# South East London Gambling Harms Needs Assessment

July 2026

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# Section 1: Executive Summary

# Executive Summary: Key findings (part 1)

**Gambling is common and gambling-related harm is widespread.** Around 37-44% of adults in SEL gambled in the last four weeks, with an estimated 207,000 adults experiencing gambling-related harm, including 39,000 at high risk.

**Gambling-related harm extends beyond the individual.** For every person gambling at a high-risk level, an average of six other people are affected, including partners, friends, families, and children.

**Gambling is highly normalised across society.** Exposure to gambling is widespread through advertising, sport, digital medial, and everyday environments. Around 60% of adults report seeing gambling advertisements at least once a week.

**Gambling harm is shaped by commercial influences.** The gambling industry generated £15.6 billion in 2023-24, with 86% of gross online betting profits coming from just 5% of customers.

**Children and young people are widely exposed to gambling.** 30% of 11–17-year-olds (nationally) report gambling in the last year and 21% of Year 8 and Year 10 pupils in Greenwich report betting on skins or loot boxes.

**Harms are wide-ranging and interconnected.** Gambling-related harm can affect finances, mental health, relationships, housing, employment and community safety. Harms often compound and escalate over time.

**Gambling-related harm is strongly linked to poor mental health.** Poor mental health can act as both a cause and consequence of gambling-related harm. Research estimates that 4-11% of all suicides each year in the UK are related to gambling.

**Economic and social costs are substantial.** The estimated economic burden of gambling-related harm in SEL is approximately £35 million per year (not including the direct cost of gambling to the gambler).

# Executive Summary: Key findings (part 2)

**Gambling harms reinforce existing inequalities.** Higher levels of harm are seen among people living in deprived communities, men, young adults, people with mental health conditions, veterans, and those in contact with the criminal justice system.

**There is a substantial gap between need and support.** Around 207,000 adults in SEL experience gambling-related harm, yet the three main specialist treatment providers received only 324 referrals from SEL residents in 2024-25.

**The local gambling environment contributes to harm.** SEL has 241 licenced gambling premises, which are disproportionately located in more deprived areas. 82% are located in the 40% of areas with the highest crime levels.

**Harm is often identified late.** Among SEL residents accessing specialist treatment, 75% reported a diagnosed mental health condition, 39% debts exceeding £10,000, and 40% unemployment, suggesting many people seek support only after harms have significantly escalated.

**Workforce confidence in addressing gambling-related harm is variable.** 58% of frontline professionals reported low or mixed confidence in responding to gambling-related harm. Identification is often reactive and dependent on disclosure.

**Opportunities for prevention are growing.** A new statutory gambling levy is expected to generate around £100 million annually for gambling-harm prevention, treatment, and research, creating new opportunities for local action.

# Section 2: Introduction

# What is gambling and why is it a public health issue?

**Gambling is the staking of money or something of value on an activity with an uncertain outcome, where the primary motivation is the chance of winning money or a prize. This includes activities such as lotteries, betting, bingo, and casino-type games, both online and in physical premises. Gambling is a legal and widely accessed leisure activity among adults, but engagement varies substantially in frequency, intensity, and risk.**

**Gambling-related harm is increasingly recognised as a public health issue,** affecting health, wellbeing, and inequalities at both individual and population levels. While most people gamble without harm, some experience financial hardship, mental health impacts, and harms to relationships, families, and children.

**Gambling can become addictive.** Gambling disorder is recognised in international diagnostic classifications (including DSM-5 and ICD-11) and shares features with other addictions, including loss of control, strong urges to gamble, and continued use despite harm. Harm also occurs below diagnostic thresholds, with people experiencing stress, debt or relationship conflict related to gambling.

**Gambling does not take place in a neutral environment.** Modern gambling is shaped by commercial incentives and product designs explicitly intended to maximise participation, duration of play, and spend. This includes pervasive online access, rapid-cycle and continuous products, targeted promotions, and features that encourage loss-chasing and extended play. In urban settings such as London, this environment is particularly dense and visible, with high concentrations of advertising, on-street premises, and continuous exposure through sport, social media, gaming environments and digital influencers, contributing to the normalisation of gambling in everyday life.

**The scale of commercial activity provides important context for population-level harm.** In Great Britain, gross gambling yield reached £15.6 billion in 2023-24, nearly double 2008-09 levels, largely driven by online betting and casino products increasing exposure and intensity of play.

**Together, these factors demonstrate that gambling-related harm is not solely a matter of individual choice, but is patterned by availability, product design, marketing, and wider social and economic context.** Gambling-related harm is also unevenly distributed, with people experiencing social and economic disadvantage, existing mental health problems, or financial stress more likely to be exposed to harm and its impacts. In South East London, where such inequalities are already pronounced, this creates a clear public-health imperative to understand the scale, distribution and drivers of harm, and to strengthen local systems to prevent harm, identify risk earlier, and respond proportionately in ways that reduce inequalities as well as overall harm.

**Sources**: 1, 2, 3, 4, 5, 6

# Gambling-related harm is shaped by commercial determinants of health

The commercial environments described in the previous slide do not arise by chance. Gambling operates as a commercially driven system, shaped by corporate practices that influence how products are designed, promoted and embedded within everyday life.

**The gambling industry operates through a recognisable "corporate playbook".** As seen in other industries associated with population-level health harm (e.g. tobacco, junk food, alcohol), this includes lobbying and policy engagement, promotion of narratives emphasising individual responsibility, sponsorship and partnerships that normalise consumption, and influence over research, education and public debate. Together, these practices can divert attention away from the role of product design, availability and commercial incentives in driving harm.

**Gambling is not an ordinary consumer product.** Many gambling products are continuous, digitally accessible, and have no clear upper limit on time or money spent. Industry revenues are often concentrated among a small proportion of consumers who experience the greatest harm; for example, 86% of gross online betting profits come from just 5% of customers. This creates structural tensions between commercial objectives and public-health protection.

**The industry is highly adaptive and able to outpace regulation.** Digitisation enables rapid development of new products, hybrid gambling-like formats, targeted marketing, and expansion into new audiences. This adaptability can undermine reactive or fragmented policy responses and reinforces the need for anticipatory, system-wide approaches to prevention.

**Implications for public health and governance:**
Viewing gambling through a commercial-determinants lens underscores the importance of:

- protecting policy, research and commissioning of prevention, treatment and education services (e.g. NHS gambling clinics, third sector provision, awareness campaigns) from commercial influence
- maintaining independence and transparency in funding of research, treatment services and public health programmes (e.g. avoiding reliance on industry voluntary donations or sponsorship) and in the evidence base
- supporting informed decision-making among councillors and system leaders
- strengthening capacity to respond to industry adaptation and normalisation

This framing provides essential context for later sections on prevention, system response and recommendations.

**Sources**: 7

# Aims & Objectives of this Health Needs Assessment

**Gambling-related harm is increasingly being recognised and understood as a public health issue in South East London (SEL).** Its consequences cut across mental health, financial wellbeing, communities and health inequalities. This Health Needs Assessment brings together the best available evidence, including national research and policy, local data and intelligence, stakeholder engagement, and a gambling harms literature review undertaken concurrently by the Bexley Public Health team, to inform a coordinated, system-wide response.

## Aims:

- **Understand** the scale, distribution and determinants of gambling-related harm across SEL, and its impact on health, wellbeing and inequalities.
- **Assess** the local gambling environment and current system response, identifying strengths, gaps and inequities across prevention, early identification and treatment pathways.
- **Support** system-wide improvement and collaboration, by providing a shared evidence base to inform strategic planning, commissioning and partnership working across local authorities, the NHS and the voluntary and community sector.

## Objectives:

- Summarise the national evidence and policy context, including definitions of key terms (e.g. harmful gambling, problem gambling severity index PGSI thresholds).
- Describe the burden of gambling-related harm in SEL, including its prevalence, associated inequalities, and associated health and social impacts.
- Characterise how gambling-related harms are experienced.
- Map the local gambling environment and its relationship to deprivation and other determinants.
- Assess the utilisation of prevention, early identification, and treatment services in SEL.
- Identify gaps, inequities, and misalignments between need and provision.
- Develop actionable recommendations for local prevention, treatment, and harm-reduction strategies, informed by local intelligence and national evidence.
- To provide a data-driven foundation for subsequent qualitative engagement with residents and professionals, to deepen understanding of lived experience and local need

# A note on language and gambling-related harm

The language used to describe gambling-related harm matters, as it shapes public understanding, stigma, and assumptions about responsibility. Guidance from public-health bodies and lived-experience organisations highlights the importance of using person-first, non-stigmatising language, and avoiding terms that reflect industry-led narratives or place responsibility primarily on individuals (Figure 1).

This assessment deliberately moves away from industry framing, which often emphasises concepts such as “responsible gambling”, individual choice, or personal self-control. Instead, it adopts a public-health approach that recognises gambling-related harm as shaped by commercial practices, product design, availability, marketing and wider social and economic contexts, as well as individual behaviour.

People are not described using labels such as “problem gambler”. The assessment refers to people who gamble or people experiencing gambling-related harm, recognising that harm exists on a spectrum and that anyone can be affected.

Where terms such as “low-risk”, “moderate-risk” or “problem gambling” are used, this is solely in reference to the Problem Gambling Severity Index (PGSI). These terms describe risk categories used in national surveys, not identities, and are used here to ensure consistency with data sources and comparability across areas.


**Figure 1:** see the ‘Words can hurt: language guide for gambling harms’ for more information around terms to use when talking about gambling to avoid stigmatising and to encourage people who are being harmed by gambling to seek support.

# Section 3: National and local policy context

# The Gambling Act 2005: national legislative context

**The Gambling Act 2005** provides the statutory framework for gambling regulation in Great Britain. The Act is underpinned by three licensing objectives:

1. Prevent gambling from being a source of crime or disorder
2. Ensure gambling is conducted in a fair and open way
3. Protect children and other vulnerable persons from being harmed or exploited by gambling

Gambling-related harm is not explicitly defined in the Act, though protection of vulnerable groups is a core principle

Overall responsibility for gambling policy sits with the **Secretary of State for Culture, Media and Sport**, with statutory regulatory and licensing functions exercised through the Gambling Commission and local authorities.

The Act designates the **Gambling Commission** as the national regulator for gambling, responsible for:

- Licencing gambling operators and key personnel
- Setting and enforcing licence conditions and codes of practice
- Oversight of compliance, enforcement, and consumer protection across both land-based and online gambling

In 2023, the Government published the **Gambling Act Review White Paper**, following a statutory review gambling legislation. This responded to changes since 2005, including the growth in online and high-intensity gambling and stronger evidence around gambling-related harms. The White Paper proposed strengthening regulatory controls, including:

- Improved consumer protections and harm-prevention measures
- Enhanced oversight of online gambling products and incentives
- A clearer focus on children, young people, and financially vulnerable adults.

**Sources**: 9, 10

# The statutory role of Local Authorities in relation to Gambling

- **Under the Gambling Act 2005, local authorities act as licensing authorities for gambling premises in their area,** responsible for reviewing, granting, and enforcing premise licences in line with the Act's three licencing objectives.
- **In determining applications, licensing authorities are required to "aim to permit" gambling** where proposals are consistent with the licensing objectives, relevant legislation and local policy. This means authorities cannot refuse licences on the basis of general opposition to gambling.
- **Each authority must publish a Statement of Licensing Policy (SLP) for Gambling**, setting out how it will exercise its licensing functions locally and how vulnerability and local risk will be considered (see Table 1).
- **Local authorities may also adopt a 'no casino resolution'** within their SLP, formally preventing casino premises licences from being granted in their area. Although there are currently no casinos across SEL, only Bromley currently has a no casino resolution in place; Lambeth removed this provision in 2026.
- **Local area profiles** are non-statutory tools that may be included within an SLP to support informed and proportionate licencing decision-making. They bring together information on local characteristics relevant to gambling-related risk (e.g. deprivation, population vulnerability, sensitive locations, and clustering of premises).
- **Alongside licensing, local authorities also have a role through the planning system.** Planning teams consider applications for gambling premises in relation to Local Plan policies, wider land-use planning considerations and local context, providing an additional point at which the location and concentration of premises can be shaped over time, within the limits of planning legislation. A full summary of Local Plan restrictions on gambling premises by borough is included in Appendix 3.

**Table 1**: Summary of Statements of Licencing Policies, local area profiles, and gambling restrictions in Local Plans by local authority (policies can be accessed via links in the table)

| Current Statement of Licencing Policy for Gambling | Is there a current, published Local Area Profile? | Does the Local Plan include restrictions on gambling premises? | No casino resolution in place? |
|---|---|---|---|
| Bexley | No | Yes | No |
| Bromley | No | No | Yes |
| Greenwich | Yes | Yes | No |
| Lambeth | Yes | Yes | Being removed |
| Lewisham | No | Yes | No |
| Southwark | Out of date (the previous version is from 2017. A refresh is planned in 2027) | Yes | No |

**Sources**: 9

# The Statutory Gambling Levy and the evolving gambling harms system

**In April 2025, the UK government introduced a statutory levy on gambling operators.**

- The levy is expected to generate at least £100 million per year to fund an independent, sustainable response to gambling-related harm across research, prevention, and treatment. This reform reflects growing evidence of harm, changing patterns of gambling, and concerns about the sustainability and independence of previous funding arrangements
- The introduction of the levy marks the end of the previous system, where gambling operators made voluntary donations to GambleAware, which then commissioned services across prevention and treatment.
- Going forward, funding and oversight will be held by national public bodies. Funding is now organised across three dedicated strands covering:
  - Prevention (30%) – commissioned via the Office for Health Improvement and Disparities (OHID)
  - Treatment (50%) – commissioned via the NHS
  - Research (20%) – commissioned via UK Research and Innovation (UKRI)
- A phased transition is underway to avoid system disruption, including interim approaches to declarations of interest, recognising the historic reliance of many providers on industry-linked funding.

**Implications for local authorities:**

- In the short term, local authorities are receiving grant funding to strengthen prevention, intelligence, and system capacity. Over time, (likely from 2027-28 onwards), national commissioners have indicated an intention to delegate commissioning of some VCSE-delivered prevention activity to local authorities, embedding gambling-harms prevention within place-based public health systems.
- This strengthens the importance of:
  - Robust local intelligence
  - Clear governance and partnership working across councils, the NHS, and VCSE sector
  - Alignment between licencing, prevention, and wider strategies to reduce health and socioeconomic inequalities (e.g. poverty reduction, cost-of-living support, housing, and place-based regeneration)

**Sources**: 11

# Section 4: Prevalence of gambling and gambling-related harm

# Understanding gambling-related harm relies on a small number of national surveys

Unlike many public health issues, there is no routine local data collected on the prevalence of gambling or gambling-related harm. Most evidence comes from a small number of national cross-sectional surveys, rather than ongoing local data collection, with local intelligence incorporated throughout this assessment wherever available.

Three different national surveys contribute different, but complementary insights:

- The **Gambling Survey for Great Britain (GSGB)**: this provides the clearest picture of how common gambling is, how people gamble, and the severity of gambling behaviours.
- The **Health Survey for England (HSE)** places gambling within the wider population health context, helping to understand how risky and harmful gambling aligns with factors such as deprivation and health inequalities.
- The **Adult Psychiatric Morbidity Survey (APMS)** explores gambling alongside mental health conditions and vulnerability, providing insight into the relationship between gambling harm and mental health.

These surveys rely on self-reported data collected through household surveys, using online, paper or face-to-face interviews depending on the study. As a result, estimates may be affected by under-reporting, recall bias, stigma, or non-participation by people experiencing more severe harm, including those not in private households.

While these national surveys do not have sufficient sample sizes to produce direct borough-level estimates, recent work commissioned by the Office for Health Improvement and Disparities (OHID) used the GSGB survey to produce modelled local authority estimates of gambling participation and gambling-related risk using Small Area Estimation.

Taken together, this evidence shows that gambling participation sits within a much wider picture of risk and harm. Many people gamble without experiencing harm, while a smaller proportion experience gambling in ways that increase the risk of significant harm. **Beyond this, gambling can also have substantial impacts on partners, families and children, which are not captured when prevalence focuses only on the individual gambler.**

# How common is gambling?

**Gambling is a common activity in England,** with GSGB survey data indicating that around 47% of adults spent money on gambling in the past four weeks, showing that gambling continues to be a routine activity for a large proportion of the population.

**Participation in gambling has declined over time**, with long-running data from the Health Survey for England showing that the proportion of adults participating in any form of gambling has decreased by 17 percentage points between 2012 and 2024, indicating a sustained long-term decline at a population level.

**London has the lowest gambling participation of any English region**, with around 37% of adults reporting spending money on gambling in the past four weeks, substantially lower than the England average.

**Within SEL, gambling participation varies across boroughs**, with modelled local authority estimates suggesting that between around 37% and 44% of adults in SEL spent money on gambling in the past four weeks (Figure 2). While all SEL boroughs are below the England average, participation is not uniform across the sub-region.

**Interpreting participation levels requires caution**. Gambling participation alone does not indicate gambling-related harm, and boroughs with similar participation levels may experience very different levels of harm once vulnerability, deprivation and gambling type are taken into account.

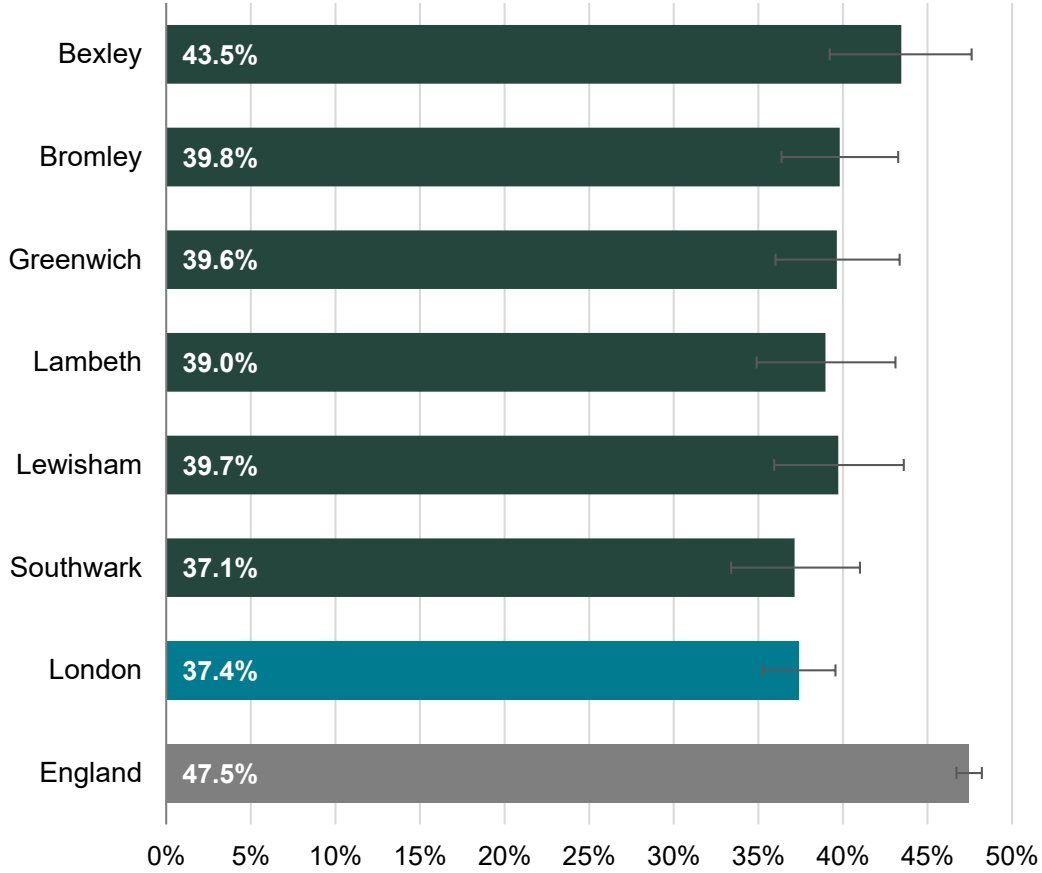


**Figure 2:** Percentage of adults spending money on any gambling activity in the last 4 weeks, modelled local authority estimates from GSGB, 2024)

**Source**: 1, 12

# Why do people gamble?

People report gambling for a range of reasons. Evidence from the GSGB shows that motivations include (Figure 3):

- **Enjoyment and leisure**: gambling is often perceived as entertainment or a social activity
- **The chance of winning money**: particularly for betting and lottery products
- **Habit and routine**: for example, regular lottery or scratchcard play
- **Social connection**: gambling with friends, family, or colleagues
- **Excitement and stimulation:** especially for faster-paced or interactive products

These motivations differ by age, sex, and type of gambling, and by whether gambling takes place online or in person. These motivations can interact with vulnerability, product design or life circumstances in ways that cause harm.

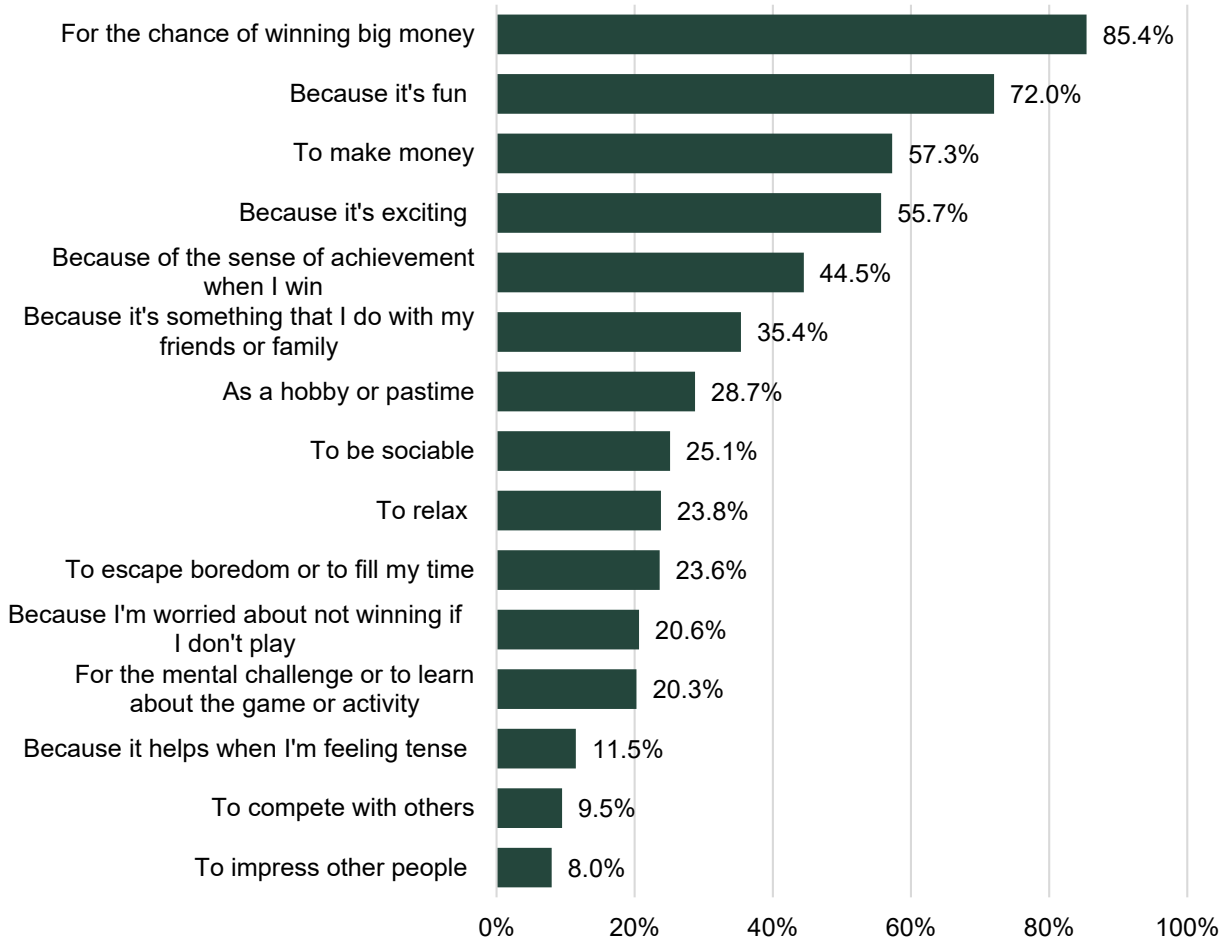


**Figure 3**: Why do you gamble? (GSGB, 2024)

**Source**: 1

# Who participates in gambling?

## Gambling participation is not evenly distributed across the population

While gambling is a common activity overall, national survey data shows clear differences in participation by age, sex, and deprivation.

