SLIPPING THROUGH THE CRACKS?

How frontline services identify (and miss) gambling harms

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By Niamh O Regan

KEY FINDINGS

- Gambling is a common activity in the UK. However, health, financial and social harms can be associated with the activity – with 2.7% of adults in Britain scoring an eight or higher on the Problem Gambling Severity Index (representing problem gambling).
- There has been a gradual shift to viewing gambling associated harms through a public health lens, but this approach is much less common than with other similar issues, such as alcohol or drug related harms. On a national level, progress has been slow. Locally, some local government public health teams have taken it on directly, but approaches differ across the country.
- Frontline services across health and the third sector can play an important role in identifying gambling harms and supporting those experiencing them. However, the systems and processes of these services do not always enable the identification of harms, which means opportunities to identify gambling related harm are missed. Other barriers included a knowledge-action gap, lack of expertise, and long waiting lists creating pressure on services
- Common challenges faced by frontline services to identifying harms and providing support include: siloed rather than integrated support, considerable variation between local public health strategies, patchy information sharing and a lack of inclusion of gambling in long-term planning.

In collaboration with

CENTRE FOR POPULATION HEALTH

KEY RECOMMENDATIONS

- NHS England and the Department of Health and Social Care should ensure there is adequate and accessible gambling treatment capacity nationwide.
- Questions on gambling should be included in patient questionnaires as standard.
- Councils should be legally mandated to address gambling related harm in their public health policies, as they are required to do for alcohol related harm, substance misuse and smoking cessation.
- A national gambling database should be created, to gather data from all Integrated Care Boards on the current state of gambling harms and to monitor treatment pathways.
- Local authorities should embed gambling prevention as a local health priority.

A full list of recommendations for health leaders, as well as both national and local government bodies are available at the end of this report.

INTRODUCTION

Gambling in the UK is a widely accepted practice: it is easily accessible, culturally normal and incredibly common. It has long been viewed as a recreational activity, and the UK has one of the biggest and oldest gambling markets in the world. While seen by many as a bit of fun, it can also be highly addictive. According to the Gambling Commission, 2.7% of adults in Britain score an eight or higher on the Problem Gambling Severity Index.[1] That's 1.4 million people.[2] There has also been an increase in demand for specialist services for treating gambling addiction. In six months of 2024, there was an almost 130% increase in the number of people referred to gambling clinics, according to NHS England.[3]

Gambling can have profound negative impacts on health and wellbeing, spanning mental and physical health, financial issues, housing and employment.[4] The wide-ranging nature of the harms means there are many opportunities to identify and provide support, that may not appear obvious at first, not just health services, but also wider public and support services, including, but not limited to, employment services, local policing, family and children's services, housing and debt advice services.

Gambling, particularly problem gambling is increasingly seen and acknowledged as something which public health systems should strive to address, as they have done before with other addictive and health harming behaviours like alcohol, cigarettes and substances. Despite this, progress on inclusion of gambling in public health strategies has been slow. Similarly, staff across frontline health services are often trained and well versed in identifying issues of alcohol and substance misuse and

addiction in their patients. The same cannot be said for identifying those experiencing gambling harms. It is also important to consider that gambling harms are not distributed evenly across society and can compound existing disadvantages associated with deprivation, poor mental health, financial insecurity and social exclusion. Addressing gambling harms should therefore be viewed as part of wider efforts to reduce health inequalities.

There has been limited research exploring how frontline services identify and support those experiencing gambling harms. Similarly, little is known about the challenges they face in providing this care or how it is accounted for in service planning. The purpose of this report is to explore those areas more to understand how frontline services currently navigate the environment, how they provide support and what prevents them from doing so.

METHODS

A note on language

Gambling products can carry health risks, including addiction, mental health issues and harms associated with financial hardship. Anyone who gambles can be at risk of harm, although risk level differs by the individual, as well as the type of gambling they are taking part in. As we will outline in the next Chapter, harms associated with gambling are not limited to the individual who gambles.

The language we use to talk about gambling and its harms is important. Some language often used can be stigmatising and/or prejudicial. To avoid use of stigmatising language, throughout this report we may refer to a person experiencing gambling harms, a person gambling at risky levels or a person being harmed by gambling. We will use “affected others” to refer to that individual’s friends, family and colleagues.

We will also use the term “harmful gambling products” when discussing products that may be more likely to create addiction.

Being mindful of the language used is important for preventing stigmatisation, and helping people access the support they need

Social Market Foundation and Centre for Population Health collaboration

A core part of this project is that it considers gambling harms as a population health issue, which is why it was conducted as a partnership between the Social Market Foundation and the Centre for Population Health (CPH). CPH brought a cross-sector population health perspective to the project, drawing on expertise from across healthcare, local government, voluntary and community organisations, leadership development and public health practice. This helped ensure the work considered not only treatment and policy responses, but also prevention, health inequalities, workforce capability and practical implementation within frontline services. Staff

from both organisations were involved in both designing and conducting the research outlined here.

Advisory board

An advisory board was established at the beginning of the project to provide guidance to the project team on the direction of research and feedback on the final report. Members brought expertise from public health, healthcare delivery, local government, voluntary sector organisations and gambling harms policy, helping to ensure the research reflected a range of perspectives.

Literature review and policy context

Research began with a literature review to understand the current policy context and degree of existing knowledge on the subject. Sources included academic literature as well as publications from local and national government. The literature review also looked at gambling harms reduction strategies in three areas (Greater Manchester, Bradford, Kent) from local government and NHS trusts in these areas to understand how and whether gambling harms were being considered as part of service planning.

Expert interviews

The literature review and policy context work has been supplemented with a small number of interviews (11), drawing on the professional experience of those working across frontline service areas. Interviewees were selected to cover several of the frontline services most commonly experiencing gambling harms to better understand how service users may interact with them.

Potential interviewees were identified through the combination of networks, including particularly the CPH's connections with frontline services and community organisations, as well as advertisements on social media. Interviews were conducted online using MS Teams. With consent, interviews were recorded and transcribed, with direct quotes used throughout this report to illustrate the themes emerging from the literature review and policy context work.

GAMBLING HARMS IN THE UK

Gambling in the UK is common

Gambling in the UK is a widely accepted practice: it is easily accessible, culturally normal and incredibly common. It has long been viewed as a popular recreational and even social activity.

The UK has one of the biggest and oldest gambling markets in the world, and people engage with it regularly. Official statistics on participation from the Gambling Commission spanning July-October 2025 (latest release available at the time of research) indicate that in the previous four weeks 48% of UK adults had participated in some form of gambling, dropping to 27% when those who only played the National Lottery were excluded.[5] The exact type of gambling that is most popular varies with each age group, with men more likely (three times as likely) to gamble than women

(15% vs 4%).[6] Over time, there has been an increased prevalence of gambling among children and young people.

Exposure to gambling has grown in the last 20 years. Digitalisation has increased access to gambling, with many gambling operators now offering app-based services. Without opening or closing times that traditional gambling venues would have, it is entirely possible to gamble at any moment of the day or night.

Changes to advertising permissions in the Gambling Act 2005 has meant that since 2007, gambling operators can advertise across all forms of media, and since the change, the number of gambling adverts has increased substantially.[7] The National Audit Office found that between 2014 and 2017, gambling operators increased their advertising spend by 54%, with this increase primarily driven by online and social media advertising. There has also been an increase in gambling operators sponsorship of sporting activities, with football clubs particularly noted. In the 2024-25 season, 145 football clubs in top EU and UK divisions (33%) had gambling sponsorship on the front of their shirts, with near double that having at least one betting partner.[8] In the Premier League, 11 out of 20 teams (55%) had gambling sponsorship on the front of their shirts, though this will be banned from the 2026-27 season onwards.[9]

But gambling can have harmful consequences

While it is both popular and normalised, gambling can be a highly addictive and health harming behaviour. Most people in Great Britain who gamble do so without issue, though there is a small percentage (2.7%) who reach the threshold of "problem gambling".[10] That is, "a person will have experienced adverse consequences from their gambling and may have lost control of their behaviour.".[11] A higher proportion (3.1%) are estimated as gambling at a moderate risks, they may experience some level of adverse consequence due to gambling.[12] Rates are measured using screening tools such as the Problem Gambling Severity Index. Though these types of screening tools are not perfect and have limitations including not taking into consideration affected others, they still provide a useful means of measuring prevalence of problem gambling.[13]

Research has shown that problem gambling shares a similar biological basis to many other addictions, with the brain's reward system playing a central role in gambling addiction. When someone gambles the brain releases dopamine, the same chemical involved in drug and alcohol addiction, creating feelings of excitement and anticipation.[14] As well as heightened excitement, the dopamine can influence risky decision making.

