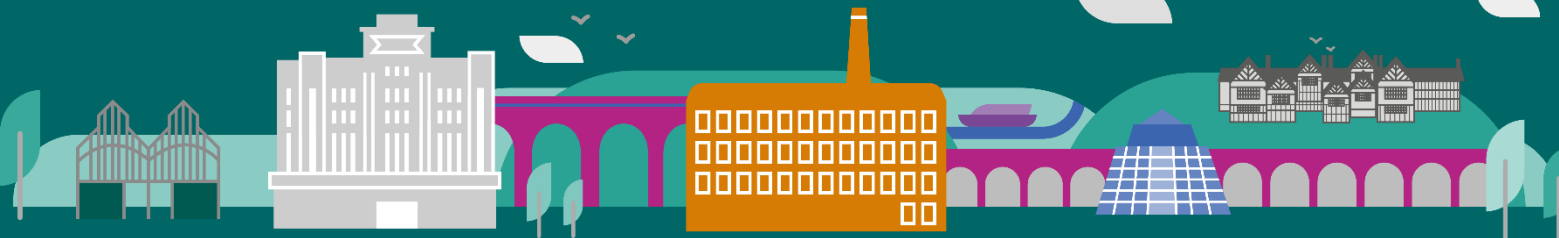




STOCKPORT
METROPOLITAN BOROUGH COUNCIL

Stockport Gambling Harms Needs Assessment 2026



Ambitious Stockport, creating opportunities for everyone

Contents

Glossary of terms.....	5
Executive Summary.....	6
Key Highlights.....	6
Summary in Numbers	7
Recommendations	8
Aim	9
Scope	9
Data / Method.....	9
Background	10
Context of gambling and public health	10
Language	11
Industry Influence	11
Types of gambling harm	12
National Picture	14
Gambling Participation	14
Gambling Harm	15
Industry Revenue	17
Groups at Risk of Harm	17
Public Health Interventions	18
Screening and Assessment	19
Regional Partners	19
Greater Manchester Combined Authority.....	19
Local context.....	20
Lived Experience Input.....	20
Wider determinants and inequalities in Stockport.....	20
Socioeconomic Deprivation.....	20
Age and Gender	22
Veterans.....	24
Ethnicity and Cultural Groups in Stockport.....	24
Homelessness.....	25

Gambling and Suicide	26
Existing policy and procedure	26
Stockport Council Workforce Policy	26
Suicide Prevention Policy.....	26
Stockport Licensing.....	27
Local planning	28
Stakeholder and Service Mapping	29
Current treatment and prevention providers	30
Adjacent Services.....	31
Primary Care.....	31
Cost of Living Advice	31
Housing.....	31
Schools	32
Drug and Alcohol Services	32
Crisis Lines and Suicide Prevention	33
Local Level of need	34
Prevalence Estimates of Harm.....	34
Prevalence Estimates of Treatment Need	36
Family Impact and Wider System Influence	39
Children and young people.....	40
Convergence of Gambling and Gaming.....	40
Costing estimation	41
Professionals Survey	42
Method	42
Results	42
Respondents	42
Awareness and Confidence	43
Screening and Conversations.....	44
Referral Pathways and Awareness of Services	45
Professional Needs and Perspectives	45
Northern Gambling Service Treatment Access	46

NGS referrals from Stockport by year	46
Referral Demographics	48
Referrals by Gender	48
Referrals by Age	48
Referrals by Ethnicity	49
Referrals by Sexual orientation	50
Referrals by Veteran Status	51
Referral measures of Wellbeing, Gambling and Life Disruption	51
Treatment Outcomes	52
Treatment Completion	52
Affected Others	52
Exposure and environment	53
Commercial Determinants of Health: Advertising, marketing and community messaging/framing	53
Links to sporting institutions in Stockport	54
Gambling Premises Mapping	54
Licensed Gambling Premises Across GMCA by Deprivation	55
Stockport Gambling Premises by Deprivation	57
Proximity to vulnerable populations - schools	58
Comparable data (GeoLytx supermarket data by IMD)	60
Online Gambling	62
Gambling Behaviours Classification	62
Online Gambling and Deprivation	63
People Gambling Online with High Frequency, High Stakes Loses	64
Betting and Gaming 5 (BG5):	64
Gaps	66
Links to wider Stockport strategy	66
Recommendations	67
References	71
Appendix A – Self exclusion information via ChapterOne and other interventions	78
Appendix B– Index of Multiple Deprivation 2025 Indicators	80

Appendix C- Excess death calculations	81
Appendix D - Stakeholder Mapping Results	83
Appendix E – Affected Other Estimations	88
Appendix F – GM Premises by Deprivation	89
Appendix G – Additional Online Gambling Figures	90
B2:	90
BG4:.....	91

Authors:

Dr. Jon H. Sissons

Contributors:

James Grimes, Fallon Slater, Dr. Beenish Hanif

Glossary of terms

ADPH – Association of Directors of Public Health

EBE – Experts by experience (lived experience)

DHSC – Department of Health and Social Care

GMCA – Greater Manchester Combined Authority

GSGB – Gambling Survey for Great Britain

IMD – Index of Multiple Deprivation

LSOA – Lower Level Super Output Area

NICE – National Institute of Health and Care Excellence

NGS – NHS Northern Gambling Service

OHID – Office for Health Improvement and Disparities

PGSI – Problem Gambling Severity Index

SDAS – Stockport Drug and Alcohol Service

START – Stockport Triage Assessment and Referral Team

Executive Summary

Key Highlights

A comprehensive needs assessment was completed, assessing the current needs across Stockport local authority in relation to gambling harms. Key findings highlighted:

Lived experience is at the heart of effective prevention: voices of Stockport residents with lived experience of gambling harm have already made key contributions to local, regional and national prevention.

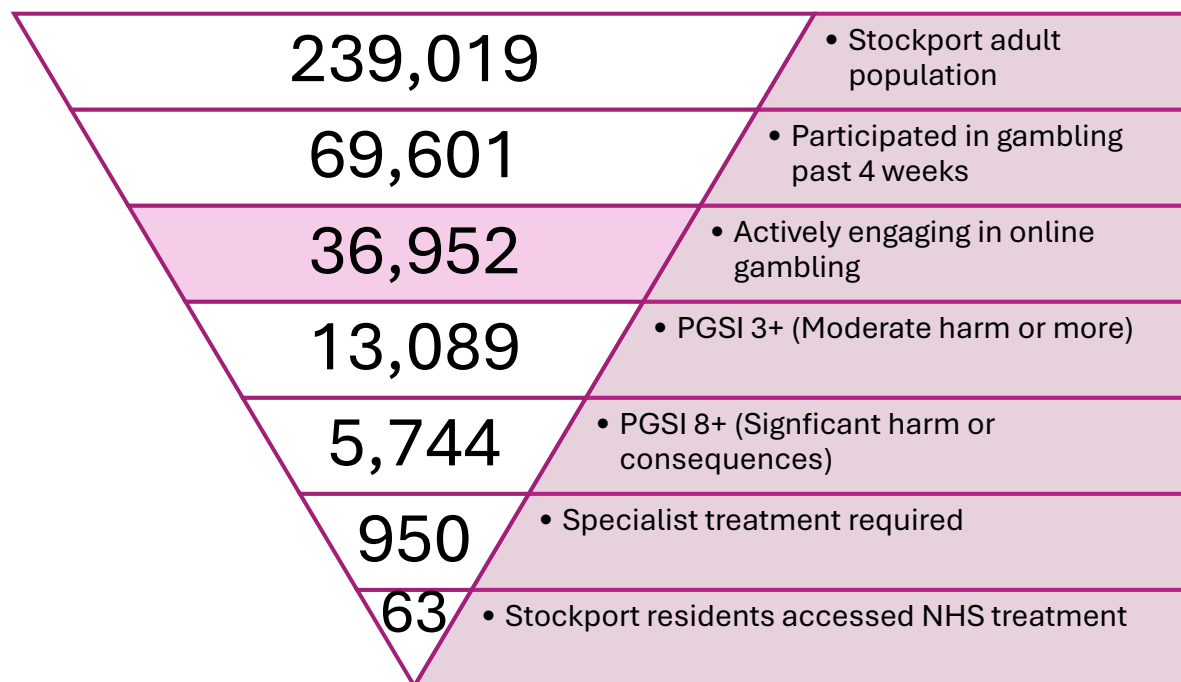
Gambling harms are far reaching – the impact of gambling harms on individuals, families and communities are widespread, including estimates in Stockport of at least **29,448 affected others** and **financial costs of £7,920,000**. Evidence suggests harms are experienced along a continuum across the population, including a significant number of people, **7,644, in need of treatment**. There are **clear gaps in treatment access**; much more people are estimated to be experiencing harm than are accessing support.

Access to services is improving; specialist NHS treatment **referrals in Stockport have increased 7x from 2020 to 2025**. Increasing treatment access has a clear benefit; of people completing specialist NHS treatment across the North of England, **88% achieve abstinence**. Local implementation of **training and screening is a promising approach** to increasing treatment access. After implementing screening, **over a third of Stockport NHS referrals** originated from Stockport Triage Assessment and Referral Team.

Commercial determinants matter; marketing, advertising and the nature of gambling products are linked to harm. Stockport shares challenges with the rest of the UK in addressing **clear inequalities in gambling-related harm**. Evidence is consistent with disproportionately high prevalence of gambling premises and online gambling activity in the most deprived areas of Stockport.

Some **evidence gaps remain**, including a need for better data on harm in children and young people, evaluation of prevention approaches and improved understanding of the harm in minoritised groups. It is likely **minoritised ethnic groups face inequalities** in treatment access, requiring tailored approaches to prevention for specific cultural and ethnic groups. Overall, this needs assessment **developed local understanding**, informing **recommended steps** to implement statutory levy funding and improve prevention of gambling-related harm.

Summary in Numbers



Recommendations

1. **Lived experience:** Meaningfully embed and learn from people with lived experience of gambling harms in approaches to prevention.
2. **Local planning:** Ensure the emerging [Stockport local plan](#) addresses gambling-related harm, paying due regard to the greater impact of gambling premises within the most deprived areas of Stockport.
3. **Screening:** Implement standardised approaches to and training to support screening for people experiencing gambling-related harms, including affected others, in key services such as adult social care.
4. **Partnerships:** Work with local stakeholders to establish a Stockport gambling harms steering group. Collaborate with wider partners such as research groups and Greater Manchester Combined Authority. Work with schools across Stockport to adopt and implement new national curriculum on gambling related harm.
5. **Suicide prevention:** Improve monitoring and recording of deaths by suicide where gambling is present. Recognise gambling as a known risk factor for suicide and collaborate with crisis services to prevent future deaths.
6. **Prevention interventions:** Implement and evaluate the effectiveness of local approaches to harm prevention, considering prevention targeted at individuals, families, professionals, communities and wider systems. Provide awareness training of gambling relating harm for priority front-line teams as part of Stockport Live Well.
7. **Public health approach:** Ensure independence from industry interests, maintain a public health framing to messaging around harms and implement conflict of interest procedures.
8. **Counter-marketing:** Adopt a counter-marketing approach to advertising campaigns, aimed at increasing awareness, shifting away from blaming narratives, and reducing stigma and shame.
9. **Community engagement:** Directly engage communities to better understand their needs in relation to gambling related harms, considering health inequalities and the experiences of minority groups.

Aim

To assess the current needs across Stockport local authority in relation to gambling harm, to inform recommendations for developing future policy, prevention and intervention within the local context.

Scope

Based on the needs framework by Burton and Merrill (1991)¹, this needs assessment aims to consider a broad range of needs, including normative, felt, comparative, expressed and anticipated needs. Normative needs encompass assessment of literature on gambling harm and available evidence within Stockport, from a public health perspective. Felt needs include what is wanted and desired within Stockport local authority and will be considered by consulting key stakeholders within services, within communities, and those with lived experience of gambling harm. Comparative needs will be assessed in terms of potential inequalities in relation to gambling harm, based on protected characteristics and vulnerable groups. Expressed needs are the expression of felt needs through actions such as engaging with services and interventions, including use of training and prevention resources across services. Anticipated needs will be considered within broad recommendations made for Stockport local authority and public health prevention.

This needs assessment will include people across the lifespan, (children, young people and adults) and across the continuum of harm (including individuals, affected others, family members and communities). Although this needs assessment will develop local understanding, it is not intended to determine individual licensing decisions. Decisions relating to gambling premises must continue to be made in accordance with the Gambling Act 2005, Gambling Commission guidance, the Council's Statement of Principles and statutory licensing objectives.

Data / Method

Within this needs assessment, multiple approaches were taken in assessing and implementing the evidence base:

- 1) Narrative summary of background literature on the context, determinants of harm, types of harm and impacts, existing interventions and policy. Existing syntheses of peer-reviewed evidence were prioritised.
- 2) Local authority level estimates of gambling participation and prevalence of harms, treatment need, family impact and analysis of local context including population needs and health inequalities.

- 3) A stakeholder mapping exercise, identifying key stakeholders within Stockport and considering their power and interest in preventing gambling related harm.
- 4) Consultation of experts by experience, providing input into the scope and aims, as well as reviewing the content and providing comments on their experiences.
- 5) Analysis of environmental exposure to gambling, including local mapping of gambling premises and online gambling participation data.
- 6) Analysis of Northern Gambling Service treatment data within Stockport.
- 7) Professionals survey on awareness, barriers to access and training needs.
- 8) Development of recommendations based on the overall available evidence.

Background

Context of gambling and public health

In a 2020 review of the Gambling Act, the UK government acknowledged the need for reform in gambling regulation and legislation. Prior to this, most current UK legislation was the [2005 Gambling Act](#) ². This UK context is unique; the 2005 act marked liberalisation of gambling activity, de-regulation of marketing, and was largely written in the context of a pre-digital landscape of gambling activity.

Set out in the 2005 act, gambling is defined legally as either 'gaming', 'betting' or 'participating in a lottery', where:

Gaming - playing a game of chance for a prize.

Game of Chance: Includes games that involve an element of chance and skill, or games where chance can be eliminated by "superlative skill," but does not include a sport.

Prize: Means money or money's worth.

Betting - making or accepting a bet on the outcome of a race, competition, or other event; the likelihood of anything occurring or not occurring; or whether anything is or is not true.

Lottery - a form of gambling where:

Players pay to participate.

One or more prizes are awarded.

Prizes are allocated based on chance.

Since 2023, a series of regulatory changes and reforms have been introduced, aiming to improve measures to prevent harm related to gambling. This includes a statutory levy, requiring operators to fund independent research, education and treatment for

gambling harms. A breadth of evidence has supported a shift towards understanding gambling as a harmful health behaviour, requiring a public health response ³. Significant work is needed to address gambling harm at the population level - recent UK figures show more bets were placed in 2025 than ever previously. Comprehensive assessment of needs at the local authority level is an essential first step to effective public health prevention of gambling harm.

Language

Following the '[Words can hurt](#)' language guide for gambling harms ⁴, this document will prioritise person-first and non-stigmatising language around gambling harms, recognising deliberate and at times subtle narratives to individualise harms and risks associated with gambling, rather than appropriately frame them as a public health issue. It is acknowledged there will be some exceptions to this, where past tools and indicators use fixed language, e.g. the Problem Gambling Severity Index is used widely including in the Gambling Commission Survey for Great Britain. Where such terms are included, they will be used in quotes to emphasise this is not the preferred choice of language.

Industry Influence

Prior to the introduction of a statutory levy, funding arrangements for gambling harm prevention relied on voluntary donations by the gambling industry. As in the context of other extractive industries, such as alcohol and tobacco, the potential for industry influence on messaging and framing of conversations around harm are well-documented ⁵.

As recognised by the Association for Directors of Public Health Position Statement on Gambling ³, a public health approach is needed to limit the influence of industry on messaging around gambling harm. Recognising potential industry influences is useful to contextualise understanding of gambling related harms and establish independent, public health interventions. The gambling industry also have had a documented influence on policy and legislation intended to regulate gambling ⁶. Examples of previously acknowledged messaging influenced by the gambling industry include:

- Emphasising individual responsibility and minimisation of the role of products and industry practices
- Safer gambling messaging, framing gambling as a fun leisure pursuit within prevention messages e.g. "When the fun stops, stop"
- Active interpretation of research and scientific evidence to present problems as in a small minority e.g. "Gambling is a leisure activity enjoyed by millions, with a small percentage of people suffering gambling related harm"

Across Greater Manchester Combined Authority (GMCA), all ten boroughs aim to identify risks of commercial influence and conflicts of interests ⁷. Due diligence processes are one element of this and have been incorporated into funding arrangements for both local authorities and VSCFE organisations in receipt of levy funds. By 2028, local authorities are expected to commission prevention related work and therefore require a clear steer away from industry-influenced approaches. Emerging evidence suggests that anti-industry, disruptive campaigns have potential as a route to successfully counter individual responsibility narratives ⁸.

Types of gambling harm

Whilst public perception might associate gambling with a specific activity, such as sports betting or lotteries, gambling encompasses a large variety of activities. Harm can occur from participation in any form of gambling, however, specific features or ‘structural characteristics’ of gambling activities are associated with increased likelihood of harms, including continued play despite losses, and gambling addiction. Features known to be associated with increased harm in the literature include: frequency of play, variable reinforcement schedules, psychological design features such as alerts, lights and colours, near-misses, losses disguised as wins, free or ‘bonus’ bets or spins ⁹.

Activities associated with more structural features associated with harm require targeted intervention for harm prevention. For example, Electronic Gaming Machines, encouraging continuous play by design, are more likely to be linked to harm than lottery tickets. Online gambling, particularly online slots, also are designed to include these high-risk structural features, alongside high levels of accessibility via personal devices. Harms from gambling are closely linked to industry profits - the majority of the gambling market exists online, with approximately half of online revenue in 2026 originating from online slots ¹⁰.

“

It ruined every area of my life, it's like an earthquake; the addiction at that moment feels the worst, like the epicentre of it, but then the waves and the ripples and the aftershocks, they go on for so long and they impact so many things and so many people.

”

*- person with lived experience
and resident of Stockport*

Harms from gambling extend beyond the immediate financial consequences of gambling participation and can be experienced across the continuum of participation. At the highest levels of harm, gambling is recognised as a behavioural addiction, where experiences of reward and reinforcement contribute to continued gambling despite significant negative consequences. In a systematic review by Public Health England (PHE, now OHID), peer-reviewed evidence was found of gambling-related harms including:

- Mental and physical health harms, including suicidal ideation
- Relationship conflict, disruption or breakdown
- Employment and educational harms
- Financial harms
- Criminal and anti-social behaviour
- Cultural harms

Understandably, treatment services provide specialist interventions and treatment to people experiencing the most significant consequences and negative impacts of gambling. However, across the population, gambling-related harm encompasses broader impacts, such as harms experienced by children and young people exposed to any gambling activity, indirect impacts on affected others (loved ones, relatives and close friends) and communities. Evidence suggests there may also be a prevention paradox in gambling harm, where the largest net contribution to harm in the population occurs at the lowest level of individual harm ^{11 12-15}.

Reward Pathway

The brain's reward pathway releases dopamine as a messenger and is activated by the **anticipation** of reward.

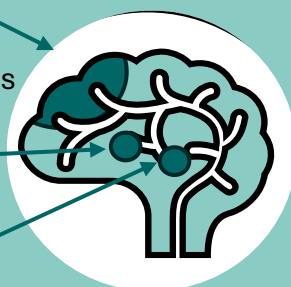
Prefrontal
cortex (PFC)



Nucleus Accumbens
(NAcc)



Ventral Tegmental
Area (VTA)



Neurobiology of Gambling

Gambling powerfully activates the brain's reward system. Over time, this causes structural and functional changes to the reward pathway ¹⁰.

This 'hijacks' the reward system, creating sensitisation to gambling cues and rewards ¹¹. Design features such as 'near misses' trigger brain activation as if a win was experienced ¹².

Unpredictable reinforcement schedules contribute to immersion in a 'dark flow' state, 'switching off' areas of the brain involved in controlling behaviour (PFC), making it harder to stop ¹³.

National Picture

Gambling Participation

Gambling participation across the UK is widely prevalent. An estimated 48% of people participated in any gambling activity in the past four weeks, and when excluding lottery tickets, this figure remains at 28%. Shown in Figure 1, this equates to an estimated 69,601 people in Stockport.

National Estimates of Percentage Gambling Participation

Map shows estimated proportion of people who participated in any gambling activity in the past four weeks, excluding lotteries, per local authority.

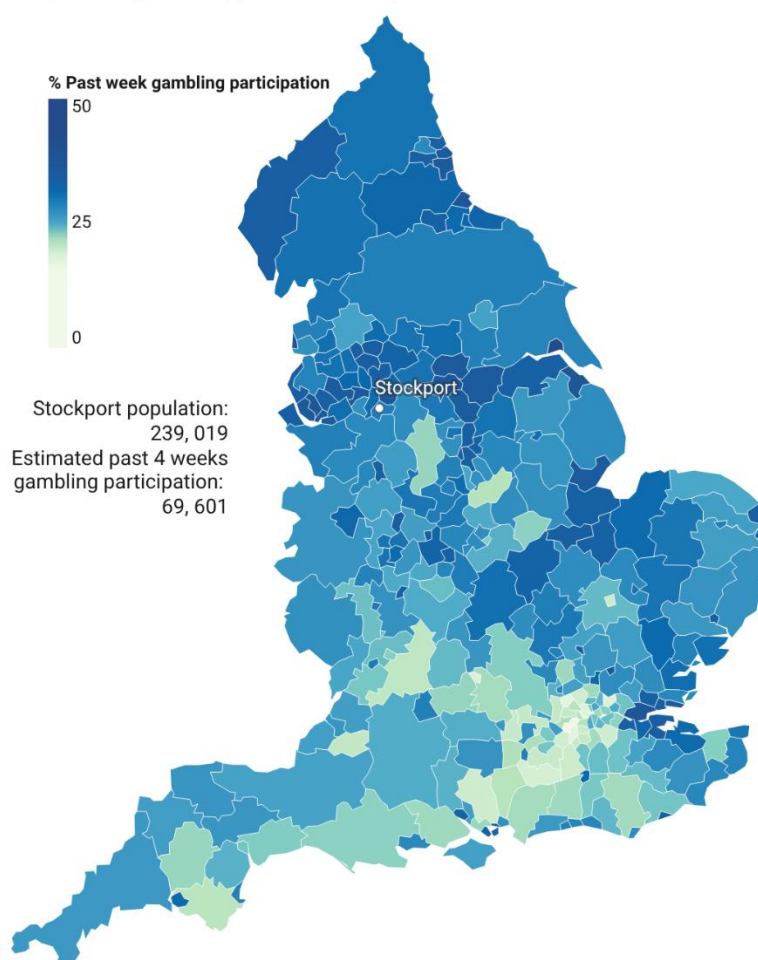


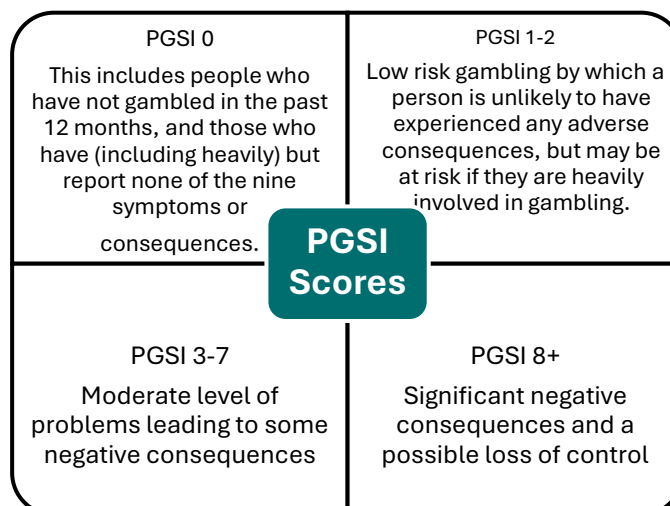
Figure 1. PGSI = Problem Gambling Severity Index. Tipping and Wardle (2026). Generating Local Authority Level estimates of Gambling Participation and Harm. Based on Small-area estimation using Gambling Survey for Great Britain (GSGB) data.

Gambling Harm

The 'Problem Gambling Severity Index' (PGSI) is a widely used population level screening tool, which estimates risk of gambling harm based on a list of nine self-reported **symptoms** or **adverse consequences** of gambling.

These nine items include:

- Have you bet more than you could really afford to lose?
- Have you needed to gamble with larger amounts of money to get the same feeling of excitement?
- Have you gone back on another day to try to win back the money you lost?
- Have you borrowed money or sold anything to get money to gamble?
- Have you felt that you might have a problem with gambling?
- Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
- Have you felt guilty about the way you gamble or what happens when you gamble?
- Has gambling caused you any health problems, including stress or anxiety?
- Has your gambling caused any financial problems for you or your household?