- **Age:** Gambling participation tends to be higher among working-age adults and lower at younger and older ages (Figure 4)
- **Sex:** Men are more likely than women to report gambling in the past 12 months, particularly among younger adults (Figure 4). This difference is greatest when looking specifically at online gambling, with 15% of men having participated in the last 12 months, compared to only 4% of women (HSE, 2024).
- **Deprivation:** Gambling participation also varies with deprivation, though to a lesser extent than for age and sex, with people from the most deprived areas less likely to report gambling in the last 12months than those from the least deprived areas (Figure 5).
- **Ethnicity**: APMS data shows substantially lower levels of gambling participation among Asian and Black ethnic groups, with 84% and 74% respectively reporting no gambling in the past year, compared with 52% of White British adults. These patterns likely reflect a combination of cultural, social and economic factors.

**Note - these patterns shape who is more exposed to gambling at a population level, but do not necessarily correspond directly to patterns of gambling at a harmful level or gambling-related harm.**

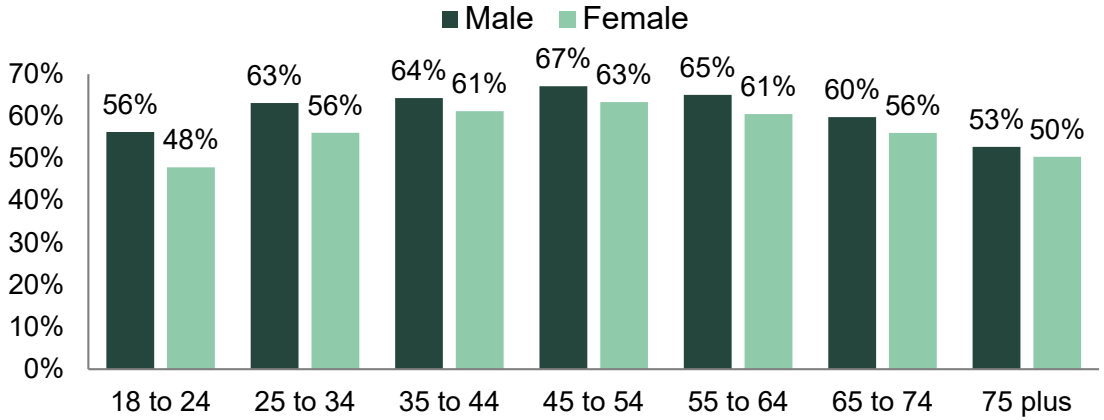


**Figure 4:** Any gambling participation in the last 12 months in England, by Age Group and Sex (GSGB, 2024)

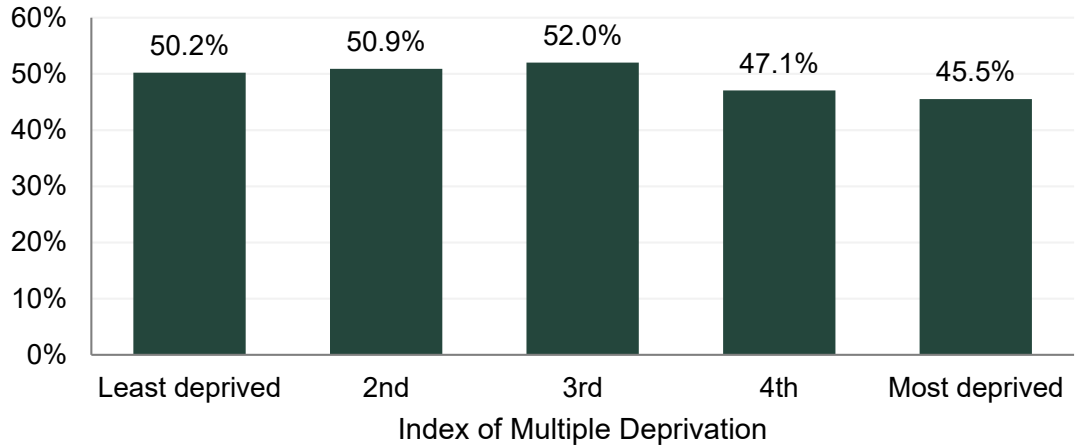


**Figure 5:** participation in any gambling activities in the last 12 months in England, by Index of Multiple Deprivation (HSE, 2021)

**Sources**: 1, 12. 13, 14

# What types of gambling do people participate in?

Gambling participation is not a single behaviour. The types of gambling people engage in (Figure 6), and how they engage with them, influence the risk of harm. Patterns vary substantially by age, sex and socioeconomic factors.

- **Online gambling**: in London, around 28% of adults reported online gambling within the last four weeks, in comparison to 21% gambling in-person. Online gambling is more common among adults aged 18-44, and declines with age. Digital platforms enable features such as rapid play, continuous availability and easy access, which facilitate more frequent, intensive, and addictive gambling.
- **Lottery products**: Across England, and in London, lottery draws and scratchcards are the most commonly reported gambling activities. Participation is widespread and typically involves lower frequency and spend than other forms of gambling. High participation in lottery activities does not tend to equate to high harm but does shape population exposure.
- **Betting** (particularly sports betting) is substantially more common among men than women. National data shows that men are around three times as likely as women to report betting activity. Betting is often characterised by repeat staking, short event cycles, and use of in-play features, which can encourage more frequent gambling within a single session. These features increase the potential for loss chasing, impulsive decision making, and higher overall spend.
- **Changes over time**: long-running national data from the Health Survey for England shows a shift in gambling participation away from predominantly land-based activities towards online and account-based gambling, particularly for betting and casino-type games. This reflects wider changes in access to digital platforms and products, with implications for gambling intensity and risk of harm.
- **Trading and cryptocurrency**: Gambling-like risk may also arise in adjacent digital environments (e.g. high-risk trading and cryptocurrency) where decisions are based on volatile and uncertain outcomes.

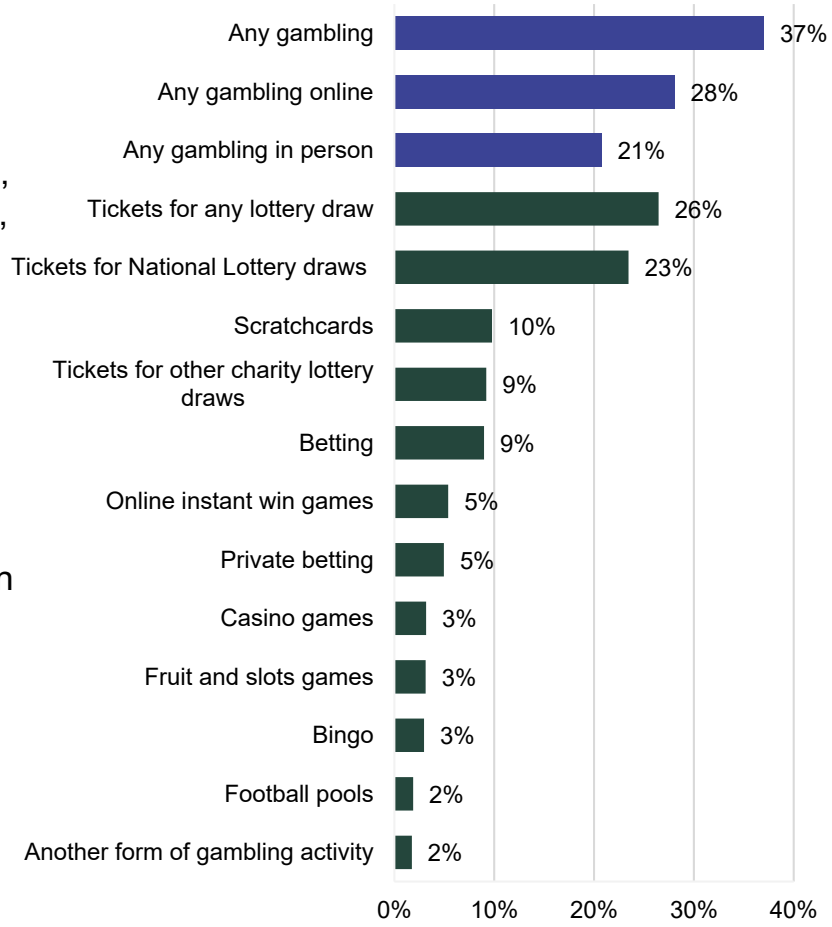


**Figure 6:** Type of gambling activity in the past four weeks in London (GSGB, 2024)

**Sources**: 1,12, 13, 14, 15, 16

# Young people are widely exposed to gambling, contributing to its normalisation from an early age

**Gambling by children and young people is illegal, but exposure is widespread.** In England, it is illegal for under-18s to take part in most forms of commercial gambling. However, the Gambling Commission's Young People and Gambling 2025 survey found that three in five (59%) young people reported some experience of gambling activities, with 49% reporting gambling in the past 12 months. Only 13% of those who had gambled reported being stopped due to their age, highlighting limitations in age-related controls and enforcement.

**Exposure and participation often occur within social and family settings**. Among young people who reported gambling, the majority said they did so with a parent, carer or guardian, suggesting that exposure frequently occurs in family or social contexts. Only 8% reported gambling alone.

**Local school surveys indicate gambling-related worry among some young people in SEL**. Findings from School Health Education Unit (SHEU) surveys in SEL vary by borough, age group and question wording, but consistently indicate that a minority of young people report concern. Around 7% of secondary pupils in Lambeth and Southwark in 2024 reported worrying about gambling "quite a lot" or "a lot", with concern highest among younger males (peaking at 11% in Year 8 males in Lambeth and 13% in Year 10 males in Southwark). In Bexley, 5% of respondents reported worrying "some" or "all of the time". Lower levels of more frequent concern have been reported in some areas and cohorts (e.g. 2% of Year 12 respondents in Bromley worrying "often" or "all of the time"), suggesting that levels of concern vary across SEL rather than following a consistent pattern.

**Digital and gaming-related exposure is increasingly evident.** Evidence highlights overlap between gambling and online gaming, particularly through features such as loot boxes, skins and in-game purchases, which involve spending real money for chance-based rewards. For children and young people, this can blur the boundary between gaming and gambling, increasing exposure to gambling-like activities before the legal age to gamble. In the 2024 SHEU survey in Greenwich, 21% of secondary school pupils in Year 8 and Year 10 reported having made bets on skins or loot boxes. Exposure is also reinforced through social media and streaming platforms, where influencers are often sponsored to gamble, sometimes with enhanced odds or incentives, further contributing to the normalisation of gambling among young audiences.

**Early exposure is associated with higher risk later in life.** Evidence suggests that people who start gambling at a younger age are more likely to gamble at a risky or harmful level in adulthood. While exposure through family, social or digital environments may not in itself lead to harm, it may normalise gambling and increase the likelihood of earlier participation, particularly when combined with other vulnerabilities.

**Sources**: 17, 18, 19, 20

# Gambling-related harm exists on a spectrum of risk

**Gambling-related harm exists on a spectrum.** Understanding gambling-related risk requires looking beyond participation alone. The extent of harm will be shaped by patterns of gambling and the impact on aspects of an individual's life including relationships, mental health, and finances.

**What is meant by gambling at a 'risky' level?** Gambling at a risky level may involve experiences such as loss of control over time or money spent, chasing losses, financial pressure, stress or conflict related to gambling, and negative impacts on wellbeing or relationships. These experiences, rather than gambling frequency alone, underpin how risk and harm are identified.

**Measuring gambling-related risk: the Problem Gambling Severity Index (PGSI).** The PGSI is a validated screening tool used in national surveys to assess gambling-related risk and harm in the general population. It captures both gambling-related behaviours (e.g. chasing losses) and adverse consequences (e.g. stress, guilt or health impacts). Based on responses, people who gamble are grouped into four categories (Table 2). Higher scores reflect a greater accumulation of harmful experiences, not simply higher gambling participation.

**Table 2**: PGSI score interpretation

| PGSI Score | Risk level |
|---|---|
| 0 | No reported problems |
| 1-2 | Low risk |
| 3-7 | Moderate risk |
| 8+ | "Problem gambling" |

**Risk and harm increase along the spectrum.** As PGSI scores increase, people are more likely to experience harm, including debt, stress, relationship difficulties, and deterioration in mental health. Those in the low- and moderate-risk groups make up a larger share of the population than those in the PGSI 8+ ("problem gambling") category and can still experience significant harm.

**Risk and harm are not evenly distributed among gamblers**. The likelihood of gambling at a risky or harmful level varies across the population, and intersects with multiple other inequalities. National and local evidence shows that risk is shaped by demographic, social and economic factors, including age, sex, deprivation and wider vulnerability. The following slides explore how gambling at a risky or harmful level is unevenly distributed, contributing to health inequalities.

**Sources**: 13

# Gambling-related risk is widespread across South East London

**Gambling-related risk affects a substantial number of adults across SEL,** with OHID-commissioned local authority estimates suggesting that around 207,000 adults (14.6%) have a PGSI score of one or more. This includes approximately 114,600 adults classified as low risk (8.1%), 53,100 as moderate risk (3.7%), and 39,100 adults experiencing problem-risk gambling (2.8%) (Figure 7).

**Modelled estimates suggest broadly similar prevalence profiles across SEL boroughs**, indicating that gambling-related risk is widespread rather than concentrated in a small number of areas. Within this overall pattern, outer-London boroughs such as Bexley and Bromley show lower point estimates for low- and moderate-risk gambling, with PGSI 1–2 at around 7% and PGSI 3–7 at around 2.5–2.9%, compared with around 8–8.4% and 4–4.2% respectively in inner-London boroughs; however, these borough-level figures are based on small-area modelled estimates, and wide, overlapping confidence intervals mean that these differences should be interpreted cautiously.

**Differences in the absolute number of adults affected are most evident in Lambeth and Southwark**, which show the highest numbers of people experiencing gambling-related harm in the figure. Given the broadly similar modelled prevalence profiles across boroughs, this largely reflects the larger adult populations of these boroughs rather than clear differences in estimated prevalence, although borough-level uncertainty remains.

See Appendices 1 and 2 for further information and data around the number and proportion of adults within each PGSI group in each SEL local authority.

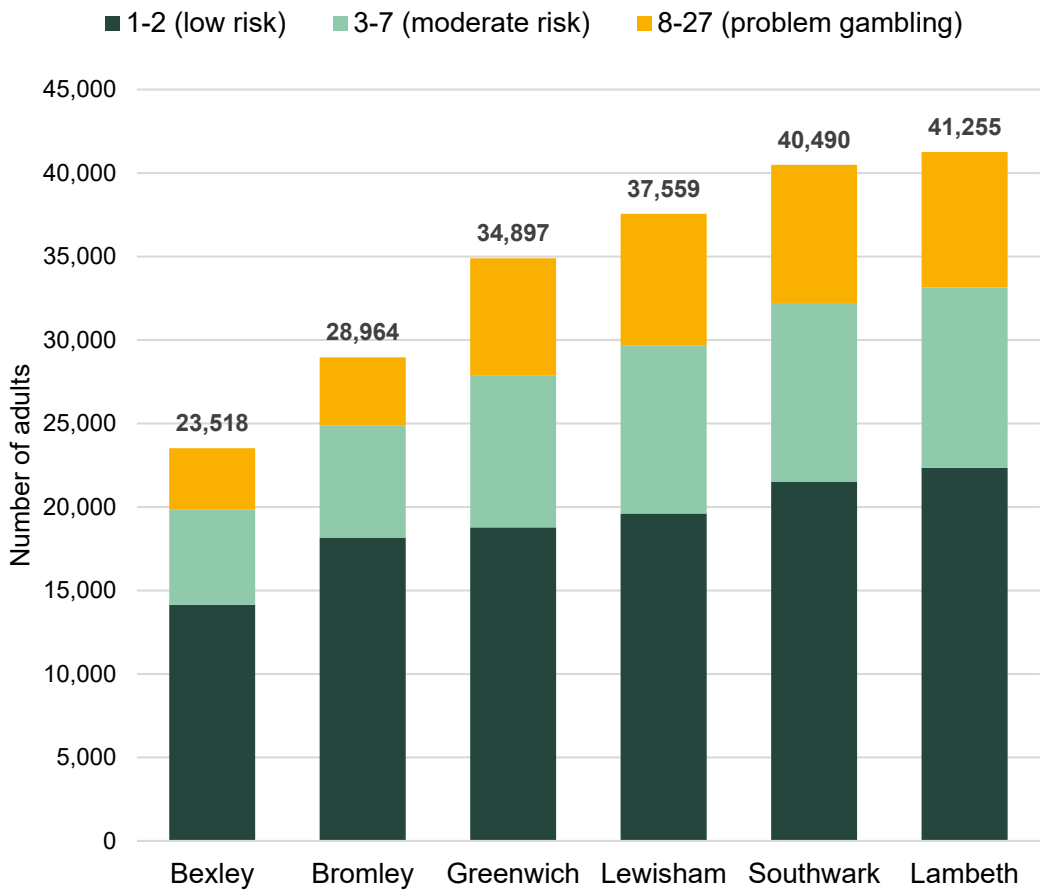


**Figure 7:** Number of adults with a PGSI score equal to or greater than 1, by PGSI score, by borough; modelled estimates from GSGB, 2024

# Gambling-related risk varies by age and sex

**National data from the GSGB shows clear differences in gambling-related risk by both age and sex:**

- **Sex:** Men are more likely than women to participate in gambling and, among those who gamble, are also more likely to gamble in ways that are harmful or risky (Figure 8). Evidence suggests this reflects a higher concentration of behaviours associated with gambling-related risk among male gamblers, including greater risk-taking, impulsive coping, and difficulty moderating gambling behaviour (2), resulting in a higher overall burden of gambling-related risk and harm among men.
- **Age**: Younger adults are less likely to gamble overall than those aged 35–64, but among those who do gamble are more likely to fall into higher PGSI risk categories. As shown in Figure 9, only 58% of 18–24-year-olds who gamble report no risk (PGSI = 0), compared with 92% of those aged 75 and over. Evidence from studies of emerging adults suggests this reflects higher levels of risk-taking, impulsive coping, and difficulty regulating gambling behaviour among younger gamblers (2), increasing susceptibility to riskier patterns such as chasing losses or continuing to gamble despite harm.

**Riskier gambling is associated with more severe harms.**

People who gamble in more risky ways are more likely to experience financial difficulties and debt, stress and impacts on mental health, and strain on relationships. As a result, differences in risky gambling by age and sex translate into unequal patterns of harm, even where overall gambling participation differs.

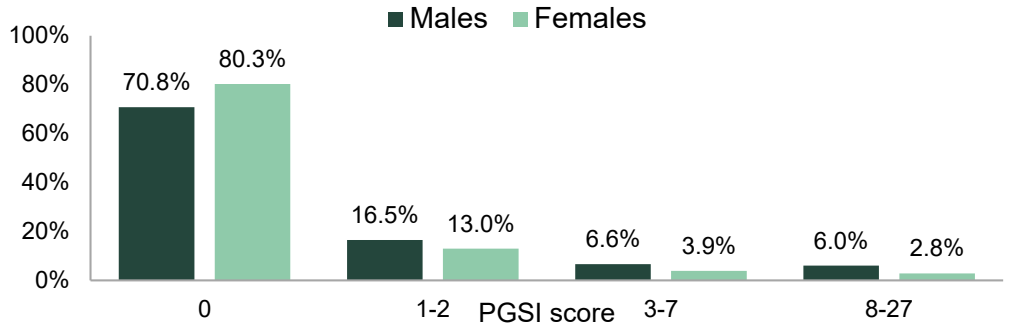


**Figure 8:** PGSI score distribution among adults who gambled in the last 12months, nationally, by sex (GSGB, 2024)

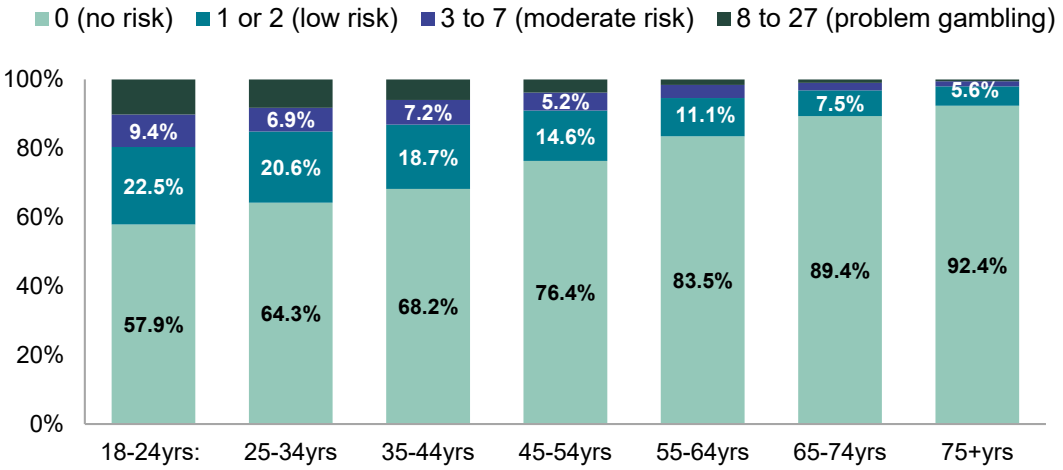


**Figure 9:** PGSI score distribution among adults who gambled in the past 12months, nationally, by age group (GSSGB, 2024)

**Sources**: 1, 22

# Gambling-related risk varies by socioeconomic deprivation

**Risky gambling varies by socioeconomic deprivation.** National survey evidence shows a clear relationship between deprivation and gambling-related risk. While people living in more deprived areas are less likely to gamble overall, those who do gamble are more likely to experience risky or harmful gambling behaviours.

**A higher proportion of gamblers in more deprived areas have higher PGSI scores.** Data from the Gambling Survey for Great Britain (2024) shows that among people who gamble, a higher proportion of those living in more deprived areas have a PGSI score of one or more (Figure 10). This includes higher proportions of gamblers classified as low-risk, moderate-risk, and high-risk compared with those living in the least deprived areas.

**These inequalities reflect differences in vulnerability to financial harm.** Evidence suggests that higher levels of risky and harmful gambling among people in more deprived areas are shaped by greater exposure to financial strain, debt and economic insecurity, which can magnify the impact of gambling losses. Gambling expenditure makes up a larger proportion of disposable income for lower-income households than for higher-income households, meaning that similar patterns of gambling behaviour can lead to more severe financial, mental health and social harms in more deprived contexts. This contributes to the concentration of gambling-related harm among disadvantaged groups.

