

GAMBLING COMMISSION

Gambling-related harm as a public health issue

Briefing paper for Local Authorities and local Public Health providers (England and Wales only) October 2017

1 Introduction and background

- 1.1 This paper sets out the Gambling Commission's position on why gambling-related harm should be considered as a public health issue, and makes recommendations for how this agenda could be advanced at a local level.
- 1.2 The Gambling Commission (the Commission) is an independent non-departmental public body (NDPB) sponsored by the Department for Digital, Culture, Media and Sport (DCMS). It was set up under the Gambling Act 2005 (the Act) to regulate commercial gambling in Great Britain in partnership with licensing authorities (LAs). It also regulates the National Lottery under the National Lottery Act 1993. The Commission permits gambling in so far as it thinks it is reasonably consistent with the three licensing objectives:
- preventing gambling from being a source of crime or disorder, being associated with crime or disorder, or being used to support crime
 - ensuring that gambling is conducted in a fair and open way
 - protecting children and other vulnerable persons from being harmed or exploited by gambling.
- 1.3 The Commission has a statutory duty to advise the Secretary of State on gambling matters, which includes providing advice on the incidence and effects of gambling. We work closely with the Responsible Gambling Strategy Board¹ (RGSB), our independent advisers who are responsible for developing a National Responsible Gambling Strategy,² and setting the priorities for research, education and treatment to minimise gambling-related harm. We also work closely with GambleAware,³ the independent charity which raises funds from the gambling industry and commission's research, education and prevention, and treatment services in Great Britain, in line with National Responsible Gambling Strategy.

Summary recommendations

- **Local public health teams recognise gambling-related harm as a public health issue and its relevance in assessing risk to the wellbeing of their communities**
- **Public health engages strategically to inform the work of their licensing authorities and in particular the review of the gambling Statement of Principles and the local area profile**
- **Awareness of gambling problems and their symptoms is raised with front line health professionals and other agencies where problem gamblers may present themselves eg debt advice**
- **Develop pathways to accredited agencies for gambling support services**
- **Given multiple and interrelated areas of interest public health works with Safeguarding Boards (young and vulnerable) to maximise effective delivery**

¹ <http://www.rgsb.org.uk>

² [National Responsible Gambling Strategy 2016-2019](#), RGSB, April 2016

³ <https://about.gambleaware.org/>

2 Gambling-related harm as public health issue

- 2.1** When the new National Responsible Gambling Strategy was published in April 2016, it set out as one of its objectives and priority actions, the acceptance by a wider range of organisations in the public and private sectors (including those with a remit for public health) of their responsibility to help address gambling-related harm, and to use their expertise and resources to work co-operatively in addressing them. To further support this priority, RGSB published a position paper⁴ in December 2016 on gambling-related harm as a public health issue and we and RGSB have been undertaking a series of stakeholder conversations to raise the profile of the issue.
- 2.2** Gambling-related harms are often not recognised and in our view require greater attention. A public health approach aims to understand all the harms and benefits of an activity to society. The legislative framework for gambling recognises it as a legitimate leisure activity that many people enjoy. It generates income, employment and tax revenue. Set against this, it also generates significant dis-benefits such as working days lost through disordered gambling, or the cost of treatment for ill-health caused by stress related to gambling debt. Less easily measured are potentially very significant impacts such as the negative effects of some gambling on family relationships, and the psychological and social development of children. Similarly, there might be some indirect benefits, including positive social impacts when happy gamblers make a greater contribution to societal well-being than they would in the absence of gambling. Much less is known of these effects.
- 2.3** A public health approach to gambling needs to address its effects on young and vulnerable people. Children and young people are a specific focus among those potentially vulnerable. Their needs are different and they may need different approaches to reducing gambling-related harm. Primary prevention efforts can be targeted at young people, often aiming to reach them before they have gambled. Treatment for young people with gambling problems needs separate consideration to adult treatment. In most cases it is likely to require lower-threshold intervention and to address other, co-occurring problematic behaviours.
- 2.4** A public health approach also needs to address the effects of gambling on the families and close associates of gamblers, and on the wider community – as well as on those who suffer harm from their own gambling. It needs to recognise that a successful strategy cannot focus solely on individual gamblers but also needs to encompass products, environments and marketing and the wider context in which gambling occurs. It needs to understand that restrictions on, or interventions related to, any of these aspects can form part of a balanced approach, backed up by accurate, objective, accessible and understandable information. It should seek to ensure efficient distribution of resources for prevention and treatment based upon need.
- 2.5** In our view, where there is potential for risk to the whole population, not just to those who are directly involved, there is a duty upon Government and its agencies to be vigilant and minimise the effects through a public health approach.
- 2.6** However research now exists which gives a clearer picture of those who are likely to be more vulnerable to gambling harm⁵. Amongst the groups where the evidence base for vulnerability is strongest are the following:
- ethnic groups
 - youth
 - low IQ
 - substance abuse/misuse
 - poor mental health.

