Problem Gambling in Leeds

Research Report for Leeds City Council

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FOREWORD

Leeds aspires to be the best city in the UK, one that is compassionate with a strong economy. As a thriving cosmopolitan city Leeds has a diverse gambling sector which for the majority of people is a safe, sociable and enjoyable leisure activity. However, we know that for some people gambling can be addictive and cause harm for both themselves and their families.

As one of the largest licensing authorities in the country we welcome this study into the prevalence of problem gambling in Leeds, which lifts the veil on an addiction which is often considered to be a 'hidden addiction'. This is because problem gambling issues are complex and are rarely the only difficulty that individuals face. This research has highlighted that although gambling related harm can impact on anyone at any time, there are groups of people and particularly those who are most vulnerable in society where the prevalence of problem gambling is more acute.

The findings of the study not only raise our understanding and awareness of the issue in the city, but crucially we hope that it will be the catalyst for action to better support those suffering from gambling related harm. Nationally the rates of problem gambling are less than 1% of the population, this study has delved deeper into the statistics and shows that problem gambling rates in large metropolitan areas are likely to be higher. This is perhaps unsurprising given the higher population density and increased availability of land based gambling. However, this does mean that as a City we need to better recognise the issue.

In 2016 the gambling industry in Great Britain is worth an estimated £12.6bn (total gross gambling yield). Annually around £7 million pounds is raised from voluntary contribution from the industry to help fund research, education and treatment services on gambling related harm across the country. I would encourage the industry to take note of the findings of this report and work with us to address problem gambling, as although gambling addiction is experienced by only a small minority of leisure gamblers, its impacts on lives and livelihoods can be devastating.

Leeds is a well-connected city, with many successful partnerships between the public, private and third sectors, and we are very fortunate to have well established and integrated organisations offering a wide range of advice and support to those in need. We need to harness the good practice to better integrate the support for people with gambling addictions. Leeds is a city that strives to be the best city in the UK, to help achieve this we need to use this research as a call for action to bring about real change in the way we deliver services and support individuals and families affected by this issue.

Councillor Debra Coupar
Executive Member for Communities

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Glossary of terms

Term	Explanation
Problem gambling	Problem gambling is defined as "gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits". In their Diagnostics and Statistics Manual 5 (DSM), the American Psychological Association classifies 'disordered gambling' as a behavioural addiction and it is classified as an impulse control disorder according to the International Classification of Diseases-10.
At risk gambling	At risk gambling is a term used to describe people who are experiencing some problems, difficulties or negative consequences from their gambling behaviour but who are not categorised as problem gamblers.
DSM-IV problem gambling screen	This is a set of questions which when taken together measures problem gambling. The questions are based on the clinical criteria set out in the American Psychological Association's Diagnostic and Statistics Manual (DSM) IV.
PGSI problem gambling screen	The Problem Gambling Severity Index (PGSI) is a set of nine questions which when taken together measures problem, moderate risk and low risk gambling. The questions measure common problems associated with gambling but also ask about the harms that gambling causes (such as harm to health).
BGPS 2010	The British Gambling Prevalence Survey (BGPS) 2010 was a national survey of gambling behaviour in Britain.
HSE 2012	The Health Survey for England (HSE) is an annual survey of the health and lifestyles of people living in England.
Co-morbidity	Co-morbidity describes the presence of one or more additional diseases or disorders which occurs alongside a primary disease or disorder. An example would be people who are problem gamblers also having other mental health conditions.

Executive summary

In May 2013, Leeds City Council (the Council) granted a licence to Global Gaming Ventures (GGV) to develop a large casino as part of the Victoria Gate development scheme in the city centre. This casino will be the fourth large casino in Britain, and it is expected to open later in 2016. Licensing followed a public consultation which raised some concerns that there may be an increase in the rates of problem gambling, and in April 2016 the Council commissioned a team from Leeds Beckett University (LBU) to conduct a study of the prevalence of problem gambling in Leeds.

The four-month study aimed to provide an in-depth understanding of problem gambling in Leeds, in order to guide the Council and partners in determining effective initiatives and support mechanisms to help citizens experiencing problems resulting from their gambling behaviour. The study, therefore, includes the following:

- a review of national evidence to assess the comparative position of Leeds

- national data on problem and at risk gambling

- detailed discussions with key stakeholders in Leeds; together with corporate and local managers of gambling operations in the city

- an analysis and review of support services (dedicated to problem gambling and more generic)

- and a small cross-section of interviews with Leeds-based leisure gamblers and gamblers in treatment

A full description of the methodology is provided in the main report and Annexes. Findings from across these different strands of research are summarised below and provided in detail within the report.

Gambling operations and problem gambling support in Leeds

Gambling opportunities in Leeds are widespread, mixing gambling, gaming and social and leisure activities in diverse and widely distributed premises. In summary, the research shows that:

- Gambling provision in Leeds is mature and highly competitive mixing social, leisure and mainstream gambling activities. Operators report spare capacity in many of the longer established premises due in part to oversupply of land-based establishments and online operators. Licensed operator numbers have seen long-standing contraction in some sectors and have fallen in all since 2013-14.

- Development in the last five years has seen some consolidation of the offer across the previously very differently focussed land-based segments i.e., casinos, bingo centres, licensed book-making offices (LBOs) and adult gaming centres (AGCs)

- Most of the recent developments, market and gambling trends in Leeds, are shared with other large metropolitan areas, and corporate managers, in particular, felt that there were few very distinctive features in the Leeds gambling market.

- Gaming machines, notably B3 category machines[1], together with the rise of multiple-accessed on-line gambling, have raised concerns in Leeds and elsewhere

The study suggests that GGV's development will be a major change in the gambling opportunities available, thus changing the gambling landscape of Leeds city centre. Current operators are concerned about increased competition from GGV but operators are also concerned about the impact of on-line offers and increased opportunities for remote access.

While the 'supply' side of gambling opportunities is well developed in Leeds, the study suggests that the provision for support services for those at risk of gambling related harm is under-developed and fragmented. The study shows:

- Leeds has a plethora of services and at least 13 different suppliers able to provide some advice and guidance. The services cut across generic advisory services, specialist addictions and recovery services and a single supplier of gambling specialist services – NECA[2] working as the GamCare[3] support agent for Leeds

- Many of these services have some exposure to clients affected by gambling related harm, usually when co-morbid[4] with more mainstream demands on debt management, alcohol or drug addiction and recovery support. Most service agencies are keen to offer further help but universally lack any screening or assessment tools which can distinguish gambling related harm; unless self-declared by clients, which remains uncommon

- With a few exceptions these services are not connected, cross-referral pathways (for problem gamblers) are at best informal and those 'in need' held back by a lack of understanding about 'who does what?' and capacity constraints

- NECA is the sole agent at present for specialist support to identified problem gamblers, focussing on integrative counselling geared at (largely) self-referred clients and with referral pathways mostly linked to the GamCare national helpline (also the major focus for external signposting to help by the industry). Funded by GamCare through the Responsible Gambling Trust (RGT) NECA has been operating in Leeds since 2008 but with extending waiting lists (4-6 weeks) capacity falls short of need. Actions to increase capacity have so far had no effect on shortening waiting lists[5].

The study concludes that although providing valuable support to some gamblers, NECA operates in almost total isolation in Leeds. Waiting lists are well above GamCare expectations of responsiveness, and act as a brake on NECA profile raising and relationship building with other Leeds agencies.

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[1] Machine categorisation and stake/prize limitations vary across machine types (A, B1-4, C and D and Appendix to Annex B) and by operator licence. For further details see: http://www.gamblingcommission.gov.uk/Gambling-sectors/Gaming-machines/About-gaming-machines/Gaming-machine-categories/Gaming-machine-categories.aspx

[2] NECA are the largest regional charity in Britain working in substance use/misuse; established in 1974 as the North East Council on Alcoholism it now works across drugs and solvents and other abuse and addictions.

[3] In addition to GamCare's nationally accessed helpline and Netline (and on-line Fora) they have a network of 11 'agents', of which NECA is one, providing support in specific localities and regions through Great Britain together with two foreign language support services (Chinese and Turkish).

[4] Two or more disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as co-morbid and See Glossary of Terms

[5] Update- subsequent to the completion of the research there has been some movement on waiting times as part of an ongoing review of service provision in Leeds

Gambling behaviour and vulnerable groups

The study has shown how gambling behaviour, and problem gambling, are not equally distributed across England. Rates are higher across Britain for those living in more Northern areas (and London), major urban areas, urban areas which are more densely populated, English Metropolitan boroughs, London boroughs, those living in wards classified as industrial, traditional manufacturing, prosperous and multi-cultural. The study shows many of these higher prevalence areas describe the Leeds Metropolitan District, and strongly suggests rates of problem gambling in Leeds should be expected to be higher than national averages. More specifically the research shows:

- Our estimate (from aggregated national data) shows problem gambling rates in Leeds and areas like Leeds are broadly twice the national average. This is consistent across all three ways to measure problem gambling

- A similar analysis of rates of at risk gambling (nationally about five times the level of problem gambling) for Leeds and areas like Leeds appear to be broadly similar to national estimates (5%-6%)

- Overall, the study suggests an aggregate measure of 7-8 per cent of people in Leeds and areas like Leeds are either problem or at risk gamblers. This is slightly higher than the national average of c.5-6%

These estimates are based on the most up to date available national survey. However, this is itself over four years old and we encourage the Council to take advantage of new (2015) data likely to be available in 2017 to *sense check* these estimates.

Problem gambling in Britain

The national evidence shows that problem gambling can affect anyone at any time. Nonetheless, rates of problem gambling among all adults in Britain tends to be low although there are some groups who are more likely to experience problems. At risk 'vulnerable' groups include:

- Younger people (including students)

- Adults living in constrained economic circumstances; particularly, those on very low incomes and benefits

- People from certain minority ethnic groups

- Homeless people and those living in areas of greater deprivation

- Adults with mental health issues and substance abuse/misuse disorders

- People with poorer intellectual functioning and learning disabilities

- Offenders and ex-offenders, (including those on probation and some custodial circumstances)

- Immigrants

The groups listed above are also more likely to be vulnerable to debt and other problems, although little is known about why these groups are more vulnerable. However, the study

suggests the Council is well placed to work with many of these groupings to assess local challenges through its existing relationships with support and community groups.

Views and perspectives on problem gambling and support services in Leeds

The views from 21 organisations across the statutory, charitable and voluntary sectors (referred to as stakeholders) were invited to contribute to the research, with 17 organisations being able to do so. Not all local stakeholders engaged in the study had direct experience of helping individuals with gambling problems within their mainstream client interest, but all stated that they would be able to provide assistance; although sometimes limited to signposting or referral to more specialist help. The study also shows:

- All of the stakeholders reported difficulties in accurately identifying problem gamblers among their mainstream client groupings. This was due to low levels of self-reporting, and what some regarded as avoidance or shame about the causes of gambling related harms such as debt and/or relationship breakdown

- All the interviewed stakeholders also lacked assessment or screening tools which could objectively assess problem or at risk gambling behaviours and associated recording deficiencies within their organisations. However, some were open to trialling such tools as part of a more integrative approach to help with wider social problems and to tackling challenges of co-morbid behaviours including problem gambling

- Where stakeholders were engaged with (self-declared) problem gamblers, support was found to be centred on the first issue presented or issues related to their gambling behaviour (e.g. debt, family, health issues). This was notably the case among diverse local agencies working with the homeless and emerging communities

- Dedicated support for problem and at risk gambling in Leeds was seen to lag behind the otherwise comprehensive and integrated approach taken in the city to address (other) addiction issues, poverty and homelessness. Many were unaware of the NECA service, those that were, reported few or no working relationships in contrast to cross-agency working in other areas.

Stakeholders nonetheless felt the experience of collaboration and referral across agencies of other addiction and social issues support provided a good foundation on which to develop more integrated support for problem gambling.

Residents' experiences of problem gambling

The study was supplemented by a small cross-section of interviews with problem gamblers, those at risk and others post-treatment, drawn from a range of activities and circumstances. Experiences were, inevitably, one sided, and focussed on the nature of problem gambling seen from gamblers perspectives and did not seek to look at the extensive social and leisure value gained from those who gamble in a responsible and sustainable manner. These in-depth profiles, exploring behaviours and experiences of harm on a one to one basis provided a number of common themes:

- Three in four participants interviewed started gambling early; often very early having been socialised into gambling environments and practice through other family

members who gambled. This is similar to wider research demonstrating the *family legacy affect* where children exposed to gambling early in life take-up gambling independently in later life. Some of the participants of this study first gambled, using their own money, when under the legal age for gambling

- Participants typically engaged in different gambling activities during their lifetime; although the diversity of gambling experiences was not necessarily an indicator of the levels of harm experienced. For many this diversity was a feature of current behaviours with multiple engagement often across different segments of the land-based gambling market; combining online gambling with land-based operations was common place

- Motivations to gamble were highly varied. Social factors and socialising were important common influences, intensification of other interests were also involved (e.g. betting on sporting events) and, for some, escaping boredom. Some also regarded city centre 'social' gambling as a safe and inexpensive leisure activity

- Impacts of problem gambling across the participants, and those around them, were equally diverse but also relative. Losses were funded through overdrafts, family loans and informal borrowing, and, for one individual, a loan shark

- Gambling behaviour commonly affected relationships amongst friends and family, and for some was seen to have underpinned relationship breakdowns. Some of the participants reported health and wellbeing impacts, often with depression associated with an inability to cope, anxiety and shame

Some of these gamblers felt that more could be done locally and nationally to improve support for gamblers; including more intensive or accessible Gamble Responsibly notification in venues and on line, notifications and advice sheets in different languages, 24hour free Help-lines, television advertisements about the downsides of gambling, and machine and on-line 'pop-ups' for time and money spent. Some called for a more robust self-exclusion mechanism which accommodated all AGCs and casinos (betting shops were not mentioned) so that a single branch exclusion affected all premises. Among those who had experience of treatment and specialist counselling it was felt that a more flexible approach, and aftercare, would better support those with more intensive needs with the option for more counselling sessions.

Issues and implications for the Council

The research proposes a number of areas for the Council and partners to underpin harm minimisation in Leeds focused on: better information to help with targeting of actions; raising awareness both among professionals and at risk gamblers; and increasing support capacity(s) within a more integrated system alongside actions to increase co-operation and partnership working. More specifically it suggests:

Data Collection

- Action to build comparative data collation from 'first contact' assessment data drawn from local agencies

- Action to encourage collection of more systematic and reliable information on client distribution, behaviours and harms on problem gamblers from NECA

- A project aimed at building a more differentiated needs assessment focused on level of need, advice 'supply' and accessibility, and any distinctive behaviours or harms affecting vulnerable groupings

Support

- Action to increase capacity and responsiveness of specialist support including NECA (and/or others) to bring waiting lists down to under 10 days

- Action to make more effective use of the existing (or enhanced) capacity to NECA through fast track initial assessment (and referral) mechanisms

- Action (and capacity) by NECA to work within this strategy to support and sustain pro-activity with a wider network of support agencies (and possibly operators)

Co-operation

- Action through a co-ordinated working group to raise agency and professional awareness across Leeds-based generic and other addiction support agencies

- Co-operation across Leeds agencies to provide for materials and appropriate pathways to raise awareness among those at risk

- Increase collaboration and co-operation between Leeds support agencies, including NECA, to optimise opportunities for early identification and referral

We have also identified the potential for some of these developments to be supported by RGT perhaps as pilot or trial actions within their new five year harm minimisation and treatment strategy nationally. We see these proposed actions as part of a co-ordinated campaign to harm minimisation in Leeds, and where successful action would place Leeds at the forefront of development for integrated local solutions which might be transferable to other similar localities.

1   Introduction

1.1   The study

In April 2016, Leeds City Council (the Council) commissioned a team from Leeds Beckett University to investigate problem gambling in Leeds.

The four-month study aimed to provide an in-depth understanding of problem gambling in the city so that the Council could be in an informed position of the issue prior to the new large casino by Global Gaming Ventures (GGV) opening in late 2016. The research was also expected to be used to guide future funding of projects to mitigate the harmful effects of problem gambling. This report draws together the findings of the different strands of the research.

1.2   Background

The 2005 Gambling Act allowed for the development of up to 16 casinos across England, Scotland and Wales; eight of these were anticipated to be large casinos[6]. Following approval by Parliament in April 2008, the Council was awarded the right to issue a single large casino licence as one of the eight anticipated in the Act. In May 2013, following a two stage process; that attracted five bidders at Stage 2, the Council awarded the large casino licence to GGV.

The new casino adds to a range of existing land-based gambling services in Leeds, including smaller casinos. It is intended to open in Leeds late in 2016. It will be the fourth large casino in operation in the UK and the first north of the River Trent. The Leeds casino will be located within a mixed use shopping and leisure scheme, a common feature for the other three large casinos in operation. In Leeds the large casino will be part of the Victoria Gate retail and leisure complex, with the casino open 24 hours each day and expected to employ around 270 staff.

GGV have committed to undertaking, and monitoring, the benefits from the casino opening, including skills training and environmental commitments. They have also committed to steps to mitigate problem gambling including contributing to the *Social Inclusion Fund* (SIF)[7]. SIF funds will support projects and initiatives to the Leeds anti-poverty agenda including activities that proactively support financial and economic inclusion. It is expected that SIF funds (for the duration of the licence) will continue to be used to fund initiatives that achieve social, financial and economic inclusion priorities, and also activities that mitigate potential harmful social effects of gambling.

Prior to granting the licence, the Council carefully considered the relative merits of the proposed development. This included a public consultation which documented a range of concerns from Leeds communities and businesses. The consultation concerns centred on risk to increasing problem gambling, debt levels, and wider impacts thought to be associated with harm from gambling such as increased alcohol consumption, issues with family cohesion, domestic violence and mental health issues. The current study aims to provide an evidence

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[6] A large casino provided for up to 150 gaming machines to be held on site; small casino allowed up to 80 gaming machines.
[7] Early funding comprised an upfront payment prior to opening and this will be followed by an annual payment after the casino opens of £450,000 or 4% of net gaming revenue.

base for better understanding some of these challenges locally, and how they might be mitigated. In addition, GGV have agreed to independent monitoring[8] and evaluation of the impact of the new casino, including risks and benefits, and this study will provide a starting point for providing baseline data to support that activity.

1.3   Looking at 'harm' and 'problem gambling'

The focus of this study has been on the nature and prevalence of 'problem gambling' in Leeds. Problem gambling is defined as "gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits". Even when defined this way, the term 'problem gambling', is in fact not without its difficulties and needs careful explanation. The licensing objectives for gambling premises, emerging from the 2005 Gambling Act, call for vulnerable people to be protected from harm from gambling, not to be protected from problem gambling. This is an important distinction. Some people may experience harm from their gambling that is short lived, or episodic, or correspondingly they may experience harm whilst not considered to be 'problem gamblers'. At the same time, some people who do not gamble or who do so responsibly and sustainably may experience harm because of the consequences of the gambling behaviour of others.

In short, the concept of *gambling related harm* is broader than that of *problem gambling*. There is an increasing expectation that policy makers (nationally and locally), industry regulators and operators in the industry consider this broader perspective and develop strategies to mitigate gambling related harm.

These issues of terminology are important to this study; but our main concern is not with the underpinning concepts but with understanding and measurement in the specific context of 'problem' gambling behaviours and consequences in Leeds. Problem gambling has had its fair share of methodological debate about measurement and there are now a number of widely accepted approaches to measurement usually based on behavioural and attitudinal psycho-metric screening.

In contrast, there is no assessment of how many people in Britain are likely to be experiencing harm from gambling although it is very likely to be significantly higher than the estimated number of problem gamblers. The nature and extent of gambling related harms have not been quantified and there are no accepted standard measures. However, the nearest approximation to harm is consideration of those who are *at risk* of gambling problems where screening tools are more useful. At risk generally refers to people who are experiencing some difficulties with their gambling behaviour but are not considered to be problem gamblers.

These terms, and the approaches to measurement (and their limitations) are looked at in more detail later in the report.

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[8] These proposals include establishing a robust system to monitoring, manage and mitigate social and health risks from problem gambling.

1.4   Aim, objectives and focus of the study

The overall aim of the study has been:

"… to ensure the Council is in an informed position to discuss the needs of those struggling with problem gambling, ensure support services are resourced and targeted towards those most in need and to work with GGV in mitigating any harmful effects of the Casino" (LCC, Research Brief, March 2016)

More specific objectives have been to:

- Establish the prevalence of problem gambling in the City

- Assess how problem gambling impacts on the lives of the people in Leeds

- Provide evidence to set a baseline for future monitoring and evaluation of the social and health impacts of the large casino

- Provide evidence to support the Council in targeting the Social Inclusion Fund at priorities and projects to mitigate the harmful effects of problem gambling in the city

As the third bullet point above states, a key objective of this research was to provide evidence to establish a baseline for the future monitoring and evaluation of the social and health impacts of the large casino. This was a desired outcome related to the terms of the licensing agreement between the Council and GGV in 2013.

However, subsequent discussions between the Council, GGV and the Leeds Becket University considered that this particular focus, although specifically referenced in the agreed terms of the licence, was too narrow a focus in the context of the wider gambling market across the whole of Leeds. It was mutually acknowledged that the monitoring process going forward should develop a much broader reach and consider potential issues associated with problem gambling irrespective of the particular type of gambling establishment. Set in this context the findings of this study offer an excellent opportunity to evaluate the current landscape across the city and to guide the Council and partners in determining effective initiatives and support mechanisms to help citizens experiencing problems resulting from their gambling behaviour.

A detailed specification and timetable to guide the project and its proposed outputs was developed by the Council (see Annex A). The focus of the research has been expected to be on the city, and specifically the Council's administrative area, but taking account of the effects of problem gambling on residents and communities. To position the evidence and experiences emerging from Leeds itself, the research has taken some account of wider evidence from across the UK to set the situation from Leeds in context.

1.5   The research approach

To achieve these objectives, a range of different research approaches were used and the study was split into five 'work packages'. These 'work packages' were set out by the Council in the study specification (see Annex A). They aimed to explore:

- The number and demographical representation of problem gamblers in Leeds

- The profile of problem gamblers and especially in how and where they gamble

- The factors that make people vulnerable to problem gambling

- The wider impacts of problem gambling on individuals, families and communities

- The current services and support methods available to problem gamblers, including how they are accessed, their capacity and their effectiveness

The LBU research team recognised the substantial challenges of providing timely evidence to meet these needs. Insight from existing national surveys, provided little local level understanding into gambling behaviour. New data through a large scale city-wide survey was beyond the scope of the planned study and also presented insurmountable challenges within the time frame.

The focus of the study agreed with the Council and the project steering group has instead centred on combining quantitative and qualitative approaches through a number of inter-related stages including:

- Review and assessment of available demographic, licensing and other scoping data including implications for the approach to harnessing the British Gambling Prevalence Survey (BGPS) and Health Survey England (HSE) data

- Collation and manipulation of BGPS and HSE data to provide baseline evidence of problem gambling and at risk prevalence in Leeds and how this relates to a small agreed number of similar localities[9]

- Interviews and liaison with key national agencies and sector bodies and at corporate level within the gambling sector (predominantly to secure access to local operators and for 'gambler' recruitment)

- Conduct of a Quick Scoping Review (QSR[10]) to update and extend available national evidence of the nature and characteristics of problem gambling in the UK and to provide a context against which to set the Leeds specific evidence

- Conduct of series of multi-agency and stakeholder interviews across a wider range of local government and related services, community, faith group and voluntary sector interests in and related to the City

- Conduct in depth interviews with a small cross-section of gambling operators in Leeds to explore their experiences of problem gambling and its impacts, and local support services and to arrange access for recruitment of gamblers

- Recruit gamblers in Leeds to take part in in-depth interviews about their gambling behaviour and the impacts it has. This included a short, first stage interview to identify those eligible for inclusion (i.e., potential problem and at risk gamblers) (through screening tools) and a second stage in-depth interview

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[9] Comparator areas were identified from the review of demographic and other data shared by the Council, and put together in a briefing paper for the Council from which specific selections were made and agreed with the Council
[10] QSRs are recommended by the Government Social Research Office to rapidly assess the range of studies available on a specific topic and produce a broad 'map' of the existing literature. As here, these use a constrained search strategy (using fewer bibliographic sources and typically focusing on those available electronically) and/or focus on a limited range of issues.

- Identification and review of locally available support services for problem gamblers and those at risk including devolved GamCare counselling and other harm minimisation advice and guidance services available to gamblers in the city

Full details of this intensive and multi-layered methodology; together with details of the organisations have been engaged in research project, are set out in Annex B.

1.6   The report

The report findings are documented into seven chapters, each drawing on the major evidence sources, and which following this introductory chapter look at:

- An overview of gambling operations and support services in Leeds providing a brief 'supply-side' assessment of different gambling operations and developments in Leeds. This combines operator and licensing data, and wider stakeholder feedback and perspectives (Chapter 2)

- An updated national review of the wider evidence relating to problem gambling in Britain and who is at greater risk of experiencing problems (Chapter 3)

- An assessment of problem gambling prevalence in Leeds to provide a data-based assessment on the comparative scale and distribution of problem gambling and at risk behaviours (Chapter 4)

- Local stakeholder perspectives on problem gambling, risk of gambling related harm and its impacts drawn from engaged agencies. (Chapter 5)

- Perspectives from gamblers in Leeds about their experiences of problem gambling, behaviours and impacts, support services and mitigation (Chapter 6)

- Issue and implications, including conclusions drawn across the evidence sources and recommendations (Chapter 7)

The structure of this report has been agreed with the Council to make best use of the multiple sources of evidence, and to draw this together into a cross-cutting assessment of the Councils main study objectives.

Supporting annexes have also been provided on: The research brief for the study and terms of reference (Annex A); The research approach and stakeholder engagement (Annex B); Comparative data approach (Annex C); Reporting and analysis conventions used in the data analysis (Annex D), Problem gambling by area type tables (Annex E); Participant profile following Interviews (Annex F) and Gambler suggestions for improvement of support and services (Annex G). A short glossary of key terms is also included on page vii and a reference of key texts cited in the report can be found on page 140.

2   Gambling operations in Leeds

2.1   Introduction

This chapter looks at the 'supply' side of gambling activity and support services in Leeds. It draws evidence from licensing records, data from the Association of British Bookmakers (ABB)

and sector-based operator and agency insight, together with selected interviews with local gambling operators and those supplying advice and guidance services for problem gamblers and those at risk; to look at:

- Gambling operations in Leeds

- Gambling activity trends in Leeds

- GGV and other prospective gambling developments across Leeds

- Support services for problem gamblers and those at risk in Leeds

It also looks at distinctive features of gambling operations and support services in Leeds to provide a forward looking assessment of developments. The analysis is provided as a reference point for the evidence which follows (Chapters 3-6) on gambling prevalence, problem and at risk gambling and support services locally. It draws on licencing, industry (some) operator data and extensive interviews (often with multiple staff) in six sector bodies, five corporates and six local operators (see Annex B for details).

2.2   Gambling operations in Leeds

Since the turn of the century, successive governments have viewed gambling as a valid recreational choice, a view enshrined within the Gambling Act, 2005. As a result of those and earlier developments, Great Britain has one of the most diverse and accessible gambling markets in the world. Gambling opportunities exist on nearly every high street, often from multiple operators, and are freely available online.

In Leeds, the 'supply' of 'land-based' gambling operators and opportunities reflects these wider characteristics and has been well documented through local licensing data[11]. This analysis takes account of these local data but aims to go further to provide a 'supply' back drop for the study which also takes into account feedback from (selected) operators and stakeholders.

Any contemporary review of gambling supply must take account of what can be mapped, and its limitations, and what cannot be. In particular, it involves the distinction between land-based 'conventional' operators of gaming and gambling (usually in fixed site premises or at licenced external venues such as horse and dog racing courses), and an increasingly diverse offer of online gambling services through 'remote' operations in the UK and globally. The distinction is not always easy to make in practice.

In particular, the gambling sector has seen increasing consolidation of the 'land-based' and 'online' offer, although the ability of existing licenced gambling operators and organisations to move into online gambling depends on (essentially) national regulation and market positioning. In Leeds, as in other metropolitan areas, consolidation has included dedicated terminal access to branded web-based online gambling in some licensed premises. The study

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[11] The council have already developed an interactive GIS map of these data for different licensing categories to local authority and ward areas for Leeds and made these available to operators for Local Area Risk Assessments. See: www.Tinyurl.com/LeedsMappingTool

has taken account of local development in consolidated supply (below) but has not attempted to map online usage or remote provision as 'supply' is not specific to Leeds.

Land based gambling supply in Leeds operates in a dynamic market environment, at present, the Council administrative area includes licences for:

- 106 licensed branches[12] of LBOs across six organisations
- 16 adult gaming centres
- 6 casinos
- 5 bingo halls
- 1 horse racing track

The 6 casino licences are situated across five sites but two are not currently operating:

- Grovesnor Westgate operates two licences in the same building

- Alea ceased operating in 2014 and the premises has been converted to other uses

- GGV Victoria Gate is under construction.

Grovesnor Leeds Arena is also expected to cease trading in autumn 2016. This will mean that only two casino sites (with 3 licences) will be in operation before the GGV Victoria Gate opens.

Figure 2.1 shows the distribution of the licensed gambling premises in Leeds. The Figure emphasises the accessibility and retail opportunities available in the city centre, however, there is a much wider dispersion of licensed betting offices (LBOs).

Figure 2.1 Distribution of licensed gambling premises in Leeds
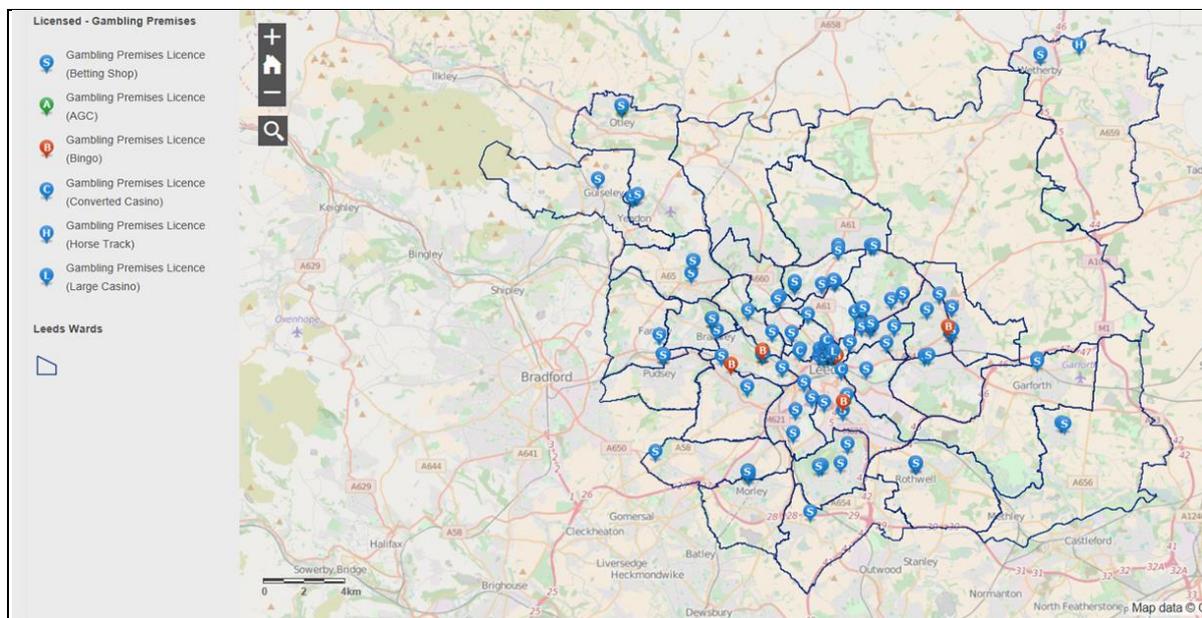
Source: Leeds City Council, Licensing data, 2015

Other venues emphasise essentially larger and non-localised catchments often with (near) city centre locations close to retail thoroughfares and key transport hubs such as Victoria Gate

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[12] Association of British Bookmakers (ABB) data shows 104 separate betting shops in the local authority area although this reflects differences in classification.

and Kirkgate Market areas and the central bus station. In a competitive market within and across the different operator segments, this central Leeds location was important in providing for a sufficiently wide catchment.

Licensing data shows how this current picture has changed over a particularly dynamic period for gambling operators (and for gamblers). Table 2.1 shows licensing trends since 2008 and with recent (half year) data for 2016, it suggests that land-based premises reached their peak earlier in this decade.

Table 2.1: Number of licensed gambling premises in Leeds, 2007-2016 (at 1 Sept each year)

Type of licence	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Bingo	8	5	6	5	7	8	5	5	5	5
Family Ent. Centre	-	1	1	1	-	-	-	-	-	-
Adult Gaming Centre	23	24	25	22	16	17	18	18	16	16
Large Casino**	-	-	-	-	-	-	-	-	-	1
Other casino	5	5	4	4	4	5	5	5	5	5
LBOs	98	99	101	105	102	104	107	108	107	106
Betting (race) tracks	2	2	3	3	3	2	2	2	1	1

* Current at 1 July 2016
** Under the terms of the 2005 Act
Source: Leeds City Council, July 2016

The data suggests some contraction in bingo establishments but this can be largely accounted for by cross-sector licencing data issues. However, in terms of retained demand from customers, Leeds operators report some shrinkage, in line with national data, which is seen as a mixture of shrinkage in the traditional customer base, inter-sector competitiveness and the impact of anti-smoking legislation. There has been contraction in AGCs from an earlier peak in Leeds in 2009. In contrast, the number of premises for casinos has been remarkably stable and has accommodated the effects of intra-sector merges. The numbers of LBOs has risen slightly to a recent peak in 2014 and has been relatively stable since, although corporate interviews suggested this is likely to fall with the effect of likely intra-sector merges in the near future and with 2015 as a probable peak in distribution.

Casino provision has reduced since 2007 but the numbers of casino licences has remained relatively static. A casino at Moortown, outside of the city centre was moved to its current location as part of Grosvenor Arena site in 2009 (due to close in September 2016). Alea ceased trading in 2014 (opened 2008). In the near future, it is unlikely that any casino licence will be surrendered as they are controlled in number, and the Council are not able to issue any more licences. The current holders are expected to maintain the existing licences by paying the annual fee every year so that it has the potential to be capitalised by transfer to another site/operator.

City centre locations have fared rather better over this period. Interviews suggested they were more resilient to erosion in demand related to wider socio-demographic changes, and/or competition especially from the accessibility of 'at home' on-line gambling services and products. These locations provided their own localised competition with some concern that the cluster of bingo, casino and AGC operators in and around the Kirkgate Market area were sharing some similar segments of the market. This, together with the reported loss of economic vibrancy in that area to retail locations such as the Trinity shopping centre, had created more acute competition challenges for city centre locations. More specific (summarised) evidence for the main sub-sectors in Leeds showed:

- **Casinos**: These were the largest gambling establishments, with a more diverse offer, and a footfall across all three venues averaging 9,100 a week in the last year (2015) although varying with seasons[13]. Venues were operating predominantly through client personal 'account-based' play. Interviews covering three existing casinos (operating under the 1968 Licence Act) confirmed these to have a maximum of 20 B1-3 gambling terminals. The exception was Grosvenor Leeds Arena (due to close in September 2016) which also held a supplementary (second) licence although operating on a reduced capacity with 10 further terminals/machines (predominantly B1 rather than B3[14] machines) on that licence. As a result Grosvenor Leeds Arena has a total of 30 B1-3 machines and aggregate capacity in these three casinos is consequently less than is currently anticipated in the single new GGV casino when fully developed (an estimated 140 machines).

- **Bingo**: The Leeds venues are mainly medium to large scale providers for the sector, typically with a footfall of around 2,000 a week each (reported to be up to 3,500 in the largest centre) although with considerable variability in daily peaks and troughs. Interviewed operators described their services as continuing to focus on " …the soft side of gambling" with a leisure social focus for the large majority of players, long duration of average visits (typically 2-3 hour sessions) and low net spend. Footfall includes repeat visits which is a significant feature for member-based establishments with a substantial social draw among established customers (up to 10-12 sessions a week for the more dedicated members). Rising investments in machine based play and changing products enabling multiple play have seen the three retained Leeds providers reverse early reductions in demand (approx. 1 to 2 % decline in footfall a year).

- **Licensed book making offices (LBOs):** This was the most extensive range of provision in Leeds, with operators offering increasing diversity in traditional placed betting and machine based play including for some, online terminals. Several corporates are active in Leeds but two of these account for the great majority of all LBO licences (William Hill and BetFred). Feedback from the interviewed (selected) LBO managers confirmed intensive and short duration visits by customers (an average session of 9.5 minutes across Leeds branches) and moderate spend (and average

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[13] This includes repeat visits but at a lower level than for other gambling venues with an estimate from Grosvenor of 7,500 unique visits across all three sites per week.

[14] Machine categorisation and stake/prize limitations vary across machine types (A, B1-4, C and D and Appendix to Annex B) and by operator licence. For further details see: http://www.gamblingcommission.gov.uk/Gambling-sectors/Gaming-machines/About-gaming-machines/Gaming-machine-categories/Gaming-machine-categories.aspx

across Leeds of £6.87 losses per session). Interviewed corporate managers (Coral, Ladbrokes and William Hill) suggested that individual operators' experiences reflected the wider Association of British Book-keepers (ABB) data but did sense that socialisation was a feature of some of the branches in more deprived communities. The Lincoln Green and Harehills areas of Leeds were singled out by one voluntary sector stakeholder as having a lack of social spaces and support for emerging communities, here the combination of chemists, Cash Converters, and pubs provided for social interactions in which LBOs were a part.

- **Adult Gaming Centres (AGCs)**: These centres have seen great market turbulence in the last decade, addressed by moves (as with Leeds Bingo Halls) by some towards a more service orientated environment to better compete with offers elsewhere in the sector. Typically, footfall at AGC venues is much lower than for Casinos and Bingo Halls, typically at 200-300 a week (including repeat visits), but also characterised as longer stays (reported as typically 2-3 hours, although shorter for category B3 machines). AGCs have also seen significant machine investments with a focus on B3 as well as the more traditional C and category D machines. Gambling in AGCs still emphasises anonymous playing set against the importance of membership and account-based play elsewhere in parts of the sector. According to managers, footfall is dominated by social and leisure use (especially with category D machines) with one manager reporting (for some players):

  "… [they] come in for the social environment and stay, stretching out a small amount of money on 10p stakes … for some mixing with other regulars and our staff may be the only social environment they have".

AGCs relied almost wholly on autonomous play and were less data rich. Most of the interviewed operators were able to share broad data on footfall but not more detailed information (e.g. breakdown by demographics or product) which was seen as commercially sensitive in a highly competitive environment.

To this provision Lottery play needs to be added as this was mentioned by some stakeholders as a significant feature of gambling for some communities in Leeds. There are multiple lottery operators, but outside the many in the charitable sector few are Leeds specific and localised specific data were not available. Reports from faith groups and hostels suggested that scratch cards were a particular feature, one going so far as to describe their use as a " ... massive problem" for some users. Another noted with concern that:

"A lot of people we see who are on benefits or low-incomes are spending a good percentage of their income on scratch cards".

2.3 Gambling activity trends in Leeds

Gambling in Great Britain operates in an increasingly dynamic and consolidating operator market. This dynamic is evident in Leeds, although apparently sharing many of the same features of restructuring and reorganisation as gambling supply in other large metropolitan areas. More specifically, the interviews (see Annex B) showed:

- **Casinos**: Existing operators reported operating in a now stable market in Leeds with no major changes in the level of demand in the last few years. Other than the closure of the Alea site in 2014, the last significant development was in 2013 when Grosvenor

rebranded the Leeds Westgate casino following the Gala takeover. One manager reported the marketplace in terms of gambling characteristics, play and admissions to have been: *"… pretty static for a number of years"*. A reluctance to share casino specific data made it difficult to corroborate but one offered the view that he had managed three other sites in other large metropolitan locations and found it similarly static since 2010 in each. Casinos offer a service intensive environment which was felt to be increasing its appeal to women who now made up just under a third of players at one of the interviewed Leeds sites. Managers felt that the entry security controls and on-site security staff meant that younger women in particular saw the casino as: *"… a safe environment for a night out"*. Spare capacity was reported for two of the three Casinos operating on their standard opening hours. One manager reported that any expansion of business hours was not commercially viable as: *"… the marketplace seems to have reached saturation point"*.