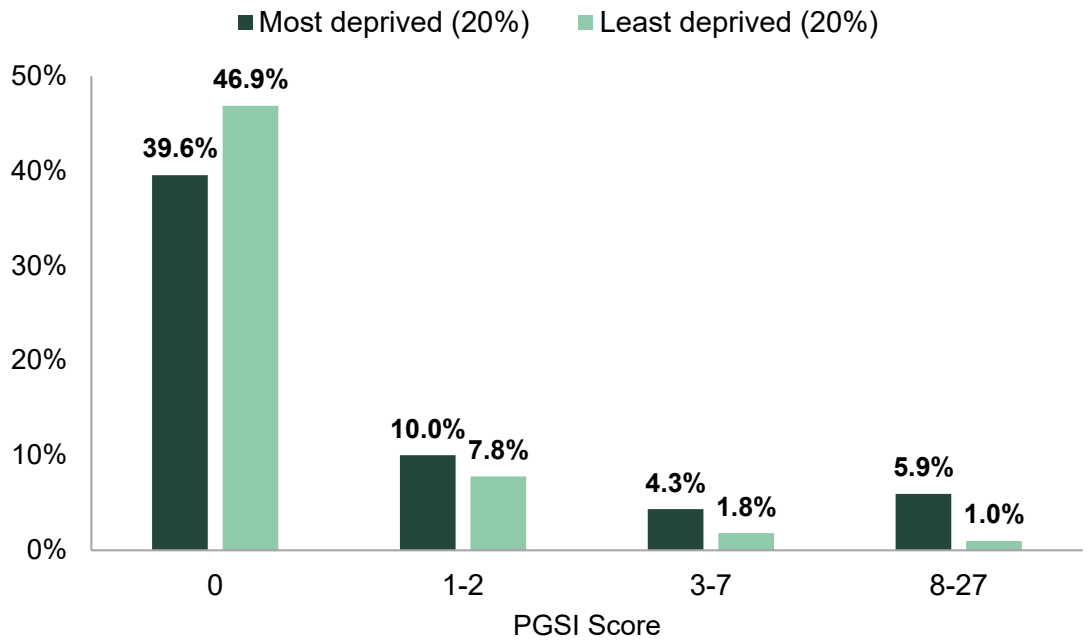


**Figure 10:** PGSI distribution of score categories by the Index of Multiple Deprivation (IMD) quintiles, in England, GSGB, 2024

**Sources**: 1, 23

# Gambling-related risk and mental health are strongly related

**Gambling participation and gambling-related risk vary by mental health status.**
Data from the APMS shows that people with mental health conditions are more likely to report not gambling at all than those without a mental health condition.

**However, gambling-related risk is more concentrated among people with a mental health condition.** Among people who gamble, individuals with mental health conditions are substantially more likely to be classified into higher PGSI risk categories, including moderate- and problem-risk gambling, compared with people without a mental health condition (Figure 11).

**Mental health difficulties and gambling-related risk frequently co-occur.**
Mental health problems may increase susceptibility to riskier gambling behaviours. Studies of gambling behaviour show that psychological distress and difficulty managing negative emotions are strongly associated with gambling-related risk. Among people with anxiety, depression or related conditions, gambling may be used as a way of coping with stress or low mood, increasing the likelihood of loss of control and persistence despite harm (2). At the same time, gambling-related stress and losses can worsen existing mental health difficulties, leading to more complex and overlapping needs.

**Implications for understanding need:**
These patterns indicate that gambling-related harm is more likely where gambling risk and mental health difficulties intersect, highlighting the importance of early identification and coordinated responses across mental health, primary care and wider support services.

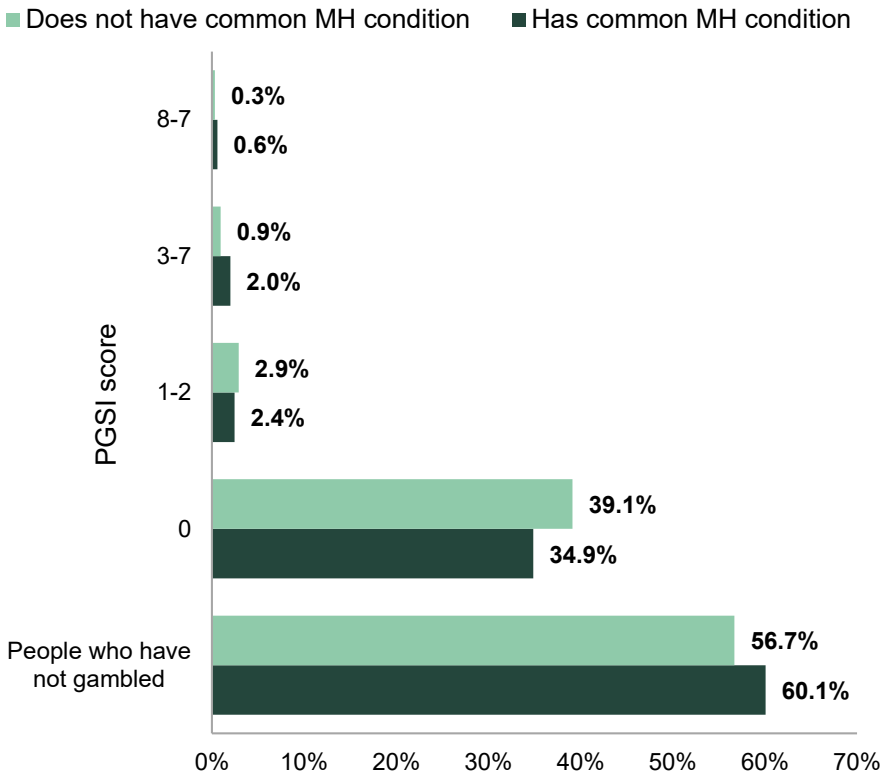


**Figure 11:** PGSI score distribution for adults with/ without a common mental health condition (APMS, 2023-24)

**Sources:** 13, 24

# People from ethnic minority groups gamble less overall, but those who do gamble are more likely to experience harm.

**In the APMS, gambling participation is substantially lower among many ethnic minority groups.** 81% of Asian/Asian British adults and 67% of Black/Black British adults reported no gambling in the past year, compared with 52% of White British adults, indicating lower overall exposure to gambling in some communities.

**Among those who do gamble, however, harm is not evenly distributed.** The proportion experiencing moderate- or problem gambling (PGSI 3+) is higher for some groups, particularly those in the Mixed ethnicity category (3.5%, compared with 1.5% of White British adults) (Figure 12). Although absolute numbers are small, this indicates that some individuals are disproportionately affected by gambling-related harm once gambling occurs.

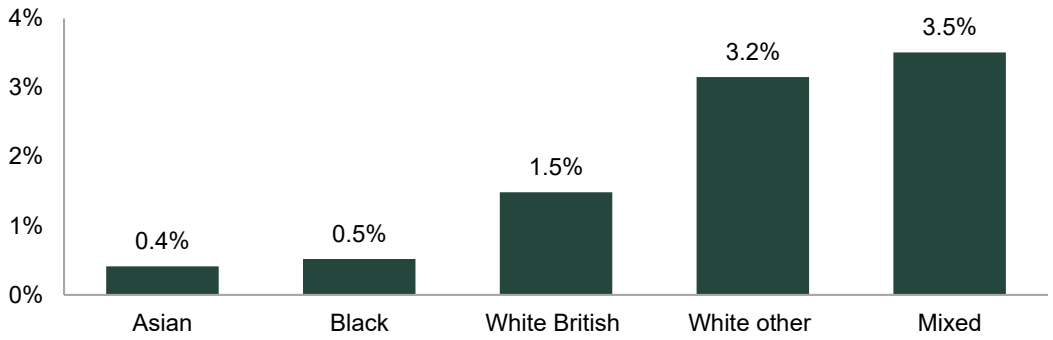


**Figure 12**: Percentage of respondents with a PGSI score of 3 or more, by ethnicity, APMS, 2024

**Qualitative evidence provides important context for these patterns.** Research with ethnic minority communities highlights how stigma, shame and fear of judgement, particularly where gambling is culturally or religiously taboo, can discourage disclosure of gambling problems. Participants also described experiences of discrimination and mistrust of statutory services, alongside concerns about confidentiality and the potential consequences of disclosure for family relationships or immigration status. Together, these factors may delay help-seeking, increasing the likelihood that gambling-related harm is identified only once difficulties have escalated.

**Locally, community-led work in Lambeth (Black Thrive Lambeth, in partnership with BetKnowMore UK) has highlighted similar concerns** within Black communities, alongside calls for stronger local leadership, preventative education and greater accountability from gambling operators. Short video interviews with Lambeth residents around their experience of gambling-related harm are available here.

**These findings should be interpreted cautiously** given small sample sizes and the interaction of ethnicity with income, migration status and mental health. Nonetheless, the evidence suggests that gambling-related harm may compound existing inequalities, reinforcing the importance of culturally sensitive approaches to identification and support.

**Sources**: 13, 25, 26

# Inequalities in gambling harm reflect the interactions of multiple, overlapping vulnerabilities

**Gambling at a risky or harmful level is associated with a range of overlapping vulnerabilities**. Beyond age, sex, deprivation, ethnicity, and mental health, evidence shows that gambling-related risk is more likely where gambling intersects with other forms of disadvantage or unmet need.

- **Substance use:** Gambling at a risky or harmful level frequently co-occurs with harmful alcohol and drug use (1). Evidence shows that people gambling at moderate- or problem-risk levels are more likely to report substance use problems, with shared mechanisms including impulsivity, difficulties with emotional regulation, and gambling or substance use as coping responses to distress (2).
- **Neurodiversity**: Evidence indicates higher levels of gambling-related risk among people with neurodevelopmental conditions, particularly ADHD (3,4). Traits such as impulsivity, compulsivity, and difficulties with emotional regulation are associated with increased susceptibility to gambling-related harm. While evidence is growing, population-level estimates remain limited and variable, highlighting an important evidence gap (3).
- **LGBTQIA+ communities**: Emerging UK evidence suggests that LGBTQIA+ individuals may gamble less frequently overall but experience a higher risk of gambling-related harm, with some subgroups (including bisexual and trans or non-binary people) appearing to face elevated risk (5). However, the evidence base remains limited, uneven across groups, and largely reliant on small samples and qualitative studies, highlighting the need for further research.
- **Veterans:** multiple studies have found that veterans are more likely to gambling at a risky level than non-veterans. Studies indicate higher rates of gambling at a harmful level among veterans, with risk shaped by the interaction of trauma, anxiety and emotional dysregulation (including CPTSD), alongside challenges associated with transition to civilian life such as employment, identity and social support. Qualitative evidence highlights gambling as a maladaptive coping strategy that may be normalised within military culture and escalate post-service, particularly in online contexts.

**Bringing inequalities together:** taken together, this evidence shows that gambling-related harm is most likely to arise at the intersection of multiple vulnerabilities, rather than being evenly distributed across the population. This reinforces the importance of a public health approach that recognises overlapping risks and informs targeted prevention, early identification and inclusive support.

**Sources:** 13, 14, 27, 28, 29, 30, 31

# For every person who gambles at high-risk levels, an average of six others are affected

**For every person who gambles at high-risk levels, an average of six others are affected**, reflecting how gambling-related harm commonly extends beyond the individual to partners, family members and close social contacts. These harms may include financial strain, relationship conflict, stress and impacts on wellbeing, meaning the population affected by gambling harm is substantially larger than estimates based only on individual gambling behaviour.

**Gambling-related harm is embedded within social and family networks**, with national survey data showing that 47.5% of respondents to the Gambling Survey for Great Britain reported that someone close to them gambles. The Gambling Commission recognises that gambling-related harms frequently impact affected others, not only those who gamble themselves.

**Children are an important group of affected others**, as gambling-related harm is often experienced within households and families. Children may be affected through the financial, emotional and relational consequences of another person's gambling rather than through their own behaviour. Analysis from GambleAware's Treatment and Support Survey, based on adult self-reports, estimates that around 1.6 million children in Great Britain may be living in households where an adult is experiencing problem gambling. While this is a modelled estimate rather than a direct count, it highlights the potential scale of gambling-related impacts on children who do not gamble themselves, and the importance of recognising gambling harm as an issue with intergenerational and safeguarding relevance.

**The population-level impact of gambling harm therefore extends well beyond prevalence among people who gamble alone**, helping to explain why gambling-related harm has implications across health, safeguarding, family support and community services. The following section explores how these harms are experienced by affected others.

**Sources**: 1, 31

# Section 5: The experience and consequences of gambling-related harm

# Gambling-related harm is wide-ranging, hidden, and shaped by stigma

**Gambling-related harm is wide-ranging and cumulative,** extending beyond financial loss to affect mental and physical health, relationships, housing, employment and safety. Harms are experienced not only by people who gamble, but also by partners, family members and others close to them.

This section explores how these harms are experienced in practice, unpicking key domains of harm (including health, financial and housing insecurity, relationship and family harm, crime and safety, and impacts on affected others). Across these domains, several cross-cutting themes consistently shape how harm emerges, is experienced, and is responded to:

- **Harms are often hidden and identified late.** Gambling-related harm may be concealed for long periods due to shame, fear of judgement or concern about the consequences of disclosure. As a result, difficulties are frequently first recognised only once harms have escalated or reached crisis point.
- **Stigma shapes experience and response**. Research shows that people affected by gambling harm experience anticipated, internalised and enacted stigma, which can deter disclosure and help-seeking and exacerbate distress.
- **Narratives of personal responsibility reinforce silence.** Dominant public and industry narratives framing gambling as a matter of individual choice and responsibility can position harm as personal failure rather than as a predictable outcome of highly addictive products, discouraging support-seeking and compounding inequality.
- **Harms extend beyond the individual and into wider social systems.** Gambling-related harm can impact families, communities and public services, contributing to relationship breakdown, crime and safety concerns, and wider economic costs that are often not visible in individual-level data.

**The following slides explore key domains of harm before examining how these combine and escalate over time.**

# Financial harm is one of the earliest and most pervasive forms of gambling-related harm

Financial harm is often the earliest and most visible form of gambling-related harm, acting as a key pathway through which wider difficulties emerge. It can escalate from immediate financial losses to longer-term debt and financial crisis, with impacts extending beyond the individual to families and wider systems of support.

- **Financial harm escalates rapidly with gambling severity**, with a steep increase in serious financial consequences among those experiencing problem gambling (Figure 13). Adults with moderate- or problem-risk gambling (PGSI 3–27) were over four times more likely to report problem debt than those with PGSI 0 (5.1% vs 1.2%)
- **Debt, arrears, and difficulty meeting basic needs are closely linked to gambling-related harm**, including reduced spending on essentials such as food, utilities and medication. Borrowing and reduced financial resilience are common, with many individuals drawing on savings or high-cost credit (e.g. payday loans), increasing vulnerability to longer-term harm.
- **Financial harm is often identified indirectly in services**, emerging through housing services (e.g. rent arrears or eviction risk), local authority teams managing council tax or benefit arrears, and debt advice or financial inclusion services such as Citizens Advice and StepChange.

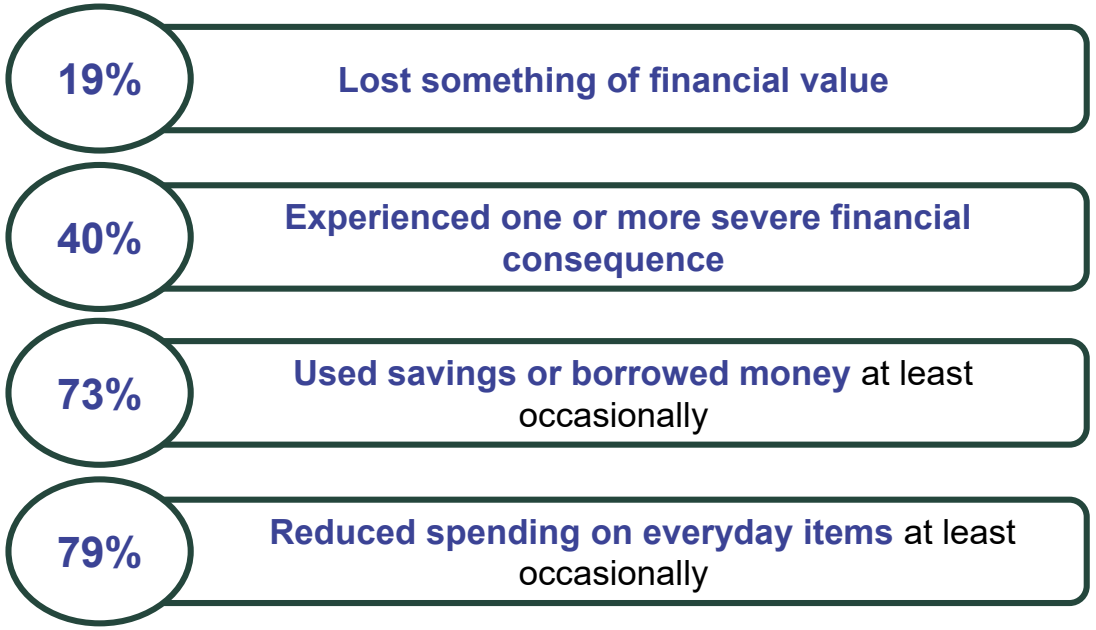


**Figure 13**: reported consequences due to gambling among those who gambled in the last 12 months with a PGSI score of 8-27, GSGB, 2024

**Local insights**: Findings from a cross-sector stakeholder survey of services in SEL reinforce this, highlighting that gambling-related harm is often identified through financial difficulties once harm has escalated. For example, some services reported that gambling may only become visible after individuals seek support for problem debt or housing instability, where more detailed assessment (e.g. income and expenditure reviews or bank statements) reveals gambling as a contributing factor. This suggests that gambling can remain hidden until financial pressures prompt more in-depth assessment, with shame and stigma further delaying disclosure until difficulties become more acute.

**Sources**: 1, 13, 32, 33.

# Poor mental health is both a cause and consequence of gambling-related harm

**Gambling-related harm is strongly associated with poor mental health**, including anxiety, depression, and psychological distress. Evidence consistently indicates a bidirectional relationship, whereby mental ill-health can contribute to gambling harm and also be exacerbated by it, creating a reinforcing cycle rather than a simple causal pathway.

- **Common mental health conditions (CMHCs) and gambling harm overlap at population level.** APMS data shows that adults with a CMHC make up a disproportionately large share of those experiencing moderate- or problem-risk gambling: 2.6% of adults with a CMHC fall into PGSI 3–27, compared with 1.3% of adults without a CMHC, indicating a clear population-level overlap between gambling harm and mental ill-health.
- **Psychological distress commonly escalates alongside harms.** Increasing gambling severity is consistently associated with depression, anxiety, emotional dysregulation and loss of control, often shaped by wider stressors such as debt, relationship breakdown, unemployment, isolation and trauma. Gambling is frequently described as a maladaptive coping response that can intensify distress over time.
- **Mental health impacts are often hidden and identified late**. Stigma, shame and fear of judgement can delay disclosure of gambling-related distress. As a result, people may present to mental health or crisis services during periods of escalation, with gambling harm recognised retrospectively or not at all.
- **Local stakeholder evidence reinforces this pattern.** Across a cross-sector stakeholder survey in SEL, responses from mental health and related services indicate that gambling-related distress is encountered within these settings, often described as arising “sometimes” or “often”. It commonly comes to light through wider conversations, although individuals may also raise it directly. This suggests that identification is variable and often dependent on disclosure or the context of broader discussions, rather than routine or systematic enquiry.

**Sources**: 1, 13, 33, 34, 35

# Gambling-related harm is associated with significantly elevated risk of suicide

**Suicide is a critical and preventable form of gambling-related harm.** Evidence shows a strong and well-established association between gambling-harm, suicidal ideation, suicide attempts, and suicide. Data from the GSGB (Figure 14) shows that 7.7% of people who gambled in the past 12 months reported suicidal ideation or suicide attempts that they attributed directly to their own gambling.

**Risk is particularly elevated among younger adults** (18–34), with 10% reporting suicidality linked to gambling, and among men, identifying key demographic groups at increased risk.

**Evidence suggests gambling contributes to a substantial proportion of suicides.** A synthesis of UK and international research estimates that around 4–11% of suicides in the UK may be gambling-related, equating to approximately 250–650 deaths per year. Longitudinal evidence indicates that people diagnosed with gambling disorder have suicide rates up to 15 times higher than the general population, with suicide frequently identified as a leading cause of death among working-age adults in these cohorts.

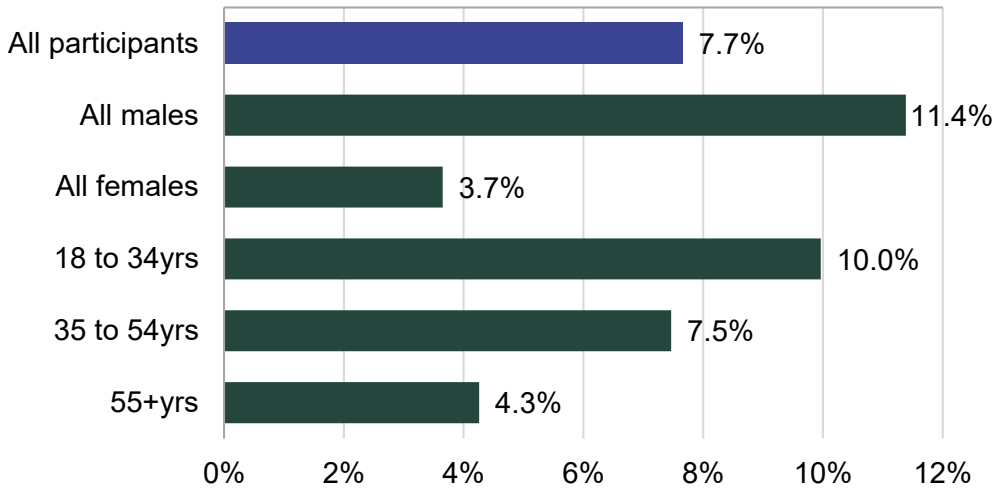


**Figure 14** % of respondents who had gambled in the last 12 months who reported that they had thought about taking their own life and indicated that this was related "a little" or "a lot" to their own gambling, GSGB, 2024

**Gambling can act as both a driver and trigger for suicidal behaviour.** Gambling intensity is strongly associated with suicidal ideation and attempts, even after accounting for co-occurring mental health conditions, substance use and socioeconomic factors. Lived-experience evidence highlights that suicidal crises may occur during periods of escalating harm or following relapse and are not always directly linked to financial debt alone.

**These findings underscore the importance of integrating gambling harm within suicide-prevention systems.** Gambling-related harm should be recognised as a suicide-prevention issue, with implications for early identification, frontline training, crisis response, and alignment with local and national suicide-prevention strategies, particularly for men and younger adults.

**Sources**: 1, 36, 37

# Gambling-related harm often co-occurs with substance misuse

**Gambling-related harm commonly co-occurs with smoking, alcohol and drug use, with a bidirectional and reinforcing relationship.** Substance use can increase vulnerability to gambling harm, while gambling harm can exacerbate or complicate substance use.

**Shared drivers and reinforcing behaviours**: Gambling harm and substance misuse are shaped by overlapping risk factors, including impulsivity, sensation-seeking, emotional dysregulation, trauma, socioeconomic stress, poor mental health and social isolation. These behaviours are often interlinked coping strategies, with each intensifying the other during periods of stress or crisis.