⁴ [Gambling-related harm as a public health issue](#), RGSB, December 2016

⁵ <https://www.geofutures.com/research-2/gambling-related-harm-how-local-space-shapes-our-understanding-of-risk/>

2.7 The Commission and RGSB have had positive conversations on this topic in Scotland and Wales. We have also seen the launch of new research to explore the public health impact of gambling throughout Wales led by Professor Robert Rogers of Bangor University, Dr Heather Wardle, and Dr Simon Dymond, Professor of Psychology at Swansea University. They will be working closely with Public Health Wales. The Scottish Public Health Network (ScotPHN), which is hosted by NHS Health Scotland has also identified gambling as one of its priority projects and has undertaken a literature review⁶ and published a scoping study⁷ on what public health in Scotland should do to address the issue.

3 The scale of the problem

- 3.1** Gambling is a legitimate leisure activity enjoyed by many and the majority of those who gamble appear to do so with enjoyment, and without exhibiting any signs of problematic behaviour. There are however some individuals who do experience significant harm as a result of their gambling. It is estimated that there are around 373,000⁸ problem gamblers⁹ in England and around 27,000 in Wales^{10,11}. These estimates are likely to be conservative as the surveys do not include certain population groups more likely to be more vulnerable to harm.¹² (In comparison we know that research by the National Treatment Agency for Substance Misuse estimates that, for the year 2011/12, there were around 293,000 opiate and/or crack cocaine users in England.¹³) For these problem gamblers, harm can include higher levels of physical and mental illness, debt problems, relationship breakdown and, in some cases, criminality. It can also be associated with substance misuse. In many cases, it is difficult to attribute these negative effects solely or directly to gambling. But the association is too strong to ignore. Younger males, and people from certain social and ethnic groups, are potentially more vulnerable than others.
- 3.2** A recent survey¹⁴ conducted by YouthSight on behalf of the Commission discovered that two thirds of students gambled in the last month and 54% of those do so to make money. A quarter of students gambled more than they could afford and 4% are in debt because of gambling.
- 3.3** Around 1.7 million¹⁵ individuals in England and around 95,000 individuals in Wales are classified as being at-risk¹⁶ of problem gambling. There are also some gamblers who would not be classified as problem or at-risk gamblers but who may on occasion experience harm as a result of their gambling (just as not all problem gamblers will necessarily experience harm every time they play). Gambling-related harms are not all directly health harms, but many of the harms – such as debt – are connected with poor health status.
- 3.4** However, it is important to remember that simply counting the number of problem gamblers is likely to underestimate the true extent of gambling-related harm. There can be considerable negative effects experienced by the wider group of people around a gambler. The health and wellbeing of partners, children, and friends can all be negatively affected. Harm can also extend to employers, communities and the economy. The numbers of those

⁶ [Gambling Related Harm: A review of the scope for population health intervention](#), ScotPHN, June 2014

⁷ [Toward a public health approach for gambling related harm: a scoping document](#), ScotPHN, August 2016

⁸ Data from the 2015 Health Survey for England.

⁹ A problem gambler is defined as meeting at least three of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria, and eight or more of the Problem Gambling Severity Index (PGSI) items used in the Health Survey.

¹⁰ Data from the 2015 Health Survey for Scotland and the Gambling Commission's Welsh Problem Gambling Survey.

¹¹ <http://live-gamble.com.cloud.contensis.com/PDF/survey-data/Participation-in-gambling-and-rates-of-problem-gambling-Wales-headline-report.pdf>

¹² For example, students living in halls of residence, homeless people, armed forces personnel and those in prison.

¹³ [Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 Summary Report](#), Centre for Public Health, Liverpool John Moores University

¹⁴ <http://www.gamblingcommission.gov.uk/news-action-and-statistics/news/2017/Commission-raises-awareness-of-potential-risks-for-students-who-gamble.aspx>

¹⁵ Data from the 2015 Health Survey for England.

