Health Needs Assessment: Gambling harms in Wakefield

Wakefield Council Public Health

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Executive summary

This Health Needs Assessment (HNA) examines the prevalence and impact of gambling harms in Wakefield. Findings reveal that an estimated 99,315 adults in Wakefield gamble regularly, with approximately 1% (993 individuals) gambling at a harmful level, exceeding regional estimates.

Inequalities exist, with increased risk of harm experienced among women, young adults (18-34) and those living in the most deprived parts of the Wakefield District. The locations of gambling venues are also disproportionately situated in deprived areas, potentially exacerbating existing health inequalities and providing additional gambling opportunity to those most vulnerable.

Despite a suggestive rise in demand for support through the recent doubling of Wakefield referrals to the NHS Northern Gambling Service, there is an absence of local, dedicated treatment services for gambling harms in Wakefield. This necessitates reliance on external providers, often with industry funding, where there are concerns about integrity and effectiveness in addressing the root causes of gambling harms.

With this, there is a clear need for action to prevent and reduce gambling harms whilst providing accessible, effective and equitable services and support to provide help to Wakefield residents who need it.

Summary of key findings

The following key findings are listed in greater detail towards the end of the HNA.

- **Prevalence of Gambling**: Over a third (35.1%) of Wakefield adults gamble regularly (99,315), with even higher numbers estimated based on national data sources.
- **Risk of Gambling Harm**: 1% of Wakefield adults (approximately 993 individuals) experience harmful gambling at a harmful level, exceeding regional estimates.
- **Underestimates**: Figures likely underestimate the true extent of gambling participation and related harm in Wakefield.
- **Inequalities in Risk of Harm**:
    - Gambling harm disproportionately affects adults in the most deprived areas in Wakefield.
    - Young adults (18-34) are more likely to engage in risky gambling behaviours.
    - The heaviest drinkers of alcohol have the highest rates of gambling participation (55.7%) whilst non-drinkers have the lowest rate (27.4%).
- **Young Adult (18 – 34) Survey**: Most young adults do not agree that gambling companies are honest and open about the risks of gambling, and support further regulation of the industry, although an outright ban would be unpopular. Most encounter gambling adverts on a daily or weekly basis and notice an increase in advertising during large sporting events. Some were unsure where or how to seek support, whilst others mentioned industry-funded providers or cited online resources.
- **Environmental Influence**: Licenced gambling venues are disproportionately situated in the most deprived parts of Wakefield.
- **Commercial Influence**: The gambling industry's variety of tactics, such as aggressive advertising and the framing of gambling as an individual's responsibility, create an environment in Wakefield (and online) where residents are susceptible to harm.
- **Increasing Demand for Support**: Wakefield referrals to the NHS Northern Gambling Service have doubled in the past year (11 in 2022/2023 versus 26 in 2023/2024). However, Wakefield currently has no dedicated local services for gambling harm. This causes reliance on regional and/or national providers, many of which are funded by voluntary donations from the gambling industry.
- **A Need for Strategic Direction**: There is currently no gambling harms strategy for Wakefield Council, no inclusion of gambling in the Wakefield District JSNA Annual Report, and no mention of gambling products in the Wakefield Council Advertising and Sponsorship Policy.
- **A Public Health Approach:** A comprehensive public health approach which encompasses various interventions, including policy, targeted campaigns, harm reduction, and community engagement is what the evidence base suggests as the most effective means to tackle the complex issue of gambling harms. No single intervention in isolation at local authority is likely to have a significant impact.

Recommendations

The following recommendations are listed in greater detail towards the end of the HNA.

1. **Develop a Gambling Harms Strategy for Wakefield**: To provide a comprehensive and coordinated framework for addressing the causes and complexities of gambling harms.
2. **Strengthen Local Licensing**: Review and explore how local gambling licensing policies can potentially be improved, with public health more embedded in the process. This could include enforcement of existing licencing compliance checks, though may depend on capacity, funding and resource.
3. **Strengthen Local Advertising Policy**: Wakefield Council's current policy does not mention gambling products. A clear policy that restricts the advertisement of gambling products (and other harmful products) on all Council-owned property and online platforms would demonstrate a commitment to protecting vulnerable groups from exposure to gambling advertising.
4. **Advocate for Advertising Regulation**: Proactively advocate for stricter national regulations on gambling advertising, particularly those targeting vulnerable demographics such as young adults.
5. **Develop Targeted Public Health Campaigns**: Design and implement evidence-based public health campaigns tailored to specific Wakefield demographics and risk factors identified in the HNA. These campaigns should employ destigmatising language and highlight the available (non-industry funded) support services.
6. **Leverage National Guidance and Regulatory Changes:** NICE guidance on gambling harms (due 2024) and completion of the review of the Gambling Act 2005, will present opportunity for the Council to align its policies with national standards and legislation, and can be used a catalyst for local action.
7. **Improve Early Intervention and Education**: Enhance early intervention efforts by integrating gambling harm education into existing programmes in schools, workplaces, and community settings. Equip frontline professionals with the knowledge and tools to identify and support individuals at risk.
8. **Establish Clear Referral Pathways:** Establish clear and accessible referral pathways between frontline professionals and appropriate gambling support services to help individuals access appropriate help when needed.
9. **Conduct Research and Evaluation**: Conduct ongoing research to monitor gambling trends, evaluate the impact of interventions, and identify emerging needs within the Wakefield community.
10. **Strengthen Local Authority Governance**: All decision making in the Council where there is corporate interest or influence should be guided by the ADPH-endorsed Good Governance Toolkit.

Contents:

1. Background

Gambling has been a long-standing fixture of the leisure landscape in England. British traditions such as the Grand National and the National Lottery, alongside Hollywood's glamourising portrayals of gambling in films such as Casino Royale, have meant gambling has become deeply embedded in British culture.

The rise and evolution of digital technology has enabled gambling to be a 24 hours a day and 7 days a week opportunity, further fuelled and incentivised by pervasive advertising, marketing, and sponsorship. Resultantly, England now has one of the most accessible gambling markets in the world, generating a profit of £15.1 billion in 2022. Although often seen as a harmless social activity, the potential for significant harm associated with gambling can be overlooked. This harm not only impacts individuals, but can ripple through families and across communities, causing physical, psychological, social, and economic harm to society.

Moreover, despite having the lowest overall participation rates, the most socio-economically deprived and disadvantaged groups in England face disproportionately high levels of gambling at a harmful level and are particularly vulnerable to its negative consequences (1). Without action, the existing health inequalities within these communities are likely to be exacerbated by the detrimental effects of the increasingly growing gambling industry.

A recent evidence review by the Office of Health Improvement and Disparities, also highlights the significant economic burden of gambling. It estimates and annual direct cost of £412.9 million, with broader societal impacts on health ranging from £635 million to £1.35 billion annually. Combined, this suggests a total economic cost of £1.05 to £1.77 billion each year.

This health needs assessment brings together the best available local and national evidence to better understand the impact of gambling harms among Wakefield residents. Additionally, a literature review exploring preventive interventions towards gambling harms in included. By developing our understanding of the scale, severity, and distribution of harm, we will be better equipped to develop effective strategies to reduce and prevent risk and provide appropriate support to those who need it.

2. Aim, objectives and scope

2.1. Aim

To better understand the prevalence of gambling in Wakefield alongside the scale of gambling harms, and to produce recommendations that progress action towards reducing and preventing this harm.

2.2. Objectives

- Estimate the prevalence of gambling activity in Wakefield.
- Summarise relevant literature on preventive measures towards gambling harms.
- Survey Wakefield residents to understand gambling behaviour and the impacts locally.

2.3. Scope

The scope of this HNA is constrained by the finite resources available, resulting in practical and logistical limitations. While the ideal scenario would involve exhaustive data collection and analysis across all ages and relevant domains, including epidemiological, socio-economic, and environmental factors, the reality is that resource limitations impose constraints on the depth and breadth of the assessment.

Within these constraints, the HNA will focus on adults and the tangible means to which gambling harms can be prevented or reduced. This will help to ensure that any assessments and recommendation remain actionable and responsive to the needs of the community.

3. Key terms and concepts

3.1. What is gambling?

Gambling is the act of risking something (money, possessions) on an event with an uncertain outcome, where the intent is to win something in return.

Gambling is comprised of three elements.

Betting: Placing wagers on the outcome of a race, competition, or event (e.g., sports betting, horse racing) or on something happening or not happening (e.g. betting on who will be the next Prime Minister)

Gaming: This refers to playing a game of chance for a prize. This includes games where some skill might be involved, but ultimately luck is the primary determinant.

Lottery: This encompasses any game where prizes are distributed based on chance, including national lotteries, scratch cards, and raffles.

3.2. **Where and how do people gamble?**

Tickets for lotteries are the most popular gambling activity in the UK, followed by scratchcards, online betting, and betting on horse racing at a bookmaker (2). There are various means to accessing gambling activities, including the following.

Casinos: Playing games like roulette, blackjack, slots, and poker.

Pubs and amusements centres /adults gaming centres: Using gaming machines e.g. fruit machines.

Betting shops: Wagering on the outcome of sporting events, including in-play events (e.g. who will score the next goal in a football match) and horse racing.

Shops: Playing national lotteries, scratch cards, and raffles.

Online: Accessing websites and apps offering various gambling options.

3.3. **Why do people gamble?**

People gamble for a variety of reasons, and no single answer fits everyone. It can be a mix of motivations, and what appeals to one person might not be the same for another.

Additionally, it is important to recognise the societal, structural and environmental influences that encourage and incentivise people to gamble. These include the design of gambling products and their advertising, marketing, and sponsorship, as well as the accessibility, availability, and social normalisation of gambling.

With these external influences in mind, people may gamble for the following reasons:

Risk Taking: The thrill of placing a bet and the uncertainty of the outcome can be appealing towards people who are naturally inclined towards risk-taking behaviour.

Escapism: Gambling can offer a temporary escape from daily pressures and worries. The focused attention or the excitement can provide a distraction from stress or boredom.

Glamorous perception: For some, gambling can hold a glamorous image. Casinos, sporting events with high stakes wagers, or the portrayal of gambling in the media can create an association with wealth, luxury, and success.

Social Activity: Gambling can become a shared activity, particularly in places like casinos or at sporting events, that can create a sense of camaraderie, fun, and competition.

Financial Gain: Some people gamble to win money, pay off debt or improve their financial circumstances. This can lead to a cycle of chasing losses and accumulating debt.

Addiction: Gambling can be addictive. The highs of winning and the desire to recapture that feeling can lead to compulsive gambling behaviour, even when the consequences are negative.

3.4. **What is gambling at a harmful level?**

Gambling at a harmful level is when gambling disrupts or has negative consequences on a person's life and a possible loss of control. It can lead to financial problems, relationship issues, mental health problems, and even criminal activity.

Signs include concealing gambling, gambling increasing amounts, restlessness when attempting to cut down, unsuccessful efforts to stop, thoughts occupied by gambling, gambling when distressed, and gambling to 'chase' losses. This has been called 'problem', 'compulsive', or 'disordered' gambling.

The language used around gambling, including descriptors of gambling at a harmful level are discussed in the Language Matters section (Section 8) of this HNA.

3.5. **What are gambling harms?**

Gambling harms refer to the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society. These harms impact on people's resources, relationships and health.

Negative effects can include:

Financial problems: Debt, bankruptcy, and loss of savings.

Relationship problems: Arguments, breakups, and family dysfunction.

Mental health problems: Anxiety, depression, and suicidal ideation.

Crime: Stealing or fraud to support gambling habits.

Work problems: Job loss or decreased productivity due to gambling.

Harms can be experienced not just by those people who gamble. They can also affect their children, partners, wider families and social networks, employers, communities, and society as a whole through "legacy" harms which have a lasting impact. For example, if a parent loses the family home due to gambling-induced debt, this negatively impacts the child/children, as they can become materially and emotionally deprived (3). This can result in such children having poorer life chances into their adult life (4).

4. Commercial determinants of gambling

The commercial determinants of health (CDoH) refer to the corporate private sector activities which impact public health, either positively or negatively, directly or indirectly, and the enabling political economic systems and norms (5).

Like many other commercial sectors (e.g. tobacco, alcohol, food) the gambling industry has a significant impact on public health and uses a variety of tactics which seek to downplay the health risks of gambling whilst maximising profits.

Framing of gambling and emphasis on individual responsibility

The industry often frames gambling as a harmless form on entertainment, emphasising excitement, fun, and the potential for quick financial gain. Conversely, the addictive nature of gambling and the associated risks are downplayed. Despite repeated calls for gambling to be reframed as a public health issue, it continues to be framed according to economic activity and consumerism (6; 7). Resultantly, public understanding of gambling harms has been undermined by this narrative of gambling being a safe and enjoyable activity if done responsibly.

This emphasis on personal responsibility, often promoted by industry campaigns despite a lack of empirical evidence, suggests that gambling at a harmful level is a personal failing and due to lack of control rather than a consequence of product design or marketing practices. This is exemplified by popular industry campaigns such as “when the fun stops, stop”. However, such messaging has been found to have no protective effect from gambling harms (8).

This framing of gambling harm aligns with the business interests of the gambling industry, with very little concern for life or health. This can be stigmatising for those who are harmed (9) and shifts the blame on to individuals including children and young people (10). The resulting shame can discourage help-seeking, limiting the reach and effectiveness of support and treatment.

Aggressive advertising and marketing

In the UK, gambling and advertising spend was reported to be over £1.5 billion in 2017, increasing by 56% from 2014. No published data is available for more recent advertising spend. However, it is highly plausible that across 2024, the advertising and marketing spend of the gambling industry will exceed the expenditure of 2017.

Gambling advertisements feature across various media platforms, causing almost constant public exposure and being highly effective in fuelling brand recognition (11). Furthermore, the portrayal of humour, excitement and positive social associations within gambling advertisements creates an emotional connection with viewers, making gambling brands highly memorable (12). This positive portrayal of gambling, which also downplays the potential risks, is associated with increased intention to gamble, frequency of gambling, and gambling at a harmful level (13; 14).

Moreover, specific advertising tactics such as promotional offers, free bets, or sign-up bonuses can further incentivise and trigger people to participate in gambling (15; 16).

Despite the recognised impact of gambling advertising on gambling behaviour and harm, Wakefield Council's Advertising Policy currently includes no mention of gambling products.

Product design and features

Gambling products are designed to be highly engaging to promote continuous and extended play. There are numerous ways in which this is achieved, visually and audibly. As documented by Schüll (17), the design of electronic gaming machines seeks to optimise speed, length, and intensity of play, creating products that extract maximum revenue per available customer.

Online gambling products particularly, have transformed gambling to be more accessible and continuous. This can increase the frequency of bets, extend the length of betting sessions, and can facilitate an illusion of control (18).

Lobbying of politicians

The gambling industry is well known to frequently lobby governments to influence regulations and policies relating to gambling. Ultimately, the purpose of this lobbying is to minimise legislative restrictions to protect commercial interests and company profits. In addition to direct lobbying efforts, the gambling industry strategically utilises various other bodies and tactics to cultivate a favourable public image and indirectly influence policy decisions. This can include endorsements from celebrities and influencers, promotion of gambling benefits through trade groups, and through sponsorship and partnerships.

Shaping the narrative, creating uncertainty and causing doubt about public health evidence

The gambling industry engages in tactics to manipulate public perception and policy direction regarding the harms of gambling. This includes not only creating doubt about existing public health evidence, but also actively funding and selectively promoting research that supports their narrative. By focusing on individual risk factors (often unchangeable) and pushing for individual-level solutions (rather than population-level regulation), the industry distracts from effective interventions. It's crucial to recognise that anyone can be at risk of experiencing gambling harms, regardless of personal characteristics, and the industry's emphasis on individual responsibility obscures this reality.

Enhance public image

To counterbalance the potential negative impacts associated with gambling, the gambling industry donates a portion of their profits to charities and good causes, including some gambling harm charities and education packages. This can help portray the industry in a positive light, highlighting their social responsibility efforts and positioning them as invested in the wellbeing of society. This is done

While some individuals may benefit from support by an industry funded charity, it is important to recognise that such donations from the gambling industry can serve the underlying purpose of strengthening public relations and deflecting criticism. Furthermore, this funding, which is largely allocated to treatment and support services, does not address the root causes of gambling harms.

Tackling CDOH

The Association of Directors of Public Health (ADPH) have published a series of recommendations to protect the public from being harmed or exploited by gambling and the gambling industry. This HNA fully supports these recommendations, which are directed towards change at a national level.

Since the publication of these recommendations, the development of a Good Governance Toolkit has been established, which is endorsed by the ADPH. The Toolkit provides a set of materials focused on improving governance of commercial interactions, relationships and influence in UK local authorities, to maximise benefits and minimise risk for population health. Applying the strategies included in the Toolkit could help ensure that decisions around licencing are transparent, free from conflict of interest, and made based on evidence, with the best interests of the health and wellbeing of the community in mind .

5. Legislative landscape

5.1. The Regulator: The Gambling Commission

The Gambling Commission is the primary regulatory body for gambling in England, established under the Gambling Act 2005. The core responsibilities of the Gambling Commission include:

Licensing: Operators must acquire a license from the Commission to offer gambling activities legally. This ensures operators meet strict criteria for fairness, social responsibility, and anti-money laundering measures.

Compliance and Enforcement: The Commission enforces gambling laws and regulations. They investigate breaches, issue penalties to non-compliant operators, and can even revoke licenses in serious cases.

Consumer Protection: A key focus is ensuring gambling is conducted fairly and transparently. The Commission works to minimise the risk of harm to consumers by promoting responsible gambling practices.

5.2. Gambling Act 2005 and Ongoing Review

The Gambling Act 2005 is the cornerstone of gambling legislation in Great Britain. It defines various gambling activities, sets age restrictions (18+ for most gambling), and outlines licensing requirements. The Act also places a duty on the Commission and licensees to promote “responsible gambling”.