- **Bingo**: Bingo clubs in Great Britain have seen a long standing decline in number of clubs and admissions. While numbers of establishments overall (allowing for cross-sector licensing complications) has remained stable in Leeds, admissions have fallen although with signs of recent stability (Table 2.1 above). While data varies, the number of clubs nationally has fallen by around a quarter (24%) in the last two decades and data from the Gambling Commission shows this continues due to a combination of circumstances but also including some industry consolidation. Admissions decline accelerated with introduction of (non) smoking legislation in 2007 and nationally have continued fall but at a slower rate in recent years (approx. 1 to 2% pa). The Leeds venues are reported to be operating below capacity with one reporting this to be a little over a quarter (25-30%). In part, this reflects the longer opening hours, at peak periods one venue has introduced a machine reservation system to reflect this. Managers also reported that in Leeds the introduction of electronic bingo terminals, which people can use to play conventional bingo games but also fruit machine-style content has been "*the saving of UK bingo halls*". This venue now has 105 new 'Max' play machines providing for multiple ticket playing which are thought to account largely for a small increase in annual operating turnover.

- **LBOs**: The most significant reported change to activity affecting LBOs across Leeds was the investment, and use of, machine based play. ABB data isolated for the Leeds Metropolitan District shows an average of 3.9 B2/B3 terminals in each branch (March 2016), close to the regulatory maximum of four terminals per venue. Data also suggest that across these branches B2 play has dominated (by spend) and now accounts for 70% of machine-based spend across the Leeds area. Interviews with local and corporate managers confirmed the rising significance of machine based play to operations. However, while average duration of play on B2/3 terminals at bingo and AGC venues is longer, in LBOs it conforms to the established pattern of short sessions of typically of less than 5 -15 minutes.

- **AGCs**: Venues have seen substantial adaptation in the last five years in particular with corporate restructuring looking to move the venues and appeal away from what one called the old *"… down at heel, nerdy, amusement and gaming"* image. Success in recasting away from pure amusements and low volume gaming is seen as *'variable'* but emphasises a more service-led environment aiming for: *"… a nicer environment to encourage people to stay and play"* and to support a wider appeal, including drop-in visits and a wider demographic. In Leeds (as with other large metropolitan environments) this has seen the development of AGC as mixed gambling and gaming activity venues with a greatly expanded gaming (C and D machine) offer and

investment also in B3 machines. Changes to the AGC offer have increasingly brought some overlap with Bingo and Casino operators and in particular through the B3 machines which is seen to have:

"… a pretty individual customer base, different from the C and D [machine] players, and overlapping with the machines in casinos and bingo … it's a small but important core [of B3 players betting on up to £50 a session".

A feature of these activity trends, led largely by the responses of the different corporate segments to competition and machine-based play has been some reduction in the distinctiveness of operator offer. Evidence from operators suggests that in Leeds, LBOs, Bingo halls and AGCs retain distinctive features in play and customer base, but with increasing overlap, especially in city centre locations, around the use of B3 machines. B3 playing transcends different sectors with some reported "cross-over" between Casinos, bingo and AGC for particular (usually small and niche) client groups.

This effect seems to trouble LBOs less but at least in part because branches are more widely dispersed. Managers' report that the people in the aforementioned "cross-over" group, in the main, are B3 players who may interact less (or not all) with other gambling and gaming offers. An AGC manager reflected that: *"… it's rare to see category C and D players on B3 machines".* They sense that in Leeds as elsewhere, most C and D core users are creatures of custom with visits emphasising player friendship, socialising and interaction with staff teams.

2.4 GGV and other prospective gambling developments across Leeds

The GGV development is arguably the most significant single investment in the gambling sector in Leeds for a generation, adding significantly to the mixed use retail and leisure-based redevelopment of the Victoria Gate area. The casino will comprise 51,000 sq. ft. facility (including the mezzanine floor with mainly back-office functions), combining space for a restaurant with the casino operations. The licence anticipates a 24 hour gambling facility (shorter hours for the restaurant) and an estimated 272 staff once it is fully functional in late 2016. At present, the operation anticipates the venue will house around 140 gambling machines and 75 roulette terminals. These details will be well known to the Council but it seems not to all stakeholders in the community. Some stakeholders either had little awareness of the proposed development (scale or location) or none at all.

Not all stakeholders greeted the development enthusiastically despite the anticipated contribution to be made to the area redevelopment and regeneration, job creation, investment in the Social Inclusion Fund (of which few were yet aware) and Council revenue. The city centre Bingo and AGC venues had some concerns about enhanced competition in an environment where they felt they were operating in a near static marketplace and on low operating margins. One AGC operator cited a similar development in Newcastle where the opening of a less large-scale casino in Chinatown close to their long established premises saw what they described as: *"… a dramatic and sustained loss of our core business".* The bingo operation shared some of these concerns over potential leakage of 'new' client groups to the new casino although they felt that recent developments in their own premises have given them greater resilience.

Others in the voluntary and community sector were concerned that the large casino would intensify risks from problem gambling, although they were not precise in their assessment of raised risks. These issues are returned to in Chapter 5 though it is worth noting there was greater concern about risks among community stakeholders related to online gambling and a disproportionate amount of low incomes being spent among some users on lottery scratch cards than the GGV development.

The GGV development takes place in a dynamic environment for gambling supply in Leeds, as elsewhere. The study consequently attempted to review other prospective developments in gambling operations and supply in Leeds with gambling operators. Interviewees may have been constrained in their responses due to commercial sensitivities and the findings should consequently be seen as indicative:

- **Casinos**: The sector locally is in a state of flux with the 2013 Grosvenor rebranding of the Leeds Westgate casino following the Gala takeover, and the Alea closure after six years of trading in 2014. Grosvenor Leeds Arena is now expected to close in autumn 2016 at about the same time as the GGV development opens. The Council is also currently (at the time of writing) reviewing an application to move a licence from the Grosvenor Merrion Way site to Grosvenor Leeds Westgate. At least two of the centres had spare capacity (operating midday through to 7am five days per week) and did not anticipate any capacity investments in a market where one manager felt it had already reached saturation point.

- **Bingo**: One city centre venue aimed to use floor-space capacity in a planned re-development of a mezzanine floor for a '*No Shush*' room[15]. This responded to an emerging market demand for group bookings, corporate events and drop-in group engagement especially among a younger clinical. Established (predominantly older female) clientele dislike too much disturbance to card based play.

- **LBOs**: No major developments are anticipated beyond branch level refurbishments and some roll-out of machine-based operations. The main change was likely to come through corporate restructuring and mergers which might result, as in the past, in some consolidation of the branch networks.

- **AGCs**: No prospective developments were identified. There is greater concern (than for Bingo or LBOs) of the quality of their resilience to the new casino offer and in particular the leakage of a small but significant part of their customer base playing (almost solely) B3 machines.

The impression overall was of GGV entering a tight and (for land-based supply) static market with some risks of leakage to the new venue from established city centre locations for casinos where for some machine use the client base was relatively volatile, and of B3 machines players from AGCs and perhaps Bingo Halls. The study did not review wider leakage or any substitution effects on the leisure sector including retail, food and restaurants.

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[15] 'No Shush' areas are for those that want to socialise whilst playing; ideal for a younger demographic, parties and corporate bookings

2.5   Distinctive features of gambling demand in Leeds

The interviews provided little evidence of if and how particular features of gambling demand, and problem gambling, were distinctive to Leeds. Cross-branch (and cross-region) movement of management staff among operators meant they felt often well-placed to reflect on Leeds' distinctiveness, but the general impression was that trends and developments here were reflected elsewhere.

One manager reflected that his own career involvement in bingo operations showed that Leeds operations were characterised by:

"The soft end of gambling, low spend, low risk, long duration and socialising as a main draw; a small number of players are high rollers but they are not focussing on bingo products but the machines".

He observed a very similar ageing demographic affecting the Leeds bingo operations as to other city centre locations. Problem gambling issues here centred almost wholly on that small niche of players but, in his view, this remained rare. In this and in the wider pattern of use, Leeds was seen as very similar to other central city locations in both the demographics of customers and also the low incidence of problem gambling (and self-exclusion) in bingo venues.

Managers of established casinos reported similarities to other metropolitan locations, with one observing he had previously worked in casinos in Aberdeen, Dundee, Edinburgh and Hull and considered all of them to be very similar in terms of gambling activity and features. This manager did feel there was a stronger cluster of Chinese ethnic users, with this providing a:

"…community atmosphere when Chinese customers come together", but he felt this reflected local demographics and not a distinctive feature of ethic gambling in casinos in Leeds. This was reflected by a corporate interviewee for one of the LBO operators.

Beyond these similarities, Leeds' city centre bingo and casino venues had been seen to share some benefit from the large critical mass of clustered retail facilities in the city and proximity to recent re-developments. A distinctive feature was that there was consequently a significant level of drop-in customer use especially from women. This was not thought to be unique to Leeds but it was a more distinctive feature, for some interviewees, than less well (re) developed city centres.

Overall the assessment appears to be that there is little distinctive to Leeds in gambling behaviours or challenges. However, this must be taken with some caution. Much of the evidence is subjective; comparative data sources which might have provided for a more objective source of contrasts between Leeds and other locations were limited to sector bodies with very different aptitudes for data sharing. Where some comparative data (Leeds vs GB or UK) was available (e.g. ABB and Bingo Association) it showed no clear distinctions[16]. Data from the AGC sector was more severely constrained by the nature of autonomous play. Subjective assessments from the voluntary and community sector stakeholders were limited in validity since few screened formally (or at all) for gambling behaviours and as such were not in a strong position to reflect on patterns, let alone contrasts over place or time. In addition,

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[16] Some of this data was limited by being membership based

beyond the managers of gambling operations, few interviewees had personal experience of gambling operations over different locations.

2.6   Support services for problem gambling

Across the support services in Leeds, the study identified three forms of support services which are currently available for problem gamblers and those at risk of harm in Leeds:

- Generic information, advice and guidance services providing support on managing debt and other consequences of problem gambling

- Specialist advice and counselling services focussing on addictions but not specific to gambling

- Specialist advice and counselling services focussing on gambling related harm and problem gamblers

These are the main areas of local advice and guidance (and treatment) support likely to impact on problem gambling and its consequences. Other information and support services such as health, social or community services may also provide information for gamblers such as *responsible gambling* leaflets. Additionally, gambling operators provide a range of information such as: posters, generic and/or branded leaflets that cross-refer to GamCare[17], referral materials together with self-exclusion interviews with operators.

Other information routes have not been considered in this study although Chapter 6 provides evidence from Leeds of gambler reflections of the wider information-advice-guidance pathways. In particular, industry based self-exclusion schemes or harm minimisation initiatives such as the 'Playing Safe' initiative in the casino sector, do offer signposting to sources of help and have some trained staff supporting this, but beyond routine information these are difficult to see as support services, and are not planned in that way. Indeed, while interviewed operator managers in Leeds felt their self-referral mechanisms were operating robustly within company or sector-wide rules, their operation tended to isolate them from providing any form of post-exclusion support, since those self-excluding were in effect banned from any contact with the premises.

Generic information, advice and guidance services: Across Leeds, support services were not routinely or directly engaged in meeting the needs of problem gamblers or those at risk. Where they were involved with this client group it was usually through associated problems or needs. In fact, co-morbidity was seen as a recurrent feature by some voluntary sector and advice centre stakeholders. One, for example, estimated that for 1 in 10 of their current 150 clients, gambling was a factor in debt generation but it was rarely the main reason for their underpinning problems, where alcohol and other substance abuse was more likely to lead to problems. Others commented on co-morbidity as an underpinning feature of the social roots of many problem gambling issues within Leeds.

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[17] GamCare are a UK-based charity and the leading provider of information, advice, support and free counselling for the prevention and treatment of problem gambling. They provide the Freephone National Gambling Helpline as well as live chat through 'NetLine' together with an online forum, daily chatrooms, and provide free face-to-face counselling in a range of localities through counselling agents.

These services are not specific to gambling, or to a specific area of client support (such as debt advice) but typically provide a range of support to vulnerable or disadvantaged Leeds residents and other residents various personal or family problems, some of which may stem from gambling related harm. Services and suppliers are diverse and the study shows very different levels of service and awareness (or experience) of handling clients with gambling related issues.

Citizens Advice Leeds is the largest generic service and part of the national Citizens Advice network. Along with all other non-specialist services it does not screen for gambling related problems[18]. Their non-judgemental approach to support means it may not be possible to identify underlying causes of problems, and advisors identify this only occasionally when it emerges as a driving issue to, usually, relationship or family debt issues. These are often brought to Citizens Advice Leeds when the debt is acute (e.g. threat of foreclosure on a mortgage; repossession or eviction) and often with parallel challenges such as consequential family or relationship breakdown. In these circumstances, unless self-declared, debt advisors are solution-centred and often not well placed to identify gambling related debt. In practice, few clients self-declare any such problems although debt advisors suspect it is a hidden cause of non-identified expenditure in budget assessment processes with clients:

> *"It's a hidden problem … only a handful [clients] open up to gambling cost. Most go to lengths to avoid it; they will tell you about what's spent on cigarettes or in the pub but not gambling beyond the odd scratch card. We see [there is] real shame associated with gambling debt when it gets to these [acute] situations … and you cannot help someone with something they are not prepared to put on the table".*

Stepchange, a national charity dealing mainly with debt advice, acknowledges similar challenges but is unable to provide a Leeds specific assessment (as a national network dealing usually with on-line and telephone support).

Beyond Citizens Advice Leeds and Stepchange there are a range of other localised services usually associated with particular needs or targeted groups where gambling related harm or problem gambling has been identified. Those identified to date are set out in Table 2.2.

Table 2.2: Local advice and guidance services accessible to problem gamblers

Leeds-based agency	Client target group(s)	Support for problem gambling etc.
Behind Closed Doors	Women and men subject to domestic abuse	Problem gambling not identified as an issue
Emmaus	Homeless men and women	Temporary shelter/homes including where homeless through gambling related problems/harm
Leeds Mind	People with mental health difficulties	Problem gambling not identified as an issue

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[18] This is standard practice across the Citizens Advice network although an RGT funded project in South Wales led by Newport CAB is trialling gambling related harm assessment and support tools and these have the potential for national roll out.

Leeds Women's Aid	Women subject to domestic abuse and violence	Not interviewed
Lighthouse	Adults with multiple and complex needs, often addiction issues.	Lighthouse offers pastoral and practical support including to those with problem gambling issues (works closely with St George's Crypt + Oxford Place Centre.
Oxford Place Centre	Vulnerable people in Leeds (cross-faith group also working with a number of national charities including Relate, Women's counselling, Basis, etc.	Pastoral and outreach support and referral to specialist (national) agencies
St George's Crypt	Vulnerable adults with complex needs, including addiction issues.	Pastoral support including to those with problem gambling issues (works closely with Oxford Place + Lighthouse.
Student and Student Union Advice Service(s)	Post compulsory/college based and SU based university service(s) for registered students	Information, advice and guidance and also wellbeing services; will include those with debt and other problems related to gambling
Touchstone	Adults with mental health, physical health and wellbeing challenges; specialises in (although not exclusively) BME and hard to reach groups.	Information, advice and guidance including outreach services

This does not encompass all the advice and guidance services which do or could provide some support to problem gamblers; but it does illustrate what some of these stakeholders referred to as the fragmentation within Leeds-based services. Not all of these services recognise problem gambling as a service need; although most do and have some experience of supporting individuals whose situation and challenges are directly or partly associated with gambling. Other evidence suggests that a failure to identify (or under-estimate) need may stem from their service focus, or more likely some limitation in initial or subsequent client assessments (i.e., capable of distinguishing problem gambling or differentiating these problems from other behavioural challenges or addictions). Not all are aware of other local service providers or the focus of others and beyond the faith-based groups, there is little evidence of working collaborations or cross-referral or problem gamblers. This is in contrast to other advice and support in Leeds for vulnerable or other people with addictive behaviours and associated problems.

Specialist advice and counselling services: These are specialist services, typically funded either through the local authority or within the NHS focussing on drug, alcohol and other addictions. Unlike some other large metropolitan areas, there are no NHS funded specialist gambling related counselling or therapeutic services covering Leeds. The addiction services

that do exist are centred mainly on alcohol and substance abuse but may also cover problem gambling where part of wider addictive or challenging behaviour although this seems to cover only a small proportion of a large client base. The major supplier in Leeds is Forward Leeds a community initiative with professional links to the City's Universities, operating across the city and funded by the Council. Previously the Leeds Addiction Unit (when funded directly by the NHS[19]) it works with a range of referral agencies including GP practices, offender and post-custodial support and courts as well as some of the generic advice and guidance services.

Forward Leeds works with individual clients in treatment and recovery through a professional healthcare related service, supported by a team of consultant psychologists (in three centres) and related support. The service is psycho-therapeutic, multi-faceted and in part client led providing a combination of:

- Early (intensive) intervention and prevention

- Fast track and 'active' recovery programmes

- Harm reduction guidance and support (including a family plus service)

- Aftercare including a 'recovery academy' and peer support programmes

The service also supports a separate young person's team.

Problem gambling has a very limited profile (or priority) in counselling or peer support set against a large client base with other addiction and associated challenges. At present Forward Leeds do not include gambling screens in client assessments (although they report they are willing to do so on a trial basis) and their problem gambling interests are through co-morbid[20] associations with individuals referred with other addictions or recovery needs. At present they have no ability to identify within their client base those with associated needs in problem gambling.

As a result Forward Leeds have an interest but no ability to provide co-morbid support to problem gamblers due to lack of screening tools within their overall assessment processes. However, the study identified a professional interest and potential to develop enhanced screening in their initial assessments. Interviews with professional staff identified the interest and potential to develop a *National Problem Gambling Clinic* (NPGC)[21] type approach for Leeds and one of the consultant psychologists of Forward Leeds has direct experience of working in the Soho clinic and a research interest in comorbid associations within addictive behaviours.

The study has identified preliminary (2015) discussions[22] between Forward Leeds and the NHS to support a NPGC type service, as an evidence based service combining psychology and psychiatry through *functional analysis.* This would probably have a wider catchment than Leeds, although there have been no specific proposals or business case development. The

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[19] Its contract with Leeds City Council runs to 2020 with an option to extend to 2028.
[20] The current service includes an agreement with Leeds CC to support clients with primary drugs/alcohol problems and an additional problem of gambling addiction/harm.
[21] The National Problem Gambling Clinic is based in London, funded by the NHS, and treats problem gamblers living in England and Wales aged 16 and over through self-referral and professional referral.
[22] This seems to have been a personal initiative by a single consultant working with Forward Leeds and is not (yet) a strategic commitment or interest of the wider service.

initial constraint to developing the proposal further is reported to be a lack of systematic evidence (for the NHS) of demand for such a service and of a service gap.

Forward Leeds have no knowledge of other support services focussing on gambling related harm locally, and no knowledge or relationship with the GamCare counselling service in Leeds (see below).

Specialist advice and counselling services focussing on gambling: In Leeds the supplier of specialist services related to gambling related harm and problem gamblers is the North East Council for Addictions (NECA)[23] who holds the contract for Leeds (together with York, Scarborough and Whitby) on behalf of GamCare, for referrals, advice and treatment[24]. The service is funded by the Responsible Gambling Trust (RGT), through GamCare nationally, with finance raised through the voluntary industry levy which underpins RGT funding. The NECA contract has been held for eight years and is expected to continue "for the foreseeable future".

The end-funders engagement with these nationally co-ordinated services is essentially 'hands-off' with the specification and management of the Service Level Agreement (SLA) with NECA (and other regional and sub-regional organisations) through GamCare. Funding of NECA changed in 2014 to block (grant) funding from an earlier per capita payment (by output) to increase flexibility of response and to provide resource to support outworking (with other Leeds agencies).

As with other GamCare local counselling services, problem gamblers in Leeds can self-refer, or may occasionally be referred by other local support agencies such as probation (West Yorkshire CRC) or the courts. Most are referred through the GamCare national help line. The service is free to users and aims to provide professional therapeutic support to reduce the frequency of problem gambling and specifically to help clients:

- Develop ways of coping with at risk behaviours

- Better understand the reasons underpinning problem gambling behaviours

- Help address harms and other issues resulting from problem gambling

NECA operates through a client-led and integrative approach to counselling to explore 'problem' gambling behaviours, underpinning associated motivations and feelings. The service provides referred (or self-referred) Leeds residents with:

- Comprehensive assessment after first point of contact to assess circumstances and complex needs

- Brief interventions where necessary and for problem and issues handling

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[23] NECA are the largest regional charity in Britain working in substance use/misuse; established in 1974 as the North East Council on Alcoholism it now works across drugs and solvents and other abuse and addictions.
[24] In addition to GamCare's nationally accessed helpline and Netline (and on-line Fora) they have a network of 11 'agents', of which NECA is one, providing support in specific localities and regions through Great Britain together with two foreign language support services (Chinese and Turkish).

- Post assessment face to face (F2F) or telephone counselling support; individual users are allocated and expected to commit to regular sessions (usually weekly within a block of 12 sessions[25]

The service does recognise substantial problems associated with co-morbidity and specifically with clients who are also alcohol dependent. Where appropriate this is supported by information and advice for clients to self-refer to other addiction services.

Support is predominantly one to one and F2F but with telephone counselling introduced to increase flexibility and access for clients facing challenges in regularly attending the NECA counselling facility in central Leeds. Group work is also supported but is seen to present often acute problems in bringing a sufficient critical mass of clients together at one time. Support is also available for 'significant others', typically family members, directly affected by problem behaviours and gambling related harm. Support is provided by a dedicated counsellor who is Leeds-based, operating from a single room in NECA leased premises.

Demand in Leeds is seen as substantial and over the last two-years the service supported 354 clients (in 2014 and 2015; the latest available data based on calendar years) of which 252 (71 %) were recorded at Leeds postcodes. Distributional or demographic data are not available with the NECA head office reporting:

> *"Client [monitoring] Information is entered onto the system, but ...there is no method of currently reporting on it".*

Some data has been provided by NECA by manual analysis but data confidentiality (and the Data Protection Act) means the source data cannot be shared anonymously for secondary analysis. This limitation in management information reporting also affects some of the dynamics of the service and reliable information is not available on drop-outs although the numbers not completing the full 12 sessions are reported to be 'significant'. Clients are not classified in terms of vulnerability groups but some data are available on risk activities and behaviours. Some data are available on gambling activities among these clients (from April 2014 to March 2016) as summarised in Table 2.3, although these data need to be treated with some caution.

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[25] Support had previously been for up a block of 24 sessions but this had high levels of drop out and was reduced as a wider GamCare initiative to improve cost-efficiencies and access.

Table 2.3: Gambling activity among help-line referrals to NECA Leeds

Self-reported gambling activity	Activity prevalence (%)	Notes
Betting/LBOs	61.6	Excludes licenced betting at courses (included in 'other')
Casino premises - misc.	33.6	
Bingo	7.3	
AGC premises	3.6	
FOBT – misc.	33.1	Note that 'slot machines' are classified separately
Slot machines	40.6	
Lottery – excluding scratch cards	9.0	
Misc. scratch cards	9.1	
Online gambling – misc.	4.5	
Other	3.6	
Not declared; missing data	10.4	

Numbers of clients included = 228

Source: GamCare analysis of gambling by mode for Leeds NECA referrals, 2014-16

- The data refers to gambling activity and shows the strength of multiple activities across these self-referred problem gamblers. However, the data has significant limitations. They Numbers of o not cover all referrals and the classification used mixes activity (e.g. FOBT) with venue classification (e.g. casinos). The effect of this mixed classification appears to be to under-report some activities, notably on-line gambling, where those classifying responses seem to macro categories – i.e. 'casinos' consequently encompassing licenced premises and on-line casinos. However, the data does confirm counsellor feedback and specifically:

- Problem gamblers are typically involved in multiple activities – on this evidence an average of just over four (4.1 over the previous year at the time of reporting) of these classified activities per individual

- Engagement in LBOs is widespread although usually in combination with other activities

- Engagement in 'soft' and leisure gambling – in Bingo and in AGCs - is not a commonly reported feature for these problem gamblers

- Use of FOBTs and also 'slot' machines (the two are differentiated in the GamCare classification) is extensive

- Scratch cards are a significant activity but may be more significant for particular social groupings

Demand for counselling from NECA in Leeds is reported to be beyond current capacity to start to support individuals within the targeted time-frame for start of counselling after referral. The NECA SLA (as with most other localised GamCare counselling services) provides for a first response to client referrals within 15 working days but with a 'preferred' contact within 10 working days). However, waiting lists have grown from an average of 10-15 working days (2014) to 20-30 at present, although at times this may be shortened depending on drop-out rates.

The waiting list has been growing over the last two years and currently average 8-10 clients waiting for first sessions. NECA explain this as a capacity constraint with a single counsellor operating from a single room and a maximum weekly capacity of an average of 25 client support sessions per week. NECA reports attempts to increase capacity which have been frustrated to date by difficulties in contracting for further appropriate space (a second counselling room) in the current premises and also by difficulties in recruiting an appropriately experienced part-time second counsellor.

The NECA service operates as a stand-alone and essentially isolated service within Leeds, although it does refer some clients with associated alcohol or other substance abuse problems to external bodies with which it has long standing working relationships (outside Leeds). NECA reports that the service has limited local awareness among other (e.g. generic) support agencies, and this is supported from interviews with other stakeholders few of which were aware of the NECA activity although just over half were aware of the GamCare central helpline. NECA sees substantial scope to enhance their engagement and profile with other agencies through pro-activity and to encourage local referral which is reported to be a stronger feature of GamCare local operations in some other metropolitan locations such as Greater Manchester. However, beyond ad hoc distribution of (GamCare) leaflets to some advice centres pro-active marketing has also been capacity constrained with the NECA counsellor focussing time and effort on client support. There is also concern that a more pro-active approach in advance of increasing capacity could only intensify current challenges with waiting lists.

2.7   Conclusion

This 'supply' side perspective of gambling operations and problem gambling related services in Leeds paints a complex picture. Provision for gambling operations across Leeds is mature and well developed. Although showing increasing consolidation of activity across previously strongly segmented markets, notably in the use of gambling terminals and B1-3 machines. The study shows that all four main land-based operations – casinos, bingo, LBOs and AGCs – retain distinctive characteristics in their distribution and offer across the city. Although inter-operator and inter-sector competitiveness has limited some of the data and comparisons, a picture emerges across operators and operations of:

- A market in Leeds which mixes gambling, gaming and leisure activity in different premises notably for casinos and bingo halls in the city centre, with spare capacity in many of the longer established premises. Corporate managers in each of these segments see operator supply as at or approaching saturation in consumer demand.

The study has not been able to look at local 'supply' of online gambling or of lottery and related gambling, but it is evident from stakeholder and operator feedback that both are significant features in Leeds, as elsewhere.

- Beyond the prospective development of the GGV 'large' casino, there are few distinctive features in the Leeds gambling environment; features seen as distinctive by some stakeholders are reflected in other large metropolitan areas. Corporate feedback and reflections by career managers with multiple branch experience across the country re-enforce the impression that most characteristics and features of gambling, and problem gambling, in Leeds are reflected in other regional centres such as Manchester, Sheffield and Newcastle.

- GGV will be a development in the gambling landscape of Leeds, and arguably a generational change to land-based capacity and the gambling offer. Other sectors see few significant developments in prospect beyond continued and organic adjustments to largely segmented products, and some consolidation particularly in the LBO network of branches across six suppliers.

- Operators have adjusted to and accommodated substantial changes in market turbulence, urban demographics, and consumer aspirations, with city centre locations proving particularly resilient. Concerns about increased competition from the GGV development at Victoria Gate are not limited to the existing smaller casinos, but also by bingo and AGC operators where operating margins (and profitability) are low, and in static markets are at risk from competition in niche areas of gambling such as B3 machines. However, concerns are greater for the sectors' continued ability to compete with online offers, often by some of the same operators, and increased opportunities by consumers for remote access.

Although the national evidence set out previously suggests that the vast majority of people who gamble do so without experiencing problems, there are those who experience difficulties with their gambling and there is a need for the provision of support services for these people. This review shows that Leeds has a plethora of services and at least 13 different suppliers able to provide some advice and guidance. These cut across generic advisory services such as Citizens Advice Leeds, voluntary and charitable agencies, specialist addictions and recovery services – albeit focussing on drugs and alcohol dependence with little or no current focus on gambling related harm, and a single local supplier of gambling specialist services – NECA working as the GamCare support agents for Leeds.

With a few exceptions, and unlike other areas of advice and guidance in Leeds, these services are not well joined up for problem and at risk gamblers. Potential cross-referral pathways are patchy and informal and held back by a lack of understanding about who does what and may suffer capacity constraints. In both the generic and specialist addiction services, there is an almost total lack of any assessment or screening for gambling related harm and this misses opportunity for early (or any) diagnosis of specialist needs. Gamblers experiencing harm also appear almost serially reluctant to self-declare their behaviours, compounding the identification challenges.

NECA provides a locally-based, integrative counselling facility geared at (largely) self-referred problem gamblers with some support for others also affected by gambling related harm such as family members. It operates to a national model with referral pathways mostly linked to the GamCare helpline, which is the major focus for external signposting to help by the industry itself. The service locally is in demand although capacity falls short of what is seen as rising

demand for advice and guidance, with significant waiting lists of 4-6 weeks which fall short of GamCare expectations of responsiveness. Adjustment responses by NECA to increase capacity have yet to be effective. The study concludes that NECA operates in almost total isolation in Leeds. Its profile among other advice and guidance services in Leeds is very low, with no evidence of pro-activity by NECA to change this situation. Although building cross-agency relationships and referral pathways and protocols remains a strategic goal it has yet to be put into good effect in Leeds.

3   Gambling behaviour and vulnerable groups

3.1   Introduction

The Gambling Act, 2005 recognised that some people experience difficulties as a result of their engagement in gambling. Although it may mostly be an exceptional experience, these difficulties range from short term harms to longer term problems and difficulties. As a result a key licensing objective for gambling is to protect young and vulnerable people from harm from gambling. A core objective for this study was to understand who is likely to be vulnerable to gambling problems.

A starting point to understanding the situation in Leeds is to review the evidence for problem gambling across vulnerable groups in England. It is generally accepted that anyone, from any type of background, can experience harm from gambling. However, there is broadly consistent evidence both from within Great Britain, and internationally, that people from certain groups may be at greater risk from gambling and in particular:

- Men

- Younger people

- Those who are unemployed

- Those from certain minority ethnic groups

- Those living in more deprived areas

This evidence was drawn together through a Quick Scoping Review (QSR), updating a previous scoping review and focussing consequently on new evidence published since May 2015 (see Wardle, 2015 for the previous scoping review). The QSR conducted for this project replicated the methods used by Wardle (2015) (see Annex B for an outline of the QSR methods). To set this evidence in context, this chapter first starts with a review of the number of people who are problem or at risk gamblers in Britain.

3.2   Problem gambling and those at risk

Since 1999, numerous studies have attempted to quantify how many people in England (or Great Britain) are likely to be affected by "gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits", known as problem gamblers. It appears that between 1999 and 2012, problem gambling rates in Britain have remained broadly stable, despite growth in the forms of gambling available during this period. Depending on the survey considered, rates of problem gambling tend to vary between 0.5% and 0.9% of adults in Britain. This equates to between 260,000 and 468,000 adults aged 16 and over.

Some studies have also looked at the number of people 'at risk' of gambling problems. At risk generally refers to people who are experiencing some difficulties with their gambling behaviour but are not considered to be problem gamblers. Estimates suggest that between 5% and 6% of people in Britain may be at risk gamblers. Measuring at risk gamblers is not the same as

measuring those who experience harm but both recognise that more people than just problem gamblers can be negatively affected by gambling.

The estimates are national averages and cover widely different social groups. Successive studies have shown that certain groups are more likely to experience gambling problems than others. These include men, younger people, those unemployed, adults from certain minority ethnic groups, and also those living in more deprived areas. What is particularly notable, especially for the unemployed and those from minority ethnic groups, is that these people are less likely to gamble generally but those who do are more likely to experience problems. This so called 'harm paradox' makes these gamblers from these groups especially vulnerable.

These groups are not the only types of people who are considered at greater risk of problems. In the sections that follow, we outline a number of different types of people who can be considered more vulnerable to problems. This builds on a scoping review conducted for Westminster and Manchester City Councils in 2015 to explore which groups of people are more likely to have a greater risk of developing gambling problems (Wardle, 2015). The 2015 study included consultation with key national stakeholders[26] to explore what type of people they felt were at greater risk of problems with this information reviewed against existing research to assess the evidence-base for stakeholder perceptions of who is at risk. Wardle (2015) concluded that there was strong evidence[27] to support that the following groups were at greater risk of gambling problems than others:

- Young people, including students

- Those from minority ethnic groups

- Those who are unemployed

- Those living in deprived areas

- Those with a low IQ

- Those with certain personality traits

- Those under the influence of alcohol or drugs

- Those with poorer mental health (and/or certain mental health conditions)

- Those with substance abuse/misuse issues

- Problem gamblers seeking treatment (because of the potential for relapse)

In addition, Wardle (2015) concluded that there was emerging evidence[28] to support that people with the following characteristics may also be at greater risk of experiencing problems with gambling:

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[26] Including policy makers, academics, problem gambling treatment providers, lawyers and the gambling industry.
[27] In this study strong evidence was defined as a number of research studies, some of which are British based using gold standard methodologies, demonstrating the association between these characteristics and problem gambling.
[28] Emerging evidence was defined where there were only one or two studies examining an issue and potentially no British based evidence.

- Those with financial difficulties/debt

- Those who are homeless

- Immigrants

- Prisoners/probation

- Those with learning difficulties

For the current study we have used a similar approach but focussed on the perceptions of local stakeholders in Leeds to explore who they thought might be vulnerable to gambling problems. We were keen to explore whether there were specific populations in Leeds that had been overlooked in the prior research. Most of the groups mentioned by local Leeds stakeholders (see Chapter 6) were also those mentioned in the prior study. However, one difference is that asylum seekers and refugees were specifically mentioned by Leeds stakeholders as potentially being a vulnerable group.

3.3   Evidence of vulnerable groups

Young people: Wardle (2015) concluded that there is strong evidence, consistent between jurisdictions, that children, adolescents and young adults are vulnerable to the experience of gambling problems or at risk of experiencing gambling problems. Rates of problem gambling among young people who gamble are higher than older adults and youth gambling behaviours were consistent with the harm paradox, whereby these age groups are less likely to gamble generally but those that do are more likely to experience difficulties with their behaviour. In November 2015, the National Lottery Commission published its most recent figures on gambling behaviour among children aged 11-15 in Britain. This showed that:

- 17% of children aged 11-15 had gambled in the previous week, with fruit machines and betting privately with friends being the most popular activities

- Around 0.6% of children aged 11-15 were problem gamblers (Ipsos Mori, 2015)

- This rate of problem gambling is similar to that for all adults aged 16 and over, whereas other jurisdictions tend to show higher rates of problem gambling among children than adults. However, the Gambling Act 2005 specifically states that children should be protected from harm from gambling and requires that legal restrictions be in place to prevent those under the age of 18 participating in many forms of gambling. Therefore, young people under the age of 18 should still be considered a risk group.

Wardle (2015) also highlighted students as a risk group; though concluded that there was very limited British evidence to assess this. This has not changed since the previous study and no further studies of gambling behaviour among British students were identified. To date, there is only one study of gambling behaviour among British students which showed elevated rates of problem gambling among students in Scotland (Moodie, 2008).[29]

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[29] Evidence from the British Gambling Prevalence Survey (BGPS) 2010 showed that students who were not living in institutions displayed similar levels of risk and problem gambling to those of the same age who were not in higher

Wardle (2015) recommended that further investigation was needed to explore whether gambling harms are increasing among British students, particularly as student finances are changing, as are costs of living and job prospects. This recommendation remains.

Minority ethnic groups: Wardle (2015) concluded that there is consistent evidence that those from Asian or Black backgrounds are more vulnerable to gambling problems and there is clear evidence of the harm paradox. This was based primarily on a review of national British survey data, which has consistently highlighted those from Asian/Asian British and Black British backgrounds to have higher rates of problem gambling. Since then, further analysis of the BGPS and HSE datasets by a different research team has confirmed these associations. James et al (2016) looked at the associations between different levels of problem and pathological gambling and found that those gamblers who showed some problems, but were not considered 'pathological' gamblers were more likely to be from minority ethnic groups whilst those with the highest problem gambling scores were more likely to be Asian/Asian British.

As Wardle (2015) noted, what underpins these associations are little explored and likely to be varied, ranging from religious adherence, cultural beliefs and practices, the economic structure and material setting of people's lives and jurisdictional differences in the provision of gambling. In this way, ethnic status may be a visible marker of vulnerability which masks a range of other processes. No additional studies were identified that explored this within a British context and this is a noted gap in the evidence base.

Unemployment and constrained economic circumstances: Wardle (2015) concluded that the evidence relating to household income and problem gambling was mixed. Generally those of lower income are less likely to gamble but those that do spend a higher proportion of their income on gambling. This was highlighted as a concern given the (likely) lesser ability of lower income households to protect themselves from financial instability (Brown et al, 2011).[30]

Since 2015, only two further British based studies were identified looking specifically at the relationship between income and gambling. The first was a survey of regular bingo players. Rates of problem gambling among regular bingo players were higher among those with both the lowest but also the highest levels of personal income – leading the authors to conclude that the relationship between gambling problems and personal income is mixed (Wardle et al, 2016). A further study looked at people who played machines in bookmakers and examined who lost the most money. This concluded that those who lost the money on machines in bookmakers had similar incomes to those who lost the least. This is notable as the gambling industry often state that those who lose the most money have higher incomes – among people playing machines in bookmakers, this does not appear to be the case (Wardle, 2016).

Wardle (2015) highlighted a small but interesting body of research looking at the relationship between debt and gambling, with those in debt and those using money lenders and/or pawnbrokers being more likely to be problem or at risk gamblers. Meltzer et al (2012) highlighted the complex relationship between debt, addictive behaviours and common mental

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education. This suggests that students should be considered as vulnerable as others of the same age, though based on the evidence available to date, it cannot be concluded that they are more so.

[30] It should be noted that national stakeholders consulted by Wardle (2015) noted some unease about labelling all low income households as vulnerable as income, gambling, debt and money management are likely to interact to shape outcomes.

disorders, showing how financial difficulties can be associated with multiple health conditions. No further research studies were identified examining this issue in this current review.

There is evidence of a strong relationship between unemployment and problem gambling, based both on international and British studies (see for example Castren et al, 2013; Wardle et al, 2011). The relationship between unemployment and gambling difficulties is likely to be more complex than those people having limited access to resources. Unemployment is related to the experience of psychological difficulties which may mediate this relationship and employment instability is related to starting and stopping gambling (Reith & Dobbie, 2013).

Recent research by Tabri et al (2015) examined this by exploring the relationship between personal relative deprivation (i.e., the feeling that you have less than you should compared with others and/or have less than you deserve), economic mobility and gambling behaviour. This showed that among gamblers who perceived barriers to improving their economic standing through conventional means (i.e., work), relative deprivation was associated with a greater likelihood of gambling for financial reasons. Whereas for gamblers who felt they could improve their economic standing through conventional methods, there was no relationship between relative deprivation and the motive to gamble for financial reasons. Among those gamblers with a perceived lack of economic mobility, relative deprivation predicted greater disordered gambling (Tabri et al, 2015).[31]

The relationship between constrained economic circumstances and gambling problems is likely to be complex and multi-faceted. It may be mediated by other economic opportunities and personal feelings about how well off you are compared with others. Despite this complexity, there is a consistent body of evidence showing that, for whatever reason, those who are unemployed and who gamble are more likely to experience adverse outcomes from their gambling than those in paid employment. The reasons underpinning this association need to be better explored.