¹⁶ At-risk gambling is measured using the Problem Gambling Severity Index (PGSI). This identifies people who have experienced some difficulty with their gambling behaviour but who are not classified as problem gamblers. Two groups are identified: gamblers at 'low risk' of harm (a PGSI score of 1-2) and gamblers at 'moderate risk' of harm (a PGSI score of 3-7).

who experience harm as a result of gambling by others will be considerably greater than the number of people who harm themselves.

3.5 These are not small numbers. They suggest a significant public health issue which has received remarkably little attention relative to other population level concerns.

3.6 The Commission is working with of a number of LAs such as Brighton and Hove City Council¹⁷ who is progressing work with their public health colleagues regarding the mapping of those at risk of gambling harm. In a recent report on problem gambling for Leeds City Council¹⁸ the research identified the following:

With a few exceptions, and unlike other areas of advice and guidance in Leeds, these services (generic advisory services such as Citizens Advice Leeds, voluntary and charitable agencies, specialist addictions and recovery services) are not well joined up for problem and at risk gamblers. Potential cross-referral pathways are patchy and informal and held back by a lack of understanding about who does what and may suffer capacity constraints. In both the generic and specialist addiction services, there is an almost total lack of any assessment or screening for gambling related harm and this misses opportunity for early (or any) diagnosis of specialist.

Whilst one cannot generalise from this study it would be surprising if similar issues do not exist elsewhere.

Gambling as a co-morbidity

3.7 In some cases, problem gambling can be co-morbid with other conditions such as mental health problems or substance misuse. It is often not recognised and/or undiagnosed. Data from the 2012 Health Survey for England^{19,20} on problem gambling as a co-morbidity shows that:

- For male gamblers, alcohol consumption is heavier in those classified as problem or at-risk gamblers with 17% drinking over 35 units versus 11% of male non-problem or non-at-risk gamblers.
- Problem gamblers are more likely to be smokers (33% versus 20% for non-problem or non-gamblers) and they are also more likely to be heavy smokers²¹ (11% for problem gamblers versus 4% for non-problem or non-gamblers).
- For self-reported anxiety and/or depression; 47% of problem gamblers said they are moderately or severely anxious or depressed versus 20% of non-problem or non-gamblers.
- For diagnosed disorders 11% of problem gamblers have a diagnosed mental health disorder versus 5% of non-problem or non-gamblers.

3.8 Research²² commissioned by the Commission in 2009 provides a helpful description of gambling as a co-morbidity:

Gambling has not been traditionally viewed as a public health matter (Korn, 2000; Griffiths, 2004). However, the social and health costs of problem gambling can be large on both individuals and society more generally. Personal costs can include irritability, extreme moodiness, problems with personal relationships (including divorce), absenteeism from work, family neglect, and bankruptcy (Griffiths, 2007). Problem gambling often occurs concurrently with other behavioural and psychological disorders, which can exacerbate, or be exacerbated by, problem gambling (Griffiths, 2007). Adult

¹⁷ <http://www.gamblingcommission.gov.uk/PDF/LA-bulletin/Licensing-authority-bulletin-March-2017.pdf> (pg4)

¹⁸ <http://www.leeds.gov.uk/docs/Problem%20Gambling%20Report.pdf>

¹⁹ We intend to run this analysis again on the 2015 Health Survey for England once the dataset has been archived.

²⁰ The survey does not include data for Wales.

²¹ Heavy smokers are defined as those that smoke more than 20 cigarettes a day.

²² [Gambling, alcohol consumption, cigarette smoking and health: Findings from the 2007 British Gambling Prevalence Survey](#), March 2009

problem gamblers also have increased rates of attention-deficit hyperactivity disorder (ADHD), substance abuse or dependence, antisocial, narcissistic, and borderline personality disorders (American Psychiatric Association, 1994; Griffiths, 2007). There is also some evidence that cross-addictions may differ among demographic subgroups and gambling types (Griffiths, 1994a). For instance, young male slot machine gamblers are more likely to abuse solvents (Griffiths, 1994b).