However, the rapid rise of online gambling and growing recognition and understanding about gambling harms have prompted calls for a review of the Act.

In December 2020, the UK Government announced a long-awaited review of the Gambling Act to assess its effectiveness in the digital age. The review aimed to ensure the legislation remains fit for purpose and adequately addresses contemporary gambling trends.

The review considered aspects including:

Online gambling regulations: Examining the effectiveness of online gambling regulations and potential updates for better consumer protection.

Affordability checks: Introducing stricter affordability checks to prevent excessive gambling and gambling at a harmful level.

Advertising restrictions: Reviewing gambling advertising regulations to minimise potential harm, particularly towards individuals with vulnerabilities.

5.3. **Current Status of the Review**

In April 2023, a white paper titled '[High stakes: gambling reform for the digital age' was published]'. This document outlines the government's proposed changes to the Gambling Act based on the findings of the review. The exact details of any upcoming changes or the timeframe for implementation have not been announced. With the recent 2024 general election bringing a change in national government, we currently await an update and direction relating to the review.

Notably and as an additional point, responsibility for gambling legislation in England, and the review of the Gambling Act 2005, currently sits with the Department of Digital, Culture, Media and Sport (DCMS). If gambling was nationally recognised as a public health issue, there would be a strong argument for shifting responsibility to the Department of Health and Social Care. This would remove any conflict of interest held by the DCMS relating to economic benefit and shift the focus to public health and harm prevention.

5.4. **Local Authority Powers**

While the Gambling Commission holds primary responsibility, local authorities have some supplementary powers. However, these cannot contradict or override the Gambling Commission's licencing decisions or broader gambling regulations.

Planning Permissions: Councils can influence the location of gambling premises (e.g. betting shops) through the planning permission process. They can consider factors like crime rates, proximity to residential areas and schools, and potential negative impacts on the community before granting approval.

Arcades and Bingo Halls: Councils can license and regulate amusement arcades and bingo halls that fall under specific categories defined in the Gambling Act. These typically involve lower-value prizes compared to casinos.

6. Regional work

An established Yorkshire and Humber Gambling harms Community of Improvement (CoI) meets quarterly with the aim to prevent and reduce gambling harms across the region, sharing practice to deliver improvements at scale whilst responding to local population needs.

The CoI is sponsored by the ADPH, chaired by Diane Lee (DPH at North Lincolnshire Council) and currently coordinated by the Office for Health Improvement and Disparities (OHID) Regional Lead for Gambling harms. Representatives from each of the 15 local authorities in the region are invited and 14 of these have membership with regular attendance. Wakefield Council has regular attendance and contribution from its Public Health team.

The CoI provides public health leadership in the region, representing a unified voice. Resultantly, the group responds to consultations, shares guidance and policy updates, and ensures consistent and coherent communication both locally and regionally.

Additionally, a three-year programme of work to prevent and reduce gambling harms was funded by the Y&H ADPH, led by Y&H OHID. A summary of the key areas of work completed or ongoing , including corresponding links to the work, are available to view via the Yorkshire and Humber Public Health Network website. Much of the work and resources such as training and marketing materials have been used at local level across the region and among the CoI.

7. Local work

The gambling harms portfolio sits within the Public Health Team at Wakefield Council and as such, is recognised as a growing public health concern. At present, Wakefield Council does not have a gambling harms strategy or strategic working group, and there is no formally structured programme of work. Moreover, the lack of a national prevention strategy adds to the difficulties of establishing local frameworks to progress public health efforts. However, a small, dedicated team seek to progress actions on this this agenda through gambling's connections to environmental and commercial determinants of health. There is also advocacy work that takes place, and regular involvement and representation at a regional level via the CoI, where programmes and initiatives align to raise awareness, educate and signpost to support on gambling harms.

8. Language – why it matters

The language we use around gambling harms is important for multiple reasons:

Stigma: Terms like "problem gambler" or "addict" can be shaming and judgmental. This can discourage people from seeking help due to fear of being labelled or feeling like they're weak-willed.

Shifts Responsibility: "Problem gambling" can place blame on the individual, overlooking the addictive nature of gambling products and the aggressive marketing tactics of the gambling industry. It downplays the influence of factors outside the individual's control.

Accuracy of Representation: Gambling harm can impact a wide range of people, not just those with a severe addiction. Less severe terms like "gambling harm" encompass a broader spectrum of individuals experiencing negative consequences.

In February 2024, Greater Manchester Combined Authority, ADPH Yorkshire and Humber, and ADPH North East published a language guide for gambling harms. The guide details language to try and avoid, with suggested alternatives and a rationale for why. Some examples are as follows.

Instead of "***problem gambler***," use "***person experiencing gambling harms***" or "***person being harmed by gambling***."

Instead of "***problem gambling***," and "***harmful gambling***" use "***harmful gambling products***" or "***gambling at a harmful level***" if talking about level of risk.

Instead of "***your gambling***" use "gambling".

Instead of "***safe***" and "***unsafe***" or "***responsible***" and "***irresponsible***" gambling, avoid making these comparisons as gambling is not binary and is far more complex.

Instead of "***vulnerable***" or "***at risk***", avoid suggesting that someone is morel likely to be harmed due to individual characteristics.

By using more empathetic, person-first, and accurate language, we can create a more supportive environment for those affected by gambling harms and encourage them to seek help. We can also acknowledge the role of the industry in potentially contributing to these issues.

Additionally, the guide suggests that gambling should not be referred to as 'fun' or a 'social/leisure activity'. This can reinforce the perception that everyone is gambling and that there is something 'wrong' with someone who experiences harm or addiction from it. Anyone who is exposed to harmful gambling products is at risk of harm.

Consistent with this guidance and for clarity, the term 'gambling at a harmful level' is used in this HNA to refer to gambling behaviour that leads to negative consequences for individuals, their families, or society. This term is used in place in place of 'problem gambling' or 'problem gambler' which may have originally featured. However, these terms may still appear in some references and citations.

9. The Wakefield Population

The City of Wakefield is a local government district and metropolitan borough in West Yorkshire, situated on the River Calder. Almost 70% of the district is designated as green belt and includes the towns of Normanton, Pontefract, Featherstone, Castleford, Knottingley, Ossett, Horbury, Hemsworth, South Kirby and South Elmsall – as well as other smaller settlements (see Figure 1).

Wakefield has a total population of 357,729 of which 74,778 are aged under-18 and 68,039 are aged 65+. Compared to many other metropolitan districts, Wakefield's age profile has a smaller than average proportion of people in the 18-23 age band (6.8%) owing to the absence of a university in the district.

There are 155,443 households in Wakefield, including 46,419 single-occupancy households and 42,922 households with dependent children (0-18).

Wakefield is the 54th most deprived district of the 317 districts in England. However, there are parts of Wakefield that fall within the most deprived decile in England.

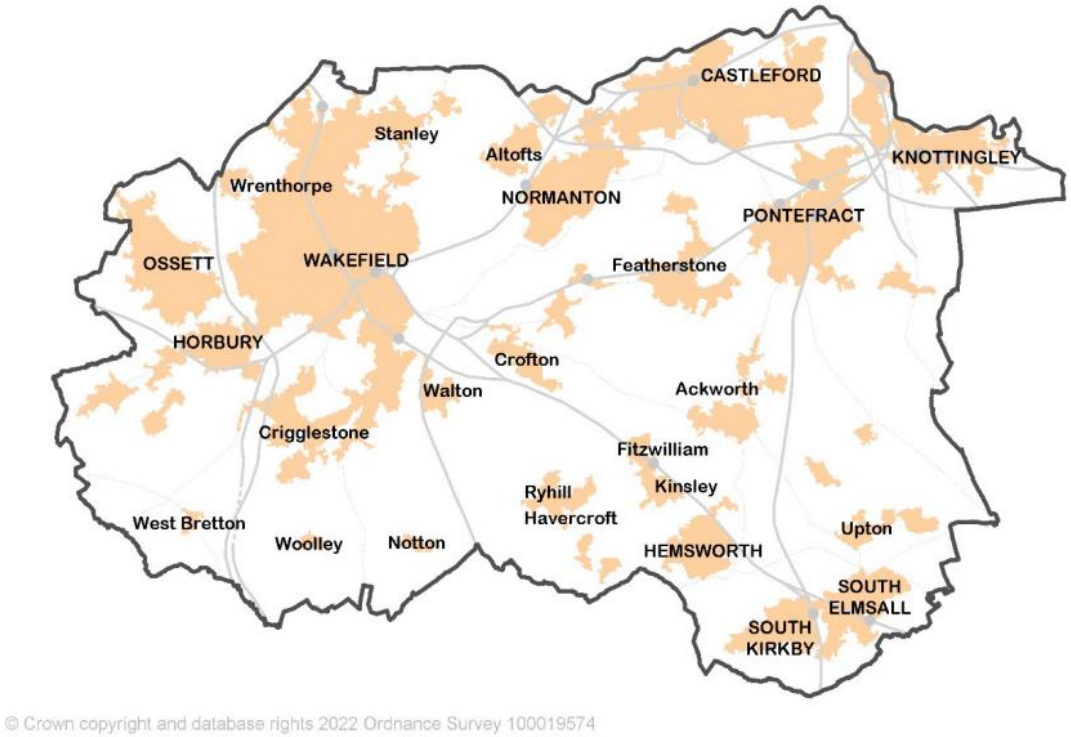

Figure 1. *Map of the Wakefield District.*

10. Gambling in Wakefield

10.1. **Nationally sourced data**

The Health Survey for England is a national survey conducted by the Office for National Statistics (ONS) on behalf of the department of Health and Social Care. Data on gambling participation and risk is extracted and published at regional level among those aged 16 years and over.

The HSE seeks to identify 'at risk' and 'problematic gambling' using two validated screening tools – the Problem Gambling Severity Index (PGSI) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The PGSI is formed from nine questions, each scored on a scale of 0 - 27. Respondents are then categorised by their cumulative scores as follows:

Table 1. *PGSI scores and associated gambling risk category*

PGSI Score	Gambling risk category*
0	Non gambler or low risk
1-3	Low risk gambler
3 - 7	Moderate risk gambler
8+	Problem gambler

*Original terms that are used in the PGSI

The DSM-IV consists of ten criteria to determine if a person meets the threshold for gambling at a harmful level (3 or more criteria met).

As with all surveys, there are methodological limitations. The HSE excludes those living in student halls, prisons, or those without a fixed address such as homeless people and traveller communities. Data is also retrospective and self-reported, meaning that recall bias could underestimate prevalence due to people failing to recall smaller or less frequent forms of gambling. Moreover, the nature of gambling could be subject to social desirability bias whereby individuals may be unwilling and less likely to disclose their gambling habits if they deem them to be socially undesirable.

Nevertheless, the HSE is currently the most valid, reliable, and robust national survey data, using random sampling and holding national statistic status.

Within the Yorkshire and Humber region, 50% of adults took part in gambling within the last 12 months.

Gambling participation in the last 12 months in the Yorkshire and Humber region was 53%. Nationally, 2.8% of adult were identified as engaging in at-risk gambling (score of 1+ on PGSI) and 0.3% were identified as engaging in gambling at a harmful level (score of 8+ on PGSI). When using DSM-IV scores, 0.4% of adults were identified as engaging in gambling at a harmful level, defined as having a DSM-IV score of 3+.

If such prevalence estimates are applied to the Wakefield population, the following number of adults are affected.

Table 2. *Projected number of people that gamble in Wakefield and their level of risk.*

Gambling participation	At risk gambling	Gambling at a harmful level
149,964	7923	849

Calculated using adult population of Wakefield (282,951) applied to HSE 2021 part 2 estimates
At risk and gambling at a harmful level estimates were calculated using HSE data for national estimates (using PGSI scores)

As already alluded to, the HSE survey data could be prone to underestimating gambling prevalence as an activity, as well as the resulting harms, particularly as the impacts on others are not quantified or included. This could also differ significantly in Wakefield compared to other parts of the country. Moreover, the distribution of gambling activity and harm between different parts of the district may be disproportionate.

Areas with a higher density of gambling establishments, such as betting shops and amusement centres, could see a corresponding increase in both participation and gambling harms. This would align with the established link between accessibility and gambling (19).

10.2. **Locally sourced data**

This HNA utilised a variety of local data sources to help articulate the health needs relating to gambling in the community. Quantitative data was obtained from the Adult Health Survey (AHS), local authority licensing data, and the government's Index of Multiple Deprivation (IMD) data. These sources provided insights into demographics, socio-economic factors, and other health outcomes that are related to gambling. Additionally, an online survey conducted by Public Health at Wakefield Council provided valuable resident perspectives on perceptions of gambling and the gambling industry. Finally, qualitative data provided by the NHS Northern Gambling Service provided insights into treatment and recovery from the perspectives of service users from Wakefield. By triangulating data from these diverse sources, this HNA offers a more coherent understanding of the gambling harms health needs in Wakefield. Where possible, comparisons will be made to the national data on gambling derived from the HSE.

10.3. **Adult Health Survey**

The (AHS) is a commissioned survey by Wakefield Council and delivered through an independent research agency, BMG Research. Questionnaires were distributed during March and April 2023 and 3,450 responses were received from adults living in Wakefield. Percentages are weighted so that the results from the sample reflect the demographic structure of the total Wakefield District population. The full AHS survey which details the survey methodology is available here.

Relating to gambling, respondents were asked whether they have spent money on gambling at least once per month over the past year. Gambling status was also established by using a short-form version of the PGSI, closely mirroring the methodology of the national Health Survey for England.

The short form PGSI is formed three questions, each scored on a 4-point frequency scale of 0 – 3 to give a total score between 0 – 9. Respondents are then categorised as follows:

Table 3. *Short form PGSI scores and associated categories of risk.*

0	Non gambler or low risk	probably will not have experienced any adverse consequences of gambling
1	Low risk gambler	likely will not have experienced any adverse consequences from gambling)
2	Moderate risk gambler	may or may not have experienced adverse consequences from gambling)
3	Problem gambler	have experienced adverse consequences from their gambling)

*Original terms that are used in the short form PGSI.

Gambling participation

Overview

Overall, 35.1% (95% CI: 33.5% - 36.7%) of adults (n = 99,315) in Wakefield had gambled monthly for the last 12 months. This estimate falls below the HSE Yorkshire and Humber regional estimate (53%, 95% CIs unavailable) for those that have gambled across the last 12 months. This observed variation in results could be due to differences in survey questioning. The Wakefield AHS focuses on frequent gambling, asking about gambling "monthly for the last 12 months". Comparatively, the HSE has a broader scope, asking about gambling "at any point across the last 12 months" therefore including those who gamble less frequently and inconsistently. Additionally, data collection occurred at different points between the two surveys. The HSE data was collected in 2021 whilst AHS was collected in 2023. Consequently, differences in economic and geopolitical circumstances between each time point could have had confounding influence.

Among those adults who gambled in the past year, the HSE does also measure gambling frequency at a national level. 53% gambled once per month or less and 47% gambled more than once a month. Of those that gambled more than once a month, 22% gambled once per a week and 12% gambled two or more times per week.

However, direct comparisons are not possible with the Wakefield AHS results as we do not have the data to differentiate between those who gambled daily, weekly or monthly; they are collectively grouped as having gambled "at least" monthly for the last 12 months or not via the binary answer options of "yes" or "no". Resultantly, we know very little

about the heterogeneity of the 35.1% of adults in Wakefield who reported they gambled monthly for the last 12 months.

Across all Wakefield wards, residents from Hemsworth (44%, 95% CI: 36.7% - 52.3%) and South Elmsall and South Kirkby (47%, 95% CI: 39.7% - 54.3%) were significantly more likely to have gambled at least once a month over the last 12 months compared to the average (35.1%). Residents from Horbury and South Ossett (26% 95% CI: 19.5% - 33.7%) and Wakefield South (26.1%, 95% CI: 19.6% - 34%) reported the lowest rates.

The rate among men (39.3%, 95% CI: 36.9% - 41.7%) was significantly higher compared to women (31.5%, 95% CI: 29.3% - 33.7%).

Age and sex

As shown in Figure 2, gambling activity was higher among men compared to women across all age groups. For both men and women, gambling activity was highest within the 34 – 64 age bracket.

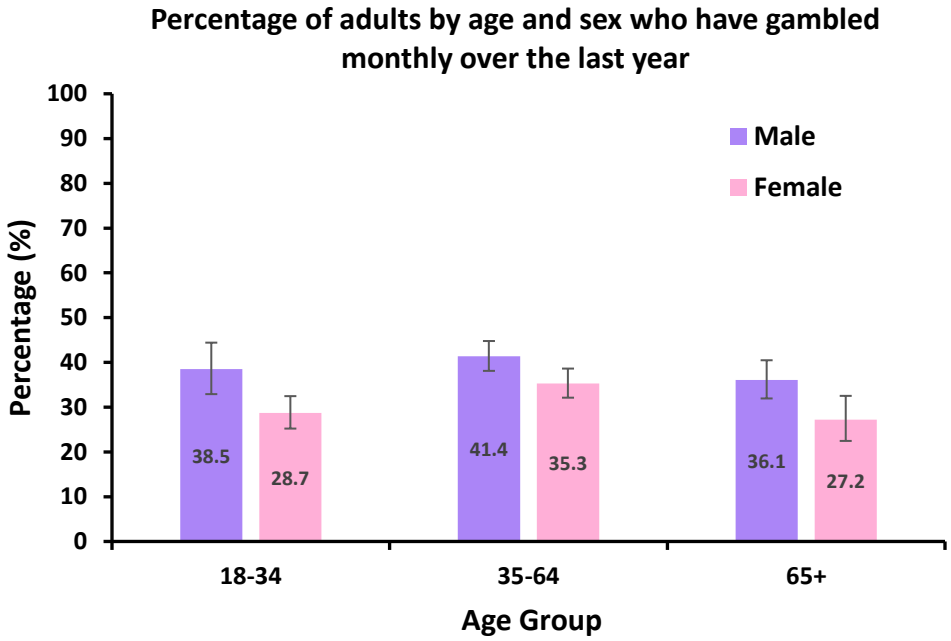

Figure 2. *Distribution of gambling prevalence among adult men and women of different age groups in Wakefield.*

When age is split into narrower age brackets (see Figure 3), gambling appears to peak in the middle age bracket (45 – 54) at 41.1% (95% CI: 36.7% - 45.6%) and is lowest among the youngest (18 – 24) and oldest (74+) age brackets, at 24.1% (95% CI: 17.4% - 32.3%) and 30.8% (95% CI: 26.2% – 35.8%) respectively.

