Beynon *et al.*, 2021b) reached the following conclusion:

'The cross-sectional evidence suggests that people with the highest gambling severity experience the greatest degree of harm. But this does not mean that people gambling at low severity experience no harm. Like other health risk behaviours such as alcohol use, gambling is likely to follow a gradient with different levels of harm associated with different levels of gambling severity. So, an entire population approach to move the distribution of risks and harms seems appropriate.'

This conclusion suggests that efforts to reduce harm should recognise those gamblers at high risk of the most severe harms, but cannot afford to ignore completely other gamblers who may appear at lower immediate risk.

The other implication of the finding that a minority of gamblers provide a disproportionate amount of gambling revenue, particularly for some forms of gambling, is that it demonstrates why the gambling industry may not be seriously motivated to reduce problem gambling. Their business model, especially for FOBTs and similar, relies on those few individuals who spend large sums of money, who are more likely to be those with a gambling problem.

7. What works

7.1 Treatment

As this strategy is concentrating on public health and local government interventions, treatment for individuals diagnosed with a gambling disorder lies largely outside its scope. NICE have recently completed a number of evidence reviews of pharmacological, psychological and other interventions to inform NHS guidelines, which are currently still in draft.

GREO (Gambling Research Exchange Ontario) released a report outlining the evidence for effective treatment and support for problem gambling in 2020. This concluded that Cognitive Behavioural Therapy (CBT) was the most effective treatment, although, given problems with low uptake and high dropout, the evidence also supports the provision of alternative treatment modalities including motivational interventions, helplines, and remote and self-help interventions (Kalbfleisch *et al.*, 2020). A recent review by Higuera-Ahijado *et al.* (2023) also concluded that CBT was an effective approach to improving the quality of life of people with gambling problems.

Affected others are also in need of support and may benefit from therapeutic intervention. A recent review found little evidence of effectiveness for psychosocial approaches, both those involving the affected other alone, and those including the person with a gambling problem as well (Vassallo, DeGiovanni and Montgomery, 2023). The authors were able to recommend the provision of a range of possible interventions, given that affected others showed variable preferences; the inclusion of financial advice and support in interventions; and increased training for those delivering interventions. Support for affected others is another area requiring much more research.

7.2 Accessing help and screening

Accessing support is rare among 'lower-risk' gamblers, who may nevertheless be experiencing harms. In Britain, 95% of low risk gamblers (PGSI 1-2) and 83% of moderate risk (PGSI 3-7) have not used any form of advice, support or treatment to reduce their gambling over the preceding 12 months, falling to 34% of those classified as high risk (PGSI 8+) (Gosschalk *et al.*, 2023). When a third of even the highest risk group are not accessing any form of advice or support, this suggests a level of unmet need. In this group, 59% had attempted to stop or reduce their gambling over the preceding year, with 87% experiencing a relapse (Gosschalk *et al.*, 2023).

There is evidence that a proportion of individuals with gambling problems, around one third, achieve recovery without psychological treatment, previously referred to as spontaneous or natural recovery. However, there is evidence that these individuals actually make use of a wide range of self-help strategies, many of which may also be useful for those experiencing lower levels of gambling harm (Rodda *et al.*, 2018). The most frequently used strategies are cognitive techniques, including *remind yourself of negative consequences of gambling; think about how money could be better spent; remind yourself that sometimes people win at gambling but the system is designed for you to lose; remind yourself of positive consequences of not gambling; and compare the costs and benefits of continuing to gamble.*

The most common motivating factor identified by gamblers that might lead them to seek support is the knowledge that support is available via a particular channel (i.e. telephone, online or in person) (Gosschalk *et al.*, 2023). This underscores the importance of ensuring a range of types of support, available through different channels. Other important factors included awareness of availability, ease and cost of access, and confidentiality.

A systematic review by Blank *et al.* (2021b) looked at the evidence for screening for gambling related harms in health and care settings, including healthcare, addiction services and social care. Broadly, this review concluded that SBIRT (screening, brief interventions and referral to treatment) approaches are feasible and acceptable in a range of settings and should be further explored, alongside effective evaluation. It is crucial, as with all screening, that appropriate treatment is available for those identified as in need or at risk, and that those doing the screening are aware of referral pathways and able to access them. The authors note that in a study by Roberts *et al.* (2019), only 35% of GPs were able to identify a recognised gambling treatment provider.

One New Zealand study exploring the feasibility of an SBIRT approach to gambling problems found that the most common barriers were clinicians being unaware of screening tools and having a perception that service users would not want to be screened (Park *et al.*, 2023). This suggests that improving early identification of gambling problems requires service providers to be confident in the use of screening tools, and normalising broaching the topic as is currently the case with smoking and alcohol.

It has been noted, both in national research and in interviews with local stakeholders, that service providers may be reluctant to probe possible gambling related issues if they do not feel qualified or informed to offer further support or signposting if problems are identified. Not only does this prevent individuals accessing appropriate support, it contributes to a vicious cycle obscuring the reality of gambling

related harm. If fewer people in need of support are identified, then prevalence is underestimated, as is the need for specialist service provision and training for wider service providers, leading to a perpetuation of the problem (John *et al.*, 2020).

7.3 Prevention and harm minimisation

There is a lot less known than we would like about what works to reduce and eliminate gambling related harm. In particular, there is little good quality scientific evidence on the effectiveness and cost-effectiveness of population-level interventions to minimise harm. Recent systematic reviews, and umbrella reviews of systematic reviews, have concluded that much of the primary research is of low quality, prone to bias, and difficult to synthesise into a robust evidence base (Akçayır, Nicoll and Baxter, 2023; McMahon *et al.*, 2019; Forsström *et al.*, 2021; Fiskaali *et al.*, 2023; Rodda, 2022).

