Gambling-related Harms in Southampton

Health Needs Assessment

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Executive Summary

Concerns over the negative repercussions of gambling are increasing. Gambling is associated with a broad range of serious and wide-reaching harms (broadly categorised as financial, relationship, health, employment and educational, and criminal behaviour), adversely affecting the health and wellbeing of gambling individuals, their families, communities, and society.

'Harmful gambling' is defined in this report as any frequency of gambling that results in people experiencing harm, problems or distress, corresponding to a Problem Gambling Severity Index (PGSI) score of 1 or more. Harmful gambling therefore affects many more individuals than those classed as 'problem gamblers' (i.e. a PGSI score of 8+) who have traditionally been the focus of treatment services. Harmful gambling is characterised by high-frequency participation in multiple gambling activities, especially: bingo and casino games; betting; use of electronic gaming machines (EGMs) in bookmakers; and online gambling. Indeed, online gambling participation amongst those experiencing harmful gambling is more than twice that of the general population. Those at greatest risk of experiencing harmful gambling include: younger age groups (especially younger men); the unemployed; those living in areas of high deprivation or from lower socioeconomic backgrounds; people with mental health problems; people with co-occurring substance use problems (especially higher levels of alcohol consumption); military veterans; students; the homeless; and those from ethnic minority backgrounds. There is also evidence to suggest that living in close proximity to gambling venues may elevate gambling-related harm.

Given the wide-reach of gambling-related harms, and the more numerous individuals bearing the burden of harm (compared to the smaller group of PGSI-classified 'problem gamblers'), harmful gambling is increasingly recognised by policy-makers, academics and healthcare professionals alike as a 'serious and worsening' public health issue in Great Britain, requiring a broad population-level strategy centred on prevention and 'upstream action' (the latter referring to community and place-based action). This suggests the need for community- and societal-level interventions alongside individual treatment and support. Sole focus on an individual-level approach is unlikely to reduce the incidence of harmful gambling in the

population; individual-level interventions may instead exacerbate health inequalities due to differing engagement abilities between groups.

Aim

This aim of this needs assessment is to:

- Understand the scale of need in relation to those experiencing, or affected by, harmful gambling (i.e. those collectively experiencing gambling-related harms) in Southampton.
- Examine what is currently being done to address those needs; and
- Identify any gaps between local action and current best-practice, including the scientific evidence-base, to help inform local recommendations.

Main Findings

Based on national prevalence data, the estimated number of adults (aged 16 years and over) experiencing harmful gambling in Southampton is between 6,160 and 31,900. In addition, an estimated 15,053 adults (aged 18 years and over) in Southampton are adversely affected by someone else's gambling. The total excess cost associated with gambling-related harm in Southampton is estimated to be in the range £4.7m to £7.9m.

A decile map of harmful-gambling risk scores for Southampton indicates that Coxford, Woolston, Bevois, Millbrook and Swaythling contain the highest numbers of neighbourhoods at greatest risk of harmful gambling in the city. Analysis by distribution of gambling premises suggests a correlation between gambling-premises density and deprivation. Furthermore, the wards with the highest densities of premises (namely Bargate, Banister & Polygon, Freemantle, Portswood and Shirley) contain at least one area at elevated risk of harm (based on risk score).

There are numerous treatment and support services available to people living in Southampton, either directly or indirectly linked to harmful gambling/gambling-related harms. Accessible services are a mixture of local and national, provided by the NHS and other providers (including the voluntary sector), funded independently or directly/indirectly by the gambling industry. An ICB-commissioned regional specialist service is also in place (the Southern Gambling Service). However, there is a general lack of clarity around signposting and support pathways, with service provider data suggesting significant unmet need based

on low usage/uptake compared to estimated numbers of people experiencing or affected by harmful gambling in Southampton.

In contrast to data on local need, there is considerable evidence in relation to measures for preventing or reducing gambling-related harm. In terms of primary prevention, the evidence is strongest for local regulatory action, e.g. around advertising policy and supply restriction (such as restricted licensing conditions and reduced venue availability /accessibility). Primary prevention education programmes and public awareness-raising campaigns have mixed evidence, the latter requiring significant community involvement in design to avoid stigma or other negative impacts.

Secondary prevention awareness-raising through safer-gambling health-promotion messaging can also have unintended negative consequences if messages are not appropriately designed, and should ideally be co-produced by people with lived experience. Early identification is possible, and tools exist for populations at-risk of gambling-related harm, but there is limited evidence and availability of early interventions to reduce harmful gambling behaviour (especially over the longer term).

Regarding tertiary prevention approaches, there is mixed evidence around gambling venue harm-reduction measures. However, harm-minimisation tools (also known as 'responsible gambling' tools) may be effective, with increased effectiveness linked to self-exclusion periods of at least 6 months; universal, irreversible and compulsory limit setting; self-appraisal or high-threat pop-up messages; forced breaks of around 60 minutes; and reduced speed of play.

Tertiary treatment approaches (as highlighted in the draft NICE guidance) include: improved early identification, addressing wider needs through integrated working; using peer models alongside other effective treatment options; involvement of a family member or close friend; and rapid re-access in case of relapse.

<u>Emerging Themes</u>

The main areas of concern emerging from this HNA are therefore:

- The high densities of gambling premises either adjacent to, or located in, areas of high deprivation and/or areas at elevated risk of harmful gambling.

- The small proportion of people experiencing harmful gambling/gambling-related harms in Southampton accessing treatment and support.

Recommendations

Recommendations for Southampton (informed by the above identified themes, UK priorities, the evidence base, draft NICE guidelines and expert opinion) have been framed around local opportunities for action and include:

- Local policy development (regarding licensing, planning and advertising) to make best use of any regulatory opportunities to reduce gambling supply/exposure and lessen the impact of gambling-related harm.
- Youth education and awareness-raising to reduce the uptake of gambling; and
- Improved support for those experiencing gambling-related harms through early identification and signposting (e.g. through increased use of the 'make every contact count' approach) and increased access to treatment.

Simultaneous advocacy for national action (in relation to regulation, taxation, advertising and marketing, and funding of appropriate services at sufficient scale to meet local need) is also recommended to ensure that the widest (i.e. societal) impact of gambling-related harms has been addressed.

Conclusion

There is limited local data on the numbers affected by gambling-related harms, but even conservative estimates suggest significant numbers of adults experiencing harmful gambling or affected by someone else's gambling. There are several evidence-based interventions available for local action to reduce harm within the current legislative framework. However, further high-quality studies are needed to address research gaps and grow the evidence-base.

Nevertheless, it is hoped that the findings in this report will increase understanding and awareness of harmful gambling in Southampton, contribute to national prevention strategies, and help inform priorities for local action - ultimately to reduce the level of gambling-related harm in the city and beyond.

Glossary

Term	Definition
Adverse Childhood Experiences	Traumatic or stressful events occurring in childhood which harm the child directly (e.g. physical or sexual abuse) or indirectly through the environment in which they live (e.g. domestic violence, or growing up in a family with substance use or mental health problems).
Affected other(s)	Those who know someone with a gambling problem, either now or in the past, and have experienced negative effects as a result of that person's gambling behaviour.
Alcohol use (problem)	Drinking in a way that is harmful, or being dependent on alcohol.
Comorbid/co-occurring (conditions)	Referring to medical conditions or diseases that are present in an individual at the same time.
Deciles	Ten equal groups into which a population can be divided according to the distribution of values of a variable.
Deprivation	A general lack of resources and opportunities.
Gambling	Playing a game of chance for a prize (i.e. 'gaming'), making or accepting a bet on the outcome of a race, competition, or other event or process (i.e. 'betting') or participation in a lottery.
Gambling Act 2005	Sets out how gambling in Great Britain is regulated. Based on three core objectives, the third of which is to protect 'children and other vulnerable persons from being harmed or exploited by gambling'.
Gambling disorder	Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress as indicated by the individual exhibiting four or more factors in a 12-month period (as defined by DSM-5 diagnostic criteria).
Gambling-related harms	The adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society.
Gross Gambling Yield	Refers to the amount of money retained by gambling operators following disbursement of winnings but prior to deduction of operating costs.
Harm reduction	A strategy that seeks to reduce, rather than eliminate entirely, the harm(s) to an individual or group associated with certain behaviours.

Harmful gambling	Any frequency of gambling that results in people experiencing harm, problems or distress (corresponding to a PGSI score of 1 or more).
Health equity	The absence of unfair and avoidable differences between groups of people (defined economically, socially, geographically or demographically, or by another dimension of inequality e.g. sex, gender, ethnicity, disability, or sexual orientation) resulting in the attainment of optimal health for all. (Adapted from WHO)
Health inequalities	The uneven distribution of health status or health resources between different populations or groups due to differences in genetic factors (including gender and ethnicity) or the social conditions in which they are born, grow, work, live and age (e.g. education, employment status, socioeconomic position). Health *inequities* arise when these differences are unfair and avoidable.
Health needs assessment	A systematic method of examining the health (including healthcare) needs of a population leading to identification of unmet needs.
Health Survey for England	An annual survey which monitors trends in health conditions, risk factors and care for adults and children in England.
Index of Multiple Deprivation (IMD2019)	The official statistic on relative deprivation in England, ranking small areas from least to most deprived.
Lower Layer Super Output Areas	Neighbourhoods containing between 400 and 1,200 households, with a resident population of between 1,000 and 3,000 persons.
Need	The potential to benefit from intervention.
People experiencing gambling-related harms	People experiencing harmful gambling and affected others.
People experiencing harmful gambling	Preferred term rather than 'harmful gambler' or 'problem gambler', both of which suggest that responsibility lies primarily with the gambling individual, contributing to shame and stigma. However, someone with a PGSI score of 8 or more is classed as a 'problem gambler', therefore 'problem gambler' is cited occasionally in the context of PGSI scores.
Population	A group of people with a common attribute, such as shared geographical area, service usage or health concern.
Poverty	The state of not having enough money to get by on.

Prevalence	The proportion of a population who have who have a specific health state, event or characteristic (e.g. illness, health indicator, infection, death or disability) during a specified time period.
Problem Gambling Severity Index	A commonly-used screening tool (featured in national surveys and quoted by many healthcare providers) for assessing the level of risk facing an individual as a result of their gambling behaviour.
Recreational gambling	Gambling for fun or leisure, with no adverse consequences.
Severe mental illness	Individuals with psychological problems (such as bipolar disorder or schizophrenia) which severely impair their ability to engage in daily activities (i.e. functional and occupational).
Substance use (problem)	Use of illegal drugs, alcohol, prescription or over-the-counter medications in a way that deviates from their intended use.
Upstream action	Community and place-based action.
Vulnerable population or group	Those susceptible to harm, or at increased risk of harm.
Ward	An area used for electoral purposes within a local authority.

Abbreviations

Term	Definition
ACEs	Adverse Childhood Experiences
CBT	Cognitive Behavioural Therapy
CJS	Criminal Justice System
DCMS	Department of Culture, Media and Sport
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.
EGMs	Electronic gaming/gambling machines
FPH	Faculty of Public Health
GA	Gamblers Anonymous
GA2005	Gambling Act 2005
GB	Great Britain
GC	Gambling Commission
GGY	Gross Gambling Yield
GHNA	Gambling-related harms needs assessment
GSGB	Gambling Survey for Great Britain
HIOW	Hampshire and the Isle of Wight
HNA	Health needs assessment
HSE	Health Survey for England
ICB	Integrated Care Board
IMD2019	Index of Multiple Deprivation, 2019
JSA	Jobseeker's Allowance
Km^2	Square kilometres
LSOAs	Lower Layer Super Output Areas
MYE	Mid-year (population) estimate

NatCen	National Centre for Social Research
NGC	National Gambling Clinic
NGSN	GambleAware's National Gambling and Support Network
NHS	National Health Service
NHSE	NHS England
NICE	National Institute of Health and Care Excellence
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PAF	Postcode address file
PCGS	NHS Primary Care Gambling Service
PGSI	Problem Gambling Severity Index
PHE	Public Health England
PHF	Public Health Framework for Gambling-related Harm Reduction
PLE	People with lived experience
PNF	Personalised Normative Feedback
RGSB	Responsible Gambling Strategy Board
SAPF	Hampshire County Council Small Area Population Forecast
SCC	Southampton City Council
SGS	Southern Gambling Service
SMHN	Southampton Mental Health Network
SMI	Severe mental illness
SOGS	South Oaks Gambling Screen
VSE	Voluntary self-exclusion
UC	Universal Credit

Tables and figures

1. Introduction

1.1 What is a Health Needs Assessment?

A health needs assessment (HNA) is a systematic method of examining the health (including healthcare) needs of a population (i.e. a group of people with a common attribute, such as shared geographical area, service usage or health concern), leading to identification of *unmet* needs.[1-3] By recommending actions to address these unmet needs (e.g. around policy development, setting priorities, or service planning), the aim of an HNA is to improve population health and reduce health inequalities.[1,3]

The term 'need' in an HNA suggests the potential to benefit from intervention.[1] 'Need' in the context of health can be further defined as either *felt* (i.e. a need as perceived or experienced by an individual), *expressed* (i.e. a need as stated by an individual, often in the form of seeking help) or *normative* (i.e. a need as decided by experts, with reference to standards).[4] The HNA process must ensure that: (i) *felt* and *expressed* needs, in combination with the best-available scientific evidence, are suitably reflected by *normative* needs; and (ii) those normative needs (met and unmet) are addressed in the HNA.[1]

1.2 Aims and Objectives of this HNA

Aims

This gambling-related harms needs assessment (GHNA) seeks to: (a) understand the needs of those experiencing, or affected by, harmful gambling (i.e. those collectively experiencing gambling-related harms) in Southampton; (b) examine what is currently being done to address those needs, identifying any gaps between local action and current best-practice (including the scientific evidence-base); and (c) utilise the findings from (b) to help inform local recommendations, ultimately to reduce levels of gambling-related harm in the city.

Objectives

Specific objectives include:

- Summarise the national evidence-base with respect to the harms associated with gambling, including wider societal- and governmental- costs.
- Clarify our definition of 'harmful gambling', including:
    - How this is measured.

    - Groups most at-risk of experiencing harmful gambling.
- Outline national policy context.
- Describe the population of individuals experiencing gambling-related harm in Southampton to elucidate need (with reference to the key descriptive epidemiological dimensions of *person* (i.e. numbers and groups affected), *place* (distribution across city) and *time* (when)).
- Identify current provision of national and local services for *preventing and/or reducing* gambling-related harms amongst Southampton residents.
- Identify current provision of national and local services for *treating* Southampton residents experiencing harmful gambling.
- Summarise (i) evidence of effective interventions for preventing or reducing gambling-related harms and (ii) best-practice guidelines.
- Identify (i) any gaps in current local action to prevent or reduce gambling-related harm, with respect to evidence-based interventions and best-practice guidelines, or (ii) mismatching between level of need and level of provision.
- Formulate recommendations for local prevention, treatment, and harm-reduction in Southampton, taking account of local intelligence, evidence-based interventions and best-practice guidelines.

1.3 HNA Methodology

The methodological steps outlined in Table 1 were followed during this HNA, sometimes concurrently.[1,3]

Table 1: HNA methodology

Step	Details
1. Define focus	○ Identify health problem of interest, including public health importance. ○ Define HNA aims and objectives
2. Scoping	○ Review national and local policy. ○ Search published literature and examine evidence base. ○ Identify local population(s) of interest. ○ Conduct mapping exercise for identification of key stakeholders.
3. Data collection	○ Gather quantitative and qualitative data to ascertain size and nature of health problem in population of interest. ○ Engage key stakeholders for richer insight into issues affecting defined population, including views on required changes.
4. Review of existing services	Identify and describe currently-available prevention and treatment services (locally and nationally) for addressing health problem in the population of interest.
5. Identify evidence-based interventions	○ Literature search for evidence of clinically- (and cost-) effective interventions to reduce health problem in target population. ○ Compare to local action to identify any gaps or unmet needs in the population.
6. Recommendations and implementation of action plan	Use HNA findings (including local intelligence) and scientific evidence to inform recommendations. Agree priorities for action (and therefore resource allocation) through consultation with

	appropriate stakeholders. Implement, monitor over time, and evaluate agreed changes to determine if HNA aims and objectives have been achieved.

Table 1: HNA methodology.

1.4 Scope

This needs assessment examines data relating to:

- Southampton residents, who are
    - Experiencing or affected by harmful gambling/gambling-related harms; and
    - Aged 16 years and over.
- Land-based gambling premises with Southampton postcodes.

The following are therefore outside the scope of this HNA:

- Children and young people under 16 years of age.
- People living in institutions (e.g. hospitals, military barracks, student halls of residence, prisons etc).
- Travelling and homeless populations.
- Online-gambling access by Southampton residents (beyond general gambling-related harm estimates).