Area deprivation: Wardle (2015) reviewed a number of British surveys which had consistently shown that those living in more deprived areas[32] are more likely to experience problems with their gambling behaviour. This was despite having roughly similar levels of past year gambling participation to those who live in less deprived areas.

Wardle (2015) looked at the distribution of machines and licenced bookmaking offices (LBOs) and argued that there was clear and consistent evidence of a spatial skew, whereby high density machine zones or areas with LBOs are more deprived than others. Recent research has shown that among gamblers who held a loyalty card for a bookmakers, rates of problem gambling (28%) were higher among those who lived within 400m of a concentration of bookmakers than those who did not (22%) (Astbury & Wardle, 2016).[33]

The relationship between area deprivation and gambling behaviour is not unique to Britain. A recent study of changes in gambling behaviour over time conducted in New Zealand,

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[31] According to this study, gambling may be viewed as one method of improving one's financial standing among those who feel that conventional methods, like work and job opportunities, are closed to them. Personal relative deprivation has also been shown to be associated with the urge to gamble generally and that this relationship was stronger among those experiencing more severe gambling problems (Callan et al, 2015).

[32] Measured either through Index of Multiple Deprivation or other indicators like Spearhead Primary Care Trust status, which are standardised national measures of deprivation.

[33] In this study a concentration of bookmakers was defined as having three or more bookmakers within 400m of each other.

demonstrated that living in a high deprivation neighbourhood was significantly associated with increased gambling problems (moving from low risk to moderate risk gambling) (Kruse et al, 2016). As with other public health areas, local areas and communities matter as there are inequalities in gambling outcomes according to where people live.

Intellectual functioning (IQ, learning difficulties): The current scoping review found no new studies examining the relationship between IQ, learning difficulties and problem gambling. Wardle (2015) highlighted that stakeholders felt that those with learning difficulties could be at risk of experiencing problems and were thus a vulnerable group.[34] This is consistent with advice from the industry regulator, the Gambling Commission, about who should be considered vulnerable, stating that those with diminished capacities to make informed decisions should be considered vulnerable. It is also consistent with the two British studies showing that those with lower IQs have a greater risk of gambling problems.

However, Wardle (2015) highlighted an evidence gap when it came to the relationship between learning difficulties and gambling behaviour. The few studies that have been conducted have focused on adolescents and showed mixed results.[35] Among adults, there is very little evidence available about the relationship between learning difficulties and gambling behaviour. This does not appear to have changed since the first review was conducted.

Homeless: Wardle (2015) highlighted the small but growing body of research examining the association between homelessness and gambling. The relationship is complex, with gambling potentially being a determinant of homelessness and housing instability for some and/or being "a way of negating some the negative experiences of [homelessness]" (Holdsworth et al, 2011) for others. Since May 2015, two further studies have been published that confirm previous research. Both show that rates of problem gambling are higher among those who are homeless than those who are not. Nower et al (2015) examined gambling behaviour among homeless people recruited from shelters living in the St Louis area, Missouri, USA. The vast majority of people interviewed were African/American and 12% were identified as 'disordered' gamblers36.

Sharman et al (2016) conducted a small exploratory study of homeless people living in Westminster. Overall, 24% of participants were identified as problem gamblers, though the small sample size and purposive sampling method suggests some caution in extrapolating this to all homeless people. Notably, 84% of participants said that problem gambling preceded their homelessness. There was also a significant relationship with job loss preceding homelessness, although these relationships need to be better explored (Sharman et al, 2016).

Whilst the evidence base relating to homelessness and gambling is thin, the evidence that does exist shows a consistent pattern, with rates of problem gambling among homeless population groups being higher than the general population. Little is known about why this is

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[34] This concern was based upon the idea that gambling should involve informed consumers, making informed choices to engage in gambling (Light, 2007).

[35] Three of the four studies reviewed showed a relationship between gambling behaviour and learning difficulties, though in some cases this was only evident for boys. These studies also discussed inconclusive findings of other studies examining the relationship between those with learning difficulties and engagement in other risk-taking behaviours.

[36] This study used the Southern Oaks Gambling screen which categorised gambling problems as 'disordered gambling'. It also used lifetime measures of problem gambling and so current prevalence of problem gambling is likely to be lower than this. This study also highlighted that homeless 'disordered' gamblers also tended to have a range of other mental health issues.

but, given associations with other mental health conditions, homeless people should be considered a vulnerable group.

Prisoners/probation: Wardle (2015) discussed the small but growing body of international evidence showing that rates of problem gambling among incarcerated populations are significantly higher than those of other adults. Exploratory evidence from pilot studies in England showed that 10% of male prisoners and 6% of female prisoners reported being problem gamblers prior to incarceration. A further 37% of male and 23% of female prisoners were identified as at risk gamblers prior to their prison sentence. These rates are significantly higher than those observed for adults in the general population (May-Chahal et al, 2012).

A more recent study of UK prisoners found a similar pattern, with 12% of prisoners being identified as problem gamblers (May-Chahal et al, 2016). This study noted that past year gambling participation (in the 12 months prior to entering prison) was much lower among prisoners, suggesting a harm paradox for incarcerated populations – they are less likely to gamble but those what do are far more likely to experience problems.[37]

These studies have tended to focus on the prevalence of problem gambling prior to imprisonment, rather than problems experienced whilst in prison. One Canadian study showed that half of those who had problems with gambling prior to incarceration continued to gamble and experience problems whilst in prison (Turner et al, 2013). An exploratory study of inmates in Ohio demonstrated that gambling was a normative way of prison life, with many engaging and continuing to engage in gambling. This highlights a dual relationship between incarcerated populations and gambling. Problem gambling rates are elevated among those who subsequently go to prison, but gambling is also an endemic part of prison life that may encourage some problem gamblers to continue to engage or promote gambling among those who previously did not gamble.

Wardle (2015) reported that stakeholders felt that those on parole or probation could be especially vulnerable because of these dual processes. This was because they may have had problems previously and not received help, or because of the gambling culture within prisons creating problems. Once out of prison, it was argued that this group may be socially excluded and stigmatised, have low incomes and look to gambling to relieve such stressors. There is very little empirical evidence examining this.[38]

Immigrants/refugees/asylum seekers: Both stakeholders interviewed by Wardle (2015) and Leeds based stakeholders interviewed for this study identified immigrants/refugees/asylum seekers as those potentially vulnerable to gambling problems. Stakeholders felt that the social and economic circumstances of these migrants meant they may have heightened vulnerability. Some recent immigrants may have poor social networks and/or little social support, be socially isolated and have limited financial resources which may contribute to increased vulnerability from harm. Others may come from cultures where gambling availability was not as widespread as in Great Britain and this may impact on their risk of harm.

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[37] International studies report similar findings, in Hamburg 7% of pre-trial detainees screened positively for gambling problems (Zurhold et al, 2014). In New Zealand, 16% of recently sentenced inmates were identified as probable pathological gamblers in the six months prior to imprisonment (Abbott et al, 2005) whereas in Canada, 27% of offenders in one institution reported some degree of problem with gambling (Turner et al, 2008).

[38] May-Chahal et al (2012) cite a study by Ricketts et al (2000) showing that of offenders on probation in South Yorkshire, 4.2% were problem gamblers. This was the only citation identified in the scoping review looking at the experiences of gambling among those on probation. This is a noted gap in the evidence base.

To date, no British studies looking at gambling behaviour and problem gambling among immigrants/refugees/asylum seekers have been conducted and there are very few studies exploring this internationally. Two studies conducted in Norway and Denmark respectively found that immigrant status (measured by birth outside the resident country) was associated with being an at risk gambler. A German study compared gambling behaviour between native Germans and immigrants using semi-structured interviews. This revealed that acculturative stress (acculturation is the meeting of two cultures) was associated with reasons for gambling among migrants (Jacoby et al, 2013). In New Zealand, a study of Asian immigrants highlighted how processes of acculturation can lead to high levels of stress and 'culture shock' when settling into a new country.[39]

Cultural contexts can affect gambling behaviour (MacMillan, 1996; Okuda et al, 2009) and it is plausible that for some immigrants processes of acculturation heighten vulnerability to gambling related harm.

Finally, an American study found that whilst immigrant status was associated with problem gambling, it varied by generation. Those who were first generation immigrants were less likely to be gamblers or problem gamblers than native born Americans whilst those who were second or third generation migrants were more likely to be problem gamblers than first generation migrants (Wilson et al, 2015).

With the exception of the American study, this evidence shows broadly consistent results. The few European studies identified suggest that non-native birth was associated with greater probability of at risk or problem gambling. Sobrun-Maharaj et al's (2013) study of the experiences of Asian migrants in New Zealand highlighted a range of mechanisms through which migrants may be more vulnerable to harm. However, with all of these studies it is not clear the extent to which findings are transferable to Great Britain. Great Britain has a particularly diverse immigrant population and it is likely that processes and consequences of acculturation vary for different groups.

Overall, there is some evidence that immigrants may represent a vulnerable group though, to our knowledge, this has not been explored in a British context. Whilst immigrant status may serve as a proxy for potential vulnerability, it is likely that a range of complex mechanisms and processes underpin this which requires further exploration.

Mental ill health: Wardle (2015) highlighted the strong association between mental ill health and problem gambling. Using survey data from England, associations were found between problem gambling and:

- General Anxiety Disorder

- Phobia

- Obsessive Compulsive Disorder

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[39] Asian immigrants described using gambling as a way to relieve stress but also gambling because it was a place where they could be with others from their community. This is related to themes of social isolation, where the casino offered a safe place for Asians to meet and be around other Asians. As with other groups, financial insecurity and the hope of winning money were also key motivators to gamble and gamble excessively. Immigrants in this study also described differences in culture towards gambling, with gambling in New Zealand being legal and heavily advertised, something they were not used to (Sobrun-Maharaj et al, 2013).

- Panic Disorders

- Eating Disorders

- Probable psychosis[40]

- Attention Deficit Hyperactivity Disorder

- Post-Traumatic Stress Disorder

- Harmful and hazardous levels of alcohol consumption

- Drug dependency

Problem gambling prevalence rates varied from 6% among those with probable psychosis to 1.5% among those with Mixed Anxiety and Depressive Disorder. This latter estimate was over twice the level of problem gambling among the general population (0.7%). Many of these associations have since been confirmed in further analysis of the same data by Cowlishaw and Kessler (2015). A further UK based study has also shown a strong link between people with bi-polar disorder and problem gambling, with 2.7% of people diagnosed with bi-polar disorder being problem gamblers and 10.6% being moderate risk gamblers.

A recent systematic review of mental health among those seeking treatment for gambling problems showed high rates of comorbid mental health (Dowling et al, 2015). Bringing together data from 36 studies, they estimated the following proportions of problem gamblers seeking treatment experienced each condition:

- Mood disorders (23%)

- Alcohol use disorders (21%)

- Anxiety disorders (18%)

- Substance use disorders (7%)

- Nicotine dependence (57%)

- Major depressive disorder (30%)

- Alcohol abuse (18%)

- Alcohol dependence (15%)

- Social phobia (15%)

- General Anxiety Disorder (14%)

- Panic disorder (14%)

- Post-traumatic stress disorder (12%)

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[40]In the Adult Psychiatric Morbidity Survey (from which this data is derived), a diagnosis of 'probable psychosis' was given for a positive (Schedule for Clinical Assessment in Neuropsychiatry (SCAN) interview (phase 2 interviews), or where no SCAN was conducted if two or more psychosis screening criteria were endorsed in the phase 1 interview.

- Attention deficit hyperactivity disorder (9%)

- Adjustment disorder (9%)

- Bipolar disorder (9%)

- Obsessive compulsive disorder (8%)

Overall, the authors estimated that three quarters of problem gamblers seeking treatment also experienced one of the co-morbid conditions listed above. These associations mirror some of those observed from the survey data of adults living in England.

These studies, however, show associations between problem gambling and mental health but not the order in which each developed. This was discussed by Wardle (2015), with different studies showing different results. It was generally concluded that "*some mental disorders might be a risk factor for pathological gambling and others a consequence" (Kessler et al, 2008).*[41]

Since then, a further Canadian study (Affifi et al, 2016) has looked at predictors of new onset of mental health conditions and predictors of problem gambling. Using longitudinal data, they showed that being a problem or at risk gambler was associated with latter onset of major depressive disorder, alcohol use and dependence, drug use and experience of any mental disorder. However, they also showed that illegal drug use and experience of any mental disorder was also associated with subsequent onset of at risk and problem gambling. These findings seem to confirm the previous conclusion that the relationship between problem gambling and mental ill health may be cyclical.

In summary, there is a consistent body of evidence from Britain and North American demonstrating a strong association between gambling problems and many mental health conditions. This suggests that those with Common Mental Disorders, psychoses and other conditions like PTSD have higher rates of problem or at risk gambling than those without these conditions.

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[41] Kessler et al (2008) analysed age of onset to try to unpick the sequence in which different disorders were experienced. They concluded that most comorbid anxiety, depressive disorders and alcohol and drug abuse began at an earlier age than pathological gambling, with 74% of pathological gambling cases occurring subsequent to the onset of other disorders. However, they also noted that this was not universal and that. Problem gamblers have periods of abstinence and relapse and problems persist over a long time frame, making sorting out the temporal sequencing of events difficult (Kessler et al, 2008). A limitation of Kessler et al's (2008) study was their reliance on retrospective self-report of age of onset for each condition. A further study (Chou & Afifi, 2011) attempted to address this by analysing data from a follow-up study to National Epidemiological Study of Alcohol and Related Conditions, 2005.[41] In the follow-up study, data about a variety of mental health issues were collected so investigators could see who now experienced certain conditions which they had not previously. Chou and Afifi (2011) demonstrated that pathological gambling was associated with the subsequent experience of mood disorders, PTSD, General Anxiety Disorder and substance abuse/misuse. However, because pathological gambling was not asked about in the second study, they were unable to look at what prior conditions may be associated with later onset of gambling problems. They concluded that there were likely reciprocal and cyclical relationships between gambling and other psychiatric disorders

However, the temporal sequencing and the specific mechanisms that underlie this relationship are uncertain. As one stakeholder interviewed by Wardle (2015) stated:

> "…it's not clear whether this [psychological difficulties] is caused by the gambling or whether it's a precursor to the gambling. The assumption is that it's a bit of both and so far as it's a bit of both, then implies that those with psychological difficulties are more at risk."

Substance abuse/misuse: The evidence base relating to the relationship between substance abuse/misuse and experience of problem gambling broadly mirrors that of mental ill health. Evidence from British based surveys has shown that rates of problem gambling were higher among those with alcohol dependence (3.4%) or drug dependence (4.4%) than the general population (0.7%) (Wardle, 2015). In America, analysis of the National Epidemiological Study of Alcohol and Related Conditions (NESARC) showed that drug use disorder, alcohol use disorder, mood, personality and anxiety disorders were related to pathological gambling,[42] with the odds of being a pathological gambler being higher among people with these disorders. The authors concluded that the "evidence for the relationship between substance use disorders and pathological gambling was unequivocal" (Petry et al, 2005).

A systematic review of those seeking treating for gambling problems showed that 15% also experience alcohol dependence and 7% have other substance use disorders (Dowling et al, 2015). Affifi et al (2016) showed that prior problem gambling predicted the subsequent onset of alcohol dependence and drug use, whereas prior illicit drug use also predicted the onset of gambling problems. A longitudinal study of gambling behaviour among young people (aged 17 to 26) in Australia showed that high frequency alcohol consumption was associated with persistent problem gambling over time. Interestingly though, alcohol consumption was not associated with the onset of problem gambling.

Analysis of problem gambling trajectories among youth in Canada showed that alcohol dependence was associated with problem gambling but not with changing patterns of problem gambling over time (either increasing or decreasing problems) (Edgeton et al, 2015). However, different analysis of the same data showed that alcohol dependency was significantly associated with being a moderate risk gambler whose problems increased over time. (Edgeton, 2014). In both Canadian studies, there was no relationship between drug dependence and problem gambling among youth.

There is strong evidence that alcohol and substance abuse/misuse are associated with problem gambling. As with other mental health conditions, these conditions can co-occur at the same time. Establishing the sequence and order of conditions is difficult, and evidence from longitudinal studies of youth has shown mixed results, with alcohol consumption being associated with later onset of gambling problems in some studies but not in others. Better understanding of the relationship between substance misuse and problem gambling is needed and, as with other mental health conditions, it should be recognised that the relationship may be cyclical, reinforcing and impact different people in different ways.

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[42] This study differs from APMS in two ways. First, it uses the diagnostic term pathological gambling, given when a score of 5 or more is attained when answering the DSM-IV screen. The APMS analysis uses a threshold of 3 or more to represent problem gambling as this is commonly used in gambling policy in Great Britain. Second, NEARC measured lifetime pathological gambling rates. That is, whether a respondent had ever experienced a range of difficulties. APMS measures current rates of problem gambling, that is problems experienced in the past 12 months.

Personality traits/cognitive distortions: Finally, Wardle (2015) discussed the relationship between certain personality traits and problem gambling. This summarised evidence from Johansson et al (2009) which concluded that cognitive distortions, such as erroneous perceptions of gambling and illusion of control, were well established risk factors for problem gambling. Odlaug & Chamberlain (2014) in a selective literature review of personality dimensions and problem gambling noted that personality traits, such as impulsivity, were associated with gambling problems. However, they also highlighted that other factors may play a role in this relationship. Odlaug et al (2013) also highlighted evidence showing that impulsivity is a key personality trait of pathological gamblers but also stated this could be mediated through a variety of other factors. They also noted that pathological gamblers experience a range of other personality disorders.

In summary, there is a strong body of evidence highlighting the relationship between various personality traits, such as cognitive distortions or impulsivity, with problem gambling. However, little research has been conducted to explore the complex interaction of personality traits with other factors and their combined influence on the experience of broader gambling harms. Certain personality traits and/or cognitive distortions are just one potential aspect of vulnerability which is likely to be affected by a range of other factors.

3.4   Other effects and vulnerability

Wardle (2015) identified problem gamblers who were seeking treatment as a vulnerable group, because they are in the process of attempting to recover from gambling problems. Wardle (2015) identified a few international studies which examined the experiences of those in treatment and their outcomes post-treatment. These studies looked at experiences of 'recovery' and 'relapse' either during or after treatment.[43] No studies were identified that looked at these issues among those receiving treatment in Britain and none were identified for this study.

This small body of evidence shows high rates of 'relapse' among those receiving treatment.. A common theme is that despite differences in the definition of 'relapse' and study methodologies, most participants experienced some form of 'relapse' after treatment (Oaks et al, 2012). In one study, the 'relapse' rate was as high as 92% (Hodgins & el-Guabaly, 2004). A more recent US-based study examined relapse (defined as deviation from a participant's treatment goal) and factors associated with it. This found that at the first follow-up post treatment, 42% of participants had relapsed, by the fourth follow-up, 26% had relapsed (since the last contact with the research team) (Gomes et al, 2016).

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[43] There are various perspectives about what 'recovery' from problem gambling and 'relapse' means (Ledgerwood & Petry, 2006). Nower and Blaszczynski (2008) argued that the concept of recovery was imprecise and that it should be viewed as any kind of movement along a spectrum of improvement. Recovery from problem gambling is not, in the views of some, synonymous with abstinence from gambling. Approaches to treatment vary from total abstinence to allowing the gambler to re-engage in a controlled way. Processes of 'natural recovery' have also been noted, whereby the gambler is able to change and moderate their own behaviour without need for outside assistance. Concepts of 'relapse' have been borrowed from substance use literature and it is not clear that 'relapse' has the same meaning in the context of gambling treatment and studies need to clearly define what they view as a 'relapse'.

A few studies have examined reasons for 'relapse' among problem gamblers and have highlighted the "complex interplay between factors integral to predicting a relapse event" (Smith et al, 2015) or stated that "relapse is a complex, non-linear process involving factors that together can increase a gambler's vulnerability to relapse" (Oaks et al, 2012). Reasons given for 'relapse' ranged from a variety of individual, personal and environmental features which interact with each other. The urge to gamble has been highlighted as particularly important by a few studies, with the urge being triggered either internally (for example, through depression or mood variance) or externally (for example, as a response to gambling related cues) (Smith et al, 2015).[44]

Since the prior review a few other studies examining relapse and recovery have been published. Jiminez-Murcia et al (2016) found that being of younger age and lower educational attainment were associated with higher rates of relapse and drop-out from therapy. In this study, relapse was described as non-abstinence from gambling. As the authors note, this is concerning as these groups, especially youth are more likely to experience problems and, based on this evidence, could be less likely to complete treatment successfully.

The extent to which this is true in Britain is unknown. Gomes et al (2016) found that life stress and a person's self-perception of their own ability to resist gambling was significantly associated with relapse post treatment. The greater a person's perception of their ability to resist gambling, the less likely they were to relapse whilst those who experience stressful life events were more likely to relapse (Gomes et al, 2016).

Although the evidence base is slim and there are difficulties with definition, findings suggest a high degree of 'relapse' post-treatment with reasons for relapse including environmental cues alongside other individual and personal explanations. This is consistent with knowledge from alcohol and drug studies where the evidence base is more advanced.

3.5   Conclusion

Problem gambling can affect anyone at any time. Whilst rates of problem gambling among all adults in Britain tend to be less than 1% there are some groups who are more likely to experience problems. These are younger people (including students), those with constrained economic circumstances, those from minority ethnic groups, homeless people, those living in areas of greater deprivation, those with other mental health issues and substance abuse/misuse disorders, those with poorer intellectual functioning, prisoners and, potentially, immigrants. These groups could all be considered vulnerable to gambling problems. Little is

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[44] Oaks et al (2012) conducted qualitative interviews with problem gamblers to examine their reasons for 'relapse'. Along with negative states and emotions, financial difficulties and boredom, environmental triggers such as gambling accessibility and visual gambling cues (ranging from advertising to the venues themselves) were highlighted as factors which push people towards 'relapse'. This is supported by work from Hodgins and el-Guebaly (2004) who argued that social and situational cues in the environment were part of the explanation for 'relapse' (alongside others). Smith et al (2015) and Oei & Gordon (2008) discussed the relevance of gambling urges as an explanatory factor in 'relapse', with gambling urges being associated with both relapse and continuation of gambling. Finally, a longitudinal study of gambling behaviour among men, where data was collected and compared over 10 years, found that the strongest predictor of past year gambling problems was a history of past gambling problems, demonstrating the potentially recurring nature of gambling problems for some (Scherrer et al, 2007).

known about why this is but simply knowing these groups are at greater risk is important as many could be considered vulnerable people more generally.

Local authorities will already be working closely with many of these groups of people and should use these relationships to think about how best to protect these people from gambling problems. Others may represent new target groups (such as students) in which local authorities may wish to build awareness of gambling problems and think about developing harm minimisation programmes. Of course, not everyone with each of these characteristics will experience harm from gambling and not everyone in each group gambles – it's simply that there is a higher risk for these groups which gives an opportunity to try to intervene to offer greater protection for those who need it.

4 Gambling behaviour and problem gambling in Leeds

4.1 Introduction

A major aim of this study was to provide Leeds City Council (the Council) with an estimate of the extent of problem gambling in Leeds. To do this, we have combined relevant national datasets to explore:

- How problem and at risk gambling varies by different types of area nationally, and;
- Drawing on this insight, provided best estimates of the likely prevalence of problem and at risk gambling in Leeds

Chapter 1 has set out the distinction around 'problem gambling' and gambling related harm, and defines problem gambling as "gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits". In their Diagnostics and Statistics Manual 5 (DSM), the American Psychological Association classifies 'disordered gambling' as a behavioural addiction and it is classified as an impulse control disorder according to the International Classification of Diseases.

In addition to problem gambling, this chapter also considers those at risk. Gambling problems exist on a spectrum of behaviour ranging from no difficulties to severe difficulties; stability in gambling behaviour is not the norm. There are some people who experience negative outcomes and harms as a result of their gambling but who are not categorised as 'problem' gamblers. Looking at this 'at risk' group is important for two reasons. First, there are greater numbers of people who are at risk than who have problems meaning the contribution at risk gamblers make to overall levels of harm across the whole population is likely to be higher than that of problem gamblers. Second, this is a group of people with whom prevention initiatives should be targeted to help prevent problems escalating.

As noted in Chapter 2, rates of problem and at risk gambling in Britain have tended to be relatively stable despite major changes in gambling opportunities (Wardle et al, 2014; Gambling Commission, 2016). However, a focus on average rates of problem and at risk gambling nationally masks important distinctions and Chapter 2 also showed extensive evidence that some groups are more likely to experience problems with their gambling behaviour. Consequently, rates of problem and at risk gambling are likely to vary in different locations, based on local demographic profiles, economic activity and other area characteristics and the communities themselves.

4.2 Measuring prevalence of problem gambling

To date, analysis of problem and at risk gambling in Britain has not focused on how problems vary regionally, with little assessment also of rates by different types of area. Most surveys of gambling behaviour tend to only identify around 50-60 problem gamblers, making analysis of regional and sub-regional variations impractical. To analyse sub-regional patterns one would need either a bespoke localised prevalence survey (which, as noted in Chapter 1 and Annex B, was beyond the scope of the resourcing or timetable for this study) or to work with, and across, combined relevant national datasets to boost sample sizes for analysis. This is the approach taken for this study.

Datasets: To date, a number of national studies have measured problem and at risk gambling among the British population. The following studies are classified as national statistics, meaning they have been conducted to the highest standards of statistical rigour:[45]

- The British Gambling Prevalence Survey[46] (BGPS) series (1999, 2007, 2010)
- The Health Survey for England (HSE) (2012, 2015)
- The Scottish Health Survey (SHeS) (2012, 2014, 2015)
- The Adult Psychiatric Morbidity Survey (2007)

The most recent data available for England is the HSE 2012, as data from 2015 will not be published until 2017.

In HSE 2012, 6791 adults aged 16 and over answered the gambling questions. Of which, 32 were identified as problem gamblers. This survey alone does not give large enough sample sizes to analyse regional variations in problem and at risk gambling. When sample sizes are small, as with the HSE, it is common to combine datasets to boost the number of people of interest for analysis.[47] For this project, we combined data from the HSE 2012 with data from the BGPS 2010 (England only) because:

- Problem gambling and at risk gambling rates have stayed broadly stable over time, therefore it is unlikely that a major change in gambling behaviour occurred between 2010 and 2012.[48]

- Both studies used the same gambling questions to collect data and the same self-completion methodology. This minimises the risk of differences between the two surveys because of what questions were asked or how they were asked

- The factors associated with problem and at risk gambling were similar in both studies

- They are both nationally representative surveys, conducted to gold standard methodology, assigned national statistic status

- Combining the two studies gives an increased national sample size for England of 13,338 people who answered the problem gambling questions (6,791 from HSE; 6,547 from the BGPS), 96 people defined as problem gamblers and 658 defined as at risk gamblers, allowing more in-depth analysis of how rates vary by area to be conducted.[49]

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[45] In addition to these data, the Gambling Commission has begun to collect problem gambling estimates, using a mini screen, in their quarterly omnibus study. The first results of this were published in 2016. However, the sample sizes of this study are not sufficient to analyse geographical variations, with around 4000 people interviewed across Britain per year.

[46] This study included England, Scotland and Wales.

[47] This approach has been used on numerous studies. For example, the HSE 2002 focused on young people and combined data from 2001 and 2002 to boost base sizes for analysis. A report for the Department of Health looking at the health behaviours of mothers and children combined data from HSE 2006 and 2008. More recently, academics at the University of Sheffield have combined gambling data from BGPS 2007, 2010 and the HSE 2012 to explore different problem gambler types. See Sproston et al (2003); Graham et al (2016); James, O'Malley & Tunney (2016).

[48] See Wardle et al, (2014) for a more detailed discussion of this.

[49] One difference between the studies is the way they were presented to participants. HSE 2012 was presented as a study of health and lifestyle, of which the gambling questions were just one small component. The BGPS 2010 was presented as a survey of the national lottery and other gambling behaviour. A Canadian experiment showed that when problem gambling data are collected within health surveys, estimates tend to be lower than those collected within gambling studies (Williams & Volberg, 2009). Although the BGPS and HSE were not conducted

This combined dataset has been used to explore how problem and at risk gambling varies among people living in different types of places and, using this insight, to provided best estimates of likely rates of problem and at risk gambling among those living in Leeds.

Measures of problem gambling: There are many different ways to measure problem gambling. The BGPS and the HSE used two different ways of measuring problem gambling. The first was based on a set of questions adapted from the American Psychological Association's Diagnostic and Statistics Manual IV (DSM-IV) to identify problem gamblers. Questions ranged from whether someone had chased their losses to whether they had committed a crime to fund their gambling. The second method was the Problem Gambling Severity Index (PGSI). This includes questions about chasing losses but, unlike, the DSM-IV also asks some questions about harm caused by gambling, such as harm to health. These two measures capture a slightly different range of problems and thus identify slightly different groups of problem gamblers. This chapter also includes a third measure of problem gambling: anyone who was identified as a problem gambler according to *either* the DSM-IV or the PGSI. Further details about DSM-IV and PGSI are provided Annex D.

These three methods also include measurement of at risk gambling. These are people who report experiencing some difficulties with their gambling but not enough to classify them as a problem gambler. In this chapter, results are presented using all three methods (the DSM-IV, the PGSI and either). Consistency of patterns in problem and at risk gambling is considered across all three methods. This gives greater confidence in the results reported.

4.3   An overview of the combined analysis

This chapter presents analysis in two ways. First, we present national level insight about how past year gambling activity, the number of gambling activities and problem and at risk gambling varies among people living in different types of areas in England. Using the combined BGPS/HSE data we explore how gambling behaviour varies by:

- Government Office Region
- The Office of National Statistics ward classification (ranging from industrial areas to countryside)
- The Department of Environmental and Rural Affairs (DEFRA) classification of Local Authorities (ranging from major urban to rural)
- Local authority type
- DEFRA's urban/rural classification[50]

More information about these classifications, including how the city of Leeds is categorised according to these national standards is given in Section 4.5.

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concurrently, this broad pattern appears to be true in Great Britain, with estimates of problem gambling collected via HSE 2012 being lower than those collected in the BGPS 2010. A reason for this is that gambling studies may be more likely to attract gamblers to take part because the topic is more relevant to them, thus giving slightly higher rates of problem gambling. For this study, we are not interested in differences in estimates *between* the two studies but rather how problem gambling rates vary by different areas/regions and among different types of people when the data are combined.

[50] See Annex D for a definition of each.

Our second set of analyses provides best estimates of gambling behaviour among those who live within the Leeds Metropolitan District. This builds on analysis of regional patterns in gambling behaviour across England and presents new analysis of gambling behaviour in Leeds and areas like Leeds.

Despite the combined BGPS/HSE dataset giving a large sample size of over 13,000 people, only 184 people lived within the Leeds Metropolitan District, making analysis difficult. To explore how gambling behaviour varied in areas like Leeds, people living in Leeds and similar places were grouped together to boost sample sizes and give more confidence to findings. We call these our comparison areas. Each comparison area was carefully chosen and matched based on a range of relevant characteristics, agreed in advance with the Council.

The places with likely similarities to Leeds considered were Manchester, Liverpool, Sheffield, Doncaster, Newcastle, Bristol and Birmingham. We compared the profile of each area to Leeds looking at the following: the proportion of economically inactive people; the ethnic profile of the population; the age profile of the population; area deprivation; median household income and population density. Based on this comparison, we determined that people living in Sheffield, Newcastle, Liverpool and Birmingham were sufficiently similar to those in Leeds to be included in our comparison areas. Grouping people who lived in these places together with those who lived in Leeds gave a total sample size of 657 people for analysis. Full details about the choice of comparison area is given in Annex C.

4.4   Measures of area type

National measures: Part of this chapter looks at how gambling behaviour varies among people living in different types of area. Because the survey data were collected in 2009/2010 (BGPS) and 2012 respectively, we use geographical and regional variables that were available for both datasets at that time. In some cases, this means our variables are based on classification systems developed using the 2001 census or that were in use in early 2000s. We acknowledge that some of these measures have since changed but we have to use data that was contemporary to the time of data collection.[51]

What type of area is Leeds: As we are analysing how gambling behaviour varies among people living in different types of area, it is important to consider the type of area that Leeds is. The Leeds Metropolitan District is diverse, incorporating commercial and cosmopolitan areas of central Leeds, areas dominated by the major universities, areas of greater deprivation and some areas with concentrated populations of people from minority ethnic groups. Recent analysis of the Leeds economy has shown that it is both growing and changing vastly, with a vibrant financial and business services sector, though Leeds still has the third highest

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[51] For example, we analyse gambling behaviour by the Office of National Statistics (ONS) 2001 classification of ward types. Wards are broadly electoral districts and in 2001, based on analysis of the census data, the ONS created a system of classifying each ward into a broader type, based on its characteristics. These classifications have since been updated, based on new analysis of the 2011 census (available from 2015 onwards). We use the 2001 definition in this report as that was the classification system available at the time of data collection. However an analysis of how Leeds' ONS 2011 Classifications would compare to the 2001 Classification types has been included in Annex D. The other measures of area type included in this main report are Local Authority type, which has not changed, and classification systems developed and used by DEFRA, which are still in broad use. For more details, please see Annex D.

manufacturing sector in the UK.[52] The city also has above average rates of deprivation, with 22% of Lower Super Output Areas in Leeds being ranked in the top 10% of most deprived area nationally.[53]

In terms of population profile, the proportion of people from minority ethnic groups in Leeds is similar to the national average (15%)[54] whilst the unemployment rate is marginally higher among those living in Leeds than nationally (5.7% vs 5.1%)[55]. Leeds also has a generally younger population profile than nationally, with 28.1% of residents being between the ages of 18-34 compared with 22.7% nationally[56]. Tables 4.1 and 4.2 below show how Leeds is classified according to area characteristics analysed in this report.

Table 4.1: Classification of the local authority area, by area characteristics

Area characteristic	Leeds
Government Office Region	Yorkshire and the Humber
DEFRA LA type	Major Urban
LA type	English Metropolitan
Urban/Rural classification	Urban (more than 10,000 people) in a less sparse setting

Table 4.2 Proportion of wards in local authority area classified by ONS type, compared with the national average

ONS 2001 ward type:	Leeds	National average
Industrial hinterland	27.4%	17.0%
Traditional manufacturing	26.0%	8.7%
Student community	14.6%	6.7%
Multicultural metropolitan	2.0%	7.0%
Suburbs & small towns	30.0%	27.2%

As Table 4.1 shows, the Leeds metropolitan district area is a major urban, more densely populated area and an English metropolitan local authority. Looking at Table 4.2, a higher proportion of wards in the Leeds Metropolitan District are classified as industrial hinterland and traditional manufacturing areas than nationally. Likewise, a higher proportion of wards are classified as student communities in Leeds than nationally. A lower proportion of wards than the national average are classified as multicultural metropolitan and broadly similar proportions of wards to the national average are classified as suburbs and small towns. Understanding these area characteristics is important, especially as our first stage of analysis seeks to explore how gambling behaviour varies in areas like these.

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[52] See http://www.leeds.gov.uk/docs/Leeds%20Economy%20presentation%20-%20March%202016.pdf
[53] See http://observatory.leeds.gov.uk/
[54] Minority Ethnic Groups - Census for England and Wales 2011
[55] ONS, Annual Population Survey Dec 2015
[56] ONS, mid-year population estimates, 2014

4.5 Results: past year gambling behaviour in England and comparison areas

In this section we set out the results for:

- Past year gambling behaviour in England overall using the combined BGPS/HSE dataset to provide a benchmark for local contrasts based on national averages; and
- analyses of how gambling behaviour varies among people living in different types of area, and finally;
- assess how past year gambling prevalence varies in Leeds and areas like Leeds

The analysis conventions are given in Annex D. All differences noted in the commentary are statistically significant at the 95% level ($p<0.05$).

The national picture: gambling behaviour in England in the past year: Analysis of the combined BGPS/HSE data showed that 67% of adults aged 16 and over in England had gambled in the past year. This ranged from people who only played the National Lottery once or twice to those who engaged in a number of other gambling activities. Overall, 4% of adults had gambled at a casino in the past year. Figure 4.1 shows the number of gambling activities undertaken in the past year. The vast majority (76%) had taken part in less than two gambling activities in the 12 months prior to interview (an average of 1.7 activities). Past year gamblers had taken part in 2.5 gambling activities on average.

Figure 4.1: Number of gambling activities undertaken in the past year in England
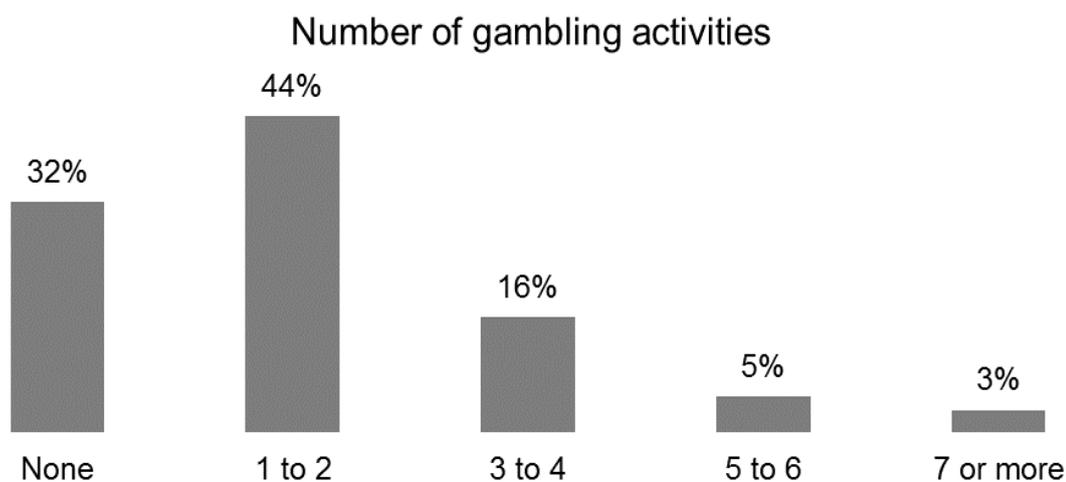
Regional variations: gambling behaviour in England by area type: Looking at general patterns across England, past year gambling on any activity varied by Government Office Region, ONS ward classification, Local Authority (LA) type and classification. As Figure 4.2 shows, there appears to be a north/south divide with rates of past year gambling being higher in the north and lower in the south. Rates of past year gambling by LA type followed a similar pattern, being lower in London boroughs (55%) and higher in other LA types (70% for metropolitan and non-metropolitan boroughs).

Figure 4.2: Past year gambling prevalence, by Government Office Region
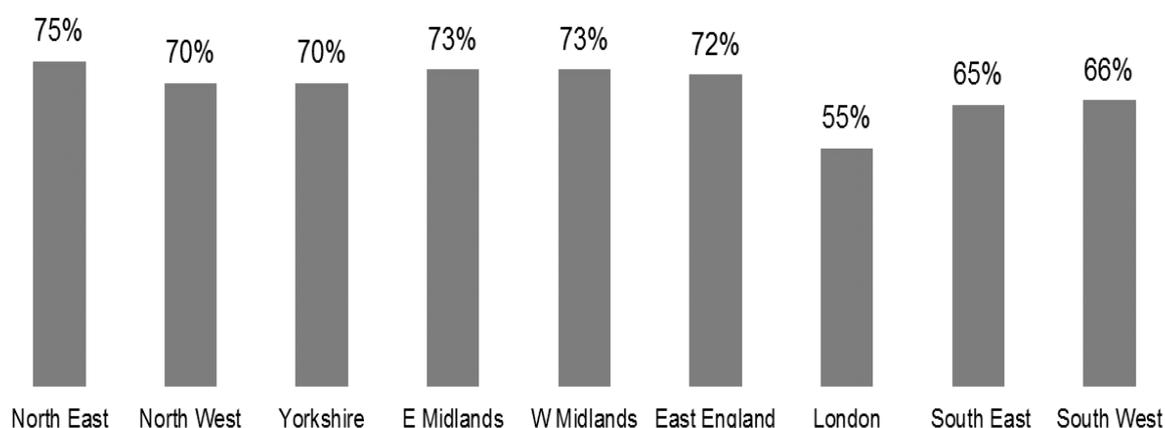
Past year gambling varied by DEFRA's classification of LA type but with no clear pattern. Estimates ranged from 63% in LAs classified as 'major urban' to 71% for those classified as 'large urban' (see Table 4.3). Finally, past year gambling varied based on ONS ward classification with past year gambling rates tending to be higher among those living in wards classified as industrial or manufacturing areas (71% and 74% respectively) and lower among those living in wards classified as multicultural metropolitan or prospering metropolitan (46% and 54% respectively).