Recent reviews of government and industry strategies to mitigate gambling related harm have concluded that the evidence base is generally weak, and that the most commonly implemented interventions are among the least effective (Abbott, 2020b). A recent Lancet review reached a similar conclusion, that evidence for interventions was lacking in some key areas, particularly effective screening and support after treatment, noting the frequency of relapse, while concluding that it is ‘**imperative to ensure that a scarcity of evidence is not used as a justification for inaction in addressing the growing burden of gambling-related harms**’ (Blank *et al.*, 2021a). It is a recognised industry tactic to emphasise the lack of evidence in some areas, while pushing for measures that evidence suggests are ineffective.

It should be noted that, while the evidence for many interventions is weak or non-existent, this is not evidence that these approaches do not work, but merely that there has not been enough good quality research into what works. Williams, West and Simpson (2012) noted that most harm reduction approaches have not been based on scientific evidence of what works, but brought in haphazardly on the basis of what was being done elsewhere or simply ‘seemed a good idea at the time’. Many researchers note that forming conclusions about what works is made more difficult by the fact that studies are often very different from each other in terms of intervention, setting, target population and outcome measure (Fiskaali *et al.*, 2023; Bijker *et al.*, 2023; Forsström *et al.*, 2021).

This underscores the importance of any interventions being brought in also being subjected to proper evaluation, and, if possible, forming part of the scientific evidence base through collaboration with an academic partner. It is not a reason to do nothing in the face of demonstrable harm.

Harm minimisation strategies have been divided into supply reduction, demand reduction and harm reduction approaches. Supply reduction is about reducing the availability of gambling opportunities, either in general or relating to the supply of particularly harmful gambling products. Demand reduction refers to strategies to reduce desire and intention to gamble in the population, and prevent or reduce initiation of problematic gambling behaviour. This includes educational programmes aimed at informing the public around gambling and its related harms. Harm reduction aims at reducing the harmful impact that result from gambling, and includes consumer protection measures, commonly brought in by the gambling industry itself.

McMahon *et al.* (2019) note that the evidence base for harm minimisation is dominated by harm reduction interventions rather than demand or supply reduction. The authors relate this to the well-known public health phenomenon of the ‘inverse evidence law’, whereby there tends to be least evidence around interventions that are most likely to be effective. In the case of gambling, focussing on individual behaviour change rather than regulation and policy, where impact is likely to be greatest.

In the UK, and other jurisdictions, the government’s priorities are divided between reducing gambling related harm and encouraging the growth of the sector and its contribution to the national economy. This results in a reluctance to reduce overall levels of gambling, but instead to focus on gambling harm as a consumer protection issue, a matter of individual responsibility, and a concern for a small minority of pathologized ‘gambling addicts’. Thus research tends to share this focus on individual-level harm reduction interventions.

Demonstrating the effectiveness of some measures may be difficult, as pointed out by Forsström *et al.* (2021), because successful interventions may not reduce measures of gambling such as expenditure or time spent, but may halt or slow a progression in gambling behaviour. In other words, without the intervention, the individual may have gone on to gamble more than they were previously, so holding at the same level represents a success. This is much harder to demonstrate conclusively.

There is a lack of research on what interventions might be more or less effective for different sociodemographic groups, and on the equity impacts of different interventions (McMahon *et al.*, 2019). To reduce inequality, both targeted and population-wide approaches are necessary.

Supply reduction

There is some limited evidence for supply-side interventions, affecting the availability and accessibility of gambling products.

A review from Australia has suggested that there is support for supply-side interventions such as reducing the number of machines in a venue, the removal of cash machines from gambling premises, capping maximum stakes and limiting opening hours (Livingstone *et al.*, 2019). Another review similarly noted preliminary support for reduced opening hours; smoking bans; removal of large note acceptors; maximum bets and removal of cash machines/ATMs (McMahon *et al.*, 2019).

Demand reduction

There is some evidence suggestive of a beneficial impact for workshops and education interventions to improve gambling knowledge and attitudes among young people, at least in the short term (Blank *et al.*, 2021a). A review by Akçayır, Nicoll and Baxter (2023) found that many researchers suggest educational campaigns and initiatives around awareness, risks and the strategies and tactics of the industry. Despite this, there is a notable lack of good quality research studying school-based education programmes. Forsström *et al.* (2021) note that, while the evidence for educational programmes is generally weak, there is slightly better evidence for longer-term programmes, i.e. more than a single session. This may explain why McMahon *et al.* (2019) found mixed results for youth prevention programmes, which varied in content, duration and approach.

Some educational programmes aimed at young people have been criticised for their framing of gambling related issues, with accusations that they fail to challenge the view of gambling as a mostly safe consumer product and keep the focus solely on personal responsibility, in keeping with industry strategies (van Schalkwyk, Hawkins and Petticrew, 2022).

A largely US-based review by Grande-Gosende *et al.* (2020) concluded that there are generally good results from gambling prevention programmes on frequency and severity of gambling in university student populations. However, extrapolating from these populations to other groups must be cautious. The authors also noted that the majority of programmes lack either a clear theoretical basis or a robust evaluation.

Evidence suggests that restrictions on gambling advertising would contribute to reducing harm, particularly among young people and those already at risk of harm from their gambling behaviour (McGrane *et al.*, 2023; Akçayır, Nicoll and Baxter, 2023).