1.5 Limitations

There are various limitations that should be taken into consideration when reviewing this HNA, most notably in relation to the data:

- Local numbers of people experiencing or affected by harmful gambling have been estimated using national prevalence data; the figures presented are therefore not accurate statistics.
- The underlying national prevalence data (used to calculate local estimates) has been derived from two national surveys of high methodological quality: the Health Survey for England (HSE) 2021 and the Gambling Survey for Great Britain (GSGB) 2023. However, the general limitations of survey data apply (i.e. self-reported information collected from only a sample of the population at a particular point in time) and are discussed further in section 3.2.4. Furthermore:

    - The screening tool used in both surveys to capture gambling information – the Problem Gambling Severity Index (PGSI) – although commonly used, has been widely criticised (see section 2.2.2.1).
    - There is considerable shame and stigma attached to harmful gambling, likely resulting in survey participants underreporting their gambling behaviour. Consequently, national prevalences in respect of harmful gambling/gambling-related harm may be underestimated.
- The economic burden of harmful gambling in Southampton is also likely to be an underestimate (as is the case for England) due to partial (or no) costing for some harm categories.
- There are several limitations concerning the harmful-gambling risk-index scores for Southampton, particularly around the weighting of health- and social- domain indicators (see section 3.4).

Whilst some key stakeholders have been involved in shaping this HNA and the recommendations, a final limitation is: limited participation by, and therefore voice of, people with lived experience (PLE) and wider stakeholders.

2. Background

2.1 Overview of Gambling

2.1.1 Definition of Gambling

According to the Gambling Act 2005 (GA2005), Gambling is defined as playing a game of chance for a prize (i.e. 'gaming'), making or accepting a bet on the outcome of a race, competition, or other event or process (i.e. 'betting') or participation in a lottery.[5] Gambling is comprised of three elements: risking money or another item of value (the consideration) on the outcome of an uncertain event (risk) in the hope of winning something else of value (a prize).[6] For commercial gambling to be profitable, there is always a negative mathematical expectation for the player i.e. they are more likely to lose than win (the game favours the organisers).[7]

2.1.2 Types of Gambling

Common forms of gambling (which may be accessible online and/or in-person at physical premises) include: bingo; casinos; sports betting (particularly horse racing, dog racing and football matches); betting on electronic gaming (or gambling) machines (EGMs), such as *fixed-odds betting terminals* and fruit machines; lotteries; instant win games; scratch cards; and amusement arcades (i.e. adult gaming centres and family entertainment centres).[8,9]

2.1.3 Gambling Behaviour in Great Britain

Gambling has long been a popular recreational activity in Great Britain.[7] Indeed, according to the first (and latest) wave of the Gambling Commission's 2024 *Gambling Survey for Great Britain* (GSGB), 48% of adults in Great Britain gambled at least once in the last four weeks. The most popular activities were lottery participation, followed by scratch cards, betting and online instant games, with 'fun/enjoyment factor' and 'monetary reasons' cited as key motivators.[10]

According to the Gambling Commission's report on gambling behaviour trends (based on collated *Quarterly Telephone Survey* results between 2015 and 2023), overall gambling participation amongst British adults (aged 16 and over) fluctuated in the range 40-48%, averaging 45%, during the period. Men were more likely to have gambled than women (48% vs 42%, respectively) and there was significant variation by age group: those aged 45-64 were

most likely to have gambled, whilst those aged 16-24 were least likely. However, as a result of the Covid-19 outbreak, overall gambling participation began to decline in 2020 (largely driven by reduced in-person gambling), reaching a low of 40% at the beginning of 2021. Conversely, online gambling rates have steadily increased over the same period, from 15% in 2015 to 26% in 2023, with participation increases observed for all age groups.[11]

2.1.4 Benefits of Gambling

In addition to being an enjoyable leisure activity, it is often suggested that there are other social and economic benefits associated with gambling:

- The gambling industry in Great Britain employs approximately 100,000 people and generated a total Gross Gambling Yield (GGY) of £15.1 billion for the year-ending March 2023.[12,13] However, it has been asserted that a large proportion of the total revenue received by gambling venues is attributable to people experiencing harmful gambling.[14,15] Furthermore, some argue that the economic contribution of the gambling industry is negligible, if not detrimental, to the economy due to the lost opportunity-cost of consumers spending money in other sectors.[16,17]

- Betting and gaming duty receipts of £3,389 million were raised in the 2023/24 financial year (i.e. April 2023 to March 2024), a 3% (£86 million) increase on those raised in the 2022/23 tax year.[18]

- For quarter four of 2023-24 (i.e. Jan-March 2024), £449 million was raised for good causes (attributable to the sale of National Lottery games and unclaimed prizes).[19]

- Where there is competition for licences for large casinos, some gambling providers choose to voluntarily donate an amount to the council each year as part of a social responsibility agreement. At the time of writing, there are only three of these arrangements in England.[20]

However, these benefits must balance against the harms that may arise due to gambling.

2.2 Harms Associated with Gambling

2.2.1 Gambling-related Harms

According to Wardle *et al*, gambling-related harms are 'the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society'.[21] The 2021 Public Health England (PHE) *Gambling-related Harms Evidence Review* identified a range of harms associated with gambling (broadly categorised as financial, cultural, relationship, health, employment and education, and criminal behaviour) with an estimated overall annual cost of £1.05 to £1.77 billion, comprised of direct costs to the UK government and intangible societal costs.[22] A summary of key harms highlighted in the evidence review (relating to gambling individuals and those affected by someone else's gambling), and the Office for Health Improvement and Disparities (OHID) 2023 estimated economic burden in England for each harm category (in 2021 to 2022 prices), is presented in Table 2.[22,23]

Harm category	Key harms	Estimated overall cost (government and societal)
Financial	○ Financial hardship ○ Gambling-related debt ○ Bankruptcy ○ Homelessness	*£ 49.0 million* (based on statutory homeless applications in England, associated with harmful gambling).
Cultural	○ Additional shame and isolation experienced by some individuals and their families due to cultural norms.	No analysis undertaken
Relationship	○ Poorer family functioning and lower social support. ○ Relationship problems including interpersonal conflict, relationship strain and domestic abuse.	No analysis undertaken
Health	○ Suicide at least twice as likely amongst those experiencing harmful gambling compared to the general population. ○ Link between gambling and anxiety and depression.	*£754.4 – 1,475.0 million* (comprising: direct governmental costs for treatment of illicit drug use, alcohol dependence and depression; quality-of-life impact of depression; and

	○ Evidence to suggest association between gambling and substance use problems, especially use of alcohol. ○ Psychological distress (e.g. shame, guilt, self-esteem issues and loneliness) reported by gamblers in qualitative studies.	wider societal costs associated with deaths by suicide).
Employment and Education	○ Loss of employment, demotion or resignation by adult gamblers. ○ Adverse impact on school performance (e.g. for children of gamblers). ○ Loss of productivity at work (e.g. lateness, absenteeism, poor concentration) for both gamblers and their close associates (i.e. intimate partners and family).	*£77.0 million* (unemployment benefit claims linked to harmful gambling)
Criminal behaviour	○ Engagement in criminal activity (e.g. theft, fraud or selling drugs) to settle gambling-related debts.	*£167.3 million* (imprisonment due to harmful gambling-related offences)

Table 2: Summary of gambling harms and estimated economic burden (2023 analysis for England).

OHID (formerly PHE) have acknowledged that these figures are likely to be underestimates due to lack of available data, resulting in some harms (financial, health, employment and education, and criminal behaviour) only being partially costed, whilst others (cultural and relationships) have not yet been analysed at all.[22,23]

Many harms are interrelated; for example, financial difficulties may lead to relationship strain and family dysfunction, in turn affecting performance at work or school. Some harms may have an enduring negative impact e.g. use of inheritances, profits from the sale of property, or lifetime savings to settle gambling debts, thus affecting the long-term financial security of partners, children and future generations.[7,21] Gambling-related harms therefore affect not only the gambling individual, but also their families, friends, work colleagues and communities. According to the 2023 Annual GB Treatment and Support Survey (administered by YouGov on behalf of GambleAware), 7% of those surveyed (equating to approximately 3.6

million adults in GB) identify as an 'affected other' i.e. 'those who know someone with a gambling problem, either now or in the past, and have experienced negative effects as a result of that person's gambling behaviour'.[21,24] Affected others are 'more likely to be women', and the majority of affected others are immediate family members (i.e. intimate partners or children).[24] Children are severely impacted by harmful gambling, both emotionally and financially, potentially giving rise to Adverse Childhood Experiences (ACEs), the impact from which may extend into adulthood.[7] Harms to society include loss of productivity in the workplace, the cost of treatment for addiction, and the financial (and other) consequences of fraud and theft.[22]

2.2.2 Harmful Gambling

Gambling behaviours exist on a continuum of harm (Figure 1), ranging from *no gambling* and *recreational gambling* (i.e. gambling for fun or leisure, with no adverse consequences) at one end, to *gambling disorder* (a recognised DSM-5 mental disorder) at the other extreme, often accompanied by severe, life-destroying consequences.[25,26] *Harmful gambling* is an umbrella term, capturing not only those with a diagnosable gambling disorder, but also those at increased risk of harm as a result of their gambling behaviour.[27] *Harmful gambling* (sometimes also referred to as problem gambling, gambling addiction, at-risk gambling, compulsive gambling, pathological gambling, irresponsible gambling, or disordered gambling) essentially means any frequency of gambling that results in people experiencing 'harm, problems or distress'.[22,27,28] Gambling behaviour may progress in a linear sequence along the continuum towards gambling disorder; however, the 'gambling pendulum' concept coined by Sakhuja (as cited by Leyshon *et al*) proposes a more dynamic, back and forth, pattern of movement between gambling categories.[25,29]

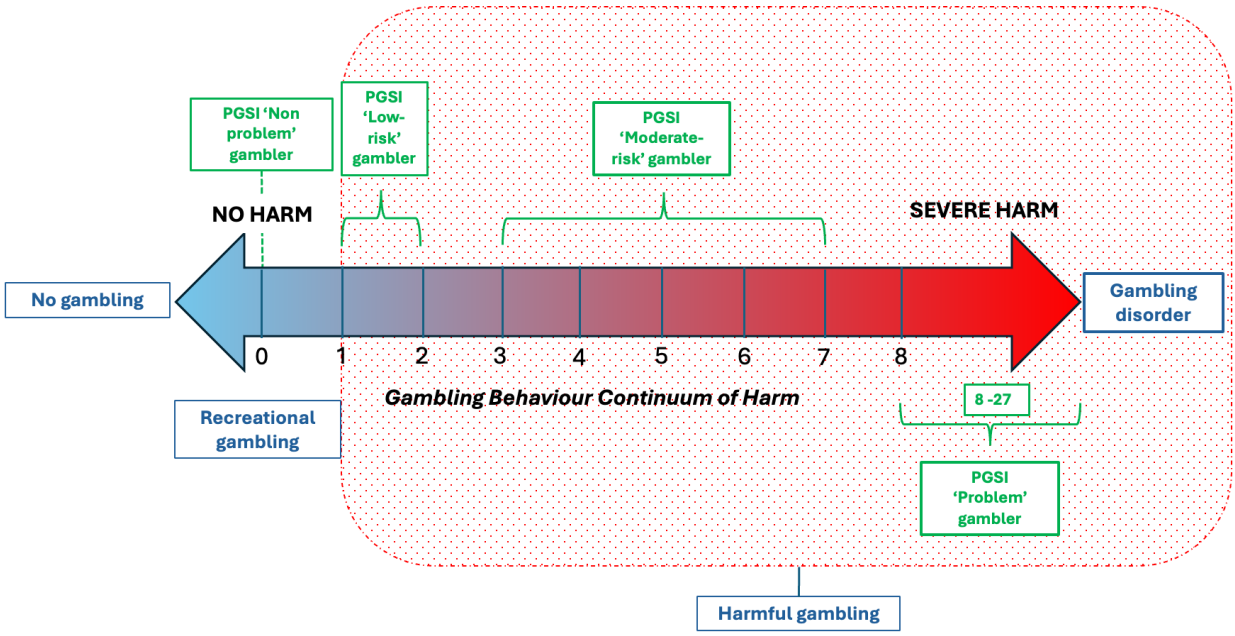

Figure 1: Gambling behaviour continuum of harm.

2.2.2.1 Problem Gambling Severity Index (PGSI)

The Problem Gambling Severity Index (PGSI) is a commonly-used screening tool for assessing the level of risk facing an individual as a result of their gambling behaviour.[30,31] Individuals are scored 0-27 based on their responses to nine questions, and the tool has been designed for use in the general population. PGSI scores, categories and definitions are presented in Table 3.[30,31] For a holistic overview of the gambling-harms landscape, PGSI categories have been incorporated into the continuum of harm (Figure 1), with harmful gambling corresponding to a PGSI score of 1 or more.

Although commonly used, the PGSI has been widely criticised: firstly, for failing to take account of the continuum of harm, along which individuals may move over time. It has been argued that, by placing individuals into one of four distinct risk categories, prevention and treatment efforts may focus solely on the minority categorised by the tool as 'problem gamblers', whilst the (more numerous) lower-risk gamblers may be starting to experience increasing levels of harm and would benefit from interventions to prevent harms-escalation along the continuum.[8,25,32]

PGSI Score	Category	Definition
0	**Non-problem gambler**	Individuals who gamble (including heavily) with no negative consequences. Also includes those who haven't gambled in the last year.
1-2	**Low-risk gambler**	Gamblers who experience a low level of problems with few or no identified negative consequences.
3-7	**Moderate-risk gambler**	Gamblers who experience a moderate level of problems leading to some negative consequences.
8+	**Problem gambler**	Gambling with negative consequences and a possible loss of control.

Table 3: PGSI scores, categories and definitions.

Secondly, the term 'problem gambler' underplays the many factors that contribute to gambling participation at this level of risk (such as the role of advertising, the conduct of gambling operators, and the risk and harm inherent in some gambling products), suggesting instead that responsibility lies predominantly with the affected individual, thus contributing to the shame and stigma already felt by those experiencing a gambling problem.[30,33] However, in spite of these shortfalls, the PGSI is one of the most commonly-used screening tools for measuring gambling severity; indeed, it is widely cited in major surveys (such as the HSE, the GSGB, the Welsh Problem Gambling Survey and the Scottish Health Survey) and used by healthcare providers, with scores quoted as grounds for signposting to further support and treatment.[34]

2.2.2.2 Harmful Gambling Activity Profile

The activity profile of harmful gambling differs from that of general gambling and is associated with frequent engagement (of longer duration and higher expenditure) in multiple forms of gambling. Whilst lottery participation is low, there is high participation in: bingo and casino games; betting on sports and other events (e.g. dog races); online gambling; and use of EGMs in bookmakers. In 2018, online gambling participation for at-risk gamblers was more than twice that of the general population (23.4% vs. 9.4%, respectively).[22]

2.2.3 Groups at Risk of Harmful Gambling

Whilst general gambling participation is highest amongst the employed, those with higher academic qualifications, and those from comparatively more affluent socioeconomic groups, harmful gambling is conversely associated with unemployment and areas of high deprivation, likely experiencing greater health inequalities.[22]

According to the PHE gambling-related harms evidence review, mental health status and sex are also strong predictors of harmful gambling: men are over four-times as likely to gamble at elevated risk-levels compared to women; and people with mental health conditions (e.g. anxiety, depression, psychological problems or mood-disorders) are twice as likely to experience harmful gambling compared to those with no mental health conditions, purportedly as a mechanism for coping with past trauma.[8,12,22,35-37] Younger age is also a risk factor for harmful gambling, with the greatest harms from gambling experienced by those aged 18 to 34 years.[11,38]

Harmful gambling is often comorbid with substance use problems. In particular, there is a clear association between harmful gambling and higher levels of alcohol consumption.[22,27] Indeed, compared to the general population, harmful gambling rates are eight times higher among people with alcohol use problems.[39] Other groups cited as more vulnerable to harmful gambling include military veterans, students, those from ethnic minority backgrounds, and the homeless.[12,38] Recent research conducted at Aston University has found harmful gambling to be both a risk factor for, and outcome of, housing insecurity.[40] There is also evidence to suggest that living in close proximity to gambling venues may elevate gambling-related harm.[41]

2.3 Policy Context

The policy history since 2005 is summarised below. The current legislative context was heavily impacted by the 2005 Gambling Act.