However, unlike these other similar products, where the Department for Health and Social Care plays a significant role in regulation, responsibility for gambling policy lies solely with the Department for Culture Media and Sport (though there has been some cross-government engagement on the issue). [15]

For the individual, common gambling related harms include financial harms, family harms, health harms, school college or work harms. Within these there are further subcategories of harm including relating to housing and criminal behaviour.[16] Financial harms may seem to be the most obvious type of harm, and can be severe, associated with gambling-related debt and bankruptcy. These harms knock on to

other areas. Crime has strong associations with gambling harms, with criminal behaviour like theft and sale of drugs [17] physical and mental health problems including higher rates of suicide and problems with housing and homelessness. Harmful gambling can contribute to a drop in employment performance including difficulty concentrating, coming to work late, or not at all, as well as job loss. This in turn can contribute to the financial harms described above. When considering these harms, it is important to remember that it is not only severe harms which are consequential.

Harms are not limited to the individual, but also their wider community (such as friends and family) and can also be societal.[18] Relationship related harms include a strain on relationships, arguments and domestic abuse, all of which can affect their wider network. Colleagues will understandably feel the impact of poorer work performance, but children's education can be disrupted due to what can be a chaotic home life, with reduced attainment and absenteeism noted among children of gamblers. Criminal behaviour can directly affect friends and family, with these parties being among those stolen from. In 2021, Public Health England calculated that gambling harms cost £1.7 billion each year.[19]

There has been a shift in attitude to view gambling through a public health lens

There has been a shift in how gambling and its associated harms are perceived. Gambling is recognised more as a commercial determinant of health, where actions of gambling organisations, in pursuit of customers, can contribute to negative health outcomes. Like with alcohol and smoking, gambling is increasingly seen on a continuum of harm rather than distinct gambling behaviours categorised as "safe" or "problem". Any amount of gambling can cause harm, just as any amount of alcohol or tobacco consumption can.

Treatment for gambling harms has historically been focused on individual responsibility, with policy focused on encouraging those experiencing the most severe gambling harms to control their gambling behaviour.[20] However, this has been changing. In 2020 medical journal The Lancet Public Health launched a Commission on Gambling to conduct a scientific inquiry "in response to an urgent, neglected, understudied, and worsening public health predicament."[21]

Public health approaches are commonly taken towards other non-communicable diseases

As awareness and discussion of gambling harms, and their effects on community and society have grown, there has been an increase in calls for the need for gambling to be seen through a public health lens and treated as a public health issue.[22] [23] A public health approach considers health on a population level and a systems level, rather than on an individual level. It accounts for and considers, for example, the role of social, commercial, political and legal determinants of harms. It involves regulation of systems, products and environment rather than focusing on individual decision making and self- regulation of behaviour. Such an approach is also multipronged. It spans prevention; early detection and intervention; and minimisation of the negative consequences.[24] [25]

A public health approach is commonly taken toward other non-communicable diseases and potentially harmful products, like alcohol, tobacco, drug use and obesity. With alcohol for instance, preventative measures involve both regulatory and health interventions (specific rules around alcohol advertising and taxation, and low consumption guidelines), identification is facilitated by encouraging screening in various health settings including at new GP registration, hospital admission, dental appointments and Health Check appointments. Reduction of alcohol related harm is embedded in local government public health programmes and receives ringfenced funding.

But for gambling this has been slower to advance

Despite recognition of gambling as a public health issue, national level policymakers have been slow to implement policies that reflect this.[26] There are currently no national guidelines on diagnosing or treating gambling harms in the UK.[27] It was only in January 2025 that the National Institute for Health and Care Excellence (NICE) published guideline recommending when healthcare professionals and social care practitioners ask about gambling behaviour. [28] Situations included when asking about smoking, alcohol, other substances, in situations when they are at increased risk of gambling related harm (e.g. presenting with a mental health problem) and when they are at increased risk of harm more broadly.[29] In contrast NICE published clinical guidelines on identifying and assessing harmful drinking and alcohol use disorders in February 2011.[30] Gambling was not referenced in the NHS 10 year plan, however it has been included in the Men's Health Strategy (published November 2025), which intends to "develop a coordinated approach to preventing gambling-related harms at national, regional and local level".[31] While anyone can experience gambling related harms, men are a group more likely to, and the inclusion of gambling within the strategy is good recognition of this. Its inclusion in the strategy is also an important step forward for its recognition as a public health issue.

Until recently, most funding for gambling harm prevention and treatment came through voluntary donations from the gambling industry. Most funding came to a single charity, GambleAware, with limited oversight over how the funding was used, effectiveness of the treatments and how this was then distributed.[32] GambleAware were then also responsible for most of the commissioning of provision from the voluntary, community and social enterprise (VCSE) sector. Funding for NHS specialist treatments came out of NHS central budget, rather than through any ringfenced funding, again in contrast to drug and alcohol treatment programmes.

The funding situation has now changed, with the introduction of Statutory Gambling Levy in 2025. Under the Levy, all licensees are required to pay an annual fee (calculated as a percentage of the their Gross Gambling Yield) to the Gambling Commission. 80% of the levy will go towards activities directed at prevention (30%) and treatment (50%) of gambling harms. Through this, funding is available to local councils as well voluntary sector organisations. The intention is that commissioning of the (VCSE) sector and the NHS will soon come under the responsibility of the local ICB.[33]

There has been more progress on a local level with some councils proactively taking a public health approach to gambling harms in their area, working collectively with health and voluntary organisations to address the problem.[34] Councils could use

some of their public health grant allocation on gambling prevention and treatment services, though unlike smoking cessation, drug and alcohol services, councils were not funded specifically to provide support for individuals experiencing problems with gambling.[35] However with the introduction of the Gambling Levy, they can now be allocated funds for gambling treatment which is ringfenced.

The current process of identification and treatment is siloed and uncoordinated

For those seeking help with gambling, the national gambling helpline is the most common route into treatment, with self-referral the second most reported route. [36] The NHS operates the Primary Care Gambling Service, which works with primary care services and third sector organisations to provide support services. More specialised treatment is also available through the NHS England regional centres. These generally map on to the regions of England with some exceptions. The Northern Gambling Service covers the North West and North East of England as well as most of Yorkshire and the Humber. The small part of Yorkshire and the Humber not covered in the Northern service is covered by the East of England Gambling Clinic. Within this, the NHS has 15 specialist clinics that offer treatment for gambling, with seven of these opening between 2023 and 2024. Clinics are spread across the country and are generally in areas of highest need.