**Substance use and gambling risk:** Smoking and hazardous alcohol use are consistently higher among people experiencing gambling harm. Alcohol can reduce inhibition and impair decision-making, increasing gambling risk, while smoking is commonly used as a coping response in gambling contexts. Co-occurring drug use is associated with greater severity of gambling harm, poorer mental health, and wider social impacts including debt, relationship breakdown and contact with crisis or criminal justice services.

**Environments that reinforce co-occurrence**: Gambling opportunities are often closely linked to alcohol environments, including licensed premises and venues with gaming machines. This co-location can normalise simultaneous use, increasing exposure and reinforcing patterns of risk.

**Implications for identification and support:** Co-occurring harms can be difficult to identify. When one issue dominates presentation, the other may go unrecognised. Stigma, shame and fragmented service pathways can delay disclosure, meaning people often present only once harms have escalated.

**Local service insight:** Across a cross-sector stakeholder survey in SEL, professionals in substance misuse, smoking cessation and addiction services reported encountering gambling-related harm relatively frequently (often described as “sometimes” or “often”). Identification is variable and not routinely embedded, and in many cases depends on individuals raising the issue themselves rather than systematic assessment.


**Figure 15**: co-location of gambling and gaming machines in pubs and other premises serving alcohol can normalise simultaneous gambling and alcohol use.

**Sources**: 33, 38, 39

# Gambling-related harm can contribute to offending and may be exacerbated within the criminal justice system

**Gambling-related harm intersects with crime and the criminal justice system in multiple ways,** including as a driver of offending, a source of vulnerability and exploitation, and an issue affecting others beyond the individual. While these links are well established, attributing causality for individual offences is often complex, as gambling harm typically interacts with financial stress, mental ill-health and wider social factors.

- **At population level, gambling-related crime is relatively uncommon but increases sharply with risk.** GSGB data show that 0.9% of people who gambled in the past year reported committing a crime due to their gambling, rising to 1.9% among 18–34-year-olds. Local analysis shows that 82.4% of gambling premises in SEL are located in the 40% of areas with the highest crime levels (IMD crime deciles 1–4), highlighting the concentration of gambling environments within already higher-risk communities.
- **Among people experiencing higher-risk gambling, rates of crime related to gambling increase sharply.** In the GSGB, 17% of those with a PGSI score of 8 or more reported committing a crime due to their gambling, demonstrating a strong concentration of harm among those most affected (Figure 16).

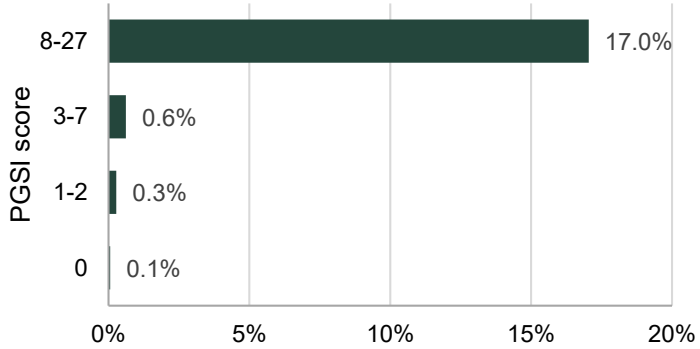


**Figure 16**: Percentage of those who gambled in the last 12months who reported committing a crime in order to finance gambling or to pay gambling debts, by PGSI score (GSGB, 2024)

- **This concentration is also reflected within criminal justice populations.** A systematic review and meta-analysis found that around 31% of prisoners experience gambling problems, compared with much lower prevalence in the general population.
- **When gambling contributes to crime, it is often financially driven**, involving income-generating behaviour, such as theft or fraud to fund gambling or repay debts. In some cases, financial harm may lead individuals to turn to illegal lenders, increasing exposure to coercion, intimidation and exploitation; data from the England Illegal Money Lending Team suggest that around 4% of borrowers they supported in 2024-25 report gambling as a factor in their debt.
- **Links between gambling and crime are often hidden and not routinely identified within the criminal justice system**. Only a small proportion of people in prison explicitly identify gambling as a driver of their offending (around 3–5%), suggesting harms are often indirect or unrecognised. Gambling is not routinely screened for within the criminal justice system, meaning problems may be identified late or not at all.
- **Gambling persists within custodial settings and can worsen harms.** Despite restrictions, in one survey of prisoners, 22% reported gambling in the past year while in custody, and 14% reported that they had seen other inmates getting into serious debt due to gambling, indicating that gambling-related harms can continue and escalate within prison environments.

**Sources**: 1, 40, 41, 42, 43, 44

# Gambling-related harm can undermine relationships and increase the risk of abuse

**Gambling-related harm can affect both individuals and those around them, placing strain on relationships and, in some cases, contributing to conflict, coercion and abuse**.

- **Common relationship harms include conflict, secrecy and isolation**, affecting both people who gamble and those close to them (Figure 17). Around 1 in 20 people who gambled report arguments, feeling isolated, or lying to family at least occasionally, rising to around 1 in 10 among younger adults. People affected by someone else's gambling report similar or higher levels of conflict and strain, highlighting how harms are experienced across relationships.
- **Over time, these harms can erode trust and relationship stability.** Behaviours such as concealment, loss-chasing and financial secrecy often lead to repeated conflict, withdrawal from relationships and increasing strain between partners and family members. As harms accumulate, financial pressures can intensify instability. Gambling-related debt and loss of income may strain shared resources, contribute to repeated arguments, and create imbalances in financial decision-making within households.
- **These dynamics can create conditions for control and coercion.** In some cases, gambling is linked to financial control and economic abuse, including restricting access to money, coercing partners into debt, or exploiting shared finances to sustain gambling behaviour.

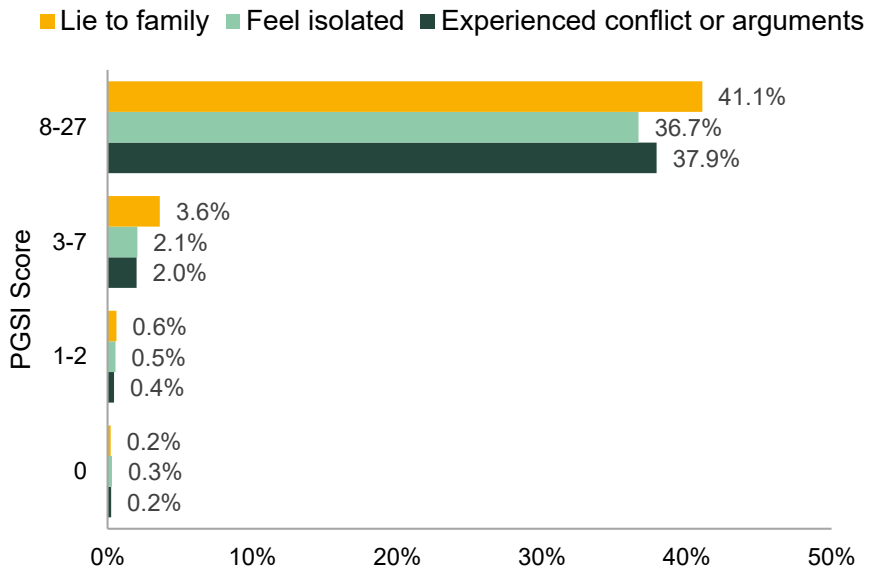


**Figure 17:** Percentage of respondents who gambled in the last 12 months who reported experiencing negative consequences 'fairly often' or 'very often', by PGSI score (GSGB, 2024)

- **Where harms escalate, this can contribute to severe outcomes.** GSGB data show that 1.6% of people who gambled reported relationship breakdown and 1.0% reported violence or abuse, rising to 3.4% and 2.2% among younger adults. Among those experiencing high-risk gambling (PGSI 8+), this increases to 29% reporting relationship breakdown and 16.9% reporting violence or abuse, demonstrating the concentration of severe harm among those most affected. These harms are often hidden and cumulative, and as relationships deteriorate, individuals may experience increasing isolation and worsening mental health, reinforcing harmful gambling behaviours and contributing to a cycle of escalating harm.

**Sources**: 1, 45

# Gambling-related harm can escalate into homelessness, unemployment and wider social and health impacts

Gambling-related harm can escalate over time, with early financial and psychological impacts progressing into wider social and economic consequences. For example, financial loss may lead to debt and arrears, which in turn increase the risk of housing instability and homelessness, while worsening mental health and relationship strain may affect people's ability to sustain employment and social connections.

- **Financial harm can escalate into housing instability and crisis.** Gambling-related debt, arrears and reduced financial resilience can lead to eviction, homelessness and housing insecurity, particularly for those already experiencing economic disadvantage. One study of gambling-related harm found that as many as one in ten homeless people experience clinically significant "problem gambling" or gambling disorder.
- **Impacts on employment and income can be significant**. Gambling harm can affect the ability to sustain employment through reduced concentration, absenteeism and impaired performance, and may contribute to job loss. Survey data show a strong gradient, with around 31% of people experiencing problem-level gambling reporting frequent absence from work, compared with very low levels among those with no gambling harm (GSGB, 2024).
- **Physical health can deteriorate alongside cumulative harm**. Gambling-related harm is associated with poorer physical health outcomes, often linked to stress, disrupted sleep, reduced self-care and co-occurring behaviours such as substance use. Physical and mental health interact, with higher levels of limiting physical health conditions among those experiencing both gambling harm and mental health problems (APMS, 2024).
- **Loneliness and social isolation are common and reinforcing consequences.** As harms progress, individuals may withdraw from relationships and social networks due to shame, stigma, financial pressure or conflict. Survey data show a steep gradient, with 41% of people experiencing problem-level gambling reporting feeling isolated often or very often, compared with less than 1% among those with no gambling harm (GSGB, 2024).

These consequences frequently co-occur and reinforce one another, with financial instability, poor health, unemployment and social isolation interacting over time. As a result, gambling-related harm is often identified only once it has escalated to crisis point and individuals come into contact with housing, welfare, health or emergency services.

**Source**: 1,13, 46, 47

# People close to someone who gambles can experience significant financial and emotional harm

**Gambling-related harm affects partners, families and others close to the individual, often without their direct involvement.** These impacts are frequently hidden and can build over time.

- **Many affected others experience everyday disruption and strain.** Around 1 in 10 report impacts such as conflict, financial pressure, or emotional distress at least occasionally, and 5.2% experience more severe harms, including relationship breakdown, abuse or financial loss (GSGB, 2024).
- **Where harm is most acute, impacts can be wide-ranging and overlapping** (Figure 18). Evidence from the GambleAware Treatment and Support Survey shows that affected others may experience financial strain, relationship disruption, emotional distress and loss of trust simultaneously, affecting multiple areas of life. Over time, these dynamics can escalate to more severe consequences, including patterns of control, coercion, and in some cases, family violence.
- **Harms can shift roles and responsibilities within households.** Affected others may take on financial control or decision-making, while also reporting feelings of helplessness, reflecting exposure to harm without control over the underlying behaviour.
- **Some groups may be more vulnerable to experiencing gambling-related harm as affected others.** Older adults and those with health or care needs may face increased risks of financial exploitation, coercion or dependency, particularly where they rely on others or are relied upon for financial support.
- **Harms experienced by affected others are often hidden and under-recognised.** Financial problems may only become visible at a later stage, and people may present with mental health, financial or relationship difficulties without gambling being identified as an underlying factor.

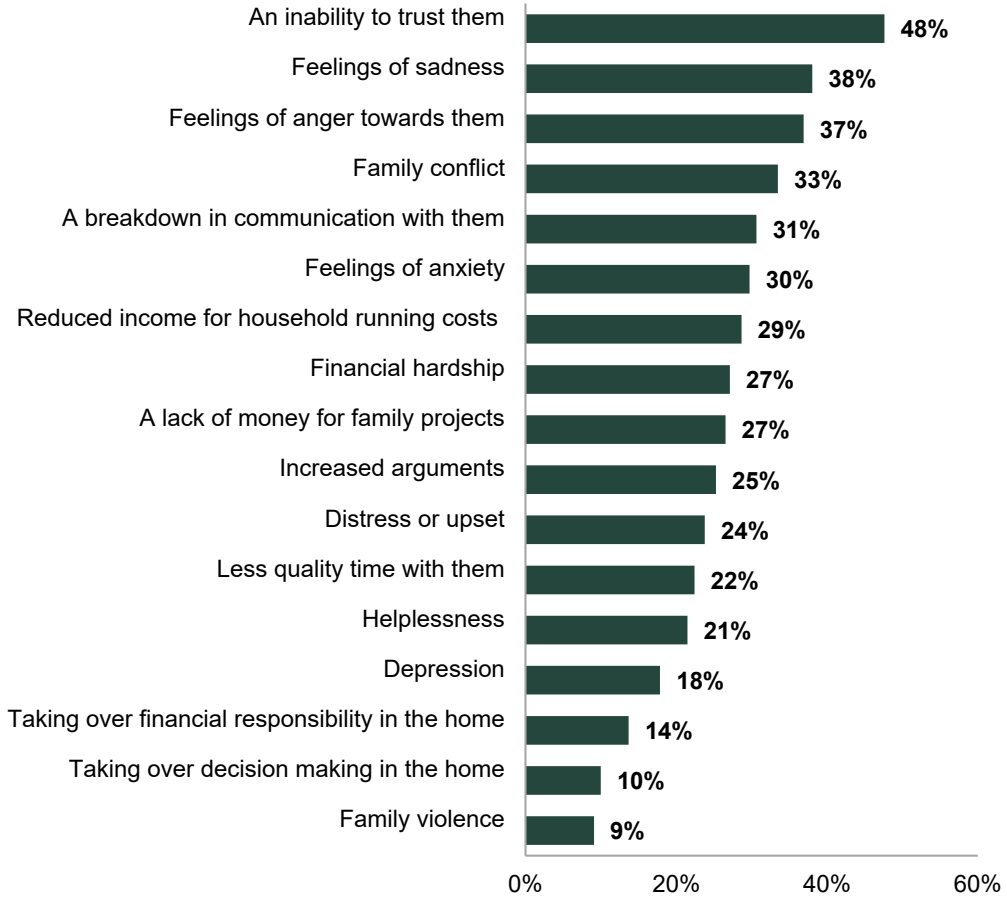


**Figure 18:** Reported impacts experienced by people affected by others' gambling, GambleAware Treatment & Support Survey, 2024

**Sources**: 1, 48, 49

# Children affected by family members' gambling may experience stress, instability, and financial pressure

**Gambling-related harm can affect children through the family and home environment, in addition to any direct gambling behaviour.** Three in ten young people report seeing a family member they live with gamble, meaning exposure is common within households. An estimated 2 million children in the UK live with an adult experiencing harm from high-risk gambling.

**Gambling within families can create financial pressure, reduce parental availability and increase tension at home.** Evidence from the Young People and Gambling Survey shows that young people directly report a range of impacts linked to family gambling (Figure 19). While some report that gambling has helped pay for activities (9%), others describe arguments or tension at home (7%), feeling worried or sad (6%), losing sleep due to worry (6%), and less time with parents (4%).

- **Parental gambling may also be linked to worsening mental health among caregivers**, shaping the emotional environment in which children are growing up.
- **As outlined in the previous section on relationships and abuse, these dynamics can escalate over time**. Children may be exposed to conflict, coercion or controlling environments, and in some cases to neglect or safeguarding risks, particularly where financial hardship is present. These experiences may contribute to adverse childhood experiences, with potential impacts on mental health, educational outcomes and long-term wellbeing, as well as increased risk of gambling later in life.

Gambling-related harms affecting children are often not identified early. Gambling is not routinely captured within safeguarding or early help systems, meaning impacts may only become visible once problems have escalated.

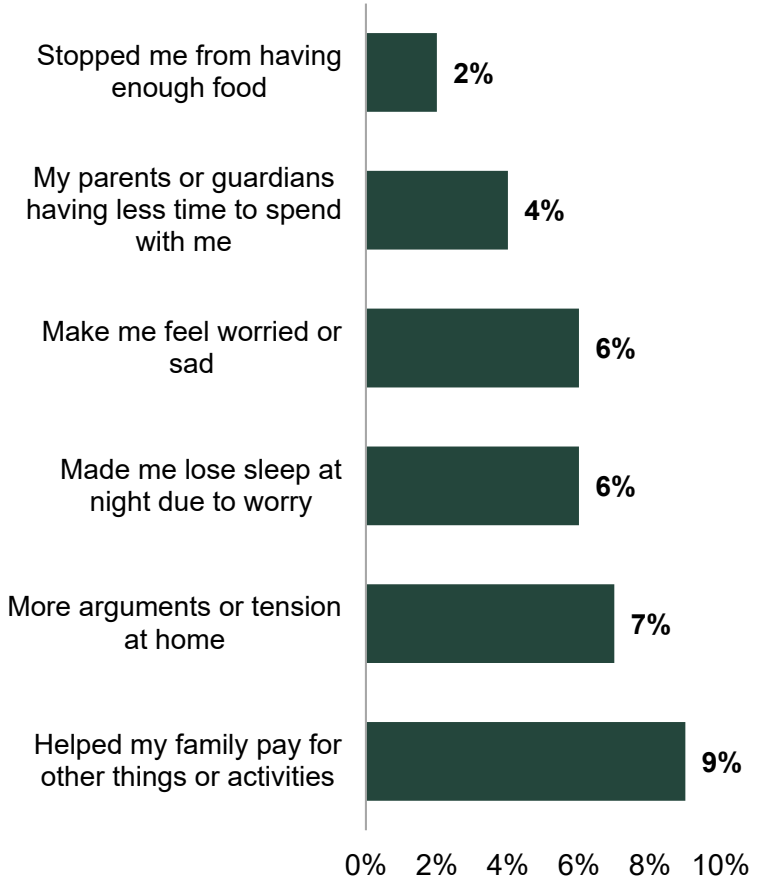


**Figure 19**: Reported impacts of family member's gambling on young people, Young People and Gambling Survey, 2025

**Sources**: 17, 50

# Gambling-related harm creates significant costs for individuals, services, and society

**Gambling is a common activity with a significant economic footprint.** In 2023–24, gross gambling yield (GGY) in Great Britain was around £16.8 billion, representing money lost by gamblers after winnings are paid out. While this reflects a transfer to the gambling industry, gambling-related harm creates additional social and economic costs.

As set out in previous slides, harms can include financial strain, relationship breakdown, mental and physical health impacts, and safeguarding concerns, many of which involve interaction with health, social care and wider public services. These impacts translate into:

- **Direct costs to public services**, such as healthcare, homelessness support, welfare, and the criminal justice system
- **Wider societal costs**, including reduced quality of life, lost productivity, and the impacts of suicide and mental ill-health

Estimates from the Office for Health Improvement and Disparities (OHID) indicate a substantial national economic burden from gambling-related harm. Scaling these estimates to SEL suggests that harms may be associated with a cost of around £35million annually across the sub-region (Figure 20). See Appendix 4 for more detail around the methodology behind these estimates, and a breakdown of estimated costs by local authority.

**These figures provide an estimate of the scale of impact, underlining the need for early intervention, prevention and coordinated system-wide action.**

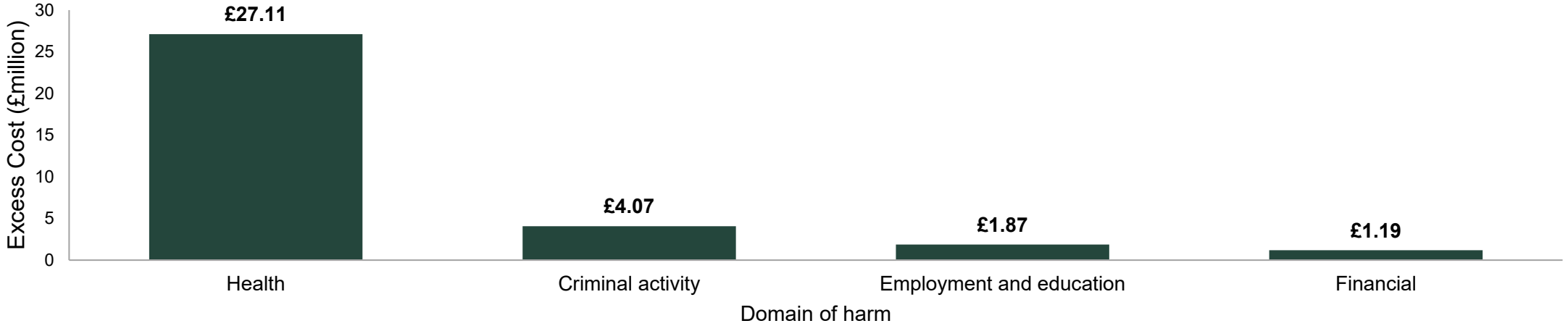


**Figure 20**: Estimated excess costs (£ million) in of gambling-related harm in South East London, in 2023.

**Source**: 6, 32, 51

# Section 6: How and where people gamble

# Gambling harm is shaped by product design, accessibility, and environment

Gambling is not a single behaviour. Differences in product design, accessibility, and context shape how, where, and how often people gamble, and the likelihood and pattern of harm.

**Key drivers of risk:**

- **Product intensity and play characteristics**: high-intensity products (e.g. online casino games, betting, and use of fixed-odds betting terminals (FOBTs)) enable rapid, continuous play, higher spending, and loss chasing increasing the risk of harm. Lower-intensity products (e.g. lottery, scratchcards) have wider reach but tend to be associated with lower levels of individual harm.
- **Access, availability and immediacy:** Opportunities to gamble are shaped by both digital and physical access. Online platforms enable continuous, on-demand play, reducing natural breaks and increasing opportunities for impulsive engagement. Meanwhile, the availability and proximity of venues influence how easily gambling can be accessed in local areas. Opportunities to gamble are not limited to licensed gambling premises; machines offering gambling-style games are also commonly located in pubs, clubs and other venues.
- **Environmental exposure and normalisation:** the location, density, and clustering of physical gambling premises in SEL influence visibility and everyday exposure within communities, while online advertising and digital platforms can extend reach and normalise gambling across a wider range of settings.
- **Wider and unequal exposure to risk**: Wider and unequal exposure to risk: gambling opportunities and product types are not evenly distributed. Exposure varies by place and socioeconomic context, with licensed gambling premises disproportionately concentrated in more deprived areas (Figure 21). This contributes to higher everyday exposure in communities already facing greater disadvantage, reinforcing patterns of harm and inequality.

**Implications:** understanding how opportunities to gamble are distributed across SEL is key to understanding patterns of harm and inequality.