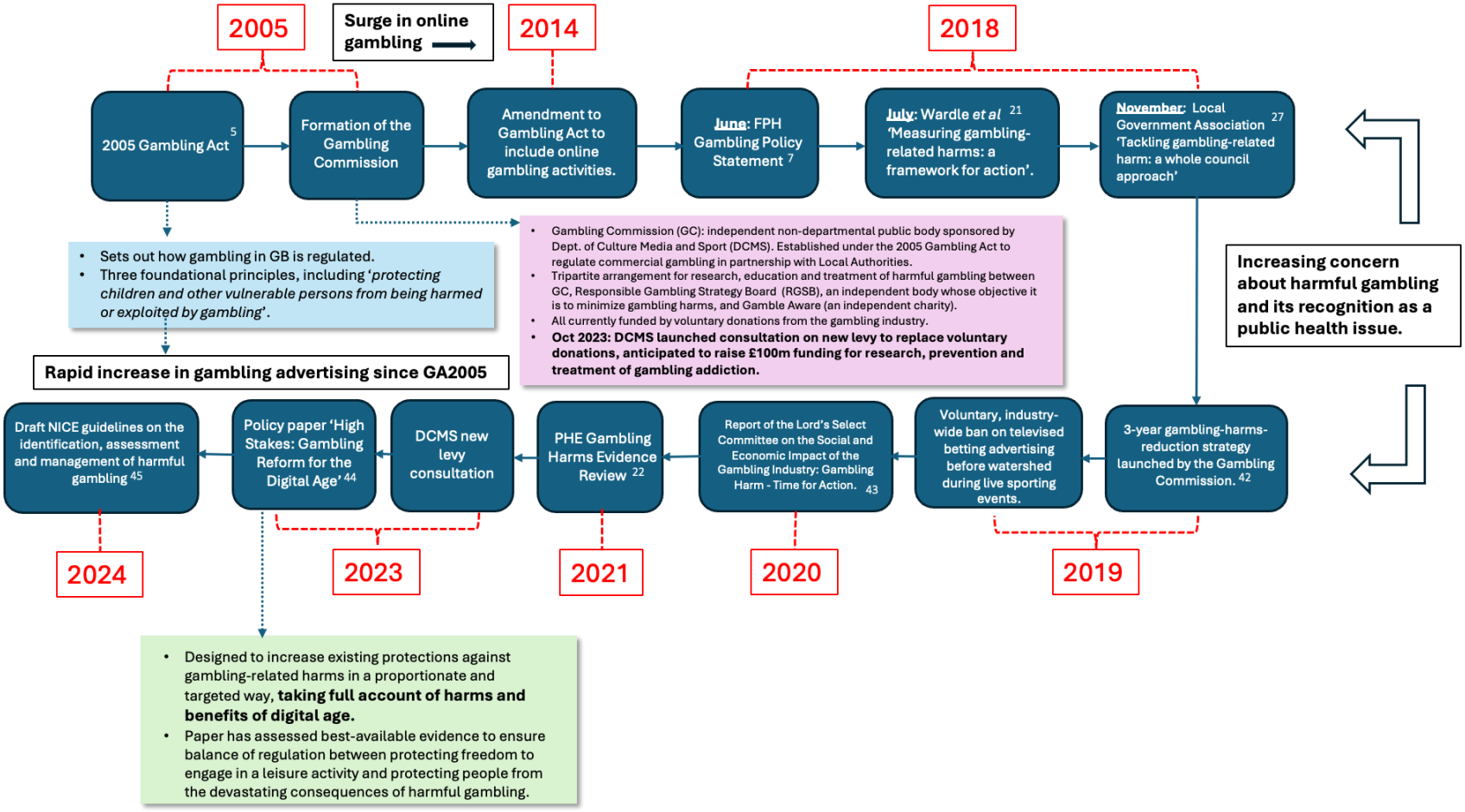

Figure 2: National gambling-policy timeline, 2005-2024.

2.4 Why is this a Public Health Issue?

Public health aims to improve population health, wellbeing and overall quality of life.[7] This includes protecting people from preventable harms and striving to achieve health equity (i.e. the absence of unfair and avoidable differences between groups, leading to attainment of optimal health for all).[7, 9, 46]

In the UK, harmful gambling has gained recognition amongst policy-makers, academics and healthcare professionals alike as a 'serious and worsening' public health issue due to increased awareness of the grave repercussions (health, financial and social) facing many individuals, their families and communities.[7,21,22,27,42] Furthermore, the distribution of harm is uneven, with the economically inactive and those living in deprivation suffering the most.[47]

2.5 Tackling Gambling-related Harms: A Public Health Approach

Growing concern in recent years over the wide-reach and impact of gambling-related harms, and recognition that the burden of harm is greater than that carried by the smaller group of PGSI 'problem gamblers', has led to greater demand for a public health approach, i.e. a population-level strategy including prevention and 'upstream action' (i.e. community and place-based action). For example, in 2018, the Faculty of Public Health (FPH) issued a gambling policy statement wherein they proposed a shift in thinking away from individuals towards a 'multifaceted population level approach' to tackling harms, incorporating lessons learned from public health work on alcohol and smoking.[7] Indeed, an individual-level approach is unlikely to reduce the incidence of harmful gambling in the population; individual-level interventions may instead exacerbate health inequalities due to differing engagement abilities between groups.[48-50]

According to Frieden's Health Impact Pyramid, interventions less-focused on individuals (i.e. with a lower emphasis on long-term individual behaviour change) have the most impact at a population-level. For maximum population impact, the Health Impact Pyramid recommends socioeconomic-level interventions (at the base of the pyramid), followed by interventions that change the environmental context to promote healthier default decisions. At the peak of the pyramid, individual-level interventions such as education and counselling are deemed to have the least population impact. However, the authors acknowledge that interventions are required at each level of the pyramid for maximum possible sustained benefit.[51]

Also in 2018, Wardle *et al* (on behalf of the Gambling Commission) produced a report on gambling-related harms, including a framework for preventive action.[21] The authors argue that gambling-related harm occurs at individual, family, community and societal levels. Wardle *et al* therefore advocate for use of the socio-ecological model, to ensure that preventative action targets each of these levels.

Prevention efforts can also be defined as primary, secondary or tertiary, defined as follows (adapted from LGA prevention definitions[52], in the context of gambling-related harms):

- **Primary prevention**: taking action to *prevent the onset* of harmful gambling/gambling-related harm, through whole-population measures or those targeting vulnerable groups (i.e. those at greatest risk of harm).

- **Secondary prevention**: *early identification* of those who have recently started experiencing harmful gambling/gambling-related harm, to prevent escalation of (and ideally reduce) harm.

- **Tertiary prevention**: measures to *lessen the impact* on those already experiencing harmful gambling/gambling-related harm.

3. Local Need

3.1 Southampton Background

3.1 1 Population Size and Structure

According to Hampshire County Council's Small Area Population Forecast (SAPF) data (considered to be a robust source of local estimates, as it takes account of natural change (i.e. births and deaths), migration and dwelling completions) the estimated resident population of Southampton in 2023 was 264,957 (219,992 adults aged 16 and over), of which 135,236 (51%) were male and 129,721 (49%) were female.[53] Southampton has a relatively young population with 18.6% (49,155) of residents aged 16-24 years, compared with 10.6% for England.[53,54] This is largely due to Southampton being a university city, home to around 38,000 students.[54] Whilst only 14.5% (38,472) of the population are aged 65 and over, compared to 18.6% nationally, this is forecasted to increase by 18.2% or 7,021 people by 2030.[53,54]

3.1.2 Deprivation

3.1.2.1 Overview

The Southampton Data Observatory describes *deprivation* as a 'general lack of resources and opportunities' i.e. more than *poverty*, where poverty is 'not having enough money to get by on'.[55] The *Index of Multiple Deprivation* (IMD2019) is the official statistic on relative deprivation in England, ranking small areas across England from least to most deprived.[56] Deprivation is measured at the level of *Lower Layer Super Output Area (LSOA*) (i.e. a neighbourhood containing between 400 and 1,200 households, with a resident population of between 1,000 and 3,000 persons) by combining indicators across seven domains of deprivation, namely: employment, income, education, crime, health, living environment, and barriers to housing & services. Each LSOA in England (of which there are 32,844) is then rank ordered by level of deprivation and subsequently arranged into 10 equal groups or *deciles*.[55-57]

3.1.2.2 Southampton Data

Based on the average deprivation rank of its LSOAs (neighbourhoods), Southampton is 55th most deprived out of 317 Local Authorities in England. Achieving a relatively high

deprivation score using the average rank measure suggests a more uniform, rather than highly polarised, distribution of deprivation in Southampton.[55]

Nineteen of Southampton's LSOAs (home to 12% of Southampton's population, approximately 32,000 people) are within the 10% *most deprived* in England, with only one LSOA in the 10% *least deprived* decile.[55] A map of Southampton LSOAs (showing ward boundaries), colour-coded by deprivation decile, is presented at Figure 3 below.[58]

[Note that there are 17 wards in Southampton, a *ward* being an area used for electoral purposes within a local authority.][59]

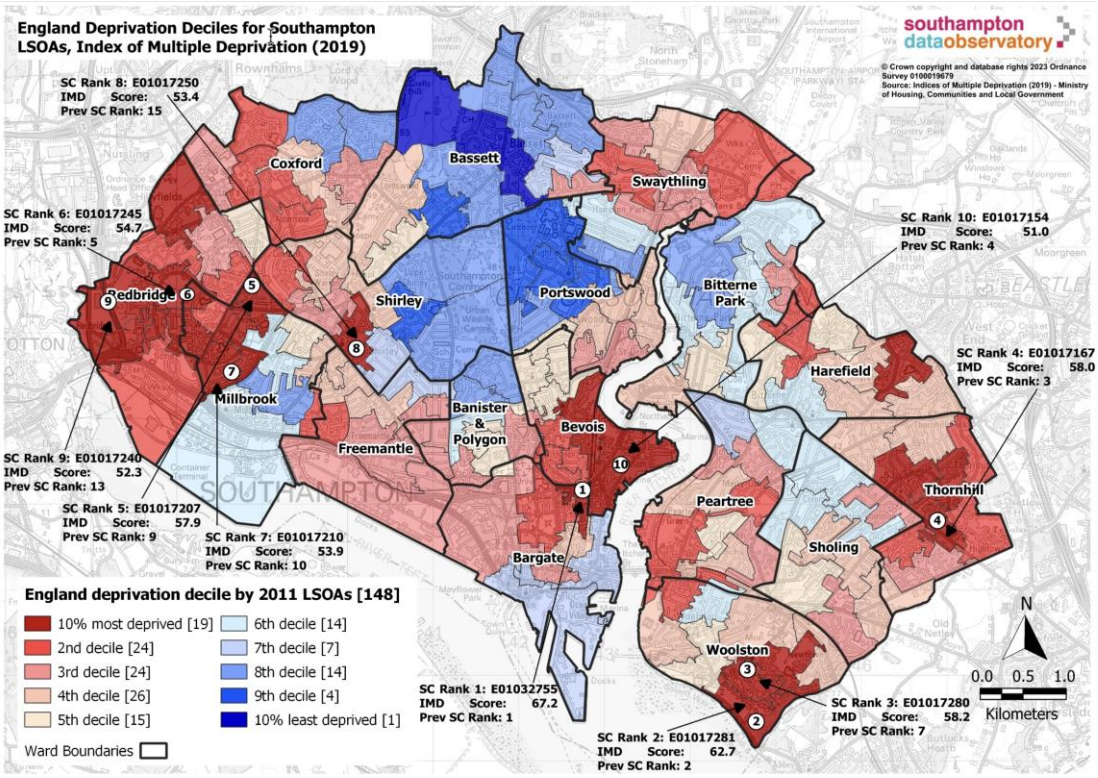

Figure 3: Map of IMD2019 deprivation deciles for Southampton LSOAs, showing ward boundaries.

- 18% of the under-18 population (compared to 12% of the total Southampton population) reside in the 10% most deprived neighbourhoods, suggesting that young people in the city are disproportionately affected by deprivation.[55]
- Approximately 120,000 people (more than 45% of Southampton's population) live in neighbourhoods within the 30% most deprived nationally.[55]

- The five most deprived neighbourhoods in Southampton (as numbered in Figure 3) are: 1. Bargate (Golden Grove); 2. Woolston (International Way); 3. Woolston (Kingsclere Avenue); 4. Thornhill (Lydgate Road); and 5. Millbrook (Lockerley Crescent).

3.2 Estimated Numbers Experiencing, or Affected by, Harmful Gambling in Southampton

Southampton-level data on the prevalence of harmful gambling (i.e. the proportion of the population classed as PGSI 'low-risk', 'moderate-risk' (collectively referred to as 'at-risk') or 'problem' gamblers) is not currently available.

However, the number of people experiencing harmful gambling in Southampton has been estimated using the results of two recent national surveys of high methodological quality: the Health Survey for England (HSE) 2021 and the Gambling Commission's Gambling Survey for Great Britain (GSGB) 2023, both of which use random probability sampling.[60,61]

3.2.1 HSE 2021[60,62]

3.2.1.1 Methodology

Since 1994, the HSE (commissioned by NHS England (NHSE)) has been designed and conducted by the National Centre for Social Research (NatCen) Joint Health Surveys Unit and the Epidemiology and Public Health Research Department at University College London. The purpose of the HSE is to monitor health trends and behaviours in England, through selection of a nationally representative sample of adults (aged 16 years and over) and children (aged 0 to 15 years), with HSE methodology being described as 'gold standard'.[30,63] For HSE 2021 (as in previous years) a *multi-stage stratified probability sampling* design was used to select individuals residing in private households in England, using the postcode address file (PAF) as the sampling frame; those living in institutions were outside the scope of the survey. [HSE 2021 acknowledges that those living in private households are likely to be younger and healthier, on average, than the institutional population]. Due to the Covid-19 pandemic, general HSE data collection was conducted by remote interview rather than face-to-face, with self-completion booklets returned by post. This methodological change means that HSE 2021 survey results are not comparable with results from previous years. To ensure that answers could be provided in confidence, (affording greater privacy from other household members, compared to an interview), questions on gambling participation and behaviour, including PGSI and DSM-IV screening questions, were included in the self-completion questionnaire booklets (returned by post by 3,847 adults).

3.2.1.2 Results

Results relating to the PGSI are presented using the tool's terms (e.g. problem gambler). Based on PGSI scores, 2.8% of adults (aged 16 and over) were identified as at-risk or problem gamblers, with 0.3% being classified as problem gamblers. Men were four times as likely to be identified as at-risk or problem gamblers than women (4.4% of men compared to 1.1% of women).

3.2.2 GSGB 2023[61,64]

3.2.2.1 Methodology

The GSGB Annual Report 2023 summarises data collected between July 2023 and February 2024 (i.e. the first year of the GSGB) from 9,804 adults aged 18 and over in Great Britain on gambling participation, behaviour, experiences and consequences. Similar to the HSE, the GSGB used *stratified random probability sampling* of GB addresses from the PAF, targeting adults residing in private households (also excluding those in institutions such as hospitals, military barracks, student halls of residence, prisons etc.). Self-completion, gambling-focused questionnaires were available online or by post for those less technologically literate. However, there is evidence that surveys conducted online produce higher estimates of problem gambling due to overrepresentation (compared to the general population) of those more inclined to gamble online and to gamble often.[63] Furthermore, gamblers may be more attracted to a survey specifically about gambling (due to its personal relevance), rather than one about 'health', meaning that the GSGB is likely affected by greater selection bias compared to the HSE (i.e. a higher representation of gamblers).[64] The GSGB is conducted by NatCen in conjunction with the University of Glasgow, on behalf of the Gambling Commission. The researchers have declared that no funds were received, directly or indirectly, from the gambling industry (including the charity GambleAware). The GSGB has replaced the *Quarterly Telephone Survey*; however, results cannot be compared due to methodological differences.

3.2.2.2 Results

Results relating to the PGSI are presented using the tool's terms (e.g. problem gambler). Based on PGSI scores, 14.5% of adults aged 18 and over were identified as at-risk or problem gamblers, with 2.5% being classified as problem gamblers. Similar to HSE findings, men were

more likely to be identified as at-risk or problem gamblers than women (17.6% of men compared to 11.4% of women).

3.2.3 Southampton Estimates

3.2.3.1 Harmful Gambling

The number of people experiencing harmful gambling in Southampton can be estimated by applying HSE- and GSGB- derived national prevalences of PGSI 'problem or at risk gamblers' (i.e. score 1+) to the 2023 SAPF estimated resident population of adults (aged 16 and over) in Southampton of 219,992.[53] [Note that the over-16 population in Southampton has been used to calculate estimates for comparability with HSE 2021 data (which relates to adults aged 16 and over) and also because younger age is a risk factor for harmful gambling; indeed, the proportion of survey respondents aged 16-24 years with a PGSI score of 1+ in HSE 2021 was higher than the all-ages average (3.0% vs 2.8%, respectively). Ranges of estimated numbers in Southampton, by gambling risk category, are presented in Table 4 below.