However, for the most part treatment is provided mostly by services outside of the NHS, by the VCSE or third sector in both residential and community settings.[37] External services can include lived experience and peer support with organisations such as Gamblers Anonymous (which operate nationally) as well as more local organisations that provide counselling and therapy and private residential rehabilitative facilities. In 2024, less than a quarter of upper tier local authorities (35 of 153) had a treatment provider physically present in their area.[38]

In their 2024 assessment of the treatment system in England, the Office for Health Improvement & Disparities cited strengths of a passionate and talented workforce, a wide range of treatment options, good examples of strong working relationships between some providers, gambling is increasingly made a health priority. [39]

However, they also found the system is beset by challenges. There is no standardized or co-ordinated approach for collecting uniform metrics on service provision and user treatment journeys and there is a lack of clarity around referral pathways and poor links with wider services. Navigating the system is a problem for users with complex needs. There is also a lack of coordination in the treatment system between NHS and third sector which prevents strategic coordination (with ICBs set to be responsible for all commissioning from 2027, this is expected to improve). There were some concerns over governance structures including on accountability and occupational standards and there is lack of awareness and knowledge about gambling among wider healthcare practitioners. The issue of poor integration was also acknowledged in the Men's Health strategy, which among its aims, includes ambition to increase access and integration of treatment and support services. [40]

Frontline services could be a key player in addressing gambling harms, if systems enable it

Frontline services are those which provide core services directly to the public. They can be made up of both public and private organisations, as well as those operating in the third sector. In this project, and in the context of public health more broadly, we are taking a wide definition, that includes those working in healthcare systems, as well as services which operate in areas on wider determinants of health like housing, financial stability, education and skills, employment and crime.

A benefit of a public health approach to tackling gambling harms is the opportunity to create a, co-ordinated cross government approach for prevention, identification and treatment. This would help it to be deployed on a local level across these different services as each can play a role in preventing and identifying gambling harms. [41]

Healthcare services

The wide array of health impacts of gambling harms means there are numerous points along a healthcare journey where healthcare providers may be able to identify someone experiencing or at risk of gambling harm.

Gambling harms have comorbidities across mental and physical health. Levels of anxiety, depression and suicide ideation are higher among those with a high Problem Gambling Severity Index (PGSI) score than those with a lower one. Those with a high score are also more likely to be experiencing issues with alcohol and other substances. People with certain medical conditions, such as an acquired brain injury, or other conditions that lead to increased impulsivity are also at increased risk of harm.[42] As such healthcare providers are in a good position to identify those experiencing harms.

As described previously, NICE have set out guidelines for the identification, assessment and management of gambling harms in individuals as well as affected others. The nature of the guidance provides ways for those working in many healthcare fields to be able to identify those experiencing gambling harms. Healthcare services are also a direct point of contact for someone actively looking for help with gambling, and requiring referral to gambling specific services. The NICE guidelines also outline how to provide initial support for people experiencing harms, as well as for referral and triage.

Council services

Local councils have a relationship with local healthcare providers, for functions of public health planning, and the delivery of health services. They may come across gambling in this way through assessing provision of gambling services locally, as well as through council funded/operated drug and alcohol treatment services.

However, council services themselves can also be a direct contact for someone experiencing gambling harms. A knock-on effect of the financial issues of gambling harms can result in issues with housing and homelessness, council housing services can become involved. Children's services and adult social services can also come across gambling, as gambling can be a contributory factor in family breakdown and domestic abuse.

Community services (including voluntary and third sector)

Community services can come across gambling harms in two major ways. Firstly, where voluntary charity organisations operate in areas that overlap with council

services and with health services. For instance, local housing and homelessness charities and local mental health support charities will come across gambling harms in similar ways to council and health services. Relatedly as financial issues are significant harms associated with gambling, local debt advice charities and other wider financial advice services are also a key touchstone for interacting with gambling harms.

The second way community services come across gambling harms, is through providing a safe and supportive space for a community. This includes communities that may be based on shared interests, faiths, ethnic backgrounds and so on. Often these groupings service as an advice hub for the particular community they serve, and can foster conversations that lead to revelations of gambling harms. This positioning also makes communities an invaluable resource of insights and co-design of solutions and services that will work best within their own communities.

Other major services

The criminal justice system, and in particular policing can also have a role to play in identification, as criminal behaviour like theft is a gambling related harm. Neighbourhood Policing Teams may be particularly likely to come across those experiencing gambling related harms, as they are designed to take a collaborative, problem solving approach, working with communities.

Other service providers can also be involved in identification and prevention of gambling harms. Banks for example can see transaction data including gambling spend, income, and debt. This gives them a unique position for intervention. Some banks have a Bank Gambling Block. Though this has to be switched on by the customer to block transactions associated with gambling, though this has its limits. It is designed to help block transactions, giving customers a cooling off period and chance to reflect[43].

..but their experiences are understudied

Despite the role these services could play, relatively little is known or formally documented about the experiences of frontline services when it comes to identifying and supporting those experiencing or affected by gambling harms.

From the evidence that does exist, it is clear that frontline service workers are faced with challenging circumstances. For local authorities, there is little data in councils regarding who needs the help and the extent of the issue in their community. [44] Frontline workers can lack capacity and resources to effectively signpost to support Healthcare professionals have been advised to ask about gambling at health checks, but it is not always done, and not mandatory[45]

As part of their research on developing a public health approach to gambling in Wales, John et al[46] interviewed providers of various third sector frontline services in Wales, covering organisations that deal with homelessness, drug and alcohol use, domestic abuse, and financial debt issues, totalling 20 people from 11 organisations. The focus of questions was on knowledge and experiences of gambling harms, approaches to identifying and assisting and signposting and referring. While most reported that they rarely came in to contact with those experiencing harms, it was also noted that non-specialist services rarely screen for problem gambling or raise

the issue informally. This is the case even if, for example a user's financial situation indicates that they may have an issue.[47] Some of the providers spoken to in the study also expressed concerns about asking, as they would not be able to provide assistance if something did arise.[48] Unfortunately, without these questions being asked, the data gap in need for services persists. In the study, service users themselves also expressed difficulty in finding help.

APPROACHES TO ADDRESSING GAMBLING HARMS VARY BY REGION

How frontline services interact with gambling varies depending on the region

As stated, councils now have responsibility for addressing and/or treating gambling harms locally. Different local authorities have taken different steps to understand the extent of gambling harm in their area, this includes Greater Manchester Combined Authority and Devon County Council.[49]

How gambling harms are addressed in a particular area is dependent on a number of factors of council and public health powers and decisions they make. Arguably the biggest power local councils have is over licensing of new gambling facilities. Local councils can collect and use public health data to create risk maps, and use this information, alongside the involvement of frontline services to develop a strategy on tackling gambling harms locally. They can also provide training for their own frontline staff, and work with local support organisations. All upper tier local councils in England have dedicated public health teams, and these teams can dictate which broad health interventions are funded in the locality. Working alongside the public health teams, Integrated Care Boards[i] make decisions over clinical commissioning, and which healthcare services should be funded.

Approaches are far from universal, which is helpful, in that services and priorities generally need to be tailored to the relevant population and their needs. However, this can mean that services may be more developed in some areas than in others.

There is also the issue of local government capacity. Changes to how gambling harms prevention and treatment is funded means that since 2025, upper tier local councils receive funding through the local council gambling harms prevention grant. This grant comes from fees collected through the Statutory Gambling Levy, and provides ringfenced funding to councils to prevent and reduce gambling harms. The amount of funding each council receives is based on both the council's population size and its index of multiple deprivation score. [50]

We have looked at three areas across England to serve as case studies for how approaches to gambling harms can vary. We have chosen to examine the practises of each Greater Manchester, Bradford and Kent. Each of these areas have higher levels of deprivation, something which is associated with higher instances of gambling

[i] Integrated Care Boards are NHS organisations responsible for planning health services for a set geographical local area, they may include more than one local authority. There are currently 42 ICBs in England.

related harms. Each also has power over public health plans and spending, each of these areas has taken different policy approaches to how gambling harms are identified and how those affected are supported, which we detail further below.

Greater Manchester

Greater Manchester Combined Authority (GMCA) is an upper-tier local authority. As a combined authority it has significant public health power and resources, and can take a much broader regional approach to gambling harms. Licensing however remains with the individual councils within the authority.

GMCA has been a pioneer in approaches to address gambling harm, and has a well-developed public health approach which is likely more advanced in having a systemic approach than other parts of the UK. However, the approach is still relatively young and there is further to go.