Table 4.3 Gambling behaviour, by area type

Base: All who answered the gambling questions in the BGPS 2010 and the HSE 2012					
Area characteristic	**Whether gambled in the past year**		**Mean number of gambling activities undertaken by gamblers**	***Bases***	
	Yes	No		*Unweighted*	*Weighted[57]*
	%	%		*n*	*n*
All (England)	**67**	**33**	**2.5**	***13338***	***13455***
Government Office Region					
North East	75	25	2.5	*876*	*682*
North West	70	30	2.6	*1926*	*1799*
Yorkshire and The Humber	70	30	2.5	*1237*	*1355*
East Midlands	73	27	2.4	*1245*	*1159*
West Midlands	72	28	2.6	*1369*	*1394*
East of England	71	29	2.5	*1524*	*1495*

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[57] Survey data are weighted to take into account non-response to the surveys and to ensure that resulting sample match the age, sex and geographic distribution of England. See Craig et al (2013) and Wardle et al (2011) for further details.

London	55	45	2.4	*1624*	*1995*
South East	65	35	2.5	*2126*	*2188*
South West	66	34	2.2	*1411*	*1389*
ONS ward classification					
Industrial Hinterlands	74	26	2.5	*2416*	*2301*
Traditional Manufacturing	71	29	2.7	*1258*	*1245*
Built-up Areas	64	36	2.6	*240*	*263*
Prospering Metropolitan	55	45	2.5	*370*	*453*
Student Communities	60	40	2.6	*748*	*783*
Multicultural Metropolitan	46	54	2.4	*814*	*1041*
Suburbs and Small Towns	70	30	2.4	*4274*	*4255*
Coastal and Countryside	71	29	2.4	*2277*	*2222*
Accessible Countryside	64	36	2.2	*837*	*792*
DEFRA's classification of Local Authorities					
Major Urban	63	37	2.5	*4368*	*4050*
Large Urban	71	29	2.7	*1738*	*1735*
Other Urban	70	30	2.5	*1930*	*1925*
Significant Rural	68	32	2.4	*1837*	*1865*
Rural – 50	70	30	2.4	*2015*	*2125*
Rural – 80	69	31	2.3	*1552*	*1621*
Local Authority type					
City of London & London Boroughs	55	45	2.4	*1615*	*1983*
English Metropolitan districts	70	30	2.6	*2696*	*2642*
English non-metropolitan districts	70	30	2.4	*6736*	*6516*
English Unitary Authorities	69	31	2.5	*2258*	*2278*
DEFRA's Urban/Rural classification					
Urban (more than 10,000 people) in a sparse setting	73	27	2.0	*144*	*136*
Urban (more than 10,000 people) in a less sparse setting	67	33	2.5	*10469*	*10736*
Rural - town & fringe in a less sparse setting	70	30	2.3	*1182*	*1133*
Rural - village in a less sparse setting	66	34	2.1	*981*	*924*
Rural – village in a sparse setting and all hamlets & isolated dwellings	66	34	2.4	*562*	*526*

Table 4.3 also shows the average number of gambling activities undertaken by gamblers. This shows whether gamblers in certain areas are more or less involved with gambling generally. Overall, past year gamblers had taken part in 2.5 activities. Gamblers in the North West and the West Midlands participated in the highest number of gambling activities in the past year (2.6) whereas those in the South West participated in the least (2.2, on average). Gamblers living in Yorkshire and the Humber participated in 2.5 gambling activities, which was the same as the average for all gamblers nationally.

The average number of gambling activities undertaken by gamblers was highest in traditional manufacturing wards (2.7) and lowest in wards classified as accessible countryside (2.2). There was an interesting pattern by which gamblers living in wards classified as built-up or student communities (2.6) participated in a higher than average number of gambling activities. This is notable as people living in these areas were less likely to gamble generally. However, it appears that those who do are somewhat more engaged in range of gambling activities than average.

Figure 4.3 shows the average number of gambling activities undertaken by gamblers by DEFRA's classification of LAs. Gamblers living in major urban areas took part in a higher number of activities (2.7) than those living in rural areas (2.3-2.4). Likewise, gamblers living in more sparsely populated areas (regardless of whether they were urban or rural) took part in a lesser range of gambling activities on average than those living in more populated areas.

Figure 4.3: Mean number of gambling activities undertaken by gamblers, by DEFRA
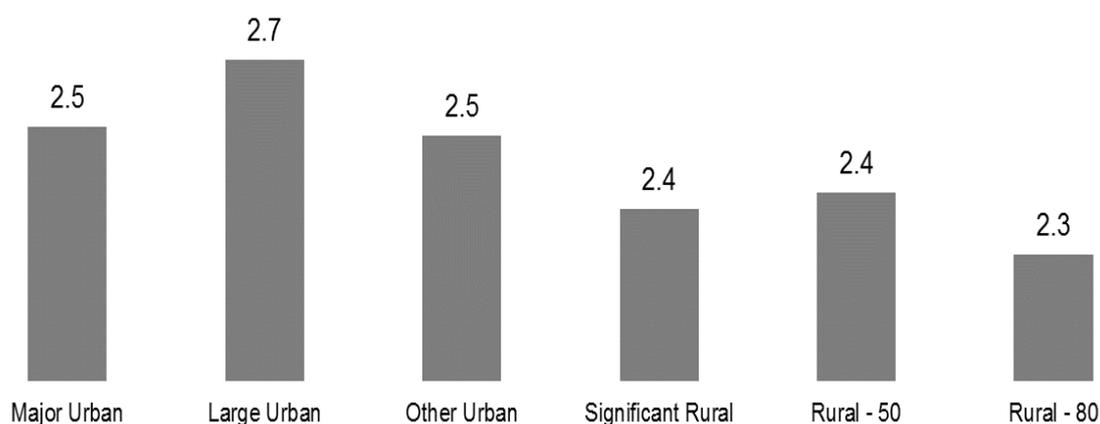
Finally, gamblers living in metropolitan LAs took part in a greater number of gambling activities, on average (2.6) than other LA types.

Past year gambling behaviour in Leeds and areas like Leeds (comparison areas): Table 4.4 shows past year gambling prevalence rates and the average number of gambling activities undertaken by gamblers living in areas with similarities to Leeds (including Leeds itself, called comparison areas).

Rates of past year gambling did not vary according to whether someone lived in a Leeds comparison area or not (rates were 68% and 67% respectively). However, the average number of activities undertaken in the past year by gamblers did vary. Among those living in Leeds comparison areas, gamblers took part in 2.7 activities per year on average compared with 2.4 for those who lived in other areas.

This means that whilst people living in comparison areas were no more likely to have gambled than others, those that did gamble typically engaged in a slightly broader range of activities. For example, 6% of those living in Leeds comparison areas took part in 7 or more different activities compared with 3% of those living in other areas. Overall, 7% of people living in Leeds comparison areas had gambled at a casino in the past year, higher than the national average of 4%. This is not surprising given that casinos are located in metropolitan areas so people in these areas have greater access to casinos whereas those in rural areas do not.

These results are in line with the findings by area type nationally. The average number of gambling activities undertaken by gamblers was higher in wards classified as traditional manufacturing or student communities, which are over-represented in Leeds. They were also higher in urban areas and metropolitan LAs, which both typify the Leeds metropolitan district.

Table 4.4 Gambling behaviour in Leeds and areas like Leeds

Base: All who answered the gambling questions in the BGPS 2010 and the HSE 2012					
Area characteristic	Whether gambled in the past year		Mean number of gambling activities undertaken by gamblers	*Bases*	
	Yes	No		*Unweighted*	*Weighted*
	%	%		*N*	*N*
All (England)	**67**	**33**	**2.5**	***13338***	***13455***
Area type					
Leeds comparison areas	68	32	2.7	*686*	*715*
Non-comparison areas	67	33	2.4	*12652*	*12741*

4.6   Results - Problem and at risk gambling

As with the prior section, we first look at problem and at risk gambling rates for England nationally, then look at regional variation among different types of areas and finally assess likely rates of problem and at risk gambling in Leeds and areas like Leeds.

The national picture: problem and at risk gambling in England: Problem and at risk gambling rates for England are shown in Table 4.5. Using the combined BGPS/HSE data, 0.7% of adults in England according to the DSM-IV were classified as problem gamblers and a further 3.4% were at risk. According to the PGSI, 0.5% of adults in England were classified as problem gamblers, with 1.4% being classified as moderate risk and 4.3% as low risk gamblers. Finally, according to either screen, 0.9% of adults in England were classified as problem gamblers and a further 5.5% as at risk, according to the combined HSE/BGPS dataset. Therefore, depending on the measure used, estimates of problem gambling among adults in England range between **0.5% and 0.9%.** The rest of this chapter looks at how these

estimates vary among people living in different places, recognising that gambling problems are not equally distributed.

Table 4.5: Problem gambling prevalence according to each measurement instrument

Base: All aged 16 and over with valid gambling responses in the BGPS 2010/HSE 2012

Problem gambling status	Problem gambling measurement instrument		
	DSM-IV	PGSI	Either screen
Non-problem gambler	96.0%	93.7%	93.7%
At risk gambler	3.4%	5.7%	5.5%
Problem gambler	0.7%	0.5%	0.9%

Regional variation: Problem and at risk gambling, by area type: In this section, we look at how problem gambling rates vary among people living in different types of area in England. (Tables of geographical contrasts for problem gambling rates are shown in Annex E). Table 4.6 summarises findings for each area characteristic considered and shows whether problem gambling rates varied significantly according to each of the three classification methods.

Table 4.6: Whether problem gambling varies significantly by area characteristics according to all three measures of problem gambling

Area characteristic	Problem gambling screen		
	DSM-IV	PGSI	Either
Government Office Region	▪		▪
ONS ward classification	▪	▪	▪
DEFRA's classification of Local Authorities	▪	▪	▪
Local Authority type	▪	▪	▪
Defra's Rural/Urban classification	▪		▪

As can be seen from Table 4.6, problem gambling varied by ONS ward type, DEFRA'S classification of Local Authorities and LA type according to all three measures (the DSM-IV, the PGSI and whether someone was a problem gambler according to either).

Looking at DEFRA's LA type first, rates of problem gambling were shown to be highest for people living in urban areas generally and where rates varied between 0.9 and 1.3 per cent. And were higher for what were classified as major urban areas. Correspondingly, they tended

to be lowest among those living in rural areas (rates varied between 0.3% and 0.7%) (See Figure 4.4).

Figure 4.4: Problem gambling (according to either screen), by DEFRA's Local Authority type
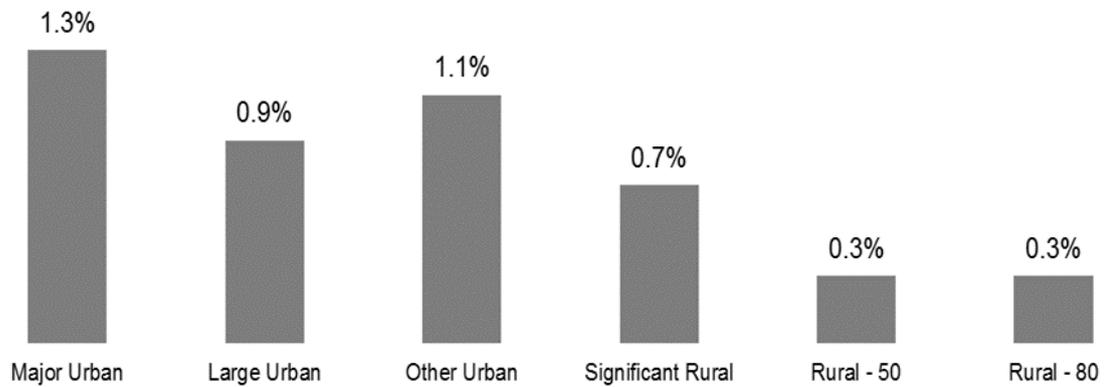
Problem gambling rates were also higher among those living in either London boroughs (rates varying between 1.0% and 1.3%, depending on the screen) and metropolitan LAs (0.7% - 1.3%) than those living in non-metropolitan LAs (where rates varied between 0.3% and 0.5%) (see Figure 4.5).

Figure 4.5: Problem gambling (according to either screen), by Local Authority type
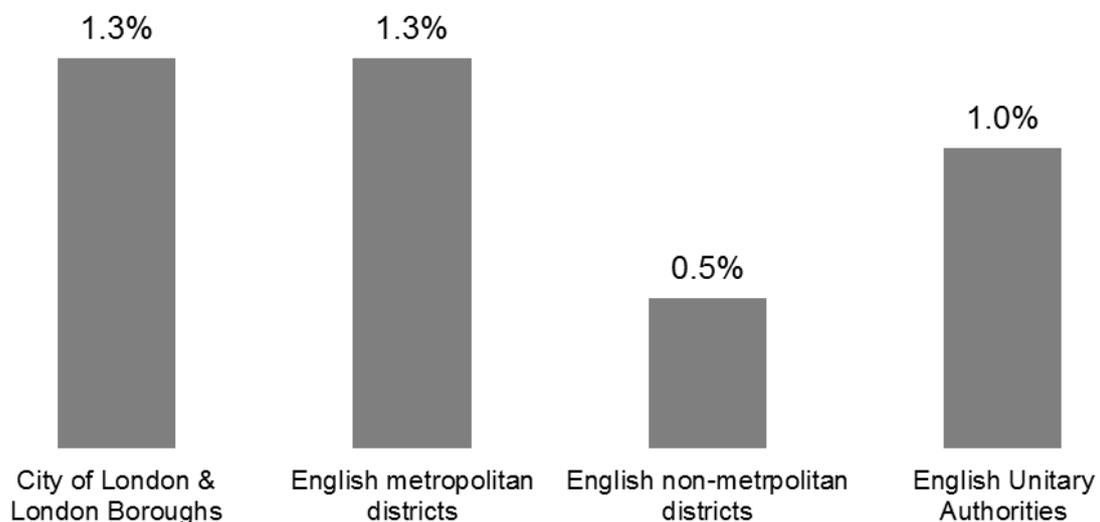
For ward classification, rates of problem gambling tended to be higher among people living in wards classified as prosperous metropolitan and multicultural metropolitan. Problem gambling was also higher than average among people living in wards classified as industrial hinterlands or traditional manufacturing. This pattern is notable as industrial hinterland and traditional manufacturing wards are over-represented in the International Classification of Diseases. Rates of problem gambling were lowest among people living in wards classified as

student communities, suburbs or small towns, coastal and accessible countryside areas (see Figure 4.6).

Figure 4.6: Problem gambling (according to either screen), by ONS ward type
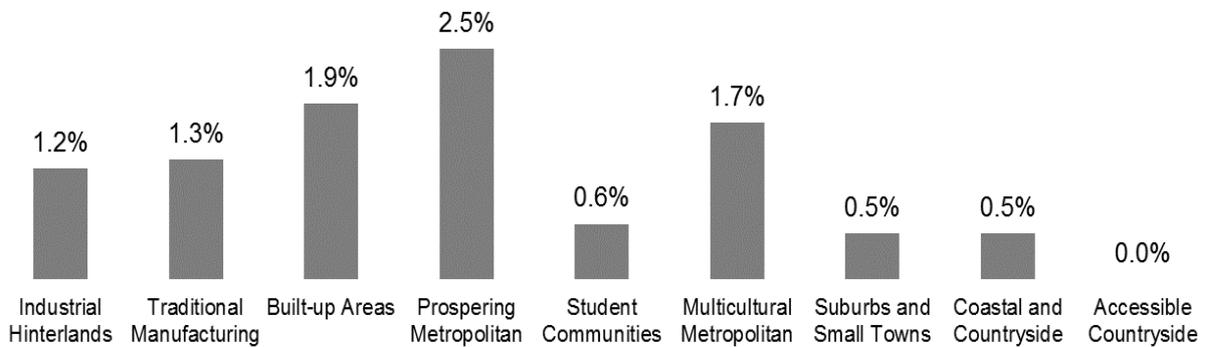
As shown in Table 4.6, for the other two area characteristics considered (urban/rural classification and Government Office Region) problem gambling rates when measured by the DSM-IV or either screen but not the PGSI.

Looking at problem gambling according to the DSM-IV or either screen, the broad pattern was that rates of problem gambling were higher in more densely populated urban areas and lower in rural, more sparsely populated areas (see Figure 4.7).

Figure 4.7: Problem gambling (according to either screen), by urban/rural classification
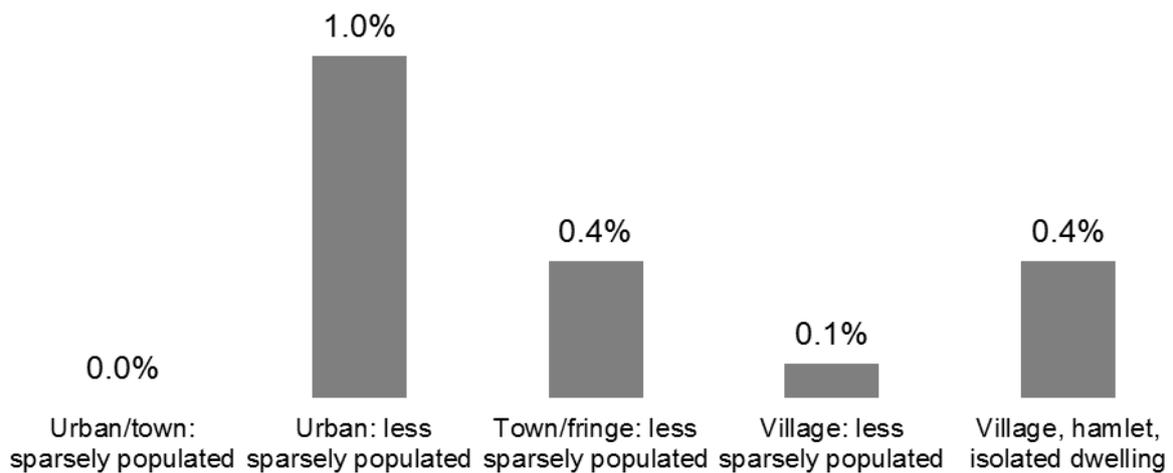
Finally, looking at Government Office Region, the broad pattern was that rates of problem gambling were higher among those living in the North (1.3% in Yorkshire and Humber; 1.2% in the North West and 1.0% in the North East), and also in the West Midlands (1.3%) and

London (1.3%). In contrast, they were substantially lower among those living in the South West and South East. (See Figure 4.8).

Figure 4.8: Problem gambling (according to either screen), by Government Office Region
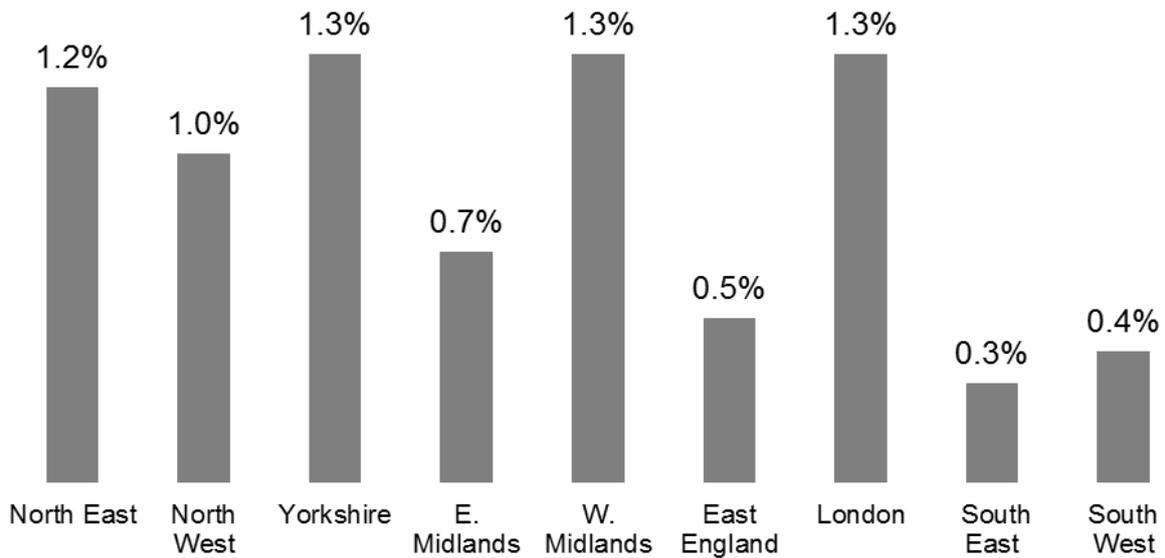
Rates of at risk gambling showed some patterns similar to that of problem gambling, being higher in urban areas and lower in rural areas, though in major urban areas (like the Leeds Metropolitan District) at risk rates were the same as average. At risk gambling tended to be higher in urban, more densely populated areas and lower in more sparsely populated areas. Rates also tended to be higher among people living in wards classified as traditional manufacturing and student communities. At risk gambling varied by Government Office Region varied with no clear pattern.

Taking this analysis together, there is a broad pattern in which the types of areas which typify Leeds generally have higher than average rates of problem gambling. However, the results for at risk gambling are more mixed.

Problem and at risk gambling in Leeds and areas like Leeds (comparison areas): Table 4.7 shows rates of problem and at risk gambling, according to the DSM-IV, the PGSI and either screen, for those living in Leeds and areas like Leeds. Looking at the DSM-IV first, overall 1.4% of those living in Leeds comparison areas were problem gamblers according to this measure. These estimates were broadly double the national average of 0.7%.

According to the PGSI, 1.4% of those living in Leeds comparison areas were problem gamblers. These estimates were roughly three times higher than the national average for England (0.5%).

When looking at problem gambling according to either the DSM-IV or the PGSI, estimates of problem gambling were 1.8% among those living in Leeds comparison areas compared with 0.9% nationally, broadly double the national average for England (see Figure 4.9). The

confidence interval for problem gambling in Leeds comparison areas according to either screen was 1.0% to 3.4%, meaning we are 95% certain the estimate falls within this range.

Figure 4.9: Problem gambling (according to either screen), in Leeds and areas like Leeds

When examining at risk gambling rates, there was not as much variation from national averages, nor was there a consistent pattern across the different measurement instruments. For example, looking at the DSM-IV screen, at risk rates were higher in Leeds comparison areas (4.2%) than other areas (3.4%) but at risk rates did not vary when measured by the PGSI or either screen. According to either screen, rates of at risk gambling were 5.6% among those living in Leeds comparison areas and were 5.5% nationally.

Table 4.7: Problem and at risk gambling according, by Leeds area type

Problem gambling screen	Area type		All
	Leeds comparison areas	Non-Leeds comparisons areas	
	%	%	%
DSM-IV			
Non-problem gambler	94.4	96.0	96.0
At risk gambler	4.2	3.4	3.3
Problem gamblers	1.4	0.6	0.7
PGSI			
Non-problem gambler	92.7	93.8	93.7
Low risk gambler	5.2	4.3	4.3
Moderate risk gambler	0.8	1.4	1.4
Problem gambler	1.4	0.5	0.5
Status according to either screen			
Non-problem gambler	92.5	93.7	93.7
At risk gambler	5.6	5.5	5.5
Problem gamblers	1.8	0.8	0.9
*Bases**			
Weighted	*686*	*12738*	*13453*
Unweighted	*715*	*12652*	*13338*

Base: All who answered the DSM-IV screen in the BGPS 2010 and HSE 2012 (table note at top)

***Bases shown are for either screen, bases vary slightly for the DSM-IV and PGSI separately.*

4.7 Conclusion

Gambling behaviour, and problem gambling, is not equally distributed across England. As Chapter 2, showed, to date, there is strong evidence that those from minority ethnic groups, those with constrained economic circumstances and those living in more deprived areas are more likely to experience problems from their gambling.

New analysis presented in this chapter has shown how problem gambling rates vary among people living in different types of area in England. Specifically, it highlighted that those living in more Northern areas (and London), major urban areas, urban areas which are more densely populated, English Metropolitan boroughs and London boroughs, those living in wards classified as industrial, traditional manufacturing, prosperous or multi-cultural are also more likely to have higher rates of problem gambling. This may be because of the type of people who live in these areas, because of certain features of the areas themselves, or most likely, a mix of the two.

These patterns are important as many of these area characteristics are consistent with features which describe the dynamics of the metropolitan district. Based on this analysis alone we would expect rates of problem gambling in Leeds to be higher than national averages. Our analysis of problem gambling rates in Leeds and areas like Leeds shows this to be the case.

Summarising findings from all three screening methods we estimate that areas with similarities to Leeds and Leeds itself are likely to have problem gambling rates broadly twice the national average. It is particularly reassuring that this evidence and pattern was consistent across all three ways to measure problem gambling.

In contrast, local rates of at risk gambling appear to be broadly similar to national estimates – at around 5-6%. Overall, we estimate that between 7-8% of people in Leeds and areas like Leeds are **either** problem or at risk gamblers. This is slightly higher than the national average of c.5-6%, with the majority of the difference being accounted for by higher rates of problem gambling.

As stated at the outset of this chapter, focus on at risk groups is important as these are people for whom early and effective interventions will aim to prevent problems escalating. They are also greater in number so effectively intervening with those at risk has the potential to have a larger impact at a population level on the reduction of gambling related harm. Based on the analysis presented in this chapter, it would also appear that demand for support services for problem gamblers in areas like Leeds might be higher than originally anticipated given the higher rates of problem gambling observed. This should be considered in any future harm minimisation strategy developed by the Council.

We also see scope for the findings from this analysis to also be considered by operators when producing their local risk assessments, which should reflect the elevated rates of problem gambling in areas like Leeds. Operators should build on this insight to outline what steps they will take to protect vulnerable people from harm.

5   Stakeholder perspectives on problem gambling and gambling related harm in Leeds

5.1   Introduction

In the previous chapter the extent of problem gambling in Leeds was estimated through analysis of survey data relating to the factors affecting problem gambling. This chapter builds on this quantitative analysis and presents an on-the-ground view of problem gambling through in-depth conversations with key support services (referred to as stakeholders within this chapter). A total of 21 organisations across the statutory, charitable and voluntary sectors were invited to contribute and just over four in five of these were able to do so (see Annex B for the list of participating stakeholders and description of the interview approach). Many provided insights from several members of staff. Extracts from these conversations are included throughout the chapter, providing vivid accounts of the issues associated with problem gambling as experienced by local support services. It looks in particular at:

- Impressions of the scale of problem gambling in Leeds

- Characteristics of problem gambling in Leeds and vulnerable groupings

- Known impacts from gambling related harms among problem gamblers

- Harm avoidance and harm minimisation in Leeds

- Support services for problem gamblers in Leeds

In addition, the interviews (see Annex B for the overall approach) reviewed available data on problem and at risk gambling from, for example, agency based monitoring or management information systems for clients, but remarkably little was forthcoming because stakeholders almost universally lacked any screening devices to isolate or identify problem gamblers from other client groups. The evidence here is consequently almost wholly subjective but its value lies in setting out the perceptions and understanding among those agencies with whom the Council is likely to be working in any future Leeds-based harm minimisation strategy.

5.2   Views on the scale of problem gambling in Leeds

Key stakeholders were asked to describe their experiences in relation to gambling related harm in an attempt to understand the scale of the issue from the perspective of support services. From the responses[58] it was clear that stakeholders had a range of experiences and considered the issue both in terms of problem gambling as defined in Chapter 1, and in terms of gambling related harm as a broader social problem. As noted, stakeholders encountered considerable difficulty in quantifying the extent of problem gambling and gambling related harm in Leeds primarily due to information deficiencies, problems of screening and a recognised reluctance of individuals to disclose information. It was also highlighted that this was even more difficult where gambling is a contributory factor to the problems which these

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[58] The evidence across stakeholders has been brought together through a Framework Analysis setting out individual agency views and experiences (see Annex B).

agencies focussed on (i.e. co-morbid) and not either the main problem source or the main focus for any intervention such as debt management.

The following stakeholders attempted to quantify their experiences of supporting problem gamblers in the last twelve months. Their insights also highlight some of the difficulties encountered by support services in accurately recording information in relation to problem gambling among the general public and identified vulnerable groups including students, the homeless, and those recovering from addiction. Only one was able to quantify as an approximate proportion the level of problem gambling among the populations they worked with:

> *"You are looking at around 1%, for ones that stood out you're probably looking at about, six, seven, eight, throughout the year, and they [University Financial Support Service] have just under a thousand applications [applications for financial support]. But it's how you categorise it, because actually the Lottery, we never really considered that a problem but you would see many more students with regular payments going out to the National Lottery. One student actually wrote on their application that it was an essential piece of expenditure that she had to have a Lottery ticket".*
> *[University Financial Support Service]*

One advice centre handling multiple information and advice needs for residents observed:

> *"We could not even guess what the scale of the problem is … people just don't declare what's behind the problems they have with debt or whatever; it's a hidden problem"*
> *[Local advice centre]*

Others saw the scale of problem gambling solely in terms of how many people they recognised from recent past client groups as having harms associated with gambling. For example:

> *"It's reasonably low for the ones I have teased it out from, probably five or ten percent, I don't necessarily think that would be the total, I would say it's probably in the region of 15-25 people [in a 12 month period] and it's pretty steady, it's difficult [to accurately quantify] because you do get some people coming back repeatedly".*
> *[Faith-based Support Service A]*

> *"I think as a primary reason ….things we know about, I would say it would be quite low, I would say we are looking at two people within a twelve month period. But it becomes higher if you equate other issues with some sort of gambling which they are undertaking, but it may not be their full support need".*
> *[Homeless Support Service A]*

> *'I think when it comes to gambling, one of the things like most types of addiction is the hidden aspect of it. For those where gambling is the main issue, since January 2014 we've seen around 20 people, and 2 or 3 of those would be gambling huge amounts of money on casinos …The rest would be scratch-cards, bookies, but not the same amounts of money, they're not putting £1000 down on a bet, [but] they're spending the money they should be spending on food ….so that's the type of proportions we're seeing'.*
> *[Faith-based Support Service B]*

Whilst not all stakeholders could quantify or had experience of dealing with individual problem gamblers, the following stakeholders expressed concern over the issue and acknowledged that screening and recording deficiencies within their organisations may prevent them from accurately capturing this data:

> *"From what I have heard from frontline workers is that it's not issues around gambling that have led to debt that have come up, although there's not always the detail where the debt has come from. So we're certainly not aware that issues have been around gambling but we've not asked explicitly either".*
> *[Mental Health Support Service]*

> *"It's not something we've specifically targeted but having said that, my personal feeling as someone who is looking for the future of the Charity is that it could be a tsunami, we've seen the tsunami from alcopops, we've seen the tsunami from legal highs like Spice, I think gambling is the hidden tsunami. I think it's repressed and hidden throughout society almost like alcoholism, it's an easy one to hide is alcoholism and I think gambling is even easier".*

> *"It's one of the things we might have to look more carefully at, because someone might say to us 'my wife kicked me out' and at the moment we would take that as gospel, but it could have been the fact that 'my wife kicked me out because of my gambling', but we're not asking that question. All we're asking is why are you here? 'Family breakdown, tick the box', so we could dig one question deeper and find out and put that on our database".*
> *[Homeless Support Service B]*

For one stakeholder engaged in supporting individuals within Black and Minority Ethnic (BME) communities, gambling among emerging communities comprising of refugees, asylum seekers and migrants from eastern and central Europe, was identified as a worrying trend. Their concerns rest on the social, health and safeguarding threats which the charity associates particularly with gambling by young men from these communities. Within the literature, emerging communities have been identified as potentially being at greater risk (see Chapter 2) from gambling related harm, although more research is needed to understand this relationship.

From this stakeholder evidence, the link between gambling related harm and emerging communities primarily focuses on their limited social, economic and environmental circumstances which lead to heightened vulnerability. These concerns were echoed during the interview(s), where it was discussed that young men with extremely limited financial circumstances from emerging communities were congregating within and around betting shops which have become social spaces for these individuals. In addition to concerns over their lifestyle and financial welfare, the stakeholder raised specific concerns over scratch-card and casino gambling behaviour among BME communities and warned of their vulnerability to involvement in exploitation, criminality and substance abuse:

> *"One worrying trend we have noticed; Take Harehills and Lincoln Green, LS9 and LS8, if you take a three mile radius you have many bookies, and you find people who are*

young and from emerging communities in the betting shops, but most of them can't find a job, they are on low income or no income, they could be an asylum seeker living on £35 a week but they hope they could multiply that money and it's becoming a sort of lifestyle for these people".

"It's not just the betting shops if you go to the casino you will find 50% of the people there from BME communities, communities that are not really visible in other areas, for example the Chinese community, you will find them there and lots of Africans, but the problem is you [also] get a lot of bad apples there, that's where young people get hooked around drugs and crime".
[Health and Wellbeing Support Service]

From these initial insights into the scale of gambling related harm in Leeds, gambling activity at the surface level can be characterised as broad based, involving different gambling products and a wide range of participants including groups considered to be at greater risk (see Chapter 2). The following section explores the characteristics of problem gambling in Leeds in more detail, focusing on distinctive features which may influence prevalence prior to an examination of stakeholder impact evidence later in this chapter.

5.3   Characteristics of problem gambling in Leeds

In order to gain a deeper understanding of the interaction between participants, gambling products and harm in Leeds, stakeholders were asked to describe gambling behaviour amongst the groups with which they work. The following sections describe gambling activity among the key stakeholder groups: students, emerging communities and the homeless and low income groups. These groupings do not precisely match those set out as vulnerable groups (from the national evidence) in Chapter 3 but they do reflect the focus of experience of stakeholders working with often specific needs groups such as the homeless or those seeking personal or family debt management support.

Student gambling characteristics: As discussed in the scoping review in Chapter 3 there is strong evidence that young adults are vulnerable to the experience of gambling problems or are at risk of experiencing gambling problems (see Chapter 3). However, data for student gambling is limited and evidence from this study has highlighted the difficulties in identifying and capturing data in relation to student gambling. Whilst gambling problems were considered to be 'outside the top ten' of student financial concerns, below issues such as student loans, credit cards, rent arrears, benefits, payday loans, council tax arrears, and childcare; student vulnerability to gambling related harm was highlighted as a concern. In response, one University Support Service described holding a small event as part of *National Student Money Week* (08.02.16 - 12.02.16) to raise awareness of the issue. This event was also held in part due to the Service becoming aware that the new GGV Casino would be opening later in the year:

"The thought process behind the event was that you have several thousand 18 and 19 year olds moving to Leeds in September / October at a similar time to when the casino is opening and there may be a fair bit of publicity, advertising and talk about it in the City and maybe use that as a little idea to highlight the dangers of it [gambling] really. You only need to walk down the Headrow and there are bookies everywhere. The

casino just triggered that awareness that maybe this is something we should make the effort to educate students on. It's attractive to students, it's a night out, maybe you have had a few too many drinks and the next day you wake up and you've lost two or three hundred pounds in a casino and that's a lot of money to a student".
[University Financial Advice Service]

Whilst the opening of the new (GGV) casino was thought likely to be attractive to students, in general the Service believed that the majority of student gambling was online, although it was acknowledged that this is easier to identify from transaction information than cash debits for other forms of gambling. It was also discussed that student gambling would be a continuing focus for the Service, as it was recognised that better data was needed to understand the extent of student gambling, and that future events would be held to raise awareness of the issue.

Emerging community gambling characteristics: In Section 5.2 gambling among emerging communities was identified by several of these stakeholders as a worrying trend. This was particularly in relation to client engagement with bookmakers and also lottery-based and scratch-card products. Digging deeper into these activities from stakeholder reports reveals more complex foundations among emerging communities and in particular a lack of accessible social spaces and poor life opportunities which were together considered to be drivers for risk behaviours within this activity. It was also highlighted that among these communities in Leeds, poor English language skills, an issue underpinning poor life opportunities, were no barrier to participation in gambling:

> *"It's the machines and also betting on football, most of them are big fans of football so they don't have an interest in horse racing, but football is a massive thing but also the slot machines. It's a paradox that even those who have limited English, you can find them playing Black Jack at the casino, they're smart, they may not have the language but they can work that out. It's all about the money so they can work it out".*
> *[Health and Wellbeing Support Service]*

Feedback gathered by the stakeholder suggests that whilst gambling activity is popular among individuals from emerging communities, the use of betting shops was also linked to the absence of other forms of leisure provision such as a leisure centres. In many areas of Leeds, for people from emerging communities, betting shops provided safe social spaces, particularly for single young men who were seen to have nowhere else to go:

> *"One is the lack of other social spaces, two, [in] life for these young people there is no source of any other hope. …they come here with ambition to turn their life around but the reality is totally different and they feel stuck, and going betting is a small source of hope. You have that small amount of money to play with and you can hope, maybe you have won one time, so that's one of the attractions".*
> *[Health and Wellbeing Support Service]*

Whilst it was discussed that the majority of gambling within emerging communities involves young single men, scratch-card gambling was highlighted as a more broadly-based (one said a *"…massive"*) problem and one that involved women as well as men engaged in betting shop gambling:

"There is a shop around the corner from our office and you see people buying five, six, seven, ten scratch-cards at a time, and if they get anything they buy another 20. I was talking about betting shops, but scratch-cards are a massive problem. Especially if it is pay day when their benefits are coming in, you see people investing a good percentage of their income on scratch-cards".

"It's a very highly deprived area where we work, if you are spending £20 on scratch-cards and your fortnightly income is £95 that's a lot of money. With scratch-cards, one of the things you notice is the majority of the people buying them are women, but there is definitely an overlap between the people you see in the betting shop and those who buy scratch-cards".
[Health and Wellbeing Support Service]

These experiences were mainly observational but stakeholders also drew on specific client experiences. One stakeholder had previous experience of a specific problem relating to casino marketing activity attracting individuals from emerging communities. Here, they cited an example of an asylum seeker in Leeds who would repeatedly visit a casino in order to benefit from promotional giveaways:

"I don't know if it's happening now, but one of the big attractions with the casinos was that they give away free stuff, and that's a massive attraction. Back in 2008/2009 this asylum seeker would almost live on this, during the summer they would get a BBQ set or a 32 inch TV and that was a massive attraction, a freebie for them, so they would get that TV and then sell it etc. If you don't have any money a small tiny freebie is a massive attraction and they get hooked there".
[Health and Wellbeing Support Service]

Homeless and very low-income gambling characteristics: Scratch-card gambling was also recognised by stakeholders working with homeless people and those on very low-incomes. For this group, as in the case of emerging community gambling, deprivation, substance abuse, convenience, hope, and instant gratification were considered to be contributory factors or motivations for gambling:

"So a story we see repeated every two weeks is that payday arrives, the person has a budget, they've had advice on how to manage their money and they know what it [the budget] looks like. Come payday they'll go to the Post Office because these guys can't have bank accounts, so the only way is for them to draw out all their cash in one go, then they've got cash in hand and they walk into the newsagents with every intention of just getting tea bags and milk, but £80 will go on scratch-cards straightaway, but then the guilt kicks in, they stop accessing services because of the guilt, but to comfort themselves they'll go out and gamble either scratch-cards or in the bookies; scratch-cards seem more appealing to those with low levels of literacy and numeracy, they're more inclined to do scratch-cards rather than at the bookies".