Gambling risk category	Prevalence range (HSE21 to GSGB23)	Estimated numbers for Southampton	
		HSE21	GSGB23
PGSI low-risk gambler	1.9% to 8.3%	4,180	18,260
PGSI moderate risk gambler	0.6% to 3.7%	1,320	8,140
PGSI low or moderate (i.e. at-risk) gambler	2.5% to 12%	**5,500**	**26,400**
PGSI problem gambler	0.3% to 2.5%	**660**	**5,500**
PGSI at-risk or problem (i.e. harmful) gambling	2.8% to 14.5%	6,160	31,900

HSE21 = Health Survey for England 2021
GSGB23 = Gambling Survey for Great Britain, Annual Report 2023

Table 4: Estimated numbers of people experiencing harmful gambling in Southampton, by risk category

3.2.3.2 Affected Others

As discussed in section 2.2.1, 7% of adults (aged 18+) surveyed in the 2023 Annual GB Treatment and Support Survey (administered by YouGov on behalf of GambleAware) identified as an affected other.[24] Applying this proportion to the 2023 SAPF population estimate for Southampton of 215,044 adults (aged 18 and over), equates to 15,053 adults in Southampton adversely affected by someone else's gambling.[53] However, this figure is likely to be an underestimate of all those affected, as it does not include children (upon whom the

impact of harmful gambling can be profound) and may not accurately capture the wide-reaching nature of gambling-related harms, which can extend beyond families to friends, colleagues and communities.

3.2.4 General Limitations of Survey Data[2]

In addition to (and expanding upon) the caveats discussed above, there are a number of general limitations associated with survey data:

1. Surveys collect information from a *sample* of the population. Although samples are usually designed to be representative of the whole population, the results are *estimates* rather than accurate statistics, often subject to a 95% confidence interval (i.e. the range within which researchers are 95% confident that the true population value lies).

2. Those who participate in a survey may have different characteristics from those who do not, giving rise to *non-responder bias* (a form of selection bias), meaning that results may not be representative of the general population. Indeed, in the context of gambling surveys, Scholes *et al* found a relationship between lower household response rate and higher gambling frequency.[65]

3. Surveys are *cross-sectional* (i.e. information is collected at a single point in time) which means that they are not appropriate for inferring causality between outcome(s) and exposure(s).

4. Surveys capture self-reported data, potentially giving rise to *responder bias* (a type of information bias). Specifically, inaccurate collection of data may occur through recall bias (where a study participant incorrectly remembers a past event) or as a result of reporting bias, for example, where study participants under-report or misrepresent their behaviour (in this case gambling habits) to appear to conform to socially desirable norms and/or through fear, shame or stigma. However, the greater privacy afforded by self-completion methods may reduce the risk of this 'social desirability' reporting bias.[64]

3.3 Estimated Cost of Gambling-related Harm in Southampton

The costs associated with gambling-related harms in Southampton have been estimated from the OHID 2023 economic analysis for England (presented earlier in Table 2).[22,23] In Table 5, costs for Southampton (column D) have been calculated as a proportion of costs for England (column C), based on relative adult (16+) population size, i.e.

$$Cost_{Southampton} = Cost_{England}\ x\ (\frac{2023\ ONS\ MYE\ Southampton\ (16+)\ population}{2023\ ONS\ MYE\ England\ (16+)\ population})$$

Office for National Statistics (ONS) mid-year estimates (MYE) for England and Southampton populations aged 16 and over in 2023 were 47,041,973 and 211,000, respectively.[23,66]

A. TYPE OF HARM	B. SUB-DOMAIN	C. ALL COSTS* ENGLAND (£millions)	D. ALL COSTS* SOUTHAMPTON (£)
Financial	Statutory homelessness	**49.0**	**219,782**
Health	Deaths from suicide	241.1 to 961.7	1,081,419 to 4,313,567
Health	Depression	508.0	2,278,561
Health	Alcohol dependence	3.5	15,699
Health	Illicit drug use	1.8	8,074
Total health harms	All health sub-domains	****754.4 to 1,475.0**	****3,383,753 to 6,615,900**
Employment and education	Unemployment benefits	**77.0**	**345,372**
Criminal activity	Imprisonment	**167.3**	**750,400**
Excess cost	**All sub-domains**	****1,047.8 to 1,768.4**	****4,699,756 to 7,931,904**

*Sum of government (direct) costs and wider societal (intangible) costs
**Figures may not sum due to independent rounding

Table 5: Estimated excess cost(s) of gambling-related harm(s), for England (C) and Southampton (D), in 2021 to 2022 prices.

The estimated annual excess cost of gambling-related harm in Southampton is £4.7 to £7.9m, consistent with other estimates.[67] (Note that OHID define 'excess cost' as the *difference between* costs incurred for a defined group experiencing harmful gambling, and costs incurred for the population who do not gamble.) This gives an indication of local economic burden and provides a starting point for further discussion and future research. However, the limitations of the economic analysis for England[23] (introduced in section 2.2.1) also apply to the estimates for Southampton:

- Costs are likely to be underestimated due to lack of information and therefore only partial (or no) costing for some harm categories.

- Estimates are based on costs *associated with* gambling; causality cannot be inferred due to limited evidence on population harms directly-attributable to gambling.
- The proportional method relies on the assumption that the population of Southampton is the same as that of England in terms of types of harm experienced, proportions in the population experiencing those harms, and the nature of assistance sought, if any (e.g. claiming unemployment benefit or submitting a statutory homeless application). Given that Southampton is more deprived than average (55th most deprived out of 317 Local Authorities in England), and deprivation is a risk factor for harmful gambling, the estimated excess costs for Southampton in Table 5 are likely to be underestimates.

3.4 Harmful Gambling Risk Map for Southampton

Public Health analysts in Southampton City Council's Data, Intelligence and Insight team have modelled *Harmful Gambling Risk Index* scores for each Southampton LSOA, to help predict which areas of the city are most susceptible to harmful gambling. Risk scores are comprised of indicators (covering health and social domains) associated with groups most vulnerable to harmful gambling, as informed by the current evidence-base. *Health* domain indicators (for those aged 16 and over) include:

- GP registered patients with depression, anxiety and/or severe mental illness (SMI).
- Hospital admissions for poisoning by illicit drugs.
- Hospital admissions for alcohol-specific conditions.
- Drug-related mental health and behavioural admissions.
- Emergency hospital admissions for suicide and self-harm.

Social domain indicators (for those aged 16 and over) include:

- Population aged 16 to 44 years.
- IMD2019 overall scores.
- Jobseekers Allowance (JSA) claimants aged 16 to 64.
- Universal Credit (UC) claimants aged 16 to 64.

Indicator descriptions can be found at Appendix A. LSOA risk scores have been calculated, ranked and then split into 10 equal groups (deciles). An LSOA decile map of harmful gambling risk scores for Southampton is presented at Figure 4, predicting areas of the city

at greatest and least risk of experiencing harmful gambling (coloured red and blue, respectively).

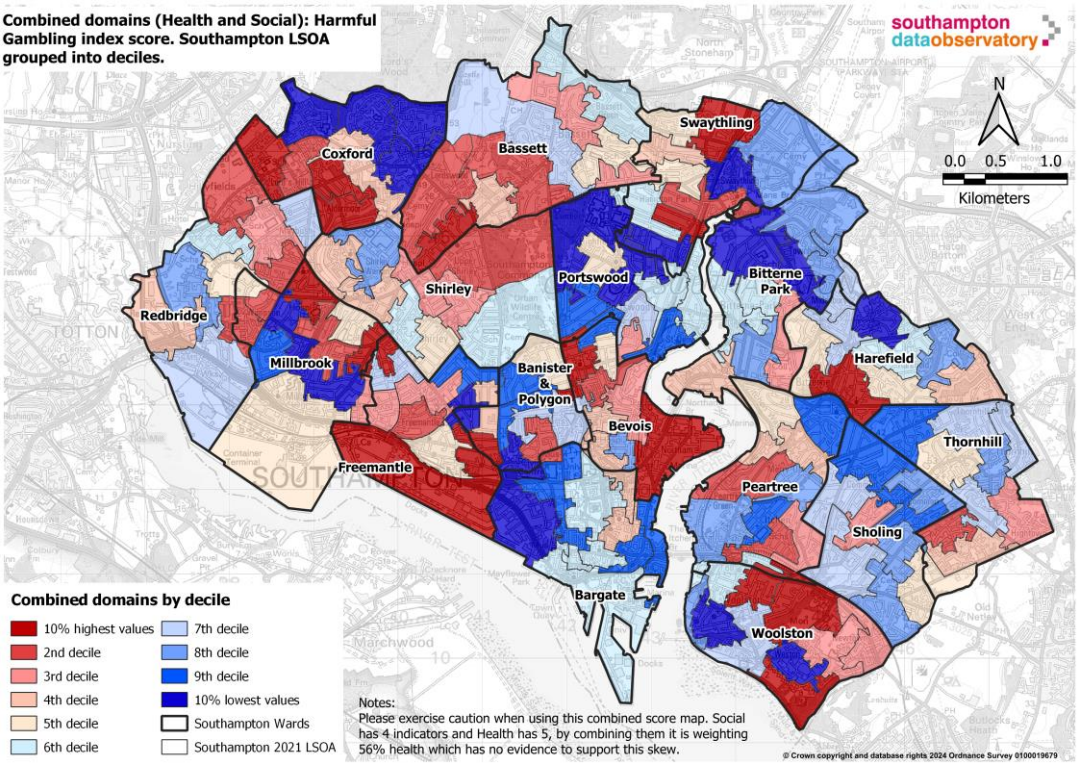

Figure 4: Decile map, by LSOA, of Harmful Gambling Risk Index Scores for Southampton.

The wards containing the highest numbers of LSOAs within the first decile i.e. the 10% most at risk of experiencing harmful gambling are: Coxford (3); Woolston (3); Bevois (2); Millbrook (2) and Swaythling (2), with numbers of affected LSOAs in brackets.

It should be noted, however, that risk index methodology has been based on the following assumptions:

1. That each health or social risk factor is independent and contributes equally to an individual's susceptibility to harmful gambling. In practice though, some indicators may overlap and/or have a greater or lesser impact on harmful gambling risk than others (although there is an absence of evidence in this regard).

2. Similarly, the model includes five health-domain indicators and four social-domain indicators, i.e. 56% health-domain indicators, but there is currently no evidence to support this skew.

Other points to note:

1. Section 2.2.3 discusses younger age as a risk factor for harmful gambling, with the greatest harms experienced by those aged 18-34 years.[11,38] However, for the purposes of risk score modelling, it was deemed prudent to extend this age range to 16-44 in line with HSE 2021 survey results (for adults aged 16 years and over) which found that the age group with the highest proportion of PGSI at-risk or problem gamblers were those aged 35-44 years (4.5%).[60]

2. Although current evidence suggests that certain groups are more vulnerable to harmful gambling (i.e. military veterans, students, those from ethnic minority backgrounds, and the homeless)[12,38] no indicators directly linked to these sub-populations have been included in the risk score methodology due to lack of evidence of independent increases in risk, the potential for stigma and an absence of available data. The chosen indicators encompass many of the risks experienced by these sub-populations.

3.5 Gambling Premises in Southampton

3.5.1 Distribution of Premises by Licence Type

The map shown in Figure 5 analyses the distribution of gambling premises in Southampton by location (based on postcode) and licence type. Licence types have been restricted to those most associated with the harmful gambling activity profile (see section 2.2.2.2); therefore, vendors of National Lottery tickets and scratchcards have been excluded. Additional exclusions are described in the footnotes to Figure 5. Further information on Southampton City Council gambling licence types can be found at Appendix B.

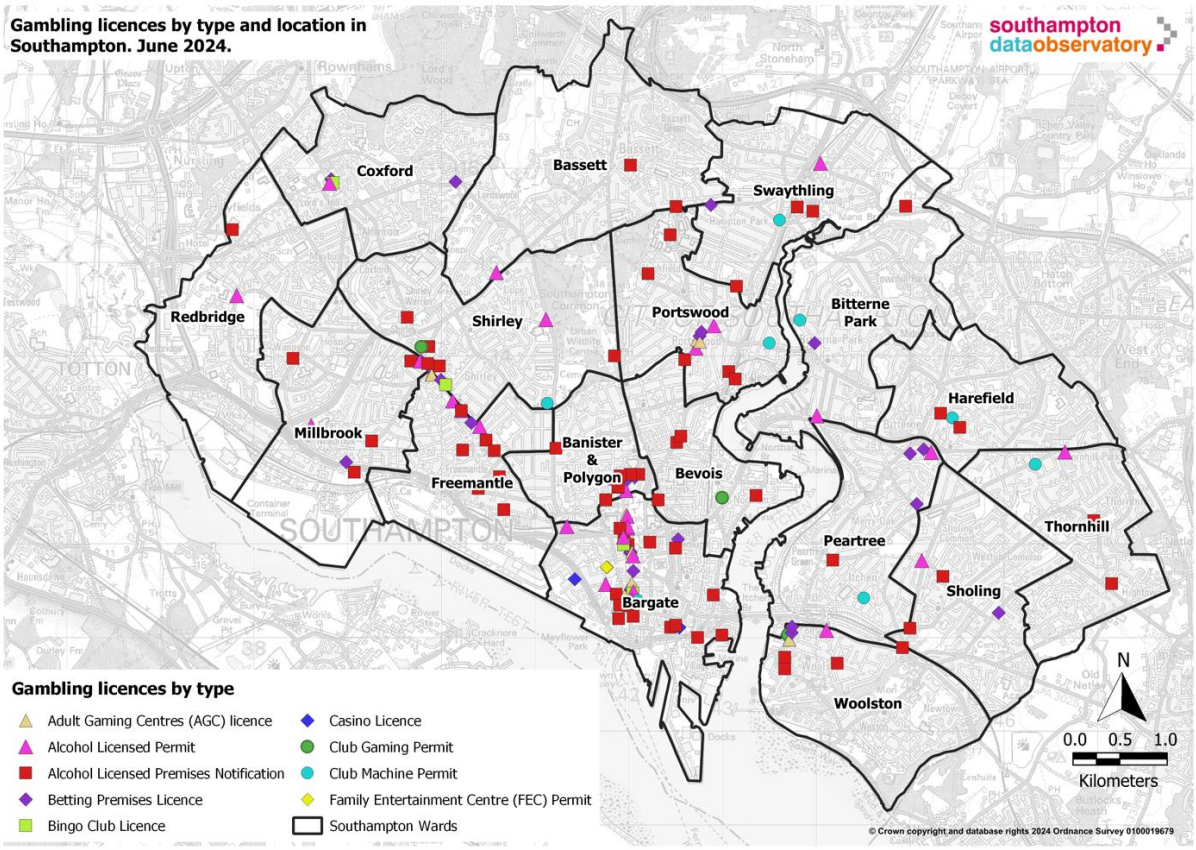

Figure 5: Gambling licences by type and location in Southampton, June 2024.

[Excludes online gambling activity. Small society lotteries (proceeds less than £20,000 per lottery or £250,000 in a calendar year) have also been excluded as no operating licences are required for such premises].

Further analysis of the of the data presented in Figure 5 indicates that:

- 20% of gambling licences in Southampton relate to betting, bingo, and casinos, i.e. some of the gambling activities most associated with harmful gambling (see section 2.2.2.2).

- The five wards with the greatest number of gambling premises per square kilometre (Km^2) are: Bargate (44 premises, 14.0 premises per Km^2); Banister & Polygon (13 premises, 8.9 premises per Km^2); Freemantle (13 premises, 4.8 premises per Km^2); Portswood (11 premises, 4.5 premises per Km^2); and Shirley (11 premises, 3.0 premises per Km^2).
- There is a suggested correlation between gambling-premises density and deprivation: Bargate ward, where the density (and number) of gambling premises is the highest, also includes the most deprived neighbourhood (LSOA) in Southampton (i.e. rank 1) and a neighbourhood in Bevois within the 10% most deprived decile shares a ward boundary with Bargate. In Banister & Polygon, Freemantle, and Portswood, gambling premises are concentrated largely in the most deprived areas of each ward. In Shirley, most gambling premises are clustered in a neighbourhood which is the 8th most deprived in Southampton.
- With respect to harmful gambling risk score (Figure 4), all of the previously highlighted wards (Bargate, Banister & Polygon, Freemantle, Portswood and Shirley) contain at least one LSOA with a risk score in deciles one to four (i.e. within the 40% most at-risk of experiencing harmful gambling). Freemantle and Shirley each contain three LSOAs with risk scores in deciles one to three (i.e. within the 30% most at-risk of experiencing harmful gambling), whilst Banister & Polygon has two LSOAs within the top 20% most at-risk, one of which is in the first decile (i.e. within the 10% most at-risk of experiencing harmful gambling).