Rather than estimating the number of people experiencing gambling addiction, these figures provide an indication of harms experienced across the continuum of harms. National surveys estimate 8.64% of people in England score between 1 to 2 on the PGSI. An estimated 6.02% of people score 3+.

Small area estimations, accounting for the context of Stockport and its population, suggests this equates to 13,089 people in Stockport. Shown in Figure 2, total prevalence is concentrated in densely populated urban areas, alongside areas at higher risk such as coastal towns. These estimates represent a significant population of people within Stockport experiencing multiple adverse consequences of gambling.

National Estimates of Gambling Related Harm

Map shows estimated population of people at moderate to high risk of gambling related harm (PGSI 3+).

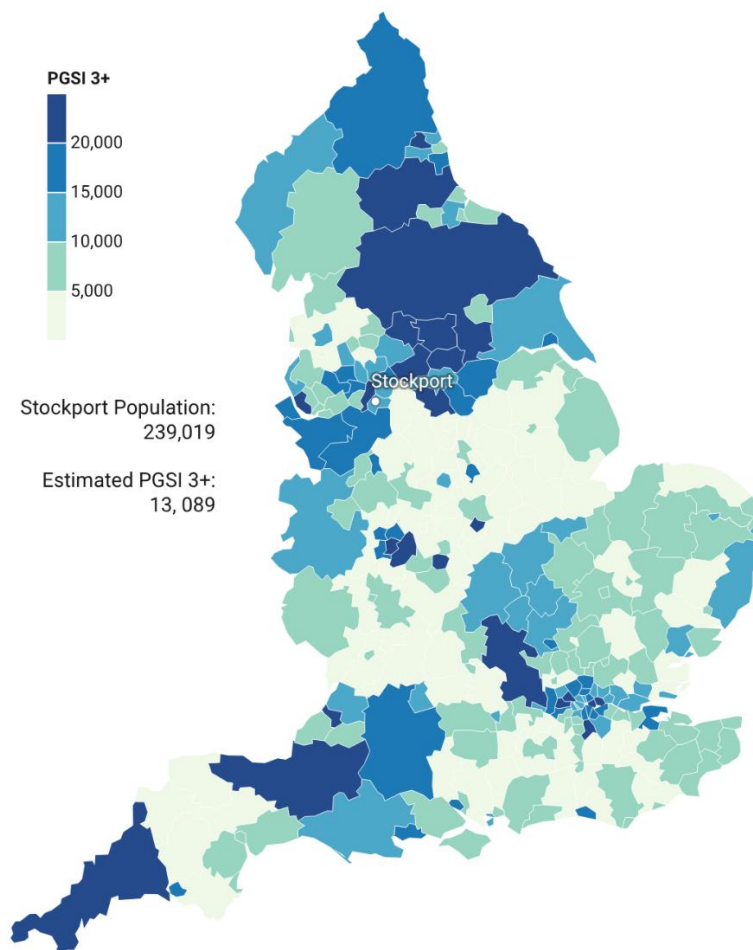


Figure 2. PGSI = Problem Gambling Severity Index. Tipping and Wardle (2026). Generating Local Authority Level estimates of Gambling Participation and Harm. Based on Small-area estimation using Gambling Survey for Great Britain (GSGB) data.

Industry Revenue

Industry data from the biggest operators shows that in 2025, 36,411,541 online slots sessions lasting over an hour were recorded ¹⁶. Based on sample of 70% of the online gambling market, approximately half of online revenue comes from online slots.

Gambling Industry figures for the financial year 2024-2025⁸ report a Gross Gambling Yield of



£16.78 billion

Gross spends on gambling, the primary driver for industry revenue, is unequally distributed in relation to harm, where people experiencing more severe gambling harms disproportionately spend and contribute to industry revenue. This pattern is particularly evident in online casinos, where people with a PGSI score of 3+ account for an estimated 80% of spend ¹⁷.

Groups at Risk of Harm

Gambling harms can happen to anyone. Accordingly, NICE Guidance on the identification, assessment and management of gambling related harms ¹⁸ recommends screening for gambling-related harm within any routine health assessment. Gambling can also exacerbate existing health inequalities or conditions, and guidance recognises the following groups may be at increased risk of gambling related harm:

- people presenting with a mental health problem or concern, in particular thoughts about self-harm or suicide, depression, anxiety, psychosis and bipolar disorder, post-traumatic stress disorder (PTSD), personality disorder, or attention deficit hyperactivity disorder (ADHD)
- people taking medicines that may affect impulse control e.g. dopamine agonists for Parkinson's disease, or aripiprazole for psychosis
- people in contact with the criminal justice system (police, liaison and diversion services, probation services, courts and prisons)
- people presenting with alcohol or substance dependence, especially use of cocaine
- those at risk of or experiencing homelessness

NICE guidance also recommends screening for harms at key points of contact with services:

- when they share that they have financial concerns
- when there are concerns about safeguarding issues or violence, including domestic abuse
- when they share that there is a family history of gambling that harms or alcohol or substance dependence

Public Health Interventions

Following the inquest into the death of Jack Ritchie, the coroner's prevention of future deaths report highlighted a woeful and inadequate system of information available "to prevent gambling or to inform of the help/treatments available". A scoping review of public health interventions to prevent gambling related harm also highlighted significant gaps in the research – more evidence is needed to understand what works and for whom ¹⁹.

Previous research has considered primary, secondary and tertiary levels of prevention ²⁰. Primary prevention is aimed at people not yet experiencing harms, typically focussing on education for children and young people. A previous umbrella review found that of eleven studies evaluating education prevention programmes for children and young people, only five demonstrated a reduction in gambling behaviours or harm ²¹. Previous UK education programmes have also promoted industry aligned messaging, such as a 'responsible gambling' narrative, problematising children's decision making and self-regulation, rather than industry practice ²². This highlights the need for future prevention interventions to take a critical, public health approach.

Secondary prevention approaches target those experiencing some level of harm. Evidence for secondary prevention is mixed, with some approaches noted to have evidence of poor effectiveness, such as training for gambling premises staff. Other approaches, such as self-exclusion schemes, are consistently used in tertiary prevention, but have less available evidence for their standalone use. When promoting self-exclusion schemes, a combined approach with multiple forms of gambling blocks is most effective (Appendix A).

Within tertiary prevention - specialist treatment and therapy for people experiencing gambling addiction - there is a good evidence base for effective treatments. However, specialist treatment sits with NHS services and is distinct from local authority level prevention. Across these levels of prevention, an international review showed most countries rely on interventions using individual, rather than systems framingⁱ. Shifting towards a systems frame, which targets restrictions and structural changes, rather than individuals, is needed to prevent harm across the population ²³

Screening and Assessment

Increasing access to treatment and support is highlighted as a key gap in prevention of gambling harm, with only a small minority of those who might benefit from interventions accessing them ²⁴. NICE guidance on gambling harms recommends the screening for gambling related harm within routine assessments in healthcare, as well as services including substance use and criminal justice. For screening within healthcare, existing reviews suggest multiple tools have acceptable psychometric properties, including sensitivity and specificity, to identify people meeting ICD-11 and or DSM-V diagnostic criteria for gambling disorder. These included the Lie Bet questionnaire, the National Opinion Research Centre Diagnostic Screen for Gambling Disorders – Loss of Control, Lying and Preoccupation (NODS-CLiP) and the Brief Problem Gambling Screen (BPGS)²⁵. Whilst certain tools have evidence for use in primary care specifically, there was insufficient evidence in NICE guidance to recommend the use of any specific screening tool across healthcare settings ¹⁸.

Beyond primary care, a range of other services are well-suited to identify people who may need support for gambling harms. As a previous review found no specific tools have been validated for use in adult social care ²⁶, a subsequent evaluation of two approaches to screening is under ongoing evaluation within local authorities ²⁷. These items show initial acceptability reliability and could be implemented across adult social care:

“Do you feel you are affected by any gambling, either your own or someone else’s?”

“Is your own gambling or that of someone else causing you any worries?”

As no tools have been validated for accuracy in detecting harms experienced by affected others, these items are based on best current practice to adapt screening questions to include affected others.

Regional Partners

Greater Manchester Combined Authority

In 2022, Greater Manchester Combined Authority completed a Strategic Needs Assessment on Gambling Related Harms across all ten boroughs ⁷. This led to region wide prevention work including delivery of training, submissions to the Gambling Act Review consultation, the Odds are they Win campaign and creation of an online resource for information about gambling harm (Appendix A). Stockport public health team continue to work alongside regional partners within GMCA Gambling ‘Working Group’. From 2026, 15% of Stockport’s Local Authority Gambling Harms Prevention grant will fund regional work across Greater Manchester. Proposed workstreams include

Greater Manchester wide communications campaigns and a regional needs assessment.

Local context

Lived Experience Input

Meaningfully engaging and involving people with lived experience is an important step towards empowering people in decision-making impacting their lives. Considering how services, interventions and policies are experienced by individuals, based on their direct insight, supports them to be effective and person-centred, reduces power imbalances, and can avoid stigmatisation²⁸. Prior to this needs assessment, voices of Stockport residents with lived experience of gambling-related harms have made significant contributions to wider policy, prevention and interventions to prevent gambling related harm. Examples of contributions made by people with lived experience of gambling related harm in Stockport include:

- Providing evidence gathered nationally for the Gambling Act Review white paper
- Co-producing a GMCA Gambling Harms Needs assessment and regional action plan
- Developing Chapter One, including in online resources for information on gambling harm and training to professionals.
- The Odds are They Win campaign, a counter-marketing prevention intervention

Within this needs assessment, experts by experience of gambling-related harm were paid for consultation, contributing to the list of areas covered, reviewing the content and figures, reflecting on their own experiences, considering the framing and messaging, and providing comments as key stakeholders. Although affected others were sought, none were involved directly in this needs assessment.

Wider determinants and inequalities in Stockport

Socioeconomic Deprivation

Of ten studies exploring links between socioeconomic deprivation and gambling harm, more than half identified increased risk of experiencing harm in more socioeconomically deprived groups²⁹.

For Stockport, wealth inequalities present a significant challenge to the health of the local population. Relative deprivation can be estimated locally using the Index of Multiple Deprivation (Appendix B). As well as large areas with low deprivation relative to the rest of England, Stockport has concentrated areas of high deprivation, with more LSOAs in the 1% Most Deprived than the average for Local Area Districts in England.

Concentrated Areas of High Deprivation Within Stockport

Stockport areas containing the top 10% most deprived LSOAs nationally.

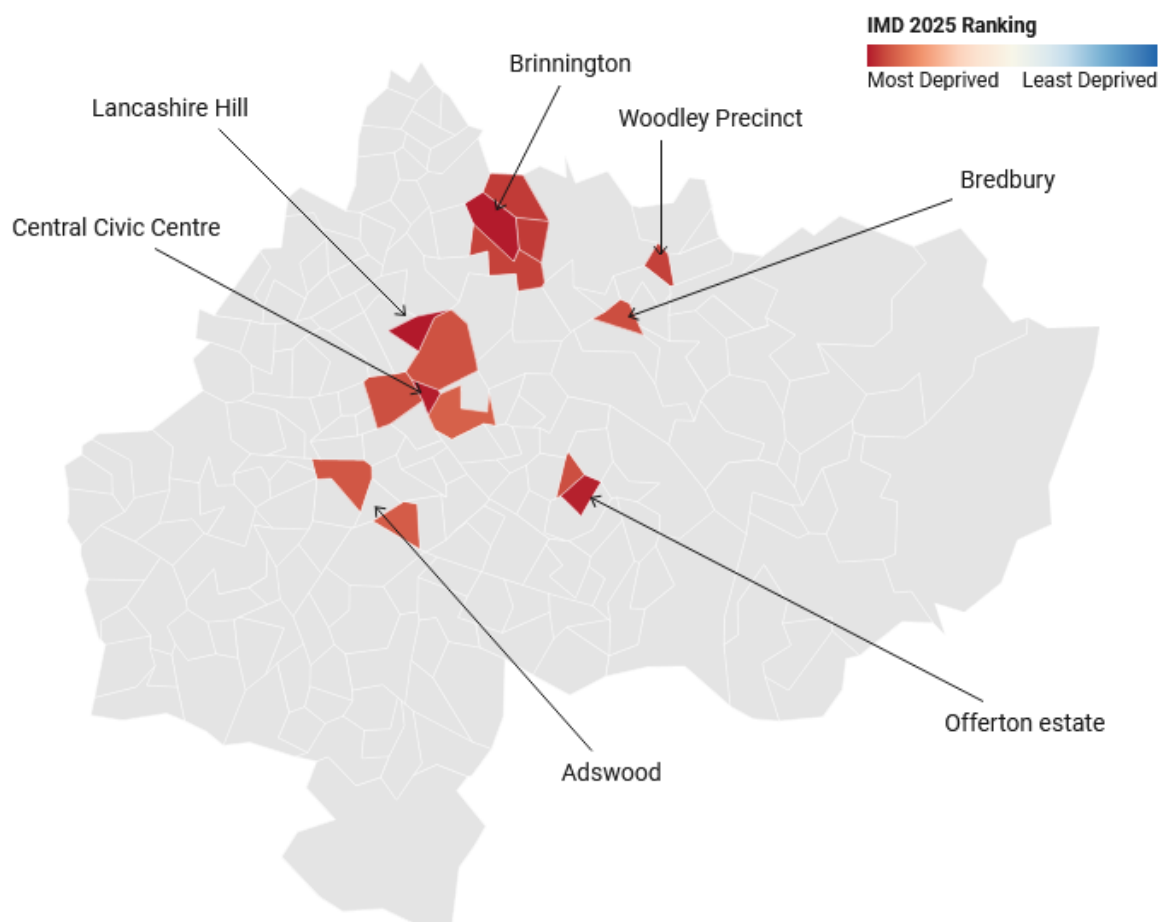


Figure 3. Highlighted LSOAs (Lower Layer Super Output Areas) within Stockport in the top 10% most deprived nationally.

Shown in Figure 3, Stockport includes concentrated areas of high deprivation, with fifteen Lower Level Super Output Areas (LSOAs) in the 10% most deprived nationally. Of these, LSOA in Lancashire Hill is the 21st most deprived LSOA in England. This area is also the most deprived in Greater Manchester. Three further LSOAs are in the top 1% most deprived in England: Brinnington West, Central (Civic centre) and Offerton Estate.

In contrast, 42 LSOAs in Stockport are in the 10% least deprived nationally (Figure 4). This contrast in deprivation is exemplified by Cheadle Hulme West, which contains the 6th least deprived LSOA in England.

Areas of Low Deprivation Within Stockport

Stockport areas containing the bottom 10% least deprived LSOAs nationally.

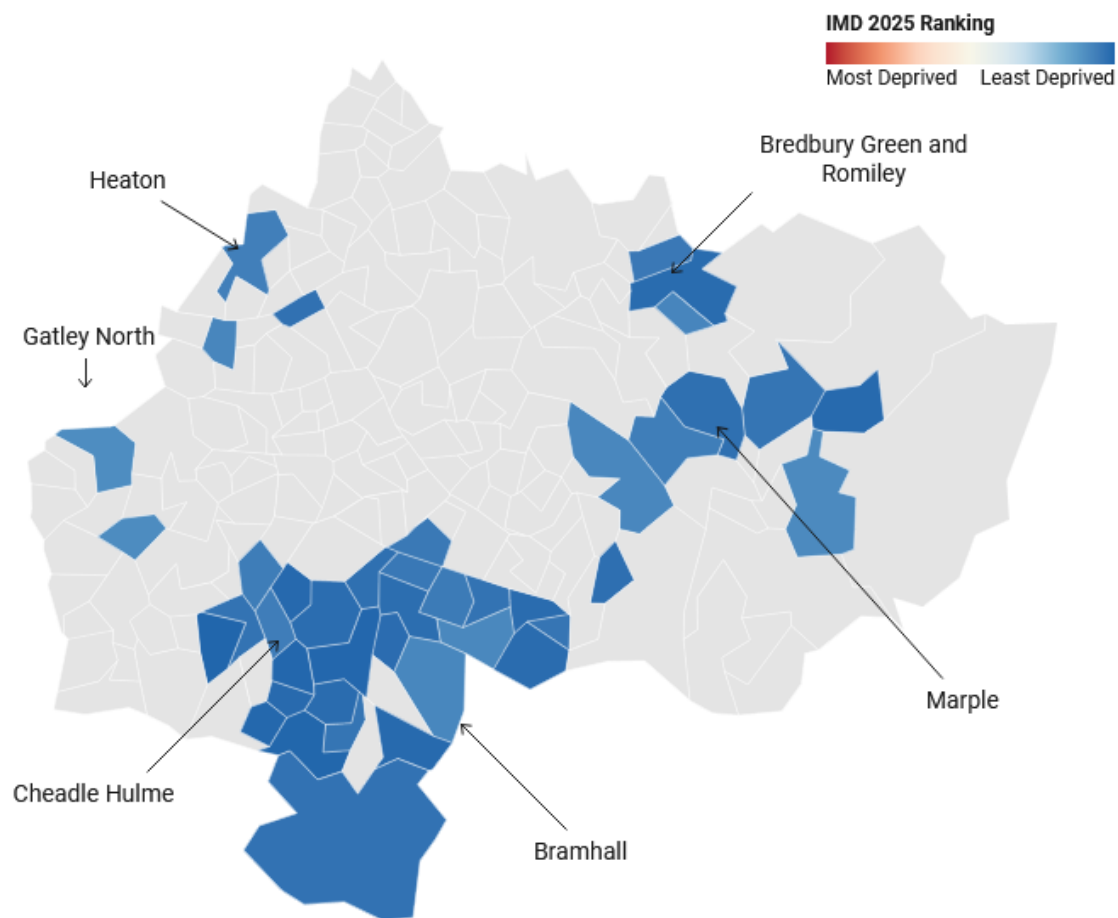


Figure 4. Highlighted LSOAs (Lower Layer Super Output Areas) within Stockport in the bottom 10% least deprived nationally.

Age and Gender

Overall, male gender and young age are associated with increased risk of gambling harms. UK data from the Gambling Survey for Great Britain (GSGB)³⁰ suggests that prevalence of PGSI scores of 3+, consistent with at least moderate harm, is highest among 25-34 year olds.

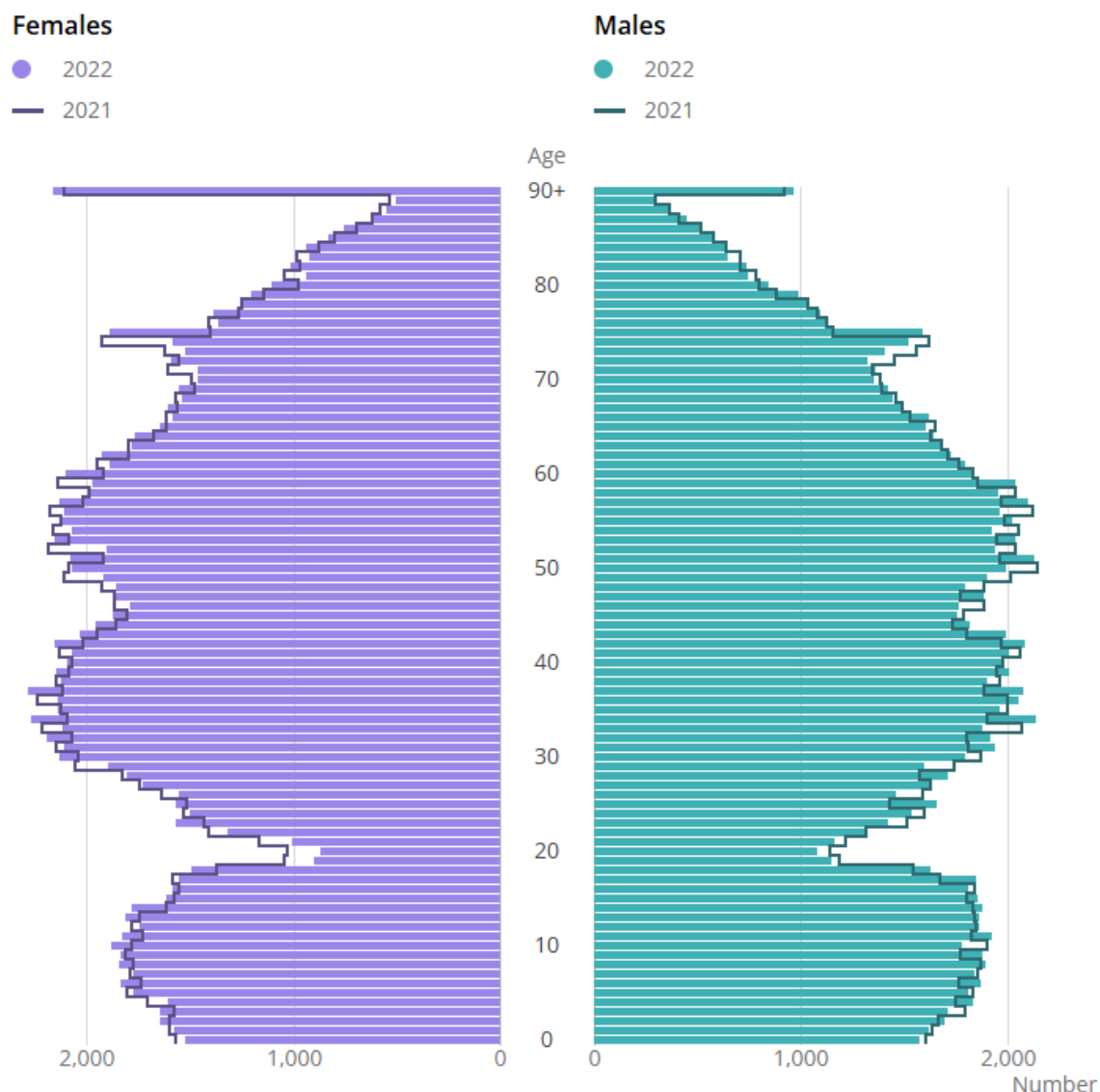


Figure 5. Stockport population estimates by age from the Office for National Statistics.

Shown in Figure 5, mid 2022 population estimates for Stockport show a larger proportion of residents are aged over 30. Relatively smaller numbers of residents may be at risk of gambling harm related to their age demographics; within Stockport, 5.5% of people are aged 15-19 and 4.2% are aged 20-24, both of which fall below the Manchester and North West average.

Veterans

Veterans are over 10 times more likely to experience gambling harms than non-veterans³¹. Qualitative research exploring the experiences of veterans identified the role of the Armed Forces in trajectories of gambling, including exposure to a culture of gambling through the Armed Forces³². Veterans may also be at particular risk of gambling harm as a result of increased rates of Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (C-PTSD). Specific barriers to support were identified for veterans, including shame and stigma around help-seeking and a need for support tailored to their experiences.

Within Stockport, 2021 census data indicate approximately 8,000 people have previously served with the armed forces. This is at a rate of 27.2 per 1000 of the population, significantly higher than the rate across Greater Manchester. However, by age, 45% of the veteran population within Stockport are aged 75+. National surveys indicate the lowest rates of gambling participation and [PGSI](#) scores of 8+ in this age group, suggesting there may be smaller numbers of veterans at the highest risk of gambling harms. Despite this, veterans remain a key group within Stockport, who may benefit from tailored prevention approaches.

Ethnicity and Cultural Groups in Stockport

Overall, more evidence is needed on experiences of gambling harm in minoritised groups. However, current evidence suggests a 'harm paradox', where specific cultural groups have lower participation in gambling but experience higher rates of harm within those that do gamble. Cultural harms related to gambling are culturally specific, but can occur in a variety of cultural groups. Some of these may mask prevalence of gambling harm. There is limited evidence of structural inequalities in access to specialist gambling treatment, however in other mental health contexts there is consistent evidence of barriers to access services and specialist psychosocial interventions.

Examples of good practice in developing culturally specific understanding of gambling harm can be drawn on to inform approaches within Stockport.

A diverse population reside within Blackburn with Darwen local authority, with more than a third of residents identifying as South Asian. Consequently, within their Gambling-Related harms engagement workshops³³, culturally specific issues in relation to gambling harm were highlighted. These included additional barriers around stigma and secrecy, where gambling may carry family shame or concerns of community judgement that add additional barriers to help seeking. Perspectives from Muslim communities also noted community perceptions of a taboo around speaking about gambling, and that seeking support for addiction is also encouraged in Islam.

Nottingham City Council piloted an approach to engaging with Arabic and Urdu speaking communities around gambling harms. They developed translated materials and checked their cultural validity with faith leaders. Tailored approaches to engagement were used, with podcasts, radio, Facebook and bus shelter ads, alongside a community engagement event in which 70 community members attended.

Outcomes evaluated from the campaign indicated visits to support websites increased from the specific postcode the campaign was targeted within. Learning highlighted the value of involving lived experience in designing effective messaging, engagement with community leaders and trusted settings, and sensitivity to cultural and religious beliefs in public health messaging.