"Then one week after they've been paid, they're skint, no food in the cupboards, you try to contact them again, then in the days leading up to the next payday they're getting loans off other people to gamble, so they start the next pay-cycle minus the loan, and

it's often in cahoots with drinking and drug addiction, and that's sometimes a way of
dealing with it … "I've done it again, I'm just worthless".
[Faith-based Support Service B]

Although scratch-card gambling was identified as prevalent among homeless people, it was considered to be a lower priority in comparison to other problem behaviours such as alcohol addiction and drug use for the little disposable income available to individuals. Mental health was also regarded as an important underlying factor influencing gambling behaviour among this group, with one well-placed stakeholder observing:

"One person I'm thinking of who we're working with at the moment. He will go and
spend all of his benefits money [on horse racing] as soon as it comes in the hope. I'm
not convinced, on many occasions he has talked about voices in his head so again I
think there are a lot of mental health issues as well. So it's not only that that this might
be 'my great win and my life is going to be easy', but underlying it there are mental
health issues".
[Faith-based Support Service A]

Stakeholders also discussed social and environmental factors with similar problems being identified to those described for individuals from emerging communities:

"I do think in Leeds City centre the availability of bookies is an issue, there are lots of
places in Leeds, it could be replicated elsewhere, where you have your classic shops
all lined up, Cash Converters next to the bookies, next to the chemists for the person
using Methadone, Lincoln Green would be an example of it here; and this is on
people's doorsteps. You can be involved in criminality, sell your goods to Cash
Converters, and while picking up your Methadone you can go and have a blast in the
bookies, and you will have a boozer next door as well, so it's very difficult for people to
escape from …their routine is tied up in their locality. It's probably being reproduced
elsewhere, but for the size of Leeds it can be magnified".
[Faith-based Support Service B]

Leeds was also described as a demographically dynamic city by one stakeholder with rich and poor living in close proximity. This juxtaposition was thought may contribute to feelings of resentment expressed by individuals who are struggling to make ends meet, echoing similar feelings of envy discussed by stakeholders working with emerging communities:

"My experience of the people I come into contact with gambling related issues are
those in the 30-40 age range. I would say 80% are people who are on benefits or on
no benefits. Most of them have a roof over their head but by no description could that
be called a home. I mean I had someone in this morning who had been given a room
or a flat and had nothing in it whatsoever, and had no money to do anything with it, so
yes he had a roof over his head but no way of furnishing it".
[Faith-based Support Service A]

Several stakeholders acknowledged their lack of information about how problem gambling related to specific activities:

"The people we help just don't own up to it [problem gambling] … if they don't say we cannot force it out of them; so we are running blind on what are often the activities which are behind problems".
[Local advice centre]

5.4   The impact of gambling related harm in Leeds

Building on the previous discussion surrounding gambling behaviour, stakeholders were also asked to describe the impact of this activity on the people they work with and the implications for supporting individuals with gambling related problems. Evidence here was more clearly objective since it stemmed from mainstream activities of many of these agencies – helping individuals in dealing with specific problems or challenges. However, the evidence tended to be case based and the lack of assessment or monitoring systems which could identify, and record, problem gamblers held back any systematic measurement.

Student gambling impacts*:* For students, the primary impact was said to be financial e.g. rent arrears and other debts, but that it could have potentially disastrous consequences for their studies. Furthermore, students with problems may withdraw from friendship groups, leading to isolation and potential mental health difficulties. It was also discussed that student gambling problems were compounded by peer pressure to maintain the lifestyle of their non-gambling friends, this coupled with a tendency to deny problems, and the optimism that they can solve things through further gambling, was said to present considerable problems for those trying to support students in difficulty:

"The students I've seen have always not seen it as a problem and they rationalise it that they did win a couple of weeks ago, so it doesn't matter that they've lost a few because they have won as well, but they don't see the downward trajectory of their finances".

"For some students there is that pressure to maintain that lifestyle which would mean we would meet them at desperation point really. But again they wouldn't be willing to admit it was much of a problem, the problem was that they didn't have any money not the way they were spending it… excuses such as 'it's because student funding is so bad' that sort of thing. Also, it's sort of that never, never, approach, this will come right at some point, that type of mentality I guess".
[University Financial Support Service]

Emerging community gambling impacts*:* The impact of gambling within emerging communities was primarily viewed in terms of the negative health and social impacts for individuals and communities in what are already deprived areas (see above). This overlap between health and gambling is illustrated below:

"Also, the trend with scratch cards, you see people going into the shop, and it's repeated frequently, they will go in and buy a massive bottle of cider and the next things on the list will be tobacco and scratch-cards and that's a repeated trend".

"So you can see the overlap between alcohol, smoking and gambling related issues. It's not a lifestyle choice but people are sort of forced into that way of living, there is a

lot of despair in their lives so the alcohol would help in their mind with their pain and the scratch cards would give them a bit of hope".
[Health and Wellbeing Support Service]

It was also identified that whilst some individuals with gambling problems would turn to support services like food banks, many, particularly young men from emerging communities would not seek professional help as they would not consider it a problem, relying instead on support from their peers. This reluctance to seek help was attributed in part to the cultural unacceptability of gambling for many BME groups.

Homeless and very low income gambling impacts: A range of impacts were identified by stakeholders involved in supporting the homeless and individuals on very low incomes. Whilst some of the problems are comparable to those identified for emerging communities living in deprived areas, for example health issues relating to comorbidity; mental health and associated physical health problems were identified as key impacts for this group:

"It's feeding issues of low-self-esteem and increased levels of anxiety, if you're anxious for pay-day, but also don't want it to happen as you're stuck in a cycle. So it's tied up with mental health, given that it leads to the complete mismanagement of money, you're then looking at adults with severe hygiene issues, everything from personal hygiene to looking after the state of the flat, nutritional poverty and relational poverty as well. Because if you've got no money you tend to be hanging out with those who also have no money".

"[It] … brings a certain level of insular behaviour – we're all a group of rejects, rather than having money to do things like go to the cinema, or go swimming or things like that, that's just off the radar".
[Faith-based Support Service B]

Other identified problems included criminality, relationship breakdown and financial ruin. Although gambling was recognised as a cause of homelessness, drink and drug addiction were considered to be more prevalent causes. However, stakeholders also felt that gambling was an underreported problem, due to individuals not considering gambling an addiction or not wanting to reveal their problems. This latter aspect was considered a key challenge for support workers and one that was notably different to other addictions such and drink or drug dependency. In comparison, gambling addictions were considered particularly difficult to support due to the problem of dealing with individuals who often have a compulsion to lie about their problems:

"What we've noticed here as support workers is that lying is closely related to it and is almost a bigger problem than the gambling because they are so used to it, lying, covering tracks and hiding things away. It makes our job as support workers difficult because you are almost dealing with a compulsive liar as much as a compulsive gambler. They might have owned up to ten things but there's a hidden eleventh problem. Whereas if you are using drugs for example you can't really hide the fact you're doing heroin every day".
[Homeless Support Service A]

Shame was also seen as a factor underpinning non-disclosure of gambling behaviours. One agency with a specialisation in debt management for citizens observed that:

> *"When they are in deep … mortgage repossession, eviction and the sort, we take them through what they have going in and what exactly is going out; and all too often it does not add up … there is a spending gap somewhere and we suspect its often gambling spend. They just don't open up about it, they say they don't know. I think its shame that it's got them that far … a sort of denial they cannot open up to".*
> *[Local advice centre]*

Another observed:

> *"Gambling is probably more in the category of pornography addiction rather than heroin or drink addiction, it's hidden, people don't want to talk about it but we know it's there, but it's harder to spot, there's a lot more shame attached to it".*
> *[Faith based organisation]*

Stakeholders also highlighted the paradox that whilst problem gambling is often stigmatised, gambling is accepted as a legitimate entertainment activity, something which is not the case with drug use:

> *"But there are people who manage their gambling well and that's the other side of it, because gambling is entertainment, for example cannabis or other drugs might be called recreation, but it's not really an entertaining evening if you shoot up heroin in your arm every night. But with gambling you can spend a perfectly legitimate three or four hours on your phone gambling and it's not a problem because it's entertainment. But for some people it is a problem, it's very difficult and I think there is still a stigma attached to gambling. For people who can't stop it's extremely destructive".*
> *[Homeless Support Service A]*

5.5   Harm avoidance and harm minimisation in Leeds

In the following sections harm avoidance and harm minimisation support in Leeds is examined in three parts. First, the current mechanisms used by stakeholders to support individuals with gambling related problems are examined. Second, examples of good practice are then identified to highlight strengths in current provision, and third stakeholders' views are reported to understand how support services can be improved in the future to better address the problem.

Current support for problem gambling in Leeds: Understanding the current support provided by stakeholders represents the first step in forming any future approach to supporting individuals with gambling related problems in Leeds. Importantly, whilst not all stakeholders had direct experience of helping individuals with gambling problems, all stated that they would be able provide assistance even if this was limited to indirect support, or partial support combined with signposting to other organisations who they considered better able to help.

However, from the stakeholder conversations it is clear that compared to other addiction problems, gambling poses a greater challenge even for organisations experienced in dealing

with individuals with multiple and complex needs. It was also expressed by several stakeholders that whilst they felt they were indirectly supporting individuals with gambling problems, for example by providing financial budgeting advice, they were treating the symptoms and not the cause.

Specific support for gambling addiction was described as limited and fragmented. There was little knowledge of the existence of a gambling specific therapy and counselling service (in NECA). Only three of the interviewed stakeholders were aware of NECA or GamCare as a local offer, and one of those interviewed felt in the Leeds agency where he was a support worker, knowledge was limited to his past experience of GamCare from a previous appointment in a statutory service in another metropolitan area. Even when prompted no others recognised the existence of NECA services although several welcome the opportunity to link with any such provision for referral. One, however, cautioned:

> *"Local support [for problem gamblers] could be much better networked ….but that could only work if and where people open up about it [problem gambling] as the root of debt or other challenges)"*
> *[Local Advice Centre]*

Stakeholder feedback suggested there was far less partnership working and collaboration relating to problem gamblers in comparison to strategies developed to tackle issues such as alcohol abuse, drug addiction, homelessness and poverty, which are seen (among these interviewees) as well established and integrated in Leeds and generally well regarded. As one stakeholder said:

> *"There seems to be very little on offer, in comparison to the way that joint working happens on other aspects such as homelessness and poverty and all those things, perhaps we are supporting indirectly, but I don't think we're supporting gambling as a problem directly and as I say I haven't been able to find anything that is specifically setup, there may be something small locally but I haven't come across anything so it's sort of suck it and see really in terms of provision and picking up once the damage has happened".*
> *[Faith-based Support Service A]*

Three of the stakeholders felt that their natural referral arrangements for problem gamblers was to services based outside Leeds. For two faith-based organisations, this was to Christian charities offering sheltered support and with which they had working relationships for other troubled clients. Another cited Spacious Places as a charity with whom they referred individuals for cognitive behavioural therapy. One other signposted to *Better Leeds Communities*, but was unsure where those signposting links took clients subsequently.

Opportunities for developing existing support services: Despite stakeholder criticism of available support for problem gambling in comparison to other addictions, the resourcefulness and willingness of several stakeholders to develop interventions was highlighted during the conversations. Many were keen to reflect on their current operations and suggest ways in which existing services could be adapted and harnessed to better provide for the needs of problem gamblers. For clarity, where interviewed stakeholders made a number of specific

proposals for development and adjustment, these are attributed here to the organisations making these.

This opportunity to benefit from transferable skills and expertise demonstrates that there is latent potential within existing service provision which could be supported to help address the problem and enhance the level of support for problem gamblers in Leeds. Some even noted that the experience of taking part in the study was sufficient to start them thinking about what they could do to enhance the services they provide:

> *"I think just knowing if there was increasing concern [around gambling] would be good so that might mean we would start asking people more questions. I think it has highlighted, and it has really helped me think about the issue more and that there may be a need and to be more aware".*
> *[Leeds Mind]*

Of the various opportunities identified, Touchstone suggested that their *Plan to Change* peer support group approach could be a way forward, building on the initiative's demonstrated success with people affected by alcohol dependency. This approach provides a friendly, non-judgemental safe space in which individuals can be supported through various activities and partner support services:

Peer-support was also put forward as a possible approach by Leeds Mind who discussed that they operate a number of peer-support groups for different mental health issues and that problem gambling could potentially be added to that list if there was a need and if the right facilitator could be found. Regarding this latter aspect, the Charity stated that they offer facilitator training to support this process:

> *"As part of that we offer a facilitator course, so if you had someone who had been affected and had been able to move on from that and wanted to help others in the same situation, we would be able to help with that. So it would be a bit like AA groups or peer support for drugs and alcohol etc. Leeds Mind has lots of peer support e.g. anxiety, bereavement, suicide, general mental health and it seems that a group for gambling could be a really good way of supporting people to manage or move away from that type of behaviour".*
> *[Leeds Mind]*

St George's Crypt also thought that their existing support service network could be harnessed to support problem gamblers who had become homeless. This includes potential support via their hostel and *Growing Rooms* support services:

> *"We're a signposting charity, we can't be experts in everything, but we are experts in in alcohol and drugs, but our dry hostel – it's a men's hostel, should any of them be detoxed from gambling, we would take them in and appropriate training would be given to our staff to deal with that. But it would also go through the 'Growing Rooms', which covers cognitive therapy on addictive behaviour, so it covers all forms of addictive behaviour, rather than the specialisms of the addiction, so I think they could quite easily manage someone with a gambling problem".*
> *[St George's Crypt]*

Further support opportunities were discussed by Lighthouse which runs a 12-step *Christians Against Poverty* programme, open to, and currently supporting people with gambling addictions. Whilst this programme provides dedicated support, the Charity stressed the need to raise awareness of the issue and noted the low uptake rates to the programme, which were attributed to stigma around problem gambling and a perception that it isn't a genuine addiction as it doesn't have a 'chemical hook':

> *"When it comes to it, people seem far more comfortable talking about being a heroin addict or an alcoholic, than they do talking about not being able to walk into a shop with £50 without spending it all on scratch-cards".*

> *"I don't think we get many people attending our 12-step programme with gambling addictions because it's not really seen as an addiction, it probably has more shame attached to it than other addictions because why can't I go and buy them? It's not the same as say heroin, where they can say it's a chemical addiction, and it seems like gambling isn't seen as a full addiction because there are no chemical hooks. So there's a need to raise the profile of the issues around gambling addiction.*
> *[Lighthouse]*

5.6   Harm minimisation support and treatment services

Building on the review of current services this section examines good practice examples identified through stakeholder conversations which could inform a future strategy for addressing problem gambling in Leeds.

Current good practice in Leeds: In the previous section stakeholder discussions highlighted differences in resourcing, approach and collaboration for addressing problem gambling in comparison to support for drug and alcohol dependency. Support via Forward Leeds was presented as a current model of good practice for supporting individuals with drug or alcohol problems by several stakeholders, whilst others praised the high levels of collaboration in Leeds for addressing addiction issues, poverty and homelessness. For these stakeholders, it was clear that a similar dedicated collaborative approach would be needed to address the issue of problem gambling, this is summed up by the following comment:

> *"For example if someone comes with a drug or alcohol problem Forward Leeds know exactly where to go, signpost them straightaway, it's a hub, you can turn up, but there's not a hub for gambling. There's a lot of joined up thinking in Leeds, but there is something missing, and in my view if you want to go down a specific route of say going to GA [Gamblers Anonymous] meetings each week, then you have some support there and that might work. But if you don't want to go down that route where do you turn? I know there are specific gambling rehab centres in the UK, but there are not loads of them".*
> *[Homeless Support Service A]*

Although the work of Forward Leeds in addressing drug and alcohol addictions was commended by several stakeholders, others thought a similar approach would not work for gambling within the communities they work with, and that a tailored outreach model would be

more effective. It was also suggested that Leeds has a good safety net in place to support the homeless and as a result, individuals with multiple and complex needs including gambling related problems, are better served than in other cities such as Manchester, York and London and this was thought by stakeholders to provide a good foundation on which to develop future interventions.

Future support for problem gambling in Leeds: Looking to the future, stakeholders were invited to consider what future gambling support was needed in Leeds. In the previous sections it was identified that many stakeholders were willing to develop interventions or suggest ways in which their existing services could be adapted to better provide for the needs of problem gamblers. In addition examples of best practice working were also identified which could inform a future strategy. In this final part, stakeholders were asked what was missing from current services and for recommendations on how this could be improved.

For one stakeholder, future support would involve greater industry involvement in partnership with local stakeholders; arguing that it was needed due to shrinking public health budgets and that it was in everyone's interest to work together to address the problem:

> *"It would be great to have more direct resources and help from industry for community projects rather than just taglines like 'drink aware' or 'gamble aware' which won't have the necessary impact'. I think if we could get better cooperation rather than vilifying the companies which I don't think works, so we need conversations where different agencies and businesses can work together on solutions, because it's in everybody's interest. Positive engagement rather than seeing them as villains, because it doesn't help".*
> *[Health and Wellbeing Support Service]*

For others dedicated support tailored to different groups was seen as a necessity as part of a holistic but specialised response to ensure that support services are appropriate for the people they are trying to help:

> *"A lot of the people we deal with have mental health issues with anxiety around not fitting in, so if they go along to a gambling support group and half the people there are sitting in suits and they are there because of casinos, and they're highly literate and drive a car, that's a culture shock for these guys and they're not going to hang around in that setting, so you really need a gambling support group which is targeted towards those with multiple and complex needs, and targeted towards the poverty end of things".*
> *[Faith-based Support service B]*

As a way forward the charity pointed to the 'dual diagnosis' approach employed to address issues associated with alcohol and drug addiction and mental health:

> *"So you need dual diagnosis with gambling issues so that mental health is taking on at the same time as the gambling issues. Some of that is dealing with underlying trauma and bereavement issues, which is going to help the person gamble less because they don't need that warm hug, that hit they get. So a holistic specialised response, specialised in the sense of targeting a particular demographic and those with multiple*

and complex needs, and holistic in the sense that it brings together mental health and the therapeutic side".
[Faith-based Support service B]

Accessible face-to-face support was also viewed as a missing element of provision by stakeholders, and one which was needed to increase the options available to people. The following quote articulates this need:

"It would be really good to have a dedicated unit or wing that people could drop in, I don't think it needs to be five days a week, just to have something where people can go. Yes you can ring GamCare, but it's about going somewhere where there are trained counsellors who know about it, I know there is an information line to GA so they can talk through what to expect, but again it's not for everyone, so just to have trained people who would be able to listen, look at any specific support available and give that advice. I think if people were at that stage where they would want to go to a centre there would be some degree of wanting something, but that costs money and training, in an ideal world that would be there".
[Homeless Support Service A]

5.7 Conclusion

All stakeholders considered that problem gambling could affect anyone, the majority worked with groups which were considered to be at greater risk, namely: students, emerging communities and the homeless (see Chapter 2 for more detailed discussion on vulnerable groups). From the conversations it was found that individuals engaged with the stakeholder organisations were involved in a broad range of gambling activity, involving different gambling products and venues. For many affected, at risk behaviours were often associated with low absolute levels of spending but which could represent a high proportion of their often low incomes. For some of these groups, these behaviours emerged not as lifestyle choices but as consequences of insular behaviours for some and/or disadvantaged circumstances for others, although this was a reflection also of the client groups many stakeholders worked with.

Importantly, whilst not all stakeholders had direct experience of helping individuals with gambling problems, all stated that they would be able provide assistance even if this was limited to indirect support or signposting. It was also found that whilst these groups were classed as vulnerable, all of the stakeholders identified difficulties in accurately recording the prevalence of problem gambling amongst the people they supported. This was primarily due to the hidden nature of the problem and acknowledged screening and recording deficiencies within their organisations which may prevent them from accurately capturing this data.

From the conversations it is also apparent that stakeholders were involved in addressing problem gambling in its broadest sense encompassing harm to individuals and as a broader social problem. This was particularly highlighted by the experiences of those working with the homeless and emerging communities.

While stakeholders were often critical of the current dedicated support available in Leeds for problem gambling, in comparison to other addictions, few were aware of the existence of the

specialist support that did exist through NECA. Arrangements were seen as fragmented and referral arrangements for problem gamblers were often weakly developed and in some cases focused on non-Leeds based services where stakeholders had existing working relationships. Many, however, were willing to develop interventions or adapt their existing provision to better provide for the needs of problem gamblers. In addition, many felt that the comprehensive approach taken within Leeds to address addiction issues, poverty and homelessness provided a good foundation on which to develop support for problem gambling.

6 Gambling experiences, impact and harm

6.1 Introduction

To set alongside the data, operator and stakeholder evidence, Leeds City Council (the Council) were keen for the study to explore gambling behaviour, impacts and harms of people in Leeds from the perspective of the gamblers themselves. This chapter sets out the findings from that part of the overall study through a qualitative and in-depth study with gamblers undertaken through one to one interviews. The participants were recruited from gambling venues, following a screening process, from stakeholder collaboration and from those who were seeking treatment for problems. The main areas of exploration included:

- Gambling activities
- Gambling motivations
- Gambling impacts
- Suggestions for support services and industry

The findings reveal that each participant engages in a range of gambling activities; some engage in gambling activities online and in venues. Their motivations to gamble vary, some with positive effects such as enjoying the fun of socialising and the thrill of winning. However, some gambling activities led to negative effects such as damaging impacts on finances, relationships, general health and well-being; and some simply gamble to relieve boredom. Participants also suggested ways in which support services and industry could help gamblers per se.

6.2 Methods and approach

The overall aim of the qualitative research study was to provide a snapshot of the gambling behaviour of participants that gamble in Leeds. During the qualitative interviews patterns of gambling behaviour, venues of choice, activity preference, personal circumstances, characteristics, and the impact gambling behaviour has upon the person and others were explored. Additionally, we examined the knowledge and recommendations gamblers have of gambling support and support services.

Gambling venues from major industry providers were contacted; who in turn provided access to participants that frequented bingo halls, casinos and betting shops. Additionally, participants who were seeking help for gambling problems from stakeholder centres were asked to volunteer to take part in the study by their counsellor/stakeholder agent. One to one interviews took place with participants. Nine participants were recruited via gambling venues, four participants were recruited via stakeholder centres and one via their probation officer. Participants were interviewed in licensed venues, at their home or via telephone. The characteristics of participants are diverse; details are shown in Annex B.

Those recruited were asked a range of screening questions to determine their eligibility to participate; questions included their regularity of play, types of gambling activities and risks.

Following a review of the interviews by two team members, those recruited were classified into High Harm, Low Harm and No Harm gamblers based on their reported experiences[59].

The general profile of those who took part in the interviews is shown in Table 6.1; a more detailed breakdown is shown in Annex F. The aim of the interviews was to map the diversity and range of experiences among these gamblers; and a mixture was secured by levels of harm, gender, age and working status. The selections did not attempt to be representative which would not have been possible either from resources or given the lack of 'population' evidence of problem and at risk gamblers to shape a probability approach.

Table 6.1: Overview of sample

Sample variable	Number in sample
Gambler group	
High harm gamblers in treatment	4
High harm leisure gamblers	6
Low harm leisure gamblers	2
No harm leisure gamblers	3
Gender	
Male	8
Female	7
Age	
18-24	4
25-34	2
35-44	1
45-54	2
55-64	3
65+	3
Ethnicity	
White	13
Not provided	1
Chinese	1
Employment Status	
Employed (F/T and P/T)	6
Retired (2 have been carers in the past)	6
Benefits (1 Learning Difficulties)	2
Carer	1

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[59] Gambler group classification. High harm: gambling affected them financially, caused family and relationship issues and affected their overall health and wellbeing and caused feelings of guilt or shame. Low harm: includes leisure gamblers that reflected on a gambling incident that caused them to feel guilt, learnt from it, fully in control and gamble responsibly. No Harm: gambling responsibly, no feelings of guilt. See Annex B.

As stated, Annexe F provides a more detailed profile of each participant from age when first exposed to gambling, indication of when they began gambling with their own money, employment status to details of the range of gambling activities in which they have engaged.

6.3 Patterns of gambling behaviour

This section provides an outline of the early experiences of gambling behaviour, time and money spent on gambling.

First gambling experiences: The legal age for gambling in the UK is currently 18; however, many participants had been exposed to gambling from a very early age. One of the main reasons for the early exposure to gambling was because, in some form or other, gambling was a leisure activity in which their family engaged. This is shown in Table 6.2 which details of the age that participants were exposed to gambling.

Table 6.2: Age: Gambling exposure and first gamble

	BF1	BF2	BF3	CM 1	CM 2	CM 3	CF1	CF2 P	TM1	TM2	TF1	TF2	BS M1	BS M2	BS M3
Age exposed to gambling	AL	25	28	17	AL	AL	ML	ML	AL	ML	20s	AL	11	AL	NC
Age activity gambling with own money*	17	25	28	17	17	25	NC	NC	14	17	20s	15	16	18	15

Code	Participant Recruitment	B	Bingo Hall
		C	Casino
		T	In Treatment (inc.1 participant on probation)
		BS	Betting Shop
		P	Proxy interview by family member (recruited via stakeholder centre)
	Gender	F	Female
		M	Male
	Age exposed to gambling	AL	All Life
		ML	Most of Life
		NC	Not clear

*In this instance asking a family member to place pocket money on a horse in the Grand National is not considered an activity of gambling with own money

In the context of the family, some participants had fond memories of gambling activities. The social bond with family members gave participants the perception of gambling being a leisure

activity. Further, seeing family members gambling normalised it and gave participants gambling opportunities.

> *"I remember saying I can't wait 'til I'm 18 and then I can go and play in the big clubs [had been to social club as a child and watched her parents play bingo]"*
> [Low Harm Bingo Female BF1 aged 45-54]

> *"He [father] always had the Daily Mirror. And the Daily Mirror was always folded so that the racing page was on both sides. And he did that almost religiously, really. [There was] perennial 'once a year' Grand National bet. My mum would say 'Oh, 'Ian'[60], put us a pound on that.' And I'd say 'Oh dad, put us a pound on this'."*
> [High Harm Betting Shop Male BSM2 aged 45-54]

> *"Yeah, my parents met in a casino and went to the casino every night for 30 years, so I grew up in a family of parents that went to casinos. They weren't addicted. They weren't in a bad way from it. They socially enjoyed gambling."*
> [High Harm Casino Male CM2 aged 18-24]

However, memories of gambling activities with family members for some participants is tainted as they reflected on later life consequences:

> *"You know when you go to the amusements when you were a kid... I think it started off with that, like it's built a stronger addiction to gambling. It's the feeling as a kid, you win a prize, you're happy. I loved [the] amusements. That's all I'd go to the seaside for."*
> [High Harm Treatment Female TF2 aged 18-24]
> **Note**: TF2 states her uncle has a gambling addiction.

> *"Yeah, he [father] took his pound back, how tight is that? [They shared the winnings]. But it got me... I never, ever blame my dad for it. My mum does...my mum does blame my dad for giving me the bug. But I don't, because I think that I understand what he was doing, he knew that I loved football... he knew that it was adding a little bit of excitement."*
> [High Harm Treatment Male TM2 aged 18-24]

Table 6.2 details the age in which participants gambled with their own money. Some participants gambled with their own money before they were legally able to:

> *"They wouldn't let me in the bookies, but my dad's mate who used to go to the bookies... I'd be stood outside and I'd be watching through the door and I'd see something and I'd say 'Here, put my £20 on'. Now £20 in 1974, 1975, is like £200 now."*
> [High Harm Treatment Male (Probation) TM1 aged 55-64]

> *"It started a few years ago, but it were nothing serious. It were 'I'll take my chance on this quid scratch card.' I wouldn't have dared spend a tenner on one scratch card and you'd lose it. It just started out then, really. I was about 15 then… I looked old enough."*
> [High Harm Treatment Female TF2 aged 18-24]

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[60] Ian in a pseudonym

These findings are consistent with other research findings in gambling behaviour. Some participants were introduced to gambling by family members which often normalises behaviours and provides a model for the future gambling behaviour of their children (Shead et al 2010, Gupta and Derevensky 1997, Wynne, Smith and Jacobs 1996).

However, others did not start gambling until much later; one participant began at age 25 when she met her partner (BF2). Another participant stated he began gambling at school with friends (CM1) and two other participants started gambling later in life, not with friends or family but alone (BF3, TF1). This suggests that not all people that gamble do so because they have seen it from an early age as a family pursuit.

Gambling activities, frequency and amounts of money spent: Participants often have favourite gambling activities; however, most have taken part in a variety of gambling activities over their lifetime. Figure 6.1 below shows the number of gambling activities in which participants have engaged.

Figure 6.1: Number of gambling activities
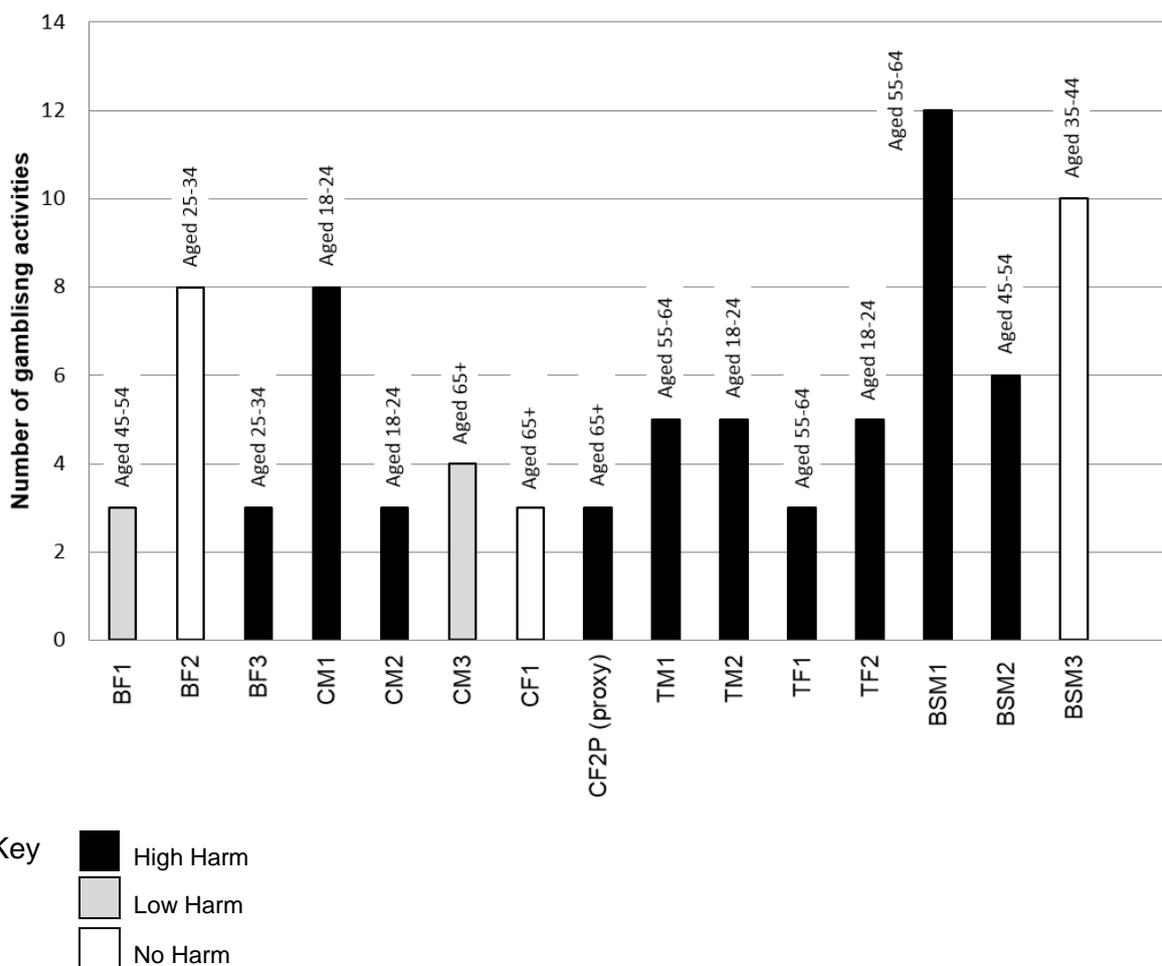
As shown in Figure 6.1 regardless of whether participants were classified as High, Low or No Harm, they have engaged in at least 3 gambling activities over their lifetime. It is interesting that some No Harm participants (BF2 and BSM3) engage in 8 or more gambling activities; a

similar number of activities to that of the High Harm Participants. Therefore, engaging in many gambling activities does not automatically pertain to high or risky gambling behaviour. Interestingly, a No Harm participant commented:

> *"We go racing [horses] quite a lot - I sound terrible, don't I? [laughing after considering her list of gambling activities] and there are two dog racing tracks nearby [to where we live]?!"*
> [No Harm Bingo Female 2 BF2 aged 25-34]

Further, participants reflected on the fact they have changed their gambling activities over their lifetime; with some no longer completing the football pools or purchasing National/Euro Lottery tickets for instance. One High Harm participant (BSM1) has now ceased going to Bingo Halls after the death of his wife as it was his wife that enjoyed Bingo and it was something they did together.

The amount of time participants engage in gambling activities, particularly in land-based gambling venues also varies. Some gambling activities are infrequent; such as attendance at the races or at a dog racing track. Whilst other gambling activities; such as attendance at bingo, casinos and betting shops, are more frequent. Table 6.3 presents a snap shot of the length of time and money spent in gambling venues for a cross-section of the participants.

Table 6.3: Approximate Time and Money Spent in Gambling Venues

Low Harm Bingo Female BF1 aged 45-54	Bingo Hall 7.00 pm to 9.30pm - 3 nights x 2 hours = 6 hours per week Bingo Hall Machines prior to Bingo 4.00pm to 7.00pm - 3 nights x 1 hours = 3 hours per week (meal often eaten between 4.00pm and 7.00pm) Online Bingo at home 7.30pm to 11.00pm – 4 nights approx. x 3 ½ hours = 14 hours Free Poker regularly played on Facebook. **Approximately 23 hours per week** **Approximate average spend £210 at Bingo (including meal) and £2 for Online Bingo**
No Harm Casino Female CF1 aged 65+	Casino Poker Tournament 6 times a week 8pm to 10.30 (approx.) 2.5 hours x 6 = 15 hours Bingo Hall 1time a week (sometimes daytime) 3 hours x 1 = 3 hours *"Well, if I'm not here I'm somewhere else. I mean, I might be down at Gala. Last night me and my husband were at Napoleons. I'm here tonight. Well, six nights a week, you can put that down, because I'd say six nights a week."* If CF1 gets to the final of the Casino Poker Tournament she stays until 1 am or 2am. CF1 also plays Black Jack on the tables during the break of 15 minutes between Poker Tournaments (unless she sees a friend she wants to talk to). **Approximately 18 hours per week** **Approximate spend £150 per week Poker Tournament and Black Jack*** **No spend included for bingo activity included as not revealed**
High Harm Treatment Male TM2 aged 18-24	Fixed odds Betting Machine (main gambling activity) 4 times a week x 30 minutes = 2 hours *"… it was normally maybe three nights after work and then on Saturday as well, so a good few times a week. And sometimes every day, but it depends… probably half past 5, 6 o'clock. Normally not too long. 20 or 30 minutes."* **Approximately 1.5 hours** **Approximately £300 per week**

The key element taken from the snap shot findings in Table 6.3 is the diversity of time and money spent on different gambling activities. Another element highlighted is that one participant, considered as a High Harm participant (TM2), suggests he spends less time gambling at a land-based venue on average per week than time spent by a No Harm participant (CF1). However, the aforementioned High Harm participant (TM2) reflected upon times when he spends significantly more than the amount shown in Table 6.3 above, however, on average his weekly spend was £300. Overall participants spend varying amounts of time and money on their gambling activities. It is worth noting that high amounts of time and money spent at a gambling venue does not necessarily indicate the person to be a high harm gambler.

Trying to find "typical" behaviour is not possible with a small scale qualitative research study such as this. However, the narrative data chosen to include in Table 6.3 above comes from

three participants recruited from different gambling venues demonstrating diverse behaviour. However, time and money spent on gambling activity from one type of venue is also vastly different from one participant to another. For example, participants recruited via betting shops; High Harm BSM1 spends 2-3 hours in the betting shop 'most days' and spends approximately £150 a week, another (High Harm BSM2) goes in twice per day if he has money to spare on betting; sometimes twice a day. Even when BSM2 has no money with which to place a bet, he still visits betting shops. During a troubled time in his life BSM2 spent 6 hours in the betting shop, most nights, in preference to going home (see Section 6.5). The third participant recruited via a betting shop (No Harm BSM3) stated he visits betting shops daily, usually at lunch time, to firstly collect coupons. BSM3 then revisits the betting shop later in the afternoon to place the bet; each time he is in the betting shop for just a few minutes. On average BSM3 spends £50 per week. As shown, these participants frequent betting shops on a very regular basis, however, their activities, time and money spent is completely different.

Despite not being able to find "typical" behaviour some general themes present themselves; notably the older gamblers visiting casinos or bingo halls seem to attend regularly each week; for example two Fridays per month (bingo) or 6 times a week (casino). Of the participants that frequent betting shops, most generally visit daily; although it must be noted these examples will be atypical of wider gambling behaviour.

Participants also gamble online. The time and money spent gambling online also varies tremendously amongst participants. The only general theme across these participants is that younger players tend to play online more than older players. Table 6.4 provides reflections of a cross-section of the participants regarding their time and money spent online.

Table 6.4: Approximate Time and Money Spent Online

No Harm Bingo Female BF2 aged 25-34	BF2 stated online gambling is between 10 minutes and 4 hours *"About £10. I would never spend any more."* **Approximately £10 per week**
High Harm Casino Male CM1 aged 18-24	*"I play online all the time, tournaments, several a day."* *"If I'm working or I've got University, obviously I don't do anything, but if I'm not doing anything it can be all day. It can be 12 hours."* *"…but on average I can spend about £50 in a day."* *"…sometimes I can't play, because I don't have the money."* **Approximately £250 per week**
High Harm Treatment Female TF2 aged 18-24	*"Once my kids have gone to bed, it's from 8 o'clock until midnight."* **Approximately £120 per month** Note: TF2 has created limits which are 4x £40 limits on 4 online sites sometimes not all the money is spent.

The general key element regarding online gambling behaviours is it varies from person to person, but what is interestingly gambling online seems to have become an activity that for some is part of their 'daily routine'.

6.4   Motivations for gambling

There are many studies, qualitative and quantitative, that explore the reasons for gambling (Kristiansen, et al 2015, Rossen et al 2013, Wardle et al 2011, Reith and Dobbie 2011). As part of this research study, participants were asked to share their reasons for gambling. As found in the aforementioned studies, the main reasons were positive and include:

- The buzz/thrill
- Fun in winning
- Atmosphere
- Interaction with staff at venue

- Socialising
- Hobby/habit/pastime
- Cheap night out
- Entertainment/makes things interesting

The following are some reflections from participants as to the benefits and motivations for gambling:

Socialising: Socialising takes many forms; here No Harm Bingo Female BF3 aged 25-34 states Bingo helps her get:

"...involved in something and having a laugh" it is part of her social scene now.

Socialising is also a benefit for High Harm Casino Female CF2P aged 65+

"She's [proxy] got a lot of people to talk to there as well, friends, and stuff".

Further:

"Socialising trips from the Bingo Hall. Yeah, they do it all over, but they have done it to Scarborough, and I've been on a couple of trips with them from here."
[Low Harm Bingo Female BF1 aged 45-54]

Makes things interesting: Generally for gambling on sporting events for example:

"Yeah, it makes it more exciting when you've got something riding on something [football bets], rather than just watching it and not [being interested]... if it's not your team."
[No Harm Betting Shop BSM3 Male aged 35-44]

"You're never interested in the games in League 2, they've got Bradford v Carlisle or something. You never bother. But if you've got a bet on, then both teams score, you're kind of looking out [for the team]..."
[High Harm Casino Male CM1 aged 18-24]

Winning: Many participants want to win; in a fun way, for example:

"Fun winning – a bonus to the night out."
[No Harm Bingo Female BF2 aged 25-34]

"Of course you enjoy winning. That is a definite. But there's also the semi-thrill of gambling, as long as you don't lose your head."
[Low Harm Casino CM3 Male aged 65+]

Inexpensive 'leisure': Another felt that gambling in some venues offered a cheap night out, for example:

> *"We come because we find it quite a cheap night out and a bit of fun ... you get some food, and it's quite cheap, but you're out all night, so it's a nice thing to do as a group". [No Harm Bingo BF2 Female aged 25-34]*

Some reflections however, suggested a more negative motivation for gambling:

Boredom: A number of participants felt that overcoming boredom in their day-to-day life was an issue:

> *"Boredom ...It's a nice buzz when you win. But it's impossible for me, now, to get my money back, unless I win the Lottery. It's impossible."*
> *[High Harm Treatment Male (Probation) TM1 aged 55-64]*

> *"I think it's more boredom, to be honest with you."*
> *[High Harm Betting Shop Male BSM1 aged 55-64]*

Generally the themes shown by the participants for this study are largely comparable with the studies highlighted at the beginning of this section. The main difference noted is one participant stated that bingo and going to the dog racing track was considered to be a "cheap night out". Other participants mentioned the friendliness of gambling venue staff was a benefit. A feature emerging, albeit from small numbers of these interviewee's was that High Harm participants tend to use expressions; which align with a physical feeling, such as "thrill" and "buzz" with one going further by stating that:

> *"When I'm working is when I feel most like I want to play, because I'm thinking 'I don't want to work, I don't want to do this. I want to win all that money."*
> *[High Harm Casino Male CM1 aged 18-24]*

Whilst the study has only a small sample it was clear the High Harm participants reflected less about the social aspects than do the Low/No Harm participants.