In 2022 GMCA published a Strategic Needs Assessment of gambling harms in Greater Manchester. Among their findings were that at least one in fifteen residents experience harm as a result of gambling, a rate 1.5 times higher than the national average. [51] Police respond to at least one incident a week where a serious concern of a risk of suicide has been raised, directly associated with gambling.[52] It also found that one-quarter of Manchester residents who gamble go without food due to a lack of money. [53]

In 2020 GMCA received funding from the Gambling Commission via a regulatory settlement, for a three-year pilot to develop the first ever city-region approach to gambling. [54] The pilot tested different test projects to understand what a local approach could look like. Projects included an informational campaign to raise public awareness of how gambling products can cause harm; and an effort to build understanding of and awareness of gambling harms amongst elected members of Greater Manchester boroughs. One of the projects developed was “Communities Against Gambling Harms”. 13 different voluntary and public sector organisations were given funding to develop approaches to gambling that met the needs of the specific communities they serve, e.g. ex-armed forces personnel, young people, an ethnic minority community. A ‘community of practice’ was established where the organisations could share their learnings and challenges, and also gain insights from those with lived experiences of gambling harms.

The National Institutes for Health Research (NIHR) evaluated the *Communities Against Gambling Harms* pilot project in 2023 and found the project had been effective at facilitating social innovation in community-based gambling harms interventions. They also said it was a model for how communities can collaborate to achieve impact.[55] Among their recommendations was that other regional governments could consider replicating the model in full. [56]

Coming through the pilot, the GMCA has since deployed a “place based whole system population health approach” in the 2023- 2026 Gambling Harms Action Plan.[57] Local organisations are encouraged to work together and use local knowledge to optimise provision for those in the community, and interventions are aimed at improving health and reducing inequalities across the whole population. A whole - system approach to public health acknowledges the complexity and interconnectedness of health issues with each other, the wider determinants of

health like housing, education and employment. [58] Many of the pilots that were tested in 2020-23, are included in the plan as full-fledged programmes.

At the time the plan was written, it was acknowledged that current treatment pathway was fragmented and commissioned outside of local health governance structures, which could reduce its effectiveness. The plan includes actions at both the Greater Manchester city-region level and local authority and neighbourhood level,

The plan contains seven core beliefs:

1. Work will be grounded in best available evidence, with plans for improved data collection to better inform place-based interventions
2. Gambling can be harmful for anyone
3. Harms are not equally distributed and can exacerbate existing inequalities. Different products carry different risks and, different circumstances can affect ability to overcome harms associated with gambling.
4. Interventions to address social economic and commercial causes will prevent harm
5. Improving identification support and treatment will reduce impact of harms.
6. Action must be independent of the gambling industry
7. Collaboration is necessary

The aims of the plan include a reduction in the number of people experiencing gambling harm; improved awareness among residents of the risks; gambling harms to be a strategic priority for GMCA for the next 10 years.[59] Responses to the plan have been positive. Local voluntary sector organisations have praised the plan and aspects of the plan have been cited by Southampton City Council as a potential learning opportunity.

Other initiative in Manchester include GaMHive and Chapter One. Launched in January 2022, GaMHive it is a lived experience group that aims to raise awareness of gambling harms and reduce stigma. They work to signpost those experiencing or affected by gambling harms, to organisations that can offer support and work with local services s that they can identify harms, and offer signposting themselves. GaMHive also co-authored the 2023-26 action plan. Chapter One is now a national gambling harm prevention provider. It was piloted also in 2022 through a partnership between GMCA and Gambling with Lives. Its work includes increasing access to evidence-based treatment for everyone who needs it, providing information and guidance for the public; creating evidence-based training and tools for frontline professionals in contact with those affected by gambling and proving preventative education for young people.[60]

Manchester is also home to one of the clinics run by the NHS Northern Gambling Service.[61] The service is a mixed clinical team of psychologists, psychiatrists, therapists and mental health nurses as well as those with lived experience.[62]

Bradford

Bradford Metropolitan District Council is an upper tier council, and part of the West Yorkshire Combined Authority. As an upper tier council Bradford receives its own public health budget, and is responsible for direct public health delivery and localised interventions.

As of 2024, there are a little over 16,000 people in Bradford, estimated to be at risk of, or experiencing gambling related harms, A rate which is the second highest in Yorkshire and the Humber.[63] Bradford City Ward is one of the highest areas of deprivation in England, and almost a fifth (18%) of Bradford's 139 gambling licenses are in this ward.

In Bradford, a local Gambling Harms Reduction (GHR) Partnership was established in 2021 between council service, local health teams and voluntary and third sector organisations working in treatment.[64] Partners involved include public health teams, local recovery and treatment organisations children's services, youth services adult social care among others. Some of their work has included training (in collaboration with King's College London) of adult social care workforce regarding early identification of gambling harms and support. A result of work of the partnership means the Drugs and Alcohol service providers have a responsibility to screen for, and support or refer, people experiencing gambling harms. Communications campaigns have been developed to raise awareness of gambling harms ahead of major sporting events, and an educational programme has been developed for schools.

The city has also developed the Bradford Gambling Related Harm Action Plan 2026-27.[65] With the plan there are five intervention areas:

1. Strengthen evidence base by utilising routinely collected data such as those accessing gambling treatment services and working with the Age of Wonder[ii] project who collect survey data on gambling in young people.
2. Build leadership and capacity, through improved research to understand the burden of harm, collaborate with academics and research groups studying gambling related harms and provide training and awareness programmes to support staff of organisations that may support people with increased risk of gambling harm as well as services where gambling related harm is less known
3. Reduce exposure and access, such as through working to make Bradford a gambling advert free zone.
4. Life course and equity approach with actions like providing children and young people with education and awareness of gambling related harms
5. Provide treatment and support for those affected by gambling harms, ensuring that treatment is equitable and accessible, and that staff have appropriate training.

As part of this plan in 2026, together with Chapter One (a gambling prevention organisation), Bradford Met District Council have launched a gambling harm prevention ad campaign, specifically aimed at 18-34 year olds, and using real-life

[ii] The Age of Wonder project is a seven-year project capturing the journey through adolescence and adulthood for all teenagers in Bradford.

stories of addiction.[66] They have also worked together to provide free training sessions for frontline professionals to provide the knowledge, confidence and skills to prevent and support gambling-related harms. The training covers: the causes and effects of gambling related harms are, brief interventions, 'having the conversation', and referring to support services.[67] Bradford is also covered by the Northern Gambling Service, though they do not have a physical clinic within the city.

Despite the commitment, there may be a gap between council planning and longer term strategic health planning. The West Yorkshire Integrated Care Board Joint Forward Plan discusses improving population health including taking a coordinated approach to supporting healthy lifestyle behaviours.[68] However within those behaviours they do not mention gambling within either its effects on core determinants of health, or in prevention of poor health.

Kent

Kent County Council is an upper tier local authority, it is not part of a combined authority. As an upper tier council, Kent receives a ringfenced public health grant, and now receives ring fenced funding through the gambling harms prevention grant.

In 2023 the Public Health team in Kent County Council in an update report on gambling addiction interventions, acknowledged that there has limited capacity for a coordinated plan to tackle gambling related harms in Kent. At least a contributor to this was that, at the time, there were no resources attached to gambling harm reduction for public health teams, whereas drugs, alcohol and smoking cessation received ringfenced funding.[69] In their report to the council, the team proposed completing a needs assessment to better understand gambling related harms in the county and working with the Kent and Medway ICB, as well as supporting interventions to prevent gambling harms and setting up a task and finish group to scope how to maximise resources for a plan of action. The same report noted that Kent Police recorded 506 gambling related crimes in 2019 and 2020, and that while they do not routinely screen for gambling habits, they have a good partnership with the public health and community safety for preventative policing.[70]

The Kent and Medway 2023-27 Joint Forward Plan refers to supporting the population to adopt positive health behaviours, such as healthy eating, maintaining a healthy weight, physical activity, maintaining good sexual health and minimise alcohol substance and tobacco use.[71] However, it does not include any explicit reference to gambling.[72] Similarly, gambling is not mentioned in the current Kent Drug and Alcohol Strategy, though we know that substance use support services may be helpful in identifying those also experiencing gambling related harms. Gambling however is mentioned in the consultation report for Kent and Medway's upcoming 2026-30 suicide prevention strategy. It acknowledges that those affected by gambling harms are a high-risk group for suicide, and that the references to gambling harms within the Real time Suicide Surveillance data is likely an underestimate. Those experiencing gambling harms are expected to be among the groups that should be prioritised as part of the strategy.