Harm reduction

There is evidence to support limited benefits of pre-commitment, limit-setting and self-exclusion schemes for gamblers, although the variation in these schemes may determine their effectiveness (Blank *et al.*, 2021a; Livingstone *et al.*, 2019; McMahon *et al.*, 2019). Even though the majority of players at some point break the self-exclusion, there is still evidence of positive psychological, financial and social impacts (Škařupová, Vlach and Mravčík, 2020). Some have raised concerns about possible negative unintended consequences, whereby those individuals with problematic gambling behaviour were most likely to set higher limits and to exceed them, potentially increasing total expenditure (McMahon *et al.*, 2019).

A systematic review by Motka *et al.* (2018) examined the characteristics of people who use self-exclusion. The authors noted significant differences in the characteristics and motivations of those gambling online and offline, and suggested that self-exclusion schemes and their promotion should be tailored toward specific groups. They conclude that self-exclusion has largely been used as a harm minimisation technique for those already gambling at a dangerous level, and suggest that it has the potential to be used for early intervention that has not yet been explored, in keeping with the findings of Bijker *et al.* (2023) that self-exclusion was most commonly used by individuals at the higher end of the risk spectrum, with low overall uptake. Motka *et al.* (2018) suggest that barriers to self-exclusion need to be addressed, including simplifying the process so that one process excludes from multiple venues, and ensuring that venue staff are properly trained. The authors also state that self-exclusion programmes need to be linked to treatment programmes to maximise their potential to effect lasting change.

There is support for pop-up messages on EGMs, particularly high-threat messages supported by medical or other authorities, or messages that are personally tailored to the gambler, such as session length reminders (Blank *et al.*, 2021a; Livingstone *et al.*, 2019; Škařupová, Vlach and Mravčík, 2020; McMahon *et al.*, 2019).

Personalised feedback interventions (PFI) change behaviour by highlighting incorrect beliefs held by an individual about normative behaviour in their peer group, for example how much their peer group spend on gambling on average. There is again some limited preliminary support for this approach (McMahon *et al.*, 2019; Forsström *et al.*, 2021). However, some have warned of a potential ‘boomerang’ effect if the normative beliefs of the individual actually err in the wrong direction – for example thinking that their peer group gamble less than they actually do – resulting in information validating that individual’s gambling behaviour.

There is also some evidence as to what does not work. A randomised online trial by Newall *et al.* (2022) found no evidence that the ‘when the fun stops, stop’ gambling message had any protective effect on gambling behaviour whether on sporting events or casino games. This message has previously been criticised for prominently foregrounding the word ‘fun’. There is no evidence for beneficial effects from these kinds of messages, which are often supported by the gambling industry and taken as an indication that they take problem gambling and harms seriously. According to one review, the provision of static information, such as leaflets and pop-up messages ‘serves more as a demonstration of a good will of gambling operators rather than [an] effective prevention strategy’ (Škařupová, Vlach and Mravčík, 2020). Similarly, relying on identification of problematic gambling behaviours and subsequent intervention by gambling venue employees is unlikely to be effective, as this is rare in practice, and personnel often report a lack of confidence, relevant skills, and clarity on responsibilities (Škařupová, Vlach and Mravčík, 2020).

Online

A recent systematic review of internet-delivered interventions for prevention and harm reduction found only a small and relatively inconclusive evidence base, and a significant proportion of that dependent on industry funding (Rodda, 2022). However, this remains a significant area for future research. Another systematic review found no conclusive evidence for the effectiveness of any of a range of preventative and harm reduction interventions for online gambling, noting that the studies reviewed were heterogenous in terms of intervention, setting, target population and outcome measure, making conclusions difficult (Fiskaali *et al.*, 2023).

8. Gambling in Blackpool

Blackpool's economy has been dependent on tourism since the Victorian era, and gambling, of various sorts, has long formed a part of the experience for tourists visiting the waterfront. Blackpool is also, by several measures, the most deprived local authority in England, putting its residents at particular risk of gambling related harm. Gambling is hard to avoid in Blackpool – to even access some of the piers, you are forced to walk through gaming areas.

It is difficult to know the size of the gambling industry in Blackpool. In 2022/23, there were ten gambling businesses registered in Blackpool, each of which employed fewer than ten people. A further twenty businesses are classed as amusements/recreation, of which fifteen employ fewer than ten people and five employ somewhere between ten and 49 people. This does not include national chains with locations in Blackpool. What is evident is that the industry provide jobs and business rates in Blackpool, although, much like the harms, this is difficult to quantify.

In preparing this document, visits were paid to Blackpool's amusement arcades. In these venues, attractions and games for children sit share premises with adult gambling machines and casino games. Although these are separated, as required by law, in reality the distance between is not great. Within the children's area you can find 'Category D' machines, including low-stakes fruit machines, with '18-plus' stickers on them. Often these machines have the same brightly-coloured cartoon images on them as the games aimed explicitly at children, and, in fact, so do the adult machines in the walled-off area.

At one family entertainment centre, you can trace the progression in only a few paces. Just by one door was a mechanical plane where a toddler could sit alongside Daffy Duck, and for 50p be rocked up and down. From there, a child could progress to coin pusher games, branded with the Minions, and then perhaps the low-stakes 'Category D' fruit machine in bright colours with a sign reading 'Over the Rainbow'. From there, it would be only a few steps more and across a waist-level wall to the adult electronic games, with higher stakes, topped with a brightly beaming Leprechaun. All this is within less than a twenty foot radius - only a few steps, even for a child.