Previous research has shown a link between gambling and alcohol, nicotine smoking and/or drug use. For example, alcohol can be used as a way of coping with depression and/or anxiety caused by gambling problems, and, conversely, alcohol may trigger gambling desire (Griffiths, Parke & Wood, 2002). Many studies have reported such links in both adults (eg Ramirez, McCormick, Russo & Taber, 1984; Ciarrocchi & Richardson, 1989; Lesieur, Blume & Zoppa, 1986) and adolescents (eg Griffiths & Sutherland, 1998; Wood, Gupta, Derevensky & Griffiths, 2004). More recently, Petry, Stinson and Grant (2005) reported that just under two-thirds of problem gamblers had a nicotine dependence (60%), approximately three-quarters had an alcohol use disorder (73%), and that just over a third had a drug use disorder (38%) el-Guebaly, Patten, Currie, et al (2006) examined psychiatric co-morbidities associated with problem gambling and reported that those with a substance use disorder were three times more likely to be problem gamblers.

Individuals with other disorders may also be prone to a wide variety of medical consequences including stress-related physical illnesses including insomnia, hypertension, heart disease, stomach problems (eg peptic ulcer disease) and migraine (Daghestani, Elenz & Crayton, 1996; Griffiths, Scarfe & Bellringer, 1999; Griffiths, 2004). Problem gambling may also result in health-related problems from withdrawal effects. For instance, Rosenthal and Lesieur (1992) found that at least 65% of problem gamblers reported at least one physical side-effect during withdrawal including insomnia, headaches, upset stomach, loss of appetite, physical weakness, heart racing, muscle aches, breathing difficulty and/or chills. When comparing the withdrawal effects with a substance-dependent control group, they concluded that problem gamblers experienced more physical withdrawal effects when attempting to stop than the control group.

4 The cost to the public purse of problem gambling in Great Britain

- 4.1** In December 2016 the Institute for Public Policy Research (IPPR) published research, funded by GambleAware, on the cost of gambling-related harm to Great Britain. The report²³, estimated that the direct cost of problem gamblers to the public purse was between £260 million and £1.2 billion per year. The report is the first attempt to provide an estimate of this kind and is subject to a number of limitations. The estimates are wide, the availability of relevant data was limited, and it only captures the fiscal impact, and not more personal or social costs. Work is in hand to try to estimate the wider costs and benefits (see next section).
- 4.2** The research highlights which parts of Government absorb the worst of the costs of gambling-related harm, set out in the table below:

Department/Interaction	Cost range for England only (range low to high)	Cost range Great Britain (range low to high)
Health:		
• Hospital inpatient services	£110 million-£290 million	£140 million-£610 million
• Mental health primary care	£10 million-£20 million	£10 million-£40 million
• Secondary mental	£20 million-£50 million	£30 million-£110 million

²³ [Cards on the table: The cost to government associated with people who are problem gamblers in Britain](#), IPPR, December 2016

health services		
Welfare and employment: • JSA claimant costs and lost labour tax receipts	£30 million-£80 million	£40 million-£160 million
Housing: • Statutory homelessness applications	£10 million-£30 million	£10 million-£60 million
Criminal justice: • Incarcerations	£30 million-£90 million	£40 million-£190 million

5 Gaps in the evidence

5.1 The absence of clearly documented evidence of actual harm, systematically collected, aggregated and reported, has made it difficult to persuade relevant agencies that gambling-related harm is an area to which they should commit more of their scarce resources. Part of the issue is that despite the large numbers of problem and ‘at risk’ gamblers, and the even larger numbers of people who are affected by gambling indirectly, the connection between gambling-related harm and resource pressures on the NHS is not as obvious as in the case of alcohol or drug-related harm or obesity. As a result, funding for epidemiological research is very limited.

Measuring gambling-related harm

5.2 That is why the National Responsible Gambling Strategy recommended research to define, measure and monitor levels of gambling-related harm, and demonstrate its impact. The aim is to understand more about the types of harm people experience from their gambling, and the gambling of those close to them.

5.3 Research is under way, commissioned by GambleAware and overseen by RGSB. A first phase has been carried out to describe the nature and characteristics of gambling-related harm and how to go about quantifying, measuring and monitoring the types of harms identified. This first phase included an assessment of a conceptual framework for measuring harm²⁴ which was developed by Erika Langham and colleagues at Central Queensland University. This framework includes seven ‘domains of harm’ around which indicators and metrics could be developed:

1. Financial harms
2. Relationship disruption, conflict or breakdown
3. Emotional or psychological distress
4. Decrements to health
5. Cultural harm
6. Reduced performance at work or study
7. Criminal activity

5.4 The next phase of research will focus on validating the framework proposed by Langham et al and identifying suitable metrics and indicators to measure harm. A different set of metrics will be needed for children and young people who experience harm differently, for example through bullying or school exclusion. We do not underestimate the difficulties in defining and assessing the extent of gambling-related harm. The work is likely to face considerable challenges, not least the attribution of identified harm to gambling rather than other factors and persuading other agencies to collect new data or share what they have already.