INTERNATIONAL EXAMPLES SHOW HOW A PUBLIC HEALTH APPROACH HAS BEEN ADOPTED ELSEWHERE

International experiences show that many countries experience similar issues to the UK

Gambling has been recognised as a significant public health issue around the world, and one which needs population level interventions harms.[73] Though the formal integration of gambling into public health schemes has been slow to gain traction, some countries have progressed further than others. The most long lasting of these is New Zealand, but Norway and Sweden are also examples of where public health framing from gambling has taken priority. We note that many of these programmes are relatively new, which makes it hard to fully determine the effectiveness and what teething issues may be in place, if any. However, they do show innovative approaches which the UK could learn from in addressing gambling harms.

Aotearoa New Zealand

In Aotearoa New Zealand gambling harm reduction is a legislative requirement.[74] The country adopted a public health approach to gambling related harms in 2003, which is implemented by the Ministry of Health. The 2010/11-2015/16 strategic plan had 11 objectives, including developing a skilled workforce, community resilience , awareness of gambling harms and policy at national regional and local levels to minimised gambling harm.[75] Included in some of the priorities to achieve this were developing tools and protocols to support the inclusion of screening, assessment and intervention in general health screening and day-to-day delivery, as well as increasing the evidence base for interventions that address harms.

The strategy has been refreshed multiple times since then evolving on the work of its predecessor, with the 2025/6 – 2027/8 strategy the most recent version. The current strategy aims to improve access to gambling harm support services, growing the workforce strengthening prevention and early intervention and improve the effectiveness of support[76] Growth of the workforce includes not only clinical staff but also peer support

Sweden

In Sweden, the Public Health Agency of Sweden is responsible for work to prevent gambling problems.[77] Part of their work includes knowledge dissemination and coordination of prevention on a national level. Sweden also maintains a longitudinal gambling study (Swelogs) which monitors prevalence of problem gambling as well as other linked, lifestyle, health and housing factors.[78] Since 2018 a clinical register, GamReg, tracks treatment for gambling addiction, with the possibility for the register to serve as a research resource for, for example analysis of effectiveness of treatment.[79]

Implementation of the prevention elements of Sweden's strategy have come under scrutiny. Responsibility for prevention and support mostly lies with local areas (municipalities) and regional healthcare providers, but a recent report by the National Audit Office found that authorities lacked clear operational guidance, tools and

consistent procedures.[80] Implementation across the country is inconsistent, resulting in something of a postcode lottery when it comes to prevention, identification and treatment. Coordination between agencies is fragmented which can lead to people falling through the cracks.

Norway

The gambling market in Norway is slightly different than in other countries, as the state continues to hold a monopoly over legal gambling. However, the (illegal) use of international gambling sites is increasing, and Norway may soon begin a move away from this monopoly system.[81] As it stands, responsibility for gambling harms prevention is spread across Norway's Gambling Authority, Media authority and Health Directorate.

Norway has recently launched a new four-year national action plan on gambling harm, which includes integration into broader public health frameworks. The plan focuses on prevention, early identification treatment and research. Children and young people are a particular focus of the strategy, recognising the rising risks/concerns to underage/youth gambling. Measures in the plan include training for those in health but also community settings to be able to recognise gambling harms. This includes employees of banks, leisure club, sports clubs, debt counsellors, child welfare and family counselling. It has an overall goal of better coordination between health services and society.

SNAPSHOTS FROM THE FRONTLINE

Our conversations with those working across frontline services show that there are systems level issues, which aggravates fragmentation. The absence of national level policies and long-term strategies could be seen in the difficulties that frontline services faced. Staff are generally keen to help support those experiencing gambling harms where they can, but for many it is not their priority, or even something they knew much about how to do it. They do not always have the tools necessary to offer the most effective support.

Barriers

- Many working in frontline services experience a knowledge-action gap. There is broad awareness of gambling harms, but focus remains on the most severe cases and awareness has come as a result of experience rather than by design
- Processes within services do not always enable self-disclosure, but identification of harms often relies on it this and not all services have training to enable them to read between the lines.
- More immediate issues often take priority and long waiting lists put pressure on services
- Lack of expertise means the support that can provided by some frontline services is limited to referrals

Challenges

- There is significant variation between local public health strategies, creating inconsistencies in local level systems approaches
- Support for those experiencing gambling harms seems siloed rather than integrated, and the services that do exist are under increasing pressure
- Information sharing between services is patchy and, in some cases, impossible
- By and large, gambling is not actively considered in future planning and delivery, and there is no structure in place to encourage them to do so.

To illustrate the different ways that gambling and frontline services can interact, we have taken the discussions we have had with frontline services staff and used them to create five hypothetical scenarios and personas. Throughout them we highlight different areas where barriers and challenges for frontline services emerge. As snapshots, the barriers and challenges highlighted are not intended to be exhaustive and a barrier may come up in more than one scenario, even if not highlighted explicitly. The scenarios present possible ways that frontline services may interact with gambling harms, but there are many more, not illustrated here.

While these scenarios are modelled on the mix of conversations we have had, none are intended to represent any particular individual and all situations are fictional.

George

George is 27. Like many of his friends, George will place bets a few times a week on different sporting events he has an app on his phone which he uses regularly but has a limit on how much he can spend on the app. Recently he has begun gambling more and more frequently and with more money. However instead of breaching his self-imposed cap on his phone, he has been taking out large amounts of cash in order to bet in person. The money he has been spending is really adding up, affecting his ability to cover some of his other needs. The main of these is housing and he is now several months behind on his rent. He borrowed some money from a friend to try and win back some money to pay off at least some of his rent arrears, but he didn't win, putting him further into debt. His friend mentions to him that he seems to be gambling a lot, and is a little concerned, but George brushes it off.

George's landlord has told him that if he does not begin paying back the arrears, that he will have no choice but to evict him. The landlord asks George what has caused him to fall behind. George mentioned a change in outgoings relative to income, but the landlord does not press him any further. He gives George the contact details of a local housing charity that provides advice and support for those at risk of becoming homeless. George contacts the housing charity and tells them he needs advice about debt and rent arrears. They ask a few questions about his lifestyle habits including around drugs and alcohol. Gambling is not one of the areas mentioned and George doesn't bring it up.

The charity determines he is not immediately at risk of homelessness, but does debt advice, and refer him to a local debt charity. The charity should help to create a debt repayment plan and help him clear his arrears. The charity has a 5 week waiting list, so he won't be seen immediately. Once his appointment comes up, he is asked to bring his last six months of bank statements. Looking over the statement the advisor notices some regular payments to gambling companies but what really gives cause for concern is the cash withdrawals. With the training she has received and noticing that the ATMs mentioned are close to a local casino, she suspects that George may be making the withdrawals to gamble. When asked about the large withdrawals, George says they are for other things, like grocery shopping or presents, he feels embarrassed and does not want to tell the advisor the real reason, afraid that she will judge him for it. Unconvinced the advisor gently presses the issue and George mentions that sometimes the withdrawals are for gambling. The

Barrier: systems do not always enable easy identification. Identification of harms relies on people disclosing, but systems don't always enable this. There can be a reluctance among those experiencing harms to self-refer or self-ID as experiencing harms. Screening tools are frequently used to identify issues regarding alcohol and other substances, but gambling is not always included in these circumstances. Inclusion of questions can depend on the experience of the questioner, rather than being included as standard leading to inconsistencies in identification. This type of screening gap occurs in both clinical and non-clinical settings

Challenge: Waiting lists for non-emergency services can be long. This poses two challenges, firstly, it means there is a delay in opportunity to identify someone experiencing or at risk of gambling harms. Secondly, pressure on services may mean there is less opportunity to identify in the first place.