3.5.2 Travel Distances from Residential Postcodes to Nearest Gambling Premises

Figure 6 shows a walking times map, between residential postcodes in Southampton and nearest licensed gambling premises (also based on postcode). Walking times have been calculated based on the Ordnance Survey road network and on the assumption that the average person can walk at 3 miles-per-hour (or 1 mile in 20 minutes). The postcode file supplied includes the Easting and Northings grid reference system. Further analysis of the data presented in Figure 6 indicates that 54.6% of Southampton households live within a 6-minute walk of their nearest gambling premises, with 82.5% of households living within a 10-minute walk.

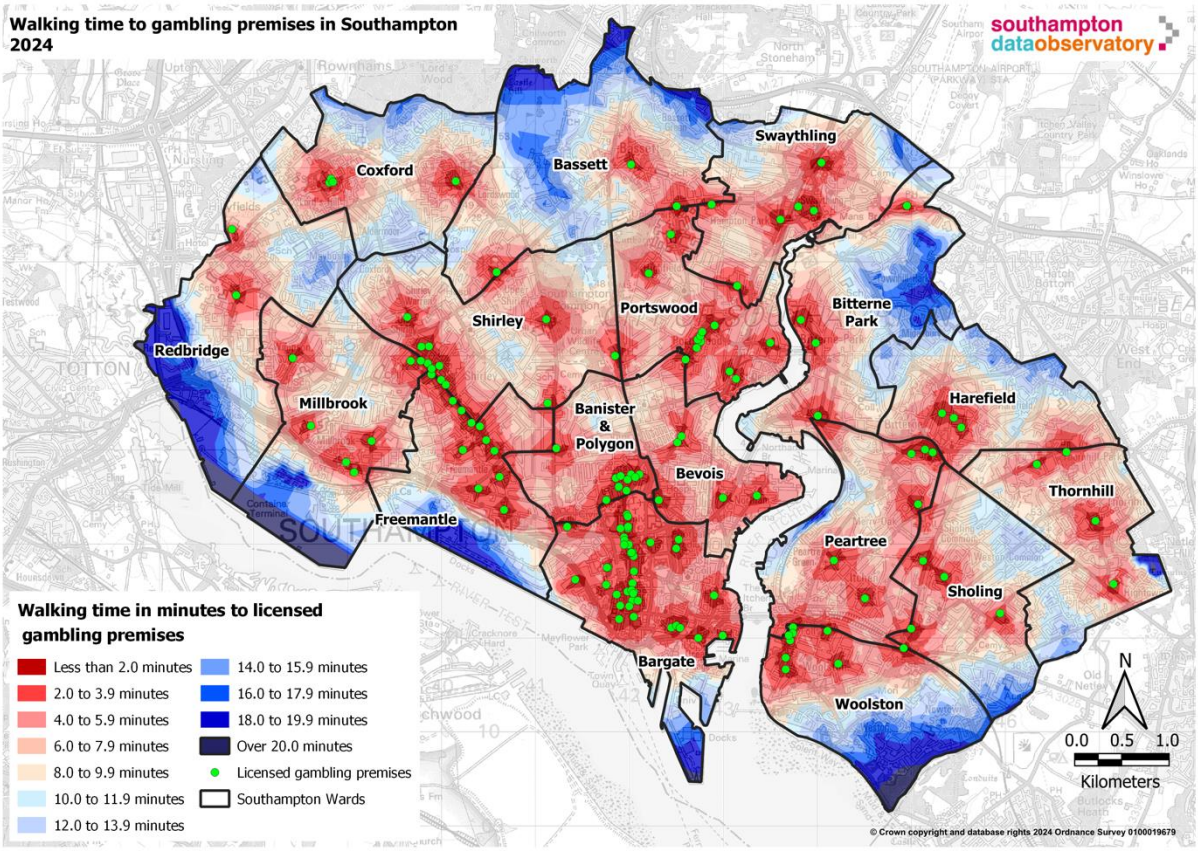

Figure 6: Walking times to licensed gambling premises in Southampton, 2024.

3.6 Southampton GamCare Data*

3.6.1 Calls to the GamCare Helpline 2022/23

During the period April 2022 to March 2023, there were 37 individual callers to the GamCare helpline from Southampton, comprising 0.5% of all callers to GamCare and only 0.7% to 5.6% of people experiencing PGSI-classified 'problem' gambling in Southampton (0.1% to 0.6% of people experiencing harmful gambling (i.e. PGSI-classified 'at-risk' or 'problem' gamblers) in Southampton); see section 3.2.3 for Southampton estimates). The majority of callers from Southampton were male (78%), and most callers were from the 26-35 age group (35.1%). The most commonly cited gambling impacts were anxiety/stress (82.8%) followed by financial difficulties (75.9%) and family/relationship difficulties (58.6%). These findings are consistent with those from 2020/21 and 2021/22.

3.6.2 Treatment clients 2022/23

During the period April 2022 to March 2023, 21 clients from Southampton entered treatment, comprising 0.3% of all clients entering treatment through GamCare and only 0.4% to 3.2% of people experiencing PGSI-classified 'problem' gambling in Southampton (0.07% to 0.34 % of people experiencing harmful gambling (i.e. PGSI-classified 'at-risk' or 'problem' gamblers) in Southampton); see section 3.2.3 for Southampton estimates). The majority of clients entering treatment from Southampton were male (85.7%) and the single largest age-group in receipt of treatment were 26-35 year olds (42.9%). Similar findings were observed in 2020/21 and 2021/22. However, the most common treatment type amongst Southampton clients in 2022/23 changed to *Tier 2 EBI* i.e. extended brief intervention sessions with clinicians (76.2%), having previously been *Tier 3 Structured* treatment (e.g. therapy) in 2020/21 (83.3%) and 2021/22 (84%).

(*Please note that data for the 2023/24 period was requested by Southampton City Council and initially supplied by GamCare, but then withdrawn shortly after due to internal discussions around data sharing. GamCare have not responded to requests for alternative data.)

3.7 Client Data Provided by the Southern Gambling Service

3.7.1 Background

The Southern Gambling Service (SGS), now part of the Hampshire and Isle of Wight Healthcare NHS Foundation Trust, was established in September 2022 and is funded by NHSE. SGS offers assessment and evidence-based treatment (via three main pathways) for people aged 17 and over experiencing gambling disorder or gambling-related harms, and considers self-referrals from (or referrals from healthcare professionals for) those registered with a GP or living in the following areas in South-East England: Hampshire and the Isle of Wight (HIOW), Oxfordshire, Buckinghamshire, West Berkshire, Frimley, Surrey, Sussex, and Kent and Medway.

3.7.2 Service Data

Southampton-level data is not currently available. However, the following statistics have been derived from HIOW Integrated Care Board (ICB) area data covering the period September 2022 (i.e. from inception) to June 2024:

- There were 208 referrals: 172 (82.7%) from men and 36 (17.3%) from women, the majority of whom (156; 75%) were of White British ethnicity. This corresponds to less than 0.7% to 3.4% of people experiencing harmful gambling in Southampton (see section 3.2.3 for Southampton estimates).
- 195 (93.8%) of referrals were from those aged 22-60 years.
- 38 out of 206 (18.4%) referrals were from people with either a history of homelessness or currently experiencing homelessness.
- Between January 2023 and December 2023, 76.3% of referrals were self-referrals whilst 23.7% were referrals made by healthcare professionals.
- Longitudinal treatment outcomes indicate: 58% improvement from first treatment in gambling severity; 54% improvement to quality of life; and 68% depression score improvement. Furthermore, a 25% reduction in health-service-utilisation costs over the six month period following first treatment.

3.7.3 Limitations

The above data was largely collected when SGS was starting up, gradually scaling-up provision and hiring staff, plus working to address any barriers to care. As such, statistics may change markedly from the above in future. At the time of writing, SGS is now fully deployed and

receives approximately 400 referrals per year across the six ICB territories i.e. in excess of the commissioned referral numbers for the service.

According to Sam Chamberlain, Psychiatry Professor and SGS Service Director, it is likely that fewer than 5-10% of those experiencing harmful gambling or gambling disorder seek evidence-based assessment and treatment in the UK at present. This is due to a variety of issues including: lack of awareness/education about the condition and NHS services; some individuals preferring not to seek NHS support; the nature of addiction itself (where the potential reward from gambling supersedes readiness for change – a necessary precursor to treatment-seeking); and stigma, etc. Therefore, those presenting for treatment at SGS (upon whom the above data is based) do not reflect the totality of harm or need, or the total local or regional populations experiencing harmful gambling.[68]

3.8 Summary of Local Need

- There is limited local data on the numbers affected by gambling-related harms, but even conservative estimates suggest significant numbers of adults (16+) experiencing harmful gambling (6,160-31,900), with a further estimated 15,053 adults (18+) affected by someone else's gambling.
- The total excess cost associated with gambling-related harm in Southampton is estimated to be in the range £4.7m to £7.9m.
- Coxford, Woolston, Bevois, Millbrook and Swaythling contain the highest numbers of neighbourhoods at greatest risk of harmful gambling in the city.
- There are high densities of gambling premises in Southampton, either adjacent to, or located in, areas of high deprivation and/or areas at elevated risk of harm.
- 82.5% of households living within a 10-minute walk of their nearest gambling premises.
- Only a small proportion of those affected by harmful gambling/gambling-related harms in Southampton are accessing support and treatment:
    - Low numbers are accessing early intervention/support through industry-funded services, with even fewer moving into structured specialist treatment.

- Specialist service data also shows small numbers entering treatment compared to population estimates, suggesting significant unmet need.

4. Services for Preventing and Treating Gambling-related Harms

4.1 National Gambling Treatment and Support Services

This section summarises the main national treatment and support services currently accessible to people living in Southampton.

[Note that a number of national harm-minimisation approaches exist (some affiliated with the gambling industry), such as self-exclusion and website-blocking schemes; however, a review of these schemes and tools is outside the scope of this HNA.]

4.1.1 GambleAware's National Gambling Support Network (NGSN)

The NGSN is a network of prevention and treatment organisations working together through referral pathways to deliver free and confidential tailored care and support for anyone experiencing problems with their gambling or affected by another's gambling. Following the results of GambleAware's 2021 Annual Treatment and Support Survey, which revealed that only a small proportion of those in need of treatment are accessing support services, the network is currently being redesigned to better meet the needs of those at-risk of or experiencing gambling-related harms in Great Britain.

The following partner organisations within the NGNS currently offer services covering the Southampton area:

a. The National Gambling Helpline (operated by GamCare)
    - 24/7 support by phone or live chat
    - Offers brief interventions and can refer to other providers in the NGSN network.

b. GamCare

    Offers:
    - One-to-one therapeutic support and treatment for those experiencing harmful gambling or affected by someone else's gambling (available in-person, online or by telephone). Delivered in five regions including South-East England (covering Hampshire).
    - Group-based, face-to-face or online recovery courses (6-8 weeks)

- Online support service: self-guided tools, peer support or access to an online practitioner.
- BigDeal (run by GamCare) is a support service for young people struggling with their own or someone else's gambling. The service offers confidential advice, information and guidance on gambling for those aged 11 to 18 and users can access support through live chat, the helpline (both available 24/7), or a self-referral form. BigDeal also provides resources for parents, carers and professionals working with young people.
- Way Forward: a support group, delivered online, for women affected by someone else's harmful gambling.

c. <u>NHS Primary Care Gambling Service (PCGS)</u>
   - The PCGS is a free and confidential national service for anyone aged 18 and over experiencing gambling-related harms.
   - The PCGS works in partnership with other organisations to provide integrated support services, including support for social, mental and physical health.
   - Offer support and therapy (short-term or long-term) in-person, by telephone or online. Online weekly group therapy also available (in single-sex or mixed-sex groups).
   - Can be accessed through self- or agency- referral.

d. <u>Betknowmore UK</u>
   - Established by PLE, Betknowmore's mission is to address gambling-related harm in the UK by raising awareness, providing education, and delivering support services for people experiencing gambling-related harm.
   - Support services embrace knowledge and insight of experts-by-experience, in combination with evidence-based methods.
   - Currently offering three services (peer support, community outreach and women's services), commissioned by GambleAware for national roll-out over next three years. The following are currently available to those in the South-East:

- Peer Aid: individual and group support and health promotion activities with peer support. Accessed via referral form or through National Gambling Helpline.
- New Beginnings: structured women-only group support. No courses available at present but can register interest.

e. Gordon Moody

- A charity offering free, structured residential treatment, online support, counselling, and advice for men and women struggling to overcome their harmful gambling.
    - Residential Treatment: 6-week intensive treatment available at male treatment centres in the South of England, and as of 2021, a centre for women gamblers aged 18 and over.
    - Retreat and Counselling Programme: two short-term residential stays and 12 weekly therapy sessions, delivered by phone or online.
    - Gambling Therapy: a text-based live-support service available in any language for anyone affected by gambling. Peer-support groups are accessible via the website. Gambling Therapy also run two weekly online support meetings for family and friends.

4.1.2 Other (Non-NGSN)

Other organisations offering help with gambling harms but not part of the NGSN include:

AdFam

A charity in England supporting people impacted by another's drug use, drinking or gambling. AdFam offer six sessions of remote (i.e. online or by phone), one-on-one support for family or friends of anyone experiencing harmful gambling.

Chapter One

Industry-independent information on gambling harms and where to access support.

GamFam

A charity that offers support and advice to anyone affected by gambling harms through structured peer support (GRA5P five-stage recovery and support, online programme) and

signposting to relevant agencies and partners. Self- and professional- referral forms available for access to peer support groups.

Gambling Lived Experience and Recovery Network (GamLEARN)

Free peer support (online courses and meet-ups) for those in active recovery and affected others. Criminal justice system support accessible via online questionnaire or by email.

Gambling with Lives

A charity that supports people bereaved by gambling-related suicide, campaigns for change, and raises awareness of harmful gambling.

National Gambling Clinic (NGC)

A free and confidential NHS service for people experiencing gambling harm. Currently accepting referrals from those experiencing harm aged 13 to 18 years (based anywhere in England), and those aged 18 or over living in London or in the South-East. NGC offers tailored individual treatment programmes (online and in-person) including relapse prevention. Support and psychoeducation is also available to family and friends who may have been impacted by another's gambling.

4.2 Local Gambling Treatment and Support Services

Gamblers Anonymous (GA)

GA is described as a fellowship of individuals who share experiences and hope with one another to help overcome their collective problem. GA advocates for the 12-step recovery programme (same as that used by Alcoholics Anonymous) and runs local support groups (both in-person and online) for people experiencing a gambling problem. An in-person meeting takes place in Southampton at St Joseph's church every Sunday from 7-9pm. GA also provides support through its website where users can access literature and a forum.

GamAnon

Similar to GA, GamAnon is a fellowship providing comfort and assistance to the family and close friends of someone experiencing harmful gambling, who have likely been affected by the gambling. 'Mixed' GA/GamAnon meetings are held on the last Sunday of each month at St Joseph's church in Southampton from 7-9pm.

Parent Support Link

Parent Support Link provides information and support (through a 24-hour helpline, individual listening sessions and support groups) to people affected by someone else's substance use problem or gambling.

Southern Gambling Service (SGS)

SGS (now part of the Hampshire and Isle of Wight Healthcare NHS Foundation Trust) was established in September 2022. The service was originally commissioned by NHS England, with commissioning for Southampton residents since passed to the local ICB. SGS offers assessment and evidence-based treatment (via three main pathways) for people aged 17 and over experiencing gambling disorder or gambling-related harms, and considers self-referrals or referrals from healthcare professionals for those registered with a GP or living in the following areas in the South-East of England: Hampshire and the Isle of Wight (HIOW), Oxfordshire, Buckinghamshire, West Berkshire, Frimley, Surrey, Sussex, and Kent and Medway

4.3 Other Local Services Working with Vulnerable Populations

The following local services, although not specifically set-up to address harmful gambling, may come into contact with those experiencing gambling-related harms in Southampton:

Beyond Reflections: a charity whose mission is to 'create a safe community for trans+ people and their allies, providing support designed with and for the community'.

Change Grow Live: a free, confidential, open access, drug and alcohol support service for adults (aged 25 and over), including a 'Free Brief Intervention Telephone Advice Line' to help people concerned about their alcohol use regain control.

Citizens Advice Bureau: a national charity that provides free advice and information to help people resolve financial, legal and other issues. Offers online self-help advice and signposting to third party organisations for people experiencing harmful gambling or concerned about/affected by someone else's gambling.

DASH - No Limits: a free, confidential, open access, drug and alcohol support service for young people (aged 24 and under).

Samaritans (Southampton and District): a UK charity offering confidential listening services and emotional support for anyone contemplating suicide or in crisis. Accessible by phone only.