While visiting these amusement centres as children can be a cherished memory for many, there is evidence that those who go on to develop gambling problems began with just these experiences of spending time with family participating in gambling activities (Gosschalk *et al.*, 2023).

At several of Blackpool's family entertainment centres, information was available for those experiencing problems with gambling. Some ATMs had stickers on them, to target those withdrawing more cash, as did

some of the gambling machines, although in many places these had been scratched off. In some, leaflets are available, always those produced by the industry body BACTA. The photograph below shows the top of the inside page of this leaflet, in which the first line reads, 'Gambling is a fun and exciting form of entertainment, which provides an enjoyable experience'. Whether this is necessary information for those seeking help can be left for the reader to judge.

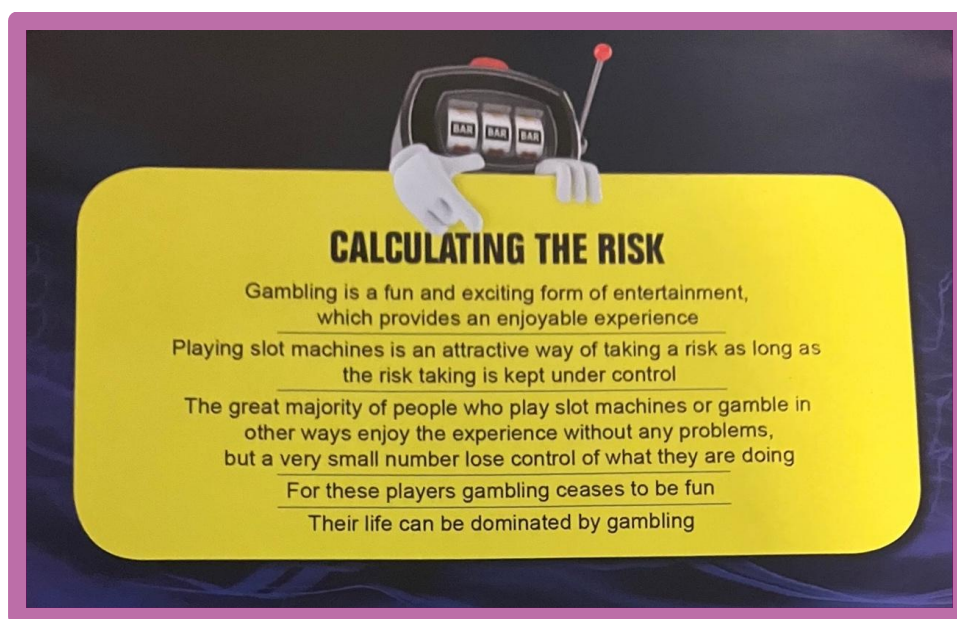


Figure 1: Bacta leaflet

8.1 Local data

There is little direct evidence as to the scale of gambling related harms in Blackpool. Services including General Practitioners, other NHS services and Adult and Children's Social Services do not routinely screen for issues with gambling.

In preparation of this strategy, meetings were held with various stakeholders providing services to those experiencing issues with gambling in Blackpool. The Northern Gambling Service were unable to provide data reflecting the level of demand for their service originating in Blackpool, noting that awareness of their services may be low.

Blackpool Citizens Advice Bureau provided an estimate that one quarter of their clients approaching with debt problems report some element of gambling expenditure. This is not to suggest that their debt is

wholly or primarily related to gambling, but it might be suggested that those with serious debt problems can ill afford any gambling spending. They also report that they saw a 28% increase in gambling related harm for under-25s in 2022; and that they saw twice the number of adults with gambling-related debts in 2022 as they did in 2019.

GambleAware have produced some estimates for Blackpool, based on statistical extrapolation from national data, taking into account demographic features of Blackpool, including levels of deprivation and other factors associated with problem gambling. This data uses the PGSI classification, whereby scores of 1-2 are defined as low-risk gamblers, 3-7 as moderate risk and 8+ as 'problem gamblers'. As noted above, this is a clinical tool and not an estimate of the full scale of gambling related harm.

GambleAware estimates that levels of low-risk (7.9%) and moderate-risk (3.4%) gambling in Blackpool are both higher than the national average (7.5% and 3.0% respectively), while levels of problem gambling (2.8%) are broadly in line with the national average (2.9%). They further estimate that a notably higher proportion of problem gamblers are accessing treatment, but lower levels of low and moderate risk gamblers are doing so, compared to the national average, and that demand for support, treatment or advice in Blackpool is generally lower (GambleAware, 2023).

GambleAware have also estimated some gambling related costs for Blackpool. These are six specific costs, and do not constitute the full burden of gambling related harm. They are the annual costs of gambling-associated: mental health consultations; hospital inpatient stays; police call-outs; court appearances; homelessness support; and Universal Credit. They estimate a total cost to Blackpool of over £2.7 million, £1.63 on Universal Credit alone. The two immediate health costs are estimated at over £955,000, and homelessness support, borne by the council, at £33,664 per year (GambleAware, 2023).

In addition, some data has been provided on callers to the National Gambling Helpline from Blackpool between April 2022 and March 2023. This includes only a small number of distinct callers identified as being from Blackpool, so conclusions must be very limited. Two thirds of the callers were men, and they most commonly reported problems with anxiety/stress, followed by depression/low mood, financial difficulties and family/relationship difficulties.

Specific gambling activities mentioned were most commonly casino slot machines and other gambling machines, and while the most common single location disclosed was online, this was in total less than the combined physical locations of bookmakers, adult entertainment centres and casinos. While users of online gambling may be more likely to seek help online rather than use a telephone hotline, it is still

suggestive that a significant proportion of harmful gambling still takes place in brick-and-mortar establishments, as well as online. This may be important for a Council strategy, as the Council’s licensing and planning powers are greater for physical locations.