Good practice: Training and education resources are available to those working in healthcare and beyond, and can provide a good grounding in how to identify harms and guide people towards support

advisor does not remark on this, and begins to create a debt repayment plan.

Once the plan has been created, the advisor asks George if he would like the details of a local gambling charity, that can help him to reduce how much he is spending on gambling, Initially, he is not interested, and says so to the advisor, however later that day he contacts the advisor, and asks to be put in touch with the service. Once referred the advisor hopes that George will attend the appointment he has with the gambling charity but she has no way of knowing if he will and no means to follow up.

Comment: George's gambling harms are noted relatively quickly, though notably, not before there is genuine harm. Even with the speed there are some points where he could be considered to have slipped through the cracks. The housing charity not including gambling harms in their assessment is a slight oversight. a few places where George could be considered to have "fallen through the cracks, where gambling harms could have been identified sooner. The first one is when put in to contact with the housing agency, as gambling was not included in their questionnaire. Inclusion could have led to him being referred to an organisation that provided more rounded support, handling gambling and debt simultaneously. This leads to the second potential fall. As the debt advice service does not provide support for gambling, George must be referred on to yet another agency. With no means of follow up, if George does not attend, there is no real record of him having sought help, and he may find himself in the same situation again.

Challenge: information sharing is patchy, and sometimes not possible. Within healthcare settings, patient information can be recorded and shared across services, relatively seamlessly. However, gambling harms are not always picked up on in health settings and there is no standard way of noting gambling harms on patient records. Outside of healthcare settings, information sharing becomes trickier. Services must understandably ask their clients for their consent before sharing any records, but they may have no formal or secure way of sharing the record with the individual's GP or with treatment service.

Debbie

Debbie is 61, and moved to a new town a few years ago with her husband, to prepare for their future retirement. She started playing bingo locally as a way of getting to know people and make new friends. This has worked and she has developed a good group of friends who she sees every week. She has won a few times, and began to play more and more, both locally and further afield. She is spending more than she had budgeted but is finding it difficult to stop playing or exclude herself. Her husband is concerned about her gambling, and that it will eat in to their retirement fund if it continues, Debbie and her husband argue more and more about money, putting extra strain on their relationship.

Feeling more lonely Debbie attends more bingo, knowing she finds friends there. But she no longer enjoys it as much as she once did.

Good practice: family and friends can be an important resource in spotting symptoms of those experiencing gambling related harms, and helping them to navigate the system and secure help

Debbie begins to develop low mood. After several months of feeling like this, thinks she may be depressed. Her husband, while still arguing with her about her bingo playing, is worried about her, and encourages her to seek help.

Debbie completes a self-referral to her local Adult Wellbeing Support Service, through her local council explaining her loneliness and concerns she may be depressed. Once her referral is accepted, Debbie receives an appointment. At the appointment, Debbie is asked about how she feels, when her feelings of low mood and depression began, and the circumstances around them. The screening process they use in the wellbeing service has recently been updated and includes a broader set of lifestyle questions which includes questions on gambling and gambling frequency.

The person conducting the assessment notes that Debbie's responses indicate she is likely experiencing gambling harms. They discuss with Debbie the different treatment options that are available locally . While the Service provides support in many other areas, it does not cover gambling directly. However they do have well established relationships with a number of organisations operating locally who will be able to support Debbie. Debbie is given a referral to one-on-one counselling for gambling harms, her GP has been notified of her initial self-referral and of the outcome of the assessment. After some time attending the counselling, Debbie recovers, and does not return to gambling. Following her recovery, Debbie decides to become a peer support worker in order to help others who are having a similar experience with gambling harms.

Comment: Debbie has not fallen through the gaps, though she could have if the wellbeing service had not updated their questionnaire to include questions on gambling. The inclusion allowed them to identify potential gambling harm, and their relationships with local organisations means they can connect Debbie with them easily. Notifying the GP of her referral means that there is a tie on Debbie's medical record of help she has sought, which could be helpful to other medical practitioners in future, particularly if she presents with similar issues. Debbie's decision to become a peer support worker will provide an invaluable lived experience voice to the support network.

Good practice: Inclusion of gambling on questionnaires helps to identify those who may be experiencing or at risk of gambling harms

Barrier: frontline services are often limited to referring on to other services rather than providing any treatment themselves. Those who have greater experience of working with those experiencing gambling harms are more familiar with the process of with was linking people with other services, both through formal referrals and signposting to services and resources that could likely help address gambling related harms. Some organisations and/or practitioners have developed good links with a wide array of local services who could provide different types of specific support. However this can mean there is inconsistency in the support that is offered e.g. where links are purely based on one to one relationships, rather than it being institutional. Others may have a more general sense of the resources they could signpost to, but are not always familiar with what wider options were available.

Challenge: Local variation and inconsistencies: What services are known about will depend on what is locally available, and this can vary significantly depending on what part of the country someone is in, what is offered in their area.

Alex

Alex is 35 and is interested in buying their first house. They earn a good salary, have a deposit saved and are not in any debt. They attend a meeting with a financial advisor to understand their mortgage options, where they are asked to provide 3 months of payslips and bank statements. The advisor notices that there are regular payments going out to online gambling websites, however as far they can see, Alex's bank balance is stable. They tell Alex that some mortgage providers may not look as favourably on someone who is gambling regularly but as they have no debts and Alex appears financial stable, there should not be an issue.

What the advisor did not note, is that Alex's gambling mostly happens late into the night. He has been staying up late and not getting enough sleep. At work Alex is tired and distracted, and is consistently performing poorly, which is affecting their relationships with work colleagues, who are frustrated that Alex is not doing their job as well as they used to. As time goes on and their performance does not improve, they lose their job.

After a few months of struggling to secure a new job through their own process of applying, Alex has lost a lot of confidence in themselves. At the suggestion of a family member, Alex attends a local employability service to try and help them get back on their feet. The employment manager Alex speaks to asks about their last job and their current circumstances. The employment manager had some formal gambling training last week, but also has some past experience with clients who experienced gambling harms, so there are some signs he knows to look out for. He waits to see if Alex brings up any issues with debt, but he does not, and so the issue is not pushed. The centre works on helping Alex build up their confidence once again, and revamping their CV.

Throughout this time, Alex has continued their late night gambling, continuing to get little sleep. As exhaustion catches up with them, they trip and fall in the street, they momentarily lose consciousness and have a long gash on their head which is bleeding. They are taken to A&E with a head injury, staff attending ask Alex what has happened, as they begin to address the injuries. They mentioned they had stayed up late the night before gaming, resulting in over tiredness and leading to the fall. Scans for drugs and alcohol come back clear and the staff patch up Alex and

Barrier: Awareness of gambling harms can focus on the most severe cases. People appear to be less familiar with earlier stages of gambling harm, or only think of harms in very negative cases. This may limit early identification, or identification could be missed entirely if the extent of gambling is hidden by other circumstances like wins or a n absence of debt.

Barrier: more urgent issues often take priority. The opportunity to identify gambling harms by frontline services can be limited. As contact with other frontline services can come about as a result of other perhaps more urgent harms, focus will often be on what harm brought them to the service in the first place. While gambling may have contributed to the harm, the condition in front of them is the top priority, and any contribution gambling may have made is a much lower priority

arrange an appointment for them at their GP's office in a few weeks to remove the stitches.