Solent Mind: is a charity offering support with mental health difficulties in Hampshire. In addition to peer and professional support (in person and online), and young people's services (including a self-harm hub), there is in-the-moment out-of-hours help for over-18s living in Southampton city at The Lighthouse (located in Bitterne and Shirley).

Southampton Mental Health Network (SMHN): supported by Southampton City Council, SMHN seeks to make Southampton a 'mental health friendly city'. Specific objectives include increasing resilience and wellbeing, promoting understanding of mental health in the city and supporting mental-ill health through signposting to other mental-health organisations.

Society of St James: a Southampton-based homelessness charity

Two Saints: services include a day centre, outreach sessions, community support, and a range of accommodation options for housing and supporting vulnerable people in Southampton, including rough sleepers and young parents.

Yellow Door Southampton: local charity offering prevention and support services for those at risk from (or currently affected by) sexual violence or abuse, domestic violence, or another form of interpersonal harm.

4.4 Summary of Services for Preventing and Treating Gambling-related Harms

There are numerous treatment and support services available to people living in Southampton, either directly or indirectly linked to harmful gambling/gambling-related harms. Services are a mixture of local and national, provided by the NHS and other providers (including the voluntary sector), funded independently or directly/indirectly by the gambling industry. An ICB-commissioned regional specialist service is also in place (the Southern Gambling Service).

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5. Evidence of Effective Interventions to Prevent, Minimise and Treat Harmful Gambling/Gambling-related Harms

5.1 Review of Evidence around Preventing or Minimising Gambling-related Harms

The GHNA for Wales includes a comprehensive review of evidence around the treatment and prevention of gambling harms, covering the period 1 January 2012 to 1 February 2022.[8] To update the review of gambling-harms prevention evidence for this GHNA, two PubMed searches were conducted for the period 2 February 2022 to 22 October 2024, the first using the search term 'gambling harm intervention' (180 results), the second using the search terms 'gambling harm AND prevention' (113 results). [Note that a full systematic review was outside the scope of this GHNA; hence, search terms were chosen to maximise relevance to gambling-harms prevention.] All study designs, from World Bank High Income Countries were included (the latter criterion to improve generalisability to the Southampton population). However, the following were excluded: non-English language articles; articles not examining the effectiveness of interventions or strategies relevant to the prevention or reduction of gambling harms; and articles relating to the clinical treatment of harmful gambling as this is covered in section 5.2. After removal of duplicates and title and abstract screening for relevance, 60 full-text articles were assessed for eligibility. Those not available in full-text, or deemed not to be meeting the above selection criteria upon closer examination, were excluded, yielding 35 articles for inclusion in the final evidence synthesis. All identified evidence, covering the period 1 January 2012 to 22 October 2024, has undergone narrative synthesis with main findings extracted, taking account of methodological quality and limitations of included studies. A summary of the best-available evidence of interventions or strategies for preventing or minimising gambling-related harms, and their effectiveness, is presented in Table 6, grouped by level of prevention to assist decision-makers (highlighted blue, yellow and orange for primary, secondary and tertiary prevention measures, respectively).

Theme	Lead author & year (research category)	Intervention type	Evidence of effectiveness	Key features and recommendations
EDUCATION	Keen 2017 (systematic review); Parham 2019; Donati 2018; Williams 2012; Schalkwyk 2022; Ren 2019; Léon-Jariego 2020; Wybron 2018; Kourgiantakis 2016	School-based gambling education programmes	All included studies (19) reported positive intervention effects on cognitive outcomes (e.g. increased knowledge of gambling, fewer misconceptions, and a more negative attitude towards gambling). However, changes in cognitive outcomes may not translate into long-term behavioural change. Five studies reported significant changes in gambling-behaviour, but methodological inadequacies were	CONTENT: programmes were generally focused on the cognitive component of gambling and raising awareness, including: signs and symptoms of harmful gambling; gambling-related harms; treatment and support options; cognitive distortions and illusions of control; gambling misconceptions and fallacies (e.g. around risk); and brief explanations of statistical terms, such as odds and negative expectation. More comprehensive programmes had better behavioural and cognitive outcomes.[69] Keen et al recommend inclusion of more complex statistical concepts in education programmes, e.g. expected value and randomness.[69] However, the findings in Parham et al highlight the need for age-appropriate statistical content to ensure pupil engagement.[70] Donati et al attest to the effectiveness of preventive interventions addressing mindware problems (considered to be predictors of gambling-related cognitive distortions).[71] Williams et al acknowledge that cognitive improvements are valuable intermediate steps in gambling education programmes, but ultimately advocate for behaviour change as the primary outcome measure.[72] Schalkwyk et al warn against use of gambling-industry-funded educational resources (including those from industry-affiliated charities) as the content largely aligns with the corporate agenda thus posing a conflict-of-interest for gambling-harms prevention. The authors found that, although offering some educational content, industry-funded discourse focused on normalisation of

			detected including brief post-intervention follow-up periods.	gambling and personal responsibility, thus shifting blame for any harms to children, young people and their families, whilst deflecting from the harmful nature of gambling services and products.[73] DELIVERY MODE: Classroom activities, lectures and discussions; use of multi-media tools (e.g. online modules and videos). ○ Delivery of initiatives by gambling psychologists (rather than school-teachers) significantly more effective at reducing students' cognitive errors.[74] ○ If not feasible, online and video-based (i.e. multimedia) programmes containing relatable examples are a cost-effective and convenient alternative to teacher-led education, whilst also being engaging and relevant for youth audiences.[69] E.g. cognitive-outcome improvements were observed following use of the 'Lucky video' and the 'Amazing Chateau' computer programme.[75-78] DOSAGE: programmes with additional sessions had better behavioural and cognitive outcomes.[69] ◦ Keen et al recommend that programmes are delivered over multiple sessions (i.e. at larger doses), especially if covering complex content.[69] Indeed, Ren et al observed improved cognitive outcomes (regarding gambling beliefs and attitudes) after delivering an intervention for the second time (median delivery gap of 368 days).[79] ◦ Keen et al also recommend universal implementation from age 10 onwards.[69] Léon-Jariego et al conversely suggest targeting gamblers and non-gamblers separately when delivering

				gambling-prevention initiatives.[80] Indeed, Wybron et al reported difficulty producing materials that resonated with the non-gambling cohort of secondary school pupils in the UK gambling education project 'Reducing the Odds'.[81] As cited in the GHNA for Wales, Kourgiantakis et al did not identify any gambling prevention initiatives targeting young people at increased risk of harmful gambling e.g. due to parents who gamble.[8,82] Family prevention initiatives have been shown to prevent harm in the context of substance use.[41,72,82,83]
EDUCATION	Grande-Gosende 2019 (systematic review) as cited by Clune 2024; Marchica and Derevensky 2016	Harmful gambling prevention programmes targeting college and university students.	Grande-Gosende et al included nine studies, all of which reported positive short-term effects in respect of increasing knowledge, lessening illusions of control and reducing harmful gambling behaviours amongst young adults. Use of the Personalized Normative Feedback (PNF) approach was associated with	Most studies used the Personalized Normative Feedback (PNF) approach, addressing knowledge and misconceptions about gambling as a secondary programme component.[84,85] Note that PNF is also known as Personalized Feedback Intervention (PFI). The PNF format includes a single, brief intervention session (10 – 60 minutes average duration) addressing the participant's gambling habits and perceived vs. actual gambling behaviour of the peer group. The strategy seeks to alter normative beliefs, thereby eliciting individual behaviour change.[84,85] PNF is described as a low-cost easily disseminated and effective intervention.[84,85] <u>LIMITATIONS</u> Clinicians urge caution as PNF is less effective than in-person treatment for those experiencing gambling problems.[85] Also, PNF may give rise to a so-called 'boomerang' effect whereby people who gamble infrequently increase their gambling activity to better align with the group norm.[86]

			longer-term reduction in harmful gambling behaviours.	
EDUCATION	Velasco 2021 (umbrella review)	Family prevention strategies	Paucity of evidence; further research required.	Although more research is needed in the context of harmful gambling behaviour, Velasco et al note that family-strengthening interventions, or those promoting effective parenting, are highly effective in reducing problematic behaviours in young people (largely derived from substance use literature).[41]
EDUCATION	MacArthur 2018 (Cochrane systematic review)	Youth interventions for preventing multiple risk behaviours	70 included RCTs; however, none were identified which aimed to prevent gambling alongside other behaviours.	Available evidence suggests that universal school-based interventions targeting multiple-risk behaviours may effectively prevent illicit drug use, tobacco use, alcohol use and antisocial behaviour. However, further research is needed to determine whether multi-risk interventions could prevent harmful gambling in young people.[83]
REGULATORY AND POLICY	Velasco 2021 (umbrella review); Gainsbury 2014; Williams 2012; Burton 2024; Young 2008	Supply restriction	A number of regulatory changes have been examined (concerning restriction of supply of gambling) which could be effective at reducing gambling-related harms, namely: restricting venues (numbers, licence criteria,	• <u>Restricting numbers of gambling venues and licence criteria</u>: a reduction in supply of gambling premises resulted in lower participation, fewer regular gamblers, less treatment demand and fewer people experiencing harmful gambling.[41] • <u>Pricing and taxation strategies</u> cited as effective schemes for reducing the supply of gambling (Gainsbury et al 2014 and Williams et al 2012).[72,87] Indeed, Burton et al report that price increases are associated with lower demand for tobacco, alcohol, sugar and unhealthy food. However, no studies were identified relating to gambling. [88] Velasco et al warn that price increases may increase illegal market activity, if not under control.[41]

			opening hours, and locations); price and taxation strategies; and enforcement of legal age limits.	• Restricting gambling premises opening hours: associated with reduction in harmful gambling if implemented consistently.[41] • Legal age restrictions: restricting youth access to gambling is an effective strategy for reducing harmful gambling amongst young people. However, legal enforcement of age limit requires increased inspection of premises, enforcement of penalties for non-compliance, and increased parental awareness/facilitation.[41] • Reducing geographical accessibility of gambling premises: Young et al 2008 (cited by Velasco et al) highlight that a relationship exists between gambling-harms, proximity to gambling venues and social disadvantage.[89] Indeed there is evidence of elevated gambling-related harms in areas close to gambling premises. Therefore, limiting accessibility by placing gambling venues away from vulnerable groups (identified in the reviewed studies as young people, those with comorbid addictions, and people from lower socioeconomic backgrounds) is potentially effective for reducing harms. The efficacy of such a strategy depends on local context i.e. the demographic and socioeconomic profile, and the distribution of other risk factors.[41] According to Velasco et al, supply restrictions should also extend to online gambling.[41]
REGULATORY AND POLICY	Erwin 2022; GREO	Sinking lid policies	Sinking lid policies adopted by local territorial authorities (i.e. councils) in New	'Sinking lid' policies are designed to gradually reduce the number of electronic gaming machines (EGMs) and gambling venues by prohibiting the transfer of EGM licences (i.e. if a gambling premises closes or relocates, its EGM licences are forfeited).[90]

			Zealand were found to reduce expenditure on gambling by 13% relative to regions adopting only national-level restrictions.	In a separate publication by GREO, it is reported that Erwin et al also compared the effectiveness of three policy types (an absolute cap on numbers of EGMs; a per-capita cap on venues, EGMs or both per 100,000 residents; or adoption of a sinking-lid policy). Whilst all three policies reduced venues and EGMs relative to councils with no local policies, the largest impact occurred with the per-capita cap, whilst the sinking lid policy produced the smallest impact. However, the sinking lid policy was the only intervention to produce both delayed and immediate impacts on EGM spend.[91]
REGULATORY AND POLICY	McGrane 2023; García-Pérez 2024; Pitt 2024	Advertising restrictions	Based on evidence of a causal, dose-response relationship between advertising exposure and gambling participation, the authors conclude that restrictions on advertising (especially those targeting vulnerable groups) could reduce gambling-related harms and associated health inequalities.	A systematic umbrella review by McGrane et al, which investigated the impact of advertising policies on gambling-related harms, consistently found evidence of a causal relationship between exposure to gambling advertising and increased individual- and population- level gambling activity. Furthermore, a dose-response relationship was detected with increased exposure to advertising leading to greater participation and therefore elevated risk of harm. There was evidence of a notable impact of gambling advertising upon certain groups, namely 'at-risk' gamblers and children/young people.[92] Similarly, García-Pérez et al found that investment in gambling promotions, sponsorship and advertising in Spain significantly increased gambling deposits, numbers of accounts held by gamblers and total money wagered.[93] Pitt et al note that social media influencers (SMIs) and celebrities are increasingly being used in gambling marketing and promotions aimed at young people. Thematic analysis of a qualitative focus group identified that SMI and celebrity gambling marketing increased recall of adverts, created extra appeal, lowered risk

				perceptions and increased social acceptability of gambling. The authors recommend that prevention strategies regarding the exposure of young people to gambling advertising not only consider stronger regulations regarding product promotion, but also address the novel methods increasingly employed by the gambling industry to appeal to the youth market.[94]
REGULATORY AND POLICY	Liu 2022	Outdoor marketing bans	The largest reduction in exposure to harmful product marketing arose through enforcement of a 400m marketing ban around bus stops.	Liu et al examined the effectiveness of harmful product marketing bans in public outdoor spaces. They found that children from high deprivation households had higher average exposure rates to harmful gambling marketing than those from low deprivation households, and that harmful product marketing often clustered in certain areas e.g. city centres. The authors recommend targeted bans e.g. around bus stops or gambling outlets to reduce exposure to gambling marketing.[95]
RAISING AWARENESS	Velasco 2021 (umbrella review); Williams 2012	Mass media campaigns	Mixed evidence regarding effectiveness of public information campaigns at reducing harmful gambling behaviours.	Williams et al reported no evidence of a reduction in gambling behaviour attributable to mass public information campaigns. They acknowledge that campaigns are a cost-effective means of delivering prevention messages to a wide audience (especially youths), but recall is usually poor e.g. the authors cite a North American campaign, where only 8% of those surveyed could remember any of the information.[72] However, there was evidence that the prevalence of gambling in young people may be influenced by campaigns targeting parents.[41] Mass media campaigns promoting treatment services were highlighted as potentially effective e.g. an Australian campaign resulted in a 70% increase in helpline callers and a 118% increase in treatment requests.[41]

RAISING AWARENESS	Kolandai-Matchett 2018	Community interventions		As reported by GHNA Wales, Kolandai-Matchett et al evaluated two public health community-action programmes (implemented nationally) for gambling-harm prevention/minimisation in New Zealand.[8,96] The programme involved media debate through local radio, community education and community-led campaigns, with a particular focus on lower socioeconomic groups. The programmes were found to enhance harmful gambling awareness and build trustful relationships. The authors concluded that these programmes could be used as sustainable harm-reduction models but emphasised that community involvement is key to ensuring in-depth knowledge of affected groups and therefore tailored programmes.[96] Similarly, key findings from a recent independent evaluation of the Victorian Responsible Gambling Foundation's Prevention Partnerships Programme (one of the VRGF's public health approaches to preventing or reducing gambling harm) include a reduction in stigmatising attitudes amongst community members and improved awareness of gambling harms and how to seek support. VRGF states that PPP is based on evidence of 'what works', comprised of: widespread awareness-raising via radio, social media and newsletter; community events; training sessions; and one-off information sessions.[97]
RAISING AWARENESS	De Jans 2023; Houghton 2024	Safer gambling health promotion messages via social media	1. Message size does not affect message efficacy. 2. Impact of message on gambling	De Jans et al investigated whether safer-gambling health-promotion messages delivered via gambling advertising affected consumer gambling-related intentions and beliefs.[98] They found that, whilst harm-prevention messages promoted the responsible gambling concept, some resulted in unintended consequences. For example, "Gamble in moderation" increased normative perceptions of gambling compared to no message, thus

			behaviour depends on content.	enhancing gambling intentions amongst 'at-risk' gamblers. However, the message "What does gambling cost you? Stop in time" made at-risk gamblers think most about gambling harms.[98] Houghton et al examined the impact of safer gambling messaging (delivered via Twitter) on gambling behaviour and readiness to change, including the impact of message content on effectiveness (self-appraisal vs emotional self-efficacy vs informational (control)). Behavioural change was detected across all groups including the control condition, suggesting that impact was independent of message type. However, overall, only 16% of participants chose to alter their behaviour after receiving safer gambling messaging, citing personal reflection triggered by message content. Those who did not change behaviour felt that either they did not need to change, or that the message content was not relevant for them.[99]
RAISING AWARENESS	Newall 2024; Ortiz 2021	Safer gambling health promotion messages via television adverts	Newall et al reported an increase in gambling-urge-scale (GUS) scores, relative to a control advert, after participants viewed an operator's safer gambling advert, or a financial inducement advert.[100]	However, the authors observed a significant decrease in GUS scores after participants at higher risk-of-harm viewed a GambleAware 'bet regret' or 'stigma reduction' advert.[100] Newall et al recommend independent evaluation prior to public release of safer-gambling interventions, to reinforce internal validity and ensure effectiveness.[100] Furthermore, Ortiz et al (as cited by Newall et al) noted that the involvement of 'experts-by-experience' (i.e. PLE) in advert design is an important factor in effectiveness.[100,101]