8.2 Mapping gambling in Blackpool

The maps below show the locations of gambling premises within Blackpool.

Figure 2 shows gambling premises by type overlaid on a map of Blackpool’s wards. In particular, it is easy to see the concentration of adult and family entertainment/gambling centres, as well as bingo halls, along the seafront.

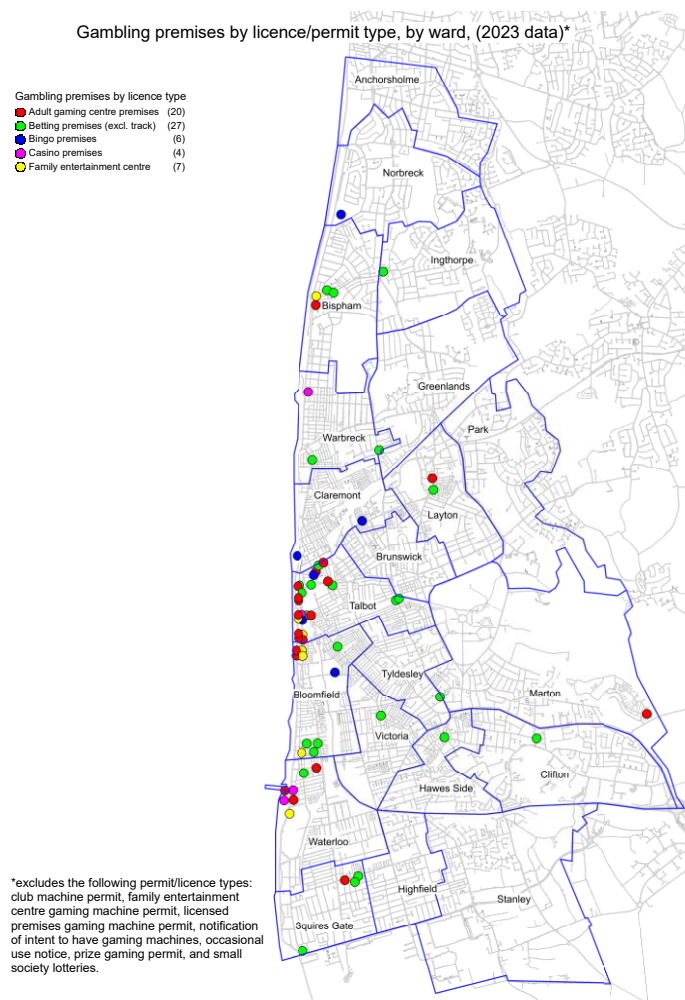


Figure 2: Gambling premises in Blackpool

Figure 3 shows the concentration of gambling premises per head by ward. The greatest concentration is evidently in the town centre. This is in part due to the establishments along the front, and the placement of these as tourist attractions, but it must be noted that this concentration also correlates with the highest levels of deprivation in the town, as shown in figure 4.

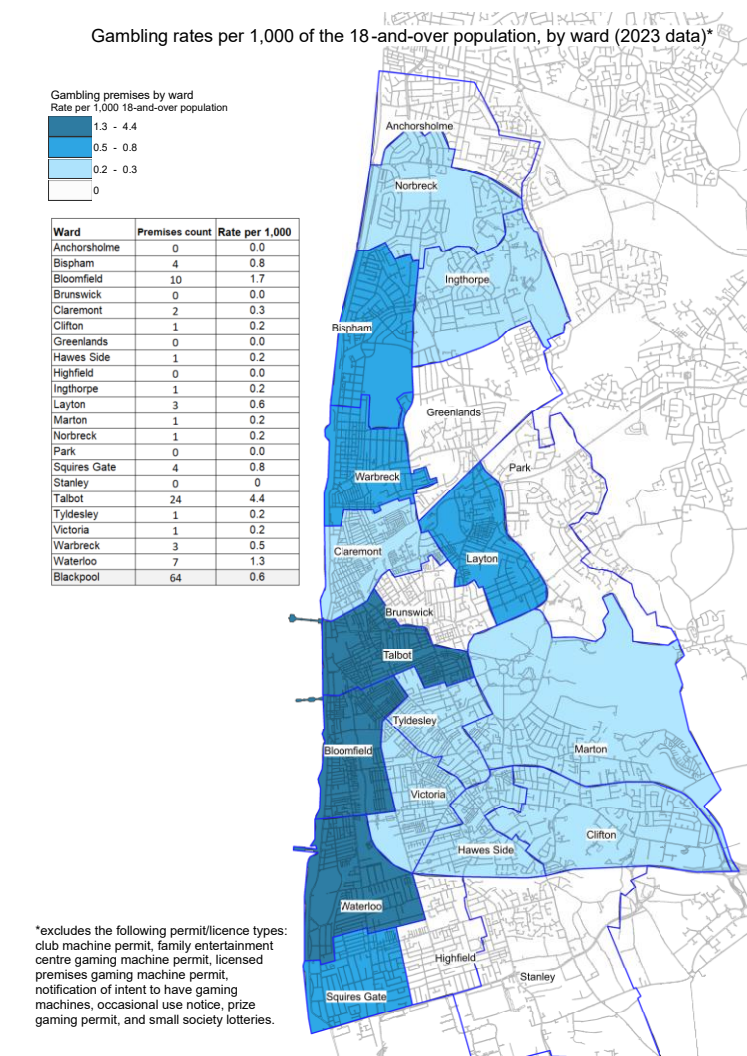


Figure 3: Concentration of gambling premises in Blackpool

In addition to the entertainment centres and bingo halls, there are also high concentrations of bookmakers in the town centre, especially in Talbot and Bloomfield wards.