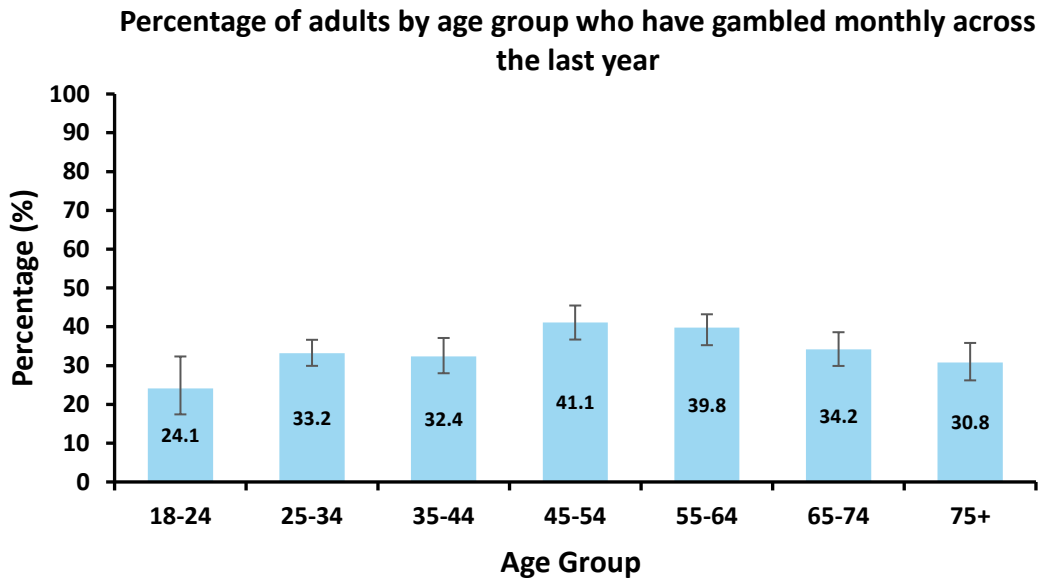

Figure 3. *Distribution of gambling prevalence among adults by 5-year bands in Wakefield.*

Ethnicity

As indicated by the wide confidence intervals in Figure 4, the sample of non-white ethnic group participants was very small and should therefore be interpreted with caution. The data does however suggest that gambling is not polarised between ethnicities and that a spectrum of participation likely exists. Gambling behaviour is influenced by many factors and individuals are subjected to these regardless of their ethnicity.

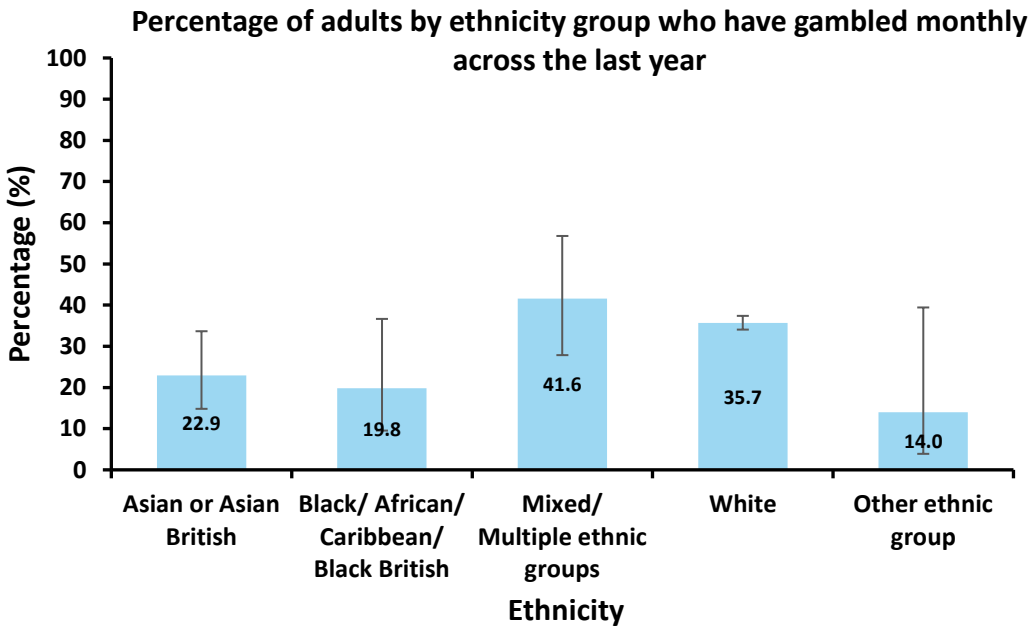

Figure 4. *Distribution of gambling prevalence among adults from different ethnicity groups in Wakefield.*

Employment

Figure 5 shows the variation in gambling rates across different employment groups. Those working full time (30+ hours per week) had the highest rate (40.5%), followed by those who are retired (33.5%), long term sick or disabled (32.6%), self-employed or freelance (32.1%), and looking after family/home (27.3%). Full time students had the lowest rate (19.3%)

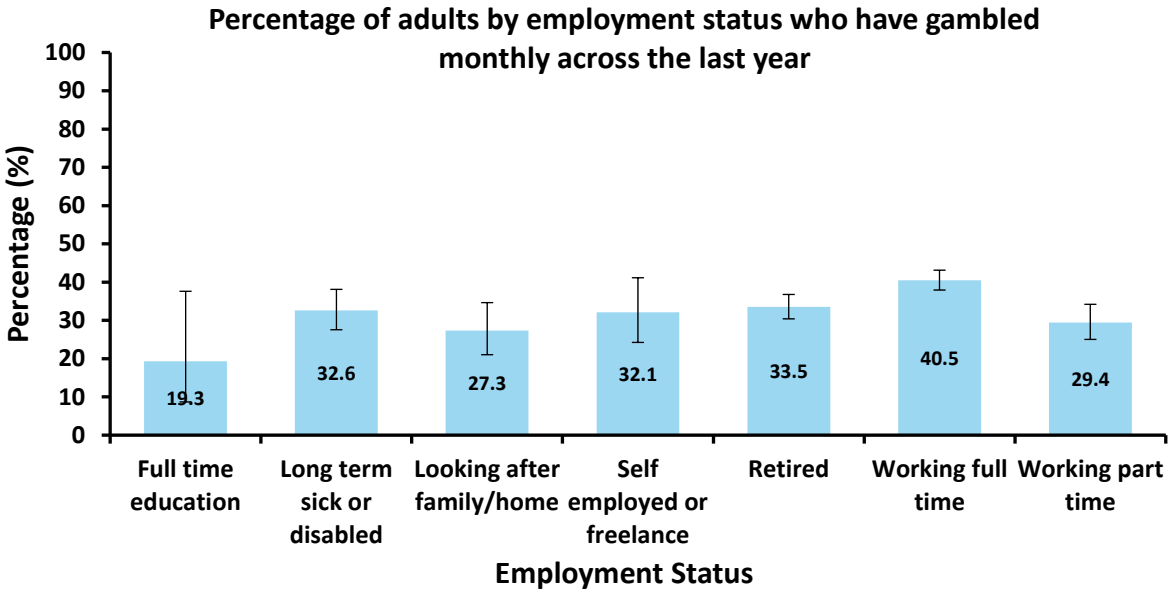

Figure 5. *Distribution of adult gambling prevalence by different employment status.*

Education

Respondents with no qualifications reported very similar gambling participation to those grouped with the highest qualifications (31.9%, 95% CI: 27.8% - 36.3% versus 32%, 95% CI: 29.1% - 35.1%). The highest gambling participation was reported among those with 1-4 O-levels / GCSEs or equivalent, at 40.1% (95% CI: 35.7% - 44.6%).

Deprivation

Gambling participation across the last 12 months was similar among residents who reside in areas across each quintile of deprivation (measured by Indices of Multiple Deprivation). As shown in Figure 6, there was slight variation across quintiles, with the most deprived having the highest rate (37.4%, 95% CI: 33.8% - 41.1%) and the least deprived having the lowest rate (30.9%, 95% CI: 27.6% - 34.5%). However, these differences would not be deemed statistically significant as the 95% confidence intervals cross.

Similar observations have occurred nationally, with gambling activity being similar across area deprivation levels with the results of the HSE. It should be noted that this does not mean that gambling has the same impact on different socioeconomic groups. Even with similar participation rates, some people, for example those living in more deprived areas, may be more vulnerable to gambling harms.

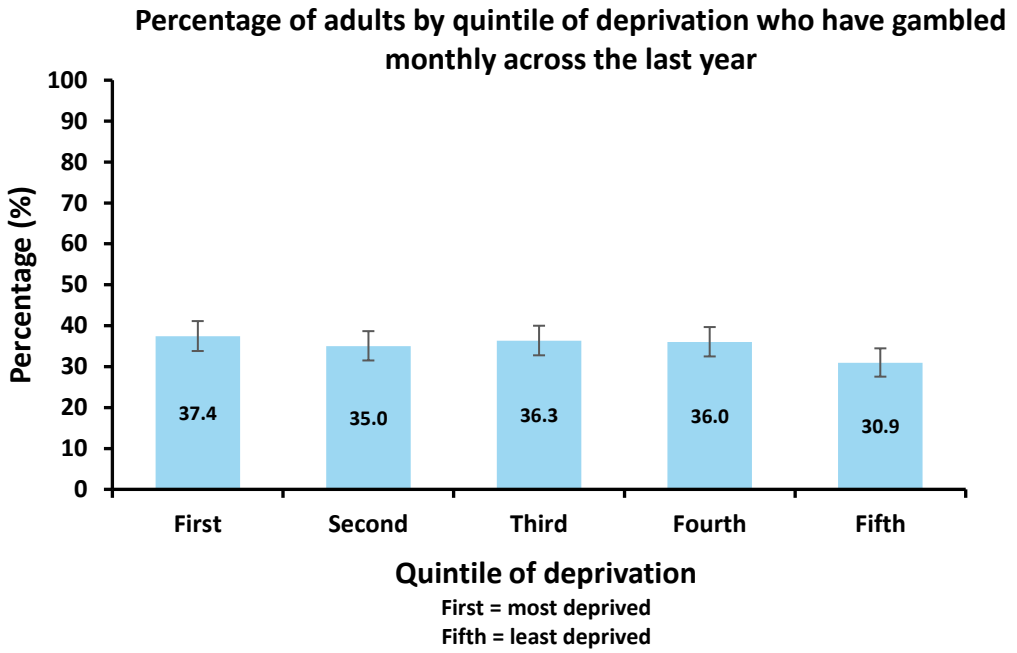

Figure 6. *Distribution of adult gambling prevalence across different quintiles of deprivation in Wakefield.*

Mental wellbeing

Mental wellbeing status did not correlate with gambling activity, as those categorised as having *poor mental wellbeing*, *good mental wellbeing*, and *high mental wellbeing* all reported similar participation in gambling (34.9%, 35.1%, and 34.9% respectively).

Obesity

Respondents living with overweight or obesity were more likely to have gambled (39% and 40% respectively) whilst those within a healthy BMI range were less likely to have gambled (27%).

Alcohol

As displayed in Figure 7, there was a positive linear relationship between status of alcohol consumption and gambling activity. Among non-drinkers, 27.4% reported to have gambled across the last twelve months. This proportion increased consistently with each incremental alcohol consumption category, peaking at 55.7% among higher risk drinkers. Although causation cannot be established from these data alone, this is suggestive of a dose response relationship between alcohol and gambling.

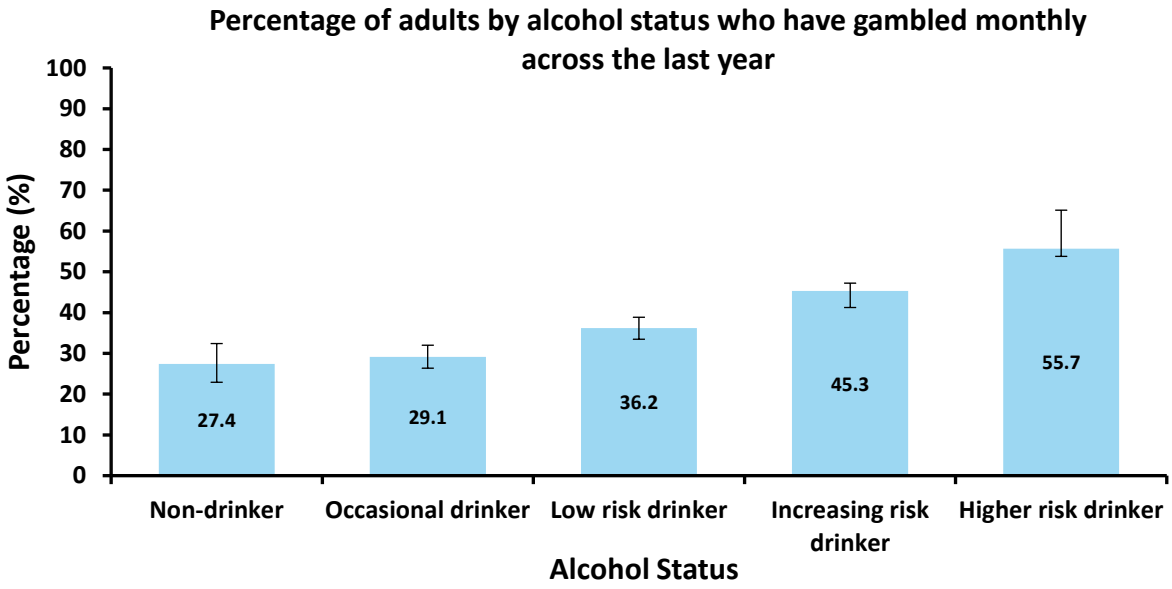

Figure 7. *Distribution of adult gambling prevalence categorised by their alcohol consumption status.*

Risk of gambling harms

In addition to estimating the prevalence of gambling activity in Wakefield, the AHS also estimates the severity of risk among those that gamble, for experiencing directly related adverse consequences.

Within the AHS, risk of gambling harms was determined using the short-form PGSI, which categorised the percentage of those who gamble into one of the four possible categories*.

Non-problem gambler. This group probably will not have experienced any adverse consequences of gambling

1 - Low risk gambler. This group likely will not have experienced any adverse consequences from gambling

2-3 - Moderate risk gambler. This group may or may not have experienced adverse consequences from gambling

4+ - Gambling at a harmful level. This group are those who have experienced adverse consequences from their gambling.

*__Language only used to refer to categories of the PGSI.__

Gambling at a harmful level in Wakefield

Of those adults in Wakefield who gamble, 88.1% were estimated to experience no risk, whilst 6.1% were at low risk, 4.8% were at moderate risk, and 1% were categorised as participating in gambling at a harmful level. Based on these figures from the AHS, an estimated 11,818 adults in Wakefield are gambling at levels of increased risk, with 993 of those adults gambling at a harmful level.

Although there are methodological differences, this estimate is over three times higher than the HSE-derived regional (Yorkshire and Humber) estimate of 0.3% for those engaging in gambling at a harmful level.

Sex

Although prevalence of gambling is lower in women than men, the relative proportion of women gambling at a harmful level in Wakefield is far greater than among men (1.6%, 95% CI: 0.9% - 3.1% versus 0.4%, 95% CI: 0.1% - 1.3%). However, the wide and overlapping confidence intervals, due to sample size, indicates that this difference is not deemed statistically significant and should be interpreted cautiously. Additionally, this contrasts to the national HSE evidence from the HSE which suggests across the country, men are around four times more likely to engage in gambling at a harmful level.

Deprivation

In line with national evidence, there is a correlation in Wakefield between deprivation and risk of adverse consequences from gambling. Table 4 shows each decile of deprivation and the corresponding proportion of gamblers categorised as having 'no risk'. This shows that the higher the deprivation, the lower the proportion of people are gambling at levels of no risk. Observing the confidence intervals, the difference between the most deprived decile would be deemed statistically significantly different to the least deprived decile as well as the second least deprived decile.

Table 4. *Association between deprivation and being at no risk of gambling harms.*

Decile of deprivation	Proportion at 'no risk'	Lower 95% CI	Upper 95% CI
First (most deprived)	79.8%	74.4%	84.3%
Second	87.2%	82.4%	90.9%
Third	88%	83.4%	91.5%
Fourth	91.8%	87.7%	94.6%
Fifth (least deprived)	94.7%	90.8%	97%

Levels of increased risk are shown in Figure 8, which continues to demonstrate the link between deprivation and increased risk of adverse consequences from gambling. Adults living in the most deprived decile had the highest rate of gambling at a harmful level (2.5%, 95% CI: 1.2% - 5.2%) . Comparatively, adults living in the least deprived decile had 0.0% categorised as gambling at a harmful level.

Figure 8 also shows that those living in the most deprived decile had the highest rates of low risk and moderate risk. Collectively, 20.3% of people who gamble that are living in the most deprived decile are gambling at a level of increased risk (low risk, moderate risk, or gambling at a harmful level), compared to 5% among those in the least deprived decile.