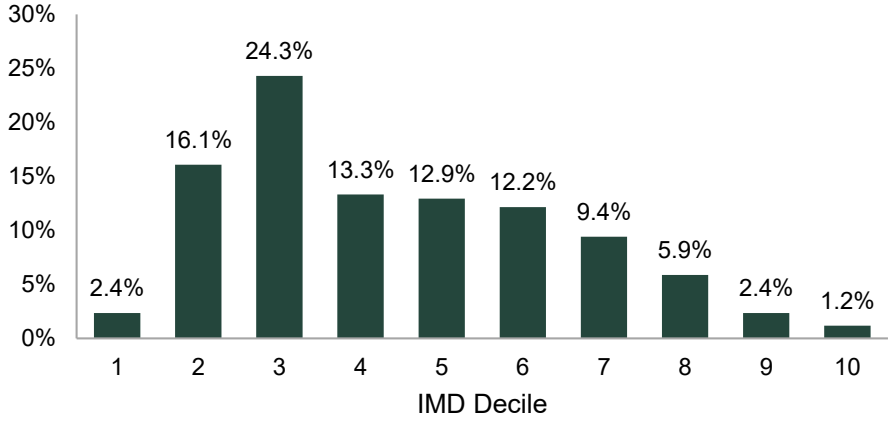


**Figure 21**: Percentage of licenced gambling premises in SEL based within each Index of Multiple Deprivation (IMD) decile (2025)

**Sources**: 52

# Gambling premises in Bexley

**As of March 2026, Bexley had 28 licenced gambling premises**:

- 23 betting shops
- 3 adult gaming centres
- 2 bingo halls

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 22, there are notable clusters in areas that are relatively more deprived, including Welling and Bexley Heath.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling.*

Since 01/04/2021, Bexley has received one premise licence application, which was granted.

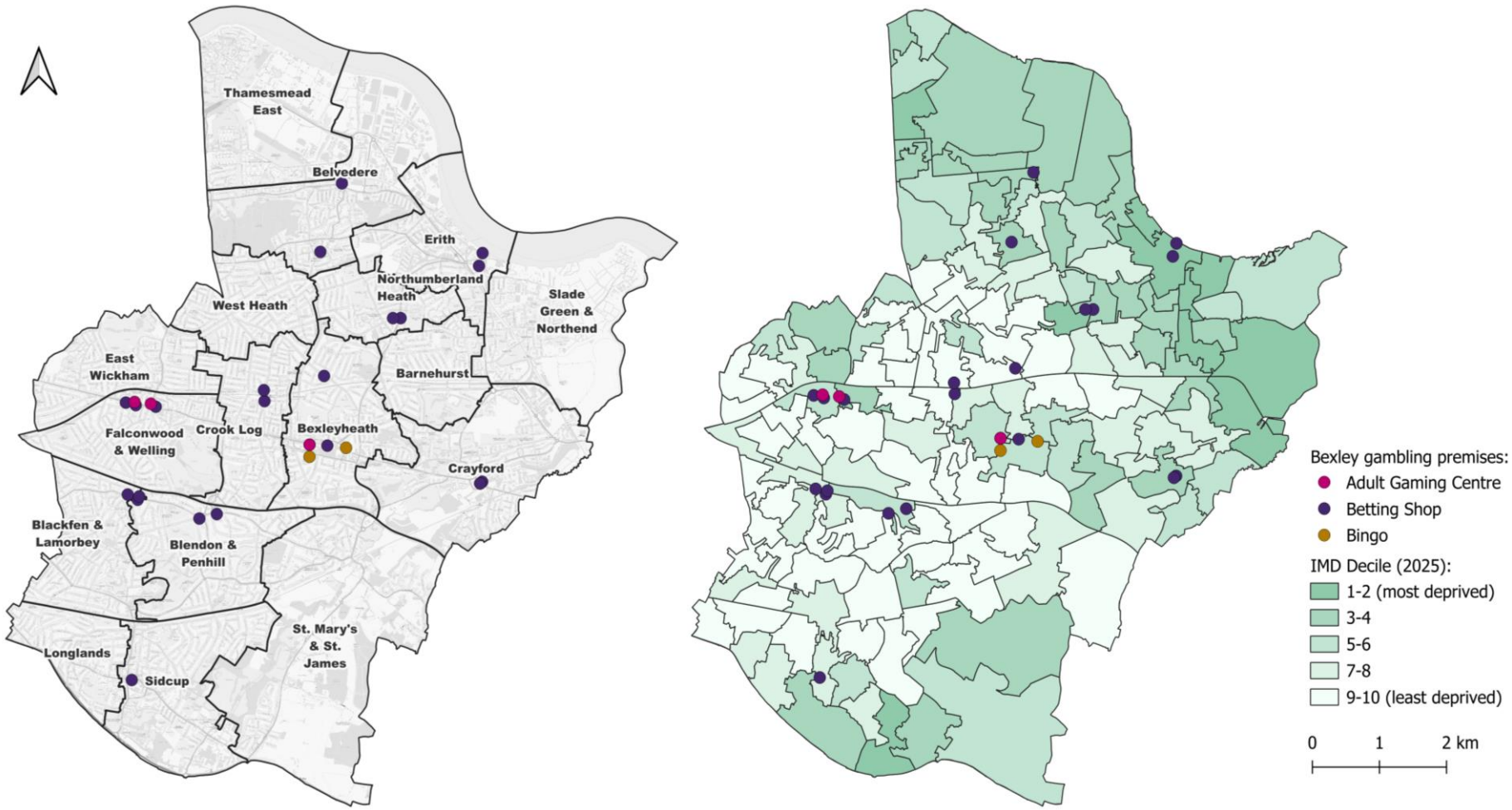


**Figure 22**: licenced gambling premises in Bexley mapped by ward (left) and by index of multiple deprivation (right), March 2026

**Source**: 40, 53

# Gambling premises in Bromley

**As of June 2026, Bromley had 43 licenced gambling premises**:

- 35 betting shops
- 7 adult gaming centres
- 1 bingo hall

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 23, there are notable clusters in areas that are relatively more deprived, including Bromley Town Centre, Orpington High Street, and Penge.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling.*

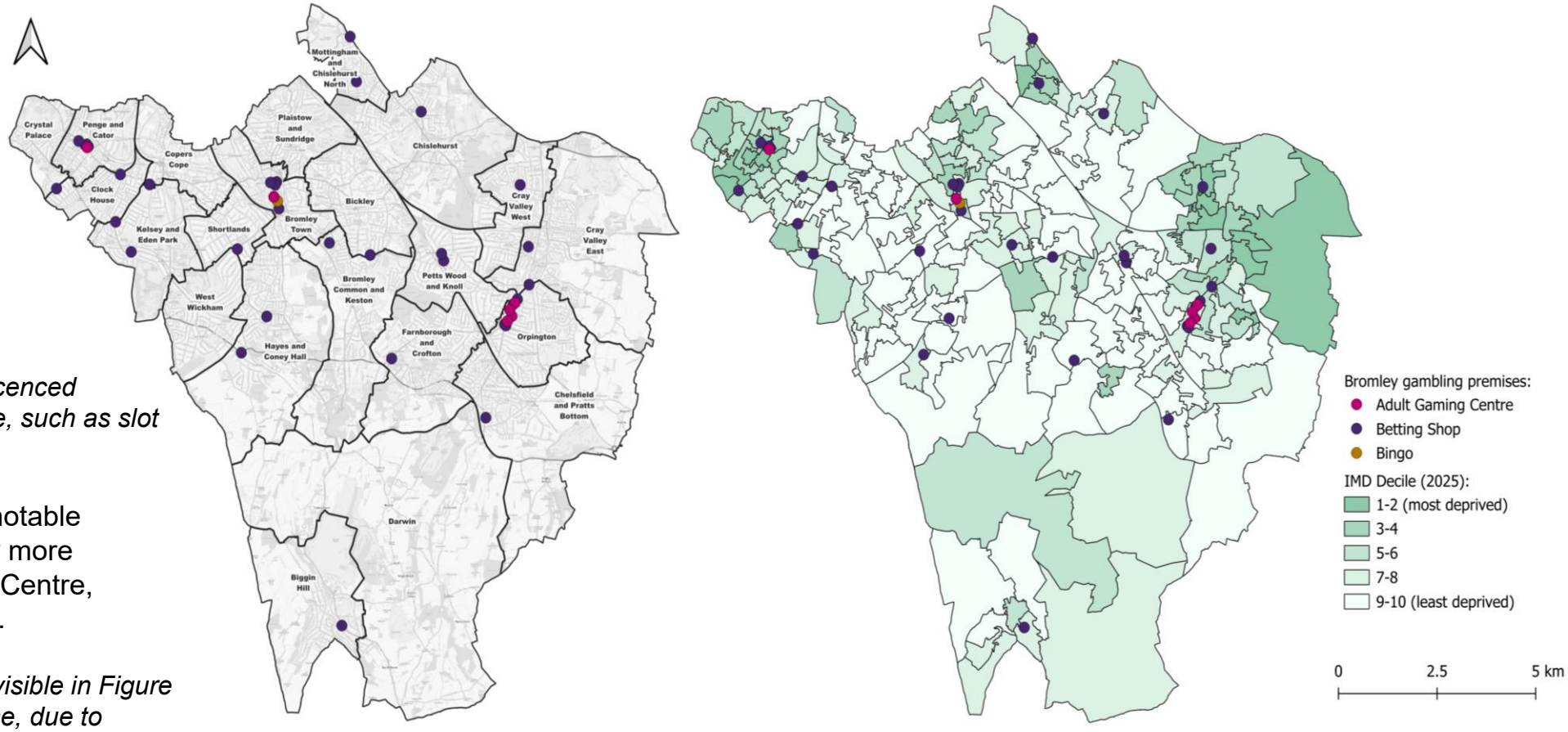


**Figure 23**: licenced gambling premises in Bromley mapped by ward (left) and by index of multiple deprivation (right), March 2026

**Source**: 40, 54

# Gambling premises in Greenwich

**As of March 2026, Greenwich had 40 licenced gambling premises:**

- 34 betting shops
- 5 adult gaming centres
- 1 bingo halls

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 24, there are notable clusters in areas that are relatively more deprived, including Woolwich, West Greenwich, and Eltham High Street.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling.*

Since 01/04/2021, Greenwich has received three premise licence applications, all of which were granted.

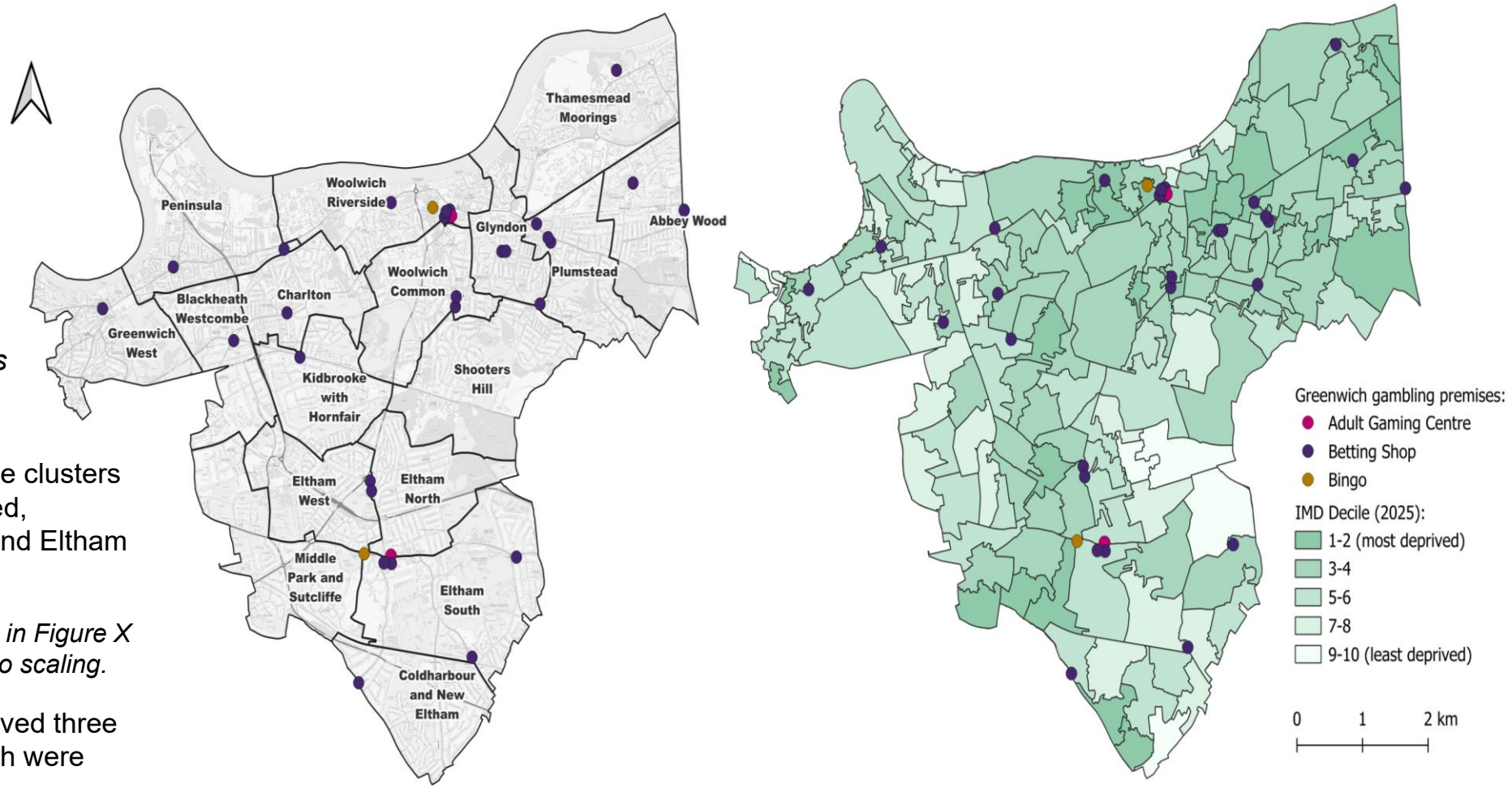


**Figure 24**: licenced gambling premises in Greenwich mapped by ward (left) and by index of multiple deprivation (right), June 2026

**Sources**: 40, 55

# Gambling premises in Lambeth

**As of March 2026, Lambeth had 37 licenced gambling premises:**

- 29 betting shops
- 5 adult gaming centres
- 3 bingo halls

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 25, there are notable clusters in areas that are relatively more deprived, including along Streatham High Road, Brixton Road, and Waterloo.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling*.

Since 01/04/2021, Lambeth has received 8 new premises licence applications, all of which were granted.

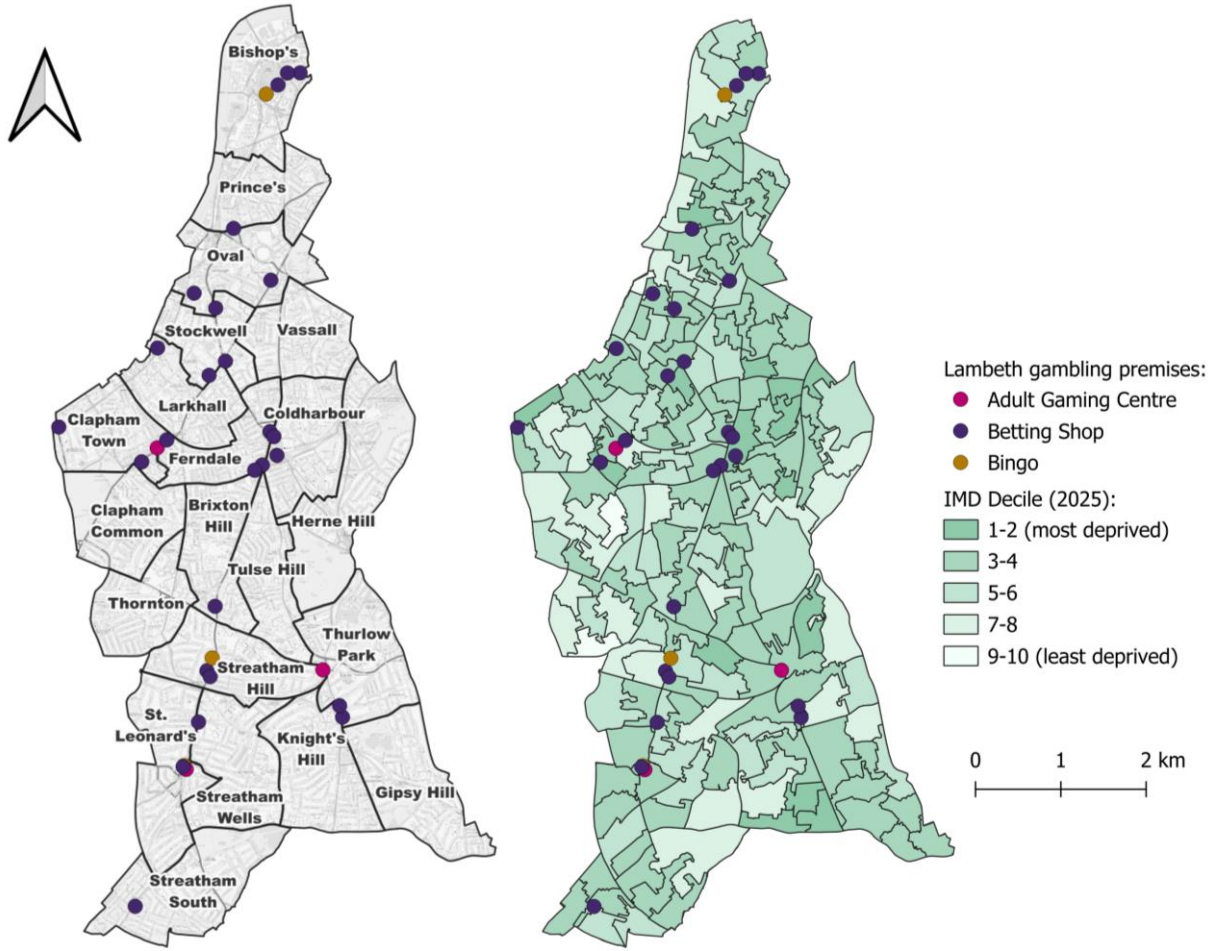


**Figure 25**: licenced gambling premises in Lambeth mapped by ward (left) and by index of multiple deprivation (right), March 2026

**Source**: 40, 56

# Gambling premises in Lewisham

**As of May 2026, Lewisham had 47 licenced gambling premises:**

- 36 betting shops
- 5 adult gaming centres
- 6 bingo halls

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 26, there are notable clusters in areas that are relatively more deprived, including Rushney Green, Evelyn Street, and Lewisham High Street.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling.*

Since 01/04/2021, Lewisham has received six premise licence application, five of which were granted, and one of which is pending as of May 2026.

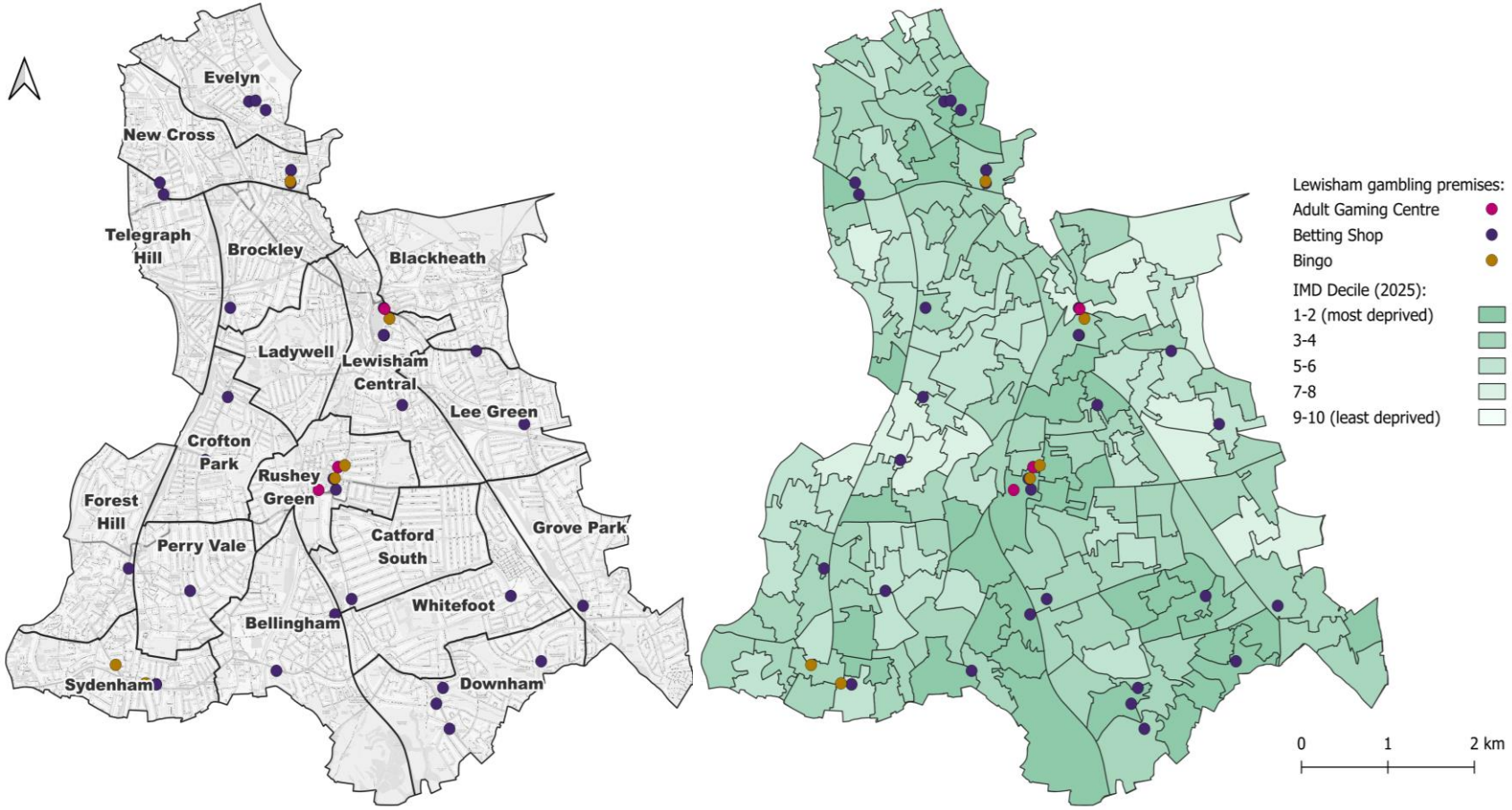


**Figure 26**: licenced gambling premises in Lewisham mapped by ward (left) and by index of multiple deprivation (right), March 2026

**Source**: 40, 57

# Gambling premises in Southwark

**As of June 2026, Southwark had 44 licenced gambling premises:**

- 37 betting shops
- 7 adult gaming centres
- 2 bingo halls

*Note that this does not include non-licenced premises where gambling takes place, such as slot machines in pubs.*

As shown in Figure 27, there are notable clusters in areas that are relatively more deprived, including Walworth Road, Rye Lane, and along Southwark Park Road in South Bermondsey.

*To note, some premises may not be visible in Figure X where very close to another premise, due to scaling*.

Since 01/04/2021, Southwark has received one premise licence application, which was accepted. Over this same time period, 11 premises have been surrendered.