EARLY IDENTIFICATION	Rafi 2022	Workplace prevention initiatives	Statistically-significant increase in inclination to act on harmful gambling concerns amongst managers who attended the skills training.	Rafi et al conducted a cluster-RCT to examine the effects of a workplace-based, harmful-gambling prevention programme. Ten workplaces in Sweden were randomised to control or intervention conditions. The intervention comprised six hours of skills training for managers around harmful gambling, gaming and drug-use and a further six-eight hours of assistance with gambling-policy development. Rafi et al report a statistically-significant increase in managers' inclination to act if concerned about an employee's gambling for those who attended the skills training, but this finding did not hold for the whole intervention group. GHNA Wales report an earlier qualitative study by Rafi et al (conducted around the time of cluster-RCT protocol development) to ascertain participants' intervention experiences.[102]
EARLY IDENTIFICATION	Blank 2021; Reid 2024; Yarbakhsh 2023; Forward 2022;Murray Boyle 2022; Browne 2022;	Screening	Some evidence of effectiveness of screening tools for detecting gambling-harms-risk in substance use - mental health- and general practice-settings.	Blank et al found that screening interventions are acceptable and feasible in a range of healthcare and community settings for those at risk of gambling harm. However, they acknowledge that further work is required to assess (cost) effectiveness due a paucity of evidence.[103] Implementation barriers were highlighted such as patient concerns about confidentiality, as well as staff training and knowledge of where to signpost individuals for further support or treatment.[103] Similar findings around onwards referrals and signposting issues are discussed by Reid et al following their pilot study to evaluate an embedded harmful-gambling screening model in general practice and community care settings. Reid et al note however that screening data can be useful for establishing local harmful gambling prevalence.[104]

				Yarbakhsh et al identified a range of validated gambling-harms screening tools for use by clinicians in substance-use treatment environments.[105] However, Forward et al found no evidence of a suitable brief or single-item screening tool for use in adult care.[106] The Short Gambling Harm Screen (SGHS) is described by Murray Boyle et al as a valid short screening tool for measuring the presence and degree of gambling-related harm.[107] Browne et al conclude that the SGHS and the PGSI estimate similar levels of gambling harm at a population level.[108]
EARLY IDENTIFICATION	Quilty 2019	Brief intervention	Compared to an assessment-only control, brief interventions were associated with a significant reduction in short-term harmful gambling behaviour.	Quilty et al conduced a meta-analysis of randomised controlled trials to assess the efficacy of brief (i.e. three sessions or fewer), in-person psychosocial interventions for reducing harmful gambling.[109] Brief interventions comprised motivational interviewing, brief advice, provision of support materials and personalised feedback.[109] Results support brief intervention efficacy over short-term follow-up periods; however long-term gambling behaviour changes were not statistically significant.[109]
HARM MINIMISATION TOOLS	Riley 2024; Lischer 2023; Hopfgartner 2023; Clune 2024; Blank 2021;	Active and passive engagement tools for gamblers	Harm minimisation tools are potentially effective, in particular: self-exclusion periods of at least 6 months; universal,	A recent review by Riley et al examined the evidence for effectiveness of gambling-harm minimisation tools (also known as responsible-gambling or consumer-protection tools).[110] Results are summarised as follows: <u>Self-exclusion</u>: Mixed evidence for VSE (i.e. voluntary self-exclusion, where gamblers exclude themselves from online or land-based gambling venues), with positive outcomes reported for some

	Škařupová 2020; McMahon 2019; Armstrong 2018; Newall 2022		irreversible and compulsory limit-setting; self-appraisal or high-threat pop-up messages; forced breaks of around 60 mins and reduced speed of play.	gamblers but generally low utilisation rates. Furthermore, breaches are common and often overlooked by gambling venue personnel.[110] Lischer et al examined the impact of a multi-operator-exclusion initiative on gambling behaviour in Switzerland and found that 12% of excluded gamblers quit altogether. They asserted that self-exclusion was associated with significant decreases in the duration, frequency and severity of harmful gambling but that the exclusion duration should be at least 6 months.[111] Similarly, Hopfgartner et al found that longer self-exclusion periods (over 90 days) resulted in gamblers not returning to the online platform.[112] <u>Precommitment (i.e. limit-setting):</u> Clune et al report that limiting money spent per session or per bet is more effective than limiting time.[85] Blank et al, however, noted variable compliance with imposed limits and that pre-commitment systems often fail to prevent concurrent gambling elsewhere.[103] Škařupová et al conclude that precommitment strategies are moderately effective but only when irreversible, compulsory and applicable to all available gambling opportunities in a country.[113] <u>Pop-up messages:</u> Riley et al report mixed evidence around the effectiveness of pop-up messages as a harm-minimisation strategy, noting that message perception and engagement may depend on whether the gambler is losing or winning.[110] McMahon et al report that eight out of nine studies (examining the effectiveness of gaming-machine messaging) detected a positive impact on gambling behaviour, largely attributable to self-appraisal rather than informational messages.[114] However, a study by Armstrong et al (as cited by Riley et al) reported an increase in gambling after seeing a self-evaluative or negative messages.[115] Studies reviewed

				by Blank et al found poor evidence regarding the effectiveness of static signs in venues, but noted the harm-reduction potential of high-threat or warning messages endorsed by medical organisations or government agencies.[103] Forced breaks: Inconclusive evidence; however, longer breaks of around 60 minutes may be more effective than shorter 1 minute breaks.[110] Speed of play: a study by Newall et al reported a reduction in gambling expenditure when speed of play was limited in an online roulette game.[116]
GAMBLING VENUE HARM REDUCTION STRATEGIES	Velasco 2021; Škařupová 2020	Early intervention by venue staff	Insufficient evidence of effectiveness of early intervention by gambling operators, i.e. little known about outcomes for venue gamblers.	In many countries, gambling venue personnel receive training on surveillance for harmful gambling behaviours and the ability to intervene/refer the gambler to support services. However, reviews by Velasco et al and Škařupová et al found that this rarely occurs in practice, as staff are underconfident in their ability to handle harmful gamblers so fail to be proactive and facilitate intervention.[41,113] Škařupová et al also noted that motivation and ability deteriorates over time, favouring additional training sessions.[113] Allcock (as cited by Škařupová et al) argues that after identification of emerging harmful gambling behaviours, venue staff should only signpost to support services rather than attempt therapeutic intervention as not adequately qualified to provide the latter.[113,117]
GAMBLING VENUE HARM REDUCTION STRATEGIES	Velasco 2021; Blank 2021; McMahon 2019; Tanner 2017; Williams 2012	Changes to the physical environment	Mixed evidence of effectiveness with respect to clock-use, EGM location and use of smaller notes. Strongest	Velasco et al and Blank et al reviewed evidence around physical environment modifications as strategies for reducing gambling harms: Ambient lighting: Velasco et al note that the absence of windows and a lack of ambient lighting may promote continued play.

			evidence of effectiveness for cash machine removal and smoking restrictions. Paucity of evidence around ambient lighting and alcohol restrictions.	However, more evidence is required to substantiate this assertion.[41] Clocks: Blank et al report mixed effects for use of counters or on-screen clocks.[103] Velasco et al note that clock-use can promote responsible gambling and found that, in many studies, on-screen clocks were associated with better time-keeping.[41] Indeed, McMahon et al report that 22% of gamblers in one study stopped playing in response to an on-screen clock.[114] However, other studies (reviewed by Velasco et al) report that only a minority of people use clocks or find them helpful, and that clock-use did not reduce overall gambling time or money spent.[41] Monetary restrictions: According to Velasco et al, a number of authors have identified cash-machine-removal as a potentially-effective harm-minimisation strategy. Indeed, an Australian study reported a 7% reduction in EGM spend when ATMs were removed in the vicinity of gambling premises.[41] However, Tanner et al (as cited by Blank et al) reported mixed evidence regarding use of smaller bank notes as an alternative money-restriction strategy.[103, 118] EGM location: Mixed findings were reported regarding placement of EGMs: some studies identified central EGM placement as an effective means of reducing gambling; conversely, others reported isolation of players, leading to excessive play.[41] Smoking restrictions: Blank et al report mixed findings on smoking-ban effectiveness (albeit from low quality studies overly reliant on self-reporting), whereas Williams et al and other authors (as cited by Velasco et al) consider smoking restrictions amongst the most effective harm-reduction strategies for gambling premises. The

				movement of gamblers to designated smoking zones provides a natural break in play and indirectly lowers expenditure.[72,103] Alcohol restrictions: although no evidence currently available to support this strategy, Williams et al postulate that alcohol restrictions may offer a break in play similar to smoking restrictions, thus potentially offering an effective harm-minimisation approach at gambling venues. Furthermore, as noted by Velasco et al, those experiencing harmful gambling tend to drink and gamble concurrently, with alcohol consumption increasing risk-taking and reducing gambling restraint.[41,72]

Table 6: Summary of evidence of interventions or strategies for preventing or minimising gambling-related harms, and their effectiveness.

5.2 Treatment of Harmful Gambling: Draft NICE Guidance[45]

In October 2023, NICE published draft guidance on identifying, assessing and managing harmful gambling (currently out for consultation). The guidance applies to adults (aged over 18) experiencing harmful gambling, and to people of any age experiencing harm due to someone else's gambling. The guidance contains recommendations for (cost) effective therapies and treatments, formulated by an independent committee who have examined currently-available evidence. The guidelines are primarily intended for use by: healthcare professionals (across tertiary, secondary, primary and community health and social care); practitioners working in the criminal justice system (CJS); providers and commissioners of services that treat harmful gambling; gamblers themselves; and their affected others. Consultation responses and final guidelines are not published or available at this time so there may be challenge or change to the key recommendation areas.

Recommendations have been grouped into seven key areas:

1. Case identification, assessment and initial support
    - Ask about gambling alongside questions on alcohol and smoking, for example when registering for a GP or during a health check.
    - Ask about gambling under the following circumstances, which suggest that an individual is at increased risk of gambling-related harm: presenting with a mental health concern or an addiction; new contact with the CJS; experiencing or at risk of homelessness; financial concerns; suspected violence (including domestic abuse) or safeguarding concerns; family history of addiction or gambling problems; taking certain medications; acquired brain injury or a neurological condition; and past/present occupation.
    - People should be encouraged to assess gambling severity using the PGSI questionnaire on the NHS website and advised on how to interpret scores.
    - Provide initial support for those identified as experiencing harmful gambling/gambling-related harm, through (for example): brief motivational interviewing; referring and/or signposting to further help; discussion around self-exclusion methods; where and how to access support on housing, financial and employment issues.

- Assess risk of suicide or self-harm and advise on further support, arranging appropriate help if required (including urgent referral to specialist mental health services if posing a considerable risk to themselves or others).
- Treatment service providers are encouraged to: use a validated tools such as the PGSI or the South Oaks Gambling Screen (SOGS); discuss the individual's gambling with them; and formulate a care and safety plan, informed by assessment results.

2. Information and support
   - Gambling support services and treatment providers should provide unbiased and accessible information to those experiencing harmful gambling and also to those affected by another's gambling, with the assurance that access to resources is anonymous.
   - The mode of information provision and support should take account of the individual's preferences e.g. online, through apps, in -person or via social media.
   - Information and support about harmful gambling and gambling-related harms should be adequately signposted and promoted in health and social care settings (including the CJS).

3. Models of care and service delivery

   Providers and commissioners of gambling treatment services should ensure that they:

   - Provide timely support and treatment, with easy access to services (including for those in military service and in the CJS) and multiple entry points including self-referral.
   - Work with local authorities (including social care) and a range of providers from the voluntary sector and across health services (e.g. services relating to mental health and substance use) to deliver coordinated/integrated support for people experiencing gambling-related harms.
   - Adequately train those in the workforce delivering treatment and support services.
   - Routinely collect demographic, gambling severity and treatment outcome data.

4. Improving access to treatment
    - Providers and commissioners of gambling treatment services should design referral and treatment pathways, including delivery method(s) and location(s), to support and encourage engagement with services, taking account of those who may find it difficult to access support e.g. people with mental health problems.
    - Providers and commissioners should also recognise that stigma (which may be particularly problematic for certain groups e.g. women, migrants, some cultural backgrounds) may prevent people from seeking help, and aim to lessen its impact where possible (e.g. gender-specific services).

5. Treatment of harmful gambling and gambling-related harms
    - Providers and commissioners of gambling treatment services should, as a general principle of treatment, provide holistic care involving multidisciplinary teams where necessary and involve a family member or close friend in communication around care (by agreement with the person undergoing treatment).
    - Peer support is recommended as an integral component of treatment and support.
    - Harmful gambling treatment options are broadly classed as psychological (i.e. motivational interviewing, and individual/group CBT) and pharmacological (naltrexone).

6. Relapse and ongoing support

    It is recommended that providers and commissioners of gambling treatment services provide follow-up, continued support and 'rapid re-access' if required, considering additional treatment if necessary and recognising that self-harm or suicide risk may be higher after relapse.

7. Interventions for families and affected others

    The guideline states that the recommendations around information and support, treatment access (including the role of stigma), and general principles of treatment also apply to those affected by someone else's harmful gambling.

[Note that the specialist service (Southern Gambling Service) is aware of the above draft recommendations. A review of service quality or commissioning oversight is outside the scope of this HNA.]

5.2.1 Summary of Draft NICE Guidance

Key recommendations include:

- Delivery of **timely and coordinated support**, involving a range of providers from the voluntary sector and across health services.
- Increasing use of a 'make every contact count' approach in a range of settings, to improve **early identification** and onwards signposting or referral
- Commissioners and service providers to ensure that:
    a. Referral pathways are **easily accessible** (i.e. simple and user-friendly) through different routes (self-referral or referral by a healthcare professional).
    b. Location and delivery method of treatment reflects the **needs and preferences of the patient/client**.
    c. Treatment arrangements take account of groups particularly affected by **stigma** (e.g. women, migrants, those engaging in crime related to gambling, those from certain cultures) e.g. through provision of women-only groups or culturally- sensitive services.
    d. Support structures are in place to provide follow-up and help **prevent relapse** (e.g. rapid re-entry to treatment).

5.3 Summary of Evidence of Effective Interventions and Southampton Availability

A summary of interventions or actions identified in the preceding sections of this chapter as potentially effective for the prevention, minimisation and/or treatment of gambling-related harms is presented in Table 7 alongside current availability in Southampton.

Key Effective Approaches	Availability in Southampton
Education programmes	Free GamCare sessions offered to some secondary schools across Southampton. However, no industry-independent programmes identified from discussions with stakeholders.
Regulation and policy	Legal minimum. Compliance not considered in this review.
Raising awareness	No local campaigns identified.
Early identification and brief intervention	Unknown from local and national offers, but no well-established referral and signposting pathways to support access to available services.
Gambling premises harm-minimisation	Likely to be in place to varying degrees across premises.
Specialist treatment services	Regional specialist service is in place (Southern Gambling Service) but receiving in excess of NHSE-commissioned referral numbers for the service, and data suggests significant unmet need compared to estimated numbers of people experiencing or affected by harmful gambling in Southampton.

Table 7: Evidence-based approaches to the prevention, minimisation and treatment of gambling-related harms, and availability in Southampton

6. Recommendations and Conclusions

6.1 Recommendations

Recommendations for Southampton have been informed by:

- Key findings from the HNA, in relation to specific populations at risk in Southampton, and action or service provision for local residents.
- The evidence base, draft NICE guidelines (both Chapter 5) and/or expert consensus (the latter being highlighted and discussed in footnotes).

To ensure completeness, the recommendations have also been considered against:

- UK priorities (identified by Akçayir et al 2022 as online gambling, children and young people, and EGMs).[119]
- The three main public health goals of primary, secondary, and tertiary-level prevention (defined in section 2.5), similar to those used in the framework presented by Wheaton et al.[120]
- The *Public Health Framework for Gambling Related Harm Reduction* (PHF) to ensure relevance in a local-authority context.[121] [The PHF was developed as a practical aid for Local Authorities to accompany the Gambling Commission's 2018 publication (by Wardle et al) on measuring gambling-related harms, with chosen interventions within the sphere of influence and limited resources of a local authority.[21,121]]

This HNA focuses on opportunities for local action. Outside of this scope, opportunities and national action to reduce gambling-related harm include regulation (including legal framework and price promotions), taxation, advertising and marketing (national and local) and funding of appropriate services at sufficient scale to meet all levels of need.