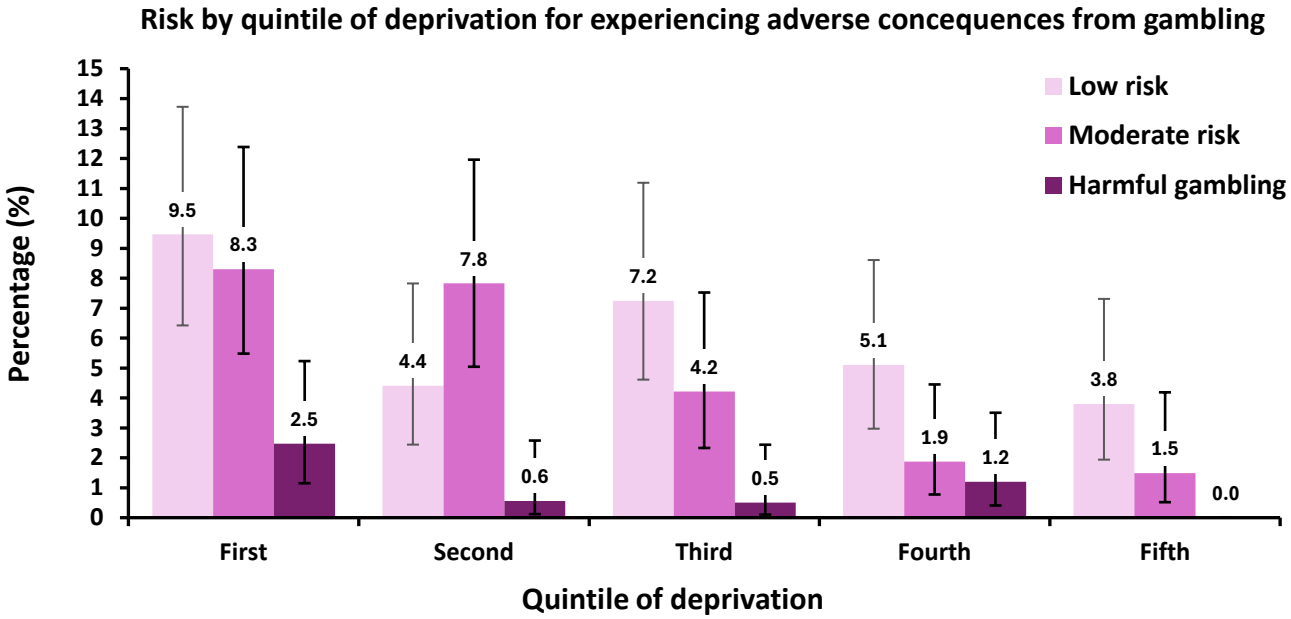

Figure 8. *Distribution of adults living in different deciles of deprivation who are at low risk and moderate risk of gambling-related harm.*

Age

The 18-34 age group had the highest risk of gambling at a harmful level (1.5%, 95% CI: 0.6% - 3.7%) and the highest rates of low risk and moderate risk gambling, as shown in Figure 9. Whilst the wide confidence intervals reflect a degree of uncertainty, the repeated pattern of risk being higher among younger age groups in Wakefield provides valuable insight and the potential need for further exploration and research among younger adults.

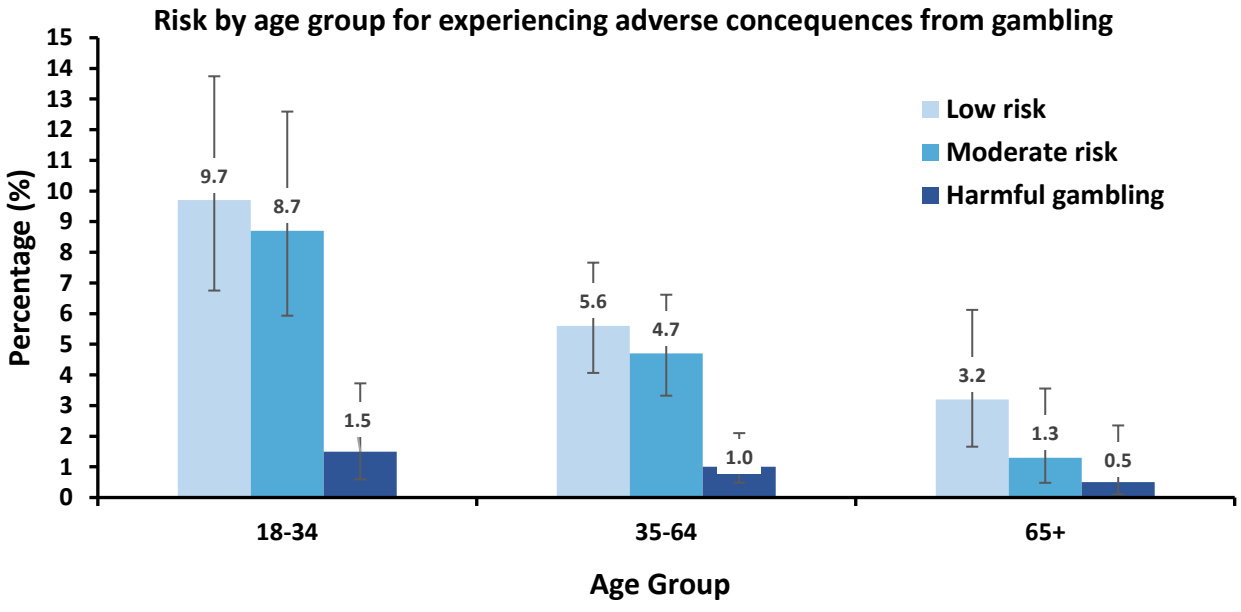

Figure 9. *Distribution of the level of risk for experiencing harm from gambling across different age groups of adults in Wakefield.*

10.4. **Mapping data**

There is no local authority licence required to sell National Lottery tickets, only a retailer agreement with Allwyn, the Swiss operator of the UK National Lottery. Resultantly, if we were to map every single outlet in Wakefield which sold National Lottery tickets and/or scratchcards, the map would be almost fully saturated. This would include almost every corner shop, newsagents, post office, supermarket, petrol station etc. across Wakefield.

The Wakefield Council Public Register Person/Premises Search is an online tool that allows searches for information related to licensing activities within Wakefield. The following type of gambling licences were included in the mapping activity, which reflect the scale and diversity in means to which people have physical access to gambling products.

Licenced Betting Premises

A license for shops or physical locations that allow people to place bets on various events, typically sporting events like horse races or football matches.

Race Tracks

This license is for the operation of a horse racing track or similar venue where racing events are held. This license typically covers elements like the track itself, spectator facilities, and tote betting facilities (on-site betting pools).

Wakefield has Pontefract Racecourse, which was established in 1801, and Kinsley Greyhound Stadium which first opened in 1939 Resultantly, despite being associated with gambling, they hold cultural and historical significance in the local area and across the community.

Bingo Premises

This license is for venues specifically dedicated to the game of bingo.

Adult Gaming Centres

This license is for venues offering a variety of electronic gaming machines for amusement or small prize redemption. These machines are distinct from casino slot machines and typically have lower maximum stakes and prizes.

Licenced Premises Gaming Machine Permit (LPM)

This is a permit, not a standalone license, that allows certain existing licensed premises to have a limited number of category C or D (low stakes) gaming machines on-site. These premises could be pubs, clubs, or even certain types of shops.

Alcohol licenced premises are automatically entitled to two category C or D gaming machines upon notification to the council. Permits for additional machines can be provided upon application.

Club Machine Permit (CMP)

Similar to an LPM, this is a permit for members' clubs, miners' welfare clubs, or commercial clubs to have gaming machines on their premises. Like LPMs, CMPs restrict the number and type of machines allowed (typically category B3A, B4, C, or D machines).

Visit the Gambling Commission website for a full explanation of different gaming machine categories.

Deprivation and density of gambling licenced premises

Figure 10 maps quintiles of deprivation across the Lower Super Output Areas (LSOAs) in Wakefield, with the shade of turquoise indicating the level of deprivation; the darker the shade the higher the level of deprivation. This is overlayed with the individual location of licenced betting premises in Wakefield, each indicated by a red dot.

From this mapping exercise, it is clear to see that licenced betting premises are disproportionately situated in areas of higher deprivation. Notably, of the 69 licenced betting premises, only one is situated across LSOAs in the least deprived quintile. In contrast, there are seven in Wakefield City Centre, an LSOA in the highest quintile of deprivation.

This pattern is maintained in Figure 11 which additionally maps all other premises which hold alternative gambling licencing types (racetracks, bingo premises, adult gaming centres, LPMs, and CMPs). Of the 236 licenced premises in Wakefield, only 15 operate within LSOAs of the least deprived quintile.

This points to an association between deprivation and licenced gambling premises. However, this does not imply that gambling rates are higher in areas with higher density of licenced betting premises or in areas with higher deprivation. There are too many other influencing variables to consider, not least the almost universal access to online gambling which nullifies the requirement of physical access to licenced betting premise to gamble.

This may be important in determining the impact of local authority licencing powers in relation to access to gambling. Limiting or reducing licences may not have the impact it once could have, due to online access to gambling. However, the remaining presence of gambling premises on the Highstreet, which are equally visible to children as they are to adults, normalises gambling, acts as a form of advertisement and a potential subconscious cue to gamble.

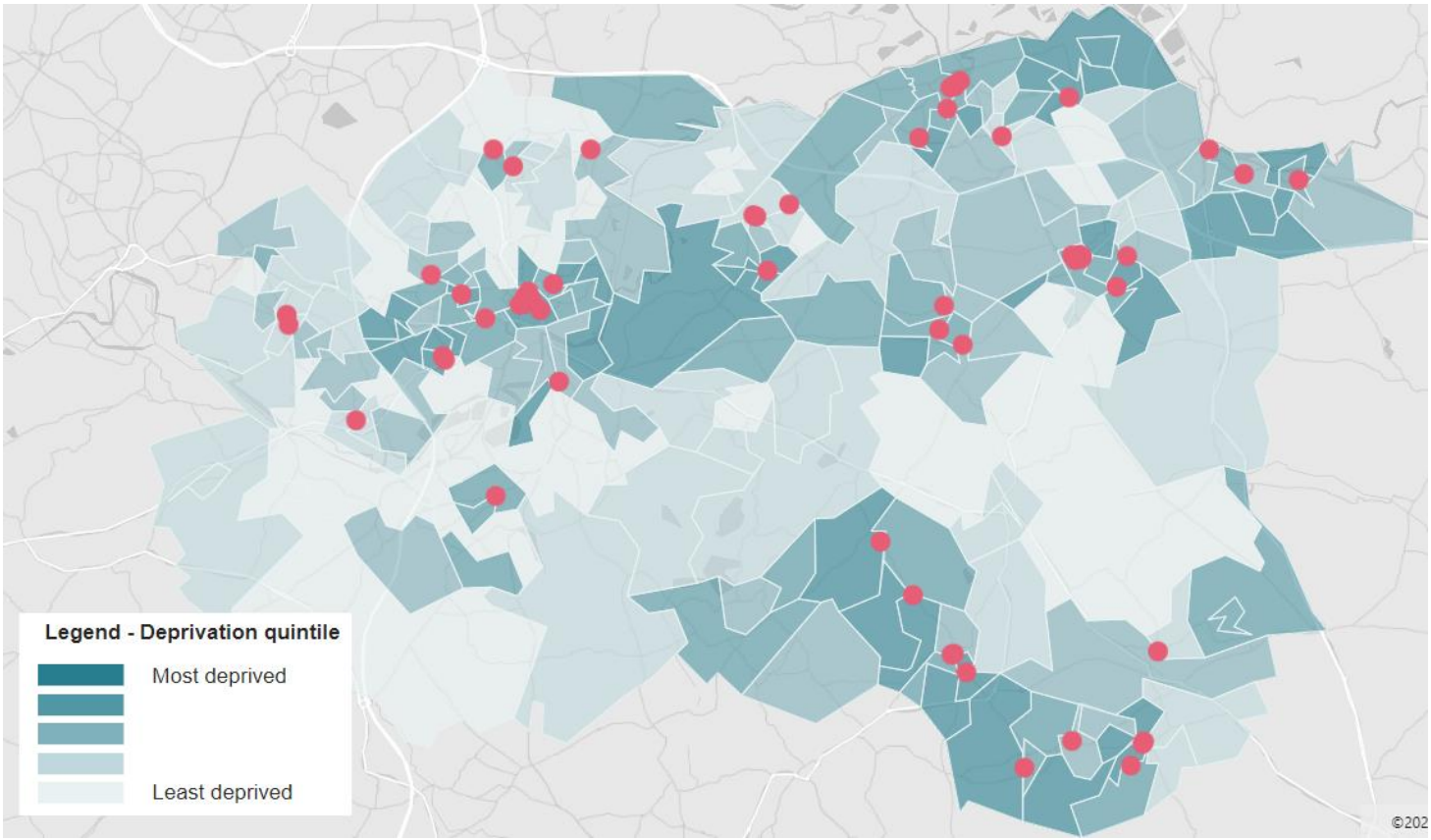

Figure 10. *Quintiles of deprivation by Wakefield LSOAs, overlayed with the individual location of each licenced betting premise.*

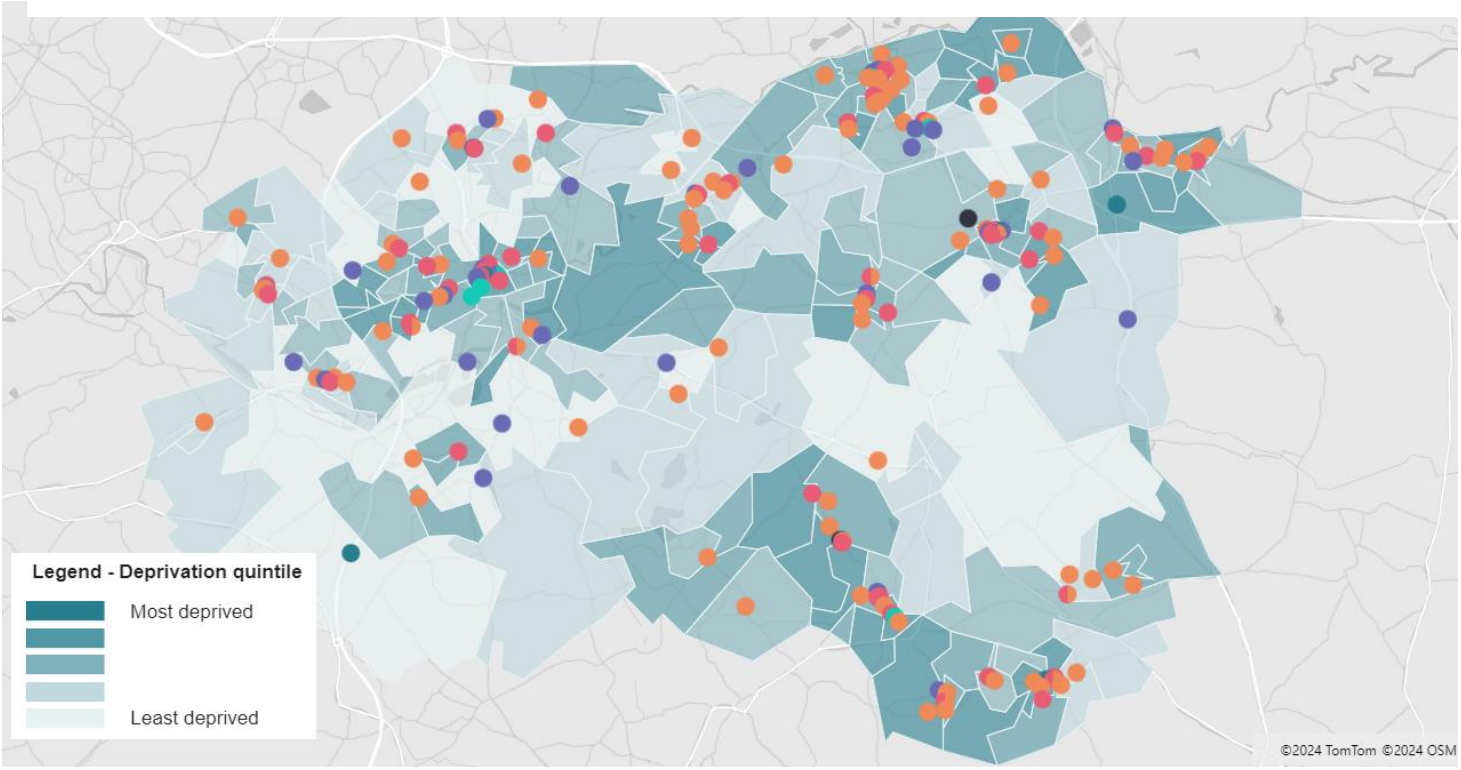

Figure 11. *Quintiles of deprivation by Wakefield LSOAs, overlayed with the individual location of all types of licenced betting premises.*

10.5. **NHS Northern Gambling Service data**

The NHS Northern Gambling Service were contacted with a request to provide referral data across the last four years for Wakefield residents.

There has been a total of 53 referrals from Wakefield into the NHS Northern Gambling Service during this period. As shown in Figure 12, referrals remained steady for the first three years before more than doubling between 2022/2023 and 2023/2024.