Within Stockport, 2021 census data indicated 83.4% of the population self-identify as White British. The second largest ethnic group in Stockport is Asian Pakistani, with 3.7% of the population estimated to identify as Asian Pakistani in 2021, equating to an estimated 10,950 people.

The population of religious people within Stockport is changing, with under half (47.5%) of people describing themselves as Christian, 39.6% as no religion and 5.5% as Muslim. This figure has increased by 90% from 2011 to 2021 and is estimated to have grown further by 2026.

2021 census estimates 2.3% of households in Stockport have no residents within the household that speak English as a main language.

Homelessness

Gambling can be both a cause and a consequence of homelessness. Meta-analysis suggests that 1 in 10 people experiencing homelessness, also experience significant gambling harm or gambling addiction³⁴. Evidence from the UK suggests that relative risk of homelessness increases alongside gambling-related harm, with relative risks of homelessness of 2.13, 2.38 and 27.35 in people scoring (1+, 3+ and 8+) on the [PGSI](#) respectively³⁵. Addressing homelessness arising due to gambling related debt, relationship breakdown or financial issues is an important element of local strategy to prevent homelessness, with significant figures of 448 households made homeless each year on average in Stockport³⁶.

More evidence is needed to better understand the complex interaction between gambling-related harm and homelessness, as gambling harms may be particularly under-reported and hidden within the population of people experiencing homelessness. For example, people rough sleeping may be particularly vulnerable to the 24/7 availability of land based gambling premises, given their need to seek relative safety³⁷. The treatment needs of people experiencing homelessness may also differ to other

adults seeking support for gambling-related harms, given high prevalence of multiple areas of disadvantage, including significant adversity and complex trauma ³⁸.

Gambling and Suicide

Gambling is a known risk factor for suicidality including thoughts of suicide and risk of taking one's own life ³⁹. UK based evidence estimates people with a recorded diagnosis of 'gambling disorder' are 30 times more likely to die by suicide than the general population ⁴⁰. People who gamble across a range of activities both online and in person, including electronic gaming machines, are at highest risk of suicide. Existing monitoring within Stockport, such as coronial records and Stockport Real Time Suspected Suicide Surveillance (RTSSS) data, share limitations in with the national evidence base in that there is no consistent approach to reporting gambling.

Nationally, there has been increased recognition of the importance of recording when gambling harms may relate to a death by suicide, with the 2020 Coroner's determination of Suicide bill advocating for coroners to record when gambling addiction is a factor contributing to suicide. A [report](#) by Gambling with Lives and Voicing Loss interviewed 14 individuals with experience of the coroner service from 2013 to 2023 following a gambling-related suicide ⁴¹. They found that as well as concerns about the reporting of gambling in Records of Inquests, there is a need for increased compassion and support for families through the process.

Methodology used by [OHID](#) to estimate the number of deaths related to gambling nationally were adapted to local data within Stockport (Appendix C). Based on conservative estimates, 0.75 to 1.57 excess deaths by suicide associated with gambling are expected to occur in Stockport per year. These conservative estimates are consistent with the lower bound of national estimates; that 2% of all suicides are gambling related. Although these are expected rather than actual figures, this indicates a clear need for effective prevention and surveillance of deaths related to gambling.

Existing policy and procedure

Stockport Council Workforce Policy

Stockport Metropolitan Borough Council's Health and Wellbeing Policy covers managing gambling harms in the workplace. This includes recognising gambling harms, signs, risks and avenues for support to for employees affected. It also recommends staff have access to relevant training and resources, such as Chapter One Training for Professionals.

Suicide Prevention Policy

In line with national ⁴² and regional ⁴³ suicide prevention strategies, Stockport suicide prevention forum developed a Stockport Suicide Prevention Action Plan for 2025/26.

Within this, gambling is recognised as a common risk factor linked to suicide at a population level. A continued action within the plan aims to “strengthen informational messaging on the risk of suicide associated with gambling”. A 2025/6 focussed action also included promoting the Zero Suicide Alliance training to people working in betting shops.

Stockport Licensing

Reviewed in 2025, Stockport’s Statement of Licensing Principles, 2025-2028 outlines the following priorities:

- Developing our understanding of gambling related harms
- Improving access to high quality treatment and support
- Supporting interventions to prevent gambling from becoming a harmful activity
- Engaging with people and communities to co-design our work

Existing licensing principles in Stockport follow national policy, meeting the statutory framework for licensing, which may be subject to future review following any changes to national legislation. As of May 2026, statutory frameworks are based on three licensing objectives from the 2005 Gambling Act:

- 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

Within Stockport, licensees are required to undertake local area risk assessments to consider risks to licensing objectives. This includes “how vulnerable people, including people with gambling dependencies, are protected” and “how children are to be protected”. Relevant elements of these assessments, such as the proximity of premises to schools and whether premises are in an area of deprivation, are considered in the exposure and environment section of this needs assessment.

Other notable elements of the principles include the expectations of operators to share and gather data, and the expectations of applicants to consider staff training and knowledge. At time of publication, Stockport licensing authority has not currently implemented a ‘no casino’ resolution under Section 166 of the Gambling Act 2005.

Since Royal Assent in April 2026, Section 87 of the English Devolution and Community Empowerment Act 2026 provides a legal framework for licensing authorities, rather than applicants, to publish a Gambling Impact Assessment (GIA). These gambling impact assessments may state whether licenses are not likely to be consistent with the licensing objectives of the authority. This is a shift away from the previous “aim to

permit” in S.153 of the Gambling Act 2005, representing an opportunity for local authorities to understand local risks and consider appropriate measures to mitigate and prevent impacts on population health. As GIAs would need to be included in a licensing authority’s gambling policy statement before use, amendment of Stockport’s existing licensing principles would need to be considered to facilitate this. Any future use of GIAs would also need to be consistent with legislation, the statutory licensing objectives and forthcoming national guidance.

Local planning

Prior to 2015, gambling premises fell under the planning use class of financial and professional services (A2). In practice, this meant buildings with existing A2 planning permission, such as banks, could potentially be converted to gambling premises (subject to obtaining licensing approval). From 2015, gambling premises have been re-classified as requiring *sui generis* use class, enabling the specific planning impacts of gambling premises to be considered. However, existing Stockport policies covering planning predate this 2015 change to *sui generis* use.

[Stockport’s local plan](#) is currently out to consultation (September 2026) and includes a proposed policy relating to gambling harms (CEN 5b Management of new gambling premises), replacing previous policies from Stockport’s Core Strategies and Unitary Development Plan. As in other local authorities, local policy around *sui generis* planning applications present an opportunity to consider the impacts of additional gambling premises on the local area and population health. For example, considerations may include the cumulative impact of the premises on the population and the effect on town centre vitality. Cumulative impact considerations could include similar elements to a licensing GIA (gambling impact assessment), such as the clustering of premises, risk of negative health consequences and proximity to locations such as treatment services. Town centre planning may also consider factors such as active ground floor use, positive contributions of shop frontage and use active frontage that engages people on the high street.

Stakeholder and Service Mapping

As part of this needs assessment, a stakeholder mapping process was completed, aiming to identify relevant services and partners within Stockport communities to engage in gambling harm prevention.

For each stakeholder, their power (i.e. can they influence systems to affect change?) and interest (i.e. how important is this to them?) in preventing gambling harm within Stockport were rated on a 1-10 scale frame from, where 1 = 'low', 5 = 'medium' and 10 = 'high'. This approach was taken to consider how stakeholders may need to be engaged within prevention strategy, such as working closely with high power, high influence stakeholders, or empowering high interest and low influence stakeholders to have greater influence (Figure 6).

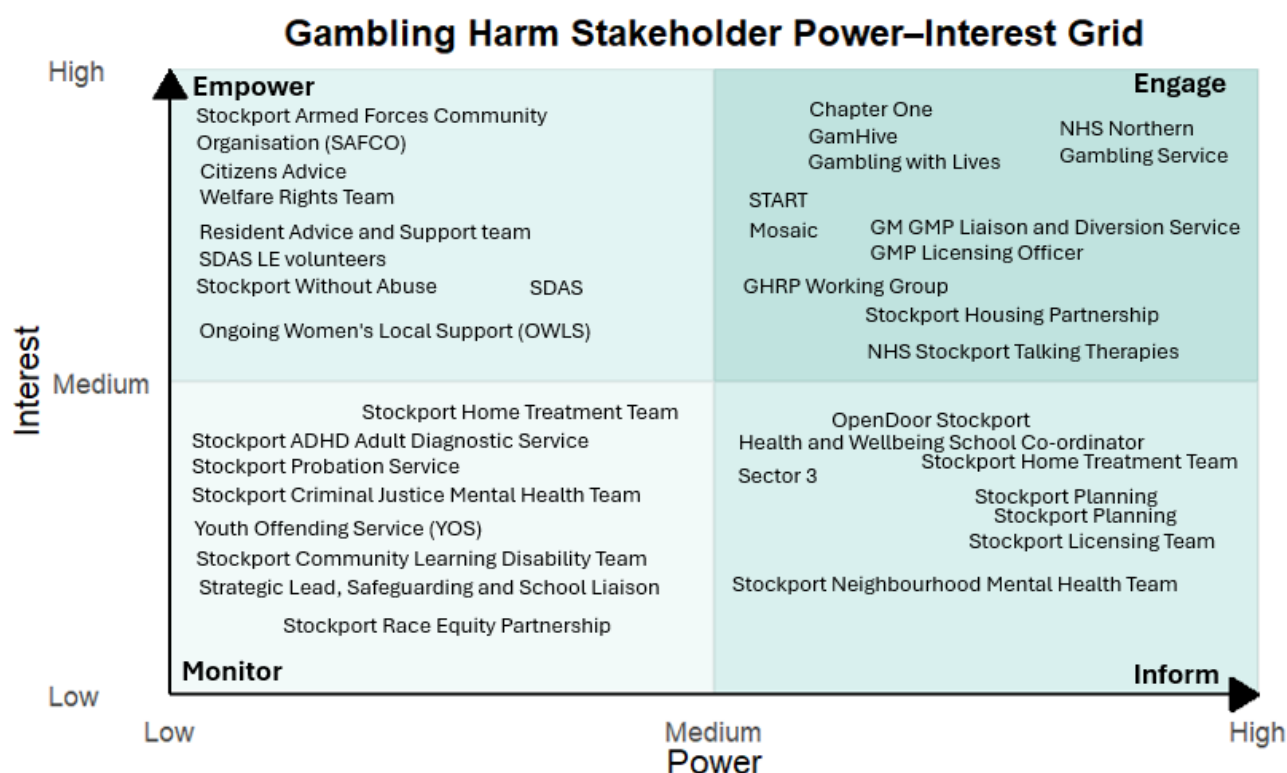


Figure 6. Results of a stakeholder mapping exercise, where stakeholders were rated from Low to High in their interest and power in preventing gambling related harm within Stockport,

Current treatment and prevention providers

The NHS Northern Gambling Service, commissioned by the DHSC (formerly NHS England), provides specialist support and intervention for adults experiencing gambling harms across the North of England. For people in Stockport, the North West Gambling service has clinics in Liverpool, Manchester, Blackpool and Preston and is also commissioned to provide support virtually.

North West Gambling Service

1. Liverpool
2. Manchester
3. Blackpool
4. Preston

North East & Yorkshire & Gambling Service

5. Leeds
6. Sheffield
7. Newcastle

Remote Video Consultations

We also offer remote video consultations to ensure that wherever you are you can receive our full offer, and you do not need to travel.



Figure 7. Areas covered by the NHS Northern Gambling Service. Stockport is included within the North West Gambling Service. Source: <https://www.northerngamblingservice.nhs.uk/i-am-a-professional/our-support-services/where-we-cover/>.

Although the NGS provides specialist intervention, Stockport residents only need to have concerns about gambling and experience some harm to access the service. Treatment includes support and therapy for affected family members, peer support, connection to community resources post treatment and therapy for related mental health difficulties where this may impact on risk of gambling harms.

Adjacent Services

Of stakeholders identified in the service mapping exercise, a number of organisations provide adjacent services, including support for groups who may be at increased risk of gambling related harm. Some of these Stockport services have existing screening, signposting and referral processes in place, whilst others may be well-placed to offer these.

Primary Care

Primary care is the main interface the population has with healthcare services for their mental and physical health. GPs have been argued to have a role in identifying in addressing gambling related harm. The Royal College of General Practitioners offer a Gambling Harms [e-learning course](#) and have produced a curriculum for primary care for capabilities in addressing gambling harms ⁴⁴. This was developed with GambleAware, an industry-funded organisation. Over 360 GPs nationally have 'GP Practice Accreditation in Gambling Harms' through this. In Stockport, there are 36 GP practices, representing a significant opportunity for screening of gambling related harm.

Cost of Living Advice

Stockport's Resident Advice and Support Team (RAS) provide advice on benefits, housing, cost-of-living support and safeguarding vulnerable residents. Citizen's advice are an independent charity, which also provide confidential advice on debt, housing, employment, benefits and legal issues and have existing screening for gambling-related harms in place.

Crisis Resilience Fund

From April 2026, Stockport's RAS team are also in receipt of a Crisis Resilience Fund (CRF) to provide financial assistance to low-income households and prevent individuals from entering crisis. Although guidance has no prescriptive definition of a crisis that causes a financial shock, gambling-related harms could be considered within point 17 of guidance, a "mental health crisis, leading to unplanned spending or incurring increased expenses". Guidance also recommends that staff working to deliver CRFs should be aware of 'resilience services' relevant to gambling-related harms.

Housing

Stockport Housing Partnership includes eight registered providers of housing within Stockport. Each of these offer different levels of welfare support to tenants, including support around finances and debt to help prevent evictions and signpost onward to other services. Preventing homelessness arising due to gambling related debt, relationship breakdown or financial issues is an important element of harm reduction for those who may be at risk as a result of their gambling.

Schools

From September 2026, new Department for Education statutory guidance will be in effect on Relationships, Sex and Health Education (RSE), covering age-appropriate curriculum for all pupils in England. Within this, content on gambling includes: the risks related to online gambling and gambling-like content within gaming, including the accumulation of debt; that gambling can lead to serious mental health harms, including anxiety, depression, and suicide, and that some gambling products are more likely to cause these harms than others; how advertising and information is targeted at them and how to be a discerning consumer of information online, understanding the prevalence of misinformation and disinformation online.

Schools may also be well placed to identify families requiring specific support or prevention, in particular for families of people experiencing gambling addiction, as evidence suggests they may be more likely to experience future gambling harm themselves ⁴⁵. Alongside implementation of new RSE curricula, guidance for VCSE sector gambling harms prevention and resilience funding, suggests local authorities work with prevention and education providers funded by the VCFSE fund to ensure programmes within Stockport are evaluated for long term benefit (> 3 months).

Drug and Alcohol Services

Stockport Drug and Alcohol Service (SDAS)

Stockport Triage Assessment and Referral Team (START)

Stockport Triage Assessment and Referral Team (START) have been provided with training by Chapter One on recognising gambling harms, including referring on to treatment, or signposting to community support. Out of 3097 people assessed through START from 2023-2025, approximately 5% of people (153) were identified as needing support for themselves. Shown in Figure 8, roughly half of those identified accepted a referral or were signposted onwards, and half declined support. Over this period, five affected others were also identified.

START Gambling Support Referrals

Clients identified as needing support around their own gambling by Stockport Triage Assessment and Referral Team (START) from January 2023 - February 2026.

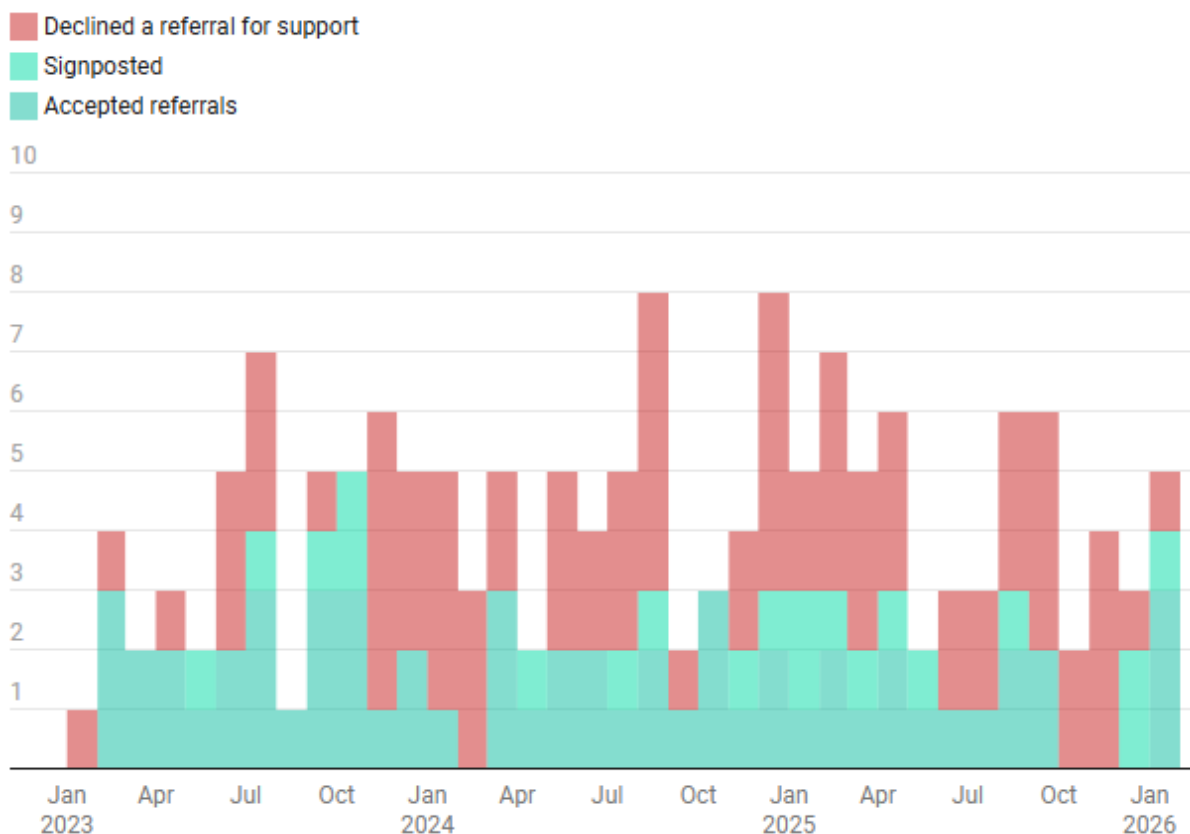


Figure 8. People referred from the START team to treatment services or signposted for support and information.

Mosaic

Mosaic provides drug and alcohol services to children and young people up to the age of 26 years old. They offer specialist interventions for individuals and families.

Crisis Lines and Suicide Prevention

NICE guidance for the treatment of gambling harms includes to “Recognise that gambling and gambling-related harms can be a dominant risk factor for suicidal ideation and suicide attempts, even in the absence of other risk factors.”

Within Stockport, beyond NHS statutory crisis services, Open Door are the main community-based provider of crisis and mental health support.

Local Level of need

Prevalence Estimates of Harm

Whereas other mental health conditions, such as depression, might be routinely diagnosed in primary care, incidence estimates of people with a diagnosis of ‘gambling disorder’ are likely to underestimate harm resulting from gambling given limited rates of diagnosis within healthcare systems. Population level screening tools, most often the ‘Problem Gambling Severity Index’ have been widely used, which estimate risk level based on self-reported symptoms or adverse consequences. However, as with diagnostic labels, [PGSI](#) risk scores do not map directly onto a need for treatment or support i.e. an individual seeking and able to benefit from treatment may score as low risk on the PGSI. Shown in Figure 9, an estimated 36,765 adults within Stockport report at least one negative symptom or consequence of their own gambling.

Stockport Adult PGSI Estimates

Estimated number of adults within Stockport by each Problem Gambling Severity Index (PGSI) category.

 95% Confidence Interval

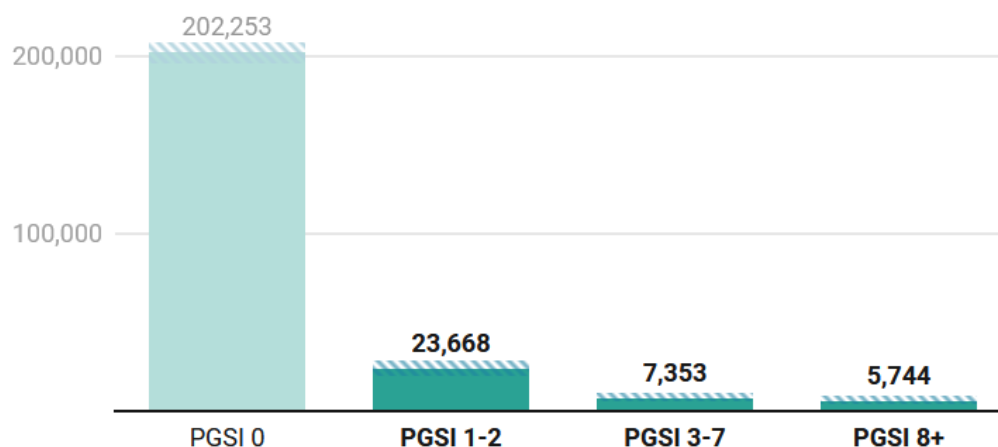


Figure 9. Estimated number of Stockport residents per PGSI category. Source: Tipping and Wardle (2026). Generating Local Authority Level estimates of Gambling Participation and Harm. Based on Small-area estimation using Gambling Survey for Great Britain (GSGB) data.

Within this substantial population of residents experiencing some negative consequences of their gambling, Stockport has a comparable distribution to the rest of the North West (Figure 10). Estimates suggest a greater distribution of people at lower levels of harm; presenting an opportunity for earlier intervention prevention. However, an estimated 5,744 adults in Stockport are estimated to score at least 8+ on the PGSI.

Distribution of Gambling-related Harm Among People with Any Negative Consequences

Distribution of Problem Gambling Severity Index (PGSI) risk categories among those scoring PGSI 1+ (excluding those with no risk/non-gamblers).



Figure 10. Regional and national comparison of the estimated proportion of people within each PGSI category, of those that score at least 1 or higher. Source: Tipping and Wardle (2026). Generating Local Authority Level estimates of Gambling Participation and Harm. Based on Small-area estimation using Gambling Survey for Great Britain (GSGB) data.

Prevalence Estimates of Treatment Need

While incidence estimates are based on a disease model, readiness to engage in treatment for gambling harms can vary through individual's lives. Rather than understanding treatment engagement through an illnesses model of onset, identification, diagnosis and treatment, the transtheoretical model of behaviour change can provide an alternative framework to understand the process of engaging in treatment for gambling addiction (Figure 11).

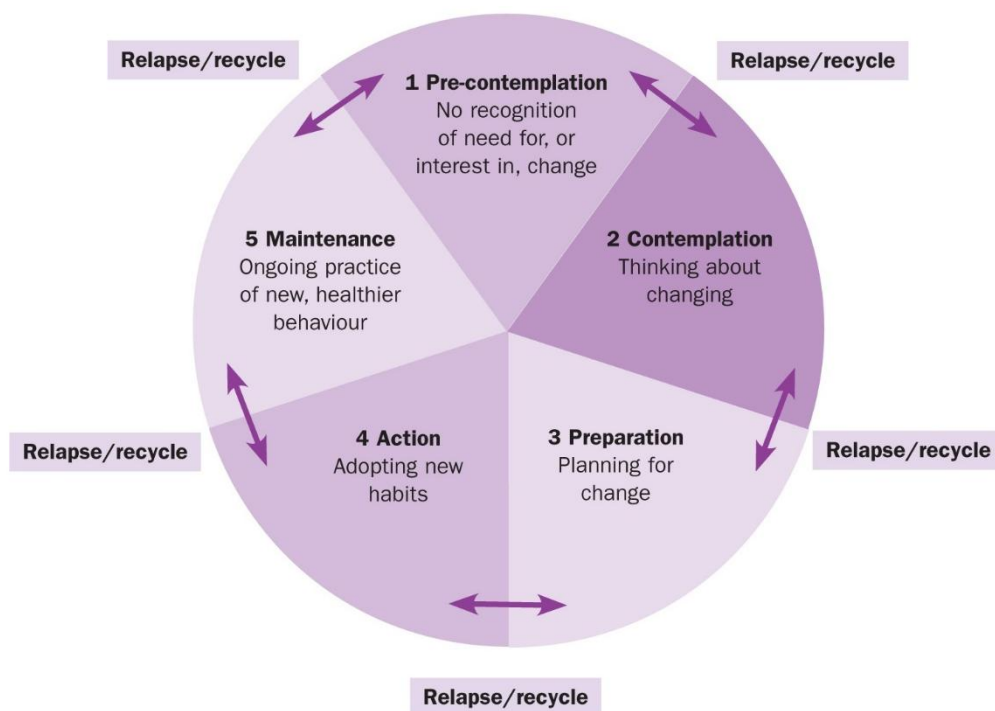


Figure 11. Transtheoretical Model (TTM) or 'Stages of Change' model to understand the stages of contemplating behaviour change. In this model, people may move through different levels of recognition and steps towards change. Source: Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of*

Within this model, people experiencing high levels of harm may not yet be at a point of recognising a need for change. While services provide evidence-based interventions which support contemplating change, it is important to recognise the dynamic relationship between the population of people experiencing harm and the population ready to access support. For many, continued community resources, relationships or activities, known as 'recovery capital', may be beneficial to stay in the maintenance stage of recovery post-treatment. For people initially not ready to make change, or those who experience relapse, it is especially important to have an experience of help-seeking which avoids stigma and shame. This then facilitates people to return to support in future, at a time when they are ready.