Attending their GP appointment a few weeks later, the GP notes on Alex's record no reference to drugs or alcohol, something she often sees when it comes to head injuries in someone Alex's age. She does note that the A&E staff recorded that Alex said they were up late gaming and had not gotten enough sleep. The GP only has a basic knowledge of gambling harms, but from past interactions with other patients, and colleagues working in other parts of the health service, she suspects there is more to it than meets the eye. The GP begins to ask Alex questions about their online gaming and discovers that they partake in online casinos. GP cannot provide treatment themselves, but puts Alex in touch with one of the social prescribers working with the practice who has some experience of gambling harms and can connect them to people with lived experience. The GP also refers them to a local gambling harms prevention charity that can provide Alex with the help and support they need.

Comment: Alex has fallen through a lot of cracks in identifying gambling harms. While they have clearly experienced gambling harms, these have been missed by many people and services along the way. This is not necessarily the fault of the services, gambling is not within their remit, and they are dealing with matters which are. It is only as a result of the GP having some awareness and experience themselves that they have been able to identify the issue, rather than it being through any formal mechanism

Barrier: awareness of gambling related harms has come about as a result of experience rather than by design. Experiences of specific training to recognise and identify gambling harms were not routine (though not entirely absent either), and familiarity with the subject appeared to have developed over time as and when gambling or issues associated with it presented themselves.

Stephen

Stephen is 46. He has lived in his suburb for many years and is relatively well known by and recognised in the local community. Stephen has been using slot machines for many years, first in pubs and now also within high street gaming centres.

Stephen feels that he is experiencing harms as a result of gambling. He has self-excluded from a number of venues, but some new ones have opened which he has not excluded from. He has had financial issues in the past, has issues with alcohol misuse and also experiences anxiety and depression. These feelings and his alcohol consumption can be heightened after gambling, no matter whether he wins or loses.

Challenge: Some of those who are in most need of support may be hardest to access. Primary care workers can be really important in identifying those experiencing gambling harms but are only able to do so if they come in to contact with them. This

He wants to stop gambling, but has found it difficult to navigate the system and find support. He doesn't know where he should look for information, and can't see anything at any local services. He never registered for a GP when he moved to the area and still doesn't have one. He is embarrassed about his gambling and he feels isolated and unable to ask anyone within the community if they know how he can get help.

Feeling increasingly isolated and depressed, Stephen has been thinking about suicide a lot over the past few months. One evening he attempts to take his own life. A passerby notices Stephen and calls 999. The police are the first to arrive and they work to deescalate the situation. Once they are sure that Stephen is safe again, they offer him some crisis support. In talking to the police Stephen mentions the extent of his gambling, but the officers are not familiar with responding to gambling specifically, more focused on crisis intervention there is little they are able to offer him in terms of gambling specific support. The officer does not note down Stephen mentioning his gambling.

Later, a police wellbeing officer knows of a local mental health charity that he thinks may be able to help and refers Stephen to them. Attending his appointments Stephen works to address his mental health issues but feels he is in a vicious cycle, as the service does not provide simultaneous support for alcohol misuse or gambling, both of which Stephen continues to engage with.

Comment: Stephen persistently falls through gaps, finding that there is no "right door" for him to go through. Unsure of where to find support, he tries when he is in situations where he thinks someone could help point him in the right direction, but it never seems to provide what he needs.

can also make referrals to other, more specialised treatments or services difficult.

Challenge: Siloed rather than integrated services. Support may often need to be multifaceted, not just addressing gambling but associated harms too. An organisation which focuses primarily on one harm is not often not in a position to assist with other harms. They may be able to refer on to another organisation, but an individual may need simultaneous support. Combined with limits on data sharing, this can be harder to achieve.

This fragmented provision also poses a difficulty for someone who is looking for help, but is unsure of where to go, or how to ask for help. Combined with a lower awareness and consciousness of gambling can mean that those who need help, do not get it, or only do so after being passed from pillar to post and possibly after a long time of looking for support

Maya

Maya has three children, aged 14 to 20. Her eldest child is at university but comes home most weekends, as she has a job in her home town which she has kept while studying. The job, combined with her maintenance loan should be enough to help her to cover her living expenses while at university, but her parents have said they can provide a small amount of additional support if she has one off larger expenses like textbooks or if

she ends up working slightly fewer hours each week.

Since starting her final year, Maya's daughter has asked for this additional support a few times, more than she has done in the past. Maya doesn't think her hours have been cut, or that she would have so many big expenses. She has asked her about the additional expenses but Maya has not been forthcoming. She seems more irritable and is not as social with her family as she normally is. One weekend, Maya notices her daughter taking money from her purse, without permission. While this is a great shock to Maya, it also make her extremely concerned, and she decides not to confront her daughter about it.

Maya's faith community hosts a weekly coffee morning offering advice and general socialisation. Maya attends regularly, and begins to voices her concerns about her daughter. She talks about what she perceives to be financial issues and the change in her behaviour. The community group routinely arranges training for community organisers, to help them identify different types of harm in their community, including gambling. One of them speaks to Maya after the session and voices to her that it may be possible that her daughter is experiencing gambling related harms. This shocks Maya. She knows that gambling is an issue for many young people, however, it is not permitted in their faith, and she never considered it might be something her daughter would be experiencing.

Maya determines to ask her daughter about it when she is home at the weekend. At first she denies it is gambling, but then admits that she is, and that she is finding it difficult to stop, and has been embarrassed to look for support. Maya assures her daughter of her support and asks a member of the community group to provide her with some information on help and support available, that considers the needs of their community.

Looking at what is available where her daughter is at university, Maya is surprised there is not a more comprehensive offering for gambling, noticing that most of the support is around drugs and alcohol, rather than gambling. Maya also struggles to find support for herself, not as someone who is gambling, but as someone who has been affected by family member's gambling.

Comment: As an "affected other" Maya falling through gaps is a different case to that of her daughter. However Maya strongly benefits from the training that members of her community group

Good practice: Community and voluntary partners can be involved in the co-design of solutions

Challenge: Absence of tailored support some of those we spoke to referenced the need for services to be able to take account of things like cultural differences, neurodiversity and gender specific services, that tailored support to how different groups may experience gambling harms

Challenge: Services are not actively considering gambling in their future planning and delivery. With gambling not being a primary or urgent issue in their remit, it tends not to be included as part of their service planning and delivery. Some healthcare frontline service staff we spoke to noted that service planning at a high level did not always understand the importance of integrating gambling into planning or had not yet begun to incorporate it into their public service model. Others noted that in service planning, when something is freshly prioritised, it tends to mean that something else is deprioritised.

have received. Without this training and knowledge, it is plausible that Maya would remain unaware of the harms her daughter was experiencing and/or unable to find appropriate support.	

RECOMMENDATIONS

For health leaders

- **All Integrated Care Boards and Directors of Public Health should include a strand on gambling harms in their strategy.**
- **Questions on gambling should be included and/or automatically prompted in patient questionnaires** including those currently covering topics such as drugs, alcohol, and mental health.
- **There should be greater inclusion of behavioural addictions, including gambling, within medical and healthcare training programmes** - including undergraduate, postgraduate and continuing professional development programmes, supported by protected learning time.

For national government

- **NHS England and the Department of Health and Social Care should ensure there is adequate and accessible gambling treatment capacity nationwide.** While it is positive that more gambling harm clinics are being opened to meet rising levels of need, adequacy of this provision needs to be carefully monitored and additional capacity added, if necessary, particularly if improved screening goes on to identify additional need.
- **Councils should be legally mandated to address gambling related harm in their public health policies,** as they are required to do for alcohol related harm.
- **A national gambling database should be created**, to gather information on the number of people experiencing gambling harms, with clear approaches to data collection established to support national level planning and evaluation of interventions. The system should also seek to understand impacts on affected others, including family members and carers.
- **An "All Our Health" resource pack** (a suite of bite-sized resources and e-learning sessions for health and care professionals, with existing resources on both drugs and alcohol issues) **should be created for gambling.**

For local government

- **Data should be gathered by local authorities on local gambling activity and interventions**, to understand the extent of harmful gambling and support local level planning.
- **Gambling harms prevention should be embedded as a strategic local health priority,** to ensure a coordinated approach is taken within local government.