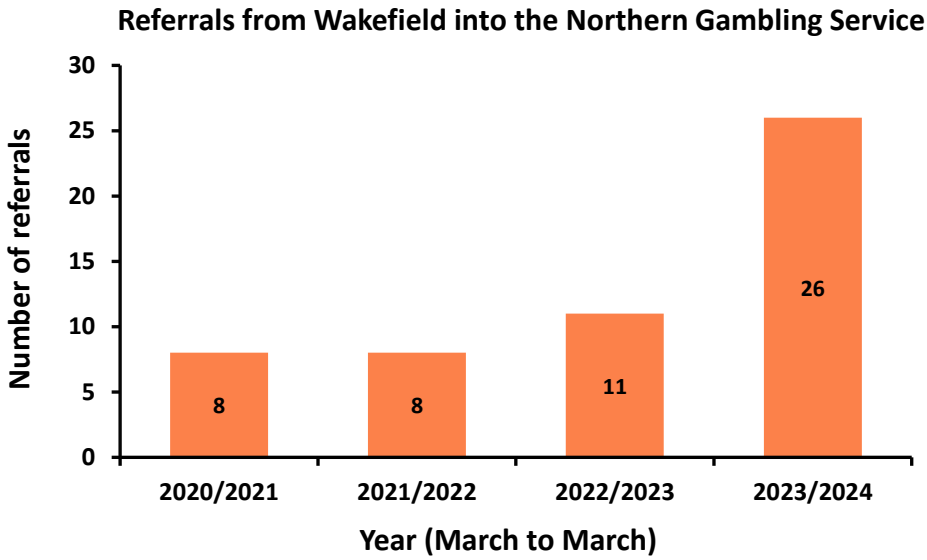

Figure 12. *Total yearly referrals made into the NHS Northern Gambling Service for adults from Wakefield between 2020 and 2024.*

Figure 13 shows the distribution of referrals by age and sex. Most referrals were between the ages 20 and 39 (79.3%) and men made up 73.6% (n = 39) of all referrals during this period. Of all referrals 49 have been White British, one White Other Background, and the ethnicity of three referrals is listed as unknown.

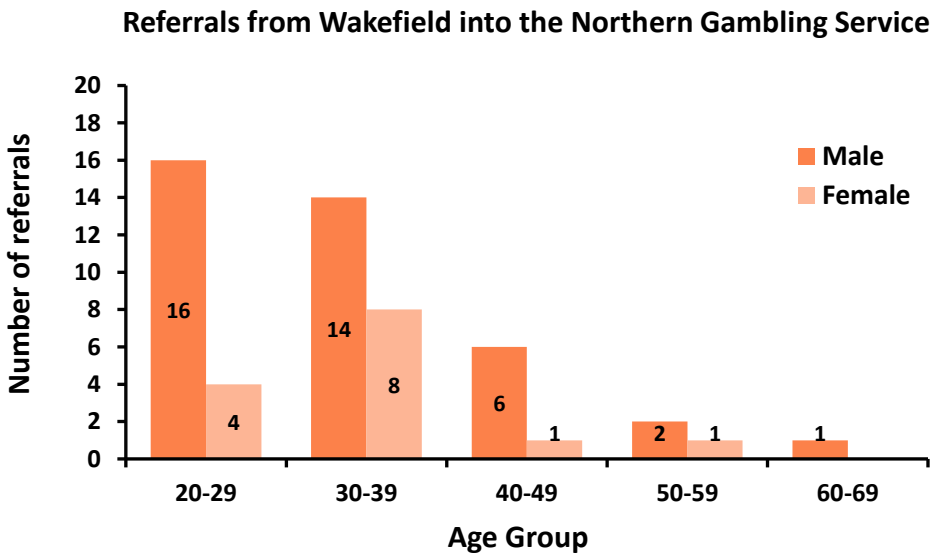

Figure 13. *Breakdown of referrals into the NHS Northern Gambling Service by men and women and by ten-year age groups.*

The support offered by the NHS Northern Gambling Service can be provided across three platforms; face to face, telephone, and video consultation. Wakefield referrals predominantly attended video consultation appointments (*n* = 223), with a small amount attending telephone appointments (*n* = 17) and face to face appointments (*n* = 18).

Due to the small referral numbers, it is difficult to make inferences from this data. However, the higher number of referrals among younger adults corroborates with the data from the AHS which suggests that this age group, particularly men, may be more likely to gamble at levels of increased risk, more in need of support, and more likely to access to support.

10.6. **Young adult's perceptions of gambling in Wakefield**

As identified in the findings of the AHS, young adults within the 18 – 34 age bracket in Wakefield have the highest rate of gambling at a harmful level. Resultantly, to gain further insight into behaviours and attitudes towards gambling and the gambling industry among this cohort, an online survey was developed and distributed online. The survey was open for three weeks, between 7th – 28th August 2024.

The survey asked questions with a selection of options available for each, usually on a five-point Likert scale. Scales were either frequency ("never" to "daily"), extent of agreement ("strongly disagree" to "strongly agree") or likelihood ("a lot less likely" to "a lot more likely").

The survey results should be interpreted alongside the understanding of the methodological limitations, of which the prominent ones are acknowledged here;

Small sample

Due to small sample size, statistical power is limited. Because of this, statistical tests were not performed. Rather, the survey results are reported descriptively, to indicate suggested patterns in thoughts and behaviours relating to gambling.

Age and residency not validated

The target sample may not match the actual sample who completed the survey, due to no verification. This opens the possibility of data from individuals outside of the target age bracket and outside of Wakefield being included in the results.

Convenience sampling

Respondents may not be representative of the target population. This could lead to selection bias, where certain groups are over or underrepresented in the sample. Therefore, results may be biased towards the characteristics of a group that's more likely to participate in the survey, limiting the generalisability of findings.

By transparently acknowledging these limitations, I hope to provide a more nuanced interpretation of the survey results which provide unique insights into gambling behaviours and attitudes among young adults in Wakefield. From this, the rationale for more robust and comprehensive research in the future may be established.

Survey results

The survey structure and responses to each question can be found in Appendix A.

Demographics and gambling activity

A total of 34 residents completed the survey. Nine participants were excluded for not meeting inclusion criteria, leaving an analysed sample of 24. Of these, the average age was 30 (range; 19 – 34). Twelve participants were female, six were men, and six did not answer. All participants were White, besides one who was Asian or Asian British – Chinese.

As shown in Figure 14, 15 of the 24 participants (63%) participate in gambling. Of these, six reported gambling once or twice a year, six gambling monthly, two gambling weekly and one gambling daily. Eleven participants (46%) reported not having a gambling app on their phone. One participant had five or more apps, with the remaining participants (*n* 14 / 58%) having between one and three. Notably, of those that engage in gambling, 80% had at least one gambling app on their phone.

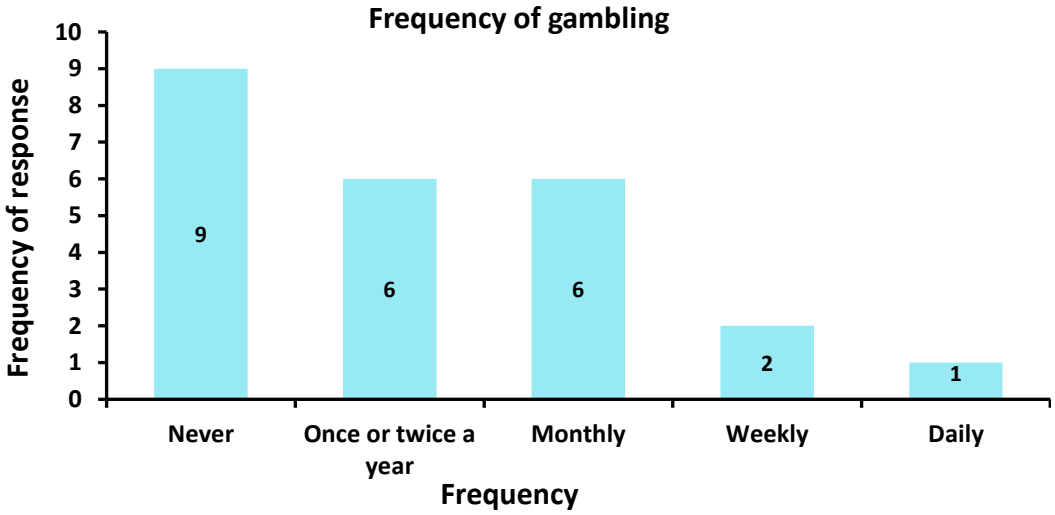

Figure 14. *Breakdown of how frequently adults aged 18-34 in Wakefield gamble.*

Opinions on gambling

Figure 15 presents the distribution of participant responses to the statement "**it is up to people to make their own choices about gambling**." There was a strong consensus among participants, with a clear majority endorsing the notion of individual autonomy in gambling decisions.

Specifically, 77% of respondents (*n* 12) indicated agreement with the statement, and an additional 43.8% (*n* 7) expressed strong agreement. In contrast, only 12.5% (*n* 2) disagreed, and none strongly disagreed. A small proportion (*n* 2, 12:5%) remained neutral, and one participant did not provide a response.

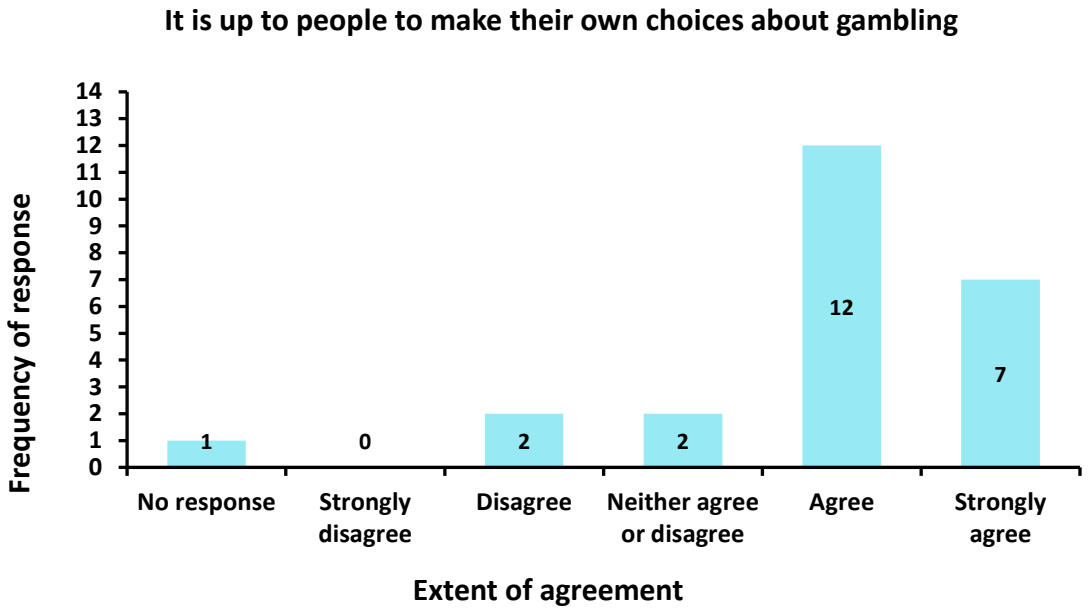

Figure 15. *Extent to which Wakefield adults (18-34) agree about gambling being a personal choice.*

Most participants strongly agreed (*n* 9, 38%) or agreed (*n* 7, 29%) that **"gambling is fun and exciting"**. Seven participants (29%) neither agreed or disagreed, two (8%) disagreed, and three (13%) strongly disagreed.

Despite a strong consensus on gambling being a personal choice and fun and exciting, there was mixed perception in response to the statement "**most people who gamble, do it safely**". Twelve participants agreed and two strongly agreed. However, five disagreed, with a further two who strongly disagreed. Five participants neither agreed nor disagreed.

Some participants agreed that "**people are less likely to gamble harmfully if they see warning messages**" – eight agreed (33%) and three strongly agreed (8%). However, responses were mixed. Six (25%) neither disagreed or agreed, five (21%) disagreed, and three (13%) strongly disagreed.

When asked about their extent of agreement with the statement "**on balance, gambling is good for society**", the majority (*n* 13, 54%) disagreed or strongly disagreed. Only two participants (8%) agreed with the statement. No participants strongly agreed and the remaining 9 participants (38%) neither agreed nor disagreed with the statement.

When presented with the statement "**there are too many ways to gamble nowadays**", most participants agreed, with 14 (58%) who strongly agree and three (13%) who agree. Only two participants disagreed (2%), with the remaining five participants (42%) neither agreeing nor disagreeing.

As displayed in Figure 16, perceptions around whether "**the government should do more to control the gambling industry**" were broadly supportive. Thirteen (54%) participants either agreed or strongly agreed. Only one participant disagreed, with the most popular response being neither agree or disagree (*n* 10, 42%).

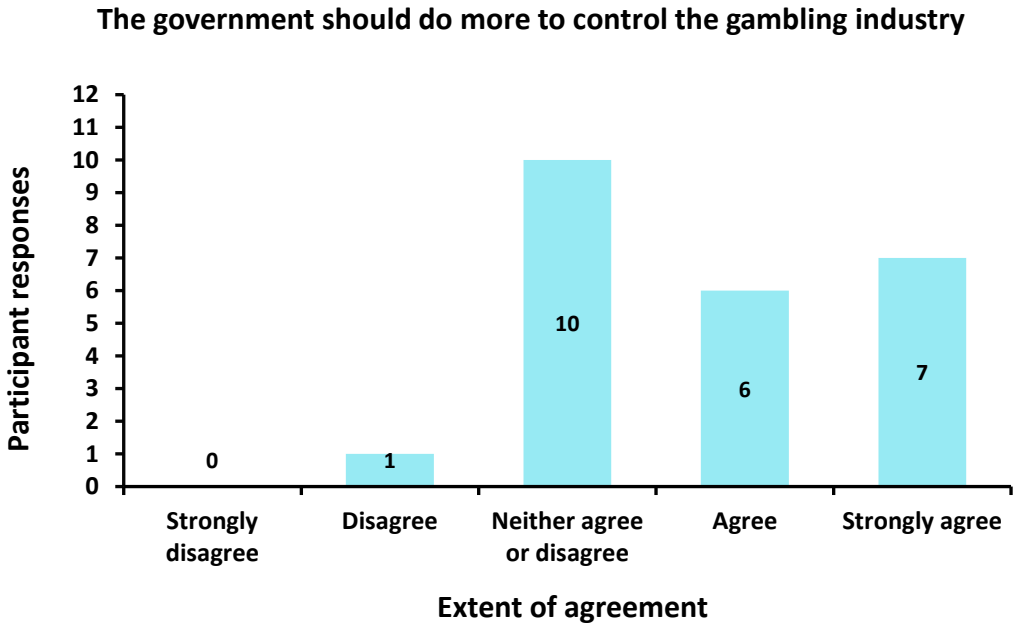

Figure 16. *Extent to which Wakefield adults (18-34) agree that the government should do more to control the gambling industry.*

However, perceptions on whether "**it would be better if gambling was banned altogether**" were less popular. Fourteen participants (55%) either disagreed or strongly disagreed and 14 participants (42%) neither agreed or disagreed. Seven participants (29%) either agreed or strongly agreed.

Perceptions of the gambling industry

As shown in Figure 17, participants generally disagreed that "**gambling companies are honest and open about the risk of gambling**", with 13 who disagreed and four who strongly disagreed. Only four participants agreed with the statement.

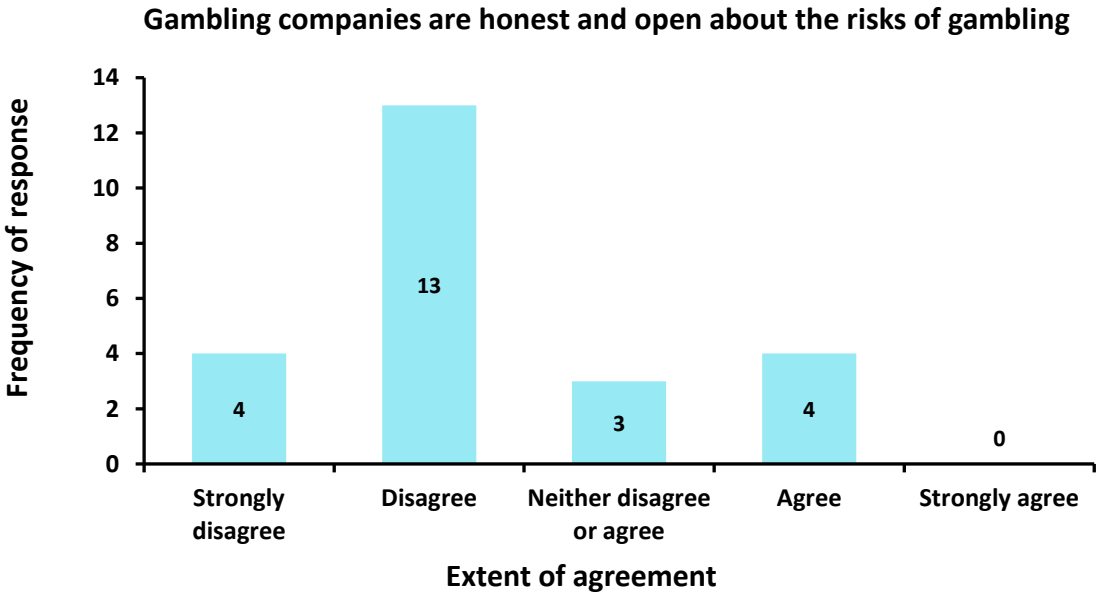

Figure 17*. Extent to which Wakefield adults (18-34) agree that the government should do more that gambling companies are honest about the risks of gambling.*

Why people gamble

Participants were asked to select from a defined list "**the three things which they think are most likely to encourage people to gamble"**. The frequency of selected answers is featured in Figure 18 which shows that "to win money" and "because it's a big sporting event" were the joint most common answers, each selected by 19 participants (79%). Drinking alcohol and taking drugs were selected least, each by only three participants (13%).