Of support, OHID data estimates a significant proportion of adults would benefit from some form of intervention, including brief advice.

Table 1. Types of treatment needs and support identified.

1. Brief advice	This typically involves a brief conversation that could be delivered by non-specialists. It also includes referral to 'self-help' such as online forums.
2. Extended brief interventions.	This typically involves 2 or 3 sessions of motivational interviewing delivered by gambling-specialist practitioners.
3. Third sector psychosocial interventions	This typically involves around 6 sessions of psychosocial treatment delivered one-on-one or in a group format by gambling treatment practitioners in the third sector.
4. Psychologist-led cognitive behavioural therapy (CBT).	This typically involves 8 to 14 sessions of CBT for gambling disorder, delivered by clinical psychologists or CBT-accredited psychotherapists. It may also include psychological therapy for comorbid mental health conditions.
5. Intensive residential treatment.	This typically involves a 12-week residential treatment programme that would include one-to-one therapy and group sessions.

Shown in Table 2, current OHID figures estimate the population of people who would benefit from support around their gambling in Stockport. This ranges from brief advice through to specialist intervention, such as NHS treatment. With an estimated 950 people in Stockport who would benefit from psychologist-led cognitive behavioural therapy (CBT), far fewer people in Stockport access treatment than those who might benefit from it. Increasing access to treatment has a clear benefit, as across the North of England, 88% of people completing specialist NHS treatment achieve abstinence ⁴⁶.

Table 2. Estimated number of adults who would benefit from gambling treatment and support in Stockport.

Type*	Total	(95% CI)	Rate per 100,000 adult population	(95% CI)
Brief advice	736	(549-974)	320	(239-423)
Extended brief interventions	4,985	(4436-5589)	2164	(1926-2427)
Third sector psychosocial interventions	822	(617-1097)	357	(268-476)
Psychologist-led cognitive behavioural therapy (CBT)	950	(742-1225)	412	(322-532)
Intensive residential treatment	151	(83-277)	65	(36-120)
Any	7644	(6427-9162)	3319	(2791-3978)

Note: 95 CI = 95% Confidence Interval. Source: OHID 2024 Gambling treatment need and support: prevalence estimates.



In our clinics we see the lives of service users and their families upended by an industry marketing addictive products, placing profit ahead of health and life. With evidence-based treatment, recovery is achievable, but we need a public health, system-wide approach for effective prevention of harm in the first place.



Dr. Matt Gaskell MBE
Clinical Lead, NHS Northern Gambling Service

Family Impact and Wider System Influence

Gambling harms are not just situated in individuals experiencing addiction; they also negatively impact others, most frequently close family members, including spouses and children ⁴⁷.

For each person
experiencing
gambling addiction



on average 6
others are directly
affected.



A scoping review of available evidence ⁴⁸ reported that, based on population studies, emotional harms were the most reported type of harm in affected others. Feelings of a lack of control and insecurity, as well as experiences of shame and stigma were common examples of emotional impacts on affected others. Impacts on relationships, such as interpersonal difficulties and strain were the next most common type, followed by financial harms, impacts on work or education, and crime. Health harms are also frequently reported, typically thorough the secondary impact of financial difficulties on wider determinants of health.

Affected others are also themselves more likely to experience harm directly from gambling themselves ⁴⁹. Accounting for this overlap between populations of affected others and people affected by their own gambling, an estimated 29,448 adults and children in Stockport are affected at some level by another person's gambling (Appendix E). For children specifically, evidence suggests that parental gambling exposure increases the risk of experiencing gambling harms in later life ⁴⁵. Shown in Table 3, within Stockport an estimated 4, 274 children reside in the same household as adults who may benefit from treatment or support around their gambling.

Table 3. Estimated number of children living in the same household as adults who might benefit from gambling treatment or support.

Type*	Total	(95% CI)
Brief advice	386	(289-510)
Specialist brief intervention	2,781	(2,483-3,108)
Third sector psychosocial treatment	479	(363-633)
Specialist intervention	552	(436-709)
Residential Treatment	76	(42-138)
Any	4,274	(3,613-5,098)

Children and young people

In the UK, gambling activities are illegal up until the age of 18². Prior to 2023, previous legislation permitted specific gambling activities such as national lottery games and scratchcards from the age of 16. In 2026, the exceptions to this are arcade gaming machines such as claw grabbers and penny pushers.

Results from the 2025 Gambling Commission survey on Young People and Gambling in 2025 found that almost half (49%) of young people saw or heard gambling adverts or promotion on social media at least weekly. In terms of participation, 30% of 11- to 17-year-olds had spent their own money on any gambling activity within the past 12 months. This includes arcade gaming machines and placing bets or playing cards between friends and family.

As an estimate of significant gambling related harm, 1.2% of children and young people surveyed responded consistent with Diagnostic and Statistical Manual of Mental Disorders 4th Edition – Multiple Response Juvenile (DSM-IV-MR-J) criteria for ‘problem gambling’.

At the local level, no estimates or data are available on gambling participation in children and young people within Stockport specifically.

Convergence of Gambling and Gaming

A recognises the convergence of gaming and gambling⁵⁰. This convergence includes both the gamification of gambling features, increasing the appeal to children and young people⁵¹, and the gamblification of gaming activities. Lootboxes are a prominent example of the gamblification of gaming activities – they involve a randomised chance

to win in-game items, typically in return for virtual currencies which require real money to purchase. Psychologically Lootboxes resemble gambling, as although they do not involve the chance to win money, in-game items such as character-skins may produce significant experiences of reward in players⁵². Lootboxes can also share features of gambling products designed to reinforce play, such as near-misses and variable reinforcement ratios⁵³.

For children and young people, concerns particularly surround a potential 'gateway effect', where children and young people who spend on Lootboxes may be at increased risk of subsequently gambling. Emerging evidence supports this longitudinal association⁵⁴. Although further evidence of a directional relationship between Lootboxes and gambling harm is needed, consistent evidence of an association between the two⁵⁵ warrants the precautionary prevention of harm.

Costing estimation

Previous evaluation by Greater Manchester Combined Authority Research Team in 2022 estimated costs of gambling harm within Stockport of £7,920,000. This approach utilised the same methodology as costing estimates for England⁵⁶, scaled to the population in Stockport.

All Costs - Stockport

Cost category	Lower estimate	Higher estimate
 Statutory homelessness	£289,827	£289,827
 Deaths from suicide	£1,426,068	£5,688,301
 Depression	£3,004,738	£3,004,738
 Alcohol dependence	£20,702	£20,702
 Illicit drug use	£10,647	£10,647
 Unemployment benefits	£455,443	£455,443
 Imprisonment	£989,553	£989,553
 Total: All sub-domains	£6,197,568	£10,459,801

Using these same estimates and adjusting for inflation from 2022 to 2026, all modelled costs of gambling harm in Stockport in 2026 are estimated at between £6,197,586 and £10,459, 801.

Professionals Survey

Method

A short, 5–10 minute survey was developed to understand the experiences, knowledge and understanding of supporting people with gambling harms in professionals within Stockport. Survey items covered current awareness of gambling harms, needs for training and the barriers to identifying and referring people experiencing gambling harms to treatment. Surveys were sent out in online format via email to contact lists for relevant stakeholder organisations across Stockport (Appendix D).

Results

Respondents

From 28/06/2026 to 06/08/2026, 17 people working within Stockport completed a professionals survey. Shown in Figure 12, the majority of these respondents were professionals working within Stockport local authority.

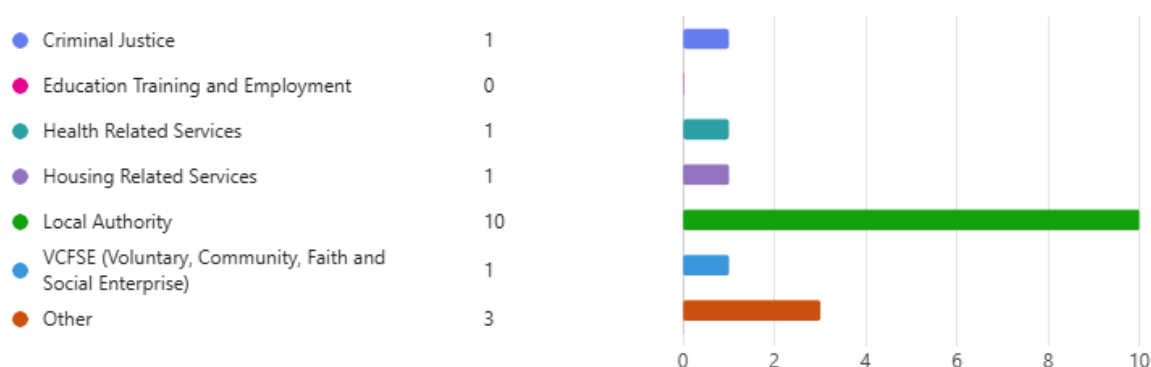


Figure 12. Professional areas of work survey for respondents (n=17) self-reported.

Shown in Figure 13, surveyed professionals work with a range of populations, including groups facing inequalities in gambling-related harm, such as people experiencing homelessness (12/17) and people experiencing mental health issues (14/17).

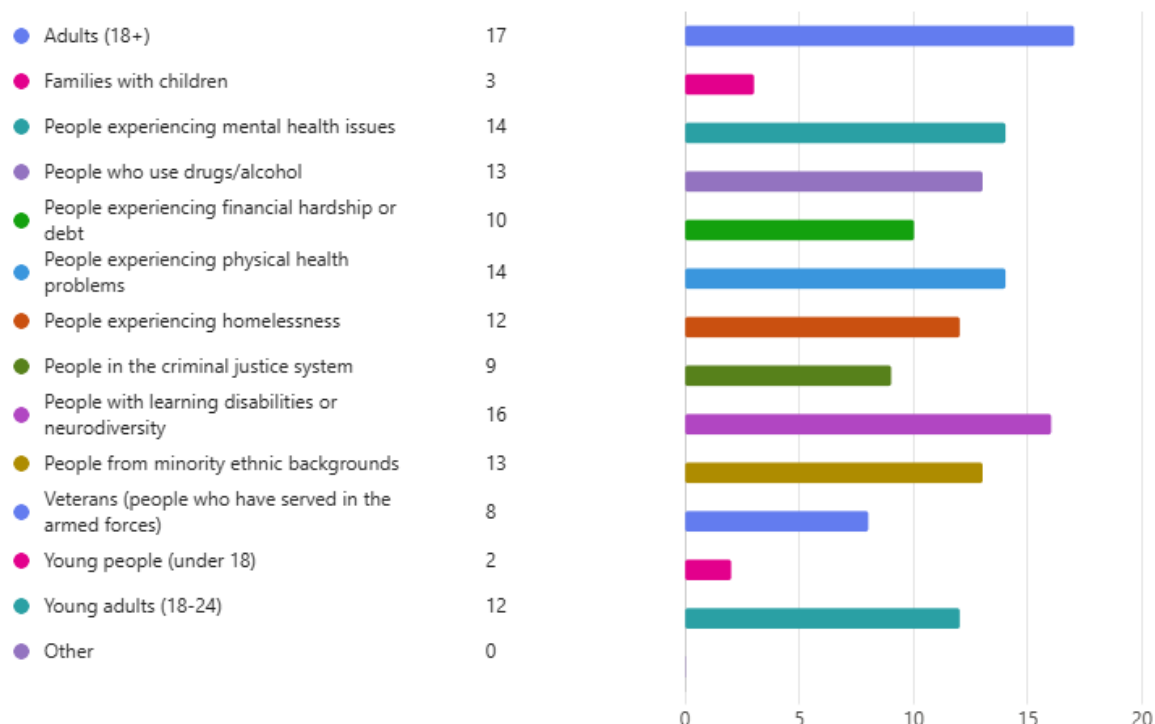


Figure 13. Client populations worked with by surveyed respondents (n=17) self-reported

Awareness and Confidence

Only 35% of people surveyed were aware of any support or treatment services for gambling harms available to Stockport residents. Services identified by respondents included: BeGambleAware, Chapter One, GamSTOP, NHS Northern Gambling Service, The National Gambling Helpline, GamFam, GamLEARN, Gamblers Anonymous meetings and GamCare.

How confident do you feel in..?

...recognising signs that someone may be experiencing gambling-related harm?

Not at all	Not very confident	Fairly confident	Very confident
1	2	3	4

...asking people about gambling or gambling-related harms?

Not at all	Not very confident	Fairly confident	Very confident
1	2	3	4

...having conversations with people from minoritised ethnic groups about gambling harms?

Not at all	Not very confident	Fairly confident	Very confident
1	2	3	4

Figure 13.1. Confidence ratings in recognising and having conversations around gambling related harm. Highlighted in bold and yellow indicates modal (most frequent) response (n = 17).

Screening and Conversations

65% of professionals surveyed do not ask about gambling as part of their routine practice. Of reasons for not asking about gambling as part of routine practice, a lack of training or knowledge was the most frequently reported (Figure 14).

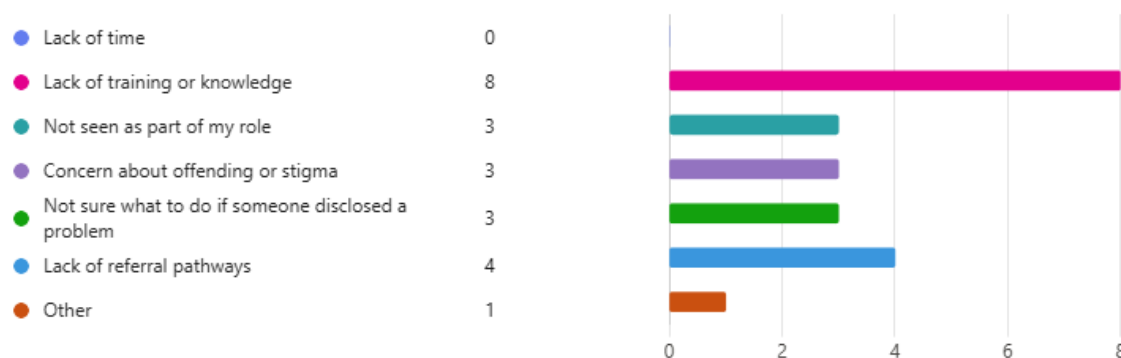


Figure 14. Survey respondents' reasons for not asking about gambling as part of routine practice (n = 17).

Referral Pathways and Awareness of Services

When asked ‘what would improve your ability to refer people into support’, clear pathways was the most frequently reported answer (Figure 15). Under ‘other’, one respondent answered “knowing what would happen so that I can tell the person”.

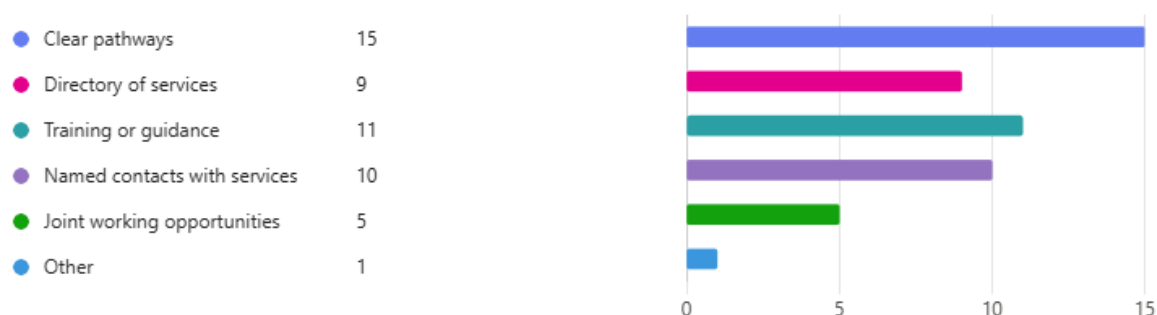


Figure 15. Reported gaps that would help improve professionals’ ability to refer people into support for gambling related harm (n=17).

Professional Needs and Perspectives

Free text answers were provided in response to the following three questions:

‘What do you think are the main strengths of current support for gambling harms in Stockport (if any)?’

Respondents highlighted benefits of accessing timely support online, and being able to intervene early. Respondents also highlighted limited awareness of support options available.

‘What do you think are the main gaps or challenges in current provision in Stockport?’

Respondents consistently referred to a lack of training and limited awareness of the support available for people experiencing gambling-related harm. One respondent suggested gaps in asking routinely about gambling related harm for people under adult social care.

‘What would help improve prevention, early identification, or support for gambling harms locally?’

Respondents made suggestions including: more training including how to talk about gambling, collaboration across teams, social media campaigns/awareness, expert by experience education in schools and integration of standard questions about gambling harms into assessments. One respondent also mentioned the importance of prevention beyond Stockport, highlighting wider availability of online gambling adverts.

Northern Gambling Service Treatment Access

NGS referrals from Stockport by year

Since accepting referrals, Figure 16 shows an overall trend of increased referrals to the NHS Northern Gambling Service. From 2020 to 2025, the number of Stockport residents referred for specialist NHS treatment increased by a factor of 7 x. Available data from the first half of 2026 suggests a referral rate in 2025 equivalent to the 63 people per year referred in 2025.

Stockport NHS Northern Gambling Service Referrals

Referrals made to the NHS Northern Gambling Service (NGS) from Stockport postcodes (SK).

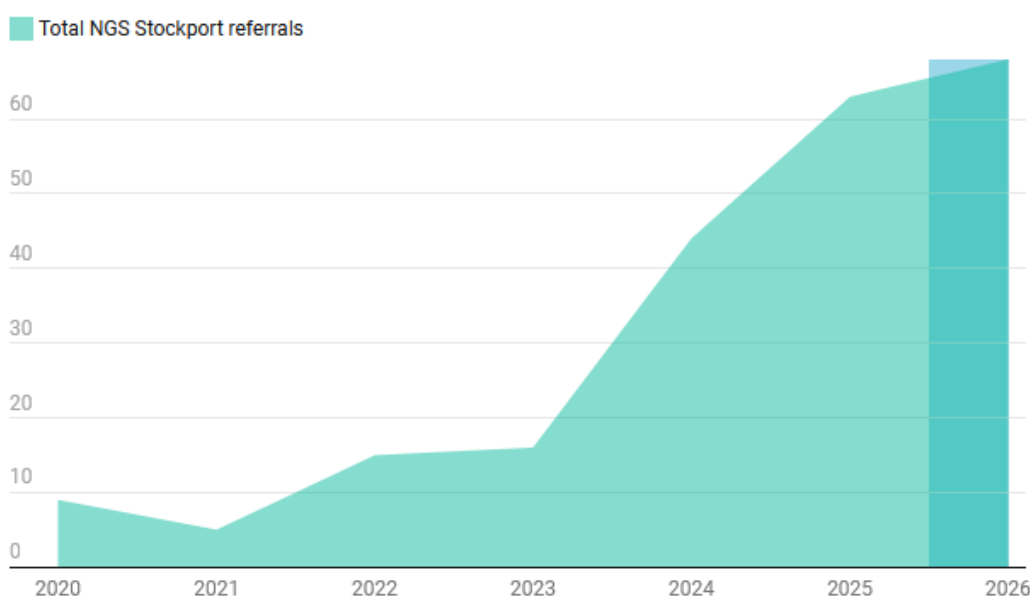


Figure 16. NGS treatment referrals based on available data until June 2026. Highlighted data (blue bar) shows predicted referrals, assuming the referral rate from January to June continues until December 2026.

As previously shown in Figure 8, from 2023, drug and alcohol assessments under the START team began including screening questions for gambling harm. As the landscape of treatment providers has changed, from 2024 onwards, accepted professional referrals were directed to the NGS only. On average across these years (2024/5), over a third of Stockport NGS referrals originated from the START team (Figure 17). This demonstrates the value of local screening and referral processes in improving access to specialist treatment.

START Contribution to NHS Northern Gambling Service Referrals

Stockport residents referred to the NHS Northern Gambling Service (NGS) by year, and professional referrals made to the NGS from Stockport Triage Assessment and Referral Team (START).

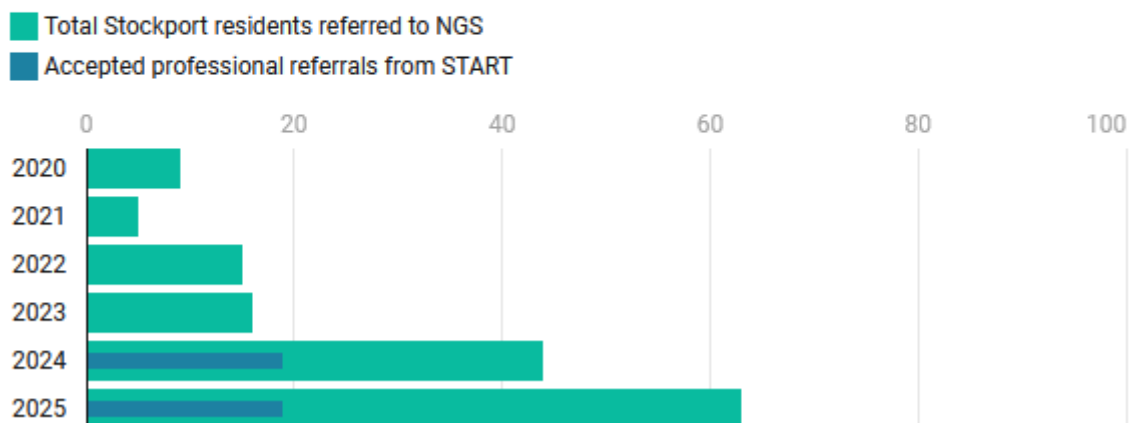


Figure 17. Comparison of total referrals to the NHS Northern Gambling Service (NGS) from Stockport postcodes to those made from the Stockport Triage Assessment and Referral Team (START).

Referral Demographics

Referrals by Gender

Shown in Figure 18, the majority (79%) of people referred to the NGS within Stockport were male. This figure is consistent with national treatment figures; across NHS and third sector treatment services nationally, most people accessing treatment were also men (69%)⁵⁷. Whilst referrals include people who were referred by professionals and who self-referred, GSGB data also estimates that the proportion of men who gambled in the past 12 months and sought help from gambling support services for themselves was double the proportion of women (1.9% versus 0.9%)³⁰.

NHS Northern Gambling Service Referrals by Gender

Percentage of Stockport referrals to the NHS Northern Gambling Service (NGS) by gender.

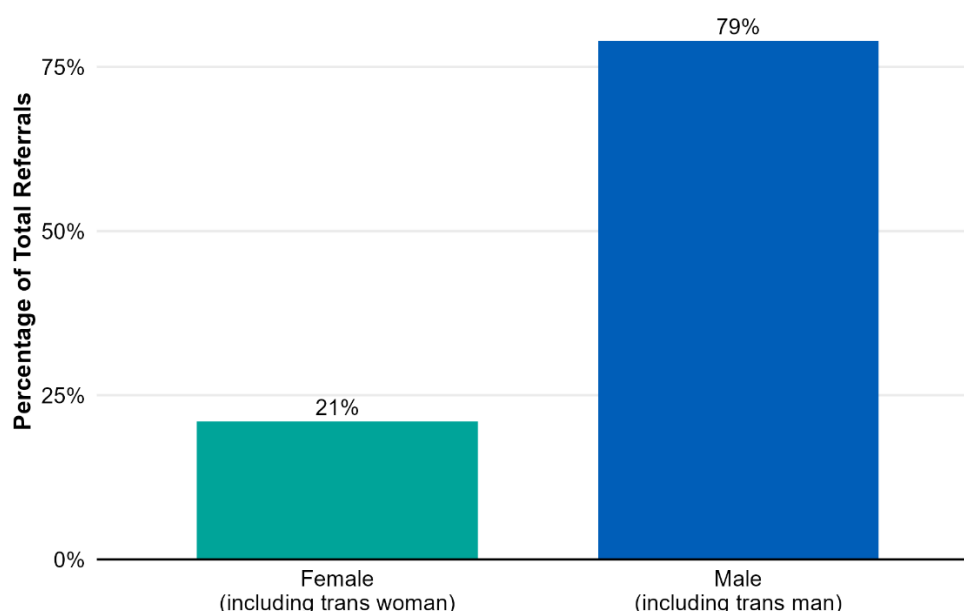


Figure 18. Percentage of total (n=186) referrals to the NHS Northern Gambling Service from Stockport identifying as male or female.