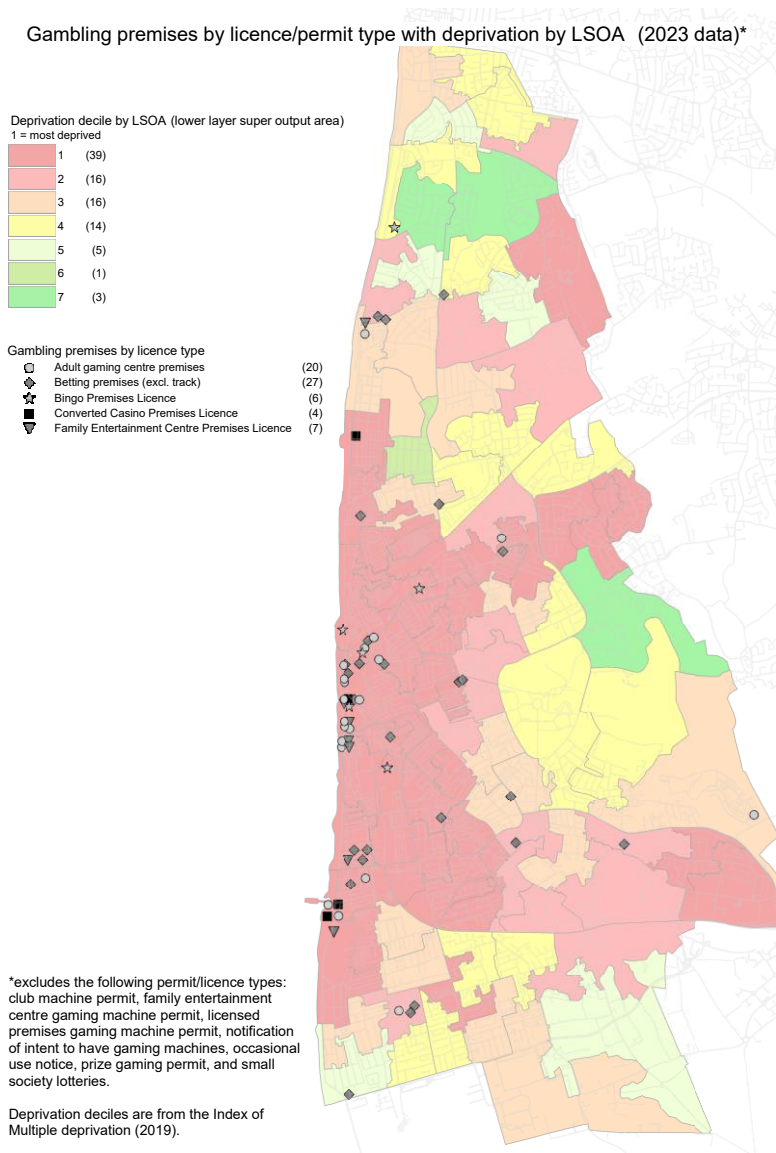


Figure 4: Gambling premises in Blackpool overlaid on map of deprivation

In Blackpool, as elsewhere, deprivation and gambling appear to correlate geographically.

8.3 Services in Blackpool

Support for those experiencing issues with gambling is provided on a tiered basis, with increasing levels of support. Tier 1 interventions are typically provided in non-specialist settings and may include provision of information and advice, or onward referral. Tier 2 interventions are more likely to take place in specialist settings, and may include motivational interviewing or extended brief intervention sessions with clinicians.

Tier 3 includes more structured interventions such as therapy. Tier 4 includes the most intensive forms of support, and typically takes place in a residential setting.

Nationally, gambling support services are commissioned by GambleAware through the National Gambling Support Network, a network of organisations working together to provide free and confidential support for anyone affected by gambling. Previously, GambleAware commissioned GamCare to provide this support, but have more recently moved to a regional model, and support is provided locally by the Beacon Counselling Trust (BCT). GamCare continues to run the National Gambling Helpline, available 24/7 anywhere in the country.

GambleAware are a registered charity. They receive funding from voluntary donations from the gambling industry. However, they stress their independence and state that industry has no influence on the services they commission, the research they fund or other activities. The recent Government white paper has proposed a mandatory levy on industry, which GambleAware supports.

The Gambling Commission is the statutory regulator of the gambling industry. GambleAware has a framework agreement with the Gambling Commission to deliver the National Strategy to Reduce Gambling Harms.

In addition to this structure, the NHS also provides treatment services for people with gambling problems. Blackpool is served by the North West Gambling Service, who launched their newest clinic in 2024, based in Preston. The service has expressed an intention to open a clinic in Blackpool and are in discussions to identify a suitable location.

Appendix A outlines some of the sources of support available to people experiencing issues with gambling in Blackpool. These include specialist and general support services. Additionally, there are services for particular groups, for example, Sporting Chance, who provide mental health support for professional sportspeople, including the GATE programme particularly targeting gambling harms.

It is critical for those seeking support that there is 'no wrong door' into support. Coordination and cooperation through networks like the NGSN are intended to ensure that any individual seeking support can be signposted to appropriate care locally, in a range of forms, venues and levels of intervention to match that individual's support needs.