  Where they hold relevant levers, such as control of advertising on transport and public estate, Combined authorities should consider gambling harm alongside other public-health issues.

There is a considerable opportunity for those working across frontline services, communities, local government and healthcare to play a greater role in preventing, identifying and responding to gambling harms. Realising this opportunity will however require stronger leadership, greater workforce capability, improved coordination between services and a clearer population health approach at both national and local level.

For the health systems planners

All Integrated Care Boards should include gambling harms in their strategy

Each Integrated Care Board (ICB) will have different priorities, depending on the specific needs of the population they cover. However, there are some consistencies across all ICB strategies, including a focus on prevention, and reduction of alcohol related harms. The same approach should be taken towards gambling harms, and all ICBs should have an explicit gambling strand in their strategies. Doing so will improve the focus on gambling harms on a systems level, and should then facilitate improved coordination of services. From Spring 2027 it is the intention that all ICBs will be responsible for the full gambling harms treatment pathways, covering NHS and third sector commissioning, which should facilitate this further.

Directors of Public Health (DsPH) should also include gambling harms in their own, more local health strategies. DsPH can create more tailored and targeted strategies, that are aligned with the needs of the local population. Working with local government, they can also can help to ensure that strategies that focus on the wider determinants of health consider gambling in their design.

Questions on gambling should be included alongside those on drug, alcohol and mental health, in settings where these questions are asked

Questions on smoking, alcohol and substance use are standard procedure in certain, non-crisis settings, such as at GP registration, holistic health checks and social care visit. In GP registration for instance, questions such as “How often do you drink alcohol or have a drink containing alcohol?” and “How many units of alcohol do you drink on a typical day when you are drinking?” are included. These questions are optional, and not a requirement for registration with the GP. However, they are an important tool in helping to detect those at risk of alcohol harms. Similar questions may be asked when a patient attends a routine GP appointment through triage forms.

NICE recommends healthcare professionals and social care practitioners consider asking people about gambling when asking them about smoking, alcohol consumption or use of other substances.[82] We recommend that policy goes a step further. Questions on gambling should be included as standard on the “optional responses” section of GP registration. For routine GP appointments holistic health checks and social care visits, affirmative responses on questions relating to alcohol and substance use should automatically prompt questions on gambling. Questions on gambling should also be incorporated as standard, into mental health triage. This should help to identify both those experiencing and those at risk of gambling harms, earlier.

There should be greater inclusion of behavioural addictions, including gambling, in medical training programmes

Gambling is currently not included as standard in healthcare training programmes. GPs qualification training has a mandatory module concerning smoking, alcohol and substance misuse. Though there is a close relationship between gambling related harms and alcohol and substance misuse, gambling is not noted within the module in "common and important conditions".[83] Gambling is referred to in the mental health module of the curriculum, however this is not particularly detailed.

Gambling harms *can* be studied separately as part of Continuing Professional Development courses. However, this also means that undertaking the programme is at the discretion of the practitioner and depends on their own availability and ability to be able to undertake such courses. While some NHS trusts offer protected learning time, where staff can be guaranteed uninterrupted time to participate in training, it is by no means standard practice and can be pushed or deprioritised when service pressures are high.[84]

Including training on gambling harms in medical training, in the same way other non-communicable diseases are, would help to embed a deeper awareness and familiarity of the issue from an earlier stage, likely to allow for earlier identification of and support for those experiencing harms.

The NHS 10 year workforce plan recognised that protected time for learning is a core responsibility for employers, noting the importance of CPD and its continued funding. All NHS trusts should consider instituting and enshrining protected learning time for their staff. Those working in frontline services should be encouraged to undertake CPD or other training programmes that helps them to identify those experiencing gambling harms, and how to signpost them to appropriate supportive services.

For national government

NHS England and the Department of Health and Social Care should ensure there is adequate and accessible gambling treatment capacity nationwide.

Demand for gambling treatment has grown in recent years, which has lead the NHS to establish seven new gambling clinics, bringing the total up to 15. That the demand for greater support has been matched with new clinics is positive. There is also a good VCSE coverage, and, under new funding arrangements there is now ringfenced and discrete funding for the NHS and the voluntary sector. Which should help to support the demand for treatment. However, While, adequacy of provision needs to be carefully monitored and additional capacity added, if necessary, particularly if improved screening, as described above goes on to identify additional need.

Councils should be legally mandated to address gambling related harm in their public health policies

Councils have had a statutory responsibility for improving the health of their populations. They are also legally mandated to address alcohol and substance use dependency issues in their public health plans.[85] Other prescribed functions include

sexual health services, smoking cessation services and NHS health checks. Gambling prevention and treatment services, however, is not a prescribed function.

Many councils, as we have highlighted will have developed a gambling harms prevention strategy, as part of their broader public health and wellbeing goals. However it is possible that as it is not a prescribed function, it is not included in health planning as it may be deprioritised in favour of something more urgent, or similarly funding pressures means the programme gets cut. The introduction of the Statutory Gambling Levy however now means there is ring fenced funding available to local government, to address gambling related harms. With this dedicated funding, gambling harms prevention and treatment should become a prescribed function of local government, and alongside it, should have requirements to monitor harms prevalence and treatment need.

A national gambling database should be created

A national gambling database, would help to better understand the breadth and scale of gambling activity, gambling harms, and the success of treatment pathways. The Gambling Survey for Great Britain provides a good overall national picture of gambling behaviour, as well as the experiences of affected others, and should continue. However this data should also be supplemented and matched with data from each of the ICBs, that covers gambling harms as well as the number of people accessing gambling treatment services, both within the NHS and the third sector. This will help to give a fuller picture of the state of gambling harms on a national level, will provide opportunity for "what works" analysis and give clarity on where demand for services is highest, or may be increasing. It should therefore help to direct national level policy.

Taking learnings from the Swedish experience, to ensure there is consistency across the information received, the government should set out clear standards on how data should be collected. The database should be owned and maintained by the Gambling Commission.

For local government

Data should be gathered by local authorities on local gambling activity and interventions

As part of requiring local authorities to address gambling related harm, as mentioned above, local authorities should also be required to gather local level data on those experiencing or at risk of experiencing harms locally. A similar approach should be taken to what is currently in place for local alcohol harm measurement, with data gathered from local healthcare providers, as well as the VCSE sector, housing & education services, and local police. It should look to capture what treatment is being accessed locally, and the experiences of those affected. All data collection should abide by the national data collection requirements described above. Data can then be fed to the ICB and subsequently the Gambling Commission (via the national database) and used by the ICB to inform and develop national strategies. It can also be used by the local authority themselves to inform their own local policy and strategy on gambling harms prevention, identification and treatment.

Gambling harms prevention should be embedded as a strategic local health priority

Given the wide ranging harms that can be related to gambling, local level policymakers should make gambling harms prevention the lens through which they see other local level policy, beyond healthcare. Where they can they should coordinate action on gambling harm across health, debt advice, housing, policing and employment services

Council staff across drug and alcohol treatment, housing services, financial inclusion services and family and children's services are themselves frontline workers who may encounter people experiencing gambling harms regularly. However, as non-healthcare workers, these staff may be less aware of gambling harms and less familiar with how to identify them among people using their services.

Councils should, outline how council staff in frontline roles can play an important role in identifying those experiencing gambling harms, across their services. Councils should also provide training to their staff so that they are in a position to be able to identify someone experiencing gambling related harms, or an affected other. Being able to identify affected others is likely to be particularly important for council staff working within family and children's services.

Where devolution means local government has more power, such as with combined authorities, this should be leveraged. Combined authorities for example have control over their local transport network, and any subsequent advertising displayed on the transport network (e.g. on the sides of buses and in bus shelters), as well as on the public estate.

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