6.1.1 Reduce Gambling Supply and Exposure: Regulatory and Policy

Supply Restrictions

1. Consider inclusion of reduction of local gambling-related harm as a key objective in licensing policy (i.e. Statement of Principles), taking account of areas in Southampton at greatest risk of harm (as informed by this HNA).*
2. Consider ability to include gambling-related harm evidence in decisions regarding issuance of new operating licences in areas of the city characterised by an existing high

density of gambling premises, high deprivation, or an elevated risk of harmful gambling/gambling-related harm, or by cumulative effect as done in Westminster (2015)[27], with a view to reducing numbers of premises in these areas over time.*

3. Similarly, consider ability to amend local planning policy to address the proliferation of gambling premises in these areas, e.g. considering the vitality and viability of high streets.
4. Consider ability to amend local planning and licensing policies to include evidence on gambling related harm in decisions regarding the number of EGMs (all categories) in gambling premises** (e.g. through implementation of a per-capita cap and/or a sinking-lid policy).
5. Consider options for new operating licences to include gambling-related harm and actions related to:
    a. Placement of new gambling premises away from high density, high deprivation, high risk areas, to ensure reduced accessibility for vulnerable groups.
    b. Restrictions in opening hours and penalties for breaches to ensure consistent city-wide implementation.
    c. Maximum daily and weekly limits on EGM operating hours.**
    d. Data collection and sharing
6. Consider local regulatory options to reduce exposure to gambling in venues frequented by children and young people.*
7. Increase activity to ensure compliance with legal age restrictions (e.g. age verification by operator to ensure patron is aged 18 or over before participating in any form of gambling* and use of age-verification software), enforcing penalties when operator in breach of licence.

<u>Advertising, Marketing, Promotional and Sponsorship Restrictions</u>

8. Review use of Southampton City Council (SCC) -owned or -managed advertising and marketing space for gambling products, and consider options to limit gambling advertisement, especially in areas frequented by vulnerable groups (including children and young people).

9. Review SCC ethical sponsorship policy and consider treating gambling like alcohol- and tobacco- sponsorship, especially at events attended by children and young people.

[*Deemed as 'highly effective' and 'likely to be successfully implemented in England' by the Delphi consensus on effective policies and strategies to reduce harmful gambling, reported by Regan et al.** Deemed as 'moderately effective' and 'likely to be successfully implemented in England' by the Delphi consensus on effective policies and strategies to reduce harmful gambling, reported by Regan et al.][122]

6.1.2 Reduce the Uptake of Gambling: Education and Awareness

Wheaton et al identified 'Education and Awareness' as a main public health strategy for the prevention of gambling-related harms (alongside 'Screening, Measurement and Intervention' and 'Environment and Product') based on their review of strategies employed in other harmful product sectors.[120] 'Education and Awareness' is also promoted as a key harm-minimisation strategy by Akçayir et al, together with advertising restrictions and the development of online gambling interventions.[119] Education and awareness recommendations emerging from this HNA include:

10. Explore opportunities for a schools-based gambling-education programme for children aged 10 and over, taught over multiple sessions via multimedia and ideally facilitated by a gambling specialist. Content should be independent of industry-funded discourse and programme should ultimately aim to deliver behaviour change in addition to cognitive outcomes.[69,73]
11. Explore opportunities for a harmful-gambling prevention programme in colleges and universities using a Personalised Normative Feedback (PNF) approach (noting the 'boomerang effect' caution) to alter normative beliefs (as described by Grande-Gosende et al 2019) whilst also addressing knowledge and misconceptions about gambling (again, ensuring content independent of industry-funded discourse).[73,84]
12. Explore opportunities for e-safety awareness training for young people, teachers and parents to raise awareness of the potential for childhood exposure to gambling products via social media and online (e.g. gaming). Evidence suggests that awareness-raising campaigns targeting parents may influence gambling-prevalence amongst children and young people.[41]

6.1.3 Lessen the Impact of Gambling-related Harm

13. Explore opportunities to reinforce or extend operator harm-minimisation approaches through local licensing.

6.1.4 Identify and Support those Experiencing Gambling-related Harms

Working in Partnership

14. Recognise, raise awareness and advocate for a preventative approach to gambling-related harm and resulting costs and impacts in strategic partnerships including Safe City Partnership and through Health in All Policies.

Early Identification

15. Commissioners and service providers to increase use of a 'make every contact count' approach to gambling harms as per draft NICE guidelines[45] i.e. encourage internal and external colleagues to ask people standardised questions about gambling in a range of settings with locally agreed signposting information, for example:
    - At health appointments, including GP registrations
    - When presenting with a mental health problem
    - Upon contact with the Criminal Justice System (CJS)
    - When presenting with substance misuse/addiction
    - At-risk of- or experiencing- homelessness
    - Presenting with financial concerns or requiring debt support
    - Reporting domestic violence or seeking family support

6.1.5 Improve Research and Intelligence

16. Embed routine data collection in processes for screening and signposting.
17. Collect suicide audit data on suicides attributable to harmful gambling/gambling-related harm.
18. Collaborate with local research institutions to build local knowledge and evidence-base. Conducting independent, longitudinal research into harmful gambling prevalence and risk factors are key research priorities for the UK as identified by Bowden-Jones et al.
19. Collaborate with PLE and ensure their voice is heard in Local Authority decisions on gambling-related harm.

6.1.6 Improve Access to Treatment

20. Bring together commissioners across the footprint of the commissioned specialist service to understand specialist-service quality and activity by place and key equalities groups (in line with wider direction of travel for commissioning).
21. Commissioners to consider wider service gaps (using the estimates presented in chapter 3 of this HNA) and opportunities to improve local referral pathways between different commissioned providers (e.g. mental health services, substance use services, primary care, learning disability services, and other services in contact with those experiencing gambling harms).
22. Commissioners to understand and engage with local places in relation to the allocation and use of the gambling levy of 1% via ICBs if received.
23. Commissioners to ensure implementation of NICE guidelines, in particular ensuring that:
    a. referral pathways are easily accessible (i.e. simple and user-friendly) through different routes (self-referral or referral by a healthcare professional)
    b. the location and delivery method of treatment reflects the needs and preferences of the patient/client.
    c. treatment arrangements take account of groups particularly affected by stigma (e.g. women, migrants, those engaging in crime related to gambling, those from certain cultures) e.g. through provision of women-only groups or outreach via a community leader.
    d. support structures are in place to provide follow-up and help prevent relapse (e.g. rapid re-entry to treatment).

6.1.7 Alignment of Recommendations with Existing Frameworks

To ensure that the wider impact of gambling-related harms has been addressed, recommendations have been mapped to three domains of the socio-ecological model (individual/family/community) as suggested by Wardle et al (discussed in section 2.5).[21] The fourth domain 'societal' is addressed by national-level advocacy as described earlier in this chapter. Each recommendation has also been linked to the relevant section of the PHF

(colour-coded in Table 8 for ease of cross-reference with PHF section descriptions in Appendix C).[121]

A summary of the recommendations, linked to key findings from the GHNA and analysed by prevention level, socio-ecological domain and PHF section, is presented in Table 8.

Gambling issues emerging from HNA	**Mitigating strategy**	**Recommendations Overview**				
		Category	Details	Prevention level(s)	Socio-ecological domain	PHF Section
Number and location of existing gambling premises in Southampton: ○ 82.5% of households are currently within a 10-minute walk of their nearest gambling premises. ○ High densities of gambling premises either adjacent to, or located in, areas of high deprivation and/or areas at elevated risk of harmful gambling.	Reduce gambling supply and exposure	Regulatory and Policy	Supply restriction: licensing and planning (recommendations 1-7). E.g. Westminster	1-3	Community	2
			Advertising, marketing, promotional and sponsorship restrictions within SCC and beyond (recommendations 8 -9).	1-3	Community	3
	Reduce the uptake of gambling	Education and awareness-raising	○ Schools-based gambling harm prevention programme (recommendation 10) ○ Harmful-gambling prevention programme in colleges, universities and workplaces (recommendation 11). E.g. GAMFam in Suffolk, Norfolk, Essex	1,2	Individual	3, 8
			E-safety awareness training for young people, teachers and parents (recommendation 12). E.g. Suffolk, Norfolk, Essex.	1,2	Individual, Family	4, 8
	Lessen the impact of gambling-related harm	Harm-minimisation approaches	Explore opportunities to reinforce or extend operator harm-minimisation approaches through local licensing (recommendation 13).	3	Individual, Community	5

		Gambling venue harm-reduction strategies	See above (recommendation 13).	3	Individual, Community	5
Only a small proportion of those affected by harmful gambling/gambling-related harms in Southampton are accessing treatment and support.	Identify and support those experiencing gambling-related harms	Working in partnership	Recognise, raise awareness and advocate for a preventative approach to gambling-related harm in strategic partnerships (recommendation 14).	2,3	Community	1
		Early Identification	Commissioners and service providers to increase use of a 'make every contact count' approach (recommendation 15).	2,3	Community	4 / 6
	Improve research and intelligence	Recommendations 16-19.		2,3	Community	11
	Improve access to treatment and early intervention	Recommendations 20-23. Include signposting to treatment and support in any public gambling communications.		2,3	Individual, Family, Community	6 / 7

Table 8: Summary of recommendations, analysed by prevention level and socio-ecological domain, with reference to the Public Health Framework for Gambling-related Harm Reduction.

6.2 Conclusions

This aim of this GHNA was to determine the needs of those experiencing, or affected by, harmful gambling in Southampton and to examine what is currently being done to address those needs, identifying any gaps between local action and current best-practice (including the scientific evidence-base) to help inform local recommendations.

There is limited local data on the numbers affected by gambling-related harms, but even conservative estimates suggest significant numbers of adults experiencing harmful gambling (6,160-31,900), with a further estimated 15,053 adults affected by someone else's gambling.

There are high densities of gambling premises in Southampton, either adjacent to, or located in, areas of high deprivation and/or areas at elevated risk of harm. Indeed, 82.5% of households are currently within a 10-minute walk of their nearest gambling premises. Furthermore, only a small proportion of those affected by harmful gambling/gambling-related harms in Southampton are accessing treatment and support.

Recommendations for Southampton (informed by the above identified themes, UK priorities, the evidence base, draft NICE guidelines and expert opinion) have been framed around local opportunities. Tackling gambling-related harms requires a broad and multi-level response, involving individual, community and place-based action. Specific recommendations from this HNA for wider consideration in Southampton city include:

- Local policy reviews (with respect to licensing, planning and advertising) to reduce gambling supply/exposure and lessen the impact of gambling-related harm.
- Education and awareness-raising to reduce the uptake of gambling; and
- Improved support for those experiencing gambling-related harms through early identification and signposting (e.g. through increased use of the 'make every contact count' approach) and increased access to treatment.

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Appendix A: Harmful Gambling Risk Score Indicators

Indicator	Indicator description	Source	Definition
Social_indicator 1	Population aged 16 to 44 years	Hampshire County Council - Small Area Population Forecast 2022-base	Population forecast from Hampshire County Council from 2023 to 2030
Social_indicator 2	IMD2019 overall 2019	Ministry of Housing, Communities & Local Government	Overall scores for IMD 2019
Social_indicator 3	JSA claimants aged 16 to 64 years	Department of work and pensions	Number of people claiming Job Seekers Allowance, this measures the number of people claiming benefit principally for the reason of being unemployed, as a percentage of people aged 16 to 64: December 20223
Social_indicator 4	UC claimants aged 16 to 64 years	Department of work and pensions	Number of people claiming Universal Credit all people claiming, as a percentage of people aged 16 to 64: December 2023
Health_indicator 1	GP registered patients aged 16 and over with depression, anxiety and/or severe mental illness	PHM Tool June 2024	Number of registered patients flagged as having depression as a percentage of people aged 16 and over June 2024
Health_indicator 2	Hospital admissions for poisoning by illicit drugs, aged 16 and over	Hospital Episode Statistics (NHS Digital)	Rate of admissions for poisoning by illicit drugs (per 1,000 population aged 16 and over) LSOA 5 years pooled 2017/18 to 2021/22
Health_indicator 3	Hospital admissions for alcohol specific conditions, aged 16 and over	Hospital Episode Statistics (NHS Digital)	Rate of admissions for alcohol specific conditions (per 1,000 population anged 16 and over) 5 years pooled 2017/18 to 2021/22
Health_indicator 4	Drug-related mental health and behavioural admissions, aged 16 and over	Hospital Episode Statistics (NHS Digital)	Rate of drug related mental health and behaviour admissions (per 1,000 population aged 16 and over) 5 years pooled 2017/18 to 2021/22
Health_indicator 5	Emergency hospital admissions for suicide and self-harm, aged 16 and over	Hospital Episode Statistics (NHS Digital)	Rate of emergency hospital admissions for intentional self harm (per 100,000 population aged 16 and over) 5 years pooled 2017/18 to 2021/22

Appendix B: Gambling Licence Types

The Southampton City Council Licensing Team have kindly shared further information on the following types of gambling licences, including gaming machine categories:

1. Gaming Machines Categories

Category B1 gaming machines are full slot machines and only available in casinos

Category B2 gaming machines are also known as fixed-odds betting terminals (FOBT)

Category B3 gaming machines, are slot machines

Category B3A gambling machines are lotto style slot machines and are limited member's clubs only

Category B4 gambling machines can only be made available in casino, betting shops, tracks with pool betting, bingo halls, adult gaming centres, members' clubs, miners' welfare clubs or commercial clubs.

Category C machines are also known as fruit machines

Category D machines are low-stake fruit machine style machines, coin pushers (sometimes called penny falls) or crane grabs.

Further information can be found on the Gambling Commission's website: Gaming Machine Categories

2. Adult Gaming Centre (AGC) Licence

It allows for an unlimited number of category **C** and **D** gaming machines and up to 20% of the total number of machines, can be of category **B3** or **B4**. The premises is for those aged 18 and over only.

3. Alcohol Licensed Premises

Alcohol licensed premises can make gaming machines available for use under the Gambling Act 2005. They have the automatic right to make one or two gaming machines available for use or they can apply for a licensed premises gaming machine permit for more than two machines. To be eligible to apply, the premises:

- must benefit from a premises licence issued under the Licensing Act 2003 permitting on-sales;
- must have a bar;
- must not have a condition on the licence requiring alcohol only to be served with food.

4. Licensed premises gaming machine permits

Licensing authorities may issue licensed premises gaming machine permits for any number of category C or D machines in licensed premises (alcohol licensed premises). Where a permit authorises the making available of a specified number of gaming machines in particular premises. For further information please visit the Gambling Commission's website Licensed premises gaming machine permits

5. Family Entertainment Centre (FEC) Premises licence

Family Entertainment Centres (FEC) Premises Licence allows you to offer an unlimited number of category C and D gaming machines in a premises which is open to all ages. Category C machines must, however, be in a segregated part of the premises that is supervised to prevent children and young people accessing those machines. More details on the FEC page on the Gambling Commission website. Family Entertainment Centres are often known as arcades.

6. Family Entertainment Centre (FEC) Permit

Family Entertainment Centres (FEC) permit allows the premises to have Category D machines which offer low stakes and low prize value. These are the only type of gaming machines that people under the age of 18 are allowed to play.

7. Club Gaming Permit

A club gaming permit (CGP) is available to members' clubs or miners' welfare institutes, but not commercial clubs. It allows the club to offer:

- equal chance gaming, such as poker and bingo
- games of chance (pontoon and chemin de fer only)
- up to 3 gaming machines in total of categories B3A, B4, C or D, but by agreement, only one machine can be of category B3A.

8. Club Machine Permit

A club machine permit (CMP) is available to members' clubs, miners' welfare institutes and commercial clubs. It allows the club to offer:

- equal chance gaming such as poker and bingo
- up to three gaming machines in total of categories B3A, B4, C or D, but by agreement, only one machine can be of category B3A (B3A not permitted for commercial clubs).

9. Small Society Lottery

Small Society Lotteries, (proceeds less than £20,000 per lottery or £250,000 in a calendar year) - the organisation running them must be registered with city council. There is no need for a Gambling Commission operating licence.

Appendix C: Public Health Framework for Gambling Related Harm Reduction (PHF) - Menu of possible areas for action

PHF Section	Title
1	Leadership and partnership
2	Influencing the regulatory environment
3	Reducing exposure of vulnerable people to gambling products
4	Improving identification and recognition of problem gambling
5	Self-management and support
6	Providing effective treatment
7	Promoting and maintaining recovery
8	Protecting children and young people from gambling-related harm
9	Addressing gambling-related debt
10	Workplace health and wellbeing
11	Building and sharing the evidence base