However, there remain difficulties with coordination and cooperation across the system. The Office for Health Improvement & Disparities (OHID) released a report into the gambling treatment system in 2024,

noting the lack of coordination between the different parts of the system, particularly between the NHS treatment system and that run by VCFSE partners, which at times appear to be running in parallel (OHID, 2024). They identified failures in a number of areas, including a lack of standardised data collection on metrics and evaluation; lack of clarity on referral pathways; poor relationships between the NHS and VCFSE partners; inadequate governance and a lack of awareness of gambling harm in the wider healthcare, social care and justice services.

Blackpool may be well placed to tackle some of these coordination problems. The gambling related harm group that has guided the development of this strategy includes representatives from the NHS, VCFSE treatment providers, and other stakeholders. If Blackpool is able to improve and maintain the communication and coordination between partners that this process has begun, we may be able to provide a model for the prevention and reduction of gambling related harms.

8.4 The way forward

Tackling gambling related harm at scale requires a coordinated, multi-agency response, not limited to NHS and VCFSE providers of addiction services and targeted support for gamblers. It requires buy-in and support from the highest levels of the council, including our elected members and senior leadership, and engagement with all the services that encounter individuals and communities harmed by gambling, both within and without the council: housing and homelessness services; adult and children's social services; drug and alcohol services; financial and debt support; and others. As the Local Government Association has put it, '[h]armful gambling is increasingly cited as a public health issue which requires a broad response; that is to say, traditional approaches that focus on single interventions do not tend to work at a population level... no single measure is likely to be effective on its own...' (LGA, 2018). The formation of the gambling related harm group that produced this strategy, including healthcare and VCFSE partners, is an ideal start to this work.

Although the local authority does not directly commission treatment services for harmful gambling, it does provide support in a number of areas: through licensing and enforcement; through services that manage some of the harms associated with gambling, including financial advice, housing insecurity and social issues; through data gathering, signposting and referral across services; and, crucially, through coordination and leadership in setting out a shared vision and aspirations.

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Appendix A: Directory of support in Blackpool

National Gambling Helpline

To access support with gambling issues 24/7, anywhere in the country:

0808 802 0133

(Gamcare.org.uk)

Initial Response Service

To access mental health and crisis support 24/7, Blackpool and the Fylde Coast

0800 013 0709

Service	Contact details	About	For those with a gambling problem	For affected others
NHS				
GP/ Primary Care Gambling Service	Speak to your GP or contact us on: 0300 0300 111 Monday to Friday: 9:00am to 4:00pm primarycaregamblingservice.co.uk	Your GP can discuss any issues you are having with gambling and may make an onward referral to more specialist care if indicated.		
The North West Gambling Service	0300 300 1490 Referral.ngs@nhs.net	This is a specialist NHS service, accepting referrals via a number of routes including self-referral. Service users can attend clinics in Manchester, Liverpool or Preston. Virtual appointments are also available if preferred. This service is currently exploring options for a satellite clinic in Blackpool. At present, Blackpool is served by the clinic located in Preston. The clinical team includes psychologists, therapists, mental health nurses and psychiatrists. Service users will also have access to people with lived		

		experience of gambling addiction, who are now in recovery.		
Initial Response Service	0800 013 0709	24 hours a day, 7 days a week single point of access to mental health support for those in need of assistance, or in crisis, in Blackpool and the Fylde Coast.		
The NHS website also provides advice and a guide to sources of support, many of which are included in this table. www.nhs.uk/live-well/addiction-support/gambling-addiction/				
VCSFE				
GamCare National Gambling Helpline	0808 802 0133 Open 24/7 Gamcare.org.uk https://www.begambleaware.org/ngsn	National helpline run by GamCare		
Beacon Counselling Trust	support@beaconcounsellingtrust.co.uk 0151 226 0696 https://beaconcounsellingtrust.co.uk/gambling-related-harms/ 263 Townsend Lane Clubmoor Liverpool L13 9DG	Self-referral or onward referral. Beacon say that there is no wrong door for a client to be referred through. Service open to those aged 16 or over who meet any of the following eligibility criteria: • Individuals at risk of, or experiencing, gambling related harms including those impacted by another person's gambling. • Have an existing gambling problem • Have co-existing gambling problems and other issues • Are at risk of developing a gambling problem • Have been affected by the gambling of a family member or significant other Beacon offers a range of support, including: • Screening and triage • Tier 2 Extended Brief Interventions, including assessment; self-help tools; psychoeducation; signposting and onward referrals. • Tier 3 Support including assessment; safeguarding; psychosocial interventions; cognitive behavioural therapy (CBT); relapse prevention work; and trauma-informed support where necessary. • Onward referral to Tier 4 support where necessary including specialist gambling		

		treatment and residential care where necessary. • Follow-up and aftercare upon completion of treatment, including relapse prevention; group support; Trek therapy and peer mentoring. • The 6 to 10 Project, offering holistic and practical support on issues such as finances, housing and employment alongside any treatment pathway. • Breaking the Sharam, specific culturally-appropriate support for individuals who are part of the South Asian community and/or identify as Muslim.		
Empowerment Lived Experience Team	07407792241 Tracey.whiteside@empowermentcharity.org.uk	Gambling Harms Peer Support in Blackpool available to anyone experiencing gambling harms seeking help and support. Self-referral by contacting Tracey, or onward referral from other agencies. Offers a safe space; signposting to other sources of support; and education. Affected others are eligible for informal support (a brew and a chat).		
Betknowmore	www.betknowmoreuk.org/services/peer-aid Tel: 0800 066 4827	Offers Peer Aid to clients of the National Gambling Support Network (NGSN) receiving support in London, South East and North West regions.		
Gamblers Anonymous	www.gamblersanonymous.org.uk One meeting held in Blackpool weekly, 19:30 - 21:30 Wednesday. Gatehouse Church Community Centre, Waterloo Road, FY4 3AD nw.info@gamblersanonymous.org.uk 07974 668 999 at the Waterloo Road Community Centre	Gamblers Anonymous offers a 12-step programme approach for those experiencing gambling addiction.		
Gam-Anon	gamanon.org.uk According to gamanon.org.uk, the nearest meetings are in Wigan and St Helens.	GamAnon offer support to family and friends affected by another's gambling. Linked to Gamblers Anonymous, Gam-Anon also embraces the 12-step approach. Gam-Anon meetings are usually held on the same nights as GA meetings but in separate rooms. Experiences and information are not shared between the two groups.		