Participants not only shared details of their motivations to gamble some shared stories of high wins and high losses and these are shown in Section 6.5 below.

6.5   Impacts of Gambling Behaviour

This section looks at personal experiences and the impacts of gambling behaviour. This provides a personal face to some of the wider (national) research evidence and local stakeholder perspectives set out earlier in the report. Its focus is initially on reflections, from some High Harm and Low Harm interviewee's, about gambling losses, followed by impacts on:

- Debt, borrowing money and detrimental spending on gambling
- Personal relationships and relationship breakdown, and
- Health and Wellbeing

As the evidence shows these impacts are often inter-related and consequences are interlinked. For this, understanding the scale, relative and absolute of gambling incurred losses provides a starting point. This begins with a reflection from High Harm Treatment Male (Probation) TM1 aged 55-64 of an exceptional level of gambling losses:

> *"In 1995, from June to September, I lost £480,000 in cash. £480,000 in cold blood, in straight cash. That's when I was importing drugs from Spain. So I had the money. I was earning it. As quick as earning it I was losing it £5,000, £6,000 a day, it didn't bother me. I never batted an eyelid."*
> *[High Harm Treatment Male (Probation) aged 55-64]*

From the age of 14, this participant had stolen goods/cigarettes etc. to fund his gambling activities – he has been employed once in his life. Currently, he spends between £500 and £800 per week on gambling activities; mostly at the betting shop. The consequence, of stealing to fund his gambling activity, has meant that he has spent many years in prison. Whilst he has had some regrets; he does not reveal any shame as such; he states *"[I am] ... An easy-going rogue. A lovable rogue... in the nick, that's what they used to say about me."*

Another High Harm participant shared details of his financial losses:

> *"…my main problem has been just letting go of my losses. I remember being £5 grand down, I remember being £8 grand down. I remember £12 grand. And I've tried to chase and it's now at £15 grand. Is it going to reach £35 grand?"*
> *[High Harm Treatment Male TM2 aged 18-24]*

Generally TM2's 'big losses' are on the roulette wheel (Betting Shop); often the losses were between £700 and £2000 in one session. His gambling behaviour was a secret from his mother until she found bank statements. His gambling is linked to depression in earlier life; due to low self-esteem, he is often anxious and depressed about upsetting his family and the impending death of his grandma. He has recognised that he copes with big changes in his life, such as relationship breakdowns, by gambling. He has often reflected on how often he has chased his losses. During low periods, he drank heavily. This case study (TM2) shows how gambling problems can be inter-twined with other and often complex emotional vulnerabilities and problems.

Some participants described how gambling impacted on their relationship and financial hardship for example:

> *"...a few months ago I ended up losing £1,000 on one spin [Roulette at the casino], which was a stupid thing where I thought I could win £2,000, but it wasn't a very high point in my life, I'll admit that."*
> *[High Harm Casino Male CM1 aged 18-24]*

This is not the only big loss this participant experienced. He reflects on another bad experience that led him to contact a gambling helpline. At that particular time he felt ashamed and did not want to go home. His gambling has led him to feeling guilty about lying to his girlfriend and for having so little money that sometimes he could only "get by". His gambling behaviour has led to relationship difficulties and financial hardship which he overcame by taking on more shifts at his part-time work.

High Harm Casino Male CM2 aged 18-24 described how he won £12,000 on one day and lost it all the following day (Casino online). This was his largest loss in recent years. When CM2

was younger he advised he had a gambling problem; now he does not think he has a gambling problem, he has borrowed money, contacted help-lines and excluded himself by shutting down online accounts.

One participant used the "facilities" of a loan shark (who was subsequently successfully prosecuted) to pay off her gambling debts CF2P:

> *"She [spoken in proxy] borrowed money off a loan shark, which in the end she couldn't pay off."*
> [High Harm Casino Female CF2P aged 65+]

Participant CF2P has borrowed money off family members and often lied about her whereabouts. Her gambling problem led to her being fearful of her own safety and the safety of family members; including grandchildren.

Low Harm Bingo Female BF1 shared she lost £500 in one night (£2,500 in three weeks from an inheritance after her mother passed away). During that time BF1 was at a low point and used gambling as a coping mechanism and to relieve depression experienced because of her mother's passing. Currently she is a carer for her husband and she 'makes the most' of her nights out.

TF1 discussed a number of gambling losses and her behaviour:

> *"Because I got paid, say, on a Wednesday. Wednesday night I'd go to the casino [played on machines], get rid of the money that I could withdraw, and then I used to wait in the toilets until it got to midnight, and withdraw the balance [another 450 which was the maximum she was allowed to withdraw in one day]. And lose it all. Sometimes I had to walk home – I didn't even have the taxi fare."*
> [High Harm Treatment Female TF1 aged 55-64]

This loss was one she had following her husband's death. Her husband did not gamble and she gambled during her married life without him knowing; until he found bank statements.

The above reflections are just a selection from the participants about their 'losses' and the consequences of losses. It should be noted that, (BSM2) pointed out that 'loss is relative' and a £6 loss (something he experienced); was a very high loss as the money he spent on gambling should have been spent on the family groceries.

It is evident that remorse shadows Low Harm and High Harm gamblers. Similarly, it is clear that their gambling behaviour impacts their life and those around them. Indeed, many feel guilty for wasting money, wasting time, borrowing money and spending money they did not have, for upsetting family members, stretching relationships, lying and losing friends. Further some Low Harm and High Harm participants recognise that their gambling behaviour makes them ill and some realise that they gamble because they are angry or depressed. More information on these impacts are outlined in the sections below.

Generally, the impacts of gambling behaviour, from the Leeds participants, concur with many other research studies that explore gambling behaviour (Kristiansen et al 2015, Reith and Dobbie 2011, Rossen et al 2013, Shead et al 2010, Wardle et al, 2011, Wardle et al 2011b).

Impacts on debt, borrowing money and detrimental spending on gambling:

This section provides reflections from participants that found themselves in debt or at a point when they borrowed money from family and/or others. The Low Harm participants did not reflect on having debts or borrowing money; however, one Low Harm participant (CM3) lent money to another person (small amounts £5 or £10) on one occasion.

> *"I once lent somebody some money in a casino because he was desperate. I was friendly with him. And he said 'I'll pay you interest, I'll pay you interest.' He ended up giving me interest, and that's the first time I've ever taken interest."*
> *[Low Harm Casino Male CM3 aged 65+]*

One participant (CF2P) had a severe debt issue. After borrowing money from her family CF2P turned to a loan shark (unofficial money lender):

> *"...she was paying about £200 a week. I don't know how she managed to pay that. And then even though she paid so much off, it was about £6 grand, £7 grand, maybe, he said 'Oh, you still owe £13,000.' She only borrowed £3,000... she missed a few payments, [so the debt kept rising]."*
> *[High Harm Casino Female CF2P aged 65+]*

CF2P is part of the Chinese community who have a saving scheme whereby each person puts money into "a pot" for 12 months and then at the end of the 12 months they receive a 'pay out'. The loan shark had made himself known to CF2P. The loan shark became demanding and threatened her; he also threatened to hurt her and her family. This debt is now void and the loan shark prosecuted.

Other participants that have encountered personal debt problems, because of their gambling behaviour, include TF1 who increased the joint overdraft she had with her husband to £10,000:

> *"Yes, I'd been increasing it, because it was a joint account. To cover what I was doing."*
> *[High Harm Treatment Female TF1 aged 55-64]*

No further overdraft could be raised. As stated above, her husband did not know about her gambling behaviour; he did not know about the size of the overdraft. To 'rectify' the situation TF1's husband requested a loan from the bank and TF1 no longer had a bank card for the joint account.

Another participant that was borrowing money to pay for his gambling behaviour was CM2 who stated:

> *"I used to have a bit of a gambling problem [he does not think he has one now], to be honest with you, when I was at school... I was an idiot … It was the amount, really....A couple of thousand a week."*
> *[High Harm Casino Male CM2 aged 18-24]*

Participant TM1, currently on probation, also reflected upon times when he borrowed money from his father:

> *"By hook or by crook, I'll get something, even if I have to borrow it off my mam or... You know, I'm one of them. I've even borrowed money off my mam and dad... their pension, they've lent me, I've been that bad [in the need to gamble]...Lend us 80 quid dad, I'll give you £90 back tomorrow.' Or things like that."*

[High Harm Treatment Male (Probation) TM1 aged 55-64]

Other participants have spent money on gambling to the determent of themselves or others.

As stated above by BSM2; losses are relative. BSM2 has gambled most of his life, however, due to a change in circumstances (lower paid job and other debts) he began to acknowledge gambling as a problem:

> *"It first became really noticeable for me [gambling was a problem] when I left that extremely highly-paid job in 1987 … [my gambling] was probably the same, if not a little bit more. … It might sound irresponsible, and it probably was highly irresponsible, considering the situation that we were in…"*
> *[High Harm Betting Shop Male BSM2 aged 45-54]*

BSM2 was reflecting upon the fact that he was behaving in an irresponsible manner as he spent money on gambling that should have been spent on groceries.

Another participant reflected upon the consequences of money she spent on gambling:

> *"Yeah, I've missed out on food. Like not having enough food to cover two weeks' worth of shopping, sort of thing. I'd be buying two lots of mince to make eight meals of spaghetti bolognaise to get me through the week, sort of thing. Budgeting down to the 'last penny. I've done that."*
> *[High Harm Treatment Female TF2 aged 18-24]*

TF2 also stated she often went to seven shops to buy scratch cards on her way to the grocery stores, thus spending money to the detriment of herself and family (partner and two children).

Relationships: Stakeholders (see Chapter 5) have commented on the negative consequences some gambling behaviour has on relationships, and in particular on relationship breakdowns. Some participants reflected upon the happy times they have spent with their friends and family during gambling activities. One participant undertakes many gambling activities with her husband. She has fond memories of one holiday when her husband proposed to her in Paris at a horse race meeting. They regularly take part in online gambling together, go to dog racing and horse race meetings; she even goes with her husband to the betting shop when he puts on a bet. Sometimes No Harm BF2 Bingo aged 25-34 enjoys watching and discussing YouTube videos of people winning and losing at gambling. Another participant, also enjoyed gambling with her husband:

> *"Well, we like a little gamble, both of us...me and my husband went down last night, we had a meal at CASINO X, we had a drink, then we played Black Jack. Me and my husband usually go out on a weekend. But through the week he likes a lot of his sport. So he likes to see me go out and I like to go out. So no, there's nothing like that [problems]." [No Harm Casino Female CF1 aged 65+]*

However, as highlighted earlier some participants keep their gambling behaviour and gambling spend a secret from family and friends. TF1 had kept her gambling behaviour a secret from her husband for around 6 years. She used their joint overdraft to fund her gambling behaviour. When her husband found out why the overdraft was high:

> *"He wasn't very happy. He wasn't very happy at all... I was ashamed, and he wasn't very happy. It was a big blip in the marriage … [but] it was done, we don't talk about it anymore, that's it."*

TF1 recently told her friend that she had a gambling problem and has found the relationship she had with a close and long standing friend is now strained:

"Even my close friend 'Shirley'[61] [who] I've told, but I think it's put a distance between us… I feel there's a barrier come down between us. "
[High Harm Treatment Female TF1 aged 55-64]

Another participant also kept the seriousness of his gambling behaviour secret from his parents, however, when his mother saw his bank statement he had to confront the situation. He states:

"At the minute I hurt myself. I hurt my mum and my dad... because obviously they know that I've lost and it's hurting them, but it's not hurting them financially. And I don't want to ever risk anybody's money".
[High Harm Treatment Male TM2 aged 18-24]

Whilst TM2 usually gambles alone, he has friends that gambled (though he did not always know they gambled) advised there had recently been a change in the relationship he had with one of the friends:

"…one from school, who I'm not that close to at the minute, we both lost quite a bit together, that was around Christmas. The fact that we lost together sort of made us drift apart, because coming together reminded us of losing. So it [gambling] has affected relationships."
[High Harm Treatment Male TM2 aged 18-24]

Others, whose family and friends know about their gambling, lie about their behaviour:

"Yeah, I'll stay up most of the night and play on a poker tournament. When it's a tournament rather than a cash game, and you carry on until it's finished. Sometimes you can be playing through the night. She'll wake up at 3 in the morning and I'm there playing. She'll be like 'What are you doing awake? 'Nothing, I'm just going to the toilet.' [High Harm Casino Male CM1 aged 18-24]

Another stated that:

"Like I'd say I'd spent the money on something else, like food or something. And I wouldn't have eaten, and things like that. Then people would realise, because then you go home and eat food, if you know what I mean. But they're going to find out eventually – you're losing weight but you say you're still eating, money's going, you're asking for food... 'We thought you had this and this from your shopping, but you don't..."

She went on to explain she had been spending money on gambling instead of groceries for some time:

"A good few months. Until I saw myself hiding it. I had a different bag, I had a pink bag, and it had a back pocket. And I were putting all the scratch cards in there – winners, losers... I pulled them out, and I had £156 [worth of 'no win' scratch cards], or something

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like that of scratch cards, and that were over a week. So yeah, it did turn out to be a lot of money.
[High Harm Treatment Female TF2 aged 18-24]

TF2's family and partner (that lives with her) know she gambles. TF2 also advised that she also gambles when she is angry with partner *"I did it* [gamble]*"* because she knew it would make her partner angry.

Overall the findings suggest that relationships with family and friends are strong for some participants. However, when gambling behaviour has a detrimental effect on relationships it seems to be because of issues of confidence and trust, arising from secrecy and lying about the time and money spent on gambling activities.

Health and Wellbeing: The health and wellbeing of gamblers has often been studied (Wardle et al 2011a, Wardle et al 2011b) and as shown in Chapter 5 has been one of the reasons gamblers seek help and support. The reflections shown in this section include a range issues such as coping with everyday life, feeling physically ill after a big loss, depression and long lasting shame; none of which are complimentary to the wellbeing of a person. The following stories show how gambling behaviour affects the health and wellbeing of the participants from Leeds. In terms of feeling ill CM1 stated:

"The reality of what you've done [lost £12000 in one night] sort of over-rides everything else, so you kind of feel that ill, you feel that bad, that you kind of... it makes you realise."
[High Harm Casino Male CM1 aged 18-24]

In terms of coping with everyday life BF1 stated:

"Oh yeah, I still come back [to bingo]. Because it's the only day that I get to come out – because I've got a poorly husband. So it's the only day that I get out, and I make the most of it while I'm out. Believe me".
[Low Harm Bingo Female BF1 aged 45-54]

This shows that BF1 is able to take her mind away from her "carer" duties; which is a positive effect. However, coping with everyday life can take other, more negative forms. TM2 stated after seeing an ex-girlfriend, who he still has feelings for, could not get her out of his mind, he thought about her at work and then lost £700 at the betting shop, during his lunch break. Afterwards TM2 thought...

"I can't believe I've just done that [gambled so much so quickly]."

Later in the afternoon he walked out of his job, told his mum what had happened, gave her all his money and sought help via NECA as he felt he needed help.

Depression was a recurring theme in the reflections of participants, the underlying reasons, that brought on depression were different. Interestingly, Low Harm Bingo Female BF1 aged 45-54 revealed that, after her mother passed away, she spent around £2,500 of her inheritance money playing the machines at the Bingo Hall. This activity, she advised, helped her with the depression she was feeling at that time.

Another participant felt he had depression for a long time when he had general debt problems, his house was being repossessed and he was going through a marital breakdown. BSM2 stated he gambled more during this period of time than he had done in the past and went on to say:

"In hindsight, when I look back, I was unbelievably depressed at the situation I was in, because I'd got a wife and children.
[High Harm Betting Shop Male BSM2 aged 45-54]

Anxiety was also a recurring theme for one participant who states:

"Really, really anxious. And I'm not an anxious person normally. But when I've got money on me..."

The participant went on to say:

"....in February this time I stopped, I had something like £3 grand saved up and I lost possibly £1,800 or something. But I stopped and I went to my mum. What my mum does, and I don't blame her, by the way, she starts to trust me because I've not gambled for so long, so she starts giving me my card back. Because she wants, obviously, me to get to the point where I'm independent. This time I've said 'Never give me it back, not until I'm 30 years old and I've got a wife.' Because I can't... maybe when I'm settled in this job and I'm happier within myself, then I'll be able to, but at the minute I don't want to, because I feel anxious."
[High Harm Treatment Male TM2 aged 18-24]

There were instances when participants revealed that they felt shame for what they had done:

"Yeah. I had a bad experience... at the time when I did it obviously it was in the early hours of the morning and I actually Googled 'gambling help' and they were all shut, which I found really bad, seeing as how most people are going to be gambling through the night. And I literally couldn't call anyone. I remember I did it online, but I did it on the way... I just had a bad thing at the casino and I'd lost then and I did it on the phone on the way home, and I just remember I didn't want to go home. I just sat in the car park on the corner, a bit... obviously. I remember being on my phone, trying to find... I didn't want to call my mum or something, because it's like I'd feel ashamed and stuff and I don't want to worry her or anything. I just wanted to speak to someone impartial."
[High Harm Casino Male CM1 aged 18-24]

TM2 also experienced shame:

"... it's got to the point now where she holds my card, all my money. I just basically have pocket money. I'm not ashamed to say that, because I think the strongest thing for me to do was to hand over my card. If I try to deny it and say to myself 'I've got control' then I'm the weaker one there, because I'm trying to be a big man. And I'm afraid I'm not a big man."
[High Harm Treatment Male TM2 aged 18-24]

The reflections, above, show the consequences that gambling activities has had on the health and wellbeing of the participants of this study. As shown, the examples provided are mainly from participants classified as High Harm participants.

6.6 Reflections on interventions, exclusions, limits and support services

The findings in this section summarise the reflections of participants who were asked to share information about their knowledge and understanding of: offers of help, such as general

Gamble Responsibly information, interventions, GAMCARE Helpline/Chat-line, self-exclusions and cash limits. Also, participants that had received treatment from a councillor were asked to reflect on the speed of service received.

In the main, participants were aware of the general Gamble Responsibly notifications, via TV, posters and websites. It was noted that promotional alerts on mobile phones do not have the Gamble Responsibly notification; but a STOP messages feature was included. Most participants did not see the need for further posters, as participants stated, gamblers 'know' the notifications are there and as one participant suggested some gamblers will choose not to hear or see notifications.

Notifications provide Helpline and Chat-line details. Two participants advised that they had called a Helpline and discovered it was only available between certain hours (and not when they called e.g. 1 am). Another participant noted that the 0845, 0800 and 0808 numbers are not always free; a crucial element for those who are in financial difficulties. One participant reflected on her use of a Chat-line services which at that moment in time was 'less scary' than talking to someone who could 'see her face'.

Participants are pleased to see interventions by staff when gamblers were smashing gambling machines or are drinking 'too much' alcohol. However, they did feel that interventions with gamblers who are 'gambling too much' was, a) not an easy thing for staff to do - as interrupting someone gambling could make them aggressive and b) 'it [taking money] is business'.

Some of the participants reflected on their own self-exclusion experiences. Self-exclusion has taken place by participants from land-based venues. They have excluded themselves by completing the necessary paperwork. However, one participant 'wanted' to exclude himself from a gambling venue for a shorter period of time than that which is stated in the regulations; so did not exclude. Another participant agreed that 12 months is rather a long time. Self-exclusion from venues does mean approaching all venues; including all venues in other towns and cities. However, participants felt this is not possible. Despite being excluded from all local gambling venues one participant took herself to the seaside, entered a venue she is not excluded from and gambled there. For those that excluded themselves from online accounts, a simple deletion of Apps was stated as a quick and easy way to avoid temptation; whilst not fully excluding them from play. Another participant closed accounts and where necessary all email accounts aligned to all gambling websites; another suspended online accounts, both stated the process was simple to do.

Participants had different views on limiting their online bets to specific amounts per month; one reflected it was easy, another, not so.

If participants had taken the step to contact a councillor they were asked about the 'speed of this service'. Participants realised they would have to wait, however, they were pleased with the quick service; one reported just waiting between two to three weeks.

The reflections regarding offers of help, interventions, exclusions, online limits and speed of help services was insightful and enabled participants to then consider recommendations for the Council, Support Services and Industry; which is shown in section 6.7 below.

6.7   Services Gaps and user proposals for improvement

All participants were asked to identity help and support service gaps and make recommendations see Table 6.5. The main themes identified are more notifications in venues and online regarding gambling responsibly and promotions, for example television advertisements that show the negative consequences of gambling.   Participants also suggested that more could be done regarding self-exclusion. Others who have had the chance to speak with a councillor would like to extend the period of time that counselling sessions are available.

Table 6.5: User identified support service gaps and recommendations

Notification in venues	*"So I think if all machines had it and made it a little bit bigger, a bit more noticeable. Because when you're playing the machine you don't really look at them, unless it's saying 'You've got some free money here!'* BF1 "*Maybe you should get Chinese people... because Chinese people do gamble a lot. So maybe Chinese posters, maybe you could have... [for different] Target communities you see Asians there, you see Chinese people there, you see all sorts of people there [at Casino]... OK, you've got posters, posters up saying GamCare and whatever, but you could get posters with different languages*" CF2
Notification Online	[In addition to existing notifications] *"... if it [notification] hit you in the face 'You've deposited £50 in the last ten minutes', you'd be like 'Whoa, what am I doing? I could be using that for something else.'"* BF2
Self-exclusion online	*"...it should be a button, like 'how to restrict your gaming'."* CM2 (at present each online Casino lobby is different and sometimes difficult to find. *"Maybe just the message, or, like you say, where would you contact... something like that."* BSM3
Self-exclusion	It was suggested "face recognition" to help self-exclude from all betting shops and casinos. This would help participants that wanted to exclusion occur at all or betting shops and casinos in all venues in the UK. TF1
Helplines	*"Casinos used to open until 2 o'clock, then it went to 4 o'clock and now its 24 hours Well, I should say any helpline should have times they open. And if it's something like Gamblers' Anonymous, they should have... I mean, a casino is open 24 hours, so really it would be useful if it was. (helplines normally 8am to midnight)"* CM3 *"all helplines should be free"* (not 0845 as this may not be free on some mobile contracts) CM3 *"Have telephone services open 24 hours"* CM2
Television Advertisement about the problems gambling can bring	*"...it would have to be very general, because gambling, as I said, you've got to have a rich person who could lose £1,000 a night and it could mean absolutely nothing to him, and you could have another person who loses £20 and it could be their last £20. CM3* *"It's all 'Don't do drugs', 'Say no to drugs', but there isn't 'Say no to gambling.' At the end of Ray Winstone's advert, it will say 'Responsible gambling. Stop*

	when the fun stops.' It's all right saying that after you've just spent a minute promoting betting, and then having [just] *five seconds at the end."* TM2 An advert on ... *"How it destroys families, stuff like that. Arguments, money problems, debts."* TF2
More councillor sessions	After counselling sessions (12) have finished... *"I'm on my own for six months. But I can come back. Councillor said … she's got some names she can give me. Even if I just see somebody once a month."*

Annex G provides a range of suggestions to improve support for gamblers generally; these include more Gamble Responsibly notification in venues, including notifications in different languages, additional Gamble Responsibly notification online, including pop-ups for time and money spent, a more robust self-exclusion mechanism for betting shops and casinos, 24hour free help-lines, television advertisements about downsides of gambling such as family breakdown and debt and the request for more councillor sessions.

6.8   Conclusion

This perspective is, inevitably, one sided. It does not look at the social and leisure value many who gamble responsibly and sustainably bring; its focus was specifically on those seeking advice or with experience of treatment and often having experienced significant harm. When given the opportunity to explore behaviours of individual gamblers, on a one to one basis, it is clear, their background, introduction to gambling and gambling activity has impacted the (Low Harm and High Harm) participants in many different ways with some common themes.

Most of these participants started early; often very early in their life they had been exposed to gambling, often as family members gambled. Many stated that watching bingo at the local Club, going to the betting shop with their father or even being at home when their parents were at the casino was part of their upbringing. Past studies have reflected on the family legacy effects when children exposed to gambling early often take up gambling independently in later life. In the main, this was the case with these Leeds illustrations but for four participants gambling regularly came rather later in life. However, two High Harm participants did not start gambling until they were older.

Participants also reflected on the occasion when they first gambled using their own money. Some did so under the legal age for gambling. The participants of this study often engaged in different gambling activities during their lifetime; the least being 3 activities and the most being 12. The participants that have engaged in 3 gambling activities have been classified as High Harm and Low Harm participants and the person who had engaged in 12 activities over their lifetime was also a High Harm participant. However, one Low Harm participant engages in 10 gambling activities. This suggests that the number of activities cannot be the only indicator of High Harm. Participants also shared details of the amount of time spent on gambling behaviour. Findings of this study also suggest that the time spent on gambling activities is also not an indicator of High Harm. For example a High Harm participant stated they played machine roulette for 30 minutes per session around 4 times a week. However, a Low Harm

participant often spent around 24 hours a week on Bingo, machines in Bingo Halls and online Bingo at home.

The motivations to gamble were also explored as part of this study. The main factors were winning, socialising, making things more interesting (particularly when discussing bets on sporting events), boredom and one participant found Bingo to be a cheap night out.

Another of the main areas of study associated with gambling is to establish the impacts gambling behaviour has on 'the gambler' and others around them. Some, particularly the High Harm participants, shared information on their losses. An exceptionally high loss of money, over a 4 month period, was £480,000 from a participant who generally stole and sold drugs to fund his gambling behaviour. However, losses were high for other participants. Losses were reported as £10,000 over a period of time and £12,000 at one gambling session. Others stated they spent money on gambling that should have gone on groceries; which were not high losses but were significant as the money spent on gambling should have been spent elsewhere.

To continue funding gambling behaviour High Harm participants advised that they used overdrafts, borrowed (including borrowing off parents) and one participant, after borrowing from family members for some time, turned to a loan shark, got into severe financial difficulties.

Often gambling behaviour affects the relationships amongst friends and family. One participant stated they had lost a friend with whom they gambled with as both experienced high losses together in one session and seeing each other reminds them of that. Another participant advised that after telling her friend she had a gambling problem, the friendship is now awkward. One participant explained how he has 'stretched' the relationship he has with his girlfriend. Several participants have stated they have lied to friends and family about their gambling behaviour. Further, some participants stated health and wellbeing issues occur in and around their gambling, with references to illness, coping, depression, anxiety and shame. Having said all that, other participants reflected on the enjoyment gambling brings to themselves and their partners.

7 Issues and implications

7.1 Introduction

During the public consultation prior to the approval of the large casino licence, concerns were raised by some stakeholders and residents about its social impact. The Council is consequently keen to ensure it is in an informed position about the needs of those struggling with problem gambling in the City. To do this the study has been tasked with providing baseline evidence of the likely prevalence of problem gambling in Leeds and its impacts; whilst also providing a forward look at the needs and priorities for mitigating gambling related harm. This chapter draws together the issues and implications for each of the four objectives of the study looking across the findings set out in Chapters 2 to 6 to look at:

- Problem gambling and gambling related harm in Leeds

- Impact of problem gambling in Leeds

- Baseline evidence for future monitoring and evaluation

- Gaps in provision and support mitigating harmful effects of problem gambling.

This cross cutting assessment starts with a brief look at the context against which the GGV development takes place.

7.2 Gambling activity and provision in Leeds

Leeds provides for a breadth of land-based gambling opportunities, and provision is long established and mature. Its more recent developments, prior to the new large casino due to open in autumn 2016, reflects a wider national picture of peaking and consolidation of the land-based gambling offer across previously very different sectors. Some of this consolidation has been driven by cross-sector investments in B1-3 machines. These together with the almost ubiquitous rise of multiply-accessed on-line gambling, have been a focus for rising concerns in Leeds as elsewhere of the potential for greater harm to at risk gamblers.

Current operators consequently see extensive provision in an increasingly competitive market within a large network of LBOs, casinos, bingo halls and AGCs notably within or close to the city centre. There is considerable spare capacity in many of the longer established premises in and close to the city centre. Many of these features are shared with other large metropolitan areas, and corporate managers in particular felt that there were few very distinctive features in the Leeds gambling environment.

The study suggests that GGV's development will change that landscape (Chapter 3). It will certainly be a major development in the gambling landscape of Leeds, and will see Leeds as one of a handful of large metropolitan centres with a large casino (under the terms of the 2005 Act). Current city centre operators are concerned about increased competition from the development at Victoria Gate, and with some precedents from developments in other urban areas. They are also concerned about their continued ability to cross-fertilise their land-based offer with online products and the consequences of increased opportunities for remote access by consumers.

7.3   Prevalence of problem gambling in Leeds

The study has set out some of the practical distinctions between problem gambling and gambling related harm, and the substantial challenges to measuring either. Previous studies have provided best estimates of problem gambling in England and this insight has been used to look at who is more likely to experience problems. These studies provide an important foundation for assessing likely prevalence levels in Leeds.

Put together, this evidence suggests problem gambling and harm can affect anyone at any time. Although the focus of this study is problem gambling, it is important to remember that rates of adult problem gambling in Britain have consistently been found to be under 1%, and have changed little in a decade of increasingly accessible gambling opportunities. However, a broader definition which looks at those whose behaviours present a risk of harm suggests around 1 in 20 experience some difficulties with their gambling (between 5 to 6% of adults).

Nonetheless, some groups of people have a higher prevalence for problem gambling and (or) may be more likely to experience harm as a result of those behaviours. In Chapter 2 a detailed and up to date review of those groups was set out, with the evidence nationally (and in some cases internationally) underpinning the assessment. It identifies younger people (including students); those with constrained economic circumstances; those from minority ethnic groups; homeless people; those living in areas of greater deprivation; those with other mental health issues and substance abuse/misuse disorders; those with poorer intellectual functioning; custodial and non-custodial offenders; and, potentially, immigrants; all can be considered (more) vulnerable to gambling problems.

Looked at locally, stakeholder perspectives on vulnerable groups susceptibility to problem gambling in Leeds (Chapter 5) are more piecemeal. Operators were not able to provide particular perspectives on vulnerable groups, and the various self-exclusion processes supported by all were seen by branch managers to isolate themselves[62] and other staff at premises from the nature of problem gambling (and its impacts). Voluntary and community groups were often better placed to comment, but many were looking at this through the prism of their own, often specific, client group focus. None were able to draw on systematic evidence to identify vulnerable groups, nor comment robustly on the scale of the issue mainly because they lacked the screening or monitoring mechanisms which could provide this insight. Nonetheless, put together, their subjective assessments of vulnerable groups in Leeds re-enforced the national picture and pointed in particular to the risks to students, emerging communities, those on very low incomes and the homeless; although with many often combining other risk behaviours such as a legacy of offending or substance abuse.

Given these social and economic contrasts, prevalence levels vary considerably in different parts of the country. A more detailed review of survey evidence from the BGPS and HSE, and other sources (Chapter 4), shows that based on 2001 ward classification, those living in more Northern areas (and also London), major urban areas, urban areas which are more densely populated, English Metropolitan boroughs and London boroughs are more likely to have

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[62] As noted in Chapter 2, local branch managers reported across different providers that once an individual had self-excluded the surveillance and monitoring systems automatically isolated the problem gambler from the branches.

higher rates of problem gambling. In urban areas, prevalence is also increased for those living in wards classified as industrial, traditional manufacturing, prosperous or multi-cultural. The study also acknowledges that despite this extensive research and survey evidence, remarkably little is (yet) known about the reasons underpinning these contrasts about who and where has greater prevalence for problem gambling, or risk.

For Leeds City Council (the Council) and its partners, there are two crucial implications from this assessment. The first is that as a major urban area, based in the north of England, with a legacy of industrial activity and prosperity, and a multi-cultural population, it is very likely to experience levels of problem gambling higher than national averages. This is returned to as a monitoring and evaluation issue below.

Second, as with other local authorities, the Council will already be well placed to start mitigating these levels and risks, its statutory duties and community relationships mean it will be working closely with many of these more vulnerable groups. The Council can use the evidence set out here to exploit existing relationships, to look at where they can build new or improved relationships, and to start to assess what harm minimisation actions may be appropriate for each. There is also scope to bring this together as a multi-faceted harm minimisation strategy which is embedded in current Leeds institutions and exploiting already well developed relationships with target vulnerable groups. Such action would reflect the recommendations of the new National Responsible Gambling Strategy (published in April 2016). This sets out priority actions to mitigate risk of harm from gambling. Priority Action 4 is to "encourage a wider range of organisations in the public and private sector to accept their responsibility to tackle gambling related harm" (Responsible Gambling Strategy Board 2016).

7.4   Impact and gambling related harm in Leeds

Evidence of local impacts from problem gambling came from stakeholders, support services and problem gambler interviews. However, objectively assessing problem gambling impacts is very challenging. Some help and advice centres cautioned that their knowledge was held back by only having a narrow window of reflection on the harms, and the impracticality of unpicking problem gambling effects from other personal behaviours such as alcohol and substance abuse. Others felt their viewpoints were constrained by what was in effect a shadow community of problem gamblers often shamed by their behaviours and not seeking or actively avoiding help. Operators were not able to add to the local evidence as the process of self-exclusion effectively removed any subsequent relationship with individuals affected.

Where impacts were identified they were varied, often leading to acute challenges for individuals. Students with problem gambling behaviours faced accelerating debt with consequences for rent arrears, and knock on effects for qualification completion (or achievements) and subsequent job prospects. Students with problems were also felt to be more likely to increase their isolation, withdrawing from friendship groups, and risking mental health difficulties. The impacts on people in emerging communities were more often seen in in terms of the negative health and social impacts for individuals, relationships and communities in what were already deprived areas. Here problem gambling was often interwoven with inactivity, narrow social groupings, alcohol abuse and smoking, although the cause and effect association with offending behaviour seems more difficult to unpick. The study identified through interviews with health and wellbeing support services that those from

minority ethnic groups also faced being ostracised from the community and their own families due to the cultural unacceptability of gambling for some cultural and faith groups.

Some of these impacts on emerging communities were shared by homeless people. Here the effects of problem gambling were often intensified by co-morbidity from mental health, hygiene and associated health problems, alcohol or substance abuse. This made any causal assessment of impacts from problem gambling itself impractical but the combined effects were seen as erosion of self-esteem; locking individuals into a cycle of despair and dependence.

Many of these stakeholder perspectives were also reflected in the personal experiences of problem gamblers, and those able to reflect back on recovery and past experience. Here, the insights from stakeholder interviews and in-depth interviews with high and lower harm individuals identified associated impacts with relationship breakdown, loss of homes and eviction, and sometimes acute levels of debt especially for those on benefits or with limited incomes. The reluctance to either self-recognise problem gambling behaviours or to seek, and sustain, professional help when people were aware, was also apparent. Avoidance was also reflected in lying to others about their behaviours; for some it was apparent that individuals did not consider gambling as an addiction or were circumspect about impacts.

It's clear that impacts from problem gambling are substantial for many individuals, variously constraining opportunities, relationships, health and prospects, re-enforcing what may be other co-morbid health and behaviour problems, and in some cases contributing to locking individuals and sometimes families into a cycle of disadvantage.

This evidence, has some implications for the Council. In particular, it emphasises actions through those closest to the risk groups, including operators and peers, to raise awareness of risk behaviours, to promote self-appraisal, and to make information about advice and guidance sensitive to problem gambling contexts readily available. Greater awareness cannot rely on self-awareness alone. It is likely to need a broader awareness and understanding of risk behaviours, including gambling, among a wider cross-section of medical, policing and judicial, offender management, social services and other professionals likely to come into contact with vulnerable individuals. It also suggests a need to develop networks of interest and awareness which can support cross-referral and break down some of the access, awareness, and other barriers which hold back those affected by the consequences of problem gambling from seeking help. Some of these issues are returned to in the assessment of current support services below, followed by cross-cutting recommendations in Section 7.7.

7.5   Towards a baseline for monitoring and evaluation

An important goal of the study was to inform future monitoring and evaluation, including of change following the GGV development. There will be particular interest in the quantitative element of the study, not least for providing a starting point against which to assess subsequent changes.

In this, we have harnessed available data to provide for national and geographical area breakdowns which can be used by the Council to show how Leeds contrasts generally with national and broader area-type 'averages'. However, we have not been able to use any local stakeholder data to sense check this as such data have been shown to not exist; with an almost total absence of screening and recording mechanisms which could provide for this.

Nonetheless, the study suggests that any future assessment will need to recognise that the national benchmarks of prevalence are not likely to reflect the situation in Leeds well, and we expect rates of problem gambling in Leeds to be elevated and broadly twice the national average.

The base data we have used are drawn from available 2010 and 2012 data; so given the dynamic nature of the sector overall, these data on their own are not likely to be appropriate as a baseline for a *before and after* assessment of the GGV development. The forthcoming (in Spring 2017) 2015 data can be used as a sensitivity test to our interpretation of the 2010/2012 analysis. However, sample sizes mean the new data also will not have the power to detect change at the Leeds, or any other, local level.

Future monitoring could look towards a large-scale, bespoke, local survey to provide the quality of locality evidence that the Council would need. Such a survey would need to be developed to be replicable, it would be costly and methodologically intensive (and challenging). However, even this would have significant limitations in assessing impacts of individual operators, even as large as the GGV development.

We would suggest, a more effective, and sustainable, approach to monitoring and evaluation would go beyond looking at levels and change in problem gambling prevalence rates. The study has shown that, taken on its own, prevalence is an insensitive measure of the complex and multi-faceted issues surrounding problem gambling. Nationally, over the last decade, despite gambling provision having changed substantially, overall prevalence rates have stayed broadly stable, masking differential changes between vulnerable and other groups. The same is likely in any longitudinal approach to measuring prevalence in Leeds.

A more useful focus would be an integrated approach to measuring (or estimating) prevalence, at risk behaviours, the changing characteristics and composition of each, and (changing) determinants and consequences. Here, the study also suggests that there is scope to develop this integration with stakeholders as an *embedded* evaluation approach, based on the introduction and recording of local screening which had a common core content across advice and support agencies directly dealing with clients. The study suggests potential for screening to apply to all individuals' seeking advice and support using a small number of indicators at first to identify any problem gambling or at risk behaviours, with a further screen to assess characteristics and needs where they were identified and volunteered to provide this information.

'Common' data could be compiled in this way as part of ongoing client monitoring across diverse needs groups to identify problem gambling and at risk behaviours. It is likely to be using modified existing screening tools (as with this study) and integrated with any existing client assessment systems. The more stakeholders who could be engaged with this, across different vulnerable groups, the more accurate the measurement and understanding it would support.

Sharing this 'embedded' evaluation data (anonymously) across partner organisations already active in working with vulnerable groups could inform further development of a set of replicable and comparable indicators of changing prevalence levels but also, crucially, a better understanding of influences and what is happening on the ground across diverse groups at risk. The study has shown an appetite among some of the stakeholders to start to develop more sensitive approaches to assessing if and when problem gamblers access their services;

these can be built on to existing tools to co-develop the necessary assessment systems. National bodies such as RGT and GamCare may see value in investing in such developments where they might provide replicable tools and models which could be transferred to other localities and contexts.

We see value in the potential of such an embedded approach in its sustainability, cost effectiveness and in providing a more integrative approach to understanding change overall and among vulnerable groups. It would be well placed to look at rates of both problem and at risk gambling alongside harms. It could also be harnessed to incorporate generic outcome and impact indicators which could in turn be used to evaluate the effectiveness of any local actions aimed at harm minimisation within specific vulnerable groups.