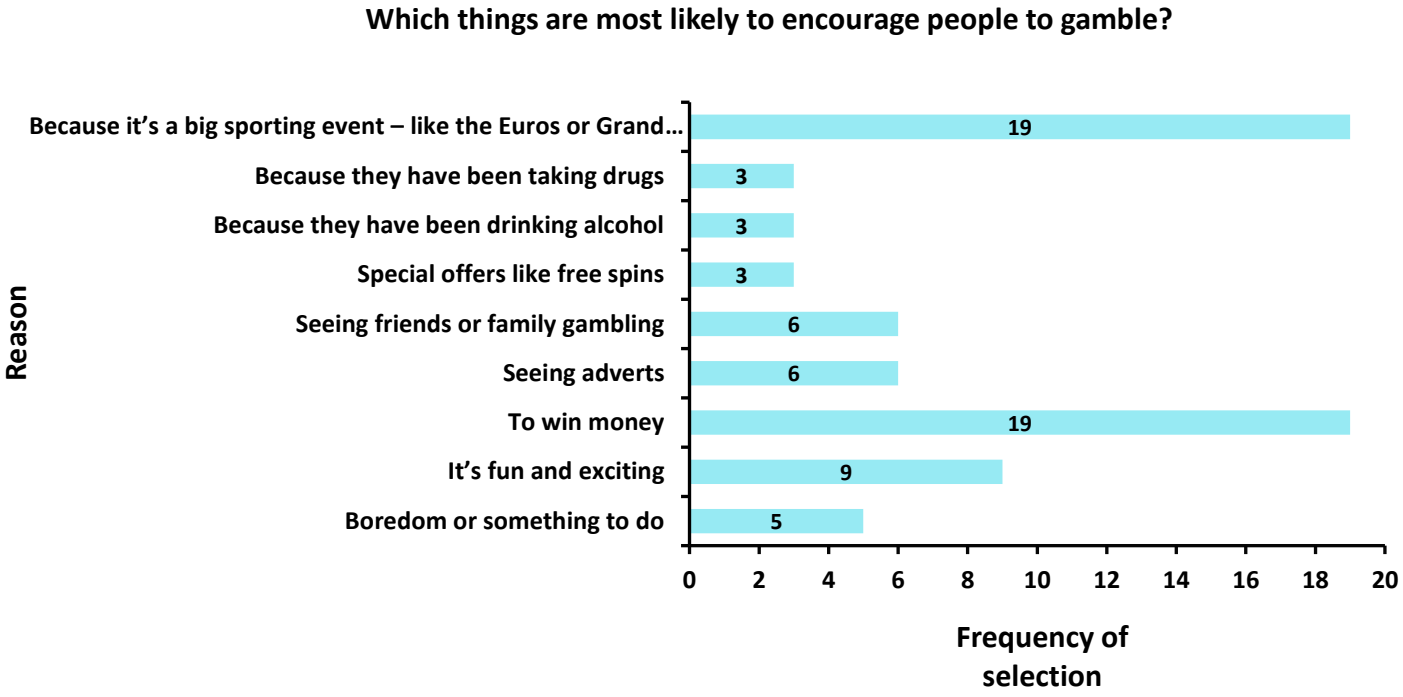

Figure 18. *Distribution of which things Wakefield adults (18-34) think are most likely to encourage people to gamble.*

Gambling advertisements

The data revealed that participants encounter gambling advertisements with considerable frequency. To the question "**how often do you see gambling adverts?**", the most common response was "Daily" (*n* 10), indicating significant exposure for a portion of the sample. The next most frequent response was "weekly" (*n* = 9). While a smaller group of participants reported seeing gambling adverts "monthly" (*n* 4), only one person indicated "never" encountering them.

When asked "**do you notice a change in the amount of advertisements for gambling during large sporting events such as the Euros, Grand National and Golf Open**?" there was a clear consensus where participants perceived an increase in gambling advertising. Twenty participants responded with "more" (*n* 9) or "much more" (*n* 11) with the remaining three perceiving "no change" and no selections of "less" or "much less".

Commercial impacts on gambling behaviour

Figure 19 shows participant responses to how large sporting events, gambling adverts, and special offers impact their gambling behaviour. Overall, **"large sporting events, such as the Euros, Grand National, and Gold Open"** influenced participants to be "a lot more likely to gamble" (*n* 10, 42%) more than "seeing gambling adverts" (*n* 1, 4%) and "receiving special offers or promotions from gambling companies" (*n* 2 (8%).

The distribution of responses for large sporting events shows fifteen participants (63%) thought they made them either a bit more likely or a lot more likely to gamble. Seven (29%) perceived no change and only two (8%) thought large sporting events resulted in them being a lot less likely to gamble.

When asked how "**seeing gambling adverts**" impacts their gambling behaviour, half of the participants perceived no change, whilst a third were a bit more likely to gamble and one participant was a lot more likely to gamble. Three participants selected that they would be a lot less likely to gamble.

For **"receiving special offers or promotions from gambling companies"**, the most common response was "no change" (*n* 10, 42%). Twelve participants (46%) were either a bit more likely *(n* 9) or a lot more likely to gamble (*n* 2) whilst three were a bit less likely or a lot less likely to gamble

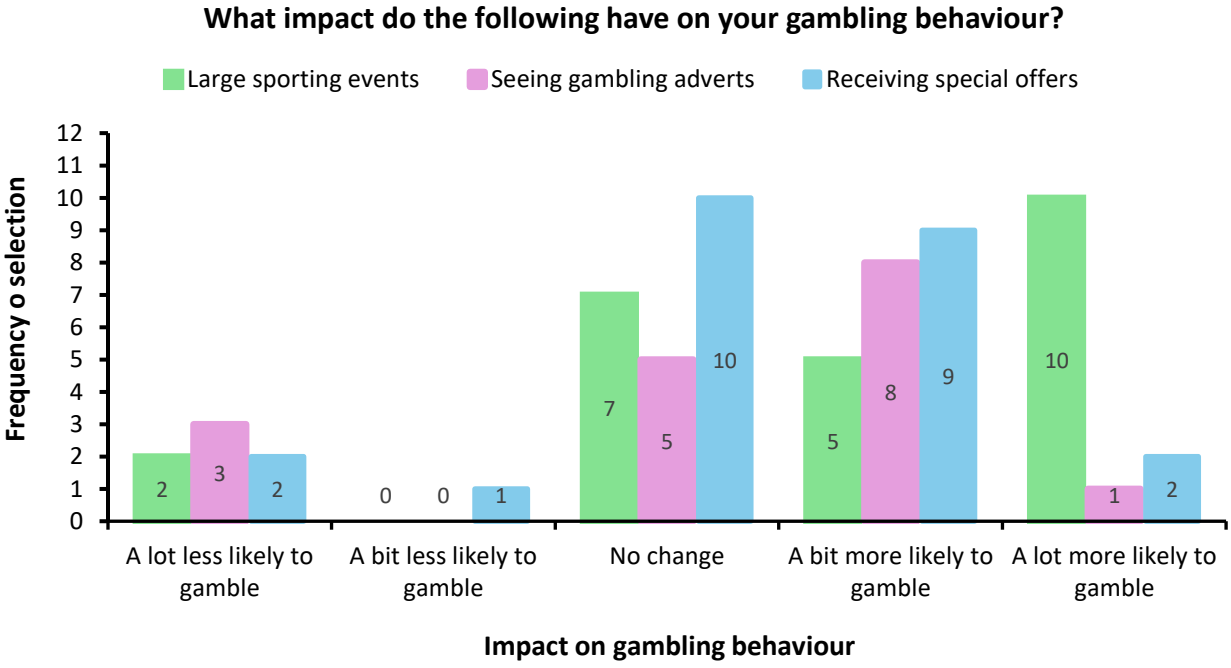

Figure 19. *Impact of commercial activities on gambling behaviour among Wakefield adults (18-34).*

At the end of the survey, participants were asked where or how they would seek help or support if they were concerned about their gambling. Mention of online resources appeared frequently, highlighting the prominent role that online platforms could have in providing support and treatment for young adults. Five participants did not know or were unsure where or how they would seek support. Responses are listed below.

Websites likely Gamble aware or gamstop
I would google 'Gambling support Featherstone'
Begambleaware website
Online addiction help websites
Online
Google
I'd google gambling support.
Gamcare or maybe my GP
Don't know
Not sure
Internet
Unsure
No idea
I'd never gamble but if I did I'd speak to a Dr
Delete my apps
Online
Speak to family
No idea

Interpretation of findings

Whilst acknowledging the limitations of the survey and the caveats placed on its findings, the survey results highlight a complex series of perceptions towards gambling among the sample of young adults in Wakefield.

Of the sample, 63% engage in gambling and of those, 80% have at least one gambling app on their phone, emphasising the increasing accessibility of gambling through online platforms and mobile apps.

While gambling is seen as a personal choice and a source of fun and exciting entertainment, there was apparent awareness of the potential risks and harms. The mixed views on whether most people gamble safely, and the effectiveness of warning messages suggests an awareness of the risks and harms of gambling. This was reiterated by the observed disagreements on whether gambling is good for society, and by the large majority of participants who agreed that there are too many ways to gamble nowadays.

Most participants also disagreed that gambling companies are honest and open about the risks of gambling. This suggests that participants are aware of the potential for exploitation and manipulation by gambling operators.

In support of this, most participants agreed that the government should do more to regulate the gambling industry, although support for an outright ban was far less popular. This indicates that there may be a nuanced perspective towards gambling regulation that causes greater transparency and the prevention of harm but that does not prohibit.

When asked about where and how to seek help, many participants were unsure, mentioned industry-funded providers, or cited online resources. The reliance on online resources underscores the importance of accessible and user-friendly online support services for gambling harms. However, it also highlights the need to increase awareness of specialised non-industry organisations such as the NHS Northern Gambling Service, which wasn't included in any of the participant's responses.

The survey results also clearly illustrate the pervasive presence of gambling advertisements in the lives of young adults. Most participants reported encountering such adverts on a daily or weekly basis, highlighting their significant exposure to gambling-related marketing.

Furthermore, the perceived increase in gambling advertising during large sporting events raises concerns about the potential impact of such targeted marketing strategies. The excitement and heightened emotions associated with major sporting events, coupled with increased exposure to gambling adverts, could create a potent mix that may trigger or exacerbate gambling behaviours. Indeed, 63% of participants felt as though large sporting events made them more likely to gamble.

While the direct impact of gambling adverts on individual gambling behaviour appeared mixed, with a significant proportion reporting "no change," it's important to recognise the cumulative and subtle effects of advertising. Repeated exposure to gambling promotions can shape attitudes and perceptions, making gambling seem more appealing and less risky.

The findings also suggest that special offers and promotions from gambling companies can be perceived to influence gambling behaviour, although to a lesser extent than major sporting events. This highlights the need for stricter regulations on gambling advertising and promotions, particularly those targeting vulnerable populations.

Of course, these findings are limited in their generalisability, and it would be naïve to draw accurate conclusions from them. However, the results provide useful insights and lay the foundation for future exploration and research into gambling behaviours and perceptions of young adults in Wakefield.

11. Service provision

There are currently no free local services specifically dedicated to supporting those affected by gambling within Wakefield itself. Such services do exist, but these are regional and national, some of which are industry funded. There are local support groups available, such as Gamblers Anonymous, however such groups do not offer clinical treatment and support.

Being industry funded means that such organisations are not entirely independent from industry influence. As the gambling industry profits from people gambling, and treatment services serve to prevent and reduce further gambling, then by principle this would reduce industry profit. Resultantly, there could be lack of genuine incentive to effectively prevent or treat gambling harms, with commercial interests prioritised over public health. This also manifests through industry-published resources (e.g. GamCare Changing your relationship with gambling) which focus on individual responsibility with no acknowledgment of harm caused by industry tactics such as advertising and marketing.

Indeed, recently analysis of gambling education programmes (20) has shown a dominant focus on personal responsibility and the normalisation of gambling, demonstrating that the underlying discourse aligns with industry interests. This demonstrates one way in which commercial entities have power to influence public health. Recognising this, a recent position statement by the ADPH provides detail of the commercial determinants of health and a public health approach to counter such detrimental commercial tactics.

Furthermore, data published by the Gambling Commission, estimates that of the 2 million adults across Great Britain experiencing gambling harm, only 2% access treatment services. Resultantly, even by providing treatment services, industry profits remain largely unaffected, regardless of how effective treatment services are.

11.1. **Local and regional services and support**

NHS Northern Gambling Service

The NHS Northern Gambling Service provides specialist therapy and recovery programmes to people affected by gambling addiction. Help is also provided to those close to those gambling addiction, such as family, partners, and carers. The service covers the whole of the North of England. There is no clinic to provide face-to-face support in Wakefield. The closest available clinics are in Leeds and Sheffield. However, remote video consultations are available.

Website: Home - NHS Northern Gambling Service

Gamblers Anonymous Wakefield

Gamblers Anonymous is a peer-to-peer support group where men and women affected by gambling can share their experiences and provide each other with help and support.

In Wakefield, a weekly Gamblers Anonymous runs on Thursday evenings between 19:30 – 21:00. No appointments are needed.

Website: Gamblers Anonymous

11.2. **National services and support**

GambleAware [receives industry funding]

GambleAware is a national charity who develop and run campaigns to educate the public about the risk of gambling and promote 'responsible gambling' practices. Aswell as being industry funded, GambleAware also work closely with the gambling industry to develop 'responsible gambling' practices.

GambleAware does not provide a service. Rather, they signpost to the National Gambling Helpline which is provided by GamCare.

Website: https://www.gambleaware.org/

GamCare [receives industry funding]

GamCare provides support and information to people affected by gambling. This includes individuals directly affected, as well as family and friends impacted that are impacted. GamCare operate a free 24/7 helpline (0808 8020 133) and webchat function providing information, support and counselling.

Website: https://www.gamcare.org.uk/

Gordon Moody [receives industry funding]

Gordon Moody is a residential rehabilitation service offering treatment for those experiencing gambling harm. Individuals can self-refer or be referred by a professional. There are no Gordon Moody sites in Wakefield or across Yorkshire. The nearest site is in Manchester.

Website: https://gordonmoody.org.uk/

The Primary Care Gambling Service (PCGA) [partners with industry funded services]

The PCGS is a national free confidential NHS service for adults who experience harms from hambling. Support and therapy can be provided face-to-face, online or over the phone. The service works with a range of partnering organisations, some of which are industry funded.

Website: https://www.primarycaregamblingservice.co.uk/

12. Literature review – Prevention: what works?

12.1. **Why prevention?**

Although we do not well understand the scale and distribution of gambling harms in Wakefield, we do know how harm manifests across individuals and communities. Resultantly, given the limited resources available, it would be superfluous to conduct a literature review into how gambling causes harm.

Given the constraints of limited resources, this rapid literature review focuses on what works best for preventing gambling harms. This decision is driven by several considerations. Firstly, upstream prevention is a key pillar of public health, with potential to reduce incidence of gambling harms at local, regional, and population level.

Secondly, we know that gambling harms is multifaceted and incredibly complex. It would be beyond the scope of a HNA literature review to explore how different harms manifest. What is clear, is that gambling itself is a single common cause of this harm. By focusing on root cause prevention, we can address the many branches of potential harm.

Providing effective, efficient, and equitable treatment and support to those adversely affected by gambling is crucially important and cannot be overstated. Both prevention and treatment are integral to a comprehensive strategy for addressing gambling harms. However, the impact of this HNA is more likely influence and yield actional outcomes at the preventative level. While treatment services are essential, they often require significant funding to establish and deliver, which is likely beyond the immediate scope of influence for the HNA.

Finally, the National Institute for Health and Care Excellence (NICE) is currently developing guidance on gambling harm. This guidance will not focus on preventing gambling harms and instead will focus on identifying and treating individuals experiencing harm from gambling. Draft guidelines have been published which are due to be finalised and launched this year (2024). Resultantly, the published guidance will be based on the best available evidence from published treatment studies but will omit details on how best to prevent such harms in the first place.

12.2. **Search strategy**

The UK Health Security Agency (UKHSA) Knowledge and Library Services service was contacted for support in conducting a literature search to obtain relevant titles for review. Sarah Catton (UKHSA) is to be credited for her support and exceptional literature search.

The search sought to answer the following research question; *Which preventive interventions work best for reducing gambling harms among UK adults?*

Inclusion criteria consisted of studies being published in English between 2014 – 2014, with samples being adults (18+) and interventions focussing on gambling prevention and harm minimisation.

A summary of the resources searched is shown in Table 5. The 225 retained references were organised by sub-themes as listed below. 65 results appear in more than one sub-theme category:

1. Potential Channels of Engagement; Support Enablers and Understanding Vulnerability (84 papers)
2. Whole System Understanding; Resistance Opportunities and Training Development (41 papers)
3. Local Licensing and Advertising Reduction Considerations and Other Place-based Levers (32 papers)
4. Local PH Understanding, Context, Strategy and Policy Development (63 papers)
5. National Change, Advocacy, additional online and financial check viability (70 papers)

The full search strategy and all references, including abstracts, can be found in Appendix B.

Table 5. *Literature review search strategy references (included and excluded).*

Source (in order searched)	**Before removing duplicates and screening**	**After removing duplicates, before screening**	**After removing duplicates and re-screening**
Citation searching (forward) using citation chaser	96		28
Embase	461	106	55
Emcare	270	53	17
PsycInfo	207	34	5
Social Policy and Practice	63	24	11
HMIC	42	29	15
Psychology and Behavioural Sciences Collection	19	6	5
Health Business Elite	42	10	4
CINAHL	62 + 297	34 + 82	35
Scopus	97 + 296	36 + 48	29
Citation searching (backward)			
PubMed			4
Google Scholar			3
Bibliographic database sub total			**225**
Additional grey literature resources not included in the Endnote library			33
TOTAL references retained after screening			258

Theme selection

Due to time constraints and limited capacity, it was unfeasible to review all 225 studies. Resultantly, this evidence review focuses on retained references across the two sub-themes that were deemed most relevant from a local authority perspective. These themes are *local public health understanding, context, strategy, and policy development* and *local licencing and advertising reduction considerations and other place-based levers*.