Referrals by Age

Shown in Figure 19, just under a third (31%) of people referred to the NGS were aged 30 or under. The modal age group referred to the NGS was 31-35, and given a predominantly male population in treatment, this is largely consistent with the median age of men accessing treatment in the UK of 34. However, the median age in women accessing treatment nationally is slightly higher at 39 years; referral age by gender was not available for more detailed comparison.

Gambling Survey for Great Britain 2025 data estimates rates of people with [PGSI](#) scores of 8+ were highest in adults aged 18-24 (5.0%), followed by those aged 25-34 (4.6%). PGSI scores of 8+ do not map directly on to treatment need, however, almost half (46.3%) of people scoring 8+ on the PGSI are estimated to experience one or more severe consequences of their gambling including losing something of financial value, experiencing relationship breakdown, experiencing violence or abuse and having committed a crime. Findings that relatively smaller proportions of people accessing treatment from Stockport were aged under 16-25 (13%), likely reflect the lower proportion of Stockport's population within these age groups than the Manchester and North West average.

NHS Northern Gambling Service Referrals by Age

Distribution of Stockport referrals to NHS Northern Gambling Service (NGS) by age group.

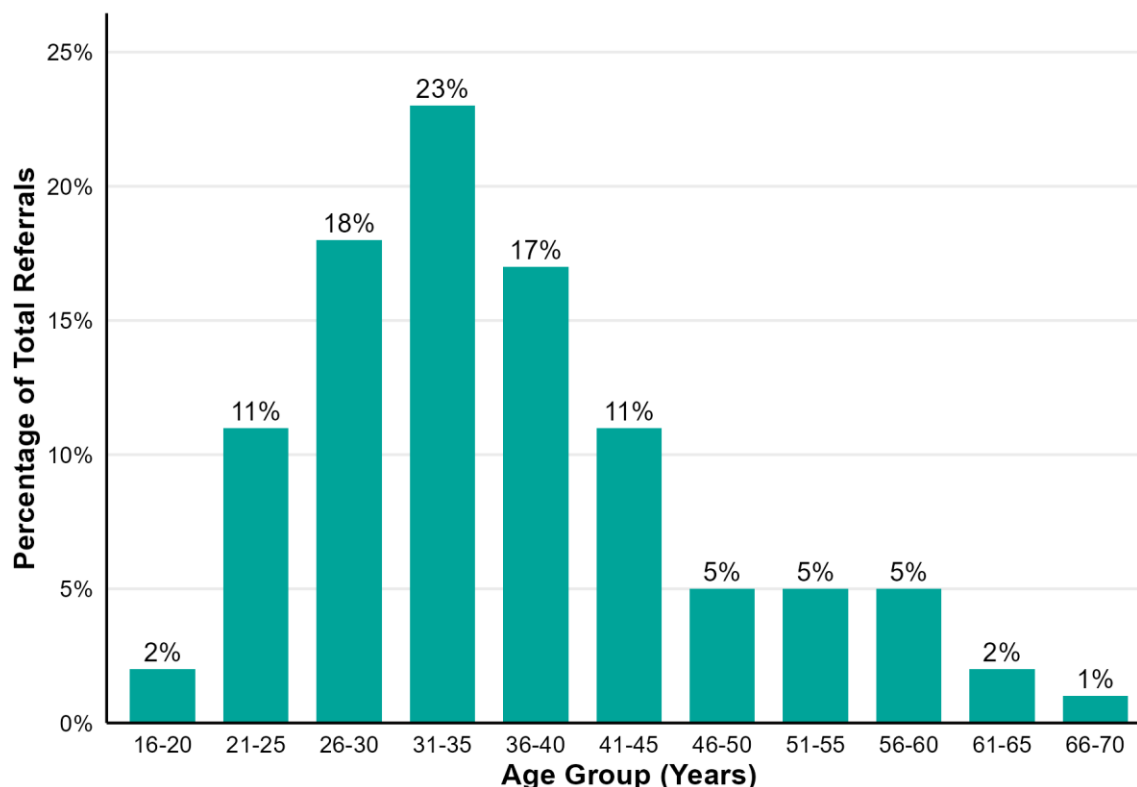


Figure 18.1. Percentage distribution of total (n=186) referrals to the NHS Northern Gambling Service by 5 year age bracket.

Referrals by Ethnicity

Nationally, most people in treatment under NHS and third sector providers who provided information on their ethnicity were White (88%). In Stockport, data from 2020-2026 showed 94% of people referred to the NGS identified as White, in contrast to 87% of the population in Stockport ⁵⁸.

Understanding ethnic inequalities in gambling treatment access is challenging given limited research on gambling harms in minoritised ethnic groups in the UK. Available evidence suggests there is a harm paradox, where minoritised ethnic groups may have lower participation in gambling overall, but higher risk of gambling-related harm in those who do gamble. Shown in Figure 19, 7% of the population in Stockport identify as from Asian, Asian British or Asian Welsh ethnic background, in contrast to only 1% of people referred to the NGS. Conservatively assuming that the overall relative risk of gambling-related harm is equal in people from White British and Asian, Asian British or Asian Welsh ethnic backgrounds, this highlights a probable ethnic inequality in gambling treatment access in Stockport. In Stockport, people identifying as Pakistani within the 'Asian, Asian British or Asian Welsh' ethnic group represent the second-largest ethnic group, accounting for 3.7% of the local population, however, this level of ethnicity data was not available for NGS referrals.

NHS Northern Gambling Service Referrals by Ethnicity

Stockport referrals to Northern Gambling Service (NGS) treatment by ethnicity.
 Comparison with 2021 Census estimates for the Stockport population

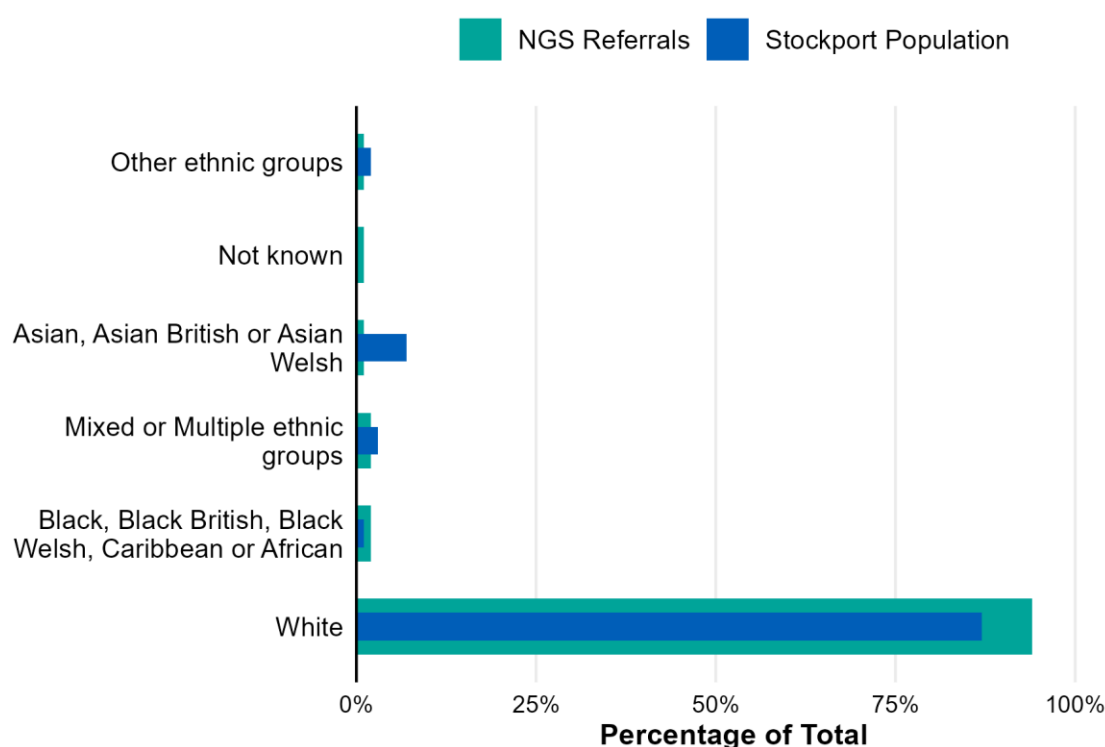


Figure 19. Percentage of total (n=186) referrals to the NHS Northern Gambling Service compared to the percentage figures of Stockport's 2021 census.

Referrals by Sexual orientation

Nationally, only half (52%) of people in treatment provided information about their sexual orientation when asked. Of these, 92% identified as heterosexual or straight.

Similarly, data was only available in only 67% of people referred to the NGS within Stockport. Shown in Figure 20, of these 95% identified as heterosexual or straight. Significant gaps in the proportion of people reporting their sexual orientation limit

NHS Northern Gambling Service Referrals by Sexual Orientation

Percentage of Stockport referrals to the NHS Northern Gambling Service (NGS) by reported sexual orientation.

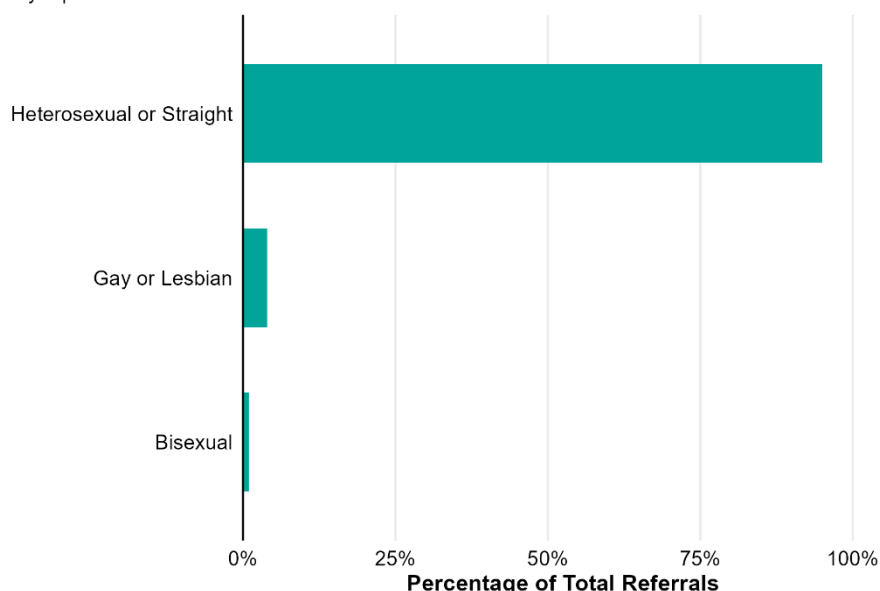


Figure 20. Percentage of total referrals to the NHS Northern Gambling Service by self-reported sexual orientation of those who provided this information (n=124).

Referrals by Veteran Status

From 2020-2026, only 54% of people referred to the NGS provided information on whether they are Veterans – people who previously served in the Armed Forces. Of those with data, only 2% were recorded as Veterans.

Referral measures of Wellbeing, Gambling and Life Disruption

On referral to the NGS, people are asked to complete a set of validated self-report measures assessing their overall wellbeing (CORE-10), gambling symptoms (Gambling Symptom Severity Scale, G-SAS) and life disruption (Work and Social Adjustment Scale, WSAS). Shown in Figure 21, mean scores across these measures indicate the average person referred experiences at least clinically significant distress, moderate gambling symptoms and substantial impacts on their work and social lives.

Mean Outcome Scores at Referral

Blue bars show mean scores on referral to the NHS Northern Gambling Service (NGS). Dashed green lines indicate established clinical thresholds.

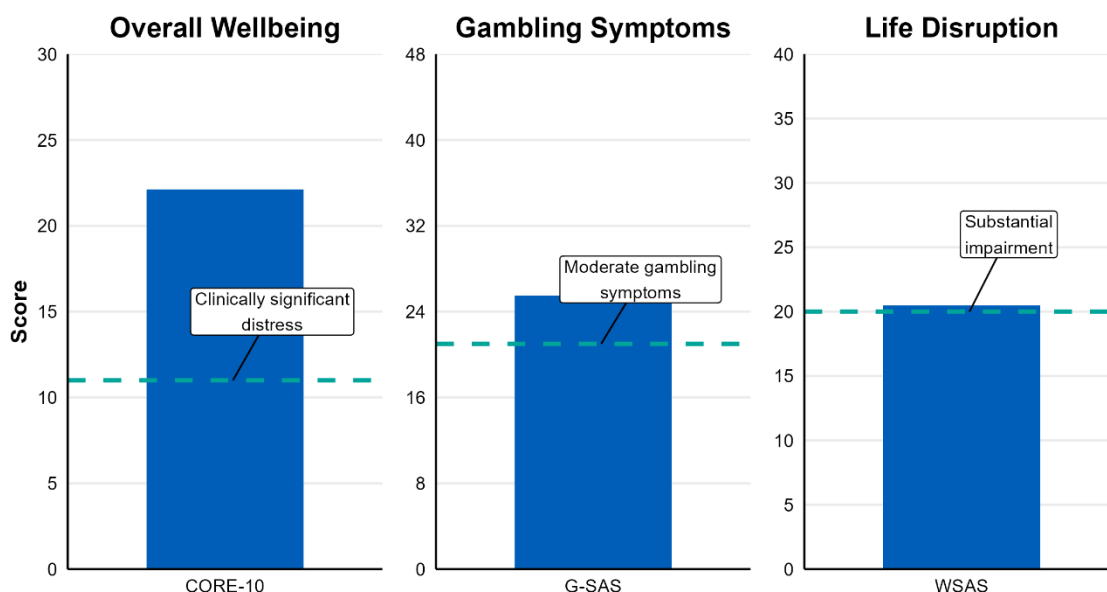


Figure 21. Mean scores on self-report outcome measures of people at the point of referral to the NGS. CORE-10 = Clinical Outcomes in Routine Evaluation -10; G-SAS = Gambling Symptom Assessment Scale; WSAS – Work and Social Adjustment Scale.

Over this period from 2020 to 2026, all people referred to the NGS scored above clinical cut-offs for the CORE-10 scale (11 or higher), indicating clinically significant distress.

Treatment Outcomes

Treatment Completion

Of 166 people who were discharged from the NGS between 2020 and mid-2026, approximately one quarter (24%) completed structured treatment, 73% did not attend, requested discharge or declined further service; 1% were referred to another specialty or service and further treatment was not appropriate in a further 1%.

Treatment outcomes are not available for Stockport referrals specifically; however, outcomes from across the NGS indicate that 88% of service users are abstinent from gambling after completing treatment.

Affected Others

From 2023-2026, a total of nine Stockport residents were referred to the Family Support Worker offer delivered by the NGS.

Exposure and environment

Commercial Determinants of Health: Advertising, marketing and community messaging/framing

Whilst there are gaps in the evidence base on interventions to prevent harm, there is clear evidence of the harmful effect of gambling marketing and advertising. An umbrella review⁵⁹ summarised evidence showing a consistent, causal relationship between exposure to gambling advertising and increased gambling participation. Gambling advertising also increased indicators of likelihood to gamble, including increased positive attitudes towards gambling and greater intentions to gamble. Reviewed evidence showed a ‘dose–response’ effect; greater advertising exposure increases participation, which leads to a greater risk of harm. Gambling advertising also disproportionately influences children and young people, and people already at risk of experiencing gambling harm.

In 2022, a review of local authorities found that of 106 councils with policies restricting commercial advertising and sponsorship of harmful commodities, 79% had policies in place related to gambling⁶⁰. Within their [position statement on gambling harms](#), the ADPH recommends “phasing out all forms of gambling advertisement across local authority owned estates”³.

As of 2026, Stockport’s policies prevent the use of Stockport owned estates for gambling advertising. However, the majority of gambling advertising exposure is online, which may limit the ability of local authorities to reduce advertising exposure experienced by local residents, it has been argued national legislation is also needed⁶¹.

Previous approaches to mitigate the influence of advertising, such as ‘responsible gambling’ messaging, originate from industry rather than being informed by an independent, public health approach⁶². Evidence suggests that ‘responsible gambling’ framing is ineffective, and is experienced negatively by people with experiences of harms, as it emphasises individual responsibility, reinforcing shame and stigma⁶³. Counter-marketing is one alternative approach which may mitigate the impacts of gambling advertising and is feasible at the local level. An example of counter-marketing is seen in the cross-GMCA campaign ‘Odds Are They Win’⁸. In contrast to ‘safer gambling’ messaging, experimental evidences indicates such counter-marketing approaches can be seen as relevant and acceptable to people experiencing gambling

harms ⁶⁴.



every other advert is a gambling advert...on the way to five-a-side football, I see probably six gambling adverts on huge, big, bright LEDs



*- person with lived experience
and resident of Stockport*

Links to sporting institutions in Stockport

Gambling advertising and promotion has documented presence within sporting institutions and culture within the UK ⁶⁵. As with other types of advertising, a systematic review of studies found that sports-advertising is associated with increased gambling behaviour ⁶⁶. Previous campaigns have argued for a removal of gambling-related advertising from football, with agreements in Premier League teams, but not in the English Football League (EFL) to remove gambling sponsorship. Within Stockport, Edgeley Park is the largest sports stadium, home to the EFL team Stockport County FC. As of 2026, Edgeley Park stadium has a partnership for branding and advertising with a large betting advertising company (Quinnbett).

Gambling Premises Mapping

Premises mapping enables local authorities to consider environmental exposure to gambling premises. Geospatial mapping has previously been used to indicate risk or gambling harm, and can highlight clustering of premises, including patterns of premises clustering in areas of high deprivation ⁶⁷. As well as the accessibility of gambling venues within the environment, gambling premises can be considered an additional form of advertising exposure. National licensing requirements for premises are also based on risk of harm, for example, limiting the number of Electronic Gaming Machines (EGMs) per venue ⁶⁸. A study from Australia rated as low risk of bias by PHE ⁶⁹ found that, based on longitudinal data from 2011 to 2018, one additional EGM venue increased the number of non-business personal bankruptcies by an estimated 1.44 per year (95% CI = 0.24, 2.65).

Licensed Gambling Premises Across GMCA by Deprivation

Across Greater Manchester, licensed gambling premises are more likely to be present in the most deprived neighbourhoods. Figure 22, shows the distribution of licenced gambling premises across Greater Manchester, alongside deprivation from the 2025 Index of Multiple Deprivation ⁷⁰. Clustering can be seen across town centres and in Manchester city centre. Clustering is also seen in areas of high deprivation, with 63% of gambling premises Greater Manchester in LSOAs in the bottom 20% most deprived nationally.

Shown in Appendix F, exploration of the number of gambling premises per LSOA per IMD decile shows gambling premises are statistically more likely to be present in the most deprived LSOAs across than would be due to chance. Appendix B details the seven overarching domains used in IMD scores, which notably include the proportion of people experiencing low income and the proportion of people unable to work because of unemployment, sickness or disability.

Gambling Premises Across Greater Manchester by Deprivation

IMD 2025 Deciles and licensed gambling premises.

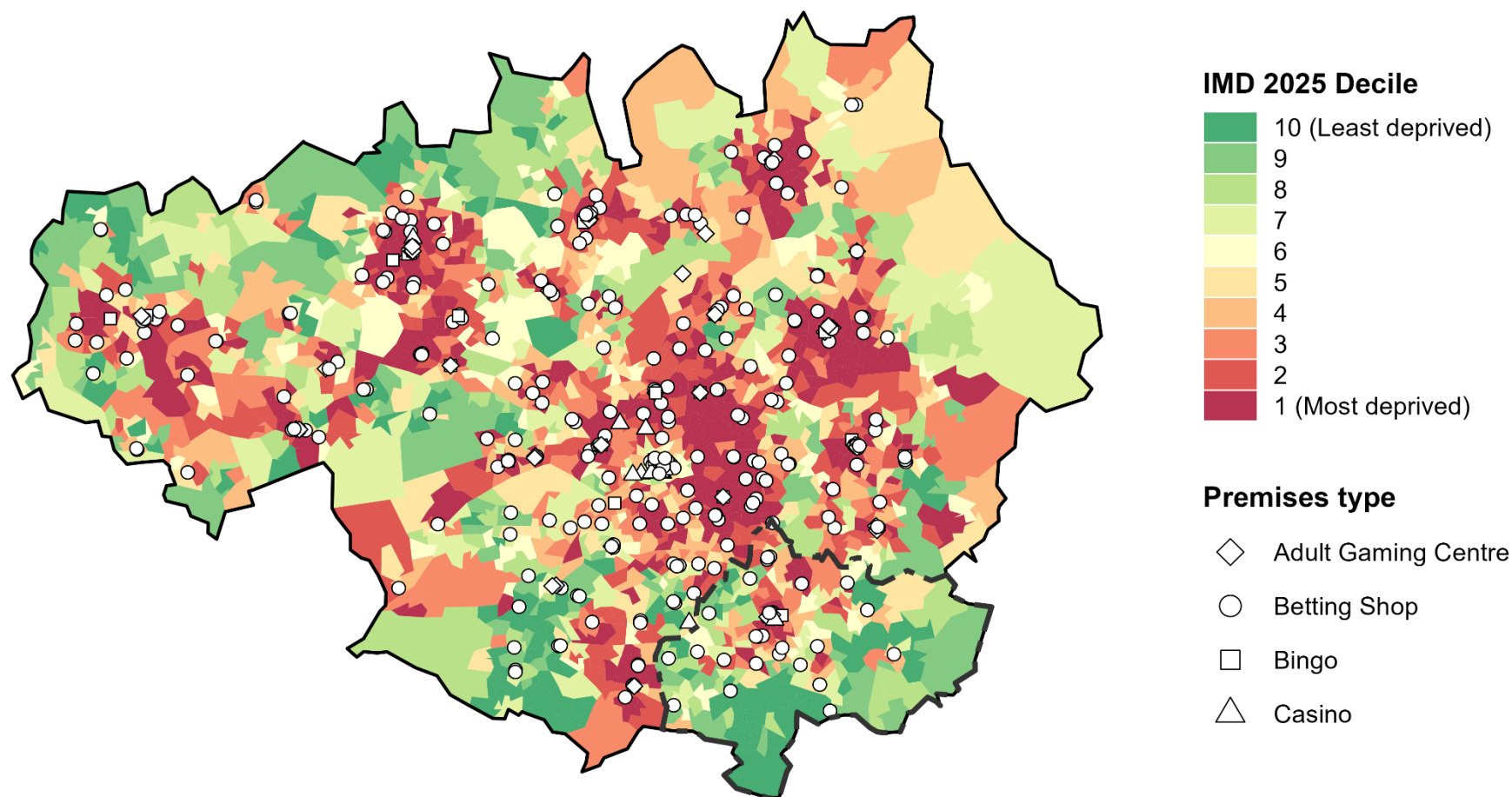


Figure 22. Gambling premises across Greater Manchester, overlayed onto 2025 Indices of Multiple Deprivations Deciles per 2021 LSOAs. Sources: Premises register; <https://www.gamblingcommission.gov.uk/public-register/premises/download>. IMD 2025⁶⁰

Stockport Gambling Premises by Deprivation

Within Stockport, the publicly available premises register lists 37 active gambling premises. Shown in Figure 23, similar patterns to the broader picture across Greater Manchester can be seen: town centre clustering and high concentration of premises in the most deprived areas of Stockport.