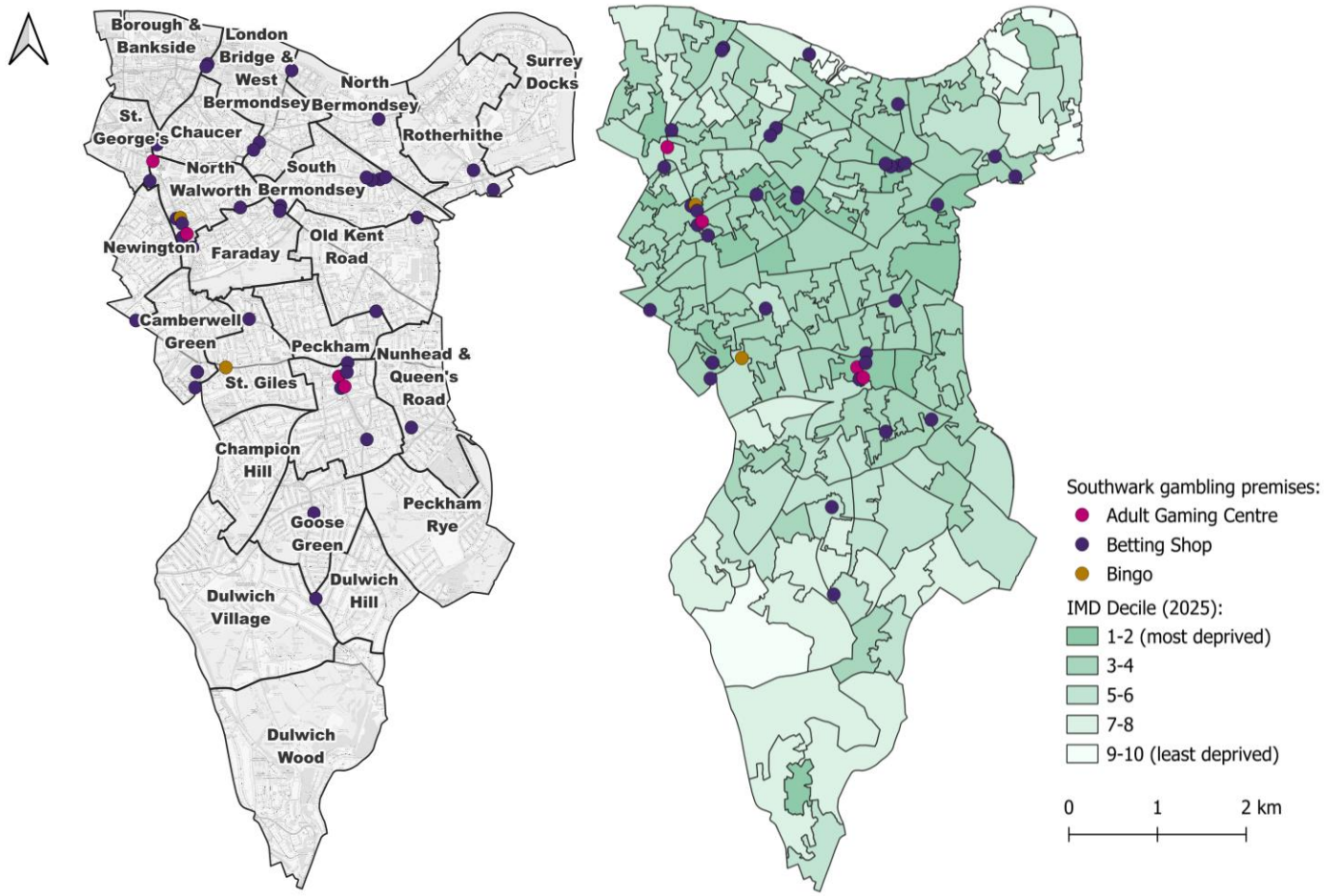


**Figure 27**: licenced gambling premises in Southwark mapped by ward (left) and by index of multiple deprivation (right), June 2026

**Source**: 40, 58

# Section 7.1: System response – primary prevention

# Primary prevention reduces gambling-related harm by shaping exposure, availability, and normalisation

**Primary prevention aims to reduce gambling-related harm before it occurs,** by shaping the environments in which gambling is encountered and limiting exposure to risk at a population level. In the context of gambling, this means acting upstream to reduce the likelihood that everyday exposure, availability, or marketing contribute to the development of harm.

**Evidence shows that exposure to gambling opportunities and marketing is not evenly distributed.** Research consistently demonstrates higher concentrations of gambling premises, advertising and promotional activity in more deprived areas, and greater exposure to gambling marketing among groups already experiencing social and economic disadvantage. These patterns matter because increased exposure is associated with higher participation, greater intensity of play and elevated risk of harm.

**Primary prevention therefore focuses on availability, visibility and normalisation**. This includes where gambling premises are located, how frequently people encounter gambling through advertising and sponsorship, and the extent to which gambling is embedded in everyday settings such as high streets, sport, online platforms and digital media. For children and young people in particular, repeated exposure can contribute to the normalisation of gambling long before the age where legal participation begins.


**Primary prevention plays a key role in addressing inequalities**. Because exposure to gambling opportunities and marketing is patterned by place and population, reducing harmful exposure at a population level has the potential to prevent harm and to avoid widening existing health and social inequalities.

**Both local authorities and national policy shape primary prevention.** Regulatory, planning and policy levers influence the gambling environment in different ways, with local authorities playing a key role in place-based decision-making. The following slides examine primary-prevention mechanisms most relevant to South East London, including licensing and planning, advertising and sponsorship, and action to reduce the normalisation of gambling among young people and through sport.

**Sources**: 59, 60

# Licencing can shape gambling exposure, but refusals require strong local evidence

**Licensing decisions operate within the statutory requirement to "aim to permit",** making refusals difficult and frequently contested. In practice, licensing is most effective as a tool to manage risk and shape exposure, rather than to prevent gambling outright.

**Statements of Licensing Policy (SLPs) set the local framework for decision-making.** SLPs define how licensing objectives are interpreted locally, including consideration of vulnerability, safeguarding, crime, deprivation and local risk. While SLPs cannot override national legislation, they provide the primary basis for weighing local evidence, imposing conditions and, where justified, refusing applications.

**Examples of actions that can be taken by licencing teams to limit or restrict gambling premises:**

- **Cumulative impact and saturation can, in principle, inform decisions but are difficult to sustain.** Local authorities may consider cumulative density where premises are clustered, particularly in areas of deprivation or vulnerability. However, in the absence of a formal cumulative-impact framework for gambling, refusals based on saturation are frequently overturned on appeal, reflecting the high evidential bar under "aim to permit".
- **Crime, anti social behaviour and local disorder have supported refusals where clearly evidenced.** In Westminster (Harrow), a new betting shop application was refused following evidence that an existing premises had become a focal point for street drinking, drug dealing and the sale of stolen goods, with objections supported by the local authority, police, councillors, businesses and residents.
- **Safeguarding and protection of vulnerable people have also supported sustained resistance to applications.** In Kirkwall (Orkney Islands), repeated betting shop applications were refused as being inconsistent with the licensing objective of protecting vulnerable people.
- **Where refusal is unlikely to be defensible, strengthened licence conditions have been used to manage risk.** These include restrictions on external advertising and visibility (particularly near schools), controls on hours of operation, requirements for trained staff and supervision, and use of SIA licensed security during operating hours.

Taken together, these examples show that evidence led conditions,  and in some cases informed refusals or strategic policy choices (e.g. no casino resolutions),  are possible within a restrictive legal regime. However, they depend on high quality local data, clear links to licensing objectives (particularly safeguarding), cross departmental input (including public health and community safety), and sustained legal resilience.

# Planning can shape long-term exposure to gambling through place-based policy

**Planning operates upstream of licensing and influences where gambling premises can locate and cluster over time**. Unlike licensing, which is reactive and case-by-case, planning decisions are made within Local Plan policies alongside wider spatial, regeneration and placemaking considerations, shaping long-term exposure within town centres, neighbourhood centres and local parades, within the limits of planning legislation.

**Evidence suggests that clustering of gambling premises is associated with deprivation and vulnerability, making planning an important upstream prevention lever** where Local Plan policies are sufficiently clear and specific. Where policies rely mainly on qualitative judgement, outcomes depend more heavily on interpretation, supporting evidence and consistency of application.

**Across SEL, Local Plans vary considerably in how explicitly they restrict gambling and betting premises**. Some boroughs include explicit, quantified planning controls, such as numerical caps or separation distances (for example Lambeth and Southwark), while others rely primarily on qualitative tests relating to over-concentration, amenity, vitality and safety (Lewisham and Greenwich). In contrast, Bromley's Local Plan does not explicitly reference gambling premises.

**Variation in Local Plan policies means that the strength of planning-based primary prevention differs by borough**. Where plans include clear thresholds or spatial rules, planning can be a relatively strong mechanism to limit concentration. Where policies are less specific, scope to restrict new premises is more limited.

A full summary of Local Plan restrictions on gambling and betting premises by borough is set out in Appendix 3.

**Sources**: 62

# Advertising and sponsorship play a key role in normalising gambling

**Gambling advertising and promotion are widespread in the** UK, shaping everyday exposure across broadcast media, online and social platforms, in-play advertising, sport, and the physical environment. The gambling industry spends an estimated £1.5 billion per year on advertising (almost double the estimated £800million spent on alcohol advertising each year), contributing to the normalisation of gambling within daily life.

**High exposure to gambling advertising is associated with increased gambling behaviour**. Around 6 in 10 adults report seeing gambling adverts or sponsorship at least once a week, and over one-third of people who gambled in the past 12 months report having been prompted to spend money by advertising. Exposure is most intense for those already experiencing harm: 35% of people experiencing problem gambling receive gambling incentives daily, compared with just 4% of those not experiencing gambling harm, reinforcing cycles of risk and loss.

**International comparisons show that the UK has a relatively permissive advertising environment** (Figure 28). As illustrated, gambling advertising and sponsorship remain widely permitted across multiple media in the UK, while many other countries have introduced targeted restrictions in specific settings such as sport, online advertising, inducements or public spaces. These examples demonstrate that stronger primary-prevention approaches to advertising are feasible and already in place elsewhere.

**While most regulation of gambling advertising sits at a national level, local authorities can still act to reduce place-based exposure.** This includes decisions about gambling advertising on local-authority owned land, buildings, transport infrastructure and street furniture, and the use of licence conditions to restrict external advertising and visibility on gambling premises, particularly near sensitive locations. Across SEL, only Southwark currently applies explicit restrictions on gambling advertising on local authority assets, highlighting variation in local practice.

**Local action can also be supported by collective national engagement.** Given that key levers sit nationally, participation in initiatives such as the Coalition to End Gambling Ads represents one way local authorities can contribute to wider primary-prevention efforts to reduce harmful advertising exposure, alongside local place-based measures.

| COUNTRY | SPORT SPONSORSHIP | ONLINE ADVERTISING | TV & RADIO | SOCIAL MEDIA | TARGETED ADS | PUBLIC POSTERS | TV ADS DURING SPORTS EVENTS | INDUCEMENTS* |
|---|---|---|---|---|---|---|---|---|
| BELGIUM | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ |
| ITALY | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ | ⊗ |
| SPAIN | ✗ | ⊗ | ✗ | ✓ | ✓ | ✓ | ✗ | ✓ |
| GERMANY | ✓ | ⊗ | ⊗ | ✗ | ✗ | ⊗ | ⊗ | ✗ |
| NETHERLANDS | ⊗ | ✓ | ⊗ | ✗ | ✗ | ⊗ | ⊗ | ⊗ |
| AUSTRALIA | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ⊗ | ✗ |
| GREAT BRITAIN | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

✓ ALLOWED

✗ BANNED WITH CAVEATS

⊗ BANNED

*Inducements refer to sign-up bonuses and bonuses sent to inactive players,

**Figure 28:** policies on gambling advertising by country (sourced from Coalition to End Gambling Ads website)

**Sources**: 63, 64, 65, 66

# Reducing gambling harm among young people requires tackling normalisation, not just enforcing age limits

**Despite gambling being illegal for children and young people, exposure begins early and is widespread.** Gambling-related content is encountered through advertising, digital platforms, gaming environments and everyday social settings, contributing to familiarity and acceptance before legal participation. Regulatory safeguards exist but are limited in practice. Advertising codes state that gambling promotions should not strongly appeal to young people, reflect youth culture or feature under-25s gambling. However, these principles are broad and open to interpretation, and many adverts and promotional formats still use visual, cultural or game-like features that can appeal to younger audiences.

**Normalisation is reinforced through digital environments, influencers and blurred boundaries between gambling and gaming.** Research led by YGAM and academic partners highlights the growing presence of gambling-related influencer content on platforms such as YouTube, TikTok and Twitch, often embedded within entertainment and without clear disclosures. Gambling-like mechanics such as loot boxes, skins and in-game purchases involve spending real money for chance-based rewards but are not defined as gambling in the UK, allowing them to be legally marketed to children despite being classified as gambling in some other countries.

**Social and cultural influences play a particularly strong role.** As shown, the 2026 Annual Student Gambling Survey found that friends, social media and sporting events were the most commonly reported influences on gambling behaviour among young adults (Figure 29), outweighing traditional advertising and highlighting how gambling becomes embedded within peer networks and leisure activities during key transition periods.

**Best-practice primary prevention focuses on reducing exposure across systems, not just enforcing age limits**. Schools are a key setting for prevention. Updated statutory RSHE guidance (2025) now includes clearer content on gambling-related harms, including links to mental health, online gambling and gambling-like features within gaming. However, schools have flexibility in how content is delivered, and it is not currently well understood how consistently or in what depth gambling-related harm is addressed through PSHE and wider school-based provision across SEL.

**More comprehensive, multi-strand prevention models illustrate what strengthened approaches could look like in practice.** For example, YGAM's work with ages 7–25 spans education, families, health, youth justice, community and gaming settings, including peer-to-peer identification and brief advice approaches.

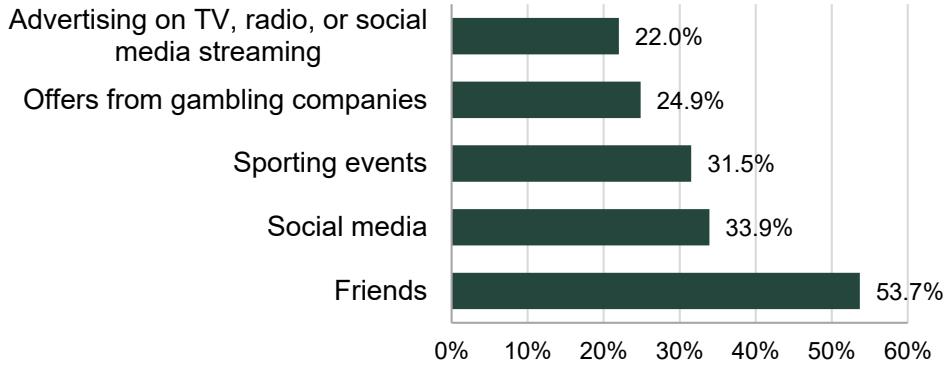


**Figure 29:** Percentage of respondents reporting influencers to gamble (top five), Annual Student Gambling Survey, 2026

**Sources**: 67, 68, 69, 70, 71

# Sport plays a powerful role in normalising gambling

**Sport is a powerful environment through which gambling becomes normalised.** Gambling promotion is embedded across sponsorship, broadcast coverage, in-play odds and digital content, reinforcing gambling as part of the sporting experience rather than a risk-bearing activity.

**Normalisation is intensified through digital platforms and major sporting events**. Sport-related gambling now occurs predominantly online: 10% of adults placed a bet on a sporting event online compared with 5% in person, with similar patterns for horse racing (DCMS Participation Survey, 2024–25). Exposure and inducement peak around major competitions such as the FIFA World Cup, when advertising and promotional activity increases.

**Research shows gambling has become embedded within sports fandom, particularly among younger men**. Online betting is often framed as knowledge-based and low-risk, with mobile apps, in-play betting and promotional offers acting as key mechanisms of normalisation, which can make gambling-related harm harder to recognise and discuss.

**Targeted public-health communications show that this normalisation can be disrupted**. During the 2022 World Cup, Greater Manchester's "Odds Are: They Win" campaign challenged dominant industry narratives and coincided with a 500% increase in views of 'access to treatment and support' webpages in the first six weeks of 2023 compared with the whole of 2022, suggesting increased awareness and help-seeking following exposure to counter-normalisation messaging.

**Reducing normalisation in sport therefore requires proactive primary prevention**. Effective approaches focus on reducing routine exposure during major events, weakening the cultural link between gambling and sport, and promoting health-focused narratives rather than relying solely on age- or content-based controls.

**Local authorities can act where they influence sporting environments**. While sponsorship regulation largely sits nationally, councils can support prevention through community sport provision, use of local authority facilities, commissioning and coordinated communications, particularly around high-profile sporting events.


**Figure 30**: social media message from Greater Manchester's 'Odds are They Win' Campaign around the 2022 Football World Cup

**Sources**: 72, 73, 74, 75

# Community perspectives on prevention and local action

A community assembly, led by Black Thrive Lambeth and Betknowmore UK brought together 60 participants, including local residents, service providers, practitioners, community stakeholders, and the Mayor for Lambeth as a dedicated space for learning, reflection, and collective problem solving around the growing impact of gambling harms locally. The participants worked together to co-produce the following priorities to strengthen local prevention and reduce harm in relation to gambling:

1. **Supporting communities affected by gambling-related harms:** where gambling operators are already established in the borough, explore mechanisms to directly support communities most effected by gambling related harms.

2. **Proactive Public Awareness and Prevention Campaigns**: deliver visible, council-led awareness campaigns that clearly communicate the risks and signs of gambling harm, routes to support, and available local services. Participants emphasised the importance of culturally relevant messaging and outreach through trusted community spaces and networks.

3. **Limiting Operating Hours**: use local licensing powers to restrict late-night and 24-hour gambling premises where possible. Residents highlighted that extended opening hours can increase vulnerability, anti-social behaviour, and harm, particularly for young people and those already experiencing financial or mental health pressures.

Across discussions, there was a clear call for local leadership, preventative education, and greater accountability from gambling operators.

Taken together, these priorities emphasise prevention as a system-level responsibility, requiring visible local leadership, proactive public awareness, and action to reduce exposure to harm. They reinforce the importance of embedding community-informed approaches within primary prevention and provide a clear mandate for the prevention and policy actions set out in the recommendations that follow within this JSNA.

**Sources**: 26

# Section 7.2: System response – secondary prevention

# Secondary prevention sits where harm becomes visible

Gambling-related harm does not begin at a single point and does not progress in a uniform way. It develops over time and exists on a spectrum, affecting people at different levels of risk and severity, from emerging harm through to high-risk or problem gambling.

**Secondary prevention focuses on the earlier identification and response to gambling-related harm across this spectrum**, including:

- Recognising harm as it emerges or escalates,
- Supporting people at lower levels of risk,
- Identifying people experiencing high-risk or problem gambling and connecting them with appropriate specialist services in a timely way.

In practice, secondary prevention is concerned with how gambling harm becomes visible, how people disclose or seek help as harm develops, and how different points of contact across the system respond to that harm. The way these early interactions occur plays a critical role in shaping patterns of escalation, support, and later demand for specialist treatment.

# Most people experiencing gambling-related harm seek support outside gambling services, or do not seek formal support at all.

**Help-seeking is uneven and non-linear.** When gambling-related harm emerges, people seek help and support in different ways and at different points along the spectrum of risk and severity, and many people do not initially approach gambling-specific services.

**Overall use of formal support is low.** Data from the GSGB show that only 3.4% of people who gamble access any formal support in a given year, and that use of gambling support services is particularly low (only 1.2%). When support is accessed, it is more commonly through mental health services, welfare or food-bank support, or relationship counselling, rather than gambling-specific services.

**Help-seeking increases with severity but remains fragmented.** Among people with problem gambling (PGSI 8+) nationally, 41.8% accessed some form of support, yet only around one in five (20.1%) accessed gambling support services, with similar or higher proportions accessing mental health, welfare or relationship support.

**Barriers vary across the spectrum of harm**. Findings from the GambleAware Treatment & Support Survey (2024) indicate that at lower and moderate levels of harm, the most common barrier to seeking help is not recognising gambling as a problem, while at higher severity levels, barriers shift towards stigma, perceived relevance, and access to services (Figure 31).

Together, these patterns show that gambling-related harm is often recognised and responded to outside gambling services, and that barriers to help-seeking change as harm escalates.

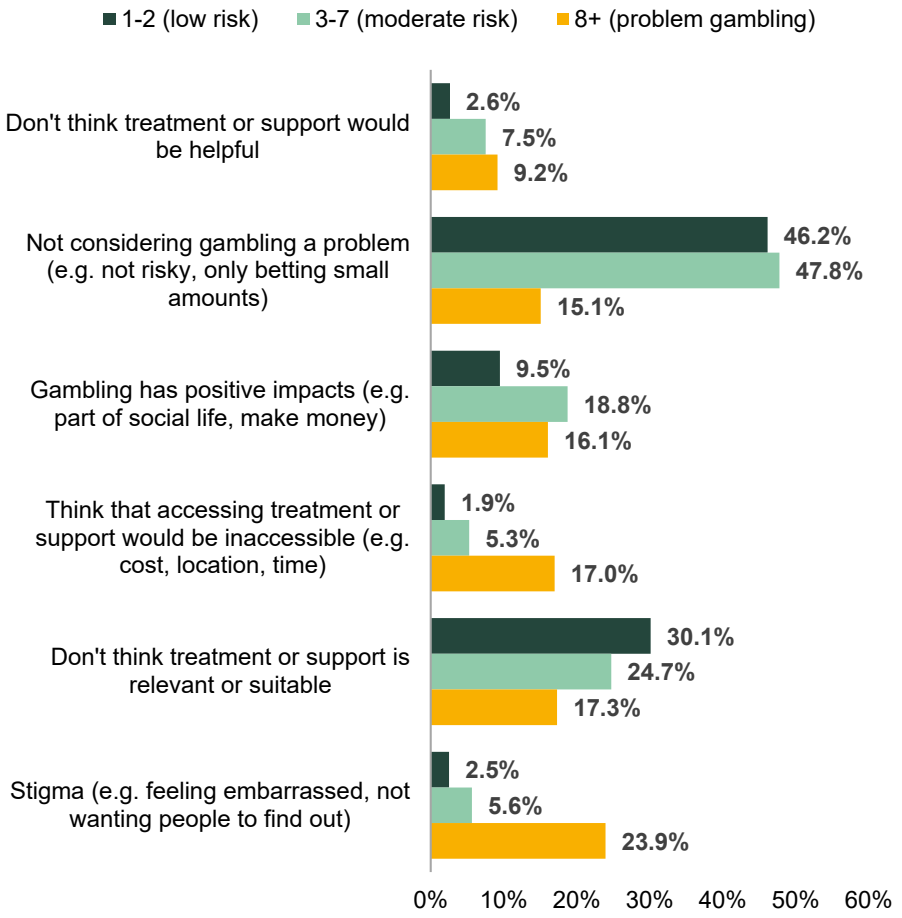


**Figure 31**: Barriers to demand for treatment and support (GambleAware Treatment and Support Survey for Great Britain, 2024)

**Sources**: 1, 48

# Gambling-related harm is often identified late, inconsistently, and in response to crisis

A cross-sector stakeholder survey in SEL (n=123) identified consistent barriers to early identification and response across primary care, mental health, substance misuse, housing, and voluntary sector services.

**Key barriers to identification and response:**

- **Identification is reactive rather than routine**: gambling-related harm is typically identified indirectly, through wider conversations or once difficulties have escalated. Routine enquiry is uncommon, and many services only discuss gambling if raised by the individual, with limited use of structured screening.
- **Workforce confidence and capability are variable:** confidence in recognising, discussing and responding to gambling-related harm is mixed, reflecting gaps in knowledge, training and awareness of referral pathways (Figure 32). A minority (26/123) of respondents reported accessing training (e.g. online training with Betknowmore UK and GamCare), but this was not consistent.
- **Service context and competing demands limit opportunities**: Some respondents highlighted time pressures, competing priorities, or the nature of their service (e.g. short-term or crisis-focused work) as barriers to raising gambling or exploring it in depth.
- **Engagement, visibility and role clarity challenges**: stigma and sensitivity around gambling and finances can prevent disclosure, and conversations about finances can feel intrusive. Harms are often only partially visible (e.g. debt, mental health or housing issues), and views vary on whether addressing gambling falls within service roles, which may limit routine enquiry.