Although all sub-themes are relevant and warrant a full review, the rationale for selecting this these two sub-themes was that they may help most in discovering local authority levers that can be utilised to potentially reduce exposure to gambling opportunities at local level.

Referencing

To aid clarity and to highlight specific citations, references in this literature review are provided in a Harvard format. The reference list appears at the end of the literature review section, separate to the overall reference list featured at the end of the HNA, which follows a Vancouver format.

12.3. **Introduction**

This literature review delves into preventive interventions for mitigating gambling harms, encompassing studies across diverse research designs and methodologies across the two aforementioned selected themes. It should be caveated that not all studies are cited. The review focuses on interventions and policies aimed at various stakeholders and levels of influence, with a specific emphasis on implications for local authorities, to maintain relevant and applicability to Wakefield. Key findings are collated into the preventive themes which form the following sub-headings; Regulation and Policy Interventions, Public Health Campaigns and Education, Advertising and Marketing Interventions, Harm Reduction Strategies, and Engaging Stakeholders and Community-Based Approaches. The review finishes with practical suggestions for Wakefield.

These selected themes do not encompass all possible categories of preventive interventions. For example, school-based interventions, community empowerment, and psychological interventions do not feature. It is important to note that the exclusion of these themes does not diminish their potential importance in preventing gambling harms. They could be considered for future research or included in a broader public health strategy to address gambling harms.

12.4. **Regulation and Policy Interventions**

Several studies underscore the significance of regulation and policy interventions in preventing gambling harm. Marionneau et al. (2022) conducted a comparative study in Italy and Finland, where policies have been implemented to reduce the number of electronic gambling machines (EGMs). Their results show that a 35% reduction in the availability of electronic gambling machines (EGMs) in Italy resulted in a 6% decrease in EGM gambling actfivity. Due to data issues, the authors could only analyse the first two month of EGM reductions in Finland, which was 5% and had negligible impact on associated gambling activity. While reducing EGM availability may decrease EGM gambling , it was acknowledged that this may not necessarily lead to a proportional overall decrease, possibly due to substitution effects (e.g., gamblers switching to other forms of gambling). It was also suggested that strong media opposition and industry lobbying in both countries may have hindered the scale and impact of reductions in EGMs.

In an opposing policy direction, Stevens and Livingstone (2019) examined the impacts of policy changes in the Northern Territory of Australia which introduced note acceptors on EGMs in community venues, and an increase in the cap from 10 to 20 EGMs in hotels and 45 to 55 in clubs. User losses in community venues increased between 2013 and 2016, with annual increases ranging from 5% to 19%. Increases were particularly notable in clubs and hotels with the maximum allowable number of EGMs, suggesting a dose

response relationship. The study also estimated that between 2005 and 2015, EGM user losses among those gambling at a harmful level increased by 34%. This suggests that policy changes that increase gambling availability may disproportionately impact individuals experiencing gambling harms.

Similarly, Erwin, Pacheco, and Turcu (2021) investigated the effectiveness of "sinking lid" policies which progressively reduce the number of EGMs over time through preventing licence transfers, in reducing gambling expenditure in New Zealand. The results showed that that sinking lid policies led to a 13% ($p < 0.01$) reduction in gambling expenditure relative to regions that did not adopt such policies beyond national-level restrictions. However, the study did not account for potential spillover effects, where gamblers may travel to neighbouring areas with more relaxed gambling policies. Additionally, the study focused on gambling expenditure rather than other indicators such as gambling frequency, and symptoms of gambling harms. Nevertheless, such a policy approach provides a gradual and sustainable way to reduce the availability of EGMs, which could face less political, or industry opposition compared to immediate and total bans.

Santos et al. (2023) propose extending health taxation to gambling activities as a preventive measure, suggesting that a 10% increase in taxes could lead to a 3-5% decrease in gambling participation. However, they acknowledge the need for careful consideration of the social and economic impacts of such taxation. In contrast, Woodhouse (2023) critically examined existing gambling advertising regulations in the UK, revealing potential loopholes and the need for stricter measures to protect vulnerable populations. Supporting this, Newall, Allami, and Andrade (2024) advocate for caution when interpreting the lack of causal evidence in gambling advertising research, emphasising the importance of not conflating the absence of evidence of harm with evidence of safety.

A recurring theme in the literature is the challenge of translating policy recommendations into effective action. Bhuptani et al. (2023) exposes the influence of industry lobbying on government consultations, revealing that alcohol and gambling industry responses largely used the same framings, both in terms of the problems and solutions. This included arguing that harms are only experienced by a 'minority' of people, emphasising individual responsibility and shifting blame for harms to other industry actors. They promoted targeted or localised solutions to these harms, in place of more effective population level solutions, and emphasised the perceived harms of introducing regulation not in the industries' interests. This highlights the needs for strong public health advocacy and community engagement to counter-balance and refute industry influence and promote evidence-based policies that prioritise prevention and harm reduction rather than profits and corporate interests.

Additionally, studies like McKevitt et al. (2023) and Junaid and Badrinath (2023) emphasise the importance of local government involvement in gambling licensing and policy development, such as Directors of Public Health being statutory consultees in gambling licensing processes to ensure that public health considerations are integrated into decision making. McKevitt et al. suggests that English local authorities are currently underutilising their levers to reduce the negative impact of harmful commodity industry marketing. They also acknowledge the need for standardised guidance on defining and

applying local restrictions in policies, whilst recognising the limited resource available at local often.

Beyond local government policy interventions, there are calls for changes to national legislation to tackle gambling harms. In their critique of current UK gambling regulation, van Schalkwyk and Cassidy (2024) call for a radical transformation of UK gambling policy, focussing it on public health principles and prioritising harm prevention over industry growth. They argue that this requires a new Gambling Act and a shift in the government's approach to gambling regulation. This builds on previous research by Van Schalkwyk et al. (2021) that argues for a public health approach to gambling, which prioritises social justice and emphasises the need for policymakers to prioritise evidence-based approaches, address the commercial determinants of health, and ensure independence from industry influence. This would help create a regulatory environment that truly safeguards the well-being of individuals and communities.

Until such legislative changes occur however, the resulting impact will remain unknown. In their evidence review, Clune et al (2024) found a significant gap in empirical evidence regarding effective interventions to reduce gambling harms at the population level. Resultantly, there is an overarching need for more research on population-level programmes that adopt a public health approach to preventing gambling harms across different groups.

From a logistical perspective, in a study exploring the political challenges associated with implementing effective public health policies, Bhattacharya and Chami (2023) reviewed UK public opinion polls and conducted in-depth interviews with policymakers involved in the implementation of major public health in the UK. Their review of the polls revealed that public opinion is generally not the primary barrier to implementing public health policies, with most receiving strong public support. Interviews with policymakers revealed that the main challenges to public health policy implementation come from powerful vested interests, such as the industries targeted by these policies and media outlets that may be aligned with them. Moreover, policymakers also reported facing resistance from within their own political parties, particularly from colleagues concerned about the potential electoral consequences of unpopular policies. From the results, the authors suggest carefully selecting battles and focusing on policies that are likely to pass, and gradually building support and momentum for more ambitious measures.

12.5. **Public Health Campaigns and Education**

The literature on public health campaigns and educational interventions aimed at preventing gambling harms presents a mixed picture of effectiveness. Several studies highlight the potential of these approaches to raise awareness and promote ‘responsible’ gambling, but their impact on actual behaviour change and harm reduction remains questionable. Supporting this, a mapping review of interventions to reduce the public health burden of gambling harms (Blank et al. 2021) found some supporting evidence but suggested that the long-term impact and cost-effectiveness of public health campaigns and educations programmes remains unclear.

Lim and Wang (2015) investigated the framing of slogans for responsible gambling campaigns, finding that gain-framed messages (e.g., "Control your gambling, enjoy your life") were significantly more effective ($p < 0.05$) than loss-framed messages (e.g., "Don't let gambling control you") in promoting responsible gambling intentions. However, the study did not assess the long-term impact of these messages on actual gambling behaviour. Moreover, intention may not be an accurate predictor of behaviour and could be shaped by social desirability bias.

Disrupting the typical focus of gambling harms campaigns, Mills et al (2023) presents a rationale for shifting the focus from individual responsibility to the harmful practices of the gambling industry, aiming to empower individuals and communities to challenge these practices and demand change. The study provides the development process of the “Odds Are: They Win” campaign. This campaign aims to raise awareness of how the gambling industry manipulates the situational and structural context of gambling to maximise profits. This approach aligns with Livingstone and Rintoul (2020) who argue that the dominant discourse around gambling harm prevention, centred on the concept of "responsible gambling", is fundamentally flawed and needs to be replaced with a comprehensive public health approach. This appears logical and aligns to the growing body of evidence demonstrating the commercial sectors’ influence over health behaviours. However, further research is needed to evaluate the effectiveness of this Odds Are: They Win campaign, and others that follow.

Others have explored the role of educational interventions in raising awareness and knowledge about gambling harms. For example, the Public Health England report (2021) titled "'You don't just lose money, you can lose things worth so much more'" presents a qualitative analysis of stakeholder perspectives on gambling harms. The study highlights the importance of raising awareness of the wider impacts of gambling, beyond financial losses, to encourage help-seeking and reduce stigma. However, the report does not provide quantitative evidence on the effectiveness of such awareness-raising efforts.

Similarly, London Council’s (2018) report titled "A 'whole council' approach to gambling" provides guidance for local authorities on developing comprehensive strategies to address gambling harms. The report emphasises the importance of educational initiatives that target different population groups, including young people, vulnerable adults, and ethnic minority communities. However, it acknowledges the lack of robust evidence on the effectiveness of such programmes and calls for further research to evaluate their impact.

Several studies have also examined the role of frontline workers in educating and supporting individuals at risk of or experiencing gambling harms. Riley et al. (2024) completed a comprehensive review of 49 studies involving strategies, practices, and policies employed by land-based gambling venues regarding their employees' role in preventing gambling harms and responding to those ambling at a harmful level.

The review found that while a set of behavioural indicators for identifying those gambling at a harmful level = exists, their use in practice is challenging. Staff responses to gamblers with potential problems are often limited to observation and internal discussion between staff, with rare direct interaction with customers. Gamblers themselves hold diverse views

on venue responsibilities, ranging from expectations of active intervention to a preference for a hands-off approach. The review also found that corporate social responsibility programmes tend to focus on staff training, but implementation and clear guidelines are often lacking. Moreover, staff expressed a need for more comprehensive training and support, including clear guidelines for interaction and access to external resources. Overall, the review suggests that the current emphasis on staff identification and intervention with those gambling at a harmful level is ineffective and a more holistic, supportive approach is needed to reduce and prevent gambling harms.

Similarly, Manian, Yan, and Zeng (2023) explored the experiences of 15 frontline casino workers in China, through qualitative interviews. The authors interpreted several key challenges faced in identifying and supporting individuals gambling at a harmful level with; lack of training and resources, conflicting priorities between customer service and a desire to help those gambling at a harmful level, emotional burnout, and limited support. Although conduced specifically among casino workers, this study has potential implications for practice among front line workers in wider gambling settings. It highlights the need for comprehensive training programmes on the identification and response to gambling at a harmful level. It also underscores the importance of creating supportive workplace cultures that prioritise employee well-being and the encouragement of support for customers.

The reviewed literature suggests that public health campaigns and educational interventions can play a role in raising awareness and promoting responsible gambling. They may be an effective way to reach large audiences are raise awareness. However, their effectiveness in preventing gambling harms is likely to be limited unless they are part of a comprehensive approach that also addresses the broader social and environmental determinants of gambling behaviour, such as advertising, accessibility, and cultural norms. Further research is needed to evaluate the long-term impact of public health campaigns and to identify the most effective strategies for different population groups. It is likely that messaging needs to be tailored to resonate with different demographics and cultural backgrounds.

12.6. **Advertising and Marketing Interventions**

The literature consistently identifies advertising and marketing as a significant factor in normalising gambling and potentially contributing to gambling harms. In their published opinion piece, Newall and Allami (2024) highlight the persuasive power of gambling advertisements, particularly their use of framing techniques that downplay risks and promote positive outcomes. This evidence, which demonstrates the health-harming tactics and strategies of unhealthy commodities is supported, among many others, by Knai et al. (2021) and by Goyder et al. (2020).

McGrane et al. (2023) conducted a systematic umbrella review of 1024 studies, examining the evidence base for the impact of advertising policies on gambling harms. Results were synthesised narratively due to the diverse nature of the evidence. Evidence of a dose-response effect was found, with greater advertising exposure increasing gambling participation, leading to greater risk of harm. There was more evidence for the impact on children and young people and for those already at risk of harm from current gambling

activity, with the most vulnerable more likely to be influenced. Indeed, similar findings were published in a previous umbrella review (Velasco et al. 2021) which reported restricting gambling advertising to be a promising strategy for reducing gambling harms, particularly among young and vulnerable populations. Resultantly, restrictions to gambling advertising may not only reduce overall harm but also mitigate the impact of advertising on gambling-related inequalities.

Furthermore, Newall et al (2024) suggest that research designs may underestimate the impact of advertising by failing to consider the cumulative and interactive effects of various forms of marketing and promotion. Indeed, gambling advertising is pervasive, and individuals are exposed to it through multiple channels, including television, radio, online platforms, social media, and sports sponsorships. The cumulative impact of this constant exposure may be greater than the sum of its parts but would be difficult to replicate in a research setting.

In their international Delphi consensus and implementation study, Regan et al, (2022), aimed to establish expert consensus on policies and interventions to reduce gambling harms. Consensus for effectiveness was evaluated for 103 measures across four implementation dimensions: practicability, affordability, side-effects, and equity. Consensus was reached on 83 measures. Of the 15 measures in the domain of marketing, advertising, promotion and sponsorship, 14 were judged as effective, with 6 of these judged as highly effective. Indeed, these measures would be entirely new to England, having no current feature in existing gambling legislation or policy.

A House of Commons research briefing by Woodhouse (2023) critically examined gambling advertising regulations in the UK, identifying potential gaps and weaknesses in the current framework, such as the lack of restrictions on inducements and the limited enforcement of existing rules. They argue that stricter regulations, particularly those targeting online advertising and protecting vulnerable groups, could be instrumental in preventing harm. This suggests that current regulations may be inadequate in protecting communities from the potential harms of gambling advertising.

Research has also investigated the content and targeting of gambling advertisements. Critchlow et al. (2020) conducted a content analysis of 210 paid-for gambling advertisements in the UK, revealing that only 29% displayed age restriction warnings prominently, and only 12% included harm reduction messages. They also found that 89% of adverts had terms and conditions that had poor or very poor visibility. This suggests that current advertising practices may not adequately protect young people and vulnerable individuals from gambling harms. Resultantly, the authors recommend regulatory changes to improve the visibility and clarity of these elements, such as mandating larger and more prominent warnings, using clearer and more concise language, and requiring harm reduction messages in all gambling advertisements

Advertising and marketing can shape public perceptions of gambling and influence social norms. McCarthy et al. (2022) explored women's perceptions of strategies to address the normalisation of gambling, finding that 85% of participants believed that gambling advertising contributed to the normalisation of gambling, and 70% supported stricter regulations on gambling advertising. This highlights the need for advertising policies that

not only restrict the volume and content of gambling advertisements but also challenge the social acceptability of excessive gambling.

Overall, the evidence suggests that advertising and marketing play a significant role in the initiation, maintenance, and normalisation of gambling behaviour. Stricter regulations on advertising content, targeting, and volume, as well as public health campaigns that challenge the social acceptability of excessive gambling, are crucial for preventing and reducing gambling harms.

12.7. **Harm Reduction Strategies**

Harm reduction strategies aim to minimise the negative consequences of gambling for individuals who continue to gamble. Lischer et al. (2024) investigated the effect of exclusion on gambling at a harmful level in Swiss casinos, finding that while exclusion may reduce gambling frequency by 35%, it did not necessarily lead to improvements in subjective well-being or reductions in gambling at a harmful level.

Lischer et al. (2023) examined the impact of casino self-exclusion on a sample of 143 individuals who had voluntarily or involuntarily self-excluded from Swiss casinos. Using a control group of non-excluded gamblers, they measured various subjective wellbeing indicators (e.g., life satisfaction) and 'problem gambling severity' (using the PGSI) at baseline, 6 months, and 12 months after exclusion.

The results of the study were mixed. While self-exclusion led to a statistically significant decrease in gambling frequency of 35% ($p < 0.01$) and monthly expenditure of 86% ($p < 0.01$) among excluded gamblers, there were no significant improvements in subjective wellbeing or 'problem gambling severity' at the 6-month and 12-month follow-ups. This suggests that while self-exclusion may help reduce gambling participation in the short term, it may not sufficiently address the underlying psychological and social factors contributing to gambling at a harmful level in this context.

Similarly, Hopfgartner et al. (2023) assessed the efficacy of voluntary self-exclusions (VSE) among British online casino players. A total of 888,536 players were included in the analysis, of which 4,309 opted for a VSE during the study period. Results showed that self-exclusion was associated with a statistically significant reduction in the number of active gambling days (78% less, $p < 0.001$) and total amount waged (73% less, $p <0.001$) compared to the six months prior. Despite this however, relapse rates were high. Of those players who self-excluded, 41.3% returned to gambling within six months of their VSE period ending.

With regards to seeking help, Lischer et al. (2023) explored the motivating factors and barriers to help-seeking for casino gamblers, finding that shame and stigma were significant barriers, while financial concerns and relationship problems were key motivators for seeking help. Qualitative data such as this facilitate exploration into these complex issues. However, the lack of quantitative data limits the ability to generalise findings to other gambling population, as participants were casino gamblers. Additionally, it was not possible to assess the relative importance of different motivators and barriers.