Such an embedded approach would be novel, imaginative and evidence-based, but will take some time to develop, trial, pilot and roll out to a sufficiently large number of stakeholders. This will not provide for a 2016-17 baseline for any impact evaluation related specifically to the GGV development. However, we caution that it is unlikely that any impact evaluation strategy can be developed which assesses the specific impact of the GGV development on any measures of change in problem gambling and at risk prevalence and behaviours. The inter-relationships in the land-based market, multiple gambling activities among many gamblers and the uncertain effects of on-line gambling, means that any future evaluation will need to look beyond causal relationships between the large casino and such changes. A more useful focus for any specific review geared at the GGV impacts might be a longitudinal survey combined with qualitative evidence from clients of the new casino to unpick the evolving impact of the casino upon gambling behaviours.

Finally, we would also suggest that findings from this analysis should be considered by operators when producing their local risk assessments, which should reflect the elevated rates of problem gambling in areas like Leeds. Operators should build on this insight to outline what steps they will take to protect vulnerable people from harm.

7.6   Gaps in provision and support

This study shows there are substantial challenges to building appropriate specialist support and referral for problem gamblers in Leeds. The starting point, however, is more positive in that Leeds has a plethora of services willing and able to provide some advice and guidance to problem gamblers and also those at risk. At least 13 different suppliers are involved although for most their direct experience of providing such support is usually limited to a few individual and self-declared cases. Outside of NECA (the single service providing specialist advice and guidance to problem gamblers), there is an almost total lack of any assessment or screening for gambling related harm. This means that many services which could either provide some support, or could provide referral pathways to those that could, miss opportunities for early (or any) diagnosis of specialist needs.

The study suggests this is a significant gap in the potential network of support and referral services whose effect is intensified because in Leeds (as elsewhere) gamblers experiencing harm also appear almost serially reluctant to self-declare their behaviours. In this, the potential network of support and referral is diverse and includes both specialist services supporting drug and alcohol addictions where there may be significant co-morbidity with problem gambling, and more generic advice and guidance services in the community e.g. support for particular

needs groups such as homeless people or those with debt problems. However, with a few exceptions these services are not well joined up, cross-referral pathways are informal and held back by a lack of understanding about who does what in relation to problem gamblers. The study suggests there is the potential for a community of interest across these agencies regarding problem and at risk gambling; but some focus is needed to raise advisor awareness, understanding and to develop mutually supportive outreach and referral.

NECA is the sole focus for locally-based specialist support geared at (largely) self-referred problem gamblers although with integrated support for others also affected by gambling related harm. Its referral pathways stem mostly from national helplines and specifically from GamCare which is also the major focus helpline for operator signposting. Despite obvious challenges to its monitoring systems and management information, which may not be confined to NECA, the service in Leeds appears to have high (and rising) levels of demand locally. However, the study shows capacity falls short of that demand for advice and guidance, with significant waiting lists of 4-6 weeks. These fall short of GamCare expectations of responsiveness, and (as yet) adjustment responses by NECA to increase capacity have done little more than slow the extension of the waiting lists.

The study also points out that NECA is operating in almost total isolation in Leeds. Its profile among other advice and guidance services in Leeds is very low, and the potential for enhancing 'national' helpline self-referral with a localised referral network across other agencies is not being exploited. Although building cross-agency relationships and referral pathways and protocols remains a strategic goal for NECA in Leeds, there is no evidence of pro-activity to put this into effect. This situation in Leeds appears to be in contrast to some other GamCare local support services.

7.7   Recommendations

The research has been commissioned with a view to guiding future prioritisation and funding of projects to mitigate the harmful effects of problem gambling. Although we have not been asked to provide specific recommendations we would draw attention to the following four areas which emerge from the study as early needs and possibilities:

- Better information to help fine tune future targeting of harm mitigation actions

- Raising awareness

- Increasing support capacity(s)

- Increasing co-operation and partnership working.

Better information to help fine tune future targeting of harm mitigation actions: The research has revealed the challenges involved in dimensioning the scale and nature of problem and at risk gambling, when individuals themselves may refuse to recognise the behaviours and families and even their advisors may not be aware. Operators have harm avoidance and eventually self-exclusion systems, but here too, operator understanding seems to be impaired especially when contact is lost through self-exclusion schemes. This study has provided a snapshot but has also shown lost opportunities in current monitoring systems which might be better used to support ongoing measurement and monitoring, and to do so cost

effectively and sustainably. As noted above, the Council will be well advised to not rely on disaggregation from national survey evidence for regular re-appraisal of the situation in Leeds. We consequently propose:

- An initiative to build comparative data collation from 'first contact' assessment data drawn from local agencies. This is anticipated in the evaluation and monitoring suggestions set out above. We suggest this would need systematic and comparative use of screening using existing tools*, or some streamlined adaptation fitted to these circumstances, and an approach to data sharing across this which is consistent with data protection and ethical demands. This would be an ambitious development. A starting point might be a trial of a preliminary screening process with one or more agencies working with associated behaviour's such as debt management, alcohol and drug abuse, or offending. A candidate might be Forward Leeds who have large numbers of clients and are likely to be receptive to piloting.

- Action to encourage collection of more systematic and reliable information on client distribution, behaviours and harms on problem gamblers from NECA. Over time this will provide not only a valuable guide to local behaviours and trends, but will also help assess effectiveness of specialised treatment and support. This is likely to require a focus on building more robust and reliable classification and monitoring systems including aftercare monitoring to assess outcomes. NECA on its own may be unable to tackle this without the co-operation and support of their referral and end funding bodies, RGT and GamCare; an early priority would seem to be liaison between the council and both bodies to explore these possibilities and the development needs.

- A project aimed at building a more differentiated needs assessment focused on level of need, advice 'supply' and accessibility, and any distinctive behaviours or harms affecting vulnerable groupings. This might draw on the screening initiative proposed above* but we sense that some of these groups will be too small, specialised or culturally resistant to measurement through screening. We would anticipate the starting point being the Council harnessing existing working relationships across a wider range of support and community bodies to build a cross-group and comparative assessment of any distinctive needs in each of the major vulnerable groupings we have identified in this research.

- Briefing by the Council to operators to encourage each to take account of the study evidence when producing their local risk assessments. In particular this should reflect the elevated rates of problem gambling in areas like Leeds, with operators building on these insights to outline what steps they will take to protect vulnerable people from harm. As a preliminary, the council might wish to work with GGV to explore what specific measures they propose to take to offer additional protections to likely vulnerable groups; where this study has identified both minority ethnic groups and students as likely particular needs groups.

The Council may also be looking to reflect key messages from the study into their own learning and continuous improvement of their gambling licensing policies, and their own local profiles, to support all operators in building this local level knowledge into practice.

Raising awareness: The research has shown often low levels of awareness among some stakeholders about the nature of the problem and the potential for support. Added to this there

remains potential to work with these agencies and operators to further raise awareness of risk behaviours and advice pathways among those directly affected – problem gamblers and those at risk. We propose:

- Action to provide for materials and appropriate pathways to raise awareness among those at risk, through a cross-agency information activity with collaboration from operators in Leeds. This would need to go beyond corporate signage and the national helpline to provide a more distinctive localised pathway which would supplement existing materials. A starting point might be for the Council to undertake a rapid evidence review of what is viable and transferable from a review of successful localised awareness raising elsewhere possibly in collaboration with one or more operators and/or RGT as a pilot project.

- Action also to raise awareness among generic and other addiction support agencies in Leeds. We would anticipate a programme targeted at professional advisors and counsellors, alongside their managers, providing briefings with supplementary support materials developed to provide post-briefing support for dealing with identification, assessment, co-morbidity, support and referral.

Building capacity for specialist advice and guidance support to problem and at risk gamblers: The increasing waiting lists, and their lengths for NECA support suggest a mismatch between support supply and demand in Leeds. Current data are limited but there seems every likelihood that if there were better awareness about, and/or referral mechanisms to NECA, these waiting lists would be even longer. We therefore propose:

- Action to increase capacity and responsiveness of specialist support and specifically for NECA, and/or others with specialist capacity, to bring waiting lists down and to below GamCare guidelines for preferred maximums (i.e. 10 days). Early liaison with RGT may show the Council that the trust, in line with the national responsible gambling strategy, are open to supporting treatment where there is a demand for services and constrained supply. We would encourage LCC and NECA to liaise with RGT based on the findings of this report, so as to demonstrate likely elevated need in the Leeds area for problem gambling services.

- Action to make more effective use of the existing (or enhanced) capacity to NECA through fast track initial assessment (and referral) mechanisms. RGT are currently devising their forward funding strategy, which includes consideration of how best to provide effective treatment nationwide. The Council may find scope to work with RGT under this strategy to pilot an 'initial assessment' fast track assessment process which would anticipate waiting list additions and secure early action on 'problems' from referral to other agencies.

Increasing co-operation and partnership working: The study has shown that on understanding problem gambling, and sharing knowledge and capabilities in co-morbid situations, a plethora of information, and advice and guidance agencies in Leeds are currently operating in isolation. We anticipate the need for greater cohesion and collaboration and in particular building harm minimisation potential by:

- Action to increase collaboration and co-operation between other support agencies, including NECA, to optimise opportunities for early identification of at risk and build co-

morbid referral pathways to appropriate agencies for handling impacts from harm and/or treatment.

- Action (and capacity) by NECA to work within this strategy to support and sustain pro-activity with a wider network of support agencies (and operators) and to build on the experiences of other GamCare agents in other localities with effective action to build engagement and co-operation with other agencies.

We see these proposed actions as part of an integrated approach to harm minimisation in Leeds. It is likely that other large metropolitan centres may be experiencing similar challenges; the suggested actions here would place Leeds at the forefront of development for integrated local solutions which might be transferable to other similar localities.

The study has provided valuable intelligence to take forward an integrative approach to harm minimisation and one which is distinctive to Leeds and its potential for a support infrastructure.

Annex
Annex A The Research Brief

1. Aim

To establish the prevalence of problem gambling and assess how it impacts on the lives of the people in Leeds, in order to set a baseline from which we can continue to monitor and evaluate the social and health impacts of the large casino, which is set to open in autumn 2016.

The research will also be used to guide future funding of projects to mitigate the harmful effects of problem gambling.

2. Background Information

In May 2013 the council granted a large casino licence to Global Gaming Ventures (GGV). The licence was granted using an approved evaluation methodology and scoring criteria, which sought to maximise the financial, social and economic benefits for the city.

Before the licence was awarded to GGV, a public consultation was carried out to document and respond to the concerns from Leeds' communities and businesses. The key concerns about the large casino opening in Leeds were that there may be an increase in problem gambling, debt levels, and wider impacts associated with gambling such as increased alcohol consumption, issues with family cohesion, domestic violence, and mental health.

On being granted the licence, GGV committed to undertaking a wide range of benefits, including commitments to employment, training, mitigating problem gambling, commitment to environmental principles and the physical development of the casino.

Further commitment was also secured to contribute to a Social Inclusion Fund (SIF) which comprised an immediate upfront payment followed by an annual payment, when the casino formally opens, of the greater sum of £450,000 or 4% of net gaming revenue. All monies received prior to the casino opening were designated to fund projects and initiatives that support the city's anti-poverty agenda and closely aligned to a range of activities that will proactively support financial and economic inclusion. From the first anniversary of the casino opening (formal opening likely to be September 2016), for the duration of the licence, monies will continue to be used to fund initiatives that achieve social, financial and economic inclusion priorities, and will also fund projects that mitigate potential harmful social effects of gambling.

GGV have also agreed to fund work to independently monitor the performance of the licensee and its compliance with the agreed benefits and the operation of a robust system of monitoring, management, and mitigation to ensure that the social and health risks are closely monitored to minimise any potentially harmful effects of the new casino.

3. The Leeds Casino

The 2005 Gambling Act allowed for 16 casinos across England, Scotland and Wales – 8 large casinos and 8 small casinos. A large casino allows for up to 150 gaming machines to be held on site and a small casino allows up to 80 gaming machines on site.

When GGV opens its casino in Leeds in 2016, it will be the fourth large casino to be in operation in the UK. In December 2011, Aspers casino was opened in Newham in London, within the newly developed Westfield shopping centre and was the first large casino to be in operation in the UK. Aspers also operate the large casino in Milton Keynes, which is part of

the Xscape retail and leisure complex which opened in 2013. The third large casino to open was at Gentings International Casino at Resort World Birmingham.

As with the three existing large casinos, the Leeds casino will be located within a mixed use shopping and leisure scheme. In Leeds this will be the Victoria Gate complex, being developed by Hammerson Plc. Victoria Gate is a major urban retail and leisure complex anchored by a new John Lewis store. The casino will comprise 59,000 sq. ft., made up of 50,000 sq. ft. footprint with a mezzanine floor to add the further 9,000 sq. ft. (mainly for back house functions). The retail and restaurant space on the ground and mezzanine levels and the casino space on the floor above will all sit to the west of the new John Lewis store. The casino is likely to be open 24 hours each day and the restaurants are likely to close around 11 pm. GGV estimate that the casino will employ 272 staff once it is open in late 2016.

4. Establishing a baseline of the social and health risks of a large casino

In terms of measuring the impact of casinos, the 16 local authorities chosen to host a small or large casino formed the Casino Network. The Network is a working group which aims to address local sensitivities regarding positive or negative effects, and harness the potential for regeneration at a local level. In order to complement the national impact assessment research the Network commissioned Community Sense with Lancaster University, to develop a robust impact assessment toolkit to facilitate the development of a baseline and support regular monitoring of the social and economic impact of each casino in its respective locality.

Community Sense published their 'Impact assessment toolkit for new casinos' in 2011, which recommends an extensive set of qualitative and quantitative indicators that could be used. The indicators involve multiple data sets around individual debt, levels of problem gambling, health and community wellbeing, drug and alcohol use, gambling impact on crime, and gambling spend, in addition to economic impacts around jobs created and displaced. Although comprehensive, much of this toolkit's recommendations are considered to be too wide reaching to assess the impact of the Leeds casino, as it is a regulated casino which is set within a city centre retail development.

The Council acknowledge that GGV have gone beyond the scope of the mandatory requirements of the Gambling Act to mitigate any harmful effects of the casino. Through the monitoring arrangements agreed with GGV the Council will be able to assess performance against employment and training commitments and socio- economic responsibilities including establishing a Responsible Gambling Forum and an Impact Committee, alongside compliance with the terms of the licence. However, there is a current lack of knowledge and understanding about the scale and impact of problem gambling in the city. Therefore the priority for this research is more narrowly focussed on gaining a better understanding of problem gambling in the city. This research will enable Leeds City Council to target the Social Inclusion Fund at projects to mitigate and deal with the effects of problem gambling.

Below is the information required for this baseline study. The intention of this research is to ensure the Council is in an informed position to discuss the needs of those struggling with problem gambling, ensure support services are resourced and targeted towards those most in need and to work with GGV in mitigating any harmful effects of the Casino. It is also intended that this research will be the framework from which we can continue to monitoring problem gambling in the city.

Requirements: In order to establish a baseline of problem gambling in Leeds, we are looking to commission consultants to undertake the following activities:

- Establish the number and demographical representation of problem gamblers in Leeds (e.g. by age, sex, ethnicity, socio economic factors, location etc.)
- Establish a profile of problem gamblers in terms of how and where they gamble
- Identification of the factors that make people vulnerable to problem gambling
- Consideration of the wider impacts of problem gambling in terms of personal finance, health and families
- Identification of the current services and support methods available to problem gamblers, including how they are accessed, their capacity and their effectiveness

5. Required Outputs

- Regular meetings throughout the project
- A draft report
- A final report with recommendations
- The report should include recommendations for future monitoring of the prevalence of problem gambling and targeting of funding for projects to mitigate the effects of problem gambling
- The report will be used as a basis for comment and consultation within the Council and amongst a number of partner organisations
- A survey report (if undertaken)
- An executive report
- A presentation at a dissemination event

Annex B The research approach

Introduction

The Leeds City Council (the Council) specification for the study (see Annex A) anticipated intensive research to provide for broadly-based 'baseline' evidence to use for future monitoring and evaluation purposes. Quantitative and qualitative methods were anticipated and a four-month time frame was proposed for the evidence gathering, analysis and draft reporting.

Addressing these needs was not without its challenges. In its proposed approach[63], we acknowledged the contribution of the 2011 Community Sense toolkit, developed by the local government Casino Network with Lancaster University, yet suggested this had a doubtful fit to the Council's requirements or the Leeds context. We also noted that a dedicated survey of problem gamblers in Leeds would not be possible for resourcing reasons, and was, in any event, a doubtful option given sourcing and sampling challenges[64]. However, we pointed out that available evidence has also improved greatly in the five years since the Community Sense toolkit; in particular through the British Gambling Prevalence Survey (BGPS) 2010, and the Health Survey for England (HSE) 2012.

The proposed approach; subsequently agreed with the Council and refined in discussion with the cross-stakeholder project Steering Group (21 April 2016), went beyond the methods of the Community Sense toolkit. The approach adopted and delivered is set out below in terms of the Councils five required work packages a) to e). This provides consistency with the description of the methodology approved by the Council, although it is important to recognise the methods used provided evidence which cut across the work packages. Figure B1 summarises the sources and provides a signpost to the explanations set out below:

Figure B1 Multiple sources of evidence for the study

Focus (LCC work package)	Preva-lence data & analysis	Problem gambler inter-views	Sector & operator inter-views	Quick scoping review	Local stake-holder review	Other source
a): Leeds no's and demographics of problem gamblers	a)	bii)	bii)	-	-	-
b): Profiling problem gamblers	-	bi)	bii	cii)	ciii)	-
c): Vulnerability factors	-	ci)	-	cii)	ciii)	-
d): Impacts of problem gambling	-	di)	-	dii)	diii)	-
e): Leeds support & services for problem gamblers	-	ei)	-	eii)	eiii)	eiv)

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[63] As set out in the LBU tender to the Council of 2 March 2016.
[64] Other options were considered at the tender stage, such as omni-bus survey, random digit dial telephone studies, randomised postal studies, and were also rejected as not viable technically and/or for resourcing and time constraints.

Establishing the number and demographics of problem gamblers in Leeds: the Council's work package a)

In the absence of viable primary data collection methods, we combined the datasets from British Gambling Prevalence Survey (BGPS 2010) and the Health Survey for England (HSE 2012) to explore how problem and at risk gambling varies among people living in different types of places and to estimate likely rates of problem and at risk gambling among those living in the Leeds metropolitan district.

The main reason for combining the datasets was because the national survey sample could provide only 184 people (out of 13,338 in the national sample) who lived in the City. Whilst the City-national differences assessed from that small subset would be statistically significant, we anticipated very large confidence intervals around any prevalence estimates derived from them. To overcome this, we also provided a further measure by combining the Leeds sample with closely matched metropolitan comparator areas.

A comparator selection methodology was applied using 'matched' characteristics by key socio-economic indicators and also similarities in problem gambling features to identify areas with similarities to Leeds. A comparator area analysis (see Annex C) drew on extensive demographic and economic data from national sources, and the Councils own previous analyses. In June 2016, this was presented to the Council, suggesting Leeds be 'matched' with nine other potential metropolitan areas with recommendations for comparators. It was subsequently agreed, Leeds plus four close comparators (Sheffield, Newcastle, Liverpool and Birmingham), would be used to provide an enhanced sample size of 657.

By combining the datasets of BGPS 2010 and HSE 2012 and forming a comparator area data to provide for three measures:

- the National measure
- the 'pure' Leeds measure (based on 184) and
- the comparator areas + Leeds estimate (based on 657)

The analysis also drew on contrasts across different screens and for other area-type disaggregation from the national data to provide for further comparisons. A full description of the source material, analysis, and conventions, to supplement that in Chapter 4, is also provided in Annex D.

Profiling problem gamblers – The Council's work package b):

To achieve this, we conducted:

- Qualitative, in-depth interviews with a small cross-section of high-risk, low-risk and no-risk gamblers, and
- Interviews with a small sample of operators to explore gambling issues from different perspectives to harness local evidence and experience

The findings from the above interview supports work packages c), d) and e) – as shown below:

i) Interviews with volunteer gamblers: The study aimed to recruit Leeds-based volunteer gamblers from selected venues (see bii below), treatment agencies and from identified sources from local stakeholders. The hybrid approach aimed to optimise opportunities in a situation where we expected to encounter identification challenges and possible reluctance from potential recruits.

A non-probability quota sampling method was used, to emphasise depth of interviewing rather than breadth. The results were consequently expected to be illustrative of a range of problem gambling experiences (by age, sex, gambling preference, etc.) and not to be statistically representative (which would have required a much larger sample, resources, and timeframe). It was anticipated that recruitment would be challenging; especially as the interview process has two stages; namely the Recruitment Stage and the Interview Stage. Further, the researcher is very aware that that gamblers may be vulnerable, therefore, the research process is governed through a high degree of control under the terms of the Research Ethics Policy of Leeds Beckett University.

Stage 1 - the Recruitment Stage. General recruitment took place in one Leeds-based casino, one bingo centre, and two LBOs. The researcher approached over 100 gamblers; but many refused to take part, pre-screened 49 individuals and recruited 15 gamblers. Gamblers were recruited via gambling venues and were asked a range of screening questions to determine their eligibility to progress to State 2. The screening questions were around regularity of play, types of gambling activities and risks.

Stage 2 - the Interview Stage. Gamblers that were eligible went on to for the research, participants were given Participant Information sheets and were asked to sign a Consent Form; which set out their option to withdraw at any time up to two weeks following the depth interview at Stage 2. Despite offering a gift voucher of £20 as an incentive, there was substantial drop out between the first and second stages.

In total, 15 participants were recruited to take part in Stage 2[65], although four dropped out and did not attend/complete Stage 2.

Four problem gamblers in treatment were also recruited. The NECA counsellor mediated three problem gamblers in treatment and the probation service mediated one problem gambler who had attended treatment sessions as part of his probation conditions. Ethical procedures were followed and an incentive given as per details above. It was expected that the local stakeholders (see iii below) would provide individuals that had gambling related issues and come to them for advice/shelter etc, however, no individuals were presented.

Given the potential vulnerability of participants, interviews took place at safe locations customised to the participant's needs and circumstances. Interviews were structured and based on an interview schedule agreed with the Council to explore, in particular, socio-economic characteristics, legacy behaviour, and rationales, current gambling behaviour, evidence of impacts and harms and experiences of support or treatment; together with recommendations for the Council to support existing and future problem gamblers. The focus was on in-depth profiling with the evidence captured and analysed through a Framework

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[65] One from the Chinese community was conducted by proxy due to language difficulties.

Analysis. In the Framework Analysis the voices of the participants, reflected through individual quotes (which were anonymised), were synthesised and presented in Chapter 6.

During the data analysis process, the 15 participants that completed Stage 2, were categorised as High Harm (problem gamblers), Low Harm and No Harm participants based on the reflections of their gambling behaviour. High Harm participants include all treatment gamblers and recruited individuals who shared their stories of how gambling affected them financially, caused family and relationship issues, affected their overall health and wellbeing and caused feelings of guilt and/or shame. Participants that were categorised as Low Harm participants reflected upon events that had caused some harm; from which they learnt, took heed and felt they were once again in control of their gambling behaviour. Participants that are categorised as No Harm presented reflections signalling full control of their gambling behaviour. Participants profiles, including a range of sociodemographic characteristics and gambling activities, are summarised in Annex F. Post-interview each participant received a summary of local advice services and sources of support.

ii) Sector experience and engagement: In addition to the gambler interviews, we drew on evidence and experience from a cross-section of venues and operators. This started with collation and review of available licensing information (from the Council) and trend data (from 2008) to define the relevant scope of 'Leeds' operators (at inception). This focussed on land-based operators and online operations not necessarily 'dedicated' to Leeds. For this stage of we:

- Engaged and briefed key sector operator groups nationally including ABB, BA, BACTA, NCIF, COA and RGA and asked them to provide access to corporate managers
- Liaised with appropriate corporate managers to provide 'branch' access, and to optimise the scope for collaboration from Leeds branches. We anticipated reluctance to commit to interview and assistance from hard-pressed local managers without corporate approval and offered a fast track approach to accessing branches necessary within the intensive timescale of the study
- Collated where possible, locally disaggregated data on gambling activity and operator trends, from membership records and management information systems. ABB and the Bingo Association were able to provide some local data. These and other data refers to machine classifications among operators for which the national definition and operator requirements are set out in the Appendix to this Annex*
- Subsequent to this, local operator interviews were conducted covering eight Leeds branches (casino's, bingo, AGC and LBOs). We asked manager to share their experiences of local circumstances. Interviews were semi-structured and based on a modified version of the stakeholder checklist (see work package c) below). Interviews were conducted in-branch, in two cases with corporate managers also present, and provided, where possible, reviewing (in confidence) local self-exclusion documentation

The corporate and branch interviews also gave permission for the LBU team to recruit volunteer gamblers.

Identification of problem gambling vulnerability factors: the Council's work package c)

The evidence for this part of the study drew on:

- The in-depth interviews conducted with gamblers categorised High Harm, Low Harm and No Harm
- An updated review of national and sub-national evidence on vulnerable groups, and
- A series of interviews with local stakeholders

Evidence of vulnerability was also sought from the local operator interviews. However, their evidence and experience did not cast light on causes beyond speculation and self-excluding processes. This, therefore, tended to isolate branch managers from underpinning the following factors:

i) Interviews with gamblers: insights into the factors affecting vulnerability – thus only the gamblers themselves, as per the procedure set out in bi) provided information about their vulnerability

ii) Review of national and sub-national evidence: A Quick Scoping Review (QSR) was conducted to update the recent (July 2015) national review *Exploring Gambling-related harm: who is vulnerable*? This centred on an intensive, constrained search strategy focusing on UK-based evidence and sources accessible electronically and focussed on identifying specific or multiple vulnerable groups to problem gambling. Some of the in-scope studies drew on locality or sub-regional evidence.

For consistency, the review followed the same conventions as the earlier (2015) review and excluded those quantitative studies based on purposive sampling methods or through non-representative population groups. For qualitative studies, assessments were made about the design, methods and appropriateness of conclusions drawn. The evidence was drawn together to provide for a detailed assessment identifying likely vulnerable groups within Leeds, and with the supporting evidence to illustrate factors underpinning vulnerability. This was expected to provide a significant part of the evidence base-line against which any subsequent monitoring of problem gambling characteristics could be set.

iii) Stakeholder interviews: An important part of the overall study involved interviews with a cross-section of other local stakeholders to understand who they view as vulnerable. These stakeholder (semi-structured) interviews contributed local evidence on vulnerable groups and also experiences of support and other agencies on the factors influencing vulnerability. The interviews also contributed wider evidence which supported the profiling evidence of problem and at risk gamblers (see work package b) above) and also local, mainly qualitative, evidence to support the assessment of impacts from gambling related harm and to help define local support services (work packages d) and e) below).

A total of 12-15 interviews were planned but in the event the scope was expanded to encompass a wider range of selected local agencies. A total of 21 agencies were invited to contribute with the great majority (around 80%) taking up the opportunity, often including

several staff in the feedback process. Only two of those invited were unable to participate[66] and two others felt they had no experience to draw on[67].

Nevertheless we drew together experiences from a mix of voluntary and community organisation, advice centres, 'umbrella' bodies and referral and treatment centres including:

- Behind closed Doors
- Emmaus
- Forward Leeds
- Illegal Money Lending Team
- Methodist Church
- Money Advice Centre, Leeds Beckett University
- NECA
- Leeds CAB
- Leeds Mind
- Oxford Place Centre
- LBU Wellbeing Service
- St George's Crypt
- Stepchange
- Student Union – Leeds Beckett University
- Touchstone
- Voluntary Action Leeds
- West Yorkshire CRC.

The selections and mix were agreed with the Council at inception. Interviews were conducted using an agreed interview schedule to explore the agency context and capacity, knowledge of the gambling sector locally and of the GGV development, engagement with problem and at risk gamblers, evidence of prevalence (including any monitoring data), vulnerability factors and determinants, support provided or available including referral and relationships with other agencies, and knowledge and views of localised specialist support for problem gamblers. Stakeholders were also invited to make suggestions for any gaps, future focus or priorities to be included in any future harm minimisation strategy by the Council. A Framework Analysis was conducted to provide for common messages with results synthesised in Chapters 3 and 5 of the report.

Impacts of problem gambling: the Council's work package d)

Evidence for this part of the study; which sought to review a wide range of personal and related impacts, drew on evidence from:

- The interviews with gamblers (see work package bi as above)
- The QSR update of vulnerability and its influences (see work package cii above)
- Stakeholder interviews (see work package ciii above)

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[66] Despite multiple requests, two organisations – Leeds Women's Aid and Leeds City College were unable to participate in the time available.
[67] National Probation service Local offices and also the Leeds Community Heath NHS Trust.

Impact evidence was also sought from the interviews with local operators but beyond speculation these were not able to cast light on gambling related harms. As with work package d) self-excluding processes tended to isolate branch managers from looking at harm and any interviews within self-referral processes tended to highlight the GamCare helpline as the source for any advice on gambling related harm.

The qualitative interviews with Leeds High Harm gamblers (WP bi) gave valuable and in-depth insights into the local experience of harms and adverse consequences from gambling. Evidence from stakeholder interviews included those working specifically in the area of management of personal finance and debt issues, health and family relationship advisory services although predominantly as a 'generic' service (e.g. Leeds CAB) or focussed on other addictions (e.g. drug, alcohol counselling and recovery such as at Forward Leeds) or with for particular groups with differing needs (emerging communities, homeless people). Input was also provided by the counsellor supporting NECA services (see below). The use of the multiple sources of impact evidence provided triangulation across local sources and benchmarking of Leeds experience with national research in harms generated.

Identifying Leeds services and support for problem gamblers: LCC work package e)

The Council's brief sought information on the range of service available, how these were accessed and their capacity. To this we added a review of inter-relationships between support agencies and also any formal referral protocols, mechanisms or working arrangements. The LBU team cautioned that this study could not look at the effectiveness of these services in supporting problem gamblers but did agree to seek both stakeholder and gambler views on any gaps and improvement needs. Four sources of evidence contributed to this:

- The interviews with High, Low and No Harm gamblers (see bi) above)
- Interviews with stakeholders (see cii) above)
- Discussions with selected national agencies concerned with harm minimisation
- Interviews with NECA.

i) Interviews with gamblers: These provided some 'end-user' insights into support services where these had been accessed and seen by (most) participants; problem gamblers (High Harm) in particular.   Participants also provided a number of personal suggestions for improvements although these tended to encompass national as well as local support (See Annex G).

ii) Interviews with stakeholders: Interviews with specific stakeholders were expected to provide most of the insights although all were invited to contribute their own evidence and experiences. Interviews with Voluntary Action Leeds; the umbrella body for the voluntary and community sector, did not identify any specific pathways relating to problem gamblers, therefore, to gain a picture of support we drew on finding across all interviews. A loose classification was developed to capture service-level evidence within:

- Generic information, advice and guidance services providing support on managing debt and other gambling related harm(s)
- Specialist advice and counselling services focussing on addictions but not specific to problem gambling

- Specialist advice and counselling services focussing on gambling related harm and problem gamblers (NECA)

Details of these interviews and their coverage is set out in cii) above.

iii) Discussions with selected national agencies: Brief discussions were conducted with RGT and also GamCare. Neither RGT nor GamCare were able to provide direct experience of Leeds based services but were able to provide wider evidence on support for harm minimisation and as funders and contractors respectively for the NECA service in Leeds. The GamCare discussion provided access to their agents in Leeds – NECA – which was necessary to commence recruitment of problem gamblers in treatment. The RGT discussion also provided for useful evidence on the prospective 'new' five year national strategy for harm minimisation (and treatment) against which to set some of the proposals set out in the study (Chapter 7).

iv) Interviews with NECA: After arranging access (through GamCare) an initial briefing was conducted with the nominate head office contact at NECA, and subsequent interviews were conducted with the operational lead for Leeds (and also West Yorkshire and York) at NECA and with the local counsellor in Leeds. The NECA interviews harnessed the generic stakeholder checklist as approved by the Council, to explore wider issues. Supporting data were also sought, although proved to be very limited (see Chapter 2) due to the nature of the underpinning monitoring and reporting system in NECA.

Appendix to Annex B*

Gaming Machines Classification and Stake/Prize Limitations

Machine category	Maximum stake (from January 2014)	Maximum prize (from January 2014)	Allowed premises
A	Unlimited	Unlimited	Regional Casino
B1	£5	£10,000 (with the option of a maximum £20,000 linked progressive jackpot on a premises basis only)	Large Casino, Small Casino, Pre-2005 Act casino and Regional Casinos
B2	£100	£500	Betting premises and tracks occupied by pool betting and all of the above
B3	£2	£500	Bingo premises, Adult gaming centre and all of the above
B3A	£2	£500	Members' club or Miners' welfare institute only
B4	£2	£400	Members' club or Miners' welfare club, commercial club and all of the above.

Machine category	Maximum stake (from January 2014)	Maximum prize (from January 2014)	Allowed premises
C	£1	£100	Family entertainment centre (with Commission operating licence), Qualifying alcohol licensed premises (without additional gaming machine permit). Qualifying alcohol licensed premises (with additional LA gaming machine permit) and all of the above.
D money prize	10p	£5	Travelling fairs, unlicensed (permit) Family entertainment centre and all of the above
D non-money prize (other than crane grab machine)	30p	£8	All of the above.
D non-money prize (crane grab machine)	£1	£50	All of the above.
D combined money and non-money prize (other than coin pusher or penny falls machines)	10p	£8 (of which no more than £5 may be a money prize)	All of the above.
D combined money and non-money prize (coin pusher or penny falls machine)	20p	£20 (of which no more than £10 may be a money prize)	All of the above.

 Gaming machines (fruit machines, slot machines) fall into categories depending on the maximum stake and prize available (available via http://www.gamblingcommission.gov.uk/Gambling-sectors/Gaming-machines/About-gaming-machines/Gaming-machine-categories/Gaming-machine-categories.aspx)

Annex C Choosing comparison areas

Introduction

To understand the likely rates of problem gambling in Leeds, analysis was approached in three ways. First, we analysed the rates of problem gambling in areas with different characteristics. Second, we analysed the rates of problem gambling among people who lived in the City. However, only 184 people out of 13,338 lived in Leeds. Whilst results were broadly commensurate with those reported in Chapter 4 for other areas like Leeds, there were very large confidence intervals around this estimate, ranging from 0.7% to 6.6%. Therefore, to further assess how robust this estimate was we also looked at problem gambling rates in areas with similarities to Leeds. These are called our comparison areas (and include data from Leeds itself). A key issue was how to choose which areas are sufficiently similar to Leeds to give a reasonable approximation of likely problem gambling rates in Leeds. This appendix outlines our choice of comparison area, which was reviewed and agreed with Leeds City Council.

Choice of comparator areas

In order to choose the most appropriate comparator areas, we compared Leeds with a number of other metropolitan areas across a range of characteristics. These characteristics were grouped into two types:

- Those known to have a strong association with problem gambling
- Those which may be related to problem gambling but there is little evidence to support this OR that describe the characteristics of the area more generally

When identifying potential comparator areas, preference was given to the former group and specific characteristics within this group. These were:

- Proportion of residents aged 18-34
- Proportion of residents from Asian/Asian British backgrounds
- Proportion of residents from Black/Black British backgrounds
- Proportion of resident who are unemployed
- Proportion of residents who are claimants
- Proportion of Lower Super Output Areas in the top 10% of the most deprived areas

These are the main characteristics known to be most associated with problem gambling rates and are treated as priorities in our comparative analysis.

Summaries of the data used are shown in Tables C1 and C2. Table C1 shows the main comparative data for each characteristic considered; Table C2 shows the extent to which the values are different to Leeds with data expressed as a proportion by dividing the value for a characteristic for each area by the value for Leeds. A proportion higher than 1 means that comparator areas have more of each group than Leeds, a proportion of less than 1 means they have less than Leeds. A figure of exactly 1 means it is the same as Leeds. For example, a proportion of 1.32 in Manchester of people aged 18-34 means that the number of people in this age group in Manchester is 32% higher than that of Leeds. In Table C2, those values which are within 10% of the value for Leeds are shown in bold.

Table C1: Comparison of key characteristics with Leeds									
					Area				
	Leeds	Manchester	Sheffield	Liverpool	Newcastle	Doncaster	Bristol	Birmingham	Nottingham
Group 1: characteristics with known relationship to problem gambling									
Age profile									
% residents aged 18-34	28.1	37.2	28.3	30.6	33.2	21.5	32.0	27.5	35.7
% residents aged 35-55	25.6	23.8	25.2	25.0	23.1	26.7	24.9	24.8	23.4
% residents aged 55 and over	25.4	17.0	26.0	25.3	24.3	30.4	22.3	22.0	20.3
Ethnic population profile									
% of residents White/White British	85.1	66.6	83.7	88.9	85.5	95.3	84.0	57.9	71.5
% of residents Asian/Asian British	7.8	17.1	8.0	4.2	9.7	2.5	5.5	26.6	13.1
% of residents Black/Black British	3.4	8.6	3.6	2.6	1.8	0.8	6.0	9.0	7.3
Unemployment									
% of residents aged 16 and over unemployed	5.7	8.1	8.1	7.6	9.0	7.7	5.1	9.1	9.1
% of claimants (of working age population)	2.3	2.9	2.5	3.6	2.7	2.8	1.7	4.2	3.3
Income									
Median weekly resident income (£)	419	392	390	393	397	365	445	403	352
Deprivation									
% of LSOAs in top deprivation decile	22	41	23	45	22	21	16	40	34
Group 2: General characteristics									
No. of active businesses	26,280	17,045	14,555	11,690	7,320	8,090	16,635	29,520	8,075
No. of alcohol licenses	2394	2164	1666	2120	1166	1103	1739	2998	1220

No. of casino licenses	6	9	6	5	5	0	3	8	6
No. of LBO licenses	118	122	85	167	67	58	67	178	55
No. of AGC/FEC licenses	24	9	13	18	12	12	10	25	11
No. of Bingo licenses	6	5	3	8	7	4	5	16	7
Population density (people per household per hectare)	20.0	36.1	29.3	37.3	34.8	9.0	37.7	36.8	32.0

Table C2: Extent to which key characteristics vary from Leeds (those values within 10% of Leeds are shown in bold)

	Area							
	Manchester	Sheffield	Liverpool	Newcastle	Doncaster	Bristol	Birmingham	Nottingham
Group 1: characteristics with known relationship to problem gambling								
Age profile								
% residents aged 18-34	1.32	**1.01**	**1.09**	1.18	0.77	1.14	**0.98**	1.27
% residents aged 35-55	**0.93**	0.98	0.98	**0.90**	**1.04**	**0.97**	**0.97**	**0.91**
% residents aged 55 and over	0.67	**1.02**	**1.00**	**0.96**	1.20	0.88	0.87	0.80
Ethnic population profile								
% of residents White/White British	0.78	**0.98**	**1.04**	**1.00**	1.12	**0.99**	0.68	0.84
% of residents Asian/Asian British	2.19	**1.03**	0.54	1.24	0.32	0.71	3.41	1.68
% of residents Black/Black British	2.53	**1.06**	0.76	0.53	0.24	1.76	2.65	2.15
Unemployment								
% of residents aged 16 and over unemployed	1.42	1.42	1.33	1.58	1.35	0.89	1.60	1.60
% of claimants (% of the working age population)	1.26	**1.09**	1.57	1.17	1.22	0.74	1.83	1.43
Income								
Median weekly resident income (£)	**0.94**	**0.93**	**0.94**	**0.95**	0.87	**1.06**	**0.96**	0.84
Deprivation								

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% of LSOAs in top deprivation decile	1.86	**1.05**	2.05	**1.00**	**0.95**	0.73	1.82	1.55
Group 2: General characteristics								
Number of active businesses	0.65	0.55	0.44	0.28	0.31	0.63	1.12	0.31
Number of alcohol licenses	**0.90**	0.70	0.89	0.49	0.46	0.73	1.25	0.51
Number of casino licenses	1.50	**1.00**	0.83	0.83	0.00	0.50	1.33	**1.00**
Number of LBO licenses	**1.03**	0.72	1.42	0.57	0.49	0.57	1.51	0.47
Number of AGC/FEC licenses	0.38	0.54	0.75	0.50	0.50	0.42	**1.04**	0.46
Number of Bingo licenses	0.83	0.50	1.33	1.17	0.67	0.83	2.67	1.17
Population density (people per household per hectare)	1.81	1.47	1.87	1.74	0.45	1.89	1.84	1.60

Focusing first on the characteristics with a known association with problem gambling, we can see that Sheffield, Liverpool and Birmingham have the closest match to Leeds in terms of age profile of the resident population, with all three cities being within 10% of the value for Leeds for those aged 18-34. This is followed by Bristol and Newcastle, where values are within 20% of the value for Leeds for those aged 18-34. Nottingham and Manchester have a notably higher proportion of young people whereas Doncaster has a notably lower proportion than Leeds.