**Figure 32**: proportion of survey respondents reporting that they feel not at all, or not very confident or mixed confidence in identifying and responding to gambling-related harm.

**Sources**: 33

# Earlier identification and response could be strengthened through practical system changes

Findings from a cross-sector stakeholder survey of services in SEL highlight actions that could support earlier identification and more effective response to gambling-related harm (Figure 33):

- **Increase awareness of available support services** to strengthen referral pathways, for example by developing and sharing clear, accessible information on local and national provision and how to refer into it.
- **Provide practical resources to support conversations and signposting**, including materials that practitioners can use with service users, information on support options, and targeted resources for people affected by someone else's gambling.
- **Develop and embed clear guidance on how to respond when gambling is identified**, including simple, practical steps for frontline staff and clear referral options, as reflected in national work to develop tools and guidance for primary care (e.g. Royal College of General Practitioners).
- **Incorporate simple prompts and questions into existing assessments and routine interactions**, enabling staff to raise gambling in a structured, consistent and non-intrusive way without requiring standalone screening processes.
- **Expand access to training and shared learning opportunities to build confidence across the workforce**, including structured training for local authority and frontline staff (e.g. Betknowmore) and opportunities to learn from other services and sectors.
- **Embed gambling within existing service pathways and safeguarding processes**, so that identification and response do not rely on individual awareness, including work to integrate gambling harms into safeguarding systems and wider local authority processes (e.g. Gambling Harm UK).

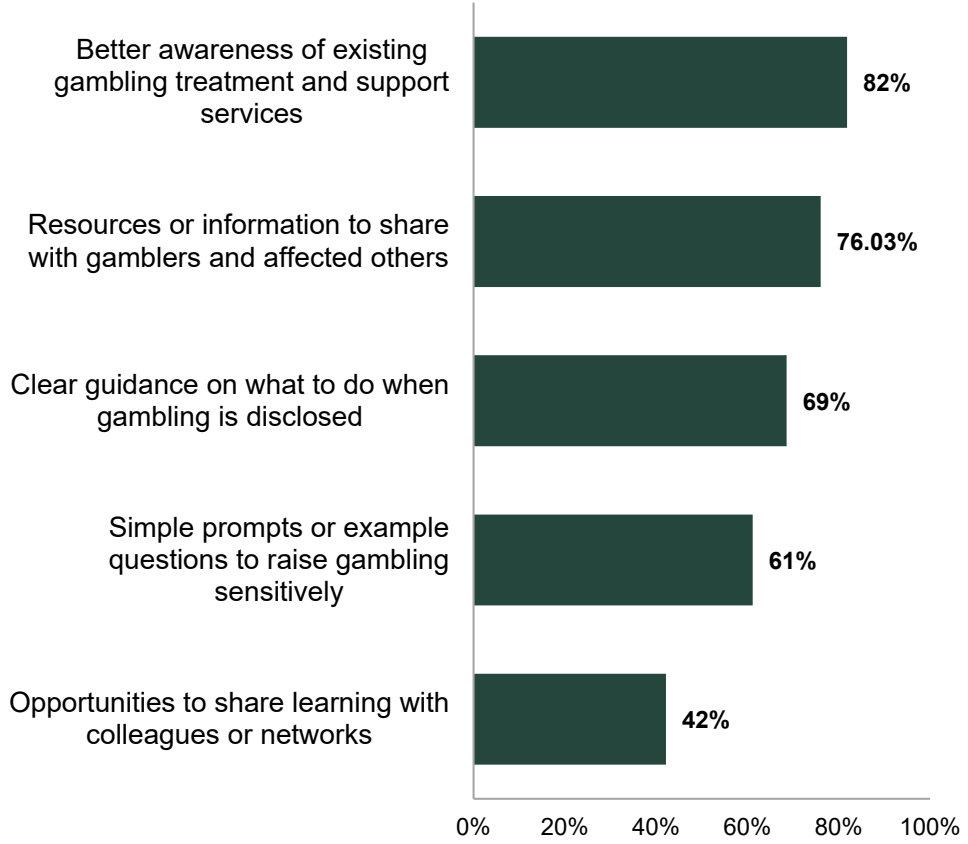


**Figure 33**: Proportion of SEL survey respondents (n=121) who reported that they would find the following helpful in supporting them or their team to identify or respond to gambling related harm?"

**Sources**: 33

# Advice and support for gambling-related harm spans gambling-specific and wider services

The following slides shift from analysis of system barriers to an overview of the support currently available to people experiencing gambling-related harm and those affected by someone else's gambling. They illustrate how secondary prevention operates through multiple routes rather than a single pathway.

This section begins with key services and helplines that can offer advice, emotional support, practical help and onward referral, reflecting how support is most often accessed in practice:

| Type of support | Examples |
|---|---|
| **Gambling-specific support** | • **The National Gambling Helpline (GamCare):** provided by GamCare, is 24 hours a day, every day of the week. Callers can talk to Advisers on Freephone 0808 8020 133 or live chat via ww.gamcare.org.uk whenever they need some advice and support, or just to talk. |
| **Emotional, Family, & Relationship support** | • **Samaritans**: provide support during crisis or distress. Call them free on 116 123 or visit samaritans.org<br>• **Family Lives:** provides targeted early interventions and crisis support for families. Call them on 0808 800 2222 or visit www.coramfamilylives.org.uk/<br>• **Relate:** provide relationship advice and counselling. Call them on 0300 100 1234 or visit relate.org.uk<br>• **Carers UK**: provide advice and support for anyone providing care for another. Call 0808 808 7777 or visit carersuk.org |
| **Debt, Financial & Welfare support** | • **Citizens Advice:** provide free, confidential advice on a range of issue including those relating to debt/money, consumer rights and benefits. Visit www.citizensadvice.org.uk<br>• **National Debtline**: provide free, independent, and confidential advice on money and debt problems. Call 0808 808 4000 or visit https://nationaldebtline.org/<br>• **StepChange:** provide free, confidential and expert debt advice and money guidance. Call 0800 138 1111 or visit www.stepchange.org |

*Note – this is not an exhaustive list.*

# Harm-reduction and self-exclusion tools provide early, practical ways to reduce gambling-related harm

**Harm-reduction and self-exclusion tools enable people to reduce, control or interrupt gambling behaviour** once harm is recognised. These options can be used independently of formal services, often at an early stage, and may be accessed alongside peer or professional support. They are particularly important for people who want to retain privacy, are not yet ready to engage with treatment, or are seeking practical ways to manage risk and prevent escalation.

| Type of support | Examples |
|---|---|
| **Online self-exclusion schemes** | • **BetBlocker:** is a free app that can be used to block yourself from accessing over 15,000 gambling websites. You can select how long you want to be blocked for. https://betblocker.org/<br>• **GamStop**: is a free scheme that can be used to allow gamblers to self-exclude from online gambling websites and apps run by companies licensed in Great Britain. www.gamstop.co.uk<br>• The **National lottery a self-exclusion scheme** allows players to ban themselves from playing for 6 months to 5 years, or permanently, via "spend and play" settings in their account. This covers online instant win games and draw games. |
| **Digital blocking software** | • **GamBan**: provides a software licence enables people to block access to online gambling apps and websites. The licence can be obtained free if it is requested through the National Gambling Helpline. https://gamban.com |
| **Financial controls and transaction blocks** | • **Some banks offer blocks on gambling transactions**, with some having a 48-hour cooling off period before it can be removed which may help to prevent relapse. For information about which banks offer a gambling blocking service go to: https://www.gamblingcommission.gov.uk/public-and-players/page/i-want-to-know-how-to-block-gambling-transactions |
| **Venue-based self-exclusion** | • All gambling premises such as arcades, bingo halls and casinos must be part of a **multi-operator self-exclusion scheme (MOSES)**. This allows a gambler to make a single request (by filling in a form) to self-exclude from all premises offering the same type of gambling, such as betting shops. Once a self-exclusion agreement is made, the gambling company must close the gambler's account, return money in it and remove personal details from their databases. For more information see: https://bettingandgamingcouncil.com/sense-self-exclusion-scheme |

*Note – this is not an exhaustive list.*

# Peer, lived-experience and community-based support play a key role in responding to gambling-related harm

**Peer-led and community-based support plays an important role in responding to gambling-related harm**, particularly where people are ambivalent about treatment or where harm is experienced alongside other social and emotional needs. Lived-experience offers can support disclosure, reduce stigma and isolation, and provide trusted routes into further help for people who gamble and for affected others.

| Type of support | Examples |
|---|---|
| **Peer and lived-experience support** | • **Gamblers Anonymous**: a fellowship of people who share their experience, strength and hope to help themselves and others recover from gambling addition. With in-person and online meetings, it offers a supportive, confidential environment where members use peer support and abstinence to overcome gambling problems.<br>• **GamFam**: runs GRA5P (The GamFam Recovery and Support Programme), a structured 5-stage self-help peer support programme to support those in recovery, conducted over Zoom.<br>• **Betknowmore**: Peer Aid is a free support service, designed and delivered by people who have experience of gambling harms to support people who want to recover from the harmful effects of their own gambling. New Beginnings is a digital women-only peer support service, providing a safe space for women affected by gambling harms. |
| **Community-based outreach and tailored support** | • **Age UK Lambeth - Better Together:** provides community-based support for older adults affected by gambling-related harm, using a social-prescribing and outreach model to support early identification, practical help and emotional support, with clear pathways into specialist services where needed.<br>• **Betknowmore**: the Gambling Outreach and Living Support (GOALS) programme provides face-to-face and digital support to people in London and the Southeast experiencing gambling harms.<br>• **Reframe Coaching**: one-to-one, non-clinical recovery-focused support<br>• **Prison Radio Association**: run a podcast called “Hold or Fold” aimed at people in prison to raise awareness of gambling harms. They also run in-prison workshops and national messaging campaigns. |
| **Support for affected others** | • **GamFam**: runs GRA5P (The GamFam Recovery and Support Programme), a structured 5-stage self-help peer support programme to support those affected by someone else’s gambling, conducted over Zoom.<br>• **GamAnon**: a fellowship providing support for partners, family, and friends affected by a loved one’s gambling problem.<br>• **Betknowmore:** Peer Aid is a free support service, designed and delivered by people who have experience of gambling harms to support people who want to recover from the harmful effects of someone close to them. New Beginnings is a digital women-only peer support service, providing a safe space for women affected by gambling harms. |

*Note – this is not an exhaustive list.*

# Section 7.3: System response – tertiary prevention

# Gambling Treatment and Support Services in London

**Tertiary prevention for gambling harms focuses on specialist treatment and structured support for people experiencing established gambling-related harm.** This includes support for individuals whose gambling has led to significant financial, mental health or relational difficulties, as well as partners, family members and others affected by someone else's gambling. Services typically provide psychological therapies, practical and financial support, and help to manage wider impacts such as relationship breakdown, employment problems and co-occurring mental health needs.

**In England, specialist gambling treatment is now commissioned through the NHS.** In London, treatment is delivered through a combination of NHS specialist services and national voluntary-sector providers. Key services accessed by SEL residents include:

| National Gambling Clinic (NGC) | Primary Care Gambling Service (PCGS) | GamCare |
|---|---|---|
| A service for people who are experiencing harm from gambling, aged 13 to 18 from anywhere in England, and 18 and over living in Greater London. | A GP-led, multi-disciplinary service for adults over 18 anywhere in the UK experiencing gambling harm (including affected others). | A free support service, incorporating the National Gambling Helpline, and one-to-one treatment services for adults aged over 18 in South East, East Midlands, London, Scotland, and Yorkshire & Humber |

Together, these services form the core tertiary-prevention offer for gambling harms in London. For a small number of people with particularly severe or complex gambling-related harm, residential treatment, delivered by specialist providers such as Gordon Moody and Adferlad Recovery may be also appropriate.

**Access to gambling treatment can usually be accessed by either self-referral or a referral from GPs or other health professions, or VCS organisations.** This open-access model is intended to reduce barriers to support, though in practice awareness, stigma and complexity of need may still influence who reaches treatment.

**The following slides examine access to gambling treatment and support in SEL**, how this compares to estimated population-level need, and what this indicates about equity, system pressures and unmet demand within the tertiary-prevention response.

# Only a small proportion of SEL residents experiencing gambling-related harm access specialist treatment services.

**South East London residents access gambling treatment and support through several specialist services**. Figures 34-36 below summarise referrals accepted by each service and are presented separately, as they relate to different service provision and reporting periods. They should therefore be interpreted within individual services, rather than compared or combined.

**Referral patterns vary across boroughs**, reflecting differences in population size, underlying need, and help-seeking. GamCare accounts for the highest volume of referrals, consistent with its role as a national provider offering both the National Gambling Helpline and structured treatment.

**The gap between estimated need and access to specialist support is substantial.** In 2024-25, the three main gambling treatment providers serving London received just 324 referrals for SEL residents, compared with an estimated 207,000 adults experiencing gambling-related harm (PGSI 1+), including around 39,000 experiencing problem gambling (PGSI 8+).


**Figure 34**: Number of referrals accepted by NGC, by Local Authority, 1st April 2021 and 31st March 2025

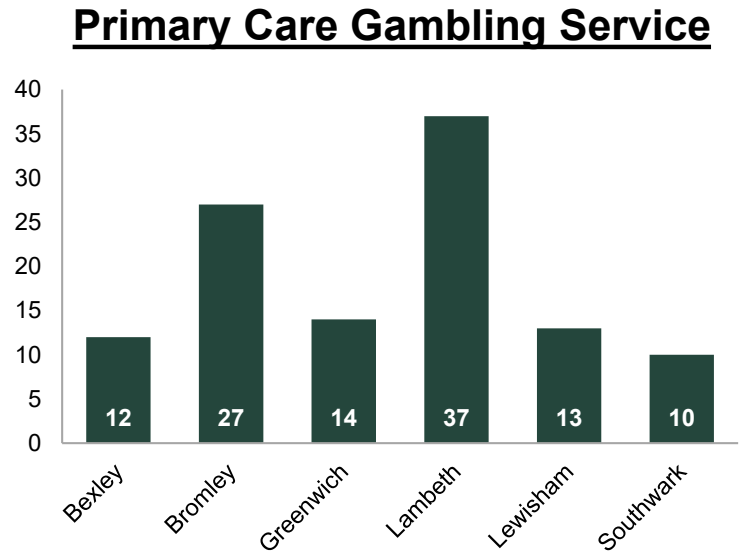


**Figure 35:** Number of referrals accepted by PCGS, by Local Authority, 1st April 2023 to 5th March 2026

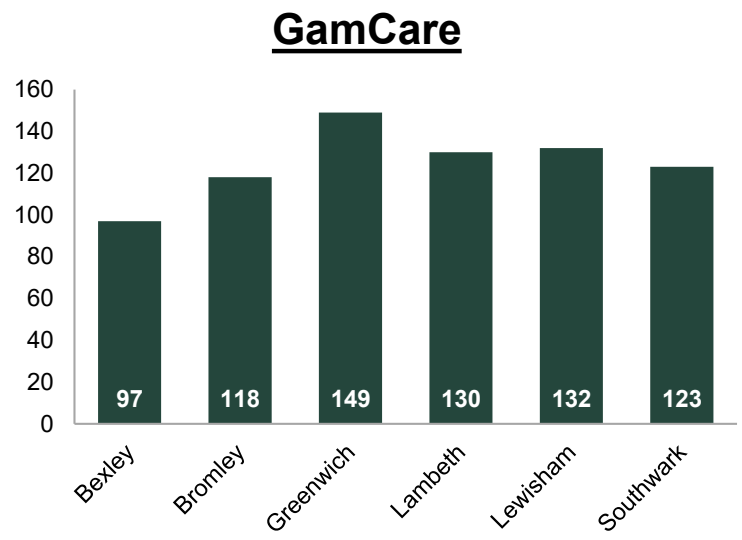


**Figure 36**: Number of referrals accepted by GamCare, by Local Authority, 1st April 2021 to 31st March 2025

**Sources**: 21, 77, 78, 79

# The profile of people accessing specialist gambling treatment does not fully reflect the distribution of gambling-related harm.

This slide compares who reports gambling-related harm nationally with who accesses specialist gambling treatment locally, to highlight patterns of representation:

- **Sex:** As shown earlier, national data indicate that 29.2% of men and 19.7% of women who gambled in the last 12months score PGSI ≥1, and 6.0% of men and 2.8% of women score PGSI 8+ (GSGB, 2024). In contrast, local treatment data for SEL show a more male-skewed pattern of access, with men accounting for approximately 70–84% of treatment users and women for around 16–29% across services (Figure 37). This indicates that women are under-represented in gambling treatment relative to both overall and higher-severity gambling-related risk.
- **Age:** National data show that PGSI ≥1 is reported by 42.1% of adults aged 18–24 who gambled in the last 12months, and 35.7% of those aged 25–34, compared with 16.5% of adults aged 55–64 and 10.6% aged 65–74; PGSI 8+ follows the same gradient (GSGB, 2024). Local treatment data in SEL are concentrated among people aged 25–44, while younger adults (18–24) and older adults (55+) account for smaller proportions of treatment users than their prevalence of gambling-related risk would suggest (Figure 38).

Taken together, these patterns show that the profile of people accessing specialist gambling treatment does not fully reflect the distribution of gambling-related harm in the wider population.

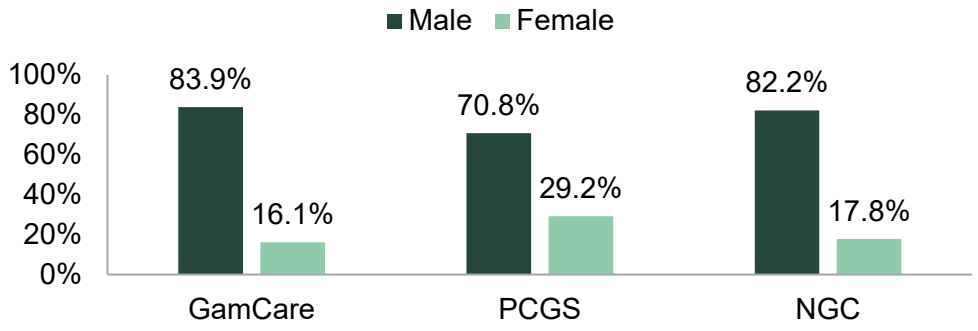


**Figure 37:** Percentage of SEL service users from each Sex, by treatment service

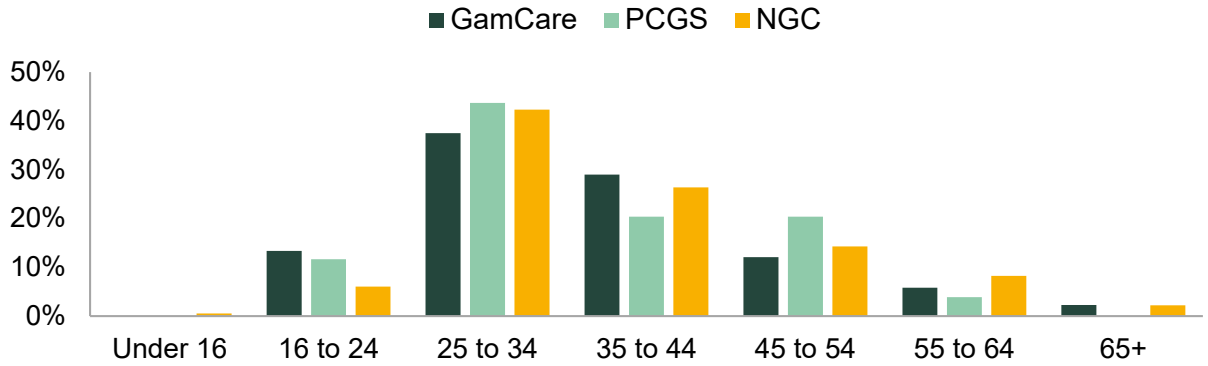


**Figure 38:** Percentage of SEL service users from each age group, by treatment service

**Sources**: 77, 78, 79

# Those accessing gambling treatment typically present once harm is well-established

When people access specialist gambling treatment, service data indicates that gambling-related harm is typically well established and frequently co-occurs with wider mental health, financial and social difficulties.

- **Severity at presentation**: Pre-treatment data from the PCGS show that most SEL residents accessing treatment present with high PGSI scores at initial assessment (Figure 39), indicating that harm has often escalated before specialist support is reached.
- **Socio-economic impact**: Of SEL residents referred to the PCGS who reported employment status (n = 87), 40% were unemployed or out of work due to long-term sickness or disability, indicating wider socio-economic vulnerability. Financial harm was often severe: among those who answered the question about gambling-related debt (n = 65), the median debt was £8,000, and 39% of service users reported debts exceeding £10,000. A similar pattern is seen among those referred to GamCare with 62% reporting financial difficulties.

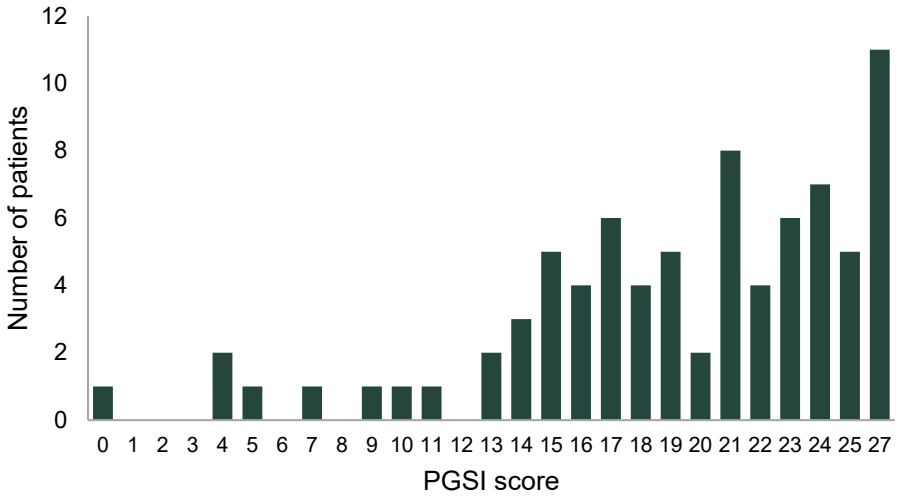


**Figure 39:** Distribution of pre-treatment PGSI scores among PCGS service users

- **Mental health complexity**: Among PCGS service users who responded to questions on mental health (n=71), 75% reported a diagnosed mental health condition, most commonly depression (48%) and anxiety (42%). Similarly, 69% of SEL residents referral to GamCare reported anxiety and stress, and 47% depression or low mood. This highlights a high level of co-occurring mental health need among those reaching treatment.
- **Engagement with treatment:** Not all individuals referred to specialist services go on to complete treatment. Among SEL referrals to the National Gambling Clinic, 70% started treatment and only 40% completed it. Similar trends were seen in the PCGS data, reflecting the challenges of sustained engagement where needs are complex and circumstances unstable.

Taken together, these data show that specialist gambling treatment services predominantly reach people with more severe and complex presentations, reinforcing the gap between population-level gambling harm and those who successfully engage with treatment.

**Sources**: 78

# Affected others can access gambling treatment, but uptake remains limited relative to need

Affected others can access gambling treatment and support services, even where the person who gambles does not engage with services themselves. Support for affected others recognises that gambling-related harm is often relational and focuses on coping with stress and anxiety, managing financial and relationship impacts, and boundary-setting, rather than changing gambling behaviour directly.