Gambling Premises in Stockport by Deprivation

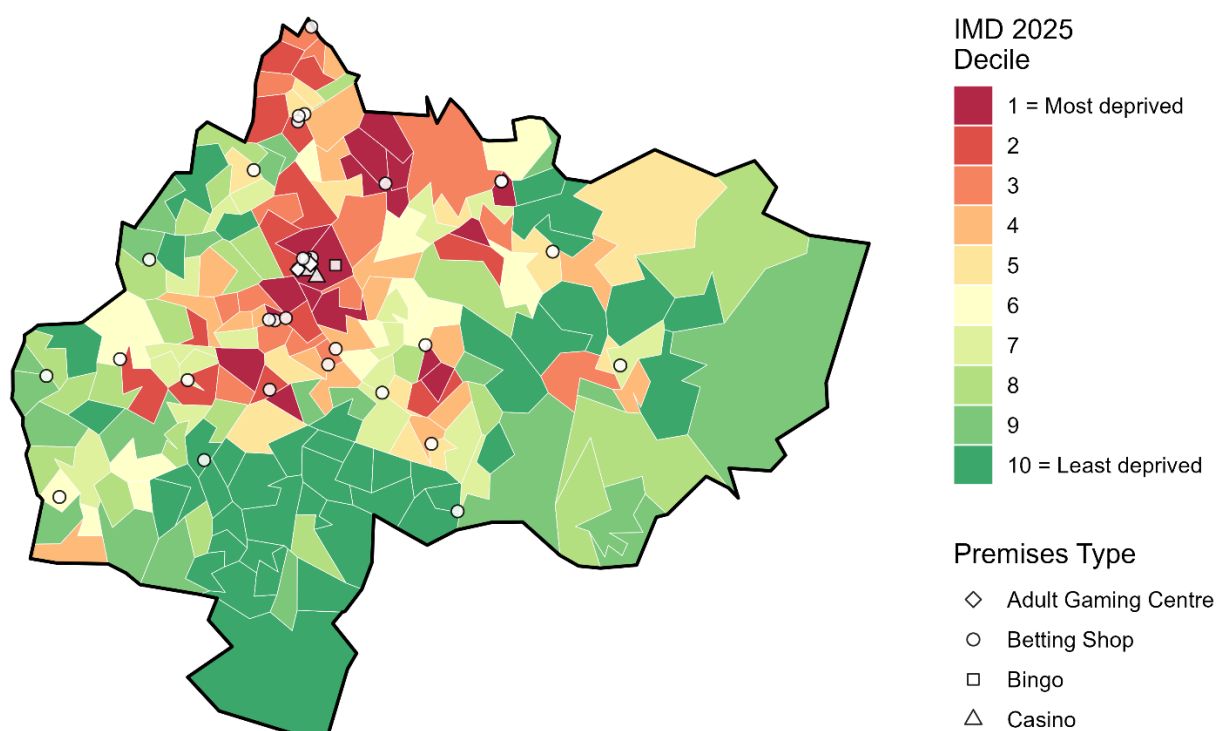


Figure 23. Gambling premises within Stockport, overlayed onto 2025 IMD Deciles, mapped per 2021 LSOAs. Sources: Premises register; <https://www.gamblingcommission.gov.uk/public-register/premises/download>. ⁶⁰IMD 2025

For people residing in Lancashire Hill, the most deprived LSOA in Greater Manchester, this means eight gambling premises are clustered within a kilometre area.

Proximity to vulnerable populations - schools

In Figure 24, a continuous 400m buffer zone is shown surrounding all primary schools, secondary schools and colleges within Stockport. Only four gambling premises are located outside of this buffer zone; the majority of existing premises are located within a 5-minute walk from schools in Stockport.

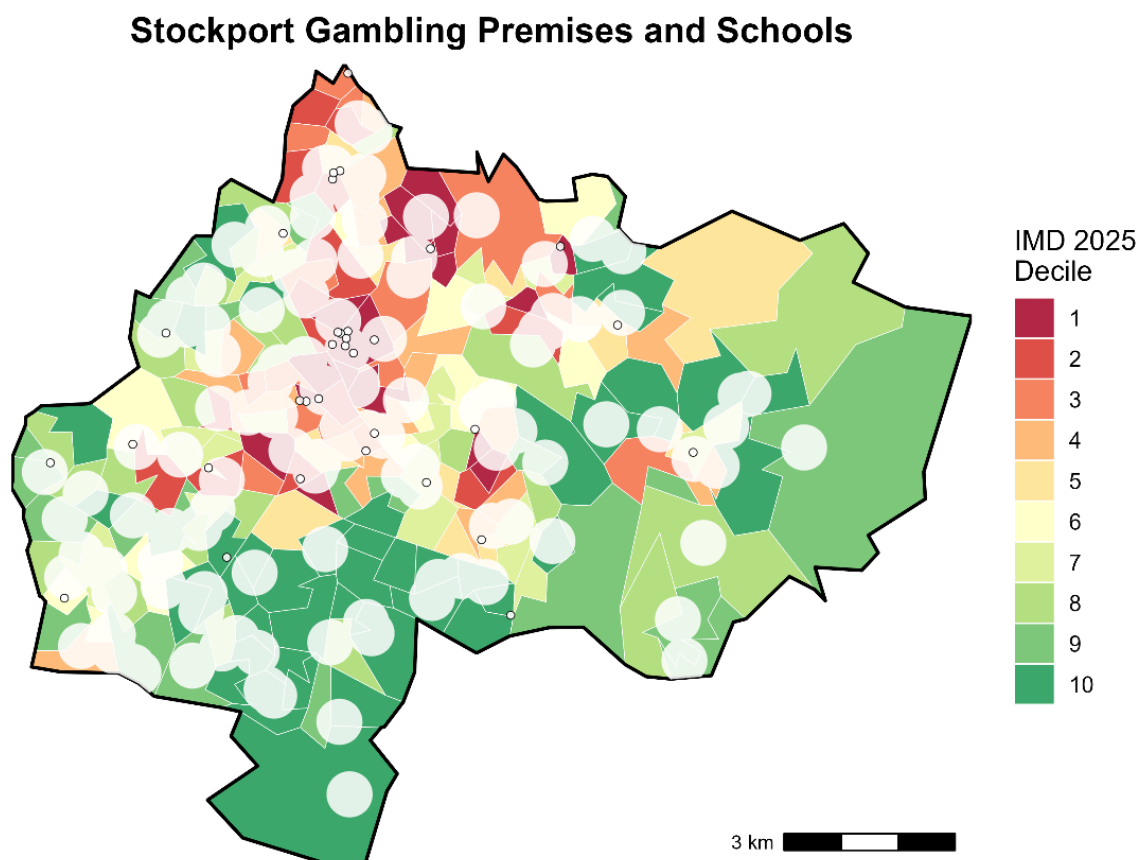


Figure 24. Gambling premises within Stockport, overlayed onto 2025 IMD Decile mapped per 2021 LSOAs. Continuous buffer zone (white) shows 400m radius around Stockport schools. Sources: Premises register; <https://www.gamblingcommission.gov.uk/public-register/premises/download>. IMD 2025; <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025/english-indices-of-deprivation-2025-statistical-release>. Schools; <https://www.compare-school-performance.service.gov.uk>.



Figure 25. Gambling Premise in Stockport, with display features including bright yellow framing around door, transparent windows and promotion such as 'Open24/7' and 'Play inside'. These features shown all form part of marketing and appeal strategies facilitated by the 2005 Gambling act.

Although Under-18s are prohibited from entering gambling premises, as seen in Figure 25, premises exteriors often also include advertisements or visual displays. Evidence suggests that gambling advertisements can contain attention strategies with particular appeal for children, such as catchy slogans ⁷¹. There is also a gamification of gambling, where gambling activities are increasingly presented as akin to gaming to increase their appeal ⁵¹.

Comparable data (GeoLytx supermarket data by IMD)

To explore how the spatial distribution of gambling premises differs from other retail premises, comparisons can be drawn to publicly available supermarket data. Using data on the locations of over 20 different types of supermarkets, Figure 26 shows the distribution of gambling premises per each IMD decile in comparison to the distribution of supermarkets, mapped across Stockport. Retail shops are more evenly distributed across areas of deprivation, whereas gambling premises are more likely to be located within the 10% most deprived LSOAs in the country.

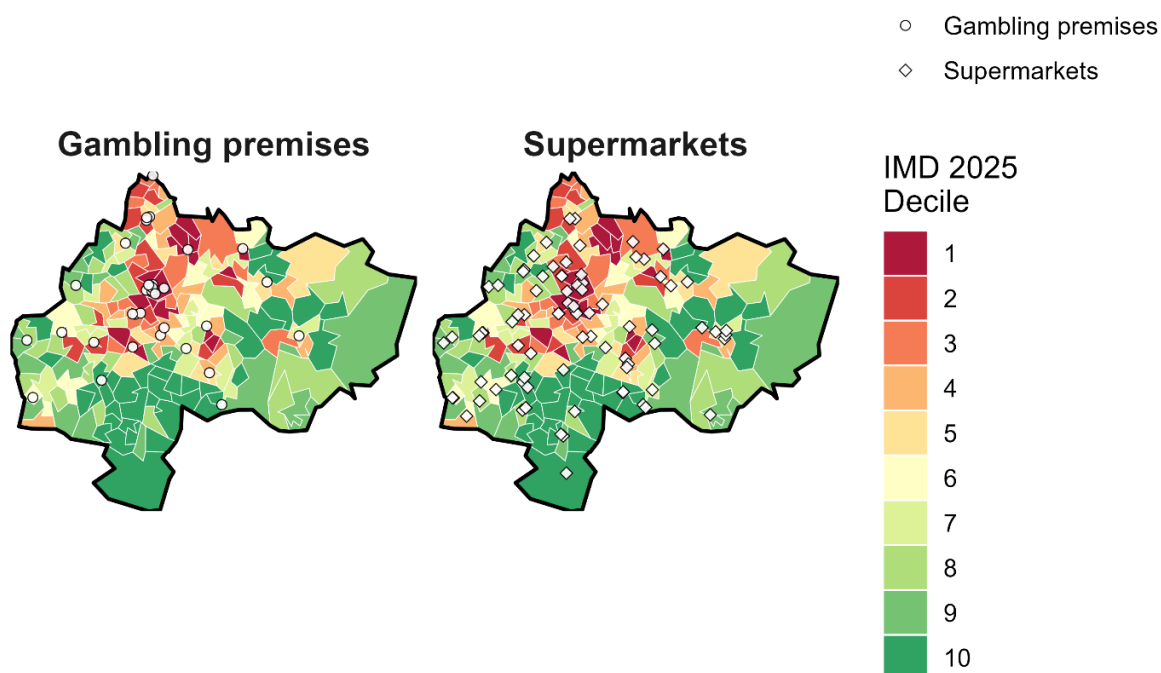


Figure 26. Gambling premises compared to supermarkets within Stockport, overlayed onto 2025 IMD Decile mapped per 2021 LSOAs. Sources: Premises register; <https://www.gamblingcommission.gov.uk/public-register/premises/download>. IMD 2025; <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025/english-indices-of-deprivation-2025-statistical-release>.

Visual exploration of this distribution (Figure 27) shows the skewed distribution of gambling premises towards areas of high deprivation.

Comparison of Retail and Gambling Premises by Deprivation (Stockport)

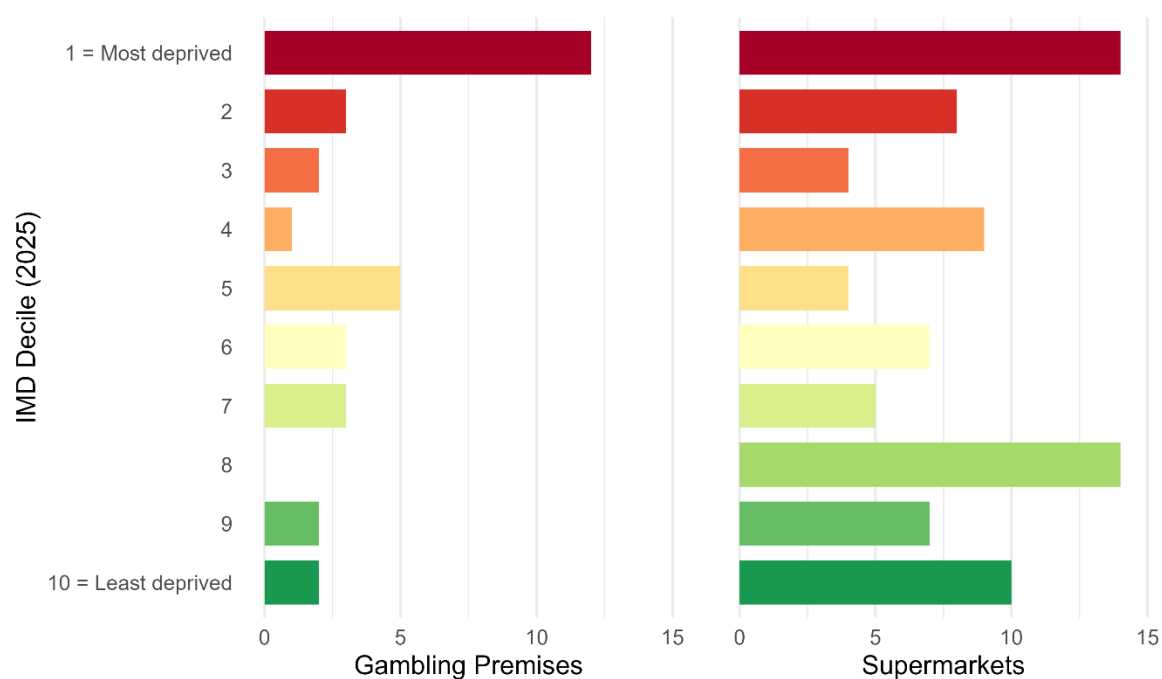


Figure 27. Figures show number of gambling premises per Stockport 2021 LSOAs of each IMD decile, compared to supermarkets. Sources: Premises register;

<https://www.gamblingcommission.gov.uk/public-register/premises/download>. IMD 2025⁶⁰

Supermarket locations; <https://geolytix.com/blog/supermarket-retail-points/>

Online Gambling

Online gambling represents a challenge for local harm prevention. Evidence suggests the majority of gambling is online, and online gambling products are disproportionately associated with harm. However, online spaces fall outside of the licensing control of local authorities.

Links between physical venues and online gambling should be considered. Although there are legal restrictions in place to limit cross-marketing from physical to online venues without consent, this does not limit all forms of promotion of online gambling within physical venues, such as QR codes in venues linking to online gambling.

Understanding local participation in online gambling is essential to inform the overall picture of gambling-related harms and has been facilitated through access to the Great Britain Gambling Behaviours Classification (GB2C) (LSOA Geography).

Gambling Behaviours Classification

Modelling based on 1.2 million online gambling accounts estimates 36,952 adults in Stockport actively engaging in online gambling. This is defined as people with “sustained gambling activity, including gambling at least once a month on average and maintaining an account tenure of over three months.”. Figure 28 shows this in the broader context of the numbers of people participating in gambling, and experiencing gambling related-harm in Stockport.

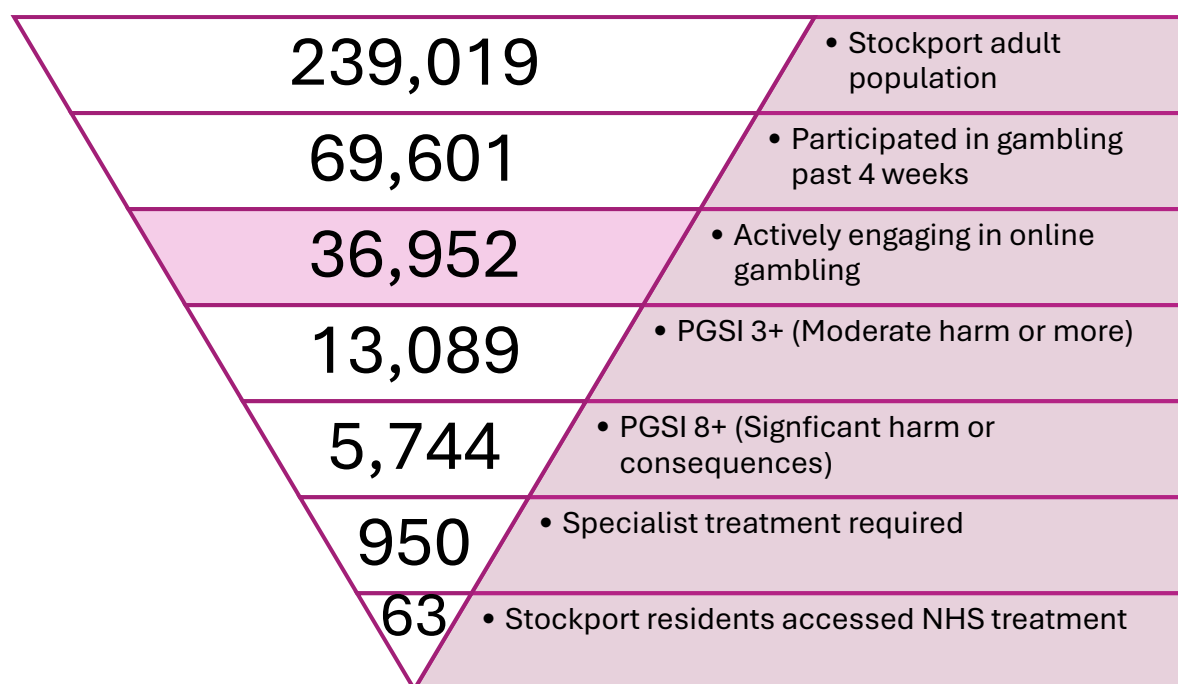


Figure 28. Snapshot of gambling harms in numbers within Stockport. Figures based on most current available numbers per year.

Online Gambling and Deprivation

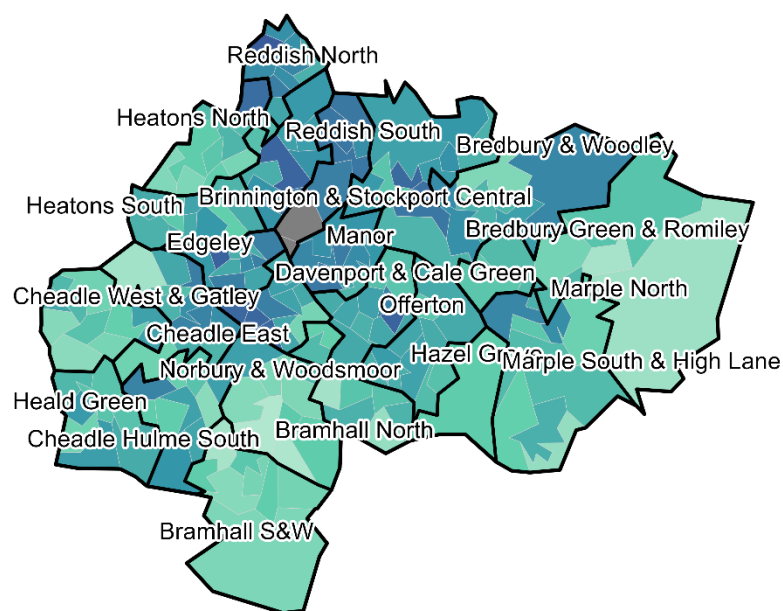
In Stockport, participation in active gambling is associated with deprivation, where LSOAs with higher relative deprivation are associated with a higher proportions of adults actively gambling online (Figure 29).

Online Gambling Activity and Deprivation Across Stockport LSOAs

Data shows the percentage of the adult population (18+) per LSOA estimated to be people who actively gamble online.

Local Prevalence Online Gambling

LSOA-level prevalence



Online Gambling by IMD Decile

Each point represents an LSOA, grouped by IMD 2025 decile.

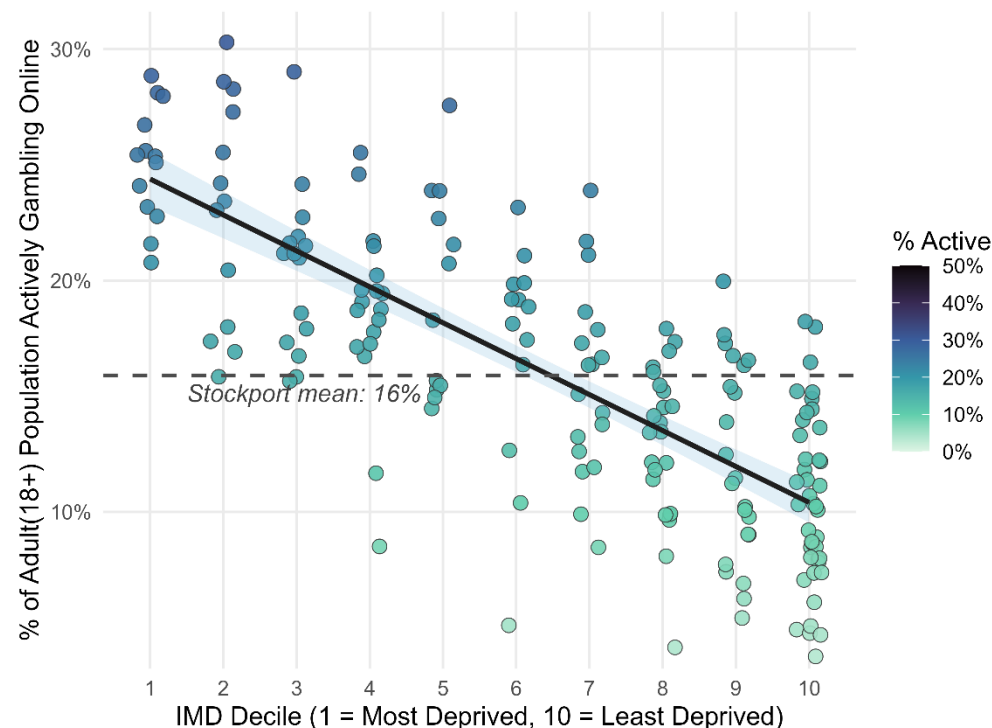


Figure 29. Online gambling activity mapped per Stockport LSOAs and plotted by IMD decile. The average proportion of people actively gambling online is 16% per LSOA. Source: Great Britain Gambling Behaviours Classification (GB2C) (LSOA Geography).

People Gambling Online with High Frequency, High Stakes Loses

Statistical techniques (see Appendix G) were used by the data authors to classify people who actively gamble online into groups according to their online gambling behaviours (e.g. patterns of play, frequency, method of gambling) and their demographic characteristics (e.g. age, gender). Of these, nationally over half (54%) are grouped as those who take part in betting and gaming (BG), 21% in betting only (B) and 26% in gaming only (G). Across Stockport LSOAs, the most common classification of people who gamble online was Betting and Gaming 5 (BG5), characterised by high frequency, high stake losses. Although the most common classification overall, the estimated proportion of people classified as BG5, of those who actively gamble online, varies substantially across Stockport (Figure 30). For example, estimates range from 0% to 37%, with a mean of 14% per LSOA.

Betting and Gaming 5 (BG5):

Frequency: 57% days of each year (209 days)

Deposits: 18 per month on average

Monthly losses: 6x average losses

Gender: 16.5% female

Percentage BG5 Online Gambling Across Stockport

Percentage of people estimated to be in the Betting and Gaming 5 (BG5) Classification, of those who actively gamble online, per LSOA.

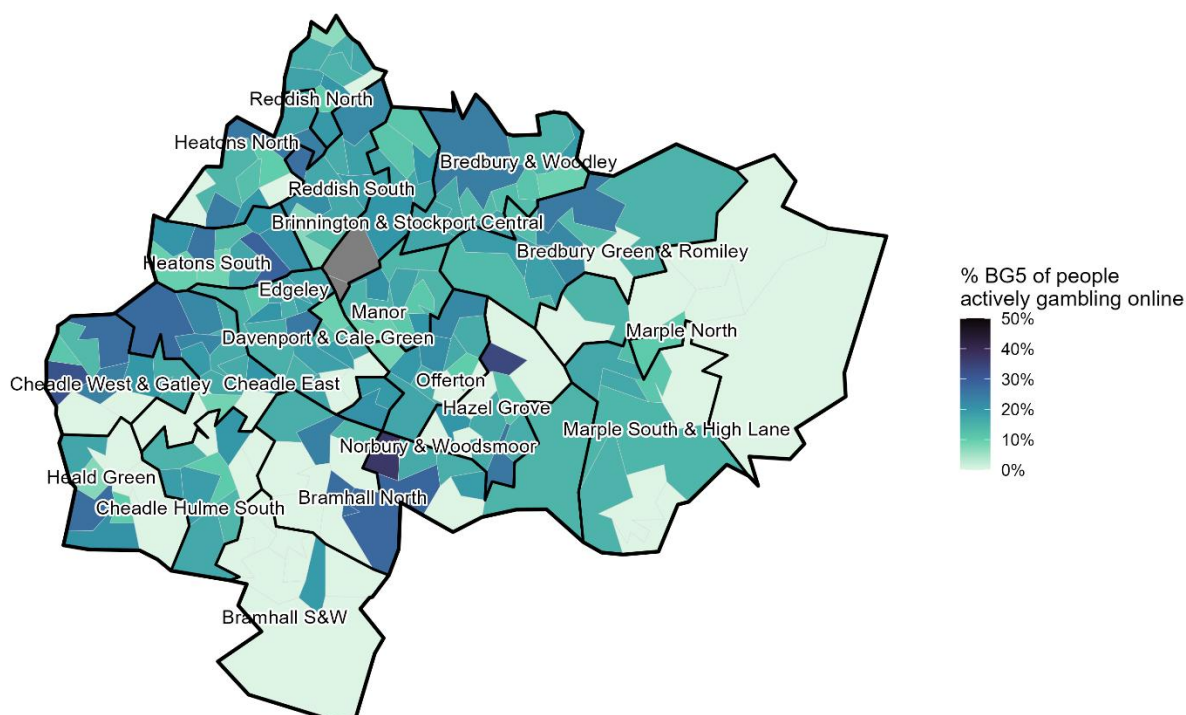


Figure 30. Percentage of active gamblers estimated in the BG5 classification mapped per Stockport LSOAs. Source: Great Britain Gambling Behaviours Classification (GB2C) (LSOA Geography).

Of the subgroups people who gamble online were classified into, BG5 (people with high frequency, high stake losses) is most strongly associated with deprivation. At the ward level, Bredbury & Woodbury, Davenport & Cale Green, and Reddish contain the largest estimated populations of people classified as BG5 online gamblers. Shown in Figure 31, Norbury & Woodsmoor had the highest proportion of the ward population classified as BG5, but with a smaller total population.