²⁴ [Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms](#), Langham et al, 2016

The effect of marketing and advertising on children, young people and vulnerable people

- 5.5** One of the most vulnerable groups in our society, and potentially the ones with most to lose, are children and young people. An increase in the volume of gambling marketing and advertising, combined with advances in technology offering new opportunities for promotion, has exacerbated concerns about the effect of marketing and advertising, particularly on children, young people and other vulnerable people. That is why the RGSB Research Programme²⁵ has identified as a high priority, new research (currently out to tender by GambleAware) into the content and tone of gambling marketing and advertising and its effect on behaviour and perceptions of gambling. A key focus of this work will be to explore the influence of gambling marketing and advertising on children and young people between 11 and 18 years of age, and on young adults (those aged between 18 and 24 years of age), who have recently become permitted to gamble and who are a key target market for gambling operators.
- 5.6** From a public health perspective we do not know enough about the effects of a normalised attitude to gambling on the development and wellbeing of children and young people.

6 Current treatment provision

- 6.1** The majority of treatment for those affected by gambling-related harm in Britain is funded via GambleAware and currently consists of three main services offering psychosocial interventions ranging from brief information and advice, through counselling and Cognitive Behavioural Therapy (CBT), psychiatric care and residential treatment. The largest of the funded providers is GamCare, which operates the National Gambling Helpline and a partner network of 15 treatment organisations across Great Britain providing counselling. The Gordon Moody Association offers 12 week residential care at centres in Dudley, West Midlands, and Beckenham, Kent. The National Problem Gambling Clinic, based within the Addictions Service at Central North West London NHS Trust, offers CBT and psychiatric care and is also largely funded by GambleAware. The absence of any other dedicated NHS provision is striking.
- 6.2** GambleAware spent in the region of £4.8 million on treatment services in 2016-17 and the services it funds saw around 8,800 clients across Britain between them. Waiting lists at GambleAware funded treatment agencies are relatively short. But it is noteworthy that, for whatever reason, only a very small proportion of those adults who would be classified as problem gamblers access such treatment. Some may not recognise the need for change. Some are likely to recover naturally, possibly as the circumstances of their life change. Some may be attempting self-help, for example through attending meetings of Gamblers Anonymous. Others will be receiving some form of intervention through the NHS, more usually directed at co-morbidities associated with problem gambling rather than at problem gambling itself. It is likely, however, that a significant number of those who would benefit from treatment are not receiving it, in any form.
- 6.3** The RGSB Research Programme includes a project which GambleAware will commission shortly on what we know about who is affected by gambling-related harm and who presents for treatment. This gap analysis will provide insight into unmet need, demand and service capacity, to enable strategic development of treatment and support, and in the longer-term, early intervention, prevention and education. It will include specific questions on the demand for, and availability of, treatment for young people. GambleAware is also piloting a common screening tool in five services which it hopes to be able to roll out more widely later in the autumn. The common screening tool is designed to be used by specialist and non-specialist providers to screen and triage those who may require treatment for their gambling.

²⁵ [Research Programme 2017-2019](#), RGSB, May 2017

7 Current prevention actions and approaches

- 7.1** Much less attention has been given to, and much less is spent on, the prevention of gambling-related harm. However, GambleAware is funding pilots of different approaches to prevention, including work in schools and other educational contexts to educate children about the risks of gambling and how these risks can be avoided. It is also funding projects that are addressing some groups thought to be especially vulnerable (such as professional sportspeople and the homeless), and projects to raise awareness of gambling-related harm among professionals working on related topics (for example debt counselling). There are also some prevention actions being carried out by the gambling industry itself – including a Responsible Gambling Week from 12-18 October 2017 – and GambleAware is helping with the evaluation of some of these.
- 7.2** In common with other areas of public health, while ‘prevention may be better than cure’ implementing effective prevention is difficult, not least because outcomes are tricky to measure. GambleAware, working within its evaluation framework is assessing all of its projects, and will build its prevention activities based on the evidence generated by these evaluations, as well as knowledge from other areas of public health prevention.
- 7.3** Children and young people are naturally a specific focus for prevention efforts because of their age, vulnerability and the fact that they are, as a group, able to be reached through school. But, given the many demands on schools, it has proved difficult to embed gambling-specific education in the curriculum. However, evidence suggests that educational approaches which develop young people’s generic skills for dealing with risky situations may be more effective than topic-specific interventions: gambling-related harm prevention could in this way be included in schools’ personal social and health education.
- 7.4** Targeting parents is also a potentially effective way of reaching young people. But evidence from other fields (and limited experience in the gambling field) has demonstrated how difficult it is to engage parents, especially those with children who are more vulnerable; and even if they can be engaged, difficult to convert this interest into simple action, such as having a conversation with their children about gambling. Nevertheless, there is scope for developing creative approaches to involving parents in gambling-related harm prevention.