- **Access within the gambling treatment system**: gambling treatment services accept referrals for affected others as well as people who gamble. Among SEL referrals to the National Gambling Clinic, around 7% were affected others (13 of 182), and across NHS-commissioned treatment delivered by providers such as GamCare, affected others accounted for around 12% of accepted referrals within SEL.
- **Demand compared with observed usage**: Evidence from the GambleAware Treatment & Support Survey (2024) indicates that affected others are more likely to report need for treatment or counselling than is reflected in observed use of specialist gambling treatment services, suggesting that demand for affected-other treatment exceeds current levels of engagement within the treatment system.
- **Demographic profile of affected others accessing treatment and support**: The same survey shows that affected others are more likely to be women and younger adults, with 10% of those aged 18–34 and 9% of those aged 35–54 reporting being affected by someone else's gambling, compared with 6% of those aged 55+. Despite this, affected-other treatment usage remains comparatively low across the system.
- **Distinct focus of treatment:** Treatment and counselling for affected others typically address stress and anxiety, relationship breakdown, financial impacts and boundary-setting, rather than gambling behaviour itself. Access does not depend on the person who gambles entering treatment.

Overall, while affected others are eligible for NHS-commissioned gambling treatment and counselling, they remain less visible within tertiary-prevention services than demand data would suggest.

**Sources**: 48, 77, 78, 79

# Section 8: Recommendations

# Primary prevention: reducing exposure and preventing gambling-harm before it occurs

| Priority area | Initial recommendations |
|---|---|
| **Strengthen prevention leadership** | 1. **Establish coordinated, system-wide governance for gambling harm across SEL**. Align action across public health, licensing, planning, the NHS and VCSE partners. |
| **Challenge normalisation and stigma** | 2. **Deliver visible, council-led awareness and prevention activity** to raise awareness, challenge normalisation, and tackle stigma.<br>3. **Reduce exposure to gambling advertising** and incentives (e.g. by limiting advertising on local authority estates)<br>4. **Support national efforts to strengthen regulation of gambling marketing** (e.g. via CEGA). |
| **Protect groups at highest risk of harm** | 5. **Deliver targeted prevention work towards groups at highest risk of harm** through targeted awareness campaigns, community outreach, and embedding prevention messaging within services most likely to interact with these groups. This includes, but is not limited to, children and young people, people experiencing mental ill-health or addiction, veterans, people living in the most deprived areas, and those in contact with the criminal justice system.<br>6. **Embed gambling-harm within key local strategies and policies** (e.g. suicide prevention, community safety, and safeguarding). |
| **Embed lived experience** | 7. **Develop meaningful, supported ways to involve people with lived experience (including affected others)** in shaping prevention activity: ensuring insights inform priorities, programme design, and decision making. |
| **Strengthen place-based regulation and control** | 8. **Strengthen the use of planning and licensing to limit the growth and impact of gambling premises**: support evidence-based refusals where possible and otherwise apply strong licence conditions, drawing on learning from other local authorities' successes.<br>9. **Strengthen the local evidence base on exposure, vulnerability, and lived experience** to support defensible decisions, promoting closer collaboration between licencing, planning, public health, community safety, and safeguarding teams.<br>10. **Support councillors involved in licencing decisions** to better understand gambling-related harm. |

# Secondary prevention: identifying harm early and strengthening support

| Priority area | Initial recommendations |
|---|---|
| **Strengthen workforce capability** | 11. **Build system wide capability through training, shared learning and practical tools:** work with VCSE partners and specialist services to ensure frontline staff across health, social care, housing, and community safety are confident in recognising and responding to gambling-related harm. |
| **Identify harm earlier and more consistently** | 12. **Embed routine, non-stigmatising enquiry within frontline services:** support brief interventions and improve how information is recorded and used to enable earlier action. |
| **Improve awareness and access to support** | 13. **Increase visibility of clear, accessible routes to support:** promote local and national services, self-referral pathways, self-exclusion tools, and peer support offers. |
| **Improve equity of access** | 14. **Address barriers for groups under-represented in support services:** use targeted outreach and engagement to reduce stigma and improve awareness among groups at higher risk of harm. |

# Tertiary prevention: improving access to specialist treatment

| Priority area | Initial recommendations |
|---|---|
| **Align treatment with local need** | 1. **Work with SEL ICB and system partners to ensure services reflect local priorities** and are integrated with mental health and wider support pathways. |
| **Plan for rising demand and diverse needs** | 2. **Strengthen system planning and intelligence to respond to increasing need:** improve data sharing, monitor demand and service use, and use local insight to inform joint planning.<br>3. **Work with treatment and support providers to ensure services meet diverse and complex needs:** support the development of flexible, inclusive pathways that respond to different patterns of need, including people with co-occurring needs. |

## Recommendation Delivery & Next Steps:

This JSNA provides an initial, data-driven assessment of gambling harms across SEL, forming the first phase of work in understanding local need. These recommendations set out a shared strategic framework for preventing and reducing gambling-related harm across SEL. Delivery will require coordinated action and shared ownership across multiple partners, including multiple departments within local authorities and the NHS.

A detailed, multi-agency action plan will be developed to support implementation, setting out specific actions, lead responsibilities and timescales, informed by local need and capacity within each borough. This will be complemented by a second phase of in-depth qualitative engagement with residents and frontline professionals to deepen understanding of lived experience and service needs.

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# Appendices

# Appendix 1: estimates of the number of people within each PGSI group, by local authority

**Methodology**: Small area estimation has been used to generate estimates of the number of adults (aged 18yrs+) within each PGSI group within each SEL borough. This draws on combined data from year 1 (2024) and year 2 (2025) of the Gambling Survey for Great Britain, and takes into account local demographics such as population size, education levels, deprivation, health, crime, urban/ rural classification and the number and type of gambling or betting premises.

**Table 3**: The estimated number of adults (18yrs+) in each PGSI group, by local authority. The table contains the estimate and accompanying upper and lower bounds.

| Area | PGSI 0 | PGSI 1-2 | PGSI 3-7 | PGSI 8-27 |
|---|---|---|---|---|
| **Bexley** | 174,192 (169,743 to 178,103) | 14,152 (11,249 to 17,451) | 5,688 (3,905 to 8,033) | 3,678 (2,223 to 5,674) |
| **Bromley** | 232,898 (227,396 to 237,699) | 18,161 (14,474 to 22,356) | 6,703 (4,602 to 9,480) | 4,100 (2,455 to 6,378) |
| **Greenwich** | 199,306 (192,775 to 205,160) | 18,777 (14,816 to 23,258) | 9,113 (6,245 to 12,837) | 7,008 (4,327 to 10,589) |
| **Lambeth** | 224,211 (216,552 to 231,080) | 22,340 (17,652 to 27,626) | 10,804 (7,413 to 15,206) | 8,110 (4,963 to 12,329) |
| **Lewisham** | 201,644 (194,654 to 207,943) | 19,611 (15,440 to 24,319) | 10,051 (6,891 to 14,141) | 7,897 (4,901 to 11,857) |
| **Southwark** | 218,670 (211,070 to 225,494) | 21,516 (16,926 to 26,703) | 10,710 (7,323 to 15,107) | 8,263 (5,072 to 12,526) |
| **London** | 174,192 (169,743 to 178,103) | 14,152 (11,249 to 17,451) | 5,688 (3,905 to 8,033) | 3,678 (2,223 to 5,674) |
| **England** | 232,898 (227,396 to 237,699) | 18,161 (14,474 to 22,356) | 6,703 (4,602 to 9,480) | 4,100 (2,455 to 6,378) |

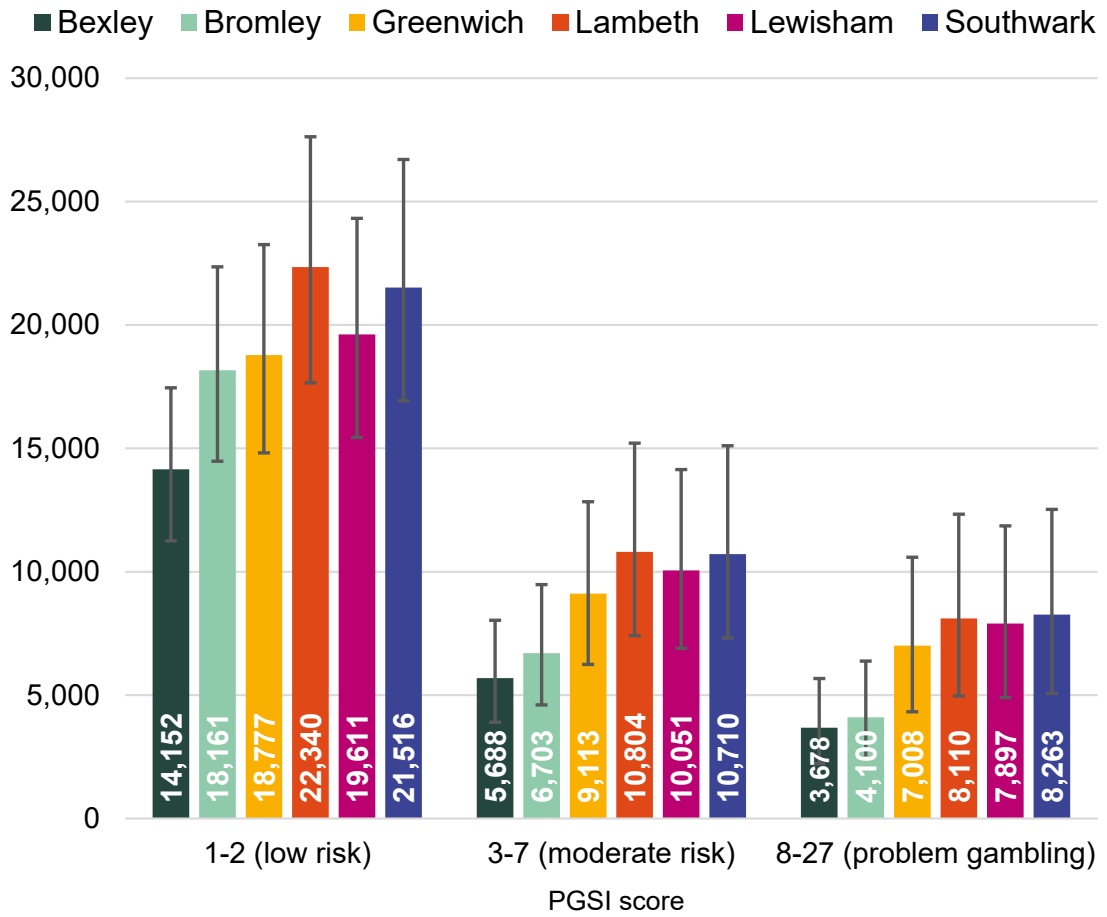


**Figure 40**: Estimated number of adults in each PGSI group, by local authority

**Sources**: 21

# Appendix 2: estimates of the proportion of people within each PGSI group, by local authority

**Methodology**: Small area estimation has been used to generate estimates of the proportion of adults (aged 18yrs+) within each PGSI group within each SEL borough. This draws on combined data from year 1 (2024) and year 2 (2025) of the Gambling Survey for Great Britain, and takes into account local demographics such as population size, education levels, deprivation, health, crime, urban/ rural classification and the number and type of gambling or betting premises.

**Table 4**: The proportion of adults (18yrs+) in each PGSI group, by local authority (and national and regional comparators). The table contains the estimate and accompanying upper and lower bounds, each expressed as percentages.

| Area | PGSI 0 | PGSI 1-2 | PGSI 3-7 | PGSI 8-27 |
|---|---|---|---|---|
| **Bexley** | 88.1% (85.9% to 90.1%) | 7.2% (5.7% to 8.8%) | 2.9% (2.0% to 4.1%) | 1.9% (1.1% to 2.9%) |
| **Bromley** | 88.9% (86.8% to 90.8%) | 6.9% (5.5% to 8.5%) | 2.6% (1.8% to 3.6%) | 1.9% (0.9% to 2.4%) |
| **Greenwich** | 85.1% (82.3% to 87.6%) | 8.0% (6.3% to 9.9%) | 3.9% (2.7% to 5.5%) | 1.9% (1.8% to 4.5%) |
| **Lambeth** | 84.5% (81.6% to 87.0%) | 8.4% (6.6% to 10.4%) | 4.1% (2.8% to 5.7%) | 1.9% (1.9% to 4.6%) |
| **Lewisham** | 84.3% (81.4% to 86.9%) | 8.2% (6.5% to 10.2%) | 4.2% (2.9% to 5.9%) | 1.9% (2.0% to 5.0%) |
| **Southwark** | 84.4% (81.4% to 87.0%) | 8.3% (6.5% to 10.3%) | 4.1% (2.8% to 5.8%) | 1.9% (2.0% to 4.8%) |
| **London** | 85.6% (83.9% to 87.1%) | 7.8% (6.8% to 9.0%) | 3.6% (2.9% to 4.6%) | 2.9% (2.2% to 3.9%) |
| **England** | 85.3% (84.8% to 85.9%) | 8.6% (8.2% to 9.1%) | 3.4% (3.1% to 3.6%) | 2.7% (2.4% to 3.0%) |

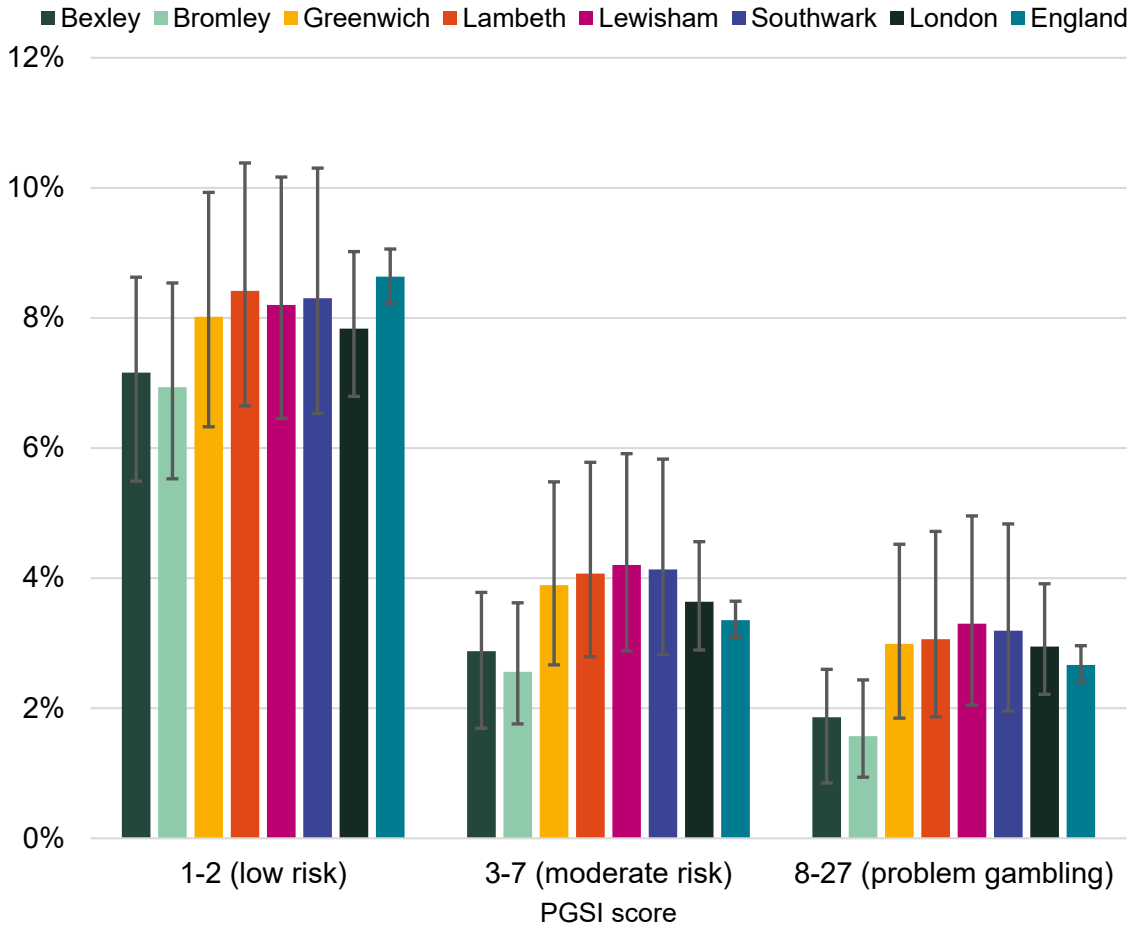


**Figure 41**: The proportion of adults within each PGSI group, by local authority (and regional and national comparators), with error bounds

**Sources**: 21

# Appendix 3: Summary of Gambling/ Betting Shop Planning Restrictions by Local Authority

| Local plan | Summary of restrictions applying to gambling/ betting premises |
|---|---|
| Bexley | • Betting shops require a desktop Health Impact Assessment<br>• Development proposals for betting office/ shops, pay day loan shops, pawn brokers and takeaways are subject to clustering limits, depending on where they are located. In town and neighbourhood centres, proposals must avoid two or more adjoining units of these premises and have no more than 10% of units with these uses collectively across the centre. In small parades the proposed development must not be considered to be of harm to viability, vitality, or wellbeing across the parade. |
| Bromley | • No reference to gambling premises or betting shops. |
| Greenwich | • When determining applications for new betting shops within protected retail frontages, consideration will be given to the number of existing betting shops in the centre and the need to avoid over-concentration and saturation of this particular type of use. Applications for non-retail uses in areas of designated retail frontage that would increase the likelihood of anti-social behaviour or the fear of crime will be resisted. |
| Lambeth | Applications for betting shops will not be permitted:<br>• in district centres, other than West Norwood, where this would lead to an over concentration, defined as being more than three betting shops or more than 1 in 10 consecutive premises; or<br>• in local centres where this would lead to an over concentration defined as being more than one betting shop per centre; or<br>• where it would lead to an increased perception or likelihood of reduced vitality and commercial viability in the area; or<br>• Where, because of its nature and its location, it is likely to give rise to anti-social behaviour and disturbance to local residents and users of the town centre and a risk to the level of crime. |
| Lewisham | • Development proposals for betting shops must submit a desktop Health Impact Assessment<br>• Development proposals must not result in a harmful over-concentration of betting shops. This is assessed on the basis of similar uses within 400m, the viability and vitality of the town centre, and the character of the area, including the impact of anti-social behaviour and public safety.. |
| Southwark | Development of betting shops, pay loan shops and pawnbrokers must:<br>• Be located within a protected shopping frontage; and<br>• Not exceed more than 5% of the total number of betting shops, pay day loan shops and pawnbrokers within the protected shopping frontage; and<br>• Be at least 10 premises away from other premises of the same use. |

# Appendix 4a: estimating the economic impact of gambling-related harms in South East London (part 1)

The Office for Health Improvement and Disparities (OHID) estimates the economic burden of gambling-related harm using a cost-of-illness approach, combining direct costs to government (e.g. homelessness, unemployment, criminal justice) with the wider societal value of health impacts such as suicide and depression. This model estimates the "excess cost" associated with gambling, defined as the difference between outcomes observed among people experiencing harmful gambling and those expected if outcomes matched the wider population.

For this analysis, national cost estimates for England have been applied to South East London based on the relative size of the adult (16+) population in each local authority (using mid-year estimates from 2023). This provides an indicative estimate of local economic impact.

**Limitations**: this approach assumes that gambling-related harm is distributed in proportion to population size. It does not account for differences in demographic or socioeconomic profiles, variations in gambling behaviour or risk across areas, or the full range of harms (many of which are not represented in the OHID model). Estimates should be interpreted as indicative only, showing the scale of economic impact, rather than precise values.

**Table 5**: Estimated excess costs of gambling-related harms in England in 2023, Office for Health Improvement & Disparities

| Type of harm | Sub-domain | Cohort | Government (or direct costs) (£million) | Wider societal (or intangible) costs (£million) | All Costs - England (£million) |
|---|---|---|---|---|---|
| Financial | Statutory homelessness | Adults | £49.0 | N/A | £49.0 |
| *Health* | *Deaths from suicide* | *Adults* | *N/A* | *£241.1 to £961.7* | *£241.1 to £961.7* |
| *Health* | *Depression* | *Adults* | *£114.2* | *£393.8* | *£508.0* |
| *Health* | *Alcohol dependence* | *Adults* | *£3.5* | *N/A* | *£3.5* |
| *Health* | *Illicit drug use* | *17 to 24yr olds* | *£1.8* | *N/A* | *£1.8* |
| Total health harms | All health sub-domains | All health cohorts | £119.5 | £635.0 to £1,355.5 | £754.4 to £1,475.0 |
| Employment and education | Unemployment benefits | Adults | £77.0 | N/A | £77.0 |
| Criminal activity | Imprisonment | Adults | £167.3 | N/A | £167.3 |
| **Excess cost (£ millions)** | **All sub-domains** | **All cohorts** | **£412.9** | **£635.0 to £1,355.5** | **£1,047.8 to £1,768.4** |

**Source**: 32

# Appendix 4b: estimating the economic impact of gambling-related harms in South East London (part 2)

**Table 6**: Estimated excess costs of gambling-related harms in South East London in 2023 prices, by local authority. Based on the proportion of costs for England, based on relative adult (16+) population size.

| Type of harm | Sub-domain | Bexley | Bromley | Greenwich | Lambeth | Lewisham | Southwark | SEL |
|---|---|---|---|---|---|---|---|---|
| **Financial** | Statutory homelessness | £160,572.2 | £214,494 | £189,955 | £217,191 | £195,858 | £213,648 | £1,191,718 |
| *Health* | *Deaths from suicide* | *£790,081 to £3,151,476* | *£1,055,397 to £4,209,770* | *£934,658 to £3,728,167* | *£1,068,670 to £4,262,710* | *£963,699 to £3,844,004* | *£1,051,233 to £4,193,160* | *£5,863,738 to £23,389,287* |
| *Health* | *Depression* | *£1,664,708.1* | *£2,223,732* | *£1,969,334* | *£2,251,697* | *£2,030,523* | *£2,214,958* | *£12,354,953* |
| *Health* | *Alcohol dependence* | *£11,469.4* | *£15,321* | *£13,568* | *£15,514* | *£13,990* | *£15,261* | *£85,123* |
| *Health* | *Illicit drug use* | *£5,898.6* | *£7,879* | *£6,978* | *£7,978* | *£7,195* | *£7,848* | *£43,777* |
| **Total health harms** | All health sub-domains | £2,472,157 to £4,833,522 | £3,302,329 to £6,456,702 | £2,924,539 to £5,718,047 | £3,343,858 to £6,537,899 | £3,015,407 to £5,895,712 | £3,289,300 to £6,431,228 | £18,347,591 to £35,873,140 |
| **Employment and education** | Unemployment benefits | £252,327.8 | £337,062 | £298,501 | £341,301 | £307,776 | £335,732 | £1,872,700 |
| **Criminal activity** | Imprisonment | £548,239.5 | £732,343 | £648,562 | £741,553 | £668,714 | £729,454 | £4,068,865 |
| **Total excess cost** | **All sub-domains** | **£3,433,297 to £5,794,629** | **£4,586,228 to £7,740,601** | **£4,061,558 to £6,855,066** | **£4,643,903 to £7,837,944** | **£4,187,754 to £7,069,059** | **£4,568,134 to £7,710,061** | **£25,480,874 o £43,006,423** |

**Source**: 32, 51