Early detection of risk through gambling screening tools could be seen as a useful part of a harm reduction and prevention strategy. Davies et al. (2023) conducted a systematic review to explore the challenges in identifying and assessing low-risk gamblers. The review found that many current gambling screening tools are not well-suited for public health initiatives, especially for early intervention. Tools tend to focus on identifying clinical symptoms of gambling at a harmful level rather than assessing risk and harm associated with low-risk gambling behaviours. This makes it difficult to identify individuals who may be at risk of gambling harms but do not yet exhibit severe symptoms. The authors suggest that to facilitate early identification and prevention, the focus of screening tools should look beyond clinical symptoms and consider a broader range of harms associated with gambling, even at low levels of engagement. This suggests that harm reduction interventions such as screening, may overlook a significant proportion of the population at risk. The somewhat 'invisible' population of people who gamble at a low risk level may be experiencing harm that goes undetected by existing screening tools and therefore goes unaddressed.

Other harm reduction strategies explored in the literature include brief motivational interventions targeting high-risk gamblers. In a randomised controlled trial by Jonsson et al. (2019) a statistically significant reduction in monthly gambling expenditure of 15% (95% CI, 5-25%, $p = 0.003$) was observed in the intervention group (brief motivational telephone call) compared to the control group at the three-month follow-up. In a subsequent study, Jonsson et al. (2020) replicated these findings, observing a 30% reduction (95% CI, 17-42%, $p < 0.001$) in theoretical loss (the amount a player is expected to lose over the long run based on statistical advantage of the operator) over 12 months for the telephone intervention group compared to the control group. However, both studies focused on short-term outcomes, and the long-term effectiveness of these interventions remains unclear.

Another postulated means to reduce harm are centralised player tracking systems (CPTS). In his published commentary, Allami (2024) proposes that CPTS, which gather and analyse individual-level gambling data across multiple operators and platforms, could enhance the identification of at-risk gamblers, facilitate the implementation of personalised interventions, and strengthen regulatory oversight. For example, CPTS could enable early pattern detection of gambling at a harmful level, allowing for timely interventions like personalised messages or temporary gambling restrictions. Additionally, these systems could help identify individuals who may benefit from self-exclusion programs or other forms of support.

However, this remains theoretical. Empirical research is needed to evaluate the impact of CPTS on gambling behaviour and harm outcomes. Moreover, the implementation of such systems raises ethical and practical concerns regarding privacy, data security, and potential misuse of personal information. Perhaps even more concerning, is the potential for this data to be collected and held by the gambling industry and used to proactively target those most at risk, i.e. those who are likely to gamble, with marketing nudges, promotions, and incentives.

A 2019 of umbrella review of ten systematic reviews (McMahon et al. 2019) found that harm reduction interventions were limited by voluntary adherence, with less than half of the studies showing positive effects on behaviour. Moreover, the authors reported the overall quality of evidence as being poor and no reviews examined the differing impacts of interventions across socio-demographic groups. This highlights a gap in the literature and the need for good quality primary studies.

12.8. **Engaging Stakeholders and Community-Based Approaches**

Engaging a wide range of stakeholders and utilising community-based approaches seem to be increasingly recognised as crucial components of effective gambling harms prevention strategies. However, the literature reveals both the potential and the challenges inherent in these approaches.

The call for a comprehensive approach involving diverse stakeholders is echoed across multiple studies. Thomas et al. (2023) advocate for a public health approach to gambling harm prevention, highlighting the need for collaboration between researchers, policymakers, practitioners, and individuals with lived experience. Their conceptual framework emphasises the importance of understanding the complex interplay of individual, interpersonal, community, and societal factors that contribute to gambling harm. By engaging all relevant stakeholders, a more holistic and effective response can be developed, encompassing prevention, early intervention, treatment, and recovery support. This is also supported by Wheaton et al. 2024 who recognised that gambling harms can manifest at various levels; individual, family, social network, community and societal, and thus emphasised the importance of collaboration in fostering a multi-sectoral approach to gambling harm prevention. Indeed, this collaborative approach is also suggested within the findings of a systematic review of gambling problems and suggested interventions by Akçayır, Nicoll, and Baxter (2022).

The importance of incorporating the perspectives and experiences of individuals directly affected by gambling harm is highlighted by Nyemcsok et al. (2022). Their qualitative study with gamblers in the UK revealed diverse views on gambling reform, ranging from calls for stricter regulations to concerns about individual responsibility and the need for support services. This diversity demonstrates the importance of inclusive decision-making processes that involve people with lived experience in the development and implementation of prevention strategies. Participants in the study expressed that the stigma surrounding gambling addiction prevented them from seeking help earlier. Furthermore, they suggested that involving individuals with lived experience in the design of public health campaigns and educational materials could make them more relatable and effective.

McCarthy et al. (2022) further emphasises the importance of considering the unique experiences of different groups. Their study explored women’s perceptions of strategies to address gambling harm. The women perceived current measures as insufficient and advocated for stronger regulation and community-based support tailored to their specific needs. Specifically, 82% of women in the study reported feeling that gambling harm was

not taken seriously enough by society, and 65% felt that support services were not adequately tailored to their needs. This finding suggests that tailored interventions towards preventing gambling harms (e.g. gender specific) are necessary to address the diverse needs of different populations.

Saunders et al. (2023) demonstrated the potential of geospatial mapping to identify gambling harm hotspots across communities. The study found a strong and statistically significant positive correlation between deprivation scores and the density of gambling venues ($r = 0.65$, $p < 0.001$). This approach could inform targeted interventions in specific communities. However, correlation does not imply causality, thus further validation and consideration of other socio-economic factors, which are likely associated, is required.

Corroboratively, Evans (2021) also found a statistically significant positive association between density of British gambling premises and deprivation ($r = 0.56$, $p < 0.001$), supporting the need for policies that address the unequal distribution of gambling opportunities.

Incidentally, these associations between gambling availability and deprivation observed in the literature, support the findings of our local mapping in Wakefield which showed that licenced betting premises are disproportionately situated in the most deprived parts of the district.

In depth reports by Public Health England (2019, 2021) emphasise the importance of engaging with industry stakeholders in developing harm reduction strategies. However, these studies rely on qualitative data and do not provide quantitative evidence of the impact of such engagement. Future research should investigate the effectiveness of different stakeholder engagement models and measure their impact on gambling harm reduction outcomes.

In conclusion, engaging stakeholders and utilising community-based approaches hold significant promise for preventing gambling harm. However, the successful implementation of these approaches requires addressing challenges such as limited resources, lack of training for frontline workers, and the need for more inclusive decision-making processes. By recognising the diverse perspectives and needs of different stakeholders, tailoring interventions to specific communities, and providing adequate support for frontline workers, we can move towards a more comprehensive and effective approach to gambling harm prevention.

12.9. **Limitations and Practical Implications for Wakefield**

The reviewed literature offers insight into preventive interventions for gambling harms and their effectiveness. However, several limitations must be considered when applying the findings to Wakefield or other local areas.

Many studies are conducted in specific contexts and populations, limiting generalisability. For example, participants in Lischer et al. (2023) were Swiss casino gamblers, who likely have different cultural and socio-economic characteristics compared to the Wakefield population. Furthermore, Wakefield has no casino. Methodological limitations such as

reliance on self-reported data and small sample sizes may also affect the validity and reliability of results. Additionally, the long-term effectiveness of preventive interventions remains unclear, with limited research on sustained behaviour change.

Although incredibly complex and perhaps unfeasible in many research designs, there was also a lack of comprehensive analysis on how social determinants of health, such as poverty, education, employment, and housing, contribute and interact with the effectiveness preventive interventions.

Despite these limitations, this literature review provides several practical suggestions for Wakefield Council to consider when designing interventions to prevent and reduce gambling harms:

- **Tailoring interventions to the local context**: Preventive strategies should be adapted to the specific needs and characteristics of the Wakefield population, considering factors like demographics, cultural context, and gambling preferences. To understand this local context, further research may be required as well as public involvement in intervention development.
- **Adopting a multifaceted approach**: Combining various preventive strategies, including policy interventions, public health campaigns, harm reduction, and community engagement, is likely to be more effective than relying on a single approach. A gambling harms strategy for Wakefield would help focus and coordinate this collective action.
- **Building strong partnerships and collaborations**: Effective prevention requires collaboration among local government, healthcare providers, community organisations, and individuals with lived experience to ensure comprehensive and sustainable interventions. Building strong partnerships within local authorities, across departments such as public health, planning, and licencing, is also important.
- **Prioritising evaluation and monitoring**: Rigorous evaluation and ongoing monitoring of preventive interventions is essential to assess their impact over the long term and identify areas for improvement, ensuring that resources are allocated efficiently and effectively. Well-evaluated interventions from other local authority areas may provide a useful benchmark for this.

12.10. Conclusion

This literature review highlights the complexity and multifaceted nature of preventing gambling harms across populations. Findings show the potential impact of various preventive approaches, including regulation and policy interventions, public health campaigns, harm reduction strategies, and community engagement. While challenges remain in translating research, often national or international, into effective and tangible local actions, a holistic approach that considers individual, interpersonal, community, and societal factors offers the most promising avenue for tackling gambling harms in Wakefield.

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13. Key findings (expanded)

- **Prevalence of Gambling:** An estimated 99,315 adults in Wakefield (35.1%) engage in gambling activities at least once per month, demonstrating the significant prevalence of gambling within the local population. This figure, derived from the AHS, represents a considerable proportion of the local adult population who are gambling with varying degrees of frequency and intensity. This estimate is much higher when modelled from national data (149,964) which highlights the unknowns and the need for more accurate and reliable data around gambling behaviour.

  Gambling participation varies across Wakefield. Residents living in the most deprived quintile have the highest rate of gambling participation whilst residents living in the least deprived quintile had the lowest rate. Residents from Hemsworth and South Elmsall and South Kirby have the highest rates in the district. Residents from Horbury and South Ossett have the lowest.

  Men are consistently more likely to gamble than women across all age groups, with the highest rates for both sexes being among those aged 34-64. Full-time workers (30+ hours per week) have the highest rate of gambling participation whilst full time students have the lowest. Education appeared to have little association with gambling participation. The AHS data also suggests that alcohol use and obesity are associated with increased gambling activity.

- **Elevated Risk of Gambling Harm:** Within the population of regular gamblers in Wakefield, approximately 1% (~993 individuals) are gambling at a harmful level. This indicates that a substantial number of residents are experiencing adverse consequences related to gambling, such as financial difficulties, mental health problems, and relationship strain. Although direct comparisons are difficult due differing data sources, prevalence of gambling at a harmful level in Wakefield likely exceeds regional estimates.

- **Underestimation of Harm:** It is widely acknowledged that official figures on gambling participation and harm are likely underestimated due to the methodologies used in data collection and the often-secretive nature of gambling behaviour. Individuals may underreport gambling activities due to stigma or shame, and the full extent of harm, including impacts on families and communities, may not be adequately captured in surveys and nationally published statistics. Consequently, the true number of individuals gambling in Wakefield is likely higher than the estimates we have available, as is the number of people experiencing gambling harms.

- **Inequalities in Risk of Harm:** Local data from the AHS reveals inequalities in the risk of gambling harms across different population groups:

- **Socioeconomic Inequality:** Adults residing in the most deprived areas of Wakefield face a disproportionately higher risk of gambling harms compared to those in more affluent areas.
- **Gender Disparity:** While more men gamble than women in Wakefield, the AHS results suggest that a higher proportion of women (1.6% versus 0.4%) who gamble are experiencing harmful consequences. However, due to small samples in this category of risk, the difference is not deemed statistically significant and should be interpreted cautiously, particularly as this differs from the national trend.
- **Vulnerability of Young Adults:** The 18-34 age group in Wakefield exhibits elevated engagement in risky gambling behaviours, including a higher prevalence of gambling at a harmful level compared to other age groups.

- **Young Adult (18 – 34) Survey**: Most young adults do not agree that gambling companies are honest and open about the risks of gambling, and support further regulation of the industry, although an outright ban would be unpopular. Most encounter gambling adverts on a daily or weekly basis and notice an increase in advertising during large sporting events. Some were unsure where or how to seek support, whilst others mentioned industry-funded providers or cited online resources.

- **Environmental Influence:** The distribution of gambling venues within Wakefield is clustered within deprived areas and sparse within more affluent areas. This spatial clustering of gambling opportunities in areas with existing socioeconomic challenges raises concerns about potentially exacerbating existing inequalities in gambling harms. This is caveated by the rise in online gambling, which provides almost all residents with universal access to gambling products.

- **Commercial Influence**: The gambling industry's variety of tactics, such as aggressive advertising and marketing and the framing of gambling as an individual's responsibility, create an environment in Wakefield (and online) where residents are susceptible to gambling harms.

- **Increased Demand for Support:** Referrals from Wakefield to the NHS Northern Gambling Service, the regional provider of specialist (non-industry funded) gambling treatment and support, have doubled in the past year (11 in 2022/2023 versus 26 in 2023/2024). This indicates a growing need for accessible and effective support However, this is caveated by small absolute numbers and may fluctuate annually.

- **A Need for Strategic Direction:** Gambling harms as a programme of work sits within Public Health (Adults and Health Directorate) at Wakefield Council. However, there is limited resource and no designated officer whose' primary role is to progress the work. There is also currently no gambling harms strategy for the Council, no mention of gambling in the current Wakefield District JSNA Annual Report, and no mention of gambling in the Wakefield Council Advertising and Sponsorship Policy. Despite this,

there are a handful of officers who work hard to progress the gambling harms work, particularly at a regional level through representing Wakefield at the regional CoI.

- **A Public Health Approach:** The evidence base suggests a comprehensive public health approach encompassing various interventions, including policy, targeted campaigns, harm reduction, and community engagement as the most effective means to tackle the complex issue of gambling harms. No single intervention in isolation at a local authority level is likely to have a significant impact on the local population.

14. Recommendations (expanded)

The following recommendations are directed to Wakefield Council, with the understanding that addressing the complex issue of gambling harms requires concerted efforts at both local and national levels. While national legislative changes are vital for creating a comprehensive framework and systemic change, Wakefield Council can play a pivotal role in mitigating the impact of gambling within the local community.

1. **Develop a Gambling Harms Strategy for Wakefield**: This would provide a comprehensive and coordinated framework for addressing the causes and complexities of gambling harm across Wakefield. This strategy should include prevention, early intervention, treatment, and support to provide a holistic approach to tackling gambling harms.
2. **Strengthen Local Licensing**: Explore stricter licensing policies for gambling venues, considering a reduction in their density, particularly in areas with higher deprivation. This could begin by reviewing the existing Wakefield Council licencing policies to identify areas to embed public health more significantly. This could then result in closer consultation with Public Health during the licencing process, community input, and evidence-based decision making. It acknowledged that this may be difficult to achieve without the backing of national legislation. It may be more within scope to improve the enforcement of existing licencing compliance checks among betting premises, though this will depend on existing capacity, funding and resource.
3. **Strengthen Local Advertising Policy**: Wakefield Council's current policy does not mention gambling products. A clear policy that restricts the advertisement of gambling products (and other harmful products) across all Council-owned property and online platforms would demonstrate the Council's commitment to protecting vulnerable groups from exposure to gambling advertising. There are already good examples in the region, with published advertising policies by Barnsley Council and Sheffield Council which prohibited the advertisement of gambling or betting products, services or organisations, along with other commodities harmful to heath (e.g. HFSS foods and tobacco).

4. **Advocate for National Advertising Regulation**: Proactively advocate for stricter national regulations on gambling advertising, particularly those targeting vulnerable demographics such as young adults. This would involve participating in government consultations on gambling regulation, providing evidence-based submissions as well as continuing to be an active representative of the Yorkshire and Humber Gambling harms CoI.
5. **Develop Targeted Public Health Campaigns**: Design and implement evidence-based public health campaigns tailored to specific Wakefield demographics and risk factors identified in the HNA. These campaigns should employ destigmatising language and highlight the available (non-industry funded) support services.
6. **Leverage National Guidance and Regulatory Changes:** Once NICE guidance on gambling harms is published (due 2024) and the review of the Gambling Act 2005 is complete, Wakefield Council could use this as catalysts for action. This will present opportunity for the Council to align its policies and preventive work with national standards and legislation.
7. **Improve Early Intervention and Education**: Enhance early intervention efforts by integrating gambling harm education into existing programmes in schools, workplaces, and community settings in Wakefield, ensuring that resources are free from industry influence. Educational materials and interventions would need to be adapted for different age groups and cultural backgrounds to maintain relevance and engagement.
8. **Establish Clear Referral Pathways:** Establish clear and accessible referral pathways between frontline professionals and appropriate gambling support services, such as the NHS Northern Gambling Service, to help individuals access appropriate help when needed. Frontline professionals who may come into contact with individuals at risk of experiencing gambling harms need to be provided with the knowledge and tools to identify and support these individuals and understand the pathway themselves. Relevant frontline professionals include but are not limited to; GPs and other healthcare professionals, social workers, financial support services, and West Yorkshire Police.
9. **Conduct Research and Evaluation**: Conduct ongoing research locally to monitor gambling trends and attitudes in Wakefield, evaluate the impact of interventions, and identify emerging needs within the Wakefield community. The more This will help improve our intelligence around gambling harms.
10. **Strengthen Local Authority Governance**: All decision making in the Council where there is corporate interest or influence should be guided by the ADPH-endorsed Good Governance Toolkit. This will help prioritise the health and wellbeing of the community when the Council makes decisions about harmful activities like gambling. The toolkit helps ensure that public health evidence and concerns are central to the decision-making process, without influence of commercial interests.

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16. Appendix

Appendix A - Questionnaire (repo

Appendix B - Lit Review Search Strate