GamFam	gamfam.org.uk	Offer peer support through GRA5P – The GamFam Recovery and Support Programme. GRA5P is a structured 5-stage self-help peer support programme, which was designed originally to support those affected by someone else's gambling. However, more recently and out of increasing demand, GamFam have now developed a programme to support those directly in recovery too.		
Gambling with Lives	If you or someone you know has been bereaved by gambling-related suicide, then please get in touch with Judith for an informal chat at support@gamblingwithlives.org or on 07774 617771. www.gamblingwithlives.org/	Gambling with Lives is a charity set up by families bereaved by gambling-related suicide. They work to raise awareness of the dangers of gambling and to campaign for legal reform. They also offer support to families who have been bereaved by gambling-related suicide.		
Samaritans	Telephone line available 24/7: 116 123 Email: jo@samaritans.org samaritans.org/how-we-can-help/contact-samaritan/	Samaritans is the UK's leading suicide prevention charity. It's helpline is available 24 hours a day, 365 days a year.		

Residential Services

Gordon Moody	Tel: 01384 241292 Email: help@gordonmoody.org.uk gordonmoody.org.uk	Gordon Moody provide residential services including: • Residential Treatment Centres – two specialist centres, providing an intensive residential treatment programme for men with a gambling addiction. • Recovery Housing – specialist relapse prevention housing for those who have completed the treatment programmes requiring additional recovery support. • Retreat & Counselling Programme – retreat programmes for women-only-cohorts and men-only-cohorts which combine short residential stays with at-home counselling support.		
Adferiad	Tel: 01492 203 421 https://adferiad.org/	Adferiad have been commissioned by GambleAware to provide residential rehabilitation for men and women experiencing gambling related harms with concurrent issues with alcohol or other substance		

		use. They operate two Parkland Place residential settings, one in Conwy in North Wales and one near Chorley in Lancashire. The treatment pathway is operated in partnership with Gordon Moody. Details here: https://parklandplace.co.uk/adferiadwithgambleaware/		
Online				
GamStop	https://www.gamstop.co.uk/	GamStop is an online tool to help control online gambling. Once registered, users will be prevented from using gambling websites and apps run by companies licensed in Great Britain, for a period of their choosing.		
GamBan	https://gamban.com/	GamBan is software that once installed on your devices will block access to thousands of gambling websites and apps. It is available free to all UK residents through the TalkBanStop partnership between GamStop, GamBan and GamCare.		
GamLearn	https://www.gamlearn.org.uk/meet-ups	GamLearn is a lived experience and recovery network that offers a range of online meet-ups.		
Gamblers in Recovery	gamblersinrecovery.com/	Offers a database of online Gamblers Anonymous meetings worldwide.		
Debt Advice				
Citizens Advice Bureau Blackpool	blackpoolcab.org.uk • Freephone advice line 0808 278 7818, Monday to Friday 9am to 5pm. • If you require debt advice, we have a dedicated Citizens Advice Blackpool debt line 01253 308 401 • If you need a face to face appointment, please leave a message on our appointment line 01253 308 405	Citizens Advice is a national charity and a network of local bureaux. They offer free confidential advice, online, over the phone or in person on a range of issues including debt and finances.		
National Debt Line	https://www.nationaldebtline.org/ Telephone: 0808 808 4000	The National Debt Line is a charity offering free, impartial expert advice on managing debt, over the telephone or online. They also work with a range of		

	Monday to Friday, 9am to 8pm Saturday, 9:30am to 1pm	partners for onward referral, including Citizens Advice and Mental Health and Money advice.		
The government provides a directory of other sources of debt advice here: www.gov.uk/debt-advice				
For Children and Young People				
National Problem Gambling Clinic	https://www.cnwl.nhs.uk/services/mental-health-services/addictions-and-substance-misuse/national-problem-gambling-clinic 69 Warwick Road, London SW5 9HB To make a referral: - Email gambling.cnwl@nhs.net providing a contact number - If you do not have access to email, call 020 7381 7722 leaving a contact number.	The National Problem Gambling Clinic is a specialist NHS service operated by the Central and North West London NHS Foundation Trust. It provides treatment for people aged 13 or over who live in England and are experiencing gambling harms. It is the only specialist NHS service that provides treatment and support for young people between the ages of 13 and 18.		
SHINE: Support and Help IN Education, Fylde Coast Mental Health Support Team	8.30 am to 4.30pm Monday to Friday, excluding bank holidays. Telephone: 0800 121 7762 : Option 4 Email: bfwh.shine-MHST@nhs.net	Provided by Blackpool Teaching Hospitals NHS Foundation Trust. Covering selected secondary schools, special schools, appropriate provision settings, sixth forms and colleges in Blackpool.		