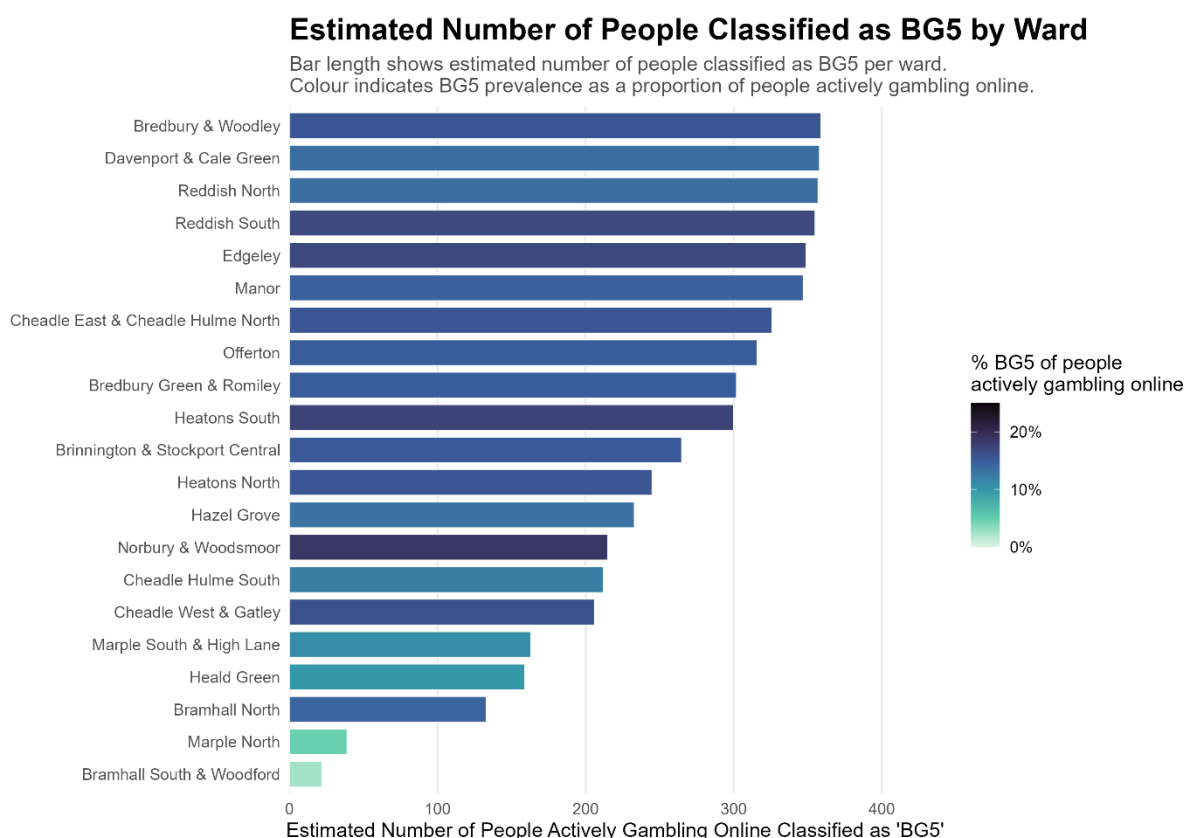


Figure 31. Total estimated numbers of active gamblers estimated in the BG5 classification per Stockport Wards. Colour indicates values as a proportion of the population within each ward. Source: Great Britain Gambling Behaviours Classification (GB2C) (LSOA Geography).

Gaps

Following this needs assessment, several knowledge gaps were identified for further development. These areas for further research and local understanding include:

- Evaluation of effectiveness of prevention level interventions, including cost-benefit estimations.
- Greater assessment of online gambling participation and associated harms. For example, real time data linkage could be considered to better understand patterns of online gambling at the local level.
- Community engagement across Stockport, to better understand the views, perspectives and experiences of Stockport residents, including those not currently experiencing gambling-related harm.
- Evidence of the uptake and use of existing prevention interventions within Stockport, such as use of in-person and online self-exclusion schemes.

Links to wider Stockport strategy

Approaches to local prevention of gambling-related harm are consistent with wider strategy to improve health and wellbeing for everyone in Stockport, including:

- The One Health and Care Plan 2024-2029
- The Early Help and Prevention Strategy 2025 to 2030
- One Stockport Mental Health and Wellbeing Strategy 2023-2030
- Stockport Local Plan 2026-2042 (in development)
- Greater Manchester Live Well

Recommendations

Recommendation	Example Actions
Local policy	
Ensure the emerging Stockport local plan addresses gambling-related harm, paying due regard to the greater impact of gambling premises within the most deprived areas of Stockport.	Embed a specific policy limiting the development of gambling premises through Stockport's Local Plan, currently in development. Broadly consider environmental factors linked to gambling-related harm, such as gambling advertising and premises, referring to health impacts and inequalities.
Ensure organisational policies within Stockport local authority work to prevent gambling-related harm and support people affected.	Include gambling related harm as a priority in Stockport local authority workforce policy.
Licensing	
Share local understanding of gambling-related harm with colleagues in licensing to support decision-making consistent with existing licensing objectives and priorities outlined in Stockport's 2025-2028 Statement of Licensing Principles.	Public health teams work together with licensing to explore the potential of using Gambling Impact Assessments (GIAs) to affect future licensing issues.
Consider a review of Stockport's Statement of licensing principles, with a view to better enable its outlined priorities.	Amend Stockport's Statement of licensing principles to include the option of GIAs in line with the English Devolution and Communities Act 2026.
Marketing and advertising	
Prevent the use of council owned estates for gambling promotion, sponsorship or advertising.	Formalise a unified policy on marketing and advertising in relation to commercial determinants of health.
Advocate for key community partners to seek alternative sponsors and promotions from gambling-industry funding.	Work in partnership with groups such as the Association of Directors of Public Health to recommend national policy changes based on evidence of harm e.g. the introduction of a gambling advertising, promotion, and sponsorship ban.

Take steps to counter-act the impacts of targeted marketing and advertising where there is evidence of probable harm.	Heighten or tailor counter-marketing strategies at key periods such as during major sporting events, when residents may be at increased risk of the consequences of advertising.
Develop understanding and improve the evidence base on local resident's experiences of marketing and advertising.	Use surveys, qualitative research, community engagement or experience sampling methods to understand the reach and impact of online gambling advertising within Stockport.
Partnership working	
Build relationships and establish networks with stakeholders across Stockport to share learning and decision making around gambling harms.	Establish a Stockport gambling harms steering group, inviting key stakeholders including those identified in stakeholder mapping.
Establish research links to academic institutions to support research and evaluation into public health approaches to gambling harms within Stockport.	Work with an established research institution, such as a local academic institutions or partnerships (e.g. Gambling Harms Research UK (GHR-UK) Evidence Centre) to deliver a piece of research or evaluation.
Work alongside regional partners to achieve shared strategic aims and priorities in the prevention of gambling related harm.	Contribute to Greater Manchester Combined Authority Gambling Harms Working Group. Standardise approaches to collecting and data collection and sharing across the region.
Children and young people	
Schools across Stockport will work together to adopt and implement new national curriculum on gambling related harm.	Support schools to deliver new curriculum, involving stakeholders and promoting a public health approach to the messaging used in education settings.
Suicide prevention	
Record and report deaths by suicide where gambling is present and may have contributed.	Work with Manchester coroner's service to support the recording and monitoring of gambling in prevention of future deaths reports.
Evaluate pathways for families affected by bereavement with gambling-related suicide.	
Ensure gambling is recognised as a risk factor for suicide in local resources and training. Include local crisis services as a key recipient of training.	Offer training or joint-working with Open Door Stockport on gambling-related harms an suicide.
Screening and training	

Encourage statutory services to audit adherence to NICE guidance in the screening of gambling harms.	Support Stockport primary and secondary care health services to trial and audit assess current screening of gambling related harms.
Increase awareness of frontline staff about gambling related harms and preventative actions that can be taken as part of Stockport Live Well	Complete Gambling Harm Awareness Training (ChapterOne)
Support Stockport partners to implement brief screening questions to identify people experiencing gambling related harms, including affected others.	Work with partners in key areas such as adult social care, resident advice and support to train staff in screening for gambling harm. Embed a standardised approach to recording referrals and signposting within this, so that this can be compared to local NHS treatment data.
Prevention interventions	
Consider local feasibility of prevention interventions, prioritising those with low risk of harm or an established evidence base for effectiveness. Consider iatrogenic harm from 'healthwashing' when assessing risk of harm.	Promote and share access to self-exclusion information alongside signposting , as a form of intervention which has an evidence base alongside .
Implement and adhere to OHID guidance on conflict of interests processes in the funding and provision of prevention interventions.	Ensure all recipients of local authority statutory levy funding complete a declaration of potential conflicts of interest.
Avoid a 'one size fits all approach' to engagement, tailor counter-marketing campaigns towards specific groups.	Target counter-marketing at the neighbourhood level based on local evidence of gambling activity or inequalities such as high deprivation.
Be proactive in developing a culturally nuanced understanding of counter-marketing and best practices for engaging minoritised communities and specific cultural groups around gambling harms.	Consult community members on gambling-related harms to seek their input, regardless of whether they have direct experience of gambling harms themselves.
Lived experience	
Embed and learn from people with lived experience of gambling harms in approaches to prevention.	Include experts by experience in a Stockport gambling harms steering group.

Promote engagement with and share the stories of people with lived experience of gambling harm who may have limited representation.	Tailor lived experience resources to better recruit and seek the engagement of people with experiences of intersectionality, such as people from the LGBTQ+ community and the Global Majority.
Evaluation and monitoring	
Develop frameworks for the evaluation of approaches to gambling harm prevention.	Consider at a minimum the potential impact of interventions such as activity, reach or engagement. Work towards cost-benefit evaluations, and process evaluation of complex interventions.
Establish systems to monitor the access to treatment and specialist intervention by people experiencing gambling-related harms.	Standardise the recording of data on screening, referrals and signposting for gambling-harms across Stockport commissioned services and partners. Continue to work with treatment service to share information and evaluate the number of referrals.
Work with local or partner experts in research to evaluate Stockport's approaches to gambling-related harm prevention.	Complete qualitative evaluation of a public health intervention, with aims such as to understand the experiences of people accessing an intervention or evaluating its feasibility and acceptability.
Evidence gaps	
Update reviews of the evidence base as it continues to develop in key under-researched areas.	Review evidence of gambling related harm in people experiencing homelessness and gender-based violence.
Develop advanced approaches to understanding an increasingly online landscape of gambling harms.	Consider data linkage or sharing approaches. Maintain independence from gambling industry, but consider advance approaches such as modelling based on banking transaction data.
Build on present needs assessment to improve insights at the local and neighbourhood level.	Implement a 'gambling vulnerability index', based on local and national indicators to inform where public health interventions should be prioritised locally.

References

1. Burton JK, Merrill PF. Needs assessment: Goals, needs and priorities. In: Briggs LJ, Gustafson KL, Tillman MH, 2nd, eds. *Instructional Design: Principles and Applications*. Educational Technology Publications; 1991:17-43.
2. Gambling Act 2005. 2005;Chapter 19.
<https://www.legislation.gov.uk/ukpga/2005/19>
3. Association of Directors of Public Health. *Policy Position: Gambling*. The Association of Directors of Public Health; 2026:1-7. <https://www.adph.org.uk/wp-content/uploads/2026/03/ADPH-Gambling-Policy-Position-Statement-1.pdf>
4. Greater Manchester Combined Authority, Association of Directors of Public Health Yorkshire and Humber, Association of Directors of Public Health North East. *Words Can Hurt: Language Guide for Gambling Harms*. Greater Manchester Combined Authority; 2024:1-8. <https://www.greatermanchester-ca.gov.uk/media/9505/language-guide-01-03-24.pdf>
5. van Schalkwyk MCI, Petticrew M, Cassidy R, et al. A public health approach to gambling regulation: countering powerful influences. *Lancet Public Health*. 2021;6(8):e614-e619. doi:10.1016/S2468-2667(21)00098-0
6. van Schalkwyk MC, Cassidy R. Why do we tolerate the activities of the gambling industry? *Future Healthc J*. 2025;12(2):100267. doi:10.1016/j.fhj.2025.100267
7. Greater Manchester Combined Authority. *Gambling Harms in Greater Manchester: Strategic Needs Assessment*. Greater Manchester Combined Authority; 2022. Accessed July 2, 2026. <https://www.greatermanchester-ca.gov.uk/media/6155/gambling-harms-in-gm-needs-assessment-may-2022.pdf>
8. Mills T, Grimes J, Caddick E, et al. 'Odds Are: They Win': a disruptive messaging innovation for challenging harmful products and practices of the gambling industry. *Public Health*. 2023;224:41-44. doi:10.1016/j.puhe.2023.08.009
9. Luquiens A, Guillou M, Giustiniani J, et al. Pictograms to Aid Laypeople in Identifying the Addictiveness of Gambling Products (PictoGRRed Study). *Sci Rep*. 2022;12(1). doi:10.1038/s41598-022-26963-9
10. Gambling Commission. *Gambling Business Data on Gambling to December 2025 (Published February 2026)*. Gambling Commission; 2026. <https://www.gamblingcommission.gov.uk/statistics-and-research/publication/gambling-business-data-on-gambling-to-december-2025-published-february-2026>
11. Canale N, Vieno A, Griffiths MD. The Extent and Distribution of Gambling-Related Harms and the Prevention Paradox in a British Population Survey. *J Behav Addict*. 2016;5(2):204-212. doi:10.1556/2006.5.2016.023

12. García-Castro J, Cancela A, Cárdaña MAM. Neural cue-reactivity in pathological gambling as evidence for behavioral addiction: a systematic review. *Curr Psychol N B NJ*. Published online November 4, 2022;1-12. doi:10.1007/s12144-022-03915-0
13. McGrath DS, Meitner A, Sears CR. The specificity of attentional biases by type of gambling: An eye-tracking study. *PloS One*. 2018;13(1):e0190614. doi:10.1371/journal.pone.0190614
14. Habib R, Dixon MR. Neurobehavioral evidence for the “Near-Miss” effect in pathological gamblers. *J Exp Anal Behav*. 2010;93(3):313-328. doi:10.1901/jeab.2010.93-313
15. Dixon MJ, Stange M, Larche CJ, Graydon C, Fugelsang JA, Harrigan KA. Dark Flow, Depression and Multiline Slot Machine Play. *J Gambl Stud*. 2018;34(1):73-84. doi:10.1007/s10899-017-9695-1
16. Gambling Commission. *Industry Statistics - Annual Report - Financial Year April 2024 to March 2025 - Official Statistics*. Gambling Commission; 2025. <https://www.gamblingcommission.gov.uk/statistics-and-research/publication/industry-statistics-annual-report-financial-year-april-2024-to-march-2025>
17. Wardle H, Kolesnikov A, Fiedler I, Critchlow N, Hunt K. Is the economic model of gambling dependent on problem gambling? Evidence from an online survey of regular sports bettors in Britain. *Int Gambl Stud*. 2023;23(1):139-159. doi:10.1080/14459795.2022.2088823
18. National Institute for Health and Care Excellence (NICE). Gambling-related harms: identification, assessment and management. *NICE Guidel*. Published online January 28, 2025. <https://www.nice.org.uk/guidance/ng248>
19. Fisher ML, Piper T, Fitzpatrick M, et al. Legal and regulatory responses to online gambling harms: a scoping review of evidence. *Harm Reduct J*. 2025;22(1):163. doi:10.1186/s12954-025-01292-y
20. Clune S, Ratnaik D, White V, et al. What is known about population level programs designed to address gambling-related harm: rapid review of the evidence. *Harm Reduct J*. 2024;21(1):118. doi:10.1186/s12954-024-01032-8
21. McMahon N, Thomson K, Kaner E, Bamba C. Effects of prevention and harm reduction interventions on gambling behaviours and gambling related harm: An umbrella review. *Addict Behav*. 2019;90:380-388. doi:10.1016/j.addbeh.2018.11.048
22. van Schalkwyk MCI, Hawkins B, Petticrew M. The politics and fantasy of the gambling education discourse: An analysis of gambling industry-funded youth education programmes in the United Kingdom. *SSM - Popul Health*. 2022;18:101122. doi:10.1016/j.ssmph.2022.101122

23. Heirene RM. Preventing lower-level gambling harms: Shifting from individual- to system-frame approaches. *Addiction*. 2026;n/a(n/a). doi:10.1111/add.70467
24. NHS England. *Chapter 7: Gambling Behaviour*. NHS England; 2025. Accessed July 2, 2026. <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/gambling-behaviour>
25. Dowling NA, Merkouris SS, Dias S, et al. The diagnostic accuracy of brief screening instruments for problem gambling: A systematic review and meta-analysis. *Clin Psychol Rev*. 2019;74:101784. doi:10.1016/j.cpr.2019.101784
26. Forward C, Norrie C, Bramley S, et al. Assessing potential brief screening questions for use within different social care-related contexts to identify individuals experiencing gambling-related harms: A scoping review. *Health Soc Care Community*. 2022;30(6):e3519-e3533. doi:10.1111/hsc.13976
27. Norrie C, Forward C, Manthorpe J, et al. *Recommendations for Embedding a Question about Gambling Harms to Individuals and Affected Others in Adult Social Care Services*. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London; 2023. doi:10.18742/pub01-159
28. World Health Organization. *WHO Framework for Meaningful Engagement of People Living with Noncommunicable Diseases, and Mental Health and Neurological Conditions*. World Health Organization; 2023. <https://www.who.int/publications/i/item/9789240073074>
29. Raybould JN, Larkin M, Tunney RJ. Is there a health inequality in gambling related harms? A systematic review. *BMC Public Health*. 2021;21(1):305. doi:10.1186/s12889-021-10337-3
30. Gambling Commission. *Gambling Survey for Great Britain - Annual Report (2025): Official Statistics*. Gambling Commission; 2026. <https://www.gamblingcommission.gov.uk/statistics-and-research/publication/gambling-survey-for-great-britain-annual-report-2025-official-statistics>
31. Dymond S, Dighton G, Wood K. *The United Kingdom Armed Forces Veterans' Health and Gambling Study*. Forces in Mind Trust / Swansea University Centre for Military Gambling Research; 2021. <https://s31949.pcdn.co/wp-content/uploads/20210906-SwanseaUni-Gambling2-Report-v8-FINAL.pdf>
32. Dighton G, Treacy S, Hoon A, Dymond S. Gambling-related harm as experienced by UK Armed Forces veterans and affected others: a thematic framework analysis. *BMJ Mil Health*. Published online August 4, 2025:military-2025-003028. doi:10.1136/military-2025-003028

33. Bunn C, Ukhova D, Biggar B, et al. *Gambling Harms in Blackburn with Darwen: A Needs Assessment*. University of Glasgow; 2025. doi:10.36399/gla.pubs.352430
34. Deutscher K, Gutwinski S, Bermpohl F, Bowden-Jones H, Fazel S, Schreiter S. The Prevalence of Problem Gambling and Gambling Disorder Among Homeless People: A Systematic Review And Meta-Analysis. *J Gambl Stud*. 2023;39(2):467-482. doi:10.1007/s10899-022-10140-8
35. Sharman S, Dreyer J, Clark L, Bowden-Jones H. Down and Out in London: Addictive Behaviors in Homelessness. *J Behav Addict*. 2016;5(2):318-324. doi:10.1556/2006.5.2016.037
36. Stockport Homes Group, Stockport Metropolitan Borough Council. *Homelessness and Rough Sleeping Strategy 2021-2026PY - 2021*. stockporthomes.org
37. Bramley S, Norrie C, Manthorpe J. Gambling-related harms and homelessness: findings from a scoping review. *Hous Care Support*. 2018;21(1):26-39. doi:10.1108/HCS-02-2018-0003
38. Mabhala M, Esealuka WA, Nwufo AN, et al. Homelessness Is Socially Created: Cluster Analysis of Social Determinants of Homelessness (SODH) in North West England in 2020. *Int J Environ Res Public Health*. 2021;18(6). doi:10.3390/ijerph18063066
39. Wardle H, Wetherall K, Wyllie J, et al. Suicidal ideation among people with different gambling behaviour profiles: analysis of a longitudinal survey of people who gamble regularly in the UK. *BJPsych Open*. 2026;12(1):e38. doi:10.1192/bjo.2025.10935
40. Jones M, Boering P, Patel K, Leightley D, Dymond S. Gambling, suicide and mental health treatment utilisation in Wales: case-control, whole-population-based study. *BJPsych Open*. 2025;11(6):e234. doi:10.1192/bjo.2025.10867
41. Templeton L, Jacobson J, Murray A. "We Were Not Included – There Was No Thought about Our Loss": Experiences of the Inquest Process among Families Bereaved by Gambling-Related Suicide. ICPR, CDAS, and Gambling with Lives; 2025. <https://www.gamblingwithlives.org/wp-content/uploads/2025/01/VL-GwL-report-FINAL.pdf>
42. Department of Health and Social Care. *Suicide Prevention Strategy for England: 2023 to 2028*. 2023. <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028>
43. Greater Manchester Integrated Care Partnership. *Greater Manchester Suicide Prevention Strategy 2025–2030*. 2025. <https://gmintegratedcare.org.uk>
44. Royal College of General Practitioners. Gambling. Published online September 11, 2023. <https://elearning.rcgp.org.uk/course/view.php?id=760>

45. Suomi A, Bailey M, Lucas N, Dowling N, Delfabbro P. "It's like you're not even there...": Gambling harm experienced by children of gambling parents. *Child Youth Serv Rev.* 2023;145:106800. doi:10.1016/j.childyouth.2022.106800
46. NHS Northern Gambling Service. 2026.
<https://www.northerngamblingservice.nhs.uk/>
47. Goodwin B, Browne M, Rockloff M, Rose J. A typical problem gambler affects six others. *Int Gambl Stud.* Published online June 7, 2017:1-20.
 doi:10.1080/14459795.2017.1331252
48. Dowling NA, Hawker CO, Merkouris SS, Rodda SN, Hodgins DC. Addressing gambling harm to affected others: A scoping review (Part I: Prevalence, socio-demographic profiles, gambling profiles, and harm). *Clin Psychol Rev.* 2025;116:102542. doi:10.1016/j.cpr.2025.102542
49. Gambling Commission. *Insights into Affected Others from the GSGB: Prevalence and Characteristics of Affected Others.* Birmingham: Gambling Commission; 2026.
<https://www.gamblingcommission.gov.uk/report/insights-into-affected-others-from-the-gsgb/prevalence-and-characteristics-of-affected-others>
50. Kolandai-Matchett K, Wenden Abbott M. Gaming-Gambling Convergence: Trends, Emerging Risks, and Legislative Responses. *Int J Ment Health Addict.* 2022;20(4):2024-2056. doi:10.1007/s11469-021-00498-y
51. Kim HS, King DL. Gambling-gaming convergence: new developments and future directions. *Int Gambl Stud.* 2020;20(3):373-379.
 doi:10.1080/14459795.2020.1822905
52. Larche CJ, Chini K, Lee C, Dixon MJ, Fernandes M. Rare Loot Box Rewards Trigger Larger Arousal and Reward Responses, and Greater Urge to Open More Loot Boxes. *J Gambl Stud.* 2021;37(1):141-163. doi:10.1007/s10899-019-09913-5
53. Han W, Li R, Lin Y. Adolescents and loot boxes: a systematic review of behavioral mechanisms and problematic outcomes. *Addict Behav.* 2026;181:108738.
 doi:10.1016/j.addbeh.2026.108738
54. Palmer L, Brooks GA, Clark L. A longitudinal replication study testing migration from video game loot boxes to gambling in British Columbia, Canada. *BMC Psychol.* 2025;13(1):459. doi:10.1186/s40359-025-02766-1
55. Zendle D, Cairns P. Loot boxes are again linked to problem gambling: Results of a replication study. *PloS One.* 2019;14(3):e0213194.
 doi:10.1371/journal.pone.0213194
56. Office for Health Improvement and Disparities. *The Economic Cost of Gambling-Related Harm in England: Evidence Update 2023.* Department of Health and Social Care; 2023.
<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attach>

hment_data/file/1128002/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf

57. Office for Health Improvement & Disparities. *Gambling Treatment: Assessing the Current System in England*. GOV.UK; 2024.
<https://www.gov.uk/government/publications/gambling-treatment-assessing-the-current-system-in-england/gambling-treatment-assessing-the-current-system-in-england#findings>
58. Office for National Statistics. Ethnic group, England and Wales: Census 2021. Published online 2022.
<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021>
59. McGrane E, Wardle H, Clowes M, et al. What is the evidence that advertising policies could have an impact on gambling-related harms? A systematic umbrella review of the literature. *Public Health*. 2023;215:124-130.
 doi:10.1016/j.puhe.2022.11.019
60. McKevitt S, White M, Petticrew M, et al. Characterizing restrictions on commercial advertising and sponsorship of harmful commodities in local government policies: a nationwide study in England. *J Public Health Oxf Engl*. 2023;45(4):878-887.
 doi:10.1093/pubmed/fdad155
61. Fenton K, Prochaska W. Ending gambling adverts could prevent harm to millions of adults and children in the UK. *BMJ*. 2025;388:r158. doi:10.1136/bmj.r158
62. Maani N, van Schalkwyk MC, Petticrew M, Buse K. The pollution of health discourse and the need for effective counter-framing. *BMJ*. 2022;377:o1128.
 doi:10.1136/bmj.o1128
63. Marko S, Thomas SL, Pitt H, Daube M. The impact of responsible gambling framing on people with lived experience of gambling harm. *Front Sociol*. 2023;8:1074773.
 doi:10.3389/fsoc.2023.1074773
64. Spicer A, Andrade M, Weiss-Cohen L, et al. 'Gambling products are designed to be addictive': an experimental comparison of counter-industry gambling harm prevention messages. *Behav Public Policy*. Published online 2026:1-24.
 doi:10.1017/bpp.2026.10034
65. Torrance J, John B, Greville J, O'Hanrahan M, Davies N, Roderique-Davies G. Emergent gambling advertising; a rapid review of marketing content, delivery and structural features. *BMC Public Health*. 2021;21(1):718. doi:10.1186/s12889-021-10805-w
66. Killick E, Griffiths M. Impact of Sports Betting Advertising on Gambling Behavior: A Systematic Review. *Addicta Turk J Addict*. 2022;8:201-214.
 doi:10.5152/ADDICTA.2022.21080

67. Saunders M, Rogers J, Roberts A, Gavens L, Huntley P, Midgley S. Using geospatial mapping to predict and compare gambling harm hotspots in urban, rural and coastal areas of a large county in England. *J Public Health*. 2023;45(4):847-853. doi:10.1093/pubmed/fdad096
68. Gambling Commission. *Gaming Machine Categories*. Gambling Commission; 2024. <https://www.gamblingcommission.gov.uk/licensees-and-businesses/guide/gaming-machine-categories>
69. Badji S, Black N, Johnston DW. Association between density of gaming venues in a geographical area and prevalence of insolvency: longitudinal evidence from Australia. *Addict Abingdon Engl*. 2020;115(12):2349-2356. doi:10.1111/add.15090
70. Ministry of Housing C and LG. English indices of deprivation 2025. Published online November 17, 2025. <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025>
71. Pitt H, Thomas SL, Bestman A, Randle M, Daube M. Do betting advertisements contain attention strategies that may appeal to children? An interpretative content analysis. *Health Promot J Aust Off J Aust Assoc Health Promot Prof*. 2018;29(3):265-273. doi:10.1002/hpja.12
72. Browne M, Tulloch C, Woodbright MD. From 'Six Others' to Edge Conservation: A Network Reconciliation of Gambling Harm to Others. *J Gambl Stud*. Published online June 17, 2026. doi:10.1007/s10899-026-10521-3

Appendix A – Self exclusion information via ChapterOne and other interventions

CHAPTER ONE

[Home](#)
[Gambling harms](#)
[How and where to get help](#)
[About gambling](#)
[Chapter One](#)

NEED URGENT HELP?