Looking at ethnic population profile, and specifically focusing on those from Asian/Asian British groups, only Sheffield has a proportion of residents who are Asian/Asian British which is similar to Leeds. This is followed by Newcastle, whose proportion of people from Asian/Asian British groups is 24% higher than that of Leeds. Manchester and Birmingham have a proportion of people from Asian/Asian British groups that are 2-3 times higher than Leeds, whereas rates in Liverpool and Doncaster are around half that of Leeds.

Median weekly income is similar to Leeds in nearly all areas, except Doncaster and Nottingham where it is lower.

Sheffield, Doncaster and Newcastle have similar percentages of LSOAs in the top deprivation quintile to Leeds. Rates in Liverpool are over 2 times higher and over 1.8 times higher for Manchester and Birmingham. Rates in Bristol are 0.74 times lower than in Leeds, showing that Bristol does not have as many deprived areas as Leeds.

For more general characteristics, very few of the other areas had a similar profile to Leeds. Leeds has a greater number of active businesses than other areas (with the exception of Birmingham). Leeds also has more establishments with an alcohol licenses than other areas (again, with the exception of Birmingham). Average population density was higher in almost all other areas than Leeds (with the exception of Doncaster, where it was lower).

Finally, most other areas had a varying provision of gambling licenses.

Our recommendations for comparison areas were based on two considerations:

1. the analysis described in Table C2, focusing on those characteristics most strongly associated with problem gambling, and
2. the need to ensure that we select enough comparison areas to enable robust analysis to be undertaken.

With regards to 1) and 2), it was clear that Sheffield was the area with the most in common with Leeds, with a similar age, ethnic, income and deprivation profile. Liverpool, Newcastle, Birmingham, Doncaster and Bristol have commonalities in some areas, but not in others. Nottingham and Manchester stand out as being the least like Leeds according to these characteristics. Therefore, we recommended that Manchester and Nottingham were excluded and Sheffield included in our analysis. The inclusion of other areas required balancing the similarity and differences of areas with gaining sufficient numbers for analysis.

Table C3 shows the number of people in the combined HSE/BGPS dataset with valid problem gambling data by area:

Table C3 Number of individuals in combined HSE/BGPS dataset, by area	
Area	No of respondents in combined dataset
Leeds	184
Manchester	146
Sheffield	111
Liverpool	84
Newcastle	99
Doncaster	39
Bristol	55
Birmingham	208
Nottingham	72
Other areas	12340

If we were to limit our comparison areas to just Leeds and Sheffield, this would give a combined base size of 295. Assuming that problem gambling rates among other areas are around 0.7%, this would mean that problem gambling rates in Leeds and Sheffield would have to be around 2.7 percentage points higher than this to be statistically significant (3.4% in total). Problem gambling rates rarely reach this level among sub-groups, meaning that our analysis would be underpowered to detect differences.

We consequently recommended adding further comparator areas, accepting that there are some differences between them. Our recommendation was to also include Liverpool, Newcastle and Birmingham. Newcastle, Liverpool and Birmingham have broadly similar age profiles to Leeds; Newcastle has a similar deprivation profile and the second nearest proportion of those from Asian/Asian British Backgrounds. Liverpool and Birmingham have greater numbers of unemployed people and greater levels of deprivation, which needs to be borne in mind. In terms, of percentage of population from Asian/Asian British groups, Birmingham is over-represented whilst Liverpool is under-represented comparative to Leeds. Including both may cancel out this source of bias. We recommended excluding Doncaster because its age and ethnic profile was very different to Leeds. We also suggest excluding Bristol because it is far less deprived, with fewer unemployed people than Leeds. We also believed there is coherence of focusing on more northerly towns.

This gave a total comparator sample size of 686 and a greater ability to detect differences in problem gambling rates. The increased sample size saw the breadth of the confidence around the problem gambling estimate reduce compared with Leeds alone. Confidence intervals for the problem gambling estimate according to either screen were between 1.0% and 3.4% for those living in comparison areas.

Annex D Analytical sources and conventions for estimating problem gambling in Leeds

Introduction
This annex supplements annex B which describes the overall methodology by setting out some of the issues necessary to better understand the data used for estimating problem gambling in Leeds, and its analysis, including:

- Definitions of the measures used in the analysis
- Data use, table layout and reporting conventions
- Weighting of (source) data
- Analytical conventions and confidence intervals

In the combined BGPS/HSE data, 184 participants were identified who lived in the city. Of these people the proportion identified as problem gamblers according to either screen was significantly a little over double the proportion of people who lived in other areas. The confidence interval around this estimate for Leeds was broad; a function of the low number of people surveyed living in Leeds. For this reason, we recommend focusing on data from the comparison areas.

Measuring problem gambling
Many different ways exist to identify and measure problem gambling (with over 20 different types of screening instruments being in existence). To date, there is no agreed 'gold standard' instrument recommended for use in population surveys. Because of this it has been common practice (in Britain at least) to include two different screening instruments in population-based surveys of gambling behaviour. As the instruments tend to capture different types of people using two different 'screens' they give a better reflection of the range of issues associated with problematic gambling. In both the BGPS 2010 and the HSE 2012, the two screening instruments used were one based on the DSM-IV and another called the Problem Gambling Severity Index (PGSI). More detail is given about each below.

DSM-IV
The DSM-IV (Diagnostic and Statistics Manual-IV) screening instrument contains ten diagnostic criteria ranging from 'chasing losses' (described to participants as '[when you] go back another day to win back money you lost') to committing a crime to fund gambling. Each DSM-IV item is assessed on a four-point scale, ranging from 'never' to 'very often.' Responses to each item are given a score of either 0 or 1 to show whether a person meets the criteria or not. Once answers to all ten items are summed, a total score between 0 and 10 is possible. A person is classified as a problem gambler if they have a total score or 3 or more. This cut-off point has been found to give good discrimination between criterion groups and has provided the closest match to prevalence estimated by other screening instruments.

Clinicians currently use an additional threshold of a DSM-IV score of five or more to represent pathological gambling. For a variety of reasons, this threshold is not used in this study. First, the number of people falling into this category would be too small to allow any detailed analysis to be carried out. Second, the term 'problem gambling' is preferred as it has less negative and medicalised conceptual issues associated with it than the term 'pathological gambling.' Finally, the label 'pathological gambling' has now become obsolete as it has been renamed 'gambling disorder' and the criteria varied in the recent publication of the DSM-5. A DSM-IV score of 1-

2 is commonly held to identify those at risk. This means these people report some difficulties with their gambling behaviour but these people do not meet the threshold for problematic gambling (McManus et al, 2009).

This study uses the combined BGPS/HSE data to provide estimates of at risk and problem gambling according to the DSM-IV, as defined above.

PGSI
The PGSI was developed for use among the general population rather than within a clinical context and was tested and validated within a general population survey in Canada. The instrument consists of nine items ranging from chasing losses to gambling causing health problems and feeling guilty about gambling. Each item is assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores:

- Never = 0
- Sometimes = 1
- Most of the time = 2
- Almost always = 3

Scores for each item are summed to give a total score ranging from zero to 27. A score of eight or more on the PGSI represents problem gambling. This is the threshold recommended by the developers of the PGSI and the threshold used in this report. The PGSI was also developed to give further information on sub-threshold problem gamblers. PGSI scores between three and seven are indicative of 'moderate risk' gambling and scores of one or two are indicative of 'low risk' gambling. These definitions are used in this study to provided estimates of problem, low risk and moderate risk gambling according to the PGSI.

Problem and at risk gambling according to either the DSM-IV or the PGSI
Finally, recognising that each measurement instrument captures a slightly different range of harms and problems, it has become common practice in British studies to assess the prevalence of problem gambling according to either the DSM-IV or the PGSI (Wardle et al, 2011; Wardle et al, 2014). This measure is also used in this study and has been modified to include at risk gambling. It is classified as follows:

- Non problem gambler: a score of 0 on both the DSM-IV and the PGSI
- At risk gambler: a DSM-IV score of 1-2 or PGSI score of 1-7[68]
- Problem gambler: a DSM-IV score of 3 or more or a PGSI score of 8 or more.

In this study, we present three different measures of problem and at risk gambling. These are:

- Those classified as problem and at risk gamblers according to the DSM-IV
- Those classified as problem and at risk gamblers according to the PGSI
- Those classified as problem and at risk gamblers according to either measure.

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[68] People are only classified as at risk if they have a score on either measure indicating they are an at risk gambler and they are not classified as a problem gambler according to either screen.

The purpose of presenting these three different methods is to assess how robust and consistent results are between them, thus giving greater confidence in findings.

Definitions of area measures used in analysis

The Department for Environment and Rural Affairs created a typology of Local Authorities in 2009, which has been used in this chapter.[69] The definitions for each category are as follows:

- Major Urban: districts with either 100,000 people or 50% of their population in urban areas with a population of more than 750,000.
- Large Urban: districts with either 50,000 people or 50% of their population in one of 17 urban areas with a population between 250,000 and 750,000 people.
- Other Urban: districts with fewer than 37,000 people or less than 26% of their population in rural settlements and larger market towns.
- Significant Rural: districts with more than 37,000 people or more than 26% of their population in rural settlements and larger market towns.
- Rural-50: districts with at least 50% but less than 80% of their population in rural settlements and larger market towns.
- Rural-80: districts with at least 80% of their population in rural settlements and larger market town.

The Office for National Statistics classifies wards in Great Britain into different types based on a range of census statistics and dimensions. These include demographic structure, household composition, housing, socio-economic, employment and industry sector. At the highest level, these ward classifications are categorised as super-groups, with further differentiation within each super-group. It is the super-group classification that has been used in this report, with wards classified as follows:

- Industrial hinterlands
- Traditional manufacturing
- Built-up areas
- Prospering metropolitan
- Student communities
- Multi-cultural metropolitan
- Suburbs and small towns
- Coastal and countryside
- Accessible countryside

Finally, this study has also used DEFRA's Urban/Rural classification. The Classification defines areas as rural if they fall outside of settlements with more than 10,000 resident population. For the smallest geography areas, the full classification assigns them to one of four urban or six rural categories:

- Urban: Major Conurbation
- Urban: Minor Conurbation
- Urban: City and Town
- Urban: City and Town in a sparse setting

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[69] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/239063/2001-la-class-intro.pdf

- Rural: Town and Fringe
- Rural: Town and Fringe in a sparse setting
- Rural: Village
- Rural: Village in a sparse setting
- Rural: Hamlets and Isolated Dwellings
- Rural: Hamlets and Isolated Dwellings in a sparse setting

Those described as "in a sparse setting" reflect where the wider area is remotely populated. In this study, some categories have been combined because of low base sizes. The following groups have been presented:

- Urban (more than 10,000 people) in a sparse setting
- Urban (more than 10,000 people) in a less sparse setting
- Rural – Town & Fringe in a less sparse setting
- Rural – Village in a less sparse setting
- Rural – Village in a sparse setting, all hamlets, and isolated dwellings

As stated in Chapter 4 of the main report, analysis of how Leeds' ONS 2011 Classifications would compare to the 2001 Classification types has been included to provide a more current picture and context to the type of area Leeds has become.

The data releases and Super Group Classifications for the 2001 Characteristics differ from the 2011 release and the two types are not directly comparable without some understanding of the datasets.

For the 2001 Classifications, ONS produced data at ward boundary level and had a robust system to classify each ward into broad Super Groups. The ONS methodology could not be robustly replicated with publically available information for the 2011 Classifications data.

ONS 2001 Ward Classifications		
Super Group Name	England	Leeds
Suburbs and Small Towns	27.2%	30.0%
Industrial Hinterlands	17.0%	27.4%
Traditional Manufacturing	8.7%	26.0%
Student Communities	6.7%	14.6%
Multicultural Metropolitan	7.0%	2.0%

The 2011 Classifications data was produced at Output Area level, not ward level. Output areas are the lowest geographical level at which census estimates are provided and usually contain around 125 households. The 2011 Classification also re-categorised the 2001 Classifications into eight new Super Groups. These are not comparable to the eight 2001 Super Groups. When the 2011 Area Classifications are proportioned into output areas for Leeds and England, the results provide a broader view of how Leeds is split into each Super Group:

Proportion of Output Areas (OA) classified by ONS type 2011

ONS 2011 Super Group Name	Leeds % OA areas	England % OA areas
Suburbanites	21.3%	20.6%
Urbanites	20.9%	18.6%
Hard-Pressed Living	16.6%	17.4%
Multicultural Metropolitans	16.6%	13.4%
Constrained City Dwellers	10.9%	7.5%
Cosmopolitans	8.3%	5.1%
Ethnicity Central	3.7%	6.5%
Rural Residents	1.7%	10.9%

Comparing the 2001 Ward data to 2011 Output Area data

The ONS 2001 Classifications project a former image of Leeds which can appear at odds with the city's current position as one of the most diverse economies of the North. While Leeds was seen to have a particularly higher proportion of wards classified as Industrial Hinterland, Traditional Manufacturing and Student Communities than nationally in 2001, similar analyses of the 2011 data reveals Leeds has above national dominance in Multicultural Metropolitan, Constrained City Dwellers and Cosmopolitan characteristics. In 2001, Leeds areas were dominantly classified as:

- Suburbs and Small Towns, Industrial Hinterland and Traditional Manufacturing with a higher proportion of wards attributed to these classifications than nationally. These three area classifications all contain characteristics where populations are described as being diverse in terms of ethnicities, these areas also have a high proportion of students and people who work in the hotel or catering industry, mining or construction
- Almost 15% of Leeds wards were classified as Student Communities. These areas typically include students, people with a higher education qualification, household spaces which are flats and rented from the private sector
- Just 2% of wards were classified as being Multicultural Metropolitan in 2001. This would indicate an area with people who work in wholesale or retail and those who work in the health or social work industry. The definition of this classification has changed for the 2011 classifications

When compared to the ONS 2011 Classifications Leeds has evolved into a cosmopolitan city with a more diverse economy than in 2001. According to the 2011 Classifications:

- Over 40% of Leeds OAs are described as Urbanite and Suburbanite. These areas contain a mixture of people in private rented or home owner accommodation, working

in professional services, educational and public administration sectors. Leeds areas are similar to national trends on these characteristics.

- Almost 17% of areas are defined as Multicultural Metropolitan areas, compared to 13% nationally. Under the 2011 definition, these areas are said to contain transient communities, living in terraced housing that is rented. Residents who are employed are more likely to work in the transport and administrative related industries.

- Although Leeds was below national average on this characteristic, 17% of areas were classified as Hard-Pressed Living. Households in these areas are more likely to have non-dependent children and are more likely to live in semi-detached or terraced properties, and to socially rent. Rates of unemployment tend to be above the national average in these areas. Those in employment are more likely to be employed in manufacturing, wholesale, retail, and transport related industries.

- Leeds was more dominant than the national average in Constrained City Dweller areas. This group have more households living in flats and social rented accommodation, with a higher prevalence of over-crowding. There is a higher level of unemployment within these areas than nationally and no definitive work sector to define this group.

- Leeds was higher than National averages on the Cosmopolitan characteristics. 8% of OAs was described as Cosmopolitan areas, compared to 5% in England. Cosmopolitan areas are places where residents are likely to live in flats and communal establishments, and private renting is more prevalent than nationally. The population of the group is characterised by young adults, with a higher proportion of single adults and households without children than nationally. There are also higher proportions of full-time students. Workers are more likely to be employed in the accommodation, information and communication, and financial related industries, and using public transport, or walking or cycling to get to work.

- Leeds was considerably below national averages on the Ethnicity Central and Rural Resident characteristics.

Data use and reporting conventions

Unless otherwise stated, the tables set out in the report are based on the responding sample for each individual question (i.e., item non-response is excluded): therefore bases may differ slightly between tables. The group to which each table refers is shown in the top left-hand corner of each table. In addition, the following conventions have been used through this report:

- The following notations have been used in the tables:

    -    No observations (zero values)
    0   Non-zero values of less than 0.5% and thus rounded to zero
    [ ] An estimate presented in square brackets warns of small sample base sizes. If a group's unweighted base is less than 30, data for that group are not shown. If the unweighted base is between 30-49, the estimate is presented in square brackets.
    *   Estimates not shown because base sizes are less than 30

- Because of rounding, row or column percentages in the tables may not exactly add to 100%.

- A percentage may be presented in the text for a single category that aggregates two or more percentages shown in the table. The percentage for that single category may, because of rounding, differ by one percentage point from the sum of the percentages in the table.
- Some questions were multi-coded (i.e., allowing the respondent to give more than one answer). The column percentages for these tables sum to more than 100%.
- The term 'significant' refers to statistical significance (at the 95% level) and is not intended to imply substantive importance.
- Only results that are significant at the 95% level are presented in the report commentary.

Weighting of data

The data drawn on in this report have been weighted although both weighted and unweighted base sizes are shown at the foot of each table. The weighting strategy is described in the full in the main reports for each source survey (see Wardle et al, 2011; Craig et al, 2013).

The weighted numbers reflect the relative size of each group of the population, not the number of interviews achieved, which is shown by the unweighted base.

Analytical conventions and confidence intervals

The confidence intervals and range for the source data are shown in Table C.1 below by designated area characteristic.

Table C.1: Confidence intervals for problem gambling estimates according to either the DSM-IV or the PGSI, by area type				
Base: All who answered the DSM-IV or PGSI screens in the BGPS 2010 and HSE 2012				
Area characteristic	Problem gambling according to either the DSM-IV or the PGSI			*Bases*
	Problem gambling estimate	Lower confidence interval	Upper confidence interval	*Unweighted*	*Weighted*
	%	%	%	*n*	*n*
All	0.9	0.7	1.1	*13338*	*13453*
Leeds comparison areas					
Comparison area	1.8	1.0	3.4	*686*	*714*
Non-comparison area	0.8	0.6	1.1	*12652*	*12738*
Government Office Region					
North East	1.2	0.6	2.5	*876*	*682*
North West	1.0	0.6	1.7	*1926*	*1799*
Yorkshire and The Humber	1.3	0.6	2.7	*1236*	*1353*
East Midlands	0.7	0.3	1.4	*1246*	*1160*
West Midlands	1.3	0.7	2.3	*1369*	*1394*
East of England	0.5	0.2	1.1	*1524*	*1495*
London	1.3	0.7	2.5	*1625*	*1996*
South East	0.3	0.1	0.8	*2126*	*2187*
South West	0.4	0.2	0.9	*1410*	*1388*

Table C.1: Confidence intervals for problem gambling estimates according to either the DSM-IV or the PGSI, by area type					
ONS ward classification					
Industrial Hinterlands	1.2	0.8	1.8	*2417*	*2302*
Traditional Manufacturing	1.3	0.6	2.8	*1258*	*1245*
Built-up Areas	1.9	0.6	5.4	*239*	*262*
Prospering Metropolitan	2.5	0.9	6.4	*370*	*453*
Student Communities	0.6	0.3	1.6	*748*	*783*
Multicultural Metropolitan	1.7	0.7	3.7	*814*	*1040*
Suburbs and Small Towns	0.5	0.3	0.9	*4274*	*4254*
Coastal and Countryside	0.5	0.2	0.9	*2277*	*2222*
Accessible Countryside	-	-	-	*837*	*792*
DEFRA's classification of Local Authorities					
Major Urban	1.3	0.9	1.9	*4050*	*4366*
Large Urban	0.9	0.5	1.6	*1738*	*1741*
Other Urban	1.1	0.6	2.0	*1925*	*1930*
Significant Rural	0.7	0.4	1.3	*1865*	*1837*
Rural – 50	0.3	0.1	0.6	*2125*	*2015*
Rural – 80	0.3	0.1	0.7	*1618*	*1548*
Local Authority type					
City of London & London Boroughs	1.3	0.7	2.6	*1616*	*1984*
English Metropolitan districts	1.3	0.9	1.9	*2695*	*2640*
English non-metropolitan districts	0.5	0.3	0.7	*6735*	*6515*
English Unitary Authorities	1.0	0.6	1.8	*2259*	*2279*
DEFRA's Urban/Rural classification					
Urban (more than 10,000 people) in a sparse setting	-	-	-	*144*	*136*
Urban (more than 10,000 people) in a less sparse setting	1.0	0.8	1.3	*10471*	*10736*
Rural: town & fringe in a less sparse setting	0.4	0.2	1.1	*1181*	*1132*
Rural: village in a less sparse setting	0.1	0.0	0.6	*981*	*924*

Table C.1: Confidence intervals for problem gambling estimates according to either the DSM-IV or the PGSI, by area type					
Rural: village in a sparse setting, all hamlets & isolated dwellings	0.4	0.1	1.4	*561*	*525*

Source: LBU analysis of BGPS and HSE, July 2016

Annex E Problem gambling by area type tables

Table E1	Problem and at risk gambling according to the DSM-IV, by area type				
Base: All who answered the DSM-IV screen in the BGPS 2010 and HSE 2012					
Area characteristic	**DSM-IV problem gambling category**			*Bases*	
	Non-problem gambler	At risk (score 1-2)	Problem gambler (score 3 +)	*Unweighted*	*Weighted*
	%	%	%	*n*	*n*
All	96.0	3.4	0.7	*13338*	*13453*
Government Office Region					
North East	95.6	3.5	1.0	*876*	*682*
North West	96.4	2.8	0.8	*1926*	*1799*
Yorkshire and The Humber	95.7	3.6	0.7	*1236*	*1353*
East Midlands	95.4	4.1	0.5	*1246*	*1160*
West Midlands	95.8	3.0	1.2	*1369*	*1394*
East of England	95.9	3.7	0.4	*1524*	*1495*
London	94.3	4.5	1.2	*1625*	*1996*
South East	97.5	2.3	0.2	*2126*	*2187*
South West	96.3	3.4	0.3	*1410*	*1388*
ONS ward classification					
Industrial Hinterlands	95.5	3.6	0.9	*2417*	*2302*
Traditional Manufacturing	94.5	4.7	0.8	*1258*	*1245*
Built-up Areas	96.5	1.6	1.9	*239*	*262*
Prospering Metropolitan	92.0	6.0	2.0	*370*	*453*
Student Communities	95.7	3.8	0.5	*748*	*783*
Multicultural Metropolitan	93.6	4.7	1.7	*814*	*1040*
Suburbs and Small Towns	96.7	2.9	0.4	*4274*	*4254*
Coastal and Countryside	96.6	3.1	0.3	*2277*	*2222*
Accessible Countryside	98.5	1.5	-	*837*	*792*
DEFRA's classification of Local Authorities					
Major Urban	94.9	4.0	1.1	*4050*	*4366*
Large Urban	95.8	3.5	0.7	*1738*	*1741*
Other Urban	95.5	3.8	0.7	*1925*	*1930*
Significant Rural	96.7	2.8	0.5	*1865*	*1837*

Table E1	Problem and at risk gambling according to the DSM-IV, by area type				
Rural - 50	97.4	2.3	0.2	*2125*	*2015*
Rural - 80	96.8	3.1	0.2	*1618*	*1548*
Local Authority type					
City of London & London Boroughs	94.3	4.5	1.2	*1616*	*1984*
English Metropolitan districts	95.2	3.7	1.0	*2695*	*2640*
English non-metropolitan districts	96.8	2.8	0.4	*6735*	*6515*
English Unitary Authorities	95.7	3.6	0.7	*2259*	*2279*
DEFRA's Urban/Rural classification					
Urban (more than 10,000 people) in a sparse setting	96.2	3.8	-	*144*	*136*
Urban (more than 10,000 people) in a less sparse setting	95.7	3.6	0.8	*10471*	*10736*
Rural: town & fringe in a less sparse setting	96.4	3.2	0.4	*1181*	*1132*
Rural: village in a less sparse setting	98.3	1.7	-	*981*	*924*
Rural: village in a sparse setting, all hamlets & isolated dwellings	97.0	2.8	0.2	*561*	*525*

Table E2	Problem and at risk gambling according to the PGSI, by area type					

Base: All who answered the PGSI screen in the BGPS 2010 and HSE 2012

Area characteristic	PGSI problem gambling category				*Bases*	
	Non-problem gambler	Low risk (PGSI score 1-2)	Moderate risk (PGSI score 3-7)	Problem gambler (PGSI score 8+)	*Unweighted*	*Weighted*
	%	%	%		*n*	*n*
All	93.7	4.3	1.4	0.5	*13295*	*13414*
Government Office Region						
North East	93.9	4.1	1.5	0.5	*872*	*680*
North West	93.7	4.5	1.3	0.5	*1921*	*1794*
Yorkshire and The Humber	94.1	3.4	1.5	1.0	*1232*	*1348*
East Midlands	93.3	5.2	1.2	0.4	*1240*	*1155*
West Midlands	93.0	4.6	1.7	0.7	*1358*	*1382*

Table E2	Problem and at risk gambling according to the PGSI, by area type					
East of England	92.4	5.7	1.7	0.2	1523	1494
London	93.6	3.6	1.8	1.0	1624	1995
South East	94.5	4.2	1.1	0.1	2118	2181
South West	94.8	3.9	1.0	0.3	1407	1385
ONS ward classification						
Industrial Hinterlands	93.1	4.2	1.9	0.8	2410	2296
Traditional Manufacturing	92.3	5.5	1.5	0.7	1252	1239
Built-up Areas	93.4	4.7	1.9	-	238	261
Prospering Metropolitan	92.2	3.7	2.4	1.7	370	453
Student Communities	92.0	6.5	1.0	0.5	747	783
Multicultural Metropolitan	92.8	4.7	1.3	1.2	814	1040
Suburbs and Small Towns	94.4	4.1	1.2	0.3	4264	4244
Coastal and Countryside	94.5	4.0	1.3	0.3	2265	2212
Accessible Countryside	96.3	2.8	0.9	-	832	788
DEFRA's classification of Local Authorities						
Major Urban	93.3	4.3	1.5	0.8	4042	4359
Large Urban	92.2	5.6	1.7	0.5	1732	1734
Other Urban	92.4	5.0	1.9	0.6	1918	1924
Significant Rural	94.7	4.0	0.9	0.4	1851	1824
Rural - 50	95.1	3.5	1.3	0.1	2122	2013
Rural - 80	95.1	3.8	0.9	0.3	1613	1544
Local Authority type						
City of London & London Boroughs	93.6	3.6	1.8	1.0	1615	1983
English Metropolitan districts	93.5	4.2	1.5	0.7	2686	2632
English non-metropolitan districts	94.3	4.4	1.1	0.3	6710	6493
English Unitary Authorities	92.5	5.0	1.9	0.6	2251	2270
DEFRA's Urban/Rural classification						
Urban (more than 10,000 people) in a sparse setting	95.3	2.5	2.3	-	144	136
Urban (more than 10,000 people) in a less sparse setting	93.3	4.6	1.5	0.6	10437	10704

Table E2 Problem and at risk gambling according to the PGSI, by area type

Rural: town & fringe in a less sparse setting	95.3	3.0	1.5	0.2	*1179*	*1131*
Rural: village in a less sparse setting	95.8	3.5	0.6	0.1	*977*	*921*
Rural: village in a sparse setting, all hamlets & isolated dwellings	95.0	3.2	1.4	0.4	*558*	*523*

Table E3 Problem and at risk gambling according to either the DSM-IV or the PGSI, by area type

Base: All who answered the DSM-IV or PGSI screens in the BGPS 2010 and HSE 2012

Area characteristic	Problem gambling according to either the DSM-IV or the PGSI			*Bases*	
	Non-problem gambler	At risk	Problem gambler	*Unweighted*	*Weighted*
	%	%	%	*n*	*n*
All	93.7	5.5	0.9	*13338*	*13453*
Government Office Region					
North East	93.9	4.9	1.2	*876*	*682*
North West	93.6	5.4	1.0	*1926*	*1799*
Yorkshire and The Humber	94.1	4.6	1.3	*1236*	*1353*
East Midlands	93.0	6.3	0.7	*1246*	*1160*
West Midlands	92.7	6.0	1.3	*1369*	*1394*
East of England	92.4	7.1	0.5	*1524*	*1495*
London	93.6	5.1	1.3	*1625*	*1996*
South East	94.5	5.2	0.3	*2126*	*2187*
South West	94.8	4.8	0.4	*1410*	*1388*
ONS ward classification					
Industrial Hinterlands	92.9	5.8	1.2	*2417*	*2302*
Traditional Manufacturing	92.1	6.7	1.3	*1258*	*1245*
Built-up Areas	93.4	4.7	1.9	*239*	*262*
Prospering Metropolitan	92.2	5.3	2.5	*370*	*453*
Student Communities	92.0	7.3	0.6	*748*	*783*
Multicultural Metropolitan	92.7	5.7	1.7	*814*	*1040*
Suburbs and Small Towns	94.3	5.1	0.5	*4274*	*4254*
Coastal and Countryside	94.5	5.1	0.5	*2277*	*2222*
Accessible Countryside	96.3	3.7	-	*837*	*792*

Table E3	Problem and at risk gambling according to either the DSM-IV or the PGSI, by area type				
DEFRA's classification of Local Authorities					
Major Urban	93.3	5.5	1.3	*4050*	*4366*
Large Urban	92.1	7.0	0.9	*1738*	*1741*
Other Urban	92.4	6.5	1.1	*1925*	*1930*
Significant Rural	94.7	4.6	0.7	*1865*	*1837*
Rural - 50	95.1	4.6	0.3	*2125*	*2015*
Rural - 80	95.1	4.6	0.3	*1618*	*1548*
Local Authority type					
City of London & London Boroughs	93.6	5.1	1.3	*1616*	*1984*
English Metropolitan districts	93.4	5.3	1.3	*2695*	*2640*
English non-metropolitan districts	94.2	5.3	0.5	*6735*	*6515*
English Unitary Authorities	92.4	6.6	1.0	*2259*	*2279*
DEFRA's Urban/Rural classification					
Urban (more than 10,000 people) in a sparse setting	95.3	4.7	-	*144*	*136*
Urban (more than 10,000 people) in a less sparse setting	93.2	5.8	1.0	*10471*	*10736*
Rural: town & fringe in a less sparse setting	95.3	4.2	0.4	*1181*	*1132*
Rural: village in a less sparse setting	95.8	4.1	0.1	*981*	*924*
Rural: village in a sparse setting, all hamlets & isolated dwellings	95.1	4.6	0.4	*561*	*525*

Annex F Participant profile following interviews

	BF1 aged 45-54	BF2 aged 25-34	BF3 aged 25-34	CM1 Aged 18-24	CM2 aged 18-24	CM3 aged 65+	CF1 Aged 65+	CF2P (proxy) Aged 65+	TM1 aged 55-64	TM2 aged 18-24	TF1 aged 55-64	TF2 aged 18-24	BSM1 aged 55-64	BSM2 aged 45-54	BSM3 aged 35-44
Age exposed to gambling	All life	25	28	17	All life	All life	Most of life	Most of life	All life	Most of life	20's	All life	11	All life	Not clear
Age involved in gambling activity with own money*	17	25	28	17	17	25	Not clear	Not clear	14	17	20's	15	16	18	15
Gambler Profile	Low harm	No harm	High Harm	High harm	High harm	Low harm	No harm	High Harm	High harm	High harm	High harm	High harm	High harm	High Harm	No harm
Employment Status and other characteristics	Part Carer £=Benefits White	FT worker £36,000 White	Benefits £8,400 Learning difficulties White	PT worker £11,000 + student loan White	FT worker £not shared	£ Retired Jewish	£ Retired White	£ Retired Chinese	£ Retired Never earned money Income from theft White	FT worker FT £22,000 White	Retired was Carer £14,000 pensions White	£Benefits White	£Retired was Carer White	FT worker £17,000 White	FT £35,000 White
Preferred Main Activity	Bingo and machines at Bingo Hall and online Bingo	Bingo twice per week Online, horse and dog racing	Bingo	Casino Venue and Online	Casino Venue and Online	Casino and machines in casino	Casino	Casino	Betting shops	Betting shop machines and some betting and online	Arcades Casinos Machines	Online Scratch cards	Betting Shop	Betting Shop	Betting Shop Various online
National lottery draw															Sweep
Scratch cards															
Another lottery (e.g. Euro)															
Bingo in person															
Bingo-online															
Football pools															
Betting on horse races at betting shop							Grand national once a year	Grand national once a year							
Betting on dog races at betting shop															
Betting on sports events at betting shop		Football		Wimbledon Masters Golf Superbowl etc.					Superbowl big events	Football			Football	Football	Football
Betting on other events at betting shop															
Online betting with a bookmaker															
Using a betting exchange															
Horse racing track in person															
Dog racing track in person															
Accumulators (football teams)													Football	Football	Football
Fixed odds betting terminals							At Casino			At betting shop Roulette			At betting shop		
Fruit machines/slot machines	Machines At bingo hall	Machines at bingo	Fruit machines								At arcades and casinos	One in the house			

			at bingo hall												
Poker in a pub tournament															
Casino table games in person				Poker tournament Cash poker Blackjack	Poker tournament Cash Poker Roulette	Poker tournament Cash Poker Roulette Black Jack	Poker tournament Black Jack Kaluki		Roulette						
Casino games online				Texas Hold'em Poker Blackjack Roulette	Poker						Roulette				
Other online gambling		Horses													Slots Roulette poker
Online slot machine style games													Tombola		
Private betting with friends or colleagues (houses)				School	School										
Pub games – quizzes, cards															
Other gambling activities – FREE*gambling/betting games e.g., bingo, casino	Free Poker	Free Facebook bingo									Free Double Down Casino	Free Bingo, Free Poker Stars			
Total *FREE excluded from total	3	8	3	8	3	4	3	3	5	5	3	5	12	6	10

EG Grand National they did with family; first time they parted with their own "real" money. Free gambling activities included

Source: LBU Interviews with gamblers, July 2016

Annex G Proposals for service and support improvement

Posters/websites etc.	*"It's on the toilet doors and everything. I can't say that I do [know anything else], really"..... "it were a good few years ago now, but when you were playing the machines they used to come and give you a little card. It were just like a little debit card, and it were on there, were the number. And I don't know if that helped people who thought 'Oh God, I have got an addiction, I'm bad. And, you know, the number's there if I need it.' But I'm going back a lot of years"* BF1
	"Posters Potentially, yeah, but it's quite big in the window. Maybe not so much in the actual buildings." BF2
	"[no need for any more posters or leaflets]...because all the gamblers know that [play responsibly and telephone numbers of services]. They play beyond their means. Most of them. But that's their business, isn't it?" CF1
	Online notifications *"...what I have noticed recently, in the last probably about a month or so, when I've logged in to each different account that I've got, there has been a thing come up about awareness. I forget what it was called now, but something new has been added and it pops up - only once."* BSM3
	Posters [Read] *"When the fun stops, stop."* Do you think that does any good? *"No. Not a blind bit of difference."* Should they be bigger posters? *Not a blind bit of difference.* More? *"Not a blind bit of difference. The red mist descends when you're chasing money. People don't hear things, they don't see things."* BSM2
Interventions in venues	*"Well, I think they must have some sort of responsibility. They are seeing the same people again and again. However, to be fair, they are a business. How do they know they're not winning every day? Or how do they know they're not losing every day? They won't know, will they? To be fair. I mean, she could be winning every day and they wouldn't know it, would they."* CM2
	"I have seen the aggressive people in these sorts of places, and I'm not sure I could work there. It takes a lot of guts to be in that sort of environment. Plus the times that they're open until. People are in there at the crack of dawn placing bets, until 10 o'clock at night. You think 'Oh, my goodness.'" BF2
	How do you know that?
	"Because we've been in [betting shops]. I wouldn't want to be that person in that building on my own who has to say 'You've had enough.'" BF1

	"They [young people] will pay out at various times, but they're evil. You get people damaging them, being loud, abusive... And that's when staff intervene. And they're pretty good at it." BSM1 *"And I have seen people drunk and I have seen a manager go up, pull them to one side and say 'No more drinks.' And I think that is a good thing. [because] If you drink too much, then you lose your inhibitions. And a part of losing your inhibitions is when you're gambling and you've got money, throwing more on the table."* CM3
Helpline and Chat line	Two participants wanted help in the early hours, but the helpline is only open from 8am to midnight CM1, CM2 "*Yeah, Gamblers' Anonymous. I can never understand why it's not an 0800 number. It's an 0845 number. So if you're bloody skint you can't afford to blooming ring them. I've got money, but to me, if I've got to ring an 0845 number, I think 'Bloody hell'. [some mobile phone and landline companies allow the 0845, 0800 and 0808 number to be free – but sometimes there is a charge]"* CM3 Phone GamCare "[was on the telephone] *Half an hour. They're really good, because they'll try and help you all they can, and suggest ways to you*". TF1 *"It was scary, but being able to communicate with someone over chat is less scary. They don't see your face, they don't know who you are. They ring you back, this place, they contact you. So it's not like you're talking to the person, you just go straight to these people* [chat line] advisors" TF2
Self exclusion in venues	*"A think a year would be a bit too much for people, depending on what sort of circumstances they're in, then twelve months probably would be good, but if somebody was wanting help and they were barred – well not barred, but put a cap on for however long – it might have helped them. But I think twelve months might be a bit over the top."* BF1 *"Yeah... I once knew a feller that did that. But there's that many bookies now. If you can't get in there you'll go somewhere else".* BSM1 *"I've barred myself from there [local arcade]. I can go in and have a cup of tea, but can't go on the machines. That's for five years. But most other places, [the participant had excluded herself from] it's a lifetime ban...I did want to do it. I was quite proud of the fact that I was doing it"* TF1 but.... "*Self-exclusion is fantastic... But it's different at the seaside* [she very recently went to the seaside on a trip] *... it didn't work* [at the seaside, so the participant gained access to machines and gambled]. TF1 *"You can set limits, but it's not easy, because there have been times when I've wanted to exclude myself. And in Poker Stars, one of them... it took me a while to actually find out how to actually exclude myself. I mean, once you've done it, it's great, you can't place... At the time I was like 'I want to go back on.' You can't reverse or anything."* CM1

	"When I did lose all that money, I did want to, but a lot of people here say you can only do it for... a minimum is, like, 6 months or something. And I don't want to not be able to play for 6 months. Right now, I may have done a stupid mistake, but I don't want to not be able to play live poker for 6 months. Maybe when I've got it back I personally won't come for a while, but once I've sorted it out I want to be able to come back. If you could maybe reduce it [time for exclusion], that would be a lot better... if you could exclude yourself from the casino for a month that would be a lot better." CM1
Limits and Self exclusion online	*"Because I have put limits on it, and it's come to the point where I've been slamming money on it, and it's been 'right, you can't deposit money on it [game] no more'. And you can't change your deposit limit, so it stops you that way. So I have done that".* TF1 *"…deleted the app"* TF1 *"…suspended online accounts"* TF2 *"And yet I had to search. Because there was nowhere on the actual lobby that you go on online that was clear where you could go. I actually had to search, it was in a window inside another thing, saying 'responsible gambling' and then you can limit your deposit, and you can exclude yourself."* CM1
Getting through to support services	*"They ring you back, this place* [NECA]*, they contact you. There's only one place in town at the minute, and it could be up to so many weeks. They got back to me pretty quick."* TF2 After seeing the a doctor MT2 rang GamCare *"I think I was lucky that somebody else had just finished. I don't know if it's normal, two or three weeks...I see two counsellors, you see. I see GamCare, but I also see one for personal... like anxiety. A lot of my anxiety is linked to gambling.* Where do the two come from? *"The other one is from the NHS, and this one... he just said 'Have you heard of GamCare?' So then I contacted these."* TM2

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