8 Recommendations for local authority and public health engagement

- 8.1** That local public health teams recognise gambling-related harm as a public health issue and consider it as a key issue when assessing risk to the wellbeing of their communities.
- 8.2** Whilst public health is not listed as a responsible authority²⁶ under the Act, we consider that they can have an important strategic role in informing the way that licensing authorities²⁷ carry out their gambling responsibilities.
- 8.3** LAs are required to publish a Statement of Principles as a part of their duties under the Act. The next Statement is required to be published in January 2019. The current Guidance to Licensing Authorities (Sept 2015) encourages LAs to develop a local area profile²⁸.

²⁶ There is already scope for this as one of the responsible authorities listed is described as ‘an authority which has functions by virtue of an enactment in respect of minimizing or preventing the risk of pollution of the environment or of **harm to human health** in an area in which the premises are wholly or partly situated’ (s157 (g)).

²⁷ Knowsley Metropolitan Borough Council specify in their Statement of Principles for gambling the following ‘4.5 The Licensing Authority will consult the Director of Public Health on all premises licence applications’

²⁸ http://www.gamblingcommission.gov.uk/for-licensing-authorities/GLA/Part-6-Licensing-authority-policy-statement.aspx#DynamicJumpMenuManager_1_Anchor_6

*An effective local area profile is likely to take account of a **wide range** of factors, data and information held by the licensing authority and its partners. An important element of preparing the local area profile will be proactive engagement with responsible authorities as well as other organisations in the area that can give input to map local risks in their area. These are likely to include public health, mental health, housing, education, community welfare groups and safety partnerships, and organisations such as GamCare or equivalent local organisations.*

Good local area profiles will increase awareness of local risks and improved information sharing, to facilitate constructive engagement with licensees and a more coordinated response to local risks. The local area profile will help to inform specific risks that operators will need to address in their risk assessment.²⁹

- 8.4** Such a risk based approach helps in both ensuring that the LA targets inspection and enforcement activity where it is needed most but also ensures gambling operators have all the appropriate safeguards in place to protect those most at risk of gambling harm.
- 8.5** More specifically front line health professionals³⁰ and those working in other agencies where problem or at risk gamblers may present themselves such as debt advice centres and CABs should be trained to identify the signs of gambling issues. (For example Newport, South Wales CAB delivers training to their staff along these lines and Sheffield Safeguarding Board deliver training to gambling staff and others on the protection of young people.)
- 8.6** When encountering an individual with gambling related harm agencies have the knowledge in order for them to be referred to appropriate accredited agencies for help and support (eg the National Problem Gambling Helpline, GamCare or others financed by GambleAware).
- 8.7** At a strategic level, the Safeguarding Boards³¹ (or equivalent, for both young people and vulnerable people have a specific remit for the groups who are often at greatest risk of gambling harm. By working closely together, Safeguarding Boards and public health can deliver synergies and efficiencies in achieving enhanced protections for these two groups.
- 8.8** Given the range of co-morbidities (**3.6** above) it is highly likely that a percentage of those presenting with other conditions (eg. mental ill health and addictions) are also either experiencing or are vulnerable to gambling-related harm. However as the Leeds report identified (**3.5** above) they are not being screened for gambling-related harm and/or may not disclose underlying gambling problems. Engagement between safeguarding and public health can contribute to both agencies achieving wider strategic goals.

October 2017

Keeping gambling fair and safe for all

www.gamblingcommission.gov.uk

²⁹ Brighton - <http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Gambling-register-local-area-profiles-07042016.xlsx>

³⁰ <http://www.gamcare.org.uk/news/gamcare-raise-awareness-great-yarmouth>

³¹ One of the Responsible Authorities listed under the GA2005 is s157 (h) 'a body which is designated in writing for the purposes of this paragraph, by the licensing authority for an area in which the premises are wholly or partly situated, as competent to advise the authority about the protection of children from harm'