Note: While complete elimination of all gambling content might not be possible due to extensive advertising, taking these steps significantly reduces your exposure.



Block access to gambling websites, products, and online accounts



Block gambling transactions through your bank



Self-exclude from physical venues



See less gambling advertising

GAMSTOP is a free service that will block you from opening or accessing gambling accounts in your name with all licensed online UK gambling companies. You can sign up for six months, one year or five years. At the end of your chosen self-exclusion period, GAMSTOP will not automatically be removed – it will remain in place for a further seven years, or until removed.

Gamban is online software that you buy and install to restrict your phone, laptop, or computer from accessing gambling websites. This is an important part of managing your online safety.

Please be aware it can take up to 24 hours for blocks to start working. You can also do a digital detox and delete any gambling apps and games from the devices you own or access.

Many gambling companies offer user-controlled online tools to limit online gambling, such as deposit limits and "cool off periods". However, the evidence shows these tools are unlikely to provide adequate protection, especially for someone currently suffering harm, so we recommend blocking them completely using the above tools.




Other forms of intervention:

Individual-frame interventions

Target individuals and their decision making or self-regulation.

- (Self)-exclusion
- Informed choice
 - Mandatory statements to players
- Information on treatment
- Staff training
- Voluntary limits
- Pro-active interventions with 'at-risk' players
 - Use of electronic systems for player behaviour monitoring
- Awareness campaigns
 - School-based programmes
- Funding for treatment
- Treatment programmes and education for medical staff

System-frame interventions

Target systems and structures across populations.

- Ban on minors/youth gambling advertisement)
 - Targeted at protecting minors
 - Targeted at protecting self-excluded and 'at-risk' players
 - Targeted at whole population
- Mandatory player identification
- No credit / bonuses
- Restricting location of venues and gambling outside of gambling venues
- Limiting product design
- Funding for prevention
- Limiting number of venues
- Restrictions on ATMs
- Data sharing for research
- Limiting number of EGMs per venue
- Mandatory limits
- Product risk analysis
- Limiting smoking / alcohol
- Limiting gambling venue hours
- Ban on turnover-based pay for staff
- Restricting venue access to higher socio-economic classes only
- Non-resident gambling only

Appendix B– Index of Multiple Deprivation 2025

Indicators

Domain	Description	Weighting
Income Deprivation	Measures the proportion of the population experiencing deprivation relating to low income.	22.5%
Employment Deprivation	Measures the proportion of working age population involuntarily excluded from the labour market.	22.5%
Education, Skills and Training	Measures the lack of attainment and skills in the local population.	13.5%
Health Deprivation and Disability	Measures the risk of premature death and impairment of life quality through poor physical/mental health.	13.5%
Crime	Measures the risk of personal and material victimisation at local level.	13.5%
Barriers to Housing and Services	Measures the physical and financial accessibility of housing and local services.	9.3%
Living Environment	Measures the quality of both the 'indoor' and 'outdoor' local environment.	9.3%

Appendix C- Excess death calculations

Using OHID's methodology, estimated suicide rates attributed to gambling addiction were calculated and applied to the population within Stockport.

Standardised Mortality Ratios were kept consistent with OHID's approach using lower and upper bound estimates from Karlsson and Hakansson (2018), of 9.6-19.3. An age standardised suicide rate per 100,000 of the population was taken from [ONS data from 2022 to 2024](#), with a rate of 9.6 per 100,000. Two approaches to estimating the prevalence of gambling were taken, recognising that the SMR values from Karlsson and Hakansson (2018) are based on estimates of 'gambling disorder'.

OHID estimates of the number of people requiring Tier 4 specialist treatment (n = 950) were used as the preferred indicator. Based on this, between 0.76 and 1.56 excess deaths attributable to gambling per year are estimated within Stockport. Less conservative estimates based on PGSI 8+ prevalence (n = 5755) resulted in estimates between 3.94 and 10.36 excess deaths attributable to gambling per year within Stockport.

$$y = (1 - g)x + gxSMR$$

$$x = \frac{y}{(1 - g) + gSMR}$$

Variable	Meaning	Form
y	Overall suicide rate	deaths per 100,000/year
x	Non-GD suicide rate	deaths per 100,000/year
g	Gambling prevalence	proportion (0–1)
SMR	Mortality ratio	unitless multiplier
PGpop	Gambling population size	persons
Expected	Expected suicides	deaths/year
Actual	Observed suicides	deaths/year

Excess	Attributable suicides	deaths/year
Utility	EQ-5D weight	0–1
QALY value	Treasury value	£70,000/QALY

		Total population	239019		
		PGSI 8+		CBT Tier 4 Treatment Required	
		5755		950	
Stockport	g	0.024		0.004	0.004
	SMR	9.600	19.300	9.600	19.300
	y	9.600		9.600	9.600
	x	7.953	9.837	9.283	8.949
	Expected suicides without gambling	0.458	0.566	0.088	0.085
Actual per year		4.394	10.926	0.847	1.641
Excess		3.936	10.360	0.758	1.556

Appendix D - Stakeholder Mapping Results

Stakeholder Type	Name	Description
Primary care		
	Viaduct	GP federation in Stockport; 32 practices, aim to reduce GP wait times
	NHS Stockport Talking Therapies	NHS service providing evidence-based psychological treatments (e.g. CBT, counselling) for common mental health difficulties such as depression and anxiety. Includes guided self-help and digital interventions.
Cost of Living Advice		
	Resident Advice and Support team	Local authority service providing advice on benefits, housing, cost-of-living support and safeguarding vulnerable residents
	Citizens Advice	Independent charity providing free, confidential advice on debt, housing, employment, benefits and legal issues.
	Welfare Rights Team	Supports residents with the process of appealing benefits claim decisions.
Housing		
	Stockport Housing Partnership	Eight below registered providers forming a partnership with Stockport Council and Stockport Homes.
	Stockport Homes	Arms-length management organisation delivering housing services on behalf of Stockport Council, including tenancy support, homelessness services and neighbourhood management.
	Arawak Walton	Social housing provider with a focus on supporting diverse communities and reducing inequality.
	Great Places Housing Group	Large housing association providing social housing, tenancy support and community development services (including wellbeing initiatives).
	Guinness Northern Counties	National housing provider offering affordable housing and support services, including for vulnerable adults.
	Jonnie' Johnson Housing Trust	Housing association with a strong focus on older people and supported living.
	Mosscares St Vincents	Housing provider offering social housing and community support, including tenancy sustainment and wellbeing services.

	Onward Homes	Regional housing association delivering housing, employment support and neighbourhood regeneration.
	Your Housing Group	Large housing provider delivering general needs housing, supported housing and community programmes.
Schools		
	Health and Wellbeing School Co-ordinator	Role focused on supporting schools to promote health and wellbeing, including prevention, early intervention, and linking education to health services.
	Strategic Lead, Safeguarding and School Liaison	Senior leadership role overseeing safeguarding processes across education settings, ensuring coordinated responses to risk and vulnerability among children and young people.
Drug and alcohol services		
	Mosaic	CYP drug and alcohol service <26yrs, offering family interventions and support (council owned service).
	START	Assessment treatment and referral service
	SDAS (Stockport Drug and Alcohol Service)	Integrated adult treatment service delivered by Pennine Care, Acorn and Intuitive, providing structured treatment, recovery support and harm reduction.
Secondary Care		
	Stockport Neighbourhood Mental Health Team	Formerly Living Well, includes Pennine Care mental health teams, Stockport Mind, Pure Innovations, Stockport Progress and Recovery Centre (SPARC), Age UK Stockport and Disability Stockport.
Homelessness		
	The Wellspring	Homelessness support service.
	Buxton Road	Men's hostel
Domestic Violence		
	Stockport Without Abuse	Specialist domestic abuse service providing refuge accommodation, outreach, advocacy and prevention programmes.
	Ongoing Women's Local Support (OWLS)	OWLS is an award winning community group of experts with lived experience, which offers peer support for women that have, or are going through, domestic abuse.

Specialist mental health		
	Military Veterans Service	MVS is community-based psychological therapy service for veterans who live in Greater Manchester and Lancashire commissioned through Pennine Care.
	Stockport ADHD Adult Diagnostic Service	ADHD and ASD adult assessment and diagnosis service for people aged 16 years and above who are registered with a Stockport GP, commissioned through Pennine Care.
	Stockport Community Learning Disability Team	Multi-disciplinary service supporting people with learning disabilities (healthcare, behavioural support, and care coordination).
Gambling Treatment		
	NHS Northern Gambling Service	Specialist NHS service providing assessment and treatment for people experiencing gambling-related harm and affected others across Northern England
Crisis lines and suicide prevention		
	OpenDoor Stockport	Community-based mental health support service offering counselling, wellbeing groups and crisis support
	Stockport Home Treatment Team	Provide acute (short term) mental health to people aged 16+ in crisis.
	Manchester South Coroner's service	Covers Stockport, Trafford, and Tameside, holding responsibility for investigating deaths that occur that are sudden, unnatural, involve state detention, or have an unknown cause.
Criminal Justice		
	Youth Offending Service (YOS)	Youth Justice team - preventing and reducing offending and re-offending people in young people (8+)
	Stockport Probation Service	Supervises adult offenders in the community and supports rehabilitation.
	Stockport Criminal Justice Mental Health Team	Pennine Care commissioned mental health teams for people with mental health problems who have committed an offence, or show signs of offending behaviour. They provide advice, assessments, risk

		assessment, and some short term interventions, as well as a service for vulnerable adults who are referred by Greater Manchester Police.
	GM GMP Liaison and Diversion Service	Service operates across Greater Manchester and supports those coming into contact with the criminal justice system, screening for vulnerabilities and signposting them to access appropriate healthcare support.
	GMP Licensing Officer	Police licensing role, reviews applications and visits premises.
Experts by experience		
	Chapter One	Manchester wide
	GamHive	Lived experienced group of people directly affected by gambling harms or affected others, across Greater Manchester.
	Gambling with Lives	National charity supporting families affected by gambling-related suicide and campaigning for reform.
	SDAS LE volunteers	Peer support network contributing to service design and recovery support.
Local community		
	Live Well	
	Stockport Armed Forces Community Organisation (SAFCO)	SAFCO is a collaborative of groups, businesses and organisations who work together to support the armed forces and veterans community in Stockport. Run a hub at Hazel Grove civic hall every Tuesday 11am to 2pm, open to those who have served, or are still serving in HM armed forces, and their families.
	Stockport Race Equity Partnership	Stockport based community-rooted strategic charity organisation aiming to create opportunities to improve the integration of ethnically diverse people and increase representation at key decision making levels to help decrease the inequalities that exist.
	Sector 3	Links with VCFSE organisations across Stockport.
Licensing		
	Stockport Metropolitan Borough Council (SMBC) Stockport Licensing Team	Official Licensing Authority responsible for regulating and authorising betting shops, tracks, amusement arcades, and registered small society lotteries.

Planning		
	Stockport Metropolitan Borough Council (SMBC) Planning Team	Stockport Metropolitan Borough Council (SMBC) Planning Team are responsible for managing land use and development, including setting of local planning and granting of <i>sui generis</i> applications.
Academic		
	GHRIP Working Group	Gambling Harms Research and Innovation Partnership Working Group

Appendix E – Affected Other Estimations

Based on modelling by Browne et al., (2026), estimated numbers of people affected by someone else's gambling were calculated, accounting for overlap between people experiencing harm from their own gambling whilst also impacted by someone else's. Small area estimations of the population of people in each PGSI category from Tipping & Wardle (2026) were used in combination with 'fan-out' estimates from Browne et al., (2026)⁷². This method is based on a network approach, estimating of the number of people impacted and the number of relationships between affected people. Mean 'fan-in' estimates of 1.66 were then applied to the estimated figure of unique affected others.

This approach enables estimation of wider harm across a continuum, accounting for the population paradox, where greater total harm occurs at the lower level. As modelling of affected others by Browne et al., (2026) included adults and children over 5 years as affected others, applying a correction to this estimate for adults only (of 0.829), results in a total estimated 24,412 adult affected others in Stockport. A limitation of this approach is that modelling estimates from Browne et al. (2026) are based on the Australian context, however, this estimate of 24,412 adult affected others equates to 10.21% of the Stockport adult population, consistent with higher rates of harm in Stockport compared to the most recent national average estimates of 9% of adults affected by someone else's gambling⁴⁹. To combine this figure for an estimate of overall harm, an overlap of 24.52% reported by Browne et al., (2026) was used, resulting in **an estimated 58,992 people affected by their own or someone else's gambling in Stockport.**

$$36,765 + 29,447 - (29,447 \times 0.2452) = 58,992$$

Upper and lower bound estimates of PGSI populations within Stockport from Tipping and Wardle (2026) were also used.

	Fan out value*	Stockport estimate	LB	UB	Estimate AO	LB	UB
PGSI 1-2	0.62	23668	19425	28479	14673.95	12043.78	17656.87
PGSI 3-7	1.59	7353	5144	10132	11692.05	8178.708	16110.28
PGSI 8+	3.92	5744	3668	8464	22518.29	14377.73	33180.16
Mean Fan-in	1.66						
		36766		Sum/fan-in	29448.37	20843.51	40329.71

Value blend fan-out parameters from Browne et al. (2026) alongside Stockport PGSI estimates (Tipping and Wardle, 2026). LB = Lower Bound, UB = Upper Bound.

Appendix F – GM Premises by Deprivation

Shown in Figure 32, statistically significantly more gambling premises are present in the most deprived LSOAs across Greater Manchester than would be expected for the number of LSOAs in the most deprived IMD 2025 decile across the region. This data is based on publicly available premises register, which may not reflect premises which have active licenses but have since closed or are not in use.

Distribution of Gambling Premises Across Greater Manchester by Deprivation

Observed distribution, compared with 'expected' even distribution per the number of LSOAs in each IMD decile in Greater Manchester.

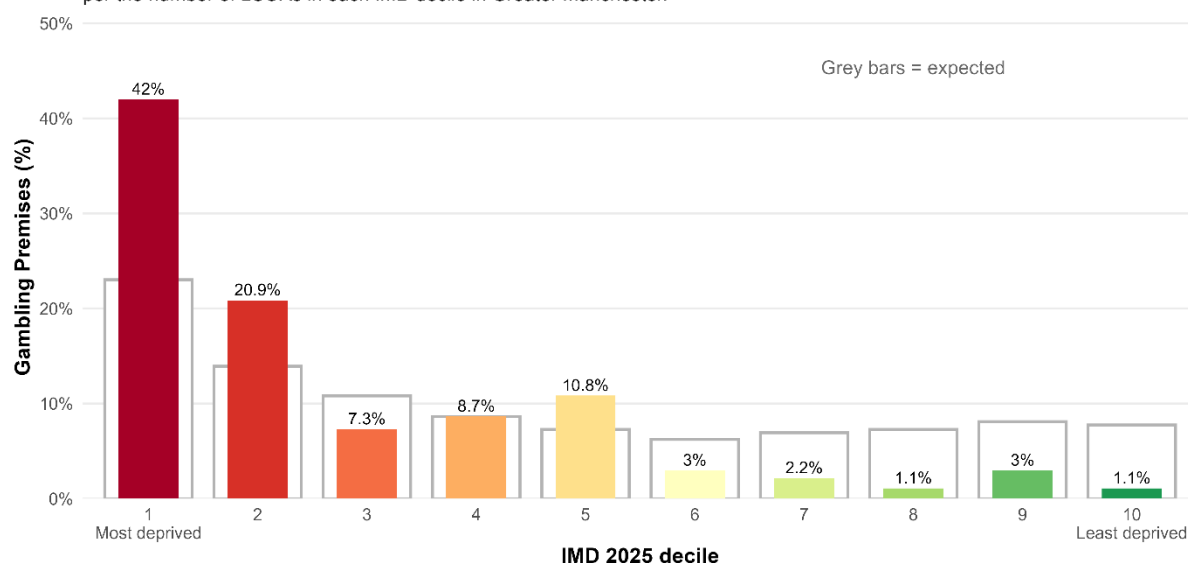


Figure 32. Gambling premises across Greater Manchester, per LSOA by IMD 2025 deciles. Grey bars show expected numbers of premises assuming an even distribution of premises per the number of LSOAs in each IMD 2025 decile. Sources: Premises register; <https://www.gamblingcommission.gov.uk/public-register/premises/download>. IMD 2025⁶⁰

Appendix G – Additional Online Gambling Figures

B2:

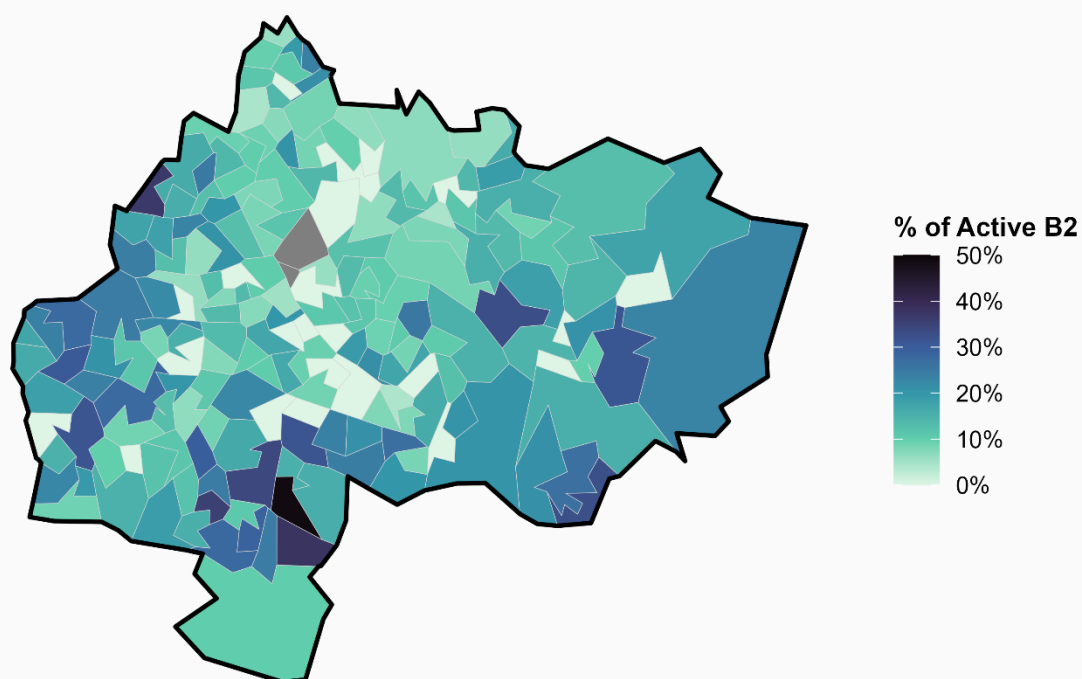
Frequency: 7.5% days of each year (28)

Method: predominantly football betting (80%)

Pattern: typically at weekends or major sports events.

Percentage of Active Gamblers Classified as B2

LSOA-level prevalence of people actively gambling online classified as B2



Sources: GeoDS GB2C; Gambling Commission Premises Register
LSOA = Lower Layer Super Output Area

BG4:

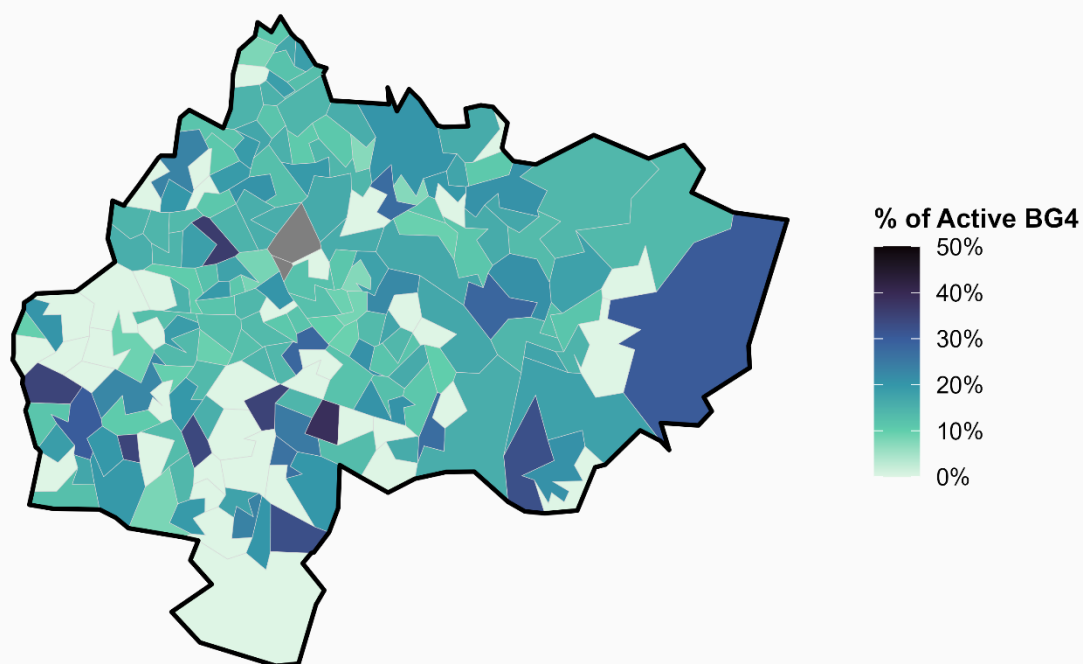
Frequency: 55.5% of days each year (203)

Deposits: 0.5x the average

Gender: 17.9% females

Percentage of Active Gamblers Classified as BG4

LSOA-level prevalence of people actively gambling online classified as BG4



Sources: GeoDS GB2C; Gambling Commission Premises Register
LSOA = Lower Layer Super Output Area